REPUBLIC OF KENYA

MINISTRY OF HEALTH

The Implementation of HIV Differentiated Service Delivery in Kenya Using a Quality Improvement Approach, 2024

Operational Manual

June 2024

NASCOP

The Implementation of HIV Differentiated Service Delivery in Kenya Using a Quality Improvement Approach, 2024

2024 Edition

The Implementation of HIV Differentiated Service Delivery in Kenya Using a Quality Improvement Approach Operational Manual, 2024 edition contain relevant information required by healthcare providers in the implementation of DSD as at the date of issue. All reasonable precautions have been taken by NASCOP to verify the information contained in this guideline document.

For clarifications contact National AIDS and STI Control Program (NASCOP) at P. O. Box 19361 - 00202, Nairobi Kenya, Tel: +254 (020) 2630867, Email: info@nascop.or.ke, Website: www.nascop.or.ke

The recommended citation for this document is:

Ministry of Health, National AIDS & STI Control Program. The Implementation of HIV Differentiated Service Delivery in Kenya Using a Quality Improvement Approach, 2024 Edition. Nairobi, Kenya: NASCOP, June 2024. Print.

Design and Layout: Collins Etemesi - NASCOP

ISBN 978_9914_766_45_5

Foreword

Kenya has made tremendous progress towards achieving the UNAIDS 95-95-95 Global Targets and is on path to attaining HIV epidemic control. This is a result of concerted efforts to reduce the number of new HIV infections and AIDS related mortality, as envisioned in the Kenya AIDS Strategic Framework II.

Central to attaining and sustaining gains made in HIV prevention, care and treatment, are health systems that are responsive, resilient, community focused and aligned to client needs. This calls for innovative approaches to service delivery that not only expand the scope of service but also bring service closer to the community, as per the nation's initiatives towards Universal Health Coverage.

Differentiated Service Delivery (DSD) is key in enhancing access and use of HIV prevention, care and treatment services. DSD leverages on existing platforms to optimize the service package and service utility for health service recipients, whilst limiting the strain to health systems through sound resource application.

This operational manual provides guidance to support the implementation of differentiated service delivery models using a quality improvement approach in the context of HIV prevention, care and treatment for various populations. Additionally, this guidance is intended towards improving the integration of other proximate services including TB screening, diagnosis and management; sexual and reproductive health services; sexual and gender-based violence prevention, response and management; screening and treatment of non-communicable diseases (NCDs); and mental health and substance use screening and management; towards a holistic, tailored, service approach.

This guidance is an important tool and is meant to be used by policy makers, health managers both at national and county level, as well as service providers at all levels of the health sector in Kenya.

In effect, revamp and scale impactful human centered interventions, towards healthier communities.

Dr. Patrick Amoth, EBS

Ag. Director General for Health

Ministry of Health

Acknowledgement

The operational manual for The Implementation of HIV Differentiated Service Delivery in Kenya Using a Quality Improvement Approach, 2024 edition has been developed through a collaborative effort of key stakeholders both at individual and institutional level, steered by the Ministry of Health Division of National and STI Control Program (NASCOP).

This operational manual draws on an extensive review of local experience and adoption of international guidance, as well as consultations with health care workers, communities, and people living with HIV.

I take this opportunity to appreciate the Ministry of Health technical team at NASCOP, the county governments health directorates, and other institutions that steered the process of finalizing this document.

The Ministry of Health expresses sincere gratitude to various partners for the financial and technical support in the development, finalization, printing and dissemination of this manual.

Dr. Rose Wafula

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Ministry of Health

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List of Abbreviations

ADT	ART Dispensing Tool
ABYM	Adolescent Boys and Young Men
AHD	Advanced HIV Disease
AIDS	Acquired Immunodeficiency Syndrome
AGYW	Adolescent Girls and Young Women
aPNS	Assisted Partner Notification Services
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYP	Adolescents and Young People
BMI	Body Mass Index
CAG	Community ART Group
CASCO	County AIDS/STI Coordinator
CBOs	Community Based Organizations
CCC	Comprehensive Care Clinic
CHMT	County Health Management Team
CHP	Community Health Promoter
CHRIO	County Health Records Information Officer
CHW	Community Health Worker
CITC	Client Initiated Testing and Counseling
CPT	Cotrimoxazole Preventive Therapy
CQI	Continuous Quality Improvement
CSOs	Civil Society Organizations
C-TWG	County HIV Technical Working Group
DAR	Daily Activity Register
DG Health	Director General Health
DSD	Differentiated Service Delivery
DHIS	District Health Information System
DICE	Drop-In Centre
DMAPS	District Monthly ART ROC Summary
DQA	Data Quality Assessment

DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored & Safe
EBIs	Evidence-informed Behavioral Interventions
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
eMTCT	Elimination of Mother to Child Transmission
F-MAPS	Facility Monthly ART ROC Summary
FP	Family Planning
HCW	Healthcare Worker
HEI	HIV exposed Infant Prophylaxis
HIV	Human Immunodeficiency Virus
HIVST	HIV Self Testing
HRIO	Health Records Information Officer
HTS	HIV Testing Services
IEC	Information Education and Communication
IPV	Intimate Partner Violence
IRIS	Immune Reconstitution Inflammatory Syndrome
KHIS	Kenya Health Information Systems
KHQIF	Kenya HIV Quality Improvement Framework
KVP	Key and Vulnerable Population
KP	Key Population
LMIS	Logistics Management Information System
MMD	Multi Month Dispensing
MDT	Multidisciplinary Team
M&E	Monitoring and Evaluation
MFL	Master Facility List
MoH	Ministry of Health
MOPC	Medical Outpatient Clinic
NASCOP	National AIDS and STI Control Program
NCD	Non-Communicable Disease
NDWH	National Data Warehouse
OI	Opportunistic Infection
PBFW	Pregnant and Breastfeeding Women

PCR	Polymerase Chain Reaction
PDSA	Plan Do Study Act
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PSSG	Psycho-Social Support Group
pTB	Pulmonary Tuberculosis
PWID	People Who Inject Drugs
QI	Quality Improvement
QIT	Quality Improvement Team
ROC	Recipients of Care
SCHMT	Sub-County Health Management Team
SCHRIO	Sub-County Health Records Information Officer
SGBV	Sexual and Gender Based Violence
SNS	Social Network Strategy
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TAT	Turn Around Time
TPT	TB Preventive Therapy
TWG	Technical Working Group
U=U	Undetectable = Untransmissible
VMMC	Voluntary Medical Male Circumcision
VL	Viral Load
WHO	World Health Organization
WIT	Work Improvement Team
YFC	Youth Friendly Clinic

Definition of terms:

i. **Recipients of care:** Persons who routinely access and benefit from HIV care and treatment services.

ii. **Clinicians:** These are health providers who are directly involved in examination, prescription and administration of health procedures. For this manual, these include: nurses, clinical officers and medical officers.

iii. **DSD Focal Person:** This is a designated individual (HCW) responsible for coordination of DSD models in both facility and community settings.

iv. **Peer educator:** These are individuals who have a shared experience of the context, disease or intervention and are able to guide colleagues on various subject matters and their HIV prevention or care journey. For example, mentor mother, mentor father, youth champions, PrEP champions.

v. Multi-month Dispensing: Refers to the provision of multiple months' supply of antiretroviral medicine and/or other medicines at single time point. (NB; MMD by is facilitator of DSD and not considered a model by itself)

CHAPTER 1: INTRODUCTION

Differentiated service delivery (DSD) is a person-centered approach that simplifies and adapts HIV services in ways that serve the needs of people, are mindful of community dynamics, and optimize available resources in health systems. This is applicable to HIV testing, preventive and treatment services across the cascade. DSD reflects the preferences and expectations of various recipients of HIV services and reduces unnecessary constraints on the health system. By providing differentiated service delivery, the health system can refocus resources to those most in need.

Differentiated service delivery can be organized based on various considerations, such as:

- Setting of service delivery (i.e., community or facility)
- Clinical characteristics (e.g., ROCs with advanced disease)
- Sub-populations (e.g., pregnant and breastfeeding women, adolescents, children, adults, key populations).

This differentiated service delivery operational manual should be used in conjunction with related resource materials, including: the Kenya HIV Prevention and Treatment Guidelines, the Kenya HIV Quality Improvement Framework, the Kenya HIV Testing Services (HTS) operational manual and Private Sector Engagement Framework.

Rationale

This manual is intended to be used by National, County, Sub-County Health Management Teams, implementing partners, health facility leadership, healthcare workers and community health actors for DSD:

i) Planning

ii) Implementation

iii) Monitoring and evaluation

Planning

- Sensitization of County Health Management Teams (CHMT)
- Situational assessment (County/Facility/Community)
- Resource mapping
- Identification of appropriate DSD Models
- Work Planning
- Healthcare workers training for both facility and community staff
- Quality Improvement Team Sensitisation

Implementation

- Client communication and mobilization
- Categorization and differentiated service delivery for ROC who present well or with advanced disease
- Categorization and differentiated service delivery for ROC who are established or not established on ART (after at least 6 months in care)
- Implementation of DSD models with QI approaches for clients receiving prevention, care and treatment services

Monitoring & Evaluation

- Support supervision
- Routine monitoring, evaluation, and reporting
- Continuous quality improvement
- Implementation research on aspects of differentiated service delivery
- Client satisfaction surveys

Figure 1.1: Differentiated service delivery planning, implementation monitoring & evaluation

1.1 Planning for DSD Implementation

Planning for implementation of differentiated service delivery (DSD) includes county, facility and community units' readiness assessments, resource mapping, work planning, capacity building and sensitization of key stakeholders.

1.1.1 DSD Implementation Assessments

The status of DSD implementation should be conducted to guide implementation to scale. The assessment identifies the status of implementation at county, facility and community level (coverage and model mix at facility and community level) and identifies gaps that should be addressed to implement DSD to scale.

1.1.1.1 County Situational Assessment

The County HIV Technical Working Group (C-TWG) should complete the County situational assessment tool (Annex 1) and based on the findings support facilities to implement at DSD while addressing identified gaps.

The C-TWG will coordinate implementation of DSD within the county. The TWG is composed of members of the County Health Management Team (CHMT), donors, implementing partners, learning institutions and communities within the county.

1.1.1.2 Facility Situational Assessment

The C-TWG will support facilities to conduct the facility situational assessment (Annex 2). The findings of the self-assessment will be utilized by the facility under leadership of the Multi-Disciplinary Team (MDT) to inform implementation of DSD while addressing the gaps identified.

The C-TWG, in collaboration with implementing partners, should work with facilities based on the situational assessment to address any barriers for DSD implementation. The facility should address the gaps identified using the CQI approach as described under chapter 5 of the DSD manual. The facility Quality Improvement teams/Work Improvement teams (QIT/WIT) should monitor improvement weekly or as per the existing SOPs for monitoring CQI projects. DSD assessment should be re-evaluated quarterly until gaps have been addressed.

1.1.1.3 Community Situational Assessment

Facility leadership, working in collaboration with the SCHMT, CHMT, and community health actors will conduct a community situational and needs assessment for HIV prevention and care services, through community participatory approaches.

The assessment, can be conducted guided by the facility assessment tool parameters and adapted as relevant. This will assess the various communities-based service delivery points, resources, barriers, facilitators and opportunities for delivery of DSD. In addition, assess the distribution of various typologies in various catchment populations. The assessment findings shall inform and define the scope and structure of community DSD delivery units/models.

The C-TWG should additionally identify gaps in access and utilization of HIV prevention and care services by under-reached as well as key and vulnerable populations. Working with various stakeholders, the C-TWG can set up community DSD models to reach and serve these populations. These may include models such as community pharmacy DSD, Drop In Centres (DICEs), Safe spaces, outreaches targeting various population groups.

1.1.2 Work Planning

To implement DSD to scale, counties and facilities should draft an implementation work plan. Annex 4 provides a sample work plan template. A work plan development session is included in the healthcare worker (HCW) training package on DSD. The work plan shall be tailored to the level of care (community, facility, sub/county) and responsive to the situation assessment. A workplan should incorporate various components of DSD Implementation and should backed with plans on demand creation, QI and M&E.

1.1.3 Capacity Building on Differentiated Service Delivery

To strengthen the roll-out of DSD, the orientation package on DSD/QI has been developed as outlined in Table 1.1. The orientation of the CHMT, HCW and non-clinical workers using this package should be aligned with the recommendations of current Kenya HIV prevention and treatment guidelines whenever necessary. Training for DSD shall be conducted as a separate training or as integrated with trainings on other program areas.

Table 1.1: Capacity Building on Differentiated Service Delivery

Level	Target Audience	Training Package	Structure of Training
County	• County and Sub-County Managers (CHMT and sCHMT) • Implementing Partners	• PowerPoint slides	• Didactic sensitization
Health Facility	• Facility managers & healthcare workers	• PowerPoint slides • Facilitator's guide • Participant's workbook • Algorithms • Case Studies • Role-plays	• Didactic and case-based
Community	• Healthcare workers in community settings • Non clinical health workers.	• PowerPoint slides • Flip charts • Facilitator's guide • Participant's workbook • Case studies • Role-plays	• Didactic and case-based
	• PLHIV attending HIV clinic services • Community groups e.g., AYP, KP.	• DSD IEC Materials	• Daily health talks • Group and individual sessions

1.2 Implementation of DSD

Implementation of differentiated service delivery for recipients of services can be largely organized into the four blocks namely: **what** (service provided), **when** (service frequency), **who** (health care cadre providing services) and **where** (location of service) (figure 1.1). This will be delivered in community and facility settings as befits the service and the client across HIV testing, prevention, care and treatment. The details on implementation are outlined in chapter 2.

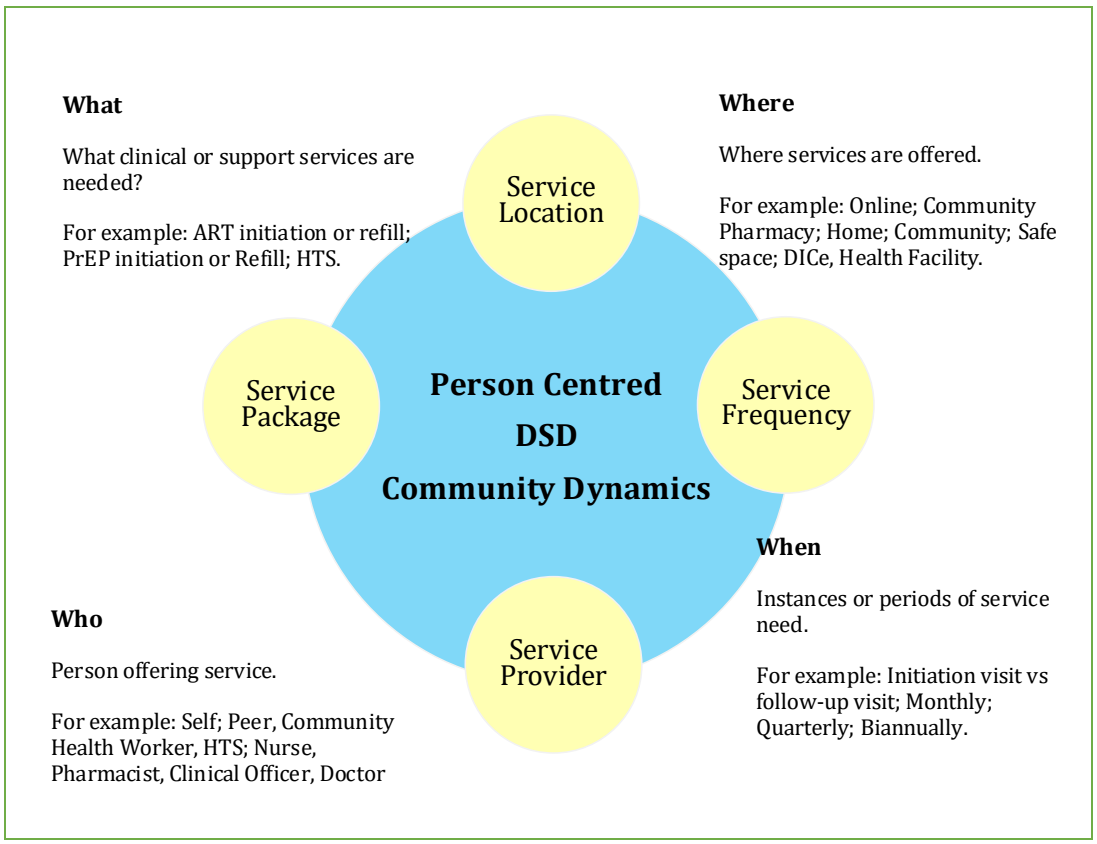


Figure 1.2: The four blocks of differentiated service delivery

1.3 Monitoring and Evaluation of DSD.

Implementation of DSD will make use of standard M&E tools for daily data capture, summary and reporting. DSD will leverage on EMR and the routine data management system involving the facility and sub/county HRIOs. There will be periodic SQAs, Data reviews and DQAs to monitor progress in implementation of DSD. The details on monitoring and evaluation of DSD are outlined in chapter 6.

CHAPTER 2: IMPLEMENTATION OF DSD

2.1 DSD In Delivery of HIV Combination Prevention

2.1.1 Overview

The implementation of Differentiated Service Delivery (DSD) for HIV prevention, care & treatment services it is essential to effectively address the varied clients' HIV needs in HIV. A combination prevention package should be offered, incorporating biomedical, behavioral, and structural interventions, customized to each client's requirements. This approach acknowledges that a singular approach may not suffice in tackling the complexities of HIV prevention.

Behavioral interventions provide information, motivation, education and skills-building to help individuals reduce risky behaviors, make informed decision, and sustain positive change. Behavioral interventions are an avenue to biomedical and structural interventions, as clients are better placed to accept and use the other interventions as appropriate for them.

Structural interventions work by altering the social, economic, political, and environmental factors that affect individuals, to influence their behaviors and reduce their HIV risk.

Biomedical interventions are prevention products that act as a barrier against virus transmission or prevent acquiring infection even if one gets exposed to the virus.

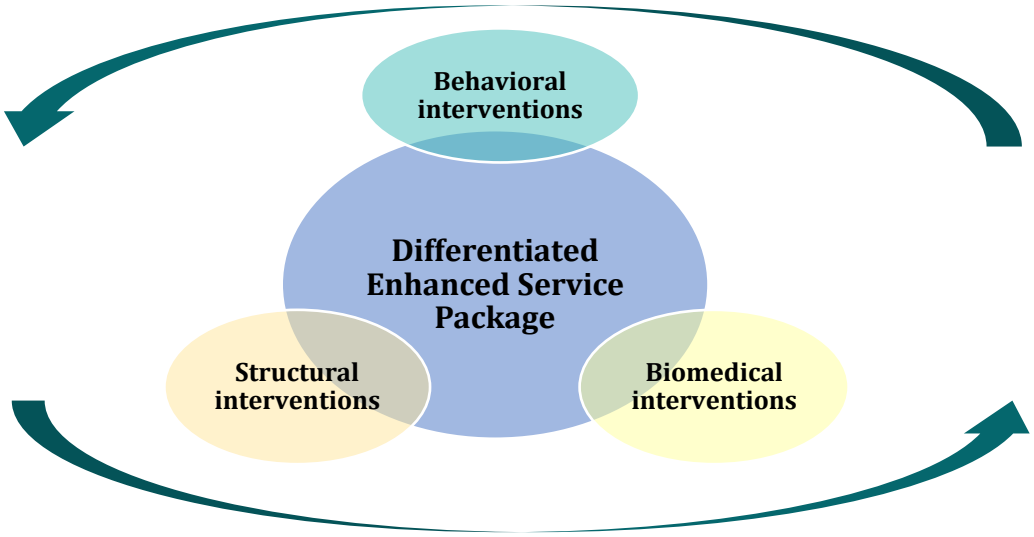


Figure 2.1: Differentiated Enhanced Service Package

2.1.1.1 Behavioral Interventions

Some of the behavioral interventions include:

- Peer education programs
- Targeted information, education, and communication (IEC) e.g., edutainment
- Promotion, demonstration, and education on biomedical products, for example, male and female condoms and water-based lubricants.
- Risk assessment and risk-reduction counseling
- Skills-building
- Evidence-informed behavioral interventions (EBIs)

2.1.1.2 Structural Interventions

Some of the structural interventions include:

- Shaping policy and creating enabling environments.
- Reducing stigma and discrimination.
- Empowering the community, including ownership and leadership.
- Sexual and Gender-Based Violence (SGBV) prevention and response.

2.1.1.3 Biomedical Interventions

Some of the biomedical interventions include:

- Comprehensive condoms and lubricant programming
- Post-Exposure Prophylaxis (PEP) & Pre-Exposure Prophylaxis (PrEP)
- Elimination of Mother to Child Transmission (eMTCT)
- Undetectable equals untransmissible (U=U)
- Sexually Transmitted Infections (STI) screening & management
- Voluntary Medical Male Circumcision (VMMC)
- Harm Reduction for persons who inject drugs (PWID) (Needle and Syringe Programme and Opioid Substitution Therapy)
- Tuberculosis (TB) screening and treatment.
- HIV Testing Services (HTS)

2.1.2 Factors to consider to determine choice of DSD

Clients should be supported and offered an appropriate choice of DSD based on the following considerations:

- Clients understanding and self-sufficiency in using the HIV prevention intervention
- Documented good adherence
- Ease of access of services
- Pregnancy and breastfeeding status
- Concurrent illnesses
- Client preventive and broader health needs
- Population category e.g. AYP friendly setting; KP aligned setting
- Community support structures in place – support groups, peer support, community health units

2.2 HIV Testing Services (HTS)

2.2.1 Overview

HTS is the gateway to HIV prevention, care and treatment. Differentiated delivery of HIV testing services make the services more accessible, acceptable and applicable to varied settings. This bridges the unmet need in testing towards achieving universal knowledge of HIV status, thereby, closing the gap in prevention and treatment.

Differentiated HIV testing services should be offered to all age groups, gender, and population types. However, special attention should be placed on hard-to-reach populations that include Adolescents and Young People, men, Key Populations, and other vulnerable groups who may have higher HIV incidence or lower HIV testing rates and ART coverage.

As the country approaches epidemic control, testing for HIV case finding and prevention has been adopted to reach the prevention and treatment targets.

