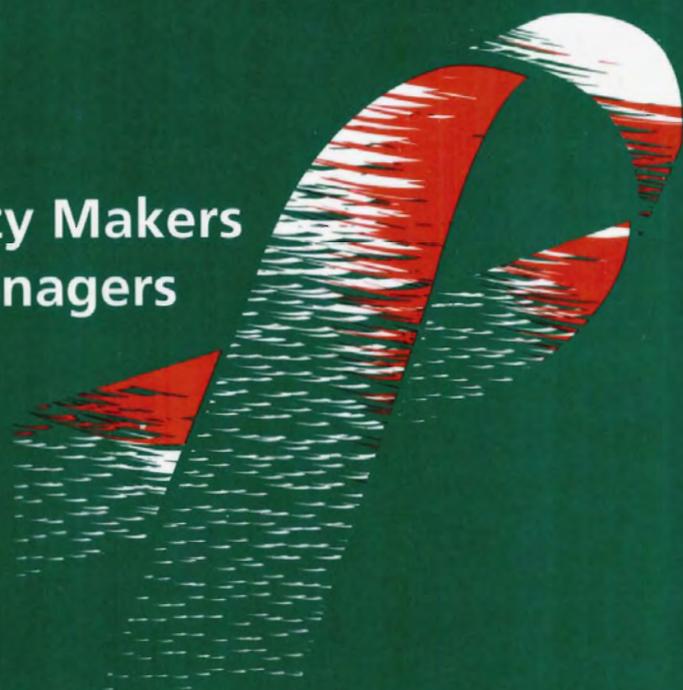


Integrating
STD/HIV/AIDS
services with
MCH/FP
programs

A Guide for Policy Makers
and Program Managers



AIDS is no longer a time bomb waiting to go off. AIDS is here...AIDS is real. AIDS is devastating sub-Saharan Africa -

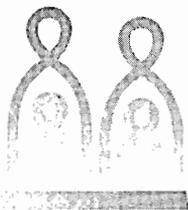
- ♣ 23.3 million adults and children living with HIV/AIDS are in sub-Saharan Africa—almost 70% of the global total of 33.6 million.
- ♣ In 1999, 68% of the 5.6 million new infections were in sub-Saharan Africa.
- ♣ In 1999, 2.2 million of the 2.6 million AIDS deaths were in sub-Saharan Africa.
- ♣ Among children under 15, sub-Saharan Africa's share of new infections is 9 out of 10.
- ♣ Since the epidemic began, 37.8 million of the global total of 52.9 million infections have occurred in sub-Saharan Africa.
- ♣ Since the epidemic began, 13.7 million of the global total of 16.3 million deaths have occurred in sub-Saharan Africa.

Health care providers in the region can't cope with this onslaught. This booklet is intended to help health policy makers and program managers make the most of the resources they have available – by providing guidelines for integrating STD/HIV/AIDS prevention and care services into other reproductive health programs to help stem the tide of the AIDS pandemic.

Integrating
STD/HIV/AIDS
services with
MCH/FP
programs

**A Guide for Policy Makers
and Program Managers**

Wilson Kisubi • Elizabeth Lule • Charles Omondi • Pamela Onduso
Paul S. S. Shumba • Francesta Farmer • Margaret Crouch



Pathfinder
INTERNATIONAL

Africa Regional Office

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Since the HIV/AIDS epidemic, we simply can't cope... What we need, you know, is information we can use to decide how to proceed...



Abbreviations and definitions

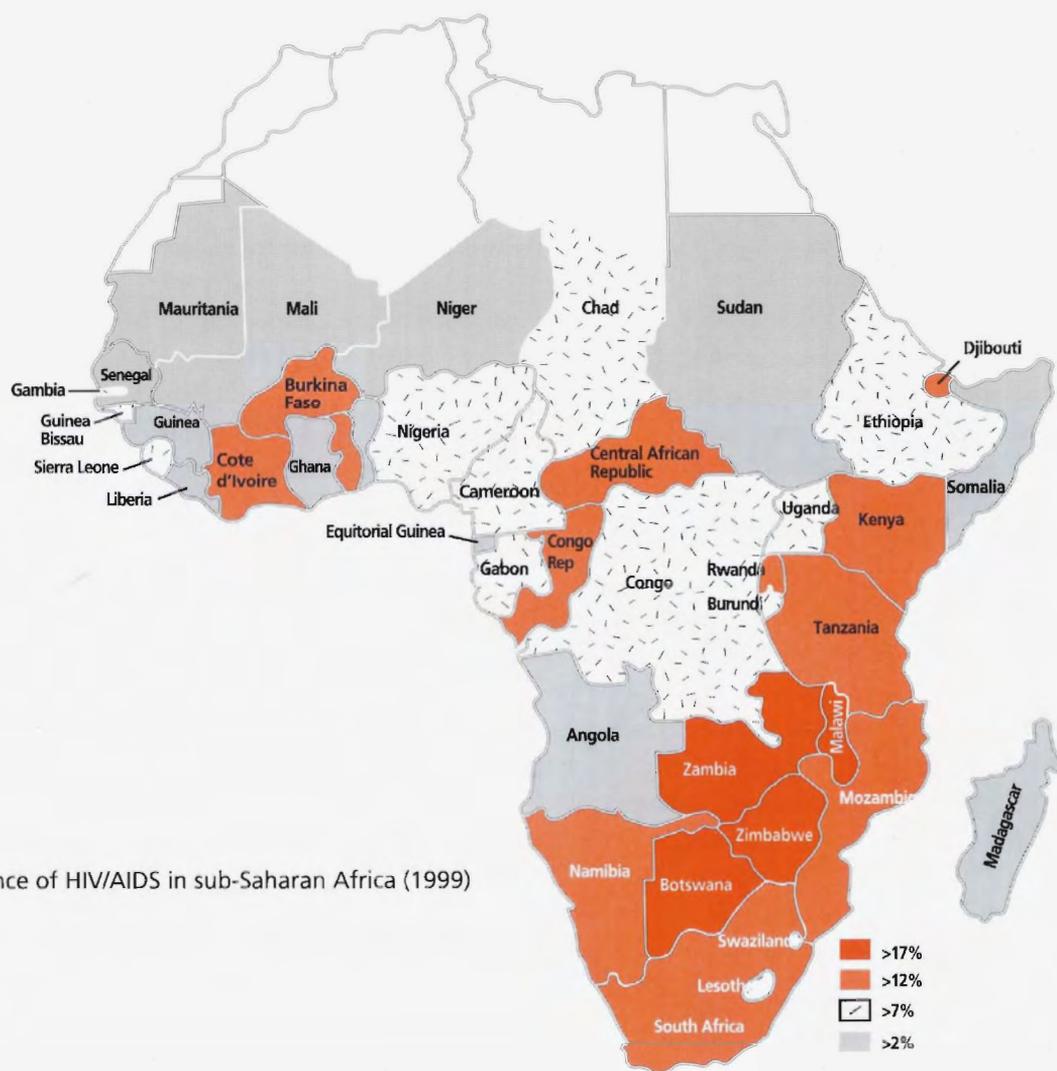
AIC	Aids Information and Counseling Centre
AIDS	Acquired immune deficiency syndrome
CBD	Community-based distribution
CPR	Contraceptive prevalence rate
CYP	Couple years of protection
FLEP	Family Life Education Program
FP	Family planning
FWE	Family welfare educator
HIV	Human immune deficiency virus
IEC	Information, education, and communication
IP	Infection prevention
IUD	Intrauterine device
KAP	Knowledge, attitudes, and practices
MCS	Mkomani Clinic Society
MIS	Management information system
MOH	Ministry of Health
MSRDP	Multisectoral Rural Development Program
NGO(s)	Non-government organization(s)
NMC	Nakuru Municipal Council
ORT	Oral rehydration therapy
REDSO	Regional Economic Development Services Office for Eastern and Southern Africa
RTI	Reproductive tract infection
SDP	Service delivery point
STD(s)	Sexually transmitted disease(s)
STI	Sexually transmitted infection
TASO	The AIDS Support Organization
USAID	U. S. Agency for International Development
VCT	Voluntary counseling and testing
VHW	Village health worker
VSC	Voluntary surgical contraception
WHO	World Health Organization

Diagnostic algorithm: Simple decision flow chart used in syndromic analysis of STDs.

Risk assessment: Set of specific questions used to gain information to help determine whether a particular client is at risk for STD/HIV infection.

Syndromic management: Means of identifying possible STD presence on the basis of broad syndromes of infection in women (and one in men): urethritis, lower abdominal pain, genital ulcers, and other conditions. The patient is treated on the basis of the syndrome rather than more expensive laboratory tests.





Incidence of HIV/AIDS in sub-Saharan Africa (1999)

The magnitude of sub-Saharan Africa's HIV/AIDS burden

The worldwide AIDS pandemic has hit Africa hard. Today almost 70% of persons with AIDS are in sub-Saharan Africa—23.3 million of the 33.6 million infected people around the world (UNAIDS, 1999). More than 80% of the women worldwide and 87% of the children infected with HIV/AIDS are in sub-Saharan Africa, as are 95% of the world's AIDS orphans. SSA has 21 of the highest national HIV prevalence rates in the world, and five of the world's most severe HIV epidemics (Botswana, Malawi, South Africa, Zambia, and Zimbabwe). The added demands for STD/HIV/AIDS information and services are swamping existing MCH/FP health care systems. As many as a third of women seeking MCH/FP services suffer from STDs, and studies indicate that controlling STDs is one way to slow the spread of HIV transmission.

Regionally, reproductive health care needs are increasing, while resources to supply services are declining. Thus ministries of health, donors, and local health service agencies are urgently seeking ways to extend their services so as to fight the spread of AIDS without compromising MCH/FP services. One way of doing this is to integrate services to detect and treat STD/HIV/AIDS into existing MCH/FP service programs. The idea is that since the basic infrastructure for delivering reproductive health services already exists, the addition of STD/HIV/AIDS services will not require extensive additional resources. Integration thus seems to be a cost-effective way of expanding health services.

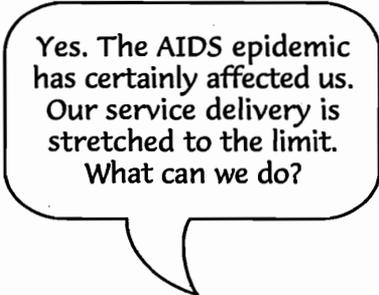
In December 1998, almost 200 people from across the continent and beyond gathered in Nairobi to outline an agenda for strengthening integrated reproductive health services in Africa and making them more accessible. Supported by USAID/REDSO/ESA and facilitated by Pathfinder International, The Population Council, Family Health International, and BASICS, this conference—*Setting the Africa Agenda II*—was a follow-up to a groundbreaking integration workshop held in May 1995 (called *Setting the Africa Agenda I*).

Agenda I focused on practical, technical, and programmatic aspects of initiating the integration of STD/HIV/AIDS and MCH/FP services in the sub-Saharan Africa region. Agenda II, like its predecessor, was a time of networking, assessing experiences, and mapping out new approaches.

In the interval between the two conferences The Population Council conducted assessments of four programs in the region that have integrated their services. The results of these efforts, and the experiences shared at Agenda II, are mixed because the programs are inconsistent in design, expectations, and performance—not least because there is not yet a clear definition or model for integration. Even now, policy makers and program managers have little to guide them beyond the belief that integration can work, is acceptable to clients, and will be cost-effective.

The purpose of this booklet is to help bridge that information gap. The booklet is intended to provide useful and usable information about the integration of the two types of health services. It includes both theoretical background and practical guidelines. The booklet first summarizes the approach to integration identified by the *Agenda* workshops in order to give an overview of the issues at hand. Then it addresses the concerns that may arise when considering the whys and hows of integration, beginning with a very basic definition of and rationale for integration and a review of the integration experiences of five very different health care programs. Next come pros and cons of integrating services. The booklet then explains how different types of MCH/FP programs can expand to include STD/HIV/AIDS services, and focuses on the special requirements of service delivery for men and young people. Finally, there are guidelines for gathering the necessary data for planning and monitoring the integration process and evaluating the effectiveness of integrated services. A series of annexes presents samples of training slides, diagnostic algorithms, a risk assessment guide, and supervisory checklists.

The booklet is intended for use by health policy makers and program managers who are considering whether to integrate their services. A complementary booklet contains copies of presentation slides for use in training. (Sample slides may be found in Annex A.)



Yes. The AIDS epidemic has certainly affected us. Our service delivery is stretched to the limit. What can we do?



The African integration agenda

The 1995 and 1998 *Setting the Africa Agenda* workshops attracted health care professionals and representatives from USAID, ministries of health, and local and international NGOs providing health services in Africa. Both occasions were thoughtful, focused, and highly participatory. All concerned recognized the need for immediate, wide-ranging action by players at all levels.

Agenda I

The first African integration workshop—Agenda I—identified the five most immediate challenges to improving reproductive health services and reducing the spread of HIV as:

- ❑ Finding more persuasive ways to convince clients, especially men, to modify unsafe sexual practices, discuss sexual and reproductive health matters more easily with partners and health service providers, and use condoms regularly without resistance.
- ❑ Documenting what works and sharing it broadly with all public health institutions, NGOs, donors, and policy makers.
- ❑ Focusing on high impact, cost-effective activities that can ensure access and availability of quality reproductive health services throughout the region.
- ❑ 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.
- ❑ 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.

Above all, Agenda I said, the effort to contain the AIDS epidemic in Africa should be Africa-led, with strong partnership 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 result in better, more lasting strategies, programs, and performance. Donors in particular can be better informed by regular exposure to the on-the-ground challenges and choices faced by local agencies to ensure that financial and technical support is targeted most effectively.

