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**APHIA II
CENTRAL**



Shining Star CBO community health workers receive follow-up instruction after a training sensitization exercise in Nyandarua District.

END OF PROJECT PERFORMANCE REPORT

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Acronyms

A2C	APHIA II Central
A2NC	APHIA II Nairobi/Central
AB	Abstinence and Be Faithful
ABY	Abstinence and/or Be Faithful (Youth)
AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual Operating Plan
APHIA	AIDS, Population & Health Integrated Assistance Program
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs)
CACC	Constituency AIDS Control Committee
CHBC	Community and Home Based Care
CBO	Community Based Organization
CCC	Comprehensive Care Center
CDF	Constituency Development Fund
CHW	Community Health Worker
CME	Continuous Medical Education
CMMB	Catholic Medical Mission Board
CSW	Commercial Sex Workers
CYP	Couple Years of Protection
DASCO	District HIV/AIDS Coordinating Officer
DBS	Dry Blood Sample
DHMT	District Health Management Team
DHRIO	District Health Records and Information Officer
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DMLT	District Medical Laboratory Technologist
DMS	Director of Medical Services
DPHN	District Public Health Nurse
DTC	Diagnostic Testing and Counseling
DTLC	District TB and Leprosy Coordinator
ECD	Early Childhood Development Center
EID	Early Infant Diagnosis
EMMR	Environmental Monitoring & Mitigation Report
FBO	Faith Based Organization
FKE	Federation of Kenya Employers
GoK	Government of Kenya
GSN	Gold Star Network
HBC	Home Based Care
HCS	Home and Community Support
HCW	Health Care Worker
HIV	Human Immune-deficiency Virus
HTC	HIV Testing & Counseling
HWWK	Hope World Wide Kenya
IAP	Integrated AIDS Program
ICB	Institutional Capacity Building
IEC	Information, Education and Communication
IP	Implementing Partner
IUD	Intra-Uterine Device
IYCF	Infant and Young Child Feeding
KAPC	Kenya Association of Professional Counselors
KCPE	Kenya Certificate of Primary Education
KCSE	Kenya Certificate of Secondary Education

KEMSA	Kenya Medical Supplies Agency
KNASP	Kenya National HIV/AIDS Strategic Plan
KGGA	Kenya Girl Guides Association
KTDA	Kenya Tea Development Authority
MoE	Ministry of Education
MoH	Ministry of Health
MOPHS	Ministry of Public Health & Sanitation
MLVCT	Moonlight Voluntary Counseling and Testing
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
NVP	<i>Nevirapine</i>
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PASCO	Provincial AIDS and STI Coordinator
PDPHS	Provincial Director Public Health Service
PEPFAR	President's Emergency Plan for AIDS Relief
PGH	Provincial General Hospital
PHMT	Provincial Health Management Team
PI	Pathfinder International
PITC	Provider Initiated Counseling and Testing
PLHIV	People Living with HIV
PMO	Provincial Medical Officer
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
PTLC	Provincial TB and Leprosy Coordinator
RAAG	Ruiru AIDS Awareness Group
RH/FP	Reproductive Health/ Family Planning
RRI	Rapid Results Initiative
SCMS	Supply Chain Management System
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOT	Training of Trainers (also refers to a trainer him/herself)
USAID	United States Agency for International Development
VCT	Voluntary Counseling & Testing
VHC	Village Health Committee
Y/BCC	Youth/ Behavior Change Communication

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Executive Summary

The AIDS Population and Health Integrated Assistance Project (APHIA) II Central (A2C) has the pleasure of presenting its end of project report (March 2009-February 2011).

Based on an agreement between the Government of Kenya (GoK) and the United States Agency for International Development (USAID), A2C was implemented by a consortium of five experienced international and local organizations led by Pathfinder International. The A2C 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, A2C 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 GoK, local, and international entities, as well as stakeholders. Increased networking among agencies, facility-community linkages, and sustainability were core elements of A2C.

A2C partners brought to the project a rich pool of technical expertise derived from their relevant ongoing programs in Central Province before the inception of this project. The consortium comprised 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), with Pathfinder International being the lead agency.¹ 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 A2C team designed a comprehensive project that linked strategically to other related programs at the national and regional levels with the aim of leveraging results. Activities within Central Province were linked to national targets to support achievement of national goals thus contributed to the Kenya National AIDS Strategic Plan (KNASP) and the Millennium Development Goals. The A2C 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 A2C was to recognize; fully utilize; and build on the existing strengths, facilities, and abilities of its government and civil society implementing partners with the aim of making these centers of excellence capable of giving services that are comprehensive, efficient, and affordable.

