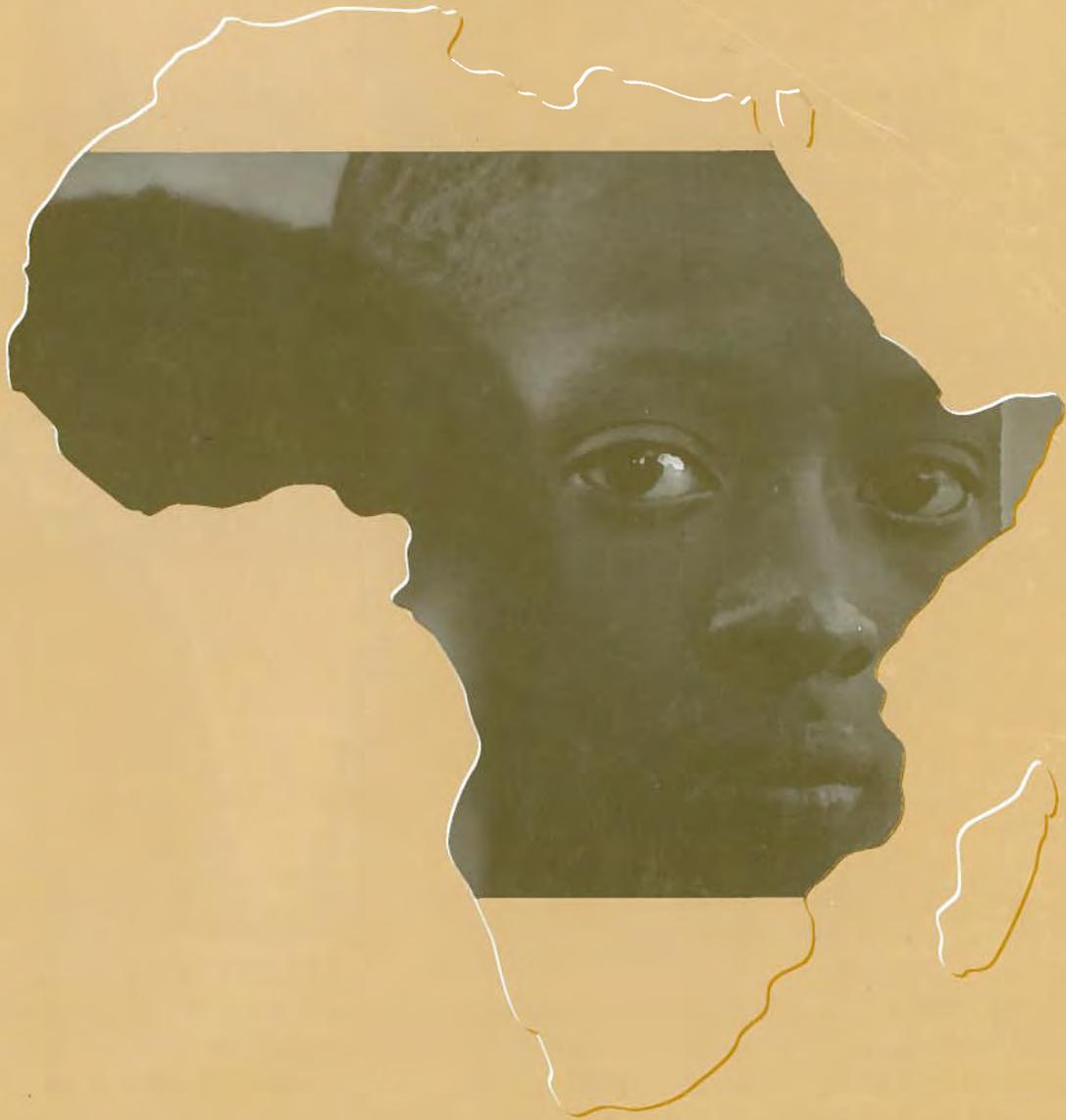


**AN AFRICAN RESPONSE TO THE CHALLENGE OF
INTEGRATING STD/HIV-AIDS SERVICES
INTO FAMILY PLANNING PROGRAMS**



40  **Pathfinder**
YEARS INTERNATIONAL

**AN AFRICAN RESPONSE TO THE CHALLENGE OF
INTEGRATING STD/HIV-AIDS SERVICES INTO
FAMILY PLANNING PROGRAMS**

**Wilson Kisubi
Francesta Farmer
Richard Sturgis**

in collaboration with

Elizabeth L. Lule
Douglas Huber
Tom Fenn
Betty Farrell
Elly Oduol
Hammouda Bellamine
Paul Shumba
Pamela Onduso
Ezra Teri
Beth Mbaka

edited by

Ritu Shroff
Penelope Riseborough
Nicolene Hengen

© 1997, Pathfinder International. This publication was made possible with support provided by United States Agency for International Development under the terms of Cooperative Agreement No. CCP-3062-A-00-2025-00. The views expressed in this document are those of the authors and do not necessarily reflect those of USAID, other Cooperating Agencies, or local implementing partners.

July 97



AN AFRICAN RESPONSE TO THE CHALLENGE OF INTEGRATING STD/HIV-AIDS SERVICES INTO FAMILY PLANNING PROGRAMS

Table of Contents	i
Abbreviations and Acronyms	iii
Preface	vii
Acknowledgements	ix
Introduction	1
Chapter 1: Concepts of Integrated Service Delivery	11
Chapter 2: The Kenya Experience	29
Chapter 3: Two Case Studies, Integrating Services in Uganda and Kenya	39
Chapter 4: Setting the Africa Agenda	57
Chapter 5: The Way Forward	69

Appendices

Appendix A: Glossary of Terms

Appendix B: STD/HIV-AIDS Prevention Within Family Planning Efforts: Guiding Principles

Appendix C: Bibliography

Appendix D: Funding Sources

Figures

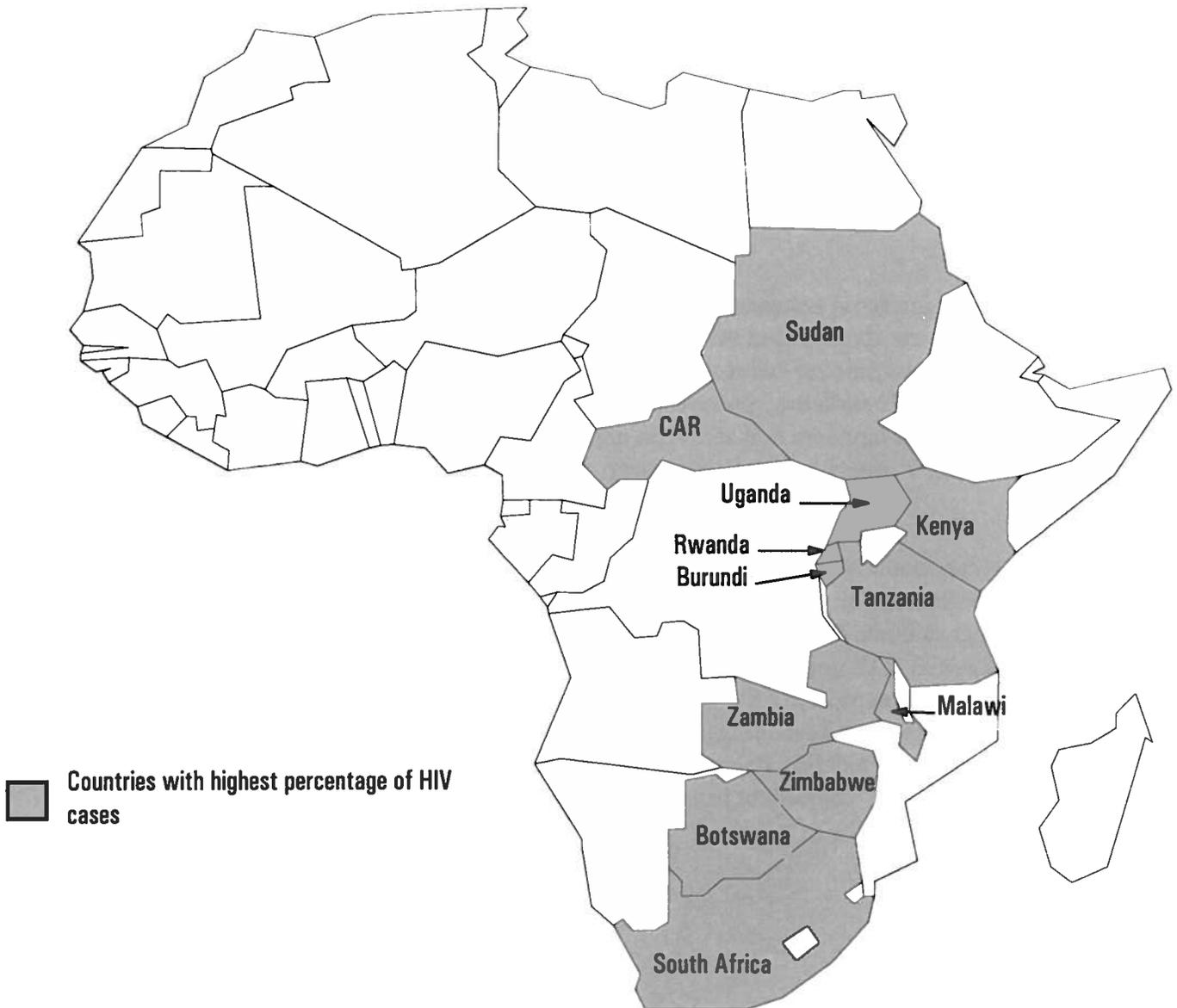
Figure 1: Components of Service Delivery Programs	4
Figure 2: Movement from Vertical to Integrated Services	6
Figure 3: Key Components of Integrated FP/STD/HIV-AIDS Services	14
Figure 4: Levels of Integrating STD/HIV-AIDS into FP Services	18
Figure 5: Examples of Social Marketing In-Roads in Africa	26
Figure 6: Sample List of Preventive Indicators for Preparing a Risk-Assessment Checklist	28
Figure 7: Advantages/Disadvantages of Types of Integration Programs Found in Kenya	35
Figure 8: Mkomani Clinic Condom CYP	51
Figure 9: Mkomani Clinic Total CYP	51
Figure 10: Impact and Time Required for Integration Activities	58
Figure 11: Advantages/Disadvantages of Integration	60
Figure 12: The African Integration Agenda	62

ABBREVIATIONS AND ACRONYMS

AIC	AIDS Information Center
AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
CA	cooperating agency
CAR	Central African Republic
CBD	community-based distribution
CEDPA	Center for Development and Population Activities
COPE	Client Oriented Provider Efficiency
CPR	contraceptive prevalence rate
CWF	child welfare
CYP	couple-years of protection
DISH	Delivery of Improved Health Services
ECPs	Emergency Contraceptive Pills
FHI	Family Health International
FLAS	Family Life Association of Swaziland
FLEP	Family Life Education Program
FP	family planning
FPAK	Family Planning Association of Kenya
FPMMD	Family Planning Management Development
FPPS	Family Planning Private Sector
GTI	genital tract infection
HIV	human immunodeficiency virus
IEC	information, education, and communication
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
IWG	Integration Working Group
JFPA	Jamaican Family Planning Association
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/CCP	Johns Hopkins University/Center for Communication Programs
MCH	maternal and child health
MCS	Mkomani Clinic Society

MIS	management information system
MOH	Ministry of Health
MRSDP	Multi-Sectoral Rural Development Program
MSH	Management Sciences for Health
NGO	non-governmental organization
OR	operations research
ORS	oral rehydration salts
OTTU	Organization of Tanzanian trade Unions
PATH	Program in Appropriate Technologies for Health
PHC	primary health care
PI	Pathfinder International
PSI	Population Services International
PVO	private voluntary organization
QOC	quality of care
REDSO/ESA	Regional Economic Development Services Office for East and Southern Africa
RH	reproductive health
RIP	Regional Integration Partners
RTG	Regional Technical Group
RTI	reproductive tract infection
STI	sexually transmitted infection
STD	sexually transmitted disease
SWG	small working groups
TASO	The AIDS Support Organization
TB	tuberculosis
TBA	traditional birth attendant
TFR	total fertility rate
TOT	training of trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHW	village health worker
VSC	voluntary surgical contraception
WHO	World Health Organization

THE AIDS BELT



¹ Adapted from: Caldwell, John C. and P. Caldwell. *The African AIDS Epidemic*. Scientific American. March 1996: 274 (3), 64-65.

PREFACE

Worldwide attention first focused on the rapid spread of the human immunodeficiency virus (HIV) in sub-Saharan Africa some 15 years ago. Today, the region contains almost 60 percent of the global total of infected persons. The acquired immune deficiency syndrome (AIDS), the final stage of infection with HIV, has reached epidemic proportions in much of the region. Unfortunately, other sexually transmitted diseases (STDs) that facilitate HIV transmission and that also further compromise the health of those infected are also rising at alarming rates in many African countries.

During the last 10 years, family planning providers have grown increasingly concerned about the transmission of HIV and other STDs. Health care providers are struggling to cope with requests for STD/HIV-AIDS information and services while trying to meet the ever increasing demand for maternal health and family planning services. These two sets of services, though distinct, are both closely linked to reproductive health and sexual behavior.

This linkage is forcing the global public health community to reassess programs that serve sexually active men, women, and young adults. While reproductive health needs are continuing to increase, resources are diminishing. Faced with these realities, it has become even more important to manage programs in the most efficient and cost-effective way possible. Preliminary evidence indicates that integrating STD/HIV-AIDS prevention activities into maternal and child health and family planning (MCH/FP) services can help programs achieve more with their limited resources.

The United States Agency for International Development (USAID), its Cooperating Agencies (CAs), Ministries of Health, and Pathfinder International are working in partnership with local non-governmental organizations (NGOs) to integrate reproductive health services in sub-Saharan Africa (see **Appendix B** for USAID's *Guiding Principles in Addressing STD/HIV-AIDS Prevention within Family Planning Efforts*). With support from the USAID/Kenya Mission, Pathfinder has been coordinating a series of activities for CAs and NGOs focused on integrating services in Kenya. Since mid-1993, meetings and workshops have enabled collaborating organizations to share experiences and expertise. Working groups were formed to discuss:

1. Service delivery
2. Policy advocacy
3. Research and evaluation
4. Training
5. Information, education, and communication (IEC)

All of these groups have been working to articulate concerns and identify key issues associated with integration. In August 1994, a workshop on *Integrating STD/HIV-AIDS Services into*

Family Planning Programs was convened for several Cooperating Agency grantees in Kenya. This workshop was designed to provide a common forum for in-country partners to discuss how to develop a strategy for integration activities in Kenya.

In May 1995, USAID's Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA), in collaboration with The Population Council, Harvard University's Data for Decision Making Project, and Pathfinder International, organized a regional workshop, *Setting the Africa Agenda*. The workshop, attended by 165 health care professionals and colleagues from 17 sub-Saharan countries, was held in Nairobi, Kenya and focused on integrating STD/HIV-AIDS services into existing MCH/FP programs.

This document, *An African Response to the Challenge of Integrating STD/HIV-AIDS Services into Family Planning Programs*, followed by a soon-to-be-published Resource Guide, is based on the experiences gained from the preceding activities, a review of current literature, and discussions with host-country partners. It presents several relevant issues including defining integration and related concepts; documenting the process of integration; and identifying and managing appropriate activities for integration based on the program's or service delivery site's levels of sophistication, capacity, community needs, and available resources. Moreover, it describes practical considerations for program managers who must determine how they might integrate services. Emphasis is placed on meeting the reproductive health needs of individual clients, couples, families, and communities more comprehensively.

ACKNOWLEDGMENTS

This document is the product of a collaborative process. Pathfinder International's principal donor, the United States Agency for International Development (USAID), local non-governmental organizations (NGOs), USAID-funded cooperating agencies (CAs), and several other East African public and private sector organizations concentrating on reproductive health care issues all contributed to a productive and dynamic exchange. Pathfinder International is extremely grateful for the time, insight, energy, and innovative ideas that were shared and incorporated into this document. Both the process and the resulting document will hopefully stimulate the practical, appropriate expansion of reproductive health service delivery in ways that are more responsive to clients' needs. The support of USAID/REDSO/ESA and USAID/Kenya has been critical to this initiative.

Pathfinder International would like to extend warm thanks to USAID/Kenya and REDSO/ESA for their support, helpful review, and constant encouragement. In particular, Pathfinder recognizes and thanks Mr. Gary Newton, former Chief, Health, Population, and Nutrition, USAID/Kenya. He is widely recognized as the catalyst and inspiration for moving family planning CAs and NGOs working in Kenya from vertical programs toward integrated service delivery models. REDSO's Regional Health Office staff who reviewed this document and provided useful feedback and suggestions are also greatly appreciated.

This document was shaped in varying ways by many people and organizations, especially the reproductive health implementing community in Kenya. The development of this document was a collaborative effort of task force contributors, reviewers, editors, CAs, and other partner agencies who are the true authors of this *African Response to the Challenge of Integrating STD/HIV-AIDS Services into Family Planning Programs* in sub-Saharan Africa. Pathfinder International would like to thank them all. Special thanks are also extended to Winnie Machuki and Pauline Awuonda for their long hours of hard secretarial work.

In addition, Pathfinder International wishes to thank The Population Council for its welcome collaboration on regional integration case studies, particularly those on the Mkomani Clinic Society (Mombasa, Kenya) and the Family Life Education Project (Busoga Diocese, Jinja, Uganda). The two project managers, Dr. Amina Twahir and Mrs. Joy Mukaire, enriched our collective understanding of the practical aspects and challenges of providing integrated services. Pathfinder International also acknowledges the important work of Dr. Stacey Young, a consultant who conducted initial research and prepared materials used to develop this document.

Finally, the success of this African integration initiative is a credit to many other organizations working throughout the region and, especially, the members of the Kenya CAs Integration Forum and other supportive collaborators. Pathfinder International is therefore grateful to the following organizations:

USAID Cooperating Agencies

AIDS Control and Prevention Program (AIDSCAP)
AVSC International
Center for Development and Population Activities (CEDPA)
Family Health International (FHI)
Family Planning Logistics Management (FPLM)
Family Planning Management Development (FPMD)
Family Planning Private Sector of John Snow International
The Futures Group International
Program for International Training in Health (INTRAH)
Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)
Johns Hopkins University/Center for Communication Programs (JHU/CCP)
Management Sciences for Health (MSH)
The Population Council
Population Services International (PSI)
Regional Assistance in Child Health (REACH)

Other Agencies

Division of Family Health, Ministry of Health (Kenya)
Family Life Education Project (Busoga Diocese, Jinja, Uganda)
Kenya AIDS NGO Consortium
Mkomani Clinic Society (Mombasa, Kenya)
National AIDS/STD Control Program (Kenya)
Program in Appropriate Technologies for Health (PATH)

INTRODUCTION

Hardly any man, woman, or child living or working in Africa is unaware of the dramatic and tragic impact of the AIDS pandemic. This fatal disease is the consequence of the rapidly increasing transmission of HIV infection. From the beginning of the pandemic until mid-1996, an estimated 27.9 million people worldwide have been infected with HIV, of which 19 million people were from sub-Saharan Africa. More than 5.8 million adults and children have died from AIDS.² Of those infected with HIV, approximately 14 million adults and adolescents live in sub-Saharan Africa, representing 60 percent of all HIV infections in the world.³ By 2010, it is projected that half of all deaths in 13 sub-Saharan countries will be due to AIDS.⁴ Women and young adults shoulder a disproportionate health burden of STDs and HIV in sub-Saharan Africa. UNAIDS estimates that half of all HIV infections to date have been among 15 - 24 year olds, and in some countries, 60 percent of new infections occur among 15 - 24 olds with a female to male ratio of two-to-one among 15 - 19 year olds. In Africa, the number of women infected outnumber men by a ratio of 6 to 5.⁵

The pandemic in Africa has acquired a human face as friends, families, and communities are decimated by the spread of HIV. Societies are left with thousands of AIDS orphans and many others who, weakened by HIV, have lost their productivity and ability to contribute to their own welfare and to national development. In many African countries, practices such as widow inheritance by her husband's brother; the failure to provide young adults with accurate information and services to promote safe sexual practices; and a chronic inadequacy of health care resources all contribute to accelerating the transmission of HIV. Thus, there is an urgent need to mobilize health and population programs providing services for those at risk to address the spread of HIV-AIDS.

Ultimately, we are not dealing with numbers, but with human lives. Population programs are intended to improve the quality of life for individual women and men; their aim is to build security in the family and the community; they are intended to help bring human numbers and resources into balance. AIDS does precisely the opposite. AIDS destroys families and weakens society. It takes away from individual women and men their power to plan for their future. It weakens their motivation to plan their families. AIDS is our enemy. [All of us who have committed our lives to fighting for development by means of more and better population

² *The Status and Trends of the Global HIV-AIDS Pandemic*. Symposium Final Report. XI International Conference on AIDS. AIDSCAP/FHI/Harvard School of Public Health/UNAIDS, Vancouver, BC, July 5-6, 1996.

³ Atman, Lawrence. *UN Reports 3 Million New H.I.V. Cases Worldwide for '96*. New York Times. November 28, 1996.

⁴ *Presentations at Setting the Africa Agenda Workshop*. Nairobi, Kenya, May 22 - 24, 1995. [Unpublished]

⁵ Russell-Brown, Pauline and N. Williamson. *The Role of Caribbean FP Programs in AIDS Prevention*. UNAIDS, 1996. [fact sheet]

programs, should commit ourselves even more strongly to the battle against HIV-AIDS.⁶

The modes of HIV transmission are well-documented: HIV is transmitted through sexual intercourse; from the mother to the newborn infant; through infected needles (used during intravenous drug use or in hospitals or clinics not adhering to infection prevention standards); or by using infected blood during a transfusion. The primary mode of transmission in Africa is through heterosexual contact, followed by transmission from the mother to the newborn.⁷

It has been said that HIV infection walks in the footsteps of sexually transmitted diseases (STDs).⁸ The linkage between STDs and HIV-AIDS is attributed to biological mechanisms; the presence of STDs increase susceptibility to and infection with HIV.^{9,10} It is recognized that prevention, early diagnosis, and treatment of STDs can have a significant positive impact on HIV prevention.¹¹ Yet, in many African countries, scant resources have been devoted to early and effective diagnosis and treatment of STDs. Provision of accurate information that reduces stigma, refutes rumors, and conveys positive and specific preventive messages is also limited.

Maternal and child health (MCH) and family planning (FP) service providers have realized that improved STD prevention and use of family planning services can reduce HIV transmission. A practical implication is that program managers, service providers, and donors recognize that they can no longer support and maintain vertical programs in the face of clients' needs, limited resources, and the deepening public health emergency caused by STD and HIV transmission. This recognition has led USAID/Botswana to observe:

Integration of HIV/STD/FP services will be a key factor in improving reproductive health. With HIV-AIDS as a significant force . . . separation of services is no longer a realistic reflection of clients' needs. Sexual behavior and sexually transmitted infections affect fertility and HIV risks; HIV risk affects contraceptive choice and sexual behavior; HIV status affects fertility decisions; these all affect childbearing, which affects the next generation's reproductive health . . . the list goes on. . .¹²

⁶ Nafis Sadik. *Statement at the Roundtable on Population Policies and Programs: Impact of HIV-AIDS*. Berlin, Germany, September - October 1993. Nafis Sadik is the Executive Director of UNFPA.

⁷ *The Status and Trends of the Global HIV-AIDS Pandemic*. op. cit.

⁸ The authors recognize that the term "sexually transmitted infections" is used sometimes in place of STDs in many parts of the world, especially in Africa, in reflection of the fact that not all infections become diseases. For the purposes of this document, the term STDs was chosen as it is most commonly used in the literature.

⁹ *Healthy People: Progress Report For Sexually Transmitted Diseases*. Public Health Services, U.S. Department of Health and Human Services, Washington, DC, October 26 1994. [newsletter]

¹⁰ *Sexually Transmitted Diseases and HIV, an Epidemiological Survey*. *Sexually Transmitted Diseases in the AIDS Era*. December 1993: 7(4):753-770.

¹¹ Grosskurth, Heiner, F. Mosha, J. Todd, E. Mwijarubi, A. Arnoud, et. al. *Impact of Improved Treatment of Sexually Transmitted Diseases on HIV Infection in Rural Tanzania: Randomised Controlled Trials*. *The Lancet*. August 26, 1995: 346(8297):530-536.

¹² *Linking Family Planning and Reproductive Health: New Directions for the Office of Population*. USAID, 1994.

This introductory chapter defines, and outlines concepts related to, integrated reproductive health services. The primary purpose of this document is to provide information about lessons learned from and difficulties of implementing integrated services for NGO and public sector program managers and service providers. CAs and donors, however, will also benefit from this information. In particular, they will find it useful to determine if, how, and where they should focus financial and technical resources to strengthen integrated reproductive services.

Defining Integration

Ever since integrated service delivery began moving to the forefront of MCH/FP organizations' agendas, varying definitions of "integration"—each with its own practical implications—have emerged. Simply put, integration entails incorporating some or all of the STD/HIV-AIDS services into existing MCH/FP services, or vice versa. Integration can best be viewed as a process evolving along a continuum. At its simplest, integration occurs when dedicated service providers, on their own initiative, respond to client needs for an increased array of reproductive health services. In such cases, integration may include the addition of IEC, counseling about STD/ HIV-AIDS, and condom promotion to FP/MCH programs. The other end of the continuum is represented by a USAID/Washington advisory group's definition:

The incorporation of activities to prevent and/or manage sexually transmitted infections (STI), including HIV, into programs of family planning, maternal and child health, and/or primary health care. The incorporation of STD activities may occur at the level of the services that individual health care workers provide to clients, at the level of the management of STD programs and other health programs, and/or at the level of shared support systems (e.g., shared systems for training, logistics transportation, record-keeping).¹³

Most definitions of and attempts at integration lie somewhere between these two extremes. In Botswana, for example, integration began with MCH/FP, STD, and HIV-AIDS services provided within the same organization, but through different service providers either in different locations or different offices (in effect, operating as several vertical programs with separate, unrelated, services).¹⁴ More ideally, integration should take place in a service delivery environment where, depending on the clients' needs, a comprehensive selection of FP/STD/HIV-AIDS services are provided to clients by one service provider, preferably during the same visit. Moreover, services should be integrated after undertaking substantial organizational planning, allocating resources, training providers, and reviewing changing client or community needs. In Kenya and Uganda, this mode of service delivery has been adopted as the definition of integration. Nevertheless, in practice it often remains a goal yet to be reached.

¹³ Minutes of March 7, 1995 Meeting of USAID Technical Advisors for Research on the Integration of STI Prevention and Management into Other Health Programs. [electronic mail communication]

¹⁴ Maribe, L., and S. Stuart. *A Case Study of Botswana's National Program of Integrated Services: What are the Costs?* Presented at Annual Meeting of the American Public Health Association, San Diego, CA, October 1995.

