



## KENYA: HIV/AIDS treatment model provides lessons

Tuesday, September 11 2007

**SUBJECT:** The experience of the Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH) in Kenya.

**SIGNIFICANCE:** Having recently enrolled its 50,000th patient, AMPATH provides an excellent window from which to investigate the challenges and opportunities inherent in expanding HIV/AIDS prevention and treatment programmes in sub-Saharan Africa.

**ANALYSIS:** The HIV/AIDS pandemic continues to devastate Africa. With just over 10% of the world's population, sub-Saharan Africa accounts for almost two-thirds (24.7 million) of the global population living with HIV and the region's estimated 2.1 million AIDS deaths in 2006 comprised 72% of total worldwide AIDS deaths.

Ambitious UN targets for providing treatment to HIV-positive people have not been met (see [INTERNATIONAL: HIV/AIDS targets will not be met - June 28, 2005](#)). However, significant progress has been made. More than 1 million people in sub-Saharan Africa are now receiving anti-retroviral treatment, a ten-fold increase since 2003.

Within the context of this general expansion, the growth of the Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH) is noteworthy. Started in 1990 as a purely medical-school-to-medical-school collaboration between the Indiana University School of Medicine and what became the Moi University School of Medicine in Kenya, the programme did not treat its first AIDS patient until October 2000. The programme reached 1,000 patients in 2003, and then grew rapidly as it received funding from the President's Emergency Plan for AIDS Relief (PEPFAR). By 2004, AMPATH was treating 10,000 patients and today it treats more than 50,000 (about half of whom are already receiving anti-retroviral therapy) through its hub at the Moi Teaching and Referral Hospital in Eldoret and 18 rural clinics predominantly radiating out towards the Ugandan border and Lake Victoria in western Kenya.

**Existing programme criticisms.** A variety of criticisms have been levelled against the increased international funding directed towards HIV/AIDS, tuberculosis (TB) and malaria:

- **Funding.** The global increase in funding for these three diseases has been accused of crowding out funding for other equally serious diseases like diarrhoea, pediatric respiratory and intestinal infections, measles and a variety of neonatal killers such as tetanus, birth asphyxia and meningitis (see [AFRICA: 'Neglected' diseases still pose serious threat - November 28, 2006](#); and see [SCIENCE/TECHNOLOGY: Infectious disease threat remains - June 30, 2006](#)). Such funding has also been criticised for being 'stovepiped' down narrow channels for particular programmes or diseases (for instance, preventing mother-to-child transmission of HIV) rather than towards a broader expansion of the public health system.
- **Coordination.** The literally tens of thousands of non-governmental organisations (NGOs) working on AIDS alone have been accused of unnecessarily duplicating efforts, failing to coordinate their programmes and acting more on behalf of their donors' concerns than the host government's policy priorities. Their international funding allows them to pay higher salaries which drain already limited personnel resources from overstretched public health systems.
- **Sustainability.** Repeated concerns have been expressed about the longer-term financial stability of these international efforts. The Global Malaria Eradication campaign ultimately failed owing to a lack of financial commitment from the international community (see [AFRICA: DDT use against malaria causes controversy - October 4, 2006](#)). Problems meeting existing commitments do not bode well for almost certainly expanded needs in the future (see [INTERNATIONAL: Fighting AIDS requires policy changes - September 11, 2006](#)).

**AMPATH experience.** While AMPATH has not necessarily been immune to such problems nor has it solved all of them, its experience demonstrates that many of these criticisms can be successfully addressed. Although much of AMPATH's funding is now stovepiped by PEPFAR for particular HIV/AIDS prevention and treatment initiatives, the programme has never regarded the pandemic in solely medical terms or as something that could be addressed outside other, larger questions in such areas as poverty, stigma, gender, nutrition and sanitation:

## KENYA: HIV/AIDS treatment model provides lessons - p. 2 of 2

- **Nutritional support.** In 2002, the programme started the Highly Active Anti-Retroviral Treatment and Harvest Programme to provide food assistance and agricultural training to address the needs of its HIV-positive patients and their families. With high-production farms and in cooperation with the UN World Food Programme, AMPATH currently provides food assistance to approximately 30,000 people per month. All new patients entering AMPATH are screened by a nutritionist and those found to be food insecure are provided with a nutrition prescription ensuring access to 100% of daily nutrition requirements. Food support covers the patient and all dependents 'eating from the same pot'. This period of intensive feeding lasts for the first six months of the patient's initial period of anti-retroviral drug treatment. After six months, most patients are strong enough to return to their own farms and produce their own food.
- **Financial assistance.** In 2003, AMPATH launched the Family Preservation Initiative to provide micro-credit, job training and a fair trade certified craft workshop to help HIV-positive patients and their families obtain income security. While much of its AIDS funding is narrowly targeted, AMPATH has collaborated with private philanthropists, other UN and government agencies, faith-based organisations and civil society groups to fund programmes like the Family Preservation Initiative or its more recent pilot programmes for orphans and vulnerable children to address broader aspects of the pandemic.
- **Capacity building.** AMPATH is not an NGO. All 19 AMPATH facilities are owned and operated by the Kenyan Ministry of Health. Rather than drain resources away from the government health sector, AMPATH's focus is on building Kenyan institutions in the public sector and on training and rewarding Kenyan healthcare workers for in-country efforts. Its programme is largely managed and staffed under Kenyan leadership and is integrated into both the Kenyan public health system and the Kenyan educational system.
- **Resource management.** In order to deliver quality care in a resource-constrained setting, AMPATH primarily utilises teams of Kenyan clinical officers, nurses, nutritionists and social workers. Standard referral procedures are in place to manage challenging patients but efforts are directed towards continually minimising the involvement of medical doctors in the care of stable patients. The bulk of the anti-retroviral therapy is prescribed by clinical officers per clinical algorithm.

AMPATH remains vulnerable to a cut in PEPFAR funding but its own success has helped forge an increasingly bipartisan consensus on the importance of global public health funding that makes such a scenario unlikely (see [US/AFRICA: Terror policy strains other strategic goals - August 7, 2007](#)). Indeed, US President George Bush, with significant congressional support, has recently proposed increasing PEPFAR funding.

**Model that can be replicated?** One part of the explanation for the success of AMPATH that cannot easily be replicated in today's race to expand treatment programmes is the fact that the medical school collaboration was in place for a decade before it started addressing HIV/AIDS. That decade enabled relationships to develop and trust to be built over time, and ensured that a solid working partnership was already well established by the time significant increases in funding arrived.

However, another key part of the model is replicable: its basis as a collaboration between academic medical centres. AMPATH's success is fundamentally premised on the academic medical centre partnership model because only such institutions can handle the simultaneous challenges of clinical care, training and research, and only a partnership with a local African institution can provide home-grown leadership while building local capacity.

**CONCLUSION:** With an estimated 1.3 million HIV-positive people in Kenya, even AMPATH's spectacular growth over the past five years leaves much work yet to be done. While the programme does not offer any 'silver bullet' solutions to the HIV/AIDS pandemic, its experience demonstrates that many of the critiques about existing prevention and treatment programmes can be addressed successfully by working with a variety of partners in resource-constrained settings.

**Keywords:** AF, Africa, Kenya, United States, economy, politics, social, aid, education, employment, fiscal, government, health, pharmaceutical, reform

*Word Count (approx): 1252*