A young boy with a bright smile is looking out from a window. He is wearing a grey polo shirt and has his hand resting against his face. The window frame is made of weathered wood. In the background, a fire is visible, suggesting a rural or semi-rural setting.

Providing Treatment,
Restoring Hope

AIDS  **RELIEF**[™]

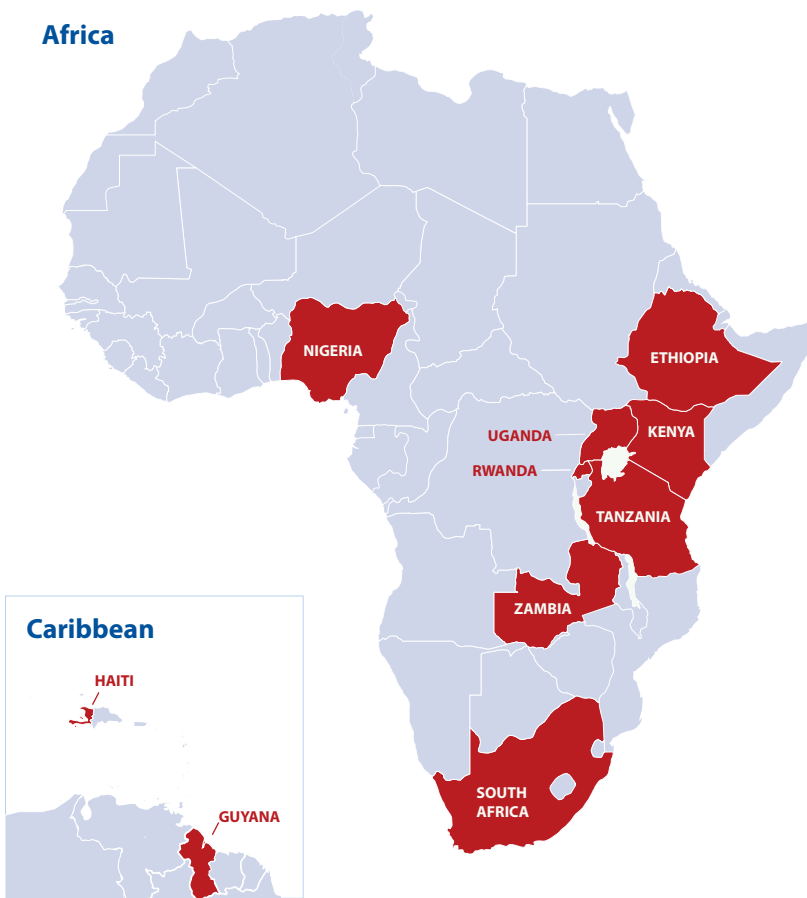
KENYA

FINAL REPORT 2004-2013

AIDSRelief, a five-member consortium funded through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), supported rapid scale up of HIV care and treatment services for poor and underserved people in ten countries across Africa, the Caribbean, and Latin America. Over nine years, the program served more than 700,000 people, including more than 390,000 who enrolled on antiretroviral therapy through 276 treatment centers.

AIDSRelief countries

Africa



AIDSRelief worked largely through rural facilities and established basic packages of care and treatment that exceeded what many thought possible in a resource-constrained environment. Instead of merely offering HIV tests and dispensing medicine, AIDSRelief helped broad cadres of health workers to identify and manage treatment failure or other adverse drug events; to diagnose, treat, and prevent opportunistic infections such as tuberculosis or pneumonia; and to provide patients with adherence counseling and support, empowering them to effectively manage their own treatment.

AIDSRelief consortium partners included Catholic Relief Services as prime grantee; the University of Maryland School of Medicine Institute of Human Virology as technical lead for clinical care and treatment; Futures Group as lead agency for strategic information; IMA World Health and Catholic Medical Mission Board as implementing partners; and Children’s AIDS Fund as a key sub-grantee, operating sites in three countries.

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From 2004 to 2013, AIDSRelief Kenya provided HIV care and treatment to more than 141,000 patients, including more than 88,000 who enrolled on lifesaving antiretroviral therapy at 31 treatment sites and 100 satellite health facilities. Consortium members Catholic Relief Services, University of Maryland School of Medicine Institute of Human Virology, Futures Group, and Catholic medical Mission Board worked hand in hand with local partners to build the skills and systems needed to support high-quality care. A deep commitment to partnership underscored AIDSRelief's

relationships and capacity strengthening activities, which culminated in late 2011 when two local partners—the Christian Health Association of Kenya and the Kenya Episcopal Conference—won new grants to receive PEPFAR funds directly and assume responsibility for managing the program.

This report outlines key outcomes and lessons learned during the eight-year program. It also describes approaches and methods that contributed to the program's success.

