

Linking Sexual and Reproductive Health and HIV/AIDS

Gateways to integration

a case study from Kenya

Antiretroviral delivery within a sexual
and reproductive health setting:

Transition from traditional to
pioneering role



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Acknowledgements	2
Acronyms and abbreviations	2

Linking Sexual and Reproductive Health and HIV/AIDS

Global commitments to strengthen linkages	3
Identifying and meeting the challenges	4
Tools to make it happen	4
Turning theory into practice	5

A case study from Kenya

Providing ARVs in a sexual and reproductive health setting: Transition from traditional to pioneering role	6
Interconnected health needs: The case for mainstreaming HIV/AIDS	7
Voluntary counselling and testing: Complex and sensitive issues	8
Nakuru: A model of integrated services	9
Care without walls: Community outreach	10
Antiretroviral therapy: Training and treatment	12
Taking treatment out to the community: Follow-up care and support	13
Services for young people: A pressing need	14
The legal and policy environment: Additional constraints	15
The challenge of sustainability: On the knife-edge of survival	16
Plausible, possible and practical: Conclusions and lessons learned	18
Contact details for more information	20
Endnotes	20

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
FHOK	Family Health Options Kenya
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Linking Sexual and Reproductive Health and HIV/AIDS

The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding, all of which are fundamental elements of sexual and reproductive health care. In addition, sexual and reproductive health problems share many of the same root causes as HIV/AIDS, such as poverty, gender inequality, stigma and discrimination, and marginalization of vulnerable groups. Despite this, services for sexual and reproductive health and for HIV/AIDS still largely exist as separate, vertical programmes.

Global commitments to strengthen linkages

Building blocks

To raise awareness of the pressing need for more widespread linkages between sexual and reproductive health and HIV/AIDS, UNFPA and UNAIDS, in collaboration with Family Care International, held a high-level consultative meeting in June 2004 with government ministers and parliamentarians from around the world, ambassadors, leaders of United Nations and other multilateral agencies, non-governmental and donor organizations, as well as young people and people living with HIV. The meeting resulted in *The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health*,ⁱ which challenges the sexual and reproductive health and HIV/AIDS communities to examine how they might improve collaboration.

An earlier meeting, held in Glion, Switzerland (May, 2004), and initiated by WHO and UNFPA, took a close look at the role of family planning in reducing HIV infection among women and children. This conference resulted in *The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children*.ⁱⁱ

In December 2005, a global partners' meeting was convened to discuss progress in implementing a comprehensive approach to prevention of mother-to-child transmission. This consultation also stressed the importance of linking

sexual and reproductive health and HIV/AIDS services, and led to a *Call to Action: Towards an HIV-free and AIDS-free Generation*,ⁱⁱⁱ as did the most recent PMTCT consultation in Johannesburg November 2007, resulting in a Consensus Statement: *Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services*.^{iv}

Linking HIV/AIDS and SRH was included as one of the Essential Policy Actions for HIV Prevention in the UNAIDS policy position paper on *Intensifying HIV Prevention*, which was issued in 2005.^v

Framework for universal access

The above commitments culminated in the Political Declaration on HIV/AIDS arising from the 2006 Review of the United Nations Special Session on HIV/AIDS (UNGASS), which also stressed how vital it is to link HIV/AIDS with sexual and reproductive health.^{vi} Following the commitment by G8 members¹ and, subsequently, heads of states and governments at the 2005 United Nations World Summit, the UNAIDS Secretariat and its partners have been defining a concept and a framework for Universal Access to HIV/AIDS Prevention, Treatment and Care by 2010.^{vii} Efforts towards universal access underline the importance of strengthened linkages between sexual and reproductive health and HIV/AIDS.

¹ G8 summits: Since 1975, the heads of state or government of the major industrial democracies have been meeting annually to deal with the major economic and political issues facing their domestic societies and the international community as a whole. G8 countries are France, United States, United Kingdom, Germany, Japan, Italy, Canada and Russian Federation.

The potential benefits of linking sexual and reproductive health and HIV/AIDS include:

- improved access to sexual and reproductive health and HIV services
- increased uptake of services
- better sexual and reproductive health services, tailored to meet the needs of women and men living with HIV
- reduced HIV/AIDS-related stigma and discrimination
- improved coverage of under-served and marginalized populations, including sex workers, injecting drug users and men who have sex with men
- greater support for dual protection against unintended pregnancies and sexually transmitted infections, including HIV
- improved quality of care
- enhanced programme effectiveness and efficiency^{viii}

Another aim of linking sexual and reproductive health and HIV/AIDS is to accelerate progress towards achieving the goals agreed at the International Conference on Population and Development^{ix} and the Millennium Development Goals,^x especially those that aim to reduce poverty, promote gender equality and empower women, improve maternal health, combat HIV/AIDS, and attain universal access to sexual and reproductive health.

