



Ministry of Health

STANDARD OPERATING PROCEDURES for Establishing and Running Key Populations Clinics in Kenya





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Clinical outreach using a mobile van

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CME	Continuous Medical Education
CQI	Continuous Quality Improvement
DIC	Drop-In Centre
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IEC	Information, Education, and Communication
IP	Implementing Partner
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
KP	Key Population
M&E	Monitoring & Evaluation
MARP	Most-At-Risk Population
MAT	Medically Assisted Therapy
MoH	Ministry of Health
MSM	Men Who Have Sex with Men
NASCOP	National AIDS & STI Control Programme
NGO	Non-Governmental Organisation
NSEP	Needle and Syringe Exchange Programme
ORW	Outreach Worker
PC	Programme Coordinator
PE	Peer Educator
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infection
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
TB	Tuberculosis

INTRODUCTION

Female sex workers (FSWs), men who have sex with men (MSM), and people who inject drugs (PWID) commonly encounter stigma and discrimination at medical facilities. Such experiences discourage these key populations (KPs) from seeking screening and treatment for sexually transmitted infections (STIs) and/or testing to learn their HIV status, and thereby impede efforts to halt the spread of HIV. To increase uptake of clinical services by key populations, NASCOP's key populations programme implementing partners (IPs) operate special clinics, referred to as KP clinics, in which staff do not stigmatise or discriminate against KPs.

In Kenya, KP clinics exist in two forms: **facility-based clinics**, which are either stand-alone or integrated with another facility (e.g., a drop-in centre), and **outreach clinics**, which serve isolated clusters of KPs in remote locations.

These standard operating procedures (SOPs) for establishing and running facility-based and outreach KP clinics aim to standardize the delivery, quality, and impact of implementing partners' clinical services for key populations throughout the country.

■ The Scope and Intended Audience of these SOPs

This manual describes procedures for establishing KP clinics, for providing HIV-prevention and care services to KP clients in these clinics, and for referring clients to other providers for other services. These SOPs do not cover specialized clinical care that is not offered in KP clinics (e.g., treatment for anorectal carcinomas). Such care should be provided only in facilities that are designated and equipped for such services. All KP clinics should therefore have strong referral networks with facilities that provide broader clinical and psychosocial services that KPs require.

These SOPs have been prepared to provide guidance to key populations programme implementing partner programme managers, KP clinic coordinators, clinicians, and counsellors. Although each KP clinic may primarily serve one type of key population, some individuals represent more than one key population (e.g., male sex workers who inject drugs, and women who sell sex and inject drugs). Implementing partners should therefore familiarize themselves with the KP clinic guidance for all types of key populations.

1.1 Plan the Number and Location of KP Clinics

KP clinics should be easily accessible to the KPs because easy access can significantly enhance ownership and utilization of clinic services. It is therefore important for KP clinics to be located in or near areas where KPs are concentrated. Consultation with key populations to decide the location of the clinic is encouraged.

Use the hotspot maps that were created during the intervention's micro-planning session to determine the requisite number and location of facility-based and/or outreach KP clinics. There should be one facility-based clinic per 1,000 KPs. If 1,000 KPs are concentrated in hotspots that are clustered together, one facility-based clinic will be sufficient. If the KPs are spread out and the distance from the KP concentrations to the facility-based clinic exceeds 5 km, then clinical services should be extended to KPs in isolated or remote hotspots through outreach clinics.

Considering that each outreach clinic should serve 40–50 KPs, if a county contains a target population of 2,000 the implementing partner should plan to have either two facility-based clinics or one facility-based clinic and 20–25 outreach clinics per quarter to reach all the targeted KPs once in a quarter. Through outreach clinics, implementing partners should aim to serve over 80% of the KP population who are not served by facility-based clinics.

After the general locality for a clinic is determined, a programme team of peer educators, outreach workers (ORWs), and field coordinators should micro-plan to identify the optimal location for the facility-based or outreach KP clinic in consultation with KPs so they feel safe and comfortable in the location. Micro-planning is explained in Section 2.5 of Kenya's *National Guidelines for HIV/STI Programming with Key Populations* (NAS COP 2014a).

Facility-based KP clinics may be located near or in the same building as drop-in centres (DICs). There are practical advantages to co-locating clinics with DICs, such as the convenience of dealing with just one landlord and the closer links between community activities and KP clinic services.

The decision to co-locate a facility-based KP clinic with a DIC depends on the distance from the DIC to the nearest KP-friendly clinic that offers STI screening and treatment; HIV testing and counselling; and HIV treatment, care, and support. If there is no such KP-friendly clinic near the DIC, the implementing partner should co-locate a facility-based KP clinic with the DIC. Outreach clinics should be held wherever dense clusters of KPs exist in hotspots that are distant from KP-friendly clinics.

1.2 Select and Prepare Premises for the KP Clinics

Involve KPs at every step when selecting and preparing premises to become KP clinics. Ensure that KPs participate in activities such as painting/renovating/arranging the facility-based and/or outreach KP clinic.

1.2.1 Setting up facility-based clinics

Facility-based KP clinics must have rooms for a waiting bay, a clinical exam room, a counselling room, and a lavatory (separate lavatories for men and women should exist in clinics for PWID or sites where male and female KPs seek services).

WAITING BAY / RECEPTION ROOM

In addition to accommodating clients while they wait to see the clinic's clinician or counsellor, the waiting bay can also be used as a training venue and for meetings for outreach workers and peer educators. The waiting bay should be furnished and equipped with

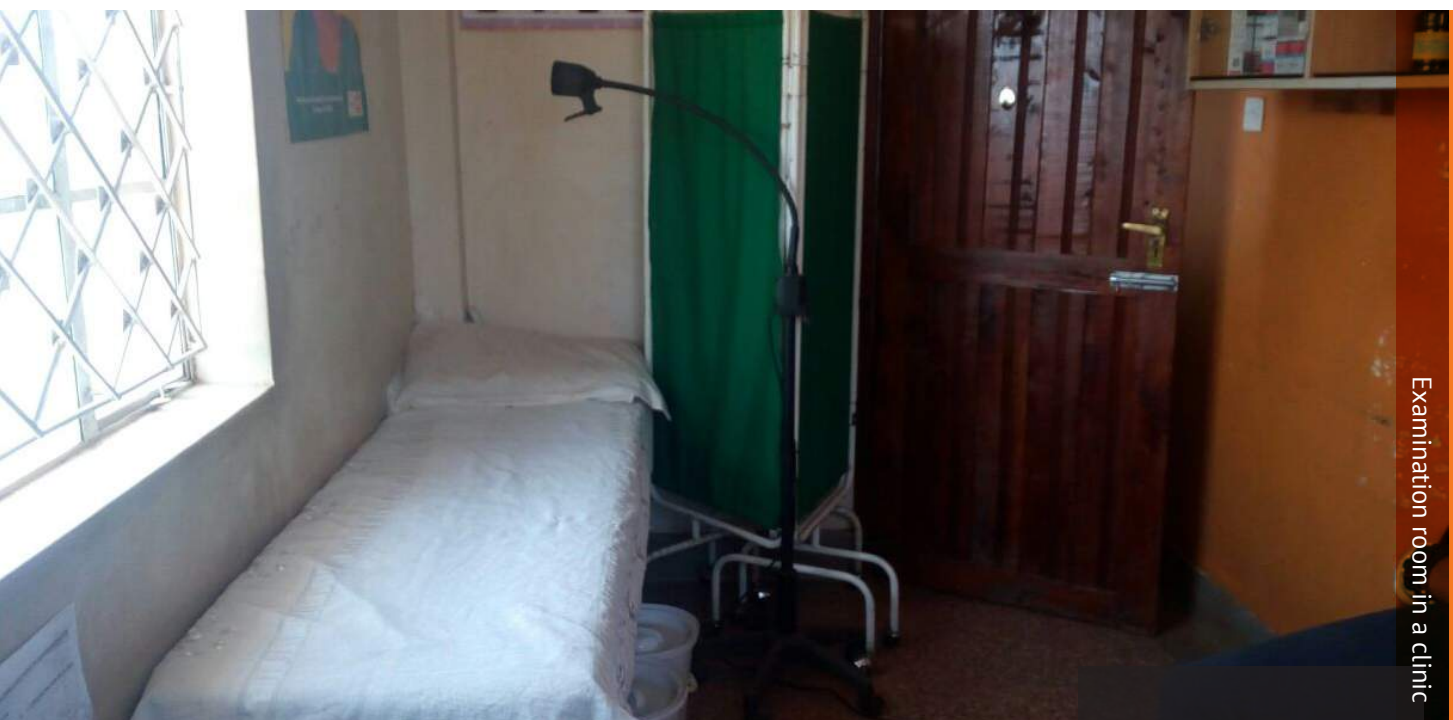
- A sign indicating clinic operating hours
- A cabinet for storing a first aid kit and other material
- Table and chairs
- A telephone
- Lights
- Table to display behaviour change communication (BCC) and other print materials
- Comment/ suggestion box
- Chart showing patient flow (see Annex 2)
- Picture of the clinic's organization structure with staff pictures, and roles and responsibilities of each person working at the clinic
- Patients' Rights Charter (see Annex 1)
- A TV and DVD player
- Rubbish bin
- A mirror
- Power outlets
- A fan
- A fire extinguisher



