

APHIAplus Northern Arid Lands

Quarterly Program Report



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LIST OF ABBREVIATIONS

AAC	Area Advisory Committee
AB	Abstinence and/or Being Faithful
AFB	Acid Fast Bacillus
AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual Operational Plan
APHIA	AIDS, Population and Health Integrated Assistance Program
APR	Annual Progress Report
ARIFU	AIDS Response in Forces in Uniform (Project)
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communications
C4M	Care for Mothers
CT	Counselling and Testing
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
CHC	Community Health Committees
CHW	Community Health Worker
CIC	Community Implementation Committee
CME	Continuing Medical Education
CTS	Clinical Training Skills
CSI	Child Survival Index
CSW	Commercial Sex Worker
DASCO	District AIDS and STI Control Officer
DCC	District Community Coordinator
DFC	District Facility Coordinator
DHMT	District Health Management Team
DHRIO	District Health Records Information Officer
DHSF	District Health Stakeholders Forum
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DMS	Director of Medical Services
DMLT	District Medical Laboratory Technologist
DTC	Diagnostic Testing and Counselling
DQA	Data Quality Audit
DRH	Division of Reproductive Health
EID	Early Infant Diagnosis
EHP	Emergency Hiring Plan
EMOC	Emergency Obstetric Care
ESD	Extending Service Delivery
FBO	Faith-based Organization
FPPS	Family Programmes Promotion Services
FHI	Family Health International
FRL	Female Religious Leaders
GOK	Government of Kenya
GPS	Global positioning system
GIS	Geographic Information System
HAART	Highly Active Antiretroviral Therapy
HBC	Home-based Care
HCBC	Home and Community-Based Care
HCT	HIV Counselling and Testing

HCW	Health Care Worker
HIV	Human Immunodeficiency 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
IYCF	Infant and Young Child Feeding
KAIS	Kenya AIDS Indicator Survey
KCIU	Kenya Council of Imams and Ulamaa
KEMRI	Kenya Medical Research Institute
LIP	Local Implementing Partner
LLITN	Long-Lasting Insecticide-Treated Nets
LDP	Leadership Development Program
LOC	Locational OVC Committee
LOE	Level of Effort
LOP	Life of Project
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MDR-TB	Multi-Drug Resistant Tuberculosis
MLS	Management and Leadership Specialist
MOH	Ministry of Health
MOPHS	Ministry of Public Health and Sanitation
MOMS	Ministry of Medical Services
MT	Magnet Theatre
MSH	Management Sciences for Health
MTC	Medical Training College
NACC	National AIDS Control Council
NAL	Northern Arid Lands
NASCOP	National HIV and AIDS and STI Control Program
NCAPD	National Coordinating Agency for Population and Development
NCCS	National Council of Children Services
NEPTRC	North Eastern Province and Tana River County
NEPHIAN	North Eastern Province HIV and AIDS Network
NEWS	North Eastern Welfare Society
NHSSP	National Health Sector Strategic Plan
NOPE	National Organization of peer educators
NP HLS	National Public Health Laboratories Services
NQMG	National Quality Management Guidance
OBA	Outputs-Based Financing
OI	Opportunistic Infection
OJT	On-the-job training
OOP	Office of the President
OVC	Orphans and Vulnerable Children
PAC	Post Abortion Care
PASCO	Provincial AIDS and STD Coordinator
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Program for AIDS Relief
PGH	Provincial General Hospital
PHMT	Provincial Health Management Team

PICT	Provider Initiated Counselling and Testing
PLHIV	People Living with HIV
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
RRI	Rapid Results Initiative
SCMS	Supply Chain Management System
SIMAHO	Sisters Maternity Home
STI	Sexually Transmitted Infections
SUPKEM	Supreme Council of Kenyan Muslims
TA	Technical Assistance
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TIMS	Training Information Management System
TMP	Training Master Plan
TNA	Training Needs Analysis
TR	Tana River
TOF	Training of Facilitators (also refers to a facilitator him/herself)
TOT	Training of Trainers (also refers to a trainer him/herself)
UES	Upper Eastern/Samburu
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WASDA	Wajir South Development Agency
YFS	Youth-Friendly Services
YTD	Year to Date

INTRODUCTION

APHIA*plus* (AIDS, Population, and Health Integrated Assistance; *plus* stands for people-centered; leadership; universal access; and, sustainability) is an agreement between the Government of Kenya and USAID. The APHIA*plus* Northern Arid Lands (NAL) service delivery project brings together a team of organizations under the umbrella of the Extending Service Delivery project: Pathfinder International; Management Sciences for Health; IntraHealth International; Food for the Hungry; and, International Rescue Committee. The project also works with numerous other local implementing partners, including government ministries, non-governmental, faith-based and community organizations.

APHIA*plus* supports integrated service delivery in technical areas of HIV/AIDS, malaria, family planning, tuberculosis and MNCH, and selected interventions related to the social determinants of health. APHIA*plus* emphasizes service integration at all levels as a build-up to sustainability; all project activities are aligned with GoK policies and strategies.

The project covers the northern 60% of Kenya, an area characterized by remote, nomadic communities with limited access to goods and services. Innovative strategies are required to address the unique challenges faced by communities in this zone. Project activities occur at both health facility and community levels and involve a high degree of collaboration with GoK partners and stakeholders at provincial and district levels. Activities fall into two result areas:

- increased use of quality health services, products and information; and,
- social determinants of health addressed to improve the well-being of marginalized, poor and underserved populations.

Some highlights from the current quarter

- Spurred on by its abbreviated Life-of-Project time span (less than 17 months), APHIA*plus* NAL achieved a rapid start-up of Project activities. The Project recruited, hired, equipped, oriented and posted 90% of its required new staff within the first three months of operations. It established operational sub-regional field offices in Lodwar and Isiolo (in addition to its existing sub-regional office in Garissa), as well as six new district-level field offices in Turkana, Samburu and Marsabit Counties. All offices are furnished, have standard operating procedures and are enabled with communication technologies. Where feasible, offices are co-located within Ministry of Health facilities.
- The official launch of APHIA*plus* NAL took place in Garissa on January 18th; Guest of Honor was the Provincial Commissioner for North Eastern province. Other guests included the Provincial Directors of Medical Services and Public Health and Sanitation, as well as the APHIA*plus* NAL Project Management Team of USAID/Kenya. APHIA*plus* NAL also featured in the launching of APHIA*plus* projects in Rift Valley, Eastern, and Coast provinces, a reflection of the presence of APHIA*plus* NAL in districts within each of those provinces.
- The Project utilized a consultative and participatory process to develop a Life-of-Project work plan which is closely aligned with the GOK annual planning process, targets and indicators.
- APHIA*plus* NAL participated in and sponsored orientation sessions for PHMT and DHMT members in each of the four provinces which APHIA*plus* NAL cuts across: Rift Valley; Eastern; North Eastern; and, Coast. These meetings provided opportunities for the Project to gather information on Provincial AOP 7 targets; brief PHMT/DHMTs on the APHIA*plus* NAL mandate and communicate available resource envelopes from the Project; and, agree with the PHMT/DHMTs on a “menu” of illustrative activities and approaches which the Project could support.

- The Project participated in AOP 7 consolidation meetings in each Province. The objective of the Project's participation was to provide a reality check on proposed activities to be supported by APHIAplus NAL, in terms of both financial resources and congruency with the APHIAplus Service Delivery mandate. The AOP 7 orientation and consolidation meetings generated valuable inputs to the development of the APHIAplus work plan and PMP.
- The Project held separate work plan development meetings in Garissa, Isiolo and Lodwar. The purpose of these meetings was to orient new staff and selected external partners to the APHIAplus Service Delivery mandate; review AOP 7 targets and activities; develop initial work plans; and, develop the budget for identified activities. The process was necessarily iterative and time-consuming, with nearly a week required in each sub-region. Separate work plans for each sub-region and each Province were consolidated into one complete LOP work plan for submission to USAID. The separate sub-regional and Provincial work plans are retained for use by the sub-regional offices and for tracking contributions to the Provincial AOPs.
- The Project initiated an assessment in Isiolo township of sexual behaviors amongst key populations at risk which will be completed in May 2011. Modeled after a similar study conducted by APHIA II NEP in Garissa and using a rapid survey methodology similar to the Priorities for Local AIDS Control Efforts (PLACE) approach, the assessment will create an evidence base for targeted prevention programming. A similar assessment will commence in Lodwar township in May.
- The project conducted facility and community assessments in Turkana, Samburu, Marsabit, Isiolo and Tana River Counties. These assessments are used to introduce the project to stakeholders, confirm programmatic needs and priorities, and identify potential local implementing partners.
- APHIAplus NAL rapidly established agreements with local implementing partners who had previously been supported under APHIA II to provide comprehensive support to over 15,000 orphans and vulnerable children.
- The Project supported the establishment of a laboratory in Garissa PGH Comprehensive Care Center to improve the laboratory diagnostic services to PLHIV. The CD4 machine was moved from the main laboratory to the CCC laboratory to enhance CD4 specimen collection and networking. A microscope and reagents were also availed in the laboratory to carry out other supportive tests. This move appears to have had a positive impact on patient care, CD4 lab networking coordination and QA/QC in HIV testing.
- The entire Northern Arid Lands zone continued to experience prolonged drought during the quarter. This has had a negative impact on livelihoods, health and security and will continue to add to the challenges which the Project faces in implementing proposed activities.

Table 1: Consolidated APHIAplus NAL achievements against targets

Performance Indicator	NEP/TR	UES	Turkana	NAL Total	NAL Y1 Target	% Y1 Target Achieved
GENDER						
# of people reached by an individual, small group or community level intervention that explicitly address norms about masculinity	1,147	0	0	1,147	TBD	
Number of people reached by an individual ,small group, or community-level intervention or service that explicitly address Gender-based violence and coercion related to HIV/AIDS	381	0	0	381	TBD	
# of people reached by an individual, small group or community level intervention or service that that explicitly address the legal rights and protection of women and girls impacted by HIV/AIDS	381	0	0	381	TBD	
# of people reached by an individual, small group or community level intervention or service that that explicitly address aim to increase access to income and productive resources of women and girls impacted by HIV/AIDS	70	326	0	396	TBD	
MARP						
# of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	2,391	0	0	2,391	TBD	
PREVENTION WITH POSITIVE (PwP)						
# of (PLHIV) reached with a minimum package of prevention with PLHIV (PwP) intervention	251	478	0	729	TBD	
SEXUAL AND OTHER BEHAVIORAL RISK PREVENTION						
# of targeted population reached with individual and/or small group level prevention interventions that are based on evidence and/or meet the minimum standards required (OB/C-BAB/C)	968	326	0	1,294	TBD	
# of targeted population reached with individual and/or small group level prevention interventions that are primarily focused on abstinence and/or being faithful and are based on based on evidence and/or meet the minimum standards required (AB/F)	5,859	326	0	6,185	TBD	
IR3: Increased use of quality health service, products and information						
COUNSELING AND TESTING						
# of service outlet providing counseling and testing according to national or international standards	36	35	20	91	162	56%
# of individuals who received testing and counseling services for HIV and received their test results	31,286	13,071	1,964	46,321	197,000	24%
HIV/AIDS TREATMENT/ARV SERVICES						
# of service outlets providing ART services according to national or international standards	35	25	13	73	49	149%
# of clients with advanced HIV infection newly enrolled on ART	76	135	31	242	2,450	10%
<i>Paed</i>	6	14	7	27		

Performance Indicator	NEP/TR	UES	Turkana	NAL Total	NAL Y1 Target	% Y1 Target Achieved
<i>Adults</i>	70	121	24	215		
# of clients with advanced HIV infection receiving ART (currently)	1,239	2,030	214	3,483	6,050	58%
<i>Paed</i>	94	241	27	362		
<i>Adults</i>	1,145	1,789	187	3,121		
# of clients with advanced HIV infection who ever started on ART	1,606	2,806	284	4,696	7,500	63%
<i>Paed</i>	119	312	31	462		
<i>Adults</i>	1,487	2,494	253	4,234		
% of adults and children known to be alive and on treatment 12 months after initiation of ART	Not reported	Not reported	Not reported		82	0%
% of HIV positive persons receiving CD4 screening at least once during the reporting period	11	Not reported	Not reported	11	70	16%
# of HIV positive persons receiving CD4 screening CTX prophylaxis	421	Not reported	Not reported	421	8,300	5%
# of HIV clinically malnourished clients who received therapeutic or supplementary food	61	Not reported	Not reported	61		TBD
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)						
# of services outlets providing the minimum package of PMTCT services according to national or international standards	188	134	90	412	398	104%
# of pregnant women who received HIV counseling and testing for PMTCT and received their test results	13,621	5,169	1,496	20,286	79,000	26%
% of HIV positive pregnant women who received ART to reduce the risk of MTCT	100	52	100	252	83	304%
# of HIV positive pregnant women newly enrolled into HIV care and support services	91	84	33	208	850	24%
# of infants tested for HIV at 6 weeks	14	32	2	48	680	7%
% of infants born to HIV+ women who received and an HIV test within 18 months of birth	70	Not reported	Not reported	70	50	140%
# of HIV exposed infants provided with ARVs prophylaxis	91	36	33	160	850	19%
PALLIATIVE CARE (EXCLUDING TB/HIV)						
# of individuals provided with HIV related palliative care (excluding TB/HIV)	219	342	72	633	2,800	23%
# of individuals provided with HIV related pediatric palliative care (excluding TB/HIV)	34	25	60	119	220	54%
% of HIV positive patients who were screened for TB in HIV care or treatment settings	5	39		44	80	56%
# of HIV positive patients in HIV care or treatment (pre-art or ART) who started TB treatment	30	67	14	111	520	21%
# of TB patients who received HIV counseling, testing and their test results at USG supported TB outlets	595	228	217	1,040	3,500	30%
VMMC						
# of VMMC clients	N/A	N/A	0	0	3,000	0%
MNCH/RH/FP/SI						

Performance Indicator	NEP/TR	UES	Turkana	NAL Total	NAL Y1 Target	% Y1 Target Achieved
# of deliveries performed in a USG supported health facility	4,256	1,517	274	6,047	10,450	58%
# of ANC visits with skilled providers in USG supported health facilities	25,482	10,849	1,398	37,729	79,500	47%
# of children less than 12 months of age who received DPT3 from USG supported programs	9,308	Not reported	847	9,308	86,838	11%
# of children <5 years of age who received vitamin A from USG supported	26,625	14319	2,204	43,148	201,500	21%
# of children receiving measles vaccine	9,329	3993	1,899	15,221	56,000	27%
# of children receiving BCG	7,468	5876	2,748	16,092	79,500	20%
# of cases of child diarrhea treated in USG supported site	17,173	8931	0	26,104	TBD	
# of new FP acceptors as a result of USG assistance by FP method	10,280	9,300	6,228	25,808	31,250	83%
Pills	1,572	923	94	2,589		
Injections	5,083	4,028	372	9,483		
I.U.C.D.	12	77	0	89		
Implants	95	230	0	325		
Male Sterilization	0		0	0		
Female Sterilization	6	2	0	8		
Condoms	2,887	3,793	5,562	12,242		
Other	625	247	200	1,072		
3.1 increased availability of an integrated package of quality high impact intervention at community and facility levels						
# of services availability of an integrated package vitamin A from usg supported program	17	16	0	33	49	67%
# of service outlets providing HIV-related palliative care (excluding TB/HIV)	48	25	24	97	196	49%
# of service outlets providing HIV-related pediatric palliative care (including TB/HIV)	39	27	57	123	130	95%
# of service outlets providing PEP	35	25	13	73	58	126%
% of pregnant women receiving 2 doses of IPT	43	15	0	58	57	101%
# of service outlets providing clinical prophylaxis and/or treatment for TB to HIV-related individual (diagnosed or presumed according to national or international standards)	39	27	57	123	170	72%
# of USG assisted service delivery points providing FP counseling or services	183	134	90	407	398	102%
CYP provided through USG supported programs	2,447	2,446	346	5,239	5,200	101%
# of targeted condoms service outlets	37	10	0	47	120	39%
# of condom distributed (GOK health seek indicator and standard OP)	56,546	63,571	0	120,117	24,000	500%
% of district with community IMCI intervention	46	0	0	46	78	59%
# SP participating in CME or CE	235	0	0	235	330	71%

Performance Indicator	NEP/TR	UES	Turkana	NAL Total	NAL Y1 Target	% Y1 Target Achieved
# of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MNCH services by facility type	16	16	0	32	170	19%
% of facilities with stock outs of methods	0	0	0	0	18	0%
# of service outlets with full contraceptive method mix	16	16	0	32	88	36%
# of mobile units with providing testing	9	0	0	9	46	20%
# of service outlet with youth friendly services	3	16	0	19	28	68%
3.2 Increased demand for a integrated package of quality high impact intervention at community and facility						
# of facilities with private counseling areas	13	16	0	29	25	116%
# of facilities with functioning facility management committee	54	9	0	63	75	84%
# of functioning Community Units (GOK Heath sector indicators and SOP manual)	0	0	0	0	6	0%
# communities implementing the CS	0	0	0	0	6	0%
3.3. Increased adoption of healthy behavior						
# of BCC products distributed by type	3	0	0	3	15	20%
3.4 Increased program effectiveness through innovative approaches						
% of facilities use data for performance monitoring	51	0	0	51	78	65%
# of CU using data for DM	7	0	0	7	6	117%
# of eligible adults and children provided with a minimum of one care service	14,256	13,291	0	27,547	31,000	89%
# of local organization and service points provided with technical assistance for strategic information	8	4	0	12	135	9%
# of local organizations and service points provided with technical assistance for HIV related policy development	0	0	0	0	20	0%
# of local organizations and service points provided with technical assistance for HIV related institutional capacity building	0	0	0	0	20	0%
IR4: Social determinant of health addressed to improve the wellbeing of the community, especially marginalized poor and underserved population						
4.1. Marginalized poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs						
# of people actively involved in economic security initiatives through project linkages	11	0	0	11	1,000	1%
# of PLHIV support groups formed and/or linked to other service as appropriate	7	8	0	15	16	94%
4.2: Improved food security and nutrition for marginalized poor and underserved population						
# of eligible clients who received food and/or other nutrition services	1,057	2,192	0	3,249	10,000	32%
4.3: Marginalized poor and underserved groups have increased access to education, life skills and literacy initiatives through coordination and integration with education program						
# of schools supported by child friendly program	0	0	0	0	210	0%
# of youth trained in life skills	0	0	0	0	15,500	0%
# of OVC enrolled in ECD program through APHIAplus referrals	153	0	0	153	3,200	5%
4.4: Increased access to safe water, sanitation and improved hygiene						

Performance Indicator	NEP/TR	UES	Turkana	NAL Total	NAL Y1 Target	% Y1 Target Achieved
# of water and/or sanitation projects established in project supported facilities through linkages with usg funded WSS project	1	0	0	1	80	1%
# of organization and outlets selling POU and SW project through linkages with HCM project	5	0	0	5	90	6%
# of hygiene sessions held at schools	0	0	0	0	420	0%
4.5 Strengthening systems, structures and services for protection of marginalized poor and underserved population						
# of OVC assisted by the project to obtain legal birth certificate	0	0	0	0	7,000	0%
# of VHH identified and referred to services	0	0	0	0	1,450	0%
4.6 Expanded social mobilization for health						
# of RL who are advocating for reduced stigma and improved MNCH	3	0	0	3	11	27%

NORTH EASTERN PROVINCE/TANA RIVER SUB-REGION



Table 2: Achievements against targets for NEP and Tana River County Sub region

Performance Indicator	Jan-Mar 2011	NEP/TR Target	% Year 1 Target Achieved
GENDER			
# of people reached by an individual, small group or community level intervention that explicitly address norms about masculinity	1,147		TBD
Number of people reached by an individual ,small group, or community-level intervention or service that explicitly address Gender-based violence and coercion related to HIV/AIDS	381		TBD
# of people reached by an individual, small group or community level intervention or service that that explicitly address the legal rights and protection of women and girls impacted by HIV/AIDS	381		TBD
# of people reached by an individual, small group or community level intervention or service that that explicitly address aim to increase access to income and productive resources of women and girls impacted by HIV/AIDS	70		TBD
MARP			
# of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	2,391		TBD
PREVENTION WITH POSITIVE (PwP)			
# of (PLHIV) reached with a minimum package of prevention with PLHIV (PwP) intervention	251		TBD
SEXUAL AND OTHER BEHAVIORAL RISK PREVENTION			
# of targeted population reached with individual and/or small group level prevention interventions that are based on evidence and/or meet the minimum standards required (OB/C-BAB/C)	968		TBD
# of targeted population reached with individual and/or small group level prevention interventions that are primarily focused on abstinence and/or being faithful and are based on based on evidence and/or meet the minimum standards required (AB/F)	5,859		TBD
IR3: Increased use of quality health service, products and information			
COUNSELING AND TESTING			
# of service outlet providing counseling and testing according to national or international standards	36	75	48
# of individuals who received testing and counseling services for HIV and received their test results	31,286	6,000	521
HIV/AIDS TREATMENT/ARV SERVICES			
# of children with advanced HIV infection newly enrolled on ART	6	50	12
# of adults with advanced HIV infection newly enrolled on ART	70	450	16
# of children with advanced HIV infection receiving ART (currently)	94	225	42
# of adults with advanced HIV infection receiving ART (currently)	1,145	1,125	102

Performance Indicator	Jan-Mar 2011	NEP/TR Target	% Year 1 Target Achieved
# of children with advanced HIV infection who ever started on ART	119	250	48
# of adults with advanced HIV infection who ever started on ART	1,487	1,250	119
% of adults and children known to be alive and on treatment 12 months after initiation of ART	Not reported	85	0
% of HIV positive persons receiving CD4 screening at least once during the reporting period	11	100	11
# of HIV positive persons receiving CD4 screening CTX prophylaxis	421	2,000	21
# of HIV clinically malnourished clients who received therapeutic or supplementary food	61		TBD
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)			
# of services outlets providing the minimum package of PMTCT services according to national or international standards	188	170	111
# of pregnant women who received HIV counseling and testing for PMTCT and received their test results	13,621	35,000	39
% of HIV positive pregnant women who received ART to reduce the risk of MTCT	16	90	18
# of HIV positive pregnant women newly enrolled into HIV care and support services	91	250	36
# of infants tested for HIV at 6 weeks	14	200	7
% of infants born to HIV+ women who received and an HIV test within 18 months of birth	70	50	140
# of HIV exposed infants provided with ARVs prophylaxis	91	250	36
PALLIATIVE CARE (EXCLUDING TB/HIV)			
# of individuals provided with HIV related palliative care (excluding TB/HIV)	219	1,700	13
# of individuals provided with HIV related palliative care (including TB/HIV)	34	100	34
% of HIV positive patients who were screened for TB in HIV care or treatment settings	5	80	6
# of HIV positive patients in HIV care or treatment (pre-art or ART) who started TB treatment	30	190	16
# of TB patients who received HIV counseling, testing and their test results at USG supported TB outlets	595	1,500	40
VMMC			
# of VMMC clients	N/A	N/A	N/A
MNCH/RH/FP/SI			
# of deliveries performed in a USG supported health facility	4,256	4,000	106
# of ANC visits with skilled providers in USG supported health facilities	25,482	35,000	73
# of children less than 12 months of age who received DPT3 from USG supported programs	9,308	26,250	35
# of children <5 years of age who received vitamin A from USG supported	26,625	45,000	59

Performance Indicator	Jan-Mar 2011	NEP/TR Target	% Year 1 Target Achieved
# of new FP acceptors as a result of USG assistance by FP method	10,280	13,000	79
Pills	1,572		
Injections	5,083		
I.U.C.D.	12		
Implants	95		
Male Sterilization	0		
Female Sterilization	6		
Condoms	2,887		
Other	625		
3.1 increased availability of an integrated package of quality high impact intervention at community and facility levels			
# of services availability of an integrated package vitamin A from usg supported program	17	24	71
# of service outlets providing HIV-related palliative care (excluding TB/HIV)	48	100	48
# of service outlets providing HIV-related palliative care (including TB/HIV)	39	60	65
# of service outlets providing PEP	35	25	140
% of pregnant women receiving 2 doses of IPT	43	60	71
# of service outlets providing clinical prophylaxis and/or treatment for TB to HIV-related individual (diagnosed or presumed according to national or international standards)	39	85	46
# of USG assisted service delivery points providing FP counseling or services	183	170	108
CYP provided through USG supported programs	2,447	2,500	98
# of targeted condoms service outlets	37	50	74
# of condom distributed (GOK health seek indicator and standard OP)	56,546	10,000	565
% of district with community IMCI intervention	46	85	54
# SP participating in CME or CE	235	180	131
# of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MNCH services by facility type	16	85	19
% of facilities with stock outs of methods	0	15	0
# of service outlets with full contraceptive method mix	16	50	32
# of mobile units with providing testing	9	10	90
# of service outlet with youth friendly services	3	15	20
3.2 Increased demand for a integrated package of quality high impact intervention at community and facility			
# of facilities with private counseling areas	13	20	65
# of facilities with functioning facility management committee	54	35	154
3.3. Increased adoption of healthy behavior			
# of BCC products distributed by type	3	5	60

Performance Indicator	Jan-Mar 2011	NEP/TR Target	% Year 1 Target Achieved
3.4 Increased program effectiveness through innovative approaches			
% of facilities use data for performance monitoring	51	85	59
# of CU using data for DM	7	22	32
# of eligible adults and children provided with a minimum of one care service	14,256	15,000	95
# of local organization and service points provided with technical assistance for strategic information	8	50	16
IR4: Social determinant of health addressed to improve the wellbeing of the community, especially marginalized poor and underserved population			
4.1. Marginalized poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs			
# of people actively involved in economic security initiatives through project linkages	11	450	2
# of PLHIV support groups formed and/or linked to other service as appropriate	7	8	88
4.2: Improved food security and nutrition for marginalized poor and underserved population			
# of eligible clients who received food and/or other nutrition services	1,057	4,000	26
4.3: Marginalized poor and underserved groups have increased access to education, life skills and literacy initiatives through coordination and integration with education program			
# of schools supported by child friendly program	0	100	0
# of youth trained in life skills	0	7,000	0
# of OVC enrolled in ECD program through APHIAplus referrals	153	1,500	10
4.4: Increased access to safe water, sanitation and improved hygiene			
# of water and/or sanitation projects established in project supported facilities through linkages with usg funded WSS project	1	40	3
# of organization and outlets selling POU and SW project through linkages with HCM project	5	40	13
# of hygiene sessions held at schools	0	200	0
4.5 Strengthening systems, structures and services for protection of marginalized poor and underserved population			
# of OVC assisted by the project to obtain legal birth certificate	0	2,500	0
# of VHH identified and referred to services	0	700	0
4.6 Expanded social mobilization for health			
# of RL who are advocating for reduced stigma and improved MNCH	3	5	60

RESULT 3: INCREASED USE OF QUALITY HEALTH SERVICES, PRODUCTS AND INFORMATION

3.1 Increased availability of an integrated package of quality high-impact interventions at community and facility levels

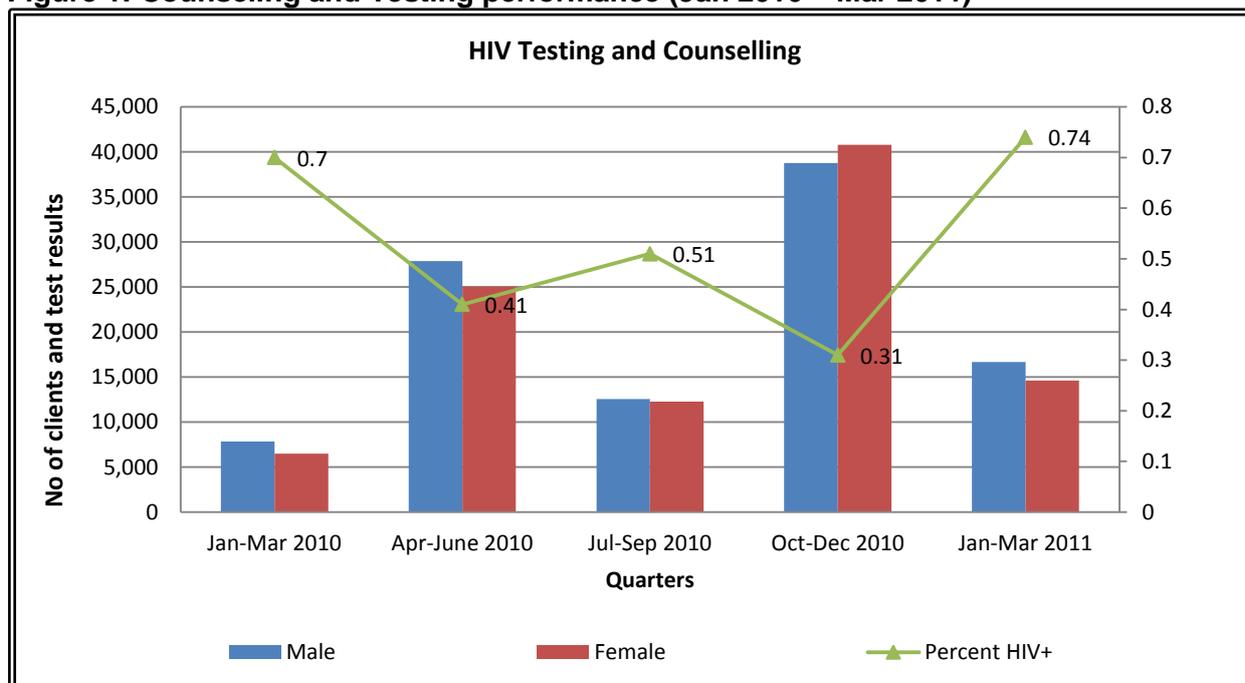
3.1.1 Counseling and Testing

APHIAplus NAL has achieved 52% of its annual targets in counseling and testing during the quarter under review. The number of counseled and tested was low as compared to last quarter, which was due to the nationwide HTC RRI in Nov/Dec 2010. The Project has put emphasis on implementation of PICT as routine services in all the health facilities and it is working towards a strategy of achieving a minimum of 80% of its inpatients and 50% of the outpatient clients. The VCT mobile outreaches, mainly the door-to-door and moonlight outreaches, were conducted in urban and peri-urban settlements to increase the access of MARPs to CT services.

Table 3: Counseling and Testing Performance (Jan 2010 – Mar 2011)

Reporting period	Male	Female	Percent HIV+	Total
Jan-Mar 2010	7,835	6,480	0.70	14,315
Apr-June 2010	27,896	25,024	0.41	52,920
Jul-Sep 2010	12,541	12,282	0.51	24,823
Oct-Dec 2010	38,783	40,792	0.31	79,575
Year 4 target				35,000
Total as percent of Year 4 Target				227%
Jan – Mar 2011	16,669	14,617	0.74	31,286
Year 1 Target (APHIAplus)				60,000
Total as percent of Year 1 Target (NEPTRC)				52%

Figure 1: Counseling and Testing performance (Jan 2010 – Mar 2011)



Key Observations on Performance

- The Project continued to support HTC services. During the quarter under review, 31,286 individuals (5,114 from Tana River) were tested of whom a total of 231 (95 from Tana River County) were HIV+. The HIV positive rates vary among HTC entry, e.g. the HIV positive rate in PICT was 0.5%; VCT1.2% ; and, PMTC 0.6%.
- APHIAplus NAL has completed the renovations of 6 additional VCT sites (initiated under APHIA II NEP) in the new district hospitals (Buna, Bute, Takaba, Elwak, Rhamu and Griftu) that will boost access to voluntary counseling and testing services.
- Capacity Project renewed the contracts of 5 VCT counselors and recruited 2 additional VCT counselors for the newly-designated districts that have VCT sites.
- There was marked improvement in PICT services in the region as a result of institutionalizing PICT through the appointment of PICT focal persons in hospitals and holding interdepartmental meetings to sensitize health workers.
- APHIAplus NAL supported 39 VCT outreach services during the quarter, including mobile, house-to-house and moonlight VCT targeting MARPs in the urban centers.
- The Project supported the establishment of a HIV/TB/RH resource center in Garissa Provincial General Hospital. This is a one-stop shop for health workers and people living with HIV who need information on various areas of health. The Project renovated a room and hired casuals to catalogue and index the resource materials. .
- APHIAplus NAL supported VCT mobile outreach in Tana River County. There was a good client turnout, especially in Tana Delta.
- There was a noted improvement in the supply and distribution of HIV test kits to the facilities. However, some facilities did not receive test kits in the quarter due to mix up of names in SCMS distribution list. Modogashe District Hospital is an example, registered

“The integrated Comprehensive Care Center (CCC) offering all services complete with a laboratory and a pharmacy and a HIV/TB/RH resource center marks a watershed in the provision of comprehensive AIDS care. Indeed NASCOP has confirmed that Garissa PGH CCC is the only one of its kind in the country.” Noor Sheikh, PASCO North Eastern province

both in Eastern and NEP but received no supplies for the whole quarter. This issue was resolved by following-up with SCMS.

- The Project participated in the dissemination of the National Quality Management Guidance (NQMG) framework in HTC for NEP program managers that was sponsored by NASCOP in collaboration with SPEAK 2 (JICA) Project. The Project intends to roll-out the NQMG to the facility level.

Challenges

- Poor uptake of PICT services in Tana River County facilities despite trained health workers and the availability of test kits, primarily due to over-reliance on HTC RRIs.
- Non-delivery of HIV test kits to some facilities due to problems in the SCMS distribution list. Some facilities in Tana River County order their test kits from district stores instead of receiving directly.
- Limited staffing in the existing VCT sites. Most VCT centers are manned by single VCT counselors, hence there are disruptions of services when staff are absent.

Planned Activities for the Next Quarter (April - June 2011)

- Partner with Rotary Club (Garissa/Tana River) in conducting RRI for counseling and testing for the Rotary Family Day commemoration.
- Continue supporting the mobile, house to house, moonlight VCTs within the urban centers in NEP and Tana County.
- Initiate and support monthly counselor supervision meetings and networking in each district and follow-up of the trained counselors.
- Strengthen PITC services in all the facilities through CMEs/OJTs and supervision, with special attention to Tana River facilities.
- Collaborate with SCMS in ensuring that the HIV test kits distribution list is updated to ensure all facilities receive their stocks.

3.1.2 Palliative Care TB/HIV

APHIA^{plus} NAL puts emphasis on TB/HIV integration at district and facility level and the provision of TA during support supervisions in improving data management and infection prevention and control at TB sites. The Project has completed the renovation of 14 laboratories in the province; this should result in increased access to TB diagnostic and treatment services. There has been a fairly constant performance on number of TB clients screened for HIV but the screening of HIV clients for TB is still a challenge.

