Scaling up DSD: Kenya Experience

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Empowering Health for 15 years
ICAP
Columbia University
Mailman School of Public Health

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

Outline

- Kenya statistics
- How our ART guidelines have addressed DC implementation
- Coverage of DC implementation and availability of DC monitoring data
- Uptake of some DC models in the country
- Experience sharing - County best practices forum
- Identified best practices
- Challenges cited
- Reflections
- Key highlights
- Acknowledgements

Kenya HIV Estimates, 2018

HIV Prevalence =
4.9%
Female = 6.2% ; Male = 3.5%

PLHIV (all ages) =
1.5M

Adults living with HIV (15+)
= 1,388,200

Children living with HIV (0-14)
= 105,200

Number of new HIV Infections in 2017

All ages = 52,800

Adults (15+ = 44,800)

Children (0-14) = 8,000

Adolescent and Young People

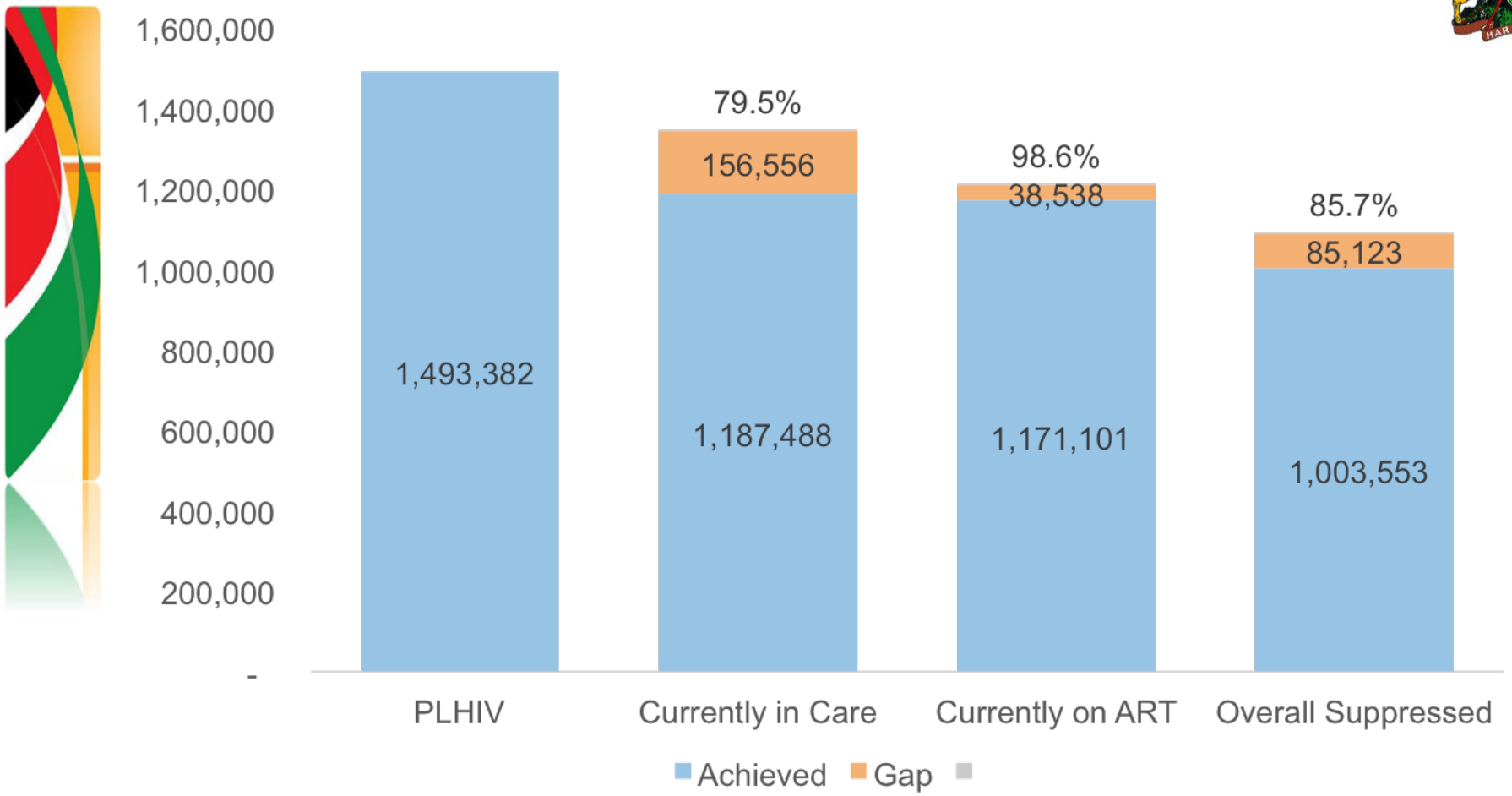
Adolescents 10-19 years

PLHIV = 105,200
New infections = 8,200

Young Adults 15-24 years

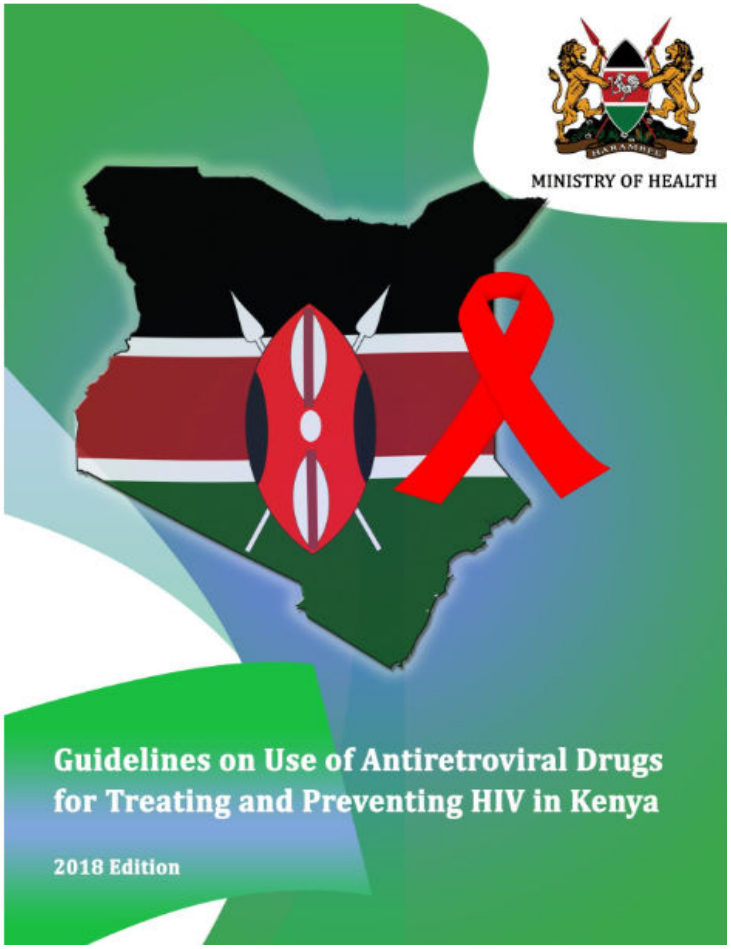
PLHIV = 184,700
New infections = 17,700

Progress towards 90 90 90



DHIS2 March 2018

2018 ART Guidelines



