



## Setting the Africa Agenda

### Workshop on Integration of Services for Sexually Transmitted Infections with Maternal-Child Health and Family Planning Services

*Nairobi, Kenya: May 22-24, 1995*

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#### Table of Contents

Background .....	1
Rationale for SARA Participation.....	1
Highlights from Workshop Presentations.....	2
The Kenya Integration Network.....	2
What Can We Learn From Existing Integrated Reproductive Health Services?.....	3
The Inventory of Integrated Projects.....	3
Case Studies .....	3
Highlights from Working Group Sessions.....	4
Advantages and Disadvantages of Integration.....	4
Highest Priority Activities.....	5
Conclusion and Recommendations for Next Steps.....	7
Recommendations for Next Steps.....	8

#### Appendices:

Appendix A: Inventory Findings

Appendix B: Recommendations from the Workshop—Program Activities, Networking, Policy  
Administration, OR and Case Studies

Appendix C: Highlights from Questionnaire Pre-testing

## Acronyms

AFR/SD/HRD	Africa Bureau, Office for Sustainable Development, Human Resource and Democracy Division
AIDS	acquired immunodeficiency syndrome
AVSCI	Association for Voluntary Surgical Contraception International
CA	cooperating agency
CBD	community-based distribution
CEDPA	Center for Development and Population Activities
CRHCS/ECSA	Commonwealth Regional Health Community Secretariat for East, Central, and Southern Africa
ESA	East and Southern Africa
FHI	Family Health International
FP	family planning
HIRAA	Health and Human Resources Analysis for Africa
HIV	human immunodeficiency virus
IEC	information, education, and communication
MCH	maternal and child health
MIS	management information systems
MOH	ministry of health
NGO	non-governmental organization
OR	operations research
PATH	Program for Appropriate Technology
REDSO	Regional Economic Development Support Office (USAID)

RPR	rapid plasma reagin
RTI	reproductive tract infection
SARA	Support for Analysis and Research in Africa
STI	sexually transmitted infections
TBA	traditional birth attendant
USAID	United States Agency for International Development
WCA	West and Central Africa

## **Background**

Under the joint leadership of USAID/Africa Bureau, USAID/REDSO/ESA and the Commonwealth Regional Community Health Secretariat (CRHCS) in Tanzania, a variety of activities are already underway to clarify what is being done to integrate services for sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV) infection, into existing maternal and child health (MCH) and family planning (FP) services. These activities contribute toward "Setting the Africa Agenda" for integration and include the development of research and program inventories, conferences, operations research case studies, south-to-south consultancies and how-to booklets. The Population Council, Pathfinder International, the Data for Decision Making project at Harvard, and the Centers for Disease Control will be the major players responsible for conducting these activities.

With this background, *Setting the Africa Agenda*, a three day workshop on the integration of services for sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV) infection with maternal and child health (MCH) and family planning (FP) services was held in Nairobi, Kenya, May 22-24, 1995. A total of 165 participants representing USAID/Washington, USAID field missions, cooperating agencies and non-governmental organizations involved in health care services in Africa, as well as representatives from 18 African countries attended the workshop.

The workshop objectives were: 1) for participants to learn about global interests and approaches toward integrated STI/HIV services in MCH and FP projects; 2) to increase awareness of the advantages and constraints of integration; and 3) to identify activities to assist research, program, and policy professionals working on or interested in integration of services in sub-Saharan Africa.

## **Rationale for SARA Participation**

One of the key strategic areas identified as a priority topic for research, analysis and information dissemination in the *Strategic Framework for HIV/AIDS, STIs, and Tuberculosis in Africa* is "integration," or the incorporation of HIV/STI activities within other health programs. A SARA Issues Paper, **Providing Services for Sexually Transmitted Infections Within Other Health Programs** has also been developed on the topic. This Issues Paper was one of the background documents at the integration workshop. As SARA's Public Health Advisor who developed both the Strategic Framework and the Issues Paper, I was sent by AFR/SD/HRD, through its SARA contract, to participate in the integration workshop. It was an opportunity for HIRAA/SARA to gather integration-related information from health planners, policy makers, service providers and representatives from different cooperating agencies (CAs) attending the workshop, and also to pre-test an integration-related

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## *Highlights from Workshop Presentations*

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questionnaire that SARA had developed for program managers and administrators working in integrated programs.

