2017

DIFFERENTIATED CARE:

OPERATIONAL GUIDE

NASCOP

January 2017

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Foreword

Clinical trials and observational studies demonstrate benefits of starting antiretroviral therapy (ART) early for People Living with HIV (PLHIV), both for individual health benefits and also for the public health benefit of reducing onward transmission of HIV. To end the HIV epidemic, a new set of ambitious global targets for the year 2020 have been set by UNAIDS known as "90-90-90". The goal is for 90% of all PLHIV to know their HIV status, 90% of all people diagnosed with HIV to receive ART and 90% of all people receiving ART to be retained on ART with viral suppression.

In 2015 WHO released a recommendation that all PLHIV initiate ART irrespective of CD4 cell count or clinical stage. The new recommendation, often referred to as "Test and Treat", removed eligibility assessment barriers that may contribute to delay or deferral of ART initiation and sub-optimal retention. Kenya has adopted this new recommendation into the revised national *Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya – 2016 Edition.*

According to the 2015/2016 HIV Estimates, 33% of PLHIV in Kenya are unaware of their HIV status and therefore cannot access life-saving treatment; furthermore patient attrition in many HIV treatment programs remains high among those on ART as well as among pre-ART patients. To reach the 90-90-90 targets, a combination of innovative HIV testing strategies and service delivery models are necessary to identify, link to care, promptly start and maintain PLHIV on life-long ART.

Test and Treat represents a paradigm shift with tremendous potential for streamlining the pathway to ART initiation. However, successful implementation of Test and Treat would be expected to substantially increase the number of patients starting ART and patient volume at ART sites, many of which are already overburdened. Differentiated models of care, including longer intervals between clinical consultation and drug refills, as well as community–based delivery of ART, are interventions intended to better meet client needs while decongesting overburdened ART sites, ensuring that care meets the diversity of patient needs and program expansion.

This *Differentiated Care Operational Guide* is a healthcare worker handbook designed to equip the Kenyan service delivery providers with strategies for implementing differentiated care as described in the Kenya *Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya – 2016 Edition.*

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Abbreviations

ADT	ART Dispensing Tool
AIDS	Acquired Immunodeficiency Syndrome
AMPATH Plus	Academic Model Providing Access to Healthcare
ART	Antiretroviral Therapy
ARV	Antiretroviral
BMI	Body Mass Index
CAG	Community ART Group
CASCO	County AIDS/STI Control Officer
CCC	Comprehensive Care Clinic
CDC	Centers for Disease Control & Prevention
CHMT	County Health Management Team
CHRIO	County Health Records Information Officer
CHS	Centre for Health Solutions - Kenya
CPT	Cotrimoxazole Preventive Therapy
C-TWG	County HIV Technical Working Group
DC	Differentiated Care
DHIS	District Health Information System
DMAPS	District Monthly ART Patient Summary
DQA	Data Quality Assessment
EMR	Electronic Medical Records
FACES/UCSF	Family AIDS Care and Education Services / University of California San Francisco
FMAPS	Facility Monthly ART Patient Summary
FP	Family Planning
HEALTHQUAL International	HEALTHQUAL International
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
HRIO	Health Records Information Officer
HTS	HIV Testing Services
ICAP	ICAP at Columbia University's Mailman School of Public Health
IEC	Information Education and Communication
IPT	Isoniazid Preventive Therapy
IRIS	Immune Reconstitution Inflammatory Syndrome
KHQIF	Kenya HIV Quality Improvement Framework
LMIS	Logistics Management Information System
MDT	Multidisciplinary Team
M&E	Monitoring and Evaluation
MFL	Master Facility List
MoH	Ministry of Health
MSF Belgium	Medicines San – Frontiers Belgium
MSF France	Medicines San – Frontiers France
NASCOP	National AIDS and STI Control Program
OI	Opportunistic Infection
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
pTB	Pulmonary Tuberculosis
QI	Quality Improvement

sCHMT	sub-County Health Management Team
sCHRIO	sub-County Health Records Information Officer
STI	Sexually Transmitted Infection
TA	Technical Assistance
TWG	Technical Working Group
UMB	University of Maryland Baltimore
UNAIDS	United Nations Programme on HIV/AIDS
VL	Viral Load
WHO	World Health Organization
UoN	University of Nairobi

Introduction

The International AIDS Society defines differentiated care as a client-centred approach that simplifies and adapts HIV services across the clinical cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. By providing differentiated care the health system can refocus resources to those most in need.

Differentiated care can be organized based on the specific needs of groups of patients, such as clinical characteristics of patients (e.g. patients with advanced disease), sub-populations (e.g. pregnant and breastfeeding women, adolescents, children, key populations, HCWs), or context (e.g. low-prevalence vs. high-prevalence settings). Differentiated care is the basis for many national initiatives and publications on HIV service delivery including the Adolescent Package of Care, the Pediatric Toolkit, Guidelines for Programming with Key Populations, Guidelines for HIV/STI Programs for Sex Workers, and almost every section of the 2016 ARV Guidelines.

For the purposes of this Operational Guide, differentiated care focuses on differential management of patients based on their initial presentation (clinical/immunological status around the time of enrollment) and then once they have been in care for at least 12 months (Figure 1).

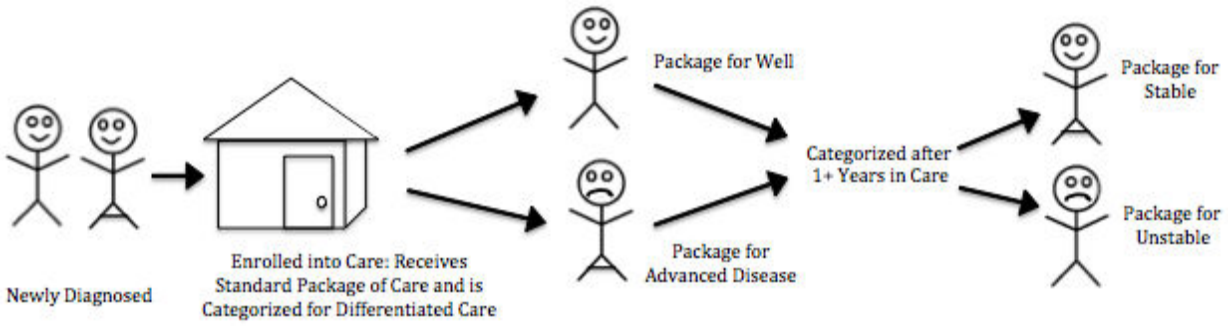


Figure 1: Differentiated Care Based on Patient Clinical Status

This Differentiated Care Operational Guide is intended to be used by County and Sub-County Health Management Teams, health facility leadership, and healthcare workers to plan, implement, and evaluate differentiated care (Figure 2). The Operational Guide should be used in conjunction with companion resource material, including: the Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya – 2016 Edition; Improving the Quality and Efficiency of Health Services in Kenya: A Practical Handbook for HIV Managers and Service Providers on Differentiated Care; the Healthcare Workers Orientation Package on Differentiated Care in Kenya; the Lay Health Workers Orientation Package on Differentiated Care in Kenya; and the Differentiated Care IEC Material.

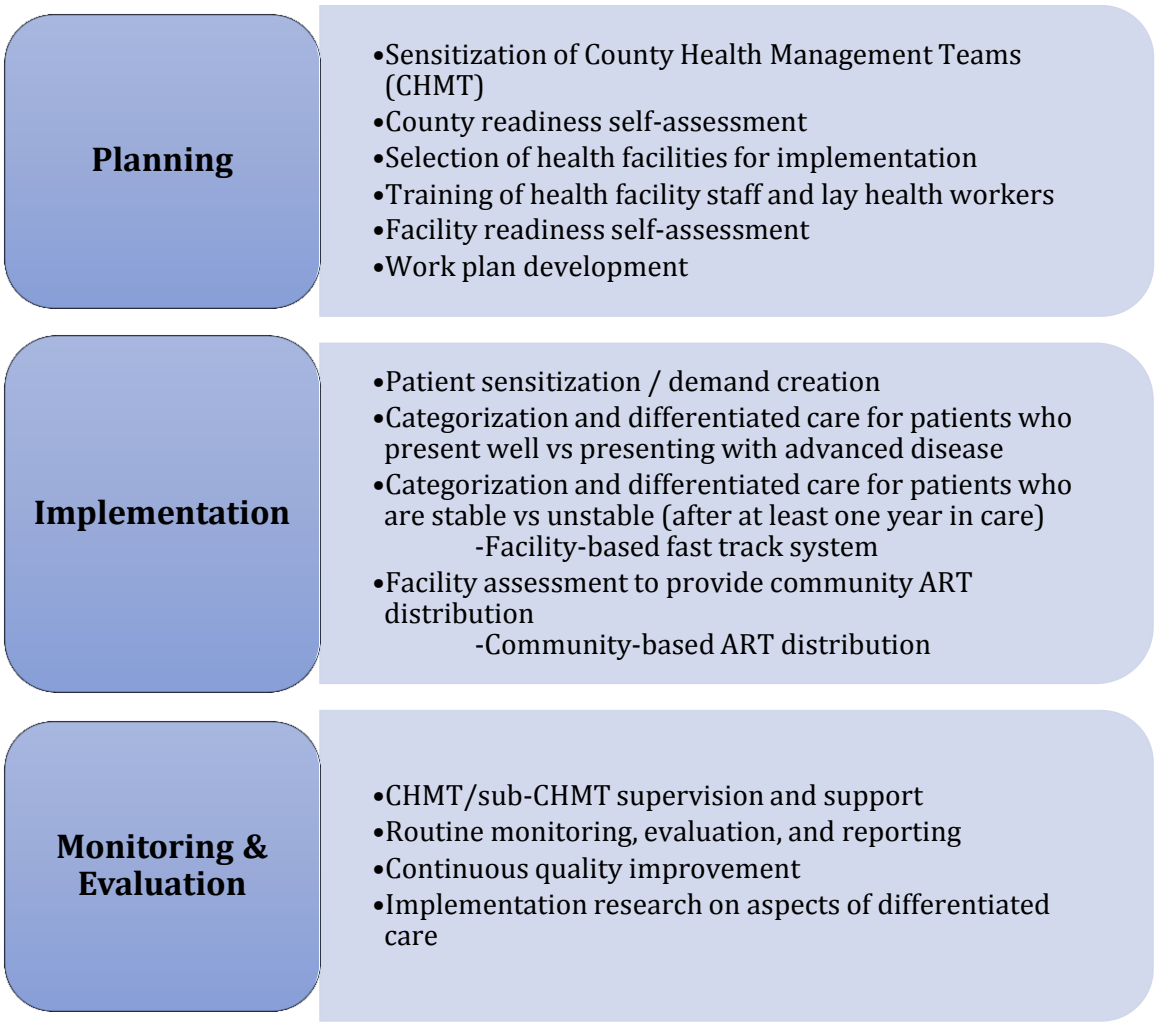


Figure 2: Summary of Steps for Differentiated Care Planning, Implementation, and Evaluation

1. Planning

Planning for implementation of differentiated care (DC) includes county and facility readiness assessments, work planning, and capacity building, as described below.

1.1 Readiness Assessments

Readiness assessments should be conducted at the county level and facility level before implementation of DC. The readiness assessments identify which counties and facilities are prepared to implement DC, and identify gaps that should be addressed before or during implementation.

1.1.1 County Readiness Self-Assessment

The County HIV Technical Working Group (C-TWG) will coordinate implementation of DC within the county. This TWG is comprised of members of the County Health Management Team (CHMT), donors, implementing partners, learning institutions and people living with HIV (PLHIV) within the county.

The County AIDS/STI Control Officer (CASCO), County Health Records Information Officer (CHRIO), and other C-TWG members should complete the County Readiness Self-Assessment (Annex 1) and report results to the C-TWG to determine next steps. Based on the results of the self-assessment the C-TWG can move forward with identifying facilities for assessment/implementation of DC, or they can address gaps identified in the self-assessment before moving to the facility level.

1.1.2 Facility Readiness Self-Assessment

Facilities selected by the C-TWG to implement DC will identify key staff to be oriented and trained on DC and supported to conduct the Facility Readiness Self-Assessment (Annex 2). These findings should be reviewed and discussed at the facility's multidisciplinary team (MDT) meeting. Based on the results of the self-assessment the MDT can move forward with organizing services to implement DC, or they can address gaps identified in the self-assessment before implementation.

