

# APHIA II North Eastern Project

## *Quarterly Program Report*



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## LIST OF ABBREVIATIONS

AAC	Area Advisory Committee
ABY	Abstinence and/or Being Faithful (Youth)
AED	Academy for Educational Development
AFB	Acid Fast Bacillus
AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual Operational Plan
APHIA	AIDS, Population & Health Integrated Assistance Program
APR	Annual Progress Report
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communications
CACC	Constituency AIDS Control Committee
CBT	Capacity Building Team
CCC	Comprehensive Care Center
CDC	Centers for Disease Control and Prevention
CDF	Constituency Development Fund
CHBC	Community and Home-Based Care
CHW	Community Health Worker
CIC	Community Implementation Committee
CME	Continuing Medical Education
COMPASS	Community Participation for Action in the Social Sector
CSW	Commercial Sex Worker
CTO	Cognizant Technical Officer
DASCO	District HIV/AIDS Coordinating Officer
DCC	District Community Coordinator
DFC	District Facility Coordinator
DHMT	District Health Management Team
DHRIO	District Health Records Information Officer
DMS	Director of Medical Services
DMLT	District Medical Laboratory Technologist
DTC	Diagnostic Testing and Counselling
DQA	Data Quality Audit
EID	Early Infant Diagnosis
EMOC	Emergency Obstetric Care
ESD	Extending Service Delivery
FBO	Faith-based Organization
FPPS	Family Programmes Promotion Services
FHI	Family Health International
GOK	Government of Kenya
GIS	Geographic Information System
HBC	Home-based Care
HCBC	Home and Community-Based Care
HCT	HIV Counselling and Testing
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
HR	Human Resources
HRM	Human Resources Management
HRH	Human Resources for Health
HRIO	Health Records and Information Officer
HTSP	Healthy Timing and Spacing of Pregnancies
ICB	Institutional Capacity Building
IDP	Internally Displaced Persons

IEC	Information, Education and Communication
IP	Implementing Partner
KAIS	Kenya AIDS Indicator Survey
KEMRI	Kenya Medical Research Institute
LLITN	Long-Lasting Insecticide-Treated Nets
LDP	Leadership Development Program
LOE	Level of Effort
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOPHS	Ministry of Public Health and Sanitation
MOMS	Ministry of Medical Services
MSH	Management Sciences for Health
MTC	Medical Training College
NACC	National AIDS Control Council
NASCOP	National HIV/AIDS & STI Control Program
NCCS	National Council of Children Services
NEP	North Eastern Province
NEPHIAN	North Eastern Province HIV/AIDS Network
NEWS	North Eastern Welfare Society
NHSSP	National Health Sector Strategic Plan
NOPE	National Organization of Peer Educators
OI	Opportunistic Infection
OJT	On-the-job training
OVC	Orphans and Vulnerable Children
PAC	Post Abortal Care
PASCO	Provincial AIDS and STD Coordinator
PGH	Provincial General Hospital
PHMT	Provincial Health Management Team
PICT	Provider Initiated Counselling and Testing
PIS	Performance Improvement Specialist
PLWHA	People Living with HIV/AIDS
PMO	Provincial Medical Officer
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PNA	Performance Needs Assessment
PTC	Provincial Training Committee
QA	Quality Assurance
QC	Quality Control
SAM	Senior Alignment Meeting
SAPR	Semi-Annual Progress Report
STI	Sexually Transmitted Infections
SUPKEM	Supreme Council of Kenyan Muslims
TB	Tuberculosis
TIMS	Training Information Management System
TMP	Training Master Plan
TNA	Training Needs Analysis
TOF	Training of Facilitators (also refers to a facilitator him/herself)
TOT	Training of Trainers (also refers to a trainer him/herself)
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
VSAT	Very Small Aperture Terminal
WASDA	Wajir South Development Agency
YFS	Youth Friendly Services

## INTRODUCTION

APHIA II (AIDS, Population, and Health Integrated Assistance Program) is an agreement between the Government of Kenya and USAID. The APHIA II North Eastern Province (NEP) project brings together a team of organizations under the umbrella of the Extending Service Delivery project: Pathfinder International; IntraHealth International; and, Management Sciences for Health.

APHIA II is designed to provide improved and expanded, sustainable HIV/AIDS and tuberculosis (TB) prevention, treatment, care and support together with integrated reproductive health and family planning services. Increased service access and use and the promotion of healthy behaviors among groups most-at-risk of HIV infection are also goals. Project activities occur at both health facility and community-levels and involve a high level of collaboration with GoK partners and stakeholders at district and provincial levels.

Currently the HIV/AIDS clinical care burden remains limited in NEP compared to other regions in Kenya, but increasing prevalence and confounding factors such as high TB prevalence and low women's status signal the need to particularly address prevention, as well as improve access to treatment/care. Also of concern is the increasing TB prevalence and TB's increasing association with HIV, which is less than in the rest of Kenya, but may also be on an upward trend. As for women's and children's health and well-being, NEP has particularly dire conditions as a result of recent drought, past civil strife, an extremely high fertility rate, and low healthcare-seeking behavior and access to services. Recent droughts, inadequate diet, and less than 1% exclusive breastfeeding have resulted in high levels of wasting in children and high infant mortality rates.

Some highlights from the current quarter:

- The project continues to outperform its targets for reaching individuals with prevention messages through community outreach, having already surpassed its annual targets after the first two quarters of Year Two. While behaviors generally do not change based upon a single message, there is clearly an attitudinal shift taking place in many parts of NEP in terms of reduced stigma related to HIV. Proxy indicators include increasing numbers of individuals coming for counseling and testing; people beginning to speak in public of their HIV status; and the increasing membership in PLWHA groups in major towns across the province. As the project's support to the formation and functioning of PLWHA groups increases, it is anticipated that membership in these groups and registration with the CCCs will also increase.
- The project continues to have unprecedented impact in terms of numbers of clients counseled, tested and receiving results. The second quarter alone achieved nearly 87% of the annual target. Innovative approaches like moonlight VCT and house-to-house (family) CT are proving to be both popular and effective.
- Beginning this quarter, the project has focused its CT interventions on key populations at higher risk in urban and peri-urban areas. Comparing CT results between last quarter, which featured extensive CT outreach in the rural areas during the HCT campaign, and this quarter, appears to validate this strategy. The rate of all VCT clients in NEP testing positive this quarter was 3.0%, compared

with 0.3% last quarter. The KAIS estimated prevalence rate for the province as a whole is 0.8%.

- This quarter, the project piloted SDM in Ijara district as a method of pregnancy spacing. There has been a common vision and close collaboration between local MOH officials and APHIA II NEP staff on introducing SDM as part of pregnancy spacing services. APHIA II NEP has also engaged religious leaders in discussions on increasing awareness of the SDM as a modern method, which has contributed to high social acceptance in Ijara District. The significant contribution of SDM to CYP this quarter in comparison to the previous quarter is a clear indicator that the method is not only acceptable but popular. Based on the performance so far, the project is confident that SDM can now be rolled out to other districts in the province using the same approach.

**Table 1. Achievements against Targets**

Indicator	Achievements			Y2 targets	Percent Y2 to date
	Oct-Dec 2008	Jan-Mar 2009	Total		
<b>Prevention (Abstinence and being faithful)</b>					
Number of individuals reached through community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	58,563	65,864	124,427	120,000	<b>103.7%</b>
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence	77,934	17,159	95,093	N/A	
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	0	29	29	920	<b>3.1%</b>
<b>Condoms and other prevention activities</b>					
Number of targeted condom service outlets	0	9	9	20	<b>45.0%</b>
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful, by gender	44,170	10,912	55,082	7,000	<b>786.9%</b>
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	22	28	50	60	<b>83.3%</b>
<b>Palliative care (TB/HIV)</b>					
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) according to national or international standards	58	66	66	10	<b>80.0%</b>
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	12	76	88	350	<b>25%</b>
Number of TB patients who received HIV counselling, testing, and their test results at a USG supported TB outlet	459	339	798	700	<b>114%</b>
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed)	0	27	27	50	<b>54%</b>
<b>Orphans and vulnerable children</b>					
Number of OVC served by an OVC program	3,615	2,431	6,046	5,000	<b>121%</b>
Male	2,906	1,165	4,071	2,500	<b>163%</b>
Female	709	1,266	1,975	2,500	<b>79%</b>
Number of individuals trained in caring for OVC	0	154	154	500	<b>31%</b>
<b>Counseling and Testing</b>					

Number of service outlets providing counseling and testing according to national or international standards	22	29	29	10	<b>70%</b>
Number of individuals who received counseling and testing for HIV and received their test results	25,282	8,349	33,631	10,000	<b>336%</b>
Number of individuals trained in counseling and testing according to national and international standards	0	0	0	100	<b>0%</b>
<b>Strategic Information</b>					
Number of local organizations provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS)	9	11	20	15	<b>133%</b>
Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	8	20	28	35	<b>80%</b>
<b>Systems Strengthening</b>					
Number of local organizations provided with technical assistance for HIV-related policy development	0	13	13	4	<b>325%</b>
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	2	11	13	4	<b>325%</b>
Number of individuals trained in HIV-related policy development	0	0	0	40	<b>0%</b>
Number of individuals trained in HIV-related institutional capacity building	0	15	15	40	<b>38%</b>
<b>Palliative care (excluding TB/HIV)</b>					
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	23	28	28	70	<b>40%</b>
Number of service outlets providing pediatric HIV-related palliative care (excluding TB/HIV)	6	6	6	N/A	
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	0	27	27	50	<b>54%</b>
Number of individuals provided with pediatric HIV-related palliative care (excluding TB/HIV)	32	30	62	N/A	
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	805	904	904	3,000	<b>30%</b>
<b>HIV/AIDS treatment/ARV services</b>					
Number of service outlets providing ART services according to national or international standards	6	8	8	15	<b>53%</b>
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	23	47	70	500	<b>14%</b>
	(0-14)	1	3	4	
	(15+)	22	44	66	
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)*	435	490	490	1,100	<b>45%</b>

	(0-14)	29	32	32		
	(15+)	406	458	458		
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites), by gender, age and pregnancy status*						
	Male (0-14)	1	10	11		
	Male (15+)	121	144	144		
	Female (0-14)	0	14	14		
	Female (15+)	183	191	191		
	Pregnant female (all ages)	0	7	7		
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)						
		0	0	0	50	0%
<b>Prevention of Mother-to-Child Transmission</b>						
Number of service outlets providing the minimum package of PMTCT services according to national or international standards						
		82	85	85	60	142%
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results						
		6,402	6,900	13,302	29,407	45%
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting						
		13	18	34	879	4%
Number of health workers trained in the provision of PMTCT services according to national and international standards						
		0	38	38	120	32%
<b>Additional Indicators</b>						
Couple years of protection (CYP) in USG-supported programs						
		936	972	1,908		
Number of people trained in FP/RH with USG funds						
		27	25	52		
Number of counseling visits for FP/RH as a result of USG assistance						
		Not reported	Not reported			
Number of USG-assisted service delivery points providing FP counseling or services						
		20	24	24		
Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP						
		Not reported	Not reported			
Number of new FP acceptors as a result of USG assistance, by FP method						
		1,418	1,513			
Number of service outlets renovated or equipped to facilitate provision of HIV/AIDS or TB related services						
		0	16	16		
Number of PLWHA support groups formed and/or linked to other services as appropriate						
		0	5	5		
Number of health workers trained in stigma reduction						
		28	0	28		
Number of individuals trained in the provision of laboratory-related activities						
		0	11	11		

**RESULT 1:  
IMPROVED AND EXPANDED FACILITY-BASED HIV/AIDS, TB AND RH/FP**

APHIA II NEP's strategy during Project Year Two is to focus interventions primarily on forty "high volume" facilities throughout the province. The high-volume facilities were identified during the facility assessments conducted at the end of 2007 and beginning of 2008. As the capacity of these facilities is strengthened, APHIA II NEP will expand its support to include lower-volume facilities.

