HOW TO INTEGRATE FEMALE GENITAL SCHISTOSOMIASIS INTO SEXUAL AND REPRODUCTIVE HEALTH

Lessons learnt from an implementation science project in Kenya

Webinar 12 June 2025

CIFF CHILDREN'S INVESTMENT FUND FOUNDATION

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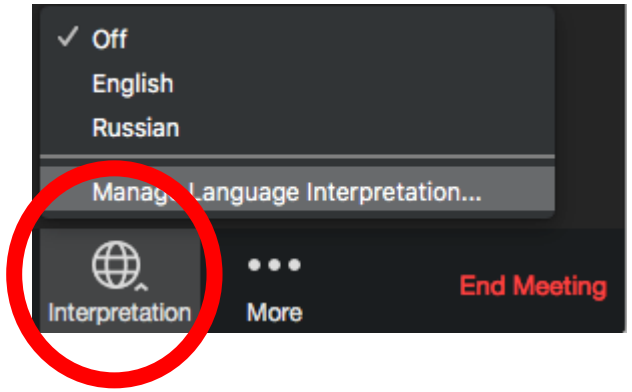

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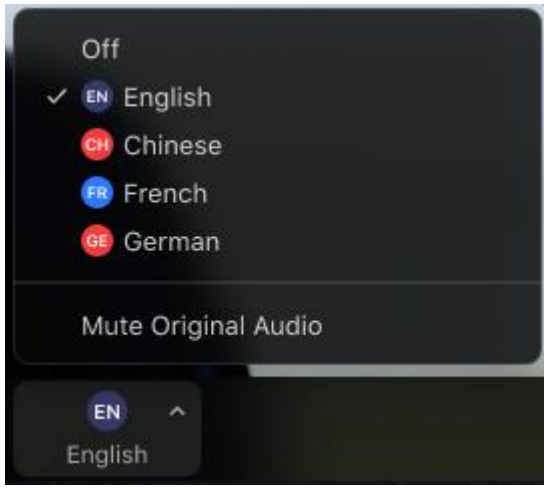

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Webinar Agenda

Welcome

Presentations (~1 hour)

- The FGS integration project
- The minimum service package for integration of FGS into SRHR (MSP)
- Lessons learnt from implementation in Kenya
- FGS integration study: feasibility and acceptability
- FGS integration study: costs

Questions and answers (~30 minutes)

FGS integration project 2023-2025

Female genital schistosomiasis

- Manifestation of chronic infection with *Schistosomiasis haematobium*
- Affects an estimated 56 million women and girls in sub-Saharan Africa
- FGS remains misunderstood, under-researched and under-reported
- Symptoms similar to those of STIs – often misdiagnosed
- Preventable and treated with Praziquantel
- Can lead to serious SRH complications and increases risk of HPV and HIV acquisition
- FGS exposes women to stigma and gender-based violence

Why integrate FGS with SRHR interventions?

- FGS is widely misdiagnosed as a sexually transmitted infection (STI) and increases risk of HIV, HPV and cervical cancer.
- Due to the clinical presentation and symptoms, FGS is more appropriately positioned under sexual and reproductive health services, working with neglected tropical diseases (NTD) and SRH points of service.
- Sexual and Reproductive Health and Rights (SRHR) interventions often involve gender-based violence (GBV) and stigma interventions – which are required for FGS services.
- Siloed programming results in misdiagnosis.

FGS integration project overview

- **Partners:** Frontline AIDS, LVCT Health, Bridges to Development
- **Funder:** Children's Investment Fund Foundation (CIFF)
- **Dates:** March 2023-July 2025

- **Goal:** Female genital schistosomiasis (FGS) prevention, diagnosis, and treatment is integrated into SRHR interventions, budgets, policies, and guidelines at national and global levels.

REPUBLIC OF KENYA
MINISTRY OF HEALTH

With financial support from
CHILDREN'S INVESTMENT FUND FOUNDATION

FGS integration project overview

Outcome 1: Expanded access and increased use of quality, inclusive and integrated FGS and SRH (including HIV and cervical cancer) services among the target population.

- Development of a minimum service package for FGS integration into SRHR
- Resources for training
- Implementation of this integrated approach in nine sites in Kenya following training

Outcome 2: The evidence base regarding the feasibility, acceptability, and affordability of integrating FGS into SRH services informs county and national level policy and funding.

- Study
- Dissemination of evidence
- Local, national and global events

Minimum Service Package for FGS and SRH integration

Minimum Service Package for FGS and SRH Integration

Minimum service package was developed to integrate FGS into Sexual Reproductive Health and Rights (SRHR) interventions.

It was developed to fill **programmatic guidance** for health planners, programmers, policy makers.

MSP intervention integration split across:

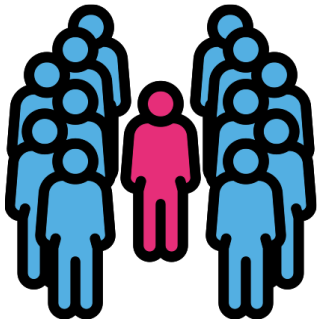
1. Health literacy
2. Screening and diagnosis
3. Treatment and care
4. Social inclusion and equity.

1. Health literacy

Outlines how FGS health literacy/communication can be integrated into routine SRHR health literacy and demand creation, community dialogues and outreach (for family planning, cervical cancer, HIV and STIs):

1. FGS signs and symptoms
2. Overlap of STIs
3. Links with HIV and cervical cancer
4. Screening and diagnosis of FGS
5. FGS prevention and safe use of water

- **WHO: By peer educators, community health care workers**
- **WHERE: in communities, schools, facilities**



2. Screening and diagnosis

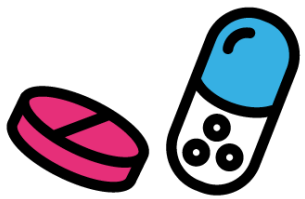
- Outlines how an FGS risk assessment and screening can be conducted in routine SRHR interventions (such as cervical cancer screening, HIV tests, STI screenings, family planning)
- Details how FGS diagnosis can be done through a pelvic examination during routine SRHR services (such as STI/cervical cancer screenings, HIV testing)
- Applicable referrals for other health concerns, gender-based violence and stigma.