Identifying and meeting the challenges

Linking sexual and reproductive health and HIV/AIDS policies and services presents many challenges for those on the front line of health care planning and delivery. These include:^{xi}

- making sure that integration does not overburden existing services in a way that compromises service quality, by ensuring that integration actually improves health care provision
- managing the increased workload for staff who take on new responsibilities
- allowing for increased costs initially when setting up integrated services and training staff
- combating stigma and discrimination from and towards health care providers, which has

the potential to undermine the effectiveness of integrated services no matter how efficient they are in other respects

- adapting services to attract men and young people, who tend to see sexual and reproductive health, and especially family planning, as 'women's business'
- reaching those who are most vulnerable but least likely to access services, such as young people
- providing the special training and ongoing support required by staff to meet the complex sexual and reproductive health needs of HIV-positive people effectively
- motivating donors to move from parallel to integrated services, and sustaining support for integrated policies and services.

Tools to make it happen

Several tools prepared by IPPF, UNFPA, UNAIDS and WHO offer guidance on how to link sexual and reproductive health with HIV/AIDS. These include:

- *Sexual and Reproductive Health and HIV/AIDS – a framework for priority linkages*^{xii}
- *Linking Sexual and Reproductive Health and HIV/AIDS – an annotated inventory*^{xiii}
- *Sexual and Reproductive Health of Women Living with HIV/AIDS – guidelines on care, treatment, and support for women living with HIV/AIDS and their children in resource-constrained settings*^{xiv}
- *Integrating HIV Voluntary Counselling and Testing Services*

into Reproductive Health Settings – stepwise guidelines for programme planners, managers and service providers^{xv}

- *Meeting the Sexual and Reproductive Health Needs of People Living with HIV*^{xvi}
- *Gateways to Integration – a series of case studies of country-level experiences on how to link and integrate services*^{xvii}
- *Reproductive Choices and Family Planning for People Living with HIV – Counselling Tool*^{xviii}
- *Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide*^{xix}

Turning theory into practice

The process of linking sexual and reproductive health and HIV/AIDS needs to work in both directions: this means that traditional sexual and reproductive health services need to integrate HIV/AIDS interventions, and also that programmes set up to address the AIDS epidemic need to integrate more general services for sexual and reproductive health. While there is broad consensus that strengthening linkages should be beneficial for clients, only limited evidence is published regarding real benefits, feasibility, costs and implications for health systems.

This publication presents one of a series of country experiences, set against a different public health, socio-economic and cultural background, embedded in radically different legal and health care environments and using different entry points as they strive to strengthen linkages between sexual and reproductive health and HIV/AIDS.

The case studies featured in this series have been chosen to demonstrate this two-way flow and to reflect the diversity of integration models. While these case studies focus primarily on service delivery components, structures/systems and policy issues are also important ingredients of the linkages agenda. The case studies are not intended to be a detailed critique of the programmes or to represent 'best practice' but to provide a brief overview that shows why the decision to integrate was taken, by whom, and what actions were needed to make it happen. The intention is to share some of the experience and lessons learned that may be useful to others who wish to consider actions to strengthen the integration of these two health care services. They are real experiences from the field, with important achievements but also with real limitations and shortcomings. One of these shortcomings lies in the nomenclature currently being used. There is currently no globally accepted definition of the terms 'linkages', 'mainstreaming' and 'integration' in the context of sexual and reproductive health and HIV. At times in these case studies the terms are used by different organizations in a variety of settings in different ways. While we propose the following definitions, it should be noted that the different implementing partners have not used these consistently:

Mainstreaming:

Mainstreaming HIV/AIDS means all sectors and organizations determining: how the spread of HIV is caused or contributed to by their sector, or their operations; how the epidemic is likely to affect their goals, objectives and programmes; where their sector/organization has a comparative advantage to respond – to limit the spread of HIV and to mitigate the impact of the epidemic and then taking action.

Linkages:

The policy, programmatic, services and advocacy synergies between sexual and reproductive health and HIV/AIDS.

Integration:

Refers to different kinds of sexual and reproductive health and HIV/AIDS services or operational programmes that can be joined together to ensure collective outcomes. This would include referrals from one service to another. It is based on the need to offer comprehensive services.

A case study from Kenya

Vital statistics at a glance

Estimated population (2005)	34,256,000
Adult population aged 15 to 49 years (2005)	16,662,000
Life expectancy at birth:	
Men	51 years
Women	50 years
Crude birth rate (2005)	39.5/1,000 population
Total fertility rate (2004)	5
HIV prevalence rate in adults aged 15 to 49 years (2005):	6.1% (5.2 – 7.0%)
Estimated number of people living with HIV (2005)	1,300,000
Estimated number of adults aged 15 years and over living with HIV (2005)	1,200,000
Estimated number of women aged 15 years and over living with HIV (2005)	740,000
Deaths due to AIDS (2005)	140,000
Estimated number of adults in need of antiretroviral therapy (2005)	240,000
Estimated number of people receiving antiretroviral therapy (2005)	66,000
Percentage of young people aged 15 to 24 years who used a condom last time they had sex with a casual partner:	
Men	47%
Women	25%
Percentage of young people aged 15 to 24 years who had sex before age 15 years:	
Men	30.9%
Women	14.5%
Contraceptive prevalence rate (2003)	39.3%
Births attended by skilled health personnel (2003)	42%

Sources: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. UNAIDS, UNICEF, WHO: www.who.int and www.unaids.org/en/CountryResponses/Countries/kenya.asp; Kenya Country Profile, May 2007^{xx} (Check UNAIDS website for updated data available from end of July 2008).