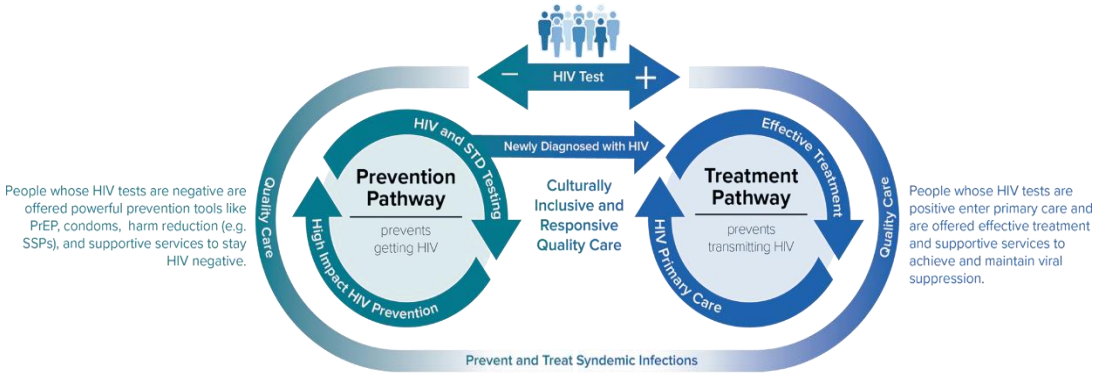


Figure 2.2: HIV Testing for Identification and Prevention (Image Credit: CDC)

2.2.2 DSD Components for HTS

This manual outline three components of DSD for HTS, namely:

- Awareness creation and Demand generation
- Testing
- Linkage.

2.2.2.1 Awareness Creation and Demand Generation

Differentiated HTS delivery should be sensitive to the settings of various populations of interest. Awareness creation should go beyond the usual and regular service provision approaches, roping in various channels that are more inclusive and able to reach disenfranchised populations, so as to improve access to HTS and other HIV services in the cascade.

As such, HTS service should be tailored and offered at various community locations to reach these populations, for example, schools, bars, work places, public forums, community events, hotspots etc.

Various persons can play different roles in engaging communication, mobilization and access to services. This may take the form of peer mobilization, social networks, community health promotion, outreach services etc.

For more details on demand creation, reference is made to Chapter 3.

2.2.2.2 HIV Testing

Client-centered HTS approaches have been developed for a variety of strategies to address the needs of diverse populations and accommodate geographic differences. The available differentiated testing approaches include:

Provider Initiated Testing and Counseling (PITC)

Provider-initiated testing and counseling (PITC) is an approach where a service provider offers HIV testing to clients, regardless of the reason for the visit. PITC places the responsibility of initiating HTS on the health provider, rather than the client. PITC service is offered with an "opt-out" option based on informed choice and consent.

Client Initiated Testing and Counseling (CITC)- Client initiated testing and counseling (CITC) is where the client seeks and initiates HIV testing in the community or at a health facility on his/her own volition.

Index Testing is an approach whereby the exposed contacts (i.e., sexual partners, biological children and anyone with whom a needle was shared) of a HIV positive person (i.e., index client), are elicited and offered HIV testing services

Social Network Strategy (SNS)- this involves offering to high-risk negative client or newly tested high-risk positive clients (also referred to as Seeds) self-guided options to informally extend invitation for HIV testing and other services to a broader set of social network members who have an elevated risk of HIV infection.

HIV Self Testing (HIVST) allows individuals to collect their own specimen, perform the test, and interpret the results on their own. This can be conducted either within a health facility, at home or in any other convenient place.

Directly Assisted HIV Self-Testing refers to when trained providers, peer educators or community health promoters (CHPs) give an individual an in-person demonstration before or during HIVST on how to perform the test and interpret the test result. This approach can be used to support self-testers with disabilities, low literacy levels, and individuals who may require or request direct assistance in the form of in-person demonstrations and explanations before, during and/or after testing.

PCR testing: This involves HIV Nucleic Acid Amplification Testing (NAAT) which is used for Early Infant Diagnosis (EID) algorithm at 6 weeks, 6 months and month 12.

DSD For HIV Retesting Services

Different populations have different retesting recommendations (Frequency) based on the risk and vulnerability of the client as described in details on the testing DSD building blocks.

Table 2.1: DSD For HIV Testing Services

Population for Differentiated Testing Services	What?	Where?	When	Who?
Pregnant and Breastfeeding women	PITC CITC	Health facility and Community (including private retail pharmacies/online pharmacies)	1st ANC / 1st Contact 3rd Trimester Labor and delivery, Post Natal (6 weeks, every 6 months until cessation of breastfeeding)	Clinicians, HTS providers, medical Laboratory officers, pharmacists and pharmaceutical technologists
Infants and Children	Index testing/ aPNS PITC PCR testing Assisted HIV Self-Testing	Health facility and Community/private retail pharmacies/online pharmacies Immunization Clinics/ child welfare clinics	HIV exposed - PCR at 6 weeks, 6 months, 12 months and antibody at 18 months, then 6 monthly until cessation of breastfeeding, then 6 weeks after complete cessation of breastfeeding. At 1st contact of the child when the parent/guardian status turns positive. Children with clinical symptoms of immunosuppression	Clinicians, HTS providers, medical Laboratory officers
AYP (AGYW and ABYM)	CITC, HIV Self-testing (HIVST), Social Network Strategy (SNS), PITC	Health facility. Community (including private retail pharmacies/online pharmacies) Venue based Testing (Institution of higher learning, parties, AYP camps, rite of passage events, conferences, concerts, sporting events)	Establish status at first contact and test if the AYP doesn't know status. Thereafter test after every two years if not at risk. Targeted HIV testing to AYP who are screened and found eligible for HIV test (Risk based testing)	Clinicians, HTS providers, and medical Laboratory officers, pharmacists and pharmaceutical technologists. Self for AYP above 18 years, 15-17 to receive assisted self-test.

Population for Differentiated Testing Services	What?	Where?	When	Who?
Adult Men	Social Network strategy (SNS) Index testing HIV Self-testing PITC	Community (including private retail pharmacies/online pharmacies), Health facility Workplace testing-Targeting Met, men's forums	After every two years Risk Based testing	Clinicians, pharmacists and pharmaceutical technologists, HTS providers, medical Laboratory officers, self
Adult Women)	Social Network strategy (SNS) Index testing HIV Self-testing PITC CITC	Community (including private retail pharmacies/online pharmacies) Health facility	After every two years Risk Based testing	Clinicians, pharmacists and pharmaceutical technologists, HTS providers, medical Laboratory officers, self
Key Populations	Social Network strategy (SNS) Index testing HIV Self-testing PITC CITC	Health Facilities Community (including hot spots, private retail pharmacies/online pharmacies) - Venue Based Testing	At enrollment in the program Retest Every six months	Clinicians, pharmacists and pharmaceutical technologists, HTS providers, medical Laboratory officers, Self
Vulnerable populations (Fisherfolk, Truckers, People in prison settings)	Social Network strategy (SNS) Index testing HIV Self-testing PITC CITC	Health Facility Community (including private retail pharmacies/online pharmacies)	At enrollment in the program After every 6 months for Truckers, Fisherfolk and people in Prison setting)	Clinicians, pharmacists and pharmaceutical technologists , HTS providers, medical Laboratory officer, self
Discordant couples	Index testing PITC CITC	Health Facility Community (including private retail pharmacies/online pharmacies)	After every three months for Discordant couples until the positive partner achieves sustained viral	Clinicians, pharmacists and pharmaceutical technologists , HTS providers, medical

Population for Differentiated Testing Services	What?	Where?	When	Who?
			suppression, then thereafter every 6 months	Laboratory officers
SGBV survivors	PITC CITC	Health Facility	Test at first contact after sexual violence, 4 weeks, and at 12 weeks for negative survivors	Clinicians, HTS providers, medical Laboratory officer
Other priority populations (internally displaced persons (IDPs), refugees and migrant populations, populations in humanitarian settings, street families, people living in large scale agricultural plantations, people with disabilities, and members of uniformed services.	Index testing HIV Self-testing PITC SNS CITC	Health Facility Community (including private retail pharmacies/online pharmacies) Access to services in this population is limited. Therefore, more emphasis on mobilization for service uptake is required and need to bring the services close to the affected population.	After every two years Risk Based testing	Clinicians, pharmacists and pharmaceutical technologists , HTS providers, medical Laboratory officer, self

2.2.2.3 Linkage

All people presenting for HIV testing require linkage to comprehensive package of services, regardless of their HIV results. Persons with HIV negative results should be linked to a tailored HIV combination prevention package. This should be differentiated according to the risk of HIV infection in a specific population, providing those at risk with additional prevention interventions such as PrEP. Persons who test HIV positive should immediately be linked to the comprehensive package of care in line with the test and treat policy. Providers should aim to provide holistic services responsive to the needs of the client, using integrated approaches.

2.3 Differentiated Service Delivery for PrEP

Differentiated service delivery for PrEP involves the delivery of client-centered services that simplifies and adapts PrEP service provision in ways that serve the needs of people and communities at substantial risk of acquiring HIV, as well as reduce unnecessary burdens on the health system. Differentiated PrEP services can make PrEP services more acceptable and accessible, as well as support uptake and effective use of PrEP.

This involves the following;

- Multi-month dispensing – Clients who demonstrates good adherence during the initial three months following PrEP initiation can be offered multi-month dispensing.
- Integration and decentralization of PrEP into multiple service delivery points, in both health facility and community settings. Innovations are encouraged that avail PrEP to communities, involves more personnel and varies the service package for PrEP and combination prevention based on client needs.
- Expanded product choice - PrEP products choice continues to expands as new products becomes available. Oral PrEP is available in two dosing strategies; Daily & Event driven Oral PrEP. The Dapivirine Vaginal Ring has also been approved and Long Acting Cabotegravir Injection will be made available for public use upon approval by Pharmacy & Poisons Board. All PrEP products should be offered as per the current guidelines Intended duration of PrEP use – clients who understand their risk profile may use PrEP for brief periods. Such clients should be support.

2.3.1 Building Blocks of DSD For PrEP

Differentiated service delivery for PrEP can be organized based on the specific needs of a person at ongoing risk of acquiring HIV and can be categorized into the four blocks of **what** (service provided), **when** (service frequency), **who** (health care cadre providing services), and **where** (location of service).

Figure 2.3: Building Blocks of DSD for PrEP

2.3.2 Considerations for specific populations

Notwithstanding the expansion of DSD options to community settings, the following category of clients should ideally be offered and followed up for PrEP within the facility setting:

- Pregnant and breastfeeding women
- Persons with chronic renal or liver conditions
- Persons with significant comorbidities requiring specialized clinical care or frequent facility visits.

These clients can still be offered DSD that bears in mind the special needs of these groups.

2.3.3 PrEP Package of Service

Clients on PrEP require tailored package of service for different visits. There are mainly two types of visits, i.e., Clinical visits and Refill visits. The package of services to be offered at each visit is summarized in Table 2.1 and is applicable in both facility and community settings with the appropriate service provider/s.

Table 2.2: PrEP Package of Service

Baseline Service Package	**Month 1 (30 days after initiating PrEP)**
i. Risk assessment & classify if ongoing risk	**i.** Adherence assessment & support
ii. Establish HIV status - HIV testing	**ii.** Screening for: side/adverse effects, STI, risk of kidney disease, SRH needs
iii. Determine eligibility for PrEP use - Medical, laboratory & willingness criteria	**iii.** HIV testing
iv. Complete medical history & physical exam – screening & diagnosis for other conditions	**iv.** Risk reduction counseling & condoms provision
v. Client education & counseling	**v.** Management /address any conditions/ client concerns
	vi. Prescription & dispensing of PrEP
	vii. Referral for any other services

Clinical Follow up Visit	PrEP Refill Visit
(Indicated every 3 months after the initial visit (i.e., months 3, 6, 9, 12, 15, 18 etc.) **i.** Adherence assessment & support **ii.** Screening for: side/adverse effects, STI, risk of kidney disease, SRH needs **iii.** HIV testing **iv.** Counseling -Risk reduction & condoms provision **v.** Management of concurrent ailments **vi.** Prescription (multi-month) & dispensing of PrEP **vii.** Referral for any other services	(For PrEP refill visits in between the clinical follow-up visits e.g., at month 2, month 4, 5, 7…) **i.** Risk assessment & risk reduction counseling **ii.** Adherence assessment & counseling & support **iii.** Management /address any conditions/ client concerns **iv.** Refill client's prescription

2.3.4 PrEP DSD MODELS BY SETTING

DSD models for PrEP can be classified based on the setting of PrEP service into two broad categories:

- Facility Based Setting
- Community Based Setting

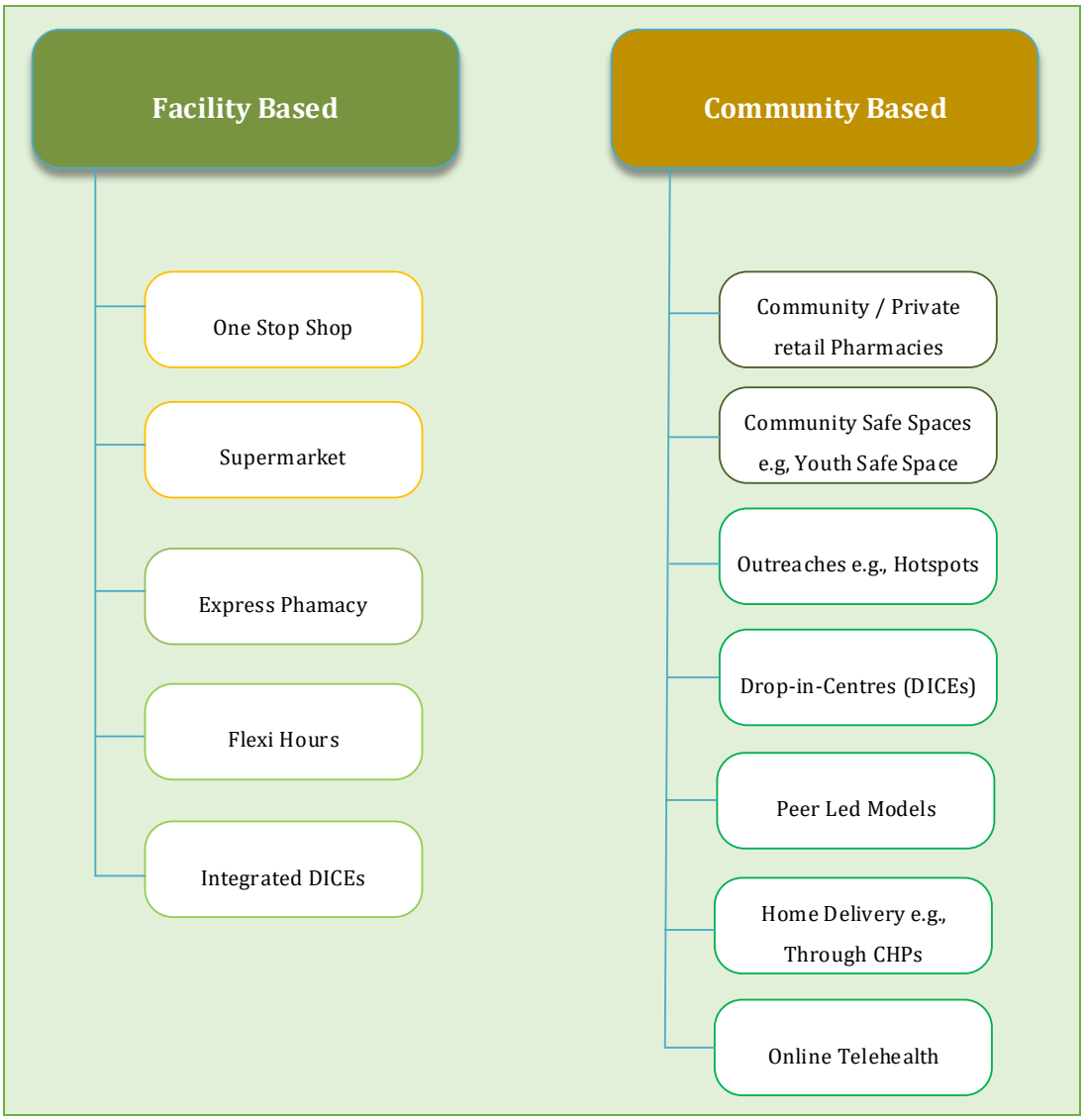


Figure 2.4: DSD Models

2.3.4.1 FACILITY BASED SETTING FOR DSD

Clients presenting to the facility who may benefit from PrEP should be considered for PrEP initiation, restart, refill, and follow-up, based on the PrEP method and regimen they are on. PrEP is indicated for eligible clients at ongoing risk of HIV infection.

DSD for PrEP can be varied and adapted in the facility to incorporate various components, including:

i. Tailored package of service
ii. Varying client's visit times
iii. Expanding and varying service delivery points
iv. Fast-tracking clients
v. Task sharing from facility to community or from clinician to other healthcare and lay providers
vi. Multi-month dispensing
vi. Client self-care

The following models can be adopted in a facility-based setting:

Integrated one-stop shop model

PrEP should not be offered as a stand-alone service but should be integrated into existing services. Every effort should be made to decentralize PrEP services from HIV care clinics and integrate them into other service delivery points.

One stop-shop, also known as a 'kiosk model', is where PrEP services are integrated into other services within a health facility. These services are offered by one service provider in one room during the same consultation. The client receives an array of different services within a single consultation. For example: a client visiting the family planning clinic is also offered HTS and PrEP services during their consultation for contraceptives.

The service delivery points where PrEP can be integrated include outpatient clinics, antenatal clinics, postnatal clinics, family planning clinics, SGBV clinics, chest clinics and special clinics.

Supermarket Model

In this model, the PrEP service package is offered in various components, with one or more components being integrated into other services at different service delivery points. The client is attended to by more than one service provider within one facility during the same visit. The client moves from one service delivery point to another to attain the comprehensive package of prevention service. Every effort should be made to escort and fast-track clients as they move from one service delivery point to another.

Some examples of supermarket model are:

- A contraceptive client receives contraceptive services, screening for HIV risk and prescription at the FP clinic and is referred to the pharmacy to collect their PrEP medication.
- A HTS counselor screens for HIV risk and offers HTS, then links the client to the clinician at the outpatient department for eligibility assessment and prescription, and the client picks up their PrEP medication in the outpatient pharmacy.

Express Pharmacy Model (Fast track model)

This model is mostly applicable for PrEP refill visits, whereby the client goes directly to the pharmacy to get PrEP refills.

These refills may have been pre-packaged by the provider based on the expected return date of the client.

The client records are updated at each refill visit to indicate they have refilled their earlier prescription.

Flexi Hours

PrEP clients' visit times can be varied based on the facility's workload and peak times. They can be scheduled to come during off peak hours or the clinic hours extended to later in the evenings or weekends to cater for PrEP clients.

This is done with the input of the clients and the community representatives to schedule times which are convenient and practical for PrEP visits.

Table 2.3: Facility Based DSD for PrEP

Model	Where	What	When	Who
Integrated One-Stop Shop Model	Antenatal Clinic Family Planning Clinic Post Natal Clinic Outpatient Consultation Room Hospital Pharmacy Youth Friendly Clinics Integrated DICEs HIV Care Clinic	Screening for HIV risk Initial & follow up HIV Testing Counseling & client education Initiation/ Re-initiation Management of concurrent ailments SRH services Clinical follow up Refill follow up Referral for other services Documentation on appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	Clinicians, pharmacists and pharmaceutical technologists
Integrated Supermarket Model ***	Outpatient Consultation Rooms	HIV Risk Assessment Initiation/ Re-initiation Clinical Follow up Initial & follow up HIV testing (PITC) Counseling & client education Prescription for PrEP Management of concurrent ailments Documentation on the appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	HTS Providers Clinicians Lab Personnel Pharmacists
	Antenatal clinic*	Screening for HIV risk Initial & follow up HIV Testing	Baseline / Re-initiation Month 1	Clinicians

		Counselling & client education Initiation/ Re-initiation Dispensing of PrEP Clinical & Refill follow up Management of concurrent ailments Documentation in the appropriate tools	Clinical and refill follow up visits	
	Post Natal & Family planning clinics**	Screening for HIV risk Initial & follow up HIV testing Counseling & client education Initiation/ Re-initiation Clinical & Refill Follow up Management of concurrent ailments Documentation on the appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	Clinicians
	Special Clinics (MOPC, YFC, SGBV clinics etc.)	Screening for HIV risk Counseling & client education Initiation/ Re-initiation Clinical Follow up visits Documentation on appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	Clinicians
	HIV testing rooms	Screening for HIV Risk Counseling & client education Initial & Follow up HIV testing Refill Follow up visits Documentation on appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	HTS providers
	Lab	Initial & follow up HIV Testing	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	Lab Personnel

	Pharmacy	Initiation & Re-initiation Clinical & Refill follow- up visit	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	Pharmacists Pharmaceutical technologists
Notes **Visits are aligned with antenatal care visits, after delivery the client should be linked to another PrEP service delivery point for continuity of service* ***For post-natal clients, follow up for HIV services should be aligned with postnatal care visits and* ****The "What" for the integrated supermarket model site can choose what to offer, a select or full package of the services indicated.*				
Express Pharmacy	Pharmacy	Refill Follow up visits Documentation on appropriate tools	Months 2, 4, 5 etc. (For clients not on MMD)	Pharmacist
Flexi Hours	Antenatal Clinic Family Planning Clinic Post Natal Clinic Outpatient Consultation Room Labs Hospital Pharmacy Youth Friendly Clinics Integrated DICEs HIV Care Clinic	Screening for HIV risk Initial & follow up HIV Testing Counseling & client education Initiation/ Re-initiation Management of concurrent ailments SRH services Clinical follow up Refill follow up Referral for other services Documentation on appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	HTS Providers Clinicians Lab Personnel Pharmacists & Pharmaceutical technologists

2.3.4.2 COMMUNITY DSD For PrEP

Community based DSD for PrEP is used to tailor client needs for PrEP and wider combination prevention offering in a way that is accessible and acceptable to the client, through leveraging on community structures to deliver and decentralize PrEP services from traditional health settings.

In addition, community DSD for PrEP enhances access to PrEP by availing structure for provision of PrEP in the community and creating an avenue for community providers to appropriately participate in offering of PrEP and combination prevention. This reduces the need for clinical health facility visits when they are not necessary. Cadres such as peer educators, community PrEP Champions, community health promoters and online health delivery support staff, can be engaged in whole or various parts of the prevention cascade.

PrEP initiations occurring in the community should follow stipulated guidance from the Ministry i.e., should be done by qualified personnel and align to the package of service for PrEP including documentation.