Table 4: TB/HIV Indicator Performance (Oct 2010 – Mar 2011)

TB/HIV Indicators	Oct - Dec 2010					Jan-Mar 2011				
	Children		Adults		Total	Children		Adults		Total
	F	M	F	M		F	M	F	M	
TB cases detected	15	26	177	253	471	94	51	269	418	832
Smear positive	3	0	74	101	178	19	15	91	153	278
Smear negatives	2	11	129	170	312	44	41	190	248	523
Extrapulmonary TB patients on treatment	8	9	26	39	82	10	12	47	42	111
TB patients on re-treatment	0	0	15	27	42	3	3	33	72	111
TB Patients tested for HIV	12	27	124	191	354	59	38	237	261	595
TB Patients HIV	1	5	9	7	22	4	4	10	16	34
TB HIV patients on CPT	0	1	14	13	28	4	3	9	19	35
Defaulters	0	0	4	10	14	7	0	6	5	18
TB patients completed treatment	17	19	151	166	353	59	18	115	145	337
TB deaths	0	0	2	7	9	2	2	6	11	21

Key observations on performance

- APHIAplus NAL facilitated the District TB and Leprosy Coordinators in NEP and Tana River County to carry out support supervision in all the TB sites. It is expected that TB CAP will be able to carry out this support in the coming quarter. Technical assistance was given for TB sites to improve on quality service provision and data management during the supervisions.
- The Project completed renovation of the Garissa Provincial General Hospital TB center. The renovation was done for the TB clinic, creation of a patient waiting area in line with recommendations for infection prevention and control.
- The Project supported screening of suspected TB cases through sputum examination on site in Fafi where 130 clients were screened and one was smear positive and put on treatment and in Ijara 5 new clients were put on treatment with the support of the Project.
- APHIAplus NAL supported 3 integrated TB/HIV outreaches in areas that had no facilities or laboratory services. The clients who tested positive for either TB or HIV were linked to services.
- The Project supported the commemoration of World TB Day in Fafi and Ijara districts through a five-day TB screening outreach and health education for the target populations.
- The Project completed the renovation of 14 laboratory facilities, of which 4 are now operational. In collaboration with NLTB, there are plans to provide TB diagnostic and treatment services through these renovated sites.
- APHIAplus NAL strengthened district stakeholder management by facilitating health stakeholder forums in Garissa, Ijara and Fafi districts as well as the new districts of Tana Delta and Tana River.

Challenges

- Screening for HIV patients for TB and vice versa; inadequate reporting of HIV positive clients screened for TB in the non-integrated sites due to lack of reporting tools.

Planned activities for the next quarter (April - June 2011)

- Continued support for targeted TB screening outreaches and MDR surveillance in densely populated villages, especially the peri-urban settlements.

- Initiate logistic support for the referral of TB specimens through the already established CD4 laboratory networking.
- Support initiation of new TB diagnostic sites through the newly renovated laboratories.
- Strengthening of TB/HIV committees at district and facility level to enhance integration.
- Integration of TB services in HIV clinics to enhance the screening of all HIV positive clients for TB.
- Ensure availability of reporting tools in HIV clients screened for TB.
- Continued strengthening of District Health Stakeholder Forums (DHSF).
- Support data dissemination/review of performance of AOP7 workshops.

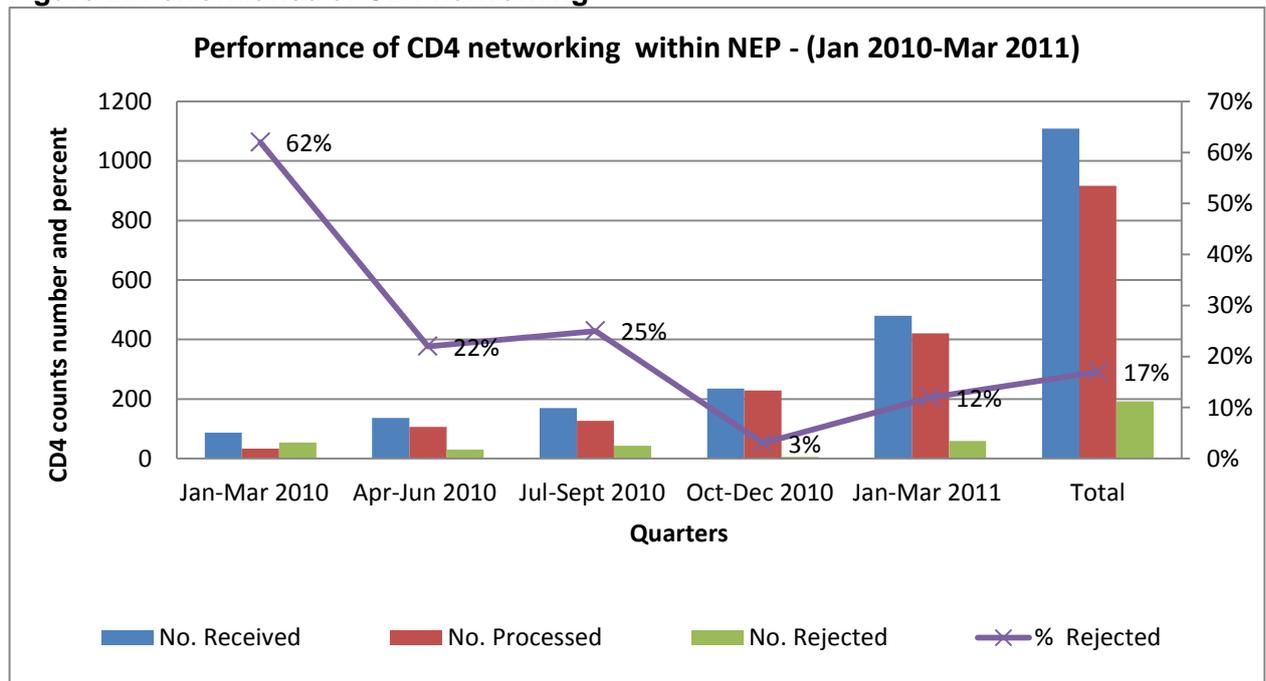
3.1.3 Palliative Care (excluding TB/HIV care)

Key observations on performance

Laboratory services

- The Project continued support for CD4 sample referral during this quarter, expanding the CD4 networking to Tana River County. During the baseline assessment in Tana River County it was found that samples were being referred to Malindi and Mombasa; however, clients were waiting 3-8 months for results and most samples were being rejected. Essentially patient care in Tana River County was dependent on WHO staging. This is against the current guidelines, as inaccurate clinical judgments by new or inexperienced staff may deny deserving patients access to ART services. The Project has embarked on supporting laboratory networking for CD4 count in Tana River County.

Figure 2: Performance of CD4 networking



- Supported routine collection and submission of DBS samples to HIV national reference laboratory for quality assurance.
- Supported programmatic supervision with laboratory services as an integral component of the supervision.
- Completed the renovations for seven (7) more new laboratory structures in NEP and Project is working with TB program to upgrade the facilities as TB diagnostic sites.

- The Project participated in meeting with national lab TWG on the assessment of capacities of labs in northern arid lands to support ART services. The Project was successful in lobbying for the placement of FacS count machines in Wajir, Mandera and Ijara district hospitals.

Challenges

The laboratory networking in Tana River County came with its share of challenges:

- During the quarter Tana Delta district sent samples but all the samples were rejected due to:
- Sample pooling instead of client pooling: Samples were collected from various facilities for a period of 5 days using EDTA tubes instead of CD4 stabilizer tubes. Actually all the samples were spoilt before leaving source.
- Inadequate knowledge of CD4 testing amongst the laboratory staffs in the district. The providers in Tana River were enthusiastic about CD4 testing for their clients in Garissa and couldn't wait to be oriented to how the network works.
- The district has a network of small routine laboratories approximately 50km apart with similar staffing and equipment, thus there is no superior lab to support the other.

Table 5: CD4 sample referral performance (Jan-Mar 2011)

FACILITY REPORT	DISTRICT	PGH LABORATORY REPORT		
		No. Received	No. Processed	No. Rejected
IRC Lab Hagarder	Fafi District	20	20	0
Elwak	Mandera Central	10	10	0
Police Line	Garissa	6	6	0
Ngao DH	Tana Delta	54	0	54
Griftu DH	Wajir West	2	0	2
Bura HC	Tana River	4	4	0
Iftin SDH	Garissa	4	4	0
Modogashe	Lagdera	3	0	3
PGH, Garissa	Garissa	377	377	0
	Total	480	421	59
			% rejected	12%

Planned Activities for the next quarter (April - June 2011)

- Conduct CMEs and CD4 sample referral performance review meetings in NEP and Tana River County.
- Printing and dissemination of job aides on CD4 sample collection and shipping.
- Support TB MDR surveillance through specimen referral to TB central lab and timely dissemination of results to the testing labs in the province.

3.1.4 HIV/AIDS Treatment/ARV Services

During the quarter under review, APHIAplus NAL completed the ART mentorship training and follow-up of mentees with Kenya Pediatric Association. The Project supported the roll-out of the mentorship program to the districts which is anticipated to enhance quality adult and pediatric ART care and treatment. The Project has also seen the growth of CD4 networking to the peripheral facilities despite the frequent breakdowns of the only CD4 machine based in PGH Garissa.

Table 6: HIV Care and treatment status as at March 2011

ART Indicator	Garissa	Wajir	Ijara	Mandera	Tana River
Newly enrolled on HIV Care	95	16	7	8	93
Newly initiated on ARVs	39	4	-	1	30
Cumulative on Care	1,931	11	113	314	1,397
Cumulative on ARVs	741	123	45	118	579
Currently on ARVs	703	83	29	87	337



Key observations on performance

- There was noted improvement in the supply of ART commodities to the ART sites in all of the districts and there were no stock outs, as was experienced in the last quarter. This was achieved through the orientation of service providers on the national/KEMSA procurement, tracking and utilization systems of ARV commodities.
- APHIAplus NAL supported the Kenya Pediatric Association Mentorship technical team in conducting a follow-up mentorship site visit to NEP to assess and mentor the 30 trained ART mentors for NEP.
- APHIAplus NAL supported 2 ART mentorship support supervision visits in Garissa County districts and the refugee hospitals. The mentorship team of 6 persons comprising of a pharmacist, clinician, nurse/counselor, lab tech, nutritionist, and records officer visited 13 ART sites. This followed an initial site assessment done last quarter that recommended on-site mentoring for the staff.
- The Project supported the establishment of a laboratory in Garissa PGH Comprehensive Care Center to improve the laboratory diagnostic services to PLHIV. The CD4 machine was moved from the main laboratory to the CCC laboratory to enhance CD4 specimen collection and networking. A microscope and reagents were also availed in the laboratory to carry out other supportive tests. This move appears to have had a positive impact on patient care, CD4 lab networking coordination and QA/QC in HIV testing.

- The Project supported the final phase of ART data reconstruction in Garissa PGH ART central site, which will enhance the smooth flow of real-time data.
- The Project supported CME/CPD departments in the major hospitals through provision of TA and logistic support. The Project refurbished the CME venue for Garissa Provincial General Hospital. In the quarter under review, a total of 15 CME sessions were conducted with 235 health providers on HIV/TB/RH topics.
- The Project provided logistic support in the re-distribution of ART commodities among the sites in NEP, especially in sites that had limited stocks.
- APHIAplus supported the roll-out of CD4 laboratory networking to the peripheral facilities through TA and logistic support. In the quarter under review, a total of 480 CD4 samples were received at Garissa Provincial General Hospital laboratory. CD4 networking was also extended to Tana River County districts, resulting in improved timeliness and reliability of sample processing. They were previously sending their samples to Coast but experiencing challenges.
- The Project participated in the National and regional pediatric quality of care meetings held in Nairobi and Garissa for NEP region that evaluated the current treatment practices in children versus the guidelines and the implications. It also addressed the low uptake of pediatric HIV care and immediate programmatic actions were identified.



Lab tech drawing blood at the PGH CCC laboratory

Challenges

- The only CD4 machine serving the province has been on and off due to mechanical problems, hence slowing the pace of CD4 specimen processing and initiation of clients on ARVs.
- Uptake of pediatric ART is still a challenge in the region.
- Weak referral and departmental linkages noted in Tana Delta, hence loss of clients for initiation into care and treatment.

Planned activities for the next quarter (April - June 2011)

- Continued support of ART mentorship program in NEP and initiation of the same in Tana River County sites.
- Continue implementation of PwP program through sensitization of health workers and distribution of job aides and IEC materials.
- Ensure that the only CD4 machine remains in good condition (temperature control) through procurement of an air conditioner for the CD4 room in PGH laboratory.
- Initiate new ART satellites in Idsowe, Ozi and Kau in Tana Delta district.
- Strengthen community linkages for adherence support in Tana Delta through replicating the Garissa model of attaching PLHIV advocates to the CCC.
- Distribution of pre- ART and ART registers, policy guidelines and SOPs in all the ART sites, both old and upcoming sites in Tana River County facilities.
- Procurement and distribution of suspension and spring files in support of data reconstruction in ART sites.
- Strengthen and scale-up CD4 laboratory networking to support the referral of all the surveillance samples (TB, EID, polio, measles, Rift Valley Fever).
- Conduct CME to update health workers on the new WHO ART guidelines.

3.1.5 Condoms and Other Prevention Activities

Key observations on performance

- During the quarter, a total of 56,546 condoms were distributed within facility and community channels. The Project surpassed its annual target, attributed to the consistent distribution at the health facilities, CCCs and FP integration into ART.
- The BCP kit distribution through the CBHC has enhanced the acceptance of condom use in Garissa, Wajir and Tana River. This was evidenced by the demand for refills by clients after the distribution of BCP kits at the CCC.
- Condom distribution in various taxi stages through Peer Educators; outlets stands at 37.

Challenges

- The frequent vandalism of condom dispensers, especially at rural health facilities, due to community attitude.

Planned Activities for the next quarter (April - June 2011)

- Replacement of vandalized condom dispensers and improve security at the sites.
- Provision of TA and supervision for the public health technicians in the refilling of condom dispensers and distribution of condoms.
- Sensitization of FMCs, facility-based CHWs and public health technicians in the affected facilities on protection and regular refilling of the condom dispensers.
- Increase condom outlets in Tana River County.

3.1.6 Prevention of Mother-to-Child Transmission

APHIAplus NAL supported the provision of PMTCT services in 148 sites in NEP and an additional 40 sites in Tana River districts. The Project is ensuring that the sites conform to national standards through follow-up of PMTCT trained staffs, dissemination of new PMTCT guidelines and distribution of more efficacious dual/triple prophylaxis regimens to the PMTCT sites.

Table 7: PMTCT cascade Jan 2010 – March 2011

Indicators/Quarters	Jan-Mar 2010	April-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011
No. of women starting ANC	7,406	7,540	8,026	8,291	10,329
No. of women attending ANC as revisits	10,873	9,566	10,041	9,927	15,153
No. of women counseled	7,303	8,184	8,579	9,575	11,412
No. of women who had HIV test	7,027	7,705	8,182	9,241	10,838
No. of women tested HIV +	28	24	17	21	61
Mothers given NVP at ANC	19	22	20	21	61
Percentage of women testing HIV+	0.40	0.31	0.21	0.23	0.56
No infants tested for HIV after at 6WKS	-	21	9	12	14
No infants tested for HIV after at 3 months	1	6	17	22	7
Infants issued with preventive ARVs	9	15	17	21	61
Mothers tested at maternity	1,388	1,453	2,248	1,833	2,783
Maternity HIV	-	-	-	10	30
Deliveries	2,627	3,324	3,703	3,566	4,256

Figure 3: HIV Counseling and Testing at ANC

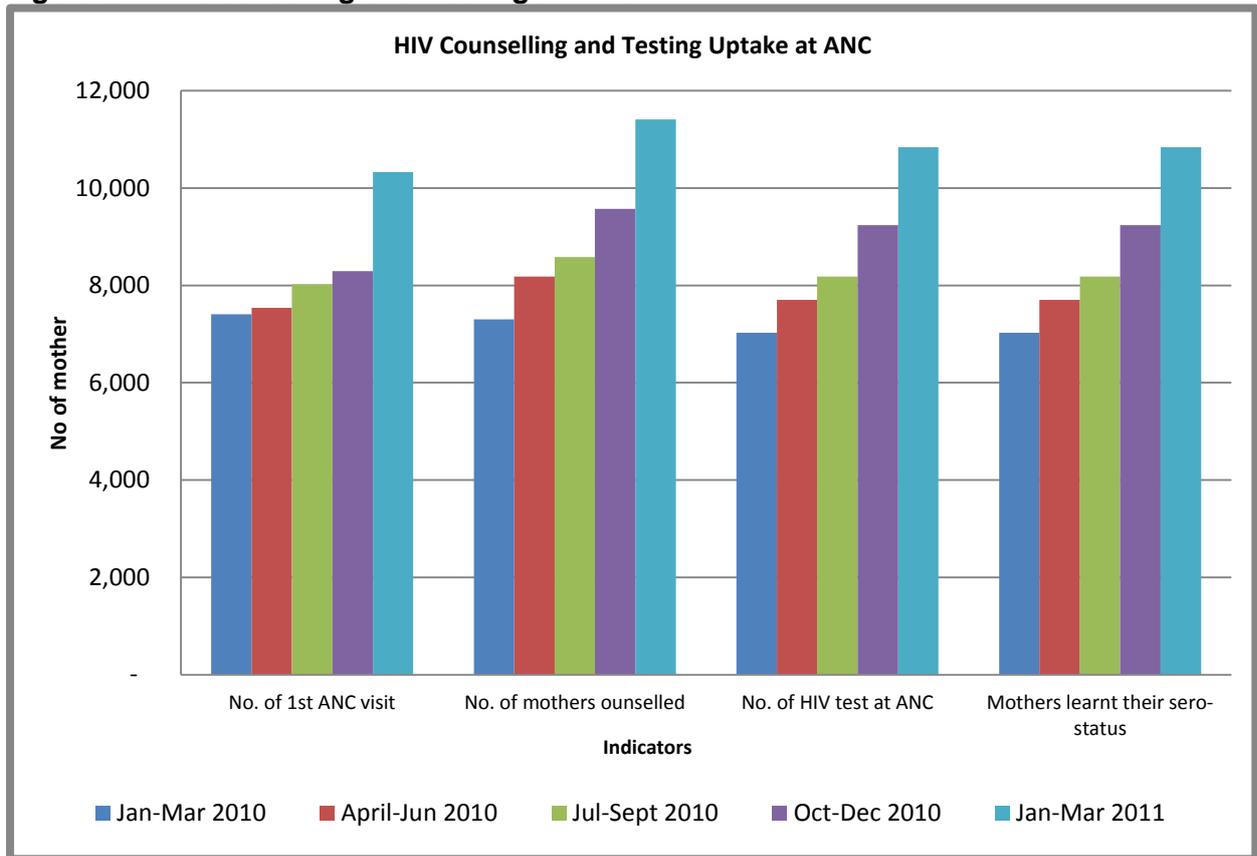


Figure 4: Mother and Infant NVP uptake at ANC (Jan 2010 – Mar 2011)

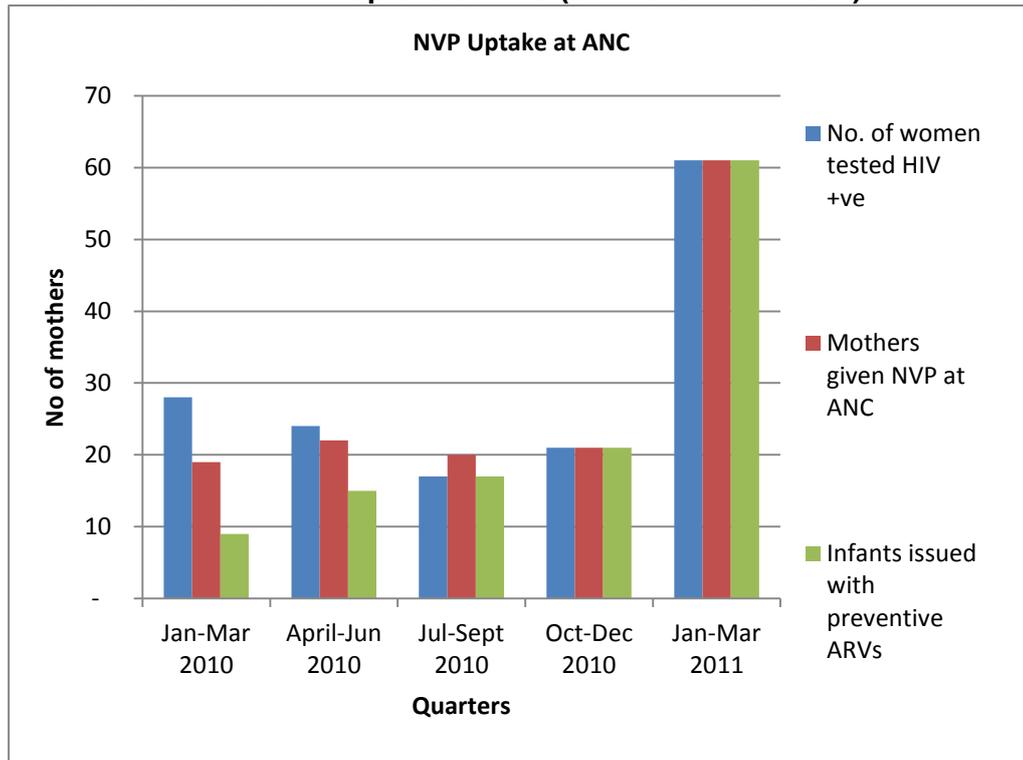
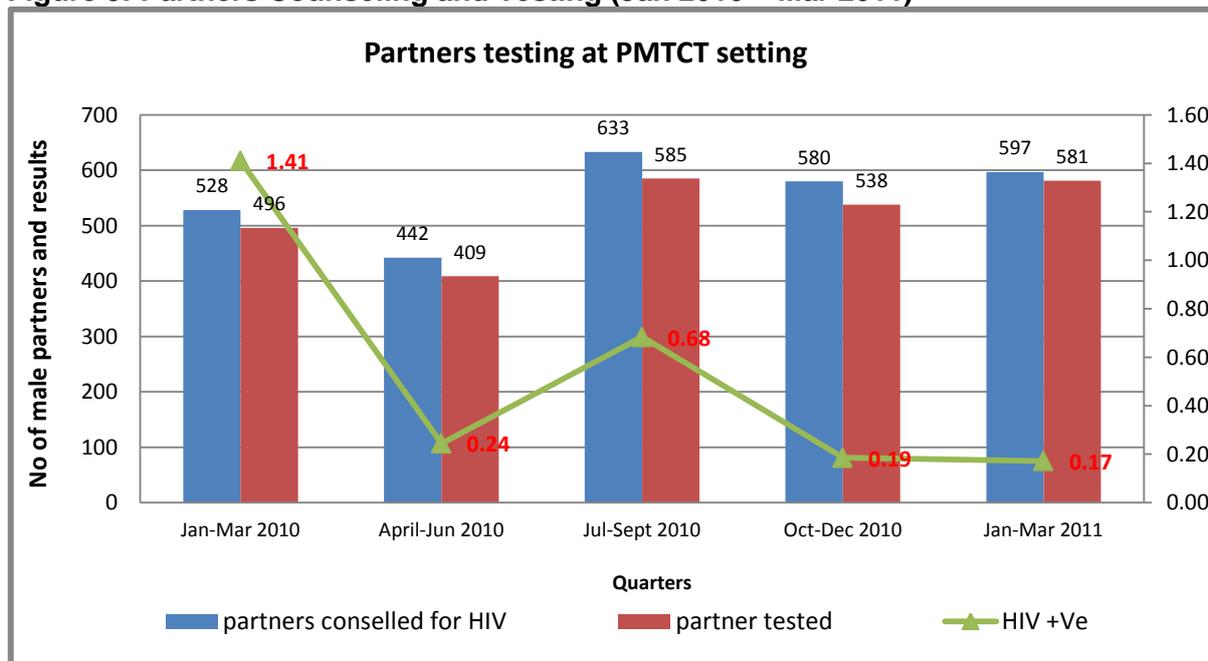


Figure 5: Partners Counseling and Testing (Jan 2010 – Mar 2011)



Key observations on performance

- In the period under review the number of women counseled and tested increased from 9,241 to 10,838 of whom 2,190 came from Tana River County; 61 were positive (30 from Tana River County) and prophylaxis provided.
- Most PMTCT sites in NEP had dual/triple ART prophylaxis but few sites in Tana River County had the same. OJT was provided to the health workers in these sites that had no prophylaxis during the support supervision and there are plans to distribute the ART prophylaxis to the sites in Tana River County.
- The Project supported and increased the facility-based motorbike integrated outreach services from 65 to 83 facilities in NEP and Tana River County districts through provision of fuel for motorbikes and allowances. Each facility conducts a minimum of four routine outreach activities per month.
- APHIAplus NAL supported quarterly DHMT support supervision in all the 14 Districts in NEP and Tana River County through the provision of staff allowances, fuel and transport. The Tana River County DHMTs were inducted into the process of conducting facilitative supervision and use of the comprehensive supervision tool. Action plans on the gaps noted during the supervisions were drawn.
- The Project continued support for the strengthening and implementation of Early Infant Diagnosis. A total of 17 samples were sent to KEMRI reference laboratory and results for 13 were received. One sample was positive and the infant was started on treatment.
- Partner counseling and testing uptake increased significantly over the last quarter. This is a result of the continued delivering of messages by the religious leaders.
- APHIAplus NAL facilitated the sensitization of health workers on the new PMTCT guidelines during joint support supervision in all the PMTCT sites.

Challenges

- The uptake of EID services, especially in Tana River County is low.
- The high turnover of PMTCT trained health workers is still a challenge. The recruitment of nurses through the Economic Stimulus Program (ESP) has had an unintended negative impact on the region. Many nurses left to take up appointments in their constituencies, leaving NEP and Tana River with many unfilled positions.
- The long and persistent drought resulted in the movement of nomads in search of pasture and water, reduced health uptake, increased malnutrition and increased disease burden.

Planned activities for the next quarter (April – June 2011)

- Strengthen EID activities through CME, OJT and support of laboratory networking for EID.
- Ensure availability of triple ARV prophylaxis regimens in all the PMTCT sites in Tana County and the replenishment of stocks in the others.
- Continue strengthening couple counseling at PMTCT sites.
- Continue support of integrated outreach services in all the districts.
- Continue support of joint DHMT/APHIAplus quarterly support supervision in all the 14 districts and follow-up of the service providers trained in PMTCT.
- Roll out the implementation of the Standards Based Management and Recognition approach in Tana River County.
- OJT on data collection and data quality improvement during the support supervision and data dissemination meetings.
- Expand PMTCT sites from 188 to 200 sites in the sub-region. Initiate PMTCT services in 12 new facilities.

- Strengthen post-natal clinics in PGH and district hospitals to minimize losses to follow-up and improve pediatric care and treatment for HIV-exposed infants.

3.1.7 Maternal Health

Table 8: Summary of Maternal Services

Indicator	Oct – Dec 2010	Jan – March 2011
# of skilled care deliveries	3,546	4,256
# of new ANC visits	8,248	10,329
# of 4+ ANC visits	2,570	3,961
# of lactating mothers receiving Vitamin A		7,550
# of ANC clients receiving IPT2		4,411
# of MVAs performed	31	65

Key observations on performance

- Facility assessment for Tana River County was carried out during the quarter and some of the identified gaps are being addressed and better practices borrowed for replication in NEP.
- Deliveries by skilled care attendants have continued to improve with the quarter realizing an increase of 20% over the last quarter (due in part to substantial contribution from Tana River County).
- Antenatal attendance also showed marked improvement with 1st ANC visits increasing significantly by 25% and the ratio between 4th ANC visit to 1st ANC narrowing by 7%, showing improved access and utilization.
- The project distributed MVA equipment (procured with non-USG funds) to selected facilities to support post abortion care services (earlier procured for PAC training)
- Vitamin A supplementation to lactating mothers during the quarter was impressive compared to total number of deliveries (4,256); 7,550 lactating mothers received vitamin A.
- End-line survey was carried out for the 'Care for the Mothers' pilot project during the quarter but the report is yet to be disseminated. It is hoped that the findings will provide a clear road-map for engagement with women groups and other community groups to create demand for health care services, thus improving access and utilization of health services.
- Screening for cervical cancer is routinely performed in most health facilities in Tana River; measures are underway to tap this specific skill and orientate health workers in NEP, starting with the PGH Garissa.

Challenges

- Movement of humans and livestock across the border from Somalia continues to pose a threat of outbreaks of disease among the pastoralist communities.
- Shortage of Basic EmOC equipment and supplies facilities.
- Inadequate referral infrastructure for emergency obstetric care.
- Shortage of staff (many facilities manned by CHWs without requisite knowledge and skills to offer technical services). Economic Stimulus Package (ESP) recruitment lacked applicants and many vacancies still exist in most districts.
- Few skilled care deliveries due to TBA influence.

Planned activities for the next quarter (April - June 2011)

- Support and participate in sub-regional facilitative supervision with PHMT and DHMTs.

- Undertake targeted MNCH/FP technical assistance to districts and health facilities to promote uptake of maternal, child health and family planning services.
- Support MoH to develop referral directory and early preparedness for obstetric emergencies and pooling of referral transport by counties.
- Procure and distribute basic equipment for EmOC to targeted facilities.
- Support review and distribution of standards, guidelines and job aides.
- Dissemination of end-line survey report for the “Care for the Mothers” pilot project.
- Support the MOH to re-orient TBAs to changed roles and induct them in health information messaging, counseling, “buddying” and referral of clients for skilled care delivery at health facilities.

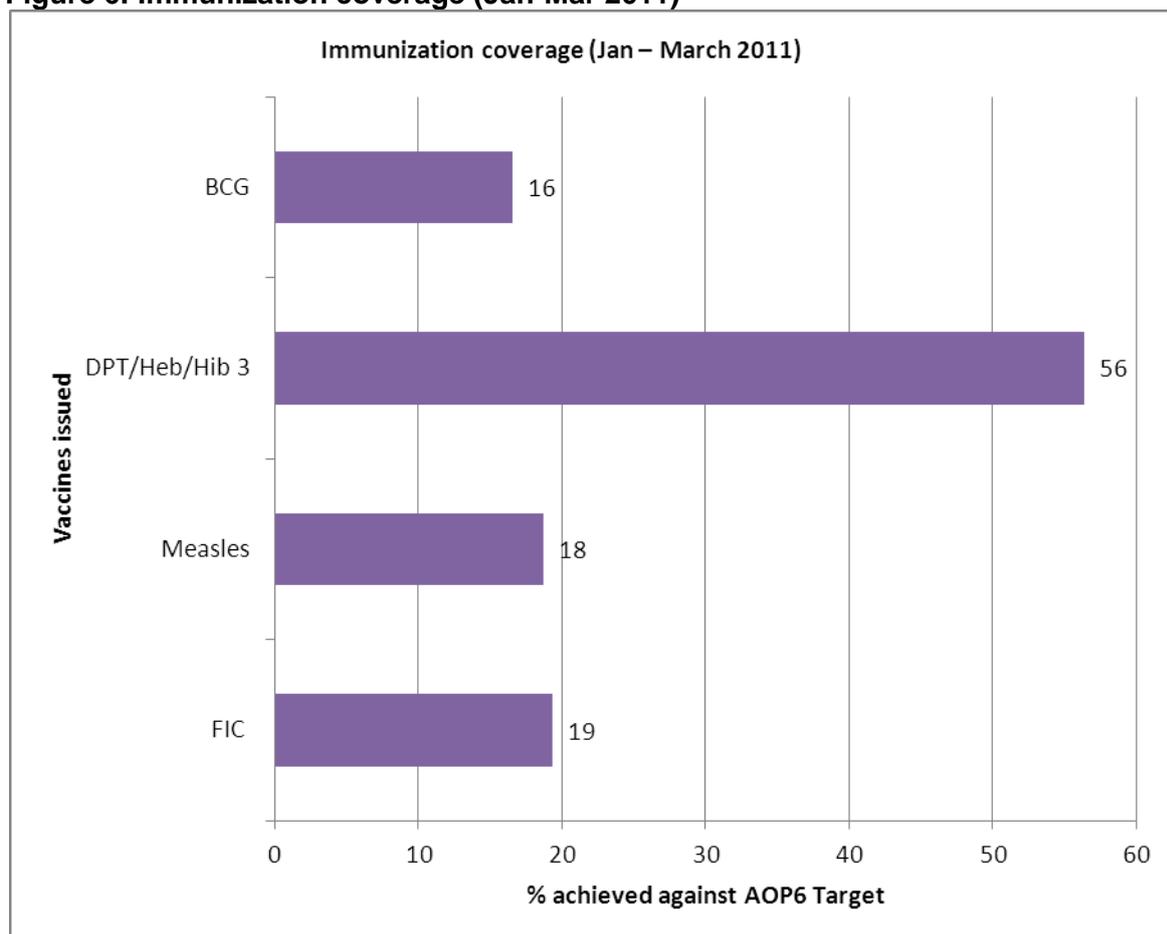
3.1.8 Newborn and Child Health

Table 9: Child Health Performance (Jan-Mar 2011)

Indicator	Jan – March 2011
# of newborns with LBW*	119*
# of newborns receiving BCG*	7,468*
# of children < 1 year who received DPT/HepB/Hib 3	9,308
# of children <1 year vaccinated against measles	9,329
# of children <1 year fully immunized	8,469
# of children < 5 years receiving vitamin A	26,625
# of children < 5 years treated for malaria	15,554
# of cases of child diarrhea treated	2,014
# of cases of child pneumonia treated with antibiotics	1,059

***Data not available for Tana River County for these indicators due to lack of reporting tools**

Figure 6: Immunization coverage (Jan-Mar 2011)*



*BCG indicator does not include Tana River

Key observations on performance

- Childhood immunization maintained an upward trend; in the quarter. The coverage for measles and FIC in NEP currently stands at 60% and 54% respectively .
- APHIAplus NAL supported the response to the outbreak of measles in NEP through facilitation of rapid response teams in the affected districts, DHMT support supervision and scale-up of integrated outreach services. During the quarter under review, 412 measles cases were line-listed and 21 samples returned positive results for measles virus, denoting measles outbreak.
- Vitamin A supplementation for children aged under 1 year at 9,472 was satisfactory in comparison to children fully immunized (8,469); however, supplementation for children aged 12 months up to 5 years is still low.
- The Project supported integrated motorbike outreaches, thus reducing missed opportunities and reaching the underserved children
- The quarter also saw the introduction of Pneumococcal vaccine to the childhood immunization schedule; the uptake so far is satisfactory.

Challenges

- Low demand for prevention services.
- Aged and dilapidated cold chain facilities (refrigerators and LPG cylinders) for storage of immunization vaccine.

- Shortage of staff (many facilities manned by CHWs without requisite knowledge and skills to offer technical services). ESP recruitment lacked applicants and many vacancies still exist in most districts for 20 facilities.

Planned activities for the next quarter (April - June 2011)

- Distribution of ORT furniture and utensils to selected health facilities.
- Support integrated outreaches and other National Immunization Days (NIDs) and Malezi Bora initiative.
- Support vaccine security through targeted re-distribution of vaccines and related logistics
- Support review and distribution of standards, guidelines and job aides.
- Supported targeted supportive supervision to promote comprehensive FP method mix and service integration.
- Participate in periodic performance review in the districts in all NEP and Tana River County.

3.1.9 Family Planning/Reproductive Health

During the quarter, couple years of protection attained from family planning usage rose impressively. This could be mainly attributable to contribution from Tana River County and the sustained SDM scale-up. The Project for the first time reported on permanent methods (BTL) from an outreach post in Tana River (5 clients) and PGH-Garissa (1 client).

