

MSF  
April 2010

# A Model of HIV/AIDS Care and Treatment in a Rural Setting

The experiences of MSF in the Greater  
Busia District, Western Kenya  
2000 – 2010



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# Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>ART</b>	Antiretroviral Treatment
<b>ARV</b>	Antiretroviral
<b>CAN</b>	Communication, Advocacy and Networking
<b>CCC</b>	Comprehensive Care Centre
<b>CO</b>	Clinical Officer
<b>DHMT</b>	District Health Management Team
<b>FDC</b>	Fixed Dose Combination
<b>GoK</b>	Government of Kenya
<b>HAART</b>	Highly Active Antiretroviral Therapy
<b>HIV</b>	Human Immune Deficiency Virus
<b>HR</b>	Human Resources
<b>HTC</b>	HIV Testing and Counselling
<b>IEC</b>	Information, Education and Communication
<b>MoH</b>	Ministry of Health
<b>MSF</b>	Médecins sans Frontières
<b>MSF OCBA</b>	MSF Operational Centre Barcelona Athens
<b>NASCOP</b>	National AIDS and STIs Control Programme
<b>NIMART</b>	Nurse Initiated and Managed ART
<b>NGO</b>	Non-governmental Organisation
<b>OI</b>	Opportunistic Infection
<b>PCR</b>	Polymerase Chain Reaction
<b>PEPFAR</b>	US President's Emergency Plan for AIDS Relief
<b>PHC</b>	Primary Health Care
<b>PITC</b>	Provider Initiated Testing and Counselling
<b>PLWH</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>RHF</b>	Rural Health Facilities
<b>SGBV</b>	Sexual and Gender Based Violence
<b>VCT</b>	Voluntary Counselling and Testing
<b>WHO</b>	World Health Organisation

# –1 Letter from HoM

Dear Colleagues,

It is with pride and satisfaction that I deliver to all of you this report as a summary of the successes and challenges experienced throughout our 10 years in the HIV/AIDS project in Busia, Western Kenya.

MSF intervened in the HIV /AIDS Kenyan epidemic at a time when there were no other actors and the MoH was unable to cope with the situation. MSF with its HIV/AIDS interventions around the world has demonstrated the feasibility of offering HIV care and treatment services in both rural and urban, poor resource settings.

A lot of progress has been made in the access to HIV care and treatment in Kenya. To date, 320, 000 adults and 29, 000 children are receiving ARVs in the country. A total of 950 facilities offer adult HIV care services and 700 health facilities are offering paediatric HIV care services. This growth has been attributed to several actors combining resources so as to support the Ministry of Health in the provision of HIV care services.

Nevertheless the challenges remain huge. Today, 40% of people in need are still unable to access ARV treatment. When new WHO criteria to receive ARV therapy are applied the gap will grow bigger.

More over, in the international arena, the progress made in HIV care is under threat due to a lack of funding. Some of the key donors are scaling down their direct support to HIV/AIDS interventions and governments are unable to meet the funding needs for their country. A lack of generic drugs for emerging, less toxic regimens limits access to treatment while other ARV regimens are expensive. This should warrant that efforts are doubled to maintain the successes achieved until now and guarantee the continuation of services to those people in need.

Through the Busia project we have been able to establish a model of HIV/AIDS care and treatment in a rural setting. Originally it was planned that the MoH would continue the services supported by MSF, however, ultimately the project had to be handed over to another international partner.

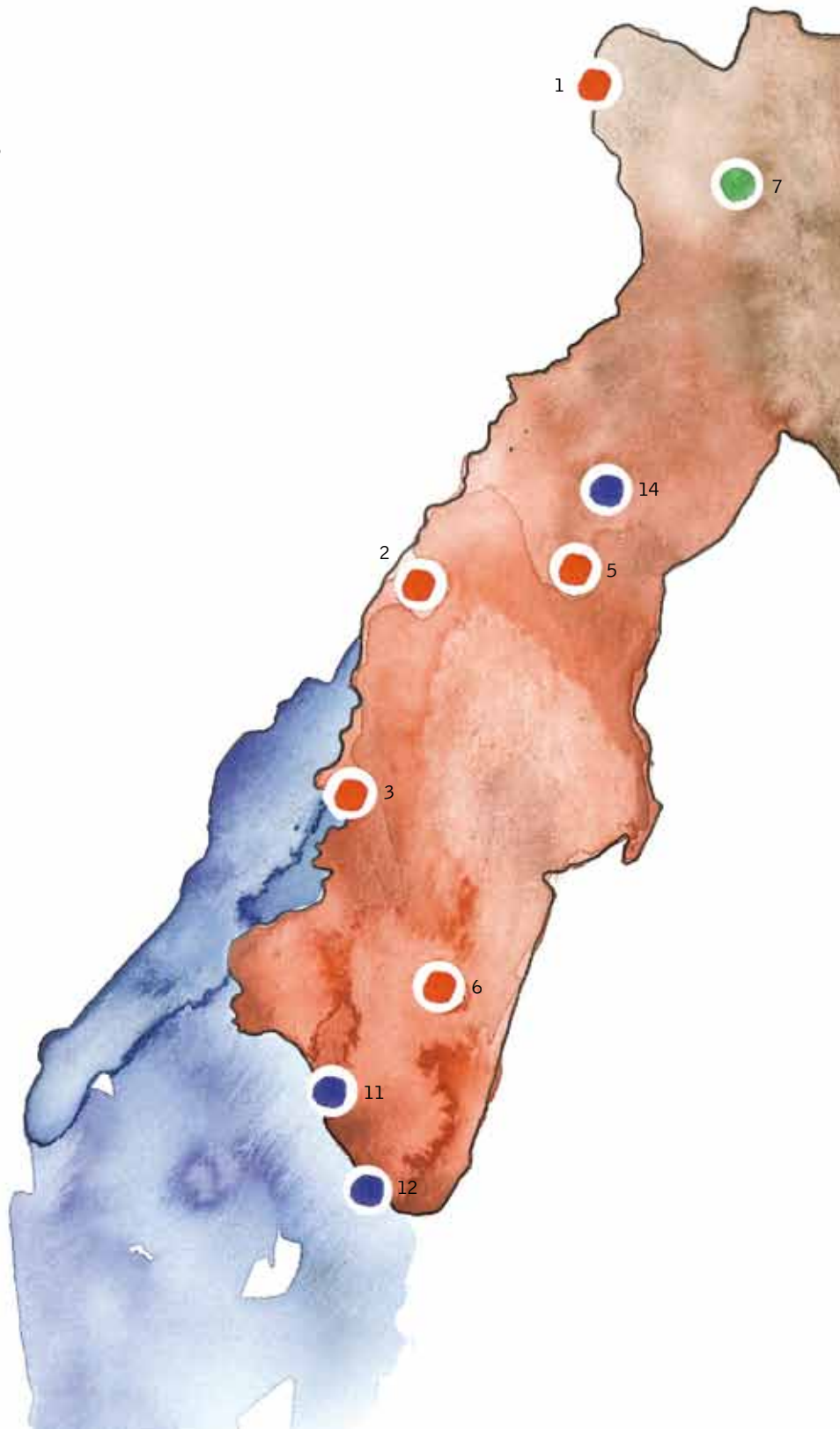
MSF is still active in the fight against HIV/AIDS and is at the forefront in advocating for free access to treatment for PLWH, reduced prices for new drugs and continued funding for HIV care and treatment in resource limited countries.