The months of January to March normally consist of the dry season that sees great movement of populations in search of water and pasture. This period for this particular year was more severe than usual: the last four rainy seasons in NEP have been unsatisfactory. The radical change in migratory patterns created a great challenge for the project to map planned activities against target populations. Some facilities traditionally marked as high volume were practically abandoned while small facilities with inadequate infrastructure for integrated service delivery suddenly found themselves swamped with clients seeking services.



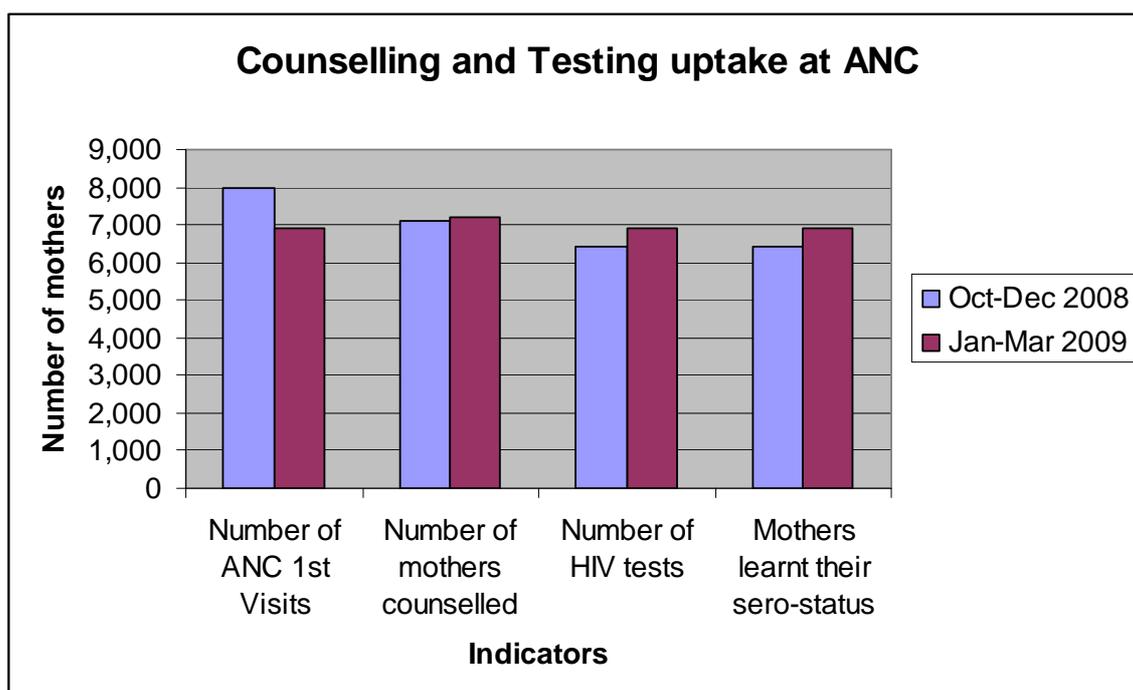
*Severe drought: APHIA II NEP staff assisting pastoralists with drinking water during a field trip.*

## 1.1 Prevention of Mother to Child Transmission (PMTCT)

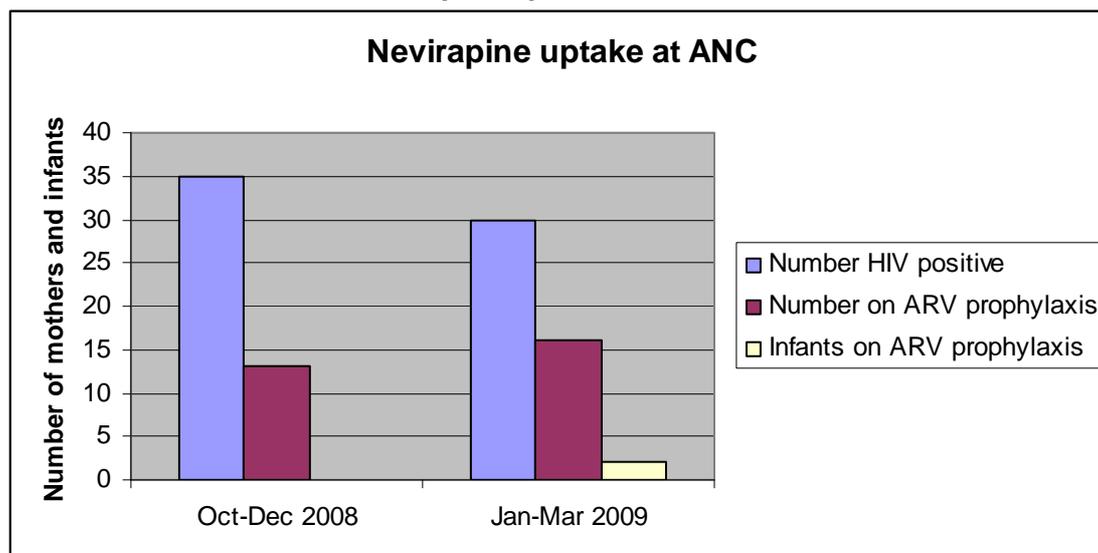
Table 2: Cascade for overall uptake of PMTCT services: October 2008 – March 2009

PMTCT Cascade	Oct-Dec 2008	Jan-Mar 2009	Totals
Number of ANC 1st Visits	7,971	6,900	14,871
ANC revisits	8,441	8,263	16,704
Number of mothers counseled	7,084	7,217	14,301
Number of HIV tests	6,408	6,900	13,308
Mothers learnt their sero-status	6,402	6,889	13,291
Number HIV positive	35	30	65
Number on ARV prophylaxis	13	16	29
Infants on ARV prophylaxis	0	2	2
Mothers tested at maternity	68	21	89
Number of deliveries	2,981	2,372	5,353

Figure 1: Counseling and testing at ANC: October 2008 – March 2009



**Figure 2: Mother and infant nevirapine uptake at ANC**



### 1.1.1 Key observations on performance

- Number of PMTCT reporting sites increased during this quarter from 52 to 85. This tremendous increase has been made possible through intensified support by the new MCH/RH/FP coordinator and concerted efforts of the DFCs and DHMTs.
- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results increased by nearly 10% over the previous quarter and reflects a continuous upward trend since the beginning of 2008. The project anticipates meeting its annual target should the trend continue.
- Over 95% of mothers counseled were tested and, of these, 99.8% received their results. This is an improvement over the previous quarter when the percentages were 86% and 96% respectively.
- Number of mothers attending ANC first visit declined by 24 per cent. This was attributed to the laying off of contract nurses during the month of December and January, as well as the Christmas break during which some facilities were closed. Contract nurses resumed in January/February and the project anticipates the number of ANC visits to increase in the next quarter.
- The project's success in improving access to PMTCT services can be attributed to a multi-pronged strategy which includes training of providers, provision of furniture and equipment, supporting quarterly facilitative supervision, improving internal referral linkages and supporting facilities to provide a comprehensive antenatal package.
- According to the data, 53% of mothers who tested positive were put on nevirapine. As for those who did not receive nevirapine, after conducting follow-up the project has confirmed that in the majority of cases mothers actually were issued with nevirapine but it was not correctly recorded; however, there are also confirmed cases where mothers did not receive nevirapine and these are still being followed up by the project. Initially most facilities did not stock nevirapine but this has been addressed. Some facilities are stocking AZT as well.

- Two infants born of HIV positive mothers (6 per cent) received nevirapine syrup. This is a slight improvement from last quarter but it remains a big challenge. Although nevirapine syrup has been rare in NEP, even where available, it has been a challenge to offer 2ml per kg from a bottle containing 240 ml in total. Cases of nevirapine syrup expiring have been reported. Innovative ways to provide smaller doses of nevirapine syrup are being pursued.
- Service providers trained by APHIA II NEP to offer PMTCT services continue to receive refresher updates on emerging issues. One area that APHIA NEP has emphasized is the issuance of both mother nevirapine tablets and infant syrup on the establishment that the pregnant mother is HIV positive. This is a reversal on the earlier practice where mothers were referred to the CCC to receive prophylaxis. Previously, nevirapine syrup had been in short supply in the province although the situation has now improved.
- DBS for early infant diagnosis is being supported logistically by APHIA II NEP. This quarter, 7 EID tests were sent to KEMRI; results are being awaited. District Medical Laboratory Technologists are being assisted to coach other lab techs to take up this activity.
- The project continued the distribution of national PMTCT policy guidelines, as well as maternity, ANC and postnatal registers, and national guidelines and manuals for various services, throughout the province.
- Support by APHIA II NEP for DHMT facilitative supervision in all the eleven districts and the provincial general hospital has resulted in generally improved reporting and better planning by some DHMTs. The project is putting continued emphasis on improving the quality of supervision through training and use of supervision tools and guidelines.
- Support for integrated mobile outreaches continues to yield better results than most static facilities for numbers of mothers counseled and tested. Fortunately, the large majority of rural mothers routinely test negative.
- Couple counseling in PMTCT settings is gaining increasing acceptance, particularly in Garissa and Ijara (see tables below).

**Table 3: Partner counseling and testing**

**October-December 2008 Partners counseled and tested**

	Ijara	Garissa	Wajir	Mandera*	Total
Partners counseled for HIV	18	152	124	0	294
Partner tested	18	142	106	0	266
HIV +ve	0	4	0	0	4

\*Data not available for Mandera district

**January-March 2009 Partners counseled and tested**

	Ijara	Garissa	Wajir	Mandera*	Total
Partners counseled for HIV	73	192	126	0	409
Partner tested	68	147	108	0	341
HIV +ve	0	1	1	0	2

\*Data not available for Mandera district

### 1.1.2 Challenges

- The project is working on putting in place proper outreach and defaulter tracing mechanisms particularly at higher volume facilities.
- The packaging of nevirapine syrup for infants in 250 ml bottles is unfavorable considering that the individual dose is 2 ml and, once opened, it remains potent for only 2 months. In the coming quarter, APHIA NEP will facilitate the provision of micro-test tubes with caps to enable easy issuance of nevirapine syrup throughout the province.
- APHIA II NEP continues to support identification of gaps in specific facilities, particularly in terms of anthropometric tools, furniture and space, through joint quarterly supervisions. The project is procuring and supplying basic essential equipments and furniture at the sites which it supports.
- High staff turnover both at management and facility levels, particularly among staff whose contracts have expired and are not picked up by MOH or NASCOP.

### 1.1.3 Planned Activities for the next quarter (April - June 2009)

- Continue logistic support for EID in order to increase coverage of infants in need of ARVs and care.
- Ensure that AZT and HAART are available in high volume facilities.
- Support quarterly PMTCT supervision focusing on test distribution, nevirapine prophylaxis and reporting by DASCOS/District RH coordinators/DMLTs in order to improve quality of PMTCT services.
- Improve storage facilities of test kits at district laboratory stores through air conditioning where possible or refrigeration and creation of more space where space is an issue and the intervention is feasible.
- Train/update 30 health workers on PMTCT.
- Support improved nutritional interventions such as infant feeding options and food by prescription in all the operational PMTCT sites by building linkages and coordination with partners. Where dire need is identified, material support will also be explored.
- Continue supporting divisional/district CMEs for PMTCT service providers.
- Support on-the-job training of more service providers on EID and PMTCT.
- Support stigma reduction interventions through couple counseling and testing.

