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# TOOLKIT FOR TRANSITION OF CARE AND OTHER SERVICES FOR ADOLESCENTS LIVING WITH HIV: KENYA PILOT EVALUATION

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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The authors' views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the United States Government.

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# ACRONYMS

AIDS	acquired immunodeficiency syndrome
ALHIV	adolescents living with HIV
AMPATH	Academic Model Providing Access to Healthcare
CCC	Comprehensive Care Clinic
CCP	community care provider
COGRI	Children of God Relief Institute
EDARP	Eastern Deanery AIDS Relief Program
HCP	health care provider
HIV	human immunodeficiency virus
MOE	Ministry of Education
MOH	Ministry of Health
MTRH	Moi Teaching and Research Hospital
NASCOP	National AIDS & STI Control Programme
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SRH	sexual and reproductive health
TB	tuberculosis
USAID	U.S. Agency for International Development



# EXECUTIVE SUMMARY

With the growth in the number of vertically infected adolescents living with HIV (ALHIV), the need to support their transition from pediatric to adult care is increasing. In 2012, to meet this need, AIDSTAR-One created a *Toolkit for Transition of Care and Other Services for Adolescents Living with HIV* (“the Toolkit”) to provide tools and guidance to health care providers (HCPs) and community care providers (CCPs) as well as to the adolescents and their families and caregivers. To test the usefulness of this Toolkit and to gather information on how to adapt it to increase its utility, a pilot program was carried out from October 2012 through April 2013 at four health facilities—three in or near Nairobi, Kenya, and one in Eldoret, in the western part of the country. The pilot program began with a one-day training comprising a look at the special needs of ALHIV; an overview of the Toolkit; a description of Toolkit utilization to provide a framework for transition of care and other services; an explanation of how to put the Toolkit into action; and a practice co-facilitation. Following the training, each site received a cascade training by the original trainees as well as an introductory supportive supervision visit and monthly supportive supervision visits by an AIDSTAR-One consultant.

This training was followed in March and April 2013 by a mixed-methods rapid evaluation. This evaluation gathered information on provider satisfaction and Toolkit utility and feasibility. The vast majority of respondents found the Toolkit useful, citing its comprehensiveness in addressing all adolescent needs and its topics’ relevance to adolescents, even adolescents without HIV. In addition, most providers found the Toolkit feasible to use and to integrate into their services. Some, especially those working in busy hospital settings, suggested making the Toolkit more user friendly by decreasing its size or by integrating its checklists into forms already in use at their sites.

The evaluation revealed that the Toolkit was utilized mainly in direct provider–client interactions but sometimes, in addition, as a means to provide group education. The three most often used modules covered sexual and reproductive health; clinical considerations; and psychosocial development. The three modules most often listed as difficult to use covered alcohol and substance use; loss, grief, and bereavement; and mental health due to the fact that these topics that are sensitive and difficult to approach with clients.

The Toolkit was responsible for several perceived changes in care. Providers’ ability to work with ALHIV improved with the Toolkit as a guide to effectively identify and address issues that arise as ALHIV transition to adult care. It was also reported that adolescents are sharing more information as a result of the tools and that adherence to antiretroviral treatment seems to have improved as a result of the Toolkit’s clinical considerations module.

## RECOMMENDATIONS

Recommendations for the Toolkit were made in four areas:

- **Expand the Toolkit’s use to more community-based providers.** Adolescents will be more likely to benefit from the Toolkit with increased exposure to the modules; expanding Toolkit use within the community—for example, to more community-based organizations, among peer

counselors, and at sites by setting aside a day when adolescents can access services and be more engaged with the Toolkit.

- **Improve Toolkit utilization, content, and format.** Wherever possible, sites should consider integrating Toolkit content into existing forms to eliminate redundancy and improve ease of utilization. The Toolkit should be condensed and should be made more adolescent friendly by adding illustrations and simplifying the language.
- **Improve training on Toolkit use.** Training duration should be increased to between 3 and 5 days to permit Toolkit review in greater depth as well as additional technical training on ALHIV. Scaling up Toolkit training to additional providers at each site will lighten the workload of those already using the Toolkit. Pilot participants were also interested in receiving continuing medical education credits for Toolkit training.
- **Identify opportunities for scaling up the Toolkit.** Sites should standardize a referral system and scale up Toolkit utilization to sites within their networks that have expressed interest in the Toolkit. In addition, Toolkit use should be scaled up to other government clinics, including comprehensive care clinics and youth centers, with the support of the National AIDS & STI Control Programme within the Ministry of Health, using master trainers to provide ongoing training and supportive supervision. It was also suggested that psychosocial services be strengthened and psychosocial components of the Toolkit be task-shifted to counselors working with ALHIV.

# BACKGROUND

With the growth in the number of vertically infected adolescents living with HIV (ALHIV), the need to support their transition from pediatric to adult care is increasing. Given the limited number of health care providers (HCPs) and community care providers (CCPs) in sub-Saharan Africa, it is unlikely that many adolescents will have the opportunity to physically transition from one clinic to another as often times sites do not offer separate pediatric and adult services. Furthermore, sites that do offer separate pediatric and adult services often are not equipped to provide transition specific support to adolescent clients. Despite these barriers, all ALHIV undergo a mental transition to adulthood, and during this period, learning about self-care and self-management of HIV is essential. Adolescence is a developmental phase between childhood and adulthood that is characterized by physical, psychological, and social changes at the individual level.<sup>1</sup> The World Health Organization defines adolescence as the ages between 10 and 19<sup>2</sup>; others place the upper limit at age 25. Transition is a “multifaceted, active process that attends to the medical, psychological, and educational or vocational needs of adolescents as they move from child-focused to adult-focused health care.”<sup>3</sup>

To respond to the unique needs of ALHIV and to smooth their transition into adulthood, AIDSTAR-One created the *Toolkit for Transition of Care and Other Services for Adolescents Living with HIV* (“the Toolkit”) to provide tools and guide HCPs and CCPs, adolescents, and their families and caregivers. The Toolkit was designed to be useful for all ALHIV, whether exposed perinatally or behaviorally.

Included in the Toolkit are tools and information that HCPs and CCPs can use to develop a minimum package of client services that addresses the need for psychosocial support as well as assistance with mental health, sexual and reproductive health (SRH), and protection; alcohol and substance use; beneficial disclosure; loss, grief, and bereavement; positive living; clinical considerations; and linkages among health facilities and community programs. The Toolkit is meant to help adolescents and their families and caregivers participate in and guide the transition process as they are ready. In addition, the Toolkit will allow HCPs and CCPs to support adolescents during their transition to maximize resiliency, minimize risk factors, and promote positive personal growth.

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<sup>1</sup> World Health Organization (WHO). 2010. *Strengthening the Health Sector Response to Adolescent Health and Development*. Available at [www.who.int/child\\_adolescent\\_health/documents/cah\\_adh\\_flyer\\_2010\\_12\\_en.pdf](http://www.who.int/child_adolescent_health/documents/cah_adh_flyer_2010_12_en.pdf). (accessed June 2013).

