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**APHIA II**  
NAIROBI/CENTRAL



**OVC in Central Province**

## **END OF PROJECT REPORT**

<b>ACTIVITY TITLE:</b>	<b>APHIA II NAIROBI/CENTRAL</b>
<b>AWARD NUMBER:</b>	<b>CA 623-A-00-09-00025</b>
<b>PROJECT DATES:</b>	<b>1 AUG 2006 – 31 JULY 2011<sup>1</sup></b>
<b>DATE OF SUBMISSION:</b>	<b>JUNE 15, 2011</b>

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<sup>1</sup>. This report constitutes the first part of a two-part report for the APHIA II Nairobi/Central project. Part two covers the period March 2009 – February 2011.

## **ABBREVIATIONS AND ACRONYMS**

A2N	APHIA II Nairobi
A2N/C	APHIA II Nairobi Central
AB	Abstinence and Be Faithful
ABY	Abstinence and/or Be Faithful (Youth)
AIDS	Acquired Immune Deficiency Syndrome
ANC	<b>Antenatal Clinic</b>
APHIA	AIDS, Population & Health Integrated Assistance Program
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs)
AZT	Zidovudine
BCC	<b>Behavior change communication</b>
BMI	<b>Body Mass Index</b>
CA	<b>Collaborating agency</b>
CACC	Constituency AIDS Control Committee
CBO	Community Based Organization
CBSS	Community Based Support System
CCC	Comprehensive Care Clinic
CDC	Centers for Disease Control and Prevention
CDF	Constituency Development Fund
CFK	Child Fund Kenya
CHBC	Community and Home Based Care
CHW	Community Health Worker
CIC	Community Implementation Committee
CII	<b>Community Implementing Initiative</b>
CLAN	Children Legal Action Network
CLAN	<b>Child Legal Action Network</b>
CME	Continuous Medical Education
CMMB	Catholic Medical Mission Board
CORPS	Community owned resource persons
CPU	<b>Children protection unit</b>
CSO	Civil Society Organization
CSW	Commercial Sex Worker
CT	<b>Counseling and Testing</b>
CTU	<b>Contraceptive technology update</b>
CYP	Couple Years of Protection
DASCO	District HIV / AIDS Coordinating Officer
DBS	Dry Blood Sample
DCO	<b>District children officer</b>
DHMT	District Health Management Team
DHRIO	District Health Records and Information Officer
DMLT	District Medical Laboratory Technologist
DMS	Director of Medical Services
DTC	Diagnostic Testing and Counseling
DTC	District TB and Leprosy Coordinator
ECD	Early Childhood Development
EID	Early Infant Diagnosis
EMMR	Environmental Monitoring & Mitigation Report
FANC	<b>Focused Antenatal Clinic</b>
FBO	Faith Based Organization

FKE	Federation of Kenya Employees
GCH	Gertrude's Garden Children's Hospital
GOK	Government of Kenya
GSN	Goldstar Network
GVRC	Gender Violence and Recovery Center
HAART	<b>Highly Active Antiretroviral Therapy</b>
HCS	Home and Community Support
HIV	Human Immuno-deficiency Virus
HTC	HIV Testing and Counseling
HWWK	Hope <i>Worldwide</i> Kenya
IAP	Integrated AIDS Program
ICB	Institutional Capacity Building
IDP	<b>Internally displaced person</b>
IEC	Information, Education and Communication
IGA	<b>Income Generating Activities</b>
IP	Implementing Partner
IUD	Intra-Uterine Device
IYCF	Infant and Young Child Feeding
KAPC	Kenya Association of Professional Counselors
KATSO	<b>Kenya AIDS treatment support for OVC</b>
KDA	<b>K-REP development agency</b>
KEMSA	Kenya Medical Supplies Agency
KENERELA	<b>Kenya network of religious leaders living with HIV/AIDS</b>
KENWA	Kenya Network of Women with AIDS
KGGA	Kenya Girl Guide Association
KNH	Kenyatta National Hospital
K-REP	<b>Kenya rural enterprise program</b>
LAAC	Locational Area Advisory Council
LDP	Leadership Development Program
M&E	<b>Monitoring and evaluation</b>
MARPS	<b>Most at risk population</b>
MDH	Mbagathi District Hospital
MDR	Multi Drug Resistance (TB)
MOCASO	<b>Mother / child with AIDS support organization</b>
MOH	<b>Ministry of health</b>
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health & Sanitation
MSH	<b>Management Sciences for health</b>
MVCT	Mobile Voluntary Counseling and Testing
NACC	National AIDS Control Council
NARESA	Network of AIDS Researchers of Eastern & Southern Africa
NASCOP	National HIV / AIDS & STI Control Program
NGO	<b>Non-governmental organization</b>
NHMB	Nairobi Health Management Board
NHSSP	National Health Sector Strategic Plan (MOH)
NOFI	Njiru Organic Farmers Integrated
NVP	Nevirapine
OI	Opportunistic Infection
OJT	<b>On job training</b>
OPH	USAID Office of Population and Health
OVC	Orphans and Vulnerable Children

PAC	Post abortion care
PASCO	Provincial AIDS and STI Coordinator
PDPHS	Provincial Director Public Health Service
PEPFAR	President's Emergency Plan for AIDS Relief
PHMT	Provincial Health Records Information Officer
PI	Pathfinder International
PITC	Provider Initiated Counseling and Testing
PITC	<b>Provider Initiated Testing and Counseling</b>
PLHIV	People Living with HIV
PMO	Provincial Medical Officer
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Service International
PTLC	Provincial TB and Leprosy Coordinator
PYI	Positive Youth Initiative
QA /QC	Quality Audit / Quality Control
RGC	Redeemed Gospel Church
RH/FP	Reproductive Health / Family Planning
RHP	Riruta Health Project (at Kivuli Center)
RRI	Rapid Results Initiative
SAPTA	Support for Addiction, Prevention and Treatment in Africa
SCMS	Supply Chain Management System
SDO	Senior Data Officer
SOP	Scope of Practice
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers (also refers to a trainer him / herself)
TWG	Technical Working Group
UoN	University of Nairobi
USAID	United States Agency for International Development
VCT	Voluntary Counseling & Testing
VHC	Village Health Committee
VS&L	Village savings and loan
WJEI	Women's Justice and Empowerment Initiative
YFS	Youth friendly services

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## Executive Summary

APHIA II (AIDS Population, and Health Integrated Assistance Program) Nairobi/Central (A2N/C) is pleased to present the End of Project program performance report.

With a carefully selected group of highly experienced partner organizations and subcontractors, the A2N/C Team designed interventions that provided quality, expanded and sustainable HIV/AIDS and tuberculosis (TB) prevention, treatment, care, and support, along with integrated reproductive health (RH), family planning (FP), malaria, and maternal and child health (MCH) services. In addition to increasing service access and use, A2N/C contributed to the development of healthier behaviors among the most-at-risk Kenyans and the general population. Project activities took place at both the health care facility and community level and involved a high degree of collaboration with all relevant Government of Kenya (GOK), local, and international entities, as well as stakeholders. Increased networking among agencies, facility-community linkages, and sustainability were core elements of A2N/C.

A2N/C partners brought to the project a rich pool of technical expertise derived from their relevant ongoing programs in Nairobi and Central provinces before the inception of this project. In addition to Pathfinder as Collaborating Agency, the A2N/C is comprised of Population Services International (PSI), Child Fund Kenya (formerly Christian Children's Fund CCF), Malteser International, and the Network of AIDS Researchers in East and Southern Africa (NARESA). Short-term technical assistance was provided by three subcontractors: the Kenya Association of Professional Counselors (KAPC), the Federation of Kenya Employers (FKE), and Kenya Rural Enterprise Program (K-REP).

Pathfinder's A2N/C Team designed a comprehensive project which linked strategically to other related programs at the national and regional levels with the aim of leveraging results. Activities within Nairobi and Central Provinces were linked to national targets to support achievement of national goals thus contributed to the Kenya National AIDS Strategic Plan and the Millennium Development Goals. The A2N/C Team envisioned communities where HIV/AIDS, RH/FP, and MCH needs are met through sustainable, quality, integrated services delivered through close cooperation at all health care levels. The guiding principle of A2N/C was to recognise, fully utilise and build on existing strengths, facilities and abilities with the aim of making these centres of excellence capable of giving services that are comprehensive, efficient, and affordable.

The project was grounded on three Result Areas: Improved and expanded facility-based HIV/AIDS, TB, RH/FP, Malaria, and MCH services; Improved and expanded civil society activities to increase healthy behavior; and, Improved and expanded care and support for people and families affected by HIV/AIDS. Within each Result Area there were three Sub-Results set out as detailed objectives. This design helped greatly to keep the project focused and provided clear objectives against which to measure progress.

Result 1	Result 2	Result 3
<p><b>Improved and expanded facility-based HIV/AIDS, TB, RH/FP, Malaria, and MCH services</b></p> <p><b>Sub-Result 1.1</b> <i>Expanded availability of HIV/AIDS Prevention, Care and Treatment Services</i></p> <p><b>Sub-Result 1.2</b> <i>Expanded availability of FP, RH, and MCH services with HIV/AIDS services</i></p> <p><b>Sub-Result 1.3</b> <i>Reinforced networking between levels of care and between clinical services and communities</i></p>	<p><b>Improved and expanded civil society activities to increase healthy behavior</b></p> <p><b>Sub-Result 2.1</b> <i>Expanded and strengthened community and workplace prevention programs</i></p> <p><b>Sub-Result 2.2</b> <i>Expanded prevention programs targeting most-at-risk populations</i></p> <p><b>Sub-Result 2.3</b> <i>Reinforced networking between communities and clinical services</i></p>	<p><b>Improved and expanded care and support for people and families affected by HIV/AIDS</b></p> <p><b>Sub-Result 3.1</b> <i>Expanded home and community support programs</i></p> <p><b>Sub-Result 3.2</b> <i>Expanded support for OVC</i></p> <p><b>Sub-Result 3.3</b> <i>Reduced stigma and establishment of safety nets for PLHIV and their families</i></p>

Recognizing the need to carefully hone the project to address the needs of specific target groups – those most in need – and in response to the original call for proposals, the project was

- PRINCIPLE APHIA II N/C TARGET GROUPS:**
- **Women** of reproductive age within the general population.
  - **Orphans and Vulnerable Children** through a broad range of community services.
  - **People living with HIV/AIDS.**
  - **Families and communities** affected by HIV/AIDS.
  - **Young people**, through youth-friendly services.
  - **Men**, by adapting service delivery to the needs of the male population.
  - **Postpartum women and newborns**, to address high rates of maternal and infant mortality.
  - **Most-at-Risk** (e.g., CSWs and their customers, discordant couples, etc.)

designed to address the needs of women; OVC; PLHIV; families and communities affected by HIV/AIDS; young people; men; postpartum women and newborns; and several most-at-risk groups including CSWs and their customers and discordant couples.

**Facility-based HIV/AIDS, TB, RH/FP, and malaria services were improved and expanded** through the strengthening of the quality of clinical services and functional referral systems, ensuring a full continuum of care from hospital to community. Activities resulted in greater access to health care and information for all age cohorts and diverse segments of the population. Interventions included Behavior Change Communication to raise demand for services while improving healthy behaviors. Comprehensive linkages were established and strengthened between facilities and communities to ensure well-coordinated services, maximum effectiveness and utilization of services, and sustainability. Activities under this result led to expanded availability of HIV/AIDS prevention, care, and treatment services; greater availability of FP services; and reinforced networking between levels of care and between clinical services and communities. Facility-based services were more available to all those who needed them, including marginalized and under-served groups such as youth. Strengthened networks and referral systems brought comprehensive care to a greater number of individuals and improve client follow-up.

**Expansion and strengthening of civil society activities to increase healthy behaviors** involved community and workplace programs, prevention activities targeting most-at-risk populations, and reinforced networking between communities and clinical services. Collaboration with communities was a central aspect of the project. In addition to its grants program, A2N/C conducted capacity building activities for NGOs/CBOs/FBOs so that they are now better able to implement quality and sustainable community-level activities. Local leaders and stakeholders were involved in all stages of the project and the team improved networking and collaboration among all relevant institutions and organizations, and between communities and clinical services. Activities took place in the workplace to sensitize managers and educate employees, while reducing stigma. A range of community BCC activities were conducted to reach those most-at-risk of infection, reduce stigma, and improve healthier behaviors. A2N/C strengthened networks, including the formal health care system, to improve both the continuum of preventive care and community-facility relations.

**Care and support for people and families affected by HIV/AIDS** included expanded home and community support, effective interventions for OVC, and reduction of stigma and establishment of durable safety nets for PWHIV and their families. Community Home-Based Care (CHBC), a cornerstone of Pathfinder's Kenya program, included home nursing, clinical care, nutrition, STI/HIV prevention, education, paralegal support and protection, psychosocial support, and links to income-generating activities. Communities participated directly in providing support for PWHIV, OVC, and their caregivers. Clinical referrals and linkages created synergies with other elements of A2N/C, along with community mobilization. The safety net for OVC continued to be expanded under A2N/C. Stigma reduction activities involved key community leaders and stakeholders, PWHIV, youth, men, and women.

**Project Strategy** incorporated a decentralized approach to implementation including a focus on staff field presence and field-based management and decision-making. Community participation has long been a core strategy of A2N/C partners and was expanded along with the collaboration of public and private institutions. A2N/C utilized and scaled-up evidence-based best practices and state-of-the-art approaches to HIV/AIDS services and integration with RH/FP and MCH. Lessons learned were incorporated throughout the life of the project to further promote achievement of results. Integration of FP/RH and HIV/AIDS services had a positive impact on the health of all segments of the population accessing services. A2N/C built on existing capacities to scale-up the prevention-to-care continuum. The project also built the capacity of CBOs/FBOs and provided crucial training to community- and facility-based health care providers. The team built partnerships and strategic linkages, both regional and national, between health and non-health, and public and private sectors, to reach common goals. Networking,

**THE APHIA II N/C APPROACH INCLUDED:**

- Linkages with national and regional activities and expanded coordination and networking.
- Community-based activities conducted in close coordination with local CBOs/FBOs.
- Strengthened facility-based services through training and linkages with communities.
- Institutional capacity building for NGOs/CBOs/FBOs to strengthen community and facility-based services.
- Integration of HIV/AIDS services with RH/FP, TB, and MCH.
- Close coordination and planning with relevant institutions and projects.
- Promotion of healthy behaviors and stigma reduction through BCC activities in communities and the workplace.
- Expansion of quality and accessibility of services.
- Coverage of marginalized and at-risk groups.

linkages and respect for existing programs, funded by both the US government and other donors, was an integral component of the project.

**Project management**

Pathfinder’s long and good track record as a USAID collaborating agency (CA) ensured that the project was managed in a cost-effective manner to achieve key results. Pathfinder’s management model was based on principles of open and proactive collaboration among partners, the community of CAs, and other projects addressing relevant USAID objectives and strategies. The team was uniquely qualified to implement the A2N/C project given its tested rapid response mechanisms; on-the ground presence and relationships with public, NGO, and private commercial sector organizations in numerous USAID assistance countries; technical

capability to apply state-of-the-art approaches to reach disenfranchised and underserved populations; an integral M&E plan; and outstanding personnel.

**Project achievements** successfully met most targets and, in a number of cases, exceeded them as is shown on the attached Performance Monitoring Plans. Lessons learned were applied to improve performance of both health and community programs while some planned activities were adapted to the reality of the Kenyan context. The project anticipates a period of rapid expansion in the next phase during which beneficiaries will receive even more accessible, improved and quality community and health services.

**Table 1 - Summary of Results – Nairobi and Central Provinces – 1 Aug 06 – 28 Feb09**

Indicator	Nairobi				Central				Total A2N/C
	Year 1	Year 2	Year 3	Total	Year 1	Year 2	Year 3	Total	
Prevention - No. individuals reached with messages of abstinence and/or being faithful (AB)	28,788	186,141	107,312	<b>322,241</b>	16,089	173,378	74,255	<b>263,722</b>	<b>585,963</b>
Prevention - No. individuals reached with messages of abstinence (A)	4,550	6,620	88,053	<b>88,053</b>	4,506	6,763	77,193	<b>11,213</b>	<b>161,246</b>
Prevention - No. individuals reached with messages of other behavior change (OP)	204,754	299,145	137,365	<b>641,264</b>	239,547	686,618	281,681	<b>1,207,846</b>	<b>1,849,110</b>
PMTCT - No. pregnant women counseled, tested for HIV and received test results	-	15,425	7,085	<b>22,510</b>	22,714	<b>33,765</b>	14,682	<b>71,161</b>	<b>93,671</b>
PMTCT - No. pregnant women received complete course of antiretroviral prophylaxis in a PMTCT setting	-	826	444	<b>1,270</b>	798	1,422	401	<b>2,621</b>	<b>3,891</b>
No. individuals received counseling, testing and test results	13,875	123,239	97,332	<b>234,446</b>	303	27,591	40,399	<b>68,293</b>	<b>302,739</b>
No. of registered TB patients who received HIV counseling and testing and received results	-	3,785	2,443	<b>6,228</b>	-	517	363	<b>880</b>	<b>7,108</b>
ART New clients	1,477	3,098	1,650	<b>6,225</b>	147	913	700	<b>1,760</b>	<b>7,985</b>
ART Ever (cumulative) clients	2,911	12,711	15,524	<b>15,524</b>	372	6,348	6,797	<b>6,797</b>	<b>22,321</b>
ART Current clients	2,075	10,047	11,602	<b>11,602</b>	363	4,815	4,965	<b>4,965</b>	<b>16,567</b>
No. individuals received HIV-related palliative care (including clinical prophylaxis and/or treatment for TB)	10,165	29,748	25,846	<b>25,846</b>	2,862	19,407	11,269	<b>11,269</b>	<b>31,115</b>
No. individuals attending HIV care treatment who received treatment for TB disease	428	1,147	613	<b>1,147</b>	5	237	415	<b>415</b>	<b>1,562</b>
OVC served	4,168	12,611	13,855	<b>13,855</b>	13,391	25,699	25,683	<b>25,683</b>	<b>39,538</b>
OVC served - Primary Direct	320	11,994	11,770	<b>11,770</b>	281	18,881	18,791	<b>18,791</b>	<b>30,561</b>
OVC served - Supplementary Direct	3,374	617	2,085	<b>2,085</b>	13,584	6,818	6,892	<b>6,892</b>	<b>8,977</b>
No. of individuals provided home-based care	3,006	6,903	8,860	<b>8,860</b>	2,542	6,899	8,273	<b>8,273</b>	<b>17,133</b>
CYP Achieved (through health facility outlets)	-	12,687	12,072	<b>24,759</b>	4,262	52,010	51,233	<b>107,505</b>	<b>132,264</b>

The integration of project activities involved the health facility and community levels with a high level of collaboration with Government of Kenya (GOK) partners and stakeholders at district and provincial levels. Good planning and effective implementation of project activities resulted in **16,567** individuals currently accessing anti-retrovirals by end February 2009 (**11,602** - Nairobi; **5,116** - Central). Of these, **7,985** were new clients (**6,225** - Nairobi; **1,760** - Central).

Encouraging adherence to drugs and propounding prevention of transmission as well as secondary infection by the virus are skills which CHWs must now possess and practice. The

**17,133** home-based care clients (**8,860** -Nairobi – **8,273** – Central) benefited from the attention of **1,533** CHWs (**556** - Nairobi; **977** - Central) who provided a range of services to both mobile and bed-ridden clients. CHWs liaised closely with the health center(s) which form part of the service network. PLHIV must also understand the need to adhere to anti-retroviral drugs and to address this need, A2N/C provided treatment literacy training to 337 individuals in Nairobi using the MSF/Belgium curriculum.

While prevention needs to be tailored to affect the behaviors of populations at higher risk of infection, at the same time the more general prevention campaigns must continue, be updated and refreshed as new individuals become sexually active. Prevention efforts will need to continue for many decades and with increasingly refined targeting. A2N/C planned its prevention interventions carefully with programs tailored to address populations at high risk. Considerable prevention effort was focused on achieving 'HIV free' populations in the future through the PMTCT program, Early Infant Diagnosis and the children in and out of school programs. At PMTCT-supported sites, **93,671** pregnant women were tested for HIV and received their test results. Of these, **3,891** women were administered prophylaxis (**1,270** – Nairobi; **2,621** – Central). Through the PMTCT program, the project contributed to the national effort to ensure an HIV-free generation of Kenyans. The Early Infant Diagnosis program was initiated and expanded well, testing a total of **518** infants (Central, **375**; Nairobi **143**). Through the PMTCT program, the project contributed to the national effort to ensure an HIV-free generation of Kenyans.

School children attended weekly sessions of the "'Chill" Club', a year-long program which provided a broad package of skills designed to empower young people to make informed, life decisions based on sound knowledge. A total of **14,798** children benefited from the "'Chill" Club' program supported in primary schools (**7,545** - Nairobi; **7,253**- Central). A2N/C worked with the Kenya Girl Guides who reached another **12,114** school children with messages of abstinence. These activities focused on abstinence messages for younger people while messages encouraging faithfulness and/or behavior change for older individuals and those at high risk were also delivered by A2N/C and benefited **1,849,110** individuals (**641,264** – Nairobi; **1,207,846** – Central). Counseling and testing continued to expand appreciably with a total of **302,739** people accessing this service at A2N/C supported sites (**234,446** – Nairobi; **68,293** – Central). Mobile counseling and testing (MVCT) was also offered and much appreciated.

Family planning and reproductive health formed a part of the Result I Area and effort was made to ensure that all A2N/C target population was availed competent and complete services. FP/RH services were provided to **15,627** new clients (**5,414** - Nairobi; **10,213** - Central) while a total CYP of **120,322** (**12,817** Nairobi; **107,505** Central) was reached by end of project.

Palliative care is a critically important component of overall care and treatment of HIV infected individuals. This applies to both those clients already using anti-retrovirals as well as those not yet requiring drugs but who must be closely tracked and supported. Palliative care covers a very wide range of activities from the spiritual, psychosocial and physical. By the end of the project, **31,115** HIV infected individuals were receiving palliative care.

The epidemic has had a devastating impact on the structure of Kenyan society resulting in very high numbers of children who have been orphaned or made vulnerable. In Kenya, the definition of orphan includes children with one parent as well as those with no biological parents. Many children are protected by caretakers ranging from family members to neighbors. The project by the end of February 2009 was supporting **39,538** OVC of whom **30,561** were receiving three or more services.

A primary mandate of A2N/C was to strengthen the capacity of a range of individuals and groups who assist in the struggle to cope with the effects of the epidemic. A2N/C, through the life of project, provided training to **2,200** individuals including health care workers, community organizations and government staff. In addition to the training, numerous ‘Continuing Medical Education’ (CMEs) sessions were held with health care workers.

### **Lessons Learned**

In the life of a three year project such as A2N/C with a broad scope of objectives and activities, it is to be expected that numerous lessons will have been learned. This was true of A2N/C thus highlights will be listed here while each section of the report contains its own lessons and challenges as well as suggested way forward for the project.

- Support and buy-in and good work relationships with the PHMT, DHMT, clinical implementing partners and consortium partners are critical to successful implementation of a project’s work – sustainability will result only through such collaboration. Engagement of the PHMT and DHMT in supervision of service provision and training of private service providers is key to ensuring quality of service provision in the private sector.
- A laboratory network is essential for the scale-up of ART services as demonstrated by the number of new clients initiated on ART following improved and increased collection of blood samples for CD4 count test.
- Mobile outreaches and home testing assist greatly to reach otherwise elusive clients for HIV testing.
- Trainings, updates, CMEs, mentorship, on-going TA support by project staff and on-job-training are key in building services providers competency, reducing provider bias, stigma and improving provider attitudes especially towards provision of services to adolescents, men, couples, unmarried but sexually active women and PLHIV
- Support of minor site renovations, procurement of basic hospital and lab equipment, furniture and reagents, printed and/or distributed M & E tools, SOPs, guidelines, protocols, job aids and IEC materials, and ensured availability of drugs, commodity and other medical supplies contribute much to provision of quality services.
- Support for quarterly clinical meetings with supported MOH staff facilitates experience sharing among service providers, forums for technical updates; discussions on how best to progress towards achieving goals.
- ‘Task-shifting’ is an important method to extend services.
- HIV+ children are greatly empowered and enabled to cope through a carefully tailored psychosocial support program.
- Treatment literacy training is a powerful tool to assist both children and adults to understand and live positively with their HIV status.
- ‘Fun Day’ activities were a great success and helped children to feel empowered.
- The provision of basic hospital furniture, hospital and lab equipment is key to provision of quality services.
- Youth friendly service training results in better treatment adherence, increased knowledge of HIV, RH and sexuality, and, lower defaulting rates amongst youth.
- Involvement of private sector sites in world event days enhances the relationship between public and private sector sites.
- Community and clinical services linkages are key to creating demand for services, subsequent client follow up and maintaining clients on ART.
- We learned that the Somali community in Eastleigh is in great need of and eager for information about HIV/AIDS.

- Deaf individuals feel neglected by HIV/AIDS programs. They also feel vulnerable to rape as they cannot call out for help.
- The project learned that religious leaders are increasingly influencing care and treatment, albeit negatively through their advice to patients to discontinue ART. Overall, many religious leaders are uninformed, or misinformed about HIV and AIDS. Also learned that faith healers purport to provide cures through herbal remedies.
- Economic strengthening is a key factor in the establishment of sustainable safety nets for PLHI and OVC.
- While the project focused on distribution of items to individual OVC, it became clear that the project must shift focus to provide quality services at all levels.
- A scale-up of institutional capacity of all IPs is important in order to effectively implement activities

### Challenges

- Insufficient human and funding resources for the enormous task at hand were often challenging to implementation of project activities.
- A reduction in the uptake of maternal ARV prophylaxis due to the implementation of a new ARV commodity ordering system for PMTCT sites; high staff turnover, thus loss of trained staff; poor data recording and record keeping practices challenged the PMTCT program.
- Stigma, while a serious challenge throughout the country, was a special challenge in portions of Central Province where very few development partners had worked previous to A2N/C.
- Withdrawal of the NASCOP/Global Fund supported VCT counselors from supported sites affected HCT services
- Stock-outs of ARVs, septrin and other OI drugs, HIV test kits, FP commodities were a challenge to providing optimum care to patients.
- Shortage of testing kits for the mobile and moonlight VCT was challenging several times in the life of the project.
- Staff redeployment and high staff turnover within the MOH and City Council of Nairobi led to disruption of provision of HIV and RH services.
- The post election violence of 2008 demonstrated the negative impact of civil unrest on health care provision.
- Tracing defaulters was challenging due to lack of a unique identifier at the national level.
  - Due to free primary education, there were many older children in the lower classes not reached by the “*Chill*” prevention program.
  - There was a lack of a program to address sex workers’ HIV prevention and economic empowerment needs reaching informal schools was extremely limited.
  - It was challenging to reach spouses and partners of the transport workers in order to encourage couple counselling and testing which in turn assists with disclosure.
  - A great challenge was that the K-REP Development Agency did not manage to implement the voluntary savings and loan scheme.
  - Food insecurity, together with scarcity of nutritionists was a persistent challenge throughout the life of project.
  - Defaulting by clients from adherence to ART was a great challenge to the project
  - OVC needs far surpassed the available resources.
  - Many reported cases of abuse of children of all ages, with uncoordinated and limited support from GoK hampered greatly the implementation of the project.
  - Occasionally, project paralegals were threatened by relatives of the perpetrators while other families did not cooperate to expose perpetrators of violence especially when the latter were family members.

- Police were often reluctant to perform proper investigation of perpetrators of violence against children and women.
- Alcohol abuse is a major problem among youths and older men, especially in Central Province.

**Table 2: Nairobi Province**

Indicator	Year 1			Year 2			Year 3		
	Target	Achieved	% Achieved	Target	Achieved	% Achieved	Target	Achieved	% Achieved
Prevention - No. individuals reached with messages of abstinence and/or being faithful (AB)	4,500	28,788	640	103,900	186,141	179	142,477	107,312	75
Prevention - No. individuals reached with messages of abstinence (A)	4,500	4,550	101	5,000	6,620	132	62,907	88,053	140
Prevention – No .individuals reached with messages of other behavior change (OP)	110,560	204,754	185	218,040	299,145	137	58,324	137,365	236
PMTCT - No. pregnant women counseled, tested for HIV and received test results	-	-	-	17,178	15,425	90	6,292	7,085	113
PMTCT - No. pregnant women received complete course of antiretroviral prophylaxis in a PMTCT setting	-	-	-	1,248	826	66	805	444	55
No. individuals received counseling, testing and test results	29,074	13,875	48	44,500	123,239	277	54,167	97,332	180
No. of registered TB patients who received HIV counseling and testing and received results	-	-	-	2,100	3,785	180	1,500	2,443	163
ART New clients	1,393	1,477	106	1,740	3,098	178	1,950	1,650	85
ART Ever (cumulative) clients	5,537	2,911	53	12,667	12,711	100	10,124	15,524	153
ART Current clients	4,787	2,075	43	9,500	10,047	106	8,968	11,602	129
No. individuals received HIV-related palliative care (including clinical prophylaxis and/or treatment for TB)	4,800	10,468	212	26,600	29,748	112	6,500	25,846	398
No. individuals attending HIV care treatment who received treatment for TB disease	428	428	100	1,500	1,147	76	625	613	98
OVC served	7,750	3,694	48	10,600	12,611	119	13,440	13,855	103
OVC served - Primary Direct	-	320	-	-	11,994	-	13,440	11,770	88
OVC served - Supplementary Direct	-	3,374	-	-	617	-	-	2,085	-

**End of Project Report**

**NAIROBI PROVINCE**

**1 August 2006 – 31 July 2011**

**Result 1: Improved & expanded facility-based HIV/AIDS, TB, RH/FP, Malaria and MCH services**

**1.1 Expanded availability of HIV/AIDS prevention, care and treatment services:  
overall description of activities**

**Executive summary of accomplishments in achieving results**

- At the end of the project, **109** health facilities in Nairobi Province were being supported. By service component, the project supported 63 ART sites, 34 PMTCT sites, 32 TB sites, 56 CT (PITC and VCT) sites and 27 RH/FP sites.
- **22,510** pregnant women had received HIV counseling and testing for PMTCT and received their test results while **1,270** pregnant women were provided with ARV prophylaxis.
- **234,446 clients** accessed counseling and testing services and received their test results.
- **1,147** HIV-infected clients attending HIV care/treatment services received treatment for TB disease.
- **6,228** registered TB patients received counseling and testing for HIV and received their test results.
- **15,524** clients had ever received antiretroviral therapy while **11,602** clients were receiving treatment in 63 ART sites by the end of the project.
- **6,225** clients were newly initiated on ART.
- A total of **24,759** couple years of protection was achieved through provision of FP services at supported sites.

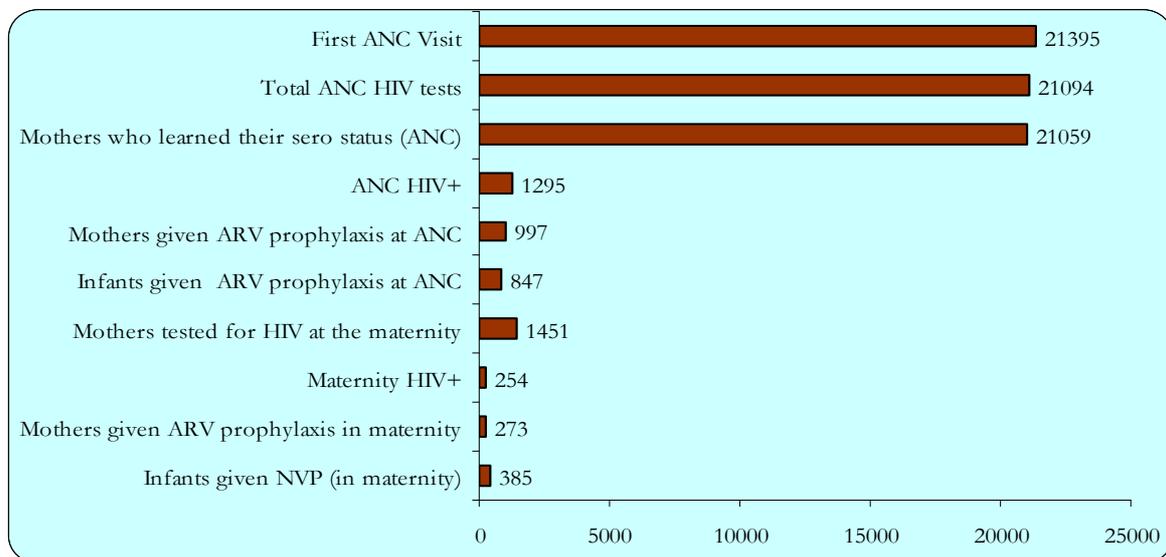
**Strengthening Preventive Services:**

By the end of the project period, A2N/C supported in Nairobi Province 34 PMTCT sites (private sector and FBO) and had counseled and tested 22,510 pregnant women for HIV within PMTCT settings. A2N/C within Nairobi Province provided support to private sector sites which are challenged in terms of high staff turnover, staff technical competency in PMTCT, early infant diagnosis (EID) and IYCF, and staff shortages, thus not able to avail staff for long trainings. During the project period, 253 health care workers were trained on PMTCT related topics that included PMTCT, Infant Young Child Feeding, and Early Infant Diagnosis as per national guidelines. To facilitate PMTCT services at supported sites, additional staff capacity building was also undertaken through continuous medical education sessions both at facility level and at district level for PMTCT services providers. The project supported staff at three high volume sites (AMURT Health Center, Divine Worship Parish Dispensary, Guru Nanak Hospital) challenged by high staff turnover and shortage. To strengthen the implementation and roll out of EID services, the project trained nurses as well as laboratory technicians and supported TOT EID training. In addition, the project established an EID lab network with motorcycle riders ferrying dried blood spot (DBS) samples for EID from supported sites to the Kenya Research Institute EID lab and returning results to the lab.

During the life of project, the overall HIV positive rate at the PMTCT sites was 6.8% with a counseling uptake at first ANC of 98.6% and maternal ARV prophylaxis uptake at both ANC and maternity of 81% and infant ARV prophylaxis of 79.5% at both ANC and maternity as depicted in the graphs below. There was a steady increase in the number of sites supported, an increase in maternal uptake of CT services within PMTCT settings and increase in uptake of maternal prophylaxis. The project experienced a reduction in the uptake of maternal ARV prophylaxis due to the implementation of a new ARV commodity ordering system for PMTCT sites, high staff turnover thus loss of trained staff, poor data recording and record keeping practices. Various measures implemented to curb this included – recruitment of staff for high volume sites, on-job-training and CMEs for new staff until the staff could attend a centralized training, special emphasis on routine supervision by project staff . Also provided were technical assistance site visits on record keeping practices, collaboration and coordination with District Health Management Team (DHMT), Kenya Medical Supply Agency (KEMSA), Kenya Pharma and Supply Chain Management System to ensure consistent supply of test kits and ARVs to supported sites. The project also linked with the Axios Donation program and Abbot to acquire Determine HIV test kits, nevirapine tablets and syrup as well as dispensers. Stocks from the Axios Donation program and Abbot were maintained and distributed to supported sites when required.