## 1.2 Counseling and Testing

**Table 4: Counseling and testing performance against Year 2 target**

<b>Counseling and Testing Performance against Year 2 Target</b>			
<b>Reporting period</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
<b>Oct-Dec 2008</b>	11,321	13,961	25,282
<b>Jan-Mar 2009</b>	4,505	3,842	8,349
<b>Total</b>	15,826	17,803	33,631
<b>Year 2 target</b>			<b>10,000</b>
<b>Half year results in percent</b>			<b>336%</b>

Figure 3: Counseling and testing (July 2008 – March 2009)

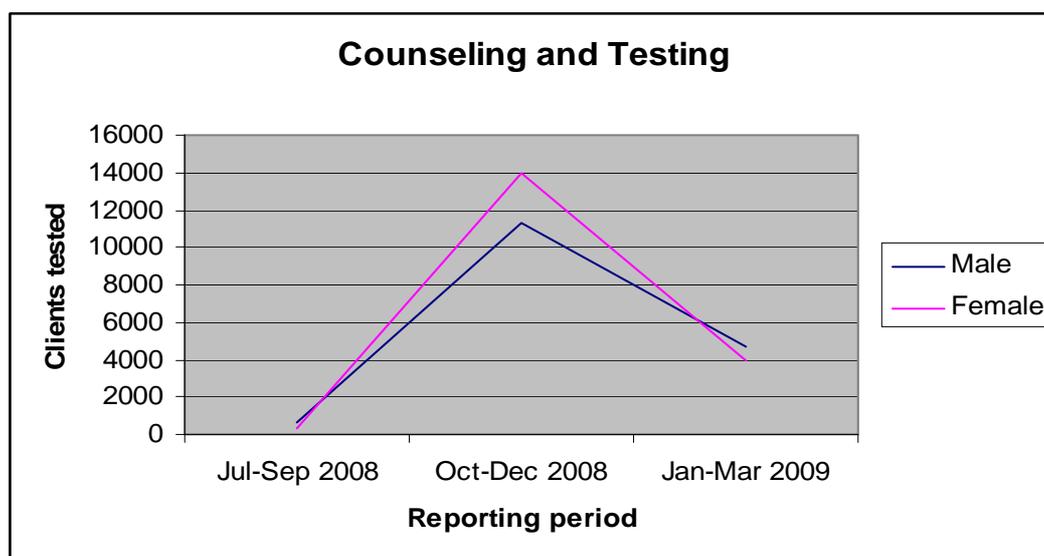


Table 5: Counseling and testing with results, by district (October 2008 – March 2009)

Oct-Dec 2008 Counseling and testing with results						
	Males tested	Males HIV+ve	Percent HIV +ve	Females tested	Females HIV+ve	Percent HIV +ve
Garissa	3,888	23	0.59%	3,939	27	0.69%
Ijara	1,630	4	0.25%	2,107	6	0.28%
Mandera	398	2	0.50%	1,641	2	0.12%
Wajir	5,405	12	0.22%	6,274	15	0.24%
<b>Total</b>	<b>11,321</b>	<b>41</b>	<b>0.36%</b>	<b>13,961</b>	<b>50</b>	<b>0.36%</b>

Jan-Mar 2009 Counseling and testing with results						
	Males tested	Males HIV+ve	Percent HIV +ve	Females tested	Females HIV+ve	Percent HIV +ve
Garissa	3,787	90	2.38%	3,096	84	2.71%
Ijara	143	1	0.70%	192	3	1.56%
Mandera	125	8	6.40%	71	12	16.90%
Wajir	452	36	7.96%	483	18	3.73%
<b>Total</b>	<b>4,507</b>	<b>135</b>	<b>3.00%</b>	<b>3,842</b>	<b>117</b>	<b>3.05%</b>

### 1.2.1 Key observations on performance

- Last quarter's counseling and testing numbers were unnaturally high because of the national HCT campaign. However, even taking that into account, the project continues to have unprecedented impact in terms of numbers of clients counseled, tested and receiving results. The second quarter alone achieved nearly 87% of the annual target. Innovative approaches like moonlight VCT and house-to-house (family) CT are proving to be both popular and effective.

- Beginning this quarter, the project has focused its CT interventions on key populations at higher risk in urban and peri-urban areas. Comparing CT results between last quarter, which featured extensive CT outreach in the rural areas during the HCT campaign, and this quarter, appears to validate this strategy. The rate of all VCT clients in NEP testing positive this quarter was 3.0%, compared with 0.3% last quarter. The KAIS estimated prevalence rate for the province as a whole is 0.8%.
- Mandera registered very high rates of CT clients testing positive this quarter. The project is investigating this further to try and determine the cause.
- Renovation and furnishing of VCT sites continues. So far, 23 facilities have benefited or continue to benefit from this intervention. Greater Mandera was negatively affected in this program area due to the temporary withdrawal of APHIA II NEP staff due to insecurity.
- Initiated support for moonlight VCT in Wajir town.
- Scale-up of counseling and testing, including PICT, in the service provision facilities.

### **1.2.2 Challenges**

- Initiating PICT is challenging since health workers have to re-align their operations to accommodate the new practice and that there are no national tools on collecting the data.
- Linking of HIV+ persons with care and support services is still inadequate and related to stigma levels in the province which, while starting to come down, still remain unacceptably high. As the project's assistance to the formation and functioning of PLWHA groups increases, it is anticipated that membership in these groups and registration with the CCCs will also increase.
- VCT counselors supported by NASCOP had their contracts terminated. This rendered VCT sites like Takaba to become non-operative. Others were left with low capacity to operate as a result of having only one counselor. The project is exploring the possibility of hiring these counselors on behalf of the MOH through Capacity Project.
- Privacy is compromised in some VCT sites which are yet to be renovated and at times during VCT outreach, but the project is assisting providers to rectify this.
- Test kit storage is a challenge in terms of space and cold chain in most district stores. The project is working with the MOH to address this challenge.

### **1.2.3 Planned activities for the next quarter (April - June 2009)**

- Operationalize an additional 8 VCT sites according to national and international standards.
- Hire an additional 10 VCT counselors on behalf of the MOH in order to meet demand.
- Finalize discussions to absorb NASCOP laid-off VCT counselors in affected VCT sites.
- Initiate and strengthen counselor supervision and networking for active counselors to consolidate quality counseling and mitigate burnout.
- Support supply of test kits and reagents to the all active VCT sites.

- Develop QA and QC policies and systems for HIV testing internally and externally.
- Create extra CT rooms in VCT sites that are in the process of being upgraded to CCCs.

### 1.3 Palliative Care and TB/HIV Integration

**Table 6: TB indicators (January - March 2009)**

		Totals		
		New	Re-att	Grand Total
1	No. of TB cases detected	751	53	<b>804</b>
2	No. of smear positive	305	98	<b>403</b>
3	No. of smear negatives	386	111	<b>497</b>
4	No. of Extrapulmonary TB patients on treatment	133	61	<b>194</b>
5	Total No. of TB patients on Treatment	3,783	268	<b>4,051</b>
6	Total No. of TB patients on Re-treatment	204	96	<b>300</b>
7	Total No. completed treatment	452	70	<b>522</b>
8	Total No. of TB Patients tested for HIV	522	128	<b>650</b>
9	Total No. of TB Patients HIV+ve	44	32	<b>76</b>
10	No. of TB HIV patients on CPT	152	39	<b>191</b>
11	No. of defaulters	43	14	<b>57</b>

#### 1.3.1 Key observations on performance

- Opened 5 new TB treatment centers and helped to equip them.
- Continued to achieve 100% DTC services for all TB patients (all new patients diagnosed with TB were screened for HIV), apart from Mandera where two DTLCs supervise the entire greater Mandera District.
- The project attended the quarterly provincial TB meeting held in Habaswein in February 2009. It was agreed that the next quarterly meeting will be held jointly with DASCOS and DMLTS to better address issues of TB/HIV co-infection.
- Provided and fixed furniture for Wajir East TB Manyatta VCT.
- Support for the marking of World TB day at Dambas, presided over by the PTLC/PMLT.
- Continued to support MDR-TB surveillance through logistical facilitation and specimen referral to Central Reference Laboratory.
- All patients diagnosed with TB are screened for HIV at the TB clinic (coverage >99% apart from Mandera where coverage is about 80% (report from PTLC)).

- The practice of putting TB patients who are HIV positive on prophylactic cotrimoxazole seem to have been institutionalized. The report indicates low coverage but available data in the TB program indicates >99% coverage.
- Provided and fixed furniture for TB Manyatta VCT and other TB diagnostic centers in Garissa.

### **1.3.2 Challenges**

- Data provided by PHRIO is obtained from district summaries and is not complete because DTLCs routinely do not update MOH 711 on a monthly basis.
- Transport is a major challenge for the DTLC to conduct routine supervision; however the project continues to provide logistic support for the district TB activities.
- Pathetic state of TB manyattas poses a great challenge. The TB program needs to specifically outline plans for the manyatta concept into the future, including making a decision on whether the manyatta concept is one that has outlived its usefulness thanks to improved access to facilities. In the absence of clear policy direction, the project will be reluctant to invest significantly in upgrading the manyattas.
- Collaboration between TB and HIV programs in the ministry has been a challenge due to inequity in resource allocation. Joint TB/HIV collaboration committees have been dormant.

### **1.3.3 Planned activities for the next quarter (January – March 2009)**

- Continue support for integrated TB/HIV social mobilization, screening and follow-up in all districts.
- Continue support for joint support supervision for DTLCs, DASCOS and DMLTs to improve quality of service provision.
- The project will support the harmonization of HMIS and the vertical TB program data.
- Support TB MDR surveillance in conjunction with the respective DTLCs.
- Continue supporting TB/HIV collaboration by provision of TA and logistic support and rejuvenation of the Provincial and District TB/HIV collaboration committees.
- Support improvement of diagnostic sites by supporting lab technologists and minor renovations to selected labs to offer TB microscopy services in 14 labs.
- Training of DTLCs and DASCOS in TB/HIV/AIDS and ART to cover all active CCCs and TB diagnostic sites.
- Training service providers in TB microscopy and basic TB/HIV integration.
- TB laboratory and clinical support supervision for quality assurance by the project in collaboration with the provincial and national TB program.
- The project will support external quality control for sputum specimens.

## 1.4 ARV Treatment Services

### 1.4.1 Key Observations on Performance

- By the end of the reporting period, APHIA II NEP was supporting 8 care and treatment sites, all of which are offering ART treatment. All ART sites offer adult HIV treatment while two of these sites also provide pediatric HIV treatment.
- The project supported client follow-up and initiation of ARVs for eligible clients (WHO guidelines) in the active sites.
- Seven new sites were identified and information forwarded to KEMSA by the PASCO for registration as satellite ARV sites. The process is on course and APHIA II NEP is supporting infrastructural and logistic inputs to finalize the initiative.
- 



*Ijara DMLT testing new lab equipment procured with support from USG to improve ART services.*

### 1.4.2. Challenges

- Attrition and transfer of trained personnel continue to affect the provision of this service. Clinical officers and doctors are the only ones currently mandated to offer these services and there are very few of them in the province. Furthermore these cadres seem to be the ones most affected by staff movements.
- Patients on ARVs are not monitored according to national standards as basic reagents for the biochemistry analyzer donated by CDC and the CD4 counter machine still remain a gap in this quarter.

### 1.4.3 Planned activities for the next quarter (April - June 2009)

- Supplement the supply of basic essential reagents for monitoring HIV care for priority facilities.
- For CD 4 count (initial and follow-up), support district labs with logistics (CD4 stabiliser tubes and transport) to PGH for processing.

- Provide furniture in the new CCC sites.
- Follow ART commodity management at the satellite sites.
- Continue to support ARV supply and client follow up in the new districts.
- Training for service providers to enable them offer quality HIV/AIDS care and treatment services including pediatric ART.

