Republic of Kenya

National Reproductive Health and HIV and AIDS Integration Strategy

August 2009

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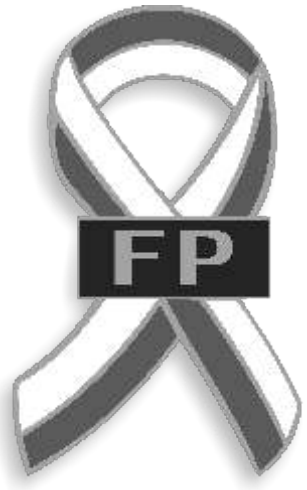

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
AOP	Annual Operating Plan
ARH	adolescent reproductive health
ART	antiretroviral therapy
ARV	antiretroviral
CBD	community based distributors
CBO	community-based organisation
CBRH	community based reproductive health
CCC	comprehensive care centre/clinic
CT	counselling and testing
DRH	Division of Reproductive Health
EC	emergency contraception
FANC	focused antenatal care
FBO	faith-based organisation
FP	family planning
HBC	home-based care
HCBC	home and community based care
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IUCD	intrauterine contraceptive device
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
KNASP	Kenya National HIV and AIDS Strategic Plan
M&E	monitoring and evaluation
MCH	maternal and child health
MDG	Millennium Development Goal
MIS	management information system
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Programme
NHIF	National Hospital Insurance Fund
NRHP	National Reproductive Health Policy
NRHS	National Reproductive Health Strategy
OI	opportunistic infection
OVC	orphans and vulnerable children
PAC	post-abortion care
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
RH	reproductive health
RTI	reproductive tract infection
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
TFR	total fertility rate
USAID	United States Agency for International Development
VCT	voluntary counselling and testing

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FOREWORD

The National Health Sector Strategic Plan II 2005-2010 seeks to ensure that health service delivery is made more effective and accessible. The Kenya Essential Package for Health recommends the integration of health programmes into a single package that focuses interventions towards the improvement of health at different levels of the human development cycle.

Reproductive Health and HIV services have similar characteristics, target populations and desired outcomes. Client seeking HIV services and those seeking RH services share common needs and concerns and integrating services will enable health care service providers to efficiently and comprehensively address them. FP programs are good entry points for most of the STI and HIV and reproductive cancer services, and vice versa. Strong linkages will help to ensure that the RH needs and aspirations of all people including people living with HIV are met. Integrated services are a good approach to access the hard-to-reach, including men and youth and may help overcome the challenges posed by stigma and lack of male involvement which may be associated with stand-alone HIV and AIDS or FP services. This justifies the need to create synergies between the two programmes in order to address missed opportunities in HIV prevention and care as well as in RH care across the service delivery levels.

This RH and HIV strategy seeks to lay a framework for the integration of RH and HIV services. The aim of integration is to provide more comprehensive, convenient , acceptable and cost effective RH and HIV and AIDS programmes at all service delivery points/levels. Integrating RH and HIV and AIDS policies, programs and services have been considered essential for meeting international and local goals and targets including the United Nations Millennium Development Goals particularly goal 4,5 and 6.

The strategy provides the necessary framework for provision of coordinated RH and HIV integrated services across the two programmes.

We wish to appreciate the contributions and efforts of all individuals, organizations and stakeholders who gave their valuable time, inputs and feedback during the development process to ensure the strategy was all inclusive.

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PREAMBLE

The integration of reproductive health (RH) and HIV and AIDS involves restructuring and reorienting health systems to ensure the delivery of HIV and AIDS services within the same sexual and reproductive health (SRH) services or delivery of SRH services within HIV and AIDS services, during the same hours. This strategy aims to provide a coherent framework to ensure improved coordination and collaboration among key agencies and organisations offering integrated RH and HIV and AIDS services. It identifies priority activities for major implementers of RH and HIV and AIDS programmes to provide sustainable integrated RH and HIV and AIDS services. This strategy elaborates on the relevant provisions in the 2007 Kenya Reproductive Health Policy, Kenya National AIDS Strategic Plan III, and National Health Sector Strategic Plan II.

The goal of this strategy is to increase access to comprehensive, high-quality, effective, efficient, affordable, and sustainable RH and HIV and AIDS services. To achieve the desired goal and objectives, the following key strategies are envisaged:

- Strengthening systems to improve the performance and quality of service delivery, with a major focus on institutional capacity building at all levels of service delivery
- Supporting evidence-based advocacy and policy dialogue among the stakeholders and the policy elite
- Building a knowledge base through an effective monitoring and evaluation system and supporting research for continued learning
- Sustaining resource mobilisation and accountability
- Promoting, strengthening, and coordinating partnerships and collaboration with relevant stakeholders through continued information sharing among practitioners

The lessons learnt from various pilot programmes in Kenya and elsewhere in Africa suggests that the programming for RH and HIV integrated approaches must be tailored to the specific context because not all HIV services need to be integrated with RH services and vice versa. At the same time, integration may not be appropriate in every setting. Programme implementers need to consider the possible synergies from integration in each particular context. However, this strategy outlines the service delivery levels and corresponding service areas with respect to the provision of reproductive health and HIV and AIDS and the services that can be integrated.

In view of limited resources but a high demand for relevant services, it is important to plan programmes and services that reach as much of the targeted population as possible. Partnerships and networks providing the infrastructure support and leadership for going to scale should be involved in such processes. Therefore, effective implementation will require the coordination and documentation of lessons learnt, appropriate support for human resources development, community participation, and leadership. The players in the coordination shall include but are not limited to; The Ministry of Medical Services and the Ministry of Public Health and Sanitation but also involve collaboration at different levels of government, civil society organizations, private sector and the communities. The Ministry of Medical Services and the Ministry of Public Health and Sanitation, through the Division of Reproductive Health and the National AIDS and STD Control Programme, will ensure that there is adequate capacity in terms of staffing; that equipment, supplies and standards are maintained.

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND

Kenya's population is currently an estimated 37.4 million, with an annual growth rate of about 2.9 percent per annum (which is still considered to be high). The population is expected to reach 42 million by 2012. The results of high growth rates in the 1970s and early 1980s created a youthful population, with nearly half of the population under age 18.

The rapid rise in Kenya's fertility levels in the early 1970s, reaching a total fertility rate (TFR) of 8.1 (one of the highest in the world), was followed by a rapid decline in the 1980s, reaching a TFR of 4.7 in 1998. However, results of the 2003 Kenya Demographic and Health Survey (KDHS) showed that further fertility decline had stalled at a TFR of about five children per woman. Regional differentials indicate that most of the provinces, except Central and Coast, experienced an increase in fertility, with Nyanza Province recording the highest increase. The contraceptive prevalence rate among married women for all methods rose from 27 to 39 per cent between 1989 and 1998. The unmet need for family planning is estimated at 24 per cent, largely due to inadequate service provision and poor access to family planning (FP) commodities. Despite the impressive decline in the fertility rate in the 1990s, when compared with other sub-Saharan African countries, about one in four women between age 15 and 19 has had a first child.

Kenya experienced a rapid decline in mortality in the 1970s and 1980s. The infant mortality rate declined from 119 deaths per 1,000 live births in 1969 to 88 and 66 in 1979 and 1989, respectively, but increased to 78 in 2003 (CBS, 2004). The life expectancy at birth declined from 58 years to 54 years for males and 61 years to 57 years for females in the last decade. The neonatal mortality rate was estimated at 33 per 1,000 live births in 2003 and 45 per 1,000 live births in 1998. The upsurge in infant and childhood mortality since the 1990s makes it unlikely that the country will achieve the fourth Millennium Development Goal (MDG). Studies on mortality suggest that HIV and AIDS has been a major factor in the rise in mortality in sub-Saharan Africa (Kenya included). Unfortunately, the productive and reproductive segments of the population have been the most affected by the pandemic.

The use of reproductive health (RH) services has declined over time. For example, the proportion of women making the recommended number of antenatal care visits of four and above declined from 64 per cent in 1993 to 52 per cent in 2003, while the proportion receiving skilled care during delivery declined from 45 per cent in 2003 to 42 per cent in 2003. An unmet need for RH services translates into unacceptably high maternal mortality and morbidity levels. The maternal mortality ratio, estimated at about 365 deaths per 100,000 live births in 1995, increased to about 414 deaths per 100,000 live births in 2003.