Agenda II

The prevailing mood of Agenda II participants, conscious of the growing impact of the AIDS pandemic—which is escalating beyond anyone’s predictions—was “scale up and hurry up.” The issues cited and recommendations made in five programmatic areas reflect this sense of urgency and the desire for immediate, effective action. The five areas are primary prevention and reaching special groups; clinic-based approaches; community-based services; policy and networking; and research, monitoring, and evaluation. They can be summarized briefly as:



- ❑ **Primary prevention and reaching special groups:** Special groups are defined as those who are high risk, under-served, and difficult to reach. In particular, high transmitters (including sex workers and their clients), men in the general population, adolescents, and orphans require targeted programs (e.g., condom promotion) if their needs are to be met.
- ❑ **Clinic-based approaches:** Some of the issues here are the workload implied by integration, provider biases in service delivery, client follow-up and partner notification, improving facilities, and securing consistent supplies of commodities.
- ❑ **Community-based services:** Weak links between community-based services and clinical facilities, the continuing gap between the strategies and the implementation of community mobilization efforts, and failure to adapt approaches to higher quality community-based services are some of the problem areas that must be addressed.
- ❑ **Policy, networking, and funding:** Policy formulation, policy implementation, and advocacy face attitude and resource constraints that limit the effectiveness of integrated services, for example leaving men and young people outside the reach of many program efforts.
- ❑ **Research, monitoring, and evaluation:** Research is urgently needed to determine the impact of integrated services and effects of policy barriers and to identify best practices that can be easily replicated.

In all cases, Agenda II demanded more focused attention from policy makers and donor partners, and called for increased resources to meet the growing demands, enhance regional partnerships, improve service provider training, and allow greater sharing of information and experiences. Among the training needs identified were development of service protocols and curricula, counseling skills, and management and assessment capacity. To ensure the relevance of research on integration, Agenda II also recommended increased emphasis on the review, updating, and wide dissemination of information flowing from studies on the most effective and cost-effective models for providing integrated services.

Time is running out!
It is imperative that
we scale up and hurry
up now to address the
AIDS pandemic!!



Why integration?

Against the background of the pressing needs in reproductive health services, integration may be defined as:

“Combining services to prevent or manage sexually transmitted infections (including HIV) with services for family planning and maternal/child health care into a single, coordinated, synergized program.”

There are a number of important reasons for integrating these two types of reproductive health services:

- They both serve the same target population—the sexually active.
- They both promote safe and responsible sexual behavior through information, education, and communication activities.
- They both promote and distribute condoms, which can reduce STD/HIV transmission and provide protection against unwanted pregnancy.
- They both support effective prevention, diagnosis, and treatment of sexually transmitted diseases.
- They require similar medical/health skills and staff.
- Integrated programs are more convenient for clients.
- Integrated programs minimize missed opportunities for screening/treating STDs.
- Integrated programs may be more cost-effective than parallel or vertical programs.
- Integrated programs can reach a very large population because most African women attend MCH/FP clinics regularly.

Just exactly what is this integration idea, anyway?

☞ *Integration may take place in any or all of three ways:*

- *By individual health care workers*
- *At management level of health programs*
- *Through shared support systems (training, logistics)*
- *By introducing new target groups, such as youth and men*

☞ *At the program level, integration requires:*

- *Substantial organizational planning*
- *Resource allocation*
- *Training for service providers*
- *Review of client/community needs*

Regional experiences with integration

Because the idea of integrated MCH/FP–STD/HIV/AIDS services is fairly new, it may be useful to look at the experiences of health care programs that have already begun to integrate their services. This section briefly reviews case studies of five very different MCH/FP programs that offer STD/HIV/AIDS services.

Family Life Education Program, Busoga, Uganda

FLEP, which started in 1986, is part of the Anglican Church of Uganda's Multisectoral Rural Development Program (MSRDP). The goal of this rural-based, community-supported program is to increase awareness of and access to family planning and STD/HIV/AIDS information. FLEP operates through community-based distributors and clinics offering varying levels of services. It serves a total population of nearly 2 million people scattered over three largely rural districts in southern Uganda. FLEP is Uganda's leading family planning CBS program and is a model for others. Contraceptive prevalence in FLEP areas is 19%, compared with the national average of 7.8% (DHS 1995).

FLEP's experience to date indicates more effective service delivery and better response to client needs. Community health workers say that they are more respected and more likely to be listened to, since their message is no longer restricted to reducing family size. FLEP knows it must expand its resource base through better staff training, appropriate IEC materials and activities, better risk assessment and testing mechanisms, and improved clinic facilities. FLEP's experience also highlights the need to reach beyond traditional clients to other members of the community, especially men and adolescents.

BUSOGA FLEP INTEGRATION MODEL

- Carry out STD/HIV risk assessment for all MCH/FP clients at FLEP clinics
- Screen high-risk MCH/FP clients for STD/AIDS using diagnostic checklist
- Manage clients with STDs using the syndromic approach
- Inform/educate all clients receiving FP/other services from MSRDP clinics and village health workers about STD/HIV/AIDS
- Inform/educate persons in Busoga diocese about STD/HIV/AIDS through public meetings, seminars, drama, song
- Inform/educate in-school youth about STD/HIV/AIDS using trained community resource persons (e.g., schoolteachers)
- Mobilize communities for STD/HIV/AIDS prevention
- Offer voluntary counseling and testing (in collaboration with AIDS Information Center)

National MCH/FP Program of Botswana

The Government of Botswana operates an extensive system of health care facilities and provides family planning services to 94% of contraceptive users in the country. The system has three levels—health posts, clinics, and hospitals. FP services are available at all facilities, though some methods are offered only at clinics and hospitals. The sup-

ply of FP commodities and drugs to treat STDs is not generally a problem in Botswana, but the logistics of specimen testing may add extra time and trips to the service centers, which discourages clients. High rates of HIV infection (about one in seven of the sexually active population) prompted the MOH to take steps to integrate control of STD/HIV with basic MCH/FP care. In 1992, syndromic management of STDs was introduced. In 1994, a number of other measures were

taken to strengthen the overall health care system. The three that apply to FP/STD/HIV are in-service training for service personnel that focuses on clinical skills, counseling, and reporting and use of data; strengthening of management information systems; and production and distribution of IEC materials for FP and prevention of STDs.

BOTSWANA NATIONAL MCH/FP PROGRAM MODEL

- Carry out a risk assessment for STD/HIV/AIDS for all MCH/FP clients
- Provide information and education on STDs, family planning, and relationships between the two to all clients, including promotion of dual protection/dual method
- Provide individual counseling for all MCH/FP clients identified to be at risk
- Use the syndromic approach to manage STDs
- Carry out community IEC activities through trained family welfare educators to raise awareness about STDs and HIV/AIDS
- Establish STD/HIV/AIDS management teams at “centers of competence” to manage referrals from lower health facilities
- Practice infection prevention procedures when managing clients
- Carry out contact tracing using self-referral cards issued to the index client
- Identify and refer clients for HIV testing
- Test or refer all antenatal clients for syphilis
- Collect, analyze, and use data on services at the clinic level

Mkomani Clinic Society, Mombasa, Kenya

The Mkomani Clinic Society is a private charitable organization founded in 1980. It provides basic medical services for poor residents of Mombasa, Kenya’s second largest city. The Society operates two full-service clinics with laboratories and resident doctors and has a community outreach service. The clinics served 23,000 clients in 1994, almost half of whom were interested in family planning. STD/

MKOMANI CLINIC SOCIETY INTEGRATION MODEL

- Carry out risk assessment for STD/HIV/AIDS among all clients visiting the clinics for antenatal care, child welfare, 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 STD/HIV/AIDS and the availability of services at the MCS clinics through public meetings and seminars
- Protect staff and 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/refer all clients with symptoms/signs of HIV infection, or those requesting HIV testing, to institutions with HIV counseling/testing facilities
- Notify partners, assess partner risk, screen, diagnose, treat identified contacts

HIV/AIDS services were integrated into the clinics’ services in 1992. The Society has found that it is cheaper to provide integrated services than it is to provide the same services separately. Mkomani recognizes the importance of community participation and mobilization. Staff are streamlining and standardizing information, management, and counseling procedures for STD/HIV/AIDS clients. More attention is also being given to the quality of the overall integrated services from the perspective of the clients.



Nakuru Municipal Council, Kenya

Nakuru, Kenya, is a major commercial center and transfer point on the railway and highway from the coast to points in other countries in eastern and central Africa. It has a population of about a quarter million people, and in 1995 an estimated 27% of antenatal care clients were HIV-positive (up from 23% in 1993). The Nakuru Municipal Council operates five health centers. All five give

NAKURU MUNICIPAL COUNCIL INTEGRATION MODEL

- Carry out STD and HIV/AIDS risk assessment and screening for all clients receiving MCH/FP and other services at the facilities
- Provide IEC to all clients about STD/HIV/AIDS
- Provide IEC to hard-to-reach groups like commercial sex workers, men at the workplace, migrant workers, and youth out of school using clinic staff and trained peer educators
- Diagnose and treat STDs using syndromic approach and available algorithms
- Refer clients requiring HIV and specialized STD testing to the STD clinic
- Protect staff and clients from infection during treatment procedures
- Carry out contact tracing and treatment for partners of STD clients
- Screen and treat all antenatal clients for syphilis

basic antenatal, child welfare, and STD and other curative services. Four also offer FP services. The five clinics have a very heavy workload—an average of 17,300 MCH clients per clinic in the 12 months prior to the study. There is also an STD clinic in Nakuru, as well as an MOH provincial referral hospital with a laboratory. Since 1989 the seven facilities have been cooperating in a program to integrate MCH/FP and STD/HIV services. In operation, the integrated effort is often hampered by lack of basic equipment and

supplies, as well as IEC materials for STD/HIV/AIDS. Clinic staff have been trained in diagnosis, treatment, and counseling, but lack formal checklists to assure that all steps are followed.

Delivery of Improved Services for Health, Uganda

DISH started in 1994 as the first large-scale project in the region to focus on implementing integration. It was implemented by Pathfinder, Johns Hopkins University, and INTRAH from start-up until 1999. Operating in 10 of Uganda's 33 districts, DISH works at the national level with MCH, AIDS/STD Control, and other MOH departments and at district level with members of the district health teams. It also works with The AIDS Support Organization (TASO), the AIDS Information and Counseling Centres (AIC), and the SOMARC Social Marketing Project. Six major activities are carried out under the project: in-service training, IEC, management information and logistics systems, health care financing, CBS, and social marketing. The IEC component relies heavily on radio to reach its largely low-literate clientele.

According to DISH, **integration means providing clients with a variety of health services during one visit, often from the same health provider.** The purposes of the project are to increase the availability and improve the quality of services, increase the use of services, and better inform clients about their health needs and problems. Under DISH the health services that are integrated include family planning, STD diagnosis and treatment, HIV testing and counseling, antenatal and postnatal care, delivery assistance, and breastfeeding and maternal and infant nutrition counseling.



DISH INTEGRATION MODEL

- Carry out STD/HIV risk assessment for all MCH/FP clients; counsel and refer where necessary
- Provide emergency contraception, safe motherhood, and post-abortion care
- Carry out contact tracing and treatment for partners of STD clients
- Provide information on STD/HIV/AIDS to all clients
- Inform the public about STD/HIV/AIDS primarily through radio broadcasts
- Use the syndromic approach to the management of STDs
- Practice infection prevention procedures when managing clients
- Provide IEC to vulnerable groups, especially youth, for behavior change
- Mobilize communities for STD/HIV/AIDS prevention and behavior change
- Refer for VCT and STD management and treatment of opportunistic infections
- Promote condom use through social marketing
- Establish and use strong management information and logistics systems
- Introduce health financing and cost recovery

DISH faced a number of implementation challenges: ensuring that there was capacity at all levels to manage integration; recognizing that the change to integration is a significant shift with management implications and not just an expansion of activities; and addressing the notion that integration is “doing more for less” without adequate provision for the resources that are needed to effect the change. In practice, the project found that training increased provider competence and sensitivity to privacy and informed consent. It also found that erratic supply of commodities, inadequate supervision, and negative provider attitudes affect the pace and achievement of integration.

According to the last project assessment (1997), the use of modern contraception by married women rose from 13.3% in 1995 to 19.7% in 1997 and among married men from 14.5% to 26.2%. UNAIDS found that between 1990 and 1996 the incidence of HIV infection in selected districts of Uganda—many of them DISH project areas—declined by over half among 15– to 24-year-olds, the first such change on the continent.

SOME THOUGHTS ON VOLUNTARY COUNSELING AND TESTING

- Demand for VCT is high when there is good community information and education.
- Training of existing health personnel will give better prospects for the sustainability of services.
- Commitment to quality of service is essential.
- AIDS counselors can serve more clients through community-based outreach services than at static health clinics.
- Training the counselors as trainers to train local community workers pays dividends in increased coverage and services.

*AIDS Information and Counseling Centers
The AIDS Support Organization*



Summary of Integration Models

Program activity	FLEP	Nakuru	Mkomani	Botswana	DISH
Risk assessment, counseling and referral	**	**	**	**	**
IEC for behavior change for all clients	**	**	**	**	**
Targeted IEC for high STI/HIV transmitters	*	**	**		
IEC targeting vulnerable groups, especially youth	**	**		**	*
Syndromic management of STDs and referral	*	**	**	**	**
Referral for VCT and STD management	**	**	*	**	**
Infection prevention	**		*	*	*
Contact tracing and treatment of partners	*	**	*	*	*
ANC screening for syphilis and treatment		*	*		
Promotion of dual method or dual purpose use			*		
Community mobilization and locally appropriate IEC	**		**	**	*
Strong MIS and logistic systems	**		*		**
Social marketing	*				**
Other RH services: EC, Safe motherhood, PAC, Home-based care	— — *				* ** —
Cost recovery	**	*	*	*	**

Note: * program component
** major program focus

Maybe it worked for them but we really have too much to do already...