### **Highlights from Workshop Presentations**

#### *The Kenya Integration Network*

USAID Kenya presented the Kenya Integration Network, which is a collective response by CAs toward understanding and managing integrated activities. The network is a self-managed group that has undertaken the responsibility of linking integration activities in Kenya. Members of the network include CAs such as Pathfinder International, Center for Development and Population Activities (CEDPA), Program for Appropriate Technology (PATH), Family Health International (FHI), Population Council, Population Services International and Association for Voluntary Surgical Contraception International (AVSCI).

Four working groups have been formed in the network:

- ◆ the Information, Education, Communication (IEC) working group;
- ◆ the Training and Curriculum Development working group;
- ◆ the Service Delivery working group; and
- ◆ the Research and Evaluation working group.

Some highlights from presentations by each working group follows:

**IEC Working Group:** recognition that the elements to achieving full integration include IEC, condom distribution and STI control; the challenge being “to make reproductive tract infections (RTIs) and STIs discussable” in IEC strategies.

**Training and Curriculum Development Working Group:** most trainings train the same individual; current lack of integration in developed curricula and the need for CAs to share curricula and training materials; the need to study different training integration models in Kenya, and to identify and disseminate lessons learned.

**Service Delivery Working Group:** recognition that service delivery personnel cannot do it all; importance of provider attitude including “fear of bad reputation”; constraints regarding pharmaceuticals for STIs and related supplies such as condoms, gloves, etc.

**Research and Evaluation Working Group:** operations research activities which are on this working group’s list include case studies of on-going integration activities; situation analysis study of integration in clinical service delivery points; role of com-

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## *Highlights from Workshop Presentations*

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munity based distribution agents in providing STI/HIV information and counseling; and testing new approaches to integrating STI/HIV services in MCH/FP programs.

### *What Can We Learn From Existing Integrated Reproductive Health Services?*

This presentation by the Data for Decision Making project identified common problems encountered by integrated programs and made recommendations to ensure efficient and effective services. The presentation was based on a literature review of published articles and agency reports concerning integrated programs. Fourteen programs from Latin America, Africa, and Asia were reviewed and summarized.

The most common problems encountered were in the areas of staff training and quality of services, logistics and delivery of drugs and laboratory supplies, and information systems. Twelve of the fourteen programs reviewed felt that their expanded services enhanced the program's image and utilization of clinic services, while the remaining two programs felt that adding RTI/HIV activities stigmatized the facility and resulted in a decline of patients.

Recommendations based on findings from the literature review were the need for high quality, client-centered services; enhanced training and supervision of staff; reliable logistics and supplies, and accurate information and evaluation systems.

### *The Inventory of Integrated Projects*

This inventory, jointly carried out by Pathfinder International and the Population Council, was to "address the three "Ws" and "H": Who is doing what? What is being done? Where? and How? The inventory is on-going. At the time of the workshop, 73 projects/programs from 14 countries had been identified under the general rubric of "integration," but no clearly stated policy guiding integration efforts seemed to exist for these projects/programs. Sixty-five percent of the projects/programs provide a combination of clinic and/or community-based distribution (CBD) and/or other outreach, and half have on-site laboratories. Sixty-seven percent have trained fewer than half of their staff to provide integrated services, although in some projects/programs, "none" have been trained in integrated delivery. (See Appendix A — Inventory Findings — for a complete list of conclusions based on responses received during the inventory.)

### *Case Studies*

Five case studies were presented: two from Kenya, one from Botswana, one from South Africa, and one from Uganda.