Requirements for community DSD for PrEP:

The following shall be met when setting up a community DSD model for PrEP:

- Community models shall be linked to a regulated facility authorized to offer PrEP services.
- Providers offering PrEP in the community should be trained and designated to offer whole or various components of the prevention package. They should offer only the component(s) which they are designated and refer to other components as applicable.
- Access to various commodities necessary to delivery services e.g., PrEP, condoms, test kit etc.
- Commodity security and accountability systems should be put in place. Commodity access and management should follow stipulated policy directions. Commodities accessed through the Government pipeline should be accounted for as directed by various policies.
- Documentation, reporting, monitoring and evaluation should be done properly for systems offering PrEP through community DSD. Various reports to reporting authorities should be issued as stipulated.
- Clinical oversight and clear referral systems will need to be factored in the planning to accommodate complex and additional needs for clients choosing community DSD models.
- Other health needs should seamlessly be integrated in the delivery of PrEP and

prevention services to cover holistic prevention and treatment needs of a client through a person-centered approach,

- Community sensitization and community involvement in planning, mobilization, service delivery, monitoring and evaluation
- Setting that has privacy and confidentiality when offering service
- Adherence to national guidance on health delivery

2.3.4.3 Community Based DSD Models:

The following models can be deployed in a community-based setting:

Community/Private Retail Pharmacy

PrEP delivery in community/private retail pharmacies provide an opportunity for easier access, acceptability, and convenience for clients than traditional health care facilities. Studies have noted a huge number of persons receiving health services through private pharmacies who may not interact with the traditional health delivery model. In order to provide a one stop, shop PrEP services; HIV counseling and testing services should form part and parcel of PrEP prescribing and dispensing at the private retail pharmacies with provision of a private consultation room for clients.

This platform can be used to initiate, restart and follow-up PrEP clients, whilst offering combination prevention packages and other health services as needed.

Community/private pharmacies offering PrEP should be authorized to do so and must follow the guidance indicated in this manual.

Community Safe Spaces

Community safe spaces are hubs for designated groups to accord them a safe haven to access services, shield one from harm, interact with peers, learn and gain support. These include safe spaces for various groups like AYP, SGBV survivors, KP, and vulnerable persons.

PrEP and combination prevention packages should be offered based on the needs of these communities through a person-centered approach. Facilities and organizations supporting these spaces shall organize to have a clinical team go to the sites for initiations and clinical visits whilst working with the site staff to do refills and non-clinical prevention services.

Key population Outreaches

Various members of key populations can be reached at different spots they frequent. These can be places of work or recreation, including hotspots, brothels and hangout joints.

Outreaches to these sites need to be sensitive to the dynamics of the site and need to be supported by peer educators and the community intended with the service.

PrEP initiations, re-initiations, refills and follow-ups can be done at these sites by health personnel supported by non-clinical staff.

Peer led models

Peer led models can be varied and can be applied to different components of the prevention package. Peers can support screening, client education, counseling and if trained, HTS and even PrEP refills.

This can take various forms: in person one on one support, support groups or linked to telehealth models like audio and video. They can support education, counseling, screening and assisted self-testing through these platforms. They can also support facility delivery of components of the prevention package.

Studies have shown good PrEP uptake and persistence as a result of peer-based support. This model therefore has potential to be integrated and scaled to offer large components of DSD.

Peers can be within the setting of AYPs, key population, vulnerable population and pregnant and breastfeeding cohorts.

Home Model

This is applicable where PrEP refills are collected by a third party at the health facility or community point and then delivered to the individual at home. The drug collection can be carried out by a community health promoter, trained peer or an authorized private service provider.

This model applies to clients attached to a PrEP delivery site where they can be supported for clinical visits outside of the non-clinical prevention support package.

Online pharmacy/Telehealth for PrEP

The delivery of healthcare services using distant telecommunication technologies enabled by virtual platforms seeks to improve accessibility and convenience for individuals who might encounter difficulties receiving in-person services. Online and telehealth services may be utilized for PrEP initiation through authorized providers who are able to complete the package of service. They can also do follow-up and offer both clinical and non-clinical components.

Various components of the package of service must be supported by trained and certified personnel, and the minimum considerations for community DSD must be achieved.

Online/telehealth prevention package of service may include:

- Online consultation with qualified provider
- Online screening and assessment
- Certified provider going to client site to conduct HTS and initiate, restart or give refill PrEP, through coordination with online clinician to do prescription and deliver PrEP
- Use of vending machines to deliver various products in the prevention package.

Table 2.4: Community Based DSD For PrEP

Model	Where	What	When	Who
Home delivery	Home Designated point	Screening for HIV risk Initial & follow up HIV Testing Counselling & client education Documentation in the appropriate tools	Refill visits	Community health worker Trained Peer Outreach by healthcare worker
Community points	Community Pharmacy Outreaches e.g., Hotspots Safe spaces e.g., DREAMS safe space Peer led models	Screening for HIV risk Initial & follow up HIV Testing Counselling & client education Initiation/ Re-initiation Dispensing of PrEP Clinical & Refill follow up Management of concurrent ailments Documentation in the appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	PrEP trained Pharmacist PrEP trained Pharm tech Clinicians HTS providers Trained peers
Online & Telehealth	E-pharmacy Telehealth	Screening for HIV risk Initial & follow up HIV Testing Counselling & client education Initiation/ Re-initiation Dispensing of PrEP Clinical & Refill follow up Management of concurrent ailments Documentation in the appropriate tools	Baseline / Re-initiation Month 1 Clinical and refill follow up visits	Online and home service: Clinicians HTS Providers Pharmacy personnel Counsellors

2.4 Differentiated Service Delivery for Care & Treatment

This operational manual provides guidance on differential management of all recipients of care, including those enrolling based on clinical/immunological status and those beyond six months on care. It covers patient categorization, recommended DSD models, and steps for implementing DSD at facility and community levels. Additionally, it defines the roles and responsibilities of each stakeholder in the implementation process.

2.4.1 Recipient of care categorization process

Categorization in DSD involves grouping recipients of care based on a defined criteria to establish and determine the package of services that are responsive to their needs and expectations. This should be done at every clinical visit.

The HCW will conduct categorization to all recipients of care as provided in the Kenya HIV Prevention and Treatment Guidelines (see annex 5 and annex 6).

The figure below describes recipient of care categorization

(Figure 2.5).

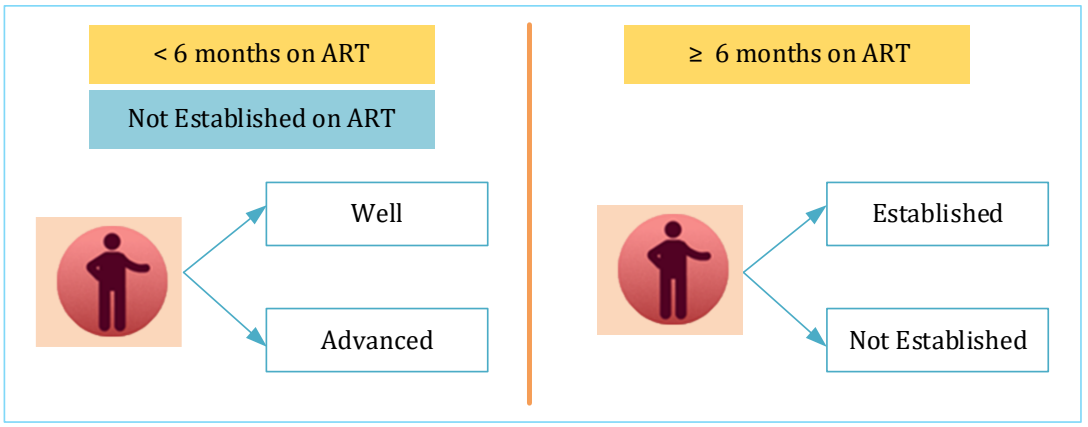


Figure 2.5: Categorization of ROC on ART

HCWs and peer educators should continuously sensitize ROC through facility health talks and one-on-one discussions on the service delivery models being offered. The HCW should inform the ROC on the available DSD models and enroll them appropriately based on patient category and choice.

Categorization of ROCs < 6 months on ART

The recipients of care on ART at enrollment or re-engaging to care may present well or have advanced disease. ROCs with advanced disease are more likely to have opportunistic infections (OIs) and may need frequent consultations or referral for complicated clinical issues. Equally, more focus needs to be placed on adherence counseling with emphasis on the benefits of starting ART early.

Table 2.5: Criteria for ROC who present well or with advanced HIV disease (AHD)

Criteria	
Presenting well	• WHO stage I or II Or • CD4 cell Count ≥ 200 cells/uL
Advanced HIV Disease	• Children <5 years except children below 5 years who are on ART for >1 year and are clinically stable Or • WHO stage III or IV Or • CD4 cell Count <200 cells/uL

Categorization of ROCs ≥6 Months on ART

After six months on ART, most ROCs are expected to have good adherence, developed good coping mechanisms and support systems and have achieved full virological suppression.

It is recommended that they are enrolled in less intensive DSD models which may result to;

- reduced costs
- improved convenience
- improved quality of care

Table 2.6: provides the criteria for determining if a ROC is either or not established on ART

Table 2.6: Criteria for categorization of ROC ≥6 Months on ART

Criteria	Established on ART (ALL applicable)	Not Established on ART (ANY applies)
Duration of ART Regimen	≥ 6 months	< 6 months
Active OI in previous 6 months	None	Present
Comorbidities/Chronic Conditions	Well controlled	Poorly controlled
Adherence to scheduled clinic visit and medication in the last 6 months	Adherent	Poor/not adherent
VL within the last 6 months	Suppressed (≤200 copies/ml)	Not suppressed (>200 copies/ml)

Note:

- This definition should be applied to all populations, including those receiving second- and third-line regimens, those with comorbidities, children above 2 years, adolescents, pregnant and breastfeeding women, and key populations.
- Categorization should be conducted at every visit.

Table 2.7: Package of Care for ROCs Who are Established on ART

What	When	Where	Who
Clinical Appointment			
• Standard Package of Care (Refer to the Kenya HIV Prevention and Treatment Guidelines) • Viral Load and Other routine Investigations (aligned with clinic visits) • Re-assessment of status at Every visit (established vs. not established) • ART: Offer MMD of up to 3 Months (through facility or community-based DSD models) in between clinic appointments • FP: ROCs on injectable contraception should be provided with FP through a fast-tracked process between clinical follow-up visits; oral contraception and condoms should be distributed with ART • Adherence Support • Additional visits as required to address any medical or psychological concerns • Closer follow-up based on ROC preference	6 monthly	Facility/Clinic	Clinician pharmacist, Adherence counselor Lab technologist
ART Refill			
• Provide ART Refills • TB Screening • Oral FP • Medication refills for ROCs with well controlled NCDs	3 monthly	Facility/ Community	Clinician Peer educator Pharmacist

ROCs not established on ART should receive case management to address the various clinical, psychosocial and treatment adherence issues.

Table 2.8: Package of Care for ROCs Who are NOT Established on ART

What	When	Where	Who
• Standard Package of Care (as per the Kenya HIV Prevention and Treatment Guidelines) • Case management • Clinical Assessment - assess/address factors why ROC is not established on ART • Assessment and provision of package for ROC with AHD (OI screening, diagnosis, and management) • ART Refills 1 - 2 monthly • Adherence monitoring, and support • Additional visits as required to address any medical or psychosocial concerns • Home visits	1-3 monthly	Facility	Clinician Adherence Counselor Lab Technologist Pharmacist peer educators

2.4.2 Advanced HIV Disease (AHD)

PLHIV with AHD have compromised immune systems and are at increased risk of morbidity and mortality which may lead to high health-care costs and frequent monitoring needs.

The leading causes of mortality in AHD include immune reconstitution inflammatory syndrome (IRIS), tuberculosis (TB), severe bacterial infections, cryptococcal disease, cervical cancer, histoplasmosis, toxoplasmosis, Pneumocystis Jirovecii pneumonia and malnutrition.

2.4.2.1 Package of Care for Advanced HIV Disease

The following populations of ROCs should be offered CD4 testing to identify presence of AHD and determine eligibility for package for care:

- Initiating ART:
    - CD4 testing should be conducted as a baseline test for ALL PLHIV
- ROCs treatment experienced:
    - PLHIV ≥5 years of age reinitiating ART after 3 or more months of treatment interruption
    - Individuals who have documented persistent unsuppressed viral load (two viral load VL >1,000 within 3-6 months).

PLHIV with Advanced HIV Disease (AHD) need to be promptly identified and offered a package of care.

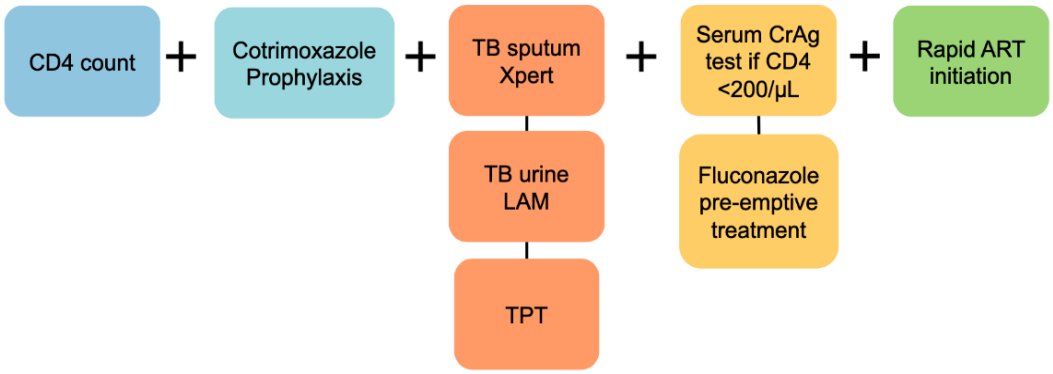


Figure 2.6: WHO recommended package for identification care for AHD

Note: *All PLHIV women of child bearing age should be screened for cervical cancer as per the national guidelines.*

The following table 2.9 summarizes the package of care for PLHIV with AHD.

Table 2.9: Package of care for PLHIV with AHD

What	When	Where	Who
(a) Nutritional assessment and support: Provide intensive support management for those with illness and moderate or severe acute malnutrition. **(b) Prompt identification and management of opportunistic infections:** • GeneXpert ultra for TB diagnosis for all PLHIV with presumptive TB • TB-LAM in addition to GeneXpert ultra, for PLHIV with presumptive TB, those with a CD4 of ≤ 200 cells/mm3 (CD4% ≤ 25% in children < 5 years), have signs of severe illness, or are currently admitted to hospital. • Cryptococcal antigen screening for adolescents and adults with CD4 ≤ 200 cells/mm3 or clinical suspicion of meningitis **(c) OI Prophylaxis** • Provide Cotrimoxazole Preventive Therapy (CPT) for all ROCs with AHD. • Provide TB Preventive Therapy (TPT) as per the national guidelines for all ROCs screening negative for TB symptoms. **(d) Immediate ART initiation:** • ROCs with TB: Start anti-TB treatment immediately and initiate ART as soon as anti-TB medications are tolerated, preferably within 2 weeks. For TB meningitis delay ART for 4 to 8 weeks. • ROCs with cryptococcal meningitis (CM): defer ART until after 5 weeks of CM treatment. • **Close monitoring for development of immune reconstitution inflammatory syndrome**	• Weekly follow-up until ART initiation, and then at week 2 and 4 after ART initiation, and then monthly until confirmed viral suppression. • More frequent visits or hospitalization may be required to stabilize acute medical conditions. • Frequent follow up as maybe needed post-discharge.	• Outpatient or CCC • In patient referrals and management for acutely ill ROCs	• Clinician • Adherence Counselor • Lab Technician • Pharmacy staff • Physician • Peer educator

2.4.3 Differentiated service delivery models

Differentiated Service Delivery for HIV Care can be broadly classified as follows:

- **More-intensive service delivery models;** These are facility-based DSD models preferred for people who are not established on ART e.g., newly starting HIV treatment, those with opportunistic infections and/or co-morbidities, people with unsuppressed viral load, groups who need close follow-up and those with psychosocial issues or barriers to adherence.
- **Less-intensive service delivery models**; These are either facility or community-based models preferred for recipients of care who are established on ART. These models typically emphasize on education and empowerment of recipients of care, streamlined services, and less frequent visits to health facilities.

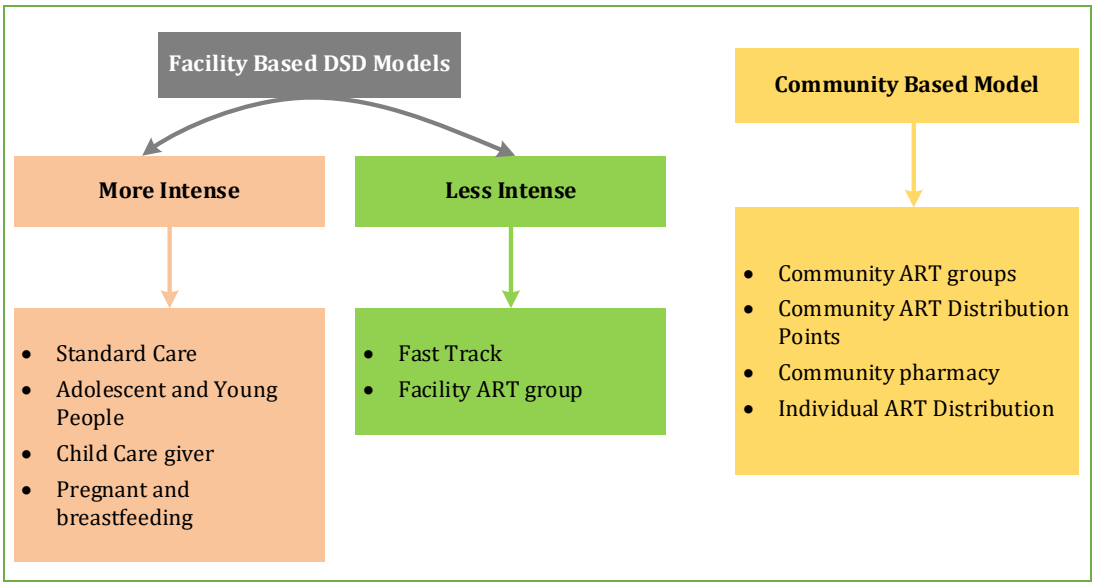


Figure 2.7: Summary of adopted DSD models for HIV services in Kenya

2.4.4 DSD Models for ROCs Established on ART

ROCs who are established on ART require less frequent facility follow-up, with up to six months between clinical appointments, they can either receive their ART refills at the health facility or in the community, as discussed in the following sections. ART distribution can be through a facility-based or a community-based process.

ART distribution, whether facility or community-based, must always be documented on the ART Distribution Form (Annex 7). The Pharmacy Dispensing Tool/ADT must be updated after every refill.

2.4.4.1 Facility Based Models

The ROCs in all categories should receive clinical evaluation, investigations, and ART prescriptions at the health facility. ROCs established on ART can be enrolled in other facility-based DSD models (Standard care, Fast track, Facility ART groups, outreach clinics and flexi hours etc.)

All ROCs regardless of the model should be evaluated 6 monthly during their clinical visit at the facility as per the ART guidelines or when there are other clinical concerns.

2.4.4.1.1 Facility-Based Fast Track Model

The facility-based fast track is a simple model implemented at the health facility. The ROC is still required to come to the clinic every three months for ART refill, however the refill appointments require minimal or no waiting time at the clinic.

Table 2.10: below summarizes the steps for implementation of facility fast track model.

Established: Facility Fast Track ART Refill visit 	**Categorization and Entry into Fast Track Model** ● The Clinician uses the ROC categorization checklist (Annex 6) to identify ROCs established on ART during their routine clinic visit. ● The ROC is sensitized about Fast Track ART Refill model and agrees to come back in 3 months for a refill, then in 6 months for another full clinical appointment ● Appointment dates set for the refill in 3 months and the clinical appointment in 6 months, are recorded in the Clinic Appointment Diary
Registration and file Retrieval 	**Before Day of Refill Appointment:** ● The HCW in charge of tracking ART refill appointments, uses the master clinic appointment Diary for ART Refills to identify ROCs who are expected to pick their ART refills on the following day. ● The HCW confirms client's regimen from the ART register, ROC file or in the EMR. The ART and other commodities (condoms, CPT, family planning, etc.) are pre-packed by the HCW and clearly labeled with the ROC's regimen and number. ● The HCW completes the first section (A of Annex 7) of the ART Distribution Form and signs the form.
Triage 	**On Day of ART Refill Appointment:** ● Upon arrival at the facility, the ROC goes directly to the ART refill pick-up point upon triage (e.g., the ART Distribution pharmacy window, or the ART distribution designated desk/point of care,) ● The person distributing the pre-packed ART (e.g., the pharmacist or peer -educator completes the second section (section B of Annex 7) of the ART Distribution Form (which includes a simple clinical assessment) for each ROC. ● The ROC is reminded of the date for their next appointment in 3 months for a clinical review ● The completed ART Distribution Forms are used to update the Pharmacy Dispensing Tool/ADT ● All ART Distribution Forms are collated at the end of each

Pharmacy 	day and submitted to the health Records Officer or designee who records them in the ART Refill Register and places the forms into the ROC file • ROC comes for clinic appointment following the standard ROC flow, is recategorized and receives the standard package of care • The Health Care Worker reviews the Refill Appointment Schedule at the end of the day to confirm all expected ROCs came to pick their refills. If any ROC did not come for their refill as expected, the ROC should be entered into the facility's missed appointment/defaulter register for tracing.
↓ **Appointment Booking**  **Schedule next appointment for a comprehensive clinical evaluation**	**On Day of Clinical Review Appointment** • ROC comes for clinic appointment following the standard ROC flow, • Recategorization is done to inform the standard package of care

Figure 2.8: Steps for implementation of Facility Fast Track Model

Each health facility can determine the precise process for a facility-based fast track model that works best for their staffing levels, ROC load, and infrastructure. Possible modifications include:

- Another HCW or peer counselor other than the pharmacist, can be responsible for maintaining the clinic appointment diary listing the ROCs that are expected to come for refills the next day, and identifying and flagging defaulters who did not pick their refills as expected.
- ART refill pick-ups can be available during normal working hours, as well as designated extended hours such as early morning, evenings, and weekends

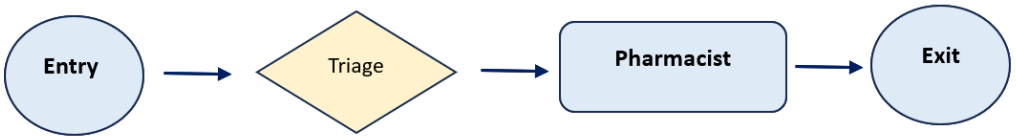


Figure 2.9: Client flow for facility fast track ART refill visit

2.4.4.1.2 Facility ART distribution group (FAG) model

This is an ART distribution model where a group of PLHIVs meet at a designated location within the health facility for ART refill while ensuring peer support and treatment literacy.

