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Integration of Family Planning and HIV Counselling and Testing

- Results of Research in Kenya

- Diplomarbeit -

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[redacted]

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“Integration of family planning and VCT is important to reduce HIV prevalence and unwanted pregnancies. A faster implementation can save life!"(District Clinical Officer)


SUDAN
ETHIOPIA
Ilemi Triangle
Lake Rudolf
Lodwar
Moyale
Marsabit
Wajir
UGANDA
KENYA
GREAT RIFT VALLEY
SOMALIA
KENYA
Eldoret
Mount Kenya
Meru
Kisumu
Nakuru
Garissa
HIGHLANDS
Lake Victoria
NAIROBI
Machakos
Lamu
Malindi
TANZANIA
INDIAN OCEAN
Mombasa
0 100 200 km
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It is my hope that this work will positively contribute to the intended purpose.
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Abbreviations

Aids	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CDC	U.S. Agency Centre of Disease Control
CPR	Contraceptive Prevalence Rate
DHMT	District Health Management Team
FHI	Family Health International
FP	Family Planning
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
KSPA	Kenya Service Provision Assessment Survey
KDHS	Kenyan Demographic and Health Survey
LVCT	Kenyan NGO Liverpool VCT
MCH	Mother and Child clinic
MoH	Ministry of Health
NASCOP	National AIDS and STI Control Programme
PHMT	Provincial Health Management Team
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual and Reproductive Health
STIs	Sexual Transmitted Infections
TFR	Total Fertility Rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	U.S Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Abstract

Background: WHO and UNAIDS have advocated integration of reproductive health and HIV/AIDS an effective approach to increase HIV prevention in high prevalence countries. By integrating HIV Counselling and Testing (VCT) and family planning the access to HIV information and contraceptive methods can be expanded which would lead to a more effective response to the epidemic. Sub-Saharan African countries continue to be most affected by the HIV/AIDS epidemic. In Kenya, the HIV prevalence rate is 6.7% while the contraceptive uptake is relatively low. The Kenyan government has recognized the benefits of integrated family planning and VCT service delivery and implemented the strategy on integration in 2003. It identifies four levels for integrating family planning into VCT sites. The national family planning guidelines define two levels for integrating VCT into family planning services.

Methodology: A cross sectional study was carried out in 2006 in Kenya to investigate the extent of integrated family planning and VCT services currently being provided by service providers. The research was conducted in ten health facilities in Bondo District and applied three different study tools. These include semi-structured interviews with providers of family planning and VCT services, In-depth interviews with key informants engaged in the management of these settings, and a facility assessment. Data analysis was done by using Epi Info and Microsoft Excel.

Results: Family planning and VCT service providers generally offer less than level one of integrated service. Difficulties faced in supervision, training of staff and adequate supplies affect integrated service delivery. At the service delivery level, the study indicate VCT providers are not adequately trained to provide family planning at level one of integration while family planning providers have difficulties in initiating discussions on HIV/AIDS with their clients.

Conclusions: The implementation of the integration strategy in Kenya is a step forward to respond to the HIV epidemic more effectively. But improvements at the management and implementation level are necessary to make good quality integrated service possible. VCT trainings curricula have to contain more comprehensive education on family planning while the nurse's curricula should emphasize on sensitising and strengthening family planning providers for HIV counselling issues. A monitoring and evaluation system should make sure that the conditions at family planning and VCT sites facilitate providers to offer at least level one of integration. Logistic systems have to be improved in a way that HIV testing possibilities are accessible at family planning settings and contraceptive methods are available at VCT sites.

1 Introduction

In 2006, the researcher conducted a study on “Integration family planning and HIV Voluntary Counselling and Testing (VCT) in Kenyan health facilities”. The study was carried out within the German Development Cooperation, on behalf of the German Technical Cooperation (GTZ). Within the GTZ´s reproductive health project in Kenya the study was conducted to investigate to what extent family planning is integrated in Kenyan VCT services and vice versa. The aim of this investigation is to ultimately improve the access to family panning services and HIV-related information for the poor population in rural areas in Kenya, in particular in Nyanza Province.

With a HIV prevalence rate of 6.7%, a total fertility rate of 4.9%, and a relatively low contraceptive uptake of 39%, both HIV prevention and family planning are essential for Kenya. Despite efforts of implementing family planning and VCT services by the Kenyan government and its development partners, the above mentioned indicators are still relatively weak and have become even worse in the last five years. Nyanza Province in the western part of Kenya has the highest HIV prevalence rate of 15% and less then 26% of modern contraceptive utilization.

VCT services are accepted to be a key strategy for HIV prevention and behaviour change. The VCT services offer counselling which enables people to make an informed choice whether they want to undergo HIV testing. People tested positive are provided information on how to live with their status and those who test negative are informed on how to prevent an HIV infection.

Family planning is an integral component of sexual and reproductive health. The objectives of family planning programmes are determined in the reproductive health concept agreed at the International Conference on Population and Development (ICPD) 1994 in Cairo. In line with this concept family planning programmes provide education on contraceptive use and make contraceptive methods available in order to enable individuals to make an informed choice about their reproductive life. The World Health Organization (WHO) emphasises that family planning and education play an important role in preventing unwanted pregnancies, and in reducing maternal mortality, HIV infection rates and unsafe abortions.

The majority of HIV infections are transmitted sexually or as a result of mother-to-child transmission. Thus, the interaction between sexual reproductive health and HIV/AIDS is internationally accepted, and the relevance to Public Health is recognised by international organizations such as the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS), one of the United Nations organizations to assist in the coordination of the

global AIDS response. Integration of reproductive health and HIV/AIDS services is recommended as an effective approach to expand the access to these services and improve their cost-effectiveness.

For the first time integration has been stressed at the ICPD. The agreed ICPD Programme of Action requires universal access to reproductive health services not only as a human right but also as an effective approach to intensify HIV prevention. Since 1994 some efforts have been made to integrate service delivery but they have been not very effective so far. Recently, the WHO and UNAIDS have advocated for integrating HIV/AIDS and reproductive health services to improve HIV prevention.

Integrated family planning and VCT service delivery is expected to reduce HIV infection rates, strengthens awareness of the consequences of sexual behaviour, and increases the utilization of these services. Both services target individuals of reproductive age who are either at risk of getting infected or likely to transmit HIV and at the same time, are also vulnerable to contract other sexually transmitted infections (STIs) and unintended pregnancies. By providing integrated family planning and VCT services individuals are more likely to be assessed for HIV risk and status.

The Kenyan government has already recognised these benefits. Since 2003, the strategy paper on “Integration of HIV Voluntary Counselling and Testing and Family Planning services” has been implemented at the national level. It identifies four levels for integrating family planning into VCT services, each of which takes the providers qualifications and the resources at particular facilities into account. The levels range from level one, the distribution of condoms and oral contraceptives to level four, the provision of a full range of contraceptives by VCT counsellors. Furthermore, the national family planning guidelines define two levels of integrating VCT into family planning service provision, depending also on the level of provider’s training and resources available at the health facility.

As GTZ is one of Kenya’s development partners in the health sector it has realized the need to improve the access to family planning and HIV-related information to the Kenyan population in particular, in the rural areas of the country like in Nyanza Province. For the last 15 years the GTZ focuses its activities on reproductive health in Kenya. In collaboration with the Ministry of Health it works on the improvement of maternal and adolescent health, particularly through the utilization of community-based family planning services. The prevention and control of HIV/AIDS is an integral component of the project. The GTZ initiated this study to investigate whether clients of family planning services receive sufficient education on HIV/AIDS.

The researcher identified integration of family planning and VCT services as an effective strategy to meet the health needs of Nyanza`s population suffering from the highest HIV prevalence rate in the country. Although integration efforts of the Kenyan government were already underway when this study was being conducted no research existed whether and to which extent both services were integrated. Therefore, the main objective of the study was to investigate to what extent VCT and family planning is actually integrated during the counselling sessions by VCT and family planning providers in Nyanza Province, particularly in Bondo District. For that purpose the researcher carried out interviews with providers of these services and with key informants engaged in the management of family planning and VCT settings, and applied a facility assessment in order to collect data on the infrastructure of these facilities. Finally, the study results aim to provide recommendations for improvements of integrated service delivery that would result in an effective integration of family planning and VCT services in Kenyan health services.

The specific objectives of the study are:

- to describe the existing family planning and VCT services
- to identify to what extent family planning is integrated in VCT services and vice versa
- to identify factors affecting integrated family planning and VCT service provision negatively or positively

The following paper includes background information on the study, the study's methodology and its results. At the end the results are discussed in order to formulate recommendations for the improvement of integrated service delivery in Kenya.

The background of the study entails information on the German development policy and the GTZ in addition to the GTZ´s reproductive health project in Kenya (chapter 2.1). The next chapter provides basic demographic data on Kenya and gives an overview on the Kenyan health system. Chapter 2.3 gives background information on family planning. It makes data available on contraceptive use and fertility rates in Kenya in order to demonstrate that particularly rural areas like Nyanza Province have a need to expand the accessibility of family planning services. The last part of this chapter presents national family planning programmes and its service provision. Information on the HIV/AIDS epidemic in general and the situation in Kenya in particular along with efforts that have been made by the Kenyan government and the international community have been reflected upon in chapter 2.4. The last section informs about VCT as a key HIV prevention strategy in Kenya. The chapter 2.5 includes information on integration of HIV/AIDS and

sexual reproductive health and reveals the advantages expected of integrating family planning and VCT service delivery. It demonstrates efforts made by the Kenyan government to integrate these services. It presents the strategy paper on integration comprising of the four levels for integrating family planning into VCT. In addition, it highlights the two levels of integrating VCT into family planning as defined in the family planning guidelines.

Chapter 3 describes the design and methods used to conduct this study, and further it informs about the study's intention and research related questions. Chapter 3.1 shows the study tools used to carry out interviews with family planning and VCT service providers as well as with key informants including policymakers, programme managers and unit managers. Following this 3.2 provides more detailed information on the selected sample. The process of data collection and analysis is described in chapter 3.3 and 3.4. The last chapter reflects on the limitations of this study.

Chapter 4 represents the study results. It provides data describing the VCT and family planning settings visited in Bondo District (4.1). The results in chapter 4.2 indicate to what extent family planning is currently integrated in VCT service provision and vice versa. Chapter 4.3 states and summarizes the factors affecting integrated service delivery.

In chapter 5 the study results are discussed. In 5.1 core results of the study are summarized and compared with the levels defined in the national family planning guidelines and the national strategy paper on integration to assess the level of integration actually provided at family planning and VCT settings. Afterwards (5.2) factors are discussed affecting the integration process which leads to recommendations demonstrated in chapter 6. Finally, in chapter 6.2 areas requiring further improvements to enhance integrated service delivery are stated.

2 Background of the study

The study's background entails information on the German development policy and the GTZ and specifically on the GTZ´s reproductive health project in Kenya. Furthermore, it provides basic data on Kenya and its health system, the family planning situation and the status of the HIV/AIDS epidemic in the country. In the end information on the advantages of integrated HIV/AIDS and sexual reproductive health service delivery is provided. Following this, efforts that have been made by the Kenyan government to implement integrated family planning and VCT services are described.

2.1 The German Development Policy and the GTZ

The GTZ, established in 1975, is organised as a private, government-owned corporation with international operations in sustainable development. It works mainly on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ). The GTZ provides technical support within the International and German Development Cooperation. The German Development Cooperation comprises of the technical cooperation delivered through the German Development Service[1] (DED), the Centre for International Migration and Development[2] (CIM), the Capacity Building International[3] (InWent) and the financial cooperation through the KfW Development Bank.

GTZ focuses on capacity building within its bilateral and multilateral cooperation. In contrast to other German development organizations, it provides advisory services on all levels ranging from implementation to policy making. It works together with local governments and non-governmental organizations (NGOs) in its partner countries and with public and private development organizations at the international level. The GTZ carries out its activities in Africa, Asia, Latin America and Eastern Europe comprising in over 130 partner countries worldwide. Sub-Saharan Africa constitutes a focal region on account of the problems faced by these countries in dealing with high poverty rates, wide-spread HIV/AIDS and the presence of political conflicts.

GTZ´s objectives are embedded in the German development policy. As Germany is a partner country in the international community, its development policy framework, the

[1] The DED assign technical advisors to developing countries. It supports local organizations and self-help initiatives by counselling, and financing small programmes and promoting local specialists. DED has no projects of its own, but reacts at the request of organizations in the partner countries (DED 2007).
[2] CIM places managers and technical experts on behalf of employers in partner countries and supports them with services and with subsidies to improve their local salaries. It recruits experts who have been educated in Germany and want to return to their home countries (CIM 2007).
[3] InWent provides training for international assigned employees in Germany (InWent 2007).

Programme of Action 2015, is based on international agreements and objectives. Since 2000, the Millennium Development Goals (MDGs) derived from the United Nations (UN) Millennium Declaration represent the targets of the international development policy. Within the declaration 189 UN member states agreed on the reduction of world poverty as central global task for international cooperation in the 21st century. Both industrialised and developing countries agreed on eight MDGs to be achieved jointly by 2015 (BMZ 2005).

2.1.1 Activities on Sexual and Reproductive Health

The Programme of Action 2015 includes ten key working areas where from GTZ has derived its five working fields. The health sector is one of GTZ´s main fields of activity. At the latest since the conference in Alma Ata 1978 where the concept of primary health care was identified as a principle strategy for reaching the goal of Health for All by 2000, health is accepted as a basic fundamental right. The enforcement of reproductive and sexual rights for all to reduce infant and maternal mortality, and the control of special diseases including HIV/AIDS are main components of the health sector (GTZ 2006a).

The sexual and reproductive health activities not only of the GTZ but also of all international development partners are based on the Programme of Action derived from the International Conference on Population and Development in Cairo (ICPD) in 1994. Within this conference the universal access to sexual and reproductive health services by 2015 was formulated as a fundamental human right and a key issue to reduce poverty. A wide-ranging 20 year action plan was endorsed that included the concept of reproductive health as follows:

> *"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."* (ICPD 1994)

The concept emphasizes the importance of universal access to sexual and reproductive health services also in order to respond to the rapid spread of HIV/AIDS more effectively. 75% of HIV infections globally, are sexually transmitted and 10% are transmitted during pregnancy and childbirth. It is shown that sexually transmitted infections[4] (STIs) increase the risk of HIV infections and at the same time, HIV/AIDS makes STIs more difficult to treat. The concept recognizes the interrelation between HIV/AIDS and reproductive health. Thus, it puts prevention and treatment of STIs and HIV, as an integral component of reproductive health programmes and services in its centre (ICPD 1994).

The WHO states sexual and reproductive health is an integral component of health because it contributes to the fight against some of the most prevalent causes of illness and death such as unsafe abortion and pregnancy, early pregnancy and STIs including HIV/AIDS. The main reason why pregnancy and sexual behaviour in many countries represent a threat to the health in particular, of women is due to the lack of education, along with shortages of contraceptives and inadequate medical care during pregnancy and childbirth. Thus, the prevention of unwanted pregnancies through family planning and comprehensive education play an important role in reducing maternal mortality and HIV infection rates as does a reduction in the number of unsafe abortions performed (WHO, UNFPA[5]2004).

In line with the ICPD´s programme and in accordance with the WHO's five components of reproductive health[6] and the BMZ "Position Paper on Sexual and Reproductive Health" the GTZ developed its sexual and reproductive health guidelines comprising of the following focal areas (GTZ 2006b):

- Information, public awareness-raising and health promotion with regard to health of the population with the aim of enabling self-decision, as well as to contribute to responsible behaviour
- Realisation of sexual rights, including measures aimed against violence and genital mutilation
- Prevention of unwanted pregnancies and family planning

[4] Sexually transmitted diseases (syphilis, gonorrhoea) are often caused by bacterial and mycological agents and come along with any symptoms. A sexually transmitted infection, gonorrhoea, results in a disease, cervicitis, which may lead to a complication. Permanently impaired fertility would be a resulting sickness (UNAIDS, WHO 2007).

[5] United Nation Population Fund (UNFPA) is an international development agency that promotes human rights of women, men and children to have a life of health and equal opportunities. UNFPA provides technical and financial support in reproductive health activities, gender equality and HIV/AIDS prevention (UNFPA 2007a).

[6] The Who's five major components of reproductive health comprise maternal and newborn health, family planning, prevention of unsafe abortions, prevention of sexually transmitted diseases (STIs) and the promotion of sexual health (WHO, UNFPA 2004).

- Provision of care for women during pregnancy and birth
- The prevention and treatment of STIs, including HIV/AIDS

2.1.2 The Sexual and Reproductive Health Project in Kenya

Since the mid 1970s, the German Development Cooperation provides technical and financial support to the Kenyan government to respond to the relatively low development indicators of the country. 56% of its population live below the poverty line and only 10% of the inhabitants have access to appropriate reproductive health services (Central Bureau of Statistics (CBS) 2003 p. 2-4).

