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Assessment of Adolescent HIV Service Delivery in Kenya: The PHASE study

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Background

Adolescent HIV

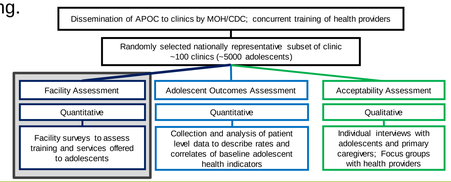
- Adolescents have low retention, adherence and viral suppression
- Adolescence is a time of rapid transition, requiring specialized care
- Behaviors adopted during adolescence impact lifelong health outcomes
- AIDS is the leading cause of death in 15-29 year olds in Kenya. Adolescents and youth (15-29 years of age) account for ½ of all new HIV infections in Kenya
- The Kenya Ministry of Health (MOH) launched a new Adolescent Package of Care (APOC)

Adolescent Package of Care (APOC)

- Developed by CDC, partner organizations, and the Kenyan MOH
- Targets provision of care to all adolescents, with an emphasis on HIV-infected adolescents
- Includes a care booklet, standardized checklist, and provider training materials

Evaluation Objective:

The Kenya Public Health Adolescent Services Evaluation (PHASE) is a mixed methods assessment of adolescent service provision and health outcomes in Kenya. Results presented describe facility level data including: uptake of adolescent HIV service delivery models, the APOC and training.



Methods

Study Design

We conducted a survey at 102 large (≥300 HIV-infected patients) facilities in Kenya randomly selected from all facilities using electronic medical record systems.

Data Collection and Analysis

Facility managers purposively selected health care workers (HCWs) directly involved in caring for adolescents to complete interviews. Interviews were conducted in person or by phone between February-May 2017. HCWs provided information on provision of care for adolescents ages 10-19 years including: adolescent-dedicated services, workforce training, HIV treatment practices, and reproductive health services. Basic descriptive analyses were conducted in STATA and maps were generated using arcGIS.

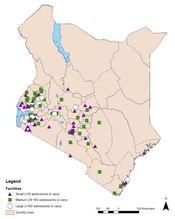
Results

Study Population

Interviewees: HCWs were mostly clinical officers (55%) and nurses (30%), and had worked with HIV-infected adolescents for a median of 2.7 years (IQR: 1.1-4.0).

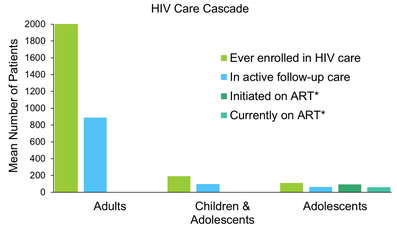
Facilities: Facilities represented 31 of 47 counties; half (50%) from high HIV burden counties. Sites were both urban (58%) and rural (42%), and mostly sub-county hospitals (40%) or health centers (34%).

Figure: Clinic distribution and size



Adolescent Population

Facilities reported an average of 110 adolescents (Range: 4-1462) ever enrolled in care and a mean of 62 (Range: 3-508) currently in active follow-up.



Only 11% of facilities had >150 adolescents in care. Adolescents (10-19 years) in active follow-up accounted for 6.4% (IQR: 4.5%-8.1%) of the total number of patients currently in care.

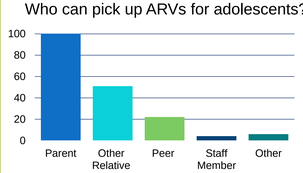
Facility Staffing

- Forty-four percent of clinics had dedicated pediatric and adolescent clinic staff
- There were very few medical officers available overall, and no medical officers providing HIV services for adolescents, even in large volume facilities
- Only 2 small and 2 large facilities had adolescent-dedicated staff that did not also provide adult HIV care

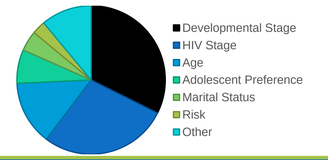
Adolescent Service Delivery Models

- Adolescents were most often given one month (51%) or three months (22%) of medication. Fifty percent of clinics reported varying medication delivery based on school schedules and/or medication adherence.
- Almost all clinics (99%) allowed a proxy to pick up medication for adolescents.
- One-third (34%) required a parent or primary caregiver to be present when providing HIV care to adolescent minors (ages 10-17) while 47% listed specifications for when care could be provided in the absence of a caregiver, including adolescent maturity and disease severity.
- The median age for initiating transition from pediatric to adult care was 15 years (IQR: 12-18) and completing transition was 19 years (IQR: 18-20).