<sup>2</sup> WHO. 2013. *Adolescent Health*. Available at [http://www.who.int/topics/adolescent\\_health/en/](http://www.who.int/topics/adolescent_health/en/) (accessed June 2013).

<sup>3</sup> Reiss, J., R. Gibson, and L. Walker. 2005. Health Care Transition: Youth, Family, and Provider Perspectives. *Pediatrics* 115:112–20.



# THE TOOLKIT PILOT PROGRAM

Between October 2012 and April 2013, to test the Toolkit’s usefulness and to inform final adaptations prior to dissemination, AIDSTAR-One conducted a pilot program with the Toolkit involving four sites in Kenya. The program consisted of an initial training; a pilot testing of Toolkit materials; a rapid evaluation; and a wrap-up meeting.

## INITIAL TRAINING

The pilot program began on October 23, 2012, with a one-day training in Nairobi for 14 HCPs and CCPs from four sites. The session comprised a look at the special needs of ALHIV; an overview of the Toolkit; a description of Toolkit utilization to provide a framework for transition of care and other services; 10 case studies in order to practice putting the Toolkit into action; information on how to adapt the Toolkit contents into varying cultural contexts; and a practice co-facilitation. A training-of-trainers format was used; individuals who attended this training were prepared to become “transition leaders” at their sites and to provide subsequent on-site training and follow-up leadership and guidance for their colleagues throughout the pilot activity.

## PILOT TESTING TOOLKIT MATERIALS

Immediately following the initial training, site visits were made to gather baseline data, to introduce the Toolkit pilot to all site staff, to assist in planning for site-level trainings, and to provide assistance in starting to adapt the Toolkit to local contexts.

To continue testing the Toolkit’s usefulness and to explore its feasibility in clinics serving ALHIV, AIDSTAR-One then allowed all the trained providers to use the Toolkit and experience its benefits and challenges, with monthly supportive supervision site visits from an AIDSTAR-One consultant to identify and address logistical and technical challenges. Sites varied in the time given to implementing this phase of the pilot program: three sites spent more than three months each (the range varying depending on how soon after the Nairobi training each site carried out its site staff training and on the length of site closures over the December holidays and during the national elections in March). See Table 1 below. One site allocated less than a month for the pilot because of an unrelated internal dynamics.

**Table 1. Pilot Length**

<b>Location</b>	<b>Clinic</b>	<b>Length of Pilot</b>
Nairobi	EDARP	January-March
Nairobi	Lea Toto	January-March
Machakos	CCC at Machakos District Hospital	March
Eldoret	MTRH-AMPATH Center	January-March

## **RAPID EVALUATION**

From March 31 through April 10, 2013, following the piloting of Toolkit materials, a rapid evaluation was conducted at all four sites to gather information from participating HCPs and CCPs on Toolkit usefulness, feasibility, and effectiveness and to gather information to guide its final adaptations.

Specifically, the rapid evaluation explored, among trained HCPs and CCPs:

- Satisfaction with the Toolkit
- Perceived feasibility of Toolkit integration into routine services
- Perceived improvement in holistic service provision for adolescents
- Perceived improvement in community and facilities services referrals and linkages
- Perceived improvement in the transition process for adolescents.

The rapid evaluation also explored perceived clinical outcomes and client behavior change through data collection on select care and support indicators of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Questions related to perceived gains on these indicators were administered in the pretraining, post-training, and post/post evaluations to providers who received either centralized training or on-site, on-the-job training on the Toolkit.

In addition, one stakeholder within the Ministry of Health (MOH) was asked to discuss country ownership and ease of integration among other health priorities, as well as future plans to utilize the Toolkit. A focus was on determining barriers and successful approaches to integration as a means of providing guidance to other African countries on how best to incorporate the Toolkit use into routine services.

## **TOOLKIT EVALUATION WORKSHOP MEETING**

This meeting, entitled, "Taking the *Toolkit for Transition of Care and Other Services for Adolescents Living with HIV* to Scale to Meet the Needs of ALHIV in Kenya," was held in April 2013, at the end of the rapid evaluation period. The purpose was to assemble the original transition leaders (the individuals who participated in the initial training) to create an opportunity for them to present promising practices and lessons learned from their experience as well as their recommendations for continuing use of the Toolkit and for scaling it up in the Kenya context. AIDSTAR-One also presented preliminary findings from the rapid evaluation.

This present report includes information presented during the Toolkit evaluation workshop meeting by representatives of the four clinics and by two MOH representatives.

# EVALUATION METHODOLOGY

The rapid evaluation included the use of a pre/post structured qualitative questionnaire and a semi-structured qualitative questionnaire. Some quantitative measures were also included on the pre/post providers' questionnaire to measure perceived clinical and behavioral outcomes.

## DATA COLLECTION

### PROVIDER QUESTIONNAIRE

This questionnaire (Annex A of this document)—administered to HCPs and CCPs—included questions to understand provider satisfaction with the Toolkit, its perceived overall usefulness and the feasibility of integrating it into routine services at each pilot clinic and hospital; the most and least useful Toolkit modules; perceived improvements in services provided for adolescents, in referrals and linkages made with other services, and in clinical and behavioral outcomes for adolescents; barriers and challenges to Toolkit use; and successful approaches to using the Toolkit.

### STAKEHOLDER QUESTIONNAIRE

This questionnaire (Annex B of this document)—used to guide the interview with the MOH stakeholder—was meant to gather information to better understand the local context and availability of services for ALHIV; the degree of collaboration that exists within various ministries of the government of Kenya for providing services for adolescents and ALHIV; current and future plans to modify existing services and strategies; and strategies to add new services and to build on and scale up services and strategies for ALHIV in Kenya.

## SAMPLING

Convenience sampling was used to select respondents to receive the provider questionnaire. Each pilot site was visited once by the interviewer. During the visit, the interviewer met with all available providers who had used the Toolkit, including both those who had attended the initial training and those who were later trained at the clinic and on the job by the Nairobi-trained transition leaders. At each clinic, there were between 3 and 6 respondent interviews. Questionnaires were administered individually except at the Comprehensive Care Clinic (CCC) in Machakos District Hospital, where a single individual interview was held followed by a group interview attended by three respondents. Three respondents were interviewed at the Eastern Deanery AIDS Relief Program (EDARP), four at Lea Toto, four at the Machakos CCC, and six at the Eldoret site where the Moi Teaching and Research Hospital (MTRH) and Academic Model Providing Access to Healthcare (AMPATH) have collaborated to establish the MTRH–AMPATH Center. Thus, the total sample size was 17 by individual interview and 3 in the single group interview. See Table 2 on the following page.

