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Linking HIV-positive family planning clients to treatment and care services in Kenya

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Linking HIV-Positive Family Planning Clients to treatment and care services in Kenya

APHIA II Operations Research Project/ Population Council
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Ministry of Medical Services, Kenya
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Executive Summary

In recent years, there has been interest in the integration of HIV/AIDS and other Reproductive Health services, as a means of improving clients’ access to both types of services, improve efficiency and reduce costs. In Kenya, different approaches have been tested, including integrating HIV into Family Planning services and integrating Family Planning into HIV services. The government has also developed a national Reproductive Health and HIV/AIDS integration strategy which emphasizes the need to provide coordinated RH and HIV integrated services across the two programs.

Under the USAID-funded FRONTIERS Program, the Population Council tested two models of integrating HIV counselling and testing (CT) into Family Planning (FP) services. The two models involved ‘testing’ and ‘referral’ of FP clients - in the “testing” model, FP providers were trained to offer CT services and post-test counselling to FP clients during the same visit while in the “referral” model, FP clients were counselled on HIV prevention and testing, and then referred to a specialized CT facility for services. When the project was evaluated, it was found that integrating STI/HIV counselling and testing within FP services was feasible and acceptable to clients and providers. It also led to significant improvement in the quality of care provided, and between 50-75% of the women seeking FP services who were offered an HIV test accepted it.

However, a major limitation was that FP clients who tested HIV-positive were not actively linked to care and treatment services, including antiretroviral treatment (ART), and screening and management of sexually transmitted infections (STIs). The health providers simply advised the clients to attend any of the health facilities (mainly hospitals) that had comprehensive care centres (CCCs) for managing HIV/AIDS. This made it difficult to establish whether the clients received the necessary services. To address this gap, APHIAII Operations Research (OR) Project and the Ministry of Health developed and tested a modified approach for linking HIV-positive FP clients to HIV care and treatment and STI services. The research goal of the project was to design and test a referral framework for linking HIV-positive FP clients to treatment and care in selected health facilities; assess the acceptability of the proposed referral framework to providers; and assess its effectiveness in increasing the number of eligible HIV-positive FP clients received at HIV care and treatment services. The intervention involved five activities implemented over a period of six months in six facilities:

- Strengthening the referral system for HIV-positive FP clients
- Review of existing training materials and job aids
- Updating service providers with referral system information
- Strengthening health facility supervision activities
- Strengthening health management information systems
The findings of the project evaluation show that the referral mechanism put in place was effective – 93% of the HIV-positive FP clients received at CCCs had been referred from the MCH/FP unit of the same facility. Some facilities also received HIV-positive clients seeking FP services referred from other facilities. There was a significant increase in the proportion of FP service providers reporting having a directory of HIV/AIDS/CCC facilities in their locality and to which they could refer FP clients testing HIV positive. There was also a significant increase in the proportion of providers who reported discussing referral issues during routine management meetings. In addition, there was a significant improvement in the proportion of clients recorded as continuing on ART (over 6 months) at the endline, compared to baseline.

In the assessment, it was found that only half of the facilities had the minimum number of staff in the MCH/FP and CCC units necessary to support referrals; in addition, some facilities did not have adequate infrastructure to support referral of HIV positive FP clients to the care and treatment centres such as a directory, a register for documenting referral practices and client/patient tracer card. These inadequacies were discussed with the local health management teams, and have been rectified in some cases.

The study recommends that the Division of Reproductive Health, NASCOP and KEMSA and the provincial and district health management teams strengthen the supply of tools and commodities to health facilities in order to support the referrals of HIV+ FP clients to care and treatment centres. Update training on referral practices including the use of appropriate tools should be provided to all health providers working in any health facility in order to improve coverage and quality of care provided. Correct documentation and recordkeeping should be improved in order to keep track and monitor all referred cases in the facilities making and receiving referrals.

Given its potential role in improving referral practices within the RH and HIV settings, the study recommends that the Division of Reproductive Health, NASCOP and other units within the MOH such as the Health Management Information System support the provincial and district health management teams to scale up the use of the referral form developed under this project to other FP clinics within Central and other provinces. The tool could also be adopted for use with HIV+ clients in antenatal and postnatal services.
**Abbreviations**

AIDS  Acquired Immune Deficiency Syndrome  
ARV  Antiretroviral  
ART  Antiretroviral Therapy  
BCS  Balanced Counseling Strategy  
CCCs  Comprehensive Care Centers  
CT (C&T)  Counseling and Testing (for HIV)  
DASCO  District AIDS Control Program  
DHMT  District Health Management Team  
DH  District Hospital  
DRH  Division of Reproductive Health  
FP  Family Planning  
GEP  Guide to Essential Practice  
HIV  Human Immunodeficiency Virus  
IUCD  Intra-Uterine Contraceptive Device  
KDHS  Kenya Demographic and Health Survey  
KEMSA  Kenya Medical Supplies Agency  
MOH  Ministry of Health  
NASCOP  National AIDS Control Program  
PASCO  Provincial AIDS and STD Control Officer  
PGH  Provincial General Hospital  
PHMT  Provincial Health Management Team  
RH  Reproductive Health  
RTIs  Reproductive Tract Infections  
SDH  Sub-District Hospital  
STI  Sexually Transmitted Infection  
USAID  United States Agency for International Development  
WHO  World Health Organization
Background and Problem Statement

There has been growing interest in integrating family planning (FP) and HIV/AIDS services in sub-Saharan Africa as a means of improving clients’ access to both types of services, as well as injecting efficiency and cost-effectiveness in the provision of the services.\(^1\)\(^2\) In Kenya, efforts to integrate RH services started after the 1994 International Conference on Population and Development (ICPD) held in Cairo that emphasized the need for integration. Initial efforts focused on integrating sexually transmitted infections (STIs) into Reproductive Health (RH). In recent years, there has been interest in integrating HIV into FP services (FHI 2006; Liambila et al 2008) and FP into HIV/AIDS services. The Government of Kenya has, however, developed a national RH and HIV/AIDS integration strategy which emphasizes the need to provide coordinated RH and HIV integrated services across the two programs.

Through the former FRONTIERS program, the Population Council worked with the Ministry of Health (MOH) to test the feasibility of two models for integrating counseling and testing (CT) for HIV into FP services. The project was implemented between November 2005 and March 2007. The two models involved ‘testing’ and ‘referral’ and have been described in detail elsewhere (Liambila et al 2009). In the “testing” model, FP providers were trained to offer CT services and post-test counseling during the same visit while in the “referral” model FP clients in need of CT services were referred to a specialized CT facility. Both models included client education on HIV prevention during FP visits. The intervention included the development of training materials, support for supplies and HIV test kits, and modification of registers to monitor CT services. Providers were trained to use the Balanced Counseling Strategy Plus (BCS+) toolkit, an adaptation of the Council’s BCS tool for improving the quality of FP counseling\(^3\) modified for high HIV prevalence settings. The findings showed that: (1) integrating STI/HIV counseling and offering CT within FP services was feasible and acceptable to clients and providers; (2) quality of care improved significantly in both models; (3) counseling and testing for HIV increased significantly during FP consultations; and (4) between 50-75% of the women offered an HIV test accepted it.