- *"Differentiated care minimizes inconvenience and unnecessarily frequent follow-up, thus reducing costs and time related to clinic visits. It also allows resources to be focused on those patients who require additional attention."*
  National ARV Guidelines 2018

DC - integral part of routine Service delivery

The standard package of care should always be applied using a patient- and family-centered approach. Patient-centered care includes: considering the individual patient's health needs; eliciting and addressing the patient's concerns and expectations; involving the patient's (and their family and friends as appropriate) in decision-making, and; respecting the patient's values and preferences. Family-centered care identifies, engages and provides care to all HIV-

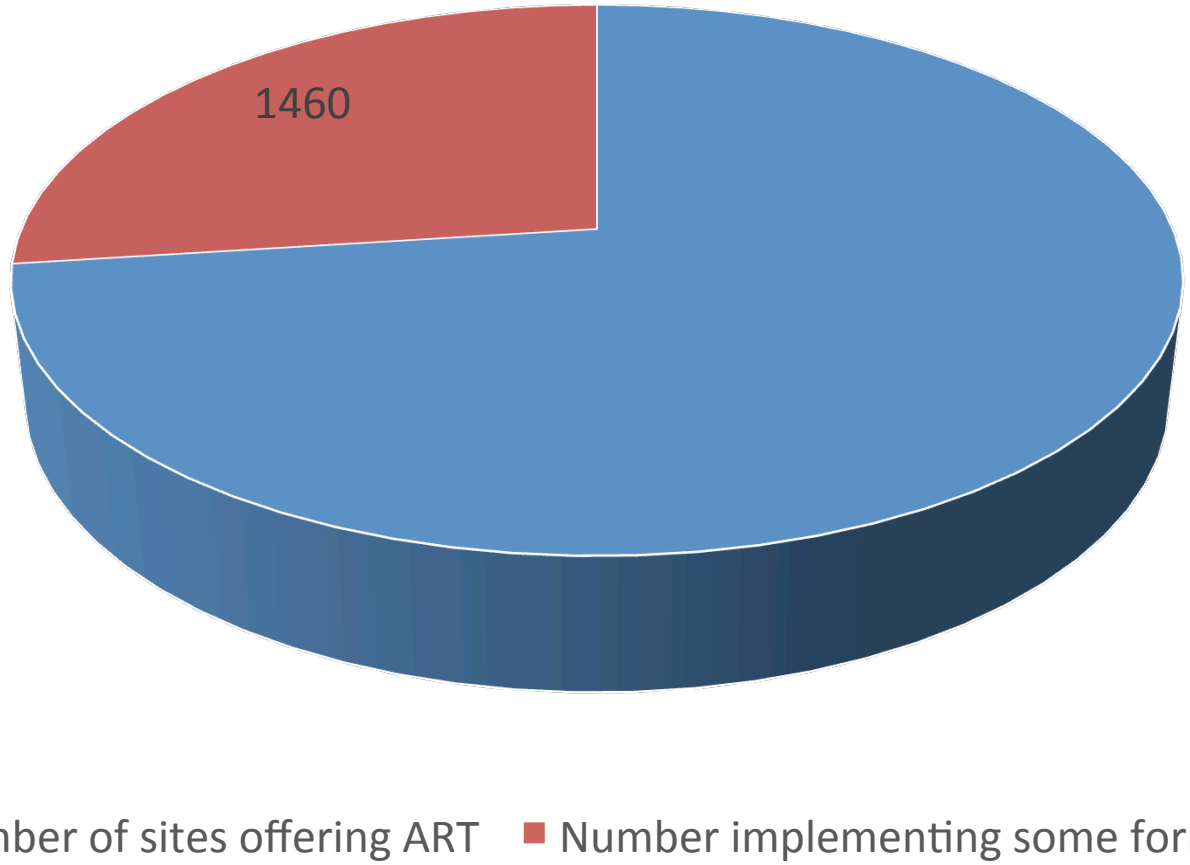
3.5.2. Differentiated Care for Children, Adolescents and Pregnant/breastfeeding Women

Children, adolescents and pregnant/breastfeeding women should not be excluded from differentiated care (DC). The "stable/unstable" criteria in Table 3.5 are used to identify patients who qualify for longer follow-up periods vs. those that may benefit from closer follow-up.