- **WHO: By clinicians and nurses**
- **WHERE: in primary, secondary and tertiary health facilities**

3. Treatment and care

- Outlines how praziquantel can be provided as treatment/prevention alongside SRH services/treatment (Such as STI treatment, family planning, ART)
- Outlines how FGS syndromic management can be done during the provision of SRHR services
- Appropriate referrals for GBV, counselling, other SRH needs

- **WHO: By clinicians and nurses**
- **WHERE: in primary, secondary and tertiary health facilities**



4. Social inclusion and equity

- Outlines how mental health support **must** be provided for FGS diagnosis, gender-based violence and stigma
- How the provision of services must include gender-based violence referrals

- Interventions should include advocacy for praziquantel access in facilities and for FGS services and awareness raising

WHO: ALL cadres of staff
WHERE: in ALL facilities and communities

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MINIMUM SERVICE PACKAGE FOR THE INTEGRATION OF FEMALE GENITAL SCHISTOSOMIASIS INTO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTERVENTIONS

SHARE |

A new technical guide developed by Frontline AIDS and partners aims to help health planners and programmers to integrate female genital schistosomiasis services with wider sexual and reproductive health and rights (SRHR) interventions.

Written by
Robinson Karuga and Leora Pillay
17 Jun 2024

Female genital schistosomiasis (FGS) impacts an estimated fifty-six million women and girls across sub-Saharan Africa. It is a condition that results from a parasitic infection and leads to significant sexual and reproductive health (SRH) complications, including increased risks of HIV transmission and cervical cancer. Despite its widespread impact, FGS often goes unrecognised

FRONTLINE AIDS lvct health healthy societies [FIG] TOGETHER TO END FEMALE GENITAL SCHISTOSOMIASIS

MINIMUM SERVICE PACKAGE FOR THE INTEGRATION OF FEMALE GENITAL SCHISTOSOMIASIS INTO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTERVENTIONS

Female genital schistosomiasis (FGS) impacts an estimated fifty-six million women and girls across sub-Saharan Africa. It is a condition that results from a parasitic infection and leads to significant sexual and reproductive health (SRH) complications, including increased risks of HIV transmission and cervical cancer. Despite its widespread impact, FGS often goes unrecognised within the broader context of SRH services, due to a lack of awareness and integrated care approaches. Addressing this gap, Frontline AIDS and its partners under the FGS integration project, have developed a Minimum Service Package (MSP) aimed at providing globally applicable programmatic guidance for the integration of FGS and sexual and reproductive health and rights interventions.

Read more about the MSP on the Frontline AIDS website here.

Access the full article in Frontiers here.

For further information, including implementing the MSP in your own context, please contact Leora Pillay, HIV Prevention Advocacy Lead, Frontline AIDS on lpillay@frontlineaids.org

APPENDIX A: MINIMUM SERVICES PACKAGE DOCUMENT

Global Minimum Service Package for Female Genital Schistosomiasis (FGS)
The Minimum service package (MSP) has been developed as a global guidance document that can be contextualised in different countries. The MSP is targeting: government and non-government planners and programmers providing sexual and reproductive health (SRH) services and sexual and reproductive health and rights (SRHR) programmes. The MSP will provide information to support health planners and programmers to incorporate FGS interventions and services within standard sexual and reproductive health (SRH) services.

INTEGRATION IN KENYA - LESSONS

Integration in Kenya - Lessons

WHO Health systems Building blocks against the FGS-SRH MSP

1. Health literacy
2. Screening and diagnosis
3. Treatment and care
4. Social inclusion and equity (cutting across the three above)

1. Information ~ Health Literacy

- Knowledge gap about FGS in general.
- Training resources such as IEC materials are needed.
- Health literacy needs to start at the **beginning** from health managers as decision makers and leaders at the county level to Community Health Promoters.
- Trainings with health care workers need more time. Implemented 3-4 days sensitisation with FGS champions, but this wasn't enough.
- Involve community health teams (NHOs, CHAs and CHPs) during sensitisation as a link between community units and health facilities.
- Job aid as IEC used.

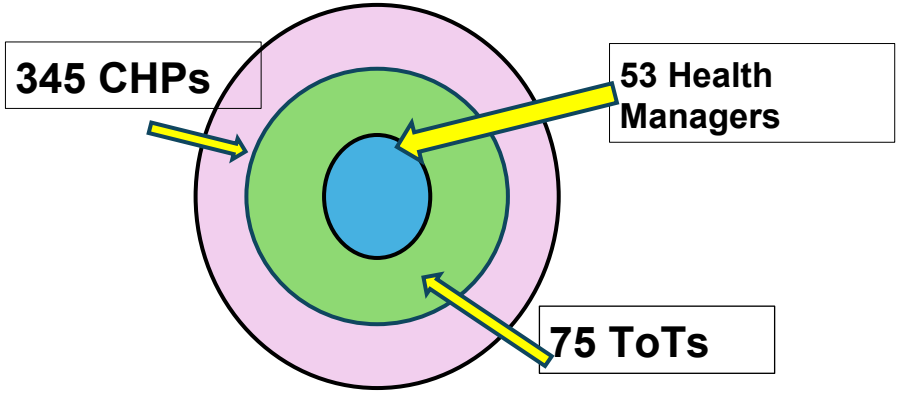
Photo credit: LVCT Health. Consent obtained

Lesson:

There is need to implement a full ToT model of training.

2. Human resources ~ Integrated approach from community to health facility levels

- Health managers across the three counties were trained as FGS champions and decision makers.
- Ownership and sustainability. HCWs as champions cascaded the training of 700+ HCWs through Continuous Medical Education (CME) and On-Job-Trainings (OJTs).
- CHPs have been able to integrate FGS awareness creation during community dialogues and refer FGS suspected cases. Currently most community members are seeking FGS services without referral.