The C-TWG, in collaboration with implementing partners, should work with facilities that do not pass the readiness assessment in order to address any gaps preventing DC implementation. DC readiness should be re-evaluated quarterly until gaps have been addressed.

1.1.3 Facility Assessment to Provide Community ART Distribution

After achieving adequate performance on the Facility Readiness Self-Assessment a health facility can move forward with all aspects of DC described in this Operational Guide except for the community-based ART distribution program (described in Sections 2.4.2-2.4.4). Before implementing a community-based ART distribution program a health facility should first have a functional facility-based fast track system for stable patients in place, and meet the criteria in the Facility Assessment to Provide Community ART Distribution (Annex 3). The C-TWG should conduct this assessment and approve plans for community ART distribution before implementation.

In some circumstances a facility may have a strong community support system with well-functioning support groups that are closely linked to the health facility. If adequate systems are in place, the facility may choose to implement community follow-up and ART distribution for stable patients even before implementing a facility-based fast track process, but should still undergo the Facility Assessment to Provide Community ART Distribution and have approval from the C-TWG.

1.2 Work Planning

Once counties and facilities are prepared to implement DC they 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 on DC.

1.3 Capacity Building on Differentiated Care

To strengthen the roll-out of DC as per this Operational Guide, national curricula on DC have been developed for managers, HCWs, and lay health workers, as outlined in Table 1. The county-level sensitization and the HCW training should be combined with the sensitization/training on the 2016 ARV Guidelines whenever possible.

Table 1: Capacity Building on Differentiated Care

Level	Target Audience	Training Package	Structure of Training
County	• County and Sub-county Managers (CHMT and sCHMT) • Implementing Partners	• PowerPoint Slides	• Didactic half day sensitization (combined with the 2016 ARV Guidelines dissemination when possible)
Health Facility	• Facility Managers & Healthcare Workers	• Power point slides • Facilitators guide • Participants workbook • Algorithms • Case Studies • Role-plays	• Didactic and case-based one day training (combined with the 2016 ARV Guidelines dissemination when possible)
Community	• Lay health workers (e.g. peer educators, community health volunteers, community ART group members)	• PowerPoint slides • Facilitators guide • Participants workbook • Case studies • Role-plays	• Didactic and case-based one day training
	• PLHIV attending HIV clinic services	• DC Flip chart • DC IEC Materials	• Daily health talks • Group and individual counseling sessions

2. Implementation

This section outlines the steps required to implement DC at the facility and community level. In addition, it defines the roles and responsibilities of each stakeholder in the implementation process. For the purposes of this Operational Guide, DC focuses on differential management of patients based on initial presentation (clinical/immunological status around the time of enrollment) and then once they have been in care for at least 12 months (Figure 1).

2.1 Categorization and Management of PLHIV Around the Time of Enrollment

Patients with advanced disease (based on clinical or immunological status) around the time of enrollment may require a different level of care than patients who present well. Patients with advanced disease are more likely to have an opportunistic infection (OI), are more likely to need consultation or referral for complicated clinical issues, and are more likely to develop immune reconstitution inflammatory syndrome (IRIS) upon starting ART. For patients who are clinically well, more focus needs to be placed on adherence counseling, with emphasis on the benefits of starting ART early despite feeling fine. Table 2 provides the categorization and management of patients around the time of enrollment.

Table 2: Differentiated Care Based on Initial Patient Presentation

Patients who Present with Advanced HIV Disease: WHO Stage 3 or 4, or CD4 count ≤ 200 cell/mm^3 (or ≤ 25% for children ≤ 5 years old)	
Package of Care	• Standard Package of Care (Section 4 of the 2016 ARV Guidelines) • Intensive management of presenting illnesses • Priority for identification, management and prevention of OIs • Priority for ART initiation • Close monitoring for development of immune reconstitution inflammatory syndrome (IRIS)
Location of Services	• Management at any ART service delivery point; all facility levels • Initial management and ART initiation by trained and experienced HCW • Consultation with MDT, TWG, mentors, and senior clinicians as needed (including telephone consultation such as Uliza! Clinicians' HIV Hotline) • Referral to a higher-level facility when feasible if consultation is not adequate to stabilize the patient
Focus of Treatment Preparation Counselling	• ART is required to prevent further damage to the immune system • Starting ART soon will decrease risk of disease progression, including wasting and OIs • ART is the most important treatment to restore health
Frequency of Follow-up	• 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 and address psychosocial and other concerns
Patients who Present Well: WHO Stage 1 or 2, and CD4 count > 200 cell/mm^3 (or > 25% for children ≤ 5 years old)	
Package of Care	• Standard Package of Care (Section 4 of the 2016 ARV Guidelines)
Location of Services	• Management at any ART service delivery point; all facility levels • Initial management and ART initiation by trained and experienced HCW
Focus of Treatment Preparation Counselling	• ART is the most important treatment to maintain good health and an active life • Starting ART soon will decrease risk of developing wasting and other infections
Frequency of Follow-up	• Weekly follow-up until ART initiation, and then at week 2 and 4 after ART initiation, and then monthly until confirmed viral suppression • Additional visits as required to address any medical or psychosocial concerns

Note that the patient's category can change at any time so there is a need for a reassessment as new information becomes available: during the first clinic visit the patient will receive preliminary WHO staging, but this may change as a diagnosis is confirmed (e.g. geneXpert results showing pTB), and CD4 count results may come back during a subsequent visit. Patients should be categorized/re-categorized using the simple tool in Annex 5, with management based on category.

2.2 Categorization and Management of Patients after 12 Months in Care

After the first year of ART, most patients will have developed good adherence habits, have adequate coping mechanisms and support systems in place, and will have achieved full virological suppression. With their improved self-care, these "stable patients" require less intensive follow-up and monitoring than other patients, allowing facility resources to be focused on patients who have not achieved these milestones (as well as those newly enrolling into HIV care as discussed in the previous section). Less intense follow-up for stable patients may also decongest health facilities, reduce patient costs and inconvenience, and improve quality of care by allowing more time for sick and/or unstable patients.

Stable patients can either receive their ART refills at the health facility or in the community, as discussed in the following sections. Unstable patients should receive case management to address the reason/s for not meeting stable eligibility criteria, in order to help them move to the stable category as quickly as possible. Table 3 provides the categorization and management of patients after being in care for one year.

Table 3: Differentiated Follow-up of Patients Beyond the First Year in Care

Unstable Patients	
Unstable Patients (have **any** of the following): • On their current ART regimen for < 12 months • Any active OIs (including TB) in the previous 6 months • Poor or questionable adherence to scheduled clinic visits in the previous 6 months • Most recent VL ≥ 1,000 copies/ml • Has not completed 6 months of IPT • Pregnant or breastfeeding • BMI < 18.5 • Age < 20 years • Healthcare team has concerns about providing longer follow-up intervals for the patient* **Note: children and adolescents may be clinically stable, however they are not usually eligible for less frequent follow-up because of the need for weight-based dose adjustments and/or close monitoring of support systems. Appointments for pregnant women should be aligned with Focused Antenatal Care visits; appointments for breastfeeding women should be aligned with HIV-exposed infant follow-up**	
Package of Care	• Standard Package of Care (Section 4 of the 2016 ARV Guidelines) • Case management to address reason/s for not meeting stable eligibility criteria
Location of Services	• Management at any ART service delivery point; all facility levels • Consultation with MDT, TWG, mentors, and senior clinicians as needed (including telephone consultation with Uliza! Clinicians' HIV Hotline) • Referral to a higher-level facility when feasible if consultation is not adequate to stabilize the patient
Focus of Counselling	• ART is the most important treatment to improve health and return to an active life • Targeted counselling to address reason/s they have not meet stable eligibility criteria
Frequency of Follow-up	• Every 1-3 months, based on clinical judgment and the specific reason/s they have not met stable eligibility criteria • Additional visits as required to address any medical or psychosocial concerns

Stable Patients	
Stable Patients (have achieved **all** of the following): • On their current ART regimen for ≥ 12 months • No active OIs (including TB) in the previous 6 months • Adherent to scheduled clinic visits for the previous 6 months • Most recent VL < 1,000 copies/ml • Has completed 6 months of IPT • Non-pregnant/not breastfeeding • BMI ≥ 18.5 • Age ≥ 20 years • Healthcare team does not have concerns about providing longer follow-up intervals for the patient* **Note: some patients may not meet all eligibility criteria but could benefit from specific aspects of the stable patient package of care, such as community-based ART delivery (e.g. patients with disabilities), or less frequent follow-up (e.g. children at boarding school)**	
Package of Care	• Standard Package of Care (Section 4 of the 2016 ARV Guidelines) • Viral load monitoring (and any other routine investigations) timed to coincide with patient appointments (e.g. the annual VL can be drawn 2-4 weeks before the patient's clinical follow-up visit so that the results are ready for discussion and decision-making during the visit) • Re-assessment of criteria as a stable patient at every visit (and move to "unstable" category if any criteria not met)
Location of Services	• Clinical review and ART prescription from any ART service delivery point; all facility levels • Fast track distribution of ART between clinical appointments, which can be facility-based or community-based
Focus of Counselling	• Encourage patient to continue with what is working; they are doing well • Reminders that any significant life event or major change in daily routine could interfere with adherence
Frequency of Follow-up	• Maximum of 6 month intervals between facility-based clinical review • ART can be distributed for up to 3 months (through fast track pick-up at facility or through community-based distribution) between clinical review appointments • Patients on injectable contraception should be provided FP through a fast-tracked process between clinical follow-up visits; oral contraceptives and condoms should be distributed with ART • Additional visits as required to address any medical or psychosocial concerns • Closer follow-up based on patient preference
*The healthcare team can consider other criteria such as mental illness, alcohol or substance abuse, unstable comorbid conditions, inadequate support systems, etc., if they feel the patient requires closer follow-up, despite meeting the other criteria listed	

Note that the patient's category can change at any time so there is a need for a reassessment at each visit. Patients should be categorized at every visit using the simple tool in Annex 6, with management based on category. If a stable patient no longer meets stable criteria, they should move to unstable care (including case management to address the reason/s they are no longer stable).

Differentiated Care for Children, Adolescents and Pregnant/breastfeeding Women

Children, adolescents and pregnant/breastfeeding women should not be excluded from differentiated care. The differentiated packages of care for these sub-populations are described extensively in the 2016 ARV Guidelines, the Adolescent Package of Care, and the Pediatric Toolkit. The "stable/unstable" criteria in Table 3 are used to identify patients who qualify for longer follow-up periods vs. those that may benefit from closer follow-up.

For caregivers/parents who are enrolled in DC as stable patients, their children or adolescents who also meet "stable" patient criteria (other than the age criteria) can be considered eligible for DC. This should follow a family-centered approach in which the family is given aligned appointments with longer prescription periods.

As part of the case-management approach for children and adolescents, appointment spacing must be determined based on the specific needs and situation of the individual. For example, children and adolescents may need their ART refills and clinical reviews harmonized with school holidays, even if it is longer than three months.

Children require close monitoring of growth and developmental milestones, and weight-based dose adjustments of their ART and CPT (although this becomes less frequent beyond 2 years of age). If enrolled as stable patients with less frequent appointments, weight monitoring and dose adjustments should be incorporated in both the facility and community models (e.g. by using portable weighing scales if out of the health facility).

Adolescents have unique challenges with adherence related to their psychological development and social support systems. For those enrolled as stable patients with less frequent appointments, psychosocial support and ongoing adherence assessments and counseling should be aligned with clinic visits and community follow-up.

Pregnant/breastfeeding women may be clinically stable but it is recommended that their HIV clinic appointments are integrated with Focused Antenatal Care visits and with follow-up of the HIV-exposed infant.

2.3 Redesigning Facility Work Flow

Facility managers, with the support of the MDT, will need to map out and review the current workflow to support DC.

2.3.1 Categorization Process

To start implementation of DC, all patients will need to be categorized and flagged using the simple tools in Annexes 5 and 6. Files can be flagged (e.g. color-coded files or stickers) for easier identification. For new patients, this can be part of the enrollment process. For patients currently in care, categorization can be performed for each patient as they return for a regularly scheduled follow-up visit. Patients should be counseled on the DC based on their clinical category, including their follow-up visit schedule. HCWs and lay health workers can use the DC IEC package to sensitize patients through health talks and one-on-one discussions on the service delivery models being offered, with a focus on criteria and benefits for stable patients.

