

Community Based & Mobile HIV/AIDS Care

KABALE DISTRICT

A KIGEZI COMMUNITY PROJECT

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List of acronyms

HIV-	Human immunodeficiency virus
AIDS-	Acquired immune deficiency syndrome.
STD-	Sexually transmitted diseases
MOH-	Ministry of health
ART-	Antiretroviral therapy
VCT-	Voluntary counselling and testing.
UNAIDS-	
UDHS –	Uganda Demographic Health Survey (2001 – 2003)
NGO-	Non - Governmental Organizations
OI`s –	Opportunistic Infections
PLWA`s-	People living with HIV/AIDS

Project Summary:

The Kigezi Community Project (KCP) is a new non-governmental organization established to improve the quality of HIV/AIDS care and education to underserved rural communities. For the proposed pilot program, KCP will target the Kabale District of southwestern Uganda.

The Kabale District has a large rural population, a poor transportation infrastructure, high illiteracy levels, low doctor patient ratio (1:20000), and high poverty levels. With most health centers located in the crowded village center, availability and accessibility to health care is extremely difficult for many in the district.

The KCP strategy for the Kabale District will be to empower community leaders to perform primary HIV/AIDS education and counseling, and then support them with visits from a mobile health care unit. Community leaders will be trained and educated at “hubs” spread out in the district. Once a hub is established, and a community team is trained, preparations will be made for a visit from the mobile health care unit. Upon its arrival, the community team will work alongside the mobile care unit to provide advanced health care services to members of the community.

The objective of the Kabale District project is to reduce HIV/AIDS transmission, improve case detection, help hard to reach patients access the necessary treatment, fight stigma, and generally improve the standard of living for people living with HIV/AIDS.

Introduction:

To date, over 65 million people have been infected with HIV/AIDS, and more than 25 million people have perished due to the virus. Even with all the lives lost, a vast majority of the people living with the disease are unaware of their status. Only one in eight people who want to be tested are currently able to do so. (UNAIDS, Global facts and figures 2005)

Sub-Saharan Africa remains the most affected region in the world. Two thirds of all people living with HIV are in sub-Saharan Africa where 24.5 million people were living with HIV in 2005.

In Uganda, HIV/AIDS is the leading cause of ill health and death, accounting for 12% of death and 50% of hospital admissions among 15-49 year olds (UDHS (2000-2001) As of December 2001, 1.05 million Ugandans were living with HIV/AIDS, of which 945,500 were adults. AIDS had orphaned 2 million Ugandan children.

To get ahead of the epidemic, HIV prevention efforts must be scaled up and intensified, as part of a comprehensive response that simultaneously expands access to treatment and care. In particular, attention is needed in rural areas where accessibility and availability to proper health care is difficult.

The Kigezi Community Project will increase service to rural communities with a grassroots, community based, mobile approach. The pilot Kabale Project will create the framework for a strategy that will become a model for an organic approach to fighting the global HIV/AIDS epidemic.

Project Background:

According to Dr. Margaret M. K. Muganwa, President of the Society of Women and AIDS in Africa (SWAA), the most effective approach to changing the habits of individuals is a “trickle down” cultural change model¹. In this approach it is not the government or the institution that makes the impact on the individual. It is the community leader. The community leader knows his/her community the best and will have the most effective face to face interactions.

For this reason, the first phase of activities for the Kabale District project will target community leaders. Empowering them with the necessary resources, skills and knowledge will translate to good health practices in the community.

While awareness of the HIV/AIDS virus is universal in Uganda, the awareness is not matched by knowledge of how to avoid contracting the disease. For example, 13.4 percent of women and 4.7 percent of men either do not know whether AIDS can be avoided or believe that there is no way to avoid AIDS. 12.4 percent of men and 22.8 percent of women do not know that a healthy looking person can be HIV-positive (UDHS 2000-2001)

The information must reach the young population, the average reported age of first sexual intercourse among men 25-29 was 19.4 years and among women in the same age group, was 16.8 years. (UDHS 2000-2001)

Overall, condom use is also low. 6.9 percent of women who had sex in the past year used a condom, and for men this figure is 14.7 percent. Only 53.3 percent of Ugandan women know a source for male condoms, and only 36.2 percent report that they could obtain a condom. (UDHS 2000-2001).

