Revitalizing the National STI/RTI Control Activities in Kenya

Report of a high level Consultative Meeting
October 14th – 15th 2009, Nairobi
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November 2009

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MESSAGE OF APPRECIATION

Over 150 health professionals, researchers, policy makers, planners, and representatives of development partners gathered in Nairobi for two days (14th and 15th October 2009) to explore various strategies for revitalizing the prevention and control of STIs/RTIs in Kenya. The magnitude of the meeting (the largest in about 15 years) was a clear testimony regarding the emerging interest and renewed vigour by the majority of stakeholders to address the disease burden imposed by STIs/RTIs among Kenyans.

A meeting of such magnitude would not have been possible had it not been through collaborative efforts of the two Ministries of Health (Ministry of Medical Services and the Ministry of Public Health and Sanitation). We wish to specifically thank the programme managers at the National AIDS and STI Control Programme (NASCOP) and the Division of Reproductive Health (DRH) as well as other government institutions such as the National AIDS Control Council (NACC) for having played key roles in convening the meeting.

We would like to take this opportunity to acknowledge the substantial support the Government of Kenya and its development partners – World Health Organization (WHO), Population Council, UNFPA and CDC – provided towards the meeting. WHO, UNFPA and the Population Council are acknowledged for having supported various activities during the pilot phase of the study on integrating STIs/RTIs into reproductive health settings in Kilifi and Meru-South Districts (2007-2009). These institutions are thanked for having supported the process of adapting the WHO ‘Guidelines for Essential Practice’ (GEP) for integrating STIs/RTIs into reproductive health services (December 2004 to June 2006), which culminated into the finalization and launch of the National RTI Guidelines in June 2006.

Our gratitude also goes to Dr. Nathalie Broutet of WHO Geneva and Dr. Nuriye Ortayli of UNFPA New York for having found time to attend the meeting and share valuable strategies for controlling STIs and integrating the management of STIs / RTIs into reproductive health settings. Centres for Disease Control and Prevention (CDC) is specifically acknowledged for having supported the rapid assessment survey on the situation of STIs in Kenya that was conducted in March 2009 and the participation of provincial teams in the October 2009 meeting held in Nairobi.

We would like to thank all participants for coming up with forward-looking strategies that are likely to make a significant impact in revitalizing the National STI/RTI Control Activities in Kenya. We look forward to the provincial directors in the Ministries of Medical Services and Public Health and Sanitation to share the details of the deliberations with their respective district teams. Specifically, we expect them to share the priority activities identified in the meeting, disseminate the National RTI Guidelines as widely as possible and share the findings and lessons learnt from the pilot project on integrating STIs/RTIs into reproductive health settings in Kenya among other key issues.

Finally, given the enormity of the STI/RTI control and prevention activities, the Government of Kenya through the Ministries of Medical Services and Public Health and Sanitation would like to appeal to more stakeholders to provide assistance in order to sustain the fight against STIs/RTIs and their attendant complications that often impose a huge disease burden among Kenyans.

Dr. Francis Kimani
Director of Medical Services
EXECUTIVE SUMMARY

Reproductive Tract Infections (RTIs) is a broad term that includes sexually transmitted infections (STIs) as well as other infections of the reproductive tract that are endogenous or transmitted iatrogenically. STIs, as a major sub-group of RTIs, present a major burden of disease in Kenya’s population. STIs are among the most important causes of maternal and infant morbidity and mortality. Serious complications attributable to STIs/RTIs include ectopic pregnancy, pelvic inflammatory disease, preterm labour, pregnancy loss, congenital infection, infertility, genital cancer and AIDS.

Recent evidence from the Kenya AIDS Indicator Survey (KAIS 2007) revealed that the prevalence rate of Herpes (HSV-2) among the general population (15-64 years) is 35.1% and that 80.7% of HIV infected adults are also infected with HSV-2. Although STIs remain one of the leading causes of the disease burden in Kenya, the focus on HIV/AIDS in the last 10-15 years has overshadowed the predominance of STIs.

It is on this basis that the Kenya Government, through the National AIDS and STI Control Programme (NASCOP), the Division of Reproductive Health (DRH) and the National AIDS Control Council (NACC), with support from the World Health Organization (WHO), the United Nations Population Fund (UNFPA), Population Council and the Centers for Diseases Control (CDC), has initiated a series of activities to revitalize the STI programme at all levels in Kenya. NACC accesses STI resources through regional activities such as GLIA and IGAD, which are supported mainly by the World Bank and member states in the region.

To stimulate engagement of the main stakeholders that are already participating in various aspects of STI/RTI control and prevention activities, a meeting was convened by the Ministries of Medical Services and Public Health and Sanitation on 14th-15th October 2009 in Nairobi to chart the way forward for strengthening prevention and control of STIs/RTIs in Kenya.

The objectives of the two day-meeting were to:

- Share local and international experience in implementing STI/RTI control activities
- Discuss current STI/RTI control activities in Kenya
- Share results and lessons learnt from the pilot project on integrating STIs/RTIs into Reproductive Health settings in Kenya
- Discuss innovative ways of building on STI/RTI Control program opportunities and how to address various weaknesses to achieve desired program outcomes
- Discuss strategies for mainstreaming STI/RTI control activities into the NHSSP/ Joint Programme of Work and Funding (JPWF)/AOP process
- Discuss and reach consensus on priority STI/RTI Control activities and develop an action plan for STI/RTI Prevention and Control activities.

Key issues that emerged from the discussions were:

- The National RTI Guidelines, as well as the WHO Guidelines for Essential Practice on STIs/RTIs, support the syndromic approach as a standard practice in the diagnosis and treatment of STIs. The syndromic approach needs to be strengthened, given its practical importance and the ease with which it can be used by many health providers in settings without laboratory facilities.
• Rapid assessment on the situation of STI management in Kenya conducted by NASCOP and CDC in March 2009 revealed that very few health facilities had copies of the National RTI Guidelines. In addition, it was clear from the discussions in the plenary sessions of the meeting that the National RTI Guidelines were not widely disseminated in the country. The assessment also showed that the management of STIs varied from facility to facility as well as from one health provider to another. Whereas some facilities used the syndromic approach, other facilities used aetiological (laboratory based) approach in managing clients with STIs. Therefore there is need to disseminate the National RTI Guidelines and unify the STI/RTI management.

• Participants acknowledged that there has been weak policy level support for STI/RTI management. For instance, the National Health Sector Strategic Plan (2005-2010) and the Kenya National AIDS strategic Plan III (2009/10 – 2012/2013) do not put sufficient emphasis on the management of STIs.

• The last time health providers were trained in STIs was in the 1990s. Kenya does not have adequate numbers of well-trained human resources to effectively manage STIs.

• Drug sensitivity tests, as well as national STI surveillance studies, have not been carried out in the past 10 years. This implies that the drugs being used in the treatment of STIs may no longer be effective.

• Pilot studies carried out in Kilifi and Meru districts by NASCOP, DRH and Population Council on integrating STIs/RTIs into Reproductive health settings highlighted a number of issues:
  - A significant proportion of clients seeking reproductive health services in different districts have symptoms of STIs/RTIs that often go undetected. Hence, integration of STI/RTI management into reproductive health settings improves case detection of some of the common STI syndromes.
  - Integration of STI/RTI management in reproductive health settings is an acceptable and cost effective way of managing STI cases.
  - Integration of STI/RTI management into reproductive health settings improves the quality of care provided to clients and reduces incidences of missed opportunities.

To effectively address the main issues raised in the meeting, participants made the following recommendations:

i. **Reconstitute the National STI Technical Working Group.** A reconstituted STI Working Group developed STI prevention and control targets and an action plan that could be incorporated into the National Plan of Action (2009-2010)/2011) for KNASP III that covers the period (2009/2010- 2012/2013) and the National Health Sector Strategic Plan. The National STI TWG should be mandated to reset the research agenda and strengthened to coordinate STI/RTI research activities and dissemination of the research findings.

ii. **Disseminate the current National RTI Guidelines** to all provinces/districts, including the training institutions, as soon as possible. Orientation packages of the National RTI Guidelines should be developed for various users with job aids and flow charts.

iii. **Review the syndromic management charts** so that they are consistent with available drugs for managing STIs in Kenya. This activity will support health workers to provide services to clients or patients seeking services at the moment of contact and should be handled separately from recommendation iv below.
iv. **Undertake studies of drug sensitivity and STI surveillance** to inform comprehensive revision of the National RTI Guidelines. The STI surveillance system should be clearly defined (syndromic versus etiologic types) and these should be used to inform the information needs and data collection tools. A consistent surveillance system should continuously validate the various treatment algorithms.

v. **Scale-up lessons learnt and experiences from integrating the management of STIs/RTIs** into reproductive health settings such as FP, ANC, PNC, maternity units, outpatient clinics etc.

vi. **Strengthen the commodities and logistics management system.** This action will facilitate availability of sufficient quantities of STI drugs in all the health facilities.

vii. **Formulate and implement a national training programme** to build the capacity of health providers at all levels of care in the management of STIs/RTIs. Every health care provider should be able to manage STIs/RTIs effectively. Pre-service training activities in STIs/RTIs should be incorporated into the national training programme and the curricula of medical training colleges.

viii. **Identify mechanisms for accessing donor funds** (e.g. from the Global Fund) to support STI/RTI revitalization efforts and to sustain the implementation tempo. Similarly, provincial and district health managers ought to take advantage of established mechanisms, such as the Joint AIDS Program Review (JAPR) and other available opportunities, to highlight STI/RTI issues in their respective regions so as to facilitate mobilization and allocation of resources towards the identified gaps by the Kenya Government and the development partners.

ix. **Disseminate costing data on integrating STI/RTI services** so as to assist quantification of the financial resources required to scale up integrated services.

x. **Revise existing health facility registers** to have appropriate columns to capture STI/RTI data. Other routine data collection and reporting tools in the health facilities be reviewed and harmonized to include control activities on STIs/RTIs.

xi. **Ensure STI/RTI control activities are integrated within the Community Strategy**. Some of the activities will include updating CHEWs and CHWs on STI/RTI signs and symptoms; basic management and referral.
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ABBREVIATIONS AND ACRONYMS

AIDS        Acquired Immune Deficiency Syndrome
BCC         Behaviour Change Communication
CDC         Centre for Disease Control
DHMTs       District Heath Management Teams
DMS         Director of Medical Services
DRH         Division of Reproductive Health
FP          Family Planning
GEP         Guidelines on Essential Practice
GUD         Genital Ulcer Disease
GLIA        Great Lakes Initiative on AIDS
HIV         Human Immune-Deficiency Virus
HSV 2       Herpes Simplex Virus Type 2
IRAPP       IGAD Regional AIDS Partnership Project
IGAD        Inter-Governmental Authority on Development
KAIS        Kenya AIDS Indicator Survey
KEMRI       Kenya Medical Research Institute
LVBI        Lake Victoria Basin Initiative
NACC        National AIDS Control Council
NASCOP      National AIDS and STI Control Programme
NDP         National Development Plan
NGO         Non Governmental Organization
OPD         Out Patient Department
PID         Pelvic Inflammatory Disease
PMTCT       Prevention of Mother to Child Transmission
UD          Urethral Discharge
UNFPA       United Nations Fund for Population Activities
RTIs        Reproductive Tract Infections
STIs        Sexually Transmitted Infections
WB          World Bank
WHA         World Health Assembly
WHO         World Health Organization
**INTRODUCTION**

This report provides a summary of the deliberations of a meeting that was convened to revitalize the national STI/RTI control activities in Kenya. The meeting was organized by NASCOP in collaboration with DRH and NACC on 14th to 15th October 2009 in Nairobi, through financial and technical assistance from WHO, UNFPA, Population Council and CDC. During the meeting, local and international experts shared experiences and provided technical updates in STI/RTI management including suggestions on how best to integrate these activities into various reproductive health settings. The priorities and strategies identified by participants will form the basis of future work in the prevention and control of STI/RTI activities in Kenya. The report is structured as follows: introduction, approach followed an structure of the meeting, highlights of the opening session, summary of presentations on technical components, key issues discussed in the plenary, group work tasks and feedback, conclusions, recommendations and closure of meeting as well as appendices.

**Background and justification**

Sexually Transmitted Infections (STIs) remain one of the leading causes of disease burden in Kenya. STIs have also been shown to have a link with increased vulnerability to HIV infection. Despite their public health importance, the focus on HIV/AIDS in the last 10-15 years has overshadowed the predominance of other STIs.

Recent evidence from the 2007 Kenya AIDS Indicator Survey (KAIS) revealed that the HSV-2 prevalence rate among the general population (15-64 years) is 35.1% and that 80.7% of HIV infected adults were also infected with HSV-2. KAIS 2007 also showed that, whereas the prevalence of syphilis among the general population is about 2%, it is higher among adults aged 50-64 years (4.4% males and 2.5% females). Among participants who were sero-positive for syphilis, 16.9% had HIV; 71.5% had HSV-2 and 15.9% had both HIV and HSV-2.

