STAKEHOLDER ENGAGEMENT AND MANAGEMENT AS A DETERMINANT OF HEALTH INTERVENTION OUTCOMES: THE VARIED MESSAGES COMMUNICATED DURING HIV AND AIDS INTERVENTIONS IN KISII COUNTY, KENYA

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Abstract

Introduction. The management of stakeholder relationships, a key feature and function of communication, determines the outcomes of health interventions. This study sought to establish how stakeholder involvement and stakeholder relationship management were influencing the outcomes of the interventions against HIV and AIDS in Kisii County, Kenya. **Materials and methods.** Data was collected from 89 respondents drawn from 14 high volume hospitals in the county. These hospitals were purposively selected. The respondents comprised of health care staff, representatives of bodies involved in HIV and AIDS interventions in the county. These were selected purposively. Female sex workers and men who have sex with men were selected using convenience sampling technique. Data was collected from these respondents using interviews and focus group discussions. Additional data was collected from county and national strategic plans and policy documents selected purposively. **Results and discussion**. The key findings were that effective strategies of targeting, engaging and managing relationships with PLHIV and FSWs were employed. However, the strategies were effectively implemented in very few hospitals. There were no clear and consistent strategies and messages targeting and engaging the general population, men, young people, and victims of GBV in HIV and AIDS activities. Furthermore, the effectiveness of all the strategies employed in stakeholder relationship management was being undermined by lack of consultation with and involvement of health care workers by donor agencies and the relevant county government authorities in making critical decisions. **Conclusions**: Without proper stakeholder mapping, engagement and relationship management, the HIV and AIDS interventions may not be useful in achieving sustainable behaviour change.

Keywords: *stakeholders, involvement, consultation, relationship management, behaviour change.*

1. INTRODUCTION

Kisii County is one of the forty-seven counties in Kenya. The County shares common borders with Nyamira County to the North East, Narok County to the South and Homa Bay and Migori Counties to the West (COUNTY GOVERNMENT OF KISII, 2014). It covers a total area of 1 317.5 km2 and has nine constituencies namely: Kitutu Chache North, Kitutu Chache South, Nyaribari Masaba, Nyaribari Chache, Bomachoge Borabu, Bomachoge Chache, Bobasi, South Mugirango and Bonchari (COUNTY GOVERNMENT OF KISII, 2014).

The National AIDS Control Council (NACC) ranks Kisii County as 5th among 9 counties classified as high HIV incidence cluster (NATIONAL AIDS CONTROL COUNCIL, 2014; NATIONAL AIDS CONTROL COUNCIL, 2015). According to the Kenya HIV Estimates (2015), HIV prevalence in Kisii is lower than the national prevalence at 4.7%. The HIV prevalence among women is higher at 5.0% than that of men which is at 4.3%. A report published by the NACC entitled *The Kenya HIV County Profiles 2016* indicates that Kisii County contributed to 2.2% of the total number of people living with HIV in Kenya, and is ranked 11th nationally. By the end of 2015 a total of 34 014 people were living with HIV in the County, with 22% being young people aged 15-24 years and 6% being children under the age of 15 years. These statistics continue being high irrespective of the fact that interventions have been going on to reduce new infections. This study sought to find out how the stakeholders involved in the HIV and AIDS interventions in the county engage and relate and how these influences the outcomes of the

HIV and AIDS interventions in the county. In this process of engagement and relationship management, communication is central.

The World Health Organization (WORLD HEALTH ORGANIZATION, 2017) defines community engagement as a process of developing relationships that enable stakeholders to work together in addressing health-related issues and promoting well-being to achieve positive health outcomes. The appropriate implementation of community-clinical linkage models, such as community health workers, have been found to be effective in providing healthcare services to people with or at risk of chronic diseases in resource-limited settings (ROSENTHAL et al., 2010; LOHR et al., 2018).

NACC indicates that the major categories of stakeholders engaged in HIV and AIDS interventions in Kenya include international organizations, public sector, private sector, the civil society organizations, Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and Most at Risk Populations (MARPS) and the youth. NACC has a Stakeholder Coordination Division which coordinates key populations (KP), People Living with HIV (PLHIV), Faith Sector and Vulnerable and Marginalized Groups (VMGs).