HIV and AIDS, first diagnosed in Kenya more than two decades ago, spread rapidly in the 1990s. Although HIV prevalence appears to have declined in the early 2000s, the rate remains high and is now more pronounced among young people between ages 15 and 25. There are also wide regional and social class differentials.

The Kenya AIDS Indicator Survey (KAIS) estimated the HIV prevalence rate among adults ages 15–49 to be about 7.8 per cent, compared with 6.7 estimated by the 2003 KDHS. Women are more disproportionately infected (8.7%) compared with men (5.6%). Approximately 1.4 million people are currently living with HIV. Nearly 1 out of 10 pregnant women in Kenya are HIV positive (9.6%), with

minimal differences by urban and rural residence. In 2003, the KDHS estimated that HIV prevalence among pregnant women was 7.3 per cent. About 83 per cent of HIV-positive people do not know their HIV status, while 26 per cent of those who reported themselves uninfected tested positive. However, there has been an increase in HIV testing among women in part due to prevention of mother-to-child transmission (PMTCT) services and testing in antenatal clinics. About one-third of women who reported having ever tested said they were tested at an antenatal clinic. The unmet need for antiretroviral therapy (ART) is about 18 per cent among adult Kenyans who are HIV positive. Unmet need is largely attributed to a low level of awareness of HIV status among those infected. As a result of the KAIS report, the government intends to respond by implementing a series of rapid HIV testing campaigns targeting adults.

Kenya has made several institutional and policy responses to address HIV and AIDS. As a result of establishing the AIDS Control Committee in the Ministry of Health in 1987, a five-year strategic plan (1987–1991) for AIDS control was launched, followed by sessional paper number 4 of 1997 to provide a framework for service provision advocacy efforts. Since then, a marked improvement in service provision has revolutionised care, particularly the prevention of mother-to-child transmission.

Although the government has increased its commitment to the promotion and provision of adequate RH and HIV and AIDS services, several factors—such as social and cultural beliefs and practises, lack of women's empowerment, lack of male involvement, poverty, and weak health management systems—impede the demand for and use of these services.

Kenya experienced poor economic growth in the 1990s, leading to the deterioration of the welfare of majority of the population. This resulted in slightly more than half of the population living below the poverty line. However, the economic and structural reforms established in 2003 led to growth in real gross domestic product from 2.8 per cent in 2003 to 7 per cent in 2007. Positive change in the economic growth resulted in the proportion under the poverty line to decline from 56 per cent to 46 per cent in the 2003–2007 period. However, due to several factors, such as the post-election violence and the global rise in fuel cost and food prices, the GDP growth rate is expected to decline to 4.5 per cent by the end of 2008 but is projected to reach 10 per cent by 2012. Poor economic outcomes affect the investment in high-quality health services and, at the same time, reduce the opportunities for individuals to use the services.

1.2 HEALTHCARE CHALLENGES

The health sector has undergone a number of reforms since the 1990's due to various challenges, such as poor economic performance, rapid population growth, and weak health systems Sexual and reproductive health provision in Kenya has been guided by the 1994 International Conference on Population and Development (ICPD); 1995 Fourth International Conference on Women; post-Cairo ICPD (ICPD+5 and ICPD+10); and the Millennium Declaration of 2000. As a result of these international agreements, Kenya formulated the National Reproductive Health Strategy (NRHS) in 1997 and the National AIDS Strategic Plan.

The NRHS 1997–2010 has been guiding implementation of the country's RH programme but has faced numerous challenges, especially inadequate funding. This has led to deterioration in the quality of health service delivery, resulting in negative health indicators. Over the past decade, funding for family planning has plummeted, while HIV and AIDS allocations have soared. For example, the U.S. Agency for International Development (USAID)/Kenya one of the leading supporters for the Kenyan population programme, cut its support for family planning by one-third from 1995 to 2002, while increasing its

funding for the HIV and AIDS programme six fold. In 2004, USAID budgeted US$35 million for HIV and AIDS and US$6 million for family planning in Kenya.

A key challenge to attaining the ICPD and MDG is Kenya's limited capacity to manage health programmes, stemming from a shortage of skilled health workers, inadequate budgetary provision, and weak procurement and supplies systems, among other critical management problems. These aspects of healthcare provision have also been acknowledged in the First Medium-Term Plan of 2008–2012 of the Vision 2030.

Access to FP/RH services by disadvantaged groups such as people living with HIV (PLHIV), youth, and people with disabilities has also been a challenge due to stigma and discrimination as well as inadequate provider and community support for the provision of SRH services to these population groups.

The core principles of Kenya's National HIV and AIDS Strategic Plan 2005/6–2009/2010 include a focus on gender and youth. Among the services recommended are youth-friendly HIV and RH information and other services. Despite this acknowledgement, only 12 per cent of facilities are youth friendly according to the 2004 Kenya Service Provision Assessment. Its second priority area stresses improvement of the quality of life of people infected and affected by HIV and AIDS. A key initiative here is ensuring that counselling on legal, treatment, and reproductive health rights is included in the comprehensive care services package offered to PLHIV. The National Reproductive Health Policy (NRHP) 2007 recognises that the continued unmet need for RH services among HIV-positive people remains a challenge. About half of HIV-positive women have an unmet need for family planning. To achieve some of the objectives in this priority area, the NRHP 2007 seeks to integrate HIV and AIDS services into expanded RH care and vice versa. The aim of integration is to provide more comprehensive, convenient, and hence more acceptable, cost-effective RH and HIV and AIDS programmes at all service delivery points/levels, where appropriate.

1.3 LESSONS LEARNT FROM PREVIOUS REPRODUCTIVE HEALTH/HIV INTEGRATION EFFORTS IN KENYA

The process of integrating RH and HIV services commenced in Kenya more than a decade ago. Initial efforts included the integration of counselling and testing for pregnant women attending antenatal services (PMTCT). Later efforts included the integration of FP into voluntary counselling and testing (VCT) services and counselling and testing (CT) into FP with the goal of "maximising on the opportunities provided by VCT and FP services to reach out to women, men, and couples with these services using a more cost-effective and sustainable approach." The FP/VCT Strategy adapted the following working definition of integration: "the incorporation of some or all of the different FP services into existing VCT services and vice versa."

The recommended FP/VCT integration included four levels of integration (depending on resources and level of provider training and skills):

- Level 1: Condoms and pills
- Level 2: Condoms, pills, and injectables
- Level 3: Condoms, pills, injectables, and intrauterine contraceptive devices (IUCDs)
- Level 4: A full range of contraceptive methods

All levels of integration should involve a risk assessment for pregnancy and STI/HIV infection,

information and counselling on FP methods, and referrals of clients to services not available at the VCT facility.

The recommended HIV/FP service integration included two levels of integration of VCT into FP services.

Level 1
- Risk assessment for STIs and HIV
- Information, education, and communication on VCT and availability of VCT centres
- Referral to other appropriate services

Level 2
- All VCT services in Level 1
- HIV counselling and testing

In addition to the provision of VCT and FP integrated services at various levels of service delivery, the country has developed materials for integrating FP and STI services comprehensive care centres (CCC).

Integration Challenges

Integration efforts have been hampered by a lack of (1) evidence; (2) best practises documentation; (3) scientific evaluations on which methods of integration are most effective and how these methods are best operationalised; and (4) coherent national policies, guidelines, and strategies. A lessons learnt survey on both RH and HIV programmes, policy analysis, and other studies in Kenya and other sub-Saharan African countries reveal the following challenges to the full integration of services:

Financial resources
- Inadequate financial resources to efficiently and effectively integrate services and renovate or expand overcrowded health facilities and no budget line for the integration of services

Structural/systems
- Inadequate commodity security (e.g., frequent commodity stockouts across service delivery points, inadequate contraceptive supplies at VCT sites, and frequent referrals for FP commodities because of systemic issues such as contraceptives requirements for VCT sites not being taken into account when forecasting and procurement exercises are carried out)
- Weak or nonexistent follow-up and feedback systems for referrals, especially for integrated service provision
- Limited space, which also compromises privacy and confidentiality
- Inadequate RH and HIV services targeted to youth, which contributes to increased stigma and discrimination in this high-risk group

Management
- No structure for the supervision of integrated services at all levels
- Weak monitoring and evaluation system to measure the progress of RH and HIV service integration
- Lack of advocacy campaigns to gain and sustain stakeholder support for integration

