

Controlling an HIV Hotspot: A Realistic Ambition?

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Abstract

Despite a concerted international effort in recent decades that has yielded significant progress in the fight against HIV/AIDS, the disease continues to kill large numbers of people. Although there is still no definitive cure or vaccine, UNAIDS has set an ambitious goal of ending the epidemic by 2030, specifically via its 90-90-90 ('treatment cascade') strategy – namely that 90 per cent of those with HIV will know their status, 90 per cent of those who know their status will be on antiretroviral therapy and 90 per cent of those on antiretroviral therapy will have an undetectable viral load. These bold assumptions were put to the test in a five-year pilot project launched in June 2014 by MSF and Kenya's Ministry of Health in Ndhwa district, where an initial NHIPS 1 study by Epicentre (MSF's epidemiology centre) in 2012 revealed some of the world's highest HIV incidence and prevalence, and a poor treatment cascade. Six years later, a new Epicentre study, NHIPS 2, showed that the 90-90-90 target had been more than met. What explains this 'success'? And given the still-high incidence, is it truly a success? MSF Deputy Director of Operations Pierre Mendiharat and physician Léon Salumu, Head of MSF France Kenya programmes, discuss the political, scientific and operational challenges of the Ndhwa project in an interview conducted by Elba Rahmouni.

Keywords: epidemic; epidemic hotspot; HIV/AIDS; Ndhwa; Homa Bay County; Kenya; 90-90-90 strategy; treatment cascade; NHIPS 1; NHIPS 2; model of care; patients; partnership; social mobilisation

Despite a concerted international effort in recent decades that has yielded significant progress in the fight against HIV/AIDS, the disease continues to kill large numbers of people, especially in certain regions like rural Ndhwa district in Homa Bay County, Kenya. Although there is still no definitive cure or vaccine, UNAIDS has set an ambitious goal of ending the epidemic by 2030, specifically via its 90-90-90 (treatment cascade) strategy – namely that 90 per cent of those with HIV will know their status; 90 per cent of those who know their status will be on antiretroviral therapy and 90 per cent of those on antiretroviral therapy will have an undetectable viral load. These bold assumptions were put to the test in a five-year pilot project launched in

June 2014 by Médecins Sans Frontières (MSF) and Kenya's Ministry of Health in Ndhwa district, where an initial NHIPS 1 study by Epicentre (MSF's epidemiology centre) in 2012 revealed some of the world's highest HIV incidence and prevalence, and a poor "treatment cascade". Six years later a new Epicentre study, NHIPS 2, showed that the 90-90-90 target had been more than met. What explains this 'success'? And given the still-high incidence, is it truly a success? What follows is an interview on the political, scientific, and operational challenges of the Ndhwa project with MSF Deputy Director of Operations Pierre Mendiharat and physician Léon Salumu, Head of MSF France Kenya programs, conducted by Elba Rahmouni.

Introduction: MSF and the Fight against the HIV Epidemic

Elba Rahmouni: To start, I'd like to broaden the scope of this interview by looking at how Ndhiwa fits into MSF's long history with AIDS. Almost forty years after the epidemic began, can you retrace MSF's action in the fight against this catastrophe?

Pierre Mendiharat: In the early 1990s there were HIV outbreaks in nearly all the places where MSF was already working. Without any treatments, caring for those patients was impossible and end-of-life support very difficult. Patients were highly stigmatised, even by some in the medical profession. There was an internal debate at the organisation about whether it was pertinent for MSF to do prevention projects; because there was no vaccine, prevention was based solely on behavioural changes like condom use and abstinence.

In 1996, the advent of triple therapies [combinations of several antiretroviral drugs (ARVs) against AIDS] raised the question of access to treatment for the hardest-hit populations. The vast majority were in the South – particularly in sub-Saharan Africa – and the drugs were in the North. The extremely high price of treatment [\$10,000 per patient per year when triple therapy first arrived], the lack of generic versions and the requirement that patients pay part of the costs put triple therapy out of the reach of patients in resource-limited countries. Taking its cues from patient organisations in the North, such as ACT UP, MSF began doing public advocacy to make triple therapies accessible to patients in all countries.

