



Ministry of Medical Services

HIV/AIDS Decentralization Guidelines



MINISTRY OF HEALTH
HIV/AIDS Decentralization Guidelines

May 2009

National AIDS & STI's Control Program, NASCOP

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Forward

HIV/AIDS is still among the most important health challenges facing not only Kenya but also many developing countries in Sub Saharan Africa. The management of HIV & AIDS services initially assumed a parallel dimension. However it is now clear that it's only through decentralization and integration with other services, that the greatest impact can be realized towards combating this pandemic.

Treatment of eligible persons living with HIV & AIDS has resulted in decreased mortality and morbidity, increased quality of life, decreased hospitalization and promoted economic growth as persons on ARVs regain their health. All these efforts have to be sustained and scaled up from the current ART sites located in most district and provincial hospitals to lower level health centers and dispensaries. Thereby patients will easily access HIV care and treatment so as to decrease time and costs associated with traveling to and from hospitals.

When patients can easily access health facilities near their homes, this increases compliance to treatment and improves treatment outcomes.

The Ministry of Health continues to scale up and improve service delivery through employment of qualified staff and provision of medical and pharmaceutical supplies to public and faith based facilities. In the fight against HIV & AIDS, the Ministry appreciates efforts of all partners through indirect and direct support.

The HIV & AIDS Decentralization Policy Guidelines will thus provide an implementation framework for all partners to refer to especially in their support for decentralization of HIV services. The Ministry appreciates all organizations and development partners who have so far contributed greatly to the success of HIV programs.

We look forward to the same spirit of cooperation and collaboration as we implement this policy on HIV & AIDS decentralization.



Director of Medical Services

May 2009

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NASCOP, CDC, USAID, MSH/SPS, WHO, FACES, AIDS RELIEF, MSF-FRANCE, ICAP, JHPIEGO, AMREF

We would like to acknowledge all partners who gave technical assistance towards development of this policy document in particular CDC and AIDS Relief. The HIV & AIDS Decentralization Policy Guidelines will definitely go a long way in guiding key stakeholders in their implementation strategy towards combating the HIV & AIDs pandemic in all regions within Kenya as well as a reference document for other countries with similar challenges.



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Abbreviations and Acronyms

ART-Antiretroviral Therapy
ARVS-Antiretrovirals
CHEW-Community Health Worker
CHV- Community Health Volunteer
DASCO - District AIDS and STI’s Coordinator
DHMB- District Health Management Board
DHMT- District Health Management Team
DMLT- District Medical Laboratory Technician
DMoH- District Medical Officer of Health
DTLC- District TB and Leprosy Control Officer
HAART-Highly Active Antiretroviral Therapy
HBC-Home based Care
HIV-Human Immune deficiency Virus
M & E-Monitoring & Evaluation
MOH-Ministry of Health
MTEF-Medium Term Expenditure Framework
NASCOP-National AIDs& STIs Control Program
NGO-Non-Governmental Organization
OVC-Orphans and Vulnerable Children
PASCO- Provincial AIDS and STI Coordinator
PGH-Provincial General Hospital
PHMT- Provincial Health Management Team
PLWHA-Persons Living with HIV/AIDS
PMLT- Provincial Medical Laboratory Technician
PTLC- Provincial TB and Leprosy Control Officer
SDPs-Service Delivery Points
SOP-Standard Operating Procedures
TB-Tuberculosis

EXECUTIVE SUMMARY

There are estimated 1.5 million Kenyans living with HIV/AIDS of whom over 390,000 qualify for ART. By the end of March 2009, over 260,000 Kenyans were receiving antiretroviral (ARVs) drugs through government and donor supported programs. The government supported ART program has experienced rapid growth over the last three years as evidenced by an increase in the service delivery points (SDPs) from 15 ART sites in 2003 to over 700 ART sites by end December of 2008. Most of these SDPs are provincial hospitals, district and sub-district hospitals. At lower health facilities, most people have poor access ART care and treatment services. The challenge to improve access to HIV care and ART provision has created a need for more ART service delivery points in health centres and dispensaries (also known as satellite ART sites) beyond district and sub-district hospitals without increasing the number of facilities directly ordering ARVs and other HIV related commodities from the KEMSA central warehouse in Nairobi.

The Kenya National Health Strategic Plan II (2005/2010) defines decentralization of decision making and management of peripheral health facilities by the district health system where districts are able to make plans and also effectively budget for their drugs and other services.

Decentralization is geared towards; decongesting the current system where all ART sites from all districts countrywide have to make reports and request for ARVs centrally; build sense of program ownership at district level by allowing management of HIV related commodities by district pharmaceutical staff; increase efficiency in service delivery by minimising logistical challenges for ARVs management at central level; provide clinical mentorship to sites not currently offering ART services and allow for continued nationwide ART scale up by availing much required ARVs to patients on care at health centres and dispensaries.

In line with the National Health Sector Strategic Plan, NHSSP II-(2005-2010), NASCOP has developed a decentralization model that uses the concept of “satellite” sites attached to a “central ART service delivery site or a District pharmaceutical store for ARVs re-supply.

The model proposes a decentralization of ART Clinical Services to patients at the satellite health facilities from an existing central ART site, Clinical Mentorship (by existing central ART site appropriate staff) to service providers at the satellite health facilities, ARVs and HIV related commodities management to central/district ART site level from the national NASCOP/KEMSA Warehouse level and the creation of laboratory service linkages and networking with centralised and best equipped regional or district based laboratories.

1.0 INTRODUCTION

1.1 Background

HIV continues to be the leading cause of morbidity and mortality in sub-Saharan Africa, accounting for two thirds of the global HIV burden. In 2003, Kenya with an estimated population of 34 million, reported adult HIV sero-prevalence of 7.4 % (KAIS 2007). With increased donor support, Kenya has made tremendous efforts in scaling up antiretroviral treatment. In 2003, only about 7,000 patients countrywide were receiving ART mainly from the private sector. By the end of July 2008, over 230,000 patients had benefited from the provision of HIV care and treatment. As a result of this rapid scale up of the ART program, HIV related morbidity and mortality has reduced significantly. In order to increase on the gains made, Kenya is aiming to achieve Universal Access by 2010 and reduce HIV related mortality by 50%.

Despite the scale up of HIV treatment in Kenya, treatment programs have been concentrated in the national, provincial, district and large sub-district hospital. There's is a need to increase access to treatment through decentralization. The key aim of decentralization is to achieve universal access to HIV care and treatment by availing services closer to those in need and assure program sustainability. It will also allow for continuity of care and treatment at the nearest health facility as well as ensure equitable distribution of services. Decentralization also seeks to enhance integration of HIV/AIDS care and treatment into the rest of the health care delivery system. It has the potential of improving quality of service delivery and patient management while increasing access and coverage.

The initiative to decentralize HIV services is in line with the Kenya National Health Sector Strategic Plan (NHSSP) II through the Kenya Essential Package for Health (KEPH) and the Kenya National AIDS Strategic Plan (KNASP). Decentralization involves sharing the responsibility of providing HIV prevention, care and treatment services and the resources available within a geographical region among all available levels of health care facilities as well as with the community. The result of which should be that patient care is provided at the most appropriate level and as close to the patient as possible. To this end the health care managers at the peripheral levels will be required to identify needs in the community they serve and expand services and coverage appropriately.

This is especially important because the HIV/AIDS epidemic presents with significant variance in nature and burden of disease from region to region.

Decentralization of HIV care is also in line with the Community Strategy of the Ministry of Health, as it seeks to utilize the local communities in various ways such as creating health awareness, minimizing stigma, home based care and patient tracking thereby supporting patient management. Hence the community will become a stakeholder in the care and management of HIV patients.

Key to successful implementation is the active involvement of all health care workers at every level for maintenance of high quality of patient care and development of required systems including patient and laboratory specimen referral systems. In summary, decentralization aims to make the rapid scale-up of HIV care and treatment in Kenya feasible and sustainable by maximizing on and rationalizing limited resources at all health care delivery levels.

1.2 Definition of decentralization

The term 'decentralization' is used to describe a wide variety of resource and power transfer arrangements as well as accountability systems. Decentralization has become the driving force for health sector reform and is driven by the wider sectoral reform efforts. The parameters for decentralization such as the speed, the pressures, and the scope of issues to consider vary considerably

In decentralization, a significant amount of authority and resources is delegated to lower levels (provincial, district, and sub-district and primary health care). As a result, each level of service provision is able to determine the range of and have a sense of ownership for the services they are offering. In so doing they can scale up new and region-specific services, expand the range of services offered, monitor and evaluate them, identify problems and solve them avoiding the bureaucratic delays of a centralized system.

1.3 Definition of decentralization in the context of HIV Care and Treatment in Kenya

Decentralization of HIV services can be defined as “sharing the responsibility” of providing HIV prevention, care and treatment services at multiple levels of health care service provision within the existing Kenyan health care system, with the goal of expanding access to quality HIV services.

“Sharing responsibility” allows appropriate management of patients at the appropriate level ensuring quality at all times. Shared patient care would support expansion of care, such that basic HIV care and treatment is provided at lower levels while complicated opportunistic conditions or complications arising from ART are managed at higher levels of health care. Shared human resource capacity can be achieved through mentorship, supportive supervision, referral of patients or regular visit of lower level facilities by experienced HCWs. Other services that can be shared in a region include laboratory resources through networking and commodity management and reporting systems.

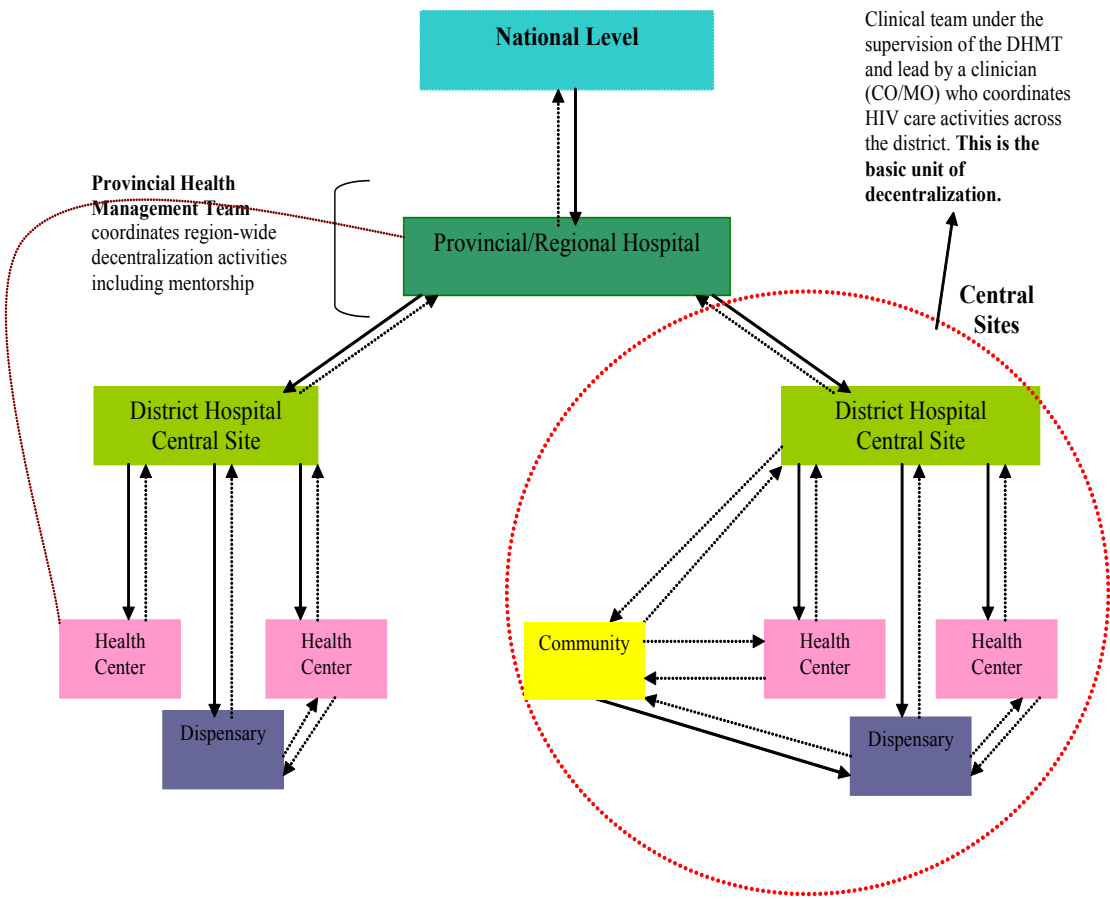
Decentralization within a geographical region (e.g. district) results in shared responsibility for the comprehensive care of HIV positive patients among all available levels of health care facilities and the community, within that region. Prior to effective decentralization, most HIV services with the exception of PMCT services would have been provided within the larger health facilities, usually large sub-district and district hospitals (KEPH level 4 facilities) and above. With effective decentralization lower level facilities become involved in providing varying packages of HIV services. For instance in a district, most dispensaries may be enabled to provide the basic package of HIV care which includes testing and counseling services; WHO staging, prevention activities, condom distribution, provision of other contraceptives, dispensing of Cotrimoxazole and multivitamins, psychosocial and, adherence support, defaulter management and referral of patients. Health centers could also be enabled to provide the basic HIV care package as well as initiating and follow-up of patients on ART, managing some OIs, effective triage and appropriate referral of patients under the supervision and support of the district hospital and the district health management team. Over time decentralization results in supervised transfer of responsibility for some or all aspects of comprehensive HIV care and treatment services from the larger facilities to lower level health facilities.

Alongside regional decentralization among health facilities, there should also be decentralization of HIV services by integration into other services within health facilities, in order to continue expansion of access to HIV care services. In this case, decentralization involves creating multiple entry points into HIV care at different service points within the facility. This would ensure expansion of access to HIV services by capturing eligible individuals at all service points.

For example, through provider initiated testing and counseling (PITC), PLWHAs can be identified and enrolled into care from in-patient and out-patient services, including the relatively high prevalence service points such as pediatric and medical wards, TB, family planning and STI clinics. In addition other service points that have not been much targeted for PITC such as surgical wards, dental services, eye clinic etc can also be used to identify PLWHA needing care. Within the HIV care clinics, decentralization could involve task shifting to enable effective and optimal utilization of existing human resource capacity. This would involve for instance use of trained non-professional medical personnel to perform certain tasks under supervision such as meeting/greeting patients, reception work, weighing patients and taking vital signs, support management of patient records, patient education and adherence preparation and support, defaulter management etc. This form of task shifting would allow professional nurses in turn to support clinicians by following-up stable patients whether or not on ART as well as other clinical tasks that they are trained to provide. As a result clinic capacity and efficiency would increase.