The process of developing the Kenya National Guidelines on the integration of services for Reproductive Tract Infections (RTIs) was completed in 2006. The process, which started in 2004, was a collaboration between the Division of Reproductive Health (DRH) and the National AIDS Control Program (NASCOP) of the Kenyan Ministry of Health (MOH), the Department of Reproductive Health and Research at WHO (RHR/WHO), and the Population Council’s USAID-funded Frontiers in Reproductive Health (FRONTIERS) programme. Financial support was provided by WHO (through its Strategic Partnership with UNFPA) and USAID (through the FRONTIERS programme’s Memorandum of Understanding with RHR/WHO). The national guidelines were adapted by drawing from recommendations in the “Guide to Essential Practice for Sexually Transmitted and other Reproductive Tract Infections” (GEP-RTI), produced by WHO.

NASCOP and DRH, with technical support from Population Council, established a National RTI Working Group to coordinate the guideline development process. The National RTI
Working Group was to ensure that the national guidelines were comprehensive, and that the process of their development was as inclusive as possible. Six task teams were established to address adaptation, integration, training, service delivery, supervision, monitoring and evaluation, and communication and advocacy, to facilitate the process as well as the subsequent implementation phase. The members of the RTI Working Group and task teams were drawn from institutions involved in policy, programmatic, research and implementation aspects of STIs/RTIs in Kenya.

The RTI Working Group recommended that training for health providers should focus on integrating the management of STI/RTIs within other reproductive health services, such as antenatal care, postpartum care, and family planning among others. The effect of training health providers on providing integrated services was documented and evaluated through a pre-post design that assessed the effect of training and the introduction of guidelines and job aides on the quality of care provided to RH clients and on the proportion of RH clients provided with an RTI-related service. Prior to this initiative, health providers managed STI/RTIs separately, with an emphasis on clinical diagnosis and treatment of clients explicitly presenting with symptoms; little attention was paid to identifying and recognizing symptoms and signs in other settings, such as MCH-FP clinics that provide opportunities for managing RTIs outside the traditional outpatient departments and STI clinics.

It is against this background that NASCOP, DRH and NACC, together with various partners, have embarked on a programme of action to revitalize the STI program at all levels in Kenya. This meeting was an opportunity to convene the key institutions, local and international, that are involved in policy formulation, programme coordination, research, training and implementation of STI/RTI control and prevention activities, to plan such a programme jointly.

**Objectives of the meeting**

The objectives of the two day-meeting were to:

- Share local and international experience in implementing STI/RTI control activities
- Discuss current projects to strengthen STI/RTI Control activities in Kenya
- Share results and lessons learnt from the pilot project on integrating STIs/RTIs into RH Settings
- Discuss innovative ways of building on the STI/RTI Control program opportunities and how to address various weaknesses to achieve desired program outcomes
- Discuss strategies for mainstreaming STI/RTI Control activities into the NHSSP/ Joint Programme of Work and Funding (JPWF)/AOP process
- Discuss and reach consensus on priority STI/RTI Control activities and develop an outline of the National Implementation Plan for STI/RTI Prevention and Control activities.
Meeting outputs

The main outputs of this meeting were as follows:

- Consensus achieved on the need to have a new approach in addressing STI/RTI Control activities in Kenya
- Best practices and priority areas in STI/RTI control and prevention identified from sharing local and international experiences, as well as results and lessons learnt from operational research activities
- Clear Road-Map showing activities that are urgent, and which require immediate implementation (within 1-2 years), medium term activities (3-5 years) and long term (over 5 years) identified.

Approach followed and structure of the meeting

Three approaches were used in conducting the two day meeting, namely plenary presentations, discussions and group work. Group Work tasks were based on key themes that had been distilled from plenary discussion. Day one was mainly devoted to discussions and presentations in the plenary, while day two was devoted to group work discussions and receiving feedback in the plenary. The meeting proceedings are outlined in Appendix 1.

The theme for day one (14th October 2009) was: “Sharing local and international experience in controlling STI/RTI activities”. The main presentations were as follows:

- **Sharing local and international experiences**
  - Highlights of initial STI/RTI control activities in Kenya
  - Global strategy and response for the prevention and control of STIs
  - International experiences on integrating STI/RTI activities in the PHC system
  - Highlights of the current situation in Kenya
  - Findings of the rapid assessment survey in Kenya
  - Common STIs in Kenya as reported in KAIS 2007

- **Integrating STIs/RTIs into Reproductive Health settings**
  - Adoption of the WHO GEP Guidelines in Kenya
  - Development of the National Guidelines for RTI Services
  - Study objectives, methodology and intervention
  - Findings of the study on integrating STI/RTI prevention and control into RH settings
  - Conclusions and lessons learnt from the study.
- **On-going and planned regional and local initiatives on STI control and prevention**
  - Kenya’s STI prevention and control regional activities coordinated by NACC (GLIA, IGAD)
  - CDC support for STI control activities in Kenya
  - WHO support for STI control activities in Kenya

- **Summary of key issues discussed in the plenary**
  The theme for day two (15th October 2009) was “Strategies for strengthening implementation and co-ordination of STI/RTI control activities in Kenya”. The first activity on day two was a recap of the previous day’s activities. This was conducted by the meeting rapporteur (Ms Eva Muthuuri).

**HIGHLIGHTS OF THE OPENING SESSION**

The welcome and introduction session was led by the head of NASCOP, Dr. Nicholas Muraguri. He thanked Population Council, UNFPA, CDC, and WHO for organizing and supporting the conference and asked participants to introduce themselves. Appendix 2 contains the full list of participants. The opening speeches to set the pace and focus of the meeting was made by: UNFPA Country Representative, WHO Representative and the Director of Medical Services.

**Remarks by UNFPA Country Representative**

The acting UNFPA Country Representative (Dr Alexander Ilyn) said that STIs/RTIs are usually over-shadowed by other health issues such as HIV/AIDS. Consequently funding for STIs has been inadequate, mainly due to the lack of interest by many stakeholders in this component. He emphasized UNFPA’s commitment in strengthening STI programs in Kenya. He highlighted the need to focus on adolescents since they form a significant proportion of the population and that STI and HIV prevalence rates among them has remained high. He said that there is need to raise awareness on Herpes Simplex Virus 2 and its role in driving the HIV epidemic.

**Remarks by the WHO Country Representative**

The WHO Country Representative (Dr. David Okello) was represented at the meeting by Dr. Rex Mpazanje. The WHO Representative shared the global situation regarding STIs. He said that more than 340 million new cases of Sexually Transmitted bacterial and protozoal infections occur throughout the world every year. In pregnancy, untreated early syphilis will result in a still birth rate of 25% and be responsible for 14% of neonatal deaths. Syphilis prevalence in pregnant women in Africa for example ranges from 4% to 15% and about 4,000 new born babies are born with chronic infections or born blind. The presence of STIs such as Syphilis greatly increases the risk of acquiring HIV.
He said that Programs on STIs have lost momentum over time and that there is need to revitalize the STI/RTI control activities in Kenya in order to meet the MDGs. WHO promotes the syndromic approach to STI management and relies on other support interventions like sentinel surveys, flow charts, routine syphilis testing in pregnancy to augment this approach, among others. There is need to make sure that screening is done where necessary, especially for the sexually active youth. He said WHO will continue to support STI programs in Kenya.

**Opening remarks by the Director of Medical Services (DMS)**

The Director of Medical Services (Dr. Francis Kimani) started his remarks by first sharing the history of STI/RTI control activities in Kenya. He noted that worldwide, STIs are a major cause of mortality; 3 million people are diagnosed annually. STIs spread faster than HIV. Dr. Kimani also informed the participants that Kenya has had specialized STI clinics for a long time. These include the Casino STI Clinic in Nairobi and the Ganjoni STI clinic in Mombasa, which were established long before the first case of HIV was diagnosed in Kenya. With the advent of HIV, the MOH established STI clinics with full-time counsellors in all provincial hospitals in 1991 and 1992. The Counsellors offer comprehensive diagnosis, proper treatment, Behaviour Change Communication, and counselling services.

In his candid speech, Dr. Kimani said that things fell apart as from 1995 onwards when HIV/AIDS management and opportunistic infections were given more attention by providers, donors and the program responsible for STI control in Kenya. The Director was optimistic that the renewed interest to revitalize STI control activities will be sustained in the years to come.

**SUMMARY OF PRESENTATIONS ON TECHNICAL COMPONENTS**

**Objectives of the meeting**

This session was presented by Dr. Ibrahim Mohammed of NASCOP. The meeting had been planned in order to give an opportunity to all institutions (both international and local) which are involved in research, policy formulation, programme coordination, training, and implementation of STI/RTI control and prevention activities to plan jointly on how to strengthen the STI/RTI control activities in Kenya.

**Specific Objectives**

- Share local and international experience in implementing STI/RTI control activities.
- Discuss the current STI/RTI control project activities in Kenya.
- Share lessons learnt from the pilot project on integrating STIs/RTIs into RH Settings.
- Discuss innovative ways of strengthening STI/RTI Control activities to achieve desired program outcomes.
- Discuss strategies for mainstreaming STI/RTI Control activities into the NHSSP/Joint Programme of Work and Funding/AOP process.
- Identify priority program activities and develop a two year draft Implementation Plan for STI/RTI Prevention and Control.
- Develop the Plan of Action and chart the way forward.

**Expected Outputs**
- Consensus achieved on a new approach in addressing STI/RTI Control activities
- Best practices and priority areas in STI/RTI control and prevention identified
- Clear Road-Map for implementing short, medium and long term activities identified
- An outline of the National Implementation Plan for STI/RTI Prevention and Control developed, based on appropriate targets contained in KNASPIII’s National Plan of Operations 2009/10-2010/11.

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**A note on presentations made during meeting and use of Terminology**

In order to keep this report short, only key issues (or in some cases abridged versions of presentations made during the meeting) are highlighted in this chapter. Readers interested in having access to detailed documents or require additional copies should contact the STI focal point at NASCOP or Population Council.

Reproductive Tract Infections (RTIs) is a broad term that includes sexually transmitted infections (STIs) as well as other infections of the reproductive tract that are not transmitted sexually. In most cases STIs have much more severe health consequences than other RTIs. Therefore the terminology - STIs/RTIs or STI/RTI is used throughout this report to highlight the importance of STIs within Reproductive Tract Infections. Where information is relevant to sexually transmitted infections, the term STI is used alone.

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**Sharing local and international experiences**

**Highlights of initial STI/RTI control activities**

*This session was presented by Dr. Sarah Masyuko of NASCOP.*

**Introduction**

- Initial STI activities were supported by Belgian Cooperation and CIDA (STI research and pilot testing of STI treatment in Nairobi and several other towns since 1990)
- Other donors who supported STI projects were DFID (through HAPAC project), German (KFW)
- Later, STI project in Kenya (1995-2001) funded by World Bank, GOK and through Donor co-financing
- Initially piloted in 15 districts
- During midterm review (1997) the Bank refocused the project towards the establishment of national AIDS Control programme later established in 1999.
Problem statement

- STI prevalence was high in the general population at the time of project design
- 5-10% of women attending antenatal clinics tested positive for syphilis or gonorrhoea in the early 1990s
- High-risk groups such as truck drivers and commercial sex workers had higher rates
- Evidence then suggested that presence of STIs facilitated the transmission of HIV.
- As a result, WHO advocated STI treatment as a cost-effective strategy to prevent HIV transmission
- HIV prevalence was high in the country – 15%.

Objectives of the Initial project

- Strengthen institutional capacity at the national and district levels to design, implement, monitor, and evaluate HIV/STI interventions;
- Promote preventive measures to reduce the risks of HIV/STI transmission; and
- Enhance both health sector and community provision of physical and psychological care and develop strategies to mitigate the social and economic consequences of AIDS.

STI Project components

- Component (1) aimed to strengthen the institutional capacity at the national and district levels to design, implement, and evaluate interventions.
- Component (2) sought to promote preventive measures to reduce the risks of STI transmission.
- Component (3) sought to enhance both the health sector and the community provision of physical and psychological care, and to develop strategies to mitigate the socioeconomic consequences.

Component 1 – Focused on Supporting and strengthening:

- National capacity to provide adequate policy, planning, coordination, supervision, and technical support related to STIs;
- District capacity to plan, coordinate, implement, and evaluate integrated multisectoral HIV/AIDS activities;
- National and district STD surveillance systems;
- Research grants to improve interventions supported by the project;
- Monitoring and evaluation of the degree to which the project's objectives are being met;
- Support for innovative nongovernmental (NGO) and community-based (CBO) organization programs; and
- Project management.
Component 2 – promote preventive measure through:

- Provision of accessible, acceptable and effective clinical management of STDs;
- Development and implementation of information, education, and communication (IEC) activities for STIs and HIV; and
- Supply and distribution of condoms to districts, municipalities, NGOs, and to those providing health services to the military, police, and security services as well as to refugees.

Component 3- enhance measures and strategies through:

- Support of measures to control Tuberculosis (TB);
- Treatment of opportunistic infections;
- Support of district-based NGOs/CBOs, home-based care and counselling for people with HIV/AIDS; and
- Promotion of occupational safety activities and minimization of risk exposure to health workers.

