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:

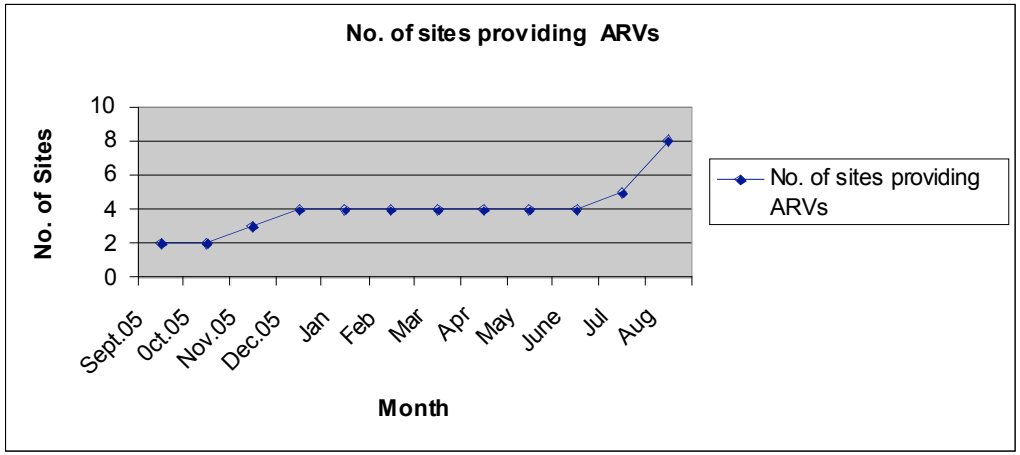
- Clinical care alongside MOH staff on site
- Clinical mentoring and consultations
- Technical assistance:
  - Medical records
  - Patient flow
  - Referral sources
  - Commodities management
  - Data collection and reporting
- Laboratory specimen transport

