EFFECTS OF INTEGRATION OF HIV-AIDS CARE INTO REPRODUCTIVE
HEALTH SERVICE ON UTILIZATION OF REPRODUCTIVE HEALTH
SERVICES IN KENYA

Lucy Anne Wanjiru Waweru Bsc. (Family and Consumer Sciences)
Reg. No. I57/11031/04

A research thesis submitted for the award of the degree of Masters of Public Health in the
School of Health Sciences of Kenyatta University

October, 2009
DECLARATION

This thesis is my original work and has not been presented for a degree or any other award in any other University.

Lucy Anne Wanjiru Waweru

I57/11031/04

Signature __________________ Date 09/11/09 __________________

SUPERVISORS’ APPROVAL

This thesis has been submitted for review with our approval as University supervisors

Dr Margaret Keraka

Department of Public Health

Kenyatta University

Signature __________________ Date 09/11/09 __________________

Dr B. M Okello Agina

Department of Public Health

Kenyatta University

Signature __________________ Date 09/11/09 __________________
DEDICATION

To my dear parents, husband and siblings for their unconditional support.
ACKNOWLEDGEMENT

Let me express my heartfelt appreciation to my supervisors Dr Margaret Keraka and Dr B.M Agina Okello for their invaluable guidance, counsel, suggestions, critical comments and encouragements during the writing of my thesis. Many thanks to Dr David Kiragu, Dr Naftali Oirere in addition to the members of staff of the Department of Public Health of Kenyatta University for their continued support. Special thanks go to Dr Joachim Osur and community of Family Health Options Kenya for creating a conducive environment for the study to be carried in. In addition to the members of staff and clients who took part in study in Nairobi-west and Thika Family Care Medical Clinics.

My appreciation goes to all my friends for their friendship, support and encouragement throughout the study period. I am greatly indebted to my parents, Miriam and Michael Waweru, my husband Julius Karuga and siblings for their prayers, support, and encouragement and for being my role models. Lastly to the Almighty God for granting me sound health, wisdom, strength and grace to go through my Masters education. In addition to providing the resources that were required to facilitate my education.

To every other person who supported me in one way or another, may the almighty God bless you abundantly.
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OPERATIONAL DEFINITION OF TERMS

Reproductive health services: These are techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems.

Comprehensive HIV/AIDS care: Focused care that meets patients’ physical, social, psychological, emotional and spiritual needs.

Integration: Offering two or more services at the same facility, during the same operating hours with the provider of one service actively encouraging clients to consider using the other services during the same visit.

Clients: Refers to women within the reproductive age bracket (15-49 years) seeking reproductive health from the clinics under study.

Effects: Refers to the short-term results or outcome of integrating HIV and AIDS care into reproductive health services and it can either be positive or negative.

Service providers: Refers to the member of the medical clinics health facilities offering reproductive health services.
The utilization of reproductive health and HIV and AIDS services that had been integrated. Synonymous to sought and uptake.
## ABBREVIATIONS AND ACRONYMS

<table>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARBEF</td>
<td>Association Rwandaise pour le Bien-Etre Familial</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>CBOs</td>
<td>Community Based Organizations</td>
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<td>EGPAF</td>
<td>Elizabeth Glaser Pediatric AIDS Foundation</td>
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<tr>
<td>FBOs</td>
<td>Faith Based Organizations</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FHOK</td>
<td>Family Health Options Kenya</td>
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<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organizations</td>
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<td>OVCs</td>
<td>Orphans and Vulnerable Children</td>
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<td>People Living With HIV/AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>ZNFPC</td>
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ABSTRACT

In most settings throughout the world, reproductive health and HIV and AIDS services are offered with little or no integration. Reproductive health services primarily target married women of reproductive health age bracket while HIV and AIDS services target individuals at high risk of HIV and AIDS infection. However, the potential benefits of integrating these services are increasingly apparent as ever more women of reproductive age are becoming infected with HIV and AIDS or are at risk of getting infected. In addition to the potential of reproductive health providers reaching women who account for nearly half of all adults living with HIV and AIDS with HIV prevention, information and treatment. This has resulted in many types of integration being explored but their effects on reproductive health services have not been rigorously evaluated and are largely unknown. Therefore, the study sought to expose the effects of integration of HIV and AIDS care into reproductive health services on the utilization of reproductive health services in Kenya. The study was carried out at Nairobi-west and Thika family care medical clinic which were conveniently sampled. A longitudinal study design was employed where records of clients utilizing reproductive health services from the study sites were reviewed. Retrospectively and prospectively for six months from the onset of integration. The results of the retrospective review generated the baseline data while the prospective review generated results that would be compared against the baseline data to assess whether the integration had affected the utilization of the reproductive health services. In addition to how the integration had affected the utilization of the reproductive health services. To build on the data generated from the review of records, primary data was collected from a sample of a hundred and ninety-four clients and service providers from the study sites. The clients were sampled on availability while all service providers were considered. Interview schedules and self-administered questionnaires were used to collect the data from clients. Key informant interviews were used to collect the views of service providers regarding integration. Data analysis was done using SPSS software. Descriptive statistics were done to determine frequencies, means, and percentages. A paired sample t-test was used to determine whether there was a significant difference in uptake of reproductive health services before and after integration. Chi-square was used to establish associations of various variables. Data from key informant was summarized and discussed under various themes. Data was presented in graphs and tables. Integration had improved the access of services because of the increments in the total number of clients that were registered in general and in the respective study sites after integration. Moreover, it had improved the quality of services and it was widely accepted among the clients and service providers. While most of the clients were aware of existence of HIV/AIDS services, only a minority could specify the nature of services available at the facilities. Awareness was mainly acquired through pamphlets and brochures. In addition, the utilization of HIV/AIDS services integrated into reproductive health services was low. The findings of the study will be used by the players in the health sector in the formulation of policies, conceptual and legislative frame works in support of integration.
CHAPTER ONE
INTRODUCTION

1.1 Background

Sub-Saharan Africa bears the largest burden of HIV and AIDS. In the year 2004, an estimated 3.1 million people became infected, while 2.3 million people died of AIDS almost 75% of deaths globally (UNAIDS, 2004). In 2005, Sub-Saharan Africa accounted for 64% of the 5 million people who became newly infected with the HIV and AIDS globally (UNAIDS, 2005). During 2006, around 4 million adults and children became infected with HIV and AIDS. An estimated 39.5 million people were living with HIV and AIDS globally with around 63% of PLWHA’s living in Sub-Saharan Africa. The year also saw around 3 million deaths from HIV and AIDS despite recent improvement in access to antiretroviral treatment (UNAIDS 2006). Like many other parts of the world, this region faces a rapid feminization of the epidemic. In Kenya, HIV and AIDS is still a burden with 1.4 million people living with HIV. According to the results of the 2007 Kenya Aids Indicator Survey, 7.4% of adults aged 15-64 are infected with HIV, with high HIV infection rates registered among old adults aged 50-64 years (KAIS, 2007).

HIV and AIDS is disproportionately affecting women and girls. This is aggravated by social and economic inequalities between men and women. Women and girls commonly face discrimination in terms of access to education, employment, credit, health-care, land and inheritance in addition to their biological vulnerability. These factors put women in a position where they are particularly vulnerable to HIV and AIDS infection (UNAIDS 2006). With 75-80% of all HIV and AIDS infection in Sub-Saharan Africa transmitted
heterosexually, the vulnerability of women is increased by the fact that in many African countries, sexual relationships are dominated by men as such women cannot always practice safe sexs even when they know the risks involved (UNAIDS, 2006). Until an effective and affordable vaccine or microbicide is developed they lack the means within their control to prevent HIV/STI infection (UNAIDS, 2006). When women fall ill, their families lose their primary care giver and often a primary bread winner. The women who die leave behind millions of orphans. Meanwhile other sexually transmitted infections remain both a cofactor in the spread of HIV and AIDS and a major problem in their own right with an estimated 340 million new cases of STI's annually (WHO, 2003).

The gap in HIV and AIDS prevalence between men and women continues to grow. In the year 2006, in Sub-Saharan Africa around 59% of those living with HIV and AIDS were women. Many more young girls than young men are affected due to lack of access to HIV and AIDS prevention services which leave them at risk for themselves and their unborn children. In many countries of Southern Africa, one in five pregnant women is infected with HIV and most children contract HIV and AIDS from their mothers (FHI, 2005). In 2005, an estimated 4.6% of women were living with the virus against 1.7% of men living (UNAIDS, 2005). As is the case in many African countries, HIV prevalence in Kenya is higher among women (8.7%) than among men (5.6%). According to the results of Kenya Aids Indicators Survey released in 2007, young women between 15 and 34 years are more likely to have HIV in comparison to young men of the same age group. Hence HIV/AIDS is a leading cause of morbidity and mortality among women.
Majority of the women infected with HIV come into contact with the health-care delivery system seeking reproductive health services. They do seek the services either within clinical settings or through community based distribution programs. Reproductive health providers serve millions of women in developing countries now at the centre of global HIV and AIDS pandemic (AGI and UNPF, 2003). Some half a million women in developing countries use a modern contraception method. Majority of pregnant women make at least one visit for prenatal care during pregnancy and a significant proportion of women make at least one post-natal clinic visit (AGI and UNPF, 2003). According to the Kenya Demographic Health Survey carried out in 2003 by Central Bureau of Statistics, 31% of women are on a modern method of contraception; about 90% of pregnant women make at least one antenatal visit, while post-partum care is accessed at least once by 42% of women, thus extending access to infants. Other reproductive health services that women seek from the clinics are well-baby, well-woman, management of STI’s, management of infertility and lastly post-abortal care. For these reasons, the clinics and Community Based Distribution programs create opportunities to reach women with HIV and AIDS prevention information and services (AGI and UNPF, 2003).

By virtue of their experience in providing a range of services to millions of women in developing countries, reproductive health providers could make a significant contribution in closing the gap in HIV and AIDS pandemic. Reproductive health providers are critical agents for HIV and AIDS prevention especially where the prevalence is high (Centre for Disease Control, 1999). In addition reproductive health providers already have the expertise in the very areas that are important for HIV and AIDS control. This forms a
solid base upon which stepped up interventions for HIV and AIDS prevention and management can be built. These areas are counseling and advice about sexual health, skills in communication with defined groups, sexual education for young people, programs concerned with women's role in development, contraceptive counseling especially valuable for PLWHA's and management of STI's. As such they are poised to play an important role in reducing the incidents of HIV and AIDS infections over the coming years. Policy makers, donors, researchers and activists should recognize the benefits of supporting the fuller integration of HIV and AIDS prevention efforts with reproductive health services (AGI and UNFPA, 2003).

All these in addition to the shift of focus at the beginning of 21st Century to provision of integrated reproductive health and HIV and AIDS services formed the basis for integration to be implemented in Family Care Medical Centers managed by Family Health Options Kenya (FHOK). FHOK formerly Family Planning Association of Kenya is the pioneer of the family planning movement in Kenya. It was legally registered in Kenya and affiliated to the International Planned Parenthood Federation (IPPF) in 1962. The integration was implemented in four Family Care Medical Centers. The four, Nairobi-West, Thika, Nakuru and Eldoret Family Care Clinics were selectively upgraded for the introductory phase of the integration, which is more than four years old. The integration has been rolled out to remaining four of the Family Care Medical Clinics namely Kisumu, Rebeiro, Phoenix and Meru. It is anticipated that after the integration is fully implemented, the two services will interact and have linkages between them.
However the effects of the integration on the uptake of reproductive health services are yet to be established since in most settings the two services are offered independently.

1.2 Statement of the Problem

In most settings in the world, reproductive health and HIV and AIDS services have been offered separately with little or no integration. Reproductive health services primarily target married women of reproductive age bracket while HIV and AIDS services target individuals at high risk of HIV infection (Foreit et al., 2002). However the potential benefits of integrating these services are increasingly apparent as ever more women of reproductive age become infected with HIV and AIDS or at risk of infection (Foreit et al., 2002). In developing countries about half of the 40 million people now living with HIV and AIDS are women of reproductive age with percentage approaching 60% in some African countries. The potential of reproductive health service providers reaching women who accounted for nearly half of all adults living with HIV and AIDS with HIV prevention, information (UNAIDS 2004). In addition to a ready infrastructure which is as a result of donors and government investing heavily in reproductive health services over the last three decades and services (AGI and UNFPA, 2003).