The first treatment-related actions by MSF members consisted of helping individual colleagues and friends by secretly bringing in drugs that were impossible to find locally. That was also the era of our first HIV programmes, in particular in Thailand and Kenya [in Homa Bay County, where the operation began in 1996], the creation of the Access Campaign¹ in 1999, our activism in South Africa alongside patient organisations and the first victories against the pharmaceutical companies, who agreed to go beyond their policy of charging the same price worldwide and adjust their prices to a country's resources.² By the early 2000s the price of the treatments had fallen considerably, to about two hundred dollars per patient per year.

With the arrival of two global actors with multibillion-dollar budgets, namely The Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002 and the United States' PEPFAR programme³ in 2003, the 2000s were a time of worldwide consensus on radically boosting the number of patients on treatment. At MSF, the number of HIV projects supplying drugs to initially small, and then larger, patient cohorts in Africa, Asia and Latin America

multiplied. To offset the burden such large cohorts were placing on health systems, we had to find ways to simplify and decentralise care. MSF contributed greatly to the operational research, and that effort brought us a certain fame in the global health world. The PEPFAR and Global Fund programmes were bearing fruit, and by the early 2010s, ARVs were available in most of the world's countries; the barriers to treatment for people living with HIV lay [and still lie] mostly in local health systems' weaknesses and a lack of political will.

For the past decade or so, MSF has had two main objectives. The first is to design projects with a population-based approach in an attempt to impact virus transmission, as was the case with the Ndhiwa project. The second is to improve medical quality, in particular for more difficult-to-care-for patients like children or patients in treatment failure, given that national systems are now capable of managing the simple cases relatively effectively. For the medical teams it's a question of ensuring successful treatment for all patients – in particular, by measuring viral loads and by taking drug resistance and individual constraints like mobility into account. The number of HIV projects has decreased, and in a sense they have become more specialised.

In contrast to the 2000s, MSF is now a minor player in the fight against HIV. We are, however, influential with regard to developing innovative strategies and care models such as simplified management. Thanks to our long-standing efforts in the fight against HIV, we have developed some competence in following patients with chronic disease.

Controlling an Epidemic Hotspot

Elba Rahmouni: What were MSF's initial aims in Ndhiwa district?⁴

Léon Salumu: The Ndhiwa project was designed with the admittedly ambitious aim of reducing HIV incidence in the district using every known biomedical tool – that is, mass testing, early treatment of all positives, better patient care and follow-up and circumcision – to ensure continuity of treatment and sustained viral suppression. It was a medium-term four-year population-based approach;⁵ it targeted the entire population of Ndhiwa [rather than just a cohort of patients] in the hopes of controlling this health calamity.

Pierre Mendiharat: The Ndhiwa project was being devised at a key moment in HIV research. In 2008, the Swiss health authorities claimed – in what would come to be known as the *Swiss Statement* – that patients who were taking their medications correctly were no longer contagious. That claim, which was especially crucial to serodiscordant couples,⁶ was the subject of debates at that year's IAS [International AIDS Society] conference

in Mexico: *Has this really been proven?* and *Can we tell the patients this?* Then, in July 2011, the HPTN 052 randomised trial in a cohort of serodiscordant couples showed that early ART (antiretroviral therapy) had resulted in a 96 per cent reduction in transmission to non-infected partners. That confirmation of the Swiss Statement gave rise to the notion that it might be possible to control the HIV epidemic, because the *treatment* becomes a *means of prevention*; if everyone with HIV has access to treatment, then transmission will stop.⁷ In practical terms, that meant urging everyone to get tested, making access to treatment universal, establishing long-term relationships with patients and then watching to see whether the strategy resulted in a lower incidence at the population level. The plan was totally conjectural; although a halt or dramatic reduction in transmission had been shown to occur in a cohort of serodiscordant couples, it had never been proven at the population level.

Elba Rahmouni: How did MSF take up the 90-90-90 strategy?