A peer or HCW provides ART refills every 3 months. Each ROC in the model is required to attend their clinical review appointment every 6 months.

FAG model may provide ROCs with psychosocial support if they do not belong to any support group. The model maybe more convenient for ROCs who are in urban settings and would not wish to be enrolled in a community ART group.

The implementation of FAGs may operate as described below;

Step 1: MDT discussion 	• Facility MDT discusses and agrees on whether to adopt a peer or HCW led FAG and appoints a focal person (who can be a HCW or peer counselor). • Identify all the eligible ROCs within the clinic who are interested in facility DSD model regardless of their physical location.
Step 2: ROC sensitization and enrollment 	• Sensitization on the available models for DSD during the facility health talk. • Provide focused sensitization for those ROCs interested in the FAG model. • After sensitization, ROCs form preferable groups with members in consultation with the HCW and referred to the focal person for enrollment.
Step 3: Group enrollment 	• Each group should have 6 - 15 members. • Members should decide their preferred day and time for their meetings once the group attains the minimum membership.

Step 4: FAG meeting 	**The first meeting:** • The focal person convenes an introductory meeting and educates the ROCs on the model using the DSD sensitization orientation package. • A group leader is selected who will coordinate the group's activities and be the liaison with the health facility. • Every group member receives a synchronized clinical visit and drug refill appointment date. • All ROCs also receive drugs to cover until the next refill date. **ART refill meeting** • A peer or HCW provides pre-packed ART refills to group members during the scheduled meetings and documents appropriately.

Figure 2.10: Steps to Implementation of facility ART distribution Group

2.4.4.1.3 Adolescent and young persons (AYP) clubs

Adolescents and young persons have unique challenges related to their psychological development and social support systems. Some considerations need to be factored during the clinical encounters with more focus to those with adherence and viral suppression challenges.

An AYP club is a facility-based model offered to all adolescents and young persons living with HIV to;

- Support treatment literacy
- Enhance adherence
- Provide psychosocial support towards combination prevention, retention in care, improved treatment outcomes and sustained viral suppression.

The health facilities provide convenient clinic days preferably on weekends or school holidays aiming to provide AYP friendly services.

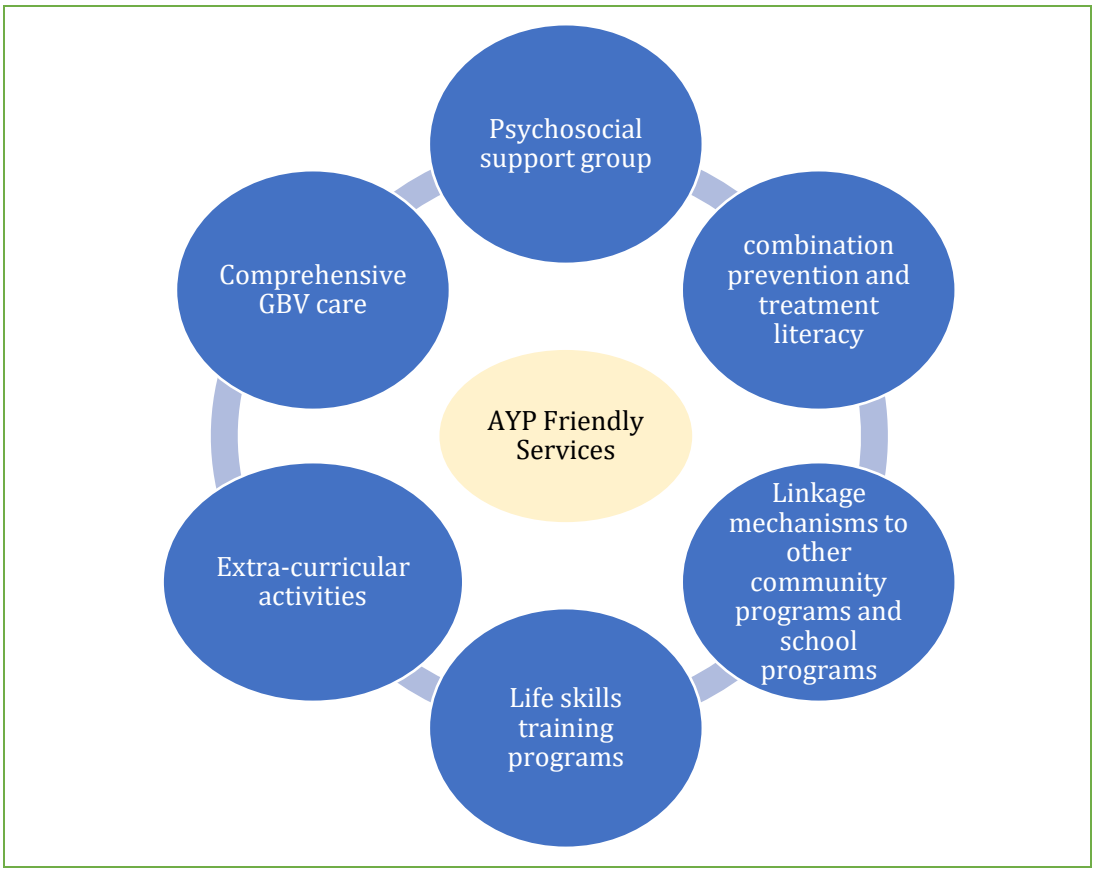


Figure 2.11: AYP friendly services

Table 2.11: Steps of AYP Club Formation

Steps of AYP Club formation	Description
Step 1: Formation	• Sensitize all staff at on AYP models available at the facility • Line list all the AYP in care and stratify them by age 10-14yrs; 15-19 years and 20-24 years. • Provide focused sensitizations for all AYP using the DSD orientation package • Sensitize primary caregiver on AYP model and post disclosure process • Each cohort should identify their peer champion from both genders to address specific needs. • Among the identified peer champions, MDT can identify one of them to coordinate the club's activities.
Step 2: During AYP meeting	• Organize at least quarterly AYP club meetings and document activities of each meeting • Align combination prevention, peer to peer psychosocial support, adherence assessments and counseling and ART refill during the visit.
Step 3: At the end of AYP meeting	• AYP are given clinic appointments synchronized with the academic calendar. • Organize at least quarterly AYP club meetings and document activities of each meeting.

2.4.4.1.4 Child care giver model

Differentiated service delivery may need to take a special form with children as their treatment hinges a lot on the dynamics of the family and support from their caregivers. This should follow a family-centered approach where synchronized appointments with longer prescription periods are provided.

Enrollment into the child- care giver model should be supported by a well-defined eligibility criterion which should recognize the need for dose adjustments.

Steps to Establish the child-caregiver model

Pairing of the parent/caregiver and child is based on virological and clinical assessment of either or both as described in Table 2.12 below. All children between the ages 2-10 years should be line listed alongside their primary caregiver to categorize the pairs.

Table 2.12: Definition of child-caregiver pairs

Stable child - caregiver pair	Unstable child-caregiver pair
• When the caregiver is negative, and the recent VL of the child is ≤ 200 copies/mL **Or** • Caregiver of unknown HIV status/institutionalized children e.g., in orphanages or in juvenile prison with a viral load of ≤ 200 copies/mL **Or** • When both the child and caregiver are on ART and have a recent viral load of ≤ 200 copies/mL	• Either or both the caregiver and child have a recent viral load >200 copies/mL **Or** • Caregiver is HIV negative, and the child has VL >200 copies/mL

Each pair is addressed individually according to their needs. The following services are provided for the established and not established pairs as outlined below.

Table 2.13: Services for the caregiver/child pair-based categorization

Stable Pair	Unstable pair
• Enhancing ROC literacy on care and treatment focusing on the caregivers and child • Age-appropriate disclosure counseling sessions • Synchronized clinical reviews for the pair • Multi month dispensing up to 3 months	• Enhancing ROC literacy on care and treatment focusing on the caregivers and child • Age-appropriate disclosure counseling sessions • Synchronized clinical reviews for the pair • 2 weeks to 1-month clinical appointments • Assign the pairs to case manager • Ensure drug witnessed ingestion • Optimize treatment • Address ART adherence barriers • Regimen switch where appropriate. • Address other care aspects e.g., nutrition, mental health, linkage to social support

2.4.4.1.5 Considerations for Pregnant and Breastfeeding Women

- Pregnant women who have been on ART and are established on ART may have their HIV clinic appointments integrated with Focused Antenatal Care (FANC) visits.
- Pregnant women initiated on ART during pregnancy may need close follow up to support them in adherence, retention and achieving viral suppression.
- Breast feeding women and their babies will have their clinical visit aligned with the immunization clinics schedule.
- Pregnant and breastfeeding women should receive standard packages as per the national guidelines on the use of ART and their risk categorization.
- Psychosocial support groups are encouraged for both pregnant and breastfeeding mothers including peer to peer support.

Women who were already on multi-month dispensing (MMD) refills before pregnancy should be allowed to continue with the same frequency of refills while ensuring they attain the minimum required number of FANC visits.

2.4.4.1.6 DSD For Special Consideration

Outreach Clinics

All ROCs (both established and those not established on ART) may be eligible for this model. The model serves special populations such as people residing in hard-to-reach areas, pastoralist community and key and vulnerable population. The range of services include ART refill, standard package of care.

Steps on how to implement outreach model

- Primary health facilities identify ROCs under their care who need outreach services
- Mapping of outreach sites is conducted such as dispensary, school, church, social hall, pastoralist watering points etc.
- Line listing of ROCs preferring this model is done and they are allowed to select their preferred outreach sites.
- Specific dates for each outreach are determined and ROC appointment dates are aligned.
- Communication is done to the ROCs prior to the scheduled outreach dates as a reminder using text messages platforms e.g., *Ushauri.*
- ROCs get their services during the outreaches
- Complete documentation is done at the outreach site and updated in the facility.

Flexi hour model

This model may serve ROCs who have challenges to keep clinic appointments due to the nature of their work or other daily activities. All services are provided outside the facility working hours which may include;

- early morning
- evening hours
- weekends
- public holidays

The facility makes a schedule to ensure that the flexi hour clinic has a HCW to available during the clinic. Documentation is done just like in a routine clinical encounter.

The implementation of outreach and flexi hour DSD are described below.

Table 2.14: Implementation of outreach and flexi hour DSD

	Outreach clinic	Flexi Hours
What	Standard package of care, ART Refill	Standard package of care, ART Refill
Where	Out of Facility	Within The facility
When	Established on ART • 6 monthly clinic visits • 3 monthly for ART refills. Not established (frequent as needed)	Established on ART • 6 monthly clinic visits • 3 monthly for ART refills Not established (frequent as needed)
Who	Health care worker, Peer Educator	Health care worker

2.4.5 Community based DSD models

The ROCs established on ART can receive their ART refill through various community-based models and may benefit from home visits for adherence monitoring and support, which can be provided on a case-by-case basis.

2.4.5.1 Community ART groups (CAG)

A CAG provides an alternative to the facility-based models for ART refills. CAGs which can be peer led or HCW led also provide ROCs with psychosocial support. A support-group structure is used in which individuals are required to visit the facility every six months for a clinical review, while ART refills are distributed through the CAG every three months between these facility appointments.

CAGs may work in both rural and urban settings where members are comfortable to have their ART refills in their preferred localities within the community. All facilities should have a functional facility-based fast track system in place before the implementation of CAGs. The formation of CAGs and examples of how peer-led and HCW-led CAGs may operate are described below.

Table 2.15: Steps to formation and supervision of Community ART Groups (CAGs)

Step	Description
Step 1: Mapping	• Facility MDT discusses and agrees on the model of CAGs to adopt either peer or HCW led and appoints a DSD focal person. • Map out and line list all villages/locality served by the facility. • Secure a list of all villages/locality and community units with known common identifiable landmarks for ROCs to identify proximity when selecting which CAG to join in.
Step 2: Sensitization and enrollment	• ROC who prefers to be enrolled in CAG should be provided with continuous in-depth education and re-sensitization on how the model functions. • A line list of ROCs who prefer this model is developed and stratified per their community units. • A second sensitization and ROC education is undertaken for ROC cohorts that have opted for the CAG to ensure all ROCs clearly understand what is expected of them in terms of keeping appointment and adherence to treatment. • ROC are linked to the DSD focal person for enrollment.
Step 3: Group formation	• ROC stratified by their villages and community units voluntarily choose group members putting into consideration factors such as proximity based on known common landmarks, preferred meeting day and time (e.g., weekend or evening club meetings) and a line list of all the proposed groups are created • This process should be continuous until each group has of 6 - 15 members. • Once the group attains the minimum number, plan for the first CAG meeting and synchronize their ART refill dates and clinical appointments. **NB:** ROC not enrolled in a CAG are continually sensitized on the various existing groups and voluntarily choose the CAG to join. ROC should not be in two CAGs at the same time

Step	Description
Step 4: First CAG meeting	• The first CAG meeting should be held at the facility to set norms and expectations and should not be a refill meeting. • The DSD focal person re-sensitizes the ROCs on the CAG model. • Each CAG selects the group leader who will coordinate the group's activities and is the liaison with the health facility. • On this day everyone receives a merged clinical visit and every CAG member receives ART drugs to cover for any deficit that may occur before the synchronized refill date.
Step 5: Supervision of CAGs	• The DSD focal person should meet with all the group leaders quarterly and any time there is concern about CAG performance (clinic attendance, timely refill distribution, viral suppression, non-adherence to group norms, etc.). • The DSD focal person should attend the first 3 CAG meetings and decrease the frequency of supervision to bi-annual group leadership meetings once the group stabilizes. • Refresher training on group dynamics, ART distribution, ART refill forms, referrals, and M&E should be provided as brief update sessions to CAG leaders and members during regular CAG meetings.

2.4.5.2 Health Care Worker /Peer-led Community ART Groups

An example of how the HCW/peer-led CAG model may operate is described in Figure 2.11

Community ART Group – HCW/Peer led	**Preparation for Community ART Group refill**
	1. The CAG DSD focal person/HCW identifies which CAGs are due for their 3 months refill a day prior to the appointment. 2. The ART and other commodities medicines (CPT, family planning, etc.) are pre-packed by the HCW and clearly labeled with the ROCs' unique identifier. 3. The HCW completes and signs the first section of ART distribution form 4. The pre-packed ART, other commodities ART and ART Distribution Forms are given to the HCW/CAG peer lead who will be attending the CAG meeting and distribute the ART and other commodities.

CAG meeting in the community

Complete ART Distribution Form for each ROC

CAG Refill Meetings (HCW/Peer-led)

1. Each member presents their ROC card to the meeting chair as they introduce themselves to other members
2. The CAG leader gives a brief overview of the ground rules that have been established for the group
3. Any member in the CAG with a psychosocial need, a concern related to HIV or taking their ART is allowed to share.
4. The HCW/ peer assists to conduct individual pill count and gives a brief group adherence counseling session
5. Completion of the ART Distribution Form for each member and screening for any new symptoms/danger signs is done and anyone with a symptom is referred to the facility for clinical review.
6. Distribution of pre-packed ART and other commodities to each member is done as they sign the ART distribution form.
7. Follow-up plan for any CAG members who did not attend the meeting is discussed
8. ROCs are reminded of their next clinical appointment

Updating Tools at the Facility

1. The filled and signed ART Distribution Forms are returned to the facility within 24 hours.
2. These forms are used to update the pharmacy daily ART Register, and the Pharmacy Dispensing Tool (ADT)
3. The forms are then filed in the ROC file or entered in the facility EMR (ART refill form)
4. ROCs who did not attend the CAG meeting to pick up their ART refill as expected are entered into the facility's missed appointment/defaulter register for tracing.

Clinical Review Visit

1. The group members attend the scheduled bi-annual clinical review at the health facility.
2. Each ROC is assessed and re-categorized during this clinic visit.

Book next appointment  **Group Clinical visit for CAG members** **Clinical assessment of CAG members** **Pharmacy: Collect pre-packed ART for group members**  Use information in ART Distribution Form to update facility M&E tools during visit	3. Offer the Standard Package of Care 4. Issue and document 3 months refill and six months clinical review appointments **NB:** The CAG members are encouraged to attend the clinical review as a group. The clinical review visit can also occur in the community instead of the health facility. If such a request is made by the CAG members, the CAG leader should ensure that the venue for the meeting where a HCW will attend for clinical visit is conducive to allow clinical and ROC privacy. The HCW is required to carry ROC medical records to a CAG meeting, perform and document appropriate history, physical examination, offer the standard package of care, and draw samples for laboratory investigations if needed.

Figure 2.12: HCW/peer-led CAG model

2.4.5.2 Community ART distribution points (CAPD)

The model can be implemented like the HCW/peer-led CAG described above, except the ROCs receiving their ART refills are not part of a CAG.

Step	Description
Preparation for ART distribution	• Map and locate ART distribution points to be served by the facility. The mapping list should have all possible known landmarks per village/locality and identifiable friendly environments as proposed distribution points. Additionally, a schedule for ART distribution points per month should be identified in order to support ROC appointment date alignments when they select a specific distribution point • ROC sensitization should be done on the ART distribution model • Share and discuss the available list of mapped distribution

Step	Description
	points and schedule. • Line list individual ROCs based on their preferred ART distribution points • Synchronize client's appointments with ART distribution points. **NB;** ROC should pick their refill from one CAPD. In case the ROC needs to change their collection point they have to be deregistered from their current CAPD before getting enrolled to a new one.
Activities before the scheduled Distribution Day 	• Pre-packed ART and other commodities (e.g., CPT, FP, etc.) and ART distribution forms are given to the HCW/peer assigned to the ART distribution point • Send a reminder to ROCs about the ART refill prior to the community distribution appointment as per the existing appointment management system.
ART and other medicines Distribution 	• A HCW or peer brings pre-packed ART and other commodities to a predetermined location in the community on a date when several ROCs are due for their ART refill. • The HCW or peer completes the ART distribution form with each ROC and provides the 3-month ART refill. • Screening for any new symptoms/danger signs is done and anyone with a symptom is referred to the facility for clinical review. • Remind the ROCs of their next clinical review appointment at the facility. • ART and other commodities not distributed are returned to the facility pharmacy for accountability.
Updating Tools at the Facility 	• The filled and signed ART distribution forms are returned to the facility within 24 hours • These forms are used to update the Pharmacy Daily ART Register or Pharmacy Dispensing Tool. • The forms are then filed in the ROC file or entered in the facility EMR • ROCs who did not pick up their ART refill at the distribution point are entered into the facility's missed appointment/defaulter register for tracing.

Figure 2.13: Implementation of Community ART Distribution Points

2.4.5.3 Individual ART community distribution (IACD)

ART and other commodities refills can be distributed by HCWs, peer educators or through courier services at an agreed convenient location with individual ROCs.

Step	Description
Preparation for individual ART distribution 	• The DSD focal person line lists all ROCs who prefer this model with their updated physical location and phone details • Identify an HCW/peer-educator preferred by most ROCs on this model to conduct ART distribution. • The HCW/peer-educator can be assigned several established ROCs to follow for ART refills, using a case management model. • The HCW/peer educator uses the line listed physical locations of ROCs in the model to identify travel routes for ART distribution. • Align specific routes to specific ART refills dates **NB:** For ART distribution through courier, the HCW will complete ART distribution form virtually before dispatch.
Activities before individual ART distribution 	• Pre-packed medications and ART distribution forms are given to the HCW/peer assigned to the individual ROCs. • For ART distribution through courier, the HCW will complete ART distribution form virtually before dispatch. • Send a reminder to ROCs about the ART and other commodities delivery date, time and location.
ART and other commodities distribution day 	• A HCW/peer brings pre-packed ART and other commodities refills to the ROC • The HCW or peer completes the ART distribution form and provides the 3-month ART refill. • Screening for any new symptoms/danger signs is done and anyone with a symptom is referred to the facility for clinical review. • Remind the ROCs of their next clinical review appointment at the facility. • ART and other commodities not distributed are returned to the facility pharmacy for accountability.

Step	Description
Updating tools at the facility 	• The filled and signed ART Distribution Forms are returned to the facility within 24 hours. • These forms are used to update the pharmacy Daily ART Register or Pharmacy Dispensing Tool. • The forms are then filed in the ROC file or entered in the facility EMR • ROCs who did not receive their ART refill are entered into the facility's missed appointment/defaulter register for tracing. • For ROCs receiving ART and other commodities through courier, the HCW will confirm receipt and document appropriately

Figure 2.14: Implementation Individual ART Community Distribution

2.4.5.4 Community pharmacy model (CP)

This model is alternative in differentiated service delivery targeting ROCs established on ART who are willing and able to pay a dispensing fee to receive their ART refills and other commodities from private retail pharmacies.

Participation by private pharmacies is on an opt-in basis as guided by the Kenya Private Sector Engagement Framework for HIV Services. The HIV care package will be offered as per the national MoH standards.

Participating pharmacies will meet the following criteria:

- Have qualified, registered and certified health provider(s)
- Be licensed by the relevant/applicable regulatory authority/agency
- Have a master facility list (MFL) code
- Have a pharmacy module linked to the hub's EMR
- Meet the facility assessment checklist for baseline and eligibility criteria
- The Memorandum of Understanding (MOU) - this service agreement document will be signed between participating hub and the private pharmacy outlet and endorsed by the county department of health).

Services that may be offered at the private pharmacy will include:

- Refills of ART and other related medicines for opportunistic infection prophylaxis
- Provision of HIV prevention commodities including HIV test kits, PrEP, PEP and condoms
- TB screening
- Referrals for other services as relevant

A bi-directional referral mechanism between the private and public settings will be established for the ROCs, laboratory samples and sharing of results.