This has resulted to many types of integrations being explored but their effects on reproductive health services have not been rigorously evaluated and largely unknown. Research is essential to assess the effects of integration on service quality, acceptability, utilization of services and cost-effectiveness (Askew and Berer, 2003). It is in view of
this that this study was carried in selected Family Care Clinics that have implemented the integration of services.

1.3 Justification of the Study

Majority of HIV and AIDS infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. The interactions between reproductive health and HIV and AIDS are widely recognized. Most of HIV infected persons are within reproductive age, 63% of all HIV and AIDS cases are in Sub-Saharan Africa with women accounting for 60%, 75-80% of all HIV and AIDS infections in this region are transmitted heterosexually, with women and youth being most vulnerable (UNAIDS 2006). In addition, reproductive ill-health and HIV and AIDS share root causes including poverty, gender inequality and social marginalization of the most vulnerable population (UNFPA, 2005) The international community agrees that the Millennium Development Goals will not be achieved without ensuring access to reproductive health services and an effective global response to HIV and AIDS (UNFPA, 2005). This can be achieved through the integration of services.

The integration of HIV and AIDS and reproductive health services creates a number of important synergies. When programs offer clients the chance to meet multiple needs, either within the same visit or via referral, they are more likely to achieve these important health goals. Integrated services or better linkages may promote reaching broader groups with information and services that are not typically reached in a particular vertical program (Path finder, 2003). In African countries, many HIV infected women likely need
reproductive health services like family planning services. However the unmet need for these services is often greatest in countries with high HIV and AIDS prevalence (Myaya, 2004). These needs can be better met if the reproductive health services are offered where such women access HIV and AIDS services.

Meanwhile clients accessing reproductive health services may well need HIV and AIDS prevention, diagnosis and treatment services. Many of these clients are married women who are usually considered at low risk of HIV and AIDS infection (Altman, 2004). But evidence from several countries suggest that marriage may offer women little protection against HIV and AIDS infection since married women may have little or no power to negotiate safe sexual practice with their husbands (Altman, 2004). Forty percent of new infections in Thailand occur between spouses and 90% of those infections are transmitted from husband to wife (Agence France Presse, 2004). For the integration to be effective and realize the potential benefits; policies, conceptual frameworks and legislative frameworks supporting the integration of services are required, rigorous research is needed to expose the experiences of other sites integrating services, evaluate the impact of other models of integration and identify effective models. This study will generate findings that will be used to this end.
1.4 Research Questions

1. What were the utilization patterns of reproductive health services before integration of HIV and AIDS care into reproductive health services?

2. What were the changes in the uptake of reproductive health services following integration HIV and AIDS care into reproductive health services?

3. What were the effects of integration of HIV and AIDS care into reproductive health services on the utilization of reproductive health services?

4. What were the factors determining the utilization patterns of the integrated services?

1.5 Null Hypothesis

1. Integration of HIV and AIDS care into reproductive health services does not affect the utilization of reproductive health services.

1.6 Objectives

1.6.1 Broad Objective

1. To determine the effects of integration of HIV and AIDS care into reproductive health services on the utilization of reproductive health services.

1.6.2 Specific Objectives

1. To determine the level utilization of reproductive health services that were offered before integration of HIV and AIDS care into reproductive health services

2. To find out the changes in the uptake of reproductive health services following integration of HIV and AIDS care into reproductive health services
3. To establish the effects of integration of HIV and AIDS care into reproductive health services on the uptake of reproductive health services.

4. To determine the factors contributing to the utilization patterns of integrated services

1.7 Significance and Anticipated Output

The AIDS epidemic is integrally linked to sexual and reproductive health. The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding (UNFPA, 2009). Both HIV and AIDS and poor sexual and reproductive health are driven by common root causes including poverty, gender inequality and social marginalization of the most vulnerable populations. Responses to both health issues should be closely linked and mutually reinforcing (UNFPA, 2009). UNFPA, along with the rest of the international community, strongly advocate for closer linkages between HIV and AIDS interventions and sexual and reproductive health care. This makes sense in terms of public health benefit, economic efficiency and human rights. Integration of services was called for at the 2005 World Summit when leaders identified universal access to reproductive health as a combating HIV and AIDS and achieving the other Millennium Development Goals (UNFPA, 2009).

The integration between reproductive health and AIDS programme should lead to a number of important public health benefits:

- Improved access to, and uptake of key services.

- Better access of people living with HIV to services tailored to their needs.
• Reduced AIDS-related stigma and discrimination.

• Improved coverage of underserved and marginalized populations such as injecting drug users, sex workers or homosexuals.

• Greater support for dual protection against unintended pregnancy and STIs including HIV, for those in need, especially young people.

• Improved quality of care.

• Enhanced programme effectiveness and efficiency.

The investigation of effects of integration of HIV and AIDS Care into reproductive health service on the utilization of reproductive health services is becoming increasingly important. This is as a result of the shift of focus at the beginning of 21st century from vertical programmes to integrated programmes. The shift in focus has led to many types of integrations being explored and or implemented. Integrated services would be convenient, perhaps a lifesaver to individuals who have limited access to sexual and reproductive health care (UNFPA, 2009).

In Sub-Saharan Africa, where the HIV and AIDS epidemic is widespread, almost 61% of women were living with HIV in 2007 (UNAIDS 2007). Majority of whom have unmet need for effective contraceptive and consequently a high proportion of unintended pregnancies. Many of these women do not know their HIV status, have limited access to information and services thus risk to passing the virus to their children (UNFPA, 2009). Under these circumstances, access to even a minimal integrated package of care can enable women to protect themselves from both unintended pregnancies and HIV and
AIDS in addition to preventing HIV transmission to their children. Integration of HIV and AIDS care and reproductive health services is one of many steps called for by the Maputo Call to Action ‘Plan of Action on Sexual and Reproductive Health and Rights’ (UNFPA, 2009). Therefore the integration of HIV and AIDS care and reproductive health services in Thika and Nairobi-West Family Care Medical clinic can help in reversing the feminization of HIV and AIDS in the Kenya. More so the integration will aid in meeting the unmet reproductive needs of women.

1.8 Delimitation and Limitation of the Study

1.8.1 Limitations of the Study

The study was limited to only two of the four Family Care Clinics implementing the integration due to a scarcity of resources. In addition, due to limited time the retrospective and prospective study of services following integration was carried for a short period of time as such yielding short term effects only. Respondents thought they would be given a token of participation since there was a parallel study taking place in one of the clinics where participants were rewarded financially. As such they had to be convinced to participate. Lastly there was a degree of non response from the respondents.

1.8.2 Delimitations of the Study.

The study focused on people both in the urban and rural set-ups of Nairobi-West and Thika Town and their vicinities respectively. The findings were limited to Nairobi Province and Thika District. The study established the short term effects of integration
only. As such the findings should be generalized selectively in studies establishing long term effects of integration.

1.9 Basic Assumptions of the Study

The following assumptions were made to serve as a guideline for the study;

- Integration of service had been fully implemented and yielded effects on the existing reproductive health services, service providers and clients.

- Both the service providers and clients were aware that integration had been implemented.

- Clients who utilized the services were aware of the effects of integration on existing reproductive health services.
1.9 Conceptual Framework

**Independent variable**
Components of comprehensive HIV/AIDS

- VCT
- PMTCT
- Ante-retrieval therapy
- Psychological care
- Home based care
- Nutritional counseling
- Management of opportunistic infections

**Dependent variables**
Reproductive health services

- Family planning
- Well baby clinic
- Well-woman clinic
- Antenatal clinic
- Post-natal clinic
- Post-Abortal care
- Management of STI's
- Management of infertility

**Expected outcome**

- Improved access to and uptake of key HIV/AIDS & Reproductive Health Services

---

**Figure 1.0**

**Key**

→ Point of formation of Linkages and Interactions between the two sets of services once the integration is fully implemented

Adopted from www.Unfpa.org/icpd/10/docs/hiv-aids-rh-call-commitment.doc
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

As the spread of HIV and AIDS has spiraled into a pandemic, funds have been poured into vertically structured efforts to combat the disease. HIV and AIDS is primarily a sexually transmitted disease, separating prevention, care and treatment from reproductive health context hampers long term prevention efforts and solution to reproductive health issues related to HIV and AIDS. Hence the need for the integration of the two services to counteract this (Moloney et al, 2003).

2.2 Reproductive Health Services

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes (Jay and Sharifar, 1994). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law. More so the rights of access to appropriate health care services that will enable women go through pregnancy, child birth and provide couples with the best chance of having a healthy infant (Jay and Sharifar, 1994). In line with the above definition, reproductive health care is defined as constellation of methods, techniques and
services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproductive and sexually transmitted diseases (Jay and Sharifar, 1994). Although the priority for specific reproductive health services will differ from country to country, the following are the basic components of reproductive health; family planning counseling, information, education and services, prevention and treatment of reproductive tract infections including sexually transmitted infection, prenatal care, delivery, postnatal care including breastfeeding and infant and women’s health care, prevention and appropriate treatment of infertility, prevention of abortion and post-abortal care and gynecological services for women (Jay and Sharifar, 1994).

According to World Bank, in the year 1993, about a third of the total disease burden in women in developing countries is linked to health problems related to pregnancy, child birth, abortion HIV/AIDS and reproductive tract infections. In addition problems such as FGM malnutrition, unregulated fertility, osteoporosis and prolepses contribute to women’s ill health in their lifecycle (Jay and Sharifar, 1994).

2.3 Care for People Living With HIV and AIDS

Treatment and care for HIV and AIDS consists of a number of different elements apart from ARVs and indeed should be provided before ARVs are available. The care must be comprehensive and continuous and not simply restricted to treatment (National AIDS/STD Control Program, 2005). It focuses on the patient and provides him or her
with not only physical but also social, psychological, emotional and spiritual care (National AIDS/STD Control Program, 2005). Such comprehensive care encourages disclosure of status, thus helping prevent on-going transmission, promote positive living, promote good nutrition, encourage living a healthy lifestyle, manages opportunistic infections and sexually transmitted infections medically, provides treatment with antiretroviral therapy and lastly provide home-based care and end of life support (National AIDS/STD Control Program, 2005). Home based care is the care of people infected and affected by HIV and AIDS within the home and community, serving as a link between hospital or health facility and the client’ home through family participation and community involvement (National AIDS/STD Control Program, 2005).

In Kenya, home based care is community based with most care provided by community health workers, volunteers supported by clinicians, nurses, and spiritual counselors. Quality home-based care has four main components; clinical care which entails early diagnosis, prescribes rational treatment and plans for follow-up care of HIV related illnesses, nursing care which promotes maintaining good health, hygiene and nutrition, counseling and psycho spiritual care that helps reduce stress and anxiety, promotes positive living and helps make informed decisions on testing for HIV, changing their behavior and planning for the future and lastly social support which provides information about support groups and welfare services and refers patient to them, provides legal advice for individuals and families, including surviving family members and where feasible provide material assistance.
The most important entry point into the continuum of care is voluntary HIV counseling and testing. The VCT is an important part of any national prevention program. It is widely recognized that individuals living with HIV and AIDS who are aware of their status are less likely to transmit HIV infection to others and that through testing they can be directed to care and support that can help them stay alive (UNAIDS, 2006). VCT also provides benefit for those who test negative in that their behavior may change as a result of the testing. The provision of VCT has become easier, cheaper and more effective as a result of the introduction of the rapid HIV testing, which allows individuals to be tested and get the results the same day (UNAIDS 2006). The testing and counseling is now available through VCT, PMTCT, diagnostic testing and counseling in tuberculosis clinics as well as out and in-patients department.

2.4 Integration of Reproductive Health Services and HIV and AIDS Care

Integration in the health sector has been defined as offering two or more services at the same facility during the same operating hours, with the provider of one service actively encouraging clients to consider using the other services during the same visit in order to make those services more convenient and efficient (Foreit et al., 2002). In practice integrated services are not always offered under one roof, but in such instances strong referral systems are required to ensure that clients receive the high quality services that they deserve (Myaya, 2004). Where services are currently integrated some HIV and AIDS services are usually provided through family planning programs.
When the HIV and AIDS epidemic emerged in 1980s, family planning organizations responded with some of the first HIV and AIDS prevention projects in the developing world. Yet a review of the contributions of sexual and reproductive health services to HIV and AIDS, conducted in 2003 for the World Health Organization found that integrating HIV and AIDS services had not yet been implemented effectively except in a few cases (Askew and Berer, 2003). Still it would be premature to conclude that integration does not work. Much has been learnt, moreover from implementing various strategies designed to achieve integration. Such strategies include diagnosis and treatment of STIs, sexual risk reduction counseling, condom promotion and HIV voluntary counseling and testing (Kathleen, 2004).