Elena Velilla  
*Head of Mission*  
*MSF Spain Kenya Mission*

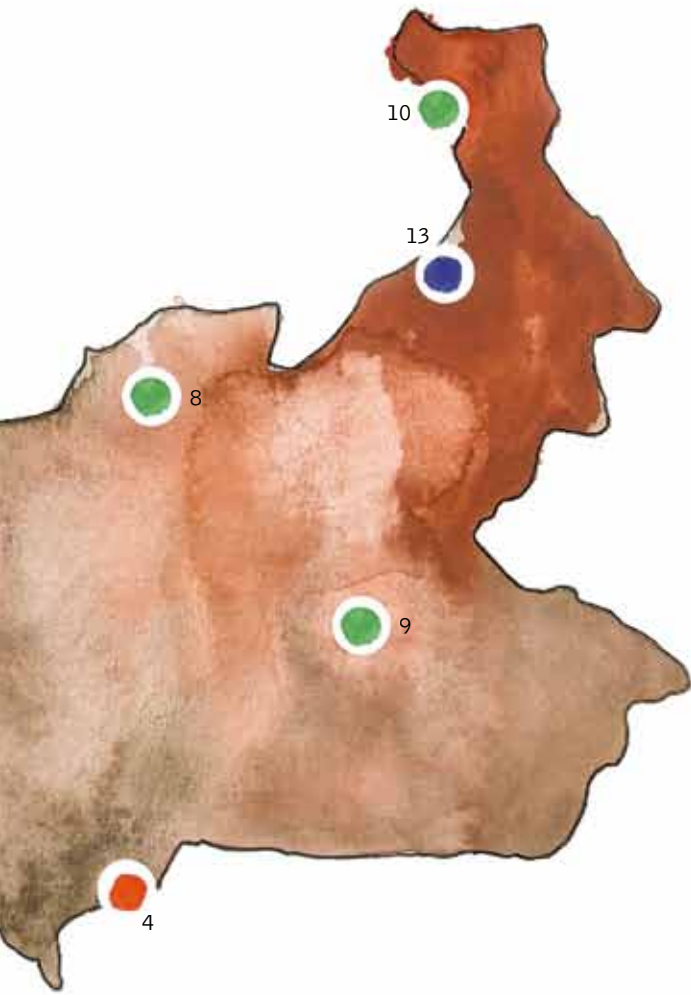
- **District Hospital /ARV site**
- **Health Centre / ARV site**
- **Dispensary, PMTCT site**

- |   |   |   |
|---|---|---|
| <p><b>1 Busia</b><br/>District Hospital<br/>ARV Site<br/>AMPATH</p> <p><b>2 Sioport</b><br/>District Hospital<br/>ARV Site<br/>MSF</p> <p><b>3 Port Victoria</b><br/>District Hospital<br/>ARV Site<br/>AMPATH</p> <p><b>4 Khunyangu</b><br/>District Hospital<br/>ARV Site<br/>AMPATH</p> <p><b>5 Holy Family</b><br/>Priv. Hospital<br/>ARV Site<br/>CMMB/AIDS<br/>Relief</p> <p><b>6 Mukhobola</b><br/>Sub District<br/>Hospital<br/>ARV Site<br/>AMPATH</p> | <p><b>7 Matayos</b><br/>Health Center<br/>ARV Site<br/>APHIA II</p> <p><b>8 Nambale</b><br/>Health Centre<br/>ARV Site<br/>AMPATH</p> <p><b>9 Bumala B</b><br/>Health Centre<br/>ARV Site<br/>AMPATH</p> <p><b>10 Lupida</b><br/>Health Center<br/>MOH/AMPATH</p> | <p><b>11 Rukala</b><br/>Dispensary<br/>MOH/AMPATH</p> <p><b>12 Bulwani</b><br/>Dispensary<br/>MOH/AMPATH</p> <p><b>13 Madende</b><br/>Dispensary<br/>MOH/AMPATH</p> <p><b>14 Nangina</b><br/>Dispensary<br/>MOH</p> |
|---|---|---|



### Medical Intervention

MSF was present in 4 District Hospitals, 1 SubDistrict Hospital, 4 Health Centers and 4 Dispensaries in which the following services were provided: Counselling and testing services, Antiretroviral Therapy and OI's, PMTCT, Training and Mentorship of the health staff.



### HBC Programme

This programme provided health care services to PLWH in their home set up and linked them with Health Facilities.



### CAN Programme

PLWH activities supported the training and involvement of PLWH, peer educators and support groups. Community activities raised awareness about HIV/AIDS in the communities.

## —2 Summary



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MSF Spain has been present in Kenya since 1992, working in a variety of emergency programmes. These programmes have focused on victims of violence, displaced populations due to ethnic conflicts, nutritional programs in the arid and semi arid areas of North Eastern Province, response to disease outbreaks, intervention in floods, urban health programmes and HIV/AIDS.

Following a high HIV prevalence and low intervention from health actors, the MSF Spain HIV/AIDS project was implemented in the year 2000 in close collaboration with the Ministry of Health (MoH).

The overall objective of the project was to reduce HIV/AIDS transmission and related morbidity and mortality in Busia District, Western Province of Kenya.



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For the first 3 years MSF focused on preventative and palliative care for already identified people living with HIV (PLWH). Then in 2003, MSF introduced antiretrovirals (ARVs) to the Busia District Hospital which then became the first HIV care site to provide antiretroviral treatment (ART) and prevention of mother to child transmission (PMTCT) services in Western province. Over the following years HIV care was decentralised to rural health facilities where PMTCT and ART services were offered.

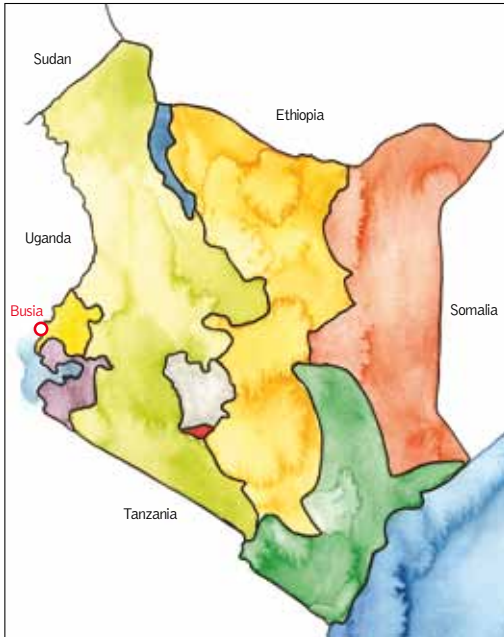


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Integration of HIV care and treatment into primary health care (PHC) services and the project's extensive community component were successful at expanding the number of PLWH who had access to HIV care services and at reducing associated stigma and discrimination.

# —3

## Background



Map of Kenya

In 1999, the Kenyan government declared HIV/AIDS a national disaster and a public health emergency that exceeded the Kenyan government's ability to cope adequately with limited resources.