Lesson:

Genital schistosomiasis (MGS and FGS) needs to be included in medical training.

Photo credit: LVCT Health. Consent obtained

3. Service delivery ~ Screening, Diagnosis & Treatment

- FGS cases were often misdiagnosed as STIs, UTIs or presumptive cervical cancer.
- Misuse of antibiotics, exposing patients to unnecessary traumatising procedures like thermal ablations.
- Debilitating nature of FGS: Some patients had lived with FGS for more than 10years, visited all levels of hospitals, private and public.
- Self stigma, isolation, low self esteem and intimate partner violence.

FGS

My battle with waterborne disease misdiagnosed as STI

BY ANGELINE OCHIENG AND GEORGE ODIWUOR

Ms Timina Ogot is all smiles as we settle for an interview on a sunny Tuesday afternoon. She is eager to tell the story of her battle with a medical condition that health experts were unable to diagnose for eight years.

Timina's case was initially misdiagnosed as cervical cancer and later as urinary tract infection (UTI). "I was having abnormal vaginal discharge with an odour. My vagina was also itchy and had a bloody discharge," says Timina.

In November 2024, Timina was finally diagnosed with Female Genital Schistosomiasis (FGS), a neglected tropical disease caused by parasitic worms (Schistosoma) that live in freshwater. The worms infect individuals in contact with contaminated waters.

According to the World Health Organization (WHO), the condition, which is preventable and treatable, affects millions of women and girls without access to safe clean water in rural Africa. They are at higher risk due to daily activities like bathing, washing, and farming, which exposes them to the parasites. FGS is characterised by a range of gynaecological complications, including lesions, vaginal bleeding, pain, and infertility. According to the global health agency, healthcare providers often confuse FGS with sexually transmitted infections or other gynaecological conditions due to overlapping symptoms.

Speaking to *Healthy Nation*, Timina revealed that her troubles began way back in 2016. She sensed something was wrong after noticing abnormal vaginal discharge and bleeding. The 42-year-old went ahead to consult a relative, who advised her to seek medical attention, suspecting she could have cervical cancer.

Upon visiting Homa Bay County Teaching and Referral Hospital, a health worker prescribed medication upon suspecting that Timina had UTI. Timina, however, opted to visit a different health facility a couple of weeks later when the bleeding failed to stop.

"Doctors at the hospital advised that I should undergo cervical cancer screening," says Timina, adding that she was later diagnosed with the cancer.

Doctors assured her that the disease was still in its initial stages and could be treated. She was taken through cryotherapy, a medical treatment that uses extreme cold to freeze and destroy diseased cells, including some cancers.

After the procedure, she was discharged and told to go back for check-up in six months. During her next hospital visit, she was referred to Homa Bay Teaching and Referral Hospital for an ultrasound. The procedure did not, however, reveal any cervical cancer strain.

"Despite the new development, my genitals were still itchy and the abnormal discharge persisted. I was also still bleeding," says Timina. In 2024, Timina was selected to participate in a staff medical education programme offered by Liverpool Voluntary Counsel-

Timina Ogot during the interview. GEORGE ODIWUOR | NATION

Photo credit: LVCT Health. Consent obtained

https://nation.Africa/Kenya/health/my-battle-with-waterborne-disease-misdiagnosed-as-st1-5061338

Lessons:

FGS must be tackled with some patients often experienced multiple misdiagnoses and given antibiotics multiple times (potential for AMR). Stigma, isolation and IPV a concern.

4. Governance ~ Advocacy for sustainability

- Ensuring adequate engagement can help address competing tasks and timelines from the government and the implementer's side.
- Have all the necessary approvals before seeking for the county Ethics Committees
- Buy-in from the managers can be game changing - influenced procurement of praziquantel by the counties, initially distributed during MDA
- Counties tapping on other partners on the ground to help continue FGS integration.
- Explore subsidised care/linkages to ease women from co-morbidities' treatment burden.
- **Myths, Misconceptions, and Community Sensitisation -** Community success stories should be documented to build trust and counter misinformation,
- **Youth engagement and local languages: Posters to be youth-friendly and translated to all local languages e.g. Digo, Duruma, Giriama, Mijikenda, and Kamba for coastal communities.**

Lesson:

Continuous stakeholder/govt engagement from inception to dissemination is crucial

5. Lessons

More positive FGS cases identified during integrated community outreaches and lower-level facilities

- This was MoH initiative to reach more females during an integrated reproductive health services approach.
- Spent more time concentrating on trainings/sensitisation and facility screenings.
- Women who have suffered self-stigma and low self esteem rarely come to the hospitals – lived experience.
- Some mentioned travel cost to the hospitals as a barrier.
- **Men asking why it's only a female agenda, yet they have same environmental risk.**
- **Health care workers are very innovative – using locally available resources**

Photo credit: LVCT Health. Consent obtained

FGS Positivity by Integration Points

Department	Screened	Pelvic Examination	Positive	Positivity
Oncology	1,656	1,642	142	8.65%
Out-Patient Department(OPD)	499	87	19	**21.84%**
Comprehensive Care Clinics	1,993	1,993	14	0.70%
Maternal & Child Health(MCH)	2,190	2,189	617	**28.19%**
Maternity	323	323	21	6.50%
Community Outreach	2,195	2,075	1,488	**71.71%**
Total	**8,856**	**8,309**	**2,301**	**27.69%**

1. Community outreaches were the most effective in identifying new cases of FGS. This is a testament to the feasibility and acceptability of FGS integration.

2. The MCH and OPD Departments had the highest yield for FGS positivity in health facilities.

FGS Positivity by County

County	Screened	Pelvic Examination	Positive	Positivity
Homabay	4,687	4,575	1,304	28.50%
Kilifi	1,881	1,528	235	15.38%
Kwale	2,288	2,206	762	34.54%
Total	**8,856**	**8,309**	**2,301**	**27.69%**

5. Lessons cont'd

Not all high prevalence areas were covered during this pilot study

- The study was a pilot, hence could not exhaustively cover all schisto-endemic areas in the three counties.
- Cases being referred from the other regions to the pilot sites – e.g. Kinango in Kwale the Suba Counties in Homa Bay.