Empowering community leaders will help spread the message of better health, but this will not solve the problem of access. 8.4 percent of women and 12.0

percent of men have been tested for HIV. Among those not tested for HIV, 63.7 percent of women and 65.4 percent of men would like an HIV test.(UDHS 2000 – 2001) There are approximately 300,000 PLWA's in need of ARV in Uganda, but only 80,000 people have access. (UDHS 2000 – 2001) In districts where community based NGO's provide care to HIV/AIDS patients case detection is high and care is good. (UDHS 2000-2001) However, in the Kabale District this service is lacking, and due to poor transportation infrastructure and difficult terrain, a mobile strategy is being pursued.

Kabale District

The Kabale District lies in the extreme southwest corner of Uganda, bordered by The Republic of Rwanda, Kisoro, and Ntungamo districts.

Kabale District has a total area of 1,827 square kilometers, of which 1,695 sq km is arable land, 48.5 sq. km is water body, 79.4 sq. km is swamp or wetlands, and 41.1 sq km is marginal land.

The district has a population of 471,730 with a ratio of 86.0 males to 100 females. Out of these, only 45,757 live in the Municipality and the remaining 426,026 in the rural area. The population density is 258.2 persons per sq. km. Thirty three percent of households are female headed, and the average family size is 5.0 persons, with an average birth rate of 6.5 children per woman.

The dominant cultural group in the area are the Bakiga. The Bakiga are a Bantu group, thought to have originated from what is present day Rwanda (Nzita and Mbaga-Niwampa, 1995;Purseglove, 1946). Bakiga women are the caregivers of their society, and are responsible for the care and upbringing of the family, including food production and health care provision.

Only one Government hospital, 48 Government Health Units, 16 NGO Health

Units, 13 private clinics and 14 drug shops provide public health care in the district for both rural and urban population.

Problem statement:

According to the Ugandan MOH STD/HIV/AIDS Surveillance Report (2003) a total of 745 clinical cases were detected from health centers in the Kabale District. Most of these health centers are located in the crowded town village center, inaccessible to the large rural population due to lack of transportation and difficult terrain. Due to these issues, there are a high number of undetected cases and deaths linked to the AIDS virus.

The Kabale District population is at high risk for HIV/AIDS transmission due to practices like polygamy and wife inheritance, high school dropout rates, early engagement in sexual activities (UDHS 2000-2001) and increased sexual coercion (Bagarukayo H et al 1993)

Goals and objectives:

Goal:

To create a health care system that reduces incidence and prevalence of HIV/AIDS and provides care to those infected and affected by HIV.

General Objective:

To improve access to HIV/AIDS information and health care in the Kabale District.

Specific objectives

1. To Test at least 60% of the people for HIV by the end of 5 years.
2. To provide basic care including prophylaxis, treatment of OI's, Malaria treatment and prevention and provision of safe water to 80% the HIV positive people tested by the project by the end of five years
3. To empower community leaders with health education with emphasis on HIV prevention and positive living and support the leaders with radio programs,

brochures, and community gatherings for a period of 5 years.

4. To provide ART to 60% of individuals screened and deemed eligible for ART by the end of five years.
5. To carry out observational and follow up research on patients enrolled into the project.

Activities and inputs

The initial activities of the Kabale Project will focus on creating hubs that feature empowered teams of community leaders. Teams will consist of clinicians, counselors, mobilizers and selected volunteers. These individuals will meet at a scheduled hub to learn the basics of healthy living, along with knowledge needed for proper HIV/AIDS pretest counseling, testing, and posttest counseling in accordance to the Ugandan Ministry of Health protocols. Graduating from the training sessions, each community leader will be given a medical bicycle to increase visibility in the community and enable timely home based care.