National HIV prevalence based on ANC sentinel surveillance sites was estimated at 21% in 1998. AIDS related mortality and morbidity were high and the health sector was overstretched with around 50% of all admissions being for AIDS related conditions. At that time no ART was available.

It was in this context and following a situational analysis of the impact of the HIV epidemic in Kenya that MSF Spain decided to open the Busia HIV Prevention and Care project in the year 2000. The Busia population was one of the most affected populations at that time.

Busia District is situated in Western Province, bordering Uganda and Lake Victoria. The 2009 projected population for greater Busia was 503,802.

Over time Busia District was divided into the four districts of Busia, Samia, Bunyala and Butula. These districts are collectively referred to as the Greater Busia District which was the focus area for the MSF project.

The main sources of livelihood in greater Busia are subsistence farming, sugar cane farming, fishing in Lake Victoria and trading along the Kenya – Uganda border. Busia town is an important truck stop on the Trans Africa Highway from Mombassa to Kampala.

Greater Busia therefore combines a number of risk factors that may have contributed to the high HIV prevalence. These are:

- A large mobile population and associated commercial sex work
- A regular stop for truck drivers along the Trans Africa Highway to Uganda
- Itinerant fishing communities with frequent 'sex for fish' practice
- Relatively low rates of male circumcision in some communities
- Wife inheritance practices

Prior to the year 2000, HIV prevalence from ANC sentinel sites in Busia district was estimated at 20%. By 2008 the HIV prevalence was estimated at 7.4%<sup>1</sup>.

Western Province and Busia Districts were among those with the highest HIV prevalence in Kenya and no other actor with an HIV care and treatment focus was present.

1

This number comes from the 2008 Busia ANC sentinel surveillance sites.

# —4

## Project Overview



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MSF began its intervention with a focus on prevention, HIV testing and palliative care. A comprehensive care centre (CCC) was set up soon after at the District Hospital.

Decentralisation of HIV services and integration of HIV care into PHC was a key strategy to increase access to HIV care in rural areas and to decongest the District Hospital.

MSF decentralized and supported the integration of HIV care and treatment into PHC in ten MoH rural health centres and seven dispensaries. The health centres initiated ART and provided PMTCT services and the dispensaries provided HIV testing, treatment of opportunistic infections (OI), PMTCT services and referral for ART. Task shifting helped reduce the health facility work load thus improving the quality of care provided.

### 4.1— Counselling and Testing Services

Counselling and testing were carried out at health facilities by health care workers, volunteers and peer educators. They all received training based on the MoH curriculum and the national guidelines. Health facilities had to meet the minimum criteria required by the MoH for them to be registered as VCT sites.

Voluntary counselling and testing (VCT) services were provided free of charge and provider initiated testing and counselling (PITC) services were later introduced. PITC allowed health care workers to initiate the possibility for the patient to have an HIV test. VCT and PITC services served as an entry point for HIV care.

Counselling services and patient education included the following topics: HIV testing, living positively, treatment literacy and drug adherence, among others.

### 4.2— Antiretroviral Therapy and Opportunistic Infections

MSF introduced free of charge ARVs in Busia district at a time when ARVs were inaccessible. The MoH started to provide ARVs to the public sector in late 2003, piloting them in five different sites. The entry criteria for ART initiation was a WHO AIDS classification Stage IV regardless of the CD4 count, WHO clinical Stage III with a CD4 count of less than 350 and WHO clinical Stage I and II with a CD4 count below 200.

Health care workers were trained to initiate and monitor patients on ARVs. Stable patients were first tracked by being reviewed by trained nurses, while complicated and new cases were attended to by clinical officers. All clinicians providing HIV care received theoretical training using a nationally



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approved curriculum and were mentored by experienced clinicians. A medical doctor provided technical support for complicated cases. Task shifting to nurses and peer educators was achieved by having nurses review stable patients instead of the clinical officer or doctor, and peer educators who conducted HIV testing and adherence counselling instead of nurses.

Monitoring of people enrolled in HIV care was done using regular clinical appointments and CD4 tests. Counselling services and the possibility to join support groups were provided to help create a supportive environment to encourage adherence to treatment.



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Treatment protocols were based on WHO recommendations and MoH guidelines, and changed with emerging scientific findings. Patients failing 1st line treatment were initiated on second line ARVs.

Management of opportunistic infections was the key to providing quality HIV care. Prompt management of opportunistic infections helped improve patient progress, compliance with treatment and mortality.

### 4.3— Medical supplies

ARV supply through the MoH was introduced gradually because of existing large patient cohorts who were receiving ARVs from MSF. The MoH ARV supply was to the District Hospital and rural health facilities received their ARVs as satellite sites of the District Hospital.

The District Pharmacist was responsible for the management of ARV supplies for the District. Satellite sites reported their consumption and placed their orders to the District Pharmacist. The District Pharmacist placed orders to the National AIDS and STIs Control Programme (NAS COP) pharmacist who then authorised central stores to provide the supplies.

The MoH ARV supply chain helped improve access to HIV care in the rural health facilities and made it possible to handover ARV drug supply to the MoH. Opportunistic drugs and home based care kits were provided by MSF until the end of the project as the MoH had funds to support only a few of the OI drugs. These were Cotrimoxazole, Fluconazole, Acyclovir, and Multivitamins.

NAS COP held monthly ARV commodity meetings that aimed at monitoring stock status of the country. All actors providing ARVs in the country participated in these meetings.

### 4.4— Prevention of Mother to Child Transmission

PMTCT services were introduced in the facility antenatal clinics. Pregnant women were offered an opportunity to have counselling and



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an HIV test done. Mothers testing HIV positive were enrolled for PMTCT services and initiated on ARV prophylaxis or ART depending on their CD4 count. Prophylaxis for the mother and infant evolved from mono therapy to a more efficacious regimen over time. After delivery mothers were supported on infant feeding options. Early infant diagnosis was done at 6 weeks and at the end of breastfeeding using a PCR test done at a regional laboratory.



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PMTCT services were provided by nurses and when a mother or child required ART initiation a referral was done to a clinical officer. In the dispensaries a mother requiring ART was referred to a health centre that offered ART.

Despite intensive community awareness interventions and counselling services, acceptance and adherence of PMTCT services remained challenging due to gender related stigma. This experience was also observed in other MSF projects such as the one in Malawi.

#### 4.5— Training and Mentorship



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When MSF started the intervention in HIV/AIDS, there were large gaps in the knowledge of HIV care. The capacity of staff to provide HIV care was built through trainings using lectures, on the job training and mentorship programmes.

Training of health care workers on adult and paediatric HIV care, nutrition and HIV/AIDS, PITC and paediatric psychosocial care was done using nationally approved curriculums. The participants were MoH health care workers providing HIV care services in the District. Nationally recognized certificates were issued to the participants.

Other trainings were conducted by MSF concerning correct waste management and drug orders, storage and supply. Regular refresher trainings were done to update knowledge on current HIV care practices among the health care workers, HBC volunteers and peer educators. In addition, peer educators regularly informed newly diagnosed PLWH about how to live positively and about when and why treatment is initiated.

Mentorship was done by experienced clinical staff with the support of a medical doctor. The duration of the mentorship varied with the ability of the health care worker but it averaged six months per facility. A total of 46 staff were mentored in this programme.