Achievements of the Initial Project

- Sessional paper No. 4 of 1997 on AIDS in Kenya:
  - Called for establishment of a multi-sectoral prevention and control strategy, enhancing resource mobilization,
  - Established National AIDS Control Council (1999),
- In 1998, the project and several donor partners sponsored a meeting among professional and political leaders in Nyanza Province, at which the President issued his first strong public statement regarding HIV/AIDS, including a call for increased condom use
- President declared AIDS a National Disaster in 1999 during a Parliamentary session in Mombasa.
- Achievements of the Initial Project
- Improved Quality and Coverage of STI treatment –policies, guidelines, training, Drugs
- Development of STI protocols
- Establishment of DASCOs, PASCOs and District Inter-sectoral committees
- Multimedia Campaigns-ABC, Silent Epidemic
Challenges of the Initial Project

Project design had several weaknesses:

(i). project objectives stated in terms of quantitative benchmarks for sexual behaviour and STI treatment while no baselines were established

(ii). Inadequate mechanisms to collect the data necessary to track progress towards stated objectives

(iii). Project design gave insufficient attention to implementation arrangements

(iv). The project did not establish specific mechanisms to target high risk groups (MARPS).

(v). No overall strategy to monitor the program was put in place.

Fig 1: Summary of Background STI Activities in Kenya

![Diagram showing the initial STI/RTI control activities and trends in Kenya.](Source: Christine Awuor et al 2009: findings from the Rapid Assessment Survey on STI situation in Kenya).

The diagram above shows the initial STI/RTI control activities and trends in Kenya. In spite of a well developed infrastructure to address STI issues in Kenya the program has lagged behind as HIV, AIDS and other opportunistic infections took centre stage.

Current Status of STI activities

- STIs are still a problem in Kenya.
- Facilities use syndromic management of STIs.
- Syphilis screening and treatment offered in all ANC clinics.
- Etiological surveillance of STIs not yet implemented.
- Pilot activities for integrating STIs/RTIs in RH settings completed in Kilifi and Meru South.
- Orientation package on STIs management for HIV service providers being implemented by NASCOP and partners.
- Regional STI activities (Great Lakes Initiative on AIDS - GLIA and IGAD) on-going.
- Draft KNASP III completed but there is still opportunity to develop more outputs on STIs in the National Plan of Operation covering the period 2009/10 – 2010/11.
Global strategy and Response for the Prevention and Control of STIs

This session was presented by Dr. Nathalie Broutet of WHO Geneva

In her presentation Dr Broutet highlighted the global response for the prevention and control of STIs/RTIs. The goal of the global strategy is to provide a framework to guide an accelerated global response for the prevention and control of STIs, towards the attainment of international development goals. The objectives of the Global Strategy and Response for the Prevention and Control of STIs are to:

- **Increase the commitment** of national governments and national and international development partners for STI prevention and control.
- **Promote mobilisation and reallocation of resources**, taking into account national prioritized results-oriented interventions that ensure aid effectiveness, ownership, harmonization, results and accountability.
- **Ensure that policies**, laws and initiatives related to provision of STI care are non-stigmatizing and gender-sensitive within the prevailing socio cultural context.
- **Harness the strengths and capacities of all partners** and institutions in order to scale up and sustain interventions for STI prevention and control.

**Fig 2: A public health perspective on prevention and control of STIs**

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**A public health perspective on prevention and control of STIs**

- Total Population
- Number infected with STI
- Aware of infection
- Seek care
- Correctly diagnosed
- Correctly managed

- Primary prevention efforts
  - Vaccination
- Screening
- Selective targeted interventions
  - Improve health-care seeking behaviour
- Improve diagnosis
- Improve case management
- Improve partner management

---

World Health Organization

Reproductive Health and Research

UNDP > UNFPA > WHO > World Bank
Special Programme of Research, Development and Research Training in Human Reproduction
**Policy to integrate services**

In practical terms integration of health services is defined as:
- Bringing together common functions within and between organizations in order to:
  - Solve common problems
  - Develop a commitment to shared vision & goals
  - Use common technologies and resources to achieve these goals.

**Promote safer sex**
- Develop policies that support dual protection
- Support policy development on comprehensive safer sex services for young people, PLWHA and other key populations
- Broaden SRH services to key populations
- Promote condom use for dual protection within all family planning and HIV prevention programmes
- Provide full range of SRH services (including prevention) for PLWHA
- Empower women and girls to negotiate safer sex and access SRH and HIV/AIDS services
- Include services that address gender-based violence (counselling, emergency contraception, HIV post-exposure prophylaxis).
Dual Protection
• Promoting methods to prevent unplanned pregnancy and STI
• FP consultations are logical place to address both risks
• Minimal incremental activities and resources needed to promote dual protection.
• Condom is the only method that provides dual protection.

However:
• FP clients often see themselves (and often are) at low risk of STI
• Careful balance needed while discussing dual protection
• Use of permanent or highly effective methods, reduces use of condoms

Table 1  A collaborative implementation of STI prevention and control interventions

<table>
<thead>
<tr>
<th>Programme</th>
<th>Primary Core</th>
<th>Collaborative Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>• HIV prevention and care&lt;br&gt;• Positive prevention&lt;br&gt;• VCT/DTCPITC&lt;br&gt;• 2nd generation surveillance with STI indicators&lt;br&gt;• Monitoring and Evaluation&lt;br&gt;• Operational research</td>
<td>• Sexual health&lt;br&gt;• Targeted interventions for HIV and STI prevention and care&lt;br&gt;• Promotion of STI syndromic management</td>
</tr>
<tr>
<td>STI Programme</td>
<td>• Guidelines, curricula development and integration, training, quality assurance&lt;br&gt;• STI syndromic management in STI services&lt;br&gt;• Partner treatment guide and plan&lt;br&gt;• STI surveillance&lt;br&gt;• Targeted interventions for STI prevention and control&lt;br&gt;• STI vaccines for STI patients&lt;br&gt;• Monitoring and Evaluation&lt;br&gt;• Operational research/PDAS cycle</td>
<td>• Positive prevention STI&lt;br&gt;• Antenatal syphilis screening&lt;br&gt;• 2nd generation surveillance&lt;br&gt;• VCT in STI services</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>• Antenatal syphilis&lt;br&gt;• Sexual health guidelines&lt;br&gt;• Services for STIs in RH setting&lt;br&gt;• Monitoring and Evaluation&lt;br&gt;• Operational research/PDAS cycle</td>
<td>• 2nd generation surveillance&lt;br&gt;• STI vaccines in RH clients and/or babies&lt;br&gt;• Syphilis screening ANC&lt;br&gt;• Counselling on dual protection</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>• Age-appropriate comprehensive sexual health education and services, including production of IEC materials</td>
<td>• School health centres where feasible&lt;br&gt;• STI vaccines</td>
</tr>
<tr>
<td>Ministries of labour, tourism, etc.</td>
<td>• Workplace interventions with peer education and information&lt;br&gt;• STI screening and treatment health clinics</td>
<td>• Health clinics with capacity to screen for and treat STIs</td>
</tr>
</tbody>
</table>

Key strategic coalitions for the Global STI Strategy
1. Strategies for the control of GUD
   - Eradication of Chancroid
   - Control of syphilis in population
2. Strategy/Interventions for the control of genital herpes (HSV-2) infections – focus for 2010-11
   (Review of current research to agree on outcome measures)
3. Strategy for the elimination of congenital syphilis
Goals for the elimination of congenital syphilis

- Addressing MDG 4, 5, and 6 for 2015:
  - Reduce child mortality
  - Improve maternal health
  - Combat HIV/AIDS, malaria and other diseases
- Elimination of CS as a public health problem
- Prevention of transmission of syphilis from mother to child

Congenital Syphilis Elimination: 4 Pillars

- I  Ensure sustained political commitment and advocacy
- II  Increase access to, and quality of, maternal and newborn health services
- III Screen and treat all pregnant women
- IV Surveillance, monitoring and evaluation systems (and QA systems)

STI Surveillance

Core components of STI surveillance systems to be implemented by all countries are summarized in the following Figure:

**Figure 5: Core components of STI surveillance**

- **Improve Patient Care**
  - Effective Treatment Services
  - Antimicrobial Resistance Studies
  - Aetiologies of STI Syndromes
- **Improve Programming**
  - Magnitude of STI Problem in Target Population
  - Data Reporting
  - Prevalence Assessment
  - Universal/Sentinel
  - Integrated/Vertical

Integrated STI surveillance activities

- **Second Generation HIV Surveillance**
  - integrated surveillance, incl. HIV, STIs & Behaviours
    - use same sampling methods
    - use same population group(s)
    - use same survey methods: sentinel/population based
  - Plan & implement in an integrated manner
    - training, data collection, analysis and interpretation
  - Consider **Ethical, Logistical & Funding** Issues

Built on the essential elements

- Strengthen health system support components-information, training, guidelines, laboratory support, surveillance, research
- Deliver good quality STI care in various settings
- Ensure a reliable supply of medicine and commodities
- Review policies, laws, regulations that affect STI care
- Promote healthy behaviours
- Advocacy
- Cross cutting issues – Collaborative implementation
The challenges
- The effective exchange and transfer of information to change and improve practice
- Collaboration between programmes and private sector to define joint objectives

Integrating STI/RTI Diagnosis and Management into Essential SRH Package: A Global Perspective

This session was presented by Dr. Nuriye Ortayli of UNFPA Headquarters in New York.

The presentation focused on the international perspective of STI/RTI transmission, prevention and treatment.

The ICPD definition of reproductive health is:
“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. (…)"

Universal access to reproductive health by 2015

Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level. Special outreach efforts should be made to those who do not have access to reproductive health-care programmes.

All health-care providers, including all family-planning providers, should be given specialized training in the prevention and detection of, and counselling on, sexually transmitted diseases, especially infections in women and youth, including HIV/AIDS.

Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

Challenges
- Difficult to talk about:
  - For policy makers
  - For program managers
  - For service providers
  - Community leaders, rights advocates etc.
- Difficult to diagnose, especially in women without expensive and sophisticated lab tests, well-trained staff
- Services to be integrated are already short of funding, understaffed etc.
Universal access

- Must be an essential part of PHC
- Linked to higher levels of care
  - Feasibility of integration
  - Which parts can be integrated to PHC, what parts to secondary care
  - Infrastructure (availability of lab, transportation of specimens)
  - Human resources
  - Cost-effectiveness, closely related to prevalence
- We hope to find answers to these questions

New Aid Environment (NAE)

- Key principles:
  - MDGs-framework for national policy setting
  - National development plan - centre of programs
  - Country ownership and government leadership
  - Strengthening national and local capacities
  - Scaling up effective interventions
  - Reliance on national systems and procedures

In short

- No more vertical programmes; health system strengthening instead
- No more ear-marked funding
- But prioritizing in national plans and budgets
- We need to be more specific in cost, feasibility,
- Develop our evidence-base and advocacy skills.

UNFPA’s roles

- Policy dialogue and advocacy for inclusion of SRH including STI/RTI management in national development and poverty elimination strategies
- Ensure relevant national planning and budgeting (indicators and monitoring tools are essential)
- Resource mobilization
- Technical support for developing and scaling-up of SRH models;
- Capacity development
- Building partnerships, brokering and strengthening cross-sectoral approaches
Next Steps

✓ Disseminate model to UNFPA offices and partners along with guidance on adaptation
✓ Strengthen policy advocacy with decision makers at global and national levels
✓ Provide technical support in implementation of model and scaling up
✓ Bring on other countries to make changes in trainings both pre-service and in-service
✓ Support M&E of SRH model implementation

Highlights of current STI/RTI situation in Kenya

This session was presented by Christine Awuor of NASCOP

Objectives of the CDC-supported Rapid Assessment:

• Describe clinics and clinic staff where STI services are offered
• Assess laboratory capacity regarding tests related to STIs
• Determine availability of medications used to treat STIs
• Investigate clinicians’ practices regarding diagnosis and management of STIs.

Rapid Assessment: Sampling Method

• Convenience sample of clinics
• Central, Nairobi, and Eastern Provinces
• Site selection
  – Discussions with PASCOs
  – Referral from clinics
  – Range of levels of health institutions.

Sampling Method

• Convenience sample of clinics offering STI services
• Central, Nairobi, and Eastern Provinces
• Site selection
  – Discussed with PASCOs
  – Referred from clinics visited to nearby clinics
  – Encompassed various levels of health institutions
Rapid Assessment: Data collection methods.

- Open-ended discussions with clinicians and staff
- Assessment tool
  - Clinics
  - Staffing
  - Laboratory
  - Pharmacy
  - Approach to diagnosis and management

Clinics visited

Central Province
- Ruiru Health Centre/Sub-District Hospital
- Githunguri Health Centre/District Hospital
- Miguta Community Dispensary

Nairobi Province
- Kenyatta National Hospital
- Special Treatment Centre Casino

Eastern Province
- Machakos Provincial/District Hospital.

Staffing and staff training

- Level of training of clinic director
  - 3/5 had Clinical officers
  - 2/5 had Nurses
- Registrar on call in the Level 6 facility (KNH)
Fig 7: Availability of STI Treatment Medications

![Bar chart showing availability of various STI treatment medications.]

STI Management Practices
- None used only syndromic management
- All used some etiologic management
- Practices differed widely

FIG 8: Management of Urethral Discharge

![Bar chart showing management of urethral discharge.]