Bladder mass as a presentation of FGS:

- This stood out in some patients (male and females) in Kwale where health care providers suspected cancer of the bladder. Biopsy results revealed schisto eggs and they got better after PZQ treatment.

Photo credit: LVCT Health. Consent obtained

5. Lessons cont'd

No tool to Document FGS indicators

- Health workers adopted ways of reporting FGS cases in the Cervical Cancer screening registers since none of the MoH service registers have Genital schistosomiasis indicators.
- Advocacy ongoing about the need to add FGS indicators.

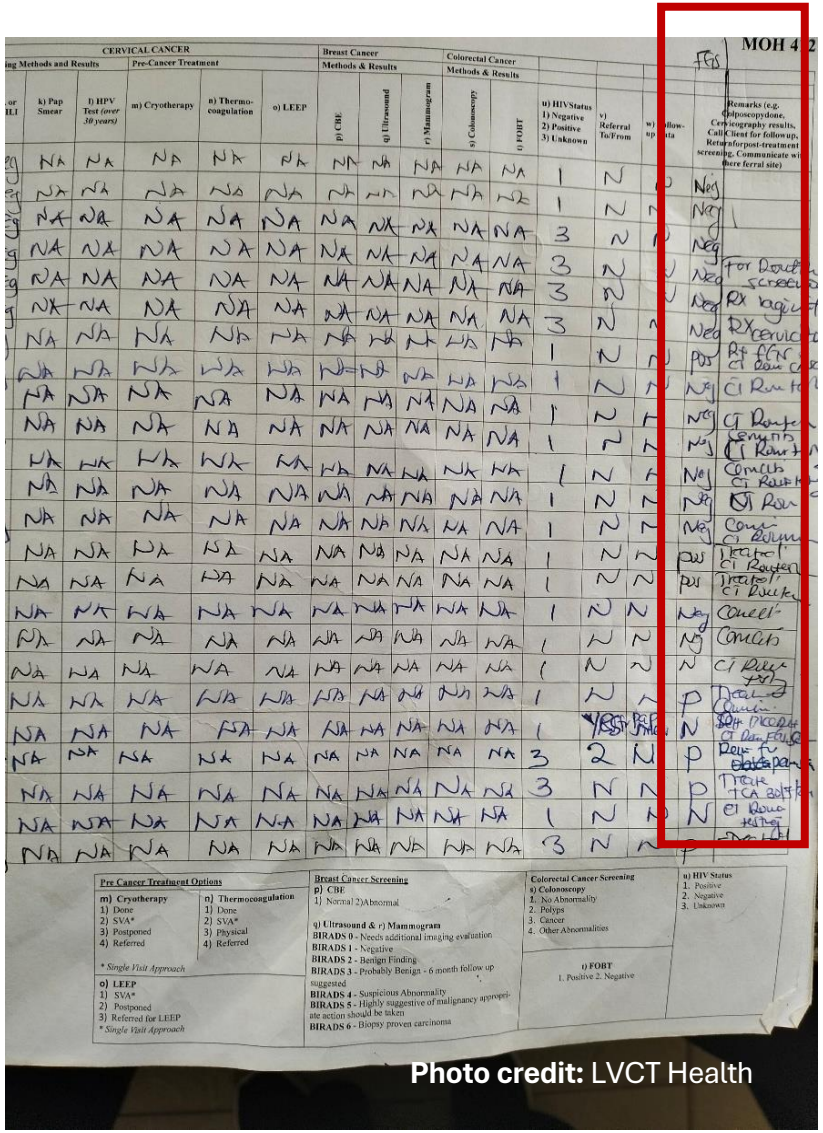


Photo credit: LVCT Health

Acceptability & Feasibility of Integration

Methods

Study design: Mixed methods Implementation Research

Study sites:
Community Unit, Primary Health Facilities, Hospitals (Level 5)

Study participants:
a) Health Managers
b) Health workers
c) Community Health Promotors
d) Clients – Women of Reproductive Age (15-49 years)
e) Community gatekeepers

Methods: Inclusion criteria

a) Adults aged over 18 years and above or emancipated minors aged at least 15 – 17 years

b) Current resident of the study site

c) Health workers: Delivered services in the study sites for at least 12 months

d) Provided written informed consent

Photo credit: LVCT Health. Consent obtained

Methods: Data collection

Qualitative Methods

- Interviews
- FGDs

Quantitative Methods

- Survey on the acceptability of integration

Monitoring and Evaluation

- Review of health records
- Data audits
- Data reviews and harmonisation

Methods: Recruitment of study participants

Participants	Homa Bay	Kilifi	Kwale	Totals
Interviews				
Health Managers	11	8	12	**31**
Female Clients	29	34	24	**87**
Health Care Workers	28	18	13	**57**
Quantitative survey				
Female Clients	366	350	351	**1067**
Health Care Workers	15	9	12	**36**
Focus Group Discussions				
Female clients	2 (n= 14)	2 (n= 16)	3 (n= 19)	**38**
Community opinion leaders	2 (n= 13)	1 (n= 9)	2 (n=27)	**49**
Community Health Promoters (CHPs)	3 (n= 16)	4 (n= 37)	3 (n= 24)	**77**