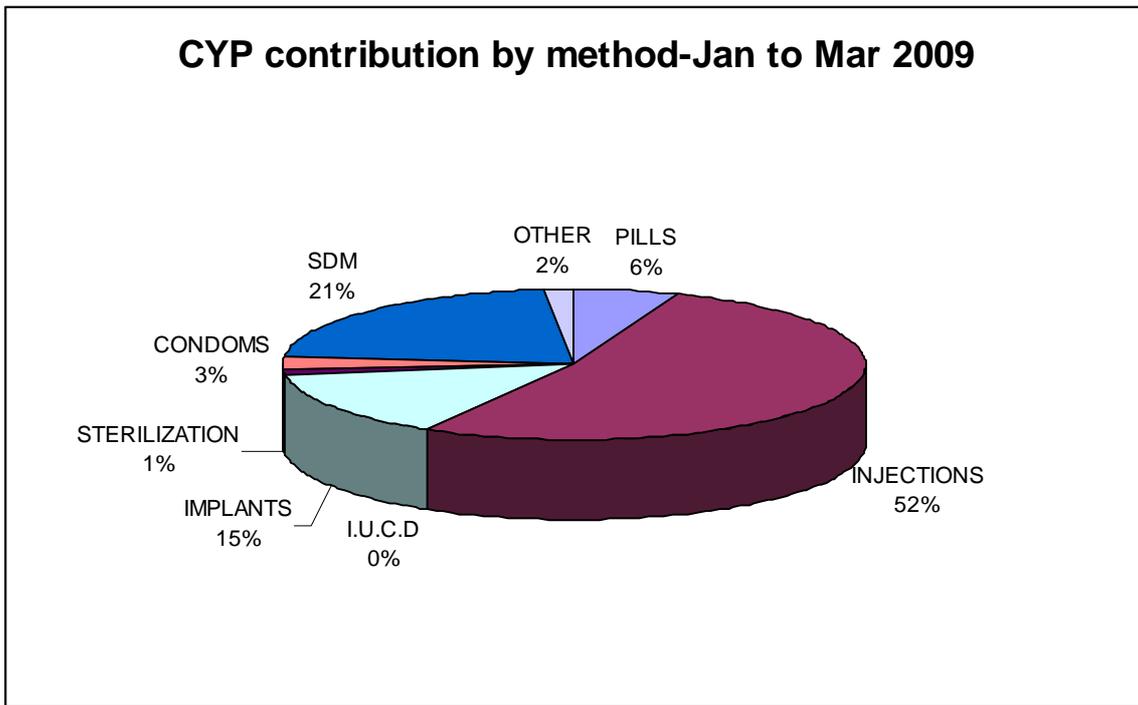
### 1.5 Reproductive Health/Family Planning

**Table 7: Summary of FP method provided (October 2008 – March 2009)**

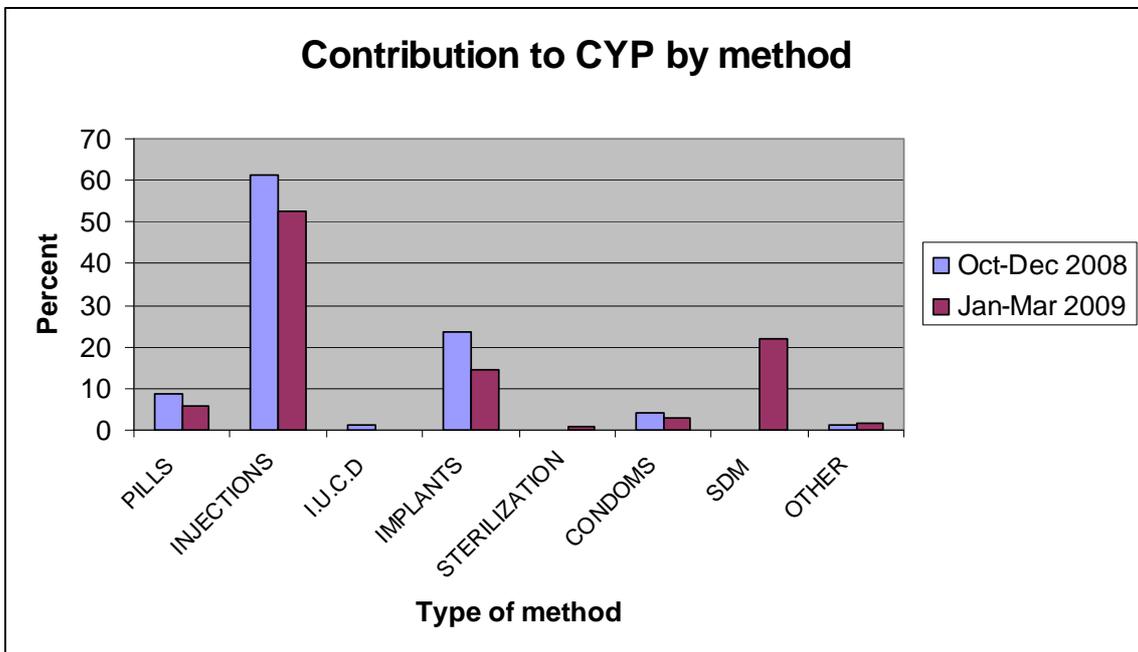
			Totals Oct-Dec 2008		
			New	Re attendance	Total
1	PILLS	Microlut	212	135	347
		Microgynon	214	292	506
2	INJECTIONS	Injections	675	959	1,634
3	I.U.C.D	Insertion	3	0	3
4	IMPLANTS	Insertion	43	10	53
5	STERILIZATION	B.T.L	1	0	1
		Vasectomy	30	0	30
6	CONDOMS	No. of Clients receiving	2,408	803	3,211
7	ALL OTHERS: (specify)		150	9	159
8	TOTAL NUMBER OF CLIENTS		3,718	2,208	5,926
9	REMOVALS:	IUCD	2	0	2
		IMPLANTS	8	0	8

			Totals- Jan-Mar 2009		
			New visits	Re-attendance	Grand Total
1	PILLS	Microlut	211	142	353
		Microgynon	235	238	473
2	INJECTIONS	Injections	797	1,153	1,950
3	I.U.C.D	Insertion	0	0	0
4	IMPLANTS	Insertion	29	16	45
5	STERILIZATION	B.T.L	1		1
		Vasectomy	20		20
6	CONDOMS	No. of Clients receiving	2,243	770	3,013
7	ALL OTHERS: (specify)		359	46	405
8	TOTAL NUMBER OF CLIENTS		3,892	2,365	6,257
9	REMOVALS:	IUCD	4		4
		IMPLANTS	3		3

**Figure 4: Contribution to CYP by contraceptive method (January – March 2009)**



**Figure 5: Contribution to CYP by contraceptive method (October 2008 – March 2009)**



### **1.5.1 Key Observations on Performance**

- This quarter, the project piloted SDM in Ijara district as a method of pregnancy spacing. There has been a common vision and close collaboration between local MOH officials and APHIA II NEP staff on introducing SDM as part of pregnancy spacing services. APHIA II NEP has also engaged religious leaders in discussions on increasing awareness of the SDM as a modern method, which has contributed to high social acceptance in Ijara District. The significant contribution of SDM to CYP this quarter in comparison to the previous quarter is a clear indicator that the method is not only acceptable but popular. Based on the performance so far, the project is confident that SDM can now be rolled out to other districts in the province using the same approach.
- FHI-Kenya has been collaborating with APHIA II NEP project staff and NEP MOH officials to conduct research that will help answer the question of who uses the SDM. Preliminary findings indicate that the SDM is bringing in new users to FP. The results of this study will be available around July 2009 and could be used to inform the Division of Reproductive Health on its efforts to support future SDM integration efforts.
- The project, with technical support from the Extending Service Delivery (ESD) project, is creating a model for Mothers' (Safe Motherhood) Clubs as an entry point for discussion of safe motherhood topics in a safe environment. The intention of the clubs is to have women of reproductive age educated on the need for healthy timing and spacing of pregnancy, attendance to antenatal clinics, delivery under skilled attendance, and the role of HIV counseling and testing services, among other topics. It is expected that by increasing the knowledge of women on safe motherhood topics that the demand for and utilization of related services will increase, thus ensuring that services are used by those who need them most. During the quarter, three pilot sites for the Mothers' Clubs were identified at Balambala, Sankuri and Saka in Garissa district. In addition, the project will formalize its support to a similar club that had already started off in Masalani, Ijara district.
- Thirty five service providers were trained on counseling and testing in FP clinic settings, 30 service providers were provided with a contraceptive technology update and one service provider was trained in post-rape management.
- The project continued to support RH activities through support supervision and some basic equipment and supplies.

### **1.5.2 Challenges**

- FP data collection and verification still remains a challenge with late submission of data from the province being observed throughout the quarter.
- Lack of the MoH Service Delivery Point (SDP) numbers for stand-alone VCT centers is hindering provision of FP services as part of FP into VCT integration.
- Most facilities lack basic equipments and job aids for promotion of these services.
- Lack of contraceptive method mix across most of the districts.

- Stockouts of FP commodities due to poor reporting/ordering practises.

### **1.5.3 Planned activities for the next quarter (April - June 2009)**

- Train and update service providers on FANC and contraceptive technology update
- Increase the number facilities providing contraceptive commodity mix through provision of essential equipment and supplies.
- Provide appropriate job aids and basic equipments.
- Sensitize maternal death audit committees in the new districts.
- Support post training follow up and RH/FP supervision for staff yet to be trained.
- Train health care workers on post-abortion care and post-rape management, including trauma counseling.
- Scale SDM to new districts after successful piloting in Ijara. As expansion continues in other districts, it will be important to do close follow up of service providers in the first months after training to ensure that they are providing quality counseling on the method, including ensuring a woman's eligibility to use the method and ensuring that new users understand how to use the method before they leave the clinic. Additional things to note during supervision are whether MOH guidance on ordering new supplies and recording of SDM users is followed, and whether providers are making efforts to understand how women and couples are accepting the method and whether they are experiencing problems using the method.

## **1.6 Systems Strengthening and Other Capacity Building**

### **1.6.1 Key Observations on Performance**

#### **Training activities**

The Provincial Training Committee has continued to play a critical role in the approval, coordination and monitoring of all training activities in the province. In a meeting of the PTC held on 27<sup>th</sup> March 2009, APHIA II NEP was designated secretary of the committee.

The PTC noted that there is need to update the training master plan based on the TNA done by DHMTs and APHIA II NEP district teams. Thereafter, a gap analysis should be done and appropriate trainings to address these gaps should then be organized and conducted. The revised Training Master Plan (TMP) will be presented to the PTC for approval in April.

The Capacity Building Team coordinated and facilitated the following training events:

- A lab tools dissemination workshop for 11 District lab in-charges from all NEP districts. Updated information was shared on lab registers, forms, and commodity and supply management tools.
- A Project and Grants Management workshop for 6 Board members and 10 project staff of two APHIA II NEP sub-grantees: NEWS and SIMAHO.

- Five OVC caregivers' workshops focusing on Rights of the Child, attended by 30 OVC caregivers and 124 district Area Advisory Council (AAC) members from Garissa, Wajir East, Wajir North, Mandera East and Fafi districts. Each workshop developed a follow-up plan which included quarterly supervision by the AACs.
- The CHBC training for 30 participants drawn from 5 implementing partners in Garissa district.

### **Training and Technical Assistance for HIV-related Policy Development**

The Capacity Building and Community Outreach teams initiated discussions with the relevant stakeholders for HIV policy development, including the Provincial Education Office, the NACC field office and children's department.

Training of 40 members of the PHSF and DHSF from the education, livestock and agriculture sectors; uniformed personnel under the Office of the President; and, the Gender, Youth and Children ministries is scheduled for next quarter.

### **Training and Technical Assistance for HIV-related Institutional Capacity Building**

The project continued to support local partners SIMAHO and NEWS to develop their institutional capacities in HR management, financial management, strategic information systems and project management and with the submission of their December–February quarterly reports.

APHIA II NEP provided financial and technical support for development of the district Annual Operating Plans (AOP) and consolidation of the Provincial AOP5. This involved guidance on planning, target setting, identification of priority activities, human resources management and development and budgeting activities of the plans. It also involved supporting the Provincial Health Records Officer to review AOP5 targets, consolidated formats for community units, levels 2 - 4 facilities, the PGH and the district management teams. This process should contribute to the development of better district and provincial AOP5 plans.

The project supported a financial management rapid assessment covering all 11 districts and a Financial Management workshop attended by 25 DHMT members. The project will provide follow-up support for the improvement of financial management in the region during the months of May through September.

APHIA II NEP is supporting the rollout of the Leadership Development Program (LDP) program in NEP. LDP is meant to address leadership and management capacity gaps in the health sector in the province in order to improve service delivery and quality. The LDP is a team-based, learning-by-doing process that takes place over 3 mini-workshops and 3 meetings across 4-6 months. Unlike traditional leadership training programs that introduce leadership theories, values, and behaviors in a course setting without link this learning to producing measurable organizational results, the LDP participants learn about leading and managing frameworks that resonate with their experiences.

The teams work on a required leadership project focused on a specific work-based challenge and receive feedback and support from facilitators, colleagues, and local managers as they work towards their results. Through this project, teams learn a proven method of leading and managing to address their challenges and produce measurable results. This creates learning experiences that move through the experiential learning cycle and are associated with transformative change.