2.4.1 Integration of STI / HIV Prevention Messages into Family Planning.
Incorporating STI/HIV prevention messages in family planning services has been an appealing strategy because family planning programs attract clients who often do not access HIV programs services. Family planning staff can be trained to provide basic HIV and AIDS prevention information and run an infrastructure of clinics and community based programs for service delivery (Askew and Berer, 2003). However providing STI/HIV prevention services through family planning programs is problematic because these programs usually do not reach those at the greatest risk of HIV and AIDS infection, including men, youth and single women (Lush et al., 1999). Even when married women are among those at the highest risk of HIV and AIDS, they often do not have the powers to protect themselves by either abstaining from sex insist on fidelity or condom use by their husbands (O’Reilly et al., 2002).
Family planning programs providers are often reluctant to offer HIV and AIDS services. Many are concerned about the potential negative effects of HIV and AIDS responsibilities and overall quality of services. Others fear occupational exposure to HIV and AIDS or worry that providing the services will discredit family planning programs (Maggwa and Ominde, 2003). Nevertheless providers have an obligation to their clients to do what they can, wherever family planning services are offered, providers should be equipped to counsel clients about STI’s and HIV and AIDS and refer them for services (Maggwa and Ominde, 2003).

2.4.2 Integration of Family Planning into HIV and AIDS Services.

Integration is also starting to move in the opposite direction. Pilot efforts have begun to add family planning counseling and services to HIV services such as VCT and PMTCT. VCT centers are emerging as primary targets for integration. Research from Africa and the Caribbean shows that such integration is feasible and acceptable and large scale integration efforts are being launched and expanded there (Strachan et al., 2004). In response to research demonstrating the feasibility of integrating family planning into VCT centers in Kenya, the government has moved quickly to develop and begin implementing a strategy for family planning services at all VCT centers in the country. Government leadership, an effective task force and stakeholder commitment have been key to translating this important research into improved family planning and VCT services for Kenyan clients.
The research conducted in June 2002 on the feasibility of integrating family planning into VCT centers in Kenya suggested that it was feasible (Reynolds et al., 2003). The feasibility research identified the opportunities, challenges for integration and to inform the development of integration strategy. Overall, results suggested that counselor training, referrals and contraception supply needs varied among centers. Researchers concluded that decisions on whether to integrate services and to what extent to integrate needed to be made at the facility level (Strachan et al., 2004).

Kenya was a promising site for integration even before the feasibility research was conceptualized. The Ministry of Health had an ambitious program to expand VCT services. Nearly 300 VCT centers have been registered in the country and it is one of the few countries to have developed national VCT guidelines. The government also recognized the benefits of family planning; with Kenya identified in a recent analysis as one of six countries to mention family planning in its VCT guidelines (Strachan et al., 2004). The VCT centers were funded through different mechanisms and because some service providers thought they might be overburdened if family planning was introduced into their facilities. To address these concerns the MOH established a subcommittee to develop a strategy that could be applied to all facilities would not disrupt existing VCT services and would not compromise the quality of either the family planning or the VCT services provided (Kenya Ministry of Health, 2004).

The subcommittee developed a strategy that identifies four levels of integration, each contingent on resources available at particular facilities. The Assessment of pregnancy
and sexually transmitted infections, provision of information and counseling on contraceptive methods that are not available at the VCT centers are included in all levels.

Each progressive level requires more extensive training of VCT counselors and more equipments and supplies. Thus the strategy recommends that VCT centers first focus on achieving at least the first level of provision, while the fourth is viewed as a long term goal (Kenya Ministry of Health, 2004). Tools for training current and new VCT counselors to provide family planning services have been developed and will be combined to one comprehensive curriculum by Ministry of Health. The levels shown on the table below differ however, in the methods that are provided on site (Kenya Ministry of Health, 2004).

FHI is working with AMKENI and JHPIEGO to implement the first level of integration as outlined in the strategy, into 20 proposed VCT centers in two provinces in Kenya. Operations Research will test the effectiveness, cost of implementation and lessons learnt from this will inform activities to scale up integration throughout Kenya (Kenya Ministry of Health, 2004).
Table 2.0 Adding Family Planning to VCT: Levels of Integration in Kenya

<table>
<thead>
<tr>
<th>Level</th>
<th>Services Provided</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| I     | • Assessment of pregnancy and STI risks  
       | • Information and counseling on methods  
       | • Provision of condoms and pills  
       | • Referral for other methods | • Minimal training of counselors to provide services  
       |                     | • Availability of job aids, condoms and pills  
       |                     | • Time and space to provide services |
| II    | • All services in level I  
       | • Provision of injectables | • All requirements in level I  
       |                     | • Counselors trained to provide injectables  
       |                     | • Adequate infection control procedures in place  
       |                     | • Additional equipment and supplies |
| III   | • All services provided in level II  
       | • Provision of IUDS | • All requirements in level II  
       |                     | • Counselors trained to provide IUDS  
       |                     | • Additional equipment and supplies |
| IV    | • All services provided in level III  
       | • Provision of full range of methods | • All requirements in level III  
       |                     | • Medical doctor to perform surgical procedures  
       |                     | • Additional equipments and supplies |

In 2006, in promoting an integrated approach to PMTCT in Sub-Saharan Africa, WHO named Uganda a learning site where different ways of providing comprehensive PMTCT services can be tested and evaluated (FHI, 2007). The integration was as a result of findings of a research carried out in rural parts of the country by the US. Centre for Disease Control and Prevention in Uganda. Nine out of 10 pregnancies among HIV-positive women were unintended. These preliminary findings, based on 86 pregnancies among 618 women in Tororo, Uganda, highlight the need to integrate the country's family planning and HIV and AIDS services. Providing such services can help HIV-positive women avoid unintended pregnancies and contribute to preventing PMTCT (FHI, 2007).

The MOH of Uganda began integrating family planning, maternal and child health and HIV and AIDS services in 2005. The technical support from WHO gives the Ministry an opportunity to accelerate these efforts while strengthening the evidence base for integration. A working group of reproductive health and HIV and AIDS expert has laid a foundation for an integrated approach in Uganda. Its members incorporated information about how to provide and evaluate HIV and AIDS services into family planning tools and guidelines. They also developed training materials and service delivery guidelines, which were used to train a central team of master trainers. Non-medical health workers will be trained to provide certain community based services including HIV testing and counseling (FHI, 2007).
This kind of integration aims at providing VCT and PMTCT clients, regardless of their HIV status, the opportunity to avoid unintended pregnancies. For HIV infected women ready access to family planning can help avert unintended pregnancies and thus reduce the number of HIV infected infants. ART programs are also ideal sites for linking HIV and AIDS and reproductive health services, such as gynecological care and screening for gender-based violence. In Ghana, Engender Health and FHI are integrating family planning interventions in ARV treatment and care programs (Perchal and Farrel, 2006).

Also being explored is the integration of family planning into care and support for PLWHA. An FHI study was assessing integration of family planning promotion into the services provided by volunteer care givers in a home-based care program for PLWHA in South Africa and the results are yet to be published (USAID, 2003). Managers of a similar program in Kenya, the HIV and AIDS care support and prevention (COPHIA) program carried out by US based Pathfinder International, decided that it was important to train community healthy workers in family planning services and HIV prevention so that they could respond to the reproductive health needs of clients and family members.

2.4.3 Integration of HIV and AIDS Services outside Clinical Setting

HIV and AIDS services or preventive health messages can also be integrated outside clinical settings through interventions such as behavior change communication, peer education, communication outreach, youth programs and social marketing (Shelton, 2004). For example in Nigeria’s Lagos state, family planning counseling and referrals are available through a HIV and AIDS hotline established in 2001 by the Health
Communication Partnership. After training hot line counselors in family planning counseling and referral in February 2004, HCP began promoting the new services through radio advertisements, community rallies and USAID-sponsored family planning programs (Shelton, 2004). In addition partners such as FBOs and CBOs can be crucial in the integration of services. At the same time play a part in a successful referral systems. Many CBOs represent the only accessible service point for integration at the community levels and they need support in their efforts to deliver integrated services (Moloney et al., 2003). In Ethiopia, the main entry points of integrated services are the community-based reproductive health agents who in their role in reproductive health services not only promote family planning but also provide PLWHA’s with HIV and AIDS and OVC’S with home-based care kits, provide referrals for HIV and AIDS services and spread preventive messages (Kane and Colton, 2005).

Zimbabwe has followed suit and integrated family planning and HIV and AIDS services at the community level. In primary health care clinics throughout the country, a single health care provider is expected to offer not only basic services such as immunizations, but also family planning services and information about HIV prevention. Some also provide the antiretroviral drug nevirapine for prevention of mother to child transmission of HIV and AIDS (FHI, 2007). At other levels of the country’s health system, however, family planning and HIV and AIDS services are separate, vertical programs. Providers countrywide are uncertain about how to advise HIV-positive women and couples about family planning, which is a primary strategy for reducing HIV-infected births. Despite the growing desire in Zimbabwe to better integrate family planning and HIV and AIDS
services, family planning services have not been well integrated into PMTCT and remain the program’s weak link as such a change at the national level is required to strengthen this link (FHI, 2007).

The integration initiative began with an assessment of the family planning content of national HIV and AIDS and reproductive health policies, guidelines and training materials in June 2006. Eight of the 14 documents mentioned family planning, but none provided guidance on how to integrate services. By October 2006, the assessment’s recommendations for strengthening or adding family planning content had been incorporated into the national strategy on PMTCT and pediatric HIV and AIDS prevention, care and treatment. Contraception for women and couples with HIV/AIDS, a training module developed by FHI and Engender Health, was adapted for inclusion in the national PMTCT training curriculum to strengthen providers’ ability to provide family planning services (FHI, 2007). The module was also to train HIV and AIDS counselors supported by a partnership project. These efforts and most other integration work in Zimbabwe have introduced family planning into HIV/AIDS services. Recently, however, the Zimbabwe National Family Planning Council (ZNFPC) together with partnership project trained family planning counselors to provide HIV and AIDS services. The training covered; family planning and other ‘positive living’ issues such as diet, exercise, medical care and psychological and social support.