Coinciding with the empowering of community leaders will be a campaign to create awareness of the Kigezi Community Project. Community gatherings around youth groups, informative radio programs, and the circulation of brochures will be utilized to create awareness.

Once a hub is established, a mobile health clinic will schedule a visit to conduct HIV testing and other advanced medical consultations. In return visits to the hub, the mobile clinic will offer repeat testing, confirmatory testing, basic care and ART provision to those confirmed HIV positive, follow-up for HIV positive persons, and opportunistic infections management.

Baseline information about persons who come for care will be collected using coded questionnaires to be used later in follow up, assessment of results and observational research.

All the proposed activities will lead increased support and care for HIV infected patients and affected families as well as instill practices for healthy living among the population. The project will start its piloting activities using Kabale municipality and will later spread to the entire district. We will have an office in Karubanda, southern division, Kabale municipality.

Log frame

Specific objectives	Activities	Results	Indicators of results	Assumptions
To acquire basic infrastructure for initial functioning	Acquiring office space for rent. Recruit staff Purchase of supplies like test kits, drugs ,stationery etc	Office space, supplies, eg drugs, test kits	Quantity of supplies attained	If prices remain constant as quoted
To Test at least 60% of the people for HIV by the end of 5 years	Mapping out the operational area Train community mobilizers. Organize community visits for VCT	Operational areas secured, mobilizers trained, people counseled and tested	Number of mobilizers, number of people tested.	If acceptability of the services is maximum
To provide basic care including prophylaxis, treatment of OI s , Malaria prevention and provision of safe water to 80% the HIV positive people tested by the project by the end of five years	Distributing the basic care kits. Treatment of opportunistic infections Prophylaxis with Cotrimoxazole. (Septrin).	Reduction of opportunistic infections, malaria and hospital admissions	Number of kits given, number patients on prophylaxis, number of patients admitted	Right adherence practices
To provide health education with emphasis on HIV prevention and positive living to the people	Organize community gatherings for health education Acquire and distribute health	Increase community awareness about HIV, capacity building,	Number of radio programs, community gatherings conducted	If the level of knowledge influences community practices

through radio programs, brochures, and community gatherings for a period of 5 years	education brochures Conduct monthly talk shows on local FM radio	behavior change and encourage positive living	and brochures distributed	
To provide ART to 60% of individuals screened and deemed eligible for ART by the end of five years.	Screening for ART: -Clinical -Laboratory Distribution of free ARVS Monitor for adherence	Getting eligible people to start ARV's, Increase access to ARV's, reduce resistance to ARV's	Number of patients screened and started on ARV's	Correct lab results and good adherence practices

Time frame

Activities	2007			2008			2009			2010			2011		
	E	M	L	E	M	L	E	M	L	E	M	L	E	M	L
Acquiring rental office space and office equipment	✓														
Purchase of supplies.	✓	✓													
Training community mobilizers		✓	✓												
Community mobilization and sensitization	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Voluntary counseling and testing			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Distributing basic care package			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Opportunistic infection treatment and prophylaxis.			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health education through community gatherings, brochures and radio shows.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Screening for ARVS				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Distributing ARVS				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Monitoring for adherence				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Key

- E – Early (Jan – Apr)
- M – Mid (May – Aug)
- L – Late (Sept – Dec)

“Trickle Down” Cultural Change Model

- 1) Policy Level: Laws are made at the local, regional, or national level
- 2) Institution Level: Institutions such as schools, hospitals, law enforcement agencies, adopt laws and facilitate them into their daily practices and customs
- 3) Community Leader Level: Public figures at the community level, may they be religious, non -secular, media related or governmental, exemplify new practices and traditions
- 4) Individual level: The “trickle down” effect helps the citizen realize a new way of thinking. Culture is changed at an organic grassroots level.