

# COMMUNICATION STRATEGIES IN THE MANAGEMENT OF HIV AND AIDS IN KISII COUNTY, KENYA: SUCCESSES AND GAPS

Augustus ONCHARI NYAKUNDI<sup>1</sup>, Geoffrey MOKUA MAROKO<sup>2</sup>,  
Gladys NYAMOITA MOKUA<sup>3</sup>, Meshack ONDORA ONYAMBU<sup>3</sup>

<sup>1</sup>Lecturer, Chuka University, Kenya

<sup>2</sup>Associate Professor, Machakos University, Kenya

<sup>3</sup>Lecturer, Kenyatta University, Kenya

Corresponding author: Augustus Onchari Nyakundi; e-mail: augustusosoro@gmail.com

## Abstract

Although interventions on HIV and AIDS in Kisii County have been ongoing for over ten years, the County's infection rates are among the highest in Kenya. The purpose of this paper is to describe stakeholder communication strategies and tools in the management of HIV and AIDS interventions in the County. A sample of 73 informants drawn from 16 selected hospitals in the County was identified. The sample included, sex workers, officials of units affiliated to the National AIDS Control Council (NACC), and one Community Based Organisation (CBO). Data was collected using interviews, analysis of communication documents used to put to effect HIV and AIDS intervention. Further, an analysis of the websites of selected stakeholders was done to elicit their communication strategies. Findings revealed that interpersonal communication strategies used by peer navigators, mentor mothers and among People Living with HIV (PLHIV) were the most effective in the interventions against HIV and AIDS in the County. Mobilization was also found to be effective in targeting sex workers and Men who have sex with men (MSM). It emerged that the audiences targeted by the communication strategies were PLHIV and sex workers. The general population, men, the youth and other key populations were not effectively targeted. The study concludes that the communication strategies, as packaged, may not be effective in bringing about significant behaviour change among vulnerable populations. The paper recommends tailor-made communication strategies targeting specific groups for improved outcomes.

**Keywords:** *HIV and AIDS interventions, communication strategies, tools, outcomes.*

## 1. INTRODUCTION

Kisii County is one of the forty-seven counties in Kenya. According to the Kisii County HIV/AIDS Strategic Plan 2014/15-2018/19, 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). The strategic plan indicates that the County covers a total area of 1,317.5 km<sup>2</sup> and is divided into nine constituencies which double as sub-counties 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 County has an estimated population of 1,236,966 (COUNTY GOVERNMENT OF KISII, 2014). Of these, 597,934 are male while 639,032 are female. According to a Ministry of Health Report entitled "Kenya HIV Prevention Revolution Road Map" (MoH, 2014a), Kisii County has a HIV prevalence of 8.0%. The report estimated that 63,715 people live with HIV with prevalence among women being higher at 8.5% than that of men at 7.3% (MOH, 2014b). Annual new infections stood at 5,976 (BERKLEY-PATTON et al., 2009).

The Kisii County Strategic Plan 2014/15-16/17 explains that the provision of HIV services in the County started in the year 2000 at the Kisii District Hospital, now known as the Kisii Teaching and Referral Hospital (COUNTY GOVERNMENT OF KISII, 2014). Then, the facility carried out voluntary counselling and testing. However, minimal counselling was done and the results were not being disclosed to the clients. The programme was supported by National AIDS and STI Control Programme (NASCOP) and Liverpool VCT. Later, with increased support from partners through the Ministry of Health (MoH), these services were scaled up to higher volume health facilities.

Currently, 80% of the facilities are offering ART services (COUNTY GOVERNMENT OF KISII, 2014).

There are several stakeholders involved in HIV and AIDS interventions in Kisii County. Among those indicated in the County's HIV and AIDS Strategic Plan 2014/15-2018/19 we find the Kisii County Government, the Ministry of Health (MoH), Ministry of Education (MoE), National AIDS Control Council (NACC), National AIDS & STI Control Programme (NASCOP), County HIV Committees (CHAC), Sub-county AIDS and STI Coordinator (SASCOS), Joint United Nations Programme on HIV & AIDS (UNAIDS), Care Kenya, Kisii University, Community-based Organizations (CBOs), Faith-based Organizations (FBOs), People Living with HIV (PLHIV), Key Populations and vulnerable groups, Men having Sex with Men (MSM), People Who Inject Drugs (PWIDs), orphans and the youth (COUNTY GOVERNMENT OF KISII, 2014). Other stakeholders not included in the County's HIV and AIDS strategic plan are the University of Maryland, the Health Strat, and the AIDS Healthcare Foundation (AHF).

For better outcomes in HIV and AIDS actions, the adopted communication strategies and tools need to be effective. There is little evidence of any research that evaluates the communication strategies employed by implementing partners in their HIV and AIDS interventions in Kenya and the outcomes of those interventions. To plug this void, this paper sought to establish the communication strategies stakeholders used in HIV and AIDS interventions in Kisii County.

## **2. LITERATURE REVIEW**

---

According to NATIONAL AIDS CONTROL COUNCIL (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 at 4.3%. A report published by the National AIDS Control Council indicates that Kisii County contributed to 2.2% of the total number of people living with HIV in Kenya, and is ranked eleventh nationally (NATIONAL AIDS CONTROL COUNCIL, 2016). The report indicates that by the end of 2015, a total number

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.