Fig 9: Management of Urethral Discharge as per the National RTI Guidelines

**Syndromic management (National Guidelines):**
- Norfloxacin 800 mg stat and
- Doxycycline 100 mg BD x 7 days

**Alternative treatment:**
- IM Spectinomycin 2 gm stat and
- Doxycycline 100 mg BD x 7 days

**NO LABORATORY TESTING**
Figure 10: Management of GUD

![Management of GUD Diagram]

Figure 11: Management of GUD in the National RTI Guidelines

**Syndromic management (National Guidelines):**
- Erythromycin 500 mg TID x 7 days and
- Benzathine Penicillin 2.4 mg IM stat (If penicillin allergy, use erythromycin 500 mg QID x 14 days)

**Alternative treatment:**
- Ciprofloxacin 500 mg single dose

**Include HSV2 treatment if prevalence is 30% or higher:**
- Acyclovir 400 mg TID x 7 days

**NO LABORATORY TESTING**

Limitations of Assessment
- Limited sample
  - Small number of clinics visited (N=6)
  - Non-random selection
  - Geographically limited
- Interviewees’ responses might not have been accurate
- Did not compare interviewees’ responses to patient charts
- Assessment limited to clinical services

Rapid Assessment: Summary
- STI services integrated into other services
  - Job aids lacking at some sites
- All sites have some laboratory capacity
- Limited medication availability
- Clinician management practices vary widely
  - None use only syndromic management
- All use etiologic management to some extent
- Practices differed widely

Recommendations
- STI programme needs
  - Unified approach to STI management
    - Syndromic vs. etiologic management
  - Capacity building
  - Dissemination of job aids
  - Medication availability
  - Laboratory capacity
- Monitoring and evaluation as programme evolves

Fig 12: National STI Surveillance in Kenya

Common STIs in Kenya (Source - KAIS 2007)

This session was presented by Dr. Nicholas Muraguri, Head, NASCOP.
The presentation was based on the results of the KAIS 2007, and focus on status of three STIs: HIV, HSV2, and Syphilis.

HIV
STIs are a major public health problem and a risk factor for HIV infection and transmission.
Recent survey had revealed that HIV in rural areas is increasing among men who are poor and uneducated.
- HIV prevalence rate in Kenya is 7.1%. (Male 5.4% and Female 8.4%)
- Trends show that girls aged 15–24 years have highest incidence of HIV infection matched by men 44 years and above.
- 40% of all women live with a HIV positive counterpart.
- Nairobi, Nyanza and Coast is home to 50% of all HIV positive people in Kenya

Figure shows HIV prevalence by province. As can be seen HIV prevalence is lowest in North Eastern province (1%) and highest Nyanza (15%).

**Fig 13: HIV Prevalence by province**

- HSV2
  - 35.1% of adults in Kenya have HSV2 while 41.6% are women and 26.3% are men which translates to 7 million adults aged 15-64 years with the HSV2 infection
  - An individual with HSV2 has 5 fold chance of being infected with HIV.
  - Quite often HSV2 infection is a symptomatic
    - Women have higher prevalence rate (Figure 3) than men. The risk increases with number of sexual partners.

STIs infections have reduced in Kenya (1993 – 5% and 1.6% in 2002)
Anecdotal evidence suggests that Chancroid has been eliminated completely in Nairobi especially among the commercial sex workers – CSW
Fig 14: HSV-2 prevalence among women and men aged 15-64 years by age group, Kenya 2007

Syphilis
- The prevalence rate of syphilis in Kenya is 1.8% out of these (1.7% women & 1.9% men)
- Of this 1.8%, 16.9% have both the Syphilis and HIV co-infection.
- Syphilis infected patients have a 2.5 fold chance of HIV infection.

In summation the following key questions were raised:
- Ending the debate on whether STI/RTI is an HIV or RH issue.
- Improvement of MIS and surveillance
- Revision of guidelines in Syndromic and etiologic management of STIs/RTI
- The HSV2 influence on STI/HIV prevalence and control.

Given the huge disease burden caused by STI and associated complications there is urgency in revitalizing STI control programs. Integration into other RH or HIV services is key.

Integrating STIs/RTIs into RH Settings - Process and Findings

Adaptation Process of GEP and Development of National RTI Guidelines

*This session was presented by Dr. Bartilol Kigen, Head DRH.*

**Session Outline**

- Adaptation of the International GEP Guidelines in Kenya National Guidelines for RTI Services
- Highlights of the STI/RTI components in the RH Policy/RH strategy.
Adaptation of the International GEP Guidelines in Kenya

RTIs, including STIs, are a significant public health problem globally, particularly in low resource settings

- RTIs can infect the foetus or newborn infant resulting in serious outcomes and even death
- A significant proportion of those attending RH and PHC services have an RTI
  ✓ Kenya ANC 2.4-10% (NG) 8-8.8% (CT), 19.9% (TV), 20.6% (BV)
  ✓ Lack of RTI prevention, detection and treatment in PHC and RH settings results in missed opportunities

- WHO in collaboration with Population Council and FHI, developed guidelines for program managers and providers on integrating RTI prevention, detection and management into FP, ANC, Delivery, PNC, and OPD services
- Reference and training materials developed, peer-reviewed and validated in five countries
- Dec. 2004: Establishment of National Working Group, including six task teams
- July 2006: MOH endorses draft national guidelines
  - Training manual
  - Student Handbook
  - Job aids

- National Working Group recommends field testing guidelines to provide evidence for scaling up

Fig 15: National RTI Guidelines
Situational Analysis of STIs/RTIs in Kenya

- Occurrence and spread of RTIs is poorly understood due to inadequate reporting system in health institutions
- Indicative data available from NASCOP’s sentinel surveillance sites reveal that STIs/RTIs are common in the population
- The consequence of STIs/RTIs on RH can be severe and life threatening and can also cause poor pregnancy outcomes.

The main objective for RTI prevention and control in the National RH Policy is to reduce the burden of RTIs and improve access to high quality RTI services within RH programmes and activities.

Key challenges

- Inadequate integration of RTIs treatment into RH services
- Inadequate access to, and poor quality of RTI services
- Low levels of community awareness of RTIs
- Scarcity of data on RTIs.

Priority actions to address challenges

- Enhance community awareness on impacts of RTIs on reproductive health of women and men
- Ensure integrated, high quality RTI services at all levels
- Ensure STI prevention and control approaches contribute to HIV prevention
- Adopt proven new modalities of prevention and treatment of RTIs
- Encourage research and information generation on RTIs

4.4.3 Study Objectives, Methodology and Interventions

This session was presented by Dr. Nimrod Garama, DMOH Meru South District.

He started the session by giving the social economic profile of Kenya and highlighted the steps followed in integrating STIs/RTIs into RH Settings in both Meru South and Kilifi Districts.
Sensitization of DHMTs

- Team from NASCOP, DRH & Population council met with the DHMT members in June 2006.
- Introduced the new STI/ RTI guidelines to be integrated with RH activities.
- Introduced the study objectives and study designs to be carried out in Kilifi and Meru South Districts.

Study objectives

- To assess the feasibility of training providers and introducing the guidelines on:
  - Provider knowledge
  - Provider practice
  - Client knowledge
  - Quality of care provided to PHC clients
- Assess the proportion of PHC clients provided an RTI-related service

Study design

- Cross-sectional assessment conducted pre and post intervention
- Ten facilities chosen purposively by the District Health Management Teams
  - FP load > 100 per month
  - Minimum of two health providers
- Providers assessed through interview using open and closed-ended questions
- Quality of care assessed through observations of client-provider interactions during PHC consultations and client exit interviews
DHMT-Implementation

- Selected 24 officers to be trained as research assistants to be used in the surveys.
- Selected 14 TOTS to train the selected health providers.
- Selected 40 health providers to be trained on the new RTI guidelines.
- Selected the 10 (ten) facilities to be used in the study.

Facilities selected: Chuka District Hospital, Muthambi Health Centre, Mpukoni Health Centre, Kini Dispensary, Kanjuki dispensary, Kilifi District Hospital, Vipingo Health centre, Rabai Health Centre, Mtwapa Dispensary and Pingilikani Dispensary.

Implementation approach

- Sensitization meeting at the district level.
- Implementation of training
- 14 trainers (TOTs) and 40 providers trained to counsel, educate, screen for symptoms, examine, manage syndromically.
- Trained to use job aides, guidelines and complete registers
- Modification of registers
- Supportive supervision and monitoring by district health management teams.

Baseline survey

- The selected 24 research assistants underwent a 3 day training to familiarize them with the tools (client observation & exit interview questioner) August 2006
- The research assistants administered the tools to the 10 (ten) selected facilities for 10 (ten) days.

Training of TOTS

- The 14 officers were trained as TOTS April 2007. The selected TOTS included Doctors, Pharmacists & Nurses.
- The TOTS were to be used to train the 40 health workers on the new STI/RTI guidelines (i.e. trained to counsel, educate, screen for symptoms & manage syndromically)

Training of service providers

- Training of the 40 (forty) service providers was done using the TOTS – May/June 2007.
- During this training we were privileged to have teams from NASCOP, DRH & POPULATION COUNCIL who came as observers to support the TOTS teams.
DHMT- supervision

- Distributed the modified registers.
- Supervision done monthly using an integrated tool. All our supervision is integrated.
- Limiting factors-Competing priorities
  - Poor road networks
  - Staff turnover
  - Limited funds

End line survey

- The 24 research assistants were sensitized again on the tools (client observation & exit interview questionnaire)
- Questionnaires were administered to the 10 (ten) facilities for 10 (ten) days

Conclusion

- The DHMT’S were glad to be chosen for the pilot study and unlike other programs were in constant contact with the DRH/NASCOP teams organizers and so owned the process.
- The DHMT’S would wish the STI/RTI to be integrated in RH services so as to address all the client’s needs in one sitting (one stop shop)

Findings on Integrating STI/RTI Prevention and control into RH settings

*This session was presented by Wilson Liambila of Population Council, Nairobi Office.*

Data Sources

- Client-provider interactions in ANC, FP, Maternity, Postpartum Care, OPD/STI units to assess the quality of services provided
- Conducted client exit interviews (on clients who had been observed) in same units to obtain feedback on type of services received

Sample sizes achieved

**Table 2: Sample Sizes achieved**

<table>
<thead>
<tr>
<th>Study</th>
<th>Section/Unit where Client-Provider interactions were observed</th>
<th>FP</th>
<th>ANC</th>
<th>Delivery</th>
<th>PNC/PPC</th>
<th>OPD/STI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section/Unit where Client-Provider interactions were observed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Baseline</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N%</td>
<td>103</td>
<td>100</td>
<td>81</td>
<td>98</td>
<td>94</td>
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<tr>
<td></td>
<td>%</td>
<td>21.6</td>
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<td>17.0</td>
<td>20.6</td>
<td>19.8</td>
<td>100.0</td>
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<td></td>
<td><strong>Endline</strong></td>
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<tr>
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<td>N%</td>
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<td></td>
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<td>204</td>
<td>261</td>
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<td></td>
<td>%</td>
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<td>24.2</td>
<td>14.4</td>
<td>18.4</td>
<td>20.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Client social demographics

- Mean age: 26 yrs (range 16 – 48 yrs)
- Majority (93%) in married monogamous relationship
- Most (53%) had primary education
  - 20% no formal education
  - 19% up to 4 years secondary education
- 41% ever used a condom
- 69% reported having an HIV test

Provider knowledge: improved after training (N=40). They were tested on:

- Knowledge of common syndromes,
- mode of transmission of STIs,
- history taking,
- diagnosis,
- treatment,
- integration issues,
- HIV/AIDS (transmission, prevention and management)

Fig 17: Information given to clients improved (N pre=476, post=941)

The proportion of consultations in which the providers gave information to clients on various aspects of STIs improved significantly at endline (Fig 17).
The proportion of consultations in which the providers counselled clients on various aspects of condoms improved significantly (Fig 18).

The most significant improvement occurred in consultations in which the providers discussed history of STIs/RTIs and ways of preventing these infections (Fig 19).
Despite overall improvement, in some of the indicators there were no improvements in the proportion of consultations in which provider checked the status of syphilis in mother and completion of treatment and among consultations which the provider conducted counselling and post test counseling in maternity units (Fig 20).

As seen in Fig. 21, there wasn’t any case in post-natal clinics in which new born babies were given prophylaxis for ophthalmia neonatorum at baseline (fig.21). The proportion of consultations in which the providers discussed with PNC clients various aspects of STIs/RTIs improved significantly (Fig. 21).
Fig 22: Integration in FP Services Improved (N pre=103, post=214)

Significant improvements occurred in FP clinics across all the main indicators of integration (Fig.22).

