



Centre for Health Solutions - Kenya

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ESSENTIAL PACKAGE FOR HIV CARE AND TREATMENT





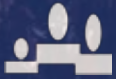
Essential Care & Treatment Package for Adult PLHIV

1. All patients should have a confirmed and documented HIV diagnosis in their file
2. All HIV infected adults should be evaluated clinically in the CCC at least every month till stable, then every three (3) months; follow-up should be as individualised as possible
3. HTS should be provided to partner(s) and family members of the index patient
4. Adherence assessment and counselling, psychosocial support and PHDP services should be provided to all PLHIV at every visit
5. All PLHIV should be provided with long-term HIV care and follow up including community linkages
6. All patients should undergo nutritional assessment and counselling at every visit, and if needed, nutritional services
7. All PLHIV should receive STI screening at every visit
8. All HIV infected women should receive pregnancy screening at every visit
9. Cervical cancer screening should be integrated into routine care for all sexually active women
10. All HIV infected women of reproductive age should receive dual contraception at every visit
11. All patients should be screened for TB at enrolment and at every visit
12. All patients should be screened for IPT and isoniazid provided to eligible patients as per national guidelines
13. Co-trimoxazole prophylaxis therapy should be provided to all patients regardless of CD4 counts
14. Anti-HBV, pneumococcal polysaccharide and influenza vaccines should be offered to all eligible patients where available
15. All patients must be triaged at every visit and trends in BMI and blood pressure monitored
16. Clinical assessment must be conducted for all patients at enrolment and at every visit
17. Basic laboratory tests where available, should be conducted for all patients at baseline, at ART initiation, and thereafter as directed by the patient's symptoms or ART regimen
18. Cryptococcal antigen test should be conducted for all patients with $CD4 < 100$ cells /mm
19. CD4 tests should be done for all patients within two (2) weeks of enrolment and for pre-ART patients, every six (6) months thereafter
20. Patients who are eligible for ART should be initiated within one (1) month of enrolment
21. All patients on chronic HAART should be monitored for antiretroviral treatment failure using clinical criteria at every visit
22. All PLHIV on chronic HAART should be monitored for ART failure using virologic criteria after six (6) months on ART, after one (1) year, and annually thereafter
23. All patients should be monitored for adverse events at every visit including six (6) monthly creatinine test for patients on TDF
24. All HIV infected patients should be managed promptly for all opportunistic infections

Essential Care & Treatment Package for Adolescent PLHIV



1. Clinical care should be provided for adolescents as detailed in the essential package of care for adults in addition to the following:
2. Adolescent care should be provided in adolescent friendly settings
3. Adolescents should be provided with flexible follow-up dates
4. Adolescents should receive Tanner staging at each visit
5. ART dosing for the adolescent should be based on Tanner staging & weight of the adolescent
6. All adolescents should be enrolled into age-specific psychosocial support groups (PSSG) led by trained staff & peer educators within one (1) month of diagnosis. Facilities with more than five (5) adolescents should have a trained adolescent peer educator
7. All adolescent caregivers should be enrolled into PSSGs led by trained staff
8. SHADASS assessment should be conducted for all adolescents at enrolment
9. All adolescents should undertake a disclosure program that is responsive to their development stage, socio-cultural situation and care giver readiness
10. All adolescents should be linked to a community support group or youth friendly centre
11. Defaulter tracing should be conducted for all adolescents who miss a clinic appointment
12. All adolescents should undergo health education including basic facts of HIV/AIDS, sexuality and life skills training at every visit
13. All adolescents should receive STI screening at every visit and treated as per national guidelines
14. All adolescent girls should receive pregnancy screening at every visit
15. All pregnant adolescents should receive PMTCT services as detailed in the PMTCT package
16. Cervical cancer screening should be conducted for all eligible adolescents
17. All sexually-active adolescents should be provided with dual contraception
18. All sexual partners and children of adolescents should be traced and offered HTS
19. All adolescents should be educated on appropriate vaccine schedules and those eligible vaccinated where possible
20. Adolescents aged 19 years should be supported to transition into adult services