Due to staff shortages in the district, MSF hired additional staff. They represented 51% of the total staff needed in the health facilities to guarantee adequate staffing for comprehensive integrated HIV management in the rural health facilities. All new staff went through the mentorship programme.



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## 4.6— Community Activities

### Home Based Care (HBC)

The aim of the HBC programme was to strengthen the link between the HBC clients and the health facilities providing HIV care (by 2009 over 80% of HBC clients attended the CCC). It incorporated clinical, medical, nursing, counselling, palliative and social care at the same time as active tracing of defaulters.

Defaulter tracing was a very important component of the HBC programme which had a significant positive impact on adherence, resulting in a low treatment failure in the cohort.

The programme started in 2002 as a pilot program in one division of the District with 50 HBC volunteers, eventually spreading to most of the divisions in greater Busia. It grew to include 209 HBC volunteers and more than 5000 clients. By the end of the project each volunteer had on average 25 clients each.

The volunteers attended community meetings (Barazas), gave health education talks, undertook community mobilization and HIV/AIDS sensitization activities and informed the communities about the services available in the health facilities for care and support of PLWH. HBC kits, condoms and treatment literacy materials were provided to the volunteers.



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### Communication, Advocacy and Networking (CAN)

The MSF CAN programme was divided into two aspects: one addressing the needs of People Living with HIV (PLWH) and the other looking at the concerns of the larger community.

#### PLWH Programme

#### Peer Educators and Support Groups

This program was initiated in 2003 when MSF introduced ARV treatment in the Busia District Hospital with the objective that patients could access treatment literacy and support one another. Patients who were the first to be put on treatment acted as peer educators for new PLWH and eventually formed support groups.

Peer educators were specifically selected PLWH who were trained to manage and organize the support groups in the community. Additional tasks performed by the peer educators were ART initiation counselling and health education talks in the health facilities.

The objective of the support groups was to help people cope with their HIV positive status and to increase adherence. The peer educators



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provided health facility staff with lists of the support groups to facilitate referral of PLWH to the groups.

There were more than 690 active peer educators and 127 community based support groups were meeting each month.

**Table 1: Support Group Initiatives**



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Who	What
Positive Living Teachers (35)	Formed a lobby group that took networking to the national level to aim for a reduction in discrimination against HIV positive teachers. It is now a recognised support group at national level and teachers are able to receive treatment through the Ministry of Education.
PMTCT Men Volunteers (110)	Targeted men within communities to talk about the benefits of PMTCT.
Children's Clubs	A group for children over 5 who were on ARVs and also for their carers to discuss issues of concern. It grew to include almost 250 children.
Mother to Mother Support Group	For women enrolled in the PMTCT programme to support each other through the sharing of their experiences.
Patients on 2nd Line ARVs	This provided support to patients who had failed on 1st line ARVs and aimed to enhance adherence and positive living.
People with Substance Abuse	This was a special group dedicated to PLWH who suffered from alcohol addiction and addiction to drugs.
General Support Groups	These groups were based in the communities and people were referred to them after testing positive. They received support from other PLWH.

### PLWH Advocates

The PLWH advocates were trained in simple advocacy skills to address the stigma issues that PLWH were facing at the community level: for example, stigma against children at school whose parents had died as a result of HIV and wife disinheritance when her husband had died of HIV.

The PLWH advocates also raised advocacy issues with the health service providers to reduce discrimination and stigma against PLWH at health facilities.

As of the end of 2009 there were seven groups of trained PLWH advocates with a total of 210 persons.



© MSF

## Community Programme

This program aimed at providing HIV/AIDS information to the larger community in Busia through 395 volunteers known as Information Disseminators. It involved the promotion of and access to condoms within community set-ups, conduction of educational sessions, group discussions and open meetings.

Other activities at the community level were:

**Strategic Static Points Volunteers (SSPs):** they provided condoms at service points such as barber shops, hair salons and video shops, which were fitted with both male and female condom dispensers.

**Organized groups of fish traders** with whom HIV/AIDS sensitization activities were organized at the beaches and trading centres. Over 2400 fishermen and women were trained in community sensitization.

### **Law enforcement officers**

CAN has been working together with the police force and provincial administration to train police and administration officers on HIV/AIDS related issues and Sexual Gender Based Violence (SGBV).

**Condom distribution in the community** was done significantly by peer educators, Information Disseminators, Strategic Static Points Volunteers and HBC volunteers, all of whom instead of whom were also trained on condom promotion and use.



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## **4.7— Monitoring and Evaluation**

The project monitored key indicators using “FUCHIA”, an electronic data base from which a monthly report was generated and shared with the MoH.

Based on the project outcomes and adaptation to the changing trends in HIV care, the logical framework was revised annually.

Technical visits from HIV specialists helped to monitor the implementation of the project and provide advice on new best practices. An evaluation of the PMTCT programme was done in order to improve its outcome and an overall end of project evaluation was conducted at the end of 2009.

MSF participated in MoH planning meetings, in which various HIV actors in the district shared their project activities and outcomes. This helped inform on coverage, gaps and priority areas for the district.

Supportive supervision was done in the health facilities together with the district health management team (DHMT) and gaps in the provision of



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services were identified and resolved. These ranged from human resources (HR), supplies and technical skills for the health care workers among other gaps.

#### 4.8— Networking and Collaboration

Lobbying and advocacy was carried out at project and at national levels. MSF OCBA (operational centre Barcelona Athens) together with other MSF sections and actors advocated for a free ARV policy as well as numerous medical protocol changes. These included generic drugs, treatment literacy and paediatric FDCs among others.

At district level, MSF empowered and advocated together with PLWH to fight against discrimination and stigma.

From the start of the project there was good collaboration between the MoH and MSF. Joint planning of activities was implemented in the MoH facilities; existing national curriculums were used in trainings and new, simplified guidelines were developed together. MSF also used the MoH ARV supply system once it had been established.