In the reporting quarter, the project initiated the rollout of the LDP in NEP by holding a senior alignment meeting (SAM) at Garissa with the participation of 21 provincial and district health sector leaders. The SAM developed the provincial vision for the LDP program, identified 5 LDP champions, 4 sponsors and 5 supporters at the provincial level and developed a plan for the rollout of the program. A performance assessment for the LDP in NEP has been planned to take place in May to be followed by a ToFs training workshop in June 2009.

In the reporting quarter, the project initiated renovation works in 9 facilities and completed works at Bute DH VCT, Wajir North district. The facilities which saw the initiation of renovation works include: PGH; Modogashe DH; Sankuri Dispensary and SIMAHO Dispensary (Garissa District); Habaswein DH in Wajir South district; Elwak DH in Mandera Central District; Takaba DH in Mandera West District; Khorofharar SDH; and, Griftu DH. The renovations have largely focused on VCT sites and laboratories. APHIA II NEP also carried out assessment of a multi-purpose hall at Al-Hiraya Orphanage.



*Renovated VCT centre at Bute District Hospital, Wajir North.*

## **Quality Improvement and Management**

The Performance Improvement Specialist (PIS) visited greater Wajir (4 districts) in January 2009 to identify challenges and opportunities for quality programming and conduct task-skill assessments to determine the staff development needs of the DFCs and DCCs, as well as give guidance on general quality management to the district teams.

APHIA II NEP held a Quality Management orientation workshop for its service delivery district level staff during which the PIS shared draft quality management tools. The tools include, among others, Facility Assessment (Performance Needs Assessment or PNA) checklist, Provider Assessment checklist and Summary of Training Needs form. The tools are continually improved to reflect feedback from users. Subsequently, the PIS led one-day quality improvement capacity building sessions for Garissa, Fafi and Lagdera DHMTs respectively.

The purpose of the PNA checklist is to form a baseline and basis for any interventions at the 40 high volume facilities. The facility's needs in relation to APHIA II NEP's mandate are identified, and form the basis for negotiations with the stakeholder (MOHs) on what APHIA II NEP can support. The data collected also forms a yardstick against which to measure the effect of interventions made by APHIA II NEP in the facility supported. Application of the tool is done together with the district level MOH staff (DHMTs). In one instance in Garissa district, by using the tools, the DHMT was able to get assistance from another donor to meet needs for supplies and equipment since they were able to show the actual needs by facility (using the summary of equipment, supplies and infrastructure development tool).

The Provider Assessment (training needs assessment) and summary of training needs form shall be updated on a quarterly basis and forwarded to the Training Coordinator and informs the process of determining need for particular kinds of training, as well as helping to rationalize invitation of staff for training.

APHIA II NEP is building the capacity of the MOH to conduct systematic, facilitative supervision. Working through APHIA II NEP's district teams, supervision tools and supervision plans are being used to conduct supervision visits. It has been demonstrated that use of the tools contributes greatly to improving the quality of supervision. To strengthen this further, APHIA II NEP intends to conduct training for managers in NEP on Facilitative Supervision and Quality Improvement to complement the coaching and mentoring on FS/QI that APHIA II NEP has been providing the teams on-the job.

### **1.6.2 Challenges**

- i) Delays in deploying 22 lab techs on behalf of the MOH due to delays in the award of the next Capacity contract.
- ii) Approximately 80 service providers employed on contract with UNICEF saw their contracts end and left their posts in December. This had a catastrophic effect upon the delivery of services, with many facilities closing, reducing their hours and/or reducing the types of services offered. Many of the staff had been trained and supported by APHIA II NEP in the provision of various services. Although subsequently recalled for a three-month contract extension, the

incident highlighted the degree to which NEP is dependant upon contract employees for the provision of health services to its residents.

### 1.6.3 Planned Activities for the next Quarter (January - March 2009)

#### Training Activities

- Coordinate and monitor quality of prioritized trainings for the following programs: AB, C&T, TB/HIV, ART and HIV-related Policy Development (as indicated in the table below):
- Use of the PNA results from the districts to prioritize and organize training and Technical Assistance activities.
- IEC materials development workshop has been planned for the next quarter.
- The following table shows balances of programmatic trainings areas not completed in the reporting quarter that will be implemented in quarters 3 and 4:

**Table 8: Balances of Programmatic Training Areas to be Implemented in Q3 and Q4**

Program Area	PMP Target	Planned	Pending
		Apr – Jun 09	Jul – Sept 09
PMTCT	120	30	21
AB	920	460	430
Other Prevention	150	70	58
Palliative care (TB/HIV)	50	25	25
Palliative care ( BHC ) - HBC, Nutrition	100	30	43
OVC Care & Support	500	120	115
Counseling and Testing	100	60	40
ART	50	30	20
Lab Services	0	0	15
Strategic information ( Data Management)	35	24	0
Systems Strengthening- HIV -related Policy Development	40	50	40
Systems Strengthening- HIV -related Institutional Capacity Building	40	0	108
Systems Strengthening- HIV-related Community Mobilization for Prevention, Care & or Treatment	0	29	0
<b>OTHER INDICATORS:</b>	<b>PMP Target</b>	<b>Apr – Jun 09</b>	<b>Jul – Sept 09</b>
FP/RH - FANC/MIP/TB	150	60	24
FP/RH - CTU/HIV	50	0	26
FP/RH - PAC	0	0	0

- Continue work on a training information management system that disaggregates and updates data on a quarterly basis by district, facility, type of training and date of training among other features under development.

## **Technical Assistance Activities**

### **HIV-related Institutional Capacity Building and Quality Improvement**

- Follow-up and support for the improvement of financial management in the region shall follow in the months of May through September.
- Continuous support for project management of the SIMAHO and NEWS sub-grantees.
- Carry out a performance assessment for the LDP in NEP in May, to be followed by a ToFs workshop in June 2009.
- Carry out Performance Assessment for 12 pilot Health Center/Dispensary management committees.
- Continuous development of a number of performance improvement draft tools including for; comprehensive supervision; Leadership Development Program Facilitators needs assessment and selection; knowledge and practice assessment, and Facility Management Committee needs assessment.

## **RESULT II:**

### **EXPANDED CIVIL SOCIETY ACTIVITIES TO INCREASE HEALTHY BEHAVIOR**

The project continues to outperform its targets for reaching individuals with prevention messages through community outreach, having already surpassed its annual targets after the first two quarters of Year Two.

As noted in previous reports, the province is culturally and socially receptive to AB messages. The project continues to work closely with and through religious and traditional leaders to ensure that they have the right information about HIV/AIDS prevention and are getting it out to their constituents. Youth leaders working particularly within the structure of Chill clubs are getting messages out to thousands of young people.

Religious leaders, in particular, reach large numbers of individuals (there are over 100 mosques in Garissa town alone) with messages promoting abstinence before marriage and being faithful to one partner. These messages are in accordance with religious teachings; the role of the project is to provide religious leaders with technical information and support.

Other prevention messages beyond abstinence and behavior change are being passed through religious leaders and peer educators, with special emphasis put on reaching key populations at higher risk, particularly in urban areas.

While it is unlikely that behaviors will change based upon a single message, there is clearly an attitudinal shift taking place in many parts of NEP in terms of reducing

stigma related to HIV. Proxy indicators include increasing numbers of individuals coming for counseling and testing; people beginning to speak in public of their HIV status; and the increasing membership in PLWHA groups in major towns across the province.

**Table 9: Number of individuals reached in prevention activities (October 2008 – March 2009)**

Indicators	October - December	January - March	Year 2 Achievement to Date	Year 2 Target
Number of individuals reached through community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	58,563	65,864	124,427	<b>120,000</b>
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful, by gender	44,170	17,159	95,093	<b>7,000</b>

### 2.1 Abstinence/Being Faithful

- Findings and implications of the Sexual Networks Assessment were shared and discussed with religious leaders in most of the districts.



*A “Chill” club session in Garissa Girls Secondary School.*

- Continued dissemination throughout the province of the resolutions from the Religious Leaders' conference which was held in May 2008.
- The project held monthly monitoring meetings with youth leaders and "Chill" Club patrons in greater Garissa, Wajir and Ijara. The "Chill" Clubs continue to be popular among the school-going populations. Monthly meetings in Mandera were hindered due to security operations targeting young men, causing most of them to flee the region.

### **2.1.1 Other Prevention Activities**

The project engaged the National Organization for Peer Educators to assist in assessing the quality of the project's peer education activities. The project has been very successful in meeting or surpassing its outreach targets; now the project is putting increasing emphasis on improving both the quality and the targeting of the messages – both AB and OP.

The assessment had four major objectives:

1. to establish the current status of APHIA II NEP peer education approaches with regards to qualitative and quantitative standards;
2. to link the peer education system with the findings of the Sexual Networks Assessment, which established the basis for interventions to reduce HIV/STI risk among key populations in Garissa, North Eastern province and in Eastleigh, Nairobi;
3. to assess the connection between the peer education process and the *Twaweza* behavioral communication strategy (BCS); and,
4. to provide recommendations that will strengthen the system to attain the ultimate impact.

The assessment report is attached as Appendix I.

### **2.1.2 Challenges**

- The security situation in Mandera forced the project to suspend operations at its office and had a negative impact on the ability to conduct monthly monitoring visits.
- High turn over of trained youth for the school health program.

### **2.1.3 Planned activities for the next quarter (April - June 2009)**

- Discuss findings and recommendations of NOPE peer education assessment and agree on next steps.
- Conduct KAP survey to evaluate the impact of the year one activities.
- Expand the school health program to 15 primary schools and 5 secondary schools.
- Training of youth leaders for secondary schools using the secondary curriculum (G-pange).
- Monthly monitoring meetings with youth leaders and chill club patrons in greater Garissa, Wajir, Mandera and Ijara.

- Two NOPE facilitators will conduct a one-week Information, Education and Communication (I.E.C.) materials development workshop. During the workshop, stakeholders will generate messages targeting key populations at higher risk (identified during the Sexual Networks Assessment), that will then be pretested in Garissa and produced through media such as posters, billboards, caps, T-shirts, wall murals, flyers, etc.
- Participate in the AB Partners Meeting to review the implementation plan of the Ministry of Education life skills curriculum.
- Conduct an education stakeholders' workshop to give feedback to stakeholders in NEP on the proposed rollout of the life skills curriculum.
- Train 60 peer educators to reach more population with OP message

### **RESULT III: EXPANDED CARE & SUPPORT FOR PEOPLE AND FAMILIES AFFECTED BY HIV/AIDS**

#### **3.1 Home and Community Support: Home-based Care**

The implementation of a successful community and home-based care strategy will be an important contribution, not only towards improving access to palliative care but also the reduction of stigma. It is a relatively new concept in NEP, but is already showing signs of promise and reflecting gradually reduced levels of stigma in that PLWHA groups are coming forward and keen to participate. As usual, the support of religious and traditional leaders is also being cultivated and will be critical to the success of this program.

##### **3.1.1 Key observations on performance**

- The project is working with five PLWHA groups operating within Garissa municipality or just across the Tana River in Madogo. These five PLWHA groups were chosen because they were deemed to be representative of their constituents and also because of their consistent reporting on their activities to NACC.

<b>PLWHA Group</b>	<b>Areas of Operation</b>
Ebeneza	Windsor; Jamhuri Club; Kambi Moto
Mwangaza	Mororo; Madogo; Ziwani; Bakuyu
OPAHA	Garissa market; Bulla Rig; Garissa Ndogo; NEP Girls; Northern zone
SIMAHO	Township; Bulla Sheikh
Pastoral Aid	Wagberi; Iftin; Msalani; PGH area

- Last quarter, the project assisted each PLWHA group to identify 10 CHWs from their respective zones. First priority was given to PLWHA and families affected, followed by retired nurses, PHTs, and social workers. Literacy was also an important criterion.

In January, the project trained half of the CHWs on Community and Home-based Care for PLWHA, using the national training curriculum. The training had two goals:

1. To develop the skills of the community-based health workers in home-based care delivery and the transfer of nursing care skills to primary caregivers as well as to people living with HIV/AIDS to enable them to take care of themselves.
2. To improve the quality of life for PLWHAS by establishing linkages between health professionals and untrained primary caregivers at home.