2.3.2 Follow-up Visits

Patient follow-up should be based on their category (as per Tables 2 and 3) and any medical or psychosocial concerns identified by the healthcare team or raised by the patient. Patients should be encouraged to come to the clinic any time they have a concern, even if it is before a scheduled appointment date.

2.3.3 Location of Services

Facility Level Service Delivery

Patients in all categories (well/advanced; stable/unstable) can receive clinical evaluation, investigations, and ART prescriptions at the health facility, as per Tables 2 and 3. Stable patients may also receive facility-based fast track ART refills between regular clinic appointments, as described in Section 2.4.1.

Community Level Service Delivery

Stable patients may receive ART refills through community-based distribution (community ART groups, community ART distribution points, home visits, etc.) as described in Sections 2.4.2 – 2.4.4. Patients in all categories may also receive home visits or other community based services for specific indications, such as home visits for adherence monitoring and support, on a case-by-case basis.

2.4 Models of ART Delivery for Stable Patients

Stable patients should have a clinic appointment at least once every 6 months for clinical review, to ensure the Standard Package of Care is delivered (Section 4 of the 2016 ARV Guidelines), and to review if the patient still meets the stable criteria. Between these clinical review visits, stable patients should receive their ART, CPT, family planning, and any other chronic medicines through a distribution system that minimizes the burden on patients (travel costs, waiting times, inconvenience) and burden on the health facility (personnel time, space constraints, etc.) (Figure 3). This must be on a voluntary basis (i.e. the patient can choose to remain in standard care if they prefer).

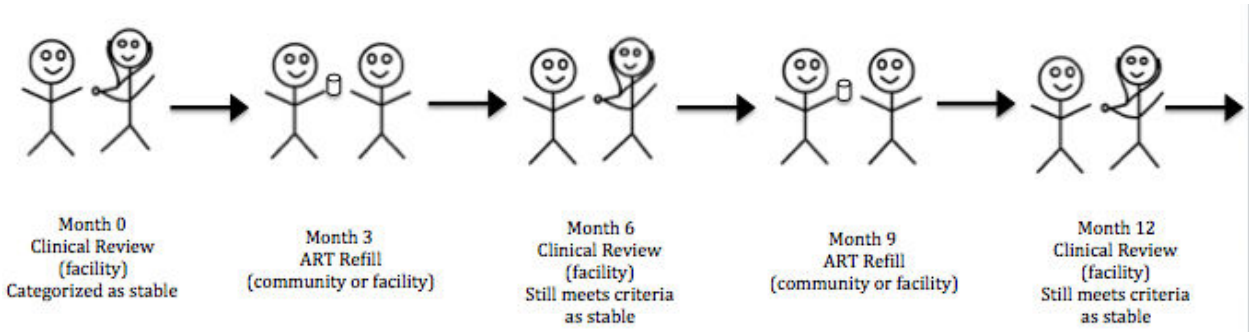


Figure 3: Minimum Frequency of Stable Patient Clinical Review Appointments and ART Refills

ART distribution can be through a facility-based fast track process (Section 2.4.1) or through a community-based process (Sections 2.4.2 – 2.4.4). Patients should be encouraged to return to the facility at any time if they have any concerns, even if they are not scheduled for an appointment.

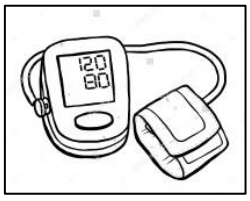
ART distribution, whether facility-based or community-based, must always be accompanied with completion of the ART Distribution Form (Annex 7), updating the Appointment Diary for ART Refills (Annex 8), and updating the Pharmacy Dispensing Tool.

All HCWs and lay health workers involved in ART distribution for stable patients must be trained to perform their expected duties using the national curricula.

2.4.1 Facility-based Fast Track System for ART Refills

The facility-based fast track system for ART refills is the simplest model for a health facility to implement. The patient is still required to come to clinic every three months, however the refill appointments (Figure 3) should require minimal or no waiting time at the clinic.

An example of how a facility-based fast track system may operate is presented in Figure 4.

Stable: Facility Fast Track ART Refill visit  ↓	**Categorization and Entry into Fast Track Program** 1. Clinician uses the patient categorization checklist (Annex 6) to identify stable patients during their routine clinic visit 2. Stable patient is sensitized about ART refill system and agrees to come back in 3 months for a refill, then in 6 months for another full clinical appointment 3. Appointment dates set for the refill in 3 months and the clinical appointment in 6 months, and recorded in the Appointment Diary for ART Refills and Clinic Appointment Diary
Registration and file retrieval  ↓	**Before Day of Refill Appointment:** 4. The pharmacist, who is in charge of tracking ART refill appointments, uses the Appointment Diary for ART Refills to identify clients who are expected to pick their ART refills on the following day 5. The ART and other medicines (CPT, family planning, etc.) are pre-packed by the pharmacist and clearly labeled with the patient's name and number. The pharmacist completes the first section of the ART Distribution Form and signs the form
Triage  ↓	**On Day of ART Refill Appointment:** 6. Upon arrival at the facility, the patient goes directly to the ART refill pick-up point (e.g. the pharmacy dispensing window) 7. The person distributing the pre-packed ART (e.g. the pharmacist or lay health worker) completes the second section of the ART Distribution Form (which includes a simple clinical assessment) for each patient. Clients who have any "danger signs" are referred to the clinician for further evaluation. Patients on injectable contraception should be fast-tracked for their injection while at the facility for their ART refill 8. Clients who have no "danger signs" are issued their ART. The person distributing the ART and the patient both sign the ART Distribution Form

Pharmacy  ↓ **Appointment Booking** Schedule next appointment for a comprehensive clinical evaluation	9. The patient is reminded of the date for their next appointment in 3 months for a clinical review 10. The completed ART Distribution Forms are used to update the Pharmacy Dispensing Tool 11. All ART Distribution Forms are collated at the end of each day and submitted to the Data Entry Clerk who records them in the ART Refill Register and file the forms into the patient file 12. The pharmacist reviews the Appointment Diary for ART Refills at the end of the day to see if all expected patients came to pick their refills. If any patients did not come for their refill as expected, the patient should be entered into the facility's missed appointment/defaulter register for tracing (Figure 5.3 of the 2016 ARV Guidelines) **On Day of Full Clinical Review Appointment** 13. Patient comes for full clinic appointment following the standard patient flow, receives the standard package of care, and categorization as a stable patient is confirmed

Figure 4: Example of a Facility-based Fast Track System for ART Refills

Each health facility can determine the precise process for facility-based fast track ART refills that works best for their staffing levels, patient load, and infrastructure. Possible modifications to the example in Figure 4 include:

- Another HCW or lay health worker, other than the pharmacist, can be responsible for maintaining the Appointment Diary for ART Refills, listing the patients that are expected to come for refills the next day, and identifying and flagging defaulters who did not pick their refills as expected
- The patient may go to the reception and/or triage before picking up their ART refill
- The ART Refill pick-up point does not need to be at the pharmacy (e.g. a lay health worker could bring all the pre-packed refills and the Appointment Diary for ART Refills to a separate fast track distribution room, and fast track patients go directly to that room where the second part of the ART Distribution Form is completed)
- ART refill pick-ups can be available during normal working hours, as well as designated extended hours such as early morning, evenings, and weekends

2.4.2 Community ART Groups for ART Refills

Community ART Groups (CAG) use a support-group structure to provide ART refills to patients in the community. Each patient in the CAG is required to come to the facility every 6 months for a clinical review appointment, with ART refills distributed through the CAG every 1-3 months between these facility appointments (Figure 3).

The CAG model is more complex to implement than the facility-based fast track systems for ART refills; however it may provide patients with additional psychosocial support if they are not already part of a support group. Community ART distribution may also be more convenient for patients who have to travel long distances to the health facility if their CAG meeting venue or community ART distribution point is closer to their home. For most facilities, CAGs should not be introduced until a functional facility-based fast track system is in place.

CAGs can be peer-led or HCW-led. Although CAGs usually meet outside of the health facility, they can choose to use the health facility as their meeting point if it is convenient for the members. The

formation of CAGs and examples of how peer-led and HCW-led CAGs may operate are described below.

Formation and Supervision of Community ART Groups

Step 1: Facility MDT discusses and agrees on the model of CAG to adopt (peer-led or HCW-led), and appoints a CAG focal person (which can be a HCW or lay health worker)

Step 2: Enrollment

- All patients are sensitized on DC (with a focus on follow-up options for stable patients) during health talks
- During routine clinical evaluation, patients categorized as stable are counseled on the available options for follow up, including remaining in routine care, shifting to facility-based fast-tracked refills, or shifting to a CAG
- The patient's file is flagged based on their preferred follow-up option
- Patients opting for CAGs are referred to the CAG focal person for enrollment into the CAG program

Step 3: Train the stable patients registered in the CAG program

- Once enough stable patients are registered for the CAG program, the CAG Focal Person convenes an introductory meeting and trains the patients on the CAG model using the national DC curriculum for lay health workers

Step 4: Group registration

- The last session of the DC training is for CAG formation. The participants are guided to organize themselves into groups of 6-12 members (larger groups can be considered in consultation with the CHMT) based on geographic proximity and group member preference, considering factors such as preferred meeting days/times (e.g. weekend or evening club meetings)
- During this last session of the training, each CAG selects the group leader who will coordinate the group's activities and will be the group's liaison with the health facility

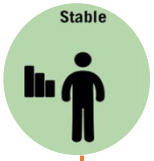
Step 5: Supervision of CAGs

- The CAG focal person should meet with all the group leaders periodically and any time there is concern about CAG performance (clinic attendance, timely refill distribution, viral suppression, etc.). As the CAGs form, the focal person should attend the first three CAG meeting and meet with the group leaders quarterly. As each group stabilizes, the frequency of supervision can decrease to a bi-annual group leadership meetings
- Refresher training on group dynamics, ART distribution, referrals, and M&E should be provided as brief update sessions to CAG leaders and members during regular CAG meetings or through centralized trainings

Peer-led Community ART Groups

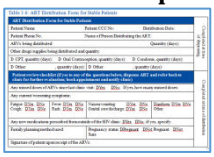
An example of how the peer-led CAG model may operate is described in Figure 5.

Stable: Community ART Distribution – Peer led



CAG meeting in the community

Complete ART Distribution Form for each patient



Clinical visit for CAG representative

Clinical assessment of CAG member

Pharmacy: Collect pre-packed ART for group members and self

Book next appointment

Use information in ART Distribution Form to update facility M&E tools during visit

Categorization and Entry into the CAG

1. Clinician uses the patient categorization checklist (Annex 6) to identify stable patients during their routine clinic visit
2. Stable patient is sensitized about ART refill system and agrees to join a CAG; patient is referred to the CAG focal person for registration and entry into a CAG
3. Appointment date is set for the next clinical review appointment within 6 months, and recorded in the Clinic Appointment Diary (all CAG members' clinic appointments are staggered over a six-month period, so that each member attends clinic once in six months, and there is at least one member coming to clinic each month)

CAG Meetings

4. Members meet every month at a pre-determined venue in the community
5. The group's leader facilitates a standing agenda, including completion of the second part of the ART Distribution Form, which includes a review for "danger signs"
6. ART (which was picked up from the facility by a CAG member) is distributed to each member upon completion and signing of the ART Distribution Form
7. Any member with danger signs on the ART Distribution Form or who would like to be seen at the health facility for any reason is referred to the health facility
8. A member is assigned to return the ART Distribution Forms to the facility within 7 days (including forms and drugs for any member who did not attend the CAG meeting as expected)

Updating Tools at the Facility

9. The ART Distribution Forms that are returned to the facility are used to update the Appointment Diary for ART Refills, ART Refill Register, and the Pharmacy Dispensing Tool, and then are placed in the patient file (or entered into the facility EMR for electronic sites)
10. Any patients who did not attend the CAG meeting and pick up their ART refill as expected is entered into the facility's missed appointment/defaulter register for tracing (Figure 5.3 of the 2016 ARV Guidelines)

Clinical Review Visit

11. The group member scheduled for the bi-annual clinical review attends a regular clinic visit at the health facility. The Standard Package of Care is offered, and patient is assessed to see if they still meet stable criteria
12. During the facility visit, the member picks up a one-month supply of ART for themselves and the other group members (pre-packed and named, with corresponding ART Distribution Forms that have the first section already completed and signed)

Figure 5: Example of a Peer-led Community ART Group for ART Refills

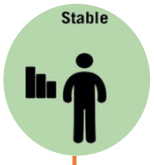
Each health facility can determine the precise process for peer-led CAGs that work best for their staffing levels, patient load, and infrastructure, and with input from the CAG members. Possible modifications to the example in Figure 5 include:

- The CAG can meet every 2 months or every 3 months, with ART being dispensed and distributed for 2 or 3 months respectively (instead of every month as described in Figure 5). In this scenario, several group members may attend clinic together instead a different member coming each month
- Members can come for their clinical review appointment together every 6 months. In this scenario, a member is nominated to visit the facility every 1-3 months to pick up the ART refills. Nomination can be based on need (e.g. a patient who does not feel well) or on a rotational basis. Since the members have all attended their clinical review visit the member picking up the ART refills can do so through a fast track process
- The clinical review visit can also occur in the community instead of the health facility, if a HCW can carry patient medical records to a CAG meeting and perform and document appropriate history, physical examination, offer the standard package of care, and draw samples for laboratory investigations if needed

Healthcare Worker-led Community ART Groups

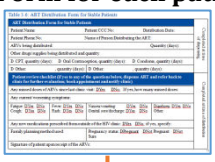
The HCW-led CAG model is similar to the peer-led model. However, in this model a HCW attends every CAG meeting in order to distribute ART and complete the ART Distribution Form. An example of how this model may operate is described in Figure 6.