Pierre Mendiharat: MSF fully subscribes to the objectives summarised by the ‘90-90-90’ slogan, which was only ever the quantitative expression of good practices for controlling an epidemic, i.e. giving the greatest possible number of patients access to diagnosis and treatment and then providing high quality care to ensure follow-up and successful treatment. The question then becomes whether those objectives are sufficient. What about the other 10-10-10? Adopting those targets means being satisfied that only 73 per cent of HIV-positive people have an undetectable viral load. UNAIDS now recommends aiming for 95-95-95.⁸

When the Ndhiwa project started in Kenya in 2014 – before the results from Epicentre’s 2018 epidemiological survey *Ndhiwa HIV Impact on Population Survey 2* (NHIPS 2) became available⁹ – we weren’t really sure whether the 90-90-90 strategy was realistic, though we had already come close in Chiradzulu, Malawi. I don’t even think most of us believed in it, given the enormous amount of individual and collective discipline the strategy demanded.

Léon Salumu: All programmes have targets – otherwise it would be impossible to measure the progress made by organisations or countries more generally. In addition, our organisation frequently adjusts its objectives as new studies come out. While the 90-90-90 targets – which were based on the latest knowledge on the individual and collective benefit of early HIV treatment – were certainly ambitious, they were necessary, insofar as they made it possible to set a course. The targets also made it possible to link individual benefit – i.e. treating people to reduce mortality – to collective benefit – i.e. reducing transmission by identifying patients and starting early treatment in the hopes of controlling the epidemic.

Elba Rahmouni: How did the organisation position itself with regard to the UNAIDS slogan about ending the epidemic by 2030?

Pierre Mendiharat: Unlike the 90-90-90 targets, eliminating HIV by 2030 has never been part of our strategy. Generally speaking, that type of objective is very foreign to how MSF works, i.e. having narrowly focused projects and more short-term objectives. ‘Ending AIDS by 2030’ is a slogan that UNAIDS has been using since the 2011 IAS conference in Vienna to re-energise institutional donors, given what was perceived to be ‘donor fatigue’ [decline in donations for fighting the HIV epidemic]. We certainly should have distanced ourselves more sharply from that misleading slogan, because I think anyone who has studied the subject seriously knows that there’s no hope of being finished with HIV by 2030. MSF communications have always evoked the reality of the disease as experienced by the patients, the treatment failures, the day-to-day problems and the still-high mortality, often oversimplifying, without really doing justice to the very significant progress that has also been made.

The Ndhiwa Project: Toward a Simplified Model of Care

Elba Rahmouni: What were the major phases of the project?

Léon Salumu: During the first two years [2014 and 2015], MSF expended significant resources in the villages in testing and awareness-raising campaigns conducted outside of the health centres, whose capacities we also strengthened. Then, beginning in 2016, we worked to decentralise care and laboratory activity in order to improve access and follow-up [increasing the number of facilities that could test, start treatment and dispense the medications] and to simplify our model to ensure continuity of care, particularly after we left. In 2018, after we had done testing in the entire district, we continued testing at healthcare facilities, reserving home testing for the contacts [family and friends] of those who tested positive in the centres. We also focused on specific categories like children and adolescents, severe cases and patients in treatment failure.

Elba Rahmouni: What, in concrete terms, does this idea of developing a simplified care model mean?

Pierre Mendiharat: At the Ndhiwa project, like at others, it meant further reducing the number of visits. In countries with weak health systems, you have to lighten the workload for the personnel who are following cohorts with thousands of patients and enable them to focus on visit quality. From the patient’s perspective, less frequent visits can be a significant advantage in terms of

time and transportation costs. We offered visits every six months and the option of picking up the medications every three months. That is not so easy to implement because we had to ensure that there was always a stock in health centres and that the patients were able to store their drugs at home. We also set up Community ART Groups (CAGs), a model used at other MSF missions in the southern region; in remote villages, the patients constitute a group. The group members take turns going for an annual visit and bringing back the drugs for the other patients, who don't have to go anywhere. We've been trying to do all that for the past few years as part of the DSDM, or differentiated service delivery model; rather than forcing patients to be followed in a certain way, each person can choose how they would like to be followed. Though it seems obvious, in practice it wasn't being done systematically. So, even in the HIV sector, which is supposed to be somewhat advanced in terms of considering the patients' opinion, there is still lots of room for improvement.