*Training of CHWs on Community and Home-based Care for PLWHAs – Garissa, January 2009.*

- The project held a one-day training for 5 CHWs supervisors on data collection and use, supervision and leadership skills
- CHWs started providing support to PLWHA from February 2009. Their responsibilities include registration of PLWHA and orphans; community mobilization; referrals of PLWHA and linking to services; home visits to PLWHA; counselling and report writing.
- CHWs started CHBC activities in February. As of the end of the reporting period, there were 116 clients registered in the CHBC program; out of this total, 38 (33%) were male and the rest female. All of these clients are on ARVs and are visited by CHWs from time to time. A total of 167 home visits were made by CHWs in the months of February and March 2009.



*Training of CHWs on Community and Home-based Care for PLWHAs - practical session on good nutrition.*

### **3.1.2 Challenges**

- The project is putting in place systems for systematically collecting and analyzing CHBC data. This will be operational from next quarter.
- While levels of stigma remain unacceptably high, inroads continue to be made and the continued growth of PLWHA groups is evidence of this.

### **3.1.3 Planned Activities for the next quarter**

- Conduct two weeks training in CHBC for the remaining CHWs in Garissa town.
- Continue to support the local partners to register more PLWHA into the CHBC program.
- Ensure that all members of PLWHA groups in Garissa are registered at the CCC.
- Provide support for the establishment of 2 PLWHA support groups, in Mandera and Wajir districts respectively.

## **3.2 Orphans and Vulnerable Children (OVC)**

APHIA II NEP is supporting OVCs through both direct support through local partners and a subagreement with the North Eastern Welfare Society (NEWS).

Over 50% of OVCs identified and supported this quarter were girls, a reflection of the renewed emphasis being put by the project on enrolling girl orphans through community-based organizations.

### 3.2.1 Summary of Achievements – OVC

OVC Institutions	YEAR 1			YEAR 2				Grand Total	
	Male	Female	Total (Y1)	Primary direct support (3+)		Supplementary direct support(2+)			Total(Y2)
				Male	Female	Male	Female		
<b>Totals</b>	<b>2,906</b>	<b>709</b>	<b>3,615</b>	<b>989</b>	<b>1,118</b>	<b>176</b>	<b>148</b>	<b>2,431</b>	<b>6,046</b>
Al Faruq Orphanage	490	0	490	0	140	0	0	140	630
Garissa Special School	40	13	53	0	0	0	0	0	53
KRCS	13	19	32	0	0	0	0	0	32
Mama Hani Children's Home	53	27	80	0	0	0	0	0	80
Najah Children's Home	150	0	150	0	0	0	0	0	150
SIMAHO Dispensary	10	9	19	10	10	0	0	20	39
Umal Kheir Girls Centre	0	80	80	0	0	0	16	16	96
Balambala primary	0	0	0	150	141	0	0	291	291
AMA Children Home	0	0	0	200	100	0	0	300	300
Pastoral Development Organization	0	0	0	50	50	0	0	100	100
Community based with LOCs	0	0	0	0	0	137	92	229	229
Al Furqan Children's Home	364	50	414	0	50	0	0	50	464
Masalani primary	0	0	0	24	26	0	0	50	50
Abu Huraria Children's Home	350	0	350	0	0	0	0	0	350
Al Hidaya Children's Home	220	0	220	0	120	0	0	120	340
Al Sunnah Orphanage	90	0	90	0	116	0	0	116	206
Aluteibi Children's Home	79	0	79	103	16	0	0	119	198
Al Weis Children's Home	0	0	0	132	66	0	0	198	198
Al Fouazan Organization	0	0	0	176	72	0	0	248	248
Takaba Primary School	0	0	0	144	106	0	0	250	250
Daua Integrated School	133	67	200	0	0	39	40	79	279
Mandera Islamic Centre	170	0	170	0	0	0	0	0	170
Abubakar Sadiq Children's Home	240	0	240	0	27	0	0	27	267
Al-Riaya Orphanage	70	0	70	0	54	0	0	54	124
Islamic Call Foundation	172	0	172	0	24	0	0	24	196
Itisam Children's Home	60	0	60	0	0	0	0	0	60
Wajir Catholic Mission	100	0	100	0	0	0	0	0	100
Wajir Girls Integrated School	0	400	400	0	0	0	0	0	400
Wajir Islamic Centre	50	0	50	0	0	0	0	0	50
Wajir School for the Deaf	52	44	96	0	0	0	0	0	96

### **3.2.2 Key observations on performance**

- During this quarter the OVC database was populated for Garissa and Wajir districts. The process for data reconstruction for Ijara and Mandera is ongoing.
- In close collaboration with the Provincial Children's Office, the project trained four Area Advisory Councils (Garissa, Wajir, Mandera and Ijara districts) on their roles and mandate, using a curriculum developed by the National Council of Children Services (NCCS). The project trained a total of 120 participants.
- Training of three locational OVC Committees. These committees are chaired by the area chiefs and are mandated by law to implement OVC support in their locality. The project trained a total of 106 participants in the three locations. The training in Mandera could not take place because of security concerns.

### **3.2.3 Challenges**

- District Children's Departments require considerable support in order to fulfill their mandates; however, the project has developed excellent relationships with them and plans to continue collaboration.
- Unavailability of OVC materials in large quantities within the province contributes to the high cost of transportation and very challenging logistical arrangements to deliver the materials to appropriate locations.
- Insecurity in Mandera and other border towns in NEP has largely affected and caused delays and sometimes cancellations of planned activities for the OVC program.

### **3.3.3 Planned activities for the next quarter**

- Direct support to Garissa and Ijara districts targeting community-based OVCs.
- Monitoring and follow-up support to assisted OVCs and institutional partners.
- Identify new, community-based partners for channeling increased support to OVCs in households, particularly female OVCs.
- Direct support to Wajir and Mandera districts targeting community-based OVCs.
- Training of four Locational OVC committees.

## **IV: STRATEGIC INFORMATION**

### **4.1 Achievements**

#### Distribution of the Indicator and SOP manual

One of the key milestones registered by APHIA II NEP during the reporting period was the sourcing and distribution of the MOH's Health Sector Indicator and Standard Operating Procedure manual in over 100 facilities in North Eastern province. This activity was done in collaboration with the Ministry of Health headquarters in Nairobi and the Provincial Health Records and Information Office. It is expected that these

manuals will assist the health workers to conduct basic analysis on the service data that they collect from their respective facilities.

### OVC database

The OVC database developed by the program is currently in use and is expected to assist the program and its OVC partners to manage the supported OVCs in an efficient and transparent manner. During the reporting period, the institutions offering services to OVCs were trained on how to collect and store individual profiles for the OVCs. APHIA II NEP is currently inputting data into the OVC database that is expected to be fully functional once all the data has been entered.

### Facility Data audits

Facility data audits supported by the program have proved useful in ensuring that services rendered are recorded accurately and submitted in a timely fashion thus improving the data quality in North Eastern. Prior to these audits, most health workers would estimate numbers related to certain indicators based on previous trends – data feedback in the province was not a common occurrence, hence the lethargy associated with reporting. In quarter 2, the program continued to support targeted data audits, especially in the area of PMTCT, with a total of 22 sites visited while conducting the exercise.

### ART data reconstruction

The importance of ensuring HIV positive clients receive quality care cannot be understated. One of the processes that ensures that patients receive standard care is the management of crucial information on the patients. When the data is analyzed, it would provide the program with vital information critical in decision making as far as care and treatment for HIV positive clients is concerned. It is against this background that APHIA II NEP supported the reconstruction of data at the PGH, the largest ART site in the province, accounting for about 80% of patients in care and treatment. The process is currently on-going and is expected to be completed in quarter 3.

## **4.2 Challenges**

The main challenge that the program is experiencing in relation to strategic information is the parallel reporting system for the TB program in the province and by extension in the country. Reporting requirements and deadlines are usually not synchronized thus presenting obstacles in timely and accurate reporting.

Reporting on ART offers the greatest challenge especially when reporting systems are paper-based. Health workers trained in reporting ART data seem to find difficulty in recording the correct information, especially when submitting the monthly summary data.

## **4.3 Planned Activities for the next quarter**

## Data Feedback

The current practice within the project in relation to information feedback involves performance feedback to staff on each component of the program in every quarter, enabling evidence-based decision making on programmatic issues. The project will facilitate information feedback to DHMTs and facility in charges in the coming quarter.

## ART data reconstruction

With the near-completion of ART data reconstruction at the PGH, the program intends to borrow from the lessons gained to carry out similar data re-construction in other ART sites.

## **V: OTHER ACTIVITIES**

### **5.1 Re-opening of Mandera office**

APHIA II NEP suspended activities operating out of its Mandera office in October 2008, i.e. at the beginning of this COP year. The closure of the Mandera office was precipitated primarily because of insecurity along the border with Somalia. Clan clashes related to persistent drought also occurred in early October and led to the imposition of a curfew in Mandera town.

APHIA II management visited Mandera in January to re-assess the security situation there. A detailed security situation analysis and recommendations report was done and widely circulated to major stakeholders. Its key recommendation was to recommence operations at the Mandera office as soon as possible. As a result, the office was re-opened in March 2009.

Although the Mandera office was closed during this period, operations were managed out of our Wajir office and many activities continued, although at a necessarily reduced pace.

### **5.2 Overall challenges**

- **MOH staffing** – Approximately 80 service providers employed through UNICEF saw their contracts end and left their posts in December. This has a catastrophic effect upon the delivery of services, with many facilities closing, reducing their hours and/or reducing the types of services offered. Many of the staff had been trained and supported by APHIA II NEP in the provision of various services. Although subsequently recalled for a three-month contract extension, the incident highlighted the degree to which NEP is dependant upon contract employees for the provision of health services to its citizens.
- **Drought/Insecurity** – The disappointing rains for the fourth consecutive season mean that thousands of people in North Eastern province are likely to

be facing extreme food and water shortages in the coming months. Water sources and pasture have not been replenished, a situation which in the recent past contributed to insecurity as clans fought over the diminishing resources. Meanwhile, there have already been isolated incidences of cholera in several districts in Wajir and Mandera with concurrent requests for emergency assistance being directed to APHIA II NEP. The project is advocating for a provincial-level body to coordinate requests for assistance and will be monitoring the situation closely in the coming months.

**APPENDIX I: PEER EDUCATION SYSTEMS ASSESSMENT REPORT**

# **Peer Education Systems Assessment Report**

**Conducted in Garissa, North Eastern Kenya, Kenya  
March 8<sup>th</sup> - 14<sup>th</sup>, 2009  
Conducted by NOPE Kenya**

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## LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APHIA II	AIDS Population and Health Integrated Assistance II
CHW	Community Health Worker
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
KAPB	Knowledge Attitude Practices and Beliefs
M&E	Monitoring and Evaluation
NEP	North Eastern Province
NOPE	National Organization of Peer Educators
OPAHA	Organization of Persons Affected by HIV and AIDS
PE	Peer Educator
PLWHIV	People Living with HIV
QA	Quality Assurance
QI	Quality Improvement
BCS	Strategic Behavioral Communication
YL	Youth Leaders

## INTRODUCTION

This Peer Education assessment was conducted with four major objectives: one, to establish the place of Peer Education in North Eastern with regards to standards in significant qualitative and quantitative areas; two, to link the system with the Sexual Networks Assessment, which was conducted in the same area in September 2008 to establish evidence for interventions to reduce HIV/STI risk among women and men in Garissa, North Eastern Province and in Eastleigh, Nairobi; three, to assess the connection between the peer education process and the *Twaweza* behavioral communication strategy (BCS), which was developed and later presented by NOPE; and, four, to provide recommendations that will strengthen the system to attain the ultimate impact.

The assessment took seven days involving discussions and key interviews with Programs coordinators, Trainers of trainers, and actual Peer Educators. We also perused through various training manuals and attended actual peer education sessions. The Sexual Networks Assessment had identified Youth out of School, traders in *Miraa*, Transporters and Civil Servants as primary beneficiaries who require systematic interventions. The consequent BCS identified Peer Education as a priority intervention which would reduce STI and HIV incidence and prevalence. The spirit of this assessment is focused on standards and the recommendations will hopefully improve the quality of the program regarding recruitment, retention, supervision, facilitation, oversight, monitoring and evaluation of peer educators.