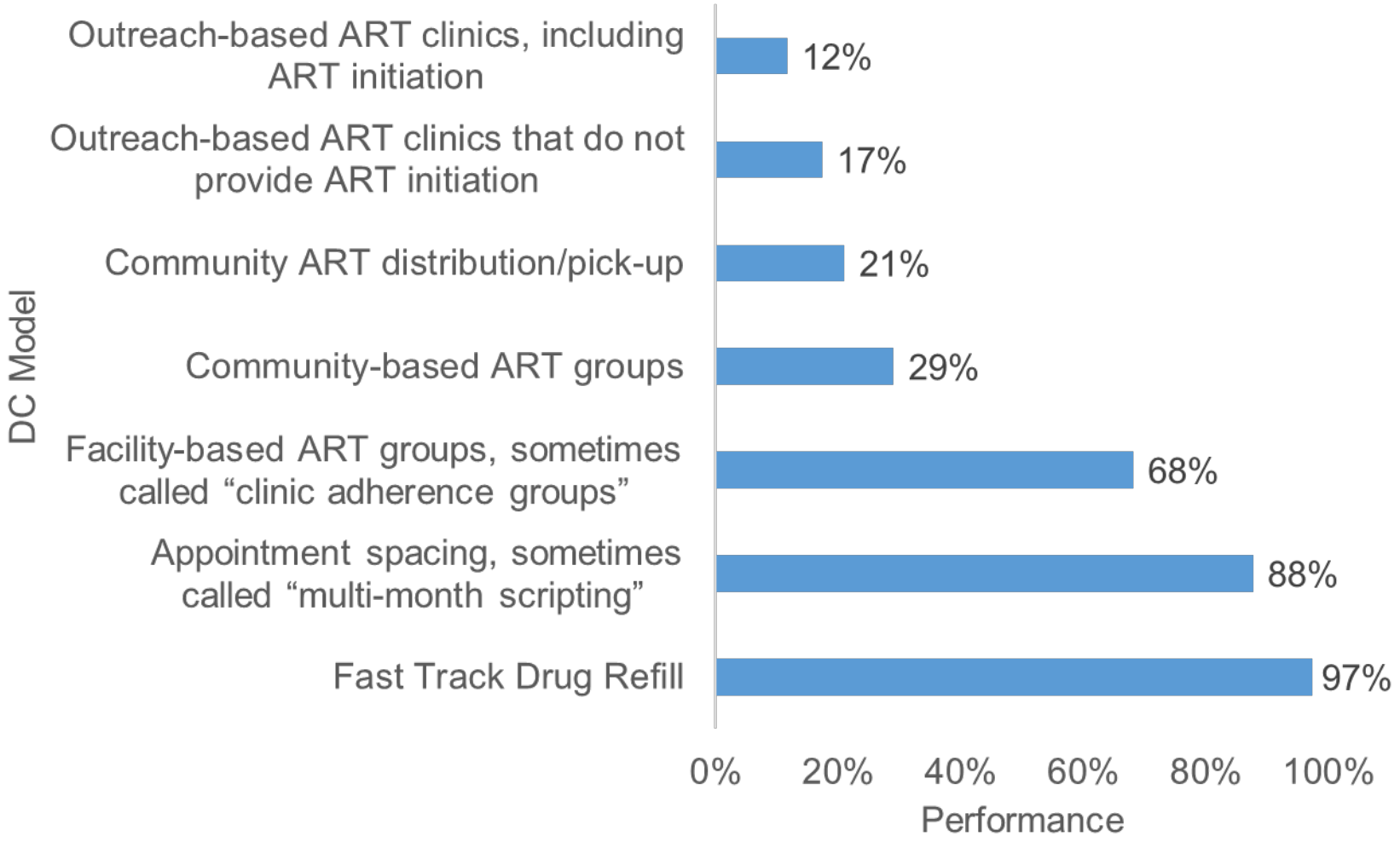
ART Refill Distribution Points for Stable Patients

The health facility is responsible for ART prescription, dispensing, and distribution for all patients enrolled into care. ART distribution for stable patients can take place at the health facility or through a community distribution system, depending on patient preference and health facility systems and resources. **No patient should be pressured into receiving ART at a community-based distribution point or through a fast-track process.**