**Table 2. Sample Size by Pilot Site**

<b>Location</b>	<b>Clinic</b>	<b>n</b>
Nairobi	EDARP	3
Nairobi	Lea Toto	4
Machakos	CCC at Machakos District Hospital	4
Eldoret	MTRH–AMPATH Center	6
	<b>Total</b>	<b>17</b>

Of the 17 respondents, there were 6 nurses, 5 clinical officers, and 3 social workers, plus a CCP, an administrative officer, and a psychological counselor (Table 3). Of the 17 respondents, 7 had attended the initial training in Nairobi, and the remaining 10 were trained at their clinics and on the job.

**Table 3. Sample Size by Type of Provider**

<b>Type of Provider participating in evaluation</b>	<b>n</b>
Nurse	6
Clinical officer	5
Social worker	3
Community care provider	1
Administrative officer	1
Psychological counselor	1
Doctor	0
<b>Total</b>	<b>17</b>

## **PARTICIPATING FACILITIES**

The pilot activity was implemented at four clinic sites that varied in scope, breadth, and services provided.

### **LEA TOTO**

Lea Toto is a small- to medium-size clinic in Nairobi operated by the private, faith-based Children of God Relief Institute (COGRI). Lea Toto provides clinical and support services to approximately 3,100 children and adolescents living with HIV. Adolescent and pediatric services address psychosocial, medical, nutritional, and social support needs. Approximately 148 adolescents (69 males and 79 females) are being served weekly at the clinic as well as during teen support groups. Two HCPs (a clinical officer and a nurse) were trained during the Nairobi session and then provided cascade training to 11 on-site staff and 14 community health workers. All site staff, including counselors, nurses, social workers, a clinical officer, a nutritionist, a pharmacist, and an administrator, implemented the Toolkit during the pilot period, both one on one with clients and caregivers and in group sessions. After the end of the AIDSTAR-One Toolkit pilot program, Lea Toto is planning to roll out the Toolkit to six other sites with the support of Lea Toto’s own funding and has made the Toolkit part of the organization’s next annual operational plan.

## **EASTERN DEANERY AIDS RELIEF PROGRAM**

The faith-based EDARP, a clinic founded in 1993 and operating under the wing of the Roman Catholic Church, provides TB and HIV care and support services to pediatric, adolescent, and adult clients in Nairobi's Eastlands. EDARP serves 670 adolescents, including 132 ALHIV. Three HCPs received the initial Toolkit training and subsequently trained all EDARP staff on Toolkit use and implementation. During the five-month implementation period, 101 ALHIV (76.5 percent) were supported with the Toolkit, and three successfully transitioned to adult care.

## **COMPREHENSIVE CARE CLINIC AT MACHAKOS DISTRICT HOSPITAL**

This hospital is a Level 5 government hospital an hour outside Nairobi. The clinic site offers treatment, care, and support services to children, adolescents, and adults living with HIV. Adolescent-specific services are provided once a week in conjunction with pediatric clinical services. The adolescent client load as of April 2013 was 143. Two nurses received the initial Toolkit training and subsequently conducted cascade training for 26 HCPs within the CCC. Following this cascade training, five nurses were formally charged with implementing the Toolkit.

## **MTRH-AMPATH CENTER**

This collaboration of MTRH, Moi University, and AMPATH is in Eldoret, an hour's flight west of Nairobi near the Uganda border. The clinic promotes and fosters comprehensive HIV services for all people living with HIV and as of April 2013 served 250 adolescents (aged 11 to 21), 110 of them HIV positive. Clients are scheduled for monthly, bimonthly, or trimonthly visits, depending on their status and adherence records. AMPATH sponsors a peer-led program encompassing issues of adherence, substance use, and SRH. Three HCPs were initially trained on the Toolkit and subsequently conducted cascade training for 30 staff members from various disciplines, including nursing, nutrition, outreach, and psychosocial services. During the three-month pilot period, the Toolkit was utilized with more than 30 adolescents. Two of these adolescents reported using the Toolkit to initiate their own peer education support group.

When asked about the perceived overall quality of services for ALHIV provided at the four sites, 59 percent of providers rated the quality of their clinical and supportive services as very good, while another 24 percent rated their overall quality as extremely high.



# EVALUATION FINDINGS

## OVERALL TOOLKIT USEFULNESS

On a scale of 1 to 5, where 5 is the most useful and 1 is least useful, 15 out of 17 respondents rated the Toolkit's overall usefulness as either a 4 or 5, citing the comprehensiveness of its content in addressing all adolescent needs and the relevance of its topics to adolescents, even adolescents without HIV. Using the Toolkit helped make many providers more organized and systematic in their approach to adolescent clients. Providers said that they had always offered the services but now had the facts to back up their practices, so their work with adolescents was easier and more helpful. Although nearly all providers concurred, one also mentioned that she appreciated that the Toolkit spoke to adolescents, health professionals, community health workers, and caregivers alike.

Two respondents rated the Toolkit's overall usefulness lower, with a 2 or 3, indicating that there is still room for improvement. Several providers found Toolkit language not always appropriate for or comprehensible to adolescents and suggested that the language be simplified or the document itself made more adolescent friendly—for instance, by adding pictures or cartoons. Another provider noted that a Swahili version would be helpful for her clients for whom English was difficult. Several providers found the Toolkit too bulky, even for providers to use. They struggled to find the information they needed or did not have time to study all its details, and expressed a wish for a summary version. One provider said she wanted her own copy, highlighting the fact that at some clinics, providers were sharing the Toolkit and it was not always available when they needed it.

## OVERALL FEASIBILITY OF THE TOOLKIT

Although nearly all provider respondents rated overall usefulness very high, the rating for the overall feasibility of integrating the Toolkit into clinic practice varied. Eleven respondents rated feasibility as 4 or 5 (very good or extremely high quality). On the other hand, four respondents gave a 2 (fair) and two more assigned a 3 (good).

As with the positive responses about the Toolkit's usefulness, many respondents noted that the Toolkit facilitated their work by making it more systematic. They also felt that the Toolkit legitimized the care they were already providing and that Toolkit guidance made it easier to handle adolescents, often a challenge. Providers using the Toolkit felt more confident in the soundness of their guidance and direction and in their ability to assist clients through the transition.

The lower ratings were given by providers who felt that the Toolkit was theoretically useful but not so easy to implement. This was perceived most commonly among providers at the two larger hospitals, where workload, client load, and bureaucratic procedures were greatest. Several providers felt they lacked the time to go through all the tools and checklists. A few others believed that there were too many questions in the tools and checklists and would have preferred open-ended questions in lieu of the many that were closed ended. Two or three providers asked whether modules could be summarized into a page each, with just one question for each module. In larger hospitals, they noted, where there are already too many forms to fill out, implementing the Toolkit is an extra burden, albeit one they wished they could somehow use. A few respondents pointed out that using the Toolkit meant spending much more time with each client—benefiting those particular

individuals while slowing the progress of others out of the waiting room. In addition, providers felt there was never enough time in the day to be so thorough with individual clients. One provider reported needing additional staff to use the Toolkit properly. At one facility, all providers interviewed asked whether Toolkit questionnaires and checklists could be integrated into existing encounter forms.