Essential Care & Treatment Package for PMTCT

1. Clinical care should be provided for PMTCT clients as detailed in the essential package of care for adults in addition to the following:
2. All women in ANC, maternity and post-natal settings should be offered HTS at first contact, and this should be repeated after three (3) months
3. All HIV pregnant or breastfeeding women should be initiated on lifelong ART regardless of CD4 count or WHO stage immediately upon diagnosis
4. All PMTCT clients should be issued with infant nevirapine (NVP) at first contact
5. All PMTCT clients should be offered cervical cancer screening before 20 weeks gestation or after six (6) weeks post-partum
6. All PMTCT clients should receive FP counselling, and be offered condoms during the antenatal period, and dual contraception from six (6) weeks post-partum
7. All HIV infected pregnant women should receive the focused ante-natal care package including iron and folic acid supplementation, malaria prophylaxis, tetanus toxoid injection, syphilis screening, de-worming
8. All PMTCT clients should receive maternal, infant and young child feeding counselling
9. All PMTCT clients should be counselled and supported to develop a birth plan which includes skilled delivery
10. Facilities should offer male involvement programs for partners of women attending ANC services (both HIV negative and positive women)
11. Partners of PMTCT clients should be enrolled in male involvement activities where available
12. HIV exposed infants should be identified and provided with EID as per national guidelines
13. HIV exposed infants should be provided with NVP, co-trimoxazole, and TB screening as per national guidelines
14. HIV exposed infants should receive vaccinations as per KEPI schedule
15. HIV exposed infants should be retained in care until final status is confirmed, and those negative discharged while those HIV infected linked to and provided ART immediately

Essential Care & Treatment Package for Children



1. Clinical care should be provided as indicated in the essential package of care for adults in addition to the following:
2. Early testing for HIV infection should be provided for every child regardless of the entry point into health system (including EID for children less than 18 months of age)
3. All HIV infected children should be evaluated clinically in the CCC at least every month till stable, then every three (3) months; follow-up should be as individualised as possible
4. Siblings and parents of index child should be offered HTS
5. Children who are eligible for ART should be initiated within two (2) weeks. All HIV infected children less than 10 years should receive ART regardless of CD4 count
6. Children receiving ART should be provided with fixed-dose formulations
7. All HIV-infected children on ART should have clearly documented, weight appropriate ARV dosing at every visit
8. Health education and counselling of the child's caregiver on infant/child feeding & HIV related symptoms should be conducted at every visit
9. All children < 5years should receive presumptive de-worming every six (6) months
10. All children < 5years should receive vitamin A supplementation
11. All children should receive immunisations as per KEPI schedule
12. Growth assessment should be conducted for all children at enrolment and every visit and correctly plotted on growth monitoring charts
13. Any child with malnutrition should receive nutritional services as appropriate
14. All HIV-infected children should have accurately documented neuro-developmental (milestones) assessment at every visit
15. All HEI should receive a DNA PCR test at six (6) weeks or at earliest opportunity followed by antibody test at nine (9) and at 18 months



Essential Care & Treatment Package for TB/HIV Integration

1. All facilities should offer integrated one-stop shop services for the TB/HIV co-infected patient
2. TB screening should be conducted on all HIV infected patients at enrolment and at every visit
3. All HIV-infected patients who are TB suspects should be appropriately evaluated, diagnosed and appropriately managed
4. The primary diagnostic test for TB among PLHIV is GeneXpert
5. All TB patients should receive HIV testing at first contact
6. All TB/HIV co-infected patients should be initiated on ART within two (2) to eight (8) weeks of initiating anti-TB treatment, and appointments synchronised to accommodate this
7. All TB/HIV co-infected patients should be initiated on Co-trimoxazole Preventative Therapy immediately after diagnosis
8. Sexual partners and children of TB/HIV co-infected patients should receive HTS
9. Isoniazid Preventive Therapy (IPT) should be offered to all eligible PLHIV in CCC and PMTCT settings
10. All facilities should have an infection prevention and control (IPC) focal person, an IPC committee, and a work plan that is updated monthly to ensure implementation
11. All facilities should trace defaulters and document outcomes within two (2) weeks of a missed appointment
12. Household contacts of smear positive TB & DR TB especially children under five (5) years should be traced using invitation letters & contact tracing registers and thereafter screened for TB and managed appropriately
13. IPT should be offered to all paediatric contacts (under five (5) years of age) of PTB+ patients in whom TB has been ruled out
14. All patients diagnosed with TB should receive an internationally accepted treatment regimen and the treatment response monitored as per national guidelines
15. All TB/HIV co-infected patients registered for TB re-treatment and with treatment failure should receive drug susceptibility testing and results documented within one (1) month
16. Patients with DR TB should be treated with specialised regimens containing second line anti-TB drugs
17. Patients with DR TB will be reviewed monthly by a county (or sub-county) multidisciplinary team until treatment completion