Peer Educators expressed conviction in their duty to enrich others with knowledge and skills that will impact on all lives positively; however, they are few and have some concerns that they feel should be addressed.

One Religious Leader said, "Even if I quit the program I would continue with the work except that I will not hand in reports."

Another Sheikh said, "We do this work as a service to Allah. We know he will reward us, but you (APHIA II NEP) should give us more support, without which, anyway, we will still continue in our own design."

The Chill program was more Youth-led which was quite relevant given that its beneficiaries are youth in school especially class seven who need more guidance. During the period under the assessment there was training for new comers going on that also served as a refresher for the older ones.

### *How the Assessment was Conducted*

The assessment was conducted between March 8<sup>th</sup> and 14<sup>th</sup> 2009. It began with an orientation meeting on the assessment tool with APHIA II NEP staff followed by

discussion on the week's schedule. This was followed by meetings with Community Health Workers (CHW), Religious leaders, People Living with HIV (PLWHIV) at the premises of the Organization of Persons Affected by HIV and AIDS (OPAHA), Youth Leaders, Trainers, and Peer Educators at Garissa Primary School, each of which discussed their perspectives on the operation of the Peer Education system freely. There was also a visit to the training of Youth Leaders conducted at Almond Hotel in preparation for "Chill club" facilitation. Actual peer education sessions were observed at Prisons and Miraa Traders. Four "Chill" club sessions were observed in Mwangaza primary and Garissa Academy. The facilitators comprised those who had been trained earlier and those who had been recently recruited and were being inducted.

### **OVERVIEW OF PEER EDUCATION ACTIVITIES:**

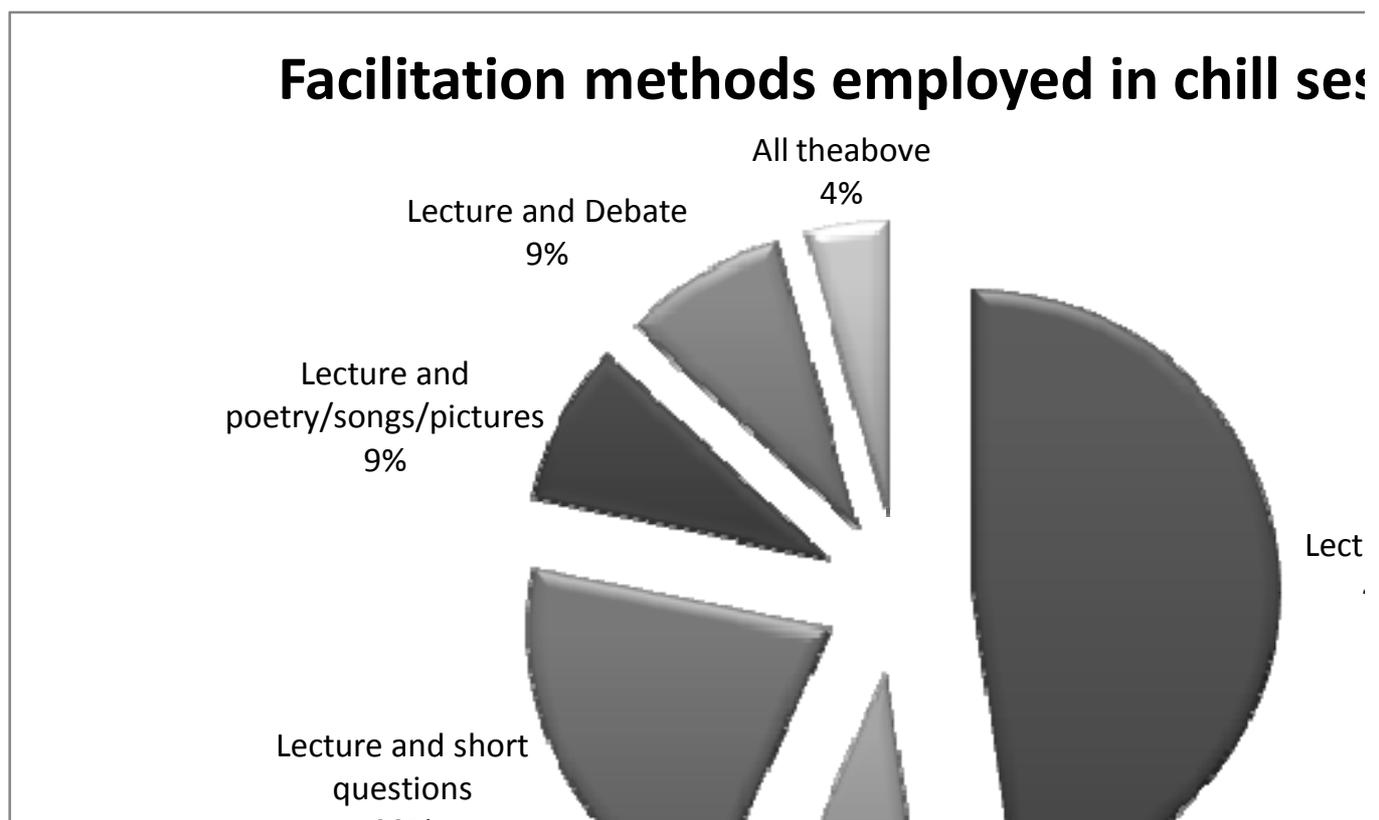
- APHIA II NEP implements and monitors all activities in NEP directly; there is no implementing partner contracted for peer education.
- Three Islamic religious leaders are trained in peer education and disseminate messages regularly to some more than 120 mosques in Garissa and its environs; they provide approximated numbers of people reach.
- The religious leaders provide information on abstinence and being faithful through their preaching in mosques that have been zoned into three.
- All peer educators are reimbursed transport for them to communicate easily.
- Only fourteen peer educators were recorded as being active from the initial trained lot of twenty four accounting for an attrition of nearly 50%.
- There are referral forms provided for cases that require psychosocial support, counseling and testing, nutritional support, legal redress, and Prevention of Mother to Child Transmission (PMTCT).
- PLWHIV are involved as peer educators and are often engaged in forums.
- The Workplace Peer Education program at the Prisons is carried out by a single peer educator who also doubles as a counselor providing HIV counseling and testing services. He also extends services to the surrounding community.
- The beneficiary population generally appreciates the value of peer education: One Prison Guard said, *"sasa tunaweza kuongea na kufundishwa mambo ya ukimwi kama vile mtu anaweza kuwa na Ukimwi na mpenzi wake apatikane hana"*.

trans: *We can now discuss issues around HIV like the incidences of discordant couples*

### **OVERVIEW OF THE CHILL CLUB APPROACH**

- Youth leaders (YL) generally have a good understanding of messages for the Chill Clubs and are comfortable discussing them.
- YLs carry the curriculum with them during session; some read directly from it while others use it only for specific reference.
- There are about 25 trained youth leaders half being replacements.

- YLs are paired up in each school; a male and a female; they each however conduct sessions in separate classes.
- Each Chill club has about 25 students who attend the sessions in the afternoon hours after formal classes, often between 2 pm and 4 pm. Some YL prefer the last class of the day as it provides more time.
- The club patrons work closely with the school administration and YLs to ensure smooth running of the activities.
- Most youth leaders find the time allocated for sessions limiting especially for the use of participatory methodology.
- Parents in some cases complain that it is inappropriate to expose their children to “strangers”, this often happens when the YLs have not been formally introduced to parents.
- All the youth leaders employ lecture methods comfortably but seldom use drama or role play, debate, pictures, poetry, song and other innovative options to disseminate information.
- Some youth leaders inadvertently mention HIV and AIDS interchangeably. For example one Peer Educator said, “during transfusion one can get HIV/AIDS”



- Students see the sessions as important and say they “discuss the topics with our friends at home and during leisure time, but not with our parents.” Mohamed, a student in Garissa Academy said, “we are now not scared of touching someone with HIV. We know how it is transmitted”

- Some community members do not understand the course content of the sessions and become unreceptive to the peer educators. Some feel that there are funds that are being justified yet the very funds do not reach them. One man, about 38 yrs old, said, *"In fact we will write them a memorandum asking them to quit; you see them moving with big vehicles, yet we do not get anything."* A teacher who saw us enter a class to talk with Peer Educators asked, *"Do you have some money for us, too?"*

### **KEY CHALLENGES/ SHORTCOMINGS**

- The number (three) of Islamic religious leaders, who serve each more than forty mosques, is not sufficient; it is difficult to determine the numbers reached with specific messages and the exact nature of the messages.
- Peer educators and religious leaders perceive the allowances reimbursed as a salary that needs to be reviewed. Volunteer expectations are not currently well managed.
- Since the provision of free primary education, the number of students has virtually doubled; consequently, there are now virtually twice as many clubs as there were earlier, thus outnumbering the existing Youth Leaders.
- There is need for the inclusion of comprehensive facilitation skills in the curricula.
- Women and women groups have not systematically incorporated in the peer education approach.
- Weak integration of stigma and discrimination in the curriculum.
- Well trained workshop trainers. The use of a standardized curriculum to carry out the sessions is commendable. Nonetheless, the application of sessions is staggered as opposed to systematic planning about which topics follow each other; in this regard it becomes difficult to tract all sessions meaningfully. At the same time if someone were to drop out for any reason it would disorienting for another facilitator to proceed from the previous.
- The element of the monitoring and evaluation of APHIA II NEP Religious Leaders dissemination is conspicuously unclear. There referral mode is similarly weak.

### ***Summary of Recommended Actions for APHIA II NEP***

- Renegotiate with and reorient the peer educators on the monthly allowances. Most see the allowance as a 'salary' that has to be reviewed time to time. They compare their 'salary' to that of the religious leaders which should not be the case.
- Involve women and women groups in peer education. There is need for woman-to-woman communication to handle the socio-cultural dynamics of their context.
- Initiate peer education for all the beneficiaries listed in the Sexual Networks Assessment including as a priority, youth-out-school, *Miraa* traders, taxi drivers/transporters. The current number of around 14 active peer educators is acutely inadequate. Use social mapping information to determine the new number and clarify expectations before engaging them.
- Develop a simple and up to date referral directory in order to refer correctly, faster and conveniently for both the facilitator the individual referred to a service.

- Address the inadequacy of staff members for peer education. Mohamed Ali currently handles OVC, Youth, and Laboratory issues; He needs an additional coordinator to handle the many emerging issues from peer education.
- Involve implementing partners (IP) to carry out peer education so that it is easier for APHIA II NEP to monitor performance. Consider partnerships where APHIA II NEP still manages the fund for these partners until their capacities are enhanced.
- Integrate stigma and discrimination sessions in all community activities to strongly address language use, behavior, and attitudes towards PLWHIV.
- Build the capacity of organizations of People Living with HIV (OPAHA, SUMAHO, Mwangaza, Ebenezer) on Financial management so that they can be stable and more useful in implementing with participatory methods. Members of OPAHA for instance explained that poor management of finances caused divisions and formation of splinter groups.
- Engage Religious leaders as mobilizers who can also conduct informal referrals and endorse APHIA II, Chill clubs, Organizations of People Living with HIV, and various interventions in the *Twaweza* BCS strategy, instead of them reporting and being evaluated in the process. Train more religious leaders so that each has a manageable number of mosques.
- Initiate peer education programs in Madrassa so that more youth interact with messages and get space to place them into their social and cultural contexts in face to face discussion with the peer educators. Religious Leaders can promote these sessions in their preaching. This model has worked very well in Zanzibar which is similarly predominantly Islamic.
- For *Chill* clubs, train another lot about twice the current number to deliver effectively in new clubs whose number has also apparently doubled. One lot ought to be trained to handle secondary schools.
- Conduct KAPB surveys for both the in-school and the out-of-school youth.
- Produce enough IEC material for Religious leaders, Youth Leaders and peer educators to give away as handouts after sessions.
- Provide incentives like umbrellas, bags and T-shirts to identify motivate peer educators. Distribute them in a spread out manner to avoid heightening their expectations.
- Upgrade one or two of the long-serving Youth Leaders into Supervisor level to increase human resource available and to foster retention.
- Give refresher training intensely on facilitation skills and accuracy of language of communication. This will also equip them with skills to address the emerging challenges in order to clearly define their roles by differentiating between peer education and peer information.