A major limitation of the previous project was that HIV-positive FP clients were not actively linked to care and treatment services, including antiretroviral treatment (ART), and screening and management of sexually transmitted infections (STIs). The health providers simply advised the clients to attend any

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\(^1\) Askew, Ian and Ndugga B. Maggwa. 2002. “Integration of STI Prevention and Management with Family Planning and Antenatal Care in sub-Saharan Africa—What More Do We Need to Know?” *International Family Planning Perspectives* 28(2):77-86.


\(^3\) For more information: www.popcouncil.org/pdfs/frontiers/Manuals/BCS/BCS_Cards
of the health facilities (mainly hospitals) that had comprehensive care centers (CCCs) for managing HIV/AIDS. Failure to link HIV-positive FP clients to treatment and care and STI services more systematically made it difficult to establish whether the clients visited the facilities or received the necessary services. In order to address this gap, Population Council and MOH, through APHIAII Operations Research (OR) Project in Kenya, developed and tested a modified approach for linking HIV-positive FP clients to HIV care and treatment and STI services. The project was implemented in line with the national guidelines that encourage the integration of HIV testing with care and support-related HIV services for reproductive health (RH) clients. It answers the following research question: “What is the most effective mechanism for linking family planning clients found to be HIV-positive to HIV care and treatment services?”

The project responds to the MOH efforts to achieve comprehensive integration of RH and HIV services. It also generates evidence on how institutional arrangements could be organized to reduce any barriers to linking HIV-positive FP clients to HIV and STI services. The project further contributes to the Government of Kenya (GOK) and United States Government (USG) goals of achieving healthier behaviors and increased use of high quality HIV/AIDS, RH/FP and maternal and child health (MCH) services. It also provides invaluable lessons on how provider-initiated testing and counseling (PITC) for HIV, which was launched in Kenya in 2008, can be effectively implemented4.

Project Objectives

The overall objective of the project was to develop a feasible and acceptable referral framework for linking family planning clients who test HIV-positive or know their HIV status to appropriate care and treatment services. Specifically, the project aimed to:

- Design and test a referral framework for linking HIV-positive FP clients to treatment and care in selected health facilities;
- Assess the acceptability of the proposed referral framework to providers; and
- Assess the effectiveness of the referral framework in terms of increasing the number of eligible HIV-positive FP clients received at HIV care and treatment services.

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4 Provider Initiated Counselling and Testing implies Routine offer of HIV testing in health care settings such as those attending STI services, ANC and other RH services including those attending TB clinic services among others (see WHO 2006 and 2007 and UNAIDS, 2007 references).
Project Design

This was an operations research (OR) project involving pre- and post-intervention data collection without a control group. The project was implemented in Nyeri and Thika districts in selected sites where the original CT-FP pilot project was conducted. A total of six intervention sites were purposefully selected for inclusion in the study from the original 23 CT-FP project sites that were already offering integrated CT-FP services. To be included in the study, a facility had to have a comprehensive care center as part of its operations. The six facilities chosen were: Nyeri PGH and Warazo HC in Nyeri, and Thika DH, Gatundu DH, Ruiru SDH, and Kirwara SDH in Thika. The selected facilities were also implementing a prospective study on assessing the benefits of integrated HIV and RH services in Kenya, supported by the Gates Foundation through International Planned Parenthood Federation (IPPF) in collaboration with Population Council and the London School of Hygiene and Tropical Medicine. The following table summarizes the FP workload at the project sites during the project period:

The evaluation of the project was based on the following hypotheses:

- HIV-positive FP clients in intervention clinics are more likely to receive referral to ART services after the intervention than before.
- HIV-positive FP clients are more likely to visit the CCCs after the intervention has been introduced than before.

The study protocol was cleared by the Population Council’s Institutional Review Board (IRB) in September 2009.

An algorithm (Fig.1) was developed during the design phase of the project, to guide health providers in counseling and testing clients wishing to know their HIV status. It was designed for use in facilities where the HIV test is carried out by the FP provider during the FP consultation, or at least on the same day and at the same facility. This algorithm does not apply to clients being referred to other facilities to be tested for HIV, since the person doing the HIV test is the one who would have responsibility for linking an HIV+ client to the CCC.

### Table 1: Workload data in FP clinics pre- and post-intervention period (Source: Facility FP Registers)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of clients attending family planning services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nyeri PGH</td>
<td>2,803</td>
</tr>
<tr>
<td>Thika DH</td>
<td>6,104</td>
</tr>
<tr>
<td>Gatundu DH</td>
<td>3,623</td>
</tr>
<tr>
<td>Ruiru SDH</td>
<td>2,624</td>
</tr>
<tr>
<td>Kirwara SDH</td>
<td>1,847</td>
</tr>
<tr>
<td>Warazo SDH</td>
<td>1,254</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18,255</strong></td>
</tr>
</tbody>
</table>
**Intervention development, implementation and monitoring**

The interventions were conceptualized around a modified protocol for linking FP clients who test HIV-positive to care and treatment services summarized in Figure 1.

**Figure 1: Modified Protocol for Testing Clients seeking FP Services**

- Assess and address FP client’s contraceptive needs using Balanced Counseling Strategy Plus (BCS+) job aids
  - Discuss with client about STIs/RTIs/HIV transmission and awareness
  - Conduct STIs/RTIs/HIV/AIDS risk discussion as well as dual protection. In case of RTI/STI symptoms, treat syndromically as per the National RTI Guidelines
  - Discuss with client STIs/RTIs/HIV prevention and the need for HIV testing with emphasis on benefits of taking test, implications for positive and negative results.