The Ministry of Health and Child Welfare of Zimbabwe in conjunction with partnership project and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) developed a list of
seven indicators of success in their integration efforts. Two of those indicators measure progress in training providers in comprehensive PMTCT services that include family planning. Three indicators address how the training has affected whether clients’ actually receive enhanced family planning counseling. The final two indicators will assess impact, monitoring postpartum changes in reported use of contraception and in couple years of protection (FHI, 2007)

Table 2.1 Potential Benefits and Challenges of Integration

<table>
<thead>
<tr>
<th>Types of Integration</th>
<th>Potential Benefits</th>
<th>Potential Challenges</th>
</tr>
</thead>
</table>
| Family planning to HIV and AIDS or HIV and AIDS to Family planning | • More people reached with needed services  
• Providers better able to meet clients’ various needs  
• Cost saving through reduced duplication of service delivery functions  
• Fewer HIV and AIDS infections and unintended pregnancies | • High initial costs of establishing services and training staff  
• May over burden staff and weaken services particularly if programs are poorly funded  
• Family planning and HIV and AIDS services often implemented by different programs with different policies and sources of funds |
| HIV and AIDS/STI prevention to Family planning (clinics or outreach), Maternal and Child Health and Antenatal Care | Increasingly common | • Improved provider counseling skills and greater client satisfaction  
• Increased knowledge of HIV and AIDS prevention strategies among women of reproductive age who are at HIV risk but might not act on prevention messages without a partner’s support  
• Provider and client |
<table>
<thead>
<tr>
<th>VCT to Family planning or Antenatal care</th>
<th>Otherwise receive HIV and AIDS information and counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Many HIV-infected births averted by preventing HIV infection among women of reproductive age</td>
</tr>
<tr>
<td></td>
<td>• Difficult for many Family planning programs to assume new tasks due to reduced funding and weak systems</td>
</tr>
<tr>
<td></td>
<td>• Need to train providers to talk about sexual behavior and relationships</td>
</tr>
<tr>
<td>Limited but increasing</td>
<td>Bias against condoms</td>
</tr>
<tr>
<td></td>
<td>• May not be cost-effective if most clients are not at risk of HIV and AIDS</td>
</tr>
<tr>
<td></td>
<td>• Possible provider reluctant to offer HIV and AIDS services due to stigma associated with HIV and AIDS and fears of occupational exposure to the virus</td>
</tr>
<tr>
<td></td>
<td>• For VCT, special skills and equipment plus strong systems for supervision, monitoring, logistics management and referrals for follow-up care needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family planning to VCT or Antenatal Care (usual site of PMTCT services)</th>
<th>Expanded access to family planning for all VCT clients, including men and</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• For family planning, special provider skills, equipment, supplies and space</td>
</tr>
<tr>
<td>Limited, but increasing youth</td>
<td>as well as strong systems for supervision, monitoring logistics management and referrals for follow-up care needed</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>• Increased knowledge of dual protection strategies to prevent both unintended pregnancies and HIV and AIDS infection</td>
<td></td>
</tr>
<tr>
<td>• Greater opportunity for clients, regardless of HIV serostatus to avoid initial or subsequent unintended pregnancy</td>
<td></td>
</tr>
<tr>
<td>• Can greatly contribute to averting HIV-infected births among HIV-infected women</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STI care to Family planning, Maternal and Child Health or Antenatal Care (Emphasis decreasing)</th>
<th>• Reduced risk of HIV and AIDS infections through STI prevention, detection and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fewer cases of secondary infertility, pelvic inflammatory disease and negative pregnancy outcome arising from untreated reproductive tract infections/STI’s in women</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STI care to Family planning, Maternal and Child Health or Antenatal Care (Emphasis decreasing)</th>
<th>• Misdiagnosis more likely since family planning clients may not be at high STI risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Current lack of simple, effective technologies to diagnose and treat STI’s in asymptomatic women or women with vaginal discharge</td>
<td></td>
</tr>
<tr>
<td>• When diagnosis is uncertain, partner notification not feasible; women treated syndromically at risk of reinfection</td>
<td></td>
</tr>
</tbody>
</table>

Source: Network, volume 23 Number 3, 2004
Regardless of when, where and how family planning and HIV and AIDS services are integrated, family planning remains one of the most effective ways to enhance the well-being of women and their families. By enabling women to avoid unintended pregnancies and by reducing the risks associated with age at pregnancy, too many pregnancies, or pregnancies spaced too closely together, family planning prevents about 2.7 million infants deaths and 215,000 pregnancy-related deaths in the developing world each year. These benefits of family planning may be particularly important for HIV-infected women, whose health is already compromised and for their children (Singh et al, 2003).

2.5 Factors to consider when Integrating HIV and AIDS and Reproductive Health Services

According to the new technical guidelines from the US Agency for International Development (USAID), integration is most appropriate in countries where the epidemic is generalized. In these countries the number of people who need reproductive health services and HIV and AIDS services are likely to be high (USAID, 2003). Family planning and HIV and AIDS services needs intersect in a growing number of countries. In 2000, 55 countries had generalized epidemics up from 25 countries in 1990 (Walker et al, 2001). In contrast in countries where the epidemic is low level or concentrated among people at highest risk of infection, HIV and AIDS services specifically targeting those individuals are needed. Integrating services in such settings is unlikely to be cost-effective (USAID, 2003). Even in countries where HIV and AIDS primarily affect high-
risk groups, good opportunities may exist to reach people in need HIV and AIDS or family planning services through service integration.

Table 2.3 Appropriate Service by Type of HIV/AIDS Epidemic

<table>
<thead>
<tr>
<th>HIV/AIDS Epidemic Type</th>
<th>Service for Type of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized: HIV prevalence above 1% among pregnant women.</td>
<td>Integrated family planning and HIV and AIDS services for general population and high-risk population.</td>
</tr>
<tr>
<td>Concentrated: HIV prevalence above 5% in at least one at risk sub population but below 1% among pregnant women.</td>
<td>Family planning for general population HIV and AIDS services and possibly family planning for high-risk population.</td>
</tr>
<tr>
<td>Low level: HIV and AIDS prevalence below 5% in at risk sub-populations and below 1% among pregnant women</td>
<td>Family planning for general population HIV and AIDS services for high-risk population.</td>
</tr>
</tbody>
</table>

Table 2.3 shows the appropriate service by type of HIV and AIDS epidemic adapted from USAID. Family planning and HIV integration: Technical Guidance for USAID-supported field program.

Some reproductive health services for instance may tailor their services to reach those at highest risks such as the youth, men and commercial sex workers (Kathleen, 2004). Before attempting to integrate services, program managers need to be aware of the potential benefits and challenges confronting them and consider whether integration make sense. The likely hood that combining the two services will be cost effective depends on clients' need, the prevalence of HIV and AIDS in the area and the strength of reproductive health programs in place (USAID, 2003). The appropriate level of
integration depends on a program's capacity, the costs and resources available to support and maintain integrated services directly or through referrals (Foreit et al., 2002)
CHAPTER THREE

MATERIALS AND METHODS

3.1 Research Design

A longitudinal study design was employed. Records of clients utilizing the eight reproductive health services namely family planning, antenatal, postnatal, well-baby, well-woman, Postabortal, management of STIs, and management of infertility from the study sites were reviewed. Retrospectively and prospectively for six months from the onset of integration. The results of the retrospective review generated the baseline data. While the prospective review generated results that would be compared against the baseline data to assess whether the integration had affected the utilization of the respective reproductive health services. In addition to how the integration had affected the utilization of the respective reproductive health services. To build on the data generated from the review of records, primary data was collected from clients seeking reproductive health services from the study sites and to service providers working in the same sites.

3.2 Definition and Measurement of Study Variables

The independent variable was HIV and AIDS Care that was integrated into reproductive health services. The utilization of reproductive health services was the dependent variable. The study used several variables within the independent variable to assess the effects of integration on the utilization of reproductive health services. The variables
were changes in uptake of services, acceptance levels of integrated services, changes in quality of services and awareness.

3.2.1 Changes in Uptake of Services

Uptake of services refers to the utilization of HIV and AIDS Care and reproductive health services. It is synonymous to sought and access. The changes were measured through the comparison of the total number of clients who utilized services before and after integration in general. Also comparisons were drawn between the total number of clients utilizing services from Nairobi-West and Thika Family Care Medical clinics before and after integration. Further, comparisons were drawn between the number of clients who utilized the respective reproductive health services in general and from Nairobi-West and Thika Family Care Medical clinic before and after integration. The data that was used for comparison purposes was generated through the review of monthly medical records prospectively and retrospectively for six months after integration.

3.2.2 Acceptance of Integration

Acceptance is the willingness to adopt and utilize the services that had been integrated. Information to assist the study to measure the acceptance of integration was collected through questionnaires. The study population responded to questions on awareness of the implementation of integration, their preference based the pro and cons of integrated services vis a vis vertical services.
3.2.3 Changes in Quality of Services

Quality is the goodness of services. Rating of goodness of services as very poor, poor, fair, good and very good was used to capture the views of clients. To measure changes in quality, clients utilizing the services drew comparisons on four parameters of qualities of services before and after integration. The four parameters were; waiting time before being attended to, efficiency and number of service providers, availability of services sought for and accuracy of information relayed to clients. Clients responded to questions related to these parameters.

3.2.4 Awareness

Awareness is being well informed on the implementation of integration and the HIV and AIDS services that were integrated. The awareness was measured through the study population responding to questions on how they got informed about the integration and the availability of HIV and AIDS care services.

3.3 Location of the Study

The study was conducted in Nairobi-West and Thika Family Care Medical clinic in Nairobi city and Thika town respectively. The two clinics are part of the four Family Care Medical Clinics currently integrating HIV and AIDS care into reproductive health clinics managed by F.H.O.K.
3.3.1 Description of Thika Town

Thika town is a market town in Central Province, Kenya lying on the A2 road, 40 km north east of Nairobi city and on the Thika river. According to 1999 census results, the town has a population of 88,265 people. It is externally serviced by a dual carriage way to Nairobi city, a high way to Garissa and also a railway line. Economic activities of the town include agriculture, food processing, tannery, textile and motor vehicle assemblies. The Thika Family Care Medical clinic is located opposite the main bus terminus along workshop road in the town.

3.3.2 Description of Nairobi City

Nairobi is the capital and largest city in Kenya. It is the most populous city in East Africa with an estimated population of 3 million. It is currently the 13th largest city in Africa. In addition, it is one of the most prominent cities in Africa politically and financially. It is home to many companies and organizations. Moreover, it is an established hub for business and culture. Nairobi enjoys full administrative province and is the smallest province in size and entirely urban. Nairobi – West Family Care Medical clinic is located along Mai - Mahiu road off Langata / Mbagathi road junction in Kibera division.

3.4 Target Population

Service providers working in integrated set-ups and clients seeking services in the same settings were targeted.
3.5 Study Population

The study population consisted of:

- Reproductive health services offered in Nairobi-West and Thika Family clinic. The reproductive health services of interest to the study were; antenatal, postnatal, management of STIs, postabortal care, family planning, well-woman, well-baby, and management of infertility.

- Clients seeking reproductive health services from the two clinics. The clients were women of the reproductive age bracket which is 15 to 49 years of age.

- Service providers working in the study areas.

3.5.1 Criteria for Inclusion

i. Clients seeking reproductive health services at the specific time of the study and were willing to participate.

ii. Service providers who were on duty at the specific time of the study in the clinics and were willing to participate.

3.5.2 Criteria for Exclusion

i. Clients seeking reproductive health services at the specific time of the study and were not willing to participate

ii. Service providers who were on duty at specific time of the study and were not willing to participate.
3.6 Sampling Techniques and Sample Size

3.6.1 Sampling Techniques

Nairobi-West and Thika Family Care Clinics were conveniently sampled due to their proximity to the research team. A census of all reproductive health services offered in the study was conducted. In addition a key informant interview was carried out where all the service providers working in the two facilities were eligible. Availability sampling was used to select the clients who participated in the study. This involved the sampling of clients readily available and willing to participate in the study till desired sample size was arrived at. The study employed the availability method of sampling because the population of interest to the study was out patient. This meant that the members of the population visited and left the clinics at their own convenient time without being admitted into the wards.

3.6.2 Sample Size Determination for Clients

The sample size was arrived at by calculating using the standard formula as used by Fisher et al., (1998).

\[ N = \frac{Z^2pqD}{d^2} \]

Where,

N = Sample size

Z = standard normal deviate (1.96) which corresponds to 95% confidence interval

P = proportion of clients seeking reproductive health services in an integrated set-up (0.5)
q = 1 - p = 0.5

d = Degree of accuracy = 0.05

D = Design effect = 1

= Thus n = \(1.96^2 \times 0.5 \times 0.5 \times 1\)

\[= \frac{0.05^2}{0.05^2}\]

= 384

The above formula is only applicable for a population that is more than 10,000. Therefore after calculation of sample size with the above formulae, the formulae below was used since the average monthly population of clients seeking reproductive health services in the two clinics was 391 which was less than 10,000

\[nf = \frac{n}{1+n}\]

Where,

nf = sample size of a population less than 10,000

n = sample size arrived at using the formula as it was used by Fishers et al., (1998), for a population greater than 10,000

n = the population of clients seeking reproductive health services i.e. 391: \(\hat{N}\)

\[nf = \frac{n}{1+n} \frac{1}{N}\]
Probability proportion to sample size as shown below was used to determine the number of clients to be interviewed in the two clinics as shown below.

Nairobi West = \( \frac{140 \times 194}{391} = 69 \) women

Thika = \( \frac{251 \times 194}{391} = 125 \) women

3.7 Construction of Research Instruments

Interview schedules and self-administered questionnaires were used to collect clients’ perception towards integration. The instruments contained both open and close-ended questions. Further the instruments were subdivided into three sections; demographic, reproductive health services and integrated services. This was to aid in capturing the clients’ perception of integrated services. In addition a key informant interview schedule was constructed to collect the views of service providers regarding integration.