APSC Package Summary



1. All newly diagnosed patients should receive re-enrolment counseling to encourage timely enrolment and retention
2. Patients should be offered psychosocial counselling at enrolment and ART initiation (as per guidelines and SOPs), and at least quarterly thereafter
3. Patients should receive baseline psychosocial assessment at baseline to inform psychosocial support provision
4. All new patients (or caregivers) should be enrolled in treatment literacy classes. Upon completion, adults should graduate and be linked to community based support groups
5. All new patients should be supported to identify treatment buddies to provide them with treatment support
6. Peer educators should be engaged to provide peer support. These include mentor mothers, adolescent peers and others as appropriate
7. Patients should be enrolled in age-appropriate psychosocial support groups. Caregivers of children should be enrolled in caregiver support groups. Where available, patients may be enrolled in other specific groups such as men-only, recovering alcoholics, singles, etc. PMTCT clients should be enrolled in PMTCT-specific support groups
8. Patients should receive adherence assessment and counselling at each visit. Patients failing treatment and those on second-line should receive more intensive and frequent counselling and support
9. Paediatric and adolescent specific clinic days
10. Child, adolescent and youth friendly clinics (infrastructure, attitude)
11. Appointments should be indicated in the appointment diary, and should be coordinated for families, or for other services patients are receiving e.g. lab tests, ANC care, immunisation, TB, support groups, etc.
12. Where available, SMS reminders should be sent to patients to support retention and adherence
13. Patient locator information should be reviewed regularly to ensure patients can be reached when needed
14. Defaulters should be identified within one day of missing appointments, be traced on phone, and for children, adolescents and PMTCT clients, be traced physically within three (3) days as per SOP, and re-integrated as per the return-to-care package
15. Patients needing services in other health facilities or community sites should be referred using the facility or community referral tools and referral directory.
16. PHDP services should be offered to all patients including condoms, FP as appropriate, disclosure support, among others



Package for/approach to HIV Testing Services (HTS)

HTS is offered to all eligible patients accessing health services, regardless of the reason for their visit as per national guidelines. The following model of support is used:

- *Service delivery* – HTS should be offered at every service delivery point by a multi-disciplinary team. HTS at OPD is supported by HTS counselors engaged with support from CHS. While in-patient testing is supported mostly through nursing staff. Targeted testing to family and partners of HIV infected clients in HIV clinics and PMTCT settings is supported through provision and mentorship on use of a line listing register. Logistical support is provided for home testing on need basis.
- *Capacity building* – offered to HTS providers through mentorship, training, CMEs and supervision. Mentorship done on service delivery and documentation and reporting.
- *Quality assurance* – support through annual observed practice, quarterly counselor support supervision, administrative support supervision, laboratory lot testing for new batches of test kits, provision of timers, job aids and standard operating procedures, and data quality assurance. External quality assurance (EQA) ensured by enrolling HTS providers to proficiency testing (PT). Corrective action offered to PT failures.
- *Commodity management support* – done through mentorship on reporting, quantification, forecasting, storage, ordering of test kits and HTS commodities, as well as support for county RTK quantification and allocation forums.
- *Referrals and linkages* – HIV infected clients linked to HIV care through patient escorts, provision of referral tools including referral forms, linkage register and referral directory, and support of linkage officers including airtime for tracking referred clients, as well as physical tracing for those failing to be enrolled.

CHS Approach to Continuous Quality Improvement (CQI)



CHS supports the scale up of continuous quality improvement (CQI) initiatives in supported health facilities with the aim of integrating CQI at facility level and development of QI champions at county level.

CHS CQI activities are informed by national standards i.e. the Kenya Quality Model for Health (KQMH) whose implementation guidelines were released in 2011 and its subset, the 2014 operational manual of the Kenya HIV Quality Improvement Framework (KHQIF). In conformity with the KHQIF operational manual, CHS supports a six (6) monthly QI cycle i.e. January – June and July – December.

Details:

- *Support for CQI infrastructure:* setting up of work and quality improvement teams at departments (TB, MCH, CCC) and facility level respectively
- *Support for CQI capacity:* training, mentorship on CQI
- *Tools:* CHS provides sampling, and data abstraction, analysis and display tools
- *Framework:* internal quality of care system integrating with the MoH KHQIF
- *Indicators:* developed and revised regularly based on changing environment e.g. guidelines, and performance. Indicator definitions and targets are provided to HCWs
- *Process:* carried out bi-annually, jointly between MoH and CHS staff at facility level. The QOC tool is used, and performance measured against set targets. Implementation plans for poorly performing indicators are agreed upon and documented, with the agreed timelines. This is implemented using the PDSA approach
- *Documentation:* all this is documented in the CQI file at the facility

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