Partnership with the Ministry of Health

Elba Rahmouni: This project was conducted in partnership with the Ministry of Health. Why? What did that entail?

Pierre Mendiharat: What we had in mind right from the start was to create an activity that was *sustainable* [because HIV infects patients for life, treatment doesn't stop until they die] and *replicable*. By demonstrating that it's possible to have a population-scale impact on transmission, we were hoping the health authorities would try to do the same thing in other districts. Another major aim of this project was behaviour change, since the entire adult population would have to be screened every year. So we had to act in concert with legal authorities like the Ministry of Health (MoH), and also other leaders like traditional chiefs and local notables.

While we always say that we work with the ministries of health, we generally prefer to find a place within the health system that allows us to be as autonomous as possible. MSF has historically worked hard to be able to act as independently as possible; while this has been successful, it has also had the disadvantage of making us notorious isolationists who have learned little about working in partnership. MSF staff are unaccustomed to consulting with ministerial authorities before making important decisions; we tend to make our decisions after internal consultation, and then think about how to convince the ministry that it was the right decision. There are many situations, however, where we could benefit by working with others – certainly more than there were 30 years ago, because the capacities of the countries where we work and of other aid actors has

increased. Now we're trying to fight our isolationism. Right from the start, work at the Ndhiwa project aimed to be much more balanced, with technical committees and steering committees within which the MoH, MSF and other HIV actors in the county were supposed to make joint decisions. Yet the first head of mission explained that he had to constantly struggle with his colleagues to make sure that the time frame for decision-making allowed for discussion with the other actors.

Léon Salumu: We didn't have just one collaboration, but two: one with the MoH and the other with the village chiefs and influential figures at the local level. It was essential to ensuring continuity of care after our departure. In order to work with the MoH we had to revise our own standards to adapt to the realities in the field, in particular regarding the number of caregivers, the protocols and compensation. On the other hand, the participation of village chiefs and local figures in developing our activities was an important aspect of their success. They were involved in all phases of the project, especially when it came to setting up testing and awareness-raising activities. That collaboration was a way of asking ourselves, 'What is essential to the patients with regard to their care?' One answer, for example, was being able to get medications close to home.

Elba Rahmouni: This project was developed at a time when Kenya was undergoing significant changes in its constitution, with the so-called devolution process giving the regions and their subdivisions greater autonomy. Did that decentralisation process have an impact on how the project was conducted?

Léon Salumu: The decentralisation of power also meant decentralisation of our interlocutors. The *devolution* was a great help to us, because the decision-makers were nearby in the field, and not in the capital. Hence our interlocutors were well acquainted with the reality in the field. However, the central government retained responsibility for defining policies and protocols and for supplying diagnostic tests and drugs. While we often had to deal with coordination problems between the two levels, *devolution* enabled us to quickly decentralise care by enabling more facilities to test and dispense HIV drugs. It also allowed us to test some simplified care strategies without having to get validation by national authorities.

Social Mobilisation

Elba Rahmouni: The project's success was predicated on significant behaviour changes on the part of the population. What did you do to bring about those changes, and with what successes and failures?

Pierre Mendiharat: The relationship between caregivers and the cared-for is always unbalanced, with the

caregivers in a position of superiority. This is true for both psychosocial and patient education visits and for public health messages aimed at the population as a whole. HIV programmes have relied heavily on attempts to change population behaviour, in this case prescribing abstinence [particularly PEPFAR-funded programmes], fewer sexual partners and routine condom use. These rules overwhelmingly continued even after such policies failed. That was particularly true in this part of Kenya, where the anthropological literature had established a link between the HIV epidemic's explosion and traditional sexual practices in the Luo community. A survey conducted by Dr Xavier Plaisancie¹⁰ among the male population of Homa Bay showed the contradictions that existed between the social rules regarding normalcy and virility and the public health messages, and the difficulty individuals had in resolving them.

In Ndhiwa, we immediately made clear our desire not to venture onto this 'anthropological' terrain and to focus more on 'biomedical' tools: screening, treatment, viral load measurement and circumcision. While that required that patients adopt certain health behaviours, it had little impact on sexual practices and we scrupulously avoided any moralising. We were mindful of the quality of the caregiver-patient relationship both in the design phase of the project and in its implementation, conducting surveys in an attempt to understand how our actions and messages were perceived by patients. I think that strategy contributed to the project's success, as measured by the very good testing numbers.