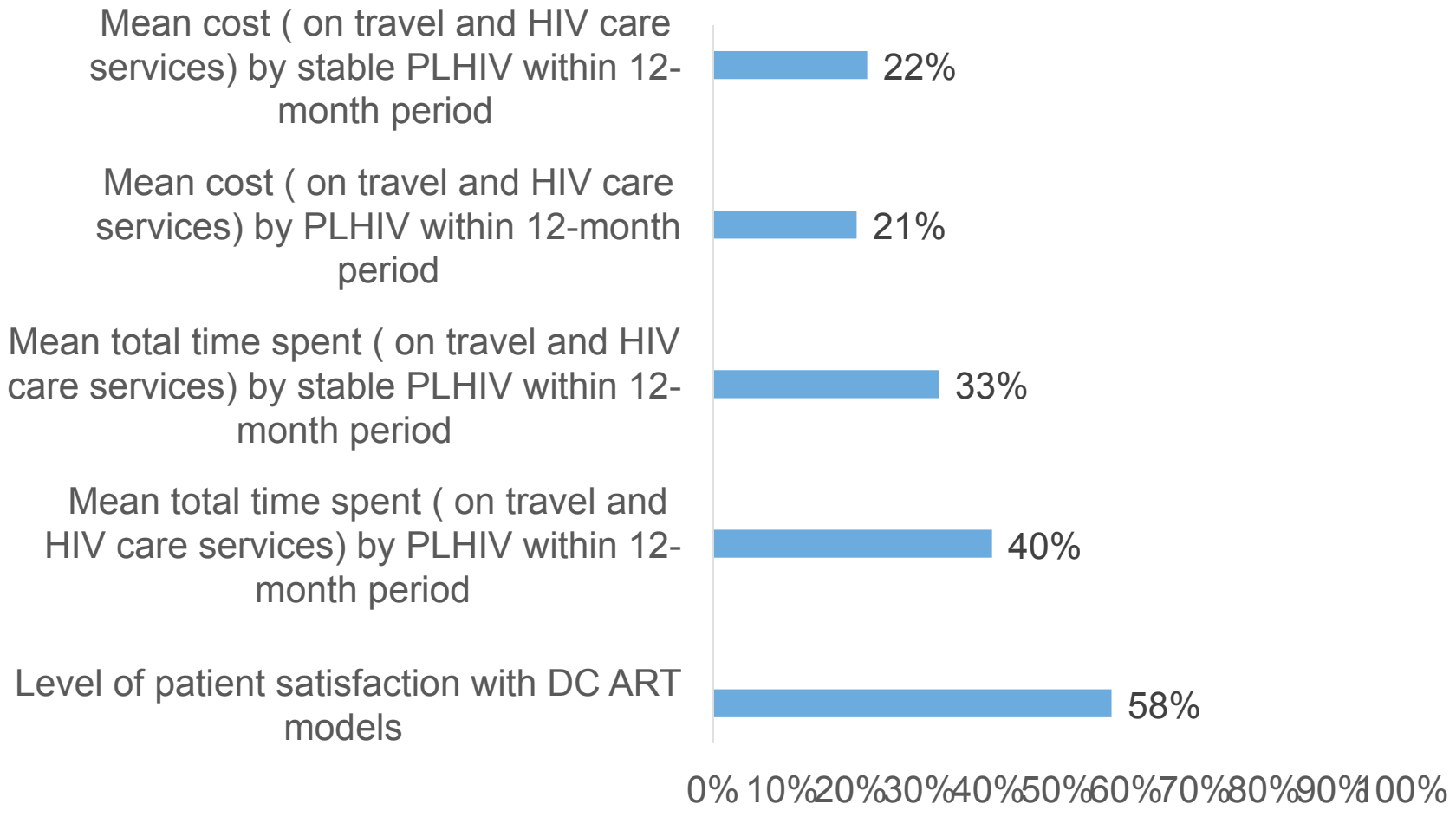
Facility coverage of DC model implementation



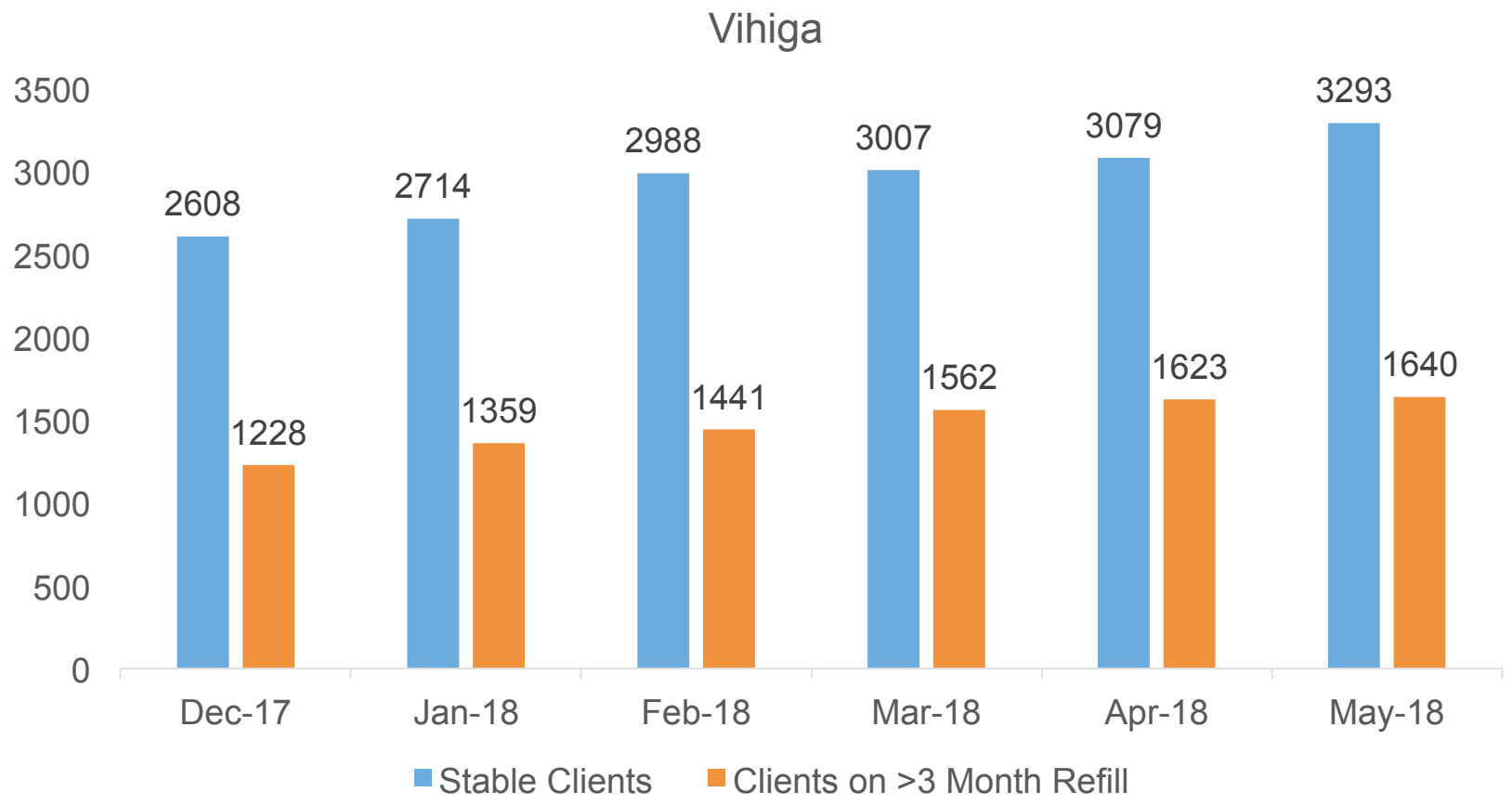
Level of Implementation of DC models in 400 national sites