Because of the expansion of services both within individual facilities and among health facilities within a region, effective decentralization could help the country achieve the goals of universal access to care, such that all PLHWA can receive appropriate care at the most fitting level and as close as possible to their community and home. Thus for instance, trained personnel may follow up a stable patient on ART at a satellite site (health center or a dispensary); should the patient develop new complaints they would be referred to the central site (district level and above facilities) where experienced clinicians would assess the patient and institute appropriate interventions. Alternatively a clinician from the central site may review the patient at the satellite site and institute appropriate interventions. Once the patient has been stabilized they can be referred back into the care of the staff at the satellite with a new treatment plan for continued follow up.

Summary of Relationship between Facilities within a Region



2.0 MANAGEMENT AND COORDINATION

Effective leadership results in improved health outcomes due to improved work climate and management systems. The effective health manager applies leadership practices, prioritizes planning and problem anticipation and prevention and seeks for opportunities to improve management of systems and health delivery.

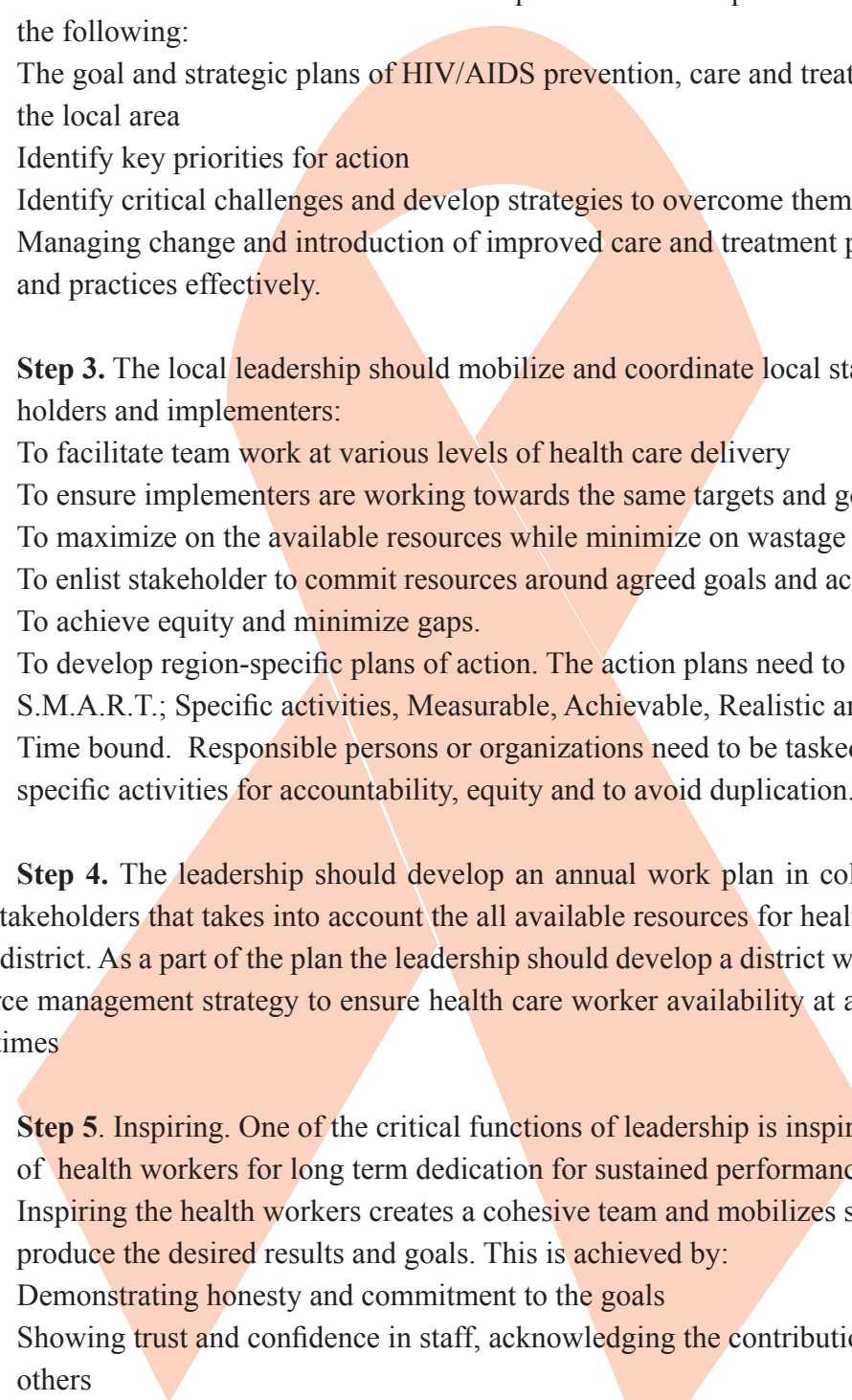
Leadership and management skills are best developed in training, practice and support. Leadership practices improve over time through the process of facing challenges, receiving feedback and support.

2.1 Principles of good leadership practices for effective decentralization

To decentralize effectively, health managers at all levels of care, especially at the district and central facility level are required to adopt the following key leadership practices and steps:

1) Step 1. Equip themselves with relevant information pertaining to health care service development and delivery including following:

- a. The national health sector strategic plans, goals and priorities; the national strategic plan for HIV prevention, care and treatment
- b. Demographic and health indicators of their region
- c. HIV/AIDS disease trends in their region
- d. Health care and health intervention targets for the region including the universal access targets for HIV prevention, care and treatment
- e. Health care environment in the region
- f. Capacity of health delivery systems in the region including human and institutional capacities
- g. Key stakeholders and their capacity mandate and interests. This will enable the manager to know how and when best to engage the stakeholder for the benefit of health service delivery
- h. Opportunities and risks that can affect the health delivery services in their regions
- i. Prioritize local operational research issues for evidence based program planning and management

- 
- 2) **Step 2.** The leadership should clearly define local goals targets to help focus the local stakeholders and health care implementers with specific reference to the following:
 - a. The goal and strategic plans of HIV/AIDS prevention, care and treatment for the local area
 - b. Identify key priorities for action
 - c. Identify critical challenges and develop strategies to overcome them.
 - d. Managing change and introduction of improved care and treatment protocols and practices effectively.
 - 3) **Step 3.** The local leadership should mobilize and coordinate local stakeholders and implementers:
 - a. To facilitate team work at various levels of health care delivery
 - b. To ensure implementers are working towards the same targets and goals
 - c. To maximize on the available resources while minimize on wastage
 - d. To enlist stakeholder to commit resources around agreed goals and activities
 - e. To achieve equity and minimize gaps.
 - f. To develop region-specific plans of action. The action plans need to be S.M.A.R.T.; Specific activities, Measurable, Achievable, Realistic and Time bound. Responsible persons or organizations need to be tasked with specific activities for accountability, equity and to avoid duplication.
 - 4) **Step 4.** The leadership should develop an annual work plan in collaboration with stakeholders that takes into account the all available resources for health services in the district. As a part of the plan the leadership should develop a district wide human resource management strategy to ensure health care worker availability at all services at all times
 - 5) **Step 5.** Inspiring. One of the critical functions of leadership is inspiring of health workers for long term dedication for sustained performance. Inspiring the health workers creates a cohesive team and mobilizes staff to produce the desired results and goals. This is achieved by:
 - a. Demonstrating honesty and commitment to the goals
 - b. Showing trust and confidence in staff, acknowledging the contributions of others
 - c. Providing health workers with challenges, feedback and support
 - d. Being a model of creativity, innovation and learning.

- 6) **Step 6.** Develop effective communication links with health care workers, stake holders and superiors and create mechanisms for information feedback across all levels.

2.2 Good management practices for effective decentralization at various levels

Decentralization of HIV/AIDS care and treatment will result in delineation of roles and responsibilities of health managers at the various levels of care:

2.2.1 National Level Roles and Responsibilities

NASCOP will be involved in the following areas to lead decentralization:

- Assess the HIV disease patterns in the country.
- Develop national level strategic plan for HIV/AIDS care and treatment in collaboration with stakeholders and partners;
- Advocate for and participate in resource mobilization for health care delivery. This will involve articulating the HIV/AIDS burden and its impact on health and other aspects of society in a bid to receive increased funding from the Government and partners for program implementation and procurement of commodities. Secondly it will involve active participation in crafting financing policies and allocation efforts and budget proposal development such as the MTEF and Global fund proposal development. In particular, decentralization will require additional resources to support additional human resources, capacity building and the logistics to support decentralization.
- Setting of national targets setting and dissemination of guidelines on how the targets can be translated into regional goals.
- The development of policies, frameworks and guidelines and the dissemination of documents that pertain to HIV/AIDS care and treatment.
- Participate in needs determination, procurement and distribution of health commodities required for the delivery of quality HIV health services
- Harmonization and coordination of stakeholders and partners implementing HIV health services for equitable service delivery
- Consolidation of HMIS data from the provinces and districts ,analysis and timely transmission to stakeholders and for use in decision making and program planning

- Support, monitor and evaluate program implementation at the peripheral levels
- Build the leadership and management capacity of health managers in HIV/AIDS.
- Monitor and ensure transparency and accountability of utilization of resources including funds
- Monitor for quality of health care.

2.2.2 Provincial Level: PHMT Roles and Responsibilities

For HIV/AIDS care and treatment activities the following specific roles and responsibilities at the provincial level should be carried out by the PHMT with the PHMT as the focal person:

- Support districts to set targets for HIV related activities in line with national targets, local disease prevalence and national strategic plans;
- Support implementation of HIV/AIDS related activities at district level to achieve a good balance between national goals and local needs;
- Provincial coordination and alignment of partners and HIV/AIDS service delivery organizations in line with the national guidelines and policies. This will prevent duplication and maximize on resource mobilization and utilization;
- Advocate for additional support and resources for specific and unique local health care needs from the national level and other stakeholders;
- Ensure equitable distribution of resources including human resources and health services among the districts;
- Consolidation of HMIS data from the various districts and health facilities and timely transmission to the national level;
- Identification and Accreditation of Central and satellite sites in collaboration with the DHMTs;
- Support supervision to be conducted with the relevant departmental head(s) eg Provincial TB and leprosy coordinator with the PHMT will work together to supervise and strengthen the TB/HIV activities;
- Supervision and coordination of mentorship and other training activities in the region to support human resource capacity building around the health priorities;
- Monitoring and evaluating the delivery of local services to ensure quality, impact and responsiveness to local needs and conditions and in line with national requirements.
- Monitor and ensure transparency and accountability of utilization of resources including funds

2.2.3 District Level: DHMT Roles and Responsibilities

For HIV/AIDS care and treatment activities the following specific roles and responsibilities at the provincial level should be carried out by the DHMT with the DASCO being the focal person to lead the decentralization process. The DHMT should:

- Plan for district needs and advocate for support and resources for specific and unique local health care needs from the national, provincial level and other stakeholders. The annual work plan should clearly chart out these needs, resources and partner contribution.
- Set district targets for HIV related activities in line with national and provincial targets, local disease prevalence and national strategic plans.
- Provide district-wide coordination and alignment of partners and HIV/AIDS service delivery organizations. This will prevent duplication, gaps in service delivery and maximize on resource mobilization and utilization.
- Support facilities to set targets for HIV related activities in line with agreed district targets and local disease prevalence
- Support implementation of HIV/AIDS related activities at district level in line with agreed district targets
- Ensure equitable distribution of resources and health services within the district;
- Develop a district-wide human resource management plan to ensure health care worker availability at all facilities in the district at all times. The HR plan should include identification of training needs and plans to support HR capacity development in line with service requirements in the district.
- Provide support supervision and coordinate of district-wide mentorship and training activities by using a multidisciplinary team
- Consolidate the HMIS data from the various health facilities and timely transmission to the provincial level;
- Identify, set up, strengthen and coordinate activities of central site(s) in collaboration with the PHMT
- Work in collaboration with central sites in identifying, setting up, strengthening and coordination of satellite sites
- Support the integration of services
- Source funding for, establish, support and maintain patient care networks e.g. referral, commodity distribution, and reporting and laboratory networks.

- Coordinate for community involvement in HIV/AIDS care and treatment in line with the MoH community strategy and with the local health needs.
- Monitoring and evaluating the delivery of local services to ensure quality, impact and responsiveness to local needs and conditions.
- Mainstreaming and facilitate integration of services thereby maximising on available resources and avoiding duplications.
- Monitor and ensure transparency and accountability of utilization of resources including funds

2.2.4 Facility level Roles and Responsibilities

At the facility level, the facility management team, which should include HIV service coordinator and providers, makes decisions that ensure overall smooth running of the facility. The responsibilities vary depending on the capacity of the facility and whether it is a central (mainly provincial, district and sub-district hospitals) or a satellite site (health centres and dispensaries). The facility management should be involved in all aspects of decision making regarding HIV prevention and care in the facility as well as in the community and should include the following:

- Central sites should be part of the district-wide HIV coordination team and may be represented in the DHMT. They should contribute to the development of systems to support decentralization, and coordinate and participate in district-wide training, mentorship and commodity and networks management.
- Each facility should have a multidisciplinary leadership team that deliberates and provides leadership on HIV related issues within the facility and in collaboration with other facilities and
- The central site together with the DHMT should have a comprehensive staff management plan which should include a staff training plan and be flexible enough to allow coverage of absence and/or leave at all sites within the district.
- The leadership should aim to strengthen the central site to ensure it complies with requirements as per the defined criteria with particular emphasis on quality issues, data management compliance and human resource capacity to facilitate effective site support
- Satellite sites should be able to report on commodities use and requirements as well as basic patient information data. The central site should be able to collate and transmit data from the satellite sites to higher levels to ensure commodities shortages do not occur. The central site should be able to also support satellite sites to utilize the data for program planning and patient care.

