

Rapid decentralised scale-up of HIV care and treatment in Suba District MOH health facilities

Suba District, Nyanza

- Population ~200,000
- Life expectancy 37 years
- Highest HIV prevalence in Kenya (30% versus national average of 6.7%)
- High-risk group: Large proportion of population involved in fishing industry
- Local transportation is infrequent and expensive because of poor road network on the mainland and wide distribution of beach/island communities (116 landing beaches in Suba)
- Main economic activity is fishing

Scale-up strategy

Priority on decentralised scale-up to increase accessibility

- Close collaboration with DHMT, including joint site visits
- Central team based at District Hospital
- Island team based at island Health Centre
- Peripheral sites begin with one day per week for their HIV day
- Mobile support to peripheral sites every week during their HIV day (as volume increases, this becomes the ARV and complicated patient day)
- Ongoing use of Site Assessment Tool to monitor progress and identify gaps and areas to focus on
- CHW and peer educators at each site
- ARVs supplied to new sites via sites already supplied by KEMSA
- Task shifting

Mobile support

Weekly visits to provide:

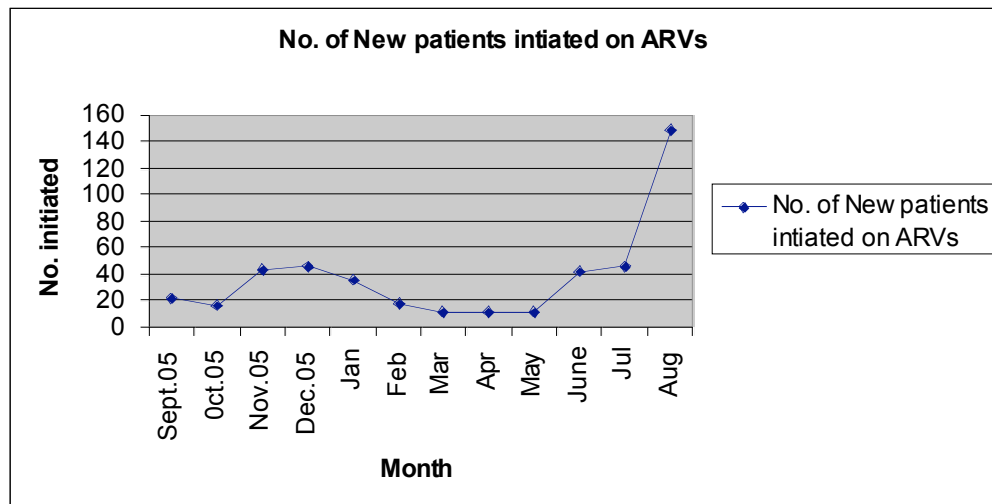
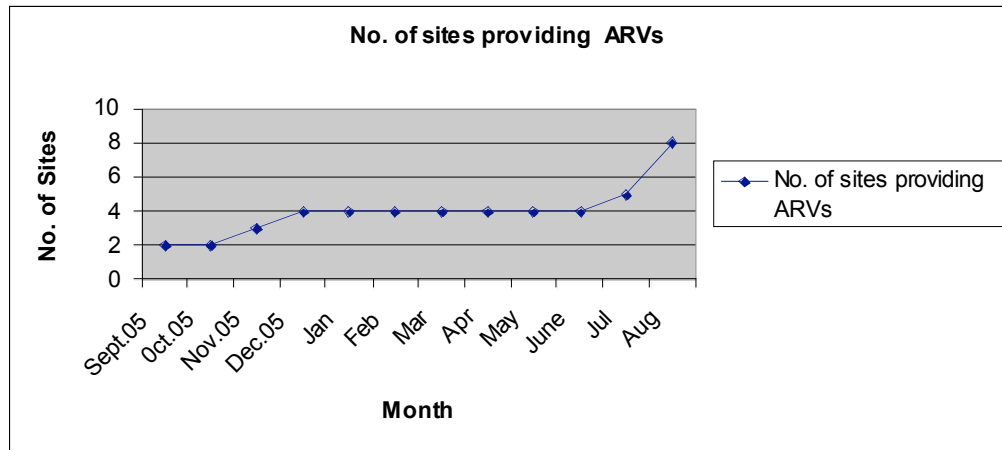
- Clinical care alongside MOH staff on site
- Clinical mentoring and consultations
- Technical assistance:
 - Medical records
 - Patient flow
 - Referral sources
 - Commodities management
 - Data collection and reporting
- Laboratory specimen transport