Stable: Community ART Distribution – HCW led



Pharmacy: Pre-pack ART for group members

Completion of ART Distribution Form for each patient



Categorization and Entry into the CAG

1. Clinician uses the patient categorization checklist (Annex 6) to identify stable patients during their routine clinic visit
2. Stable patient is sensitized about ART refill system and agrees to join a CAG; patient is referred to the CAG focal person for registration and entry into a CAG
3. Appointment date is set for the next clinical review appointment within 6 months, and recorded in the Clinic Appointment Diary (each member must attend the clinic every 6 months. Members can coordinate their clinic visits to all be on the same day or within a few days of each other so that their ART prescriptions and refills coincide with each other)

Preparation for ART distribution

4. The pharmacist, who is in charge of tracking ART refill appointments, identifies which CAGs are due for their 3-month refill the following day
5. The ART and other medicines (CPT, family planning, etc.) are pre-packed by the pharmacist and clearly labeled with the patients' name and number. The pharmacist completes

HCW deliver ART to pre-agreed location in the community

Group and one on one counseling

Completion of ART Distribution form for all patients

Confirm next clinical appointment

Return ART Distribution Form to facility and update all registers (Pharmacy, ART Register, Appointment Diary, Daily Activity Register)

the first section of the ART Distribution Form and signs the form

6. The pre-packed medicine and ART Distribution Forms are given to the HCW who will be attending the CAG meeting and distributing the ART

Community Meetings and ART Refills

7. Members meet every 1-3 months at a pre-determined venue in the community
8. The group's leader facilitates a standing agenda
9. The HCW attending the CAG meeting completes the second part of the ART Distribution Form with each member and distributes the ART. The HCW and patient both sign the form
10. Any member with danger signs on the ART Distribution Form or who would like to be seen at the health facility for any reason is referred to the health facility
11. The HCW returns the ART Distribution Forms to the facility

Updating Tools at the Facility

12. The ART Distribution Forms that are returned to the facility are used to update the Appointment Diary for ART Refills, ART Refill Register, and the Pharmacy Dispensing Tool, and then are placed in the patient file (or entered into the facility EMR for electronic sites)
13. Any patients who did not attend the CAG meeting and pick up their ART refill as expected should be entered into the facility's missed appointment/defaulter register for tracing (Figure 5.3 of the 2016 ARV Guidelines)

Clinical Review Visit

14. The group members attend their bi-annual clinical review at the health facility. The Standard Package of Care is offered, and the patient is assessed to see if they still meet stable criteria
15. Three months of ART is dispensed for the patients attending clinic that day

Figure 6: Example of a Healthcare Worker-led Community ART Group for ART Refills

Each health facility can determine the precise process for HCW-led CAGs that works best for their staffing levels, patient load, and infrastructure, and with input from the CAG members. Possible modifications to the example in Figure 6 include:

- Another HCW or lay health worker, other than the pharmacist, can be responsible for maintaining the Appointment Diary for ART Refills, listing the CAGs that are due for refills, and identifying and flagging defaulters who did not attend the CAG meeting as expected
- A lay health worker (trained using the national curriculum for lay health workers) can be assigned to attend the CAG meetings and distribute the ART, instead of a HCW
- The clinical review visit can also occur in the community instead of the health facility, if a HCW can carry patient medical records to a CAG meeting and perform and document appropriate

history, physical examination, offer the standard package of care, and draw samples for laboratory investigations if needed

2.4.3 Community ART Distribution Points

Community ART Distribution Points can be implemented like the HCW-led CAG described above, except the patients receiving their ART refills are not part of a CAG. A HCW or lay health worker brings pre-packed ART refills to a pre-determined location in the community on a date when several stable patients are due for their ART refill. Patients should receive a reminder about the ART refill a few days before the community distribution appointment. The HCW or lay health worker completes the ART Distribution Form with each patient, provides the 3-month ART refill, and then returns the forms to the health facility for completion of the documentation as per the other models.

2.4.4 Individual Patient ART Distribution in the Community

ART refills can be distributed by HCWs or lay health workers in the community to individual patients during home visits or one-to-one meetings at another convenient location. For example, a lay health worker can be assigned several stable patients to follow for ART refills, using a case management model. The lay health worker uses the Appointment Diary for ART Refills to keep track of when each patient is due for a refill, distributes the refill to the patient during a home visit (and completes the ART Distribution Form), reminds the patient of the next clinic appointment, identifies and takes action for any missed appointments, and ensures documentation is completed correctly. The lay health workers must have a coordinator at the health facility that ensures all patients getting ART through this model are followed appropriately.

2.5 Assignment of Roles

Implementing DC should decrease the workload at the facility and does not require increased staffing. However, some additional roles need to be distributed among the team of HCWs, lay health workers, and patients.

This section provides examples of how roles can be distributed amongst the team, and should be customized based on facility staffing levels, workload, and the model/s of DC being implemented.

Facility in-Charge/HIV Clinic in-Charge

- Oversee the planning, role assignment, implementation and monitoring of DC
- Ensure training of HCWs and lay health workers on DC using the national curricula
- Consult with and report to Sub County, County and National teams

Facility Multi-Disciplinary Team (MDT)

- Map out and review the patient flow in the HIV clinic, and determine changes required for implementation of DC
- Agree on role division for DC
- Support the implementation of DC
- Conduct performance review of the DC model/s being implemented
- Compile and share best practices on DC

ART Distribution Coordinator and/or CAG Focal Person (may be a Nurse Counselor)

- Support the formation and training of CAGs
- Train the lay health workers on DC using the national curriculum, with emphasis on how to support stable clients within facility-based and community-based refill programs
- Conduct health talks using the DC IEC material
- Provide mentorship and support supervision to the CAGs
- Oversee the day-to-day operation of facility-based and community-based refill programs for stable clients

HIV Clinic Clinician

- Categorize patients for the differentiated packages of services
- Provide the Standard Package of Care plus additional differentiated services based on patient category
- Reassess patients for changes in their categorization

Laboratory Technologist

- Ensure results from laboratory investigation are available for patient management at their scheduled visit

ART Pharmacist/Pharmaceutical Technologist

- Reorganize the pharmacy processes to accommodate DC (e.g. ensure adequate stock for more patients getting 3-month ART supplies; tracking patients to ensure refills are distributed)
- Maintain the Appointment Diary for ART Refills and the Pharmacy ART Dispensing Tool
- Prepackage ART and other medication for individual patients marked with their details
- Work with the CAG Focal Person to ensure the pre-packed drugs are delivered to the clients

Lay Health Worker (peer educator, community health volunteer, and leader of each CAG)

- Conduct health talks on DC
- Support the formation of CAGs
- Assist patients with appointment keeping for drug refills and clinical visits
- Ensure safe transportation and distribution of pre-packed medicines for facility and community refill programs
- Complete the ART Distribution Form whenever distributing ART to stable patients
- Ensure ART Distribution Forms are returned to the CAG Focal Person within 7 days
- Provide counseling and support to the CAGs

Health Records Information Officer/Data Entry Clerk

- Verify ART Distribution Forms and enter data collected into the pre-requisite M&E tools (see M&E section)

Community ART Group Members

- Attend CAG meetings and clinic appointments as scheduled
- Sensitize other patients on available DC models and benefits

3. Monitoring and Evaluation

This section describes the minimum monitoring, evaluation, and reporting that is expected from all health facilities implementing differentiated care, 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 care 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, patient waiting times, patient satisfaction, quality of care (for stable patients and for patients in the other three categories), etc.

3.1 Indicators

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

Table 4: Differentiated Care Indicators

Domain	Indicator Definition	Computation	Disaggregation: Facility Level	Disaggregation: National Level	Source Documents	Period of Reporting
HIV Screening and Testing						
1. HIV positivity /yield	Proportion of individuals who test HIV positive within the reporting period	Numerator: HV01-26 Total count of all clients who tested HIV Positive during a given reporting period Denominator: HV01-10 Total of all clients who took a HIV test during a given reporting period	Facility and Community	Age and gender	HTS/linkage register	Facility: Monthly National: Monthly
2. Linkage to care and treatment	HV01-02 Proportion of new diagnosed with HIV linked to treatment within 3 months of diagnosis	Numerator: Number of patients identified as HIV positive 3 months ago and linked to care Denominator: Number of patients identified as HIV positive 3 months ago	Facility and Community	Age and gender	HTS/linkage register	Facility: Monthly National: Monthly

HIV Care and Treatment						
3. PLHIV who present well	Proportion of newly enrolled patients who present well (Refer to section 2 for definition)	Numerator: Number of newly enrolled patients who present well Denominator: HV03-011 Number of patients enrolled into care	Age and sex	Age and sex	Facility: Treatment preparation register & MoH 731 EMR National: Data warehouse	Facility: Monthly National: Quarterly
4. PLHIV with advanced disease	Proportion of newly enrolled patients with advanced disease (Refer to section 2 for definition)	Numerator: Number of newly enrolled patients with advanced disease Denominator: HV03-011 Number of patients newly enrolled into care	Age and sex	Age and sex	Facility: Treatment preparation register & MoH 731 EMR National: Data warehouse	Facility: Monthly National: Quarterly
5. ART initiation	Proportion of patients with HIV infection who are initiated on ART	Numerator: Number of persons with HIV infection newly started on ART Denominator: HV03-03 Number of persons with HIV infection newly enrolled in care	Well and Advanced disease	Well and Advanced disease	Facility: Treatment preparation register ART Cohort Register National: Data warehouse	Facility: Monthly National: Quarterly
6. Timely ART initiation	Proportion of patients with HIV infection who initiated on ART within 2 weeks	Numerator: Number of persons with HIV infection newly started on ART who initiate ART treatment within 2 weeks	Well and Advanced disease	Well and Advanced disease	Facility: Treatment preparation register ART Cohort Register	Facility: Monthly National: Quarterly