Human resources
- Inadequate motivation and support for multi-skilled and multi-tasking workers
- Staff shortages
- Lack of pre-service and in-service training of health personnel on components of service integration,

contributing to the negative attitudes exhibited by some service providers
- Inappropriate deployment and frequent rotation of services providers trained in the provision of integrated RH and HIV services making it difficult to maintain the services
- Perception of integration as additional work on top of already heavy workload

Integration Opportunities

In spite of these challenges, several opportunities exist if current services are reorganised through an integrated approach. For example:

- A positive policy environment already exists—most of the current Ministry of Health strategies and guidelines support linkages between RH and HIV programmes.
- Interventions for HIV and AIDS and RH both target sexually active individuals, including hard-to-reach populations (e.g., men, youth, as well as those with special needs such as people with disabilities).
- Existing logistical systems can be used to procure supplies and commodities for both services.
- Existing infrastructure can just be slightly modified to provide integrated RH and HIV services.
- Existing staff can be trained to offer integrated RH and HIV services (e.g., incorporating FP into the VCT training curriculum and vice versa).
- The expansion of HIV and AIDS services, such as PMTCT, VCT, ART, and home-based care (HBC) offers opportunities to satisfy the unmet need for FP/RH among their clients.
- Clients coming in for either RH or HIV services present an opportunity to offer integrated RH and HIV services.
- There are current funding opportunities for integrated RH and HIV services

1.4 JUSTIFICATION OF THE STRATEGY

The government of Kenya is committed to achieving the ICPD and MDG goals to ensure that the adverse RH outcomes as well as AIDS-related pandemic are reversed. The First Medium-Term Plan of Vision 2030 acknowledged the growing concern of reversals in RH gains made in the 1980s and early part of 1990s. In addition, the 2007 NRHP seeks to operationalise the ICPD Programme of Action (PoA) and the Maputo Plan of Action on Sexual and Reproductive Health and Rights in joint partnerships under the Sector-Wide Approach process. Several recent international agreements, such as the New York Call to Commitment 2004 and Glion Call to Action 2004, recognise that both SRH and HIV and AIDS initiatives must reinforce each other and that stronger linkages between the programmes will result in more relevant and cost-effective programmes with greater impact. Within this framework, the second National Health Sector Strategic Plan of Kenya (NHSSP) II 2005–2010 seeks to ensure that health service delivery is made more effective and becomes accessible to as many people as possible. It's Essential Package for Health (KEPH) recommends the integration of all health programmes into a single package that focuses interventions towards the improvement of health at different phases of the human development cycle.

It is now widely recognised that linking RH and HIV and AIDS policies, programmes, and services is of great importance to essential healthcare service delivery. First, clients seeking HIV and AIDS-related services and those seeking RH services share common needs and concerns. Second, a stronger linkage

National Health Sector Strategic Plan II (2005–2010); Kenya National Reproductive Health Strategy (1997–2010); National Reproductive Health Policy, 2007; Family Planning Guidelines for Service Providers, 2005; National HIV and AIDS Strategic Plan 2005/6–2009/2010; Health Sector HIV and AIDS Strategic Plan 2005–2010; VCT Policy, 2001; Strategy for the Integration of HIV Voluntary Counselling and Testing and Family Planning Services, drafted in 2004 and adopted in 2008; Guidelines to Antiretroviral Drug Therapy in Kenya, 2001; National PMTCT Guidelines, 2002; National Home-Based Care Programme and Service Guidelines, 2002; Adolescent Reproductive Health and Development Policy, 2005.

between RH and HIV and AIDS ensures that the RH needs and aspirations of PLHIV are met. Third, linking RH and HIV policies, programmes, and services is an integral strategy in meeting the MDGs.

1.5 OBJECTIVE OF THE STRATEGY

This strategy therefore aims to improve coordination and collaboration among key agencies and organisations offering RH and HIV and AIDS services in order to meet the needs of clients. It also seeks to identify priority interventions for major implementers of RH and HIV and AIDS programmes and provide an avenue and basis for resource mobilisation and management of sustainable integrated RH and HIV and AIDS services.

1.6 PROCESS OF DEVELOPING THE STRATEGY

The development of this strategy document involved several steps, namely (1) conducting rapid assessments to assess lessons learnt, best practises, and the benefits that could be obtained from the pilot programmes on the integration of services; (2) conducting desk reviews using available literature from Kenya and other countries; (3) holding consultative meetings with the key stakeholders; (and 4) drafting the status report that informed the strategy's development and writing of narratives based on agreed goals, objectives, strategies, and possible key interventions.

A review was conducted of available relevant documents on national policies, strategies, and implementation plans yielded the necessary information for developing the strategy, allowing for harmonisation and linkages between this strategy and ongoing efforts in addressing both the RH and HIV and AIDS needs of people in the country. The development process was highly consultative and involved various stakeholders.

CHAPTER 2: INTEGRATION STRATEGIES

2.1 INTRODUCTION

Integrating RH and HIV and AIDS services involves the reorientation of health systems to ensure the delivery of HIV and AIDS services within the same setting for SRH services or the delivery of SRH services within HIV and AIDS services setting—during the same hours and where providers encourage clients/patients of one service to take up the other within the facility or community-based setting or through a facilitated referral. Majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth, and breastfeeding. Closer linkages between RH and HIV and AIDS services can address some missed opportunities in HIV prevention and care as well as in RH care. There are also many similarities between the two—both programmes

- Serve similar target groups and rely on effective prevention messages and methods;
- Promote and distribute condoms within and outside clinics and other health services;
- Require services that use similar healthcare skills and facilities
- Rely on community participation to address sensitive sexuality issues and socio-cultural determinants of behaviour change;
- Desire common outcomes such as improved gender equality and equity and a reduction in maternal, infant, and child mortality; and
- Address the vulnerability and high-risk behaviours of young people that fuel the epidemic in this age group, as well as early child bearing and high maternal mortality contributing to high infant mortality.

2.2 POLICY IMPERATIVE

The principles of NHSSP II 2005–2010 are grounded in a fundamental respect for human rights and community participation, and its objectives include the following:

- Increase equitable access to health services
- Improve the quality and responsiveness of services to client needs
- Improve the efficiency and effectiveness of service delivery
- Foster partnerships in improving health and delivering services

The KEPH seeks to ensure that all health programmes are integrated into a single package. Similarly, the NRHP 2007, while echoing the objectives and principles of the NHSSP II and the Kenya Health Policy Framework 1994, noted that RH and HIV and AIDS services offer certain advantages if planned and provided in an integrated way.

2. 3 GUIDING PRINCIPLES

The guiding principles determine the strategy's priorities, the design of the interventions, and the approach of the integration. These principles derive from the Health Care Policy Framework 1994, the NHSSP II, the NRHP 2007, and the Kenya National HIV and AIDS Strategic Plan (KNASP II) 2005–2010. Therefore, the policies and programme actions necessary for effectively integrating RH and HIV and AIDS services need to be built on the following principles:

- Focus on human rights. Human rights and freedoms must be respected by all regardless of age,

race, religion, culture, and socio-economic status. In this respect, people with disabilities, youth, adolescents, and people in hard to reach areas are especially vulnerable, and their rights need to be taken into account. The sexual and reproductive rights of all people, including PLHIV, need to be emphasised, as well as the rights of marginalised populations, such as injecting drug users, men who have sex with men, women having sex with women and commercial sex workers.

- Ensure equitable access to services. A focus on improving equitable access to high-quality services is needed.
- Aim to improve the quality of services and client responsiveness. It is important to increase the demand for services and be fully responsive to the needs of all clients.
- Foster partnerships. Programmes should take a participatory approach that will account for the needs and concerns of all relevant stakeholders.
- Meaningfully involve people living with HIV. PLHIV need to be fully involved in designing, implementing, and evaluating policies, programmes, and research that affect their lives.
- Reduce stigma and discrimination. More vigorous legal and policy measures are urgently required to protect PLHIV and vulnerable populations from discrimination.
- Foster community participation. Young people, key vulnerable populations, and the community at large are essential partners in implementing an adequate response to the challenges and meeting the needs of affected people and communities.
- Promote a coordinated and coherent response. Sexual and reproductive health priorities should be considered within a coordinated and coherent response to HIV and AIDS that builds on the principles of one national HIV and AIDS framework, one broad-based multisectoral HIV and AIDS coordinating body, and one country-level monitoring and evaluation system.
- Promote the use of evidence-based decision making and programming.

2.4 GOAL, OBJECTIVES, EXPECTED RESULTS, STRATEGIES, AND KEY ACTIVITIES FOR INTERVENTION

Goal

Enhanced access to comprehensive, high-quality, effective, efficient, affordable, and sustainable RH and HIV and AIDS services.