2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Schiavo (SCHIAVO, 2014) observes that in public health and healthcare settings, stakeholders include patients, physicians and other health care providers, hospital employees, professional and advocacy groups, non-profit organizations, academia, health care-related companies, public health departments, the general public and policy makers, among others. Among the stakeholders involved in interventions against HIV and AIDS in Kisii County are the County Government of Kisii, national agencies involved in interventions against HIV and AIDS, all public and private hospitals, non-governmental organizations, civil society, educational and research institutions, faith-based organizations, and PLHIV and their support groups. With each of these stakeholders playing a distinct role, it is

only through effective communication that their relationships can be properly managed to ensure positive intervention outcomes. This study focused on the roles various stakeholders played in the interventions, how the stakeholders related with each other and the outcome of the interventions as a result of these relationships.

Schiavo (SCHIAVO, 2014) defines stakeholder relations as the process of convening, exchanging information, and establishing and maintaining strategic relationships with key stakeholders, communities, and organizations with the intent of identifying common goals that can contribute to the outcomes of a specific communication program or mission. In Kisii County, the various stakeholders involved in HIV and AIDS interventions have the common goal of reducing the HIV and AIDS infection rates and linking the infected to care and treatment.

Schiavo (SCHIAVO, 2014) observes that in many healthcare institutions such as private and public hospitals, stakeholder relations may be explained by looking at the stakeholder theory (FREEMAN, 1984). The theory was developed to describe the groups that should receive management attention. These include external as well as internal parties whose needs and wishes should be addressed as part of corporate decisions and initiatives. This understanding of the stakeholder theory was applied in the assessment of the stakeholders involved in HIV and AIDS interventions in Kisii County.

3. SUBJECTS AND METHOD

Study Design

Data was collected in April 2019 by the four authors as part of a project entitled 'A Situational Analysis of HIV and AIDS Intervention Measures in Kisii County.' All the study participants were purposively sampled from the stakeholders involved in HIV and AIDS interventions in Kisii County. They were sampled from among healthcare personnel, peer navigators, female sex workers (FSWs), men who have sex with men (MSM), educational and research institutions, members drawn from Constituency AIDS Control Committee (CACC) and County AIDS Coordinator (CASCO),

Community Health Extension Workers, Community Health Strategy Focal Person and a civil society group.

Hospitals provide the setting for engagement of all stakeholders in health interventions. Therefore, they were the primary site from which data was collected. According to the Kisii County HIV/AIDS Strategic Plan (KCHSAP), the County had 169 health facilities. Out of these, 127 were ART (Antiretroviral Treatment) sites (COUNTY GOVERNMENT OF KISII, 2014). From these ART sites, 14 high volume hospitals were purposively sampled representing each of the 9 constituencies in the county. These healthcare staff were purposively sampled from departments offering HIV Testing Services (HTS). The number of health care staff interviewed were 66 from all the hospitals sampled.

Data was collected using interviews, focus group discussions and textual analysis. Interviews were conducted with healthcare staff interviewed were clinicians, HTS Supervisors, nurses, psychosocial counsellors, data clerks, peer navigators, mother mentors, and volunteers. Other interviews were conducted with 6 staff from an HIV Control Unit of a public university. Interviews were also conducted with 2 CACC coordinators from 2 constituencies, the CASCO in the county, 1 Community Health Extension Worker, 1 Community Health Strategy Focal Person, and members of a civil society group who were purposively sampled because of the roles they played in the interventions. Focus group discussions were held with 7 FSWs who were sampled purposively from one hospital which had a programme with 808 FSWs, the highest number enrolled in any hospital in the county. The sampled FSWs were enrolled in the programme, they had embraced behaviour change, played a significant role in encouraging others to change their behaviours and they were willing to take part in the study. There was also 1 representative of MSM. Though the hospital had 40 MSM, only 1 was available and willing to take part in the study. Therefore, he was conveniently sampled. In total, 89 people participated in the study. Additional data was collected from documents such as the Kisii County HIV Strategic Plan, national policies on HIV and relevant reports.

Ethical considerations

In line with research guidelines and procedures in Kenya, relevant authorizations were obtained before the data collection process began. A research permit (Research Permit Number: NACOSTI/P/18/50245/24190) was obtained from the National Commission for Science, Technology and Innovation (NACOSTI). Ethical approval (Approval Number: CU/IERC/NCST/18/53) was obtained from an institutional ethical board. Authorizations were also obtained from the Kisii County Commissioner's office to conduct research in the County and from the County Director of Medical Services. All respondents were asked to sign the informed consent form before participating in the study.

4. FINDINGS AND DISCUSSION

The findings presented below explain how stakeholders identified, involved, engaged and consulted others in the management of the interventions and the influence these approaches had on the outcomes of the interventions. The stakeholders included PLHIV, FSWs, MSM, victims of GBV, the youth, and orphans.

