THE EFFECTIVENESS OF SEXUAL AND REPRODUCTIVE HEALTH COUNSELLING SERVICES FOR HIV POSITIVE WOMEN IN COMPREHENSIVE CARE CENTRES IN LANGATA, KENYA

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The Effectiveness of Sexual and Reproductive Health Counselling Services for HIV Positive Women in Comprehensive Care Centres in Langata, Kenya

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DECLARATION

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

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DEDICATION

This dissertation is dedicated to my beloved mother, Ms. Persis Milly Senninde, my husband, Mr. Kanobe Fredrick and children Faith, Joy, Joshua and Josiah whose encouragement has made me sail through all these academic endeavors.

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AIDS	Acquired Immune-Deficiency Syndrome.
AIC	AIDS Information Centre Uganda
AMREF	African Medical Research Foundation
ANC	Antenatal Care.
ARVS	Antiretrovirals
ART	Antiretroviral Therapy
CCC	Comprehensive Care Centre
CRS	Catholic Relief Services
GPA	Global Programme on AIDS
HC	Health Centre
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
KAIS	Kenya AIDS Indicator Survey
KI	Key Informant
MDGs	Millenium Development Goals
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHSSP II	National Health Sector Strategic Plan
OI	Opportunistic Infection
PLHIV	People Living With HIV/AIDS
PHC	Primary Health Care.

PTCs	Post Test Clubs
PMTCT	Prevention of Mother to Child Transmission
SPA	Service Provision Assessment
SRH	Sexual and Reproductive Health
UNAIDS	United Nations Program on AIDS
UNICEF	United Nations International Children's Fund
WHO	World Health Organization

DEFINITION OF KEY TERMS

Sexual and reproductive health:

"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. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (ICPD, 1994).

Reproductive health care:

"… the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (ICPD, 1994)".

Sexually Transmitted Infection:

This is a disease resulting from bacteria or viruses and often acquired through sexual contact. Some STIs can also be acquired in other ways (i.e. blood transfusions, intravenous drug use, mother-to-child transmission). The term 'STI' is slowly replacing 'STD' (sexually transmitted disease) in order to include HIV infection (IPPF, 2014).

Unintended pregnancies:

An unintended pregnancy is a pregnancy that is mistimed, unplanned, or unwanted at the time of conception. It is a core concept to better understand the fertility of populations and the unmet need for contraception (birth control) and family planning. Unintended pregnancy mainly results from the lack of, inconsistent, or incorrect use of effective contraceptive methods (Centers for Diseases Control, 2014). An unintended pregnancy is associated with an increased risk of problems for the mother and the baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. For example, women with an unintended pregnancy could delay prenatal care that may affect the health of the baby.

ABSTRACT

In Kenya, women living with HIV account for 52%of the 1.5million people living with HIV. With advent of Antiretroviral Therapy (ART), many HIV positive women have become pregnant intentionally or unintentionally. In 2009, 81,000 women living with HIV became pregnant where between 6% and 35% of pregnancies were unintended. In the same year, there were approximately 22,000 children living with HIV produced. Without any intervention, a third of these childrenwould die by the first birthday and half by the second birthday. For over eight years, Kenya has been trying out four models of Sexual and Reproductive Health (SRH)/HIV integration innovations that is through; (i) stand-alone family planning clinics and antenatal clinics, (ii) through STI screening clinics, (iii) through HIV counselling and testing sites and (iv) through HIV care and treatment centres. There was however a limited evidence onthe extent to which health workers and counselors implement effective SRH counseling services within the Comprehensive Care Centres (CCCs) to prevent unintended pregnancies and also reduce the risk for acquiring STIs.This case control study was carried out on HIV positive women (71 cases and 71 controls) agedbetween 18 and 49 years. A case was defined as an HIV positive woman, aged 18-49 years that became pregnant and had attended the CCC for antenatal services between January and December of 2013 at the selected health facility for not less than three times. Both cases and controls were selected on the basis of having been exposed or not exposed to SRH counseling to ascertain itseffectiveness to preventunintended pregnancies and STIs among them. Quantitative andqualitative methods of data collection and analysis were utilized using chi squares (at p=0.001 and 0.05) and odds ratios were used to analyze the relationships among variables. The study also explored factors that promote or hinder the utilization of SRH counseling information and services provided to women living with HIV at the CCCs in Langata. The findings show a close match for demographical data amongst the cases and controls in terms of the age, education level, period and frequency for accessing SRH service with HIV diagnosis with women aged 30-39 years seeking the SRH counselling services more among the cases and controls as compared to other age groups. Among the cases, all HIV positive women were equally and likely to get unintended pregnancies irrespective of whether they had received SRH counselling or not (odds ratios [OR]: 1.114; 95% confidence interval [CI]: 0.427–2.911). The study further reveals that SRH counselling had no significant impact in supporting the HIV positive women to reduce the risks factors of unintended pregnancies, it even strongly lacked enough information to empower HIV positive women to prevent STIs.There were notable factors impacting on the use and uptake of SRH counselling services such as stigma and discrimination, lack of follow-up, financial and logistical challenges to access the health facility, the long queues at the facility to mention among others. This calls for a review of the SRH counselling process, more training for SRH counsellors on effective SRH counselling; more mentorship and constant support supervision to uphold the counselling proficiencyin SRH.

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, there are approximately 36.7 million people currently living with HIV, with women representing half (50%) of all adults living with HIV worldwide (UNAIDS, 2016). Eastern and Southern Africa, the hardest hit region, is home to 17.1 million people living with HIV where women aged 15-49 years accounting for 60% of this population. The UNAIDS (2012) global epidemic report on HIV and AIDS, states that there were approximately 3.3 million children (under 15 years) living with HIV globally at the end of 2011 with 91% found in Sub-Saharan and most of them had been infected by their mothers.

Kenya has an adult HIV prevalence of 5.9% with an estimated 1.5million people were living with HIV. Women aged 15-49 years living HIV account for 55% of the 1.5million people living with HIV (UNAIDS, 2016). Women in this age group fall within the reproductive age category and have varied sexual and reproductive health (SRH) needs and desires. Children less than 15 years of age account for 16% of all HIV infections; most of these infections were acquired through mother-to-child transmission. The government of Kenya is committed to eliminating the mother-to-child transmission (MTCT) of HIV by 2015. Key strategies to prevent the mother-to-child transmission (PMTCT) of HIV have included efforts to increase knowledge of PMTCT, greater male involvement in PMTCT, universal attendance of pregnant women at antenatal clinics, universal uptake of HIV testing among pregnant women, as well as the provision of antiretroviral drugs (ARVs). HIV care and treatment services in the health care facilities at the district level are provided at the

Comprehensive Care Centers (CCCs) which have been very active 2005according to the Kenya National AIDS Strategic Plan (KNASP III, 2009/10-2012/13).

The Comprehensive Care Centers (CCCs) were established to ensure that people living with HIV have access to comprehensive physical and psychological health care services. The other services provided include; education and empowerment of clients, including provision of counseling on HIV prevention, sexual and reproductive health, HIV testing, antiretroviral therapy, nutrition education, immunizations, connections to support groups, and legal advice. Some of the specific service mentioned may be common to all while other may not.

1.1.1 Integration of SRH Services into HIV Treatment and Care Services

The linkage of sexual and reproductive health with HIV at the policy, programme and service levels is universally acknowledged as critical to ensure the protection of the reproductive rights and address the (reproductive) needs of people living with HIV (WHO, 2009). Despite the gains in ensuring that women have access to contraception, and quality reproductive health services, there were 85 million unintended pregnancies worldwide between 2008 and 2012 with Africa accounting for 35% of these pregnancies according to astudy conducted by Sedgh, Singh, Shah & Ahman (2012) on intended and unintended pregnancies worldwide in 2012 and recent trends. The study further revealed that 50% of all unintended pregnancies ended up in abortion, 38% in unplanned births, and 13% in miscarriage with thousands of women dying and many more are seriously injured as a result of unsafe clandestine abortions.

A study conducted by Myer, Carter, Katyal, Toro, El-Sadr & Abrams (2010) shows that women living with HIV are more likely to become pregnant after starting antiretroviral treatment. While reasons for the link are unclear, the study further highlights the need for pregnancy planning and management as a key component of HIV treatment and care where among HIV-infected women who began antiretroviral treatment, the chance of becoming pregnant increases almost 80% higher for than for HIV-infected women not on treatment for over four years of antiretroviral treatment.

The support for better integration of reproductive health services into HIV prevention programs or vice versa, stretches back to the 1994 United Nations International Conference on Population and Development (ICPD) which articulated a more comprehensive, client-centered approach to sexual and reproductive health, encompassing HIV prevention, as well as services that traditionally fall under family planning. The outcomes of the 1994 United Nations International Conference on Population and Development in Cairo and the 1995 fourth World Conference on Women held in Beijing on Sexual and Reproductive Health, focus more on a right based approach for both men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. They should be provided with other methods of their choice to regulate their fertilitydesires which are not against the law and the right to access appropriate health-care services that will enable women to go through pregnancy and childbirth safely and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care therefore defined as;

"… the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health

problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (ICPD, 1994)".

Irrespective of the HIV status of the woman, the definition of SRH from ICPD highlights the *"right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant"* (ICPD Program of Action 1994). Central to the quest of the ICPD (1994) outcomes on reproductive health is the need to expand coverage of primary health care, with special attention to quality of services, equity of access, and relevance to women and young people. This implies countries had to ensure access good quality reproductive health services that ensure privacy, fully informed and free consent, confidentiality and respect for the client.

Building on the ICPD outcomes, the UN Millennium Development Goals (MDG) to be achieved by 2015 reaffirmed the goals of poverty reduction, universal education, gender equality, improving reproductive/maternal health, reducing child mortality, curbing the spread of HIV/AIDS and strengthened partnerships. A systematic review of HIV/AIDS and SRH linkages literature conducted by IPPF, UCSF, UNAIDS, UNFPA & WHO (2008) revealed that linking SRH and HIV was considered beneficial and feasible, especially in Family Planning (FP) clinics, HIV counseling and testing centers, and HIV clinics towards addressing the unmet need for contraception in both concentrated and generalized epidemics among HIV clients.

1.1.2 Kenya's Context on SRH Integration in HIV Care & Prevention Programs

The Ministry of Health in Kenya has developed a number of policy statements that indicate Kenya's commitment to the achievement of the ICPD and MDG goals, as well as other international development goals and targets. The National Reproductive Health Strategy (NRHS) (2009 – 2016) is a revision of the National Reproductive Health Strategy (1997-2010) that seeks to promote and protect the sexual and reproductive health rights of all Kenyans as well as provide a framework for program implementation for sexual and reproductive health services through a national multi-sectoral approach. The provisions in the NRHS policy are also guided by the Kenya Health Sector Strategic Plan (KHSSP III – 2012-2017) which indicates that all health units should ensure that that there is access to a minimum health care package for sexual and reproductive health services.

The National Reproductive Health Strategy (2009 – 2015) prioritizes the integration of HIV services into reproductive health programmes at all levels of health care. The reproductive health package not only includes provision of family planning, preventing mother to child transmission (PMTCT) services among other but also routine screening and treatment for Reproductive Tract Infections (RTIs) to increase early detection and treatment, as well as follow-up. Within comprehensive package of service provision, the NRHS policy advocates for counselling and provision of male and female condoms, voluntary counselling and testing towards the provision of family planning services, introducing family planning services in HIV clinics – and providing Sexual and Reproductive Health counselling, HIV

counselling and life-skills, and sexuality education in both HIV and reproductive health clinics.

The UNAIDS guidelines on HIV Counselling (2000;2007) defines counselling as a confidential dialogue between the service provider and the client that should take place in a confidential manner and with informed consent. It plays a critical role in the assessment of risk factors as well as providing the best options for risk reduction for either transmission or acquisition of HIV. While evidence is limited evidence on the extent of integration, the main focus on counselling people living with HIV on SRH should include;

- Providing information and counselling about reproductive rights, fertility intentions and options as well as infertility services, advice on planning a pregnancy for discordant and sero-concordant HIV-positive couples, and contraception.
- Promotion of dual protection
- PMTCT for those who wish to become pregnant and for women already pregnant
- Prevention of sexual transmission of HIV to partners

For HIV-positive women in resource poor-settings, as for all women, making a choice to use contraception or not, which method to use, compliance, whether to use sterilization or seek an abortion are complex decisions and depend upon socio-economic, cultural as well as religious factors. A study conducted by Engender Health & UNFPA (2006) in Brazil, Ethiopia and other countries indicates that

women are unable to make independent decisions about their sexual and reproductive health because of political instability, economic dependence, as well as cultural and religious attitudes to women's rights. However effective sexual and reproductive health counselling is critical in helping women with HIV and couples delay pregnancy, limit their number of children, or avoid pregnancy altogether, access to voluntary family planning services and reliable contraceptives.

Stover, Fuchs, Halperin, Gibbons, and Gillespie (2003) indicate that prevention of unintended pregnancies can reduce costs related to PMTCT services and eventually the numbers of children orphaned by HIV and in need of care and support. Examples of evidence-based successful integration of SRH integration later on counselling for SRH among HIV positive women are wanting, making it difficult to develop evidence-based recommendations. In particular, rigorous evaluation with measurement of sexual and reproductive health outcomes is largely absent, hence a need to explore further the impact of sexual and reproductive health counselling services for HIV positive women on their reproductive choices.

1.1.3 Significance of the Study and Expected Application of Results

This study is of program and policy relevance and contributes to improving the quality of sexual and reproductive health counselling services in Kenya. The findings of the study will contribute to the knowledge base on issues related to improving the sexual counselling services within the HCT service delivery and quality that are provided to HIV positive women.

The research findings would be disseminated to research participants, as well as other individuals and institutions in the communities where the research has been conducted i.e. the HIV positive women, participant agencies, health departments, researchers, policy makers, and health advocacy groups. A dissemination plan has been developed that includes the goals of dissemination, the targeted audience, the medium of dissemination and the execution plan for dissemination.

A research summary document" that clearly and concisely summarizes the key conclusions from the research was prepared to disseminate the findings and presented to stakeholders for example flyers, posters, brochures, research briefs, policy briefs or fact sheets. Through participatory methods, the stakeholders were invited to discuss on how best to improve the quality of SRH counselling based on the key findings.

At the community and national level, the findings will inform the improvement of SRH services in the CCC, inform policy improvement and also open up new areas for further research. The findings of the research will also contribute to the knowledge base of many interventions and effort that are geared towards the scaling up of SRH Counselling services for HIV positive women. Once the SRH needs of HIV positive women of reproductive age living with HIV are met as a result of improved service delivery, this will help in reducing reduce illegal and unsafe abortions, reduce the number of HIV positive births as well as HIV–related infant and child deaths. Maternal and child morbidity rates will be reduced considerably in view of helping to meeting the sustainable development goals.

1.2 Statement of the Problem

Antiretroviral treatment has been known to significantly restore health among HIV Positive women. It also restores fertility desires where many women on ART are able to resume socially productive and sexually active lives that involve both protected and unprotected sex with or without the desire to have children (Cooper, 2007; Homsy, Bunnell, Moore, King&Malamba, 2009). As a result, a number of HIV positive women have become pregnant intentionally or unintentionally. In 2009, 81,000 women living with HIV aged 15-49 years became pregnant where between 6% and 35% of pregnancies were unintended (UNICEF 2009). In the same year, 22,000 children were born with HIV. Todate, Kenya registers between 15-16% of its new infections through Mother to Child Transmission of HIV (UNAIDS, 2016). Without any intervention, a third of them would die by the first birthday and a half by the second birthday. Langata county is among those areas with one of the highest HIV prevalence rates and also registers high rates of MTC among HIV positive women. While Kenya has implemented several models of integrating Sexual and Reproductive Health (SRH) into HIV treatment and care programs, the extent to which these services empower HIV positive women to make informed choices in regard to their sexuality and reproductive health desirestowards reducing the risk for acquiring STIs and transmitting HIV to their unborn babies.is yet to be established

1.3 Justification

Previous studies have indicated that there are several factors that influence and determine the sexuality desires of women as well as the determination of women living with HIV to have or not have children (Homsy, Bunnell, Moore, King & Malamba,2009). These factors which are multiple and complex include age, marital,

educational and socio-economic status, cultural and religious beliefs, sexual behaviour as well as family size and losses, access to family planning services, stigma and discrimination, beliefs and attitudes of health care providers.

In resource-poor settings, notably in Sub-Saharan Africa, these factors may be greatly influenced by the traditional role of women, the importance given to motherhood and the desire of the woman's partner for children. The factors fuelling planned or unplanned pregnancies among HIV positive are however resulting into high numbers of children with HIV as alluded to in the statement of the problem.

IPPF, UCSF, UNAIDS, UNFPA & WHO (2008) noted that expanding Sexual and Reproductive Health (SRH) for HIV positive women continues to be challenging in many countries. There is still very little evidence for the effectiveness and integration of SRH counselling within HIV treatment and care programs targeting the various cadres of health staff and on how to sustain good quality SRH counselling in health care facilities. It is therefore of great importance to understand fully how women living HIV are being supported by health workers as they represent a subset of the most vulnerable of populations that is continuously faced with gender inequality, gender-based violence, stigma and discrimination and social marginalisation.

Supporting HIV positive women on theirthe Sexual and reproductive health needs of women of reproductive age living with HIV, who represent approximately half of all global HIV infections, will reduce illegal and unsafe abortions, reduce the

acquisition of STIs and other sexually transmitted infections, reduce the number of HIV-positive births as well as HIV-related infant and child deaths. Maternal and child morbidity and mortality rates will be reduced considerably and so help meet the Sustainable Development Goals (SDGs) by 2030. This can be achieved mainly by empowering HIV positive women and supporting them to make informed choices for effective behavioral change. Counselling is the bedrock for achieving self-actualisation.

SRH counseling is a process of helping individuals to understand themselves by discovering their own needs, interests and capabilities in order to formulate their own goals and make plans for realizing those goals. To HIV positive women, SRH counselling helps in giving them the necessary information sothat they make informed choices regarding reducing the risks of transmitting HIV or even acquiring other sexually transmitted infections that may affect their lives. Analysing the effectiveness of SRH counselling services will therefore help to throw more light on how best SRH integration in HIV programming can best be addressed to support women manage their sexuality desires and also reduce the risks of transmitting HIV or even acquiring other sexually transmitted infections that may affect their lives.

1.4 Broad Objective

To assess the effectivenessof the SRH counselling services provided within the Comprehensive Care Centres (CCCs) in the selected public health facilities in Langata countyin reducing the risks of unintended pregnancies and STIs among HIV positive women in Kenya.

1.5 Specific Objectives

The specific objectives of the study were to;

- assess the SRH counselling process which HIV positive women undergo within the selected Comprehensive Care Centre located in the selected government health facility in Langata;
- assess the effectiveness of SRH counselling services in relation tothe prevalence of unintended pregnancies and STIs amongst HIV positive women that have undergone SRH counselling at the Comprehensive Care Centre within the selected government health facility in Langata;
- determine factors that promote the utilisation of SRH counseling information and services provided to HIV positive women at the Comprehensive Care Centre within the selected government health facility in Langata.
- determine factors that hinder the utilisation of SRH counseling information and services provided to HIV positive women at the Comprehensive Care Centre within the selected government health facility in Langata Sub-county.

1.6 Hypotheses

1.6.1 The Null Hypotheses (H_0)

- There is no difference in the prevalence of unintended pregnancies amongst the HIV positive women that have undergone SRH counselling and those that have not undergone counselling in the CCCs in government health facilities in Langata.

- There is no difference in the prevalence of STIs amongst the HIV positive women that have undergone SRH counselling and those that have not undergone counselling in the CCCs in government health facilities in Langata.

1.6.2 The Alternative Hypotheses (H_1)

- There is a significant difference in the prevalence of unintended pregnancies amongst the HIV positive women that have undergone SRH counselling and those that have not undergone counselling in the CCCs in government health facilities in Langata.
- There is a difference in the prevalence of STIs amongst the HIV positive women that have undergone SRH counselling and those that have not undergone counselling in the CCCs in government health facilities in Langata.

(i) The number of counseled HIV positive women that had unintended pregnancies in comparison with those that never received SRH Counselling;

(ii) The number of HIV positive women that ended up with STIs with a particular focus on the presence of one or more STIs as depicted in the records in comparison with those that never received SRH Counselling.

CHAPTER TWO

LITERATURE REVIEW

2.1 Conceptual Framework of the Study

Given that the study examined the effectiveness of the SRH counselling process in helping HIV positive women make informed choices on pregnancy and STI prevention and /or risk reduction; a conceptual framework was developed that highlighted the key independent and dependent variables as shown in the figure below;

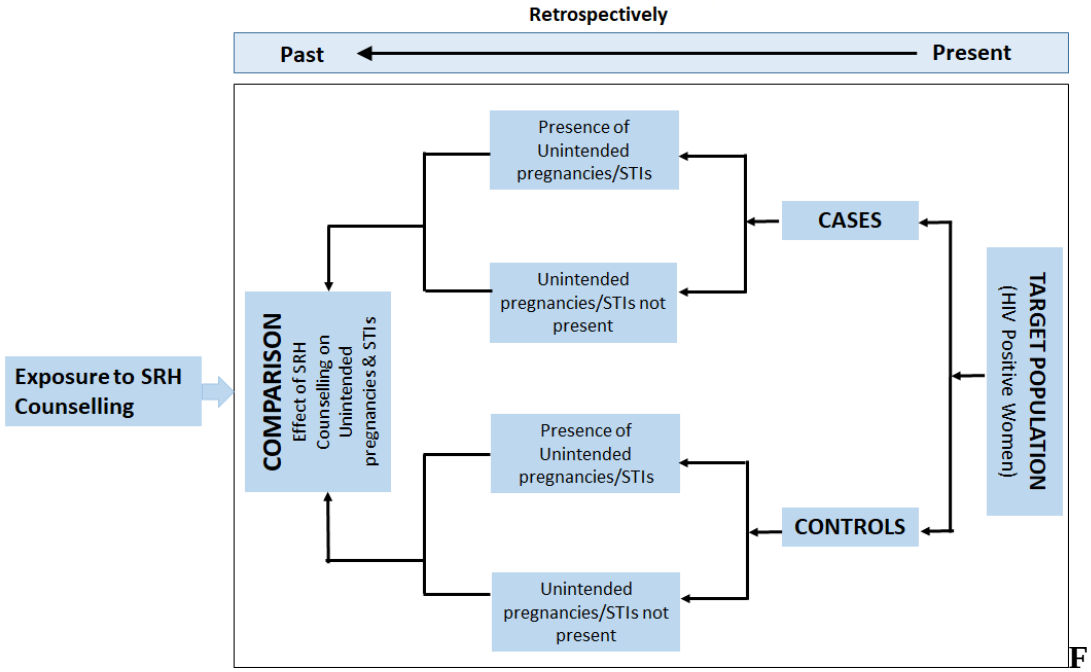

Figure 1: Conceptual Framework

The independent variable for the study was the exposure to the SRH counselling process while the dependent variable was unintended pregnancies and presence of STIs among HIV positive women as indicated in the conceptual framework above. The independent variable (SRH counselling) has more factors that were assessed

under major sexual reproductive health counseling dimensions that included the following;

(i) The SRH Counselling Procedure,

- Provision of a conducive environment that ensures confidentiality and friendly services to HIV positive women in a timely manner
- Establishment of rapport and maintenance of confidentiality
- Assessing HIV positive women on their sexuality desires, intentions and needs
- Providing information and counselling on the Sexual and Reproductive Health needs under the following categories;
  - *a) Sexual and reproductive Health intentions and Reproductive rights*
  - *b) Fertility intention, pregnancy planning and infertility concerns/services*
  - *c) Family planning – including dual protection*
  - *d) Sexual Transmitted Infection (STIs)*
  - *e) Prevention and management of Breast and cervical cancer*
  - *f) Maternity care, including PMTCT services for already pregnant women on PMTCT and Postpartum contraception*
  - *g) Information, Education and Communication and Counselling and Psychosocial support*
  - *h) Policy priorities and programmatic needs*

(i) The number of times the HIV positive women came for counselling in a particular year;

(ii) A determination of the factors that hampered the uptake of the SRH counselling knowledge hence affecting the process of behavioral change process. Such factors may include:

a) an assessment of the service providers' competencies

b) availability of SRH materials for the successful implementation of the counselling services, the client to service provider level,

c) the institutional and government support towards SRH service;

d) presence of commodities and supplies and many other factors.

2.2 Unintended Pregnancies and STIs Among HIV Positive Women

Several studies are indicating that many HIV positive women are falling pregnant after initiation on ART and most of these pregnancies are not intended. A study conducted in Mbarara district in Uganda, that focused on 351 HIV-positive women (18–49 years) who enrolled on ART between 2005–2011, revealed that nearly one-third of the HIV positive women became pregnant within three years of initiating ART (Kaida, Matthews, Kanters, Kabakyenga &Muzoora, 2013).

Another study in Mbararadistrict in Uganda that followed up 3,144 HIV positive women between June 2006 and January 2010 in Mbarara district in Uganda showed that younger HIV positive women aged 18 years were more likely to becomepregnant than those aged 39 years (Kabami, Turyakira, Biraro& Bajunirwe, 2014). The factors that were associated with incidence of pregnancy in this cohort were: the social-economic pressures of getting married early while still young, the lack of knowledge of spouse HIV serostatus, lower socio economic status among others.

The findings from a cross-sectional study in Kigali, Rwanda in 2007, confirm ahigh prevalence of unintended pregnancies among HIV positive women where 82 (62.7%) of the 132 women became pregnant unintentionally even though they had known their HIV sero-positive status. The study further indicates that those who had two or more children (adjusted OR, 3.83) were more likely to get pregnant unintentionally (Kikuchi, Wakasugi, Poudel Sakisaka & Jimba, 2011) as compared to those that had never given birth to any child.

Another prospective cohort study in South Africa that followed up 850 HIV positive women from August 2009–March 2011 on the incidence of unintendedpregnancy after Antiretroviral Therapy (ART) initiation indicated that out of the 850 women that had enrolled into care, there were 170 pregnancies detected in 161 women of which 105 pregnancies (62%) were unplanned (Schwartz, Rees, Mehta, Venter& Taha, 2012). In this study, 47% (80/170) of the unintended pregnancies that occurred among women on ART there were not carried to term; a substantial burden of pregnancy loss observed that put the mother at risk of their personal health. Even though the study does not explicitly explainthe cause of pregnancy loss, a study conducted by Burnett, Tammy & Lindsay (2013) that focused on the incidence of STIs among HIV positive women reveals that untreated STIs if not detected early among HIV positive women, can increase harm to the foetus hence leading to pregnancy loss.

A study conducted among HIV positive women in USA followed up from 2003 through to 2013 showed that out of the 414 pregnancies, 266 (64%) were complicated by a concomitant STI diagnosed during their pregnancy. STIs were diagnosed in the following proportions: Human Papiloma Virus (HPV) 44.6% (n=186), Herpes SimplexVirus (HSV) 16.2% (n=67), chlamydia 14.5% (n=60), trichomoniasis 14.5% (n=60), gonorrhea 4.1% (n=17), and syphilis 2.4% (n=10). Of the HIV infected women with concomitant STIs, most had one STI during their pregnancy (n=165) 62%; however 22% (n=59) of the women had two STIs, and 12% (n=32) had three or more STIs (Burnett et al, 2013). The study further revealed that HIV infected women who acquire a concomitant STI during pregnancy had a 2-fold increased risk of spontaneous preterm delivery and likely therefore Respiratory Distress Syndrome (RDS) hence highlighting the importance of routine STI screening in HIV infected women during pregnancy.

There are several factors that haveinfluenced the HIV-positive women's desire to bear children. Theseinclude: age; health status; cultural significance of motherhood; number of living children; previous experience of a child's death from HIV-related causes; the availability of HIV treatment and prevention of mother-to-child transmission (PMTCT) programs; the attitudes and influence of partners, family, and health care workers; and stigma and discrimination on the basis of HIV status especially for women coming from already marginalized populations (Nattabi, 2009). Spousal, family, community and cultural influences greatly shape the HIV-positive women's desire to become pregnant. Studies in India, South Africa, Taiwan and Vietnam have demonstrated the weight of culture-specific spousal and family

wishes that a woman will need to consider in addition to her own pregnancy desires and HIV status (Kanniappan, Jeyapaul &Kalyanwala, 2008).

