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KENYANS WITH HIV

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SNAPSHOTS FROM THE FIELD



USAID
FROM THE AMERICAN PEOPLE

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Cover photo: The women's acute-care ward at St. Mary's Hospital in Mumias, a CCC partner. Mosquito nets hang above each bed, since the area has a high prevalence of malaria. Photos by Steve Taravella/FHI

A 34-year-old teacher, crying uncontrollably, was brought into Kakamega Provincial General Hospital in Kenya's Western Province in January 2004 by a relative. The teacher, who was HIV-positive, was suffering in many ways. Much of her hair had fallen out. She had pneumocystis carinii pneumonia. And tuberculosis. And a troubling skin condition. And an alarming CD-4 count of 44. And she had just lost a dear friend to AIDS.

But none of this is why she was crying.

She was crying because, overwhelmed by despair, she had taken leave from her job for the specific purpose of allowing herself to die. But her leave had now come to an end and she found herself still very much alive. The anguish of expecting to die but instead facing a return to work was too much for her to bear.

At the hospital that day, she encountered Beth Barasa, who supervises counselors in the hospital's voluntary counseling and testing (VCT) service. Barasa spent time educating the woman about antiretroviral therapy (ART), helping her see that her life need not end now. The teacher went on ART in February 2004. By August 2004, her CD-4 count had risen to 206. She was receiving treatment for her TB, she had regained weight and even her hair had regained most of its luster. Barasa, who supported the teacher with follow-up home visits, says, "When she looks at me now, she just laughs because she had given up on life."

Antiretroviral drugs (ARVs) are transforming HIV care in the developing world, and Kenyans are benefiting in profound ways. What happened to this teacher is happening across this country of more than 32 million people, a nation with an HIV infection rate of about 6.7 percent. And the U.S. Office of the Global AIDS Coordinator is playing a leadership role throughout.

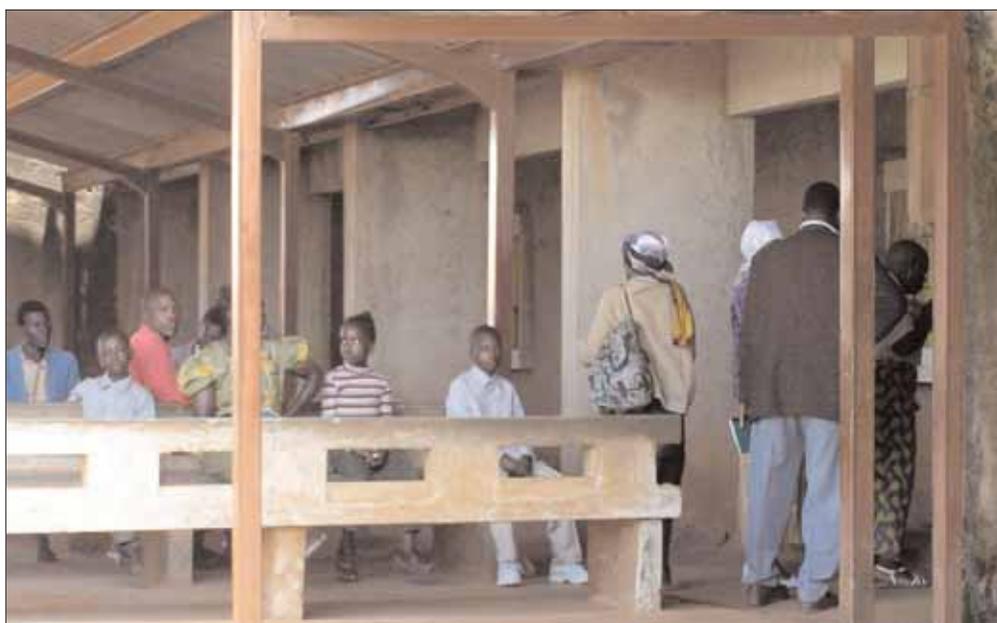
In this teacher's case, the U.S. Agency for International Development (USAID) is providing technical assistance, laboratory equipment, ARVs and salary support to the Provincial Hospital. USAID also renovated the Provincial Hospital's facilities so the hospital could become a Comprehensive Care Center (CCC), part of a new delivery system that Kenya's Ministry of Health has adopted as the prototype for HIV care and treatment. USAID's assistance is delivered by the Implementing AIDS Prevention and Care (IMPACT) Project, managed by Family Health International (FHI). To jump-start the Kenya program's ART component, FHI contributed \$10,000 of its own funds to purchase drugs for two of these new CCCs.

CCCs have so quickly become known as a source of life-saving treatment that "once people test positive, their mind is already on ARVs. They want to just walk from the test to the CCC center," says Gertrude Lwanga, who manages VCT on a clinical care coordination team at St. Mary's Hospital in Mumias, Western Province.

