UNIVERSTY OF NAIROBI

Institute of Tropical and Infectious Diseases (UNITID)
&
Teachers Service Commission

Establishing Referral and Linkage Networks for Comprehensive HIV Care at the Teachers Service Commission

Rose Misati, B. Pharm, MPH

UNITID Fellowship Program

HIV Program Management

Signatures

Fellow…………………………………………………………………….

18th December 2017

Rose Misati

UNITID fellowship program

Program management

Supervisor…………………………………………………………………..

18th December 2017

Prof. Christopher Gakuu

University of Nairobi

Track Lead………………………………………………………………...…

18th December 2017

Dr. Ann Nderitu

University of Nairobi

TABLE OF CONTENTS

1 Table of Contents

LIST OF ABBREVIATIONS AND DEFINITION OF TERMS....4
LIST OF ABBREVIATIONS....4
DEFINITION OF TERMS....5
PROJECT SUMMARY....6
2 INTRODUCTION AND BACKGROUND 7
2.1 Introduction 7
2.2 Background 7
2.3 OBJECTIVES 9
2.3.1 Goal 9
2.3.2 Purpose 9
3 PROJECT IMPLEMENTATION METHODS AND MANAGEMENT PLAN 9
3.1 Methodology 9
3.2 Activities done 9
3.3 Results 12
3.4 Sustainability Plan 12
3.5 Projected Impact 12
3.6 Project Monitoring and Evaluation 13
3.7 Ethical Issues 13
4 CONCLUSION 13
5 REFERENCES 14

LIST OF ABBREVIATIONS AND DEFINITION OF TERMS

LIST OF ABBREVIATIONS

ACU	Aids Control Unit
ADR	Adverse Drug Reaction
AIDS	Acquired Immune deficiency syndrome
CACC	Constituency Aids Control Council
CDRR	Consumption Data Report and Request
CPT	Co-trimoxazole Preventive Therapy
CSO	Civil Society Organization
HIV	Human Immunodeficiency Syndrome
HSSF	Health Sector Service Fund
HTS	HIV Testing Services
KEMSA	Kenya Medical Supplies Agency
KENEPOTE	Kenya Network of HIV Positive Teachers
M&E	Monitoring and Evaluation
NGO	Non Govern mental Organization
OCA	Organizational Capacity Assessment
OI	Opportunistic Infections
OJT	On the Job Training
PLHIV	People Living with HIV and AIDS
SCASCO	Sub County AIDs and STI ControlOfficer
SCHMT	Sub County Health Management Team
SCHRIO	Sub County Health Records and Information Officer
SCMOH	Sub County Medical Officer of Health
TESCONEP	Teachers Service Commission Network for Positive Living
TSC	Teachers Service Commission
WHO	World Health Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
MOH	Ministry of Health

DEFINITION OF TERMS

Anti-Retroviral Therapy- Long term use of antiretroviral drugs to treat HIV/AIDS.

Care- Support provided to an individual during illness to preserve mental and physical well-being through the services offered by the medical and allied health professions.

Linkages- The formal structures or conduits between institutions or organizations through which the process of referral occurs.

Opportunistic Infections- A medical condition that is harmful to people whose immune system is weak (usually due to HIV/AIDS).

Referral- The process through which a client is moved or moves through the continuum of treatment, care and support.

Treatment- Refers to the clinical management and care of physical symptoms and pathologies.

Stakeholders - Organizations, groups or individuals who have a direct or indirect stake or commitment in the programme / project design, implementation, benefits or its evaluation.