Among HIV sero discordant couples, the desire for pregnancy has been shown to outweigh concerns about horizontal transmission. Studies conducted in South Africa, Tanzania and Ukraine by Rispel, Metcalf & Moody (2009) indicate that the sexual and reproductive choices of HIV sero discordant couplesare still poorly understood with a lot of service provider bias especially in supporting them to make reproductive choices. While research from Brazil suggests that cultural norms are important, and in some settings HIV-positive men may be more likely to want children than HIV-positive women (Paiva, 2007); at the same time, studies show women may not want to become pregnant for fear of infecting their children with HIV (Kanniappan, Jeyapaul & Kalyanwala, 2008).

The lack of safer conception counselling (SCC) as a glaring gap in the current state of services for people living with HIV/AIDS (PLHIV) across Africa is an impediment towards guiding the HIV positive women in making informed choices about their sexual and reproductive health (Kathy, Mindry& Beyeza-Kasheya, 2014). The lack of accessible supportive services negatively impacts HIV-infected women's ability to make informed reproductive health decisions and reduces the likelihood that HIV-infected men will employ risk reduction methods with their uninfected female partners. It also leads to delays and thereby reduces the efficacy of preventing mother-to-child transmission of HIV.

The United Nations convention of women (1979) gives all women the right "*to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights*."

For women living with HIV this principle requires providers, as noted by Wilcher & Cates (2009), to consider four reproductive possibilities i.e.; a) If a woman does not wish to become pregnant, she should be referred to or offered family planning services; b) If she wishes to become pregnant, she should be educated about the local infertility and prenatal services, the types of chemoprophylaxis available to reduce the risks of transmission to her child, and if in a serodiscordant relationship, HIV prevention approaches to minimise the risk of transmission to a partner when trying to conceive, c) If she is currently pregnant and wishes to continue her pregnancy, she should be offered the opportunity to obtain antiretroviral therapy to reduce HIV transmission risks (and for her own health), and d) If she is currently pregnant and does not wish to continue her pregnancy, she should be referred to safe abortion services. Postpartum contraception could be offered as an option for those who do not wish to become pregnant again.

It is therefore important to note that improved access to sexual and reproductive services not only allow women (including women living with HIV) control over their reproductive lives but also offers them safe fertility options but will have significant public health benefits from improved maternal and infant morbidity and mortality. When HIV positive women are denied access to these services,

2.3 The Context of SRH Services for HIV Positive Women

The sexual and reproductive health of women living with HIV/AIDS is fundamental to their well-being and that of their partners and children (WHO and UNFPA, 2006). Like any other women, HIV positive women have the right to access quality sexual and reproductive health (SRH) counselling services to avoid unintended pregnancies and prevent HIV among infants. Access to quality SRH counselling services is anchored in the right-based approach for reproductive health that was first officially recognised at the United Nations International Conference on Population and Development (ICPD) in Cairo in 1994 (ICPD Program of Action, 1994).

Within this approach, HIV positive women have the right to make choices regarding their own sexuality and reproductive health as they respect the rights of others. They also have a right to access information and services to support them make informed choices that promote positive and quality sexual and reproductive health especially around pregnancy, parenthood, sexuality & relationships. However, despite this international commitment on SRH, it has taken a while for stakeholders and service providers to fully understand the sexual and reproductive health needs of HIV positive women as well as provide the necessary support needed (IPPF, UCSF, UNAIDS, UNFPA & WHO, 2008).

With a view of expanding coverage of SRH services for HIV positive women, the interagency framework on sexual and reproductive health and HIV/AIDSdeveloped by WHO, UNFPA, UNAIDS & IPPF (2006) highlights prioritized strategic programmatic linkages between services for SRH and HIV that are believed to

promote more efficient use of resources, and be better service provision from the service user's perspective. These include; a) improved access to and use of key HIV and SRH services; b) efficiencies in providing similar services jointly rather than separately; and c) reduced HIV-related stigma and discrimination within service provision.

This approach concurs with the WHO (2009) guidelines on reproductive choices for women with living HIV advocate for the following strategies towardsintegrating family planning into HIV services: (i) establishing mechanisms to ensure that the addition of family planning services does not compromise the quality and coverage of the base HIV service (service delivery); (ii) equipping providers and supervisors with the technical knowledge and skills to address the contraceptive needs of clients with HIV (health workforce); (iii) ensuring a steady supply of contraceptives in the HIV clinic (medical products and technologies); (iv) modifying HIV programme monitoring and information systems to capture routine data on family planning services provided (health information system); (v) advocating for a line item for family planning within the national HIV programme budget (health financing); and (vi) revising relevant policies and guidelines to reflect the role of family planning within HIV service delivery settings (leadership/governance).

Several governments have endeavoured to integrate SRH services within the continuum of care for people living with HIV having recognised that with the advent of ART, the sexual health of many HIV positive women had been restored and quite a big number were falling pregnant unintendedly (TASO, 2007). The package that

mirrors (WHO, 2006 and 2013 guidelines) includes prevention, diagnosis, counselling, treatment and care services relating to: a) Antenatal, perinatal, postpartum & newborn care; b) Family planning services including infertility and contraception; c) Elimination of unsafe abortions; d) Prevention & treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc and e) Promotion of healthy sexuality.

Within the context of the rights based approach, this implies that the relevant governments and stakeholders should provide relevant knowledge, skills and resources to HIV positive women who in turn will endeavor to behave responsibly and make informed choices about their sexual health (Shaw, 2006).

In Kenya, the unmet need for family planning among HIV positive women and men was estimated at 60% in 2007 according to the Kenya AIDS Indicator Survey (KAIS), (2007). The integration of family planning and reproductive health services into HTC presents an opportunity for persons receiving HTC to make decisions regarding the number, spacing, and timing of pregnancies, and the use of contraceptive methods (The National Reproductive Health and HIV&AIDS Integration Strategy, 2009). The Ministry of Public Health, through the Division of Reproductive Health (DRH), and the Department of Obstetric Services in the MOMS, are addressing this challenge through the integration of FP and HIV services in all health care facilities.

The national reproductive health strategy and policy (2009 – 2015) has been developed that aims at ensuring improved coordination and collaboration among key

agencies and organisations offering RH and HIV/AIDS services in order to meet the needs of clients. Among the strategies employed is quality provision of SRH services and ensuring that all service providers receive adequate training on reproductive health towards addressing the special needs of HIV-positive clients. The strategy also ensures that all service providers intensify the fight against stigma, discrimination, and other barriers so that all HIV-positive individuals have easy access to reproductive health (RH) and FP services throughout the country.

To date three main models of integration have been piloted in Kenya that have included; (i) integrating HIV services into family planning; (ii) integrating HIV services into post-natal care and postpartum family planning, maternal and child health (MCH services), STI care, cervical cancer screening, and services for youth and (iii) integrating SRH services into HIV prevention care and treatment services. The National Reproductive Health and HIV&AIDS Integration Strategy (May, 2009), the National Guidelines for HIV Testing and Counselling (2008) and the National Guidelines on Prevention of Mother-to-Child Transmission of HIV (2012) also provide guidance to the HIV/FP integration process.

A systematic literature review of HIV/AIDS and SRH linkages conducted IPPF, UCSF, UNAIDS, UNFPA & WHO (2008) reported that integrated services are considered beneficial and feasible, especially in the uptake of services in family planning (FP) clinics, HIV counselling and testing centres (C&T), and HIV clinics. But results from a five-country study of HIV/AIDS and FP integration in Ethiopia, Kenya, Rwanda South Africa and Uganda which examined the three models of

FH/HIV integration revealed that service providers needed to be trained on how to utilise a specific integration strategy and to systematically integrate the services. Other challenges experienced included regular stock outs of HIV testing kits, contraception supplies, and lack of IEC materials that would generate the demand of the services (World Bank, 2009).

There are other challenges that were noted in the study conducted by Integra Initiative (2012) within public health facilities in Kenya, Malawi and Swaziland which included impact on the integration of SRH and HIV services which included the high staff turnover in some health facilities and weak monitoring strategies of the SRH and HIV integration. The loss of staff with knowledge and skills in provision and tracking of integrated services resulted in delays in the initiation of new services such as pharmacy and laboratory services in Malawi which were essential for ART provision.

Overall, integrated services are now seen as a key strategy for overcoming missed opportunities of meeting the needs of overlapping target populations in HIV prevention and SRH services (World Bank, 2009). Moreover, there is widespread recognition that strengthening linkages between HIV/AIDS and SRH programs could lead to a number of important public health, socio-economic, and individual benefits, such as:

- improving access to and use of key HIV and SRH services;
- better access of PLHIV to SRH services tailored to their needs,

- reduction in HIV-related stigma and discrimination and improved coverage of underserved/vulnerable/key populations;
- greater support for “dual protection” (correct and consistent condom use to prevent HIV and unintended pregnancy;
- improved quality of care for all clients;
- decreased duplication of efforts and competition for resources;
- better understanding and protection of individuals’ rights;
- mutually reinforcing complementarities in legal and policy frameworks;
- enhanced program effectiveness and efficiency and
- better utilization of scarce human resources for health.

2.4 The Role of Counselling in the Provision of SRH to HIV Positive Women

According to the WHO (2009), Information and counselling are critical components of all sexual and reproductive health services to support women in making these choices and carrying them out safely and voluntarily. Counselling is an important prerequisite for the initiation and continuation of any family planning method and HIV positive women require additional care and counselling towards their reproductive health. Counselling for reproductive health assists HIV positive women in making decisions on such issues as the number, spacing and timing of pregnancies, use of contraceptive methods and infant-feeding practices and avoiding unintended pregnancies (UNFPA & WHO, 2006).

Counselling is an interactive process between the service provider and client; it allows for information exchange and support, so that clients can make decisions, design a plan, and take action to improve their health (WHO 2009). There should be

no incentives or coercion to adopt reproductive health practices or to use any particular method of contraception. If a woman is able to make an informed choice (preferably with her partner), she is more likely to be satisfied with the method she has chosen and continue to use it. Concerns around transmission of HIV and other sexually transmitted infections (STIs) warrants special consideration during family planning counselling.

The National Reproductive Health and HIV and AIDS Integration Strategy (2009) for Kenya indicates that within the CCCs counselling for HIV positive women should also include counselling on legal, treatment, and reproductive health rights. The services should also include provision of pills, condoms, injectables, implants, IUCDs, TL/vasectomy, cervical cancer screening, post-rape care (PEP + EC). This implies that service providers should be competent in counselling for all family planning methods with skills to tailor the counselling to the individual client needs, ensuring confidentiality and respect for all clients. Counsellors are expected to emphasise dual protection as a strategy to prevent both STI/HIV transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual method use), or by practicing abstinence. In addition, Counsellors need to explain to HIV-positive clients the risk of MTCT, as well as the benefits of FP. Both men and women should be encouraged to use FP services to make informed decisions about pregnancy and contraceptive measures appropriate to their HIV status. Family practice service providers should be able to discuss safer ways to get pregnant (i.e., minimizing the risk of transmitting infection to both child and partner).

The WHO & UNFPA (2006) guidelines on Sexual and reproductive health of women living with HIV/AIDS state that although the reasons women living with HIV/AIDS seek contraception are mostly the same as those for women not infected with HIV, there should be additional considerations in family planning counselling and for the selection of contraceptive methods by women living with HIV/AIDS. Further, more women living with HIV/AIDS should be assisted in choosing a contraceptive method and make an informed choice that is most suited to their situation and needs, including disease stage, treatment situation, lifestyle and personal desires as family planning services that are directly concerned with the outcomes of sexual health. The guidelines therefore advocate for the following approach towards family planning counselling for HIV positive women which should include;

- information about effective contraceptive methods to prevent pregnancy, including recommending dual protection;
- the effects of progression of HIV disease on the woman's health and the implications for planning a family;
- the risk of HIV transmission to an uninfected partner while having unprotected intercourse (for instance, when trying to become pregnant);
- the risk of transmission of HIV to the infant and the risks and benefits of antiretroviral prophylaxis in reducing transmission and
- information on the interactions between HIV and pregnancy, including a possible increase in certain adverse pregnancy outcomes

The National Family Planning Guidelines for Service Providers (2009) makes reference to the utilisation of a combination of specific counselling protocols and procedures which include;

"Greet, Ask, Tell, Help, Explain, and Return" (GATHER); "Rapport, Exploration, Decision making, and Implementation of decision," (REDI); and, more recently, The Balanced Counselling Strategy Plus (BCS+) (Population Council, 2012) which incorporates counselling, screening, and services for STIs, including HIV, within routine FP consultations. In general, counselling can be divided into three phases:

- Initial counselling on arrival. The provider describes all methods and helps the client to choose the method appropriate for him or her.
- Method-specific counselling prior to and immediately following service provision. The provider instructs the client on using the method and discusses common side effects with him or her.
- Follow-up counselling during the return visit. The provider discusses with the client the use of the method, the client's satisfaction with the method, and any problem that the client might have experienced.

The Table 2.1 below presents a summary of the counselling protocol adapted from The Balanced Counselling Strategy Plus (BCS+) (Population Council, 2012);

Table 2.1: A Summary of the FP counselling protocol

Pre-Choice Stage	Method Choice Stage	Post-Choice Stage	Systematic screening for other services
Step 1. Establish and maintain a warm, cordial relationship.	**Step 7.**A brief review of the methods and their effectiveness.	**Step 10.** Discuss the method chosen with the client, using the method brochure as a counselling tool. Determine client's comprehension and	**Step 13.** Using information collected previously; determine client's need for postpartum, newborn, and infant care or well-child services.

Pre-Choice Stage	Method Choice Stage	Post-Choice Stage	Systematic screening for other services
		reinforce key information	
Step 2. Inform client that there will be an opportunity to address other health needs after family planning needs are addressed.	**Step 8.**Ask the client to choose the method that is most convenient for her/him.	**Step 11.**Making sure that the client has a definite decision. Give him/her the method chosen and/or a referral, and back-up method, depending on the method selected.	**Step 14.** Ask client when she had her last screening for cervical cancer (VIA/ VILI or pap smear).
Step 3. Ask client about current family size, desire to have more children, and current contraceptive practices. Counsel the client on Healthy Timing and Spacing of Pregnancy using counselling card. If client is currently using a family planning method, ask about her/his satisfaction with it and interest in continuing or changing the method.	**Step 9.**Using the method procedure checking if the client has any conditions for which the method is not advised.	**Step 12.**Encourage the client to involve partner(s) in decisions about/ practice of contraception through discussion or a visit to the clinic.	**Step 15.** Discuss STI/HIV transmission & prevention and dual protection with the client using the counselling card. Offer condoms and instruct her/him in correct and consistent use.
Step 4. Rule out pregnancy using the checklist to be reasonably sure a woman is not pregnant			**Step 16.** Conduct STI and HIV risk assessment using the counselling card. If symptoms are identified, treat her/him syndromically
Step 5. Display all of the method cards. Ask client if she/he wants a particular method.			**Step 17.** Ask client whether she/he knows her/his HIV status.
Step 6. Ask all of the following questions. Set aside method cards based on the client's responses.			**Step 18.** Give follow-up instructions or procedures or information brochure for methods chosen and set date for next visit
			Step 19. Thank her/him for the visit. Complete the counselling session.

Source: The Balanced Counselling Strategy Plus (BCS+)

(Population Council, 2012)

The Balanced Counselling Strategy Plus (BCS+) (Population Council, 2012) which advocated for in the Kenyan policy, is an interactive, client-friendly approach for

improving counselling on family planning and prevention, detection, and treatment of sexually transmitted infections (STIs) including HIV.

Under each step above there are specific procedures a counsellor is expected to follow. For women who intend to become pregnant, they should be made aware of the additional risks pregnancy may have on both her own health and the infant's health. The extent to which this protocol is fully implemented at the CCCs is yet to be established.

2.5 Factors Promoting or Hindering the Utilisation of SRH Counseling Information and Services Provided to HIV Positive Women

Whereas access to integrated SRH/HIV services is seen as crucial towards improving the quality of the family planning services and enables providers to address clients' needs related to STIs and HIV during the same consultation, there are some factors that impacting on HIV positive women's access to these services. Women living with HIV face problems in accessing appropriate services which meet their specific sexual health needs, which are rarely understood or addressed by health service providers. These factors whether socio-cultural, religious, arising from service providers or self imposed do not differ a lot from what HIV negative women would encounter though they could have a big impact on their sexual health as described below;

Stigma and discrimination

Most women living with HIV/AIDS suffer or fear stigmatization (WHO and UNFPA, 2006). Forms of stigma and discrimination include: perceptions that women living with HIV/AIDS as promiscuous; being deemed irresponsible if they desire to have children; blame for bringing HIV into a relationship or family; and being considered as vectors of HIV transmission to their children. With some of these perceptions, some health care workers maybe hesitant to provide care for women living with HIV/AIDS because of fears of HIV transmission. Because of the stigma and discrimination so often attached to HIV, it is particularly important that health service providers be able to protect the reproductive rights of women living with HIV. These rights include having access to sexual and reproductive health services and sexuality education, being able to choose a partner, deciding whether to be sexually active or not and deciding freely and responsibly the number, spacing and timing of their children. Women also have the right to make these decisions free of discrimination, coercion and violence (ICPD, 1994).

Service provider attitudes

The negative attitudes or biases that health workers may have towards women living with HIV/AIDS, particularly regarding their sexual and reproductive health practices could be another impediment. They can also be confronted with fear and judgmental attitudes of health workers, who may pressure them to abort, be sterilized, or use contraception because they think that people with HIV should not have children due to the possibility of vertical transmission. It's therefore important to involve peer counsellors and support groups involving other women living with HIV/AIDS as a powerful and positive influence and assist women and their families in coping with

HIV and with stigma and discrimination as well as access SRH services(WHO and UNFPA, 2006).

Lack of disclosure to partners

Where there is not partner disclosure, women living with HIV may not be able to access SRH services. Couple counselling regarding sexual choice can reduce tensions between partners and enable both partners to make sexual and reproductive choices together as partners in a relationship. Mediated disclosure to partners can be explored if the women concerned are in agreement. Counselling and information for men with HIV must include family planning, the risk of transmission of HIV to uninfected partners and to infants, antiretroviral therapy, condom use and dual protection. It also encourages male involvement in decision making. (WHO & UNFPA, 2006).

Socio-cultural factors

Socio cultural factors are crucial in determining the nature of sexual relationships, sexuality and sexual behaviour, and vary hugely across and within countries. Women in particular may have to deal with pressure from their families to have or not have children, challenges in negotiating safer sex and issues around disclosure. That withstanding, issues around sex and sexuality are taboo in most cultures, which leads to a reluctance to discuss and address sexual health issues. This also leads to stigma of those who do not conform to socially accepted norms of behaviour, for example HIV positive women, adolescents and young people who have sex before marriage. This in turn reduces access to SRH services by these groups (WHO & UNFPA,

2006). Involvement of men and the greater community is important to counter cultural norms that limit women's ability to control their own sexual and reproductive health and subject women to harmful practices. However, men's involvement in sexual and reproductive health services is generally low, and specific outreach activities may be needed to promote and facilitate the participation of men, both as individuals and as a partner in a relationship.

Traditional practices and beliefs and religion

Many studies have documented how traditional practices and beliefsalso affect access to services. For example, in many countries it is standard practice to seek the services of traditional healers over public health service providers, in particular for SRH issues; a study in India found that many pregnant women preferred services of a lay attendant to those of a midwife (Matthews, 2005). Religionhas had a major influence in the field of SRHR, where tit advances particular sexual & reproductive rights.

Gender norms

In most societies tend there is male dominance while women play the passive role making them vulnerable in different ways to SRH problems and inhibiting access to services. For example, men may take risks in their sexual relations that expose them to HIV and STIs, and may be reluctant to seek services (which are often focussed on women).

Economic dependency

Women are often economically dependent on men, and have limited power to claim their SRH rights, for example through condom use, or determining resource use for accessing services. It is also often culturally unacceptable for women to express sexuality, which for example could make them unwilling to seek condoms. Violenceagainst women has direct effects such as increased risk of STIs/HIV, as well as indirect such as fear of accessing services, requesting use of condoms (Griffin, 2013).

Poverty& Infrastructural challenges

Poverty is a key factor excluding many from accessing services. For example, studies have found that access to a skilled birth attendant at delivery is over 3 times higher for women in the richest quintile than those in the poorest in sub-Saharan Africa, and 8 times higher in South Asia (Greene 2005 as cited by Griffin, 2013). Poor communications and transport infrastructure can be important in preventing access to services in rural areas, especially in maternal health care where transport to referral services is an essential component of dealing with emergencies and preventing mortality. A central principle of a rights-based approach to access is that of equity.

A huge challenge in attaining universal access is overcoming the existing inequity in access to services. Currently there is much evidence to suggest that although access may be increasing at a national level in some countries, access is not equal across different social groups. The list of factors could be more than what is mentioned here; however, it is worth noting that when HIV positive women are not supported

effectively there are several resultant effects. These include unsafe abortions unsafe abortions (those performed by unskilled providers and/or in unhygienic conditions), high rates of STIs, high rates of maternal deaths to due inadequate services and an increase in the number of the children born with HIV as a result of mother to child transmission.

2.6 Reflections on the Literature Review

The literature review has indicated that while all women have the same rights concerning their reproduction and sexuality, women living with HIV/AIDS require additional care, counselling and support during their reproductive life. The evidence indicates an increase in the number of pregnancies once HIV positive are initiated on treatment with a big percentage of unintended pregnancies many of which result in preterm labor. While the World Health Organization (WHO, 2007) and its UN partners recommend a comprehensive four-pronged approach for the prevention of mother-to-child transmission which include; Pillar One - Prevention of HIV in women, especially young women, Pillar Two - Prevention of unintended pregnancies in HIV-infected women, Pillar Three - Prevention of transmission from an HIV-infected woman to her infant and Pillar Four -Support for mother and family; the focus in many health care facilities has been on HIV testing to identify pregnant women already HIV-infected and provide them with antiretroviral treatment and PMTCT.

Prevention of unintended pregnancies among women living with HIV should be given equal importance in this framework. A study from Engender Health (2008)

conducted in Uganda revealed that nearly all contraceptive methods are safe and effective for women living with HIV including those on antiretroviral treatment and can ably contribute to the reducing illegal and unsafe abortions, reduce the number of HIV-positive births as well as HIV-related infant and child deaths.

CHAPTER THREE

MATERIALS AND METHODS

3.1 Study Design

This study design was a case control study employing both quantitative and qualitative methods of data collection to meet the objectives of the study. Kaelin &Bayona (2004) define a case control study as an analytical epidemiological study design in which individuals who have the disease or phenomenon under study, also called cases, are compared to individuals free of disease (controls) regarding past exposures. Exposure differences between cases and controls are helpful to find potential risk or protective factors. The purpose is to determine if there are one or more factors associated with the disease or phenomenon under study. This study therefore involved selecting randomly a sample size of two groups defined by outcome measures, one consisting of cases and one consisting of controls. The study compared outcomes between the HIV positive women who got the SRH counseling intervention and those who did not get the SRH counselling intervention. The selection of cases and controls is discussed comprehensively in the next sections.

3.2 The Study Area

The study area of interest was Lang'atawhich lies in the suburb of Nairobi County, south west of the city centre and covers an area of 223 km², with a total population of about 368,274 people.

The Kenya Essential Package for Health (KEPH) as introduced by the National Health Sector Strategic Plan (NHSSP) II (2005 – 2010) advocates that all health care facilities (from level 1- the community level service delivery to level 6 – specialized

tertiary hospitals) should focus on the provision of comprehensive, integrated curative and preventive health services, available at the first point of contact and accessible to all including integrated reproductive health services.

3.2 Study Site

The CCC selected for this study was located in a hospitalthat has been providing SRH counselling and antenatal services, as an intervention or part of an intervention to HIV positive women for over 3 years with proper and documented evidence in the Langata. The selection was determined based on aspects of accessibility, location and the number of HIV positive women accessing the facility. Currently, the hospital offers more services which include Curative In-patient Services, Antiretroviral Therapy, Family Planning, HIV Counselling and Testing and immunization. HIV prevention, care and treatment services in the health care facilities especially the sub district and district hospitals are provided for at the Comprehensive Care Centers (CCCs) since 2005.

3.3 Study Population

The study population included sampled adult HIV positive women aged 18-49 years that visited the CCC within the selected health care facility in Langata for sexual and reproductive health services during the period defined for the study. In the context of this study, the focus was on the prevalence of unplanned pregnancies and STIs amongst HIV positive women that have undergone SRH counseling as compared to those that have not undergone SRH counselling to help determine the impact of SRH counselling towards supporting HIV positive women in making informed decisions

and choices on their reproductive health, particularly pregnancy. The study also targeted sampled HCT service providers that provide services to the HIV positive women at implementation level i.e. Officer in Charge of the counselling Coordination Centre, the Nurse counselors in charge of PMTCT, the HIV/AIDS Clinic, the Breast and Cervical Cancer clinic, the Pharmacy and the Senior Counselor for the SRH Unit.

3.3.1 Case Definition

A case defined for this study was an HIV positive woman, aged 18-49 years that became pregnant and had attended the CCC for antenatal services between January and December of 2013 at the selected health facility for not less than three times. The cases may or may have not have undergone SRH counselling. The study also focused on HIV positive women that attended the CCC and were diagnosed to have one or more STIs such as syphilis even though they may or may not also have undergone SRH Counselling at the CCC. Syphilis of significance interest in this study given that its recommended by WHO (1999) to be part of the antenatal STI screening using a clinic-based serological test so that results could be available. In summary, cases were HIV positive women that attended the CCC and had unplanned pregnancies and/or STIs.

3.3.2 Definition of Controls

A control defined for this study were an HIV positive woman aged 18-49 years, living in Langata and that may or may have not been exposed to SRH Counselling between January and December, 2013and never acquired an STI or an unplanned pregnancy.

3.3.3 Inclusion criteria

a) The CCC was selected on the basis that it must have been providingSRH counselling and antenatal services, as interventions or part of the interventions for HIV positive women for atleast three years;

b) Evidence was soughtthrough the use of programme evaluation reports and records for SRH counselling interventions, antenatal services and the number of clients that have been served overtime;

c) The study involved HIV positive women that are aged between 18 and 49 years who come to access SRH services and antenatal services at the CCC.

3.3.4 Exclusion criteria

a) The study did not includeall pregnant women who were HIV negative.

3.3.5 Thematic presentation of the study population

The diagram below shows how the groups were selected in the case control;

Table 3.2: Examining unplanned pregnancies among HIV positive women

HIV positive women	**Cases**	**Controls**
	Got Pregnant	**Did not get Pregnant**
Exposed to SRH Counselling	**A**	**B**
Not exposed to SRH Counselling	**C**	**D**

Table 3.3: Examining STIs among HIV positive women

HIV positive women	**Cases**	**Controls**
	Got STIs	**Did not get STIs**
Exposed to SRH Counselling	**A**	**B**
Not exposed to SRH Counselling	**C**	**D**

3.4 Sampling Techniquesand Sample Size Determination

3.4.1 Sampling Techniques

Selection of Cases

A census was conducted first of all to determine the number of HIV positive women that accessed the CCC for antenatal services between January 2013 and December 2013using the patients' records. During this census, HIV positive women that had attended the CCC that had been diagnosed with STIs were also selected. A random sampling was used to select the participants of the study based on the set criteria as long as they consentedto participate in the study. A coding system was utilized for each of the participants selected to participate in the study.

Selection of controls

Using a sampling frame, controls were selected for HIV positive mothers that are matched with the same age group as with the case(s) who attended the antenatal clinic at the CCC. The study ensured there is at least one control for each of the cases. Two separate sampling frames were developed with one for the cases and the other for the controls. The participants were assigned code numbers which were used in the sampling frame for confidentiality. Code numbers such as IA0010808, IA0020808, and IA0030808 were assigned to the cases and code numbers such as ND0010808, ND0020808, and ND0030808 were assigned to the control. These same codes were used for data collection.

3.4.2 Sample size determination

After identification of the cases of interest in the source population, (e.g. from vital data, registry data) at the CCC a relatively large sample size of 142 participants (71 cases and 71 controls) was estimated using the modified Kish(1965) formula. Previous studies have indicated that the prevalence of pregnancies among HIV positive women ranges from 20-30% while that of STIs is as low as 5% (KAIS, 2008). Therefore, with assuming a power of $Z\beta$at 80% (0.84), and detecting at an Odd Ratio (OR) of 2 or greater; with $Z\alpha$=1.96, r=1(implying equal numbers of cases and controls), proportion of controls exposed as 30%(0.3); the sample size has been calculated using the formula below.

$$n = (\frac{r+1}{r}) \frac{(\bar{p})(1-\bar{p})(Z_{\beta} + Z_{\alpha/2})^2}{(p_1 - p_2)^2}$$

To get the proportion of cases exposed or the attributable fraction,

$$P_{\text{cases exposed}} = \frac{OR * P_{\text{controls exposed}}}{P_{\text{controls exposed}} (OR-1) +1}$$

This implies the $P_{\text{cases exposed}} = \frac{2 * 0.3}{(0.3)(2-1) + 1} = 0.461$

Average proportion of exposed = (0.461 +0.3)/2 = 0.38

The sample size (n) therefore was calculated as follows:

$$\frac{0.38 (1-0.38) (0.84 +1.96)^2}{(0.461 - 0.3)^2} = \frac{1.8471}{0.0259} = 2 * 71 = \mathbf{142}$$

Therefore **n= 142 (71 cases and 71 controls)**

3.4.3 Purposive Sampling techniques for SRH counseling providers

The purposive sampling technique was used to select those service providers that are involved in SRH counseling and the managers of the CCCs. A list of health facilitySRH counselors or service providers was prepared with the assistance of the in-charges, and they were approached to participate in the study.

