FRONTLINE AIDS

INTEGRATION OF FEMALE GENITAL SCHISTOSOMIASIS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES

A SUSTAINABLE APPROACH TO PROMOTING EQUITY – LESSONS FROM KENYA

BACKGROUND

Female Genital Schistosomiasis (FGS) affects over 56 million of girls and women across sub-Saharan Africa, yet it remains invisible in health systems and is all too often ignored. An implementation study in Kenya (2023-2025) shows that combining FGS care with routine sexual and reproductive health and rights (SRHR) interventions is not only feasible and acceptable, it is also transformative for integrated healthcare and will ensure the delivery of quality services for women and girls in Africa.

THE CHALLENGE: A NEGLECTED CRISIS HIDING IN PLAIN SIGHT

FGS is a preventable but little-known gynaecological condition that disproportionately affects women and girls who lack access to safe, clean water, adequate sanitation and quality, affordable healthcare. The disease is caused by chronic inflammation of the genital tract due to long-term infection caused by a waterborne parasite, *Schistosoma haematobium*. The inflammation occurs when eggs of this parasite become lodged in genital organs and tissues (e.g. the vaginal wall, vulva, cervix or uterus) causing an immunological and physiological response, including the development of lesions.

FGS symptoms include pelvic pain, abnormal vaginal discharge, painful sexual intercourse, post-coital bleeding and genital irritation. These symptoms are often misdiagnosed as common sexually transmitted infections (STIs), urinary tract infections or cervical cancer, leading to stigma, unnecessary medical procedures, the overuse of antibiotics and poor treatment outcomes.

Across the world, health workers lack awareness, training and tools needed to diagnose and treat FGS, while national policies and data systems do not include indicators to capture the prevalence of the disease. The medication, praziquantel, is used to treat schistosomiasis but is not consistently available in primary healthcare settings and is largely limited to mass drug administration targeted at school-aged children. While praziquantel is effective at treating the parasitic infection that causes schistosomiasis, there is limited data about how well it treats the longer-term effects of FGS, such as chronic lesions and scarring.

IMPACT ON WOMEN AND GIRLS

Genital schistosomiasis affects both men and women, but the impact and increased risks for women and girls when left untreated can be life changing. FGS is a disease of poverty that exposes the deep intersection between gender, marginalisation and disadvantage facing women. It contributes to the layers of disadvantage that many women already face – exacerbating social, economic and health inequalities. FGS can lead to complications such as ectopic pregnancy, infertility and miscarriage. The disease also increases women's susceptibility to HIV and Human Papillomavirus (HPV). Misdiagnosis can lead to the overuse of antibiotics and the potential for anti-microbial resistance. It can also result in stigma and social exclusion, mental health challenges and gender-based violence.

Although the disease affects millions of women and girls across Africa, FGS remains largely invisible in health systems, undermining efforts to provide equitable and integrated healthcare access.

Integrating FGS and sexual and reproductive health and rights services offers a valuable opportunity to tackle gender inequality and provide more holistic, person-centred care for women in marginalised communities.

THE OPPORTUNITY: INTEGRATION IN ACTION

From March 2023 to July 2025, the Children's Investment Fund Foundation (CIFF) funded the FGS Integration Project to document the acceptability, feasibility and cost of integrating FGS services into routine SRHR services in public healthcare facilities.

The project was implemented in three Kenyan counties where FGS is endemic – Kwale, Kilifi and Homa Bay. Data from this project will inform advocacy efforts to embed FGS prevention, diagnosis and treatment into SRHR policies, budgets and interventions in Kenya and globally.

A key output was the development of a **Minimum Service Package (MSP)**, which provides programmatic guidance for FGS and SRHR integration across four areas: health literacy; screening and diagnosis; treatment and care; and a cross-cutting element – social inclusion and equity.