The GTZ focuses its activities on sexual and reproductive health in Kenya since 15 years in order to respond to the relatively weak health indicators. The goal is to improve the access to adequate sexual and reproductive health services for Kenya's population by the expansion of these services, their orientation to the needs of the population and quality standards, and its improved financing mechanisms (Kenyan German Development Cooperation 2003, p. 3). For this purpose the GTZ works in close collaboration with the Kenyan Ministry of Health (MoH) and provides technical assistance to the MoH/division of reproductive health.

The MoH/GTZ Reproductive Health Project carries out activities on the prevention of female genital mutilation in the southern regions of Kenya. In the districts of Western and Nyanza Province the project focuses on family planning because there contraceptive use is low and fertility rates are still the highest in the country. Detailed information on family planning will be provided in chapter 2.3.2.

To increase the access to family planning GTZ carries out the Community Based Distribution project. Trained outreach workers provide family planning to people living in rural areas. In 1996, the project was supplemented by the youth counsellor's component including community-based peers for delivering family planning services to the youth.

2.2 The Kenyan context

This chapter provides basic information on the country and its population, and gives an overview on the structure of Kenyan's health system and its financing.

2.2.1 Demographic data

Kenya is situated in the eastern part of sub-Saharan Africa with a total population of 33.4 million inhabitants (CBS 2006). The country is divided into eight provinces and 72 districts which are further divided into several administrative divisions. Kenya has 42 ethnic groups which are distributed throughout the country. About 80% of its population are living in rural areas and are engaged in peasant subsistence agriculture. While the official language is English the national language is Kiswahili. The main religions are Christianity and Islam.

Despite socio-political stability and efforts in reform processes by the government and its development partners[7] since independency in 1963, Kenya is still among the poorest countries in the world. As mentioned earlier about 56% of Kenya's population live in poverty and over half of them live below the absolute poverty line with less than $1 a day (CBS et al. 2003, p2).

The country is characterized by a young population. Nearly half the population (44 %) is under the age of 15 while no more than 3% are over 65 years old. Women of reproductive age (15-49 years) represent about 26% of the total population. Life expectancy of men and women declined from 60 years in 1989 to 53 years in 2005 (CBS 2006, p.4). While the population growth rate has steadily decreased from 3.8% in 1979 to 2% in 2004 (MoH 2006) the mortality rate has been showing an increasing trend since the 1980s. According to the Kenyan Demographic and Health Survey 2003[8] (KDHS) the increasing mortality rate is associated with the larger number of deaths due to the HIV/AIDS epidemic, the deterioration of health services, and widespread poverty (CBS et al. 2003, p.4).

2.2.2 The health system

Weak health indicators of Kenya's population pose a challenge for the health care system. The government in collaboration with its development partners is working on its improvement to respond to the population's health concerns more effectively. In line with international agreements and resolutions the National Health Sector Strategic Paper II (NHSSP II 2005-2010) has been implemented. It is based on primary health care in order to make healthcare affordable and accessible for the entire population (MoH 2005a, p. 6).

[7] Development partners are a heterogeneous group of international and national public and private organizations providing a variety of technical and reporting requirements and funding modalities. They support a range of interventions in order to reduce poverty and increase population's living standard in a country.

[8] The KDHS 2003 is designed to provide data to monitor the population and health situation in Kenya as a follow-up of the 1989, 1993 and 1998 KDHS surveys. It was carried out by Central Bureau of Statistics in partnership with the Ministry of Health and the National Council for Population and Development.

The Kenyan health services have been decentralized by a layered system of health units, ranging from national referral hospitals to lower-level health centres. As can be seen in the figure below this has led to a pyramidal structure of the health system where the quality of treatment advances the higher up in the pyramid they are found.

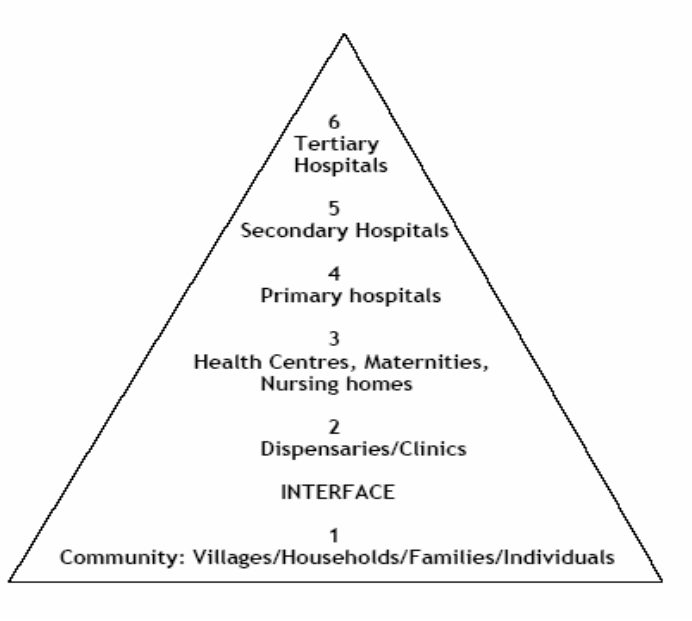

Figure 1: Kenyan health system (NHSSP II 2006, p.13)

While basic primary care is provided at health sub-centres including health centres, dispensaries and mobile units, curative and rehabilitative care is provided at district and provincial hospitals. Dispensaries and health centres are often the first contact for people seeking medical care whereas hospitals are difficult to reach, in particular for the poor population living in rural areas of the country (KIPPRA[9], 2004 p.26).

The decentralisation of power from national to local authorities since the 1990`s intends to ensure that national activities are transferred to the lower health care levels and that people's specific health needs are recognized at national level (MoH 2005a, p.5). The Kenyan Ministry of Health (MoH) is responsible for the formulation and implementation of new policies and has a decisive role in coordinating the health activities of all partners in the health sector. Established Provincial Health Management Teams and District Health Management Teams are responsible for obtaining the community's interest in health planning and to coordinate and monitor the implementation of health projects at district level (KIPPRA 2004, p. 41).

[9] The Kenyan Institute for Public Policy Research and Analysis (KIPPRA) is a private institute whose primary intention is to conduct public policy research (KIPPRA 2004).

Financing of the health system

The Kenyan government uses three sources for financing the health sector. The *budgetary allocation* that is paid by the government either directly to the MoH or indirectly to other sectors that are involved in health-related functions, the *funds of development* partners that address specific national Public Health Programmes and additionally, the support by the *private sector*[10].

While the public health expenditures by the government have declined or remained constant over the last decade due to poor economic growth, the donor support has increased from 8% of the total health budget in 1994 to 16% in 2001(CBS et al. 2004, p.24). However, the Kenyan Service Provision Assessment Survey[11] (KSPA) 2004 and the review of the health system by the Kenyan Institute for Public Policy Research and Analysis show the under financing of Kenyan health sector. This has reduced its ability to ensure an appropriate service provision and has led to low quality due to inadequate medical supplies, lack of transport, and imbalances in staffing. As mentioned earlier the poor population have predominantly access to the primary health care facilities. These facilities are often understaffed, under equipped and have limited access to medicines (KIPPRA 2004, p.26-34).

2.3 Family Planning

The following chapter presents an overview on family planning programmes. The second section provides information on family planning in Kenya including data on contraceptive use and fertility rates, the response of the Kenyan government, and furthermore, it informs about family planning service provision in Kenya.

2.3.1 Objectives and Take-up of Family Planning Programmes

> *"Family Planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility"* (WHO 2006a).

[10] The private sector comprises private-for-profit organizations; private not-for-profit organizations including Faith Based Organizations (FBO), Non Governmental Organizations (NGOs) and Civil Society Organizations (CSO) that are involved in the provision of interventions in poor countries.

[11] The KSPA 2004 is a follow-up to the KSPA 1999. It provides national information on the availability and quality of services from a representative sample of 440 health facilities including hospitals, health centres, dispensaries, maternities, clinics and VCT centres. Family planning, STIs, and HIV/AIDS services were of main interest.

Since the late 1960s family planning programmes have been implemented in national health care systems in most countries of the world. In developing countries family planning were one of the major social and health interventions in the second half of the 20th century and a key component of international development support (Seltzer 2002, p.10). Their implementation has been financially and technically supported by international organizations, such as the U.S. Agency for International Development[12] (USAID), the United Nations Populations Fund (UNFPA), the World Bank and the private sector.

Reasons for their implementation have changed over the last three decades. In the beginning, family planning programmes focused on demographic concerns because negative consequences of the rapid population growth were expected on the economy, natural resources, the environment and thus on people's living standard and welfare. By reducing high fertility rates, family planning programmes were intended to lower population growth which reached 3% in some developing countries in Africa[13] and Asia. During the 1980s concerns about the health consequences of high fertility rates became the main point of interest. High rates of maternal, infant, and child mortality were associated with a high number of pregnancies of older and younger women, and unsafe abortions. In the 1990s concerns on human rights became predominant with the focus on women's rights, reproductive rights and the reproductive health of women and men. This shift toward reproductive rights as a human right is associated with the International Conference on Population and Development (ICPD) in Cairo in 1994 (Seltzer 2002, p.10-14).

Objectives of family planning programmes

Today, the ICPD concept for reproductive health (see chapter 2.1.2) gives the direction for family planning programmes. It says that people should *"(…) have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law (…)"* (ICPD 1994).

Thus, family planning programmes aiming to enable individuals of reproductive age to live their reproductive intention and make their informed choice on contraceptive

[12] USAID is an independent federal government agency that receives foreign policy guidance from the Secretary of State. It has been the principal U.S. agency for supporting countries in recovering from disaster and poverty, and engaging in democratic reforms (USAID 2007).
[13] The following paper uses the term Africa for regions relating to sub-Saharan Africa.

methods[14] by providing information and education on family planning (Hardee et al. 2005, p.105). In addition, family planning programmes intending to make a variety of contraceptive methods available and affordable to all because contraceptives differ in their functioning, their effectiveness, their side effects, and the ease with which they can be administrated as well as their acceptability and attractiveness to users (UNFPA 2004, p.92).

The Take-up of Family Planning programmes

Different indicators are used to measure the take-up of family planning programmes.

- The ***contraceptive prevalence rate*** (CPR) gives information on the proportion of women of reproductive age (15-49) who are using or whose partner is using a contraceptive method at a given point in time. The CPR is also an indicator of health, population, development and women's empowerment (WHO 2007a).
- ***Family planning unmet needs*** are defined as *"(…) the discrepancy which occurs when sexually active women who can become pregnant, and do not wish to have a child in the next two years are not yet using a modern contraceptive method"* (UNFPA 2005, p. 40). Following this, the level of unmet needs also describes the demand for contraceptive methods.
- The ***total fertility rate*** (TFR) provides information on the average expected number of children born alive to a woman during her reproductive years, according to prevailing fertility rates for each age group. The TFR is one of the three principal components including mortality and migration explaining population dynamics (WHO 2007b).

Worldwide data shows that the take-up of family planning has increased over the last three decades. Overall, since the 1970s the fertility rates among women in most parts of the world have declined from 5.7 births per women to 3.0 in 2005. Contraceptive use has significantly increased from about 10% of women in 1965 to about 60% in 2000 but there are significant differences in contraceptive use. While in most countries in Asia and Latin America, contraceptive prevalence is now at 71% and 64%, respectively, the contraceptive prevalence has increased more slowly in Africa. There the use of any method is only 27% and levels of unmet needs are highest in Africa at 63% (UNFPA, PATH 2006, p.9-12). Due to the fact that the number of reproductive age couples in Africa grew by 23% it is expected that up to 2015 the demand for contraceptives will increase in

[14] Contraceptive methods include female and male condoms, sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and natural family planning, as well as lactational amenorrhoea (lack of menstruation during breastfeeding) where it is cited as a method.

African countries by 40% (UNFPA 2005, p.22). Therefore, international organisations such as the WHO and the UNFPA stress the importance of family planning programmes (WHO, UNFPA 2004).

The individual's contraceptive choice is influenced by the social, cultural and economical environment they have grown up with. In African countries gender inequality is high leading to disadvantage for women including access to resources and education and decision making authority. This has its impact on sexual behaviour where men generally have greater control than women over when, where and how sex takes place. In addition, in many African traditions women who bear many children stand for both the man's potency and the woman's healthiness so that women who want to use a contraceptive method often need to hide it (UNFPA, PATH 2006, p.9). Therefore, many women choose a contraceptive method that they can control by themselves and that can be reversed easily (Caldwell J., Caldwell P. p.108).

2.3.2 Contraceptive use, fertility rates and unmet needs in Kenya

Kenya has the third highest contraceptive prevalence rate in Africa. The country has experienced a demographic transition in the late 1970s. It transformed from an African country with the highest fertility rate (8.1%) in the world in 1979 to a country with a contraceptive prevalence rate of 39% in 2003 and a current total fertility rate of 4.9% (CBS et al. 2003, p. 65). Consequently, over the same period population growth rate has steadily decreased from 3.8% in 1979 to 2% in 2004 (MoH 2006) and unmet needs declined from 38% in 1989 to 24% in 2003 (APHRC[15] 2001, p.1).

However, data from the Demographic and Health Survey 2003 indicate a worsening of the situation. The contraceptive prevalence rate has remained unchanged since 1998, the total fertility rate increased from 4.7 in 1998 to 4.9 in 2003 and 20% of pregnancies were unintended in 2003 (CBS et al. 2003, p.52). This suggests that there are gaps in addressing family planning needs in Kenya (Hardee et al. 2005, p.5).

Among the 39% of married women who use contraceptive methods almost all (32%) use a modern method. Injection contraceptives are by far the most preferred method whereas the use of oral contraceptives decreased among all women as well as female sterilization and the use of Intrauterine Contraceptive Devices (IUCDs). The male condom is the most common and most widely available barrier method in Kenya. While 34% of

[15] The African Population and Health Research Center (APHRC) is a international non-governmental organization committed to conducting policy-relevant research on population and health issues facing sub-Saharan Africa (APHRC)

unmarried women use male condoms only 10% of married women use it (CBS et al. 2003, p.65-68).

As is reported in the KDHS 2003 the general awareness of family planning in Kenya is almost universal at 95% among men and women in the reproductive age 15-49 (CBS et al. 2003, p.63). But disparities occur in contraceptives use related to regions and education.

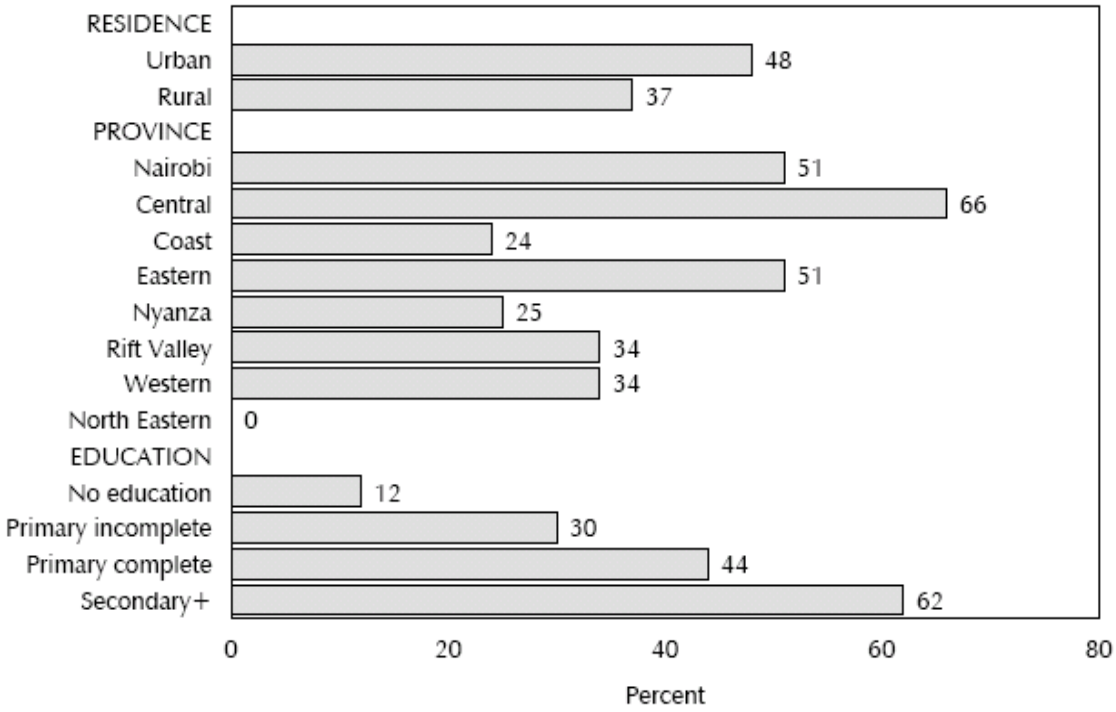

Figure 2: Use of contraceptives among married women (15-49) (CBS et al. 2003, p.72)

As the figure above demonstrates the contraceptive use increases with the level of education. For instance, only 12% of married women with no education use a modern contraceptive method whereas 62% with secondary education use such a method. The regional disparities show that the use of modern methods among married women is the highest in Central Province at 66% and lowest in Coast Province at 24% and Nyanza Province at 25% (CBS et al. 2003, p.70). Consequently, the disparities in fertility rates and unmet needs show a similar picture. The fertility rate at 5.4 children per woman is significantly higher in rural areas than in the urban areas such as Nairobi with 3.3 children per woman (CBS et al. 2003, p.52). The unmet need at 35% is the highest among women living in Nyanza Province and the lowest with 11% in the central region of Kenya (CBS et al. 2003, p. 107).