Léon Salumu: A number of studies have shown the tensions that existed in the caregiver-patient relationship. Caregivers often act like deciders who give orders without explanation, and ask that patients simply obey. In Ndhiwa, village-based activities allowed us to break those habits to some extent. At home visits, the medical team had to start by introducing themselves, and then explain and justify what they were doing. It was the person who welcomed the caregiver; that person had the opportunity and ability to ask whatever questions he or she wanted in order to understand, and the caregiver took the time to answer. The patient could then make an informed choice about refusing or agreeing to the test. In the health centres, in contrast, caregivers spend little time explaining and patients have hardly any opportunity to ask questions. Caregivers tend to assume that if a patient has come in, they consent to the various medical acts – including testing! It's unfortunate that we did not do enough to improve that aspect at healthcare facilities. Home visits enabled the teams to understand and integrate the importance of real dialogue with patients.

I had an opportunity to participate in that activity and I was impressed by the teams' engagement and willingness to listen; their work was appreciated and

undoubtedly helped change behaviours in terms of testing, as evidenced by the fact that more than 93 per cent of HIV patients knew their status at the time of the 2018 Epicentre survey, compared to 60 per cent six years earlier.

Pierre Mendiharat: There are indeed guidelines and trainings that all stress empathy, listening, respect and being non-judgmental. We can reasonably hope that they will pay off. But the quality of the caregiver-patient relationship is hard to assess. The survey conducted by MFS between 2016 and 2018 among Ndhiwa patients who had gone through periods of treatment failure showed the lack of social and economic support in the programme, though some patients in serious difficulty could have used them.¹¹ It also showed that the conversation and care were not personalised enough. Lastly, there was no robust mechanism for preventing and detecting patient abuse. Nevertheless, the inequality and in some cases violence that characterises the relationship between the medical profession and patients goes beyond the therapeutic relationship, reflecting the inequalities in society as a whole.

Elba Rahmouni: What was the impact of mobile testing campaigns in Ndhiwa's villages?

Léon Salumu: The testing campaigns, both home-based and in the villages, gave us access to hard-to-reach people – primarily men who did not frequent healthcare facilities on a regular basis. Screening 'outside the walls' of health centres [by MSF or other actors] accounted for 15–20 per cent of the tests; 80–85 per cent of people were tested at healthcare facilities. While we focused on *mobile testing* at the start of the project, we later chose to support the healthcare facilities more [compared to the community-based part], to make testing activities sustainable. At the healthcare facilities, we set up a strategy for tracing the contacts of those testing positive. That involved asking the person who tested positive to encourage family members and contacts to come get tested.

Pierre Mendiharat: When encouraging people to get tested, it is essential not to underestimate the terrible ordeal that learning their HIV-positive status always is, due to the impact on their emotional, family and sex lives – on top of their fear of illness and death. Nevertheless, we surely benefitted from an underlying change that was occurring: the HIV epidemic had become so widespread in the region that stigmatisation was declining. A quarter of adults there are HIV-positive, and everybody among the three-quarters that are HIV-negative knows, or has known, several HIV-positive people.

Elba Rahmouni: The project also considered expanding access to male circumcision, which several studies say reduces the risk of contracting HIV by 50–60 per cent. Why did you end the circumcision activity?

Léon Salumu: We ended that activity because other organisations were taking care of it and getting better results. Culturally, circumcision isn't readily accepted by Ndhiwa's Luo community. Unlike us, the other actors were giving cash or clothing to candidates who agreed to be circumcised. We didn't use that strategy because we couldn't agree on it internally. The 'opponents' argued that paying someone to be circumcised would influence their choice. To me, it was a matter of compensating them for the lost income from the days they couldn't work after the operation. Aside from that debate, we would have done it if others weren't doing it or weren't getting good results.

