INTEGRATING REPRODUCTIVE HEALTH AND HIV CARE AND TREATMENT SERVICES

A TOOLKIT FOR SERVICE PROVIDERS

MINISTRY OF HEALTH

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DOCUMENT INFORMATION

TITLE
A Toolkit for Integrating Reproductive Health and HIV Care and Treatment Services

DATE
March 14th, 2016

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LIST OF ACRONYMS

AMCR	Average Monthly Consumption
ANC	Antenatal Care
ART	Antiretroviral Treatment
BCC	Behaviour Change Communication
BMI	Body Mass Index
BTL	Bilateral Tubal Ligation
BCS	Balanced Counselling Strategy
COC	Comprehensive Care Centres
CCC	Combined oral contraceptives
DAR	Daily Activity Register
DMPA	Depot Medroxyprogesterone Acetate
EID	Early Infant Diagnosis
FANC	Focused Antenatal Care
FIF	Facility Improvement Fund
FP	Family Planning
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
LARC	Long-Acting Reversible Contraception
MCH	Maternal and Child Health
MEC	Medical Eligibility Criteria
MIYCN	Maternal, Infant and Young Child Nutrition
MOH	Ministry of Health
MoS	Months of Stock
PAC	Postabortion Care
PIFP	Provider-Initiated Family Planning
PITC	Provider-Initiated HIV Testing and Counselling
PNC	Postnatal Care
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
RTI	Reproductive Tract Infections
RT	Reproductive Tract
SDP	Service Delivery Points
SRHR	Sexual and Reproductive Health and Rights
SGBV	Sexual and Gender-Based Violence
WHO	World Health Organization
SGBVS	Sexual and Gender-Based Violence Services
STI	Sexually Transmitted Infections
YFS	Youth-Friendly Services

FOREWORD

The Ministry of Health supports the realisation of Universal Health Coverage (UHC), which is well enshrined in the Kenyan Constitution 2010, the Kenya Health Policy 2014-2030 and the Kenya Health Strategic and Investment Plan 2013-2017. One of the evidence-based approaches for the efficient and effective delivery of care is through the integration of health services. Integrating reproductive health (RH) and HIV and AIDS policies, programs and services has been considered essential for meeting global and national goals and targets including the Sustainable Development Goals and Vision 2030.

In line with the above, the Ministry of Health developed the National Reproductive Health and HIV and AIDS Integration Strategy, which provides a framework for the integration of RH and HIV services. Additionally, the Ministry of Health developed the Minimum Package for RH & HIV Integrated Services, which seeks to provide guidance to implementers and service providers on the minimum requirements for infrastructure, human resources, skill sets and training materials, equipment, commodities and supplies, and monitoring and evaluation that are necessary at all levels of care for effective service provision.

The RH-HIV Integration Toolkit aims to operationalise the Minimum Package for RH & HIV Integrated Services. The primary intent of the RH-HIV Integration Toolkit and accompanying documents is to aid managers and facility and departmental in-charges in integrating the various clinical services for more efficient service delivery.

It is the Ministry's hope that the implementation of RH and HIV service integration as outlined in this Toolkit will assist the health sector in realizing national targets and will also contribute to the attainment of global goals.

I wish to appreciate the contributions and efforts of all individuals, organizations and stakeholders who gave their valuable time, input and feedback during this all-inclusive development process that resulted in the RH-HIV Integration Toolkit.

Dr. Jackson Kioko
Director of Medical Services, MOH
Ministry of Health

PREFACE AND ACKNOWLEDGMENT

The Ministry of Health [Reproductive and Maternal Health Services Unit (RMHSU) and National AIDS & STI Control Programme (NASCOP)] would like to acknowledge all stakeholders, individuals and organizations that have contributed to the development of the RH-HIV Integration Toolkit.

Dr. Kigen Bartilol of the RMHSU and Dr. Martin Sirengo of NASCOP provided overall leadership during the development process. The RH-HIV Integration Taskforce with membership from RMHSU, NASCOP, United States Agency for International Development, Centers for Disease Control and Prevention, Kenya Obstetrical and Gynaecological Society, United Nations Population Fund, FHI 360, University Research Co., LLC, KEMRI-FACES, University of California, San Francisco, Marie Stopes International-Kenya, Family Health Options Kenya, JHPIEGO-Maternal and Child Survival Program (MCSP) Population Council and ICAP-Centre for Health Services provided the much needed stakeholder consultations and pooled resources to ensure the Toolkit was all inclusive. We acknowledge the team spirit f the RH-HIV Integration Taskforce members that culminated in the development of the RH-HIV Integration Toolkit to operationalize the Minimum Package for RH & HIV Integrated Services. The members include Gladys Someren, Rose Wafula, Laura Oyiengo, Margaret Gitau, Marsden Solomon, Jerusha Karuthiru, Isabella Yonga, Evelyn Mwania, Benjamin Odongo Elly, Maricianah Onono, Dan Okoro, Prisca Muange, Ann Githige, Esther Muketo, Mwaniki Kivwanga, Lynn Kanyuuru, Paul Nyachae, Wangui Muthigani, Gabriel Tembula, Kennedy Mwai Okoth, Kevin Okoth, Lulu Oguda, Jonah Maina, Dorcas Mang'oli, Hambulle Mohammed, Diana Kamar, Amos Oyako, Nakato Jumba, Margaret Makumi, Samson Muga, and Timothy Abuya.

The feedback from the RH-HIV dissemination regional meetings provided information on specific regional requirements. We thank the regional teams comprised of CASCOs, CRHC, county representatives and other stakeholders.

We express deep gratitude to the consultants Rebecca Njuki and Mercy Kamau for their enormous efforts in leading the development of this toolkit. We also acknowledge and are grateful to Rachel Burger and Drs. Maricianah Onono, Craig R. Cohen and Sara J. Newmann for their overall guidance and oversight throughout.

The efforts of Pamela Kato in designing the cover, preparing and formatting the Toolkit and collating the matrixes are greatly appreciated.

Financial support for the development of the Toolkit was provided by the Bill & Melinda Gates Foundation.

INTRODUCTION

This Toolkit provides step-by-step procedures that can be followed to successfully implement reproductive health (RH) and HIV service integration at the health facility level. It further discusses the resources required to support the implementation process and provides useful resources such as training curricula, communication materials, implementation guidelines, and monitoring and evaluation (M&E) tools that facilitate the successful integration of RH and HIV services. The Toolkit is based on a systematic review of documents, reports and peer-reviewed journals, program review, real-time observations and a panel of experts on the integration of RH and HIV services.

For more information regarding integration initiatives and best practices for linking HIV and SRHR, visit:

1) http://www.integrainitiative.org/resources/integra-project

2) http://www.srhhivlinkages.org

3) http://integrationforimpact.org/

PURPOSE OF THE TOOLKIT

There has been a growing programmatic need to integrate RH services and HIV care and treatment in Kenya, necessitating guidance on how integration can be implemented in a sustainable manner in different health system levels. In Kenya, the policy environment promotes the integration of RH and HIV services, as described in two Ministry of Health policy guidelines for RH-HIV service integration:

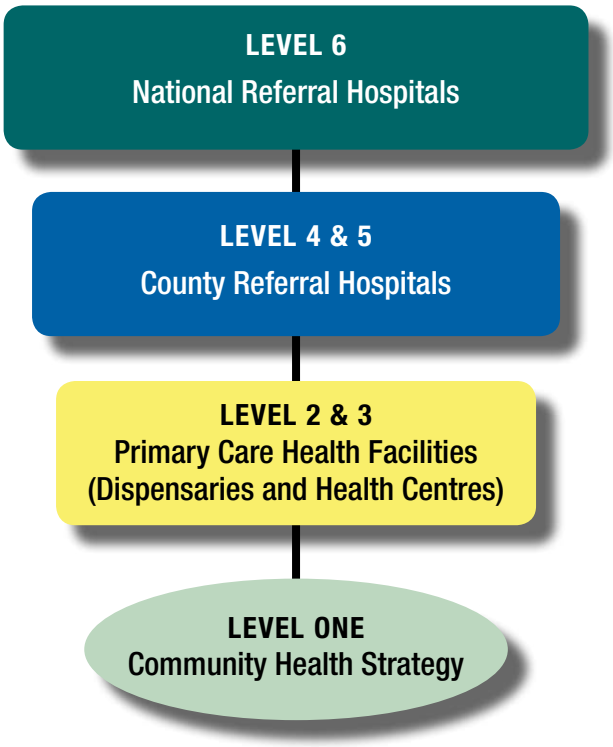
- National Reproductive Health and HIV and AIDS Integration Strategy-2009
- Minimum Package for Reproductive Health (RH) & HIV Integrated Services-2012

The implementation of RH-HIV integration cannot be successful, however, without proper guidance for county and sub-county health management teams, facility and departmental incharges, health workers and other relevant stakeholders on the steps required to integrate RH and HIV services. The Toolkit aims to fill this gap by providing feasible ways of integrating RH and HIV services within different health facility levels and service areas. The Toolkit will be utilized within, or adapted to the context of the counties using available resources.