Some lessons from the case studies

The experiences of these five programs offer some pointers to designers of integrated programs. A few of the main lessons of the programs are:

- ❑ Client records were generally not complete, because family planning **record forms** had not been revised to include risk assessment and history related to STD/HIV.
- ❑ Facilities often lacked sufficient **privacy** (both visual and auditory) for the comfortable discussion of sensitive matters like sexual behavior and STDs.
- ❑ Clinic **staff attitudes** often prevented proper screening. Staff felt that their clients were not at risk of STDs and that they would be offended by questions related to sexual behavior. In interviews, however, clients indicated they themselves often felt they were at risk (mostly because of their partner's behavior) and they didn't mind being asked such questions.
- ❑ Clinic staff often don't follow **laid down procedures** for examining or screening either FP or STD clients, thus missing many opportunities to detect infection. Sometimes staff lacked **guidelines or checklists** for assessment, but it was not always clear why procedures were not followed. If full FP procedures were always followed, the additional STD/HIV procedures would not add significantly to consultation time.
- ❑ Some **policy issues** impeded program effectiveness. Kenyan law prevents nurses from prescribing certain drugs, including those for STDs. Clients must first see the nurse for diagnosis and then the doctor for prescription, which increases client waiting time, impinges on privacy, and undermines the credibility of the nurses. In some cases national policy mandates that available drugs can be used only for STDs, even when other conditions are more serious; this undermines the principles of integration.
- ❑ In nearly all cases effective **information, education, and communication materials** were lacking. Clients said that they had never been given any kind of brochure or flyer to take home. Most service centers lacked all but the most basic wall charts or posters.
- ❑ The **syndromic approach** to the management of STDs included syndromic management of vaginal discharge, which is now recognized as ineffective for cervicitis although it may work reasonably well for vaginitis using simplified treatments. The syndromic approach now focuses on urethritis, genital ulcer disease, and lower abdominal pain (pelvic infection), as well as other conditions.
- ❑ **Contact tracing** is a problem in all cases, not the least because staff do not routinely inform clients of the importance of telling their partners about an STD infection.

But how CAN we keep proper service records?? There's not enough space on these forms!

Oh, no!! I could never talk to HIM about something like THAT !!!

- ❑ **Cultural perceptions** sometimes cause problems. Women may not be able to discuss sexual matters with their partners, or insist on using protection. Or staff may be related to clients, which inhibits their ability to discuss sensitive matters.

☞ *These and other shortcomings can be taken into account and addressed by designers of new integration programs.*

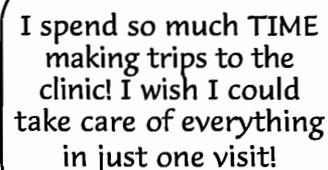
Integration pros and cons

There are many advantages to integrated services. There are also many disadvantages. It is important for program planners and managers to know both the strengths of and the challenges to integration so that they can plan and manage their programs effectively. It may be seen from the lists below that most of the challenges can be met by careful planning and cooperation between and among health services.

Strengths

On the one hand, integrated services:

- Are client centered and convenient, thus better addressing client needs for “one-stop shopping”
- Promote/enhance counseling, discussion, confidentiality, privacy
- Mean “no missed opportunity” for STD/HIV assessment, diagnosis, treatment
- Expand clientele for FP services by involving men/youth/community
- Reduce client drop-out rate through enhanced referral services and outreach
- Increase the range of barrier methods
- Increase promotion/use of condoms
- Facilitate screening for STDs and FP methods
- Can reduce the stigma of STDs/HIV
- Are cost and time effective
- Can build/expand existing skills and facilities
- Enhance/promote the use of all services equally
- Increase sustainability
- May attract additional funding
- Expand knowledge/skills of service providers
- Enhance service provider confidence and satisfaction
- Enhance teamwork/responsibility-sharing among service providers

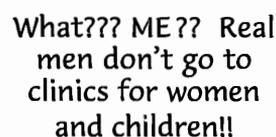


I spend so much TIME making trips to the clinic! I wish I could take care of everything in just one visit!

Challenges

On the other hand, integrated services:

- Require a needs assessment
- Can lead to message overload for clients
- If primarily clinic-based, may exclude men, youth
- May be resisted by service providers and clients
- May increase client waiting time during any one visit
- Create a time burden on service providers
- Increase workload without extra compensation for staff
- Can result in reduced quality and focus of services
- May be made ineffective by high referral drop-out rate
- May reduce resources available for MCH/FP services
- May demand that programs look for other funding sources
- Require additional training for staff without appropriate skills
- May not be viable in current facilities, which are inadequate for full service
- Require extra records, monitoring/evaluation data, indicators of objective quality standards



What??? ME?? Real men don't go to clinics for women and children!!

How to integrate services

Though integrated STD/HIV services are fairly recent, integration itself is not new to health programs. Family planning has long been integrated into mother–child health services—and for many of the same reasons people now propose for integrating STD/HIV/AIDS services. This section looks at the different types of services offered by MCH, FP, and STD/HIV/AIDS programs and how those services can be combined effectively. Program managers need to follow several steps in assessing the feasibility of integrating their programs:

1. Define the basic service
2. Determine integrated service needs
3. Identify the necessary tools
4. Review management and support systems
5. Factor in sustainability issues

Hmmm...How would we go about integrating the services in OUR program?

Basic reproductive health services

Reproductive health services traditionally fall into two major categories, mother–child health, and family planning. Since the advent of the AIDS epidemic, a third category has been added, STD/HIV/AIDS. Services in these three areas generally consist of the following:

➔ *MCH services*

- Antenatal care
- Referral of high-risk deliveries
- Postpartum care
- Breastfeeding
- Immunization
- Growth monitoring
- Oral rehydration therapy
- Infection prevention/quality of care

➔ *FP services*

- Counseling and IEC
- Provision of contraceptive methods
- Side-effects follow-up/management
- Emergency contraception
- Screening of RTIs for IUD/VSC clients
- Infection prevention/quality of care

➔ *STD/HIV/AIDS services*

- Behavior change communication
- Increased condom promotion/distribution
- STD diagnosis and treatment
- HIV pre/post test counseling and referral
- Infection prevention/quality of care

ANALYZING THE STRATEGIC ISSUES

A strategic analysis of the operational and management issues in integrating STD/HIV services into reproductive health programs begins with the answers to several questions:

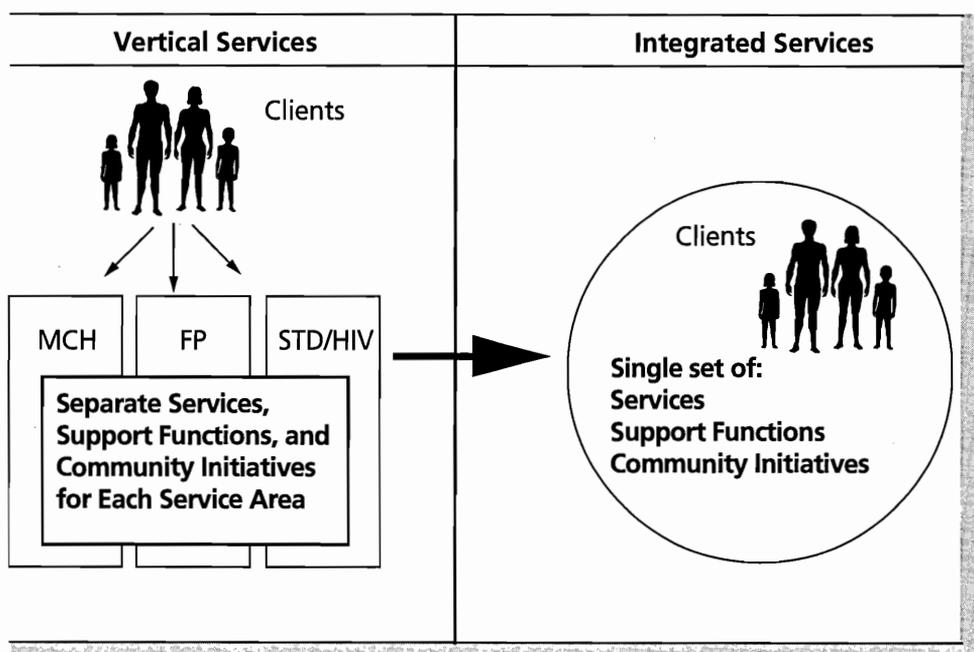
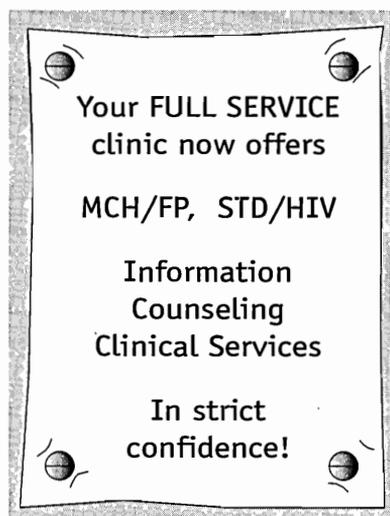
- What is the size of the problem in our client and catchment area population?
- To what extent are clients (or potential clients) at risk of acquiring and transmitting STIs?
- Are there other STD/HIV services available and accessible in the general area?
- What are the positive and negative consequences of integrating STD/HIV activities into reproductive health settings?

Adapted from *The Manager*, Fall 1998.

Integrated services

In an integrated program, the emphasis is on primary prevention of STD/HIV/AIDS, or preventing infection in uninfected people. Basic services are often combined into the following menu of services:

- Information and education at service delivery point
- Behavior change communication
- Counseling on
 - Family planning methods
 - Responsible parenthood
 - Condom use and negotiation skills development
 - Client/couple risk assessment
 - Behavior change
 - STD/HIV prevention, including safer sex practices
 - Pre and post HIV testing
 - Using condoms (including female condom) for dual protection against STD/HIV and pregnancy
 - Male and adolescent health needs
- Condom distribution for FP and STD/HIV prevention
- FP services, emergency contraception, post-abortion care
- Laboratory testing for STDs and HIV
- Syndromic STD diagnosis and treatment—but with limited use of syndromic management of vaginal discharge (See Annex B for sample diagnostic algorithms.)
- Referral
- Contact tracing
- Risk assessment
- Community outreach
- Home care and referral for persons living with HIV/AIDS
- Pre- and postnatal services and other MCH services
- Curative services



Four categories of mother/child health and family planning services

Within the broad range of MCH/FP services, four categories of delivery can be identified, ranging from CBS programs to full-service clinics. Services in each category include:

➤ **Community-based service program**

- Assessment of FP clients' needs
- IEC and counseling for informed choice
- FP services for non-clinical methods
- Follow-up of FP clients
- Referral of FP clients for clinical methods and complications
- Community participation and outreach

➤ **Clinic services or clinic linked CBS**

- Assessment of FP clients' needs
- IEC and counseling for informed choice
- FP services for clinical and non-clinical methods
- Follow-up of FP clients
- Infection prevention and quality of care
- Referral of clients for VSC and complications
- Community participation and outreach

➤ **Clinic with lab and VSC**

- Assessment of FP clients' needs
- IEC and counseling for informed choice
- FP services for all methods including VSC
- Follow-up of FP clients
- Infection prevention and quality of care
- Referral for complications
- Community participation and outreach

➤ **Full-service clinic**

- Assessment of FP clients' needs
- IEC and counseling for FP
- FP services for the full range of methods
- Follow-up of FP clients
- Infection prevention and quality of care
- Management of complications
- Community participation and outreach

☞ *Talk to your clients to find out what services they want—and how to provide those services most effectively and conveniently.*



So.... We have to figure out exactly what it is that we do now, and then decide what other services it makes sense for us to offer... Is that right?

HOW MUCH WILL IT COST?

Integrating RH service delivery will have some costs. For example, it will probably be necessary to produce new client record forms and prepare integrated IEC materials. Staff will have to be trained and equipment and supplies may have to be purchased.

On the other hand, initial investigations indicate that considerable savings may be realized from integration. A preliminary analysis of the Mkomani Clinic Society, which relies on nurses rather than doctors, showed that their cost of providing integrated STD/HIV and MCH/FP services to a new client using oral contraceptives was US\$8.10. This was \$3.80 less than the cost of the same services (\$12.40) Mkomani had provided separately—a savings of 31%.

Introducing STD/HIV/AIDS services

As programs plan to integrate services they need to consider the type of additional service that is appropriate for their level of operation. Some of the services that can be integrated at various levels are shown in the steps below. The letters for the levels indicate the order in which services can most appropriately be phased in. To decide how to phase services into your program, start with Level A for the most basic additions, and work your way through the alphabet adding levels as appropriate for your resources and requirements. For example, both CBS programs and full-service clinics would begin the integration process with the addition of services at level A, but a clinic could also add STD screening by its providers.

➔ **Level A integrated services - add:**

- IEC and counseling to promote behavior change for prevention of STD/HIV/AIDS
- Promotion and distribution of condoms for STD/HIV prevention
- Risk assessment and screening of clients to determine risk of exposure to STD/HIV, and referral for management (see Annex C for risk assessment guide).
- For full-service clinic, add:* STD screening and management by skilled providers

➔ **Level B integrated services - add:**

- Follow-up of STD/HIV/AIDS clients
- Referral for diagnosis and management of STD/HIV/AIDS clients
- For clinic-linked CBS programs and upward, add:* Check adequacy of infection prevention and quality of care standards

➔ **Level C integrated services - add:**

- CBS programs
 - Referral for supportive care
 - Training of home-based care providers for AIDS patients
- Clinic-based CBS programs and upward (more comprehensive services)
 - Follow-up of STD/HIV/AIDS clients
 - Referral for diagnosis and management of STD/HIV/AIDS clients

➔ **Level D - add for all programs:**

- Partner notification of STD clients

➔ **Level E for all but CBS programs - add:**

- STD syndromic management and referral

➔ **Level F for clinics with lab/VSC service and full-service clinics - add:**

- Referral for HIV testing
- Pre/post-test counseling
- STD lab diagnosis

➔ **Level G for full-service clinics - add:**

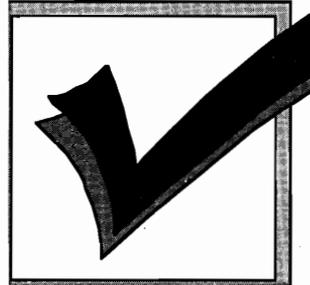
- HIV testing
- Referral for supportive care - to AIDS support organizations, e.g., TASO

You know, maybe it could work - if we phased it in and made sure everyone was well trained....

