PROJECT SUMMARY

# Bungoma AIDS Home Care Programme

**Background:**
The Bungoma district consists of a number of small towns and villages. Farmland is good in the area, however intensively populated. As farm plots are small, income levels are small. This population density combined with the fact that many men go to the cities to find work has led to the rapid rise of HIV infections. Official figures are 9%, but observation by ICROSS suggests that actual levels may be higher. There is neither the money nor the infrastructure for the Ministry of Health to deal with AIDS in its regional hospitals and an increasing emphasis has been put on Home Based Care.


**Bungoma District Facts**

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| **Population** | 876,000 |
| **Tribe** | Luyiah |
| **Household Size** | 5 |
| **Geographic Area** | 2,100km² |
| **People per km²** | 424 |
| **HIV/AIDS prevalence** | 9% |
| **Average Annual Income** | US$ 730 |
| **% in Paid Employment** | 20% |
| **% Below poverty line** | 52% |
| **Infant mortality** | 7.4% |
| **Primary source of income** | Agriculture |

*Source: Regional Government Statistics, AIDS in Kenya 2001*
*Note: HIV prevalence is of pop aged 10+. % in paid employment is % of economically active population*

**ICROSS Role:**
ICROSS was asked by Family Health International (FHI) to develop a home based care programme in Bungoma as part of their IMPACT programme. IMPACT takes a holistic approach to AIDS with a number of linked and complementary programmes. Usually these cover: behaviour change education, voluntary testing and counseling, mother to child transmission, orphans and vulnerable children as well as home based care. ICROSS has worked closely with the ministry of health, its IMPACT partners and other local non governmental organisations to develop the programme. FHI gave ICROSS funding of Ksh 15.5 million (US$200,000). The programme ran over a three year period (2000-2003).

**ICROSS Project:**
The ICROSS project covered four main steps:

1. Establishing a local office and field team of four and contacts with the local ministry of health, regional hospitals and local IMPACT partners.
2. Identification and training local trainers of trainers. These are usually local nurses who are identified by the ministry of health. ICROSS carried out a five day training programme and the ministry of health committed to make the training of trainers available one day a week to the programme.
3. Identification and training of local community health workers. These are frequently carers of people with AIDS or active members of the community who are known to the field team. They were given a three day training programme about AIDS, the diseases linked to AIDS (such as TB), home based care, sanitation and hygiene and were then required to identify three to four clients (not patients) whom they will support. The community health workers are volunteers who commit to spending at least one day a week visiting and supporting their clients.
4. Provision of home based care for clients. The ICROSS staff and volunteers were divided into teams to cover different regions (in Bungoma there were 13 teams covering three regions; Bungoma, Nzoia and Webuye). Individually and collectively, team members would visit their clients at least once every two weeks, providing them with drugs,

advice and support. In addition, the community health workers were encouraged to undertake at least one awareness raining event a month – speaking at women's groups, church functions, schools etc to encourage community involvement. The professional field team were out in the field with the community health workers and trainers of trainers every day of the week, encouraging the volunteers, ensuring the monitoring of clients were done effectively and linking the clients to other IMPACT partners and non governmental organisations as required.

The teams and volunteers were not only providing physical help but also moral support, allowing clients to talk about their illnesses and share concerns and also just chat and laugh. The teams played an active role in allowing those who were sick to plan for the future and look for partners and support networks who work in the area required (e.g. orphans and vulnerable children). They also raised awareness in the community, both of the needs of the patients and of the dangers of the HIV virus. Being from the community themselves, they were better at understanding the networks and dynamics involved, making this programme sustainable once ICROSS' direct involvement was complete.

The field team covered a wide area, a significant portion of Bungoma's 2,000km$^2$, a challenge which was not helped by the lack of vehicles. They were dependent on local buses (Matatus) and often had to walk several kilometres from a main road to a client's house (most people return to their rural home when sick). The project leader worked closely with the ministry of health, encouraging access to drugs and testing and ensuring a successful handover of the programme once funding runs out.

*Provision of drugs by ICROSS CHW*

**Case studies:**

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**Alice** lives in a slum in Webuye, she shares one room with her five children. She is 37 and was an ICROSS client for six months. Her husband died four months after she enrolled the ICROSS programme. Her eldest daughter, at 15, is a 'grown up' and provided for the family by selling vegetables by the road. The other children had dropped out of school; there was no money for fees. Alice had TB (a hackling cough, night sweats and weight loss). The ICROSS team ensured she followed the drug regime. She has rashes on her arms and legs. With the drugs ICROSS supplied they dried up and were less sensitive to infection. The community health volunteers spent time teaching the family about hygiene; how they had to clean their spoons and dishes in boiling water and not share dishes – they only had two dishes and two spoons. The weekly visits helped to build Alice's spirit – "*without ICROSS I would have been dead six months ago"* They also helped Alice to plan for the future: her funeral and the care of her children once she had passed away.

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**Joseph** was a factory worker in the sugar refinery in Wabuye. When he became ill he was given one and half months pay – after that the family had no income, but were allowed to stay in the two roomed house on the company ground. Joseph's wife died in 1996. Joseph was bedridden for 6 months before he got enrolled with the ICROSS programme. He was emancipated and his chest was covered with a vast festering abyss, which could not heal due to AIDS. The head of the family is Elvis, he was 20 at the time. Under ICROSS guidance he kept the house immaculate, washed the sheets daily, bathed his father and anointed the wounds and sores. The ICROSS team gave him advice on diet – his father could only eat soup as it is easy to digest. Elvis had planned to go to college but became a full time carer with four younger siblings to look after – of whom only two could go to school. The ICROSS team found a part time job for Elvis, but he was too nervous to take on extra responsibility

**Alex** was 42 and was an ICROSS client for six months. He used to work in a hotel in Kisumu but got too weak. All the family now had was what they could grow and what the village provided them with. Alex has seven children; the youngest was a baby at the time. The ICROSS team visited them every other week. Alex had ups and downs, days where he felt well and other days when he was weak. Alex had malaria two times and recovered with the anti-malarials provided by ICROSS. The community health worker talked through his diet with his wife and provided them with Vaseline to ease his skin rash and re-hydrants to help him retain fluids. Alex was not tested at the time he got enrolled with ICROSS and was afraid of going to the hospital alone. The community health worker went with him … his wife also went for a test.

**Impact:**

The Bungoma project trained 50 trainers of trainers and 400 community health workers. We had a record low drop out rate from training given the huge emotional commitment these people made. More than 5000 households benefited from the programme. Much of the benefit ICROSS provide was qualitative; improving the last few months of life of our clients and ensuring that after their death the families were supported as much as possible. The skills the trainers of trainers and community health workers acquired from ICROSS are today still being practiced. ICROSS is currently looking for funding to re-establish the home based care programme in Bungoma.

**Donors:**

fhi Family Health International

ICROSS