Six SRH Counselling providers participated in the study through key informant interview and these included the Manager in Charge of the CCC, the officer in charge of the SRH Unit, the Senior Counsellor in charge SRH Counselling and 4 nurse counsellors (who handle patients on a day to day basis) and have firsthand knowledge about the SRH counselling at the CCC. These experts, provided insight on the nature of problems and gave recommendations for solutions. The details are presented in Chapter four of the findings. Service providers who consented to participate in the study were asked to select a time convenient for them to be part of the data collection process.

3.5 Data Collection Procedures, Instruments and Techniques

In this study, both quantitative and qualitative methods of data collection were employed. The methods included; administration of questionnaires, conducting exit interview for both the SRH service providers and HIV positive women and if required, observation of counseling sessions. Data collection for quantitative data was done through the administration of questionnaires to HIV positive women (cases and controls). It focused on specific thematic areas for sexual and reproductive health as well as the procedures involved in provision of SRH counselling services to PLHIV at the Comprehensive Care Centres in making reproductive choices.

3.5.1 Quantitative Methods of Data Collection

Administration of questionnaires:

The main mode of data collection included administration of questionnaires given to selected HIV positive women (cases and controls) at an appropriate time. These could be administered in a supervised or non-supervised setting. Where participants may experience difficulty in interpreting the questionnaires, these tools were administered by the research assistants to ensure accuracy and completeness of the tool. Questionnaires consisted of a section on the demographic data of the participants semi-structured and structured questions for the respondent based on the variables of choice. All the filled in questionnaires were collected immediately and verified to ensure that all sections have been filled.

3.5.2 Qualitative Methods of Data Collection

Conducting Key Informant (KI) interviews with SRH Counselling providers at the CCCs:

Key informant interviews were conducted with the SRHCounsellingproviders to help describe the counseling process provided to HIV positive women, how the SRH counseling services are implemented and explore the factors that promote or hinder the utilisation of SRH counseling information and services provided to HIV positive women at the selected Comprehensive Care Centre within the government health facility in Langata.

Conducting In-depth focus group discussions (cases and controls):

In-depth focus group discussions (FGD) were held with selected participants from the controls and cases to obtain views and on the SRH counselling process, counselling sessions and factors that hinder or promote the utilization of the SRH information they have received. Five groups were formulated that comprised 8 – 11 HIV positive women who were selected with the help of the nurse counselors who have access to patients' records as per the categories listed below. Further support was provided by the CCC staff to help locate the women. The categories therefore included the following;

- Group 1 comprised of HIV Positive women who were exposed to SRH counselling but got pregnant (10);
- Group 2 comprised of women who were exposed to SRH counselling but never got pregnant (11);
- Group 3 comprised of HIV positive women who had been diagnosed with STIs (Syphilis) during pregnancy but had been exposed SRH counselling (8);
- Group 4 comprised of HIV Positive women who underwent SRH counselling but were not diagnosed with STIs (Syphilis) during pregnancy (9);
- Group 5 –constituted HIV Positive women that were never exposed to SRH counselling but got pregnant and had been diagnosed with STIs (9).
- The idea was to encourage participants to speak more freely and to explore the effectiveness and impact of SRH counselling they have received.

Coding sheets were developed for each category of Key Informants' interviews and FGDs. With consent, audio visual equipments were utilized to record the FGD sessions and key informant interviews.

3.5.3 Training of Research Assistants

Four short listed research personnel fluent in English and Swahili were recruited to support the data collection process by ensured accuracy and completeness of the research tools. Where consent was provided, they acted as external assessors to observe the SRH counselling sessions and also interview both clients and SRH Counselling providers. The selection of the research personnel was based on previous experience in research work; and previous experience as SRH counselling. All the research personnel had to also possess basic knowledge on the SRH. The training was for one week based on the MOH-SRH counselling protocol and procedures deemed necessary to carryout observation of counselling sessions and key informant interviews as well as in-depth focus groups discussions.

The training covered background information about the integration of SRH into HCT services, and general interviewing procedures (chronology and probing). An overview of qualitative research methods was done with an emphasis on the use of in depth interviews in data collection. The training also focused on obtaining consent, maintaining neutrality, privacy issues, personal relation and ethics in research.

3.6 Quality Assurance and Control Before and During Data Collection

In order to evaluate the questions and checklists before the study, data collection tools were pre-tested and modified accordingly using a site that has similar qualities and characteristics. The questionnaire was pre-tested using five cases and ten controls at another CCC in Langata to:

- Determine the length of time required;
- Check the logical sequence of questions;
- See the clarity of wording and simplicity of the language;
- Reduce some biases as a result of un- standardized questions;

Problems faced during the pretest were presented by the data collectors/ research assistants and modifications were made to the questionnaire which was then used to collect data for the main study. The pre-tested data collection tools i.e. the checklists, KI guides and the FGD interview questionnaires was administered by trained research personnel to ensure that all questions are answered consistently and correctly.

3.7 Data Management

Once the data was collected, each interview and FGD transcript was checked against the original recording by the lead researcher. Detailed feedback was given to the research assistant in the earlier interviews and the transcriptions were rechecked to ensure that the feedback was incorporated. Subsequent transcriptions improved in quality and did not require detailed feedback incorporation. Facilitators and note takers for the FGDs were given detailed orientation to the purpose and objectives of the study, and the expected outcomes of the FGDs. Facilitators of the FGDs were

given feedback on how they can sharpen their probing and exploring in subsequent FGDs, based on the checking of the transcriptions. The audio recordings were coded and transcribed to provide data that complimented the analysis process. Two researchers coded each interview and FGD transcripts and the data is presented within the findings.

3.7.1 Quality ControlafterData Collection

There were daily checks for the data at the end of each day data to ensure that the data delivered is of high quality, is complete and correct. The research team also shared experiences on the collection process and how it can be improved.

3.7.2 Handling of Missing Data

The questionnaire and checklists were filled in by the researchers in order to ensure that all relevant questions are filled in. The recording of the KI interviews or workshops ensured retrieval of information that had not been captured during note taking.

3.8 Data Analysis

3.8.1 Quantitative Data Analysis

Responses contained in a cleaned questionnaire were entered into a data entry template using the latest version of the Statistical Package for the Social Sciences (SPSS 18) version. Data was entered in SPSS and validated before analysis wasdone. Both descriptive and inferential analyses were employed in comparing the social, economic and obstetric backgrounds of cases and controls. Given that the data

obtained was categorical, Chi squares and Odds ratios were used to test the hypotheses on differences in the socio-demographic characteristics, economic characteristics and reproductive history between cases and controls. The level of significance used was at p= 0.05 and p=0.01. Graphical presentation such as tables, graphs and pie charts was utilized to present the results and to illustrate the findings.

3.8.2 Qualitative Data Analysis

Qualitative data obtained from recorded interviews by the help of interview guides, was decoded, transcribed and arranged into thematic areas. Qualitative data analysis software called Nvivo was used to help speed up the process of data analysis and so that the findings can be shared accordingly.

3.9 Ethical Consideration

3.9.1 Ethical Clearance

Ethical clearance for the study was obtained from the KEMRI Ethics Review Committee, the KEMRI/SSC Committee and the study allocated the following number - **KEMRI/SSC/2706.** The approval lettersareincludedin the appendix. Permission to conduct the field study was also sought from Langata Health Offices and Health facility managers and the approval letter provided. Informed consent was sought for all participants in order to be eligible to participate in the study, an example of the consent form is also appended in this documents.

3.9.2 Consent Explanation

Informed consent

An informed consent form fully explaining the purpose of the study was presented to participants and a written consent obtained before any observations or interviews take place *(See Appendices 1 for copies of the consent forms)*. Clients consented voluntarily and were not coerced or pressured to participate in the study. For those that were unwilling or felt uncomfortable about participating in the study, their requests to opt out were respected.

Conditions for withdrawing

Even after consenting to participate in the study, the respondents were given an opportunity to voluntarily withdraw from the study at anytime without consequences of any kind and also have an option of removing their data from the study.

3.9.3 Confidentiality

Strict confidentiality was maintained throughout data collection and analysis by use of anonymous identifiers only known to the research team. It was extremely important that participants' privacy (confidentiality) be protected. Participants' serostatus was considered the most confidential of information and was protected at all times. Audio recordings were only used for verifying KI/workshop discussions and weredestroyed or erased after they have been used to clean, edit and retrieve the required data.

CHAPTER FOUR

RESULTS

4.1 Social Demographic Characteristics of The Respondents

4.1.1 Age of the respondents

The age of the respondents ranged from 18 years to 49 years where 80.3% of the cases and 74.6% controls were aged 39 years or younger as shown in Table 4.4.

Table 4.4: Social DemographicCharacteristics

		Cases N=71)		**Controls (N=71)**	
Demographic Factor	**Category**	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)
Respondent's Age	18-29	21	29.6%	24	33.8%
	30-39	36	50.7%	29	40.8%
	40-49	14	19.7%	18	25.4%
Highest Education Level	None	0	0%	0	0%
	Primary	13	18.3%	14	19.7%
	Secondary	35	49.3%	40	56.3%
	University	23	32.4%	17	23.9%
Marital Status	Married	48	67.6%	34	47.9%
	Never	13	18.3%	17	23.9%
	Separated	5	7%	17	23.9%
	Widowed	5	7%	3	4.2%
Employment Status	Employed	42	59.2%	34	47.9%
	Not Employed	11	15.5%	22	31%
	Part timer	18	25.4%	15	21.1%
Time since HIV Diagnosis (Months)	0-11	0	0%	2	2.8%
	12-23	17	23.90%	23	32.40%
	24+	54	76.10%	46	64.80%

4.1.2 The Education Level of the Respondents

The results in table 4.4 indicate an almost equal distribution for the highest level of education among the cases (81.7%) and controls (80.2%) for secondary level and university level of education implying that over 80% of the HIV positive women that participated in the study could ably read and write.

4.1.3 Marital Status and Employment

While 67.6% of the cases were married women, only 47.9% of the controls were married and presumed to be involved with a steady partner. The findings also show that more controls were separated at 23.9% as compared to 7% of the cases. In terms of employment, the data indicates that most of the cases and controls had some form of employment with only 15.5% of cases and 31% of controls not employed.

4. 2 Accessibility to Sexual and Reproductive Health Counselling services at the CCC

4.2.1 Period and frequency for attending the CCC since HIV diagnosis

An analysis was done to examine the period within which the HIV positive women had been receiving services from the HIV prevention care and treatment facility since HIV diagnosis. The findings show that all cases had been receiving HIV prevention care and treatment services at the health facility for more than a year. Only 4.2% of the controls had received HIV prevention care and treatment services in less than a year since HIV diagnosis as indicated in table 4.5.

Table 4.5: Period for attending the HIV prevention and treatment facility

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Category		Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)
Period receiving services from an HIV prevention care and treatment facility	Less than 1	0	0%	3	4.2%
	1-2 years	25	35.2%	36	50.7%
	3-4 years	25	35.2%	31	43.7%
	Above 5 years	21	29.6%	1	1.4%
Times, you came to the facility	1-5	69	97.2%	69	97.2%
	6-10	1	1.4%	2	2.80
	11-15	0	0%	0	0%
	16-20	0	0%	0	0%
	Above 21	1	1.4%	0	0%

The frequency of the visits by the HIV positive within the period marked for this study (January – December 2013) was also analyzed and the results show a close match for 1-5 times in a year for cases and controls at 97.2%, (SD = 30.63). Only one person among the cases had visited the CCC for more than 5 times in one year, the reasons for this frequent attendance could not easily be established as indicated in the table 4.5.

4.2.2 Accessibility to Sexual and Reproductive Health Counselling services

This study sought to find out how many HIV positive women had accessed SRH counselling services as part of their HIV prevention care and treatment package at

the CCC. Out of the 71 casesand 71 controls, more cases (62%) had accessed SRH counselling services as compared to the controls (54.9%) (Table 4.6).

Table 4.6: Accessibility to SRH counselling services

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Categories		Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)
Have you ever accessed counselling regarding sexual reproductive health	Yes	44	62%	39	54.9%
	No	27	38%	32	45.1%

The findings in figure 2 and figure 3 show that more women aged 30-39 years were seeking the SRH counselling services among the cases (32.39%) as compared to controls 25.35%). Among the controls, the access to SRH counselling significantly dropped to 8.45% among the 40-49 year olds as compared to the cases 12.68%.

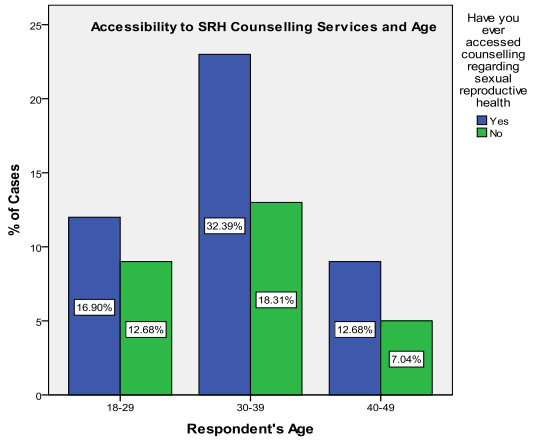

Figure 2: Accessibility of SRH counselling Services among Cases

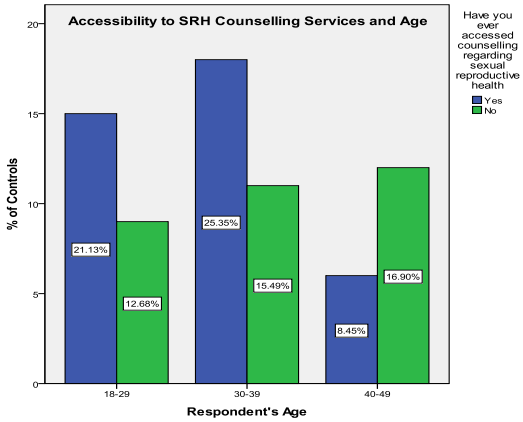

Figure 3: Accessibility of SRH counselling Services among Controls

4.2.3 Number of sexual partners in the past six months

While in table 4.4 some of the HIV positive women stated that there were single and not married as per the marital status, the findings in table 4.7 show that over 92.96% of both cases and 85.92 controls had been involved with a sexual partner in the last six months. This indicates that irrespective of the marital status, a number of women were involved in sexual activity with some partners.

Table 4.7: Number of partners and type of relationship in the past 6 months

Descriptive Factor		**Cases (N=71)**		**Controls (N=71)**	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
No. of partners in the past 6 months	One partner	66	92.96%	61	85.92%
	More than one	2	2.82%	4	5.63%
	No Response	3	4.23%	6	8.45%
	Total	71	100%	71	100%

Reasons for this behavior were partly linked to the unmet need for sexual desires among the HIV positive women as indicated in the interview extract below;

> R1: "Hmm…the problems are general such as making the right choices to satisfy ones' sexual desires …"
> R6: "[*adds*]...for example when one feels like having sex and the partner is not willing as thus they are left with a choice of looking for other partners who may be infected too and not want to use protection to make sure that the sexual need is addressed".
>
> **Source: Interview Data from FGDs with HIV Positive Women**

4.2.4 Partner Disclosure of HIV status

There was a significant number of HIV positive women among the cases (19.7%) and controls (15.49%) whose partners did not know their HIV status as indicated in table 4.8.

Table 4.8: Partner disclosure of HIV status

Descriptive Factor		**Cases (N=71)**		**Controls (N=71)**	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
Disclosure of HIV status	Partner knows HIV Status	50	70.42%	50	70.42%
	Partner does not know HIV Status	14	19.72%	11	15.49%
	No response	7	9.86%	10	14.08%
	Total	71	100%	71	100%

This lack of disclosure of the HIV status to the partner implies that some of the HIV positive women still have personal fears hinderingthem from disclosing their HIV status to their partners, which could be related to fear of divorce, violence, blame among others as indicated in the interview data below;

> R3: “My fiancé broke our engagement when he discovered that I was attending the clinic, despite his knowledge of my status. My sexual desires are therefore not being met especially after I insisted on using contraceptives (condoms) during sex with my fiancé” ….
>
> **Source: Interview Data from FGDs with HIV Positive Women**

With the resultant effects mentioned above, it may take time for some HIV positive women to disclose their HIV status despite the SRH counselling they may have received.

4.2.5 Reasons for accessing sexual and reproductive health counselling services

Interview data from the key informants indicated that there were various reasons as to why HIV positive women visited the health facility regarding their sexual and reproductive health as expressed in the extracts below;

> R8: "We come to the CCC for contraceptives, counseling, and collection of drugs, HIV+ children clinic, breast and cervical cancer clinic, nutrition counseling, among other services".
> R5: "We also come for pregnancy related counseling, especially at the PMTCT clinic..."
> R7: "…and for STI screening".
>
> **Source: Interview Data from FGDs with HIV Positive Women**

After the analysis of all interview data obtained from KIs & FGDs, the following list summarizes the reasons for accessing the SRH services;

- Counseling and psychosocial support
- Family planning knowledge including contraceptive and condom use.
- To obtain contraceptives
- Counseling on antenatal services, family planning needs and abortion related issues
- Counseling on post natal care
- Demonstration on the proper and consistent condom use
- Breast and cervical cancer counseling, opportunist infections, domestic and gender based violence.
- Medical support on prevention and treatment of STIs, breast and cervical cancer
- Counseling on sexual issues
- Maternity care including PMTCT
- Counselling on gender based violence issues,
- Weighing and evaluation of client condition
- To obtain information on sexuality and sex.
- Collection of drugs and other facilities
- Information education and communication (IEC), Counseling and psychosocial support.

Source: KI & FGD Interview Data

The list above shows a broad range of reasons which require theSRH service provider to be well prepared and knowledgeable in understanding of the SRH needs of the HIV positive women. One Nurse Counsellor mentioned that;

> S1: "HIV positive women access the counseling services to help them reduce the number of children who are being born and infected by HIV. Therefore, we as service providers should ensure that our role in providing necessary services is in accordance with guidelines and policies that guide the provision of SRH counseling services in this unit" ...
>
> **Source: Interview Data from KI interviews with SRH Service Provider**

Where the HIV positive women present a variety of reasons for accessing the CCC, this also calls for clear procedures and counselling protocols to ensure that their SRH needs are fully catered for and met during their visits at the CCC.

4.2.6 Sexual and Reproductive Health Services provided at the CCC

The findings from key informant interviews held with the in-charge of the CCC and the nurse counsellors revealed that service provision for SRH service for HIV Positive women follows on the guidelines provided by the Kenya National Reproductive Health and HIV&AIDS Integration Strategy (May 2009), the National Guidelines for HIV Testing and Counselling (2008) and World Health Organization (WHO) guidelines on integrating the SRH/HIV and AIDS (2009) to ensure quality care and treatment of all infected people as indicated by the female nurse counsellor in the interview extract below;

> S4: "The government and the hospital are also keen on reducing new infections and effective prevention strategies are implemented as per the national guidelines for Kenya on integrating the SRH/HIV into the services for HIV Positive women …"
>
> S2: "We use the Kenya National and World Health Organization (WHO) guidelines on SRH/HIV and AIDS counseling and testing. "…Yes, since some clients are still willing to have more children and there is need to prevent infected births…"
>
> **Source: Interview Data from KI Interviews with SRH Service Providers**

Interview data revealed that SRH services are provided particularly in the unit that is responsible for PMTCT and HCT counseling services. These services are accessed by HIV positive women, their men and couples and include family planning services including infertility and contraception, Antenatal, perinatal, postpartum & newborn care, elimination of unsafe abortions, prevention & treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc and promotion of healthy sexuality. Data from the respondents confirms that the following services are provided at the CCC as indicated in the table 4.9.

Table 4.9: Type of SRH Services provided at the CCC as per responses from Cases

Descriptive Factor		**Cases (N=71)**	
Categories	**Response**	**Frequency (n)**	**Percentage (%)**
Counselling for fertility intention, pregnancy planning and infertility concerns	Yes	63	90%
	No	7	10%
Provision of FP/Contraception methods	Yes	68	95.8%
	No	3	4.2%
Emergency Contraception Method	Yes	46	64.8%
	No	25	35.2%
Collection of Condoms	Yes	68	95.8%
	No	3	4.2%
Sexual and Reproductive Health Counselling	Yes	67	94.4%
	No	4	5.6%
Antennal care including PMCT services for already pregnant women	Yes	59	83.1%
	No	12	16.9%
Post Natal Care	Yes	58	81.7%
	No	13	18.3%
Prevention and treatment of breast and cervical cancer	Yes	45	63.4%
	No	26	36.6%
Treatment of STIs	Yes	58	81.7%
	No	13	18.3%
Pre-and Post abortion counselling	Yes	37	52.1%
	No	34	47.9%

Descriptive Factor		Cases (N=71)	
Categories	**Response**	**Frequency (n)**	**Percentage (%)**
Education on legal and ethical issues and human rights	Yes	68	95.8%
	No	3	4.2%
Premarital Counselling	Yes	40	56.3%
	No	31	43.7%

The findings indicatethat counselling is one of the main sexual and reproductive health services provided at the CCC in addition to other services that are known to be provided at the CCC.

4.3 Sexual and Reproductive Health Counselling at the CCC

4.3.1 The Sexual and Reproductive Health Counselling Process at the CCC

The provision of sexual and reproductive counselling is emphasised in the Kenya National guidelines on the integration of SRH into HIV and AIDS counselling and testing (2009:3, 16). In terms of the counselling process, the guidelines indicate that at all levels of SRH integration into HIV services, there should be risk assessment for pregnancy and STI/HIV infection; information giving and counselling on family planning methods; cervical cancer screening and referrals of clients to access services which many not be available at the HCT facility.

The SRH counselling process should include provision or education of the client on the scope of family planning services delivery; client assessment on their sexual and reproductive health needs; education on the effectiveness and safety of family planning methods to the client;assessment of the client's readiness to take up the family counselling; counselling on the quality of care, infection prevention; provision of pills, condoms, injectables, and implants and how they should be

utilised as well as providing an opportunity for cancer screening (the Kenya national family planning guidelines, 2010: 0).For example, the counselling procedure for family planning therefore advocated should take place in the following phases indicated in table 4.10;

Table 4.10: The Family/SRH Counselling Procedure

	Counselling phase	Suggested Approach to Counselling
1.	Initial counselling on arrival.	The provider describes all methods and helps the client to choose the method appropriate for him or her.
2.	Method-specific counselling prior to and immediately following service provision	The provider instructs the client on using the method and discusses common side effects with him or her
3.	Follow-up counselling during the return visit	The provider discusses with the client the use of the method, the client's satisfaction with the method, and any problem that the client might have experienced.

Source: The Kenya National Family Planning Guidelines (2010:54)

The guidelines recommend that for HIV positive women special considerations should be undertaken during counselling which should focus on;

- Safety of the family planning method when used by a person living with HIV/AIDS;
- Whether the chosen family planning method protects against STIs;
- Interactions between contraceptive methods and some drugsused in treatment for HIV/AIDS, including ARVs, and anti-TBdrugs;
- Knowledge and guidance on dual protection practices, withemphasis on the consistent and correct use of condoms orabstinence as the most effective means of protection. In thisregard, appropriate counselling messages depend

on the HIVstatus of the client or couple, whether HIV positive concordant or discordant.

At the time of the study and due to time constraints, it was not possible to observe the SRH counselling sessionsto examine how the Nurse Counsellors were utilizing the recommended procedureor scripted protocolsfor SRH counselling provided for in the toolkit and as per the national guidelines. This study rather focused on examining the SRH Counsellors' understanding of the counselling procedure and its major outcomes to the HIV positive women. Interview data on the Counsellors' understanding of the SRH counselling procedures revealed differences in terms of which SRH counselling protocol should befollowed when an HIV positive woman visits the facility to access SRH services. Extracts from the interviews held by three different service providers yielded the following variations in their understanding of the SRH counselling procedure asdescribed in table 4.11;

Table 4.11: Service providers understanding of the SRH Counselling Protocol

Nurse Counsellor A	Nurse Counsellor B	Officer in Charge
• Welcoming client • Assuring client of confidentiality/assuring client of any concerns they may have about the service • Registration • Preparation talk/getting to know the client • Assessing client's history based on the needed services • Involving client in understanding her/their condition and needs • Giving relevant counseling and advice as per clients' needs • Bidding client bye after giving any necessary IEC	• Registration on first come basis • Taking client's history • Preliminary diagnosis • Medical/ clinical services (referral on need) • Nutrition advice and services	• Registration on first come basis • Taking client's history • Preliminary diagnosis • Pre-test counseling (individual/couple/family/group) • Laboratory diagnosis • Post test counseling (individual/couple/family/group) • Referral to specialist care (if needed e.g. for pediatric, PMTCT services) or general medical care • Nutritional care services • Pharmacy (collection of drugs/ contraceptives/ other necessary resources • Collection of information and

materials and referral to relevant units		communication materials from the pigeon holes (all through the process)

Source: Interview Data from KI Interviews with SRH Service Providers

The findings indicate that some service providers have a different understanding of the SRH counselling procedure that should be undertaken for their clients who attend the CCC. This is also dependant on how much knowledge the service providers have of the SRH counselling process as well as their understanding of the clients' needs. The findings also indicate that the procedure undertakenduring counselling mainly depends on the circumstances and needs with which the client may present with therefore making it difficult for the counsellor to adhere to the proposed SRH counselling protocols in the national guidelines. Whereas the service providers mention the importance of follow-up of clients as recommended by the Kenya National Family Planning Guidelines (2010:54), interview data indicated that follow-upis usually not done as expressed in this interview extract below by the Nurse Counsellor:

> S2: "The issue of follow-up of the client is still poor as it is challenging to follow-up each of the clients. The hospital has so many clients but with very few community health workers who are working as volunteer. In addition, some of others clients do not come from the hospital catchment area and therefore it become challenging to follow-them up..."
>
> **Source: Interview Data from KI Interviews with SRH Service Providers**

4.3.2 The Competence of the SRH Counselling Service Providers

Whereas the data above indicated that there were gaps in understanding the counselling protocol, 95.8% of the cases and 66.2% of the controls found the service providers competent in their work. It was also noted that some of the HIV positive women had been forced to use particular methods for family planning as indicated in table 4.12.

Table 4.12: Competence of the SRH Service Providers

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
Did you find the service provider at the facility competent	Yes	68	95.8%	47	66.2%
	No	3	4.2%	24	33.8%
	Total	**71**	**100%**	**71**	**100%**
Provider forces clients to use particular treatment/method	Yes	18	25.4%	6	8.5%
	No	53	74.6%	65	91.5%
	Total	**71**	**100%**	**71**	**100%**

4.4 The Sexual Health and Behaviour of HIV Positive Women

4.4.1 Child bearing concerns among HIV Positive Women

Child bearing is often referred to as the right of every woman for reproduction and this study wanted to find out whether this was a critical SRH need among HIV positive women and how if counselling impacted in any way regarding making and informed choice. The findings presented in table 4.13 reveal that 61.97% of the cases and 66.2% of the controls did not want to have any children. For those that desired to have children, they preferred to have 1-2 children more in the cases (29.58%) as compared to the controls (28.2%).

Table 4.13: Number of children desired among HIV Positive Women

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Categories	**Variable**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**
Number of children desired	None	44	61.97%	47	66.2%
	1-2	21	29.58%	20	28.2%
	3-5	5	7.04%	4	5.6%
	No Response	1	1.41%	0	0%

A further analysis was done to find out if the age of the HIV positive women had an impact on the desire to have children among the cases and the controls. The findings in figure 4 and figure 5 show that the desire not to have children increases with age where older women aged 30-39 and 40-49 years do notdesire to have more children as compared to the younger women aged 18-29 years.