- Analysis of facility data and its utilisation for program planning and patient care should also be possible at all levels. Ideally in an organized system a district/central site could have one consolidated report and receive commodities on behalf of all sites through a single logistics system.
- Management at site level should be responsible for effective utilization and appropriate modification of existing space at site level to ensure service provision is offered optimally. In particular facilities should ensure adequate TB infection control within spaces used for patient care.
- Each facility should ensure that continuous quality improvement becomes integrated in service processes. Mentorship, continuous medical education, effective data management, use of chart reviews, morbidity and mortality meetings, case discussions are all essential for improving quality of patient care.
- The facility in-charges at the HIV treatment central sites should have the additional responsibilities of organising and supporting the mentorship teams to the satellite clinics
- Facility management should provide support supervision alongside training and mentorship. Systems issues that are identified should be addressed to ensure patient care is improved. Management should also work at supporting health care workers and develop team spirit
- Involve the community in identifying health needs and patient care and support in collaboration with the community health extension worker;
- Mainstreaming and facilitate integration of services thereby maximising on available resources and avoiding duplications. For example the HIV and TB services are to be integrated into the existing services e.g. MCH, OPD, in-patient, with minimal impact on the provision of other services.

2.2.5 Community Role and Responsibilities

The chronic shortage of health care workers is recognized as one of the major bottlenecks to health care provision including scaling up HIV care and treatment. Most public health facilities in Kenya are staffed at about 50% of their needs. This has created an increasing need for task shifting of roles and responsibilities from the health care workers to the community. Strong community ownership of and participation in health care delivery has benefits in improving the general quality of health care services. Engaging community in HIV/AIDS care is a proven way to enhance program quality, in terms of clinical outcomes, adherence rates and retention Kenya has developed a community strategy that has set out the approaches to be taken to ensure that Kenyan communities have the capacity and motivation to take up their essential role in health care delivery.

It is critical that communities are empowered to play their role in policy setting, program development, resource mobilization and allocation, implementation and evaluation. Participatory approaches to program development and monitoring should be adopted to create an effective interface between communities and the public health system.

2.2.6 Leadership and Management Challenges of Decentralization

1. The major challenges in decentralizing are to stabilize the entire health system through new accountabilities, resource flows and systems that support service delivery.
2. Achieving a cohesive and integrated HIV/AIDS care and treatment program that adheres to national health policies and strategies. This involves identifying and maintaining competent management and technical expertise. The national and provincial managers will use national information systems to support management decisions, responsibilities, evaluate program progress and effectiveness.
3. Mobilization of resources across the health care system. Promoting equitable access to health services while ensuring availability and accessibility of HIV/AIDS care and treatment commodities.

2.2.7 Financial Resource Requirements

Upfront costs:

- Laboratory: The strengthening and provision of appropriate infrastructure and equipment
- Capital equipment: Satellites may need basic equipment such as refrigeration/coolbox for lab samples, shelving for patient files, locking cabinets for drugs, dispensing trays, pillboxes, increased seating (benches), and mobile phones for communication.
- Trainings: There is need significant training funding to support IMAI, ART, Pediatric ART, etc workshops. Central sites may need to assist satellite sites with CHW trainings to support defaulter tracing mechanisms.
- Job Aids and SOPs: Development and dissemination may need to be done with consultation with provincial and national levels.
- Infrastructure: If the existing satellite site does not have adequate space, then funding is needed for refitting or remodeling of existing structures to ensure private clinical and counseling rooms, and to support expansion of CCC services over time.

On-going costs:

- Facilitating movement: Access of the central site to satellite sites enables mentorship, supportive supervision, M&E, etc., and requires a vehicle/motorbike/fuel OR funds for public transport. (However, it is unadvisable to carry lab samples on public transport.)
- Communication: Two-way communication between the central and satellite site is on-going for clinical consultation, reporting, lab networking, and other coordination and assistance. Funding is needed for phone calls, mail / courier services, and in some cases, e-mail.
- Community: Defaulter tracing has costs related to travel and communication. Community support has costs such as CHV training, incentives, and coordination meetings.
- Lab and pharmacy supplies: If the satellite is not part of the GOK system, then funding may be required to support purchase of OI drugs, lab reagents, and other lab and pharmacy supplies (e.g. gloves, tubes, cotton, etc).

When decentralizing care to a non-GOK facility (faith-based or private), there is also the aspect of financing. Support of HIV patients with care and treatment at these satellites will not generate any income to cover their operations, although provision of this care requires a great amount of resources in terms of pharmacy and lab supplies and human resources, etc. Central sites that are in the faith-based sector also require funds to provide up-front and on-going support to satellites. A clear mechanism for support of these costs must be considered when planning decentralization at the district level, keeping in mind that these facilities play an important role in decentralization, as they reach under-served communities, have existing health networks across communities, and have the technical capacity to mentor satellites.

2.2.8 Human resource capacity management

The deployment, retention, motivation and training of health care workers will need to be well managed at all levels of health care. Although initial decentralization can occur using existing satellite site staff (three staff at minimum), a clear staffing plan for scale-up will need to be developed to support the satellite over time. Currently, there is not clear guidance on the staff-to-patient ratio for adherence preparation and follow-up and for HIV clinical care. If satellite staff are undertaking all care responsibilities at the satellite, from MCH to VCT to non-HIV care to dispensing, then the existing staff could quickly become overwhelmed with an influx of patients requiring HIV care services. When starting a satellite, forward planning for human resources is required and should be tied to expected scale-up targets and plans for downward referral of patients.

2.2.9 Maintaining quality of care

The biggest risk of decentralizing HIV care is one of maintenance of quality. If patients do not receive quality comprehensive HIV services at the satellite site, then the individual is at risk of poor adherence, poor clinical management, both of which lead to viral resistance, which has long-reaching ramifications at the family, community, and at the national level. Maintaining quality of care involves implementing strategies to achieve compliance with minimum standards and practices across the nation/region. The government needs to identify clear minimal quality standards in all areas of comprehensive HIV care, including:

- Clinical practice (e.g. following national guidelines; using appropriate regimens; regimen switches)
- Clinical outcomes (e.g. change in CD4; change in weight; viral load monitoring if available)
- M&E (e.g. complete, accurate and timely reporting)
- Adherence (e.g. defaulter rates; reported adherence behavior)
- Community linkages and integration for comprehensive support (e.g. existence of support groups, etc)
- Pharmacy (e.g. uninterrupted supply chain of ARVs and key OI drugs for HIV management; timely and accurate reporting)
- Laboratory (e.g. through external quality assurance)

There should be a clear monitoring schedule for all satellites with clear roles and responsibilities defined across the national, provincial, district, central site, and satellite site levels. Quality monitoring for decentralization is not a stand-alone activity, but is part of the national approach to monitoring implementation and quality outcomes of the national HIV care and treatment program.

3.0 SERVICE DELIVERY

There should be clear management structure and leadership provided at all levels of services including health administration and clinical leadership at provincial and district level to provide direction and coordination of decentralization.

Central sites

These are facilities providing comprehensive HIV care and treatment services to a large population, and include provincial, district and large volume sub-district hospitals, as well as faith-based or private hospitals. Other than HCWs with experience in HIV care, these facilities should have adequate laboratory capacity as well as the human resource, logistics, and systems capacity to supervise, support and provide mentorship for HCWs to a regional network of satellite sites.

Satellite sites

These are small sub-district hospitals, health centers, dispensaries, either GOK, faith-based, or private, which may or may not be offering some level of HIV prevention and care services and which have the potential for expanding and improving HIV care services with support by and under the supervision of a central site. Satellite sites may provide different levels of HIV care, starting with the “**basic care package**” as the bare minimum level of service and adding additional components of ART, OI management and patient follow up according to the capacity and access to support from the central site. The level of services provided by a satellite site may change over time and may increase to a point where a satellite site requires minimal oversight and support from a central site.

Mobile Satellite sites

An alternate model of decentralization, which does not necessarily involve extensively sharing care with a satellite site and building capacity over time, may be adopted depending on the situation. This involves provision of central site like services at a satellite location (i.e. a mobile comprehensive care service). In this model a central site sends HCWs with necessary supplies on a regular basis (e.g. once a month) to a satellite site to directly provide HIV care and treatment services at the satellite site. This model may result in the transfer of capacity to the satellite site and devolving some services to the satellite site staff over time. It has immediate benefits to the community served, with high quality of care and may cost less early on. Over time it is likely to be less sustainable and more costly to run than a satellite site that is enabled to provide services. It also has the disadvantage of lack of services during the period of time that the mobile service is not at the site.

3.1 Central site: Model of care and resource requirements:

The central site plays a crucial role in capacity building of the satellite sites to provide quality HIV care and treatment services. The central site should already be engaged in providing quality care and treatment services and implement efficient inventory, laboratory, and monitoring and evaluation systems. Comprehensive care services that must be in place at the central site including, at minimum, HIV counseling and testing; HIV care and treatment including effective defaulter management and adherence support; effective PMTCT including appropriate ARV drug use in pregnant women, follow up of mothers and their infants, early infant diagnosis and interventions for improved infant survival; TB/HIV services, and reproductive health services.

The central site will be responsible for providing intensive initial mentorship, continuous quality monitoring, and supportive supervision to the satellite sites. It is preferable that the mentors be trained mentors as well as practicing health care workers (hands on) in the facility to ensure that they have the ability to transfer knowledge and skills. The site should already implement standard operating procedures (SOPs) for clinical management of patients and adhere to national guidelines. They should be able to access guidelines, manuals and job aids for distribution to satellite sites. Any weakness in central site's systems will be further complicated by decentralization, and the satellite site may not receive sufficient mentorship to ensure that these gaps from the central site are not repeated at the satellite site. The satellite site and central site relationship can collapse if the central site cannot manage the responsibilities that accompany decentralization, such as on-going mentorship, timely reporting, inventory management, and, in some cases, donor funds management.

Prior to decentralization, the central site must be assessed to ensure that minimal qualifications are met to ensure that the central site has sufficient capacity to support decentralization. A standard checklist for this assessment can be found in **Appendix A**.

The checklist assesses all aspects of a comprehensive HIV care and treatment program provided by the central site, including the following key areas:

- Referral systems.

Effective referral and communication systems and tools for use between central and satellite sites must be established. Referral may involve clinician review of patients at the satellite site on a regular basis. If clinicians visit satellite sites frequently (e.g. weekly) this is practical, since patients do not have to wait long for an appointment. Referral may also involve movement of patients to the central site either because of emergencies or because they have serious conditions for which care in a small facility is inappropriate. Where patients have to move to another facility there should be clear standard operating procedures to ensure that patients are seen at the appropriate level of expertise as expeditiously as possible and that patient follow up is arranged to avoid patient falling through the gaps. Stable patients may be referred to satellite sites to ensure that patient care is as close to their home as possible; there should however be no coercion of patients to move.

- HMIS and M&E:

Central sites should have the ability to accurately complete patient data collection, M&E tools, and monthly reports. The site should be reporting HMIS data on time to NASCOP's M & E department as per the national recommendations. Most central sites will have computer-supported reported systems because they are high volume sites and often receive partner support for this. They need to be able to train satellite sites to report on patient care and commodities use and requirements and supervise sites to ensure adequacy of these reports.

- Lab services:

Central sites should have the capacity to perform basic diagnostic and HIV monitoring lab tests, including hematological, biochemical and CD4 count measurement. They should have the capacity to provide lab services and be able to form viable networks with satellite and other regional sites that do not have access to these tests. Central sites should also form appropriate networks for other tests that may not be available on-site, e.g. viral load, infant diagnostic tests.

- Commodities management:

The central site should have proper commodity logistics management to be able to forecast, quantify, order and report on time. The facility staff should be proficient in inventory management practices and should have all the necessary tools for inventory management and use them proficiently.

- The facility should have the capacity to use computerized information systems for HIV/AIDS-related commodity management efficiently. The central site should have adequate secure storage for HIV/AIDS-related commodities for itself as well as all the proposed satellite sites. The bulk and dispensing stores should be separate and the facility should be compliant to recommended storage guidelines.

- Adherence support mechanisms:

A central site should have a system for preparing patients for adherence to ART and monitoring adherence to ART over time. A central site must set up a functional defaulter tracing mechanism and demonstrate low defaulter levels. A central site should be linked to a community patient support network e.g. HBC, CBO, CHEWs.

- Program / finance management capacity:

The central site together with the DHMT should determine the number of satellite sites it can efficiently manage for adequate patient care based on their human resource capacity and logistics capacity. Central sites should have financial systems and accountability to manage their own funds and the funds for the satellite sites in their management.

- Logistics and infrastructure:

Capacity for regular supervision visits, transportation of commodities to the satellite site, submission of NASCOP reports via courier, and communication with satellite sites. This should include adequate number of health care workers to allow for continued service provision at the central site as well as regular supportive and mentorship visits to satellite sites. The logistics to provide these services is a crucial factor requiring adequate funding and effective facility-level planning.

If the minimal criteria are not met, then the PHMT and DHMT can assist the central site with capacity building either directly or through linkages to other partners, appropriate training and mentorship opportunities to ensure that gaps in systems, skills, and/or knowledge are adequately filled. In this case, reassessment would be required after a certain time period to see if the central site meets the requirements for decentralization.

In addition to completing the assessment checklist, prior approval by the PHMT and PHMT in collaboration with the DHMT/DASCO is required before the site should undertake decentralization.

Human resources requirements at Central sites

The CCC at the central site will be staffed by a care and support team that matches current and planned patient load. The team will work together to offer comprehensive, integrated services at the central site, and will have the additional responsibility of providing mentorship in their area of expertise to the satellite site. This usually requires additional staff hired to ensure that staff has adequate time available to provide regular mentorship of satellites without compromising quality of care at the central site. For rational use of limited human resource capacity in the country task shifting is an essential strategy to enable sites achieve their goals, as reflected in the list below. The numbers of each cadre will depend on the patient population and the service requirements and need to change with the demand.