- Discuss and offer client opportunities for Counseling and Testing for HIV
  - If client declines test (opt out) and doesn’t know HIV status, provider to identify reason and allow for repeat counseling in subsequent visits
  - If client is already +ve, there is no need for retesting. Follow the national guidelines for managing HIV+ clients

- Client accepts test (opt-in). Test and counsel client for negative or positive test results

  - If positive:
    - Counsel for positive test results
    - Encourage dual protection and condom use
    - Discuss partner’s status and the need for testing for HIV
    - Advise on partner reduction if appropriate
    - To continue with chosen FP method
    - Discuss care options and make appropriate referrals to ART/CCC or other places where client can be assessed and advised on treatment and care options using referral form/letter
    - At the same time, assess whether services sought during previous referrals were obtained, especially for repeat FP clients

  - If negative:
    - Counsel for negative test results
    - Encourage dual protection and condom use
    - Discuss partner’s status and the need for testing for HIV to know status
    - Advise on partner reduction if appropriate
    - Discuss preventive strategies e.g. encourage dual protection and condom use
    - Continue with chosen FP method
    - Provider/counselor to discuss with client the concept of "Window Period" and advise those who may be at high risk of exposure to be retested after 3 months.
The interventions involved five activities implemented over a period of six months (November 2009 - May 2010). These included:

(i) Strengthening the referral system for HIV-positive FP clients
(ii) Review of existing training materials and job aids
(iii) Updating service providers with referral system information
(iv) Strengthening health facility supervision activities
(v) Strengthening health management information systems

**Activity 1: Strengthening referral system for HIV-positive FP clients**

A modified, strengthened referral system for HIV-positive FP clients was introduced in the six sites following the steps described in Box I.

**Box 1: Steps followed in conducting referrals of HIV positive FP clients**

1. Care options were discussed and appropriate referrals made using the referral form (See Annex 1) which was designed to capture information on client background characteristics, name of facilities conducting referrals and receiving clients, reasons for referral and appropriate comments.

2. Client told that the referral form is in triplicate. Original copy to be given to the client to take to the CCC (care and treatment centre of the receiving facility), duplicate copy is kept by the Provincial or District Reproductive Health Coordinator (project staff) and triplicate retained in the referral book at referring facility/clinic.

3. Once client arrives at the receiving facility, she/he is told to hand in the original form to the nursing officer in charge of CCC (or the officer on duty) who is expected to fill the referral forms, sign and file them in a designated referrals folder.

4. Client counseled on what to expect in CCCs including discussion on the types of investigations or assessments the client was likely to go through, such as CD4 count, testing and counseling on specific interventions recommended to the client, cost of treatment (especially if the facility is private) depending on her or his condition.

5. Client assured that the management of her or his condition is dependent on the outcome of the physical clinical assessment of her or his condition and laboratory evaluation of immunity using CD4 count assessments.

6. Client told that regardless of his/her state of immunity, everyone starts on Septrin (cotrimoxazole) to prevent opportunistic infections.

A directory of possible referral CCCs sites and other ART/STI services available in the vicinity of each study site was developed (Annex 1). The referral directory indicated the location, opening hours, fees and services provided and names of contact persons at the receiving sites. A total of 26 facilities with CCCs in Nyeri

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It is recommended that as referral practices become institutionalized, there will be no need for the triplicate copies. Duplicate copies will be sufficient. Original copy to be given to the client to take to the care and treatment centre of the receiving facility and the duplicate copy to be retained in the referral book in the facility initiating the referral.
and 15 in Thika and the surrounding districts were included the directories. Meetings were held initially between the referring and receiving sites to discuss the referral modalities and ensure that the receiving sites recognize, respect and act upon the referral. The receiving sites also gave feedback on the outcomes of the referral, such as whether the client was registered for care or declined care. Monthly meetings were conducted throughout the study period to discuss challenges of the referral system and devise strategies for addressing them.

**Activity 2: Review of training materials and job aids**

Existing training and participant manuals for integrating CT into FP were reviewed and updated to include the component on screening for HIV and knowing the status and referrals. In addition, the Balanced Counseling Strategy (BCS+) tools (algorithm, cards and brochures) were revised to include information on STIs. The BCS-plus tools were subsequently translated into Kiswahili. The revision of the counseling cards was done in August 2009 jointly by the Population Council, Division of Reproductive Health (DRH), the National AIDS and STI Control Programme (NASCOP), and the Provincial Health Management Team (PHMT). It is worth noting that the BCS+ algorithm already includes a component on referral of clients. The revised materials were discussed and validated at a provincial-level meeting held in November 2009, which brought together district and facility stakeholders.

**Activity 3: Training service providers on updated tools**

Providers at the six sites were updated on the modified referral system (within the facility and to other facilities or from other facilities) as well as on the revised training materials and job aids. An example of the job aid on RTI/STI management in family planning care settings is found in Annex 2 of this report. A mentorship approach was used in updating the providers’ knowledge and skills required to effectively link HIV-positive FP clients to ART/STI services. Mentors were selected from among health providers with experience in training. This approach encourages the providers to appreciate the fact that the roll out of HIV testing in Kenya has increased the proportion of women seeking FP services that want know their status, or who have been tested previously. During the update session, providers were told that FP clients who had tested negative in previous visits could also be re-tested depending on their history of exposure to HIV risk after the last test.

Twenty four (24) providers received on-site training using the mentorship approach from the six participating facilities. These included FP and HIV

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6 Mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality HIV/RH/FP services. Mentoring of less experienced individuals (mentees) by experienced staff (mentors) was an essential element of all health care learning in the pilot facilities. The need for mentorship arose to transform the existing didactic training, which has not always been successful in translating the acquired knowledge into practice, especially when conducted outside of the health facility settings. The mentorship approach sought to involve all health care workers providing RH/FP services.
providers as well as those working in the CCCs. Other professionals such as laboratory and pharmacy staff also received training on the job. The training focused on service integration, as well as an update on referral for HIV-positive FP clients. Proficiency in the use of the algorithm and job aids for integration and referral during post-test counseling among HIV-positive clients was also emphasized.

**Activity 4: Strengthening the referral system**

The fourth activity involved two major interventions: (1) strengthening the management information system; and (2) introducing a referral tool. FP registers at each facility provide the main source of information on the numbers of clients being referred to ART services. Although the FP registers have information on clients counseled and tested for HIV, there was no indication whether those who tested positive were referred to the CCCs. The project therefore trained providers to indicate whether the clients were referred to the CCCs in the remarks column in the FP registers.

In addition, the project developed a referral form (Annex 2) in collaboration with DRH and NASCOP. This was then pre-tested before sharing with service providers in the field. Each booklet had 50 copies of the referral forms in triplicate - the client was given the original copy to take to the receiving clinic/site and the duplicate copy was retained in the facility making the referral. The triplicate copy was retained in the booklet. The receiving site kept a file of all the received referral forms.

**Activity 5: Strengthening of supervision activities and monitoring of interventions**

Monthly supervisory visits to facilities were conducted by members of Provincial Health Management Team (PHMT) and the District Health Management Team (DHMT) to monitor the intervention using a structured supervisory tool for the first six months of introducing the intervention. Information from the supervisory tool (Annex 3) and routine data collected from the facilities was analyzed and interpreted jointly with MOH officials at the district, provincial and national levels. Intensive supervision was undertaken in the initial six months to ensure early implementation of the intervention. Any problems that providers experienced in their clinic situation were dealt with immediately. Since some of the supervisors from the provincial level took part in the training of mentors, visits to the project sites were combined with routine supportive supervision visits in order to minimize duplication of effort and reduce supervision costs.