Tools for integration

It is clear from the case studies that program design must take into account the full range of tools and management systems necessary for quality service delivery. These range from relatively simple changes in client records to provision for privacy during consultations. Service providers must give serious consideration to the items on the following checklist.

- ✓ Service protocols
- ✓ Training materials
- ✓ Risk assessment guidelines and screening checklists
- ✓ Well-trained service providers and managers
- ✓ IEC and counseling materials with integrated messages
- ✓ Strong management systems, e.g.:
 - Effective management information system
 - Efficient use of resources, including personnel
 - Effective supervision (See Annex D for sample supervisory checklists.)
 - Monitoring
 - Regular self-assessment
 - Strong referral linkages
 - Management of training
 - Reliable supply systems for IEC materials
 - Reliable supply systems for condoms, contraceptives, STD drugs, etc.
- ✓ Assessment of physical facilities to assure provision for client flow, privacy
- ✓ Provision for infection prevention procedures
- ✓ Income generation/cost recovery
- ✓ Evaluation, replanning
- ✓ Infrastructure development—including liaison with laboratory services
- ✓ Resource mobilization to support service delivery
- ✓ Strategic planning for sustainability
- ✓ Operations research



Sustainability issues

To sustain integrated health programs, planners should provide for:

- Community level information and education to:
 - Stimulate demand for and use of service
 - Promote self risk assessment
 - Ensure supportive community environment for people living with HIV/AIDS
 - Mobilize community participation
- Advocacy for:
 - Supportive community environment for program
 - Supportive policies
 - Removal of service barriers
 - Women's reproductive health rights (including violence against women, female genital cutting)
 - Services for youth
 - Male involvement
- Establishment of social marketing of condoms and contraceptives

Recap

To summarize: The necessary integration ingredients are:

- ✓ Political commitment at highest levels
- ✓ Clear definition of service integration
- ✓ Active and sustained community participation
- ✓ Involvement of persons living with HIV/AIDS (through personal testimonies) to reduce stigma
- ✓ Empowerment of women to negotiate safer sex and increase skill in condom negotiation
- ✓ Advocacy through skillful use of IEC approaches
- ✓ Targeting of high transmitters, e.g., commercial sex workers, and vulnerable groups, especially the youth
- ✓ Voluntary counseling and testing services for individuals, couples, and families
- ✓ Social marketing and promotion of condoms
- ✓ “No missed opportunity” for HIV prevention by providing integrated RH services
- ✓ Locally appropriate IEC and counseling for promoting positive behavior change
- ✓ Treatment of STDs, including risk assessment, referral, and partner notification and treatment

No missed opportunity

Finally, in making the decision whether to integrate services, consider the chart below.

STD, TB, AND HIV									
•	Almost any STI increases the chance of HIV transmission, particularly those that cause genital sores or ulcers.								
•	A study in Malawi showed: <table><thead><tr><th></th><th><i>HIV concentration in semen (virus particles/ml)</i></th></tr></thead><tbody><tr><td>Men without urethritis:</td><td>17,000</td></tr><tr><td>Men with urethritis:</td><td>125,000</td></tr><tr><td>Men 2 weeks after STD treatment:</td><td>37,000</td></tr></tbody></table>		<i>HIV concentration in semen (virus particles/ml)</i>	Men without urethritis:	17,000	Men with urethritis:	125,000	Men 2 weeks after STD treatment:	37,000
	<i>HIV concentration in semen (virus particles/ml)</i>								
Men without urethritis:	17,000								
Men with urethritis:	125,000								
Men 2 weeks after STD treatment:	37,000								
•	Rapid, effective treatment of STIs curbs the spread of HIV.								
•	Infected men provide the route for finding asymptomatic women: in a high-risk population in rural Uganda, 65% of women partners had STIs, but only 8% reported vaginal discharge.								
•	18% to 73% of TB cases are HIV seropositive. TB is the most common opportunistic infection among AIDS patients.								
•	HIV is a major cause of the 300–400% rise in TB cases and deaths in sub-Saharan Africa.								
•	A person living with TB infects on average 16 people per year.								
•	25% of people dying from TB among HIV-negative people in the future would not have been infected in the absence of HIV.								

Not for women only - Getting men involved in reproductive health

Another aspect of integration is to promote greater equality between men and women in the area of reproductive health. Not only do men have reproductive health concerns of their own, but their health status and behaviors directly affect women's health.

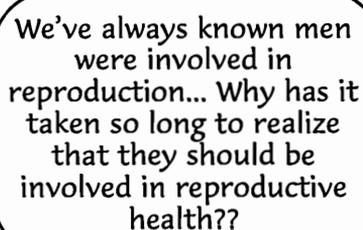
What kind of reproductive health concerns do men have?

Men's reproductive health concerns include family planning, STD prevention and treatment, sexuality and sexual dysfunction, infertility, and urologic conditions, among others. Men can be directly involved in women's reproductive health by using contraceptive methods that require their direct participation such as condoms, natural family planning, vasectomy, and withdrawal; supporting their partners' use of contraception through joint decisions about contraceptive methods and family size; and preventing the spread of STDs by using condoms even with their wives, limiting their sexual activity to one partner, and seeking treatment. Men can play an important role in preventing gender-based violence, a significant reproductive health concern, and in supporting efforts to improve women's status.

Why have men been left out so far?

As family planning programs were traditionally institutionalized, through the MCH facilities of ministries of health, they focused on women (and children). This effectively barred men from access to services and from exercising a number of responsibilities in the areas of the reproductive health of their wives and the health of their children.

Commonly held myths and wrong assumptions about men's views on family planning, sexuality, and health arise from the lack of data on male perspectives and the extent of men's involvement in reproductive health issues. The surveys most relied on for reproductive health programs usually ask questions only of women, assuming that women are the ones who make the decisions about reproduction and that men are either not involved or are only marginally involved. But we know that gender relations are in delicate balance; separate programs for men and women emphasize the differences between the sexes rather than their complementary roles, and may tend to tip the balance in undesirable ways.



We've always known men were involved in reproduction... Why has it taken so long to realize that they should be involved in reproductive health??

How should male-involvement programs be designed?

Unfortunately, men actually don't often know very much about their own or women's sexuality. They communicate about sexuality very little in their relationships, and they often believe many sexual myths. Moreover, they are suspicious of family planning programs, which they regard as a conspiracy to undermine their power. To meet men's needs and overcome their fears, programs should:

- ❑ **Encourage men to support women's contraceptive choices:** Men who are educated about reproductive health issues are more likely to support their partner's decisions and to encourage enlightened public policies in reproductive health care.
- ❑ **Increase the promotion of male methods:** Some programs are using creative promotional campaigns for vasectomy, for example, which may expand acceptance of this safe and effective method.
- ❑ **Help men avoid infection with STDs and HIV:** Behavior change messages include staying with one faithful partner. If this is not possible, then always use a condom with any outside partner, particularly with sex workers, bar girls, etc. This healthy behavior will also have major benefits for women's health.
- ❑ **Address men's own reproductive health needs:** Men have their own reproductive health problems beyond family planning and STDs, such as infertility and sexual dysfunction. A lack of services to address these needs contributes to stress, anxiety, and loss of self-esteem among men.
- ❑ **Encourage men to become more aware of related family issues:** Men need to be more involved in raising children, in encouraging schooling for both girls and boys, in reducing violence in families, and in making resources available to meet the needs of the family. These are complex cultural issues, and in many settings, family concerns are closely linked to family planning and reproductive health.
- ❑ **Overcome service provider biases:** Service providers must learn to recognize their own personal values about gender equity, and how these values might result in biases toward men or women.
- ❑ **Promote male-friendly services:** Clinic promotion through talks and home visits by male promoters, billboards, magazine advertisements, and radio and television spots can be instrumental in informing potential clients about male services.

What do men want in reproductive health services?

Men generally want the same things women want! Service outlets that have been successful in attracting and retaining male clients have many of the following characteristics:

- ❑ **An array of services:** Men prefer to visit facilities that offer a variety of services, including general medical care and treatment for urological problems, sexual dysfunction, STDs, and infertility. Men want their reproductive and sexual health care needs to be met without having to visit multiple facilities.
- ❑ **Sensitive counseling:** Skillful counseling can help men to articulate their concerns and health care needs, clarify their views, and make appropriate choices about reproductive behavior. Men are more likely to return to a clinic where they feel valued as a client.
- ❑ **Low-cost services:** Men are attracted to low-cost services, especially for vasectomy. Experience shows that men are not more willing than women to pay more for services.
- ❑ **Privacy and confidentiality:** Men need to be reassured that they can discuss their reproductive health problems in complete confidence. Some men prefer to travel to a distant site to avoid being seen entering a health facility in their local area.
- ❑ **Skilled clinicians:** Experienced, well-trained clinicians inspire confidence that services meet accepted medical standards. Maintaining aseptic procedures is especially important.

- ❑ **Inviting atmosphere:** Men appear to be at least as sensitive as women to the physical appearance of a clinic, perhaps because many men are unaccustomed to visiting clinics.
- ❑ **Accessibility:** Men are more likely to visit service outlets that are easy to get to, have convenient hours (open evenings and weekends), and are easy to identify.

How do we add these services - but keep costs down?

Steps that can be taken right away, with limited capital investment, include the following:

- ❑ Integrating HIV prevention with family planning in counseling and education.
- ❑ Ensuring that condoms and vasectomy services are widely available and that male methods are discussed in client counseling, staff training, and IEC materials.
- ❑ Making men feel more comfortable in existing clinics by treating them well and by offering appropriate counseling, medical services, and referrals.
- ❑ Encouraging women to come with their partners for couple counseling and services.
- ❑ Educating both men and women on the use of condoms. Condoms can be a partly woman-controlled method if she is skillful in putting a condom on her partner so that this is pleasurable for him. The condom is more likely to be used.
- ❑ Reducing clinic waiting times and establishing evening and weekend hours.
- ❑ Including male-involvement themes in promotional activities, e.g., a radio show on satisfied vasectomy adopters or a TV drama on STD hazards.
- ❑ Removing program barriers to male involvement, e.g., improving service provider training, easing restrictions on condom sales and prerequisites for vasectomy.
- ❑ Including male-involvement indicators, such as counseling and referrals, in program outputs and staff appraisals.



Focus on youth

An estimated one-third of the population of sub-Saharan Africa is between the ages of 10 and 24 years—some 206 million young people. The young generation is very different from its predecessors, and the changes are affecting patterns of sexuality and fertility. Despite advances in the recognition of personal strategies to avoid unwanted pregnancies and STDs, most young African women and their partners begin sexual activity with little knowledge about, use of, or access to reproductive health services, including contraception. And given the numbers and the practices, the HIV pandemic brings a problematic dimension to the question of reproductive health among young people.

Policy makers and program designers considering integrated service delivery must come to grips with youthful sexual activity and the special needs of young people. Besides ensuring that conducive policies are developed and widely disseminated, consideration should be given to a number of important lessons learned in programs serving the youth:

- ❑ Young people must be engaged in finding solutions to their reproductive health problems. Involving them as active participants, even as planners and managers, implementers and evaluators, is critical to success.
- ❑ Staff hired to work in youth programs must have the right attitude and be genuinely committed to helping young people deal with reproductive health concerns. In most situations, the age and gender of the staff seem to matter less than their attitude, knowledge, and concern for their clients. A strong, comprehensive, and holistic training guide or curriculum can make a major contribution to staffing skills. Similarly, incentives can improve the motivation, productivity, and accountability of volunteer staff.
- ❑ The introduction of condom use is a critical starting point. Condoms prevent pregnancy and STDS, are easily available, can serve as a transition to other methods depending upon the user's situation and needs, and suit the episodic nature of adolescent sexual behavior. A well-designed referral system can support the transition to other methods and is also an essential part of a successful program for behavior change communication.
- ❑ Evaluation designs must be built in from the onset of activities, and should examine individual program characteristics to reveal what helps make programs successful.



Why do young people have difficulty using reproductive health services?

In most developing country settings, young unmarried adults tend not to go to health facilities—particularly public clinics—for their reproductive health needs. The history of family planning service delivery explains some of this reluctance. Traditional MCH/FP services were designed to serve the childbearing and child-spacing needs of married women, not singles or teens. Furthermore, few providers have had any specialized training or gained much experience in meeting the special reproductive health needs of adolescents. Many providers, therefore, remain ill-equipped to serve this group.

Compounding this, young people have many unvoiced fears about their sexuality and their need for services. Thus, service characteristics and their own attitudes combine to keep young people away from reproductive health services. For example, many adolescents are unaware of the risk of pregnancy, unfamiliar with STD symptoms, and afraid of medical procedures, particularly pelvic exams. Unmarried young people often think that such services are not for them, and they are embarrassed to be seen in a reproductive health facility. They are likely to be concerned about lack of privacy and confidentiality—especially that their parents might find out. They may be ashamed of having experienced coercive or abusive sex.

On the service side, young people are often unaware of where reproductive health services are located, they are unfamiliar with the kinds of services offered, and they fear encountering hostile clinic staff. When they do get the courage to go for services, they may find that the health facility is not open at convenient hours, there may be no transportation to the clinic, and the cost of services is beyond their means.

What kind of services do young people want?