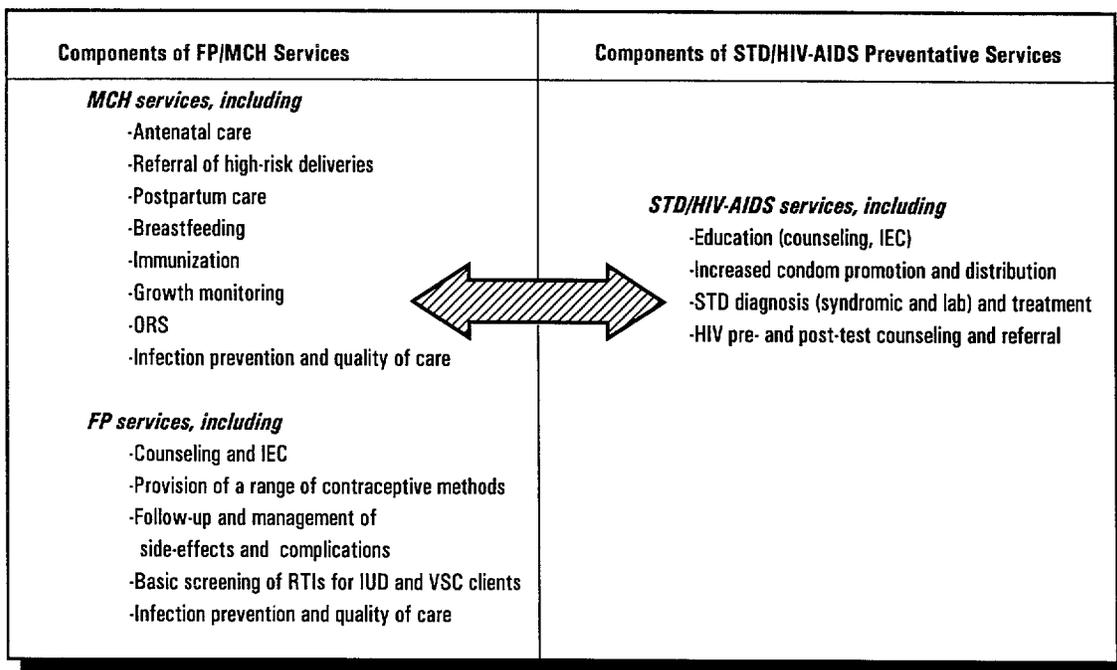
As organizations move toward integrating family planning and STD/HIV-AIDS services, they often pass through several stages of varying degrees of integration. These stages, and the speed with which some notion of full integration can be achieved, reflect the availability of both human and material resources, the state of infrastructural development, and the presence or absence of a supportive policy environment.

What Is Being Integrated?

As summarized by Dr. Malcolm Potts in his closing remarks at the *Setting the Africa Agenda* workshop, three things can be done to slow the spread of HIV: 1) educate people to avoid multiple partners, to use condoms correctly and consistently, and to seek STD treatment, 2) promote condoms and dual method use, and 3) treat STDs. For the most part, this document focuses on providing strategies to integrate these *three* primary components of STD/HIV-AIDS services (**Figure 1**) into family planning services. The authors have added a *fourth* component: HIV pre- and post-test counseling and referral, based on program experiences in Uganda. Incorporating all four components may only be possible for a small percentage of service delivery programs; nonetheless, they are presented to indicate what services might be included in a more comprehensive program.

In Africa, almost all public health programs already combine MCH with FP services. Therefore, this document focuses mostly on integration of STD/HIV-AIDS services (described in the right hand column) with MCH and FP services (listed in the left hand column).

FIGURE 1: COMPONENTS OF SERVICE DELIVERY PROGRAMS



There is some rationale for believing that multiple components, when incorporated, act in a synergistic manner. For example, simulation models that measure a program's potential for impact in typical high-prevalence urban areas have been developed. These models demonstrate that the combination of services such as STD control, promotion of condom use and partner reduction have a far greater impact on HIV seroprevalence than the sum of the effects of each distinct component.¹⁵ Program managers should be aware of the potential synergy from combinations of services instead of relying solely on one intervention.

Why Integrate STD/HIV-AIDS with Family Planning Services?

There are four main reasons for integrating STD/HIV-AIDS services with family planning programs:

1. Integrated programs minimize missed opportunities for screening for and treating STDs.
2. Integrated programs are likely to be more cost effective than parallel or vertical programs with duplicative project components that waste resources (see **Figure 2**).
3. Integrated programs are more convenient for clients.
4. Family planning programs already promote and distribute condoms, an effective intervention for reducing STD/HIV transmission.

Minimizing missed opportunities

Programs that are providing MCH/FP services in Africa reach large numbers of sexually active women who are increasingly affected by the AIDS epidemic. Many STDs are asymptomatic until complications have developed; unfortunately, health care systems in most African countries are designed to treat symptomatic patients seeking curative services. Thus, the majority of asymptomatic women with STDs attending MCH/FP services remain undetected and untreated. Symptomatic women often do not seek curative services because they think their symptoms are "normal," they fear the stigma associated with seeking health care, or they experience other barriers to access such as distance and cost of services. Women in these categories constitute a significant pool of clients who cause service providers to miss opportunities. Since MCH/FP programs are directly concerned with promoting sexual and reproductive health, those trying to integrate STD/HIV-AIDS preventive services generally adjust current program services to further reduce missed opportunities for treating asymptomatic STDs among women, and encourage symptomatic women to seek help immediately and without fear.

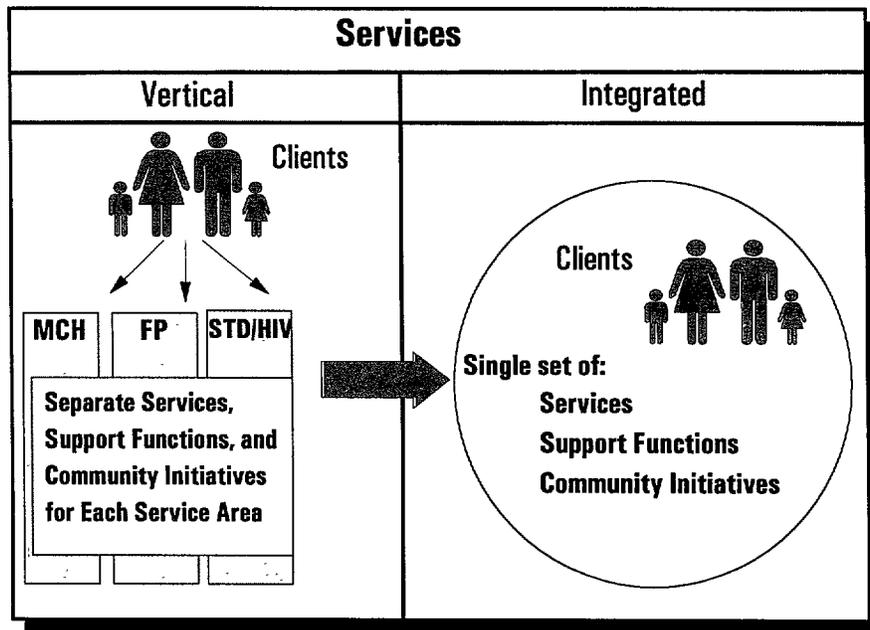
Effective use of available resources

Each vertical health program may have its own information, education, and communication (IEC) strategies and materials; protocols, curricula, and guidelines for service delivery; service

¹⁵ *AIDS Control Annual Report, 1996.*

providers; and dedicated space, equipment, supplies, and information and reporting systems. Since these programs have similar configurations, each program may also have its own separate support functions and development initiatives.¹⁶ Most vertical programs require that clients seek services at differing locations and at differing times. The result is duplicate activities and inefficient use of limited resources.

FIGURE 2: MOVEMENT FROM VERTICAL TO INTEGRATED SERVICES



Family planning workers can develop and implement integrated service interventions that are cost-effective because services, infrastructure, and materials often already exist and require only minor adaptation. Furthermore, in many programs, a certain level of integration already exists (e.g., MCH/FP with STD diagnosis and treatment). When services are integrated, all of the clients' needs can be addressed during the same visit, making services more convenient, increasing client satisfaction, and ensuring more effective use of resources.

Client convenience

Because of the emphasis on better quality, more accessible maternal and child health care in Africa over the last two decades, MCH/FP clinic and community-based workers are often the only health care practitioners available to women. Therefore, women bring their questions and concerns about HIV infection, as well as other STDs and sexuality matters, to MCH/FP workers. These providers will often need less training in STD/HIV services than other health care professionals because of their experience in providing education and counseling on reproduction and condom use.

¹⁶ The term "development initiatives" is based on WHO's recommended program configuration, and refers to external or community-based initiatives designed to garner support for and sustain the program.

This means that institutions offering MCH/FP services already have built-in advantages should they wish to integrate services by adding STD and HIV-AIDS services and information. Moreover, there are issues related to STDs that affect both mother and child. For example, HIV and other STDs are transmissible from the mother to the fetus or infant before, during, or shortly after birth. Women who are at high risk for HIV infection should be informed that their infants' health, as well as their own, may be at risk. MCH/FP workers are well-placed to communicate this information through appropriate counseling and to discuss women's concerns about any potential connection between breastfeeding and HIV infection.

Condom distribution

In Africa, sexual intercourse is the most common means of HIV transmission. Although sexual abstinence or a stable, mutually monogamous relationship with another uninfected person will prevent transmission, for those sexually active with more than one partner, condoms offer the best protection against STDs, including HIV. Since family planning programs are directly concerned with sexuality and reproductive health, they distribute condoms. It is logical therefore for such programs to include STD and HIV-AIDS services when infrastructure, resources, and staffing permit.

Examples of integration

Service providers and program managers also cite several reasons for preferring integrated services, such as the high prevalence of STDs among family planning clients; client demand for STD services; a moral and professional response to the rapid increase of HIV-AIDS; perceived client satisfaction with comprehensive services; and a predicted increase in the number of family planning clients if comprehensive services are provided.

Although research on integrated programs is limited, several studies demonstrate the positive public health impact of integrated reproductive health services. PROFAMILIA, a non-governmental organization working in Colombia, provides reproductive health services to approximately two million, mostly low-income, clients nationwide. In 1988, PROFAMILIA introduced HIV-AIDS activities into its RH programs.

Key activities included providing clinic-based counseling, diagnosis, and treatment for AIDS and STDs, implementing social marketing programs to promote condom use, undertaking community outreach, and designing and producing mass media materials. PROFAMILIA found that providing integrated services is not only feasible, but, more importantly, it is also beneficial to clients. Overall, client knowledge and awareness of HIV-AIDS increased as a result of the program, and information about HIV-AIDS continued to be in high demand. Furthermore, integrating activities did not harm the image of the program and contraceptive sales were not affected.¹⁷

¹⁷ Russell-Brown, Pauline and N. Williamson. *The Role of Caribbean FP Programs in AIDS Prevention*. UNAIDS, 1996. [fact sheet]

In July 1993, the Jamaican Family Planning Association (JFPA) integrated an STD/HIV prevention program into its community outreach family planning activities in rural areas and at two MCH/FP clinics in Kingston. JFPA developed client education materials, held group education sessions, counseled clients about STDs and HIV-AIDS, promoted correct and consistent condom use even when using another method of family planning, and, at the clinics, offered clinical diagnosis, referral for, and treatment of STDs if one was suspected. As a result of these activities, including changes in counseling, quality of care has reportedly improved, awareness of STD/HIV risk and recognition of common STD symptoms have increased, and dual method use has increased.¹⁸

In Quezon City and Muntinlupa, The Philippines, HIV/STD prevention and treatment activities were introduced by the Women's Health Care Foundation as part of their clinic-based FP/MCH programs. Key activities included counseling clients (including commercial sex workers) about STDs and high-risk behavior, promoting condom use, holding small group discussions and slide presentations for clients, and diagnosing and providing referrals for STDs. During the second half of 1994, the program experienced a significant increase in the number of women, men, and youth receiving STD prevention counseling or treatment services. The presentations were enthusiastically received and increased awareness of reproductive health services. Finally, integrated counseling about family planning and STDs has motivated clients to use condoms.¹⁹

Cost studies in Kenya and Botswana have demonstrated that the cost of delivering integrated services is lower than that of providing separate services to the same client. A case study of Kenya's Mkomani Clinic Society estimated that integrating family planning and STD services would be one-third less than the total cost needed to provide the same services separately to the same client.²⁰ In Botswana, initial estimates from a similar study have found that the cost of providing integrated services was \$0.84 per visit lower than providing separate services.²¹

Conclusion

The challenge of HIV-AIDS and other STDs, coupled with Africa's high fertility rate, has posed epidemiological and other imperatives requiring that MCH/FP program managers consider integrated services. Programs that are providing MCH and family planning services reach large numbers of sexually active women who are increasingly affected by STDs and AIDS. When a client seeks MCH/FP services, opportunities occur for STD/HIV screening, early diagnosis, treatment,

¹⁸ Roistein, Florencia, J. Becker, and F. Williams. *A Model Integration of HIV and STD Prevention into Family Planning Programs: Case Study in Jamaica*. October 1993.

¹⁹ *AIDS and STDs: Priorities for FP Programs*. Policy Information Kit, Number 10. Population Action International, Washington, DC, May 1995.

²⁰ Twahir, Amina, B. N. Maggwa, I. Askew. *Integration of STD and HIV-AIDS Services with MCH-FP Services: A Case Study of the Mkomani Clinic Society in Mombasa, Kenya*. The Population Council, April 1996.

²¹ Maribe, L., and S. Stuart. *A Case Study of Botswana's National Program of Integrated Services: What are the Costs?* Presentation at Annual Meeting of the American Public Health Association, San Diego, CA, October 1995.

and counseling; all have potential impact for reducing HIV transmission. There are several very important concerns that MCH/FP service providers must keep in mind when undertaking efforts to integrate STD/HIV-AIDS services. Although MCH/FP programs are the most widespread health initiatives throughout sub-Saharan Africa, many are fragile and struggling. Consequently, care should be taken not to “derail” or damage existing services. With appropriate planning and implementation, evidence thus far suggests that effective integration can be accomplished, but these are issues for program managers to consider as integration efforts move forward.

Program managers in Africa who are operating with limited resources need guidance and reference materials documenting relevant experience and lessons learned; concepts behind integration; and issues to consider as they attempt to integrate their services. This publication attempts to fill some of the aforementioned gaps.

The chapters that follow share information that was derived from many sources, including regional workshops, collaborations among CAs, local implementing agencies (public and private sector health care institutions and NGOs), academics, and research findings. Theoretical and practical considerations for, as well as the challenges and benefits of, offering integrated services are reviewed (**Chapter 1**). The reader will be able to see the array of issues and concerns that should be addressed before integrating services based on the experiences of a network of CAs and local implementing agencies working in Kenya (**Chapter 2**), case studies of two reproductive health NGOs that have achieved a level of integration in their services (**Chapter 3**), and a regional workshop that explored several aspects and examples of integration (**Chapter 4**). Finally, “The Way Forward...,” (**Chapter 5**) outlines some of the major problems that still must be tackled by those who are interested in promoting family planning, ensuring sound reproductive health, and doing their part in slowing the spiraling rates of STD and HIV transmission that are becoming a central preoccupation for health care programs throughout the sub-Saharan Africa region.

CHAPTER 1

CONCEPTS OF INTEGRATED SERVICE DELIVERY

Movement toward integrated reproductive health services presents program managers and service providers with an array of issues and options. Organizations will need to conduct thorough assessments of community and client needs—as well as of service delivery infrastructure and overall program strengths and weaknesses—to identify priority issues and options for integration. There is no single blueprint for integrating STD/HIV-AIDS services into family planning programs or vice versa. However, there are basic ingredients that most (if not all) program managers should pay special attention to, such as the quality of services, strength of program management, organization of services for client convenience, referral systems and networks with follow-up, community support, and cost-effectiveness. The evolution of programs toward integration is not without difficulties and constraints. This chapter reviews some of the major challenges to integration and presents ways of conceptualizing and responding to them.

Challenges to Providing Integrated Services

When organizations begin to integrate STD and HIV-AIDS services into existing MCH/FP programs, they are often forced to contend with a variety of obstacles or barriers, including:

- ♦ Provider attitudinal barriers
- ♦ Client attitudinal barriers
- ♦ Service-related barriers
- ♦ Government or donor policy barriers
- ♦ Resource barriers

Provider attitudinal barriers

Service providers often have their own biases based on cultural, social, religious, and moral beliefs. All of these influence service delivery to some degree. Some providers are uncomfortable with initiating or facilitating open discussions about sexuality and reproductive health matters. Providers may also assume that family planning services should target adult women only. As a result, critical groups such as men and adolescents become marginalized with regard to services.

MCH/FP providers have also expressed reluctance to integrate STD/HIV-AIDS services based on worries that their programs will be stigmatized or linked to promiscuity. They may also fear that the original focus of family planning programs will be diluted or compromised due to costs, increased workload, or greater emphasis on curative rather than preventive services. Some providers may not recognize that STDs, including HIV, are also critical health issues for their family

planning clients. The majority of FP clients are women in ongoing partnerships or marriages. Therefore, service providers may be reluctant to discuss STDs and HIV infections, and related behavioral issues, with those whom, it is assumed, have no “outside” sexual contacts.

Client attitudinal barriers

Clients, too, are influenced by their own religious, cultural, and social beliefs when seeking services. Clients are sometimes reluctant to speak frankly about matters related to sexuality with providers. For various reasons, they may be reluctant to use condoms. African women in particular are often not in a position to negotiate condom use. Men and women may not use reproductive health services because they are afraid of testing positive for an STD or HIV, of notifying partners, or of stigmatization associated with STDs.

Service-related barriers

Even when service providers and program managers are enthusiastic about integrating services, they may be hindered by inadequate resources and insufficient infrastructure. Chronic shortages of drugs to treat STDs, limited access to laboratory facilities, and lack of supplies (including condoms and infection prevention equipment and supplies) continue to impede the integration process. In addition, many facilities do not have private rooms for history-taking, counseling, and physical examinations.

Integration requires a strong commitment to training and upgrading service providers’ and program managers’ skills, especially in counseling, syndromic diagnosis, and infection prevention. Unless a program has resources to hire additional staff, current staff may find it difficult to manage increased workloads due either to an influx of new clients or additional requirements in treating or counseling additional clients posed by integrated service delivery. Programs may also need assistance with establishing new service delivery protocols to clarify what service providers must do, and monitoring systems to ensure proper supervision, appropriate service provider activities or competence, and client satisfaction.

Government or donor policy barriers

Restrictive policies, or even the lack of supportive policies, hamper effective integration. For example, in some countries, it is illegal to promote or advertise family planning methods, particularly condoms. Other countries limit or prohibit services to adolescents, or require parental permission. Laws permitting only physicians to prescribe or provide drugs can serve as a barrier in countries where the majority do not have access to physicians and seek services from other health providers, especially nurses. In many countries, STD and AIDS prevention programs are given limited resources and accorded low priority. Donors also may have restrictive policies. For example, they may prevent using funds to purchase antibiotics for STDs treatment or limit the number of staff that are available for integrated programs.

Resource Barriers

Many existing programs are faced with the challenge of meeting client health needs with decreasing resources. Providing integrated services requires additional financial investments, including upgrading facilities and provider training. In African countries, the majority of individuals cannot afford to pay for expensive laboratory tests and drugs. The lack of service delivery resources continues to pose a challenge for everyone engaged in service integration.

Major Components of Integrated Services

There are three major program components²² that, in combination, can provide a guiding framework for implementing integrated services. As seen in **Figure 3**, the component elements are linked to and interdependent with each other. The three components are:

1. Menu of services provided by the program (e.g., MCH, FP, STD diagnosis and treatment, and counseling on a range of reproductive health issues)
2. Support functions needed to ensure effective, responsive, and efficient program management (e.g., service provider training; MIS and other management systems; strategic, sustainability, and other planning; resource mobilization and logistics)
3. Development initiatives to create an enabling environment and community awareness, demand, advocacy, mobilization, involvement, and support (e.g., community-level seminars and IEC; social marketing; targeted services, especially for high-risk groups)

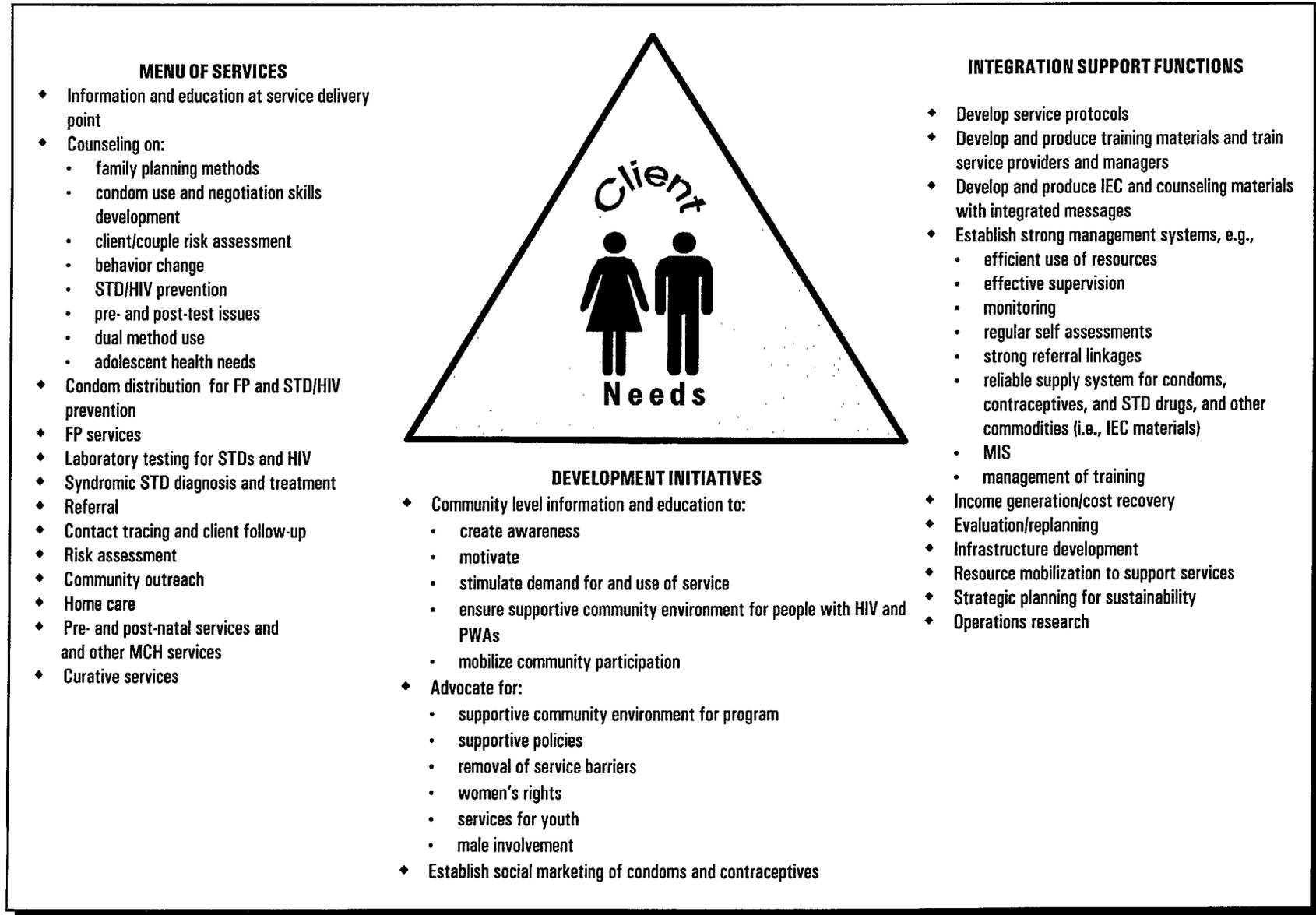
Each of these three components contain several basic elements that must be carefully considered when integrating services. Programs will have more success if they address each component (and its constituent basic elements) at the outset, continually reviewing and revising program components and their elements in relationship to one another and in response to changing client needs.

This three-part framework serves as a general guide for ensuring that programs are ultimately coherent, effectively focused on meeting clients' and community needs, and sustainable. The importance of sustainability depends on several factors beyond the scope of this document. However, sustainability should be always considered. Resource limitations, and the type of program or MCH/FP facility in question, also may dictate how many of, and in what sequence, these various components can be implemented. While this framework encompasses most significant options, programs should decide, based on the best available data, what specific elements they can offer given their priorities, structure, and goals.

Programs often routinely gather data (using baseline or catchment area surveys, needs assessments, client surveys, focus group discussions, or situation analyses) that yield valuable information and vital clues about the communities in which they work and the clients whom they serve. Programs also generate data through monitoring, supervision, and evaluations (using self-

²² Components based on discussions at Kenya CAs' meetings (see Chapter 2).

FIGURE 3: KEY COMPONENTS OF INTEGRATED FP/STD/HIV-AIDS SERVICES



assessment techniques such as COPE²³, operations research, strategic planning, management audits, or inventories) that reveal their own internal strengths, weaknesses, “niche” or unique characteristics, and overall performance. Much of this information should be reviewed, and additional data gathered as warranted, before programs undertake integrated service delivery. By conducting thorough assessments and careful analyses of their internal and external environments, programs can identify specific next steps to be taken or deficiencies that must be addressed—in institutional and community contexts—if high-quality, sustainable, integrated services are to be offered.

Menu of services

The **menu of services** includes basic family planning, STD and HIV-AIDS services, counseling, and curative services. The menu provided by a specific program or facility should be realistic, reflecting identified community or client needs, type of program or facility, and a commitment to high quality of care standards. While limitations on human, financial, technical infrastructure, and other resources are often barriers to comprehensive services, program strategic plans should reflect unmet needs as a trigger for resource mobilization and fundraising. Programs and facilities will have varying limitations to providing adequate services for all clients. In such instances, strong referral and follow-up networks must be established so that clients receive needed services and assured continuity of care. Referrals may be especially important in sensitive matters which cannot be handled in all facilities such as HIV screening, pre- and post-test counseling, and home or advanced medical care for persons with AIDS.

Support functions

Programs must have strong **internal support functions** to provide selected services efficiently and effectively. These functions include training so that service providers acquire basic competencies for integrated services. Efficient management systems such as supervision, planning, monitoring, evaluation, MIS, and resource development and allocation are key to successful integration. Service effectiveness in many program settings has been compromised by an acute scarcity of appropriate IEC and training materials, particularly those with integrated messages. Training curricula targeting various service providers have been developed by CEDPA (CBD), Pathfinder International (CBD and integration training curricula) as well as Pathfinder’s DISH project (clinic service providers), INTRAH, JHPIEGO, AVSC, and others (see **Appendix C**). These materials should be reviewed and adapted to program needs.

Finally, strengthening institutional development, often a neglected aspect of program implementation, is a vital precondition to well-managed, appropriate, high-quality integrated services. Institutional capability to synchronize services, allocate scarce resources, improve staff performance, and monitor performance are as much a part of integrated service delivery strategies as the mix of services offered. Attention paid to these issues will enhance client satisfaction and community support, thus improving prospects for longer-term sustainability.

²³ COPE (Client Oriented Provider Efficiency) is a clinical quality assurance self-assessment tool.

Development initiatives

For services to be adequately responsive to community needs, a conducive environment and enabling policies are required. Therefore, those offering integrated services must make every attempt to inform, educate, and mobilize the community to support and participate in program activities. Removing service barriers and promoting women's rights, male involvement and support for youth reproductive health education and services for young adults all can contribute to positive program impacts.

In many African countries, services are disrupted by the irregular availability of condoms and other contraceptives in part because systems are often driven by external donor funding. This means that supplies may fluctuate or brands may change depending upon donor interest and levels of funding. Some countries also have yet to overcome transportation and logistical difficulties to distribute supplies efficiently when they *are* available. Although these factors may be beyond the control of the program managers, however, they have extensive influence over the logistic system. Establishing community social marketing outlets often helps maintain a more steady condom supply at affordable prices. Social marketing is being implemented on a large scale in many countries such as in Uganda's DISH project, with documented success (see **Figure 5**).

After becoming familiar with the three major components and elements of integrated service delivery, and reviewing self- or other assessment results and available resources, each program must determine which of its existing services can be combined and integrated, and which new services should be added. The next section is designed to help program managers determine the level and scope of activities their program can realistically undertake. It is intended to assist managers to plan appropriate expansion of services, provider training, infrastructural improvements, management systems upgrades, and take other steps needed to maximize the quality and effectiveness of its reproductive health services.

Levels of Integrating STD and HIV-AIDS Services into FP Services

In Africa, acceptance and use of modern family planning methods have generally been increased by using trained community residents to: a) implement community-based distribution (CBD) of non-prescriptive methods (pills, condoms, foaming tablets); b) provide accurate information about family planning and encourage its use; and c) make referrals to medical facilities when necessary for longer-lasting methods or complications. In the face of rapidly increasing rates of STD and HIV transmission, many on-going CBD programs have incorporated STD and HIV-AIDS prevention messages and activities; some CBD agents have even been trained in syndromic diagnosis of STDs. Based on a survey conducted in 1995 for the *Setting the Africa Agenda Workshop*,²⁴ and recognizing that full-service facilities are still rare in many communities, most

²⁴ Kisubi, Wilson W. *An Inventory of Integration in Sub-Saharan Africa*. (survey of 73 integrated projects and programs from 14 countries) Presentation at Annual Meeting of the American Public Health Association, San Diego, CA, October 1995.