A team of staff drawn from DRH, NASCOP and Population Council conducted quarterly supervisory visits to the six implementation sites for the first two quarters of implementation. The visits focused on assessing referral practices for HIV positive FP clients from FP clinics to onsite or offsite CCC/ART units. The team also visited facilities that receive referral cases and discussed with
the respective health facility management team’s issues regarding how referred HIV positive FP clients are received and eventually enrolled into treatment and care programmes. Other activities during supervision involved checking on the availability of supplies and commodities in addition to monitoring the implementation of the mentorship programme.

During supervision, additional information was sought on the following issues:

- Number and frequency of formal meetings held at the facility level during which facility management issues are discussed, including referral of HIV positive FP clients and how they are linked to treatment and care services in CCCs/ART units.
- The extent to which project supervision is integrated in the overall institutional supervision activities. Integration of project activities into the overall institutional supervision activities made it possible for all the staff in the facility MCH/FP and the CCCs to get involved in reviewing findings pertaining to project supervision more critically and in taking action to address the identified gaps using available resources.

**Project evaluation**

Data collection involved facility assessment, provider interviews, and record reviews.

**Facility assessment:** A systematic inventory/audit, including interviews with staff in charge of clinic, was undertaken at each of the six study facilities (Table 2) to determine clinic readiness to link HIV-positive FP clients to ART. The assessment focused on staffing and infrastructure - availability of CCC, equipment and supplies. Two research assistants spent half a day at each clinic completing the inventory.

**Provider interviews:** A total of 24 providers (Table 2) both at baseline and endline were interviewed (four FP and CCC service providers per facility). These included seven enrolled nurses, 14 registered nurses, and three clinical officers at both baseline and endline. Information was collected on provider training, knowledge of counseling for referral, and experience with implementing referral guidelines.

**Record review within the CCC and in FP clinics:** At baseline and endline, trained research assistants extracted records of clients referred to CCC from FP clinic using a standardized checklist, that was based on the national guidelines for managing HIV positive clients (for treatment and care options). Specifically, the following information was extracted from the records: (1) source of referral (2) whether client went through pre- ART counseling; (3) appropriate attachments and other documents/records that constitute standard care for HIV positive patients, and whether the records were filled correctly; and (4) whether all the necessary procedures such as investigations and care were received and whether these
were documented appropriately. At baseline a total of 454 HIV positive FP client records were reviewed for the period August-March 2009 (six months preceding the interventions) in the six health facilities. Post-intervention measurements took place in June 2010, during which a total of 487 HIV positive FP client records were reviewed at the CCC for the period December 2009 to May 2010 (the six months intervention phase). Table 2 provides a summary of the data collected in the research.

Table 2: Sample sizes achieved by type of survey conducted at baseline and endline by facility

<table>
<thead>
<tr>
<th>Type of survey conducted</th>
<th>Timing/Phase</th>
<th>Nyeri PGH</th>
<th>Thika DH</th>
<th>Gatundu DH</th>
<th>Ruuru SDH</th>
<th>Kirwara SDH</th>
<th>Warazo SDH</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP Client Records Review in CCCs</td>
<td>Baseline</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>37</td>
<td>36</td>
<td>21</td>
<td>454</td>
</tr>
<tr>
<td></td>
<td>Endline</td>
<td>87</td>
<td>150</td>
<td>86</td>
<td>99</td>
<td>37</td>
<td>28</td>
<td>487</td>
</tr>
<tr>
<td>Provider Interviews</td>
<td>Baseline</td>
<td>4</td>
<td>4</td>
<td>4</td>
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<td>24</td>
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<tr>
<td></td>
<td>Endline</td>
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<td>4</td>
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<td>24</td>
</tr>
<tr>
<td>Facility Assessment</td>
<td>Baseline</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Endline</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

Data analysis
Analysis involved simple descriptive statistics (frequencies, percentages, and scores) with significant tests (of means and proportions) to determine if there are any significance differences in the indicators of interest between before and after time-periods.

Findings

Characteristics of clients whose records were reviewed
At both baseline and endline, the mean and median age of clients from the records was 33 years with the oldest client being 60 years and the youngest 18 years old. Repeat and new FP clients constituted 97% and 3% of the total clients respectively at baseline while at endline repeat clients constituted 94% and new clients 6%. Majority of clients were married and in monogamous relationships (63% at both baseline and endline). Within the CCCs, over 97% of the records had CD4 values with 61% of the values being below 350 while 39% were above this cutoff range in both baseline and endline surveys.

The following sections summarize the findings in the three key areas of the assessment: facility preparedness to support referral of HIV-positive clients to treatment and care services; acceptability of referral among providers and clients, and the effectiveness of the referral framework in terms of linking HIV-positive FP clients to treatment and care services.
Facility preparedness

Table 3 presents the distribution of the key indicators used in this study to assess facility preparedness to support referral services for HIV-positive FP clients in the MCH/FP and CCC units of the participating facilities at baseline. In addition to staffing levels, facility preparedness was also assessed through the following factors:

- availability of registers and cards: 6 items (partner notification card, client card, FP, pre-ART, ART, and antiretroviral drugs (ARV) registers)
- availability of FP commodities: 6 items (combined oral pill, depo provera, implants, male condoms, and female condoms)
- availability of STI drugs: 5 items (drugs for management of urethral discharge, genital ulcers, ophthalmia neonatorum, virginal discharge/pruritus, and lower abdominal pain)
- availability of HIV test kits and reagents: 6 items (Determine, Bioline, Unigold, laboratory reagents for urinalysis, full haemogram reagents, and infection prevention items)
- availability of infrastructure: 6 items (availability of directory for use in referring clients to the CCCs and other STI services, referral guidelines; a register for documenting referral practices; client/patient tracer card; mechanisms for reviewing referral decisions/arrangements e.g. through monthly meetings; and feedback mechanisms between referring and receiving facilities).