Providing antiretroviral treatment in a sexual and reproductive health setting: Transition from traditional to pioneering role

Family Health Options Kenya (FHOK), registered in 1962, is a Member Association of IPPF and is the second largest supplier of contraceptives in the country after the Government.

FHOK grew out of a grassroots movement started in the 1950s by a number of people concerned about the effects of Kenya's high birth rate on development, and who formed a network of volunteers to promote family planning at the community level.

FHOK today is a non-profit organization still governed by its volunteer members – there are around 5,000 volunteers in branches across Kenya. The annual delegates conference, made up of representatives from the grassroots branches, is the policy making body of FHOK. To make sure that FHOK represents and services all stakeholders, there is a stipulation that at least half the delegates must be women, and each branch must send a young person to represent the interests of their peer group.

FHOK runs nine clinics across the country that serve around 120,000 clients per year. Over the years these clinics have transformed their programmes from basic family planning services to provide more comprehensive family health services, with an emphasis on sexual and reproductive health care. Kenya's health infrastructure is extremely poor and in many areas the FHOK clinic is one of the few health facilities available, so the Association works closely with the Ministry of Health to try to extend coverage. As the AIDS epidemic has taken hold, FHOK clinics have become more and more involved in providing services for people living with HIV.

FHOK's formal debut into the HIV/AIDS field started in 1999, coinciding with the President of Kenya's declaration that AIDS is a "national disaster."^{xxi} The Association looked at where traditional sexual and reproductive health services and HIV/AIDS services overlapped then made decisions based on the capacity and resources of each clinic to pinpoint what HIV/AIDS services they could provide. Currently:

- eight of the nine FHOK clinics provide voluntary counselling and testing for HIV
- all clinics offer programmes which aim to prevent mother-to-child transmission of HIV as part of their maternal health services
- five of the nine clinics provide antiretroviral therapy to people living with HIV.

FHOK's antiretroviral therapy programme is part of the Models of Care project initiated by the GTZ, which is working with IPPF to develop models of integration across sexual and reproductive health and HIV/AIDS care.^{xxii} FHOK's programme is a pioneer in the field – offering antiretroviral therapy in a sexual and reproductive health setting.

Interconnected health needs: The case for mainstreaming HIV/AIDS

Teenage pregnancy is a serious problem, and maternal mortality remains extremely high at 560 deaths per 100,000 live births^{xxiii}. In addition, the high incidence of sexually transmitted infections, which increase the risk of HIV transmission, is a cause for concern. Services for sexual and reproductive health and HIV/AIDS must march in step for genuine progress to be made on either front. This will require a change in mindset of health care providers and donors alike, in the sense that sexual and reproductive health and HIV/AIDS are inter-connected and should therefore be addressed using an integrated approach.

Voluntary counselling and testing: Complex and sensitive issues

Expanding access

The civil-society community recognized the importance of expanding access to client-initiated voluntary counselling and testing services. FHOK's clinics were ideally placed for this: the Association was already offering treatment for sexually transmitted infections and opportunistic infections and believed it had the space and relevant staff to take on voluntary counselling and testing. It sent a number of family planning nurses to train as voluntary counselling and testing counsellors, trained laboratory technicians to conduct the tests, and started offering free voluntary counselling and testing services in its clinics in 2001.

Developing policy

In setting up HIV counselling and testing, FHOK also had to explore and develop policies about such vital and sensitive issues as:

- confidentiality
- informed consent
- how to ensure clients' privacy when attending clinics
- how to counsel clients about disclosing a positive test result
- parental consent in the case of minors seeking voluntary counselling and testing.

Some of these issues are particularly complex and delicate. For example,

disclosure can increase the risk of violence and stigmatization, especially for young women, and this is an additional factor that service providers need to consider. The policies developed by FHOK corresponded with those of the Ministry of Health's National AIDS Control Programme, through which HIV clinical services in Kenya are supervised.

Increasingly diverse client base

As the service became more widely known, FHOK found that the demand for sexual and reproductive health services offered at its clinics increased, along with the steadily increasing demand for HIV counselling and testing. Crucially, it also brought men into the clinics. The Association soon found its regular staff had become overloaded in some clinics and had to recruit more staff.

Meeting the needs of young people

FHOK has a number of youth centres that provide recreational activities, libraries and vocational training opportunities as well as voluntary counselling and testing. There, young people of any age can be offered HIV counselling, but anyone less than 15 years must, by national policy, have the consent of a parent or guardian to be tested for HIV.

In 2005, four young people already

experienced in peer education for sexual and reproductive health were trained to run voluntary counselling and testing services. It soon became apparent that providing information created demand, and therefore it was important to be able to provide services to meet these demands. On their own initiative, they started a mobile HIV counselling and testing service that goes out at least twice a month, and operates out of a tent if no other suitable venue is available.

The main aim of the mobile service is to encourage responsible sexual behaviour among young people – offering voluntary counselling and testing is, therefore, seen as part of the wider campaign to provide sexual and reproductive health services for young people. The mobile unit uses rapid tests and provides pre- and post-test counselling. The counselling addresses HIV prevention, including safer sex counselling, and correct and consistent condom use, and is linked to condom distribution – free of charge for all those who need them. The unit uses a number of different rapid tests. Anyone who tests positive to two of the three different tests used is informed of the result. They are then referred for a confirmatory test at the FHOK clinic. At the clinic they can also be registered for other HIV services, such as continuing counselling, care, antiretroviral therapy for those who meet medical eligibility criteria, and treatment for opportunistic infections as necessary.