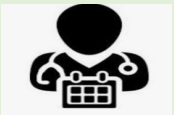
Step	Description of Process
Preparation for community pharmacy model 	• At the referring site, the clinician continuously sensitizes ROCs on existing DSD models including community pharmacy model. • During the clinical visit, the clinician categorizes the ROCs and enrolls those who are eligible and prefer the pharmacy model. • The HCW provides the ROCs with a list of all participating pharmacies for them to select their preferred ARV refill points. • The clinician will then refer the ROC to the community pharmacy. The clinician will enroll the ROC to the pharmacy of choice via EMR where a prescription will be sent to the pharmacy for ART and other medicines refills. • The facility will also provide a list of enrolled ROCs to the community pharmacy outlet and a supply of ART and other commodities.
ART and other commodities refill at community pharmacy 	• During the refill, ROCs enrolled in the community pharmacy model will collect their refill from their preferred pharmacy. • The licensed and trained pharmacy staff will receive the prescription to identify the ROC. • The ART refill form will be completed for each ROC and screening for any new symptoms. • ROC presenting with any danger signs/symptoms is referred to the facility (Hub) for clinical review. • The pharmacy staff will then check the prescription and retrieve the ART and other commodities. • The ROC will then receive adherence messaging including medication use and side effects. • The pharmacy staff will then remind the ROC on their next clinical review appointment date as indicated in the MOH 258 card.
Clinical review visits at the health facility 	• The ROC visits their parent health facility (hub) where the standard package of care is provided and re-categorization is established. • A prescription for their next ART refill which will be collected at the community pharmacy is provided.

Figure 2.15: Implementation of community pharmacy model

For detailed information on implementation of community pharmacy model refer to

community pharmacy model *Implementation Toolkit for HIV Commodities*.

2.5 Leadership and Governance

The purpose of leadership and governance is to assess and support processes for DSD implementation to ensure accountability and dedication of resources. Leadership roles are defined based on level of implementation and structure. Table 2.16 defines the leadership structure and roles in DSD implementation:

Table 2.16: Structures and roles of different levels of leadership

Level	Structure	Roles
National	**NASCOP** • **C&T TWG** ○ **DSD & Integration sub-Committee**	• Develop and review DSD policies, guidelines, and standards. • Develop and update DSD ROC literacy materials. • Conduct routine DSD quality assessment • Coordinating DSD implementation • Capacity building of Health care workers • Oversight and technical assistance • DSD monitoring and evaluation • Resource mobilization for implementation • Integrate DSD quality assessment in the national HIV Service quality assessment.
County	**CHMT**	• Coordination of DSD implementation at the county level • Quarterly review of DSD implementation • Capacity building of Health care workers ○ Mentorship ○ Support supervision • Assessment of DSD implementation through routine M&E data • Resource mobilization and allocation Collaborate with other stakeholders within the county to support DSD implementation
Sub County	**SCHMT**	• Coordination of DSD implementation at the sub county level • Capacity building of healthcare workers ○ Training ○ Mentorship ○ Support supervision

Level	Structure	Roles
		• Assessment of DSD implementation through routine M&E data • Quarterly review of DSD implementation
Facility	**HMT** • **CCC** ○ **MDT/WIT**	• Conduct facility readiness assessment for various DSD models • Implementation of DSD models • Sensitization of ROCs on DSD models for informed decision making • Conduct quarterly performance review on DSD implementation, • Data Review meetings • Routine data collection and reporting on DSD implementation • Document and share best practices • Create and support community structures for implementing DSD • Conduct bi-annual ROC satisfaction surveys • Distribute required commodities to support DSD implementation • Perform routine DQA • Assessment of eligible community pharmacies for DSD implementation • Identification of ART pick up points in the community • Perform routine DQA
Community	**Recipients of care**	• Participate in identification of ART pick up points in the community • Own the community DSD models and provide feedback (community led monitoring)

2.5.1 Assignment of Roles

Implementing DSD can create efficiencies in facility processes despite staffing challenges, but it requires distributing additional roles among healthcare workers and lay health workers, with ROCs actively involved in their care.

Table 2.16 provides examples of how roles can be distributed amongst the team, and should be customized based on facility staffing levels, workload, and the models of DSD.

Table 2.17: Distribution of roles among the various healthcare workers.

NB: ***FIC –*** *Facility in Charge.* ***MO*** *– Medical Officer,* ***CO*** *– Clinical Officer,* ***MDT*** *- Facility Multi-Disciplinary Team,* ***WIT*** *- Work Improvement Team,* ***AC*** *– Adherence Counselor,* ***Pharm Tech*** *- Pharmaceutical Technologist,* ***Lab Tech*** *- Laboratory Technologist,* ***HRIO*** *– Health Records and Information Officer,* ***DC –*** *Data Clerk,* ***PM –*** *Peer Mentor*

No.	Role/Responsibility	FIC	MO/ CO	MDT)/ (WIT)	NO	AC	Pharm Tech	Lab Tech	HRIO / DC	PM
1	Oversee the planning, role assignment, implementation, and monitoring of DSD	**X**	X	X	x					
2	Consult with and report to Sub County, County and National teams on DSD implementation	**X**								
3	Ensure training of HCWs and lay health workers on DSD using the Kenya HIV Prevention and Treatment guidelines.	**X**	X	X	X		X			
4	Support the formation and training of ROCs on available DSD models	X	**X**		X	X				X
5	Conduct health talks using the DSD IEC material		X		**X**	X	x			X
6	Categorize and re-categorize ROC for the differentiated service delivery		**X**		X					
7	Provide the Standard Package of Care and additional differentiated services based on ROC category		**X**	X	X	X	X	X	X	X
8	Map out and review the ROC flow in the HIV clinic, and determine changes required for implementation of DSD	X	X	**X**	X	X	X	X	X	X
9	Ensure results from laboratory investigation		X		X	X		**X**		X

No.	Role/Responsibility	FIC	MO/ CO	MDT)/ (WIT)	NO	AC	Pharm Tech	Lab Tech	HRIO / DC	PM
	are available for ROC management at their scheduled visit									
10	Reorganize the pharmacy processes to accommodate DSD (e.g., ensure adequate stock for more ROC getting 3-month ART supplies; tracking ROC to ensure refills are distributed)	X	X	X	X		**X**			
11	Maintain the ART Refill Register and the Pharmacy ART Dispensing Tool		X		X	X	**X**			X
12	Pre-package and label ART and other medication for individual ROC		X		X		**X**			
13	Work with the DSD focal person to ensure the pre-packed drugs are delivered to the ROC		X		X		**X**			X
14	Manage client's appointment system for drug refills and clinical visits		**X**		X	X	X			X
15	Ensure safe transportation and distribution of pre-packed medicines for facility and community refill programs		X		X	X	**X**			X
16	Complete the ART Refill Form when distributing ART to eligible ROC		X		X	X	**X**			X
17	Ensure ART Distribution Forms are returned to the DSD Focal Person within 24 hours		X		X		**X**			X
18	Provide counseling and psychosocial support to ROC accessing DSD models		X		X	**X**				X
19	Verify ART Refill Forms		X				**X**		X	X

No.	Role/Responsibility	FIC	MO/ CO	MDT)/ (WIT)	NO	AC	Pharm Tech	Lab Tech	HRIO / DC	PM
	and enter data collected into the prerequisite M&E tools (see M&E section)									
20	Conduct performance review of the DSD model(s) being implemented	X		**X**						
21	Document, compile and share best practices on DSD Models	X	X	**X**					X	X
22	Provide mentorship and support supervision on the available DSD models	**X**	X		X	X	X	X	X	X
23	Oversee the day-to-day operation of facility and community-based refill programs for all DSD ROC	**X**								
24	Conduct data quality assessment on DSD			**X**					**X**	

CHAPTER 3: DEMAND CREATION FOR DSD MODELS

Demand creation for DSD involves strategic advocacy efforts, communication, and social mobilization to raise awareness, secure stakeholder buy-in, and encourage the uptake and resource allocation for differentiated service delivery models. DSD models prioritize client-centered approaches, ensuring that services are more accessible, efficient, and responsive to the unique circumstances of each person.

The table below provides factors to consider when developing a demand creation plan for DSD

• Current HIV epidemiological data for the target populations • Coverage of HIV prevention and treatment services • Summary of key target audiences, profile and characteristics • Communication objectives, interventions and measurable targets for various target populations e.g., Opinion leaders/ gate keepers, service providers and communities/ beneficiaries.	• Approaches, key messages and communication channels for various target populations/audiences • Feedback mechanism and opportunities for continuous improvements • Opportunities for co-creation with target audience/ beneficiaries • Knowledge, Attitudes and Practices of the target community

Demand creation for DSD can utilize a variety of channels, including community dialogues, audiovisual mobilization, radio, TV, print media, and digital platforms like social media, apps, websites, and SMS groups. These efforts are supported through advocacy, effective communication, and social mobilization as highlighted below

3.1 Advocacy Interventions for DSD

The advocacy initiatives for DSD focus on advancing ownership/buy-in, mobilizing resources for capacity building and facilitating rollout and scale-up adaptation. These efforts aim to establish a solid foundation for DSD within Kenya's healthcare framework. The table below gives a detailed description of the structural approach to advocacy across various targeted audiences.

Table 3.1: Structural Approach to DSD Advocacy Interventions

Target Audience	Key Message	Mode/ Approach	Forum for advocacy	Responsible Office/ personnel
National Government Leaders (Ministry of Health and Stakeholders)	What is a DSD? - How it improves access and reach for HIV prevention, care and treatment interventions - DSD offers person centered care. Benefits of DSD to the client - It leads to optimum resource utilization hence the need to allocate resources. - Ownership of the DSD models of care as a service delivery intervention i.e., Government led	Policy Brief Power point	Office briefing Stakeholder meetings e.g., breakfast meeting to disseminate	Director Department of Family health Head NASCOP Program leads- Care and Treatment and Prevention
Development /Technical Partners	Enabling policy framework at Global and National levels, e.g., the UNAIDS-95-95-95, WHO DSD model, Implementation/Rollout Framework: e.g., Kenya AIDS Strategic Framework (KASF), Kenya Private Sector Engagement Framework (KPSEF), Partnerships Framework & Multilateral and Bilateral Collaborations, Funding Mechanisms such as PEPFAR, Global Funds, Government of Kenya (G.o.K).	Policy briefs Technical briefs PowerPoints	National Health Sector Coordination Committee (NHSCC), National County Intergovernmental Coordinating Committee (IGCC), Inter-Agencies Coordination Committees (ICCs),	Head, NASCOP; CEO National Syndromic Diseases Control Council (NSDCC); Chair, Kenya Coordination Mechanism (KCM), DG, Health, PS, Health
Implementing Partners	What is DSD Summary of Operational manual for DSD	Power point Technical brief	TWGs Sensitization meetings (National and county)	NASCOP- National HIV (DSD subcommittee)

		DSD operational manual	Dissemination Meetings Stakeholders' forum (NASCOP) County Health/ HIV stakeholder forum County planning meetings (AWP, CIDP)	CHMT (Director, CASCO)
County Government Leaders (Department of Health and Stakeholders e.g., CECM, CHMT, C-TWG)	What is a DSD? (An introduction to DSD) Operational manual for DSD Resource needs and mobilization for DSD. Benefits of DSD to the County health system and population.	IEC Materials PowerPoint presentation Technical Brief Policy brief (CECM)	Interpersonal-Office briefing, CHMT Meetings County Sensitization meetings Virtual platforms-meetings, webinars	NASCOP-National HIV (DSD subcommittee CHMT Focal Person-Directors, CASCO
Sub County Leaders (Sub County Health Stakeholders)	-Introduction to DSD -Available DSD models -Benefits of DSD on Sub County Health systems -Roles of the Sub County leaders in DSD implementation -Resource mobilization for DSD -Operational manual for DSD	PowerPoint presentation DSD IEC materials Operational manual for DSD	-SCHMT meetings -Community dialogue meetings -Sub County TWG forums	NASCOP CHMT SCMOH

3.2 Communication and Social Mobilization for DSD

Communication and social mobilization strategies are crucial for raising awareness about DSD, increasing knowledge and understanding, reducing stigma and discrimination, and improving access to quality HIV prevention and care services. Effective communication should be relevant, appropriate, and evoke trust, using empowering, simple, and positive messages aligned with community values and healthy relationships. Utilizing various channels, such as mass media, community outreaches, social media, interpersonal communication, and peer networks, ensures that key messages are effectively delivered to diverse audiences, promoting acceptance and uptake of these services.

Social mobilization efforts create a supportive environment for DSD by engaging community leaders, and other stakeholders to promote acceptance, access and uptake of DSD services. This approach involves organizing community events, training peer educators, and fostering partnerships with local organizations and health facilities. Key considerations include identifying target audiences, which are categorized into:

- ✓ Primary Audiences
- ✓ Secondary & Tertiary Audiences – Healthcare workers highlighted as a significant category in this group

The table below gives a detailed description of the target audience, key messages and communication channels for various sub-populations.

Table 3.2: Structures for Communication and Social Mobilization for DSD

Target Audience	Key DSD Message(s)	Communication & Mobilization Channels- Where
3.2.1: Primary Audience		
Pregnant and Breastfeeding women (PBFW)	• Testing & Retesting with Duo kit for HIV and Syphilis • One stop shops MCH model for all ANC PNC services including HIV PMTCT • Multi-month dispensing (MMD) for HIV + PBFW	• Community Dialogues - CHPs, church, health camps. • Facility Health Talks. • One on one communications • Phone communication - SMS • Posters, Fliers & other print media
Infants and Children (2-9 yrs.)	Flexi clinics Mother baby pairing Alignment of HIV care appointments to KEPI schedule	Influencers (caregivers) communication & mobilization through community and facility engagement forums.
AYP (AGYW & ABYM) (10-24 years)	HIV Self testing MMD for ART and PrEP Access options - Flexi hours; safe spaces; community pharmacies & on-line pharmacies Prevention products choice	• Educational institutions events - conventions, music, art events. • Community events - parties, youth camps, sports events, church youth events. • Safe spaces - TVs, webpages, apps, print media, health talks. • Peer reach. • Digital/virtual spaces - social media, apps, web. • Health Facility - Youth Friendly Clinics, Youth Integrated service delivery points TVs, webpages, apps, print media, health talks
Adult Men (25+ Years)	• HIV Self testing • Event Driven PrEP • Access options - Community /private retail pharmacy; outreaches; online	• Community - Venue Based: workplace, places of worship, entertainment joints, - Event Based: Political events, Barraza's, sports events. • Radio and TV • Social media • Print media • Partners and social networks reach • Peer reach
Adult Women	HIV Self Testing	• Community Dialogues - CHPs, church, health camps.

	Access options - Community /private retail pharmacy; outreaches; online	• Facility Health Talks. • Posters & other print media. • Phone communication - SMS • Social media • Radio & TV • Peer reach
Key Populations	• HIV Self Testing • Social Network Testing • Safe and Ethical Index Testing • Access options - Outreaches; DICEs; safe spaces; online/digital access • Peer led service options	• Community dialogues - Hotspots, Moonlight outreaches, entertainment joints, KP events. • DICEs - Health talks, Print media, support groups. • Peer and social networks. • Phone communication – SMS
Vulnerable populations (Fisherfolk, Truckers, People in prison settings)	• Social Network Testing • Safe and Ethical Index testing • Access options - Outreaches; DICEs; Safe spaces, mobile clinics, courier services for PrEP, online consultation, home, private clinic • Peer led service options	Community - Operating sites e.g., beaches, truck stops and cell blocks, Venue based Outreaches, Moonlight outreaches Health Facility - Talks, print media, support groups
Discordant couple	• Index testing • U=U Messaging • PrEP for seronegative partner before partner achieves suppression	• Partner reach • Peer reach • Print media • Support groups
PLHIV	Express CARGs Community ART Dispensing U=U messaging VL suppression for DSD.	• Community - Peer and social networks. • Phone communication - SMS • Health Facility - Talks, print media, support groups.
Other key priority populations	• Access options - Community /private retail pharmacy; outreaches; mobile clinics • Social network testing • Adopting human centered design (HCD)-approaches	• Community dialogues - Refugees camps, streets, plantation farms, work places, health camps, sport events. • Peer and social networks • Radio & TV • Print media • Phone communication

Other key priority populations *(internally displaced persons (IDPs), refugees and*

migrant populations, populations in humanitarian settings, street families, people living in large scale agricultural plantations, people with disabilities and members of uniformed services

A. Approaches for Facility Level Demand Creation

Facility health care workers should continuously create demand for DSD by engaging ROC individually or in group facility health talks.

ROC should be empowered to choose their preferred model for accessing ART services.

HCWs must conduct a clinical and psychosocial assessment to determine if the ROC is eligible for enrolment to a model. Enrolment can be;

- ***Passive enrolment:*** Involves ROC asking to be enrolled in available DSD Models.
- ***Active enrolment:*** Involves health care workers actively assessing ROC eligibility and offering them the service model options.

The figure 3.1 provides a flowchart for client education models for DSD models

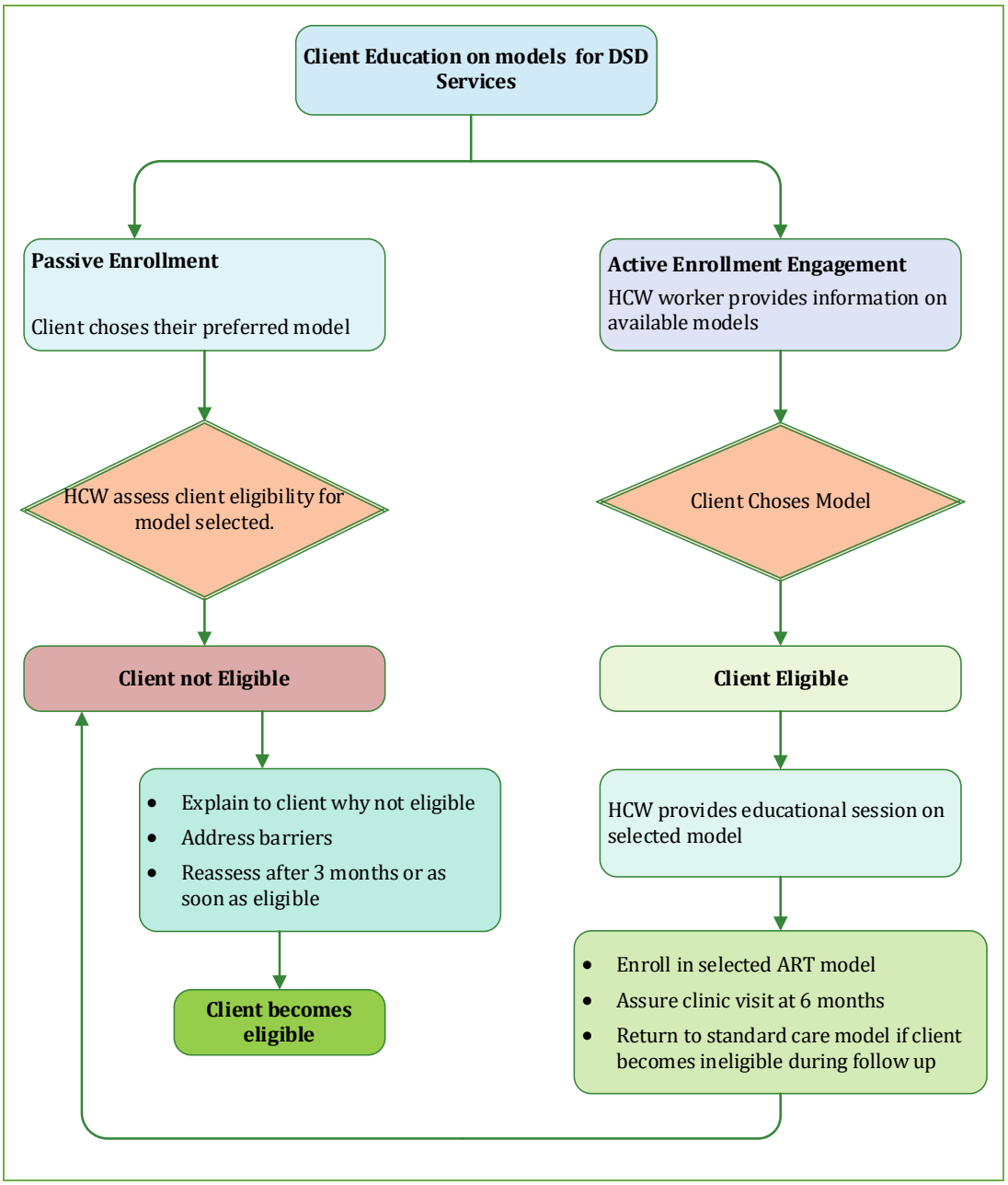


Figure 3.1: Demand Creation at Facility Level

B. Approaches for Community Level demand creation

ROC should be involved as part of meaningful engagement of People Living with HIV/AIDS (MIPA) to create demand for DSD using existing networks and community structures including psychosocial support groups (PSSGs) and community engagement meetings. Nationally approved lay worker curriculum and Information Education Communication (IEC) materials should be utilized during sensitization.

3.2.2: Secondary & Tertiary Audiences

Communication and social mobilization efforts should target both secondary and tertiary audiences who directly or indirectly influence the primary audience.

Table 3.3: Stakeholder Engagement Strategy for Differentiate Service Delivery Model

SECONDARY AUDIENCES *(DIRECT INFLUENCE):*	**WHO:**	PARTNERS, PARENTS, CLOSE RELATIVES, HEALTHCARE WORKERS, COMMUNITY AND RELIGIOUS LEADERS, FRIENDS AND PEERS, COMMUNITY HEALTH WORKERS, CBOS, AND SOCIAL WORKERS.
	Approach:	These audiences should be reached with key messaging on HIV, TB, SRH, SGBV, MH education, service access, and support structures for the primary audience through targeted communication approaches.
TERTIARY AUDIENCES *(INDIRECT INFLUENCE):*	**Who:**	Policy and decision-makers, private sector organizations, civil society organizations, line government ministries and departments, and the general population.
	Approach:	These audiences should be engaged through advocacy efforts to influence policies and create a supportive environment for the primary audience.

By strategically targeting and reaching these secondary and tertiary audiences, we can enhance the effectiveness of our communication and social mobilization efforts to support the primary audience for DSD service delivery model.

3.2.3: Health Providers Sensitization

Healthcare workers in health facilities and community settings are the primary facilitators for the communication plan. To equip them effectively, it is essential to disseminate the DSD package to these workers. The goal is to prepare them for DSD service delivery and support the communication of DSD to the primary audience. This preparation will involve the use of various media, such as; PowerPoint presentations, DSD manuals, and IEC materials, delivered through dissemination meetings, continuous sensitization sessions, and ongoing mentorship programs.

CHAPTER 4: INTEGRATION IN THE CONTEXT OF DSD

Differentiated Service Delivery should ideally be delivered in an integrated setting to holistically tend to the needs of the clients.