The main objectives of this Toolkit are:

- To operationalize the implementation of the Minimum Package for RH & HIV Integrated Services.
- To provide guidance to county and sub-county health management teams, facility and departmental in-charges, health workers and other relevant stakeholders on how to strengthen RH and HIV service integration at different levels of health care.

LEVELS OF RH-HIV SERVICE INTEGRATION

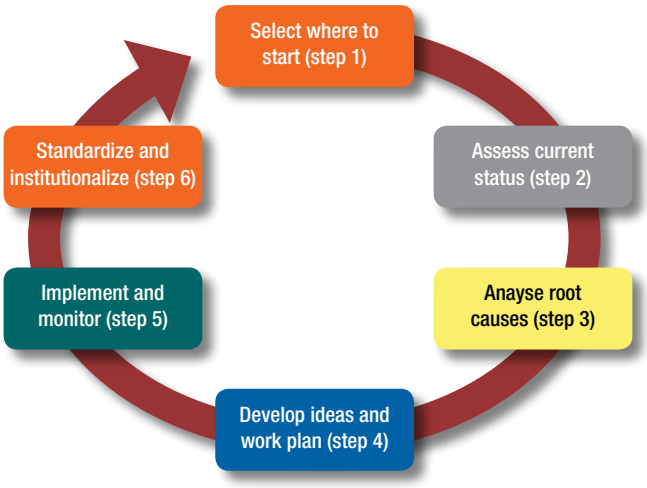


1. The community services: All community-based, demand-creation activities organized around the Comprehensive Community Strategy defined by the health sector.
2. The primary care services: All dispensaries, health centres and maternity homes of both public and private providers.
3. The county referral services: Hospitals operating in and managed by a given county, which includes all of the former level 4 and district hospitals in the county government. They form the County Referral System.
4. The national referral services: The service units providing tertiary and highly specialized services including high-level specialist medical care, laboratory support, blood product services and research. The units include the former Provincial General Hospitals and National Level Semi-Autonomous Agencies, and they operate under a defined level of selfautonomy from the National Health Ministry, allowing for self-governance.

LEVELS OF RH-HIV SERVICE INTEGRATION

The Toolkit is to be operationalised using a team-based approach. The Ministry of Health, through the Kenya Quality Model for Health (KQMH) and the Kenya HIV Quality Improvement Framework, mandates that every facility needs to put into place a quality improvement team (QIT) that oversees holistic improvement in service delivery. Facilities without these teams would need to form them in line with the KQMH. The QIT is composed of a departmental in-charge or designee. Further, each work unit/department is required to put in place a work improvement team (WIT) to oversee specific service area performance. The WIT is composed of all personnel working in a particular department or unit (at least 3 to 15 members). Smaller facilities with less than 15 workers are required to only form one WIT. The frequency of WIT meetings should be at least once every two weeks, and the QIT should meet at least once every month. The teams will be applying the following cyclic steps:

i. Select the service area(s) to start integrating in the health facility.
ii. Assess the current performance of these service area(s).
iii. Analyse the root cause of the current performance of the service area(s).
iv. Develop ideas and a work plan outlining how to undertake integration based on the root cause analysis of the service area(s).
v. Implement and continuously monitor performance through M&E.
vi. Standardise and institutionalise the integration of the service in the selected areas.
vii. In a stepwise manner, teams should aim to integrate all service area(s) as stipulated in the Minimum Package by repeating steps 1-6 above.



The Toolkit has checklists and indicators for both internal and external performance monitoring. County Health Management Teams (CHMTs) should continuously offer supportive supervision to ensure their teams are operational and offer additional support as required.

This Toolkit is organized into two areas:

1. Integration at the community level, and
2. Integration at the health facilities. This section presents the implementation of RH and HIV integration in the different service delivery points (SDPs).

In each area, the steps that facilitate the integration of RH services and HIV testing, care and
treatment are discussed.

INTEGRATION OF RH AND HIV AT THE COMMUNITY LEVEL

Introduction

Kenya's Ministry of Health, through its National Health Sector Strategic and Investment Plan III (2013-2017), emphasizes the promotion of individual and community health through the Community Health Strategy. This is a community-based approach in which households and communities take an active role in health-related and development issues. Its goal is to enhance community access to health care at the household and community levels through: building the capacity of Community Health Extension Workers (CHEWs) and Community Health Volunteers (CHVs) to provide health services at the community level; strengthen household-community-facility linkages; and raise the community's awareness of its rights to health.

Rationale

1. The uptake of RH-HIV services is largely influenced by social and cultural factors in a given community; therefore, understanding a community's perspectives is important.
2. CHVs are members of the community and thus have certain advantages over service providers because they can easily and effectively access and communicate with clients in need of RH-HIV services as equals.
3. CHVs are able to develop culturally acceptable RH-HIV messages for their communities and adapt the health care system to better suit the client's needs since they are linked to health facilities.

Human resources for level one

1. Sub-County Community Strategy Coordinator (SCCSC)
2. Community Health Extension Workers (CHEWs)
3. Community Health Committees (CHCs)
4. Community Health Volunteers (CHVs)
5. Champions and key opinion leaders

Step-by-step guidance on RH-HIV integration at the community level

1. Establishing and/or strengthening community units

RH-HIV services need to be offered within community units, and thus the establishment or strengthening of the community units is important. The entire process needs to be guided by the community strategy. The facility needs to work within the existing system to establish and/or strengthen the community unit within its catchment area.

2. Training of the CHEWs

The CHEWs need to be trained on the management of community health services as guided by the CHEW curriculum. In addition, they need to be trained on the technical modules for RH-HIV integration. This will enable them to offer supportive supervision to the CHVs and monitor the quality of RH/HIV integrated services at the community level.

3. Training of the CHVs

The CHVs need to be trained using the integrated curriculum that comprises the basic modules and the technical modules to equip the CHVs with the appropriate knowledge and skills to offer integrated RH-HIV services at the community level. The modules are outlined below.

Basic Module	Technical Modules
1. Health and development in the community	1. Water, sanitation and hygiene
2. Community governance and leadership	2. Community nutrition
3. Communication, advocacy and social mobilisation	3. Integrated community case management
4. Best practices for health promotion and disease prevention	4. Maternal and newborn health
5. Management and use of community health information and community disease surveillance	5. Family planning
	6. HIV/AIDs, TB and malaria
	7. Non-communicable diseases

4. Provision of RH-HIV services at the community level

After training, the CHVs are expected to offer services at community level that include:

a) RH-HIV information and psychosocial support

CHVs, under the supervision of the CHEWs, need to provide accurate information about RH and HIV. The provision of information should be supported by information, education and communication (IEC) materials that are culturally sensitive and contextualized to the community's needs. In addition, the CHVs need to provide psychosocial support to the clients in need especially during the HIV client's psychosocial support group meetings.

b) Service delivery

Based on competence, the CHVs need to provide the following services at the community level:

Service	Clients	Training Required
Combined oral contraceptives (COCs)	Revisit clients	Provision of COCs
Progesterone only pills (POPs)	New and revisit clients	Provision of POPs
Condoms (male and female)	New and revisit clients	Condom demonstration
Emergency pill	New and revisit clients	Emergency Pill
Depo-Provera	New and revisit clients	New and revisit clients