2.3.2.1 Institutional and policy response

The Kenyan government has responded early to the high population growth (3.3%) and fertility rates 7.2 that occurred in the late 1960s. Kenya was the first African country that adopted a family planning programme in 1967. In 1969 the programme was integrated in a more focused Maternal and Child Health (MCH)/Family Planning Programme (MoH 1997, p.5). However, it was not before 1984 that the National Policy Guidelines and in 1997, its revised version the National Policy for Sustainable Development were implemented to guide the operation of the programme aiming to attain a balanced population growth rate and sustainable development (APHRC 2001, p.2).

In the same year, the Ministry of Health implemented the National Reproductive Health Strategy 1997-2010 based on the principles of the ICPD concept. In line with this concept the strategy integrates family planning as an integral component. It emphasizes the need of MCH/Family Planning Programme to address a broader range of reproductive health issues including HIV/AIDS (MoH 1997, p.vii). The Reproductive Health strategy directs family planning activities and projects carried out by the Kenyan government and its development partners.

2.3.2.2 Family Planning services

The universal access of family planning services implies the location of services within a reasonable travelling distance, user-friendly rules and regulations such as convenient clinic hours, as well as the knowledge of potential users of where to find them and furthermore, the affordability of contraceptives (Seltzer 2002, p.31).

In Kenya three different channels are used for family planning service delivery. They are integrated into ***public and private Mother and Child Health clinics*** like dispensaries, health centres, and hospitals. These facilities generally offer their services five days a week and eight hours a day (CBS et al. 2004, p.7). The family planning services are provided by nurses and midwifes trained in the provision of contraceptive methods. Overall, in Kenya's public health centres family planning providers are represented with 85% (CBS et al. 2004, 29).

Given that the poor population have only limited access to the health infrastructure contraceptive services are also provided through trained ***community based distributors*** (CBDs). The CBD project was implemented in Kenya in the late 1970s. It is using trained outreach workers to make family planning services available at village and community levels. The trained distributors are not allowed to provide the full range of modern contraceptives, only condoms and oral contraceptives.

Furthermore, contraceptives are provided through ***social marketing*** in which they are distributed through existing channels for instance pharmacies where they are sold at low prices. Social marketing is a discipline where the same marketing principles as are being used for selling products to consumers are used, but instead of benefiting the marketer its aim is to influence social behaviours.

Service provision

To provide standardised and quality family planning services national guidelines have been implemented in Kenya since 1991. Currently, the third version "Family Planning Guidelines for Service Providers" 2005 developed by the Ministry of Health with the technical assistance of Family Health International[16] is in operation. It emphasizes that family planning providers should offer a wide range of services comprising of post-abortion care, contraceptives for adolescents, STI/HIV/AIDS prevention and screening, and STIs diagnoses and treatment (MoH 2005b, p.2). In accordance with the guidelines family planning service delivery requires a coordination of activities involving counselling, provision of a wide range of contraceptive methods, follow-up and appropriate referral, supervision, and evaluation and logistic systems. Within these categories the guidelines offer service providers information, instruction and assistance (MoH 2005b, p. 11).

Counselling is highlighted as a central contribution to achieve client's informed consent to adopt a contraceptive method, and furthermore, to enable them a safe and effective use of the method. ***Supervision*** is stressed as an important component to guarantee guidelines are being followed by the providers and problems in service delivery are being identified. For the ***administration of modern contraceptives*** the guidelines are based on the Medical Eligibility Criteria for Contraceptive Use 2004 that is one of the WHO's two guidelines on contraceptive use. It tells family planning providers whether women with a known medical or physical condition can use a given contraceptive method safely and effectively (WHO 2007c).

Availability of contraceptive methods

Results of the Service Provision Analysis 2004 show that not all health facilities in Kenya are able to provide a wide range of modern methods. In fact, the provision of family planning within facilities depends on aspects of the provider's qualification and training as well as on the infrastructure of the facility. While modern contraceptive methods such as

[16] Family Health International (FHI) is among the largest established non-profit organization active in the prevention of HIV/AIDS, support of reproductive health and to improve the health of women and children through research and education. It works together with governmental and non-governmental organizations, research institutions and the private sector (FHI 2007).

oral contraceptives and condoms can be provided with minimal training, the provision of injectable on contraceptives and Intrauterine Contraceptive Device (IUCDs) or implants require a higher level of skill and infrastructure. As results of the survey show, oral contraceptives and male condoms are available in almost all health centres (84%) injectable contraceptives in 80% of these facilities, while IUCDs are accessible only in 32%, and implants only in 4% of these facilities. The proportion of health centres offering any modern contraceptive method have decreased from 88% to 75% during the last five years whereas in general, dispensaries are less likely to have a wide range of methods (CBS et al. 2004, p.93).

2.4 HIV/AIDS

This chapter provides an overview on the HIV epidemic and the international response in general. In particular, it presents data on HIV/AIDS in Kenya, the national response and further, information on HIV Voluntary Counselling and Testing (VCT) services as a key HIV prevention strategy in Kenya.

2.4.1 HIV/AIDS and the international response

Since the first case of HIV/AIDS occurred 25 years ago the HIV epidemic has spread rapidly throughout the world. In 2006, 39.5 million people were infected by HIV/AIDS globally, constituting 37.2 million adults and 2.3 million children. The poorer regions, in particular African countries, continue to be the ones most affected by the epidemic. As reported by the UNAIDS[17] 63% of all HIV infected adults and children live in these countries and the AIDS related death rates continue to be the highest representing 72% of the global AIDS deaths. This has an impact on the life expectancy that has fallen from 60 years to 45 years in some African countries. In 2006, HIV incidence rates in Africa were by far higher than in all other regions of the world (UNAIDS, WHO 2006, p. 3-10).

In African countries conditions exist that increase their population's vulnerability to HIV/AIDS. There HIV/AIDS has always been a heterosexual epidemic and thus the risk

[17] UNAIDS, brings together the efforts and resources of ten UN system organizations to the global AIDS response. Their aims and principles are in line with the Declaration of Commitment on HIV/AIDS and the MDGs. UNAIDS assists in ensuring better coordination among its partners in the UN system, governments, civil society, donors, and the private sector and others (UNAIDS 2007a).

becoming infected is closely linked to sexual and reproductive health behaviours (Mayhew 2004, p. 8).

Biological Factors:

As mentioned before people with untreated STIs have a significantly higher risk of getting infected with HIV. In Africa, many people suffer from STIs which for several decades ranked among the top five causes for which adults sought health care services (UNAIDS, WHO 2007). Furthermore, in settings with high HIV prevalence rates the risk of becoming infected increases enormously (UN Department of Economic and Social Affairs 2005, p.11). It can be said that, the higher the HIV prevalence rates in a country the higher the risk of HIV transmission.

Socio economical factors:

The HIV infection risk is strongly influenced by the socio-economic situation of a country. Primarily the region's poverty is blamed for the rising HIV infection rates because it has reduced the effectiveness of health systems to respond to the epidemic effectively. African health systems often have limited capacities because of lack of trained staff, appropriate supplies and equipment for AIDS prevention work, treatment and care. Besides this, Aids further arguments poverty as it has significant negative effects on the economic conditions of individuals and countries. It affects people in their productive years when they could work and support their families. Thereby, AIDS increases the number of people living in poverty and at the same time it increases the number of people at risk of infection, because those with the smallest resources often have the least access to health care or health-related information (UN Department of Economic and Social Affairs 2005, p. 12-13).

Gender inequalities and traditions:

Gender inequality is another factor influencing the spread of HIV/AIDS. Not only that women and girls generally have a higher risk of becoming infected but also that they live in an economical, social and cultural deprivation which leads to their lack of power in relationships. Many women find it difficult or impossible to speak openly about sex or negotiate condom use with their male partners (UN Department of Economic and Social Affairs 2005, p.13). On the other hand, the poor living conditions force large numbers of African men to migrate in search of work and while away from home they may have multiple sex partners that significantly increase their risk for STIs and HIV/AIDS. The

percentages of HIV infected women in some African countries make up 60% of the infected population (UNAIDS 2004, p.22).

HIV programmes established in national health care systems aim to reduce the number of new HIV infections through prevention programmes and to provide care and treatment using antiretroviral therapies (ARVs) for those who are suffering from AIDS. HIV prevention is the main focus of the global response to HIV (UN Department of Economic and Social Affairs 2005, p.47). A study found out that scaling up existing prevention approaches on a global level could prevent 60% or more of the new infections that are expected to occur between 2002 and 2010 (Stove et al. 2002, p.75).

HIV prevention packages are focusing on:

- the prevention of sexual transmission,
- the Prevention of Mother-to-Child Transmission (PMTCT)
- blood transfusion, and
- the support of people who are particularly vulnerable to HIV as sex workers and truck drivers.

Prevention programmes are focussing on the provision of HIV/AIDS education and awareness aiming to obtain a behaviour change leading to a reduction of risky sexual behaviour. AIDS awareness programmes are found in many African schools and increasingly, at the workplace, where employers are recognizing their interest in reducing infection rates among their employees. In addition, many HIV projects attempt to make condoms readily available and to provide instruction in condom use. Within Prevention of Mother-to-Child Transmission (PMTCT) programmes pregnant women receive counselling on HIV and testing. In accordance with their HIV status they receive ARVs and information on breastfeeding to prevent mother-to-child transmission (UN Department of Economic and Social Affairs 2005, p.47-48).

To address the root causes and consequences of HIV/AIDS and its link to poverty, gender equity development partners mainstream AIDS into all relevant development areas.

> *“Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, through both their usual work and within their workplace.”* (UNAIDS 2005a p. 4).

Funding

Today, there is an increased commitment by affected countries themselves and by development partners to respond to the epidemic. In particular, the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), increased the total amount of funding for AIDS. As a financing mechanism, the Global Fund works closely with other multilateral and bilateral organizations involved in health and development issues. It commits about 60% of its grant funds to Africa, and about 60% of its grants worldwide go toward fighting AIDS (UNAIDS 2007b).

2.4.2 Status of the HIV epidemic in Kenya

The first HIV case in Kenya was detected in 1984. From there on the HIV prevalence rate increased steadily to 10% in the late 1990s. In recent years decline or stabilisation of the national HIV prevalence rates are being observed in East Africa. In Kenya the national adult HIV prevalence fell to about 7% in 2003 and just over 6% in 2005 (MoH, NASCOP 2005b, p.5). Despite these positive trends the country is still challenged by a serious AIDS epidemic.

In Kenya with a population of 33.4 million, 1.3 million people are living with HIV, 140.000 have died from AIDS, and approximately 150.000 are HIV positive children under 15 years (CBS et al. 2003, p.215). HIV has spread through all regions and levels of the Kenyan society. Gender differences and regional disparities are recognized as follows.

Gender differences

Gender differences in HIV infection rates occur in all age groups. Among adults the HIV prevalence for women aged 15-49 is 8.7% while it is 4.6% for men aged 15-54. This represents a female-to-male ratio of 1.9 to 1 (CBS et al. 2003, p.221). As can be seen in the figure below young women are particularly vulnerable to HIV infections.

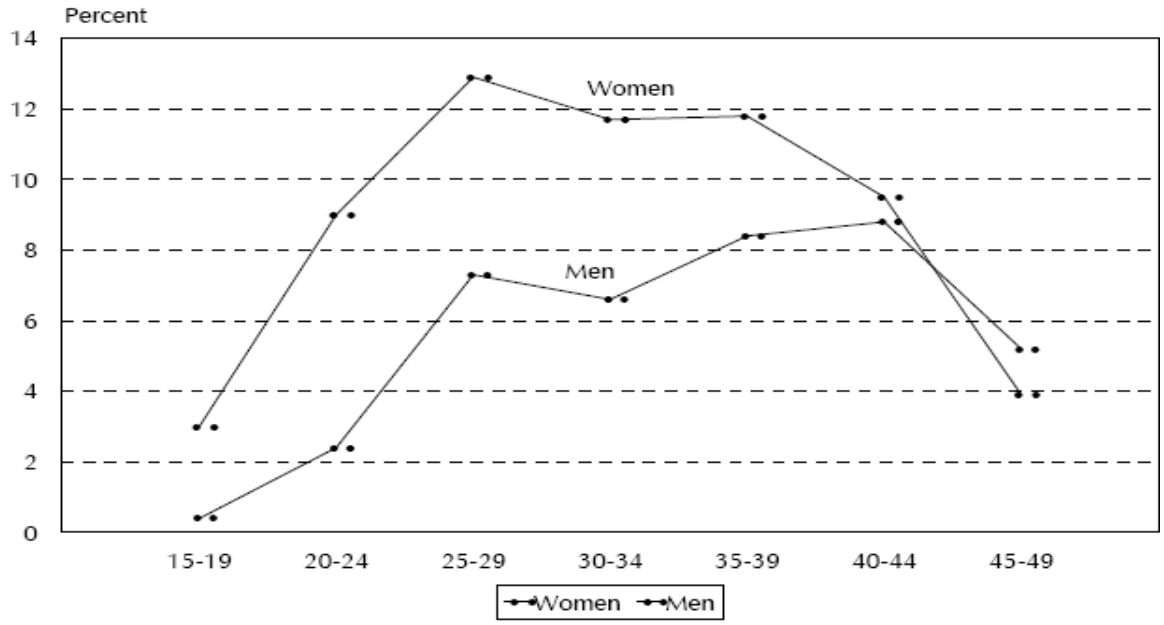

Figure 3: HIV prevalence by age group and sex (KDHS 2003, p.222)

In the 15-19 year age group for instance, 3% of all women are HIV infected compared to 0.5% of men in the same age group. The HIV prevalence among women age 20-24 is 9% which is over three times higher than that of men. Overall, the prevalence at the age of 15-24 is almost 4%, with a prevalence rate of 6% among women compared with slightly over 1% among men. As the figure shows only in the age group 45-49 the HIV prevalence rate is higher among men than among women.

This gender difference leads to a higher appearance of discordant couples, which means that one partner is infected with HIV and the other is not. Almost 7% of married couples in Kenya are discordant. The Ministry of Health stated that therefore today, a significant portion of new infections take place within the family (MoH, NASCOP 2005c, p.2).

Regional disparities

The HIV epidemic shows significant regional heterogeneity. The urban population has a significantly higher risk of 10% to get infected, compared to the rural population with 6%. Although the urban population in Kenya represents only 20% of the total population (15-49), it is of great concern that almost 40% of these people are HIV infected. On the other hand, Nyanza Province in the rural western part of Kenya has the highest HIV prevalence of 15%, followed by Nairobi with 10% (CBS et al. 2003, p.222-224).

2.4.2.1 Institutional and policy response

It was not until 1999 that the previous Kenyan president Moi declared HIV/AIDS as a national disaster. Since then the government has undertaken multiple efforts to fight the HIV epidemic. Today, the national response focuses on the “Three Ones” principles. These principles were endorsed by UNAIDS and key development partners in 2004 to achieve the most effective use of national resources in affected countries, and to ensure a rapid and collective action by the development partners in combating the epidemic (UNAIDS 2007b). In Kenya the “Three Ones” principles constitute the framework for the national response to the epidemic (NACC 2005, p.20):

1. *The implementation of the second National HIV/AIDS Strategic Plan* (KNASP)
   It is the strategy for all HIV/AIDS interventions implemented by the government and its development partners. The strategy is based on core principles such as prevention of HIV new infections and mainstreaming HIV/AIDS to realize a multi-sectoral approach
2. *The establishment of the National Aids Control Council* (NACC)
   It is the national coordinating authority on AIDS which is responsible for HIV/AIDS mainstreaming through all relevant ministries.
3. *The national monitoring and evaluation framework*
   It is developed to identify the overall performance and impact of the national response.

2.4.2.2 HIV Voluntary Counselling and Testing services

> *“Voluntary Counselling and Testing is the process by which an individual undergoes counselling to enable him or her to make an informed choice about being tested for the human immunodeficiency virus (HIV). This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential”* (UNAIDS 2001, p.7).

HIV Voluntary Counselling and Testing (VCT) is a widely accepted behaviour change and prevention strategy where people learn their HIV status and how to live with their status and when tested HIV negative, how to prevent an HIV infection (UNAIDS 2001, p.11).