African reproductive health programs offer services using one of four configurations: 1) integrated CBD services; 2) clinics or clinics linked with CBD; 3) clinics offering laboratory and voluntary surgical contraception services; and 4) comprehensive or full-service clinics, health centers, or hospitals.

Figure 4 presents different integration activities that might be included in reproductive health programs, ranging from basic CBD services to full-service clinics. Four examples illustrating program comprehensiveness, design, and infrastructure development are depicted by the four columns in **Figure 4**. The basic services that **all** programs should be offering, adjusted for program configuration, are found in **Row A**. By moving from left to right (**columns with Roman numerals I to IV**), the reader will be able to see additional services that should be offered based on the increasing program complexity and competencies. Using the major components and basic elements described above, **Figure 4** contains seven levels of program activities, designated by the **letters A to G**.

While **Level A** lists the most basic integration services, an increase in the range of services offered is shown at each progressive level (moving upward in **Figure 4**). For example, when upgrading from syndromic diagnosis (Level E) to lab diagnosis (Level F), the program may still need staff trained to conduct syndromic diagnosis because lab fees may not be affordable to some clients. Moreover, labs may not always be fully functioning because of a lack of supplies and technicians. Programs offering integrated services, however, should try to minimize referrals that are external to the program or facilities as much as possible. Thus, each program should progressively introduce new services and upgrade provider skills so that the client's needs can be met, ideally, by one service provider during the same visit.

Prior to integration, and regardless of service configuration, it is important that a minimum level of care or FP services exists. As **Figure 4** indicates, programs can achieve higher levels of complexity and sophistication by progressively phasing-in services (**Rows B through G**) that are appropriate to their existing service configuration, resources, staff skills, and client or community demand.

For example, integrated CBD programs can ensure that IEC materials promote integrated messages, effective counseling is provided, condoms are distributed, and CBD agents conduct thorough risk assessments and referrals. Eventually, even STD client partner notification should become an element of integrated CBD service delivery.²⁵ Program assessment results can play a significant role in determining the pace, strategies, and resources needed to achieve full integration in a particular program or facility.

Clinical facilities or clinic-linked CBD should also strengthen infection prevention, quality assurance systems, and quality-of-care standards as part of the basic integrated service delivery system. This should be followed by adding risk reduction counseling or risk assessment and referral,

²⁵ The authors use the term partner notification to include notification through both partners and providers (contact tracing). Please refer to the glossary for a complete definition.

FIGURE 4: LEVELS OF INTEGRATING STD/HIV-AIDS INTO FP SERVICES

PROGRAM CATEGORY	I. INTEGRATED CBD SERVICES	II. CLINIC SERVICES OR CLINIC-LINKED CBD	III. CLINIC WITH LAB AND VSC	IV. FULL-SERVICE CLINIC
Read →	Four configurations (I-IV) of service delivery			G ♦ HIV testing ♦ Referral for supportive care - to AIDS support organizations e.g., TASO
Read ↑	Increasing levels (A-G) of comprehensiveness in integrating services		F ♦ Referral for HIV testing ♦ Pre and post test counseling ♦ STD lab diagnosis	♦ Pre and post test counseling ♦ STD lab diagnosis
		E ♦ STD/HIV-AIDS syndromic diagnosis, management and referral	♦ STD/HIV-AIDS syndromic diagnosis, management and referral	♦ STD/HIV-AIDS syndromic diagnosis, management and referral
		D ♦ Partner notification of STD clients	♦ Partner notification of STD clients	♦ Partner Notification of STD clients
C	♦ Partner notification of STD clients ♦ Referral for supportive care ♦ Training of home-based care providers (AIDS)	♦ Follow up of STD/HIV-AIDS clients ♦ Referral for diagnosis and management and STD/HIV-AIDS clients	♦ Follow up of STD/HIV-AIDS clients ♦ Referral for diagnosis and management and STD/HIV-AIDS clients	♦ Follow up of STD/HIV-AIDS clients ♦ Referral for diagnosis and management and STD/HIV-AIDS clients
B	♦ Follow up of STD/HIV-AIDS clients ♦ Referral for diagnosis and management of STD/HIV-AIDS clients	♦ Follow-up of STD/HIV-AIDS clients ♦ Check adequacy of infection prevention/quality-of-care standards	♦ Follow-up of STD/HIV-AIDS clients ♦ Check adequacy of infection prevention/quality of care standards ♦ Referral for diagnosis and management and STD/HIV-AIDS clients	♦ Follow-up of STD/HIV-AIDS clients ♦ Check adequacy of infection prevention/quality of care standards ♦ Referral for diagnosis and management and STD/HIV-AIDS clients
A	♦ IEC & counseling for STD/HIV-AIDS ♦ Distribution of condoms for STD/HIV prevention ♦ Risk assessment & screening potential high-risk clients	♦ IEC & counseling for STD/HIV-AIDS ♦ Distribution of condoms for STD/HIV prevention ♦ Risk assessment & screening potential high-risk clients	♦ IEC & counseling for STD/HIV-AIDS ♦ Distribution of condoms for STD/HIV prevention ♦ Risk assessment & screening potential high-risk clients	♦ IEC & counseling for STD/HIV-AIDS ♦ Distribution of condoms for STD/HIV prevention ♦ Risk assessment & screening potential high-risk clients- Internally to more skilled providers
BEFORE INTEGRATION	♦ FP services for non-clinical methods ♦ IEC & counseling for FP ♦ Assessment of FP client's needs ♦ Follow up of FP clients ♦ Referral of FP clients for clinical methods and complications ♦ Community diagnosis/ outreach	♦ Follow up of FP clients ♦ Referral of clients for VSC and complications ♦ FP services for clinical and non-clinical methods ♦ Infection prevention and QOC ♦ IEC & counseling for FP ♦ Assessment of FP client's needs ♦ Community diagnosis/outreach	♦ FP services for all methods including VSC ♦ Infection prevention and QOC ♦ IEC & counseling for FP ♦ Assessment of FP client's needs ♦ Follow up of FP clients ♦ Referral for complications ♦ Community diagnosis/outreach	♦ FP services for the full range of methods ♦ Infection prevention and QOC ♦ IEC & counseling for FP ♦ Assessment of FP client's needs ♦ Follow up of FP clients ♦ Management of complications ♦ Community diagnosis/outreach

client follow-up, and partner notification where feasible (**Rows C and D**). Even relatively simple clinic environments should have service providers who can perform STD/HIV-AIDS syndromic diagnosis, management, referral, and reporting as a normal part of their contact with and counseling of clients (**Rows E, F, and G**).

Once programs add the basic integration elements to existing FP activities, each program must thoroughly reassess its own internal and external environment. Data and information resulting from these assessments should be used to continuously adjust program priorities, reorganize service delivery for integration, measure project performance or impact, and monitor client and community satisfaction and support.

Although the World Bank is attempting to provide STD drugs in many African countries, many other donor agencies also provide support for antibiotic purchases. Availability of low-cost STD treatment drugs on-site is essential for adequate care. Even when drugs are available, use of antibiotics for other conditions, such as acute respiratory infections in children, may have higher priority. It often becomes necessary, therefore, to develop plans for client payment for antibiotics, either purchasing them at the clinic or through prescriptions if not available at the service delivery point.

This means that effective treatment is often compromised by any of the following: higher cost, non-subsidized drugs sometimes are not available to programs at all; drugs, when available, are generally used for curative care interventions which are deemed more important than STD treatment; service providers may not want to be burdened by cumbersome client drug payment systems that barely, if ever, meet costs; client follow-up is difficult for those given prescriptions to be filled outside the program; and costs at pharmacies may be prohibitive, so some clients may not be able to complete the appropriate dosage or purchase drugs at all.

Rational use of cost-effective drugs is discussed in AIDSCAP's publication *Control of Sexually Transmitted Diseases*.²⁶ Purchase of low-cost drugs for programs, such that they actually can recover the costs from clients, is one way of ensuring that clients are treated. In addition, antibiotic social marketing, revolving drug funds or payment schemes may also create the basis for financial sustainability. Donor organizations must be recruited to assist with facilitating continuous access to low cost-effective antibiotics, keeping in mind that logistics is as important as procurement.

Suggestions for Basic Services

At a minimum, family planning programs integrated with STD/HIV services should provide:

1. IEC for STD/HIV-AIDS prevention
2. Counseling for integrated services

²⁶ Dallabeta, G., M. Loga, and P. Lamptey, eds. *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs*. AIDSCAP/FHI, Arlington, VA. 1996: Chapter 7.

3. Condom distribution and social marketing
4. Risk assessment or screening for STDs and HIV-AIDS

The speed of phasing in, and choice of, other services are dictated by several variables discussed elsewhere in this chapter (e.g., type of program or facility, program goals, and availability of resources).

IEC for STD/HIV-AIDS prevention

Views about STD and HIV-AIDS prevention and treatment are strongly linked to target audiences' attitudes which, in turn, are influenced by community norms and social, religious, and cultural beliefs. Program managers should thoroughly understand beliefs and needs of populations being served before designing and implementing integrated programs.

Effective IEC initiatives must, therefore, address audience misconceptions, beliefs, and values; counter provider biases; and reinforce healthy behaviors. When developing and implementing IEC initiatives, programs employ a wide variety of media, including electronic mass media (such as radio and television), print media and drama performances. Traditional forms of communication (such as story telling, puppetry, and song) have proved to be among the most effective strategies. Research also indicates that when IEC is combined with local humor and entertainment, it communicates information more persuasively, and thus promotes behavior change. Communication efforts, whether using traditional, interpersonal, or mass media channels, also require development of accurate information materials with integrated messages. A process that includes audience research and pretesting must be followed to ensure that materials, media selection, and messages are sensitive, appropriate, and clear to the audience.

Counseling for integrated services

Service providers may need to be trained or updated in interpersonal communication and counseling skills. Research and experience indicate that lecture-style talks delivered to large groups are not as effective in promoting behavior change as more personalized counseling. One-on-one counseling has been very important in stimulating behavior change among FP clients and other health care clients; ongoing peer support groups are also helpful. Indeed, one recent study suggested that:

...the Western, one-on-one model of counseling may not be appropriate [where, as in Africa], ...an individual does not necessarily take action on her or his own. Rather, the individual's behavior is a product of a broader familial and societal context. Therefore, modification of behavior to adopt safer sexual practices or to adopt family planning must be considered in this broader context. Group counseling, training of peer counselors, and broader community education programs are examples of ways to approach this concern.²⁷

²⁷ HIV-AIDS Prevention and Control. Population Technical Assistance Project, 1993: 26.

Major counseling categories

Ideally, service providers should be trained to provide effective counseling in four different categories: Pre- and post-test HIV counseling (where feasible), couple counseling, peer counseling, and risk-reduction counseling. The purpose of most counseling is to foster sustained behavioral change on the grounds that a full understanding of risks and preventive steps will enable persons to modify their conduct and use safer sexual, or more sound, reproductive health practices.

Pre- and post-test HIV counseling

Pre- and post-test counseling requires a degree of sophistication and training that is beyond the usual MCH/FP facility or provider experience. Clients who come for HIV testing are often afraid about the repercussions of a positive test. In addition, regardless of test outcomes, clients who take the test must be guided about how to plan their lives to maintain a negative status (if the test is negative) and a coping and hopefully positive attitude towards life (if the test is positive). Therefore, providers require additional training to enable them to counsel clients in a sensitive manner and assuage client fears prior to the test. After the test, depending on the outcome, providers will need to handle a client's grief and shock if the outcome is positive, inform clients about risks to partners, and suggest ways of partner notification. Even where a facility does not offer pre- and post-test HIV counseling, providers should know how to identify and refer clients who may be at risk of HIV infection.

Couple counseling

Couple counseling is an effective way to promote condom and dual method use, increase male involvement, facilitate partner notification, and encourage interspousal communication. Providers should be trained to regularly recommend and capitalize upon opportunities to conduct such counseling, recognizing that cultural preferences and patterns may make this sometimes difficult for providers and clients alike. However, when women are encouraged to bring their partners with them for FP/STD/HIV-AIDS services, both are exposed to joint counseling and the same information simultaneously. Since this counseling can give partners better understanding of the risks associated with pregnancy and STD infection, it can also facilitate effective future discussions, joint reproductive health decision-making, and condom negotiation.

Peer counseling

Peer counseling is particularly useful with adolescents. Since adolescents most often learn about sex or reproduction from each other, exposure to reproductive health information during interactions with peers has greater impact and offers more possibility of long-term behavior modification than intergenerational communication. Young people have their own ways of expressing themselves, looking at life, and evaluating risk; only a peer can fully understand this outlook and best use this knowledge to counsel or respond to

reproductive health concerns. Where they have been used, adolescent peer counselors have had a positive effect on rates of pregnancy and school dropouts, STDs, substance abuse, sexual exploitation, and other health or social problems.²⁸ Providers can, by working with peer counselors, gain new insights about the most effective ways of offering services and information to adolescents. These insights may also bolster competencies gained from more formal training in offering “youth-friendly” or other services targeted for high-risk or special groups.

Women’s support groups have also been identified as a way of helping women take greater control over their reproductive health; similarly, reaching males is bolstered by peer counseling or support groups. Regional experience verifies that males and adolescents shy away from traditional service delivery outlets, fearing stigmatization, provider bias, embarrassment, or refusal to be served.

Risk-reduction counseling

When providers encounter clients who appear to be at risk or manifest STD symptoms, it is important that the provider first explore the client’s circumstances and lifestyles. While discussing how to cope with situations where there is potential risk for the client without embarrassment or unease, the provider should also encourage clients to generate their own solutions, and set limits on the degree of risk that they are prepared to take in sexual encounters. In this way, the provider can give advice that is most appropriate and realistic for the client’s lifestyle, and is maintainable.

Most clients seeking advice on STD or HIV infection either have been at risk of infection or perceive themselves to have been so. [Longer-term] behavior change is most likely to occur if they recognize that a) even if their current infection is curable, a future STD may not be; b) future infections may be asymptomatic until permanent damage has occurred; c) other STDs may facilitate the acquisition of HIV infection; and d) a risk activity for other STDs is also a risk activity for HIV infection.²⁹

For successful risk-reduction counseling, providers must understand the modes of STD transmission and guidelines for safer sex so that they can be fully and accurately explain them to the client. It is helpful if the provider’s advice can be reinforced by written IEC materials. Providers should also be trained to address these issues candidly, acknowledging what is known and what is not, so that the client can gauge the potential risks s/he confronts more accurately.

Providers must possess a high level of comfort in discussing human sexuality so that they can answer clients’ questions frankly and engage in detailed, explicit conversations about sexual matters. During counseling sessions, providers and clients should, for example,

²⁸ Paxman, John, A. Sherpick, and J. Benavente. *Adolescent University-Based Project Evaluation at Kenyatta University Family Welfare and Counseling Center and Egerton University*. 1994. [unpublished]

²⁹ *Management of Patients with Sexually Transmitted Diseases*. WHO Technical Report Series (810). World Health Organization, Geneva, Switzerland, 1991.

discuss how and when clients can raise the question of safer sex with partners and strategies for dealing with negative reactions. In risk reduction counseling the aim is to help clients take action to prevent future infection over the long term, instead of concentrating on immediate health concerns.

Dual methods: Encouraging use of barrier methods

Integrated programs should encourage clients to use dual methods—a long-acting method for contraception and a barrier method for preventing transmission. It may be difficult to motivate clients to use condoms if they fear that partners or spouses will accuse them of sexual infidelity. In some instances, this may be resolved by providing more information about all the ways by which HIV may be transmitted and clarifying the fact that HIV does not necessarily have to be transmitted sexually. Once this is understood, a partner's suggestion to use condoms may be seen as generally protective against infection rather than as evidence or accusation of sexual activities or promiscuity.

In addition, family planning providers can encourage condom use as a back-up contraceptive method for those using other methods. Couples should be instructed to use condoms in the event that pills or injectables are not available, if the IUD should become displaced, and for general protection against infection. Family Health International's (FHI) recent research on the protective value of other barriers, primarily virucides and spermicides like Nonoxynol-9, suggests that couples should use these with condoms for maximum protection.³⁰

Available evidence regarding dual method use, however, suggests that as women move toward more effective contraceptive methods, they are less likely to insist that their partners use a condom.³¹ An alternative approach, having some success with men in India, is to promote condoms for both contraceptive and STD protection. Indian truck drivers received multiple messages that condoms provide double protection, and condom sales increased dramatically over 18 months. More research on this topic is needed in the African context.

Clearly, programs integrating services must address and resolve tensions created by a woman's reliance on a more effective contraceptive method and her consistent condom use with all sexual encounters. Most women have been advised to switch to other methods for spacing births because barrier methods have lower efficiency. This creates the danger of "message confusion" since barrier methods (especially condoms) are now being strongly promoted for protection from STD transmission. This is a challenge that must be met forthrightly. Programs may start, for example, by promoting dual barrier methods that complement each other in contraceptive and STD protection (e.g., condoms with spermicides). The future availability of emergency contraceptive pills (ECPs) will encourage more couples to rely on condoms and/or spermicides as their primary method(s) of contraception.

³⁰ Kuyoh, Maureen, I. Achwal, A. Spruyt, and L. Fox. *Protocol: Dual Method Use Among Family Planning Clients*. FPAK/FHI, January 24, 1996. [draft]

³¹ Dallabeta, G. et al. eds., *op. cit.*

Programs should also use clear and persuasive messages, accompanied by male motivation initiatives and couple counseling, to reduce resistance to condom use. Teaching male partners to use condoms properly and appreciate their health benefits (by deploying male peer counselors for example), and ensuring that clients have condoms readily available when needed, may also encourage men to use condoms for all sexual encounters. Protecting men from acquiring STDs or HIV is an important way of protecting women both in stable relationships or during casual contacts.

Male motivation

Male motivation is a crucial issue in STD and HIV-AIDS prevention programs. Although pregnancy prevention and spacing can be achieved with female-controlled methods, preventing STD and HIV-AIDS infection requires that men play an active role. According to a recent study by Family Planning Private Sector (FPPS) in Kenya, focus group discussions among condom users and non-users reveal that the most common reason people reject condoms is that they associate them with illicit sex and people who have STDs. Many family planning clients want to distance themselves from these characterizations.³²

Many respondents reported that men will use condoms with extramarital partners but not with their wives. Another common reason that men gave for rejecting condoms is that pleasure is reduced. Condoms purchased by men may be more likely to be used with casual sexual partners who are generally more likely to transmit HIV to men than their wives or long-term stable partners and men are generally acknowledged to have more extramarital sexual exposures than women.³³ Survey work in Africa frequently reports on HIV-positive women who have had no sexual encounters outside marriage.

According to the WHO publication *AIDS Prevention*³⁴ and general experience in the region, efforts to increase male involvement in FP and STD/HIV-AIDS prevention must take into account the fact that men do not usually visit FP clinics or other facilities associated with women and/or children. Locating STD/HIV-AIDS counseling services for university students at a Center for Women's Studies and Gender Analysis, for example, discourages men from seeking out these services. There have been suggestions that condom promotion and other activities designed for men should be conducted away from traditional MCH/FP sites. Since formal employment in Africa is male dominated, organizations that provide work-based services such as the Organization of Tanzanian Trade Unions (OTTU) in Tanzania and Family Life Association of Swaziland (FLAS) in Swaziland have significant opportunities to involve men in reproductive health services and promote condom use.

³² Wilson, Melinda. *Condom Use in Kenya: Results from Focus Group Discussions Conducted at FPPS Assisted Service Delivery Sites*. June, 1994.

³³ Wasserheit, Judith N. *The Significance and Scope of Reproductive Tract Infections Among Third World Women*. *International Journal of Gynecology and Obstetrics*. 1989: Supplement 3, page 151.

³⁴ *AIDS and Family Planning, AIDS Prevention Guidelines for MCH/FP Programme Managers*. World Health Organization, Geneva, Switzerland, 1990.

Condom distribution and social marketing

Programs that are integrating services must ensure that adequate supplies of condoms are always available. Managers and providers will have to work to enhance the image of condoms, to increase their effective use and proper disposal, to improve contraceptives logistics and distribution systems to guarantee condom availability, and to reinforce quality control measures.

Social marketing plays an important role in condom distribution outside MCH/FP clinics. **Figure 5** shows over 20 brands of condoms being marketed in 39 sub-Saharan African countries. This is indicative of the social marketing in-roads which are being made in the region with notable success. Social marketing is being used throughout the region with varying success to promote condom use through community commercial outlets and CBD programs by making condoms available at affordable prices. Commercial outlets for social marketing have included male-dominated sites such as bars, duka/kiosks (small open stores), men's rooms (using condom dispensers) and sports clubs as well as pharmacies, supermarkets, market sites (especially on market days), and at community centers hosting recreational and educational activities.

Condom promotion activities may also be conducted during male-only clinics or at clinics that have been modified to be more user-friendly for men. In these places, men can be encouraged to discuss what they dislike about condoms (e.g., loss of sensitivity, lack of availability of appropriate sizes, breakage, disposal problems, and cost). Rumors about condoms can be discussed and addressed during these sessions, and men can be given messages about preventing STDs and promoting the benefits of family planning for men and their partners. At the same time, men can receive treatment for STDs in an environment that protects their privacy and dispels the belief that clinical services are for women and children only. This misperception is common among men and is often inadvertently reinforced by service provider insensitivity.

Risk assessment or screening for STDs and HIV-AIDS

Traditionally, in family planning settings, medical and social histories were used to help clients select the FP method considered most appropriate and acceptable to her or him. Risk of STDs was not part of a routine assessment, except during a pelvic examination prior to IUD insertion. In light of increasing rates of STD and HIV transmission, risk assessment must now become an integral part of service delivery for projects or organizations that integrate their services.

Risk assessments identify clients that need diagnosis, treatment, and counseling by eliciting information from clients on their sexual attitudes, knowledge, and practices. Information gained allows providers to determine clients' level of risk for STDs and HIV-AIDS and tailors family planning counseling to assist clients or couples to accept and practice safer-sex behaviors; identify clients or couples requiring referral for diagnosis and treatment of STDs, or HIV counseling and testing; and help clients identify the sources of his/her potential risk directly.

FIGURE 5: EXAMPLES OF SOCIAL MARKETING CONDOM PRODUCTS IN AFRICA

Country	Social Marketing Organization	Condom Brand Name
CENTRAL AFRICA		
Burundi	PSI	PRUDENCE
Central African R	PSI	PRUDENCE
Chad	PSI	PRUDENCE
Congo	PSI	PRUDENCE
Zaire	PSI	PRUDENCE
EAST AFRICA		
Eritrea	PSI	About to Launch
Ethiopia	DKT/PSI	HIWOT & TRUST
Ethiopia	DKT	HIWOT
Kenya	PSI	TRUST
Madagascar	SOMARC	PROTECTOR
Tanzania	PSI	SALAAMA
Uganda	SOMARC	PROTECTOR
Uganda	SOMARC/GTZ	ENGABO
SOUTHERN AFRICA		
Botswana	PSI	LOVERS Plus
Lesotho	PSI	LOVERS Plus
Malawi	PSI	CHISHANGO
Mozambique	PSI	JEITO
Namibia	PSI	About to Launch
South Africa	PSI	REALITY
South Africa	PSI	LOVERS Plus
Zambia	PSI	MUXIMUM
Zimbabwe	SOMARC/PSI	PROTECTOR
WEST AFRICA		
Benin	PSI	PRUDENCE
Burkina Fasso	PSI	PRUDENCE NOUVEAU
Cameroon	PSI	PRUDENCE Plus
Cameroon	PSI	PRUDENCE Promesse
Ghana	SOMARC	PROTECTOR Plus
Ghana	SOMARC	PANTHER
Ghana	SOMARC	CHAMPION
Guinea	PSI	PRUDENCE Plus
Guinea Bissau	PSI	PANTE
Mali	SOMARC	PROTECTOR
Morocco	SOMARC	PROTEX
Niger	SOMARC	PROTECTOR
Nigeria	PSI	RIGHT TIME
Nigeria	PSI	COOL
Nigeria	PSI	GOLD CIRCLE
Senegal	SOMARC	PROTEC
Togo	PSI	PROTECTOR

Risk assessment has implications for a facility's physical structure (especially space to ensure privacy); service providers' workload; time allocated for service delivery; waiting time for clients; service provider knowledge, attitudes, and skills so that this function is performed competently; and availability of referral points to accommodate clients who need more specialized attention.

One way to conduct risk assessments with literate clients is by providing them with a checklist of risk factors which they can complete on their own; semi- or illiterate clients should be asked the same questions orally. Programs are encouraged to design locally-appropriate checklists and protocols. These might be based on risk indicators developed by the STD Task Force of the Evaluation Project.³⁵ A sample of these indicators is found in **Figure 6**, which also provides helpful guidance for program managers and others who are using indicators to generate specific numerical data showing performance and/or impact. After using the checklist, the service provider should further explore with the client whether s/he thinks that s/he is at risk. Clients' responses provide the basis for further, more individualized counseling and dialogue. This approach minimizes client discomfort, decreases the chances that s/he will not be truthful, and allows the service provider to correct misinformation about what behavior is risky.

Delivering integrated services using CBD presents other issues and requires a different level of skills and training, particularly in relation to assessing risk. Like trained clinicians, CBD workers should be able to recognize and screen potential high-risk clients. As they build a relationship during home visits and other community-based activities, they are often told about their clients' fears, needs, concerns, and behavior patterns. During training, CBD agents must learn to recognize symptoms of common STDs; behavior patterns or activities that can raise the level of risk or increase potential for transmission of STDs or HIV; and simple preventive messages or information that clients can share with their neighbors. Most critically, CBD agents must learn *when* and *where* to refer for potentially significant reproductive health problems that they confront during community-based activities or for more in-depth counseling, diagnosis, and treatment by trained service providers.

³⁵ Dallabeta, G. et al. eds., op. cit.

FIGURE 6: SAMPLE LIST OF PREVENTIVE INDICATORS³⁶

10 Indicators of Progress and Outcomes of Prevention Activities	Calculation
1. Knowledge of preventive practices	Number of people citing at least two acceptable ways of protection from HIV infection <i>divided by:</i> Total number of people aged 15-49 surveyed
2. Condom availability (central levels)	Total number of condoms available for distribution during the preceding 12 months
3. Condom availability (peripheral level)	Number of people who can acquire a condom <i>divided by:</i> Population aged 14-49 years
4. Reported non-regular sexual partners	Number of people aged 15-49 who report having had at least one sex partner other than a regular sex partner(s) in the last 12 months <i>divided by:</i> Total number of people aged 15-49 years who report having been sexually active in the last 12 months
5. Reported condom use with non-regular sexual partner	Number of people aged 15-49 reporting the use of a condom during the most recent act of sexual intercourse with a non-regular partner <i>divided by:</i> Total number of people aged 15-49 reporting sexual intercourse with a non-regular sex partner in the last 12 months
6. STD case management	Number of people presenting with STDs in health facilities assessed and treated in an appropriate way (according to national standards)
7. STD case management	Number of people presenting with STDs or for STD care in health facilities who received basic advice on condoms and partner notification
8. STD prevalence, women [under development]	Number of pregnant women aged 15-24 with positive serology for syphilis <i>divided by:</i> Total number of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened
9. STD incidence, men	Number of reported episodes of urethritis in men aged 15-49 in the last 12 months <i>divided by:</i> number of men aged 15-49 surveyed
10. HIV prevalence, women [under development] *	Number of HIV-seropositive pregnant women aged 15-24 years <i>divided by:</i> Total number of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened

* There are no reliable HIV prevalence formulae for men at this time

³⁶ Dallabeta, G. et al. eds., op. cit.