Objectives

1. Strengthen the policy environment at all levels for the provision and use of high-quality integrated RH and HIV services
2. Ensure that adequate resources are committed, allocated, availed, and utilized for the effective and sustainable provision of integrated RH and HIV services
3. Strengthen the capacity for provision of integrated RH and HIV services at all levels
4. Strengthen supply chain management systems for RH and HIV commodities at all levels
5. Increase demand for RH and HIV services
6. Strengthen the monitoring and evaluation and reporting systems for the effective tracking and performance assessment and delivery of high-quality integrated RH and HIV services
7 Support operational research, documentation and dissemination to inform the RH and HIV integrated process in line with national priorities.

Strategies

The key strategies applied in the process will include strengthening systems to improve performance and

quality of service delivery, with a major focus on institutional capacity building at various levels. To foster a supportive policy environment and regulatory framework and sustainability, other strategies will include conducting evidence-based advocacy and policy dialogue; building a knowledge base through an effective monitoring and evaluation system, and supporting research. Because additional resources will be required for effective integration, the strategies will also include creating a sustainable resource mobilisation mechanism and ensuring accountability to those that provide resources and to the public. Furthermore, partnerships among the relevant stakeholders will be necessary for achieving effective integration; therefore, it will be necessary to continue promoting, strengthening, and coordinating partnerships between the Ministry of Public Health and Sanitation and the Ministry of Medical Services, in collaboration with relevant stakeholders through continued information sharing among practitioners.

2.4.1 Objective 1

To strengthen the policy environment at all levels for the provision and use of high-quality integrated RH and HIV services.

Expected result
- Clearly articulated and operationalised policies

Strategy 1: Advocacy and policy dialogue

The key strategy will include conducting evidence-based advocacy and policy dialogue to engage stakeholders in order to ensure that integration is placed on the policy agenda at all levels.
Key activities

- Review and revise, as needed, relevant policies, implementation plans, guidelines, and protocols on RH and HIV and AIDS
- Define and harmonise the roles and responsibilities of key coordinating agencies, such as the Division of Reproductive Health (DRH) and National AIDS and STD Control Programme (NASCOP) in the provision of integrated RH and HIV services
- Develop clear operational guidelines and ensure a harmonised approach towards integrated RH and HIV service provision
- Develop an advocacy strategy to obtain and sustain commitment to integrated RH and HIV services at all levels

2.4.2 Objective 2
To ensure that adequate resources are committed, allocated, availed, and utilised for the effective and sustainable provision of integrated RH and HIV services.

Expected results
- Established/strengthened and sustained integrated RH and HIV services
- Adequately funded integrated RH and HIV services and resources accounted for

Strategy 1: Resource mobilisation
The key strategy will involve conducting an assessment of the costs of integrating RH and HIV services and continued advocacy for equitable allocation of resources to support the services. It will also involve continued policy dialogue to engage practitioners, programme implementers, and policymakers to ensure the sustained equitable allocation of resources for strategy implementation.

Key activities

- Define the minimum/essential service delivery package for RH and HIV integration at all levels
- Determine the resources required for implementing the integrated RH and HIV services by developing and costing a yearly action plan for the integration strategy
- Mobilise resources and advocate for equitable allocation
- Conduct an economic evaluation to determine the efficiency and effectiveness of integrated service provision
- Use information from the economic evaluation for relevant planning to ensure the sustainability of resources

2.4.3 Objective 3

To strengthen the capacity for providing integrated RH and HIV services at all levels.

Expected result

- Enhanced capacity to provide integrated RH and HIV services at all levels

Strategy 1: Capacity building

To ensure that appropriate service integration is achieved at all levels, the key strategy will include building the capacity of practitioners and programme implementers to be multi-skilled and perform multiple tasks.

Key activities

- Review and revise staffing norms
- Advocate for appropriate employment and deployment and the retention of skilled service providers at all levels
- Regularly conduct supportive supervision and mentorship
- Review and revise existing pre-service training curricula to incorporate RH and HIV integration
- Conduct training for different cadres of service providers to provide high-quality integrated RH and HIV services at all levels
- Develop, disseminate, and distribute job aids and information, education, and communication (IEC) materials relevant to healthcare workers and the provision of integrated RH and HIV services
- Conduct a facility assessment to identify the infrastructure requirements and supply needs for providing integrated RH and HIV services, as appropriate
- Improve the infrastructure of health facilities to support integrated RH and HIV services at all levels

2.4.4 Objective 4

To strengthen supply chain management systems for RH and HIV commodities at all levels.

Expected result

- An adequate supply of RH and HIV commodities at all levels of service delivery

Strategy 1: Systems strengthening

The key strategy will involve strengthening the logistics system to sustain an adequate supply of commodities in the respective service sites. It will also involve building the capacity of various stakeholders to forecast the supply of commodities to accommodate the provision of relevant supplies at each service site.

Key activities
- Strengthen the logistics management system at all levels
- Ensure a sustained supply of commodities for the broad range of RH and HIV integrated services at all levels
- Train relevant staff on commodity logistics and management
- Advocate for sustained commodity security for integrated services

2.4.5 Objective 5

To increase demand for high-quality RH and HIV services.

Expected result
- Increased use of integrated RH and HIV services

The key strategies will include creating awareness, engaging the community, and improving the quality of care and availability of commodities so as to create and meet the demand for services. The strategies will also involve building the capacity of practitioners, programme implementers, and communities to develop appropriate culturally sensitive materials for advocacy activities.

Strategy 1: Awareness creation
Key activities
- Develop, disseminate, and distribute relevant IEC materials for a targeted audience
- Conduct mass media campaigns to create and increase awareness about the availability of RH and HIV integrated services

Strategy 2: Community engagement and participation
Key activities
- Utilise community sector programmes to sensitise communities on the availability of integrated RH and HIV services
- Involve community own resource persons - e.g leaders and CHWs

Strategy 3: Improvement in quality of care
Key activities
- Develop performance standards and devise monitoring and accountability mechanisms for the provision of high-quality integrated services
- Monitor standards for practise and ensure focussed supervision
- Expand the coverage of integrated RH and HIV services

2.4.6 Objective 6

To strengthen the monitoring and evaluation (M&E) and reporting systems for the effective tracking and performance assessment and delivery of high-quality integrated RH and HIV services.

Expected results
- Established functional management information systems
- Available high-quality data and information for planning and management of integrated RH and HIV services

The key strategies will include adapting the current management information system (MIS) to enable the

tracking of integrated services, using M&E data and information for building a knowledge base, and fostering knowledge sharing among practitioners for priority setting and evidenced-based advocacy.

Strategy 1: Systems strengthening
Key activities
- Review and modify the existing MIS to ensure that it facilitates the collection of information on integrated RH and HIV services
- Develop and/or adopt available and appropriate indicators for integrated RH and HIV services
- Develop and/or adopt available and appropriate data capture tools for monitoring integrated RH and HIV services
- Train relevant staff on M&E

Strategy 2: Building a knowledge base and supporting knowledge sharing among practitioners for priority setting
Key activities
- Develop an information use plan based on the M&E products
- Regularly inform all stakeholders on the performance of integrated RH and HIV services
- Hold regular consultative meetings to review information/data use challenges

2.4.7 Objective 7

To support operational research, documentation, and dissemination to inform the RH and HIV integration process in line with national priorities.

Expected result
- Available information for the planning and management of integrated RH and HIV services

The key strategy will include support for promoting the use of research results to influence policy and programming.

Strategy 1: Building a knowledge base and supporting knowledge sharing among practitioners for priority setting
Key activities
- Develop a research agenda for RH and HIV integration
- Facilitate relevant operations research in key areas of the RH and HIV integration programme
- Facilitate the dissemination of research results to all stakeholders (including local communities)
- Support the communication of research findings to policymakers at all levels
- Document lessons learnt to further inform the implementation process
- Establish documentation centres to store relevant information on the integration process
- Advocate for the use of operations research data findings

CHAPTER 3: SERVICE DELIVERY LEVELS, SERVICE AREAS, AND POTENTIAL INTEGRATED SERVICES

3.1 INTRODUCTION

The lessons learnt from various pilot programmes in Africa and Kenya indicate that programming for RH and HIV integrated approaches must be tailored to the specific country context. In countries with generalised epidemics, integration efforts may include a range of interventions, with RH integrated into HIV activities and HIV activities integrated into RH activities. In more concentrated epidemics, integration efforts should be focussed on ensuring access to HIV prevention information and RH services for higher risk populations. In addition, not all HIV services need to be integrated with RH services and vice versa. At the same time, integration may not be appropriate in every setting. It is therefore imperative that programme managers consider the synergies to be gained from integration in each particular context. Such factors may include but not be limited to HIV prevalence and transmission and areas of unmet need for reproductive health. The following chapter outlines the service delivery levels and corresponding service areas relevant to the RH and HIV and AIDS services that can be integrated. It therefore provides a road map for implementing an essential package for RH and HIV integration.