Table 3: Results of Client Exit interviews

<table>
<thead>
<tr>
<th>Selected questions asked by Research Assistants during exit interviews</th>
<th>Resposnes</th>
<th>Pooled</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>a) Assessing the quality of STI/RTI/RH integrated services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Discuss risks including history of symptoms of STIs/RTIs with you**</td>
<td>Yes</td>
<td>202</td>
<td>674</td>
<td>72</td>
</tr>
<tr>
<td>ii. Look for signs of STI/RTI e.g. discharge, swollen lymph nodes, tenderness, etc**</td>
<td>Yes</td>
<td>177</td>
<td>519</td>
<td>56</td>
</tr>
<tr>
<td>iii. Discuss the effect of STIs/RTIs on pregnancy and baby**</td>
<td>Yes</td>
<td>132</td>
<td>465</td>
<td>50</td>
</tr>
<tr>
<td>iv. Discuss with you other ways of reducing RTI risk e.g. use of condoms/reducing**</td>
<td>Yes</td>
<td>156</td>
<td>562</td>
<td>60</td>
</tr>
<tr>
<td>v. Inform you that STIs/RTIs can increase the chance of being infected with HIV**</td>
<td>Yes</td>
<td>137</td>
<td>524</td>
<td>56</td>
</tr>
<tr>
<td>vi. Inform you that a woman can pass HIV to her baby during pregnancy, delivery**</td>
<td>Yes</td>
<td>154</td>
<td>478</td>
<td>52</td>
</tr>
<tr>
<td><strong>b) Condom Use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Ask you if you know how to use a condom**</td>
<td>Yes</td>
<td>111</td>
<td>460</td>
<td>49</td>
</tr>
<tr>
<td>ii. Show you to correctly use a condom**</td>
<td>Yes</td>
<td>70</td>
<td>265</td>
<td>28</td>
</tr>
<tr>
<td>iii. Have you ever used a condom?**</td>
<td>Yes</td>
<td>192</td>
<td>521</td>
<td>56</td>
</tr>
</tbody>
</table>
Significant improvements occurred across all the main indicators of integration in RH units regarding the quality of STI/RTI/RH integrated services provided, condom use and testing and counseling for HIV services on the day of the interview (Table 3).

### Prevalence of STI syndromes in RH units

**Fig 23: Prevalence of STI Syndromes – ANC (%)**

Cases of vaginal discharge or pruritis constituted the largest component of the STI syndromes that were detected in ANC clinic (Fig 23).
Vaginal discharge or pruritis followed by lower abdominal pain constituted the largest component of the STI syndromes that were detected in FP clinic (fig.24).

Overall the proportion of women who had any of the common STI syndromes was low in maternity units (Fig 25).
Urethral discharge in males followed by genital ulcer disease in both females and males were the most common STI syndromes seen in outpatient departments or units (fig.26).

Detection of Syndromes in RH clinics
There was an overall increase in the number of STI syndromes detected in FP, Outpatient and Postnatal clinics compared to those detected among maternity and ANC clients.

As seen from Fig 27 there was an overall increase in the number of STI syndromes detected between the year 2006 and 2009 (Fig. 27)
Although cases of vaginal discharge or pruritus increased, overall other symptoms such as genital ulcer disease (GUD) and lower abdominal pain in women appeared to have reduced (Fig. 28).

As seen from Fig 29 there was an overall increase in the number of STI syndromes detected between the year 2006 and 2009 in post natal clinics (PNC).
Summary of the findings

- Overall, integrating the management of STIs/RTIs into RH settings improved the quality of services received by clients across the 2 districts.
- RH Settings offer additional opportunities for clients seeking RH services to get HIV/STI/RTI services.
- Evidence on the role of integration in detecting STI/RTI syndromes is inconclusive.
- Some limitations to the study included purposive site selection; did not include a detailed review for accuracy of treatment regimens prescribed.

Conclusions and Lessons Learnt from the Study

This session was presented by Cosmas Mutunga of the Division of Reproductive Health.

- Evidence from the results shows that integration of STIs/RTIs into RH setting is feasible, acceptable and effective in improving the quality of services offered to clients in various RH settings.
- The approach enabled many clients to be tested for STIs/RTIs in the RH settings.

Lessons Learned

The lessons learned are captured in fig. 30 below:

Fig.30: Lessons learned

<table>
<thead>
<tr>
<th>Accounting for Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing and utilizing a comprehensive problem-based training package was useful in facilitating integration.</td>
</tr>
<tr>
<td>Providers’ willingness to give comprehensive package and clients’ preference to receive information from one stop shop accounted for improvements in service delivery.</td>
</tr>
<tr>
<td>Nurturing good working relations between DRH, NASCOP, KEMSA, PHMT, DHMTs and health facility teams motivated the districts.</td>
</tr>
<tr>
<td>Supportive monitoring and supervision especially from DRH NASCOP and provincial teams encouraged health providers on the ground.</td>
</tr>
</tbody>
</table>

Challenges

- Staff shortage
- Occasional interruptions in supplies and commodities did affect some of the services.
- Condom use/dual protection - only moderate improvements realized.
Policy Implications and Recommendations from the study

This session was presented by Daniel Sande of the Division of Reproductive Health

Some of the policy level implications from the findings are:

- There is need to review the syndromic management algorithm for STIs given that infections such as herpes simplex 2 and syphilis are more prevalent than initially thought (based on KAIS 2007).

- There is need for a policy review of how STIs/RTIs are managed given that Kenya no longer has the drug kit system for STIs/RTIs.

Policy implications during Planning Phase

- Support to the provincial and district teams by HQ was a motivation.

- Success of the project was based on involvement of the provincial and district level managers and trainers in the initial phase of the project especially in sensitization and development of training materials improved ownership of the project at implementation level.

- The provincial and district teams were able to explain the project goals and the design to the staff in pilot health facilities. This improved health providers’ understanding of the project activities and their role in the implementation phase.

Policy implication during Training Phase

- Training needs assessment was useful in identifying deficiencies in knowledge among health workers.

- Development of training materials was done by HMTs, DHMT, PHMT, DRH, NASCOP and PC. The teamwork enhanced the relevance and ownership of the materials developed.

- Targeted training was done to focus on service delivery issues.

Policy implication during Implementation phase

- Availability of supplies was improved through DHMTs.

- Monthly supervisory visits by DHMTs with on-job updates motivated the health workers.

- Utilization of data at facility and district levels with frequent feedback from headquarters motivated the health workers.

- However, there was a delay in conducting endline survey (this needs to be avoided in future)
Recommendations

- STIs/RTIs testing within RH settings be expanded to other districts and regions. This is in line with WHO’s and UNAID’s recommendation to implement provider-initiated HIV testing and counselling in health facilities.
- There is need to strengthen long-term methods for FP since most clients are on short-term.
- The government through the two ministries to address the issue of staff shortage
- There is need to investigate behavioural factors that surround the use of condoms with a view to improving uptake
- Routine HIV testing in other RH settings should be considered.

Examples of the on-going and Planned Regional and Local Initiatives on STI Control

Kenya STI Prevention and Control Regional activities coordinated by NACC (GLIA, IGAD) etc.

This session was presented by Dr. Francis Muu of NACC (National AIDS Control Council)

Introduction

- GLIA: Great Lakes Initiative on AIDS-Kenya, Uganda, Tanzania, Rwanda Burundi, DRC. WB, Burundi
- IRAPP: IGAD Regional AIDS Partnership Project-Kenya, Uganda, Djibouti, Ethiopia, Somalia, Eritrea, Sudan (both South and overall). WB, Kampala
- IUCEA/EALP: East Africa Community/AMREF / Lake Victoria Basin Commission Partnership Project with partnership of the IUCEA. SIDA, Kampala

Areas of Focus

- GLIA and IRAPP very similar in design, both funded by WB
- Component 2 of IRAPP: Cross-border collaboration on the Health Sector Response to HIV and AIDS
- Component 2 and 3 of GLIA: Support to HIV and AIDS association networks, and support to the Regional collaboration in the health sector

IRAPP Component 2 Focus:

- Provide a forum for interaction among IGAD countries-information sharing, best practices, protocol harmonization
- Continuity of services across borders including referral systems in selected sites
- Develop and adopt a regional strategy for improved HIV/AIDS, STIs prevention, treatment and care services directed to cross-border and mobile population.
GLIA Areas of Focus

(a) Inventory of effective interventions and sharing of experience
(b) Review of existing protocols, materials and training opportunities in prevention and treatment
(c) Information sharing on prevention, care and treatment programs for refugees, internally displaced persons, returnees and affected communities
(d) Coordination of strategies in the transport sector and pilot packages of services along the two main road axes selected
(e) Exchange information on drug policies and procurement

GLIA Target Population

- Long distance truck drivers and owners
- Fishermen, fisherwomen and surrounding communities
- Commercial sex workers
- Uniformed services
- Refugees and surrounding communities
- IDPs and Returnees
- Women affected by sexual and gender violence

IUCEA/EALP and Lake Vic Basin Commission Projects

- IUCEA/EALP project focus is on mobile populations be they students, university staff, fisherfolk, and surrounding communities. Coordinated by Lake Victoria Basin Commission, Implementation by AMREF and IUCEA
- Lake Victoria basin project also under the EAC

Conclusion

- Like many other regional initiatives the projects have their own challenges key among them bureaucratic processes that ensure interventions take long to initiate.
- Initiatives such as harmonization of treatment protocols and standardization of referral systems may never be achieved because of individual countries needs based on existing national priorities.

CDC Support for STI Control activities in Kenya

This session was presented by Dr James Odek of CDC Kenya

Topic: STI Surveillance among HIV Patients in Kenya

Collaborative Effort:
- National AIDS and STI Control Program (NASCOP)
- Kenya Medical Research Institute (KEMRI)
- University of Washington,
- Centers for Disease Control and Prevention, Kenya and US
STIs and HIV-infected individuals

- Many studies note STI impact on HIV acquisition
- Ulcerative/inflammatory STIs associated with a 2-5-fold increase in HIV transmission and acquisition
- Less known about the impact of HIV on STIs
  - STIs increase genital HIV viral shedding, which may increase HIV transmission
  - STI treatment associated with decrease in seminal or cervicovaginal HIV-1 levels
- 2007 KAIS STI data
  - 1.8% syphilis prevalence
  - syphilis 2.5 times more common (4.5%) among HIV-infected individuals than those without HIV
- Limited data on STI rates among HIV-infected individuals

Current approaches to STI prevention in HIV-infected individuals

- STI diagnosis/management should be supported by laboratory results
- Challenges
  - access to trained medical personnel, sophisticated lab facilities
  - laboratory testing may delay initiation of appropriate treatment
  - lack of equipment, trained staff and diagnostic testing costs
- World Health Organization (WHO) recommends STI syndromic approach for
  - GUD
  - UD in men
  - VD and PID in women

Study Rationale

- Assess the STI burden among HIV-infected adults in HIV care clinics
- Improve the integration of STI prevention, diagnosis and treatment into HIV outpatient care
- Inform/develop screening guidelines for asymptomatic STIs in HIV seropositive

Study Design

- Cross-sectional survey
- 42 CCCs with >1600 enrolled adult ART patients
- Sampling frame
  - All adult patients enrolled in a CCC
- Four study teams (one nurse and three study assistants)
- One to three weeks at each designated clinical site, enrolling the assigned 40 to 270 participants per site.
- Each study team will cover up to 11 sites.

**Eligibility**

1. **Inclusion criteria**
   - HIV-infected patient receiving care at one of the selected HIV care clinics
   - ≥ 18 years old
   - Able and willing to provide informed consent for inclusion in the evaluation

2. **Exclusion criteria**
   - Prior participation in the protocol
   - >36 weeks pregnant

**Timeline**

- CDC IRB approval has been given.
- University of Washington IRB process ongoing
- KEMRI IRB process ongoing
- The study should begin in 2010 and end June 2011 (18 months).

**Objectives**

- **Primary objective**
  - Determine the STI prevalence and aetiology among HIV-infected adults in care

- **Secondary objectives**
  - Determine validity of syndromic STI diagnosis for HIV-infected patients
  - Determine co-factors associated with genital infections including CD4, duration in HIV care, partner disclosure, sex, age, sexual behaviour, HAART use and duration, and geographic region

**Questions**

- What is the burden of symptomatic and asymptomatic STIs among adults?
- How do co-factors including immune status, HIV treatment, and behavioural risk factors impact STI prevalence and presentation?
- What is the validity of syndromic management to treat STIs in HIV-infected adults?