Table 10: Summary of FP methods provided (Oct 2010 – March 2011)

Methods		Oct-Dec 2010			Jan-Mar 2011		
		New	Revisit	Total	New	Revisit	Total
PILLS	Microlut	277	197	474	242	181	423
	Microgynon	404	394	798	466	683	1,149
INJECTIONS	Injections	1,055	1,353	2,408	1,459	3,624	5,083
I.U.C.D	Insertion	14	-	14	12	-	12
IMPLANTS	Insertion	63	-	63	95	-	95
STERILIZATION	B.T.L	-	-	-	6	-	6
	Vasectomy	-	-	-	-	-	-
CONDOMS	No. of Clients receiving	2,309	1,113	3,422	1,725	1,162	2,887
ALL OTHERS: (CycleBeads)		551	-	551	431	194	625
TOTAL NUMBER OF CLIENTS		4,673	3,057	7,730	4,424	5,855	10,279
REMOVALS:	IUCD	5	-	5	116	-	116
	IMPLANTS	32	-	32	75	-	75

Figure 7: Contribution to CYP by contraceptive method (Jan – March 2011)

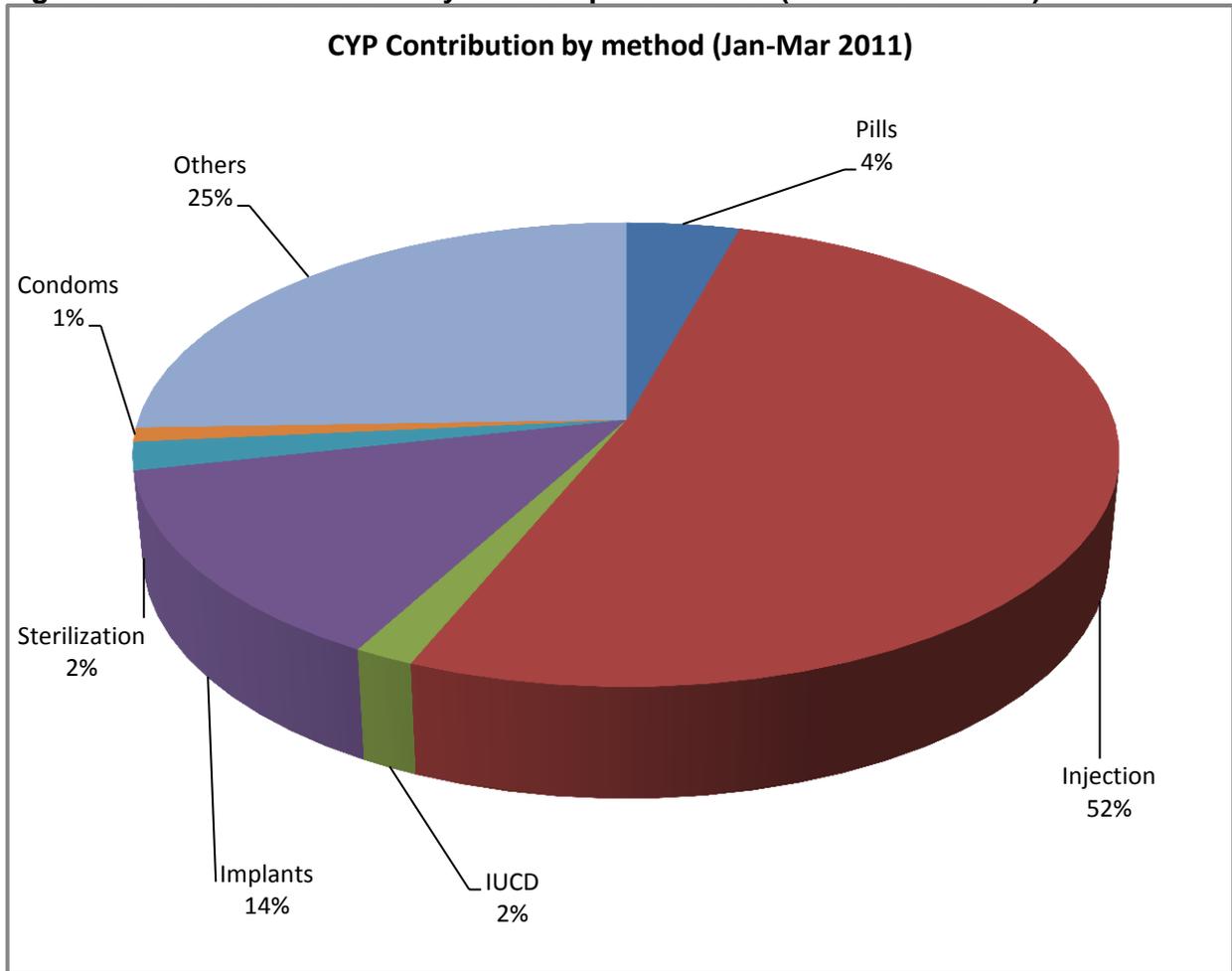
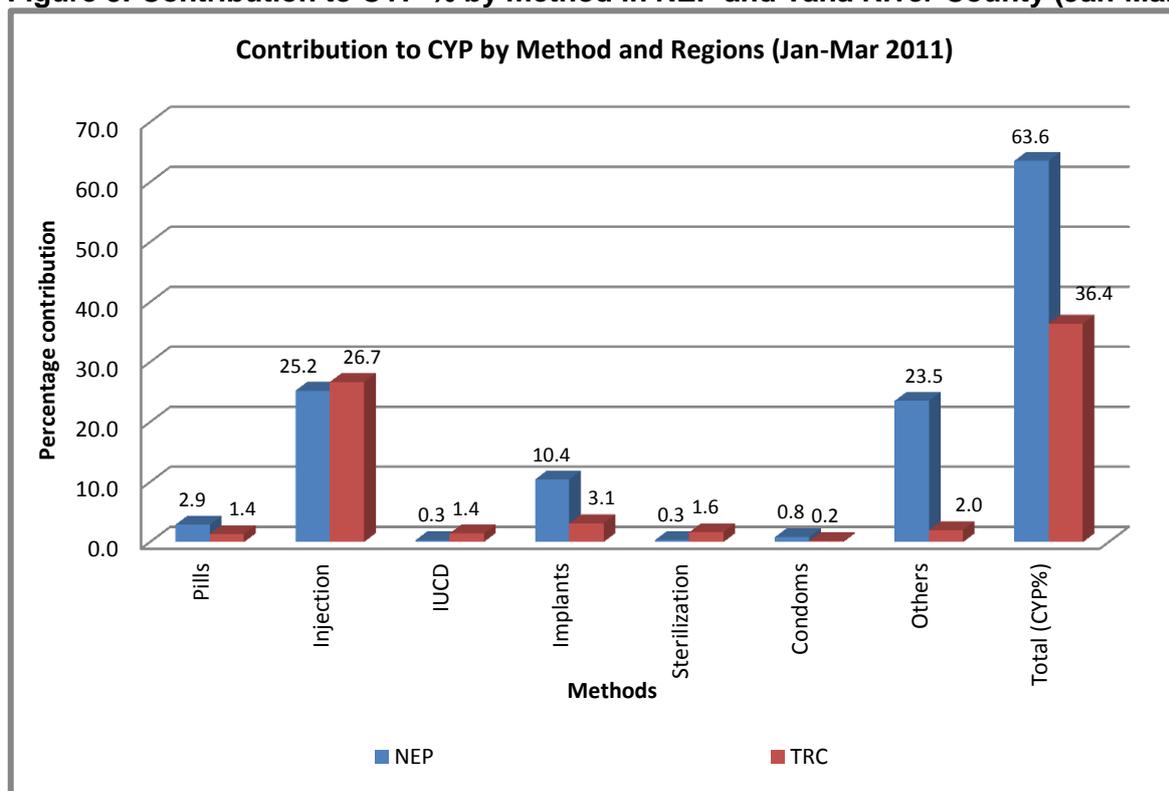


Figure 8: Contribution to CYP % by method in NEP and Tana River County (Jan-Mar 2011)



Key observations on performance

- Couple years of protection (CYP) improved markedly during the period from 1,535 to 2,439, whereby injectables continued to contribute the largest portion (52.1%) in the region. The Tana River County contributed 36.4% of the overall CYP for the sub-region.
- The quarter also saw a slight decline in the number of new visits compared to last quarter but the repeat (revisits) clients improved showing good service utilization.
- The improved performance in CYP could be attributable to SDM scale-up in NEP and contributions from Tana River County, where there is greater acceptance of family planning.
- Integration of HIV counseling into FP services has continued to perform well with most health facilities reporting nearly 100% HIV testing for FP clients. FP integration into ART services is also showing an upward trend, especially at Level 4 facilities.
- The Project continued the support for FP commodity reporting through on-job-training and distribution of reporting tools, CycleBeads and job aides.

Challenges

- Inadequate skilled health care providers trained in long acting family planning methods and related equipment (IUCD and implants insertion kits).
- Shortage of staff (many facilities manned by CHWs without requisite knowledge and skills to offer technical services). ESP recruitment lacked applicants and many vacancies still exist in most districts.

Planned activities for the next quarter (April - June 2011)

- Support review and distribution of standards, guidelines and job aides.

- Supported targeted supportive supervision to promote comprehensive FP method mix and service integration.
- Participate in quarterly AOP7 performance review in the districts for NEP and Tana River County.
- Continue supporting SDM scale-up (including TR).
- Provide TA to sites on RH/FP to include FP/HIV integration.
- Initiate cancer screening at PGH-Garissa through TA and logistics.
- Support postpartum FP integration with immunization services.
- Support FP and counseling and testing for HIV integration with post-abortion care.

3.1.10 Nutrition

Key observation on performance

- The number of children receiving vitamin A were 26,625, representing 43% of the target under five population for the sub-region. Lactating mothers receiving vitamin A were 7,550, representing 48% of the target population.
- APHIAplus NAL renovated the nutrition clinic of Garissa Provincial General Hospital and created a store for FBP and supplementary foods.
- The Project through Capacity Project recruited a nutritionist for Takaba District Hospital in Mandera West who reported during the quarter.
- APHIAplus NAL participated in the provincial/ district health and nutrition stakeholder forums in the region to mitigate the long spells of drought that have resulted in loss of livestock.
- Most facilities have supplementary feeding programs and thus some supporting management of malnourished children and mothers.
- The Project supported the District Nutritionist from 5 districts in NEP in conducting support supervision and OJT in Integrated Management of Acute Malnutrition (IMAM).
- Strengthened exclusive breastfeeding and effective complementary feeding, at supported facilities through initiation of breastfeeding clubs.
- Supported baby friendly hospital assessment to motivate health facilities engaging in supportive child health feeding practices.

Challenges

- Inadequate growth monitoring tools (both height and weight).
- Persistent drought and food insecurity.
- High staff attrition.

Planned activities for next quarter (April – June 2011)

- Continue supporting integrated outreaches.
- Support targeted supervision.
- Procurement and distribution of anthropometric equipment.
- Integration of lab services in MCH/ANC services for 5 district hospital.
- Strengthen baby-friendly hospital initiative at Garissa PGH.
- Support Malezi Bora and measles campaign to enhance vitamin A uptake

3.1.11 Adolescent SRH

Key Observations on Performance

- The Project mainstreamed gender activities into the work plan.

- The Project identified 17 health facilities in NEP and TRC for implementation of integrated youth-friendly services.

Challenges

- Inadequate number of health workers trained in provision of youth-friendly services.

Planned activities for the next quarter (April – June 2011)

- Support youth-friendly services through targeted TA, OJT and CME to selected health facilities in NEP and Tana River County.
- Establish youth-friendly corners at Garissa PGH.
- Support establishment of post-rape and GBV counseling and treatment centers in Garissa pgh.
- The Project will collaborate with G-Youth Garissa to refurbish and equip a youth resource center at PGH-Garissa.
- Strengthen the integration of GBV at Garissa PGH and district hospital.

3.1.12 Malaria

Key observations on performance

- The quarter witnessed increased number of children under the age of 5 years treated for malaria; however, most facilities reported reduced stocks of Co-artem (1st line treatment regimen).
- Distribution of UNICEF-procured LLITN to pregnant mothers and children under age five continued in the quarter, especially in Tana River County and some parts of NEP.
- In the quarter under review, IPT 2 coverage stood at 4,411, representing 73% of clients who received IPT 1.

Challenges

- Inadequate supply of LLITN to health facilities.
- Inadequate supply of SP drugs for IPT.

Planned activities for the next quarter (April – June 2011)

- Support facilitative supervision and OJT on malaria diagnostics and treatment.
- Support re-distribution of LLITN and other related supplies.
- Support provision of ACTs, RDTs through TA, linkages and logistics.
- Support distribution of malaria guidelines, SOPs and posters to facilities.

3.1.13 Water and Sanitation

Key Observations on Performance

- The Project supported the establishment of a water storage facility in Shimbirey Dispensary.
- The Project supported infection prevention initiatives through supportive supervision, OJT and other related TA on instrument processing, medical waste segregation and disposal.

Challenges

- Most facilities in NEP and Tana River County districts do not have a reliable water supply due to reliance on water pans in the rural villages and inadequate rainfall.
- During the quarter 6 health facilities (4 in Mandera West and 2 in Tana River district) were closed due to lack of water.

Planned activities for the next quarter (April - June 2011)

- Establishment of water storage tanks in 5 facilities in each county.
- Embed hand-washing demonstration areas in ORT centers to promote hygiene.
- Support provision of hand washing facilities in 5 facilities in each County.
- Collaborate with HCM Project in the provision of water treatment supplies to the facilities.

3.2 Increased demand for an integrated package of high impact interventions at community and facility levels

3.2.1 CHW Outreach Activities/Community Strategy

Key observations on performance

- During the reporting quarter the Project revised modalities of engaging community groups in conformity to the PEPFAR New Generation Indicators.
- The Project continued engaging Youth Leaders in providing peer education programs for school health, maternal and child health, integrated outreaches, SDM roll-out and support for PLHIV to reduce stigma.
- Integration of outreaches in Wajir to be conducted by involving OPAHA group in a follow-up and linkage of PLHIV to health services.
- The *Chill* Clubs continue to provide services through trained YL who were oriented on NGI reporting tools.
- Initiated assessment for establishment of school health programs in Tana River County.
- In collaboration with HIV Free Generation and other partners the Project conducted social mobilization, passing of health messages and counseling and testing of 50 youth during Sakata football tournament in Garissa County.
- The Project is expanding roll-out of its work site interventions in Tana River and the rest of NEP, using the Garissa work site program as a model.
- The Project finalized production of audio visual materials targeting youth, in line with the Project's behavior change strategy, which was based on an earlier assessment and targeted youth for stigma reduction.
- The Project embarked on sensitization of head teachers and school chairmen for the formation of school health clubs in Tana River County. The Project works through the respective DEOs and the link persons are the school patrons.
- The Project is giving priority to the creation of condom outlets in Tana River County since condom demand was noted to be high in most of the areas visited during the facility and community assessments.

Challenges

- Change in programming approach has slowed implementation of community outreach activities in NEP and Tana River County in line with NGI requirements.
- Preparation time required for development of Fixed Obligation Grants for local implementing partners.

Planned activities for the next quarter (April – June 2011)

- Roll out community outreach program to Tana River County.
- Train/update workplace peer educators in NEP and Tana River County.
- Roll out of evidence-based workplace peer education and integrated outreach program to all districts.
- Utilize local FM stations to enhance social mobilization by passing messages to enhance behavior change and health service utilization.
- Scale-up stigma reduction through alliance of RLs and PLHIV during BCC outreach activities.
- Sensitization meeting for the head teachers and patrons of the schools identified in Tana River County.
- Disseminate and utilize theatre-based video scripts on stigma reduction in all forums and trainings. The target groups are youth, service providers and community opinion leaders.

Community Strategy

The Project continued to support community units in Garissa (Medina) and Ijara (Kotile) CUs.

Key observation on performance:

- Identification of existing CUs in Tana River County in anticipation of support to two CUs by the Project.
- Rollout of NGI tools.
- CHWs completed household registration in Kotile CU.
- Data collection by CHWs and provision of chalkboard to Medina CU.
- Community dialogue days initiated.
- Supported Medina CU activities through CHW and CHEWs.

Challenges:

- Inadequate supervision from DHMTs and CHEWs.
- Lack of commitment and ownership from MOH partners. This will be addressed during community dialogue days where ownership and commitment of the community and MOH will be discussed.
- High turnover of CHWs and CHEWs.

Planned activities for the next quarter (April – June 2011)

- Procurement of bicycles and motorbikes for CHWs and CHEWs to support CU activities.
- Identification of CHWs and CHEWs for 2 CUs in Tana River County.
- Training of the CHWs, CHEWs and CHCs in Tana River County.
- Support DHMTs to include level 1 quarterly support supervision and share CU progress reports with partners and PHMT.
- Support regional facilitative supervision for community strategy.
- Lobby for deployment of committed CHEW for Kotile CU.

3.2.2 Care and Support for PLHIV

Table 11: Summary of CHBC services (October 2010 - March 2011)

Activities/Services	Oct-Dec 2010	Jan-Mar 2011		
		NEP	TR	Total
Number of clients served	682	725	314	1,039
Clients who died	1	3	0	3
No of care givers	309	333	1,060	1,393
No. of new HBC clients (Male)	215	232	93	325
No. of new HBC clients (Female)	451	477	221	698
No. of clients on ARVs (Male)	137	154	92	246
No. of clients on ARVs (Female)	312	323	221	544
No. of ARVs clients dropped out	0	1	0	1
No. of referrals for VCT	119	118	0	118
No. of referrals for CCC	200	233	0	233
No. of referrals for FP	10	6	0	6
No. of referrals for Nutrition	3	0	0	0
No. of referrals for Support group	126	285	0	285
No. of referrals for PMTCT	4	11	0	11
Condom distributed	334	436	0	436

Key observation on performance:

- More clients identified for CHBC program in Wajir and Garissa.
- During the quarter the Project supported identification of CHBC structures for community outreach program roll-out in Tana River County.
- Project supported quarterly PTC and group therapy meetings.
- The PTC PLHIV meeting used to mobilize clients for CD4 referral.
- Trained TOT advocates from NEP conducted treatment literacy training for 30 caregivers in Wajir.
- PLHIV advocates passed PwP messages at community-level.
- PLHIV groups were linked to food and nutrition services provided by the provincial administration; about 40 groups received various food items in Mandera.
- During the quarter the Project linked one support group – Ushirika in Mandera – to TOWA PWP funds.
- The Project linked PLHIV advocates to a local organization (Habiba International) in Mandera for capacity building in good governance.
- The Project facilitated roll-out of BCP in Wajir, with 300 kits being distributed through the Wajir CCC.

Challenges

- Few partners to provide support to PLHIV support groups.
- Disorganized PLHIV support groups.
- Inadequate capacity of some of the PLHIV support groups to lobby for IGA, food and nutrition services.

Planned activities for the next quarter (April – June 2011)

- Follow up CHBC/OVC integration program in Mandera and Wajir.
- Initiate OVC/CHBC integration activities in Ijara district
- Identify potential CHWs in Mandera, Masalani and Tana River County to plan for the training on CHBC.
- Identify additional PLHIV support groups and plan for treatment literacy training roll-out.

3.3 Increased adoption of healthy behaviors

Key observations on performance

- In collaboration with HIV Free Generation and other partners, the Project participated in the Sakata football tournament in Garissa. The Project supported VCT counselors to conduct outreach HTC. Peer educators mobilized the community and 50 youths were counseled and tested; none tested positive.
- The Project finalized the installation of billboards with messages targeting stigma and discrimination in the main district headquarters of NEP. The billboards were strategically placed. A total of four billboards have been erected, one in each of the Counties of NEP (plus Ijara district).
- Peer educators continued to deliver OP messages in “hot spots” throughout the region where they targeted key populations at risk: miraa sellers/chewers; bar attendants; taxi drivers; truck drivers; CSWs; street tea/milk vendors; uniformed services personnel; alcohol and other drug users.
- The Project finalized the production of video clips targeting reduction of stigma and discrimination in NEP. Separate segments targeting the youth, service providers and community opinion leaders were produced.
- The Project supported several BCC integrated outreaches targeting MARPs. The DASCOS, DPHOs and local community groups participated in this activity for social mobilization.
- The Project initiated prevention with positive messaging to PLHIV through the trained advocates as TOTs. The intention is to provide comprehensive PWP messaging through various community entry points.

Challenges

- Linkage to services and follow-up of individuals who test HIV+ during outreaches.
- Most of the clients prefer counselors unknown to them, due to fear of stigmatization and concerns about confidentiality.

Planned activities for the next quarter (April – June 2011)

- Support evidence-based peer education program in all districts of NEP and Tana River County.
- Update/train 30 peer educators from work places in NEP and Tana River County.
- Link HIV positive clients to trained advocates during BCC outreach.
- Support targeted health education to address stigma and confidentiality during BCC outreach.

3.4 Increased program effectiveness through innovative approaches

3.4.1 Integrated mobile and other outreach services to reach MARPs, women, girls and hard-to-reach populations to bring care closer to the client

Key observation on performance:

- Work site peer education program continued throughout the region.
- Targeted HTC outreaches in NEP and Tana River County: door-to-door and moonlight VCT for uniformed personnel and CSW.
- Project developed NGI MARP and HIV prevention monitoring tools for community groups.
- OJT on NGI tools was done for peer educators across the region.

Initiation of PwP

In Garissa the Project initiated prevention with positives messaging to PLHWAs through the trained advocates as TOTs. Ten TOTs were engaged to do the reporting. The design is to provide comprehensive PwP messaging through various community entry points. Locations include during PTC group therapies, at the CCC clinic and during CHWs home visiting.

Challenges

- Frequent transfer of work place peer educators.
- Stigma.

Planned activities for the next quarter (April – June 2011)

- Establish 20 condom outlets in Tana River County
- Rollout peer education activities in Tana River.
- Identify 30 more PE, train and scale-up worksite PE activities.
- Review community reporting tools and distribute to PE.
- Carry out monitoring and supervision of PE activities in the region for quality and evidence-based messaging.

RESULT 4: SOCIAL DETERMINANTS OF HEALTH ADDRESSED TO IMPROVE THE WELL-BEING OF THE COMMUNITY, ESPECIALLY THE MARGINALIZED, POOR AND UNDERSERVED POPULATIONS

4.1 Marginalized, poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs

Key observations on performance

- During the quarter the Project linked PTCs to key partners for various support and services e.g. food security. In Mandera County, the Project liaised with partners and managed to support PTCs with food in form of rice, beans and cooking oil on monthly basis. PLHIV OVC were also linked to MoH SFP and receive nutritional support.
- During the quarter the Project facilitated linkage of PTC groups for PwP funding; In Mandera East and Wajir, PTCs received TOWA PwP funds to enable them to undertake IGAs.
- Modogashe PTC linked to food security committee and 24 members benefit from relief food on monthly basis.
- The Project linked PLHIV advocates to organizations for attachments to carry out advocacy work on good governance (Habiba International in Mandera).
- CHWs in Garissa CHBC continued to be linked by the Project to K-Rep for micro-credit support and IGA activities.
- OPAHA Garissa members linked to G-Youth Project for TA on entrepreneurship and formation of self-help groups.
- APHIAplus NAL continued to link PLHIV to PGH CCC for basic care package; 173 clients benefited from BCP kits during the quarter.
- Mwangaza CHBC magnet theatre continued with community mobilization and dissemination of health messages. They were linked to other key departments for hire and from this activity they procured megaphones and speakers.

Challenges

- Persistent drought.
- Displacement of pastoralist populations and settling in the outskirts of urban centers.
- High food prices.

Planned activities for the next quarter (April – June 2011)

- Identify key partners for linkages in NEP and Tana River.
- Follow-up with PASCO for supplies of BCP kits from NASCOP to Mandera and Ijara districts.
- Continue to link marginalized and vulnerable groups to potential partners to support different services.

4.2 Improved food security and nutrition for marginalized, poor and underserved populations

4.2.1 Improved food security and nutrition for OVC

The Project is working with NHP on the food by prescription (FBP) Program to improve food security and nutrition for OVC in five support groups in Garissa municipality.

Key observations on performance

- Sensitization of support group management structures on FBP. Together with counterparts from Ministries of Health, the Project successfully sensitized three (3) members in each of the support groups.
- The Project continues orientation for the network of CHWs working with the support group during the routine monthly meetings.
- Field-based MUAC screening has been initiated and is ongoing for OVC and PLHIV in Garissa municipality.
- CHWs conduct nutritional assessments at the community-level and refer cases to PGH Garissa, Iftin SDH and SIMAHO dispensary.
- In collaboration with District Nutritionist, Ministry of Public Health and Sanitation, the Project managed to decentralized FBP sites to Iftin DH and SIMAHO dispensary.

Table 12: Summary of FBP distribution within facilities in Garissa District

Facility	No. referred	No. of eligible adults	No. of eligible children
Garissa PGH	30	6	0
SIMAHO	22	10	2
Iftin	13	6	1

Challenges

- Most of the OVC and PLHIV families have little or no source of income – managing expectations is a big challenge for the CHWs carrying out assessments in the field since not all referral clients qualify.
- Low education level of most CHWs makes orientation to assessment tools and equipment challenging.
- Prolonged drought is increasing malnutrition and disease burdens in the sub-region.
- Mobilization of OVC to access FBP creates high expectations.

Planned activities for the next quarter (April – June 2011)

- Continuation of orientation of CHWs in conducting assessments; strengthening the referral system.
- Mobilize OVC caregivers and create an understanding on FBP amongst the target population.
- Provide logistic support for FBP supplies from PGH to the decentralized sites (Iftin and SIMAHO).

4.2.2 Improved food security and nutrition for PLHIV

Key observations on performance

- The Project successfully lobbied for food for 54 PHLIV families in Mandera County.

Table 13: Summary of food assistance in Mandera County

District	Name of support group	No. families benefited	Source of food
Mandera East	OPAHA Ushirika Support Group	15 families	GOK
Mandera East	OPAHA Maberu Support Group	10 families	GOK
Mandera East	OPAHA Opendo Support Group	15 Families	GOK
Mandera West	Takaba Support Group	7 Families	GOK
Mandera North	Rhamu Support Group	7 Families	GOK

Challenges

- Inadequate food supplies
- Bureaucracy in food distribution

Planned activities for the next quarter (April – June 2011)

- Facilitate access by PLHIV and their families to facility-based nutrition support. .
- Ensure PLHIV groups are included as a priority target group for general food distribution by provincial administration.
- Strengthen ties between PLHIV support groups and food distribution networks in NEP and Tana River County. Link PTC groups to key partners for food and nutrition support.

4.3 Marginalized, poor and underserved groups have increased access to education, life skills, and literacy initiatives through coordination and integration with education programs

Key observations on performance

- During the quarter, the Project supported capacity-building for 30 PLHIV to promote the quality of their lives through treatment literacy training. PLHIV were trained. The training was for one week and conducted by trained TOT advocates from Wajir.
- Through support to WASDA, the Project supported a one-week PLHIV caregivers training in Wajir. The trainers are MoH TOTs and PLHIV advocate TOTs. The aim of the training is to reduce stigma and discrimination among PLHIV caregivers and provide them with knowledge on how to care for PLHIV. The care givers were drawn from Wajir town. The curriculum used for the training was Home-Based Caregivers for PLHIV, Curriculum for Training CHWs, NASCOP 2nd Edition, August 2006.
- HCM and APHIAplus NAL trained CBO members on Education Through Listening (ETL) as a facilitation skill. The training targeted concurrent sexual partners (CSP) in Garissa.



Training members of youth groups in Education Through Listening in Garissa

Challenges

- Most of the CHWs trained from outside Garissa are illiterate and therefore are unable to complete the data tools.
- Stigma felt by the newly-registered PLHIV hinders linkages for support.
- Geographical vastness and nomadic lifestyles made follow-up and linkage to services for new clients from rural towns very difficult.

Planned activities for the next quarter (April – June 2011)

- Roll out treatment literacy training for Mandera and Ijara district clients.
- Liaise with HCM to carry out sensitization and training of CHWs in Mandera and Ijara.

4.4 Increased access to safe water, sanitation and improved hygiene

Key observations on performance

- Supported community action days in Medina community units where the community members supported the cleaning of the streets in Medina location, Garissa district.
- Through linkage with HCM program, the Project sensitized CHWs on safe water systems and offered IEC materials (e.g. brochures, fliers) for POU water treatment products (PUR, WaterGuard).
- The Project supported the establishment of a water storage facility in Shimbirey Dispensary.

Challenges

- Inadequate hand-washing programs in schools.

Planned activities for the next quarter (April – June 2011)

- Support hand washing programs in schools implementing *Chill* program.

4.5 Strengthened systems, structures and services for protection of marginalized, poor and underserved populations

4.5.1 Orphans and vulnerable children

Key observation on performance

During the quarter, the Project developed a Fixed Obligation Grant with the Diocese of Garissa to continue support to OVC in Tana River County. The FOG will provide support to 2,749 (1409 male and 1340 female) OVC in Tana River County.



Catholic Diocese of Garissa and APHIAplus team meeting at the Chief's office during OVC/HBC assessment in Hola

Alfarooq Integrated OVC Service Project:

During the quarter, the institution recruited 150 additional OVC to the 630 OVC supported previously. The additional OVC were issued with mattress, bed sheets and mosquito nets.



Support for community-based OVC at Al Farooq, Ijara

The Project supported OVC with uniforms and desks in Wajir and Mandera counties. The educational services will enhance and strengthen attendance and retention of OVC in schools.

Table 14: Wajir County School Uniforms Distribution

INSTITUTION	MALE	FEMALE	TOTAL
Abubakar Sadik	75	25	100
Islamic Call Foundation	80	20	100
Wajir Catholic Mission	0	79	79
Wajir Islamic Center	48	0	48
Wajir School for the Deaf	50	32	82
Al-Riaya Children Home	35	0	51
Wajir Girls Integrated School	0	200	200
Catholic Primary School	70	32	102
Sub-Totals	358	388	762

Table 15: Mandera County School Uniforms Distribution

INSTITUTION	MALE	FEMALE	TOTAL
Abu Huraria Children's Home	100	50	150
Al Hidaya Children's Home	106	44	150
Al Sunnah Orphanage	90	30	120
Aluteibi Children's Home	79	61	140
Al Weis Children Home	55	61	116
Al Fouazan Organization	101	49	150
Takaba Primary School	80	60	140
Daua Integrated School	50	30	80
Sub-Totals	661	385	1046

The Project supported the procurement of 65 school desks for Abu-Bakr Sadiq children home and 10 school desks for Wajir School for the Deaf. The desks support 225 OVC.

Support to Area Advisory Council

The Project supported and participated in AAC quarterly meetings in Garissa, Wajir South, Ijara, Wajir North, Mandera East and Tana Delta districts. These meetings provide a forum to articulate all issues affecting children. This is a good platform and entry point to children's issues in any district. The roles of AACs are basically partnering, resources mobilization and taking the lead in child care and protection. Issues discussed include issuance of birth certificates.

OVC Quality Improvement

APHIAplus NAL conducted QI learning sessions for the QI pilot sites in Garissa with the aim of sharing experiences and challenges encountered during the piloting of OVC QI standards. The Project also supported secondary data collection using CSI in the QI piloting site through checking the progress and status of OVC. Project staff participated in the National QI Stakeholders' Workshop for work planning development.

Challenges

- Drought situation in NEP has made home visits to OVC very difficult due to migration of the households in search of water and pasture.
- Geographical vastness and nomadic lifestyles makes documentation of OVC work challenging.
- Insecurity in Mandera and Tana River Counties affected the ability of the Project to visit these areas.

Planned activities for the next quarter (April – June 2011)

- Train 60 OVC caregivers in NEP
- Conduct OVC Needs Assessment in NEP
- Procure and distribute OVC supplies.
- Support AAC quarterly meetings.
- Support commemoration of the Day of African Child

- Identification of OVC for vocational training.
- Carry out assessment and initiate establishment of child-friendly schools
- Conduct training for 100 ECD teachers on child friendly initiative using MoE and UNICEF curriculum.

4.6 Expanded Social Mobilization for Health

Key observations on performance

- APHIAplus NAL sponsored a women's forum in Dadaab and Saretho locations. The aim was to mobilize women and community opinion leaders to increase MNCH uptake. The Project addressed issues on women empowerment in health decision making. The initiative reached 41 members of the community.
- Through workplace peer educators, the Project mobilized most-at-risk populations for counseling and testing across the region.
- APHIAplus NAL supported social mobilization on hygiene, water and sanitation through the Project-trained CHWs in Medina Community Unit.
- CHWs in Garissa and Wajir CHBC program continued to register new clients into CHBC program through mobilization.
- Mwangaza CHBC through magnet theatre group composed of CHWs continued with community mobilization and dissemination of health messages. They were linked to other key partners who pay the group for performances during occasions. The funds generated by the magnet theatre benefited the group to the extent that they were able to procure megaphones and speakers.
- The trained RLs have proved to be of help in mobilization and scale-up of services in the health facilities through SDM roll-out and linkages with PLHIV during integrated outreach activities.

Challenges

- Pastoral lifestyle hinders client follow-up and consistency in service delivery.
- Limited availability of communications media to reach more people.
- Socio-cultural norms that negatively impact on health seeking behavior, e.g. male dominance.
- Demand for incentives from community groups involved in mobilization.

Planned activities for the next quarter (April – June 2011)

- Support social mobilization to improve health service uptake through enhanced outreaches and linkages.
- Strengthen and improve performance of CHWs, peer educators through OJTs.
- Conduct women's health forum to sensitize them on MNCH, FP and HIV/AIDS.

4.7 Performance Improvement Management

Key observation on performance

1. Strengthening Support supervision

- The Project supported strengthened support supervision through capacity building, provision of technical assistance on best practices and development of supervision tools for the health managers.

2. Quality Assurance management

- The Project participated in the dissemination of the national quality management guidance framework (NQMGM) in HTC for NEP program managers sponsored by NASCOP in collaboration with SPEAK 2 (JICA). The Project intends to rollout the NQMGM to the facility level.

Challenges

- There are identified training needs in NEP and Tana River County which are now beyond the mandate of the Project to address.

Planned activities for the next Quarter (April – June 2011).

- Orientation of the Project staff, PHMT, DHMT and facility in-charges on quality and performance improvement approaches (QI/PI models and application)..
- Following-up of facility staff on implementation of intervention action plans on QI/PI (monitoring and evaluation of QI process application).
- Support quality improvement community involvement meetings with an expectation of improved community partnership for improved health outcome and increased demand for health services
- Formation of QI teams at all district hospitals

4.8 Strategic Information

Key observation on performance

a) Trainings and workshop participation

APHIA*plus* NAL participated in trainings on new versions of KePMS and HIV/AIDS data management tools to strengthen reporting demands and skills. During the quarter, the Project participated in the following workshops to improve its monitoring of various activities:

- HIV/AIDS Pillars meeting convened by NACC regional for NEP.
- Partners meeting on health/nutrition supported by UNICEF through Ministry of Health, Division of Nutrition.
- APHIA*plus* Kenya Quality Improvement workshop for OVC programming.

b) Data for decision making

- The Project supported data feedback sessions in five districts for DHMT and facility in-charges. The sessions focused on facility performance and addressed all the indicators as captured by HMIS reporting. This also enables the Project to analyze, review and report on KePMS in a timely manner and to update Project staff on quarterly performance.

c) District-level facility and community support

- The Project supported Garissa and Tana Delta districts on the data quality improvement process, focusing on ART, PMTCT, HTC, MNCH and RH/FP in order to improve reporting quality and provide OJT to health care workers on understanding of the data collection tools and reporting indicators.
- The Project redesigned the community reporting tools to reflect the NGI reporting requirements and related changes in community programming approaches.
- APHIA*plus* NAL provided technical assistance during Coast province, District TOT training on HIV/AIDS data management tools and also supported GPS coordinates collection for facilities in Tana River County during the facility and community assessments.