CLINICAL EXAM ROOM

At all times, this room should be kept clean and tidy, and there should be enough sterile equipment on hand for all visits throughout the day. The clinical exam room should have

- Clean water supply
- Power supply
- Male and/or female condoms, banana model (dildo), and other materials for condom demonstration
- Fans or an air conditioner
- Autoclave
- A black rubbish bin for general waste, a yellow rubbish bin for infectious waste, and a red rubbish bin for pathological waste (see Figure 2)
- Disposable sharps container
- Disposable gloves
- Lubricant
- Sink and soap for hand washing
- Obstetric examination table
- Adequate lighting and an examination light for performing vaginal and anal examination
- Mirror for KPs to observe their internal body while the doctor performs the vaginal examination
- A door with a functional lock
- Toilet in the room for privacy
- Curtains for each window to ensure privacy
- Table and chairs for doctor and patient to have a private conversation
- Requisite forms, NASCOP reporting tools, and other recording books
- Skirt or gown for patient to wear when getting ready for the examination



Examination room in a clinic

COUNSELLING ROOM

The counselling room should be equipped with

- A desk, a work table, and at least three chairs
- Basic kits for the HIV test
- Power outlets
- Lights
- Male and/or female condoms and lubricant
- Refrigerator to store HIV test kits
- Basic equipment for male and/or female condom demonstration (condoms, dildo, and lubricant)
- Filing cabinet with a lock
- NASCOP recording forms and record books
- List of telephone numbers of persons working for the clinic and other important numbers
- Locking door to ensure privacy
- Fan



LAVATORY

The lavatory should have

- Lights
- Toilet
- A wash basin with running water
- Cleaning supplies (liquids, detergents, disinfectant, and other cleaning materials)
- Toilet paper
- Rubbish bin
- Towels
- Soap for bathing
- Mirror
- A locking door
- Signs to indicate proper use (e.g., “Please don’t flush sanitary towels in the toilet.”)

Other supplies and furnishings of the KP clinic

- Bleaching powder for preparing fresh 1% Na hypochlorite solution
- Condoms and lubes
- Emergency lights
- IEC material on safe injecting and safe sex
- Medical equipment: stethoscope; protoscope; speculum (disposable); BP apparatus (sphygmomanometer); thermometer; torch; tongue depressor; weighing scales; kidney trays; disposable gloves and masks; hydrogen peroxide solution; antiseptic solution; solvent ether spirit; povidone iodine solution; freshly prepared eusol; Cheatle’s forceps in antiseptic solution; sterile drums with sterile gauze and bandages; sterile packets of catgut, ethylon, prolene, silk, etc.; autoclaved linen; sticking plaster; 2% lignocaine without adrenaline; suture cutting scissors
- Needle destroyer/burner/crusher
- Needles and syringes for exchange (in clinics for PWID)
- Notice board for displaying announcements and information
- Post-exposure prophylaxis (PEP) drugs with visibly displayed instructions
- Steriliser
- Storage space for drugs
- Occupational infection control materials

Registration

All clinics should be registered with the Kenya Master Health Facility List. Each health facility and community unit in Kenya is identified with a unique code and the details describing the geographical location, administrative location, ownership, type, and the services offered. The Ministry of Health (MoH) will assess all facility-based clinics, and those that meet the above minimum requirements will be issued a Master Facility List Code (MFL Code) from the Division of M&E, Health Research Development, and Health Informatics of the Ministry of Health’s Department of Policy, Planning, and Health Financing. Registration of the KP clinic with the MoH will mean that it is recognised as an MoH clinic, and the MoH will be responsible for providing drugs and other commodities, continuous training, and supervision to registered clinics. In return, the clinics will have to fill in the MoH’s forms and report to the MoH regularly.

1.2.2 Setting up outreach clinics

The outreach clinic model, called the “moonlight model” (as most outreach clinics happen at night), expands clinical service coverage to areas where KPs do not have KP-friendly clinical services. Outreach clinics are not stationary; they can be held in any convenient and suitable site (e.g., brothel, lodge, home of a KP, or bar). The outreach clinic must have a waiting bay, a clinical exam room, and a counselling room.

WAITING BAY

The waiting bay should have

- Chairs
- Lights
- Table to display behaviour change communication and other print materials
- A rubbish bin

CLINICAL EXAM ROOM

This room should be clean and tidy. The clinical exam room should have

- Clean water supply for drinking
- Power supply
- Male and/or female condoms, banana model (dildo), and other materials for condom demonstration
- A black rubbish bin for general waste, a yellow rubbish bin for infectious waste, and a red rubbish bin for pathological waste (see Figure 2)
- Disposable sharps container
- Disposable gloves
- Lubricant
- Sink and soap for hand washing
- Obstetric examination table
- Adequate lighting and an examination light for performing vaginal and anal examination
- A door with a functional lock
- Curtains for each window to ensure privacy
- Table and chairs for doctor and patient to have private conversation
- Requisite forms, NASCOP reporting tools, and other recording books
- Skirt or gown for patient to wear when getting ready for the examination

COUNSELLING ROOM

The counselling room should be equipped with

- A desk or work table and at least three chairs
- Basic kits for the HIV test
- Power outlets
- Lights
- Male and/or female condoms and lubricant
- Basic equipment for male and/or female condom demonstration (condoms, dildo, and lubricant)

- NASCOP recording forms and record books
- Locking door to ensure privacy

1.3 Recruit KP Clinic Staff

Each facility-based KP clinic should be staffed by a clinician, a counsellor, an outreach worker, peer educators, and a caretaker. Their roles and responsibilities are described in this section.