3.8 Pilot Study

Pilot study was carried out at Phoenix Family Care Clinic along Kenyatta Avenue in Nairobi town. The clinic was conveniently selected. Interview schedules and self-
administered questionnaires were used to collect clients’ perception on integration. Availability sampling was used to select the clients. Key informant interviews were also carried out to collect the service providers’ views regarding integration. After the pilot study a mini analysis was carried out to determine whether the instruments yielded the required data. Based on the results of the mini analysis the instruments were revised accordingly.

3.8.1 Validity

Research assistants were trained on the contents of the interview schedule and on how to carry out an interview. The research instruments were pre-tested in the selected pilot center.

3.8.2 Reliability

The research instruments were pre-tested in the selected pilot center. A mini analysis was done the data collected. After which the instruments were reviewed accordingly.

3.9 Data Collection

Primary and secondary data were used. Interview schedules and self-administered questionnaires were used to collect the views of the clients regarding integration. The two research instruments were administered to each and every client who was available and willing to participate in the study at the time the research was happening till the desired sample size of 194 was achieved. The literate clients filled in the self-administered questionnaires. While the semi-literate and illiterate clients filled in the interview
schedules with the help of a researcher. Key informant interview schedules were used to collect service providers’ views regarding integration. The information collected through the key informant interview was used to build on the data collected through the questionnaires and interview schedules. Records of reproductive health services utilized by clients were reviewed retrospectively and prospectively. The review entailed extracting the number of clients who utilized the respective reproductive health services from the medical reports generated on a monthly basis in the study sites. Retrospective study covered six months preceding integration while the prospective study was done for six months from the onset of the integration.

3.10 Data Analysis
Statistical analysis was done using SPSS software. Data was edited, coded and entered. Descriptive analysis was done to determine frequencies, percentages and means. ANOVA was used to test whether there was a significant difference in the utilization of reproductive services before and after integration. Chi-square was used to test clients’ perceptions and the views of service providers regarding the integration of the services. Data was presented in graphs, pie-charts and tables.

3.11 Logistical and Ethical Considerations
Permission to carry out the study was sought from the Ethical Committee of Ministry of Education, FHOK and Graduate School Kenyatta University. Participation was voluntary
through informed consent. Confidentiality of data collected was observed and was used for the purposes of the study only.
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CHAPTER FOUR
DATA ANALYSIS, RESULTS AND DISCUSSIONS

4.1 Introduction
This chapter covers the analysis and discussions of the findings of the study. The data is classified into three categories; data obtained from review of records of reproductive health services utilized by clients retrospectively and prospectively for six months from the onset of integration, information obtained from interview schedules and self administered questionnaires and data collected through key informant interviews. Records of all reproductive health services were reviewed on monthly basis for a period of six months pre- and post-integration. A total of 194 (100%) respondents completed the schedules and questionnaires. Nine service providers took part in the key informant interviews. Data was analyzed using SPSS package. A paired sample t-test and Chi-square test were used to analyze data obtained by reviewing records and from the questionnaires and schedules respectively. Data from key informant interviews was summarized and discussed under various themes. The findings are organized according to the research objectives and presented in tables, pie-charts and graphs.

4.2 Socio-Demographic Characteristics of Study Population
The study population composed of women in the reproductive age bracket (15-49 years). Table 4.1, shows that majority of the respondents were women between 25-29 years (38.1%), followed by respondents between the ages of 30-34 years who accounted for
22.2%, while those between ages 20-24 years and 35-39 years had an equal scoring of 14% each.

Table 4.1: Socio – Demographic Characteristics of the Study Population

<table>
<thead>
<tr>
<th>Socio- Demographic Characteristics</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age in years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20-24</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>25-29</td>
<td>74</td>
<td>38.1</td>
</tr>
<tr>
<td>30-34</td>
<td>43</td>
<td>22.2</td>
</tr>
<tr>
<td>35-39</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>40-44</td>
<td>14</td>
<td>7.2</td>
</tr>
<tr>
<td>44-49</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>166</td>
<td>85.6</td>
</tr>
<tr>
<td>Single</td>
<td>21</td>
<td>10.8</td>
</tr>
<tr>
<td>Non response</td>
<td>17</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>17</td>
<td>8.8</td>
</tr>
<tr>
<td>Secondary</td>
<td>62</td>
<td>32</td>
</tr>
<tr>
<td>Tertiary</td>
<td>113</td>
<td>58.2</td>
</tr>
<tr>
<td>Non response</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>76</td>
<td>39.2</td>
</tr>
<tr>
<td>Not employed</td>
<td>45</td>
<td>23.2</td>
</tr>
<tr>
<td>Self employed</td>
<td>72</td>
<td>37.1</td>
</tr>
<tr>
<td>Non response</td>
<td>1</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Women in the ages between 40-44 years represented 7.2% of the study population while Women in the ages 15-19 and 45-49 years accounted for 1% and 2.6% of the respondent respectively. Eight five point six percent of the respondents were married while 10.8%
were single. This is consistent to Altman in 2004, majority of women who access reproductive health services are married and may need HIV/AIDS prevention, diagnosis and treatment services. All respondents had attained some level of education. Out of the total respondents, 58.2% were educated up to tertiary level, 32% were educated up to secondary levels while 8.8% were educated up to primary level. Respondents who were employed accounted for 39.2% while self-employed and unemployed respondents accounted for 23.2% and 37.1% respectively (Table 4.1).

4.3 Reproductive Health Services Utilized by Respondents

A hundred and one respondents (51.8%) utilized the eight reproductive health services in various combinations, while 93 respondents (47.9%) utilized the respective services. Table 4.2 below shows the number of clients who utilized the specific reproductive health services.

Table 4.2: Reproductive Health Services Utilized by Respondents

<table>
<thead>
<tr>
<th>RHS</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td>36</td>
<td>18.6</td>
</tr>
<tr>
<td>Well baby</td>
<td>15</td>
<td>7.7</td>
</tr>
<tr>
<td>Well woman</td>
<td>8</td>
<td>4.1</td>
</tr>
<tr>
<td>Postnatal</td>
<td>6</td>
<td>3.1</td>
</tr>
<tr>
<td>Antenatal</td>
<td>28</td>
<td>14.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
<td><strong>47.9</strong></td>
</tr>
</tbody>
</table>

According to the findings in table 4.2, family planning services were utilized by majority of the clients with 18.6%, second on the ranking was antenatal services that were utilized
by 14.4% followed by well baby services (7.7%). Clients utilizing well woman and postnatal services accounted for 4.1% and 3.1% of the respondents respectively. However none of the respondents utilized postabortal care and management of STI’s and infertility.

4.4 Duration of Utilization of Services by Respondents from Time Services Sought

Table 4.3: Duration of Utilization of services from time services first sought

<table>
<thead>
<tr>
<th>Duration in Months</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>36</td>
<td>19</td>
</tr>
<tr>
<td>3-6</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>6-9</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>9-12</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>12-15</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>15-18</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>18-21</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>21-24</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Above 24</td>
<td>48</td>
<td>25</td>
</tr>
<tr>
<td>Non response</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>194</strong></td>
<td><strong>100.5</strong></td>
</tr>
</tbody>
</table>

Majority of the respondents had sought services for more than 24 months (25%), 19.3% had utilized services for 0 to 3 months, 14.6% had accessed the services for between 3 to 6 months and 13% utilized services from 9 to 12 months (Table 4.3). Those who had utilized services for 6 to 9 months accounted for 10.4% of the study population, 8.9% utilized the services for 12- 15 months, 4.2% accessed services for a period of 15 to 18
months and 3.6% had visited the clinic from 21 to 24 months. Clients who had utilized the services for a period of 18 to 21 months represented the smallest percent of the respondents with 2%. According to the findings, none of the respondents utilized post-abortal care, management of infertility and STI’s. Clients who utilized family planning services accounted for 18.6% of the respondents.

4.5 Reasons for Seeking Services from the Clinics

Respondents reported that the proximity of the clinics to the residential area, cleanliness of the clinics and their environs, dedicated, friendly, experienced and efficient members of staff. Additionally, they also reported about affordable hospital rates, availability of high quality services that are delivered promptly, follow-up on patients and excellent service provider-client relationship are the factors that have contributed to their seeking of services from the clinics.

4.6 Utilization Patterns of Reproductive Health Services before Integration

According to the findings shown in table 4.5, a total of 6536 clients utilized reproductive health services before integration. Out of the 6536 clients, a total of 2019 (31%) utilized well-baby services. Second was antenatal services utilized by 1835 (28%) clients. Following closely was family planning utilized by 1750 (27%). Fourth was well-woman services accessed by 650 (10%) clients. Fifth was postnatal utilized by 143 (2%). Sixth was management of STIs utilized by 94 (1%) clients. Management of infertility was number seven in the ranking having been utilized by 38 (0.6%) clients. Last was,
postabortal care utilized by 7 (0.1%) clients. Before integration, well-baby services were utilized by the highest number 2019 (31%) clients while postabortal care was least utilized by only 7 (0.1%) clients.

Table 4.4: Utilization Patterns of Reproductive Health Services in Nairobi-West and Thika Family Care Medical clinic before Integration

<table>
<thead>
<tr>
<th>Reproductive Health Services</th>
<th>THIKA Frequency</th>
<th>THIKA Percent</th>
<th>NAIROBI -WEST Frequency</th>
<th>NAIROBI -WEST Percent</th>
<th>Total Frequency</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal</td>
<td>86</td>
<td>4.7</td>
<td>1749</td>
<td>37.1</td>
<td>1835</td>
<td>28</td>
</tr>
<tr>
<td>Family planning</td>
<td>1010</td>
<td>55</td>
<td>740</td>
<td>16</td>
<td>1750</td>
<td>27</td>
</tr>
<tr>
<td>Postnatal</td>
<td>48</td>
<td>2.6</td>
<td>95</td>
<td>2</td>
<td>143</td>
<td>2</td>
</tr>
<tr>
<td>Well baby</td>
<td>157</td>
<td>8.6</td>
<td>1862</td>
<td>40</td>
<td>2019</td>
<td>31</td>
</tr>
<tr>
<td>Well woman</td>
<td>443</td>
<td>24.2</td>
<td>207</td>
<td>4.4</td>
<td>650</td>
<td>10</td>
</tr>
<tr>
<td>Management of infertility</td>
<td>28</td>
<td>1.5</td>
<td>10</td>
<td>0.2</td>
<td>38</td>
<td>0.6</td>
</tr>
<tr>
<td>Management of STI's</td>
<td>53</td>
<td>2.9</td>
<td>41</td>
<td>0.9</td>
<td>94</td>
<td>1</td>
</tr>
<tr>
<td>Postabortal care</td>
<td>7</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1832</strong></td>
<td><strong>99.9</strong></td>
<td><strong>4704</strong></td>
<td><strong>100.6</strong></td>
<td><strong>6536</strong></td>
<td><strong>99.7</strong></td>
</tr>
</tbody>
</table>

A total of 4704 clients utilized reproductive health services from Nairobi-West in comparison to 1832 clients who utilized the services from Thika Family Care Medical Centre. The big margin registered between the total number of clients who utilized services from Nairobi-West and Thika could be attributed to the location and the population of the respective locations where the clinics are located. Majority of the clients 1862 (40%) utilized well baby services from Nairobi-West. This trend is a
replication of the observation noted in the total number of clients who utilized the well baby health services before integration (table 4.3). In Thika, family planning was utilized by the highest proportion 1010 (55%) clients of the total number of clients who accessed services before integration. Postabortal care was least utilized 7 (0.4%) clients in Thika while in Nairobi- West management of infertility was least utilized by 10 (0.2%) clients. None of clients utilized postabortal care from Nairobi-West.