*One respondent said that Toolkit use is helping to reduce workloads, explaining that after ALHIV transition to the adult clinic, there is more time to spend with the remaining children.*

## **TOOLKIT IMPLEMENTATION**

Most respondents reported implementing the Toolkit one on one with clients, feeling that they would open up more when seen alone and that each needed to be served individually. A few providers sometimes see clients in groups—for instance, when addressing larger topics, such as positive living, that many adolescents share. In one facility, additional group work is planned for specific days during the school holidays, when adolescent clients have more time. Another provider explained that in her facility, an ALHIV goes through a triage upon arrival at the clinic; the triage nurse sends clients to one provider or another for one-on-one care and support, depending on the problems or issues. In another clinic, adolescents choose a staff member they feel comfortable with to share their experiences.

Toolkit activities meant for ALHIV themselves are implemented differently in different facilities. In one facility, adolescents sit in a separate room to go through the activities in the Toolkit modules. At another, providers send clients home with activities to work on and bring back at their next visit. At two other facilities, the Toolkit is used exclusively by providers as a guide for working with ALHIV—ALHIV have not been given activities to undertake on their own. Providers in one of these two facilities did not seem to know that they could make assignments to the adolescents. In the other facility, the pilot had been implemented for only a few weeks at the time of the rapid evaluation, and providers there had not had the chance to fully explore Toolkit use.

## **MOST USEFUL MODULES AND TOOLS**

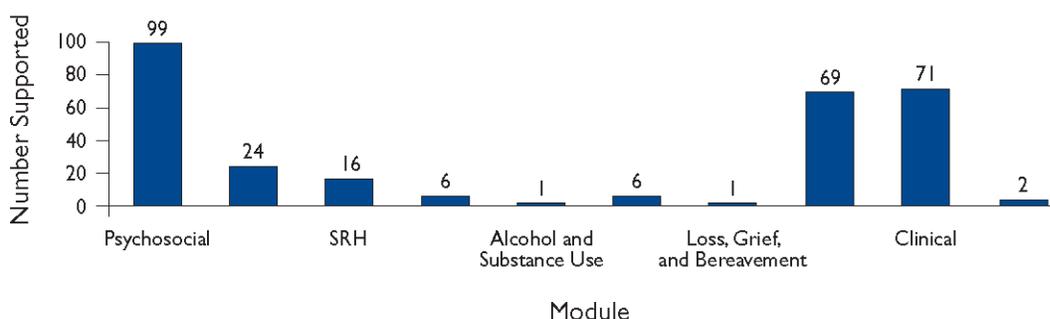
The three modules most commonly rated as “most useful” (Table 4) were those addressing SRH, psychosocial development, and clinical considerations, especially the section relating to adherence. Each of these modules was mentioned by at least two-thirds of respondents. About one-third of respondents mentioned the positive living and beneficial disclosure modules. Providers also mentioned the modules on mental health considerations, protection, alcohol and substance use, and loss, grief, and bereavement. Importantly, all modules were termed most useful by at least two or more respondents. Universally, the reason given for identifying a module as most useful was that it provided good guidance on the most-common ALHIV issues. One provider, who mentioned the SRH module, found it useful because it helps her guide adolescents in making decisions about personal values, which she likes to do.

**Table 4. Toolkit Module by Number of Providers Who Reported the Module as “Most Useful”**

Toolkit Modules	Most Useful
SRH	13
Clinical Considerations	11
Psychosocial Development	11
Positive Living	6
Beneficial Disclosure	5
Alcohol and Substance Use	3
Loss, Grief, and Bereavement	3
Mental Health Considerations	2
Protection	2
Linking Health Facilities and Community Programs	2

EDARP HCPs outlined their use of modules to support clients in the figure, below.

**Figure 1. Toolkit Utilization To Support Adolescents With Transition: EDARP**



Additionally, during the evaluation workshop, HCPs from the Machakos District Hospital mentioned the health worker and adolescent checklists as the Toolkit’s most easily adaptable tools.

## **MOST DIFFICULT MODULES TO USE**

When asked about which modules in the Toolkit were the most difficult to use, five respondents described all modules as easy to use. Among the other dozen respondents, three modules were named between two and four times (modules on alcohol and substance use, mental health considerations, and loss, grief, and bereavement). Modules on clinical considerations, positive living, beneficial disclosure, and protection were mentioned by only one respondent each, while the remaining modules were not mentioned by any respondent (see Table 5 on the next page).

Referring to the alcohol and substance use, mental health considerations, and loss, grief, and bereavement modules, three providers expressed that it is not exactly these modules that are difficult to use, but rather that the topics themselves that are both challenging for their adolescent clients and uncomfortable or difficult for them as adults to discuss with clients. One provider noted needing more time to become comfortable with the issues. Another provider described referring cases with

difficult issues to a psychologist. Together with another provider, she noted that the issues addressed in the modules mentioned are uncommon.

A few providers had specific suggestions. One provider suggested that questions in the modules on mental health considerations and alcohol and substance use be framed in a friendlier manner, to encourage the adolescents to share their stories. Another provider suggested that the alcohol and substance use module address substances other than hard drugs that can be abused, such as glue and cleansing products. Finally, one provider pointed out that some of the foods in the nutrition section of the positive living module were unfamiliar to her and not available in her region.

**Table 5. Toolkit Module by Number of Providers Who Reported that Module as Most Difficult**

<b>Toolkit Modules</b>	<b>Most Difficult</b>
Alcohol and Substance Use	4
Loss, Grief, and Bereavement	3
Mental Health Considerations	2
Clinical Considerations	1
Positive Living	1
Beneficial Disclosure	1
Protection	1
Sexual and Reproductive Health	0
Psychosocial Development	0
Linking Health Facilities and Community Programs	0

## **MISSING MODULES**

Respondents were asked whether they thought any modules were missing from the Toolkit or any topic that should have been covered was not. All but three respondents found the Toolkit complete. The remaining three respondents named gender equality, information technology, and an exploration of an individual’s talents as potential additional modules. The provider who mentioned gender equality felt that many adolescents face this issue and that the clinic setting was an opportune venue for discussion. Another provider noted that a section on information technology would help adolescents learn more about a skill that might improve their lives. Yet another provider suggested that a section that would help their adolescent clients explore their talents might leave them with a positive outlook on life.

## **CHANGES IN CLINIC PRACTICES, PROVIDER/CLIENT SATISFACTION, AND TRANSITION**

Providers were asked what changes, if any, they had seen in their clinics since they started using and integrating the Toolkit into their practice—both changes among all providers and changes among clients. Responses centered on two themes: first, improved provision of care, and, second, improved client adherence, self-esteem, and empowerment.