The benefits of the integration of services include;

- More person-centeredness
- More efficient for recipient of care
- Minimized missed opportunities

Approaches to integration:

- **One-stop shop**:

  HIV and other health services should be provided in the same place and time.

- **Coordinated referral within the same health facility:**

  Co-schedule HIV services provided at the ART clinic and other health services to maximize convenience, minimize waiting time, and enhance sharing of medical records and communication between clinics.

- **Non-coordinated referral within the same health facility**

  HIV services at ART clinics and other health services elsewhere are provided at the same facility but without co-scheduling.

- **Referrals between service delivery sites**

  HIV services are provided at one health facility and non-HIV services at another.

  This includes referrals between facilities (including public, private, and faith-based facilities), pharmacies, community-based services and more

4.1 HIV Prevention

HIV prevention services provided in any DSD setting should facilitate access to a basic package including:

- Sexual and reproductive health education
- STIs screening, testing (if applicable) and management
- Reproduction intention and contraceptive needs
- Cervical cancer screening, linkage
- Sexual and gender-based violence prevention, response and management
- TB screening, testing and management
- Hepatitis B screening, prevention and treatment.
- Mental health evaluation, linkage and support
- Hypertension, diabetes symptomatic screening and management

4.2 Care and Treatment

ROC requires other services beyond HIV care. Integrating services is aimed at reducing missed opportunities along the cascade of care, enhancing long-term adherence support, and optimizing ROC retention. Integration ensures that HIV and other services are provided as a one-stop shop for ROC, increasing their convenience and improving efficiencies in the health system.

4.2.1 TB/HIV integration

TB is a leading cause of morbidity and mortality amongst PLHIV

Efforts should be made to ensure integration of HIV and TB services at every point to optimize coverage of HIV testing, screening, and diagnosis of active TB as well as timely initiation of treatment. (Table 4.1)

Table 4.1: TB HIV services along the cascade of care.

Service	Integration Approach
Active and Intensive Case Finding	• All clients receiving HIV services should be screened for TB during various visits in their DSD setup at every visit. • All symptomatic clients should be referred to the facility for diagnostic TB work up and TB Preventive Therapy (TPT) or treatment as appropriate. • HIV Testing should be offered as per national guidance to clients suspected of or on treatment for TB.
TB Preventive Therapy	• Clients on care who are on less intense DSD models but had missed TPT should be retained in the same models once they initiate TPT. • TPT and ART refills should be synchronized. • TPT should be provided in line with national TB guidelines.
TB Treatment	• Clients diagnosed with TB should be started on TB treatment. • TB treatment should be integrated at service delivery points offering HIV preventive and care services

4.2.2 NCD/HIV integration in DSD

There is an increased risk of non-communicable diseases (NCDs) in the populace due to a number of risk factors.

Table 4.2: NCD/HIV integration in DSD

Service	Integrated Approach
Hypertension screening and prevention	- Clients receiving HIV services should be offered screening for hypertension through serial BP measurements. - Clients at risk of hypertension should be advised on prevention modalities available and followed up to assess progress.
Hypertension management	- Once clients are diagnosed as hypertensive, they should be started on treatment by designated personnel. - Follow up and management should be integrated with other services including HIV prevention or care. - Refill medications can be offered in various DSD models including community as appropriate for each client clinical status.
Diabetes screening and prevention	- Clients receiving HIV services should be offered screening for diabetes through symptomatic and rapid tests. - Clients at risk of diabetes should be advised on prevention modalities available and followed up to assess progress
Diabetes management	- Once clients are diagnosed as diabetic, they should be started on treatment by designated personnel. - Follow up and management of diabetes should be integrated with other services including HIV prevention or care, whenever possible. - Refill medications can be offered in various DSD models including community as appropriate for each client clinical status.

ROC with well controlled comorbidities should be included in less intense DSD models with synchronized visits.

4.2.3 Sexual Reproductive Health (SRH)/HIV integration

Sexual reproductive health including choice-based family planning (FP) should be integrated with HIV services for all women of childbearing age.

Capacity should be built at the CCC for continuous assessment of pregnancy intention among women of childbearing age. Women with no intention to get pregnant either by choice or due to clinical status should be counseled and offered choice-based FP.

Where supply chain and adequate capacity allows, FP commodities should be provided at the CCC as a one stop shop.

Oral FP may also be provided as part of medication refills including during community group models both by peers or HCWs.

The table below provides a summary on how SRH services can be integrated.

Table 4.3: Sexual Reproductive Health (SRH)/HIV integration

Service	Integration Approach
Sexual and reproductive health education	- All persons accessing HIV services should undergo comprehensive sexual and reproductive health education as part of the prevention or care package.
STIs screening, testing (if applicable) and management	- STIs symptomatic screening and testing (if applicable) should be conducted for persons accessing preventive and care services. - Duo-testing should be conducted for MCH clients - Persons suspected of having STIs should be put on appropriate treatment. - Common STIs medication should be part of the commodities package for settings offering integrated DSD.
Reproduction intention and contraceptive needs	- Clients being offered DSD should be asked on their pregnancy intention. - Clients who are interested in contraceptives should be offered information and choice of a suitable contraceptive. - Family planning commodities should be included in various DSD models as appropriate for setting.
Cervical cancer screening, linkage	- Female clients of reproductive age should have cervical cancer screening conducted every… - Eligible clients should be offered HPV vaccination - Clients with suspected pre-cancerous or cancerous lesions should be managed or linked to prompt and accessible treatment.

4.2.4 Sexual and gender-based violence (SGBV)

All clients accessing HIV care and prevention in a DSD setting should be screened for any form of violence including intimate partner violence (IPV). Preventive services and management for SGBV services should be provided as appropriate for setting. Various support structures including clinical, social and legal support should be availed or mechanisms set to link to these.

It also encouraged that all clients presenting with SGBV complains are provided access to HIV prevention and care services.

4.2.5 Emerging public health priorities for integration in the DSD setting.

Clients accessing HIV preventive and care services should be provided with screening, prevention and support for emerging public health concerns such as mental health and viral hepatitis.

CHAPTER 5. CQI APPROACH TO ENSURE FIDELITY TO DSD IMPLEMENTATION

5.1. Introduction

Quality Improvement (QI) is a management approach that includes the combined effort of all stakeholders (healthcare professionals, clients and their families and educators) to identify system gaps and make the changes that will lead to desired improvement. The healthcare facilities can apply the improvement cycle model in CQI while implementing DSD to improve any step in the care process.

CQI is an approach that seeks to achieve small, incremental changes in the processes of service provision in order to improve efficiency and quality. It focuses on improving health service processes through use of routine data to meet client's needs. It is critical to maintain the quality of services as facilities introduce and implement differentiated service delivery.

5.2 Rationale

To implement DSD effectively, Continuous Quality Improvement (CQI) approach should be integrated. This operational manual will support county, sub-county and facility teams to implement both facility and community-based DSD efficiently by applying the Plan Do Study Act (PDSA) improvement cycle model. Integration of CQI in implementation of DSD borrows the PDSA model as described in the Kenya HIV Quality Improvement Framework (KHQIF).

The PDSA approach has been used successfully to test new ideas to identify and address gaps in the wider HIV prevention, care and treatment cascade. Successful interventions have been included to streamline clients' appointments, adherence, reducing consultation waiting times and clinic flow in a facility.

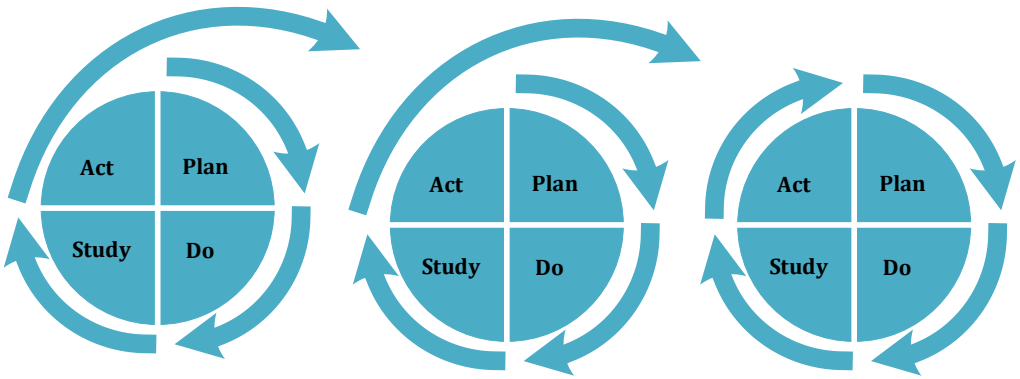


Figure 5.1: Improvement cycle model

The PDSA improvement cycle model has three fundamental questions:

- *What are you trying to improve?*
- *What changes will result in an improvement?*
- H*ow will you know a change is an improvement?*

These questions shall be applied when facilities are deciding which DSD models to implement.

Applying this model shall enable facilities to test potential solutions towards DSD implementation.

The steps involved are outlined below:

- **P**lan a change
- **D**o try it out on a small scale
- **S**tudy the results
- **A**ct to make necessary changes

5.3 CQI Application in DSD

Success in DSD implementation will depend on the efficiency of existing processes and systems. To apply the PDSA model the following steps should be used to address existing gaps:

- **Step 1:** Conduct a situational Analysis
- **Step 2:** Identification of the opportunity for improvement (Problem Identification)
- **Step 3:** Planning and Prioritizing
- **Step 4:** Change package development
- **Step 5:** Performance Measurement
- **Step 6:** Dissemination

These steps are described in table 5.1.

Table 5.1: CQI Steps applied in DSD

CQI Process	Proposed Strategy	Proposed Activity for implementation	Supporting tools and resource materials
Step 1: Conduct a situational Analysis	1. Engage leadership for support of DSD implementation (CHMT/SCHMT/ facility leadership)	Conduct a sensitization meeting on the need and benefits of DSD	• DSD/QI orientation package section for leadership
	2. Identify a team (MDT/WIT) to conduct the situational analysis and identify any gaps and challenges.	Conduct a DSD situational assessment using the DSD situational analysis form	• DSD situational analysis form
	3. Engage with clients to identify priority areas for improvement in DSD implementation	Conduct client's satisfaction survey/feedback session	Clients' satisfaction survey –Annex 8
Step 2. Identification of the opportunity for improvement (Problem Identification)	1. Utilize results from situational analysis and findings from client's satisfaction surveys to identify gaps in DSD implementation	Conduct root cause analysis E.g. If the facility doesn't have a streamlined appointment management system based on findings from the situational assessment the WIT/MDT can resolve this.	Root cause analysis tools –
	2. Apply appropriate CQI tools to characterize and contextualize the gap	• Develop suitable change idea based on the gap using appropriate tools. e.g., Clients may report long waiting times in the facility at consultation and pharmacy. • Based on the identified gap the MDT can conduct	• Process Map template • Driver diagram, • Decision matrix template (Annexe12)

CQI Process	Proposed Strategy	Proposed Activity for implementation	Supporting tools and resource materials
		an actual process map or clients flow to contextualize points of delays. • This may assist to determine a desired DSD model.	
Step 3 **Planning and Prioritizing**	Use priority methodology to understand the contextual factors to determine the intervention	Line list proposed change ideas and prioritize accordingly based on the context E.g. A facility may have noted several gaps that impede the choice of DSD model to offer. In such instances, the facility will be required to use the prioritization matrix, to identify the most appropriate model.	Prioritization matrix tool (Annex 12)
Step 4 **Change package development**	Change package and activity plan development to outline the potential CQI project.	Document the CQI project in the PDSA form and define the period of implementation e.g., 3 months	• PDSA reporting Template (Annex 13 • CQI Digital platform (https://cqi.mgickenya.org)
Step 5: Performance Measurement	Determine how to measure improvement against set target	Identify appropriate indicators to measure e.g., % of established ROCs that will be in community ART group	• Refer to DSD performance indicators list • Process indictor e.g., % of ROC line listed as eligible for less intensive DSD models
	Develop performance monitoring plan to be	Continuously monitor the CQI project on a	• CQI digital platform link

CQI Process	Proposed Strategy	Proposed Activity for implementation	Supporting tools and resource materials
	tracked	regular basis. For example, the team can meet every month to monitor ROC waiting time.	• Data warehouse dashboard
Step 6: Dissemination	Develop package of change ideas for implementation of DSD models for dissemination and scale up	Share findings through peer learning sessions and other county and national forum e.g., implementation of Flexi clinics	Best practice documentation journal

5.4 Tips to consider when implementing CQI activities

A detailed plan is developed to address the identified root cause and should be outlined in the facility workplan (Annex 4) as described below:

- WHAT do you want to do?
- WHEN do you want to do it?
- WHERE will the activity be done?
- WHO will do the activity?
- HOW will the activity be done (This may include data collection and indicator selection)?

5.5 Case study: Use of CQI to improve implementation of CAG Model

Standard: PLHIV categorized as established should be provided with quality care in a manner that meets their needs and expectations while creating efficiencies in the process of care. This will support refocusing resources to those most in need. The ROC established on ART should be enrolled in less intensive models either facility or community based.

Problem Description: During routine monthly performance reviews, Good Hope County Referral Hospital noted low enrollment of ROCs categorized as established into the CAG Model.

Aim Statement: The facility aimed to increase number of established ROCs enrolled into CAGS from current performance of 10% to 50% in 12 months

Gaps identified from a brainstorming exercise included:

- Inadequate sensitization on existing DSD Models
- Sub optimal categorization
- Challenges in group formation

A decision matrix was used by the Facility QI Team to prioritize the identified gaps as follows:

- Sub optimal categorization
- Inadequate sensitization on existing DSD Models
- Challenges in group formation

The facility QI Team conducted a root cause analysis for poor categorization process using a Fishbone diagram.

All categories of the fish bone which include; People (Health staff and ROCs), Place, Procedures, Policies, Provision were analyzed.

Good Hope County Referral Hospital agreed to improve the knowledge gap among Health Staff on categorization of ROCs and long TAT for viral load results.

What was done: A brainstorming session was held to propose change ideas to address the identified root causes. Health care workers' sensitization through mentorships, CMEs and OJTs sessions were held jointly by implementing partner and sub county QI teams.

For long TAT, facility staff nominated a member of the team to be accessing the EID/NASCOP website weekly to print, and ensure results are filed in the ROCs files.

These changes were implemented for a period of six weeks. Data was collected weekly to monitor progress and conduct small tests of change. All QI activities were documented on real time in PDSA sheets.

At the end of the six weeks, performance measurement was conducted to assess health providers ability to categorize ROCs and TAT for viral load results. TAT for viral load improved from 21 days to 7 days and all the health providers in the CCC were able to conduct ROC categorization as per the guidelines. ROC categorization improved from 30% to 90% at Good Hope County Referral Hospital. The above change ideas were successful and adopted as a best practice. During the subsequent data review the QIT noted an improvement in ROCs enrollment in CAGs from 10% to 60%.

The Facility QI Team addressed the other prioritized gaps of ROC sensitization and group formation following similar steps as outlined above.

5.6 Case study: Use of CQI to improve uptake of PrEP Options

Standard: Clients screening negative for HIV exposure and with an established ongoing risk for HIV should be provided with PrEP as a measure of HIV Prevention. This should be done in a manner that simplifies convenience and acceptability for different PrEP options.

Problem Description: During routine monthly performance reviews, Tumaini Drop In Center (DICE) noted low enrollment of clients for PrEP services. These were mainly; AYP, FSW, PWID and MSM with a documented ongoing risk of HIV and were accessing other prevention services at the DICE.

Aim Statement: The DICE aimed to increase number of enrollments for PrEP services for clients testing HIV Negative and with a potential ongoing risk of exposure to HIV, from current performance of 5% to 80% in 12 months

Gaps identified from a brainstorming exercise included:

- Inadequate sensitization of clients on existing PrEP options
- Low integration of PrEP services by Health care workers during clinic visits
- Stigma and discrimination by Health care Workers on PrEP options e.g., Use of Dapivirine vaginal ring among AYP
- Increased incidence of STI's among PrEP users

A decision matrix was used by the Facility QI Team to prioritize the identified gaps as follows:

- Low integration of PrEP services by Health care workers during clinic visits
- Stigma and discrimination by Health care Workers on PrEP options e.g., Use of Dapivirine vaginal ring among AYP
- Inadequate sensitization of clients on existing PrEP options

The facility QI Team conducted a root cause analysis for low integration of PrEP services during clinic visits using a Fishbone diagram.

All categories of the fish bone which include; People (Health staff and ROCs), Place, Procedures, Policies, Provision were analyzed.

Tumaini DICE staff agreed to improve access to PrEP options by hearing views from clients and improving the use of Risk Assessment Screening Tool.

What was done: A brainstorming session was held to propose change ideas to address the identified root causes. Client sensitization on PrEP options were held through one-on-one health talks and by peer educators during Psycho social support groups. Client views on PrEP options were tallied daily.

For the RAST Tool, facility staff nominated a member of the team to sample its use every week by counting the number for correctly filled screening tool found in clients' file.

These changes were implemented for a period of 4 weeks. Data was collected weekly to monitor progress and conduct small tests of change. All QI activities were documented on real time in PDSA sheets.

At the end of the 4 weeks, performance measurement was conducted to assess health Care providers' ability to screen ROC's using the RAST Tool. DSD Options for PrEP were reviewed and out of facility-based models' options were expanded to include Telehealth and community PrEP DSD models based on feedback from clients. The identified community pharmacies that were to serve as spokes were sensitized on the new models and engaged accordingly. Clients accessing PrEP services improved from 5% to 90% at Tumaini DICE. The above change ideas were successful and adopted as a best practice. The DICE addressed the other prioritized gaps following similar steps as outlined.

5.7 Quality Assurance in DSD

Quality Assurance is a means of establishing standards (e.g., Clinical Protocol and Guidelines, Program and administrative standard procedures) and consistently using them as a basis for assessing performance. National or County quality improvement teams can conduct external/internal evaluations using a DSD quality assurance checklist during routine supportive supervision to inform quality Improvement processes. The facility WIT/QIT should conduct internal evaluations on a regular basis to ensure the expected national standards are attained.

5.7.1 Cross Cutting Standards DSD Models

The following cross cutting standards should apply when implementing DSD models in any facility.

Table 5.2: Cross Cutting Standards for DSD models

	DESCRIPTION
General principles	• All clients should be treated with respect regarding their human rights, ethics, privacy and confidentiality, informed consent and choice, autonomy, and dignity. • All DSD models should be delivered in a way that acknowledges specific barriers identified by clients and that empowers them to manage their needs with the support of the health system. • All DSD models should meet standards for client's satisfaction. • All DSD models should demonstrate excellent retention and viral suppression rates.

	DESCRIPTION
Eligibility and enrolment	• All clients are eligible for a DSD Model • All clients can opt-in to their preferred DSD model or to remain the standard care (Conventional) • Recipients of care enrolled in less-intensive DSD models who develop issues requiring more intensive services are promptly identified, assessed by health care workers, and transferred to an appropriate, more-intensive DSD model. If/when they become eligible for less-intensive services, they are offered the option of re-enrolling in a less-intensive DSD model. • Key information about people in DSD models is accurately and completely recorded in health facility records/DSD registers for monitoring and follow-up.
Package of Care Services for DSD	• All ROCs should receive the minimum standard package of care services as per the *Kenya HIV Prevention and Treatment Guidelines* regardless of the DSD models they are enrolled in that that includes: o Antiretroviral therapy o Positive Health, Dignity and Prevention, GBV/IPV & HIV Education and Counseling o Screening for and prevention of specific OIs o Reproductive health services o Screening for and Management of Non-communicable Diseases o Mental health Screening and Management o Nutrition services o Prevention of other infections
Facility Processes Support DSD	• Facilities should set in place systems that ensure: o Efficient client pathways and data at health facilities o Prompt identification and response to missed appointments o Key DSD data is documented and reported promptly irrespective of where services are delivered as well as timely review of data for decision making. o Efficient medication management including ordering, storage, prescription, pre-packing, dispensing/refills, adherence monitoring and documentation.

5.7.2 Model Specific Quality Standards

The standards for facility and community-based DSD models are described below.

Table 5.3: Standards for Facility and Community based DSD Models

Standards for Facility based DSD	Standard for Community based ART Models
• Categorize ROCs based on the criteria outlined in the current ART guidelines. • ROCs should be informed about the facility-based models available to them and given the opportunity to choose their preferred model. • All ROCs on various facility-based Models should receive a standard package of care as per the current ART guidelines during their clinical visit. • ROCs on the fast track should receive a drug refill every three months, undergo a clinical review every six months, and have the option to seek medical attention if they experience any clinical symptoms between appointments. • ROCs on less intensive Facility based DSD model should be triaged and screened for any clinical symptoms as per the ART distribution form. • ROCs on facility-based models should have a valid Viral load result. .	• Categorize ROCs based on the established criteria outlined in the current ART guidelines • ROCs should be sensitized on the available community-based models and be allowed to make an informed model choice. • Facilities implementing community-based models should appoint a DSD focal person to serve as a liaison between the facility and community groups. • Facility HCW should reach out to ROCs for clinical review in case of abnormal laboratory results instead of waiting for the next clinical appointment. • ROCs on Community based Models should be empowered to report back to the facility in case they don't receive correct regimen and or correct regimen dose. • All ROCs on the community DSD models should receive a standard package of care as outlined in the current ART guidelines in monthly clinical visit review. • ROCs on community DSD Models should have a valid Viral load result. • DSD focal person and members should be empowered on the need to see a clinician when they experience any clinical symptoms • If a member of a community-based model fails to pick up their drugs, the DSD focal person should work with the clinical team to initiate tracing.

The process of conducting internal or external Quality Assurance involves random selection of a representative sample of files.

The CHMT should conduct annual DSD quality assessment using the DSD Quality Assessment Checklist the (Annex 9).

Additionally, the CHMT should conduct routine support supervision for DSD to all facilities offering ART services. Key question to be considered during the DSD support supervision include:

- Do you have all the necessary data collection and reporting tools to implement DSD?
- How many data review meetings have been conducted in the last three months to discuss DSD?
- Are there action plans agreed upon after the meeting with clear responsibilities?
- What are some of the challenges faced by the HCW implementing DSD at the heath facility?
- What are some of the proposed solutions to address the challenges?
- What support would you require from the CHMT to improve DSD in the health facility?
- Is there any CQI project that is addressing DSD implementation?
- Does the facility monitor the uptake of various DSD models?

CHAPTER 6: MONITORING AND EVALUATION

This section describes the minimum monitoring, evaluation, and reporting that is expected from all health facilities implementing differentiated service delivery and describes some differences for paper based and EMR sites.