- FP counselling
- Distribute pills to revisit clients (COCs & POPs)
- Provide Depo-Provera to new and revisit clients in hard-to-reach areas where CHVs have been trained as per the annexed MOH policy guidelines (Baringo, Garissa, Mandera, Marsabit, Narok, Samburu, Tana-River, Turkana, Wajir, West Pokot, Kajiado, Kilifi and Isiolo)
- Distribute male and female condoms
- Provide emergency contraception (EC)
- Psychosocial support

c) Commodity management

The CHEWs will use MOH form S11 to request commodities from the pharmacy and will issue commodities to the CHVs using the CHV commodity tracking tool. At the end of each month the CHEWs convene a CHV monthly meeting where the CHVs report the commodities they have issued and the balances at hand. The CHEWs use the monthly consumption figures to quantify commodities for the coming months, as outlined in the RH-HIV commodity management section (page 25).

d) Community-facility referrals

CHVs are expected to refer clients in need of more specialized RH and HIV services to the health facility. The referral needs to be written in triplicate where one copy is left in the CHWs referral booklet and the other two copies are given to the client to present to the facility. One copy is filed at the facility to measure the effectiveness of the referral system while the other copy is returned back to the CHV by the client for any follow-up support at the community level.

e) RH-HIV integrated outreach

The CHEWs and the CHVs need to identify areas with large unmet need for RH-HIV services and plan for integrated outreach. Where possible, outreach services can leverage other existing outreach activities or community events. The venues for the outreach should be community based such as churches, schools, or community halls. The CHEWs and the CHVs need to mobilize the community members to come for services during the outreach through various mobilization strategies such as fliers, public address systems, door-to-door mobilization and announcements in churches and markets. The clients identified with more specialized care needs should be referred appropriately.

f) Supervision

To strengthen the quality of community RH-HIV services, the CHEWs need to offer supportive supervision to the CHVs. Monthly supervision meetings with CHVs to review the quality of community RH and HIV activities need to be conducted where best practices, lessons learned, and challenges are shared. The meetings also provide a forum for continuous updates and refresher sessions on specific RH and HIV technical issues of concern to the CHVs.

g) M&E

The following data tools need to be used at the community level:

- MOH 513 CHIS Household Register
- MOH 514 CHW Service Delivery Log Book
- MOH 515 CHEW Summary
- MOH 516 CHIS Chalk Board
- MOH 100 Referral Booklet
- Counter Requisition and Issue Voucher (S11)

Tips for improving community-facility linkages

- Encourage CHEWs to participate in facility continuing medical education (CME) on RH-HIV-related areas
- Strengthen and link the community health information systems with health facilities
- Engage CHEWs/CHVs in community outreach

INTEGRATION OF RH AND HIV SERVICES IN HEALTH FACILITIES (LEVELS 2-6)

Introduction

As described in the Minimum Package for Reproductive Health (RH) & HIV Integrated Services, the type of integration will differ by the types of facilities at the different care levels. Three main approaches can be adopted to integrate RH and HIV services:

- The on-site approach: This could be a one-stop shop where RH-HIV integrated services are offered by one service provider in one room during the same consultation or where the services are offered by more than one service provider within one department or facility during the same visit.
- The off-site approach: A client accesses one type of RH-HIV integrated service and receives the other service outside of the facility/site through a referral.
- The mixed approach: If the base services are provided at the facility, but inadequacies in skills and/or equipment exist in that facility or site (e.g., bilateral tubal ligation), then the client is referred for these services.

Areas of RH-HIV integration

This section provides guidance on the implementation of RH and HIV integration at all health care facilities. The chapter is divided into two sections. The first section is the generic step-by-step processes for integrating RH-HIV into the different SDPs. The next section discusses specific steps for any SDP that does not fit the generic steps. The SDPs included are:

a) **Integrating RH and HIV into the Maternal and Child Health (MCH)/FP unit:**

This includes providing FP services (information, counselling and provision of FP methods), STI screening and treatment, nutrition services, prevention of mother-to-child transmission (PMTCT) including ARV prophylaxis and treatment, and information and screening for reproductive organ cancer.

b) **Integrating RH into Comprehensive Care Centres (CCC):**

This includes providing FP services, STI screening and treatment, and information and screening for reproductive organ cancer.

c) **Integrating RH and HIV into Maternity:**

This includes providing postpartum FP, STI screening and treatment and PMTCT services.

d) **Integrating RH and HIV into Inpatient Wards:**

This includes providing PITC, comprehensive postabortion care (PAC), TB screening, FP services, STI screening and treatment and reproductive organ cancer screening.

e) **Integrating RH and HIV into Outpatients Services:**

This includes providing STI screening and treatment, sexual and gender-based violence (SGBV) screening and treatment, providerinitiated HIV testing and counselling (PITC) and reproductive organ cancer screening.

f) **Integrating RH, HIV and Youth-Friendly Services (YFS):**

This includes providing FP services, HIV testing and counselling (HTC), STI screening and treatment, reproductive organ cancer screening, comprehensive SGBV services, HIV care and treatment services, substance abuse services, focused antenatal care (FANC) and postnatal care (PNC).

GENERIC GUIDANCE FOR INTEGRATING RH AND HIV SERVICES IN HEALTH FACILITIES

Introduction

Integrating RH-HIV services in the various SDPs provides multiple opportunities to streamline and improve care. This is important for maximizing RH and HIV treatment and care in the population. In Kenya, it is estimated that 1.2 million persons aged 15-64 years are infected with HIV, 89.3% of whom are currently enrolled in an HIV care clinic (KAIS 2012). This provides a great opportunity to provide RH-HIV integrated services to these clients given that clients seeking RH and HIV services often share common needs and concerns.

Why is it important to integrate RH and HIV services into the MCH/FP department?

- MCH services are the most pervasive services in the health sector (from the community to level 6) and form an important entry point of care.
- MCH clients are often healthy clients who would benefit from information and services related to sexual and reproductive health (SRH) and HIV.
- It provides clients with more comprehensive health care, which in turn leads to better health outcomes for the mother and child.

The scope of integration in the MCH/FP department

At the MCH department the following services can be offered:

- FANC
- PNC
- Child welfare
- FP services
- Maternal, infant & young child nutrition (MIYCN)
- Reproductive tract (RT) cancer screening (breast and cervical cancer)
- Post-exposure prophylaxis
- HIV testing and early infant diagnosis (EID)
- Treatment of HIV and provision of prophylaxis and treatment
- Screening for TB and other opportunistic infections
- GBV screening, care and treatment
- STI and reproductive tract infection (RTI) screening and treatment/referral

Why is it important to integrate RH and HIV services into the CCC department?

Clients seeking HIV-related services and clients seeking RH services:

- Are often both sexually active and fertile
- Are at risk of HIV infection or might be infected
- Need access to condoms and FP services
- Need to know how HIV affects contraceptive options

The scope of integration in the CCC department

At the CCC department the following services can be offered:

- ARVs
- Opportunistic infection screening and treatment
- FP services
- STI screening and treatment
- Information and screening (cervical, breast and prostate cancer)
- TB screening
- EID
- Psychosocial support
- HTC
- Post-exposure prophylaxis
- Pregnancy testing
- GBV screening

Why is it important to integrate RH and HIV services into the Maternity department and Inpatient wards?

- Provides an opportunity to offer postpartum FP, especially implants, intrauterine contraceptive devices (IUCDs) and tubal ligation
- Provides an opportunity to screen for STIs , HIV and RT cancer

The scope of integration in the Maternity department and Inpatient wards

- Postpartum FP (implants, IUCDs and tubal ligation)
- STI screening
- HTC
- Information on other RH services
- Initiation of ART
- Postabortion care

Why is it important to integrate RH and HIV services into the Outpatient services?

- Provides an opportunity to offer RH and HIV services to people who are accessing other services

The scope of integration in Outpatient department

- STI screening and treatment
- SGBV screening and treatment
- PITC
- Reproductive organ cancer screening

Why is it important to integrate RH and HIV services into the YFS department?

- Young people face numerous biological changes in their transition to adulthood that affect their SRH, highlighting the need for an integrated RH and HIV approach.
- Many young people are reluctant to seek SRH services from the health care system and when they do, there are many missed opportunities; therefore, there is a significant need for a comprehensive integrated RH and HIV package targeted toward young people.