PROJECT SUMMARY

Countries with the highest disease burden have the lowest ART coverage; this may be partially explained by poor testing to care linkages. Referring people living with HIV (PLHIV) into care remains a priority in the HIV chronic care model. The fellow aimed to establish referral and linkage networks for comprehensive HIV Care at the Teachers Service Commission through a participatory process. The stakeholders involved included the TSC senior management in order to seek their buy in, Sub County Medical Office for policy direction, Constituency Aids Control Office, Non-Governmental Organizations and Civil Society Organizations. The outcomes of this project were; sensitized stakeholders, service delivery staff capacity build on the new HIV treatment guidelines, scaling up HTS, availability and initiation of Anti Retro Viral Therapy (ART) where necessary, linkage to other health facilities and availability of relevant M&E tools. As a result of this there was improved referral and linkage networks among the ART clients. The goal of this project was to reduce morbidity and mortality due to HIV/AIDS among the Kenyan population. The project commenced with an initial stakeholders' sensitization and capacity building of both service delivery staff and People Living with HIV/AIDs (PLWHAs) both at the TSC headquarters and Machakos County. The culmination of all this was establishment of linkage networks to care and treatmentin all HIV testing Services at TSC.This project was implemented from April 2016 to May 2017 at a cost of KES. 497,000.

2 INTRODUCTION AND BACKGROUND

2.1 Introduction

Appropriate and timely referral is essential for a well-functioning health system; unfortunately, it is often the weakest link in most in the system. Linkage to care is the period starting with HIV diagnosis and ending with first enrollment into HIV care and treatment. Referral is the process by which immediate client needs for comprehensive HIV care and supportive services are determined and clients are supported to gain access to services (Leine*et al.,* 2005). It is also necessary for referral to include reasonable follow up efforts to facilitate contact between service providers as well as to solicit clients' feedback on satisfaction with services.

Many individual testing positive for HIV (almost half in sub-Saharan Africa) are not effectively linked to comprehensive HIV care while many who are linked to care do not receive antiretroviral therapy (Rosen & Fox 2007). Finally retention in care for those who commence HIV treatment remains grossly sub-optimal;subsequently if such individuals return to care, it is often at an extremely late stage when effectiveness of antiretroviral therapy is compromised(WHO/UNAIDS;2013). These gaps slow down the efforts towards scaling up HIV treatment, reducing the population living with HIV who achieve viral suppression.

There's global concerted effort towards a final, ambitious, but achievable target:

- By 2020, 90% of all people living with HIVwill know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression (UNAIDS 2014).

2.2 Background

In the year 1999 HIV was declared a National disaster by the then president Daniel Toroitich Arap Moi. Consequently all government ministries in Kenya were mandated to establish AIDS control units to serve the line ministries and large government departments. The Teachers Service Commission (TSC), in conjunction with the Ministry of Education, Science and Technology, established HIV and AIDs control (sub) Unit in September 2000. An interim committee under the guidance of the principal administrative officer was formed to start off the

unit. One year later, a sub unit was established as part of the Ministry of Education ACU manned by three senior officers and two support staff. In March 2004 the Sub-ACU was upgraded to a fully-fledged ACU with increased mandate.

The key mandate of TSC AIDS control unit include to;

1. Support implementation of the National Aids Control Council (NACC) policy and strategic plan.
2. Mainstream HIV/AIDS issues into the core functions of the commission.
3. Implement the National HIV/AIDS policies within the organization.
4. Operationalize objectives and implementation plans for the management of HIV/AIDS issues at the work place.
5. Liaise with the NACC, Directorate of Personnel Management (DPM), and other stakeholders involved in the management of HIV/AIDs.

The ACU has since changed its name to Wellness Section in order to incorporate additional programmes including Alcohol and drug abuse and primary healthcare. Since its inception the service area has made tremendous achievements including establishing a functional VCT and employment of two nurses who offer primary health care services.

For greater effectiveness in management of HIV/AIDS there is need to enhance intervention based programmes including;

1. Capacity building of the TSC secretariat wellness section staff on management of HIV/AIDS at the work place.
2. Initiation of ART for those testing HIV positive.
3. Establishment of linkages with other health facilities for comprehensive HIV/AIDs care.
4. Respond to emerging issues of HIV/AIDS in the workplace.

Astudy conducted in Mozambique indicates that while there has been tremendous improvement in access to antiretroviral therapy (ART) in resource-limited setting; countries with the highest disease burden record significant gaps in ART coverage partially as a result of poor testing to care linkages (Sarah *et al.,*2014). Scaling up ART in the developing countries mostly affected by HIV therefore has tremendous economic and development benefits.