The core CCC team at the central site should be composed of the following cadres of staff:

Health Cadre	Roles and responsibilities
Medical Officers	Clinical supervision and facility/district management Management of HIV patients in all aspects
Clinical Officers	Clinical Management of HIV patients in all aspects Service management
Nurses	Triage of Patients Continuation of clinical care of stable patients Nursing Care Adherence Counselling Supervision and training of the community and home treatment support workers Post pharmacy counselling
Nutritionists	Nutritional Assessment & Counselling
Laboratory Technologist/Technician	Phlebotomy Laboratory services Supplies Management

Counsellors, including lay counsellors	Diagnostic and Voluntary Testing Counselling Patient education Adherence Counselling
Community health workers	Community and home treatment support including defaulter management
Health Records Information Officer / data clerks	Patient Record Management
Accountant/Finance Clerk	Receiving of Cost Sharing Fund Financial Management
Pharmacist/Pharmaceutical Technologist	Drug Adherence Counselling, Rational Use of ARVs, ARVs Dispensing And effective Commodity/Inventory Management
Store Keeper	Commodity Management (in conjunction w/ Laboratory and Pharmaceutical staff)
Social Worker AND/OR Community health co-workers AND/OR Defaulter tracing personnel	Adherence Support Patient Assessment for Waiver Defaulter tracing Establishing/maintaining community linkages for patient support

All central site clinical staff should have basic training on Adult and Paediatric ART, and be providing hands-on HIV services currently. The staff should be implementing systems consistently and according to SOPs, including referral, commodities management, and monitoring and evaluation. The central site leadership as well as the core CCC team must be committed to decentralization, as once support is extended to the satellite site it should be followed through to ensure that patients receive quality care services. One challenge to continuity of satellite clinic support is retention of core CCC staff at the central site. In Kenya, health facilities experience high staff turnover. Decentralization may help to curb the rate of turnover by providing staff motivation through additional training opportunities, recognition and/or certification of mentors, and added responsibility. To manage staff turnover in the CCC, the central site can use the following strategies:

- Train/capacitate different people per facility for continuity
- Advocate for more staff where there is shortage to avoid burn out.
- Recommend rotation strategies for staff within facilities especially during peak hours
- Recommend flexible duty rosters
- Recommend/suggest minimum staff required in CCCs at different levels of care or depending on patient load weighted against the added responsibilities.

The DHMT should ensure improved human resource management to ensure that staff turnover, absence training or leave does not interfere with patient care through effective district wide planning of HR requirements and forecasts. The Kenya health system is also faced with a shortage of qualified staff. Deployment of staff by the MOH should be rational and well planned to ensure that central sites supporting decentralization are not left without staff.

When necessary, the central site can encourage deployment within the facility (intra-facility) and between facilities (inter-facility) to address staff shortages. The central site should work with the DASCO to recommend to relevant authorities (e.g. MOH) the need for structured deployment and staff replacements where there is transfer.

3.2 Satellite site: Model of care and human resource requirements

Satellite sites are expected to provide at a minimum set of care services including HIV counseling and testing, PMTCT, TB treatment, reproductive health care and HIV care (do-no-harm approach); in addition to this ART may be added depending on capacity. The satellite site will likely need significant upfront and on-going capacity building from the central site to provide quality HIV care services. Use of standard operating procedures (SOPs) for clinical management of patients and national guidelines, manuals and job aids will also be necessary if not already existing at the satellite site. Satellites will require additional focused mentorship and support for both nurses and clinical officers in order to initiate ART at the satellite clinic level. Nurse-led clinics are working in various parts of the country often with the aim of providing basic HIV care without ART on-site (the do-no-harm approach). Capacity building in these sites can expand quality and range of available services.

The satellite site should have been formally assessed by the DHMT, PHMT and central site and approved as able to provide at a minimum the basic package of care. The DHMT will be responsible for regular assessment of satellites to ensure they meet the criteria and are mentored appropriately. A standard checklist for this assessment can be found in **Appendix B**.

The checklist assesses all aspects of a HIV care and treatment program at satellite clinic level, including the key areas of referral, M&E, lab services, commodities management, adherence support and defaulter tracing mechanisms, and community linkages. In addition, the satellite site should have capacity to communicate effectively and efficiently with central sites

Human resources at satellites sites

To provide the HIV care services, the satellite clinic should have the following human resource capacity:

- Staff to provide patient triage, clinical care and treatment of OIs, patient monitoring plus/minus ART (Nurse and/or clinician. Ideally, if a nurse is providing clinical care she should have been trained (Primary Level Management Of HIV Patients) and they should be working under the supervision of a clinician and be able to communicate with the clinician during clinic times (e.g. through a Clinicians Hotline). Furthermore patient referral for assessment and/or treatment by a clinician as described above should be possible.
- Staff to provide adherence counseling, post pharmacy counseling and community-based treatment and support (community health workers supervised by a nurse)
- Staff to dispense drugs and ensure proper inventory management (trained pharmacist)

The satellite must have a clinician support and supervision in order to initiate ART.

As with the central sites, satellite sites may also face challenges of staff turnover and inadequate staffing levels. DHMT should ensure that satellite sites have adequate staff deployed from the central site or other health facilities when necessary to address staff shortages. The central site can assist the satellite site to advocate to relevant authorities (e.g. MOH) for structured deployment and staff replacements where there is a transfer. If satellite sites are unable to provide adequate staffing, it may be prudent not to set up services until such time that the HR needs can be met.

Task shifting is already happening and is expected to increase with decentralization of HIV care services. Task shifting at the satellite level can involve the use of different cadres of professional staff as well as community members, people living with HIV, and peer educators in the care of patients. Task shifting should take advantage of the MOH community health strategy and utilize these structures to facilitate community patient treatment support, defaulter management, referral people suspected of TB and follow up. It should always be implemented in a way that maintains and promotes quality of care, and may require a support package for each of the cadres, which should include training, mentorship, job aids, SOPs etc.

3.3 Community Participation in HIV Care and Treatment

Communities need to be empowered and provided with resources so that they fully participate in the development and delivery of care and treatment services. NGOs and associations of PLHIV need to be involved in HIV support.

Key stakeholders in the community include PLHWA and their families, community-based organizations, church, administrative and traditional leaders, schools, and CHEWs or other existing health volunteers. The community can interact with HIV services in a number of ways as follows.

- Home-based and palliative care provision
- Referral of patients for counseling and testing or HIV care services
- Referral of patients for assessment of TB and other health care interventions
- Follow up of patients on TB treatment
- Community-based ART support and defaulter management
- PLHWA support groups can provide peer support for disclosure, adherence support, and psychosocial counseling.
- Psychosocial counseling and spiritual counseling and support
- HIV prevention education including prevention with positives, behavior change communication, and condom distribution in the community.
- Integration of HIV care services with other community-based programs, e.g. microfinance, agriculture, etc.
- House-to-house counseling and testing
- Defaulter tracing
- Advocacy and stigma reduction

The main strategy for involving community is to train community members, with particular focus on PLHWA to carry out clearly defined tasks such as treatment adherence counseling, supporting patient self management, and providing counseling and testing, prevention services, and palliative care in the community. Working with the MOH community strategy may facilitate HIV specific community based interventions. Other community resources should be identified relationships established between care and community resources. In terms of decentralization of HIV care services; there is a clear need for developing effective communication and referral systems between community and the health facility.

3.4 Guidelines Defining the Relationship between Central and Satellite Sites

1. The central site should ideally support satellite clinics/facilities that are located within the same district, and preferably in the same catchment area. The central site and satellite site should ideally have an existing administrative relationship, although this does not preclude any decentralization models across the various health networks, e.g. GOK – FBO, FBO – private, GOK – private. This facilitates ease of management under the existing ministry of health and provincial/district administrative management structure. This would also facilitate logistics management. The models of care should as much as possible build on existing systems or ultimately aim at strengthening sustainable systems. Decentralization outside the public sector administrative structures should nonetheless be channeled through the DHMT, which should remain in overall charge of the process in the district.
2. Satellite sites may be supported to provide different levels of HIV care services. This may vary from the basic HIV package of care to a more comprehensive service which may include any or a combination of the following: recommending patients for ART; initiating, ART; follow-up of patients on care and ART; basic OI management; etc.
3. The level of responsibility of and of services offered by the satellite can change over time. The local management (DHMT and the district clinical lead), the capacity of the satellite site including human resource availability, capacity, training and mentorship as well as access to laboratory networking services and logistics systems will determine the level of services offered at the satellite site. Patient volumes may also influence the level of services that satellite sites offer. Thus, in high volume areas, satellite sites may have patient volumes comparable to those at district hospitals elsewhere.
4. The community is another key level involved in decentralization. Effective use should be made of existing community organizations and the yet to be implemented MOH community strategy to ensure that patient care at the community and home level complement and support the care at health facility level. The approach to decentralization must take into account the levels of health care system that is offering or being prepared to offer care and/or treatment of HIV-infected individuals.

3.5 Steps to Implementing Decentralization

The process proposed to ensure successful realization of decentralization is described below. This description has been informed by “best practice” observed in parts of the country where decentralization is already being implemented. In situations where decentralization has been implemented but is not working well, the process described may be used to review management structures and systems and to guide changes needed to ensure success.

Management

The decentralization process includes local managerial capacity building, accountability, clear transparency, division of responsibilities, and adequate funding to meet the local priorities. In addition, coordination functions must be regionalized in order to be effective in responding to day-to-day needs arising from facility level activities.

To further assist with decentralization roll-out, there will need for on-going feedback mechanisms from central sites to the DHMT, PHMT, and to the national level to monitor results of decentralization, appropriateness of the model, and to aid with the development of standardized tools for assessment, preparation, and activation.

Planning and Preparation

Within a geographical or administrative area, a global view of the region should be considered in the overall plans for decentralization. Where satellite sites are being developed for HIV care and treatment, regional goals should be a consideration in the patient intervention targets and overall plans. The planning process of decentralization should go through the following stages:

1. The DHMT should carry out an assessment of and map the resources in the district. This stocktaking process should include the capacity of each organization or agency or groups to support decentralization as well as other strengths of major partners. It should also include the location of stakeholders, partners, facilities and organizations in the district leading and/or providing HIV prevention, care and treatment.
2. There should be a review of the regional universal access targets for 2009/2010 based on the national targets and local HIV prevalence. The district health management team (DHMT) should be in charge of, and lead this process. This review will help define regional needs and thus the services necessary to provide these needs. Stakeholders involved in the regional decentralization process should be cognizant of these targets and take them into account in developing individual interventions and plans.
3. The DHMT should work with stakeholders to translate the universal access targets into local goals and targets and give clear time lines
4. The DHMT and local stakeholders should develop an operational plan for decentralization in the district.
5. The plan should include clear definition of leadership, definition of what needs to be done to meet the goals and targets, how they are going to be achieved, who is to be responsible for different aspects and timelines. This plan should define the level of decentralization required for each district/region, the sites to be targeted for decentralization. An illustration is given below:

In order to meet the universal access targets for HIV prevention, care and treatment services for district u , v number of PLHWA in living in district by 2010 should be provided with at minimum the basic care package. Thus, *all* health centers and x number of dispensaries in the district will need to provide HIV care services to w number of patients with the basic care package including prevention including education, condom distribution and provision of other contraceptives; patient referral; dispensing of cotrimoxazole and multivitamins; counseling and support; adherence support and defaulter management at community level. This process would also involve z CHEW areas in community support of BCP delivery.

6. Once overall regional targets have been defined and the operational plan made site.
7. Specific activities should be developed and be prioritized accordingly.
8. The DHMT should identify an individual to be tasked with coordinating decentralization of HIV prevention, care and treatment within the district.

Step 1: Assessment and Preparation of Central Site

- The DHMT in collaboration with the PHMT and hospital management conducts a formal assessment of the central site(s) to determine if the central site(s) is (are) ready to support decentralization. Refer to **Appendix A** for the assessment checklist and to Section 4 below for more details.
- Identification of areas for capacity building of the central site followed by an appropriate response to ensure that the central site can support the development of other facilities
- The central site together with the DHMT in consultation with the PHMT should determine the number of satellite sites it can efficiently manage for adequate patient care based on their human resource and logistics capacity. This should take into account the need for regular supervision and satellite site-based mentorship
- Mapping and allocation of geographic catchment areas to central sites.

Output:

- DHMT in collaboration with the PHMT approves central site for support of decentralization
- Appropriate capacity building to be arranged to realize the above
- Satellite sites identified for decentralization.

Step 2: Assessment and Preparation of Satellite Site

- DHMT and Central site staff conduct a formal assessment of the satellite site to identify existing capacity and services and capacity-building needs. Refer to **Appendix B** for the assessment checklist and to Section 5 below for more details.
- Identification of the capacity-building areas required to strengthen the satellite site for HIV service provision. This should be followed by an appropriate response to ensure that the satellite site can provide the desired level of HIV prevention, care and treatment.
- Detailed outline of systems, logistics and infrastructure necessary to support decentralization process (e.g. lab networks, infrastructure, human resource needs, reporting, commodity management, communication)
- Developing a framework for community linkages
- Together the DHMT, Central and Satellite site should deliberate over and write an agreement that defines functions, roles and responsibilities of both the central and satellite site.

Output:

- An agreement reached on the level of services to be offered at the satellite site.
- Agreement reached on the level of supervision required to initiate services.
- Clear SOPs on flow of commodities, reporting and communication
- Clear SOPs on laboratory services available in network with central site
- Central site and satellite site clearly define upward referral mechanism for patients who cannot be managed at the satellite site.
- Central site and satellite site clearly define downward referral mechanism for patients in HIV care for ongoing follow-up at the satellite

Step 3: Activation

- Activation is the period of intensive mentorship of the satellite site by the central site. The goal of site activation is to ensure that patient flow works well, clinic systems are in place and health care workers understand and use the systems correctly. Activation should also clarify logistics and commodity management systems.
- It is best for activation to occur through on-site visits to the satellite site by central site staff; this can be a consolidated long visit or multiple visits over a period of time. Attachment visits of the satellite site staff to the central site may also be used, however systems between such facilities are often too different to enable lessons learned from central sites to be effectively put to use in satellite sites. (Refer to Part III below for capacity-building areas.)
- Activation may also involve workshops, meetings, etc organized through the DHMT to ensure coordination within the district and to maximize capacity-building across several satellites.

Output:

- The satellite site has a foundation of technical skills, strengthened systems, and additional capacity to increase the level of HIV care provided on-site.

Step 4: Continuation

- On-going supportive supervision, mentorship, and capacity building by the central site to the satellite site.
- On-going assessment of the quality of HIV services provided at the satellite site.
- Mentorship focused on identified gaps in capacity.
- Increased capacity of staff at satellite site to offer an increasing complexity of HIV care and treatment with the result that supervision and mentorship requirements may become less intense or evolve over time.
- Response to any changes in staffing over time (turnover of managerial or clinical staff may often result in beginning the process of capacity building all over again)
- Downward referral of stable patients on ART from the central site to the satellite site for on-going clinical management and follow up. Satellites with clinical capacity may be able to initiate ART.

Output: The satellite site maintains and/or increases the HIV prevention, care and treatment capacity over time while maintaining and improving quality.