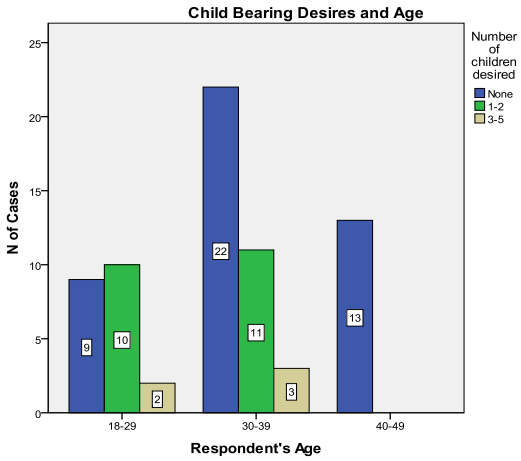

Figure 4: Child Bearing Desires among the Cases

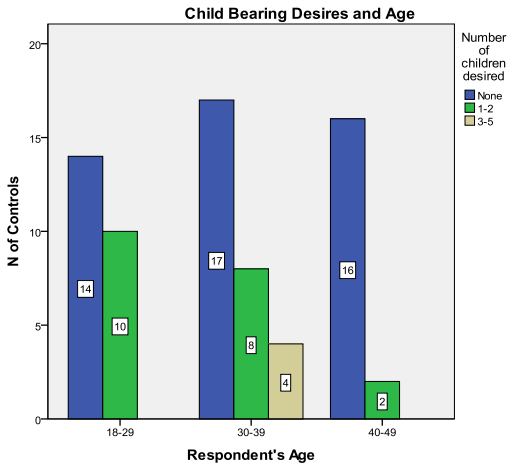

Figure 5: Child bearing Desires among the Controls

Several reasons are given by HIV positive women regarding their desire to have or not have children. The main reason for child bearing is attributed to having the right number of children in cases (40.4%) or the aspect of motherhood among the controls (22.8%) as indicated in table 4.14. There was also a significant number of mothers who indicated that they wanted to have children because they loved them in 15.4% of the cases and 12.3% of the controls. Those that did not want to have children among the cases (11.5%) and controls (19.3%) indicated that they were not ready.

Table 4.14: Reasons for whether to have or not have children

Descriptive Factor		**Cases (N=71)**		**Controls (N=71)**	
Categories	**Variable**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**
Reason for the no. of children	They are enough	21	40.4%	9	15.8%
	Resources	3	5.8%	2	3.5%
	Nature	2	3.8%	2	3.5%
	Motherhood	7	13.5%	13	22.8%
	Loves children	8	15.4%	7	12.3%
	Not ready	6	11.5%	11	19.3%
	Widowed	3	5.8%	2	3.5%
	Fear	2	3.8%	8	14%
	Husband not ready	0	0%	2	3.5%
	Can’t bear children	0	0%	1	1.8%

The role of service providers was also analysed and over 90% of the cases and controls indicated that service providers would play a significant role in supporting in their child bearing concerns as indicated in the figures 6 and 7 below;

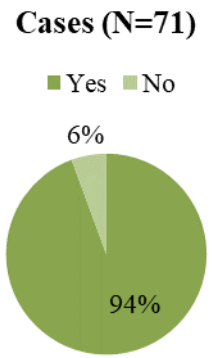

Figure 6: Accessibility of SRH counselling Services among Cases

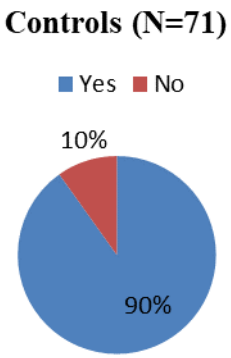

Figure 7: Accessibility of SRH counselling Services among Controls

4.4.2 Decisions for Family Planning

In terms of who makes decisions regarding the sexual and reproductive health concerns and needs at home (for example family size), the findings in table 4.15 show that most of the decisions on SRH concerns are made by the couple among 74.6% of the cases and 75.4% of the controls.

These findings are an indicator that more HIV positive women are able to negotiate with their partners concerning their sexual health and child bearing desires.

Table 4.15: Decisions forFamily Planning

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
Who make the decisions about the reproductive health concerns and needs at home(e.g. family size)	Female partner	15	21.10%	9	13.80%
	Male partner	3	4.20%	7	10.80%
	The couple	53	74.60%	49	75.40%

4.4.3 Condoms use and family planning method preference for HIV positive women

The findings in table 4.16 below reveal that more controls (85.9%) reported condom use as compared to the cases (76.1%). The most preferred family planning method is the condom which is used by 74.7% of the cases and 85.9% of the controls.

Even though condoms are used by over 76% of the HIV positive women among the cases and controls, some women still find it difficult to use them as expressed in the interview extract below;

> R2: "Some of the recommendations of the counselors are difficult to implement, especially use of condoms and attending the clinic with my partner..."

Source: Interview Data from FGDs with HIV Positive Women

Table 4.16: Use of Condomsand preferred family planning methodpreference among HIV positive women

Descriptive Factor		**Cases (N=71)**		**Controls (N=71)**	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
Do you use condoms?	Yes	54	76.1%	61	85.9%
	No	17	23.9%	10	14.1%
	Total	**71**	**100%**	**71**	**100%**
Family planning method	Using condom	53	74.6%	61	85.9%
	Using other methods *(pills, IUDS, injectables)*	9	12.7%	3	4.2%
	No family planning	9	12.7%	7	9.9%

Further analysis to examine if there was a significant relationship between condom use and SRH counselling for cases indicated no association. An independent samples test also known as the unpaired t-test was used to compare the mean scores of the two groups in order to compare condom use among those that had received SRH counselling and those that did not.Among the controls, the p value was 0.0001 with t value of 3.912 at df=70 indicating a statistically significant difference in condom use among women that have undergone SRH counselling and those that haven't undergone SRH counselling among the controls as indicated in table 4.17 below;

Table 4.17: Comparison of SRH counselling and condom use

		Cases (N=71)		Controls (N=71)	
Descriptive Factor	**Variable**	**Do you use condoms**		**Do you use Condoms**	
		Yes (N)	**No (N)**	**Yes (N)**	**No (N)**
Exposed to SRH Counselling	**Yes**	33 (46.5%)	11(15.5%)	31 (43.7%)	8 (11.3%)
Not exposed to SRH Counselling	**No**	21 (29.6%)	6(8.5%)	30 (42.3%)	2 (2.8%)
		t= 1.795, p=0.077, $\propto$ = 0.05		**t= 3.912, p=0.0001, $\propto$ = 0.05**	

This implies that among the controls the HIV positive women who had undergone SRH counselling were more likely to use more condoms as compared to those that have not undergone counselling in the CCCs. For those that had been exposed to SRH counselling, only 62% of the cases and 55% of the controls found the counselling effective towards addressing their sexuality and reproductive health desires.

4.3.4 Barriers impacting on the use of other Family Planning Methods

The findings reveal that lack of knowledge is the biggest barrier towards the selection of an appropriate family planning method among the cases 40.5% as compared to controls (51%). The other barriers mentioned in table 4.18 which include fears of side effects and self denial.

Table 4.18: Reasons for preference for condom use and barriers to using other methods

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
What are the barriers for not using the other methods?	Lack of preference	10	14.1%	13	18.3%
	Lack of knowledge	15	21.1%	25	35.2%
	Side effects	10	14.1%	10	14.1%
	No longer engages in sex	2	2.8%	1	1.4%
	No response	34	47.9%	22	31%

4.3.5 Knowledge and information sharing on SRH issues

The findings in table 4.19 reveal that other than their families, over 90% of the cases and controls would love to discuss their SRH issues with the service providers because they understand them better and for confidentiality issues. The most common issues discussed among the cases include safe sex (59.3%) and then number of children (25.9%).

Table 4.19: Source of information for sexuality concerns

Descriptive Factor		Cases (N=71)		Controls (N=71)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**
Do you discuss sex-related issues with your family members or husbands?	Yes	59	83.1%	59	83.1%
	No	12	16.9%	12	16.9%
	Total	**71**	**100%**	**71**	**100%**

4.4 The Prevalence of Unintended Pregnancies and STIs Among HIV Positive Women

4.4.1 The Prevalence of Unintended Pregnancies among the cases

The prevalence of unintended pregnancies was examined mainly among the cases given who were HIV positive women that had become pregnant and attended the CCC during the time of study and/or reported any STIs. The findings reveal that out of the 71 HIV positive women that had become pregnant during the selected period, 53.5% of the pregnancies were unintended as indicated in the table 4.20.

Further analysis revealed that there was however no statistically significant difference between the prevalence of unintended pregnancies amongst HIV positive women that were married and those that were not married (X^2_1=2.687, p=0.442) since p>0.05. Likewise, the odds of having unintended pregnancies among those married and not married were the same for both groups (odds ratios [OR]: 1.098; 95% confidence interval [CI]: 0.654–1.841).

The findings indicate that there are mainly two options for a woman got pregnant i.e. to either retain the unplanned pregnancy or abort it. The results show that of the 59% that had unintended pregnancies (58%), opted to retain the pregnancies because they wanted to bear children. The decision to retain or not retain the pregnancy was also influenced by other factors and not necessarily supported by the service provider as 70.3% indicated that the service provider did not support them in decision making.

Table 4.20: Prevalence of unintended pregnancies STIs among HIV positive women

Descriptive Factor		Cases (N=71)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**
Did you have unintended pregnancies	Yes	38	53.5%
	No	33	46.5%
	Total	71	100%

Sub—categories for those with unintended pregnancies

a) Choice to retain the pregnancy

Descriptive Factor	Those with unintended pregnancies	Cases (n=38)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**
Choice between retaining the pregnancy or not	Abortion	16	42%
	Retaining the pregnancy	22	58%
	Total	38	100%

b) Why the HIV positive woman chose the option?

Descriptive Factor	Those with unintended pregnancies	Cases (n=38)	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**
Why choose the option?	Do not support abortion	12	31.6%
	Not prepared to take care of baby	8	21.1
	Baby was not for my husband	3	7.9%
	My partner denied the pregnancy	2	5.3%
	Fear of death	3	7.9%
	I liked the baby	10	26.3%

b) Influence of service providers in making pregnancy choices

Descriptive Factor	**Those with unintended pregnancies**	**Cases (n=38)**	
Categories	**Variable**	**Frequency (n)**	**Percentage (%)**
Did the service provider support you in making a choice?	Yes	12	31.6%
	No	26	68.4%
	Total	38	100%

4.4.2 The effectiveness of SRH on the Prevalence of Unintended Pregnancies

A further analysis was done to examine if there was a significant difference in the prevalence of unintended pregnancies amongst HIV positive women that have undergone SRH counselling and those that have not undergone counselling. The findings in table 4.21 show that among the cases, all HIV positive women were equally likely to get unintended pregnancies irrespective of whether they had received SRH counselling or not (odds ratios [OR]: 1.114; 95% confidence interval [CI]: 0.427–2.911).

The chi square test (χ^2_1= 0.049, p=0.825) gave an observed chi-square statistic of 0.049, which is associated with an 82.5% risk of being wrong in rejecting the null hypothesis. This is too great a risk (far exceeding the standard of 5% risk or $p<0.05$); so, the null hypothesis was not rejected as there was no statistically significant association between the prevalence of unintended pregnancies amongst HIV positive women that have undergone SRH counselling and those that have not undergone counselling. This implies that SRH counselling was not effective in supporting the HIV positive women to reduce the risks factors of unintended pregnancies.

Table 4.21: Prevalence of Unintended pregnancies among HIV positive women exposed to SRH counselling

Descriptive Factor		Did you have unintended pregnancies?					
		Yes		No			
Categories		Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	Odds Ratio	(95% CI)
Have you ever accessed counselling regarding sexual reproductive health	Yes	24	33.8%	20	28.2%	OR = 1.114 P = 0.8252	0.427 to 2.910
	No	14	19.7%	13	18.3%		

4.4.3 The prevalence of STIs among HIV Positive Women

The findings in table 4.22 indicate that 28.2% of the cases had been diagnosed with STIs during their pregnancy. While 33.3% of the cases suffered from herpes, only 2.8% had suffered from syphilis which is routinely checked as art of the antenatal care as indicated in table 4.23.

Table 4.22: Prevalence of STIs among HIV positive women

Descriptive Factor		Cases (N=71)	
Categories	Variable	Percentage (%)	Frequency (n)
Have you had STI in the past 1 year?	Yes	20	28.2%
	No	51	71.8%

Table 4.23: Types of STIs among HIV Positive Women

Descriptive Factor			**CASES**	
Categories		**n=20**	**% against n=20**	**% against N=71**
Which STI had been diagnosed?	Herpes	6	30%	8.5%
	Yeast infection	3	15%	4.2%
	Discharge of smelly coloured vaginal fluid	2	10%	2.8%
	Candidiasis	3	15%	4.2%
	Chlamydia	1	5%	1.4%
	Trichomonas	1	5%	1.4%
	Vaginitis	1	5%	1.4%
	Ghonorhea	1	5%	1.4%
	Syphllis	2	10%	2.8%

4.4.4 The Effectiveness of SRH on prevalence of STIs among HIV positive women

This study sought to find out if there was a difference in the prevalence of STIs amongst the HIV positive women that have undergone SRH counselling and those that have not undergone counselling in the CCCs. The findings in table 4.24 show that among the cases those HIV positive women who received SRH counselling were 2.3 times more likely to get STIs as compared to those that did not receive SRH counselling OR (95% CI =) (Odds Ratios [OR]: 2.2759; 95% confidence interval [CI]: 0.7178 -7.2158).

Table 4.24: Prevalence of STIs among HIV positive women exposed to SRH counselling

Descriptive Factor		Have you had STI in the past 1 year?					
		Yes		No			
Categories		Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	Odds Ratio	(95% CI)
Have you ever accessed counselling regarding sexual reproductive health	Yes	15	21.1%	29	40.8%	OR = 2.2759, P= 0.162	0.7178 to 7.2158
	No	5	7.0%	22	31.0%		

The chi square test (χ^2_1= 2.005, p=0.157) gave an observed chi-square statistic of 2.005, at p>0.05. With this finding, the null hypothesis (H_o)was rejected implying that there is a statistically significant association between the prevalence of STIs amongst HIV positive women that have undergone SRH counselling and those that have not undergone counselling. The study therefore recommends that SRH counselling should be strengthened with more messages and information about STI prevention and control for HIV positive women.

Overall for those that had been exposed to SRH counselling, only 62% of the cases and 55% of the controls found the counselling effective towards addressing their sexualand reproductive health desires.

4.5 Factors That Promote or Hinder the Utilization of SRH Services Among HIV Positive Women

4.5.1 Factors that hinder the utilization of SRH services among HIV positive women

According to the questionnaire data gathered from the respondents, there are several factors impacting on access to SRH services at the CCC among which economic, social - cultural, environmental and situational. The findings in table 4.25 show that more controls are reported to experience difficulties in accessing SRH counselling services at 45.1% as compared to the cases at 25.4%.

Table 4.25: Challenges to access SRH counselling services

Descriptive Factor		**Cases (N=71)**		**Controls (N=71)**		
Categories		**Frequency (n)**	**Percentage (%)**	**Frequency (n)**	**Percentage (%)**	**Odds Ratio (95% CI)**
Did you have any difficulties accessing the care centre for sexual and reproductive counselling	Yes	18	25.4%	32	45.1%	OR = 0.4139, P = 0.0149,
	No	53	74.6%	39	54.9%	

Some of the reasons the respondents presented in the questionnaire data were summerized in the table 4.26 where lack of transport is the greatest challenge towards accessing SRH counselling services as reported by both cases and controls;

Table 4.26: Categories of Challenges Experienced to access SRH Counselling Services

Descriptive Factor	Cases (n=18)		Descriptive Factor	Controls (n=32)	
Categories	**Frequency (n)**	**Percentage (%)**	**Categories**	**Percentage (%)**	**Frequency (n)**
Transport	6	33.3%	Transport	14	43.8%
Lack of time to come to the CCC	3	16.7%	Lack of time to come to the CCC	8	25%
Fear of stigma	4	22.2%	Fear of stigma	5	15.6%
Not enough time to discuss with Counsellor	3	16.7%	Not ready to engage in sex	4	12.5%
I am a widow	1	5.6%	I am a widow	1	3.1%
Desires to engage in sex but no partner yet	1	5.6%	-		

The findings in table 4.26 did not differ from the issues identified in all the focus group discussions on the factors that hinder women from utilizing the SRH services in general. Interviews and focus group discussions indicated that in addition to transport there are challengesrelated to stigma and discrimination, financial and logistical to access the health facility, previous misconceptions around the healthy facility, the long queues at the facility which impact on the waiting period of the

clients and negative attitude towards the services being provided among others. A detailed description of the factors is therefore presented as follows;

Social cultural beliefs

The study reveals that 80% of the HIV positive women who participated in this research study indicated cultural beliefs among the community as one of the major factors that are preventing some HIV positive mothers to attend to the services at the hospital. Within the cultural beliefs some men do not believe in planned or limiting the number of children. This was also evident in the interview data as expressed by the following respondent;

> R9: .."it was difficult to tell my husband to start using condoms and go for HIV test, but through a counselor I have been able to do it". I also longed for a child but did not know how to go about it for fear of infecting the child...
>
> **Source: Interview Data from FGDs with HIV Positive Women**

Lack of transport

Responses from the majority of the HIV positive women who took part in the research as respondents indicate a big challenge of the costs they incur in transport from the homes to the hospital as one of the factors that fail them to access the SRH services with easy (see interview extracts). This therefore, means that there is need to extend the services closer to their end users for easy access to the service users.

- **R5:** "Transport cost and logistics – some of us come from absolute poverty situation and may not make it to the facility as required.."
- **R4:** Financial, Stigma, Lack of awareness of the facility
- **R3:** "Financial constrains because of distances from our residences, being that some of us are leaving in near poverty conditions..."

Source: Interview Data from FGDs with HIV Positive Women

Waiting for long hours

Regarding the processes that HIV positive women go through to acquire the SRH services, the majority critically had sentiments about the long waiting hours spent at the hospital before they are attended to. They observed that the hospital is understaffed therefore the current number of staff cannot afford to do the assigned tasks on time due to the overwhelming number of clients. One HIV positive woman commented that, *"The long queues at the facility that tend to weigh us down".*The medical staff do not only attend to the HIV positive women only but also other categories of other clients or patients hence limiting their total attention and effectiveness to the HIV positive women. The fear to wait for long hours to access SRH services has led many to abandon the SRH program.

Gender related issues and norms

It was further noted that gender sensitive among the HIV positive women in Mirembehospital to a great extent prevent them to access SRH services from the hospital. The women are not very free to express their problems relating to their health to male medical staff. Most of them prefer to be attended to by their fellow women; therefore, in absence of adequate number of female medical staff at the hospital, many women end up failing to go for the recommended SRH services.

Lack of community health care facilities

All the medical staff (100%) urged that the lack of community health workers to strengthen on the linkages between the CCC at thehospital and the community has had a negative effect on the access of SRH services by HIV positive women. The

hospital where the CCC is located generally lacks capacity to dispense factual information among women accessing the services, which role can be well played by community health workers.

The medical staff interviewed all agreed that follow up visits are very critical for the successful provision of SRH services to HIV positive women. However, due to the limited number of medical staff, follow up visits to the women attending the services have never been implemented, yet their clients are weak, frustrated and need motivation. This gap can easily be narrowed with the existence of community health workers.

When asked about mobilization strategies, most correspondents confirmed that it is wanting and need to be strengthen to have all HIV positive women access SRH services at the hospital. The information, education, communication and behaviour change communication materials are not simple and targeting HIV positive women. The materials are mainly in one language which leads to misinformation and therefore, the need to have it different languages for easy and fast understanding of everyone.

Lack of knowledge & low literacy levels

The medical staff interviewed believe strongly that among other core factors for HIV positive women fail to access SRH services at the CCC is the low level of literacy among women regarding the benefits of SRH services. Many women do not believe in SRH services due to ignorance and fear.

Religious beliefs

The HIV positive women who participated in this study, indicated that religious beliefs have impacted on the uptake of SRH services as well impacted on the utilization of some family planning commodities. Interview data indicated some religious leaders discourage their followers to go to the hospitals to access and use SRH services and commodities such as family planning, condoms to mention among others. This to some extent has impacted on the reproductive health of some HIV positive women who end up acquiring unintended pregnanices and STIs. The same ideologies to a great extent have forced some women to forego the SRH services at the hospital with fear to lose their spouses to other partners who are committed to produce unplanned and unlimited number of children.

Domestic violence

Domestic violence has also been cited among the key factors hindering HIV positive women to access SRH services at the CCCs. A number of men who do not believe in the use of SRH services and would bitterly fight their wivesand hinder them from to the SRH clinics. Due to fear of being punished by their husbands, a number of women, abandon the SRH services as indicated in the interview extracts below;

> **R1: ..”**convincing partner to use contraceptives, especially condoms, and addressing my sexual needs”
> **R2: ..”**I have challenges convincing my partner to accept my contraceptive choices, especially whether to use condoms or not.”
> **R1:**“..I chose to stop having children and resolved to using condoms but this caused misunderstanding between me and my husband and its still not resolved. He doesn’t want to come for counseling and I feel lonely with this decision”.
> **R6:**..”I chose to abstain from sex and this drove away my husband, and when I talked to him to attend the CCC, he beat me and left. He has never come back”.
>
> **Source: Interview Data from FGDs with HIV Positive Women**

Stigma and discrimination

According to medical staff, some HIV positive women are still suffering stigma and denial due to ignorance. They fear to be identifying themselves as HIV positive women, therefore, fail to go to thehospital for the SRH services.

- **R10:..”**the common factors that prevent HIV positive women from coming to the facility include self stigma, time spent (long lines) waiting for services and negative attitude towards the services being provided”.
- **R9:**..”Stigma, especially as the facility caters for only HIV+ people, and wecan be only seen by other patients within the hospital grounds..”.
- **R1:** “Most of us women fear being seen at the centre for fear of exposure of our status...”

Source: Interview Data from FGDs with HIV Positive Women

Poor community mobilization strategies

The responses from medical staff and HIV positive women, portrayed that inadequate mobilization strategies have partly contributed to the limited utilization of SRH services utilization at CCC. For those that manage to access the SRH services, they are not followed up for for futher visits. Hence the need to establish involving and well focused community mobilization strategies.

Confidentiality and stigma

HIV positive women indicated during the interviews that confidentiality is very critical for their access to SRH services at the CCC. But due to the overwhelming number of clients, the environment is not conducive enough for full confidentiality to the women. Therefore, the environment, limits some women to access SRH services at the hospital.

Regarding stigma, some HIV positive women stated that their partners are not pleased to see them*(HIV positive women)* acquire SRH services at the hospital despite the fact that the status of the women has been known to them before. Women's failure to comply to their partners' restrictions to attend to the hospital to access SRH services has led to broken engagements and marriages. Therefore, the fear to break the marriages and engagement has prompted a number of HIV positive women to access the services at the hospital.

Lack of staff at the CCC

There were complaints that the hospital in general is not only understaffed but basing on HIV positive women involved in this study, the medical skills and experience of some medical personnel is wanting. This to some extent has instilled fear among the HIV positive women to comfortably access the SRH services at the hospital. There is need to conduct refresher training for the medical staff and train them to give out all SRH methods and modern methods other than the condoms which according to them limit their pleasure to sex enjoyment with their partners.

4.5.2 Factors that promote the utilization of SRH services among HIV positive women

Despite some challenges affecting the full utilization of SRH services at the CCC by HIV positive women, several suggestions are provided to improve the situation which will be discussed in the subsequent sections of the report. Interview data proposes the following ways;

- **R4:**"..These can be addressed by initiating community/home visits by counselors, especially to clients who have already been identified, and mobilizing the clients at the centre to help in identifying their peers who may need the service to sensitize them on the benefits of visiting the centre..".
- **R2: "..**Comprehensive counseling to help de-stigmatize the potential clients' attitudes towards their conditions..."
- **R7:**"...Public awareness can help, and also capacity building of client to mobilize their peers.."
- **R8:**"...expanding the facility and bringing in more services providers, positive awareness creation in more community members by stakeholders and the government..."

Source: Interview Data from FGDs with HIV Positive Women

It is recommended that SRH services be extended closer to the community level where women can easily access the services. This will eliminate the challenges of long travel distance and transport costs involved. There other recommendations include the following;

i) Enhance community mobilization strategies to involve community leaders and the church. Planning for targeted mobilization strategies, and using simple and different languages to address all people;

ii) Introduction of mobile clinics to reach all HIV positive women will aid limiting confidentiality caused by environmental factors at the CCC and also address stigma among women;

iii) Provide high priority to HIV positive women at the CCC during the clinic time to avoid long waiting hours that discourage women to access the service;

iv) Build the capacity of medical staff and community health workers through training, conferences and workshops to equip them with update skills for provision of effective and efficient SRH services at the district medical hospitals, and;

v) Provision of updateson the various SRH services at the CCC that can be accessed by the HIV positive women.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussion of Results

This sectionpresents the discussion of the key finding arising out of the study through which conclusions and recommendations of the study are drawn.

5.1.1 Demographic Data of the Respondents

The findings have shown a close match for demographical data amongst the cases and controls in terms of the age, education level, period and frequency for accessing SRH services since HIV diagnosis with women aged 30-39 years seeking the SRH counselling services among the cases and controls as compared to other age groups. While there are high rates of accessing HIV prevention care and treatment services after HIV diagnosis (97.2%, SD = 30.63), more cases are reported seeking sexual and reproductive health services by 1.3 as compared to the controls. Increased access to the services can be attributed to the significant progress in recent years towards achieving the goal of *'universal access'* to HIV testing and counselling services through the scale-up of voluntary counselling and testing (VCT) and Provider Initiated Testing and Counselling (PITC) services (Ministry of Health and Sanitation, 2009).

These findings concur with the Kenya AIDS Response Progress Report (2014:24) which confirms that the coverage of pregnant women tested for HIV increased from 68.3% to 92.2% between 2009 and 2013.Ministry of Health and Sanitation, (2011)

adds that the intention is to provide an unparalleled opportunity to expand access to a wide range of care for women and their families, including family planning, HIV testing and counselling, and other health services including cervical cancer screening and physical exams. WHO & UNFPA (2006:14) add that information and counselling should be critical components regarding sexual and reproductive health services, to help in supporting women to making informed choices about the SRH and carry them out safely and voluntarily.

5.1.2 Reasons for accessing SRH Services

A broad range of reasons have been mentioned in the findings which show that HIV positive women have various reasons for accessing SRH counselling services which are closely linked to their sexual and reproductive health needs among which include; obtaining counselling and information on contraception, sexuality, STI prevention, antenatal services, family planning needs, breast and cancer screening and abortion related issues.

There are other psychosocial issues reported which include obtaining information and counselling on opportunist infections, domestic and gender based violence to mention among others. This implies that SRH service providers need to be well prepared and knowledgeable in understanding and addressing the SRH needs of the HIV positive women. There is need therefore for clear procedures, counselling protocols, mentorship and counselling supervision to ensure that service providers are supported to meet the SRH needs are of the HIV positive women during their visits at the CCC.

5.1.3 Sexual Behaviour of the HIV Positive Women

Irrespective of the marital status, over 96% of both cases and controls had been involved with a sexual partner in the last six months with 21.9% of the cases and 16.92%) controls having not disclosed their HIV status to their partners due to fear of stigma, fear of divorce, violence, blame and many other factors. The results mirror the findings of a study conducted in Cape Town in South Africa by Vu, Andrinopoulos, Matthews, Chopra & Kendal (2012) among a sample of 630 HIV-infected men and women on ART which also confirmed that about 20% of the sample size had not disclosed their HIV status to their most recent sex partners. Likewise, HIV disclosure to the sexual partner was more likely to take place among participants who had a steady sex partner. The findings support the strengthening of positive prevention strategy that empowers HIV positive women to reduce casual sex partnerships and address stigma on HIV status disclosure particularly within steady sex partnerships which could be accomplished through individual and couple SRH counselling.

5.1.4 Child Bearing and Contraception Use among HIV Positive Women

In terms of child bearing and contraception use, just less than 40% of the cases and controls desire to have children. Older women aged 40-49 years are less interested in having children as compared to the younger age groups. Among the reasons provided is the fear of infecting the infant with HIV, lack of money to support the children etc. The low numbers for child bearing are also expressed in the study

conducted by Kaida, Laher, Strathdee, Janssen& Money (2011) where only 44% (N= 674) HIV positive women aged 18 to 44 years recruited from the Perinatal HIV Research Unit in Soweto, South Africa reported their intent to have children.