Each CCC features a set of common core services, including: a care-based counseling and testing service to establish an HIV diagnosis; a clinical ability to diagnose, treat and manage opportunistic infections; counseling for treatment adherence and nutrition; and delivery of ART. People with HIV can access a variety of additional services that are provided offsite but which are



USAID has funded renovations at Kakamega Provincial Hospital to improve delivery of care for Kenyans with HIV. Above, the psychiatric and ear, nose and throat departments were moved to different quarters so that HIV services could be centrally housed in a new CCC. Below, after this photo was taken, FHI constructed “booths” at these pharmacy dispensary windows to allow for greater patient privacy.



linked, ensuring greater coordination in their care and saving them time. These include treatment for tuberculosis, home-based care, inpatient care, services for preventing mother-to-child HIV transmission, and management of sexually transmitted infections other than HIV.

In the 14 CCC facilities established in four provinces with FHI assistance, the focus is on the spectrum of health services. “There’s a big danger of just focusing on the pills because the pressure (to deliver ARVs) has been so great. But there’s a lot more that goes with the pills—a whole

package of services,” explains Dr. John Adungosi, FHI’s technical officer for comprehensive care and ART in Kenya. CCCs are building partnerships between patients and providers, guided by a plan developed for each patient’s care after an individual assessment.

The CCC effort also reflects a partnership among organizations. IMPACT works closely with the RPM+ Project (Rational Pharmaceutical Management Plus) at Management Sciences for Health for commodities delivery, and with the Horizons Project at Population Council for the CCCs’ operational research component.

Some CCCs, such as one at 700-bed Coast Provincial General Hospital in Mombasa, have a large operational research focus, while others, such as one in Nakuru, primarily respond to direct patient needs. Regardless, throughout Kenya, the CCC approach is redefining care for people with HIV/AIDS, bringing life-saving medications to those who had no such access before. Since IMPACT began providing ART in Kenya in June 2003, launching it at Coast Provincial General Hospital, 14 sites have managed the care of approximately 9,401 people, including the teacher in Kakamega. Through March 31, 2005, 3,391 patients have begun taking ARVs. FHI studied a subset of patients who had completed at least six months on ART to assess immunologic and clinical responses. Median CD-4 counts rose from 69 to 176, and median weight increased from 56 to 62 kilograms.

“We’re talking about people who were so depressed they couldn’t get up and would rather be dead. Now they get up and go to work,” says Dr. K.S. Shikely, chief administrator at Coast Provincial General Hospital. Dr. Babu Bora, a physician at Rift Valley Provincial General Hospital in Nakuru, says, “We’re able to do something for sick people who otherwise had given up life.” He offers a few examples of lives changed by ARVs in this community:

- A 36-year-old Airport Authority employee came to this hospital in late 2003, sweating profusely and obviously ill. Tests revealed HIV and a CD-4 count of one—so low the hospital repeated the test to rule out a lab error. After nine months of ART, the man’s CD-4 count jumped to 500 and he returned to work. His treatment has since been managed by Nakuru’s Comprehensive Care Center.
- A distraught staff member came to Dr. Babu Bora in the fall of 2003 with concerns about her own health, which was causing her to miss work. She had malaria, TB and cryptococcal meningitis. Her CD-4 count was 25. Dr. Babu Bora admitted her and introduced ART. Her health improved dramatically, and she ultimately returned to work at the main hospital.
- The first patient whom Dr. Babu Bora put on ARVs is thriving, his care also managed by the Nakuru CCC. The patient is a father of four who tested positive in 1987 and who in 1996 began taking a combination of invirase, DDI and AZT. Without ARVs, “these four children would otherwise be orphans,” Dr. Babu Bora says.

The impact of the CCC extends beyond an individual’s health, points out Dr. Jane Nyikuri Wenyaa, a Nakuru pediatrician. When people are not wrestling with illnesses they cannot manage, “they have more time to do other things. This has had a big impact in the community,” she

says. In Mombasa, Dr. F.P. Otieno says ARVs have resulted in fewer visits per patient. Up to 40 percent of the CCC's patients now come to the facility only once a month, mostly to collect their drugs, he says.

Indeed, CCCs have improved the broader patient experience for PLHA in Kenya. Doctors say patients are more comfortable seeking services from the CCC, more confident, and less reluctant to be identified as someone with HIV. On a reporter's recent visit, for instance, patients were waiting comfortably on benches outdoors in what was clearly a clinical AIDS setting. The CCC also reduces the need to navigate a maze of hospital services and minimizes the distance patients must walk. It also reduces the time patients must wait; before CCCs, physicians were inclined to delay seeing HIV patients until the end of the day because caring for them was more complicated than treating someone with malaria, stroke or other conditions. One patient told Dr. Babu Bora, "I have time to cry for 15 minutes and the doctor is not hurrying me up."

Some CCCs have emerged from new construction, such as the Nakuru CCC, which was funded by USAID in collaboration with the Embassy of Japan and the Japanese International Cooperation Agency. Others have been developed by renovating existing facilities. At Kakamega Provincial General Hospital, IMPACT constructed booths around pharmacy "windows" to give



This KiSwabili sign invites Kakamega Provincial Hospital visitors to "Link Into a New Life: Volunteer to be Counseled and Tested for HIV."

patients more privacy, and at Coast Provincial General Hospital, existing space has been transformed into a nurse's station, counseling offices and records area.