CHAPTER 2

THE KENYA EXPERIENCE

AIDS is now recognized as a severe public health problem in Kenya and is publicly acknowledged by most policy makers as a threat to national development. Although the National AIDS Control Program **estimates** the actual AIDS cases to be more than 200,000, official reports for the same period cited only 65,647 AIDS cases. In 1995, 1,100,000 were estimated to be infected with HIV. Adult HIV prevalence has more than doubled in the last five years, from 3.5 percent in 1990 to 7.5 percent in 1995 (estimates based on sentinel surveillance data). More frightening, it has than quadrupled among pregnant women in Nairobi from 5.8 percent in 1990 to 24.6 percent in 1995.³⁷

The rapidly escalating epidemic is exacerbated by increasing numbers entering high-fertility age groups. Currently, Kenya's female population aged 20 through 24 years totals 1.1 million, while the population in the 15 through 19 year old group is 1.5 million; these large cohorts result from Kenya's high fertility rates of the past two decades.³⁸ These two converging factors, population and disease, pose a great threat in Kenya as well as other countries of sub-Saharan Africa and form a compelling imperative for integrating STD/HIV-AIDS and family planning programs.

In Kenya the concept of integration is not new. Maternal and child health and family planning services have already been integrated in most programs, as is true throughout sub-Saharan Africa. Furthermore, Kenya's existing FP and STD/HIV-AIDS programs enjoy strong government commitment. Research data are not yet available to show that integration, particularly that of STD/HIV-AIDS into family planning services, really works nor are there data to describe specific effective, alternative options. Faced with Kenya's rising STD/HIV dilemma, for implementers and donors it was never a question of **whether** or not to integrate, but **how** to integrate. Major USAID cooperating agencies (CAs) in Kenya, with support of the USAID/Kenya Mission, initiated the processes of dialogue, networking, sharing of experiences, and exchanging of ideas on integration.

This chapter provides a brief history of the CAs' and local agencies' networking activities. It describes what was achieved, challenges faced, and lessons learned to date. The purpose of describing the Kenya experience is to share with other countries and programs in the region some of the practical steps that USAID CAs and their partners have taken.

³⁷ *AIDS in Kenya*. National AIDS Control Programme, Ministry of Health, National Council for Population and Development, 1996.

³⁸ Johnston, Alan. Presentation at the IWG Workshop. USAID's POLICY project, 1996.

Brief History of Networking Activities

In May 1993, the USAID/Kenya Mission initiated discussions with CAs working in health and population to gather information about integration. CAs then formed what was called the Kenya CAs Integration Network. Subsequently, the group came to be known as the CAs Integration Working Group (IWG). Participants' shared experiences have yielded important, practical information related to integration and stimulated planning of future collaborative efforts. This Kenyan integration initiative was reinforced by over 20 years of CAs' experience in family planning promotion and program expansion; condom distribution; national campaigns bolstering STD and HIV-AIDS prevention; program management; and strengthening training and counseling skills. As the discussions evolved, CAs determined that it was essential to involve their local implementing partners and key government agencies.

The IWG's overall goal was to jointly plan steps for achieving integration carefully and use each other's experiences and comparative advantages to support sustainable integrated service delivery. The IWG believed that a collective effort would expedite development of well-designed integration workplans; give local agencies opportunities to explore new models and approaches for managing, improving, and sustaining integrated services; and establish an interactive, multifaceted network among CA sub-grantees. Quarterly meetings to enhance collaboration and foster the initiation of integrated services evolved into a forum for discussing and devising the best approaches.

Early IWG objectives were to:³⁹

- ♦ Agree upon common definitions of terms (e.g., integration, RTI, STD, STI)
- ♦ Conduct a review of existing integrated services in Kenya and identify lessons learned about the integration process
- ♦ Coordinate plans for integration among CAs
- ♦ Coordinate closely with Kenya-based and international organizations with expertise in STDs or HIV-AIDS issues, including WHO/UNAIDS, the local AIDS NGO Consortium, and the MOH's National STD and AIDS Control Programs
- ♦ Establish a clearinghouse for information on integration at the Secretariat
- ♦ Incorporate Kenyan service provider views, experiences, and needs into IWG plans

Pathfinder International's coordination role entailed:

- ♦ Establishing a secretariat with a Coordinator and a secretary at the Pathfinder office in Nairobi, Kenya
- ♦ Facilitating networking among the CAs and local implementing agencies

³⁹ Lule, Elizabeth L. *Presentation: STD Prevention in Family Planning—Kenya*. 1994 USAID Cooperating Agencies Meeting, Washington, DC, February 22-25, 1994.

- ♦ Convening a forum for sharing ideas about integration with CAs and their partners
- ♦ Documenting and disseminating integration models, strategies, and research findings
- ♦ Establishing a clearinghouse for IEC and other materials on integration
- ♦ Facilitating development of technical assistance capabilities to strengthen integrated services

Structure and Arrangement of the IWG

After a few general meetings, several issues emerged that could no longer be discussed in a large group. To facilitate more focused review, IWG members were grouped in four small working groups (SWGs) according to CAs' areas of expertise and general program-related topics. The four SWGs were:

- ♦ Service Delivery
- ♦ IEC
- ♦ Training and Curriculum Development
- ♦ Policy, Research, and Evaluation

Each group developed a scope of work and selected a chairperson from one of the CAs. Chairpersons were responsible for convening their respective quarterly SWG meetings, and writing and distributing minutes to all IWG members. SWG chairpersons also constituted a committee of convenors responsible for planning and coordinating SWG activities and meeting regularly.

After two years of meetings and discussions, an Integration Secretariat, with a Coordinator and secretary, was established at Pathfinder's Kenya office in early 1995. The USAID/Kenya Mission and the CAs jointly determined the Secretariat's responsibilities which included:

- ♦ Strengthening inter-CA collaboration
- ♦ Chairing and organizing Convenors' meetings
- ♦ Facilitating IWG functions
- ♦ Providing direction to integrated services in Kenya
- ♦ Influencing government policy

In mid-1995, the format of the SWG meetings changed from general discussions of concepts and processes to in-depth discussion of selected strategic themes, such as adolescents, CBD, and clinic-based services. SWGs discussed these in depth and presented recommendations to a larger

IWG plenary meetings. This format has been more effective in generating innovative ideas and approaches to integration which can be discussed and implemented locally.

In January 1996, reductions in USAID funding caused the IWG to review its operations. Consequently, issues related to grantee sustainability became significant and review of existing research information, as opposed to new research projects, were emphasized. In light of this situation, the SWGs refined their agenda, identifying four priority issues: a) condom prevention and advocacy; b) sensitization of policy makers; c) review of service protocols and guidelines; and d) application of research through the preparation of an annotated bibliography of relevant research in Kenya. A task force was established for each priority area to design interventions, implementation plans, deliverables, and budgets.

IWG Achievements

In November 1996, the CAs held a workshop to review what had been achieved, identify remaining challenges, and discuss next steps. There was a clear consensus that the Network is an invaluable resource for promoting joint CA-implementing partner activities that support integration. Participants also agreed that a **group** of IWG members was a stronger lobbying force for increased financial and other assistance for reproductive health activities and effective implementation of IEC campaigns.

Several spin-off activities have been inspired by IWG initiatives. For example, the Group organized a family planning integration symposium to review current STD/HIV-AIDS programs with implementing partners (grantees, government, and local NGO representatives). Workshop information and recommendations were used by individual CAs to organize similar orientation workshops for their own grantees. Independent of IWG activities, members have:

- ♦ Reviewed or developed curricula to include STD/HIV-AIDS modules (CEDPA, FPPS, AVSC, Pathfinder, and JHPIEGO).
- ♦ Designed and introduced integrated services programs (e.g., FPPS's "missed opportunities") for MCH/FP and STD/HIV-AIDS projects.
- ♦ Reviewed, designed, and tested needs assessment tools (INTRAH).
- ♦ Distributed STD/HIV-AIDS and IUD updates and reference materials to implementing partners (AVSC).
- ♦ Conducted a study on condom use in Kenya (FPPS).
- ♦ Conducted case studies on integration, including cost analyses (The Population Council and Pathfinder International).
- ♦ Produced *Contraceptive Technology Update* modules on Barrier Methods and the Reproductive Health of Young Adults (FHI).

The Secretariat has established a resource center containing publications, model IEC materials or curricula, and monographs or research studies on integration, based at Pathfinder's Regional Office in Nairobi. It has helped CAs and their local implementing partners to initiate several projects such as developing a comic booklet for youths on FP/STD/HIV-AIDS, conducting and publishing a literature review on risk assessment and the syndromic approach to STD management, and preparing an annotated bibliography of integrated activities in Kenya. The Secretariat produces a quarterly newsletter and provides technical assistance to individual reproductive health programs upon request.

Review of Integrated Services in Kenya

The Secretariat conducted an inventory of existing integrated services in Kenya and documented lessons learned about the integration process. Kenya benefits from the strong government commitment to both family planning and AIDS control programs articulated in the *National Implementation Plan for 2000 and Health Policy Framework*. Both documents reveal that these Kenyan programs:

- ♦ Serve the same target population—the sexually active
- ♦ Promote safe and responsible sexual behavior through IEC
- ♦ Distribute condoms
- ♦ Support effective diagnosis and treatment of STDs

As CAs began to recognize and articulate the need for integration, more specific information on the status of reproductive health services was required to gain a more complete understanding of integration activities in Kenya. Subsequently, the Secretariat conducted a formal in-country review in early 1995. This review identified organizations and institutions at various levels of integration. Levels were determined by the demonstrated facility or program capacity and evidence of management's comprehension of the need for integration. The review documented various approaches, opportunities, and constraints for integration and assessed integration's effectiveness and replicability. Review results were shared with USAID, other donors, CAs, and public and private service providers and program managers.

Visits to 15 project sites in Nairobi, Mombasa, Naivasha, Kisumu, and Siaya were a major review activity. Written questionnaires were sent to health care organizations throughout Kenya. Personal interviews and group discussions were held with 85 health care managers, providers, and CBD agents. The review revealed that progress towards integration depended on a wide range of factors, including institutional policies or mandates, target populations, physical facilities, individual perceptions, and commitment to innovation. Based on survey results, three scenarios for integrating STD/HIV-AIDS services in Kenya were outlined for adding STD/HIV-AIDS services:

- ♦ to existing FP programs;
- ♦ to outpatient services;
- ♦ and/or to MCH/FP services.

Much of the post-review discussion focused on the potential overlap among three types of services: family planning, STDs, and HIV-AIDS. It was agreed that maintaining separate, vertical programs at a time when organizations are striving to increase cost effectiveness has significant resource implications that must be faced by program managers and CAs. In light of these health and financial realities, integration was viewed as the preferred option.

CAs and local partners concluded that integrating services is dependent on overall institutional service delivery and management capacity. For the most part, the review demonstrated that stand-alone community-based distribution models provided IEC materials, distributed condoms and non-prescriptive contraceptives, and provided basic counseling and referral services. In such models, an assumption was made that CBD agents must communicate integrated messages and information as a matter of course and that they should also be trained to recognize clients' STD or AIDS symptoms. In more highly developed programs, substantial client follow-up and contact tracing were routine.

Clinic models varied. At the most basic levels, clinics provide non-prescriptive contraceptives, conduct risk assessments, or syndromic diagnoses, and make referrals for STD management. In more complex models, a facility provides all basic services as well as laboratory diagnoses, STD treatment, acceptance of referrals, VSC, pregnancy tests, and (in more rare instances) pre- and post-test HIV counseling.

The Secretariat's review helped classify Kenya's clinic-based integrated service delivery programs into five different *clinic program* categories. Major advantages and disadvantages associated with each category (see **Figure 7**) were also outlined in the review report. The five categories are:

Category A: Dispensaries offering non-prescriptive FP, syndromic diagnosis, antenatal, and child health care. No drugs are available, and such facilities are isolated with few or no referral points.

Category B: Comparable to Category A facilities, but with a wider range of clinical FP methods and some STD treatment. Such facilities have established referral points for VSC and STD case management.

Category C: Facilities like the Mkomani Clinic Society offering a wide range of MCH, FP, STD, and laboratory services. All counseling and services related to HIV are carried out at selected referral points.

FIGURE 7: ADVANTAGES/DISADVANTAGES OF TYPES OF INTEGRATION PROGRAMS FOUND IN KENYA (1995)⁴⁰

INTEGRATION CATEGORIES	ADVANTAGES	DISADVANTAGES
<p>Category A Provision of MCH/FP and STD/HIV-AIDS services at a level consistent with the organization's resources/capabilities but without a referral system</p>	<ul style="list-style-type: none"> ♦Addresses client convenience and promotes development of good provider-client relationships ♦May enhance confidentiality ♦Provides a wider range of reproductive health services 	<ul style="list-style-type: none"> ♦Requires more resources for separate vertical services ♦May have serious limitations in meeting clients needs (services depend on institutional capacity)
<p>Category B Provision of MCH/FP and STD/HIV-AIDS services at a level consistent with the institutional capacity but with an external referral system/network</p>	<ul style="list-style-type: none"> ♦Promotes sharing of resources and experiences ♦Increases client knowledge of sources where different types of services are available 	<ul style="list-style-type: none"> ♦May compromise quality of care due to referrals to institutions of lesser quality ♦May decrease client confidentiality ♦May inhibit contact tracing and follow-up due to referrals ♦May result in loss of clients due to inconvenience associated with referrals
<p>Category C Provision of MCH/FP and STD/HIV-AIDS services in single or two adjoining rooms by one or two health care providers who are adequately trained to address the reproductive health needs of MCH/FP clients</p>	<ul style="list-style-type: none"> ♦Reduces clients' inconvenience and waiting time ♦Limits number of service providers with whom client interacts ♦Enhances confidentiality ♦Allows providers a greater understanding of client needs ♦Enables improved provider-client relationship/interactions ♦Enhances client's confidence in the services and the provider ♦Reduces internal referral 	<ul style="list-style-type: none"> ♦May increase work-load for the provider ♦May increase client waiting time ♦Requires increased resource input particularly in training providers ♦Lacks appeal to clients if there isn't adequate infrastructure, especially for privacy and skilled personnel for STD management and counseling ♦Provider bias
<p>Category D In-reach approach using "no-missed opportunity" policy in which a client/patient's reproductive health needs can either be referred to a specialized unit within the facility or addressed at the point of contact</p>	<ul style="list-style-type: none"> ♦Increases CYP as clients are counseled and/or referred for FP services within the facility ♦Increases clients' access to reproductive health information because all client contacts with facilities utilized as chances to impart information ♦Increases opportunities to provide comprehensive health services to an individual or family and client convenience 	<ul style="list-style-type: none"> ♦Requires increased resources to provide additional services
<p>Category E Provision of comprehensive MCH/FP/STD/HIV-AIDS services under one roof or facility through different specialized units (MCH, FP, STD, VSC, outpatient clinics, etc.)</p>	<ul style="list-style-type: none"> ♦Makes all services available within one facility ♦Allows specialized attention if there is a functional internal referral system and sufficient technical and other infrastructure 	<ul style="list-style-type: none"> ♦May force client to use more than two SDPs due to internal referral procedures ♦Lacks effectiveness if there are no strong internal referral linkages and client follow-up

Category D: Self-contained facilities offering the full range of FP services (including VSC), IEC and counseling for FP and STDs, laboratory treatment (except for HIV screening), and having the capacity to diagnose and treat most STDs. HIV pre- and post-test counseling is offered, and services are organized using the “in-reach” approach so that there are no “missed opportunities;” referral is therefore seldom necessary. The Sulmac Clinic in Naivasha, Kenya is an example of this type of facility.

Category E: Facilities that are the most comprehensive, offering specialized services and acting as referral points for facilities in the other categories. Generally, private facilities provide integrated services, while public sector facilities maintain vertical, or separate, service units. Coast General Hospital in Mombasa, Kenya and the Pangani Clinic in Nairobi are examples of Category E facilities.

Challenges and Lessons Learned

Since the integration process is still evolving in Kenya, CAs and local implementing partners frequently confront new challenges and impediments to implementation. Other countries interested in integrating services may be in a position to avert, or at least minimize, some of these impediments based on the lessons learned in Kenya.

At the time Kenya’s family planning programs started exploring ways to integrate due to the rapid spread of STDs and HIV-AIDS, there were limited data to explain or guide the integration process, or effective alternatives to integration. In Kenya, a few research-oriented groups expressed concern about embarking on initiatives that have not been tested. In response, the Network has, over time, refined its OR agenda. Network participants have focused on documenting lessons from available research and collecting new information on service quality, cost-effectiveness, and use. These data are useful in providing technical assistance to implementing partners. As other countries attempt to initiate integrated programs, research components should be included in their implementation plans.

The Kenyan collaboration experience has accelerated the integration process within organizations that have, in the past, primarily focused on family planning.⁴¹ Both CAs and local implementing partners are increasingly **emphasizing longer-term, collaborative processes** that bolster integrated program initiatives, including joint planning, research, and resource identification. Shared agendas and strategies emerging from meetings and working group activities, such as joint training curricula, and workshops, technical assistance, written implementation guidance, and IEC materials, also enable CAs and local partners to benefit from pooling resources.

As with most new initiatives, it is critical to **maintain the high level of enthusiasm** that initially exists among collaborators. The Kenya experience reveals that enthusiasm has not been consistently high; in part, this may be attributed to recent uncertainties related to USAID and other donor funding. In situations such as these, working groups and task forces should be encouraged to

⁴¹ Lule, Elizabeth L. op cit.

continue meeting on a regular basis, focusing on resource identification and mobilization as well as developing solutions. This will counter the normal tendency, when resources are increasingly scarce, for organizations to compete rather than collaborate. Realizing that a group is a more effective advocate for resources than individual organizations, the Network has emphasized problem solving through consensus-building.

Local implementing partners and CAs have learned it is useful to **work closely together** whenever possible. For example, while CAs provide financial support and technical assistance, managers and service providers who are implementing activities provide valuable perspectives on setting priorities and the most cost-effective ways to integrate. The partnership that has been forged in Kenya preserves each CA's separate role and responsibilities, but enriches shared agendas and activities, and helps them to operationalize integration with grantee programs and staff at all levels.

For example, during the review of impediments to integration, involvement of institutions' leaders was identified as an essential element for success in introducing integrated services. It was also concluded that **technical reproductive health training should include management staff**, so important elements of reproductive health service delivery are clearly understood and accepted by all, and program staff are supported in their efforts to practice the new skills that they have learned.

Referral networks among service organizations were initiated or strengthened as various organizations learned about each other's services, capabilities, and expertise. Because of consistent coordination with, and commitment of, the Kenya government and local organizations, expansion of integrated services will be more sustainable and more reflective of local reproductive and future health needs. Equally important, regular sharing of information and lessons learned will contribute to smoother program implementation.

In summary, Kenyan experiences have provided CAs and their implementing partners with challenges and opportunities that are not unique to Kenya; they are applicable to the Africa region as a whole. It is hoped that this model will help other countries which are also contending with the dual problem of a rapidly escalating AIDS epidemic and high population-growth rates while there are diminishing resources to address both.

CHAPTER 3

TWO CASE STUDIES: INTEGRATING SERVICES IN UGANDA AND KENYA

Service delivery programs in Uganda and Kenya have made major strides in tackling issues related to integrating STD/HIV-AIDS services into FP services. Despite difficulties and deficiencies in infrastructure, staff skills, and resources, organizations in both countries have embraced the integrated approach as the most cost-effective, client-centered, and responsible way to respond to the HIV-AIDS pandemic and sustain momentum toward greater acceptance and longer-term use of modern contraceptive methods.

Organizations with some measure of success in integrating services are characterized by:

- ♦ A shared commitment to integration that begins at the top levels of the organization and involves all levels of staff in developing and implementing strategies required to make integration a success.
- ♦ Dedicated service providers who are willing to absorb additional workload burdens to address client needs more effectively.
- ♦ Sound basic infrastructure and strong referral linkages with other local organizations that have additional expertise or facilities.
- ♦ Effective communication flow and information sharing so that managers and providers can acquire skills, learn what works (and what does not), and determine how clients are reacting to, or benefiting from, new services.
- ♦ A detailed, but flexible, plan that allows managers and staff to integrate services systematically while responding to new insights or information about their own or others' experiences with integration.

In partnership with USAID/REDSO and Pathfinder International, The Population Council has conducted several integrated service delivery case studies in the Africa region. Three have been completed: Family Life Education Project (FLEP) in Busoga Diocese (Uganda)⁴²; Mkomani Clinic Society in Mombasa (Kenya)⁴³; and the Ministry of Health (Botswana).⁴⁴ Cost data, available for two of the three studies, indicate that integrated reproductive health services are more cost-effective than vertical or stand-alone family planning and STD, or HIV-AIDS, programs. Key findings from two programs (FLEP and Mkomani), both of which are at the forefront of implementing the integrated approach, are reported in the following pages.

⁴² Mukaire, J., F. Kalikwani, B. N. Maggwa, and W. Kisubi. *Integration of STI and HIV-AIDS Services with MCH-FP Services: A Case Study of the Bugosa Diocese Family Life Education Program*. Uganda, January 1997.

⁴³ Twahir, Amina, et al. op. cit.

⁴⁴ Maribe, L., et al. op. cit.

UGANDA CASE STUDY
FAMILY LIFE AND EDUCATION PROGRAM, BUSOGA DIOCESE JINJA, UGANDA:
A RURAL CLINIC/CBD CASE DESCRIPTION

In 1992, the Family Planning Education Program (FLEP) developed and implemented a project to integrate STD/HIV-AIDS services with its FP program in Uganda's Busoga Diocese (Jinja and surrounding rural communities).

Background

The Family Life Education Program (FLEP) began in 1986 as a part of the health care component of the Multi-Sectoral Rural Development Program (MSRDP) of the Church of Uganda's Busoga Diocese. Busoga Diocese, which is 90 percent rural, covers three districts (including the city of Jinja) near Lake Victoria in southern Uganda and has a population of approximately 1.86 million people. The three districts have been divided by FLEP into 46 rural project areas and two peri-urban (densely populated) areas, each of which is served by a clinic (constructed by the community) that offers reproductive health care and supports community-based services. In 1994, FLEP became an independent NGO with a Board of Directors and a mandate to increase its capacity to address significant community health concerns.

FLEP's institutional mission is to promote the health status of families, with special emphasis on mothers and children by providing health and other related services in the context of Christian principles. Its programmatic goal is to increase awareness of and access to family planning and STD/HIV-AIDS information and services using community-based approaches. One of FLEP's

The Family Life Education Project's Integration Model

- ◆ Carry out STD/HIV risk assessment for all clients receiving MCH/FP services from the Multi-Sectoral Rural Development Program (MRS DP) clinics.
- ◆ Screen all clients receiving MCH/FP services for STDs and AIDS using a diagnostic checklist.
- ◆ Identify and refer clients for HIV testing.
- ◆ Diagnose and treat clients with STDs using the syndromic approach.
- ◆ Inform and educate all clients receiving family planning and other services from the MRS DP clinics and Village Health Workers about STDs and HIV-AIDS.
- ◆ Inform and educate persons living within the Busoga Diocese about STD and HIV-AIDS through public meetings, seminars, drama and song.
- ◆ Inform and educate in-school youth about STDs and HIV-AIDS using trained community resource persons (e.g. school teachers).

objectives is to increase Bugosa rural communities' participation in their own health management. Toward this objective, FLEP established Community Health Committees, consisting of 15 people, to manage local program activities in each project area, recruit staff and CBD agents, mobilize communities to construct health units, and promote use of program services.

FLEP employs 148 community-based distributors (CBDs) and 48 nurse midwives to serve a total population of 1,860,600, of whom 22 percent are women of reproductive age. CBDs distribute educational information and contraceptives and refer clients to area clinics for treatment of STDs and other family planning services. Its education-through-entertainment component (called "enter-educate") has brought clear messages to thousands of local people. FLEP has also become a major provider of South-to-South technical assistance and training to other Ugandan organizations.

Although FLEP operates only in eastern Uganda, it is the country's leading family planning CBD program, and has become a model for other health projects. FLEP has had a demonstrated impact on accessibility, acceptance, and use of modern contraceptive methods in the communities where it works. The contraceptive prevalence rate in areas served by FLEP is 19 percent as compared to the national average of 8 percent.

Identifying Key FP/STD/HIV-AIDS Issues

Unlike most programs, FLEP has built-in community mobilization and participation efforts including building clinics through self-help schemes and establishing committees to supervise health services. As a result, program managers and service providers are able to join with the community in identifying reproductive and other health trends or problems and developing effective responses to them. This has created a shared understanding of Busoga's priority health needs, and what issues FLEP will face in trying to address them. Prior to program design, FLEP staff conducted a needs assessment which included dialogue with the community and a review of relevant research findings on integration to determine urgent health and programmatic needs.

Socio-demographic and health characteristics of the communities

Like the rest of Uganda, Busoga Diocese has relatively high fertility rates and low contraceptive prevalence rates. While the total fertility rate (TFR) is 6.8 and contraceptive prevalence rate (CPR) is 7.8 nationally, FLEP's impact can readily be seen because Busoga's CPR of 18 percent is more than 2.5 times the national rate. Throughout Uganda, maternal and infant morbidity and mortality are also high throughout Uganda. The HIV seroprevalence rate ranges from 8 percent to 36 percent, STD prevalence from 6 percent to 25 percent, with national infant mortality rates of 110/1000, and maternal mortality of 500/100,000. The poor health status of women and children in FLEP communities is exacerbated by many other factors, including negative attitudes, towards adolescent sexuality education, which limit access to reproductive health services; lack of male involvement (despite male dominance in family reproductive decisions); low status of women leading to poor interspousal communication and rare joint decision-making about

reproductive health concerns; lack of condom negotiation skills; and low literacy rates that curtail access to accurate reproductive health information.

Programmatic issues

While the health needs of women and children in FLEP communities are substantial and urgent, existing health care networks or facilities have been unable to respond adequately. Insufficient numbers of well-trained service providers; service provider biases (for example, an unwillingness to treat or counsel adolescents or clients with STDs), method preferences (especially toward oral contraceptives or condoms that provide income to community service workers and depot-holders), and religious opposition to providing contraception for single clients; and lack of equipment and drugs for STD diagnosis and treatment were impediments to smooth service delivery. Moreover, eroding health infrastructures; the traditional emphasis on curative rather than preventive services; and vertical FP, MCH, and STD/HIV-AIDS health programs made it difficult for clients to find high quality, accessible services. Finally, a non-supportive national policy environment served as an additional barrier to effective service delivery. Addressing these programmatic issues was key to increasing access to high-quality reproductive health services in Busoga Diocese. The shared recognition of these needs and issues by communities, managers, and providers, as well as policy makers, has shaped FLEP's program.

The Integration Process

FLEP provides integrated services in eight project areas or project zones. FLEP's menu of services responds to community demand and needs, existing staff skills, and referral linkages. To meet the demands of integrated service delivery, FLEP has recognized that it must expand its own resource base by training existing staff, developing appropriate IEC materials and activities, developing a risk assessment checklist, establishing a testing system, designing mechanisms for treatment of complications, and improving clinic facilities.

Training project staff

FLEP does not have the in-house capacity to provide training in HIV-AIDS counseling. In 1992, its management approached The AIDS Support Organization (TASO), a Ugandan NGO with this training capability, to train VHWs and medical practitioners to counsel clients on HIV-AIDS. Project staff have also attended in-house seminars on modes of STD transmission, symptoms, and signs and syndromic diagnosis of STDs. Most training sessions and refresher sessions are two weeks long and include theoretical information as well as skills-building.

Developing appropriate IEC materials and activities

FLEP has encouraged local IEC teams to develop plays and songs with integrated FP/STD/HIV-AIDS messages, especially since there are very few IEC materials in Uganda on STD/HIV-AIDS

with integrated messages. The limited IEC materials originally available were not useful in project communities because they were in English and were developed for urban environments.

Developing a risk assessment checklist

The project has developed a checklist for health staff to determine clients' risk status for STD/HIV-AIDS. The checklist collects information on marital status, health status of children, and symptoms or signs suggestive of STDs or AIDS, but does not address the client's sexual behavior. Thus, the checklist is useful in identifying clients who are already showing symptoms of AIDS but not those either at risk of being infected or with early HIV. Although program managers have planned to upgrade VHW skills and tools, VHWs have not yet been provided with similar screening checklists.

Establishing an HIV testing system

None of FLEP's clinics have laboratory facilities. Therefore, an arrangement was made with the AIDS Information Center (AIC) to provide mobile HIV testing facilities in four of the eight project zones. AIC mobile HIV testing teams visit project areas on a monthly basis, and all the clients tested by AIC receive pre- and post-test counseling. Plans have made to introduce mobile testing in the other four zones in the next fiscal year.