3.2 ESSENTIAL PACKAGE FOR INTEGRATED RH AND HIV AND AIDS SERVICE INTEGRATION

Table 3.1 shows the various levels and areas of service delivery and the potential aspects for integrating HIV into RH services and vice versa. It thus provides each programme manager or service provider with the essential areas to consider for integration, depending on the specific context.

Implementation of the essential package will entail close collaboration with a wide range of partners within the facilities and the programmes. Each programme will therefore develop its own operational indicators, depending on the area of service integration, which must feed to the national indicators. Annex 1 provides results frame work and some of indicators that are needed for monitoring and evaluation of this strategy. Minimum operational indicators at the service delivery level are included in Annex 2 for reference. Partners, such as faith-based organisations (FBOs) and community-based organisations (CBOs), can be crucial to building the capacity and advocacy for integrated services and may play a critical role in developing successful linkages and referral systems. The next chapter describes the various roles and responsibilities of different stakeholders in high-quality service delivery, advocacy, and resource mobilisation.

Table 3.1: Service Delivery Levels, Service Areas, and Potential Integrated Services

Service Delivery Level	Service Areas	Potential RH or HIV Services to Add/Include to Current Services
Level 1 (Community)	CBRH (Community Based Reproductive Health) • CBD (Community Based Distribution) • Community Midwifery	HIV counselling and referrals for testing, IEC, adherence, psychosocial support, health promotion CT, FP, OI prophylaxis and referral, adherence and nutrition
	HCBC (Home & Community Based Care)	FP counselling, condoms and referrals, basic care package, nutrition
	OVC (Orphans & Vulnerable Children) and PwP	HIV counselling, FP counselling and provision of condoms and pills, IEC for ART, adherence counselling, psychosocial support, PEP counselling and referral for testing, youth RH and life skills, behaviour change communication
	HIV outreach • HTC (HIV Testing and Counseling) • Home Testing	FP counselling and provision of condoms and pills, referral for other methods, behaviour change communication
Level 2 (Dispensary)	ANC (Ante Natal Clinic)	FANC-PMTCT, ART, Antenatal Testing, CT and OI prophylaxis, nutrition
	FP (Family Planning)	CT, referral to CCC, TB screening, nutrition
	Maternity	CT, ARV prophylaxis, TB screening
	MCH (Maternal Child Heath Clinic)	Post-natal testing, ARV prophylaxis, TB screening, referral, FANC
	ART (Anti Retroviral Therapy)	FP counselling and referral, provision of condoms, pills and referral for other methods, referral for cervical cancer screening, TB screening, RTI screening, referral
	TB clinic	FP counselling and referral, provision of condoms, pills and referral for

		other methods, cervical cancer screening, Prostate cancer information.
	STI/RTI clinic	TB screening, CT, FP counselling, Prostate cancer information, provision of methods and referral for other methods.
	Post-natal ward	Post-natal clinic and ward CT, FP, ARV prophylaxis, referral to care and treatment or FP clinic
	PAC (Post Abortal Care)	HIV counselling and testing
	Youth-friendly	Comprehensive ASRH (Adolescent Sexual Repro. Health) and HIV services
	Post-rape	Emergency contraception, HIV counselling and testing, psychosocial support
Level 3 (Health Centres, Maternity Homes, Nursing Homes)	ANC/MCH	FANC (Focused Ante Natal Care) -PMTCT, ART, OI prophylaxis
	FP (Family Planning)	FP-CT, referral to the CCC, TB screening, nutrition
	HTC (HIV Testing & Counseling)	FP counselling and provision of FP commodities in some facilities, referral, cervical cancer screening
	TB clinic	FP counselling and provision of FP methods if applicable, referral, cervical cancer screening and Prostate cancer information.
	Maternity	CT, ARV prophylaxis, TB screening Post-natal clinic and ward CT, FP, ARV, prophylaxis, referral to care and treatment or FP clinic
	Post-natal ward	ART/CCC-FP counselling and provision of pills, condoms, injectables, and implants in some facilities, referral, cervical cancer screening, post-rape

		care (PEP + EC)
	MCH (Maternal Child Heath Clinic)	Post-natal testing, TB screening, RTI screening, FP counselling and provision of FP methods if applicable, ARV prophylaxis, referral, nutrition
	STI /RTI	TB screening, CT, FP and Prostate cancer information
	Comprehensive ART	CT, FP, FANC, PEP+ EC, referrals
	PAC (Post Abortal Care)	HIV counselling and testing
	Post-rape care	EC, HIV counselling and testing, psychosocial support, PEP
	Youth-friendly	Comprehensive ASRH and HIV services
Level 4 (Primary Hospitals-Sub-District Hospitals, District and Mission Hospitals)	ANC/MCH	FANC-PMTCT, ART, and OI prophylaxis, breast cancer screening and information
	FP (Family Planning)	FP-CT, referral to the CCC, TB screening, nutrition
	HTC (HIV Testing & Counseling)	FP counselling and provision of FP methods in some facilities, referral, cervical cancer screening
	TB clinic	FP counselling, referral, cervical cancer screening
	Maternity	CT, ARV prophylaxis, TB screening
	MCH (Maternal Child Heath Clinic)	Post-natal testing, ARV prophylaxis, referral, nutrition, TB screening
	Comprehensive ART	FP counselling and provision of condoms and pills, referral, cervical cancer screening, TB screening, RTI screening

	STI/RTI clinic	TB screening, CT, FP counselling and provision of FP methods if applicable prostate cancer screening and information
	PAC (Post Abortal Care)	HIV counselling and testing
	Youth-friendly	Comprehensive ASRH and HIV services
	Post-rape care	EC, HIV counselling and testing, psychosocial support, PEP
Level 5 (Secondary Hospitals—Provincial Hospitals)	ANC/MCH	FANC-PMTCT, ART, OI prophylaxis, breast screening and information
	FP (Family Planning)	CT, referral to the CCC, TB screening, nutrition
	HTC (HIV Testing & Counseling)	FP counselling and provision of FP commodities in some facilities, referral, cervical cancer screening
	TB Clinic	FP counselling, referral, cervical cancer screening
	Maternity	CT, ARV prophylaxis, TB screening Post-natal clinic and ward-CT, FP, ARV, prophylaxis, referral to care and treatment or FP clinic
	MCH (Maternal Child Heath Clinic)	Post-natal testing, TB screening, RTI screening, FP counselling and provision of FP methods, ARV prophylaxis, referral, nutrition, FANC
	Post-natal clinic	STI/RTI-TB screening, FP, CT, referral PAC-TB screening, CT, FP
	Comprehensive ART	FP counselling and provision of condoms and pills, referral cervical cancer screening, TB screening, RTI screening

	STI/RTI clinics	TB screening, CT, FP counselling and provision of FP methods, if applicable, prostate cancer screening, breast cancer screening and information for men
	PAC (Post Abortal Care) Youth-friendly	HIV counselling and testing Comprehensive ASRH and HIV services
	Post-rape care	EC, HIV counselling and testing, psychosocial support, PEP
Level 6 (Tertiary Hospitals—National Referrals and Teaching Hospitals, Private For-Profit Hospitals)	ANC/MCH	FANC-PMTCT, ART, OI prophylaxis, breast cancer screening
	FP (Family Planning)	CT, referral to the CCC, TB screening, nutrition
	HTC (HIV Testing & Counseling)	FP counselling and provision of FP methods in some facilities, referral, cervical cancer screening
	TB clinic	FP counselling, referral, cervical cancer screening
	Maternity	CT, ARV prophylaxis, TB screening
	MCH (Maternal Child Heath Clinic)	Post-natal testing, TB screening, RTI screening, FP counselling and provision of FP methods, ARV prophylaxis, referral, nutrition, FANC
	Post-natal ward	ART/CCC-FP counselling and provision of pills, condoms, injectables, implants, IUCDs, TL/vasectomy, cervical cancer screening, post-rape care (PEP + EC)
	Post-natal ward	STI/RTI-TB screening, FP, CT, referral PAC-TB screening, CT, FP
	ART (Anti Retroviral Therapy)	FP counselling and provision of condoms and pills, referral cervical cancer

		screening, TB screening, RTI screening
	STI/RTI clinic	TB screening, CT, FP counselling and provision of FP methods, if applicable prostate cancer screening and breast cancer screening for men
	PAC (Post Abortal Care)	HIV counselling and testing
	Youth-friendly	Comprehensive ASRH and HIV services
	Post-rape care	EC, HIV counselling and testing, psychosocial support, PEP