Because young people are not all the same, it is important to find out about service preferences in different cultural settings. In general, the following have been found to be true:

- Young adults are more likely to go to a clinic with special hours just for them.
- Separate youth-friendly services may be more important in the case of high-risk youth who need to overcome their resistance to using traditional health care systems.
- Young people prefer centers that offer many different services, that remain open afternoons and evenings, and that do not look like a clinic (in terms of location, decor, atmosphere).
- Youth prefer that reproductive health services be private, confidential, affordable, and accessible, and they want staff who are friendly, empathetic, knowledgeable, trustworthy, respectful, and sensitive.

What would youth-friendly services look like?

Concerned program professionals are now beginning to address many of the difficulties and obstacles confronting young people. Some clinics now serve young women before their first birth, or welcome young men as clients. There is also a trend toward providing a broader array of reproductive health services. Clinics that have tailored their service provision to attract young people and meet their special reproductive health needs usually have a number of specific characteristics related to providers, facilities, and services.

Provider characteristics

- Staff are specially trained to work with young people, to respect them and their needs.
- Staff acknowledge the central importance to adolescents of privacy and confidentiality.
- Clinic managers make sure there is extra time allowed for counselors or medical staff to discuss young people's special issues.

Health facility characteristics

- Separate space or special times are set aside for young adult clients.
- Clinic hours are convenient for young adults—late afternoons, evenings, weekends.
- Facilities are conveniently located, and have acceptable waiting times.
- There is adequate space, and it is arranged so that young people's privacy is protected.
- Clinic surroundings are comfortable, as “unmedical” as possible, and made appealing for young people.
- Couples are welcomed for counseling together if desired.

Service characteristics

- Essential services are offered, and free, informed choices promoted.
- Drop-in clients are welcomed, overcrowding is avoided, waiting times are short, and service charges are as low as possible, so that young people can afford them.
- Boys and young men are encouraged to attend, and special male services are offered. They are also encouraged to practice responsible sexual behavior and other positive behaviors and attitudes, such as staying in school, seeing females as equals in relationships, and supporting

female partners' reproductive health needs and decisions.

Audio-visual and print materials dealing with issues relevant to young adults are offered in waiting areas.

Young people are involved in the planning of the services, which are widely publicized in schools, offices, factories, and recreational and other community settings.

ESSENTIAL RH SERVICES PACKAGE FOR YOUTH

Information, education, counseling, and services or referral for:

- Safer sexual behaviour
- Contraception – pills, condoms, injectables
- Emergency contraception
- Pregnancy testing and ante/postnatal care
- STD treatment, dual protection, partner notification
- Voluntary HIV testing
- Sexual violence/abuse, substance abuse

Adapted from Dickson-Tettah, et al., 1999.

YOUTH SERVICES WORK

Experience in Uganda indicates that programs targeting youth are beginning to make a difference:

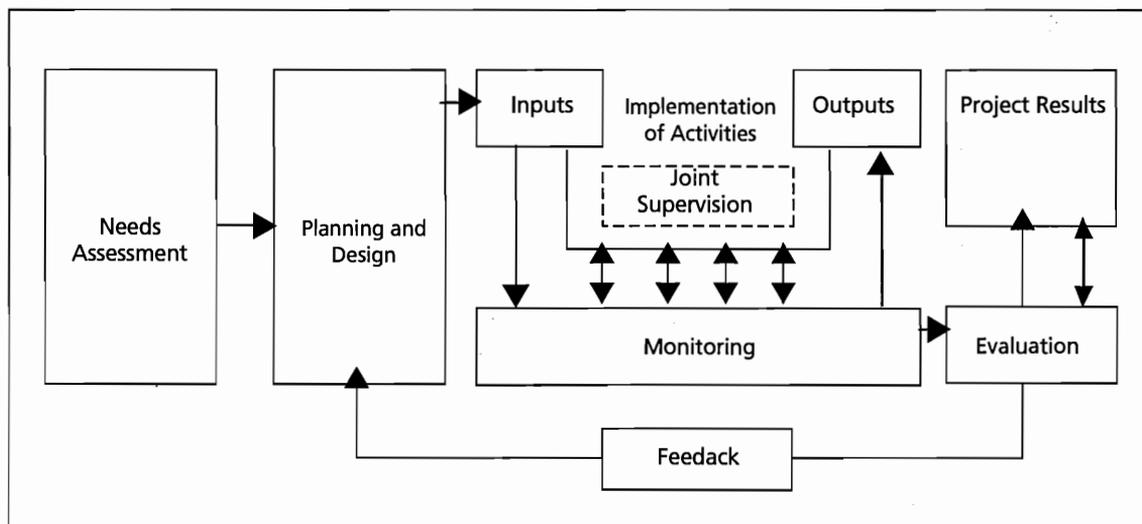
- HIV prevalence in 15-19 and 20-24 age groups fell from 22% to 10% between 1990 and 1996
- Number of women aged 15-19 who have never had sex rose from 26% to 46%
- Number of men reporting sex outside a regular partnership fell from 22.6% to 18.1%
- Men aged 15-19 and 20-24 who use condoms rose from 20% to 65%

The decline in HIV prevalence goes beyond what might be expected from the natural course of the epidemic and probably results from behavior change.

How to make decisions and monitor your progress

We have seen that MCH/FP–STD/HIV/AIDS integration requires many carefully thought out steps. At each point, decisions must be made on the basis of available data. Moreover, once the program is under way, data for checking and analysis are required for effective monitoring and evaluation. Some programs will already have some of these data available. Where collection systems are lacking, they can and should be designed into the integrated program.

The process can be illustrated like this:



The foundation

An appropriate management information system (MIS) is imperative for program managers to be able to monitor activities continuously, allowing them to direct resources where they will have the greatest impact.

Record-keeping and reporting formats should be simple, user-friendly, and set up to collect only essential information. They should be designed in collaboration with key players. Existing formats should be reviewed and redesigned to ensure their appropriateness to integrated service delivery, as well as their uniformity and comparability among project sub-elements, project objectives, components, sites, and cadres of service providers.

Service providers, supervisors, and managers should be trained to monitor more effectively, to collect and collate data, to interpret data, and to use findings in planning, implementation reviews, and management decision making.

The service statistics system should be used not only to assess outputs and effects, but also to appraise staff and facility performance, set performance targets and assess performance against those targets, facilitate decision making for optimal corrective action, and improve systematic planning. Such a system is at the heart of a sound monitoring and evaluation approach.



The objectives of the monitoring and evaluation system should focus on:

- Providing continuous information on the implementation of activities.
- Assessing how appropriately and adequately each programmatic component is being implemented, administered, and managed at the selected levels of the community-based and clinic-based integration models.
- Measuring the impact of integration (in both qualitative and quantitative terms).

The baseline study

You won't know how effective your integration efforts have been unless you know where you started. Ideally, a population-based baseline survey and a site-based service delivery analysis should be conducted before integrated services are introduced. The information gained will be invaluable in the design of the service delivery system. The baseline survey should gather data on FP, STD, and HIV/AIDS knowledge, attitudes, and practices among the target population and specific population groups.

The baseline survey should specifically derive indicators for a majority of the following:

- Existing knowledge, attitudes, and practices that may have an impact on the design of appropriate integration interventions
- Coverage of areas and specific target populations at specified service delivery points/catchment areas (CPR and method mix)
- Method-specific contraceptive prevalence rates
- Proportion of STD/HIV/AIDS at-risk populations
- Patterns of dual-method/dual-protection use
- Patterns of STD prevalence among clients
- Levels of spousal/partner communication on reproductive health issues
- Effectiveness of negotiation skills for condom use and safer sex practices
- The extent of demand and unmet need for specific FP and STD/HIV/AIDS interventions
- Availability of appropriate antibiotics to treat STDs



There certainly is a lot to think about and plan for, isn't there??

If possible, a situation analysis should also be conducted to gather data on community clinic sites, such as staff skills, knowledge, attitudes, and practices; service quality; equipment/supplies; and effectiveness of management systems (e.g., service delivery, supervision, referrals, training, MIS, logistics, and financial management).

The evaluation plan

A comprehensive evaluation plan considers processes, outputs, effects, and short-term impact, each of which is discussed in further detail below.

Process evaluation

Continuous monitoring and supervision are a major part of process evaluation, which examines how well integration activities are being implemented. Specifically, process evaluation activities

focus on the development and strengthening of existing systems, protocols, and guidelines necessary to support, standardize, and institutionalize integrated service delivery activities. These activities support planning, implementation, and supervision to assess progress in integration against project goals and objectives.

Process evaluation information should establish:

- What the intervention has done since implementation
- Whom the intervention has reached and how it has reached them
- The response of the target population to the intervention

Process evaluation should also review what is working and what is not in order to enable service delivery staff to develop corrective actions; determine whether resources, equipment, supplies, and provider skills are adequate and used efficiently and effectively; identify barriers to integration; establish coverage; and identify strategies, training needs, and technical assistance requirements to improve the integration of services.

The agencies collaborating on the integrated service delivery should ensure that all key players—service providers, NGOs, provider institutions, and district and national-level policy makers—are involved in, are committed to, and understand the process of integration. Sample client studies, exit interviews, and focus group discussions may be used to gather feedback from clients about their satisfaction with the services. When program deficiencies are detected, program staff should take corrective actions.

Project management should ensure that service providers do not focus on meeting targets at the expense of providing high-quality services.

Integration partners should emphasize the selection of mutually agreed-upon and clearly defined standard indicators that reflect program implementation needs and activities. Process evaluation should also support the development of protocols and checklists for quality assurance and quality improvement. Indicators—the qualities you look at to measure your progress—should be developed and monitored to answer questions related to quality of care in integration. For example:

- Are various contraceptive methods, medical services, and counseling available for specific target groups?
- Is accurate and useful information being given to clients so that they can make informed choices and decisions to prevent pregnancy, STDs, and HIV?
- Are new acceptors and continuing clients receiving effective counseling for FP and STD/HIV/AIDS?
- Are trained service providers using skills gained in counseling, clinical procedures, clinic management, and infection prevention?
- How much time, on average, is being spent with each client?
- Are providers respectful, courteous, and non-judgemental?
- Are clients informed about sources of resupply, timing of revisits, referrals, and drug prescriptions?
- Are service hours convenient for clients?
- Are integrated services meeting the needs of specific population groups?
- Do providers help clients assess their reproductive health needs and risks?
- Do service providers recognize the importance of treating STDs not only in their clients but in clients' partners as well?



- Do providers understand the importance of managing STDs to reduce the risk of HIV transmission?
- Do service providers promote dual method use and dual protection use of condoms?

You may need to train your staff in new service delivery modes. The quality of service provider training should also be continuously assessed through follow-up systems. Indicators to evaluate the training process will need to be developed to answer the following questions:

- Did the training course achieve its goal of preparing service providers for integrated service delivery?
- Was the training methodology appropriate for the transfer of skills, attitudes, and knowledge?
- Did trainees acquire and retain relevant knowledge and become competent in performing integrated service delivery tasks?
- Are trainees still competent and using newly acquired skills after a certain period post-training?
- How many trainees need retraining?
- Are program training objectives being achieved?

Output evaluation

The output evaluation assesses integration achievements on-site by viewing defined, quantifiable indicators of program performance such as access, quality and acceptability, CYPs generated, and use of integrated services by the target populations. Output indicators are usually quantitative.

Effects evaluation

Effects measurement focuses on changes observed within the target population in the catchment area, for example: observed changes in reproductive health attitudes, changes in staff and skills, and changes in provider attitudes toward providing and managing integrated FP and STD/HIV/AIDS services. Evaluation of effects should specifically assess changes in:

- Attitudes of service providers, supervisors, managers, and trainers trained
- Service delivery sites equipped and refurbished to provide quality integrated services
- New clients provided with methods, counseling, medical examinations, and treatment
- Revisits for resupply
- Revisits for counseling
- Contraceptive supplies distributed
- CYPs generated
- Increase in referrals made and confirmed for FP, STDs, and HIV/AIDS
- Persons reached with behavior change messages and counseling
- Number of clients using a modern method with condoms (dual method use)
- Number of clients receiving voluntary testing and counseling

An effective MIS should provide program managers with information to monitor these indicators for each level of the program (e.g., by service delivery site, in CBS by agent, by area, by month, by quarter, and annually).

Short-term impact evaluation

The findings from the original baseline survey will be used to derive the indicators for the short-term impact evaluation. This evaluation is conducted at a specified, predetermined time following the introduction of the integrated services. It will help you determine how well you are actually doing with your new service delivery system.

Comparison of the initial baseline and situational analysis with similar post-implementation surveys will indicate the changes in the indicators that have occurred over time in the target population, at project sites, and among service providers as a result of the integration. Relevant data from reports, service statistics, and training information systems contribute to the analysis of short-term impact. For example, an analysis of service statistics over time will show trends in condom distribution, changes in method use, and increases (or otherwise) in STD/HIV clients served, especially return visits (recurrences).

Where to get data for decision making, monitoring, and evaluation

You will need data from a variety of sources for your baseline analysis and the evaluation and monitoring that take place over the life of your program. The following are the most useful and frequently used sources:

- Situation analyses and needs assessments of service sites and communities in the catchment areas
- Clinic service statistics and training records
- Monthly/quarterly reports
- Regular program document reviews (e.g., proposals, reports, studies)
- Client, staff, and community interviews
- Client follow-up reports
- Exit interviews
- Focus group discussions
- Clinic inventories
- Annual work plans
- Strategic/sustainability plans
- Guidelines, manuals, training curricula, needs/self-assessments
- Observation
- Supervisory visit reports
- Special studies

The following charts present evaluation indicators for two types of integrated services—CBS-based and clinic-based.