Collaboration and coordination with international, national and constituency bodies and the local community in reaching out to the general population and PLHIV

The CASCO indicated that NACC and the National AIDS and STI Control Program (NASCOP) received 80% of their funding from donors. Technical working groups coordinated activities on HIV and AIDS in the county. NACC and NASCOP were in-charge of these activities.

The Ministry of Health (REPUBLIC OF KENYA MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY, 2013) through NACC collaborated with and coordinated donor agencies and CBOs in reaching the general population with messages meant to inform them about the spread of HIV and AIDS, those at risk, its prevention and symptoms, the need to visit health facilities for counselling, testing and linkage to treatment, the link between Gender Based Violence (GBV) and HIV/AIDS, and the fight against stigma. PLHIV were targeted to inform them about treatment and the benefits of adherence

to treatment, among others. Two strategies commonly used to reach the general population and PLHIV with these messages were posters hang on walls in all the hospitals sampled and public *barazas* (gatherings). All these posters were in English. None was in Kiswahili or the local language, Ekegusii. Therefore, the messages in the posters were not accessible to those whose proficiency in English was low.

Though there were radio and TV stations broadcasting in the local language which could have ensured wider reach and participation among the target audience, they were not deployed for information, communication and education. In addition, information was not available in Braille and sign language, thus excluding the blind and hard of hearing from HIV literacy. Messages on HIV and AIDS were developed by NACC and the donor agencies. Therefore, there was no collaboration with members of the local community in designing these messages, perhaps explaining why they were mainly in English. By not making HIV prevention messages accessible to those who are not proficient in English, the blind and hard of hearing, and by not using other commonly accessible channels of communication, those concerned with developing these messages were refusing to empower the majority of the residents of Kisii County with appropriate knowledge and involve them in the recommended behaviour change. Overall, based on the records obtained from the informants, the number of individuals reached with HIV prevention information in 2018 was 65 211, higher than 32 735 reached in 2017. This was much lower compared to the estimated population of 1 236 966 in Kisii County (COUNTY GOVERNMENT OF KISII, 2014).

As hospitals sought to reach people for ART and HTS services, there were stakeholders who were unwilling to seek these services because of stigma or lack of bus fare. Four strategies were commonly used to reach these stakeholders. They included moonlight testing which was done at night when people could not see those going for tests. One hospital and an AIDS Control Unit of a university were using it. The next strategy was Partner Notification Service (PNS) where a client who had been tested and found to be infected with HIV and AIDS was persuaded to give the

mobile phone number of his/her sexual partner or partners who were then contacted by personnel in the PSC for arrangements on counselling, testing and linkage to treatment. These clients were therefore collaborating with health care staff in reaching those who had not been tested and linking them to treatment. All the hospitals sampled used PNS.

Data obtained indicated that the PNS strategy was successful in only one hospital in the county. In all the hospitals sampled, informants said there were inadequate funds for the strategy as personnel were not given airtime and transport. Other limitations associated with PNS included personnel being challenged and their requests rebuffed by angry recipients of their calls; some people being unwilling to share the contacts of their sexual partners for fear of violence; some partners claiming to be far from the health facility where they were being called from and married female clients refusing to share the contacts of their partners in order to protect their marriages.

The third approach was family testing which involved health care staff visiting selected homes to offer HTS services. The challenge associated with this strategy was that some people did not want HTS staff to be seen visiting their homes. One informant said, 'Members of a family can leave their homes when they see HTS personnel coming.'

The final strategy was using volunteers. Three health facilities had volunteers who played a major role in convincing PLHIV, particularly men, to be linked to treatment. These volunteers were trained on the services they were meant to offer. In one of the hospitals, Community Health Volunteers (CHVs) were being used to support orphans living with HIV in adhering to treatment. CHVs also did testing and counselling during their outreach missions.

At the constituency level, there was the CACC which was meant to coordinate HIV and AIDS activities within the county. These activities included fighting stigma, funding CBOs, visiting groups carrying out HIV and AIDS activities and receiving proposals for funding from these groups. Though NACC was supposed to fund CACC, they had not done so in 2018. They had also not done capacity building of CACC committee members in the constituencies

sampled. As a result, CACC was unable to carry out its mandate and HIV activities carried out by CBOs had stalled.