Challenges

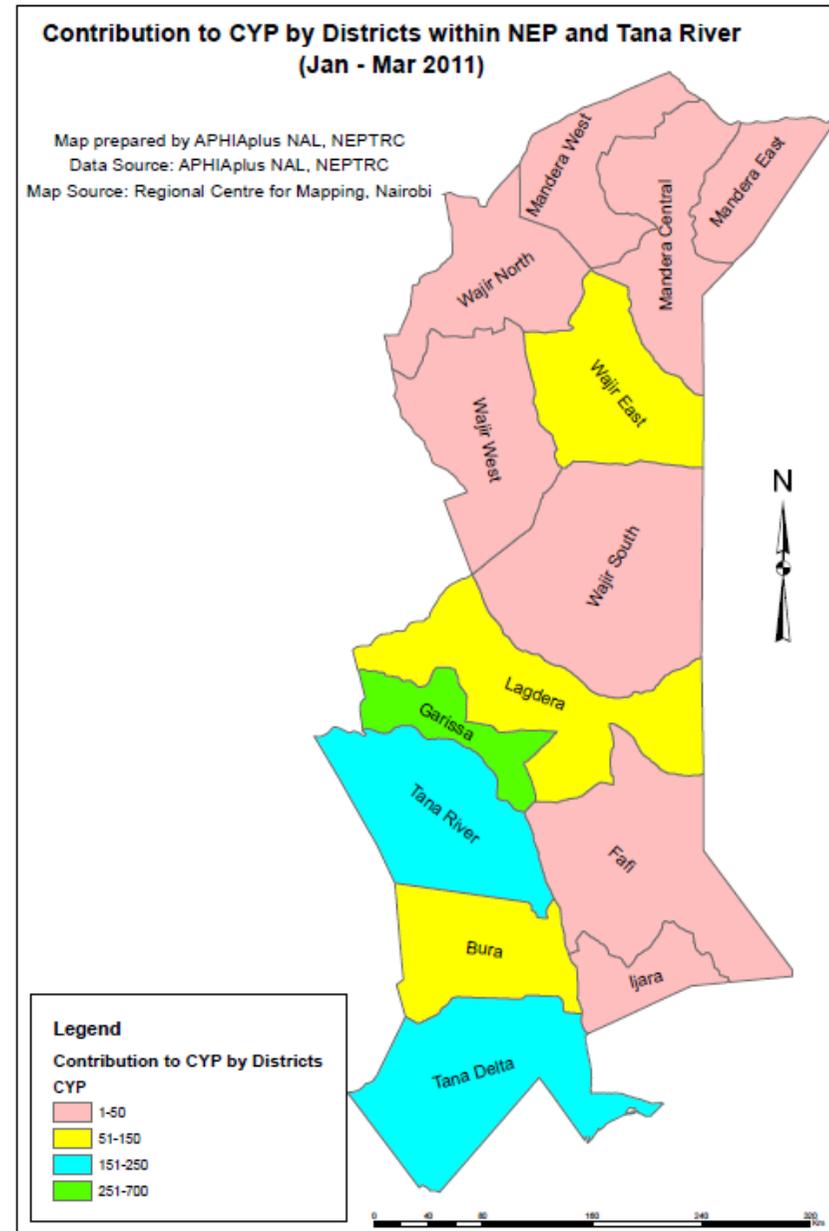
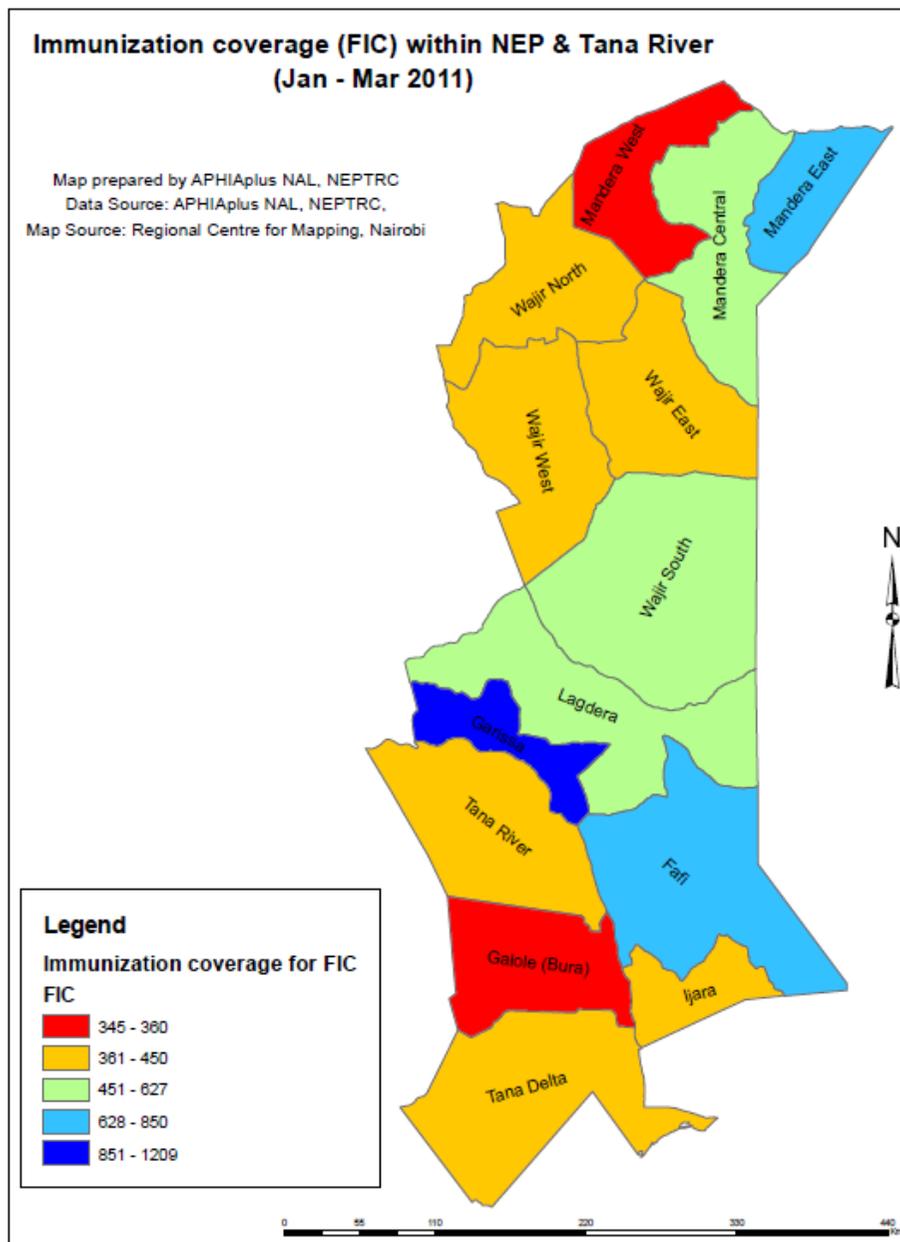
- Skirmishes in Mandera due to cross-border clashes delayed timely reporting and submission of data.
- Changes in community activities programming and new reporting requirements.
- Changes on revised HIV/AIDS data management tools had to be aligned with the NGI facility reporting data elements.

Planned activities in the next quarter (April – June 2011)

- Provide technical assistance during NEP District TOT trainings on HIV/AIDS data management tools.
- Carry out data dissemination feedback meetings in NEP and Tana River districts for facilities, LIPs and community units.
- Support Health Worker follow-up (post -training) on revised HIV/AIDS data management tools for TRC

- Distribution of newly revised HIV/AIDS data management tools and withdrawal of existing tools.
- Data quality improvement and supportive supervision in Tana River, Wajir East/West, Lagdera and Mandera Central Districts for both facility and community-levels.
- Orientation of CHWs on reporting tools for community prevention/OVC/HCBC in Tana Delta district.
- Quarterly meeting with FOGees/LIPs on M&E and data management.
- Supporting the DHRIO's offices with filing materials for data management.

Figure 10: Spatial analysis of immunization (FIC) coverage and CYP contribution by districts



UPPER EASTERN/SAMBURU SUB-REGION



Table 16: Achievements against targets

Performance Indicator	Jan-Mar 2011	UES Target	% Year 1 Target Achieved
GENDER			
# of people reached by an individual, small group or community level intervention that explicitly address norms about masculinity	0		TBD
Number of people reached by an individual ,small group, or community-level intervention or service that explicitly address Gender-based violence and coercion related to HIV/AIDS	0		TBD
# of people reached by an individual, small group or community level intervention or service that that explicitly address the legal rights and protection of women and girls impacted by HIV/AIDS	0		TBD
# of people reached by an individual, small group or community level intervention or service that that explicitly address aim to increase access to income and productive resources of women and girls impacted by HIV/AIDS	326		TBD
MARP			
# of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	0		TBD
PREVENTION WITH POSITIVE			
# of (PLHIV) reached with a minimum package of prevention with PLHIV (Pw) intervention	478		TBD
SEXUAL AND OTHER BEHAVIORAL RISK PREVENTION			
# of targeted population reached with individual and/or small group level prevention interventions that are based on evidence and/or meet the minimum standards required	326		TBD
# of targeted population reached with individual and/or small group level prevention interventions that are primarily focused on abstinence and/or being faithful and are based on based on evidence and/or meet the minimum standards required	326		TBD
IR3: Increased use of quality health service, products and information			
COUNSELING AND TESTING			
# of service outlet providing counseling and testing according to national or international standards	35	50	70
# of individuals who received testing and counseling services for HIV and received their test results	13,071	60,000	22
HIV/AIDS TREATMENT/ARV SERVICES			
# of children with advanced HIV infection newly enrolled on ART	14	80	18
# of adults with advanced HIV infection newly enrolled on ART	121	620	20
# of children with advanced HIV infection receiving ART (currently)	241	270	89
# of adults with advanced HIV infection receiving ART (currently)	1,789	1,350	133
# of children with advanced HIV infection who ever started on ART	312	300	104

Performance Indicator	Jan-Mar 2011	UES Target	% Year 1 Target Achieved
# of adults with advanced HIV infection who ever started on ART	2,494	1,500	166
% of adults and children known to be alive and on treatment 12 months after initiation of ART	Not reported	80	0
% of HIV positive persons receiving CD4 screening at least once during the reporting period	Not reported	1,200	0
# of HIV positive persons receiving CD4 screening CTX prophylaxis	Not reported	2,500	0
# of HIV clinically malnourished clients who received therapeutic or supplementary food	Not reported		TBD
PREVENTION OF MOTHER TO CHILD TRANSMISSION			
# of services outlets providing the minimum package of PMTCT services according to national or international standards	134	120	112
# of pregnant women who received HIV counseling and testing for PMTCT and received their test results	5,169	30,000	17
% of HIV positive pregnant women who received ART to reduce the risk of MTCT	12	80	15
# of HIV positive pregnant women newly enrolled into HIV care and support services	84	350	24
# of infants tested for HIV at 6 weeks	32	280	11
% of infants born to HIV+ women who received and an HIV test within 18 months of birth	Not reported	50	0
# of HIV exposed infants provided with ARVs prophylaxis	36	350	10
PALLIATIVE CARE (EXCLUDING TB/HIV)			
# of individuals provided with HIV related palliative care (excluding TB/HIV)	342	700	49
# of individuals provided with HIV related palliative care (including TB/HIV)	25	50	50
% of HIV positive patients who were screened for TB in HIV care or treatment settings	39	80	49
# of HIV positive patients in HIV care or treatment (pre-art or ART) who started TB treatment	67	280	24
# of TB patients who received HIV counseling, testing and their test results at USG supported TB outlets	228	1,200	19
VMMC			
# of VMMC clients	N/A		N/A
MNCH/RH/FP/SI			
# of deliveries performed in a USG supported health facility	1,517	3,500	43
# of ANC visits with skilled providers in USG supported health facilities	10,849	25,000	43
# of children less than 12 months of age who received DPT3 from USG supported programs	Not reported	17,500	0
# of children <5 years of age who received vitamin A from USG supported	14319	35,000	41
# of new FP acceptors as a result of USG assistance by FP method	9,300	8,000	116
Pills	923		
Injections	4,028		

Performance Indicator	Jan-Mar 2011	UES Target	% Year 1 Target Achieved
I.U.C.D.	77		
Implants	230		
Male Sterilization	0		
Female Sterilization	2		
Condoms	3,793		
Other	247		
3.1 Increased availability of an integrated package of quality high impact intervention at community and facility levels			
# of services availability of an integrated package vitamin A from us supported program	16	13	123
# of service outlets providing HIV related palliative care (excluding TB/HIV)	25	60	42
# of service outlets providing hive related palliative care (including TB/HIV)	27	40	68
# of service outlets providing PEP	25	18	139
% of pregnant women receiving 2 doses of IPT	15	60	25
# of service outlets providing clinical prophylaxis and/or treatment for TB to HIV related individual (diagnosed or presumed according to national or international standards)	27	65	42
# of USG assisted service delivery points providing FP counseling or services	134	120	112
CYP provided through USG supported programs	2,446	1,800	136
# of targeted condoms service outlets	10	40	25
# of condom distributed (GOK health seek indicator and standard OP)	63,571	9,000	706
% of district with community IMCI intervention	0	80	0
# SP participating in CME or CE	0	100	0
# of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MNCH services by facility type	16	65	25
% of facilities with stock outs of methods	0	20	0
# of service outlets with full contraceptive method mix	16	30	53
# of mobile units with providing testing	0	8	0
# of service outlet with youth friendly services	16	8	200
3.2 Increased demand for a integrated package of quality high impact intervention at community and facility			
# of facilities with private counseling areas	16	20	80
# of facilities with functioning facility management committee	9	25	36
3.3. Increased adoption of healthy behavior			
# of BCC products distributed by type	0	5	0
3.4 Increased program effectiveness through innovative approaches			
% of facilities use data for performance monitoring	0	80	0
# of CU using data for DM	0	9	0

Performance Indicator	Jan-Mar 2011	UES Target	% Year 1 Target Achieved
# of eligible adults and children provided with a minimum of one care service	13,291	12,000	111
# of local organization and service points provided with technical assistance for strategic information	4	50	8
IR4: Social determinant of health addressed to improve the wellbeing of the community, especially marginalized poor and underserved population			
4.1. Marginalized poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs			
# of people actively involved in economic security initiatives through project linkages	0	350	0
# of PLHIV support groups formed and/or linked to other service as appropriate	8	5	160
4.2: Improved food security and nutrition for marginalized poor and underserved population			
# of eligible clients who received food and/or other nutrition services	2,192	2,500	88
4.3: Marginalized poor and underserved groups have increased access to education, life skills and literacy initiatives through coordination and integration with education program			
# of schools supported by child friendly program	0	80	0
# of youth trained in life skills	0	6,000	0
# of OVC enrolled in ECD program through APHIAplus referrals	0	1,200	0
4.4: Increased access to safe water, sanitation and improved hygiene			
# of water and/or sanitation projects established in project supported facilities through linkages with usg funded WSS project	0	30	0
# of organization and outlets selling POU and SW project through linkages with HCM project	0	30	0
# of hygiene sessions held at schools	0	150	0
4.5 Strengthening systems, structures and services for protection of marginalized poor and underserved population			
# of OVC assisted by the project to obtain legal birth certificate	0	3,500	0
# of VHH identified and referred to services	0	500	0
4.6 Expanded social mobilization for health			
# of RL who are advocating for reduced stigma and improved MNCH	0	4	0

RESULT 3: INCREASED USE OF QUALITY HEALTH SERVICES, PRODUCTS AND INFORMATION

3.1 Increased availability of an integrated package of quality high impact interventions at community and facility levels

- Upper Eastern and Samburu sub-region (UES) is made of 3 Counties that consist of 12 districts. Out of the 12, 9 are older districts that have functional and fully-formed DHMTs while 3 are newly formed and have skeletal or incomplete DHMTs. The fully functional districts are recognized by the Project for purposes of resource envelope allocation; the three newer districts are covered under their “mother” districts.
- The sub-region has 155 facilities that serve a population of about 570,000 people. Faith-based organizations provide a significant proportion of the services and are evenly situated throughout the sub-region (see Appendix X). The HIV prevalence rate in this sub-region is about 4%. During the reporting quarter, the Project undertook preliminary facility assessment of 40 high-volume facilities to form a baseline for activities implementation.

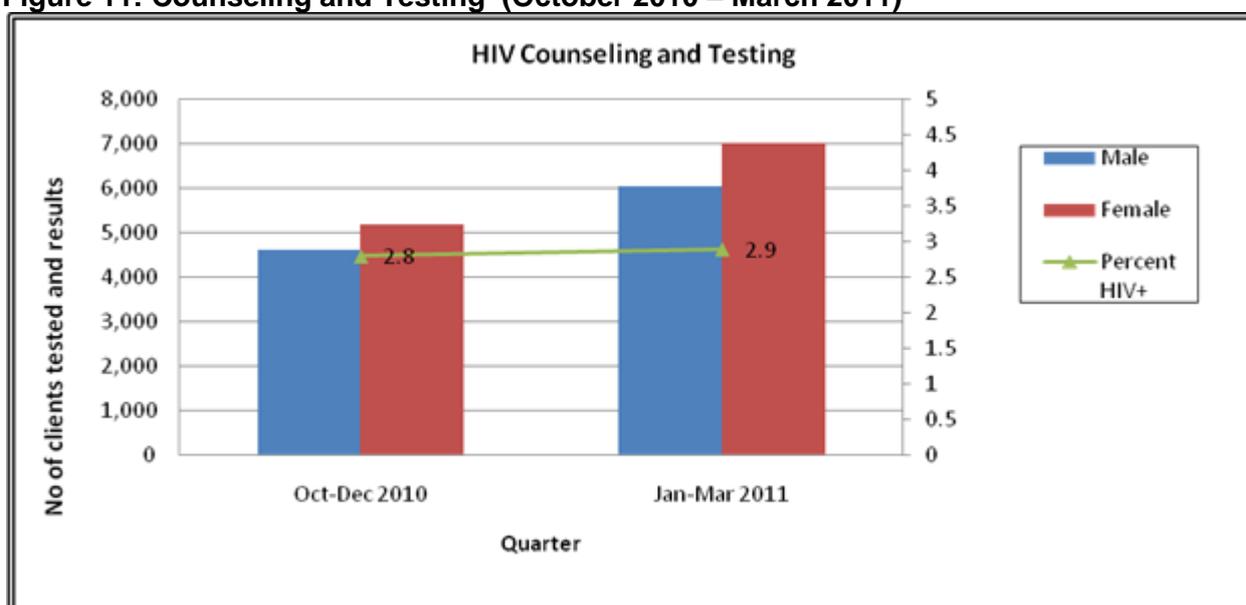
3.1.1 Counseling and Testing

Table 17: Counseling and Testing Performance

Reporting period	Male	Female	HIV+	Totals
Oct-Dec 2010*	4,617	5,187	2.8%	9,804
Jan-Mar 2011	6,057	7,014	2.9%	13,071
Year 1 Target (APHIAplus)				60,000
Total as percent of Year 1 Target (UES)				22%

*does not include Samburu County

Figure 11: Counseling and Testing (October 2010 – March 2011)*



*Oct-Dec data does not include Samburu

Key Observations on Performance

- Out of those facilities assessed, 21 facilities have accredited VCT centers in the sub-region and were doing counseling and testing.

- Each of the 40 high-volume facilities assessed offer HIV counseling and testing services, although there is variance in the use of counseling and testing protocols used in about 25% of the assessed facilities due to inadequate supply of test kits, particularly Unigold, in these dispensaries. The GOK policy is that all the CT facilities should have all the three test kits at any one given time.
- Integrated outreaches offering CT services are being offered in each district.
- Relatively fewer men than women are going for CT in the sub-region. This is due to both higher mobility of men (searching for pasture and water) and high levels of stigma.

Challenges

- Most dispensaries in hard to reach areas within UES are manned by only one provider. The government efforts to employ nurses through the economic stimulus package did not work well in these districts as the teams there could not get the required numbers. The few nurses who were employed by the ESP could not fill the gap of the health workers required.
- The assessment team noted that there are very few trained counselors. Most facilities, even district hospitals, only have one trained counselor.
- Due to high workload at the facilities and shortage of staff, the staff and counselors are at risk of suffering burnout and stress, with a resulting compromise in the quality of service delivery to clients.
- There is inadequate supply of test kits, particularly Unigold, in the dispensaries due to irregular supply of kits to all facilities by SCMS. The GOK policy is that all CT facilities should have all the three test kits at any one given time.

Planned Activities for the Next Quarter (April - June 2011)

- Identify facilities with critical CT HRH needs in liaison with the Ministry of Health, generate a list of VCT counselor gaps and discuss it with the Capacity Project.
- Dissemination of national CT guidelines in at least 40 CT sites during the quarter to ensure national protocols are being adhered to.
- Provision of logistical support and technical assistance for establishing and integrating HCT services where they don't exist but are needed.
- Integrate counseling and testing services in all facility and mobile outreaches to enhance CT uptake.
- Strengthen and increase frequency of support supervision in all HCT service outlets within the high-volume facilities through interdepartmental monthly meetings, OJT and during CMEs.
- Liaise with relevant DHMTs so that all Integrated mobile outreaches target men at livestock watering points, night dances of Morans, weddings and other social gatherings.
- Provide OJT and CME to DHMTs and service providers on the CT protocols and facility rollout of required CT standards to all facilities providing the services.
- Liaise with SCMS to address the irregularity of the test kits supplies in UES.

3.1.2 Palliative Care TB/HIV

Indicator	Jan-March 011	2011 Target	Performance
# of individuals provided with HIV related palliative care (including TB/HIV)	25	50	50 %
% of HIV positive patients who were screened for TB in HIV care or treatment settings	39	80	49%
# of HIV positive patients in HIV care or treatment (pre-art or ART) who started TB treatment	67	280	24 %
# of TB patients who received HIV counseling, testing and their test results at USG supported TB outlets	228	1,200	19 %

Table 18: TB indicators (January – March 2011)

Jan - March 2011							
Indicators	Children 0-14 yrs		Adults >14yrs		Totals by Gender		Totals
	F	M	F	M	F	M	
TB cases detected	15	10	116	113	131	123	254
Smear positive	2	0	42	35	44	35	79
Smear negatives	8	3	63	73	71	76	147
Extrapulmonary TB patients on treatment	5	4	14	13	19	17	36
TB patients on re-treatment	0	3	7	9	7	12	19
TB Patients tested for HIV	15	7	101	105	116	112	228
TB Patients HIV +ve	3	2	32	30	35	32	67
TB HIV patients on CPT	5	2	36	31	41	33	74
Defaulters	0	0	6	0	6	0	6
TB patients completed treatment	5	6	16	16	21	22	43
TB deaths	0	0	1	4	1	4	5

Key Observations on Performance

- Out of the 228 TB patients tested for HIV, 67 were HIV positive and 25 of them were put on palliative care. This indicates weak referral systems between the high-volume facilities or departments (TB Manyatta and the CCC) and clients, making it difficult for follow-ups and defaulter tracing. Nomadic lifestyle and poor health-seeking behavior due to high levels of stigma worsens the situation.
- Record keeping on TB drug management is good, although some gaps were observed in treatment regimens and staff confirmed low adherence to TB drug treatment due to ignorance and pastoral lifestyles.
- Most district hospitals provide food by prescription to the clients with low body mass index (<16). This has helped in reduction of defaulters and survival of the targeted clients.
- There were no scheduled TB/HIV collaborative meetings in any of the supported districts, contributing to weak HIV/TB integration.

Challenges

- Delayed TB/HIV reporting and late data submission due to quarterly rather than monthly reporting and little or no participation by the DTLCs in the monthly facility data dissemination meetings.
- Inadequate information in some communities on TB/HIV due to IEC in English/Kiswahili that most community members cannot understand.
- Weak referral systems between the high-volume facility departments (TB Manyatta and the CCC).
- Weak integration of TB/HIV services attributed to lack of logistical support in 2010 and good will across the responsible departments.

Planned activities for the next quarter (April - June 2011)

- Facilitate and support TB/HIV quarterly collaborative meetings with the DTLCs, DASCOS, DMOHs and DPHNs to strengthen appropriate reporting, linkages, referrals and follow-up of TB and co-infected clients. This will help increase the number of HIV/TB clients put on palliative care.
- Provide OJT/CMEs on data reporting to DTLCs and facility in-charges to address TB/HIV integration gaps and improve the quality of reporting.
- Organize and hold strategic partnership and programmatic discussions with HCM program and the national TB program with a view to explore appropriate mass media options and adoption and modification of IEC materials on TB/HIV into local languages.
- Establish two additional ART sites within the region every quarter through respective DHMTs in districts with trained personnel. These new sites should be TB treatment centers for purpose of integration.

3.1.3 Palliative Care (excluding TB/HIV care)

Palliative care given to PLHIV in UES is not well established but more advanced in clinical settings as compared to community and household settings. It includes: OI treatment at the facility level and psychosocial, social, nutritional, household economic strengthening support at the community and household level. With an HIV prevalence of 4% in UES, about 25%, or 5,700, of all PLHIV are estimated to be eligible for HBC services. 2,569 are currently being supported through integrated OVC/HBC programs supported by APHIAplus NAL.

Key Observations on Performance

- Current initiatives supported by APHIAplus NAL through FOGees and other partners are reaching about 39.5% of the estimated eligible population of individuals needing CHBC so there exists a gap of about 60%, or 3,900, clients that need to be identified through CT and provided with quality CHBC support.
- Clinical support: OI treatment at the facility level has not been decentralized for the most part to facilities other than the high-volume facilities, including district hospitals and health centers. Referral for management of OIs is to the nearest GOK and mission health facilities. In Marsabit there was a significant increase in effective referrals to Tumaini Clinic (Food for the Hungry), which is well equipped.
- The Project is in the process of establishing the state of the psychosocial support received by PLHIV.
- Nutritional support: through community gardens in Isiolo County, 5185 OVC got food rations throughout the quarter with support from APHIAplus NAL. OVC caregivers continued to provide labor for the community gardens as their contribution. Their participation has been a learning experience for caregivers who are currently replicating the same in their own gardens.
- 6025 OVC were linked to FH, WFP, and GOK relief efforts for direct food support in areas hard hit by drought (Marsabit and Isiolo Counties). Rations included maize, beans and cooking oil.

- Social support: The Project has not yet embarked on mapping of existing PLHIV support groups and post-test clubs but plans to do so in the next quarter.

Challenges

- Some referral points have high charges for medication, which is often unaffordable for many PLHIV.
- Clinical support through OI treatment at the facility level has not been decentralized for the most part to facilities other than the high-volume facilities, including district hospitals and health centers.
- Psychosocial support: Stigma levels are still high in the sub-region due to cultural beliefs, myths, low literacy levels, and life skills¹ among PLHIV, services providers and general community.
- Nutritional support: other than linkages to GoK relief food, there are very few HBC clients who are supported through nutritional supplements from the partners.
- Social support: The structures of support groups in UES are weak and unable to counter the high levels of stigma or to increase access to support services and household economic strengthening support.
- Household economic strengthening currently receives limited support from most of the development partners as a result of other competing priorities. However, some of the partners are supporting PSS and IGA activities.

Planned Activities for the Next Quarter (April - June 2011)

- Provide TA and disseminate guidelines to MoH and FBO service providers to ensure they are able to provide a minimum package of services for the PLHIV.
- Support and promote the establishment of HIV treatment committees at Level 4 and 5 facilities to address issues of treatment failure including waivers for PLHIV who cannot afford services.
- CHBC clients have been and will continue to be identified through the CCCs of the 40 high-volume facilities; the Project will support them with treatment literacy training that addresses stigma, encourages positive living and empowers the PLHIV to demand for their rights. This type of training has been proven to produce strong results in NEP and is expected to do the same in UES because of a good number of similarities in cultural and socio-economic factors.
- The trainees will be followed-up and encouraged to form post-test clubs so as to cement social support for the PLHIV as well as make monitoring of stigma reduction efforts easier. The trained PLHIV will be encouraged to form post-test clubs to make it easier for them to access benefits from a cross-section of development partners and GoK ministries and departments.
- Strengthen referrals for OI treatment by expanding the number of facilities offering support to PLHIV in rural locations.
- Identify potential partners in UES implementing livelihood and HES activities with a view to developing and implementing a referral/linkage mechanism for household economic strengthening for the Project's CHBC /OVC clients.

3.1.4 HIV/AIDS Treatment/ARV Services

- Out of an eligible population of 22,800 PLHIV, about 10%, or 2,280, are expected to be on HAART. About 30%, or 684 persons, of this target population is expected to be children aged 0 -14 years eligible for pediatric HAART. Thirty-one of the high-volume facilities are providing ART services. The Project plans to support the establishment of 10 ART sites by May 2012.

¹ Abilities for adaptive positive behavior that enables individuals to deal effectively with demands and challenges of everyday life - critical thinking, problem solving, self-awareness and interpersonal skills. (WHO definition)

Key Observations on Performance

- There are four CD4 machines donated by well-wishers and serviced by the MOH which are strategically placed to cover the three Counties in the sub-region. By strengthening the laboratory networks within the region more clients can be initiated into ART.
- Seventeen of the 31 ART sites have functional psychosocial support groups that meet routinely for experience sharing and technical support. These groups serve as avenues for stigma reduction, drug adherence, partner encouragement and defaulter tracing..
- Fourteen children were started on ART care and treatment in the sub-region while 121 adults or 17% were started on ART. There is a need to strengthen EID/CD4 logistics to ascertain the number of pediatrics and adults put on ART care.
- All the 31 ART sites have at least a CHW, who is the link between the community and the facility for client follow-up, passing of relevant health information, and giving basic home-based care. Some community elders in Moyale specifically are also using the CHWs to conduct evening classes in adult literacy.
- Erratic support to the laboratory systems by the government, stock-out of reagents for CD4 machines and poor lab networking has led to late initiation of clients on ARVs and also makes the monitoring of patients challenging.
- Only 17 sites offer PEP. This is due to health worker knowledge gaps . Stigma associated with rape in the communities and the cultural beliefs about it also hinders the use of PEP.

Challenges

- Weak CD4 lab networking in the sub-region due to poor referral systems coupled with the fact that CD4 lab networking is a relatively new concept.
- High social stigma and discrimination associated with HIV/AIDS in the communities within UES hinders ART uptake. There is general low awareness, especially among rural folks, and perceptions that HIV infection is associated with promiscuity and immorality.
- Defaulter tracing is a major challenge due to nomadic pastoral lifestyles. The community migration in search of water and pasture makes it difficult to follow-up clients.
- Frequent stock outs of OI drugs.
- There are only one or two CHWs attached to the ART treatment sites, with the exception of the 8 facilities that have active Community Units attached to them.

Planned Activities for the Next Quarter (April - June 2011)

- Strengthening of CD4/EID lab networking and other referral issues through technical and logistic support and initiation of interdepartmental meetings in the seven functional district hospitals. This will enhance early initiation of ARVs and proper monitoring of clients.
- Support initiation and implementation of PEP services in at least 10 ART/PMTCT sites through DHMTs/HMTs, by conducting OJT, CME and support supervision.
- Emphasize on the initiation/establishment of 2 more ART sites within the region through respective DHMTs, especially the DASCO and DTLC (where there are trained personnel on ground). These new sites should be already existing TB treatment centers for purposes of integration.
- Address high levels of stigma among HWs through OJT on PwP, empowerment of PLHIV through TL training and formation of PTCs, strategic BCC, IEC and PE messaging.

3.1.5 Condoms and Other Prevention Activities

- According to KAIS 2007 survey results, condom use at last sex was low in marital/cohabiting partnerships compared to non-marital/ non-cohabiting partnerships. HIV prevalence among uncircumcised men aged 15 to 64 years was three times greater than among circumcised men. Unfortunately, there is no disaggregated data for UES to compare with the KAIS national findings.

- The Project targets both the general population but also the key populations at risk. The key populations in UES include: commercial sex workers, military personnel, prisoners, truck drivers, youth out of school, Morans and their *sintanis* (girlfriends). The Project will support the establishment of a variety of condom outlets and sites including public facilities, mission facilities and places where MARPs are known to congregate.
- During the community assessments it was observed that the condom dispensers at strategic places like bars were empty. This was due to the lack of condoms in the country. In general, the DMOHs in the region have not put in place a mechanism that would ensure consistent refilling of the dispensers in the community.

Key Observations on Performance

- Strong religious beliefs (Catholic and Muslim) in the sub-region which prohibit condom use. However, Catholic mission facilities are now dispensing condoms for use by couples living with HIV after the Pope declared that this is acceptable.
- The utilization of condoms in major towns and surrounding areas has been enhanced by the presence of CBDs/CHWs and peer educators who distribute and sensitize their communities on condom use.
- Condoms are distributed by 134 out of the 155 public and Mission facilities in the sub-region for the purpose of prevention of HIV. Other than GoK and Mission facilities, there are 6 mobile clinics that operate from specific community sites and 4 sub-grantee sites offering integrated outreach services that include condoms and other prevention interventions.
- Other prevention activities planned for in UES include: PwP, VMMC, PE, BCC, and PE initiatives to be implemented through community outreach programs. At the facility level, the Project will make condoms accessible to discordant couples.

Challenges

- Strong religious beliefs which discourage condom use outside marriage, low awareness levels among rural community members and frequent stock outs have conspired to negatively affect level of condom use and HIV prevention efforts. Female condoms are not readily available and there has been low sensitization to the communities on its usage.
- Knowledge on the use of condoms is low particularly in the rural areas. This is mainly attributed to low awareness, religious teachings and low literacy level of the community.
- There are frequent shortages of condoms in the region as a result of delays in national procurement and distribution.
- Proper tools for reporting on condom use for prevention other than for FP and penile models for demonstration are not readily available in the facilities.
- The Project has planned to support distribution of condoms at places where MARPs congregate.
- At the 31 facilities providing ART, only about 5 staff are trained on prevention with positives.

Planned Activities for the Next Quarter (April - June 2011)

- Initiate discussions with key Christian and Muslim religious leaders in UES as a starting point for further engagement with them on HIV and health challenges in the region. The Project will use its experience working with religious leaders in NEP as a model and, where possible and appropriate, will make use of resource persons from amongst trained Islamic leaders in NEP.
- Support provision of community-level training and technical assistance on HCT for MARPs, PE, drama and mobile theatre to promote the use of condoms for prevention.
- Distribute prevention IEC materials through CHWs and community leaders so that they can be translated to enhance their effectiveness.
- Hold consultation with DHMTs and the Division of Reproductive Health to make available penile models and condoms.

- Support distribution of condom dispensers and frequent replenishment in strategic locations through the DPHOs, facility in-charges, CHEWS and CHWs.
- Identify 40 leaders of 2 Moran clusters and 40 leaders of 8 youth groups in Isiolo, Marsabit and Samburu counties for training on PE using the NASCOP guidelines with the aim of assisting the target groups to increase awareness on risky behavior and adopt positive behaviors.
- APHIAplus NAL is still establishing the number of condom dispensers in the community. However, the Project has planned in collaboration with DPHOs to support distribution of 20,000 condoms to the community outlets next quarter through the CHWs.
- The Project will implement treatment literacy for 50 PLHIV, 25 each in Marsabit and Isiolo and then expand the same activity to other districts in subsequent quarters as part of a PwP strategy.
- The Project shall prepare a clinical training needs assessment report covering all the 40 high-volume facilities in conjunction with the D/HMTs and share it with the Capacity project and with the national mechanism responsible for training so that plans to fast-track the performance and capacity building actions for service providers can be prioritized.