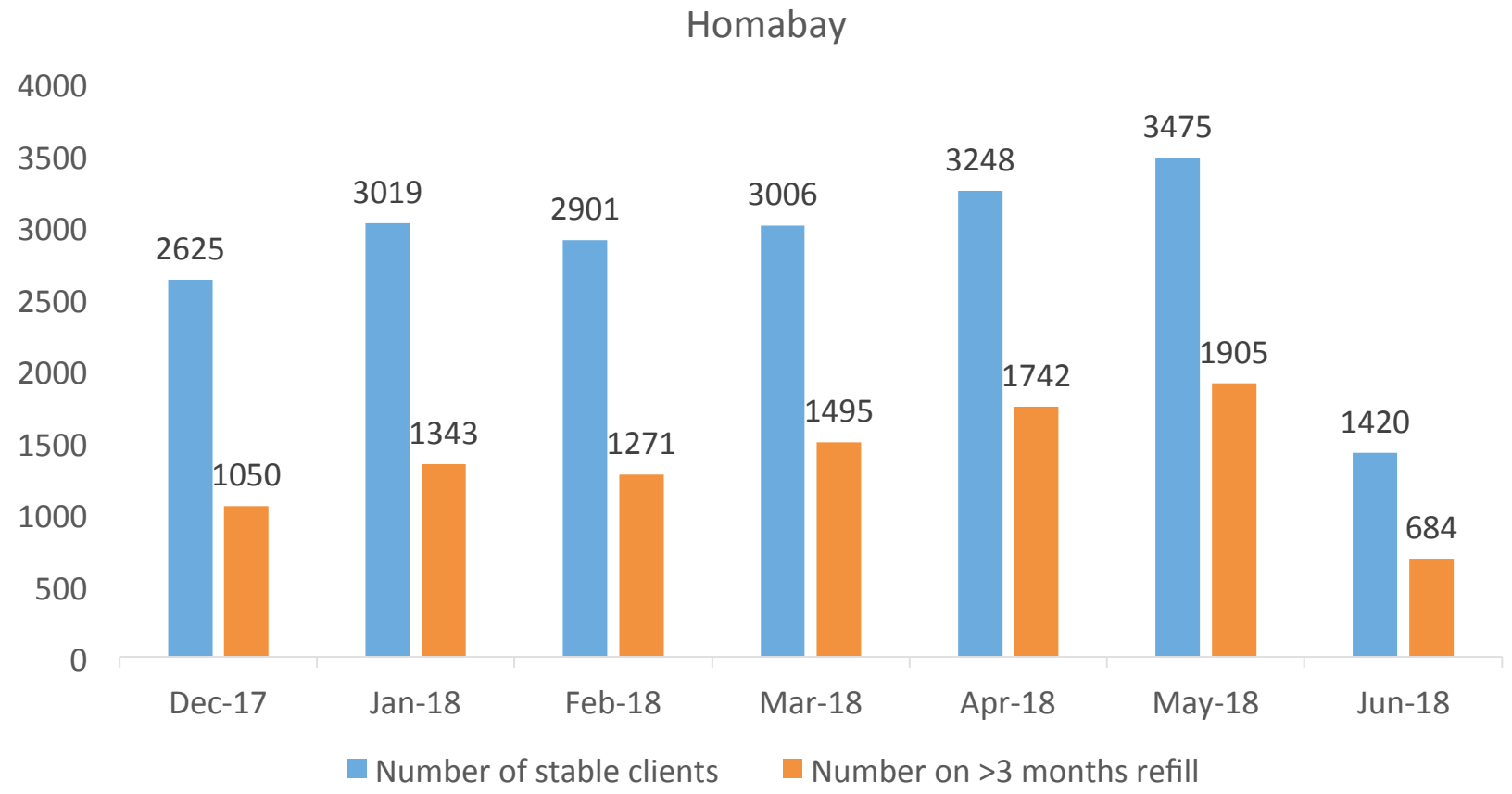
Level of availability of ART patient data in 400 national Sites