CLINICIAN: DOCTOR, CLINICAL OFFICER, OR NURSE (CLINIC IN-CHARGE)

A clinician with basic medical qualification should be designated as the KP clinic in-charge. This person can be a medical doctor, a nurse, or a clinical officer. The clinician should have the following qualifications:

- Degree or diploma in clinical medicine and surgery/ nursing from a recognized institution
- Registered and licensed by the Kenya Medical Practitioners and Dentist Board / Clinical Officers Council / Nursing Council of Kenya
- Must have training on ART/STI/TB and reproductive health
- Must have training and certification on NASCOP MARPs sensitivity training
- Should have training and certification on good clinical practice
- Computer literacy skills with MS Office software
- Good communication skills, good inter-personal skills
- Able to provide stigma-free and non-discriminatory services
- Able to work independently with minimal supervision
- Experience working with key populations, including HIV testing services, TB, ART provision, and other HIV co-infection

The clinician should provide clinical care to the KPs and their sex partners (if applicable) at the clinic on all days that the clinic is open.

The key roles/responsibilities of the clinician at the KP clinic are to

- Assess clients for common physical and mental health challenges (Refer to *National Guidelines for HIV/STI Programming with Key Populations* for details).
- Screen for and treat STIs and opportunistic infections, and provide abscess management.
- Advise for investigation and referral.
- Screen for violence and refer appropriately.
- Motivate clients for follow-up and partner notification.
- Train staff on KP clinical issues as per national guidelines.

KP CLINIC COORDINATOR

Depending on the staff structure, either the clinician or the programme coordinator is the KP clinic coordinator. The KP clinic coordinator should be on duty daily.

The specific roles and responsibilities of the clinic coordinator in the KP clinic are to

- Supervise clinic activities on a regular basis.
- Facilitate advocacy meetings and focus group discussions.

- Develop and monitor the weekly work plan of the KP clinician, outreach workers, and counsellor.
- Arrange weekly and monthly meetings to identify shortfalls and to develop corrective measures and plans of action.
- Ensure adequate supply of drugs, test kits, condoms, and lubricants.
- Build capacity of the staff.
- Oversee the management information system.
- Develop KP clinic policies and plans.

In KP clinics providing needle and syringe exchange for PWID, the PC/ KP clinic coordinator will also have the following responsibilities:

- Ensure adequate staff for NSEP service delivery.
- Monitor and replenish NSEP kits daily or as needed.
- Manage waste management and disposal systems by instituting mechanisms to collect used needles and syringes.
- Provide additional supplies specifically requested by PWID.
- Ensure that all targeted areas are fully covered and served by outreach clinics.
- Organize weekly meetings to review progress and to address bottlenecks to NSEP implementation.
- Compile and present monthly site reports to national stakeholders.

COUNSELLOR

A counsellor should be available in the facility-based and outreach KP clinics when they are operating. If necessary, additional counsellors can be hired to meet increased demand at outreach clinics. A counsellor-to-client ratio of 1:15 should be ensured at all times. If the counsellor is designated as the KP clinic in-charge, he/she should also manage the KP clinic on a day-to-day basis.

The roles/responsibilities of the counsellor at the KP clinic are to

- Manage clients, and ensure partner notification, case follow-up, and one-to-one counselling on STI.
- Conduct pre- and post-test counselling as per national guidelines.
- Counsel KPs with high-risk behaviours.
- Provide brief psychosocial interventions.
- Conduct one to one or group counselling.
- Screen for violence and provide first line support.
- Build ORW capacity.
- Create and coordinate links/network.
- Maintain NASCOP registers.
- Promote, demonstrate, and distribute condoms.
- Assist the programme coordinator / KP clinic coordinator in team-building.
- Record KP feedback.

OUTREACH WORKERS

A roster of ORWs should be drawn up for KP clinic duties, and one outreach worker should be stationed at the facility-based and outreach KP clinic on a rotational basis. The outreach worker should assist the KP clinic in-charge in managing the KP clinic by ensuring that activities of the KP clinic are conducted as per plan.

The key roles/responsibilities of the ORW at the KP clinic are to

- Welcome KPs and make them comfortable in the KP clinic.
- Ensure KP involvement in KP clinic activities (e.g., peer navigators and having a KP as a clinic receptionist).
- Maintain rules and regulations at the KP clinic.
- Encourage KPs to visit the KP clinic and to access services.
- Facilitate formation of self-support groups in the KP clinic.
- Ensure that the concerns and suggestions of KPs reach programme managers.
- Ensure a respectable and orderly environment for KPs.
- Manage inventory of condoms, lubricants, syringes, needles, IEC materials.
- Facilitate referrals.
- Engage in BCC and distribute IEC materials on safer injecting and sexual practices to KPs.
- Review with peers the coverage of outreach clinics, and provide feedback on outreach organisation.

In KP clinics providing NSEP for PWID, the outreach workers have also the following responsibilities:

- Welcome the KPs.
- Record their history, assess their risk, and examine their injecting sites.
- Educate PWID on overdose/withdrawal/ drug dependence management, including MAT.
- Provide psychosocial counselling.
- Provide and replenish NSEP kits and other supplies.
- Provide BCC materials.
- Promote the safe disposal of used injecting equipment and related paraphernalia.
- Provide brief interventions as per individual PWID needs and available resources.
- Recording and reporting as required.

PEER EDUCATORS

Recruit peer educators who collectively represent the diversity that exists within the key population (e.g., older and younger; living with HIV and not infected; male and female PWID; MSM who are more feminine and who are more masculine in their gender expression; brothel-, home-, and street-based sex workers; etc.)

RECEPTIONIST

The receptionist should be a member of the KP community that is served by the clinic. The receptionist welcomes KP clients, tells them about the clinic's services and rules, enters the client's details in the clinic register, assesses the client's immediate and follow-up needs, and provides condoms/lubricant and needles/syringes.

The caretaker is responsible for keeping the KP clinic hygienic by cleaning the clinic daily.

Clinic staff should possess the following competencies and skills:

- thorough knowledge about harm reduction, drug use, and safe sex
- thorough understanding of social mapping, and the capacity to conduct group discussions with and brief assessments of key populations
- knowledge on waste management, especially for used syringes and needles
- ability to provide KP support and assistance
- ability to understand the community and community dynamics
- ability to promote harm reduction within the community
- ability to conduct health promotion activities with clients and the community
- ability to carry out administrative tasks such as inventory management and data collection
- ability to liaise with hospitals and emergency services to deal with KP clinical incidents
- ability to liaise with the local police station to create an enabling environment
- ability to offer immediate support and to make appropriate referrals if a client discloses violence

1.4 Train Staff and Service Providers

All clinic staff should undergo a NASCOP-approved, five-day induction training that sensitizes them to KPs and gives the staff a shared understanding of the programme's context, goals, and objectives; of HIV/STI; and of the importance of teamwork. This should be followed by separate, role-specific trainings on each staff position.

NASCOP has trained certified facilitators for all trainings. NASCOP will provide the IPs with facilitators for all their trainings.

 **CLINICIAN**

Clinicians must be trained on clinical, presumptive, and/or syndromic diagnosis and management of STIs as per national guidelines, HIV testing services, anti-retroviral therapy, and reproductive health before joining the KP programme. Algorithms for syndromic STI management are found in NASCOP's *Rapid Advice on Syndromic STI Management in Kenya* (NASCOP 2015a), and in NASCOP's *Algorithms for Managing Common STI Symptoms* (NASCOP 2015b).

Clinicians may also undergo 3-day training on gender-based violence using the curriculum developed by NASCOP.

Refresher training for clinicians

In refresher training, which will be in form of continuous medical education (CME), the facilitator (most of the time, MoH staff) will review the latest guidelines or rapid advice and will provide a refresher training for the clinicians.