**Outcomes**

- National sample of etiologic data of prevalent STIs
- Comparison of syndromic vs. microbiologic diagnosis for the detection/management of STIs among HIV+ adults
WHO Support for STI Control Activities in Kenya

This session was presented by Dr. Rex Mpazanje, HIV Officer, WHO/Kenya

Introduction

- The 59th WHA adopted the Global Strategy on STI Control in 2006 committing countries towards improvement and acceleration of their STI programmes
- UN joint programme of support on AIDS in Kenya (2007 – 2012) identified STI control as one of the priority areas for UN joint support
- KNASP III (2009 – 2014) has identified STI control programme strengthening as one of its priorities
- African Region Ministers of Health adopted a resolution committing countries towards revitalization of STI control in 2009

Actions already being undertaken

- Strengthening of advocacy for revitalization of STI control programmes
- Updating of STI service guidance tools covering all elements of a comprehensive STI programme
- Supporting development of RH/HIV service delivery integration strategies that fully integrate STI control activities
- Supporting second generation HIV/STI surveillance

Continued Support Areas: Countries

- STI programme review and strategy/plan development
- Adaptation of WHO generic guidelines, training materials and other tools for the country
- HIV/STI surveillance, etiological surveys and antimicrobial sensitivity profile surveys for drugs used in syndromic approach
- Training of health workers, routine monitoring and global/regional reporting on STI control

Note: Appendix 3 contains core indicators for monitoring and evaluation of STIs in the WHO AFRO Region

Strategies for mainstreaming STI/RTI Control activities into NHSSP/JPWF/AOP

Participants felt that there is need to include STI/RTI issues in the national policy documents and strategies in order to guarantee the sustainability of these activities and prevent them from falling off the “policy and resource radar”. This will also assist to link these priorities to the MTEF (Medium Term Expenditure Framework) process.
SUMMARY OF KEY ISSUES

Key issues distilled from day one presentations and discussions in the plenary were grouped into the following thematic areas:

i. Policy related issues
ii. Resource Mobilization
iii. Health Systems
iv. Service Delivery
v. Coordination at all Levels
vi. Supervision Monitoring and Evaluation
vii. Linkages with other Sectors
viii. Research
ix. Community Based Interventions

Specific issues discussed under the above nine thematic areas were:

a) Policy related issues
   i. STI RTI GEP Guidelines recommend Syndromic management
   ii. Regional meeting of Ministers in the AFRO regions resolved to revitalize STI treatment and control
   iii. Harmonization of regional protocols and cross border regimens
   iv. (iv) Proper STI prevention and treatment is essential in the context of HIV prevention
   v. According to all presentations: there is need to revitalize STI/RTI - focus should be on:
      - Dissemination of Guidelines/ regular updates/HSV2
      - Review of curricula
      - Staffing and capacity building
   (vi) Kenya National AIDS Strategic Plan needs to incorporate STI control activities
   (vii) There is need to address HSV-2

b) Resource Mobilization
   - Mentorship of local researchers
   - Staffing issues – Work-load and attrition
   - Focus of development partners;
   - WHO, UNFPA and Population Council are already committed to supporting the strengthening of policy issues, advocacy, resource mobilization, national planning, capacity development, and building of partnerships
   - CDC-Support for STI Control Activities in Kenya
   - New Aid Environment such as Paris declaration and MDGs
c) Health Systems
- Unified approach
- Capacity building for health care providers
- Dissemination of Job Aids on STIs/RTIs to be done
- Chain supply system-Equipment and medical supplies
- Health Management Information Systems
- Use of guidelines -Health Facility quality assurance and standards

d) Service Delivery/Sharing lessons from pilot study on integrating STIs/RTIs into RH
Results from the pilot study showed that integrating STIs/RTIs into RH settings is feasible and improves the quality of care.
- The mechanism for scaling up STI /RTI/HIV integration within SRH needs to be worked out.

e) Supervision, Monitoring and Evaluation
- Periodic supervision by the DHMTs
- Data collection and reporting is a challenge to service providers
- Supervision monitoring will enable tracking of costs of treating an STI on the health system
- Supervision to be able to monitor work load to enable task shifting
- Monitoring will inform on methods of cutting down clients time at facility through multi tasking

f) Coordination at all Levels and Linkages with other Sectors
- Regional meeting of Ministers resolved to revitalize STI treatment and control-Harmonization of regional protocols and cross border regiments
- Linkages with GLIA, IRAPP- IGAD regional Aids Partnership program
- STI management among mobile populations e.g. Refugees, track drivers, university students

g) Research
Historical Challenges:
(i). No baseline - Not able to track outputs
(ii). Challenges in recording and data management
(iii). Choice of population for surveillance
- Surveillance in special clinics
- Antimicrobial resistance to Drugs
- Behavioural surveillance studies-Population based surveys
- Aetiology of STI -Focus of HIV negative 93%
(iv). More operational research to help answer many of the pending questions
h) Community Based Interventions
- Unprotected sex- increase condom use
- Adolescents reproductive health
- 40% discordant couples
- Syphilis testing (VDRL) among antenatal mothers
- Neo-natal syphilis tracking

**GROUP WORK AND FEEDBACK**

Group work was conducted on day two of the meeting. Group work discussions focused on issues that had been distilled from day one presentations and discussions in the plenary. Four groups were constituted to deal with different aspects of STI/RTI components or tasks. For each of the tasks listed (see details below), each group was required to identify key issues or problems that needed to be addressed and priority activities for tackling the identified issues using the following format:

<table>
<thead>
<tr>
<th>Key Issues (Problems)</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Short-term (1 year)</td>
</tr>
</tbody>
</table>

**Group Work Tasks**

**Group 1: Eastern, Central and Western Provincial teams.**

*Chair: Dr. Gichuyia Nthuraku M’Riara*

**Topic:** Service Delivery and National Scaling up of the Meru-South/Kilifi STI/RTI/RH Integration model.

  a) Supply chain issues
  b) Quality assurance issues
  c) Coordination issues
  d) Linkage
  e) Health Management Information System (HMIS)
  f) Scaling up of the Meru-South/Kilifi STI/RTI/RH Integration model
Group 2: Rift Valley and Coast

Chair: Dr. Maurice Siminyu

Topic: MARP (Most at Risk Populations) and Dealing with Service Delivery Gaps.

a) MARPs
b) Health System/ Health Service Delivery Issues
   - HMIS
   - Supply Chain Management
   - Quality Assurance
   - Linkages/Coordination at all levels
   - Community based interventions

Group 3: North-Eastern, Nairobi and Nyanza Teams

Chair: Dr. Lusi Ojwang’

Topic: Interventions to address service delivery issues and MARPs (most at risk populations).

a) HMIS
b) Stigma
c) Staff attitude and Training
d) Supply chain
e) Infrastructure
f) Community level issues
g) Linkages at all levels
h) Research

Group 4: NASCOP, DRH, NACC, MOMS/MOPHS (HQs), Development Partners, Research Institutions, NGOs and FBOs.

Chair: Dr. Otieno Nyunya

Topic: Policy and Research Issues

a) Policy level issues
   - Guidelines
   - Resource Mobilization
   - Technical Updates
   - Staffing
   - Supervision
   - Linkages
b) Research issues

1) Challenges in record keeping and data management
2) Choice of population for surveillance
   - Surveillance in special clinics
   - Antimicrobial resistance to drugs
   - Behavioural surveillance studies-Population based surveys
   - Aetiology of STI – Focus of HIV negative persons who constitute 93% of the population as well as HIV positive ones
3) The need for more operations research activities to help answer many of the pending questions.

Group Work feedback

Group 1: Feedback on Service Delivery and National Scale up of the STI/RTI/RH Integration model

a) Supply chain

<table>
<thead>
<tr>
<th>KEY ISSUES</th>
<th>ACTIVITIES</th>
<th>SHORT TERM</th>
<th>MEDIUM TERM</th>
<th>LONG TERM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disintegration</td>
<td>Micro pharmacies, STI clinics, Parallel/personal program, Stigma</td>
<td>Patients to be seen in their Various departments/consulting rooms</td>
<td>Drugs to be supplied in the normal supply system under the custody of the pharmacist</td>
<td>STI training to all HCP at all levels of care</td>
</tr>
<tr>
<td>Drug Expiry</td>
<td></td>
<td>Drugs to be ordered through the pull system determined by workload</td>
<td>The pharmacists to monitor short/long expiries and redistribute where necessary</td>
<td>Supply STI commodities with long shelf life</td>
</tr>
<tr>
<td>Supplies</td>
<td>Condoms should be at all points in service delivery</td>
<td>Same as short term</td>
<td>Adequate supply of STI/RTI commodities at all levels of care</td>
<td></td>
</tr>
<tr>
<td>Bureaucracy in accessing drugs for other needy clients</td>
<td>All clients should have equal access to care</td>
<td></td>
<td>Innovations on Models (Penile, Vaginal)</td>
<td></td>
</tr>
</tbody>
</table>
b) Quality Assurance

<table>
<thead>
<tr>
<th>KEY ISSUES</th>
<th>ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SHORT TERM</strong></td>
<td><strong>MID TERM</strong></td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Partitioning serving points at the dispensing area to maintain privacy</td>
</tr>
<tr>
<td>BCC among HCP</td>
<td></td>
</tr>
<tr>
<td>Waiting time</td>
<td>Clear labelling/directions</td>
</tr>
<tr>
<td>Introduce/maintain Citizens service charter well displayed at all levels of care</td>
<td></td>
</tr>
<tr>
<td>QA/QI team Drug effectiveness</td>
<td>Functional QA/QI team at all level of care</td>
</tr>
<tr>
<td>Curriculum</td>
<td>Disseminate current STI Policy guidelines for reference at all levels of health care including the training institutions</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

c) Co-ordination of Quality Assurance

- Integration of DRH/NASCOP programme activities
- Focal persons -PASCO/DASCO/HF -in charges
- Intensify detection of SS on STIs/RTIs
- Benchmarking
- Stakeholders Forum for sharing

d) Linkages

- The two ministries -MOPHS/MOMS
  - Inter-departmental:-internal linkage
  - Inter-facility horizontally, vertically:-external linkage
- Other development partners
- Implementing partners : CBOs
- Other ministries-Education, Youth, Sports & Gender, PA
- Use of established referral tools at all levels of care.
e) HMIS

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Short Term</strong></td>
</tr>
<tr>
<td>Vertical Reporting</td>
<td>Data collected compiled at the SDP should be shared at facility level, DMOH</td>
</tr>
<tr>
<td>Data collection tools</td>
<td>Review and harmonize STI/RTI reporting tools</td>
</tr>
<tr>
<td>Reporting/data storage</td>
<td>Supply of STI Registers/reports</td>
</tr>
</tbody>
</table>

f) Service delivery: scale up of the STI/RTI/SRH Integration Model

- What did the Kilifi/Meru South study tell us about integrating STIs/RTIs into SRH settings?
- What needs to be explored? - cost etc,
- How to scale up HIV STI RTI interventions within SRH?
- What worked (from experience of working in 5 clinics -ANC, OPD, PNC, Mat, FP)
- What interventions are required? - Training, Job Aids, Monitoring, Guidelines, etc drawing from policy implications and recommendations
- How do we conduct a national scale up of the Kilifi/Meru South STI/RTI/SRH integration model in order to reach the general population?

Service Delivery

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Short Term</strong></td>
</tr>
<tr>
<td>CLIENT CARE PATHS</td>
<td>Customer care desk</td>
</tr>
<tr>
<td>Cost</td>
<td>Reduced client cost</td>
</tr>
<tr>
<td></td>
<td>Integrate STI/RTI services into the available services at all level of care</td>
</tr>
</tbody>
</table>
Scaling up of the Kilifi/Meru South STI/RTI/SRH integration model

<table>
<thead>
<tr>
<th>What worked</th>
<th>ACTIVITIES</th>
<th>Short Term</th>
<th>Mid Term</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies</td>
<td>Integrate STI/RTI services into the available services at all level of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Acquisition of Job Aids, Policy guidelines, disseminate research findings to other DHMTs</td>
<td></td>
<td></td>
<td>Standardize training material to be used in scaling up the training to other parts of the country</td>
</tr>
<tr>
<td>Enhancement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Group 2: Feedback on Service Delivery targeting the MARPs

MARPs
- CSW
- IDU
- Long Distance Drivers
- MSM
- Fishermen and fish mongers
- University students.

Intervention Targeting High Risk Population
- Health system (service delivery)
- HIMS
- Supply Chain Management
- Quality Assurance
- Linkages /Coordination at level
- Community based interventions

Gap in the HMIS
- There are gaps in data and reporting tools (tally sheets, 711/726 and CBHIS)
- HMIS-Activities (Short term)
- SHORT TERM - Review, print, disseminate and distribute the tools for use by health workers
- MEDIUM- M/E. Sustainability of the supply of tools
- LONG TERM – M/E. Computerize tool, Sustainability of the supply of tools

Gaps in Health System
- Health workers have inadequate knowledge and skills in the management of STIs/RTIs
Health system

- **Short term**
  - STI management should be integrated into the general services delivery and referrals be done through the normal referral system
  - Capacity building of staff, Pap smear and STI Mgt
  - Update and distribute STI charts and guidelines

- **Medium and Long time**
  - Review pre service curriculum and M/E

**Continuous**

- Routine screening of STIs in clients who came for services for active case finding, especially the MARPS.

**Gap in Supply management**

- Some of the STI drugs are not stocked through the Essential drugs and standard drug orders.
- Inadequate staff knowledge on Logistic management.

**Supply chain management**

**Short term**

- Revise the standard order form and essential drug list to include missing STI drugs.
- Sensitize the policy maker on the need of STI drugs as essential drugs.
- Capacity building staff on logistic management
- Strengthen the logistic reporting system.

**Medium/long term** – Mobilize funds to Sustain logistics supplies

**Gap in Community based interventions.**

- Poor linkage with community in HIV/AIDS/STI interventions
- No proper reporting of community activities.
- There is no good harmonization of activities of stakeholders on the ground.
Community based interventions.