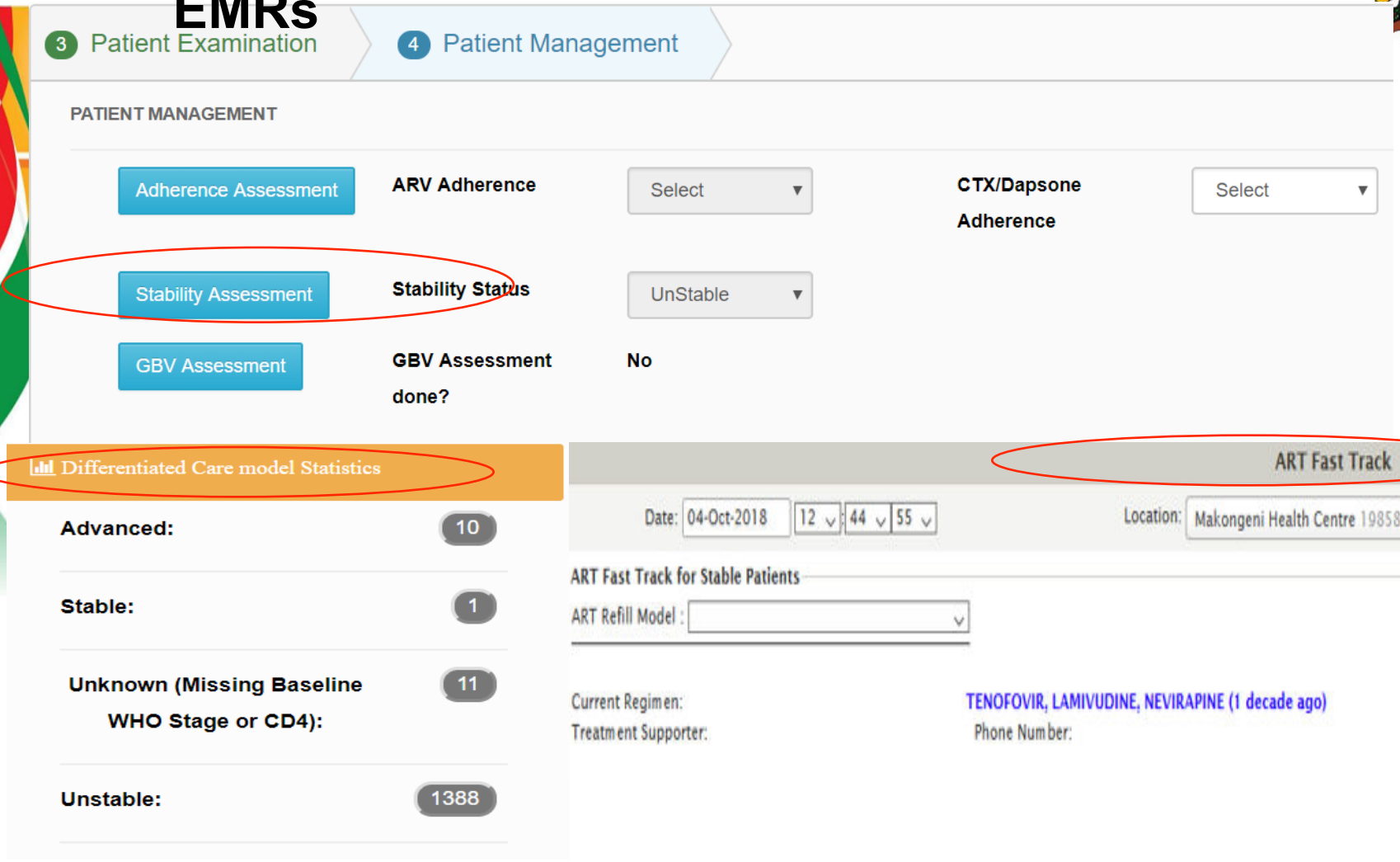
Proportion of stable clients on more than 3 months refill,Vihiga



Proportion of stable clients on a >3 months refill, Homabay



Differentiated care data parameters in the EMRs



Differentiated Care Experience Sharing Forum

- Nationwide DC experience sharing forum – August 2018
- Counties identified 10 high volume facilities implementing DC for at least one year
- Template developed to collect key variables and this presented in form of poster presentations
- Top 3 Counties with most innovations and most facilities implementing DC were awarded

Differentiated Care Implementation Performance
Nairobi County

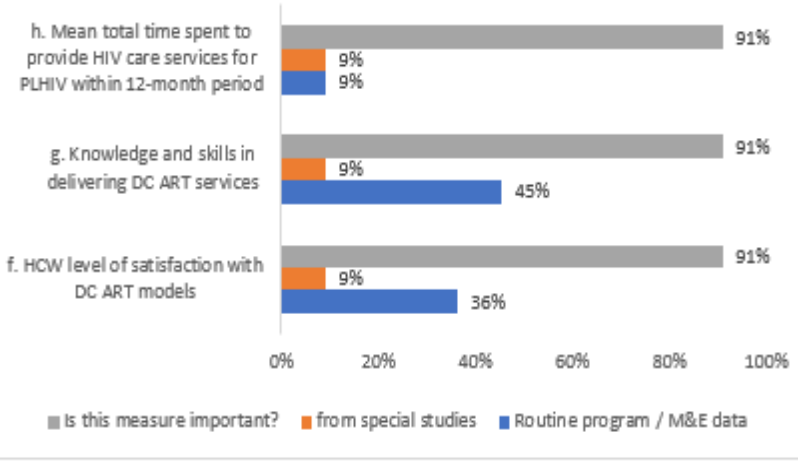
Authors: Dr. Carol Ngunu, Levitan Ombima, Esther Mbithi, Vanessa Chelimo, Diana Odock, Eric Omasaja