3.1.6 Prevention of Mother to Child Transmission

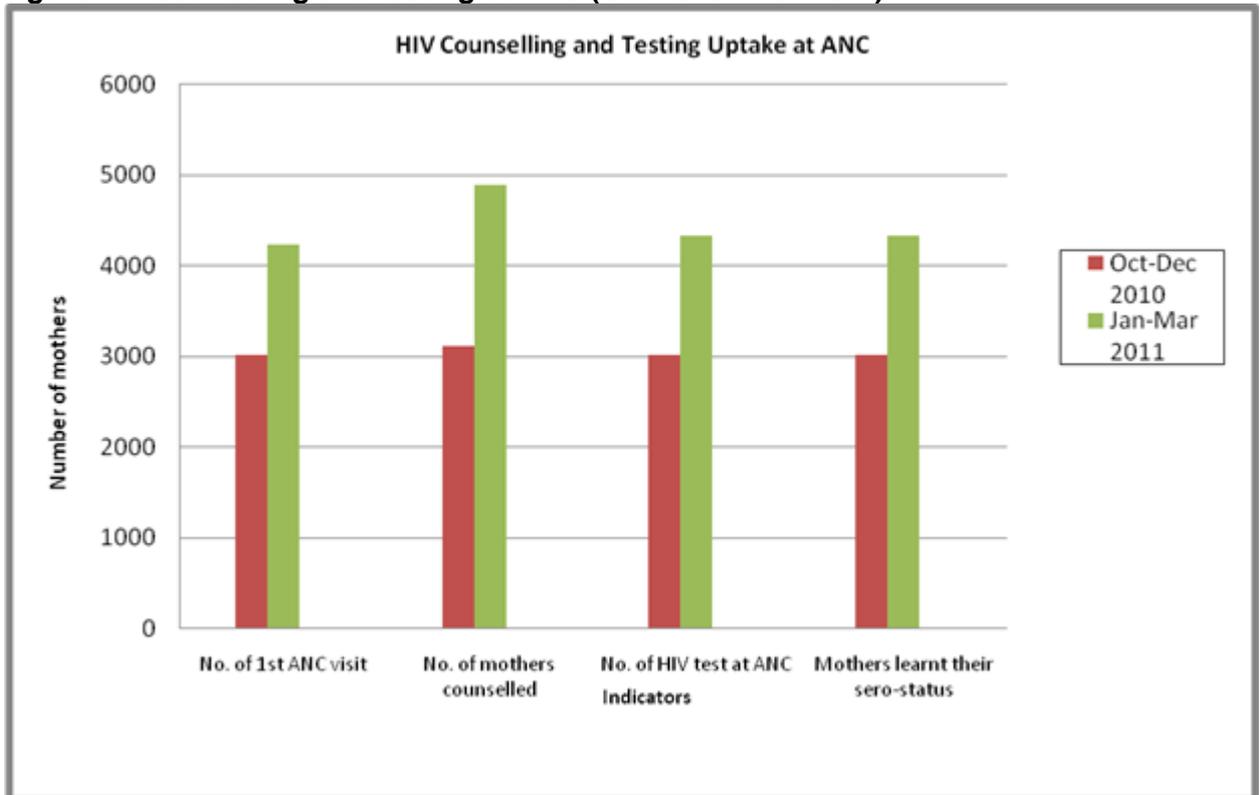
- MTCT of HIV without any intervention is nationally known to be at 40%. The PMTCT strategy has been initiated nationally to reduce the high percentage of MTCT to 10%.
- In UES, PMTCT services are available in 134 out of 155 facilities in the sub-region. Out of those offering services, 103 are currently offering only the minimum package (CT and single dose Nevirapine) of PMTCT, while 31 sites are offering the full (CT and AZT, 3TC and NVP) PMTCT package as they are either District hospitals or high-volume facilities. .
- In UES sub-region the Project plans to have all those facilities offering ANC to be providing PMTCT services by the end of 2012.

Table 19: PMTCT cascade (Oct 2010 - Mar 2011)

PMTCT Cascade	Oct-Dec 2010*	Jan-Mar 2011
Number of ANC 1st visits	3,020	4,230
No. of women attending ANC as revisits	4,778	6,619
No. of women counseled	3,112	4,893
No. of women who had HIV test at ANC	3,010	4,331
Number of mothers who learned their sero-status:	3,010	4,331
No. of women tested HIV +	45	82
Mothers given NVP at ANC	45	42
Percentage of women testing HIV+	1.50	1.89
No infants tested for HIV after at 6WKS	22	32
No infants tested for HIV after at 3 months	7	13
Infants issued with preventive ARVs	45	36
Mothers tested at maternity	121	838
Maternity HIV	4	14
Deliveries	971	1,517

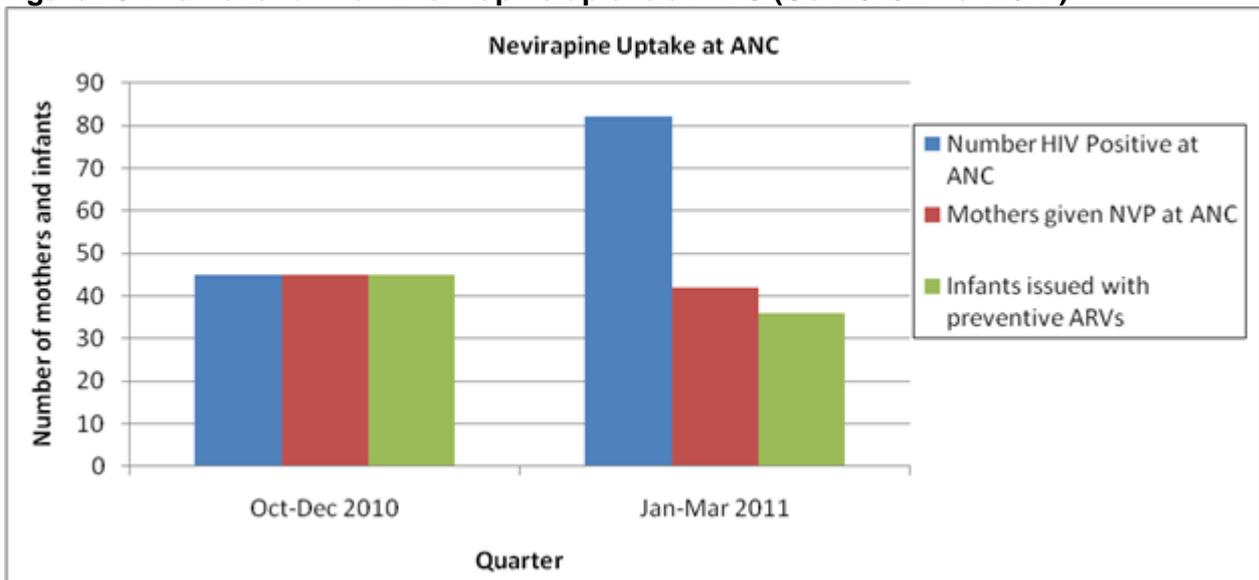
*does not include data for Samburu County

Figure 12: Counseling and testing at ANC (Oct 2010 - Mar 2011)



*data for Oct-Dec does not include Samburu County.

Figure 13: Mother and infant Nevirapine uptake at ANC (Oct 2010 - Mar 2011)



*data for Oct-Dec does not include Samburu County.

Table 20: Partner Counseling and Testing

Indicators	Jan - March 2011
Partners counseled for HIV	170
Partners tested	157
Number HIV +	9
Percent HIV+	5.73

Partner testing in PMTCT is a national issue but worse for the pastoralists where men go out with the animals in search of water and pasture, leaving the women at home. A total of 157 partners were tested during the quarter, of whom 9 tested positive, a rate of 5.7 % within this small group.

Key Observations on Performance

- There is some knowledge gap on provision of ARV prophylaxis amongst the service providers because the new PMTCT guidelines have not been disseminated to the majority of facilities in the sub-region.
- 14 facilities that are offering PMTCT services have a maternity for deliveries while all others keep an emergency delivery pack. This is a good practice that supports deliveries by skilled personnel.
- There is poor follow-up of HIV positive mothers and their exposed children after delivery due to pastoralists' lifestyles and weak linkage systems to CCC making it also challenging to test exposed infants at 18 months.
- EID is done in only 4.5% (6 facilities) of the total facilities offering PMTCT.

Challenges

- Smaller PMTCT facilities rarely stock prophylactic ART drugs or have expired ones because they rarely get HIV positive pregnant mothers as the prevalence rate is too low in rural areas. Knowledge gap on current PMTCT/EID guidelines also hinders quality PMTCT service provision.
- Home deliveries still persist in the region as a preference and this has hindered PMTCT, especially during delivery and post-partum periods. This is associated with a number of factors, key among them: traditional/cultural beliefs and practices on delivery and care for mothers who have just given birth; the nomadic lifestyles; and, the quality of maternity services provided in facilities.
- Delayed submission of monthly PMTCT reports by service providers hampers the provision of supplies and logistical support to the facilities, including the supply of test kits and IEC materials.
- Shortage of staffs is a cross-cutting issue in all HIV testing outlets.

Planned Activities for the Next Quarter (April – June 2011)

- Support initiation of comprehensive PMTCT sites in 10 facilities through the DHMTs/HMTs by providing TA and logistical support.
- Integrated supportive supervision by DHMTs to the service providers will be supported to ensure improved service provision and OJT on the need to keep at least 1dose of the prophylactic ARV drugs.
- To address negative impact of cultural beliefs and practices on skilled delivery, the Project shall engage with cultural custodians, religious leaders and peers to create more awareness on the benefits of skilled delivery. It shall also provide TA, OJT and CME on skilled delivery to service providers through facilitative supervisions to improve the quality of skilled delivery

- Identify maternity infrastructure and equipment gaps during continued facility assessment and supervision and share this gaps in a report with the national mechanism responsible for facility renovations and equipment so as to address identified gaps.
- Support 10 existing PMTCT sites through respective DHMTs to provide comprehensive services. These new sites will be existing TB/ART treatment centers for purposes of integration.
- Strengthen/support quarterly HIV/AIDS interdepartmental heads meetings for follow-up of mothers and their exposed infants into care in the CCC.
- Support EID/CD4 logistics to enhance enrollment of infected babies and their mothers into care and treatment as early as possible, thus reducing infant/maternal mortality rate due to HIV infection.
- Strengthen the integration of PMTCT services into all outreach services, including mobile clinics, so as to reach as many pregnant women, their partners and exposed children as possible.
- Support the transportation of DBS for EID; conduct OJT, CME on PMTCT/PWP; and, disseminate new guidelines on DBS collection for early infant diagnosis.

3.1.7 Maternal Health

- Upper Eastern is predominantly Borana and Somali but Samburu County is inhabited by Samburu, Turkana, Rendille and other smaller communities. All the main communities have cultural beliefs that in one way or the other affect maternal and child health; e.g. among the Borana and Somali communities, majority of whom are Muslim, preference is for delivery by a female rather than male nurse due to religious teachings on relations between men and women. They also believe in 40 days seclusion after delivery (no going out during this period). This affects postnatal clinic attendance within the first two weeks as required. Samburu believe in home delivery because of the culture of holding a high rope (the laboring woman gives birth while squatting, rather than lying on her back, and holding a high rope tied inside the Manyatta).

Key Observations on Performance

- All the 40 assessed high-volume facilities have basic equipment and trained personnel who were able to provide the basic ANC services.
- The improving ANC attendance compared to previous quarter was attributed to more integrated outreaches targeting pregnant mothers. Most mothers believe in 1st ANC because of the tetanus toxoid vaccinations; however, subsequent visits are significantly fewer due to cultural beliefs and practices around delivery.
- Mothers from UES communities attend postnatal clinic services at 6 weeks and this is associated with the 40 days seclusion period in Somali and Borana communities. It is also at this time that mothers bring their children for the first DPT.
- Due to high stigma on pregnancies outside marriage, abortions are common among young girls across all the communities. PAC services are available in 50% of the high-volume facilities assessed, though rarely provided because the service providers are not adequately trained in stigma reduction.
- Cervical cancer screening services through Pap smear is available in 8 GOK and 3 faith-based hospitals within the sub-region.

Challenges

- Stigma amongst the service providers on abortions hinders PAC service delivery in the communities they serve. This reduces the number clients being attended on PAC at facility level and increases the risk of unsafe abortions at the community level.
- Home deliveries are common in most communities because of the cultural beliefs. This results in high rates of maternal mortality from PPH, prolonged labor, pre-eclampsia, etc. Postnatal clinic attendance is low due to the same beliefs.

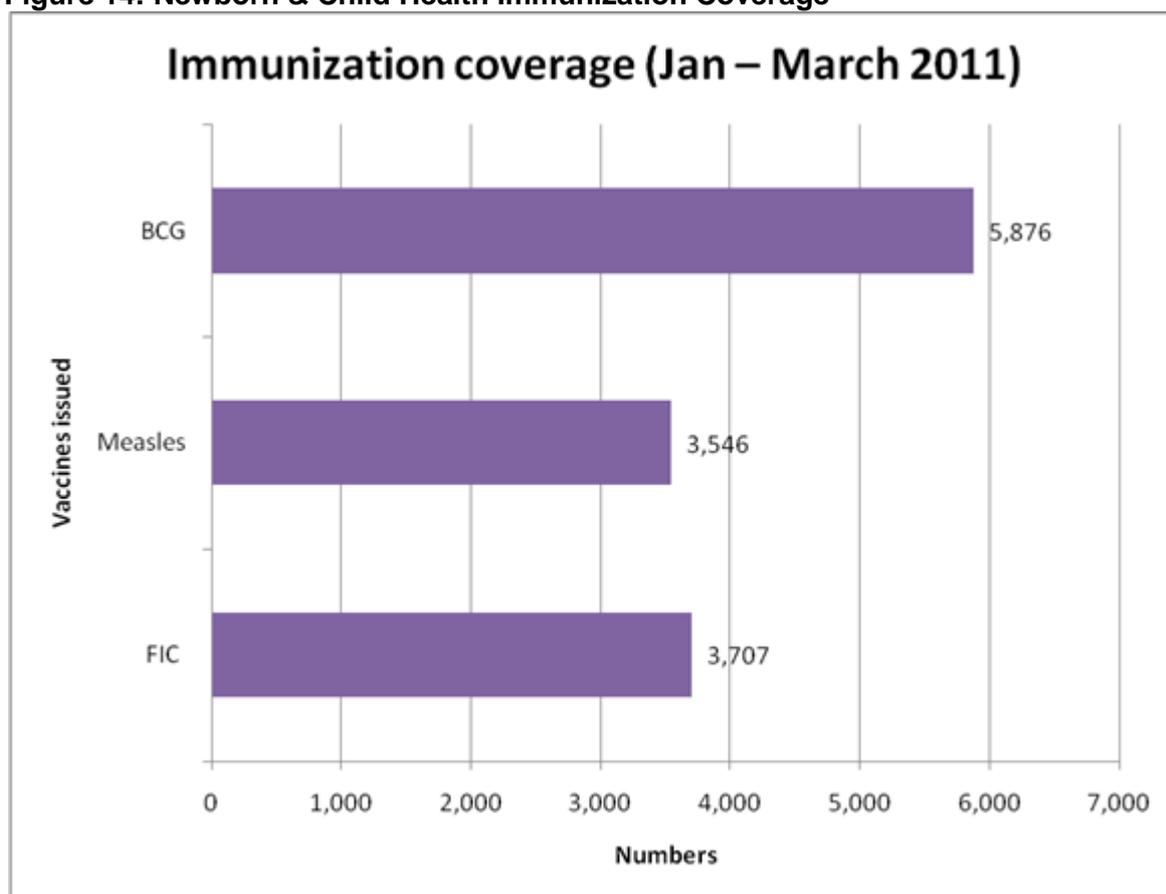
- The UES sub-region has been identified as a low endemic malaria zone and so distribution of ITNs to pregnant mothers by GoK and other partners has been reduced, though some areas, such as Samburu, have high malaria prevalence.
- Antenatal profile is only done in facilities with lab services while other facilities refer for these services, with no guarantee of the referred client being served . It is a national policy that all pregnant women be screened for good outcomes of the mothers and their unborn children
- Inadequate transport means in the vast region needed to refer complicated gynecological or obstetrics cases contributes to the high maternal mortality rate.

Planned Activities for the Next Quarter (April – June 2011)

- Support OJT during support supervision with the DHMTs and provide CMEs to health providers on FANC, PPH, PAC and stigma reduction.
- Encourage frequent micro-teaching at the facility level in favor of the importance of deliveries by a skilled attendant and attending post-natal clinics.
- Encourage formation of reproductive health and Maternal Death Review committees to enlighten the community on safe motherhood and assess the causes of maternal death within the communities.
- Identify pockets of high malaria incidence in UES and support the DHMTs to distribute the limited available ITNS to targeted locations.
- Support affected districts with fuel to provide transportation for limited number of emergency and complicated cases.

3.1.8 Newborn and Child Health

Figure 14: Newborn & Child Health Immunization Coverage



Key Observations on Performance

- Deliveries conducted within the quarter were 1,517, of which 80 were still births. This can be attributed to low ANC attendance after the 1st ANC visit due to socio-cultural beliefs and practices, as well as long distances to the nearest health care facility.
- ORT corners are available in all the 40 assessed high-volume facilities, though not always well-organized and stocked. The ORS corner needs to be properly set for proper demonstration of diarrheal diseases management, a very common ailment with children below 5 years.
- A total of 8,065 children in the region completed their immunization schedule during this quarter. This was attributed to high turn up for immunization as most mothers remained at home after some districts received rains and good supply of vaccines from KEPI.
- ANC, immunization and growth monitoring services are offered in 134 out of 155 facilities. However the Project noted that over 75% of these facilities offer BCG and measles immunization on weekly or monthly basis which is not in accordance to national guidelines of daily immunization services. Some facilities do it on weekly/monthly basis instead of on a daily basis due to inadequate staffing.
- Those children found to be malnourished are put on OTP/SFP. There are nutrition programs in the region supported by IMC and World Vision.
- Early infant diagnosis services through use of DBS are still below average with only 9 of the 40 assessed facilities offering EID and pediatric ART. The Project supported delivery of 45 EID samples to KEMRI during the quarter. Out of the 1517 deliveries by a skilled attendant, 14 delivered children were exposed to the risk of HIV and all of them received ARV prophylaxis as required by policy. It is however notable that more prophylactic ARVs were dispensed during ANC.

- In the reporting quarter, 23,254 children were also dewormed. The national policy is that these activities continue up to age of five years.
- During this quarter, 7,489 children who attended the child welfare clinics were found to be underweight. This is attributed to the dry spell in the sub-region that is occurring. All the 40 assessed facilities were offering food by prescription (FBP) to malnourished children.

Challenges

- The diarrheal diseases are associated with poor hygiene due to the shortage of water because of the drought experienced for the last 1 year and high levels of poverty in the region.
- Malaria associated with poor environmental hygiene and lack of mosquito nets.
- The nomadic life style of pastoralists hinders immunization coverage of children which then translates to high dropout rates.
- Strong traditional beliefs and practices that encourage the birth of many children regardless of the ability of the parents to take care of them leads to families that are unable to provide appropriate nutrition and food security in the face of persistent drought, and rapidly changing pastoralists' way of life that does not support large families.
- ORT corners were available in 40 high-volume facilities assessed, but underutilized due to lack of clean running water.
- In view of the high prevalence rate (3%) among PMTCT clients, the few EID sites (9 against 134 facilities) are inadequate for service provision. There are also few PITC sites for sick children. This is attributed to HRH gaps, skills and knowledge gaps of lab staff in the sub-region and lack of transportation for samples.
- No regular integrated outreach services in some areas due to distance, cost, lack of transport and staff shortages.

Planned Activities for the Next Quarter (April – June 2011)

- Identify and work with key community resource persons in finding sustainable solutions to minimize the impact of traditions that affect their communities negatively.
- Establish and build on strategic partnerships with GoK ministries, departments and CSOs present in UES with significant nutrition programs, in order to refer clients for nutritional support.
- Support continuous dialogue with men and women on child spacing through frequent facility-based and community-based micro-teaching by the service providers and CHWs.
- Encourage improved water management, sanitation and hygiene in the communities through health education at health facilities, integrated outreach and school health clubs. This will include referring WATSAN initiatives to highly deserving clients, schools and facilities.
- Revitalize the existence of ORT corners in the facilities during support supervision and emphasize on the same during CMEs.
- Support the initiation/establishment of more (2 per quarter) EID sites, ensuring availability of ARV prophylaxis for infants in all facilities through CME/OJT on EID and active follow-up of HIV-exposed infants (HEI).
- Establish and support laboratory networking in 10 facilities that do PMTCT. Advocate for and support improved immunization coverage by integrating it into facility outreach services and implementation of the RED strategy which targets the low-performing facilities. This can be achieved through OJT and CME on EPI.
- Support integrated mobile outreach services in the facilities that have community settlements far from the facility in order to reach them with health services
- Support monthly DHMT supervision, OJT, mentorship to reduce the knowledge gaps in IMCI, EID, PMTCT, EPI, RED strategy.

3.1.9 Family Planning/Reproductive Health

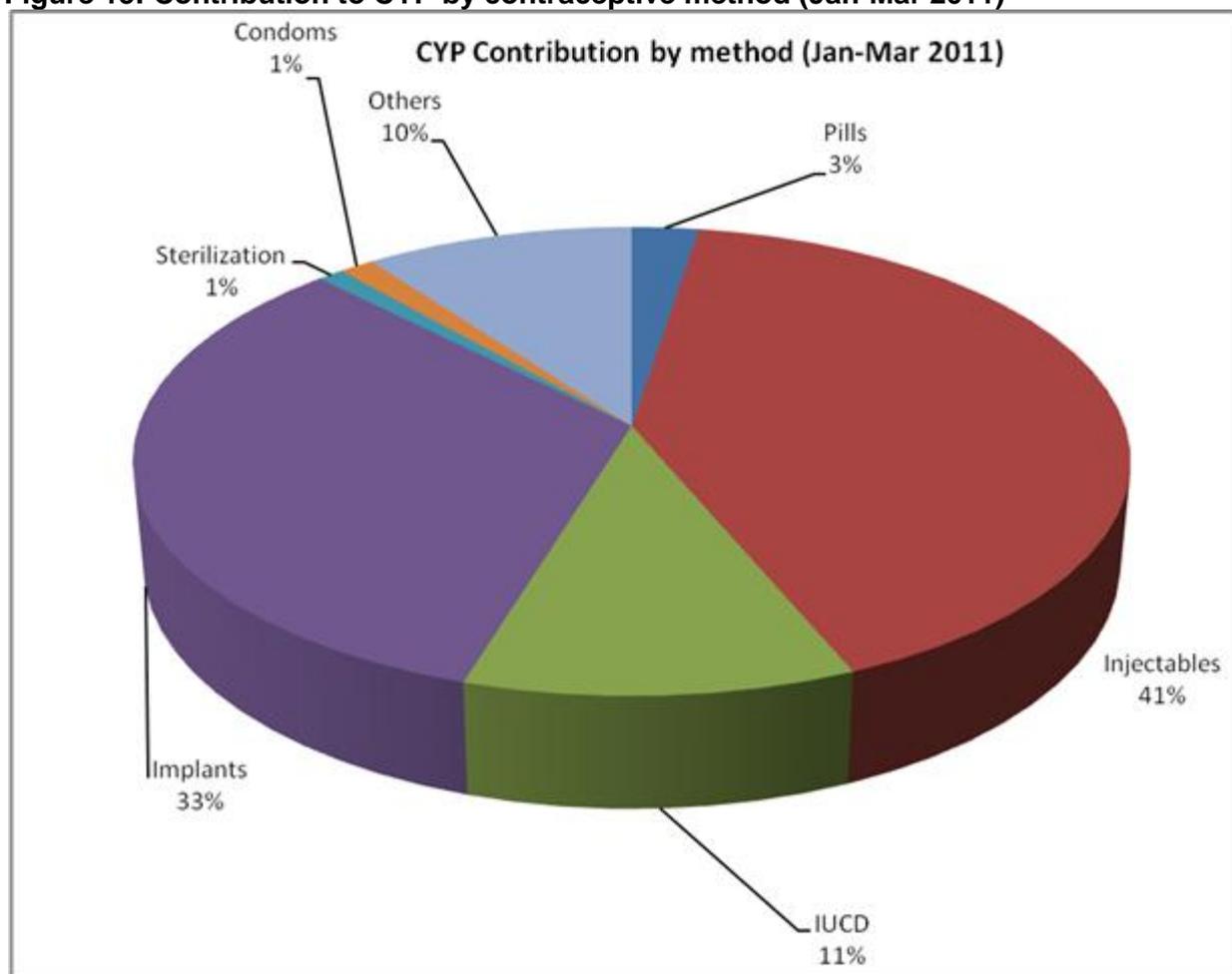
- Family planning is a term that is not well received culturally in the UES sub-region; the Project uses “healthy timing and spacing of pregnancy” instead.
- Of the total facilities supported by the Project, 83% are offering selected FP methods. The majority do not provide long-acting or permanent methods. Only five facilities offer a full mix of FP methods. Twenty-one FBO (Catholic) facilities offer only natural methods. Interestingly, CycleBeads technology is not well known by service providers as it has only been introduced into the country recently; however, it is a method that can easily be accepted by even the faith-based facilities.
- The long-acting and permanent methods have very few users because most communities believe in women giving birth after every 23 months until menopause sets in.

Table 21: Summary of FP methods provided

Methods		Oct-Dec 2010*			Jan-Mar 2011		
		New	Revisit	Total	New	Revisit	Total
PILLS	Microlut	94	113	207	105	84	189
	Microgynon	176	305	481	296	438	734
INJECTIONS	Injections	740	2,077	2,817	1,445	2,583	4,028
I.U.C.D	Insertion	64	20	84	39	38	77
IMPLANTS	Insertion	56	32	88	185	45	230
STERILIZATION	B.T.L	2	-	2	2	-	2
	Vasectomy	-	-	-	-	-	-
CONDOMS	No. of Clients receiving	976	538	1,514	2,155	1,638	3,793
ALL OTHERS:		37	10	47	176	71	247
TOTAL NUMBER OF CLIENTS		2,145	3,095	5,240	4,403	4,897	9,300
REMOVALS:	IUCD	8		8		0	0
	Implants	25		25		0	0

*Does not include data for Samburu

Figure 15: Contribution to CYP by contraceptive method (Jan-Mar 2011)



Key Observations on Performance

- Of the total number of women of reproductive age in the sub-region representing 5% of the total population of 28,500 women, only 9,300 clients, or roughly 32.6% of eligible women, used FP services in the past quarter. The FP services utilization is therefore lower than the national target of 80%. This is attributed to a number of factors, including Catholic and Islamic cultural/religious beliefs and practices, long distances from service points/facilities and inadequate exposure to IEC by the target communities.
- Only about 20% of the 40 assessed facilities had a Tiaht chart..
- Integration of FP into MNCH service was evident in all the 40 assessed facilities but this integration needs to be extended and strengthened to include HIV/AIDS, TB and postpartum services.
- 80% of the service providers working in the 40 facilities that were assessed during the quarter at least have the basic knowledge on FP. This is because FP basics is a mandatory requirement during the training of medics and paramedics. However, there were knowledge gaps in FP/PAC especially among the new facility staff who have not been updated on FP mix methods.

Challenges

- A large number of the faith-based facilities clients are not accessing comprehensive FP information to make informed choices. Even in faith-based facilities that promote SDM, 80% of the service providers have limited awareness of the CycleBeads technology, as this is totally new in the region.

- Majority of the community members have never seen a female condom as they are not readily available.
- Less than 10% of the service providers are updated regularly on contraceptive technology.
- FP education aids and penile models for demonstration are also not available in many facilities. This compromises the quality of information given to clients at the facility particularly on use of the male condom.
- 25% of the facilities did not have essential equipment for IUCD insertion such as speculums and spot lights.

Planned Activities for the Next Quarter (April – June 2011)

- Introduce CycleBead technology to faith-based facilities and organizations in UES in the next quarter and scale it up to key gate keepers in the subsequent quarters while introducing it to potential clients. Support and conduct OJT and CMES on SDM (as part of the overall method mix), as well as disseminate national policy guidelines on FP/RH to service providers during support supervision. This will enhance performance and quality of FP/RH services provided to clients.
- Encourage DHMTs to integrate FP/RH services into all integrated outreaches so as to reach as many women of reproductive age as possible and ensure that service providers know how to give full information on FP/RH choices to all clients, including the benefits of long acting FP methods.
- Facilitate the placement of Tiahr charts and other FP/RH job aids in all facilities starting with the 40 high-volume facilities.
- Encourage initiation/establishment of integrated nomadic/camel clinics, outreaches and postnatal service provision to secluded manyattas and key watering points to reach out to the mainly pastoralist communities and target women during the 40 days seclusion period.
- Assist District Reproductive Health Coordinators to make available in the facilities the female condoms and penile models to enhance the quality of counseling for clients.

3.1.10 Nutrition

- The main staple food in almost all the districts in UES is milk, meat and flour or rice with the largest food portions constituting livestock products which the communities in the north depend on for their livelihoods. Food source diversification is still very limited for the majority of rural folks in this region who have diets largely deficient of micro-nutrients. The most affected are children and the aged.

Key Observations on Performance

- All the 40 assessed facilities during the quarter offer supplementary feeding as well as vitamin A supplementation to infants and children. Of the 20,769 children who attended CWC, 36% were found to be under weight. This dire situation is attributed to the long spell of drought.
- The importance of exclusive breastfeeding is encouraged at both the facility and the community level, though the practice of mixed feeding is common due to episodes of drought within the sub region. Members of the Somali community in particular do not practice exclusive breastfeeding because of cultural beliefs.
- The Project provided access by 326 members of HIV/AIDS support groups to FH Kenya's economic strengthening initiatives in Marsabit Central.
- The Project has been actively engaged with the GoK village relief committees to ensure that children supported by the Project do not miss food rations provided by the government every two months.
- 5185 OVC got food rations through the community gardens in Isiolo County with OVC caregivers providing labor to the community gardens as their contribution. Their participation has been a learning experience for other caregivers who are currently replicating the same in their own gardens.

- 6,025 OVC were linked to FH, WFP, GOK relief food programs for direct food support in areas hard hit by drought (Marsabit and Isiolo Counties). Rations included maize, beans and cooking oil.

Challenges

- Technical capacity in the sub-region is highly limited since there are only five trained nutritionists against 12 districts and 155 facilities and a population of 650,000. However, the facilities have CHWs/HWs trained to advocate for adoption of improved nutrition practices among the target communities and to do nutrition assessment follow-ups.
- Poor food security due to effects of climate change and persistent drought as families are now unwilling to sell their few remaining livestock
- The food crisis has heightened the rate of absenteeism in schools which further worsens vulnerability among children in the long run. Areas not covered by the school feeding program are hard hit.

Planned Activities for the Next Quarter (April – June 2011)

- Assess UES districts and high-volume facilities without nutritionists and lobby the Capacity Project to prioritize recruitment of this cadre of staff.
- Closely monitor and leverage strategic partnerships for the strengthening of the school feeding program in all schools that the Project supports.
- Advocate for the development of household kitchen gardens to diversify diets and improve nutrition for communities along the Waso Nyiro river, where there are deep wells and dams.
- Encourage the D/HMT to integrate vitamin A supplementation and growth monitoring into outreach programs so as to reach as many children as possible.
- Monitor and facilitate provision of quality food by prescription services offered at the community levels through integrated facilitative supervision with the D/HMT and facility staff.
- Provide TA and support to the local implementing partners and rolling out of household economic strengthening interventions (HES). This will include exploring ways and methods of leveraging, networking and collaboration with livelihood support, food security and relief agencies and partners in the sub-region so as to strengthen household economic structure and sustainable nutrition support. This shall be discussed on the 5th of May with LIPs during our program review in Isiolo followed by similar meetings in other districts.
- Strengthen linkages with relief agencies through drought monitoring meetings for emergency and general food distribution, particularly among PLHIV and highly vulnerable households.

3.1.11 Adolescent SRH

Key Observations on Performance

- In UES, youth-friendly services have been initiated in 21 high-volume facilities which represents only 14% of the total number of facilities. Only a handful of service providers have been trained on youth-friendly services within the sub-region leaving a large gap that needs to be addressed.
- As much as there is integration of youth services with other routine services in the lower level facilities, the services have not been well accepted because of the violation of culturally acceptable standards for various age groups. The youth (Morans), women and the elders meet together in facilities which is not culturally comfortable as Morans and the elders do not traditionally want to be seen by women as being weak, and youth should not be discussing sexual issues in the presence of the elderly.

Challenges

- The numbers of service providers trained on youth-friendly services are very few in all the counties making it difficult to initiate the services in many sites.

- Most facilities are not well equipped to provide integrated services to the youth.
- Creation of youth-friendly centers (YFC) and or innovative ways of reaching the youth has not been cascaded down to the dispensary/ community level.

Planned Activities for the Next Quarter (April – June 2011)

- Support more service providers and facilities on provision of youth-friendly services through customized OJT and CMEs .
- Support provision of life skills through the school health clubs.
- Target out-of-school youth groups for CT, BCC, SRH and other health services. This can be done by initially meeting the youth groups and encouraging mobilization activities like drama festivals and sports, then subsequently introduce the rest of the services.
- Explore possibilities for the use of appropriate mass media health messages targeting the youth through local radio stations.

3.1.12 Malaria

- UES has been classified as a low malaria prone zone and therefore given less attention for ITNs distribution. The Project however noted high numbers of malaria cases during the assessment of the 40 high-volume facilities. Of the 20,769 children attending CWC, 12,580 or 60.5% of these children below five years were confirmed to have suffered malaria. Most of these are diagnosed based on clinical signs and symptoms because of the lack of laboratories.

Key Observations on Performance

- Over 50% of the assessed facilities had anti-malarial drugs but not a single one had ITNs.
- The newly employed nurses have some knowledge gaps on the current management of malaria due to lack of adequate training.

Challenges

- Protocols for the management of malarial cases has recently been changed by the MOH; however, many staff are not aware of the new guidelines.
- Lack of active community units to act as channels for information on malaria prevention and treatment.

Planned Activities for the Next Quarter (April – June 2011)

- Support malaria control OJT and CMEs for facility staff and dissemination/distribution of malaria guidelines, SOP and posters to facilities during the support supervision visits.
- Support community training on malaria control for CHEWs and CHWs that can be integrated into other planned community training.
- Liaise with PSI/HCM to support distribution of ITNs in the sub-region for the benefit of children under five, pregnant and lactating mothers.

3.1.13 Water and Sanitation

- The national guidelines state that each person in a rural village should be entitled to 50 liters of water per day while those in urban settings should have access to at least 60 liters per day. Less than 40% of the populations in UES have access to safe and adequate water in their households. There is no permanent or piped water supply in most rural areas of UES region. The community rely on bore holes and dams which are dry most of the time due to long dry spells. Those in urban areas are constrained primarily by the cost of water sold by vendors.

Key Observations on Performance

- Over 40% of the assessed facilities depend on boreholes and rain water catchment tanks.
- Waste disposal in most facilities is by burning and burying.
- There are various sources of water for humans and livestock, including dams, boreholes and water pans in rural settings. Donkeys, carts and children are used to ferry water to schools and health facilities. Some schools have ferro-cement water tanks to collect roof water during the rainy seasons. In urban centers there is piped water to households either from dams or boreholes.
- Water management is under the Northern Water Services Board. Marsabit Central and Moyale face chronic water shortages (although there is a huge dam under construction in Marsabit). In Isiolo the Water Services Regulatory Authority is constantly fighting with farmers upstream of Isiolo river who are diverting water to irrigate their farms at night, thereby diverting water from the main dam that serves Isiolo town.
- Due to the ongoing drought some of the villages have migrated to dams that have been dug to cushion livestock owners during such dry spells.
- Most of the schools have sanitation hardware, i.e. latrines, and hand washing facilities.
- PLHIV in Marsabit County have been provided with water tanks by partners supporting them.