Common constraints encountered were discomfort between client and health worker in taking sexual history and discussing sexuality issues and sexual behavior

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## *Highlights from Working Group Sessions*

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(clients are often friends or relatives of health workers); time constraints due to added responsibilities; problems with treatment because of unavailability of expensive STI drugs or because treatment failed as a result of antibiotic resistance or non-compliance; problems with partner notification because clients are reluctant to reveal partners' names; inadequate number of staff trained in provision of integrated services; and lack of guidelines/protocols for the management of STI/HIV/AIDS in FP/MCH programs as well as lack of efficient referral systems.

The following were pointed out as important to the success of integration programs:

- ◆ donor assistance with drugs and equipment;
- ◆ political will and government support;
- ◆ a consultative process from the policy level to the grass roots level;
- ◆ training and supervision of integrated staff; and
- ◆ increasing the awareness of the community about integration and the services that will be available.

A notable strategy was the "No Missed Opportunities Approach" employed by the Sulmac Clinic in Kenya. The clinic serves 5000 employees of a flower farm, and the policy of the clinic is that all attendees are counselled on FP and STIs and receive a card signed by the clinic that counseling had taken place.

## *Highlights from Working Group Sessions*

The participants were divided into five working groups to 1) identify advantages and disadvantages of integration; and 2) work through a two-step process of identifying priority activities under four headings:

- ◆ program activities,
- ◆ networking activities,
- ◆ policy and administration activities, and
- ◆ operations research activities.

## *Advantages and Disadvantages of Integration*

Many advantages and disadvantages of integration were identified by the participants. Some major ones were:

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## *Highlights from Working Group Sessions*

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### **Advantages**

- ◆ Cost and time effective (cost-effective by avoiding duplication of services and maximizing use of scarce resources; time-effective by serving as one-stop clinics for a range of services).
- ◆ Expands the knowledge and skills of health care providers.
- ◆ Increases sustainability.
- ◆ Expands the clientele for family planning services by involving men, youth and the community.
- ◆ Provides an increased database for planning, therefore is easier to carry out baseline data collection.
- ◆ Reduces the stigma for women in the general population seeking health care for STI/HIV.
- ◆ Increases promotion and use of condoms and other barrier methods as well.

### **Disadvantages**

- ◆ Increased cost to MCH/FP services, for which there is already a lack of resources.
- ◆ Time burden on service providers.
- ◆ Increases workload without extra compensation for staff.
- ◆ Increases client waiting time.
- ◆ Can lead to message/information overload.
- ◆ Can result in reduced quality and focus of services.
- ◆ Staff require additional training for which current MOH staff do not have appropriate skills.
- ◆ High drop-out rate with referrals.

### ***Highest Priority Activities***

The activities receiving the highest priority (as identified by workshop participants) to be undertaken over the next three years were as follows:

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## *Highlights from Working Group Sessions*

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### **Program Activities**

- ◆ Develop, update, share, standardize national curriculum for STI/HIV/AIDS (including communication skills, STI management) at pre- and in-service levels.
- ◆ Promote condom distribution including the use of dual methods.
- ◆ Train nurses, midwives, physicians, community-based workers and laboratory technicians for integrated service delivery.
- ◆ Develop, update guidelines, standards and protocols for integrated service delivery.
- ◆ Develop mechanisms for increased community participation and mobilization, so as to support and empower clients to use services designed to meet expressed need.

### **Networking Activities**

- ◆ Identify funding sources and engage all donors in broad-based strategies and operations research.
- ◆ Establish a task force in each country, including donors, private sector, ministries, health providers and clients to establish goals and objectives for integrated programs.

### **Policy and Administration Activities**

- ◆ Refine models of integration and develop service delivery at all levels that reflect the models.
- ◆ Review policies on prescription STI drugs as well as policies on nurses prescribing STI drugs.

### **Operations Research Activities**

- ◆ Adolescent participation and utilization of services.
- ◆ Situation analyses of policy, and client and provider attitudes on integration.
- ◆ Cost-effectiveness of integrated programs.
- ◆ Male participation and use of services.