Task Shifting

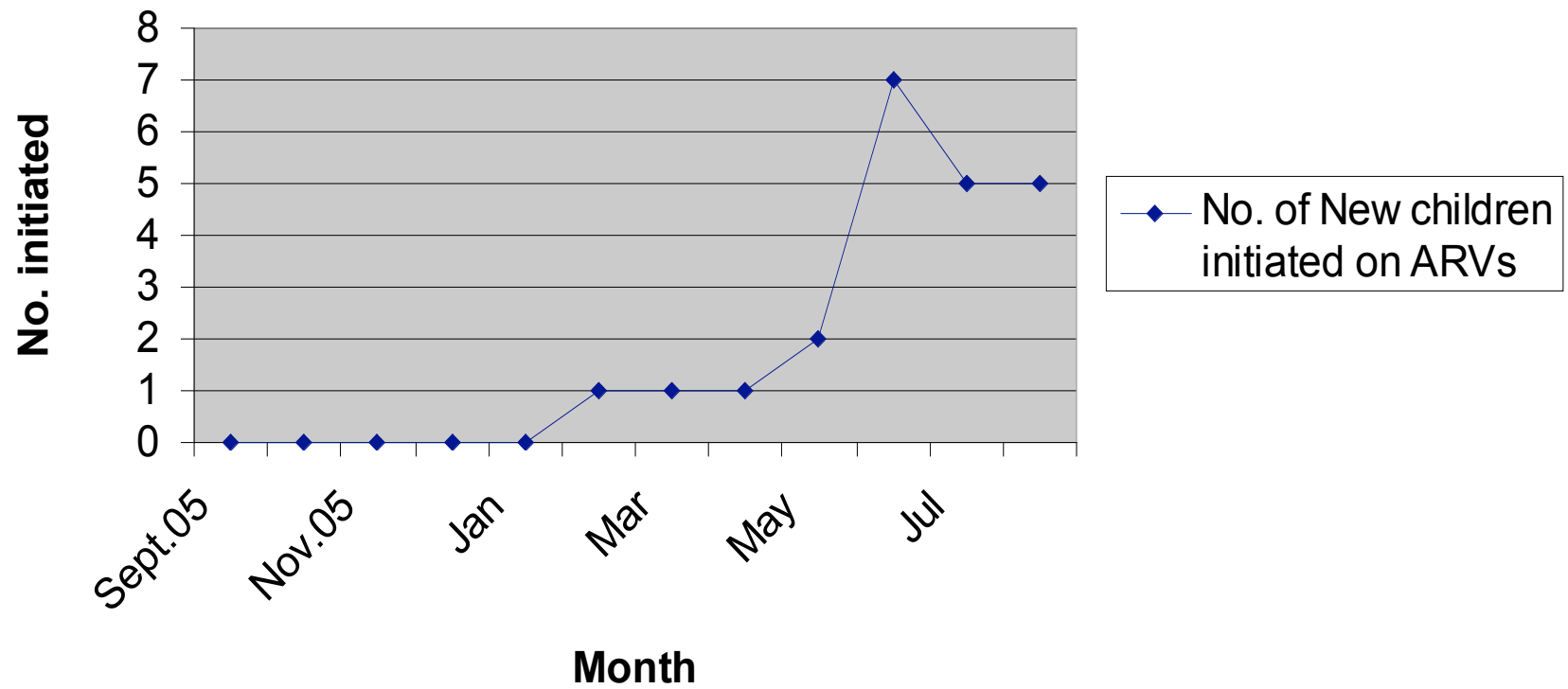
Roles of PSC support staff (CHWs, peer educators, drivers):

- Patient registration and filing
- Taking vital signs and weight
- HIV education
- Adherence counseling
- Pill counting, dispensing
- Completing locator information and tracing defaulters
- Formation and oversight of peer support groups and patient advisory groups
- Data collection and facility-level reporting
- Commodities management