		Denominator: HV03-03 Number of persons with HIV infection newly started on ART			National: Data warehouse	
7. 12 month retention on ART for patients who present well and with advanced disease at enrollment	PLHIV who are active 12 months after ART initiation	Numerator: Total number of PLHIV who are active 12 months after ART initiation Denominator: Total number of PLHIV enrolled 12 months prior to the reporting period	Well and Advanced disease	Well and Advanced disease	Facility: Non-EMR: Treatment preparation register ART Cohort Register EMR: EMR system National: Data warehouse Treatment preparation register & ART register	Facility: Monthly National: Monthly
8. 12 month retention for stable and unstable patients who are still active on ART 12 months after enrollment into the refill program	Proportion of stable patients who are still active on ART 12 months after enrollment into the refill program	Numerator: Total number of patients who are still active on ART 12 months after categorization as stable / unstable Denominator: Total number of PLHIV who have been on ART for at least 12 months	Stable (including by refill model: standard track, fast track, or community ART distribution) and Unstable	EMR facilities: Data warehouse	Facility: Daily Activity Register & ART Cohort Register National: Data warehouse	Facility: Monthly National: Quarterly
9. Viral suppression	Proportion of active patients on ART for at least 1 year (Monthly Cohorts) who are virally suppressed (VL < 1000)	Numerator: Number of active patients who are virally suppressed 12 months after categorization into stable or unstable Denominator: Total number of patients categorized as stable	Stable (including by refill model: standard track, fast track, or community ART distribution) and Unstable	EMR facilities: Data warehouse	Facility: DC facility summary form National: Data warehouse	Facility: Monthly National: Quarterly

		or unstable				
HIV Drug Deliveries						
10. Uptake of ART refill program for stable patients	a. Proportion of total stable patients issued with ≥ 3 months ART prescriptions	Numerator: Number of stable patients issued with ≥ 3 months ART prescriptions Denominator: Total number of stable patients	Drug collection point: Facility & Community		ART Refill Diary and Daily Activity Register	Facility: Monthly
	b. Proportion of stable patients in the ART Refill Program collecting the ART refill prescription at month 3	Numerator: Number of stable patients in the ART Refill Program collecting the ART refill prescription at month 3 Denominator: Number of stable patients issued with ≥ 3 months ART prescriptions	Drug collection point: Facility & Community		ART Refill Register and ART Refill Diary	Facility: Monthly
11. Coverage of ART refill program for PLHIV	Proportion of stable patients issued with ≥ 3 months ART among all patients on ART	Numerator: Number of stable patients issued with ≥ 3 months ARV prescriptions Denominator: Total number of PLHIV on ART	Drug collection point: Facility & Community		ART dispensing tool and ART Refill Diary	Facility: Monthly
12. Community ART distribution uptake	HV03-15: Proportion of stable patients receiving ART through	Number of stable patients on ART who receive ART through community	Disaggregated by sex into males and females		MoH 731 & ART Dispensing Tool	Facility: Monthly National:

	community dispensing systems	dispensing mechanisms HV03-038: Number of stable patients currently receiving ART				Monthly

3.2 Monitoring & Evaluation Tools

Implementation of DC will require the use of standard M&E tools as well as a number of interim tools (Table 5). 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 (see Annex 1 – 12).

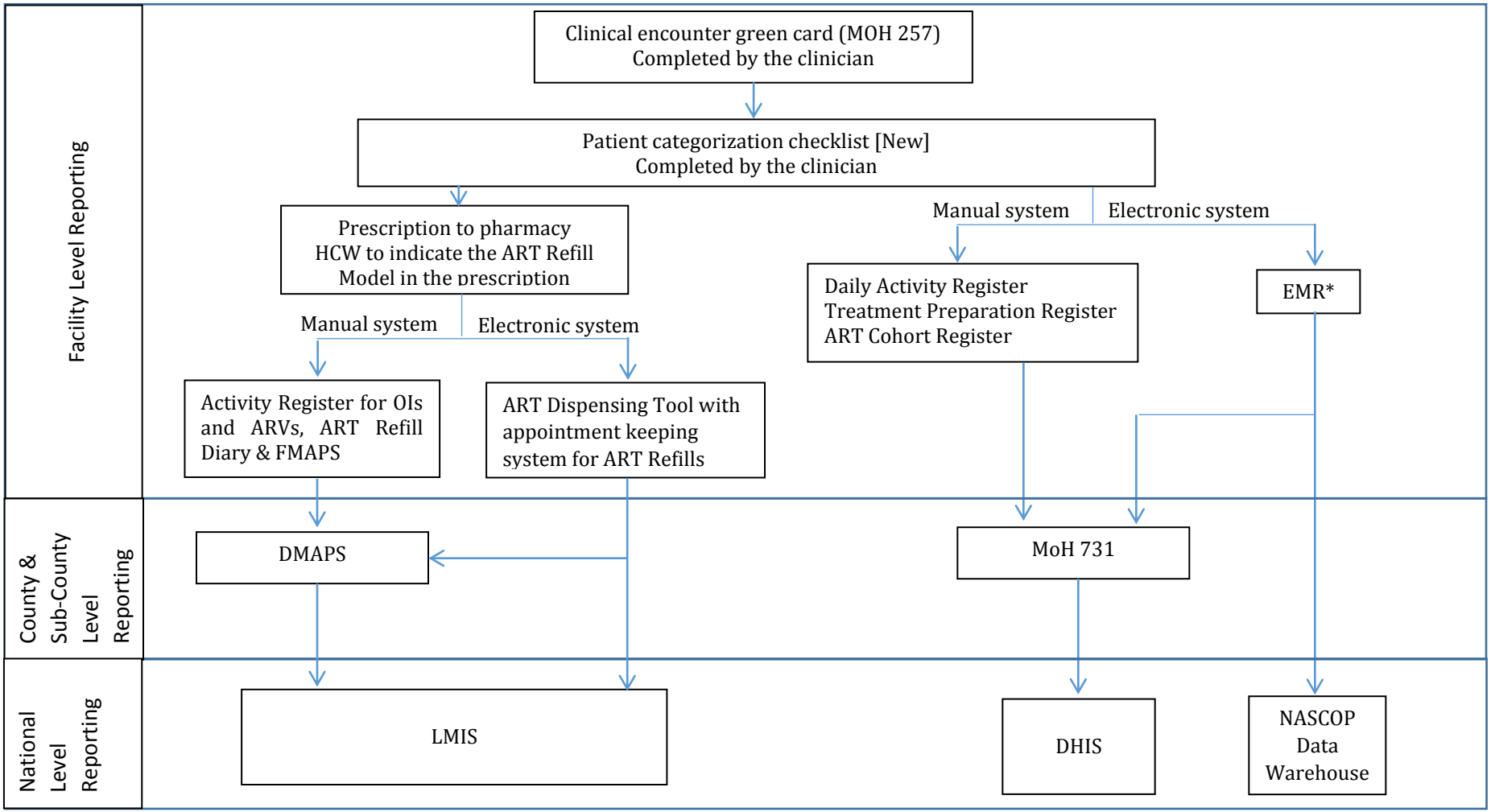
Table 5: Clinical and Monitoring & Evaluation Tools to Support Differentiated Care

Clinical / M&E tool	Purpose	Location
1. Clinical Encounter Green Card (MOH 257)	Patient clinical evaluation	Placed in patient file
2. Patient Categorization Checklists [New]	Assess patient category	Placed in patient file
3. ART Distribution Form [New]	Assess for "danger signs" during ART refill distribution and document ART refill distribution	Placed in patient file
4. ART Dispensing Tool	Monitor the ART Refill program	Pharmacy
5. Appointment Diary for ART Refills [New]	Track ART refill appointments and identify defaulters	Pharmacy
6. ART Refill Register [New]	To disaggregate stable patients into the model of ART distribution they are enrolled in	Records room
7. Differentiated Care Facility Aggregation Form [New]	Summarize DC indicators at facility level	Records room
8. Customer Satisfaction Survey [New]	Assess patient satisfaction	Facility triage area
9. Health Facility Readiness Assessment Tool: Community ART Distribution [New]	Assess facility readiness to providing community ART distribution	CHMT/sCHMT
10. Supportive Supervision Tool [Revisions]	Quarterly review of differentiated care implementation at county and sub-county levels	CHMT/sCHMT

3.3 Data Flow

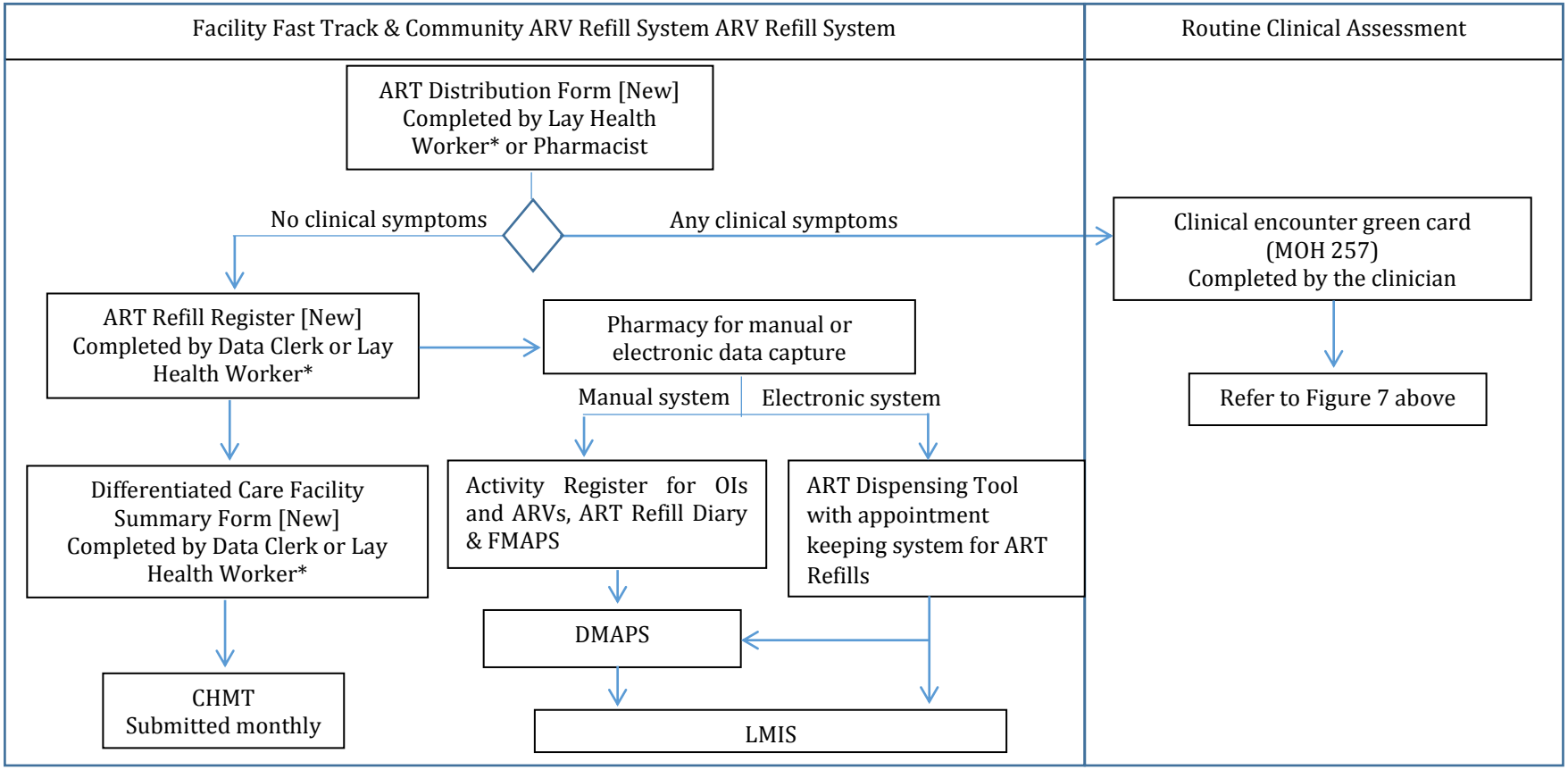
DC data summaries should be completed at the facility level using the Differentiated Care Facility Aggregation Form (Annex 12). The DC Facility Summary Form is submitted to the CHMT through the s/CHRIO. National Differentiated Care data summary will be collated from facilities with Electronic Medical Records systems using the NASCOP National Data Warehouse on a quarterly basis. The data flow for DC is summarized in Figure 7 (Initial Evaluation) and Figure 8 (Follow-Up Visits).

Figure 7: Differentiated Care Data Flow for Patient Evaluation and Categorization



*The facility EMR must be configured to capture all the variables in the clinical encounter green card (MOH 257) and the patient categorization checklist.