Challenges

- The main challenge in providing for safe water to communities in UES is lack of commitment from the responsible GoK departments to develop adequate rain water catchment infrastructure in the region and poor capacity of the local water management committees for the existing water systems in the urban areas.
- Shortage of running water in over 40% of the facilities assessed, including some of the district hospitals.
- Infection prevention is poorly practiced due to the attitudes of the health care workers and perhaps knowledge gaps. Sharps containers and disposal bins are available but one still finds used gloves, syringes and gauze carelessly discarded.
- About 20% of the lower level facilities assessed lacked basic infection prevention equipment, i.e. the bucket system.
- Due to chronic poverty, communities lack resources and initiative to provide water to health facilities and schools. These are facilities present opportunities for collecting water during rainy seasons.
- Water scarcity coupled with poor hygiene leads to frequent outbreaks of communicable diseases.

Planned Activities for the Next Quarter (April – June 2011)

- Liaise with our partners dealing with WATSAN challenges in the region – including Food for the Hungry, Pastoralist Integrated Support Program, World Vision, Cordaid and the Kenya Red Cross society – and with the MOH to improve water storage and treatment in health facilities and schools through installation of roof catchment tanks and water pans..
- Support organization of regular WATSAN partners meetings and outreaches to address water and sanitation challenges.
- Conduct OJT and CMEs on infection prevention skills and practices for facility staff. Continue to conduct hygiene education through school health clubs and assemblies in collaboration with the DPHOs, school health club patrons and CHEWs.
- Support community outreach on sanitation, hygiene and disease prevention by school children organized by the school health patrons. Songs and dramas during school parents' gathering is one avenue for passing conveying information.

3.2 Increased Demand for An Integrated Package Of High Impact Interventions At Community And Facility Levels

3.2.1 CHW Outreach Activities/Community Strategy

- There are 12 Community Units that have been established in UES by various stakeholders in collaboration with the Ministry of Health. In total there are 500 CHWs in the 12 units or an average of 41 CHWs per Community Unit.

Key Observations on Performance

- 96 CHWs working with FH Kenya in nutrition activities are spread within Marsabit County and supporting implementation of key health activities. Their activities include child growth monitoring; nutritional assessment and referral of severely malnourished children for treatment and supplementary feeding; tracing of ART and TB defaulters; referring pregnant mothers for ANC and skilled delivery at health facilities.
- CHWs also provide health education on immunization; micro-nutrients supplementation for the malnourished children, HIV/AIDS prevention; safe water and sanitation practices; TB; and, ART defaulter tracing.
- CHEWs and CHWs are instrumental in organizing and conducting community action days where major health challenges are identified along with opportunities for addressing them.
- The CHWS report outbreaks of strange and known ailments and emergencies to CHEWs and then to the facilities.

Challenges

- Minimal capacity-building support for CHWs, especially updates on the community strategy, due to inadequate resource envelopes.
- Partially inactive CUs for lack of incentives to CHWs and monthly reporting and monitoring meetings. APHIA II Eastern was only supporting one CU in Upper Eastern in Isiolo town.
- Limited support for the Community Units from grass root leaders because the leaders were not adequately involved in initiation of the units.
- Inconsistent supply of reporting tools and incentives to the CHEWs and CHWs.
- Frequent facility staff departures and absenteeism that adds workloads to the CHWS.
- Institutional memory loss and information flow breaks between CHEWs and CHWs due to transfers of trained CHEWs.

Planned Activities for the Next Quarter (April – June 2011)

- The Project has planned to rejuvenate 3 Community Units, one in each of the three Counties of Isiolo, Marsabit and Samburu, in collaboration with the DHMTs. The process will include potential CU identification, CHWs mapping, updating of the CHWS and follow-up, monthly incentives and monitoring of CU activities through monthly reporting. The criteria for CU selection include those with trained CHWs and who have initiated operations but are currently semi-active due to lack of incentives for CHWs and lack of or inadequate supervision and monitoring.
- In consultation with the PHOs, the Project shall support 3-day Community Strategy refresher trainings for the three CUs and implement a system for providing monthly incentives pegged on submission of CU reports. The incentives shall be in line with the current practices by other partners in the sub-region.
- The Project shall also facilitate CHWs supporting integrated mobile outreaches conducted by MoH and FBO facilities where there is no other partner support.
- The Project shall support photocopying of CU data collection tools for use by the CHWs and provide them through the PHOs as needed.
- The Project shall put more emphasis on MNCH, FP/RH integration and HIV prevention with special focus on the most-at-risk populations, e.g. the Morans and their *sintanis* in the Samburu and Rendille communities, and youths involved in drug abuse.
- CHWs shall be involved in the distribution of 20,000 condoms for HIV prevention targeting MARPs and the general population in UES.

3.2.2 Care and Support for PLHIV

- With an estimated 22,800 PLHIV in UES, about 5,700 (25%) persons, are estimated to be eligible for CHBC services. 2,569 PLHIV were supported through integrated OVC/HBC programs supported by APHIAplus NAL.
- PLHIV continued to receive psychosocial support through home visits by community volunteers to provide counseling and advice for positive living.

Key Observations on Performance

- The CHBC focus by project LIPs and other partners has been on provision of a minimum package of care and support.
- The Project has embarked on provision of a continuum of care and support to PLHIV accessible to all those who need it and adequately supported by facility and community health workers.
- Through weekly or monthly support group meetings, beneficiaries met in their respective communities and shared encouraging experiences and conducted other group activities, especially IGA/ Savings and Internal Lending Communities (SILC) activities.
- In terms of household economic strengthening and protection services, most of the existing support groups are registered with the Ministry of Social Services, have opened bank accounts and are engaged in various HES activities, including; SILC, chicken rearing, dairy goat rearing, vegetable growing and bead making. The HES activities are varied according to geographical area.
- The social support and experience sharing by the PLHIV is helping the new clients in the groups to open up and disclose their status to peers, thus helping to bring down self-stigma.
- Nutrition care and support for PLHIV and their caregivers included; TA for development of kitchen gardens, poultry farming and milk goats provided to beneficiaries. In Isiolo County, clients involved in kitchen gardening were networked with MOA, MOW and MOL for technical support.

Challenges

- Stigma is quite high, contributing to low turn-out for comprehensive care services and support groups.
- CHBC capacity gaps in the sub-region are significant among health workers, CHEWs and CHWs.
- Poor ART adherence by some PLWHIV is mostly due to high levels of poverty and inadequate food and nutritional supplementation. These clients are also engaged/ employed in casual jobs which can cause interruptions in drug adherence.
- Majority of trained CHWs in the sub-region lack incentives necessary for them to commit their time to CU activities and therefore provision of effective CHBC activities.

Planned Activities for the Next Quarter (April – June 2011)

- CHBC clients have been and will continue to be identified through the CCCs of the 40 high-volume, other facilities and LIPs.
- To address the high stigma levels and CHBC capacity gaps among HWs, CHEWS and CHWs in the sub-region, the Project has planned to support identification, training, support supervision and OJT/CMEs for these cadres of health workers. This will be followed by support for regular meetings of PTCs and integrated advocacy/awareness campaigns in the community through various forums.
- The Project will provide TA, guidelines and resources to MOH and FBO service providers to ensure a minimum package of services are available for those who test positive, at both high and low-volume facilities, including those which don't provide treatment services.

- The identified PLHIV shall be trained on treatment literacy, demonstrated to empower PLHIV and communities to reduce stigma levels, fast track formation of post-test clubs and increase demand for quality HIV services.
- The Project will build upon existing networks of CHWs and volunteers/caregivers for continued follow-up for adherence, positive living, and referral. The Project will implement a system for providing monthly incentives to CHW supervisors/CHEWs and CHWs in selected community units in consultation with the DHMTs and pegged on agreed performance and submission of CHBC reports. The incentives shall be in line with the current practices by other partners in the sub-region. Strengthening of psycho-social support groups at Gataab and Loyangalani and linking them to other service providers as appropriate in consultation with DASCOS.
- Strategic partnerships will be established between RLs, responsible GoK officers and PLHIV groups (including OVC), as has happened in NEP, for provision of ongoing psycho-social support.
- Liaise with the DSGs in the UES districts so that the PLHIV groups can be given priority in the distribution of GoK relief food so as to improve their adherence to ART.

3.3 Increased Adoption Of Healthy Behaviors

- .Through on-going community assessment, the Project is identifying the socio-cultural beliefs and misconceptions among different communities in UES that are barriers to healthy behaviors. The Project will help populations identify high-risk behaviors due to socio-cultural and other factors and encourage actions that contribute to change.

Key Observations on Performance

- The most-at-risk populations identified in the UES sub-region during the community assessment include; uniformed services personnel, Morans and their *sintanis*; unaccompanied civil servants; CSWs; and truck drivers.
- The Project initiated an assessment during the quarter to identify most-at-risk populations and behaviors in Isiolo township. Modeled after a similar study conducted by APHIA II NEP in Garissa and using a rapid survey methodology similar to the Priorities for Local AIDS Control Efforts (PLACE) approach, the assessment will create an evidence base for targeted prevention programming, including CT and condom availability. This type of research is a first for Isiolo; the assessment report will be ready next quarter.
- Other than Garbatula and Moyale districts, which have predominantly Muslim populations, rural villages in most of the other districts engage in local brewing which contributes to unsafe sexual behaviors.

Challenges

- The main focus of HIV/AIDS prevention interventions in the sub-region has been awareness creation. However, awareness creation sessions have not consistently led to behavior change, primarily because of lack of ownership of the interventions by those who are being targeted.
- There is little awareness on HIV and AIDS in the nomadic communities, primarily because of low literacy levels.
- Most of the NGOs are concentrating their awareness efforts to the community gatekeepers rather than MARPs and the general community.
- Most of the CBOs funded by the CACC are not competent to train the community on programmatic areas related to HIV/AIDS.

Planned Activities for the Next Quarter (April – June 2011)

- The Project will provide tailored messages based on the outcomes and recommendations of the Isiolo sexual networks survey, promote accurate information, encourage healthy behaviors, and engage communities to overcome socio-cultural barriers to healthy behaviors. HIV prevention messages will include promoting HIV testing, partner reduction, consistent/correct condom use, stigma and discrimination reduction, and improving gender norms.
- The Project's HIV BCC strategy will be to help populations identify high-risk behaviors due to socio-cultural and other factors and encourage actions that contribute to change.
- Review the findings of the sexual networks assessment. Disseminate with key stakeholders, including MARPs. Use the validated findings to inform the development of an evidence-based behavior change strategy for UES.
- Identify 40 leaders of 2 Moran clusters and 40 leaders of 8 youth groups in Isiolo, Marsabit and Samburu counties for training on PE using the NASCOP guidelines with the aim of assisting the target groups to increase awareness on risky behavior and adopt positive behaviors
- Hold discussions with DASCOS and managers of key potential work places including; army, administration, regular police and high-volume schools with a view to develop appropriate strategies in addition to peer education in the work places.

3.4 Increased program effectiveness through Innovative Approaches

Health systems strengthening

- APHIAplus technical staff worked closely with districts during the development and consolidation of their AOPs to ensure that support anticipated from APHIAplus NAL is realistic, consistent with the APHIAplus service delivery mandate, complementary to support received from GOK and other partners, and contributing to APHIAplus NAL programmatic targets.
- The Project communicated a resource envelope related to APHIAplus NAL support for each district with the MOH to inform decision-making at the AOP planning stage.
- CME programs with mentoring teams to replace or supplement formal, residential training.

Planned Activities

- The Project will continue successful collaborations to strengthen P/DHMT capacity to plan, manage, supervise, and monitor facility service delivery and to coordinate services.
- The Project will expand upon work initiated in NEP to ensure that all the Districts have functioning and effective District Health Stakeholder Forums (DHSF) as a pre-requisite to improving coordination between key stakeholders and complementary resource contributions.
- APHIAplus NAL will support joint mentoring and supervision with P/DHMT members, leveraging the NASCOP mentorship program; Continuing Medical Education (CME) opportunities; cross-training of P/DHMT members; and the development of district and provincial AOPs, ensuring prioritization of selected high-impact interventions for maternal, newborn and child survival and HIV.
- The Project will support DHMT members to roll out the AOP process to health facility level by jointly facilitating work-planning exercises at key, high-volume sites.
- Comprehensive support supervision is an initiative that cuts across health services and is critical to building capacity within the MOH and FBOs. This will be supported with technical assistance (particularly around quality improvement) and financial support (MOH resource envelope and subgrants to FBO partners).
- APHIAplus will provide direct TA to facilities for organizing laboratory services, for example in establishing laboratory networking systems for improving access of clients to selected services. The Project will also assist DHMTs to prioritize laboratory strengthening sites and interventions in order to leverage national mechanisms for HRH, equipment, commodities, training and infrastructure.

- Under APHIA II NEP, strong existing community structures and leaders were leveraged to mobilize communities around key health issues and messages. Traditional structures can be an asset in this regards and APHIAplus NAL will use a similar approach, working with and through opinion leaders such as elders, religious leaders, traditional birth attendants and more formal institutions such as Community Health Committees and Facility Management Committees.

HIV Counseling and Testing

Planned Activities

- Innovative approaches to be implemented include: employing GIS and spatial analysis in order to identify emerging trends in HIV prevalence and strategically position CT resources; forming of strategic alliances between religious leaders, MARPs and service providers UES for enhanced accessibility and use of CT services; integrating CT into existing integrated outreach programs by both GoK, FBO and NGO facilities, providing transportation for cool boxes containing test kits during the hot seasons. The Project will help with planning and DHMT-support to exploit major events (e.g. national days, livestock markets, agricultural shows) and Rapid Results Initiatives for CT activities.

Prevention of Maternal-to-Child Transmission of HIV

Planned Activities

- **The Project** will support health facilities that provide ANC services to provide universal HIV testing for pregnant mothers, so that they are provided with appropriate care.
- The Project will strengthen CD4 lab networking in UES based on the NEP model which engenders ownership by the MOH and therefore sustainability.
- Support stronger focus on community-level counseling, including couple counseling and attention to discordant couples, to promote the importance of knowing one's status and living positively.
- Refresher training of CHWs and technical support to health providers, as well as IEC dissemination, will stress the perspective of treating HIV as a chronic disease that requires appropriate management.
- The Project will improve the interface between public health care providers and community health workers, so as to improve the interaction of these distinct yet complementary PMTCT service providers.
- The initiation and use of reproductive health committees in the facilities to strengthen advocacy for hospital delivery thus reducing maternal and child mortality.

Maternal, Newborn and Child Health

Planned Activities

- Identify and utilize existing groups of community midwives to complement facility-based services and increase access to skilled deliveries, tapping into the Outputs-Based Approach and other funding sources that may be available at the local level.
- Collaborate with MDONKAL to leverage resources for provision of basic EOC equipment and improved referral systems, including transport.
- Given the dependence on TBAs in NAL, APHIAplus NAL will support TBAs within the limits of MOH policy. TBAs can be empowered to educate, encourage and assist women, their partners and families to anticipate and recognize signs of life-threatening complications, to know when and where to refer cases, to encourage development of birth preparedness plans including emergency transport, and where possible to accompany women coming for delivery at health facilities.

- The Project will partner with influential opinion leaders in UES to discourage early marriage, FGM and other harmful traditional practices.

HIV Care and Support

Planned Activities

- The Project will use PLHIV resource persons developed under APHIA II NEP to conduct training in treatment literacy in UES.
- APHIAplus NAL will provide TA, guidelines and resources to MOH and FBO service providers to ensure a minimum package of services are available for those who test positive, at both high and low-volume facilities, including those which don't provide treatment services.
- The Project will build upon existing networks of CHWs and volunteers/caregivers for continued follow-up for adherence, positive living, and referral. Strategic partnerships will be established between RLs and PLHIV groups (including OVC), as has happened in NEP, for provision of ongoing psycho-social support.
- Pre-ART registers will be included in all facilities in order to capture patients who have been put on care. Minimal assessment will also involve WHO staging at first contact.

HIV/AIDS Treatment

Planned Activities

- Support and promote the establishment of HIV treatment committees at level 4 and 5 facilities to address issues of treatment failure.
- Support the development of satellite CCCs to increase access to comprehensive TB/HIV services for hard-to-reach populations both nomadic and sedentary.
- Facilitate strategic partnerships between religious leaders and PLHIV groups (including OVC) for provision of psychosocial support.
- The Project will assist the MOH and FBOs to decentralize ART clinical services to patients at satellite health facilities from existing central ART sites.
- Clinical mentorship (by existing central ART site appropriate staff) to service providers at the satellite health facilities.
- Support for decentralization of ARVs and HIV-related commodities management to central/district ART site level from the national NASCOP/KEMSA warehouse level and the creation of laboratory service linkages and networking with centralized and best equipped regional or district-based laboratories.
- The Project will also support relevant MOH personnel to analyze data related to treatment failure in order to inform the initiation of appropriate medical care, including second line ART.

Family Planning and Reproductive Health

Planned Activities

- The Project plans to introduce CycleBeads outside of NEP, including in Diocesan facilities.
- Through the Project's support of DHMT planning and supervision, and service provider skills building, the Project will strengthen the FP commodities supply chain; ensure FP-related IEC is relevant and appropriate; expand FP methods mix at public and private facilities; strengthen FP integration into HIV counseling and testing and ANC; promote FP for prevention with positives (PWP) and PMTCT; improve HTSP; expand FP/PAC integration; and, improve service provider knowledge on safer pregnancy/contraception choices for women on ART.
- The Project will work closely with DHMTs and FBOs to enable facility managers and supervisors to monitor the quality of integrated services. Monitoring activities will include assessing adherence to service protocols, checking for contraceptive stock outs, and

reviewing service statistics, such as the number of FP clients referred to HIV-related services or the number of HIV clients referred to FP services.

- Given the importance of outreach services in NAL, outreach workers will be equipped to offer information on HIV prevention, provide referrals to HIV-testing services, counsel on all methods of FP, and provide select methods. CHWs and all community outreach workers will be linked to the nearest health facility for supportive supervision, problem-solving, case management, supply distribution, and records management.

3.4.1 Integrated mobile and other outreach services to reach MARPs, women, girls and hard-to-reach populations to bring care closer to the client

Key Observations on Performance

- The primary activity conducted this quarter was the facility and community assessments.
- During the facility and community assessments, the Project noted that there are approximately 500 CHWs identified and trained by different partners working within the region for this purpose. However, the CHWs' potential is not fully utilized, especially in expanding integrated mobile outreach services to remote rural communities because of many inactive Community Units.
- Most facilities in UES do not distribute female condoms, lack PAC services and youth-friendly services that would be beneficial to girls. Access is even more limited for remote rural villagers and pastoralists, especially during nomadic movements in search of water and pasture.
- Services targeting truck drivers, uniformed services, migrant workers and commercial sex workers and their clients are very limited in the sub-region.
- The other MARPs not effectively reached by health information and services are the Morans found among the Samburu and Rendille communities.

Challenges

- Inadequate information about MARPS in UES and what interventions would work best to address their priority health needs and HIV/AIDS prevention.
- High stigma within the communities that makes it difficult to isolate MARPs and provide them with comprehensive information to help them change their risky behaviour and help address stigma.
- Outreach to truck drivers is difficult during the day since this is when they are traveling on the road. Night outreaches to CSWs would equally be challenging as that is the time they are engaging their clients for economic gain.
- Morans are mostly accessible only to their age mates and elders from their community and so it is challenging reaching them directly, especially since they reside in the bush most of the time.

Planned Activities for the Next Quarter (April – June 2011)

- Review existing data on MARPs and the findings of the sexual networks assessment; describe the MARP populations; determine availability and appropriateness of existing services; disseminate and use the validated findings to inform the development of an evidence-based behavior change strategy for UES. Ensure the participation of key stakeholders, including MARPs.
- Tailor services – behavioral, biomedical and structural – as needed, creating an enabling environment in which MARPs have access to appropriate, affordable, acceptable and accessible health services (including HIV/STI prevention, and HIV/STI treatment and care). Part of action to strengthen outreach to MARPS will include providing service providers with appropriate OJT/CMEs and regular mentorship (through NASCOP) to strengthen their skills in interacting, counseling, and treating MARPs with compassion and care.

- Target the MARPs for HCT during the upcoming Rapid Result Initiative in collaboration with DHMTs, facility staff and LIPs.
- Conduct periodic moonlight counseling and testing in major UES towns including Isiolo, Laisamis, Marsabit, Turbi, Sololo, Moyale, Wamba, Maralal and Baragoi, particularly targeting CSWs, truck drivers, uniformed services personnel and bar patrons. This will be instrumental for both for scale-up of testing and counseling and for accessing MARPs with health promotion through pre- and post- test counseling and follow-up.
- Identify groups of Morans and their *sintanis* and conduct HIV/AIDS prevention education sessions for them through their cultural leaders and peers.
- Ensure the condom dispensers at the local bars and other locations frequented by MARPs are consistently refilled with the help of local bar owners association, DPHOs and DASCOS.
- During the integrated mobile outreaches in conjunction with other partners, ensure the CHWs become conduits between the community and those providing services to MARPs.
- Initiate and use reproductive health committees in the facilities to strengthen advocacy for hospital delivery thus reducing maternal and child mortality.
- Support the introduction and or scaling-up of outputs-based financing (OBA) for hospital delivery, including meeting with TBAs for sensitization on PMTCT and escorted hospital deliveries.
- Initiate discussion with DHMTs on implementing motorbike integrated outreaches, based on the successful APHIA II NEP motorbike outreach model for the provision of integrated services in rural areas. Implemented in coordination with CHWs, motorbike outreach improves access to health services particularly for women and girls.

RESULT 4: SOCIAL DETERMINANTS OF HEALTH ADDRESSED TO IMPROVE THE WELLBEING OF THE COMMUNITY, ESPECIALLY THE MARGINALIZED, POOR AND UNDERSERVED POPULATIONS

4.1 Marginalized, poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs

- Food security is a continual challenge in NAL, where people's access to and control over critical livelihood resources such as land is insecure, and where climate change increases unpredictability of seasonal rains.
- The most marginalized and underserved group in UES are the "pastoral drop-outs": individuals and households who have lost their livestock as a result of cyclical drought, insecurity and cattle rustling and migrated to the urban centers as a survival tactic.

Key Observations on Performance

- The Project identified and developed agreements with local implementing partners (LIPs) providing support to vulnerable households with PLHIV and OVC. These LIPs were previously supported under APHIA II Eastern in Upper Eastern and APHIA II Rift Valley in Samburu county. They have either been given fixed obligation grants (FOGs) or sub-grants to continue provision of services to the most vulnerable populations.
- The Project expanded OVC/HBC services in Marsabit County, including Moyale, through the ongoing work of one of the Project partners, Food for the Hungry to continue OVC/HBC work and services through its strong grassroots network of local groups and CBOs.
- The other LIPs include: Catholic Diocese of Maralal, WAYAAP and Ripples. The Project provided TA and continued monitoring and evaluation of these LIPs to ensure quality and support for household economic strengthening and other services to vulnerable households.

Challenges

- There are few NGOs or private sector programs address household economic strengthening, especially among the marginalized and the poor. This continues to limit access to urgently needed assistance and support for establishing sustainable livelihood activities by these households.
- Inadequate livestock sector infrastructure and limited access to markets for their livestock and livestock products on which the majority of UES communities depend on means that levels of poverty are increasing each year with the frequent droughts and worsening weather effects of climate change.
- The aridity of the sub-region and the nomadic lifestyle of most communities in UES makes it challenging to initiate alternative food security and nutritional initiatives.
- Because of high illiteracy levels in UES, most households lack knowledge and productive skills needed to initiate and sustain alternative livelihoods in the face of dwindling benefits of pastoralism due to climate change and increasing population.

Planned Activities for the Next Quarter (April – June 2011)

- Improve the quality of FP/CS/RH services and support partner efforts meant to introduce diversified livelihood security capacity through linkages with partners active in livelihood initiatives. Introduction and piloting of the "Care for Mothers" model implemented in NEP will help to provide not only FP/RH knowledge and skills to women of reproductive age but will act as conduit for health education and HES actions.
- Facilitate development and ownership of alternative livelihood sources by UES community groups through community education days and include project strategic partners to provide technical assistance for HES. HES activities appropriate for UES would include kitchen gardens where water can be conserved through roof catchment and community dams,

customization of traditional artifacts for external markets, bee keeping and honey harvesting, diversified micro-enterprises in urban centers, community nature and wildlife conservancy to attract tourism, dryland farming and exploitation of high value plants that do well in ASAL areas like gum arabic, Moringa tree which has multiple uses and jatropha for bio-fuel production.

- Through the DSGs, support initiatives meant to step up peace-building efforts between conflicting communities and strengthen security services in the sub-region.
- Hold partnership discussions with the CDF committees and participate in DSGs to advocate for large-scale rain water harvesting through use of decentralized funds and relevant support partners.
- Ensure equitable access to projects benefits by the marginalized, poor and vulnerable groups and communities through area mapping and identification of more local implementing partners for OVC/HBC as well as expand the mandate of existing LIPs in subsequent quarters.

4.2 Improved food security and nutrition for marginalized, poor and underserved populations

- The main food security sector that is heavily relied on is the livestock economy described above which supports over 80% of the households in UES. In addition, a section of these communities relies on fishing, irrigation and small business enterprises for their livelihoods.
- The entire project area is currently experiencing drought due to inadequate rains for a long period. Though some beneficiaries considered most deserving have been receiving relief food through their area Member of Parliament, GOK, WFP, FH and other stakeholders, many more are experiencing difficulties which can force them to consume or sell their only assets.

4.2.1 Improved food security and nutrition for OVC

- According to FEWSNET, 100% of all the UES districts except in Samburu County are now rated as food insecure and this affects over 90% of all households with the most affected being the most vulnerable households, including the OVC-headed households and the OVC within them.

Key Observations on Performance

- Caregivers and OVC supported by the Project continued to benefit from community kitchen gardens initiated under APHIA II and currently being supported by APHIA *plus* NAL. The Project linked six PLHIV groups with 102 members in Isiolo County to food support by the GoK.

Challenges

- The prevailing drought has increased food insecurity significantly, meaning more relief food will be required in the short to mid-term.
- Most targeted households for food and nutrition support do not possess sustainable economic activities which they can rely on to meet their basic food and other livelihood needs.

Planned Activities for the Next Quarter (April – June 2011)

- Strengthen linkages with WFP and GOK relief operations to support school feeding programs, thus minimizing malnutrition risks to OVC and ensuring that learning continues. There are new schools that have not been registered under MOE and are therefore not eligible for food support. The Project will liaise with MoE to hasten the registration process.

- Review LIP OVC/HBC activities in subsequent contract period to capture Household Economic Strengthening activities. HES support includes the provision of chicken and goats that continually provide nutrition to OVC/HBC clients in terms of eggs or milk and income that is used to purchase other nutritious foods.

4.2.2 Improved food security and nutrition for PLHIV

- Other than dependence on the livestock economy, there are small-scale irrigation schemes implemented by project LIPs and other partners that are serving the PLHIV at Isiolo, Kinna, Gafarsa and Merti in Isiolo County.
- Other sources of food security and nutrition in Marsabit County are the small-scale farms in Marsabit and Moyale that rely on rain water. However, these have been badly affected by climatic change and inconsistent rainfall over the last four years.

Key Observations on Performance

- The Project started to map out existing groups of PLHIV and will continue in the subsequent quarters with the aim of identifying gaps in services and support that the Project and its strategic partners, including relevant GoK ministries, can provide.
- Some of the PLHIV groups identified had been supported with dairy goats by other partners to improve their nutrition.
- The Project linked 6 groups of PLHIV with 102 members to monthly GoK food rations in Isiolo County.

Challenges

- Aridity of over 95% of the UES sub-region makes food security and nutrition support a major challenge for any one organization and can only be addressed through multi-sectoral efforts with significant GoK inputs. Even where land is arable like in Marsabit Central, Isiolo and Samburu, rain and/or water for irrigation remains a major challenge. APHIAplus NAL will identify workable initiatives to address food security and nutrition and leverage the resources of other partners to address existing gaps.
- The Project has the challenge of going around the existing GoK policy on famine food relief that states people in central divisions of each affected district are not eligible for food relief because they are thought to be urban poor who have coping mechanisms. This excludes the very poor and vulnerable households, most of whom are pastoralist dropouts who have lost their livelihoods and way of life.

Planned Activities for the Next Quarter (April – June 2011)

- Discuss and plan together with strategic partners involved in community economic strengthening initiatives to support PLHIV and women groups that engage in petty trade, e.g. restocking programs, beekeeping, etc.
- Influence the DSG to include PLHIV and pastoralist dropouts in the government basket that covers pockets of vulnerable populations in the central divisions through support for small-scale business ventures that would support them in the towns. This could be in the form of micro-credit and or small grants and related capacity-building.
- The Project will expand upon the partnership with NHP which supports food by prescription and nutrition status monitoring to malnourished PLHIV through the Comprehensive Care Centers (CCC).

4.2.3 Improved food security and nutrition for pregnant women and TB patients

- Pregnancy and breastfeeding are the most nutritionally demanding times of a woman's life. The pregnant and lactating woman needs enough nutrients every day to support the growth of the baby and the maintenance of the mother's body. It is also important for her to eat the

right foods every day since the fetus' tissues and organs develop rapidly during certain weeks of pregnancy.

- TB clients are also given good attention at the health facilities and put on food by prescription when they are malnourished. However, they do not receive similar attention at home.

Key Observations on Performance

- During the community assessment, project teams observed that there is no special diet that women are given, particularly in the rural areas. They are exposed to hard labor of fetching water and firewood just like other women until they reach second trimester, when they are allowed to do light work.
- The average ANC attendance up to the 3rd visit is up to 70% but this drops sharply with over 80% of these women delivering at home due to various cultural beliefs, misconceptions and perceptions of quality of service provided at facilities.
- Supplementary food (Unimix) is given to the severely malnourished ANC and TB clients at facilities, usually by prescription.
- Nutritional education is given at TB clinics and ANC clinics though most district hospitals lack nutritionists. Weighing of the pregnant mothers and TB clients is also common during every visit.
- Once an individual is infected with TB, there is definite negative economic effect on household food security. Such individuals need support from the community and health care providers.

Challenges

- There is limited dietary variety in the rural villages in most parts of UES where milk, meat and cereals from relief food form the staple food. There is need to supplement pregnant mothers' and TB patients' diets with vitamins and minerals through FBP and community and kitchen gardens initiatives.
- Limited awareness of the need for good diet for pregnant mothers and TB patients in rural communities who, even if they are aware of these needs, are usually constrained by poverty and food insecurity.

Planned Activities for the Next Quarter (April – June 2011)

- Ensure integration of TB screening in mobile outreach programs.
- The Project will promote healthy nutritional practices (including early and exclusive breastfeeding) for PLHIV, lactating women, and children under 5 through facility and community health education days and messages passed during integrated community outreaches.
- Create awareness in the community through Community Units, CHWs and community radio on the importance of diversifying diets for better nutrition, especially for pregnant mothers, newborns and TB patients.
- Support provision of educational materials designed to improve the dietary habits of pregnant mothers and TB patients.
- Support monthly nutritional assessment for both pregnant mothers and TB patients and more regular supplementary and therapeutic feeding and FBP to address gaps identified in facilities.
- Collaborate and liaise with the OOP through the DCs and DMOHs to prioritize TB patients in the allocation of GoK food relief (maize/beans).
- Support supplementation and FBP at the facility level as well as community and kitchen garden initiatives for pregnant mothers and TB patients.

4.3 Marginalized, poor and underserved groups have increased access to education, life skills, and literacy initiatives through coordination and integration with education programs

- Almost all the villages in the UES have primary schools and early childhood education classes are common in the urban settings. However, enrollment and completion rates are very low due to poor education infrastructure, limited supervision for quality education, harsh climatic conditions, gender inequalities and increased poverty levels in the community.
- Inadequate education infrastructure including buildings, toilets and water; inadequate competent teaching staff, numerous levies that the poor cannot afford and corruption in some schools are some of the other key factors behind poor performance and uptake of basic education in the sub-region, often leading to high dropout rates.

Key Observations on Performance

- In the reporting quarter, the Project conducted a baseline community assessment that included an overview of high-volume primary and secondary schools that would inform its school health program and outreach to in-school youth activities.
- The Project identified 12 secondary schools and 36 primary schools in the sub-region that it plans to work with in rolling out the school health program starting in the next quarter.

Challenges

- Poor performance in KCPE in rural schools is prevalent due to lack of refresher courses and motivation by teachers as well as inadequate leadership and management skills by school management committees.
- High dropout rates, particularly among girls, is aggravated by the existing cultural beliefs and practices that include prioritization of boys over girls in formal education and early marriages, sometimes forced in exchange of dowry to increase the dwindling stock levels due to drought and rustling.
- Drug abuse, especially in urban centers, contributes to early pregnancies and early marriages of girls.
- Low literacy levels due to limited investment by successive GoK administrations and failure of local MPs to articulate this need in parliament.
- Life skills training is a new concept in the sub-region that needs customization to reach the most deserving.

Planned Activities for the Next Quarter (April – June 2011)

- Participate in discussions with the 12 DEOs, DSGs, district children's departments, school boards, heads and patrons to identify ways of increasing school performance, including capacity-building of teacher and school boards and addressing the high dropout rates, particularly of girls.
- The Project will incorporate training in life skills targeting school health program patrons, other teachers and school children through the clubs.
- Conduct at least four life skills trainings through the Project LIPs and school health clubs.

4.4 Increased access to safe water, sanitation and improved hygiene

- The national guidelines state that each person in a rural village should be entitled to 50 liters of water per day while those in urban settings should have access to at least 60 liters per day.

Key Observations on Performance

- A significant minority of households in UES have access to safe and adequate water. There is no permanent or piped water supply in most rural areas of the sub-region. The communities rely on boreholes and dams which are dry most of the time. Those in urban areas are constrained primarily by the cost of water sold by vendors.
- The community assessment teams noted that most schools have sanitation infrastructure, i.e. latrines and hand washing facilities, but are generally not committed to maintaining good hygiene and sanitation standards.
- The Project noted that environmental hygiene in homesteads, schools and facilities is not a top priority. Construction of compost pits and incinerators for proper disposal and burning of refuse is required.
- During interviews with FH and MoH counterparts in Marsabit, the Project noted that members of some PLHIV groups in Marsabit County have been provided with water tanks by partners supporting them.

Challenges

- Poor capacity of the local water management committees for the existing water systems in the urban areas leads to frequent water supply breakdowns, illegal connections due to corruption and poor planning for the water and sanitation needs of the rapidly increasing urban population.
- Sanitation and hygiene in many rural households, villages and schools is not a top priority.
- Due to chronic poverty, communities lack resources and initiative to provide water to health facilities and schools. These facilities present opportunities for collecting water during rainy seasons.