The Results

Elba Rahmouni: After the first Ndhiwa HIV Impact in Population Survey (NHIPS 1) epidemiological survey, conducted prior to the project's opening in 2012, Epicentre did a new survey (NHIPS 2) in 2018. A comparison of those two studies was needed to provide follow-up and assess the project. The results showed a markedly improved treatment cascade and a reduction in incidence and prevalence. What conclusions can we draw from this?

Pierre Mendiharat: The results were better than we had hoped; according to the NHIPS 2, it wasn't 90-90-90 that we achieved, but 93-97-95. Fewer than 12 per cent of HIV-positives had a detectable viral load and were potentially contagious. That represents 16,000 people who had access to a treatment that was working, which is a remarkable result.

It was harder to answer the question about the decline in the incidence of new infections, due to a statistical problem of overlapping confidence intervals. In 2012 there was a 95 per cent probability that the incidence was between 1.1 and 2.5 per cent per year, and in 2018 there was a 95 per cent probability that it was between 0.4 and 1.2 per cent per year. So, there was an extremely low, but not zero, probability that the incidence fell somewhere between 1.1 and 1.2 per cent in both 2012 and 2018. A larger sample would have been needed to ensure the robustness of the comparison. There were, however, other indicators pointing to reduced transmission of the virus. In 2018, 88 per cent of HIV-positives had an undetectable viral load and thus were not contagious, compared to only 40 per cent in 2012; that's a huge difference. Next, the prevalence among 15- to 24-year-olds fell compared to 2012; that is consistent with low incidence in that age group. So we at MSF were in agreement on the claim that the incidence likely fell in the years prior to 2018, and that we therefore achieved the unheard of and very ambitious goal of markedly reducing virus transmission in a place where the HIV

epidemic had been most devastating. I think we can be proud of having contributed to that outcome.

Elba Rahmouni: To what extent can MSF take credit for those good results, given that other actors – the Ministry of Health and EGPAF [Elisabeth Glaser Pediatric AIDS Foundation], in particular – were also working in the district?

Pierre Mendiharat: It's impossible to know how much can be attributed to MSF, since the project was conducted in partnership and in complementarity with the Ministry of Health and the other healthcare actors, themselves funded by institutional donors. The advantage of a partnership lies in the outcomes that can be achieved together. To try to determine MSF's added value we would have to compare with similar, neighbouring districts or with other actors we weren't working with, but we don't have any equivalent, equally detailed, surveys.

Elba Rahmouni: What led to those good results?

Pierre Mendiharat: There is no magic formula in the fight against HIV. Without a vaccine, we had to use whatever we had – from health centre laboratories to hospitals to village-based actions. That general mobilisation took a lot of resources, sometimes to the detriment of other diseases, but given the prevalence in Homa Bay, I think it was justified.

And then there are the people behind the projects. The determination and long-term commitment of some key people were crucial to achieving those good outcomes; they had to stay on course despite the inertia inherent to any large organisation, whether MSF or the Ministry of Health. I'm thinking about the heads of mission, the project coordinators, the deputy medical coordinator, the epidemiologists, the desk manager and the Medical Department HIV advisor who supported the project for many years.

Elba Rahmouni: The KENPHIA (Kenya Population-based HIV Impact Assessment) survey is a national survey on HIV done in 2018 by the Kenyan Ministry of Health. How would you interpret the results of that survey?

Pierre Mendiharat: The results of the KENPHIA national survey are broken down by region. The only results in Homa Bay County that weren't as good as the NHIPS 2 results in Ndhiwa [a district within that county] pertained to the percentage of HIV-positives tested. Systematic home testing in Ndhiwa district and the massive mobilisation it both required and generated was key to gaining a few extra percentage points. However, the results were almost the same for the percentage of patients who tested positive and actually started treatment, and for the percentage of those patients who had an undetectable viral load [the second and third '90']. In that regard, the 2015 change in the national protocol in

favour of Test & Treat [offering treatment to patients as soon as they test positive] was crucial.

Léon Salumu: I'm not surprised that there wasn't much of a difference between our results and those from the KENPHIA survey. First, they aren't *our* results, but the results of a collaboration with the Ministry of Health and the other actors [working throughout the country]. It also proves that more resources aren't always needed to get better results. We contributed to that success, and I think the most important thing now is being able to sustain it.