HIGHLIGHTS INCLUDE:

- » Patients on treatment in AIDSRelief-supported facilities maintained a viral suppression rate of 84%¹, indicating excellent adherence to treatment.
- » Community-based treatment support expanded services from clinic to community and contributed to low loss to follow-up (5.9%), high retention (87.2%), and very low mortality (6.1%)².
- » AIDSRelief Kenya employed innovative strategies to enroll children, who accounted for 10.4% of the total receiving ART, and represented 15% of Kenya's overall national pediatric treatment coverage.
- » Training and mentoring focused not only on clinical issues but also on comprehensive laboratory and pharmacy management, monitoring and evaluation, and organizational management. More than 4,000 participants attended off- and on-site training sessions.
- » More than 10,000 people underwent HIV testing and counseling and received their results.
- » A focus on strategic information prioritized comprehensive and timely access to clean, complete, and accurate data. Teams used data to make informed decisions and address gaps in program operations and services.

1 Based on an analysis of summaries for 43,547 patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys. Earlier analysis in 2007 indicated a viral suppression rate of 94.9%.

2 Rates are derived from survival (time to event) analysis. At each time period, the probability of 'survival' is calculated. These 'survival probabilities' are then cumulated (multiplied) over several time periods. For instance, 12 month retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100 % minus the survival probability

In the process, AIDSRelief has provided hope and has afforded longer and higher-quality lives to thousands of people affected by HIV, particularly the poor and those in rural areas. In the last decade, ART has become common and patients no longer have to travel long distances to access care and treatment.

OUR CALL TO ACTION

Prior to the unprecedented roll-out of antiretroviral therapy (ART) launched by PEPFAR and other donors in 2004, an alarming number of the patients occupying beds in Kenya's hospitals were HIV-positive. In spite of dramatic, life-saving treatments becoming almost commonplace for people living with HIV in wealthy industrialized countries, Kenyans were without hope. AIDS-related mortality in the country peaked in 2003 when an estimated 130,000 adults and children lost their lives to the disease.³ Most clinicians were unfamiliar with ART and even with the basics of HIV. Lacking the necessary skills and commodities, most health care providers could only leave these patients to die.

By 2010, more than 430,000 Kenyans, or 61% of those in need, were on ART, HIV prevalence fell by almost half from its peak in the mid-1990s (from 10% to 6.3%), and

43 percent of HIV-positive pregnant women received medication to prevent transmission of the virus to their infant.⁴ Generous donors and dedicated implementers, including AIDSRelief, made these great strides possible.

As in many resource-constrained countries, public, private, and faith-based facilities make up Kenya's diverse health care system. About 40 percent of facilities are run by faith-based organizations (FBOs) that strive to reach underserved populations in impoverished and/or very rural areas. The Government of Kenya is supportive of the important role FBOs play in the health system, and secondly government staff, supplies some medicines and laboratory commodities, and offers trainings to faith-based facilities. However, the government generally does not help fund or manage these facilities.

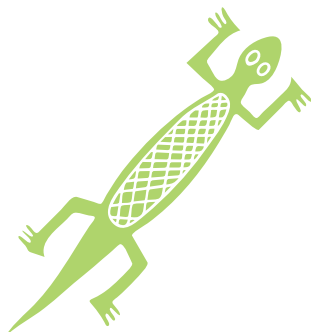


3 <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>

4 <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>

AIDSRelief Kenya included four of the five global consortium members: Catholic Relief Services (CRS), Futures Group, the University of Maryland School of Medicine Institute of Human Virology (IHV), and Catholic Medical Mission Board (CMMB). The consortium partners worked together to implement a care and treatment model that emphasized its core components equally: clinical care, strategic information, and site management. This model was supported by a foundation of health systems strengthening activities designed to ensure excellent patient outcomes that can be sustained over time by local partners, a goal that is wholly dependent on a functional health system.

CRS was the prime grantee and provided overall program coordination and oversight for grant administration and compliance, in addition to coordinating representation of the grant to the United States government donor agencies; local government, particularly the Ministry of Health; and other stakeholders. IHV served as the clinical lead for AIDSRelief in developing and implementing activities that built local partners' capacity to provide comprehensive, high-quality HIV care and treatment within the framework of national policies and guidelines. Futures managed strategic information through data collection and analysis; monitoring; and, generation of reports for donors, government, and other key stakeholders, and development and implementation electronic health records and other health informatics applications. CMMB provided site management and capacity strengthening assistance for selected health facilities.