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## *Conclusion and Recommendations for Next Steps*

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- ◆ Testing of models of integration.
- ◆ Effectiveness of the syndromic approach.

(See Appendix B for the complete list of recommended activities identified by workshop participants.)

### **Conclusion and Recommendations for Next Steps**

The workshop provided me with a network of participating partners in integration, and I took advantage of that opportunity to pre-test an integration-related questionnaire that had been developed for program managers and administrators working in integrated programs. In addition, the workshop gave me a chance to talk with health personnel working with integrated clinics, and was able to test the validity of the issues on integration that were identified in the paper I had prepared. I found that their issues, concerns and perspectives on integration were similar to those I had identified - issues that need to be addressed in the planning and implementing of integrated programs.

The breakout sessions could have been more useful. In my working group, for example, generic, non-integration issues were discussed rather than integration-specific activities. Some participants were sensitized to and knowledgeable about integration, while some were not at all informed. Several important integration-specific activities such as:

- ◆ planning for adequate supplies of STI drugs and contraceptives,
- ◆ strengthening services such as laboratory, counseling and screening capability,
- ◆ refining the MIS for integrated services including monitoring and evaluation indicators, and
- ◆ logistics, drug procurement, commodity distribution

were listed, but not given the priority they merited on the activity agenda. Several workshop presentations as well as my pre-testing findings (although a small sample of respondents), also indicated that these are priority issues for effective implementation of integrated services. (See Appendix C: Highlights from Questionnaire Pre-testing.)

REDSO FSA should be commended for organizing this workshop. Their role in integration will not end here; REDSO is taking on the role of network hub for infor-

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## *Conclusion and Recommendations for Next Steps*

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mation giving and sharing among participating partners in integration over the next two and a half years.

### *Recommendations for Next Steps*

- ◆ A similar workshop in francophone Africa should be encouraged.
- ◆ The collaboration of cooperating agencies on integration, such as the Kenya Integration Network, needs to be explored in francophone Africa.
- ◆ Collaboration with CRHCS/ECISA: CRHCS/ECISA plays a relevant role in integration. HIRAA/SARA should look into the possibility of supporting integration-related activities proposed by CRHCS/ECISA. For example, HIRAA/SARA should follow-up CRHCS's proposal to SARA to develop a curricula and train nurse/midwives in integrated service delivery.
- ◆ One lesson learned from this workshop was that not all participants were knowledgeable about integration. Thus, information giving and information sharing should be a major activity over the next two and a half years. REDSO/ESA should utilize HIRAA/SARA's information dissemination capability and should involve HIRAA/SARA in the dissemination of findings and lessons learned from on-going, planned and future integration-related studies and OR activities. HIRAA/SARA should also collaborate with REDSO/WCA in order that information dissemination involves francophone Africa as well.

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*Appendix A: Inventory Findings*

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## INVENTORY FINDINGS

- ◆ GOVERNMENT AND NGO ORGANIZATIONS ARE THE KEY PLAYERS.
- ◆ MOST OF THE SERVICES ARE CENTERED IN URBAN AREAS INCLUDING CAPITAL CITIES
- ◆ THE MAJORITY OF SERVICES ARE A COMBINATION OF CLINIC AND COMMUNITY BASED.
- ◆ POLICIES THAT SUPPORT INTEGRATION EXIST BUT MOSTLY THEY ARE NEITHER WELL DEFINED NOR WELL KNOWN. THEY ARE MOSTLY UNCLEAR.
- ◆ FP PROGRAMS ROUTINELY SCREEN FOR STDS. HOWEVER, LESS THAN HALF OF ANC/PNC CLIENTS ARE SCREENED.
- ◆ SYNDROMIC DIAGNOSIS IS NOT WIDELY PRACTICED BY ITSELF. THERE IS MORE CONFIDENCE IN A COMBINATION OF SYNDROMIC AND LABORATORY TESTS.
- ◆ COUNTRIES WITH BETTER HEALTH SERVICES INFRASTRUCTURE (SUCH AS KENYA) HAVE ON-SITE LABS. HOWEVER, ABOUT HALF OF THE SITES HAVE LABORATORIES. HOWEVER, THE SAMPLE IS NOT REPRESENTATIVE.
- ◆ THE MAJORITY OF PROGRAMS PROVIDE COMPREHENSIVE SERVICES FOR CLIENTS WITH STD INCLUDING COUNSELLING, TREATMENT AND FOLLOW-UP.
- ◆ MOST PROGRAMS DO NOT HAVE SERVICE POLICIES/GUIDELINES THAT GUIDE CONTRACEPTIVE METHOD CHOICE, FOR A CLIENT WITH STD.