Step 5: Sustainability

- The satellite now has the appropriate level of capacity to provide quality HIV care and treatment services at the defined level with minimal assistance from the central site.
- HCWs at satellite receive support and mentorship through DHMT and district-wide continuous medical education
- Linkages between the central and satellite site will mainly be for reporting, commodities supply, lab network and upward referral for treatment complications.

Output:

- Successful decentralization of responsibility.

The length of time that decentralization process moves between stages can be very short or very long depending on the specifics of the context in which the decentralization is occurring.

Case 1: District-based Decentralization of HIV Care and Treatment: Kitui District, Eastern Province (DHMT Support)

1.0 Introduction

The larger Kitui District is 20,402 sq Km in size with a population of 586,811 .The prevalence of HIV in the district is 5.8%.

ART services in Kitui District begun with the district hospital in the year 2002. Later Muthale Mission Hospital and Mutomo Mission Hospital also began offering services.

1.1 Decentralisation of ART in Kitui

The cumulative number of patients on care and those on ART has continued to rise through the years and therefore the hospitals have become congested. Due to the vastness of the district a large percentage of clients still cannot access care. In view of this, the DHMT through RRI implemented the decentralization model and 4 satellite sites were started in April 2007 .Kitui District Hospital acted as a Central Site. By April 2008 the hospital was serving 5 satellite sites(Kauwi,Ikutha,Ikanga,Mutito,Yatta) and conducting fortnightly mobile ART services to 3 sites (Mbitini,AIC Zombe,Kanyangi).

This resulted in an increased rate of recruitment and decongesting of the District Hospital as shown below.

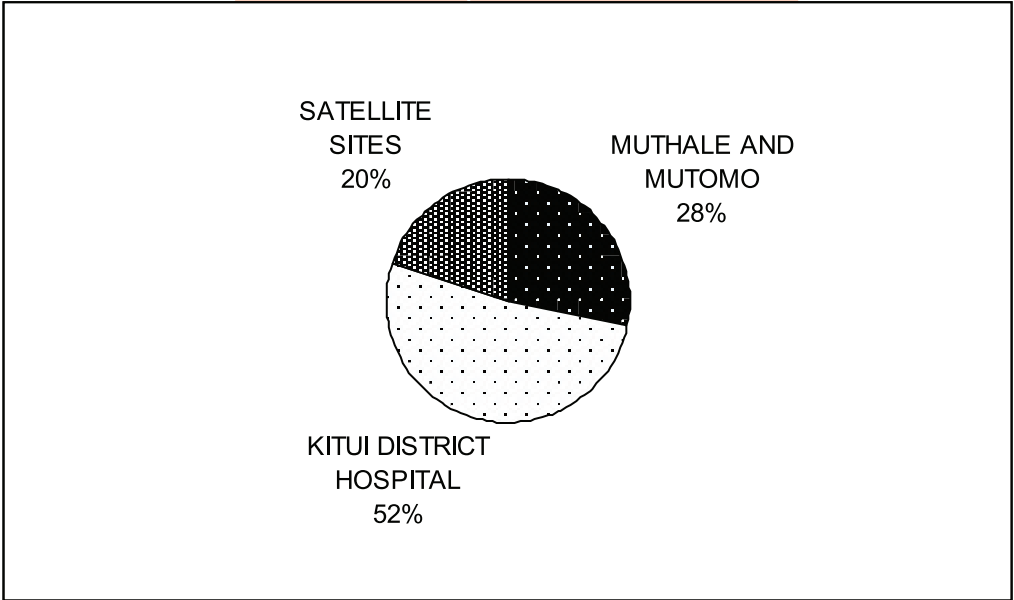
Table on ART Data for the entire District as per the Year

MONTH/YEAR	CUMULATIVE PATIENTS ON CARE	CUMULATIVE PATIENTS ON ART
DEC 2005	2030	746
DEC 2006	4023	1201
DEC 2007	5002	2729

Table on ART statistics per facility as at December 2007

FACILITY	PATIENTS ON CARE	PATIENTS ON ART
MUTHALE MISSION HOSPITAL	230	109
MUTOMO MISSION HOSPITAL	1095	667
KITUI DISTRICT HOSPITAL	2701	1404
KAUWI H/C	256	135
IKUTHA H/C	132	95
MUTITO SDH	173	80
IKANGA H/C	189	94
YATTA H/C	77	37
MBITINI H/C	140	101
AIC ZOMBE DISP	9	7
TOTAL	5002	2729

As shown in the pie-chart below, satellite sites contributed 20% of patients on ART as at December 2007.



Bearing in mind this happened over a period of 9 months, this percentage is expected to increase in the following year.

1.2 Discussion

The above achievements were made possible due to the fact that there was a constant supply of Anti-Retroviral Drugs to the satellite sites through the central site. The central site is supported by GOK/NASCOP.NASCOP through KEMSA honored orders placed.

There however is still a large percentage that is un-reached hence the need for increased decentralization of services even to every facility as they have done with TB drugs.

1.3 Challenges & Constraints

- Supply of Drugs for opportunistic infections for example acyclovir is inadequate to cater for the satellite sites
- The deadline for monthly reports is difficult to achieve.
- Regular supportive supervision is difficult to perform due to lack of staff, fuel
- Inadequate storage facilities at the District Hospital hence need to create another central site.
- Division of the district into Kitui South and North has resulted in the need to create a central site in Kitui North as soon as possible.

Case 2: District-based Decentralization of HIV Care and Treatment: Suba District, Nyanza Province (Partner Support)

Management and supervision:

- District health management team (DHMT) involved in the process including site selection and supervisory visits
- District ART coordinator manages HIV treatment and care-related issues including decentralization

Model:

- Central “hub” site/s are Sindo District hospital and Sena Health centre for the islands
- Satellite sites are health centres and dispensaries within the district (14 sites in total; 12 providing ART including pediatric treatment. The other 2 providing basic care packages)
- Clinical staff at satellite sites are trained on adult and pediatric ART using NASCOP didactic curricula. Some staff come for attachment at a cenral site for more intensive clinical mentoring, but this is not a prerequisite for having services at the peripheral site.
- Multidisciplinary support team from the central site visits each peripheral site one day per week.
- Support team is made up of a clinical officer, nurse, CCHA (Clinic and community health assistant – a cadre of lay health workers)
- Sometimes Pharm tech monitoring and evaluation staff and lab staff join the support team
- Supervisory visits from DHMT may also occur as part of the site visit

Operationalization/Activation:

- Use of clear objective criteria to determine when the site is ready for ARVs (use standard evaluation tool where the site staff review the services they offer and can see what’s required to move to the next level, etc.)
- Peripheral site picks one day which will be the HIV clinic day as the services begin
- Once they have at least 10 patients booked on that day then the support team starts to visit (less patients than that does not allow enough for mentoring)
- As more patients are enrolled the site books on that days of the week and saves more complicated patients, peditrics patients etc for the day the support team comes
- Site has access to ULIZA hotline for any questions on days when mobile team in not there
- Mobile team provides clinical mentoring, consultations and technical assistance on.

- o Medical records
- o Patient flow
- o Referral sources/linkages
- o Commodities management
- o Data collection and reporting
- o Patient HIV education and counseling, defaulter management
- o Clinical mentoring and support of task shifting
- o +/- supervision by DHMT
- Specimens are collected during mobile visits so all patients have access to all the lab tests which are run at the central site. Results are returned the following week with the support team (or can call for urgent results)
- ARVs generally come from central site; occasionally delivered directly to the satellite site. Peripheral sites make returns to central site and orders to NASCOP are made centrally
- Non medical duties are shifted to CCHAs so that nurses and COs can focus on clinical care
- Sites receive quarterly progress updates using the data they produce, in easy to interpret formats such as graphs
- Additional support to sites as able: furniture, clinical equipment and supplies, diaries, CME, training opportunities.

Important observations from experience:

- ART has been introduced very quickly at sites since the mobile team is there every single week on a specified day. Early on, ARV initiation takes place on the support day. As site staff gain skills and confidence they can start initiating patients on other days.
- Pediatric ART has been scaled at the same time as the adult ARVs for same reason as above
- If support day becomes too busy then mentoring suffers because everyone is busy just clearing the queue. Recommend 1. Support team includes more than one clinician so that one person can assist in clearing the queue and the other can focus on mentoring. 2. The support day is booked lighter than other days so that the focus can be mentoring. 3. Regardless of how busy the clinic is, mentoring always takes place for a certain number of clinic encounters before starting to clear the queue
- Lay health workers are essential. Task shifting to CCHAs results in more clinical time for nurses and CCHA involvement also results in improved clinical organization, reporting, better patient education and adherence counseling and additional services such as defaulter tracing and support groups.

- Staff absenteeism is common at peripheral sites but improves greatly with regular visits from DHMT
- “How to run an HIV clinic’ is not taught in ART courses and cannot be learned on attachment at big sites since the systems are very different in small sites with minimal staff. Technical assistance in this area is essential, particularly early on in the service
- Supply chain may be slow to respond to new ARVs to allow peripheral sites to have buffer stock, despite timely orders. This creates dangerous situations if the support team cannot visit for any reason, or if consumption increases more than expected. Recommended: work with KEMSA to allow buffer stock at peripheral sites
- Quality of care needs to be continuously emphasized by all parties and systems created to review on a regular basis the quality of patient care and implement changes that provide desired outcome.

Case Study 3: Case Study: St Joseph Mission Hospital-Migori and Asumbi Mission Hospital.

St Joseph Mission Hospital, located in Migori (Nyanza Province), has provided comprehensive HIV care and treatment services since 2004. In 2007, they were asked to support Asumbi Mission Hospital in recognition of the high HIV prevalence and care and treatment needs. Although the two facilities are located in different districts, St Joseph was the closest mission hospital with the capacity to provide intensive mentorship to Asumbi and they both fall under the Diocese of Homa Bay.

The senior leadership and HIV care staff held a series of collaborative planning meetings to clearly identify roles and responsibilities of each health facility, including supply chain, reporting, lab networking, community follow-up, funding, staffing, etc.

AIDS Relief assisted with assessment, funding, and additional mentorship, while APHIA II also provided additional complementary support to Asumbi.

In December 2007, St Joseph staff began traveling once a week to Asumbi to provide on-site mentorship to build capacity for comprehensive HIV care and treatment services. Staff from Asumbi also visited St Joseph to learn from their CCC model, build capacity, and exchange ideas.

Once Asumbi's CCC was established, Homa Bay District Hospital referred over 100 patients living in the Asumbi catchment area to Asumbi for follow-up care and treatment.

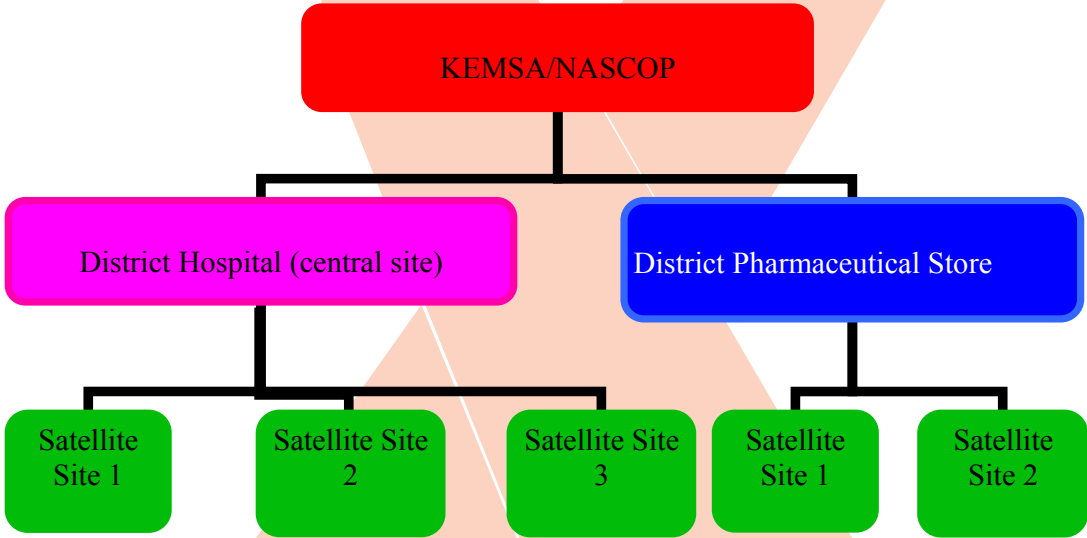
Currently, Asumbi conducts daily patient enrollment, care and adherence support at both facility and community level, while ART initiation is done during mentorship visits by St Joseph staff. As capacity is built at Asumbi over time, the role of St Joseph will expected to decrease.

4.0 SERVICE DELIVERY SYSTEMS

4.1. Pharmacy Commodity Management

The NASCOP decentralization model uses a commodity management system in which the satellite site is either attached to a central site or to the District pharmaceutical store for ARVs re-supply. The figure below provides a diagrammatic view on how the decentralization of pharmaceutical management was modeled.

Figure 1: ART Pharmaceutical Management Decentralization Model



Satellite sites access their supplies of ARVs and opportunistic infection (OI) drugs from a central dispensing point such as a district hospital or a district pharmaceutical store on a monthly basis. Central sites should have the infrastructure and human resource capacity to mentor and supervise pharmaceutical management at satellite sites.

Please refer to Appendix C: Public Sector Antiretroviral Commodity Flow Pipeline and Appendix D: Public Sector ART Commodity Information Pipeline for diagrams that provide additional information about the system for commodities management in decentralization.

Roles and Responsibilities in Decentralization of ART Pharmaceutical Management

A) National level

- National quantification
- Coordination commodity supply and re-supply
- Policy and guideline formulation,
- Quality assurance and supervision
- Standardization of procedures
- Coordinate trainings
- Support PHMT, DHMT and HMT in upgrading of the standalone facility to a Central site or use of the District store for ART decentralization

B) Central Site or District pharmaceutical store

- Quantifies for and orders commodities for ART, PEP and PMTCT.
- Receives and stores ART commodities.
- Issues ART commodities monthly to the satellite sites (and to central site where relevant).
- Receives monthly reports from Satellite sites, aggregates and compiles the reports for onward transmission as required by the national ART program on a timely basis.
- Liaises with the relevant ART supply chain for commodity supply, distribution support, and product quality issues.
- Organises with DHMT or other relevant personnel for distribution of the commodities, guidelines and tools to the satellite sites.
- Provides drug information and technical assistance to satellite sites, treatment partners and other ART program staff at district and regional level in matters related to ART commodity use
- Conducts Monitoring, Supervision and Mentorship of Satellite sites to ensure quality services.
- Ensures rational use of ART commodities at satellite sites.
- Regularly checks the satellite site data collection and reporting tools to ensure proper maintenance of these records.
- Sets up linkages with other central sites / district stores or standalone ART facility for ART commodity support (e.g. re-distribution), and sharing of knowledge and experiences (best practices).