## SPECIFIC ISSUES IN THE PEER EDUCATION AND STANDARDS ASSESSMENT

The results of the assessment are contained here with indicative suggestions for improvement in areas of planning, recruitment and retention, training and supervision, peer education supervision, management and oversight and monitoring and evaluation.

### *Assessment of PE Planning and APHIA II NEP APHIA II NEP Improvement Points*

<b>Summary of Current Situation</b>	<b>Improvement Points</b>
<ul style="list-style-type: none"> <li>- There is weak participation of all stakeholders; Government officials, Women groups and youth groups not well involved.</li> <li>- Religious Leaders are involved at planning levels.</li> </ul>	<ul style="list-style-type: none"> <li>- Have a systematic peer training program targeting Women.</li> <li>- Young people should engaged as partners</li> <li>- There is need to involve the youth and youth groups at planning levels.</li> </ul>
<ul style="list-style-type: none"> <li>- Youth in schools, work places, small scale traders, pastoralists identified as beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>- Miraa traders, Transporters/taxi drivers should be included as part of the beneficiary population</li> </ul>
<ul style="list-style-type: none"> <li>- there are annual meeting for Youth Leaders for the Chill Clubs</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct termly meetings to share experiences.</li> </ul>
<ul style="list-style-type: none"> <li>- Chill clubs are visited regularly</li> <li>- Topics are discussed randomly</li> </ul>	<ul style="list-style-type: none"> <li>- Topics should be approached systematically in the order they appear in curriculum for easy flow.</li> </ul>
<ul style="list-style-type: none"> <li>- APHIA II goals are well explained to some PEs.</li> </ul>	<ul style="list-style-type: none"> <li>- Improve level of youth participation in planning and implementation of peer education program and explain the goals of APHIA II to all stakeholders.</li> </ul>
<ul style="list-style-type: none"> <li>- Lack of KAPB survey for the Youth in school and out of school.</li> <li>- There are plans to conduct KAPB survey</li> </ul>	<ul style="list-style-type: none"> <li>- Proceed to conduct KAPB surveys promptly</li> </ul>
<ul style="list-style-type: none"> <li>- Work plans are generated constantly.</li> <li>- Payments and reimbursements made on time</li> </ul>	<ul style="list-style-type: none"> <li>- Follow the work plan as laid out consistently and guided in the curriculum.</li> </ul>
<ul style="list-style-type: none"> <li>- Peer educators are supported with manuals and are promptly reimbursed transport.</li> </ul>	<ul style="list-style-type: none"> <li>- APHIA II NEP should create an incentive Scheme: There is need to include incentives like T shirts, umbrellas, bags, and assorted IEC material.</li> </ul>
<ul style="list-style-type: none"> <li>- Referral tools available</li> </ul>	<ul style="list-style-type: none"> <li>- Develop a more comprehensive referral directory detailing types of services, physical address, and contact persons for effective and efficient referrals.</li> </ul>
<ul style="list-style-type: none"> <li>- Quantitative data well collected</li> <li>- Feedback is not gathered in a systematic manner</li> <li>- Religious leaders not an effective channel to report data</li> <li>- It is not clear when fresh numbers have been reached and with which topics</li> </ul>	<ul style="list-style-type: none"> <li>- More stakeholder meetings need to be held to get feedback and foster involvement.</li> <li>- Feedback ought to be continuous and timely.</li> <li>- Retain RLs for mobilization but establish PE in Madrassa quantitative and qualitative reporting.</li> <li>- Develop criteria of determining when new numbers are reached as opposed to reaching the same population over the period of implementation.</li> </ul>

<ul style="list-style-type: none"> <li>- Strong Monitoring and Evaluation (M&amp;E) component already exists under the auspices of Service Delivery Department.</li> </ul>	<ul style="list-style-type: none"> <li>- Engaging other implementing partners (IP) will be more effective in order to reinforce M&amp;E effectively.</li> <li>- Programmers should specialize in one area in order to fully pursue delivery: This applies to Mohammed Ali who currently handles a three tiered docket: OVC, Youth and Laboratory Services.</li> </ul>
<ul style="list-style-type: none"> <li>- High mobility of youth is not planned for yet APHIA II NEP has invested a lot.</li> <li>- Number of YL for Chill Club Sessions too small</li> <li>- Number of Chill clubs has doubled</li> </ul>	<ul style="list-style-type: none"> <li>- Train thrice the current number of YL so that they can retain the required standards of performance</li> <li>- Develop ranks so that is a kind of upward mobility in the Practice</li> </ul>

### *Assessment of Recruitment, Retention and APHIA II NEP Improvement Points*

<b>Summary of Current Situation</b>	<b>Improvement Points</b>
<ul style="list-style-type: none"> <li>- The recruitment criteria is not written down</li> <li>- It relies on spontaneity and presumes that it is possible to make quick judgment</li> <li>- Some current PEs took as short as 10 minutes while others more than 30 mins.</li> </ul>	<ul style="list-style-type: none"> <li>- Develop written questionnaire that can be followed consistently with every interviewee.</li> <li>- Develop criteria for recruiting women, Youth out of school, <i>miraa</i> traders, and taxi operators beforehand.</li> </ul>
<ul style="list-style-type: none"> <li>- Expectation are clarified at the recruitment phase; however, many of the stakeholders still hold much financial expectations</li> </ul>	<ul style="list-style-type: none"> <li>- Targets and desired outputs and outcomes need to be explained clearly to peer educators at the recruitment stage</li> <li>- There is need to document the recruitment process for transparency in order to guide subsequent recruitments.</li> <li>- Involve stakeholders in the process especially for out of school, traders and women</li> </ul>
<ul style="list-style-type: none"> <li>- Feedback mechanisms are at their minimal</li> <li>- PEs rely on unscheduled /chance meetings with beneficiary population</li> </ul>	<ul style="list-style-type: none"> <li>- Include feedback promptly during facilitation of sessions (this includes chill club sessions)</li> </ul>
<ul style="list-style-type: none"> <li>- Certificates are provided at the end of each training but there are no contracts established with peer Educators. (maintain status quo)</li> </ul>	<ul style="list-style-type: none"> <li>- Explore Linkage to income generating activities for out of school youth.</li> <li>- Create some incentive scheme for PEs and teachers as well as club leaders</li> <li>- More opportunities need to be explored for graduating peer educators</li> </ul>

### *Assessment of Training and Supervision and APHIA II NEP Improvement Points*

<b>Summary of Current Situation</b>	<b>Improvement Points</b>
<ul style="list-style-type: none"> <li>- Training currently takes five days: this includes pretest and post test</li> <li>- 30 peer educators are trained at ago and each of them is awarded a certificate at the completion of</li> </ul>	<ul style="list-style-type: none"> <li>- Put deliberate emphasis on use of effective facilitation skills in sessions e.g. language, explanations, posture, analogies, tempo, rhythm, eye contact, gesticulation of body</li> </ul>

<p>the training.</p> <ul style="list-style-type: none"> <li>- There are measures to ensure that attendance is 100 % and that no one gets a certificate without attending through all the scheduled days.</li> </ul>	<p>language and much more.</p> <ul style="list-style-type: none"> <li>- Ensure that peer educators include energizers regularly to keep participants alert.</li> <li>- Should have a clearly defined supervision process of the trainings being conducted.</li> </ul>
<ul style="list-style-type: none"> <li>- Pre and post training evaluation is conducted</li> </ul>	<ul style="list-style-type: none"> <li>- Involve the youth in designing session evaluation formats.</li> </ul>
<ul style="list-style-type: none"> <li>- Feedback is through chance encounter with the chill club members</li> </ul>	<ul style="list-style-type: none"> <li>- Club members can give feedback through filling a simple one page questionnaire.</li> </ul>

### *Assessment of Peer Education and Chill Sessions and APHIA II NEP Improvement Points*

<b>Summary of Current Situation</b>	<b>Improvement Points</b>
<ul style="list-style-type: none"> <li>- Youth leaders use the provided manuals and some read directly from it.</li> <li>- Chill sessions do not involve energizers and other modes that make it more interesting.</li> <li>- Peer educators employ more lecture than other creative options</li> <li>- Peer Educators go to any topic with a new audience and seldom do the very beneficiaries get reached with other topics.</li> </ul>	<ul style="list-style-type: none"> <li>- Provide peer educators with a simple but detailed standardized 'how to' peer education manuals/guides.</li> <li>- Insist on repeated attendance at sessions to guarantee quality and behavior change.</li> <li>- Increase the number of sessions that impart on particular behavior skills and not just information.</li> <li>- There is also a need to train on a wide variety of participatory methods to avoid monotony.</li> </ul>

### *Assessment of Management and Oversight and APHIA II NEP Improvement Points*

<b>Summary of Current Situation</b>	<b>Improvement Points</b>
<ul style="list-style-type: none"> <li>- The organization has the advantage of people of having staff with different backgrounds e.g. nurses, journalists, counselors, teachers etc.</li> </ul>	<ul style="list-style-type: none"> <li>- Establish a monitoring system on how the project achievements are contributing to national statistics.</li> <li>- There should be a well-defined and documented code of conduct for peer educators.</li> <li>- Have all decisions made and shared with the gate keepers in the community.</li> <li>- Ensure timely feedback sharing</li> <li>- Increase involvement of young people in decision making in the program.</li> </ul>

### *Assessment of Monitoring and Evaluation and APHIA II NEP Improvement Points*

<b>Summary of Current Situation</b>	<b>Improvement Points</b>
<ul style="list-style-type: none"> <li>- APHIA II NEP staff members have the capacity to plan and implement Monitoring (in M &amp; E)</li> <li>- There are indicators in place but in most cases they are not clearly measurable</li> </ul>	<ul style="list-style-type: none"> <li>- Need to develop tools for evaluation in order to determine how much outcomes</li> <li>- There should be regular evaluation to measure achievement of goals and objectives of Peer education system.</li> </ul>

	<ul style="list-style-type: none"> <li>- Tracking referrals and linking output to outcome is necessary as part of monitoring.</li> <li>- There is need to conduct KAPB for all beneficiary Populations in order to evaluate development after a time.</li> </ul>
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### ***Youth Adult Partnership in Peer Education***

Most of the youth are currently engaged as Youth Leaders who guide Chill sessions in schools. There is need to explore methods of involving the youth meaningfully. There seem to be several youth groups that possibly have weak structures and capacity, but they can have their capacity built and then have their lot trained on peer approaches. Many can establish alternative activities that utilize leisure e.g. sports, music, drama, community work and have all these linked to IEC and behavior change.

The youth will then be involved from the planning stage to the implementation in a sense making them partners holistically.

### ***Partnership with Women***

Women have conspicuously occupied an outsiders place. This is probably an oversight that abets patriarchy and alienates women further. It is noticeable that men are the major decision makers in the social and cultural context of NEP. For example, the men have more freedom of decision, movement and interaction; women are complacent and confined or encouraged to be confined, even in mosques; men may marry up to four wives, a case largely determined by the man; it is the man who authorizes a divorce easily.

When women divorce they experience a unique freedom for the first time; that freedom makes one vulnerable and without well established life skills they will engage in risky behavior. Notice that divorce rates are very high in NEP.

Women need to be included as partners and trained in Peer Education to equip each other with skills and play a role in reversing STI and HIV incidence.

### ***Stigma in Peer Education***

Stigma in Peer Education, as it is now, is not prioritized as a major constituent in the existing curricula. It is important to make stigma and discrimination a large component which invites more attention and discussion. This will explore better questions of definitions, attitudes, language, behavior, dehumanization of both perpetrator and the individual who is stigmatized, harassment, isolation, violence, human rights, legal issues, etc. It is agreed that APHIA II NEP staff will ensure that all peer education activities undertaken are devoid of stigma right from planning to execution. With particular importance will be to ensure the messages passed across by the PEs and YLs do not discriminate those who are infected or affected.