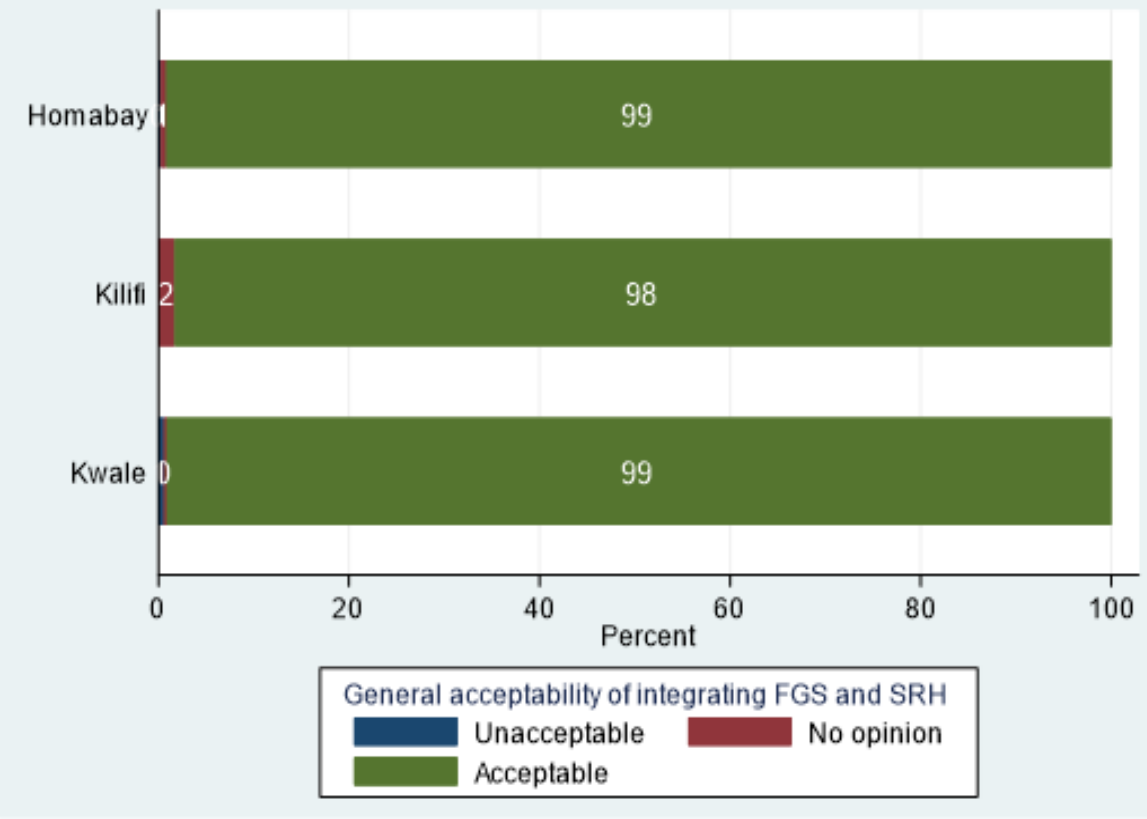
The Framework of Acceptability: 7 Constructs

TFA Constructs	Definition
1. Ethicality	The extent to which the integration of FGS and SRH services is a **good fit with an individual's value** system.
2. Affective attitude	How an individual **feels** about the integration of FGS and SRH services, after taking part.
3. Burden	The **amount of effort** that was required to participate in the integration of FGS into SRH services.
4. Opportunity Costs	The **benefits, profits or values that were given up** to engage in the integration of FGS into SRH services.
5. Effectiveness	The extent to which the integration of FGS and SRH services is **perceived to have achieved** its intended purpose.
6. Self-efficacy	The participant's **confidence that they can perform the behaviour(s)** required to participate in the integration of FGS and SRH services
7. Coherence	The extent to which the participant **understands the integration** of FGS and SRH services and how it works.

Findings: Acceptability of FGS-SRH Integration

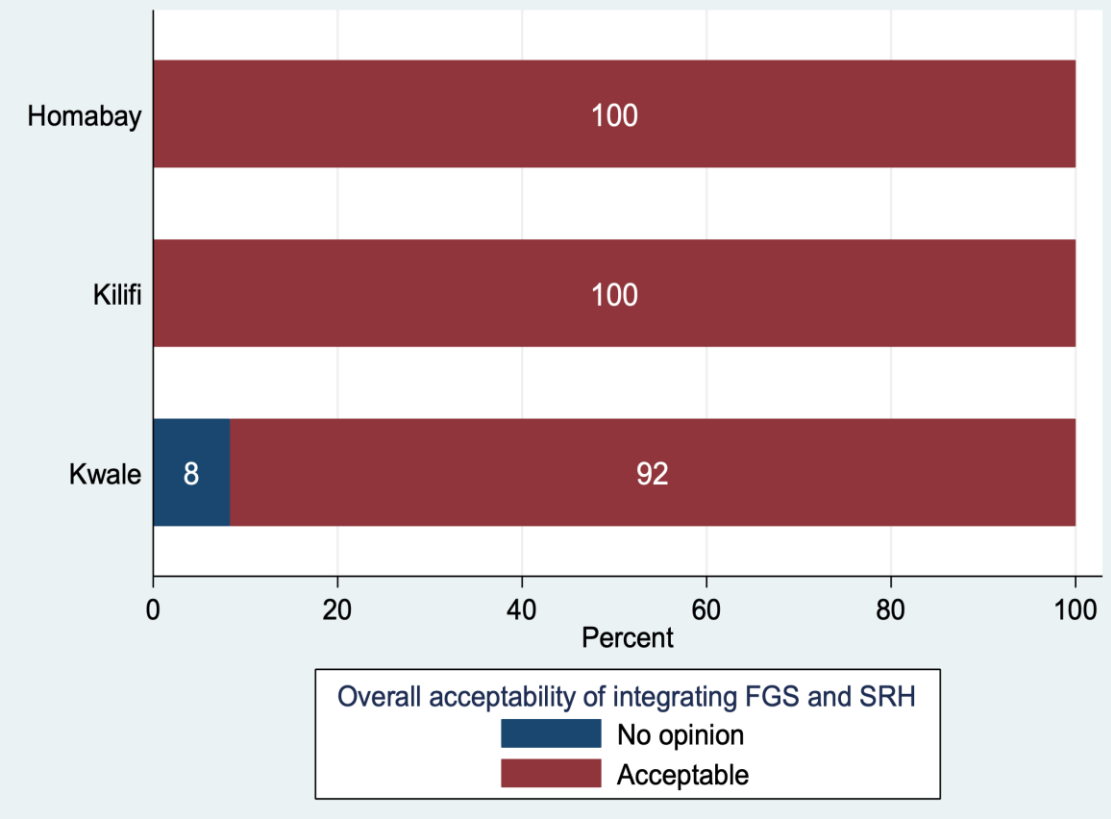
Acceptability among clients (n=1041)