Treating STDs and complications of HIV-AIDS

Medical practitioners at the clinics have been trained in syndromic STD diagnosis and treatment. Arrangements have been made with public sector district hospitals and other better-equipped sites to accept referrals from FLEP clinics for clients with complications from STDs or HIV-AIDS.

Improving clinic facilities

Communities are being encouraged to construct more permanent clinics that are well-planned, shelter clinic equipment, and allow for greater privacy. Some of the present clinics are temporary structures, with one or two rooms, made of traditional materials (e.g., mud, wattle, and thatch). Once communities are convinced that higher quality is needed, FLEP staff and communities work together, with FLEP providing the building plans, cement, and iron sheets to build more permanent and secure structures.

Project Accomplishments

FLEP has several notable accomplishments in providing integrated services and developing plans on which to build in the future:

- ♦ VHWs are providing information on STDs/HIV to all their FP/MCH clients. They also provide counseling for families with members who are HIV-positive or have AIDS, as well as some training in the care and support of HIV-AIDS patients.
- ♦ The community has recognized the important role VHWs have played in informing people about STD/HIV-AIDS. VHWs are invited to address church and other public gatherings whenever possible.
- ♦ FLEP is no longer viewed as an FP-only project. The project's integrated approach has facilitated discussions about family planning and MCH services with community members who would otherwise not have been reached. As a result, demand for family planning, prenatal, and child welfare services has increased. For example, since STD and HIV services were introduced in 1994, new FP acceptors at the clinic grew by 28% over the previous year, and new acceptors through CBD increased by a dramatic 60%. Between 1994 and 1995, the number of clients seeking STD services grew by an astounding 230%.
- ♦ Anecdotal evidence and service statistics indicate that the use of drama and music performed by people who are respected in their communities has been very successful in educating people about FP/STD/HIV-AIDS.
- ♦ More people are now using condoms to prevent STD/HIV transmission. One clinical practitioner identified condom requests along with childbirth as the most common emergencies that arise at night. When integrated services started after training CBD's in April 1993, condom distribution almost doubled from a quarterly maximum of 54,900 in 1992 to 106,950 in 1993 and 113,400 in 1994.

Many of the project's successes can be attributed to extensive community involvement; health emergencies which gripped and united communities which FLEP serves; intensive training and commitment of VHWs; and close linkages which FLEP has fostered with organizations that offer specialized reproductive health services such as TASO and AIC.

Challenges to Providing Integrated Services⁴⁵

FLEP has enjoyed marked success in project and community involvement initiatives. As with any new project, however, new challenges have surfaced. Ironically, some of the challenges and complexities flow from one of FLEP's strengths: its relationship with the 48 communities it serves.

- ♦ Since field staff are recruited from communities in which they live, some of their clients are family members or related to them. Traditions and cultural attitudes make it difficult for staff to discuss matters pertaining to sexual behavior openly with their relatives. To resolve this issue, the staff have decided to let clients who are relatives be served by a

⁴⁵ Mukaire, Joy. *Presentation to Pathfinder International's Board of Directors*. Atlanta, GA, March 1995.

non-related colleague. Using written and audio/visual IEC materials to communicate sensitive messages has also assisted in addressing this issue.

- ♦ Like many mobile services controlled by another organization, the HIV testing system of AIC has not always been responsive to FLEP program needs. For example AIC, due to its own constraints, has not always been able to keep appointments for mobile team visits. As a result, testing for HIV and other STDs is not reliable and some clients have lost confidence in the service. Since AIC is the only organization with trained counselors to provide more complicated post-test counseling, more realistic planning and scheduling will be undertaken jointly with AIC management in the future.
- ♦ Uganda's MOH has yet to publish standardized guidelines for management of STD/HIV-AIDS, making it difficult for the project to standardize its protocols and make them consistent with national norms.
- ♦ Area health subcommittees purchase STD treatment drugs for individual clinics based on requests from clinic practitioners and resources available. This limits the range of appropriate drugs available to practitioners. As a result, treatment regimens vary from clinic to clinic.
- ♦ Problems with transportation and treatment costs have made it difficult to establish a referral network for treating complicated STDs.
- ♦ VHWs are working harder and have begun to ask for compensation. Most donors, however, are now not in favor of compensating VHWs.
- ♦ Partner notification (contact tracing) and promoting dual method use have been hampered by socio-cultural barriers. In rural Uganda, women are not expected to initiate discussions about sexual matters with their partners. In a project like FLEP, where women are the primary clients, their inability to communicate with partners limits the impact of FLEP's STD/HIV-AIDS messages and services.

Lessons Learned⁴⁶

Some of the lessons learned from FLEP's programs can be generalized and are applicable to most CBD- and clinic-linked programs. For example, STD and HIV services raise issues of sensitivity and confidentiality to new levels. Service provider openness and willingness to discuss reproductive health issues must be accompanied by training to improve counseling and interpersonal communication skills. To be highly successful, programs must reach beyond traditional clients to other underserved community members, especially adolescents and men.

⁴⁶ Mukaire, Joy. *Integration of HIV/AIDS Control and Management into Family Planning Services: Lessons from Bugosa Family Life Education Program's Experiences*. Presentation at the HIV/AIDS/STD Family Planning Integration Symposium, Nairobi, Kenya, February 1994.

HIV-AIDS counseling demands great sensitivity, tact, and skill. Project experience demonstrates that it may be preferable to concentrate on training those CBD agents who already have a good record in interpersonal communication for providing integrated services.

Effective interspousal communication on problems associated with HIV-AIDS and STDs is a key aspect of promoting family reproductive health. FLEP recognizes that **male motivation and involvement are key to interspousal communication** in its cultural setting. A male motivation curriculum has been developed to train field staff in promoting reproductive health, family planning, and safer sexual practices among men. FLEP is also training women in condom negotiation and communication skills.

Concern about teenagers dying of AIDS provides motivation for parents' increased involvement in adolescent sexuality and family life education. FLEP has capitalized on this trend to develop initiatives that **strengthen parent-child communication** and train parents to guide their children on sexual and reproductive health matters; FLEP is still weighing their impact. However, FLEP has concluded that in sensitive matters of reproductive health, most clients have established such strong client/provider relationships that they prefer to use VHWs as their first contact in the local health care system.

Continuing Directions

FLEP is already making plans to consolidate and institutionalize integrated service delivery. FLEP's continuous self assessments, along with recent evaluations, have highlighted steps that now are being taken to improve the quality of integrated services to clients, including:

- ♦ Conducting intensive new and refresher training of service providers.
- ♦ Revising its CBD curriculum to incorporate HIV-AIDS and STD service delivery and counseling.
- ♦ Redesigning IEC activities and materials for integrated interventions, particularly those highlighting linkages among reproductive health issues.
- ♦ Increasing networking with other organizations and government programs to share resources and develop a directory of relevant services and sites so that internal and external referral systems are strengthened.

**KENYA CASE STUDY
MKOMANI CLINIC SOCIETY, MOMBASA, KENYA:
AN URBAN CLINIC/CBD CASE DESCRIPTION**

The Mkomani Clinic Society (MCS) developed and implemented a model for integrating STD and HIV-AIDS services into its MCH/FP program in 1992. This was a response to increasing rates of HIV infection among clients, coupled with a perception that clients had limited understanding about the risks of HIV and STDs.

Background

The Mkomani Clinic Society (MCS) is a private charitable organization founded in 1980 to provide basic medical services for Mombasa's economically disadvantaged residents through two clinics: one in an area called Mkomani and the other in Bomu. It was founded by a group of civic-minded Asian and African community residents. The resulting coalition has strengthened Mkomani's outreach and options for sustainability. USAID, through Pathfinder International, is the major source of funding for MCS activities. Over the past few years Mkomani has also been supported by several other USAID-funded projects, including AVSCI and FPMD. The society provides antenatal care, child welfare, FP, and basic curative services at both clinics.

The Mkomani Clinic Society Integration Model

- ◆ Carry out a risk assessment for STD/HIV-AIDS among all clients visiting the clinics for antenatal care, child welfare, and FP services.
- ◆ Provide information on STD/HIV-AIDS to all clients who receive any services at the clinics or from the community service workers.
- ◆ Inform the public about STDs and HIV-AIDS and the availability of services at the MCS clinics through public meetings and seminars.
- ◆ Protect health personnel and MCH/FP clients from infection during clinic procedures.
- ◆ Request and/or refer all antenatal clients for syphilis testing.
- ◆ Diagnose and treat common STDs within the MCH/FP unit.
- ◆ Identify and refer all clients with symptoms/signs of HIV infection, or those requesting HIV testing, to institutions with established HIV counseling and testing facilities.
- ◆ Carry out partner notification, risk assessment, screening, diagnosis and treatment for identified contacts.

MCS employs 15 professional staff, including five doctors, one clinical officer, seven community nurses, and two laboratory technologists. These are assisted by two nurses' aides and two laboratory assistants. MCS has 30 community service workers serving densely populated areas such as Mombasa town, Old Town, Likoni, Bamburi, and Changamwe. MCS doctors and nurses completed basic training more than 10 years ago, and only two doctors and one nurse have attended an in-service course on management of STD/HIV-AIDS services.

Both the Bomu and Mkomani clinics have adequate equipment and supplies for all STD and MCH/FP services. Clinics are equipped with generators and water tanks that have an adequate supply for several days. The narrow and poorly lit corridors used as waiting areas at both clinics are frequently crowded. Both clinics have an examination area that is separate from the counseling area but adequate privacy is not always possible. At Mkomani, the material used to separate the areas is not soundproof, while at Bomu, the two rooms are separated by a space used as a waiting room.

Both clinics are extremely busy. In 1994 they served 23,000 clients, almost half of whom were family planning clients. Services at both clinics were initially provided for a small, fixed fee (70 Kshs) that covered consultation and treatment costs. Family planning, antenatal, and child welfare services, which had previously been provided separately on different days, were reorganized in 1992 so that clients could have access to these services every day from the same nurse. The clinics are open from 8:00 am to 5:00 pm Monday to Friday and up to 12:30 pm on Saturday. Mkomani also has substantially upgraded its laboratory facilities, and is generating increasing revenues from the laboratory back-up services provided to small local clinics and private practitioners.

Identifying Key FP/STD/HIV-AIDS Issues

Mombasa municipality has experienced high HIV and AIDS prevalence rates. Data from the National Sentinel Surveillance system show that the prevalence of HIV infection among women attending antenatal clinics rose from 10 percent to 16 percent between 1990 and 1993. With such a swift increase, the implication is that of the 5,119 antenatal clients served by MCS in 1994, 819 women would have tested positive for HIV. Contraceptive use, as measured by the 1993 Kenya Demographic and Health Survey, indicates that 23 percent of Mombasa's women experienced an unmet need for FP services. In summary, Mombasa's health indicators demonstrate that expanding delivery of reproductive health services is critical. Innovative approaches, such as developing and implementing an integrated program were devised by Mkomani Clinic Society (MCS) as a cost-effective, client-responsive way to address this challenge.

Until 1992, STD/HIV-AIDS services were available only through its clinic curative services departments. Clients seeking family planning, antenatal, and well-child services who also needed STD/HIV-AIDS services were referred to this department. Clients were dissatisfied with this arrangement because the curative department did not offer the same confidentiality and client-provider relationship as in the MCH/FP unit. Clients also found that the time needed at the clinic

was doubled because they had to queue twice for services. Early in 1993, the MCH/FP nurse began providing basic IEC and counseling on STD/HIV-AIDS to her clients on her own initiative. This, however, increased her workload and the time she spent with each client. In late 1993 and early 1994, MCS management noticed this individual effort to and decided to adopt an integrated service delivery approach.

In 1995, a case study of Mkomani's integrated program was carried out by The Population Council, in collaboration with Pathfinder International and MCS.⁴⁷ This study included a review of the literature, an in-depth interview with the Project Director, clinic inventories, interviews with staff, and exit interviews with 36 clients. Analysis and comparison of the cost of providing integrated versus vertical services was also included. Key findings from this case study are discussed below.

The Integration Process

To the MCS management, integration meant ensuring that all clients' health needs and concerns are met during a clinic visit within the primary health department. To meet this goal, STD and HIV-AIDS services had to be added to existing MCH/FP services. The MCS management held consultations with staff at all levels before developing an institutional framework within which the STD/HIV-AIDS services could be provided without disrupting existing services. Several activities were planned:

Staff recruitment

Two community nurses were recruited to assist in providing integrated services.

Technical seminars and workshops

MCS senior medical staff held seminars for:

- ♦ nurses to introduce them to syndromic diagnoses of STDs and AIDS;
- ♦ support staff on protection against STD/HIV infection, safe waste disposal mechanisms, modes of transmission of STD/HIV, and safe sexual practices; and
- ♦ commercial sex workers on modes of STD/HIV transmission, safe sex practices, condom use, and other reproductive health topics.

Developing guidelines

The process of standardizing protocols and guidelines for all levels of service providers was initiated.

⁴⁷ Twahir, Amina, B. N. Maggwa, Ian Askew. op. cit.

Testing for STDs

The Bomu clinic laboratory was expanded to include tests for common STDs.

Project Accomplishments

After participating in these training seminars, evaluations and on-site observations reveal that all appropriate MCS medical staff are capable of:

- ♦ Conducting risk assessments for STD/HIV-AIDS for all clients who obtain family planning, antenatal, and well-child services.
- ♦ Providing information on STD/HIV-AIDS to all clients who receive services from community service workers.
- ♦ Providing counseling on STD/HIV-AIDS for all clients who received MCH-FP services at the clinics or in the community.
- ♦ Referring all antenatal clients for syphilis testing and clients who test positive for STDs to clinic doctors for treatment.
- ♦ Referring all clients exhibiting signs/symptoms suggestive of STDs or HIV-AIDS to the laboratory for testing.

Figure 8 and **Figure 9** are from a paper, presented at the 1996 annual meeting of the American Public Health Association, which describes cost efficiency and program effectiveness associated with providing integrated services.⁴⁸ The figures show increases in condoms distributed and couple-years of protection (CYP) generated during the integration of services which began in early 1993. Although the data do not justify conclusions about causality, they indicate the dramatic increase in condoms. These were distributed mainly by community service workers. Although it is not shown by the accompanying data, without condoms, there was a significant increase in CYP largely from increased use of FP services. In brief, the data indicate that with effort, condom distribution can increase dramatically and that family planning services, aside from condoms, can increase at the same time. The decrease during the last two quarters, may be reflective of decreased donor support to which Mkomani is attempting to adjust.

⁴⁸ Ladha, Sophia, E. Lule, O. Picazo, and R. Sturgis. *Cost Efficiency and Program Effectiveness Associated with Providing Integrated STD/HIV/MCH/FP Services*. Presentation at Annual Meeting of the American Public Health Association, New York, NY, November 1996.

FIGURE 8: MKOMANI CLINIC CONDOM CYP

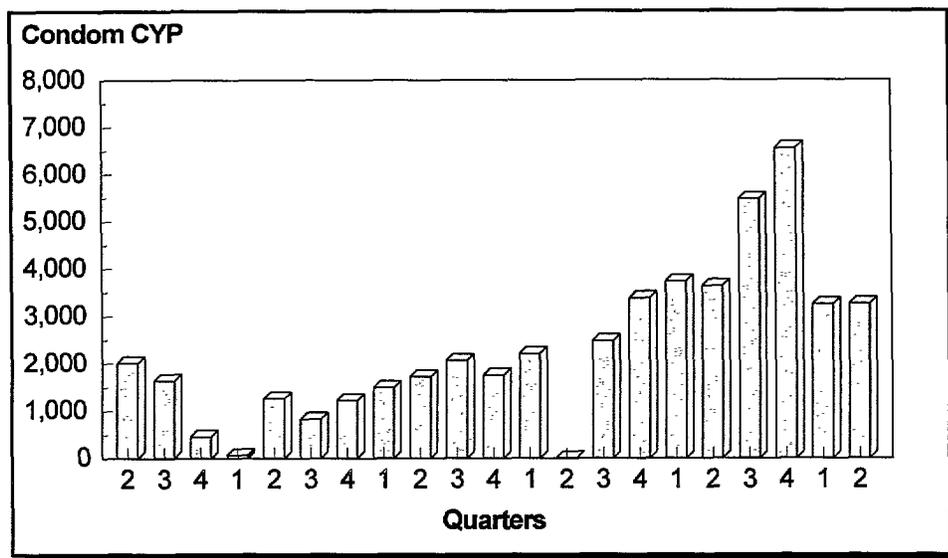
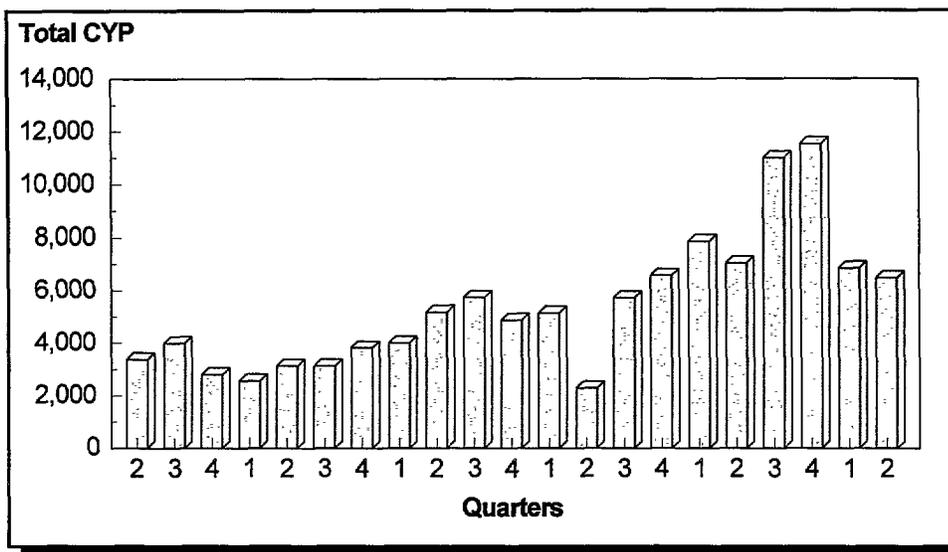


FIGURE 9: MKOMANI CLINIC TOTAL CYP



Cost Analysis Results

An analysis of the cost-effectiveness of separate (vertical) services for FP and STD/HIV, as compared to integrated service, was conducted as part of The Population Council’s case study evaluation. Preliminary results indicate that the cost of providing integrated STD/HIV and MCH/FP services to a new client using oral contraceptives is US\$8.10. This is \$3.80 less than what the same services would cost (\$12.40) at Mkomani if provided separately. These initial

findings indicate a cost savings of 31 percent for integrated services resulting from reduced staff costs, supplies, and overhead. While the study showed a difference in costs, however, there still may be considerable variation in costs for other facilities depending upon type of STD services required or offered, and family planning method being selected. Nevertheless, the difference in costs shown by these initial results is encouraging.

Challenges to Providing Integrated Services

The case study also identified many other challenges to providing integrated services, many of which are currently being addressed jointly by MCS staff and Pathfinder International.

- ♦ Despite having trained staff to conduct risk assessments, not all MCH/FP clients are routinely being asked necessary screening questions. For example, evaluators observed that of 36 women surveyed who had received MCH/FP services, only nine (9) were asked any questions about behaviors or common symptoms and signs associated with STDs and AIDS. Staff asked questions only if the client complained of, or presented with, symptoms suggestive of an STD or AIDS. When asked about this observation, the nurses stated that: they do not have enough time to “question” every client; they were reluctant to question clients, especially those without symptoms or complaints, about their sexual behavior; and they feared that such questions might be intrusive and discourage clients from returning for other services. This indicates that staff need further training on the importance of and procedures for risk assessments.
- ♦ Although staff provide both group and individual information and counseling, and STD/HIV-AIDS services are readily available at both clinics, most clients are still not aware of these services. In fact, only 3 of 36 MCH/FP clients interviewed knew of the services MCS offers. MCS is preparing a client hand-out and plans to review, adopt, and develop its own IEC materials with assistance from USAID-funded projects. Materials developed by Kenya's national STD and HIV-AIDS Control Programs do not appear to be tailored for or acceptable to communities served by MCS. The case study revealed that both field and clinic providers found the IEC materials alarmist and culturally inappropriate; they felt that there had been limited or inadequate pre-testing; and that current materials were not effective.
- ♦ Nurses refer clients with symptoms suggestive of an STD or AIDS for laboratory testing. MCS' laboratories have the capacity to conduct tests for syphilis, gonorrhea, candida, and trichomoniasis. MCS has also made arrangements with the provincial hospital and other private facilities in Mombasa to do HIV testing. Clients referred for laboratory tests pay an extra 50-80 Kshs. While all antenatal clients should be tested for syphilis, the majority of MCS' clients are not. At one MCS site, of 1,500 antenatal clients served in 1994, only 27% were tested for syphilis although all of them were referred. Nurses believe that the additional cost for the test is a major factor in determining how many and which women go for testing.

- ♦ Based on test results, the nurses make a diagnosis and refer an infected client to the doctor, who reviews the findings and prescribes treatment. Clinic nurses are not allowed to prescribe any medications, although public sector nurses with similar training are allowed to both diagnose and prescribe medications. This restriction has limited nurses' participation in the integration process.
- ♦ MCS has made several efforts to provide appropriate treatment, including increasing fees for STD treatment to cover costs of antibiotics or other drugs. It is exploring the establishment of a revolving drug fund and recently became eligible to receive essential drugs under Kenya's MOH-World Bank program. Clinic doctors rely on national and WHO guidelines and recommendations for treating STDs. They are not always able to follow the recommended regimens, however, due to drug shortages. As a result, doctors are forced to issue prescriptions, sending clients to commercial outlets to purchase drugs or referring them to community hospitals. This situation compounds MCS' difficulties in following-up STD clients and their partners; service providers can never be sure whether prescribed drugs were purchased, taken, or are effective in curing clients' STDs.
- ♦ One negative result of raising fees for cost-recovery is that total cost for STD treatment is often too high for low-income clients who use the MCS clinics. Clients are required to pay 70 Kshs (approximately US \$1.40) for a consultation, between 50-80 Kshs (US \$1-1.60) for a laboratory test, and 100 Kshs (US \$2.00) for the treatment. Thus, a client must have a minimum of 220 Kshs (or approximately US \$4.40) for STD diagnosis and treatment, enough to discourage the lowest-income clients from seeking adequate and appropriate treatment.
- ♦ As with most STD programs, partner notification is still a problem. Clinic staff request clients with an STD to inform their partners and ask them to be checked and treated. Apart from verbal requests, notes have occasionally been sent to clients' spouses. Attempts to use community social workers to trace STD/HIV-AIDS clients' contacts have been opposed by clients because they do not want anyone else to inform their partners. Partner notification seems to be easier if the primary contact (index patient) is male. Since premarital sexual relationships are strongly condemned by both providers and the community, partner notification is especially difficult for single women.

Lessons Learned

New insights into project design and project staff's experience with implementation issues since 1994 have contributed to MCS' relative success in integrating services. As a result, management approaches have become more inclusive and systematic, and MCS managers have learned that:

- ♦ A **participatory approach** involving all staff in developing the integration framework was key to the program's success.

- ♦ **Networking with other institutions** has reduced human and financial resources needed by MCS for implementing integrated services.
- ♦ **Positive service provider practices and attitudes** are important determinants of program success.
- ♦ **Clear service protocols** and guidelines are necessary for successful implementation of the integration process.
- ♦ IEC materials must be explicit about new and existing MCS services so that clients may be fully aware of the services that are being offered.
- ♦ Since the costs of laboratory diagnosis and drugs for STDs are too high for some patients, syndromic diagnosis should be used (when clients cannot afford laboratory charges) and supplies of low-cost antibiotics at the clinic should be made available.

MCS has also noted that other viable alternatives to partner notification should be explored where there are cultural barriers and client resistance. These alternatives may include treating the partner with a presumptive course of antibiotics, and sending these to the partner through the client with instructions for use. This practice is fairly common in Western countries for certain infections such as trichomoniasis, and it is quite successful. Other infections that will be reacquired unless the partner is concurrently treated should also receive consideration for presumptive partner treatment. Diagnoses of gonorrhea or chlamydia are usually a justifiable reason for treating the partner with a similar course of antibiotics as is used for the client.

Continuing Directions

Building on efforts to introduce an integrated approach in both its clinical and CBD operations, MCS is in the process of consolidating and strengthening its integration of STD and HIV-AIDS services with MCH/FP services. Staff have started developing a guide to streamline and standardize information, counseling, and management procedures for STD/HIV-AIDS clients. Staff also have outlined other initiatives or steps to strengthen the integration process, including focusing more attention on the quality of the integrated services; establishing a practical and continuous monitoring and evaluation system; developing more realistic mechanisms for sustaining the integration process such as interacting regularly with clients to gauge needs, satisfaction, and willingness to pay; conducting regular fee surveys to determine service fees; conducting on-the-job training or other updates to strengthen or expand provider skills; engaging in regular dialogue with community leaders about health needs or issues; and exchanging experiences with other institutions in the region.

Summary of Busoga and Mkomani

The two case studies clearly demonstrate that integrated services can be initiated in programs that vary considerably. FLEP, for example, serves a largely rural community while MCS is urban-

based. MCS has comprehensive services, including curative, family planning, MCH, antenatal and postnatal, and laboratory services. FLEP, on the other hand, is just beginning to augment the FP and MCH services it offers. MCS has a complete range of full-time, medically trained staff, including physicians, nurse-midwives, laboratory technicians, and medical officers, while FLEP relies on sessional doctors and CBD or other community-based activities. Mkomani's two static clinics are fully equipped and staffed, while FLEP's network is comprised largely of small clinics managed by nurse midwives. Because both share a strong organizational commitment and are known for efficient delivery of services, however, they have been able to make fairly impressive achievements in a relatively short time.

Both have experienced increases in the number of clients. They have altered their planning and service delivery protocols, expanding them to include reproductive health issues such as STD and HIV prevention and treatment, and institutionalizing and strengthening their referral networks so that service providers know when and where to refer clients who have special or more complicated health problems. Providers and managers at all levels in both projects share in the planning and assessments of issues related to implementing integrated services. This means that the levels of commitment and "ownership" of this new way of delivering services remains high, despite some challenges.

FLEP and MCS have identified similar constraints to efficient delivery of integrated services. For example, inadequate supplies of drugs for STD treatment remain a difficulty, and both organizations have attempted to solve the problem. FLEP actually raised funds from a new donor for a revolving loan fund while MCS uses funds generated by laboratory service fees and charges. As demand increases, however, it is now clear that supplies from these sources are insufficient. The programs still lack adequate IEC materials and strategies, and staff counseling skills need improvement. They have recognized that provider bias must be faced aggressively. Both are operating in a climate of uncertainty with regard to national health and internal program policies, and so have not yet completed protocols for integrated services. Partner notification/contact tracing and client follow-up, rarely easy in Africa, present particular challenges that both projects still must address.

FLEP and MCS have not yet reached sustainability, but they are actively considering their options and planning initiatives to increase their resource bases and revenue flow. As part of their strategic planning, they have recognized that **community participation, mobilization, and perceived ownership are essential in achieving longer term self-sufficiency and sustainability**. These projects have made important contributions to their countries and the region in creating a better understanding of the problems and benefits associated with integrating services. Both organizations actively participate in networks with other providers to share resources, plans, and useful strategies. As a result, FLEP and MCS continue to be closely watched by service organizations, donors, and ministries with the hope that their experiences, applied and adapted by others, will accelerate the process of integration throughout sub-Saharan Africa.

CHAPTER 4

SETTING THE AFRICA AGENDA

In 1995, USAID/REDSO, Pathfinder International, The Population Council, and Harvard University's Data for Decision Making Project, organized a three-day workshop to provide a forum for discussing key regional and national issues related to integration of STD/HIV-AIDS services into MCH/FP programs. This workshop, called *Setting the Africa Agenda*, was attended by 165 health care professionals from 18 countries in sub-Saharan Africa, the United States, and Thailand. Participants included representatives from USAID, senior MOH officials, and representatives from local and international NGOs providing health services in Africa. The workshop's overall objective was to provide opportunities for participants to:

- ♦ Learn about global interests and approaches for integrating STD/HIV-AIDS services into MCH/FP programs.
- ♦ Review advantages and disadvantages of integration.
- ♦ Develop an agenda of activities to help donors and implementing agencies better understand the limitations of and opportunities for integrating services.