Planned Activities for the Next Quarter (April – June 2011)

- Liaise with partners with WATSAN initiatives in the region – including Food for the Hungry, Arid Lands project II, Pastoralist Integrated Support Program (PISP), World Vision, Cordaid and the Kenya Red Cross society – in conjunction with the Ministries of Development of Northern Kenya, Water and Health, to improve water storage, availability and treatment, particularly in health facilities and schools.
- Support organization of regular WATSAN partners meetings and outreaches to address water and sanitation challenges.
- Conduct OJT and CMEs on infection prevention for facility staff. Continue to conduct hygiene education through school health clubs and assemblies in collaboration with the DPHOs, school health club patrons and CHEWs.
- Support community outreach on sanitation, hygiene and disease prevention by school children. Songs and dramas during school parents' gathering is one avenue for conveying information.
- Refer highly deserving groups of clients like post-test clubs, pastoralist villages and the poor in urban slums to strategic partners with WATSAN initiatives and opportunities.
- Through DSGs, advocate for improved management of urban water supply through review of existing policy and systems on urban water supply management.
- Through the school health clubs, use the club members to actively involve the school community in environmental hygiene and awareness creation among the communities in the nearby villages. This will include advocating to the schools management and the families of the children to provide leak tins and soaps for hand washing. Two schools per district are targeted in the next quarter.
- The DPHOs shall be involved in hygiene education for the school health clubs.

4.5 Strengthened Systems, Structures And Services For Protection Of Marginalized, Poor And Underserved Populations

- The marginalized, poor and underserved in UES include the small minority groups like the Dasnach and Elmolo, small populations of pastoralist dropouts of communities located elsewhere but who migrated to live around and within major UES towns where other communities are predominant, e.g. Turkanas in Maralal and Isiolo, Samburus in Isiolo and Laisamis etc.
- The minority urban groups are generally marginalized politically and therefore lack a voice in demanding for rights and share of urban resources.
- Other groups that fall under this category are the OVC and PLHIV.

4.5.1 Orphans and Vulnerable Children

- The Project continued to provide the standard OVC care and support services in line with the PEPFAR OVC guidelines, picking up from where the APHIA II programs left off.
- APHIAplus NAL strategy is to identify the most vulnerable communities and households for appropriate interventions. Households with OVC automatically fall into the Project's targeted groups. In delivering services to OVC, care is taken to not further marginalize the other members of the household by providing services that can, as much as possible, also benefit both the supported child as well as other members of the household. Purchase of blankets, mattresses, dairy goats, referral to GoK relief food distribution, etc and TA for establishment of kitchen gardens will also benefit the other members of the household.

Key Observations on Performance

- In UES, APHIAplus NAL transitioned 4 OVC/HBC LIPS, 3 from APHIA II Eastern and 1 from APHIA II Rift Valley. There are potentially 4 more to be brought on board in the next quarter.
- The four LIPs include FH, WAYAAP, Ripples International, and the Catholic Diocese of Maralal. The LIPs and partners continued to offer primary direct and supplemental direct support to the OVC supported by the Project.
- The Project participated in an AAC meeting supported by Children's Office in Moyale district.
- Most Vulnerable Committees (MVCs) in schools were supported for lobbying and advocating for the OVC issues relevant to the school, particularly waivers.

Challenges

- The AAC meeting in Moyale reported that a high number of children from vulnerable families are going out to the streets.
- There are no decentralized structures below the district level from the Children's Department and there are only 11 LOCs in the entire UES sub-region. VCOs are nonexistent. This makes it very difficult for the Children's Department to provide services to OVC.
- High expectations on the Project for OVC/HBC support from GoK, communities and potential LIPs.
- High levels of poverty among the most vulnerable households that lack productive skills and assets.
- High cost and logistical challenges of doing outreach in neglected districts of UES such as Loyangalani and North Horr; these remote districts lack local implementing partners.

Planned Activities for the Next Quarter (April – June 2011)

- In conjunction with the DCOs, DMOs, and DMOHs, map out the marginalized areas and identify potential LIPS that the Project can work with through FOG arrangements to provide OVC/HBC and HES services to the most vulnerable households. The Project plans to participate in the district/AAC meetings in the 10 functional districts and support the strengthening of LOC and VCO systems in the region.
- Provide logistical support to the Children's Department and collaboratively work with the Project LIPs to identify and support the vulnerable children.

- Continue mapping of the marginalized areas and identify potential LIPS that the Project can work with through FOG arrangements to provide OVC/HBC and HES services to the most vulnerable households.

4.6 Expanded Social Mobilization for Health

- The major health care providers in UES are the government, faith-based organizations and private clinics/chemists. Very few of the private clinics provide nutrition, FP/RH or HIV/AIDS services. Since they are profit-oriented, the private clinics normally provide diagnostic and curative services.
- The structures that exist for the management of health services are DHMTs for rural facilities and HMTs that manage district and sub-district hospitals. District Health Stakeholders Forums, Facility Management Committees, Community Units, networks of CHWs, community-based organizations and key community groups are other key structures for increasing access to and improving the quality of health services.
- The District Health Stake Holder Forum (DHSF) has a mandate to discuss issues related to access, quality, equity and coverage of health services and other emerging health priorities in the respective districts. The D/HMT is the moderator.

Key Observations on Performance

- In the Jan- March quarter, APHIAplus NAL focused on assessment of the community outreach programs, forming a baseline to guide future actions. The assessment teams observed and learnt that effective mobilization to create demand for quality health products, services and information can be achieved through strategic partnerships, collaboration and involvement of community gate keepers, District Health Stakeholders Forums, Facility Management Committees, Community Units, networked of CHWs, community-based organizations and key community groups e.g. youth groups, women groups and support groups of PLHIV.
- Community FM radio stations can be used to effectively reach large catchment populations with basic health messages and information aimed at risky behaviour change and adoption of better health practices.

Challenges

- Conventional health seeking behavior is limited because of the low levels of education coupled with strong cultural and religious beliefs. Due to myths and beliefs, some diseases are still associated with evil spirits, “bad eyes”, etc.
- The traditional herbalists command a strong following and pose a strong challenge to modern medicine. There is a need to find ways of working with them to improve access to better health practices.
- Negative attitudes towards health facilities and health services by local religious and cultural leaders because they have not been adequately involved in health system management and health service delivery.
- Weak capacity and limited involvement of the Facility Management Committees, resulting in missed opportunities for strengthening community/facility referrals and linkages.
- Under-utilization and dormancy of a good number of existing CHWs trained by various organizations due to failure to plan for and implement incentives programs.

Planned Activities for the Next Quarter (April – June 2011)

- Complete the on-going assessment of community structures and mapping of key community opinion, religious and cultural leaders, key community-based organizations and groups in readiness for appropriate and social mobilization for health action.
- Engage with key religious, cultural and opinion leaders to win their support for community mobilization for health.

- Engage with owners and managers of private facilities to identify points of synergy in the delivery of quality health services, products and information. Such services that would interest private clinic owners would include packages of free HCT/PMTCT and paid for skilled delivery/maternity services, free laboratory support in exchange for free CT and waiver/subsidized additional diagnostic services and dispensing of free condoms.
- Provide OJT/CME and TA to increase the management capacity and effectiveness of FMCs and DHSFs.
- Coordinate with D/HMTs and DHSFs to organize trainings and incentives for CHWs who will then be involved as champions of social mobilization for health. In the next quarter, the Project has planned refresher training for 60 CHWs in 3 community units across the 3 UES counties in collaboration with DPHOs. 41 more CHWs in rural areas within the CUs will be given incentives and a basic monthly travel and lunch allowance while doing social mobilization for integrated health outreaches, clients monitoring and referrals. The incentives for the CHWs under the CUs will be sustained by linking them to the HSSF fund through facilities that have been incorporated into the fund. This can also be incorporated into the OBA and results-based financing based on their efforts in referring mothers for PMTCT and skilled deliveries.
- Map out existing community/vernacular radio stations in the sub-regions for social mobilization for health and behavior change communications. Examples include Serian FM in Samburu and Marsabit FM in Marsabit. These stations will be instrumental for public health education on HIV/AIDS, safe motherhood, and adolescent sexual and reproductive health, and provide information on products and services that are available at GoK facilities.

Monitoring and Evaluation

Key Highlights

Whereas the project conducted a comprehensive assessment on the status of the facilities, its primary focus was to understand the status and adequacy of facilities to provide services in the area of HIV/AIDS, MCH/RH, TB and malaria. The assessment investigated some of the principal barriers to effective case-management practices while at the same time looked at the adequacy of furniture, equipment and infrastructure in relation to the project mandated areas. Another key aim of this activity was to serve as a baseline against which to assess APHIAplus NAL's outputs and eventual impact. A total of 40 high-volume facilities were assessed and preliminary analysis was conducted during the period under review.

Support to FOG (Fixed Obligation Grant) partners

In the quarter under review, APHIAplus NAL identified and entered into partnership with three organizations working with OVC and HBC clients. Preparatory assessments were made and the M&E team was able to pay a visit to these partners before the engagement was formalized. These assessments by the M&E team established targets for creating or improving on reporting as stipulated by USAID. They also acted as a needs assessment that has since seen the project fast-track the printing of revised data collection tools as required by the FOGs. The need to support APHIAplus NAL partners to report accurately and in a timely manner will guarantee a double-barrel effect: a) it will instill a culture of reporting for accountability purposes in the NAL region and b) assist the implementing partners in utilizing data for decision-making. The regular interaction with the partners enabled the project to report during the semi-annual period in an accurate and timely manner.

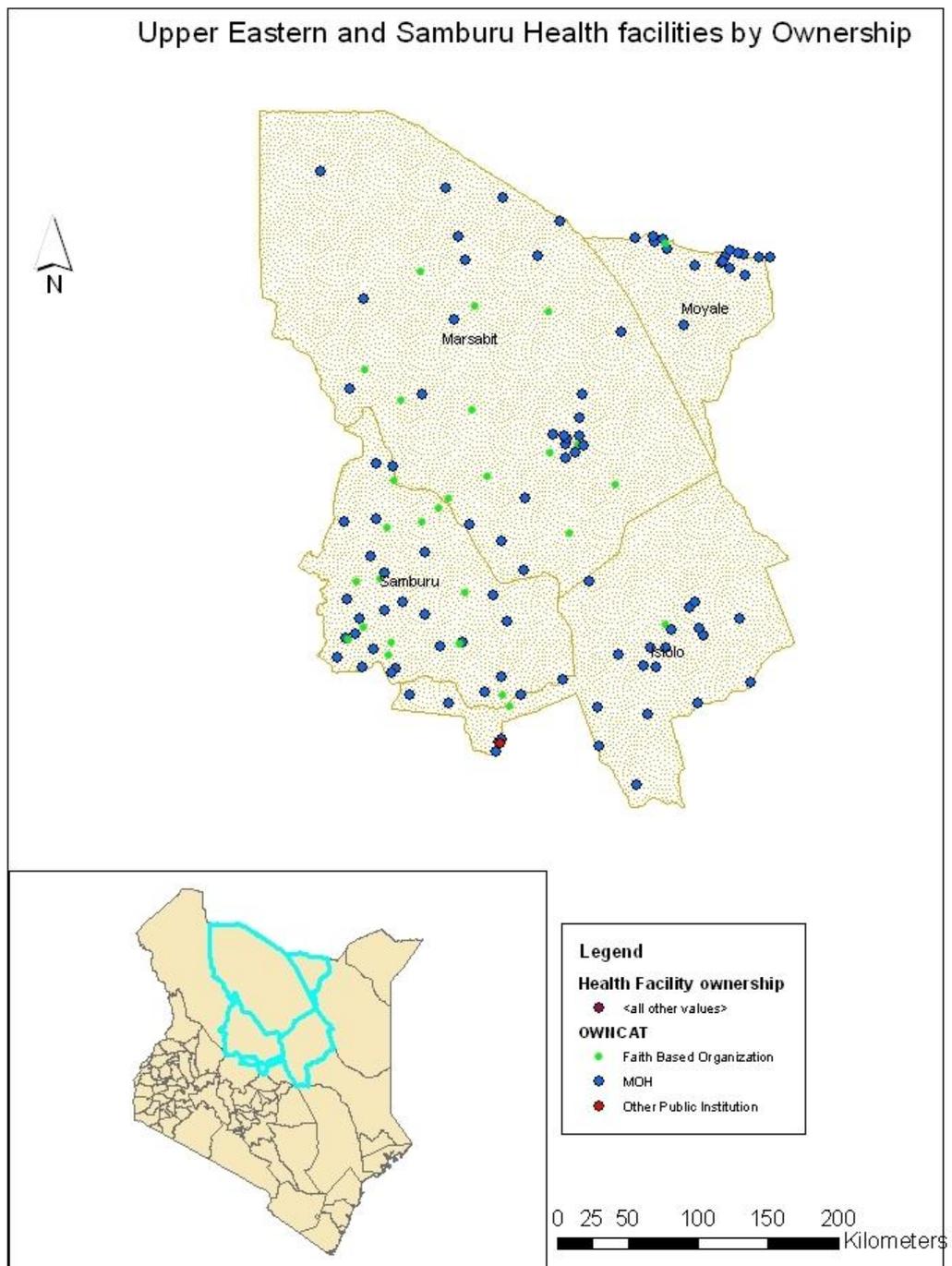
Support to Health Facilities

Some observations made during the quarter:

- Acute staff shortage in some health facilities leads to poor record keeping and late submission of data.
- Inaccurate and untimely submission of reports to the district from most of the health facilities.

- The MOH 711 monthly summary reporting tool is not available in the district. Only 20 copies of the same were received from the province last year and distributed to high volume facilities within the district. Some facilities within the district did not receive the reporting tool.
- There is need for the DHMT to strengthen support supervision to all health facilities within the district.
- There is need to conduct routine data quality audits/ assessments.

Figure 16: Facilities Map – Upper Eastern and Samburu



TURKANA SUB-REGION



Table 22: Achievements against targets

Performance Indicator	Jan-Mar 2011	Turkana Target	% Year 1 Target Achieved
PREVENTION			
# of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence	0		TBD
# of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond and/or being faithful	0		TBD
GENDER			
# of people reached by an individual, small group or community level intervention that explicitly address norms about masculinity	0		TBD
# of people reached by an individual, small group or community level intervention or service that that explicitly address the legal rights and protection of women and girls impacted by HIV/AIDS	0		TBD
# of people reached by an individual, small group or community level intervention or service that that explicitly address aim to increase access to income and productive resources of women and girls impacted by HIV/AIDS	0		TBD
MARP			
# of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	0		TBD
PREVENTION WITH POSITIVES			
# of (PLHIV) reached with a minimum package of prevention with PLHIV (Pw) intervention	0		TBD
SEXUAL AND OTHER BEHAVIORAL RISK PREVENTION			
# of targeted population reached with individual and/or small group level prevention interventions that are based on evidence and/or meet the minimum standards required	0		TBD
# of targeted population reached with individual and/or small group level prevention interventions that are primarily focused on abstinence and/or being faithful and are based on based on evidence and/or meet the minimum standards required	0		TBD
IR3: Increased use of quality health service, products and information			
COUNSELING AND TESTING			
# of service outlet providing counseling and testing according to national or international standards	20	35	57
# of individuals who received testing and counseling services for HIV and received their test results	1,964	7,000	28
HIV/AIDS TREATMENT/ARV SERVICES			
# of children with advanced HIV infection newly enrolled on ART	7	20	35
# of adults with advanced HIV infection newly enrolled on ART	24	230	10

Performance Indicator	Jan-Mar 2011	Turkana Target	% Year 1 Target Achieved
# of children with advanced HIV infection receiving ART (currently)	27	180	15
# of adults with advanced HIV infection receiving ART (currently)	187	900	21
# of children with advanced HIV infection who ever started on ART	31	200	16
# of adults with advanced HIV infection who ever started on ART	253	1,000	25
% of adults and children known to be alive and on treatment 12 months after initiation of ART	Not reported	80	0
% of HIV positive persons receiving CD4 screening at least once during the reporting period	Not reported	850	0
# of HIV positive persons receiving CD4 screening CTX prophylaxis	Not reported	1,800	0
# of HIV clinically malnourished clients who received therapeutic or supplementary food	Not reported		0
PREVENTION OF MOTHER TO CHILD TRANSMISSION			
# of services outlets providing the minimum package of PMTCT services according to national or international standards	90	35	257
# of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1,496	4,000	37
% of HIV positive pregnant women who received ART to reduce the risk of MTCT		80	0
# of HIV positive pregnant women newly enrolled into HIV care and support services	33	250	13
# of infants tested for HIV at 6 weeks	2	200	1
% of infants born to HIV+ women who received and an HIV test within 18 months of birth		50	0
# of HIV exposed infants provided with ARVs prophylaxis	33	250	13
PALLIATIVE CARE (EXCLUDING TB/HIV)			
# of individuals provided with HIV related palliative care (excluding TB/HIV)	72	400	18
# of individuals provided with HIV related palliative care (including TB/HIV)	60	70	86
% of HIV positive patients who were screened for TB in HIV care or treatment settings		80	0
# of HIV positive patients in HIV care or treatment (pre-art or ART) who started TB treatment	14	50	28
# of TB patients who received HIV counseling, testing and their test results at USG supported TB outlets	217	800	27
VMMC			
# of VMMC clients	0	400	0
MNCH/RH/FP/SI			
# of deliveries performed in a USG supported health facility	274	1,200	23
# of ANC visits with skilled providers in USG supported health facilities	1,398	7,000	20

Performance Indicator	Jan-Mar 2011	Turkana Target	% Year 1 Target Achieved
# of children less than 12 months of age who received DPT3 from USG supported programs	847	4,900	17
# of children <5 years of age who received vitamin A from USG supported	2,204	10,000	22
# of new FP acceptors as a result of USG assistance by FP method	6,228	4,000	156
Pills	94		
Injections	372		
I.U.C.D.	0		
Implants	0		
Male Sterilization	0		
Female Sterilization	0		
Condoms	5,562		
Other	200		
3.1 increased availability of an integrated package of quality high impact intervention at community and facility levels			
# of services availability of an integrated package vitamin A from us supported program	0	12	0
# of service outlets providing HIV-related palliative care (excluding TB/HIV)	24	35	69
# of service outlets providing HIV-related palliative care (including TB/HIV)	57	35	163
# of service outlets providing PEP	13	15	87
% of pregnant women receiving 2 doses of IPT	0	50	0
# of service outlets providing clinical prophylaxis and/or treatment for TB to HIV-related individual (diagnosed or presumed according to national or international standards)	57	20	285
# of USG assisted service delivery points providing FP counseling or services	90	35	257
CYP provided through USG supported programs	346	900	38
# of targeted condoms service outlets	0	30	0
# of condom distributed (GOK health seek indicator and standard OP	0	5,000	0
% of district with community IMCI intervention	0	70	0
# SP participating in CME or CE	0	50	0
# of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MNCH services by facility type	0	20	0
% of facilities with stock outs of methods	0	20	0
# of service outlets with full contraceptive method mix	0	8	0
# of mobile units with providing testing	0	18	0
# of service outlet with youth friendly services	0	5	0
3.2 Increased demand for a integrated package of quality high impact intervention at community and facility			
# of facilities with private counseling areas	0	9	0

Performance Indicator	Jan-Mar 2011	Turkana Target	% Year 1 Target Achieved
# of facilities with functioning facility management committee	0	15	0
3.3. Increased adoption of healthy behavior			
# of BCC products distributed by type	0	5	0
3.4 Increased program effectiveness through innovative approaches			
% of facilities use data for performance monitoring	0	70	0
# of CU using data for DM	0	3	0
# of eligible adults and children provided with a minimum of one care service	0	4,000	0
# of local organization and service points provided with technical assistance for strategic information	0	35	0
IR4: Social determinant of health addressed to improve the wellbeing of the community, especially marginalized poor and underserved population			
4.1. Marginalized poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs			
# of people actively involved in economic security initiatives through project linkages	0	200	0
# of PLHIV support groups formed and/or linked to other service as appropriate	0	3	0
4.2: Improved food security and nutrition for marginalized poor and underserved population			
# of eligible clients who received food and/or other nutrition services	0	3,500	0
4.3: Marginalized poor and underserved groups have increased access to education, life skills and literacy initiatives through coordination and integration with education program			
# of schools supported by child friendly program	0	30	0
# of youth trained in life skills	0	2,500	0
# of OVC enrolled in ECD program through APHIAplus referrals	0	500	0
4.4: Increased access to safe water, sanitation and improved hygiene			
# of water and/or sanitation projects established in project supported facilities through linkages with us funded WSS project	0	10	0
# of organization and outlets selling POU and SW project through linkages with HCM project	0	20	0
# of hygiene sessions held at schools	0	70	0
4.5 Strengthening systems, structures and services for protection of marginalized poor and underserved population			
# of OVC assisted by the project to obtain legal birth certificate	0	1,000	0
# of VHH identified and referred to services	0	250	0
4.6 Expanded social mobilization for health			
# of RL who are advocating for reduced stigma and improved MNCH	0	2	0

RESULT 3: INCREASED USE OF QUALITY HEALTH SERVICES, PRODUCTS AND INFORMATION

3.1 Increased availability of an integrated package of quality high-impact interventions at community and facility levels

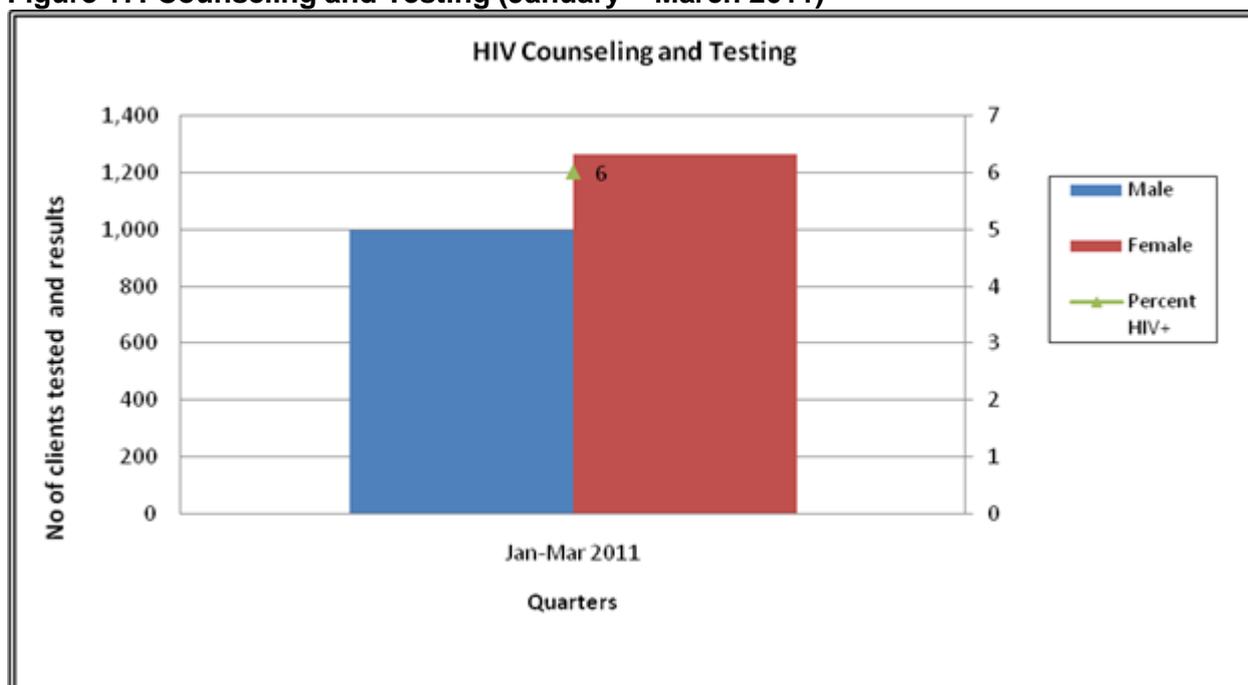
3.1.1 Counseling and Testing

Less than half of the all facilities in Turkana County offer VCT services according to the assessment done by APHIAplus NAL. In addition, none of the outreach services offer the service. The project will support counseling and testing as an evidence-based prevention strategy for MARPs as well as the general population. The approaches are PITC, VCT and DTC. Non-conventional methods such as mobile outreach and moonlight will also be utilized.

Table 23: Counseling and Testing Performance (January-March 2011)

Reporting period	Male	Female	Percent HIV+	Total
Jan-Mar 2011	995	1,262	6	2,255
Year 1 Target (APHIAplus)				7,000
Total as percent of Year 1 Target (Turkana)				32%

Figure 17: Counseling and Testing (January – March 2011)



Key Observations on Performance

- There are other USG-supported organizations such as IRC and EGPAF which are providing counseling and testing services in high-volume facilities in Turkana County. APHIAplus NAL, under the coordination and leadership of the DHMTs, is complementing these efforts by supporting peripheral facilities and outreach interventions to reach those with limited access to services.
- HIV prevalence in women appears to be almost double that of men. APHIAplus NAL will seek to find out the reasons for this in the upcoming Sexual Network Assessment to be conducted in Lodwar in the next quarter.
- From the results, more people access PITC at health facilities than standalone VCT services, most likely because of high levels of stigma. Therefore the Project will focus on promoting PITC through OJTs and protocol dissemination as well as utilize innovative approaches such as moonlight VCT to increase service uptake.

Challenges

- There have been reported cases of stock outs of test kits within facilities and at the district headquarters.
- The room temperatures in Turkana vary markedly with the norm being greater than the average 25°C, this necessitates use of air conditioning (absent in all facilities except the district hospital) or fridges which most facilities lack.
- Most facilities have been slow to embrace PITC with the result being lower number of clients tested than would be expected based on monthly facility workloads.
- Stigma is still a barrier to HIV testing and counseling within the County.

Planned Activities for the Next Quarter (April - June 2011)

- Providing transport and allowances to DASCO for distribution of test kits during supervision visits to address stock outs of test kits at facility level.
- Advocate for solar or LPG powered cold chain equipment with MOH (utilizing the APHIAplus NAL resource envelope) and other partners including UNICEF/WHO and Ministry of Energy.
- Explore with the DPHNs/DASCOs/DMOHs the possibility of using vaccine cold chain equipment for the storage of HIV test kits or look for innovative ways of getting cool boxes which can store the kits using ice packs.
- Support St Patrick's dispensary for moonlight VCT for at least 10 nights in a month targeting MARPs in Lodwar Town.
- Implement testing and counseling services in 8 integrated mobile outreaches through MOH and partners (AIC and DOL).
- Conduct OJT and mentorship on PITC during the DHMT support supervision in 6 facilities.

3.1.2 Palliative Care TB/HIV

A high TB/HIV co-infection rate necessitates continued support for TB/HIV collaborative activities to increase efficiency and improve quality of services offered to patients.

Table 24: TB Indicators (January – March 2011)

Indicators	Children 0-14 yrs		Adults >14yrs		Totals by Gender		Totals
	F	M	F	M	F	M	
TB cases detected	9	4	79	179	88	183	271
Smear positive	0	0	26	87	26	87	113
Smear negatives	3	10	56	63	59	73	132
Extrapulmonary TB patients on treatment	7	1	31	28	38	29	67
TB patients on re-treatment	2	0	3	110	5	110	115
TB Patients tested for HIV	2	0	23	21	25	21	46
TB Patients HIV+	7	3	36	121	43	124	167
TB HIV patients on CPT	8	3	51	155	59	158	217
Defaulters	3	3	12	42	15	45	60
TB patients completed treatment	2	3	23	56	25	59	84
TB deaths	0	1	2	4	2	5	7

Key Observations on Performance

- From the above table it is clear that there is low TB case detection in the pediatric age group and there is also a markedly lower rate of TB prevalence in women than in men. This highlights challenges facing health workers in pediatric TB case detection.
- Creating awareness on TB at community level remains a priority and support for initiatives such as World TB day is important. APHIAplus NAL assisted in the planning and implementation of World TB day in Lodwar.

Challenges

- The low TB case detection in children can be attributed to variety of factors including shortage of trained health workers, lack of TB diagnostic equipment (such as microscopes and staining equipment, X-ray machines) and low immunization coverage rates among children.
- There are high numbers of TB treatment defaulters and TB treatment centers have inadequate capacity to conduct client follow-up.
- TB diagnostic and treatment centers are few and face logistical problems in defaulter tracing.

Planned activities for the next quarter (April - June 2011)

- Disseminate national guidelines and protocols on TB/HIV
- Conduct OJT on pediatric TB case detection for health workers in 15 ART sites.
- Orientation of available community health workers on TB case detection, referral and treatment follow-up (CB DOTS).
- Provide logistical support (fuel, allowances) to the 3 DHRIOs to distribute TB/ART registers and mentor 15 facility in charges on data capturing and reporting.
- Conduct 1 CME on TB diagnosis and treatment in Turkana North/West districts.

3.1.3 Palliative Care (excluding TB/HIV care)

Key Observations on Performance

- TB is the leading opportunistic infection in Turkana County based on numbers of people receiving palliative care for non-TB/HIV versus TB/HIV palliative care.
- The County has 3 CD4 count machines; 2 in Turkana North, 1 in Turkana Central and none in Turkana south. During the health facility assessment, the CD4 machine in AIC Lokichoggio (Turkana North) was not in use because of lack of reagents. All these sites are CDC-supported through EGPAF.

Challenges

- There is weak laboratory networking leading to slow processing and dissemination of CD4 test results to clients in peripheral facilities.
- There are few PLHIV groups and no functional home-based care programs in the County.

Planned Activities for the Next Quarter (April - June 2011)

- Develop a lab networking protocol for sample collection, transportation and dissemination of results to clients in the County.
- Provide transport to DTLC to conduct OJT to 15 TB diagnostic sites on palliative care.
- Facilitate complementary programming and filling of gaps by supporting quarterly DHSF meetings and ensuring that the meetings achieve their objectives.

3.1.4 HIV/AIDS Treatment/ARV Services

Key Observations on Performance

- There is an overall low enrolment of children into ARV programs in the County. This could be linked to the few facilities offering ART and a lack of EID services in the facilities.
- During the facility assessment it was clear most facilities were not aware of or were not using the national guidelines.
- Incompleteness of key data reports reflects in several missing indicators such as numbers of patients in cotrimoxazole prophylaxis or numbers receiving CD4 screening during the reporting period. These will need to be strengthened so that reports reflect the true number of clients receiving HIV care and treatment.

Challenges

- ARV service provision is focused around the few towns and trading centers in the County. This implies a lack of access to the majority of the population that resides in remote scattered villages in the County.
- There is a County-wide shortage of staff trained in pediatric and adult HIV care and treatment, with the few available staff opting to work in urban facilities.
- Lack of strong community and facility linkages makes it difficult to follow-up clients on home-based care.
- There is an unmet need for nutritional support through food by prescription.

Planned Activities for the Next Quarter (April - June 2011)

- Based on the results of the health facility assessment exercise, identify 10 sites and initiate ART services including obtaining and disseminating ART guidelines, protocols and SOPs to the staff in each site.
- Provide transport support for the FBP commodities from the central stores to the peripheral ART facilities.
- Strengthen ART mentorship through quarterly support supervision by the DASCOS.
- Orient CHWs on home-based care and reporting.

3.1.5 Condoms and Other Prevention Activities

Key Observations on Performance

- Most potential condom distribution outlets, especially in hotels, lodges and bars within the towns, lack condom dispensers.
- There is lack of involvement of youth groups, CHWs and other sexually active community groups like the hawkers, matatu touts, and support group members in condom promotion activities.
- It has been observed that at night, within entertainment areas in Lodwar town, there are usually groups of young men and women loitering around entertainment areas. These areas can be targeted for condom distribution.
- The Catholic Diocese of Lodwar, which provides facility and outreach-based health services to a majority of the population, does not promote condom use.
- The health facility assessment showed that VMMC is not offered as a routine service in any of the health facilities.
- During the survey very few facilities had condom dispensers, and even the few that had dispensers had problems with restocking. In most cases nobody seemed to be responsible for routine monitoring of the dispenser.

Challenges

- The community has a negative perception regarding condom use. Within Turkana County, the FBOs, which provide health services to majority of the population, do not promote condom use.
- Condom use among the support group members has been a challenge mainly because male partners are unwilling to use condoms.
- VMMC services are unavailable in most facilities due to lack of trained personnel, equipment and supplies.

Planned Activities for the Next Quarter (April - June 2011)

- Map sites for condom dispensers at major urban centers with involvement of MOH.
- Identify other avenues of condom distribution like CBOs, institutions, and support groups.
- Purchase/avail penile and vaginal models for condom demonstration/promotions.
- Liaise with Capacity Kenya to employ 2 teams to carry out VMMC services in Turkana North/South districts.
- Procure equipment and surgical consumables for VMC.
- Identify a VMMC team (1 surgeon, assistant surgeon, counselor, hygiene officer) to be mentored for 10 days by the NRHS on VMMC using the national guidelines and protocols while awaiting recruitment by Capacity Kenya.