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*Appendix B: Recommendations from the Workshop - Program Activities, Networking, Policy Administration, OR and Case Studies.*

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## Recommended Program Activities

Color Me Blue

- Develop/update guidelines, standards, and protocols for integrated service delivery
- Develop/update/share/standardize national curriculum for RTI/HIV/AIDS (including communication skills, STD management, infection prevention) at pre- and in-service levels.
- Provision of IEC materials (integrated messages) and condoms.
- STD training for syndromic approach, plus supply of treatment drugs.
- Provide antenatal syphilis testing.
- Include STD risk assessment in antenatal risk assessment
- Condom promotion and distribution including dual methods.
- Develop mechanism for integrated service supervision.
- Revise logistics, drug procurement, commodity distribution/transportation system.
- Include sustainability as part of the integrated program design.
- Develop mechanism for more community participation and mobilization for support of clients' empowerment to use services designed from expressed need.
- Involve managers in all parts - planning, implementation, and evaluation of projects.
- Train program managers/coordinator in integrated service delivery.
- Develop mechanism for community participation to design culturally appropriate and attractive integrated services targeting men, women, and youth.
- Refine MIS for integrated services including: improved data collection, monitoring and evaluation indicators.
- Plan for adequate supplies such as RTI drugs and contraceptives.
- Train for integrated service delivery - nurses, midwives, physicians, CBD, lab-technicians.
- Establish/strengthen support services such as laboratory, counselling, and screening capability.

## **Networking**

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- Conduct in-country study tours
- Establish a task force in each country, including donors, private sector, ministries, providers and clients to establish goals and objectives for integrated programs.
- Identify funding sources and engage all donors in broad based strategies and operations research
- Establish links between national and international integrated programs.
- Use in-country professionals for consultancies and technical assistance.

## **Policy and Administration**

Color Me Rec

- Review policies on prescription drugs and on nurses prescribing RTI drugs
- Revise policies on health system funding and cost recovery
- Refine models of integration and develop service delivery at all levels that reflect those models.
- Consensus building and advocacy among policy makers, esp. MOH

## OR and Case Studies

Color Me Orange

- Or on different delivery strategies for high risk groups
- OR on the effectiveness of dual methods.
- OR testing of models of integration.
- OR on the effectiveness of the syndromic approach
- OR on adolescent participation and utilization of services.
- OR on male participation and use of services.
- OR on drug resistance.
- OR on partner notification.
- OR on cost effectiveness of integrated programs.
- OR on pilot "supermarket" approaches comparing rural and urban programs.
- Continue case studies and expand to include EPI and FP.
- OR comparing costs before and after integration
- Conduct situational analysis of policy, client attitude and provider attitude.
- Identify lessons learned about integration.

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*Appendix C: Highlights from Questionnaire Pre-testing*

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The workshop provided me with a network of participating partners in integration, and I took advantage of that opportunity to pre-test an integration-related questionnaire that I had developed for program managers and administrators working in integrated programs. Despite the time constraint (the workshop was only two and one-half days), nine participants took time to answer the questionnaire that I was pre-testing. *Based on the pre-testing, the questionnaire will be modified and refined for future use in integration-related research.*

The following are highlights from the pre-test findings:

### ***Constraints to Condom and Dual Method Promotion***

- ◆ Negative image and negative information of condoms.
- ◆ Clients did not consider themselves to be at risk.
- ◆ Cultural bias.
- ◆ Condom disposal problem.
- ◆ Most clients are women, and women cannot introduce condoms to male partners.
- ◆ Clients think one type of contraceptive can protect both pregnancy and STIs.
- ◆ Clients cannot afford two methods.