A similar cross sectional study conducted in Ethiopia on fertility intentions among HIV positive women aged 18–49 years in Addis Ababa Ethiopia revealed the same proportion of women (44%) with fertility intentions (Asfaw & Gashe, 2014). These findings are similar to the normal trends of child bearing as indicated where young age, being single and having fewer or no children were found to be predictors of fertility intentions. As thus the need to ensure that HIV positive women are fully supported to freely and responsibly decide on their fertility desires.

The use of condoms was indicated as the most preferred method for family planning by 74.7% of the cases and 85.90% of the controls, there was a statistically significant difference in condom use among women that have undergone SRH counselling and those that haven't undergone SRH counselling among the cases. The SRH counselling process should provide more information and promote other family planning methods to enable the HIV positive women make informed choices on which methods to use.

5.1.5 SRH Counselling and the Prevalence of Unintended Pregnancies and STIs

Interview data from the nurse counsellors did not indicate presence of specific SRH counselling protocols tailor-made to the hospital settings other than the considerations provided for by the national guidelines. However, the Kenya National

Family Planning Guidelines (2010: 54) suggest that service providers should use '*The Balanced Counseling Strategy Plus (BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings'* developed by Population Council (2012) during the SRH counselling process. This tool kit referred to is an interactive, client-friendly approach for improving counseling on family planning and prevention, detection, and treatment of sexually transmitted infections (STIs) including HIV. This tool kit is also complimented with a detailed counselling protocol within the newly developed RH and HIV Integration clinical assessment tool for mentors/facilitators guide for RH/HIV integrated service provision developed for Kenya (2013) *(details are indicated in Appendix 4).*

While such frameworks exist, these findings have identified a variation in the service providers' understanding of the SRH counselling protocol as recommended by the Kenya national guidelines on HIV/SRH integration. This concur with the findings from the Integra Initiative (2012) Project which assessed the benefits of integrated HIV and SRH Services in Public Health Facilities in Kenya. This study noted that the implementation environment and process for integrating SRH in HIV prevention services remains very complex which requires continued mentorship and training of the service providers to adhere to the proposed SRH counselling protocols in the national guidelines. The findings also indicate a lack of follow-up on HIV positive women in their communities which needs to be strengthened.

There rates of unintended pregnancies remain high at 53.5% among the cases (N=71) where 41% for unintended pregnancies were aborted. Even though the odds of

having unintended pregnancies among those married and not married were the same for both groups (odds ratios [OR]: 1.098; 95% confidence interval [CI]: 0.654–1.841), the findings show that both groups of HIV positive women among the cases (i.e. those who received SRH counselling and those that did not receive SRH counselling) were equally likely to get unintended pregnancies (odds ratios [OR]: 1.114; 95% confidence interval [CI]: 0.427–2.911) hence the null hypothesis was not rejected.

These results imply that SRH counselling was not effective in supporting the HIV positive women to reduce the risks factors of unintended pregnancies. A study conducted by Obare, Kwaak & Birungi (2012) on factors associated with unintended pregnancy, poor birth outcomes and post-partum contraceptive use among HIV-positive female adolescents (15-19 years) in Kenya further reveals that the experience of repeat unintended pregnancies among HIV-positive female adolescents was partly due to inconsistent use of contraception to prevent recurrence of the pregnancies. This underscores the need for HIV and AIDS programs to provide appropriate sexual and reproductive health information and services to HIV positive women in order to reduce the risk of undesired reproductive health outcomes.

The findings show that 28.2% of the cases had been diagnosed with STIs during their pregnancy mainly suffering from herpes (33.3%) and only 2.8% suffering from syphilis. However among the cases those HIV positive women who received SRH counselling were 2.3 times more likely to get STIs as compared to those that did not

receive SRH counselling OR (95% CI =) (Odds Ratios [OR]: 2.2759; 95% confidence interval [CI]: 0.7178 -7.2158) indicating that the counselling provided is not yet effective in supporting HIV positive women reduce unintended pregnancies.

The study therefore recommends that SRH counselling should be strengthened with more messages and information about STI prevention and control for HIV positive women.

5.1.6 Factors Hindering the Utilization of SRH Services among HIV Positive Women

The study identified factors that hinder women from utilizing the SRH services among which included stigma and discrimination, financial and logistical challenges to access the health facility, previous misconceptions around the healthy facility, the long queues at the facility which impact on the waiting period of the clients and negative attitude towards the services being provided among others. There is need to build the capacity of health workers to equip them with the relevant knowledge and skills for provision of effective and efficient SRH counslling services at the facility, as well as implement community based outreaches.

5.1.7 Factors promoting the utilization of SRH Counselling Services among HIV Positive Women

The study identifies factors the promote the utilization of SRH counselling servicesamong which include extending the services closer to the community level to eliminate the challenges of long travel distance and transport costs involved. There

other recommendations include extending the SRH services to the community through the use of mobile clinics, and building the capacity of medical staff and community health workers for effective and efficient provision of SRH services atthe hospitals.

5.2 Limitations of the Study

There are possible limitations that may affect the results of the study arising from selection bias, information bias, systematic error and the role of chance bias; confounding and sampling errors. Bias is a systematic error in the design, measurement, sampling, procedure and analysis of a study that affects the findings of the study. The study was also limited in scope due to lack of finances and time.

Selection bias may have arisen through the process of selecting the HIV positive women that participated in the study. It is worth noting that each of thewomen had a different lifestyle, sexuality needs and sexuality behaviour. So, to minimise this form of bias, confounding and sampling errors, a selection criteria was developed and consistently utilised in the selection process of the individuals that participated in the study since no statistical adjustment for the effects of this bias is possible after the data has been collected.

Information bias could have been possible as a result of apprehension in talking about sensitive issues related to sensitive topics in sexuality such as abortion, the number of sexually partners and the sexual and reproductive intentions and behaviours of the HIV positive women. To minimise this bias, the researcher

ensured that the study participants were made fully-aware that questionnaires would be self-completed, anonymous and not accessible by the clinic staff and any other person without their consent.

Information bias could also have arisen as a result of the length of the questionnaire hence leading to response fatigue while filling in the tool. The questionnaire had numerous questions linked to the many variables of interest in this study and subsequently the significant results may have occurred by random chance. This limitation was handled by having a clear analysis plan for the results key variables of interest in the questionnaire. The study also utilised various methods of data collection are to triangulate the information to be collected. But if this study is to be repeated its worth shortening the questionnaire to minimise information bias and the role of chance bias.

5.3 Conclusions

This study presents the following conclusions based on its study objectives:

- ***Assessment of the SRH counselling process:*** whereas there are national guidelines that spell out the SRH counselling process which HIV positive women undergo within the Comprehensive Care Centre, the implementation of these SRH counselling procedures differs depending on many circumstances hence impacting on the quality of SRH counselling;

- ***The effectiveness of SRH counselling towards the prevention of unintended pregnancies and STIs amongst HIV positive women;*** The prevalence of unintended pregnancies among HIV positive women was significantly high

among HIV positive women which implies that SRH counselling is not yet effective in supporting the HIV positive women to reduce the risks factors of unintended pregnancies. The high rates of unintended pregnancies, STIs and abortions equally have a significant impact on the quality of life and health for the HIV positive women which if not well managed would lead to further adverse effects like death.

There was no statistically significant association between the prevalence of unintended pregnancies amongst HIV positive women that have undergone SRH counselling and those that have not undergone counselling. This implies that SRH counselling was not effective in supporting the HIV positive women to reduce the risks factors of unintended pregnancies.

The findings however revealthat even though HIV positive women that have undergone SRH counseling, this counsellingis not adequate to empower HIV positive women preventSTIs. The study therefore recommends that SRH counselling should be strengthened with more messages and information about STI prevention and control for HIV positive women.

- ***Factors that hinder the utilisation of SRH counseling information and services:***There were notable factors such as related to stigma and discrimination, lack of follow-up, financial and logistical challenges to access the health facility, previous misconceptions around the healthy facility, the long queues at the facility which impact on the waiting period of the clients and negative attitude

towards the services being provided among others that have been impacting on the use and uptake of SRH services which need to be addressed.

- ***Factors that promote the utilisation of SRH counseling information and services:***The study concludes that in order to promote the uptake of SRH counselling services there is need to extend the services closer to the community level, through the use of mobile clinics, and building the capacity of medical staff and community health workers for effective and efficient provision of SRH services at the hospitals.

5.3 Recommendations

The key recommendations arising from the study there include the following;

Towards SRH Counselling Procedures: Given the lack of clear understanding of the SRH counselling protocols by the SRH Counselling Providers, there is need for continued training and capacity building of the service providers to fully support the HIV positive women at the CCC. There is need therefore for clear procedures, counselling protocols, mentorship and counselling supervision to ensure that service providers are supported to meet the SRH needs are of the HIV positive women during their visits at the CCC especially in the utilization of the recommended SRH counselling protocols. SRH service providers need to be well prepared and knowledgeable in understanding and addressing the SRH needs of the HIV positive women.The study therefore recomends that SRH Counsellors need training, more mentorship and constant support supervision to uphold their proficiency towards

supporting HIV Positive women in making informed choices about their sexual and reproductive health needs.

Towards the Sexual Behaviourand SRH for HIV Positive women: The findings support the strengthening of positive prevention strategy that empowers HIV positive women to reduce casual sex partnerships and address stigma on HIV status disclosure particularly within steady sex partnerships which could be accomplished through individual and couple SRH counselling.

Towards Contraception Use among HIV Positive Women: The study recommends more education on the various contraceptives to ensure that HIV positive women have a variety of choices to use. SRH counselling should provide more information on other family planning methods other than the condoms to enable the HIV positive women make informed choices on which methods to use. More support is also needed to ensure that HIV positive women are fully supported to freely and responsibly decide on their fertility desires.

Towards the Reduction of Unintended Pregnancies and STIs: the study This underscores the need for HIV and AIDS programs to provide appropriate sexual and reproductive health information and services to HIV positive women in order to reduce the risk of undesired reproductive health outcomes. The study also recommends that SRH counselling should be strengthened with more messages and information about STI prevention and control for HIV positive women. This calls for training, close mentorship and support supervision of the health workers even though

each counselling procedure undertaken mainly depends on the circumstances and needs with which the client may present with therefore making it difficult for the counsellor to adhere to the proposed SRH counselling protocols in the national guidelines. The findings also indicate a lack of follow-up on HIV positive women in their communities which needs to be strengthened.

Towards Factors That Hinder the Utilization of SRH Services among HIV Positive Women: It is therefore recommended that the CCC institutes mechanisms to provide SRH services closer to the community level where women can easily access the services to eliminate the challenges of long travel distance and transport costs involved. Community mobilization strategies need to be strengthened with the involvement of the community leaders as well as introduce follow-up visits and mobile clinic. It is also recommended that the capacity of health workers be built to equip them with the right skills for provision of effective and efficient SRH services at the district medical hospitals. More staff need to be recruited to meet to be able to reach out to as many HIV positive as possible and also strengthen follow-up and community interventions for HIV positive women.

5.4 Key Areas for Further Research

The study therefore recommends that further research can target the following areas;

- A detailed analysis on how service providers are utilizing the SRH counselling protocols and how this process impact on the health of the HIV positive women.
- A comparative analysis of the same study in other district and provinces in Kenya

- Following up on the impact of impact of counselling for PMTCT
- Analysing the extent to which institutional activities which counsellors are engaged other than SRH counselling are likely to influence the quality of their counseling practice and proficiency

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APPENDICES

Appendix 1: SRH Counselling Protocol

Extracted from the mentors/facilitators guide for the RH/HIV integrated service provision guidelines for Kenya (2013)

SECTION 6: Family Planning, HIV Counselling and Testing, STI Prevention and Management, and Balanced Counselling Strategy Plus	**Score** **Date**	**Date**	**Date**
After establishing rapport...			
A Explore clients reproductive health goals			
B Take reproductive health history, including name, age, marital status, parity, last menstrual period, date of last delivery, occupation, medical and surgical history, future fertility intentions			
C Rule out pregnancy			
C1 Have you abstained from sexual intercourse since last menstruation or last delivery?			
C2 Did your menstruation start in the last seven days?			
C3 Did you have a baby less than six months ago and are you exclusively breastfeeding?			
C4 Have you had a baby in the last four weeks?			
C5 Have you had a miscarriage or abortion in the last seven days?			
C6 Have you been using a reliable contraceptive consistently and correctly?			
D Balanced Counselling Strategy Plus (BCS+)			
D1 Algorithm			
D2 Display all method cards for the client to see			
D3 Ask specific questions listed in the algorithm correctly and in order; set aside method cards not appropriate for the client			
D4 Give information on methods that are not set aside in the order of their effectiveness (mode of action, benefits, and side effects)			
D5 Ask client to choose method that is most convenient for her/him			
D6 Review brochure for selected method with client			
D7 Demonstrate proper use of WHO Medical Eligibility Criteria			
D8 Ask client to select another method if limitation exists			
D9 Provide counselling and education about method chosen using method brochure			
D10 Determine client's comprehension; reinforce information if needed			
D11 Ensure that the client has made a definite decision			
D12 Provides the method chosen (extent of additional procedures depend on method chosen, see appropriate section of Checklist if needed)			
D13 Refers when necessary			
D14 Provides back-up method			
D15 Encourage client to involve partner through discussion or clinic visit			
D16 Discuss RTI/STI/HIV/TB transmission and prevention			
D17 Conduct Risk Assessment for RTI/STI/HIV/TB			
D18 Conduct necessary physical and/or pelvic assessment if necessary (see appropriate section of Checklist if needed)			
D19 Treat client syndromically, if RTI/STI symptoms present			
D20 Refer client appropriately, if needed			
D21 Discuss and offer client an opportunity for cervical cancer screening			
D22 Discuss dual protection with the client			
D23 Ask if the client knows how to use a condom			
D24 Demonstrate how to use condom			
D25 Offer condoms and instruct on correct and consistent condom use			
E Demonstrate how to use a condom properly			
F Offer condoms and instruct on correct and consistent condom use			
G Discuss and offer client the opportunity for HIV testing and counselling			

Source: http://www.integrainitiative.org/blog/wp-content/uploads/2014/04/RH_HIVMentorsGuide2013.pdf

Appendix 2: Written consent form for HIV Positive Women (English Version)

JOMO KENYATTA UNIVERSITY OF AGRICULTURE AND TECHNOLOGY (JKUAT)
Institute of Tropical Medicine and Infectious Diseases (ITROMID)

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY
The Impact of Sexual and Reproductive Health Counselling Services for HIV Positive Women in Comprehensive Care Centres(CCCs) in Langata

INTRODUCTION AND STUDY PURPOSE
Good morning/good afternoon, my name is….. …… and I am from the Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. You have been requested to participate in a research study being carried out by Victoria Kisaakye Kanobe, a MPH student at the JKUAT.This intends to investigate the impact of Sexual and Reproductive Health Counseling services provided within the CCCs in reducing the risks of unplanned pregnancies and STIs in Kenya among HIV positive women. To achieve the study goals, the research will interview HIV positive women that have received sexual and reproduction health counselling services at the Langata CC clinic for the period January 2012 to December 2013. The findings from this study are expected to inform policy on scaling-up SRH services among HIV positive women to be able to meet their SRH needs and to improve the quality of service provision.

PROCEDURES
If you agree to participate in this study, I will conduct an interview with you. You may also be asked to participate in a focus group discussion. The interview will take place in a private setting, and it will take approximately 30minutes. During this interview, you will be asked about your perceptions on Sexual and Reproductive Health Counseling services provided within the CCCs. You will be asked structured questions with optional answers and the interviewer will tick the appropriate answers as you shall provide.

If you volunteer to participate in this study, we would ask you to do the following things:
- To take 10 – 20 minutes and respond to the key question we will ask where a questionnaire has been administered
- To give us 10 – 20 minutes to participate in the short interview and discussion that focuses on assessing your perceptions in regard to the quality of Sexual and Reproductive Health services you have received.

POTENTIAL RISKS AND DISCOMFORTS
This study will possess no potential risks as all information provided will treated with utmost confidentiality and all names of the participants will remain anonymous.

POTENTIAL BENEFITS TO PARTICIPANTS
There are no direct benefits related to your participation in this study. The findings of the study will however help to provide new knowledge that will be used to improve the quality of sexual and reproductive health counselling services for HIV positive women within the HCT service delivery and quality.
You will not be paid for participating in this study

CONFIDENTIALITY

Every effort will be made to ensure that the information you provide regarding this study remains confidential. Only pseudo names will be used if required and all the data will be treated with respect and utmost confidentiality. Your personal information may be disclosed if required by law. Any publication of this study will not use your name or identify you personally.

STORAGE AND USE OF DATA FOR FUTURE STUDIES

All data collected from the study will be kept for only five years to allow for data processing and make reference to the data during the time of study. All data will be assigned a code tagged to your name after which it will be destroyed. All qualitative research recordings within the data collected will be destroyed after one year. This timeline has been selected to allow enough time for transcription. No future studies will use this data unless approved by an Institutional Review Board or Independent Ethics Committee, which watches over the safety and rights of research participants, which must approve any future research studies using your data.

RIGHTS OF RESEARCH PARTICIPANTS

Your participation in this study is completely voluntary. You may choose to participate or not participate in this study. Your decision will in no way affect your current access to health services from this facility. If you do choose to participate, you can decide not to answer certain questions, or to stop the interview at any time

You are free to ask questions before signing this form. If you later want to talk to anyone about this research study or have questions, regarding your rights as a research participant, contact:

Secretary,
Ethics Review Committee, Kenya Medical Research Institute,
P.O Box 54840-00200,
Nairobi , Kenya
Telephone 254 (020) 2722541, 0722205901; 0733-400003
Email:info@kemri.org

STATEMENT OF CONSENT AND SIGNATURES

I have read this form or had it read to me. I have discussed the information with study staff. My questions have been answered. I understand that my decision whether or not to take part in the study is voluntary. I understand that if I decide to join the study I may withdraw at any time. By signing this form I do not give up any rights that I have as a research participant.

_____ _____

Participant Name Participant Signature/Thumbprint

Date

(print)

_____ _____

Staff Conducting Study Study Staff Signature

Date

Consent Discussion (print)

_____ _____

Witness Name Witness Signature

Date

USE OF YOUR DATA # FOR FUTURE STUDIES:

Please initial and date one option:

_____ I DO agree to store my data for future research into HIV, HIV- related diseases, and other sexually transmitted diseases.

_____ I DO NOT agree to store my data for future research into HIV, HIV-related diseases, and other sexually transmitted diseases.

_____ _____

Participant Name Participant Signature/Thumbprint

Date

(print)

_____ _____

Staff Conducting Study Study Staff Signature

Date

Consent Discussion (print)

_____ _____

Witness Name Witness Signature

Date

CONCLUSION:

If you have any questions or concerns about the research, please feel free to contact Victoria Kisaakye Kanobe using the telephone number 0714-781310 or email kisaakye@yahoo.co.uk

Signed: _____

Participant

Signed:_____

Interviewer

Appendix 3: Written consent form for HIV Positive Women (Swahili Version)

JOMO KENYATTA CHA KILIMO NA TEKNOLOJIA (JKUAT)
Tarsisi ya Tropical Medicine na Magonjwa ya Kuambukiza (ITROMID)

IDHINI YA KUSHIRIKI KATIKA SOMO LA UTAFITI
Matokeo ya huduma ya ushauri kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi unaotolewa katika Vituo vya Malezi kwa Kina (Comprehensive Care Centres -CCCs) katika Wilaya ya Langata

UTANGULIZI NA LENGO
Habari za asubuhi / mchana nzuri, jina langu ni ..... nina toka Chuo Kikuu cha Jomo Kenyatta cha Kilimo na Teknolojia mjini Nairobi, Kenya katika Chuo cha Sayansi ya Afya. Umeombwa kushiriki katika utafiti unaofanywa na Victoria Kisaakye Kanobe, MPH mwanafunzi katika JKUAT. Utafiti huu unakusudia kuchunguza matakeo yanayo tokana na kutolewa ushauri and huduma kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi zinazotolewa katika kituo hiki cha Malezi kwa Kina (CCCs) katika kupunguza hatari za mimba zisizotarajiwa na magonjwa ya zinaa katika Kenya miongoni mwa wanawake walio na Virusi vya Ukimwi (VVU).

Ili kufikia malengo ya utafiti, wanawake wanaoishi na Virusi vya Ukimwi (VVU) na wamepokea huduma za ushauri kuhusi afya ya uzazi na katika Langata CC kliniki kati ya kipindi cha Januari 2012 hadi Desemba 2013 watahojiwa. Matokeo ya utafiti huu yanatarajiwa kutoa taarifa katika sera kupanua huduma ya afya ya uzazi miongoni ya wanawake wanaoishi VVU ilikuweza kushughulia mahitaji yao ya ngono au kimapenzi pamoja na afya ya uzazi na kuboresha ubora wa utoaji wa huduma.

TARATIBU
Kama utakubali kushiriki katika utafiti huu, nitakuhoji. Unaweza pia kuulizwa kushiriki katika majadiliano ya kundi. Mahojiano yatafanyika katika mazingira ya binafsi, na itachukua takribani dakika 30. Wakati wa mahojiano hii, utaulizwa mitazamo yako juu huduma wa ushauri kuhusu kimapenzi na Afya ya Uzazi zinazotolewa katikaKituo cha Malezi kwa Kina (CCC) ya Kituo hiki cha Afya. Utaulizwa maswali muundo na majibu hiari na mhojaji atakuwa akitia alama kwenye majibu sahihi utakayo ya jibu.

Ikiwa utajitolea kushiriki katika utafiti, tutakuuliza kufanya mambo yafuatayo:
- Kuchukua 10 - 20 dakika na kujibu swali muhimu tutakayo uliza ambapo dodoso/questionnaire itatumika
- Kutupatia 10 - 20 dakika ya kushiriki katika mahojiano mafupi na majadiliano ambayo yanalenga kuelewa mitazamo yako kuhusiana na ubora wa huduma ya kimapenzi na Afya ya Uzazi umepokea.

UWEZEKANO WA HATARI NA MADHARA
Utafiti huu hauna madhara au hatari zozote kwani taarifa zote zinazotolewa zitahifadhiwa kwa njia ya siri na majina yote ya washiriki kutojulikana.

FAIDA KWA WASHIRIKI
Hakuna faida ya moja kwa moja kuhusiana na kushiriki kwako katika utafiti huu. Matokeo ya utafiti huu yatasaidia kutoa elimu mpya ambayo itatumika kuboresha hali wa huduma za ushauri wa afya ya uzazi kwa wanawake wenye VVU ndani ya utoaji wa huduma HCT na ubora. Hakuna malipo kwako kutokana na kushiriki kwako .

USIRI

Kila juhudi zitafanywa ili kuhakikisha kwamba habari utakayoitoa kwa utafiti huu kuwa ya siri. Majina bandia tu yatatumika kama inavyotakiwa na habari zote tumika kwa heshima na usiri mkubwa. Maelezo yako ya kibinafsi yanaweza kuwa wazi kama inatakiwa na sheria. Nakala zozote za utafiti huu hazitatumia jina lako au kukutabwa.

UHIFADHI NA MATUMIZI YA TAKWIMU KWA AJILI YA TAFITI ZIJAZO

Taarifa zote zinazokusanywa kutoka utafiti huu hifadhiwa kwa miaka mitano tu kwa ajili ya kuruhusu kufanya kurejea kwa habari wakati wa utafiti. Habari yote itakuwa na namabri spesheli itakayo itakayosimaimia jina lako na baadaye kuharibiwa. Habari zote zitakazonaswa kwenye chombo hiki, zitaharibiriwa baada ya mwaka mmoja. Muda huu umependekenzwa kwa ajili ya kuruhusu hiyo habari kuchapishwa.Hakuna tafiti zijazo zitatumia habari hizi hila kwa idhini kutoka na Bodi ya Taasisi au Kamati ya Maadili (Institutional Review Board or Independent Ethics Committee) ambayo inahakisha kuweko kwa usalama na haki kwa washiriki wa utafiti, iliyo na mamlaka kuhidhinisha tafiti za siku zijazo kutumia kumbukumbu/habari zako.

HAKI YA RESEARCH WASHIRIKI

Kushiriki kwako katika utafiti huu ni kwa hiari kabisa. Unaweza kuchagua kushiriki au kutoshiriki katika utafiti huu. Uamuzi wako hauthiri kupokelewa kwa huduma za afya kutoka kituo hiki. Ikiwa utachagua kushiriki, unaweza kuamua kutojibu maswali fulani, au kutia kikomo mahojiano wakati wowote

Uko huru kuuliza maswali kabla ya kutia sahii kwenye fomu hii. Kama baadaye utahitaji kuzungumza na mtu yeyote kuhusu utafiti huu au una maswali, kuhusu haki zako kama mshiriki katika utafiti, wasiliana na:

Katibu,
Kamati ya kisayansi, Kenya Medical Research (KEMRI)
Sanduku la Posta 54840-00,200, Nairobi, Kenya
Nambari ya simu 254 (020) 2722541, 0722205901; 0733-400003
Barua PepeEmail:info@kemri.org

TAARIFA YA IDHINI NA SAHIHI

Nimesoma fomu hii au mimesomewa. Nimejadijliana na mtfaiti kuhus habari hizi. Maswali yangu yamejibiwa. Naelewa kwamba uamuzi wangu wa kushiriki au kutoshiriki katika utafiti huu ni wa hiari. Naelewa kuwa ikiwa nitajiunga na utafiti naweza kujiondoa wakati wowote. Kwa kutia sahihi kwenye fomu hii sijatupa haki zangu nilizonazo kama mshiriki wa utafiti.

_____	_____	_____
Jina la mshiriki	Sahii Mshiriki /kidole	Tarehe
_____	_____	_____
Wafanyakazi kufanya utafiti	Sahihi	Tarehe
_____	_____	_____
Jina Shahidi	Shahidi Sahihi	Tarehe

MATUMIZI YA TAKWIMU YAKO # YA MASOMO YA BAADAYE:

Tafadhali weka sahihi kwenye sehemu moja

_____ Mimi na kubaliana na kuhifadhiwa za takwimu zangu kwa ajili ya tafiti za siku zijazo za VVU na magonjwa mengine ya zinaa.

_____ Sikubaliani na kuhifadhiwa kwa takwimu zangu kwa ajili ya tafiti za siku zijazo za VVU na magonjwa mengine ya zinaa.

_____	_____	_____
Jina la mshiriki	Sahihi ya Mshiriki	Tarehe
_____	_____	_____
Mfanyikazi katika utafiti	Sahihi	Tarehe
_____	_____	_____
Jina la Shahidi	Sahihi ya shahidi	Tarehe

HITIMISHO:
Kama una maswali yoyote au wasiwasi kuhusu utafiti, tafadhali jisikie huru kuwasiliana na Victoria Kisaakye Kanobe kutumia namba ya simu 0714-781310 au barua pepe kisaakye@yahoo.co.uk

Saini: _____
Mshiriki

Saini: _____
Mhoji

Appendix 4: Written consent form for Service Provider (English Version)

JOMO KENYATTA UNIVERSITY OF AGRICULTURE AND TECHNOLOGY (JKUAT)
Institute of Tropical Medicine and Infectious Diseases (ITROMID)

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY
The Impact of Sexual and Reproductive Health Counselling Services for HIV Positive Women in Comprehensive Care Centres (CCCs) in Langata

INTRODUCTION AND STUDY PURPOSE
Good morning/good afternoon, my name is….. …… and I am from the Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. You have been requested to participate in a research study being carried out by Victoria Kisaakye Kanobe, a MPH student at the JKUAT.This intends to investigate the impact of Sexual and Reproductive Health Counseling services provided within the CCCs in reducing the risks of unplanned pregnancies and STIs in Kenya among HIV positive women.

To achieve the study goals, the research will interview HIV positive women that have received sexual and reproduction health counselling services at the Langata CC clinic for the period January 2012 to December 2013. The findings from this study are expected to inform policy on scaling-up SRH services among HIV positive women to be able to meet their SRH needs and to improve the quality of service provision.

PROCEDURES
If you agree to participate in this study, I will conduct an interview with you. You may also be asked to participate in a focus group discussion. The interview will take place in a private setting, and it will take approximately 30minutes. During this interview, you will be asked about your perceptions on Sexual and Reproductive Health Counseling services provided within the CCCs. You will be asked structured questions with optional answers and the interviewer will tick the appropriate answers as you shall provide.

If you volunteer to participate in this study, we would ask you to do the following things:
- To take 10 – 20 minutes and respond to the key question we will ask where a questionnaire has been administered
- To give us 10 – 20 minutes to participate in the short interview and discussion that focuses on assessing your perceptions in regard to the quality of Sexual and Reproductive Health services you have received.

POTENTIAL RISKS AND DISCOMFORTS
This study will possess no potential risks as all information provided will treated with utmost confidentiality and all names of the participants will remain anonymous.