In all the hospitals sampled, the informants indicated that there was coordination between different departments offering HTS. The coordination ensured that patients were effectively attended to and records from different sections reconciled. However, Ministry of Health personnel in two of the hospitals sampled were said to be discriminating against medical personnel employed by the donor. They also did not attend to HIV and AIDS clients.

Hospitals collaborated with a CBO in identifying and targeting defaulters, youths, TB patients and the general population. The CBO obtained the names from the registers in hospitals and followed them to the community. They also did family testing.

Strategic Management and Partnership with PLHIV

Strategic management of PLHIV included cultivating a culture of inclusivity as a way of fighting stigma against HIV and AIDS. In one hospital, all members of staff, health care and subordinate, had been trained to treat PLHIV with dignity. This had increased the uptake rates of HIV and AIDS services. Table 1 below shows the number of PLHIV surviving and retained on ART in the county from 2014 to 2018.

Table 1. PLHIV Surviving and Retained on ART

YEAR	ART NET COHORT AT 12 MONTHS SURVIVAL AND RETENTION ON ART
2014	13352
2015	5215
2016	4817
2017	5781
2018	2526

The other area in which integration and inclusivity were embraced was in dispensing drugs to PLHIV. Eleven of the hospitals sampled issued drugs to PLHIV from the same pharmacy where they served patients suffering from other health problems, thus promoting confidence among PLHIV as well as acceptance among other patients. Initially, HIV and AIDS drugs in these hospitals were issued at the Patient Support Centre (PSC), a room meant for PLHIV. However, three of the sampled hospitals still served PLHIV in separate pharmacies from those used to serve other patients. In one of these hospitals, PLHIV were given drugs from the backdoor of the pharmacy while patients suffering from other health problems were served from the front door. In the same hospital, the informants reported that PLHIV did not like lining up to be served with other patients for fear of their prescriptions being seen.

Informants from all the hospitals sampled reported facing the challenge of defaulting among patients, with the majority being men. This finding is in agreement with Sharma, Barnabas and Celum (SHARMA et al., 2017) who observe that men in sub-Saharan Africa are less likely than women to engage in HIV services across the care cascade. Similarly, the observation that health care facilities have achieved limited HIV testing and treatment coverage in men (SHARMA et al., 2017), is supported by the feedback obtained from all the informants who participated in the study. Among the barriers that inform this situation include confidentiality concerns, inconvenient hours, perceptions that facilities provide women-centred services and that seeking health care compromises masculinity. To address this, Sharma, Barnabas & Celum argue that community-based interventions should be tailored to the needs of men to maximize uptake, including flexible hours, multiple follow-up visits, and convenient and private access to care (SHARMA et al., 2017).

Several reasons for defaulting on treatment were given. In one hospital, it was found that patients defaulted due to lack of reminders. The commonest reason for defaulting was that some clients travelled from far and therefore lacked bus fare. Some new clients were also said to be giving false contact information. Other reasons were some clients not wanting their status to be known by their families and some refusing to take drugs in different colours and bearing different names from the ones they were familiar with. One communication strategy used to reduce defaulting in all hospitals was usage of

Client Locator Forms where PLHIV provided key information about themselves including their full name, mobile phone number, and village, the names and phone numbers of the closest friend, the area chief, one's church and pastor, and a sketch map. Thus, there was community involvement in ensuring PLHIV did not default on treatment.

The second communication strategy used in all the hospitals sampled was making phone calls to clients who had not turned up to pick medicine on their assigned days. Those who were not reached through phone calls were traced to their homes using the locator form. In instances where a client said they had enrolled for treatment in another health facility, a phone call was also made to that facility for confirmation. Thirdly, informants in five hospitals said that health talks, in which adherence was emphasized, were given to PLHIV during every visit. Topics for these health talks were either suggested by health care staff or patients. Lastly, in one hospital HIV patients received short text messages to remind them to go for medication. Other approaches used to reduce defaulting among PLHIV were support groups, adherence counselling during every hospital visit, family members living with HIV picking medicine for each other, explaining the reason for different drug names and colours, giving inmates living with HIV a bigger share of food and milk daily, threatening some defaulters with abandonment and rewarding adolescents whose viral load had been high but later stabilised. All these strategies were found to be effective as the majority of defaulters were traced and linked back to care. A reporting tool provided indicated that out of 105 ART defaulters, 93 had been traced and linked back to care in 2017. In 2018, the defaulters were 147, and those who were traced and linked back to care were 138.