4.7: Changes in Uptake of Reproductive Health Services Following Integration

Table 4.5: General Changes in Uptake of Reproductive Health Services following Integration

<table>
<thead>
<tr>
<th>Reproductive Health Services</th>
<th>Before Integration</th>
<th>After Integration</th>
<th>Margin of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>Antenatal</td>
<td>1835</td>
<td>28</td>
<td>2167</td>
</tr>
<tr>
<td>postnatal</td>
<td>143</td>
<td>2.2</td>
<td>224</td>
</tr>
<tr>
<td>Management of STIs</td>
<td>94</td>
<td>1.4</td>
<td>156</td>
</tr>
<tr>
<td>Post abortal care</td>
<td>7</td>
<td>0.1</td>
<td>6</td>
</tr>
<tr>
<td>Family Planning</td>
<td>1750</td>
<td>26.7</td>
<td>1368</td>
</tr>
<tr>
<td>Well woman</td>
<td>650</td>
<td>10</td>
<td>576</td>
</tr>
<tr>
<td>Well baby</td>
<td>2019</td>
<td>31</td>
<td>2003</td>
</tr>
<tr>
<td>Management of Infertility</td>
<td>38</td>
<td>0.6</td>
<td>38</td>
</tr>
<tr>
<td>Total</td>
<td>6536</td>
<td>99.5</td>
<td>7038</td>
</tr>
</tbody>
</table>
According to the findings in table 4.5, changes were registered in the total number of clients in addition to the number of clients who utilized seven of the eight reproductive health services after integration. Generally, the total number of clients experienced an increment of 502 clients (8%) after integration. Following integration, an increment in the total number of clients was noted in the following services, antenatal 332 clients (18%), postnatal 81 clients (57%) and management of STIs 62 clients (66%). Conversely, a decline was registered in the total number of clients utilizing postabortal care 1 client (14%), family planning 382 clients (22%), well-woman 74 clients (11%) and well-baby services 16 clients (0.8%). No changes were observed in the total number of clients that utilized management of infertility after integration. There was no significant difference between the means of clients who utilized the services before and after integration; t = -0.004, df = 7, P = 0.997 > 0.05

4.7.1 Changes in Utilization of Reproductive Health Services in Nairobi-West Family Care Medical Clinic following Integration.

As per the findings in table 4.6, after integration, Nairobi -West experienced an increase in the total number of clients with a margin of 142 clients (3%). This trend was also observed in Thika Family Care Medical Clinic (Table 4.6.1) All the eight reproductive health services registered changes in the number of clients who utilized them after integration. Increments were observed in four of the eight services namely; antenatal services 329 (19%) clients, postnatal 68 (72%) clients, management of STIs 63 (54%) clients and postabortal care 4 clients. Declines were noted in the remaining four services which are; family planning 238 (32%) clients, well-baby 74 (4%) clients, well-woman 7
(3%) clients and lastly management of infertility 3 (30%) clients. There were no significant difference in the means of clients who utilized services before and after integration; \( t = -0.361, \text{df} = 7, p = 0.761 > 0.05 \)

Table 4.6: Changes in Utilization of Reproductive Health Services in Nairobi-West Family Care Medical Clinic following Integration.

<table>
<thead>
<tr>
<th>Reproductive Health Services</th>
<th>Before Integration</th>
<th>After Integration</th>
<th>Margin of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>Antenatal</td>
<td>1749</td>
<td>37.1</td>
<td>2078</td>
</tr>
<tr>
<td>Family planning</td>
<td>740</td>
<td>16</td>
<td>502</td>
</tr>
<tr>
<td>Postnatal</td>
<td>95</td>
<td>2</td>
<td>163</td>
</tr>
<tr>
<td>Well baby</td>
<td>1862</td>
<td>40</td>
<td>1788</td>
</tr>
<tr>
<td>Well woman</td>
<td>207</td>
<td>4.4</td>
<td>200</td>
</tr>
<tr>
<td>Management of infertility</td>
<td>10</td>
<td>0.9</td>
<td>7</td>
</tr>
<tr>
<td>Management of STIs</td>
<td>41</td>
<td>0.2</td>
<td>104</td>
</tr>
<tr>
<td>Postabortal care</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>4704</td>
<td>100.6</td>
<td>4846</td>
</tr>
</tbody>
</table>

4.7.2 Changes in Uptake of Reproductive Health Services in Thika Family Care Medical Clinic Following Integration.

According to the findings shown in table 4.6.1, Thika also registered an increment in the total number of clients with a margin of 360 clients (20%) after integration. In addition, changes were registered in the number of clients who utilized the respective services after
Integration. Increments were noted in five of the eight services. The five are: antenatal 3 clients (3%), family planning 356 clients (35%), postnatal 13 clients (27%), well-baby 58 clients (37%) and management of infertility 3 clients (11%). Declines were noted in well-woman services 67 clients (15%), management of STIs 1 client (2%) and postabortal care 5 clients (7%).

Table 4.6.1: Changes in Uptake of Reproductive Health Services in Thika Family Care Medical Clinic Following Integration.

<table>
<thead>
<tr>
<th>Reproductive Health Services</th>
<th>Before Integration</th>
<th>After Integration</th>
<th>Margin of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>Antenatal</td>
<td>86</td>
<td>4.7</td>
<td>89</td>
</tr>
<tr>
<td>Family planning</td>
<td>1010</td>
<td>55</td>
<td>1366</td>
</tr>
<tr>
<td>Postnatal</td>
<td>48</td>
<td>2.6</td>
<td>61</td>
</tr>
<tr>
<td>Well baby</td>
<td>157</td>
<td>8.6</td>
<td>215</td>
</tr>
<tr>
<td>Well woman</td>
<td>443</td>
<td>24.2</td>
<td>376</td>
</tr>
<tr>
<td>Management of infertility</td>
<td>28</td>
<td>1.5</td>
<td>31</td>
</tr>
<tr>
<td>Management of STI’s</td>
<td>53</td>
<td>2.9</td>
<td>52</td>
</tr>
<tr>
<td>Postabortal care</td>
<td>7</td>
<td>0.4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1832</strong></td>
<td><strong>99.9</strong></td>
<td><strong>2192</strong></td>
</tr>
</tbody>
</table>

There was no significant difference between the means of clients who utilized services before and after integration; t = -0.316, df = 7, p = 0.761 > 0.05.
4.8 Effects of Integration on the Utilization of Reproductive Health Services

The study used the acceptance levels of integrated services and the change in quality of services after integration as parameters to assess the effects of integration on utilization of reproductive health services.

4.8.1 Acceptance of Integration by Clients

Table 4.7 Acceptance of Integration by Clients

<table>
<thead>
<tr>
<th>Acceptance of Integration</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Integration</td>
<td>173</td>
<td>89.4</td>
</tr>
<tr>
<td>Against Integration</td>
<td>21</td>
<td>10.6</td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>100</td>
</tr>
</tbody>
</table>

According to the findings in table 4.7, eighty nine point four percent of the respondents were for integration of HIV and AIDS Care into reproductive health services while 10.6% of the respondents were against. Therefore there is an indication that integration is acceptable among the clients who utilize reproductive health services. According to those who were for integration, it offers a sense of privacy, reduces stigmatization/discrimination, it is convenient since one can access the two services which are readily available at the same time, it is cheaper and time saving. In addition, it offers an avenue for creating awareness, learning more and getting a better understanding of HIV and AIDS, it makes monitoring and follow up of relevant cases easier and lastly reproductive health services and HIV and AIDS services are related as such they will complement each other.
According to (Shelton and Fuch, 2004) integration is expected to expand services and make them cost effective. Moreover, anecdotal evidence from India, Ethiopia and Cote d'Ivore suggest that integration can reduce stigma associated with HIV and AIDS and increase awareness of healthy sexual behaviors (Myaya, 2004). While those who opted for the parallel mode expressed fear of contamination, fear of not getting proper attention since a lot of time is required when dealing with matters pertaining to HIV and AIDS, some might not be comfortable emotionally as such may shy away and lastly the delivery of services is faster when not integrated.

4.8.2 Socio-Demographic Attributes and their Influence on the Acceptance of Integration by Clients

There was a significant relationship between acceptance and the duration clients had utilized services from the clinics ($\chi^2 = 34.964$, df = 8, $p = 0.004 < 0.05$ level of significance). Acceptance of integration was high among women who had sought services for over 24 months and between 0-3 months. Women who had utilized services for more than 24 months had utilized the services when not integrated and when integrated for a long time for them to weigh the pro and cons of both set ups. Hence they prefer the integrated set up since they have realized that the benefits of integrated services exceed the benefits of vertical services. Women who had sought services for 0-3 months in the study areas utilized services after integration had been implemented. As such they could only indentify the benefits of integrated services. However there was no significant relationship between age and acceptance ($\chi^2 = 13.691$, df = 6, $p = 0.321 > 0.05$ level of significance), between marital status and acceptance ($\chi^2 = 7.336$, df = 2, $p = 0.119 > 0.05$ level of significance), education and
acceptance ($\chi^2 = 4.309$, df = 3, p = 0.635 > 0.05 level of significance) and between occupation and acceptance ($\chi^2 = 10.280$, df = 3, p = 0.133 > 0.05 level of significance).

Out of the one hundred and fifty five clients (79.9%) who aired their views and comments about integration, only 0.5% was of the opinion that it was a bad idea. One hundred and fifty four (79.4% clients) were positive and supported integration. The reasons that the clients advanced for supporting integration were; one, it was a smart and a good idea aimed at saving lives of the community, secondly integration makes services cheaper, increases accessibility of both reproductive health and HIV and AIDS services, thirdly it reduces stigma by making PLWHA's feel appreciated, loved and cared for, and lastly it creates a conducive environment of creating awareness and reaching people with information related to HIV and AIDS regardless of their status.

Six out of the nine service providers who participated in key informant interview supported integration of HIV and AIDS Care into reproductive health services while three were against the integration. Offering the two services as a package is convenient, cost effective, increases accessibility, confidentiality, reduces referrals and stigmatization are the reasons that service providers who are for integration advanced. The most successful experiences suggest that integration enables providers to offer more convenient, comprehensive services. Integration is also expected to expand access to services and make them more cost effective (Shelton and Fuch, 2004). Time was cited as a factor that would work against integration since the providers will not have enough
time to concentrate on one service and meet all the needs of clients. As such this will affect the quality of services delivered to clients.

In conclusion the service providers reported that integration of services is a positive development that should be implemented across the board. It offers a good catchment zone to provide clients with information and education related to HIV and AIDS as well as reproductive health services in one place and in good time. This is convenient to clients since it offers privacy and is likely to serve a number of Kenyans who utilize reproductive health services and shy away from utilizing HIV and AIDS services like VCT when offered separately. This will bridge the gap and assist in managing HIV and AIDS early and appropriately.

4.8.3 Quality of Integrated Services

According to the findings in figure 4.1, a hundred and fourteen clients (58.8%), rated services as being very good, 33 clients (17.0%) rated services as good, 30 members of the study population (15.5%) rated the services as being fair and 17 clients (8.8%) did not respond since it was their first time to utilize the services.
4.8.4 Changes in Quality of Services after Integration

The study used four parameters to assess the changes in terms of improvement and deterioration in quality of services after integration. The parameters were; the waiting time before being attended to, the efficiency and the number of service providers in the study sites, availability of the services they sought for and the accuracy of the information that was relayed to the clients. These parameters are discussed under the reasons for improvement and deterioration of services after integration. As per the findings in figure 4.2, fifty six (28.9%) respondents reported that the quality had not been affected by integration whereas forty six respondents (24.2%) reported a change in the quality. Twenty three point two percent of those who reported a change had noted an
improvement in the quality and 1% reported that the quality had deteriorated. The findings suggest that the services are good and the quality has not changed with integration. However there is a change in quality of services and specifically an improvement given the high percentage (23.2%) of the proportion of clients (24.2%) that noted a change in the quality of services they utilized.

Figure 4.2 Changes in Quality of Services after Integration

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>24.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>24</td>
<td>23.2</td>
</tr>
</tbody>
</table>

4.8.5 Reasons for Improvement and Deterioration of Services after Integration

The clients who noted an improvement in quality reported that it was a result of the large number of members of staff who are efficient, client-centered and readily available, expanded services that are delivered fast, quick response to emergencies, follow-up on patients and appropriate information related to HIV and AIDS related services is relayed
to clients. While the deterioration is as a result of a large number of clients which results to long queues and waiting for long before being attended to.

According to the service providers, the improvement was due to the fact that integration had opened more avenues for creating awareness/sensitization and learning on issues related to HIV/AIDS to both the providers and clients. Moreover due to an increase in facilities, equipments and providers. The increase has resulted to the good performance of clients especially seeking HIV/AIDS services in terms of adherence to treatment, appointments and follow-ups. In addition there more service on offer under one roof and some at no cost at all like the ARVS. However the providers were concerned that shortage and lack of CD4 count and viral load machines and drugs due to late delivery by suppliers may negatively influence the improvement in quality of services.