In regard to staffing in an MCH unit, the MOH guidelines recommend a minimum of four nurses, two Clinical Officers, and one pharmacist/pharmaceutical technologist at Level Three facilities (such as Ruiru Sub-District Hospital, Kirwara Sub-District Hospital, and Warazo HC). The recommendation for Level Four facilities such as Gatundu District Hospital are six nurses, two clinical officers, and three pharmacists/pharmaceutical technologists while Level Five facilities should have a minimum of 12 nurses, four Clinical Officers, and six pharmacists/pharmaceutical technologists. In addition, the minimum number of medical officers recommended for Levels Four and Five facilities are six and 15 respectively.
### Table 3: Distribution of key indicators of facility preparedness to support referral of HIV-positive family planning clients at baseline at MCH/FP and CCC units

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Thika DH</th>
<th>Ruiru SDH</th>
<th>Gatundu DH</th>
<th>Nyeri PGH</th>
<th>Kirwara SDH</th>
<th>Warazo HC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff availability (number)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical officers</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Nurses</td>
<td>23</td>
<td>7</td>
<td>4</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>52</td>
</tr>
<tr>
<td>Clinical officers</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacists/PT</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Availability of registers and cards (score on 6 items)</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>31/36</td>
</tr>
<tr>
<td>Availability of key FP commodities (score on 6 items)</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>21/36</td>
</tr>
<tr>
<td>Availability of STI drugs (score on 5 items)</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>16/30</td>
</tr>
<tr>
<td>Availability of HIV test kits and reagents (score on 6 items)</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>29/36</td>
</tr>
<tr>
<td>Availability of infrastructure (score on 6 items)</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>9/36</td>
</tr>
</tbody>
</table>

Note: PGH: Provincial General Hospital; DH: District Hospital; SDH: Sub-District Hospital; HC: Health Centre; FP: family planning; MCH: maternal and child health; CCC: comprehensive care center; STIs: sexually transmitted infections; PT: pharmaceutical technologist

**Staffing:** The results show that only three of the six facilities had the minimum number of staff necessary to support referral and linkage of HIV-positive FP clients to treatment and care (Table 3). The exceptions were Nyeri PGH, Gatundu DH, Warazo HC and Kirwara SDH which did not have any pharmacist/pharmaceutical technologist in the MCH/FP/CCC units. Warazo HC did not have any pharmacist/pharmaceutical technologist in the entire facility. Although Nyeri PGH and Gatundu DH had seven and six pharmacists/pharmaceutical technologists respectively in other units, there were none in the MCH/FP and CCC units. In Warazo HC, therefore, providers were likely to refer HIV-positive FP clients for drugs to other facilities while in Nyeri PGH and Gatundu DH, such clients were likely to be referred to other units within the same facility. There were no changes in the staffing levels by endline.

**Registers and client cards:** Only two of the six facilities at baseline had all the essential registers and tracer/client cards to support referral of HIV-positive clients to treatment and care at baseline (Table 3). It is interesting to note that lower level facilities like Ruiru SDH and Warazo Sub-District Hospitals had all the registers and cards compared to higher level facilities. Nyeri PGH, Thika and Gatundu DH did not, for instance, have partner notification cards. This information was shared with the facility in-charge and the DHMTs in the two districts and by endline, Thika and Gatundu DH had obtained the cards from NASCOP. The situation remained the same in the other facilities.
**Availability of key FP commodities:** None of the facilities had all the six FP commodities (combined oral pill, depo provera, implants, male condoms, and female condoms) at both baseline and endline, and half had only four of the commodities. Female condoms and implants were the least available FP methods; female condoms were available only in Kirwara SDH only while only Nyeri PGH and Ruiru SDH had implants.

**Availability of STI drugs:** Only two facilities (Thika DH and Kirwara SDH) had all the required STI drugs in the MCH/FP and CCC units at baseline and endline. At Nyeri PGH, the drugs were available at the pharmacy, but none at the MCH/FP and CCC units (Table 2). In addition, only half of the facilities had all the necessary HIV test kits and reagents in the MCH/FP and CCC units at baseline, and by endline, only Nyeri PGH had all the relevant test kits and reagents.

**Availability of necessary infrastructure:** Facility preparedness was also assessed on the availability of the infrastructure needed to carry out referral and other activities for linking HIV-positive FP clients to care and treatment. This included the following six items: directory for use in making referrals; referral guidelines; a register for documenting referral practices; client/patient tracer card; the existence of mechanisms for reviewing referral decisions/arrangements e.g. through monthly meetings; and feedback mechanisms between referring and receiving facilities. At baseline, only two of the facilities (Nyeri PGH and Ruiru SDH) scored three or higher on the indicators of infrastructure availability (Table 3). This, however, improved during the project period as four of the six facilities (Thika DH, Ruiru SDH, Kirwara SDH, and Warazo HC) scored five or higher on these indicators at the endline.

The improvement in the indicators of infrastructure availability at the endline could be attributed to interventions such as the development of the referral directory and referral forms as well as strengthening mechanisms for reviewing referral decisions/arrangements.

### Acceptability of referral by providers

Acceptability by providers of referral of HIV-positive FP clients to treatment and care is measured by two indicators - the proportion of providers reporting having a directory of facilities and their contact details where HIV-positive clients could be referred; and the proportion of providers reporting discussing referral issues during routine management meetings. Between baseline and endline, there were

<table>
<thead>
<tr>
<th>Table 4: Percent distribution of providers by indicators of acceptability of referral of HIV-positive family planning clients to treatment and care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>Proportion of providers using a directory for referral (%)</td>
</tr>
<tr>
<td>Proportion of providers discussing referral of HIV-positive FP clients (%)</td>
</tr>
</tbody>
</table>

**Notes:** FP: family planning; "p<0.05; "p<0.01. a: ICAP had introduced a referral directory at Thika DH at the time this project start
significant increases in the proportions of providers reporting having a directory for use for referral (p<0.01) and discussing referral of HIV-positive FP clients during routine management meetings (p<0.05, Table 4).

Quality of care measures
A review of quality of care indicators showed that there was a significant improvement at endline in the provision of ARVs, HAART and proper documentation of records, compared to the situation at the baseline. The records show significant improvement in the proportion of clients recorded as continuing with HAART (over 6 months) at endline, compared to baseline. These measures are summarized in Table 5 below.

Table 5: Distribution of key indicators of quality of care within the CCCs (%)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (N=454)%</th>
<th>Endline (N=487)%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of records showing WHO clinical staging for HIV/AIDS(^7) had been done</td>
<td>90</td>
<td>89</td>
</tr>
<tr>
<td>Proportion of records showing CD4+ values</td>
<td>97</td>
<td>98</td>
</tr>
<tr>
<td>Proportion of records showing whether clients are on ARVs</td>
<td>34</td>
<td>49*</td>
</tr>
<tr>
<td>Proportion of records showing that the client had just started HAART (within 6 months)</td>
<td>8</td>
<td>25*</td>
</tr>
<tr>
<td>Proportion of records that had the necessary documents filled correctly</td>
<td>15</td>
<td>28*</td>
</tr>
</tbody>
</table>

\(^7\)p<0.05

Effectiveness of referral
Client records provide information on effectiveness of referral of HIV-positive FP clients to treatment and care. Initially, there was no referral of HIV-positive FP clients to CCCs. However, during the intervention period, most of the HIV-positive FP clients received at CCCs (93%) were from within the MCH/FP unit of the same facility indicating that the referral system was effective (Table 6). The facilities also received HIV+ve FP clients from other facilities except Kirwara SDH and Warazo health centre.