CBS MODEL EVALUATION INDICATORS

Process

Training needs assessments conducted
Integrated training curricula developed/modified and distributed
Training sessions for CBS agents conducted
Community knowledge, attitudes, and practices assessed
Trainee awareness of integration roles and responsibilities promoted
Integrated IEC and counseling guidelines and materials developed and used
Community mobilization strategy developed
Follow-up and referral system and linkages developed and followed
Supplies logistics system developed and instituted
Condom distribution systems established
Appropriate method mix put in place (institutions making referrals and capacity to accept referrals identified and functioning)
Condom outlets established

Outputs

of CBS agents trained in integrated service delivery
of training sessions for CBS agents
of youth served
of women served
of men served
of community sensitization meetings held
of clients served by method
of referrals by type
of clients followed up
of clients provided dual methods
and type of IEC materials distributed
of counseling sessions conducted

Effects

Increase in contraceptive prevalence
Improvements in reproductive health attitudes
Improvements in staff skills and attitudes toward STD/HIV/AIDS cases
increase in dual method use or dual protection, which is ideal
Increase in FP/STD/HIV/AIDS awareness
Increase in community involvement activities
Increase in demand for services

Short-term impact

Changes in fertility rates
Decline in STD/HIV/AIDS cases diagnosed and treated/referred
Change in community perception of STD/HIV/AIDS cases
Reduction in gaps of unmet need for family planning and STD/HIV/AIDS cases
Increase in spousal/partner communication on reproductive health issues
Decline in proportions of population at risk
Proportion of sexually active youth seeking condoms in the villages
% decrease in number of clients complaining of abnormal discharge
Increase in number of people reporting consistent condom use with irregular partners
Decrease in number of 15–24 age group males with history of burning with urination, as well as discharge from penis
Frequency of reported condom use in the last one month

CLINIC MODEL EVALUATION INDICATORS

Process

- Training needs assessments conducted
- Relevant training curricula developed and distributed
- Training sessions for clinic staff conducted
- Community knowledge, attitudes, and practices assessed
- Trainee awareness of integration roles and responsibilities promoted
- IEC, counseling, and quality of care guidelines and materials developed and used
- Community mobilization strategy developed
- Follow-up and referral system and linkages developed and followed
- Supplies logistics system developed and instituted
- Condom distribution systems established
- Appropriate method mix put in place
- Clinics equipped for screening, testing, records

Outputs

- # of service providers trained in integrated service delivery
- # of training sessions for service providers
- # of youth served
- # of women served
- # of men served
- # of community sensitization meetings held
- # of service providers carrying out risk assessment for their clients
- # of peer educators trained in STD/HIV/AIDS prevention and counseling
- # service providers who practice correct management of STDs

Effects

- Increase in contraceptive prevalence
- Improvements in reproductive health attitudes
- Improvements in staff skills and attitudes toward STD/HIV/AIDS cases
- increase in dual method use
- Increase in FP/STD/HIV/AIDS awareness
- Increase in community involvement activities
- Increase in demand for services
- Increase in numbers of men and young adults served

Short-term impact

- Changes in fertility rates
- Decline in STD/HIV/AIDS cases diagnosed and treated/referred
- Change in community perception of STD/HIV/AIDS cases
- Reduction in gaps of unmet need for family planning and STD/HIV/AIDS cases
- Increase in spousal/partner communication on reproductive health issues
- Decline in proportions of population at risk
- Percent reduction in STD incidence
- Mean number of sexual partners in the last one month, especially among men

Well, if we can begin to show progress in many of these areas, we may be able to make an impact on this epidemic. We'd best get busy...



Annex A: Sample presentation slides

Integrating STD/HIV/AIDS services with MCH/FP programs

A Guide for Policy Makers and Program Planners in sub-Saharan Africa (SSA)

1

The triple challenge to health services in SSA

- Reproductive health care needs are increasing, while resources to supply services are declining.
- Sexual activity among young people is on the increase, and the age for sexual experimentation is getting younger and younger
- The HIV/AIDS epidemic has hit Africa hard

2

AIDS in Africa

- 70% of persons with AIDS are in sub-Saharan Africa
- Over 95% of the world's AIDS orphans and 80% of women with AIDS are in SSA
- SSA has 5 of the world's worst AIDS epidemics

3

Impact of AIDS on RH services

- Other STDs facilitate HIV transmission
- 32% of women seeking MCH/FP services in Kenya have STDs
- Existing MCH/FP health care systems can't cope with AIDS-generated demands

4

Integrated services - One way to cope with the onslaught of AIDS

- Integration may be defined as combining services to prevent or manage sexually transmitted infections (including HIV) with services for family planning and maternal/child health care.

5

Why integrate STD/HIV/AIDS & MCH/FP services?

- Both serve the same target population - the sexually active.
- Both promote safe and responsible sexual behavior through information, education, and communication
- Both promote/distribute condoms

6

More reasons for integration

- Similar medical/health skills and staff
- Greater convenience for clients
- Fewer missed opportunities for screening/treating STDs
- Potential for treating more clients - most African women attend MCH/FP clinics on a regular basis
- Potential for significant cost savings

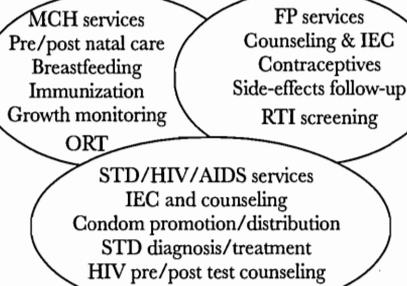
7

Vertical service delivery

<ul style="list-style-type: none"> ♦ MCH services • Antenatal care • Postpartum care • Breastfeeding • Immunization • Growth monitoring ♦ FP services • Counseling & IEC • Contraceptives • Follow-up/management • RTI screening • Infection prevention practices 	<ul style="list-style-type: none"> ♦ STD/HIV/AIDS Services • Increased condom promotion/distribution • STD diagnosis & treatment • HIV pre/post test counseling & referral • Education & counseling
---	---

8

Integrated services



9

Integration requires

- A conducive policy environment
- Service protocols & training materials
- Specific IEC & counseling materials
- Strong management systems
- Adequate infrastructure
- Training for service providers and managers

10

Some drawbacks to integration

- Requires training for service providers
- Needs new record-keeping systems
- May not be viable in existing facilities
- May increase cost of MCH/FP services
- MCH/FP clients may shy away from STD/HIV clinics

11

Busoga FLEP integration model

- STD/HIV risk assessment for all MCH/FP clients
- Diagnostic checklist for STDs/AIDS
- Syndromic approach to diagnosis of STDs
- Information about HIV/AIDS for all clients
- Community STD/HIV information campaign
- In-school STD/HIV information campaign

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Mkomani Clinic Society model

- STD/HIV risk assessment for all clients
- STD/HIV information for all clients
- Public information campaign
- Infection prevention practices
- Diagnosis/treatment of STDs in MCH unit
- Referral/counseling of HIV clients
- Partner tracking notification/treatment

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Botswana MCH/FP model

- STD/HIV risk assessment for all MCH/FP clients
- Syndromic approach to STD management
- Community IEC activities
- Infection prevention practices
- Contact tracing
- Syphilis tests for all antenatal clients

14

Nakuru Municipal Council Model

- STD/HIV risk assessment of all clients
- STD/HIV information to all clients
- IEC for hard-to-reach groups - men, sex workers, youth
- Syndromic approach to STD management
- Infection prevention practices
- Contact tracing & treatment for client partners
- Syphilis screening/treatment for antenatal clients
- Referral to STD clinic for special treatment

15

Is integration cost-effective?

- Comprehensive cost data are not yet available, but preliminary studies at Mkomani Clinic showed
 - ▶ Integrated services cost US\$8.10
 - ▶ Same services offered separately cost \$12.40
 - ▶ Savings = 31%

16

If MOH and NGO clinics are going to offer BOTH MCH and STD/HIV services

Integration is less costly than separate services

Method	Integrated Serv.	Non-Int. Serv.	Difference
Pill	3.08	4.49	1.41
Condom	3.02	4.37	1.35
IUD	3.78	4.72	0.94

Per hour cost for nurse \$0.87
Per hour cost for doctor \$7.03

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Men

are involved in reproduction... they should be involved in reproductive health

Men as partners

- Contributes to women's reproductive health
- Helps stem transmission of STD/HIV through behavior change
- Enhances inter-spousal communication
- Involves them in family health

18

What do men want?

- An array of services
- Sensitive counseling
- Skilled service providers
- Low-cost services
- Privacy and confidentiality
- Accessibility
- Inviting atmosphere

19

Male-friendly services don't have to be costly

- Treat men well and offer counseling, medical services, referrals
- Reduce clinic waiting times
- Open clinics during evenings and weekends
- Ensure that condoms, vasectomy, and other male services are widely available

20

Youth have special RH needs

- "Youth-friendly" policies
 - Non-judgemental service providers
 - Privacy, confidentiality
 - A holistic approach - RH is only one of the problems faced by modern youth
- * Programs young people are part of - in planning, design, evaluation - work better

21

Youth Services Work

Uganda experience: targeting youths can make a difference:

- HIV prevalence in 15-19 and 20-24 age groups fell from 22% to 10% between 1990 and 1996
- Number of women aged 15-19 who have never had sex rose from 26% to 46%
- Number of men reporting sex outside a regular partnership fell from 22.6% to 18.1%
- Men aged 15-19 and 20-24 who use condoms rose from 20% to 65%

22

How to integrate services

1. Define the basic service
2. Determine integrated service needs
3. Identify the necessary tools and systems
4. Factor in sustainability issues

23

In other words -

- Figure out what you do now, then decide what kind of integrated services it makes sense for you to add - and phase them in.

24

Define basic services - CBS

- Assessment of FP client needs
- IEC & counseling for FP clients
- Non-clinical FP methods
- Follow up of FP clients
- Referral for clinical methods
- Community outreach

25

Integrating CBS services

1. IEC & counseling for STD/HIV/AIDS
2. Condoms for STD/HIV prevention
3. Client risk assessment
4. Follow up of STD/HIV/AIDS clients
5. Referral for diagnosis/management
6. Referral for supportive care
7. Training HBC providers for AIDS patients

26

Define basic services - Full-service clinic

- Assessment of FP client needs
- IEC & counseling for FP
- Full range of FP methods
- Follow up of FP clients
- Infection prevention & quality of care
- Management of complications
- Community diagnosis/outreach

27

Integrating full-service clinic services

1. IEC & counseling for STD/HIV/AIDS
2. Condoms for STD/HIV prevention
3. Client risk assessment
4. Internal screening by skilled providers
5. Follow up of STD/HIV/AIDS clients
6. Infection prevention & quality of care
7. Partner notification for STD clients

28

Integrating clinic services cont.

8. STD syndromic management & referral
9. Referral for HIV testing
10. Pre/post test counseling
11. STD lab diagnosis
12. HIV testing
13. Referral for supportive care

29

Define basic services - Clinic + lab

- Assessment of FP client needs
- IEC & counseling for FP
- All FP methods including VSC
- Follow up of FP clients
- Infection prevention & quality of care
- Referral for complications
- Community diagnosis/outreach

30

Integrating clinic + lab services

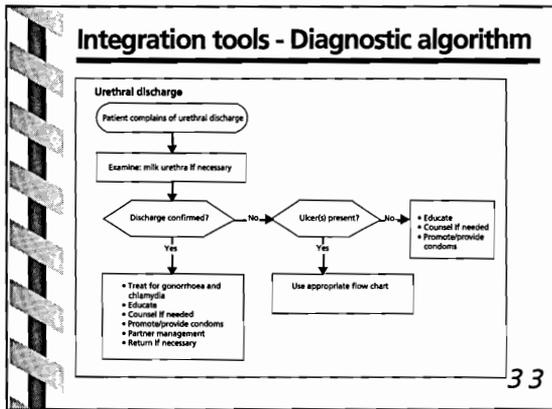
1. IEC & counseling for STD/HIV/AIDS
2. Condoms for STD/HIV prevention
3. Client risk assessment
4. Follow up of STD/HIV/AIDS clients
5. Infection prevention & quality of care
6. Follow up of STD/HIV/AIDS clients
7. Partner notification for STD clients

31

Integrating clinic + lab services cont.