The scope of integration in the YFS department

- FP services
- HTC
- Cervical, breast, and prostate cancer screening
- Comprehensive SGBV services
- ART
- Opportunistic infection screening and treatment
- STI screening and treatment
- Substance abuse services
- FANC
- PNC

Note: *The scope of RH-HIV integration will depend on the type of health facility and the organisation of services. Facilities differ by the availability of infrastructure, equipment and human resources. For services that are not available in the department/SDP, appropriate referrals should be made and documented using national tools as outlined in the Kenya Health Sector Referral Implementation Guidelines 2014.*

STEP-BY-STEP GUIDANCE FOR INTEGRATING RH AND HIV SERVICES IN HEALTH FACILITIES

1. Situational analysis (assessing performance gaps to inform the action plan)

The service provider in-charge of the health facility should carry out a situational analysis to identify the strengths, weaknesses, opportunities and threats (SWOT) related to RH/HIV integration in the department. A SWOT analysis and the following checklist can be used to assess the department's readiness for integration. A SWOT analysis begins by conducting an inventory of the internal strengths and weaknesses in the department. The primary purpose of the SWOT analysis is to identify and assign each significant factor, positive and negative, to one of the four categories, allowing you to take an objective look at the department. The SWOT analysis should be done jointly by all staff of the department. A SWOT analysis should be done for each service that is to be integrated in the department.

Table 1: An illustrative SWOT analysis for integrating RT cancer screening into MCH/FP services at a health facility

Strengths • Adequate number of staff that can be trained • RT screening commodities availablee	**Weaknesses** • Lack of privacy • Only one staff trained • Poor staff attitudes towards integration
Opportunities • Large room that can be partitioned to provide privacy • On-the-job training (OJT) and mentorship for untrained staff	**Threats** • Lack of access to facility improvement funds (FIF) to improve RT screening services

A checklist shows you how to evaluate a department's technology and technical requirements. The checklist will provide an assessment of requirements to ensure the successful implementation of the selected integrated service.

Table 2: Checklist of inputs and service availability

	Expected Inputs (Indicate Yes or No)*					
		Human Resources				
	Service Availability	No. of Trained Staff for the Service	Type of Staff	Equipment	Supplies and Commodities	IEC and Job Aids
Expected Services						
1. FANC						
2. PNC						
3. Child welfare						
4. FP						
5. MIYCN						
Additional Integrated Services						
6. RT cancer screening (breast, cervical and prostate cancer)						
7. Post-exposure prophylaxis						
8. HIV testing and EID						
9. Treatment of HIV and provision of prophylaxis						
10. Screening for TB and other opportunistic infections						
11. GBV screening, care and treatment						
12. STI and RTI screening and treatment/referral						
** Reference the Minimum Package for Reproductive Health & HIV Integrated Services for details on the specific inputs*						

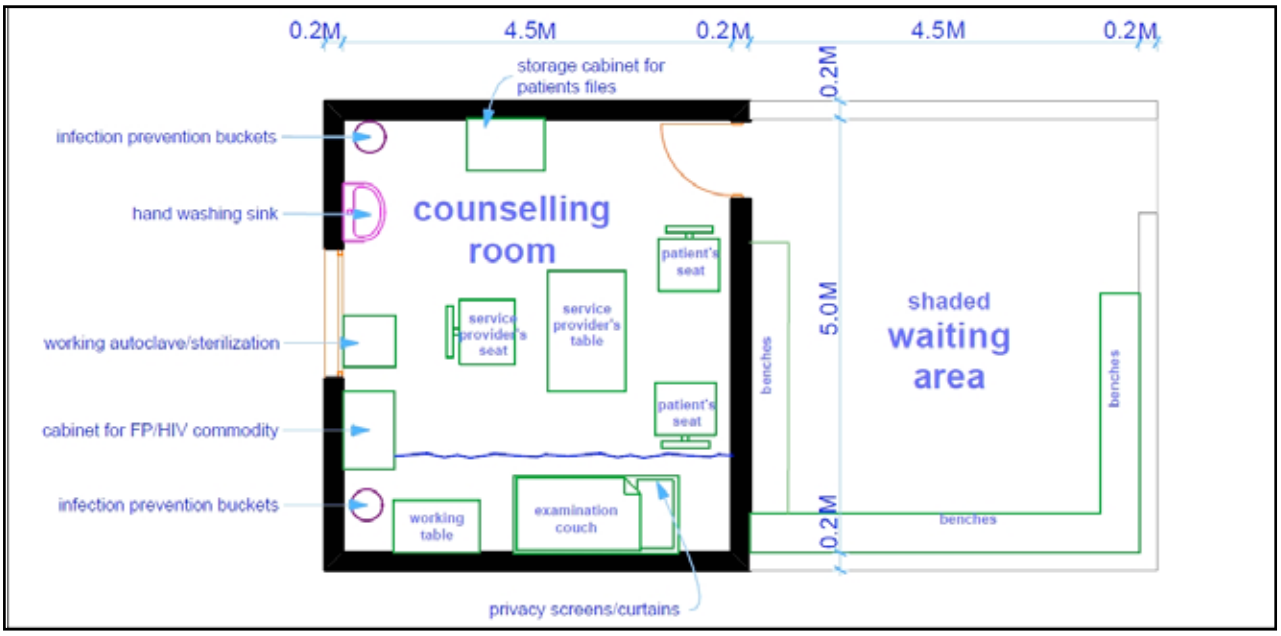
The gaps identified should be addressed by drawing up an action plan detailing how to sustain the strengths and improve the weaknesses by utilizing the existing opportunities while overcoming the threats.

2. Basic infrastructure

To enhance RH and HIV integration, basic infrastructure is required. Good infrastructure for the integration of RH and HIV services is comprised of the following:

1. A waiting area that is shaded or covered by a roof and where seating is available. This is an area where clients are received, wait for services and receive health talks.
2. Private space for examination, counselling and service provision, which enhances the client's privacy.
3. A source of clean water, infection prevention buckets, and a hand washing station for infection prevention.
4. A working autoclave/sterilization for sterilizing equipment, such as IUCD sets, within the facility.
5. Reliable lighting for examinations.

Below is a basic layout that can be adopted to suit the facility setting:



The following are some of the basic pieces of equipment that are required for RH and HIV integration:

- An examination couch.
- A cabinet for RH/HIV commodity storage. It is advisable to have the cabinet proximate to the examination couch for ease of access to consumables and equipment.
- A working table for setting out items to be used for any procedure.
- Screens/curtains around the couch for privacy.

3. Ensure human resources for RH-HIV integration

To strengthen RH and HIV integration in the different departments, competent and supportive staffing is critical. The facility in-charge needs to identify the key staff required to implement RH and HIV integration. The following are suggested key staff needed for RH-HIV integration but can be adopted based on staff availability in the facility:

- Medical doctor
- Clinical officer
- Nurses
- Pharmacist/pharmaceutical technologist
- Counsellors
- Nutritionist
- Laboratory technologist/technician
- Records officer
- Peer educators

4. Build the capacity of service providers

Facility in-charges should identify knowledge and skill gaps in the SDP into which they have chosen to integrate RH/HIV services.

a) OJT

OJT is an effective and efficient method of training in which a service provider with the skills to offer a particular service is identified to work with staff without these skills in order to show them how to perform or offer the services. OJT is cost effective because no special equipment is needed other than what is normally used. OJT can be used to train staff in the provision of long term FP methods and reproductive cancer screening, among other services.

b) Mentorship

A mentorship programme needs to be guided by the Kenya National Mentorship Policy. Mentorship may happen in two ways:

i. Internal mentorship programme

The internal mentorship programmes are conducted under the leadership of the facility in-charge. The steps taken to initiate an internal mentorship

1. The facility in-charge identifies staff within the facility that have the ability to mentor RH-HIVservices.
2. The mentor and the mentee develop a mentorship programme. The mentee and mentor should hold a debriefing session after each mentorship session to discuss achievements, lessons learned and challenges to inform the next mentorship session.
3. Once the mentee achieves the number of target clients, the CHMT conducts an assesment. If the mentee is assesed as competent in the service then she/he is recommended for certification by the MOH/Reproductive Maternal Health Service Unit.
4. The mentee is given targets to mentor other service providers working in HIV care and treatment or the outpatient department.