\(^7\)WHO staging system is a simplified AIDS staging system that is based on 4 groups of clinical conditions that have prognostic significance and therefore constitute stages, plus an assessment of physical activity performance expressed as a 4-point score; Pts are classified according to the highest stage recorded for either clinical condition or physical activity. Patients are asymptomatic; mildly symptomatic; moderately symptomatic; severely symptomatic. Clinical Stage 1 (asymptomatic, normal activity), Clinical Stage 2 (Unintentional weight loss < 10% body weight), Clinical Stage 3(Unintentional weight loss > 10% body weight, Chronic diarrhea > 1 month, prolonged fever > 1 month (constant or intermittent), Clinical Stage 4 (HIV wasting syndrome, severe opportunistic infection and severely ill).
Table 6: Distribution of HIV-positive family planning clients referred and received at comprehensive care centers from within the facility, January-June 2010

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Number of HIV+ FP clients</th>
<th>Number of HIV+ FP clients received at CCC from within facility</th>
<th>Proportion of HIV+ve FP clients received at CCC from within facility</th>
<th>Number of HIV+ve FP clients received at CCC from other facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nyeri PGH</td>
<td>3</td>
<td>3</td>
<td>100</td>
<td>10</td>
</tr>
<tr>
<td>Thika DH</td>
<td>9</td>
<td>9</td>
<td>100</td>
<td>9</td>
</tr>
<tr>
<td>Gatundu DH</td>
<td>10</td>
<td>9</td>
<td>90</td>
<td>8</td>
</tr>
<tr>
<td>Ruiru SDH</td>
<td>40</td>
<td>39</td>
<td>98</td>
<td>3</td>
</tr>
<tr>
<td>Kirwara SDH</td>
<td>4</td>
<td>2</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Warazo HC</td>
<td>5</td>
<td>3</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>66</td>
<td>93</td>
<td>30</td>
</tr>
</tbody>
</table>

PGH: Provincial General Hospital; DH: District Hospital; SDH: Sub-District Hospital; FP: family planning; CCC: comprehensive care center.

Discussions, Conclusions and Recommendations

The objective of this project was to develop a feasible, acceptable and effective referral framework for linking family planning clients who test HIV-positive to appropriate care and treatment services. The evaluation strategy included assessing facility preparedness to support referral, provider acceptance, and effectiveness of the referral framework. Although only half of the facilities had the minimum number of staff in the MCH/FP and CCC units necessary to support referral, other facilities had, in fact, adequate cadres of staff in other departments. The MCH/FP and CCC units could therefore easily benefit from internal reallocation of staff without necessarily bringing in new staff from elsewhere in such facilities.

Most facilities scored poorly at baseline in the availability of the necessary infrastructure to support referral including a directory for use in referring clients to the CCCs and other STI services, referral guidelines, a register for documenting referral practices, and client/patient tracer card. Although some of the gaps were addressed by the relevant facilities and DHMTs during the project period, such poor indicators could be due to the limitations in the health care system including inadequate supply system, as most of these are available in the MOH system.

As pointed out in the earlier sections of this report, the algorithm for the study was designed for use in facilities where the HIV test is carried out by the FP provider during the FP consultation, or at least on the same day and at the same facility. The algorithm does not apply to clients being referred to other facilities to be tested for HIV, since the person doing the HIV test is the one who would have responsibility for linking an HIV+ client to care and treatment. Following the launch of the
provider initiated testing and counseling (PITC) policy by the Government of Kenya (GOK 2008), the proportion of clients attending FP/RH clinics who know their status has increased tremendously. In addition, there are significant proportions of clients who either prefer to be referred to other health facilities to be tested for HIV or to access care and treatment in facilities of their choice. These scenarios bring out the need to develop or modify the current algorithm to enable health providers to address the needs of different FP/RH clients seeking referral to other health facilities and those willing to be counseled and tested for HIV on site.

Despite the noted gaps in facility preparedness, the project interventions led to improved provider acceptance of referral practices. Specifically, significant increases occurred in the proportions of providers reporting having a directory for use for referral and discussing referral of HIV-positive FP clients during routine management meetings between baseline and endline. Moreover, the referral system was also found to be effective as most of the HIV-positive FP clients received at CCCs were from within the MCH/FP unit of the same facility. The study therefore shows that referral and linking of HIV-positive FP clients to treatment and care is acceptable and effective even with minimal level of preparedness on the part of the facilities.

The following recommendations can be made, in view of these findings:

- **Strengthening the supply chain for tools and commodities:** Some facilities did not have the necessary resources to support referral and linkage of HIV-positive clients to treatment and care at baseline. By endline, however, most of the required resources were available at the facilities. This suggests the need to strengthen the supply of the necessary tools (e.g. referral forms, cards) and commodities (FP, HIV test kits) for the referral system to be more effective.

- **Facility-wide provider training/updates on referral:** Although the proportion of providers using the referral directory increased significantly, about 40% were still not using the directory at endline. Either most did not know that the directories exist, perhaps due to staff rotation or they referred clients to the same facility without providing information on other available options. This suggests the need for facility-wide updates/training so that more health workers within the facility are aware of the directory and the available options for clients.

- **Scaling up the use of the referral form:** The project showed that the use of the referral form can be introduced in facilities with minimal infrastructure. It also does not require intensive provider training/update. This suggests that its use can easily be scaled up to other facilities in the country. In addition, the form can easily be adopted in other departments including antenatal and post-natal care clinics as a tool for referring HIV-positive clients to appropriate care and treatment.

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8 Provider Initiated Counseling and Testing implies Routine offer of HIV testing in health care settings such as those attending STI services, ANC and other RH services including those attending TB clinic services among others.
• **Improving recordkeeping and documentation**: Health providers need to be updated on the importance and correct procedure of filling in client records especially at CCCs, to improve the current recordkeeping.

• **Modification of the testing and counseling algorithm**: There is need to modify the current algorithm to enable health providers to address the needs of different FP/RH clients seeking referral to other health facilities and those willing to be counseled and tested for HIV on site.