The MoH (2018) indicates that in 2017 Kisii County was among the counties with the highest HIV prevalence at 4.4% while the national prevalence was at 4.9% (MOH, 2018). In spite of the drop in 2017 compared to 2015, these statistics continue to be higher than in some other counties. It is therefore important to find out the communication strategies and tools different stakeholders used and their influence on the outcomes of the HIV and AIDS interventions in the county.

SCHIAVO (2014) observes that in health care settings, stakeholders include patients, physicians and other health care providers, hospital employees, professional and advocacy groups, non-profit organizations, academia, the general public and policy makers, among others. The stakeholders involved in HIV and AIDS interventions in Kisii County are drawn from similar categories. This study focused on how the various stakeholders communicated their interventions.

Most health communication interventions employ a variety of communication strategies to meet their objectives. These may be related to electronic media, print media, social media, community outreach channels, and interpersonal communication. A combination of several strategies is more beneficial than a single one because it maximizes on the strengths of each. In fact, BERTRAND ET AL., (2012) state that combining mass media with interpersonal communication or other communication activities increases the chances of better health communication intervention outcomes.

## **3. THEORETICAL FRAMEWORK**

---

This study used the social marketing theory whose ultimate goal is the behavioural change (SCHIAVO, 2014). Key features of the theory were used in analysing the communication strategies used in the HIV and AIDS interventions in Kisii County (BARAN & DAVIS, 2009). The features are methods for: inducing audience

awareness of campaign topics by using the most popular communication channels in order to reach population segments which are difficult to reach; targeting messages at specific audience segments which are most likely to be receptive or susceptible to them; reinforcing messages within targeted segments and encouraging them to influence others through face-to-face communication; cultivating images and impressions of people, products or services; stimulating interest and inducing information; inducing desired decision making or positioning; and activating audience segments, especially those targeted by the campaign (BARAN & DAVIS, 2009; BOCKING et al., 2018).

SCHIAVO (2014) observes that one of the key contributions of social marketing to the field of health communication is a systematic people-centred and market-driven approach to program research. She adds that social marketing techniques and tools are particularly helpful in developing key group profiles, situation analyses, and defining the health problem and potential solutions. Another contribution is related to the importance of cost effectiveness and competitive analyses which help develop a desirable product, likely to be adopted and to fit people's lifestyle, beliefs, and needs (SCHIAVO, 2014). Finally, social marketing strategies have been shown to help raise disease and risk awareness as well as to contribute to the achievement of behavioural and social results among different groups and populations (SCHIAVO, 2014). These strengths make the theory relevant to this study.

## 4.METHODOLOGY

### 4.1 Sample

Data was collected purposively from health facilities in Kisii County. Health facilities in Kenya are classified as Level 2, 3, 4, 5 and 6 depending on the services they offer (MoH, 2014). Level 1 facilities offer community health services, Levels 2 & 3 are primary care facilities that include dispensaries, clinics, health centres and maternity homes. Level 4 & 5 are county referral health facilities while Level 6 are national referral health facilities that provide specialized health care

services such as hospitals, laboratories, blood banks and research institutions (MoH, 2014).

According to the COUNTY GOVERNMENT OF KISII (2018), there is one Level Five hospital; fourteen Level Four; twenty-eight Level Three; ninety-one Level Two, and twenty-four clinics spread across the nine Sub-Counties in the County. The facilities from which data was collected were selected purposively from each sub-county based on their level. Higher level facilities were given priority in each sub-county in the hope that they would be data rich with regard to communication strategies and tools. Therefore, a total number of 16 health facilities were selected from all the sub-counties. Seventy-three health care providers in HIV and AIDS responses were selected purposively from the 16 hospitals sampled. Also sampled purposefully was a representative from each of the regional office of the National AIDS Control Council (NACC), Constituency AIDS Control Committee (CACC), Constituency AIDS and STI Coordinator (CASCO), Community Health Strategists, Sub-County Community Health Strategy Focal Persons and a Community Based Organizations (CBO).

### 4.2 Data collection and analysis

To gather the primary data for this study, the 73 respondents were interviewed by a team of 4 researchers using a common pre-developed interview guide. To complement interview data, secondary data was collected from the websites of the organizations involved in HIV and AIDS interventions in Kisii County, posters communicating HIV and AIDS messages and charts displayed in the health facilities. Data collected was analysed thematically following qualitative approaches.

### 4.3 Ethical considerations

In line with guidelines and procedures guiding research 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.

## 5. FINDINGS AND DISCUSSION

---

Hospitals provide the setting for engagement of all stakeholders in the HIV and AIDS interventions in Kisii County. The data collected and presented below describes the various stakeholders, their communication strategies and influence on the outcomes of the interventions.