COUNSELLOR

Train counsellors on the following:

- Sex and sexuality
- KP clinic counselling
- Harm reduction
- KP issues and rights
- Psychosocial counselling and support for sex workers, MSM, and PWID
- HIV/STI prevention counselling
- Evidence-based practices and treatment
- Counselling for survivors of violence

Clinical support supervision

Clinician support supervision/ debriefing is important for preventing ‘burn out’ of individual Clinician service providers and maintaining high quality communication between providers and clients or patients. Supervision/debriefing is an opportunity for clinicians to discuss and process issues that arise during clinical work with a qualified and experienced supervisor either during group or one-on-one sessions. Supervision/ debriefing should be offered by a trained and qualified clinical supervisor/Psychologist to service providers on a regular (at least quarterly) basis. It should be noted that clinical support supervision is different from administrative support supervision offered by the health management teams.

Client satisfaction surveys

Clinics should administer client satisfaction surveys quarterly to gauge the quality of their service delivery from the client’s perspective. Questions may be brief, and community members may be employed on a voluntary basis to help administer the interviews, which may address topics such as waiting time, cleanliness, clinicians attitude, and overall satisfaction with the service. Feedback from client satisfaction surveys should be shared with service providers and adjustments should be made to improve the quality of clinical service provision accordingly. KP clinics should provide suggestion boxes for collection of anonymous client feedback. Face-to-face client feedback should also be encouraged.

OUTREACH WORKERS

Outreach workers should undergo 5 days of NASCOP outreach and peer education training to make sure they know how to plan and manage outreach and referrals to the clinic. They will also undergo refresher training of IPC and BCC subsequently, if needed, to develop skills to create awareness and motivation among KPs to access services.

PEER EDUCATORS

Peer educators will undergo a 5-day outreach and peer education training using NASCOP’s curriculum, and will also undergo training on IPC and BCC as a follow-up, if needed.

Peer educators’ role-specific training should cover

- Basic knowledge on STI, HIV, and AIDS

- Myths and facts about STI, HIV, and AIDS
- Roles and responsibilities of peer educators, which include detecting cases of violence, offering first-line response, and referring appropriately
- Types of services provided by the KP clinic
- Conducting outreach to KPs
- Supporting positive health, dignity, and prevention for those living with HIV

1.5 Form Committees

Each facility-based clinic should form a KP clinic committee, an infection prevention and control committee, and a continuous quality improvement committee. These committees serve the outreach clinics as well as the facility-based clinic.

KP CLINIC COMMITTEE

The KP clinic committee oversees operations and service uptake. This committee addresses all issues raised by the KPs regarding the services offered and issues raised by the clinic team regarding the KPs.

Clinic Committee Objectives

- To improve the activities of the clinic through direct community input
- To ensure maximum access of KPs to the clinic
- To involve KPs in clinic related planning and implementation and to formalize their ownership
- To build the capacity of KPs to take a leadership role on related issues
- Provide KP feedback to the clinic to improve quality and access

The committee structure will have a chairperson and a secretary. The chairperson of the committee will be elected by KP members present in the first meeting of the committee, and should not be from the programme staff or the clinic staff. It is essential that the secretary of the committee be the clinic coordinator for purposes of convenience of assembly, communication, and smooth running of the committee. The committee works closely with the community advisory boards for the various KP types being served by the clinic to foster good relations and to ensure that services address KPs' needs and are KP friendly.

The committee will comprise

- the chairperson
- the clinic in-charge
- the KP clinic coordinator
- two members of the KP community advisory board from each KP type served by the clinic*
- the counsellor
- an outreach worker

* These KP community advisory board members should represent the diversity that exists within the key population (e.g., older and younger; living with HIV and not infected; male and female PWID; MSM who are more feminine and who are more masculine in their gender expression; brothel-, home-, and street-based sex workers; etc.)

Clinic Committee Functioning

- The committee should meet at least once per month.
- The meetings should always include the participation of KPs.
- The minutes of each meeting should be signed by all who attended, and circulated within a week.
- Inputs and decisions taken during the meetings should be incorporated in the project within a timeline given by the committee.
- The committee should review developments as per minutes of the previous meeting.
- The committee should monitor and supervise the clinic activities of the project.

If the clinic is attached to a DIC, the clinic committee and the DIC committee can be merged and constituted as one committee.



INFECTIOUS PREVENTION AND CONTROL COMMITTEE

The infection prevention and control (IPC) committee (IPCC) is responsible for preventing the spread of infection at the clinics.

The IPCC should

- Provide each unit (e.g., clinical exam room, counselling room) of the KP clinic with appropriate IPC documents.
- Ensure that the necessary and appropriate infection prevention equipment and supplies are available and used correctly.
- Advise staff on procedures to maintain a safe environment for clients, visitors, and staff.
- Plan and conduct continuous medical education for staff on good IPC practices.
- Through orientation, regular meetings, and in-service education, encourage KP clinic staff to practice IPC.
- Establish a system for identifying infections or suspected sources of infections and taking appropriate action.
- Verify the effectiveness of the precautions that have been implemented for IPC.
- Monitor staff adherence to IPC practices such as hand hygiene, cleaning, disinfection, and sterilization.
- Provide relevant information on infection problems to management.
- Perform any other duties as and when required (e.g., kitchen inspections, pest control, and waste disposal).
- Record IPC information and report it to the sub-county IPC coordinator.

The composition of the IPCC will vary depending on the services offered in the clinic. Members of this committee should be personnel who are in decision-making positions at the KP clinic (e.g., the counsellor or the clinician).

Duties of the IPCC chairperson

The IPCC chairperson should be the clinician in charge of the KP clinic, and should have knowledge of IPC. The IPCC chairperson reports to the programme manager/coordinator on all matters related to IPC.

The IPCC chairperson

- chairs the IPCC meetings

- liaises with programme management
- promotes IPC practices
- ensures that IPC guidelines and SOPs are implemented
- coordinates IPC activities (e.g., collecting, processing, analyzing, and reporting information; and instituting appropriate control measures)
- supports staff orientation and on-the-job training in IPC through continuous medical education
- liaises with internal and external sources
- ensures that appropriate and adequate supplies of IPC equipment and commodities are budgeted, requested, and reported

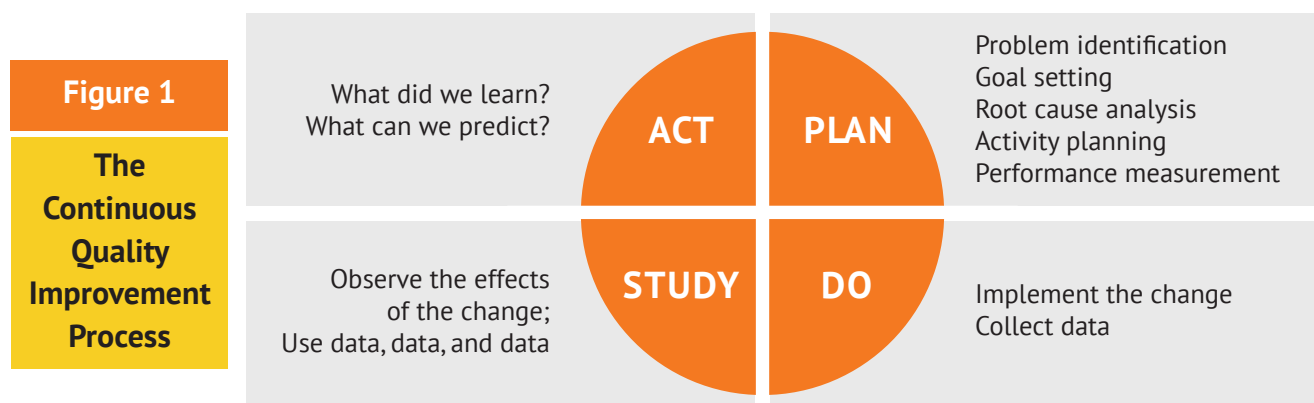
The KP clinic coordinator is the head of administration and thus will make management decisions on the action plans from the IPCC chair. For comprehensive guidance on IPC, refer to the *National Infection Prevention and Control Guidelines for Health Care Services in Kenya* (Ministry of Health 2015).