8. Syndromic management & referral
9. Referral for HIV testing
10. Pre/post test counseling
11. STD lab diagnosis
12. HIV testing
13. Referral for supportive care

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- ### Recap – Integration requires
- Political commitment at highest levels
 - Clear definition of service integration
 - Active and sustained community participation
 - Involvement of persons living with HIV/AIDS
 - Empowerment of women to negotiate safer sex
 - Targeting of high transmitters
 - Voluntary counseling and testing services
 - Social marketing and promotion of condoms
 - “No missed opportunity” for HIV prevention
 - IEC/counseling for behavior change
- 34

Planning, monitoring & evaluating service delivery

ACTIVITIES > OUTPUTS > OUTCOMES

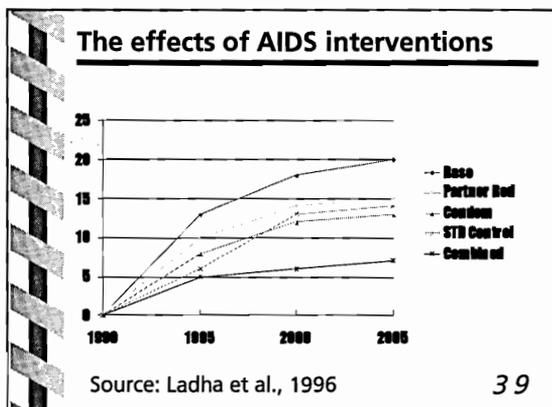
Planning & implementation steps	Measurable indicators	Effects & short-term impact
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35

- ### Sources of data for decision making and evaluation
- Situation analyses & special studies
 - Service statistics & training records
 - Project proposals & workplans
 - Client interviews, focus group discussions
 - Clinic inventories
 - Supervisory visit reports
 - Other program documents
- 36

- ### Output evaluation indicators - Clinic
- # of service providers trained in integrated service delivery
 - # of training sessions for service providers
 - # of youth, women, men served
 - # of community sensitization meetings held
 - # of service providers doing risk assessments
 - # of peer educators trained in STD/HIV/AIDS prevention/counseling
 - # of service providers who practice correct management of STDs
- 37

- ### Short-term impact indicators - Clinic
- Changes in fertility rates
 - Decline in STD/HIV/AIDS cases
 - Change in community perception of STD/HIV/AIDS
 - Reduction in gaps of unmet need for FP and STD/HIV/AIDS
 - Increase in spousal/partner communication on RH issues
 - Decline in proportions of population at risk
 - Percent reduction in STD incidence
 - Decline in number of sexual partners, especially among men
- 38



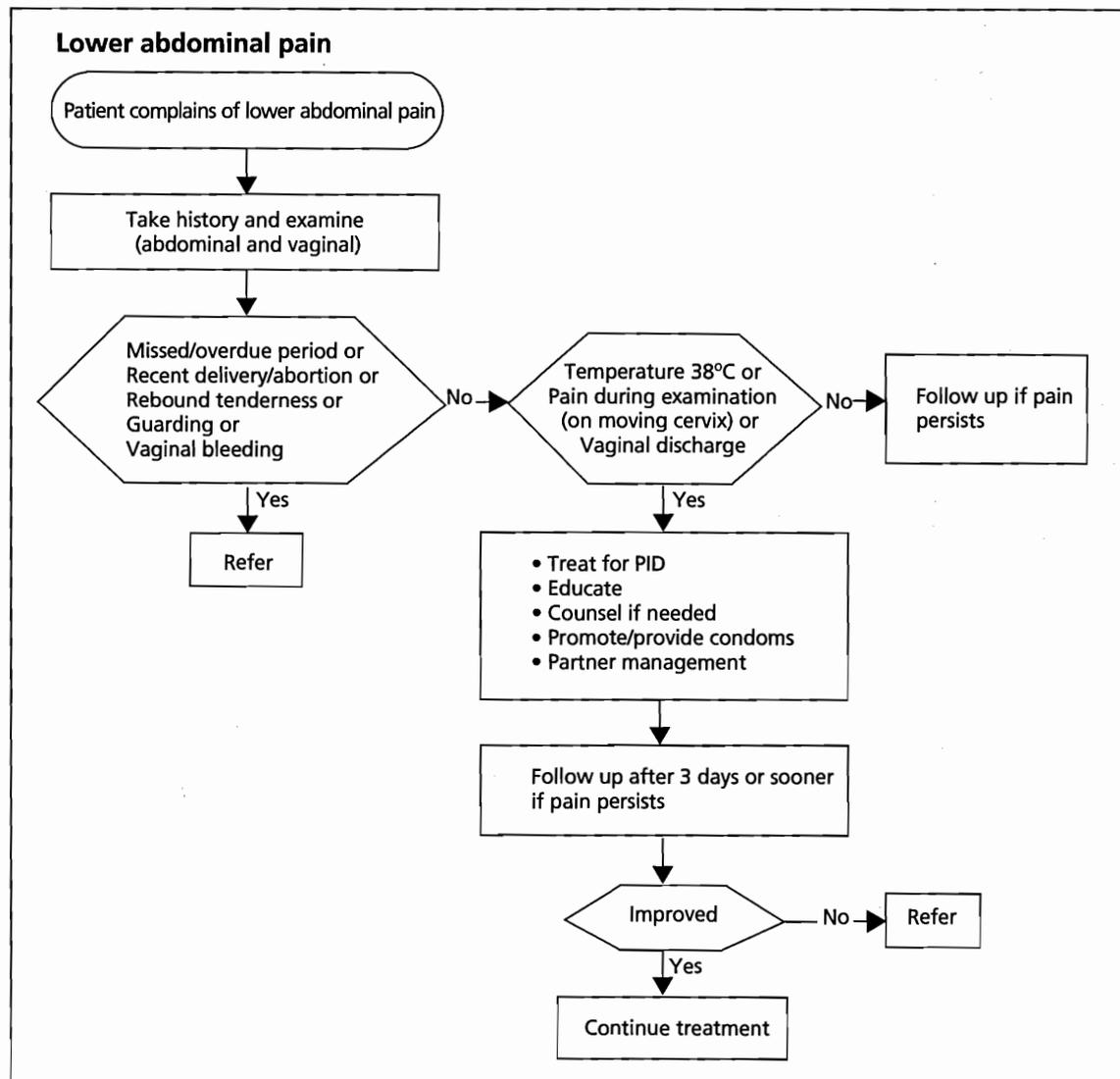
- ### We don't have all the answers yet
- Studies on risk assessment
 - Guidelines & protocols for service delivery
 - STD drugs studies
- But we have to start now to meet the challenge of HIV/AIDS**
- 40

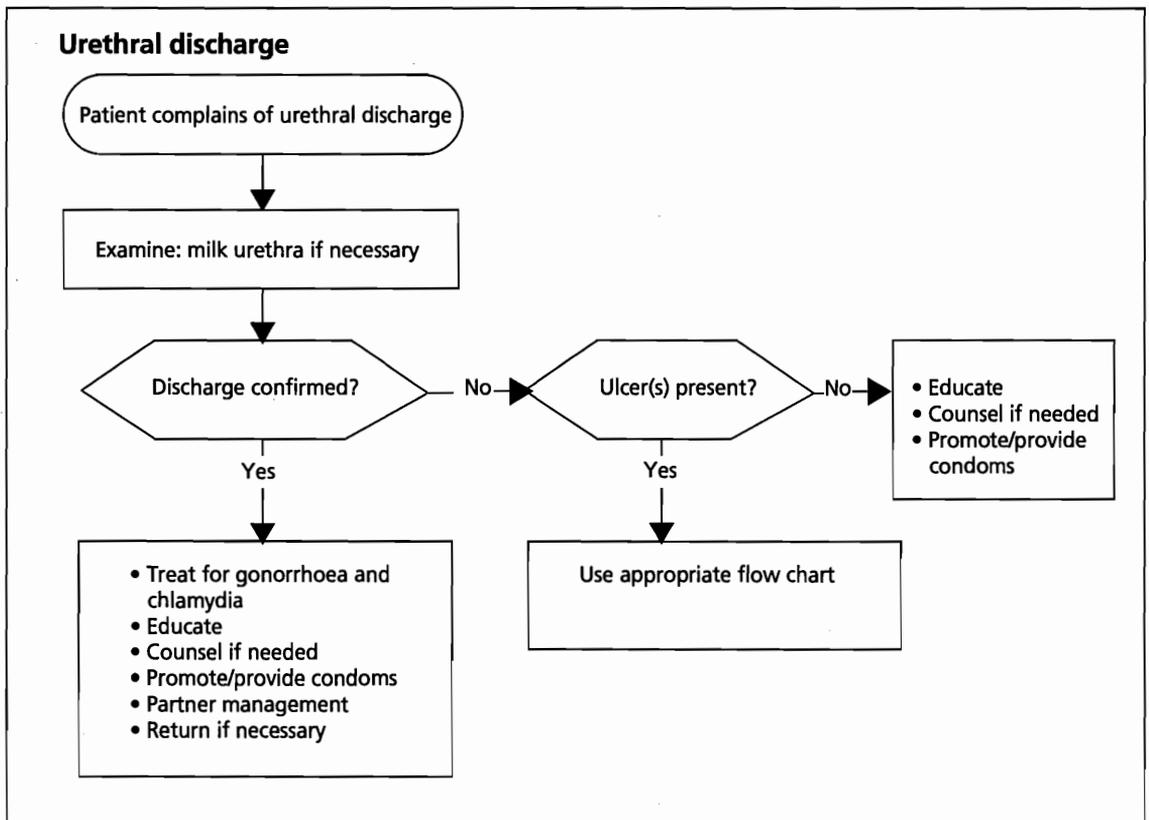
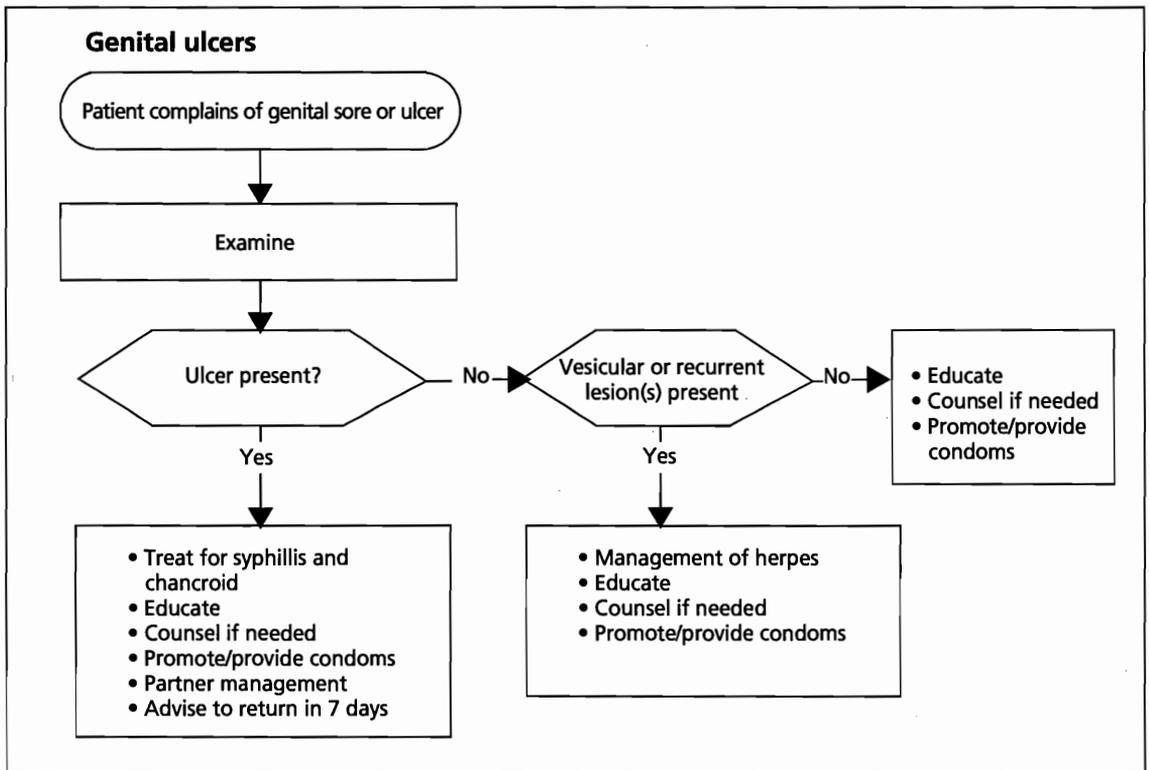
Annex B: Sample diagnostic algorithms

Algorithms or flow charts are simple graphic representations of the steps to take in the management of diseases and conditions. To use an algorithm, identify the presenting symptom and choose the appropriate chart for that condition. Answer questions/follow instructions on the chart, and then follow the arrows for diagnosis and management of the condition.

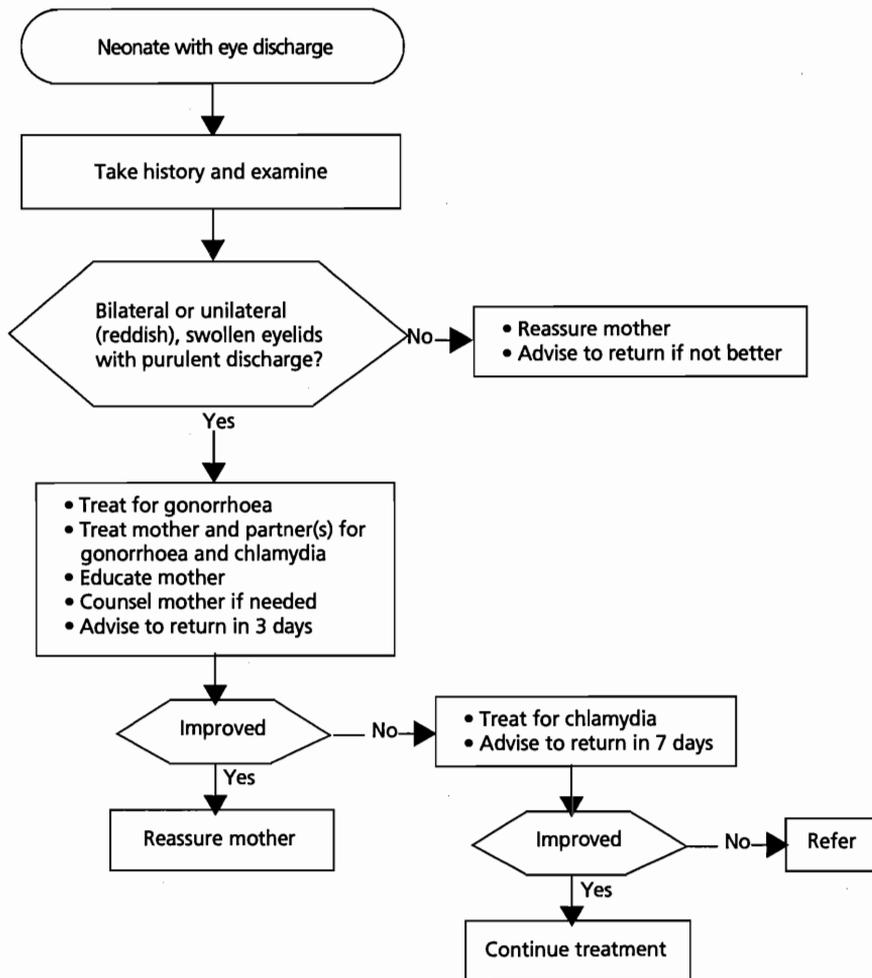
The primary advantage of algorithms or flow charts is that they allow rational choices of treatment even in the absence of laboratory analysis. The treatment regimens are based on the known patterns of drug resistance and the organisms that cause the condition in question. A big disadvantage is that they may result in prescribing unnecessary antibiotics. Moreover, as noted earlier, they are not reliable for managing certain conditions, like vaginal discharge.