AIDSRelief Supported Health Facilities 2004-2013

AIC Kijabe Hospital
 Asumbi Mission Hospital
 Baraka Medical Centre
 Consolata Mission Hospital
 Eastern Deanery AIDSRelief Program
 Friends Lugulu Mission Hospital
 Holy Family Mission Hospital
 Homa Hills Medical Centre
 Kendu Adventist Hospital
 Maseno Mission Hospital
 The Mater Hospital
 Maua Methodist Hospital
 Mombasa Community Based Health Care
 Mutomo Mission Hospital
 Nazareth Hospital, Holy Family Centre
 North Kinangop Hospital
 Our Lady of Lourdes Mwea Hospital
 PCEA Chogoria Hospital
 PCEA Kikuyu Hospital
 PCEA Tumutumu Hospital
 St. Camillus Mission Hospital, Karungu
 St. Camillus Mission Hospital, Tabaka
 St. Elizabeth Mission Hospital, Lwak
 St. Elizabeth Mission Hospital, Mukumu
 St. Elizabeth Health Center, Chiga
 St. Joseph Shelter of Hope, Voi
 St. Joseph Mission Hospital, Migori
 St. Joseph Hospital, Nyabondo
 St. Luke Mission Hospital
 St. Mary's Hospital Otiende
 St. Monica Mission Hospital

A NETWORK OF TREATMENT SITES



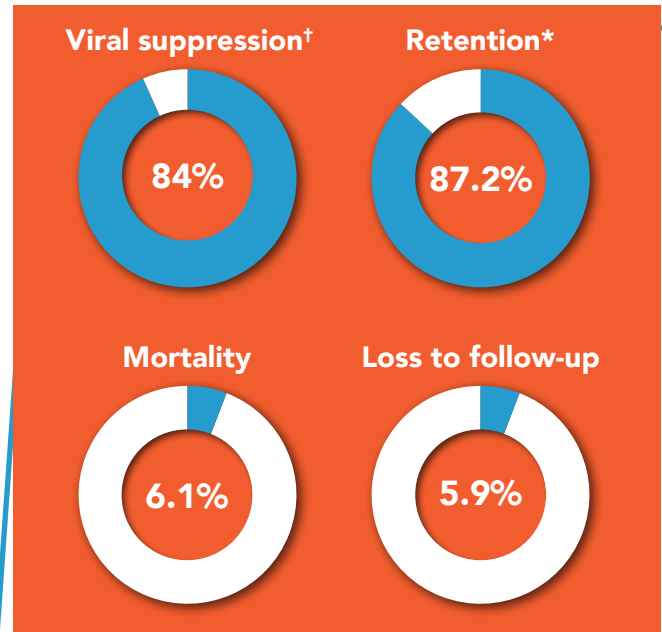
By design, AIDSRelief helped make high-quality HIV care and treatment services accessible through existing health facilities throughout Kenya. Because these facilities were established parts of the health system prior to AIDSRelief, they also linked—and continue to link—clinical services with communities and families.

Site Selection & Scale-up

With the intensive roll-out of treatment in 2004–2005 in Kenya, AIDSRelief began with eight faith-based facilities in rural areas with high HIV prevalence in order to maximize access for populations in need of care and treatment. As the program expanded to additional sites, each facility participated in a dynamic assessment process to determine what the site needed in terms of material and capacity to begin delivering quality ART services. Treatment facilities were expanded and equipped. Financial systems and an electronic patient management system were put in place. Hundreds of health workers were trained, and links were established with local clinical experts as well as with health institutions and organizations. Relationships with government health and social services agencies were strengthened.

A key component of AIDSRelief’s approach was improving the inter- and intra-facility integration of services. In addition to the 31 health facilities, AIDSRelief worked

AIDSRelief by the Numbers



[†] Based on an analysis of summaries for patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys.

* Rates are derived from survival (time to event) analysis. At each time period, the probability of ‘survival’ is calculated. These ‘survival probabilities’ are then cumulated (multiplied) over several time periods. For instance, 12 month retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100% minus the survival probability.



through 100 satellite clinics linked to the facilities that refilled prescriptions; obtained blood samples for laboratory investigation; provided basic patient counseling; and linked clients to other health facilities, such as antenatal clinics for pregnant mothers. Satellite clinics have brought AIDSRelief’s services to more patients, which has enhanced adherence and reduced loss to follow-up.

Over nine years, AIDSRelief-supported facilities provided care to 141,734 patients, including 88,615 who received ART. Priority was given to pediatric patients, pregnant mothers and TB-infected clients, with remarkable results. For every patient, there also are partners, children, and friends who face a future more hopeful than they could have imagined just a decade ago.

Patients receiving any sort of treatment are far from passive recipients of care, and myriad social factors influence their health-related behaviors and decisions. This is certainly true of PLHIV facing a complicated, often stigmatizing disease that requires life-long care and treatment. Furthermore, many HIV patients face multiple clinical and social challenges, including comorbidity, poverty, and stigma. Through AIDSRelief's unique treatment model, the program prepared and informed patients so that they could make sound decisions for their health, bolstered support for those decisions through care and support at the family and community levels, and helped link patients with complementary services.

Tuberculosis (TB/HIV)

Tuberculosis remains the most common cause of death in HIV-infected patients. Therefore, AIDSRelief has focused on TB-specific interventions aimed at prevention, aggressive identification of cases, effective co-treatment of HIV/TB co-infection and TB case management that incorporates a strong community based treatment support.