Short term and continuous

- Linkage with Community strategy. Update the CHEWs and CHWs on STI symptoms.
- Increase the availability of condoms in entertainment places.
- Strengthen the community referral system
- Linkage with CS. Update the CHEWs and CHWs on STI symptoms.
- Support the formation of support groups of MARPs where the sensitization will be easy.
- Scale up youth friendly services
- Develop a community based reporting tools
- Develop local based IEC materials
- A policy be made that owners of entertainment joints be responsible for condoms supply

Gap in QA

- Health workers are not using the guidelines in STI management.
- Guidelines and flow charts are inadequate
- Irregular supervision, mentorship and DQA

QA – Activities

- Improve supply of Flow charts and guidelines/SOPs
- Ensure adherence to the Job aids
- Hold regular Supervision, Mentorship and DQA
- Feed back at all levels

Gap in coordination

- Inadequate co-ordination of stakeholders’ activities.

Co-ordination

- CHWES
- DHMT
- PHMT
- National
- Strengthen existing coordination channels by training on FS
- National level to always follow the coordination channel
- Regular meeting at all levels
- Decentralize the RHTST
- Coordination of activities by stakeholders and within the level.
Interventions

To address the stigma, integration of STI services in all departments as a short term goal and include STI in the service charter as a long term goal.

- Change in staff attitude and good clinical practice were raised as a short term goal
- Capacity building and pre service training as the medium term
- While availing updates on STI information and its dissemination as a long term Goal.

Infrastructure

The interventions around this issue were:

- Ensuring confidentiality as a short term,
- Screening and obtaining of the equipments as medium term
- 24 hour service as long term goal.

Community Involvement

- To work with the community fully, sensitization and integration of the community were the short term goal.
- Community mobilization and outreaches as the medium.
- Coming up with support groups as a long term goal.

Linkages at All Levels

- To ensure linkages are available
- Identifying of referral systems

Interventions

- Providing care for the whole family(positive and negative) are the short term goal,
- Lab network, support link, link CCCs, TB and STI clinics, as the medium term,
- Accessing care as term then enhancing private and public partnership and linkages with countries in the region as a long term goal.

Research

- Due to lack of involvement in research many lack capacity and technical skill to involve in STI/RTI issues.
- Operational research was identified as a short tem goal and integration of research existing facilities as a long term goal.
### Group 3: Feedback on Service Delivery and on interventions targeting high risk populations

High risk populations: sex workers and their clients, Truckers, Fisher-folk, Refugees, College students

<table>
<thead>
<tr>
<th>Problem</th>
<th>Intervention</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>HMIS</strong>&lt;br&gt;Data capture tool not available&lt;br&gt;Data can't be obtained at peripheral level&lt;br&gt;No harmonized MIS/guideline</td>
<td>-Integrate STI into all registers&lt;br&gt;-Client data forms&lt;br&gt;-Improve the existing registers at the depts.: summary sheets-add information that we need to answer questions such as occupation, duration of living in the area, mobility</td>
</tr>
<tr>
<td>2</td>
<td><strong>Health Systems</strong>&lt;br&gt;<strong>Stigma</strong>&lt;br&gt;Staff attitude and training&lt;br&gt;Standards and quality assurance</td>
<td>-Integrate STI services in all depts.&lt;br&gt;-Include STI in the service charter&lt;br&gt;-Attitude change of staff&lt;br&gt;-Good clinical practice- examining patients&lt;br&gt;-capacity building of HCW/training&lt;br&gt;-Pre-service training in STI management&lt;br&gt;-Avail updated STI management guidelines&lt;br&gt;-Dissemination of guidelines</td>
</tr>
<tr>
<td>3</td>
<td><strong>Supply Chain</strong>&lt;br&gt;Stock-outs of drugs, lab reagents&lt;br&gt;Infrastructure</td>
<td>-Monitoring tools/logistic management&lt;br&gt;-Strengthen supply of drugs and lab equipment&lt;br&gt;-Maintain confidentiality and privacy of clients&lt;br&gt;-Avail screens, proper lighting, space&lt;br&gt;-Obtaining equipment e.g. stirrups, couches, speculum, gloves, running water&lt;br&gt;-24 hour services or identify specific facilities which can give services</td>
</tr>
<tr>
<td>4</td>
<td><strong>Community</strong></td>
<td>-Sensitize community on complications of STIs and in seeking treatment for clients and partners and Changing health-seeking behaviour&lt;br&gt;-Use of church leaders to do this.&lt;br&gt;-Integration into the community strategy&lt;br&gt;-Reaching out to herbalists-send same message&lt;br&gt;-Outreaches/ mass testing- for specific infections&lt;br&gt;-Support groups/ drop-in centres-(information) that are linked to treatment centres</td>
</tr>
<tr>
<td>Problem</td>
<td>Intervention</td>
<td>Timeframe</td>
</tr>
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</tr>
</tbody>
</table>
| 5 Linkages at all levels | Referral systems- intra-hospital, inter-hospital should be strengthened  
Enhance private-public partnership- include private sector in training, provision of commodity, similar service  
At all levels of facilities, have similar treatment, access to care | Short-term  
Long-term  
Continuous |
| 6 Linkages at all levels | Lab network support-link patients from lower levels  
Link to CCCs, TB Clinics, other clinics  
Linkages with counties in the region –  
Standard continuity of care for e.g. truckers  
Provide care for not only clients but also the health needs of the family- partner and children | Medium-term  
Long-term  
Short-term |
| 7 Research  
Lack of involvement in research by staff in our facilities- lack of capacity, technical skill, interest?  
Lack of data analysis/interpretation/use at facility level | Operational research in our facilities  
The research institutions can integrate research into existing system/facilities, sharing research findings with facilities  
Govt. policy-to have ongoing research at all level 5 Hospitals-exposed to peer review  
Validate Syndromic charts- carry out etiological surveillance  
Capacity building- especially in research, CMEs  
• Research Committees in major facilities  
• Provision for a database of existing studies being done/researches | Medium/Long-term  
Medium-term/ continuous  
Long-term  
Short-term/continuous/Short-term/ continuous |
Group 4: Feedback on Policy and Research issues

Guidelines

- The guidelines are not available at service delivery points in both public and private health sector.
- Delay in dissemination and utility of guidelines
- Proper dissemination and operationalisation of the guidelines to increase utility by service providers. (Job aids, tools(syndromic management chart,
- Guidelines should be user friendly; targeting the user group.
- Logistical issues should be considered when considering dissemination of the guidelines-
- Guidelines do not take into consideration specific groups e.g. use of syndromic management for PLWHIV.
- Proper follow up after dissemination.

Policy

- Need to use guidelines for pre-service training. This should be an important entry points for use of guidelines. Strengthening pre service use by trainers, trainees. (medium)
- Guidelines should validate the various STI syndromes. This should be supported by good surveillance systems that should continuously validate the various treatment algorithms. Research is key in this.
- Clear operationalisation of the NHSSP to the other subsets of health implementation plans.
- G- Issues and Action Points.
- Orientation package of the guideline to various users- popular, easy to use summary sheets for key points e.g. job aids, flow charts,
- Reinstate regular support supervision and monitoring.
- Strengthen Monitoring and supervision at all levels (national, provincial etc.
- National launch of guidelines.

Resource Mobilization

Issues and Action Points;

- Need to utilise available support systems and resources to ensure
- National plans should be developed so that necessary support and resources can be mobilized from government donor partners to implement activities.
- Strategic plans should reflect strongly clear and strong justification, outcomes. [NHSSP],
- Strengthen advocacy on importance of STI treatment/control.
• MOH should take the lead in development of the action plans. E.g. RH/STI technical working group should be re-energized to come up with a dissemination strategy, dissemination plans etc.
• Integration of STI and RH/HIV programs in resource poor setting for maximal use of resources.
• Tracking of STI statistics should be strengthened. Tools should be modified and integrated rather than encouraging parallel tools for data collection and information
• Private and public sector should collect and
• STI surveillance system should be clearly defined (syndromic versus etiologic surveillance) and these should be used to inform the information needs and data collection tools. The MOH should play a key role in harmonization of tools based on identified information needs at various levels.
• Need to identify all sector players to input into the activities of the STI Working Group
• Commodities: Commodities management system is currently weak. There is need to strengthen commodities and logistics management.
• There is need for DRH and NASCOP to harmonize the commodity management system. Integration of RH/STI should strengthen this.

Linkages: Issues:

• At policy level; Challenges in linkages of various arms within the health ministry (within the MMS and MOPHS, NASCOP, DRH etc- (does the left hand know what the right arm is doing??
• Poor coordination within the same/ various health sector players. Coordination should be strengthened.
• There is need develop a linkage framework at national level clearly showing roles and linkage between various health players at all levels (Programs (vertical or integrated), departments- internal) and external linkages (MOH with MOW, MOA; public- private linkages Private and Public Partnerships.
• Adoption of the Sector Wide approach in health (HSWAP)
• The Govt/ MOH should take a key leadership role in development of framework and coordination.
• Linkages between existing health programs e.g. STI/RH and HIV, laboratory support, especially in resource poor set-up
• Need for best practices sharing platform for linkages. E.g. Tanzania case of SWAP.
• Linkages with research institutions, academic institutions for operations research to inform linkages. This has a sustainability angle for evidence based programming.
• NASCOP/TWG should be charged to include STI/RTI in the Operation plans
• HIV/RH integration strategy should be used to develop linkages framework for STI/RTI at various service delivery.
• Linkage of health and non health players in STI control- business communities, traders, pharmacists/pharm. Techs. Training of Pharmacists, pharmaTech to administer STI drugs as per syndromic management and refer for complicated cases.

Research

• The STI/RH TWG should be mandated to reset the research agenda and strengthened to play a coordination role for research and dissemination to stakeholders.

• Key areas of research should be defined by the group and prioritized to inform service provision e.g. treatment, STI surveillance, STI/RTI management.

• Kenya AIDS Research Strategic Coordination Mechanism (KARSCOM) is mandated to identify priority research gaps relevant to KNASP 3. However STI/RTI not clearly represented - Should be integrated.

• Strengthen institutional capacity of academic institutions, health institutions to conduct operations research on STIs.

• Rapid needs assessment / situation analysis of STI services should be done to inform on the research priority areas. The TWG should commission this.

• MOH- Department of Standards and Regulations should be revamped to step into its role of coordinating in research.

• The National Council for science and Technology should be a key partner for linkage on information and regulation of research as all Research ethics board act on behalf of this council.

• Research questions and subsequent research undertakings should be informed by information from service providers and health program implementers and a clear feedback mechanism.

• Proper packaging and utilisation of research information for various consumers at various levels should be done.
CONCLUSIONS, RECOMMENDATIONS AND MEETING CLOSURE

Conclusions

Key issues that emerged from the discussions in the two day meeting were:

- That the National RTI Guidelines, as well as the WHO Generic Guidelines on STIs/RTIs, support the syndromic approach as a standard practice in the diagnosis and treatment of STIs. The syndromic approach needs to be strengthened, given its practical importance and the ease with which it can be used by many health providers in settings without laboratory facilities.

- The Rapid Assessment on the situation of STI management in Kenya conducted by NASCOP and CDC in March 2009 revealed that very few health facilities had copies of the National RTI Guidelines. In addition, it was clear from the discussions in the plenary sessions of the meeting that the National RTI Guidelines were not widely disseminated in the country. The assessment also showed that the management of STIs varied from facility to facility as well as from one health provider to another. Whereas some facilities used syndromic approach, other facilities used aetiological (laboratory based) approach in managing clients with STIs. Therefore there is need to disseminate the National RTI Guidelines and unify the STI/RTI management.

- Participants acknowledged that there has been a weak policy level support for STI/RTI management. For instance, the National health Sector Strategic Plan (2005-2010) and the Kenya National AIDS strategic Plan III (2009/10 – 2012/2013) do not put sufficient emphasis on the management of STIs.

- Participants in the meetings were informed that the last time health providers were trained in STIs was in the 1990s. This implies that Kenya does not have adequate numbers of human resource to effectively manage STIs given that the last coordinated training activities took place more than fifteen years ago.

- Drug sensitivity tests as well as national STI surveillance studies have not been carried out in the past 10 years. This implies that the drugs being used in the treatment of STIs could be of doubtful efficacy since no tests have been conducted to justify their continued use.