### 5.1. Meetings and Public Gatherings (*Barazas*)

Various stakeholders were reported to be using meetings to convey messages on HIV and AIDS. Among these, there were county government officials who held meetings with officials from the Ministry of Health (MoE), national agencies involved in the fight against HIV and AIDS, representatives of implementing partners, representatives of CBOs and FBOs. Implementing partners also held meetings with the health care personnel to discuss their interventions, targets and the achievements or challenges they were facing. They also held meetings with groups of patients especially during support group meetings. Health care personnel held meetings amongst themselves to discuss their targets in regard to HIV and AIDS, the interventions they had put in place in the facility, the achievements they had made, the challenges they were facing, and to review their patients, among others. In addition, healthcare personnel held meetings with clients to counsel them either before or after testing.

Other meetings were held by clients. For instance, monthly in-service meetings were conducted by NASCOP for Community Health Volunteers (CHVs). Informants in all the 16 health facilities sampled indicated that the partner periodically held meetings for purposes of training healthcare staff involved in HIV and AIDS activities. One-on-one meetings were conducted between the HIV Testing and Counselling Services (HTS) personnel and the

clients for testing, counselling and linking the client to treatment. They were also conducted regularly to encourage adherence when a client's viral load was found to be consistently high. In one hospital, informants reported that they held one-on-one meetings every time a patient came to pick drugs. They used these meetings to explain the colour of drugs to avoid defaulting.

Informants in three hospitals reported that they held meetings with sex workers. In one health facility sampled, a HTS Counsellor Supervisor reported:

'The previous partner conducted regular meetings with sex workers in local hotels. The sex workers were given health talks during these meetings. To encourage them to attend the meetings, the partner gave them food and bus-fare.'

Informants from the AIDS Control Units of the University and the medical training institution sampled indicated that meetings were held with new students to sensitize them on HIV and AIDS. In these meetings, students were encouraged to go for HTS.

The two CACC informants interviewed reported that CACC meetings were supposed to be conducted quarterly, but due to lack of funds, this did not happen. They observed that CACC was not known because it lacked the funding for activities. CACC was supposed to work with area chiefs and the County Commissioner's office in interventions against HIV and AIDS. Both informants reported that they had not held any meeting with any stakeholder to discuss HIV and AIDS interventions.

Meetings among PLHIV relied on interpersonal and group communication. The meetings were conducted by mentor mothers, adolescent mentors and peer navigators, and by support groups.

Mentor mothers, adolescent mentors and peer navigators were recruited from among clients who had adhered to treatment, maintained a low viral load, had accepted their status, were willing to share their experiences on HIV and AIDS and were literate. Based on the care and training they had received, mentor mothers gave birth to

babies who were HIV negative. The mentor mothers, adolescent mentors and peer navigators shared their experiences with others living with HIV in order to encourage them to adhere to treatment, live healthy lives, and overcome stigma. Additionally, the mentor mothers advised other mothers living with HIV on how to ensure their breastfeeding babies did not contract HIV. The mentor mothers and peer navigators were paid by the current partner. All the hospitals sampled had mentor mothers, adolescent mentors and peer navigators.

In all the facilities sampled, informants reported that support group members held meetings to discuss selected health topics affecting them, encouraging new members to adhere to clinical recommendations and supporting each other to live healthy lives. Hospitals used support groups to fight stigma and promote linkage and adherence. In one hospital, an informant reported that a clinical officer was always present during support group meetings.

The membership of these support groups constituted between 12-20 clients who had been tested for HIV and AIDS and found to be positive. Support group members were of the same gender, age or region. Informants indicated that support groups were started by a previous partner. It was also observed that the majority of support group members were female.

Informants reported that when this initiative was constituted, members of support groups used to be given bus fare, milk and bread whenever they held meetings. This encouraged them to attend the meetings. Among other activities, the previous donor was also reported to have used the support groups in seminars and outreach programmes. In spite of the effectiveness of these support groups in promoting adherence to treatment in all the hospitals sampled, informants reported that the current donor was not supporting them. One informant added, 'Sometimes the donor personnel call for meetings they do not attend.' As a result, most members of support groups did not attend meetings.

In the prison's health facility, support group meetings were held every Friday. During these meetings members had health talks, they sang, did farming and ate together. Each support group was led by a CHV. To overcome the

challenge of non-attendance of support group meetings, HTS personnel in all the hospitals sampled put the dates for meetings when support group members had their next appointments.

Public *barazas* were used by all the hospitals, the AIDS Control Unit of the university and the CBO sampled to sensitize people on HIV and AIDS, carry out testing and counselling, and to fight stigma. In one health facility, a HTS informant reported that personnel in the HTS department attended chiefs' *barazas* to do sensitization and testing. Similarly, members of the CBO sampled attended *barazas* where they discussed stigma against HIV and AIDS.

CHVs carried out health education on topics related to HIV and AIDS in public *barazas*. A CHV supervised 100 households and reported to the nearest health facility. There were CHVs in each sub-location based in a Community Health Unit. For appointment to a CHV position, one had to be a resident of the area, must have completed Form 4 as a minimum level of education, and had to be respected in the community. A public *baraza* was called by the area Assistant Chief to select a CHV. Once selected, a CHV was trained by NASCOP on testing, treating and tracking. The CHVs also issued condoms and referred expectant mothers and HIV defaulters to the facility. One informant reported that CHVs helped to persuade people from public *barazas* to be tested or come to the health facility for testing. However, the CHVs were not being supported to do their work as illustrated by this informant, a Community Health Strategist:

'CHVs used to be given a stipend of Kshs. 2,000. With the withdrawal of the stipend, CHVs are demoralised. A CHV updates his/her register after every 6 months. A CHV is supposed to visit each of the 100 households in his/her area and write a report. There was a daily activity register. However, lack of funding affected the execution of these roles.'