By December 2011, all sites were implementing the WHO recommended "3Is" strategy⁵ to address HIV/TB co-infection, including integration of TB and HIV services; infection control implementation; HIV testing of all TB patients; intensive case finding among enrolled patients; early initiation of ART in co-infected patients. Isoniazid preventive therapy is the one component of the strategy yet to be universally implemented at AIDSRelief-supported sites, largely due to national programmatic issues.

Testing and Counseling

In order to scale up care and treatment services, AIDSRelief has supported sites to evolve HIV counselling and testing services in tandem with the development of HIV care services. In the early years of the program, when HIV-related stigma was widespread, sites invested in community sensitization and outreach testing services. Over time, with greater acceptance of HIV testing, more cost-effective approaches have been adopted.

Thus the program has supported the adoption of family-centred HIV testing, identification of discordance allowing focused prevention interventions, and identification of children needing care. Additionally, AIDSRelief has supported institutionalization of widespread provider initiated counseling and testing, offered in all hospital entry points, including inpatient and outpatient departments, TB clinics and maternal child health clinics. To date, more than 10,000 people have been tested for TB and received their results with over two-thirds coverage of partner testing.

Maternal Child Health Care

AIDSRelief approached prevention of mother-to-child transmission (PMTCT) services from a perspective of >>

⁵ The World Health Organization (WHO) recommends the Three I's to reduce the burden of TB among people living with HIV: intensified TB case finding, isoniazid preventive therapy, and infection control for TB.



maternal-child health care. Therefore, the Kenya program supported treatment facilities to provide high quality maternal and child HIV services by integrating HIV care and treatment into existing maternal and child clinics. A universal approach to identifying all infected women, longitudinal follow up of mother-infant pairs and a case-based management approach anchored on a community based treatment support program have ensured almost universal retention of mothers and their babies. Interventions strengthened links between antenatal care and HIV clinics so that all HIV-infected pregnant women identified at the antenatal clinics were linked to ART that same day. Clinicians were trained to ensure that all HIV-positive babies under two years of age were started on ART irrespective of CD4 count or clinical stage⁶. In addition, more than 1,000 health care workers were PMTCT services for pregnant women. All health facilities established early infant diagnosis systems that included staff overseeing activities.

Treatment Preparation & Counseling

Prior to initiating treatment, all AIDSRelief patients attended a minimum of three intense, structured counseling sessions to prepare them for the life-long commitment of treatment. Treatment preparation helps patients better understand the importance of adherence, and the dedication required of and resources available to them as they embark on their therapeutic regimen. AIDSRelief-supported patients



were strongly encouraged to have a “treatment buddy”—a friend, family member, or other confidant who may or may not be HIV-positive themselves—attend treatment preparation sessions. This learned empowerment helped patients take ownership of their care.

After initiating treatment, patients participated in adherence counseling as a standard part of their monthly visits to refill ART prescriptions. Adherence sessions served as an opportunity for counselors to answer patient questions, identify potential adherence challenges, and reinforce messages about effective treatment. Adherence counselors were often on ART themselves and provided a unique perspective to other patients. Furthermore, these counseling and support roles helped provide people living with HIV a chance to earn additional income. >>

The Innovative Family Form

Understanding the increased risk of infection among family members—particularly unborn children, newborns, and sexual partners—AIDSRelief staff developed the deceptively simple “family form” for each patient. Health care providers completed the form with new patients, listing family members who then were encouraged to seek testing.

This effort was very successful: among HIV-positive patients at AIDSRelief-supported clinics, 70% of their current sexual partners (who were unquestionably at risk for infection or already infected) were tested and received their results. As an added benefit, this targeted-testing approach proved more cost-effective than community outreach campaigns in which those most at risk might be least likely to seek testing.

⁶ For HIV-infected patients, a CD4 test is the best way to determine a patient’s degree of immunosuppression. Where such tests are not available, doctors must rely on other methods to support treatment decisions. The World Health Organization (WHO) system classifies the degree of HIV disease based on symptoms that can be recognized and treated in diverse settings. See WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-Related Disease in Adults and Children.

Family-Centered Care & Support

Family members often influence a patient's health-related behavior, and family members may also be infected or at risk for infection themselves. AIDSRelief counselors brought as many family members as possible into counseling and testing so as to foster a supportive home environment for patients, determine the serostatus of family members, and enroll family members into care and treatment as appropriate. When multiple family members—particularly children and their caregivers, or couples—were found to be infected, facilities made great efforts to provide comprehensive care for affected family members together. Furthermore, HIV services sometimes served as an entry point to other care such as childhood immunizations or antenatal care.

These strategies proved particularly effective in identifying and enrolling children, who accounted for 10.4% of those in treatment. In fact, AIDSRelief Kenya represented 15% of the total national pediatric treatment coverage.