Nakuru: A model of integrated services

FHOK's clinic at Nakuru provides a good example of the Association's work in practice.

The clinic annually serves a population of about 8,000 clients – mostly extremely poor people living in overcrowded settlements where scores of families may share a single tap and latrine.

The town straddles a major highway which is a trucking route to neighbouring countries. This is a high-risk environment for HIV transmission, since the loneliness, transience and relative freedom of the trucking lifestyle are associated with casual liaisons which help to fuel the demand for sex work. Unsurprisingly, the HIV infection rate recorded by the voluntary counselling and testing unit, which opened in Nakuru in 2003, is higher at 8.3% than the national average.

As well as its original function offering family planning services, the clinic now offers general outpatient services, and has changed its name to the Family Care Medical Centre. Clients can attend for any reason, but every opportunity is taken to raise the topic of sexual and reproductive health and to advocate for voluntary counselling and testing. More than 300 people a month seek HIV counselling and testing, and in 2004 nearly 1,000 clients sought treatment for HIV-related opportunistic infections, which is offered as part of general outpatient services.

Reaching out to men: Developing an inclusive approach

Recognizing that its clientele was almost exclusively female, FHOK made an effort in the mid-1990s to encourage male involvement in family planning by opening three clinics for men only. The initiative was an eye-opener. The Association realized that the traditional messages and activities of family planning tended to be female-oriented, and that the very real needs and concerns of men were neglected. It noticed over time that in the places where the male involvement project was operating (but not elsewhere):

- there was an increase in the number of men accompanying their partners to the main FHOK clinic
- there was a significant reduction in the number of women who would leave their appointment cards on file at the clinic out of fear that their partner would discover they were using contraception
- more and more women were taking away condoms, even when not accompanied by their partners – an indication of increased acceptance of family planning by men, and easier communication between couples which is a vital component of healthy sexual relationships.

Valuable lessons were learned about how to create a more 'inclusive' image for sexual and reproductive health and to make FHOK's regular services more male-friendly. These included the need to:

- develop information materials targeted at men (which, importantly, have the effect of empowering them in family decision-making, too)
- advocate for family planning and other sexual and reproductive health services in places where men gather, such as football clubs and barbers' shops
- make sure that clinic opening times are convenient for men

After four years, separate male clinics were no longer considered necessary and were closed. It was at this point that the Nakuru clinic changed its name to the Family Care Medical Centre, to reflect both its new orientation as well as the comprehensive nature of the sexual and reproductive health services it provides, including HIV/AIDS prevention, treatment and care.

Care without walls: Community outreach

Many people cannot afford the time or travelling cost to attend a health facility. The Nakuru clinic therefore offers services to these populations through community outreach.

Volunteers

Some 50 community health volunteers and community-based distributors have been trained by FHOK and others to raise awareness of family planning, educate people about other sexual and reproductive health issues, and distribute condoms. They refer clients to FHOK for other contraceptive methods, and for diagnosis and treatment of sexually transmitted infections. Once a month, a nurse from the clinic accompanies one of the outreach teams to offer sexual and reproductive health services in the community. As an incentive, and to enable often very poor people to give their time, volunteers get a small fee if clients referred by them attend the family planning clinic.

Over recent years, volunteers have also been trained in basic facts about HIV/AIDS, and HIV prevention is now an integral part of all sexual and reproductive health outreach activities. Community health workers advocate for voluntary counselling and testing and, in 2004, in collaboration with the HIV/AIDS support group 'Tumaini na Fadhili',^{xxiv} and with technical assistance from

FHOK, they began offering home-based care as well. People living with HIV have also been trained to join the team of community health workers. They do HIV-related work such as home-based care, nutritional counselling and psychosocial support in addition to other sexual and reproductive health work.

Networking

To try to provide for the comprehensive needs of its clients, the clinic actively networks with other non-governmental organizations which have complementary services and skills to offer. Clinic colleagues also collaborate with their clients' own community support organizations who become their partners at grassroots level.

Situated in a busy market-place, the Nakuru clinic has an air of community ownership. It offers space to a puppetry troupe that is engaged in sexual and reproductive health and HIV education. It is also a regular meeting place for a 'post-test club' – about 320 people living with, or affected by HIV, who gather for group support and counselling from Tumaini na Fadhili on issues such as good nutrition, safer sexual behaviour and home care. The clinic works closely with the provincial general hospital, on which it relies for advanced laboratory services and for referral of clients it does not have the capacity to treat.

Stigma and discrimination

In every country, very real fears about stigma and discrimination inhibit people from seeking HIV services, whether it is going for testing, accessing health care for opportunistic infections or AIDS, or attending HIV-positive support groups. Kenya is no different in this respect. FHOK, in collaboration with its non-governmental organization partners, addresses these issues with sustained education about HIV and AIDS, and advocacy which raises awareness about the need to respect the human rights of people living with HIV.

Other practical steps include making sure that the entrance and waiting areas are the same for all clients so that there is no way of singling out people who come to the clinic for HIV-related services. In addition, all members of staff are trained, and reminded at every opportunity, about the importance of confidentiality and fighting stigma.