5. The identified mentors are updated on RH and HIV management by the CHMT to ensure that they communicate the most recent updates and policies to their mentees.

ii. External mentorship

Facilities need to consider external mentorship when there is a lack of internal mentors. The process of identifying and engaging external mentors is:

1. Communicate to the facility in-charge (through the departmental incharge the skills gap for RH-HIV integration.
2. The facility in-charge communicates the skills gap for RH-HIV integration at the CCC and outpatient department to the CHMT.
3. The CHMT/SCHMTs develop a standard mentorship package tailored to the facility's needs that ensures standardized knowledge and skills for RH and HIV service integration.
4. The CHMT/SCHMTs identify and list available mentors from other facilities or partner organizations in the county or within the CHMT based on the skills needed.
5. The CHMT/SCHMTs and facility in-charge develop the mentee and mentors' plan for mentorship sessions for the facility.
6. The mentees undergo a minimum amount of observed practice on clients with the help of the mentor as per MOH guidelines.
7. Upon completion, the CHMT/SCHMTs, in consultation with the facility in-charges, are expected to undertake the assessment and certification of eligible mentees.

Note: *It is recommended that the mentorship process be finalized within a period of three months; however, this may depend on the availability of mentors, the workload at the facility and the availability of mentees and clients. When implementing an external mentorship program, consider costs such as those related to training facilitation, transport and lunch for the mentors.*

c) Classroom training

This training primarily focuses on RH and HIV knowledge transfer. It includes some practical sessions, including those using humanistic models such as the perineal model and uterine model. The training is then followed by on-site mentorship to ensure skills acquisition by practicing on real clients.

d) CME

CME consists of educational activities that serve to maintain, develop or increase

the knowledge, skills and professional performance and relationships that a health worker utilizes to provide services to patients. The content of CMEs for RH-HIV service integration should be informed by the Minimum Package for Integration, and the step-by-step process of implementation should be informed by this Toolkit.

List of Relevant Checklist, Job Aids and IEC Materials for MCH/FP

- Balanced counselling strategy (BCS) job aid
- Flow chart for MCH integrated services
- FANC services
- Screening map
- Post-exposure flow chart
- HIV testing/EID algorithms

5. Introduce provider-initiated RH and HIV services

Having a provider initiate RH and HIV services is important as it assists both the health provider and clients in identifying unmet RH-HIV needs. This will prompt the clients to take up services not initially sought at the health facility. Providers should use the appropriate screening checklist for the appropriate constellation of services.

6. Disseminate and provide checklists, job aids and IEC materials to service providers

Relevant checklists, job aids and IEC materials should be made available to service providers, and updated materials should be communicated effectively to all service providers. The existing checklists, job aids and IEC materials for RH and HIV integration that should be used at the different SDPs are listed in the table of tools

Table 3: Summary of checklists, job aids and IEC materials for RH and HIV integration at the different SDPs

Tool	Who/When Used/Filled	How	Point Use
Job aids			
Implanon NXT orientation slides	Service providers transitioning from classic to NXT	Demonstration	Training, mentorship
FP bag	Service providers when counselling clients on FP methods.	Used to explain to the clients all FP methods and how they work.	Service delivery areas
Jadelle insertion poster	Service providers while inserting Jadelle	Used to illustrate Jadelle insertion procedure	Service delivery areas
WHO medical eligibility criteria 2015	Service providers before providing FP methods to clients.	Used to determine client eligibility for a method	Service delivery areas
Tihart FP chart (Kiswahili)	Used by clients to remind them about FP	Used to remind clients about FP methods offered at the facility	Service delivery areas
Key reminders about hormonal FP methods	Used by clients when offering hormonal contraceptives to the clients	Used when counselling clients on hormonal contraceptives	Service delivery areas
Learning guide on history taking and physical examination	Service providers to capture the clients' medical backgrounds.	Used as a guide during client examination	Service delivery areas
Learning guide for breast examination	Service providers during client breast examination.	Used as a guide during breast examination	Service delivery areas
Learning guide for pelvic examination	Service providers during pelvic examinations.	Used as a guide for pelvic examination	Service delivery areas
Visual inspection with acetic acid and/or Lugol's iodine	Service providers to determine possible precancerous lesions or cancer in clients	Used as a test to determine +ve or -ve cancer status using Lugol's iodine or acetic acid	Service delivery areas
Urethral discharge algorithm	Service providers during STI management	Used when examining for STI infections	Service delivery areas
Vaginal discharge or pruritus	Service providers during STI management	Used when examining for STI infections	Service delivery areas
Lower abdominal pain in women	Service providers during STI management	Used when examining for STI infections	Service delivery areas
Genital ulcer disease (GUD)	Service providers during STI management.	Used when examining for STI infections	Service delivery areas
Ophthalmia neonatorum	Service providers during neonate STI management	Used when examining for STI infections	Service delivery areas
EID algorithm	Service providers during diagnosis of HIV infection in infants and children <18 months of age	Used to illustrate procedure for EID	Service delivery areas
HIV testing algorithm	Service providers during HIV diagnosis in children >18 months, adolescents and adults	Used to illustrate procedure for HIV diagnosis	Service delivery areas
Adolescent transition to adult care algorithm	Used by service providers to ensure an essential package of care for HIV-infected adolescents	Used as a guide to ensure a comprehensive package of services to clients	Service delivery areas
Screening for TB and INH preventive therapy in children, adults and adolescents algorithm	Used by service providers for intensified case finding for TB	Used as an illustration for TB case finding	Service delivery areas

Tool	Who/When Used/Filled	How	Point Use
GeneXpert algorithm	Used by service providers for TB diagnosis and drugresistant TB surveillance	Used for TB diagnosis and resistant TB surveillance	Service delivery areas
Flowchart for the emergency management of rape survivors	Used by service providers for management of rape survivors	Used as a guide for management of rape survivors	Service delivery areas
Algorithm for TB diagnosis in children	Used by service providers for TB diagnosis in children	Used as a guide for TB diagnosis in children	Service delivery areas
Algorithm for management of children exposed to pulmonary TB	Used by service providers for management of children exposed to an adolescent or adult with pulmonary TB	Used as a guide for management of children exposed to adults with pulmonary TB	Service delivery areas
HTC protocol	Service providers when counselling clients on HTC	Used to explain to clients all HTC methods and how they work	Service delivery areas
Checklist			
COC checklist document in Kenya 2010	Used by the service provider to screen clients who wish to initiate COCs to determine if they are medically eligible	Ask the questions as guided in the tool. Follow the instructions at the back of the checklist	Service delivery areas
DMPA checklist document in Kenya 2010	Used by the service provider to screen clients who wish to initiate DMPA	Ask the questions as guided in the tool. Follow the instructions at the back of the checklist	Service delivery areas
Implants checklist document in Kenya 2010	Used by the service provider to screen clients who wish to initiate a contraceptive implant	Ask the questions as guided in the tool. Follow the instructions at the back of the checklist	Service delivery areas
IUCD checklist document in Kenya 2010	Used by the service provider to screen clients who wish to initiate an IUCD	Ask the questions as guided in the tool. Follow the instructions at the back of the checklist	Service delivery areas
Pregnancy checklist document in Kenya 2010	Used by the service provider to be reasonably sure that the client is not pregnant	Ask the questions as guided in the tool. Follow the instructions at the back of the checklist	Service delivery areas
GBV screening guide document in Kenya 2012	Used by service provider to assess GBV	Ask the questions as guided in the tool	Service delivery areas

7. Planning to overcome barriers

Facilities initiating integrated RH-HIV services may experience some barriers, and facility incharges need to plan for how to overcome these barriers.