Community-Based Treatment Support (CBTS)

AIDSRelief's highly effective model treated adherence as a therapeutic intervention. Therefore, treatment initiation and adherence and family-focused care were further supported by community-based treatment support (CBTS). This support included home visits during which trained counselors answered questions and assessed each patient's home circumstances. For example, in the home setting, a counselor might notice that the family is struggling financially and refer them to income generation activities or supplemental nutrition programs in the community. The counselors were also trained to address multiple health issues including the importance of testing for pregnant women and young infants (early infant diagnosis).

These clinic-based community supporters—who are often living with HIV themselves—encouraged formal and informal support groups to help patients overcome adherence challenges and to find patients who may be lost-to-follow-up or at risk for dropping out. AIDSRelief



Kenya further enhanced this powerful program by assigning supporters to geographic catchment areas and providing them with a list of priority patients that were likely to need additional support. The program also ensured that supporters' responsibilities and scopes of work were clearly documented, that they had realistic targets to meet, and received a stipend. This professionalization helped elevate the initiative and few question its contribution to suppressing loss to follow-up to under 6% in AIDSRelief-supported facilities.

To ensure low defaulter rates and the overall relatively low mortality of patients on ART, in last two years this component has broadened its scope to include active follow up and support of pre-ART patients.

An Enabling Policy Environment

From the outset, AIDSRelief advocated for maximizing the initial ART regimen in an effort to ensure durable treatment outcomes and long-term cost control. This is especially important in low-resource settings where extensive laboratory monitoring and multiple treatment options are not available.

In response to this critical evidence, AIDSRelief advocated for tenofovir as first-line treatment and initiated all patients with a CD4 count of 350 or below. Some experts resisted this change at first, concerned that the increased costs would limit the number of patients the project could afford to treat as tenofovir was not available as a generic at the time. Yet AIDSRelief demonstrated that a durable first line regimen was cost-effective in the long run because of improved patient outcomes and ability to minimize costly (and less well-tolerated) second- and third-line treatments. In 2011, the Government of Kenya updated its national guidelines, influenced by WHO's revisions and the clear results demonstrated by AIDSRelief.