WHO has developed diagnostic algorithms for a number of sexually transmitted diseases as part of the worldwide effort to find low-cost treatment of STDs, which are implicated in the spread of the HIV/AIDS epidemic. The samples below are from the booklet *Management of Sexually Transmitted Diseases* prepared by the Global Programme on HIV/AIDS.

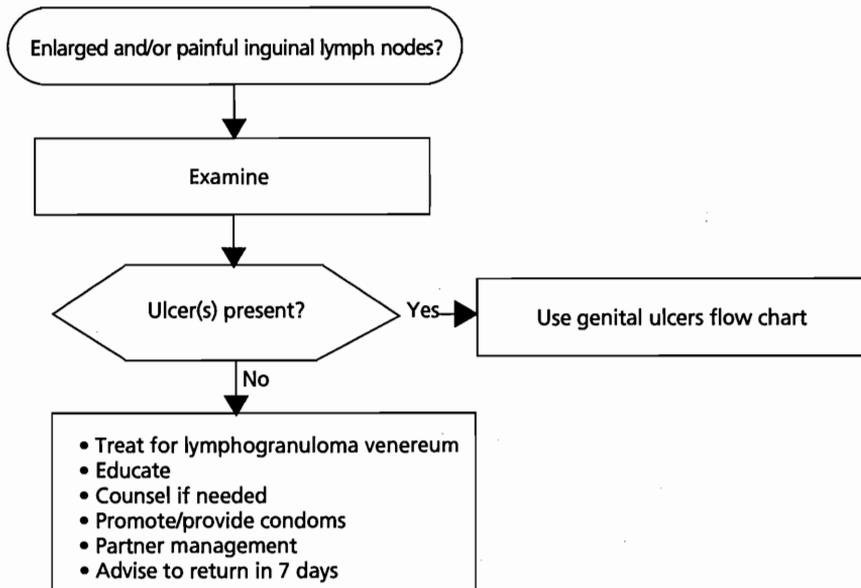




Neonatal conjunctivitis



Inguinal bubo



Annex C: Client risk assessment guide

Risk assessment is simply a checklist of questions on demographic, behavioral, clinical, and related factors. Questions cover such issues as the client's age and number of sexual partners, whether the client has had a new partner in recent months, has had a previous STD infection, has symptoms such as a discharge or abdominal pain, whether the client's partner has symptoms or other sexual partners, and whether the partner travels frequently.

Risk assessment is a practical tool that provides a unified pathway for integrated reproductive health services. It can yield information to assess the likelihood that individuals are currently infected with a STD or are at high risk of future infection. Results may also be used to help facilitate proper and effective STD clinical management, STD/HIV/AIDS counseling, and appropriate family planning counseling. Such an assessment can help make the most cost-effective use of increasingly limited resources.

Here are some samples of a very simple risk assessment to determine a patient's risk for STD/HIV using the following criteria (adapted from WHO) as a tool to focus prevention counseling and help guide the management of STD:

Criteria	Score
Age <21	1
Living apart from partner	1
Partner with symptoms	2
New partner in last 3 months	1
More than 1 partner in last 3 months	1

A positive risk assessment—meaning that the client is indeed at risk—was defined as a total score of 2 or more.

A Client A is an 18-year-old man whose steady girlfriend is away at university. He sometimes occupies himself with women he meets at bars, and last week went home with a woman he met at a party. He has come to the clinic complaining of urethral discharge.

Client A's age, absent primary partner, multiple partners, and new partner in the last three months give him a risk rating of 4. He is not only at risk, he is probably already infected with an STD. He requires immediate treatment for his condition and counseling for behavior change, plus a supply of condoms and instructions on their use.

B Client B is a woman of 35 years who has four living children. She has no partner except her husband. Her husband, however, is frequently away from home on business, and she suspects that he sees other women during his travels. The husband is expected home for a protracted stay, and she has come to the clinic seeking a reliable family planning method. She has no overt symptoms that she is aware of.

Client B's absent partner gives her a risk rating of 1. Because she is not fully aware of her husband's sexual activity when he is away from home, she needs not only advice on an appropriate family planning method, but also counseling about how to protect herself from STD/HIV infection when he returns.

The chart on the next page presents a list of questions that clinical officers can use to assess the risks their clients face. The list may be adapted to specific local usage, but it should be comprehensive enough to cover many possible circumstances.

Client risk assessment guide (women)*

Check (✓) Appropriate Answer

Questions	YES	NO	Don't know
1. Does your employment/major source of income activity involve traveling and staying away from home frequently?			
2. Have you stayed away from home for a month or more in the past three months?			
3. Have you stayed away from home in the past four weeks?			
4. Do you have a regular sex partner? By regular sex partner I mean someone you had a relationship for at least one year [for married women, other than spouse]			
5. For how long have you known your spouse (regular partner)? Years:			
6. Does your spouse's (regular partner's) employment/major source of income activity involve traveling and staying away from home frequently?			
7. Has your spouse (regular sex partner) stayed away from home for more than a month in the past three months?			
8. Has your spouse (regular partner) stayed away from your home in the past four weeks?			
9. Does your spouse (regular partner) go out to drink alcohol at least once a week?			
10. Do you go out to drink alcohol at least once a week?			
11. Some men have sex with more than one woman. Do you think that your spouse (partner) has sex with women other than yourself?			
12. Do you think that you are at an increased risk of getting an STD infection?			
12a.If yes to Q12. Why do you think that you are at increased risk?			
13. Do you think that you are at increased risk of getting HIV infection?			
13a.If yes to Q13. Why do you think that you are at increased risk?			
14. Do you think that you might be having an STD infection currently?			
14a.Have you been treated/or sought treatment for an STD in the past 12 months?			
15. Have you experienced (Read from list below —) the past 12 months before coming to the clinic today?			
Lower abdominal pain			
Foul smelling vaginal discharge			
Purulent vaginal discharge			
Blood stained vaginal discharge			
Post coital bleeding			
Painful sexual intercourse			
Pain on passing urine			
Genital ulcers/wounds			
Swellings in groin			
Sores/wounds in the mouth			
Skin rashes			
16. Does your partner currently have or has he had any of the following...in the past four weeks?			
Lower abdominal pain			
Purulent urethral discharge			
Pain on passing urine			
Wound/sores in the genital area			
Swellings in the groin			
Wounds/sores in the mouth			
Skin rash			
Treatment for STIs			
Antibiotic treatment (Capsules or injection)			
17. When was the last time you had sexual intercourse?	Day	Month	Year
18. Have you had more than one sexual partner in the past three months?			
19. Have you had more than one sexual partner in the past four weeks?			
20. With whom did you have sex the last time?			
Spouse			
Regular partner			
New partner			
Other			
21. Did your partner use a condom the last time you had sexual intercourse?			
22. (If last partner not spouse) Did you receive or give money or other types of gifts the last time you had sex?			
23. Have you used any intra-vaginal preparations for the purpose of constricting and/or drying the vagina to prepare yourself for sexual intercourse in the past three months?			

* Adapted from a tool presented by the Population Council

Annex D: Sample supervisory checklists

Effective supervision encompasses a broad range of activities that are critical to improving the quality of care. But supervisory visits are often short, and may not be frequent enough for the supervisor to keep all the various aspects in mind. Supervisors need consistent, easy-to-follow guidelines for various aspects of service delivery that need their attention, and a standardized tool for tracking performance in those areas. The sample checklists below focus on selected aspects of typical RH programs; other checklists are available or can be developed for other types of programs.

CBS program supervision checklist

Person completing this form: _____ Date of visit: _____
 Project site: _____

	Exceeds Standards	Acceptable	Unacceptable	Remarks/Problems Recommendations	Follow-up Needed/Taken
<i>Community Mobilization/Outreach</i>					
Staff meet regularly with community leaders and groups to discuss health needs, issues					
Mechanism for systematic community input					
Community financial, in-kind support					
Project staff aware of important institutions, other providers in community					
Project staff appear at events to discuss RH health issues, STD and HIV prevention project services					
Project staff has access to up-to-date data about community					
Project staff have identified groups at high risk					
Project staff have developed outreach plans for high risk groups in community					
Project aware of community knowledge, attitudes, practices, cultural norms, values and use this information in planning and delivering services.					
Project has written outreach plan					
<i>CBS Supervisor</i>					
Makes regular supervisory visits by schedule					
Identifies additional CBS support needs					
Reviews CBS agent reports for accuracy and completeness.					
Prepares/submits accurate, complete reports					
Provides on-the-spot TA to agents (including STDs, RH, and HIV)					
Assists agents in conducting community diagnoses					
Assists clinical providers in identifying RH trends in community					
Gives integrated IEC and health talks in clinic and community					
Keeps adequate records and manages, distributes, determines needs for commodities					
Develops annual workplan for area/agents supervised and monitors agents' plans					
Reviews CBS performance with agents regularly and gives feedback					
Serves as liaison with other community groups					
Assists in managing client referrals and follow-up (including contact tracing and partner notification)					
Assists in distributing supplies and equipment (if relevant)					
Collects and reports proceeds from social marketing and other income-generating activities on monthly basis					
Conducts meetings with CBS agents regularly					

Facility management checklist*

Name of Health Facility: _____ Date : _____ Facility code : _____
 Supervisee(s): _____ Supervisor(s): _____

Note: Most of the areas that you will supervise will require you to discuss the issue with the relevant service provider. In several places it will be necessary for you to verify comments with direct observation and by reviewing records and registers. **Flag indicators are in bold italic.**

ADMINISTRATION	YES	NO	COMMENTS
1. <i>Does the facility have a written (annual) workplan?</i>			
3. <i>Are the activities on the workplan on the schedule?</i>			
5. <i>Does the facility have the guidelines and standards required for management of clients/patients?</i>			
SUPERVISION	YES	NO	COMMENTS
1. <i>Are there checklists for supervision of the different activities in the facility and are they being used? (check for completed checklists)?</i>			
3. <i>Is there any documentation of the action taken as a result of supervision?</i>			
4. <i>Are staff doing self assessment on the quality of health services provided in the health facility?</i>			
FINANCIAL MANAGEMENT	YES	NO	COMMENTS
2. <i>Are all cash books posted and up to date?</i>			
3. <i>Are all cash books reconciled to bank statement and vote books?</i>			
7. <i>Are the user fees clearly posted and visible to the clients?</i>			
OTHER RECORDS/REGISTERS	YES	NO	COMMENTS
1. <i>Are accurate stores records being kept (bin card/ledger)?</i>			
CLIENT CARDS	YES	NO	COMMENTS
1. <i>Review 3 client cards for each of the following services to determine if they have been completed accurately and according to guidelines:</i>			
a. Antennatal card			
b. Family planning card			
c. Child health card			
d. STI card			
e. Referral card			
f. TB card			
g. In-patient card			
HEALTH FACILITY	YES	NO	COMMENTS
5. <i>Does the facility have clean latrine/toilets for staff and clients?</i>			
6. <i>Does the facility have and use sanitary disposal for refuse and waste (placenta pit, indinerator, rubbish pit, etc.)?</i>			
MANAGEMENT OF UNDER 5 CHILDHOOD ILLNESSES	YES	NO	COMMENTS
2. <i>Review each of the last 10 cases of malaria, pneumonia, and diarrhea with dehydration, among under 5s, and determine if there was proper case management and recording according to the guidelines.</i>			
IMMUNIZATION	YES	NO	COMMENTS
2. <i>Do the staff maintain a proper cold chain?</i>			
3. <i>Is EPI data collected monthly being utilized at the facility level, e.g., to calculate coverage and to determine supplies and other resources required?</i>			
NUTRITION	YES	NO	COMMENTS
3. <i>Are there facilities for nutrition demonstrations in the health unit?</i>			
TB	YES	NO	COMMENTS
4. <i>Does the facility have a functional lab for testing sputum smear?</i>			
REPRODUCTIVE HEALTH	YES	NO	COMMENTS
2. <i>Is there a qualified midwife in the health facility (if H/C)?</i>			
7. <i>Were there any maternal deaths in the last 6 months? (List number in the comments column and the causes.)</i>			
OTHER PUBLIC HEALTH INTERVENTIONS	YES	NO	COMMENTS
1. <i>Does the facility have emergency preparedness plans and budget to deal with emergency outbreaks in the community?</i>			

REFERRALS	YES	NO	COMMENTS
1. Is this health facility receiving very late referral in the following areas: a. Delivery care b. Malaria c. Malnutrition			
SURVEILLANCE	YES	NO	COMMENTS
1. Does the facility maintain surveillance system for the following: a. Malaria b. TB c. Diseases of epidemic potential c. Malnutrition			
INFECTION PREVENTION AND CONTROL	YES	NO	COMMENTS
1. Is the facility able to provide adequate infection control in the following areas: a. Hand washing b. Sterilization of equipment c. Disposal of contaminated waste d. Disposal of sharps and needles e. Soiled linen 4. Are the following areas being maintained as clean service environments: a. Delivery room b. Operating theatre c. Wound dressing areas 5. Is there clear evidence that the service providers are using new gloves with each new patient?			
HIV/AIDS	YES	NO	COMMENTS
1. Is there a health worker trained in basic counseling skills for HIV/AIDS at this health facility? 2. Is there collaboration between the facility staff and NGOs in the community involved in HIV/AIDS control/patient care?			
MENTAL HEALTH AND MEDICAL REHABILITATION	YES	NO	COMMENTS
2. Are PWDs identified, managed and/or referred to the appropriate levels?			

* Excerpted from tool developed by the DISH project.

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Pathfinder International
Africa Regional Office
PO Box 48147 • Nairobi • Kenya
Tel: (254-2) 224154 • Fax: (254-2) 214890
information@pathfind.org