### ***Condom Advocacy - Suggestions to Promote a Positive Image of Condoms***

- ◆ Promote condoms as a sex symbol so condoms can be appreciated and become user friendly.
- ◆ Promote condoms beyond STIs, HIV. Sensitize community to condoms through peer education activities and focus group discussions.

### ***Constraints to STI Counseling***

- ◆ Lack of staff training in counseling skills.
- ◆ Lack of guidelines, protocols in provision of STI counseling (contents of counseling, what to say, what to discuss).
- ◆ Staff uncomfortable talking about sexual diseases.

### ***Constraints to Providing STI Treatment***

- ◆ Lack of follow-up to monitor patient's compliance with medication.

- ◆ Staff's inadequate case management skills. Lack of training and case management guidelines.
- ◆ Lack of appropriate STI drugs; problems with procurement.
- ◆ Lack of affordable STI drugs.
- ◆ Drug resistance.

Some recommendations given regarding constraints to providing STI treatment: governments should identify more funding sources; advocacy - raising awareness of donors to consider supply of STI drugs as a priority.

### *Infection Prevention*

- ◆ Need in-service and pre-service training in infection prevention.

### *Increase in Cost to Programs to Provide STI Services*

- ◆ Cost of training staff.
- ◆ Cost of adding new staff to cope with increased clients and workload.
- ◆ Cost of procuring lab reagents and test kits and training lab technicians and/or nurses doing RPR tests for antenatal syphilis in pregnant women.
- ◆ Increased cost as a result of increased need of drugs and other commodities as patient load increases.
- ◆ Dual method means clients will have to pay for two methods resulting in increased cost to clients and to programs.
- ◆ Increased need for infection prevention commodities (masks, gloves, disinfectants, decontaminants)

### *Constraints to Partner Notification and Treatment*

- ◆ Patient reluctant to give partner's name.
- ◆ Patient fears partner's anger.
- ◆ Partner notification deters patients from seeking care because patient reluctant to give partners' names.
- ◆ Partners/contacts refuse to come to clinic.

- ◆ Clients do not want the clinic to notify the partners.

**Some recommendations** given regarding constraints to partner notification: sensitize communities to importance of partner notification and treatment; IEC to increase community awareness of partner notification; train community special groups (community women and youth) to trace and notify partners. The patient and provider referral approach was also thought to be the most sensitive and effective partner notification approach compared to patient referral and provider referral approaches. Regarding the feasibility of training CBD workers and TBAs in partner notification activities, some participants thought it would be feasible, while some did not think it would be feasible due to ethical constraints and respect for clients' rights.

### *Management Information System and Monitoring*

- ◆ Too much data to collect using two separate reporting forms to feed into two separate information systems.
- ◆ There is a need to coordinate STI reporting and FP/MCH reporting.
- ◆ There is a need for monitoring and evaluation tools for integrated programs.

The above was expressed by all the respondents except the respondents from Zimbabwe who said new indicators have been developed for the integrated program and that "the MOH has initiated an integrated health information system, which is being tried."

### *General Suggestions and Comments re: Effective Integration*

- ◆ Increase training for staff.
- ◆ Strengthen infrastructure - upgrade facilities not conducive to privacy.
- ◆ Strengthen lab services (training, commodities) so that simple tests can be done without need of referral.
- ◆ Increase support (via government budgets - donors) of materials for infection prevention (gloves, masks, disinfectants, decontaminants).
- ◆ Develop monitoring and evaluation tools.
- ◆ People should know the limitations of integration. Integration should be specific with specific objectives.

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