Figure 8: Differentiated Care Data Flow for Follow-up Visits



*Peer Educator, Community Health Volunteer, and Leader of each Community ART Group

3.4 M&E Roles and Responsibilities

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

Clinical Officer/Nurse at the HIV Clinic

- Update the clinical encounter form
- Update the Patient Categorization Checklists
- Complete the ART prescription forms
- Participate in data review meetings for the HIV clinic
- Participate in quality improvement review meetings

Lay Health Worker

- Complete the ART Distribution Form
- Complete the ART Refill Register
- File the ART Distribution Forms in the individual patient files

Pharmacist/Pharmaceutical Technologist

- Complete the ADT tool
- Track ART refill appointments with the Appointment Diary for ART Refills/ ADT tool
- Report missed appointments, lost to follow ups and defaulters to initiate defaulter tracing

Health Records Information Officer/Data Entry Clerk

- Mentor lay health workers on data entry into the ART Distribution Forms and ART Refill Register
- Conduct ART data aggregation from the ART Refill Registers and the Daily Activity Register into MoH 731
- Collect, verify and enter data collected into the DHIS
- Conduct and facilitate monthly data review meetings at the facility level
- Conduct DQA between Differentiated Care Facility Summary Form, ART Refill Registers and the ART Distribution Forms
- Liaise with the sCHRIO and ensure consistent supply of data tools at the facility
- Liaise with the health facility HRIO/in-charge to conduct monthly DQA between MoH 731 and DHIS data
- Export EMR data to the National Data Warehouse

NASCOP Strategic Information Unit

- Collate EMR data nationwide into the NASCOP Data Warehouse
- Conduct quarterly analysis of DC indicators using the Data Warehouse
- Offer TA to HCWs at the health facility level and county/sub-county on implementation of DC
- Print and distribute DC tools to the county and sub-counties
- Support county and national data review and stakeholders fora

3.5 Performance Measurements

Implementation of DC will be evaluated at the national level on a quarterly basis largely relying on data from the approved EMR sites. EMR data from DC implementation will be compared to data from facilities not implementing DC over the same time period. Trends of patient outcomes over time will provide guidance on the success of DC implementation. Table 6 describes the minimum performance indicators.

Table 6: Performance Measurement Indicators for Differentiated Care

	Performance Measure Indicator	Frequency of measurement
DC Uptake	Proportion of stable patients issued with ≥ 3 months ART among all patients on ART	National: Quarterly
	Proportion of stable patients issued with ≥ 3 months ART prescriptions	National: Quarterly
	HIV03-15: Proportion of stable patients receiving ART through community dispensing systems	National: Quarterly
DC Outcomes	Proportion of stable patients who are still active on ART 12 months after enrollment into the refill program	National: Quarterly
	Proportion of stable patients who are virally suppressed (VL<1,000 copies/ml) after at least 1 year on ART (Monthly Cohorts)	National: Quarterly

3.6 Differentiated Care Supervisory and Quality Improvement Systems

The CHMT, with coordination by the QI coordinator, is responsible for overseeing the DC implementation progress in the county. The CHRIO will be responsible for consolidating data from routine MoH reporting and DHIS to provide DC performance data to the CHMT.

DC data performance review should be conducted on a monthly basis at the facility level by the quality improvement team or the HIV clinic work improvement team. During these meetings, the team should discuss the progress of DC, the challenges faced and possible solutions to the challenges. DC performance should be reviewed at sub-county level during the facility in-charges meetings on a monthly basis. The CHMT should review the DC data on uptake as well as coverage on a quarterly basis at the county level through data review meetings and also integrate facility DC review during routine supervisory visits. Support supervisory tools should be customized to include the following questions to assess DC:

- Do you have all the necessary data collection and reporting tools to implement DC?
- Has the health facility conducted any data review meetings within the last month to discuss DC?
- Were there any action plans agreed upon after the meeting with clear responsibilities?
- What are some of the challenges faced by the HCW implementing DC 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 DC in the health facility?

The QI coordinator together with the CASCO should work together with implementing partners to conduct monthly mentorship visits to health facilities implementing DC to offer technical support. During the mentorship visits, health facility data should be reviewed and used to guide the mentorship.

Best practices identified within the county can be collated and shared with other facilities within the county through an annual HIV stakeholder's forum and also shared upwards with NASCOP to inform other counties on scalable interventions.

Annexes

Annex 1: County Readiness Self-Assessment Tool for Differentiated Care

The County Readiness Self-Assessment Tool is designed to capture current information on HIV-related programming in the county, based on the health system building blocks:

- Leadership and governance, including coordination and health finance
- Human resources for health
- Service delivery
- Commodity management
- Strategic information

The primary aim of the assessment tool is to assist the C-TWG in identifying current strengths and weakness of the health systems that are relevant for implementation of DC. 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.

County Readiness Self Assessment Tool for Differentiated Care*			
	Areas of assessment	**Yes/No**	**Comments**
Leadership and Governance	1. Does the county have an existing HIV Technical Working Group that includes members of the CHMT, implementing partners, health workers and people living with HIV?		
	2. Does the HIV Technical Working Group meet regularly to discuss HIV program progress with documented minutes?		
	3. Does the county keep reports of the actual allocation and use of finances for HIV services for the last financial year?		
	4. Are there sufficient funds and other resources available to support differentiated care?		
Human Resource	1. Has the 2016 ARV Guidelines Orientation been rolled out for HCWs in the county?		
	2. Have HCWs at all facilities offering HIV services been oriented on the 2016 ARV Guidelines?		
Infrastructure	1. Do facilities in the county have adequate storage space for additional commodities (ART supplies)?		
Commodity Management	1. Does the county have a County Commodity Management / Commodity Security Committee?		
	2. Does the county have a reliable supply chain management system to support facilities and prevent stock-outs?		
Quality Improvement & Supervision	1. Does the county implement the Kenya HIV Quality Improvement Framework (KHQIF)?		
	2. Does the county have quality improvement team structures at county/sub-county and facility level?		
	3. Does the County HIV TWG conduct meetings to review clinical cases and provide support to patients failing treatment or with advanced disease?		
Information Systems	1. Have all facilities been trained on the revised HIV M&E tools?		
	2. Do all facilities have the revised HIV M&E tools?		

*None of these criteria are absolute requirements for implementation of Differentiated Care; implementation should be considered even if some criteria are not met, as long as a plan is in place to address gaps

Annex 2: Facility Readiness Self-Assessment Tool

The Facility Readiness Self-Assessment Tool is designed to capture current information on HIV-related programming in the county, based on the health system building blocks:

- Leadership and governance, including coordination and health finance
- Human resources for health
- Service delivery
- Commodity management
- Strategic information

The primary aim of the assessment tool is to assist the facility MDT in identifying current strengths and weakness of the health systems that are relevant for implementation of DC. 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 facilities based on performance in each section but to identify opportunities for HIV program improvement.

Facility Readiness Self-Assessment Tool for Differentiated Care*			
	Areas of assessment	**Yes/No**	**Comments**
Leadership and Governance	Does the facility have an existing Multi-Disciplinary Team with documented meeting minutes?		
Human Resource	Has the 2016 ARV Guidelines Orientation been rolled out at the facility?		
	Have HCWs in all departments offering HIV services been oriented on the 2016 ARV Guidelines?		
Infrastructure	Does the facility have adequate storage space for additional commodities (ART supplies)?		
Commodity Management	Does the facility have a Commodity Management / Commodity Security Committee?		
Quality Improvement & Supervision	Does the facility implement the Kenya HIV Quality Improvement Framework (KHQIF)?		
	Does the facility have a quality improvement team?		
	Does the facility MDT review clinical cases and provide support to patients failing treatment or with advanced disease?		
Information Systems	Have HCWs been trained on the revised HIV M&E tools?		

*None of these criteria are absolute requirements for implementation of Differentiated Care; implementation should be considered even if some criteria are not met, as long as a plan is in place to address gaps

Annex 3: Facility Assessment to Provide Community ART Distribution

Health Facility Assessment to Provide Community ART Distribution*			
Facility name:	**MFL code:**	**Date of assessment:**	
Health system domains for community ART distribution			Yes/No
Leadership: Has the facility identified a focal person to oversee community-based ART distribution?			
Finance: Does the facility have resources to implement and monitor community-based ART distribution?			
Human Resources for Health: Has the facility identified appropriate personnel to distribute ART (Peer educators, Lay counselors and / or Community Health Volunteers)?			
Does the facility have capacity to train ART distributors?			
Service Delivery: Has the facility achieved a routine viral load monitoring uptake of ≥ 90%?			
Has the facility established a facility-based system for fast-track ART distribution?			
Commodity Management: Does the facility have ≥ three months of ART available on site?			
Has the facility identified a focal person to pre-pack and label ART for community distribution?			
Health Information Systems: Does the facility have an established system to monitor patient level outcomes specifically retention, lost to follow-up, mortalities and viral load suppression?			
Is the facility able to establish recording and reporting systems for community ART?			
Assessors' recommendations:			
Final assessment outcome:			
Facility can initiate community ART distribution Facility to implement assessors 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 Care; implementation should be considered even if some criteria are not met, as long as a plan is in place to address gaps

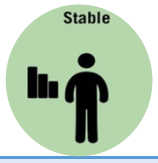
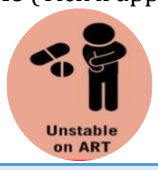
Annex 4: Work Plan Template

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.					
	C.					
…	A.					
	B.					

Annex 5: Patient Categorization Checklist at Enrollment

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 Disease**  • WHO stage III or IV, **or** • CD4 ≤ 200 cells/mm³ (or ≤ 25% for children ≤ 5 years old)	

Annex 6: Patient Categorization Checklist after 12 Months in Care

Date of Visit	**Stable** (Use Codes Below) 	**Unstable** (Tick if appropriate) 	Comments
	A patient is considered stable if they meet all of the following criteria: • On their current ART regimen for ≥ 12 months • No active OIs (including TB) in the previous 6 months • Adherent to scheduled clinic visits for the previous 6 months • Most recent VL < 1,000 copies/ml • Has completed 6 months of IPT • BMI ≥ 18.5 • Age ≥ 20 years • Healthcare team does not have concerns about providing longer follow-up intervals for the patient	*A patient is considered unstable if they have any of the following:* • On their current ART regimen for < 12 months • Any active OIs (including TB) in the previous 6 months • Poor or questionable adherence to scheduled clinic visits in the previous 6 months • Most recent VL ≥ 1,000 copies/ml • Has not completed 6 months of IPT • Pregnant or breastfeeding • BMI < 18.5 • Age < 20 years • Healthcare team has concerns about providing longer follow-up intervals for the patient	

ART Refill Model Codes for Stable Clients	
STD = Standard care FT = Fast Track CADH = Community ART Distribution – HCW Led	CADP = Community ART Distribution – Peer Led FADG = Facility ART Distribution Group

Annex 7: ART Distribution Form

Introduction: The ART Distribution Form is a facility/community based tool for tracking the ART refill program for stable patients receiving ART refills through DC. 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 stable and on long-term follow-up.

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

Who completes: Section A of the ART Distribution Form is completed by the pharmacist or person responsible for dispensing ART at the health facility, and it is completed at the time of ART dispensing. Section B is completed by a HCW or trained lay health worker responsible for ART Distribution at facility or community level at the time of ART distribution. If ART refills are distributed by the pharmacist/pharmaceutical technologist at the facility (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 Distribution Form is submitted to the pharmacist for completion of the ADT while the duplicate is submitted to Records for updating the DAR and filing into the patient 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 Distribution Form booklet is the pharmacist based at the health facility.