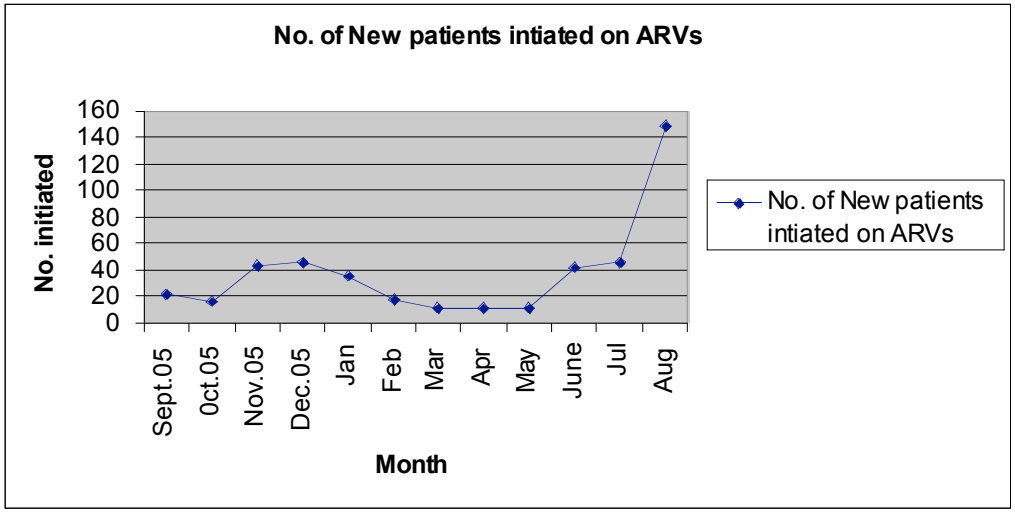
Task Shifting

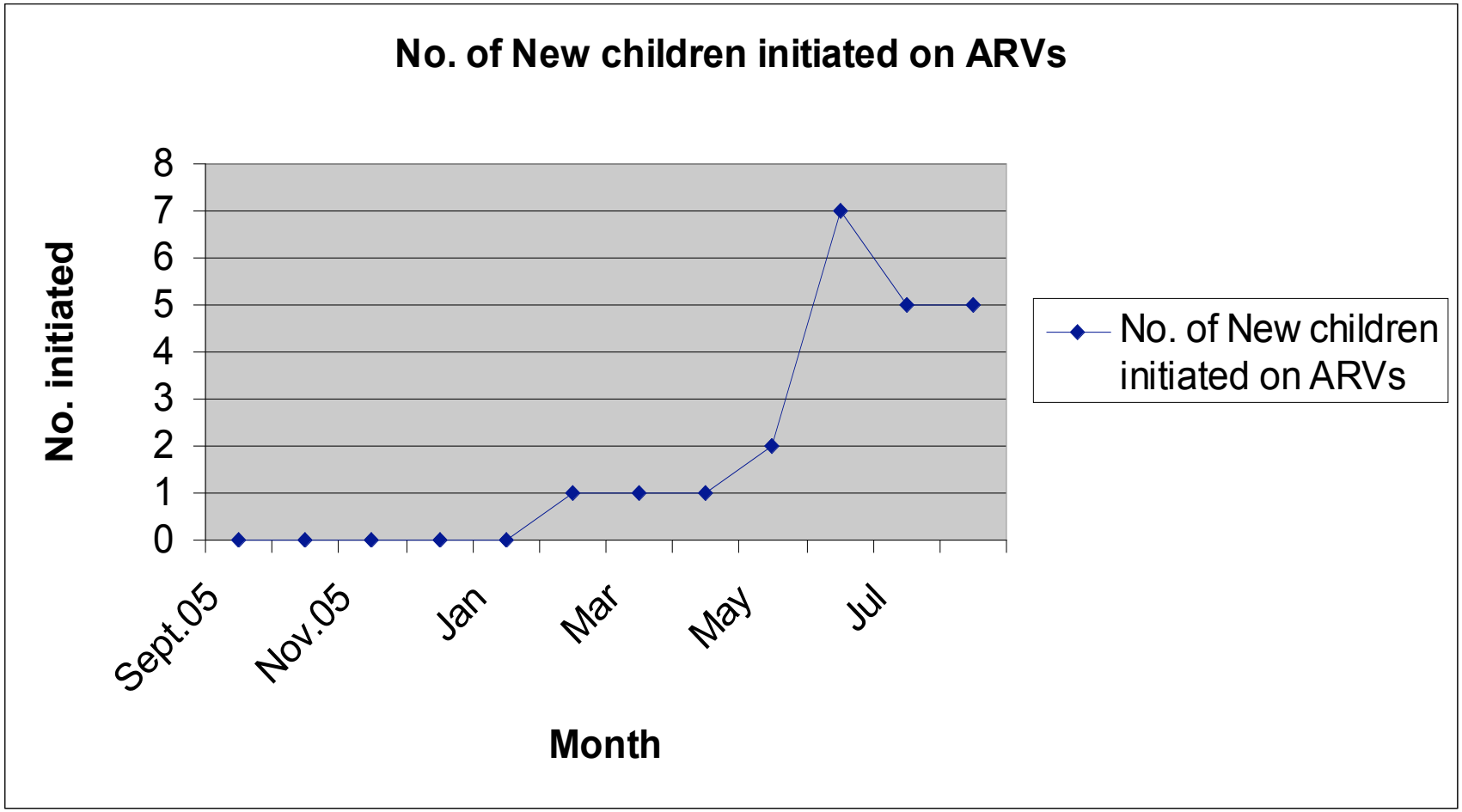
Roles of PSC support staff (CHWs, peer educators, drivers):