## 5.2 Mobilization and outreaches

In the prison health facility, informants reported that inmates and prisons' personnel were sensitized on HIV and AIDS. The prisons' personnel were sensitized during parades and *Kamukunjis* (informal gatherings).

Three of the hospitals sampled used mobilization to reach one key population: female sex workers. They used this strategy to persuade sex workers to be tested and linked to treatment and to encourage them to embrace behaviour change. The HTS Counsellor Supervisor in one of the hospitals said that behaviour change was achieved when a sex worker reduced the amount of alcohol she took, the number of sex partners she had, the frequency of sex work, and exposure to HIV and AIDS by regular use of condoms and PrEP. To affirm this, one of the sex workers linked to care and treatment said,

'I had seven sex partners. Now I have three. I stopped drinking alcohol. I have even taken my children to school.'

Additionally, the sex workers were prepared for life after sex work. Some were reported to have started businesses and even got married. A notable aspect of behaviour change was that sex workers in one of the hospitals sampled collaborated with barmaids and police officers to protect under-age girls from getting into prostitution. One sex worker reported:

'Once barmaids see men with under-age girls, they alert us. They have our numbers. We go to those bars or lodgings and beat the men up or inform the police to arrest them. We do not want under-age children to get into this work the way we did. We do not want men to take advantage of them.'

The other purpose of mobilization in the hospital was to encourage sex workers who had joined the programme to share what they had learnt on HIV and AIDS with their sex partners and other sex workers. Indeed, two sex workers reported that they persuaded their partners to be counselled, tested and linked to treatment. Sex workers also gave information to other sex workers on what to do after rape. The sex workers who participated in the programme were given a token of appreciation. The programme also targeted Men having sex with Men (MSM) whose members attended seminars and mobilized others to attend quarterly seminars.

In one of the hospitals and the AIDS Control Unit of the University sampled, mobilization was done through moonlight testing to target sex workers, students and staff respectively.

Moonlight testing was done at night to fight the stigma associated with being seen taking a HIV test. In the university, moonlight testing was done on three days in a week, from 6pm to 10pm, four times a year.

The CBO sampled also engaged in mobilization. They did general and door-to-door testing. They tested people for HIV within Kisii town at night. Their main focus was Prevention of Mother-to-Child Transmission of HIV (PMTCT). They also targeted defaulters, youths, those suffering from TB and the general population. They identified clients from the facility's registers and followed them into the community. They also did family testing. Mobilization was also used by CHVs. Through their interpersonal networks, CHVs linked people to the nearest health facilities for counselling, testing and treatment and care.

Outreach activities were conducted by all the hospitals sampled. The AIDS Control Unit of the university sampled also engaged in outreaches targeting surrounding communities and they conducted one week of sensitization in the run-up to the annual World AIDS Day. Similarly, the medical training institution sampled had open days during which they either went out to the community or invited community members for HTS. Besides HTS, outreaches were used to link those who had tested HIV positive to treatment. They were also used to reduce stigma against PLHIV. Many of the outreach activities were conducted in churches and schools. In three hospitals, the outreach activities targeted sex workers. A HTS Supervisor said:

'Outreach activities increased during peak seasons for sex workers such as when tea farmers get their annual earnings, and when wheat farmers are harvesting wheat.'

Another HTS Counsellor added:

'PrEP is taken to bars where sex workers are found. They are also tested there. These services were taken to the bars because sex workers stopped coming to the facility.'

One of the previous donors was reported to have used support groups to conduct outreaches. For instance, an informant in one hospital

reported, 'Adolescents used to be taken on an outreach in Kisumu to share testimonies and meet other adolescents living with HIV.'

A nursing officer attached to the Gender-Based Violence (GBV) department in one hospital reported that the department conducted outreach activities in churches on Health Days. She said that they visited four churches in a month. CHVs also conducted outreach missions.

### 5.3 Posters

All the 16 health facilities sampled had posters with messages on HIV and AIDS displayed on the walls in the rooms used for HTS. The AIDS Control Unit of the university sampled also distributed posters during the World AIDS Day. The posters sampled had information on relevant topics on HIV and AIDS was designed for targeted audiences, for instance adults living with HIV and AIDS, mothers living with HIV and AIDS, victims of GBV, sex workers and healthcare personnel. Indeed, one clinician said, 'The posters on the walls are meant for staff to refer from time to time.'

In another health facility, a psychosocial counsellor reported, 'Health talks are derived from these posters. Patients are also encouraged to read them.'

### 5.4 Health talks

In all the hospitals sampled, health talks were given within the hospital whenever those who had been linked to treatment visited for their next appointment. In one hospital, topics for health talk were selected monthly by the HTS personnel. In another hospital, a clinician reported:

'The health talks are based on topics agreed upon in a forum attended by peer navigators, clinicians and counsellors.'