POTENTIAL BENEFITS TO PARTICIPANTS
There are no direct benefits related to your participation in this study. The findings of the study will however help to provide new knowledge that will be used to improve the quality of sexual and reproductive health counselling services for HIV positive women within the HCT service delivery and quality.
You will not be paid for participating in this study

CONFIDENTIALITY
Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study. Only pseudo names will be used if required and all the data will be treated with respect and utmost confidentiality. Your personal information may be disclosed if required by law. Any publication of this study will not use your name or identify you personally.

STORAGE AND USE OF DATA FOR FUTURE STUDIES
All data collected from the study to be kept for only five years to allow for data processing and make reference to the data during the time of study. All data will be assigned a code tagged to your name after which it will be destroyed. All qualitative research recordings within the data collected will be destroyed after one year. This timeline has been selected to allow enough time for transcription. No future studies will use this data unless approved by an Institutional Review Board or Independent Ethics Committee, which watches over the safety and rights of research participants, which must approve any future research studies using your data.

RIGHTS OF RESEARCH PARTICIPANTS
Your participation in this study is completely voluntary. You may choose to participate or not participate in this study. Your decision will in no way affect your current access to health services from this facility. If you do choose to participate, you can decide not to answer certain questions, or to stop the interview at any time

You are free to ask questions before signing this form. If you later want to talk to anyone about this research study or have questions, regarding your rights as a research participant, contact:

Secretary,
Ethics Review Committee, Kenya Medical Research Institute,
P.O Box 54840-00200,
Nairobi , Kenya
Telephone 254 (020) 2722541, 0722205901; 0733-400003
Email:info@kemri.org

STATEMENT OF CONSENT AND SIGNATURES
I have read this form or had it read to me. I have discussed the information with study staff. My questions have been answered. I understand that my decision whether or not to take part in the study is voluntary. I understand that if I decide to join the study I may withdraw at any time. By signing this form I do not give up any rights that I have as a research participant.

_____ _____
Participant Name Participant Signature/Thumbprint
Date
(print)

_____ _____
Staff Conducting Study Study Staff Signature
Date

Consent Discussion (print)

_____ _____

Witness Name Witness Signature

Date

USE OF YOUR DATA # FOR FUTURE STUDIES:

Please initial and date one option:

_____ I DO agree to store my data for future research into HIV, HIV- related diseases, and other sexually transmitted diseases.

_____ I DO NOT agree to store my data for future research into HIV, HIV-related diseases, and other sexually transmitted diseases.

_____ _____

Participant Name Participant Signature/Thumbprint

Date

(print)

_____ _____

Staff Conducting Study Study Staff Signature

Date

Consent Discussion (print)

_____ _____

Witness Name Witness Signature

Date

CONCLUSION:

If you have any questions or concerns about the research, please feel free to contact Victoria Kisaakye Kanobe using the telephone number 0714-781310 or email kisaakye@yahoo.co.uk

Signed: _____

Participant

Signed:_____

Interviewer

Appendix 5: Written consent form for Service Provider (Swahili Version)

JOMO KENYATTA CHA KILIMO NA TEKNOLOJIA (JKUAT)
Tarsisi ya Tropical Medicine na Magonjwa ya Kuambukiza (ITROMID)

IDHINI YA KUSHIRIKI KATIKA SOMO LA UTAFITI

Matokeo ya huduma ya ushauri kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi unaotolewa katika Vituo vya Malezi kwa Kina (Comprehensive Care Centres -CCCs) katika Wilaya ya Langata

UTANGULIZI na kujifunza KUSUDI

Habari za asubuhi / mchana nzuri, jina langu ni ..... nina toka Chuo Kikuu cha Jomo Kenyatta cha Kilimo na Teknolojia mjini Nairobi, Kenya katika Chuo cha Sayansi ya Afya. Umeombwa kushiriki katika utafiti unaofanywa na Victoria Kisaakye Kanobe, MPH mwanafunzi katika JKUAT. Utafiti hhu unakusudia kuchunguza matakeo yanayo tokana na kutolewa ushauri and huduma kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi zinazotolewa katika kituo hiki cha CCCs katika kupunguza hatari za mimba zisizotarajiwa na magonjwa ya zinaa katika Kenya miongoni mwa wanawake walio na Virusi vya Ukimwi (VVU).Ili kufikia malengo ya utafiti, wanawake wanaoishi na Virusi vya Ukimwi (VVU) na wamepokea huduma za ushauri kuhusi afya ya uzazi na katika Langata CC kliniki kati ya kipindi cha Januari 2012 hadi Desemba 2013 watahojiwa. Matokeo ya utafiti huu yanatarajiwa kutoa taarifa katika sera kupanua huduma ya afya ya uzazi miongoni ya wanawake wanaoishi VVU ilikuweza kushughulia mahitaji yao ya ngono au kimapenzi pamoja na afya ya uzazi na kuboresha ubora wa utoaji wa huduma.

TARATIBU

Kama unakubali kushiriki katika utafiti huu, mimi kuendesha mahojiano na wewe. Unaweza pia kuulizwa kushiriki katika lengo majadiliano ya kundi. Mahojiano yatafanyika katika mazingira ya binafsi, na itachukua takriban dakika30. Wakati wa mahojiano hii, utaulizwa kuhusu mitazamo yako juu ya huduma ya kimapenzi na Afya ya Uzazi Ushauri nasaha zinazotolewa ndani ya CCCs. Utaulizwa maswali muundo na majibu hiari na mhojaji itakuwa Jibu majibu sahihi kama wewe itatoa.

Kama kujitolea kushiriki katika utafiti huu, tunataka kuuliza wewe kufanya mambo yafuatayo:

- Kuchukua 10 - 20 dakika na kujibu swali muhimu tunaomba ambapo watakuwa dodoso imekuwa kusimamiwa

sanywa kutoka utafiti yatawekwa kwa miaka mitano tu kwa ajili ya kuruhusu usindikaji data na kufanya rejea kwa data wakati wa utafiti. Data yote itakuwa kwa ajili code tagged kwa jina lako baada ya ambayo itakuwa kuharibiwa. Wote rekodi ubora utafiti ndani ya data zilizokusanywa kuharibiwa baada ya mwaka mmoja. Kalenda hii imekuwa kuchaguliwa kuruhusu muda wa kutosha kwa transcription. No masomo ya baadaye kutumia data hii, isipokuwa kama kupitishwa na Bodi ya Taasisi Review au Independent Kamati ya Maadili, ambayo kuona juu ya usalama na haki za washiriki wa utafiti, ambayo lazima kupitisha masomo yoyote utafiti wa siku zijazo kwa kutumia data yako.

HAKI YA WASHIRIKI

Kushiriki kwako katika utafiti huu ni kwa hiari kabisa. Unaweza kuchagua kushiriki au kutoshiriki katika utafiti huu. Uamuzi wako hauthiri kupokelewa kwa huduma za afya kutoka kituo hiki. Ikiwa utachagua kushiriki, unaweza kuamua kutojibu maswali fulani, au kutia kikomo mahojiano wakati wowote

Uko huru kuuliza maswali kabla ya kutia sahii kwenye fomu hii. Kama baadaye utahitaji kuzungumza na mtu yeyote kuhusu utafiti huu au una maswali, kuhusu haki zako kama mshiriki katika utafiti, wasiliana na:

Katibu,
Kamati ya kisayansi, Kenya Medical Research (KEMRI)
Sanduku la Posta 54840-00,200, Nairobi, Kenya
Nambari ya simu 254 (020) 2722541, 0722205901; 0733-400003
Barua PepeEmail:info@kemri.org

TAARIFA YA IDHINI na saini
Nimesoma fomu hii au mimesomewa. Nimejadijliana na mtfaiti kuhus habari hizi. Maswali yangu yamejibiwa. Naelewa kwamba uamuzi wangu wa kushiriki au kutoshiriki katika utafiti huu ni wa hiari. Naelewa kuwa ikiwa nitajiunga na utafiti naweza kujiondoa wakati wowote. Kwa kutia sahihi kwenye fomu hii sijatupa haki zangu nilizonazo kama mshiriki wa utafiti.

_____	_____	_____
Jina la mshiriki	Sahii Mshiriki /kidole	Tarehe
_____	_____	_____
Wafanyakazi kufanya utafiti	Sahihi	Tarehe
_____	_____	_____
Jina Shahidi	Shahidi Sahihi	Tarehe

MATUMIZI YA TAKWIMU YAKO # YA MASOMO YA BAADAYE:

Tafadhali weka sahihi kwenye sehemu moja

_____ Mimi na kubaliana na kuhifadhiwa za takwimu zangu kwa ajili ya tafiti za siku zijazo za VVU na magonjwa mengine ya zinaa.

_____ Sikubaliani na kuhifadhiwa kwa takwimu zangu kwa ajili ya tafiti za siku zijazo za VVU na magonjwa mengine ya zinaa.

_____	_____	_____
Jina la mshiriki	Sahihi ya Mshiriki	Tarehe
_____	_____	_____
Mfanyikazi katika utafiti	Sahihi	Tarehe
_____	_____	_____
Jina la Shahidi	Sahihi ya shahidi	Tarehe

HITIMISHO:
Kama una maswali yoyote au wasiwasi kuhusu utafiti, tafadhali jisikie huru kuwasiliana na Victoria Kisaakye Kanobe kutumia namba ya simu 0714-781310 au barua pepe kisaakye@yahoo.co.uk

Saini: _____
Mshiriki
Saini: _____
Mhoji

Appendix 6: HIV Positive Women Questionnaire – English Version

Introduction:

My name is Victoria Kisaakye Kanobe and I am studying at Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. I am undertaking a study on the *"The Impact of Sexual and Reproductive Health (Sexual and Reproductive Health) Counselling Services for HIV Positive Women in HIV Care Centres".* I am seeking for your responses for some information related to this study concerning the sexual and reproductive health counseling services at this facility and would be very grateful if you could spend a little time in filling in this questionnaire. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. Do I have your permission to continue?

Instruction
Record the responses by either making a tick in the appropriate box or writing on the provided lines.

Name of facility _____ Code: _____

A. RESPONDENT CHARACTERISTICS:

1.	Age:	18-29 ❑	30-39 ❑	40-49 ❑	50-60 ❑
2.	Highest education Level:	None ❑	Primary ❑	Secondary❑	University❑
3.	Marital status:	Married/cohabiting ❑	Never ❑	Separated ❑	Widowed ❑
4.	Employment status		Employed ❑	Not employed ❑	Part timer ❑
5.	Time since HIV diagnosis:		0-11 months ❑	12-23 months ❑	24+ months ❑
6.	Do you attend the HIV clinic here?			Yes ❑	No ❑
7.	For how long have you been receiving services from this facility?	less than 1 year ❑	1-2 years ❑	3-4 years ❑	above 5 years ❑

B. ACCESSIBILITY TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

1. In the last one year, how many times did you come to the facility?
   1-5 ❑ 6-10❑ 11-15❑ 16-20 ❑ above 21❑

2. Have you ever come to this clinic to get counselling regarding your sexual and reproductive health in the last one year?
   Yes ❑ No if no why?

3. Did you have any difficulties in reaching the care centre for the sexual and reproductive counselling services?
   Yes ❑ No ❑
If yes, what difficulties did you experience?

4. Did you find the service providers at the facility having the right skills to address your sexuality needs?
   Yes ❑ No ❑ If no, why?

5. Did the facility provide you with sexual and reproductive health education materials for further information and guidance?

Yes ❑ No ❑ If no, why?

6. Were you provided with enough commodities and supplies to support you based on your needs and choices.

Yes ❑ No ❑ If no, why?

7. For the period you have been coming to this facility, which of the following services have you received? (*Please tick all that apply)*

Type of Service	**Yes**	**No**	**Comment**
a) Fertility intention, pregnancy planning and infertility concerns/services			
b) Use of family planning methods			
c) Use of Emergency Contraception methods			
d) Collection of condoms			
e) Sexual and reproductive health Counselling			
f) Antenatal care including PMTCT services for already pregnant women and Postpartum contraception			
g) Post natal Care			
h) Prevention and treatment of Breast and cervical cancer			
i) Treatment of STIs			
j) Pre and post abortion counselling			
k) Education on legal and ethical issues and/human rights			
l) Counselling before getting married			
m) Others: please specify			

8. If, you have attended the sexual and reproductive health counselling sessions at this clinic, kindly give us your feedback in terms of the following issues based on your experiences for the last counselling session you attended?

Characteristics for analysis	**Yes**	**No**	**Comment**
A. Analysis of the Sexual And Reproductive Health Counselling space:			
1. Facilities are conveniently located for HIV positive women			
2. Counseling and examination rooms ensure privacy for HIV positive women clients			
3. There is a separate space or times used for the HIV+ women clients			
4. HIV Positive Women feel welcomed and served with ease			
5. HIV positive women show overall satisfaction with environment at the clinic			
6. Privacy is maintained during counseling and other procedures because there are no cameras and no voices are recorded			
B. Analysis of the Counselling procedure	**Yes**	**No**	**Comments**
7. Assessment of client's reason for visiting clients			
8. Counsellor ensures proper client management using the (Six 'A's)			
– Counsellor **Asks** about client's sexual history			
– Counsellor **Assesses** client's risk perception			
– Counsellor **Assesses** client's motivation to change sexual behaviour			
– Counsellor **Advices** or educates on risk prevention measures			
– Counsellor **Assists/Facilitates** behaviour change by encouraging the clients			

Characteristics for analysis	Yes	No	Comment
– Counsellor **Arranges** for follow up			
9. Counsellor provides information clearly to the client in a simple and accurate language			
10. Counsellor provides the following information about pregnancy and STI/HIV/AIDS prevention strategies			
– Effectiveness of the various Family Planning methods			
– Side effects			
– Advantages and disadvantages			
– Correct use			
– Follow-up			
– Complications			
– Clients assured of confidentiality			
– Sensitivity to verbal and non-verbal			
– communication by provider			
11. Counselor engages in dynamic interactions and encourages clients to ask questions			
12. Counsellor understands and reviews the needs of a client, to ensure that client is empowered to make the decision about the solution to their problem;			
13. Counsellor has time for exploring clients' situations, questions and answers and checks for comprehension of the clients			
C. General Assessment of Services provided	**Yes**	**No**	**Comments**
14. No discrimination in service provision oocurs in this facility (married and non married HIV positive women)			
15. HIV positive women involved in decision-making regarding their care after providing adequate information on different options of treatment/methods			
16. Clients given their preferred treatment/methods (contraceptive)			
17. Provider forces clients to use particular treatment/method			
18. Services provided with the requirement for consent from other people other than the clients			
19. Provider counsels on importance of treating clients' partners if they have STIs			
20. Encourage and provides referrals for other services available when necessary			
21. Providers identify and make plans for HIV Positive people who require special support;			
D. Use and Provision of IEC leaflets on SRH and SRH operations	**Yes**	**No**	**Comments**
22. Education materials are displayed and available to HIV positive women			
23. Use of visual aids/memory aids and correctly used			
24. Education materials give clear information and messages			

C. SEXUAL BEHAVIOUR

1. No. of partners in past 6 months:		❑One partner	❑More than one
2. Type of partner:	❑Only regular	❑Only casual	❑steadily married
3. Partner HIV status:	❑Negative	❑Positive	❑Unknown
4. Disclosure of HIV Status:		❑Partner knows	❑ Partner does not know
5. Do you have HIV Transmission concerns?		❑Yes	❑No

6. If yes, which ones?			
7. Have you had an STI in past 1 year		❑Yes	❑No
8. If yes, which one?			
9. Do you experience internal stigma:	❑Minimal/Low	❑Moderate	❑High
10. Do you use condoms?		❑Yes	❑No
11. Do you feel tired of using condoms?	❑Agree	❑Disagree	❑Do not know
12. Do you believe condom reduces pleasure?	❑Agree	❑Disagree	❑Do not know
13. Family planning method:	❑Using condom	❑Using other method	❑No family planning

D. SEXUALITY REPRODUCTIVE HEALTH NEEDS

SEXUAL AND REPRODUCTIVE HEALTH NEEDS AND DESIRES

1. Who makes the decisions about the reproductive health concerns and needs at home (e.g. family size, sex,	❑Female partner	❑Male partner		❑The couple
2. Do you desire to have children?		❑ Yes		❑No
3. How many children would you desire?	❑ None	❑ 1-2	❑ 3-5	❑6-10
Why?				
4. Do you feel that service providers support you in your child bearing concerns?			❑Yes	❑No
Why?				
5. Do you feel that your rights as a woman are respected?			❑Yes	❑No
Why?				
6. What other dilemmas have you faced?				
7. Do you feel knowledgeable about sexual matters?			❑Yes	❑No
Why?				
8. Do you discuss sex-related issues with your family members or husband?			❑Yes	❑No
What is discussed? And why?				
9. Who else do you discuss with your sexual related issues concerns?	Service provider	Clergy	Peer/friend	Relative
Why?				

USE OF FAMILY PLANNING METHODS AND CONTRACEPTIVES

USE OF FAMILY PLANNING METHODS	**Yes**	**No**	**Comments**

10. Is your partner opposed to the use of family planning methods			
11. If yes, what would be the reason for opposing the use of the family planning methods? *Tick any of the following below;*			
– HIV Positive people who lack negotiation skills			
– Victims of sexual violence			
– First time users			
– Subsequent users who are defaulting			
– Handling of first time users at the clinic			
– Friendly welcome			
– Orientation and education on services provided			
– Education on their rights to use the services			
– Assurance of confidentiality			
– Times of operations			

FAMILY PLANNING KNOWLEDGE – INCLUDING DUAL PROTECTION

16. Do you have enough knowledge on the following family planning methods? (*Please tick any*)	❑Pills	❑Injectables	❑Condoms	❑IUDs	❑Natural methods	❑Emergency Contraception methods
If no why?						
17. Which methods do you see most appropriate? (*Please tick any*)	❑Pills	❑Injectables	❑Condoms	❑IUDs	❑Natural methods	❑Emergency Contraception methods
18. What are the barriers for not using the other methods?						
19. What challenges have you experienced?						
20. How have service provider supported you?						

E. SEXUAL TRANSMITTED INFECTION (STIS)

1. Do you have knowledge on the STIs infection, transmission and control?	Yes ❑	No ❑
If no why?		
2. Have you undergone routine STI screening?	Yes ❑	No ❑
If no why?		
3. Are you aware that STIs can be asymptomatic in your body?	Yes ❑	No ❑
4. Have the service providers provided information about the STIs infection, transmission and control?	Yes ❑	No ❑

F. PREVENTION AND TREATMENT OF BREAST AND CERVICAL CANCER

1. Have you received information about Prevention and treatment of Breast and cervical cancer?	Yes ❑	No ❑
If no why?		
2. Do you undergo routine breast examinations?	Yes ❑	No ❑
3. Have you been examined for cervical cancer?	Yes ❑	No ❑

G. UNINTENDED OR UNPLANNED PREGNANCIES

1. Have you ever had unintended pregnancies?	Yes ❑	No ❑
2. What options did you choose?	Abortion	Retaining the

		pregnancy
3. Why did you choose the choice made?		
4. Did the service provider support you in making a choice?	Yes ❑	No ❑
If no why?		

MATERNITY CARE, INCLUDING PMTCT SERVICES

5. Have you ever accessed PMTCT services? *(if no skip this section)*			Yes ❑	No ❑
6. How did you know about the PMTCT services?	❑ A friend	❑Health worker	❑HCT clinic	❑News
7. What benefits did you experiences?				
8. What challenges did you experience?				
9. Did the service provider s support you through the process?			Yes ❑	No ❑
How?				

CONCLUSION

10. Do you feel that your voice in regard to sexual and reproductive health issues is being heard amongst the policy institutions?	Yes ❑	No ❑
11. Do you feel your rights are being recognized?	Yes ❑	No ❑
12. What do you think need to be done to ensure that your SRH needs are fully addressed?		
Any other comments		

The end …….. Thank you for your time

Appendix 7: HIV Positive Women Questionnaire –Kiswahili Version

Introduction

My name is Victoria Kisaakye Kanobe and I am studying at Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. I am undertaking a study on the *"The Impact of Sexual and Reproductive Health Counselling Services for HIV Positive Women in HIV Care Centres".* I am seeking for your responses for some information related to this study concern the sexual and reproductive health counseling services at this facility and would be very grateful if you could spend a little time in filling in this questionnaire. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. Do I have your permission to continue?

Kuanzishwa

Jina langu ni Victoria Kisaakye Kanobe na ninasoma katika Chuo Kikuu cha Jomo Kenyatta cha Kilimo na Teknolojia mjini Nairobi, Kenya katika Chuo cha Sayansi ya Afya. Nina fanya utafiti kuhusu kiwango cha athari ya ushauri wa maswala ya kujamiana na hali ya Afya ya uzazi kwa wanawake wanaoishi na virusi vya HIV katika vituo vya huduma vya HIV. Ni nahitaji majibu yako kwa baadhi ya habari kuhusiana na suala hili la utafiti wa ngono na afya ya uzazi katika kituo hiki na nitashukuru sana kama unaweza kutumia muda kidogo kujaza fomu hii. Sita nakili jina lako na kila kitu, utakacho nieleza yatawekwa siri kamili.kushiriki kwako ni kwa hiari, na uko huru kutojibu maswali yoyote ambayo hutaki. Je nina ruhusa yako kuendelea?

Instruction

Record the responses by either making a tick in the appropriate box or writing on the provided lines.

Andika majibu kwa aidha kufanya Jibu sahihi katika sanduku au kuandika juu ya mistari zinazotolewa.

Name of facility _____ Code: _____
Interview Date_____
Time started_____ Time Ended_____

A. RESPONDENT CHARACTERISTICS:

1. Age: *Umri*	☐18-29	☐30-39	☐40-49	☐50-60
2. Highest education Level: *Kiwango cha juu cha elimu*	☐None	☐Primary *Shule ya msingi*	☐Secondary *Shule ya sekondari*	☐University *Chuo kikuu*
3. Marital status: *Hali ya ndoa*	☐Married or cohabiting *Nimeolewa au tunaishi pamoja*	☐Never *Sijawahi olewa*	☐Separated *Tumetengana*	☐Widowed *Mjane*
4. Employment status *Hali ya kikazi*		☐Employed *Nimeajiriwa*	☐Not employed	☐Part timer *Kazi rejareja*

			Sijaajiriwa	
5. Time since HIV diagnosis: *muda tangu kupatikana virusi vya ukimwi*		☐0-11 months *miezi 0-11*	☐12-23 months *Miezi 12-23*	☐24+ months *Zaidi ya miezi24*
6. Do you attend the HIV clinic here? *Unahudhuria kliniki ya Virusi vya ukimwi hapa?*			☐Yes *Ndio*	☐No *Hapana*
7. For how long have you been receiving services from this facility? *Je ni kwa muda gani umekuwa ukipokea huduma kutoka kituo hiki?*	☐less than 1 year *chini ya mwaka 1*	☐1-2 years *Mwaka 1-2*	☐3-4 years *Mwaka 3-4*	☐above 5 years *zaidi ya miaka 5*

B. ACCESSIBILITY TO THE CARE CENTRE AND ANALYSIS OF SERVICES PROVIDED

1. In the last one year, how many times did you come to the facility?
   Katika muda wa mwaka mmoja uliopita, ni mara ngapi umekuja katika kituo hiki?
   ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐above 21

2. Have you ever come to this clinic to get counselling regarding your sexual and reproductive health in the last one year?
   Je, umewahi kupata ushauri nasaha kuhusu mahitaji yako ya ngono na afya ya uzazi katika kituo hiki katika muda wa mwaka mmoja?
   ☐Yes *Ndiyo*☐No/*La* if no why? Kwanini?

3. Did you have any difficulties in reaching the care centre for the sexual and reproductive counselling?
   Ulipata ugumu wowote kufika katika kituo cha afya kupata ushauri nasaha kuhusu mahitaji ya kufanya ngono na afya ya uzazi?☐ Yes/ *Ndiyo* ☐ No/*La*

   If yes, what difficulties did you experience?
   Kama ndiyo,ni magumu yapi uliyoyapitia?

4. Did you find the service providers at the facility competent enough to address your sexuality needs?
   Je uliwapata Wauguzi katika kituo hicho kuwa na maarifa/utaalam wa kutosha kushuguhulikia mahitaji yako ya kingono au kimapenzi?
   ☐Yes/ *Ndiyo* ☐ No/ La If no, why? *Kama la, kwa nini?*

5. Did the facility provide you with sexual and reproductive health materials for further information and guidance? *Je ulipewa vifaa vyovyote vinavyohusu maswala ya ngono na afya ya uzazi na kituo hicho kwa ufahamu zaidi na mwongozo?*
   ☐Yes/ *Ndiyo* ☐ No/*La* If no, why?*Kama la, kwa nini?*

6. Were you provided with enough commodities and supplies to support you based on your needs and choices. Je ulipewa vifaa vya kutosha kukuwezesha kujishuguhulikia kulingana na mahitaji yako na maamuzi
   ☐Yes/ *Ndiyo* ☐ No/*La* If no, why? *Kama La, Kwa nini*

7. For the period you have been coming to this facility, which of the following services have you received? (*Please tick all that apply)*
   Kwa muda ambao umekuwa ukija katika kituo hiki, ni ipi kati ya huduma zifuatazo umepokea?