In early 2008, the province was rocked by post election violence which led to disruption of PMTCT services in most health facilities. Pregnant women, like most other people, could not access health services due to insecurity, shorter working hours, lack or shortage of personnel at health facilities, and lack of transport services especially in slum settings.

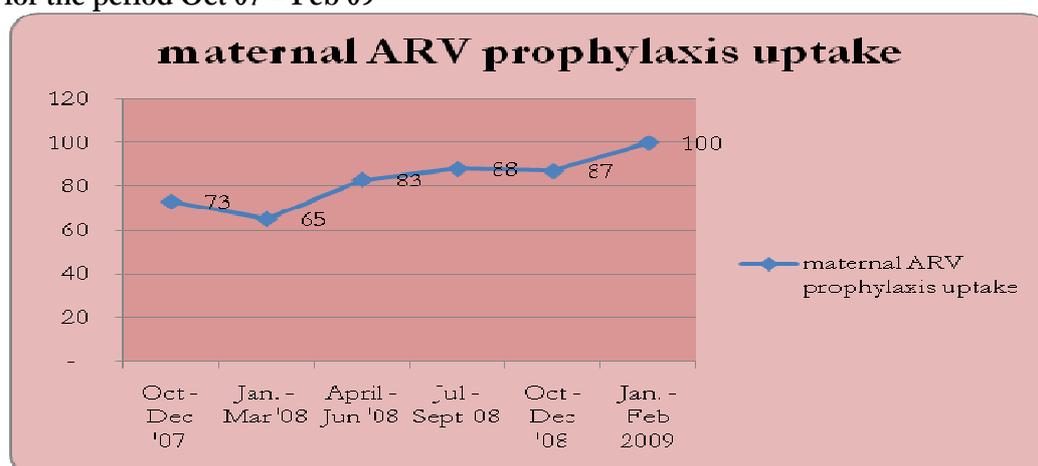
**Fig 1: Cascade for overall uptake of PMTCT services in Nairobi Province for the period Aug 06 – Feb 09**



**Fig 2: Trend of the number of pregnant women provided HIV counseling and testing and ARV prophylaxis in both ANC and maternity setting for the period Oct 07 – Feb 09**



**Fig 3: Percentage trend of the maternal ARV prophylaxis from both ANC and maternity settings for the period Oct 07 – Feb 09**



To enhance reporting and provision of PMTCT services as per the national guidelines, the project ensured availability of national data capture tools and PMTCT guidelines in all supported sites. Dissemination and orientation of service providers on the said guidelines and data capture tools was conducted by project staff in collaboration with the PHMT/DHMTs through CMEs, ongoing TA and/or during facilitative supervision.

Supervision of PMTCT services was undertaken jointly between project staff and DHMT members and this enhanced the private-public sector partnership. World events such as the bi-annual *Malezi Bora* campaign were supported to emphasize better feeding practices, child health, etc. A lesson learned was that joint supervision and support of PMTCT related world events were key in implementation of PMTCT services. The project provided a grant to Catholic Medical Mission Board (CMMB) to support seven mission hospitals in Nairobi Province. In the future, it is proposed that ART will be provided within PMTCT settings for mothers with CD4 less than 350. When this is realized, the project, in collaboration with PHMT/DHMTs, will support the initiative at supported sites as per the national guidelines as well as have in place tracking systems to confirm that mothers identified to be HIV+ through the PMTCT program are enrolled along with their infants to HIV care and treatment programs as appropriate.

A2N/C in Nairobi supported provision of Post Exposure Prophylaxis (PEP) in 29 ART sites. Service providers were trained in PEP, as part of ART training, as well as being trained on post rape care/management of sexual assault as per national guidelines. Technical assistance was sought from Nairobi Women's Hospital in training of service providers on post rape care for survivors of gender based violence as well as post training supervision of trained sites. Linkages were made to the community through sensitization of community opinion leaders, training of drama groups, and facilitating them to conduct outreaches and community fora outreaches on gender based violence and HIV.

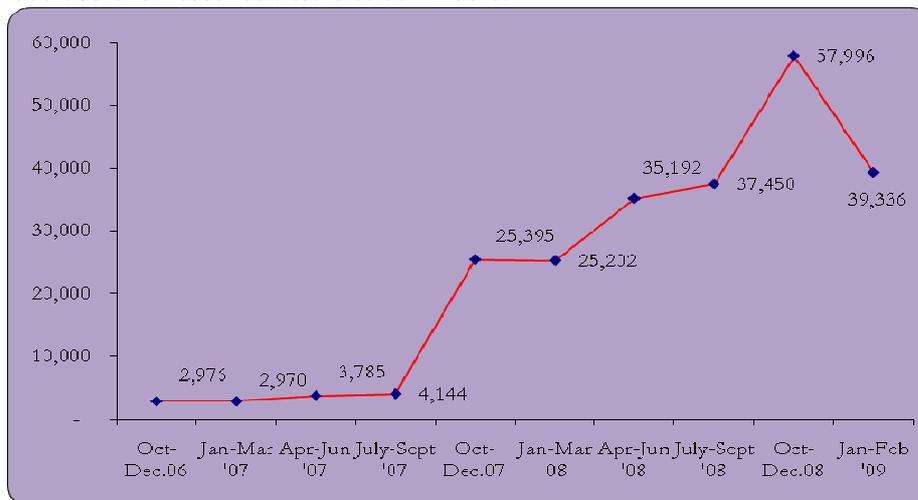
A2N/C in Nairobi Province trained 44 health care workers on injection safety. Updates on infection prevention and management of medical waste were also provided through continuous medical education sessions to various health care workers including support staff. Site assessments were made and renovation needs identified at the supported sites. It is envisioned renovations and repair/constructions of incinerators will be undertaken through A2N.

### **Expand HIV Counseling and Testing services:**

A2N/C supported the province in offering testing and facilitated entry to prevention and care through its support of 56 diagnostic testing and counseling (DTC), provider initiated testing and counseling (PITC) and VCT sites in Nairobi Province. 215 service providers were trained on provision of HIV counseling and testing services (provider initiated counseling and testing, VCT and PMTCT couple counseling, adherence counseling, and pediatric psychosocial support) as per national standards utilizing Kenya Association of Professional Counselors and key provincial HIV Testing and Counseling (HTC) trainers. In addition to trainings, service providers were provided with updates on HCT through continuous medical education sessions. A2N/C was able to reach in Nairobi 234,446 persons with HIV counseling and testing services, exceeding the targets set for each project year for number of persons reached with CT and given their test results. The project supported four lay VCT counselors at high volume VCT sites within the province to address the shortage of VCT counselors at supported sites caused in part to withdrawal of the NASCOP–Global Fund supported VCT counselors. Following the withdrawal of the NASCOP-Global Fund VCT counselors from static sites the project re-evaluated its HCT strategy and rolled out more aggressively mobile VCT outreaches to cater for the growing demand for HCT services within Nairobi Province. The mobile VCT outreaches were conducted on a monthly basis in the three Nairobi Districts and were a collaborative activity between the Result 1 and 2 teams targeting *matatu* touts, route leaders, commercial sex workers, youth, workplaces, intravenous drug users and the general population. In addition to the current HCT models that were implemented, the project will roll out home-based counseling and testing services that have been tested and proven successful in Kenya.

The project steadily expanded the number of supported sites (5 to 56) as well as mobile outreaches conducted for HCT. This led to a gradual increment in the number of persons reached with HCT services within Nairobi Province as depicted in the graph below. In the October – December quarter of 2008 there was a steep rise in the number of clients reached with HCT services following the support the project provided the province during the *HCT Rapid Result Initiative* held in November – December 2008 and on the *World AIDS Day*.

**Fig 4: Trend of the number of individuals who received counseling and testing for HIV and received their test results: Oct 06 - Feb 09**



To avert staff burn out, the project also supported counselor supervision sessions in the three districts in Nairobi. These sessions provided VCT counselors as well as nurse counselors an opportunity to share experiences and develop coping mechanisms in handling clients. To aid counselor supervision sessions, the project supported training of 24 service providers as counselor supervisors. The project supported the province in HCT outreaches during the *HCT Rapid Result Initiative* held in November – December 2007 and 2008 and on the *World AIDS Day* marked on 1<sup>st</sup> December. A2N/C liaised with NASCOP and KEMSA to ensure HIV test kit supply within the province. Through A2N, support for home-based HIV counseling and testing in slum settings and TB screening will be integrated into the HCT outreaches. Integration of HCT into FP services was also undertaken, with 26 service providers trained and 29 service providers trained in FP into VCT.

The project, through a grant to Kenyatta National Hospital VCT Center, supported HCT services in Kenya's largest referral hospital. The grant supported HCT services at the VCT center, youth center, PITC in out-patient and in-patient settings within the hospital, home based counseling and testing, mobile VCT as well as in KNH satellite VCT centers within the province. The KNH VCT grant supported counselors, counselor supervision sessions for counselors and supervisors, production of newsletters, meetings for network members, site supervision and mentorship.

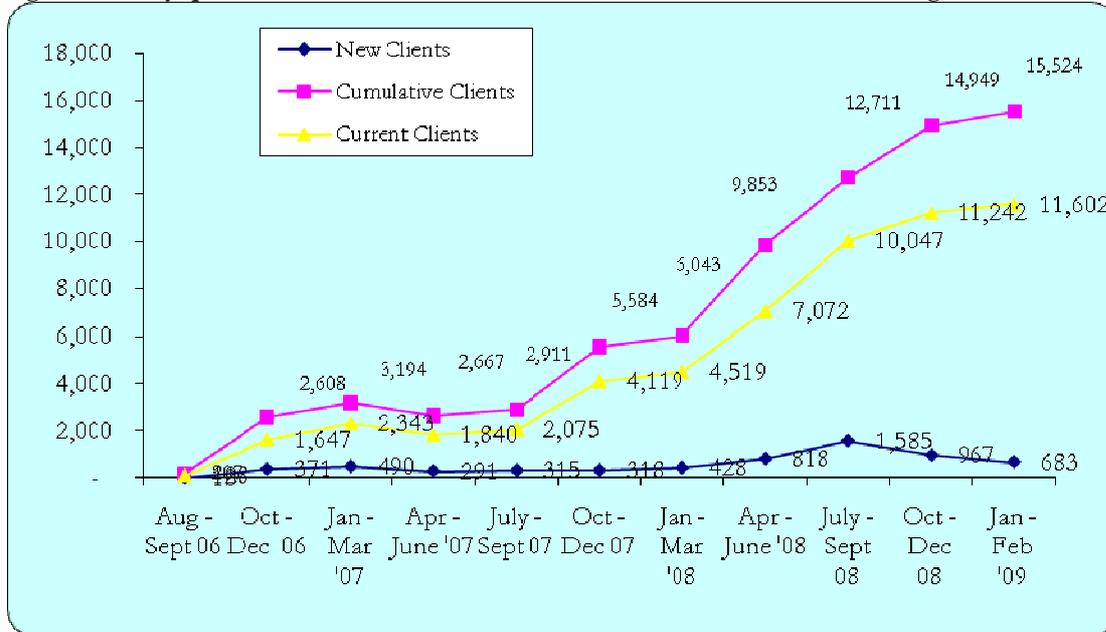
The project learned that support of mobile outreaches greatly assisted the project to reach persons who would otherwise not have sought the services at static VCT sites due to issues related to access, stigma or lack of awareness of the importance of knowing one's HIV status. The mobile VCTs proved successful as there was a better uptake of CT services and the project managed to surpass its CT target

#### **Scaling up HIV care & treatment (adult and pediatric):**

By the end of the project, A2N/C was providing support to 63 ART sites (1 District Hospital, 3 FBO/private sector hospitals, 26 health centers and 33 private clinics/dispensaries) in Nairobi Province. All public sector sites and a few faith based and private sector sites were offering a comprehensive package of HIV care and treatment services (lab testing or linked to a lab network, adherence and nutritional counseling, OI prophylaxis and treatment, nutritional support, FP, HIV prevention, psychosocial support through establishment of post test clubs and on-site ARV dispensing). During this period, 6,225 clients were newly initiated on ART, 15,524 had ever received ART while 11,602 clients were receiving ART by 28<sup>th</sup> February 2009. Each

year, the project exceeded its ART target. During the quarter April–June 2008, the project witnessed a doubling of clients newly initiated on ART following the introduction of the lab network for CD4 count tests as depicted in the graph below. Overall, there was greater confidence amongst service providers to initiate clients (both adult and children) who met the ART eligibility criteria on HAART now that CD4 lab services were accessible through the lab network.

**Fig 5: Trend by quarter of ART clients served - New, Cumulative and Current: Aug 06 – Mar 09**



By the end of the project period, 440 service providers had been trained to deliver ART services of whom 157 were trained on pediatric HIV management (Adult and Pediatric ART management, integrated management of adult and adolescent illness, commodity management, nutrition in HIV and cancer of the cervix screening) according to national standards. In addition, updates on ART services were provided to service providers through continuous medical education sessions and quarterly clinical meetings for project supported MOH staff.



**Photo: A trainee giving a health talk during the TOT for screening of cancer of the cervix. A 2-day practicum was carried out at Waithaka Health Center following the theory sessions.**

The post election violence in 2008 led to disruption of CCC services in most health facilities due to insecurity, shorter working hours, lack/shortage of personnel at health facilities and lack of transport services especially in slum settings. Other challenges faced by the project in the roll out of ART services in Nairobi included staff shortages, high staff turnover, poor infrastructure, lack of basic hospital and lab equipment including CD4 count test machines. In order to scale up ART services, the project through a memorandum of understanding with the office of the Provincial Medical Officer supported a total of 61 services providers of various cadres. This included: nurses, clinical officers and laboratory technologist to support ART services. Other strategies implemented from lessons learned to support roll out of ART services included

provision of basic hospital and laboratory equipment; staff training on ART services, record keeping, adherence counseling and commodity management; establishment of a lab network to cater for CD4 count services; quarterly clinical meetings with supported staff as well as a mentorship program. Through the project's supported mentorship program, service providers were provided with mentorship and on-the-job training. The members of the mentorship team were experts in provision of HIV care and treatment services and included a physician, pediatrician, pharmacist, nutritionist, counselor, lab and HMIS specialist. Project staff in collaboration with the DHMT and/or PHMT provided site supervision and technical assistances. The project also supported sites with stationery, M & E tools, IEC materials, job aid and ensured availability of ARV drugs at sites.

The project endeavored to scale up access to pediatric HIV care and treatment and supported 33 pediatric sites in Nairobi. This was made possible through training of service providers on pediatric ART management, pediatric psychosocial support, play therapy, technical updates on pediatric HIV care and treatment through CMEs intensive mentorship of sites by the Pediatric ART mentor and technical assistance to sites by the service delivery team. The project's grant to Gertrude's Children Hospital (GCH) was also instrumental in scaling up pediatric HIV treatment access. Support through the grant facilitated opening a satellite dispensary by GCH in Githogoro slums, salary support for staff, free consultation and laboratory services to clients, support group meetings and psychosocial support and fun day activities for children, adolescents and their caregivers. Similar grants to Nairobi Women's Hospital, Catholic Medical Missions Board and Mbagathi District Hospital HIV clinic have facilitated the scale up of pediatric services. Lessons learned from Mbagathi District Hospital in pediatric psychosocial support include: the Hero book program empowers children who are aware of their HIV status to live positively; Treatment Literacy training for children and fun day activities for children and adolescents are effective activities and they have been scaled up to other sites including GCH, some Gold Star network sites. These lessons have also been used to enrich the project Result 3 OVC program.

- **Integration of TB & HIV services:**

The project supported training of 93 service providers in TB/HIV integration, introduced TB screening for pregnant women through the Focused ANC (FANC) training as well as provided technical assistance and supervision in collaboration with the DHMT, Provincial Health Management Team (PHMT) and the Division of Leprosy, TB and other Lung Diseases on TB/HIV integration. At the project's 32 supported TB sites, HIV provider initiated testing and counseling services were provided to TB clients. A total of 6,228 registered TB patients received counseling and testing for HIV and received their test results by the end of the project period. TB screening was undertaken for HIV+ clients, with the project supporting training of laboratory technologists and technicians on TB acid fast bacilli (AAFB) microscopy. The project supported procuring and distributing basic equipment for TB microscopy and provided free chest x-ray services for TB/HIV co-infected clients. These activities were implemented, following the realization that few clients were tested in TB settings for HIV, and even fewer clients were screened for TB in HIV care settings and apart from Kenyatta National Hospital, Mbagathi District Hospital and Ngaira Health Center – there were no other public sites in Nairobi equipped with radiology services. Renovations were undertaken of radiological services and equipment at both Mbagathi District Hospital and Ngaira Health Center thus providing for free x-ray services to TB/HIV co-infected clients.

Of the 61 project supported MOH staff, 30 clinicians and 8 lab technologists were recruited for the purpose of supporting the project's efforts towards TB/HIV integration within Nairobi province. In addition to training services providers, A2N/C supported staff updates on TB/HIV

integration through CMEs. Community health workers were trained in TB/HIV basic facts as well as defaulter tracing through collaborative efforts between Results 1 and 3 teams. During the World TB Day celebrations, the project supported activities at both district and provincial level. The project also supported sites with equipment and minor lab renovations to strength TB lab diagnosis. Through A2 Nairobi, the project hopes to further strengthen TB screening within CCC and HCT settings once the tools are approved by the MOH.



**Photo: Nairobi East World TB day 2008 event**

**Nutritional support:**

A2N/C enhanced the effectiveness of TB and ART treatment by providing food support (in the form of *uji* mix) for TB/HIV co-infected clients at supported CCC sites. Clients who meet the nutritional assessment based on Body Mass Index (BMI) are provided with

food support and are weaned off the food support upon reaching acceptable nutritional status. Clients are also linked to other food supplementation activities and to food security programs within the community through referral by CHWs and service providers.

- **Prophylaxis for opportunistic infections (OIs):**

A2N/C through PHMT/DHMT supported the provision of cotrimoxazole to HIV+ clients in CCC, TB and PMTCT settings as a preventive measure for opportunistic infections as per the national guidelines. Through USAID supported MEDS (later Kenya Pharma), CCC sites were linked to OI drug supplies for prophylaxis and treatment of OI infections at CCC settings.

- **Foster health education:**

The project supported health education at health facilities through service providers, CHWs and PLHIV Advocates. The health talks covered a diversity of topics for both PLHIV and the general public. In addition the project supported procurement of televisions, video decks and video tapes with educational materials, which clients could listen to as they wait to be attended to. PLHIV were empowered on positive living and treatment adherence through health talks and mini-talks in the post test clubs/support group meetings as well as through adult and pediatric treatment literacy trainings (adopted from MSF-Belgium at Mbagathi District Hospital). These strategies were instrumental in curbing defaulter rates and enforcing treatment adherence.

- **Strengthening lab Services:**

A2N/C supported strengthening of lab services through training laboratory technicians and technologists on various laboratory related trainings. These included TB AAFB microscopy, Dried Blood Spot for Early Infant Diagnosis, refresher course for Good Diagnostic Practices, use of new lab manual registers and forms, lab commodity management, CD4 enumeration. The project liaised with Management Science for Health (MSH) for the latter 3 trainings. Updates were also provided to service providers on various lab services, proficiency panel testing and for HCT as well as lab commodity management. Sites were supported with lab standard operating procedures (SOPs), external quality assurance for TB, and M & E reporting tools and registers.

Joint supervision of sites between project staff, district and provincial lab point person was also conducted.



**Photo: MOH supported lab technician examining a sputum smear slide for TB bacillus using the new microscope at Kangemi H/C**



**Photo: The DMLT Nairobi West demonstrating to a lab technician at AMURT H/C how to use the new Haemacue machine**

A CD4 count test lab network, or hub, was also established which linked sites to three laboratories within Nairobi – Mathare North Health Center, Kenya Medical Research Institute CD4 count test lab and St Mary’s hospital. The lab hub served 3 zones within the province – East, West and North. Blood samples were ferried by motor cycle riders from sites to the labs and results returned. In addition, a lab network for ferrying of DBS for EID was also set up to cater for the private sector PMTCT sites. The project through its grants to CMMB and GSN supported other smaller CD<sub>4</sub> count test and DBS for EID networks for the faith based and private sector sites. The project also supported the procurement of lab equipment and reagents for TB/HIV services and undertook minor lab infrastructure renovation and equipment repair. The project facilitated supplies of HIV test kits and TB/HIV reagents by liaising with KEMSA through the provincial/district MOH structures and Supply Chain Management System (SCMS). A lesson learned is that a lab network is essential for the scale up of ART services as demonstrated by the number of new clients initiated on ART following their blood samples being collected for CD4 count tests. Following the establishment of a CD4 count test network, the project was able to attain an average of 1,000 new clients initiated on HAART per quarter. A2N will continue exploring ways of enhancing the lab network to ensure clients access to essential lab services.

- **Improving infrastructure and stock management:**

A2N/C conducted assessment of supported sites for infrastructural rehabilitation and furniture and equipment to strengthen service delivery. The project undertook minor renovation of sites during the project period and also benefited from site renovation undertaken through the previous Pathfinder-led COPHIA project. More extensive renovation of sites is planned to take place under A2 Nairobi as these are key to provision of quality services.

The project benefited from a humanitarian donation by a church in the United States facilitated by the Kenya-U.S. Liaison Office of the U.S. Embassy which assisted internally displaced persons (IDPs) in all provinces of Kenya. In Nairobi, A2N/C conducted IDP camp/group assessments in the province jointly with the Ministry of Health personnel under the guidance of the Provincial Director of Public Health & Sanitation to develop a distribution plan for the Nairobi donation. This plan was subsequently modified when the shipment arrived following closure of IDP camps. The donation was re-directed to persons living with HIV, orphans and vulnerable children and health facilities within the province. Fourteen A2N supported pediatric

ART sites benefited from boxes of toys while 2 health centers, 2 district hospitals and the national referral hospital benefiting from an array of medical supplies.

A2N/C supported the procurement and distribution of furniture, basic hospital and laboratory equipment to 19 health facilities with comprehensive care centers. Reagents for CD4 count testing, biochemistry and hematology were procured and benefited 9 laboratories resulting in an expanded range of services being offered at the health facilities hence better monitoring of clients. The project also liaised with supply chain management system (SCMS) for follow up supply of CD4 count test reagents to sites with CD machines. Service providers and facility in-charges highly appreciated the support extended to the facilities directly by PEPFAR and through the project toward provision of quality patient care. The lesson learned over the project period is that provision of basic hospital furniture, hospital and lab equipment is key to provision of quality services. A joint needs assessment between project staff, facility in-charges, DHMT and PHMT is key in ensuring that the items are need based and therefore of benefit to the health facilities.

To address stock management, the project supported training of service providers in ART and lab commodity management, supported printing and/or distribution of recording tools, drugs and commodities, provided districts with transport for re-distribution of available stocks from sites or district depot or from KEMSA and liaised with KEMSA through the provincial/district MOH structures and SCMS to ensure availability of commodities at sites. However, occasions arose where sites were faced with stock outs due to unavailability of supplies from the distribution agencies. The commodities greatly affected in terms of shortages included HIV test kits and FP methods.

- **Integrating services:**

The project endeavored to integrate HIV and RH/FP services through training of service providers on FP into VCT, HCT into FP, FP into PMTCT, FP/STI into CCC and cancer of the cervix into CCC. Integration of services was also emphasized during technical assistance visits by project staff, mentorship by the NARESA mentors and through joint supervision with district teams. A2N/C also supported the provision of a comprehensive package of care for PLHIV that went beyond provision of ARV drugs to clients but one that incorporated psychosocial support (support group meetings, fun days for children and adolescents), patient empowerment (health talks, treatment literacy), provision of OI prophylaxis and treatment), prevention with positives (use of condom and other FP methods), nutritional counseling and support and linkages to home based care, food security and life skills/income generating activities through collaboration of Result 1 and Result 3 teams. It is envisioned that A2N project will continue strengthening integration of services in Nairobi Province.

During the project period, 8 youth friendly service (YFS) sites were established: of special mention are those at Gertrude's Children's Hospital and Mbagathi District Hospital. At these two facilities HIV positive youth clients benefited from youth excursions/outings, youth support groups and RH/FP messages. These activities resulted in better treatment adherence, increased knowledge amongst the youth on HIV, RH and sexuality as cited from lower numbers of defaulting youth at the two facilities. The project through its extension as A2 Nairobi hopes to further strengthen provision of youth friendly services for both RH and HIV services.

**Quality improvement:** The project supported training, updates, mentorship and on-job-training of service providers thus building their competency, diminishing their provider bias, stigma and improving attitudes especially towards provision of services to adolescents, men, couples, unmarried but sexually active women and PLHIV. In addition, as highlighted above, the project

supported minor renovation of sites, procured equipment, furniture and reagents, printed and/or distributed M & E tools, SOPs, guidelines, protocols, job aids and information, education and communication (IEC) materials, and ensured flow and distribution of drugs and commodity supply. During the project period, support was provided towards facilitative/supportive supervision of sites by both the DHMT and PHMT (through training and provision of transport allowance), counselor supervision meetings for both counselors and supervisors and staffing support to sites in order to ensure provision of quality services. The project also assisted in the establishment of training teams to facilitate the various trainings.



**Photo: MOH supported staff during a session at the quarterly clinical meeting**

Through support for facilitative/supportive supervision, the project helped enforce team work of DHMT, PHMT and facility staff. The supervisory visits helped facility staff to focus efforts on challenges faced and to set targets geared towards improving quality of service delivery. A2N/C also held quarterly clinical meetings with supported MOH staff to facilitate experience-sharing among service providers. These fora also served to update staff on the project's progress towards achieving set goals and to share technical updates.

Support was also provided for facility interdepartmental meetings, district and provincial stakeholders meetings which facilitated networking, and experience-sharing among stakeholders and coordination of supported activities. At district level, the project participated in district technical sub-committees with a mandate to guide implementation of specific activities.

## **1.2 Expanded availability of FP, RH & MCH services with HIV/AIDS services**

- **Expanding FP access:**

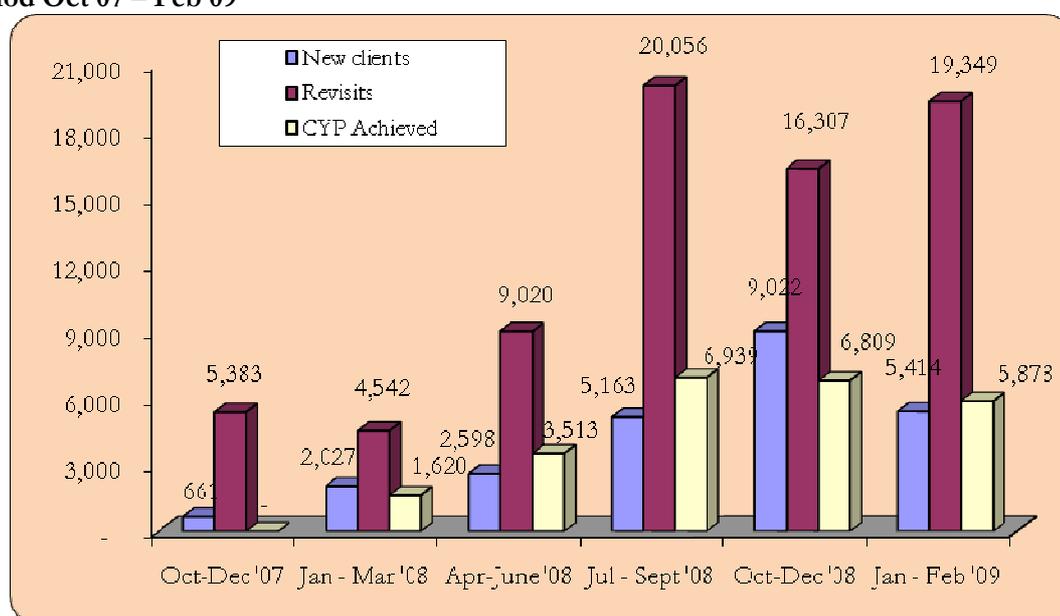
During the project period, 451 service providers were provided various RH/FP training: Contraceptive Technology Update (CTU); CT into FP; FP into VCT; and FP into PMTCT as per national standards. In addition, updates were provided to service providers through CMEs on a variety of topics such as FP methods, infection prevention and HIV/RH integration. A2N/C supported distribution of FP guidelines, FP handbooks, protocols, Tiahr charts, M & E tools as well as distribution of commodities. The project also leveraged resources from the Hewlett Foundation and provided a one-off support for FP commodities at selected sites. Integration of RH into HIV services was also undertaken to target PLHIV and promote dual and double protection as part of initiatives of prevention with positives. A challenge faced during the project period was inconsistent supply of FP commodities from KEMSA and staff redeployment within the MOH and City Council of Nairobi thus leading to disruption of RH/FP services. The project supported the re-distribution of FP commodities during times of shortage, and following the post election violence leveraged its support to FP sites serving internally displaced persons through FP commodities purchased under the Hewlett Foundation. Following staff redeployment at public sites, the project supported CMEs, OJT and when possible invited more staff from the affected sites to centralized trainings.

A2N/C supported the training of trainers on various RH/FP curricula to create a provincial pool of trainers for further strengthening of RH/FP services within Nairobi Province. Post training follow-up of service providers was also provided to ensure that trainees implemented services within their facilities

The project facilitated the procurement and distribution of FP equipment and supplies to 21 FP sites. The equipment purchased included examination couches, delivery beds, speculums, kidney dishes, surgical instruments, gloves, cotton wool, bed linen, infection prevention supplies among others. Provision of RH/FP equipment and supplies had a great impact on the quality of RH/FP services provided at supported sites

Through A2 Nairobi project it is envisioned that renovation of sites will be undertaken to further strengthen FP services, procure additional equipment and supplies, train services providers on long term and permanent methods, support on-job-training of service providers on postpartum IUCD as well as conduct RH/FP outreaches in community settings.

**Fig 6: Trend of New Clients, Revisits clients served and couple years of protection achieved for the period Oct 07 – Feb 09**



The number of sites supported with FP services continued to gradually increase as did number of new clients, revisit clients and the couple years of protection as depicted in the graph above. A total of 24,885 new clients were served with 74,657 revisit clients being attended to at supported sites. Total couple years of protection achieved during the project period was 24,759. The contraceptive method mix over the project period remained biased towards injectables and implants, closely followed by oral pills. This is attributable to the stock outs of FP commodities at sites and national level and that the project was not in a position to procure FP commodities due to restriction on use of PEPFAR/POP funds for any commodity procurement at project level. However, when commodities were available at the KEMSA or the central depot, the project availed transport for the collection and distribution of the FP commodities from KEMSA to central depot and/or health facilities. The A2 Nairobi project will continue supporting reporting of FP commodities consumption from facilities to district and onward to the province and KEMSA to enhance logistics management. In addition A2 Nairobi will support community based provision of FP services as per the national guidelines through training of CHWs and strengthening of community-facility linkages to ensure CHWs get supplies and are provided with supervision by facility based service providers.

- Antenatal care:**

Private sector PMTCT service providers were trained on FP to facilitate integration of FP services within ANC and maternity settings as well as training on Infant and Young Child Feeding practices in order to offer pregnant and lactating women with appropriate nutritional counseling as per national guidelines. This resulted in provision of FP services to mothers and follow-up on feeding practices during the postnatal period. Under A2N, it is envisioned that the project will receive the President's Malaria Initiative thus enabling it to support training of service providers in Focused Antenatal Care which includes components on malaria in pregnancy (i.e., intermittent presumptive treatment and ITN promotion), screening for and management of high risk pregnancies, use of *haematinics* and TB screening in pregnant women as per national protocols as this has been identified as gap that need to be filled within Nairobi Province.
- Labor & delivery, emergency obstetric care and child health:**

During the project period, A2N/C did not receive any funds for emergency obstetric care, maternal, neonatal and child health.
- Post-abortion care (PAC):**

A2N/C in Nairobi Province supported provision of PAC services at three sites by the end of the project period. At these sites, clients were provided with emergency treatment for complications of spontaneous or induced abortion, FP counseling and service provision, STI screening and treatment and HCT services. Eighteen service providers were trained on Post Abortion Care as per the national curriculum. During the training there was special emphasis on infection prevention and FP counseling within PAC settings. Three community PAC sensitizations were conducted within the catchment area of the sites to demystify PAC services to the community and thus mobilize the utilization of the service. The one-day sensitization workshops were attended by 86 community leaders (chiefs, religious leaders, youth and women group leaders, CHWs and trained PAC service providers. MVA kits donated to the project by the IPAS MVA draw-down account were distributed; in addition, the project procured other RH equipment and supplies for the roll out of PAC services at 9 sites. However not all the nine sites were able to implement PAC services due to implementation challenges that arose following staff reshuffle and the need to construct placenta pits and incinerators at the sites as they lack in some of the facilities. A2N will undertake additional service provider training as well as train district RH coordinators as PAC supervisors. Plans are already underway to renovate and/or construct placenta pits and incinerators for RH/FP services at supported sites which will be undertaken through A2N support. A2N project will also support the capacity building of project staff on community PAC so as to sustain the community's engagement on PAC issues.
- Men as partners:**

The project has endeavored to target men and increase their access to HIV and RH services through various activities. Initiatives to foster male involvement included HCT outreaches to the workplace, provision/dispensing of condoms at workplace sites, health facility as well as community settings, training of counselors in couple counseling for VCT and PMTCT settings. The project plans to further strengthen these initiatives under A2 Nairobi through printing and distribution of partner invitation cards, sensitizing clinicians on the need to minimize provider bias, provision of services on Saturdays and express services to couples thus creating a male friendly atmosphere. These interventions have been applied by the Pathfinder CDC supported PMTCT project and have shown an increase in service utilization by men.

- **Youth Friendly Services:**

The project supported the training of 47 service providers on youth friendly services using the national adolescent sexual and reproductive health curriculum which emphasizes information and counseling on puberty, RH, HIV and adoption of safer sexual behavior through improved ABC messages, counseling on STI/HIV prevention, testing and treatment, contraception appropriate to the client's preferences and fertility goals, dual and double protection, PEP, substance abuse counseling and treatment and youth pregnancy. The project through its extension as A2 Nairobi hopes to further strengthen provision of youth friendly services for RH services.