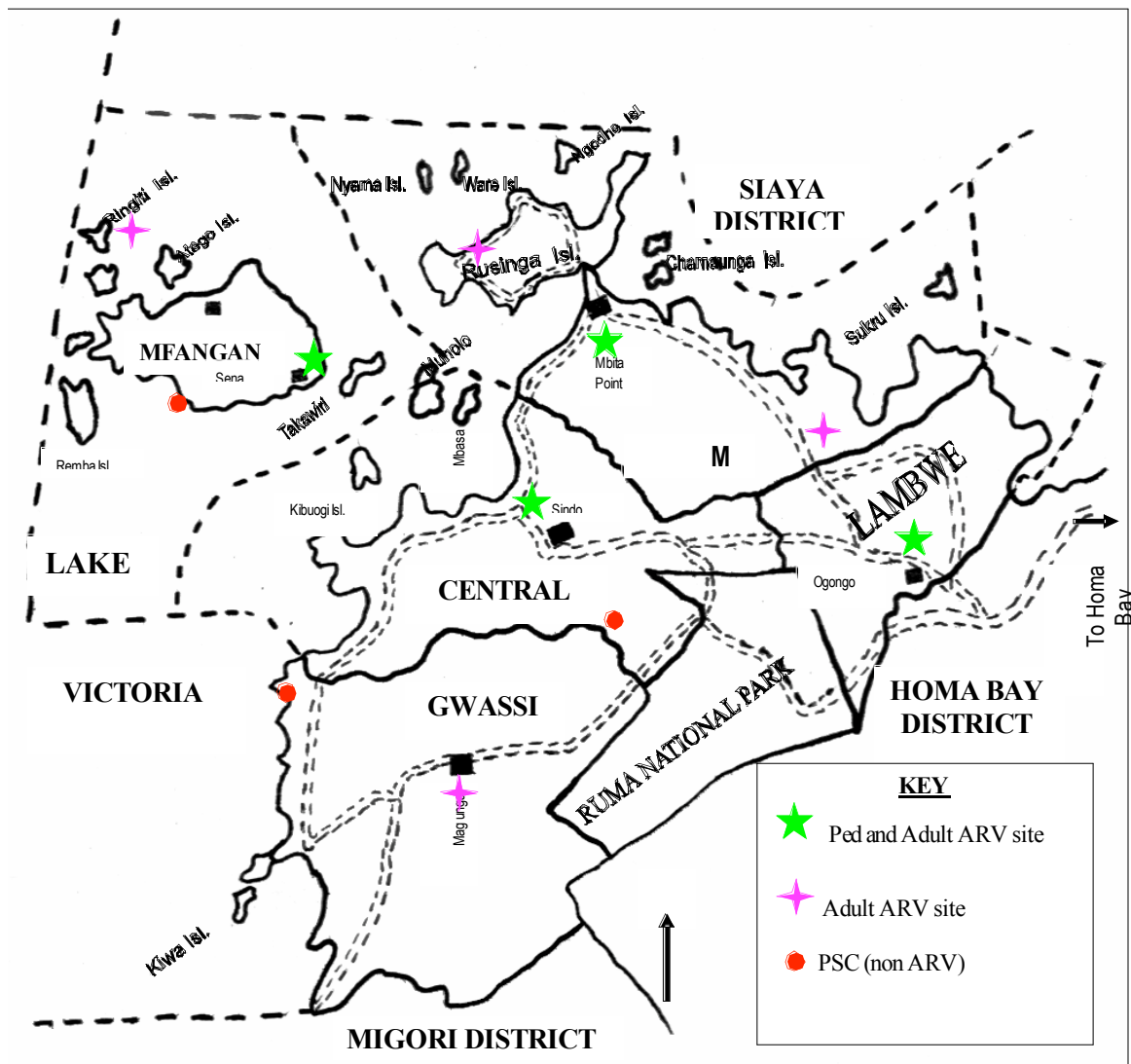
Progress



No. of New children initiated on ARVs



MAP OF SUBA DISTRICT SHOWING THE DISTRIBUTION OF HEALTH FACILITIES



Challenges

- Limited clinical staff
- Staff absenteeism due to trainings, sick-offs, informal duty rosters, and travel “over the weekends” which may include Fridays/Mondays
- Pressure from various government and partner representatives to speed scale-up without an equal emphasis on preserving quality of care
- Conflicting messages from KEMSA regarding scaling up of ARVs
- High training and mentoring needs
- Transportation for mobile teams

Lessons learned

- PSC support staff have been the most important factor in clinic organisation, supplies management, and reporting. They often do these duties better than clinical staff
- “How to run a Patient Support Centre” is not taught in formal training or during clinical attachments at most sites. This can be addressed during preliminary site visits
- Once systems are in place, expanding services to include ARVs can be done quickly while maintaining quality of care, with weekly support from experienced clinical staff

Lessons learned cont...

- Frequent supervision from DHMT members can greatly reduce staff absenteeism
- Close collaboration government and partners improves integration of prevention and care, and reduces overlap
- MOH staff motivation increases as emphasis is placed on supporting them e.g. consistent delivery of supplies, frequent support visits (not supervision), access to CME, task shifting, job aids, etc