Adherence and Retention: Critical Issues for Delivery of HIV PEP in Kenya

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LVCT

- Kenyan NGO since 2002
- strengthening government and partner response to HIV prevention, care & treatment
- scaling up HIV services
  - counselling & testing, HIV care & treatment, services to vulnerable groups (survivors of sexual violence, the Deaf, MSM & Youth)
- evidence based influence of policy & practice
  - operations research
Why post rape care?

impetus...
- health workers reporting high levels of SV
- VCT counsellors reporting SV clients
- national documents - KNASP1 (2002)

- review, analysis of post rape service provision experience (+ PEP) in sub-Saharan Africa
- status in Kenyan post rape service provision
Findings

- **policy level**
  - no regulatory framework & standards
  - no coordination
  - lack of documentation & records

- **service delivery level**
  - inconsistent services: EC, STI/ HIV prevention (PEP); counseling – trauma; HIV testing; PEP adherence

- **limited capacities** – human, technical, financial, infrastructural

- **high user costs** – cards, fees
Post Rape Care intervention

- 3 health facilities – Thika, Malindi & Rachuonyo
- stakeholder consultations - DHMTs
- ‘PRC systems algorithm’
  - protocols; procedures; client flow pathways
- records/documentation –
  - case management; legal purposes
- targeted health provider training
  - clinicians/nurses & trauma counselors
POST-RAPE CARE client flow

Survivor CASUALTY

Emergency management
PEP/EC, forensic examination,
Documentation, PRC1 filled

Counseling (primarily at VCT)
Trauma/crisis, HIV testing,
PEP adherence; preparation for
Justice system

Laboratory
HIV testing, blood monitoring (Hb)
specimen analysis

HIV care clinics: PEP management (STIs)
PRC 2 form: HIV status, age, wt, sex
Laboratory monitoring, PEP outcomes

Refer to STI clinic
if not provided at CCC

on-going follow up 4/52
Findings (2003 November to 2005 June)

- 386 survivors seen
  - (Thika 257; Malindi 83; Rachuonyo 46)
- incomplete data n=91 records
- analysis (n=295)
- median age – 16.5 IQR (9,25)
- age range of cohort (16 months – 102 years)
- 56% children & more likely to know perpetrator/s (OR 6.2; p=0)
- 88% female (Malindi – 24% males)
Client distribution by age & sex (n=295)
Service delivery (n=292)

- 86% (250) presented <72 hours
  - 99% - HIV PEP initiated
  - eligible females - 88% got EC
- 74% - lab services;
- 73% - STI prophylaxis;
- 56% - physical examination & documentation
- Counselling
  - 40% follow up for 4 sessions
HIV testing characteristics (n=292)

- Late presentation, 42, 14%
- Lost to referral, 25, 9%
- HIV+ at baseline, 13, 4%
- No to HIV test, 32, 11%
- Continued PEP, 180, 62%
HIV PEP uptake & completion

- 250 survivors eligible for PEP
  - 207 (83%) HIV baseline test taken
  - 194 HIV –ve
    - 180 (93%) continued PEP
      - 132 (68% of 194) followed up at 2 wks
      - 99 (51% of 194) followed up at 4 wks
      - 67 (35% of 194) followed for 6 wks HIV testing

- PEP completion associated with first counselling session (OR 2.7; p=0.004)
Discussions – challenges in..

- retention; PEP completion (51%); HIV testing f/u counselling f/u
  - 1 sero-conversion (7-year old; female)
- probable non adherence or PEP failure
- Q? - efficacy of delivering PEP - unknown HIV outcomes
- counselling – vital for PEP medication
- disclosure of SV, HIV testing & status challenges
  - impact on adherence
Recommendations

optimise PEP utilisation

- improving adherence
  - active follow-up mechanisms critical – retain survivors in medication & HIV testing follow up
    - ART f/u strategies?
  - retention for HIV testing

- integrating counselling & clinical care
Post rape care programme

- 13 MoH PRC sites
- >1,800 survivors seen
- 60 rape trauma counsellors
- 138 clinicians trained
- 489 health providers oriented
- on-going consultations & TA
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