The effectiveness of VCT services have been investigated in various studies and the results show that client’s use of VCT leads to behaviour change and reduction of risky behaviour, which includes a decrease of unprotected sex (UNAIDS 2001, p.65). A study conducted in Kenya shows that knowing one’s HIV status helps those who are not

infected to decide on prevention strategies and those who are infected to make decisions on how to live with the infection and protect their sexual partners. In addition, VCT connects people tested positive with early and appropriate comprehensive health services in order to prevent HIV-associated infections and mother-to-child transmission. Therefore, VCT is expected to be an important entry-point to both HIV prevention and HIV-related health care (VCT Efficacy Study Group, 2000, p.107). The following figure shows different entry points to health care services which VCT can offer to its clients.

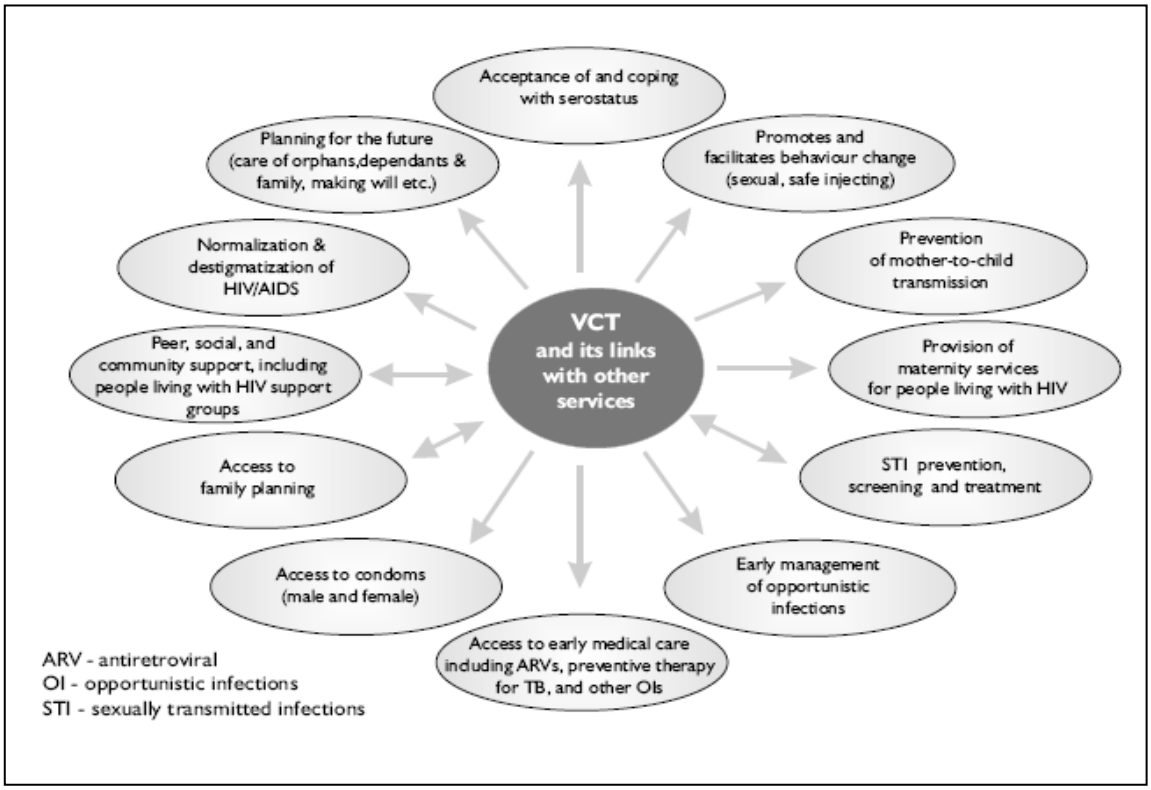

Figure 4: VCT and its links with other health services (UNAIDS 2000, p.4)

Accessibility of VCT services

In Kenya, joint efforts by the Kenyan government and its development partners have led to an increase of VCT sites from three in the year 2000 to 555 sites in 2005. Today, VCT services constitute the predominant model where people can be tested for HIV (MoH, NASCOP 2005c, p.3).

There are three types of VCT service sites in Kenya. The ***integrated VCT sites*** are located within an existing health facility infrastructure such as hospitals, health centres or dispensaries. In Kenya, 83% of VCT service delivery points are integrated (MoH, NASCOP 2005c, p.29). The second type are the ***stand-alone VCT sites*** which are not linked with a medical institution and are largely operated by non-governmental

organizations. Often they also provide ***mobile VCT services*** to remote communities where other models of VCT are not available.

The Ministry of Health undertook an analysis on the attendance of VCT sites by sex and age. It demonstrates that over 60% of the clients are below 30 years which demonstrates that the existing VCT sites in Kenya reach the most sexually active group of the population. Male clients constitute 56% of all VCT clients (MoH, NASCOP 2005c, p.31).

VCT service delivery

To ensure standardized and quality VCT service provision national VCT guidelines were developed by the National AIDS and STI Control Programme (NASCOP) in collaboration with the technical support given by UNAIDS in 2001. It represents the basis for the VCT counsellor's three weeks training.

The guidelines stress on keeping client's data ***confidential*** due to the fact that AIDS-related stigma and discrimination influence the effectiveness and acceptance of VCT services (UN Department of Economic and Social Affairs 2005, p.44). In accordance with these guidelines, confidentiality means that the client's personal information is neither directly nor indirectly revealed without the client's permission (MoH, NASCOP 2001, p.4). To guarantee confidentiality the guidelines recommend to record only code numbers instead of the client's name. In addition, the condition of the counselling rooms should provide auditory and visual privacy. Confidentiality should also be assured if referrals are necessary.

Counselling on HIV/AIDS is another major field of VCT service provision. It is *"(…) a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour"* (WHO 1994, p.20). The counselling process comprises of pre- and post-test counselling that is provided in two separate sessions. In the VCT guidelines a certain amount of time (45-60 minutes) has been allotted for the provision of counselling.

An existing ***HIV testing system*** is another important prerequisite for carrying out VCT services. In Kenya, the rapid, whole-blood HIV test is predominantly used for HIV-testing. This test allows clients to receive their results between 30 minutes to a few hours and thus they do not have to return to the site one or two weeks later. The Kenyan Service Provision Assessment shows that almost all VCT facilities in Kenya have a HIV testing system and at least one trained counsellor who can provide pre- and post-test counselling (CBS 2004, p.8).

Supervision presents another central point to ensure that national policies and guidelines are being practised by service providers and to review experiences and resolve problems related to VCT service delivery. Meetings should be carried out on regular basis for VCT counsellors and members of the District and Provincial Management Teams.

2.5 Integration of Family Planning and HIV Counselling and Testing

The following chapter informs about integration of reproductive health and HIV/AIDS services as currently provided and in particular, on the integration of family planning and VCT services. The last section describes the efforts that have been made by the Kenyan government to integrate family planning into VCT and vice versa.

2.5.1 Linkages between Sexual and Reproductive Health and HIV/AIDS

As noted before, the majority of HIV cases are transmitted sexually (75%) or as a result of mother-to-child transmission (10%). In addition, reproductive ill-health and HIV/AIDS share root causes, including poverty, gender inequality and social marginalization of the most vulnerable populations. Recently, international organizations such as WHO, UNAIDS and UNFPA have affirmed the importance to integrate HIV/AIDS and sexual and reproductive health to intensify the prevention of HIV/AIDS (WHO et al. 2005).

For the first time, the contribution that sexual and reproductive health services can make in the fight against HIV/AIDS was acknowledged at the Conference on Population and Development (ICPD) 1994. In line with the ICPD´s programme these services should include the prevention, detection and treatment of STIs and HIV, the provision of information, and education for responsible sexual behaviour, and the correct and consistent use of condoms. Furthermore, the reliable supply of condoms and the prevention of mother-to-child-transmission should be ensured within these services (UNFPA, PATH 2005, p.63).

Integrated Sexual and Reproductive Health and HIV/AIDS services

Since the ICPD in 1994, efforts have been made to integrate sexual and reproductive health and HIV/AIDS services in the poorer regions of the world. In many African and Latin American countries family planning services have integrated education and counselling on sexuality, condom use and HIV/STI counselling, which was seen to be a

successful strategy (Askew, Berer 2003, p. 52). Another integrated approach constitutes the provision of HIV counselling and testing and if necessary, of antiretroviral therapy to pregnant women within the Prevention of Mother-to-Child Transmission (PMTCT) programmes. They are provided through ante- and post-natal clinics in high prevalence settings.

The experiences with integrated service have been mixed and there is little evidence that integration of these services is an effective public health approach (Lush et al. 1999, p. 771). But the most successful experiences suggest that integrating reproductive health and HIV/AIDS enables providers to offer more convenient and comprehensive services and to facilitate the access to these services and make them more cost-effective (Askew, Berer 2003, p.61). It is said that integration could optimize the use of existing resources, reduce service delivery costs because of shared staff, equipment and administration, and additionally, reduce the client's time and travel costs (Mayhew 2004, Askew, Berer 2003, Hardee et al. 2005, Lush 1999).

However, over the last decade integration efforts have still been limited on account of the following obstacles in the integration process. The surge of interest in HIV/AIDS and the establishment of the Global Fund have led to the separation of national funding streams for HIV/AIDS and sexual reproductive health programmes. This has its impact on the programme structure which is often vertical with top down management systems and separate national HIV/AIDS and reproductive health policies and strategies (Mayhew 2004 p.8, Askew, Berer 2003, p.55).

International actions towards integration

Recently, the WHO, UNFPA and UNAIDS have advocated for the integration of reproductive health and HIV/AIDS services in order to intensify the prevention of HIV. They have formulated two policy statements on integration in 2004, the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health[18] and the Glion Call to Action on Family planning and HIV/AIDS in Women and Children[19]. In addition, they have defined key linkages that should be addressed at the policy and programme level to strengthen the programmatic linkages between sexual and reproductive health and HIV/AIDS, as can be seen in the figure below.

[18] UNFPA and UNAIDS, in collaboration with Family Care International, convened a high-level global consultation on linking HIV/AIDS and reproductive health (UNFPA, 2007b).

[19] UNFPA and WHO convened a Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS in particular in Family Planning and HIV/AIDS in Women and Children in 2004 aiming to prevent HIV infections among children (UNFPA 2007c).

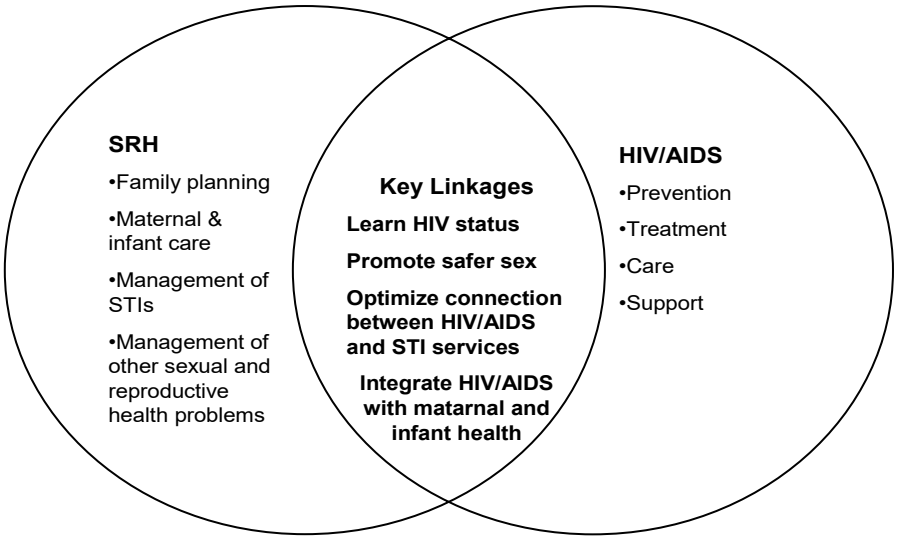

Figure 5: The framework of key linkages (WHO et al 2005)

2.5.2 The benefits of integrated Family Planning and VCT services

In general developing countries have been offering family planning and VCT services separately, with little or no integration. But the advantages of integrating these two services are increasingly apparent as the spread of HIV/AIDS increases. It is expected that integrating family planning and VCT would reduce infection rates and HIV/AIDS-related stigma, strengthen the awareness of consequences of sexual behaviour and increase the access and utilization of these services (FHI, USAID 2004, p.6).

Both services target clients in the reproductive age group, who are at greatest risk of getting or transmitting HIV and at the same time are also vulnerable to contract STIs and becoming pregnant unintentionally. By providing integrated family planning and VCT services their options can be improved to be assessed for HIV risk and status, and to be counselled on dual protection (Askew, Berer 2003, p.57). Dual protection is *"a concept on the outcome of protection against both pregnancy and HIV and other STIs. The promotion of dual protection can vary from region to region and can be done by using solely the condom or the condom in conjunction with another method"(*WHO 2007d).

Another argument for integrating these services is that clients may prefer to receive services in environments they find more acceptable. For instance, women tested HIV positive may prefer to receive contraceptive services in settings where they receive HIV-related information. On the other hand, married women may find it easier to receive HIV services at mother and child clinics where they know the setting (FHI, USAID 2004, p.15).

VCT sites offering Family Planning

There are two main reasons for integrating family planning services into VCT sites. The first being that integrated service delivery can not only help to reduce the risk of infection and re-infection[20] but it can also help to prevent unintended pregnancies among HIV positive women. In many African countries there still exist high levels of unmet family planning needs in particular, for HIV positive women for whom the access to family planning is important both for their health and to prevent mother-to-child transmission. Another reason is that men and adolescents who are often hard to reach with family planning information can be addressed within VCT settings (UNAIDS 2000).

Family Planning sites offering VCT

Providing VCT services at family planning sites is done for two major reasons. Firstly, married women who are increasingly considered as a high risk group for HIV infection can be reached with HIV counselling and testing within family planning settings. Knowing their HIV status could enable them to choose an appropriate contraceptive method which would help them to choose if, and when they would like to have children. Another reason for providing integrated service delivery at family planning sites is the opportunity to avoid the stigma that is often associated with attending stand-alone VCT services (FHI, USAID 2004, p. 6).

2.5.3 Integrated Family Planning and VCT services in Kenya

In 2002, Family Health International and the Kenyan Ministry of Health conducted a study on the advantages and challenges of integrating family planning into VCT sites in Kenya (FHI 2003). The outcomes of this study have been the basis for the development of the national strategy paper “Integration of HIV-Voluntary Counselling and Testing and Family Planning services” which was implemented in 2003.

The study results show that there is both a demand and acceptability, and feasibility of integrating family planning into VCT services in Kenya and what would also be feasible to do so. The demand for family planning services among VCT clients has been emphasized within the study because only 50% of VCT clients interviewed used a modern contraceptive method. This is of particular concern for clients who test HIV positive because they need effective pregnancy prevention to avoid the HIV transmission to their children. The study also revealed that the provision of family planning services during VCT

[20] HIV re-infection means that through sex between partners who are both HIV positive other types of HIV and other STIs can be transmitted. Therefore, the use of condoms is advised even when both partners are infected (UNAIDS 2007a).

sessions is acceptable to counsellors and pre- and post test counselling sessions are the most appropriate timings for providing family planning (FHI 2003).

The Ministry of Health established a subcommittee to develop the strategy on integration. The subcommittee includes diverse VCT and family planning experts from National AIDS and STIs Control Programme (NASCOP), the Division of Reproductive Health, as well as local and international development partners. Family Health International developed training tools to instruct teachers of the trainers to implement this strategy. Under the direction of NASCOP and the Division of Reproductive Health the trainings have been carried out in three Provinces in Kenya comprising namely the Coast, Central and Nyanza Province.

The study has recommended three levels within which integration should take place:

- At the policy level:
  National reproductive health and HIV/AIDS policies should be formulated to direct integrated service delivery. Therefore, HIV/AIDS policies should entail elements of family planning and vice versa.
- At service delivery level:
  The integration should be understood as a continuum, where the level of integration may vary by the type of facility, the training backgrounds of providers and the feasibility given at the setting.
- At the networking level:
  The integration entails a network of providers linked by a well-developed and monitored referral system.

Integration at policy level

The study revealed that there is no apparent discrepancy between Kenyan HIV/AIDS and family planning policies (FHI 2003, p.7). Kenyan national HIV/AIDS policy states that VCT among people of reproductive age provides information that can enhance decisions regarding fertility (NACC 2005, p.8). Furthermore, in the country's current VCT guidelines family planning is addressed as one component (MoH, NASCOP 2001, p.9).

The reproductive health policy specifically recognizes sexual reproductive health needs of HIV affected individuals and stresses family planning as an important entry point for the prevention of STIs and HIV/AIDS (MoH 1997, p.15).