Organization of the Workshop

The workshop operated at two levels: plenary and working group sessions. Mornings were set aside for keynote addresses and presentations from researchers, analysts, and practitioners.⁴⁹ Panel discussions and plenary sessions on the first and second days were used to outline workshop objectives and key issues based on practical experiences. Five case studies were presented: Botswana, Mkomani Clinic Society (Mombasa, Kenya), Motherwell Clinic (Port Elizabeth, South Africa), Sulmac Clinic (Kenya), and Family Life Education Project (Busoga Diocese, Jinja, Uganda). These were particularly noteworthy for their descriptions of how various contextual settings influenced the pace, configuration, and relative success of integrated service delivery.

Participants were divided into five working groups. On the first afternoon, groups discussed the advantages and disadvantages of integration. On the second afternoon, the session consisted of a two-part exercise. First, working groups were further divided into smaller "mini-groups." Mini-groups then listed activities that should be undertaken to clarify or resolve integration issues. Specifically, participants were asked to list activities in four broad areas:

⁴⁹ Keynote addresses were presented by Dr. Fred Sai, President of IPPF and Dr. Malcolm Potts, UC-Berkley. Other presenters included Dr. Julia Walsh, Dr. Karen Stanecki, Dr. Chris Elias, Dr. Steven Kinoti, and Dr. Wilson Kisubi.

- ♦ programmatic activities,
- ♦ policy and administrative activities,
- ♦ networking activities, and
- ♦ operations research and case studies.

After listing activities, participants returned to the larger groups and placed the activities in a four-cell matrix (Figure 10). One side of the matrix represented potential levels of impact on HIV-AIDS or success of integration, while the other side of the matrix represented time. Participants were asked to classify activities in two ways: by **impact** (e.g., high and low impact) and by **time required** (that is, those that could be accomplished in the shorter term, 1-3 years, and those that are longer-term). On the third day, each working group presented their matrix and described their proposed activities.

FIGURE 10: IMPACT AND TIME REQUIRED FOR INTEGRATION ACTIVITIES

	High-Impact	Low-Impact
Short-Term 1-3 Years	High-Impact and Short-Term	Low-Impact and Short-Term
Long-Term 3+ Years	High-Impact and Long-Term	Low-Impact and Long-Term

Facilitators consolidated all five lists into one comprehensive list showing the four different types of activities divided by their matrix cells: that is, high-impact, short-term activities; high-impact, long-term activities; low-impact, short-term activities; and low-impact, long-term.

Following the presentations, facilitators posted the four types of activities recommended by each working group. Participants then voted to place suggested activities in priority order (see Figure 12 for sample high-impact/short-term list). Following the voting exercise, winning priorities were disclosed and closing remarks were made.

Opening Remarks

In his opening remarks, Dr. Fred Sai, former President of the International Planned Parenthood Federation (IPPF) issued a stirring challenge to workshop participants to think carefully about the importance of balancing a focus on family planning programs with the new health care imperatives posed by the AIDS pandemic. Noting Africa’s “tremendous capacity to wreak havoc

SETTING THE AFRICA AGENDA, OPENING REMARKS

BY DR. FRED SAI

...The answer to such concerns [Africa's economic, political and health problems] is both humanitarian and scientific. It would be inhumane and callous in the extreme to call on death to help solve our population problems in the last stages of the 20th century, given the expansion of scientific advancement and general understanding of disease processes that have taken place in this latter part of the century. The [AIDS] virus mainly spreads through heterosexual activity in Africa and therefore attacks people in their most productive years. In some countries it has killed off quite a large proportion of the well-educated elite. It is also capable of producing a lot of social disintegration, killing off parents and leaving children and grandparents, or even frightening villagers to run away and leave their farms.

Another disturbing consequence of the disease is its potential to distort health services and health priorities. The major killer diseases are well known, and very few countries have really grappled with them. Over-concentration on vertical planning for HIV-AIDS would make for a neglect of conventional killers such as malaria which even today kills more Africans than AIDS.

...Scientifically, we know the cause of the disease and its modes of transmission. The fact that we have no cure or vaccine should really challenge us to do everything in our power to prevent it. One program that can help with this, if not lead in it, is family planning. Our purpose at this workshop is to accept the challenge and map out what roles family planning programs can play in the prevention and control of HIV-AIDS, how such roles are to be operationalized, funded and harmonized with other development efforts, particularly those dealing with sexual and reproductive health.

To deal adequately with the issue of integration will therefore mean an understanding of the realities of the political and social-cultural environment as well as the sexual and reproductive health practices and programs in the localities in which family planning activities are being undertaken. In an extensive search I could not come out with any convincing definition of the term *integration* and therefore feel that a description of what could or might pass as integration would do. At one extreme would be those advocates who understand integration to mean combining all activities that could be considered as reproductive health activities within one program and having them performed under one authority or management perhaps even to the extent of "one-stop shopping" as some have put it. To others, less ambitious, or perhaps more realistic, integration would mean pulling together those aspects of programs that can be harmonized in time and place to impact on the felt reproductive health needs of individuals and communities.

In my view, it is this second interpretation that should drive our search for approaches to integration. In such a search we should try and answer a few specific questions. Why integration? What should be integrated? How is integration to be done?...

with our people...,” Dr. Sai outlined the very real consequences of AIDS in Africa, including renewed questioning of the very need for family planning programs when “nature is killing so many off...” He posed several questions that, once answered, can lead health care programs and donors to realistic and practical, yet effective, reproductive health programs and approaches. Through his remarks, he set a serious and thoughtful tone for the workshop deliberations that followed.

Key Workshop Outcomes

During work group sessions, participants discussed the advantages and disadvantages of integrated projects/programs (see **Figure 11**). Conclusions drawn from this discussion include the realization that what some groups viewed as advantages, others saw as disadvantages and that research to determine costs and quality of care comparisons between integrated and non-integrated services is needed.

FIGURE 11: ADVANTAGES/DISADVANTAGES OF INTEGRATED SERVICES

ADVANTAGES	DISADVANTAGES
<p>Integrated services:</p> <ul style="list-style-type: none"> ◆ are cost and time effective ◆ expand the knowledge and skills of health care providers ◆ can build upon and expand the existing basic skills and facilities ◆ enhance and promote the use of all services equally. ◆ increase sustainability ◆ expand the clientele for FP services by involving men, youth, and the community ◆ increase the promotion and use of condoms ◆ provide an increased data base for planning and make it easier to carry out baseline data collection ◆ reduce client drop-out rate through enhanced referral services and outreach ◆ enhance teamwork and responsibility-sharing among service providers ◆ increase range of barrier methods ◆ facilitate screening for STDs and FP methods ◆ enhance service provider confidence and satisfaction ◆ can reduce the stigma of STDs/HIV ◆ are client centered and convenient, thus better addressing client needs ◆ promote enhance counseling, discussion, confidentiality, and privacy 	<p>Integrated services:</p> <ul style="list-style-type: none"> ◆ if primarily clinic-based, may exclude men and youth ◆ increase cost of MCH/FP services, which already lack resources ◆ create a time burden on service providers ◆ increase workload without extra compensation for staff ◆ increase client waiting time during any one visit ◆ may not be viable in current facilities, inadequate for the full range of services ◆ are not feasible in cases where the syndromic approach to diagnosis does not work ◆ may demand that programs look for other funding sources where donor and program interests differ ◆ require additional training for MOH staff without appropriate skills ◆ require records, monitoring and evaluation data, and indicators of objective standards of quality ◆ require a needs assessment ◆ lead to message overload ◆ can result in reduced quality and focus of services ◆ may be resisted by service providers and clients ◆ may be made ineffective due to high referral drop-out rate

Based on this analysis of advantages and disadvantages and other discussions held during the workshop, participants concluded that an enabling climate can be created throughout Africa so that integrated reproductive health services become more available, accessible, affordable, and meet the needs of young people and target groups more effectively. To accomplish this goal within a short time, within a realistic budget, and with significant, large-scale results—while making immediate, commonsense changes—program staff must pursue activities in the four broad priority areas (**programmatic activities, networking activities, policy and administrative activities, and OR and case studies**) most aggressively. Activities in these four areas should preferably ensure the highest impact in the short-term. (Figure 12 displays the activities voted as most important by workshop participants.)

Coordinating Work in the Broad Priority Areas

The ambitious and much needed agenda outlined by workshop participants actually highlighted the scarcity of currently available resources, including time, that can be devoted to integration issues. It was also clear that participants were *results oriented*—that is, reviews, coordination activities, development of new materials, and other initiatives should provide **practical** guidance for and assistance to program managers, service providers, and implementing agencies. In light of these concerns, subsequent coordination related to the four priority areas has evolved into a process with three main components:

1. A **Regional Integration Partners (RIP)** group comprised of CA and REDSO/ESA representatives. The RIP is charged with implementing key recommendations from the *Setting the Africa Agenda* workshop and other related regional integration strategies or policies; providing support, review, and inputs for the regional Technical Assistance Group (see below); and disseminating the best and most useful information about integration to public and private sector implementers and CAs working throughout the region.
2. A **Regional Technical Group (RTG)** comprised of highly-skilled program managers, service providers, and public and private sector policymakers. The RTG advises the RIP about practical implementation issues and other challenges to integration. Members will provide South-to-South technical assistance and assist in documenting experiences and disseminating useful technical information to peers throughout the region. This approach will maximize inputs from African experts.
3. Country-specific **Task Forces** modeled on the Kenyan Integration Working Group described in **Chapter 2**. The RIP will be instrumental in helping USAID missions in particular countries work with local implementing agencies in creating such task forces; upon request either the RIP or the RTG may be asked to provide technical assistance support. Task Forces will be particularly important in fulfilling the networking portions of the *Africa Agenda*.

FIGURE 12: THE AFRICAN INTEGRATION AGENDA

Programmatic Activities

- ◆ Develop/update/share/standardize national curriculum for STD/HIV-AIDS (including communication skills, STD management, infection prevention) at pre- and in-service levels.
- ◆ Promote condoms and improve distribution, including the use of dual methods.
- ◆ Train for integrated service delivery—nurses, midwives, physicians, CBD, and lab-technicians.
- ◆ Develop/update guidelines, standards, and protocols for integrated service delivery.
- ◆ Develop mechanisms for *community participation and mobilization* to support client use of services.
- ◆ Provide IEC materials (integrated messages) and condoms.
- ◆ Develop mechanisms for community participation in the design of culturally-appropriate IEC materials.
- ◆ Train providers in syndromic STD approach
- ◆ Plan for adequate supplies of STD drugs and contraceptives.
- ◆ Include managers in project planning, implementation, and evaluation.
- ◆ Develop a mechanism for supervising integrated services.
- ◆ Provide antenatal syphilis testing.
- ◆ Establish/strengthen support services such as laboratory, counseling, and screening capability.
- ◆ Revise logistics, drug procurement, and commodity distribution/transportation systems.
- ◆ Refine MIS to improve data collection and monitoring and evaluation indicators.
- ◆ Train program managers/coordinators in integrated service delivery.
- ◆ Include sustainability in integrated program design.
- ◆ Include STD risk assessment in antenatal services.

Networking Activities

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

Policy and Administration Activities

- ◆ Refine models of integration and develop modes of service delivery that reflects those models.
- ◆ Review policies on prescription drugs and on nurses prescribing STD drugs.
- ◆ Revise policies on health system funding and cost recovery.
- ◆ Build consensus among policy makers, especially MOHs.

Conduct Operations Research

- ◆ Adolescent and male use of services.
- ◆ Policy, client attitude, and provider attitudes.
- ◆ Cost effectiveness of integrated programs.
- ◆ Testing models of integration.
- ◆ Effectiveness of the syndromic approach.
- ◆ Effectiveness of dual methods.
- ◆ Different delivery strategies for high-risk groups.
- ◆ Partner notification and contact tracing.
- ◆ Pilot “supermarket” approaches comparing rural and urban programs.
- ◆ Continue case studies and expand to include EPI and FP.
- ◆ Identify lessons learned about integration.
- ◆ Drug resistance.

The work of these three bodies will be synchronized with ongoing support from REDSO/ESA. Essentially, the RIP will use the *Agenda* priorities to organize specific activities and ask the RTG to provide technical inputs and recommendations. From time to time, the RIP and the RTG may work together on specific initiatives, or they may form an initiative-specific Working Group to complete required tasks (e.g., for developing a regional advocacy initiative for integrated reproductive health services to youth, a specific, multi-disciplinary, multi-country Working Group might be formed). The RIP will generally be responsible for disseminating information or materials that result from RTG or Working Group efforts (e.g., curricula, guidelines or “do’s and don’t’s” based on experience with integration; model projects or systems designs using operations research project results; effective IEC or community mobilization materials or strategies; etc.) using the most effective means possible. Examples of specific recommended *Agenda* initiatives are described below.

Programmatic activities

Developing, updating, sharing, and standardizing national curricula for STD/HIV-AIDS service providers (emphasizing communication skills, STD management, and infection prevention) at pre- and in-service levels was the programmatic activity receiving the largest number of *Africa Agenda* participants’ votes. Since a single group (or a single effort) cannot be responsible for developing materials specific to each African country or sub-region, USAID/REDSO and its RIP agreed to review, assess and provide recommendations regarding the quality and adequacy of training curricula for STD/HIV-AIDS prevention and service delivery protocols for integration practices.

The following initiatives have been identified for implementing this portion of the *Africa Agenda*:

Review training curricula

Existing reproductive health and STD/HIV prevention training curricula in respective countries in the region will be assembled and reviewed by a Working Group that includes RTG members who are training experts working for collaborating partners or senior program managers. The Working Group’s review will involve:

- ♦ carefully defining and analyzing tasks that must be performed in delivering integrated services;
- ♦ identifying knowledge, skills and attitudes to be updated or developed in order to perform those tasks;
- ♦ reviewing assembled curricula to identify their gaps, shortfalls, and strengths; and
- ♦ making detailed recommendations that will assist program managers in updating their respective RH training or refresher training curricula for service providers so that provider skills are strengthened and attitudes towards providing integrated services are changed.

Review service protocols

Using a process that is similar to the Working Group for curricula review, RIP members will assemble available integrated service delivery protocols and guidelines. These will be assessed by a team that includes regional STD/HIV experts and FP service delivery experts. Specific recommendations will be made to assist those reviewing, adapting, or developing standards of integrated service delivery practices suitable for use in their respective countries.

Program inventory of integration activities

A database or inventory of integration activities was initiated in preparation for the *Setting the Africa Agenda* workshop to assist program managers who are struggling with the challenges of integration. This information will be regularly updated and operationalized for use. A “user-friendly” description of the data base and its contents will be prepared, highlighting information from reviews of training curricula, protocols, and “better practices.”

Preparation of *Recommended Better Practices* booklet

This additional booklet will complement *Agenda* activities. Review recommendations will be used to compile a *Recommended Better Practices* booklet. A workshop attended by RIP members, program managers, service providers, CBD agents, trainers, STD/HIV experts, FP service delivery experts and policy makers will be held to prepare the booklet which will be distributed widely throughout the region.

Networking activities

The two most important networking priorities identified by *Africa Agenda* participants were to identify funding sources and engage donors and to establish a task force in each country, including local providers and clients, to establish goals and objectives for integrated programs.

Donors

Donor identification is one resource mobilization strategy that can boost integration initiatives, especially since RIP and RTG members will share donor funding priorities, recruitment strategies, and other activities with regional implementing agencies. The RIP and RTG may also play a catalytic role in focusing donor attention on the reasons for and benefits of integration, as well as some potentially successful programs or initiatives deserving support. REDSO has agreed to ensure that donors receive all materials on integration generated by these initiatives and play an advocacy role by creating a better understanding for and support of integration.

Regional Clearinghouse

Establishing a Regional Clearinghouse on integrated reproductive health service delivery; collecting and reviewing useful training and IEC materials; providing information on chosen models; and disseminating protocols, manuals, or models were all proposed by workshop participants. The RIP has started implementing the Clearinghouse proposal; a list of available

materials will be prepared in 1997. RIP will also solicit *Agenda* participants and others to expand this resource base.

Task forces

As described above, one of the three bodies used for operationalizing *Agenda* recommendations is the country-specific Task Force. The RIP will solicit views from USAID missions throughout the region; missions, in turn, will consult with their local implementing public and private partners. Based upon these inputs, the RIP and RTG members will be available to provide in-country technical assistance (usually in the form of a one or two-day organizing workshop with follow-up review and assistance on chosen activities upon request) and establish ongoing coordination mechanisms between the new country Task Forces, the RTG and the RIP.

Other networking activities

Because of resource constraints, those working to accomplish the regional *Agenda* will require substantial ingenuity to ensure that useful, cost-effective, and mutually-supportive activities are regularly conducted. Activities to be explored by REDSO/ESA and the RIP include:

- ♦ Consultation visits to bring non-RTG program managers together to review strategies and documents created by the coordinating bodies and to provide additional advice on next steps.
- ♦ Study tours and exchange visits for program managers and service providers so that they can share experiences with more mature, regional integrated projects and country programs such as Mkomani, Busoga, Swaziland, and Botswana.
- ♦ Trips by Kenya CA representatives to other countries in the region so that they can share their perceptions of what has, and has not, worked and provide suggestions about ways to encourage local CAs and implementers to promote integration.

Policy advocacy and administration activities

Country Task Forces in particular can play a vital role in sensitizing policy makers and local experts about the extent of, and potential solutions for, reproductive health problems because they are sensitive to local views, constraints, and prior experience with integrated service delivery. Because local expertise is essential, Task Forces can take the lead in:

- ♦ Identifying common policy and administrative barriers that exist in most countries, developing strategies to eliminate them and presenting the results at a regional conference for policy makers and program managers.
- ♦ Sharing strategies and agendas at regular in-country or regional meetings to sensitize policy makers, local or traditional opinion leaders, and senior program or administrative officials about reproductive health problems and solutions.

- ♦ Fostering joint plans of action among participating organizations that encourage policy makers to formulate positive policies, legislation, and guidelines that strengthen integrated reproductive health services.
- ♦ Creating and improving technical assistance capacity (through regional and in-country collaboration) and facilitating South-to-South collaboration and exchange visits of experts, program managers, policy makers, and community leaders to raise awareness and share data and experiences about various aspects of integrated service delivery.

OR and case study agenda

Formal integrated reproductive health services are relatively new to most African countries and programs. Consequently, there is limited information on what works and what does not work. From a very large proposed research agenda, participants at the *Africa Agenda* workshop voted on adolescent participation and use of services; client and provider attitudes; and the cost effectiveness of integrated programs as their top three research and case study priorities among a wide range of other topics which were also important to workshop participants.

Other consultative groups are arriving at similar or complementary agendas. For example, a consultative group meeting in the US, with the task of identifying an Africa research agenda for STDs, identified the following areas: **“innovative treatment approaches for core groups; specific approaches to reach adolescents; partner referral; . . . the syndromic approach to diagnosis; and mass treatment of populations or sub-populations.”**⁵⁰ This suggests both a broad consensus about areas that must be investigated or studied, and that information gathered or models created and disseminated from this research will benefit a broad audience, including implementing agencies, and donors.

The RIP, with special inputs by The Population Council, already has prepared and disseminated case studies on integrated service delivery in Botswana, Kenya, and Uganda. An expansion of integration work in Kenya and Botswana is now under way. In Zimbabwe, an evaluative case study on the Ministry of Health’s efforts to improve its ability to manage and control STDs through training, strengthen laboratory facilities, and increase the steady supply of basic STD treatment drugs in MCH/FP clinics is ongoing.

OR priorities expressed by workshop participants have caused the RIP and The Population Council to pay special attention to adolescent participation and use of services; several research activities addressing adolescent reproductive health issues are now ongoing in Zimbabwe, Tanzania, Zambia, Kenya, and Botswana. Most, if not all, of these studies do not specifically address integration of services. However, they will provide useful insights into what services are available, problems currently faced by youth serving programs, and the potential of youth programs to include reproductive health services.

⁵⁰ *Developing a Framework and Agenda for Sexually Transmitted Disease Research in Africa*. Washington, DC, May 20 1994.

Provider attitudes towards integration of STD/HIV-AIDS into family planning services is another recommended focus, with various situation analyses, structured service provider training, and research into key methodological questions (what interventions? what outcomes of interest? what populations?) are also being debated. REDSO has facilitated initial cost analyses in Botswana, Kenya, and Uganda in collaboration with The Population Council, Pathfinder International, implementing partners in those countries, and the RIP; final results will be disseminated in workshops and reports throughout the region. Closely-watched technical assistance is being provided to the Family Planning Association of Kenya (FPAK) on male motivation, participation, and use of services by The Population Council. It is anticipated that a collaborative OR project on the impact of adding STD and HIV-AIDS services may be initiated. If so, OR results will also be disseminated using the coordination mechanisms.

Closing Remarks

Following are excerpts from the closing remarks delivered at the workshop by Dr. Malcolm Potts, Bixby Chair of Population and Family Planning, University of California, Berkeley. While the style and tenor of his comments were meant for oral presentation, his speech was a powerful call to action and summarized the issues that health care professionals must face as they grapple with the HIV-AIDS pandemic.

SETTING THE AFRICA AGENDA, CONCLUDING REMARKS

BY DR. MALCOLM POTTS

Rapid population growth and the catastrophe of AIDS are of a scale that must unite all interested groups, from the most bleeding-heart liberal public health professional to the most faint-hearted development economist. We need to be persuasive in explaining why too many unwanted pregnancies and too many premature deaths are a simultaneous problem. The spread of HIV is terrifying. We have little or no time to maneuver. The agenda is not set by politicians in Washington, Brussels, or Harare; it is set by a submicroscopic virus with the capacity to double its prevalence in one year; and it is set by the momentum already built into current rates of population growth in countries without the capacity to provide adequate housing, necessary health care or reasonable jobs for today's citizens.

Everything we do must be achieved within a realistic budget. In theory, integration might save a government's money, but make it more difficult to achieve cost-recovery from individuals. There are a lot of things we do not know and we need more data on costs. . . Does integration save money? With limited resources in a catastrophic situation we must produce large scale, significant results. This is perhaps our greatest challenge. . . We have had numerous pilot projects, but no continent-wide battle plans. We counseled the commercial sex workers in some cities, but not all, and the virus (which is so stupid it doesn't even know what country it is in, or whether it is infecting a man or woman) slipped past, despite our needs assessments and regression analyses. At this stage in family planning and HIV control, a donor or a government can only support a program if it is part of an affordable, achievable plan with an overall epidemiological impact, nation- or continent-wide.

We need bold solutions, but we cannot afford any mistakes. . . Before we integrate anything we need to make simple things work. Too often the diagnosis and treatment of STDs turns into a cascade of missed opportunities, like a river draining away into the desert: asymptomatic people may not seek treatment; if they do, services may be inaccessible; if they reach a service, staff may be untrained; lack diagnostic facilities; or be without antibiotics. And, if a woman finds a center with trained staff, diagnostic facilities and antibiotics, evidence suggests that 4 out of 10 cases may be given inappropriate treatment.

Preaching ideals of integration, or the values of vertical programs, will not solve the problem and could make the situation worse. To integrate everything would be a disaster; not to integrate some things is stupid. We must review each step objectively and look for pragmatic solutions.

The workshop has highlighted some immediate common sense changes we can make. 1) Simplify MIS — records should be simple and linked to supplies whenever possible. 2) Integrate things that are simple to integrate — IEC staff should deal with AIDS, as well as family planning and MCH; there are clinic staff who can be trained to treat STDs; syphilis and STD services can be improved in antenatal clinics; and experienced outreach workers can undertake some integrated services; 3) Improve logistics — if we cannot supply condoms we may as well close up shop and go home. Donors must decide if they will help pay for antibiotics.

We need to look at integration from the users' perspective. . . Integration should begin at the threshold to the client's home, not at the door of the clinic: 1) Carry as many STD/HIV and FP/MCH services as possible into the community, integrated at the client's doorstep, with the goal of large scale impact. 2) Explore targeting precious clinic resources on meeting the needs of young people in the vulnerable years between first intercourse and first wanted pregnancy, while using every opportunity of simplifying family planning services for women after the birth of the last wanted child.

Focus limited-clinic staff on the needs of young people. Continuing evidence from Uganda, Tanzania, Zambia, Kenya and other countries, indicates that, if seroprevalence is an indicator, youth are increasingly at risk of HIV, as well as for unwanted pregnancies.

CHAPTER 5

THE WAY FORWARD...

This publication, *An African Response to the Challenge of Integrating STD/HIV-AIDS Services into Family Planning Programs*, is primarily intended to help NGOs, donors, and public sector health service providers make use of family planning programs' potential for prevention of STD/HIV infections within the framework of integrated service delivery. Accordingly, theoretical **and** practical issues have been outlined which must be considered when family planning programs want to broaden existing services to encompass more complete reproductive health service delivery, including STD and HIV-AIDS services. This paper has presented a conceptualization and definition of "integration" within the context of sub-Saharan Africa and also provided some practical ways for program managers to think about their programs and **how** they might integrate services.

The country experience of Kenya and the two case studies demonstrate ways that integration activities can be undertaken in different settings and document specific integration challenges, and successes in real-life program settings. Hopefully, these will provide even more topical and useful guidance as programs that are integrating services contrast and compare their experiences with those described in this publication. The practical conceptualization and discussion of integration in the Introduction and in Chapter One provide general considerations and guidelines for integrating FP/STD/HIV-AIDS services.

An African Response proceeds from the premise that, in order to offer high-quality reproductive health services to women and men, family planning programs must strengthen linkages to full FP/STD/HIV-AIDS services. It recognizes that all programs may not be able to offer each and every service, but makes it clear that providers must know **when, where, and how** to refer. This in turn may create new burdens for more sophisticated facilities, but groups of local health care institutions should take up this challenge, allocating specializations or responsibilities for higher-level STD and HIV counseling and treatment to those institutions with the capacity. This will help create clear referral linkages, marshal resources, and curb duplication.

The way forward for dedicated service providers, CAs, and donors has been suggested in the preceding chapters and the collective experiences shared in the 1995 *Setting the Africa Agenda* workshop. Five of the most immediate emerging challenges and concerns are:

- ♦ *Finding more persuasive ways to convince clients, especially men, to modify harmful sexual practices, discuss sexual and reproductive health matters more easily with partners and providers, and use condoms regularly without resistance.* This challenge requires producing and distributing more effective and locally-appropriate IEC strategies, engaging local policy-makers and community or opinion leaders in spreading preventive

and positive reproductive health messages, and implementing programs that systematically reach marginalized, high-risk groups such as youth and men.

- ♦ ***Documenting what works and sharing it broadly with all public health institutions, NGOs, donors, and policy-makers.*** The case studies included in this document are useful to any organization that is seeking to integrate or improve its services and meet the reproductive health needs of its present and potential clients more fully.

Equally important, programs should analyze and use routinely gathered service statistics and other data, as well as results of self-assessments, to gauge program impacts, deficiencies, and probable next steps in expanding integrated services and making them more accessible. These data and information should also be shared with donors and comparable service organizations as a rich source of guidance and potential strategies.

Experiences to date also suggest a full OR agenda for organizations with strong research capability. There are many still-to-be answered questions: what are the best ways of integrating services for each mode of service delivery (e.g., CBD, worksite, clinic, mobile, university)? How can a program integrate, balance workload for service providers, and remain cost-effective? What are the ways of establishing and maintaining higher quality integrated services? How can barriers to integrated reproductive health services be recognized and addressed forthrightly? How can counseling be improved and referral linkages be strengthened? What are the best ways to reach and persuade high-risk groups?