- Sets up linkages with and gives feedback to the HMT, DHMT, PHMT, treatment partners and other relevant ART program stakeholders on matters related to ART commodity management.
- Provides on-the-job training of other pharmacy staff on decentralised ART commodity system and maintains a handover system to ensure continuity.
- Identifies and supports satellite sites

C) Satellite site

- Receives ART commodities from central site or District store
- Stores ART commodities as per the storage guidelines
- Conducts a regular monthly physical inventory count in time for monthly report preparation
- Identifies short expiry, expired or damaged stock and liaises with the central site or District store for appropriate return or disposal.
- Dispenses ARVs and related drugs according to ART treatment guidelines and ensures rational use via medication use counselling.
- Maintains the records for all the ART commodities on a daily basis
- At the end of the monthly reporting period, determines the quantities of ART commodities to order based on the consumption and Max-Min level
- On Monthly basis, accurately and completely fills out and sends the completed report to the central site or District store by the reporting deadline
- Provides on-the-job training of other pharmacy staff on ART commodity system and maintains a handover system to ensure continuity.

2. Laboratory Services

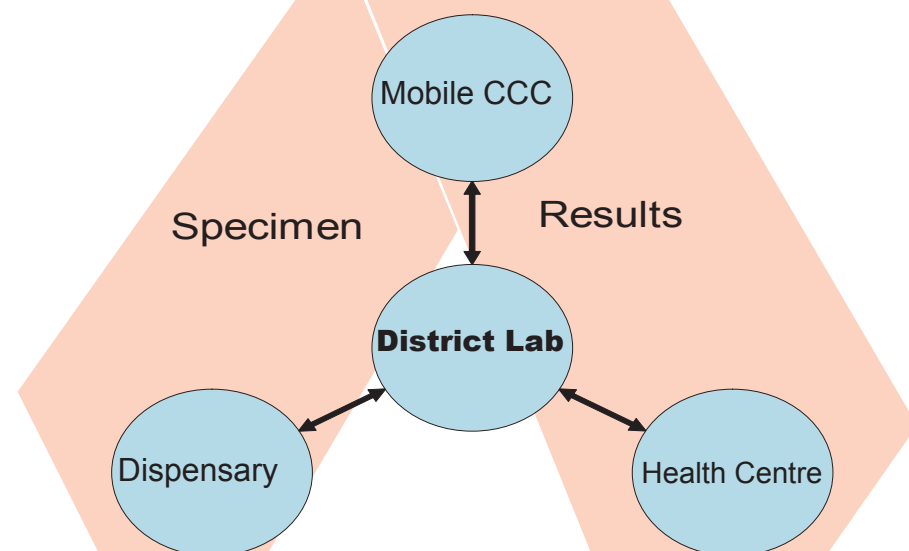
Laboratory services, an integral part of a comprehensive HIV care and treatment program, are needed to determine the HIV status of individuals, monitor the effectiveness of ART, and monitor side effects caused by ART. The decentralization of laboratory services is in line with the health sector reforms in the efforts to reverse the declining health trends of the people. There is need to support decentralization of this service from the district hospitals to health centers to bring services closer to where the people live, to enhance their ability to access services and adhere to care and treatment.

The high cost and level of administration of some of the required lab tests may determine which tests are needed and at what level. Please refer to **Appendix E: Lab services and equipments suitable for each decentralized level.**

A lab service networking system must be established to assure the effective transfer of blood samples from the peripheral level to the district and reference level where the CD4 count is performed, and the discrete and reliable reporting back of results from the reference center to the peripheral level.

- Bleeding days, mode of transport, cold boxes (potential for linking with immunization program resources), and cost of sample transport must be considered. Private channels for sample transport can also be explored, for example the availability and cost of courier services.
- Required documentation
- SOPs

LAB NETWORKING



A system for logistics and distribution and lab commodities must also be in place. The decentralization model should adopt the principles of *KENYA HIV TEST KITS* logistic system, which has been in place since 2005. Other references can be found in *Appendix F: Public Sector Blood Safety Commodity Flow Pipeline* and *Appendix G: Public Sector Laboratory Commodity Information Pipeline*.

Roles and Responsibilities in Decentralization of ART Laboratory Services

A) National level

- Coordination commodity/equipment mobilization,
- Policy formulation,
- Quality Assurance and supervision (NASCO, NPHLS, Reference Lab)
- Standardization of equipments
- Standardization of procedures
- Forecasting and quantification for national use of lab commodities and maintenance of database for use in quantification
- Coordination of training

B) Provincial level

- Coordination (PMLT) of provincial laboratory service
- Referral points (PGH)
- Quality Assurance
- Coordination of training
- Deployment of staff allocated to the PGH to central site and, when applicable, to a satellite

C) District Level/Central Site

- Coordination (DMLT) of the district laboratory services.
- Request lab reagents and consumables for the district services.
- Assess the condition of the equipments in used in the district lab
- Monitoring lab supplies and consumables to service delivery points
- Collect and assess commodities orders from health centers and dispensaries
- Discuss with DHMT on allocation of funds collected through cost sharing
- QA supportive supervision on lab equipment guided by SOPs
- Review commodities orders from satellite sites(sub-district hospitals, health centers and FBOs/ NGOs) supplied from the District stores (e.g. Rapid test kits)
- Monitor the flow of lab report sample flow from and to the referral sites (networking)
- Training, coaching, and support supervision to all the satellite sites served by the district stores
- On Monthly basis, accurately completes and sends the report as per established national reporting system.

4.3. Monitoring and Evaluation (M&E)

An efficient data monitoring and evaluation system is a key element of the decentralization process and for the success of HIV/AIDS program in general. Decentralization brings stakeholders together, which can improve the flow of information to support informed decisions making and performance evaluation at each level. M&E systems at the central and satellite site must be in line with the “Three Ones” policy, and M&E tools and indicators for decentralization must be compliant to the national M&E framework. Systematic collection, analysis, and reporting of information in a decentralized system will allow the MOH verify compliance with policy goals, analyze outcomes, and guide decision-making.

The minimum data collection tools that must be in place at the satellite site are the following:

- The patient appointment card
- The patient card (Blue card)
- CCC Monthly Summary sheet
- Pre-ART register
- ART register
- Patient Appointment Diary
- Cohort Summary

Appendix H: HIV M&E Data Flow clearly illustrates the reporting model to be used in decentralization. The facility in charge, DASCO, PHMT and NASCOP M&E manager are responsible for coordination of data collection, collation and onward submission to national level. Information generated at the facility level flows to the district level for compilation and analysis for further submission to the provincial and national level. Utilization of M&E data for decision making is encouraged at each level. Feedback mechanism from the central MOH and NASCOP level to the health facilities is essential and can be provided during supportive supervision, in regional and district stakeholders fora, or through quarterly bulletins and annual reports.

5.0 CAPACITY BUILDING OF SATELLITE CLINICS

Satellite sites will need significant capacity-building during transfer of responsibility of HIV care and treatment service provision to ensure that quality of care is maintained and systems, infrastructure, and logistics are well established.

5.1 National, Provincial, and District responsibilities in capacity-building

NASCOP has developed national mentorship guidelines and mentorship tools to facilitate capacity building of various cadres of staff at the central and satellite sites through mentorship.

Coordination between NASCOP, PHMT, and DHMTs is needed for organization (and funding) of central trainings, including:

- Training in key technical areas: Adult ART, Pediatric ART, ART Commodity Management, etc. targeting central site and satellite site staff.
- Training in IMAI for satellite site staff.
- Identification and orientation of regional mentorship teams using the national mentorship guidelines, assessment tools and orientation package.
- Trainer of Trainers (TOT) and mentorship training for central site staff and for regional mentorship teams using the national mentorship guidelines and orientation package.
- Hold workshops on leadership and management skills for the district and central sites
- Identify needs of central site staff in management and program coordination capacity-building
- Identify capacity-building mechanism to support decentralization for those with added responsibility for quality improvement e.g. leadership skills, Monitoring, Training and Planning (MTP)
- Identification of the model and funding for Continuous Professional Development seminars at district and/or provincial levels to complement the on-site mentorship.

NASCOP will play a central role in the development and dissemination of tools to support capacity-building at both central and satellite sites. Tools required include the following:

- References (e.g. ART treatment guideline, clinical manuals)

- Job Aids for specific cadres of staff. (E.g. pharmacy (11 nationally adapted ones exist), lab, clinical (algorithms, dosing charts), nutrition, etc.)
- Standard operating procedures (SOPs)
- Appropriate registers, forms, cards, prescriptions
- Mentorship guidelines, assessment tools and checklists
- Supportive supervision tools and checklists

5.2 Central site responsibility for capacity-building

Decentralization is already occurring successfully in Kenya, and numerous central sites have the current capacity to proceed with decentralization. Any potential delays in roll-out of central trainings and/or dissemination of standardized tools should not prohibit on-going decentralization activities at the district level. The onus of satellite site capacity-building will largely fall on the central sites with support from the DHMT. It is therefore critical that the central sites are assessed closely to ensure that they will be transferring quality care practices and strong systems to the satellite sites during mentorship and supervision.

Mentorship and support

The national mentorship guidelines were developed to support the decentralization process by providing a standardized implementation framework for all service providers and to ensure that quality HIV care services are available at satellite sites. Mentorship support to the decentralization policy will help shift certain tasks from more specialized to less specialized health care workers and to ensure consistent translation of classroom training into simple practical approaches that will benefit the largest number of people.

Refer to **Appendix I** for the national mentorship program structure.

Central Sites

Central site should continuously mentor the satellite sites all aspects of comprehensive HIV service provision. The central sites should ideally develop a mentorship, site visit and site supervision schedule for satellite. The main areas of support will be in technical capacity and in systems capacity.

(a) Technical Capacity:

- Clinical mentorship should include six-monthly clinical monitoring criteria for the patients as part of quality assurance.
- Ensure that national ART guidelines are followed, and share updates in HIV care and treatment.
- Scheduling the clinic visits, patient appointments, bleeding days, drug collection days
- Maintaining patient records
- Adherence preparation and on-going adherence support models. Establishment of support groups.
- Defaulter tracing.
- Identification and mapping of the geographic catchment area.
- Establishment of community linkages: Identifying available community-based HIV services and linking to CACC. If not provided by other partners, then facilitation of mobilization, training, motivating, and monitoring community health workers/ volunteers. Ensuring that HIV treatment literacy, BCC, and other prevention activities occur at the community level.

(b) Systems Capacity:

- Upward and downward referral.
- ART related commodities management.
- Systems for HMIS reporting and drug commodity supplies should be integrated into the established MOH systems.
- Provision of the necessary training and tools to collect and report their data (patients, HIV-related commodities, etc) and facilitate timely accurate submission of monthly reports to the central sites.
- Establish a referral for laboratory tests between the central sites and satellites

5.3 Commodities Management

- Central site: Capacity-building to ensure that they can support supply chain requirements of satellite sites. Requires TOT training on ART and Commodity Management.

- Satellite site: Basic training on ART and Commodity Management. Satellites will receive pharmacy mentorship and supportive supervision from the central site on reporting, inventory management. Pharmacy staff should be able to provide disaggregated patient data on ART by regimen and age and OI medication by type (i.e. Cotrimoxazole or Fluconazole. Patients on Fluconazole should further be disaggregated by diagnosis i.e. esophageal candidiasis or cryptococcal meningitis)
- Both central and satellite sites should have and use the following tools: Daily Activity Register, Facility CDRR, Bin card, Expiry tracking chart, temperature logs, ARV Dispensing Tool (preferable in sites with more than 200 patients), job aids, national set of recommended SOPs.

5.4 Laboratory:

Mentorship should be provided to the satellite site by the central site on standard operating procedures, HIV testing, referral, reporting, and QA systems and inventory management. The central site will be responsible for laboratory needs for the satellite sites (CD4, Early infant diagnosis (EID), Biochemistry) to ensure that the satellite is able to provide minimum laboratory tests according to the national guidelines. Networking is an option for laboratories lacking critical tests. Lab networks established and strengthened. Training can be further specialized according to the cadre of staff at the satellite site:

Lab specialist/technologist

- Determining CD4 counts
- Performing viral load tests
- Performing chemical blood tests
- Performing HIV ELISA tests
- Managing stocks of reagents and other lab supply