Level of integration Family Planning into VCT services

The study recommends that programme development for integration of family planning into VCT should be conceptualized as a continuum of services depending on the provider's training, referral mechanisms, and contraceptive supply channels. In line with the Kenyan strategy paper the levels of integrated service delivery range from level I to level IV. In essence, VCT counsellors should be able to assess for pregnancy and STI`s infection risks, provide information on family planning methods, and refer clients for services not available at the VCT site. The expectation is that all VCT sites should provide at least level one integrated services. The table below shows family planning services by level that should be provided during VCT sessions:

	Family Planning into VCT services
Level I	• Risk assessment for pregnancy, sexually transmitted infections (STIs), and HIV • Counselling and information and education on Family Planning and STIs and HIV • Provision of oral contraceptives and condoms
Level II	• It includes all elements of level I and the provision of injectable contraceptives
Level III	• it includes all elements of level I and II, and the provision of intrauterine contraceptive devices (IUCDs)
Level IV	• it includes the provision of the full range of contraceptive methods

Table 1: Level of Integration Family Planning into VCT services (MoH 2003, p.4)

Level of integration VCT into Family Planning services

In line with the reproductive health policy, the national family planning guidelines 2005 label two levels of VCT integration. The service delivered at each level is stated below.

	VCT into Family Planning services
Level I	• Risk assessment for STIs and HIV • Information, education and communication on VCT, and availability of VCT centres • Referral to post-test clubs and other appropriate services
Level II	• It includes all VCT services of Level I • Pre-and post-test counselling and testing

Table 2: Level of Integration VCT into Family Planning services (MoH 2005, p.20)

3 Methodology

The following chapter provide information on the design and methods used to conduct this study. It informs about the purpose of the study and the research-related questions. Furthermore, it presents study tools which were used to carry out the interviews and methods for analysing the collected data.

The study on “Integration family planning and HIV counselling and testing in Kenyan health services” was conducted within the GTZ`s reproductive health project in Kenya. In Nyanza Province, the project focuses on the extension of family planning services. The GTZ initiated this study to analyse the situation and estimate how best to respond to the unsatisfactory family planning indicators. In addition, they searched for means on how to increase the accessibility of HIV-related information particularly in Nyanza Province.

Nyanza is one of Kenya’s eight provinces located in the south-western region along the shores of Lake Victoria. Nyanza has a population of approximately 5 million, living primarily in rural areas mainly from agriculture and fishing. This region is one of the poorest in Kenya. It shows the lowest health indicators of the country with more than twice the HIV prevalence rate of the national average (15%) and high family planning unmet needs of 35% and a total fertility rate of 5.6 (CBS et al. 2003).

The researcher identified integration of family planning and VCT as a effective strategy to meet the health needs of Nyanza`s population. As mentioned in the chapter above integrated family planning and VCT service delivery contributes to the extension of family planning and HIV counselling and testing. Family planning services can play an important role in reducing the HIV/AIDS infection rates by promoting condom use and dual protection. By integrating it into VCT services the provision of family planning can be expanded, in particular to HIV positive clients and those who are hard to reach like men and adolescents. It is expected that integration is convenient, cost effective and appropriate to both, the client and the service provider.

Despite efforts made by the Kenyan government to implement a national strategy on “Integration HIV-Voluntary Counselling and Testing and Family Planning” in 2003, at the time the study was conducted no research existed on whether and to what extent both services are actually integrated by service providers. Therefore, the researcher’s interest was to investigate *“to what extent does an integration of family planning and HIV/AIDS services as currently provided by Kenyan service providers exist?”*

The study investigated how far the national strategy paper on integration and the national family planning guidelines are implemented in public health facilities in Bondo

District and identified existing barriers to and successes of integration in order to improve the integration process in Nyanza.

The study focused on the following questions:

- What level of integration is actually in operation at the Kenyan public health facilities?
- Are service providers following the national strategy paper on integration and the national family planning guidelines?
- Which factors are influencing the process of integration positively and negatively?

In Kenya, the researcher developed the study concept, formulated the research questions, and designed the appropriate tools for the study in the time from April to August 2006. Collection and analyses of data was done by the researcher in the period between July and August 2006. To identify the level of integration a cross-sectional study was conducted applying both qualitative and quantitative research techniques. This study design was chosen on purpose so as to collect data on the variation of integrated family planning and VCT service delivery at a more or less simultaneous point of time.

3.1 Development of the study tools

The study collected facts and data on the level of integration currently provided in family planning and VCT sites, in addition it investigated workflow and attitudes towards integration of these two services. The study combined three different study tools: structured interviews, In-depth interviews and, a facility assessment.

In order to measure the quantitative data, indicators were defined based on the levels of integration as determined in the Kenyan national family planning guidelines and the strategy paper of integration (see table 1 and 2 in chapter 2.5.3) .

Semi-structured interviews

The researcher conducted semi-structured interviews with VCT and family planning counsellors to gather quantitative data on the following aspects: provider's qualifications, HIV prevention messages provided to clients, family planning information and services offered, providers training backgrounds relating to VCT and family planning, VCT and family planning referral mechanisms, and counsellors' attitudes, perceptions and recommendations for providing integrated services.

A questionnaire comprising of 63 questions was developed. This included a series of closed and open ended questions. Closed ended questions aim to reduce the possibility

of misunderstanding, thereby minimising chances of misinterpretation of the replies by giving the respondents a limited choice to answer the questions. The questions were developed in accordance with the indicators for integration defined in the family planning guidelines and the strategy for integration.

Three different forms of answering formats were developed:

1. in form of real numbers: i.e. number of clients, age
2. in form of dichotomies: Yes/No questions
3. tick if relevant: i.e. the interviewer had to tick the box according to the answer selected by the respondent from a list of categories and options

Open ended questions were used for their advantage of providing qualitative information as for i.e. on the counsellors' attitude towards integrated service delivery. Hence the respondents had the freedom to answer the questions in their own terms and were not forced to choose the answer from a limited choice.

In-depth interviews

The researcher conducted In-depth interviews with policymakers on the district and provincial level, programme managers of VCT sites and the unit managers of the health facilities visited. The people interviewed were treated as key informants rather than as respondents answering questions about themselves.

Overall, 14 open ended questions were used to gather qualitative data on the process of implementation of policies and guidelines, the actual situation of integrated family planning and VCT service delivery and the key informants perspectives and perception on the effect of integration, the challenges, advantages, and disadvantages of offering integrated services and further recommendations on integrated delivery of the two services.

Facility assessment

The researcher carried out facility assessments in the health facilities visited via a check list to collect information on the infrastructure of the facility, the availability of family planning and VCT services, the location of these two services, the conditions to promote integrated VCT and family planning services, the availability of VCT and family planning Information Education and Communication (IEC) materials.

The check list used quantitative questions such as entering real numbers and Yes/No questions. They were developed also in accordance to the family planning guidelines and the strategy of integrated family planning and VCT services and additionally, in

accordance with the literature review on the provision of family planning and VCT services.

3.2 Sample selection

Since the GTZ carries out its family planning activities in eight districts in Nyanza Province it was predefined that the study should be carried out in one of these districts.

Bondo District was chosen on purpose on the following criteria:

- GTZ conducts reproductive health activities in Bondo,
- The district has low health indicators for family planning and HIV/AIDS. At the time of the study the HIV prevalence was almost 27% whereas 37% of women and 21% of men are being infected.
- The organisation AIDS Communication and Education (ACE), working in awareness rising for couple HIV counselling and testing, cooperates with GTZ and offered the interviewer the opportunity to accompany them while travelling from one health facility to the other.

To get a proportional representation of the different types of facilities to which VCT and family planning counsellors are attached stratification of public health facilities at the district level was done in terms of hospital, health centre, dispensary and stand alone VCT site. The allocation of the public health facilities (22) was done proportionally to have the desired number of ten. These health facilities were assigned numbers followed by random selection to choose the health facilities for the study. The district hospital was chosen intentionally given that it is the referral hospital in the district. This was done with the aim of strengthening the information that had been collected from peripheral health facilities as they receive in-referrals from the same.

	Total number of public health facilities in Bondo **= 22**	Selected number of health facilities after random sampling **= 10**
Dispensaries	17	7
Health centres	3	1
Hospitals	1	1
Stand alone VCT site	1	1

Table 3: Selected health facilities of Bondo District

Service Providers interviewed

Service providers were defined as those who were currently providing family planning and VCT services at the sampled health facilities. The number of service providers to be interviewed was restricted to three VCT and three family planning providers per health facility.

Overall, 19 service providers were interviewed, nine of them were family planning providers and ten were VCT counsellors. The following table provides further information on age, sex, qualifications and duration of work experience of the family planning and VCT providers interviewed.

	Health facility	***Number of providers interviewed***	***Sex***	***Age***	***Qualification***	***Working period***
VCT	Stand Alone VCT site	2	male, female	20-34	Assistant medical care	1-3 years
	Hospital	3	male	20-49	2 Nurses, Pastor	1 month – 6 month
	Health Centre	1	male	20-49	Nurse	> 3 years
	Dispensary	4	2x female 2x male	20-49	-	1 month – 3 years
FP[22]	Hospital	2	female	20-64	2 trained PMTCT[21]	1-3 years
	Health Centre	2	female	20-34	1 trained PMTCT	4 month – 3 years
	Dispensary	5	2x male 3x female	20-49	4 trained PMTCT	1 month – 11 month

Table 4: Information on FP and VCT providers interviewed

Key Informants interviewed

Key informants include policymakers, programme managers and unit managers who were selected on the following criteria:

- ***Policymakers*** had to be a member of the District or Provincial Health Management Team in Nyanza and Bondo District, respectively. They had to be involved in policy processes relating to reproductive health/family planning or to HIV/AIDS/VCT.

[21] Prevention of Mother-to-Child transmission
[22] Family Planning

- ***Programme managers*** of the VCT sites were chosen from the most important stakeholders of VCT activities in Kenya including Liverpool VCT[23] (LVCT) and the U.S. agency Centre of Disease Control[24] (CDC).
- ***Unit managers*** are the person in-charge of the health facility and had to be employed at the sampled health facility.

Policymakers

The Health Management Teams established on provincial and district levels are responsible for coordinating and monitoring the implementation of health policies and guidelines at the respective levels. While the Provincial Health Management Teams are directly linked to the national level, the District Health Management Teams are supervised by the Provincial Health Teams. Within the management teams coordinators are responsible for supervising specific public health programmes, such as the Reproductive and Maternal and Child Health/ Family Planning Programme and the National AIDS/STI`s Control Programme.

In total, seven policymakers were interviewed who were involved in supervising either family planning or VCT-related activities at provincial or district level in Nyanza. Among the seven candidates five were male and two female, and all were aged between 35-49 years. The working period in their current position varied from less than one year to more than three years.

In Bondo, the District Public Health Nurse and the District Reproductive Health Coordinator were interviewed because they supervise family planning activities in the district while on the provincial level this is done by the Provincial Public Health Nurse and the Provincial Medical Coordinator. The District AIDS/STIs Coordinator and the District Clinical Officer/senior VCT supervisor in Bondo were interviewed because they are responsible for VCT service provision in the district while the Provincial AIDS/STIs Coordinator manage VCT activities at the provincial level.

Programme managers

The VCT sites in Kenya have been established through significant investment in HIV/AIDS by a variety of development partners. CDC and LVCT significantly contribute to VCT

[23] LVCT is a Kenyan NGO partnered with the Government of Kenya, in particular with the Ministry of Health's National AIDS and Sexually Transmitted Infections Control Program (NASCOP) in scaling up quality assured counselling and testing services throughout Kenya (LVCT 2007).

[24] CDC is a U.S. public organization involved in public health efforts to prevent and control mainly infectious and chronic diseases and environmental health threats. In these areas, CDC is globally recognized for conducting research and investigations (CDC 2007).

service provision by providing financial support, training and supervision. They work in collaboration with the Ministry of Health.

Two programme managers, one of CDC and one of LVCT were interviewed as they coordinate and supervise VCT activities carried out in Nyanza Province. Both were females aged between 35-49 years who had been working in their current position for one to more than three years.

Unit managers

The unit managers were interviewed because they are the direct supervisors of the Mother and Child health facility but not of the integrated VCT site if present.

A total of seven in-charges were interviewed, their role being mainly administration, staff supervision and health care service delivery. All unit managers were trained nurses. Five of them were females. Their age varied from 20-64 years and they had been working in these facilities between 4 months and more than three years.

Services	Designation	Dispensary	Health centre	Hospital	Stand-Alone VCT	DHMT[25]	PHMT[26]	LVCT / CDC	Total
VCT	Policy makers	-	-	-	-	2	1	-	3
	Programme managers	-	-	-	-	-	-	2	2
	counsellors	4	1	3	2	-	-	-	10
Family planning	Policy maker	-	-	-	-	2	2	-	4
	Unit managers	5	1	1	-	-	-	-	7
	Service providers	5	2	2	-	-	-	-	9
Total	(n = 35)	14	4	6	2	4	3	2	35

Table 5: Sample of Semi-structured and In-depth interviews conducted

3.3 Data Collection

Before the process of data collection could begin the researcher had to ask for permission to carry out the study at provincial and district level. A meeting with the Provincial Health Management Team was arranged in order to be officially introduced to the team to explain the purpose of the intended visit to the province. A second meeting was held with the

[25] District Health Management Team
[26] Provincial Health Management Team

Provincial Medical Officer with the purpose of getting official approval to carry out the study within the province. In order to conduct the study within the health facilities in Bondo, official introduction and clearance were obtained by the District Medical Officer.

The data collection was carried out during a three week period in July 2006. The selected health facilities in Bondo District were the first units of data collection. While interviews with counsellors and unit managers of these facilities were carried out in the first two weeks of July policymakers and programme managers were interviewed during the entire three weeks period. In some cases it was difficult to get fixed appointments with study participants as they had been involved in the management of the national measles campaign during the first two weeks of July 2006.

At the health facilities visited, interviews were conducted with VCT and family planning service providers, and the unit managers of the facility. In addition, the infrastructure of the facility was assessed according to the checklist. While the interviewer was accompanied by a staff member of the ACE organisation on the first day in order to overcome language barriers, on the following days the interviewer conducted the interviews by herself sensitized for the necessity to speak slowly and if necessary to repeat questions. Before starting the interview the researcher introduced herself and informed the respondents about the purpose of the study. This was done to establish a positive relationship that encourages the respondent to participate in the interview. Overall, the interviews with service providers and unit managers took around one hour.

Due to the fact that the drive from one facility to the next sometimes took over two hours because of rough and sandy roads in the district not more than two to three health facilities could be visited per day. Three facilities had to be visited twice because neither the unit managers nor the VCT counsellors were available.

During the two weeks stay in Bondo District it was possible to arrange appointments with two members of the District Health Management Team, the AIDS and STIs Coordinator and the Reproductive Health Coordinator. To conduct interviews with the Public Health Nurse and the Medical Coordinator/senior VCT supervisor it was necessary to travel twice from Kisumu to Bondo District which were almost 50 kilometres apart and required about 4 hours. In Kisumu, the capital city of Nyanza Province interviews were conducted with the Provincial AIDS and STIs Coordinator, the Provincial Reproductive Health Nurse and the Medical Officer as well as with VCT programme managers from LVCT and CDC. The interviews with the key informants took around one to one and a half hours. For data analysis the researcher taped all interviews and took notes during the interviews. Shortly after the interviews, the researcher summarized the qualitative answers by listening to the tape and writing an interview protocol.

3.4 Data Analysis

After the process of data collection from the field, the data were analysed by the researcher within another three weeks. The qualitative data was sorted and codes assigned to the questionnaire sheets for identification purpose. The coding process consisted of two stages: First, the unstructured interviews were categorized by listening to the taped interviews and by reading the typed protocols repeatedly and making notes about the significant remarks. The codes were reviewed and generated to more general categories in relation to the questions. Secondly, numbers were assigned to the categories created. Subsequently, Microsoft Excel was used to analyse the qualitative variables. The quantitative data were entered and analysed using Epi Info version 3.22. They were measured and analysed in relation to the previously defined indicators.

Data cleaning was done to identify and correct mistakes that occurred areas during recording and data entry. Frequency was run to determine the number of occurrence of a response as per the variables. Cross tabulation was done to determine the relationship of certain variables. The qualitative data was classified according to the study topics and sub topics and transferred into qualitative form.

3.5 Study Limitations

The study was conducted in the public health facilities of one district of Nyanza Province. It did not cover all providers who were involved in family planning service delivery in the district because service providers of private, mission and non-governmental health facilities could not be interviewed. Therefore, this study should not be considered as representative for the whole of Nyanza Province or Kenya.

While the study was carried out administrative and organisational obstacles disturbed the time plan of the study. Because of lack of time, it was not possible to apply additional research tools, one being to carry out exit interviews with the clients and the other to conduct participation observations during family planning and VCT service delivery. These research tools would have provided more comprehensive information on the actual situation of service delivery. It would have helped to reinforce or reveal the discrepancies in the responses of the providers. In addition, the clients' point of view would have provided information on the acceptability of integrated family planning and VCT service provision.