2.3 OBJECTIVES

The objective of this project was to improve referral/linkage for clients newly testing to HIV at the TSC.

2.3.1 Goal

To reduce morbidity and mortality due to HIV/AIDS among the Kenyan population.

2.3.2 Purpose

To establish referral and linkage networks to comprehensive HIV care among the HIV positive clients at TSC.

3 PROJECT IMPLEMENTATION METHODS AND MANAGEMENT PLAN

3.1 Methodology

The project employed a participatory approach of the fellow, two medium term fellows from the host institution and the rest of the wellness department staff members towards establishing referral and linkage networks to comprehensive HIV care. All the stakeholders participated fully in the decision making process. The stakeholders involved were; the TSC management in order to seek their buy in, Sub County Medical Office for policy direction, Constituency Aids Control Office, Non-Governmental Organizations and Civil Society Organization (CSOs) working in the area of HIV and AIDS. Involvement of key stakeholders in a participatory process was critical due to their ability to formally and informally influence the initiation, success and sustainability of the project. Furthermore a participatory approach to this project tapped into the expertise of all the players hence improving efficiency and effectiveness.

3.2 Activities done

The following were the main steps that were undertaken;

1. ***Convening Stakeholders' workshops at different levels***

   The relevant stakeholders were identified and formerly invited for a sensitization meeting by the fellow and the PLP mentor. The Stakeholders sensitized included representatives of TSC employees living with HIV, Langata Sub County Health Management staff, in charges from private, faith based and government facilities, Non-Governmental Organizations and Civil

society Groups. Involvement of the Sub County Medical Officer of Health (SCMOH) was very essential at this point through sharing of the project plan with the Sub County Health Management Team (SCHMT). The SCHMT provided routine support supervision, continuous medical education, on the job training and mentorship to the TSC service delivery staff beyond.The fellow also shared a presentation of the project plan and progress during the routine monthly SCHMT and facility in charges meeting. This was in order promote linkage/referral and networking with the other health facilities within the Sub County. Continuous consultations were held with the university supervisor and host institution advisor. The input of the TSC wellness section staff members was also sought on a regular basis; the fellow also shared regular feedback with the wellness team for ownership of the project at section level.

2. *Participatory mapping exercise*

A list of all organizations and facilities providing HIV-related services within the geographic area was generated and included in the referral network. This exercise was made possible through the invaluable support of the identified stakeholders.The mapping identified key facilities for linkage and referral as well as potential barriers to access. The exercise further identified ways of mitigating the potential limitations to a properly functioning referral system. The PLHWA were an invaluable resource in this activity and they played a pivotal role.

A directory of services was accessed from the Sub County Medical Office showing all facilities providing comprehensive HIV care within the catchment area.

3. *Systems were put in place to develop and support the referral network*

The wellness section was identified to serve as the coordinating unit of all HTS activities done both within the TSC and during outreaches. Capacity building of the service delivery staff at the wellness section was conducted using the Revised National HIV Treatment guidelines and relevant training modules. This was accomplished by engagement of certified Trainer of Trainers (TOTs) from the Ministry of Health through the office of the Sub county HIV/AIDS coordinator (SCASCO).Sensitization meetings with stakeholders and staff of participating facilities/organizations were held to come up with the terms of reference for

each facility in the referral network. The relevant staffs within the facilities were sensitized on the Ministry of Health (MOH) referral guidelines. Of utmost importance were issues of confidentiality, stigma and the implications to the clients. It was agreed that the MOH Standardized referral forms, tools and procedures were to be used at all times.The SCHMT was charged with the responsibility of capacity building the facility staffs on appropriate use of the standardized tools. Client linkage was documented in the HTS lab register. TSC staff linked all the clients who tested positive either at the clinic or during outreach to convenient/preferred health facilities and submitted the reports to the Sub County office. Health providers at all levels were encouraged to document both telephone contacts and physical address of clients at all times in order to facilitate referrals and follow-up. The facilities' activities were supervised on a quarterly basis; lessons learnt and best practices were used to improve the system. The fellow spear headed engagement of other development partners in the area of HIV/AIDS with the TSC being involved both in the monthly facility in charges meetings and quarterly stakeholders' forum.