4.8.6 Socio-Demographic Attributes and their Influence on the Quality of Integrated Services

There was no significant relationship between age and quality of services ($\chi^2 = 39.598$, df = 18, $P = 0.24 > 0.05$ level of significance), between marital status and quality of services ($\chi^2 = 11.635$, df = 6, $P = 0.168 > 0.05$ level of significance), between education and quality of services ($\chi^2 = 8.900$, df = 9, $P = 0.711 > 0.05$ level of significance), between occupation and quality of services ($\chi^2 = 17.496$, df = 9, $P = 0.132 > 0.05$ level of significance) and between duration and quality of services ($\chi^2 = 25.292$, df = 24, $P = 0.390$ at 0.05 level of significance).
4.8.7 Work Load

Majority of service providers reported an increase in the workload, with 33.3% reporting an increase in working hours from the normal eight hours. The increase is as a result of a rise in the number clients either new or referred from the VCT within the clinic. In addition, these clients make regular visits and require more personalized attention. More so the periodic battery of tests done on clients seeking HIV and AIDS related service has led to an increase in the laboratory work. The management of prescription records and issuing of ARVs has also contributed to an increase in workload at the pharmacy. According to Maggwa and Ominde (2003), many of the reproductive health service providers are concerned about the potential negative effects of new HIV/AIDS responsibility on workload, job security and allocation of family planning services among other concerns.

4.9 Factors affecting the Utilization of Integrated Services

4.9.1 Utilization Patterns of Integrated Services

To measure the levels of utilization of integrated services, the study assessed the utilization levels of HIV and AIDS services integrated into reproductive health services. A hundred and twenty one (62.4%) clients did not utilize the HIV and AIDS related services available at the facilities while only 62 (32.0%) clients utilized the services. Eleven (5.7%) clients did not respond (Figure 4.3). From the findings, it is apparent that the level of utilization of HIV and AIDS related services is very low in general. This could be attributed to the fact that most people seek medical services only when sick. Also due to the stigma associated to HIV and AIDS which would result to most people shying away from seeking HIV and AIDS services openly. On the contrary, the utilization of VCT is high given
the high percentage (20.6%) of the proportion of clients who utilized the services (32.0%). This could be as a result of the fact that VCT is the entry to the continuum of HIV and AIDS care. Moreover, VCT services are free of charge. This finding tallies with the anecdotal evidence from pilot project conducted in India, Cote, d’Ivoire and Ethiopia that suggested an increase in access and use of VCT services once VCT was integrated into reproductive health services (Myaya, 2004).

Figure 4.3 Utilization Levels of HIV and AIDS Related Services
4.9.2 Socio–Demographic Characteristics and their Influence on the Utilization of HIV and AIDS Related Services

There was no significant relationship between utilization and age ($\chi^2 = 26.016$, df = 18, $p = 0.099 > 0.05$ level of significance), between utilization and marital status ($\chi^2 = 8.830$, df = 6, $p = 0.183 > 0.05$ level of significance), between utilization and education level ($\chi^2 = 12.003$, df = 9, $p = 0.213 > 0.05$ level of significance), between utilization and occupation ($\chi^2 = 7.295$, df = 9, $p = 0.606 > 0.05$ level of significance), between utilization and awareness ($\chi^2 = 74.083$, df = 2, $p = 0$ at 0.05 level of significance) and between utilization and duration ($\chi^2 = 32.683$, df = 24, $p = 0.111 > 0.05$ level of significance).

4.9.3 Awareness of Availability of HIV/AIDS Related Services.

According to the findings in figure 4.4, a hundred and fifty eight (81.4%) respondents were aware of the availability of HIV and AIDS related services while thirty six (18.6%) clients were not aware. Though most of the respondents were aware of the existence of HIV and AIDS related service, only a minority could specify the nature of services available. Fifty nine (37%) respondents were aware of availability of VCT and only 1.5% was aware of availability of all HIV and AIDS related services offered in the facilities.
According to the findings, clients in general were well informed on the existence of HIV and AIDS related services in the facilities. However the awareness of the nature of HIV and AIDS related services available was low.

Table 4.8: Modes of Creating Awareness of Availability of HIV and AIDS Related Services to Clients

<table>
<thead>
<tr>
<th>Mode</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pamphlets</td>
<td>51</td>
<td>26.3</td>
</tr>
<tr>
<td>Service Providers</td>
<td>39</td>
<td>20</td>
</tr>
<tr>
<td>Posters</td>
<td>24</td>
<td>12.3</td>
</tr>
<tr>
<td>Relatives and Friends</td>
<td>18</td>
<td>9.3</td>
</tr>
<tr>
<td>Total</td>
<td>132</td>
<td>68</td>
</tr>
</tbody>
</table>
A hundred and thirty two (68%) clients got informed on the availability of HIV and AIDS related services through the respective modes of creating awareness that are shown in table 4.5.4. The remaining twenty six (13.4%) got aware of the availability of HIV and AIDS related Services through various combinations of the modes in table 4.8. According to the findings shown in table 4.8, 51 (26.3%) clients were enlightened on the availability of HIV and AIDS related services in the study areas through reading pamphlets at the facilities. Services providers created the awareness of availability of HIV and AIDS related services to 39 (20.1%) clients while posters, relatives and friends creates awareness to 24 (12.3%) and 18 (9.3%) clients respectively.

Awareness was mainly acquired through pamphlets, while media played no significant role. In addition, service providers took a secondary role in creating awareness which is a strategy in the prevention and management of HIV and AIDS. The secondary role the service providers played in creating awareness is contrary to the primary role that they are poised to play in closing the gap in HIV and AIDS prevention and management (AGI and UNFPA, 2003).

4.9.5 Socio- Demographic Characteristics and their Influence on Awareness

There was a significant relationship between awareness and age of the respondents ($\chi^2 = 28.886$, df = 6, $p = 0.04 < 0.05$ level of significance). Awareness was high in clients between 25-29 years and 30-34 years and low in client between 15-19years and 45-49 years respectively. The high rates of awareness could be attributed to the fact that women in age groups 25-29yrs and 30-34yrs sought reproductive health services frequently and in high
numbers. As such they were bound to get lot of information related to availability of HIV and AIDS related services from the facilities in addition to new developments that the facilities are implementing in the reproductive health services that are on offer. The structures of most reproductive health clinics are not tailored towards attending to the reproductive health needs of the youth. For this reason most youths shy away from accessing services from these facilities. This results to the awareness of girls between 15-19yrs being low. Women in ages 45-49yrs also make less frequent visits to the clinics since they are exiting from the reproductive age as such their awareness being low.

There was a significant relationship between awareness of availability of HIV/AIDS related services and education level ($\chi^2 = 18.591$, df = 3, $p = 0.05$ level of significance). Awareness was high in clients who were educated up to tertiary levels. This is as a result of the very many avenues that higher learning institutions avail for accessing and relying information related to HIV/AIDS to people who have utilized these institutions. However there was no significant relationship between awareness and marital status ($\chi^2 = 7.076$, df = 2, $p = 0.132 > 0.05$ level of significance), between awareness and occupation ($\chi^2 = 8.085$, df = 3, $p = 0.235 > 0.05$ level of significance) and between awareness and duration ($\chi^2 = 12.473$, df = 8, $p = 0.711 > 0.05$ level of significance).

4.10 Socio-Cultural Factors

A hundred and seventy three (92.8%) respondents reported that there were no socio-cultural factors that would hinder them from utilizing services together with clients seeking HIV/AIDS services while only one person reported that they would shy away because of
social-cultural practices. Seventy five point eight of respondents were positive about being attended together with client seeking HIV and AIDS related services. The reasons that clients advanced for their positive attitude were; HIV and AIDS is a disease like any other and anyone can contract it, PLWHA are equal to everyone else and they need to be appreciated supported and encouraged to live positively, interacting with people seeking HIV and AIDS services offers a conducive environment to learn from one another and lastly everyone deserve good medical care regardless of their status. Six percent of the study population was negative because of fear of contamination and lack of surety of safety measures in reference to equipments being observed. Twelve point nine percent of the respondents were indifferent since every patient has individual needs and will be attending to these needs.

4.11. Cost of Integrated Services

Table 4.9 Cost of Integrated Services

<table>
<thead>
<tr>
<th>Cost</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate</td>
<td>148</td>
<td>76.3</td>
</tr>
<tr>
<td>High</td>
<td>29</td>
<td>14.9</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Don't Know</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td>Non Response</td>
<td>14</td>
<td>7.2</td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>100</td>
</tr>
</tbody>
</table>

According to the findings shown in table 4.9, 148 (76.3%) clients noted that the charges for integrated services were adequate hence the cost of services was user friendly to them.
Conversely, 29 (14.9%) clients reported that the cost of services was too high therefore the services were expensive for them. None of the respondents reported the cost as being low. Fourteen (7.2%) respondents did not give their views on the cost of integrated services. Three (1.5%) clients reported that they did not know whether the cost was adequate, high or low. There was no significant relationship between cost and utilization of services ($\chi^2 = 90.412$, $df = 6$, $p = 0$ at 0.05 level of significance) and between cost and acceptance of integrated services ($\chi^2 = 80.006$, $df = 3$, $p = 0$ at 0.05 level of significance).

### Table 4.10 Changes on the Cost of Services after Integration

<table>
<thead>
<tr>
<th>Changes in Cost</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased</td>
<td>30</td>
<td>25.5</td>
</tr>
<tr>
<td>No change</td>
<td>71</td>
<td>59.6</td>
</tr>
<tr>
<td>Decreased</td>
<td>8</td>
<td>6.7</td>
</tr>
<tr>
<td>Did not know</td>
<td>10</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>119</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.10, shows the changes in the cost of services after integration. Thirty (25.5%) clients reported that the cost of services had increased with integration, 71 (59.6%) clients reported that the cost had remained same following integration and 8 (6.7%) clients reported a decrease in the cost of services after integration. Ten (8.4%) respondents did not know whether the cost of services had change after integration given that they were new in the clinics. In addition they had sought services after integration had taken place so they were not in a position to compare the cost of integrated services against the cost of vertical services.
According to the service providers the cost of services reduced with integration of services. The reasons for the reduction is due to antiretroviral and other HIV/AIDS services being free, the clients do not pay any consultation fees, clients make few visits to the clinics and utilize a wide range of services and due to donor and government support which has made services affordable. A recent assessment of the cost of integrating VCT into family planning clinic in South Africa’s Northwest province found that it was likely to be less expensive than creating and staffing stand alone VCT center. In that study eighteen clinics were assigned to integration either full or partial and the standard model of separate family planning and HIV/AIDS services. According to the findings the start up and annual cost of delivering integrated services was cheaper than a stand alone VCT center (Mullick et al., 2007).
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction
This chapter summarizes the study problem and findings, presents the conclusion and recommendations based on the findings of the effects of integrating HIV/AIDS services into reproductive health services. The study used the existing reproductive health services, clients and service providers as points of references. Lastly it suggests areas for further research.

5.2 Implication of the Findings
As per the findings of the study it is apparently that integration of HIV/AIDS into reproductive health services is a very beneficial strategy that would help in the fight against HIV and AIDS in regions that have high HIV and AIDS prevalence rates and are experiencing feminization of the pandemic like Sub-Saharan Africa. The findings generated by this study are very useful and would form basis for guidelines for sites that are implementing the integration of HIV and AIDS care into reproductive health services.

5.4 Conclusion of the Study
Based on the findings of the research;

- The total number of clients who utilized reproductive health services from Nairobi-West was more than double the number that utilized services from Thika. In addition the utilization of postnatal, management of STIs, management of infertility, well woman and postabortal care was low in general.
• Integration had improved the access of services given the increments in the total number of clients that were registered in general and in the respective study sites after integration. More so the respective reproductive health services experienced changes in the number of clients who utilized them after integration generally and in the individual sites. However these changes were both increments and declines.

• Integration has led to the improvement in quality of services and it was widely accepted among the clients and service providers. However the lack of and delay in supply of drugs, CD4 and viral load machine in addition to increase in workload due an increase in number of clients which resulted to clients queuing and waiting for long before being attended to, could be detrimental for the improvement in quality.