ACCEPTABILITY AND FEASIBILITY OF FGS AND SRHR INTEGRATION

The project demonstrated **high acceptance** of the integration of FGS and SRHR among healthcare workers, health managers and women:

- Healthcare workers appreciated the efficiency and quality-of-care improvements from FGS integration.
- Training increased healthcare workers' confidence in diagnosing FGS and improved interest in incorporating FGS content into nursing curricula.
- Health literacy was delivered primarily by Community Health Promoters (CHPs) through community outreach, dialogues and health talks, which were instrumental in addressing myths and misconceptions. Health literacy was also provided during risk assessments and verbal screenings with clinicians. Enhanced literacy on FGS increased the demand for referral and pelvic examinations among women.
- National and county health managers supported integration and endorsed adding FGS indicators to national health data systems.
- Women and girls responded positively to the FGS and SRHR integration, with many expressing relief at finally receiving a correct diagnosis.

KEY RESULTS

57,237
community members reached with FGS health literacy

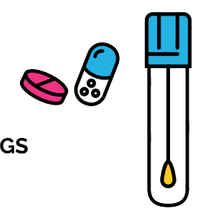
310
community health promoters trained

606
healthcare professionals trained on FGS

69
people based in three counties trained to lead sessions

9,570
pelvic examinations carried out to diagnose FGS

OVER 1 IN 4
women diagnosed with FGS and received treatment*



*25.5% of women in the study were diagnosed with FGS

FGS AND SRHR INTEGRATION: BARRIERS FOR ACCEPTABILITY

The project findings highlighted some potential barriers towards integration:

- Increased possible workload for healthcare workers.
- Stigma, disrespectful care and persisting gendered power dynamics, including between male healthcare workers and female clients.
- Lack of autonomy for women to fund travel for healthcare appointments without permission from male partners or heads of household.

FGS AND SRHR INTEGRATION IS POSSIBLE

The project findings also demonstrated that integration is **feasible if**:

- ✓ Clinical staff are trained on FGS diagnosis and receive supportive supervision.
- ✓ FGS awareness is generated in communities to create demand for services at facilities.
- ✓ Pelvic examination equipment and consumables are available in facilities.
- ✓ Facilities are adequately stocked with praziquantel.

Willis Onyango, a Field Specialist based in Kenya. © Frontline AIDS/Denis Mwangi/2023

COST OF INTEGRATION

Preliminary findings indicate that **the cost of integrating FGS into SRHR interventions is low** at $10.3 per woman for diagnosis and treatment of FGS in health facilities (calculated using Purchasing Power Parity).[1] The main cost drivers of FGS and SRHR integration are associated with training healthcare workers and supply of praziquantel.

$10.3
per woman for diagnosis and treatment of FGS

Here are projections for **sustainable, cost-effective and efficient** integration:

- Ongoing investment in FGS diagnostic capacity and treatment for healthcare workers to reach more women. This increased investment could reduce costs per woman from $10.3 in the first year to $6.2 by the third year.
- Pooling procurement processes for treatment and non-pharmaceutical supplies could further increase cost efficiencies.
- Creating awareness about FGS through the Community Health Promoters is estimated to cost $0.50 per woman.
- Reducing the overall costs of community-based programmes by integrating with water, sanitation and hygiene (WASH) and environmental health interventions by leveraging current services rather than creating parallel systems.
- Investing in FGS integration could strengthen public healthcare and improve service efficiency.
- Increasing reach in more schistosomiasis-endemic areas, despite the initial increased costs of training, could also decrease costs in the long-term.

Nancy Ogweche, a healthcare worker based in Homa Bay, Kenya. © Frontline AIDS/Denis Mwangi/2023

1. Purchasing Power Parity is a currency conversion approach that adjusts for price differences between countries, allowing for more accurate comparisons across countries and currencies.

A SUSTAINABLE APPROACH TO PROMOTING EQUITY

The FGS Integration Project demonstrates that embedding FGS into SRHR interventions is both acceptable and feasible, and the costs vis-à-vis the impact represent an affordable return on investment. It enhances integrated healthcare delivery for women and girls while contributing to the broader goals of universal health coverage and gender equity.