Partners at the grassroots: Communal self-help

The sun is beating on the tin roof and heating the air on the veranda of the small local mosque where a group of women in bright headscarves is gathered on wooden benches for an education session on tuberculosis and HIV. They are members of the Kufaana self-help group, established in Rhonda, one of Kenya's biggest slum settlements, on the outskirts of Nakuru.

Soon after the President declared AIDS an emergency, the people in Rhonda realized they were not going to get the help they had hoped for from outside, and that they had better organize themselves to address the disease that was silently destroying their community. Each week, the 40 members contribute 10 shillings (about 13 US cents) to a communal account to fund projects.

Kufaana members have received training and support from FHOK and others in peer counselling, condom distribution and home care for people living with HIV. Talking about their lives, the women gathered on the hot veranda say it is easier these days to talk about condoms with men: they are all educated about HIV and they draw strength and support from their friends in the group. Some say they wish female condoms were more accessible –at around 100 shillings (US\$1.30) each, they cost more than a family has to live on for a day. And yes, they are all in favour of family planning, but the reality is, they say shaking their heads, that even getting to the clinic for advice and consultation is beyond the means of most of them. It is a long walk to where public transport begins, and then there is the bus fare and the long hours lost to earning a living.

Extreme poverty limits what Kufaana members can do for people dying of AIDS, too, even with training in home care. In this settlement, there are days without water in the communal tap, so even rehydrating someone with diarrhoea is a challenge.

Antiretroviral therapy: Training and treatment

In 2002, the Kenyan Government started providing antiretroviral therapy through specialist comprehensive care centres set up in the major hospitals. Unfortunately, coverage of the comprehensive care centres is limited and the services are overstretched. In addition, comprehensive care centres are stigmatizing, especially for newly diagnosed HIV-positive clients: anybody who walks into these clinics is making a public announcement about their HIV status.

Expanding access

FHOK, which works closely with the Ministry of Health, decided to use its facilities to expand access to antiretroviral therapy. By the end of 2005, four clinics, including the one at Nakuru, were providing antiretroviral therapy as part of the IPPF/GTZ Models of Care project. Motivation to offer the new treatment programme also came from FHOK's own staff: clinic managers, at a quality of care workshop, identified the need to include antiretroviral therapy in the comprehensive package of sexual and reproductive health and HIV services offered by their clinics.

The initial goal was to recruit 100 clients (25 in each clinic) in the first year, and to prove FHOK's ability to provide in antiretroviral therapy before seeking support to expand provision from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other donors. A core group of doctors, nurses, laboratory staff and pharmacists have received specialist training and passed on their skills to others working alongside them in the clinics. The Ministry of Health has offered further training to clinical staff in Nakuru, on paediatric HIV care.

The clinic doctor does the initial assessment. Clients who meet the clinical criteria for treatment are started on antiretrovirals, and supported through this process. Seventeen clients were already accessing antiretrovirals through this clinic by June 2006 and the numbers continue to rise. The clinic works closely with the provincial general hospital which manages complicated cases and performs more advanced diagnostic tests, such as CD4 and viral load counts, where required. The clinic offers antiretroviral therapy services without charge and, together with the other FHOK clinics, now receives free antiretroviral supplies from the Government. The biggest challenge to uptake of services, however, is the fee for laboratory tests: even though the fees are discounted to half the commercial rate, the costs are still out of reach for the majority of clients.

Taking treatment out to the community: Follow-up care and support

Once treatment is established, and there are no problems with taking the medication, clients are then cared for by a nurse who has the authority to write repeat prescriptions for their drugs.

The community volunteers (some of whom are living with HIV themselves) play an important role too, by providing psychosocial support, nutritional counselling and, vitally, in encouraging adherence to treatment and discussing prevention strategies for people living with HIV. Volunteers also help by delivering drugs to clients who have difficulty attending the clinic, just as they do with contraceptive supplies and condoms and with medication for general home-based care. The clinics rely on their partners within communities, including the volunteers, to help identify and recruit people in need of antiretroviral therapy.

Community health volunteers: Motivation and role

Seated in the sunshine outside the provincial hospital's sexually transmitted infection clinic, Mary talks of her work as a volunteer with FHOK.^{xxv}

Mary, a working nurse, felt compelled to use her skills to help people who rarely receive health care, and joined FHOK in 1991 to do sexually transmitted infection outreach among sex workers in her spare time. Trained in syndromic management of sexually transmitted infections, she went out to diagnose and, where possible, treat these infections among sex workers and their clients, to counsel about safer sex and to distribute condoms. More recently, Mary trained in voluntary counselling and testing and to deliver home-based care for people living with HIV, and she is hoping to become involved in the antiretroviral therapy programme too.

This work is very close to her heart. As well as bringing up her own three children, Mary is raising three nephews and nieces whose parents have died of AIDS.

Services for young people: A pressing need

Statistics

The pressing need for sexual and reproductive health services for young people in Kenya is evident as the following statistics show.

- Almost 25% of the population is aged 15 to 24 years.
- The median age of first sexual intercourse for women aged 25 to 29 years is 16.5 years.
- In rural areas, up to 21.8% of young women began childbearing aged 15 to 19 years.
- The HIV prevalence for young women aged 15 to 24 years is estimated between 12.5 and 18.7% (and 4.8 to 7.2% for young men of the same age).
- Only 52% of young women aged 15 to 24 years know that they can protect themselves from HIV by consistent condom use.