Possible Barriers	Potential Solutions
Infrastructure	- Reorganize service area, partition as appropriate
Workload	- Task sharing of some duties to different cadres
Commodity man agement	- Cost effective training approaches such as OJT, mentorship - Supportive supervision
Lack of skills	- Cost-effective training approaches such as OJT, mentorship
Duplication of reporting tools	- National level is continuously harmonizing and reviewing tools - Emphasize the importance of completely filling the tools - Emphasize to partner organizations the importance of using MOH tools

8. Budgeting

The facility in-charge should consider the following costs that are associated with integrated services:

a) Training costs for service providers (stationary, training manuals and trainer's fee, printing of certificates). Many of these costs can be reduced if OJTs and facility mentors are used.

b) Costs of producing checklists, job aids, IEC materials and data tools.

c) Purchasing new equipment and supplies for RH and HIV integration.

d) Procuring relevant commodities and consumables.

9. M&E

Monitoring and reporting of RH and HIV integration provides critical data to the facilities and the county at large on the trends and achievements in terms of the provision of RH-HIV integrated services. The key indicators for integrated services are recorded in each department where the services are offered.

The facility in-charge is expected to monitor the level of integration at the facility to assess the progress and extent of integration. Monthly reporting for the services using the existing MOH forms should be done by the person in charge of records by merging all of the reports of the different services offered at different SDPs. For example, if FP is offered at MCH, Maternity, OPD, CCC and YFS, then each SDP should have the FP Daily Activity Register (DAR) at each SDP.

In each facility, the records officer or the person responsible for monthly health information data consolidates the data from all SDPs for submission to the KHIS platform. The table below summarises the data monitoring and reporting tools for each service:

Integration of RH and HIV Data Collection and Reporting Tools	
Registers	
MOH 510	Immunisation Permanent
MOH 512	Family Planning Services Register
MOH 240	Laboratory Register
MOH 513	Community Health Worker Household Register
MOH 514	Community Health Worker Service Delivery Log Book
MOH 333	Maternity Register
MOH 406	Postnatal Register
MOH 405	Antenatal Clinic (ANC) Register
MOH 365	Post-Rape Care Register

Integration of RH and HIV Data Collection and Reporting Tools	
Registers	
MOH 262	Cervical Cancer Screening and Treatment Registers
	Tuberculosis Register
MOH 511	Child Welfare Clinic (CWC) Register
Forms	
MOH 512	Daily Activity (Family Planning)
MOH 216	Maternal and Child Health Booklet
MOH 363	Post-Rape Care Form
MOH 711	Integrated Tool for RH, HIV/AIDS, Malaria, TB and Child Nutrition Health Facility Summary
MOH 512	Comprehensive Care Clinic Patient Card
MOH 729A	CDRR for Antiretroviral and Opportunistic Infection Medicine
MOH 731	Comprehensive HIV/AIDS Facility Reporting Form
MOH 364	Sexual and Gender-Based Violence Summary Form
MOH 515	Community Health Worker Summary
MOH 515	CHEWs Summary
	CBD Commodity Tracking Tool
	Referral Booklets

Indicators

Health systems indicators

Number of facilities per level able to offer integrated services as per the Minimum Package for RH & HIV Integrated Services

Service delivery level indicators

I. **Service area: CCC**

- Proportion of all CCC clients with an FP need provided with modern FP services
- Proportion of all CCC clients treated for TB
- Proportion of HIV+ women screened for cervical cancer (CaCx)

II. **Service area: ANC/Maternity**

- Proportion of HIV+ women attending ANC/Maternity provided with ARVs (HAART or prophylaxis)
- Proportion of women attending ANC/Maternity screened for TB
- Proportion of ANC/Maternity clients (with known and unknown HIV status) tested for HIV

III. **Service area: Inpatient/Outpatient**

- Proportion of clients screened for TB
- Proportion of clients screened for CaCx
- Proportion of clients screened for prostate cancer

IV. Service area: YFS

Proportion of all clients with an FP need provided with modern FP services

Proportion of young people screened for CaCx and tested for HIV/STIs

Proportion of clients screened for prostate cancer

10. RH-HIV commodity management

The availability of RH-HIV commodities is essential for integration to happen. To ensure RH and HIV commodity availability, the staff working at the health facility require proper understanding of the supply chain, compliance with the national ordering and reporting process and commodity management skills as guided by the Standard Operating Procedures and Job Aids for Reproductive Health Commodity Management *(SOPS RHCM)*.

Why is it important?

- Ensures uninterrupted availability of RH/HIV commodities in the health facility and minimizes stock outs.
- Ensures proper selection, ordering, storage and use of RH/HIV commodities and thereby eliminates waste or losses.
- Eliminates missed opportunities and provides a variety of contraceptive choices for clients corresponding with their wishes.

Essential commodities for RH-HIV integration

The essential commodities for RH and HIV integration are divided into:

1. RH commodities
2. HIV commodities
3. Equipment
4. Relevant supplies

Table 4: Essential commodities for RH-HIV integration

	Level of Service Delivery[1]				
	Level 1	Level 2	Level 3	Level 4	Level 5 & 6
FP Commodities					
Pills (COCs, POPs and ECs)	√	√	√	√	√
DMPA injectable	√	√	√	√	√
Condoms	√	√	√	√	√
Implants	x	√	√	√	√
IUCDs	x	√	√	√	√
Cycle beads	x	√	√	√	√
Maternal Neonatal Health					
Hematinic-Ferrous folate	x	√	√	√	√
Oxytocin	x	√	√	√	√
Magnesium sulphate	x	√	√	√	√
Antibiotics	x	√	√	√	√
Analgesics	x	√	√	√	√
Corticosteroids	x	√	√	√	√
TEO	x	√	√	√	√
Chlorhexidine (for cord care)	x	√	√	√	√
Chlorine	x	√	√	√	√
Pregnancy test kit	x	√	√	√	√
Cancer Screening					
Acetic acid	x	x	√	√	√
Lugol's iodine	x	x	√	√	√
Fixatives for PAP smear	x	x	√	√	√
Cancer Treatment					
Chemotherapy drugs	x	x	x	x	√
HIV Commodities and Supplies					
Condoms	√	√	√	√	√
Penile and pelvic model	√	√	√	√	√
Rapid test kit	x	√	√	√	√
ARTs for adult and paediatric patients, anti-TB drugs including drugs for opportunistic infections	x	√	√	√	√
DBS bloating paper	x	√	√	√	√
Specimen containers for sputum	x	√	√	√	√
Special stain for TB (Reagent)	x	√	√	√	√
Post-rape care kit	x	x	√	√	√

[1]X=Not available; √=Available

	Level of Service Delivery[1]				
	Level 1	Level 2	Level 3	Level 4	Level 5 & 6
Equipment					
Radiology equipment	x	x	x	√	√
Resuscitators	x	x	x	√	√
Fetoscopes	x	√	√	√	√
Delivery beds	x	√	√	√	√
Examination couches	x	√	√	√	√
Weighing scale	x	√	√	√	√
Functional incubators	x	√	√	√	√
Cryotherapy machines	x	x	√	√	√
Screen	x	x	√	√	√
Examination lamps	x	x	√	√	√
MVA kits	x	x	√	√	√
Microscope	x	x	√	√	√
MRI scans	x	x	x	x	√
Gene expert machine	x	x	x	√	√

Steps in commodity management

1. Quantification

The service provider requires knowledge of commodity quantification to avoid ordering less or excess commodities as stipulated in the Kenya Standard Operating Procedures and Job Aids For Reproductive Health Commodity Management

Who to quantify:

Level 1: The CHEWs should quantify on behalf of the CHVs

Levels 2 and 3: The facility in-charge

Level 4 and above: The pharmacist/pharmaceutical technologist in charge

Frequency:

Level 1: Should be done on a monthly basis

Levels 2-6: Should be done quarterly

Methods:

1. Consumption based: Uses past consumption data to determine the future requirements
2. Morbidity based: Uses population characteristics to determine the future requirements

Note: For the facility level, consumption data is preferred.