### **1.3 Reinforce networking between levels of care & between clinical services & community**

- **Public-private sector networks & linkages**

A2N/C supported the private sector through the Family Health International affiliated Gold Star Network (GSN) as well as directly in the implementation of PMTCT services within private sites in Nairobi. A2N/C through its support to GSN supported 33 ART sites in Nairobi and directly provided support to 34 PMTCT sites. The majority of the GSN supported sites are clinics managed by doctors while the supported PMTCT sites are mainly nurse operated clinics and nursing/maternity homes. Through its collaboration with the private sector the project has endeavored to strengthen the relationship between the privately managed health facilities with the Ministries of Health. This was accomplished through joint supervision of private facilities, training of private sector service providers by MOH trainers, monthly district CMEs for PMTCT service providers, quarterly CMEs for doctors and extension of government led campaigns such as *Malezi Bora* and National HCT to supported private sector sites. Public-private sector linkages at district level have also assisted the project in the identification of potential expansion sites in both private and public sites. The lesson learned is that engagement of the PHMT and DHMT in supervision of service provision and training of private service providers is key in ensuring quality of service provision in the private sector. Involvement of private sector sites in world events days has enhanced the relationship between public and private sector sites.

- **Linkages between levels of care**

Using the information/feedback obtained from community focus group discussions, community health care workers, community owned resource persons (CORPs), health facility staff, DHMTs, PHMT, project technical assistance site visits, supervision visits and the NARESA-lead mentorship team, the project improved and enriched service provision between the various levels of care. In line with Government policy of decentralization of services, the project through building the capacity of health centers to establish CCCs, strengthening lab services, ensuring trained personnel at supported sites has supported the decentralization of ART services from the district hospital to health centers. Through downward referral, stable ART clients are now managed at health centers while the district hospital, though still serving stable ART clients, also serves as the upward referral point for complicated ART clients. The project has endeavored to integrate and establish linkages between HIV and RH/FP services through training of service providers on the integration of FP into VCT, HCT into FP, FP into PMTCT and FP/STI into CCC. A2N/C also supported the provision of a comprehensive package of care for PLHIV that went beyond provision of ARV drugs to clients, but one that incorporated psychosocial support (support group meetings, fun days for children and adolescents), patient empowerment (health talks, treatment literacy), provision of OI prophylaxis and treatment, prevention with positives (use of condom and other FP methods), and, nutritional counseling and support.

- **Linkages between clinical services and community**

Good linkages were established between facilities and the communities within their catchment areas. This was possible due to the presence of CHWs, support groups, implementing partners (CBOs) and Community-owned Resource persons (CORPs). The project supported the sensitization of service providers on HBC and stigma reduction through CMEs. Health talks were also jointly facilitated between service providers and PLHIV Advocates at health facilities. In addition, the Result 1 team also supported focus group discussions among clients and CHWs, the feedback of which helped to improve service provision. As a follow-up to strengthening linkages between clinical services and communities, A2N project through collaboration between Result 1 and Result 3 teams will support establishment of Community Home-based Care (CHBC) desks and place CHWs at supported sites to ensure effective referral within the facility and between the community and the health facilities. The CHWs will assist service providers with issues such as health talks; adherence counseling; taking client details such as weight and height; tracking defaulters, establishing support groups where there are none; linking clients to CHWs operating within the community or to other NGOs and/or CBOs; as well as making the site more receptive to the community and assisting it to meet the community's needs. Lesson learned is that community and clinical services linkages are key to creating demand for services, subsequent client follow up and as well as to deterring clients from defaulting on treatment. A2N/C project will continue strengthening the linkages between clinical services and community services under the A2 Nairobi project through various other strategies.

### **Summary**

Overall the A2N/C project in Nairobi Province has been successful, especially in increasing uptake of ART services by PLHIV through the establishment of new CCC, improving the existing CCCs, establishment of the lab network, provision on the much-needed basic hospital furniture and equipment as well as lab equipment. Key project activities that impacted on the quality of services within the province were: capacity building of staff (centralized training and CMEs); the mentorship program; support of personnel for HIV/TB services; and establishment of a good working relationship with PHMT and DHMT members. As cited in this report, 6,225 clients were newly initiated on ART, 15,524 had ever received ART while 11,602 clients were receiving ART as at the end of the project. In addition, there was increased uptake of HCT services in line with the need for the general public to get to be aware of their HIV status. 234,446 persons were reached with HIV counseling and testing services during the project period.

### **Summary of Challenges**

The project experienced various challenges in the implementation of its Result 1 activities, as already cited earlier. Strategies applied to address these challenges are cited in the narrative. The challenges included:-

- A reduction in the uptake of maternal ARV prophylaxis due to the implementation of a new ARV commodity ordering system for PMTCT sites; high staff turnover, thus loss of trained staff; poor data recording and record keeping practices;
- Withdrawal of the NASCOP – Global Fund supported VCT counselors from supported sites which affected HCT services within the province;
- Occasions arose when sites were faced with stock-outs (ARVs, Septrin and other OI drugs, HIV test kits, FP commodities) due to unavailability of supplies at the national level;
- Staff redeployment and high staff turnover within the MOH and City Council of Nairobi thus leading to disruption of provision of HIV and RH services;

- In early 2008, the province was rocked by post election violence which led to disruption of services in most health facilities due to insecurity, shorter working hours, lack/shortage of personnel at health facilities and lack of transport services especially in slum settings;
- Poor record keeping, delays in data collection and reporting by health facilities to the district affected timely reporting to the province, national HMIS and USAID;
- Tracing of defaulters in the CCC and TB clinic due to inadequate personal details of clients and resources to undertake defaulter tracing affected the project thus leading to high defaulter rates in some facilities.
- During the project period, it was realized that more attention was needed for facilitative supervision by the project, DHMT and PHMT. This lack had resulted from the lack of training available on approaches in facilitative supervision as well as provision of the necessary tools to implement an integrated approach of supervision. In the future, through A2 Nairobi, the project will further strengthen these aspects of quality improvement.

#### **Lessons learned and recommendations:**

- Support towards facilitative/supportive supervision of sites by both the DHMT and PHMT (through training and provision of transport allowance); counselor supervision meetings to avert burn out for both counselors and supervisors; and, staff support to sites contributed to improved service provision at supported sites. There is, however, need to further support supervision through strengthening of existing facilitative supervision tools and training more DHMT and PHMT on facilitative supervision.
- Development of a standard package of care to implement both community and service delivery components is recommended.
- A lab network is essential for the scale-up of ART services as demonstrated by the number of new clients initiated on ART following improved and increased collection of blood samples for CD4 count test. Following the establishment of a CD4 count test network, the project was able to attain an average of 1,000 new clients being initiated on HAART per quarter. If possible, it is recommended that A2N project provide support for other laboratory investigations for CCC clients such as full blood count, pregnancy test, liver and renal function tests. In addition PMTCT mothers could also be supported with lab investigations for their antenatal profile – full blood count, blood group and cross match and syphilis test.
- Support of HCT outreaches that included MVCT and home based HCT greatly assisted the project to reach persons who would otherwise not seek the services at static VCT sites due to issues related to access, stigma or lack of awareness on the importance of knowing one's HIV status. The HCT outreaches proved successful as there was better uptake of CT services and the project managed to surpass its CT target. To reach all members of a household it is recommended that A2N continue to roll out home based counseling and testing.
- Trainings, updates, CMEs, mentorship, on-going TA support by project staff and on-job-training are key in building services providers competency, reducing provider bias, stigma and improving provider attitudes especially towards provision of services to adolescents, men, couples, unmarried but sexually active women and PLHIV. It is recommended that A2N continue supporting and scale up these skills and knowledge enhancing activities for service providers in order to maintain the quality of service provision at supported sites.
- Support of minor site renovations, procurement of basic hospital and lab equipment, furniture and reagents, printed and/or distributed M & E tools, SOPs, guidelines,

protocols, job aids and IEC materials, and ensured availability of drugs, commodity and other medical supplies contribute much to provision of quality services. A2N should continue to support these initiatives.

- The project's support for quarterly clinical meetings with supported MOH staff facilitated experience sharing among service providers, forums for technical updates; discussions on how best to support the project's progress towards achieving goals set allowed MOH supported staff to appreciate the contribution that their work made to the project as well as demonstrating the number of people their work was able to reach out to and thus the change their efforts made in other people's lives. A2N should continue to support these initiatives as they help much to motivate staff and help service providers to understand better their contribution to the project and the community at large.
- Support and buy-in and good work relationships with the PHMT, DHMT, clinical implementing partners and consortium partners are critical to successful implementation of a project's work. The project should continue to strive to maintain these good working relationships under A2N as they facilitate successful project implementation.

## **Result 2 Improved and Expanded Civil Society Activities to Increase Healthy Behavior**

### **2.1 Expanded and strengthened community and workplace prevention programs**

#### **Formal Workplace Sector**

Outreaches to the formal workplace sector started in January 2007 with the 15 PLHIV Advocates who were to facilitate during the workplace sessions being taken through a five day training that covered various HIV prevention topics such as condom self efficacy & condom efficacy, VCT, PMTCT and positive living. They were also taken through a facilitation skills session to enable them effectively deliver during their workplace sensitization sessions. The sessions were to be delivered in three modules that took approximately one and a half days to complete. The workplaces were allowed to pick the timing that worked best for them without jeopardizing their day to day activities.

By end of February 2009, **78** formal worksites had been reached though sensitization sessions conducted by PLHIV Advocates.<sup>2</sup> The contact person at NCPB- one of the worksites sensitized

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<sup>2</sup>. These worksites were; Kenya Revenue Authority, National Cereals & Produce Board- NCPB, Alltex EPZ, Wire products, Cooperative bank training school, Kenya Institute of Special Education, Ministry of Regional Development, Lukenya School, Kenya Institute of Education, Unilever, KIRDI, Ministry of Education Science & technology, Vanguard, Catholic Relief Services- Kenya and Sudan offices, Dandora Police, Nyayo Tea zones, Teachers' Service Commission- TSC, Population Council, Nairobi Bottlers, Office of The President, Agakhan Foundation, Agakhan Hospital, Unga Limited, Glasco Smithkline (GSK), Ministry of Foreign Affairs, Mara Conservancy, Upper Kabete Campus, Chiromo Campus, Lower Kabete Campus, Parklands Campus, National Assembly Staff, NEMA, Commercial Bank of Africa, Total Kenya, Kenya Wildlife Services, Pan Africa Life Insurance company, Swedish Cooperative Centre, ICRAF, Diamond Trust Bank, Safaricom Kenya, Nation Media Group, TPS Serena Group, Inter- News, Property Development and Management Limited, Petroleum Industries Services, UNDP Initiative, Njogu-ini Hotel, Neptune shelters, Osho Millers, Cosmocare, UN Volunteer Scheme, Unga Farmcare, Ministry of Housing, Ministry of Tourism, Kenya Pipeline company, Kenya Ports Authority, Kenya Airports Authority, Chandaria Industries, Red Brick hotel, Radar Security, Ku'lal Industries, Kenya Union for the Blind, Seniors Driving school, Double M Commuter trains, Black Hodge, Concern Worldwide, Abercrombie & Kent, Wargen Services, Nairobi Fire station, Cradle/ Prudence College,

in June 2007 - sent the project a glowing recommendation, thanking us for the work that the Advocates have done for their members of staff. It reads in part-  
*I must confess that I have attended several seminars on HIV and AIDS but the way the APHIA II Nairobi is structured is more realistic and lives the reality of HIV and AIDS, and I believe that has greatly contributed to the big impact in a very short time. My phone and that of our facilitators have become a Switch board with calls asking for advice about one thing or the other every day. This ranges from symptoms of new infections to nutrition and positive living.*

*Personally I have also been forced back to the drawing board to consider my career because in 15 years as an analyst programmer, I have not derived satisfaction close to what I have witnessed in the last two months. The fact that people are confessing with their own mouths that **"their fear is no longer to test HIV positive but to be HIV positive without them knowing"** is an indication that as NCPB we are crossing the turbulent sea of ignorance which have contributed immensely to lose of lives in our midst. The fact that they no longer see it as a death sentence is in itself comforting. I am confident that by the time we will be through with the third module, we will have won the war on HIV scourge.*

*I must say that we had the best facilitators ever on matters of family, sexuality and HIV and AIDS and that is why the staff demanded that a similar seminar be organised for them and their spouses so that they benefit as a family and if this war can be won at the family unit, then we all will have won."*

An upsurge in formal worksites needing HIV sensitization session for their staff normally peaked in December because of World AIDS day celebrations. This was a trend noticed during the life of the project.

MVCT provided at the formal worksites started in March 2007 after sensitization sessions at Sports Stadia management where 27 people were counselled and tested. This was after a request from the workers that they had no time to go and get tested because of work constraints because by the time they left their workplaces, the VCT sites would be closed. The project agreed to provide this service at no cost to the worksites. The following worksites were also offered MVCT during the course of the project and the number of their workers counselled and tested; Agakhan hospital (238 people), Kenya Bureau of Standards (113 people), Nairobi Fire Station (28 people), Everest (30 people) and Tea Board of Kenya (10 people)

A number of Nairobi schools had their teachers sensitized by the PLHIV advocates' under the schools as worksites program.<sup>3</sup>: Most of the schools with sensitized teachers are schools where the "Chill" abstinence program is implemented. This was to ensure that the teachers had adequate HIV information for their own personal use as well as giving appropriate advice to the students whom they teach.

#### Informal Workplace Sector

Outreaches to informal worksites started in February 2007 after the training of the PLHIV Advocates who were facilitate the sessions. Workers mainly in the *jua- kali* sector were trained such as the mechanics in garages, carpenters and touts at various bus termini. Since these groups

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NACC, ICRC, Government Press, Everest Enterprise, Diamond Trust Bank, Tea Board of Kenya, Nairobi Bottlers, Kobo Safaris and Panda Security group.

<sup>3</sup> Chandaria Primary, Tom Mboya primary school, Bohra Primary, Charles Lwanga Primary, Shadrack Kimalel primary, Roysambu primary, Ushirika primary, Kawangware primary, Rock Field primary Park road primary, Kileleshwa primary school, St. Peter's Clavers primary, Ronald Ngala primary school, Githurai primary school, Rabai Primary, Muthaiga primary, Kangemi primary, Baba Dogo primary, Baptist Academy, Arya primary, St. Georgina Academy, Elite Girls High school, Huruma Secondary school, Komarock Primary school, Dandora Secondary.

of people are very busy- the key attraction for them was the condom demonstration. This got their attention quickly and after that, they were open to discuss other HIV prevention issues like counseling and testing as well as correct and consistent condom use.

## **2.2 Expanded prevention programs targeting MARPS**

At the beginning of January 2007, four drama/ youth groups were recruited from within the slum communities where high risk community outreaches were to be conducted. These slums were; Kawangware, Huruma, Mathare and Mukuru. The main aim of recruiting groups from the areas was for sustainability purposes such that when the project ended, the young people trained from that community would still hold this vital HIV prevention information and would continue to pass it on to their communities. After the recruitment of the groups, they were taken through a 5 day training program that was to give them information on various HIV prevention topics like basic facts on HIV/ AIDS, condom & self efficacy, trusted partner myth, VCT, TB and PMTCT. They were also taken through theatre skills training by two theatre experts on how to deliver high quality community outreaches. With this information and training, they began to work in earnest within their communities in February 2007.

In May 2008, four additional drama/ youth groups were recruited from Githogoro, Dagoretti, Kibera and Dandora. They underwent 7 days training to bring them up to speed with HIV prevention information and theatre skills to enable them to catch up with the groups that had started community outreaches the previous year. Their recruitment and training enabled the project to expand its reach to many more community members during community outreaches.

In order to improve and sustain the quality of both information and outreaches, the drama groups were regularly taken through refresher trainings. The trainings were centered on the issues/ questions coming up during outreaches that the drama group members didn't feel confident enough to tackle. This information was given to them during these refresher trainings so that they were able to answer questions. The themes for their outreaches were also changed every three months so that their audiences didn't get fatigued by the same old messages. The changes in themes were closely monitored by the field coordinators as well as the theatre experts who ensured that the messages were delivered in an educative but entertaining way.

### **Transport Corridor activities- Matatu touts and drivers program**

Due to the sessions carried out by the PLHIV Advocates at matatu termini reaching the matatu touts- it was realized that there was a need to start a program to reach these transport workers due to their zeal to know more about HIV. A start up meeting was organized between the Under- Secretary in the Ministry of Transport, Matatu Welfare Association officials as well as program staff to agree on what the way forward would be if such a program was to be implemented. The Matatu Welfare Association officials suggested that the best place to start was to have a sensitization session with the route leaders to get their buy in and way forward.

51 matatu route leaders were sensitized on HIV/ AIDS issues on 16<sup>th</sup> – 19<sup>th</sup> June 2008 at Marble Arch hotel. The route leaders were divided into two groups and each group had a two day sensitization facilitated by PLHIV Advocates. From the sensitization, it was apparent that these people had a lot of myths and misconceptions on HIV/ AIDS. Some of the myths included:

- If you wash your penis with urine before having sex, you cannot get HIV.
- If you have sex 'softly' i.e. not rough sex, you cannot get HIV
- "Ukitaka kula nguruwe, chagua ile nono"- This is a euphemism that means "if you want to have sex with a lady, choose a fat one".
- "Afadhali uende na gari mboko"- This means that one would rather contract the HIV virus from a beautiful woman. ('Mboko' is their slang for really good)

- HIV is transmitted through casual contact. One of the participants actually confessed that he had refused to carry a person he thought was HIV positive and was quite sick. He said that he was scared that he could get infected if he touched that person.

After the sensitization sessions, there were discussion sessions with the route leaders to get a feel of how best to reach the touts and drivers. The major suggestions they gave due to their nature of work were; going to the various bus stops and carrying out half day sensitization sessions coupled with MVCT and training of peer educators. They also mentioned that the topics that would be most beneficial to them were basic facts on HIV/ AIDS, Condom efficacy, VCT and Drug abuse and its relationship to HIV/ AIDS.

As a follow up to this sensitization, **23** matatu drivers and touts were taken through a 5 day residential peer education training facilitated by NOPE at Bounty hotel. One of the new ground rules they set, was for each and every one of them to come to the training after taking a shower! The training was very enlightening as the touts and drivers had longer sessions with the facilitators since the training was residential. They were taken through sessions like sex and sexuality, communication skills, VCT, condom efficacy, stigma & discrimination, participatory training methods e.t.c.

The Matatu Welfare Association chairman, Mr. Dickson Mbugua paid a surprise visit to the training and really encouraged the participants to get tested and know their HIV statuses. The peer educators then requested for MVCT which was organized on the last day of the training. Of the 23 participants, 20 went for the MVCT and were counseled, tested and given their results. Most of them confessed that that was one of the most important part of the peer education training. They are now rearing to go and educate their peers about HIV & AIDS.

In order to keep the momentum going, MVCT at various matatu termini were arranged with the help of the Matatu Welfare Association officials, Matatu Drivers and Conductors Welfare Association as well as the trained peer educators who would mobilize their peers to come and get to know their HIV statuses. Since then, MVCT was organized at the following matatu termini with people counseled and tested; Muthurwa (193 people), Kangemi (82 people), Kawangware (384 people), Githurai (422 people), Umoja (197 people) and Kariobangi (250 people). In some cases like for Kangemi and Buru Buru, half day sensitization sessions were conducted first before MVCT provided to the touts and drivers from those routes.

For the Kawangware MVCT, the Assistant Minister for Public Health and Sanitation Dr. Gesami graced the occasion and encouraged the touts and drivers to take control of their lives by knowing their HIV statuses.

## **Youth Activities**

### *“Chill” Clubs*

The *“Chill”* program started February 2007 after a 5 day training of the youth leaders who would facilitate during the club sessions. The training gave the youth leaders knowledge and skills to facilitate sessions to younger youth using techniques like group discussions, skits and role plays in order to make the learning sessions exciting.

After the training, a head teachers’ dissemination was conducted so that the head teachers and club patrons from the 60 recruited schools could be briefed on what the *“Chill”* clubs were about, their role in the program as well as giving the day of the week that the club would be held within their schools. 52 teachers and an official from the Ministry of Education graced the occasion. The head teachers and patrons unanimously decided that the best class to reach with

the “Chill” clubs would be the Std. 7’s as that is the class that gave them the most trouble in the schools.

In November 2007, 15 more schools were recruited in order to boost the number of young people reached by the “Chill” clubs. The newly recruited schools started having their “Chill” sessions in January 2008. An additional 10 informal schools were finally added to the program in January 2009 in order to cater for the children who were not in the formal schools but really needed HIV prevention information especially because these schools are located inside slums. As at February 2009, there were 85 schools where the “Chill” clubs were being implemented.

In September 2007, an essay competition was held for all “Chill” club members on the topic- “the things I’d like to discuss with my parent or guardian but cannot”. Majority said they’d like to discuss with their parents or guardians- the changes they undergo as adolescents, the start of menstruation for the girls or even why it’s wrong to have a boyfriend/ girlfriend. Some raised serious issues like- they didn’t like the way their parents bring home different partners, how some of their fathers come home drunk and fight with their mothers, some girls had been raped but they have never discussed this with their parents while some are already abusing drugs. One boy even confessed to being a homosexual.

Here’s an excerpt from one of the essays:

*It’s even more difficult when your parents are of that type that is very strict and non tolerant of such issues. My mother is of that type and no matter how much you try talking to her, you end up gaining nothing. For instance there was a day that I went up to her and asked- ‘Mother, is it alright if I have a boyfriend?’ You wouldn’t believe what her response was- ‘Boyfriend!’ She shouted hysterically. ‘How can you be so shameless and ask me such a question, don’t you read the bible [sic] where it says all should have relationships with people of the opposite sex when intending to get married?’ Since that day, I have never uttered a word to any of my parents concerning such issues.*

Parent sessions were therefore initiated in the “Chill” schools so that the issues raised by the children were discussed with the parents. It served as an eye opener for the parents as some of them had no idea about what was going on in their children’s minds. In order to ensure that the quality of “Chill” sessions in the schools was maintained, all the youth leaders on the program were taken through yearly refresher trainings with special emphasis on topics that raised a lot of questions among the children and any new issues coming up. Also due to the challenges faced by the youth leaders in handling the issues raised during the “Chill” sessions, it was important that they be taken through a basic counseling training in December 2008. This was an initial 5 days training enabled the youth leaders practice the skills they have learnt. There was a follow up training in April 2009 for experience sharing as well as to reinforce the initial training and complete the training. “Chill” club patrons in Nairobi were taken through paralegal training in April 2008 in order to equip them to handle cases of child abuse that had been on the increase. This was a sustainability measure aimed at empowering both the teachers and the schools to handle child abuse cases with ease. This training was done in collaboration with the Result 3 team who facilitated the training.

### **SAPTA Substance abuse and HIV/ AIDS prevention sensitization- schools and out of school youth**

SAPTA (Support for Addictions Prevention and Treatment in Africa Trust) started working with APHIA II Nairobi as sub grantee in October 2008. Their mandate was to reach youth both in primary and secondary schools in Kibera with sessions on Substance abuse and HIV/ AIDS prevention. They reached 6,086 youth out of school as at February 2009 through meeting them in the video dens where they hang out as well as through sporting and theatre activities which

they used to pass Substance abuse and HIV/ AIDS prevention messages as well as offering MVCT. Through the MVCT, they have been able to identify substance abusers and enrol them in risk reduction groups as well as offering them out patient counselling sessions to help them stay sober.

### **Prevention with Positives program for young PLHIV**

PYI (Positive Youth Initiative) through MMAAK (Movement of Men against AIDS in Kenya) started working with APHIA II Nairobi in October 2008 continued to implement prevention with positives programs for both young positive people- YPLHIV and other young people. In total, PYI reached **879** people and trained **20** peer educators on positive prevention by February 2009 through various activities like sporting activities, dialogue forums, peer support sessions and sensitization sessions.

## **2.3 Reinforced networking between communities and clinical services**

### **Collaboration within communities**

APHIA II Nairobi partnered with the Area Assistant Chief for Makongeni to sponsor the Peace and HIV sports competition where the project bought sporting gear, footballs and trophies and provided MVCT which saw 82 people counselled and tested during the competition. The aim of the competition was to foster peace among the Kaloleni and Makongeni residents especially after the post election violence that had been experienced earlier. It was also aimed at providing HIV prevention information as well as counselling and testing to the area residents.

### **Partner collaboration**

The drama groups started going in and around A2N/Csupported clinics and hospitals to conduct HIV/ AIDS sensitization outreaches there in March 2008 so that the communities they were sensitizing would be made aware of the services provided at these facilities. The PLHIV Advocates also started giving health talks in APHIA II Nairobi facilities on various HIV prevention topics to boost uptake of services like VCT and PMTCT offered at the facilities. Some of the Nairobi health facilities visited this by the PLHIV advocates for health talks include: Mbagathi District hospital, Karen Health Centre, Majengo Health Centre, Makadara Health centre, Uzima clinic, Kayole health centre, Bahati Health centre, Loco dispensary, STC Casino, Jericho/ Lumumba Health centre, Ngaira Clinic, Umoja Health centre, St. Joseph Mukasa Health centre, Waithaka health centre, Dandora II health centre and St. Francis hospital.

### **Gaps and challenges faced**

The gaps identified and challenges faced during implementation were:

- Shortage of testing kits for the mobile and moonlight VCT;
- Due to free primary education, there were many older children in the lower classes not reached by the “Chill” program;
- Lack of a program to address sex workers HIV prevention and economic empowerment needs;
- Reach to informal schools limited so there’s a need to expand this reach;
- Prevention with Positives for the adults needs to be addressed;
- Need to address youth in informal settlements through mass media e.g. radio;
- Small group sessions to adequately address out of school youth HIV prevention;
- Not being able to reach spouses and partners of the transport workers in order to encourage couple counselling and testing which in turn aids disclosure.

Suggestions for the next program:

- Initiation of drama group edutainment sessions to address both the older and younger children in the “*Chill*” schools with age appropriate HIV prevention messages;
- Initiation of a program for sex workers to address HIV prevention and economic empowerment needs for those who want to get out of the trade;
- Initiation of a program that reaches youth in informal schools through innovative ways like sporting activities;
- Initiation of a prevention with positives program for the adult population;
- Initiation of a program that addresses youth in informal settlements especially through radio which is readily available in the slums;
- Small group sessions to be initiated so that HIV prevention issues like correct and consistent condom use, partner reduction and counselling and testing can be addressed with follow up sessions that encourage follow ups and ultimately behaviour change;
- Expanding the transport workers program in order to encourage them to come for sensitization sessions with their partners with MVCT provided on site to encourage couple testing.

### **Result 3 Improved & expanded care and support for people & families affected by HIV/AIDS**

This section describes A2N/C's key achievements in home and community support services for PLHIV and families affected by HIV& AIDS. The activities described were achieved through community participation and involvement in leaders' sensitizations, partnerships with the government and relevant organizations and institutions, and capacity building for community groups such as implementing partners (IPs), community health workers (CHWs), paralegals, and support groups. A2N/C endeavored to involve PLHIV meaningfully as facilitators, IP leaders and as CHWs.

#### **3.1 Expanded home and community support programs**

##### **Community mobilization**

###### **Provincial, district and community leaders**

A2N/C places great emphasis on the engagement and involvement of community leaders at all levels and at all stages of project implementation. Community leaders' sensitization contributes to advocacy and education at community level. This will lead gradually to reduction of stigma and more support for PLHIV and OVC which facilitates open dialogue about issues of sex and sexuality thus opening up avenues for prevention. In this regard, A2N/C conducted leaders' sensitization meetings for various cadres of leaders, ranging from the provincial and district administration, to grassroots community leaders and religious leaders. Within a few months of beginning to implement the project, an introductory provincial and district leaders' meeting was held, whose main aim was to provide an overview of A2N/C and thereby solicit the leaders' support in the implementation of community outreach activities. The meeting was attended by Provincial Heads of Education, Social Services, Children's Department, Provincial AIDS Coordinator, District Commissioners, District Officers, Area Education Officers, District Social Development Officers, and Constituency AIDS Control Committee (CACC) Coordinators.

A2N/C also conducted sensitization meetings to respond to various needs within communities. In April 2007, a sensitization meeting was held for leaders from Embakasi, Makadara and Starehe Districts. The main agenda of the meeting was to provide details of the project's clinic and community services, current areas of coverage and details of all the IPs in Nairobi, in order to facilitate referral of PLHIV and OVC needing assistance. A similar meeting was held in Makadara in July 2008; this time the target was not only the local community leaders, but also the youth and their parents. This particular meeting addressed the issue of substance abuse which is rampant in this area and which can lead to risky sexual behavior. Other topics covered were VCT, risk perception, and STIs. In May and June 2008, A2N/C sensitization meetings were held in Saigon (Dagoretti) and in Githogoro (Westlands). Githogoro is a slum tucked behind the wealthy Runda Estate, while Saigon is a village situated near the Dagoretti slaughter house. The two areas had poor access to HIV-related services due to stigma fueled by myths and misconceptions regarding HIV and AIDS. The main agenda of the meetings was to sensitize the community on facts on HIV & AIDS, positive living and the services available for those living with HIV. The meetings also served as an entry point for A2N/C to provide services by introducing the two IPs in the two areas, i.e., the Gertrude's Garden Hospital's outreach clinic (Githogoro) and the Riruta Health Project (RHP) (Saigon).

###### **Special groups**

There were also sensitizations conducted for special groups such as meetings targeting the Somali community in Eastleigh and two meetings for the deaf. Eastleigh is inhabited

predominantly by Islamic Somalis. The area is characterized by brisk trade from small hotels and restaurants, to clothing, to gold and even illegal weapons. There is also much interaction and close ties between the Somalis in Eastleigh and those in North Eastern Province and therefore this is largely a mobile population. In Somali culture, coupled with Islam, issues of sex (including STIs and HIV) are not discussed easily or at all. This has fueled myths on HIV and stigma towards those living with HIV. In addition, the Somali community is largely unreached with HIV-related messages due to the closed nature of the community. A2N, in close collaboration with service providers from the Eastleigh Health Center, organized the community leaders' sensitization meeting as a start towards reaching the Eastleigh Somali community with HIV-related services. Sixty persons were expected, but instead 132 turned up, a clear indication that this community is eager to know about HIV and is no longer interested in "burying their heads in the sand". The main aim of this meeting was to garner support from the leadership for A2N/C activities, and at the same time provide basic information on HIV & AIDS, as well as care and support for PLHIV.

Four sensitization meetings facilitated by Liverpool VCT (LVCT) specialists proficient in sign language reached 115 deaf persons who had expressed concern that they feel left out of the HIV/AIDS programs in Kenya. Other deaf individuals felt that they are vulnerable to HIV through rape since they cannot scream or call for help. PLHIV who also are disabled face a double stigma: disability and HIV infection. Topics of the meetings included VCT, modes of transmission, signs and symptoms of HIV & AIDS, management of STIs, HIV and Nutrition and ART.

### **Religious leaders**

A2N/C, aware that religious leaders are increasingly influencing care and treatment, albeit often negatively. For example numerous A2N/C clients who default on treatment claimed that they had been "healed" through prayer and therefore no longer needed to continue ART. Many religious leaders influence the uptake by PLHIV of other important services such as VCT and PMTCT, as well impede positive living due to the myths they perpetuate which in turn fuel stigma. As part of A2N/C's strategy to curb this negative influence, religious leaders were targeted for sensitization and education, to equip them to support care and treatment, rather than undermine it. Two religious leaders' sensitization meetings were held in February 2009 and were attended by a total of 115 leaders, including Muslims and members of the *Akorino Sect* (a Kenyan independent church). The meetings were facilitated by A2N/C advocates, and in one IP, Redeemed Gospel Church (RGC), they were assisted by a pastor who runs the Hope Community VCT at Adams Arcade. The VCT center targets church congregations as well as their leaders.

It was evident from the discussions that religious leaders are still struggling with the issue of condom use as many of them are still convinced that access to condoms promotes promiscuity. There was a quite heated debate on the subject and the role of the church in promoting condom use. In addition, there was also a long discussion on the issue of joining discordant couples in marriage: the majority of the leaders felt that such a union would be "unfair" to the HIV negative person. The facilitators painstakingly explained that as long as those seeking to be married are aware of each other's status, they are free to marry. The role of the religious leaders is to encourage all couples to be tested before marrying, whether or not there is suspicion of HIV infection!

Some of the questions asked were:

*"Is it true that one can prevent HIV infection by rubbing lemon juice on the genitals before having sex?.."*

*“Can I be sued (as a pastor) for joining a discordant couple in marriage.....can the parents of the HIV negative person sue me for marrying their son/ daughter to a person with HIV?...”*

*“Should a HIV positive mother breast-feed her baby?”*

From the questions asked and the views expressed, it was clear that religious leaders are lagging behind in information and skills in issues pertaining to HIV. This situation is having serious negative repercussions on HIV prevention, care and support because, as explained earlier, religious leaders are arguably among the most influential people in society. A2N/C will step up its efforts to educate religious leaders by conducting two-day sensitization sessions instead of the one-day meetings. In this effort, A2N/C will also work with the Kenya Network of Religious Leaders living with HIV/AIDS (KENERELA) to reach religious leaders with the relevant information, and even encourage those who are living with HIV to join this network for support.



Pastor Makena facilitating a session at the religious leaders meeting at RGC.

Following the sensitizations, some positive impact was reported - at Ruben Center in Mukuru, the CCC staff started to work with the pastors to follow up clients who have defaulted after “healing prayers”. Some of the pastors have been cooperative; in one case, a pastor was even called to the CCC during a client’s counseling session to persuade the client to resume treatment. There has been also an increase in numbers of people referred for testing at the Ruben Center VCT following the religious leaders’ sensitization. At RGC, the number of PLHIV joining the support groups increased following the sensitization with registration of at least 5-10 new members every week, in the month following the sensitization.

### **Home-based care for PLHIV**

In the implementation of HBC activities, A2N/C utilized the community structure established under the previous Community-based HIV/AIDS Prevention Care and Support (COPHIA) project. The structure consists of three levels: the Implementing Partners (IPs); the HBC Supervisors; and, the CHWs. To ensure provision of quality home-based care, A2N/C is committed to providing periodic refresher/updates trainings for its team of HBC Supervisors and CHWs. A2N/C also conducted training of new teams as part of expansion of HBC services to new districts and expansion within existing districts.