Globally, governments, donors and global health must prioritise the integration of FGS into SRHR and broader health system strengthening efforts as a strategic priority to address neglected health conditions in marginalised populations.

POLICY RECOMMENDATIONS

Integrating FGS services at both the national and global levels requires bold action. While governments are already taking steps to integrate services, global guidance can help to catalyse these efforts.

These recommendations are not dependant on one another but propose an aligned and interlinked approach, as shown through the FGS Integration Project in Kenya.

By combining expertise and resources to support governments, we can: increase awareness of female genital schistosomiasis; address barriers to testing, treatment and care; scale up reach and maximise impact across Africa.

Women and girls are disproportionately affected by genital schistosomiasis, but our recommendations apply to genital schistosomiasis more broadly to address male genital schistosomiasis in communities as well.

National level

1 Develop and track genital schistosomiasis national indicators to generate burden data.

2 Ensure reliable and equitable access to praziquantel by strengthening the supply chain beyond mass drug administration and across primary healthcare facilities in schistosomiasis-endemic areas.

3 Add genital schistosomiasis and a focus on gender in pre-service curricula, especially in nursing and clinical officer training courses. Include specific guidance for female genital schistosomiasis to recognise the overlap of symptoms with STIs, and the risk of mental health issues, stigma and gender-based violence faced by women and girls affected by the condition.

4 Build the capacity of local health planners to integrate genital schistosomiasis sustainably into SRHR planning and budgeting.

5 Invest in health literacy and community sensitisation on genital schistosomiasis by leveraging existing community platforms to promote SRHR awareness in communities, including:

- raise awareness of symptoms, treatment and prevention
- sensitise communities about safe water, sanitation and hygiene practices
- address common myths related to genital schistosomiasis
- challenge stigma and address gender-based violence linked to female genital schistosomiasis.

A woman washes her hands using water drawn from the lake © Frontline AIDS/Denis Mwangi/2023

A woman hangs her washing on a line at her home in Homa Bay, Kenya. © Frontline AIDS/Denis Mwangi/2023

Global level

6 Support integrated disease planning to enhance efficiency and maximise return on investment. Donors and development partners must address female genital schistosomiasis within broader SRHR, HIV, cervical cancer and neglected tropical disease programmes by aligning commitments to One Health,[2] an ecosystem-based and integrated approach with tangible bilateral and programmatic investments.

7 Recognise female genital schistosomiasis as a sexual and reproductive health condition for women and girls and reference female genital schistosomiasis in global, regional and national health policies for HIV, SRHR, Human Papillomavirus, cervical cancer and STIs.

8 Develop normative guidance for genital schistosomiasis, and specifically female genital schistosomiasis, to support its integration across the entire health system, building on the wealth of evidence gathered to date.

9 Develop curricula for healthcare workers, with a specific emphasis on FGS. This should build on existing materials to date ensuring that – across Africa – healthcare workers are able to diagnose and treat FGS. This must include FGS-related mental health, stigma and gender-based violence.

10 Embed female genital schistosomiasis in universal health coverage frameworks and national health insurance schemes, and integrate female genital schistosomiasis into global gender equality strategies.

2. 'One Health' is an integrated, unifying approach to balance and optimise the health of people, animals and the environment.

ACKNOWLEDGEMENTS

We extend our heartfelt gratitude to the partners of the FGS Integration Project, LVCT Health and Bridges to Development, for their dedication and hard work in advancing FGS integration in Kenya. Special thanks go to the FGS Integration Group (FIG) partners for their ongoing support throughout the project.

We are especially grateful to the women and girls who participated in this project.

Sincere appreciation also goes to the healthcare workers, clinic and health managers, and the Ministry of Health officials – national and county level in Homa Bay, Kilifi and Kwale – for their participation, engagement and unwavering commitment to ensuring women and girls receive quality integrated FGS services.

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We gratefully acknowledge the funding provided by the Children's Investment Fund Foundation (CIFF) for the FGS Integration Project.

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