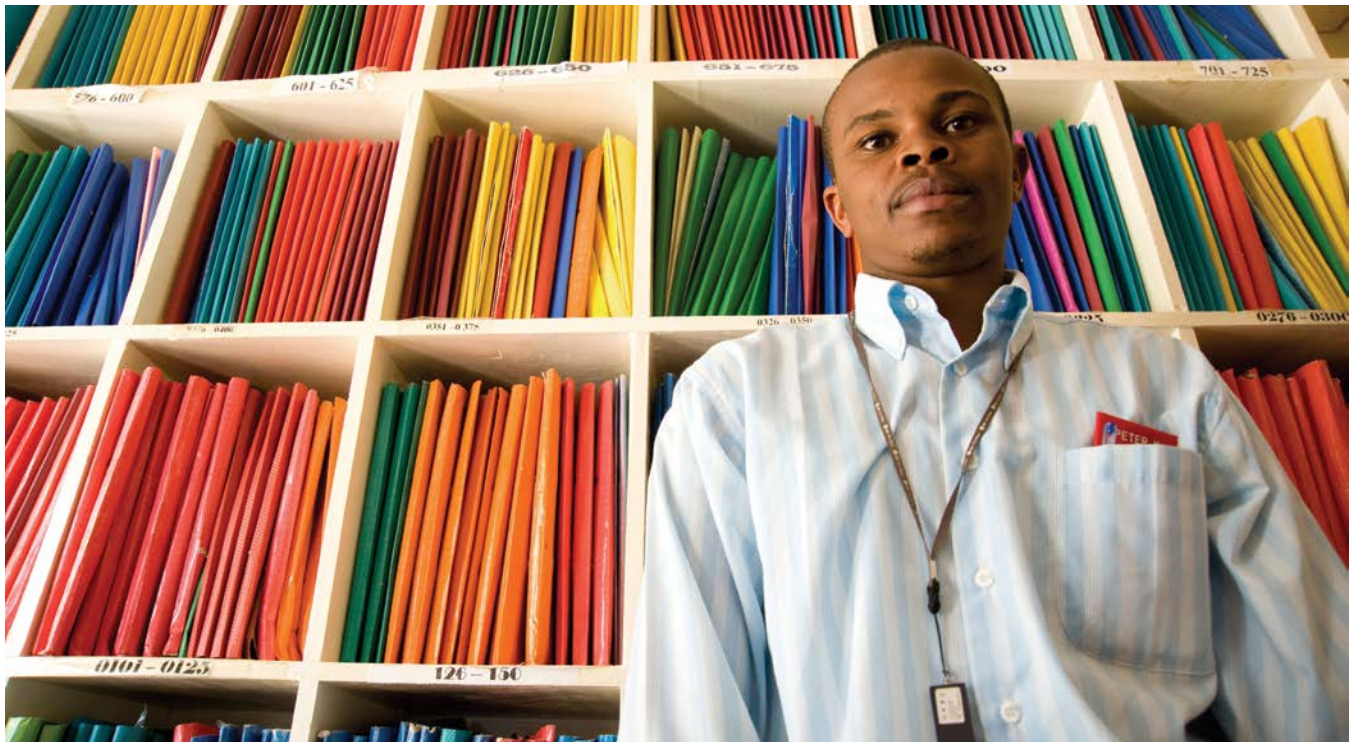
A CULTURE OF DATA USE

Strong health information systems can revolutionize patient care and site management, change the face of resource allocation, and shift an entire country's response to an epidemic like HIV. Yet prior to AIDSRelief, most sites entirely lacked electronic records and their hard-copy data collection was inconsistent at best, making it difficult for health staff to locate records and properly follow patient progress. This practice also made it difficult to generate useful statistical information that could drive evidence-based decision making. The impact reached beyond the patient level to affect the health supply chain, as the lack of data on consumption and forecasting contributed to frequent stock-outs.

To address this bottleneck, in 2006 AIDSRelief implemented a robust, customizable product, IQCare (part of the IQSolutions⁷ suite of applications), that not only managed care and treatment data but also offered

additional program modules based on need, including a module that tracks costs—a critical feature as donors require more impact for every dollar of funding. In 2010, a WHO evaluation rated IQCare as the best health management information system (HMIS) in Kenya and awarded a grant to Futures to help establish Kenya's national HMIS. Today IQCare is one of three products that Kenyan facilities can choose from.

Perhaps the greatest challenge was that, initially, facility staff did not see the need for data, regarding data management as an added burden. AIDSRelief appealed to the staff members' desire to understand progress in their work, demonstrating how data could provide answers. Clinicians and data managers were linked through combined trainings, assessments, evaluation meetings, and other continuous quality improvement activities. More than 2500 strategic information officers, data clerks, and other staff were >>



⁷ For more information, visit <http://www.iqstrategy.net/>

Optimizing Patient Flow

In the first years of AIDSRelief, the concept of using audit information for quality improvement—and the very idea of quality as an element of patient care—was unfamiliar to many facility providers and managers, but they quickly bought into the idea when it affected their facilities in profound ways.

Initially, it was common for HIV patients with appointments on the same day to all receive appointment cards for 8 am. In hopes of being seen quickly, patients would begin queuing by 7 am and a crowd quickly gathered and grew impatient and discouraged as they continued to wait for several hours. This situation was demoralizing and demeaning to patients who

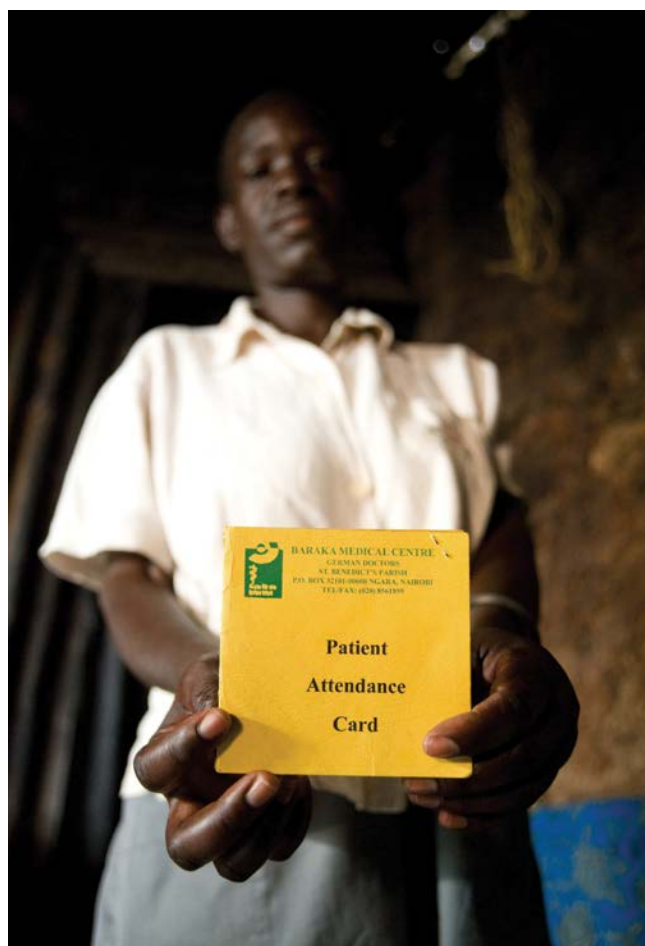
had to take an entire day off of work for even a routine medicine-refill appointment, and it created a perfect opportunity for transmission of TB and other infectious diseases among a vulnerable population.