To promote linkage and adherence to treatment among PLHIV, hospitals in collaboration with donor agencies recruited peer navigators, mother mentors, father mentors and adolescent mentors from among their patients and engaged them in the interventions. Engagement of and partnering with the most adherent among PLHIV in HIV and AIDS interventions was meant to enhance ownership of the interventions among the targeted group. Those who were recruited used interpersonal and group communication approaches to reach their target audience. To be a peer navigator, one had to adhere to treatment, their viral load had to be low, they had to be literate, without stigma against HIV and AIDS, confident and willing to share their experiences with others. All the hospitals sampled had peer navigators, mother mentors and adolescent mentors, all recruited and trained by previous donors. None had a father mentor. They were all given a stipend by the donor. Because they were also living with HIV, peer navigators, mother mentors and adolescent mentors commanded trust and wielded influence as agents of positive behaviour change because of involvement of PLHIV. This trust was further strengthened by shared demographic features such as gender, age, and cultural background.

An informant in one hospital reported that, ''Peer navigators follow up those under them who have defaulted. They also do home visits to check the social life of a client. During the home visits, they are accompanied by a psychosocial counsellor. The peer navigators are answerable to the Ministry of Health and the donor.''

Mother mentors were women who contracted HIV and AIDS and they had children born after. These women underwent training for two weeks. Their babies were not HIV+. They were trained on how to adhere to treatment while breastfeeding to avoid infecting their babies. In seven of the hospitals sampled, there were adolescent mentors who were recruited to reach out to and counsel adolescents living with HIV and AIDS.

Peer navigators have been used in several health programs, to either encourage adherence to healthy lifestyles, treatment, and overcoming stigma, among others. These include physical health care (BOCKING et al., 2017), and mental health (KELLY et al., 2014; LLOYD-EVANS et al., 2014; WROBLESKI et al., 2015). Though it is acknowledged that there is widespread support for peer roles in mental health services, the evidence linking this intervention to improved health outcomes has not yet been clearly established (LLOYD-EVANS et al., 2014; WROBLESKI et al., 2015). Bocking (BOCKING et al., 2017) argue that peer workers can contribute

immensely to health service delivery. Whereas using peer navigators was a creative strategy of managing an important stakeholder, it faced several challenges. First, no hospital had a strategy to increase linkage to treatment and adherence among men. The majority of the peer navigators were female. Secondly, informants from all the hospitals sampled observed that there were no motivational strategies for peer navigators and mother mentors. They were paid so little which hampered their roles. In addition, the peer navigators and mother mentors did not have formal contracts with their employers, certificates of recognition, uniforms or badges to identify them. This lowered their morale and affected their effectiveness. Other challenges faced by the peer navigators, mother mentors and adolescent mentors in the HIV and AIDS interventions in Kisii County were similar to those identified in a study conducted by Kemp & Henderson (KEMP & HENDERSON, 2012) among peer service workers (PSWs). These included (1) a lack of clarity in the roles for peers and employers, (2) excessive workload expectations, (3) a lack of supervision, and (4) concerns involving self-disclosure. For better outcomes in the use of peer navigators, mother mentors, adolescent peers and peer educators in HIV interventions, healthcare providers need to adopt the following best practices: design and implement a structured and well-defined system that supports peer navigators in the HIV care team, identify a specific population to be served by peers, establish a standardized title and position for the peer navigator within the integrated care team, establish protocols and procedures for peer navigation programs, train agency staff and the HIV care team, implement a system of open communication and co-ordination with other care team members, implement a competency-based training for peer navigators and supervisors, provide consistent administrative and clinical supervision to peers, and create a documentation system to describe and monitor peer-client activities (AIDS UNITED, 2015).

There was no evidence that hospitals in Kisii County had implemented a competency-based training for peer navigators, mother mentors, adolescent peers and peer educators. There was also no evidence of their supervision and a system of describing and monitoring peer-client activities linked to case management. Faulkner & Kalathil and Gruhl et al. (FAULKNER & KALATHIL, 2012; GRUHL et al., 2016) advocated for training, supervision and support for peer workers employed in health services. The training will give them relevant knowledge and skills which will motivate them, enhance their credibility, and ensure better individual outputs and intervention outcomes. These knowledge and skills include a clear understanding of the healthcare system, HIV/AIDS literacy, counselling, appropriate communication skills, confidentiality, computer literacy and record keeping. The training should also cover their roles and be made a policy to ensure standardization.