• Regardless of the clients being well informed on the availability and integration of HIV and AIDS, the utilization of these services was very low and only very few client could specify the nature of services that had been integrated. Pamphlets were the primary mode of creating awareness. Service providers played a secondary role in this also media a very effective mode of relaying information was not utilized in creating awareness. Clients’ fear of contamination and lack of surety of safety measures in references to the equipments could be hindrances towards some clients utilizing the integrated services.
5.5 Recommendations

In light of findings and conclusions of the study the following recommendations were made;

- Family Health Options Kenya should come up with mechanisms to increase the uptake of reproductive health services from Thika Family Care Medical clinic. Also it should promote and encourage clients to utilize management of infertility, management of STIs, postabortal care, well woman and postnatal services regardless of one’s health status. These would help address some of the unmet reproductive health needs of women.

- Reproductive health programmes should be encouraged to adopt integration. The sites that were used in the study should put in place mechanisms that would address the decline in access of some of the reproductive health services after integration. In addition, document these mechanisms so that sites integrating or planning to integrate can learn from them.

- Family Health Options Kenya should formulated and implement mechanisms to ensure the installation of all equipments required in the integrated set-up, the timely and continuous supply of drugs. More so hire more members of staff to cater to the needs of the growing number of clients.

- Health promotion and education by players in the field of health should be carried out to encourage people to utilize HIV and AIDS services regardless of the HIV status. Service providers working in Thika and Nairobi-West Family Care Medical Clinic should step – up the creation of awareness in addition to using media which is a
reliable means of passing on information. Sites integrating services should formulate and implement standards of operations for quality control and assurance in regard to provision of integrated services.

5.6 **Areas for Further Research.**

- Once integration is fully implemented HIV/AIDS and reproductive health services will interact and form linkages. As such it is important for the effects of reproductive health service on the HIV/AIDS services that have been integrated to be researched on. In return the findings of the two studies; Integration of HIV/AIDS Care into Reproductive Health Services and Integration of Reproductive Health Services into HIV/AIDS Care will give a holistic picture of the integration of services.

- A study to establish the long term effects of integration of reproductive health services and Comprehensive HIV/AIDS care should be carried out since this study only established the short term effects.
REFERENCES


Center for Disease Control. (1999). Family Planning Methods and Practises: Africa Centre for Chronic Diseases Prevention and Health Promotion Division of Reproductive Health Atlanta, Georgia, USA.


APPENDICES

Research Instrument

7.4.1 Consent Form

Lucy Anne W. Waweru is a student from Kenyatta University pursuing Masters in Public Health and carrying a research study is a requirement of the course. The purpose of this study is to determine the effects of integrating comprehensive HIV/AIDS services into reproductive health services. This will be attained through interviewing clients and service providers on their perceptions and views respectively towards integration. The information will be treated with utmost confidentiality and will be used only for the purpose of this study. In addition anonymity of research subjects is guaranteed. There are no foreseen risks related to the study hence no compensation. Lastly no direct benefits will be acquired from participating in the study.

Signature: ___________________________ Date: ___________________________

Number: _____________________________
Clients Questionnaire

Section A: Demographic Data

1. Age in years
   - 15-19 yrs □
   - 20-24 yrs □
   - 25-29 yrs □
   - 30-34 yrs □
   - 35-39 yrs □
   - 40-44 yrs □
   - 45-49 yrs □
   - 50-54 yrs □
   - 55-59 yrs □
   - 60-64 yrs □
   - 65-69 yrs □
   - 70-74 yrs □
   - 75-79 yrs □
   - 80-84 yrs □
   - 85-89 yrs □
   - 90-94 yrs □
   - 95-99 yrs □
   - 100-104 yrs □

2. Marital Status
   - □ Single
   - □ Married

3. Education levels
   - (a) Never been to school □
   - (b) Primary □
   - (c) Secondary □
   - (d) Tertiary □

4. Occupational status
   - □ Employed
   - □ No employed
   - □ Self employed

Section B: General Questions.

1. For how long have you been seeking services from this facility?
   - 0-3 mnths □
   - 4-6 mnths □
   - 7-9 mnths □
   - 10-12 mnths □
   - 13-15 mnths □
   - 16-18 mnths □
   - 19-21 mnths □
   - 22-24 mnths □
   - above 24 mnths □

2. What has encouraged you to seek services from this facility?

3. Are there times when you fail to honor your appointment or seek services elsewhere?
   - □ Yes (move to i)
   - □ No.

   (i). If yes, what reasons account for (iii) above.

4. What reproductive health services do you seek from this facility?
   - Family planning □
   - Well – baby □
Section C: Integrated Services.
5. Are you aware that you can get HIV/AIDS related services from this facility?
   □ Yes (move to 6) □ No (move to i)

   (i) If no, could you suggest ways of creating awareness on the availability of HIV/AIDS related services?

   (ii) If yes, how did you get to know?

   □ Pamphlets/brochures □ Service providers

   □ Relatives or friends □ Others.

6. Which of the following HIV/AIDS related services are you aware of that are on offer in this clinic?

   □ VCT
   □ PMTCT
   □ Antiretroviral Therapy
   □ Nutritional Counseling
   □ Management of Opportunistic Infections
   □ Psychological Care
   □ Home-Based Care
7. Do you get any/all the HIV/AIDS related services you seek for?

☐ Yes (move to ii) ☐ No (move to iii).

(i). If yes, could you please list the HIV/AIDS related services that you get from the facility

(ii). If no, which ones aren’t available.

(iii). If no, does the clinic:

   (a). Refer you to another facility ☐

   (b). Ask you to make own arrangements ☐

   (c). Any other ☐

8. As the service provider attends to you do they pass on messages related to HIV/AIDS services available?

☐ Yes (move to 10) ☐ No (move to 11).

(i) If yes, could you please tell us some of the messages?

(ii) If no, are there issues related to HIV/AIDS services that you would like tackled or handled by the facility.

☐ Yes (move to 12) ☐ No.

(iii) If yes, could you suggest some issues?

9. Do you have all your laboratory tests carried out in the lab in this clinic?

☐ Yes (move to i) ☐ No (move to 14)
(i) If yes, could you list the tests you take from the lab.

(ii) If no, are you;

   (a). Referred to a specific laboratory
   (b). Asked to come at later date
   (c). Asked to make own arrangements
   (d). Any other

10. Do you always get your prescription from this Pharmacy?

   [ ] Yes   [ ] No (move to 16)

(i) If no, does the clinic;

   (a). Refer you to a specific Pharmacy
   (b). Ask you to pick the prescription at later date
   (c). Ask you to make own arrangements

11. Would you say the services were delivered promptly?

   [ ] Yes   [ ] No (move to i)

If no, what suggestions would you put across to ensure that the services are delivered promptly?

12. Are the charges for the integrated services on offer?

   [ ] Adequate   [ ] Too low   [ ] Too high.

   (i) Compared to when reproductive health services were offered alone, have the charges

   [ ] Increased   [ ] Remained the same   [ ] Decreased.
13. Do the charges tally with the quality of services on offer?

☐ Yes
☐ No (move to 21)

If no, why?

____________________________________________________________________________________

14. How would you rate the quality integrated services on offer?

☐ V. Poor
☐ Poor
☐ Fair
☐ Good
☐ V. Good

15. Has the quality of services changed in comparison to when R.H.S were offered separately from HIV/AIDS services?

☐ Yes (move to 23 (i))
☐ No.

(i) If yes, has the quality

Improved ☐ (move to ii)

Deteriorated ☐ (move to iii)

(ii) What reasons would you give for the improvement?

____________________________________________________________________________________

(iii) What reasons would you give for the deterioration?

____________________________________________________________________________________

16. What is your feeling towards being attended together with clients seeking HIV/AIDS related services under one roof?

☐ Positive
☐ Negative
☐ Indifferent

(i). If positive, why?

____________________________________________________________________________________

(ii). If negative, why?
(iii). If indifferent, why?

17. Are there any social – cultural factors (e.g taboos, beliefs, practices) that would act as barriers towards you seeking services together with clients seeking HIV/AIDS services?

☐ Yes (move to i) ☐ No

If yes, which ones

18. Do you prefer services?

(a). In an integrated set-up ☐ (move to i)

(b). Separate or parallel ☐ (move to ii)

(i). what reasons would you give for preferring integrated set-up?

(ii). what reasons would you give preferring separate / nor integrated?

19. Do you get satisfied with the integrated services?

☐ Yes (move to i) ☐ No (move to 28)

(i). If yes, are you;

☐ Just satisfied ☐ Fully satisfied ☐ Very satisfied

(ii) If no, why?

20. What is your general view on the integration of comprehensive HIV and AIDS services into R.H.S?
21. Do you inform your friends, relatives and others in the availability of HIV and AIDS related services in this facility?

☐ Yes

☐ No
QUESTIONNAIRE FOR SERVICE PROVIDERS

DESIGNATION
1. Doctor/ Clinical Officer/ Nurse
2. Pharmacists
3. Lab- attendants

INSTRUCTIONS
• Please answer all questions and tick an appropriate box where necessary

QUESTIONS
1. How many members of staff are you?

2. With the introduction of HIV/AIDS services are the members able to handle the work load sufficiently?
   □ Yes □ No (Move to No. 3)

3. What would you recommend to solve the situation?

4. How many hours do you work per day?
   □ Less than 8 Hrs □ 8hrs □ More than 8 hrs.

5. Comparing to before the introduction of HIV/ AIDS services have the hours you work
   □ Increased (Move to No.6) □ Decreased (Move to No.7)
   □ Remained the same

6. Reasons for the increase in hours

7. Reasons for the decrease in hours

8. Has the workload changed with the introduction of HIV/AIDS services?
   □ Yes (Move to No.9) □ No

9. If yes, has the workload
10. Reasons for the increase

11. Reasons for the decrease

12. On the average how many clients do you attend to per day?

13. Comparing to before the introduction of HIV/AIDS services has the number of Clients,

   - Increased (Move to No. 14)
   - Same
   - Decreased (Move to 15)

14. Reasons for the increase

15. Reasons for the decrease

16. In a given day which group of clients seeks service more?
   - Reproductive health service
   - HIV/AIDS services

17. Are the facilities/commodities enough to handle/meet the reproductive health and HIV/AIDS needs of clients sufficiently?
   - Yes
   - No (Move to No. 18)

18. If no, which ones are insufficient? (Move to No. 19)

19. What would you recommend to correct the insufficiency?

20. Do you provide all the HIV/AIDS related services in this clinic?
   - Yes
   - No (Move to No. 21)

21. If no, which of the following HIV/AIDS services are not available?
   - VCT
   - PMTCT
Antiretroviral
Nutritional counseling
Management of opportunity infections
Psychological care
Home based Care

22. For the services that are not available do you
   (a) Refer to another facility
   (b) Ask clients to make arrangements
   (c) Come at a later date
   (d) Any other

23. What is the quality of the services that you offer?
   □ V. Poor □ Poor □ Fair □ Average □ Good □ Very Good

24. Has the quality been affected by the introduction of HIV/AIDS services?
   □ Yes (Move to No. 25) □ No

25. If yes, has the quality
   □ Improved (Move to No. 26) □ Gone down (Move to No. 27)

26. Reasons for the improvement

27. Reasons for the quality going down

28. Have the charges for services been affected by introduction of HIV/AIDS services
   □ Yes (Move to No. 29) □ No

29. If yes, have the charges
   □ Increased (Move to No. 30) □ Decreased (Move to No. 31)

30. Reasons for the increase in charges

31. Reasons for the decrease in charges

32. Do you prefer when
   (a) HIV/AIDS services are integrated
       Into reproductive health services □ (Move to No. 33)
   (b) HIV/AIDS services are offered
       separately from reproductive health services □ (Move to No. 34)

33. Reasons for preferring the integrated services
34. Reasons for preferring when the services are offered separately

35. Do you enlighten clients on the availability of HIV/AIDS services in addition to reproductive health services in this clinic?

☐ Yes (Move to No. 36)    ☐ No

36. Could you please list some of the messages that you pass on to the clients?

37. What is your view on the integration of HIV and AIDS services into reproductive health services?

38. Any other comments/ suggestions/ recommendations in relation to the introduction of HIV and AIDS services into reproductive health services.
MAP FOR THIKA FAMILY CARE MEDICAL CLINIC
MAP FOR NAIROBI-WEST FAMILY CARE MEDICAL CLINIC