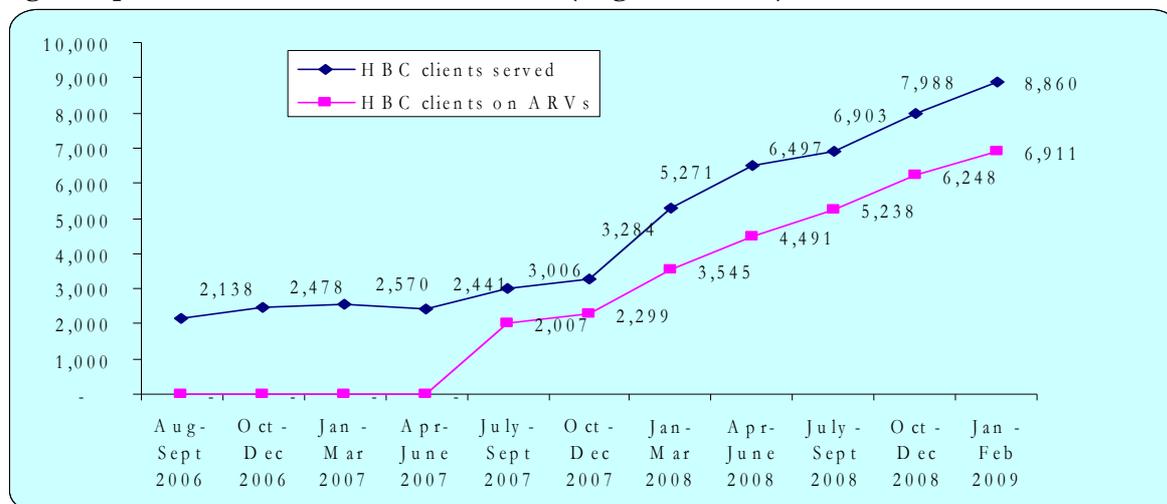
As part of the project start up activities in 2007, A2N/C conducted refresher trainings for all the former project’s HBC Supervisors and CHWs in Nairobi. The training was not only to update

the teams on the relevant topics, but also to facilitate transition from the COPHIA Project to A2N/C as well as enhance the HBC teams' skills and knowledge to meet the evolving needs of clients who were no longer bedridden but ambulatory. With the increase in access to ART, more and more clients required adherence support rather than home nursing care. Most of questions centered around ART and TB adherence clearly showing that the emerging challenges in HBC have evolved from home nursing care for bedridden clients to adherence support for mobile clients. Additionally, in response to requests from the HBC supervisors and in a bid to improve supervision and reporting, A2N/C conducted a HBC supervisors' refresher training on facilitation, supervision and report writing.

A2N/C expanded its HBC services, particularly in North and East districts of Nairobi, in order to increase access to HBC services within Nairobi Province. In Nairobi East District, A2N/C extended HBC services to a total of 10 groups. Eight of these groups were taken over from a USAID-funded OVC program implemented by World Vision, under the Kenya AIDS Treatment Support for OVC (KATSO) umbrella. These CBOs cover Ruai, Kayole, Kariobangi, Umoja, Njiru, Embakasi and Dandora areas. The other group involved in the expansion of services in East was Ruben Center in Mukuru kwa Ruben. The Reuben center is a faith-based A2N/C-supported facility with a CCC. The facility also receives support for its PMTCT activities through Pathfinder's CDC-funded program, and it therefore made programmatic sense to expand its scope of services to include HBC.

In Nairobi North District, A2N/C extended HBC services to Kasarani through the St Francis Community Hospital, and to Pumwani and Majengo area through The Mother/Child with AIDS Support Organization (MOCASO). All the CHWs in the St Francis team and 90% of those in the MOCASO are PLHIV, thus enhancing the greater involvement of PLHIV (GIPA) initiative. The last phase of the expansion of HBC services was completed through the absorption of 7 groups of CHWs and HBC Coordinators/Supervisors that had been trained by NASCOP and were affiliated with various facilities in all the 8 districts<sup>4</sup> that is Embakasi, Pumwani, Central, Langata, Dagoretti, Westlands, Makadara and Kasarani. This particular group added value to the A2N/C HBC teams as all the supervisors/HBC Coordinators were nurses, thus increasing the capacity for clinical supervision of CHWs and clients within the HBC program, and better linkages with health facilities.

**Fig 7: Expansion of HBC services in Nairobi (Aug 06 – Feb 09)**



<sup>4</sup> . Nairobi increased to nine districts at the end of 2009.

The graph above illustrates the expansion of HBC services within Nairobi during the project life.

To ensure continuity of referrals to health facilities, A2N/C continuously emphasized the importance of referrals and which were included as a topic during refresher training and the training of new HBC teams. In addition, each CHW was required to report on the referrals made for each client, the services referred for and the sites referred to. It is noteworthy that 62% of the IPs were directly linked to a specific health facility, which contributed to strong referral linkages between the community and facilities. The HBC teams used the NASCOP-approved referral tool and A2N/C facilitated the re-printing of the tool. The expansion described above raised the number of IPs from ten to twenty-seven, and the number of CHWs and Supervisors from two hundred and seventy one to five hundred and twenty-one.

## **IGA**

Economic strengthening is a key factor in the establishment of sustainable safety nets for PLHIV and OVC. A2N/C had been partnering with the K-REP Development Agency (KDA) since the inception of the A2N/C project to implement IGA activities through the continuation of the FAHIDA project that was started during the implementation of the COPHIA project. In addition, KDA was also charged with the responsibility of rolling out the Village Savings and Loan (VS&L) model of economic strengthening for PLHIV support groups and OVC caregivers. The greatest challenge during the project life was that KDA did not manage to implementing the VS&L program .

In the absence of KDA, IGA activities were still implemented through linkages and the use of clients that had been trained by other non-A2N/C groups. In RGC, members of support groups were linked to a group from the PCEA church for training in VS&L. This initiative worked quite well and RGC boasted of 42 VS & L groups, each with 15 members drawn from the RGC support groups. The groups started IGAs such as day-care, sale of clean water, bead-making, weaving and sale of charcoal. In Nairobi West, The Riruta Health Project (RHP) had a support group that also started an IGA of bead-making to improve the economic status of its members.

## **Orientation of Support Group Members in Voluntary Savings and Loan.**

A2N/C conducted orientation on voluntary savings and loan (VS&L) for support groups. The aim of the orientation was to assist the support groups to form self-help groups (of 15-20 members) whereby they could save as a group and extend credit to one another to expand or start businesses. Loans taken within the group attracted interest, which boosted the group's savings and enabled group members to take increasingly bigger loans. Due to the fact that not all the support group members may be interested in joining VS&L groups, A2N/C provided a brief orientation to all support groups, then those members in the support groups who were interested formed smaller VS&L groups. These smaller groups were then assisted by the VS&L facilitators on the modalities of group membership, leadership and book-keeping, and actual start-up of VS&L activities. The facilitators were drawn from groups with wide experience in VS&L, such as those in RGC described in the paragraph above. The facilitators were simply replicating in other IPs what they had implemented successfully in their own IPs/support groups.

Through this effort, a total of 10 support groups were given orientation. Each of the groups had a membership of between 15–40. These support groups were affiliated with CII, Makadara Health Center, St Francis, NOFI, Riruta Health Center, and PCC in Dandora. A2N/C will continue to monitor these groups and ensure they are mentored by the more mature and successful groups to ensure that they grow and in turn replicate their successes to other groups. It is also envisaged that KDA will be able to support these groups as they develop from this initial stage to the next.

## **Nutrition & Food Security**

During the project, there was not much activity directly supported by A2N/C to address food insecurity in Nairobi as efforts were concentrated on start-up activities and expansion of HBC services as described above. As such, a number of IPs were encouraged to mobilize for emergency food for the clients from the local administration. These IPs were able to do this due to the fact their activities were well known to the administration and there was a level of trust and goodwill towards them because of the work they were doing. The most successful IPs in mobilizing relief food were KENWA, RGC, RHP and CII. Food insecurity was a persistent challenge and A2N/C will explore sustainable ways to address this issue, such as kitchen or gunny sack gardens, as well as income generating activities.

## **Strengthening of support groups**

In order to enhance psychosocial support for support groups, A2N/C trained a total of 15 community counselors. The 20-day basic counseling training was conducted by KAPC. The participants were drawn from the IPs and were selected according to criteria provided by KAPC. The counselors were linked to the support groups in their respective IPs where they participated in group therapy and were available for one-on-one counseling for HBC clients.

## **Client education – Treatment Literacy**

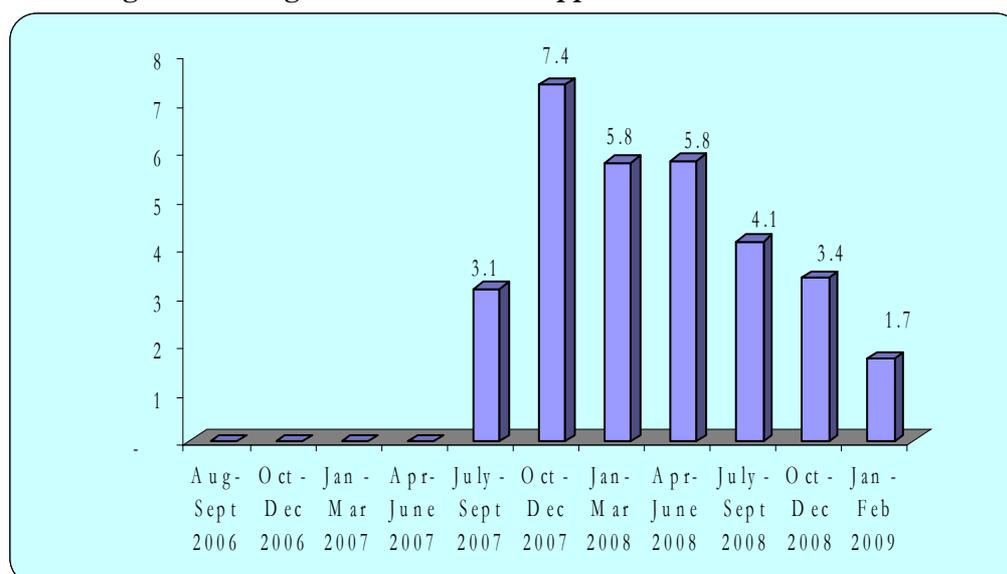
As the health of HBC clients improved due to access to quality care and support, their needs have changed over time. Previously, the needs of clients were mostly home nursing care, and frequent referral for treatment of opportunistic infections. Now, the majority of clients are in good health due to better access to ART and to quality HBC support and their needs therefore include adherence support, education on positive living and involvement in advocacy and prevention. In addition, the issue of defaulting was increasingly being mentioned by the HBC teams as a major challenge in the provision of services. Apart from the fact that defaulting from ART can be fatal, it is also quite costly to the health system as a defaulter who resumes treatment is likely to be put on a second line regimen or he/she may eventually develop resistance to treatment.

To respond to these changing needs, to address defaulting and to promote positive living, A2N/C initiated treatment literacy training for its clients. To implement this successfully, A2N/C consulted with MSF-Belgium, which has developed a treatment literacy curriculum and has used it to train expert patients as treatment literacy facilitators, as well as clients at Mbagathi District Hospital. The majority of A2N/C's Advocates have been through the MSF-B basic treatment literacy training and the facilitators' training. MSF-B gave permission for A2N/C to use its curriculum and to reproduce its IEC material on positive living.

A2N/C conducted its first treatment literacy trainings in the quarter April-June 2008 and the response from both clients and CHWs has been very encouraging. Many of those who had defaulted opted to resume treatment, and some of those who were hesitant to start treatment due to myths about ART were more prepared to consider the option of ART. Those who had defaulted cited the following reasons for defaulting:

- Side effects of ARVS
- Poor preparation for initiation of ART
- Religious reasons such as “healing prayers”
- Stigma (fear of being seen taking ARVs by family members who do not know their status).

**Fig 8: Percentage of HBC clients dropped from ARVs**



The graph above illustrates the impact of treatment literacy training. The percentage of clients defaulting on ART decreased steadily from April 2008 to February 2009. A2N/C started treatment literacy training for clients in the quarter April-June 2008. The first four quarters do not show figures for defaulters as A2N/C had not yet started collecting this data at the community level.

The main objectives of treatment literacy training are:

1. To provide relevant information on HIV and AIDS for persons living with HIV (PLHIV) for better management of the illness;
2. To promote openness and disclosure of HIV status;
3. To provide relevant information on treatment in order to promote adherence;
4. To promote positive living;
5. To ensure early recognition and effective reporting of opportunistic infections to health facilities;
6. To empower PLHIV with life skills to cope with social issues surrounding HIV & AIDS such as stigma and discrimination;
7. To promote human rights awareness;
8. To strengthen and encourage networking with relevant bodies and organizations to improve access to services.

The majority of the participants were women as most men were often at work and could not manage to get time off as they are casual laborers. There was also a mix of those who had defaulted on treatment, those who had not yet initiated treatment, those who were newly diagnosed, those who had lived with HIV for a number of years and discordant couples. The questions asked by the participants during training were evidence that many of them lacked vital information and they held many myths and misconceptions. Some of the questions asked were as follows:

- *Why is it not possible for mosquitoes and bed-bugs to transmit HIV?*
- *Can one contract HIV from sharing toilets?*
- *Is it possible for a person with HIV to give birth to a child who is HIV negative?*

Some of the misconceptions exposed were:

- *...pneumonia is a result of malaria that goes untreated...*
- *...ARVS increase fertility, and as a result, many women on ART conceive twins!..*

All the questions and misconceptions were addressed through the various topics covered such as modes of HIV transmission, and PMTCT. The curriculum used is the *Treatment Literacy Handbook – 2007*, developed by MSF Belgium as part of its Greater Involvement of PLHIV (GIPA) program. The trainers were A2N/C PLHIV Advocates who had been trained as trainers in treatment literacy. All of them were actively involved in advocacy work, health talks and even work-place based sensitization and education. The trainers ensured that the training was highly interactive through group work, discussions in plenary, question and answer sessions and sharing of personal experiences.

Follow-up on the ground revealed that the treatment literacy training is having an impact on the clients. Some of the comments received from the participants are:

- ...*We have become teachers to others....we are reaching out to those in fear and denial and helping them to come out and accept their status..*
- .... *The training was crucial since it emphasized the importance of adherence on TB treatment and ARVs....*
- *I used to blame my husband but through the training I learnt about sexual networks and the blame game ended there*
- ... *I have learned about how to prevent HIV re-infection...*

In addition, the sample below of pre and post test results from the trainings reveals that learning took place.

**Sample summary of Pre-test and Post test Scores:**

	<b>Pre-test</b>	<b>Post- test</b>
Mean	46%	63%
Minimum	27%	46%
Maximum	68%	88%

**Support to IPs**

**Grants**

As part of ongoing support to its implementing partners, A2N/C, in close consultation with the IPs, developed proposals for funding. The activities included in the proposals were those that the IPs prioritized and that contributed to the objectives of the A2N/C project. In Nairobi, four IPs qualified for funding according to criteria set out by Pathfinder. The IPs were the Kenya Network of Women with AIDS (KENWA), the Redeemed Gospel Church (RGC), the Riruta Health Project (RHP) and the Community Implementing Initiative (CII). The first 3 IPs had financial systems and staff to manage grants, but CII did not have systems, nor personnel to do so. As a result, the support to CII was provided as a Pathfinder Implemented Project (PIP) whereby all purchases were made by Pathfinder and delivered to the IP for distribution, and payments, such as rent for office premises, were disbursed directly to the landlord.

The activities supported through the grants included:

- Salary support for selected IP staff;
- Educational support for OVC (purchase of uniform and other scholastic material);
- Food support for OVC;
- Business skills training for support group members;
- Payment of rent for office premises and drop-in centers.

A2N/C provided both financial and programmatic technical assistance and monitoring throughout the grant period for all four IPs. The IPs in turn submitted quarterly reports and discussed challenges encountered in the implementation of these activities with the A2N/C team. This support to the IPs facilitated continuity of services from the COPHIA project to A2N/C which will increase sustainability in future. The amounts approved in the grants ranged between Kshs 500,000 to Kshs 3,225,000. The process of proposal development and implementation of proposed activities helps the IPs to develop skills in identification of the needs of target communities, articulation of strategies to meet those needs, implementation of the strategies, work planning, budgeting and reporting. These skills will contribute to the sustainability of these IPs as they can utilize them to mobilize resources and broaden their funding base.

### **IP sharing forums**

A2N/C facilitated quarterly IP sharing forums. These forums allowed for exchange of ideas and best practices among the IPs. The IPs also shared their challenges and discussed ways in which A2N/C could address those challenges. For instance, raising the challenge of increasing numbers of defaulters contributed to the initiation of treatment literacy training for clients. The IP coordinators, who are also HBC supervisors, indicated that they faced challenges in reporting and supervision, which led to the training in reporting and supervision described above in the section on *Home-based Care for PLHIV*. The forums were also an opportunity for A2N/C to provide performance feedback to all the IPs and discuss ways of improving on performance for those IPs who were not performing well.

All the IPs, including those without grants, received technical assistance for the implementation of HBC and OVC support services either through the sharing forums or through monthly meetings and monitoring visits by the A2N/C HCS team.

### **3.2 Expanded support for OVC**

The OVC program start-up activities took place from August to December 2006 with the program built on the earlier community program of the COPHIA (The Community-Based Program on HIV/AIDS Care, Support and Prevention) project. Steps were taken to identify additional implementing partners, to mobilize and sensitize the community on various aspects of the new program, and to develop appropriate monitoring tools.

By 2007, the project served 7,554 OVC working initially with 8 community implementing partners. A first step was to develop common criteria for recruiting OVCs into the program. By the end of the fourth quarter, the number of OVC had grown to 22, 941 and they were being served through 25 IPs.

In July 2007 a profiling study of 7,000 OVC was conducted in the IPs with greatest proximity to A2N/C supported health facilities. The study aimed to improve OVC targeting, to prioritize OVC needs and to assist with scaling-up of service provisioning. Additionally, the study aimed to assist with building the capacity of CBO implementing partners to enable them to effectively deliver services and to support OVC. Community focus group discussions and analysis of questionnaires filled by project beneficiaries (OVC), revealed that 86% of the OVC were under the age of 15 years; 36% were complete orphans; and, 68% of their parents/caregivers were engaged in employment that can be categorized as 'casual'. The four major problem areas identified by OVC in the study were nutrition, education, shelter and clothing. Other significant but lower ranked problems included: access to clean and available water, power and a shortage of desks in schools.

**Table 3: Ranking of 7 core service areas:**

Overall USAID core services area Ranking	OVC questionnaire Findings	FGD Findings
Psycho-social	5	7
Nutrition	2	3
Education	1	2
Protection	7	6
Shelter & Clothing	3	5
Health Care Access	6	4
Economic Empowerment	4	1

At this point, it was critical to ensure that the services or support provided by A2N/C corresponded proportionately to the problems identified in the study.

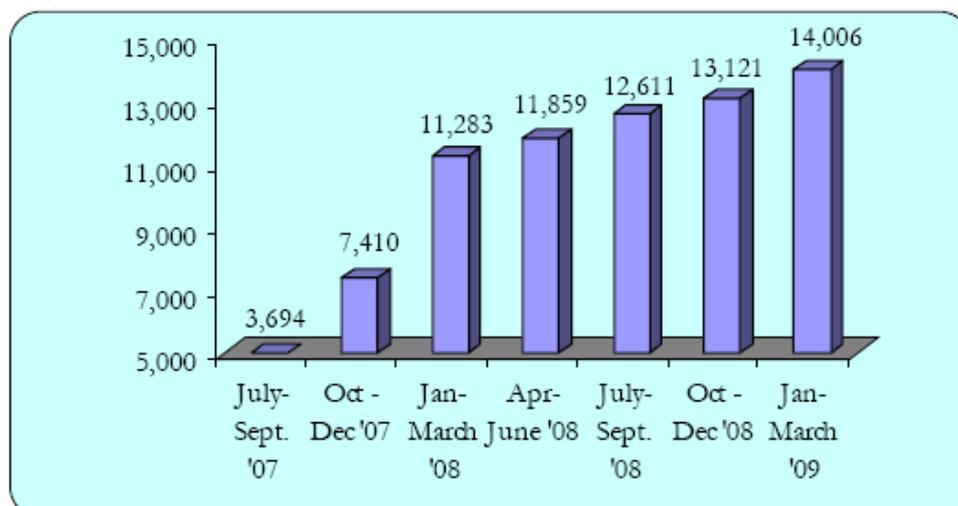
The beginning of 2008 saw Kenya plunge into post election violence which affected project operations in most parts of the country. Activity implementation in Nairobi did not resume until late February 2008, though delivery of services to OVC continued to be slow far into the second quarter of 2008 due to the uncertain security situation. In the second quarter of 2008, there was an increase in the number of OVC served with both direct and supplemental support. There was a dramatic increase in number of OVC receiving primary direct support from 2,196 in the previous quarter to 9,952. This was attributed to the backlog of delivery of services during the post election violence period.

In the same year, the A2N/C transferred seven implementing partners to the Central Province OVC team. The IPs are located in Central Province but were being served from Nairobi. The transfer aimed to maximize out-reach and efficiency while remaining within the project boundaries and jurisdictions. To bridge the gap, eight CBOs previously supported by World Vision were incorporated as implementing partners into the A2N/C project, bringing along an additional 4,018 OVC. By March 2009, 14,006 OVC in 27 IPs had been served by the project and increase from an initial 1,438 children as depicted below.

**Fig 9: Trend of no. of OVC served from Jul 06 – Mar 09**



**Fig 10: Trend of no. of OVC served from Jul 07 – Mar 09**



A2N/C provided services to OVC in all 7 core service areas during the project period. Delivery of service was a collaborative effort between A2N/C, the IPs and the CHWs affiliated to the project. Regular meetings, constant home visits and monthly reporting ensured effective implementation of all A2N/C activities.

### **Health**

All OVC who tested HIV+ in A2N/C were referred by CHWs to A2N/C supported health facilities for ART and treatment of opportunistic infections. A2N/C collaborated with the Ministry of Health to 1) immunize children under five years of age who had missed their BCG vaccine 2) carry out quarterly de-worming for all children in the A2N/C, and, 3) provide vitamin A for children below 5 years of age. ITNs were provided to 1,350 OVC under five years of age to help protect them from contracting malaria. To ensure that there was safe drinking water at household level, all OVC in the A2N/C were provided with Water Guard. Their caregivers were trained by CHWs during home visits to use Water Guard.

During the 2009 National Polio campaigns conducted by the Ministry of Medical Services, the Home & Community Service (HCS) and OVC teams combined forces to gather CHWs at very short notice to assist in mobilizing community members to take children under five years of age to be given polio vaccination. The vaccination exercise took place in all government health centers and it was a great success.

### **Psychosocial support**

At IP level, all OVC in the A2N/C were attached to CHWs. Once every month, the CHWs visited the OVC at home or at school to assess their well-being. This included physical assessment, an emotional assessment and a discussion with the OVC and/or caregiver to determine if the child was progressing well. Monthly home visit reports were prepared by the CHWs and submitted to A2N/C. Other interventions to provide psychosocial support to OVC included:-

#### *a) Child forums*

To assess the 'trickle down' to children of PSS trainings which had been provided to CHWs, teachers and caregivers in 2008, A2N/C initiated child forums. These one-day events, held every school holiday, provided an avenue for children to express issues touching on their well-being. The forums also provided an avenue for OVC to bond freely, away from their immediate home environment, while learning and exchanging ideas. As the child forums progressed in the year, it

was evident that interventions were necessary to address key areas of concern brought up by the OVC, as listed below:

*Key Issues facing OVC*

1. Inadequate communication in the family.
2. Pressure to engage in sex.
3. Lesbianism and homosexuality in schools.
4. Sexual abuse by teachers and relatives.
5. Inadequate play time because of household chores.
6. Lack of sanitary towels for monthly use due to uncaring caregivers.
7. Stigma and discrimination against HIV positive children and those with HIV+ caregivers.
8. Some parents are frustrated by rising poverty levels making them hopeless. Many resulted to alcoholism and neglected their roles.
9. Poor self image by OVC resulting in feelings of being unwanted.
10. Poor class concentration hence poor academic performance.
11. OVC suffer loneliness due to the loss of parents.

To address these issues, OVC were trained on reproductive health, especially focusing on sexual maturity. OVC, both male and female, were trained to make affordable and reliable alternative sanitary pads to ensure that they or their siblings did not miss school during their menses. Vigorous community awareness campaigns on issues that affect OVC were conducted through drama and skits. Child forums followed- up PSS sessions for over 3,000 OVC focusing on how OVC can express their feelings and perceptions freely. The sessions also explored ways in which social insecurity for OVC could be reduced. School counselors, school club patrons, parents/guardians and paralegals were trained to empower and equip OVC with up-to-date knowledge on HIV/AIDs, building self esteem, how to handle stigma and discrimination, positive living and sustainable behavior change.

The child forums proved to be an opportunity also for OVC to showcase their talents through recitation of poems, folk songs and dances, drama, choral verses, skits and taking part in various games like football, volleyball handball, racing, tug of war, and sack and potato races. Since the forums lasted the whole day, children were served with a meal at lunch time, made possible through A2N/C support. In addition, the forums also provided a good opportunity for bulk distribution of items to individual OVC.



OVC show off their wheat flour at the end of a child forum  
Ruai Organic Farmers Organization (ROFO)

...and the oil to make delicious "chapatti"  
Progressive Care Coalition-Dandora I

*b) PSS- OVC support groups*

Due to the growing need for support among HIV+ children, A2N/C, in collaboration with 7 IPs, started 7 OVC support groups, with an average of 25 members, in Nairobi West district. The support groups shared information on the OVC's well-being; challenges the OVC were facing and how to overcome them, stigma reduction and disclosure. Caregivers were consulted for consent before their children could join these support groups.

*c) Caregiver's sensitization meetings*

One day caregiver sensitizations to improve the relationship between caregivers and OVC were held. The sensitizations aimed at increasing caregiver responsibility to OVC under their care as well as encouraging caregiver disclosure of HIV status to their children.

*d) Drama outreaches on OVC issues*

Following the training of 8 drama groups in Nairobi (4) and Thika/Kiambu (4) on OVC issues, a Theatre for Development (TFD) expert conducted an evaluation of skits prepared by the drama groups on OVC issues. The main task of the TFD expert was to correct and adjust the messages about OVC prior to launch of community outreaches to ensure that they portrayed the correct messages. When the evaluation exercise was complete, the 8 drama groups proceeded to conduct a total of 16 community outreaches (8 in Nairobi and 8 in Thika/Kiambu) on various OVC issues. The outreaches generated a lot of interest and as well awareness on OVC issues in the various communities.

*e) CHWS sensitization on Basic Counseling*

One hundred and five (105) CHWs were engaged in a three (3) day basic counseling sensitization with the aim of empowering them to effectively address the psychosocial needs of OVC and caregivers. The CHWs' were also equipped with child counseling skills with special emphasis on confidentiality and adherence to the code of ethics. The training assisted the CHWs to understand themselves through self awareness. They were also able to understand how to deal with burn-out that had been a hindrance to their work causing them sometimes to stigmatize the same children they serve. A Child Counselor and a Life Skills Specialist took the participants through a number of issues including: definition of counseling, qualities of a good counselor, process and stages of counseling, counseling as a therapeutic intervention, model of self concept, HIV/AIDS & its psychosocial & cultural aspects, communication skills, overview of stress and stress management, psychosexual and psychosocial developmental stages of children, understanding OVC and their needs, development stages of a child, Child Rights and life skills on Child Protection. The facilitators also took the opportunity to train CHWs on general report writing.

*f) Pediatric HIV/AIDS Psychosocial /counseling training*

Kenya Association of Professional Counselors (KAPC) with support from A2N/C organized a 5 day training on Pediatric HIV Psychosocial training for 28 community workers. The main goal of the course was to equip health care providers with required knowledge, skills and right attitude to enable them to provide quality counseling for pediatric HIV/AIDS. The training also aimed at increasing knowledge and skills to enable participants to effectively communicate with HIV/AIDS infected and affected children. The course covered the following topics: overview of pediatric HIV; normal child development, family structure and dynamics; psychosocial aspects in pediatric HIV; communication with children; counseling the adolescent; disclosure; adherence counseling; legal and ethical issues in pediatric HIV/AIDS and loss and grief. The selected participants were community and health workers from the three Nairobi districts.

*g) Staff capacity building: PSS Care and Support Training by Regional Psychosocial Support Initiative (REPSSI)*

A2N/C staff in the OVC support unit joined other CCF-Kenya A2N/C staff for a five-day workshop on PSS Care and Support. The training was supported by REPSSI and facilitated by CCF staff extensively trained by REPSSI as master trainers on PSS Care and support. The participants were taken through some of the following topics: PSS concepts and models, child development, child rights and abuse, loss, grief, mourning and bereavement, and stigma and discrimination. The training was extremely beneficial as it provided OVC unit staff with knowledge and skills to help promote development and implementation of sustainable PSS A2N/Cs that will enhance the overall well-being of OVC.

## **Education**

To ensure that OVC continued with their education uninterrupted, the A2N/C provided OVC with school uniforms, text and exercise books, mathematical sets and school desks. 4336 children in 57 ECDs were supported with teaching aids comprising chalk, crayons, chalkboard duster, water colors, manila, felt pens, colored pencils & chalkboard rulers. The A2N/C provided St. Georges Primary school with 1 water tank. Child rights clubs in various schools provided a powerful avenue for providing information on the rights of the child. Other interventions to enhance education to the OVC included:-

*a) PEPFAR scholarships*

A total of 435 PEPFAR secondary scholarship forms were distributed to OVC through A2N/C IPs and 226 forms were filled and submitted to USAID for consideration. Feedback from USAID indicated that some OVC had been awarded the scholarship. A2N/C was not able to determine which OVC had been awarded the scholarships since the notifications were sent directly to the schools in which the OVC were enrolled.

*b) Career Counseling for vocational training beneficiaries*

A career counseling training was organized for 71 out of school youth. Although A2N/C eventually supported 60 youth, an additional 11 youth were invited to the training as back up for immediate replacement if any youth had declined to commence training. The additional youth were also on standby in case the courses the 60 youth had chosen proved to be cheaper than expected thus providing room to accommodate more beneficiaries. Two training sessions lasting one day each were organized and facilitated by a Career Counseling expert.

The main topics covered in the training included perception, interpersonal communication, self-knowledge, setting and achieving goals, self esteem and ways to enhance self esteem, dealing with pressures of life, stress management, building resilience, networking and referrals. It was clear from the participants' reactions that the training had made a difference in their lives. They opened up and freely discussed issues affecting them and even provided sound advice to one another. The participants resolved to form peer to peer support groups after the training in their respective IPs and formulate a work plan so as to build mutual accountability and come up with viable support group activities.

*c) IEC Development Workshop with Youth*

A three-day workshop for IEC material development was conducted in May, 2008 with the participation of 14 youth carefully selected from IPs in Nairobi. The aim of the workshop was to engage the youth in identifying issues affecting OVC in their communities and providing an avenue to expression these issues through art and drawing, a method that proved to be very effective and therapeutic as well.

#### *d) Alternative sanitary towels production TOT training*

A Training of Trainers was facilitated by Federation of African Women Educationalists (FAWE) for 31 CHWs from A2N/C supported IPs was held at the Marble Arch Hotel in July 2008. The CHWs were trained to make sanitary towels from locally available material (cloth, cotton wool and thread). They were also trained on steps of maintaining high standards of hygiene while using these alternative towels.

Cascade trainings on alternative sanitary towels making were conducted in the three Nairobi districts, following the TOT training in July, 2008. Twenty one (21) IPs trained an average of 32 participants each. The participants included OVC, caregivers as well as more CHWs. The participants were trained on the different steps of making alternative sanitary towels. A2N/C provided all the raw materials and meals to the participants. Each participant was able to make three different designs of sanitary towels as well as a beautiful carrier-bag for the towels.

The two-day training also provided much needed insight into the biological and physiological aspects of menstruation and the female anatomy. The group developed additional practical designs for the sanitary towels. To date, most participants have taken the initiative further to support other teenage girls in learning how to make these towels as well as keeping them clean and hygienic, an effort that has seen more girls attend school with minimum interruption.

**A caretaker measures sanitary towel**

**A caregiver shows off her complete  
Sanitary towel kit**



#### **Food and nutrition**

A2N/C established after several home visits that one of the biggest challenges OVC faced was obtaining adequate nutrition. In an effort to support OVC to access adequate nutrition, food banks were established at IP level to provide the neediest OVC households with rice, oil and beans. The criteria used to identify the most needy households was established at community level and it included child/grandparent headed household and households with malnourished children. A2N/C provided the food for the food banks and households were able to access it through the IP all year round.

In addition, A2N/C provided 12,200 OVC with rice, wheat flour and cooking oil. The project also supported 3,671 children in 57 early childhood development centers with Unimix.



Radiant children of Kitambaa ECD on break after a meal of Unimix



Distributing food- St. Francis

*a) Distribution of humanitarian shipment*

Following the post election violence, the U.S. Government generously provided a shipment of donations for internally displaced persons. A2N/C conducted IDP camp/group assessments jointly with the Ministry of Health under the guidance of the Provincial Medical Officer and identified needy OVC households who were supplied with the donated items. These items included hygiene kits, blankets, school kits, powdered milk, ATMIT (porridge flour) and new born kits.

*b) Nutrition sensitizations for caregivers*

To equip caregivers with knowledge that would empower them with on the topic of nutrition, 240 caregivers were sensitized on appropriate nutrition for OVC and their families. It was evident during the sensitizations that most caregivers were ill-informed on nutrition and it is for this reason that more sensitizations were planned for the future

*c) Gunny sack gardening training*

A2N/C collaborated with Kenya Institute of Organic Farming and 2 IPs (Njiru Organic Farming Initiative and Ruai Organic Farming Organization) to train 250 caregivers on gunny sack gardening. This combined effort, where KIOF provided the curriculum while NOFI and ROFO provided facilitators, aimed at addressing food insecurity at household level. Participants were equipped with skills on how to grow fresh vegetables in a multi-storey sack garden, using locally available resources. The participants appreciated the training and committed themselves to start the project at household level in order to improve their vegetable production for use at home as well as increase their income by selling extra the vegetables.

*d) Farmers' Day –Nairobi East*

The Ministry of Agriculture and community stakeholders within Nairobi East District organized a successful Farmers' Day at Matheka Ndilinge Farm, Kamulu Area. Three IPs - NOFI, ROFO and MoPH&S Embakasi - participated and demonstrated their skills in gunny sack gardening. They also gave talks on the various methods of farming and making of compost manure, the mainstay of organic farming. The theme of the day was "Good agricultural practices for enhanced productivity and food security". The occasion was attended by the Area Provincial Administration and line ministries which had invited various community groups. The IPs displayed great interest in demonstrations on energy saving stoves, wood saving stoves and weaving products, all from environmentally friendly projects run by various community

groupings. The Bio-fuel *Jatropha* plant also attracted their attention as they learned that apart from the plant being used as fuel wood, its oil can propel a diesel engine and be used for skin medication and ornamental use. The IPs also had the opportunity to talk about their HCS and OVC support activities and urged community members to actively support PLHIV in the family to lead positive lives.

### **Child protection**

At the start of the project, A2N/C met with the Deputy Director of Police for Community Policing, Gender & Child Protection with the aim of introducing the project and identifying ways of working with the police to enhance their child protection activities. The Deputy Director listed the following as possible police divisions to collaborate with in Nairobi, namely, Buru Buru, Gigiri, Embakasi, Lang'ata, Central, Kasarani and Kilimani..

#### *a) Paralegal training of DCOs*

This training was organized jointly by the Y/BCC and OVC teams from in April 2008. The training was reported earlier as being primarily for Chill club patrons. The OVC support team however deemed it necessary to invite the District Children Officers (DCOs) to the training for learning purposes and also as a means of building linkages between the DCOs and teachers faced with the task of handling child abuse cases in their respective schools. 5 DCOs/representatives within the A2N/C area of coverage attended the training. The Provincial Children's Office sent a representative to the meeting.