All the hospitals sampled used support groups to increase adherence to treatment among PLHIV. Interpersonal and group communication approaches were used to enable support group members to share experiences and encourage each other. A support group had between 12-30 members, majority of whom were reported to be women. In some hospitals, support groups were based on members' viral loads or the regions members came from. Adolescents, children and mothers had their own support groups. In four hospitals, orphans shared a support group with adolescents. There were also support groups of mixed gender, for couples, discordant and stable HIV and AIDS clients. Leadership of the support groups was majorly left to the members, just like the choice of topics for discussion. However, in one hospital, support groups were led by trained CHVs and sometimes the health care staff picked topics for discussion. Support group members were booked for clinics on the same day in all the hospitals sampled. While in some hospitals support groups met once a month, in one they met after 3 months and in another, they met every Friday. In six of the hospitals, the support groups of adolescents were booked on their own day during weekends to avoid disrupting school.

In all the hospitals, informants reported that when HIV and AIDS programmes were being run by the previous donor, many support group members used to attend meetings. They were being given incentives such as milk, bread and

bus-fare. Another previous donor used to motivate support groups through sponsoring ball games, and organizing seminars and outreach activities. However, the current donor withdrew these incentives. Consequently, most members did not attend support group meetings. Though support groups had empowered members with knowledge on HIV and AIDS, and encouraged consultation, co-ordination and involvement in promoting adherence to treatment and overcoming stigma, these achievements were being eroded by lack of motivation.

Targeting and Involving Key Populations in the Interventions

The Kisii County HIV-AIDS Strategic Plan lists the following groups as key populations: FSWs, sugarcane cutters and sellers, soapstone carvers, adolescents and young women (COUNTY GOVERNMENT OF KISII, 2014). However, the data obtained indicated that the only groups targeted in ongoing interventions were FSWs and the adolescents. Six hospitals had programmes targeting FSWs, a key stakeholder in the war against HIV and AIDS. Out of the six, one had enrolled 808 FSWs and 40 MSM in the programme by the year 2018. This was the highest number enrolled in the county's hospitals and it is the one from which data was collected.

In this hospital, the FSWs were identified from bars, also called *hot spots*. Others were recruited to the programme through mobilizational meetings and moonlight testing. During the meetings, recruits were given health talks on HIV and AIDS, food and bus-fare. FSWs joined the programme to receive education, share information and adopt safer sexual behaviours. The programme integrated screening for cervical cancer, training on condom and lubricant use, handling instances of GBV, overcoming drug and alcohol abuse and thinking beyond sex work. The FSWs who had been enrolled in the programme were engaged in persuading their colleagues to go for testing, counselling and linkage to treatment. They also led health care staff to the *hot spots* from where more could be recruited into the programme.

Since the sex workers operated more often from bars and hotels, the hospital partnered with bar owners and bar managers, for easy reach and recruitment into the programme. They formed a committee of bar and hotel owners to do this. Only two other hospitals with programmes for FSWs involved bar owners in the interventions. The bar owners were involved in persuading FSWs operating from their bars to get tested and linked to treatment if they were HIV+. The bar owners also allowed health care personnel to do testing and counselling for the FSWs in the bars.

The police were also involved in persuading FSWs to join the programme as they did their patrols at night and they could identify them. One of the notable partnerships between the police and FSWs was identifying underage girls engaging in commercial sex, dissuading them from the trade and taking legal action against the men found engaging or planning to engage in sex with the girls. Legal action was also taken against the bar owners who allowed underage girls to engage in commercial sex in their premises.

All the FSWs who participated in the study indicated a reduction in the amount of alcohol they took, the number of sex partners they had, the frequency of commercial sex, use of protection during sex and use of Pre-Exposure Prophylaxis (PrEP). Behaviour change among MSM included stopping drug abuse, using condoms and being economically empowered. Some FSWs and MSM with the right attitude towards behaviour change were identified and trained as peer educators.

In another hospital, PrEP and ARVs were taken to the bars to win back FSWs who had stopped going to the hospital. This led to an increase in the number of FSWs linked to treatment.

One of the challenges cited by health care staff regarding FSWs' programmes was the high defaulter rates. In one of the hospitals, staff observed, "When the facility was started, it had 32 FSWs. The active ones dropped to 5. Some migrated due to lack of a proper defaulter tracking mechanism." In another hospital, an informant disclosed that, "FSWs keep on moving and do not take drugs consistently. When they are called, they say they have transferred to different hospitals. They give false names and phone numbers and they do not produce their identification documents when tested. They also do not disclose their partners."