To analyze the cause or causes of this untenable situation, AIDSRelief staff conducted an assessment of patients' visits, from initial registration and triage to check out, and addressed the bottlenecks identified. By adequately staffing the triage point and staggering patient appointments throughout the day, the average wait-time decreased from six hours to less than two hours and providers worked more efficiently with a steady flow of patients to whom they could give their full attention throughout the day.

trained to use these tools, which allowed health facilities to do the following:

- » Identify potential defaulters by monitoring patients' monthly ARV pickup
- » Manage the clinic schedule and schedule appointments to reduce waiting time
- » Examine trends such as mortality and loss to follow-up and provide information to treatment teams and address gaps in program and services
- » Improve feedback and analysis of routine government and donor reports

AIDSRelief has had significant impact in shaping the facilities' approach to and enthusiasm for data use; health facilities now collect, review, analyze, and disseminate the data themselves. Clinics are better able to follow patients and assess treatment outcomes, determine budgets, plan for human resource needs, and inform supply chain decisions. In fact, facilities have begun performing operations research on the data they obtain and manage, rather than depending on third parties for such activities. In short, a culture of timely, data-driven information use has transformed management and patient care.





Because HIV care and treatment programs depend on strong, well-managed health systems that can provide comprehensive care, health systems strengthening was a key component of the AIDSRelief program. This meant not only improving the leadership and management of health facilities, but also strengthening the capacity of laboratory staff, the supply chain system, and human resources.

Infrastructure, Equipment & Commodities

Based on each facility's needs, AIDSRelief funded and managed structural refittings, purchased essential equipment (and trained staff to use it), and encouraged integration of HIV and non-HIV services when appropriate so that facilities could leverage the improvements for all patients. At many sites, AIDSRelief provided critical equipment and power backup systems, a necessity in areas where the power supply is unreliable and could cripple laboratory services.

Pharmacies that once lacked the physical resources to properly store and manage medicines now have shelving, pallets, and air conditioners to properly maintain stock and private dispensing areas for confidential patient counseling. Laboratories and clinics now have infection control plans, private areas for patients receiving HIV test results or adherence counseling, and more adequate space for co-located HIV and tuberculosis services. Because the refittings and equipment installations were based on specific needs, they have been used for their intended purposes and significantly improved the ability of each site to serve its patients.

Laboratory

At the onset of PEPFAR in 2004, most HIV treatment sites in developing countries did not have the sophisticated laboratory capacity required for high-level management of ART, such as CD4 counts, viral loads,

and genotypic resistance tracking. In fact, many had no reliable electricity or running water. Because poor laboratory services can compromise the quality of care, AIDSRelief Kenya made laboratory capacity development a major programmatic area.

Areas of particular focus included laboratory capacity strengthening, provision of basic diagnostic equipment, good laboratory management, and establishing advanced molecular diagnostic networks. All health facilities have integrated laboratory services with the main hospital, more than twenty sites received CD4 machines and all offer testing to detect cryptococcal infection among advanced HIV patients. This cryptococcal antigen test, or CrAg, is included in Kenya's national guidelines and is important for clinical care, but remains uncommon in facilities. In addition, AIDSRelief created standard operating procedures for all tests performed by these laboratories, and more than 200 laboratory personnel were trained in services and procedures including infection control and quality control.

Supply Chain

In the early years, AIDSRelief staff were responsible for procuring ARVs for patients at supported site. In 2009, however, that responsibility began to shift to the health facilities, which would eventually become responsible for ordering their medications through Kenya Pharma, a USAID-supported project that assists the government of Kenya with procurement of HIV-related supplies.

AIDSRelief created easy-to-use tools that assisted facilities in tracking drugs from the time they entered the country, through transport and distribution, to the point at which they were dispensed to patients. In addition, AIDSRelief placed a strong emphasis on sustainability of the supply chain by fostering therapeutic drug committees to effectively oversee and manage the clinical and supply chain aspects of the program. >>

Within facilities, therapeutic drug committees enhance communication between the various departments involved in providing care, such as clinicians, laboratory staff, and supply chain managers.

All 29 hospital pharmacies and approximately 50 satellite clinics were refitted with dispensing booths, all drug storage areas were refitted with shelving and pallets. Pharmacy staff members were trained to use electronic ART dispensing software which helped them to file timely and accurate reports. Accurate consumption-based forecasts, quantification of drug needs, and a three-month buffer stock at the central level (two months at the facility level) resulted in zero stock outs and an uninterrupted supply of ARVs throughout the nine years of the program.

AIDSRelief also worked in collaboration with Kenya's Pharmacy and Poisons Board to roll out a pharmacovigilance program, a vital aspect of quality assurance for ART commodities. This involved identifying and reporting any adverse drug reactions and reporting on poor quality medicines. Successes in this area resulted in St. Camillus Hospital (located in Karungu) being nominated as a center of excellence for pharmacovigilance by the Ministry of Medical Services. In addition, reporting of poor quality medicines by AIDSRelief sites resulted in withdrawal of a poor quality drug from the supply chain.