- ♦ ***Focusing on high impact, cost-effective activities that can ensure access and availability of quality reproductive health services throughout the region.*** This is one of our greatest challenges and was well stated in Malcolm Potts' closing remarks of the *Setting the Africa Agenda* workshop where he noted that "with limited resources in a catastrophic situation we must produce large scale, significant results." While the case studies provide data supporting the relatively lower cost of integrated services, more work must be done to validate these preliminary findings and build upon this compelling evidence to generate data that are convincing and conclusive. Equally important, programs need guidance on the ways to maximize cost effectiveness while maintaining quality. Publications such as the AIDSCAP/FHI handbook for STD program design and management, *Control of Sexually Transmitted Diseases*, and Pathfinder's training module for providers on STDs are valuable resources for program planners and managers. Existing publications and those to follow—for programs integrating STD and HIV-AIDS services into MCH and FP services—will be designed to give **practical** assistance to program managers considering integration. Programs and donors also should develop, implement, and share new approaches that build upon what exists in meeting these urgent reproductive health needs more effectively.
- ♦ ***Encouraging programs and providers to overcome ingrained prejudices and beliefs that prevent them from discussing and treating sexually transmitted diseases or other reproductive health problems.*** Service providers and community-based health workers are truly on the front lines in the battle to curb the rapid transmission of STDs and HIV-AIDS, as well as encourage the use of modern contraceptive methods and sound

reproductive health practices. Yet, without a committed effort by reproductive health service providers, clients will continue to feel stigmatized, disrespected, and unsatisfied with program services. This has significant consequences because clients' comfort levels will determine whether they use services, confide candidly in providers, accept counseling, and modify behavior.

Therefore, programs should focus on provider skills and attitude formation through intensive training, in-service technical assistance, more effective supervision and feedback, and participatory planning, monitoring, and evaluation. Curricula and protocol review, updates, and development, as well as "How-To" and systems implementation manuals, are key for such efforts.

- ♦ ***Fostering collaboration and partnerships that include the range of organizations interested in and affected by the burgeoning reproductive health needs and problems facing sub-Saharan African communities.*** Collaboration is critical to any successful integration effort. As the Kenyan CAs Integration Working Group and regional experiences with *Setting the Africa Agenda* demonstrate, the emphasis is to make use of what is working, borrow, adapt, and share. Collaborative efforts such as these must be replicated throughout the region. This collaboration and sharing should be reinforced by exchange visits among reproductive health managers and providers; joint operations research projects; and common training where feasible.

Any sustainable attempt to deal with the AIDS pandemic in Africa on a large scale, in a short time, with limited resources, should be African-led with strong partnerships and support by others working on these issues throughout the region. South-to-South technical assistance, training, planning, and evaluation—drawing on the most experienced and committed regional professionals—will inevitably result in better, more lasting strategies, programs, and performance than any outsiders can devise. Donors in particular can be better informed by regular exposure to the on-the-ground challenges and choices faced by local implementing agencies. This will allow donors to ensure that their essential contributions of financial and technical support are better targeted on areas that will strengthen integrated services and preventive messages.

As noted throughout, this publication is the result of both the public health imperatives posed by the HIV-AIDS pandemic and the many collaborative efforts that are described in its pages. Time is short, and effective actions must be taken quickly and collectively. Ensuring easy access to and use of reproductive health services for Africa's women, young adults, and men—and guaranteeing quality care and sensitivity to these difficult questions by providers rapidly and on a broad scale—are among the most nagging unresolved issues facing reproductive health programs, service providers, and donors in the region.

The *Setting the Africa Agenda* workshop participants outlined several activities and a research agenda (see Chapter 4) that, taken with the daily activities and accumulating knowledge base of local implementing agencies throughout the region, can truly be said to constitute important

pathways for the way forward. To follow these pathways and share models, information, and useful approaches without regard to national borders or boundaries is not an option; it is vital.

Suggestions in this document, based upon what we now know, present a few essentials that must be pursued by all programs and providers that are serious about meeting client and community needs and doing their part to curb the increasing, compounded rates of STD and HIV transmission and rapid population growth. But there is more: Partnerships must be forged so that service delivery institutions have adequate financial, technical, human, and community resources at their disposal.

While health care institutions **self-assess** in preparation for integrating their services, donors must **reexamine policies and procedures** so that these health concerns can be appropriately addressed. Donors also have a key role in fostering capacity building, coordination, collaboration, information and resource sharing, and dissemination of materials and research findings.

The way forward is full of difficulties, risks, and uncertainties. This publication may raise difficult issues or questions, but it also provides an outline for a general conceptualization and application to bolster the use of modern contraception and STD/HIV prevention. How this outline is filled is yet to be determined within programs and by their managers in sub-Saharan Africa. It is clear, however, that the reproductive health and quality of life for millions of African women, men, and young adults—and their families and communities—depend upon the immediate initiatives to combat the public health emergency caused by rapid population growth and spiraling STD and HIV transmission.

As Antonio Machado, the Spanish poet, has written, “*Traveler, there is no path; Paths are made by walking. . .*”

APPENDICES

APPENDIX A

GLOSSARY OF TERMS⁵¹

- STD management:** The care of a client with an STD including history-taking, physical examination, laboratory tests (where feasible), diagnosis, treatment and health education for treatment and prevention, follow-up assessment, and referral, when indicated.
- Risk assessment:** A systematic client interview designed to elicit medical, social, and behavioral history to assist in establishing potential for risk of STIs.
- Syndrome:** A set of signs and symptoms that tend to occur together and are clinically indicative of a particular disease state, such as AIDS.
- Syndromic diagnosis:** A diagnosis based on a set of signs and symptoms (syndrome) such as: genital ulcers, urethral discharge, vaginal discharge, lower abdominal pain and pelvic examination findings. The screening process is based on groups of signs and symptoms or a syndrome that the patient/client has rather than specific laboratory diagnosis of STDs. Information from the patient's history can help distinguish between infections that are sexually transmitted and other reproductive tract infections (especially vaginosis) which are not usually sexually transmitted.
- Since several STDs can cause similar symptoms, providers using syndromic diagnosis may need to treat for several STDs at the same time. For example, urethritis in men is a symptom of both gonorrhea and chlamydia infection. Therefore, in areas where both are prevalent, service providers should prescribe treatment for both STDs.
- STDs:** Sexually transmitted diseases are infections which are transmitted by direct sexual contact resulting in disease (i.e., gonorrhea, syphilis, herpes, chlamydia, AIDS). The term STD is often used with reference to disease (e.g., STD services or treatment).
- STIs:** Sexually transmitted infections are infections which are sexually transmitted, regardless of whether or not they are symptomatic. Among the common sexually transmitted infections are HIV, *Neisseria gonorrhoea*, chlamydia, trachomatis, *Haemophilus ducreyi*, *Treponema pallidum*, *Trichomonas vaginalis*, and *Herpes simplex*. Because the terms STD and

⁵¹ Terms and definitions are adapted from AIDSCAP/FHI, Pathfinder International, The Population Council, UNAIDS, USAID/Washington, and other international organizations.

STI are overlapping, and sometimes used interchangeably, in this document the term STD is used to convey both STDs and STIs.

RTI: Reproductive tract infection is a general term including four types of infections: STIs of the reproductive tract; iatrogenic infections acquired during improperly performed medical procedures (including puerperal and abortion related infections); infections caused by the overgrowth of organisms normally present in the genital tract such as yeast; and endogenous infections such as milliary TB to genital organs.

Partner notification: Partner notification involves informing sexual partners of an infected person about their exposure to an STD or HIV. In this case, partners include steady partners or spouses, casual or occasional partners, or high-risk partners. Partner notification can be carried out either by the infected person (index patient) or a provider. Notification through the provider is sometimes termed **contact tracing**. However, in this document the term partner notification includes both patient and provider notification, as this is the term currently used. Partner notification is an important intervention for interrupting the chain of transmission of both HIV and other STDs, to prevent reinfection of the index patient, and to ensure that individuals at risk have the opportunity to receive therapeutic or preventive treatment.

APPENDIX B

GUIDING PRINCIPLES IN ADDRESSING STD/HIV-AIDS PREVENTION WITHIN FAMILY PLANNING EFFORTS

USAID, Office of Population, February 1994

- ♦ Family planning is our predominant priority. Family planning is effective and has major public health benefits (e.g., women's health, women's rights, family health, community health, national health, etc.).
- ♦ The unmet need for family planning services is high. The need for improving the quality of family planning services is huge. There is still major work to do in expanding and improving family planning programs. Our programs have been generally successful; however, it will take many more resources to provide accessible quality services to women and men in need.
- ♦ We are working in an environment of scarcity. Human and financial resources are limited. We are working with a very small amount of funding relative to the needs.
- ♦ Seeking the largest public health impact. We must affect the greatest number of individuals cost effectively.
- ♦ Primary prevention is the foremost priority. Interventions such as condom promotion, behavior change, counseling, information, IEC generally, and contraceptive development (e.g., female barrier methods, virucides) are the priority.
- ♦ Treatment will have a limited role for the foreseeable future. There is some role for treatment under specific circumstances (e.g., operations research and demonstration projects).
- ♦ High leverage and low marginal cost. There are a variety of activities outside the direct programmatic arena with high leverage and low marginal cost (e.g., training, publications, management, etc.) for which it may make sense to include an STD component (program linkages, e.g., referrals, operations research).

The guidelines that were operational in 1994 have been modified by the recent re-engineering exercise (1996) that has led to the development of the USAID Center for Population, Health, and Nutrition's results framework. **Strategic Objective 4** (S.O.4) is that framework's most relevant strategic objective to integration. Following are that Strategic Objective, the Intermediate Results, and the Results expected under the Objective:

Strategic Objective 4

Increased Use of Improved, Effective and Sustainable Responses to Reduce HIV Transmission and to Mitigate the Impact of the HIV-AIDS Pandemic.

Intermediate Result 4.1.

Increased quality, availability, and demand for information and services to change sexual risk behaviors and cultural norms in order to reduce transmission of HIV.

Results:

4.1.1. Develop, improve, promote and support multi-channel information, education and communication strategies and complementary interventions to enhance awareness and knowledge of HIV and to reduce sexual risk behaviors in household, school, workplace, other community, national and transnational settings.

4.1.2. Develop, improve, promote and support cost-effective strategies (in both public and private sectors) to increase the quality, demand for, and access to, male and female barrier methods for the prevention of HIV transmission.

4.1.3. Develop, improve, promote and support models and strategies to introduce, improve and expand services by public and private health providers to prevent sexual transmission of HIV/STI.

Intermediate Result 4.2.

Enhanced quality, availability, and demand for STI management and prevention services.

Results:

4.2.1. Develop, promote and support policies, guidelines and programs which increase availability, quality and demand for STI services in private and public health settings.

4.2.2. Support research to identify, test and apply improved techniques and approaches to prevent and manage STI.

4.2.3. Develop, improve, promote and support public and private sector initiatives (including community-led initiatives) to deliver high quality STI prevention and case management services.

Intermediate Result 4.3.

Develop and promote approaches that address key contextual constraints and opportunities for prevention and care interventions.

Results:

4.3.1. Enhance the knowledge and awareness among policy-makers of the social, economic, cultural and health impacts of HIV-AIDS, and of the potential strategies to address them.

4.3.2. Identify and address key social, political, information, human resource and service barriers (including stigma and discrimination) to effective responses to HIV-AIDS.

4.3.3. Reduce key information and service barriers for vulnerable populations (especially women and youth).

4.3.4. Develop, evaluate and promote improved policies and strategies for the delivery of basic care and support services for HIV infected and affected persons.

4.3.5. Support global, regional and national policy initiatives to allocate adequate resources, and develop more cost-effective responses to HIV-AIDS.

Intermediate Result 4.4.

Strengthened and expanded private sector organizations' responses in delivering HIV-AIDS information and services.

Results:

4.4.1. Integrate HIV-AIDS prevention into policies and programs of key US PVOs working in the health sector.

4.4.2. Mobilize key US and host country commercial organizations to advocate and support HIV-AIDS prevention and care policies and programs.

4.4.3. Expand and strengthen the capacity of key indigenous NGOs religious organizations and social sector institutions to deliver HIV-AIDS information and services.

4.4.4. Design, test, evaluate and disseminate to global and field-level partners, community-led approaches to designing and implementing effective responses to HIV-AIDS.

4.4.5. Support and develop effective international, regional and national NGO networks and coalitions to respond to the pandemic.

Intermediate Result 4.5.

Improved availability of, and capacity to generate and apply, data to monitor and evaluate HIV-AIDS/STI prevalence, trends and program impacts.

Results:

4.5.1. Establish and/or strengthen surveillance and evaluation systems.

4.5.2. Develop, validate and disseminate improved tools and models to determine HIV-AIDS/STI levels, trends, intervention costs, and program impact.

4.5.3. Develop mechanisms to support timely dissemination and use of monitoring, surveillance and impact research by field programs and in policy dialogue activities.

Intermediate Result 4.6.

Develop and strengthen mechanisms to provide quality and timely assistance to partners (Regional Bureaus, Missions, Other Donors, etc) to ensure effective and coordinated implementation of HIV-AIDS programs.

Results:

4.6.1. Provide high quality and timely technical and management assistance to field programs for program design and evaluation; sharing of lessons learned in other activities, countries and regions; and keeping abreast of important developments in HIV-AIDS.

4.6.2. Establish mechanisms for USAID field missions/offices to implement HIV-AIDS activities.

4.6.3. Establish mechanisms to ensure that field implementation and research agenda inform one another.

APPENDIX C

BIBLIOGRAPHY

References

AIDS and STDs: Priorities for FP Programs. Policy Information Kit, Number 10. Population Action International, Washington, DC, May 1995.

AIDS Control Annual Report, 1996.

AIDS in Kenya. National AIDS Control Programme, Ministry of Health, National Council for Population and Development, 1996.

AIDS and Family Planning. AIDS Prevention Guidelines for MCH/FP Programme Managers. World Health Organization, Geneva, Switzerland, 1990.

Atman, Lawrence. *UN Reports 3 Million New H.I.V. Cases Worldwide for '96.* New York Times. November 28 1996.

Caldwell, John C. and P.Caldwell. *The African AIDS Epidemic.* Scientific American. March 1996: 274(3), 64-65.

Dallabeta, G., M. Loga, and P. Lamptey, eds. *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs.* AIDSCAP/FHI, Arlington, VA, 1996: Chapter 7.

Developing a Framework and Agenda for Sexually Transmitted Disease Research in Africa. Washington, DC, May 20 1994.

Grosskurth, Heiner, F. Mosha, J. Todd, E. Mwijarubi, A. Arnoud, et. al. *Impact of Improved Treatment of Sexually Transmitted Diseases on HIV Infection in Rural Tanzania: Randomised Controlled Trials.* The Lancet. August 26 1995: 346(8297):530-536.

Healthy People: Progress Report For Sexually Transmitted Diseases. Public Health Services, U.S. Department of Health and Human Services, Washington, DC, October 26 1994. [newsletter]

HIV-AIDS Prevention and Control. Population Technical Assistance Project, 1993: 26.

Johnston, Alan. Presentation at the IWG Workshop. USAID's POLICY project, 1996.

Kisubi, Wilson W. *An Inventory of Integration in Sub-Saharan Africa.* Presentation at Annual Meeting of the American Public Health Association, San Diego, CA, October 1995.

Kuyoh, Maureen, I. Achwal, A. Spruyt, and L. Fox. *Protocol: Dual Method Use Among Family Planning Clients.* FPAK/FHI, January 24 1996. [draft]

Ladha, Sophia, E. Lule, O. Picazo, and R. Sturgis. *Cost Efficiency and Program Effectiveness Associated with Providing Integrated STD/HIV/MCH/FP Services.* Presentation at Annual Meeting of the American Public Health Association, New York, NY, November 1996.

Linking Family Planning and Reproductive Health: New Directions for the Office of Population. USAID, 1994.

Lule, Elizabeth L. *STD Prevention in Family Planning—Kenya.* Presentation at USAID Cooperating Agencies Meeting, Washington, DC, February 22-25 1994.

Management of Patients with Sexually Transmitted Diseases. WHO Technical Report Series (810). World Health Organization, Geneva, Switzerland, 1991.

Maribe, L., and S. Stuart. *A Case Study of Botswana's National Program of Integrated Services: What are the Costs?* Presentation at Annual Meeting of the American Public Health Association, San Diego, CA, October 1995.

Minutes of March 7, 1995 Meeting of USAID Technical Advisors for Research on the Integration of STI Prevention and Management into Other Health Programs. [electronic mail communication]

Mukaire, Joy. *Integration of HIV/AIDS Control and Management into Family Planning Services: Lessons from Bugosa Family Life Education Program's Experiences.* Presentation at the HIV/AIDS/STD Family Planning Integration Symposium, Nairobi, Kenya, February 1994.

Mukaire, Joy. Presentation to Pathfinder International's Board of Directors. Atlanta, GA, March 1995.

Mukaire, Joy, F. Kalikwani, B. N. Maggwa, and W. Kisubi. *Integration of STI and HIV-AIDS Services with MCH-FP Services: A Case Study of the Bugosa Diocese Family Life Education Program.* Uganda, January 1997.

Paxman, John, A. Sherpick, and J. Benavente. *Adolescent University-Based Project Evaluation at Kenyatta University Family Welfare and Counseling Center and Egerton University.* 1994. [unpublished]

Presentations at Setting the Africa Agenda Workshop. Nairobi, Kenya, May 22 - 24 1995. [unpublished]

Report on Activities and Perceptions: Integration of STD/HIV-AIDS into FP Programs in Kenya. CAs Integration Program Coordination Unit, April 1995.

Roistein, Florencia, J. Becker, and F. Williams. *A Model Integration of HIV and STD Prevention into Family Planning Programs: Case Study in Jamaica.* October 1993.

Russell-Brown, Pauline and N. Williamson. *The Role of Caribbean FP Programs in AIDS Prevention.* UNAIDS, 1996. [fact sheet]

Sadik, Nafis. *Statement at the Roundtable on Population Policies and Programs: Impact of HIV-AIDS.* Berlin, Germany, September - October 1993.

Sexually Transmitted Diseases and HIV, an Epidemiological Survey. Sexually Transmitted Diseases in the AIDS Era. December 1993: 7(4):753-770.

The Status and Trends of the Global HIV-AIDS Pandemic. Symposium Final Report. XI International Conference on AIDS. AIDSCAP/FHI/Harvard School of Public Health/UNAIDS, Vancouver, BC, July 5-6, 1996.

Twahir, Amina, B. N. Maggwa, and I. Askew. *Integration of STD and HIV-AIDS Services with MCH-FP Services: A Case Study of the Mkomani Clinic Society in Mombasa, Kenya.* The Population Council, April 1996.

Wasserheit, Judith N. *The Significance and Scope of Reproductive Tract Infections Among Third World Women.* International Journal of Gynecology and Obstetrics. 1989: Supplement 3, page 151.

Wilson, Melinda. *Condom Use in Kenya: Results from Focus Group Discussions Conducted at FPPS Assisted Service Delivery Sites*. June 1994.

Additional Materials

AIDS: Images of the Epidemic. World Health Organization, Geneva, Switzerland, 1994.

AIDS Prevention in MCH/FP Programmes: A Rationale and Strategy for Action. WHO/UNFPA/UNDP, May 1993. [draft statement]

Ankrah, E. Maxine. *The Impact of HIV-AIDS on the Family and Other Significant Relationships: The African Clan Revisited*. AIDS Care. 1993: 5(1): 5-22.

Bair, William, P. Clancy, J. P. Clark, A. Leonard, J. Londono, W. Lyerly, J. Wiseman, and C. Woodfill. *HIV-AIDS Prevention and Control and Population/Family Planning: The Potential for Integration of Programs and Activities in Sub-Saharan Africa*. Population Technical Assistance Project, 1993.

Barnett, Tony and P. Blaikie. *AIDS in Africa: Its Present and Future Impact*. New York/London: The Guilford Press, 1992.

Bertrand, Jane T., R. J. Magnani, and J. C. Knowles. *Handbook of Indicators for Family Planning Program Evaluation*. The Evaluation Project, Chapel Hill, NC, 1994.

Blaney, Carol Lynne. *Clients at STD Risk Need Barrier Methods*. Network. Family Health International, May 14 1994: (4) 11-15.

Blaney, Carol Lynne. *Dual-use Prevents Pregnancy, STDs*. Network. Family Health International, May 14 1994: (4) 18-21.

Brown, Phyllidia. *Africa's Growing AIDS Crisis*. New Scientist. November 17 1990.

Caldwell, John C., I.O. Orubuloye, and P. Caldwell. *Under-reaction to AIDS in Sub-Saharan Africa*. Social Science and Medicine. 1992: 34(11).

Cameron, D.W., J.N. Simonsen, L.J. D'Costa, et al. *Female to Male Transmission of Human Immunodeficiency Virus Type 1: Risk Factors for Seroconversion in Men*. The Lancet. August 19 1989: 2(8660):403-407.

Cates, Jr., Willard and K. M. Stone. *Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update—Part I*. Family Planning Perspectives. March/April 1992: 24(2).

Cates, Jr., Willard and K. M. Stone. *Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update—Part II*. Family Planning Perspectives. May/June 1992: 24(3).

Coates, Thomas J. *Communities and AIDS Prevention: What Works*. AIDS Captions. Family Health International, May 1 1994: (2) 2-4.

Coghlan, Anne, M. Kbandu, and M. J. Musungu. *Empowering Communities to Fight AIDS Through Participatory Evaluation*. AIDS Captions. Family Health International, May 1 1994: (2) 16-18.

Contraceptive Technology Update: A monthly newsletter for health professionals. February 1994: 15(2).

Contraceptive Technology Update: A monthly newsletter for health professionals. September 1992: 13(9).

De Lay, Paul. *Adding STD Services Needs Careful Evaluation.* Network. Family Health International, May 14 1994: (4) 8-10.

Dowling, M.A.C. *Producing Health Materials that Work.* World Health Organization, Geneva, Switzerland, 1991.

Earle, Duncan. *Social Marketing: Making Condoms Available to Communities.* AIDS Captions. Family Health International, May 1 1994: (2) 27-30.

Elias, Christopher J., A. Leonard, and J. Thompson. *A Puzzle of Will: Responding to Reproductive Tract Infections in the Context of Family Planning Programs.* Presentation at the Africa OR/TA End-of-Project Conference, Nairobi, Kenya, October 1993.

Family Planning and AIDS Prevention: Technical and Managerial Guidelines. World Health Organization, Geneva, Switzerland, September 1989: (3) 146.

Family Planning and the AIDS Pandemic: Meeting the Challenges. UNFPA—MCH/FP Branch, Technical Evaluation Division. Presentation at the Roundtable on Population Policies and Programs: Impact of HIV-AIDS. Berlin, Germany, September - October 1993.

The Family Planning Manager: Management Strategies for Improving Family Planning Service Delivery. May/June 1994: 3(3).

Fenn, Suzanne. *HIV-AIDS/STD-Family Planning Integration Symposium Final Report.* Pathfinder International, Nairobi, Kenya, 1994.

Finger, William R. (1994) *Should Family Planning Include STD Services?* Network. Family Health International, May 14 1994: (4) 4-7.

Finger, William R. and B. Barnett. *Africa: Using Existing Networks.* Network. Family Health International, May 14 1994: (4) 23-24.

Fransen, L., C.J. Van Dam, and P. Pilot. *Health Policies for Controlling AIDS and STDs in Developing Countries.* Health Policy and Planning. June 6, 1991: (2) 148-56.

Garland, Miriam, B. N. Maggwa, J. K. Mati, J. Kihoro, S. Mbugua, P. Achola, and D. J. Hunter. *Knowledge of AIDS and Other Sexually Transmitted Diseases Among Women Attending a Family Planning Clinic in Nairobi, Kenya.* American Journal of Preventive Medicine. 1993: 9(1) 1-5.

HIV-AIDS Surveillance Report. STD/AIDS Control Programme, Ugandan Ministry of Health, June 1993.

Integrating AIDS Prevention into MCH/FP in Botswana: Why? Which Intervention? How? What? When? Who? Impact and Evaluation? August 1993. [unpublished].

Kapiga, Saidi H., J. F. Shao, G. K. Lwihula, and D. J. Hunter. *Risk Factors for HIV Infection Among Women in Dar-es-Salaam, Tanzania.* Journal of Acquired Immune Deficiency Syndrome. 1994: 7(3) 301-309.

Kates, Jr., Willard and K. M. Stone. "Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update—Part I." Family Planning Perspectives. March/April 1992: 24(2): 75-84.

Katz Miller, Susan. *How to Sell Safer Sex.* New Scientist. February 27 1993: 2-13.

Kelly, Patricia J. and S. Holman. *The New Face of AIDS*. American Journal of Nursing, March 1993: 26-34.
Lande, R. *Controlling Sexually Transmitted Diseases*. Population Reports. June 1993: L(9).

Larson, Ann. *The Social Epidemiology of Africa's AIDS Epidemic*. African Affairs. January 1990: Vol. 89.

Merson, M.H. Address at the Roundtable on Population Policies and Programs: Impact of HIV-AIDS. Berlin, Germany, September - October 1993.

Merson, M.H. *Slowing the Spread of HIV: Agenda for the 1990s*. Science. May 28, 1993: (260) 1266-1268.

McIntosh, N. and S. Cherry. *Managing Genital Tract Infections (GTIs) in Family Planning Service Programs*. JHPIEGO Corporation, Baltimore, MD, 1994.

National Strategy for the Protection of the Sexual and Reproductive Health of Ugandan Women. Ministry of Health and Ministry of Women in Development, Youth, and Culture. Uganda, December 1993. [working draft].

Nicoll, A., U. Laukamm-Josten, B. Mwizarubi, C. Mayala, M. Mkuye, G. Nyembela, and H. Grosskurth. *Lay Health Beliefs Concerning HIV and AIDS—a Barrier for Control Programmes*. AIDS Care, 1993: 5(2): 231-241.

Niruthisard, Somchai, R. E. Roddy, and S. Chutivongse. *Use of Nonoxynol-9 and Reduction in Rate of Gonococcal and Chlamydial Cervical Infections*. The Lancet. June 6 1992: Vol. 339:1371-1375.

Norr, Kathleen F., B. J. McElmurry, M. Moeti, and S. D. Tiou. *AIDS Prevention for Women: A Community-Based Approach*. Nursing Outlook. 1992: 40 (6) 250-256.

Orubuloye, I.O., J. C. Caldwell, and P. Caldwell. *The Role of Religious Leaders in Changing Sexual Behaviour in Southwest Nigeria in an Era of AIDS*. Health Transition Review. 3 (supplement): 93-104.

Overlapping Activities for Family Planning and HIV-AIDS/STD Services. Adapted from Nancy Williamson, *AIDS Prevention and MCH/FP: How Are They Connected?* USAID Office of Population, Washington, DC, August 1993.

Palca, Joseph. *African AIDS: Whose Research Rules?* Science. October 12 1990.

Patton, Cindy. "With Champagne and Roses: Women at Risk from/in AIDS Discourse." In Corinne Squire, ed. *Women and AIDS: Psychological Perspectives*. London: Sage Publications, 1993: 165-187.

Petros-Barvazian, A. and M. Merson. *Women and AIDS: A Challenge for Humanity*. World Health. November/December 1990.

Recent HIV Seroprevalence Levels by Country. Research Note No. 9. Health Studies Branch, Center for International Research, US Bureau of the Census, Washington, DC, June 1993.

Regional Workshop on Setting the Africa Agenda. REDSO, Nairobi, Kenya, May 1995: Page 81.

Reid, Elizabeth. *The HIV Epidemic and Development: The Unfolding of the Epidemic*. HIV Development Programme/United Nations Development Programme.

Renne, Elisha P. *Condom Use and the Popular Press in Nigeria*. Health Transition Review. 1993: 3(1) 41-56.

Report of a WHO Consultation on the Prevention of Human Immunodeficiency Virus and Hepatitis B Virus Transmission in the Health Care Setting. World Health Organization, Geneva, Switzerland, April 1991.

gaf

Roddy, R.E., M. Cordero, C. Cordero, and J.A. Fortney. *A Dosing Study of Nonoxynol-9 and Genital Irritation*. International Journal of STD & AIDS. 1993: 4: 165-170.

Sangeeta, Raja. *Evaluation of AIDS Prevention Activities by the Pathfinder Fund, 1986-89*. Pathfinder International, Watertown, MA, August 1990.

Serwadda, D., and E. Katongole-Mbidde. "AIDS in Africa: Problems for Research and Researchers." The Lancet. April 7 1990.