Coordinating many services requires managing complex relationships among many partner agencies. In Mombasa, USAID provides home-based care through

Pathfinder, with whom IMPACT collaborates. In Kakamega, IMPACT funds two home-based care projects for which Pathfinder also provides assistance.

CCCs have already generated lessons that USAID and other donors are applying elsewhere. (Programs similar to CCCs have been initiated in Kenya by the U.S. Centers for Disease Control and Prevention and the U.K.'s Department for International Development.) For instance, the importance of using more experienced staff as ongoing mentors to people who are new to HIV care. "We assumed if we trained people and provided the drugs, everything would just happen, but it didn't work out that way," says Dr. Adungosi. The adjustment that some staff experienced "puzzled us initially," until it became clear that because HIV service delivery required more of existing staff, even dedicated health workers began asking, "This is a new activity—what's in it for me?" IMPACT responded with a mentorship effort in mid-2004 in which physicians who were involved early in CCCs would guide newer clinic staff. The CCC clinical officer with the most experience in Mombasa might be dispatched to a newer site for a week or more to provide

help. (Virtually all CCC staff are Ministry of Health employees; one exception is a records clerk in Mombasa, an IMPACT staff member who helps ensure data is properly reported.)

CCCs have benefited, too, from site visits by multi-disciplinary teams of physicians, nurses, clinical officers, laboratory staff and pharmacists. Some ART medical offices and pediatricians



received special clinical training at New York University Medical School, an experience that helped motivate them even further. The training that physicians receive is preparing them to deliver more client-centered services in other areas, observes Dr. Allan Gohole, FHI's HIV/AIDS and Reproductive Health Officer in Kakamega.

Because its ARVs come from donors that have different reporting requirements, Coast General's CCC keeps its supply locked behind two sets of cabinets. At left are the single-dose ARVs provided by USAID; at right are the fixed-dose combination drugs supplied by the government of Kenya. Of the 400 to 600 prescriptions the hospital pharmacy processes each day, 15 to 20 are for ARVs.

The insights and experience of PLHA themselves also have helped these programs; people with

HIV are an invaluable resource for effectively ART delivery. On a volunteer basis, members of the Coast People Living with HIV/AIDS (COPE) provide drug adherence counseling to clients at Coast Provincial General. When people begin taking ARVs, "They can never get enough counseling. Even after you explain, they still go to the pharmacy with so many questions. They need someone to talk to," says Coast General's Dr. Otieno.

Even when CCCs are properly staffed with well-trained personal, providers must adapt to the financial, gender and food supply challenges that continue to frustrate ART delivery.

Economic issues remain perhaps the biggest obstacle to sustainable ARV treatment. Many patients at St. Mary's Hospital, part of the Western Province CCC, cannot afford tests to measure their CD-4 cells at three and six months into treatment, so clinicians must rely on other indicators, such as whether the patient appears to have gained weight, says Bernard Atsiaya, a member of the hospital's HIV clinical team. In Nakuru, everyone who receives ARVs must pay something (the amount differs based on which donor provides the drug), while in Mombasa, ARVs are given at no cost to those who are medically eligible. In Western Province, patients must pay a one-time paperwork fee of KS20 shillings, plus about KS500 per month for ARVs – but the



Caskets sold on the roadside, a short walk from Kakamega Provincial Hospital: No clearer indication of why Comprehensive Care Centers are so critical.

hospital can waive the fee based on the clinical team's assessment or the patient's inability to pay. (Private hospitals charge about KS3,000 per month.)

But to be effective, Kenyan ARV programs must recognize gender disparity, too. At St. Mary's, of the 51 men who had been declared eligible for ARVs as of September 2004, 31 (61%) were receiving it and only 20 (39%) were waiting. But of the 100 women who were declared eligible, only 20 (20%) were receiving it, while 80% waited. The polygamy practiced in some parts of Kenya, which confers great power on men, further complicates matters, says Robert Nyagah, a St. Mary's team member who explains that a man might have 20 children with three or four wives. In such cases, as in the Wanga tribe, if one of a man's wives became ill with HIV, he might simply move in with another, leaving the first to fend for herself, says Gertrude Lwanga, the hospital's VCT team member.

Nutrition is another obstacle to sustainable ART delivery. In many places, patients "don't even have the tiniest thing to put in their mouths to sustain themselves," says Dorothy Mubweka, who coordinates home-based care on the St. Mary's team. In one case, a seriously ill, HIV-positive woman who came to St. Mary's three years ago was suffering from malaria but had no money for medicine. Hospital staff pooled their own funds to buy malaria drugs for her. That same week, she died. When staff went to her home for funeral services, "We found she had not had anything to eat. Nothing," says Gertrude Lwanga. "I've never forgotten that."