MINISTRY OF HEALTH

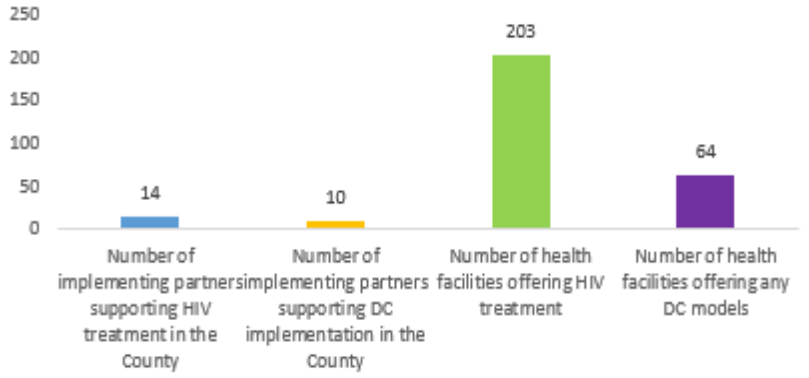
1. NASCOP 2. Ministry of Health – Kenya 3. Nairobi City County Health Services

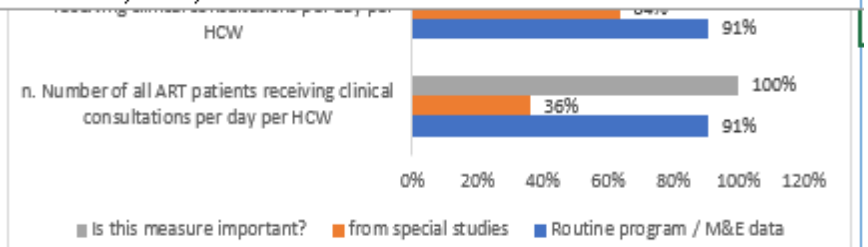
NAIROBI CITY COUNTY

AVAILABILITY OF DATA ON HEALTH CARE WORKER (HCW) EXPERIENCE



IMPLEMENTING PARTNERS & SERVICES OFFERED





DISCUSSION ON BEST PRACTICES, CHALLENGES AND WAY FORWARD

LOCAL BEST PRACTICES AND SUCCESS STORIES

• Reduced waiting times and long queues for clients who are stable with the introduction of fast track for DC • Increase in the number of viral load uptake in most of the selected DC facilities • Health Care Workers in selected sites are now conversant with DCM QI tools which they can now use to solve issues affecting their health facilities in Nairobi county • For health care workers there is reduced cases of burnout and increased focus to support the unstable

CHALLENGES AND KEY BARRIERS

• Insufficient DC tools at the facilities i.e differentiated care register • Skepticism from some of the HCWs about DCM especially the private sites • Inadequate funds to support sub county coaches when visiting the selected DCM sites for mentorship and coaching • Skills gaps on DC in some facilities

CURRENT, PLANNED, OR RECENTLY COMPLETED RESEARCH EXAMINING DC

. Nairobi County has undertaken some operational research in Jericho and Shofco and written 2 abstracts that will be presented in the NASCOP HIV conference in September. They are: • Continuous quality improvement in improving patient categorization for differentiated care model implementation at Jericho Health Centre • Continuous quality improvement approach in improving EMTCT outcomes– a case study at shofco Mathare, Nairobi County

CDC · The Global Fund · PEPFAR · NASCOP

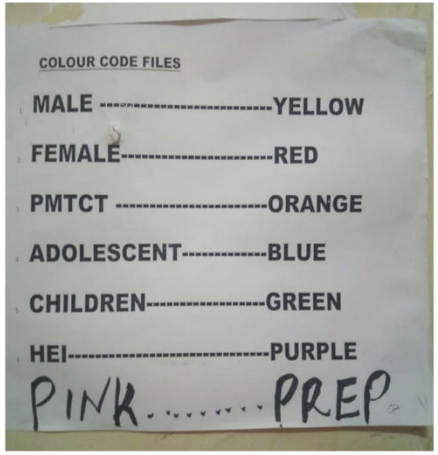
Identified Best practices (1/2)

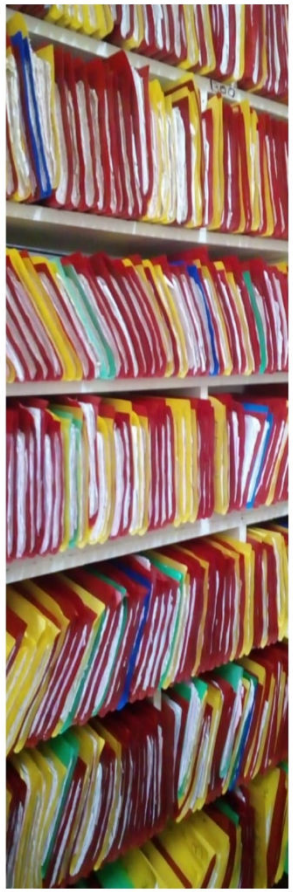
- Training of peer educators to facilitate community based models
- CARGs implemented in the County under PSSG in the community
- Use of Quality Improvement Teams/Work Improvement Teams for DC
- Use of low level facilities as drug pick up sites for high level sites
- Tiered approach in roll out of DC models from high volume facilities to low volume facilities.
- Establishment of family clubs who are used to pick up drugs for members on rotational basis.