Lab technician

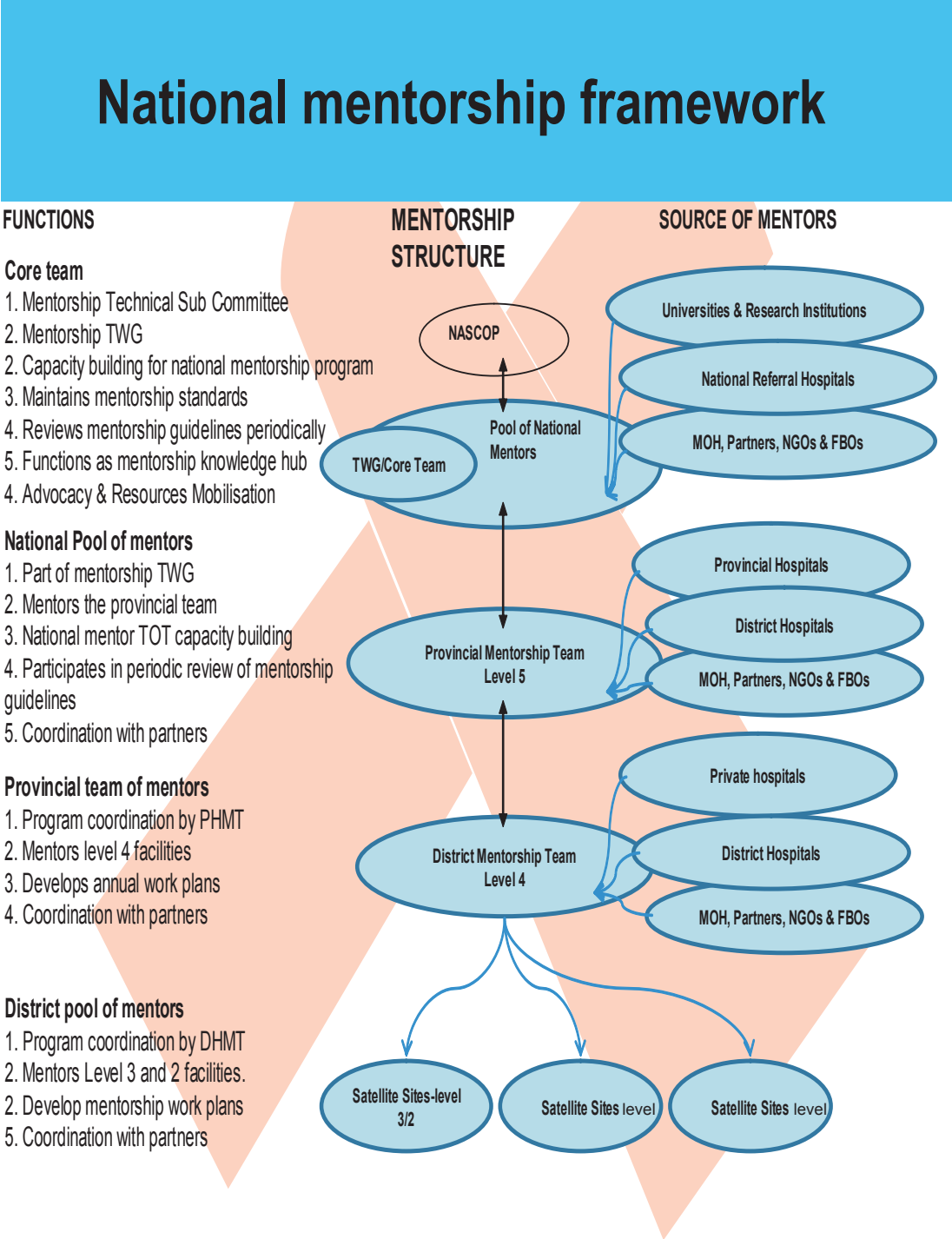
- Performing chemical blood tests
- Performing HIV Rapid tests
- Managing stocks of reagents and lab supply

5.5 Monitoring & Evaluation (M& E):

Capacity in M&E can focus on three levels:

- District level: The focus of the ART M&E unit is to strengthen decentralization by building the capacity of the districts to collect, analyze and use data at the local level before it is forwarded to the higher levels.
- Central site: Requires Training of Trainers (TOT) approach for efficiency of mentorship and monitoring data collection and validity at satellite sites.
- Satellite site: M&E capacity-building will be done through supportive supervision by the central site and will focus on:
 - o Validation of monthly reports
 - o Address challenges and constraints
 - o Mentorship
 - o Assessment and troubleshooting of data records and systems
 - o Collection of reports

6.0 LIST OF APPENDICES
Appendix A: National Mentorship Framework



Appendix B: Assessment Checklist for Central Sites

Central Site Capacity	Yes, meets Requirem ent.	Needs further capacity built before decentrali zation
Currently provides the following <i>comprehensive care</i> services: CT, PMTCT, TB/HIV, RH, HIV care and treatment, adherence support		
Has the minimum core HIV care team consisting of: MO, CO, Nurse, Pharmacy technologist/technician, Laboratory technologist/technician; nutritionist; health records information officer; social worker OR defaulter tracing personnel OR community liaison.		
Has a formal referral mechanism –upward and downward – to/from other sites for care and treatment (stable patients to the satellite sites and managing/referring complicated cases) including SOPs and referral tools.		
Has capacity either on-site or through established lab networks for: <ul style="list-style-type: none">○ Diagnostic -OI diagnosis tests, HIV tests○ Monitoring - CD4, ALT, Creatinine, Hemoglobin		
Has paper based M&E.? (please indicate if central site currently has electronic data collection system)		
Able to accurately complete patient data collection, M&E tools and monthly reports.		
Reporting HMIS data on time to NASCOP’s M & E department.		
The health care providers of the central site are practicing (hands on) at the facility and are able to provide mentorship and supportive supervision to satellite. (please indicate if the providers are ToTs)		
Has adequate logistical support and staffing levels to visit the satellite sites for regular supervision.		

Has proper HIV-related commodity logistics management to be able to forecast, quantify, order and report on time. Uses the following tools: Daily Activity Register, Facility CDRR, District CDRR, Bin card, Expiry tracking chart, temperature logs, Inventory Tracking Tool, job aids and national SOPs.		
Uses computerized information systems for HIV/AIDS-related commodity management efficiently (e.g. dispensing tool).		
Has adequate secure storage for HIV/AIDS-related commodities for itself as well as all the proposed Satellite sites. Bulk and dispensing stores are separate and the facility is compliant to recommended storage guidelines.		
Has functional <i>defaulter tracing mechanism</i> and demonstrates low defaulter levels.		
Has a system for preparing patients for adherence to ART and monitoring adherence to ART over time.		
Is linked to a community patient support network e.g. HBC, CBO, CHEWs.		
Has capacity to <i>transport the drugs</i> and other HIV/AIDS-related commodities to the Satellite sites		
Has capacity to <i>communicate</i> effectively and efficiently with satellite sites		
Implements Standard operating procedures (SOPs) for clinical management of patients and adhere to national guidelines.		
Able to access guidelines, manuals and job aids for distribution to satellite sites.		
Has financial systems and accountability to manage their own funds and the funds for the satellite sites in their management.		
Received prior approval by the PHMT and PHMT, in collaboration with the DHMT/DASCO, to undertake decentralization		
Has willingness and program management capacity to support additional satellites.		

☐ Central site meets the above requirements for decentralization.

Signature: _____

Date: _____

- ☐ Central site requires additional capacity build prior or in support to under taking decentralization (list comments on reverse).

<i>Capacity needed in the following area</i>	<i>Person/organization responsible</i>

- ☐ Re-assess capacity on: Month _____ Year _____

Appendix C: Assessment Checklist for Satellite Sites

Satellite Site Capacity	Yes, meets Requirem ent.	Needs mentor- ship and/or support
Has been formally assessed by the DHMT, PHMT and central site and approved as a Patient Support Center to provide HIV Care.		
Currently provides the following HIV care services (at minimum): CT, PMTCT, TB treatment, RH, adherence support, HIV care, follow up of ART patients.		
Has the minimum core HIV care team consisting of: a clinician and/or nurse; Nurse/Counselor; Pharmacy personnel		
Has formal referral mechanism upward to central sites for care and treatment and down to the community for support.		
Has access to basic lab tests and CD4 tests, either on-site or through formal lab service networks.		
Is able to maintain the required HMIS data collection tools, and generates monthly reports on time.		
Has basic inventory management system to be able to quantify order and report on time to the central site.		
Has adequate AND secure storage space for the HIV-related commodities required for its patient load.		
Has a functional defaulter tracing mechanism.		
Has a system for preparing patients for adherence to ART and monitoring adherence to ART over time.		
Is linked to a community patient support network e.g. HBC, CBO and CHEWs.		
Has capacity to communicate effectively and efficiently with central sites		
Implements Standard operating procedures (SOPs) for clinical management of patients and adhere to national guidelines.		
Have copies of HIV care and treatment guidelines, manuals and job aids on-site.		

☐ Satellite site meets the above requirements for further decentralization of ART services.

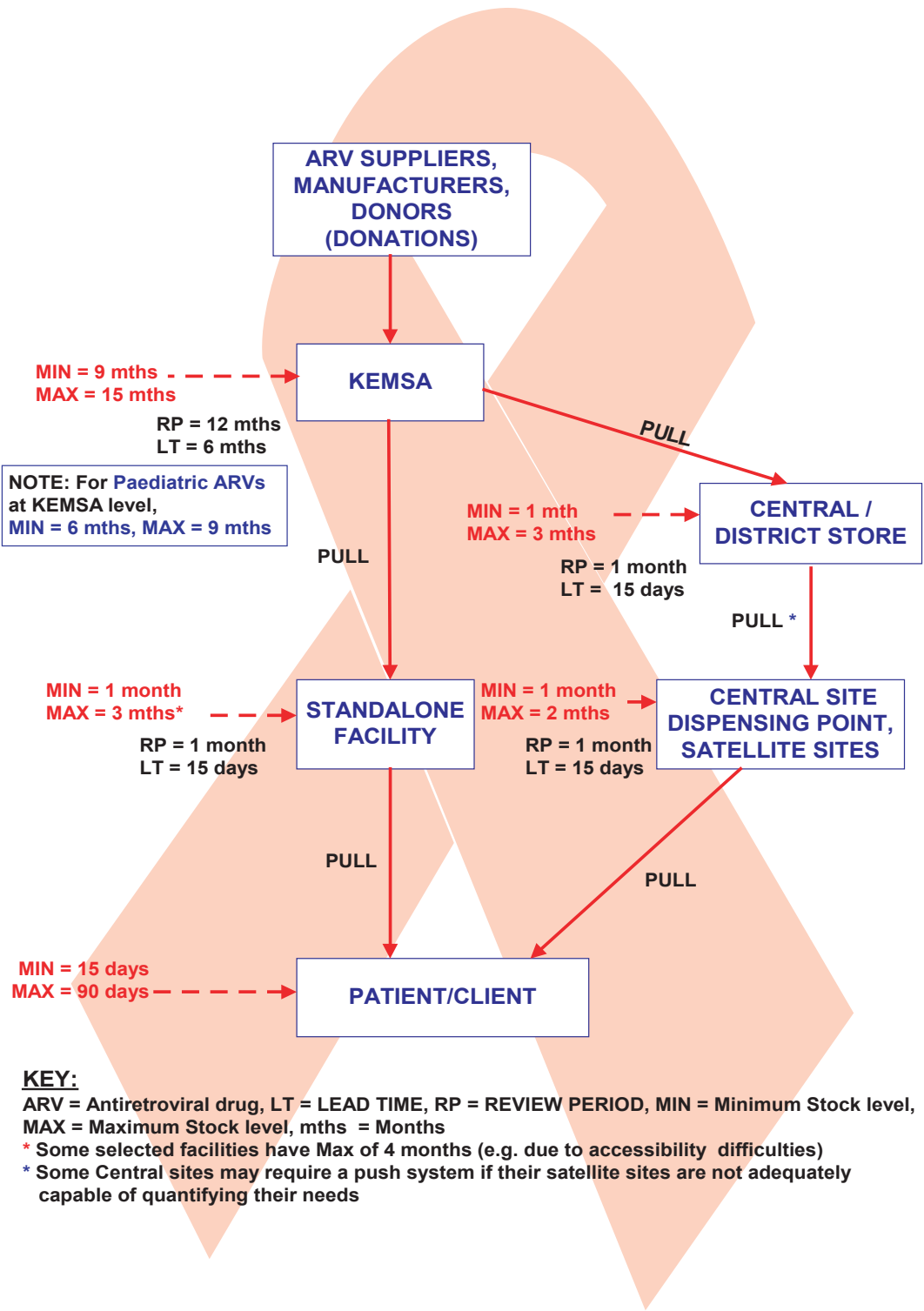
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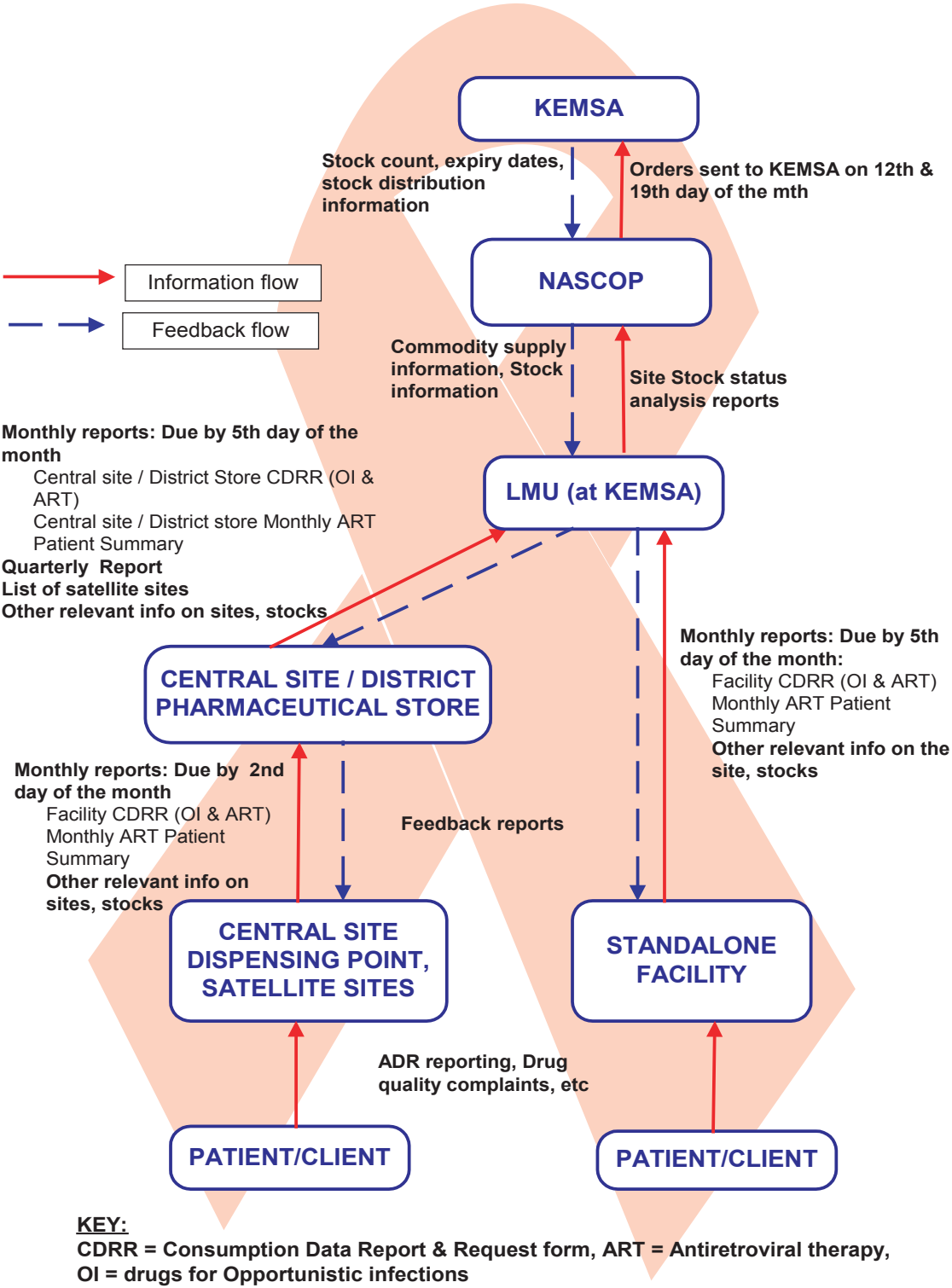
☐ Satellite site requires additional capacity or support:

<i>Capacity needed in the following area</i>	<i>Person/organization responsible</i>

Appendix D: Antiretroviral Commodity Flow Pipeline



Appendix E: ART Commodity Information Pipeline

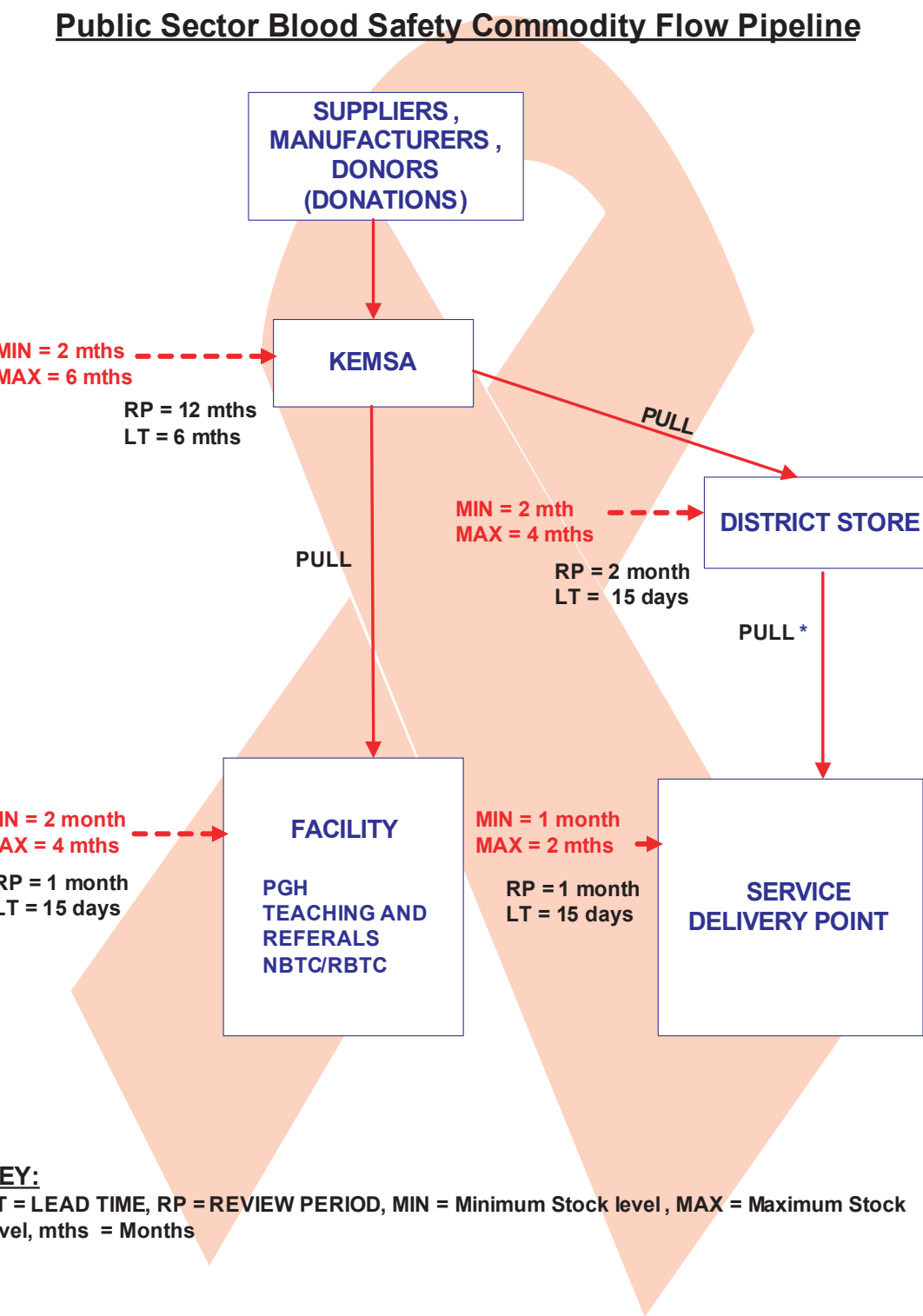


Appendix F: Lab services and equipment suitable for each decentralized level
(Refer to NPHLS policy guide on Medical Laboratory Services of Kenya)

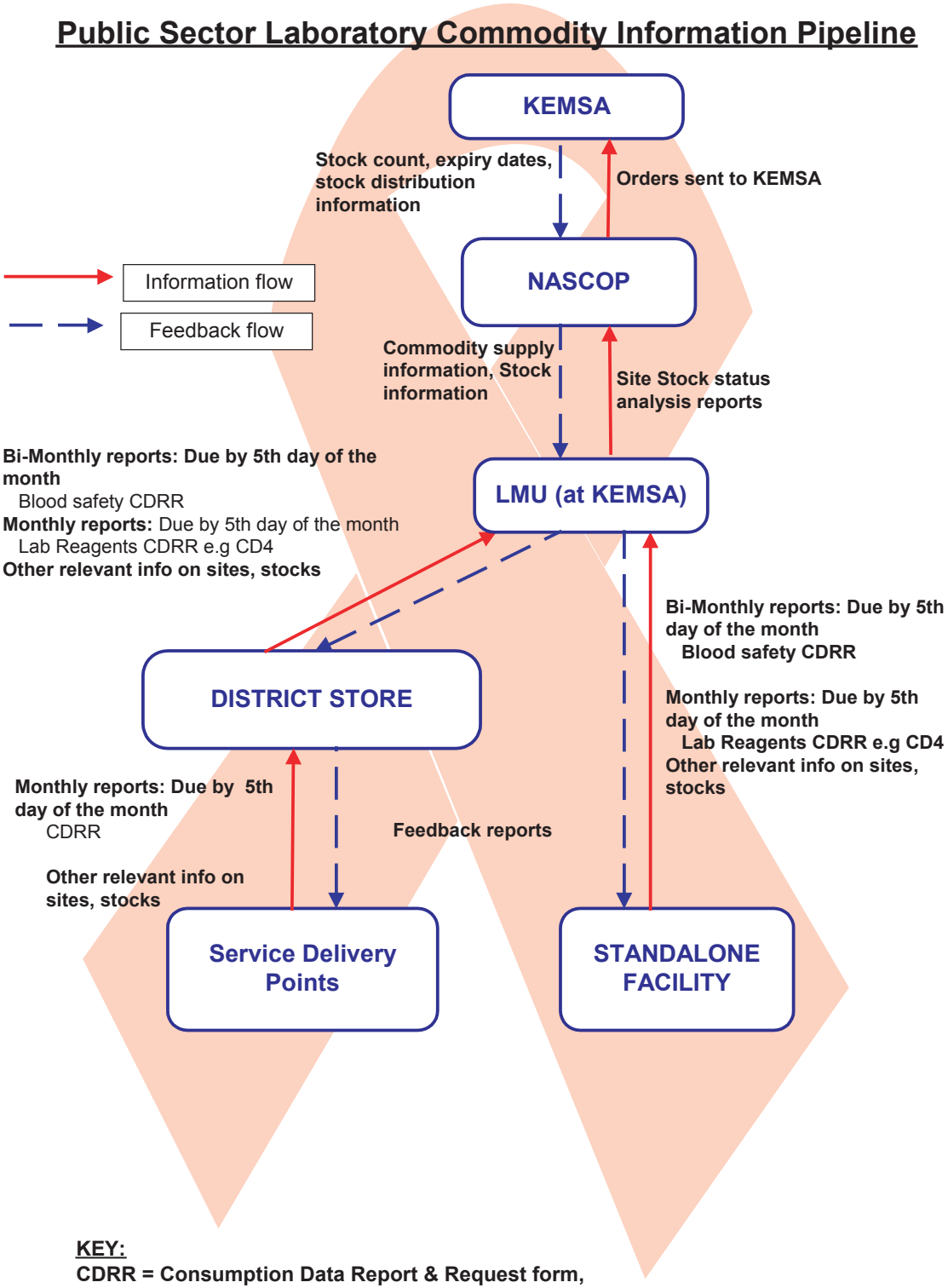
	Level		
	Dispensaries / H/centers	District labs	Reference labs
Services	<ul style="list-style-type: none"> • Rapid HIV testing • Hematocrit level • Hemoglobin level • Routine collection & analysis of Blood for malaria, Z-N for AFB in sputum , blood for syphilis, Urinalysis/ pregnancy test and blood for random glucose • Manual CD4 Counts • Referral of specialized investigations- DBS for PCR, Auto CD4 CD4 % & Chemistry 	<ul style="list-style-type: none"> • All primary level + • HIV ELISA testing • Hemoglobin level • Hematocrit level • Auto Total Blood Counts & Indices • Auto Differential blood counts • Urea & Electrolytes • ALT & Creatinine • Bilirubin level • HCV & HBsAg • CSF Analysis • Serum CrAg • Absolute CD4 count & % CD4 	<ul style="list-style-type: none"> • All district level + • Blood for Viral load-DNA-PCR • Fluorescent TB Diagnosis • Sputum culture & susceptibility testing • Cytology • Lipid profile • Blood screening for HIV,HCV & HBsAg • PSA • Bleeding & Clotting tests

Equipment	<ul style="list-style-type: none">• Microscope• Hematocrit centrifuge & reader• Glucometer• HB Meter• Hemocytometer• Rotor for RPR/VDRL• Kit for DBS sample collection• Fridge• Fume hood (class I Safety cabinet)• Cytosphere	<ul style="list-style-type: none">• All primary level machines +• ELISA machine• FACSCount• Hematology analyzer with 3 part differential• Biochemistry analyzer• Heating block or thermo-regulated water bath• Distiller• ILite or photometer for electrolytes• Power stabilizer• Fire extinguisherClass II Biosafety Cabinet	<ul style="list-style-type: none">• All district level machines +• Auto chem.- analyzer• FACSCaliber• Fluorescent microscope for TB• Viral load equipment (• Amplicor viral load 1.5 version, bDNA or Cavid)machine• Freezers• Tissue processor-automated systemBlood Banking Unit
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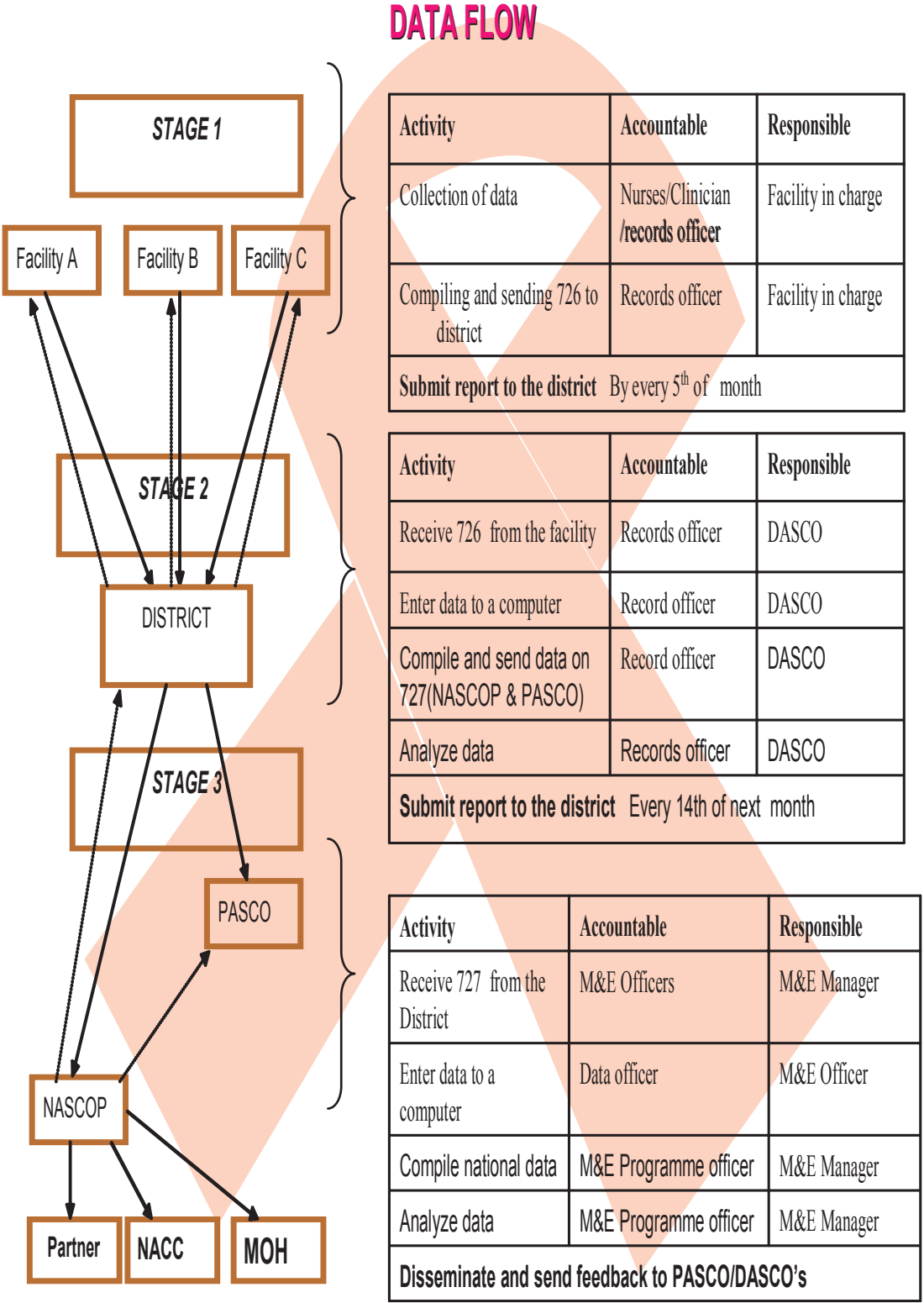
Appendix G: Public Sector Blood Safety Commodity Flow Pipeline



Public Sector Laboratory Commodity Information Pipeline



Appendix I: HIV M&E Data Flow



Appendix J: References:

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