Providers reported that their ability to work with ALHIV had much improved as a result of using the Toolkit. While their previous work with adolescents had had no logical sequence, they noted that the Toolkit enabled them to more effectively capture and deal with client problems and issues. Providers in one clinic described a more collaborative work style and praised the Toolkit for making ALHIV-related information more readily accessible to staff and for giving them additional skills to use in addressing client issues, thus enhancing client-staff relations. Some providers expressed being able to relate better to adolescents, with greater client trust as a result. One provider noted that the Toolkit gave them the knowledge to solve ALHIV problems—knowledge that he previously lacked. One respondent also said that providers were more enlightened with the Toolkit at hand, and another believed them more empowered to work with adolescents.

Providers also explained that Toolkit use had improved the situation for their adolescent clients. Several respondents described how, when they used the Toolkit, their adolescent clients began talking more freely about their problems, the issues they faced, and the reasons behind their occasional nonadherence. Some providers reported that a few clients with poor adherence had benefited most from the medication adherence diary. Another mentioned that the beneficial disclosure and positive living modules had facilitated additional disclosure sessions with clients and caregivers. Several providers mentioned that the Toolkit had helped focus them on moving clients to adult care, yielding a better, smoother transition for ALHIV. The result, seen by many providers, was that after Toolkit use, ALHIV were taking their medicines more regularly and, in general, were taking greater responsibility for their own care.

Several providers had observed other behavior changes since they began using the Toolkit, notably in the areas of SRH, drug adherence, and nutritional care. According to these providers, adolescent clients appreciated the new level of attention and care and attended their clinic appointments more regularly.

A few respondents reported that the testing period for the Toolkit was too short, with the result that they had not yet been able to see changes from its use, although they expected to do so in the future.

## **CHALLENGES OF USING THE TOOLKIT**

### **LEARNING CURVE**

Many providers said they found it difficult to use the Toolkit during the first weeks: they were not very familiar with it and had to search for the pages that addressed what they needed to know. During this initial period, even adolescent clients complained, saying they did not understand why their consultations took so long. However, providers who used the Toolkit consistently over the pilot testing period learned their way around the document; the difficulties passed, and providers started to reap the Toolkit's benefits. This learning curve generally last during the first month until they felt truly adept using the toolkit to its fullest potential.

### **LENGTH AND BULK**

Many respondents felt the Toolkit too bulky, with too many pages for each module and too many questions for each section and checklist. Providers suggested cutting the number of questions in each section.

## **FORMAT AND DESIGN**

Providers also wished the Toolkit were more user friendly, with larger type and important points highlighted in bold and with pictures. Several providers asked that the tools be simplified by possibly shortening the steps within each tool.

## **TIME PRESSURES**

Nearly all respondents, particularly those at larger clinics within hospitals, pointed to time as the main challenge. The Toolkit, they stated, contained too much material to cover in the time available. These providers asserted that given their workload and patient load, they could not properly cover the entire Toolkit with their clients. Most providers seemed to believe they needed to review the whole Toolkit with each client—and felt overwhelmed.

Some providers explained that they already had many forms to fill out and that Toolkit checklists and tools added to that burden. Some questions repeated within the Toolkit; others repeated between the Toolkit and their other mandatory forms. These providers wanted the checklists and tools integrated with their other forms to eliminate duplicative work.

Some providers explained the time shortage within the framework of limited clinic appointment times: attending school during most clinic hours, most adolescents are available only during a limited window after school, while those who attend boarding schools can be seen only over holidays. (Some providers reported offering clinic appointments two months out, so as not to disrupt school too much and to allow for planning by the adolescents and caregivers.)

## **MATERIALS SHORTAGE**

Several respondents mentioned not having enough booklets or other materials required to use the Toolkits and noted the difficulty of photocopying the Toolkit due to its length and the lack of funds for the job. In some cases, the AIDSTAR-One consultant was able to provide the needed supplies, highlighting the need to consider sustainable mechanisms in-country to continue Toolkit utilization once the pilot period ends.

## **LANGUAGE**

A few providers reported that some adolescents cannot read English well enough to understand the Toolkit. In addition, although others have some English, many lack the language competency to understand Toolkit materials and have difficulty with the density of information. These providers expressed that in general, the Toolkit should be more adolescent friendly, with pictures or cartoons accompanying the text. Several providers suggested that a pictorial job aid would be useful. Finally, a couple of providers described a client who was deaf and could not read English. They felt that for this client and perhaps others like her, additional pictures would be useful. One provider suggested that videos might also be helpful for some Toolkit modules.

## **QUESTION STYLE**

Several respondents reported that many Toolkit questions should be open ended, the better to draw out details from clients.

## **TRAINING**

One last challenge mentioned by many respondents, particularly those given their Toolkit introduction on site, was that the training was much too short. Almost all providers would have liked to have spent more than the few hours to a few days allotted to cover the whole Toolkit, including all its modules, in detail. It was suggested that the training last at least 3 to 5 days and include several role plays addressing specific issues.

Nonetheless, it is worth noting that one of the respondents said, “There have been no challenges. The Toolkit has been a savior for us.”

## **IMPROVEMENTS IN CLINICAL SERVICE PROVISION AND OUTCOMES**

Nearly all respondents reported the pilot testing period as too short to see major changes in the provision of clinical services and most behavioral outcomes. However, when asked about specific clinical or client behavioral areas, they noted perceiving some improvements (see Table 6 on the next page).

### **ADHERENCE AND MEDICATION PICK-UP**

Most providers reported an increase in ALHIV adherence to antiretroviral treatment and found that using the Toolkit had had a very strong positive effect on adherence. Before they had the Toolkit, many providers simply told the clients to take their medicine without understanding the issues connected with adherence or with any other aspect of their lives. Although provider focus has shifted some since Toolkit initiation, medication adherence rightly remains very important. The perception that the Toolkit has improved adherence seems to be a powerful motivator for Toolkit use.

About three-quarters of providers have perceived an increase in the number of ALHIV coming to pick up their antiretroviral medications on time. Likewise, about two-thirds of providers believe that since the beginning of the pilot more adolescents are keeping their scheduled appointments than previously. Providers explained that these two improvements are connected because clients most often pick up their medicines at their appointments.

### **THE MINIMUM PACKAGE OF SERVICES**

A final area where some providers have seen improvement is in the provision of a greater variety of services that are relevant to the needs of the individual adolescent creating an improved minimum package of services for ALHIV.

### **OTHER FINDINGS**

Although most respondents did not feel there had been improvements in clinical outcomes or client behavior indicators, a few did note having observed improvements for other indicators. These providers were clustered at particular facilities but never included all providers at any given facility. Similarly, only a few reported more adolescents were receiving services outside the facility since Toolkit introduction. Most providers noted no increase in the number of adolescents initiating antiretroviral treatment since the pilot’s inception. (Uniformly, respondents observed that clinical indicators determined initiation of antiretroviral treatment and that these had not changed since

Toolkit introduction.) Finally, nearly all respondents reported neither an increase in referrals out to other facilities nor an increase in referrals in from other facilities; many providers explained that because their facilities provided comprehensive services, there was no need to refer clients elsewhere. Providers who did refer ALHIV to outside services said their major referrals were to peer support groups or family support services.