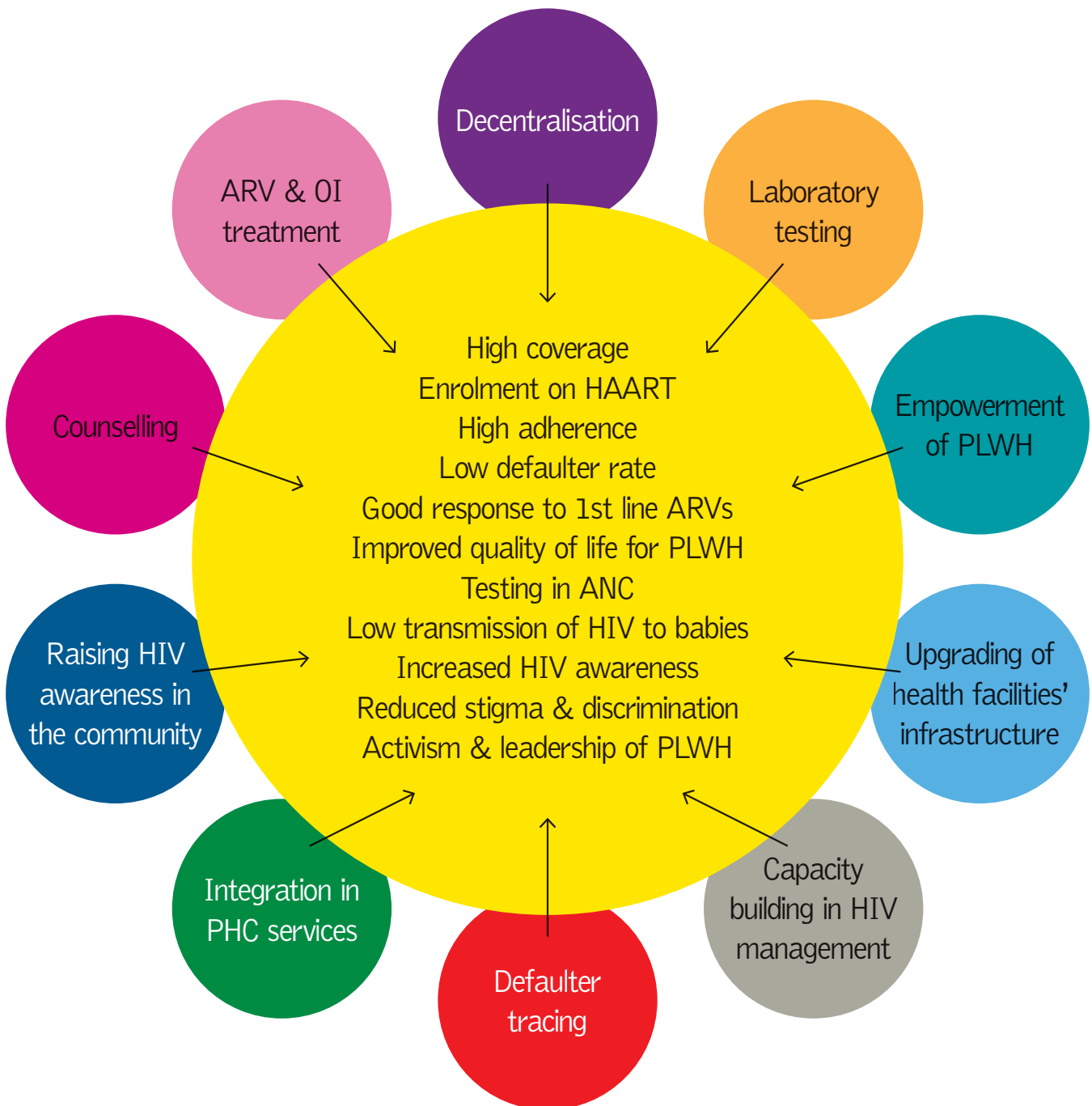


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# —5 Impact



- **High Coverage**

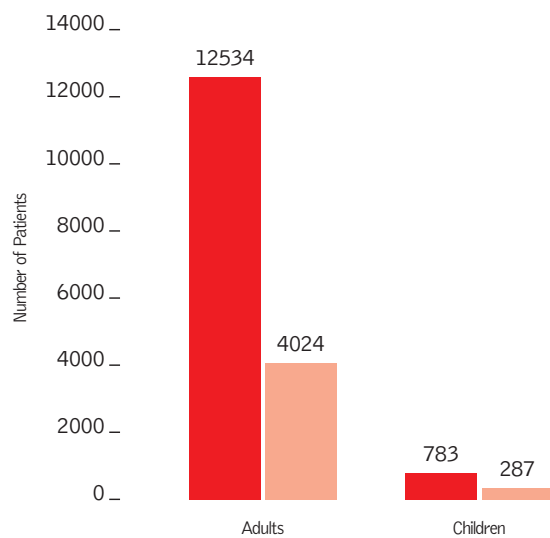
79.6% of estimated PLWH adults receiving HIV care

2009 Adult HIV Care Coverage	Assuming 8% Prevalence
Sero-prevalence estimates % ( 15-64 y)	8
Projected population for Greater Busia District (2009) 15-64 years old (55.1% of total population)	277,595
Estimated adult PLWH	22,208
Active adults in HIV care	17,688
Coverage for adult HIV care in the Greater Busia %	79,6
Estimated adults with advanced HIV disease	7,551
Cumulative patients started on ARV	10,897
Active adults patients on ARV	7,888
Total adult ART coverage in the Greater Busia %	104.5 <sup>2</sup>

- **Enrolment on ART**

4024 adults and 287 children initiated on ART

Enrolment for HIV Care and ART Among PLWH



2

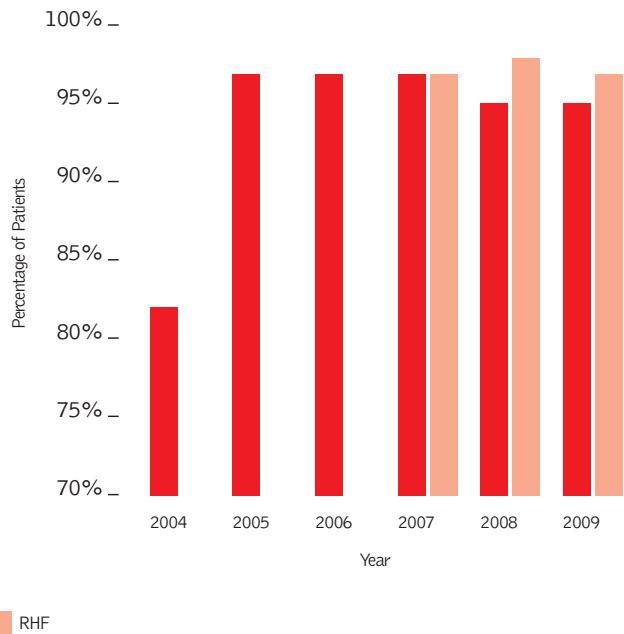
The ART coverage was 104% due to the district serving people from other districts and from across the border. Population figures are also estimates.

■ Enrolled ■ HAART

- **High Adherence**

*More than 95% of PLWH were adherent<sup>3</sup> to their treatment*

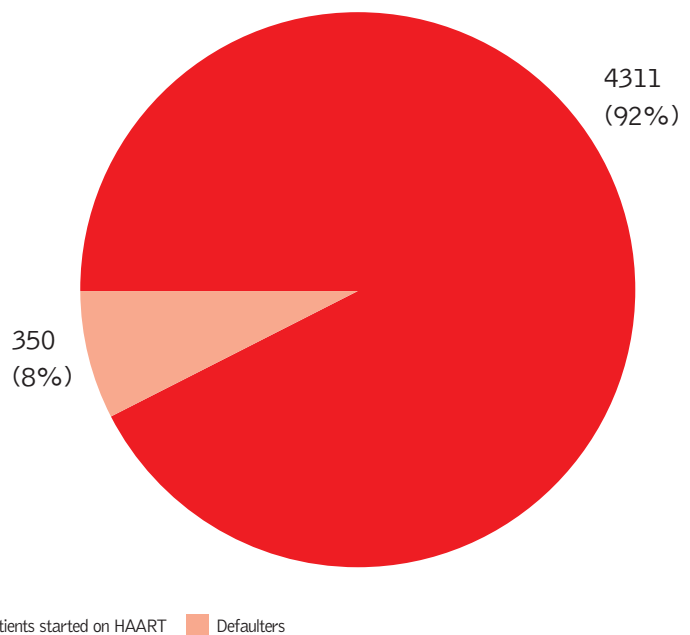
Percentage of patients with above 95% adherence to HAART



- **Low Defaulter<sup>4</sup> Rate**

*Out of 4311 patients who started on ARVs, only 8 % defaulted*

Defaulters among PLWH on ART



<sup>3</sup>

A patient was considered to have high adherence when they did not miss any of their medications.