Best Practices (2/2)

- Color coding client files for ease in locating the various categories of clients
- Viremia clinics- clinics dedicated clinics for patients with high viral loads
- Special clinics for client cohorts e.g. Children, TB/HIV; adolescents weekend clinics, early morning clinics for working class and college students
- Dedicated clinics for PMTCT mothers
- Suspected treatment failure clinics two weekly group clinics
- Patient self care classes for newly diagnosed clients up to 6 months

Colour coding- Kikuyu Hospital





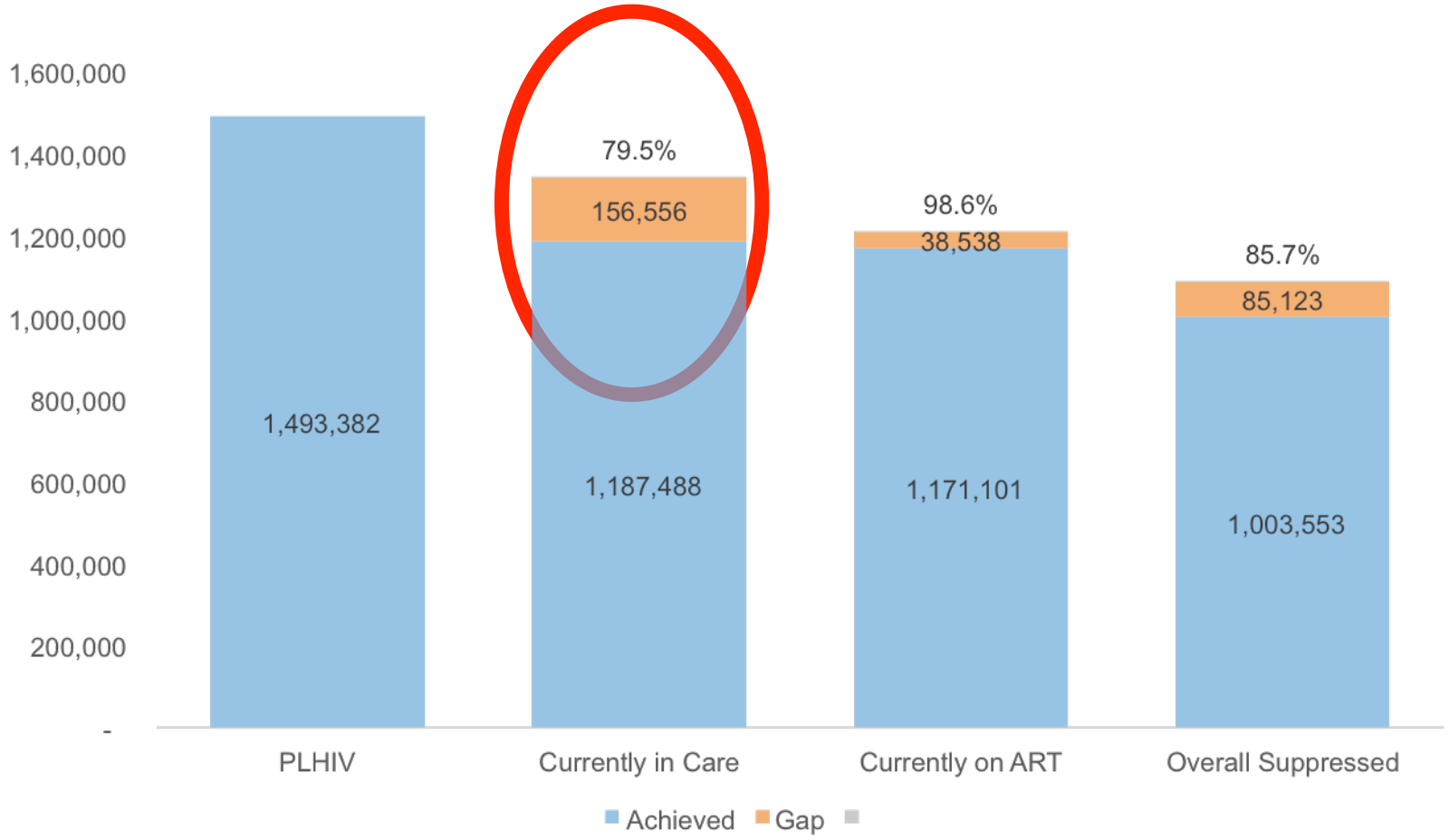
Challenges cited

- Staff turnover and competing tasks in some facilities leading to inefficiencies in HR issues
- Breach of confidentiality among some community ART refill groups resulting in members opting out to rejoin facility track models
- Little priority investment in community ART DC models
- Lost to follow up (LTFU) of clients already on DC
- Targets affects IPs decisions to implement DC
- Lack of patient awareness on DC leading to low uptake

Reflections

- What is scale up? When do we say we have optimally scaled up?
- Can the adolescent and pediatrics have family centered categorization?
- Which is the most effective model of differentiated care?
- Patient satisfaction with DC?
- HR –
  - What is the effect of DC on staff job satisfaction?
  - Has DC addressed the HR needs as purported?
- Perception of unstable clients on DC; Community ART & drug security
- Investments in EMRs
- Use of data to guide areas of focus

In the spirit of ? centered approach



Key highlights

- **Proportion of stable clients ranges between 30- 45 %**
  - This will definitely reduce with new regimens which require close monitoring
- **Focus on the first 90**
  - The biggest gap in the cascade is 1st 90
- **Fast track models more popular**
  - Breach of patient confidentiality in community models
- **Counties lack standard approach despite guidelines**
  - Need for regular supportive supervision by national program and IPs
  - Dissemination of Operational Guides and other tools
- **Need for equal investment in EMRs/HIS solutions**
  - to track service delivery and enable use of data for decision making
- **Selling DC as a parallel program/project has also affected its implementation**
  - Counties cited staffing constraints

Acknowledgements

- Health care workers
- County Government
- National Government
- NASCOP
- Network of PLHIV
- ICAP

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