#### *b) Day of the African Child festivities*

IPs in Nairobi continued to mark the Day of the African Child with support from A2N/C. OVC and community leaders participated in marking this international day. Community members held open discussions regarding OVC issues while speeches by the community leaders carried advocacy messages in support of the rights of the child. The children had a memorable time as they participated in marking the day through song and dance, poems, plays, memory verses and games. They were also treated to snacks and face painting.

#### *c) Sensitization of police personnel and other stakeholders on child protection*

This two day workshop took place at the Meridian Hotel in September 2008. The training was attended by 11 Police Officers, 2 Chiefs, 3 Assistant Chiefs, 1 Social Worker, 1 Volunteer Children's Officer and 1 Private Sector Representative with interest in OVC issues. The sensitization was carried out by two facilitators: a paralegal from St Francis (Kasarani) and the District Children's Officer (DCO), Kasarani Division. The areas of discussion during the workshop included:

- The Children's Act 2001, Cap. 586 of the Laws of Kenya;
- Legal Instruments for Child Protection;
- Forms of Child Abuse;
- Neglect, Diversion and Rehabilitation of Children in Conflict with the Law and ;
- Functions of the Area Advisory Councils (AACs).

The participants appreciated efforts by A2N/C to promote the rights of OVC and pledged to use knowledge acquired when dealing with OVC issues in their neighborhoods and work stations.

#### *d) Child Rights and Protection Sensitisation for CHWs*

This training for sixty (60) CHWs from 12 IPs within the Nairobi East District was aimed at improving service delivery and advocacy for the benefit of OVC. Specific sensitization objectives included: sensitization of participants on Children's rights and welfare; transfer of knowledge on legal requirements for administration of children services/institutions and skills on dealing with

child offenders. The training was facilitated by Children Officers from Child Helpline Kenya and District Children Officers who used the Children's Act 2001 as a guide. Participants were also issued with reference materials for future use.

*e) Service providers training on child protection*

A Service providers' training took place at Meridian Hotel in October, 2008 and was attended by a total twenty-nine (29) service providers from various health facilities in Nairobi West district. The main purpose of the training was to sensitize the service providers on issues of child Protection and child rights. Topics covered included: legal instruments for child protection; child abuse and neglect; diversion and rehabilitation of children in conflict with the law and the role of community based support in the diversion project.

*f) Child protection collaboration meetings: Kaloleni/Makongeni area*

The OVC team organized and facilitated a community sensitization meeting on OVC issues at Makongeni –Kaloleni location in collaboration with Provincial Administration Office in the area and with MoPH&S Makadara. A total of 29 participants (11 females) representing 5 like-minded CBOs/FBOs were in attendance. The sensitization session was attended and facilitated by a team comprising HCS and OVC staff. Issues discussed included:

- Overview of A2N/C with special emphasis on HCS and OVC activities and linkages to health facilities.
- Rights and responsibilities of the child, based on the Children's Act 2001, the UNCRC (United Nations Convention on the Rights of the Child) and the ACRWC (African Charter on the Rights and Welfare of the Child).
- Role of the community in supporting PLHIV and OVC.
- The need for organizations to network for the ultimate benefit of the clientele

The Area Assistant Chiefs for Kaloleni and Makongeni were also present and applauded the initiative. They called upon the CBOs/FBOs to increase their participation in support of PLHIV and OVC in the area. Participants were also sensitized on the importance of relating with respective government ministries, agencies and departments in addition to working with both national and international partners.

*Dandora area*

This sensitization meeting was held in January 2009 at the Dandora II Chief's Camp. The meeting was organized by Community Development Initiative Kenya and conjunction with Dandora II HC and was attended by 40 participants drawn from self-help groups, CBOs, NGOs and the Ministry of Youth Affairs. Topics covered included A2N/issues such as development planning and resource mobilization, policy formulation and community involvement and/or participation in project implementation.

*Child Protection Unit, Kasarani*

A meeting was held to continue discussions with the Kasarani Child Protection Unit (CPU) and the Community-based Support System (CBSS). The objective was to discuss possibilities of strengthening existing partnerships and to seek ways to address the infrastructure at the CPU which was inadequate to support child protection activities. Although no solutions were immediately reached to make the CPU work better, the Officer-in-Charge deployed 3 of his officers to support the CBSS, the Children's Department and other partners in dealing with abuse cases.

### *Meeting with CLAN*

A2N/C approached CLAN, a legal aid organization to assist with training of additional paralegals at very subsidized cost. This meeting was very fruitful as it led to a rapid mapping exercise by A2N/C which helped inform a decision to train an additional 96 paralegals in three phases beginning in the next quarter. These new paralegals will ease the work of already existing and overworked paralegals (56 in number). They will also ensure PLHIV and OVC receive professional services especially to curb the alarming rise in cases of child abuse in the community

### **Shelter and clothing**

10,000 OVC were provided with blankets, clothes to wear and toothbrushes. During one of the child forums, 5,187 T-shirts with a child rights advocacy message '*Vijana wanasay-Tuwasupport*' (*Children have a right to be heard - Support them!*) were also distributed.



**Children pose to show off their T-shirts**

### **Economic empowerment**

69 caregivers were trained on group savings and loans while 40 others were trained on gunny sack gardening, a method that enables households to produce their own vegetables.

### **Collaboration**

Through out the period, the project collaborated with the Department of Child Services, the Kenya Police, Area Advisory Councils and other GOK Ministries to ensure OVC were served around.

#### *a) Exchange Visit by South African OVC team*

A2N/C collaborated with the City of Johannesburg's new OVC Unit to host a team of three officials in Nairobi from in October 2008. The aim of the officials' visit was to gather information, exchange ideas and learn more about OVC A2N/C support. The Unit officials also requested an understanding of the Kenya National OVC Strategy (its challenges and identified best practices) and the Cash Transfer for Orphans and Vulnerable Children.

## Lessons learned and recommendations

- In order to effectively implement activities, follow-up and monitor the progress of OVC in the A2N/C, a scale up on institutional capacity building to all IPs partnering in the A2N/C is of paramount importance.

## Challenges

- While A2N/C has focused on distribution of items to individual OVC, it has become clear that the project must shift focus to providing quality services at all levels if we are to achieve a holistic well-being of the OVC
- The need on the ground surpassed the resources available
- Rampant abuse in children of all ages, with uncoordinated and limited support from GOK hampered A2N/C implementation greatly

### 3.3 Reduced stigma & establishment of safety nets for PLHIV & their families

A2N/C weaves stigma reduction activities into all its trainings and its community initiatives. Stigma reduction is part of the HBC training for CHWs, the paralegal training, the leaders' sensitization and, of course, treatment literacy. In fact, stigma reduction is at the core of all of A2N/C's home and community support services, because provision of services to PLHIV outside the health facility structure challenges stigma at the individual level, the family level and at the community level.

#### Facility-level advocacy and education

In close collaboration with the service delivery team, A2N/C conducted continuous medical education (CME) sessions on home-based care, as a way of advocating for better care for PLHIV, as well as to provide a better understanding and appreciation of community services, and the role of these services in the continuum of care for PLHIV. Details of these CME sessions are provided in Result 1 of this report.

#### Legal rights awareness

The provision of legal services and creation of legal rights awareness is an integral part of safety nets for PLHIV and OVC. The paralegal support provided seeks to raise legal awareness in the target communities to prevent victimization of PLHIV and OVC, as well as to provide legal aid when required.

#### Training of Paralegals:

With the expansion of HCS services, it was necessary for A2N/C to train new paralegals drawn from the IPs to ensure provision of legal services for the increasing number of clients and OVC. A2N/C also trained the patrons of the primary school-based *Chill* Clubs from a total of 18 schools in Nairobi, as well as Children's Officers from Kasarani, Makadara, Central Districts and one from the Provincial Children's Office. The IP-based paralegals were trained CHWs but also holding positions of responsibility in their communities, such as religious leaders, village elders, social workers, and representatives of school committees. Both trainings were conducted by *A.G.A Etyang and Company Advocates*, which provides paralegal training for a number of community-based organizations in Kenya. The company is headed by retired Justice Etyang, who has over 30 years' experience as a judge and advocate of the High Court. Justice Etyang is

familiar to many Kenyans as he handled quite a number of high profile cases. The trainers drew their training material from two main sources namely, *A Manual for Paralegal Trainers*, and *A Curriculum for Community Paralegal Workers*. Both documents are prepared and distributed by the Paralegal Support Network in Kenya (PASUNE).

The goals of this training were:

- Equip individuals from the community with basic legal knowledge and skills in order to promote legal awareness and support the well being of children and PLHIV for the benefit of the community;
- Build the capacity of IPs to provide legal aid in the community and referral linkages for legal support;
- Equip teachers and Children's Officers with basic legal knowledge and skills so that they can better support children needing legal aid.

The main topics covered during the training were:

- Paralegalism and community development
- Introduction to law and sources of law
- Family law
- Criminal procedure
- Civil procedure
- Labour law
- Alternative dispute resolution
- Human rights and HIV/AIDS stigma and discrimination.
- Gender and gender violence
- Child rights and the children's act
- An overview of parental responsibility and parenting styles
- International and domestic instruments for child rights and protection –Children's Courts
- Children's Institutions (Part V of Children's Act)

### **Linkages:**

In Nairobi North, the paralegals reaped the fruits of very good networking efforts. The RGC paralegals worked very closely with the Women's Rights Assistance Program (WRAP) and the International Justice Mission (IJM). These organizations provided rescue services as well as court representation for victims of abuse. In Kasarani, the paralegals were represented in the Area Advisory Council (AAC), and they also collaborated closely with the District Children's Office and the Kasarani police. The Kasarani Police Station has an active Child Protection Unit supported by the Girl Child Network (GCN). The paralegals referred abused children needing rescue to this unit. KENWA's paralegals worked in close referral collaboration with the Child Legal Action Network (CLAN) and the African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN) to support PLHIV and OVC needing legal assistance.

The Nairobi West team worked closely with the chiefs as well as CRADLE, Plan International and Childline Kenya. Childline Kenya were very helpful to the paralegals in rescuing abused children as it has a 24-hour call center for reporting cases of child abuse.

In Nairobi East the paralegal team had good success working with the Urban Slums Project, the Red Cross as well as highlighting cases of child neglect and abuse in the press. Some of the paralegals are also members of the AAC in Makadara and Embakasi, thus they were able to influence the AAC to intervene in cases of abuse. All the paralegals also referred cases of sexual abuse to the Nairobi Women's Hospital, which is an A2N/C-supported site.

In the absence of pro-bono legal services, the linkages described above have ensured provision of legal aid for A2N/C's clients and OVC. The linkages have also built the confidence of the paralegals to identify these cases and to report them because the NGOs mentioned above have the resources to rescue and have the perpetrators apprehended. All this work has not been without challenges. Sometimes the paralegals have been threatened by relatives of the perpetrators, while some families have not been cooperative in exposing the perpetrators of violence especially if the perpetrators are family members. In other cases, the police are reluctant to perform proper investigations to bring the perpetrators to book.

A case in point.....

*Dandora - the paralegals handled 4 cases of rape/ defilement of girls aged between 9-14 years. All the girls were referred to the Nairobi Women's Hospital for treatment and the rapists were arrested by the police and were later were jailed in Kamiti Maximum Prison. In another incident, a well known rapist in Dandora was arrested and jailed after one of the paralegals identified him to the police.*

*Embakasi – the paralegals handled 6 cases of domestic violence related to HIV infection. All the cases were reported to the area chief then the police and the perpetrators were arrested. The victims of violence were referred to Kenyatta National Hospital for treatment and but unfortunately one of them died. The paralegals also handled one case of disinheritance – a woman whose husband died of an AIDS-related illness had her property (including marriage certificate) taken forcefully by her husband's relatives. At the intervention of the paralegal, all her property was given back.*

**End of Project Report**

**CENTRAL PROVINCE**

**1 August 2006 – 31 July 2011**

## CENTRAL PROVINCE

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**Table 1: Central Province: summary report – August 2006-February 2009**

Indicator	Year 1			Year 2			Year 3		
	Target	Achieved	% Achieved	Target	Achieved	% Achieved	Target	Achieved	% Achieved
Prevention - No. individuals reached with messages of abstinence and/or being faithful (AB)	4,500	16,089	358	71,000	173,378	244	107,500	74,255	69
Prevention - No. individuals reached with messages of abstinence (A)	4,500	4,506	100	5,000	6,763	135	92,925	77,193	83
Prevention - No. individuals reached with messages of other behavior change (OP)	167,800	239,547	143	85,960	686,618	799	87,500	281,681	322
PMTCT - No. pregnant women counseled, tested for HIV and received test results	1,516	22,714	1,498	24,267	33,765	139	13,371	14,682	110
PMTCT - No. pregnant women received complete course of antiretroviral prophylaxis in a PMTCT setting	72	798	1,108	1,644	1,422	86	1,068	401	38
No. individuals received counseling, testing and test results	9,100	303	3	12,200	27,591	226	29,167	40,399	139
No. of registered TB patients who received HIV counseling and testing and received results	-	-	-	-	517	-	625	363	58
ART New clients	54	147	272	820	913	111	550	700	127
ART Ever (cumulative) clients	139	372	268	4,668	6,348	136	2,855	6,797	238
ART Current clients	119	363	305	3,500	4,815	138	2,832	4,965	175
No. individuals received HIV-related palliative care (including clinical prophylaxis and/or treatment for TB)	3,500	2,862	96	13,400	19,407	145	6,500	11,269	173
No. individuals attending HIV care treatment who received treatment for TB disease	100	5	5	600	237	40	313	415	133
OVC served	6,800	13,391	204	18,600	25,699	138	20,160	25,683	127
OVC served - Primary Direct	-	281	-	3,720	18,881	508	20,160	18,791	93
OVC served - Supplementary Direct	-	13,584	-	14,880	6,818	46	-	6,892	-

## **Result 1 Improved and Expanded Facility-based HIV/AIDS, TB, RH/FP, Malaria and MCH Services**

### **Overview of Province in August 2006**

Result 1 started activity in Central Province in August 2006. Previously only VIDHA, a Spanish organization, was supporting HIV activities in Maragua District (now renamed Muranga South District). At the time, there were seven districts in Central Province<sup>5</sup>. ICAP (International Centre for Care and Treatment of HIV Program), a CDC funded organization, also began their activities in Central Province at the same time that A2NC did. The two partners, ICAP and VIHDA only supported Care and Treatment activities, with VIDHA being confined to one district and ICAP expanding to limited sites.

PMTCT had been rolled out on a large scale by the Pathfinder International CDC project (at all level 3 public facilities in Thika and Gatundu Districts). EGPAF supported PMTCT at the District Hospitals in Gatundu, Thika and Nyandarua Districts whereas all other districts excluding Nyandarua were supported by NARESA through CDC funding. As a result no PMTCT partners were in all private facilities, FBO in the entire Province or at level 3 and 2 facilities in the Nyandarua Districts.

Reproductive health activities were supported at the national level with partners supporting training of Health Care Workers on a need basis. However, the DHMT and PHMT had to source resources to implement these activities.

Counseling and testing was supported at a national level and VCT counselors were supported by a Global Fund project. LVCT had previously been on the ground to support PEP, counselor supervision through the DHMTs and Mobile VCT but had been withdrawn before A2NC began activities in the district. Partners in Prevention occasionally supported supervision of counselors in districts of interest with the exception of Nyandarua District and they also trained VCT counselors in couple counseling and testing. PITC had not yet started in the Province as no partner supported this, with the exception of some trainings supported by JHPIEGO through funding for national implementation. JHPIEGO also supported CT into FP training in the Thika Districts but not elsewhere in the Province.

Due to gaps in service provision, A2NC started implementation in the areas most in need of Nyandarua District before moving into other areas. Strong partnerships were established with existing partners and the DHMT/PHMTs to improve service linkage and integration. DHMT/PHMTs were supported to implement and supervise services to the lowest level. Lessons learned were applied to improve services and were shared at stakeholders' forums for replication at other partner level.

### **Sub result 1.1 expanded availability of HIV/AIDS prevention, care and treatment services**

#### **Strengthening Prevention services - PMTCT**

A2NC was mandated to provide HIV/AIDS prevention, care and treatment services in Central Province. A2NC took over from Elizabeth Glaser foundation all their supported sites at the award of this project: these were PMTCT sites in Thika District hospital, Gatundu District Hospital, Nyahururu District Hospital and Ol Kalou District Hospital.

In Nyandarua South and North District, the lower level facilities (2-3) had not started implementing and keeping records for PMTCT because health care workers (HCW) had not yet received training in PMTCT at the start of the project period.

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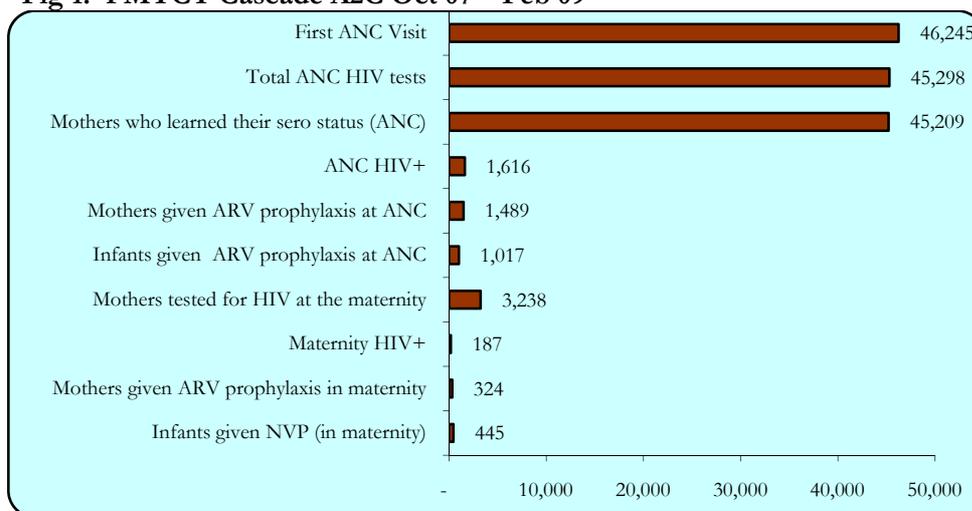
<sup>5</sup> Currently there are eleven districts in Central Province: Nyandarua District was split into South and North; Thika has become Gatundu and Thika District; Kiambu District is now Kiambu West and East Districts and Nyeri District has been split into Nyeri North and South Districts.

During the project period A2NC trained 326 HCW in PMTCT, IYCF and EID to strengthen PMTCT services. PMTCT was further expanded to private facilities and faith based organizations in the province to cover the gap in PMTCT. A grant was provided by A2NC to Christian Medical Mission Board, CMMB to further strengthen PMTCT in the faith based organizations.

EID sensitization was provided to HCW in the whole province to enable infected exposed infants to access ART services early in life as a requirement of the national guidelines. In the Nyandarua Districts, A2NC clinic site coordinators (CSC) offered technical assistance and support supervision to assist in improvement of data recording. The facilities were supported with tools for data records. IYCF trainings were offered to further strengthen PMTCT through recommended practices of infant feeding like exclusive breast feeding.

All mothers who tested positive at the PMTCT supported sites were given nevirapine prophylaxis to lower the viral load of maternal HIV thus reducing the chances of transmitting the virus to the unborn child before or during birth. This best practice of providing the prophylaxis by HCW was made possible by regular trainings and updates in PMTCT, support supervision and technical assistance offered to the facility. Mothers who had previously tested positive but not been put on prophylaxis were also offered ARV prophylaxis at the maternity. Mothers who had received their prophylaxis early in the project and their drug had expired before they delivered were given another dose before delivery and this accounted for having more mothers getting prophylaxis compared to those who tested positive. The guidelines for PMTCT were revised to include AZT as prophylaxis and for mothers with a CD4 count of greater than 350 cells per unit to be provided with HAART in addition to the single dose nevirapine., The new regimen was known as the ‘more efficacious regimen’ and A2NC provided support to roll out the new regimen through training and dissemination of the new guidelines. Drug distribution was also facilitated by A2NC especially in areas like the Nyandaruas where A2NC presence is strongest. PHMT and DHMT support also greatly contributed to the success of the program. As a result of the implementation it is expected that mother to child transmission of HIV will reduce significantly and there will be fewer children who will be living with HIV in Central Province.

**Fig 1: PMTCT Cascade A2C Oct 07 – Feb 09**



### Strengthening Prevention services - Counseling and testing

KAPC was subcontracted to train counselors in Central Province. Previously the province had relied on the few VCT counselors posted by NASCOP supported by the Global fund and LVCT

had trained nurse counselors at the facility level. The number of counselors trained was not adequate to meet the service needs in the province and many VCT sites were closed due to lack of a service provider at the facility. Nurse counselors were frequently required to serve shortages in other departments of a health facility leaving the VCT further handicapped in terms of staff. A2NC trained lay VCT counselors in Implementing Partners (IP) supported under result areas 2 and 3. These served on a voluntary basis at the VCT sites, e.g., Engineer District Hospital. In other areas, the gap in staff was filled in by ten lay VCT counselors that were employed under A2NC through an agreement with the Provincial Medical Officer (PMO). In total, A2NC was able to support 89 VCT sites in the Province by the end of the project.

Between October and December 2008, there was a national accelerated counseling and testing exercise and A2NC sites in Central Province were able to test **27,994** individuals by conducting outreaches in their environs to reach as many people as possible. A2NC provided support in mobile outreaches, logistics for test kit availability and moonlight VCT through Hope World Wide Kenya. During this period, drama groups supported by A2NC and local administration played a major role in community mobilization.

KAPC was supported by A2NC to conduct trainings in pediatric psychosocial support, adherence counseling, couple counseling in PMTCT and VCT. Targeted for training were HCW, CHW, peer educators and PLHIV who assisted in improving counseling activities at the facilities level, thus task shifting alleviated staff shortage. Trained volunteers were utilized to support counseling services at the health facilities.

#### **Care and treatment:**

A2NC increased in the number of patients provided care and treatment as well as improving the quality of care in Central Province.

At the inception of the program, 14 facilities were supported under A2NC most of which were level 3 facilities. Initially, 230 patients were on treatment, but the number rose by end of project to 7,127 ever started on treatment at the sites supported for care and treatment. New patient enrollment during the project period rose from an average of 20 to 400 per quarter.

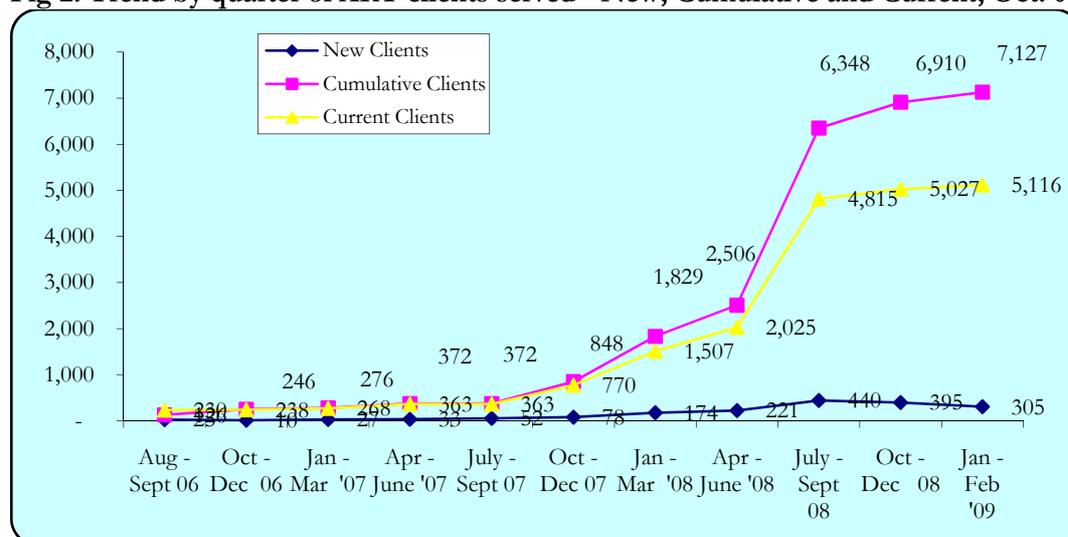
In the third year of the project, two level 4 facilities, Tigon DH and Maragua DH, were added to the sites supported by A2NC. This led to an increase in the number of cumulative and current patients on treatment as shown in the graph below. Referrals from VCT, PMTCT, DTC and TB clinic were enrolled into care and treatment.

Training of HCW in managing HIV positive patients increased their confidence in prescribing and thus motivated them to recruit more patients into treatment.

The retention rate was higher when the service providers had been trained in adherence counseling. It also improved with better access to services at lower level facilities where community linkages were strong. In Maragua District where facility- community referral was strong, adherence was good. And The Saikaka CBO, a community IP working with Pathfinder International, with members trained in treatment literacy supported patients' adherence, especially at Sabasaba HC.

The laboratory transport network was a huge boost to the program numbers as more patients were able to access immunological testing than before. A2NC trained HCW and CHW couriers in transportation of specimens to a hub lab which served a cluster of facilities. At the maturity of the project, motor bike riders were hired by A2NC to reach all facilities making transportation of specimen faster.

**Fig 2: Trend by quarter of ART clients served - New, Cumulative and Current; Oct. 06 - Feb. 09**



### Integration of services

TB and HIV service integration was found to be lacking in the province as TB services were offered independently of HIV services at the beginning of the project.

Service providers at all A2NC supported sites were trained on care and management of the TB/HIV co-infected patient therefore by the end of the project TB screening was taking place at the CCCs. The results of TB screening were recorded on the 'blue card', MoH 257; likewise testing for HIV of TB patients was encouraged in the TB clinic. A2NC assisted in compilation of the integrated data at district level.

At the CCCs, patients who were TB/HIV co-infected were supported with food (Unimix, porridge flour) which was provided quarterly by Malteser International.

Other integrated activities that were strengthened at the facility level were provision of counseling and testing to women accessing family planning services. This was through training of HCW in CT into FP using the national curriculum. Twenty-seven service providers from various facilities in Central Province were trained during the project life. Registers were provided to further strengthen the integration and technical assistance and supervision offered to ensure that they were properly filled out.

Service providers preferred integrated training of family planning into counseling and training as opposed to the contraceptive technology update training on its own: they said that with integrated services women could be monitored for new infection on a regular basis.

### Nutritional support:

A2NC provided training to service providers in IYCF and nutrition in HIV/AIDS using the national curriculum. Weighing scales which had a stadiometer were procured and distributed to 64 supported facilities, likewise pediatric weighing scales were provided to supported PMTCT sites to further strengthen measurement and recording of anthropometric measures at the supported sites.

A2NC facilitated distribution of multivitamins to facilities and IEC materials as need arose.

### Increase access to pediatric HIV treatment

At inception of project, fewer than ten percent of children on care had been started on treatment. Challenges faced at the CCCs were lack of training for service providers to support care and treatment for children. The trained service providers also lacked the confidence to prescribe ARV to children. A2NC provided training in basic pediatric ART to 84 service providers through a sub contract with Gertrude's Children's Hospital and provided technical

assistance to facilities that were supporting pediatric care and treatment through the clinic site coordinators.

Further support was provided by training peer educators to provide pediatric psychosocial support through KAPC. Cotrimoxazole was made available to facilities for prophylaxis: all 10 A2NC supported sites that provided pediatric ART were offering cotrimoxazole to all their patients on care. Service providers were trained on commodity management to strengthen supply and distribution of pharmacy and laboratory commodities.

EID and child testing needed to be strengthened as entry points into pediatric care and treatment. Pediatric psychosocial support was also a felt need as children who were on treatment grew older and had more understanding of their condition began to ask questions, therefore, during the project period, A2NC trained 26 SP but the project ended before the post training follow up was implemented.

### **Strengthen Laboratory support**

By August 2006, only two CD4 machines were offering services to HIV infected patients in public facilities in Central Province: these were placed at Nyeri Provincial General Hospital (PGH) and Maragua DH. Most patients were staged using the WHO clinical staging and only a few could access immunological staging. This made it very difficult to start patients on ART as clinicians were not as competent in the WHO clinical staging which is only a guide but not conclusive in itself. A2NC established a laboratory transport network to support the process of diagnosis.

To start the laboratory transport network, service providers from every district attended a one-day sensitization meeting supported by A2NC and afterwards the A2NC sites were supported with a transport allowance for an identified CHW or laboratory technician to transport specimens to the nearest hospital offering CD4 testing. This intervention saw a rise in the number of patients being started on ARV. Later as the number of CD4 machines supported under PEPFAR increased in the province, A2NC supported motorbike riders to transport the specimens, especially in the distant and hard to reach areas with challenging terrain like in Nyandarua Districts. Specimen collection bottles and cool boxes were procured and distributed to support the laboratory transport network.

During the same period A2NC supported eight facilities to buy equipment for reading hemograms. Microscopes were procured and distributed through Malteser International, a partner with A2NC and forty laboratory technicians trained in TB microscopy to improve their skills in TB diagnostics. Linkages were made with Kemri CDC laboratory to facilitate Early Infant Diagnosis (EID); the dry blood spot specimens (DBS) were transported to the nearest courier point by the A2NC motorbike riders. Through Malteser International, A2NC supported X-ray networking for HIV infected patients. Patients were referred to the nearest level 4 or 5 facilities which had x-ray support through an agreement between Malteser International and the medical officer in charge of the facility. The higher level facility would provide chest x-rays to the patient through an account that was credited to Malteser International. The x-ray support was provided in all districts.

### **Quality improvement**

Quality improvement through performance monitoring as well as using data for decision making, was supported through external quality assurance, especially of laboratories where TB was being diagnosed with support from Malteser International and the PTLC office. Support supervision was provided by DHMT and PHMT who were facilitated by A2NC with transport. Technical assistance during the project period was provided by A2NC clinic sites coordinators to further strengthen services in all areas supported by A2NC.

## **Result 1.2 Expanded availability of FP, RH & MCH services with HIV/AIDS services**

### **Expanding access**

Central Province is vast with poor terrain: the poor road network hampered access to pockets of hard to reach areas and to all weather roads like Nyandarua North and South districts. Service provision to the communities remained a challenge for access to services at level 3 and 4 facilities as the dispensaries were not equipped or HCW trained to provide FP and RH services. The communities' socio-economic statuses are mainly in the lower bracket and affordability of transport alone deters clients from seeking services elsewhere. A2NC identified a need for contraceptive technology updates in Nyandarua North and South, and a total of 30 service providers were trained after which they developed implementation work plans. A2NC supported the redistribution of commodities from the District Reproductive Health Office (RHO) to these facilities which further improved access to family planning service.

A2NC managed to expand access to the services at levels 1 and 2 by building capacity of the service providers thus alleviating congestion in level 3 and 4 facilities. The project also equipped the facilities, creating better working conditions for service providers. The DHMT was involved in the support supervision of facilities. Supply of consumables was another activity undertaken by A2NC to improve service provision in the province.

During the project period, expansion consisted of support of facilities offering RH services from **15** at the outset to **139** at the close of the project. The total couple year protection rose from **4,262** to **51,233** with a total of **107,505** CYP provided to Central Province through A2NC in supported sites by the end of the project. At the supported facilities, service providers were also trained in STI syndromic management, youth friendly services (YFS), post abortion care (PAC) and provided contraceptive technology updates (CTU). A total of **658** HCW were trained during this period.

### **Long-term Family Planning**

For some time the FP program provided combined oral contraceptives and depo injection mainly due to provider biases which resulted from lack of confidence to administer other methods as the two methods were easier to administer: staff shortage might also have influenced the choice of method by service providers. A2NC took the approach of on-job-training and continuous medical education for service providers while the district RH coordinator later supported the trainees to provide the services under their supervision to build on their confidence. While this was viewed to be the ultimate solution, clients declined the services due to the myths, misconceptions and peer influences in the communities. These were addressed by health talks and FP counseling provided during early morning sessions as patients awaited other services to be provided and drama outreaches from the YBCC groups as well as HCW provided the health talks.

Long acting methods of family planning are not popular and the trend was still low hence the need to come up with strategies such as IEC materials and peer counselors. Due the misconceptions in the community about long term methods, the uptake remained low despite the project providing verbal trainings, CME's coordinated by the DPHN's as well as redistribution of commodities to the facilities when there was shortage. It was, however, a challenge to train FP long-term and permanent methods as no curriculum exists nationally for didactic training and extra resources are required to support practicum.

It is hoped that in future the training will be facility-based through OJT as long-acting and permanent methods roll out is a felt need on the ground. Depo provera injection was consistently the method of choice during the period as it is easy to administer to the patients and the injections enables a woman to conceal from her husband her birth control and the women could easily access the FP method on a regular basis when she visited the market.

### **Antenatal care**

The care of a woman during pregnancy depends much on her initiative to seek services. The biggest challenge at the beginning of the project was to attract these clients to the facilities. A2NC supported CMEs during which the District Public Health Nurses (DPHN) gave updates on focused antenatal care, the 5 doses of tetanus toxoid schedule and other immunizations. Health care workers were given targets per district for the number of women who should be served with services at antenatal care. A2NC also provided the facilities with blood pressure machines, stethoscopes, thermometers and other clinical equipment. The project supported enhanced HIV counseling and testing and initiation of other PMTCT interventions in the early ANC visits by the mother through training of the HCW and regular updates on PMTCT as per the national guideline. Close collaboration with CMMB who were supporting the mentor mothers program, in some of the high volume sites like Thika and Gatundu District Hospitals, was established. VIDHA supported replacement feeding at facilities whereas A2NC ensured that all the HCW were trained on Infant and Young Child Feeding (IYCF).

### **Labor & delivery**

During facility needs assessments it was noted that there was need for delivery beds to replace the old and rusty ones as replenishment from the government had not been forthcoming. At the same time low level facilities had been sensitized against denying women maternity services to improve deliveries under skilled attendants. A2NC came to the rescue by procuring and distributing delivery beds and examination coaches to these facilities. A total of 60 beds were delivered to supported facilities during the month of September 2008. Management of 3<sup>rd</sup> stage of labor, use of ergometrine during labor and resuscitations of the newborn were topics covered in A2NC supported CMEs for HCW.

### **Emergency obstetric care**

Minimal support was offered for emergency obstetric care through topics covered in the CMEs, however, this and safe motherhood trainings were requested a number of times but existing funding did not allow support. This remained a huge challenge due to high maternal mortality especially at the rural facilities and future project should address this need.