**Study Limitations**

The study had a number of limitations. First, the number and types of participating health facilities were different and might have affected the referral mechanism. Two of the facilities (Thika DH and Nyeri PGH) are Level 5 referral health facilities while Gatundu DH is Level 4. The other facilities - Ruiru SDH, Kirwara SDH, and Warazo HC - are Level 3 facilities, which essentially function as health centers. Therefore, referrals at Levels 4 and 5 facilities are likely to be internal, while the lower level ones are likely to refer to other facilities. This has implications for client tracing and defaulting. Secondly, in Nyeri, clients from Warazo HC are likely not to take up referrals to Nyeri PGH because of distance and cost of transport.
References


Annex 1: Directory of health facilities providing care and treatment including STIs, further investigations and other services to the referred clients or patients

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Ownership: Enter code: 1=GOK, 2= Mission/NGO, 3=Private, 4=Other</th>
<th>Location</th>
<th>Opening Hours</th>
<th>Services Offered**</th>
<th>Telephone No. of Facility/ Officer-in charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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<td>4</td>
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<td>5</td>
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<tr>
<td>6</td>
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<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Insert appropriate code 1= FP provision, 2=STI counseling/treatment, 3= HIV post-test counseling, 4 =HIV care/ARV, 5= TB Screening/Diagnosis or Treatment, 6=Other OIs, 7= Psycho-social Support, 8=CD 4 Count, 9= Blood for full haemogram/Count, 10= Others (Specify--------).
Annex 2: Referral Form

Instructions for filling form: Fill in triplicate. Give original copy to client and retain duplicate at referring facility/clinic. The referring and receiving staff should insert their names, designation and date in the appropriate space provided. All completed forms should be handed to the Nursing officer in charge of CCC or MCH/FP for filing.

Serial No:______

Name of patient/client ______________________________ Date of Issue ________ Sex: M _ F _ Age ______

Physical Address: Village ____________________ Sub Location/Ward ______________ Location __________

Division: __________________ District ______________ Province ______________

Telephone contact __________________________________________________________

A) REFERRALS WITHIN FACILITY

Referred from: _________________________ (Clinic/Unit)     Referred to: _____________________________(Clinic/Unit)

B) REFERRALS FROM OUTSIDE FACILITY

Referred from: _____________________________________________________________________________ (Health facility/Clinic)

Referred to: _____________________________________________________________________________ (Health facility/Clinic)

What is client seen for? | What is client referred for?
--------------------------|--------------------------
- FP counseling          | - FP counseling          |
- FP provision           | - FP provision           |
- STI counseling/treatment | - STI counseling/treatment |
- HIV counseling         | - HIV counseling         |
- HIV testing (blood test) | - HIV testing (blood test) |
- HIV care (pre ART not on ARV) | - HIV care (pre ART not on ARV) |
- HIV care (ART on ARV)  | - HIV care (ART on ARV)  |
- TB Screening/Diagnosis | - TB Screening/Diagnosis |
- TB treatment           | - TB Treatment           |
- Other OI               | - Other OI               |
- CD 4 Count             | - CD 4 Count             |
- Psycho-socio Support   | - Psycho-socio Support   |
- ANC/PMTCT              | - ANC/PMTCT              |
- PNC for mother         | - PNC for mother         |
- Child (growth monitoring) | - Child (growth monitoring) |
- Child immunization     | - Child immunization     |
- Cervical screening     | - Cervical screening     |
- Other (specify):______  | - Other (specify):______ |

Comments________________________________________________________________________________________________________

__________________________________________

Referred by (Name of staff) ______________________________ Designation ______________ Phone No-__________

Received by (Name of staff) ______________________ Designation ___________ Section/Unit ________ Date ______

Comments________________________________________________________________________________________________________
Annex 3: Supervisory Tool

Ministries of Public Health & Sanitation, and Medical services

Integrating RH/HIV Services within PNC/FP & CCC settings and linking HIV Positive clients to treatment and care

Facilitative Supervision Tool

1. **BACKGROUND INFORMATION**

Facility Name __________________________ District: __________________________ Province: __________________________

Facility Category (Enter Code) ____________ (1=Hospital, 2=Health Centre, 3=Dipensary, 4=Other)

Managing Authority (Enter Code) ____________ (1=GOK, 2=Mission/NGO, 3=Private, 4=Other)

Date of Supervision ____________________________ (DD/MM/YY)

Facility Incharge: Name __________________________ Designation __________________________

Telephone no. of in charge/Facility: __________________________

Email address of in charge /Facility: __________________________

2. **SERVICES OFFERED IN THE FACILITY** (Tick as appropriate)

- [ ] FP counseling
- [ ] TB Screening/Diagnosis
- [ ] FP provision
- [ ] TB treatment
- [ ] STI counseling/treatment
- [ ] Other OI
- [ ] HIV counseling
- [ ] CD 4 Count
- [ ] HIV testing (blood test)
- [ ] Psycho-socio Support
- [ ] HIV care (pre ART not on ARV)
- [ ] ANC/PMTCT
- [ ] HIV care (ART on ARV)
- [ ] PNC for mother
- [ ] Child (growth monitoring)
- [ ] Cervical screening
- [ ] Child immunization
- [ ] Other (specify): ________________

2. (b) Comment on the services that you were previously offering but have not been able to offer in last one month (For each service mentioned, note and explore the underlying reasons)

________________________________________________________________________________________________________________

______________________________________________________________________________________________________________
### 3. STAFFING PROFILE

Staffing, indicate the total number of staff by cadre in the appropriate box.

<table>
<thead>
<tr>
<th>CADRE</th>
<th>Total No. of staffs at facility</th>
<th>NO. in MCH/FP</th>
<th>No in CCC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Doctors: Obs/Gyn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatricians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (Medical officers,)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Officers: RCOs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RH RCOs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses: Registered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists/ Tech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHTs/ PHOs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritionists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. STAFFING & TRAINING UPDATES IN THE LAST 24 MONTHS

<table>
<thead>
<tr>
<th>Updates / Training</th>
<th>No. Trained</th>
<th>Updates / Training</th>
<th>No. Trained</th>
<th>Others / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOC</td>
<td>PMTCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn health</td>
<td>IMAI</td>
<td></td>
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<tr>
<td>PAC</td>
<td>CTS</td>
<td></td>
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<tr>
<td>HIV/ STI/RTI/FP integration</td>
<td>ART PAED/ ADULT</td>
<td></td>
<td></td>
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<tr>
<td>CTU</td>
<td>POSTNATAL CARE</td>
<td></td>
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<tr>
<td>ASRH</td>
<td>VIA/VILI</td>
<td></td>
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<tr>
<td>Comprehensive RH training</td>
<td>IMCI</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Post Rape care</td>
<td>FANC/MIP/TB</td>
<td></td>
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<tr>
<td>Logistic management</td>
<td>Facilitative Supervision</td>
<td></td>
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</tbody>
</table>

### 5. CAPACITY BUILDING/TRAINING AND UPDATES

a) Comment on availability of a training data base in the facility

b) How does the training plan promote integration of RH/HIV activities? (Check for training schedules for RH/HIV integration)

Comment on the following issues:

- Availability of a training team
- Planning process for training
- Process of selecting participants/facilitators
- Training materials/resources, equipment, supplies and venues
- Training approaches e.g. OJT, CMEs/CPD and other fora
- Training/learning methodologies/aids
- Evaluation of trainings e.g. Knowledge and skills assessment (tools)
- Post training follow ups (Enquire on tools being used)

What are the main challenges affecting training and how have they is addressed?