- 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

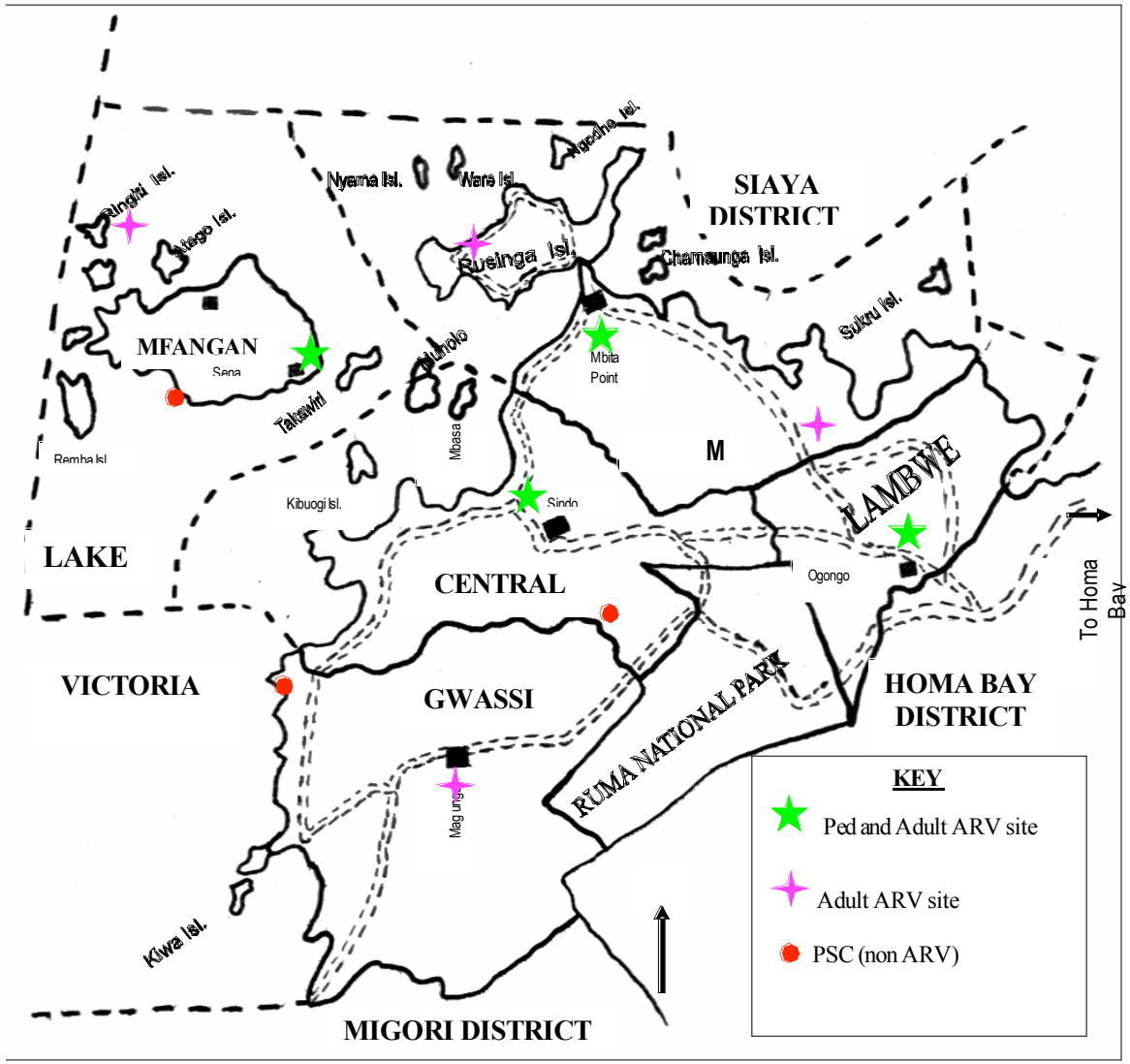
Progress


No. of sites providing ARVs
No. of Sites
10
8
6
4
2
0
Sept.05
Oct.05
Nov.05
Dec.05
Jan
Feb
Mar
Apr
May
June
Jul
Aug
Month
No. of sites providing ARVs


No. of New patients intiated on ARVs
No. initiated
160
140
120
100
80
60
40
20
0
Sept.05
Oct.05
Nov.05
Dec.05
Jan
Feb
Mar
Apr
May
June
Jul
Aug
Month
No. of New patients intiated on ARVs


No. of New children initiated on ARVs
No. initiated
8
7
6
5
4
3
2
1
0
Sept.05
Nov.05
Jan
Mar
May
Jul
Month
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