Informants in three hospitals reported that their facilities conducted health talks in schools to promote awareness on HIV and AIDS. In each of these schools, a teacher was identified to support the students living with HIV. A previous partner supported this programme by training the teachers on various issues including patient confidentiality, and giving students living with HIV food and transport. When a new partner

took over the HIV and AIDS programme in Kisii County, they withdrew this support for teachers and adolescents.

A HTS Counsellor Supervisor reported that they did not go to schools and churches to give health talks because of lack of funds and shortage of personnel. CHVs went to schools, churches, and households to promote health behaviours through health talks.

### 5.5 Phone calls

In all the hospitals sampled, mobile phones were used for health care communication in four ways: to remind those who had been tested, found positive and linked to treatment of their next appointment; as a follow-up mechanism on clients who had been tested, found to be HIV positive, linked to treatment but defaulted; to contact sexual partners of those who had been tested, found positive and linked to treatment and care; and to reach HTS personnel in facilities where those who had been tested, found to be HIV positive and linked to treatment had transferred for treatment. In two hospitals, informants reported that clients were called to be reminded of their next appointments.

The strategy of calling sexual partners of those who had been found to be living with HIV and linked to treatment was known as Partner Notification Service (PNS). In all the hospitals sampled, the personnel used PNS to reach these partners. In this service, a person who has been tested and found to be HIV positive is requested to give the mobile phone contacts of their sexual partner(s) so that they can also be tested and if found HIV positive, they are linked to treatment and care.

One hospital was ranked as the best in the county in using PNS. The hospital had a PNS tree which helped to link 35 positive clients. Informants reported that HTS personnel were trained by the partner on how to use PNS. They also underwent quarterly refresher trainings at the sub-county level. One HTS Counsellor said, 'The trainers do not have quality materials. Furthermore, they bring us the same trainers who train the same things every time instead of benchmarking with other counties on PNS.'

A number of challenges were reported in implementing PNS. One HTS Counsellor reported:

'There are inadequate funds to track clients. We are given Kshs. 750 per month for airtime for a facility phone. The phone is used by the HTS Supervisor, the HTS Counsellor, nurse and clinician. This negatively affects PNS since the airtime is not enough. Sometimes I have clients who tell me they are only available during weekends. I cannot call them since I do not have the phone. In addition, I do not have bus-fare. We used to spend our money to visit clients then we are reimbursed for the positive clients we got. But we complained and this was changed. Nowadays we are reimbursed Kshs. 200 for every client visited.'

The other challenge was that some of those contacted complained about invasion of their privacy. To illustrate this, one clinical officer observed:

'PNS is giving staff problems. One time a HTS Counsellor called a client whose number she had been given. The client was angry. He demanded to know how the HTS counsellor got his number. So, we use it sparingly. HTS personnel prefer visiting clients.'

A HTS Counsellor Supervisor added:

'PNS is not working in our facility. People are unwilling to disclose their partners. They fear violence.'

Additionally, one counsellor indicated that married female clients refused to disclose the names of their husbands for the sake of their marriages. Another counsellor observed that some clients were scared when they were told they were being called from a hospital. Informants also reported that some clients, especially sex worker, gave wrong contacts. Furthermore, sex workers did not disclose their partners since the majority were for casual sex. Overall, informants from four of the sampled health facilities reported that PNS was not working for them. Since they started using PNS, in 2017, they had been successful to link between only 3 to 5 clients.

Informants from all the hospitals and the AIDS Control Unit in the University sampled indicated that they made phone calls to the

facilities where their clients had transferred for treatment. The call was made to confirm whether indeed the patient had transferred there and to share their medical history. The AIDS Control Unit in the University made calls to the nearest facilities to the homes of their clients so that they could continue with treatment when on holiday.

### **5.6 HIV Testing and Counselling (HTC) Client Locator Form**

All the health facilities sampled used client locator forms to locate those clients who had already been tested, found to be HIV positive, counselled and linked to health facilities for treatment and care. This locator form had detailed personal information about clients. These included: three names of a client, the client's telephone number, sub-county, location, sub-location, village, the nearest church, the church one attends, the church pastor, clan elder, a CBO that could be used to contact the client and a sketch map. First, the locator form was used to help locate a client when he did not come to the hospital to pick his drugs and he was not answering the phone calls if he had previously offered his mobile phone number. This helped reduce the number of those defaulting on treatment. Secondly, it was used to trace those clients who may have been overwhelmed by drugs because of nutritional needs. Thirdly, the form was used to identify and test the family of an index contact who had tested positive to HIV, especially where the index client requested that members of his family, mainly the spouse and children to be tested at home.

### **5.7 Websites and signposts**

The HIPORS (2018) indicates that Kisii County has fourteen (14) registered implementing partners in HIV and AIDS response. Though actively involved in HIV and AIDS interventions in Kisii County, some of these key organizations did not have websites where one could access information about their activities. The organizations with websites, information on the sites was so scanty that it is not easy to identify their mission, core objectives, activities and funding. It is interesting for example that an implementing partner with interventions 109



facilities in 8 sub-counties had a website with very scanty information. Asking a Ministry of Health official tasked with the coordination of implementing partners in the county, he said:

“These implementing partners are not to share their activities publicly. Probably, they fear availing information to their competitors. They have to think about self-preservation. Sometimes, they do not even update the in-charges in the facilities where they have interventions.”