- Pilot studies carried out in Kilifi and Meru districts by NASCOP, DRH and Population Council on integrating STIs/RTIs into Reproductive health settings highlighted a number of issues. First, a significant proportion of clients seeking reproductive health services in different districts have STIs/RTIs that often go undetected. Hence, integration of STI/RTI management into reproductive health settings improves case detection of some of the common STI syndromes. Secondly, integration of STI/RTI management in reproductive health settings is an acceptable and cost effective way of managing STI cases and thirdly, integration of STI/RTI into reproductive health settings improves the quality of care provided to clients and reduces incidences of missed opportunities.
Recommendations

i. Urgent reconstitution of the National STI TWG. The reconstituted STI Working Group to develop STI prevention and control targets and an action plan which should be incorporated into the National Plan of Action (2009-2010)/2011) for KNASP III that covers the period (2009/2010- 2012/2013) and the National Health Sector Strategic Plan. The National STI TWG should be mandated to reset the research agenda and strengthened to coordinate STI/RTI research activities and dissemination of the research findings.

ii. Dissemination of the current National RTI Guidelines to all provinces/districts including the training institutions be carried out as soon as possible. Orientation packages of the National RTI Guidelines be developed for various users with easy to use job aids and flow charts.

iii. Urgent review of the syndromic management charts to be carried out so that the charts are consistent with available drugs for managing STIs in Kenya. This activity was considered urgent so as to support health workers provide services to clients or patients seeking services at the moment and should be handled separately from recommendation no. (iv) below.

iv. Drug sensitivity and STI surveillance studies be carried out to inform comprehensive revision of the National RTI Guidelines. STI surveillance system should be clearly defined (syndromic versus etiologic types) and these should be used to inform the information needs and data collection tools. A consistent surveillance system should continuously validate the various treatment algorithms.

v. Lessons learnt and experiences from the pilot study on integrating the management of STIs/RTIs into reproductive health settings such as FP, ANC, PNC, maternity units, outpatient clinics etc, be scaled up nationally.

vi. There is need to strengthen commodities and logistics management system. This action will facilitate availability of sufficient quantities of STI drugs in all the health facilities.

vii. A national training programme to build the capacity of health providers at all levels of care in the management of STIs/RTIs be formulated and implemented as soon as possible. Every health care provider should be able to manage STIs/RTIs effectively. Pre service training activities in STIs/RTIs to be incorporated into the national training programme and the curricula of training schools.

viii. Urgent mechanisms for accessing funds (e.g. from the Global Fund) to support STI/RTI revitalization efforts and to sustain the implementation tempo be explored as soon as possible. Similarly, provincial and district health managers ought to take advantage of established mechanisms such as the Joint AIDS Program Review (JAPR) and other available opportunities to highlight STI/RTI issues in their respective regions so as to facilitate mobilization and allocation of resources towards the identified gaps by the Kenya Government and the development partners.

ix. Costing data from the pilot study on integration of STIs/RTIs into Reproductive Health settings be incorporated into the final project report so as to assist the government to quantify the financial resources required to scale up this model of integration.
x. Existing registers in various departments in health facilities be revised to have appropriate columns to capture STI/RTI data. Other routine data collection and reporting tools in the health facilities be reviewed and harmonized to include control activities on STIs/RTIs.

xi. There is need to link STI/RTI control activities to the Community Strategy. Some of the activities will include updating CHEWs and CHWs on STI/RTI signs and symptoms; basic management and referral.

**Closure of meeting**

Dr. Gichuiya Nthuraku M’Riara – Provincial Director of Medical Services (Central Province) – closed the meeting on behalf of the Director, Ministry of Public Health and Sanitation. In his closing remarks Dr. M’Riara thanked the Government officials and representatives of various organizations and institutions for their active participation and in making very practical recommendations on how to revitalize the prevention and control of STIs/RTIs in Kenya. He urged health providers to update their knowledge and skills so as to manage STIs/RTIs more effectively since medical technologies and interventions because “the way STIs were managed 30 years has now changed tremendously”.
APPENDICES

Appendix 1: Programme for the meeting

*Day One: Theme - “Sharing local and international Experience in Controlling STI/RTI Activities”*

Wednesday the 14th October 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00 - 8.30 am</td>
<td>Arrival and Registration</td>
<td>Christine</td>
</tr>
<tr>
<td>8.30 – 9.00 am</td>
<td>Welcome and introductory remarks</td>
<td>Dr. Nicholas Muraguri</td>
</tr>
<tr>
<td></td>
<td>Remarks by UNFPA Country Representative</td>
<td>Dr. Alexander Ilyin</td>
</tr>
<tr>
<td></td>
<td>Remarks by WHO Country Representative</td>
<td>Dr. David Okello</td>
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<tr>
<td></td>
<td>Opening remarks by DMS</td>
<td>Dr. Francis Kimani</td>
</tr>
<tr>
<td>9.00 - 9.10 am</td>
<td>Background to the meeting and objectives</td>
<td>Dr. Ibrahim Mohammed</td>
</tr>
<tr>
<td>9.10 - 9.20 am</td>
<td>Highlights of the initial STI/RTI Control activities</td>
<td>Dr. Sarah Masyuko</td>
</tr>
<tr>
<td>9.20 - 9.35 am</td>
<td>Findings of the Rapid Assessment survey</td>
<td>Christine</td>
</tr>
<tr>
<td>9.35 - 9.50 am</td>
<td>Highlights of current STI situation in Kenya</td>
<td>Dr. Nicholas Muraguri</td>
</tr>
<tr>
<td>9.50 - 10.05 am</td>
<td>Global Strategy for the Prevention &amp; Control of STIs: Overview and promising strategies for addressing STIs and Other RTIs</td>
<td>Dr. Nathalie Broutet</td>
</tr>
<tr>
<td>10.05 - 10.20 am</td>
<td>Highlights of international experience in integrating STIs/RTIs into RH settings</td>
<td>Dr. Nuriye Ortayli</td>
</tr>
<tr>
<td>10.20 - 10.35 am</td>
<td>Discussions</td>
<td>Dr. Mohammed</td>
</tr>
<tr>
<td>10.35 - 11.00 am</td>
<td>TEA/COFFEE BREAK</td>
<td></td>
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<tr>
<td>11.00 - 11.15 am</td>
<td>Adaptation of the International GEP Guidelines in Kenya</td>
<td>Dr. Bartilol Kigen</td>
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<td></td>
<td>- Development of the National Guidelines for RTI Services</td>
<td></td>
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<td></td>
<td>- Highlights of the STI/RTI components in the RH Policy/RH strategy</td>
<td></td>
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<tr>
<td></td>
<td>Project on integrating STIs/RTIs into RH Settings in Kenya:</td>
<td></td>
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<tr>
<td>11.15 - 11.25 am</td>
<td>Study Objectives, Methodology and Interventions</td>
<td>Dr. Nimrod Garama</td>
</tr>
<tr>
<td>11.25 - 11.45 am</td>
<td>Findings</td>
<td>Wilson Liambila</td>
</tr>
<tr>
<td>11.45 - 12.00 am</td>
<td>Conclusions and Lessons Learned</td>
<td>Cosmas Mutunga</td>
</tr>
<tr>
<td>12.00 - 12.15 pm</td>
<td>Policy implications and Recommendations</td>
<td>Daniel Sande</td>
</tr>
<tr>
<td>12.15 - 1.00 pm</td>
<td>Discussions</td>
<td>Dr. Nicholas Muraguri</td>
</tr>
<tr>
<td>1.00 - 2.00 pm</td>
<td>Lunch</td>
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<tr>
<td>2.00 - 2.30 pm</td>
<td>Summary of the current STI/RTI project activities</td>
<td>Prof. Alloys Orago (Director NACC)</td>
</tr>
<tr>
<td></td>
<td>- Kenya STI Prevention and Control regional activities(GLIA supported activities and IGAD)</td>
<td></td>
</tr>
<tr>
<td>2.30 - 3.30 pm</td>
<td>CDC (Support for STI Control activities in Kenya)</td>
<td>Dr. J.Odek/Dr B. Singa Dr Rex Mpazanje</td>
</tr>
<tr>
<td></td>
<td>WHO(support for STI Control activities in Kenya)</td>
<td></td>
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<tr>
<td>03.30-04.00</td>
<td>- Strategies for mainstreaming STI/RTI Control activities into the NHSSSP/JPWF/AOP and linkage with the MTEF process</td>
<td>Dr Were S N O (/Dr H. Kiambati)</td>
</tr>
<tr>
<td>04.00-04.30 pm</td>
<td>Discussion</td>
<td>Dr. Ibrahim Mohammed</td>
</tr>
<tr>
<td>04.30-05.00 pm</td>
<td>TEA/COFFEE /END OF DAY 1 Programme</td>
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</tbody>
</table>
Day Two: Theme “Strategies for strengthening implementation and coordination of STI/RTI Control Activities in Kenya”

Thursday the 15th October 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00 - 8.30am</td>
<td>Recap</td>
<td>Christine/ Sande</td>
</tr>
<tr>
<td>8.30 - 9.00am</td>
<td>Consensus on priority STI/RTI Control activities</td>
<td>Dr. Maurice Siminyu</td>
</tr>
<tr>
<td></td>
<td>Highlights of the process of developing a National Implementation Plan for STI/RTI Prevention and Control</td>
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<tr>
<td></td>
<td>Consensus on an outline of the National Implementation Plan for STI/RTI Prevention and Control</td>
<td></td>
</tr>
<tr>
<td>9.00 - 10.30am</td>
<td>GROUP WORK on the identified STI/RTI control priority components/Activities</td>
<td>Dr Muraguri/ Provincial Directors</td>
</tr>
<tr>
<td>10.30 - 11.00 am</td>
<td>TEA/COFFEE BREAK</td>
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</tr>
<tr>
<td></td>
<td>Chair: Dr. Lusi Ojwang PDMS Nyanza</td>
<td></td>
</tr>
<tr>
<td>11.00am -1.00 pm</td>
<td>Group work continues</td>
<td>Dr Muraguri/ Provincial Directors</td>
</tr>
<tr>
<td>1.00 - 2.00 Pm</td>
<td>LUNCH BREAK</td>
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<tr>
<td></td>
<td>Chair: Dr. Godric Onyango –PDMS Western</td>
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</tr>
<tr>
<td>2.00 - 3.00PM</td>
<td>Presentation/Feedback on group work</td>
<td>Dr. Ibrahim Mohammed/ Dr. Muraguri</td>
</tr>
<tr>
<td>3.00 – 3.30Pm</td>
<td>Plenary Discussions</td>
<td>Dr. Ibrahim Mohammed/ Dr. Muraguri</td>
</tr>
<tr>
<td>3.30 - 4.00 Pm</td>
<td>Way forward and closure</td>
<td>Dr. M’Riara PDMS Central</td>
</tr>
<tr>
<td></td>
<td>TEA/COFFEE /END OF DAY 2 Programme</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2: List of Participants

<table>
<thead>
<tr>
<th>Names/Title</th>
<th>Organization</th>
<th>Designation</th>
<th>Address</th>
<th>Email</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0720441220 020 2711261</td>
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<tr>
<td>Dr. Ambrose Misore</td>
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<td>Project Director, Aphia 2 Western</td>
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<td><a href="mailto:amisore@path.org">amisore@path.org</a></td>
<td>0722810411</td>
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<tr>
<td>Mr. Amos Nyaberi</td>
<td>ATFAMICA</td>
<td>Program Officer</td>
<td></td>
<td><a href="mailto:nyaberios@yahoo.com">nyaberios@yahoo.com</a></td>
<td>0725569311 06831007</td>
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<tr>
<td>Mrs. Anasia M’Aribu</td>
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<td>DPHN</td>
<td>Chuka District Hospital</td>
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<tr>
<td>Mrs. Angela Njiru</td>
<td>MOH</td>
<td>PRHC Nairobi</td>
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<td>0722605687</td>
</tr>
<tr>
<td>Mrs. Ann Nyamu</td>
<td>NASCOP</td>
<td></td>
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<td></td>
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</tr>
<tr>
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Appendix 3: Core indicators for monitoring and evaluation of STIs in the WHO AFRO Region

(Source - The prevention and control of STIs in the WHO African Region; Framework for Action 2010-2015, Draft 28.07.2009 Table 5)

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<th>Objective 1: Promote healthy behaviour</th>
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<td>1.1 In all countries, proportion of women and men reporting symptoms of STI in the last 12 months who sought care at a service provider with personnel trained in STI care;</td>
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<td>1.2 In all countries, proportion of women and /men 15-49 using condom at higher risk sex among women and men having higher risk sex;</td>
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<td>1.3 Proportion of countries being implementing a sustainable healthy behaviour campaign concerning STI;</td>
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<th>Objective 2. Provide good quality of care</th>
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<td>2.1 In all countries, proportion of women and men with STI at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines;</td>
</tr>
<tr>
<td>2.2 In all countries, proportion of first time antenatal clinic attendees aged 15-24 years screened and treated for syphilis;</td>
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<tr>
<td>2.3 In all countries, proportion of primary health care facilities providing STI case management according to national guidelines;</td>
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<tr>
<td>2.4 Proportion of countries without any stock-out of STI medicines a year in more than 80 % of facilities;</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Objective 3. Improve the availability and use of strategic information to guide the response</th>
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</thead>
<tbody>
<tr>
<td>3.1 Proportion of countries with routine reporting of STI established and sustained over at least 3 consecutive years;</td>
</tr>
<tr>
<td>3.2 Proportion of countries conducting at least one round of STI prevalence surveys over 5 years;</td>
</tr>
<tr>
<td>3.3 Proportion of countries conducting mapping and size estimates for vulnerable populations;</td>
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<tr>
<td>3.4 Proportion of countries being implementing a surveillance system providing relevant information for policy and programme development of STI</td>
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</tbody>
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<th>Objective 4. Enhance the commitment of decision makers for STI prevention and control strengthened</th>
</tr>
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<tr>
<td>4.1 Proportion of countries mobilizing funds for the prevention and control of STI.</td>
</tr>
<tr>
<td>4.2 Proportion of countries having within their national strategic framework, plans and strategies for the control of STI infections, including HIV, for most-at-risk and other vulnerable populations.</td>
</tr>
</tbody>
</table>
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