### **Post Abortion Care (PAC)**

The attitudes of health care workers towards women in need of post-abortion care hinders service uptake as most believe that the patients are guilty of an offense and thus delay in intervention. In most circumstances, RH service providers at all primary health care levels have conducted manual vacuum aspirations without being aware of the existence of a comprehensive PAC package. PAC was supported by training 30 service providers from 17 sites and providing them with MVA kits procured using Pathfinder International private funds. The trainings were followed by community sensitization in four community groups around the facilities from which the trainees had been drawn. Three level 4 facilities had service providers trained in Youth Friendly Post Abortion Care (YFPAC) a combination of Youth Friendly Services with PAC. The facilities were: Tigoni, Thika and Gatundu District Hospitals. In total, 32 Service Providers were trained in YFS and 24 trained in the YFS teach-back curriculum to strengthen YFS. Equipment was supplied to support the initiative to the supported facilities. No youth friendly centers were established during this period as service providers perceived the facilities not to have adequate infrastructure to provide YFS. It is hoped that in future projects specific sites will be targeted for establishment of the services.

### **Men as partners**

Couple counseling in PMTCT and VCT had a slow start during the project period as very few health workers had been trained under a University of Washington research project, that recruited discordant couples for their study - Partners in Prevention. This necessitated trainings for more service providers in couple counseling: eventually, 20 SP from VCT sites were trained and 22 from PMTCT sites. This, however, did not result in a significant increase in number of couples tested as most men still refused to accompany their wives to the health facility. Throughout the duration of the project, more men were tested during MVCT outreaches than were tested at VCT sites. In future, it is hoped that more innovative approaches like invitation cards to the ANC and extended open hours at the facility will increase male involvement at the facility level.

### **Sub result 1.3: Reinforced networking between levels of care and between clinical services & community**

As the program expanded, linkages between levels of care were established and A2NC distributed referral forms to enhance documentation of referrals facility to facility and between departments in the same facility. The same forms were to be used in community to facility referral by CHWs. Referral of sick patients from the community to facility was facilitated by the CHWs and at the facility level, health care workers were sensitized to the role of CHWs in referral. Not all facilities were linked to a community unit as CHWs had been trained principally in parts of the province where A2NC presence was well established like the southern part of the province and the Nyandarua Districts. In the next project period it is hoped that A2NC will support the government to train CHWs and establish community units around all the facilities. Health education in supported facilities was offered by peer educators and advocates supported by A2NC.

In Maragua district, A2NC supported training of service providers in provision of care and treatment services at level 3 facilities. An elaborate referral system existed where patients were started on ARV therapy at the district hospital and later referred for continuation of the same at the health centers. Preparedness of the service providers at these facilities was important in the provision of quality care. In other areas, CMEs conducted at the district levels empowering the service providers with useful knowledge have made it possible for decentralization of services to Levels 1 and 2 because the facilities can continue with care of patients once treatment is initiated at Levels 3 and 4 facilities. The project, through a consortium partner, Malteser International, has provided chest x-ray support to supported Levels 1 and 2 sites by paying for the radiograph and reporting of the films hence improving the diagnosis and further management of patients with TB or any other chest related illnesses further improving linkages between levels of care- Provision to improve health services

Towards the end of the project, the Gold Star Network was subcontracted by A2NC to support the private providers in expansion of care and treatment services. They are mandated to train and provide Continuous Professional Development (CPD) sessions to private practitioners in the province as well as supervise them and provide technical assistance. This has improved the services because service providers can now refer patients among themselves regardless of whether serving in private or public facility as they are all empowered through trainings and support supervision. The private practitioners have been reached mainly in major towns like in Thika and Nyeri and it is planned to increase recruitment in other towns like Kiambu and Nyahururu. The community component for clients of private providers remains a challenge and thus stigma reduction and psychosocial support is required. In future more support groups will be formed for clients of private practitioners.

### Challenges:

- In the initial implementation of PMTCT, the major challenge encountered was non-availability of drugs and registers for roll out of the more efficacious regimen (see under PMTCT). A2NC linked the facilities to the district pharmacies where they were able to send their reports on drug consumption and replenish their ARV drug stocks. A2NC sourced and redistributed ANC registers as well as the daily activity registers to monitor PMTCT activities at the ANC.
- Stigma worked not only against mothers accessing testing for HIV but also against their partners being tested, especially in an area like Nyandarua districts where very few development partners had previously worked. Working closely with the community outreach team, drama groups and community health workers engaged stigma reduction strategies at the community level.
- There is still a small percent of women who opt out from being tested for HIV on the first ANC visit due to high level of stigma. Stigma reduction campaigns have been put in place to address this.
- There were not enough nutritionists to support nutritional activities at the facilities and A2NC had to train HCW in nutritional skills in HIV management in order to task shift. Basic anthropometric measurements and nutritional counseling was therefore supported by the other cadres especially nurses who received training and updates in nutrition though this was still not enough for proper implementation of nutritional services. In future nutritionists will be required to be based at all facilities where care and treatment services are being provided.
- The shortage of staff especially at public facilities hampered service quality as sometimes only one HCW provided all the services at the facility, e.g., FP/RH, MCH/ANC/PMTCT, TB, etc. A2NC deployed staff on contract to ease the shortage in the most affected facilities. Six Clinical Officers, ten VCT counselors, seven nurses and a laboratory technician were contracted.
- Towards the end of the project period the National AIDS and STI Control Program (NAS COP) that oversees HIV and STI activities in the country, laid off Global Fund supported VCT lay counselors, further aggravating the existing shortage of VCT counselors. A2NC plans to increase the number of VCT counselors under contract to fill in the gap that has arisen as a result of the Global Fund counselors leaving.
- The facilities lacked the necessary equipment to monitor patients on HIV care and treatment, most patients had to travel long distances for CD4, hemograms and biochemistry tests. A2NC linked the CCCs that did not have equipment with those that had through specimen transportation. In some facilities equipment was procured and it is expected that in future more laboratories will be renovated and equipped through support by partners.
- Infrastructure was often quoted health care workers as a hindrance to implementation of CCC and Youth friendly services: most facilities had been built in the earlier days when the population was still low and diseases like HIV had not emerged. Integration of services was therefore encouraged by A2NC and extra furniture was provided to maximize utilization of available space.

## **Way Forward**

In view of the chronic staff shortage that exists at the facilities, A2NC found it necessary to task shift in most areas and peer educators who are already trained in pediatric psychosocial support will be further trained to provide play therapy for children. Facilities will be provided with toys and renovations for a child friendly CCC. More staff should be employed by partners and the Ministries of Public Health and Sanitation and Medical Services with the aim of quality improvement. Volunteer lay VCT counselors should be engaged to cover up for shortage at the VCT sites.

Infrastructure is important for service provision and future partnership with the government would involve more renovations to create space for service provision especially targeting services for special groups like children and the youth. Sites have been identified for renovation based on needs assessment. Laboratories in level 4 facilities have been earmarked for renovations and equipping in future support provided to public facilities.

In future, due to high levels of stigma in Central Province which has been reported as a hindrance to access of services, stigma reduction classes will be held for HCW and sessions embedded in all trainings offered to the various cadres of staff. CMEs will also be considered as a way of disseminating information to the staff.

For stronger community-facility linkages, CHW should be based at facilities to strengthen defaulter tracing, support group facilitation and community health talks as well as be part of the multi disciplinary team.

## **Result 2 Improved and Expanded Civil Society Activities to Increase Health Behavior**

### **2.1.1 Expanded and Strengthened Community and Workplace Prevention Programs Formal and informal workplace program**

#### **Introduction**

Federation of Kenya Employers (FKE) is one of the implementing partners that contributed to the overall performance of APHIA II Nairobi. FKE implemented a comprehensive HIV and AIDS Workplace program addressing HIV/AIDS prevention, care and support and behavior change targeting men and women in the workplaces in Nairobi Province. This was achieved through conducting Training of Trainers on HIV/AIDS and workplace peer educators, designing, producing and distributing Behavior Change and Communication (BCC) materials, and providing technical assistance and follow-ups on the development and implementation of HIV/AIDS workplace policies and programs. In partnership with FKE, linkages were established with health facilities for effective referral and provision of HIV/AIDS related services including access to antiretroviral therapy (ART), prevention of mother to child transmission of HIV (PMTCT), and management of opportunistic infections and sexually transmitted diseases. FKE facilitated cluster meetings, review meetings and carried out continuous monitoring and reporting.

#### **Key Achievements**

To enhance institutional buy-in of workplace programs, senior managers and section heads were equipped with information on the impact of HIV/AIDS in the workplace and the need for institutional preparedness and response. They were also equipped with knowledge on the steps involved in establishment of comprehensive and sustainable workplace HIV and AIDS programs for their workers. This generated great support by managers during the implementation of the program. Sixty-eight managers from ten worksites were trained as coordinators/facilitators for the workplace programs in their respective worksites. The managers were drawn from major economic sectors in the country such as agriculture, transport, healthcare, local authorities, education and water.

Over 400 peer educators from 65 worksites were trained enabling them to influence the behaviors of their peers/colleagues by providing information, being role models, and providing care and support for peers/colleagues affected or infected with HIV/AIDS.

Forty six (46) worksites received technical support in HIV policy development. The policies were at different levels: some were launched and disseminated; others were finalized awaiting approval; while the rest were in draft form. The policy documents are important tools that provide guidelines in relation to HIV/AIDS including treatment, prevention, care and support.

Two Clustered HIV/AIDS Enterprise partnership (CHEP) units were formed on Enterprise Road (15 companies) and in the Babadogo Area (11 companies). These units represent one of the strategies used to increase HIV/AIDS outreach and promote sustainability of workplace-driven interventions. The approach served to increase knowledge on HIV/AIDS in the workplace, influence behavior change at enterprise level and within enterprises' sphere of control, reduce stigma and discrimination in workplaces and leverage HIV/AIDS interventions through collective efforts. CHEP networks enabled companies to continuously learn and replicate workable strategies, how best to address challenges.

Good results from the CHEP units include increased VCT uptake and referrals with over 3,000 workers receiving VCT services from various worksites. There was an increased uptake of

condoms, attributed to the confidence created in condom use through workplace sensitization, meetings, peer education trainings and sessions. More workers were also reportedly seeking services including treatment for AIDS related illnesses and over 7,000 workers were provided with information on HIV and AIDS prevention, treatment, care and support.

FKE continued to bring together different partners to mitigate the spread of HIV in workplaces. For instance, it collaborated with the Central Organization of Trade Unions (COTU) Ministry of Labor to produce the National Code of Practice on HIV/AIDS in the Workplace. Various worksites were linked to the nearby GOK health facilities to enhance access to HIV and AIDS related services. Some worksites were linked to the National Aids Control Council (NACC) for IEC materials, Liverpool VCT for mobile VCTS, and the Gold Star Network (GSN) for HIV treatment.

Lessons learned Mobile VCTs in workplaces increase access to the service and help reduce stigma related to HIV and AIDS. Most workers spend most of their time in the workplace thus missing the opportunity to get services at the static VCTs. In addition, HIV counseling and testing of senior managers/officers has an impact in the uptake of VCT services in the workplace. This clearly showed that workplace programs thrive under strong leadership and role modeling. Support group formation in the workplaces is a slow process given that some workers living with the virus are not willing to disclose their status. It is imperative that there is continuous raising of awareness about HIV/AIDS, clearly indicating the benefits of support groups such as enhancing positive living, reduction of self-stigma and their role as support systems accessible to the community.

Partnerships are a foundation for comprehensive and sustainable HIV/AIDS programs. The newly-introduced CHEP concept enables enterprises that are in close proximity to share strengths and address weaknesses, maximize on the resources and experiences in prevention, care and treatment.

### **Major challenges and proposed way forward**

- Constant monitoring and documentation of workplace activities is a challenge. The coordinators and CHEPs have been instrumental in reporting progress but more vibrant structures are recommended to sustain the tempo in the fight against HIV beyond the initial sensitization and peer education training and form part of a strong reference and learning point.
- Policy launch and implementation takes a longer time than desired after drafting, embedding, and mainstreaming of HIV/AIDS in the workplace. It is recommended that policy drafting and launch are carried out immediately after sensitization.

### **Recommendations**

- There is need to design a comprehensive workplace program that addresses HIV/AIDS together with other health issues including family planning, sexual and reproductive rights, gender based violence, sexual harassment and exploitation, and fitness program. All organizations need to be assisted to mainstream HIV/AIDS in their activities.

The success of HIV policy and activities largely depends on the focal person. It is therefore imperative to have a senior person coordinate the activity for effectiveness and sustainability among others. Further, there is need for organizations to develop a reward mechanism for recognizing peer educators whose performance is commendable in supporting effective implementation of workplace HIV program.

## 2.2 Expanded Prevention Programs Targeting MARPS

### Drama groups

Drama was used to communicate HIV/AIDS messages to the community, especially in rural areas and among the less literate populations. The drama outreaches were also carried out jointly with outreaches the PLHIV Advocates reached a total of 952,589 people, among them 421,148 male and 531,441 female. During the outreaches, the PLHIV Advocates shared their personal testimonies and emphasized positive living and the importance of knowing one's status. These outreaches were conducted among high risk populations including prison inmates, drivers, conductors, commercial sex workers, *boda boda* cyclists, prisoners, and middle-level college students. Visits were made to churches, markets, out-patient clinics, chiefs and *barazas*.

### Improving prevention and education services for sex workers (IPESS)

During the life of project, a total of 12 Mobile/Workplace and Moonlight VCT events were conducted. 625 male and 383 female sex workers (FSW) and their clients were counseled and tested in Nyeri, Karatina, Mwea, Kangari, Kenol, Sabasaba, Mutithi and Shell stations in Nyeri. During the VCT events, 14 female sex workers were referred to Maragua and Murang'a District Hospitals for STI screening and treatment. High Transmission Area (HTA) intervention with female sex workers, their clients, bar hostesses, night guards and other night population reached 8,370 individuals, comprised of 5,620 male and 2,750 female. During these events 11,900 condoms were distributed after demonstration was conducted on proper use.

During the period, 113 FSWs were trained as peer educators. The training content included facts on HIV transmission and prevention, STI transmission, prevention and management, sexual decision making skills, correct condom use and demonstration, reproductive health and family planning, and Men as Partners(MAP) methodology and facilitation skills. Hot spot mapping continued in Nyeri, Mwea, Karatina, Kagio, Nanyuki, Naro moru, Murang'a, Kenol, Saba Saba and Kangari. Two stakeholder sensitization forums were held in Mwea and Othaya where bar managers and owners, sex worker representatives, bar hostesses, CACCs, and DASCOS were sensitized on the project and pledged partnership and support in implementation of activities.

### Transport Corridor Activities – Matatu tout and rivers program

Sensitization of matatu drivers and conductors began in earnest in August 2008. Forty-five matatu representatives, among them matatu owners, drivers, conductors and stage managers, attended an HIV/AIDS workshop in Nyeri. It was evident that this group of people had very little information on HIV/AIDS. As the sensitization progressed, some of them admitted they had stigmatized their colleagues who are HIV positive. They narrated how they refuse to allow passengers they suspect to be HIV positive to board their vehicles and that some of their colleagues had even committed suicide on

learning that they were HIV positive. The few matatu owners who attended the training said they would sensitize their peers to stop sacking their drivers and conductors who were HIV positive. A five-day, residential peer education training for 23 matatu conductors and drivers was conducted in September 2008. The individuals were trained so that they could reach out to their peers with HIV prevention information and as well as promote health services among their colleagues. The matatu program began immediately and mobile VCT was also incorporated.

#### ***One of the matatu conductors made the following statement:***

*"I mobilized my neighbors and influenced my landlord to evict a colleague and neighbor after learning he was HIV positive. Due to ignorance and lack of information, I convinced everyone that he would infect all of us. Sadly, he did not live long after that. I now know that if we had not stigmatized him, he would probably be alive today leading a productive life. From now henceforth, I will protect PLHIV from stigmatization."*

## ***Youth Activities:***

### ***'Chill' program***

The prevention program for in-school youth started in 2007 after its authorization by the Director of Quality Assurance and Standards, Ministry of Education. The BCC team in a consortium partner, PSI, reviewed and adopted the Kenya Adolescent Reproductive Health Program curriculum. Two new topics, Communication Skills and Drug Use and Abuse were included in the curriculum which is referred to as the '*Chill* Adolescent Reproductive Health Program curriculum. Preliminary meetings were also held with the Ministry of Education officials, head teachers and club patrons in order to gain their full support of the program. These meetings continued to be held annually throughout the life of the project. Initially, the program started in 40 schools in Thika and Kiambu in 2007 and in the same year it was expanded to 25 more schools in Nyeri and Nyandarua North. In 2008, 30 more schools joined the program in Kirinyaga, Murang'a North and South districts, bringing the total number of schools to 95. The total number of pupils reached during this period was 44,681 comprised of 21,920 male and 22,761 female.

The topics covered in the program included Values, Life Cycle, Adolescence and Puberty Reproductive Systems, Reproduction Myths, Healthy Relationships, Communication, Parent/child relationships, Friendships, Love, Infatuation & Romantic Relationships, Cross Generation Relationships, Introduction to Gender, Gender Stereotypes, Sexuality and Behavior, Self-Esteem, Assertive, Decision Making, Setting Goals, Abstinence, Resisting Peer Pressure, Drug Use, Sexual exploitation, rape and gender violence, Teenage Pregnancy, HIV and AIDS, Other Sexually Transmitted Infections, Facts and Myths about STI's. The sessions were very participatory with much group work, role plays as well as energizers. The fact that they were facilitated by youths aged between 18 and 24 years encouraged the pupils to ask questions regarding their sexuality. They often asked questions that they could not ask their teachers or their parents. Some of the observations made by the teachers were that the program improved discipline and academic performance among the students because of the values the club instilled in them.

The highlight of the year long *Chill* program was the *Chill* Fun Days/ graduation events that were organized at the end of every year. The Fun Days were a forum for the *Chill* club members to showcase their talents as well as mark their graduation from the program. The days also served as graduation days for the current *Chill* club members as they will be moving on to Std. 8 next year. The Fun Days occurred in Thika/ Kiambu, Nyeri and Nyandarua.



***Chill Club members participating in a team building Activity in Kirinyaga***

To complement the program, a component for reaching teachers and parents was introduced. This was in recognition that teachers and parents would play an important role in supporting the adolescents to adopt healthy behaviors with an emphasis on delayed sexual debut as well as make informed choices. This component of the program was introduced after the pupils participated in an easy writing competition with the theme, “The things I’d like to discuss with my parent or guardian but I cannot...”

*“Neither my parents nor my siblings could have empowered me with the kind of information and decision making skills I have learned in the Chill club. I started puberty quite early; however I am now able to understand myself.”*

*“My self-esteem was very low before I joined Chill club, but now I feel I am somebody. I was raped and as a result I thought I was nothing and I wondered why it had to happen to me. But I thank God because through the help of the chill club, I have gained confidence to move on with a healthy and positive life.”*

PLHIV Advocates took HIV/AIDS sensitization sessions right into the staff rooms in the schools the *Chill* program was being implemented. The teachers were taken through the basic facts of HIV/AIDS, risk perception, VCT,

condom use as well as stigma reduction and promotion of health services. The advocates also raised HIV/AIDS awareness among parents. They addressed any myths and misconceptions the teachers and parents had, so that the *Chill* club messages are reinforced both in school and at home.

Two important trainings were carried out to address issues that were emerging during the *Chill* sessions. First, 55 teachers were trained as paralegals in order to help them handle or refer cases of sexual and other forms of abuse among children. The youth leaders were trained on basic counseling skills focusing on children to enable them assist the *Chill* club members who raised issues that required counseling. In most schools, the youth leaders were called upon by the teachers to offer support on cases involving even students who were not *chill* club members. Topics addressed during parents sessions included parent child communication.

### **2.3 Reinforced networking between communities and clinical services**

In order to enhance networking in the community, the project conducted joint meetings among all cadres of volunteers. They included PLHIV Advocates, youth groups, CBO’s, i.e., CHWs, the Constituency AIDS Control Council (CACC’s) and health care workers. These forums were utilized to resolve differences, to clarify project objectives and to establish opportunities for collaboration. The project also reached the provincial administration and other community leaders with HIV information.

To reinforce networking between communities and clinical services, the Advocates and the drama groups would mobilise the community to take up services at the health facilities as well as mobile services such as MVCT’s conducted by the MOH. The PLHIV Advocates also conducted regular health talks in various health facilities.



**A PLHIV advocate facilitating a health talk at the Kambiti Health Center**

## Gaps and Recommendations

- There are many cases of rape and sexual exploitation among adolescents. And even though some teachers have been trained as paralegals, the project has identified and formed linkages with legal organizations. The teachers and the community were able to refer some of the cases that needed free legal services to FIDA and Kituo Cha Sheria legal organizations.
- The second challenge faced was the fact that there were many people who purported to cure HIV through herbal remedies. The same also applied to faith healers who convinced HIV positive people that they had been healed after prayers so they should not take their ARV's. There is therefore need to address the issue of herbalists as well to reach more religious leaders with facts about HIV.
- Another gap identified while implementing the *Chill* program was that girls from low income families were having a problem accessing hygienic sanitary towels. This led some to cross generational relationships or sex for money. Others would use unhygienic materials leading to infections. It became therefore important to address this problem by training girls on how to make hygienic alternative sanitary towels.
- Alcohol abuse is a major problem among youths and older men in Central. It is a major risk factor contributing to HIV transmission. There is need to integrate prevention with a comprehensive program on alcohol and drugs abuse including treatment.

### Result 3 Improved and Expanded Care and Support for people and families affected by HIV/AIDS

**Overall Objective** – Improved and expanded care and support for people and families affected by HIV/AIDS

**Table 2: Summary of objectives, activities and expected targets: Aug 06 – Feb 09**

Objectives	Activities	Target for the project
<b>Expanded home and community support programs</b>	<ul style="list-style-type: none"> <li>Community leaders sensitizations workshops</li> </ul>	<ul style="list-style-type: none"> <li>Sensitize <b>1,250</b> community leaders</li> </ul>
	<ul style="list-style-type: none"> <li>People trained in IGA and linked to micro-finance institutions</li> </ul>	<ul style="list-style-type: none"> <li>Train <b>1,150</b> people in IGA and link them to micro-finance institutions</li> </ul>
	<ul style="list-style-type: none"> <li>Individuals provided with home based care</li> </ul>	<ul style="list-style-type: none"> <li>Provide home based care services to <b>235</b> clients</li> </ul>
<b>Reduced stigma and establishment of safety nets for PLHIV and their families</b>	<ul style="list-style-type: none"> <li>Hold community based anti-stigmatization campaigns</li> </ul>	<ul style="list-style-type: none"> <li>Conduct <b>1,685</b> community based anti-stigmatization campaigns</li> </ul>
	<ul style="list-style-type: none"> <li>Train/sensitize individuals on PLHIV care and support</li> </ul>	<ul style="list-style-type: none"> <li>Train/sensitize <b>2,842</b> individuals on PLHIV care &amp; support – CHWs, CORPs, paralegals</li> </ul>
	<ul style="list-style-type: none"> <li>Community based paralegal clinics established and linked to paralegal aid organizations</li> </ul>	<ul style="list-style-type: none"> <li>Establish <b>16</b> community-based paralegal clinics and link them to paralegal aid organizations</li> </ul>
	<ul style="list-style-type: none"> <li>Rescue centres established for victims of violence</li> </ul>	<ul style="list-style-type: none"> <li>Establish <b>4</b> rescue centres for victims of violence</li> </ul>
	<ul style="list-style-type: none"> <li>Establishment of PLHIV/OVC caretaker support groups and linkage to other services as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate the formation of <b>33</b> PLHIV/OVC caretakers support groups and link them to other services</li> </ul>
	<ul style="list-style-type: none"> <li>Health workers trained on stigma reduction</li> </ul>	<ul style="list-style-type: none"> <li>Train <b>138</b> health workers on stigma reduction</li> </ul>

#### Overall description of activities and significance

During the life of project, the number of clients receiving home-based care services reached a cumulative figure of **8,273** (2,500 male and 5,773 female). The number of new clients averaged approximately **65** per month while that of referrals for VCT, treatment of opportunistic infections, support groups and PMTCT was at **2,700**. A total of **799** CHWs were trained during the project period to offer home based care services to PLHIV and OVC.

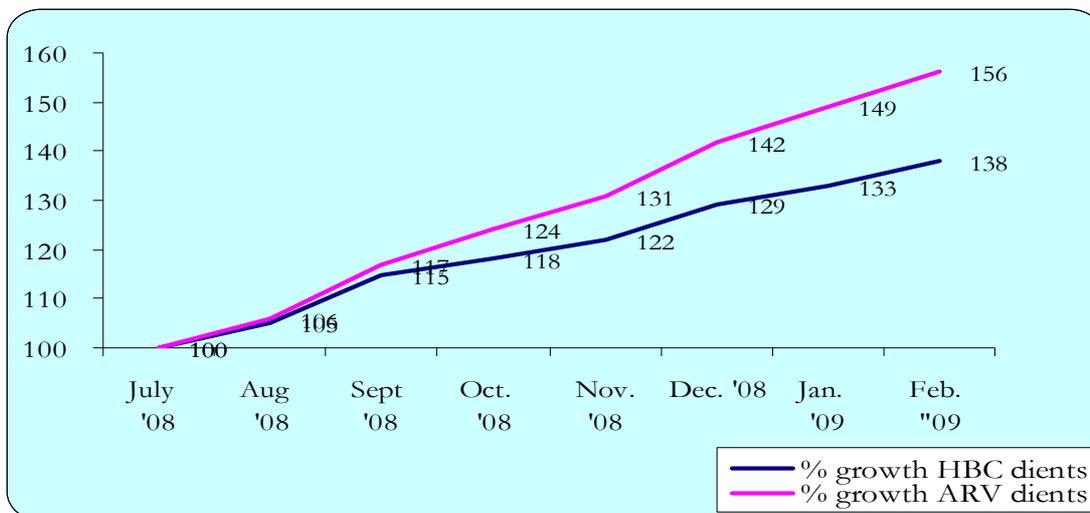
The program activities implemented during the project period included home-based care (HBC) training for community health workers (CHWs), paralegal skills, organic farming and nutritional skills, income generation skills for PLHIV/OVC caregivers and CHWs, treatment literacy for PLHIV, community leaders sensitizations, anti-stigma reduction campaigns, TB/HIV skills, HBC orientation skills for service providers, establishment and strengthening of support groups, M&E, financial management, resource mobilization and leadership skills for IP leaders

### 3.1 Expanded home and community support (HCS) programs

#### Home Based Care Services

The cumulative number of clients who received home based care services during the project period was 8,273 (as stated above). Although the project had set targets of 135 for year one and 100 for year three, the home and community services team surpassed the targets. Several activities were implemented under home-based care services including: home visits, treatment literacy, group therapies and psychosocial support, referrals to health facilities by community health workers (CHWs) and home nursing care services. In rural areas, access to RH/FP and treatment services is very limited because of distance to facilities and the associated costs of services. CHWs have helped bridge this gap by providing information and home based care services for people living with HIV/AIDS and referring those who need medical care to health facilities. Community health workers have been an important link between health facilities and the intended beneficiaries in hard to reach areas. The woman, who has never been to a clinic and finds such a visit scary, might be accompanied by a CHW, who ensures that she follows through on the referral. Such support gradually improves the clinic's reputation and reinforces its acceptance in the community. The consistent supply of home based care kits during the project period contributed to a reduction in the number of bed-ridden clients. This also improved positive living among clients and to a great extent reduced the level of stigma among PLHIV. The number of deaths recorded during the project period declined every year, a factor that can be attributed to the home based care services offered to clients and treatment literacy trainings that promoted drug adherence. Other services offered by CHWs included prevention sessions with the positives, condom promotion and distribution.

**Fig 3 : Trend analysis of the growth of HBC clients served and the number of clients accessing ARV from July 08 to Feb 09**



Since July 2008, there was a consistent growth of between 12 and 25% every quarter in the percentage of clients served and the number of clients accessing ARVs. This rise was linked to the improvement of the services offered by the CHWs at house-hold and the numbers of clients attending support groups. As a result, clients now enjoy a better quality of life.

#### Community Mobilization

The project set out to conduct community leaders' sensitization meetings and reached 1,250 people. Community leaders' sensitizations were to create fora for community entry, community mobilization, information and education sharing. From the outset we realized that the support of local leaders was important for ensuring access, sustainability and stimulating some changes in community behavior. Highly respected by their communities, local leaders are opinion leaders and are in a unique position

to gain community trust and pave the way for project staff and volunteers to introduce their services and project activities. In the first year of the project, a total of 400 leaders were sensitized, while 600 and 250 were sensitized in the second and third years respectively. Overall, 850 leaders were reached with information on HIV/AIDS prevention, care and support for PLHIV, stigma reduction and community mobilization for HIV/AIDS interventions. This activity resulted in improved collaboration with community leaders and actors especially the provincial administration, religious leaders, Ministry of Medical Services (MoMs), Ministry of Public Health and Sanitation (MoPHs), Ministry of Education, Science and Technology (MoEST) and Children's Department. This result further contributed to support and networking for community mobilization, a reduction in stigma and an improvement in access to HIV/AIDS services.

### **Income Generation Activities (IGA)**

To promote sustainability of project activities and outcomes targeting people infected and affected by HIV (PLHIV), the project planned to train 1,150 PLHIV in income generation and link them to micro-finance institutions. A total of 445 PLHIV were trained and linked to K-Rep Agency during the second and third years of the project. The IGA training and linkage beneficiaries who were mainly home based care clients, OVC caregivers and community health workers were linked to implementing partners (IPs) within A2C. The beneficiaries engaged in individual IGAs such as baking of cakes, poultry farming, tailoring and vegetable farming while some initiated group IGAs such as weaving and making baskets. Through linkages and skills acquired from A2C facilitated resource mobilization skills training, Engineer Broad Vision and Vision Gardens secured grants from the Women's Enterprise Fund and Ministry of Agriculture (MOA) to expand their basketry, kitchen gardening, chicken and rabbit rearing businesses. Income generating activities significantly improved the lives of the project beneficiaries and also helped to advance the project goals.

### **Reduced Stigma and establishment of safety nets for PLHIV and their families**

The following activities were carried out under this objective;

#### **Community and facility level anti-stigmatization advocacy**

During the project period, the home and community service (HCS) team carried out community anti-stigmatization campaigns targeting community leaders and institutions such as schools, colleges, churches and community based groups. These were integrated activities involving youth and behavior change (YBCC), Orphans and Vulnerable Children (OVC) and service delivery components. PLHIV Advocates and CHWs affiliated to health facilities were instrumental in anti-stigmatization campaigns within various facilities such as Maragua District Hospital, Othaya Sub-District Hospital and Engineer District Hospital. A total of 5,844 people were reached through these events surpassing the set target of 1,685.

#### **Support/Training towards PLHIV care and support**

Individuals were sensitized and trained in various skills to enable them offer effective services to PLHIV. These were: home based care for 799 CHWs, paralegal skills to CHWs, monitoring and evaluation, organic farming and nutritional skills, treatment literacy skills and counseling skills including VCT. A total of 109,673 people were sensitized and trained on PLHIV care and support surpassing the set target of 2,842. Collaboration with agricultural extension services focused on increased outputs related to local vegetables and crop production. Apart from household consumption of the produce, income realized from the sale of some of the crops has also increased leading to transformed livelihoods of the target beneficiaries.

#### **IPs and support offered**

To implement the project activities, A2NC worked with 21 IPs that offered support to both home based care clients and OVC. The IPs were spread within the Central Province with each district

having at least one IP. The project provided the following support to IPs to enable them offer quality services to the project beneficiaries: technical assistance (TA), leadership and management skills, reporting skills, governance skills, resource mobilization skills, monitoring and evaluation and financial management skills. Some IPs were engaged as sub-grantees and received grants to conduct own activities.

### **Paralegal clinics linked to aid organizations**

During the reporting period, the project anticipated establishing a total of 7 paralegal clinics; 5 in the first year, 3 in the second year and 8 in the third year. The project however managed to support the establishment of 16 paralegal clinics in Central. The paralegals were then linked to FIDA and the Retired Justice Etyang's Company for pro-bono services. Some cases were also linked up to the Children's Department in Nyeri for further management and follow up. Indications from the field were that most of the project beneficiaries who would otherwise have had their rights denied learned where to seek redress. They worked closely with the paralegals, the local chiefs and the CHWs to report any human rights infringements like land disinheritance and gender based violence.

### **PLHIV and Support groups**

To complement home nursing care activities, training and support in defaulter tracing, GIPA/MIPA, prevention with the positives, TB/HIV awareness, positive living, HIV status disclosure and treatment literacy were carried out. Most of these trainings targeted PLHIV and sought to improve the quality of their lives through positive living, adherence to treatment, improved nutrition and self care.

### **Stigma reduction for health workers**

In the second year of the project, the implementation team resolved to incorporate stigma reduction in all its trainings. This need was necessitated by the high level of stigma which was reported by clients attending comprehensive care centers (CCCs) and antenatal care clinics. This resolution made the team surpass the target set at 138 to achieve 1,042 people reached. By end of project, over 80 per cent of the health workers at the facilities had been trained and their approach to HIV clients had dramatically changed from being judgmental to listeners and counselors. This is explained by the huge volumes of clients patronizing the health facilities and the project surpassing its set targets.

## **GAPS AND RECOMMENDATIONS**

- It is worth noting that during the reporting period, the project concentrated on expansion. As a result, there were gaps in strategies to take care of youth infected with HIV. The project also lacked women specific/centered targets and approaches and it is anticipated that the next project will define strategies to address the gender specific needs of men and women and that of youth infected with HIV.
- However it was learned that it is important to create collaboration and partnership with other providers in order to create synergy and optimize resource mobilization and utilization. This project worked very closely with local communities through CBOs in the achievement of its objectives and in the long run, also assisted the same CBOs, to achieve relative sense of sustainability. For instance, through the efforts of building the capacities of the CBOs, most of them widened their resource base by attracting funding from National AIDS Control Council and from Constituency Development Fund. They now utilized skills of proposal writing taught to them by the project. Such links can be a sustainable way to provide services in the communities even after the end of the project.
- Another lesson learned is that working at the community level is important to improving the health and welfare of the underserved. The need to engage communities in the development

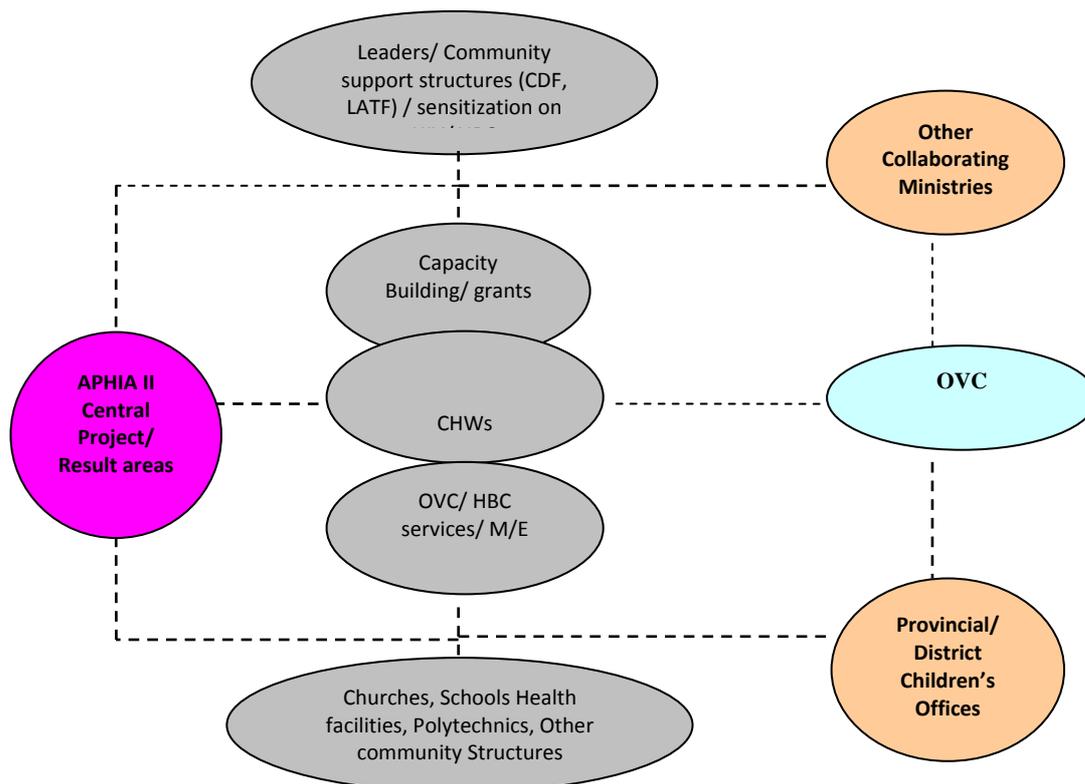
of their health services will always remain but donor interest will not. Working with communities at the grassroots has expanded access and knowledge, enhanced acceptance/ownership and created awareness of RH/FP and HIV/AIDS services.