The Kenya Fast Track Plan to End HIV and AIDS among Adolescents and Young People, 2015 estimated that Kisii County had 13 079 adolescents aged 15-24 years living with HIV, while approximately 5 012 did not know their HIV status and could have been contributing to the new infections in that age group. To respond appropriately to this HIV burden, four of the hospitals sampled established Youth Friendly Centres meant to appeal to the youth and increase the number accessing HTS services. However, the four Youth Friendly Centres were not operational because the youths recruited were few, there were no funds and no trained personnel on youth issues. Therefore, the youth as stakeholders in the Kisii County HIV interventions were not effectively managed.

Another key stakeholder not integrated into the HIV and AIDS interventions in Kisii County were orphans living with HIV. One hospital linked these orphans with adults of similar HIV status from the same neighbourhood to mentor them in adherence to treatment. In another hospital, there was a civil society group that helped to meet the needs of these orphans and vulnerable children living with HIV. In the third hospital, an orphan living with HIV and who adhered to treatment was tasked with mentoring other orphans and youth living with HIV to adhere to treatment. In all the hospitals sampled, taking care of orphans living with HIV was considered a challenge because of the difficulties in monitoring change of caregivers. The caregivers did not report consistently on the orphans' whereabouts and adherence to treatment.

Collaboration against GBV

Though informants in all the hospitals indicated receiving cases of Gender Based Violence (GBV), they explained that the hospitals did not get funding to promote awareness. Only one hospital had well-structured GBV services. The informant reported that personnel in the unit received invitations to speak in schools at individual level. Therefore, there was no formal collaboration or coordination with schools to take messages on GBV there for the benefit of vulnerable children. Members of the unit also visited at least 4 churches in a month to speak to congregations on GBV. Similarly, these visits were not organized by the unit but by other departments focusing on other health topics. The unit shared data with NASCOP and NACC. They also made presentations in County HIV and AIDS forums once a month.

In all the hospitals, victims of GBV were tested for HIV and AIDS, counselled, and advised to pursue legal action. In one hospital, the GBV Unit had a clinician. Once victims reported to the hospital, they were accompanied by a member of staff at every stage of the processes they underwent to ensure they did not give up. The clinician appeared in court to give evidence. In the AIDS Control Unit of the university sampled, there was collaboration with the Medical Department, the Gender Institute, and the Security Department all within the university, and the police in handling cases of GBV. This ensured that sexually abused students were put on ART early enough and they obtained justice. The reporting tool provided indicated that in 2017, the number of GBV survivors provided with psychosocial or health services were 134 while those who were provided with legal services were 140. In 2018 those who were provided with psychosocial services were 8 while those provided with legal services were 76. In spite of this, informants from all hospitals reported that since most GBV incidences were committed by relatives, few victims pursued legal action. Besides, many victims lacked knowledge on preservation of evidence of sexual abuse while others gave up because of frustrations in the legal framework, such as tampering with evidence or delays in hearing cases. Generally, the entire population had not been empowered in fighting GBV yet it was an essential component in the interventions against HIV and AIDS.

Collaboration with educational institutions

Schools are a key stakeholder in HIV interventions as they provide an ideal setting where stigma can be effectively fought and behaviour change taught before being transferred to the community. Informants in all the hospitals sampled observed that high levels of stigma made some of the pupils with HIV not to take drugs while in school as that made their status public. Two strategies were adopted by different

hospitals to collaborate with schools in handling the needs of pupils with HIV and AIDS. First, parents of children living with HIV were advised to disclose their children's HIV status to one teacher who could keep and be issuing the pupil with the prescribed drugs and be encouraging them. An informant from one hospital explained, 'For some pupils, both parents and teachers know they are HIV+. For others, only the parents know.' Second, two hospitals partnered with schools to conduct health talks to promote awareness on HIV and AIDS, and carry out testing and counselling. The previous donor supported this programme by training teachers on issues such as ensuring patient confidentiality. In all the hospitals sampled, meetings for schoolchildren living with HIV were organized on Saturdays, Wednesdays or during the holidays. An informant in one hospital observed that though pupils living with HIV were given permission from school to visit the hospital, there was no formal collaboration between the hospital and schools for efficient co-ordination of HIV programmes. This was attributed to shortage of personnel and funds.

Overall, schools in Kisii County were playing a very peripheral role in interventions against HIV and AIDS. Data gathered indicated that secondary and primary schools did not have any regular and structured roles in the interventions. Yet, the Education Sector Policy on HIV and AIDS (EDUCATION SECTOR POLICY ON HIV AND AIDS, 2013) seeks to among others address the needs of learners living with HIV; provide a safe non-discriminatory learning environment and ensure HIV and AIDS education is mainstreamed at all levels.