98.8% (95% CI: 98% to 99.3%)



Acceptability among health workers (n=36)

97% (95% CI: 81.7% to 99.6%)



Findings: Acceptability of FGS-SRH Integration

1. Most health workers **did not know about FGS** before the study.
   - *They diagnosed FGS symptoms as STIs.*
2. Health workers reported feeling **confident** about integrating FGS-SRH services and the **correct diagnosis** of FGS.
3. Healthcare workers recommended integrating FGS content into pre-service Nursing/Medical curriculum.
4. Health workers perceived integration as more efficient for clients.
   - *Eliminated several visits to health facilities.*

*"In MCH, we are doing a one-stop shop. When we see the client, we sell all the services. So nowadays there's nothing that needs to be changed. It's a routine. They know **we offer** all the services."*

(Female health worker, Kwale County)

Findings: Acceptability of FGS-SRH Integration

1. Clients generally felt **safe** during the pelvic examination.

2. Clients were **relieved** because they were finally diagnosed correctly.
   - After several misdiagnoses with STIs

3. Positive outcomes **motivated CHPs and health workers to integrate** FGS and SRH into their routine work.

"Previously, there used to be a lot of quarrels in the family, you find, a man wants to have sex, but the wife says she is having pain, so the husband will say that it is STI because people believed that everything is STI. Like me, I have a neighbour who had that infection, when she went to test, she was FGS positive, she was given medication and she got well..."

(Female CHP Discussant, Homa Bay County)

Findings: Acceptability of FGS-SRH Integration

Some challenges experienced when accessing services:

a) Gender related barriers

- Preferring pelvic examination by female health workers
- Spousal consent is important in some contexts

b) Some clients were anxious about pelvic examination due to disrespectful care.

*"**R4:** was being told, climb the bed, remove your clothes; I was afraid, then he calls another male doctor (sigh) (laughter) that made me fear even more. It was difficult for me to stay in this position (laughter)*

***R3**: I didn't know what to do. [The healthcare worker] just forced me to do it. There is a lot of fear, because other people are coming. You need to be told that, when you go there [pelvic examination], you are going to remove your underwear, and you have to sit like this (participant demonstrates). She [female client] should be told clearly, then she will not fear."*

(Two Community FGD participants)

Findings: Acceptability of FGS-SRH Integration

Documenting FGS in service registers: Lack of FGS indicators was a key concern among health workers.

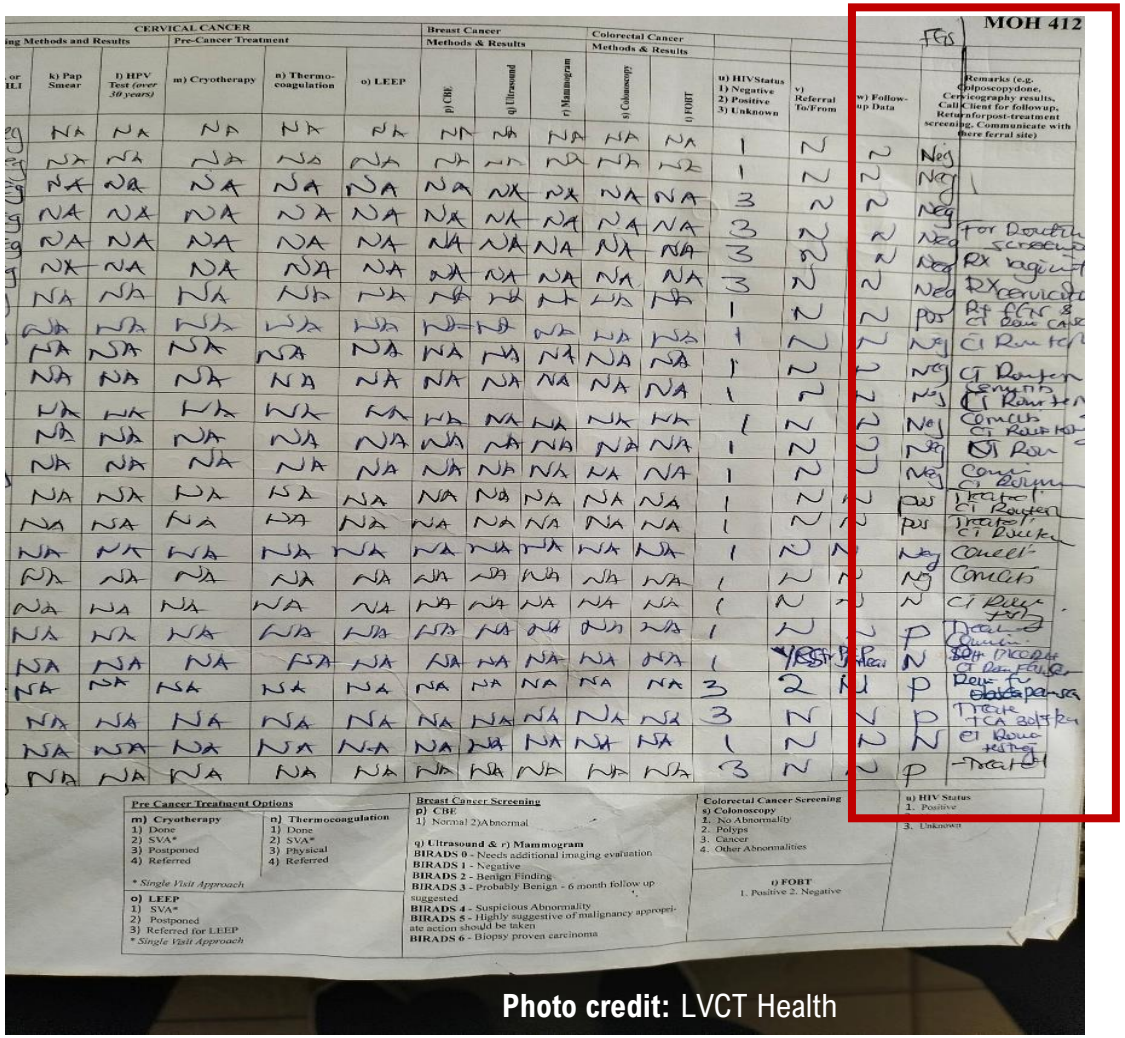


Photo credit: LVCT Health

> *"Yeah, we have a challenge because sometimes you can do screening, and you register from the cervical cancer screening and forget to mention or comment about the FGS because that register is not specifically for that. So, you can say this is not a register for FGS, you have done it, but sometimes you forget to fill the results of FGS."*
>
> **(Female Health Worker, Kilifi County)**