4. Mobilization of clients to utilize the referral system

The PLHWA both within the TSC Secretariat, Machakos and Nairobi Counties was done in the introductory phase with the aim of further scaling up the intervention to the remaining 45 counties. In order to create and sustain demand for the services; mobilization was done both at the TSC and sister organizations through the support of other stakeholders. HIV Testing Services (HTS) were scaled up with appropriate, comprehensive and effective referral and linkage to various health facilities. Clients who tested HIV positive were initiated on HIV care, treatment and support. On the other hand; those who tested HIV negative and vulnerable to HIV infection were linked to prevention services. Those clients in need of post-test services, including but not limited HIV care and treatment were issued with a triplicate referral form. The client was expected to keep the original of the referral form while the second copy was to be forwarded to the referral point; the triplicate was to be left at the facility where the client tested for reference. Follow up to the clients was done via telephone calls in order to determine whether they got access to the referred services. Support of the government through the Sub County Medical Office was sought to strengthen the referral network as well as enhance sustainability.

3.3 Results

The following was achieved as a result of the project;

1. Sensitized stakeholders on the need to improve referral and linkages to HIV care and treatment.
2. Service delivery staff capacity build on the new HTS guidelines.
3. Scale up of HIV Testing and Services.
4. Linkage/referral network established.
5. Trained 60 PLWHAs on 'Prevention with Positives'.
6. Clients referred for care and treatment.
7. Availability of the relevant M&E tools.

3.4 Sustainability Plan

To address the issue of sustainability, the TSC clinic was linked to Langata Sub County. The SCHMT will continue toprovide quarterly supportive supervision to the clinic as well as continuous mentorship and On the Job Training (OJT), through financial support from Health Sector Support Fund (HSSF) and other development partners. The fellow also lobbied for adequate budgetary allocation to the wellness section for support of HTS activities. The in charge of TSC clinic will also continue to participate in the routine monthly Sub County Health Management Team and in charges meeting.The TSC was also included in the database of the Sub county and county stakeholders in order to participate in quarterly forums to share best practices and lessons. This will further enhance networking in order to improve service delivery.

3.5 Projected Impact

The project created awareness among the TSC management on the importance of establishing a strong referral/linkage system to HIV care and treatment. The service delivery staffs at TSC clinic were capacity build on the new HTS guidelines while the PLWHAs were capacity build on 'Prevention with Positives'. This is hoped to contribute to achievement of the UNAIDs 90 90 90 target.

3.6 Project Monitoring and Evaluation

The fellow shared monthly progress reports with both the host institution advisor and university supervisor throughout the entire project implementation period. Proceedings of the stakeholders meetings were documented in minutes complete with photographs and attendanceregisters. During trainings, participants signed an attendance register and a training report was prepared and shared monthly reports from; HTS register, Pre ART register, Opportunistic Infection (OI) Daily Activity Register and linkage registers were submitted to the SCHMT office.The SCHMT conducted quarterly supportive supervision to the TSC clinic using the integrated health facility supportive supervision tool. This is according to the Ministry of Health guidelines in order to assess and offer required guidance on service delivery areas.

3.7 Ethical Issues

Consent was sought from the TSC management before project initiation. The clients were given all the relevant information and adherence counseling during referral. The project did not use individual data from clients' records during M&E but generally looked at the overall reports authenticated from the source documents. The project also upheld confidentiality and integrity when handling individual clients records particularly during referral and incase of Adverse Drug Reaction (ADR) monitoring.

4 CONCLUSION

The AIDS epidemic poses a challenge towards achieving vision 2030 subsequently transforming the economy of Kenya as a country.Although many strategies are required to accomplish this momentous task, one things is sure; it's impossible to close the book on this pandemic without proving treatment to those who need it. Through this project the fellow set out to make a contribution towards achievement of the UNAIDS 90 90 90 strategy through establishment of referral/linkage networks to HIV care and treatment at the TSC. This was achieved by strengthening the health systems by capacity building of the human resource, stakeholder involvement and operationalization of standard procedures.

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