- The greatest challenge faced by the project was how to motivate the ever hard-working CHWs. However all agree that because CHWs hold the esteem of their peers, they are effective in promoting change and challenging stigma surrounding HIV/AIDS.

### 3.2 EXPANDED SUPPORT FOR OVC

Under the A2NC agreement, one of the project’s obligations was to mitigate the suffering of orphans and vulnerable children or OVC. The number of children orphaned by HIV in Kenya was estimated at 2,500,000 by 2009, while projections indicated that by 2010, 15.4% of all children under age 15 will have lost one or both parents. The premise current at the time highlighted the need to support OVC in educational and economic support, nutrition and food security, social protection, and emotional development.

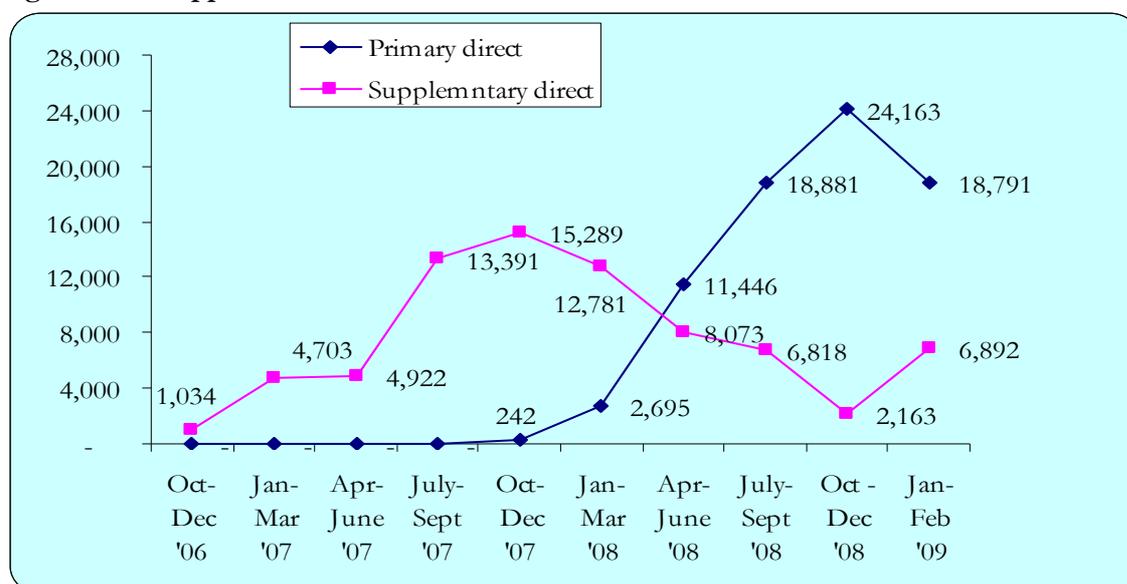
A2NC undertook a baseline survey to establish the situation of OVC in both Nairobi and Central provinces in 2007. This provided the foundation framework that relied heavily on collaboration and integration in serving the OVC and reaching her objectives.



In addition to collaboration and integration, the project delved into Child Fund experience in OVC support services throughout the country to implement integrated OVC programs that have addressed psychosocial support, health and nutrition, education, economic livelihood, shelter, and protection. By February 2009, 25,683 OVC were supported by the project. A2NC, while managing to scale up OVC care and support, also managed to scale up primary direct services to

over 80% of all enrolled OVC. This trend was maintained throughout the program period as the figure below shows.

**Fig 4 : OVC support: Oct 06 - Feb 09**



In achieving the above, the project undertook with integrated support from both Result 1 (service delivery) and Result 2 (Prevention) the technical and institutional capacity building on core OVC issues targeting 29 implementing partners (IPs), 11 Area Advisory Councils, (AACs), 11 District Children’s Officers (DCOs), 29 Constituency AIDS Control Councils (CACCs) and 799 Community Health Workers (CHWs) in close collaboration with the Provincial Director of Children’s services and various District AIDS Control Officers (DASCOS). The capacity building activities included training CHWs on psychosocial support, Journey of Life (REPSI approved manuals)<sup>6</sup> Career Counseling, Paralegalism, data collection and report writing. While IPs leaders were trained on project management, proposal writing, grant making and logistics management, it is worth noting that all CHWs also received a complete community strategy package broad enough to address all components of primary health care including HIV counseling and testing skills.

The AACs, CACCs, and IP leaders were facilitated to enhance collaboration for sustained response and ownership of OVC support. Specifically, the AACs and DCOs were linked to 29 IPs supported by A2NC and representing 25,683 OVC. This enhanced closer working relationships and follow-up on various OVC issues including quality improvement. Further, all AACs, CACCs and IP leaders were supported with the “popular” version of the Children’s Act while the DCOs were supported with the ACT itself to foster better understanding and reference on requisite policy that guides all children’s issues. A total of 45 police stations with a children and gender desk received training support to internalize current policy on children (Children’s Act 2000) and were linked to 29 IPs and other OVC support structures in order to increase coherence with GOK priorities for greater impact.

### Access to Health Services

The project strengthened referral links with supported health facilities by training service providers in Pediatric PSS, Play Therapy and Home Based Care (HBC). The project’s 799 CHWs received specific OVC psychosocial training to enable them address emotional needs of OVC

<sup>6</sup> Regional Psychosocial Support Initiative

enrolled by IPs. Each CHW was allocated between 15 to 30 OVC who received visits at least once every month. The visits to 14,589 households (OlKalua Cluster 1,318, Nyeri cluster 6,388 and Thika cluster 6,883) formed the basis for observing and discussing the emotional state of the child. The visits also assisted in household needs assessments and follow-up of the progress of the family against the seven core service areas including referrals. Screenings helped IPs identify HIV+ children, who needed specialized health and social support. CHWs also provided special RH services for adolescent OVC, including sanitary towels (for females), YFS referrals (for prevention, FP, VCT, STI), and PEP and YFPAC. During the project period, at least 80% of the OVC received screening for medical conditions, immunizations and received six-monthly de-worming and vitamin A supplementation. Thirty OVC were referred for hospital admission while 15 received support for specialized medical examination which included specialized medical diagnostics. 5,500 households were supported with improved lighting to reduce occurrence of eye-related conditions associated with poor household lighting (exposed paraffin wick lamp). Medical screening exercises reported reduced eye conditions which was associated with the improved household lights while skin conditions, ringworms and malnutrition were consistently reported as reduced by medical personnel working with IPs to access OVC with outreach medical camps during school holidays.

### **Psychosocial Support**

To support this service, the project provided Trainer of Trainers (TOT) capacity building to 180 caregivers on psychosocial support, Journey of Life and Nutrition using the Regional Psychosocial Support Initiative training curriculum and manuals. Paralegalism, as well as other identified training needs, such as organic farming and child counseling, was provided to over 10,000 targeted guardians and OVC households through continuous community education.

The project provided over 12,000 children with bonding forums during school holidays. These incorporated child participation, self awareness and esteem sessions, gender, human growth and related development, drugs and substance abuse, HIV education and prevention and child protection.

The general well-being and hygiene of all enrolled 25,683 OVC was strengthened through the provision of a bi-annual hygiene pack which included items like towels, bathing/ washing soap, hair combs/ brushes, toothpaste/ tooth brush, sanitary towels (targeted girls). The packs were follow ups from various psychosocial learning and Fun Days and responded to needs expressed by the OVC.

### **Education**

The project benefited over 85% of enrolled OVC with support in the following age groups;

0-5 years		6-10 years		11-15 years		16-18 years		above 18	
M	F	M	F	M	F	M	F	M	F
2986	2865	4805	4445	3545	4258	1791	1836	318	259

The table reflects that, at close of project, about 23,042 OVC were in need of education access either at the level of Early Child Hood Education, primary, secondary or post secondary levels. 2,400 OVC were supported to access early childhood education during the project period. It is worthwhile to mention that a rapid assessment undertaken by the project found that only about 20% of children attending Early Childhood Education Centre's were OVC. The main reason attributed to this low access was the education policy that allows Early Childhood Education Centers which are privately or community owned to charge levies which range between 200 to

5,000 shillings per term (3 months learning) which was found to be out of reach for most guardians/ households struggling with low incomes. Lobbying via the Provincial Director of Education set the levy requirement at 700 shillings per term which enabled the project to increase its support to needy OVC. Participating Center's recognition of the special needs for OVC were encouraging. The project provided support with both learning and teaching materials as well as outdoor recreational facilities which will be an ongoing project into the next project period.

About 9,000 OVC were enrolled in various primary schools and while education at this level is free (tuition fees) a host of other costs are administered on the pupils which include building fund, examination fees, desks, stationery and school uniforms which have continued to put in jeopardy OVC chances for continuity and completion of primary education. The project has reduced this risk to school access and retention rates by providing scholastic materials which have included school stationery, uniforms/ accessories like bags while engaging local IPs to address structures within their community which continue to deny OVC many chances and opportunities which perhaps would end up improving their well-being through skilled employment after completion of their education. A total of 2,000 targeted girls had during the project period been supported with counseling/ menses education and sanitary towels to increase their retention in school which was directly associated with lack of sanitary towels. Follow-up on supported girls indicate at school level significant increase in class attendance.

About 5,500 OVC are attending secondary schools. Linkages with both private and public entities has enabled A2C to access 364 scholarships (USAID/ PEPFAR) while 287 OVC have received short term scholarship support from the Constituency Bursary Funds through lobbying and representation by IPs. A total of 100 older OVC have benefited with post-school skills training in vocation centers. The beneficiaries are expected to join either the formal or informal employment sectors during the next project period after completing two years skills training in trades like carpentry, metal and joinery, plumbing, masonry, electrical wiring, tailoring and glooming services

### **Food Provision and Nutrition Education**

The project responded to alleviate hunger among all 25,683 enrolled OVC with food provisions especially during the food stress period of October through December which was pronounced by the dry spell and drought experienced through the country during the whole of the life of the project period. All 14,589 OVC households received provision for all children including caregivers. During periods with lower food stress, support was provided for needy households targeted by CBOs. This included households with HIV positive OVC; child-headed households or bereaved households identified as needy by IPs. All households with OVC 0 to 5 years consistently received supplemental nutrition support every quarter.

To increase the availability of food within households, the project undertook capacity building for all IPs to seek alternative supplemental food sources which included dairy goat<sup>7</sup> milk, rabbit<sup>8</sup> farming, chicken<sup>9</sup> rearing, organic farming as well to increase the farming of traditional foods which are more drought resistant than contemporary foods like maize and beans. This was undertaken with the collaboration of the Ministry of Agriculture and Livestock development.

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<sup>7</sup> Purchase of Dairy goats was undertaken with Childfund Kenya funds.

<sup>8</sup> do

<sup>9</sup> do

## **Child Protection**

With collaboration with other partners in the consortium, the project trained and worked with 287 trained paralegals supported by CHWs and IPs to address stigma and legal rights issues of OVC. Trained community paralegals facilitated legal assistance to address cases of abuse. Several cases were brought to the courts seeking justice.



**OVC on Psychosocial Support Day**

The project identified over 200 OVC who needed support to acquire birth certification which was being processed at close of the project. Even at this late stage of the project, it was noticeably evident that IPs supported by paralegals identified cases that required intervention to secure OVC properties that had been compromised and which required to be restituted back to the legal ownership of the OVC. This is a continuing process and will be reported in the later stages of the project.

## **Shelter and Short-term Relief**

The project provided all (100%) enrolled children with shelter materials to improve their living environments and reduce incidences of disease infestation. Materials included bedding (blankets, mattresses, water containers, mosquito nets, clothing, water purification, lighting-hurricane lanterns, towels, bath/ washing soap, hair brush and skin oil) while 20 households were renovated or built to provide OVC with their own living environments where none was previously available. Targeting for specialized support like house renovation or sanitary improvements focused specifically on OVC-headed households and those with HIV-infected members of the household.

## **Livelihood Capacity Building**

The project staff and volunteers took the responsibility to support this core service and in collaboration with IPs completed the identification of targeted households and individuals who were economically vulnerable from within OVC households and who would be supported with TOT in the Voluntary Saving and Loan (VS&L) community strategy which would form the basis for livelihood improvements.

Dairy, rabbit, and chicken raising supported via CFK direct match funds will also increase livelihood based income generation during the next project phase.

## Challenges and Recommendations

- During the life of the project it was evident that more OVC needed to be supported which invariably affected the levels of quality achieved per service area. However, the quality of service had improved by end of project with the training of more community members to appreciate the care and support of the OVC. IPs showed greater internalization of result areas and the need for integration and as such required more direct involvement in all result area programming.
- Secondary school costs, even with Government subsidy for tuition, remain the single most stressful item for OVC in secondary schools. Deliberate efforts are being made to link IPs to community resources like CDF and NACC funding.
- Support to primary schools with items like desks and water tanks or sanitation projects will facilitate IPs to lobby reduced demand for school costs among OVC and should be considered. With enhanced capacity building of IP leaders, we have seen more local resources being channeled in support to OVC.

### Success Story

..... *When the women from Eagle Neema came to visit me in school they found me feeling very miserable because that morning, a list had been circulated for all students who were being expelled to go home and collect school fees. When they told me they had come to see the Headmistress about my school fees my heart skipped a beat and it started racing because I thought they would just succeed in putting me in more trouble. It is a long story (laughing) because eventually the school found out that USAID had promised to pay my school fees but the school had not initially been convinced. Anyway my name has since been removed from those who have not paid fees and I can only pray that God bless the American people who I now know paid K.shs 24100.00 for my fees. I hope to achieve my education and go to America to thank them one day.....(Agatha Mbete, Form 4-Narumoru Girls Secondary School)*

The above was reported in the quarter report of 8th December 2008. Agatha went on to take her KCSE examination and attained a B+ while a little disappointed that the score may not quite enable Agatha secure university placement, she is confident that she will at least secure a middle level college where she can undertake a diploma in clinical medicine.

## 4.0 Monitoring and Evaluation

A2N data was well managed throughout the life of the project. Reports to PEPFAR and Quarterly Reports to both donor and headquarters office consistently met submission deadlines.

In response to the requirements of the A2N contract, an M&E 'Unit' was established to better coordinate and maximize the work of members. At the outset of the project, data was managed by the M&E Advisor and one data clerk but as activities progressed and multiplied, staff was gradually added to the Unit. By end of project, the M&E Unit consisted of the Advisor, Data Analyst, Data Manager and two Data Officers in the Nairobi office with an additional two Data Officers in the Central Province office, Nyeri.

Management of A2N/C data was somewhat complex as two provinces were reporting. While A2N/C was a single project with clear objectives and a single set of indicators, differences between the two provinces including types of population, geographical locations of facilities and IPs made data management more complicated. In addition, the maintenance and updating of two separate and dynamic PMPs was challenging. At the outset, a combined Quarterly Report was feasible but it was soon apparent that separate provincial Quarterly Reports were necessary,

furthering the complexity of the task. Nevertheless, the team successfully met the challenges and accurate and sound Quarterly Reports were submitted on schedule.

The M&E Advisor responded well to the PEPFAR mandate to strengthen the national HMIS through her active participation in the National AIDS Control Council (NACC) and the National AIDS and Sexually Transmitted Infections (NASCOPI) M&E sub-committees. She also participated in the important activity of developing the Kenya National AIDS Program indicators as well as participating in other TWGs such as the HIV/AIDS Quality Indicators TWG. Participation in these national level committees resulted in good working relations concerning data between A2N/C and national level partners. Networking on this level is critically important in establishing good working relations. Strengthening of the Ministry of Health data system, particularly the data contributing to the NASCPOP dataset, was furthered through data sharing and discussion sessions with district and provincial levels as well as training and mentoring on use of MOH tools.

The development of the project database was initiated but not completed during the life of project. It is to be finalized during the next phase of the project (March 2009 – February 2011). Nevertheless, good data management was conducted through the use of an excel database and the Kenya Program Monitoring System (KePMS) which made it possible to triangulate data (among raw reports; the excel sheets and the KePMS).

#### **Training:**

Training is an essential activity in the attempt to manage health care data for a large number of facilities, private and public. The frequent redeployment and other movement of health care workers increased the need for repeated trainings on data management. In addition, a dearth of trained and dedicated data clerks in the health sector meant that service staff were often expected to record and report health care data. MOH data and health personnel were provided training on the ART tools used to monitor the epidemic in Kenya. Training on project tools was offered to all community/Implementing Partners and the early stages of the CACC data forms were introduced.

#### **Technical Assistance:**

Technical assistance on M&E provided by A2N to all implementing partners contributed to the national aim of adhering to the 'Three Ones' Principal agreed internationally in 2004:

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System.

TA, in collaboration with public sector counterparts, was offered to both health and community partners on a regular basis in the form of support to the PASCOS, PHRIOs and their teams in the management of district and provincial data. Supportive supervision was provided regularly to both sectors of the program. The project contributed to the building of capacity to competently monitor and report activities. Provision of MoH reporting tools, training on the tools and overall M&E, computers, patient files and filing cabinets are examples of the TA provided partners.

A2N supported a one day overview and refresher on monitoring and evaluation for the District Health Records Information Officers (DHRIO), their staffs the Health Records Information officers (HRIOs) and District AIDS

### **Data Quality Audits (DQA):**

The M&E team were trained by the USAID/PEPFAR officer on the USAID developed Routine Data Quality Assessment (RDQA) tool. The tool is used to examine systematically the quality of HIV/AIDS data maintained in MOH ART registers kept at health facilities. During the project, Nineteen RDQAs were carried out which provided a good opportunity for follow-up TA.

Rigorous internal audits and ‘cleaning’ of project data were carried out throughout the life of the project. In both 2007 and 2008 extensive data cleaning of all project data was carried out which involved examining all raw data against the two databases and correcting where necessary. In addition to the staff of the M&E Unit, the clinic site coordinators (CSC) were responsible for the proper management and reporting of health care data. The CSC were expected to examine registers and data management practices during their own visits to supported health facilities. They were encouraged to carry copies of the previous month’s and quarter’s reports in order to note quickly any glaring aberrations or fluctuations in data which could then be followed up the the M&E Unit.

Occasionally, the USAID M&E Specialist would join the A2N/C team during a DQA exercise.

### **Data Use and sharing**

A significant mandate of the A2N project was to build the capacity of public and private sector health facilities and community implementing partners not only to manage the data derived from their activities, but to utilize the data for program and service improvement. Good data is necessary in order to understand the effect of an activity and is the basis for decisions taken to improve programming. The primary beneficiaries of data are the very individuals and institutions who have produced the data. Too often, data is collected as an ‘unpleasant chore’ and simply passed through the system. Data must be used at point of origin in the area of health care provision and community level activities. A2N supported ‘data sharing’ sessions through the regular DHMT meetings and community forums with the data point persons from the implementing partners. Sharing data involved far more than merely ‘feedback’; rather, it was intended to provoke interest and discussion in a manner that would create genuine interest in the recording of activities and its application to one’s daily work.

A2N/C, together with the PHRIO and DHRIOs were trained by the newly formed APHIA Evaluation<sup>10</sup> team on its District Health Profile Tool, later renamed the **Data Demand and Information Use Tool**. The tool was designed to allow district M&E staff to interpret, analyze and use their own data. The tools was constructed and background population data provided in full collaboration with MOH staff in order to ensure ownership.

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<sup>10</sup> . USAID signed a 5 year contract with Macro International (August 2008- August 2013 to work in coordination with local partners to address M&E needs at the national, provincial, and district levels through the following activity areas; 1) Strengthening and coordinating HIV/AIDS, RH/FP and MCH reporting and use of quality data among implementing partners, 2) Improving the collection, management, analysis and interpretation of quality community-level HIV/AIDS data for evidence based decision making; 3) Developing the M&E capacity of local institutions through increased availability of skilled HIV/AIDS, population, and health M&E professionals; 4) Addressing national health information gaps with technical resources and innovations in data collection and study methodologies.

## 5.0 Institutional Capacity Building (ICB)

### Background and context:

Empowering local institutions – increasing the management, financial and technical capacity of local organizations and communities - has been a long-standing Pathfinder and now by extension, A2N/C goal. The rationale is simple: to sustain quality and accessibility, partner organizations must have the capacity to design, implement, manage and evaluate cost-effective programs. Sustainability has at least two aspects, one internal and one external. Organizations become sustainable when they have the managerial, financial, and technical capacity to provide needed programs effectively and efficiently over an extended period of time, as well as the flexibility to overcome changes in the operating context. Sustainability also depends on an environment that supports those operations politically and materially.

A2N/C institutional capacity building activities fall under Result 2 of the project, i.e., *“Expansion and strengthening of civil society activities to increase healthy behaviors”*. However, since programmatic activities carried out by civil society organizations (CBOs, NGOs, FBOs) support all other results, ICB is treated as a cross-cutting activity.

As part of A2N/C’s rebuilding of safety nets, the project worked to improve the ability of implementing partners to respond to the needs of PLHIV, through technical training and institutional capacity building (cross reference sub-result 2.1),

### ICB strategy:

Civil society organizations (CSOs), including national and provincial NGOs, CBOs, and FBOs are the anchor for the provision of various forms of support for PLHIV. Beginning in August 2006 with 12 sites (9 Nairobi IPs carried over from the COPHIA project and 3 Imperative sites),<sup>11</sup> Pathfinder built on its experiences in Kenya, Tanzania, Uganda, Ethiopia and Nigeria to strengthen the capacity of Civil Society Organizations (CSO’s) to become more sustainable institutions that are able to scale up their HIV/AIDS activities; increase coverage of services; improve quality; improve efficiencies and generate more resources. Ultimately, through ICB support, A2N/C aims to leave behind more sustainable institutions integral to Kenya’s response to HIV/AIDS and FP/RH.

To make the best use of available resources, A2N/C provided training and follow-up support to all community implementing partners and selected government partners (DHMTs and PHMTs) to improve their ability to lead and manage existing grants. In addition, A2N/C supported a select group of CSOs<sup>12</sup> (3 in Central and 4 in Nairobi Province) to build their capacity to expand service coverage, increase absorptive capacity, diversify their funding sources (including increasing their ability to attract and retain funding from international, bilateral, and multilateral donors). The ICB component of A2N/C has two parts:

- (i) strengthen capacity to manage programs more effectively and efficiently;
- (ii) improve CSO’s ability to network and work collaboratively with each other and with local government, primarily DHMTs and PHMTs.

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<sup>11</sup> **Nairobi IPs (Yr 1):** Kenya Network of Women’s Association (KENWA), MADA/CII; Redeemed Gospel Church, Dandora 1 & II Health Center; Riruta Health Center, Kangemi Health Center, Kabiro Kawangware, Kivuli, Waithaka ; **Nairobi Imperative sites (Yr 1):** Kenyatta National Hospital (KNH), Gertrudes Garden Children Hospital and UNITID.

<sup>12</sup> 1) KENWA-Nairobi; 2) Integrated AIDS Project (IAP)-Central; 3) Riruta Health Project-Kivuli-Nairobi; 4) Redeemed Gospel Church-Huruma/Nairobi; 5) Karatina Self Help Group/Central; 6) Brothers of St Joseph/Central; and 7) St Francis Hospital-Mwiki/Nairobi.

In the latter instance, A2N/C program staff supported the development of Annual Operational Plans (AOPs) by the MOH thus ensuring that the annual A2N/C work plan responds to the AOP.

Beginning July 2007 through September 2008, Pathfinder Kenya with TA from Pathfinder HQ (Senior ICB Advisor) undertook a process of designing an A2N/C Institutional Capacity Building (ICB) strategy which involved a series of activities as described below:

- Entry consultative meeting with A2N/C staff facilitated by the Senior ICB Advisor. This was followed by:
- Briefs on A2N/C and A2N/CEP implementing partners (i.e., structure, history, capacities, activities, coverage.);
- Site visits to selected IPs including those slated for intensive ICB were undertaken;
- Sessions were held with A2N/C partners (Malteser, NARESA, PSI, CCF) to establish capacity building needs and expectations;
- Capacity building training/orientation was conducted for key A2N/C staff on the ICB approach, tools and curricula by the senior ICB Advisor;
- Development and documentation of the approach.

Key Terms, Definitions and Classifications:

- (i) *Technical Capacity Building* directed at service providers to improve technical skills, e.g., workshops: TA in YFS, HIV/AIDS integration in FP;
- (ii) *Institutional Capacity Building (ICB)* developed organizational management systems and individuals responsible for carrying out the management, administration and financial functions within an organization.C
- (iii) *Basic ICB support to all IPs-per Pre-Award Assessments*  
**Objective:** to strengthen the ability of all implementing partners to manage A2N/C sub-grants and establish systems to ensure that mutually agreed upon service delivery targets are met and exceeded.

**Approach:** From project inception, ICB support to community and facility-based implementing partners was based on the results of the financial pre-award assessments carried out as part of A2N/C's due diligence efforts prior to awarding grants, by the Grants Manager in collaboration with the ICB Coordinator and the Finance Management Specialist. By February 2009, **27 pre-award assessments** had been carried out (see table which follows).

**Table 3: A2N/C IPs for which Pre-Award Assessments were conducted (Aug 2006-Feb 2009)**

	<b>Grantee Name</b>	<b>Areas of Support</b>
1	Kenyatta National Hospital (KNH)-VCT Center	CT (VCT, PITC, DTC)
2	Kenya Network of Women with AIDS (KENWA)	HBC, OVC
3.	Gertrude's Children's Hospital	ART
4.	Kenyatta University	FP/RH, CT
5.	Redeemed Gospel Church (RGC)	HBC, OVC, VCT
6.	Mugutha Women's Group	HBC, OVC
7.	Ruiru Bible Baptist Church	HBC, OVC
8.	Catholic Medical Mission Board (CMMB)	PMTCT, ART
9.	Riruta Health Project (RHP)	HBC, OVC, VCT
10.	Integrated AIDS Program (IAP)	HBC, OVC, VCT,

		CCC
11.	Nairobi Women's Hospital (NWH)-Gender Violence Recovery Center	ART, GBV
12.	Kenya Girl Guides Association (KGGA)	A (Abstinence)
13.	Nairobi Network of Post-Test Clubs (NNEPOTEC)	AB (Abstinence & Being Faithful) CT.
14.	Movement of Men Against AIDS in Kenya-towards support to the Positive Youth Initiative (MMAAK/PYI)	CT, AB, OP (other prevention)
15.	Support for Addictions, Prevention & Treatment in Africa Trust	CT, AB, OP
16.	Goal Ireland – Kenya (GOAL)	CT, AB, OP
17.	Hope Worldwide Kenya (HWWK)	CT, AB, OP
18.	Mathare Youth Sports Association (MYSA)	CT, AB, OP
19.	Choose Life (ICL)	CT, AB, OP
20.	Shandumu Community Health Workers	CT, OVC
21.	Karatina HIV/AIDS Self Help Group	HBC, OVC, CT, OP
22.	Brothers of St Joseph-Mweiga	HCS, OVC, VCT
23.	Kabiro Kawangware Health Care Trust	HBC, OVC
24.	UNITID	VCT
25.	MADA/CII	OVC, HBC
26.	Dandora I & II Health Centers	PMTCT, VCT
27.	Waithaka Health Center	"

The basic IP ICB package per the A2N/C strategy within 6 months of grant award comprised:

- 1) **An initial round of training in** at least 3 areas: sub-grant Financial Management; Project Design and Development; Monitoring & Programmatic reporting. Training outputs: Action Plans. Since prerequisite Pathfinder training tools/curricula for the referenced topics were under development in 2007-2008, this round of training was postponed. However, other HIV-related ICB training was undertaken as follows:

### ICB Training Achievements

#### Planning for Financial Management Training

With the initiation of several new partners and grants to the A2N/C portfolio, ICB support was planned to improve project financial reporting. Financial Management training was scheduled for 38 participants drawn from current and potential A2N/C local implementing partners (IPs) conducted by Pathfinder's Senior International Auditor for A2N/C in Nyeri between April 27-30, 2009. In addition to training new sub-grantee staff, training was to serve as a refresher course for sub-grantees already familiar with Pathfinder/A2N/C finance reporting requirements in sub-grant financial management. Finance staff from sub-grantees would receive hands-on training through orientation on standard provisions, financial reporting requirements, reporting forms (timesheets, purchase orders, assets management, cash books, etc).

- 2) **Follow-up: on-site system support TA** from A2N/C team (Grants, ICB, program staff). Financial management TA was developed by the Grants Manager in collaboration with the ICB Coordinator and Finance Management Specialist based on the results of pre-award assessments. A2N/C financial systems strengthening TA from program inception has included direct on the job support to project accountants and IP program managers with budgeting, grants

management, grantee financial report preparation; training on compliance with USG rules/regulations; and monitoring of project progress.

**3. Generic template development to assist organizations develop and document F & A, HR policies and procedures\_– (see challenges).**

**4. Training roll-out and monitoring plans\_– (see challenges).**

**Intensive ICB support to select group of 7 CSOs.**

Objective: to build institutional capacity of selected CSOs to become more sustainable by the end of A2N/C project through building systems and staff capacity to expand service coverage; solicit and manage a more diversified donor portfolio and; improve efficiencies (reduce cost/service).

Primary CSO selection criteria developed by A2N/C included: the numbers of HBC, OVC and VCT clients served. Secondary considerations were the CSO's existing coverage and ability to have impact in and beyond A2N/C project area; potential and desire to expand beyond current geographical reach; innovation and creativity in existing approach to work; ability to provide technical support to A2N/C activities; ongoing programs to improve RH outcomes and facility-community linkages. It was further decided that a maximum of 7 CSOs be selected for intensive ICB focus and that these could change but NOT the total number supported because of resources and level of support required.

The 7 CSOs selected were: (i) The Brothers of St Joseph-Mweiga; (ii) Integrated AIDS Project - Thika; (iii) Riruta Health Project/Kivuli; (iv) St Francis Hospital; (v) Redeemed Gospel Church; Karatina (vi) HIV/AIDS Self Help Group; and (vii) The Kenya Network of Women with AIDS (KENWA).

**Organizational Capacity Assessments**

The Organizational Capacity Assessment Tool (OCAT) was introduced to A2N/C staff during their orientation to the strategy and utilized by the ICB Coordinator. The OCAT is designed for a variety of purposes. It can be used, as a whole or in part, to:

- i) Serve as a diagnostic instrument to determine the stage of organizational maturity and specific changes needed to strengthen a non-profit organization's development.
- ii) Establish a baseline measure of the existing structure and capability of a non-profit.
- iii) Monitor and evaluate progress toward the organizational development objectives of a non-profit organization.
- iv) Educate staff about the components and attributes of an effective NGO.
- v) Create a strong and shared commitment to institutional strengthening within the NGO.
- vi) Assess training needs of the staff of the NGO and provide a framework for a training curriculum.
- vii) Complement financial audits and program impact reports to provide a comprehensive evaluation of the viability or potential for growth of a NGO.
- viii) Obtain a rapid assessment or 'snapshot' of specific aspects of the NGO by administering selective questions.
- ix) Serve as a basis on which to design improved systems and procedures.

In 2008, Pathfinder HQ made changes to the OCAT and began a process of adapting the original tool developed by Pact. Pathfinder HQ consulted its staff and field-tested various iterations of the tools in sub-Saharan Africa. Because of multiple demands on Pathfinder HQ's Senior ICB Technical Adviser's time and that of the Technical Services Unit, the new tool's development progressed a little slower than anticipated. An advance draft version to have been shared for piloting in Kenya in the last quarter of 2008 was still under development in February 2009.

**Table 4: Organizational Capacity Assessments- status**

Implementing Partner	Province	Assessment Dates	Overall score & stage of org devpt.	Comments
1 Brothers of St. Joseph HIV/AIDS Self Help Gp, Mweiga	Central	Oct 29-30, 2007	1.5 Emerging	Reviewed by PI HQ Sr ICB Adviser. Dec 19, 2007. Baseline ready. Need to update info.
2 Karatina Home Based Care & Counseling project	Central	Oct 31-Nov 1 2007	2.0 Emerging	As above
3 Kenya Network of Women with AIDS (KENWA)	Nairobi	Feb 11-12, 2008	2.3 Emerging	As above
4 Redeemed Gospel Church -Huruma	Nairobi	Feb 13-14, 2008		To be completed
5 Riruta Health Project/Kivuli,	Nairobi	Feb 21-22, 2007.		As above. Follow up needed for supporting docs.
6 Little Sisters of St Francis – St Francis Community Hospital	Nairobi	Feb 25-26, 2007.		As above
7 Integrated AIDS project-IAP	Central	-		To be undertaken

Three out of seven OCAs were completed by the ICB Coordinator and reviewed by PI HQ senior ICB Adviser. Pathfinder plans to complete this activity using consultants from the list developed since many are capable of delivering a good product in a timely manner.

#### **ICB Challenges:**

- i) **A2N/C ICB strategy focused on CSOs/grantees.** A2N/C GOK partners past and present have included PMOs for Nairobi and Central, KNH, KU, JKUAT, MOU with central province Police AIDS Control Unit; MOU with Central province Prisons AIDS Control Unit. Going forward, a greater emphasis will need to be placed on developing an ICB approach for GOK partners for purposes of ownership and sustainability. An October 2008 Pathfinder strategy update meeting suggested GOK partner interventions should include district focused activities/IP training in several areas: project design/management; report writing; finance for non-finance managers; use of data for decision making; leadership; strategic planning; board roles and responsibilities; MIS, systems strengthening and resource mobilization.
- ii) **Finalization of ICB training curricula/tools:** many of the ICB tools/curricula for general ICB support A2N/C needed to be finalized or developed from scratch – Pathfinder having determined that these curricula be developed in-house, wherever possible -- and hence were not available at program inception. Some of those that were

available needed adaptation to the Kenyan context from countries in which Pathfinder had worked previously/used them.<sup>13</sup> This delayed training roll-out.