Findings: Feasibility of FGS-SRH Integration

1. Health workers perceive integration as a means of **enhancing the quality** of care with little more investment.

2. **Integration is practical** since the required equipment is already used at the integration points.

3. Health workers requested more **mentorship and supervision**.

4. Few health workers indicated the integration added workload. Due to:
   - Understaffing
   - Feeling duty-bound to examine FGS after training.

"Not really, because in the process of screening cancer, you are also screening for FGS, so workload, there is no workload at all. It is not adding anything, because as you write the report of cancer screening, you also write the FGS report. There is no workload"

(Health worker, Homa Bay County)

Key takeaways

1. **Prioritise community and MCH and outpatient entry points** for FGS service integration as well as HIV and cervical cancer services.
2. Incorporate the **treatment and management of FGS into the existing protocols and clinical guidelines.**
3. Include FGS within **pre-service medical training curricula and in-service training.**
4. Incorporate Genital Schistosomiasis indicators into **Health Management Information Systems (HMIS).**
5. Ensure **Sustainable Supply Chains for Diagnosis and Treatment commodities.**
6. Scale-Up FGS-SRH Integration.

Costing Integration

Costing FGS Integration in SRH

How much does it cost to integrate FGS and SRH services in three endemic counties in Kenya?
Perspectives: health system and patient perspectives ?

Who bears the cost? Why is this important?

- ***Financial*** costing, prevailing market rates

- Identifying all resources

-Attaching monetary value to the resources

Economic costing- exploring opportunity costs

Mapping Resource Use for FGS

Fixed, Capital costs

- Training
- Information resources
- Equipment- Table lamps

Recurrent, operational costs

- Medical supplies
- Courier services

Top-down costing & Bottom-up granular Micro-costing.

Exclude: Sunk capital costs, shared resources, utilities

Patient (+carers) costs

- ***Direct healthcare costs***



- ***Direct non healthcare costs***



- ***Monthly household expenditures***

Healthcare Screening and Data Collection Process

01 Training Healthcare Workers

02 Screening Women

03 Noting Positive Cases

04 Abstracting Medical Records

05 Recruiting Women for Interviews

06 Administering Questionnaires

Method

- Health facility records n=6234 (costing, pelvic exams)

  Review of financial and procurement records

- Exit interviews (n=927) User costs, socio-demographic data
- Community health Promoters' reports on mental health literacy (n=55,976)
- Consultation with experts

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Financial Review Components

Analysis

- Descriptive
- Total costs of implementation, Integration
- Unit costs of implementation, Integration
- Discounting (3%), and Net Present Value
- Cost Drivers
- Excel & Python

Key socio-demographic highlights

n= 927, exit interviews

Mean age, 33 years

52% < 30 years

72% Monogamous married

35% secondary education +

Casual- 41%, unemployed- 37%

Average monthly household expenditure- Kes 6189 (US$48)

Direct Non - Medical expenditures

Direct Non - Medical expenditures (n=972)	Amount in KShs	Adjusted cost in KShs	US$
Travel	153	***162***	1.2
Food Costs	52	55	0.4
Accommodation	11	11	0.1
Other Expenses	2	2	0
Companion	56	59	0.5
Total	273	289	2.2

Total Costs of Implementation

Total costs	Kenya Shillings	USD	Proportion
Community	1,340,886	10,394.5	13.8
Health Facility	9,733,915	75,456.7	86.2
Total	**11,074,801**	**85,851.2**	100

Community level costs (n=55,976)

Cost Driver	Unit costs (KSh)	Cost per woman in (US$)	% Cost drivers
Training	16.0	0.12	48%
Transport Facilitation	4.5	0.03	14%
Total Capital	**20.5**	**0.15**	**62%**
Recurrent			
CHP Stipend Reimbursement	4.8	0.04	14%
HCW Stipend Reimbursement	7.9	0.06	24%
Total Recurrent	**12.7**	**0.1**	**38%**
Grand Total (Capital + Recurrent)	**33.2**	**0.25**	**100%**

Facility-based costs, screening and diagnosis

Pelvic examinations ***(n=6234)***

Cost Category	Activities	Amount(Ksh)	USD	Cost Drivers %
Capital, Fixed costs	Training Conference costs	1,495,000	11,589.1	
	Trainers costs package	5,945,044.22	46,085.6	
	Total training	**7,440,044.22**	**57,674.8**	93
	Information Education Communication	513,286.8	3,979.0	6
	Equipment	60,000	465.1	1
Total Capital costs		**8,013,331.02**	**62,118.8**	
Recurrent costs	Medical supplies	1,720,584	13,337.9	
Total Costs		**9,733,915.02**	**75,456.7**	

Recurrent costs during implementation

Item	Unit price	Total cost	Unit cost (KShs)	Adjustment	Cost Drivers
Gloves	370	62,160	22.3	23.6	9%
Acetic Acid	600	27,000	4.1	4.3	2%
Jik	400	36,000	0.5	0.5	0%
Applicator sticks	290	1,740	0.6	0.6	0%
Praziquantel	2,150	227,900	110.0	116.4	43%
Speculum	5,000	120,000	50.0	52.9	20%
Rolls of cotton wool	270	16,200	2.4	2.6	1%
Sanitary pads	930	83,700	58.1	61.5	23%
Total Unit cost, medical supplies				270.8 ***(US$ 2.1***)	