Description of fields:

Variable field name	Description of variable
A. ART Distribution Form for Stable Patients	
Client Name	Enter the name of the client in the spaces provided in the order first, middle and last name
Client Unique ID	10 digit patient 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 Distribution	Enter the date of ARV distribution in the format DD/MM/YYYY
ART Refill Model	Enter the clients model for ART distribution as follows: **FT** = Fast Track **CADH** = Community ART Distribution – HCW Led **CADP** = Community ART Distribution – Peer Led **FADG** = Facility ART Distribution Group
Patient Phone No	Indicate the patient'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 in this space
Other drugs/supplies being distributed and quantity CPT / Dapsone: Oral Contraceptives: Condoms:	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 in this space **Note:** If provided with condoms enter yes after ticking the check box

Other:	
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 name
B. Patient 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)***	
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. fi the patient 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 client If yes, specify the medication given
Family planning method used	Check the appropriate box after screening the client If yes, specify the type of family planning being used
Pregnancy status	For female patients, 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 patient 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 client will visit the health facility in the format DD/MM/YYYY
Signature of patient upon receipt of the ART:	Client to append their signature upon receipt of the ARVs For clients who cannot sign, a thumb print can be appended

A. ART Distribution Form for Stable Patients

Client Name: _____ Client Unique No: _____

Date of ARV Distribution: DD _____MM_____YYYY_____

ART Refill Model: _____

Patient Phone No: Treatment Supporter Phone No:

ARVs regimen being distributed: Quantity (mths):

Other drugs/supplies being distributed and quantity

☐ CPT / Dapsone, quantity (mths): ☐ Oral Contraception, quantity (mths): ☐ Condoms (yes/no):

☐ Other: , quantity (days):	☐ Other: , quantity (days):
Name of pharmacist/person dispensing: Signature:	Name of ART distributor: Signature:

Complete at time of dispensing

B. Patient 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)***

Any missed doses of ARVs since last clinic visit: ☐Yes ☐No

If yes, how many missed doses: _____

Any current/worsening symptoms:

Fatigue: ☐Yes ☐No Cough: ☐Yes ☐No	Fever: ☐Yes ☐No Rash: ☐Yes ☐No	Nausea/vomiting: ☐Yes ☐No Genital sore/discharge: ☐Yes ☐No	Diarrhea: ☐Yes ☐No Other:

Any new medications prescribed from outside of the HIV clinic: ☐Yes ☐No

If yes, specify:

Family planning: ☐Yes ☐No Method used:	Pregnancy status: ☐Pregnant ☐Not Pregnant ☐Not Sure

Referred to clinic: ☐Yes ☐No

If yes, appointment date: DD____ MM____ YYYY _____

Signature of patient upon receipt of the ART:

Complete at time of distribution

Annex 8: Appointment Diary for ART Refills

Introduction: The Appointment Diary for ART Refills is a facility-based tool for tracking the ARV Refill appointment for PLHIV on stable-patient follow-up.

Normal diaries can be used to track ART Refill appointments and should include a minimum of the variables in the sample diary template below. The ADT tool can be customized to capture the variables outlined in the sample diary below. The Appointment Diary for ART Refills can also be combined with the standard clinic appointment diary (e.g. at reception) simply by adding a column to denote that it is a refill appointment instead of a clinical review appointment.

Purpose: It serves as the primary document to track the ARV Refill appointment for PLHIV classified as stable and on long term follow-up. The primary purposes of the appointment diary is to know which patients are expected for ART refills (so their medications can be pre-packed), and to identify any patient who did not pick up their ART refill as expected so that action can be taken.

When completed: It is completed after a clinical consultation and categorization of PLHIV. Only clients who are stable and opt for the ART Refill program are recorded in this diary. The clients' details are recorded on the expected ART Refill date (and not the date of the current clinical visit).

Who completes: The pharmacist will complete the ART Refill Appointment Diary after receiving the prescription from the clinician, or, if it is kept at reception then it can be completed there as the patient checks out of the clinic (the same way the standard clinic appointment diary is managed). It is also checked as each patient arrives for a refill or a clinic appointment, to check off which patients came that day and determine if any patients missed their appointment or refill. For patients receiving their ART in the community, the completed ART Distribution Forms are used to update the appointment diary and determine if any patients did not receive their refill on the date expected. Any patient who misses a refill pick-up should be moved to the facility defaulter register so they can be tracked just like any patient who misses an appointment (Figure 5.3 of 2016 ARV Guidelines).

Where is it kept in the facility: The custodian of the ART Refill Appointment Diary is the pharmacist based at the health facility, or any place the regular clinic appointment diary is kept (e.g. at the reception).

HIV CARE & TREATMENT APPOINTMENT DIARY FOR ART REFILLS SCHEDULED VISITS			
S/N	**Unique ID**	**Name** [First, Middle, Last]	**ART Refill Model** [Use codes]
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

ART REFILL ATTENDANCE SUMMARY				
Fast Track	**Community ART Distribution –** HCW Led	**Community ART Distribution –** Peer Led	**Facility ART Distribution Group**	**Total**

ART REFILL MODEL CODES
FT = Fast Track CADH = Community ART Distribution – HCW Led CADP = Community ART Distribution – Peer Led FADG = Facility ART Distribution Group

Annex 9: ART Refill Register

Introduction: The ART Refill Register is a facility-based tool that collates data from the ART Distribution Forms.

Purpose: It shows a summary of the number of clients who have received ARVs at any point in time categorized / disaggregated into the different ART Refill models. It is also a source document for the clients who have defaulted from the ART Refill program in order to institute defaulter tracing mechanisms for follow-up.

When completed: It is completed after ART Refill visits at either facility or community level.

Who completes: It is completed by the lay health worker, HCW, or HRIO using the ART Distribution Forms (a specific person at the facility should be identified to complete this form based on the facility staffing and role distribution).

NB: The lay health worker should complete the register before filing the duplicate ART Distribution Form in the patient file.

Where is it kept in the facility: The custodian of the ART Refill Register is the HRIO based at the health facility.

Description of columns:

Variable field name	Description of variable
S/N	Enter Serial Number. Serialize monthly
Patient Name	Enter the name of the client in the spaces provided in the order first, middle and last name
Client Unique No	10 digit patient 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
Sex	Enter M for male and F for Female
ART Refill Model	Enter the ART Refill Codes depending on the refill model **FT** = Fast Track **CADH** = Community ARV Distribution – HCW Led **CADP** = Community ARV Distribution – Peer Led **FADG** = Facility ARV Distribution Group
ART Refill Appointment Date	Enter the date the client is expected to be issued with ART in the format DD/MM/YYYY. This is the same date as the date indicated in the prescription
Actual Date of ART Refill	Enter the date the client was issued with ART in the format DD/MM/YYYY
Symptoms	Enter yes if client had any symptoms on the ART Distribution Form, and no if there were no symptoms
Referred to clinician	Enter yes if client was referred to clinician on the ART Distribution Form
Missed Refill Appointment	Tick if client missed the ART Refill appointment

ART REFILL REGISTER										
MONTH:										
S/N	**Date**	**Unique ID**	**Name** [First, Middle, Last]	**Sex** [M/F]	**ART Refill Model** [Use codes]	**ART Refill Appointment Date** [dd/mm/yy]	**Actual Date of ART Refill** [dd/mm/yy]	**Symptoms** [y/n]	**Referred to clinician** [y/n]	**Missed Refill Appointment** [y/n]
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										

ART REFILL MODEL CODES

FT = Fast Track
CADH = Community ARV Distribution – HCW Led
CADP = Community ARV Distribution – Peer Led
FADG = Facility ARV Distribution Group

PAGE SUMMARY

Fast Track	**Community ART Distribution –** HCW Led	**Community ART Distribution –** Peer Led	**Facility ART Distribution Group**	**Total**

Annex 10: Clinical Encounter Green Card MoH 257

Modifications to the Clinical Encounter Green Card MoH 257 Differentiated Care (S/U) and Type of Differentiated Care (S/E/C) section:

Variable field name	Description of variable
Differentiated care	Assess the clients' category according to the criteria specified in the treatment guidelines Categorize the client as follows: **W**=Well **Ad**=Advanced **S**=Stable **U**=Unstable
Type of differentiated care	The clients' category will determine the type of care to be provided. This can be through clinical consultations or through the ART refill program. Depending on the clients' category, providers can determine the frequency of clinical consultations. Clients who are well, advanced and unstable will have to see a clinician at every visit. Stable clients opting for the facility or community ART distribution model should be classified as follows: **F=** The client will receive their ART refill through a facility-based fast track system **CBART=** The client will receive their ART refill through a community distribution mechanism Stable clients who may not opt for either facility or community based distribution will continue with the routine clinical visit and will be classified as **scS**

Annex 11: Daily Activity Register

Instructions:

- Follow the DAR instructions
- Add additional column after CCC No. and indicate the DC Codes as follows:
  - Well = W
  - Advanced = Ad
  - Stable = S
  - Unstable = U

No	Date	CCC No.	DC Code	Enrolled in Care										On Treatment preparation (New&Revisits)		Starting ART										
				Tick as appropriate for age												Tick as appropriate for age										
				< 1 yrs	1-9 yrs	10-14 yrs (M)	10-14 yrs (F)	15-19 yrs (M)	15-19 yrs (F)	20-24 yrs(M)	20-24 yrs (F)	25+ yrs (M)	25+ yrs (F)	Key Population (KP)	0-14 yrs	15+ yrs	<1 yrs	1-9 yrs	10-14 yrs (M)	10-14 yrs (F)	15-19 yrs (M)	15-19 yrs (F)	20-24 yrs(M)	20-24 yrs (F)	25+ yrs (M)	25+ yrs (F)	Key Population (KP)
(a)	(b)	(c)	(C2)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)	(v)	(w)	(x)	(y)	(z)	(aa)

Annex 12: Differentiated Care Facility Aggregation Form

Introduction: The Differentiated Care Facility Aggregation Form is a facility-based tool that collates data on DC from various data sources as outlined below.

Purpose: It summarizes DC data on a monthly basis disaggregated into the different ART Refill models.

When completed: It is completed on a monthly basis.

Who completes: It is completed by the Health Records Information Officer.

Where is it kept in the facility: The custodian of the ART Refill Register is the Health Records Information Officer based at the health facility.

Description of columns:

Required Data Elements and Codes		Data Element Description
1. HIV Testing Services		
1.1 HIV Positivity - Facility		
HIV Testing Facility	DC 01-01	These data element refers to the counts of clients, who undertook an HIV test during the reporting period at the facility.
HIV Positive Results Facility	DC 01-02	This data element is a total count of all clients who undertook an HIV test at the facility and tested HIV Positive during a given reporting period.
HIV Positivity Facility (Yield)	DC 01-03	(DC 01-02/ DC 01-01)x100
1.2 HIV Positivity - Community		
HIV Testing Community	DC 01-04	These data element refers to the counts of clients, who undertook an HIV test during the reporting period through community outreach program from the facility
HIV Positive Results Community	DC 01-05	This data element is a total count of all clients who undertook an HIV test at the community and tested HIV Positive during a given reporting period.
HIV Positivity Community (Yield)	DC 01-06	(DC 01-05/ DC 01-04)x100
1.3 Linkage to Care from Facility Testing		
Linked Facility	DC 01-07	This is a count of clients who were tested for HIV at the facility and whose results were positive and have been enrolled into HIV care.
HIV Positive 3 mo Ago Facility	DC 01-08	This is a count of clients who were tested for HIV at the facility and

		whose results were positive. This data element is time-lagged by three months.
% Linked Facility	DC 01-09	(DC 01-07/ DC 01-08)x100
1.4 Linkage to Care from Community Testing		
Linked Community	DC 01-11	This is a count of clients who were tested for HIV in the community and whose results were positive and have been enrolled into HIV care.
HIV Positive 3 mo Ago Community	DC 01-12	This is a count of clients who were tested for HIV in the community and whose results were positive. This data element is time-lagged by three months.
% Linked Community	DC 01-13	(DC 01-11/ DC 01-12)x100
2. HIV Care and Treatment		
2.1 Newly Enrolled – Well PLHIV		
Enrolled Well PLHIV	DC 02-01	This is a count of clients who are enrolled in care who present well
Enrolled Total	HV03-011	Enrollment in care constitutes, but not limited to the following events: • Presenting to the CCC clinic with confirmed HIV+ results • Being allocated the CCC number and having been seen by a member of the clinical team to provide one of the following services: o WHO staging, o initiating on CTX or o o undergoing a CD4 lymphocyte count testing
% Enrolled Well PLHIV	DC 02-02	(DC 02-01/ HV03-011)x100
Enrolled Advanced Disease	DC 02-03	This is a count of clients who are enrolled in care with advanced HIV disease
% Enrolled Advanced Disease	DC 02-04	(DC 02-03/ HV03-011)x100
2.3 ART Initiation		
Start ART Well PLHIV	DC 02-05	This is a count of data on individuals who present well started on ART
Enrolled Total	HV03-011	(See above)
% Start ART Well PLHIV	DC 02-06	(DC 02-05/ HV03-011)x100
Start ART Advanced Disease	DC 02-07	This is a count of data on individuals with advanced HIV disease started on ART
% Start ART Advanced Disease	DC 02-08	(DC 02-07/ HV03-011)x100
2.4 Timely ART Initiation		
Start ART ≤ 2 weeks Well PLHIV	DC 02-09	This is a count of data on individuals who present well started on ART within 2 weeks of enrollment
Start ART Total	HV03-026	This is a count of data on individuals started on ART for treatment