**Table 6. Clinical or Behavioral Indicator by Number of Providers Perceiving an Increase or Improvement**

<b>Area of Perceived Increase or Improvement</b>	<b>Yes</b>
ALHIV picking up medicines on time	13
Adherence to antiretroviral treatment	12
ALHIV keeping scheduled appointments	11
ALHIV receiving a minimum package of services	11
Number of ALHIV served at facility	5
Number of ALHIV enrolled in antiretroviral treatment	4
Number of referrals from other facilities	4
Number of ALHIV using outside services	3
Number of referrals to other services	3

## **MINISTRY SUPPORT FOR ADOLESCENT PROGRAMMING AND SCALE-UP**

According to the stakeholder interviewed for this rapid evaluation, the Toolkit has so far been very useful, though some modifications—as indicated by providers during the rapid evaluation—will be required. Specific ALHIV programming within clinics and elsewhere is new in Kenya, but interest in these programs seems to be growing. Adolescent data is not captured by current surveillance tools, although the MOH is considering adapting them to do so. As of April 2013, the MOH is in the final stages of developing a minimum package of care for all adolescents; although this package is not ALHIV specific, one section does deal with psychosocial support for ALHIV. Once the package is developed, it is expected that several community services will be harmonized to meet the minimum standards.

As of April 2013, the MOH is also developing a handbook for adolescents and discussed the possibility of including some Toolkit information. The respondent is also hopeful that MOH adolescent school health policy guidelines for HIV-positive students will complement the Toolkit, and vice versa.

The MOH seems to be taking the lead on programs for adolescents, with programs focused in the Division of Child and Adolescent Health. There is nascent interest in involving the Ministry of Education (MOE). Once the MOE does become involved, care will have to be taken to ensure that the MOE does not duplicate MOH work and that each ministry has clear roles to play. The MOH stakeholder expressed a desire to involve the MOE in reviewing health and HIV curriculum in schools to make the most of the two ministries' complementary expertise.

These signs of increasing interest in improving services and care for adolescents bode well for the continuation and expansion of Toolkit use in Kenya.

# LIMITATIONS OF THE TOOLKIT PILOT PROJECT

As with any rapid evaluation meant to help translate lessons learned during a short implementation period into actionable improvements, there were limitations to the Toolkit pilot program and its rapid evaluation. Nonetheless, the project yielded several valuable lessons and recommendations.

- The nature of the rapid evaluation meant that only a few hours were spent at each of the four pilot facilities. The sampling methodology was simply to interview all respondents available at the clinic during the visit. The presence of a different mix of providers might have yielded different data.
- The brevity of the evaluation period also meant that only one MOH representative was interviewed. Even though that representative held a very senior, and therefore a potentially influential position at the National AIDS & STI Control Programme (NASCOP), it might have been helpful to interview other individuals as well.
- Given the decision at the project outset not to seek institutional review board approval to study on-site records, the assessment relied on provider perceptions and data recall, resulting in a wide variation in responses as to the quantitative indicators at each pilot site. Also without institutional review board approval, it was not possible to interview adolescents directly.
- Not all data collection was uniform, and not all data met the requested parameters. Specifically, although the evaluation protocol defined adolescents as individuals aged 10 to 19, MOH captures data on children ages 0 to 14 and on adults aged 15 and up. Thus, it was extremely difficult to accurately report the number or percentage of adolescents for any quantitative indicator.
- One of the pilot facilities experienced a nursing strike during much of the pilot testing period. Because nurses make up the majority of providers caring for and treating ALHIV, site start-up was significantly delayed, and implementation lasted less than a month. Thus, provider responses differed from those at other sites. (Interestingly, this difference may enrich the data. Respondents at all sites described difficulties in the beginning of the pilot due to the challenge of mastering Toolkit content and use. The delays at this site provided a firsthand look at HCPs and CCPs in the midst of those difficulties.)
- The Kenya government held national elections during the pilot testing period. In anticipation of possible election-related violence, the government instructed HIV clinics to provide clients with up to three months of antiretroviral medications—reducing the number of ALHIV visiting the clinic over the election period and therefore during the pilot. If clients who willingly ventured out to clinics during the elections differed from those who chose to stay home, the data may be biased.



# RECOMMENDATIONS

This section contains recommendations derived from the evaluation findings on how to implement, scale up, and integrate the Toolkit into daily use in Kenya and other similar settings.

Recommendations are divided into four sections: improving Toolkit use; improving Toolkit content and format; improving training on Toolkit use; and scaling up the Toolkit.

## IMPROVING TOOLKIT USE

### EXPAND USE TO COMMUNITY-BASED PROVIDERS

Scaling up the tool to community-based providers would enable ALHIV to get greater and more frequent exposure to the Toolkit and thereby derive greater benefit from it.

### ENGAGE ADOLESCENTS TO USE THE TOOLKIT

Provider instructions to engage adolescents in Toolkit activities need to be emphasized. It should not be used only to improve providers' own practices.

### ENGAGE ADOLESCENTS SEPARATELY

Several providers recommended that ALHIV would benefit from a separate adolescents-only day at clinics each week—without children or adults. Another possibility on such a separate adolescent clinic day would be to hold group sessions for education and support as well as peer counseling.

### TRAIN PEER COUNSELORS

Some providers expressed that it would be good to train peer counselors from among successfully transitioned ALHIV to work with adolescent clients. Peer counselors could be especially helpful not only on adolescents-only clinic days but also at on-site or off-site ALHIV support groups and at other times. Likewise, a couple of providers suggested a mentorship club for adolescents, with adults living with HIV as leaders and facilitators. ALHIV peer counselors and adult mentors should also be trained on Toolkit content and use.

### OFFER GRADUATION CEREMONIES

To provide incentives to adolescents, some respondents suggested sponsoring an official graduation event to mark individuals' transition from pediatric to adult care.

### ADAPT TOOLKIT FOR SITE-SPECIFIC USE

All facilities should be encouraged to modify and adapt the Toolkit to their specific cultural and working contexts and instructed in how to do so.

## **USE THE TOOLKIT OVER TIME**

Providers should be reminded that ALHIV transition can take several years, and they should be encouraged to use the Toolkit throughout the period, covering modules only as needed—there is no need to race through. Understanding this may keep providers focused on the Toolkit as helpful rather than burdensome.

## **IMPROVING TOOLKIT CONTENT AND FORMAT**

### **INTEGRATE TOOLKIT CONTENT INTO EXISTING MATERIALS**

Wherever possible, it is important to adapt Toolkit checklists and tools into facilities' existing enrollment forms and other documents. Where possible, the number of questions should be reduced, perhaps by eliminating duplications between the Toolkit and other forms and by selecting only the most important for inclusion in the Toolkit.

### **CONDENSE THE TOOLKIT**

Where possible, the information in the Toolkit should be reduced to essentials.

