Taking Differentiated Service Delivery to Scale in Kenya: A National Roadmap for Model Implementation

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REPUBLIC OF KENYA

MINISTRY OF HEALTH

BACKGROUND

With the release of the 2016 Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya, the Kenya MOH laid out two new strategies that revolutionized the national HIV/AIDS prevention program. The guidelines not only recommended the adoption of Test and Start, but included guidance on differentiated service delivery (DSD) for antiretroviral therapy (ART). In 2017, the Kenya National AIDS and STI Control Program (NASCOP) launched the Differentiated Care Operational Guide, which functions as a step-by-step manual for DSD implementation and includes tools and job aids for use by health care workers (HCW) during service provision. These guidelines lay out requirements for specific models and procedures that must be performed by HCW before determining which DSD model (DSDM) a patient is eligible for (Figure 1). Along with the guidelines and operational guide, Kenya supported the roll-out of DSDM with a training package that was implemented at county, health facility, and community levels.

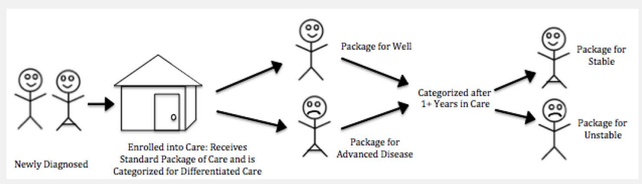

Figure 1. Differentiated Care Based on Patient Clinical Status

As Kenya continues to scale up the implementation of DSDM for ART, the MOH has identified certain vulnerabilities in the system that will require strengthening in order to achieve high quality DSD programs. Ongoing technical support during scale-up will need to be directed at counties, as well as prioritized facilities that require tailored assistance. To properly monitor the effects of DSD scale-up, monitoring and evaluation (M&E) systems will need the capability to capture data on retention and clinical outcomes for people living with HIV (PLHIV) based on DSDM, which will require coordination from the national data warehouse. As part of M&E efforts to track program progress, Kenya is developing a dashboard to measure scale-up of DSD.

DSD MODELS OFFERED

Currently, there are six distinct DSDM offered in Kenya: three that are facility-based and three that are community-based. The facility-based models include the **Appointment Spacing** and **Fast-Track Refills** models for individuals and **Facility-Based ART Groups** that is a group model that includes peer psychosocial support. The community-based models include the **Community-Based ART Groups**, also a group model that allows peers to gather together for ART distribution and adherence and psychosocial support, and **Community ART Distribution/Pick-Up**, which is an individual model. Kenya also offers **Outreach-Based Clinics**, which provide a range of services in locations that are preferable for populations that are hard to reach or face particular challenges accessing health services. Some outreach clinics provide ART services that are limited to refill clients, though some clinics also offer ART initiation in outreach settings.

In addition to the standard models of DSD for ART, Kenya also offers tailored DSDM for priority subpopulations, such as adolescents and young adults, children, discordant couples, and patients with high viral loads or other characteristics of advanced disease progression.

DSD UPTAKE

Kenya is in the process of scaling up DSDM implementation. High-volume facilities were prioritized for roll-out and planned expansion of DSDM to all 3,507 ART facilities in the country is ongoing.

In January of 2018, use of new M&E tools to capture DSD-specific data began and NASCOP is anticipating quality DSD program data to be reported starting in April 2018. A preliminary assessment of county-level uptake of DSD was performed during scale-up activities. This assessment found that, of the 47 counties in Kenya, 42 (89%) had implemented at least one model of DSD for ART (Figure 2). Community ART Groups (CAG) were found to be implemented in 7 (16%) of 45 responding counties (2 counties did not respond) and Fast Track or Different Patient Flows were being implemented in 35 (78%) of the 45 responding counties (2 counties did not respond).