Among the eight higher educational institutions sampled, only one university had an AIDS Control Unit which collaborated with hospitals. The AIDS Control Unit offered HTS services to students, staff and members of the neighbouring community. It employed several approaches to create awareness and to link those infected to treatment. First, new students underwent orientation on issues regarding HIV and AIDS. Second, the Unit had a programme for peer educators in which interested students were trained using the National Organization for Peer Educators Curriculum. The peer educators

educated other students on HIV and AIDS and distributed condoms. Thirdly, the Unit engaged in outreaches in surrounding communities during the chiefs' public meetings. Besides, they held workshops, seminars and participated in raising public awareness during the World AIDS Day. Fourthly, the Unit collaborated with medical officers serving in facilities selected by students living with HIV to ensure they continued with treatment during vacations. The Control Unit reported to NACC and a designated hospital on a monthly basis. These reports were useful in obtaining accurate data on HIV and AIDS in the University and its surrounding areas. By linking PLHIV to hospitals, the Unit helped to increase the number on treatment in the County.

Challenges facing effective partnership with health care staff

Health care workers are a very important stakeholder in HIV and AIDS interventions as they provide a link between PLHIV, key populations and the County Government and implementing partners. Health care workers involved in HTS and ART services reported facing a number of challenges that affected their performance and therefore the outcomes of the interventions. These challenges emanated from their relationship with international NGOs that were running the interventions.

The international NGOs were referred to as donors or implementing partners. All the 14 hospitals sampled had at least one international NGO supporting HIV and AIDS programmes through employing health care staff, and supplying HIV commodities such as ARVs, PrEP, lubricants, and condoms. Their involvement was related to the county HIV priority areas, which included: preventing new infections; strengthening health and community systems; strategic information management; scaling up treatment, and care and research (COUNTY GOVERNMENT OF KISII, 2014). According to NACC (NATIONAL AIDS CONTROL COUNCIL, 2016[a]; NATIONAL AIDS CONTROL COUNCIL, 2016[b]), there were more than 6 NGOs involved in HIV and AIDS interventions in Kisii County. Out of these, one leading NGO was reported to be running activities in 109 of the 127 ART sites in the County.

All the health care staff in the hospitals sampled reported that the donor did not consult their staff in health facilities before making critical decisions such as termination of contracts. As a result, informants in all the health facilities sampled observed that some HIV and AIDS services were collapsing due to unilateral termination of staff contracts. For instance, one informant reported that there was a shortage of human resource after the contracts of 11 nurses, 6 clinical officers and 23 counsellors, all of them well-trained and experienced, were terminated in 2018. The officer in-charge in one hospital reported that he learnt from his colleagues that the contracts of 3 of their colleagues had been terminated. One of them was a nurse whose performance appraisal was very good. The in-charge complained that there was no consultation with the donor on the performance of staff. This had led to frustrations and low morale.

Additionally, informants complained that personnel employed by different donors in the sampled health facilities were paid varied salaries and the supervision criteria was not the same. In one hospital an informant reported that a donor employed staff on three-year contracts, without leave. These practices were deemed to be exploitative. Furthermore, health care staff complained that the reports they submitted to the current donor weekly or monthly were repetitive and laborious.

Though these donor actions were affecting the interventions negatively and should have been addressed urgently, the informants reported that they lacked a forum to air their grievances. Lack of communication with stakeholders creates poor stakeholder relationships and raises ethical concerns (LONGEST, 2014).

5. CONCLUSIONS

Strategies employed in targeting, engaging and partnering with key stakeholders such as PLHIV and FSWs, in selected hospitals had the potential to increase the number of those being tested for HIV and AIDS, linked to and retained in care and treatment. However, they were not given adequate attention in terms of planning and resource allocation to ensure sustainability. Peer navigators, mother mentors, volunteers and support groups

had been neglected and the activities and initiatives they engaged in abandoned. Furthermore, there were no specific, harmonized and coordinated strategies targeting the general population, men living with HIV, victims of GBV and orphans. Coupled with poor relationship management between health care workers and donors, all these challenges may have been due to over-reliance on donor funding for HIV and AIDS interventions and the inability to align donor objectives, interests and resources to the needs and objectives of the other stakeholders. Therefore, the interventions may not achieve sustainable positive behaviour change.

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