There are many other potential indicators that could be used to learn more about the impact of differentiated Service Delivery and how best it can be implemented.

Counties and health facilities are encouraged to engage in implementation science where capacity exists, and can consider evaluating outcomes such as cost-effectiveness, efficiency, productivity, client waiting times, satisfaction and quality of care.

Various inputs in regard to monitoring and evaluation for both preventive and treatment aspects of DSD are considered based on learnings from implementation, these are reviewed and incorporated as appropriate to improve reporting and monitoring of differentiated service delivery. These may incorporate an expanded framework for M&E for prevention DSD.

Table 6.1: Monitoring and Evaluation Framework for DSD

Differentiated Service Delivery (DSD) Objectives:	• Ensuring efficiencies in HIV service provision using various DSD models • To provide patient centered HIV services through DSD models • Ensuring high quality HIV services for all ROCs
Objective 1: Ensuring efficiencies in HIV service provision using various DSD models	
Output 1	No of Health care workers and community groups trained/sensitized on DSD
Output 2	Proportion of ROC categorized as per the guidelines (Established on ART/NOT Established on ART)
Output 3	Proportion of ROCs enrolled into preferred DSD model
How to achieve objective 1: Training of health care workers and community groups on DSD, strengthening facility and community systems for DSD, designing facility and community-based models and enrolling ROCs into their preferred DC models	
Objective 2: To provide patient centered HIV services through DSD models	
Output 1	Clients keeping appointments
Output 2	Clients provided with HIV services based on their preferred DSD Model
Output 3	Standard package of care for different ROC categories provided
Output 4	ROC re-categorized based on clinical reviews and lab results

Output 5	ROCs enrolled in various DSD models
Output 6	ROCs with suppressed valid viral load
How to achieve objective 2: Categorize all ROCs into established or not established categories; provide the standard package of care as per the ART guideline.	
Objective 3: Ensuring high quality HIV services all DSD models	
Output 1	Periodic DSD quality assessment and support supervision based on the DSD standards checklist
Output 2	Quality improvement project to strengthen DSD implementation
How to achieve objective 3: Conduct sensitization sessions for healthcare workers and community representatives on DSD standards and assessments. Additionally, implement periodic quality audits on a monthly, quarterly, bi-annual, or annual basis.	

6.1 DSD Monitoring and Evaluation Indicators

To ensure effectiveness, efficiency and scalability of DSD approaches, it is important to routinely and periodically monitor and evaluate DSD indicators. This will also guide in evidence-based policy development.

The indicators in Table 4 can be used to monitor implementation of DSD.

Table 6.2: Differentiated Service Delivery Indicators

Domain	Indicator Definition	Computation	Source Documents	Period of Reporting
HIV Care and Treatment	Proportion of Individuals on ART ≥ 6 months after initiation categorized as Established	Numerator: Number of individuals on ART ≥ 6 months after initiation categorized as established	Non EMR Facility: C&T Daily Activity Register EMR: Kenya EMR system NDWH KHIS	Facility: Monthly
		Denominator: Number of individuals on ART ≥ 6 months after initiation		National: Quarterly
	Proportion of Individuals on ART ≥ 6 months after initiation	Numerator: Number of ROCs on ART above ≥ 6 months categorized as NOT established	Non EMR Facility: C&T Daily Activity	Facility: Monthly

	categorized as Not Established	Denominator: Number of ROCs on ART ≥ 6 months after initiation	Register EMR: Kenya EMR system NDWH KHIS	National: Quarterly
	Proportion of individuals Established on ART enrolled in less intensive facility-based DSD models	Numerator: Number of individuals established on ART enrolled in less intensive facility-based DSD models	Kenya EMR system National: Data warehouse	Facility: Monthly
		Denominator: Number of Individuals categorized established on ART		National: Quarterly
	Proportion of Individuals on ART categorized as established on community-based DSD models	Numerator: Number of individuals categorized as established enrolled on Community based DSD models	Kenya EMR system National: Data warehouse	Facility: Monthly
		Denominator: Number of individuals categorized as Established		National: Quarterly
	Proportion of individuals established on ART enrolled on less intense Facility DSD who relapse to Not established	Numerator: Number of individuals established on ART enrolled on less intense Facility DSD who relapse to Not established	Kenya EMR system	Periodic surveys
		Denominator: Number of individuals established enrolled in less intense facility-based DSD models		
	Proportion of individuals established on ART and enrolled in community DSD	Numerator: Number of individuals established on ART and enrolled in community DSD models who relapse to Not		

	models who relapse to Not established	established	Kenya EMR system	Periodic surveys
		Denominator: Number of established individuals enrolled on community DSD models		
Coverage of ART refill program for PLHIV	Proportion of individuals in More intense DSD issued with <3 ART among all individuals on ART	Numerator: Number of individuals in More intense DSD issued with <3 months ART	Pharmacy DAR ART dispensing tool	Periodic surveys
		Denominator: Number of individuals enrolled in More intense DSD models		
	Proportion of individuals on more intensive DSD issued with 3 – 5 months of ART among all individuals on ART	Numerator: Number of individuals on more intensive DSD issued with, >3 to <5 ART		Periodic surveys
		Denominator: Number of individuals enrolled in more intense DSD	Pharmacy DAR ART dispensing tool	
	Proportion of individuals on More intensive DSD models issued with >6 ART among all individuals on ART	Numerator: Number of individuals on More intense DSD models issued with >6 months of ART	Pharmacy DAR ART dispensing tool	Periodic surveys
		Denominator: Number of individuals enrolled in more intense DSD	Pharmacy DAR ART dispensing tool	Periodic surveys
	Proportion of	Numerator: Number of	Pharmacy	

	individuals in Less intense DSD issued with <3 ART among all individuals on ART	individuals in less intense DSD models issued with <3 months ART Denominator: Number of individuals enrolled in Less intense DSD	DAR ART dispensing tool	Periodic surveys
	Proportion of individuals on less intensive DSD issued with 3 – 5 months of ART among all individuals on ART	Numerator: Number of individuals on less intensive DSD issued with, >3 to <5 ART Denominator: Number of individuals enrolled in Less intense DSD	Pharmacy DAR ART dispensing tool	Periodic surveys
	Proportion of individuals on less intensive DSD issued with >6 ART among all individuals on ART	Numerator: Number of individuals on less intense DSD issued with >6 months of ART Denominator: Number of individuals enrolled in Less intense DSD	Pharmacy DAR ART dispensing tool	Periodic surveys
Continued use of DSD models for PrEP	Proportion of clients who made month 1 visit after initiating PrEP	Numerator: Total number of clients who made month 1 visit Denominator: total number at risk	MOH 267 NDWH	Quarterly
Continued use of DSD models for PrEP	Proportion of clients who made month 1 visit after initiating PrEP	Numerator: Total number of clients who made month 1 visit Denominator: Total number initiated on PrEP	MOH 267 NDWH	Quarterly

NB: DSD indicators are not limited to the ones described in the table above, facility team can evaluate other DSD setting based on their context

6.2 Monitoring & Evaluation Tools

Implementation of DSD requires the use of standard M&E tools as well as several interim tools (Table 6.3). Further evaluation on the utility of the tools in facilitating data capture and flow will be assessed during implementation for potential integration into the standard national HIV M&E tools.

Table 6.3: Clinical and Monitoring & Evaluation Tools to Support Differentiated Care

Clinical / M&E tool	Purpose	Location
1. Clinical Encounter Green Card (MOH 257)	ROC clinical evaluation	Placed in ROC file
2. ROC Categorization Checklists [New]	Assess ROC category	Placed in ROC file
3. ART Distribution Form [New]	Assess for "danger signs" during ART refill distribution and document ART refill distribution	Placed in ROC file
4. ART Dispensing Tool	Monitor the ART Refill program	Pharmacy
5. ART Refill Register	To monitor ART refill for ROCs established on ART enrolled in less intense facility or in Community DSD models	Pharmacy
6. Customer Satisfaction Survey	Assess ROC satisfaction	Facility triage area
7. Health Facility Situational Analysis Tool:	Assess facility implementation of DS implementation of DSD	CHMT/s CHMT/HMT/HMT
8. Supportive Supervision Tool	Quarterly review of differentiated care implementation at county and sub-county levels	CHMT/ SCHMT

Table 6.4: HIV Prevention Data Collection tools

Service	M&E Tool
HIV Testing Services - As per the retesting guidelines	MOH 362
HIV Risk Assessment	Rapid Assessment Screening Tool (RAST)
Choice Counselling	Counselling Checklist
PrEP services	Clinical encounter card Daily Activity Register Kenya EMR
Referrals	Referral form
Reporting – HTS & PrEP	MOH 731

6.3 DSD Data Flow

The DSD data will be documented in the ROC encounter card, Daily activity registers and will be reported through the existing tools and structures. The data flow for DSD is summarized as figure 6.1 and figure 6.2

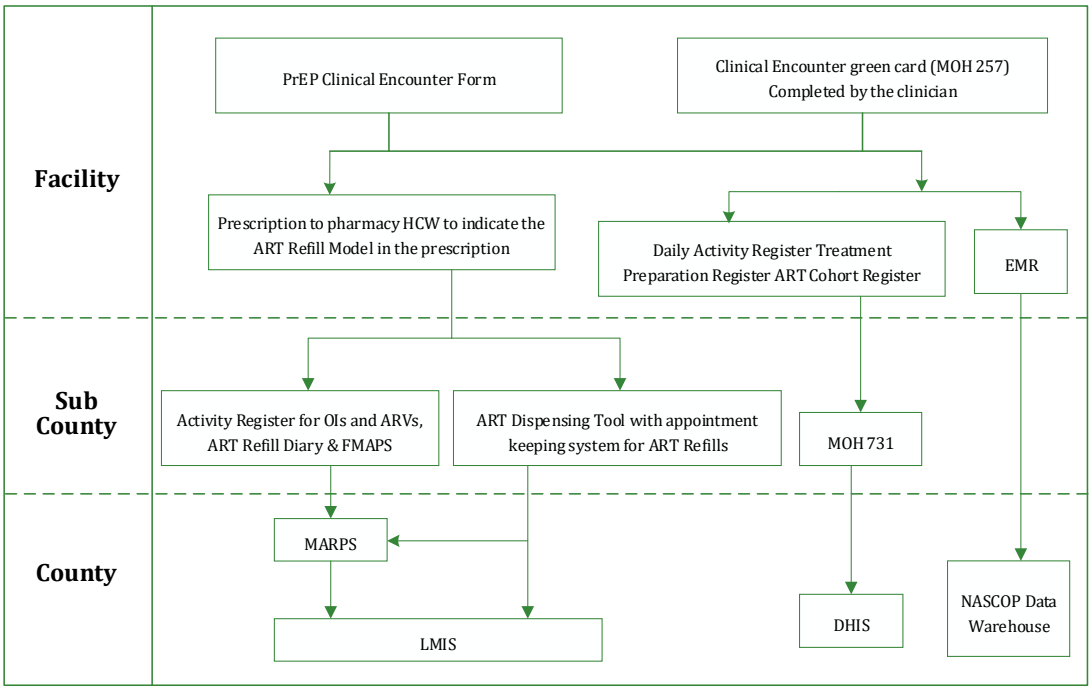


Figure 6.1: DSD Data Flow for ROC Evaluation and Categorization

The facility EMR must be configured to capture all the variables in the clinical encounter green card (MOH 257)

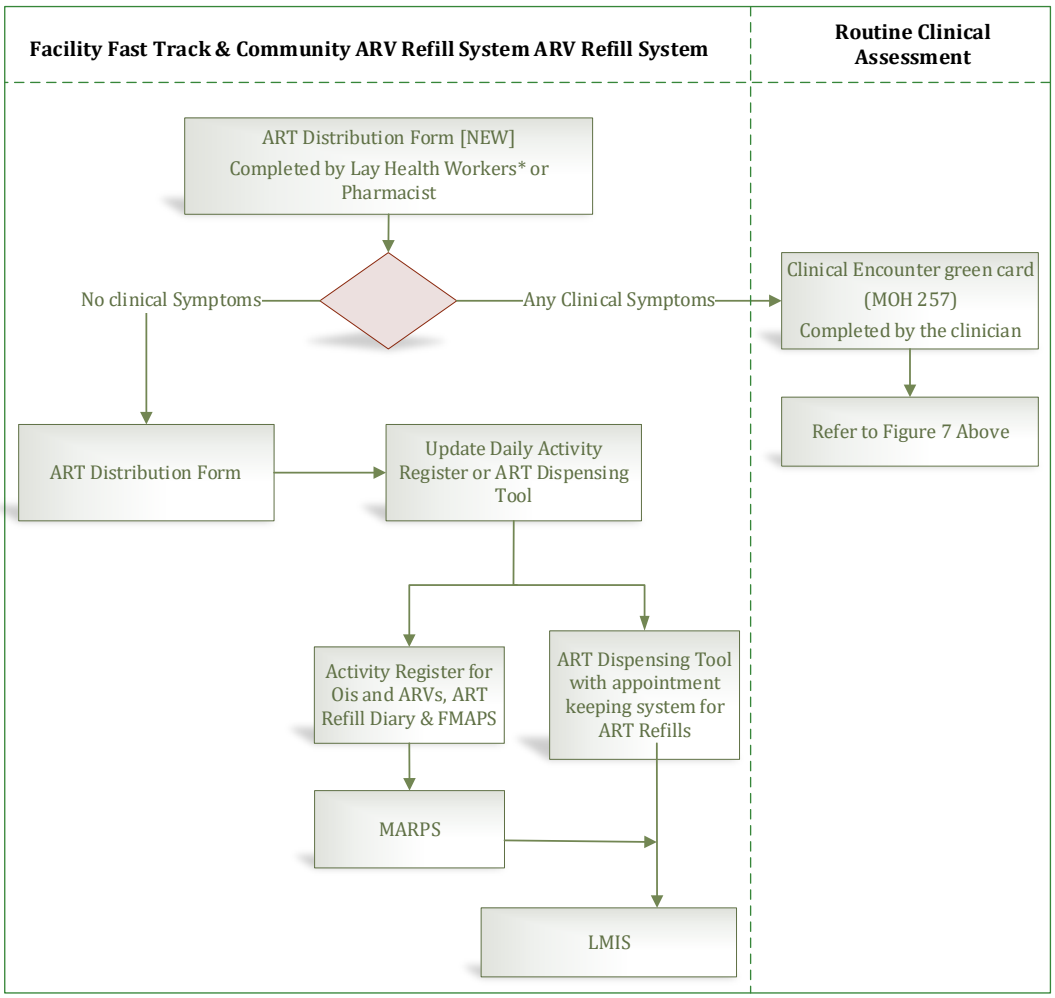


Figure 6.2: DSD Data Flow for Follow-up Visits

6.4 M&E Roles and Responsibilities

Implementation of DSD will require completion of additional M&E tools and analysis of the new data to ensure ROC care is not being compromised by introducing new models of care. This section outlines suggested role division for M&E

NB: ***RCO*** *– Registered Clinical Officer,* ***NO*** *- Nursing Officer,* ***Pharm Tech -*** *Pharmaceutical Technologist,* ***HRIO -*** *Health Records Information Officer,* ***C/SCHMT*** *– County / Sub County Health Management Team,* ***NASCOP SI*** *- NASCOP Strategic Information Unit and* ***Lay HC*** *- Lay Health Worker*

Table 6.5: M&E Roles and Responsibilities

Roles/ Responsibilities	RCO	NO	Pharm Tech	HRIO / Data Clerk	C/ SCHMT	C/ SCHMT	NASCOP SI	Lay HC/ Peer
Update the clinical encounter form	x	x						
Update the Daily activity register during the clinic visit	x	x						
Mentor lay health workers/Peer educator on data entry into the ART Distribution Forms and ART Refill Register	x	x	x	x				
Update the ROC Categorization Checklists	x	x						
Complete the ART prescription forms	x	x	x					
Participate in data review meetings for the HIV clinic	x	x	x	x	x	x	x	
Participate in quality improvement review meetings	x	x	x	x	x	x	x	
Complete Part A of the ART distribution Form	x	x	x					
Document the refill outcome in the EMR refill section using the ART distribution form Lay Health Worker/Peer Educator	x	x	x	x				

Roles/ Responsibilities	RCO	NO	Pharm Tech	HRIO / Data Clerk	C/ SCHMT	C/ SCHMT	NASCOP SI	Lay HC/ Peer
Complete part B the ART Distribution Form	x	x						x
Document the refill outcome using the ART distribution form in the Master Appointment register	x	x		x				x
Complete the ART Refill Register	x	x		x				
File the ART Distribution Forms in the individual ROC files	x	x	x	x				x
Complete the ADT tool	x	x	x					
Track ART refill appointments using ART refill register and update in the ADT /DAR with the Appointment Diary for A/ ADT tool	x	x	x	x				x
Report missed appointments, lost to follow ups and defaulters to initiate defaulter tracing			x	x				
Collect, verify, and enter data collected into the K HIS				x		x		
Coordinate and facilitate monthly data review meetings at the facility level	x			x				
Coordinate DQA between Master appointment diary ART Refill Registers ART Distribution Forms and EMR/DAR.	x	x	x	x				
Liaise with the SCHRIO and ensure consistent supply of data tools at the facility	x			x				
Liaise with the SHRIO to conduct monthly DQA between MoH 731 an KHIS data	x	x		x		x		

Roles/ Responsibilities	RCO	NO	Pharm Tech	HRIO / Data Clerk	C/ SCHMT	C/ SCHMT	NASCOP SI	Lay HC/ Peer
Upload EMR data to the National Data Warehouse				x				
Ensuring data is uploaded and sharing reporting rates with the stakeholders	x	x		x	x	x	x	
Monitor the facility/county/Sub County performance through the National DSD dashboard					x	x	x	
Offer TA to sub-county/facility on implementation of DSD					x	x	x	
Support sub county and facility data review and stakeholders' fora					x	x		
Collate EMR data nationwide into the NASCOP Data Warehouse							x	
Conduct quarterly analysis of DSD indicators using the Data Warehouse at all levels							x	
Offer TA to county on implementation of DSD							x	
Print and distribute DSD tools to the county.							x	
Support county and national data review and stakeholders' fora							x	

6.5 Performance Measurements

Implementation of DSD for both prevention and care & treatment will be evaluated at the national level on a quarterly basis largely relying on data from the approved EMR sites. EMR data from DSD implementation will be compared to data from facilities not implementing DSD over the same period. Trends of ROC outcomes will provide guidance of the success of DSD implementation.

Table 6.6: Performance Measurement Indicators for Differentiated Care

	Performance Measure Indicator	Frequency of measurement
DSD Uptake	Proportion of individuals established on ART issued with > 3 months ART	National: Quarterly
	Proportion of established individuals receiving ART through facility dispensing systems	National: Quarterly
	Proportion of established individuals receiving ART through community dispensing systems	National: Quarterly
DSD Outcomes	Proportion of established individuals who are still active on ART 12 months after enrollment into DSD	National: Quarterly
	Proportion of established individuals who are virally suppressed (<200 copies/mL) 12 months after enrollment into DSD	National: Quarterly

CHAPTER 7: ANNEXES

Annex 1: County Situation Assessment Tool for Differentiated Service Delivery

The County situational assessment tool is designed to capture current information on HIV- related programming in the county, based on the health system building blocks.

The primary aim of the assessment tool is to assist the County-TWG in identifying current strengths and weaknesses of the health systems that are relevant for implementation of DSD in both prevention and care & treatment. The tool also gathers information to inform the national program on specific county needs for optimal technical support to the counties. This information is not intended to incriminate or discriminate counties based on performance in each section but to identify opportunities for HIV program improvement.

Areas of Assessment		Yes/No/ Proportion	Comments
Leadership and governance	a) Does the county have an existing HIV Technical Working Group that includes members of the CHMT, implementing partners, health workers and communities?		
	b) Does the County HIV Technical Working Group meet regularly to discuss HIV program progress with documented minutes?		
	c) Does the county keep reports of the actual allocation and use of finances for HIV services?		
	d) Are there funds and other resources available to support differentiated service delivery?		
Capacity building for HRH	a) Has the CHMT been sensitized on the current national HIV prevention and treatment guidelines?		
	b) Have HCWs at all facilities offering HIV services been oriented on the current national HIV prevention and treatment guidelines?		
HIV DSD coverage	a) What proportion of ART sites in the County are implementing DSD in both prevention and care & treatment?		

Areas of Assessment		Yes/No/ Proportion	Comments
	b) What proportion of ROC on ART are on less intense DSD models?		
	c) What proportion of facilities offer both facility and community DSD models in both prevention and care & treatment?		
Commodity management	Does the county have a functional County Commodity Management /Commodity Security Committee for? a) Pharmaceutical commodities?		
	b) Laboratory Commodities?		
Quality Improvement & Supervision	Does the county have functional Quality Improvement Team (QIT) structure in line with KHQIF a) County		
	b) Sub-county		
	c) Facility		
	Does the County HIV TWG conduct meetings to review clinical cases and provide support to ROCs failing? treatment or with advanced disease?		
Information Systems	a) What proportion of facilities offering HIV services have been trained on the revised HIV M&E tools?		
	b) What proportion of facilities offering HIV services have a facility EMR?		

Annex 2: Facility Situational Assessment Tool

The primary aim of the analysis tool is to assist the facility MDT in identifying current strengths and weaknesses of the health systems that are relevant for implementation of DSD in prevention and care & treatment.

The tool also gathers information to inform the county on facility needs for optimal technical support to the facilities. This information is not intended to incriminate or discriminate against facilities based on performance in each section but to identify opportunities for HIV program improvement.

Facility Situational Analysis for DSD			
	Areas of assessment	**Yes/No/ Proportion**	**Comments**
Leadership and Governance	Does the facility have an existing Multi-Disciplinary Team with documented meeting minutes?		
Capacity building for HRH	Has the current national HIV prevention and treatment guidelines been disseminated to HCWs in this facility?		
	Have HCWs in this facility been oriented on the DSD Operational manual?		
HIV DSD coverage	Does the facility implement at least one less intense DSD model?		
	What proportion of ROC on ART are in less intense DSD?		
	What proportion of PrEP clients are community-based DSD models?		
	Has the facility offer integrated PrEP services?		
	Does the facility have a system that ensures continuous demand creation for DSD?		
Quality Improvement & Supervision	Does the facility have a quality improvement team (QIT)?		
	Are there completed or ongoing DSD QI projects in the last 1 year?		
	Does the facility MDT meet regularly to review clinical cases?		
	Does the facility have a DSD Focal person?		
Information Systems	What proportion of HCWs have been trained on the revised HIV M&E tools?		
	Does the facility have a functional EMR?		