CHAPTER 4: INSTITUTIONAL FRAMEWORK AND IMPLEMENTATION MECHANISM

4.1 INTRODUCTION

This strategy will be implemented in accordance with the overall national health sector management and coordination framework stipulated in NHSSP II, the National RH policy and strategy, and KNASP III. It will therefore require relevant coordinating agencies to seek collaboration with a wide range of partners within the government, civil society, donors, the community, and other stakeholders as each fulfils specific roles and responsibilities. Activity implementation will, therefore, require new arrangements for coordination and collaboration among participating partners. Effective coordination and collaboration of integrated activities will facilitate the best use of available resources by minimising duplication of efforts, aligning quality control standards to set objectives, and ensuring that the efforts of all stakeholders are harmonised towards the achievement of the common goal as articulated in the various government policies and strategies.

4.2 MANAGEMENT AND COORDINATION

When planning activities specifically designed to achieve the goal and objectives of this strategy, the actions should account for the wide range of individual and collective factors and conditions, based on evidence. The achievement of related policy and programme objectives requires strategic alliances with various agencies and communities. It will also require leadership support, political goodwill, the availability of staff and funding, as well as sustained dialogue and advocacy for the entire programme to operate at all levels. Such operations require coordinated efforts and cooperation and collaboration among the different levels of government, civil society organisations, the private sector, and the communities.

Because of limited resources and the increasing health needs of the growing population, it is important to plan programmes and services that reach as many of the targeted population as possible. However, interventions should be piloted, tested, and evaluated to determine their feasibility. Partnerships and networks providing the infrastructure, support, and leadership for going to scale should be involved. For effective implementation, documentation of lessons learnt from a variety of players shall be encouraged. The need to support human resource development, community participation, and leadership will require strengthening the capacity of various stakeholders as well as institutions at all levels.

4.2.1 ROLES AND RESPONSIBILITIES

Role of MOPHS and MOMS

The Ministry of Public Health and Sanitation and Ministry of Medical Services will, through the DRH and NASCOP, oversee and facilitate the strategy's implementation. The DRH and NASCOP will work with other relevant authorities and take a leadership role in ensuring the adequate supply of staffing, equipment, and supplies. They will also, with support of other departments and stakeholders, set standards and regulatory mechanisms, regulate and coordinate training, coordinate donor activities, and ensure the adequate allocation of resources to the integrated programmes/services.

Decentralisation will be promoted, as it is critical to the successful delivery of healthcare services countrywide. At the provincial and district levels, Provincial Health Management Teams and District Health Management Teams will supervise the planning and implementation of RH and HIV integrated services and programme activities, including enforcing standards; setting priorities; and collaborating with development partners, FBOs, civil society organisations, and other parties on related activities in their respective areas of jurisdiction. The District Health Management Board will oversee all matters related to integration, including resource mobilisation, the delivery of high-quality services, and monitoring and evaluation. The existing training and supervision teams will be strengthened to provide effective guidance to the provinces and districts.

Role of RH and HIV Integration Committee

The RH and HIV Integration Strategy will require NASCOP and DRH and implementers to review the current approaches and undertake activities that will ensure its effective implementation at the service delivery level. In the implementation process, there will be the RH and HIV Integration Committee (jointly chaired by NASCOP and DRH) whose responsibilities shall be:

- Ensure that Implementation of RH and HIV integrated programmes are well Coordinated
- Support Resource mobilization Activities
- Support advocacy campaigns
- Monitor and Evaluate the implementation of RH and HIV integrated programmes
- Provide Technical assistance including Quality Assurance and Quality Control
- Prepare Policy briefs to various policy makers
- Review existing Policies and guidelines
- Support research activities
- Prepare information use plans
- Develop or review training curricula
- Support supervision of implementation in provinces and districts

Role of National Aids Control Council (NACC)

The NACC, as per the legal notice No. 170 of 1999, remains the lead government agency in coordinating HIV and AIDS-related programmes; therefore, its key role is to spearhead HIV activities with a focus on creating a supportive policy and regulatory framework. In addition, the NACC is expected to support the following aspects of the strategy:

- Resource mobilisation
- Advocacy
- Policy review
- Monitoring and evaluation
- Research
- Preparation of information use plans

Roles of Other Ministries

A multisectoral approach is central to implementing the strategy; thus, the following key sectoral ministries should be involved (see Table 4.1).

Table 4.1: Ministries and Roles

Ministry	Role(s)
Planning and National Development	Policy, advocacy, resource mobilisation, data/information
Public Service	Human resource development, sustainability
Education	Implementation of adolescent and youth programmes, research, resource mobilisation
Youth and Sports	Implementation of adolescent and youth programmes, research, resource mobilisation
Information and Communication	IEC, RH and HIV and AIDS/STI messages and communication, infrastructure, resource mobilisation
Finance	Financial resource mobilisation and allocation
Gender	Support for gender component of the integrated RH and HIV services, resource mobilisation
Office of the President	Advocacy, resource mobilisation, initiatives for the integrated RH and HIV services
Internal Security	Security for infrastructure, service providers, and clients
Special Programmes	Advocacy, resource mobilisation, initiatives for the integrated RH and HIV services
Home Affairs	Resource mobilisation, RH and HIV and AIDS/STI issues for vulnerable groups
Roads	Road networks, resource mobilisation
Housing	Housing provision for service providers
Works	Support for the construction of infrastructure and works
Agriculture	Food security and safety, nutrition and dietrics, resource mobilisation
Water	Resource mobilisation, community and facility safe water supply

Role of NGOs, CBOs, FBOs, Civil Society, and the Private Sector

Non-public sector organisations play a key role in health service provision and more so in RH and HIV and AIDS/STI service delivery. The integration strategy will strive to tap into their significant contribution to integration. The Ministry of Public Health and Sanitation and the Ministry of Medical Services must thus provide an enabling environment for strengthening partnerships—thereby encouraging organisations to expand coverage and improve access to RH and HIV care and support as well as participate in the formulation, financing, implementation, and monitoring and evaluation of these programmes.

Role of Development Partners

Development partners will be encouraged to continue supporting healthcare delivery in accordance with national plans.

Role of Communities, Households, and Individuals

Through establishing health facility committees and village health committees, and also through community health extension workers and community health workers, communities will be able to participate in implementing RH and HIV integration—including in resource mobilisation, advocacy, planning, and monitoring and evaluation. Similarly, households and individuals will be encouraged to participate and contribute towards improvement of their own status in matters of RH and HIV integration.

Role of PLHIV

One key guiding principle for this strategy is to continue involving PLHIV. Several HIV-related programmes have already recognised the vital role of such people. It is therefore expected that PLHIV will participate in the following to help achieve the strategy's goal:

- Advocacy
- Demand creation for other integrated services
- Feedback
- Programme development input
- Resource mobilisation
- Behaviour change communication

Role of Training Institutions

Pre-service training at the designated university-based medical and nursing schools, the Kenya Medical Training Colleges, and the private and mission medical training institutions will be encouraged to introduce the concept of integration, in particular RH and HIV integration. In addition, they will also be expected to participate in quality assurance and control meetings and the regular reviews of existing training materials, policies, and guidelines.

The Role of Mass Media

The mass media will play a significant role in conducting advocacy and creating public awareness on matters related to integrated RH and HIV services.

The Role of Other Stakeholders

Other stakeholders—including women's organisations, professional associations, regulatory bodies, and political parties—are expected to facilitate greater public/private participation and involvement in planning and implementation of the integrated RH and HIV programmes.

4.3 RESEARCH ACTIVITIES IN THE INTEGRATION ARENA

Research is a powerful tool for garnering evidence-based information to inform policy formulation and review and for developing guidelines and standards. All stakeholders will be encouraged to support information sharing between the researchers and end users at different stages in the research process.