% Start ART ≤ 2 weeks Well PLHIV	DC 02-10	(DC 02-09/ HV03-026)x100
Start ART ≤ 2 weeks Advanced Disease	DC 02-11	This is a count of data on individuals with advance HIV disease started on ART within 2 weeks of enrollment
% Start ART ≤ 2 weeks Advanced Disease	DC 02-12	(DC 02-11/ HV03-026)x100
2.5 12 Month Retention on ART		
On ART 12 months Well PLHIV	DC 02-13	This is the count of all clients enrolled who present well and who are still on ART 12 months after starting ART regardless of regimen
Net Cohort 12 months	HV 03-041	This refers to the number of clients started ART in the same month plus transfer ins and minus transfer outs
% Retention Well PLHIV	DC 02-14	(DC 02-13/ HV 03-041)x100
On ART 12 months Advanced Disease	DC 02-15	This is the count of all clients enrolled with advanced disease who are still on ART 12 months after starting ART regardless of regimen
% Retention Advanced Disease	DC 02-16	(DC 02-15/ HV 03-041)x100
2.6 ART Refill Program Uptake		
Stable PLHIV given ART ≥ 3mo Facility	DC 02-17	This is the count of all stable PLHIV enrolled in the Fast Track ART Refill Program
Stable PLHIV Total	DC 02-18	This is the count of the total number of PLHIV categorized as stable in the reporting period
Uptake ART Refill Program Facility	DC 02-19	(DC 02-17/ DC 02-18)x100
Stable PLHIV ART ≥ 3mo Community	DC 02-20	This is the count of all stable PLHIV enrolled in the Community ART Refill Program
Uptake ART Refill Program Community	DC 02-21	(DC 02-20/ DC 02-18)x100
Stable PLHIV and on time drug pick up	DC 02-22	This is the count of all stable PLHIV enrolled in the ART Refill Program who receive their ART on time through the refill program
Stable PLHIV given ART ≥ 3mo	DC 02-17	This is the count of all stable PLHIV enrolled in the ART Refill Program
% Stable PLHIV and on time drug pick up	DC 02-23	[DC 02-22/ (DC 02-17+ DC 02-20)]x100
2.7 ART Refill Program Coverage		
Stable PLHIV ART ≥ 3mo Facility	DC 02-17	This is the count of all stable PLHIV enrolled in the Fast Track ART Refill Program
On ART Total	HV 03-038	This is a summary count of patients who: 1. Started therapy this month or 2. Started therapy before this month but made a visit to collect drugs this month or 3. Started therapy before this month but did not make a visit to the facility during this month because had picked enough drugs (during

		earlier visits before this month) to cover the reporting month
Coverage ART Refill Program Facility	DC 02-24	(DC 02-17/ HV 03-038)x100
Stable PLHIV ART ≥ 3mo Community	DC 02-20	This is the count of all stable PLHIV enrolled in the Community ART Refill Program
Coverage ART Refill Program Community	DC 02-26	(DC 02-20/ HV 03-038)x100
Coverage ART Refill Program Total	DC 02-27	[(DC 02-17 + DC 02-20)/ HV 03-038]x100
2.8 12 Month Retention for Stable & Unstable PLHIV		
On ART 12 months Stable STD	DC 02-28	This is the count of all clients categorized as stable 12 months prior to the reporting period, received the standard care and who are still on ART 12 months thereafter regardless of regimen
Net Cohort 12 months Stable	DC 02-29	This refers to the number of stable clients started on ART in the same month plus transfer ins and Minus transfer outs
% Retention Stable STD	DC 02-30	(DC 02-28/ DC 02-29)x100
On ART 12 months Stable FT	DC 02-31	This is the count of all clients categorized as stable 12 months prior to the reporting period, were enrolled into fast track program and who are still on ART 12 months thereafter regardless of regimen
% Retention Stable FT	DC 02-32	(DC 02-31/ DC 02-29)x100
On ART 12 months Stable CADH	DC 02-33	This is the count of all clients categorized as stable 12 months prior to the reporting period, were enrolled into CADH program and who are still on ART 12 months thereafter regardless of regimen
% Retention Stable CADH	DC 02-34	(DC 02-33/ DC 02-29)x100
On ART 12 months Stable CADP	DC 02-35	This is the count of all clients categorized as stable 12 months prior to the reporting period, were enrolled into CADP program and who are still on ART 12 months thereafter regardless of regimen
% Retention Stable CADP	DC 02-36	(DC 02-35/ DC 02-29)x100
On ART 12 months Unstable	DC 02-37	This is the count of all clients categorized as unstable 12 months prior to the reporting period and who are still on ART 12 months thereafter regardless of regimen
Net Cohort 12 months Unstable	DC 02-38	This refers to the number of unstable clients started on ART in the same month plus transfer ins and Minus transfer outs
% Retention Unstable	DC 02-39	(DC 02-37/ DC 02-38)x100
2.9 Viral suppressed 12 months after categorization into stable or unstable		
Viral Suppression Stable STD	DC 02-40	This is the count of all clients categorized as stable 12 months prior to the reporting period, received the standard care and have a viral load less

		than 1000 copies/ml
Net Cohort 12 months Stable	DC 02-41	This is the count of all stable clients in the cohort with a viral load result available
% Suppressed Stable STD	DC 02-42	(DC 02-40/ DC 02-41)x100
Viral Suppression Stable FT	DC 02-43	This is the count of all clients categorized as stable 12 months prior to the reporting period, were enrolled into fast track program and have a viral load less than 1000 copies/ml
% Suppressed Stable FT	DC 02-44	(DC 02-43/ DC 02-41)x100
Viral Suppression Stable CADH	DC 02-45	This is the count of all clients categorized as stable 12 months prior to the reporting period, were enrolled into CADH program and have a viral load less than 1000 copies/ml
% Suppressed Stable CADH	DC 02-46	(DC 02-45/ DC 02-41)x100
Viral Suppression Stable CADP	DC 02-47	This is the count of all clients categorized as stable 12 months prior to the reporting period, were enrolled into CADP program and have a viral load less than 1000 copies/ml
% Suppressed Stable CADP	DC 02-48	(DC 02-47/ DC 02-41)x100
Viral Suppression Unstable	DC 02-49	This is the count of all clients categorized as unstable 12 months prior to the reporting period and have a viral load less than 1000 copies/ml
Net Cohort 12 months Unstable	DC 02-50	This refers to the number of unstable clients in the cohort with a viral load result available
% Suppressed Unstable	DC 02-51	(DC 02-49/ DC 02-50)x100

National AIDS & STI Control Program – NASCOP

Differentiated Care Facility Summary Form (Interim Tool) Jan 2017

County: _____ Sub County: _____ Facility: _____ Month: _____ Year: _____

1. HIV Testing Services											
1.1 HIV Positivity – Facility			**1.2 HIV Positivity - Community**			**1.3 Linkage to Care from Facility Testing**			**1.4 Linkage to Care from Community Testing**		
HIV Testing Facility	DC 01-01		HIV Testing Community	DC 01-04		Linked Facility	DC 01-07		Linked Community	DC 01-11	
HIV Positive Results Facility	DC 01-02		HIV Positive Results Community	DC 01-05		HIV Positive 3 mo Ago Facility	DC 01-08		HIV Positive 3 mo Ago Community	DC 01-12	
HIV Positivity Facility (Yield)	DC 01-03		HIV Positivity Community (Yield)	DC 01-06		% Linked Facility	DC 01-09		% Linked Community	DC 01-13	
2. HIV Care and Treatment											
2.1 Newly Enrolled – Well PLHIV			**2.3 ART Initiation**			**2.4 Timely ART Initiation**			**2.5 12 Month Retention on ART**		
Enrolled Well PLHIV	DC 02-01		Start ART Well PLHIV	DC 02-05		Start ART ≤ 2 weeks Well PLHIV	DC 02-09		On ART 12 months Well PLHIV	DC 02-13	
Enrolled Total	HV03-011		Enrolled Total	HV03-011		Start ART ≤ 2 weeks Total	HV03-026		Net Cohort 12 months	HV 03-041	
% Enrolled Well PLHIV	DC 02-02		% Start ART Well PLHIV	DC 02-06		% Start ART ≤ 2 weeks Well PLHIV	DC 02-10		% Retention Well PLHIV	DC 02-14	
Enrolled Advanced Disease	DC 02-03		Start ART Advanced Disease	DC 02-07		Start ART ≤ 2 weeks Advanced Disease	DC 02-11		On ART 12 months Advanced Disease	DC 02-15	
% Enrolled Advanced Disease	DC 02-04		% Start ART Advanced Disease	DC 02-08		% Start ART ≤ 2 weeks Advanced Disease	DC 02-12		% Retention Advanced Disease	DC 02-16	
2.6 ART Refill Program Uptake			**2.7 ART Refill Program Coverage**			**2.8 12 Month Retention for Stable & Unstable PLHIV**					
Stable PLHIV ART ≥ 3mo Facility	DC 02-17		Stable PLHIV ART ≥ 3mo Facility	DC 02-17		On ART 12 months Stable STD	DC 02-28		% Retention Stable CADH	DC 02-34	
Stable PLHIV Total	DC 02-18		On ART Total	HV 03-038		Net Cohort 12 months Stable	DC 02-29		On ART 12 months Stable CADP	DC 02-35	
Uptake ART Refill Program Facility	DC 02-19		Coverage ART Refill Program Facility	DC 02-24		% Retention Stable STD	DC 02-30		% Retention Stable CADP	DC 02-36	
Stable PLHIV ART ≥ 3mo Community	DC 02-20		Stable PLHIV ART ≥ 3mo Community	DC 02-25		On ART 12 months Stable FT	DC 02-31		On ART 12 months Unstable	DC 02-37	
Uptake ART Refill Program Community	DC 02-21		Coverage ART Refill Program Community	DC 02-26		% Retention Stable FT	DC 02-32		Net Cohort 12 months Unstable	DC 02-38	
Stable PLHIV & on time drug pick up	DC 02-22										
% Stable PLHIV & on time drug pick up	DC 02-23		Coverage ART Refill Program Total	DC 02-27		On ART 12 months Stable CADH	DC 02-33		% Retention Unstable	DC 02-39	
2.9 Viral suppressed 12 months after categorization into stable or unstable											
Viral Suppression Stable STD	DC 02-40		Viral Suppression Stable FT	DC 02-43		% Suppressed Stable CADH	DC 02-46		Viral Suppression Unstable	DC 02-49	
Net Cohort 12 months Stable	DC 02-41		% Suppressed Stable FT	DC 02-44		Viral Suppression Stable CADP	DC 02-47		Net Cohort 12 months Unstable	DC 02-50	
% Suppressed Stable STD	DC 02-42		Viral Suppression Stable CADH	DC 02-45		% Suppressed Stable CADP	DC 02-48		% Suppressed Unstable	DC 02-51	

Annex 13: Customer Satisfaction Survey

Client preferences and needs survey

Date: DD____ MM___ YYYY_____

A. Respondents' profile

Gender ☐Female ☐Male ☐Other	If female, are you currently pregnant? ☐Yes ☐No
How old are you? ☐Below 20 ☐36 to 50 ☐20 to 35 ☐Over 50	What is your current occupation? _____
What category of differentiated care are you currently in? ☐Well ☐Unstable ☐Advanced ☐Stable	If in the stable category, which ART Refill model you are currently in? ☐Standard care ☐Community ARV Distribution – HCW Led ☐Fast Track ☐Community ARV Distribution – Peer Led ☐Facility ARV Distribution Group

B. Identification of barriers to treatment from clients' perspective

How often do you come to the health facility?
☐Once a week ☐Every month ☐Every three months
☐Twice a month ☐Every two months ☐More than every 3 months

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

How far is the health facility from your home? _____	How long does it take you to reach the health facility? _____

Have you ever missed a clinic appointment? ☐Yes ☐No
If yes, indicate the reason for the most recent missed appointment?
_____

While waiting at the health facility, do you feel bothered by other clients? ☐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

While at the health facility, do you think that you spend enough time with the clinician? ☐Yes ☐No

Annex 14: List of Contributors

The following team contributed to the development and review of the Differentiated Care Operational Guide, Healthcare Workers Training Package, Lay Health Workers Training Package, CHMT Orientation Package, and IEC Material.

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