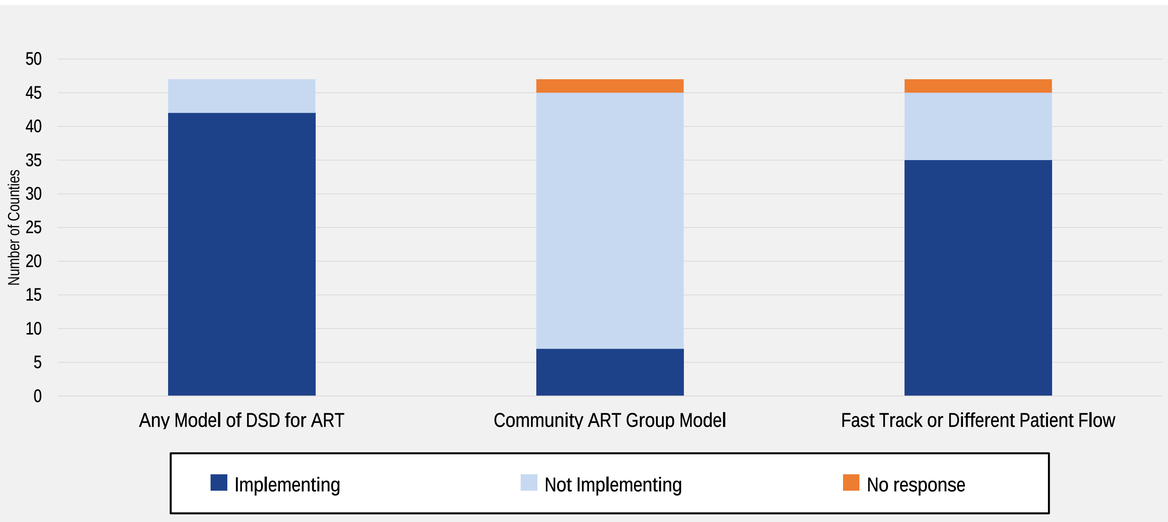

Figure 2. County Uptake of Differentiated Service Delivery (DSD) and Selected DSD Models

DSD DASHBOARD

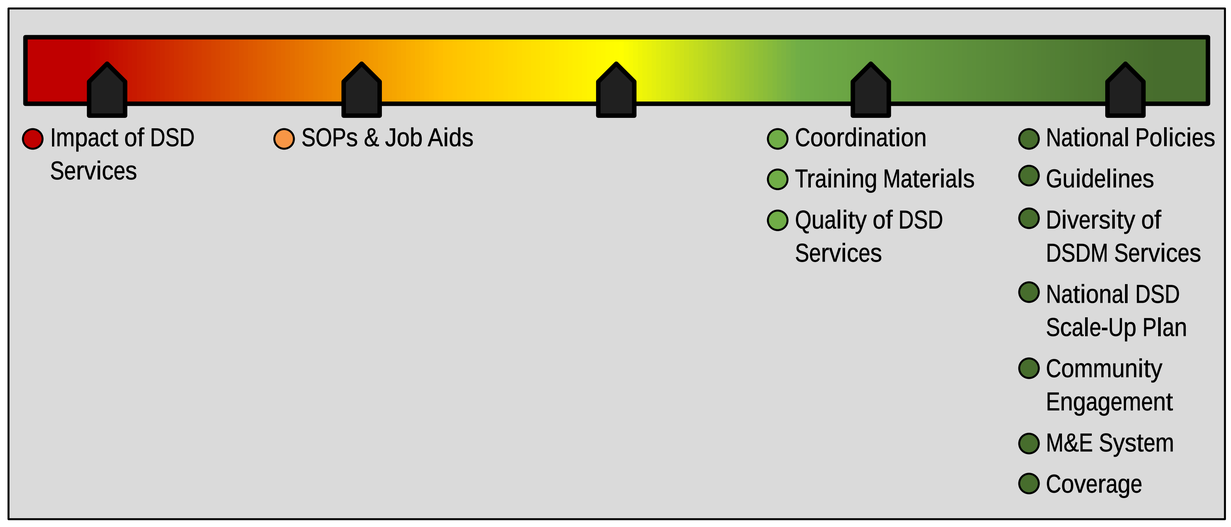

Figure 3. Kenya DSD Dashboard, January 2018

A self-assessment tool known as the CQUIN DSD Dashboard was used to quantify the progress being made as Kenya rolls out its national DSD guidelines. Across 12 different domains, a five-step color scale was used to rank progress and performance from red, indicating no activity, to dark green, indicating significant and robust implementation.