Research identifies critical issues that both inform the process and help establish priorities and strategies. There is a need to support evidence-based decisionmaking through the use of relevant high-quality data and research findings. Networks should be developed to support the dissemination of knowledge and information. In addition to funding new research, available evidence needs to be repackaged and availed for different audiences to facilitate appropriate decisionmaking.

4.4 MONITORING AND EVALUATION

The monitoring and evaluation of this strategy will utilise nationally established M&E systems, such as the M&E framework of the National Health Strategic Plan and KNASP III. Tools used in data gathering and capture will be reviewed and revised to gain relevant information encompassing various aspects of the integrated RH and HIV services.

Although no new indicators for specific RH and HIV services are envisioned, the relevant coordinating agencies will need to develop indicators for the strategies and activities outlined in Chapter 2 so as to enable the tracking and evaluation of the integration process (see Annex 1). The implementing partners will need to regularly review the indicators and participate in the M&E of integrated services.

Outputs of the M&E system

One key M&E objective is to meet the information needs of different stakeholders simultaneously and provide them with the results of service provision and the relevance of programmes initiated. While annual reports are good communication products, the need for continuous feedback is paramount. Details on the frequency of reporting are expected to be included in the different implementers' M&E plans. The key information products will include annual progress reports, in-depth analytical reports utilising data generated from the M&E system, and/or commissioned research and other evaluations relevant to the integrated services. Operationally, emphasis will be placed on generating relevant data to meet the information needs of different stakeholders and creating awareness of the available information for effective planning and decisionmaking.

CHAPTER 5: RESOURCE MOBILIZATION

5.1 INTRODUCTION

Availability of adequate resources is critical to efficient and effective implementation of integrated RH and HIV services. This chapter focuses on different strategies for mobilizing and allocating financial and non-financial resources to support the implementation of RH and HIV integrated activities. Although integration process have been implemented in some situations and pilot programs, critical costing of the services are not yet available to determine the extent of the financial outlay required to implement the integrated services in full.

5.2 FINANCIAL RESOURCES

The main sources of funds for the Health Sector are Government of Kenya (through taxes), development partners (external aid and borrowing), households and individuals throughout-of pocket contributions and pre payment schemes, and employers though contribution to covering cost of care of their employees. However, there is still under-financing of the Health Sector although budget allocations have improved tremendously in the last three years. Since enormous financial resources are required to fund RH and HIV integrated activities, the Ministries of Public Health and Sanitation and Medical Services will increasingly focus on non-traditional financial sources to raise additional funds to fill the resource gap. Such options may include:

(i) Reallocations from User fees

A major weakness of this option is that these types of funds are quite small –since most of the RH and HIV services are free. However, in hospitals, delivery charges constitute a significant proportion of the facility user fees. Such fees could be ploughed back to the generating facility to support other aspects of service delivery such as infection prevention activities, etc.

(ii) NHIF reimbursements

These are applied in case a client is hospitalised.

(iii) Leveraging of Local Development Funds

In recent years, local leaders have used the Constituency Development Fund (CDF) to build various types of infrastructure, including health facilities. Other funds such as local authority transfer funds (LATF) and the youth funds can be used to support integrated RH and HIV services.

(iv) Involving the private sector and the community

The private sector would be encouraged to use innovative ways to raise financial resources to fund activities and through corporate social responsibility. The private sector can raise money through health insurance and private health facilities that could assist the MOH in financing some activities such as sponsoring yearly trade exhibitions, workshops, media adverts, community based projects, etc, among others.

(v) Civil Society participation

Non-governmental organizations and faith-based organizations could also develop proposals and raise funds to implement RH and HIV activities in support of this strategy. The available funds can be used to revise the work plans of the civil society to address the issues of integration

(vi) Human resources

A deliberate effort will be made to forge partnerships with other stakeholders. This will also apply in technical components where the relevant Ministries may not have the capacity for implementation

The actual quantification of the resources available for RH and HIV integration will be done in the 5 year strategic plan and during the Annual Operations Plan (AOPs). The following section outlines one of the ways in which institutions or programs can use in computing estimates of resource requirements for RH and HIV integration,.

5.2.1 Methodology

The approach adopted here builds on international studies on costing tailored to Kenyan health needs. This methodology relies on population based data on costs of service provision. Thus the costs and budgets obtained and the method relate to the health needs of the target population. Provision of health services require inputs in form of labour, drugs, supplies and medical equipment, along with overheads such as supervision and systems support and each input has a cost associated with it. Once the required quantities of inputs are known for each intervention, the inputs are multiplied by their respective unit costs to obtain the total cost of an intervention. Summing up the costs of all interventions that are needed to produce a particular service provision gives the cost of service provision. Therefore, three important inputs are required in the estimation of financial resources for the implementation. These include: the population in need of the services; expected coverage targets of the population; unit costs of each intervention and frequency of service provision.

Cost (Kshs.) = Population in need x coverage target x unit cost x frequency of service provision

Therefore the outline for estimation will require the following process:

- First identify the key integrated services necessary to achieve the results and the specified targets
- Estimate the unit costs for delivering each integrated service, based on the experience of service providers in Kenya, and internationally (or study reports)
- Identify the size of the population in need of each RH and HIV integrated service, based on demographic data; and
- Identify appropriate levels of coverage for each service for each year during the strategy period, reflecting scale-up plans (if the case)
- Establish frequency of service provision and demand
- Estimate using the above formula the cost for each service, during each year of implementation.

[1]ROK (2005): The Kenya National HIV and AIDS Strategic Plan (KNASP) 2005/6-2009/10;
[1]Financing Framework: Resource Requirements for the Kenya National AIDS Strategic Plan 2005-2010, Stover, Kioko, Kimalu and Korir, January 2005.

ANNEX 1: RESULTS FRAMEWORK**

Goal

To increase access to comprehensive, high-quality, effective, efficient, affordable, and sustainable RH and HIV and AIDS services.

Objective 1

To strengthen the policy environment at all levels for the provision and utilisation of high-quality integrated RH and HIV services.

		Indicator(s)	Time Frame/Year					Responsible/ partners
Result Area Clearly articulated and operationalised policies		Existence of supportive policies on integrated service delivery[4] Health system responsiveness to clients index	1	2	3	4	5	
Strategy	*Key Activities*							
Strategy 1: Advocacy and Policy Dialogue	Review relevant policies, implementation plans, guidelines, and protocols on RH and HIV and AIDS	Number of relevant policies reviewed and revised						
	Define and harmonise the roles and responsibilities of key coordinating agencies such as the DRH and NASCOP	Coordination strategy in place indicating harmonised roles and responsibilities						

	Develop clear policies and operational guidelines and ensure a harmonised approach towards service provision	Number of guidelines for integrated services harmonised						
	Develop an advocacy strategy to support increased commitment to an integrated approach to the provision of RH and HIV services at all levels	Strategy in place						
	Engage stakeholders to support all initiatives towards strengthening and scaling up integrated RH and HIV services to improve the service provision environment	Number and type of outreach activities conducted						

Objective 2

To ensure that adequate resources are committed, allocated, availed, and utilised for the effective and sustainable provision of integrated RH and HIV services.

		Indicator(s)	Time Frame/Year					Responsible/ partners
Result Areas Established/strengthened and sustained integrated RH and HIV services Adequately funded integrated RH and HIV services		Funds allocated for integration by source Existence of costed integrated services by service delivery site and level	*1*	*2*	*3*	*4*	*5*	
Strategy	*Key Activities*							
Strategy 1: Resource Mobilisation	Define the minimum/essential package for integration at all levels	Defined package in place at all levels						
	Determine resources required for the implementation of integrated RH and HIV services by developing and costing a yearly action plan for the integration strategy	• Unit costs for integrated services established at all levels • Costed yearly action plans • Existence of methodology for costing services						
	Mobilise resources and advocate for equitable allocation	• Resource mobilisation plan • Number and type of advocacy activities • Resources generated by source						
	Conduct an evaluation to determine the efficiency and effectiveness of integrated service provision	• Existence of evaluation tools • Evaluation undertaken • Value of integrated services determined for each service area integrated						

Objective 3

To strengthen capacity for the provision of integrated RH and HIV services at all levels.