Source: UNFPA Kenya profile – www.unfpa.org

Information and life skills

There has been impassioned public debate about what kind of information and services are appropriate for young people, and a new adolescent sexual and reproductive health policy was recently adopted by the Government. It allows information and life skills to be taught in schools, but not as part of the statutory curriculum. FHOK has taken a bold lead and, as long ago as

the early 1980s, started producing educational fact sheets for young people. This initiative was followed by training young people as peer educators to provide information on sex and sexuality, family planning, prevention of sexually transmitted infections and HIV, and to distribute condoms. Though the legal age of consent to sexual intercourse has recently been raised from 14 to 16 years, condoms can still be legally distributed to young people below this age.

FHOK now has a number of youth counselling centres, supported by funding from IPPF and UNFPA, where members aged between 10 and 24 years can access clinical services on site or be referred to an FHOK clinic. At the Nairobi youth centre in Eastleigh, for example, a nurse is available three afternoons a week, and there is a voluntary counselling and testing unit staffed by the youth counsellors who also run the mobile testing facility. During the last quarter of 2004, 313 males and 222 females sought HIV testing. During the whole year the unit saw 2,025 clients, compared with 1,500 clients in 2003.

The information, personal counselling and clinical services offered at the centres are part of a more general programme of activities that attract young people. All activities are geared toward developing life skills. At the Nairobi youth centre, for example, there is a library, a video

room and an opportunity to take part in drama activities. Training in knitting, sewing, hairdressing, catering and computer skills is on offer for young women only, to encourage more girls to attend (at present about one-third of youth centre members are female), and to ensure they are given a chance to learn skills without competition from the more confident boys.

Peer education

All members can train as peer educators too, and are responsible for outreach activities at schools and on the streets. In the third quarter of 2004, nearly 20,000 out-of-school young people and 10,000 young people in schools were reached with sexual health information, and 1,600 female and more than 12,300 male condoms were distributed.

Given the socio-economic situation and level of need in Kenya, peer counselling can be extremely stressful. The key to avoiding burnout is effective networks – having somewhere to refer a client when the counsellor can give no further help. He or she can, for example, refer a girl who has been raped to the Nairobi Women's Hospital, refer someone living with HIV to Women Fighting AIDS in Kenya or to the local Médecins Sans Frontières project, and refer those with drug problems to rehabilitation programmes.

The legal and policy environment: Additional constraints

FHOK operates in a difficult legal and policy environment. Sex work and homosexuality are illegal, which encourages stigma and secrecy and makes these behaviours more difficult to address directly in health information materials. It also leaves health providers and clients unsure of their boundaries and vulnerable to the whims of the police and the courts.

Abortion

Abortion is also illegal except when necessary to save the woman's life. FHOK operates entirely within the law, by offering counselling to women with unintended pregnancies and treating the complications of unsafe abortion. However, this willingness to work on abortion subsequently led to a substantial withdrawal of funds for all areas of FHOK's activity due to a shift in donor conditionality.

Health providers cannot avoid the issue, no matter how controversial. More than half of all acute gynaecological admissions are for complications arising from unsafe abortions, and one in three maternal deaths is abortion-related. In early 2005, FHOK and partner organizations, as well as concerned individual professionals, set up the Reproductive Health and Rights Alliance^{xvii} which aims to:

- advocate for informed debate about abortion and the creation of laws and policies that protect women's reproductive health rights
- reduce the rates of unsafe abortion by all means possible
- protect care providers who are under threat from anti-choice campaigners and their supporters

Advocacy

FHOK makes provision in its budget to lobby decision makers and policy makers about sexual and reproductive health issues. It also participated in a workshop for religious leaders who were asked to acknowledge the needs of young people in their congregations and their special vulnerability to HIV, and to think about ways to protect young people's health.

The challenge of sustainability: On the knife-edge of survival

Donor constraints

Operating in an environment of widespread chronic poverty, FHOK faces a constant challenge to keep services going. Because of cutbacks in funding it has had to close clinics and withdraw support from nearly 1,000 trained community-based distributors, depriving more than 100,000 people of services.

In 1999, in an effort to ease its dependence on donors, it started charging fees for some of its services, and clinics are now required to draw up business plans. As a matter of principle, fees are waived for the poorest clients, voluntary counselling and testing remains free for everyone, and youth programmes are also fully supported. This means, however, that no clinic manages to recover more than 70% of its costs, and FHOK remains heavily reliant on outside support.

A major challenge in trying to run comprehensive services is that different donors have their own agendas and tend to earmark funds for specific purposes. A further challenge is posed by the fact that donors now tend to offer shorter contracts than they used to, which makes long-term planning difficult. Staff cannot be sure of their jobs from year to year, which affects morale, and there is a steady loss of good people – often trained at the expense of FHOK – to other non-governmental organizations, particularly international agencies.