### 5.8 Reports

In the 14 health facilities sampled, staff reported that they are expected by implementing partners to write reports on many aspects of HIV and AIDS management and care using standard templates. Accordingly, the staff are tasked with writing reports on outreach campaigns, HIV testing and counselling, linkage of those who test HIV positive to health facilities, adherence to treatment, and viral suppression. However, several clinical officers reported that reports are a hindrance to service delivery. In particular, a female clinician noted:

“The templates they have given are too detailed. They are repetitive and laborious to fill. One can take the whole day to fill only two forms.”

Absence of reporting by Community Based Organisations (CBOs) due to the lack of funding was reported by CACC informants. One of them noted:

“CBOs are supposed to submit reports of their HIV and AIDS activities to the implementing partners on a monthly basis. But some CBOs are not reporting because of the lack of funds. They are inactive and therefore have no activity to report.”

### Short Message Service (SMS)

The short Message Service (SMS) was reported as a medium for tracing People Living with HIV and reminding them of the date for the collection of the monthly medication. As a mentor mother remarked in one health facility,

“Unless we remind our clients of their next visit, some may not turn up to collect their medication. This kind of defaulting escalates their viral load and resistance to treatment regimen.”

The SMS is also used to communicate results of viral load tests to People Living with HIV. Blood samples are taken from PLHIV in order to determine the viral load after periods of three months, six months or one year in order to establish the kind of care suitable per person according to the Differentiated Care Program. In one health facility, a clinician reported:

‘Clients receive SMS messages of their viral load and are advised accordingly on their next visit for linkage to the right cohort.’

However, due to the high poverty levels in the area, some PLHIV do not own phones and therefore cannot benefit from the SMS medium. From the side of the health facilities, sometimes the phones lack airtime as the amount allocated is not enough for all communication needs.

## 6. DISCUSSION

The communication strategies and tools commonly used by various stakeholders to reach PLHIV, key populations such as sex workers and the general population included: holding meetings and addressing public gatherings (*barazas*), mobilization and outreaches, health talks, posters, HTC Client Locator Forms and phone calls. The stakeholders who were targeted more frequently and effectively with messages on HIV and AIDS were PLHIV and sex workers. The strategies and tools least used in the interventions were SMS, videos and websites.

Using mentor mothers, adolescent mentors, peer navigators and support groups to reinforce intervention messages on those targeted encouraged the ones who had already adhered to treatment and adopted a positive behavioural change to influence others through face-to-face communication (BARAN & DAVIS, 2009). This social marketing principle was also illustrated in the strategy of recruiting sex workers to persuade other sex workers to visit hospitals for HTS. Similarly, conducting outreaches in bars where the sex workers were found was in line with targeting messages the most receptive specific segments (BARAN & DAVIS, 2009; McVEY et al., 2000).

Though the short message service was used by only one health facility in the interventions

against HIV and AIDS in Kisii County, studies have indicated that text messaging or short message service (SMS) is an economically feasible communication strategy with the potential to improve care engagement outcomes, particularly retention and adherence, (CHAIYACHATI et al., 2014; GOVINDASAMY et al., 2014; HARTWIG et al., 2010). SMS has been described as cost effective to the health facilities as the cost of sending messages in bulk is low. The use of SMS for appointment reminders has been found to improve clinic attendance (FREE et al., 2013; GUROL-URGANCI et al., 2013). There is also evidence that SMS interventions that included appointment reminders, laboratory result notifications, and medication reminders have demonstrated promise in improving ART initiation and retention in care, as well as ART adherence in African settings (FINOCCHARIO-KESSLER et al., 2014; MBUAGBAW et al., 2013; CAMPBELL et al., 2007). One study also demonstrated improved rates of viral suppression among those receiving weekly SMS (LESTER et al., 2010). The main challenge with the SMS strategy is that it will only be advantageous to clients who are literate.

The general population was not effectively and regularly reached through public gatherings (*barazas*), mobilization and outreach activities since they were infrequent. They therefore reached few people. Though data indicated that men rarely sought HTS voluntarily, and few joined support groups, there were no communication strategies targeting them. There were also no communication strategies targeting the youth. Finally, sugarcane cutters, sugarcane and banana sellers, and soapstone carvers, categorized as key populations in the Kisii County HIV Strategic Plan, were not targeted by any communication strategies (COUNTY GOVERNMENT OF KISII, 2014).

Through mentor mothers, peer navigators and support groups, stakeholders were relying on interpersonal networks to achieve the objectives of their interventions. Since mentor mothers, peer navigators and members of support groups were familiar to the targeted clients and they were undergoing similar experiences, they helped promote confidence, self-disclosure and adherence to treatment and

a positive behavioural change among those newly linked to treatment. Indeed, role-model stories have been found to be promising in encouraging positive a behavioural change among PLHIV (PATTON et al., 2009). To illustrate this, the percentage of HIV clients alive and on ART after 12 months was consistently above 70 for all the 9 sub-counties since 2014. Defaulter rates were also low among those living with HIV in all the health facilities sampled and therefore retention rates high. For instance, the defaulter rates in two of the health facilities sampled from two sub-counties indicated that there were less than 5 defaulters in any given month and less than 10 annually. These outcomes can also be attributed to the use of HTC Client Locator Forms and the activities of CHVs and CHWs.