### **REVISIT TOOLKIT DESIGN AND FORMAT**

It would be helpful to add tabs to the Toolkit to make it easy to flip to specific content as needed. Alternatively, the Toolkit might be designed with pullout sections (such as in a two- or three-ring binder), so that providers would need to carry around only the section in use. Other formatting ideas should be explored to make the Toolkit more user friendly.

### **MAKE THE TOOLKIT MORE ADOLESCENT FRIENDLY**

Toolkit language, especially in sections aimed at ALHIV, should be easy for adolescents to understand. Pictures and cartoons should illustrate the modules so that they feel more inviting and less like academic text. Several respondents suggested illustrated job aids for providers to use with adolescents. A Swahili version of the Toolkit should be created and one or more copies made available at each clinic for ALHIV who cannot read English well.

## **IMPROVING TRAINING ON TOOLKIT USE**

### **INCREASE TRAINING HOURS**

Each Toolkit module covers its topic in depth, with the result that review of each requires several hours and involves such training methodologies as role plays to improve retention and learning outcomes and to effect behavior change. At least 3 to 5 days of training are recommended for initial use of the Toolkit. In addition, increased supportive supervision (at least two days per month) is needed on site during the first month or more of Toolkit implementation within a facility.

### **INCREASE TRAINING NUMBERS**

Many providers reported that although useful, the Toolkit adds significantly to their workload, making it difficult to fully implement. They suggested that the workload would be more manageable

if more staff were trained on Toolkit use and more staff were made available to handle a growing patient load.

## **OFFER CONTINUING MEDICAL EDUCATION CREDITS**

A suggestion was made to offer these credits focusing on ALHIV transition, using the Toolkit as a basis, in order to foster providers' professional interest in participating in the training.

## **SCALING UP THE TOOLKIT**

### **ESTABLISH A STANDARDIZED REFERRAL SYSTEM**

Establish a referral and network system for issues that cannot be addressed by the implementing facility.

### **SCALE UP TOOLKIT USE TO LINKED FACILITIES**

Two facilities that participated in the pilot are part of larger clinic networks. Staff from other clinics in their networks have been asking about the Toolkit and would like to incorporate it into their practices. Extending Toolkit use in this way, facilitating a quick but limited scale-up, should be encouraged.

### **SCALE UP TOOLKIT USE TO OTHER CLINICS**

Increase Toolkit scale-up to other government clinics, particularly comprehensive care clinics and youth centers, with support from NASCOP/MOH. Providers who received the initial Toolkit training should be recruited and selected to form part of a team of master trainers who could then actively assist clinics in adopting the Toolkit by providing ongoing training and supportive supervision.

### **STRENGTHEN PSYCHOSOCIAL SERVICES**

Per the suggestion of several providers, psychosocial services should be strengthened before rollout of all aspects of the Toolkit. In addition, responsibilities for this section of the Toolkit implementation should be task-shifted to counselors.

### **CONSIDER IN-COUNTRY SUSTAINABILITY MECHANISMS**

Once the Toolkit pilot period has ended, stakeholders in country should consider various mechanisms to ensure sustainability of the Toolkit to ensure that ALHIV continue to receive the minimum package of services as they transition from pediatric to adult services.



# CONCLUSION

The *Toolkit for Transition of Care and Other Services for Adolescents Living with HIV* seeks to build the capacity of HCPs and CCPs, families and caregivers, and adolescents themselves to identify and address topics that may arise during adolescence to provide the knowledge, skills, and tools needed to transition to adult-focused care in the healthiest possible way. This pilot project yielded a consensus that the Toolkit is not only useful for better serving ALHIV and improving their outcomes, but also feasible to integrate into clinical practice. The pilot testing revealed that duration of use increased provider perceptions of utility and effectiveness.

In order to further improve Toolkit usefulness, a series of changes will be made: 1) Adapt the Toolkit with adolescent-friendly graphics to increase adolescent understanding of the tools; 2) Simplify the language wherever possible to increase comprehension of the tools; 3) Identify and remove any areas of replication to shorten the length of the Toolkit to improve ease of use and; 4) Increase the length of the Toolkit training from 1 day to 3-5 days to include more time to review each tool in depth, and include ALHIV technical training components which will provide in-depth information on each module in the Toolkit to improve provider familiarity with the Toolkit at outset and provider understanding of adolescents' unique needs to improve the adolescent transition experience. The overwhelming sentiment is that with these modifications, Toolkit use should be expanded to other clinics and scaled up in Kenya and perhaps beyond. The large majority of providers pronounced the Toolkit an asset to their work and their clients and felt it will make a difference to ALHIV health outcomes by equipping adolescents with the knowledge and skills to transition to adult-focused care in a healthy and planned manner.



# ANNEX A

# QUESTIONNAIRE FOR PROVIDERS

## Introduction

Hello. My name is \_\_\_\_\_. My co-workers and I are here on behalf of the AIDSTAR-One Project, funded by the United States Agency for International Development, to conduct an assessment of feasibility and integration of the *Toolkit for Transition of Care and Other Services for Adolescents Living with HIV*.

I will be asking you questions about integration of adolescent services at this health facility and referrals to other adolescent-specific services. The main objective of this assessment is to determine the feasibility of integrating the Toolkit into your current work, how to adapt the Toolkit to best fit your needs, identify what is working well, what can be improved and what adolescent services are currently available. The goal is to collect information that will help providers develop the best possible care for adolescents living with HIV (ALHIV).

**The information you provide us is completely confidential and will not be shared with anyone else without your consent, including your supervisor.**

This is not an evaluation of your performance. The information you provide us is extremely important and valuable, as it will help the Government of Kenya and the health facilities involved in providing HIV and AIDS care and support to adolescents to improve service delivery. It will be presented with information from other sites interviewed in Nairobi. You may choose to stop this interview at any time and you may refuse to answer any question.

Do you have any questions for me at this time? (*Answer questions.*)

Do I have your agreement to participate? (*If yes, please proceed. If no, stop and note reason if offered.*)

a. Date of Birth	
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b. Name of Health Facility	
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c. Level of Health Facility (circle one)	i. ii. iii. iv.
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d. Provider Level	i. Doctor ii. Nurse iii. Clinical officer iv. Community Care Provider v. Other
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e. Did you attend the pilot adolescent Toolkit training in Nairobi in October 2012?	
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f. Date of Interview	
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## GENERAL QUESTIONS ON TRANSITION TOOLKIT FEASIBILITY AND ADAPTABILITY

1. Approximately how many adolescents (age 10-19) are you currently providing **at least one** care service to?

# of female adolescent clients \_\_\_\_\_

# of male adolescent clients \_\_\_\_\_

2. Rate the perceived overall quality of services for adolescents living with HIV at this site from 1-5. (5=extremely high quality, 1=poor)

5	4	3	2	1
Extremely high quality	Very good	Good	Fair	Poor

3. Since the Adolescent Toolkit Training, have you observed changes in practices of providing services to adolescents living with HIV?
  - a. Did you share the information from the training with your colleagues that did not attend? How?
  - b. How did the ALHIV Toolkit training contribute to improving quality of services for adolescents at this facility site?
  