		Indicator(s)	Time Frame/Year					Responsible/ partners
Result Areas Enhanced capacity for the provision of RH and HIV and AIDS at all levels		• Number of facilities offering high-quality integrated RH and HIV services by geographic distribution • Percent of service delivery points providing integrated services by type and meeting a defined standard of quality	*1*	*2*	*3*	*4*	*5*	
Strategy	*Key Activities*							
Strategy 1: Capacity Building	Review and revise staffing norms and advocate for appropriate deployment and retention of skilled service providers at all levels	• Guidelines available on staffing • Number of advocacy campaigns conducted						
	Review and revise existing pre-service training curricula to incorporate RH and HIV integration	• Training curricula in place, with conformity to best practices in service integration						
	Conduct training for different cadres of service providers to provide high-quality integrated RH and HIV services at all levels	• Existence of training needs assessment tool • Existence of training plans and with budgets • No./per cent of providers trained by cadre and geographic distribution • No./per cent of service providers receiving in-service training on integration in last year						

		Indicator(s)	Time Frame/Year					Responsible/ partners
		• No./per cent of facilities providing integrated services staffed with trained staff on integration by type and geographic distribution • No./per cent of trainees/retrained staff deployed to an appropriate service delivery point and job assignment						
	Develop, disseminate, and distribute job aids and IEC materials relevant for the provision of integrated RH and HIV services	• Number of job aid cards developed and distributed by type • Number and type of IEC materials produced and distributed • Number of dissemination activities conducted using developed IEC materials						
	Conduct facility assessment to identify the infrastructure requirements and supplies for the provision of integrated RH and HIV services where appropriate	• Existence of capacity assessment tool • Facility assessment undertaken • Number of facilities that require improvement						
	Improve health facilities' infrastructure to provide integrated RH and HIV services at all levels	• Number of facilities with adequate infrastructure to offer integrated services						

Objective 4

To strengthen supply chain management systems for RH and HIV commodities at all levels.

		Indicator(s)	Time Frame/Year					Responsible/ partners
Result Areas Strengthened supply chain management systems for RH and HIV commodities at all levels		Per cent of facilities by type with adequate supplies of commodities at the integrated service delivery points Facilities/institutions/programmes with logistics indicator assessment tool incorporating integrated services Per cent of facilities that experience a stock out at any point during a given time period Per cent of health facilities providing integrated services with an adequate drug supply	*1*	*2*	*3*	*4*	*5*	
Strategy	*Key Activities*							
Strategy 1: Systems Strengthening	Strengthen the supply chain systems from the control level to the facility to ensure commodity security for the broad range of RH and HIV services	Functional supply chain system in place incorporating integration in place						
	Advocate for sustained commodity security	Advocacy strategy in place Number and type advocacy campaigns conducted						

Objective 5

Increase demand for RH and HIV services at all levels.

		Indicator(s)	Time Frame/Year					Responsible/ partners
Result Areas Increased use of FP/RH and HIV and AIDS/STI services		Per cent of clients receiving services at the integrated service delivery sites Per cent of facilities where a given proportion of clients receive integrated services that meet the expected standards	*1*	*2*	*3*	*4*	*5*	
Strategy	*Key Activities*							
Strategy 1: Awareness Creation	Develop, disseminate, and distribute relevant IEC materials for the targeted audience	• Number and type developed and distributed • Number of dissemination activities conducted						
	Conduct mass media campaigns to increase awareness on the availability of integrated RH and HIV services	• Number and type of mass media products developed • Frequency of mass media campaigns (per year/per month)						
Strategy 2: Community Engagement	Utilise community sector programmes to sensitise communities on the availability of integrated RH and HIV services	• Number and type of community sector programmes identified • Number of programme-infusing messages about integrated services in their activities • Number of sensitisation activities undertaken						

		Indicator(s)	Time Frame/Year					Responsible/ partners
Strategy 3: Improving Quality of Care	Develop performance standards and devise monitoring and accountability mechanisms for the provision of high-quality integrated services	• Number of facilities/institutions with defined indicators of performance on integration • Institutions/facilities/ programme staff with feedback system in place • Existence of training plan linked to quality assurance and performance improvement plans						
	Monitor standards for practise and ensure focussed supervision	• Supervisors review performance expectations on an annual basis • Per cent of providers/staff who acknowledge receiving feedback on their performance in last six months • Per cent of providers/staff who received supportive supervision in last six months						
	Expand coverage of integrated RH and HIV services	• Per cent of facilities by type with integrated service delivery points by geographic region						

Objective 6

To strengthen the M&E and reporting systems for effective tracking and performance assessment and delivery of high-quality integrated RH and HIV services.

	Indicator(s)	Time Frame/Year					Responsible/ partners
Result Area Established functional management information systems and monitoring and	Number and type of policy briefs developed from data from M&E Number and type of M&E products with information on integrated services	*1*	*2*	*3*	*4*	*5*	

		Indicator(s)	Time Frame/Year					Responsible/ partners
evaluation system Available high-quality data and information for the planning and management of integrated RH and HIV services		Databases developed and accessible based on outputs of M&E system Per cent of facilities offering integrated services with up to date register in the last 7 days						
Strategy	*Key Activities*							
Strategy 1: Systems Strengthening	Review existing MIS to ensure it facilitates the collection of information on the integrated RH and HIV services	Service area points with integrated services having relevant data capture tools						
	Develop and/or adopt available and appropriate indicators for monitoring the integrated RH and HIV services	Indicators for integrated services included in indicator reference sheets for existing monitoring and evaluation system						
	Develop and/or adopt available and appropriate data capture tools for monitoring integrated RH and HIV services of services	Number and type of tools developed Number of service outlets offering integrated services with relevant data capture tools						
Strategy 2: Building a	Develop a strategy for information/data use	Strategy in place incorporating audience, objectives, costing, type of information products and channels						

		Indicator(s)	Time Frame/Year					Responsible/ partners
Knowledge Base and Supporting Knowledge Sharing Among Practitioners for Priority Setting	Regularly inform all stakeholders on the performance of integrated RH and HIV services	Number of dissemination activities carried out by type of stakeholder reached						

Objective 7

To support operations research documentation and dissemination to inform the integration process in line with national priorities.

		Indicator(s)	Time Frame/Year					Responsible/ partners
Result Areas Available information for the planning and management of integrated RH and HIV services		Number and type of policy briefs developed from data/research Policy and management decisions made by institutions/programmes using information from operations research	*1*	*2*	*3*	*4*	*5*	
Strategy	*Key Activities*							
Strategy 1: Building a Knowledge	Develop a priority research agenda for RH and HIV integration	Number and type developed and shared with stakeholders						

		Indicator(s)	Time Frame/Year					Responsible/ partners
Base and Supporting Knowledge Sharing Among Practitioners for Priority Setting	Facilitate relevant operations research in key areas of the RH and HIV integration programme	Number and type supported						
	Facilitate and disseminate to all stakeholders (including local communities) the results of operations research	Number and type supported						
	Document lessons learnt to further inform the implementation process	Lessons learnt documented						
	Establish documentation centres to store relevant information on the integration process	Number and type of repositories established Repositories with documents on research on integration						
	Advocate for the utilisation of operations research data findings	Number and type of advocacy campaigns conducted						

ANNEX 2: MATRIX FOR INDICATORS OF SERVICE INTEGRATION AT SERVICE DELIVERY LEVELS

	ART	ANC/MCH	CT	FP	STI	TB	Other RH Services
ART/CCC				# of ART/CCC clients provided FP services	# CCC clients treated for STI		# of HIV - positive women referred for cervical cancer screening
				# of ART/CCC clients referred for FP services	# of CCC clients referred for STIs		
MCH and Labour Ward	# of HIV - positive women provided with ART		# of infants screened for HIV			# of ANC clients screened for TB	
	# of HIV - positive women referred to the CCC/ART centres		# of ANC mothers undergone CT and received results			# of ANC clients referred for TB diagnosis and treatment	
	# of exposed infants put on cotrimoxazole						
	# of HIV +ve infants put on ART						
VCT	# referred to the CCC/ART centres	# referred for ANC services		# of VCT clients provided with FP services	# of VCT clients screened for STIs		

				# of VCT clients referred for FP methods	# of VCT clients referred for STI treatment		
FP Clinic	# referred to the CCC/ART centres		# undergone provider-initiated counselling and testing for HIV				
			# of FP clients referred for HIV counselling andtesting				
HBC/OVC (Community)		# referred for ANC services		# of clients provided FP services	# of clients screened for STIs		# of HIV - positive women referred for cervical cancer screening
				# of clients referred for FP services	# of clients referred for STI diagnosis and treatment		

Republic of Kenya

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