---

1 *EOC – Essential Obstetric Care; PAC – Post + Abortion Care: CTS – Clinical Training Skills: FP – Family Planning; ASRH – Adolescent Reproductive Health; FANC – Focused Antenatal Care: MIP – Malaria in Pregnancy; IMCI-integrated management of childhood illnesses; VIA/VILI – Visual inspection with acid /
6. **AVAILABILITY OF TOOLS IN THE FACILITY**

Are the following tools available and in use in the facility? Place tick √ as appropriate

<table>
<thead>
<tr>
<th>Tools available</th>
<th>In Use</th>
<th>Not in use</th>
<th>Explanation if tool(s) Not in use</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPD Register</td>
<td></td>
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<tr>
<td>Partner notification card</td>
<td></td>
<td></td>
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<tr>
<td>Monthly summary Report Forms</td>
<td></td>
<td></td>
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<tr>
<td>Job aids(RH/HIV)</td>
<td></td>
<td></td>
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<tr>
<td>FP Register</td>
<td></td>
<td></td>
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<tr>
<td>PNC Register</td>
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<tr>
<td>Child welfare Register</td>
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<tr>
<td>Maternity/Delivery Register</td>
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<tr>
<td>ANC/PMTCT Register</td>
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<tr>
<td>ART Register</td>
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<tr>
<td>ARV Registers</td>
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<tr>
<td>Daily Activity Registers:(FP, PNC, Test kits, CCC)</td>
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<tr>
<td>Client Cards:(FP,PNC,CCC)</td>
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<tr>
<td>Other specify)</td>
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</tbody>
</table>

7. **STATUS OF COMMODITIES DURING THE MONTH**

Did the facility experience stock outs of the following RH commodities for more than 7 days during the month? (Place a tick in the appropriate “yes” or “no” column for each of the items listed). If FP commodities were not available, discuss with the facility staff and outline the reasons in the appropriate row in the table.

   i) **RH Commodities**

   | Commodity stock outs for more than 7 days | Y | N | Reasons for stock outs( if response was “Yes”)
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a) Combined pill (COCP)</td>
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<tr>
<td>b) IUCD</td>
<td></td>
<td></td>
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<tr>
<td>c) Depo provera</td>
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<tr>
<td>d) Implants (Eg Jadelle, Implanon)</td>
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<tr>
<td>e) Male Condoms</td>
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<tr>
<td>f) Female condoms</td>
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<td></td>
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<td>g) Microlut</td>
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<td></td>
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<tr>
<td>h) Others (specify)</td>
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</tbody>
</table>

   ii) **STI/HIV commodities**

   | Drugs/Supplies stock outs for more than 7 days | Y | N | If yes list the item | Reasons for stock outs & action taken
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a) Drugs for Mnx of Urethral Discharge</td>
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<tr>
<td>b) Drugs for Mnx of Genital ulcer disease (GUD) cases</td>
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<tr>
<td>c) Drugs for Mnx of Ophthalmia Neonatorum</td>
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<tr>
<td>d) Drugs for Mnx of cases of Vaginal Discharge or Pruritis</td>
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<tr>
<td>e) Drugs for Mnx of Lower abdominal pain in women</td>
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<tr>
<td>f) Determine</td>
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<tr>
<td>g) Bioline</td>
<td></td>
<td></td>
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<tr>
<td>h) Uni Gold</td>
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</tbody>
</table>
i) Laboratory reagents for(Urinalysis,  

j) Full Haemogram reagents 

k) IP Items 

l) Acetic Acid 

m) Luguls Iodine 

n) General supplies e.g. gloves, Needle/Syringes, etc. 

o) Haematinics/suppliments 

p) I.V FLUIDS 

q) TRANSFUSION SERVICES 

r) TB Drugs 

s) Lignocaine 

t) NVP Tabs 

u) NVP Syrup 

v) Cotrimoxazole Tabs/Syrup 

w) AZT Tabs 

x) AZT Syrup 

y) Others specify

**Comments on RH/ HIV Commodity Procurements**

1. How do you ensure availability and adequacy of RH/HIV commodities and supplies 

2. Is there a functional procurement committee/team? 

3. What are the main challenges in the management of RH commodities? 

---

**8. EQUIPMENT**

Observe and indicate three priority RH/HIV related equipments that have been non-functional for the last three months in the facility. Explore on the challenges and give suggestions on acquisition, repair and maintenance as appropriate.

<table>
<thead>
<tr>
<th>No.</th>
<th>Equipment</th>
<th>Point of use</th>
<th>Comment</th>
</tr>
</thead>
</table>

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**9. SUPERVISION FOR QUALITY IMPROVEMENT**

1. Comment on how RH/HIV supportive supervision is conducted and whether feedback is given to the service provider 

2. How often is RH/HIV supervision done? 
   - Verify about availability of supervision schedule 

3. Is there a functional quality improvement team for RH/HIV services? 

4. What does the team do?

---

**10. MONITORING & EVALUATION**

1. How do you ensure timely submission of your reports 

2. Do you analyze the data collected? 

3. How do you utilize the data? 

4. What are the major challenges on data management?
11. LINKAGES/ REFERRAL AND COMMUNICATION SYSTEM

1. Observe and comment on the client flow and linkages within/between service delivery points
2. Comment on Referral and tracking systems/tools
3. How do you get feedback about clients who are referred
4. What is the perception/attitude of the staff on their role in relation to referrals?
5. Comment on linkages with the community.
6. What are the challenges on referral and linkage of services?

12. GENERAL ON OTHER RH/HIV PRIORITY AREAS

Male involvement.

Comment on activities undertaken to increase awareness of RH/HIV services offered e.g Posters and Outreach services
General facility infrastructure
Availability of other HIV/RH services (Infertility services, youth friendly services, Home Based care services and Patient support centers)

RECOMMENDATIONS / SUGGESTIONS FOR IMPROVEMENT AND WAY FORWARD

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Timeframe</th>
<th>Responsible person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>4.</td>
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<tr>
<td>5.</td>
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</table>

Date of the Subsequent Supervisory Visit---------------------------------------------

SUPERVISORY TEAM:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANIZATION</th>
<th>POSITION</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</tbody>
</table>
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