4. How was the Transition Toolkit implemented at your particular site?
  - a. one on one
  - b. peer support groups
  - c. group counseling
  - d. in the waiting room
  - e. other
  
5. What modules within the Toolkit did you find most useful in your daily practices?
  - a. Psychosocial Development
  - b. Mental Health Considerations
  - c. Sexual and Reproductive Health Toolkit
  - d. Protection
  - e. Alcohol and Substance Use
  - f. Beneficial Disclosure
  - g. Loss, Grief, and Bereavement
  - h. Clinical Considerations
  - i. Positive Living
  - j. Linking Health Facilities and Community Programs

Please comment why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What modules did you find most difficult to integrate into your daily practices?
  - a. Psychosocial Development
  - b. Mental Health Considerations
  - c. Sexual and Reproductive Health Toolkit
  - d. Protection
  - e. Alcohol and Substance Use
  - f. Beneficial Disclosure
  - g. Loss, Grief, and Bereavement
  - h. Clinical Considerations
  - i. Positive Living
  - j. Linking Health Facilities and Community Programs

Please comment why and how it can be more useful? \_\_\_\_\_

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7. In your opinion, were there any modules missing from the Toolkit that will increase usefulness of the Transition Toolkit?
8. Did you encounter any issues of integrating the Toolkit into your current practices at the clinic site? If so, what were some of the major issues?
  - a. Logistical—availability of paper, time
  - b. Content within the Toolkit
  - c. Other
9. What changes if any, have you seen after integrating the adolescent Toolkit into your current practices?
  - a. provider/staff satisfaction (increased and decreased)(any adaptations required)
  - b. Client (adolescent) satisfaction (increased and decreased)(any adaptations required)
  - c. Family/caregiver satisfaction (increased and decreased)(any adaptations required)
  - d. Improved client health outcomes, please explain
  - e. Improved communication with ALHIV
10. Did you give the adolescents the tools to take home and fill out or did the adolescent do it on site?

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# PERCEIVED IMPROVEMENT IN QUALITY OF SERVICES AND IMPACT ON CLINICAL CARE AND SERVICES

1. Have the number of adolescents receiving one or more care service(s) within this facility increased since introduction of the Transition Toolkit?
  - a.  Yes
  - b.  No
  - c.  Not sure
  - d. What is the approximate current number\_\_\_\_\_?
  
2. Have adolescents that you work with reported **receiving more services outside the facility** following introduction of the Transition Toolkit?
  - a.  Yes
  - b.  No
  - c.  Not sure
  - d. What is the approximate percent of ALHIV who receive services outside the facility\_\_\_\_\_?
  
3. Do you think that there are **more adolescents living with HIV on antiretroviral therapy** at your facility following introduction of the Transition Toolkit?
  - a.  Yes
  - b.  No
  - c.  Unsure
  - d. Approximate percent of adolescents on ARV treatment at your facility\_\_\_\_\_?
  
4. Have you seen an increase of the number of adolescents in your facility whom have **remained on treatment 12 months after initiation of antiretroviral therapy** since introduction of the Transition Toolkit?
  - a.  Yes
  - b.  No
  - c.  Unsure
  - d. Approximate percent of adolescents living with HIV who stay on treatment 12 months after initiating ART\_\_\_\_\_

5. Have you seen an improvement in the number of adolescents who **picked up all prescribed antiretroviral drugs on time** since introduction of the Transition Toolkit?
  - a.  Yes
  - b.  No
  - c.  Unsure
  - d. Approximate percent of ALHIV who pick up ARVs on time since introduction of Toolkit\_\_\_\_\_
  
6. Have you seen an improvement in the number of adolescents who **keep scheduled appointments** since introduction of the Transition Toolkit?
  - a.  Yes
  - b.  No
  - c.  Unsure
  - d. Approximate percent of adolescents living with HIV who routinely attend appointments as scheduled\_\_\_\_\_
  
7. Have you seen an increase in the number of referrals each ALHIV has received to outside organizations since introduction of the Transition Toolkit?
  - a.  No
  - b.  Unsure
  - c. Approximate percent of ALHIV who have received referrals to outside organizations\_\_\_\_\_
  
8. Do you believe that the introduction of the Transition Toolkit has contributed to an increase in the number of referrals ALHIV have received to your facility?
  - a.  Yes
  - b.  No
  - c.  Unsure

Why, please explain: \_\_\_\_\_

9. Have you seen an increase in the number of eligible adolescents who are provided with a **minimum package of Prevention with PLHIV (PwP) interventions** since introduction of the Transition Toolkit? (e.g.: STI prevention, loss, grief and bereavement, mental health, etc.)
  - a.  Yes
  - b.  No
  - c.  Unsure

# CONCLUDING QUESTIONS

1. Rate general usefulness of the Toolkit

5	4	3	2	1
Extremely high quality	Very good	Good	Fair	Poor

Please provide an explanation for your rating

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2. Rate your opinion of the feasibility of integrating the Transition Toolkit into daily practice?

5	4	3	2	1
Extremely high quality	Very good	Good	Fair	Poor

Please provide an explanation for your rating

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3. What are the current priorities of integrating ALHIV services into your facility?

- d. Types of activities
- e. Next steps planned, what is needed

4. What would you recommend as next steps for adapting the Toolkit for wider use and scale up throughout the country and region?

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## ANNEX B

# STAKEHOLDER INTERVIEW GUIDE

1. Are there any existing tools for Adolescents Living with HIV (ALHIV) or ALHIV transitioning into adult care?
  - In your opinion, how successful are these tools?
  - What are some challenges to implementing these tools?
  - How can these tools be improved?
  
2. How do the Ministry of Health and/or National AIDS Program collaborate with other ministries working on HIV programming to integrate ALHIV services?
  - Is there room for improvement?
  - What are some of the challenges to this collaboration?
  - How can this collaboration be improved
  
3. How does the national HIV program currently address adolescent living with HIV programming?
  - Is there information available on the number of HIV care and treatment services that provide services to ALHIV?
  - Can you share some data on the # and % of service providers that have been trained on ALHIV issues?
  - How successful has been this programming?
  - What are some of the challenges to this programming?
  - In your opinion, how can this programming be improved?
  - How many conduct ALHIV assessments?

4. Have there been any recent modifications to the current HIV programming to include ALHIV issues?
  - If so, have these modifications (e.g. policy guidelines, inclusion in national HIV strategy) been successful in increasing ALHIV retention and care rates?
  
5. Are you aware of any community mapping/assessments determining what organizations are providing ALHIV services at the local level?
  - If so, how is this information distributed to local HIV/AIDS programs?

For more information, please visit [aidstar-one.com](http://aidstar-one.com).

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