Type of Service Aina ya huduma	☐Yes *Ndio*	☐No *La*	**Comment**
a) Fertility intention, pregnancy planning and infertility concerns/services *Kupanga uzazi,kupanga mimba, hofu juu utasa au kutoshika mimba*			
b) Contraception use/ *utumizi wa vizuizi mimba*			
c) Emergency Contraception methods/ *Njia za kuzuia mimba kwa faraga*			
d) Collection of condoms/ *kuchukua mipira ya kondom*			
e) sexual and reproductive health Counselling/ *Ushauri nasaha ya ngono na afya ya uzazi*			
f) Antenatal care including PMTCT services for already pregnant women and Postpartum contraception/ *Huduma ya kuwa mjamzito pamoja na kuzuia maambukizi virusi vya ukimwi kutokata kwa mama hadi mtoto*			
g) Post natal Care /*Huduma ya baada ya kujifungua*			
h) Prevention and treatment of Breast and cervical cancer i) *Kuzuia na matibabu ya saratani ya matiti na mfuko wa uzazi*			
j) Treatment of STIs k) *Matibabu ya magonjwa ya zinaa*			
l) Pre and post abortion counselling m) *Ushauri kabla na baada ya kutoa mimba*			
n) Education on legal and ethical issues and/human rights o) *Elimu ya sheria na maadili na haki za kibinadamu*			
p) Premarital counselling/ *Ushauri kabla ya ndoa*			
q) Others: please specify/ *Mengine,tafadhali fafanua*			

8. If attended sexual and reproductive health Counselling, which of the following key aspects did you observe during the last counselling session? *Kama ulihudhuria ushauri nasaha wa ngono na afya ya uzazi,ni gani kati ya matamshi uliyoyatambuakatika mashauri ya mara ya mwisho?*

Characteristics for analysis	☐Yes Ndio	☐No hapana	**Comment**
A. Analysis of the Sexual And Reproductive Health Counselling space:Uchambuzi wa ushauri wa ngono			

na Afya ya uzazi			
a) Facilities are conveniently located for HIV positive women /*Vituo vimetengewa sehemu nzuri kwa wanawake wenye virusi vya ukimwi*			
b) Counseling and examination rooms ensure privacy for HIV positive women clients/ *Vyumba vya ushauri na uchunguzi vinahakikisha usiri kwa wateja wanawake wenye virusi*			
c) There is a separate space or times used for the HIV+ women clients *Kuna sehemu au masaa yametengwa kwa matumizi ya wateja wanawake walio na virusi*			
d) HIV Positive Women feel welcomed and served with ease/ *Wanawake walio virusi vya ukimwi wanajisikia huru na wanahudumiwa kwa urahisi*			
e) HIV positive women show overall satisfaction with environment at the clinic/ *Wanawake walio na virusi vya ukimwi uonyesha kutoshelezwa na hali ilivyo katika kliniki*			
f) Visual and auditory privacy maintained during counseling and other procedures/ *Hali ya siri inazingatiwa wakati wa mashauri na hata katika kupokelewa kwa matibabu au huduma zozote*			
B. Analysis of the Counselling procedure Uchambuzi wa njia ya mashauri	☐Yes *Ndio*	☐No *La*	**Comments**
a) Assessment of client's reason for visiting clinic/*Uchunguzi juu sababu ya mteja kutembelea kituo cha afya*			
b) Counsellor ensures proper client management using the (Six 'A's) *Mshauri kuhakikisha utunzi bora wa wateja akitumia {A sita}*			
– Ask about client's sexual history/ *Uliza mteja kuhusu historia yake ya maswala ya ngono*			
– Assess client's risk perception/ *Chunguza maoni ya mteja kuhusu hatari*			
– Assess client's motivation to change sexual behaviour *Chunguza uwezo wa mteja kubadili tabia zake kuhusu ngono*			
– Advice or counsel on risk prevention measures *Toa mawaidha au ushauri wa njinsi ya kuzuia hatari*			
– Assist/Facilitate behaviour change by encouraging clients *Saidia au wezesha ubadilishaji wa tabia kwa kuwapa wateja moyo*			
– Arranging for follow up/ *Kuweka mpangilio wa kufuatilia*			
c) Counsellor provides greater clarity of the information given to clients in an accurate and non-technical language/ *Mshauri kupeana ufafanuzi mwafaka kwa wateja kwa njia sahihi*			

na kutumia lugha inayoeleweka kwa urahisi			
d) Counsellor provides the following information about pregnancy prevention and STI/HIV/AIDS prevention strategies/ *Mshauri kupeana mafundisho yafuatayo kuhusu uzuizi wa mimba na magonjwa mengine ya zinaaa pamoja na Virusi vya ukimwi*			
– Effectiveness Utendakazi			
– Side effects / *Madhara*			
– Advantages and disadvantages/ *Manufaa na Zisizo na manufaa*			
– Correct use/ *Utumizi bora*			
– Follow-up / *Ufuatilizi*			
– Complications / *Shida au matatizo*			
– Clients assured of confidentiality/ *Wateja kuhakikishiwa siri*			
e) Sensitivity to verbal and non-verbal / *Uangalifu au kujali matamshi*			
• communication by provider/ *Mazungumzo ya mhuduma*			
f) Counselor engages in dynamic interactions;/*Mshauri kujihusisha vilivyo na mambo yote*			
– with much less telling and more listening/ *Kusema machache na Kusikiliza kwa wingi*			
– asking, responding, encouraging/ *Kuuliza,kujibu na kutia moyo*			
– establishing rapport and clarifying/ *Kuanzisha urafiki na ufafanuzi*			
– Encouraging clients to ask questions and responding/ *Kuwasihi wateja kuuliza maswali na kuwajibu*			
– seeking clarification *Kutafuta ufafanuzi*			
g) Counsellor understands and reviews the needs of a client, to ensure that:/ *Mshauri anaelewa na anayafutilia mahitaji ya mteja ili:*			
– information is more relevant to the client/ *ujumbe au habari ni wa maana kwa mteja*			
– client is empower to make the decision about the solution to their problem/ *mteja kupewa ushauri wa kuweka mikakati kuhusu suluhu ya shida zao*			
– Provides only relevant information/ *upeana tuu habari au ujumbe muhimu*			
h) Counsellor has time for exploring clients' situations, questions and answers / *Mshauri ako na muda wa kufuatilia hali ya wateja,maswali na majibu*			
– and checks for comprehension of the clients/ *na Kuangalia kuelewa/ ufahamu wa wateja*			

i) Providers inquire of client's risk perception of STI, HIV/AIDS and pregnancy/ *Wauguzi uchunguza mafikara ya wateja juu ya hali ya hatari kuhusu magonjwa ya zinaa na , virusi vya ukiwi pamoja na ujauzito*			
j) Issues of sexuality and gender discussed *Maswala ya ngono na njisia*			
C. General Assessment of Services provided	☐Yes *Ndio*	☐No *La*	**Comments**
a) No discrimination in service provision(married and non married HIV positive women)*Hakuna ubaguzi kwa utoaji huduma{ wanawake walioolewa na wasioolewa walio virusi vya ukimwi}*			
b) Services commonly used (Comment on what services)/*Huduma ambazo zinatumika kwa sana{zungumzia ni huduma zipi}*			
c) HIV Positive Women often visit the clinic/ *Wanawake wenye virusi vya HIV hutembelea kliniki mara kwa mara*			
d) Individualised care promoted and provided/ *Huduma ya moja kwa moja inaendeleshwa na kupeanwa*			
e) HIV positive women involved in decision-making regarding their care after providing adequate information on different options of treatment/methods/*Wanawake wenye virusi vya ukimwi kuhusishwa katika maamuzi kuhusu huduma yao baada ya kupewa habari kabambe kuhusu njia mbalimbali za matibabu au mbinu*			
f) Clients given their preferred treatment/methods (contraceptive) *Wateja kupewa njia matibabu au upangaji uzazi wanayo penda*			
g) Provider forces clients to use particular treatment/method /*Mhuduma kulazimisha wateja kutumia njia fulani ya upangaji uzazi*			
h) Services provided with the requirement for consent from other people other than the clients *Huduma kupeanwa kwa nia ya maamuzi ya watu wengine ila la mteja*			
i) Medical procedures (pelvic examinations and blood tests) are delayed *Mpangilio wa matibabu{uchunguzi wa sehemu ya chini ya mwili na kutoa damu}kucheleweshwa*			
j) Provider counsels on importance of treating clients' partners if they have STIs *Mhudumu kutoa ushauri wa umuhimu wa matibabu kwa wapenzi wa mteja wakiwa na magonjwa ya zinaa*			
k) Encouragement of continuity and arrangement of follow-up *Kupeana mawaaidha ya kuendelesha na mpangilio wa kufuatilia*			
l) Provides Information on location of similar services in his/her locality/community *Kupewa taarifa kuhusu sehemu nyinginezo zenye huduma kama hizi mahala anamoishi mteja]*			

m) Encourage and provides referrals for other services available when necessary *Kupewa moyo na kuruhusiwa kurudi kwa huduma zinginezo ikiwa muhimu*			
n) Providers identify and make plans for HIV Positive people who require special support; *Wahudumu kuchunguza na kuweka mipangilio kwa watu wanaougua HIV na wanahitaji usaidizi maalum*			
D. Use and Provision of IEC leaflets on SRH and SRH operations	☐Yes *Ndio*	☐No *La*	**Comments**
a) Education materials are displayed and available to HIV positive women *Makaratasi ya mafunzo yamewekwa hadharani kwa matumizi ya wanawake wenye virusi vya ukimwi*			
b) Use of visual aids/memory aids and correctly used *Utumizi mzuri wa vifaa vya kusaidia kuona au kufikiria*			
c) Education materials give clear information and messages *Makaratasi ya mafunzo zinapeana jumbe kamili*			

C. SEXUAL BEHAVIOUR

1. No. of partners in past 6 months: *Nambari ya wapenzikwa miezi sita iliyopita*		One partner *Mpenzi mmmoja*	More than one *Zaidi yammoja*
2. Type of partner: *Aina ya mpenzi:*	Only regular *Mpenzi wa kawaida*	Only casual *Mpenzi rejareja*	steadily married *Kuolewa kikamilifu*
3. Partner HIV status: *Hali ya Virusi ya mpenzio*	Negative *Hana virusi*	Positive *Ana virusi*	Unknown *Sijui*
4. Disclosure of HIV Status: *Kufichua hali ya Virusi vya ukimwi*		Partner knows *Mpenzi anajua*	Partner does not know *Mpenzi hajui*
5. Do you have HIV Transmission concerns? *Una wasiwasi juu ya umbukizaji wa virusi vya ukimwi*		Yes/ *Ndiyo*	No/ *La*
6. If yes, which ones? *Kama ndiyo, gani?*			
7. Have you had an STI in past 1 year/*Umeambukizwa ugonjwa wa zinaa katika kipindi cha mwaka mmoja uliopita*		Yes/ *Ndiyo*	No/ La
8. If yes, which one? *Kama ndiyo,ni gani?*			
9. Do you experience internal stigma:*Unakumbana na hali ya kutokubaguliwa*	Minimal/Low *Kadri au chini*	Moderate *Wastani*	High *Juu*
10. Do you use condoms?*Unatumia mipira ya kondom*		Yes Ndiyo	No/ *La*
11. Do you feel tired of using	Agree	Disagree	Do not know *Sijui*

condoms?*Unahisi kuchoka kutumia mpira wa kondom*?	*Nakubali*	*Sikubali*	
12. Do you believe condom reduces pleasure? *Unaamini kuwa mpira wa kondom unazuia utamu?*	Agree *Nakubali*	Disagree Sikubali	Do not know Sijui
13. Family planning method: Njia ya kupanga uzazi?	Using condom *Kutumia kondom*	Using other method *Kutumia njia nyingine*	No family planning *Hakuna kupanga uzazi*

SEXUALITY REPRODUCTIVE HEALTH NEEDS

Sexual and reproductive Health intentions and Reproductive rights

1. Who makes the decisions about the reproductive health concerns and needs at home (e.g. family size, sex, e.t.c.)*Ni nani hutoa maamuzi kuhusu upangaji uzazi na mahitaji nyumbani{mfano ukubwa wa familia,ngono na kadhalika}*	Female partner *Mpenzi wa kike*	Male partner *Mpenzi wa kiume*		The couple *Wote pamoja*
2. Do you desire to have children?*Una hamu ya kupata watoto?*		Yes *Ndiyo*		No *La*
3. How many children would you desire?*Ungependa kuwa na watoto wangapi*?	None *Hakuna*	1-2	3-5	6-10
Why?kwanini				
4. Do you feel that service providers support you in your child bearing concerns?*Je unahisi kuwa waauguzi wanakupa usaidizi kwa maswala yako ya uzazi*			Yes *Ndiyo*	No/ *La*
Why? Kwanini				
5. Do you feel that your rights as a woman are respected?*Unahisi kuwa haki zako kama mwanamke zinaheshimiwa*			Yes *Ndiyo*	No/ La
Why?kwanini				
6. What other dilemmas have you faced?*Ni matatizo yapi mengine umekumbana nayo*				
7. Do you feel knowledgeable about sexual matters? *Je unajihisi kuwa una ufahamu wa kutosha kuhusu maswala ya*			Yes *Ndiyo*	No/ *La*

ngono				
Why?				
8. Do you discuss sex-related issues with your family members or husband?*Je unazungumza na familia yako au mumeo kuhusu maswala yanayohusu ngono*			Yes *Ndiyo*	No/ *La*
What is discussed? And why?Nini kinazungumziwa na kwanini				
9. Who else do you discuss with your sexual related issues concerns?*Ninani mwingine unajadiliana naye kuhusu mafikira yako kuhusu ngono*	Service provider *Mhudumu*	Clergy *Wachungaji kanisani*	Peer/friend *Mwana rika au rafiki*	Relative *Familia*
Why? *Kwa nini*				

Use of contraceptives *Utumizi wa vizuizi mimba*

Use of contraceptives	☐Yes *Ndio*	☐No *La*	**Comments**
10. Is your partner opposed to the use of contraception? *Je mpenzi wako anapingamizi juu ya matumizi ya njia za kupanga uzazi?*			
11. If yes, what would be the reason for opposing the use of the contraceptive? (HIV Positive woman whose partner is opposed to use of contraceptive) *Kama ndiyo,ni nini kinamfanya kupinga utumizi wa njia za kupanga uzaz. (Kwa mwanamke mwenye virusi ambaye mumewe anapinga utumizi wa vifaa hivyo*			
– HIV Positive people who lack negotiation skills/ *Watu wenye virusi ambao hawana ujuzi wa kujadiliana*			
– Victims of sexual violence /*Wahadhiriwa wa ngono kwa lazima*			
– First time users *watumizi wa mara ya kwanza*			
– Subsequent users who are defaulting *watumiaji ambao hawatumii vifaa hivyo vikamilifu*			
– Handling of first time users at the clinic/ *Kuhudumia watumizi wa kwanza katika kliniki*			
– Friendly welcome *Makaribisho ya urafiki*			
– Orientation and education on services provided/ *Maelezo na mafunzo kuhusu huduma zinazopeanwa*			
– Education on their rights to use the services/ *Mafunzo kuhusu haki yao ya matumizi ya vifaa hivyo*			

– Assurance of confidentiality/ Kupewa uhakikisho wa siri			
– Times of operations *Masaa ya kazi*			

Family planning knowledge – including dual protection

12. Do you have enough knowledge on the following Contraceptive Methods? (Please Tick) *Je una ufahamu wa kutosha kuhusu njia zifuatazo za upangaji uzazi*	Pills/ *Madawa au vidude*	Injectables/ *Shindano*	Condoms *Mipira*	IUDs *madawa ya kuingizwa mwilini*	Natural methods *Njia halisi*	Emergency Contraception methods *Njia ya kuzuia mimba*
If no why? Kwanini						
13. Which methods do you deem most appropriate? (tick)*Ni njia zipi unaona zinafaa*	Pills Pills *Madawa au vidude*	Injectables *Shindano*	Condoms *Mipira*	IUDs *madawa ya kuingizwa mwilini*	Natural methods *Njia halisi*	Emergency Contraception methods *Njia ya kuzuia mimba*
14. What are the barriers for not using the other methods? *Ni vizuizi gani vya kutotumia hizi njia*						
15. What challenges have you experienced? *Changamoto zipi umekumbana nazo*						
16. How have service provider supported you? *Wahudumu wamekusaidia kwa njia gani*						

Sexual Transmitted Infection (STIs)

17. Do you have knowledge on the STIs infection, transmission and control? *Je uko na ufahamu kuhusu maambukizi ya magonjwa ya zinaa,njia ya kusambazwa na kuzuia*	18. Yes *Ndiyo*	19. No/ *La*
If no why? *Kwa nini*		
20. Have you undergone routine STI screening? *Umefanyiwa uchunguzi wa kina wa magonjwa ya zinaa*	21. Yes *Ndiyo*	22. No/ *La*
If no why? *Kwa nini*		
23. Are you aware that STIs can be asymptomatic in your body? *Je unaufahamu kuwa magonjwa ya zinaa zinaweza jificha mwilini mwako*	Yes *Ndiyo*	No/ *La*
24. Have the service providers provided information about the STIs infection, transmission and control? *Je wahudumu wamepeana mawaidha kuhusu magonjwa ya zinaa,njia ya kuambukizwa na kuzuia*	Yes Ndiyo	No/ *La*

Prevention and treatment of Breast and cervical cancer

25. Have you received information about Prevention and treatment of Breast and cervical cancer?*Je umepewa fahamu kuhusu njia ya kuzuia na kutibiwa kwa saratani ya matiti na mfuko wa uzazi*	Yes Ndiyo	No/ *La*
If no why?*Kwa nini*		
26. Do you undergo routine breast examinations? *Je huwa unafanya uchunguzi wa matiti* mara kwa mara	Yes Ndiyo	No/ *La*
27. Have you been examined for cervical cancer? *Je umefanyiwa uchunguzi wa saratani ya mfuko wa uzazi*	Yes Ndiyo	No/ *La*

Unintended or unplanned pregnancies Mimba zisizo pangiwa au takikana

28. Have you ever had unintended pregnancies? *Je umewahi kushika mimba usiyo hitaji*	Yes	No
29. What options did you choose *Ni njia zipi ulichagua*	Abortion *Kuavya mimba*	Retaining the pregnancy *Kutotoa mimba*
30. Why did you choose the choice made? *Kwanini ulichagua uamuzi huo*		
31. Did the service provider support you in making a choice? *Je mhudumu alikusaidia kutengeneza uamuzi huo*	Yes/*Ndio*	No/*La*
If no why? *Kwa nini*		

Maternity care, including PMTCT services

32. Have you ever accessed PMTCT services? *(if no skip this section)Umewahi kupokea huduma ya kuzuia maambukizi ya mama kwa mtoto{kama la ruka sehemu hii}*			Yes *Ndiyo*	No/ *La*
33. How did you know about the PMTCT services?*Ulifahamu vipi huduma hizi za kuzuia maambukizi ya mama kwa mtoto*	A friend *Rafiki*	Health worker *Mhudumu wa Afya*	HCT clinic *Kliniki ya HTC*	News *Habari*
34. What benefits did you experiences? *Manufaa zipi ulikumbana nazo*				
35. What challenges did you experience? Changamoto zipi ulikumbana nazo				
36. Did the service provider s support you through the process*? Je wahudumu walikusaidia kwa njia hii*			Yes *Ndiyo*	No/ *La*
How? Kivipi				

Information, Education and Communication and Counselling and Psychosocial support
Policy priorities and programmatic needs

37. Do you feel that your voice in regard to sexual and reproductive health issues is being heard amongst the policy institutions?*Je unaisi kuwa sauti yako inasikizwa na wahusika kuhusu mambo ya ngono na afya ya uzazi*	Yes *Ndiyo*	No / *La*
38. Do you feel your rights are being recognized? *Unaisi kuwa aki zako zinazingatiwa?*	Yes *Ndiyo*	No/ La
39. What do you think need to be done to ensure that your SRH needs are fully addressed?*Unadhani ni nini kinapaswa kufanywa ili mahitaji yako ya ngono na afya ya uzazi izingatiwe kikamilifu*		
40. Any other comments/ *Maelezo nyingine*		

The end …….. Thank you for your time *Mwisho.....Ahsante kwa muda wako*

Appendix 8: Focus Group Discussion Guide for HIV Positive Women

Introduction:

My name is Victoria Kisaakye Kanobe and I am studying at Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. I am undertaking a study on the *"The Impact of Sexual and Reproductive Health (Sexual and Reproductive Health) Counselling Services for HIV Positive Women in HIV Care Centres".* I am seeking for your responses for some information related to this study concerning the sexual and reproductive health counseling services at this facility and would be very grateful if you could spend a little time in filling in this questionnaire. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. Do I have your permission to continue?

Name of Interviewer: _____ Location: _____Date: _____

1. What Sexual and Reproductive Health services and programs are provided at this facility? Who can access these services?
2. What procedures do you follow when you visit this facility for Sexual and Reproductive Health services? – *ask also about confidentiality, privacy, physical examination, follow up care*
3. What are the most common Sexual and Reproductive Health needs that HIV Positive women present with during their counselling visits? Do counsellors adequately address the needs?
4. What factors do you think are preventing HIV Positive Women from coming to this facility to access the Sexual and Reproductive Health services at this facility? How should these be addressed?
5. In your view if HIV Positive Women do not access the Sexual and Reproductive Health counselling services what would happen to them?
6. What are the attitudes of the health service providers towards provision of Sexual and Reproductive Health services to HIV Positive Women? Have they influences the access to Sexual and Reproductive Health Counselling services in any way?
7. Does this facility have enough supplies and commodities for Sexual and Reproductive Health services?
8. What should be done to ensure that there enough supplies and commodities for Sexual and Reproductive Health services and also ensure that services are of high quality?
9. What problems have you faced in the implementing the choices and decisions you make during the Sexual and Reproductive Health counselling process? E.g. on pregnancy, sexual desires - Why? Any examples?
10. What plans should be used to mobilise the HIV Positive women in the community to access the Sexual and Reproductive Health counselling services?
11. What should be the role of the community in supporting/encouraging HIV Positive Women to use Sexual and Reproductive Health services at this facility?
12. In your opinion, what has been the key outcome for using Sexual and Reproductive Health by HIV Positive Women at your facility?

Appendix 9: Interview Guide for HIV Positive women- Kiswahili

Kuanzishwa

Jina langu ni Victoria Kisaakye Kanobe na ninasoma katika Chuo Kikuu cha Jomo Kenyatta cha Kilimo na Teknolojia mjini Nairobi, Kenya katika Chuo cha Sayansi ya Afya. Nina fanya utafiti kuhusu matakeo yanayo tokana na kutolewa ushauri and huduma kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi kwa wanawake wanaoishi na virusi vya Ukimwi katika vituo vya Afya. Ni nahitaji majibu yako kwa baadhi ya habari kuhusiana na suala hili la utafiti wa ngono na afya ya uzazi katika kituo hiki na nitashukuru sana kama unaweza kutumia muda kidogo kujaza fomu hii. Sita nakili jina lako na kila kitu, utakacho nieleza yatawekwa siri kamili. Kushiriki kwako ni kwa hiari, na uko huru kutojibu maswali yoyote ambayo hutaki. Je nina ruhusa yako kuendelea?

Name of Interviewer (Jina)_____ Location: _____Date (Tarehe)_____

1. Ni huduma gani na mipango ya afya ya uzazi na ngono inatolewa katika kituo hiki? Ni nani anapokea huduma hizi?
2. Ni njia zipi unafuata wakati umefika katika kituo hiki kupokea huduma ya Kimapenzi and Afya ya jamii? (*Uliza kuhusu siri,uchunguzi, na huduma fuatilizi)*
3. Ni matatizo gani ya mara kwa mara ya afya ya uzazi na ngono inayowakumba wanawake wenye virusi vya HIV.Je unadhani kuwa ushauri unaopokea inashugulikia kikamilifu mahitaji ya wanawake wenye virusi vya HIV
4. Ni mambo yapi unadhani inawakumba wanawake wenye virusi vya HIV wanaotumia huduma za Kwa maoni yako kama wanawake wanaoishi na virusi vya ukimwi hawafikihi huduma za kimapenzi na Afya ya Uzazi ni nini kitawafanyikia?
5. Ni mikakati ipi inafuatwa kuboresha huduma kwa wanawake wenye virusi vya HIV.Uboreshaji huu ni fikira ya nani haswa.wateja au wahudumu
6. Je mienendo ya wauguzi wa huduma kimapenzi na Afya ya Uzazi kwa wanawake wenye virusi ni vipi?
7. Ni shida zipi umekumbana nazo katika uchaguzi wa mikakati ya kupeana ushauri wa SRH .kwanini.Tafadhali peana mifano
8. Ni mipangilio zipi zinatumika kuwakusanya wanavijiji na wanawake wanaogua virusi vya HIV kuhusu kuweko kwa huduma za SRH
9. Ni matatizo gani umeyapitia katika kufanya chaguo na uamuzi wakati wa huduma za kimapenzi na Afya ya Uzazi? (*Mimba, haja za ngono- kwa nini- toa mifano*)
10. Kwa maoni yako,ni nini kimetokana na huduma ya SRH ikilinganishwa na hali ya matumizi kwa wanawake wenye virusi vya HIV
11. Je unadhani ni jambo lipi linaweza kufanywa ili kuendeleza utumiaji wa SRH na wanawake wenye virusi vya HIV
12. Kwa maoni yako, tokeo kuu inayotokana matumizi huduma ya huduma za Kimapenzi na Afya ya jamii katika kituo hiki kwa wanawake wanoishgi na virusi vya ukimwi?

Appendix 10: Key informant Interview Guide for Health Service Providers/Sexual and Reproductive Health Counsellors

Introduction

My name is Victoria Kisaakye Kanobe and I am studying at Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. I am undertaking a study on the *"The Impact of Sexual and Reproductive Health Counselling Services for HIV Positive Women in HIV Care Centres".* I am seeking for your responses for some information related to this study concerning the Sexual and Reproductive Health counseling services at this facility and would be very grateful if you could spend a little time in filling in this questionnaire. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. Do I have your permission to continue?

Name of Interviewer: _____ Location: _____Date: _____

1. What Sexual and Reproductive Health services and programs do you provide at your facility? Who can access these services?
2. What guidelines/policies does your facility use for the provision of Sexual and Reproductive Health services for the HIV Positive Women? Do these guidelines consider HIV Positive Women as an important group to receive Sexual and Reproductive Health services?
3. What procedures do you follow when an HIV positive woman visits your facility for Sexual and Reproductive Health services? – *ask also about confidentiality, privacy, physical examination, follow up care.*
4. What are most common Sexual and Reproductive Health needs HIV Positive women present with? Do you feel that your counselling process adequately addresses the needs of HIV positive women?
5. In your view, what factors affect HIV Positive Women' access to the Sexual and Reproductive Health services provided at your facility? What measures should be taken to ensure that HIV Positive Women access quality sexual and reproductive health services at your facility?
6. What cadre of staff do you have at your facility that provide sexual and reproductive health services? How many male and female providers are available? What about counselors who are HIV positive?
7. What is the role of health care providers in the provision of Sexual and Reproductive Health services to HIV Positive Women?
8. What are the attitudes of the health service providers towards provision of Sexual and Reproductive Health services to HIV Positive Women?
9. How would you describe the availability of supplies and other resources for the operations of the facility?
10. What problems does your facility face in the provision of Sexual and Reproductive Health services to the HIV positive women? Why?
11. What comment would you give on the effect of the location and setting of your clinic to attracting HIV Positive Women to use the services?
12. Has the community played a key role in supporting/ encouraging HIV Positive Women to use Sexual and Reproductive Health services at your facility? If no why? If yes how?
13. In your opinion, what has been the key outcome for using Sexual and Reproductive Health by HIV Positive Women at your facility?

Appendix 11: Written consent form for participation in the Focus Group Discussions (FGDs) (English Version)

JOMO KENYATTA UNIVERSITY OF AGRICULTURE AND TECHNOLOGY (JKUAT)
Institute of Tropical Medicine and Infectious Diseases (ITROMID)

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY
The Impact of Sexual and Reproductive Health Counselling Services for HIV Positive Women in Comprehensive Care Centres(CCCs) in Langata

INTRODUCTION AND STUDY PURPOSE
Good morning/good afternoon, my name is….. …… and I am from the Jomo Kenyatta University of Agriculture and Technology in Nairobi, Kenya at the College of Health Sciences. You have been requested to participate in a research study being carried out by Victoria Kisaakye Kanobe, a MPH student at the JKUAT.This study intends to investigate the impact of Sexual and Reproductive Health Counseling services provided within the CCCs in reducing the risks of unplanned pregnancies and STIs in Kenya among HIV positive women.

To achieve the study goals, the research will interview HIV positive women that have received sexual and reproduction health counselling services at the Langata CC clinic for the period January 2012 to December 2013. The findings from this study are expected to inform policy on scaling-up SRH services among HIV positive women to be able to meet their SRH needs and to improve the quality of service provision.

PROCEDURES
If you agree to participate in this study, you will be invited to a focus group discussion with other women living with HIV and receiving services from this health facility. The discussion will take place in a private setting, and it will take approximately 30minutes. During this interview, you will be asked about your perceptions on Sexual and Reproductive Health Counseling services provided within the CCCs. You will be asked structured questions with optional answers and the interviewer will tick the appropriate answers as you shall provide.

If you volunteer to participate in this study, we would ask you to do the following things:
- To give us 30 minutes to participate in the discussion that focuses on assessing your perceptions in regard to the quality of Sexual and Reproductive Health services you have received.

An audio recorder will be used to record the discussions. All recorded information will be used only for the purpose of the study and destroyed upon completion of

POTENTIAL RISKS AND DISCOMFORTS
This study will possess no potential risks as all information provided will treated with utmost confidentiality and all names of the participants will remain anonymous.

POTENTIAL BENEFITS TO PARTICIPANTS

There are no direct benefits related to your participation in this study. The findings of the study will however help to provide new knowledge that will be used to improve the quality of sexual and reproductive health counselling services for HIV positive women within the HCT service delivery and quality.
You will not be paid for participating in this study.

CONFIDENTIALITY
Every effort will be made to ensure that the information you provide regarding this study remains confidential. Only pseudo names will be used if required and all the data will be treated with respect and utmost confidentiality. Your personal information may be disclosed if required by law. Any publication of this study will not use your name or identify you personally.

STORAGE AND USE OF DATA FOR FUTURE STUDIES
All data collected from the study will be kept for only five years to allow for data processing and make reference to the data during the time of study. All data will be assigned a code tagged to your name after which it will be destroyed. All qualitative research recordings within the data collected will be destroyed after one year. This timeline has been selected to allow enough time for transcription. No future studies will use this data unless approved by an Institutional Review Board or Independent Ethics Committee, which watches over the safety and rights of research participants, which must approve any future research studies using your data.

RIGHTS OF RESEARCH PARTICIPANTS
Your participation in this study is completely voluntary. You may choose to participate or not participate in this study. Your decision will in no way affect your current access to health services from this facility. If you do choose to participate, you can decide not to answer certain questions, or to stop the interview at any time

You are free to ask questions before signing this form. If you later want to talk to anyone about this research study or have questions, regarding your rights as a research participant, contact:

The Secretary, **Ethics Review Committee (ERC),**
Kenya Medical Research Institute,
P.O Box 54840-00200, Nairobi, Kenya.
Tel: +254- (0)20 – 2722541, 2713349, 0722-205901, 0733-40003; Fax: +254 (0)20 – 2720030. Email: info@kemri.org

STATEMENT OF CONSENT AND SIGNATURES
I have read this form or had it read to me. I have discussed the information with study staff. My questions have been answered. I understand that my decision whether or not to take part in the study is voluntary. I understand that if I decide to join the study I may withdraw at any time. By signing this form I do not give up any rights that I have as a research participant.