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

Every KP clinic should have a systematic process for assessing the performance of health systems and services, identifying coverage gaps and causes, introducing measures to improve quality, and monitoring impact. The continuous quality improvement process, illustrated in Figure 1, has four stages: plan, do, study, and act. This process should be led by the continuous quality improvement (CQI) committee.

The responsibilities of the CQI committee include

- Conducting routine quality improvement activities at the facility-based clinic and outreach clinic that facilitate gap identification and problem solving on an ongoing basis.
- Periodic data reviews on specific indicators, which will be used to inform programme activities.
- Monthly meetings between clinical teams and peer educators to provide a platform for clients to give feedback on service delivery and to encourage ownership.
- Monthly programme management meetings to review programme issues and to assess issues at the sites.
- Tracking the performance of all HIV testers through the national panel testing programme to ensure excellence. The CQI committee will ensure that the personnel involved in HTS are enrolled in the National HIV Reference Laboratory testing panels for quality assurance, and as such ensure that all the HTS providers undertake the panel test biannually. For those who fail, the CQI team will review the reasons for failure to ensure that these reasons do not reduce service quality.
- Conducting client exit interviews to assess client satisfaction, and sharing client feedback with the clinic team.



2.1 Facility-Based KP Clinics

2.1.1 Promote the KP clinic in the community

Make KPs aware of the KP clinic by promoting it through word of mouth, brochures, pamphlets, and site maps, and by involving KPs at every step of setting up the clinic and planning clinic activities.

Popularize the KP clinic within the community by advocating its services and by making KPs aware of the benefits of using the clinic's services. This is to be done by the outreach team and by community members who have used the KP clinic services.

2.1.2 Operating hours

Standard operating hours for facility-based clinics are 8 a.m. to 8 p.m. However, this timing can change on weekends or holidays, when KPs are available in the hotspots for longer hours. Consultation with KPs to set the timings of the clinics is very important so that more KPs can access clinics at a time convenient to them.

Ideally, clinics should be open 7 days in a week. If an IP needs to operate the clinic only on specific days, then those days should be selected in consultation with KPs. If clinics are open in the weekend, more KPs will be able to access them, as more KPs visit hot spots during the weekend. The timings of KP clinics need to be unconventional, keeping in mind the fact that these clinics have been set up to increase KPs' access to health services.

In clinics that serve PWID, NSEP should be available for a minimum of 8 hours per day. Clinics providing psychosocial support to clients in methadone maintenance, and prevention of withdrawal and overdose should operate from 6 a.m. to 6 p.m., 7 days per week, including public holidays.

2.1.3 Procedures for a KP's first visit to a KP clinic

Usually, the KP first visits the facility-based or outreach clinic upon referral from an ORW or PE. In such cases, the referring PE or ORW must accompany the KP to the clinic for the first time. In cases when a peer educator cannot accompany, the KP should be given a referral slip to bring to the clinic. In some cases, the KP may come to the clinic on his/her own, without being referred.

Upon arrival at the clinic, the PE/ORW should introduce the KP to the clinic receptionist. During this first interaction, efforts must be made to make the KP as comfortable as possible.

During a KP's first visit, the receptionist should

- Welcome the KP and describe the services available at the clinic.
- Clearly explain the do's and don'ts at the clinic.
- Explain the Patients' Rights Charter (found in Annex 1).
- Take details from the KP for follow-up.
- Enter the KP's details in the clinic register.
- Encourage the KP to visit the clinic regularly.
- Conduct condom demonstration and provide the client with commodities, such as needles/syringes and condoms/lubricant.
- Inform the KP about the crisis management system and the crisis support telephone number.

Procedures for a PWID's initial visit to a clinic

In addition to the initial-visit procedures described above, the following initial-visit procedures apply for PWID:

- The drug and substance abuse counsellor registers the KP for needle and syringe exchange.
- The counsellor conducts crisis response/triage to address any emergency or acute condition, such as overdose or withdrawal.
- The counsellor assesses the KP's history of substance abuse and performs a physical examination.
- The clinician or the counsellor educates the KP about the availability and benefits of MAT. PWID are educated about MAT at the clinic during the health education sessions and by the peer educators in the field.
- Determine eligibility for MAT, using the eligibility checklist.
- If eligible and interested in enrolling for MAT, the KP is issued a consent form and registered for MAT.
- Eligible PWID are then escorted to a MAT facility by a PE during the induction days (Monday, Tuesday, and Wednesday). The PE takes the original assessment form filled at the clinic and the consent form.
- After induction at the MAT facility, the PWID are referred back to the clinic for further observation. The observation at the clinic continues at least three days after induction—this means the PWID must visit the clinic for three days after induction.
- The clinical officer and the psychosocial counsellor have files for all the PWID who are on MAT. In these files there are copies of the assessment and consent forms. All referrals to the MAT facility, and from the MAT facility to the KP clinic are accompanied by a written document.

2.1.4 Services to provide during a KP's subsequent visits to the clinic

During subsequent visits to the facility-based or outreach KP clinic, the receptionist should remind the KP of the services offered at the clinic. The KP should receive the following services:

- **Assessment and diagnosis:** The clinician or counsellor must record the KP's
 - basic medical history;
 - history of exposure to contaminated blood and other risk behaviours; and
 - knowledge and attitude towards diseases like TB, STIs, HIV and AIDS, and hepatitis B and C.
- **Referral to HIV-related services:** If the KP is detected as HIV positive, referral to an ART centre should be made if the clinic does not provide ART.

- **Referral to other services:** Based on the need, the KP may be referred to a TB centre, centres providing nutritional support, shelter home, vocational centre, detoxification-cum-rehabilitation centre, gender-based violence centre, and so on.
- **Counselling:** As per the KP's need, one-on-one counselling should be provided on safe injection, safe sex, importance of regular access to NSEP, safe disposal, abscess prevention, HIV, hepatitis B & C, and prevention of other blood-borne infections.
- **Group discussions:** The KP should be involved in group discussions where issues pertaining to drugs, HIV, hepatitis, STIs, and other related information are discussed. The group discussion should be organized and moderated by the outreach worker or the counsellor. The clinician can lead some of the topics, especially those related to conditions such as hepatitis B & C, abscess care, HIV-related issues, etc.
- **STI screening and management:** Assess and manage STIs according to guidance found in *Rapid Advice on Syndromic STI Management in Kenya* (NASCO 2015a) and the *Algorithms for Managing Common STI Symptoms* (NASCO 2015b).
- **Screening for family planning, pregnancy, and other sexual and reproductive health needs.**
- **Condoms and lubricant.**
- **IEC materials.**

Services for PWID

In addition to the services provided for all KPs, the following basic minimum care services for PWID must be made available at facility-based and outreach clinics:

- **Abscess and wound management:** The clinic must treat abscesses, primarily removing pus and cleaning and dressing wounds. Medicines must also be provided. The staff and KPs must be trained in prevention and management of abscesses and in self-care.
- **Overdose management:** The clinic must be equipped with relevant medicines and medical equipment to manage a case of drug overdose. The staff must be trained in detection of early signs of overdose and its management. The ORWs and PEs must be given hands-on training on first aid and basic emergency care. Education and information on drug overdose must be made available through signs and pamphlets.
- **Psychiatric treatment support:** The clinician must identify psychological changes in behaviour of KPs and provide necessary treatment referrals.
- **Hepatitis B and C:** The clinician and the counsellor should provide information on hepatitis B and hepatitis C, including on prevention and management. KPs who wish to undergo testing for these conditions should be referred to an appropriate laboratory.
- **Needle and syringe exchange.**
- **Psychosocial support for MAT maintenance.**

Special considerations for NSEP implementation and condom/lubricant distribution in KP clinics

- Do not restrict the number of sterile needles and syringes or condoms/lubricant distributed. Needles and syringes and condoms/lubricant should be supplied according to individual need and not based on a one-to-one exchange with used syringes and needles.
- At least one used needle and/or syringe should be disposed of by the PWID into a safety box made available by the NSEP facility or outreach worker in order to be eligible to receive NSEP supplies.