4 Results

This chapter presents the study results showing the extent to which family planning has been integrated in VCT services and vice versa. It highlights the achievements, benefits and challenges of delivering integrated service. This chapter is primarily based on interviews with key informants as well as service providers of both services. It entails information on the existing family planning and VCT services, the level of integration provided by VCT and family planning counsellors and furthermore, it identifies factors affecting integrated service delivery.

4.1 Existing Family Planning and VCT services

The following section informs about the currently existing family planning and VCT facilities in Bondo. This includes details on family planning and VCT service delivery, in addition information on the client's access to these services, on staff qualification and the financing of these services.

The following table lists the 10 health facilities visited out of a total of 22 public health centres in Bondo. It presents information on whether VCT or family planning services were available, the number of staff providing these services and the number of providers actually interviewed in each facility respectively.

Health facilities = 10	***VCT service provision = varies in VCT sites***	***FP services provision = 5 days/week, 8hrs/day***	***Providers interviewed =19***
Hospital Bondo District	6 counsellors: 5 days/week; 6 hrs/day	4 providers	3 VCT counsellors 2 FP providers
Health Centre Got Agulu	1 counsellor	3 providers	1 VCT counsellor 2 FP providers
Dispansery Manyuanda	2 counsellors 4 days/week; 5 hrs/days	3 providers	2 VCT counsellors 1 FP provider
Dispensary Misori	-	2 providers	1 FP provider
Dispensary Ongielo	1 counsellor 2 days /week; 5 hrs/day	2 providers	1 VCT counsellor
Dispensary Nyagoko	-	2 providers	1 FP provider
Dispensary Mahaya	-	2 providers	1 FP provider
Dispensary Uyawi	2 counsellors 4 days/week; 5 hrs/day	3 providers	1 VCT counsellor
Dispensary Got Matar	-	2 providers	1 FP provider
Stand-alone VCT Ulungu	2 counsellors 5 days/week; 6 hrs/day	-	2 VCT counsellors

Table 6: FP and VCT services at health facilities visited

Service delivery

As can be seen above, health facilities visited offer family planning services at least five days a week and eight hours per day. In four of ten health facilities a VCT site was located within the same compound premises, these were the district hospital, the health centre and two out of the seven dispensaries visited. In two of the four VCT sites counsellors were available only occasionally. At these sites they generally offer their services twice a week, for at least five hours a day.

Facilities providing both services offered these within one compound but always in separate buildings and rooms. While for the provision of VCT counselling one separate room offering a quiet and confidential atmosphere was always available family planning counselling was conducted in the same room where all other services of the health facility were provided.

Clients

At the health facilities visited all family planning providers reported that only women ask for their service. The providers on an average serve 39 clients per month, who are on an average 27 years old. The VCT counsellors reported that out of an average of 79 clients per month 51-75% are women. The mean age of the male and female clients attending the VCT sites is 30 and 29 years respectively.

For both family planning and VCT sites 76-100% of the clients are married. The same percentages (76-100%) of family planning clients also have children, while fewer (51-75%) of VCT clients have children.

Seventeen out of 19 service providers reported that their clients have to walk more than five kilometres to reach the nearest VCT or family planning site.

Staff qualification

All family planning service providers have a medical qualification as trained nurses. During nursing school they are taught family planning. Five out of nine service providers reported that they graduated more than five years ago. Almost all (7) family planning providers are trained in Prevention of Mother-to-Child Transmission (PMTCT). The trainings were provided by CDC and LVCT.

All VCT respondents received training in VCT counselling. Five counsellors have medical qualifications specifically as trained nurses (3) and one is trained as medical assistant.

The overall working period for family planning providers is on average more than three years (7) while for VCT counsellors it is on average between one to three years.

In terms of service provision, almost all (7) family planning providers revealed that medical care is the main content of their work while almost all (8) VCT counsellors identified counselling as the main content of their work.

Financing of VCT and FP services

The key informants interviewed reported that all health facilities are financed by the Ministry of Health while the VCT sites are predominantly financed by the CDC and LVCT. They provide the technical and financial support for equipment, training of staff and arrange regular meetings for supervision in the district.

While seven of the family planning providers are paid by the Ministry of Health, one is paid by the Clinton Foundation and one by Network of AIDS Researchers in Southern and Eastern Africa (NARESA). On the other hand, four out of ten VCT counsellors are working voluntarily whereas the same number receive payment from CDC and two are paid by the Ministry of Health. Those who are paid by the government are trained nurses. They provide VCT counselling in addition to their general nursing duties without receiving any extra salary. One nurse trained in VCT works on voluntary basis.

4.2 Level of integrated Family Planning and VCT service delivery

The key informants and service providers were asked to which extent family planning is addressed in VCT services, guidelines and protocols and vice versa.

During counselling session

Overall, twelve out of 19 interviewed service providers said they were already providing integrated family planning and VCT services. At the VCT sites, seven out of ten providers reported that family planning is offered as an integral component of their services to address the holistic family planning needs of their clients.

> *"(…) both services interact with each other. You must bring them together and discuss it with the client because the client asks for family planning. It can be said - VCT ends up in family planning"*
> VCT counsellor No.28

> *"But in rural areas the people do not have access to condoms. That is why I sometimes just give the whole packet"*
> VCT counsellor No.18

The family planning services the VCT providers offer include counselling on different aspects (see table 8, p.48) and the provision of contraceptive methods. While male condoms are distributed by all counsellors, the provision of oral contraceptives (4) and injectable contraceptives (2) is very limited. The VCT counsellors revealed that family

planning services are provided during pre- and post-test-counselling and is initiated either by the counsellors or by the clients.

At family planning settings, five out of nine family planning providers reported that they integrate HIV/AIDS counselling in their services. In contrast to the VCT counsellors, they only discuss HIV/AIDS after it is brought up by the clients. In other words, if the clients do not ask for HIV-related information during the session, it would not be discussed. The main reason for this passive approach was said to be the client's fear of HIV-related stigma.

> "*I ask the client but the client must be open to tell. Not all clients speak openly about their status some do not want that the nurse know their status because they fear stigma."*
>
> FP provider No.26.
>
> *"Most clients just come for family planning. They are not open to talk about HIV they just talk about it when you start to talk about it."*
>
> FP provider No.27

The following table shows HIV and family planning-related topics discussed during VCT and family planning sessions by the service providers interviewed.

	FP providers n = 9	**VCT counsellors n= 10**
Modes of STI/HIV transmission	8	10
Dual protection	9	4
High risk sexual behaviour	9	4
Signs and treatment of STIs	5	6
Interaction between HIV status and contraceptive methods	1	0
Importance of knowing the own HIV status	9	3
Risk of Mother-to-Child transmission	2	5
Risk of pregnancy	10	5
HIV re-infection	4	2
Information on different contraceptive methods	10	8
Pre-and post-test counselling	0	10

Table 7: Integrated aspects discussed during FP and VCT sessions

As can be seen in the table above almost all service providers (18) include information on different contraceptives in their service provision, and information on STIs and HIV. On the other hand, only half of all providers speak with their clients about signs and treatment of STIs.

While all family planning providers discuss with their clients dual protection only four VCT counsellors inform their clients about this topic. In contrast, none of the family planning providers include pre- or post-test counselling in their sessions and only some (7) of a total of 19 service providers inform about the risk of mother-to-child transmission. In addition, only a small number of all providers discuss the interactions between HIV status and contraceptive use with their clients and only few speak about the risk of HIV re-infection.

The following graph shows the questions and concerns that clients have either regarding family planning or on HIV-related issues. As can be seen, questions related to contraceptive use are by far the most frequently asked questions.

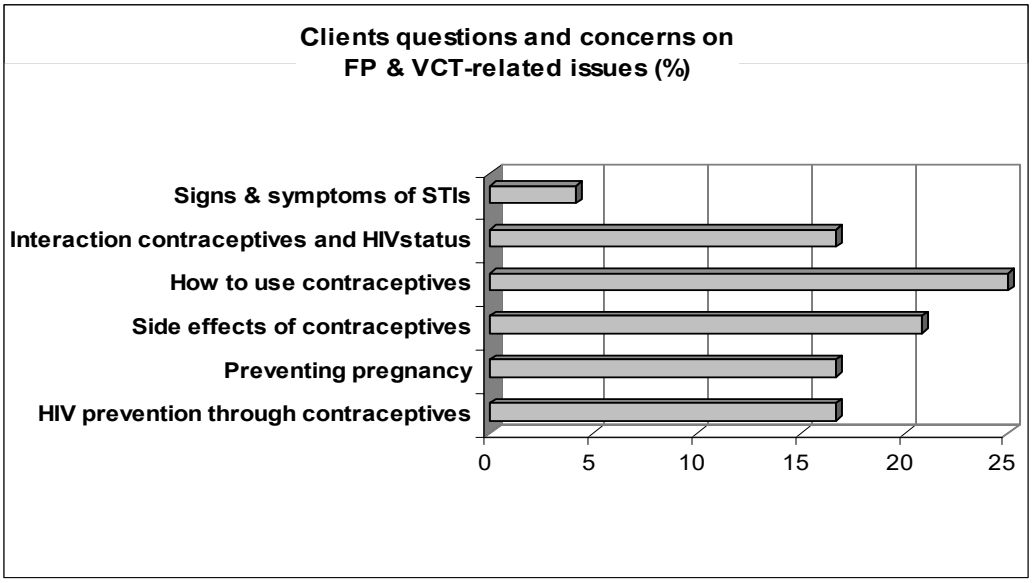

Figure 6: Clients questions and concerns on FP & VCT (%)

Both service providers agreed that HIV positive clients also need family planning services.

All family planning providers agreed that it is important to know their client's HIV status. Almost all (7) find out the client's status by referring him/her to the next VCT site.

> *"Clients fear stigma so we do not talk much about HIV. Only few ask for HIV test and they are being referred".*
>
> FP provider No.11

Use of national Family Planning and VCT guidelines

VCT and family planning providers were asked whether they have any written guidelines for service delivery at their settings. All service providers reported that they use the national, updated VCT and family planning guidelines for service delivery. Seven family planning providers and nine VCT counsellors stated that the guidelines are available in their settings.

Similarly, all key informants interviewed acknowledged that national guidelines form the basis for VCT and family planning service delivery. Usually, VCT counsellors receive the guidelines after their VCT trainings whereas family planning guidelines have to be distributed from the national level to the health facilities at the provincial and district level. Almost all unit managers interviewed noted that the new guidelines were distributed during seminars organized by the District Public Health Nurse. During the seminars the participations were briefed on the guidelines, for further information they were told to read it. The nurse who conducted the seminar is responsible for informing her colleagues about the new guidelines. Almost all family planning providers stated they have not read the guidelines yet because there is not enough time.

Supervision

To ensure that guidelines are being followed by service providers ten out of 16 key informants interviewed reported that they carry out support supervision quarterly. This included a visit of the health facility by the District Health Management Team and for VCT sites by LVCT and CDC. Supervision for VCT counsellors is guaranteed through monthly and quarterly meetings sponsored by LVCT. Although LVCT refunds the costs for the counsellor's transport and lunch the District AIDS/STIs Coordinator and the District senior VCT supervisor said that not all counsellors join the meetings regularly.

At the family planning settings, in-charges are mainly responsible for provider's supervision. This includes the provision of information and updates, and on the job training. Every nurse in charge interviewed stated that the guidelines are available at the facility and all nurses were told to read them. In contrast, one nurse quoted "*I have not read the guidelines, yet. Nobody show me the guidelines. I just find them in the nursing room."* (FP counsellor No.11).

Cooperation and Referrals

Almost all VCT counsellors (9) reported that they cannot always provide the service the clients ask for while four family planning providers noted that they cannot provide the HIV service the client asks for.

VCT providers revealed that clients who need contraceptive methods which are not offered or develop side effects that cannot be treated at the VCT site are referred to specialized family planning facilities. Four out of ten counsellors reported that they use specific referral forms that have been created for that purpose.

At the family planning settings, providers advise their clients to visit a VCT site when they ask for HIV testing except when they are pregnant. For pregnant clients most facilities have the opportunity to offer PMTCT which includes pre- and post-test counselling and HIV-testing. None of family planning providers mentioned using a specific referral form.

The graph below shows the main reasons why service providers cannot provide VCT and family planning services the clients ask for. Lack of training and the availability of supplies are the main reasons mentioned by the providers.

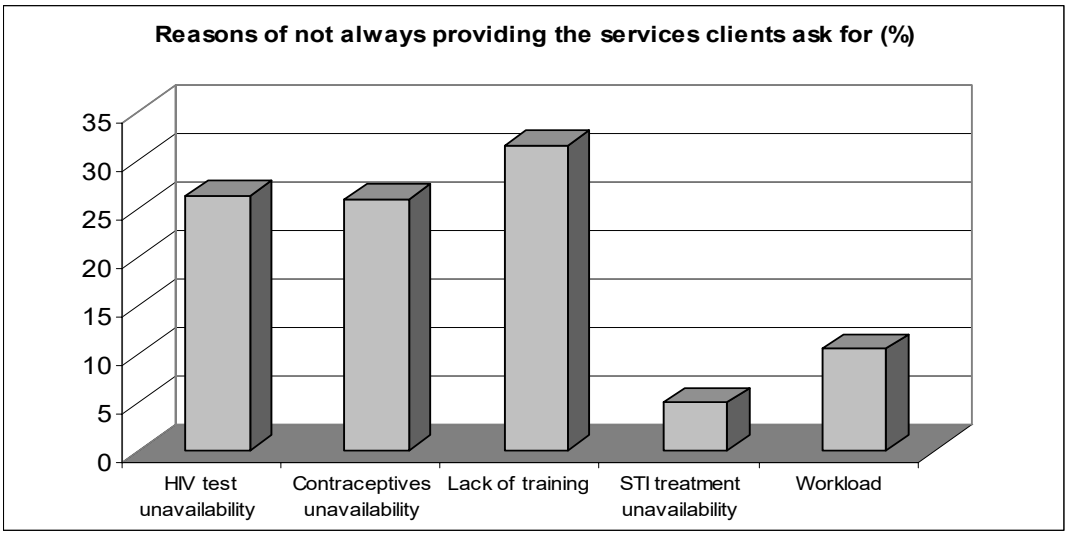

Figure 7: Reasons of not providing the services clients ask for (%)

In terms of referral, almost all family planning providers (7) and VCT counsellors (9) noted that they work in collaboration with either a VCT or family planning site. Predominantly, VCT service providers refer their clients to the health facility that is located in the same compound. Five of the family planning providers advise their clients to access VCT services at the district hospital. In this case, the clients have generally to travel more than five kilometres in order to reach the hospital.

> "*The only mechanism we have is an oral feedback from the client. We don't have documents to follow-up. It is difficult to ascertain that the clients have accessed the services referred to.*"
>
> VCT counsellor No.19

Providers Training

Ideally, effective delivery of integrated service requires that VCT and family planning providers are trained in skills that allow them to competently handle family planning and VCT needs in their settings. Service providers were asked about what aspects of family planning and VCT they had been trained on.

In terms of integrated service delivery, the VCT service providers responded that in the last year prior to the interview, none of them had been trained on family planning. Only half of the service providers have some knowledge in family planning which they obtained at nursing school. In contrast, almost all (7) family planning providers had been trained on PMTCT. Four of them reported that the training has enabled them to provide adequate and accurate information on HIV/AIDS.

In general, eight VCT counsellors responded that they feel sufficiently trained in VCT service delivery while six family planning providers feel sufficiently trained for providing family planning services. However, six of the 19 providers commented that training could be improved both in contraceptive application and for providing HIV services.

The key informants were asked how the provider's training enables service providers to carry out integrated family planning and VCT services. Eight out of 16 respondents noted that the nurses gain knowledge on HIV/AIDS, as most of them are trained in PMTCT and received information on HIV/AIDS during nursing school. On the other hand, within the VCT training programme instruction on family planning is very limited. The key informants noted that the counsellors are just briefed on family planning, in particular on the importance of condom use.

Key informants were asked whether integration has been laid down in written form in the counsellors VCT and family planning protocols. The majority answered protocols include information on the prevention of STIs and HIV/AIDS. Seven noted they include information on the prevention of pregnancy while three respondents stated that the provider's protocol does not include any information on integrated service delivery.

In terms of integration, none of the service providers received specific training in this area. But the District senior VCT supervisor noted he was trained on integration of family planning in VCT in 2005. Within the monthly VCT meetings in the district he had informed VCT counsellors on integration and urged them to integrate family planning in their counselling sessions. The District and Provincial AIDS/STIs Coordinator affirmed the supervisor's statement. The VCT counsellors interviewed said that they know about the importance of integrating family planning into their service and that clients had already asked for it.

Meetings and discussions

The service providers were asked whether they get opportunity to meet other counsellors to discuss HIV or family planning-related issues.

Almost all VCT service providers (9) meet other counsellors on a regular basis. Two meet weekly, eight see each other monthly, and four quarterly while meetings for family planning counsellors are very limited and irregular. Only one reported to have quarterly meetings and two said that they meet yearly. The main topics discussed during the VCT meetings are the challenges and difficulties faced and the experiences gained during counselling and updates on VCT service delivery.