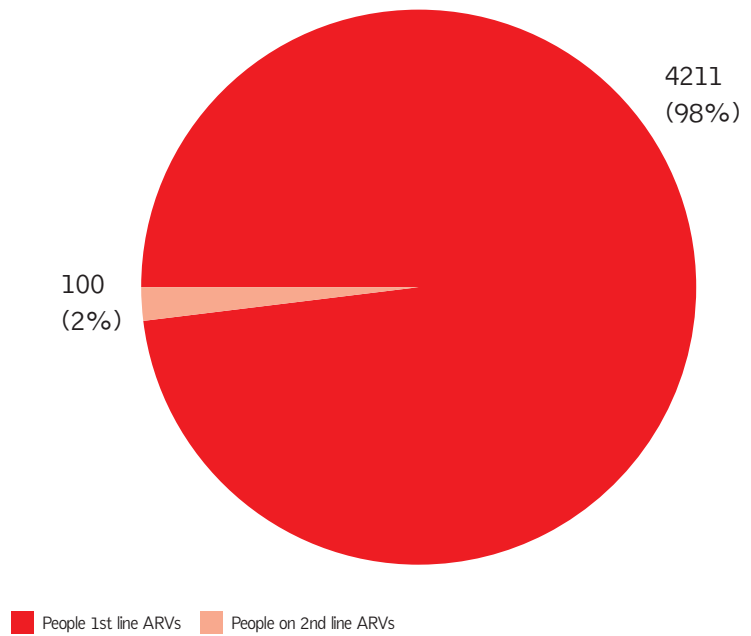
<sup>4</sup>

A person was considered to have defaulted when they missed a clinic appointment for more than 2 months and could not be traced.

- **Good Response to 1<sup>st</sup> Line ARV Treatment**

98% (4211) of people on ART had a good response to 1<sup>st</sup> line ARVs

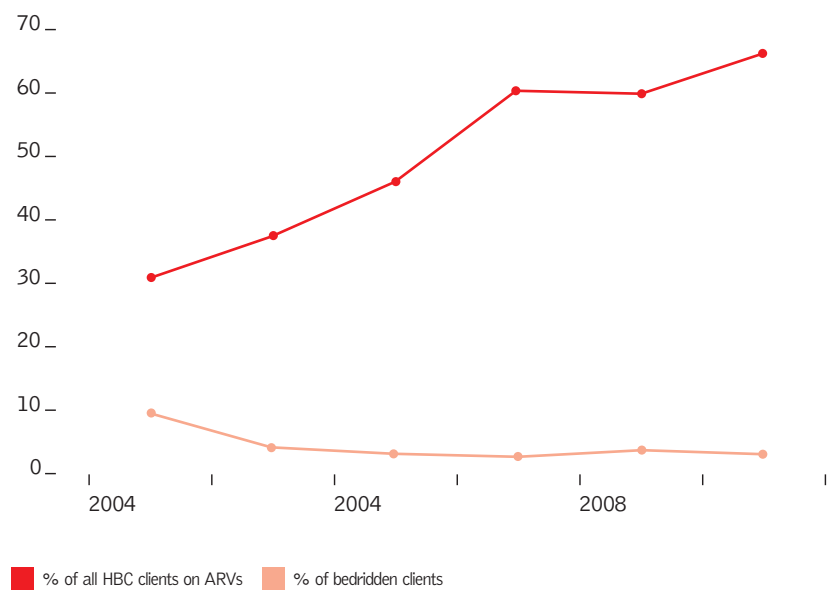
Low number of PLWH on 2<sup>nd</sup> line ARVs



- **Improved Quality of Life for PLWH**

The number of PLWH on ARVs increased resulting in a decreased number of bedridden clients requiring HBC

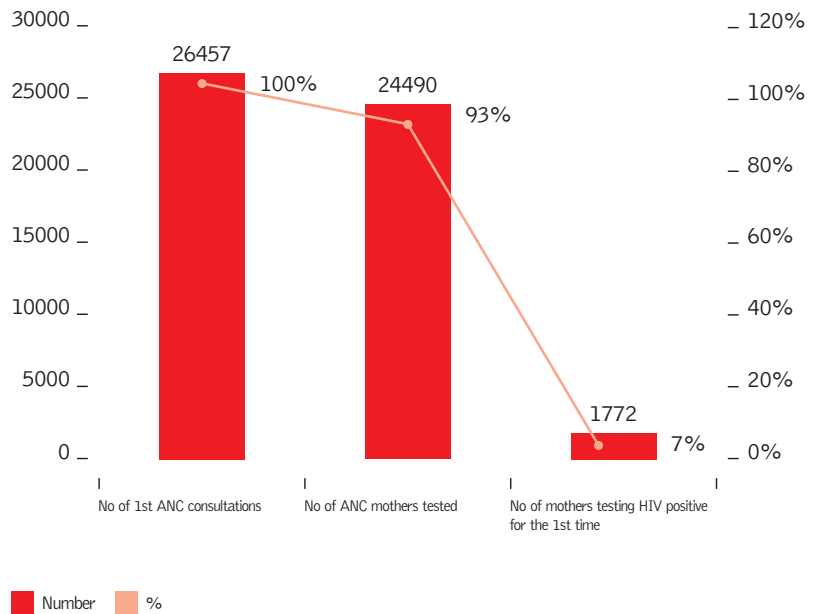
% of all HBC clients on ARVs versus % of HBC bedridden clients



- **High Rate of Testing in ANC**

*93% of mothers attending ANC services were tested for HIV*

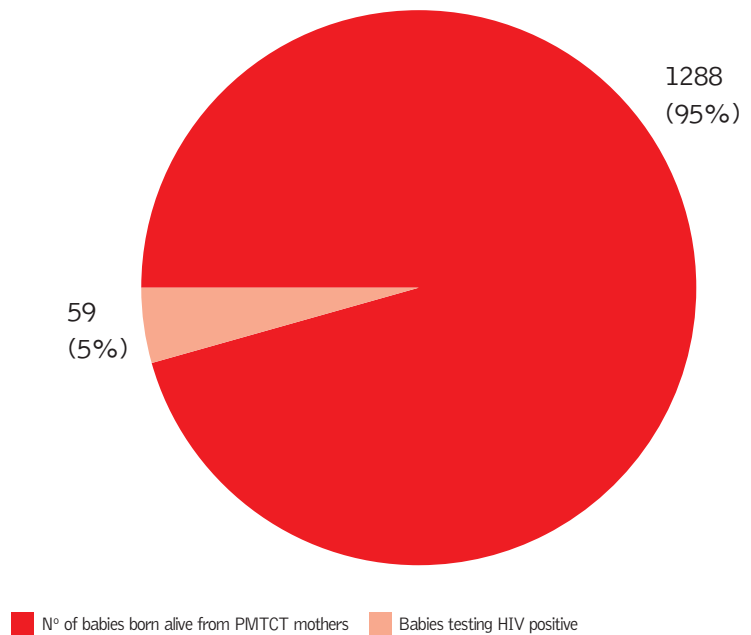
HIV Testing Among First ANC Clients



- **Low Transmission Rate for HIV Exposed Babies**

*Only 5% of babies tested HIV positive following PMTCT*

Outcome of PMTCT Babies





© MSF

- **Increased HIV Awareness in the Community**

*“There is no any NGO that came to the community except MSF and (...) first they came in terms of video shows and it attracted so many people in the community and people were interested to know what MSF is after and through that people were educated, knew their status and they have changed.”*