Kenya found that seven domains were in the dark green category (Figure 3) where standards for the highest ranking were met: **National Policies** actively promote the use of DSDM for diverse patient groups; National HIV Treatment **Guidelines** provide detailed and specific guidance on implementation of DSD; **Diversity of DSDM Services** was determined to be high due to the provision of models for diverse patient groups; the **National DSD Scale-Up Plan** is being actively implemented; **Community Engagement** is high due to PLHIV and/or civil society being systematically engaged in DSD policy development, design, implementation, and evaluation; all elements of the **M&E System** for DSD are in place and integrated into one national system for HIV/ART services; and **Coverage** of DSDM reaches >75% of the health facilities that provide ART in Kenya.

Three additional domains were ranked in the light green, indicating advanced progress: **Coordination** of DSD implementation scale-up is spearheaded by a national DSD Focal Person; national DSD **Training Materials** for both professional health workers and lay workers are available and in use; and protocols for the measurement of **Quality of DSD Services** are in place and quality improvement (QI) activities are underway.

CASE STUDY/BEST PRACTICE

Siaya County has the second-highest HIV prevalence (27%) in Kenya. During the 2017 implementation of DSD in Siaya, the county healthcare management team received DSD sensitization training and implementation of DSDM was carried out at 25 health facilities. HCW were trained on patient assessment and categorization (stable or unstable) and how to record DSD data using the M&E tools. Activities aimed at creating demand for DSDM included health talks given at facilities, information provided during counseling sessions and clinical appointments, and display of advertisements and brochures. Following the training and demand-creation phases of implementation, recruitment of patients into DSDM began.

During recruitment, a total of 22,609 (75%) of the 30,186 ART patients in the county were categorized. Of these, 2,695 (12%) enrolled in DSDM: 2,411 (89%) enrolled in DSDM for well patients and 284 (11%) in models for patients with advanced disease (Figure 4). The remaining 19,914 (88%) were stable on standard treatment.

Scale-up of DSDM in Siaya County demonstrated the benefits of a coordinated, phased approach. Challenges to scale-up included delays in the viral load test results necessary for patient assessment and categorization, high staff turnover at health facilities, and limited community structures to leverage for PLHIV support.

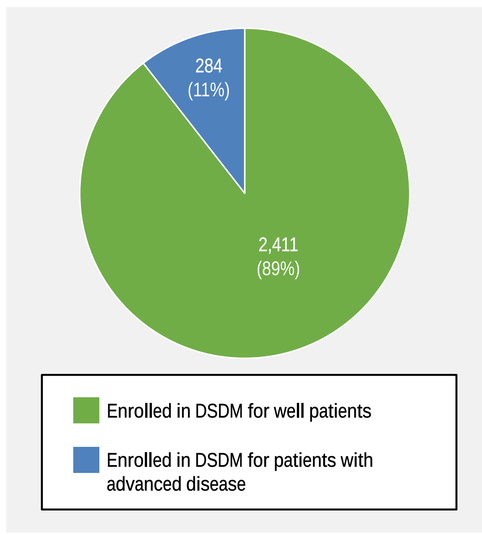

Figure 4. Patients Enrolled in DSDM in Siaya County, by Categorization

NEXT STEPS/WAY FORWARD

Moving forward, Kenya will scale up DSDM to all ART facilities, offering mentorship support to ensure accurate patient categorization, reorganization of patient flows, and training of lay providers to support community models. In 7 counties, ongoing QI activities plan to measure program efficiency and an upcoming study will measure quality and cost. A national DSDM best practices forum is planned for March 2018.

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