Availability of Information, Education and Communication (IEC) materials

Service providers were asked about what IEC materials are available at their facilities to promote family planning and VCT awareness among their clients and to enhance delivery of integrated service. In addition, the health facility assessments were used to gather information on the availability of IEC materials.

In almost all (9) health facilities visited VCT posters were available, six of these facilities also had family planning posters. Predominantly, the posters are displayed in the nursing and counselling rooms and in the waiting areas where the clients gather for health services. Handout IEC material such as leaflets and brochures for both services are very limited. Only one family planning provider and four VCT counsellors have brochures for VCT while none of the providers have family planning brochures.

4.3 Summary of factors affecting integrated service delivery

This section summarizes factors which help in the promotion of the integrated service delivery.

Service providers and key informants generally ***support*** the integration of family planning into VCT services and vice versa because it allows the clients to seek family planning and VCT services more openly and increases the awareness and acceptance of both services. The respondents agreed on the need of integrated service provision the client's benefit being the main reason. Integrated services would save client's time and money. Family planning providers noted that the time gained due to earlier access is particularly important for those clients whose partners do not know whether their wife uses a contraceptive method. They have the advantage of receiving a contraceptive and getting tested in one go. In addition, almost all respondents noted that integrated service delivery

increases the client's confidentiality because the client would only be served by one provider.

In summary, key informants and service providers emphasized that VCT issues need to be addressed in family planning services to minimize further spread of HIV. They also agreed that provision of family planning in VCT counselling sessions would increase the awareness and acceptance for contraceptive methods.

"There exist a lot of myths on contraceptives for instance, that after using a method you can't get pregnant or your child get disabled. That is why they need information on contraceptives. Myths are killing our village."
VCT counsellor No.19

Integration of FP and VCT is important to reduce HIV prevalence and unwanted pregnancy. A faster implementation can save life."
District Clinical Officer

The following section summarizes the factors which present hindrances for the integration of service delivery.

In terms of ***counselling***, VCT counsellors offer family planning services to some extent and initiate discussions on it. But aspects such as dual protection and signs and treatment of STIs are only discussed by few counsellors. All family planning providers offer HIV-related information to their clients yet in contrast to VCT counsellors, they only provide such information when the clients ask for it.

The study revealed that VCT counsellors without medical qualifications have not received any ***training*** on family planning. Only few counsellors have knowledge about family planning because they are trained nurses. On the other hand, family planning providers are trained in PMTCT and received education on HIV/AIDS during nursing school. As key informants stated these trainings should enable them to offer VCT services. But none of the family planning providers mentioned providing HIV pre-and post-test counselling.

In terms of ***referral***, all providers know where to refer their clients if they can not provide the service the clients ask for. But only few of the counsellors use referral forms. The providers are unaware whether the clients actually seek the service where they are referred to.

In both settings, ***national guidelines*** are used for service delivery. While in all VCT sites guidelines are available, only half of the family planning settings had corresponding guidelines accessible to the providers.

Supervision should ensure that quality services are provided to the clients and hence guidelines are being followed. At family planning settings supervision is very limited. As key informants responded facilities should be visited quarterly by the District Health

Management Team but mostly they are visited once or twice a year. At the facilities the unit managers are responsible for supervising family planning providers. While most unit-managers stated that providers are informed about new guidelines and its contents, service providers answered that they either do not have access to these guidelines or that they have no time to read them. VCT counsellors receive updates in service provision within meetings carried out monthly in the District.

In both settings, the availability of ***IEC materials*** is limited, in particular handouts for clients which promote awareness on family planning and VCT are scarce.

In summary, all respondents cited that staff shortage and lack of training and supplies make it difficult to address family planning and VCT during counselling session. More staff particularly qualified staff and adequate equipment and supplies were suggestions made by the respondents for the improvement of integrated service delivery.

5 Discussion

The need for integrated family planning and VCT services in order to increase HIV prevention and the access to family planning in Kenya has already been stressed in different parts of this paper. Therefore, the following discussion focuses on the assessment to what extent family planning and VCT is actually integrated at health facilities in Bondo District and on factors that affect the integration process.

5.1 Summary of core results to assess integrated service delivery

As mentioned earlier the interview partners generally supported the integration of family planning and VCT services. The benefits of integrated service delivery pointed out by the respondents were similar to those found in the papers (Askew, Berer 2003, Hardee et al. 2005, Mayhew 2004). The respondents agreed that integration leads to an increase in accessibility of family planning services and HIV prevention. Furthermore, they said that integrated service delivery is more convenient for the clients, saves their time and transport costs, and allows greater client confidentiality.

However, to assess the actual extent of integration of family planning and VCT services in Bondo`s health facilities, the main study results are compared with the levels of integration defined in the national family planning guidelines 2005 and in the national strategy paper “Integration HIV Voluntary Counselling and Testing and Family Planning Services” 2003.

Level of integration Family Planning into VCT services

According to the strategy paper level one constitutes the risk assessment on STIs and HIV/AIDS and pregnancy, and information and counselling on family planning through the VCT counsellor. In addition, it includes the distribution of contraceptives like condoms and oral contraceptives. The higher up the level the wider the range of contraceptives provided like injectable contraceptives and implants. If counsellors can not offer the service the clients ask for, they should refer those to an appropriate setting (MoH 2003).

The study results indicate that all VCT counsellors offer family planning services but not all reach level one of integration. Although counsellors are aware of the client’s family planning needs and inform them on aspects related to family planning only few of them discuss issues related to dual protection, risk of mother-to-child transmission and signs and treatment for STIs. In addition, only few counsellors provide contraceptives other than condoms. In terms of referral, research results indicate that counsellors do refer their

clients if they cannot provide the service the clients ask for but less than half of counsellors actually use a referral form.

Level of integration VCT into Family planning services

In the family planning guidelines two levels are defined for integrating VCT into family planning sessions. Level one requires the assessment for STIs and HIV, information and education on VCT and referrals to VCT sites. Level two includes all components of level one and additionally it requires the provision of pre- and post-test counselling (MoH 2005b).

The results of the research suggest that family planning providers offer VCT services but the majority do not attain level one standards. They inform their clients on HIV-related issues including information on STIs and HIV/AIDS transmission and their signs and treatment, dual protection, and the importance of knowing the personal HIV status. But similar to the VCT counsellors only few providers discuss the risk of mother-to-child transmission and HIV re-infection with their clients. In contrast to VCT counsellors, the responses given by the providers indicate that HIV and VCT issues are discussed only if asked for by the clients.

None of the providers offer level two of integration. Although most of the providers have been trained in PMTCT none of them provide pre- and pos-test counselling to their clients. In other words, when clients ask for a HIV-test they are referred to a VCT site, which in the majority of cases means that the client has to travel a long distance. Regarding referrals, none of the family planning providers used a referral form.

In summary, the study indicates that the majority of VCT and family planning providers while offering integrated service do not reach level one standards. Thus, HIV positive clients still have only limited access to family planning services as well as married women have still limited access to HIV counselling and testing. Although all providers know where to refer their clients they do not really know whether the clients actually seek the service where they are referred to and what kind of service they receive.

5.2 Factors affecting integration of Family Planning and VCT

The implementation of integrated family planning and VCT services requires certain conditions at the policy, management and implementation level. In Kenya, integration is politically initiated because an integration strategy has already been implemented. Management units including Provincial and District Health Management Teams, health

facility unit managers, and the Ministry of Health at the national level are responsible for guidelines and strategies being implemented. Therefore, they have to ensure that conditions at health facilities are such that service providers can implement integrated service delivery. In addition, providers have to be able to offer both family planning and VCT services. But the study reveals many challenges at implementation and management level that make the realization of integrated service delivery difficult.

Difficulties faced at management level

The study results suggest weaknesses in the management of VCT and family planning settings with regard to supervision and training of service providers, the availability of supplies and equipment and referral mechanism.

Supervision should contribute to the quality of health service delivery. Through supervision service providers should be updated on service-related issues. In addition, it should offer an opportunity for providers to review experiences and resolve problems, which may occur during service provision.

In Kenyan health facilities, different instruments are used to carry out supervision. At VCT and family planning sites supervisors/unit managers should offer on the job training and conduct single or group discussions for providers in order to identify the difficulties faced by them during service delivery. Outreach supervision should be carried out by the Health Management Team and organizations engaged in service delivery like CDC and LVCT. They should visit the family planning and VCT settings quarterly and discuss with providers and managers the experiences gained and problems encountered during service provision. In addition, they should check the conditions at the site. These measures would help to identify the difficulties and problems which affect service delivery at the settings. If they cannot be solved at district level help should be asked for at provincial and national level (CBS et al. 2004, MoH 2001, MoH 2005b).

In the national VCT guidelines supervision is emphasized as a central point. As the study indicates, VCT providers receive supervision as required on account of the monthly meetings arranged by the senior VCT supervisor, where they receive updates and discuss experiences of their work. In addition, supervisors attached to LVCT or CDC provide outreach supervision quarterly. The study suggests that VCT counsellors are informed about integrated service delivery because they were aware of their duty to provide family planning and initiate discussions on it with their clients.

The national family planning guidelines also stress supervision as an important component but they give little information about when and how often unit mangers should carry out supervision. The study results indicate that weaknesses in the provision of family

planning supervision exist because there is limited control over whether providers receive and implement updates as required in the guidelines and whether unit managers carry out supervision. As the responses show almost all unit managers stated that they have already informed family planning providers on new guidelines while only some providers said that they were aware of the new guidelines and its contents.

The results suggest that there are only limited possibilities for unit managers and providers to receive updates. Regular meetings might be a good opportunity for those to be updated and to discuss problems in service delivery. But as the responses show meetings on reproductive health are offered at most once in a year in the District. In addition, the study results reveal weaknesses in outreach supervision, as the health facilities in the district are only visited by the Health Management Team once or twice a year.

These weak points in supervision might influence integrated service delivery at family planning settings. However, the results indicate that VCT counsellors are more aware of providing family planning services in their sessions than family planning providers are about offering VCT to their clients.

Training is a major component enabling service providers to offer competent family planning and VCT services. The study results suggest that VCT providers are aware of their client's family planning needs but responses of interview partners indicated that counsellors are not sufficiently trained in family planning and thus the majority does not have adequate knowledge and skills to provide family planning, level one of integration. The study did not investigate the quality of VCT trainings with regard to its family planning contents but information on family planning which counsellors received during their training might not enable those without medical background to provide family planning as required in the strategy paper. On the other hand, the study shows that nurses trained in VCT have knowledge and skills to provide at least level one of integrated family planning but quite often these trained nurses are called to perform other nursing duties at the facility.

In contrast, the study suggests that all family planning providers are adequately trained on VCT. As the respondents remarked, they received education on HIV during nursing school and in addition, the majority have been trained on PMTCT. These trainings require participants to receive information on HIV/AIDS that would enable them to inform about HIV and it should sensitize them to issues like HIV-related stigma and client's confidentiality (WHO 2006c). Hence family planning providers trained in PMTCT should have the knowledge and skills to provide VCT in their sessions.

In terms of ***referral mechanism***, both documents, the national family planning guidelines and the strategy on integration requires providers to refer their clients when they can not offer the family planning or VCT service which the client asks for. In the VCT guidelines counsellors are advised to use a referral letter and note the client's name and test results on it but only when the counsellor can be sure that the organization to which they are referring the client will treat it confidentially (MoH 2001). In the family planning guidelines the operations on referral are not explicitly explained, providers are advised to follow the referral system established in the respective health facility (MoH 2005b).

The study suggests weaknesses in the referral mechanism in both settings. Although the study did not investigate whether a feedback system exists or not it indicates that providers have no mechanism to make sure whether the clients seek the service where they are referred to and which type and quality of service they actually receive.

Only few of the providers use referral forms. The study results indicate that VCT counsellors might fear about the client's confidentiality while in case of the family planning providers they might not be aware of using letters for VCT referrals. As the family planning providers pointed out VCT is voluntarily, hence they can only advise the client to go for VCT.

The ***availability of appropriate equipment and supplies*** is an important prerequisite making integrated service delivery possible. In particular, for integrating family planning in VCT services contraceptive methods and equipment to promote such methods have to be accessible at VCT settings while in family planning facilities HIV testing possibilities have to be available. The responses by the interview partners indicated weaknesses in the distribution of equipment and supplies in both settings that leads to limited recourses being available to provide either services during counselling sessions.

Difficulties faced at implementation level

The provision of integrated service delivery is not only affected by weaknesses at the management level but also by challenges which service providers have to face while implementation. As mentioned before to realize an integration of services at VCT and family planning settings it requires the availability of supplies and equipment. In addition, service providers need to have knowledge and skills in VCT as well as in family planning provision. As integrated service delivery implies providers have to offer a wider range of services and also have to be motivated to expand their service delivery.

As the study suggest most VCT counsellors are not comprehensively trained in family planning to provide even level one of integration while family planning providers are adequately trained for providing VCT. But the family planning providers have difficulties in

VCT provision as the majority do not initiate discussions on HIV/AIDS and VCT with their clients.

Counselling on HIV and as a part of VCT requires a confidential dialog between service providers and clients aiming to inform clients about HIV/AIDS and testing and to evaluate the client's risk for contracting HIV, providers have to encourage their clients to speak about his/her sexual behaviour and relationships. This requires the provider's communication skills on account of the sensitivity of the issues. For this reason HIV counselling take place in a confidential environment. The counselling process should be in accordance with the client's need and should be provided in a respectful and understanding manner (UNAIDS 2000).

All family planning providers interviewed are trained nurses. The study did not investigate for the difficulties and barriers, which keep them from discussing on HIV/AIDS and VCT with their clients but the results suggest that the provider's attitude towards counselling and sexuality, the time for counselling and the environment of the health facility are the main factors influencing HIV counselling. This was also described in other papers (Shelton, Fuchs 2004, Askew, Berer, 2003, Lush et al. 1999). They revealed that counselling on issues related to sexuality generally requires provider's skills but that nurses are more likely to be trained on medical care than on counselling. In addition, these papers showed that when family planning providers were adequately trained in sexuality counselling it was not difficult for them to facilitate discussions around sexual issues. Health clinics are generally described as weak platforms for HIV counselling due to poor continuation, and only short and intermittent contact between providers and clients (Shelton, Fuchs 2004).

This study did not gather information on the nurse's training curricula with regard to HIV counselling but the results indicate that providers do not feel counselling to be a main part of their work. Although counselling is stressed as an important element for family planning provision in the guidelines all providers stated medical care as main element of their work. This might be due to counselling is not highlighted as a component in the nurse's training curricula.

To encourage clients to speak about their sexual behaviour and relationships the providers do not only require skills but also need to have time to establish a confidential relationship. The VCT guidelines define a counselling time of 45-60 minutes for each client, while the family planning guidelines do not give any time-frame for either family planning or VCT counselling. Therefore, the provider's workload mainly influences the time providers can spend to serve each client. Due to the fact that at the time the facilities were visited, most were crowded with people waiting in line to receive services family

planning providers might have less time to integrate HIV counselling in their sessions than VCT counsellors.

VCT counselling should be conducted in a confidential environment. At the family planning facilities visited there were no separate rooms for counselling provision rather family planning along with all other services were provided in the same room. This shows that family planning facilities might not offer a quiet and confidential environment as required for HIV counselling.

***Motivation** is* another important factor influencing the quality of integrated service delivery. Integrated service implies that family planning and VCT providers have to expand service provision and that they have to have the motivation to do so. Knowledge about and belief in the importance of their work are main conditions to develop provider's motivation. In addition, financial rewards and to complimenting providers for their work also increase motivation. As stated before the study results indicate that providers are aware of the advantages of integrated service delivery which should eventually increase their motivation. On the other hand, more than half of the VCT counsellors do not receive salary for their work. This might has its effects on the counsellor's motivation because some of them said that they do not feel motivated due to lack of appropriate salary.

Acceptance of integrated service delivery

The benefits associated with integrated service delivery are only given if clients accept and avail the family planning service provided at VCT settings and vice versa. This is influenced by their awareness on integrated family planning and VCT service and further, by the accessibility and affordability of these services. Another important factor is that services have to be delivered by providers who are considered to be competent for the provision of both family planning and VCT services. In Kenya, family planning services are mainly provided through female nurses or midwifes (CBS et al. 2004). The study results show that the majority of VCT counsellors interviewed are male counsellors who have no medical background. This might influence the acceptance, as female clients might not be ready to accept family planning service delivery by male providers who are not trained nurses.

6 Conclusions, Recommendations and demand for further Research

The following chapter presents recommendations and suggestions for further research aiming to improve integrated service delivery in Kenya.

6.1 Conclusions and Recommendations

Level one of integration as defined in the strategy paper and the family planning guidelines has been reached to the extent that service providers inform the clients to some degree about the different aspects of VCT and family planning during counselling sessions. As mentioned earlier different factors affect integrated service delivery. The following recommendations address theses factors implementing them might help the Kenyan government and its development partners to improve the quality of integrated family planning and VCT service in Kenya.