Data obtained indicated that communication strategies used to target sex workers were very successful in one of the health facilities sampled. In that facility, the sex workers who had been reached and enrolled for HTS were 846. They were receiving services such as PrEP and cervical cancer tests regularly. In the same health facility, the number of MSM linked to care had grown from 8 in the year 2017 to 40 in the year 2019. PNS was found to be effective in getting new contacts for HTS in one of the health facilities. However, in all the other facilities PNS was not working effectively since none of these facilities had reached more than 10 new contacts living with HIV through it.

Though the posters had rich messages on a variety of topics on HIV and AIDS, they reached few people because of their placement. Furthermore, the targeted audience may not have given them maximum attention since many may not have been comfortable spending more time in the hospital to read them due to stigma. Additionally, the HTS personnel may not have always remembered to explain to the patients the messages on the posters. It was also noted that many of these posters contained messages in English and very few in Kiswahili, the national language in Kenya. There was none in Ekegusii, the first language spoken by the inhabitants of Kisii County, the AbaGusii. This therefore made the number of consumers of these messages lower.

Data obtained on GBV indicated that information on what to do after being sexually

abused was mainly included on the posters displayed in hospitals. There were no regular communication activities focusing on GBV as one way of combating the spread of HIV and AIDS.

The study found that the officials of a key stakeholder did not hold regular meetings with the healthcare personnel in order to discuss what the stakeholder intended to do, its goals and objectives as spelt out in its strategic plan, and to listen to complaints from its personnel. In fact, data obtained from personnel in all the health facilities sampled and members of the Constituency HIV Committees indicated that they were not aware of the stakeholder's HIV Strategic Plan. Therefore, the stakeholder had failed to inform other stakeholders about the HIV Strategic Plan and the role each stakeholder was supposed to play in order to achieve the objectives of that strategic plan.

Similarly, some stakeholders did not consult the healthcare staff in their programmes before making key decisions such as the termination of staff contracts. Consequently, key HTS functions were affected since even the contracts of committed staff were terminated. There was anxiety among staff on whose contract will be terminated next and discontentment among healthcare staff in charge of health facilities since important information was not communicated appropriately to them. They got it from their juniors.

Similarly, by not publicizing their location, activities and achievements through their websites, key stakeholders were insensitive to audiences and uninterested in stakeholder management by denying them key messages. AGARWAL et al., (2013) observe that the websites of the stakeholders are fundamental in creating awareness of the organization's activities in fighting the disease as well as describing the kind of relations exist between that organization its external public. Refusal by some donors and stakeholders to share information about their activities on HIV and AIDS in Kisii County left other stakeholders unable to learn from any best practices or correct their mistakes in order to ensure effective interventions. In fact, the lack of stakeholder communication raises ethical issues because their concerns are not being listened to (LONGEST, 2014).

## 7. CONCLUSION

The most effective communication strategies used in HIV and AIDS interventions in Kisii County use interpersonal communication networks. They effectively targeted PLHIV, sex workers and MSM. There were no communication strategies effectively targeting the general population, men, the youth and other key actors. Therefore, there is a need for stakeholders to use communication strategies and tools which can effectively reach these segments. In addition, all stakeholders need to freely share information regarding key decisions, the activities they were involved in, the challenges faced and the achievements made in order to ensure better outcomes in the intervention measures employed.

**Acknowledgement.** *The research was funded by National Research Fund-Kenya (NRF) grant number NRF/1/MMC/308. The authors are grateful to the National Research Fund-Kenya for financial support.*

## References

- AGARWAL, V., D'SILVA M., U. & LEICHTY, G. B. (2013) *Disease, Representation and Public Relations: A Discourse Analysis of HIV/AIDS Websites*. In: Ahmed, R., & Bates, B.R., editors. *Health Communication and Mass Media: An Integrated Approach to Policy and Practice*. Gower Publishing Limited, Furnham.
- BARAN, S. J., & DAVIS, D. K. (2009) *Mass Communication Theory: Foundations, Ferment and Future*. 5<sup>th</sup> Edition. Wadsworth Cengage Learning, Boston.
- BERKLEY-PATTON, J., GOGGIN, K., LISTON, R., BRADLEY-EWING, A., & NEVILLE, S. (2009) Adapting Effective Narrative-Based HIV-Prevention Interventions to Increase Minorities' Engagement in HIV/AIDS Services, *Health Communication*, 24(3), pp. 199-209.
- BERTTRAND, J, BABALOLA, S., & SKINNER, J. (2012) *The Impact of Health Communication Programs*. In: Obregon, R & Waisbord, S., editors. *The Handbook of Global Health Communication*. Wiley-Blackwell, Oxford, UK.
- BOCKING, J., EWART, S., B., HAPPELL, B., PLATANIA-PHUNG, C., STANTON, R. & SCHOLZ, B. (2018) "Here if you need me": exploring peer support to enhance access to physical health care. *Journal of Mental Health*, 27(4), pp. 329-35.
- CAMPBELL, M. K., HUDSON, M. A., RESNICOW, K., BLAKENEY, N., PAXTON, A., & BASKIN, M. (2007) Church-Based Health Promotion Interventions: Evidence and Lessons Learned. *Annual Review of Public Health*, 28, pp. 213-234.