Elba Rahmouni: In Ndhiwa district, MSF was willing to take on a very large endemic focus and provide an enormous amount of resources [200 healthcare personnel, free care, etc.] for a small population [the district had 242,726 inhabitants in 2015]. Is this type of project really sustainable and replicable?

Pierre Mendiharat: As explained earlier, we were hoping from the start to set up a sustainable, replicable activity, and that premise led us to work very closely with the Ministry of Health, and even have university partners [INSERM (French National Institute of Health and Medical Research) and Harvard] do a 'cost-effectiveness' analysis of the intervention – with very positive results, fortunately. The cost-effectiveness aspect of the intervention is important, because it suggests that the Kenyan political authorities can economically justify devoting the resources needed to use the approach on a broader scale. The question of institutional capacity and the number of qualified people that that would require still stands, however.

MSF's Departure and the Project as It Now Stands

Elba Rahmouni: How did you organise MSF's departure?

Léon Salumu: From the start of the project, our concerns centred on the continuity of our activities; as a result, we based what we were doing on MoH standards. All additional personnel were recruited in accordance with MoH standards and at MoH salaries, to facilitate their retention [50 per cent of the staff were ultimately retained in 2020]. The MSF teams did the mentoring, which consisted of long-term individual support for healthcare personnel. We had about twenty MSF mentors at the start of the project, and then gradually reduced the number and more accurately gauged the MoH teams' autonomy. We currently have only four mentors, who intervene at the request of MoH staff. It's a good transition that can go on as long as necessary.

Elba Rahmouni: What are your current objectives?

Léon Salumu: We currently have two major objectives: to preserve the gains achieved during our six years in Ndhiwa, and to continue to collaborate with the other

actors to address any jointly identified gaps or challenges. In practical terms, we are working on initiating third-line treatment in patients who need it.¹² These patients are currently waiting six to eight months before switching treatments. We are working together to shorten that wait, and in particular are proposing to speed up the process by facilitating local decision-making without going through a national committee [as is recommended at the central level]. We are also working with the MoH to improve follow-up for adolescents, for whom the treatment failure rate is still about 20 per cent. In the hopes of improving their treatment adherence, we are devising specific management strategies for adolescents: special days and clinics and support that is appropriate to each adolescent's specific needs.

Elba Rahmouni: Once the Ndhiwa project ends, will the treatment cascade be maintained?

Léon Salumu: It's hard to say. In 2019, I had hopes that that would be the case. Since our involvement was significantly reduced, we have continued to monitor the various indicators, using MoH data, to make sure that the cascade is preserved and to offer support if needed. I was convinced that the Kenyan health system would be able to continue testing, treating and following patients, and retain them, without an outside partner. The KENPHIA survey was very encouraging in that regard. What concerns me now is knowing how to sustain those positive results in the current context of the COVID-19 pandemic and its attendant restrictions.

Elba Rahmouni: What have you done in response to the COVID-19 epidemic?

Léon Salumu: The COVID-19 pandemic caught everyone by surprise. I think we overreacted by quickly applying overly restrictive measures. In April 2020 we thought, 'patients with HIV are at high risk and we have to protect them by limiting their contact with healthcare facilities'. To ensure that they continued their treatment, we focused on giving out three-month supplies of drugs. But distributing the drugs was not enough; we should also have kept in contact with the patients and known whether they were taking the drugs – especially the high-risk patients. In many countries, a lot of people were in difficulty, and didn't have food. We should have come up with some innovative strategies that would have allowed patients to continue their treatment *and* get appropriate social support and follow-up, without being put at risk. We realised that most of our patients didn't have a phone, so we couldn't do telephone follow-up. With the patient group system, you only have to contact one person to get access to the others. But that system doesn't work for every patient [in Uganda, where the practice was developed, only 20 per cent of patients are on that model]. And using community leaders to reach patients isn't easy either, because some patients don't want to disclose their illness.

Patients began returning in summer 2020, but we still don't know whether there were gaps in their treatment. These are things we'll have to explore in order to determine the impact of the COVID-19 pandemic on our HIV patients.

Elba Rahmouni: How does MSF manage AIDS patients in projects that do not specialise in HIV?