Projections of Unit costs over 3 Years

- Annualization- Direct line of Depreciation
- Total Capital costs spread over 3 years (MTEF)
- Annualised costs= ***8013331/3= 2671110.3***
- Discount Factor, 3% rate, estimate Net present values **(NPV)**
- Pelvic examinations increase by 30% every year
- Positivity at 13%, facility level
- PZQ purchase the only recurrent cost

Projections of unit costs over 3 years

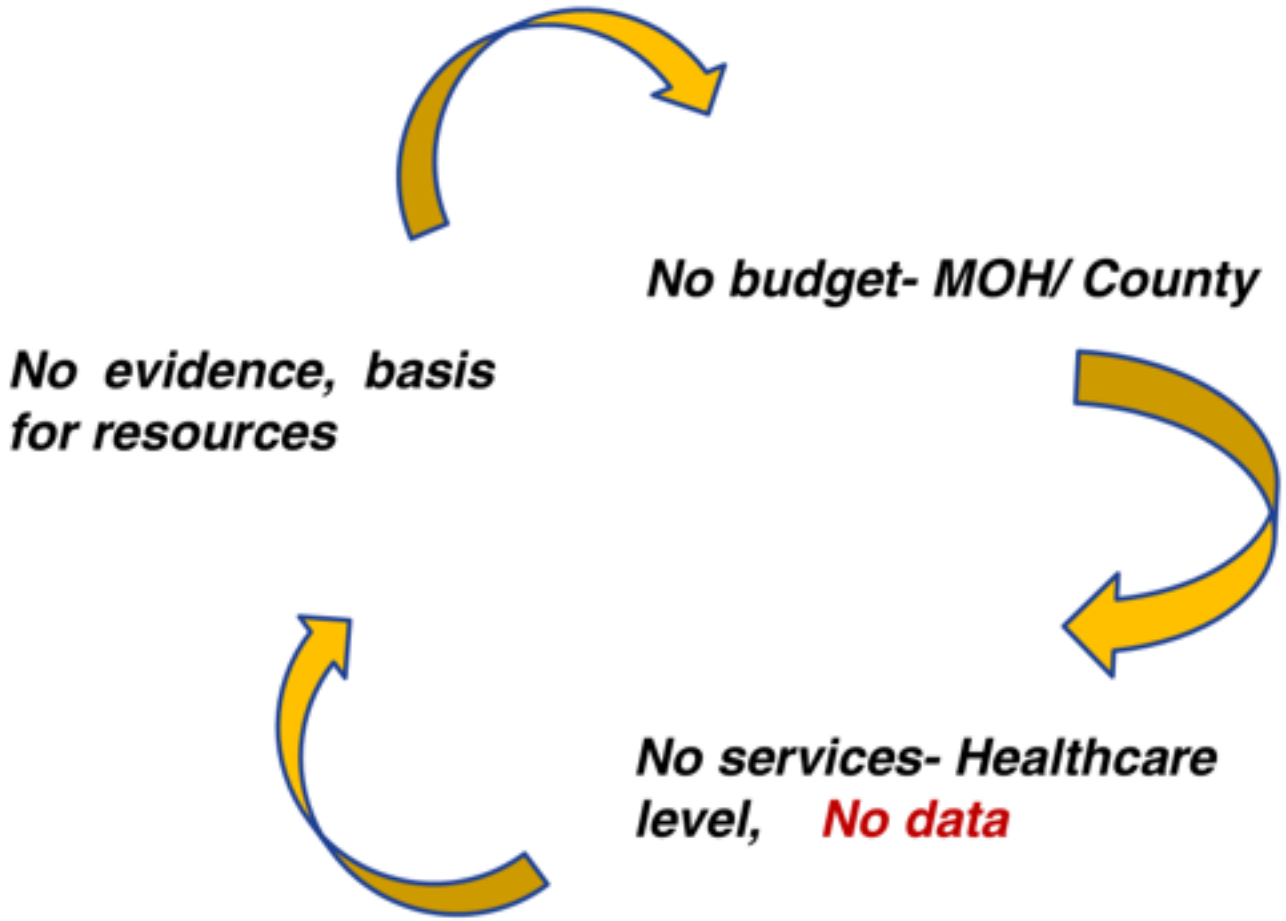
Cost Item	Year 1	Year 2	Year 3
Pelvic Exams	6,234	8,104	10,535
Recurrent costs KES(US$)	89,430.00 (693.20)	115,890.1 (898.40)	150,657.1 (1,168.00)
Annualised costs- KES (US$)	2,671,110 (20,706.00)	2,671,110.00	2,671,110.30
Total, nominal costs- KES(US$)	**2,760,540 (2,1340)**	**2,787,000 (21,605)**	**2,821,767 (21,874)**
Discount factor	1.00	0.94	0.92
Net Present Value- KES (US$)	2,760,540	2,627,015.2 (20,364)	2,582,317 (20,018)
Unit costs (KES) (NPV)	442.8	324.2	265.1
Unit costs US$ (1 US$= KES 129)	3.4	2.5	2.1
Unit Costs US$ PPP, (1US$= 43.2)	10.3	7.5	6.1

Opportunities

Data, to support decision making

- Foundation for more health economic analyses- e.g., cost effectiveness
- Lower costs- depending on strategic purchasing initiatives- KEMSA/ The African CDC Pooled Purchasing facility
- Significant local political support

Overall- disrupt the vicious cycle of neglect



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FRONTLINE AIDS

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HOMA BAY COUNTY

DEPARTMENT OF HEALTH & SANITATION SERVICES KILIFI COUNTY

KWALE COUNTY GOVERNMENT UMOJA NI NGUVU

[FIG] TOGETHER TO END FEMALE GENITAL SCHISTOSOMIASIS

Questions and discussion


FRONTLINE AIDS
JOIN US.
END IT.