Peer Educator



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*“When AMPATH arrived in a community where MSF has worked it found a lot of awareness, good sensitization by MSF, low stigma, people are very open, seeking care. Support groups at community level have fostered this. It was very easy for AMPATH to penetrate the site (Busia)”*

AMPATH Health worker

- **Reduced Stigma and Discrimination<sup>5</sup>**

*“At first the people had stigma. So many people had to hide themselves but now you find that the people themselves they come to us to seek for the services.”*

Health Worker



© MSF

*“You find somebody say (...), I am HIV positive. (And) she says I am now living positively. (...) This was not there before.”*

Peer Educator

- **Activism & Leadership of PLWH**

*“We participate in Town Council and Districts Commissioner’s committees and we have representatives in criminal courts. We are the role models and we give good examples, we educate in public gatherings and churches, we are regarded as very important people in the community.”*

PMTCT Male Volunteer

5

At the beginning of the treatment program PLWH faced stigma and discrimination from many sides. This included from spouses, family, relatives, religious groups, employers, educational institutions, the community and even from health service providers. Widows were being chased away from their homes due to allegations that they were the ones who infected their husbands; they were also dispossessed of the family property. Some orphans whose parents had died of HIV/AIDS were chased from schools so as not to infect other children. Some teachers who went public about their status were transferred to far away schools where they could not access treatment.

*“When I attended the promotion interview last year, the District Commissioner was very impressed in what I was doing as an Information Disseminator volunteer. I also presented my SGBV certificate. I was promoted to the Chief of Nambale Township. Now we are two female chiefs and we have all been volunteers with MSF”*

Chief of Nambale



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*“I received some information from some parents that particular children whose parents had died of HIV related illnesses were being discriminated against. The three pupils were being put in a class of their own and teachers would speak to them from the outside in fear of being infected. They were also being (set) aside to protect the other pupils from HIV infection.*

*This lack of information on the part of teachers touched me and I visited the school immediately. I called the parents and teachers together and wanted to know why the parents were supporting such inhumane treatment to children. I challenged the teachers to go for (an) HIV test so that those who turn positive can become the teachers to the positive children.*

*I also suggested that all the parents get tested so that those who turn positive, their children can also be segregated. No one took this challenge and all the children went to the same class and I had to explain to all how HIV is transmitted”.*

Peer Educator in Port Victoria.



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# —6

## Best Practices

### **Providing HIV care and treatment with strong community involvement**

The strong link with the community has contributed to impressive empowerment of PLWH, stigma reduction, a high level of HIV awareness, improved health seeking behaviour, very good treatment literacy, high adherence to treatment and low rate of treatment failure.

### **Decentralization of HIV care and treatment**

The experience shows that decentralised HIV care in rural settings is feasible and has helped to increase coverage of HIV/AIDS treatment and care as well as increase enrolment in ART.

### **Integration of HIV care and treatment in primary health care**

Integration contributed to a reduction in stigmatisation, increased the uptake of HIV services, improved diagnosis of HIV patients and created a 'near 1 stop service' for HIV and TB thus increasing access and quality of care.

### **Simplification of HIV care and treatment**

Task shifting freed more qualified staff for the care of more complicated patients and has empowered patients to become peer educators. FDC reduced the pill burden for patients and contributed to good adherence. Simple monitoring algorithms make possible proper follow up with less laboratory tests.

# –7 Handover of the Project



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While the needs remain massive, in stable settings like Busia, MSF is no longer alone in providing treatment. So the question of whether MSF Spain should continue providing HIV/AIDS care in this project and, if not, how can it leave without abandoning its patients, was examined.

Considering that the initial objectives were met, other interested partners were available, and considering the efforts the MoH had made in intervening in HIV/AIDS, it became apparent that MSF could hand over the responsibility to the partners while ensuring that patients were taken over with a minimum standard of care and agreed upon continued quality of care and treatment. A two year gradual handover process was planned for at both the District Hospital and the rural health facilities.

Discussions between MSF Headquarters, National, Provincial and District AIDS coordinating bodies and MSF capital and field teams were conducted. Provisional timelines for the handover dates for the overall project and for specific activities were developed for different facilities. Initially MSF was expecting the MoH to assume responsibility; however, due to the alleged lack of MoH resources, alternative partners had to be identified. An active search for and approaches to potential handover partners was done with the MoH taking the lead. Early negotiation and integration of activities with partners of interest was done and areas that would not be covered adequately like HBC, CAN and psychosocial components were integrated in the negotiations of the handover.

MSF leaving did not come as a surprise to anyone. Careful education and explanation to minimize negative reactions was done in the community, in the facilities and at administrative levels. News bulletins were developed about the exit strategy and distributed to different groups and partners. There were interim meetings with the partners on the exit plans: key groups involved were the MoH at various levels, community volunteers, patients and their families, potential partners, MSF national staff and MoH staff, activist groups and local press.

For each facility there was a one month transition period during which activities were being handed over while MSF still had a strong presence. This was a crucial period for ensuring potential problem areas were identified and strengthened early on. Minimum standards and 'acceptable' levels of care expected from the incoming partner guided the handover process. A contingency plan was made when handover timelines were not achieved due to a lack of capacity of partners. Flexibility was exercised in the handover period so as to ensure a good handover between partners and continuity of health services throughout the transition period.

Currently one facility has not been handed over to the identified partner due to a delay in meeting the minimum standards set for continued quality of care.

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## Conclusions



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Overall the project has been evaluated as a high quality, patient focused, comprehensive HIV prevention, care and treatment program. It included a very strong community component with high proximity to beneficiaries that has led to decreased AIDS related morbidity and mortality, increased awareness about HIV/AIDS in the community and empowerment of PLWH.

The project has effectively shown that ARV treatment with good outcomes is feasible in resource poor rural settings and that the availability of ART and the empowerment of PLWH reduces stigma and discrimination.

It demonstrated that decentralized care is important to increase access and coverage, and that integration of HIV care in PHC is feasible and has many advantages. However, these successes cannot remain exclusively at the level of implementation of an international NGO. The Kenyan government, and in particular the Kenyan MoH, has gained sufficient experience as to ensure this model (or adaptations of it) is assimilated into their own policies, strategies and implementation plans in this and other settings.

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## Recommendations



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### 9.1— Decentralization of the sites offering HIV care and treatment in a rural setting

Decentralization of care and treatment in a rural setting where the population is dispersed and means of transport are limited has been the key to increased access to HIV treatment.

The decentralization strategy should be accompanied by the strengthening of the HR capacity in the health sites, improvement and strengthening of infrastructure and systems and appropriate allocation of staff. As MSF illustrated in this project, an excellent link of referral and counter-referral between health facilities and community and an effective defaulter tracing system has dramatically increased health seeking behaviour and the access to care. International donors and other implementation partners could have a major role in order to support this process.