Cash flow vulnerability

With such tight financial margins, FHOK's services are extremely vulnerable to interruptions in cash flow. Changes made by some donors in their accounting periods, and in their rules and conditions of funding, have left the Association without support for its youth programme for months at a time, and without money to pay the small stipends and expenses of some community volunteers. Living on a knife-edge of survival, many volunteers have been forced to drop out of the FHOK network. FHOK juggles funds to try to keep its youth peer educators in the field at all costs.

As far as antiretroviral therapy is concerned, FHOK is well aware of the absolute imperative to avoid interruptions in treatment. It therefore opened a dialogue with the Ministry of Health to enable the Government to recognize the benefits of integration and to support the innovative model of HIV care. The fruits of this advocacy have been impressive: the Ministry of Health has registered FHOK clinics to receive free antiretroviral therapy supplies from the Government, in line with other public facilities.

The need for comprehensive services: John's story^{xxvii}

John tested HIV-positive in 1996 at the age of 19 years, when he was hospitalized with a mysterious illness. The support of other people living with HIV gave him the courage to challenge the fear and misunderstanding of his family, and when he moved to Nakuru he joined the support group at FHOK and trained as a youth peer educator. Nobody advocates more passionately than him for behaviour change and safer sex.

John became HIV-positive very soon after becoming sexually active. Many people believe marriage is out of the question for HIV-positive people, according to John, but in Nakuru he met and married a woman who had been a sex worker and who is also HIV-positive. He has talked with her about the need for people living with HIV to practise safer sex to avoid re-infection. The young couple strongly desired a child. They received excellent counselling from FHOK about pregnancy and preventing mother-to-child transmission. However, during emergency delivery of the baby two months early at the local hospital, he believes the antiretroviral prophylaxis was forgotten, and he and his wife live in fear of having their one-year-old daughter tested for HIV.

Although John is not yet in need of antiretroviral therapy, his wife is, and the family used to struggle to meet the cost of treatment at their local comprehensive care centre – about 500 shillings (US\$6.50) a month for the drugs alone – until the Government made treatment free in December 2005.

Plausible, possible and practical: Conclusions and lessons learned

In a country with a serious generalized AIDS epidemic, it makes sense on every level to link sexual and reproductive health and HIV/AIDS services.

The only real question is – how?

FHOK has sought to answer this in varying ways in its different clinics, depending on the needs of their client populations and the clinics' own resources. A notable characteristic of FHOK is the openness of its staff to change and to adapt their services and working practices to meet the evolving needs of their clients. In a situation where many people have difficulty attending health facilities, the Association has developed a model of 'care without walls', where the clinics are the hub of community-based services, and it has important lessons to share about integrating services for sexual and reproductive health and HIV/AIDS.

To create an enabling environment for linked services, donors need to review the terms and conditions of their funding and allow greater flexibility in how money is spent.

Too often donor funds are earmarked for specific purposes only – for HIV or sexual and reproductive health activities. This makes budgeting and accounting for integrated services extremely difficult and imposes a heavy administrative burden that undermines the efficiency of the programme. There is a pressing need for greater coordination among donors and for a general review of their criteria and procedures for funding in the light of new objectives.

FHOK has demonstrated that providing antiretroviral therapy within sexual and reproductive health settings is plausible, possible and practical.

The strong network of community health volunteers attached to FHOK's clinics provides an excellent infrastructure to deliver antiretroviral therapy and good prospects of reaching poor and marginalized communities with life-saving treatments. Making it happen required vision, commitment and hard work. In addition, a number of key steps that built on FHOK's existing strengths were undertaken including specialist training of staff, procuring drugs and organizing logistics, and setting up partnerships with government hospitals for laboratory services and referral of clients.

Providing services for HIV/AIDS at sexual and reproductive health clinics attracts new clients and creates opportunities for promoting sexual and reproductive health to a wider population.

Attendance at FHOK's clinics increased, sometimes dramatically, once HIV counselling and testing was introduced. The tendency since then has been for demand for sexual and reproductive health care to increase alongside demand for HIV/AIDS services. The key to encouraging take-up of sexual and reproductive health and HIV/AIDS services is to advise clients about all services offered when they attend the clinic for any purpose.

In order to achieve their core aims, and to maximize the public health impact, sexual and reproductive health and HIV programmes should take specific steps to meet the needs and concerns of men as well as women in providing services.

Sexual and reproductive health – especially family planning – tends to be seen as ‘women’s business’, which inhibits men from attending clinics. In Nakuru, FHOK countered this by opening special male sexual and reproductive health clinics for a period, and subsequently removing all unintended sexist bias in its main clinic, providing information targeted at men, ensuring opening times were convenient for both male and female clients, and renaming the clinic the Family Care Medical Centre. These actions have had a dramatic effect. They have enabled and encouraged men to share responsibility for family planning with their partners, and they have facilitated communication between sex partners, which is vital for protecting health and preventing the spread of HIV.

The best way to promote sexual and reproductive health among young people and to raise awareness of HIV is to make information and services available as part of a wider programme that addresses their social needs, and helps empower them to make healthy choices.

FHOK’s youth centres provide opportunities to engage in a wide range of recreational and skills-training activities that are a major attraction to young people, especially those from impoverished environments. As well as creating an ideal setting for educating and communicating with young people, such centres make it easy and comfortable for them to access care.

By providing space for community groups to meet, or a base for their activities, clinics can strengthen the links with their client population to their mutual benefit.