Sensitize family planning providers on HIV counselling to deal with clients in a way that encourages them to speak openly about their concerns on HIV/AIDS and HIV status!

The provision of HIV counselling appears to be passive at family planning settings. In most cases clients only receive information on HIV when they ask for it. Provision of HIV counselling should be more proactive. Therefore, family planning providers should be sensitized to the importance of HIV counselling in family planning settings. Although guidelines recognize counselling as one element of family planning, in particular HIV counselling should be stressed on to a greater extent in the guidelines. The majority of family planning settings have no quiet and confidential environment to discuss sensitive issues such as HIV/AIDS and sexual behaviour. Thus, separate rooms for counselling at family planning settings should be available so that a confidential relationship between providers and clients can be established that makes HIV counselling easier for both.

Institute a more comprehensive family planning training qualifying VCT counsellors to give better information on contraceptive methods and enable them to promote such methods!

VCT counsellors have only limited knowledge and skills for family planning service delivery. The majority of VCT counsellors have no medical background and they are just

briefed on family planning during VCT training so that they take it upon themselves to provide family planning counselling. Therefore, VCT counsellors without medical background need family planning training in order to enable them to provide at least level one of integration. A wider variety of professional family planning backgrounds should be accommodated in VCT provider's training curricula. Although family planning is mentioned in the guidelines its provision can be further integrated and strengthened through more comprehensive standardized information in the VCT guidelines.

Supervision systems have to be standardized and have to be carried out on a regular basis for both unit managers and family planning providers!

Outreach and provider supervision is weak in family planning settings. There is no coherent mechanism to make sure that unit managers receive updates, pass on the information to providers and supervise them in the proper implementation. Outreach supervision through Health Management Teams should be strengthened and conducted on a regular basis. Resources should be made available so that management teams can undertake visits to the health facilities at least quarterly. Regular meetings for unit managers as well as for family planning providers offer another good opportunity to improve the communication and supervision process in family planning settings. Joint meetings for family planning and VCT counsellors can further improve integrated service delivery. At such gatherings providers can jointly discuss their experiences and problems in service delivery and can support each other in implementing either VCT or family planning services.

Establish a formal feedback system so that service providers know if clients who receive referrals actually seek the services!

There is currently no well-defined referral mechanism. Feedback systems should be established so that providers know if clients who received referrals actually visit the services they are referred to. In this way providers can respond to deficits clients may have in family planning or VCT. Referral forms can be used to both document the service the client is referred for as well as to provide information on what kind of service the client actually received. But this requires service providers and clients to be sure that the client's confidentiality will be respected.

Increase the availability of supplies and appropriate equipment in family planning and VCT settings necessary for carrying out integrated service delivery!

The availability of appropriate equipment and supplies is important to make integrated service delivery possible. Logistic systems have to be improved in a way that HIV testing possibilities can be accessed in family planning settings while contraceptive methods should be available in VCT settings.

Create awareness and acceptance on integrated family planning and VCT services in the community!

Clients need to be aware that they can receive family planning in VCT settings and vice versa. They need to be informed that service providers in both settings are trained for providing both family planning and VCT services.

6.2 Demand for further research

Integrated service delivery in Kenya is expected to be an effective approach for increasing HIV prevention and access to family planning services, in particular for HIV positive clients. This study did not intend to investigate whether these expectations are fulfilled rather it is a situation analysis that aims to show the actual level of integration provided in Kenyan health services.

This study was not considered to be representative because it collected data only in public health facilities in one district in Kenya. Hence future research should be carried with a larger number and variety of interview partners. It should include the management and providers of private, mission and non-governmental facilities as well.

Further, this study did not interview the clients on what type of integrated family planning and VCT service they actually received. Thus, future research should preferably include interviews with clients that are the actual recipients of these services and conduct observations of service provision in order to collect more comprehensive information on the realities of integrated service delivery. At the time this study was conducted there was no research on whether and to which degree the clients felt satisfied by the integrated family planning and VCT services they received. Research should focus on this issue because it also would be helpful to make a realistic assessment whether benefits associated with integrated services can be achieved in Kenya.

This study reveals that VCT counsellors have not been adequately trained in family planning and that family planning providers need to be sensitized on HIV counselling. Research should be conducted on the contents and quality of VCT and nurse’s training curricula to investigate to what extent they integrate family planning and HIV counselling and to identify areas requiring improvement. Further, family planning and VCT guidelines

should be reviewed and updated so that they address providers concerns on family planning and VCT to enable to successfully combine both services.

The study results indicate that weaknesses exist in referral mechanism between family planning and VCT sites. Future research on the structure of existing referral mechanism to identify options for improvements with regard to integrated service delivery would be beneficial. It should lead to a formal and applicable referral system which is acceptable to both providers and their clients.

This study also exposed weaknesses related to supervision and logistic systems. Hence research should be carried out to identify communication and decision making processes between management units. Mechanism should be established that make cooperation between vertically structured reproductive health and HIV/AIDS management units possible and also ensuring that resources are equally allocated for family planning and VCT settings. Supervision systems should be developed to monitor and evaluate the integration of VCT and family planning services in order to identify problems in implementation and develop effective solutions.

The Kenyan government has made the first step towards integrated service delivery by implementing the national strategy on integration. But there are challenges to overcome like the vertical structure of sexual and reproductive health and HIV/AIDS programmes with top-down managements and separate funding streams. Managers have to find ways to link these programmes more closely in order to provide effective and good quality integrated service. Health sector reforms are still taking place in Kenya, with the second National Health Sector Strategic Plan 2005 the Sector Wide Approach (SWAp) has been initiated. The SWAp essentially, is the pooling of donor funds and the abolition of traditional programme specific approaches. It is expected that SWAp will contribute to integrated service delivery in a way that development partners can increasingly move away from specific programme funds and managements and shift towards a more collective approach to reach the goals of the health sector plan in collaboration with the Ministry of Health. Thereby the traditional vertical structure of public health programmes would be more and more reduced which could eventually help to strengthen the implementation of integrated service delivery. Hence there is hope that conditions at management and implementation level will change for a better so that providers will be in a better situation to deliver good quality integrated service. This should help to achieve the ultimate goal of healthy and satisfied clients because *“Integration of family planning and VCT is important to reduce HIV prevalence and unwanted pregnancies. A faster implementation can save life!"* (District Clinical Coordinator)

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Statutory Declaration

This is to declare that I have prepared following thesis entirely by myself using only the sources mentioned. This thesis – or any variation thereof - has never been submitted to any examination authority.

Hamburg, February 28th 2007

Frauke Heinze

7 Annex

Questionnaire for Service Providers

Information about observation

Interview Nr.

1. Date: _____

2. Level of health facility:
[ ] Hospital
[ ] Health Centre
[ ] Dispensary
[ ] Stand-alone
[...] Other, specify

3. Type of service provider: [ ] FP service provider
[ ] VCT service provider

A. Qualification and experience of service provider

4. Sex: [ ] Male
[ ] Female

5. Age (years) classification: [ ] ≤20
[ ] 20-34
[ ] 35-49
[ ] 50-64
[ ] 65-79
[ ] ≥80

6. How long have you been working in this facility? [ ] <1month
[ ] 1-3 months
[ ] 4-6 months
[ ] 7-11 months
[ ] 1-3 year
[ ] >3 years

7. What is your current technical qualification? _____

8. What year did you graduate with this qualification? _____

9. What year did you start working in your current position? _____

10. For how long have you worked in this field? [ ] <1month
[ ] 1-3 months

[ ] 4-6 months
[ ] 7-11 months
[ ] 1-3 year
[ ] >3 years

11. What are the main content of your work? [ ] Counseling
[ ] Clinical diagnosis
[ ] Medical care
[ ] Others, specify _____

B) FP/VCT client information

12. Approximately how many clients do you have per month
13. What approximate percentage are women? [ ] ≤25%
[ ] 26-50%
[ ] 51-75%
[ ] 76-100%
14. Approximately what is the age of female clients? _____
15. Approximately what is the age of male clients? _____
16. What approximate percentage is married? [ ] ≤25%
[ ] 26-50%
[ ] 51-75%
[ ] 76-100%
17. What approximate percentage has children? [ ] ≤25%
[ ] 26-50%
[ ] 51-75%
[ ] 76-100%
18. Approximately what distance do clients travel to reach this facility? [ ] ≤1km
[ ] 1-2km
[ ] 3-5km
[ ] >5km
19. Clients visit: Number of first time visit/month? _____
20. Clients visit: Number of follow up visit? _____

C) Level of integrating VCT and FP

21. What kind of issues do you discuss with your clients?

[ ] Modes of transmission of STI including HIV/AIDS
[ ] Dual protection
[ ] High risk sexual behavior
[ ] Signs and treatment of STI
[ ] Interaction between contraceptives methods and HIV/AIDS treatment
[ ] Importance of knowing one's HIV status
[ ] Pre- and post-test counselling
[ ] Knowing partner's HIV status
[ ] Risk of mother to child transmission of HIV
[ ] Risk of HIV re-infection
[ ] Different contraceptive methods
[ ] Others, specify _____

22. **If VCT sites**, which contraceptive methods do you discuss with your client?

[ ] Male condom
[ ] Female condom
[ ] Pills
[ ] Injectable
[ ] IUCD
[ ] Implants
[ ] Emergency contraceptives
[ ] Sterilization

23. Does the client come to FP/VCT clinic with any questions and concerns on FP/HIV?

[ ] Yes [ ] No

24. If **yes**, which is the main one?
25. What are the FP needs of HIV positive clients?
26. **If a FP counselor**, is it important to know your client's HIV status?

[ ] Yes [ ] No

27. If yes, how do you find out the client's HIV status? No referral letter client has to tell

28. Do you provide FP counseling to discordant couples? [ ] Yes [ ] No

29. What is the clients need on VCT related issues?

30. **If VCT service provider** what kind of different contraceptives do you provide?

[ ] Male condom
[ ] Female condom
[ ] Pills
[ ] Indictable
[ ] IUCD
[ ] Implants
[ ] Emergency contraceptives
[ ] Sterilization
[ ] Others specify _____

31. **If VCT service provider**, if the client is using any contraceptive method, who observe side effects and provide counseling?

[ ] FP service provider
[ ] VCT service provider
[ ] Spouse
[ ] Relative
[ ] Neighbor
[ ] None
[ ] Other, specify _____

32. Can you always provide VCT services client ask for? [ ] Yes [ ] No

33. If no, why _____

34. What do you do in such situation? _____ _

35. For what reason is the client referred to a VCT site?

36. Do you have any collaboration with a FP/VCT site? [ ] Yes [ ] No

37. If yes, what is the name? _____

38. How far is it from here? _____

39. Do you have a special form for clients' referral? [ ] Yes [ ] No

40. What kind of IEC material on FP/VCT does this facility have for awareness creation?

[ ] Posters
[ ] Leaflets
[ ] Brochures
[ ] Kit
[ ] Other, specify _____

41. Do you have a copy of the FP guideline? [ ] Yes [ ] No

42. If yes, observe for verification: [ ] Available [ ] Not available

43. If available, what is the main content? _____

44. **If No in Q41** above, on what basis does you then provides the services?

45. Who is paying for your salary?

46. In the last year, have you been trained on any aspects related to HIV?

[ ] Yes [ ] No

47. If yes, what was the content?

[ ] Family planning counseling
[ ] Family planning methods
[ ] Symptom management of FP methods
[ ] Rumors and misconception on contraceptive methods
[ ] Integration of VCT and FP
[ ] Pre-test counseling
[ ] Post-test counseling
[ ] Interaction between HIV treatment and contraceptive method
[ ] Modes of transmission of STI including HIV/AIDS
[ ] Signs and treatment of STI
[ ] Others, specify _____

48. If yes, by whom the training was provided? _____

49. In your opinion, does the training enable you to provide adequate and accurate information on FP/VCT? [ ] Yes [ ] No

50. Do you feel that you are sufficiently trained on FP service provision?

[ ] Yes [ ] No

51. Where are the gaps?

52. Do you meet with other counselors? [ ] Yes [ ] No

53. If yes, how often do you meet them? [ ] Daily
[ ] Weekly
[ ] Monthly
[ ] Quarterly
[ ] Yearly
[ ] not regularly

54. What are the main topic do you discuss?

55. Do you think the client is interested in integrated service? [ ] Yes [ ] No

56. Give the main reason for your answer:

57. Do you already provide integrated service in your FP/VCT counseling session?

[ ] Yes [ ] No

58. If No, what is the main reason?

59. In your opinion, should integrated service be provided in FP/VCT sites?

[ ] Yes [ ] No

60. Give the main reason for your answer:

61. What is your main challenge in your daily work to provide integrated service?

62. What are your suggestions to improve service provision of integrated service?

63. At the end of the day, what is the main thing that makes you happy about your work?

Questionnaire for Key Informants

Information about observation

1. Date: ____/06/2006

2. Level of health facility: [ ] Hospital
[ ] Health Centre
[ ] Dispensary
[ ] Stand alone VCT site
[ ] Other, specify _____

3. [ ] Policy maker
[ ] Programme Manager
[ ] Unit Manager

A. Qualification and experience of service provider

4. Sex: [ ] Male
[ ] Female

5. Age (years) classification: [ ] ≤20
[ ] 20-34
[ ] 35-49
[ ] 50-64
[ ] 65-79
[ ] ≥80

6. How long have you been working in this facility? [ ] <1month
[ ] 1-3 months
[ ] 4-6 months
[ ] 7-11 months
[ ] 1-3 year
[ ] >3 years

7. What is your current technical qualification? _____

8. What year did you graduate with this qualification? _____

9. What year did you start working in your current position? _____

10. For how long have you worked in this field?
[ ] <1month
[ ] 1-3 months
[ ] 4-6 months
[ ] 7-11 months
[ ] 1-3 year
[ ] >3 years

B. Level of Integration FP and VCT

1. Which guidelines or protocols does the health facility/district follow on providing VCT and FP services?

2. How did you get to know about new upcoming/updated FP and VCT guidelines, policies which have been implemented on the national level?

3. How do new guidelines reach the service provider from the national level?

4. How do you make sure that FP/VCT guidelines are being used by the counsellor?

5. What services related in FP/VCT have you integrated so far?

6. What are the components of integration are mentioned in the counsellor protocol?

7. On what aspects on integration the FP and VCT counsellor have been trained and by whom?

8. By whom VCT/FP sites are being financed?

9. In what way the training has enabled the FP/VCT counsellor to give accurate information on FP/HIV?

10. How is the client benefit from integrated service?

11. In your opinion should be integrated service provided in FP/VCT sites? Please give reasons for your answer.

12. What are the challenges to provide integrated service?

13. What are your suggestions to improve service provision of integrated service through FP and VCT sites?

14. Do you have any further comments in respect to FP and VCT integration?

Facility Assessment Checklist

A) Facility identification

1. Date: _____ 2. Level of health facility: [ ] Hospital
[ ] Health Centre
[ ] Dispensary
[ ] Stand alone VCT site
[ ] Other, specify _____

3. Physical address of health facility:
4. Name of officer in charge

5. Opening days of the health facility: [ ] Daily
[ ] 1-2 days per week
[ ] 5 days per week
[ ] >7 days per week

6. Opening time of the health facility: [ ] Daily
[ ] 8hours
[ ] 8-12 hours
[ ] 12-24 hours
[ ] >24 hours

B) Number and qualification of personnel

7. Number of persons in the management team
8. Number of health workers trained on counseling
9. Number of health workers providing counseling and are not trained
10. Number of trained voluntary counselor without medical background

C) Integration of FP and VCT services

i. Overview of services available in the health facility

11. Family planning: [ ] Yes [ ] No

12. Number of rooms:

13. Located in one building with other services [ ] Yes [ ] No
14. Number of health workers trained on counseling
15. Number of voluntary counselors
16. Number of others who provide counseling
17. VCT services: [ ] Yes [ ] No
18. Number of rooms
19. Located in one building with other services [ ] Yes [ ] No
20. Number of health workers trained on counseling
21. Number of voluntary counselors
22. Number of others who provide counseling

ii. Location of services

23. FP and CVT services are in one building [ ] Yes [ ] No
24. FP and VCT services are in separate building [ ] Yes [ ] No
25. FP and CVT services are in connected rooms [ ] Yes [ ] No
26. Only VCT services are available [ ] Yes [ ] No
27. Only FP services are available [ ] Yes [ ] No

iii. Places of counseling rooms

28. How many rooms?
29. Quiet and confidential rooms [ ] Yes [ ] No
30. **If No**, what are the conditions like of the room?
31. Are there signs to direct the clients to one service to another? [ ] Yes [ ] No
32. Are educational materials for FP and VCT available? [ ] Yes [ ] No
33. If yes, what kind of?
34. If yes, which ones? [ ] For VCT
[ ] For FP
[ ] For both