Annex 3: Facility Assessment to Provide Community ART Distribution

Health Facility Assessment to Implement Community models for DSD*		
Facility name:	**MFL code:**	**Date of assessment:**
Health system domains for community models for DSD models for DSD		Yes/No
Leadership: Has the facility identified a DSD focal person to oversee DSD implementation including community-based models? implementation including community-based models?		
Logistics and **Finance:** Does the facility have resources to implement and monitor community-based DSD Models based DSD Models?		
Human Resources for Health: Has the facility identified appropriate personnel for community-based DSD models? for community-based DSD models? (HCW, HCW, Peer, Lay counselors and / or Community Health Volunteers)?		
Does the facility have capacity to train personnel for community-based DSD models? Personnel for community-based DSD models?		
Service Delivery: Has the facility achieved a routine viral load monitoring uptake of ≥ 95%?		
Commodity Management: Does the facility have ≥ 3 months of ART available on site? Does the facility have the mechanisms for reporting commodities as required?		
Has the facility identified mechanisms for pre-packing ART and labelling commodities for community distribution?		
Health Information Systems: Does the facility have an established system to monitor ROC client-level outcomes, specifically retention, lost to follow-up, mortalities, and viral suppression?		
Has the facility established recording and reporting systems for community-based DSD Models?		
Assessors' recommendations:		
Final assessment outcome:		
Facility can initiate/ continue/ continue community models for DSD models for DSD Facility to implement assessor's recommendations and be re-assessed thereafter		

Names of assessors: Signature of assessors:	Name of health facility manager: Signature of health facility manager:

*None of these criteria are absolute requirements for implementation of Differentiated Service Models Service Models; implementation should be considered even if some criteria are not met, if a plan is in place to address gaps. Include a scoring criterion as follows:

Score	Key	Key Description
<90%	Green	Has met the requirements and proceed to implement
80-90%	Yellow	Put in place a plan to address the gaps and proceed to implement. Involve structures in county and sub-county to address the identified gaps.
>80%	Red	Put in place a plan to address the gaps and review the situation before proceeding into implementation. Involve structures in county and sub-county to address the identified gaps.

For identified gaps use the work plan template annexed.

Annex 4: Work Plan Template

Gap	**Objective** *(Statement of intent)*	**Activity** *(List of activities that will lead to achievement of the objective)*	**Resources** *(List of resources required to complete the activity)*	**Indicator** *(What will be used to measure success of the activity)*	**Target** *(The quantifiable target for the indicator)*	**Timeline** *(When the activity should be completed)*	**Responsible Person** *(Focal person who will implement the activity)*
1.		A.					
		B.					
		C.					
2.		A.					
		B.					
		C.					
3.		A.					
		B.					

Annex 5: Categorization checklist for ROC on ART for <6 months

Date of Visit	Tick as appropriate		Comments
	Well Client WHO stage I or II **AND** CD4 > 200 cells/mm3 (or >25% for children ≤ 5 years old)	**Advanced HIV Disease** WHO stage III or IV **OR** CD4 ≤ 200 cells/mm3 (or ≤ 25% for children ≤ 5 years old)	

Annex 6: ROC Categorization Checklist at ≥ 6 Months in Care

	Date	Date	Date	Date	Date	Date
Criteria for Categorization A ROC is considered stable if they meet **ALL** the following criteria *(Indicate Y/N)*						
• *On their current ART regimen for ≥ 6 months*						
• *No active OIs (including TB) or if co-morbid condition (well controlled) in the previous 6 months*						
• *Adherent to scheduled clinic visits for the previous 6 months*						
• *Most recent VL: <200 copies/mL*						
Final Categorization *(Indicate Appropriate Code)* • Established on ART (E) • Not Established on ART (NE)						
DSD Model ROC *(Indicate Appropriate Code)*						
Comment						

ART Refill Model Codes for ROCs Established on ART	
STD = Standard care FT = Fast Track CARG = Community ART Group - HCW Led/Peer Led CP= Community Pharmacy	CADP = Community ART Distribution Point – /HCW/HCW Peer Led FADG = Facility ART Distribution Group IAD=Individual ART distribution

Annex 7: ART Distribution Refill Form

Introduction: The ART refill distribution form is a facility/community-based tool for tracking the ART refill program for established ROCs receiving ART refills through DSD. It is in the form of a booklet that will be in triplicate, or can be developed into a mobile app.

Purpose: It serves as the primary document to track ART distributed to PLHIV classified as established.

When completed: It is completed during ART refill visits at either facility or community level.

Who completes:

- **Section A** of the ART refill distribution form is completed by the HCW or person responsible for dispensing ART at the health facility/Community, and it is completed at the time of ART dispensing.
- **Section B** is completed by a HCW or trained peer educator responsible for ART distribution at facility or community level at the time of refill. If ART refills are distributed by the HCW (which is one of the options for a facility-based fast track system) it may be the same person completing both sections. Upon completion, it is used as the primary document for completing the ART refill register. The original copy of the ART refill distribution form is submitted to the pharmacist for updating the ADT while the duplicate is taken to records for updating the DAR and filing into the ROC file. The triplicate remains in the booklet and is submitted to the pharmacist for safe keeping.

Where is it kept in the facility?

The custodian of the ART refill distribution form booklet is the pharmacist based at the health facility.

Description of Fields:

Variable field name	Description of variable
A. ART Refill Form for ROCs Established on ART	
ROC Name	Enter the name of the ROC in the spaces provided in the order; first, middle, and last name
ROC Unique ID/ NUPI	10-digit ROC unique number (CCC Number). The format of the CCC number is the First 5 digits (MFL code), a dash, then another 5-digit unique serial number assigned at the clinic.
Date of ARV refill	Enter the date of ARV refill in the format DD/MM/YYYY
Less intense DSD Model	Enter the client's model for ART refill as follows: • **FT** = Fast Track • **CARG** = Community ART group– HCW Led • **CARG =** Community ART group – Peer Led • **FAG** = Facility ART Distribution group • CADP = Community ART distribution point – Health Care Worker Led or Peer Led • ICAD =Individual Community ART distribution • CPM= Community Pharmacy Model
ROC Phone No	Indicate the ROC's telephone number
Treatment Supporter Phone No	Indicate the treatment supporter's telephone number
ARV regimen being distributed	Enter the regimen, dosage, and duration of the prescription in months
Other drugs/supplies being distributed and quantity • CPT / Dapsone • Oral Contraceptives • Condoms • Other	If CPT/ Dapsone, Oral Contraceptives and any other drugs are provided, tick in the respective check box and enter the duration of the prescription in months respectively **Note:** If provided with condoms enter yes after ticking the check box
Name of pharmacist: Signature:	Enter the name and signature of the pharmacist (or HCW responsible for dispensing) in the spaces provided in the order first, middle, and last name
Name of ART distributor: Signature:	Enter the name and signature of the ART Distributor in the spaces provided in the order first, middle, and last

Variable field name	Description of variable
	name
B. ROC review checklist ***(if yes to any of the questions below, confirm they have enough ART until they can reach the clinic and refer to clinic for further evaluation; book appointment and notify clinic)***	
Any missed doses of ARVs since last clinic visit: If yes, how many missed doses:	Check the appropriate box after assessing adherence to ARV. If yes, enter the number of missed doses since the last clinical visit
Any current/worsening symptoms (Fatigue, Cough, Fever, Rash, Nausea/vomiting, Genital sore/discharge, Diarrhea, Other)	Check the appropriate box after screening the client. Only tick for current/worsening symptoms (e.g., if the ROC had diarrhea a week ago but it has now resolved then it does not need to be listed)
Any new medications prescribed from outside of the HIV clinic: If yes, specify	Check the appropriate box after screening the ROC. If yes, specify the medication given
Family planning method used	Check the appropriate box after screening the ROC. If yes, specify the type of family planning being used
Pregnancy status	For female ROCs, tick "yes" if they have had a positive pregnancy test, tick "unsure" if they are late to have their menstrual period or their most recent menstrual period was abnormal but have not had a pregnancy test yet, and tick "no" if they have had their most recent menstrual period as expected
Referred to clinic If yes, date of clinical visit:	If the ROC has missed any doses of ARVs or has any new/worsening symptoms, they should be referred to the clinic. If this is the case, then tick yes If yes, enter the date the ROC will visit the health facility in the format DD/MM/YYYY
Signature of ROC upon receipt of the ART:	ROC to append their signature upon receipt of the ARVs for ROCs who cannot sign, a thumb print can be appended

<table>
<tr><td colspan="2">ART Distribution Refill Form for ROCs Established on ART
Part A: Filled during ART pre-packing by the HCW packing the medication</td><td rowspan="8">Complete at time of dispensing</td></tr>
<tr><td colspan="2">ROC Name: _____ ROC Unique No: _____
Date of ARV Distribution: DD _____MM_____YYYY_____

ART Refill Model: _____</td></tr>
<tr><td colspan="2">ROC Phone No: Treatment Supporter Phone No:</td></tr>
<tr><td colspan="2">ARVs regimen being distributed: Quantity (mths):</td></tr>
<tr><td colspan="2">Other drugs/supplies being distributed and quantity</td></tr>
<tr><td colspan="2">☐ CPT / Dapsone, quantity (mths): ☐ Oral Contraception, quantity (mths): ☐ Condoms (yes/no):</td></tr>
<tr><td>☐ Other: , quantity (days):</td><td>☐ Other: , quantity (days):</td></tr>
<tr><td>Name of pharmacist/ person dispensing:

Signature:</td><td>Name of ART distributor:

Signature:</td></tr>
</table>

<table>
<tr><td colspan="4">Part B: ROC review checklist (if yes to any of the questions below, confirm they have enough ART until they can reach the clinic and refer back to clinic for further evaluation; book appointment and notify clinic)</td><td rowspan="8">Complete at time of distribution</td></tr>
<tr><td colspan="4">Any missed doses of ARVs since last clinic visit: ☐Yes ☐No
If yes, how many missed doses: _____</td></tr>
<tr><td colspan="4">Any current/ symptoms:</td></tr>
<tr><td>Cough: ☐Yes ☐No
Night sweats: ☐Yes ☐No
Weight loss: ☐Yes ☐No</td><td>Fever: ☐Yes ☐No
Rash: ☐Yes ☐No
Chest pain: ☐Yes ☐No</td><td>Nausea/vomiting: ☐Yes ☐No
Fatigue: ☐Yes ☐No
Genital Sore: ☐Yes ☐No</td><td>Diarrhea: ☐Yes ☐No
Headaches: ☐Yes ☐No
Contact with TB ROC or Chronic Cougher: ☐Yes ☐No</td></tr>
<tr><td colspan="4">Any new medications prescribed from outside of the HIV clinic: ☐Yes ☐No
If ye s, specify:</td></tr>
<tr><td colspan="2">Family planning: ☐Yes ☐No
If YES, Which method?</td><td colspan="2">Pregnancy status: ☐Pregnant ☐Not Pregnant ☐Not Sure
Are you intending to get pregnant in the next 3 months? ☐Yes ☐No</td></tr>
<tr><td colspan="4">Referred to clinic: ☐Yes ☐No If yes, appointment date: DD____ MM____ YYYY _____</td></tr>
<tr><td colspan="4">Signature of ROC upon receipt of the ART:</td></tr>
</table>

Annex 8: ROC Satisfaction Survey

<table>
<tr><th colspan="3">ROC preferences and needs survey</th></tr>
<tr><td colspan="3">Date: DD_____MM____YYYY___</td></tr>
<tr><td colspan="3">A. Respondents' profile</td></tr>
<tr><td>Gender
☐Female ☐Male ☐Other</td><td colspan="2">If female, are you currently pregnant?
☐Yes ☐No</td></tr>
<tr><td>How old are you?
☐Below 20 ☐36 to 50
☐20 to 35 ☐Over 50</td><td colspan="2">What is your current occupation?</td></tr>
<tr><td>Where do you pick your medicines from?
❑ Community
❑ Facility
Where do you pick your medicines from?
❑ Community
❑ Facility</td><td>Are you comfortable with where you are receiving your medicines from?
Community
❑ Yes
❑ No
Facility
❑ Yes
❑ No</td><td>Are you comfortable with where you are receiving your medicines from?
Community
❑ Yes
❑ No
Facility
❑ Yes
❑ No</td></tr>
<tr><td colspan="3">B. Identification of barriers to treatment from ROCs' perspective</td></tr>
<tr><td colspan="3">How often do you come to the health facility?
☐Once a week ☐Every month ☐Every three months
☐Twice a month ☐More than every 3 months</td></tr>
<tr><td colspan="3">Approximately, how much time do you usually spend at the health facility?
☐Less than 30 min ☐Between 1-2hrs ☐More than 4hrs
☐30-60 min ☐Between 2-4hrs</td></tr>
<tr><td>How far is the health facility from your home? (Approximate in KM)</td><td colspan="2">How long does it take you to reach the health facility?</td></tr>
<tr><td colspan="3">Have you missed a clinic appointment in the last 12 months in the last 12 months? ☐Yes</td></tr>
</table>

☐No If yes, indicate the reason for the most recent missed appointment? _____
While at the health facility, do you feel bothered by other ROCs or health care provider? ☐Yes ☐No If yes, can you say why? _
Do you feel comfortable when interacting with health care workers? ☐Yes ☐No
Do you feel that the health care workers listen to you and understand your needs? ☐Yes ☐No
Do you consider the health care workers as being competent to treat you? ☐Yes ☐No
Did you receive the service that you came for? ☐Yes ☐No
While at the health facility, do you think that you spend enough time with the clinician? ☐Yes ☐No

ROC satisfaction survey should be self-administered. Where need be, ROCs can be assisted by a HCW

Annex 9: DSD Quality Assessment Checklist (Cross Cutting)

Differentiated Services Delivery Quality Checklist **Instructions** • *The tool may require sampling of files to respond to some questions. Use the sample tool to select the files for abstraction.* • *The tool can be used by the county or sub county teams during support supervision.* • *The tool is administered at the facility and the respondents will include facility health care workers.*	**Yes**	**NO**	**comments**
1. Is Categorization done for all the recipients of care i.e. (at enrollment and after 6 months on care)?			
2. Is re-categorization done to all ROCs on DSD models during their clinical encounter?			
3. Do all newly enrolled ROCs access baseline investigation CD4 at enrollment?			
4. Do all ROCs initiated on ART receive an initial viral load test at 3 Months of ART initiation?			
5. Did all ROCs receive the following services (standard Package of Care) as per the ART guidelines in the last clinical encounter? (*Tick where applicable.)* ❑ ART ❑ TB Screening ❑ Adherence assessment and PHDP ❑ STI and cervical cancer screening ❑ Family planning ❑ GBV/IPV screening ❑ NCD diseases screening (Blood Pressure, Body Weight) ❑ Mental Health screening (PHQ9, Cage and Craft) ❑ Nutritional services (Assessment and counselling) ❑ Prevention of other infections (CTX, immunization)			

Differentiated Services Delivery Quality Checklist **Instructions** • *The tool may require sampling of files to respond to some questions. Use the sample tool to select the files for abstraction.* • *The tool can be used by the county or sub county teams during support supervision.* • *The tool is administered at the facility and the respondents will include facility health care workers.*	**Yes**	**NO**	**comments**
6. Do all ROCs established on ART receive a standard package of care during their clinical encounter after every six months?			
7. Are the ROCs established on ART on DSD models screened for clinical symptoms using the ART Distribution Form during each drug refill?			
8. Do all ROCs on DSD models have a documented up to date viral load test result?			
9. Do ROCs on community-based models report to the facility in case they develop clinical symptoms before their scheduled clinical visits?			
10. Is there documented follow up done for ROCs who miss a refill appointment?			
11. Has the Site facility situation analysis been conducted, done and documented in the last 12 months?			
12. Is there a DSD Focal person?			
13. Did the facility report DSD data in the last reporting month?			
14. Is DSD discussed as an agenda in facility meetings/WITs/QIT?			
15. Has the facility conducted a ROC satisfaction survey??			
16. Has the facility implemented any CQI project in the last 1 year?			
Is any of the CQI projects conducted on ROC centered needs??			

Annex 10: Sample Size Determination

The sample size table is used to determine the number of files that need to be sampled depending on the population size to achieve a representative sample.

Size	Sample size for a 95% CI to have width of 0.16
up to 19	All
20- 29	26
30-39	32
40-49	38
50-59	43
60-69	48
70-79	53
80-89	57
90-99	61
100-119	67
120-139	73
140-159	78
160-179	82
180-199	86
200-249	94
250-299	101
300-349	106
350-399	110
400-449	113
450-499	116
500-749	127
750-999	131
1000-4999	146
5000 Or More	150

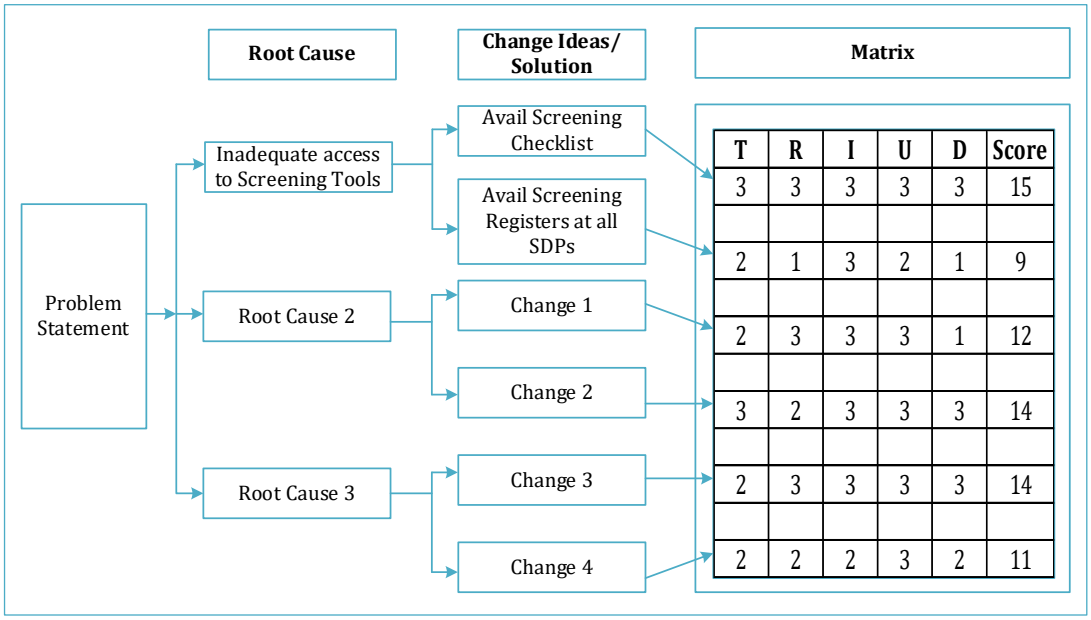
Annex 11: Tree and Matrix Diagram Tool

The Tree and Matrix Diagram is used to prioritize possible change ideas for identified root causes. The change ideas are ranked using a criteria to provide scores for the change idea that should be implemented first.

The matrix ranks change ideas from one to three based on:

- **T**ime required to implement the change (least time to implement the change idea ranks high),
- **R**esources needed to implement the change (less resources ranks high)
- **I**mportance of the change in improvement (more important ranks high)
- **U**rgency to implement the change (very urgent gets a higher rank)
- **D**ifficulty in implementing the change (easy to implement ranks high while a change that is difficult to implement is ranked low)

NB: Where two or more change ideas gets equal score, the QI team member should attempt ranking the change ideas individually to arrive at a new score. The change ideas scored highly by most members is prioritized.



Annex 12: Decision Matrix

A decision matrix template					
Potential performance gaps to be addressed	CRITERIA: Rank 1-5 where 5=totally meets criteria				
	Issue seen as important*	Realistic scope (Control)*	Likelihood of success via QI*	Potential Impact of QI project *	TOTAL
1.					
2.					
3.					
4.					

* Issue seen as important refers to a gap that is crucial or gap that does not meet standards set in National guidelines

* Realistic scope (control) refers to gaps that the facility can address at a facility level, that do not involve the macrosystem

* Likelihood of success refers to performance gaps that can be addressed easily, the so-called quick wins

* Potential Impact of QI project refers to performance gaps that if addressed will have the greatest effect

Review the rankings and select the project with the highest score

Annex 13: CQI Project Checklist/PDSA Reporting Tool

Facility Name:		**Facility MFL Code:**	
County:		**Sub County:**	
Submitted by:		**Date of submission:**	

Project Title:		
Project Team Leader:		
Project Team Members:		
Problem Statement:		
Goal Statement:		
Indicator Description:		

Baseline Data: *(Indicator Performance Result)*	Period under review - *e.g. Jan 2014 to June 2014:* _____ to _____ Results:	
Plan – Describe your analysis of the process/ problem. Attach the fishbone, flowchart and/or any tool used for planning.	Fish bone diagram done? Yes No Initial Process flow chart done? Yes No Revised Process flow chart done? Yes No	
Plan – Describe the change ideas/interventions you have selected to address the problem (Attach a workplan for intervention)	Root Cause	Change Interventions Selected
Plan – Performance measurement plan Indicators (and definition), Method for collection, frequency of collection.		
Do – Describe implementation of the change package		

Study – Describe the outcomes of the interventions (should include follow-up data using the same indicator as baseline).	Follow-up Data (*Indicator Performance Result)* Period under review - *e.g., July 2014 to Dec 2014:* ___ to _____ Results:
Was goal achieved?	Circle one: Yes No If YES, continue to Act. If NO, explain below why your team thinks the intervention did not succeed (challenges faced) and next steps/way forward e.g. beginning a new QI Project/PDSA cycle to address the problem.
Act – Describe how you have institutionalized the intervention/change and how you will continue measuring the success of the institutionalized interventions over time.	If successful, sustain and upscale Describe any challenges faced during the process and how you managed to overcome them. Describe the lessons learnt. Recommendations for further actions.

Annex 14: List of Contributors

The following team contributed to the development and review of the Differentiated Care Operational Guide.

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Annex 15: List of Participating Agencies and Organizations

Contributing organizations	
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Clinton Health Access Initiative (CHAI)	JHPIEGO
Council of Governors (COG)	World Health Organisation (WHO)
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Henry Jackson Foundation Medical Research International (HJFMRI)	United States Agency for International Development (USAID)
HP Plus	LVCT Health

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ISBN 978-9914-766-45-5

June 2024