Links to existing guidelines on quantification per level:

Links to existing guidelines on quantification per level:

Health Workers Job Aid for Quantification of FP Commodities at Facility Level

Kenya Reproductive Health Commodity Security Strategy

Standard Operating Procedures and Job Aids For Reproductive Health Commodity Management

Quantification formula for RH to be used by health facilities

Quantity required = (Average monthly consumption*4 months) – stock on hand

2. Requisition for supplies

- ✓ The facility obtains RH-HIV commodities from the Kenya Essential Medical Supply Agency on a quartely basis for the sub-county and counties.
- ✓ At the health facility level, the CCC requests FP commodities from the MCH/FP clinic or from the pharmacy depending on the facility setup. For HIV commodities, the CCC requests supplies directly from the pharmacy.
- ✓ The MCH/FP clinic requests HIV commodities from the CCC or from the pharmancy depending on the facility setup.
- ✓ Maternity wards and female wards request the FP commodities from the MCH/FP clinic, while other RH commodities are ordered directly from the pharmacy.
- ✓ HIV commodities are requested directly from the pharmacy.

Tools required for requisition

1. Counter requisition and issues form (S11): The user department fills in the form and submits it to the issuing department for supply/re-supply. It should be completed in tripilicate. The original is left with the issuing department, the duplicate is kept by the department and the triplicate is left in the book.
2. Register for controlled drugs: It is kept by the user department and is used to record drugs issued to clients.
3. Receipt of commodities:

   By Who?

   a. Level 1: The CHEWs on behalf of the CHVs.

   b. Levels 2 and 3: The facility in-charge.

   c. Level 4 and above: The store manager (pharmacist/pharmaceutical technologist or store keeper) in charge.

3. Procedures for receiving commodities

Once the commodities are delivered, the service provider should:

a) Count the issued commodities to confirm that the quantity is the same as in the issue voucher(S11)/ deliver note (not all ordered commodities might be supplied).

b) Check the expiry dates of the commodities.

c) Sign the issue voucher/delivery note and file it, etc.

d) Place the products in designated places or shelves in the cabinet.

e) Update inventory records (i.e., bin card/stock registers).

Tools required for receiving commodities

1. Bin cards
2. Stock registers
3. Expiry tracking charts
4. Job aids

4. Storage of commodities

Factors to consider during storage[2]

1. Ensuring the safety, access and security of the storage area
2. Appropriateness of the store
3. Record keeping

Tools required

1. Bin cards
2. Minimum and maximium
3. Temperature log

5. Commodity documentation and reporting

Who?

1. Level 1: The CHEWs on behalf of the CHVs.
2. Levels 2 & 3: The facility in-charge.
3. Level 4 and above: The store manager (pharmacist/ pharmaceutical technologist or store keeper, the unit in-charge).

Frequency

- For both commodities and services, the reporting should be done on a monthly basis.
- The DAR should be filled daily.
- The bin card and stock card should be updated as needed.
- The stock taking should be done monthly and recorded in the stock cards/bin cards.

Reporting channel

- The reporting channel for commodities and services is from the facility to the sub-county by the 5th of every month.
- Once the reports are received they are entered into the DHIS by the 10th of every month.

Recording and reporting tools

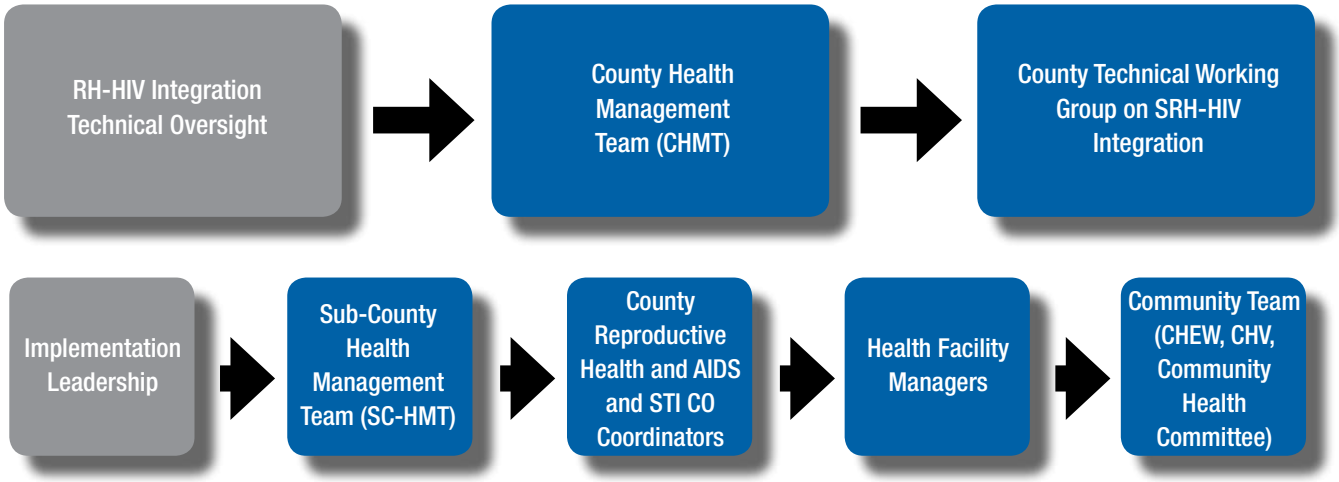
- Contraceptive Data Reporting & Requesting (CDRR) form *(SDP CDRR)*
- MOH 512 Daily Activity Register (DAR) *(DAR register)*
- Bin cards *(Bin Card S5)*
- Stock cards *(Stock Control Card)*
- *ARVs Daily Activity Register*
- *ARVs Consumption Data Reporting & Requesting form*
- *DHIS*
- MOH 514 CHW Service Delivery Log Book

[2]Refer to the SOP for commodity management.

11. Supportive supervision

Supportive supervision is a facilitative approach that promotes mentorship, joint problem solving and communication between supervisors and supervisees. At the county level, health personnel need to be provided with supportive supervision as per their roles and guide lines. In addition, the contact person for RH-HIV integration should hold regular review meetings with key stakeholders to harmonize the distribution of RH-HIV integration resources in the county.

`The CHMT implements structures for supportive supervision, reporting and monitoring of RH/HIV integration. Below is a sample structure that can be adapted by counties for the provision of supportive supervision for RH/HIV Integration.



To help promote continuous quality improvement at all levels of clinic services, the following reporting and supervision tools are used:

Reporting and supervision tools

Monitoring and Evaluation Package for Community-Based Provision of Family Planning Services

Kenya Support Supervision Checklist for Community Health Units

Republic of Kenya Health Sector Indicator and Standard Operating Procedure manual[3]

Kenya Ministry of Health Integrated Hospital Services Monitoring Tool

[3] The manual provides all integrated registers for data collection. In addition, it provides integrated tally sheets and summary sheets. The registers listed above are applicable to service levels 2, 3, 4, 5 and 6 but specific facilities will use it according to the services provided.

Sample County Supervision Checklist from Kakamega County Ministry of Health Services Support Supervision Checklist

Checklist for supervisors

- ✓ Develop a supervisory system that focuses on supervising clinic activities and achieving clinic objectives, rather than on day-to-day individual performance.
- ✓ Discuss and agree on an approach to supervision that involves the clinic manager and staff as part of the supervisory team.
- ✓ Be an advocate for the clinic manager and staff to ensure that they can take advantage of educational and training opportunities.
- ✓ Be well prepared for a supervisory visit by reviewing previous recommendations and actions you have taken to support the clinic's activities.
- ✓ At the end of each supervisory visit, prepare a list of actions with the clinic manager and staff that you all agree to implement before the next supervisory visit.
- ✓ Be committed to providing timely and regular feedback to your clinics.

How to plan for supervision

1. Budgetary consideration:

   Consider planning the budget for supportive supervision at the county and sub-county levels.

2. Supervisory skills:

   Supervisors should be knowledgeable about the existing policies and guidelines within the exiting areas of supervision. Adequate training aimed at equipping supervisors with the necessary technical expertise is key to the preparation of supervision in health facilities.

3. Mapping facilities for supervision based on geographical considerations:

   Supervisors covering many facilities within a large geographic area may only be able to provide minimal quality supervision, and facilities should therefore be clustered based on proximity to each other.

4. Plan with the facilities:

   The supervisors need to work with the facilities to plan the dates for supervision.

5. Develop feedback mechanism:

   The supervisors should be available to discuss their performance and any missed opportunities identified. Supervisors may also play important roles in helping to prioritize the actions that staff have identified.