2.1.5 Flow of clients in the clinic

- 1. Reception:** The KP will first meet the receptionist, who will initiate registration and ensure basic documentation after ascertaining the reasons for visit.
- 2. Counselling room:** The KP will next visit the counsellor, who will strengthen rapport, assure the KP of privacy and confidentiality, compile the KP's profile, complete the documentation, counsel around risks and vulnerabilities (STI, HIV, opportunistic infections, condom and lubes, violence, etc.), and prepare the KP for the clinical examination.
- 3. Clinical exam room:** The clinician will further reinforce the rapport, assure confidentiality, elicit clinical history, perform internal examination, educate the KP about the treatment and additional services, and dispense drugs. The treatment education and follow-up messages are provided in addition to education regarding condom/lubricant usage.
- 4. Counselling room:** The KP returns to the counsellor for a more detailed counselling specific to the diagnosis and advice by the clinician. The counsellor will also refer the KP (either direct or accompanied by PEs/ORWs) to other services (e.g., HTS, ART) as advised. The counsellor also maintains the completed records in a secure space.
- 5. Reception:** Before leaving, the KP again meets the receptionist to schedule the KP's next visit to the clinic.

The KP clinic patient flow chart is found in Annex 2.

2.2 Outreach KP Clinics

- Establish an outreach clinic team. The outreach clinic team comprises a clinician, a counsellor, the ORW, PEs, and community volunteers (e.g., peers, bar or spot owner). The clinician and counsellor are from the facility-based clinic or are hired specifically for the outreach clinic.
- The outreach clinic team and KP leaders select a site that has adequate space and high KP traffic for the outreach clinic, and obtain permission to hold the clinic in the site.
- The outreach clinic team and KP leaders schedule the outreach clinic to coincide with the period when the maximum number of KPs will be in the site's vicinity, as determined by information generated during micro-planning (e.g., peak days, peak hours).
- Ensure necessary resources are available and logistical planning is complete at least three days before the outreach day. Such preparations may include test kits, counselling/teaching aids such as BCC material, speculum, proctoscopes, penis model, condoms, water-based lubricants, transport, etc.
- Prepare equipment required for physical examination of the patients, as well as for internal examination if the clinic site is suitable.
- Prepare infection control materials, such as soap for hand washing; disposable gloves; bleach solution for disinfection of gloves and speculums; garbage bags that are clearly labelled for general, infectious, and pathological waste; and containers for discarded sharps.
- Promote the outreach clinic by informing the KPs well in advance about the date, place, and timing of the outreach clinic service.
- On the day of the service, the outreach team visits the site a few hours before the outreach clinic service begins and motivates the KPs to access clinical services.
- Provide the following services through the outreach clinic, to the extent that resources permit:

- HIV testing and counselling.
- Individual or group STI counselling.
- Thorough history taking and physical examination. Internal examination if the clinic site is suitable.
- Syndromic case management for symptomatic STIs.
- Treatment for asymptomatic STIs if first visit.
- Screening for family planning, pregnancy, and other sexual and reproductive health (SRH) needs.
- Screening and care for sexual and gender-based violence.
- Treatment of general ailments.
- Referrals to KP-friendly service providers for complex STI services and for other service not provided at the outreach clinic, such as ART.
- Syphilis screening.
- Intensive case finding screening for TB.
- Document all examinations and services provided during the outreach clinic on the proper forms (e.g., contact form, STI treatment form, clinic visit form, HTS form, referral form, and registration form).



REFERRING KPS TO OTHER SERVICE PROVIDERS

The KP clinic coordinator should identify and prepare a list of service providers that are KP-friendly (i.e., where at least some staff have been trained to be sensitive to KPs' needs). When referring a KP to another service provider, capture all data pertaining to the referral. Track referrals and ensure completeness of the referral process.

3.1 Procedures for Referring a KP to Another Service Provider

- If a KP requires a service that is not provided at the KP clinic, inform the KP that he or she must be referred to an appropriate service provider.
- Explain to the KP that the programme needs to capture information on the referral to know whether the referred services and “to come after” (i.e., date of next appointment) are given, and obtain the KP's consent.
- Complete a referral form in triplicate.
- One of the copies should be stored at the clinic. The clinician will provide the client with two copies of the referral form.
- The KP will present the two copies of the referral form to the service provider at the facility where she/he seeks care.
- After treatment, the service provider will indicate the service provided on the referral forms, and sign and stamp both copies.
- One copy of the referral form should be retained at the referral facility, and the KP takes home the other copy.
- A peer educator should accompany the KP to the referral service provider to ensure that the KP receives high quality treatment.

3.2 Procedures for Tracking Referrals

- Each referral facility should keep their copies of the referral forms in a file.
- At the end of each week, programme staff or outreach workers should retrieve the referral forms from all of the referral facilities. Alternatively, clients should present the signed and stamped referral forms during their next KP clinic appointment.
- The clinician should update the clients' records and the linkage register, client referral forms, transfer in forms, and transfer out forms to reflect the completed referral.

4.0

DOCUMENT AND REPORT CLINIC ATTENDANCE AND ACTIVITIES

Facility-based and outreach KP clinic staff should routinely document all clinic activities conducted. The following NASCOP documentation forms, diaries, and registers should be used to record each service that a KP receives at the KP clinics:

- KP clinic register
- Clinic visit form
- STI treatment form
- Violence form
- Client scheduling diary
- Referral and linkage form
- TB screening form (Intensive case finding form)
- HTS register
- Referral and linkage register
- Pre-ART register / Patient preparation register
- ART register
- ART patient treatment card (MoH 257)
- Daily activity register
- Daily activity sheet
- ART scheduling diary
- PEP register
- Isoniazid preventive therapy register
- Family planning register

All KP clinics are required to submit monthly reports to the sub-county health management teams using the Ministry of Health's monthly reporting tools. KP clinics must also report to NASCOP's key populations programme every three months using NASCOP's quarterly reporting tool.

5.0

WASTE MANAGEMENT

Waste at the facility-based clinic and outreach clinic requires special procedures for handling, transport, and disposal in order to prevent disease transmission to health care workers, clients, waste management workers, and the public.

Segregate waste into four categories—general, infectious, pathological, and sharp waste (see Figure 2)—at the point where the waste is produced. Such segregation creates a safe workplace and minimizes handling of hazardous material during disposal.

All staff should be aware of the different categories of waste and where each type should be disposed.

Facilities for proper handling and disposal of biohazardous waste in the facility-based and outreach KP clinics should be ensured by the IPCC. Used needles and syringes and other biohazardous materials, such as dressing materials, must be sent to private waste management agencies or to approved government hospitals for proper disposal. The IPCC should ensure that all KP clinics have proper waste disposal mechanisms.

Figure 2 Waste Segregation Guidelines

Prevention of needle stick injuries and risk of disease transmission starts with you!