3.1.6 Prevention of Mother to Child Transmission (PMTCT)

Table 25: PMTCT Cascade - Jan-Mar 2011

PMTCT Cascade	Jan-Mar 2011
Number of ANC 1st visits	1,398
No. of women attending ANC as revisits	1,204
No. of women counseled	1,426
No. of women who had HIV test at ANC	1,193
Number of mothers who learned their sero-status:	1,193
No. of women tested HIV +	23
Mothers given NVP at ANC	23
Percentage of women testing HIV+	1.9%
No infants tested for HIV after at 6WKS	2
No infants tested for HIV after at 3 months	0
Infants issued with preventive ARVs	23
Mothers tested at maternity	303
Maternity HIV	10
Deliveries	274

Figure 18: Counseling and Testing Uptake at ANC

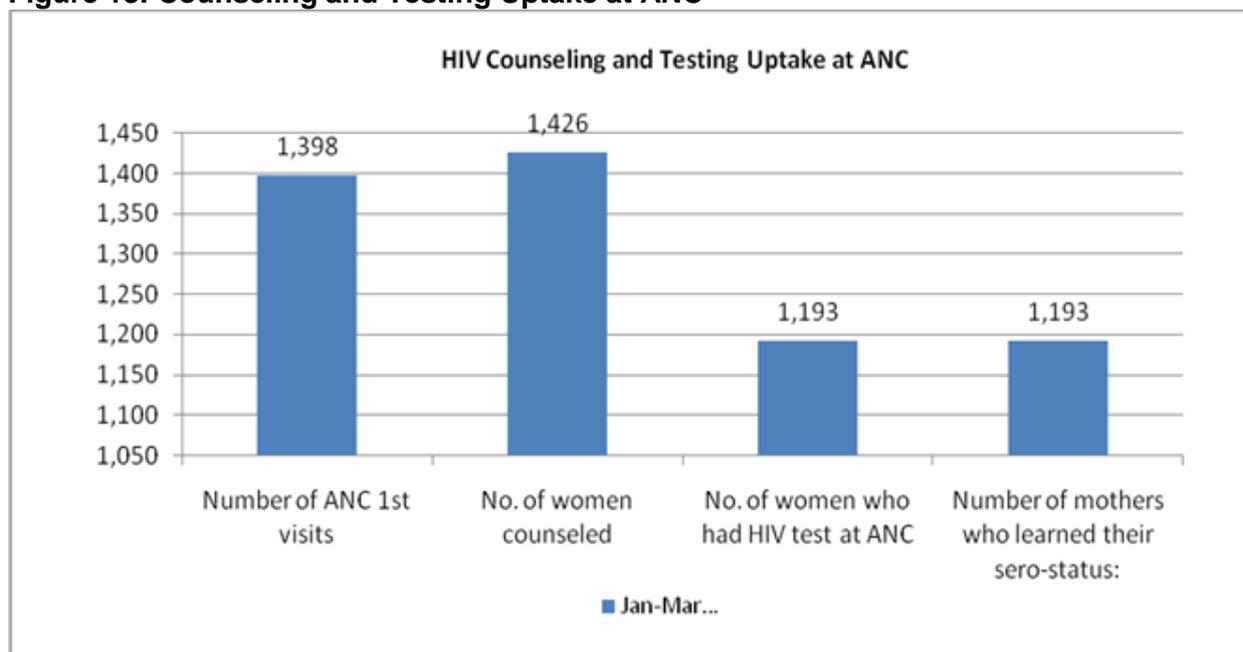
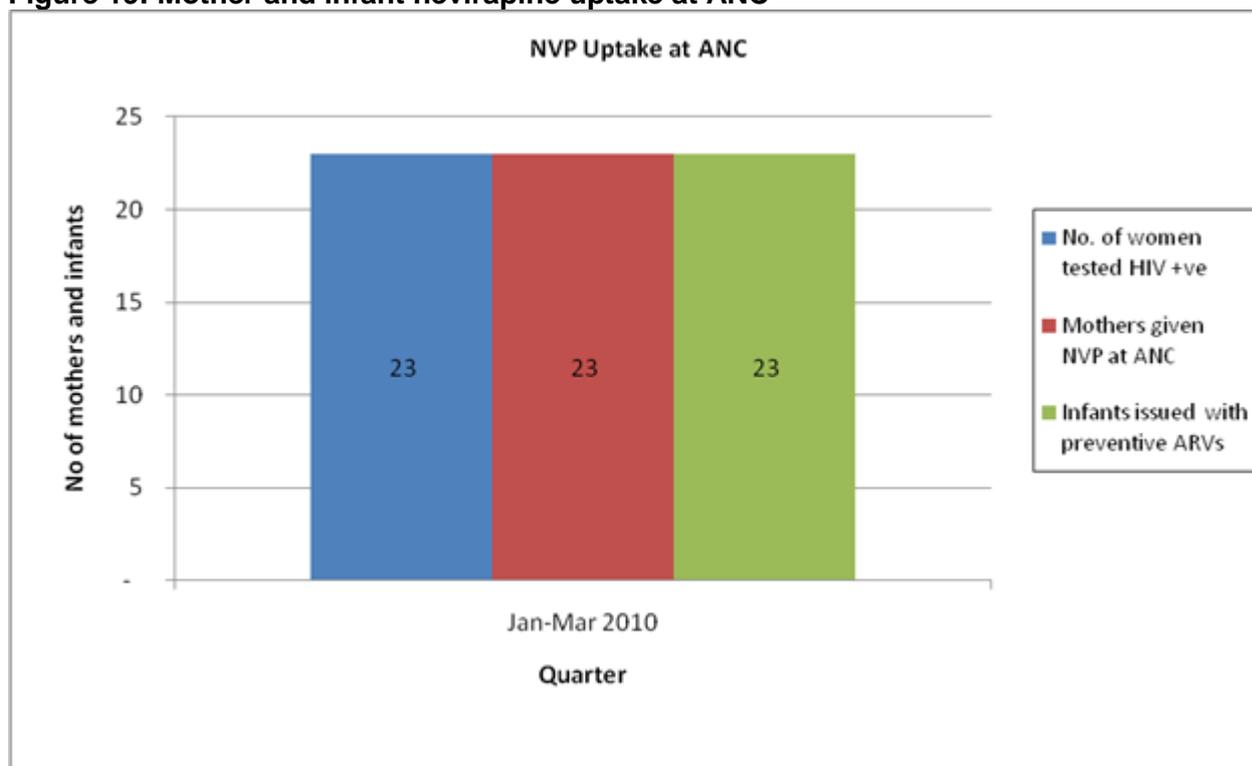


Figure 19: Mother and infant nevirapine uptake at ANC



Key Observations on Performance

- Considerable numbers of women counseled are not being tested for HIV. Reasons for this are varied including those opting out or being referred to far facilities for testing as not all facilities providing ANC are able to carry out the HIV test.
- The data received from facilities indicates that there is inadequate follow-up for HIV-exposed infants which leads to lower numbers of children on ART than would be expected based on population and HIV prevalence.
- HIV prevalence is markedly higher among women attending maternity than those in ANC, though the reasons are unclear and may be related to reporting.

Challenges

- Not all facilities offering ante-natal care are recognized as PMTCT sites in the County and thus do not receive commodities and supplies directly from KEMSA. As a result, clients are lost during the referrals.
- Collection and transportation of DBS to Lodwar by the health facilities offering PMTCT services is ineffective because staff are not clear with EID protocols and there is inadequate networking between the peripheral facilities and the referral centers. This leads to delayed EID, low pediatric ARV uptake and lack of follow-up for HIV exposed infants, contributing to high numbers of children presenting with advanced HIV infections.

Planned Activities for the Next Quarter (April – June 2011)

- Identify and establish 10 new PMTCT sites in Turkana County.
- Conduct CME/OJT on EID.
- Obtain and disseminate SOPs, registers, protocols and guidelines for HTC, PMTCT and EID.

- In collaboration with DASCO, ensure that PMTCT centers meet the minimum requirement to provide quality services.
- Conduct OJT for MCH staff on post-natal care and reporting.
- Orient the community health workers on ANC, delivery referrals and follow-up of HEIs

3.1.7 Maternal Health

Key Observations on Performance

- Majority of women are making less than the recommended 4 visits during pregnancy. This is owing to long distances to the health facilities and due to the fact that majority of the first ANC visits reported occur during the last trimester.
- During the rapid assessment it was reported that women prefer home delivery to hospital delivery which partially explains the low numbers of skilled deliveries reported by the health facilities.

Challenges

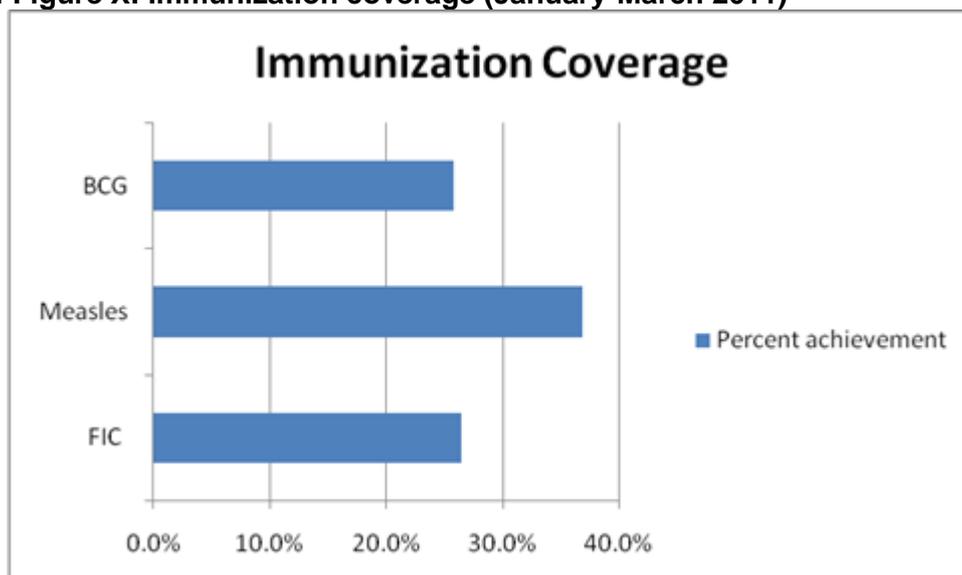
- From the facility assessment carried out by APHIAplus NAL, most health facilities do not have BEOC kits as well as other equipment such as couches, stirrups and examination/angle light.
- There is a negative attitude towards hospital delivery as it is seen as a sign of cowardice. More information is needed to fully understand this. The user fees charged by most health facilities are also not affordable to most mothers.
- Health facilities are yet to put in place functional Maternal Death Review Committees to promote maternal well-being as well as investigate and recommend local solutions to prevent maternal mortality.

Planned Activities for the Next Quarter (April – June 2011)

- Procure and distribute BEOC kits (delivery packs) for 5 health facilities.
- Obtain and disseminate EOC guidelines and maternal child health booklets to all facilities offering ANC.
- Initiate Maternal Death Review committees in 5 high-volume health facilities.
- Orientate CHWs on safe motherhood, identification of danger signs in pregnancy and referral for safe delivery.
- Support the initiation of a study by a University of Nairobi MSc student from Turkana on reasons why mothers choose not to deliver in health facilities.

3.1.8 Newborn and Child Health

Figure 20: Figure X: Immunization coverage (January-March 2011)



Key Observations on Performance

- Low numbers of children are accessing child health services such as immunization, growth monitoring and micronutrient supplementation including vitamin A.

Challenges

- 60% of facilities in Turkana do not have reliable cold chain equipment for storage of vaccines.
- Unreliable supply of vitamin A and frequent shortage of antigens from the national and provincial levels to the County.
- Difficulties in reaching the populations with immunization services due to rough terrain, insecurity and nomadic lifestyles.

Planned Activities for the Next Quarter (April – June 2011)

- Purchase 21 LPG cylinders (from the MOH resource envelope) to supplement the MOH reserve of gas to boost EPI cold chain management.
- Support the MOH with vehicle hire, fuel and allowances to conduct integrated mobile outreach services (HCT, EPI, ANC and FP services) at 6 sites serving . in hard-to-reach populations.
- Continued advocacy with HCSM and Afya House to strengthen supply of vaccines and address shortages of antigens in the health facilities.
- Provide transport for the DPHN to distribute vaccines and supplements to EPI centers.

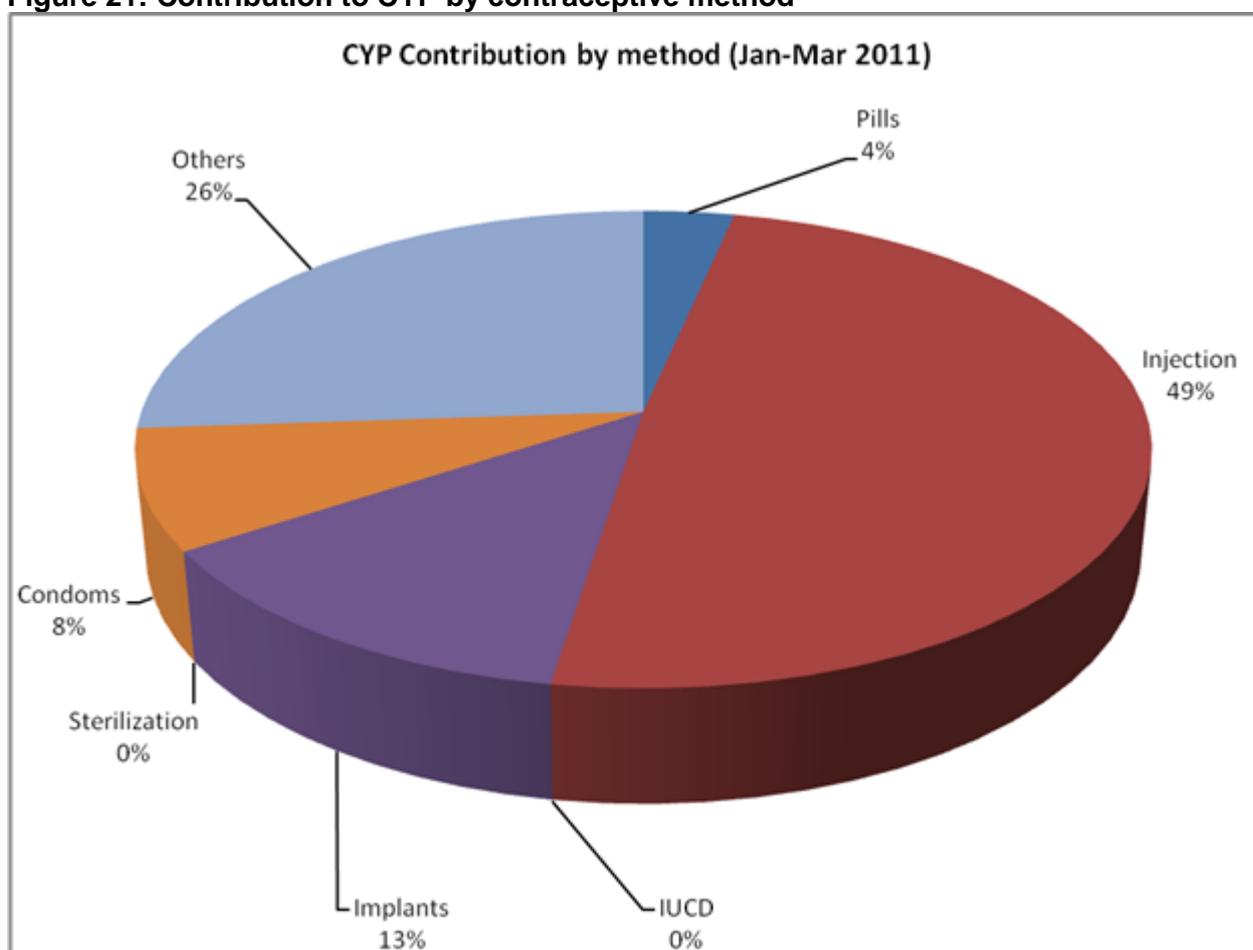
3.1.9 Family Planning/Reproductive Health

The project will equip both men, women and youth of reproductive age with information through counseling and community dialogue, as well as ensuring a mix of FP commodities is accessible in health facilities. The project will also promote dialogue among couples on FP choices. Faith leaders, community leaders and facility management committees will be sensitized through dialogue and orientation meetings on culturally acceptable methods for healthy timing and spacing of pregnancy. The project will partner with other stakeholders offering the services to ensure availability as well as strengthen reporting through provision of tools and job aids.

Table 26: Summary of FP methods provided

Methods		Jan-Mar 2011		
		New	Revisit	Total
PILLS	Microlut	133	91	224
	Microgynon	65	97	162
INJECTIONS	Injections	276	1,230	1,506
I.U.C.D	Insertion	0	0	0
IMPLANTS	Insertion	20	9	29
STERILIZATION	B.T.L	0	0	0
	Vasectomy	0	0	0
CONDOMS	No. of Clients receiving	3926	3,577	7,503
ALL OTHERS:		200	0	200
TOTAL NUMBER OF CLIENTS		4533	4896	9,429
REMOVALS:	IUCD	0	0	0
	IMPLANTS	0	0	0

Figure 21: Contribution to CYP by contraceptive method



Key Observations on Performance

Of the modern methods of FP offered, injectables are the most commonly available and used method. Cultural practices such as the wish to have many children, the community's attitude of valuing women according to how many children they bear and the objection of religious teachings towards contraception are contributors to low uptake of FP. In addition many facilities lack staff and those staff who are present often lack FP skills.

Challenges

- There is low uptake of child-spacing methods at health facilities.
- There is inconsistent recording/reporting of FP services, especially from faith-based facilities which offer natural FP counseling.
- Unavailability of the complete FP commodity mix limits the FP choices in most health facilities.

Planned Activities for the Next Quarter (April – June 2011)

- Develop and disseminate BCC messages targeting faith leaders, FMCs, men, women and youth of reproductive age on child spacing methods.
- Obtain and disseminate FP guidelines, Tiahr charts, job aids to 30 health facilities.
- Conduct OJT on reporting of FP services, especially natural methods.
- Contact MOH/KEMSA/DRH to include IUCD and CycleBeads in the method mix to health facilities offering FP and assist facilities order their start-up kits for the commodities that are missing.
- Provide fuel and allowances for facilitative supervision in the 3 districts.

3.1.10 Nutrition

APHIAplus NAL has established linkages with nutrition service providers through participation in the Turkana County nutrition technical forum. APHIAplus NAL will present the nutritional needs of the target beneficiaries to nutritional service providers such as World Food Program, IRC, Oxfam, World Vision and Merlin.

Key Observations on Performance

- Household food security is a concern and in fact many families depend on the general ration distribution throughout the year. Inadequate food supply for clients on HIV/TB treatment has been a cause of defaulters.
- During community assessment, it was observed that majority of children appeared to be malnourished. There is persistent drought and insecurity which affect the community's ability to produce enough food. Even the fishing community is constantly threatened by incidents of insecurity.

Challenges

- There is overdependence on relief food aid by households in the community.
- The pastoralist communities are vulnerable to constant raids during which households lose treasured livestock, leaving them destitute. Crop farming and fishing are the alternative and these are not well developed enough to sustain the livelihoods of most households.

Planned Activities for the Next Quarter (April – June 2011)

- Initiate food by prescription at targeted nutritional outreaches to the most vulnerable communities, including OVC, caregivers and PLHIV.
- The Project will collaborate with NHP to support screening for malnutrition in children and pregnant and post-partum women at community level. The optimum strategies include engaging local CBOs and CHW networks or facility-owned outreach services, with CHEWS supervising teams of CHWs in screening for malnutrition in these groups, referral of severely malnourished cases to the facilities, local management of moderately malnourished using Fortified Blended Flours (FBF), and offering education and counseling. Once community sites are stabilized the CBOs will be provided with FBF to dispense to the patients under supervision.
- Participate actively in County nutrition technical forum.
- Negotiate with other organizations such as Merlin, WFP, Oxfam, Ministry of Livestock, and Office of the President to advocate for nutritional support to PLHIV and OVC.
- Provide transport support for FBP commodities from the central store to the peripheral facilities.

3.1.11 Adolescent SRH

Key Observations on Performance

- During the community mapping and assessment exercise it was evident there was limited consideration to the needs of the youth within the health facilities.
- The assessment identified only one youth-friendly center, Bishop Mahon Center, which is being supported by IRC. The center has a library, recreational facility, theater group that conducts outreach activities, and provides ASRH services, including VCT.
- There are organized youth sports groups within the town and its environs that the project intends to work with as an avenue for reaching the youth out of school with sexual and reproductive health information and services.
- The project has identified informal training centers which can be utilized as an avenue for reaching out to the adolescent youth with SRH information and services. An example is Turkana Education For All (TEFA) program.

Challenges

- Due to the vastness of the County, most young people away from the town are not able to access youth YFS.
- The rapid assessment revealed that most schools within the County do not have ASRH programs. Another issue that was observed was there was limited parent-child communication on ASRH issues.

Planned Activities for the Next Quarter (April – June 2011)

- Explore avenues of establishing youth-friendly services in the County.
- Establish a working relationship with TEFA in order reach youth in the rural manyattas.
- Initiate school health programs in four targeted schools in every district to address ASRH issues.
- Assist in holding school PTA meetings to sensitize parents and teachers on ASRH so that there is a conducive environment for behavior change.

3.1.12 Water and Sanitation

The Project's resources under WATSAN fall primarily within the MCH services. Beyond this the project relies on leveraging the resources and expertise of other partners in the County.

Key Observations on Performance

- Many facilities and schools have no running water or waste disposal sites.
- Many schools in the region have no hygiene/health education programs.

Challenges

- The needs of the County outweigh the resources available.

Planned Activities for the Next Quarter (April – June 2011)

- Support DPHOs to promote hand washing for infection control in 10 facilities.
- Support the distribution of ceramic water filters at 10 ECD centers.
- Provide OJT on the use and maintenance of the ceramic filters.

3.2 Increased demand for an integrated package of high impact interventions at community and facility levels

3.2.1 CHW Outreach Activities/Community Strategy

In preparation for community-based interventions within Turkana County, there was need to learn from similar activities in the past and the people involved. The team acknowledges that different communities need different approaches depending on relationships with previous programs, cultural differences, etc.

In order to address these important factors, the project during this period conducted a community mapping and assessment exercise and initiated community contact meetings with various key leaders.

- **Meetings with Stakeholders**

The objectives of these meetings have been to identify entry points at community level that will support initiation of the project, build rapport, and identify/establish support linkages and avenues for partnership. They were also aimed at minimizing the possibility of duplication of efforts with other stakeholders. Contact meetings were held with Diocese of Lodwar, Children's Department, Area Advisory Committee members, Provincial administration, District Education Office, Arid Lands Resource Management Program, GK prison and the Ministry of Youth.

- **Community Mapping and Assessment**

The assessment was conducted within the catchment areas of the facilities in Turkana County. APHIAplus NAL conducted the assessment in partnership with MOH teams from Turkana County. The assessment oriented APHIAplus staff to health facility service providers and to health services offered at the community and facility level in Turkana district.

The community assessment generated information on school health activities within the facility catchment areas, community mobilization and awareness creation activities being implemented by other partners within the facility catchment areas and the level of community involvement in facility management through relevant community committees.

- **Meetings with Community Groups**

APHIAplus NAL held meetings with OVC/HBC/BCC/support groups within the various districts so as to establish linkages with community groups identified during the community assessment. Objectives of the meetings were to learn about the activities carried out by these groups at the local level, explore avenues for partnership with the groups and use the groups as entry points to the communities. The contact meetings resulted in the collection of information on our target population regarding the implementation of OVC/HBC/BCC/youth activities and informed the mapping of post-test clubs, MARPs and other important groups within the districts. Focused group discussions were held with Tumaini Self Help Group, Tumaini PLHIV group, Women Fighting AIDS in Turkana, Bishop Mahon youth-friendly services and Turkana Outreach Network (a local CBO).

Key Observations on Performance

- There are no functional Community Units within Turkana County.
- The few existing CHWs are working in isolation and with very weak linkages to the health facilities.

- Outreach is a key strategy for reaching the Turkana population with health services.
- There is need to strengthen/integrate outreach activities as much as possible to include a variety of services, including HTC and FP.



APHIAplus NAL Turkana and MOH team opening a village security gate during the health facility assessment and community mapping exercise.

Challenges

- Vastness of the area and the rough terrain make it difficult for CHWs and outreach staff to give service to the community.
- The CHWs have limited skills to address community health problems in a more integrated and holistic manner since most of them are trained in specific program areas.
- The few pilot Community Units collapsed due to lack of monitoring, technical support and incentives for the CHWs.

Planned Activities for the Next Quarter (April – June 2011)

- Identify innovative ways to support existing community outreach activities so that they can perform many of the same functions as the traditional Community Units but in a sustainable way.
- Identify CHWs to support community mobilization activities.
- Conduct an orientation for the identified CHWs.
- Orientation of community leaders on APHIAplus interventions.
- Conduct monitoring and support meetings with the CHWs.
- Map existing support groups for linkages to appropriate services/commodities.

3.2.2 Care and Support for PLHIV

Key Observations on Performance

During the community assessment it came out that client follow-up at the community level was a big challenge due to the few CHWs who also lack skills on conducting HBC activities. For example, the Diocese of Lodwar has only one CHW trained on HBC using the NASCOP curriculum. Contact meetings with HBC support groups indicated that most of them lack skills in leadership to sustain the groups. The support groups have loose group savings schemes which need to be coordinated and strengthened through training in business skills and linked to micro-finance institutions such as Kenya Women Finance Trust, Kenya Agency for the Development of Enterprise and Technology (microfinance subsidiary of World Vision Kenya), Mwalimu SACCO and others. Due to high stigma and discrimination, some support group members are not willing to come out as advocates while others join support groups that are far away from where they come from.



A community leaders sensitization meeting in Turkana central district

Challenges

- During sessions with support groups, members highlighted that lack of food at their homes forced them to not take their drugs.
- There are no HBC kits for bedridden clients in the County.
- Health workers have inadequate knowledge and skills on HIV-related palliative care.

Planned Activities for the Next Quarter (April – June 2011)

- Conduct training of CHWs on HBC activities.
- Identify and continue with the formation of support groups within the County.
- Conduct institutional capacity-building for support groups.
- Identify and work with organizations dealing with nutritional activities like IRC, MERLIN and WFP so that PLHIV and OVC care givers are among the targeted beneficiaries.

- Explore possibility of financial support to PLHIV/OVC through linkages to CDF.
- Liaise with Health Communication and Marketing to support the development of tailored messages and communication materials for awareness and community level advocacy.
- Identify and work with PLHIV in addressing stigma in the community.

3.3 Increased adoption of healthy behaviors

Key Observations on Performance

The community assessment revealed that most schools within the County do not have an Adolescent Sexual and Reproductive Health program. The assessment revealed that health facilities had little recognition of health concerns affecting adolescents. Four high-volume schools per district have been identified for initiation of school-based health clubs as an entry point to youth in-school activities. Since youth in-school will become youth out-of-school, early investment into this group will bring a multiplier effect into health behaviors in the community. On the other hand, the recognition of the schools as institutions that require services will create a link between the school and the facility. Moreover any health information, such as hygiene education, that is given through the schools will trickle down to the community.

Challenges

- It was observed that there is a big challenge with sustainability of school health programs in the County.
- High-volume schools in the districts are very far apart posing a great challenge in monitoring and providing technical support to their activities.
- Lack of sanitary towels is contributing to school drop outs and absenteeism among adolescent girls.
- Weak community-facility linkages which contributes to lack of follow-up and monitoring of clients.
- There is negative attitude towards skilled delivery.
- Many pregnant mothers don not complete the four ANC visits.

Planned Activities for the Next Quarter (April – June 2011)

- Through support to Diocese of Lodwar, RCEA and AIC, facilitate sessions with the girl child to address specific hygiene and sanitary needs.
- Hold dialogues with parents (PTAs) to discuss male support and parental involvement on various issues affecting students such as healthy relationships, discipline, and hygiene.
- Mobilize and orient relevant stakeholders like the Ministry of Education, PTAs, school heads and club patrons, and share with them the need to establish school health clubs.
- Establish health clubs in selected schools to act as avenues for identifying and addressing health concerns of the young people.
- Work with HCM to avail IEC/BCC materials to partner schools to support education and awareness sessions. The materials should be on ASRH, hygiene, HIV/AIDS and STIs.
- Orient the members of the health clubs to share information and experience with peers, siblings and community members.
- Mentor the club patrons to facilitate primary health care programs like child registration, immunization, de-worming.
- Organize quarterly review meetings with the school heads and club patrons.
- Identify CHWs in high volume facilities.
- Initiate follow-up schedule of the ANC attendants by the CHWs for the completion of ANC visits, skilled delivery and PNC attendance.

3.4 Increased program effectiveness through innovative approaches

3.4.1 Integrated mobile and other outreach services to reach MARPs, women, girls and hard-to-reach populations to bring care closer to the client

Key Observations on Performance

- During the assessment the project was able to identify MARPs as CSWs, uniformed services, fishing communities, cross-border truck drivers, prisoners and local livestock brokers (those who sell livestock in exchange for a commission). The MARPs currently do not have organized groups. Reaching them with interventions or linking them with support requires a clear understanding on how they operate.
- The literacy level among women is low. This has affected their level of knowledge on their rights to health services.

Challenges

- Most at risk populations and other high risk groups within Turkana community have not been clearly mapped to enable the project to identify appropriate approaches for reaching them.
- The Turkana community is a male dominated society where the men have control over resources and decision-making regarding sexual decisions, polygamy and whether to use condoms or not.
- Stigma attached to MARPs makes it difficult to access them for any health interventions.

Planned Activities for the Next Quarter (April – June 2011)

- The project will be initiating an assessment in the next quarter to identify most-at-risk populations and behaviors in and around Lodwar township. Modeled after a similar study conducted by APHIA II NEP in Garissa and using a rapid survey methodology similar to the Priorities for Local AIDS Control Efforts (PLACE) approach, this assessment will create an evidence base for targeted prevention programming, including CT and condom availability. This type of research will be a first for Lodwar; the data gathering is expected to be completed by the end of next quarter.
- Form specific groups of MARPs within the community.
- Conduct identification and orientation of MARP peer educators using NASCOP guidelines and other resource materials, such as Men as Partners and Uniformed Officers HIV Training Curriculum.
- Periodic review and monitoring meetings with MARP peer educators with guidance of the DASCO and DPHO.
- Conduct targeted outreaches to MARPs.

RESULT 4: SOCIAL DETERMINANTS OF HEALTH ADDRESSED TO IMPROVE THE WELL-BEING OF THE COMMUNITY, ESPECIALLY THE MARGINALIZED, POOR AND UNDERSERVED POPULATIONS

4.1 Marginalized, poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs

Key Observations on Performance

The community relies on livestock as the main source of livelihood. Due to persistent drought there has been increased livestock death that has led to increased food insecurity at the household level (April 2010 Drought Monitoring Bulletin). Marginalized communities in Turkana include pastoralists, those displaced due to drought and insecurity, women in rural areas, child-headed households, elderly women and men, and people with disability.

Challenges

The marginalized communities face many problems ranging from insecurity, health, shelter, water and food shortage. Food supply by relief agencies and the government is usually erratic. In fact the priority needs of the Turkana community are food, followed by security, water and health, in that order. Health of livestock is often prioritized over health of humans.

Planned Activities for the Next Quarter (April – June 2011)

- Support the creation of a community menu on economic empowerment through dialogue and partnerships with CDF committees as a long term intervention.
- Strengthen existing economic support groups for income-generating ventures like mat making and bead making.

4.2 Improved food security and nutrition for marginalized, poor and underserved populations

Key Observations on Performance

- Due to food insecurity at the household level, the community experiences school drop outs, early marriage and child labor.
- Children can be found in the streets of Lodwar town looking for food, especially during school holidays when school feeding programs are suspended.
- Food insecurity has led to high levels of malnutrition among under-five children (April 2010 Drought Monitoring Bulletin)

Challenges

- The malnutrition among children in Turkana County is high throughout the year. This affects school performance and retention. It has also major impact on the growth and development of children.
- There is limited source of livelihoods for households and especially families of those living with HIV/AIDS

Planned Activities for the Next Quarter (April – June 2011)

- Work with other organizations on nutritional support for vulnerable households.

- Build the capacity of households on economic empowerment and life skills through dialogue and action days.
- Advocate locally for increased recognition and support for vulnerable households within the community.
- Sensitization and orientation of OVC caregivers and CHWs to conduct MUAC assessments.
- Support the referral and linkage of OVC to access FBP services.
- Monitor the progress of implementation of MUAC activities by CHWs.

4.2.1 Improved food security and nutrition for PLHIV

Key Observations on Performance

- Through our sessions with support group members, they shared that it is very difficult for them to adhere to the HIV medication because of the effects of taking the drugs on an empty stomach.
- Most PLHIV clients are weak and are not able to work and provide for their families as expected.
- Most support group members don't have activities within their groups that address food security issues.

Challenges

- Most PLHIV clients depend on food aid.
- Most PLHIV do not access relief food due to stigma and denial; they are not able to come out openly.
- There is limited source of livelihoods among the Turkana community.

Planned Activities for the Next Quarter (April – June 2011)

- Sensitize support group members on the need to establish income generating activities to promote household economies.
- Work closely with NACC, CDF and other micro finance institutions to support groups' income generating activities.
- Map vulnerable households among support group members and work with organizations supporting nutritional programs, e.g. NHP, to support the referral and linkage of PLHIV to FBP services.
- Work with local leaders and advocate for increased recognition and support for PLHIV household.

4.2.2 Improved food security and nutrition for pregnant women and TB patients

Key Observations on Performance

- Special consideration is always given to TB patients and pregnant mothers during relief food aid distribution.
- Support group members note that it is very difficult for them to adhere to the HIV and TB medication because of the effects of taking the drugs on an empty stomach.

Challenges

- Food aid is irregular and insufficient.

- The food ration given to TB and lactating mothers is not enough because it is shared among the household.
- There is limited source of livelihoods.
- Dependency is high among community members.

Planned Activities for the Next Quarter (April – June 2011)

- Empower the community to establish income generating activities to promote household nutrition.
- Work with organizations such as Real Impact on nutritional programs to support households of TB patients and lactating mothers,.
- Work with FMCs, local leaders and advocate for increased recognition and support for TB patients and lactating mothers.

4.3 Marginalized, poor and underserved groups have increased access to education, life skills, and literacy initiatives through coordination and integration with education programs

Key Observations on Performance

- There was a Most Vulnerable Child program which was supported by UNICEF; this has been in existence for a long time but is currently not active due to lack of funding.
- Within the County there is Turkana Education for All (TEFA) which promotes adult literacy among community members.
- There is a youth polytechnic sponsored by the Diocese but it is underutilized by local community members mainly because the community cannot pay the fees.

Challenges

- There is lack of resources to pay training expenses.
- There is lack of awareness about which courses are offered within the institutions.

Planned Activities for the Next Quarter (April – June 2011)

- Advocate for adult literacy during community sensitization forums and work closely with adult functional literacy centers.
- Work with CDF offices for support to young people in educational/tertiary institutions.

4.4 Increased access to safe water, sanitation and improved hygiene

Key Observations on Performance

- Despite the presence of pit latrines in some communities, the uses of these latrines still remain a challenge.
- Most rural areas have insufficient supply of water; they depend on river beds and water pans.

Planned Activities for the Next Quarter (April – June 2011)

- Work with agencies working on WASH programs to support identified needy areas.
- Use the school health program to promote hygiene among community members.
- Work with CHWs and peers, FMCs, local leaders to advocate for issues of hygiene.

4.5 Strengthened systems, structures and services for protection of marginalized, poor and underserved populations

4.5.1 Orphans and vulnerable children

Key Observations on Performance

- Majority of the OVC do not have birth certificates.
- It is evident during the AAC meetings that existing systems like CDF still have not realized the need to support OVC.
- Due to stigma and discrimination, OVC are in most cases denied services at community level.
- Limited knowledge/skills on children's rights; there is limited demand for services like education or provision of birth certificates.
- Turkana County does not have a Children's Court.
- The survey revealed that the ECD centers lack certain essential requirements, such as desks, black board and even buildings.

Challenges

- There are overwhelming numbers of OVC. Research carried out in 2005 by the CACC indicated that there are 24,000 OVC in Turkana Central. By now the numbers may have increased significantly.
- Due to poverty, family and communal ties have weakened, leading to neglect of OVC by relatives.
- Low levels of literacy among caregivers and the general community hinders their full participation in moral support, motivation and material support for education.

Planned Activities for the Next Quarter (April – June 2011)

- Develop subgrants for support of OVC with Diocese of Lodwar and other LIPs.
- Work with local leaders and advocate for recognition and support for the OVC.
- Provision of educational support to identified OVC; provision of uniforms, school fees (for ECD classes), books, pens, supplementary feeding for ECD.
- Provide support for ECD centers.
- Work with institutions like CDF, District Centers for Early Childhood Education to support OVC.
- Work closely with the AAC and DCO to lobby for registration of births.

4.6 Expanded Social Mobilization for Health

Key Observations on Performance

- The project identified CDCs and FMCs as avenues for social mobilization at the community level.
- Within Turkana County there are established religious structures; a network of local religious leaders which the project can use as an avenue for social mobilization; Catholic, AIC, RCEA, Maranatha, CMC and Share International.

Challenges

- The religious leaders have limited skills on articulating health issues.
- There has been limited involvement of local leaders in community health activities to champion health issues.

Planned Activities for the Next Quarter (April – June 2011)

- Conduct sessions with religious leaders to enable them act as advocates on health issues among community members.
- Local leader's sensitization workshops.
- Identify and work closely with influential local leaders like herbalists, Council of Elders, church leaders, Imams, chief/assistant chiefs, Kraal elders and health committee members to act as advocates for VMMC, FP, MCH and utilization of services.

Monitoring and Evaluation

Planned Activities for the next quarter

- Data dissemination feedback meetings in Turkana Central and South with DHRIOs/DHMT/facility and community units.
- Support the distribution and OJT of newly revised HIV/AIDS data management tools and withdrawal of existing tools.
- Data quality improvement and supportive supervision in Turkana County for both facility and community related activities.
- Orientation of CHWs on reporting tools for community prevention/OVC/HCBC in Turkana Central districts.
- Realigning the OVC database for uploading OVC photographs.
- Rollout of OVC photography in Turkana Central Districts.
- Participation in quality improvement/child status index trainings activities for LIPs.
- System strengthening on M&E for FOGs.
- Supporting the DHRIO's offices with filling materials for data management.