6. Develop strategy for addressing missed opportunities and obstacles:

   There are a number of ways supervisors facilitate the resolving of gaps and missed opportunities at the facility level. For instance, the supervisor may be able to conduct trainings or identify someone else capable of conducting trainings or mentorship. Additionally, the supervisor may be able to identify the resources needed for the facility.

7. Planning for supervision visit follow up:

   The supervisors should plan for the next follow-up visit and jointly identify areas of focus and timelines.

12. Education and communication materials

Culturally appropriate RH and HIV-related IEC and behaviour change communication (BCC) materials should be provided at all SDPs. The IEC materials should be easy to read and understand and should include picture codes. The IEC materials should focus on prioritizing four key thematic areas: FP; youth SRH; maternal, neonatal and child health; and HIV. The IEC materials should be revised regularly to address emerging concerns in the community. Facilities should work closely with the following departments to receive the IEC and BCC materials at the county level:

- County Health Promotion Coordinators
- County AIDS and STI Control Programme
- County Reproductive Health Coordinators

[4] The manual provides all integrated registers for data collection. In addition it provides integrated tally sheets and summary sheets The registers listed above are applicable to service levels 2, 3, 4, 5 and 6 but specific facilities will use according to services provided

SPECIFIC STEPS FOR INTEGRATING YOUTH FRIENDLY SERVICES WITH OTHER RH-HIV SERVICE DELIVERY POINTS

YFS should be integrated in all SDPs (CCC, MCH/FP, Maternity, Inpatient and Outpatient). In addition to the generic steps discussed for integrating RH and HIV services, there are unique steps for the integration of RH and HIV services into the provision of YFS. The National Guidelines for Provision of Adolescent Youth-Friendly Services (YFS) in Kenya, 2005 stipulates three models for the provision of YFS. These include:

- Youth centres-based models
- Clinic-based models (youth corners)
- School-based models

Step-by-step guidance for RH-HIV integration into YFS

1. Establish demand for YFS

This can be done through conducting a needs assessment of services provided by the facility for young people in the population. The needs assessment should aim to provide information on the following key areas:

a) Types of preventive health services required by young people
b) Types of counselling to be offered
c) Voluntary counselling and testing (VCT) services offered
d) Referral system required for young people
e) IEC materials required
f) Types of health talks and how to schedule

2. Establishing community support for YFS

This can be done mainly through the approaches in the Community Health Strategy. The facility team leading the provision of services in YF centres should engage CHEWs and CHVs. In addition, efforts should be made to involve young people in identifying their needs.

3. Establish suitable infrastructure

The facility needs to identify space to offer YFS that offers the following:

a) A waiting bay with a TV set and/or with RH-HIV IEC materials tailored to youth RH needs clearly displayed.
b) A counselling area with privacy.
c) Service provision areas furnished with the necessary equipment and supplies.
d) Where possible, YFS should be co-located within health facilities proximal to where young people gather such as schools, markets and community centres.
e) An atmosphere/environment that is welcoming, youthful, informal, and culturally appropriate.

4. Train service providers on YFS integrated RH And HIV services

It is important to have younger service providers at the YFC. Service providers need to be trained as per the national YFS guidelines and training curriculum to offer the following services to young people:

- STI testing and treatment
- HTC
- HIV care and treatment and referral where necessary
- Pregnancy testing

- PAC
- Contraceptive services, including EC
- SGBV
- Life skills
- MIYCN

The different training approaches for health workers have been discussed above.

5. YFS service provision

a) Plan for suitable appointments

- Service providers need to listen to young people to offer appointments that are suitable to their work and school schedules. This can include late afternoons, evenings or weekends.
- The appointments should minimize wait times and overcrowding in the waiting room.
- Young walk-in clients need to be served promptly to avoid missed opportunities.
- Encourage young people to come with their partners.
- Use digital platforms and tools (e.g., Facebook, Twitter) to create demand for services and to educate young people about RH and HIV issues.
- Allocate convenient clinic operating hours for young people based on facility infrastructure.
- Service providers should be youth friendly, provide services in a non-judgemental manner and refrain from imposing their personal values on young people.
- Where possible service providers should to be youthful.

The recommended essential service package includes the following:

1. Counselling services on
   - Sexuality
   - Prevention of pregnancy
   - Abstinence
   - STIs and HIV/AIDS
   - Substance and drug abuse
   - Contraception
   - Rape prevention
   - Unsafe abortion and abortion prevention
   - Nutrition
   - Ante- and postnatal care
   - Skilled attendance
2. Provision of information and education on RH
3. Training in livelihood and life skills
4. Availability of IEC audio/visual materials
5. Promotion of community-based/school-based outreach IEC activities and work with peer youth educators
6. Provision of contraceptives
7. Recreation facilities (in- and outdoor games)
8. Screening for and treatment of STIs and HIV/AIDS (where possible)
9. VCT
10. Curative services for minor illnesses including ante- and postnatal care
11. Comprehensive post-rape care
12. Linkage to school-based and youth centre-based models

6. Create facility-youth partnerships

To ensure the buy-in of the RH-HIV services offered at the youth-friendly centres, involve young people in designing and running the RH-HIV services. Young people are better able than adults to accurately identify the needs of their peers and can propose appropriate ways to meet those needs.

7. Develop youth-tailored information and educational materials

Provide culturally appropriate information in the language and at the comprehension level of the client. Make sure that information meets young people's needs and concerns.

8. Conduct RH-HIV integrated outreach and inreach targeting young people

Periodically, the facility needs to conduct RH-HIV integrated outreach and inreach to increase access to services for young people and to make them aware of the importance of RH-HIV services. This will also act as an opportunity to create awareness and demand for the RH-HIV services offered at the facility.

9. Checklist for "youth-friendly" service provision

Provider and Staff
√ Staff is friendly and responsive to young clients
√ Staff is respectful to and ensures privacy of young clients
√ Staff is understanding of and knowledgeable about young people's concerns and needs
√ Staff is specially trained to work with young people
√ Counsellors spend adequate time with young clients
√ Medical providers spend adequate time with young clients
√ Information on need for and timing of follow-up visits(s) is provided and clear
√ Peer counsellors are available
Policies and Procedures
√ Young drop-in clients are welcome and accommodated (for drop-ins only)
√ Services are offered to both male and female clients
√ Facility provides information and/or audiovisual materials on RH services and concerns of young clients
√ Group talks/discussions available
√ Services are aligned with other youth services
√ Program network and necessary referrals available
√ Cost of RH services is affordable

SPECIFIC STEPS FOR INTEGRATING YOUTH FRIENDLY SERVICES WITH OTHER RH-HIV SERVICE DELIVERY POINTS

Environment and Facilities
√ SRH services are provided at convenient (and separate) hours for young clients
√ Décor and surroundings are inviting to young clients
√ Counselling and examination rooms ensure privacy for young clients
√ Facilities are conveniently located for young people's easy access
√ Education materials are displayed and available to young clients to take away
√ Peer youth education outreach programmes are available
√ Young people are involved in decision making on youth-friendly service provision
√ Community is informed about the benefits and availability of YFS through the community strategy

Tips for integrating RH and HIV services in health facilities

- A heath facility assessment should be conducted to inform utilisation trends for the entire facility. The information will inform the services to be integrated in each department.
- Conduct CMEs on RH-HIV integration with all health workers in the facility.
- The volume of clients in each department will determine the number of services that can be integrated. Services should be introduced gradually and guided by the ability of the department to provide quality services to all that require the services.
- Supporting other facilities to integrate RH-HIV services reduces referral, which in turn provides opportunities to integrate more services in each department.
- Strengthen the link with the community strategy to ensure that some services are provided through the CHEWs and CHVs to reduce the need for the services in the facility.
- CHEWs should participate in RH and HIV CMEs in order to identify existing gaps that can be filled through the community strategy.
- Start with fewer integrated services and expand gradually.
- Initiate stakeholder consultations with the CHMT, facility in-charges and service providers.
- Provide information to all clients about the new integrated services.

Tips for implementing the RH and HIV Integration Toolkit in health facilities

- Introduce the Toolkit in the facility through an integrated CME with all departments in attendance.
- Develop a departmental work plan for the implementation of the Toolkit.
- Develop clear deliverables for all staff in each department for the implementation of the Toolkit.