General Waste	Infectious Waste	Pathological Waste	Sharp Waste
Paper Packaging material Food	Gauze/ dressing Used IV/ fluid lines Used gloves Infusion set	Anatomical waste - Teeth - Placenta Pathological waste - Sputum container - Test tube containing specimen	Cannula/branula Broken slides Broken vial Broken ampules Lancet Retractables Scalpels Blades Needles Suture needles
			

It is the responsibility of health personnel to segregate waste immediately according to type

5.1 Precautions for Safely Managing Sharps and Sharps Containers

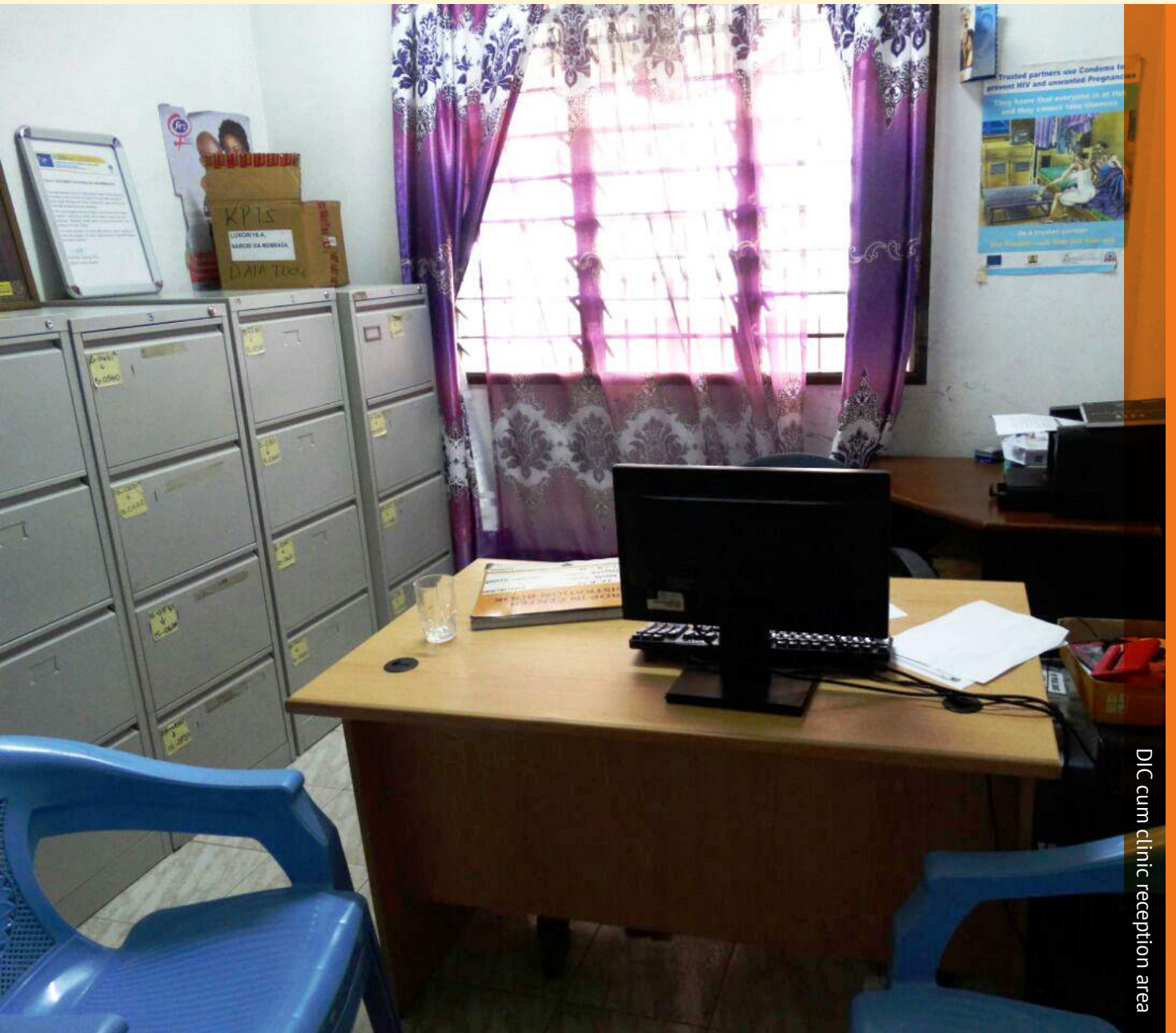
Prevent access to used needles and syringes and other sharps by disposing of them immediately after use in a designated puncture- and leak-proof container. Make sure that sharps containers are appropriately placed and easy to see, recognize, and use:

- Put sharps containers as close to the point of use as possible and practical, at a convenient height, and ideally within arm's reach.
- Attach containers to the walls or other surfaces, if possible.
- Label sharps containers clearly with a biohazard symbol so that people will not unknowingly use them as a garbage or trash container.
- Keep sharps containers in the area where sharps are being used.
- Do not place containers in high-traffic areas, such as corridors outside patient rooms or procedure rooms, where people could bump into them or be stuck by someone carrying sharps to be disposed of.
- Do not place containers on the floor or anywhere they could be knocked over or easily reached by a child.
- Do not place containers near controls/switches for lights, overhead fans, or thermostats, where people might accidentally put their hands on them.
- Mark a fill line on the sharps container at three-quarters full.
- Do not fill the sharps containers above the three-quarters-full mark.
- Do not shake a container to settle its contents and make room for more sharps.
- Seal the container when it is three-quarters full and do not reopen it. Never reopen, empty, or reuse a sharps container after closing and sealing it.
- After it has been sealed, store the used sharps containers in a secure area, out of reach of patients and other unauthorized persons, while it awaits transport for final disposal.
- Dispose of sharps waste in an efficient, safe, and environment-friendly way to protect people from exposure to used sharps.

Note: For detailed guidance on safe disposal of sharps, refer to Section 5.4 on management of health care waste in the *National Infection Prevention and Control Guidelines for Health Care Services in Kenya* (Ministry of Health 2015).

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D/C cum clinic reception area

Annex 1

CHAPTERS 1, 2, AND 3 OF KENYA'S PATIENTS' RIGHTS CHARTER *

Chapter 1: Patients' Rights

Every person, patient or client, has a:

1. Right to access health care.

Health care shall include promotive, preventive, curative, reproductive, rehabilitative and palliative care.

2. Right to receive emergency treatment in any health facility.

In emergency situations, irrespective of the patient's ability to pay, treatment to stabilize the patient's condition shall be provided.

3. Right to be informed all the provisions of one's Medical Scheme/Health Insurance Policy.

Anyone who is enjoying the provisions of a medical cover (insured) is entitled to know all the privileges accorded and also entitled to challenge, where and if necessary, the contents and decisions of the medical scheme and health insurance policy.

4. Right to choose a health care provider.

A patient's right to access a health care provider of his choice shall not be unduly restricted by third parties so long as the provider of choice is qualified, registered, retained and in current good standing with the Regulatory Authority to provide treatment for the particular ailment or illness and as long as that choice is acceptable in medical and ethical standards.

5. Right to the highest attainable quality of Health care products and services.

Every person has the right to the highest attainable quality of health care products and services.

6. Right to refuse treatment.

Any person, patient or client may refuse, withdraw or withhold treatment and such refusal shall be documented in writing by the medical service provider and in the presence of an independent witness, provided that such refusal, withdrawal or withholding does not create an immediate danger to the patient or the health of others and provided further that the consciousness and competency of the person has been taken into account.

* Ministry of Health 2013

7. Right to confidentiality.

This shall be upheld except where consent has been expressly given or disclosure is allowed by law or in the public interest. Confidentiality shall be maintained even after a patient's death.

8. Right to informed consent to treatment.

To be given full and accurate information in a language one understands about the nature of one's illness, diagnostic procedures, proposed treatment, alternative treatment and the costs involved for one to make a decision except in emergency cases. The decision shall be made willingly and free from duress.