Léon Salumu: Although we adopted a resolution in 2008–09, on the medical department's initiative, to include HIV management at all of our projects, that is currently far from being the case. The teams always find some reason not to do it. Some still don't think it's a good idea to start lifelong treatment at a short-term MSF project. I have a hard time understanding this position, because it's the patient's decision, not ours. HIV treatments are now available in every country. So we have the option of starting treatment and at the same time support patients by referring them to another facility where they can continue their treatment. And if that's not possible, we can explain the situation and let the patient decide. In addition, MSF projects that are only supposed to last six months often go on for years. As inconceivable as it may seem, there are still some projects where people being tested for blood donations are not informed that they tested positive for HIV. We should aim for a whole-patient management approach, including HIV management, and use what we've learned from HIV to develop 'simple' models for chronic disease management and follow-up.

Elba Rahmouni: What is the current status of the worldwide effort to control the HIV epidemic?

Léon Salumu: Mobilisation against the HIV epidemic is still strong, and we should keep it up so that previous efforts can be sustained. Now, with the COVID-19 pandemic, we need to remain vigilant, especially when it comes to the countries that the Global Fund considers somewhat higher-income [Kenya, in particular] and, as a result, are supposed to have their funding cut. That change will have to be taken into account so that they are not penalised. That's an issue we'll need to keep a close eye on.

Notes

- 1 Access to Essential Medicines Campaign: <https://msfaccess.org/> (accessed 24 November 2021).
- 2 <https://msf-crash.org/en/publications/agir-tout-prix-negotiations-humanitaires-lexperience-de-msf/i-stories#south-africa.-msf,-an-african-ngo?> (accessed 24 November 2021).
- 3 President's Emergency Plan for AIDS Relief.
- 4 Since the decentralisation of governance required by the new constitution (adopted in 2010), Kenya has been made up of 47 counties, themselves divided into districts. Thus, the former Nyanza Province, located in south-western Kenya on the shores of Lake Victoria, includes Homa Bay County, which itself contains eight districts, of which Ndhiwa is one.
- 5 A population-based approach aims to improve the health status of a population in a given territory via collaboration among different health actors in that territory.
- 6 In a serodiscordant couple one partner is HIV-infected and the other is not.
- 7 Up to that point, prevention programmes had recommended only condom use or abstinence, two behaviours that failed to control the epidemic. In the absence of biomedical tools, public health policies called for behaviour changes; these required a lot of discipline and gave an unreliable result.
- 8 UNAIDS (2015), 'Understanding Fast-Track: Accelerating Action to End the Aids Epidemic by 2030' (Geneva: UNAIDS), www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf (accessed 24 November 2021).
- 9 MSF (2020), 'VIH : l'amélioration de la prise en charge a fait chuter la proportion des personnes infectés dans l'un des foyers les plus touchés au monde', press release, 24 November, www.msf.fr/communiqués-presse/vih-l-amélioration-de-la-prise-en-charge-a-fait-chuter-la-proportion-des-personnes-infectées-dans-l-un-des-foyers-les-plus (accessed 24 November 2021).
- 10 Xavier Plaisancie's MD thesis, *Representations of HIV and Impact on Care Seeking among the Men of Homa Bay, Kenya*, 9 June 2020, <https://msf-crash.org/en/publications/medicine-and-public-health/representations-hiv-and-impact-care-seeking-among-men-homa> (accessed 24 November 2021) was the subject of a *Cahier du CRASH*. That process was the subject of a regular dialogue between Xavier Plaisancie and MSF-CRASH research centre members Jean-Hervé Bradol and Marc Le Pape. The survey described, in particular, the wide range of institutional actors (doctors, politicians, religious leaders, etc.) responsible for the abstinence directive.
- 11 Rose Burns *et al.* (2019), "I saw it as a second chance": A qualitative exploration of experiences of treatment failure and regimen change among people living with HIV on second- and third-line antiretroviral therapy in Kenya, Malawi and Mozambique', *Global Public Health*, 14:8, 1112–24, doi: 10.1080/17441692.2018.1561921.
- 12 Patients who fail the second-line treatment are put under third line following the resistance genotype result.