AIDSRelief's supply chain strengthening activities resulted in zero stock outs and an uninterrupted supply of ARVs throughout the nine years of the program.





“This project has laid the foundation for a strong, sustainable healthcare delivery mechanism in Kenya, in the region, and in Africa. First by demonstrating how it is done, how it can be done. How resources can be used to deliver better health by transitioning to local organizations.”

—Dr. Jared Mecha, University of Nairobi

Each AIDSRelief country program was designed to transition management of the program to a local partner, but the early project years were necessarily focused on initiating patients on treatment. As transition moved to the forefront, the program’s scope of work became clearer: 1) strengthen health facilities for sustainable provision of care and treatment services, and 2) strengthen and reinforce the capacity of the transition partners—the Christian Health Association on Kenya (CHAK) and Kenya Episcopal Conference (KEC)—to oversee and maintain the quality of services.

As the project moved toward transition, AIDSRelief continued to support the provision of quality care at health facilities while also considering their organizational capacity (e.g., management of human and material resources, governance, planning and budgeting). Furthermore, CHAK and KEC came together to determine how best to ensure their success

in absorbing responsibility for AIDSRelief-supported sites and maintaining quality of care. They each agreed to assume management responsibility for the facilities within a given geographic region, regardless of faith affiliation.

Transition was an exercise in partnership and capacity strengthening in which AIDSRelief incrementally reversed roles with the local partners, culminating with the partners taking on full leadership and overall responsibility for management of the ART program. This gradual shift from international management to local ownership reached a high point in 2011, when CHAK and KEC demonstrated their readiness for local leadership, management and ownership by developing competitive funding applications that won new grants from the U.S. Centers for Disease Control and Prevention (CDC). They now receive PEPFAR grant funds directly and are responsible for managing many aspects of the program.

While most PEPFAR funded care and treatment programs transitioned to local ownership by 2012, AIDSRelief Kenya received a one-year extension to continue mentorship and to gradually transition the health facilities to each local partner. This arrangement afforded KEC and CHAK the opportunity to progressively increase their responsibility and continue to strengthen their capacity, while ensuring that supported patients across Kenya received HIV care and treatment services without gaps in quality or availability. The transition of management responsibility of all sites was completed in February 2013.



The AIDSRelief experience was not uncomplicated; however, the program accomplished what many said could not be done: It partnered with local institutions to provide high-quality care and treatment for HIV-infected men, women, and children in a resource-constrained setting. It leveraged the influence of faith-based organizations and has strengthened the capacity of local partners to continue the program's life-saving work.

AIDSRelief's commitments to meaningful capacity strengthening, clinical excellence, data-driven quality improvement, and responsive management made an unprecedented expansion of HIV treatment possible. AIDSRelief's commitment to a truly Kenyan-owned response to the disease has helped prepare the nation to deftly manage this virus that once threatened to debilitate a continent.





ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Kenya received from our donor, our local partners, staff and management at health facilities, and the Kenyan clinical experts who gave their time and expertise to ensure that those most in need received and will continue to receive quality HIV care and treatment.

We are grateful for the financial and technical support from the program's donor, HRSA, through funding from PEPFAR. We also appreciate the CDC team in Kenya for their on-the-ground program oversight, guidance, and support. The program's impact would not have been possible without the tremendous dedication

from all levels within Kenya's Ministry of Health and with our local partners CHAK and KEC. Each and all were essential to AIDSRelief's success and are helping make sustained country ownership possible in Kenya.

We also want to acknowledge the health workers and managers in treatment sites and communities across Kenya. These often-unsung heroes and heroines of the epidemic work under challenging circumstances and directly serve those in need. It has been an honor to work in partnership with them.

Lastly, thank you to the author of this document, Rebecca Bennett, and to the reviewers whose thoughtful comments on early drafts were invaluable.

Patients Served by AIDSRelief in Ten Countries

Country	# Sites	Cumulative ever in care and treatment at transition	Cumulative ever on ART at transition	Current on ART at transition (incl. adults and pediatrics)	Current pediatrics on ART at transition
Ethiopia	5	4,125	2,179	1,062	144 (13.6%)
Guyana	3	2,443	1,519	1,083	74 (6.8%)
Haiti	11	14,644	6,473	4,469	306 (6.8%)
Kenya	31	141,734	88,615	60,549	6,320 (10.4%)
Nigeria	34	109,872	64,564	52,559	3,301 (6.3%)
Rwanda	20	11,928	6,698	4,850	670 (13.8%)
South Africa	28	73,293	35,038	21,204	1,518 (7.2%)
Tanzania	102	165,488	85,673	44,924	3,414 (7.6%)
Uganda	23	87,943	45,221	35,047	3,263 (9.3%)
Zambia	19	96,247	60,041	42,783	3,197 (7.5%)
Total	276	707,717	396,021	268,530	22,207 (8.3%)