_____	_____
Participant Name (print)	Participant Signature/Thumbprint Date

_____ _____

Staff Conducting Study Study Staff Signature
Date

Consent Discussion (print)

_____ _____

Witness Name Witness Signature
Date

USE OF YOUR DATA # FOR FUTURE STUDIES:

Please initial and date one option:

_____ I DO agree to store my data for future research into HIV, HIV- related diseases, and other sexually transmitted diseases.

_____ I DO NOT agree to store my data for future research into HIV, HIV-related diseases, and other sexually transmitted diseases.

_____ _____

Participant Name Participant Signature/Thumbprint
Date
(print)

_____ _____
_____

Staff Conducting Study Study Staff Signature
Date

Consent Discussion (print)

_____ _____

Witness Name Witness Signature
Date

CONCLUSION:

If you have any questions or concerns about the research, please feel free to contact Victoria Kisaakye Kanobe using the telephone number 0714-781310 or email kisaakye@yahoo.co.uk

Signed: _____
Participant

Signed:_____
Interviewer

Appendix 12: Written consent form for participation in the Focus Group Discussions (FGDs) (Swahili Version)

JOMO KENYATTA CHA KILIMO NA TEKNOLOJIA (JKUAT)
Tarsisi ya Tropical Medicine na Magonjwa ya Kuambukiza (ITROMID)

IDHINI YA KUSHIRIKI KATIKA SOMO LA UTAFITI
Matokeo ya huduma ya ushauri kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi unaotolewa katika Vituo vya Malezi kwa Kina (Comprehensive Care Centres -CCCs) katika Wilaya ya Langata

UTANGULIZI NA LENGO
Habari za asubuhi / mchana nzuri, jina langu ni ..... nina toka Chuo Kikuu cha Jomo Kenyatta cha Kilimo na Teknolojia mjini Nairobi, Kenya katika Chuo cha Sayansi ya Afya. Umeombwa kushiriki katika utafiti unaofanywa na Victoria Kisaakye Kanobe, MPH mwanafunzi katika JKUAT. Utafiti huu unakusudia kuchunguza matakeo yanayo tokana na kutolewa ushauri and huduma kuhusu ngono/ kushiriki kimapenzi na Afya ya Uzazi zinazotolewa katika kituo hiki cha Malezi kwa Kina (CCCs) katika kupunguza hatari za mimba zisizotarajiwa na magonjwa ya zinaa katika Kenya miongoni mwa wanawake walio na Virusi vya Ukimwi (VVU).

Ili kufikia malengo ya utafiti, wanawake wanaoishi na Virusi vya Ukimwi (VVU) na wamepokea huduma za ushauri kuhusi afya ya uzazi na katika Langata CC kliniki kati ya kipindi cha Januari 2012 hadi Desemba 2013 watahojiwa. Matokeo ya utafiti huu yanatarajiwa kutoa taarifa katika sera kupanua huduma ya afya ya uzazi miongoni ya wanawake wanaoishi VVU ilikuweza kushughulia mahitaji yao ya ngono au kimapenzi pamoja na afya ya uzazi na kuboresha ubora wa utoaji wa huduma.

TARATIBU
Kama utakubali kushiriki katika utafiti huu, nitakuhoji. Unaweza pia kuulizwa kushiriki katika majadiliano ya kundi. Mahojiano yatafanyika katika mazingira ya binafsi, na itachukua takribani dakika 30. Wakati wa mahojiano hii, utaulizwa mitazamo yako juu huduma wa ushauri kuhusu kimapenzi na Afya ya Uzazi zinazotolewa katikaKituo cha Malezi kwa Kina (CCC) ya Kituo hiki cha Afya. Utaulizwa maswali muundo na majibu hiari na mhojaji atakuwa akitia alama kwenye majibu sahihi utakayo ya jibu.

Ikiwa utajitolea kushiriki katika utafiti, tutakuuliza kufanya mambo yafuatayo:

- Kutupatia 30 dakika ya kushiriki katika mahojiano mafupi na majadiliano ambayo yanalenga kuelewa mitazamo yako kuhusiana na ubora wa huduma ya kimapenzi na Afya ya Uzazi umepokea.

UWEZEKANO WA HATARI NA MADHARA
Utafiti huu hauna madhara au hatari zozote kwani taarifa zote zinazotolewa zitahifadhiwa kwa njia ya siri na majina yote ya washiriki kutojulikana.

FAIDA KWA WASHIRIKI
Hakuna faida ya moja kwa moja kuhusiana na kushiriki kwako katika utafiti huu. Matokeo ya utafiti huu yatasaidia kutoa elimu mpya ambayo itatumika kuboresha hali wa huduma za ushauri wa afya ya uzazi kwa wanawake wenye VVU ndani ya utoaji wa huduma HCT na ubora. Hakuna malipo kwako kutokana na kushiriki kwako .

USIRI

Kila juhudi zitafanywa ili kuhakikisha kwamba habari utakayoitoa kwa utafiti huu kuwa ya siri. Majina bandia tu yatatumika kama inavyotakiwa na habari zote tumika kwa heshima na usiri mkubwa. Maelezo yako ya kibinafsi yanaweza kuwa wazi kama inatakiwa na sheria. Nakala zozote za utafiti huu hazitatumia jina lako au kukutabwa.

UHIFADHI NA MATUMIZI YA TAKWIMU KWA AJILI YA TAFITI ZIJAZO

Taarifa zote zinazokusanywa kutoka utafiti huu hifadhiwa kwa miaka mitano tu kwa ajili ya kuruhusu kufanya kurejea kwa habari wakati wa utafiti. Habari yote itakuwa na namabri spesheli itakayo itakayosimaimia jina lako na baadaye kuharibiwa. Habari zote zitakazonaswa kwenye chombo hiki, zitaharibiriwa baada ya mwaka mmoja. Muda huu umependekenzwa kwa ajili ya kuruhusu hiyo habari kuchapishwa.Hakuna tafiti zijazo zitatumia habari hizi hila kwa idhini kutoka na Bodi ya Taasisi au Kamati ya Maadili (Institutional Review Board or Independent Ethics Committee) ambayo inahakisha kuweko kwa usalama na haki kwa washiriki wa utafiti, iliyo na mamlaka kuhidhinisha tafiti za siku zijazo kutumia kumbukumbu/habari zako.

HAKI YA RESEARCH WASHIRIKI

Kushiriki kwako katika utafiti huu ni kwa hiari kabisa. Unaweza kuchagua kushiriki au kutoshiriki katika utafiti huu. Uamuzi wako hauthiri kupokelewa kwa huduma za afya kutoka kituo hiki. Ikiwa utachagua kushiriki, unaweza kuamua kutojibu maswali fulani, au kutia kikomo mahojiano wakati wowote

Uko huru kuuliza maswali kabla ya kutia sahii kwenye fomu hii. Kama baadaye utahitaji kuzungumza na mtu yeyote kuhusu utafiti huu au una maswali, kuhusu haki zako kama mshiriki katika utafiti, wasiliana na:

Katibu,
Kamati ya kisayansi, Kenya Medical Research (KEMRI)
Sanduku la Posta 54840-00,200, Nairobi, Kenya
Nambari ya simu 254 (020) 2722541, 0722205901; 0733-400003
Barua PepeEmail:info@kemri.org

TAARIFA YA IDHINI NA SAHIHI

Nimesoma fomu hii au mimesomewa. Nimejadijliana na mtfaiti kuhus habari hizi. Maswali yangu yamejibiwa. Naelewa kwamba uamuzi wangu wa kushiriki au kutoshiriki katika utafiti huu ni wa hiari. Naelewa kuwa ikiwa nitajiunga na utafiti naweza kujiondoa wakati wowote. Kwa kutia sahihi kwenye fomu hii sijatupa haki zangu nilizonazo kama mshiriki wa utafiti.

_____	_____	_____
Jina la mshiriki	Sahii Mshiriki /kidole	Tarehe
_____	_____	_____
Wafanyakazi kufanya utafiti	Sahihi	Tarehe
_____	_____	_____
Jina Shahidi	Shahidi Sahihi	Tarehe

MATUMIZI YA TAKWIMU YAKO # YA MASOMO YA BAADAYE:

Tafadhali weka sahihi kwenye sehemu moja

_____ Mimi na kubaliana na kuhifadhiwa za takwimu zangu kwa ajili ya tafiti za siku zijazo za VVU na magonjwa mengine ya zinaa.

_____ Sikubaliani na kuhifadhiwa kwa takwimu zangu kwa ajili ya tafiti za siku zijazo za VVU na magonjwa mengine ya zinaa.

_____	_____	_____
Jina la mshiriki	Sahihi ya Mshiriki	Tarehe
_____	_____	_____
Mfanyikazi katika utafiti	Sahihi	Tarehe
_____	_____	_____
Jina la Shahidi	Sahihi ya shahidi	Tarehe

HITIMISHO:

Kama una maswali yoyote au wasiwasi kuhusu utafiti, tafadhali jisikie huru kuwasiliana na Victoria Kisaakye Kanobe kutumia namba ya simu 0714-781310 au barua pepe kisaakye@yahoo.co.uk

Saini: _____
Mshiriki

Saini: _____
Mhoji

Appendix 13: KEMRI/SSC Approval Letters

KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54840-00200, NAIROBI, Kenya
Tel (254) (020) 2722541, 2713349, 0722-205901, 0733-400003; Fax: (254) (020) 2720030
E-mail: director@kemri.org info@kemri.org Website:www.kemri.org

KEMRI/SSC/102585 13th March, 2014

Victoria Kanobe

Thro'
Director, CPHR
NAIROBI

Forwarded to
18/03/2014

REF: SSC No. 2706 (Revised) – The Impact of Sexual and Reproductive Health Counseling Services for HIV Positive Women in Comprehensive Care Centres in Langata District

Thank you for your letter dated February 28, 2014 responding to the comments raised by the KEMRI SSC.

I am pleased to inform you that your protocol now has formal scientific approval from SSC.

The SSC however, advises that work on the proposed study can only start after ERC approval.

Sammy Njenga, PhD
SECRETARY, SSC

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KENYA MEDICAL RESEARCH INSTITUTE

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KEMRI/RES/7/3/1 **AUGUST 12, 2014**

TO: **VICTORIA KISAAKYE KANOBE,**
PRINCIPAL INVESTIGATOR

THROUGH: **DR. CHARLES MBAKAYA,**
ACTING DIRECTOR, CPHR,
NAIROBI

Forwarded
26/08/2014

Dear Madam,

RE: SSC PROTOCOL NO. 2706 (*RESUBMISSION2*) THE IMPACT OF SEXUAL AND REPRODUCTIVE HEALTH COUNSELLING SERVICES FOR HIV POSITIVE WOMEN IN COMPREHENSIVE CARE CENTRES IN LANGATA DISTRICT

Reference is made to your letter dated 31st July 2014 and received at the KEMRI ERC Secretariat on 11th August 2014.

This is to inform you that the Committee notes that the following issues raised at the 226th meeting of the KEMRI Ethics Review Committee held on April 22, 2014 have been adequately addressed. Consequently, the study is granted approval for implementation effective this **14th August 2014** for a period of one year. Please note that authorization to conduct this study will automatically expire on **August 13, 2015.**

If you plan to continue data collection or analysis beyond this date, please submit an application for continuation approval to the ERC Secretariat by **July 2, 2015**. The regulations require continuing review even though the research activity may not have begun until sometime after the ERC approval.

You are required to submit any proposed changes to this study to the ERC for review and the changes should not be initiated until written approval from the ERC is received. Please note that any unanticipated problems resulting from the implementation of this study should be brought to the attention of the ERC and you should advise the ERC when the study is completed or discontinued.

You may embark on the study.

Yours faithfully,

KAB

PROF. ELIZABETH BUKUSI,
ACTING SECRETARY,
KEMRI ETHICS REVIEW COMMITTEE

Appendix 14: Published Paper on Effectiveness of SRH Counselling

African Journal of Reproductive Health November 2015 (Special Edition); 35(5) 153

Sexual and Reproductive Health Counselling: A Case-control analysis of its Effectiveness in Reducing Unintended Pregnancies and STIs among HIV Positive Women in Kenya

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Abstract

With the advent of antiretroviral therapy (ART) and heightened global support of HIV and AIDS treatment, HIV positive women are living healthier and longer lives. While many are able to express their sexual and reproductive health desires as a result of the improved health, a big number are becoming pregnant intentionally or unintentionally. Studies have indicated a range of factors that are known to influence and impact on the HIV positive women's desire to bear children among which include: their age, the cultural significance of motherhood, the number of living children, the attitudes and influence of partners, family, and health care workers among others. This paper presents the findings of a case control study that aimed at examining the effectiveness of sexual and reproductive health counselling in reducing unintended pregnancies and STIs among HIV Positive Women in Comprehensive Care Clinics in Kenya.

Keywords: Sexual, Reproductive Health, HIV Positive, Counselling, Women, Kenya

Introduction

The sexual and reproductive health of women living with HIV and AIDS is fundamental to their well-being, that of their partners and their children0. Like any other women, HIV positive women have the right to access quality sexual and reproductive health (SRH) counselling services to avoid unintended pregnancies and prevent HIV among infants. Access to quality SRH counselling services is anchored in the right-based approach for reproductive health that was first officially recognised at the United Nations International Conference on Population and Development (ICPD) in Cairo in 19940.

Within this approach, HIV positive women have the right to make informed choices regarding their own sexuality and reproductive health as they respect the rights of others. They also have a right to access information and services to support them make informed choices that promote positive and quality sexual and reproductive health especially around pregnancy, parenthood, sexuality & relationships.

This paper provides a discussion towards comprehending the extent to which health workers and counsellors implementing SRH counselling services within the comprehensive care centres in

Kenya provide quality and effective SRH counselling services to HIV positive women with an intention of reducing unintended pregnancies and STIs.

The Context

Kenya has an adult HIV prevalence rate of 5.3 % with an estimated 1.6 million people were living with HIV0.Women aged 15-49 years living HIV account for 820,000 (52%) of the 1.6 million people living with HIV.Women in this group fall within the reproductive age category that has varied sexual and reproductive health (SRH) needs and desires. With the advent of ART,the HIV positive women's health has become better and many have became pregnant intentionally or unintentionally0·0·0·0·

In 2009, 81,000 women living with HIV in Kenya became pregnant; between 6% and 35% of the pregnancies were unintended[159]. In the same year, 22,000 children were said to have been born with HIV through mother to child transmission of HIV. Without treatment, a large number of these children will not live to adulthood and without any intervention, a third of these would die by the first birthday and a half by the second birthday0.

For over eight years, Kenya has been trying out four models to integrate sexual and reproductive health services into HIV prevention treatment and care programs0. These include; (i) integrating SRH/HIV services through stand-alone family planning clinics and post antenatal clinics; (ii) through STI screening clinics; (iii) through HIV counselling and testing sites and (iv) through HIV care and treatment centres.

HIV care and treatment services in the health care facilities especially the sub district and district hospitals in Kenya are provided for at the Comprehensive Care Centers (CCCs) which have been very active since 20050·0· The CCCs were established to ensure that people living with HIV have access to comprehensive physical and psychological health care services. The services provided include; education and empowerment of clients, provision of counseling on HIV prevention, sexual and reproductive health, HIV testing, antiretroviral therapy, nutrition education, immunizations, connections to support groups for those that are HIV positive, and legal advice. Some of the specific services mentioned may be common to all while others may not.

The role of counselling in the provision of SRH to HIV positive women

According to the WHO Bulletin on Reproductive Choices for women with HIV, Information and counselling are critical components of all sexual and reproductive health services to support women in making these choices and carrying them out safely and voluntarily0. Counselling,an interactive process between the service provider and client; is an important prerequisite for the initiation and continuation of any family planning method and HIV positive women require additional care and counselling towards their reproductive health. Counselling for reproductive health assists HIV positive women in making decisions, design a plan, and take action to improve their health on issues such as the number, spacing and timing of pregnancies, use of contraceptive methods and infant-feeding practices and avoiding unintended pregnancies[158]. WHO indicates that well trained health workers or counsellors should provide the most accurate, complete information on SRH in a non-judgmental way so that the woman and/or couple are able to make informed decisions0. There should be no incentives or coercion to adopt reproductive health practices or to use any particular method of contraception0. If a woman is able to make an informed choice (preferably with her partner), she is more likely to be satisfied with the method she has chosen and continue to use it.

Concerns around transmission of HIV and other sexually transmitted infections (STIs) warrants special consideration during family planning counselling.

The National Reproductive Health and HIV and AIDS Integration Strategy for Kenya indicates that within the CCCs counselling for HIV positive women on SRH should also include counselling on legal issues, treatment, and reproductive health rights[159]. In addition to counselling, the health workers should also include provision of SRH commodities such as pills, condoms, injectables, implants, IUCDs, TL/vasectomy, cervical cancer screening, post-rape care (PEP + EC). This approach implies that service providers should be competent in counselling their clients in all family planning methods and with skills to tailor the counselling to the individual client needs, ensuring confidentiality and respect for all clients. Counsellors are also expected to emphasise dual protection as a strategy to prevent both STI/HIV transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual method use), or by practicing abstinence.

More considerations need to be made to assist client make an informed choice based on the health situation and sexuality needs, including disease stage, treatment situation, lifestyle and personal desires. The guidelines therefore advocate for the following approach towards SRH counselling for HIV positive that is providing information on;

- reproductive rights, fertility intentions and options as well as infertility services and contraception;
- information about effective contraceptive methods to prevent pregnancy, including recommending dual protection;
- the effects of progression of HIV disease on the woman's health and the implications for planning a family;
- the risk of HIV transmission to an uninfected partner while having unprotected intercourse (for instance, when trying to become pregnant);
- the risk of transmission of HIV to the infant and the risks and benefits of antiretroviral prophylaxis in reducing transmission and
- planning a pregnancy for discordant and sero-concordant HIV-positive couples;
- Dual protection
- PMTCT for those who wish to become pregnant and for women already pregnant
- Prevention of sexual transmission of HIV and STIs to partners
- information on the interactions between HIV and pregnancy, including a possible increase in certain adverse pregnancy outcomes 0·0

The sexual and reproductive health counselling protocol

The National Family Planning Guidelines for Service Providers make reference to the utilisation of a combination of specific counselling protocols and procedures which include;
"Greet, Ask, Tell, Help, Explain, and Return" (GATHER); *"Rapport, Exploration, Decision making, and Implementation of decision,"* (REDI); and, more recently, *"The Balanced Counselling Strategy Plus (BCS+)"* 0·0·0**Error! Reference source not found.**. The latter incorporates counselling, screening, and services for STIs, including HIV, within routine FP consultations. In general, counselling should be divided into three phases:

- *Initial counselling on arrival:* The provider describes all methods and helps the client to choose the method appropriate for him or her.
- *Method-specific counselling prior to and immediately following service provision*: The provider instructs the client on using the method and discusses common side effects with him or her.
- *Follow-up counselling during the return visit*: The provider discusses with the client the use of the method, the client's satisfaction with the method, and any problem that the client might have experienced.

Of the many options provided in the national policy on reproductive health, the Balanced Counselling Strategy Plus (BCS+) presentsan interactive, client-friendly approach for improving counselling on SRH counselling on family planning and prevention, detection, and treatment of sexually transmitted infections (STIs) including HIV as indicated in table 1.1.

Table1.27 A Summary of the Balanced Counselling Strategy Plus (BCS+) counselling protocol for SRH

Pre-Choice Stage	Method Choice Stage	Post-Choice Stage	Systematic screening for other services
Step 1. Establish and maintain a warm, cordial relationship.	**Step 7.**A brief review of the methods and their effectiveness.	**Step 10.** Discuss the method chosen with the client, using the method brochure as a counselling tool. Determine client's comprehension and reinforce key information	**Step 13.** Using information collected previously; determine client's need for postpartum, newborn, and infant care or well-child services.
Step 2. Inform client that there will be an opportunity to address other health needs after family planning needs are addressed.	**Step 8.**Ask the client to choose the method that is most convenient for her/him.	**Step 11.**Making sure that the client has a definite decision. Give him/her the method chosen and/or a referral, and back-up method, depending on the method selected.	**Step 14.** Ask client when she had her last screening for cervical cancer (VIA/ VILI or pap smear).
Step 3. Ask client about current family size, desire to have more children, and current contraceptive practices. Counsel the client on Healthy Timing and Spacing of Pregnancy using counselling card.	**Step 9.**Using the method procedure checking if the client has any conditions for which the method is not advised.	**Step 12.**Encourage the client to involve partner(s) in decisions about/ practice of contraception through discussion or a visit to the clinic.	**Step 15.** Discuss STI/HIV transmission & prevention and dual protection with the client using the counselling card. Offer condoms and instruct her/him in correct and consistent use.
Step 4. Rule out pregnancy using the checklist to be reasonably sure a woman is not pregnant			**Step 16.** Conduct STI and HIV risk assessment using the counselling card. If symptoms are identified, treat her/him syndromically
Step 5. Display all of the method cards. Ask client if she/he wants a particular method.			**Step 17.** Ask client whether she/he knows her/his HIV status.
Step 6. Ask all of the following questions. Set aside method cards based on the client's responses.			**Step 18.** Give follow-up instructions or procedures or information brochure for methods chosen and set date for next visit
			Step 19. Thank her/him for the visit. Complete the counselling session.

Source: The Balanced Counselling Strategy Plus (BCS+)

Under each step there are specific procedures a counsellor is expected to follow. For women who intend to become pregnant, they should be made aware of the additional risks pregnancy may have on both her own health and the infant's health. The study therefore sought to (i) review the implementation of SRH counselling process which HIV positive women undergo within the selected Comprehensive Care Centre located in the selected government health facility in Langata Constituency; (ii) establish the prevalence of STIs and unintended pregnancies amongst HIV positive women that have undergone SRH counselling at the Comprehensive Care Centre within the selected government health facility in Langata Constituency; (iii) compare the extent to which the prevalence of STIs and unintended pregnancies among the HIV positive women that received SRH counselling and those that did not receive SRH counselling differs; and (iv) identify factors that promote or hinder the utilisation of SRH counselling information and services provided to HIV positive women at the Comprehensive Care Centre within the selected government health facility in Langata Constituency in Kenya.

Methods

A survey design with a case control analysis was employed for this study. The participants included 71 cases and 71 controls aged between 18 and 49 years, six service providers and 55 HIV positive women who participated in small focus group discussions. A case defined for this study was an HIV positive woman, aged 18-49 years that became pregnant and had attended the CCC for antenatal services for one complete year at the selected health facility for not less than three times. A

control defined for this study was an HIV positive woman aged 18-49 years, living in Langata constituency and may or may not have been exposed to SRH Counselling at the CCC within the one year period and never acquired an STI or an intended pregnancy.

Both quantitative and qualitative methods of data collection were employed with multiple and extensive data gathering procedures that were subsequently submitted to an interpretative analysis process. The data collection methods included; document review and analysis of various literature on SRH integration in HIV and official SRH counselling policy guidelines; administration of questionnaires; key informant interviews for both the SRH service providers and HIV positive women and if required, observation of counselling sessions.

Descriptive and inferential analyses were employed in comparing the social, economic and obstetric backgrounds of cases and controls. Given that the data obtained was categorical, Chi squares, Odds ratios, and p-values was used to test the hypotheses on differences in the socio-demographic characteristics, economic characteristics and reproductive history between cases and controls. The level of significance used was at p= 0.05 and 0.01 respectively.

Results

Thefindings reveal that while there are national guidelines which spell out detailed SRH counselling process procedures, the high rates of unintended pregnancies and STIs among HIV positive women are an indicator of the ineffectiveness of the SRH counselling procedurestowards supporting HIV positive women to reduce unintended pregnancies and STIs.

There rates of unintended pregnancies in one year were as high as 53.5% among the cases (N=71) where 41% for unintended pregnancies were not carried to term but aborted with several reasons provided for abortion. The odds of having unintended pregnancies among those married and not married were the same for both the cases and controls (odds ratios [OR]: 1.098; 95% confidence interval [CI]: 0.654–1.841). Among the cases, all groups irrespective of whether they had received SRH counselling or not were equally likely to get unintended pregnancies (odds ratios [OR]: 1.114; 95% confidence interval [CI]: 0.427–2.911).

The findings also show that 28.2% of the cases had been diagnosed with STIs during their pregnancy mainly suffering from herpes (33.3%) and only 2.8% suffering from syphilis. However more STIs were reported among women who got SRH counselling as compared to those that did not get SRH counselling indicating a statistically significant association between the prevalence of STIs amongst HIV positive women that have undergone SRH counselling and those that have not undergone counselling (χ^2_1= 2.005, p=0.157). The high rates of unintended pregnancies, STIs and abortions equally have a significant impact on the quality of life and health for the HIV positive women which if not well managed would lead to further adverse effects like death.

When asked to explain the SRH counselling protocol used at the health facility, interview data from the nurse counsellors indicated a limited understanding and variation in the SRH counselling protocol offered at the CCCsas compared to the provisions in the national guidelines as revealed in the interview extracts in table 1.2;

Table 1.28: Service providers understanding of the SRH Counselling Protocol

Nurse Counsellor A	Nurse Counsellor B	Officer in Charge
• Welcoming client • Assuring client of confidentiality/assuring client of any concerns they may have about the service • Registration • Preparation talk/getting to know the client • Assessing client's history based on the needed services • Involving client in understanding her/their condition and needs • Giving relevant counseling and advice as per clients needs • Bidding client bye after giving any necessary IEC materials and referral	• Registration on first come basis • Taking client's history • Preliminary diagnosis • Medical/ clinical services (referral on need) • Nutrition advice and services	• Registration on first come basis • Taking client's history • Preliminary diagnosis • Pre-test counseling (individual/couple/family/group) • Laboratory diagnosis • Post test counseling (individual/couple/family/group) • Referral to specialist care (if needed e.g. for pediatric, PMTCT services) or general medical care • Nutritional care services • Pharmacy (collection of drugs/ contraceptives/ other necessary resources • Collection of information and

to relevant units		communication materials from the pigeon holes (all through the process)

Source: Interview Data from KI Interviews with SRH Service Providers

For those that had been exposed to SRH counselling, only 62% of the cases and 55% of the controls found the counselling effective towards addressing their sexuality and reproductive health desires.

Interview data from focus group discussions revealed a number of factors which are impacting on the use and uptake of SRH counselling services at the CCC such as related to stigma and discrimination, lack of follow-up, financial and logistical challenges to access the health facility, previous misconceptions around the healthy facility, the long queues at the facility which impact on the waiting period of the clients and negative attitude towards the services being provided.

Discussion

The findings above concur with the analysis that was made by the Integra Initiative (2012) Project which assessed the benefits of integrated HIV and SRH Services in Public Health Facilities in Kenya0. The findings revealed that the implementation environment and process for integrating SRH in HIV prevention services remains very complex which requires continued mentorship and training of the service providers in SRH counselling and provision of service even as the government policies and practices around integration are in constant development. A study conducted by on factors associated with unintended pregnancy, poor birth outcomes and post-partum contraceptive use among HIV-positive female adolescents (15-19 years) in Kenya further reveals that the experience of repeat unintended pregnancies among HIV-positive female adolescents was partly due to inconsistent use of contraception to prevent recurrence of the pregnancies0.

This underscores the need for HIV and AIDS programs to provide appropriate sexual and reproductive health information and services to HIV positive women in order to reduce the risk of undesired reproductive health outcomes. Counselling is the bedrock for achieving self-actualisation in this process. This calls for training, close mentorship and support supervision of the health workers even though each counselling procedure undertaken mainly depends on the circumstances and needs with which the client may present with therefore making it difficult for the counsellor to adhere to the proposed SRH counselling protocols in the national guidelines. Prevention of unintended pregnancies can reduce costs related to PMTCT services and eventually the numbers of children orphaned by HIV and in need of care and support0.

Mentorship and counselling supervision upholds the counsellors' proficiency towards supporting HIV Positive women in making informed choices about their sexual and reproductive health needs. SRH service providers need to be well prepared and knowledgeable in understanding and addressing the SRH needs of the HIV positive women.The study also recommends that SRH counselling should be strengthened with more messages and information about STI prevention and control for HIV positive women.

Meeting the Sexual and reproductive health needs of women of reproductive age living with HIV, who represent approximately half of all global HIV infections, will reduce illegal and unsafe abortions, reduce the acquisition of STIs and other sexually transmitted infections, reduce the number of HIV-positive births as well as HIV-related infant and child deaths.

Acknowledgement

We would like to thank the management and staff of the selected Comprehensive Care Centre in Langata Constituency where the study was conducted. They not only granted me permission to access their facilities but also provided their time, ideas and opinions unreservedly for the study. This study would not have been possible without the participation of the HIV positive women in Langata Constituency; they are greatly appreciated for their valuable information which was granted.

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