Seeley, J., U. Wagner, J. Mulemwa, J. Kengeya-Kayondo, and D. Mulder. *The Development of a Community-based HIV-AIDS Counseling Service in a Rural Area in Uganda*. AIDS Care. 1991: 3(2): 207-217.

Singh, Jyoti Shankar. Presentation at the Roundtable on Population Policies and Programs: Impact of HIV-AIDS. Berlin, Germany, September - October 1993.

Social Context of Human Immunodeficiency Virus Transmission in Africa: Historical and Cultural Bases of East and Central African Sexual Relations. Review of Infectious Diseases. September/October 1989: 2(5): 716-731.

Standing, Hilary. *AIDS: Conceptual and Methodological Issues in Researching Sexual Behavior in Sub-Saharan Africa*. Social Science and Medicine. 1992: 34(2).

Tamashiro, H., W. Maskill, J. Emmanuel, A. Fauquex, P. Sato, and D. Heymann. *Reducing the Cost of HIV Antibody Testing*. The Lancet. July 10 1993: 42: 87-90.

Trends and Patterns of HIV-AIDS Infection in Selected Developing Countries: Country Profiles. Research Note No. 10. Health Studies Branch, Center for International Research, US Bureau of the Census, Washington, DC, June 1993.

Ulin, Priscilla R. *African Women and AIDS: Negotiating Behavioral Change*. Social Science and Medicine. 1992: 34(1).

Verbatim Report of the Focus Group Discussion Trial 2 at Pumwani. Family Planning Private Sector, 1994. [unpublished]

Waithaka, Daudi and E. Glaesor, *Profiles in Sustainability: Practical Applications in Kenya*. Report to USAID PVO Co-Financing Project of the NGO Sustainability Workshop, Thika, Kenya, September 3-5 1991.

Ward, Martha C. *Cupid's Touch: The Lessons of the Family Planning Movement for the AIDS Epidemic*. The Journal of Sex Research. May 28 1991: (2) 289-305.

Wasserheit, J.N. *pidemiological Synergy: Interrelationships Between Human Immunodeficiency Virus Infection and Other Sexually Transmitted Diseases*. Sexually Transmitted Diseases. March-April 1992: 19(2): 61-77.

Way, P. and K. Stanecki. *The Impact of HIV-AIDS on World Population*. US Bureau of the Census, Washington, DC, 1994.

Weisman, Carol S., C. A. Nathanson, M. Ensminger, M. A. Teitelbaum, J. C. Robinson, and S. Plichta. *AIDS Knowledge, Perceived Risk and Prevention Among Adolescent Clients of a Family Planning Clinic*. Family Planning Perspectives. September/October 1989: 21(5): 213-217.

Williams, Eka Esu. *Women of Courage: Commercial Sex Workers Mobilize for HIV-AIDS Prevention in Nigeria*. "AIDS Captions". Family Health International, May 1 1994: (2)19-22.

Williamson, Nancy E. *AIDS Prevention and MCH/FP: How Are They Connected?* USAID Office of Health, Washington, DC, August 1993.

Wilson, D., M. Armstrong, and S. Lavelle. *AIDS in Africa*. *AIDS Care*. 1991: 3(4): 385-90.

Global Strategy for the Prevention and Control of AIDS. Office of the Director General, World Health Organization, Geneva, Switzerland. Forty-Second World Health Assembly Provisional Agenda Item 19, Apr 11 1989:49, A42/11.

Zekeng, Leopold, P. J. Feldblum, R. M. Oliver, and L. Kaptue. *Barrier Contraceptive Use and HIV Infection Among High-risk Women in Cameroon*. *AIDS*. 1993: 7(5): 725-731.

APPENDIX D

FUNDING SOURCES

Overcoming the Resource Barrier to Integration

One of the most consistent challenges or problems facing organizations wishing to offer integrated services is that of resources. Health care organizations too often lack adequate equipment, supplies, staff, and funds for their existing services. In the initial stages, integration often requires capital outlays for retraining existing staff or hiring new staff with necessary skills; purchasing new equipment; and ensuring a steady flow of commodities and pharmaceuticals. Program managers, boards of directors, and service providers often resist embarking on integration precisely because of the resource implications.

Strategies for Diversifying Resources

Increasingly, organizations are seeking ways to become more self-sufficient, to diversify their resource base, and to sustain program efforts. In many instances, programs are:

- ♦ involving the communities they serve in the search for sustainability strategies,
- ♦ starting endowments,
- ♦ altering their service or program mix to become more attractive to a diverse group of donors,
- ♦ marketing their services more effectively to a wider "audience", and
- ♦ strengthening their capabilities so that they attract and retain more clients.

Getting Started

This list is designed to give organizations in the Africa region a "head start" in the search for additional resources. It is by no means definitive, nor does inclusion of a donor on this list suggest a willingness to fund a particular organization or activity. What is hoped is that organizations will approach these and other donors, and that you will share your experiences and "lessons learned" about fund raising with others.

Multilateral, Bilateral, and Private Funding Sources

Australian Agency for International Development

c/o Department of Foreign Affairs and Trade GPO Box 887 Canberra ACT 2601, Australia

Types of Projects: Bilateral. Child health, FP, & TBAs.

Programs/Projects in: Tanzania & Zimbabwe.

Commission of the European Communities

200 rue de la Loi B-1049, Brussels, Belgium

Types of Projects: Multilateral. RH & IEC.

Programs/Projects in: Central African Republic, Guyana, & Kenya.

Danish International Development Agency

Ministry of Foreign Affairs Asiatick Plads 2 1448 Copenhagen K Denmark

Tel: 45-3-392-0000 Fax: 45-3-154-0533

Types of Projects: Must partner with a registered Danish NGO. Maternal health, Population, & Education for women.

Finnish International Development Agency

Finland Ministry for Foreign Affairs P.O. Box 176 00161 Helsinki, Finland

Regional office: Finnish International Development Agency, Embassy of Finland P.O. Box 39379 Nairobi, Kenya

Tel: 254-2-334777 or 254-2-334778 Fax: 254-2-335986

Types of Projects: Bilateral. FP, IEC, RH, & Primary health care.

Programs/Projects in: Kenya.

Food and Agriculture Organization of the United Nations

FAO Population Programme Via delle Terme di Caracalla 00100 Rome, Italy

Types of Projects: Multilateral. Population, & IEC.

Programs/Projects in: Cameroon, Ethiopia, Kenya, Malawi, Rwanda, & Uganda.

German Federal Ministry for Economic Cooperation

P.O. Box 120322 D 53045 Bonn, Germany

Types of Projects: Bilateral. FP/AIDS, Social marketing, Rural health, & FP/MCH.

Programs/Projects in: Burkina Faso, Burundi, Cameroon, Central African Republic, Cote d'Ivoire, Ethiopia, Gambia, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Togo, Uganda, Tanzania, & Zimbabwe.

International Labour Organisation

Employment and Development Department 4 route des Morillons 1211 Geneva 12, Switzerland

Types of Projects: Policy development, Planning, & Institutional development.

Programs/Projects in: Benin, Burundi, Cameroon, Cape Verde, Ethiopia, Mozambique, & Rwanda.

The Netherlands - Ministry of Foreign Affairs

Bezuidenhoutseweg 67 P.O. Box 20061 2500 EB The Hague, Netherlands

Types of Projects: Apply through Regional Dutch Embassy/Ministry in NGO's home country/region. Women's health services, Maternal health, Population census, Research, FGM, IEC, Prevention, & Youth.

Norwegian Agency for Development Cooperation

P.O. Box 8034, Dep. 0030 Oslo, Norway

Tel: 47-2-314400 Fax: 47-2-314401

Types of Projects: Apply to local/regional office. Partnership with Norwegian NGO preferred. FP, HIV-AIDS, & Maternal health.

Programs/Projects in: Botswana, Mozambique, Namibia, Tanzania, Zambia, & Zimbabwe.

Overseas Development Administration

UK Abercrombie House Eaglesham Road, East Kilbride Glasgow G75 8 EA United Kingdom

Tel: 44-355-844000 Fax: 44-355-843457

Types of Projects: Must be partnered with NGO registered with the UK Charity Commissioners. FP/AIDS, Social marketing, & Maternal health.

Programs/Projects in: Ethiopia, Kenya, Malawi, Nigeria, Uganda, Tanzania, Zambia, & Zimbabwe.

Overseas Development Administration

94 Victoria Street London SW1E 5JL United Kingdom

Tel: 44-71-917-0111 Fax: 44-71-917-0428

Types of Projects: FLE, FP/MCH programs, Research, Training, & Provision of equipment/contraceptives.

United Nations Children's Fund - Burundi

BP 1650 Bujumbura, Burundi

Tel: 257-226888 Fax: 257-225190

Types of Projects: Maternal care, IEC, Prevention, Training, Research, Youth, & Women's health services.

United Nations Children's Fund - Guinea-Bissau

Apartado 464 1034 Bissau Codex, Guinea-Bissau

Tel: 245-201379

Types of Projects: Maternal health, Equipment/supplies, IEC, Prevention, Training.

United Nations Children's Fund - Mozambique

Avenue Do Zimbabwe 1422 Maputo, Mozambique

Tel: 268-491023 Fax: 268-491679

Types of Projects: Facilities, Communications, Maternal care, IEC, Prevention, Training, Women's health services, & Youth.

United Nations Children's Fund - Namibia

P.O. Box 1706 Windhoek 9000 Namibia
Tel: 264-61-229220 Fax: 264-61-224413

Types of Projects: Maternal care, IEC, Prevention, Training, Women's health services, Youth.

United Nations Children's Fund - Uganda

P.O. Box 7047 Kampala, Uganda
Tel: 256-41-234591 Fax: 256-41-259146

Types of Projects: Maternal care, Health education, & Prevention.

United Nations Children's Fund - Zambia

P.O. Box 33610 Lusaka, Zambia
Tel: 260-1-228665 Fax: 260-1-220370

Types of Projects: Maternal health projects, especially in terms of Care, Equipment/supplies, Health education, Research, and Training.

United Nations Development Fund for Women

c/o UNDP P.O. Box 30218 Nairobi, Kenya
Tel: 254-2-228776 Fax: 254-2-331897

United Nations Development Programme

P.O. Box 30218 Nairobi, Kenya
Tel: 254-2-228776 or 254-2-228779 Fax: 254-2-331897

United Nations Economic Commission for Africa

Population Division, P.O. Box 3001 Addis Ababa, Ethiopia
Tel: 2511-517200 Fax: 2511-514416

United Nations Educational, Scientific and Cultural Organization

Division of International Development 7 Place de Fontenoy 75700 Paris France

United Nations Population Fund

220 East 42nd Street 17th Floor New York, NY 10017 USA
Tel: 212-297-5236 Fax: 212-297-4915

United States Agency for International Development

1601 N. Kent Street, Arlington, VA 22209
Tel: 703-875-4721

U.S. Department of Commerce Bureau of Census

International Programs, Population Division, International Statistical Programs Center, Washington, DC 20233 USA

Types of Programs: MIS & Census data.

Programs/Projects in: Burkina Faso, Chad, Madagascar, & Mozambique.

World Bank Population and Human Resources Department

1818 H Street, N.W. Washington, DC 20433 USA

World Health Organization Adolescent Health Programs

20 Avenue, Appia CH1211 Geneva 72 Switzerland

Tel: 41-22-791-2111 Fax: 41-22-791-0746

World Health Organization Global Program on AIDS

20 Avenue, Appia CH1211 Geneva 72 Switzerland

Tel: 41-22-791-4660 Fax: 41-22-791-0746

World Health Organization Regional Office for Africa

P.O. Box No.6 Brazzaville, Congo

Tel: 242-83-38-60 or 242-83-38-65 Fax: 242-83-18-79

World Health Organization Special Program on Research in Human Reproduction Social Science Research

Unit 20 Avenue Appia CH1211 Geneva 72 Switzerland

Tel: 41-22-791-3370 or 41-22-791-3349 Fax: 41-22-788-1825

NGOs and Other Funding Sources

African Development Foundation

Office of West Africa & Sahel

1400 Eye Street, N.W., 10th Floor Washington, DC 20095 USA

Tel: 202-673-3916 Fax: 202-673-3810

Types of Projects: Maternal health & Safe motherhood.

Aga Khan Foundation

P.O. Box 435 1211 Geneva 6 Switzerland

Tel: 41-22-736-0344 Fax: 41-22-736-0944

Types of projects: MCH, Health education, Women's health services, & Youth.

Programs/Projects in: Kenya, Tanzania.

Andrew W. Mellon Foundation

140 East 62nd St., New York, NY 10021 USA,
Tel: 212-838-8400

Associazione Interventi Cooperazione Allo Aviluppo

via Martiri Oscuri 5 20125 Milan, Italy
Tel: 39-2-284-1423 Fax: 39-2-2614-3638

Types of Projects: Maternal health services
Programs/Projects in: Gambia, Mauritania.

Associazione Italiana Donne Per Lo Sviluppo

Via dei Giubbonari 30 00186 Roma, Italy
Tel: 39-6-687-3214 Fax: 39-6-697-2545

Types of Projects: Maternal health, IEC, & Women's health services.
Programs/Projects in: Ethiopia, Gambia, & Nigeria.

Brush Foundation

Ms. Sally Burton, President, 3135 Euclid Avenue, Suite 102, Cleveland, Ohio 44115 USA

Canadian International Development Agency

Canadian High Commission Comcraft House, Haile Selassie Avenue, P.O Box 30481, Nairobi, Kenya
Tel: 254-2-334033

CARE International in Kenya

P.O Box 43864 Nairobi, Kenya
Tel: 254-2-724674 or 254-2-724628 Fax: 254-2-728493

CARE International

151 Ellis St. NE Atlanta, GA USA 30303 - 2426
Tel: 404-681-2552

Carnegie Corporation

437 Madison Avenue New York, NY 10022 USA
Tel: 212-371-3200 Fax: 212-754-4073

Types of Projects: Economic and social development, Sustainability, & MCH.
Programs/Projects in: Kenya, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda, Zambia, & Zimbabwe.

Catholic Relief Services

209 West Fayette St. Baltimore, MD 21201 USA
Tel: 410-625-2220

Catholic Relief Services/Kenya Program

P.O Box 49675 Nairobi, Kenya

Tel: 254-2-41355 or 254-2-740985 or 254-2-750567 Fax: 254-2-741356

Charity Projects

1st Floor, 74 New Oxford Street London, WC1A 1 EF United Kingdom

Tel: 44-71-436-1122 Fax: 44-71-436-1541

Types of projects: Must work with UK registered NGO. Maternal health, IEC, Prevention, & training.

Programs/Projects in: all parts of Africa

Christian Aid

P.O. Box 100 London SE1 7RT United Kingdom

Tel: 44-71-620-4444 Fax: 44-71-620-0719

Types of Projects: Maternal health, IEC, & Training.

Christian Children's Fund

203 East Cary Street Richmond, VA 23219 USA

Tel: 804-756-2700 Fax: 804-756-2718

Types of Projects: Maternal health, IEC, Prevention, Youth.

Committee on Interchurch Aid of the Netherlands Reformed Church

P.O. Box 72 3970 AB Driebergen, The Netherlands

Tel: 31-3438-23611 Fax: 31-3438-21530

Types of projects: Maternal health, IEC, Research, Training, Women's health services, and Youth.

Programs/Projects in: Angola, Botswana, Ethiopia, Kenya, Lethoso, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, & Zimbabwe.

Deutsche Gesellschaft fur Technische Zusammenarbeit

GMBH Postfach 5180 65726 Eschborn Germany

Fax: 49-06196-79-1115

Types of Projects: Primary health care, Research, Institutional Development, FP, and MCH.

Evangelische Zentralstelle fur Entwicklungshilfe(EZE)

Protestant Association for Cooperation in Development, Mittlerstrasse 37, 5300 Bonn 2, Federal Republic of Germany

Tel: 49-228-8-1010

Family Planning International Assistance

810 Seventh Avenue, New York, NY 10019

Tel: 212-541-7800 Fax: 212-247-6274

Regional Office: FPIA Africa Regional Office P.O. Box 53538 Nairobi, Kenya

Types of Projects: FP service delivery, Adolescent health, & FP/STD.

Ford Foundation 320 East 43rd Street New York, NY 10017

Tel: 212-573-5000 Fax: 212-599-4584

Kenya office: Ford Foundation P.O. Box 41081 Nairobi, Kenya

Senegal Office: Ford Foundation Boite Postale 1555 Dakar, Senegal

Nigeria Office: Ford Foundation P.O. Box 2368 Lagos, Nigeria

Types of Projects: Comprehensive approach to RH for women, men, & adolescents.

Friedrich Ebert Foundation

P.O Box 59947 Nairobi, Kenya

Tel: 254-2-746992 Fax: 254-2-750329 or 254-2-722240

Global Fund for Women

2480 Sand Hill Road, Suite 100 Menlo Park, CA 94025-6941 USA

Tel: 415-854-0420 Fax: 415-854-8050

Types of Projects: Women's groups, Human rights groups, Autonomy for women, Rights of adolescent women, RH rights.

Instituto de Estudos para o Desenvolvimento

Institut d'Etudes pour le Development, S Domingos a Lapa, 111-3, 1200 Lisbon, Portugal

Tel: 351-1-60-9638

Types of Projects: FP & IEC

Programs/Projects in: Mozambique & Cape Verde.

Inter-African Committee

147 rue de Lausanne CH-1202 Geneva Switzerland

Tel: 41-22-731-2420 Fax: 41-22-738-1823

Types of Projects: Maternal health, IEC, Prevention, Research, Youth.

International Children's Center

Chateau de Longchamp Bois de Boulogne 75016 Paris, France

Types of Projects: HIV/families, Research, & STDs.

Programs/Projects in: Burundi, Central African Republic, Cote d'Ivoire, Kenya, Senegal, & Togo.

International Family Health

1st Floor Margaret Pyke Centre 15 Bateman's Bldgs. Soho Square London W1V 6ST UK
Tel: 44-71-287-5602 Fax: 44-71-287-5578

Types of projects: Maternal health, Fistula surgery, IEC, Prevention, Training, Women's health services, & Youth.

International Federation for Family Life Promotion

2009 North 14th Street, Suite 512 Arlington, VA 22201
Tel: 703-516-0388 Fax: 703-516-0390

Types of Projects: Maternal health, IEC, Prevention, Training, Women's health services, and Youth.

International Planned Parenthood Federation Regent's College Inner Circle Regent's Park
London NW1 4NS United Kingdom

Tel: 44-71-486-0741 Fax: 44-71-487-7950

International Women's Development Agency (IWDA)

P.O Box 372, Abbotsford Vic 3067, Australia
Tel: 61-3-419-3004

International Women's Health Coalition 24 East 21st Street New York, NY 10010 USA

Tel: 212-979-8500 Fax: 212-979-9009

Types of Projects: Reproductive rights and RH services, including abortion and RTIs.

Japan Shipbuilding Industry Foundation, 1-15-16 Toranomom, Minato-ku, Tokyo 105, Japan
Tel: 81-3-502-2371

Types of Projects: Public welfare, Health, Education, Population, & Emergency relief programs.

Japanese Organization for International Cooperation in Family Planning

Hoken Kaikan Bekkan, 1-1 Ichigaya, Sadohara-cho, Shinjuku-ku Tokyo 162, Japan

Types of Projects: FP, Health education, & Parasite control.

Programs/Projects in: Ethiopia, Gambia, Tanzania, & Zambia.

John D. and Catherine T. MacArthur Foundation

140 S. Dearborn Street Suite 1100 Chicago, IL 60603 USA
Tel: 312-726-8000 Fax: 312-917-0334

Types of Projects: Women's reproductive health, IEC, Adolescents, and Leadership.

John Merck Fund

Mr. Francis Hatch, Chairman, 11 Beacon Street, Suite 1230, Boston, MA 02108 USA

Levi Strauss Foundation

Judy Belk, Vice President of Contributions, 1155 Battery Street, 7th Floor, San Francisco, CA 94111 USA

Programs/Projects in: Lilly Endowment gives only in Mexico; Robert Woods Johnson Foundation gives only in the US

Lutheran World Relief

P.O Box 14205 Nairobi, Kenya

Tel: 254-2-447611 or 254-2-441643 Fax: 254-2-742352

Maria Stopes International

153-157 Cleveland Street London, W1P 5PG UK

Types of Projects: FP services, Health education, & STIs.

Programs/Projects in: Ethiopia, Kenya, Madagascar, Malawi, Sierra Leone, Uganda, Tanzania, & Zimbabwe.

Medicus Mundi Espana

Sanchez Barcaiztegui 38 1-Ptall 2807 Madrid Spain

Tel: 34-1-55-25-438

Types of Projects: Maternal health, Facilities, Equipment/supplies, IEC, Prevention, & Training.

Programs/Projects in: Angola, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Rwanda, Zaire, & Zimbabwe.

Memisa Medicus Mundi

P.O. Box 61 3000 AB Rotterdam, The Netherlands

Tel: 31-10-4144888 Fax: 31-10-4047319

Types of Projects: Maternal health, Facilities, Equipment/supplies, IEC, Prevention, & Training.

Mother and Child

16 Chemin de la Grande Gorge 1255 Vayrier Switzerland

Tel: 41-22-784-0658

Types of Projects: Maternal health, Facilities, Equipment/supplies, IEC, Prevention, Women's health Services, & Training.

Programs/Projects in: Ghana, Nigeria, Sierra Leone.

Oxfam UK

374 Banbury Road Oxford OX2 7DZ UK

Tel: 44-865-312310 Fax: 44-865-312600

Types of Projects: Maternal health, IEC, Prevention, Training, & Women's health services.

Pathfinder International

9 Galen Street, Suite 217, Watertown, MA 02172 USA

Tel: 617-924-7200 Fax: 617-924-3833

Types of Projects: Comprehensive family planning service delivery, HIV-AIDS integration, Training, Adolescent programs, & Institutional development.

Program/Projects: Kenya, Ethiopia, Tanzania, Uganda, Senegal, South Africa, Mozambique, Nigeria, and parts of Latin America and Asia/Near East.

Pew Charitable Trusts

One Commerce Square, 2005 Market Street, Suite 1700, Philadelphia, PA 19103-7017 USA

Tel: 215-575-4857 Fax: 215-474-4030

Population Action International

1120 19th Street NW, Suite 550 Washington, DC USA

Tel: 202-659-1833 Fax: 202-293-1795

Types of Projects: FP, Abortion, FGM, & Maternal health.

Programs/Projects: Ethiopia, Kenya, Nigeria, Sudan, Tanzania, and Zaire.

Population Action International, the Special Projects Fund

1120 19th Street, NW, Suite 550 Washington, DC 20036 USA

Tel: 202-659-1833 Fax: 202-293-1795

Types of Projects: TA & financial assistance to local organizations working in RH and FP. Women's RH care, Abortion services and training, Eradication of harmful traditional practices, Adolescent fertility, and Credit programs designed to generate demand for FP.

Population Concern

231 Tottenham Court Road London W1P 9AE UK

Tel: 44-71-631-1546 Fax: 44-71-436-2146

Types of Projects: FP service delivery, integrated programs, IEC, and community development for youth.

The Population Council

One Dag Hammarskjold Plaza New York, NY 10017 USA

Tel: 212-339-0500 Fax: 212-755-6052

Types of Projects: TA, Operations research in FP, Training, Health workers, MCH, Postpartum, and Youth.

Presbyterian World Service and Development

50 Wynfrod Drive Don Mills, Ontario M3C 1J7

Tel: 416-441-1111 Fax: 416-441-2825

Types of Projects: Maternal care, IEC, Prevention, and Women's health services.

Programs/Projects: Kenya, Lesotho, Malawi, South Africa, and Zimbabwe.

Public Welfare Foundation

2600 Virginia Avenue, NW Suite 505 Washington, DC 20037-1977 USA

Tel: 202-965-1800 Fax: 202-625-1348

Types of Projects: FP/RH education and services, RH, HIV-AIDS, Adolescents, Status-of-women, and Social marketing.

Red Barnet

Brogaardsvaenget 4 2820 Gentofte Denmark

Tel: 45-31680888 Fax: 45-31680510

Types of programs: Funder directly involved in program supervision. Women's health services, Education, and Youth.

Programs/Projects in: Burkina Faso, Ethiopia, Kenya, Lesotho, Uganda, and Zambia.

Rockefeller Foundation

1133 Avenue of the Americas New York, NY 10036

Tel: 212-869-8500 Fax: 212-764-3468

Regional Office: Rockefeller Foundation, P.O. Box 47543 Nairobi, Kenya

Tel: 254-2-228061 Fax: 254-2-721318

Types of Projects: RH, Research, and Training.

Scottish Catholic International Aid Fund

5 Oswald Street Glasgow G1 4QR UK

Tel: 44-41-221-4447 Fax: 44-41-221-2373

Types of Projects: Maternal health, IEC, Prevention, Training, Women's health services.

Programs/Projects in: Ethiopia, Kenya, Namibia, South Africa, Tanzania, and Uganda.

Stichting Wilde Ganzen (Wild Geese Foundation)

Heuvellaan 36 1217 JN Hilversum The Netherlands

Tel: 31-35-246622 Fax: 31-35-246677

Types of Projects: Facilities and Equipment/supplies.

Suomen Pakolaisapu

Finnish Refugee Council, Torkkelinkatu 19 A 2, P.O Box 311, 00101 Helsinki, Finland

Tel: 358-0-735-511

Types of Projects: FP training.

Programs/Projects in: Cote d'Ivoire, Somalia, Swaziland, Sudan, Ethiopia.

Swedish International Development Agency

Sveavagen 20 10525 Stockholm, Sweden

Tel: 46-8-698500 Fax: 46-8-208864

Regional Office: P.O Box 30600 Nairobi, Kenya

Tel: 254-2-229042 Fax: 254-2-723547

Technoserve, Inc

P.O Box 14821 Nairobi, Kenya

Tel: 254-2-743628 or 254-2-743629 Fax: 254-2-80484

Thrasher Research Fund

30 East North Temple Street, 7th Floor Salt Lake City, Utah 84150 USA

Tel: 801-240-3386 Fax: 801-240-1417

Types of Projects: Maternal health research.

Vaestoliitto

Finnish Population and Family Welfare Federation, Kalevankatu 16, 00100 Helsinki, Finland,

Tel: 358 0 640 235

Types of Projects: FP research.

Programs/Projects in: in Zambia and Kenya.

William and Flora Hewlett Foundation

525 Middlefield Road Suite 200 Menlo Park, CA 94025 USA

Tel: 415-329-1070 Fax: 415-329-9342

Types of Projects: U.S. based organizations which fund or operate programs in developing countries. Population research and FP.

W.K. Kellogg Foundation

1 Michigan Hill East Battle Creek, Michigan 49016 USA

Tel: 616-968-1611

Types of Projects: Maternal care, Health education, Prevention, Training, Women's health services, and Youth.

Programs/Projects in: Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.

Womankind

122 Whitechapel High Street London, E1 7PT UK

Tel: 44-71-247-6931 or 44-71-247-9431 Fax: 44-71-247-3436

Types of projects: Health, Education, Income generation, Empowerment of women/girls.

Programs/Projects in: Ghana, Uganda, Zimbabwe.

World Assembly of Youth

Ved Bellahoj 4 2700 Bronshoj Denmark

Tel: 45-31-60-77-70 Fax: 45-31-60-57-97

Types of projects: National youth organizations. Youth empowerment, HIV-AIDS prevention education, Adolescent fertility, RH, Young women's literacy, Population and Environment.

World Vision of Australia

GPO Box 1937 Canberra, ACT 2601 Australia

Tel: 61-06-257-2342 Fax: 61-06-257-2341

Types of projects: Partnership with World Vision HQ, local World Vision office and local NGO required. Maternal care, IEC, Prevention, and Training.

Programs/Projects in: Malawi, Mozambique, Tanzania, and Zimbabwe.

Worldview International Foundation

Malmgardsvagen 57 B 116 38 Stockholm, Sweden

Types of Projects: Rural development, RH, and IEC.

Programs/Projects in: Gambia.

Pathfinder International
P.O. Box 48147
Nairobi, Kenya



information@pathfind.org

Pathfinder International
9 Galen Street
Watertown, MA 02172, USA