Appropriate guidelines, protocols and communication among the different levels of the health system will be necessary for the implementation of decentralization in order to look for synergies and referrals.

Although national decentralization guidelines have been developed they should be disseminated so as to guide decentralization processes in the country. The process has to be accelerated and supported in order to increase access to treatment and reach universal access.

### 9.2— Integration of HIV/AIDS services in primary health care

The integration of HIV/AIDS care in primary health care is feasible for HIV care in rural settings. Existing health care delivery systems could be utilized with minimal investment in terms of human resources and infrastructure.

The main activities to integrate HIV care in a primary health care system are capacity building of human resources, access to basic laboratory tests, the availability of ART in selected facilities, access to PMTCT services and opportunistic infection drugs as well as community awareness and involvement.

### 9.3— Boost simplification of HIV/AIDS care and treatment activities

- Continue to promote the **use of FDCs and generic drugs**

FDCs have dramatically increased treatment adherence and access to quality generics at affordable prices, enabling many more patients to be treated with ARVs.



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In 2008 Kenya introduced a new law, the Anti – Counterfeit Act. The objective of the Anti-Counterfeit Act 2008 (The Act) is “to prohibit trade in counterfeit goods, to establish the Anti-Counterfeit Agency, and for connected purposes”.

Ambiguities in the definition of counterfeit products potentially include legally manufactured generics. This means that the 2008 Anti-Counterfeit Act risks banning the importation of essential life-saving medicines, which would hinder access to treatment for people living with HIV/AIDS. It would also paralyse the use of the pro-public health provision of 2001.



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The 2008 Anti-Counterfeit Act should be clarified to ensure that measures taken to prevent counterfeit medicines reaching consumers do not hamper in any way trade in and access to legitimate generic medicines.

- Boost and support **initiatives that minimize the prices of new drugs**

Newer and better ARVs are already used by patients in the US and Europe, but either are not available to people in developing countries or are simply too expensive, despite the recent recommendations by WHO. These newer drugs, with fewer side effects, are needed to gradually replace older treatments.

It is also a struggle for generic producers to develop fixed-dose combinations with these new drugs because different companies own the patents of the various drugs.

There is a way to produce new drugs at affordable prices: **the patent pool**. The patent pool is where drug companies share their drug patents with the pool so they still get their royalties. However at the same time, other companies, such as generic drug manufacturers and research institutions, can get hold of these patents to make cheaper drugs.

Kenyan civil society along with the GoK could join efforts to support the Patent Pool Initiative, advocating and creating awareness so that pharmaceutical companies join the patent pool. They could also align with other initiatives outside of Kenya to strengthen this campaign.

- Increase **task shifting policies in HR**
  - a) The lack of clinical officers is the main obstacle in providing the HIV Comprehensive Care Package. At the health facilities in Greater Busia District, MSF was contracting 72% of the COs needed, while for nurses this percentage was 28%. Poor distribution and retention practices are among the main causes of a lack of COs in the rural areas.

Therefore **nurse initiated and managed ART (NIMART)**, as part of task shifting policies, could help overcome the obstacle of staff



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shortages. NIMART in Kenya is partially recognized as nurses follow up PLWH who are stable, but nurses do not initiate ART. As most of the staffing in health facilities consists of nurses, it would be helpful to allow them to initiate ARVs as is done in South Africa.

- b) Another opportunity for task shifting lies with the peer counsellors. Among the additional staff that MSF hired in the rural health facilities there were fourteen trained peer counsellors who assumed duties previously carried out by nurses. This was an effective strategy to prove that **task shifting to lay-peer counsellors works** and even improves the uptake of HIV testing and the outcome of treatment education.



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HIV Testing and Counselling (HTC) can be done by lay counsellors as long as they are trained and registered by the MoH as VCT counsellors. However clear job profiles for these positions are still non-existent and they should be better accredited. Budget support to contract them should be given.

- c) Creative approaches should be applied to guarantee the retention and sustainability of skilled HR in the current facilities.



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In order to guarantee the absorption of staff that is temporarily sponsored by external partners, human resources should be recruited and employed through the Kenya Public Service Commission together with the MoH. This should be done at the onset of the project. Depending on the number of staff hired, sustained external funding for the time after the sponsoring period also needs to be secured. This can be achieved through strong coordination between central level government and development partners.

The handover of the remaining one site has shown how sometimes a lack of coordination and leadership in the takeover implementation can hamper efforts to implement or simply continue services that were already in place. This is despite the means and resources being available. Trained HR were transferred to other health facilities, a poorly organised selection process caused delays and brought non-qualified HR for the position required and mentorship had to be repeated more than once in the same health facility.

#### 9.4— Provision of free access for the treatment of OI's and to laboratory services

Patients are currently facing challenges regarding access and continuity of care and treatment. Currently, as in some other countries, only some OI drugs are available, while other essential OI treatments are not. For example, chemotherapy for Kaposi's Sarcoma, which remains the most cost-prohibitive treatment for patients, is not available.

While CD4 monitoring is included in the free HIV care package other laboratory costs are not fully covered.



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## 9.5— Community involvement

Facility based care and treatment were linked to a large network of community health workers involved in home based care and defaulter tracing, and to peer educators and patient support groups. An additional network of male PMTCT volunteers was set up to reduce stigma and gender based barriers to PMTCT enrolment. The strong link with the community has contributed to impressive empowerment of PLWH, stigma reduction, a high level of HIV awareness, improved health seeking behaviour, very good treatment literacy, high adherence and a low rate of treatment failure.

Community involvement should be secured by incorporating the grassroots levels of communities and PLWH and providing them with skills, recognition and support.



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**9.6— Stability in funding along with the flexibility to use funds and independence from external funding of public donors** have been key issues.

This is necessary in order to be able to develop a coherent, successful and well planned programme responding to the real needs of PLWH. The programme needs to be divorced from any political agenda. It should focus on the continuation and quality of care of PLWH, and be able to complement the MoH services when needed.

The HIV crisis and the need to constantly improve models of care is a major challenge for the public health sector. External NGOs, with their freedom of flexible budgets and human resources, can be a crucial catalyst to get programmes off the ground. Once a new programme is running smoothly the Ministry of Health should take it over. However, this has not happened in Busia, with all of the sites being handed over to international partners, not to the MoH.

Ensuring sustainability of care and treatment of HIV/AIDS in the face of increasing needs will require increased resources from the public sector and external donors, and creative approaches in implementation. Moreover, improved information sharing and coordination among all actors is essential.

However a dangerous trend is underway in the global health policy arena which is also affecting Kenya. Rather than looking for ways to leverage and replicate the success of the AIDS public health revolution to improve global health, there are increasing calls for a diversion of foreign aid away from HIV/AIDS and towards other health priorities. The most glaring sign of this decreasing political commitment to HIV/AIDS is a major funding deficit. This is already affecting those who are currently under treatment in Kenya and where 40% of PLWH who are in need of HIV treatment are still not receiving any.



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**“You find somebody say (...),  
I am HIV positive.  
(And) she says I am now  
living positively. (...)  
This was not there before.”  
Peer Educator**