Who can pick up ARVs for adolescents?

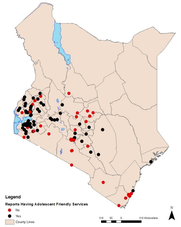


What adolescent factors are considered when determining caregiver presence at clinic visits?



Uptake of the APOC

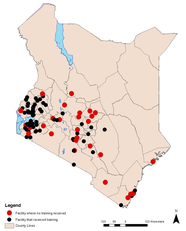
Figure: Self-reported provision of Adolescent Friendly Services



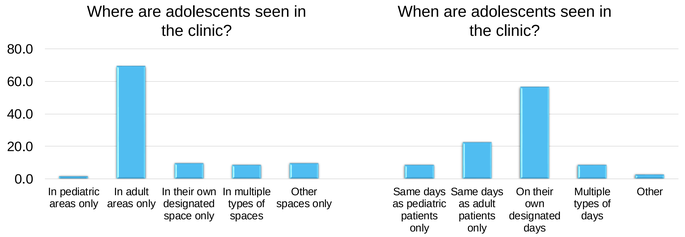
Most (71%) clinics reported using the APOC. Median time since APOC implementation was 1 year.

Most (78%) of the clinics using the APOC identified as providing "adolescent friendly services."

Figure: Self-reported receipt of Adolescent HIV trainings



Fifty-seven percent of clinics saw adolescents only on **specific adolescent days** rather than integrated into days for adults (23%), children (15%) or combined adult/pediatric days (9%). Clinics using the APOC were more likely to provide adolescent services on adolescent days, especially Saturdays. Most clinics (87%) saw adolescents in adult clinic areas, and only clinics reporting uptake of the APOC provided adolescent services in adolescent-only spaces.



- All facilities provided counseling sessions, treatment education, ARVs, viral load monitoring, and defaulter tracing
- Nutrition services and family planning services were extremely low (9.8% and 6.9%, respectively)
- Support groups, teen clubs, and camps were more prevalent in facilities reporting APOC implementation (95%) than those that had not (48%)
- The majority of facilities believed additional HIV services should be offered, including drug and alcohol abuse counseling, psychologic/psychiatric support, cervical cancer screening, and support for orphans and vulnerable children (OVCs) and those in need

Guidelines and Training Materials

- Few facilities (28%) reported having sexual and reproductive health materials for adolescents
- Facilities that reported implementing the APOC were more likely to have access to guidelines and materials

Characteristic	All facilities (n=102) n (%)	APOC-Trained (n=73) n (%)	No APOC (n=29) n (%)
Staff at clinic have access to adolescent HIV disclosure materials	59 (58)	48 (66)	11 (38)
Staff at clinic have access to adolescent HIV care and treatment guidelines	82 (80)	63 (87)	19 (66)
Staff at clinic has access to adolescent sex education materials	28 (28)	25 (34)	3 (10)

Conclusions

- Although most clinics report providing "adolescent friendly services," there is heterogeneity among clinics regarding what specific services are offered to adolescents
- There are varied levels of workforce training and staffing for adolescent HIV care reproductive health services are not consistently offered to adolescents
- Continued training on adolescent HIV service provision can ensure uniformly high quality of care across regions and facilities

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This evaluation was approved by the University of Washington and Kenya Medical Research Institute ethical review boards. All facilities provided written permission to participate and facility interviewees provided written informed consent.

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