**iii) Consultant identification**-critical for ICB scale-up and training roll-out for A2N/C was delayed, occurring late in the process. The plan was for consultants to co-facilitate training. A core group of 2-3 consultants was to be identified after they had facilitated a few interventions and their fit with Pathfinder's approach/model had been assessed. During training, a small group of trainees who showed initiative, potential, and ability to grasp training contents would be identified and provided with additional training to support other organizations to strengthen skills and systems.

During 2008, because the Boston-based Senior ICB Adviser's time was committed to supporting Pathfinder's global ICB portfolio, Pathfinder HQ initially considered creating an East Africa wide ICB Consultant position in 2008. However this idea did not materialize. Mitigating factors included funding constraints coupled with the realization that a consultant for Kenya, Ethiopia and Tanzania needed too wide a range of experience to be found easily in one person/institution; the imminent end of Pathfinder's CDC funded HBC program in Tanzania (September 2009) and the need to renew the USAID/PEPFAR supported A2N/C programs in Kenya.

In light of the following, the ICB Coordinator was advised in September 2008 by PI HQ to solicit and develop a pool of local consultants with experience in facilitating organizational processes in a wide variety of organizations from within and outside Kenya. PI HQ further advised that consultants selected be screened for various criteria including;

- checking for client satisfaction (based on their statements of past experience) regarding their facilitation skills (use of adult learning and interactive facilitation techniques), quality of the content of the training, as well as outcomes of the training-how useful and applicable was the training or consultancy services provided?
- Selection by specialization and the skills they bring to enable Pathfinder meet A2N/C ICB needs.
- Willingness to work with Pathfinder curricula and tools and develop materials on Pathfinder's behalf. All consultants were advised that if they developed materials for A2N/C, their authorship/contribution would be acknowledged, but copyright for the material would become Pathfinder's.

Solicitation and short listing of CVs was undertaken September 30-Oct 15 2008 and a full analysis of 17 local consultants completed by PI HQ in November 2008. Two key consulting

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<sup>13</sup> ICB Tools/curricula referenced include: **a) Pathfinder-adapted Organizational Capacity Assessment Tool (OPAT)** - under review by PI HQ – scheduled completion, March 2009; **b) Board Roles & Responsibilities Training Curriculum – in draft (Feb 2009)**. A2N/C advised to contract CAFS training program for NGO Boards. PI would work with CAFS to provide feedback on the design and appropriate group of invitees. **c) Project Design & Proposal Development Training Curriculum** –in draft. Pathfinder HQ's Senior ICB Adviser suggested A2N/C that Pathfinder's COMPASS Nigeria ICB Advisor (Ibidunni Adeniyi) provide STTA to A2N/C; CEDPA, IPPF guides also shared. **Generic Financial Policies & Procedures** –country office adapted Pathfinder Kenya USG policies and procedures to address this gap (April 2009); **Personnel Policies & Procedures; Project Management Training Curriculum-draft from HQ on file (Feb 2009); Resource Mobilization Training Curriculum**-in draft received Feb 2 2009); **Strategic Planning Training Curriculum**-in draft at HQ. **Leadership Development Training curriculum** –in draft at HQ: country office collaborated with the CAPACITY project of MSH to fill this gap and **Tools for MIS/M &E**-country office received COMPASS Nigeria training format from PI HQ (Feb 2009)

firms were also shortlisted: **Iceberg Africa** and **Strategic Dimensions**. In making this decision, Pathfinder reasoned that in choosing one of these organizations A2N/C could also tap into a pool of consultants/staff and reduce dependence on an individual or group of individuals. In late February 2009, PI HQ advised the Coordinator to contract both organizations and divide the organizations selected for intensive capacity building between the two. Iceberg, whose client reviews for their work with FBOs were very good, would be given preferential treatment for working with FBOs. It was further proposed that one way to potentially divide work was to have one firm work with the Nairobi grantees and the other with the Central grantees and then compare results over time.

- iv) **Sub-Grant M & E training** is managed by A2N/C M & E unit and reported to USAID quarterly and not recorded as an ICB activity. Information on how well IPs are managing their M & E responsibilities compiled by M & E unit.

### **Lessons Learned - Institutional Development**

- i) Pathfinder's experiences in Kenya and elsewhere in Africa, indicate that organizations that become sustainable fulfill a more important role than simply providing services in the communities where they work. They become critical role models for other NGOs and for the public sector, particularly in the area of generating demand, creating access, and providing quality services as well as TA and training resources. In this respect, small NGOs (e.g., KENWA, a Pathfinder COPHIA program and A2N/C implementing partner which has progressed over time from a nascent IP to a reputable emerging national NGO) can make a significant contribution to improving RH in a country.
- ii) All three components of institutional development - management, financial, and technical capacity building - must be addressed simultaneously to achieve synergies, coherent systems or operations, and sustainable programs.
- iii) When implementing partners feel "ownership" of problems and their solutions, there is a higher degree of commitment to institutional development activities.
- iv) Since many of A2N/C partners still have fragile management systems or organizational structures, it takes longer than originally anticipated to identify the most fundamental problems facing individual agencies and develop tailored programs to address them.
- v) Community support is key to sustainable organizations. Assistance in strengthening outreach and using participatory processes systematically must be incorporated into plans for institutional development or capacity building.
- vi) Monitoring and evaluation can be powerful tools for strengthening programs and increasing institutional capacity, especially when linked with TA and training for managers and supervisors using data for decision-making and program design.

### **Partnership collaboration with the Government**

#### **HBC Technical Working Group**

A2N/C is represented in the national HBC technical working group (TWG). As part of this TWG, A2N/C participated in the development of the national HBC framework, which was launched in October 2008. The development of the framework was funded by The Futures Group. The Framework is meant to guide all HBC implementers on the minimum requirements for HBC and the basic package thereof. A2N/C was also part of a task team (as a subset of the HBC TWG) that participated in the review and updating of the HBC Program and Service

Guidelines and the HBC Policy Guidelines. The review/update was necessitated by the fact that a lot has changed in the response to HIV & AIDS since the initial versions of these documents were developed. The task team of 9 persons was composed of representatives from A2N/C, St. John Ambulance, the POLICY project, Mildmay International, the Ministry of Public Health and Sanitation, FHI, and NASCOP.

### **HBC Coordination Meeting**

This meeting was convened by the PTLC with the main objective of providing a forum for stakeholders to share the progress of HBC in Nairobi. The meeting was attended by the PASCO, all the Nairobi HBC Coordinators, the CACCS and DASCOS of Nairobi, and the A2N/C HCS Coordinator. The key issues discussed were reporting of HBC activities from the district to the provincial level, referrals and networking, and the government requested for assistance in printing the HBC referral tools.

### **A2N/C Staff Orientation on the Community Strategy**

A2N/C conducted an orientation for staff on the Community Strategy in February 2009. The Goal of the Community Strategy is to take health services closer to the community by allowing community members to participate in the delivery of health care services. The strategy seeks to empower community members and to utilize community structures such as village health committees and groups of community health workers to deliver health services.

To enhance better partnership and collaboration between A2N/C and the Ministry of Public Health and Sanitation (MoPHS), the outreach team facilitated an orientation on the community strategy for program staff. The orientation was conducted by a representative from the Health Sector Reform, who was actually the originator of the strategy and has been instrumental in its implementation. The staff was given a detailed presentation of the strategy including the rationale, the structures to be supported and the training requirements and linkages with the relevant departments of the MoPHS. A2N/C will support the implementation of the community strategy in selected districts, as well as infusion of aspects of the strategy in all program areas.

### **Other meetings**

A2N/C attended and participated in Mildmay International's national dissemination workshop, held in Nairobi on 21-22 November 2006. The objective of the workshop was to share the successes and lessons learned from Mildmay's home-based care program in Nyanza, known as the Nyanza Model. The strength of this model was in strengthening the government health systems from provincial to district level, to support home-based care. This was mainly achieved through intensive training of medical personnel, who support CBOs to provide HBC services. The meeting was attended by PMOs from all provinces, selected members of DHMTs, representatives from KMTC, NASCOP, NACC, donors and other stakeholders in home-based care. Mildmay indicated that there would be USAID funding to facilitate roll out of diploma level HBC training MTCs in Nairobi and Central Province, and that the training would target service providers from A2N/C-supported sites, as well as representatives from partner organisations and A2N/C staff.

### **USAID Monitoring visits**

During the period under review, representatives from the USAID Office of Population and Health (OPH) made monitoring visits to the A2N/C's IPs. In November 2006, Dr Lucy Matu, the A2N/C CTO conducted monitoring visits with the A2N/C Home and Community Support team. The team visited 2 IPs, one in Thika and the Redeemed Gospel Church health center in Baba dogo, Nairobi. Dr Matu met with CHWS, TOTs, members of support groups, and staff from the IPs. She spoke at length with members of the support groups, as they shared their

challenges and successes in living positively. Many of them expressed their gratitude for the support they receive from A2N/C through the IPs and the CHWs, citing that they would not be alive were it not for these interventions. All the clients met are on ART and they act as advocates for VCT, ART and HBC in their communities.

A second visit was conducted in December 2007, by a team consisting of Dr Lucy Matu and Washington Omwomo, the M & E Specialist, USAID. The USAID team was accompanied by the A2N/C Director, Linda Casey and the Home and Community Support Coordinator. The team visited four IPs with the main aim of reviewing both HBC and OVC data collection and reporting systems at the IP level and the mechanism through which the data reaches A2N/C and eventually USAID. The four IPs visited were Redeemed Gospel Church, KENWA, the Community Implementing Initiative (CII) and the Riruta Health Program (RHP). The USAID team met with IP heads, TOTs and CHWs. The team reviewed the CHW records, as well as those maintained by the IP. The key recommendations from the visit were:

- CHWs need a standardized way of maintaining data – either exercise books to record their daily activities which they summarize in the ARF2 at the end of the month, or carbonated forms so that they can keep copies of what they submit to A2N/C. At the time of the visit, some CHWs had exercise books while others did not.
- CHWs need to know the various kinds of support for PLHIV and OVC that is given to their IPs through grants and they should be involved in the distribution of all items purchased by the IPs through these grants, such as food and scholastic material.
- USAID needs to see more OVC reported for the “health” service component, particularly for medical/treatment support. USAID recommended an exchange visit to A2N/Cyanza and Coast to learn more about health support for OVC.

A2N/C responded to these recommendations first by ensuring that all CHWs use exercise books to record their daily activities. In addition, all the IP heads were informed of the requirement to involve CHWs in the distribution of items provided by A2N/C for the project’s beneficiaries. A2N/C monitored closely to ensure the IPs adhere to this requirement.

### **Challenges and Ways Forward:**

**Defaulting** – During the period under review, the number of ART defaulters seemed to be increasing at an alarming rate. As a start, A2N/C conducted targeted religious leaders sensitizations to address the issue defaulting due to “healing prayers”. This was done in addition to treatment literacy training for clients. In addition, in the coming period, A2N/C will conduct defaulter tracing training for CHWs to enhance treatment support at community level.

**Post-election violence** - the post-election violence which rocked the nation made implementation of activities impossible in some areas such as Mathare, Huruma, Korogocho and Dandora. The CHWs reported that they were afraid to visit their clients. Others were delayed upcountry, as there was no transport to travel to Nairobi due to the insecurity, thus missing their clinic appointments and drug refills. In addition to hampering implementation of project activities, data collection was also a challenge as some CHWs were delayed up-country. Further, many clients were displaced and could not be traced.

**Data collection and reporting** – many of the CHWs TOTs expressed difficulty in completing the A2N/C data collection forms. Their main challenge was that the forms were very detailed and the forms themselves were many. The many forms are as a result of the indicators against

which A2N/C is required to report for clients and for OVC. The result was that often the forms had many errors, the correction of which was time-consuming. A2N/C will continue to provide monthly orientation of the data collection tools for all teams to make completion easier. Where necessary, the A2N/C HCS team members will review the data tools with individual CHWS to ensure their challenges are addressed.

**Disclosure** – disclosure is one of the major challenges experienced by A2N/C clients. During the treatment literacy trainings, many of the participants (particularly women) confessed that their partners are not aware of their HIV status, and they are afraid to reveal it to them due to fear of violence or abandonment. This is of course a serious state of affairs as lack of disclosure adversely affects adherence and discourages seeking of health services. Although there are no quick or easy solutions to the lack of disclosure, A2N/C plans to strengthen advocacy at community level through sensitization, as well as at support group level using advocates who have disclosed their status to their family members. These advocates will be selected from among the existing clients and CHWs, and will be trained to encourage participative discussion in the support group meetings in order to encourage disclosure. A2N/C will also continue to raise legal rights in the community through the paralegals so that PLHIV know that there are mechanisms for reporting violence.

## 6.0 APHIA Nairobi and Central Province Sub-Grants (August 2006 – July 2009)

APHIA II (AIDS Population, and Health Integrated Assistance Program) Nairobi (A2N/C) funded 29 sub-grants, out of these 23 are implemented through sub-grants mechanism while 5 are through Partner Implemented Projects (P.I.P) which are projects implemented by a local partner but the project costs are handled by Pathfinder Country Office directly.

The various sub-grantees implemented activities in various programmatic areas including, ART, PMTCT, FP, RH, TB, VCT, HB, OVC, PTC, AB and OP.

### Successes

The sub-granting to various organizations has led to success in implementation of the project as well as institutional capacity building making it possible for the sub-recipients be able to manage the donor funds accordingly, some of the successes include:-

- a) The project was able to reach most of the targets for the grant period.
- b) All the sub-grantees managed to account for the funds disbursed.

### Challenges

Some of the challenges faced during the period were:-

- a) Late submission of reports, and challenges to a few of the sub-grantees to report accordingly and keep good books of account.
- b) High staff turnover in most of the sub-grants, which included top management changes.
- c) Some of the sub-grantees took long to respond to some information required for modifications hence delay in signing of extension agreements.

### Suggestions

- a) It is important to have annual finance management training for finance and non-finance officers for all the sub-grants on annual basis so as to ensure compliance to donor regulations, in addition to regular follow up.

**Table 5: Summary of the sub-grants during the period - Nairobi Province**

N o.	Name	Funding Mechanism
1	Provincial Medical office Nairobi Province	P.I.P
2	Kenyatta National Hospital (KNH)	Sub-grant
3	Kenya Network of Women with AIDS (KENWA)	Sub-grant
4	Gertrude's Children's Hospital (GCH)	Sub-grant
5	Kenyatta University (KU)	Sub-grant
6	Redeemed Gospel Church Development Program (RGCDP)	Sub-grant
7	Riruta Health Project (RHP)	Sub-grant
8	Kenya Girl Guides Association (KGGGA)	Sub-grant
9	Nairobi Network Of Post Test Clubs (NNEPOTEC)	Sub-grant
10	Movement of Men Against Aids In Kenya (MMAAK)	Sub-grant
11	Mathare Youth Sports Association (MYSA)	Sub-grant
12	I Choose Life (ICL)	Sub-grant
13	Mbagathi District Hospital	P.I.P

14	Support for Addictions Prevention & Treatment in Africa (SAPTA)	Sub-grant
15	Nairobi Women Hospital (NWH)	Sub-grant
16	Kenyatta National Hospital Consultancies	P.I.P
17	Hope World Wide Kenya	Sub-grant
18	Catholic Medical Mission Board	Sub-grant
19	Goal Kenya	Sub-grant
20	University of Nairobi Institute of Tropical and infectious Diseases	Sub-grant

**Table 6: Summary of the sub-grants during the period Central Province**

<b>N o.</b>	<b>Name</b>	<b>Funding Mechanism</b>
1.	PMO Central	P.I.P
2.	CYEC	P.I.P
3.	Mugutha Women Group	Sub-grant
4.	Ruiru Bible Baptist Church	Sub-grant
5.	Integrated AIDs Programme	Sub-grant
6.	St. Joseph	Sub-grant
7.	Saikaka CBO	Sub-grant
8.	Shadumu CHW's	Sub-grant
9.	Hope World Wide Kenya	Sub-grant
10.	Catholic Medical Mission Board	Sub-grant
11.	Kenya Girl Guides Association (KGGA)	Sub-grant
12.	Jomo Kenyatta University of Agriculture and Technology	Sub-grant



APHIA II - NAIROBI PROVINCE -PERFORMANCE MONITORING PLAN (PMP)								1
AUGUST 2006 - 28 FEBRUARY 2009								
PEPFAR Indicator	Indicator	Yr 1 Target (Aug 06 - Sept 07)	Yr 1 achievement	Yr 2 Target (Oct 07- Sept 08)	Yr 2 achievement	Yr 3 Target (Oct 08- Feb 09)	Yr 3 achievement	Total Achievement
<b>Prevention -Abstinence and/or Being Faithful</b>								
2.1	Number of individuals reached through community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	4,500	28,788	103,900	186,141	142,477	107,312	<b>322,241</b>
2.1A	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence [this is a subset of the total reached with abstinence and/or be faithful - indicator 2.1]	4,500	4,550	5,000	6,620	62,907	88,053	<b>88,053</b>
2.2	Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	20	26	1,764	2,686	712	34	<b>2,746</b>
5.1	Number of targeted condom service outlets (Fixed sites or distribution on fixed schedules)	-	-	32	112	11	136	<b>136</b>
5.2	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful, by gender	110,560	204,754	218,040	299,145	58,324	137,365	<b>641,264</b>
5.3	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	280	-	210	39	208	33	<b>72</b>
<b>Prevention - Medical Transmission/Injection Safety</b>								
4.1	Number of individuals trained in medical injection safety	0	0	30	20	50		<b>20</b>
<b>Prevention of Mother-to-Child Transmission</b>								

1.1	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	10	-	20	30	23	34	<b>34</b>
1.2	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	750	-	17,178	15,425	6,292	7,085	<b>22,510</b>
1.3	Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	60	-	1,248	826	805	444	<b>1270</b>
1.4	Number of health workers trained in the provision of PMTCT services according to national and international standards	27	30	200	196	57	27	<b>253</b>
<b>Counseling and Testing</b>								
9.1	Number of service outlets providing counseling and testing according to national and international standards	16	5	40	48	35	56	<b>56</b>
9.2	Number of individuals who received counseling and testing for HIV and received their test results	29,074	13,875	44,500	123,239	54,167	97,332	<b>234,446</b>
9.2A	Number of registered TB patients who received counseling and testing for HIV and received their test results (this is a subset of Indicator 9.2)			2,100	3785	1500	2,443	<b>6,228</b>
9.3	Number of individuals trained in counseling and testing according to national and international standards	90	37	149	121	250	57	<b>215</b>
<b>HIV/AIDS Treatment/ARV Services</b>								
11.1	Number of service outlets providing ART services according to national or international standards	16	16	29	63	27	63	<b>63</b>
11.2	Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,393	1,477	1,740	3,098	1,950	1650	<b>6,225</b>
11.3	Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	5,537	2,911	12,667	12,711	10,124	15,524	<b>15,524</b>
11.4	Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	4,787	2,075	9,500	10,047	8,968	11,602	<b>11,602</b>
11.5	Number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	50	165	290	226		49	<b>440</b>
<b>Palliative Care (including TB/HIV care)</b>								

6.1	Total number of service outlets providing HIV-related palliative care (including TB/HIV)	25	30	49	91	20	88	<b>88</b>
6.2	Total number of individuals provided with HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	4,800	10,468	26,600	29,748	6,500	25,846	<b>25,846</b>
6.3	Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed) that includes those trained in facility-based, community-based and/or home-based care including TB/HIV		241	338	833	100	307	<b>1,381</b>
7.1	Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting according to national or international standards. (This is a subset 6.1).		30 (PMS)	29	58		?32	<b>32</b>
7.2	Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of 6.2)	428	428	1,500	1147	625	613	<b>1,147</b>
7.3	Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed). (Subset of 6.3)	?	18	130	71	100	0	<b>89</b>
<b>Orphans and Vulnerable Children</b>								
8.1	Number of OVC served by an OVC program,	7,750	3,694	10,600	12,611	13,440	13,855	<b>13,855</b>
8.1a	Number of OVC served by Primary Direct OVC programs		320		11,994	13,440	11,770	<b>11,770</b>
8.1b	Number of OVC served by Supplementary Direct OVC programs		3,374		617		2,085	<b>2,085</b>
8.2	Number of individuals trained in caring for OVC (CORPS, providers, caretakers)		272	250	-		60	<b>332</b>
<b>Strategic Information</b>								
13.1	Number of local organizations and service points provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS)	9	14	49	135	40	138	<b>138</b>
13.2	Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	27	-	30	24	100		<b>24</b>
<b>Other/Policy Development and System Strengthening</b>								

14.2	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	9	14	10	34	4	1	<b>49</b>
14.3	Number of individuals trained in HIV-related institutional capacity building	27	15	30	54	42	11	<b>80</b>
14.5	Number of individuals trained in HIV-related stigma and discrimination reduction	-	638	48	15			
14.6	Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment	60	64	99	917	25	233	<b>1214</b>
<b>NON-PEPFAR ILLUSTRATIVE INDICATORS</b>								
<b>IR.1: IMPROVED AND EXPANDED FACILITY-BASED HIV/AIDS, TB, RH/FP, MALARIA &amp; MCH SERVICES</b>								
<b>IR 1: Expanded availability of HIV/AIDS prevention, care and treatment services</b>								
	Number of service outlets providing PEP	16	1	29	28	29	29	<b>29</b>
	Number of individuals trained in pediatric HIV treatment	50	56	130	76	?	25	<b>157</b>
	Number of service outlets renovated & equipped to facilitate provision of comprehensive services	-	-	10	19	?	21	<b>40</b>
<b>Sub-Result 1.2: Improved &amp; Expanded Facility-based HIV/AIDS, TB, RH/FP, Malaria and MCH Services</b>								
	Number of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MCH services	16	8	29	15	15	15	<b>15</b>
	Number of service outlets expanding contraceptive method mix	0	0	26	22	22	22	<b>22</b>
	Number of service outlets with youth friendly services	0	5	16	8	8	8	<b>8</b>
	Number of service outlets whose stock levels ensure near-term availability	16	2					<b>2</b>
	Number of service providers trained, by type of training and service provider	0	150	130	301			<b>451</b>
	Couple years of protection (CYP) in USG-supported programs	0			12,072		12,687	<b>24,759</b>
<b>Sub-Result 1.3: Reinforced networking between levels of care and clinical services and communities</b>								
	Number of service outlets that provide/serve CCCs that are linked to community-based care networks/clusters	23	16	29	28	29	27	<b>27</b>
	Number of implementing partners provided orientation on the referral system/clusters and networks	9	14	20	28	27	27	<b>27</b>

	Number of implementing partners making appropriate referrals	9	14	20	28	27	27	27
<b>IR.2: Improved &amp; expanded civil society activities to increase healthy behaviors</b>								
	Number of implementing partners supported to implement quality HIV/AIDS prevention programs	9	14	20	28	27	27	27
<b>IR2.1: Expanded community and workplace prevention programs</b>								
	Number of workplace/worksites with trained health workers (peer educators, depot holders, etc.)	30	12	60	20	13	18	18 or 50? If cumulative
	Number of workplace/worksites that have HIV/AIDS workplace policies and programs	30	-	35	7	13	26	26 or 33 if cumulative
	Number of workplace/worksites with appropriate referral and access to clinical services	35	-	35	17	15	7	7 or 24 if cumulative
	Number of workers/family members served and/or referred, by type of service and/or referral	210	-	340	73	88		73
<b>Sub-Result 2.2: Expanded prevention programs targeting most-at-risk populations</b>								
	Number of informal sites reached with HIV/AIDS prevention messages	72	127	96	118	30	60	305
<b>IR.2.3 Reinforced networking between communities and clinical services</b>								
	Number of village health committees (VHC) established	2	5	10	10	2	10	10
	Number of VHCs linked to health facilities	2	5	12	10	2	10	10
<b>IR.3: Improved &amp; expanded care &amp; support for people &amp; families affected by HIV/AIDS</b>								
<b>IR 3.1: Expanded home and community support programs</b>								
	Number of community leaders who attended sensitization workshops	400	100	600	732	167	115	947
	Number of people trained in IGA and linked to micro-credit institutions	150	0	150	0	63		0
	Number of individuals provided home-based care	150	3006	135	6903	63	8860	8860
<b>IR 3.2: Expanded support for OVC</b>								
	Number of Implementing Partners supported to provide care and support to OVC	10	14	20	28	27	27	27
<b>IR.3.3 Reduced stigma &amp; establishment of safety nets for PLWHIV &amp; their families</b>								
	Number of community-based anti-stigmatization advocacy/campaign events conducted	480	1129	580	1333	200	711	3173

Number of individuals trained/sensitized towards PLWHIV, by type of training and individual (paralegals, CORPS, health workers, etc.)	1000	800	1500	390	42		
Number of community-based paralegal clinics established and linked to paralegal aid organizations	6	6	6	18	3	0	18
Number of rescue centers for victims of violence established	0	0	2	0	0	0	0
Number of PLWHIV/OVC caretaker support groups formed and linked to other services as appropriate	9	29	4	131	4	49	49
Number of health workers trained in stigma reduction	30	103	130	376	13	0	479
<b>Strategic Information</b>							
Number of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	8	16	29	73	109	109	109

APHIA II - CENTRAL PROVINCE -PERFORMANCE MONITORING PLAN (PMP)								1
AUGUST 2006 - 28 FEBRUARY 2009								
PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Total Achievement
<b>Prevention -Abstinence and/or Being Faithful</b>								
2.1	Number of individuals reached through community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	4,500	16,089	71,000	173,378	107,500	74,255	<b>263,722</b>
2.1A	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence [this is a subset of the total reached with abstinence and/or be faithful - indicator 2.1]	4,500	4,506	5,000	6,763	92,925	77,193	<b>77,193</b>
2.2	Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	20	44-PMP	1,752	2,601	538	1,509	<b>4,154</b>
5.1	Number of targeted condom service outlets (Fixed sites or distribution on fixed schedules)	-	-	35	217	21	136	<b>136</b>
5.2	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful, by gender	167,800	239,547-PMP	85,960	686,618-pmp	87,500	281,681	<b>1,207,846</b>
5.3	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	70	43	235	190	208		<b>233</b>
<b>Prevention - Medical Transmission/Injection Safety</b>								
4.1	Number of individuals trained in medical injection safety				48			
<b>Prevention of Mother-to-Child Transmission</b>								
1.1	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	10	60	42	99	20	104	<b>104</b>

1.2	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1,516	22,714	24,267	33,765	13,371	14,682	<b>71,161</b>
1.3	Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	72	798	1,644	1,422	1,068	401-PMS	<b>2,621</b>
1.4	Number of health workers trained in the provision of PMTCT services according to national and international standards	20	91	300	121-pmp	51	88	<b>300</b>
<b>Counseling and Testing</b>								
9.1	Number of service outlets providing counseling and testing according to national and international standards	5	1	40	97	17	92-pmp	<b>92</b>
9.2	Number of individuals who received counseling and testing for HIV and received their test results	9,100	303	12,200	27,591	29,167	40,399	<b>68,293</b>
9.2A	Number of registered TB patients who received counseling and testing for HIV and received their test results (this is a subset of Indicator 9.2)	0	0-PMP	0	517	625	363	<b>880</b>
9.3	Number of individuals trained in counseling and testing according to national and international standards	30	27-PMP	101	150-pmp	104	25	<b>202</b>
<b>HIV/AIDS Treatment/ARV Services</b>								
11.1	Number of service outlets providing ART services according to national or international standards	1	2-PMP	14	22	7	30	<b>30</b>
11.2	Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	54	147	820	913	550	700	<b>1,760</b>
11.3	Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	139	372	4,668	6,348	2,855	6,797	<b>6,797</b>
11.4	Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	119	363	3,500	4815-pmp	2,832	4,965	<b>4,965</b>
11.5	Number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	10	193	348	158	45	-	<b>351</b>
<b>Palliative Care (including TB/HIV care)</b>								

6.1	Total number of service outlets providing HIV-related palliative care (including TB/HIV)	6	10	34	62	13	81	<b>81</b>
6.2	Total number of individuals provided with HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	3,500	2,862	13,400	19,407	6,500	11,269	<b>11,269</b>
6.3	Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed) that includes those trained in facility-based, community-based and/or home-based care including TB/HIV	170	145	538	691	42	867	<b>1,703</b>
7.1	Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting according to national or international standards. (This is a subset 6.1).			15	41-pmp	36	51	<b>51</b>
7.2	Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of 6.2)	100	5	600	237	313	415	<b>415</b>
7.3	Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed). (Subset of 6.3)	0	0	50	119	42	27-PMS	<b>146</b>
<b>Orphans and Vulnerable Children</b>								
8.1	Number of OVC served by an OVC program,	6,800	13,391	18,600	25,699-pmp	20,160	25,683	<b>25,683</b>
8.1a	Number of OVC served by Primary Direct OVC programs		281-pms	3,720	18,881-pmp	20,160	18,791	<b>18,791</b>
8.1b	Number of OVC served by Supplementary Direct OVC programs		13,584-pms	14,880	6818-pmp	-	6,892	<b>6,892</b>
8.2	Number of individuals trained in caring for OVC (CORPS, providers, caretakers)	210	120-PMP	560	591-pmp	-	0-PMS	<b>711</b>
<b>Strategic Information</b>								
13.1	Number of local organizations and service points provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS)	10	11-PMP	34	211	18	216	<b>216</b>

	Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	15	0-PMP	24	51-pmp	42	0-PMS	<b>51</b>
<b>Other/Policy Development and System Strengthening</b>								
14.2	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	7	0-PMP	8	11-pmp	30	0-PMS	<b>11</b>
14.3	Number of individuals trained in HIV-related institutional capacity building	15	29-PMP	24	40-pmp	35	0-PMS	<b>69</b>
14.5	Number of individuals trained in HIV-related stigma and discrimination reduction	-	745-PMP	60	30-pmp	292	0-PMS	<b>775</b>
14.6	Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment	60	303-PMP	120	834-pmp	229	210-pmp	<b>1,347</b>
<b>NON-PEPFAR ILLUSTRATIVE INDICATORS</b>								
<b>IR.1: IMPROVED AND EXPANDED FACILITY-BASED HIV/AIDS, TB, RH/FP, MALARIA &amp; MCH SERVICES</b>								
<b>IR 1: Expanded availability of HIV/AIDS prevention, care and treatment services</b>								
	Number of service outlets providing PEP	1	2-PMP	15	21	16	28	<b>28</b>
	Number of individuals trained in pediatric HIV treatment	1	27-PMP	58	?	42	60	<b>87</b>
	Number of service outlets renovated & equipped to facilitate provision of comprehensive services	-	0-pmp	-	-	95	95	<b>95</b>
<b>Sub-Result 1.2: Improved &amp; Expanded Facility-based HIV/AIDS, TB, RH/FP, Malaria and MCH Services</b>								
	Number of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MCH services	4	24	15	18	60	60	<b>60</b>
	Number of service outlets expanding contraceptive method mix	0	0	15	35	139	139	<b>139</b>
	Number of service outlets with youth friendly services	4	0	14	3	3	3	<b>3</b>
	Number of service outlets whose stock levels ensure near-term availability	5	0	14	0	130	0	<b>0</b>
	Number of service providers trained, by type of training and service provider	93	27	58	550	120	81	<b>658</b>
	Couple years of protection (CYP) in USG-supported programs		4,262		52,010		51,233	<b>107,505</b>
<b>Sub-Result 1.3: Reinforced networking between levels of care and clinical services and communities</b>								

	Number of service outlets that provide/serve CCCs that are linked to community-based care networks/clusters	-	11	15	22	29	29	<b>29</b>
	Number of implementing partners provided orientation on the referral system/clusters and networks	5	11	20	25	29	29	<b>29</b>
	Number of implementing partners making appropriate referrals	tbd	11	20	25	29	29	<b>29</b>
<b>IR.2: Improved &amp; expanded civil society activities to increase healthy behaviors</b>								
	Number of implementing partners supported to implement quality HIV/AIDS prevention programs	5	11	20	22	29	29	<b>29</b>
<b>IR2.1: Expanded community and workplace prevention programs</b>								
	Number of workplace/worksites with trained health workers (peer educators, depot holders, etc.)	30	12	60	8	5	2	<b>22</b>
	Number of workplace/worksites that have HIV/AIDS workplace policies and programs	30	-	45	49	4	3	<b>52</b>
	Number of workplace/worksites with appropriate referral and access to clinical services	15	-	40	10	8	6	<b>16</b>
	Number of workers/family members served and/or referred, by type of service and/or referral	90	-	265	-	TBD	12	
<b>Sub-Result 2.2: Expanded prevention programs targeting most-at-risk populations</b>								
	Number of informal sites reached with HIV/AIDS prevention messages	72	253	96	216	60	71	<b>540</b>
<b>IR.2.3 Reinforced networking between communities and clinical services</b>								
	Number of village health committees (VHC) established	2	5	14	29	24	21	<b>21</b>
	Number of VHCs linked to health facilities	2	5	14	29	24	21	<b>21</b>
<b>IR.3: Improved &amp; expanded care &amp; support for people &amp; families affected by HIV/AIDS</b>								
<b>IR 3.1: Expanded home and community support programs</b>								
	Number of community leaders who attended sensitization workshops	400	202	600	449	250	199	<b>850</b>
	Number of people trained in IGA and linked to micro-credit institutions	150	0	400	90	600	355	<b>445</b>
	Number of individuals provided home-based care	135	2542		6899	100	8273	<b>8273</b>

<b>IR 3.2: Expanded support for OVC</b>								
	Number of Implementing Partners supported to provide care and support to OVC	5	11	20	29	29	29	<b>29</b>
<b>IR.3.3 Reduced stigma &amp; establishment of safety nets for PLWHIV &amp; their families</b>								
	Number of community-based anti-stigmatization advocacy/campaign events conducted	480	954	580	2,616	625	2,274	<b>5,844</b>
	Number of individuals trained/sensitized towards PLWHIV, by type of training and individual (paralegals, CORPS, health workers, etc.)	700	724	700	71,629	1042	37,320	<b>109,673</b>
	Number of community-based paralegal clinics established and linked to paralegal aid organizations	5	5	3	14	8	7	<b>7</b>
	Number of rescue centers for victims of violence established	0	0	2	0	2	2	<b>2</b>
	Number of PLWHIV/OVC caretaker support groups formed and linked to other services as appropriate	5	29	8	83	20	83	<b>83</b>
	Number of health workers trained in stigma reduction	30	108	58	691	50	243	<b>1,042</b>
<b>Strategic Information</b>								
	Number of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	8	61-pmp	15	26	100	187	<b>187</b>