- CHAIYACHATI, K. H., OGBUOJI, O., PRICE, M., SUTHAR, A. B., NEGUSSIE, E. K., & BARNIGHAUSEN, T. (2014) Interventions to improve adherence to antiretroviral therapy: a rapid systematic review. *AIDS*. Suppl. 2, pp. S187–204.
- COUNTY GOVERNMENT OF KISII (2014) *Kisii County HIV & AIDS Strategic Plan 2014/15-2018/19*. Available from: [www.kisii.go.ke](http://www.kisii.go.ke) [15 September 2019].
- COUNTY GOVERNMENT OF KISII (2018) *County Integrated Development Plan 2018-2022*. Available from: <https://www.kisii.go.ke> [22 September 2019].
- FINOCCHARIO-KESSLER, S., GAUTNEY, B. J., KHAMADI, S., OKOTH, V., GOGGIN, K., & SPINLER, J. K. (2014) If you text them, they will come: using the HIV infant tracking system to improve early infant diagnosis quality and retention in Kenya. *AIDS*. 28 Suppl 3, pp. S313–21.
- FREE, C., PHILLIPS, G., WATSON, L., GALLI, L., FELIX, L., & EDWARDS, P. (2013) The effectiveness of mobile-health technologies to improve health care service delivery processes: a systematic review and meta-analysis. *PLoS Med.*, 10:e1001363.
- HIPORS (2018) *NACC Report On the HIV Implementing Partners Online Reporting System (HIPORS) for The Financial Year 2016/2017*. NACC, Nairobi Kenya.
- GOVINDASAMY, D., MEGHIJ, J., NEGUSSI, E., BAGGALEY, R., FORD, N., & KRANZER, K. (2014) Interventions to improve or facilitate linkage to or retention in pre-ART (HIV) care and initiation of ART in low- and middle-income settings—a systematic review. *J Int AIDS Soc.*, 17, p. 19032.
- GUROL-URGANCI, I., DE JONGH, T., VODOPIVEC-JAMSEK, V., ATUN, R., & CAR, J. (2013) Mobile phone messaging reminders for attendance at healthcare appointments. *Cochrane Database Syst Rev.*, 12, p. CD007458.
- HARTWIG, K. N., HARTWIG, K. A., DISORBO, P., HOFGREN, B., MOTZ-STOREY, L., MMBANDO, P., MSURRI, M., MWANGI-POWELL, F., POWELL, T., SMITH, S. AND JACOBSON, M., (2010) Scaling up a Community-based Palliative Care Program among Faith-based Hospitals in Tanzania. *Journal of Palliative Care*, 26(3), pp. 194-201.
- LESTER, R. T., RITVO, P., MILLS, E. J., KARIRI, A., KARANJA, S., & CHUNG, M. H. (2010) Effects of a mobile phone short message service on antiretroviral treatment adherence in Kenya (WelTel Kenya1): a randomised trial. *Lancet*, 376, pp. 1838–45.
- LONGEST, B. B. J. (2014) *Health program management: From development through evaluation*. Jossey-Bass, San Francisco.
- MBUAGBAW, L., VAN DER KOP, M. L., LESTER, R. T., THIRUMURTHY, H., POP-ELECHES, C., & YE, C. (2013). Mobile phone text messages for improving adherence to antiretroviral therapy (ART): an individual patient data meta-analysis of randomised trials. *BMJ Open*, 3, p.e003950.
- McVEY, D & STAPLETON, J. (2000) Can antismoking television advertising affect smoking behaviour? Controlled trial of the Health Education Authority for England's anti-smoking TV campaign. *Tobacco Control*, 9, pp. 273–282.
- MoH (2014a) Kenya HIV Prevention Revolution Road Map: Count Down to 2030. Ministry of Health. Available from: [https://reliefweb.int/sites/reliefweb.int/files/resources/Kenya\\_HIV\\_Prevention\\_Revolution\\_Road\\_Map.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/Kenya_HIV_Prevention_Revolution_Road_Map.pdf) [1 October 2019].
- MoH (2014b) Kenya Health Sector Referral Implementation Guidelines 2014. 1<sup>st</sup> Edition. Nairobi: Division of Emergency and Disaster Risk Management. Ministry of Health. Available from: <http://publications.universalhealth2030.org/uploads/ministry-of-health-referral-guidelines.pdf> [25 September 2019].
- NATIONAL AIDS CONTROL COUNCIL (2015) Kenya HIV Estimates 2015. Ministry of Health. Available from <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-Estimates-2015.pdf> [25 September 2019].
- NATIONAL AIDS CONTROL COUNCIL (2016) Kenya HIV County Profiles 2016. Ministry of Health. Available from <https://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf> [1 October 2019].
- SCHIAVO, R. (2014) *Health communication: from theory to practice*. (2<sup>nd</sup> ed). Jossey-Bass, San-Francisco.