9. Right to information.

Every patient is entitled to receiving full and accurate information concerning their health and health care. In addition every patient is entitled to access and to obtain information about their health.

10. Right to be treated with respect and dignity.

11. Right to a second medical opinion.

Every person has the right to a second medical opinion if so desired, regarding diagnosis, procedures, treatment and/or medication from any other qualified health professional of one's choice.

12. Right to complain

Every person has a right to complain about health services to the relevant authorities, such complaint should be investigated and receive a response from the authority within a reasonable time that does not exceed twelve months. Where there is a delay, the relevant authority shall provide the reasons.

13. Right to insurance coverage without discrimination on the basis of age, pregnancy, disability, illness including mental disorders.

14. Right to donate his or her organs and/or any other arrangements/wishes upon one's demise.

Chapter 2: Responsibilities

Every patient has the following responsibilities:

1. To take care of his/her health by adopting a healthy lifestyle.
2. If the patient is a minor, protection, care and healthy lifestyle of the minor shall be the responsibility of the parent or guardian of the minor.
3. To adopt a positive attitude towards their health and life.
4. To protect the environment.
5. To respect the rights of others and not to endanger their life and health.
6. To give health care providers relevant, accurate information to facilitate diagnosis, treatment, rehabilitation and/or counselling while being truthful and honest on past health care.
7. To take care of the health records in his or her possession and produce them if and when required by the health care provider.
8. To keep scheduled appointments, observe time and if not possible, communicate to the health care provider.
9. To follow instructions, adhere to and not abuse or misuse prescribed medication or treatment and/or rehabilitation requirements.
10. To enquire about costs of treatment and rehabilitation and to make appropriate arrangements for payments.
11. To be aware of the available health care services in his or her locality and to make informed choices while utilizing such services responsibly.
12. To inform the health care providers, where necessary, when one wishes to donate his or her organs and/or any other arrangements / wishes upon one's demise.
13. Where an adult patient is not competent to make decisions on health care services the spouse, where applicable, next of kin and/or the guardian shall accord protection and care to the patient.
14. To seek treatment at the earliest opportunity.
15. To express any concerns through the right channels confidentially.

Chapter 3: Dispute Resolution

Disputes may arise from the following areas, including:

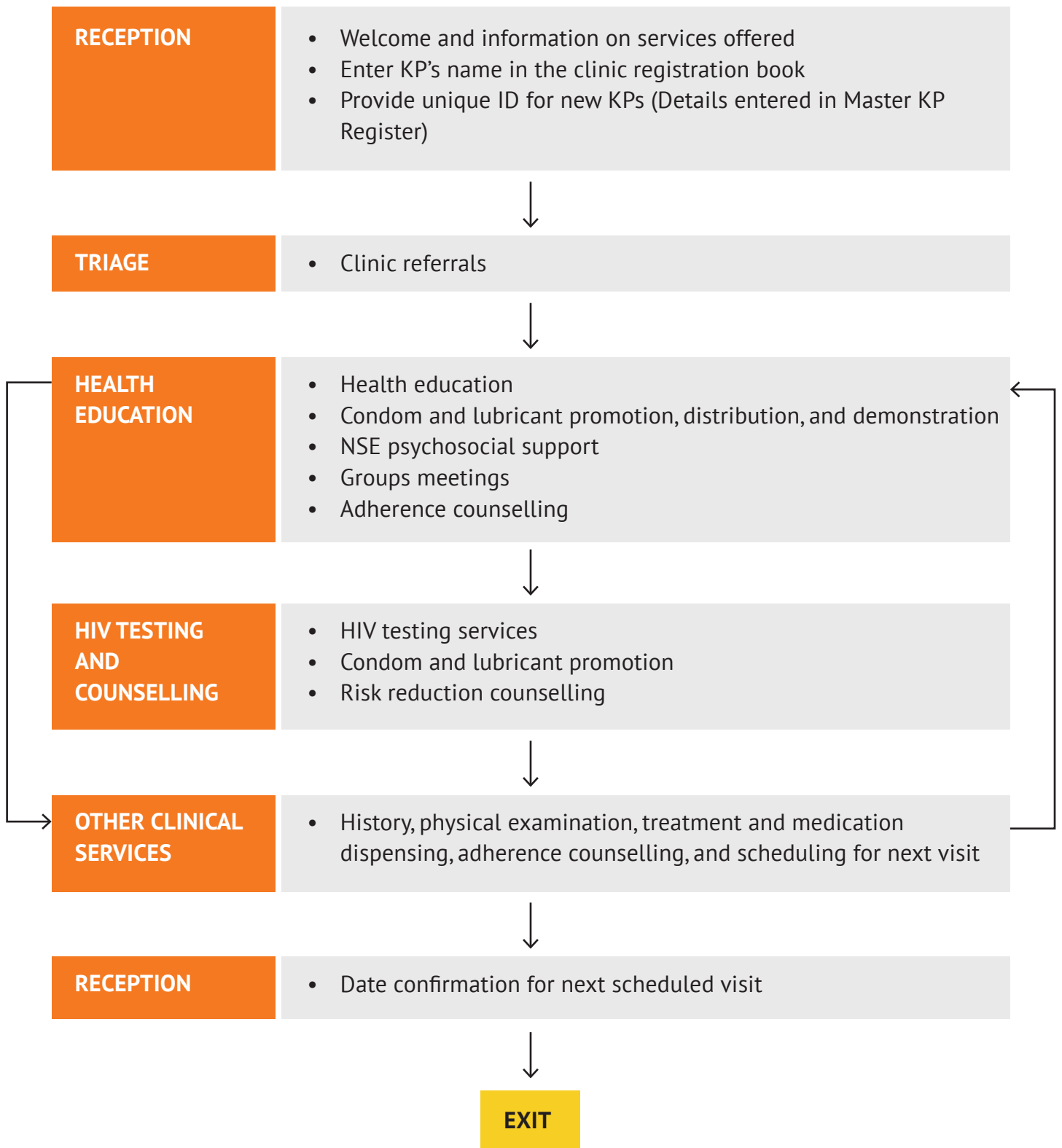
1. Patient and health care provider;
2. Patient and financier/insurer;
3. Patient and the employer, and
4. Patient and Regulatory Body.

Any dispute arising from the rights and responsibilities set out herein above, their exercise and/or enforcement may be resolved through any of the following ways:

1. The patient may lodge the dispute directly with the Health Care Provider. The provider may resolve the dispute amicably, formulate an internal inquiry, establish a committee and/or internal body to consider it and thereafter take appropriate steps which resolve the complaint conclusively to the satisfaction of all the concerned parties.
2. The patient may opt to lodge the complaint with the relevant Regulatory Authority or body as set out by the applicable Statutes, which include:
 - (i) The Public Health Act, Chapter 242 of the Laws of Kenya;
 - (ii) The Medical Practitioners & Dentists Board Act, Chapter 253 of the Laws of Kenya
 - (iii) The Pharmacy & Poisons Board, Chapter 244 of the Laws of Kenya;
 - (iv) The Nursing Council of Kenya;
 - (v) The Clinical Officers Council;
 - (vi) The Kenya Medical Laboratory, Technician and Technologists Board;
 - (vii) The Radiation Protection Board;
 - (viii) The Nutritionists and Dietician Institute,
 - (ix) The Consumer Protection Act, and
 - (x) The Public Health Officers and Technicians Act, 2013.
3. The patient may lodge a claim in Court seeking appropriate remedies as provided under Law.

Annex 2

KP CLINIC PATIENT FLOW CHART





Ministry of Health

NASCOP

National AIDS/STI Control Programme

Box: 19361-(00202) Kenyatta National Hospital (KNH) Grounds



BILL & MELINDA
GATES foundation