Among its many benefits, such an arrangement provides opportunities for health education and training that encourage and enable people to take greater responsibility for their own health; it helps foster mutual understanding and trust between service providers and their client population; it gives focus and support to communities wanting to organize activities; and it allows for peer support among people with common concerns. In addition, it fosters a sense of ownership of health services by the people they are designed to serve. Providing space for community-based organizations to meet is also a good way of encouraging collaboration and partnerships with and among groups involved with sexual and reproductive health and HIV/AIDS.

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Endnotes

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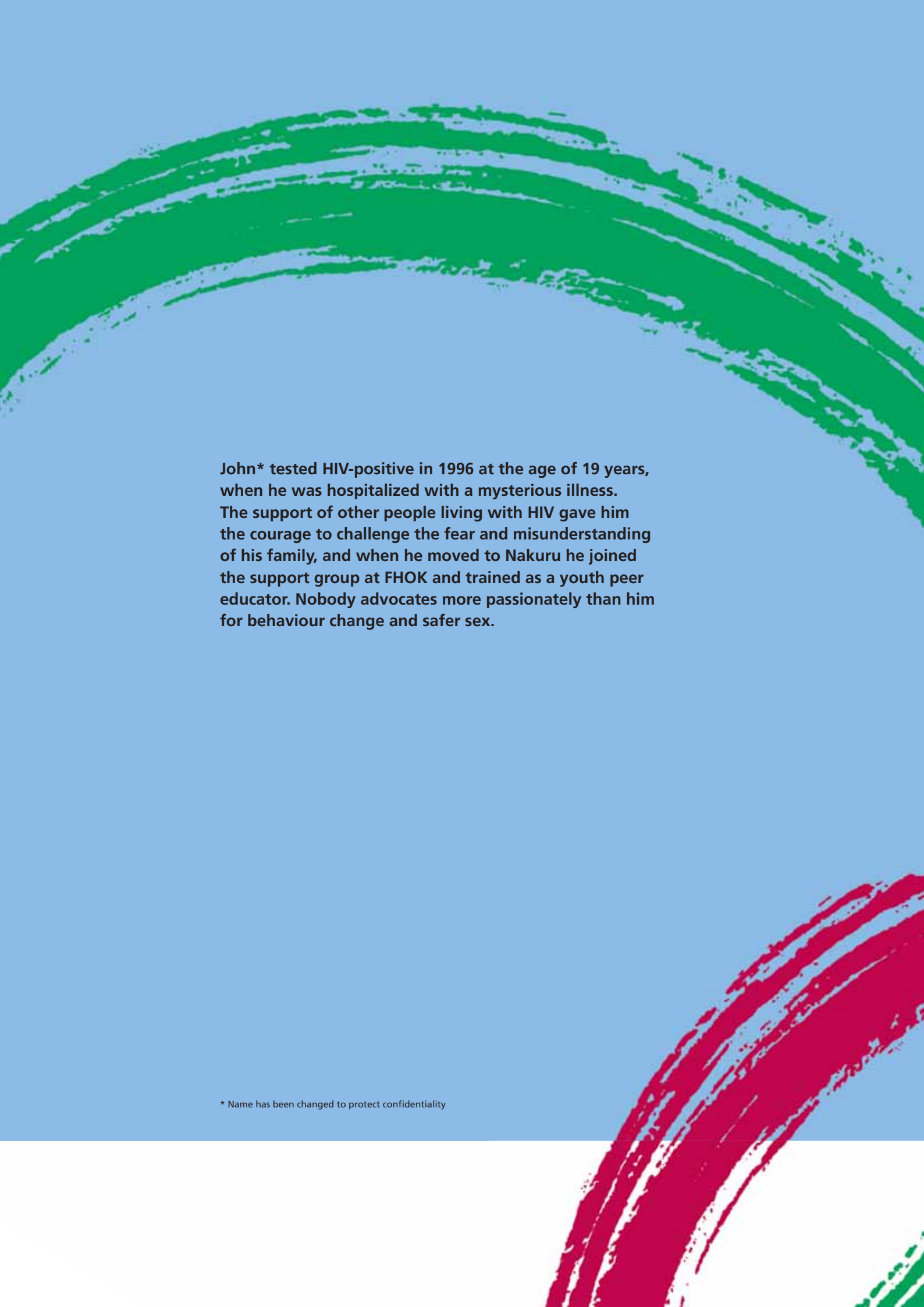
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^{xxiv} This means ‘hope, love, care and support’ in Kiswahili.

^{xxv} Name has been changed to protect confidentiality.

^{xxvi} These include FHOK, IPPF, the Kenya Medical Association, the Kenya Nursing Council, the Obstetric and Gynaecological Society of Kenya, the Planned Parenthood Federation of America, IPAS, the National Nurses Association of Kenya, the Federation of Women Lawyers Kenya (FIDA Kenya), and the Kenya Human Rights Commission.

^{xxvii} Name has been changed to protect confidentiality.



John* tested HIV-positive in 1996 at the age of 19 years, when he was hospitalized with a mysterious illness. The support of other people living with HIV gave him the courage to challenge the fear and misunderstanding of his family, and when he moved to Nakuru he joined the support group at FHOK and trained as a youth peer educator. Nobody advocates more passionately than him for behaviour change and safer sex.

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