The project was grounded on three Result Areas: (1) Improved and expanded facility-based HIV/AIDS, TB, RH/FP, Malaria, and MCH services; (2) Improved and expanded civil society activities to increase healthy behavior; and (3) 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.

¹ Pathfinder as the lead was responsible for overall project management, grants management, and home and community support. PSI was the lead partner in behavior change. CFK led in OVC. Pathfinder, NARESA, and Malteser all contributed to Result 1.

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

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 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 improved 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, A2C 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. A2C

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, family planning information and referrals, education, paralegal support and protection, psychosocial support, and links to income-generating activities. Communities participated directly in providing support for PLHIV, OVC, and their caregivers. Clinical referrals and linkages created synergies with other elements of A2C, along with community mobilization. The safety net for OVC continued to be expanded under A2C. Stigma reduction activities involved key community leaders and stakeholders, PLHIV, women, youth, and men.

Table 1: Summary Report: March 2009-February 2011²

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	140,500	190,654	136%	258,000	263,297	102%	110,000	77,607	71%
PMTCT - No. pregnant women counseled, tested for HIV, and received test results	18,667	20,492	110%	32,000	44,198	138%	13,300	18,704	141%
PMTCT - No. pregnant women received complete course of antiretroviral prophylaxis in a PMTCT setting	770	550	71%	1,360	1,340	99%	571	585	102%
No. individuals received counseling, testing, and test results	21,600	50,253	233%	60,000	202,407	337%	25,000	141,009	564%
ART cumulative clients	3,500	8,198	234%	4,000	10,110	253%	4,210	11,093	263%
ART clients at end of reporting period	3,000	6,518	217%	3,500	7,620	218%	3,710	8,435	227%
No. individuals received HIV-related palliative care (including clinical prophylaxis and/or treatment for TB)	5,872	13,488	230%	11,079	16,427	148%	15,248	17,810	117%
No. individuals attending HIV care treatment who received treatment for TB disease	237	467	197%	275	371	135%	302	396	131%
OVC served	27,000	27,254	101%	27,000	27,043	100%	27,000	27,043	100%

² Selected indicators.

The integration of project activities involved the health facility and community levels with a high level of collaboration with Government of Kenya partners and stakeholders at district and provincial levels. Good planning and effective implementation of project activities resulted in 8,435 individuals currently accessing anti-retrovirals by end February 2011 at project-supported facilities. Of these 3,749 were new clients during the project period.

Encouraging adherence to drug regimens and propounding prevention of transmission as well as secondary infection by the virus are skills that community health workers (CHWs) now possess and practice. The 11,289 home-based care clients benefited from the attention of 2,334 CHWs who provided a range of services to both mobile and bed-ridden clients. CHWs liaised closely with the health centers, which form part of the service network.

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. A2C 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, 83,394 pregnant women were tested for HIV and received their test results. Of these, 2,475 women were administered prophylaxis. The early infant diagnosis program expanded well, testing a total of 2,109 infants.

School children attended weekly sessions of the "'*Chill*' Club', a year-long program that provided a broad package of skills designed to empower young people to make informed life decisions based on sound knowledge. A total of 14,179 children benefited from the "'*Chill*' Club' program supported in primary schools. A2C also worked with the Kenya Girl Guides, who reached another 190,280 male and female students in 94 schools with prevention messages focused on abstinence.

Messages focused on abstinence for younger people and messages encouraging faithfulness and/or behavior change for older individuals and those at high risk were also delivered by A2C and benefited 508,500 individuals. Counseling and testing continued to expand appreciably, with a total of 393,669 people accessing this service at A2C-supported sites and through outreach VCT activities. Mobile counseling and testing (MVCT) was a key aspect of the project's VCT approach.

Family planning and reproductive health formed a part of the Result I Area, and A2C ensured that its target population was offered competent and complete services. FP/RH services were provided to 15,627 new clients while a total CYP of 282,474 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 and psychosocial to the physical and economic. By the end of the project, 17,810 HIV-infected individuals were receiving palliative care.

The HIV/AIDS 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 of these children are taken in by caretakers such as family members and

neighbors. By the end of February 2011, the project was supporting 27,043 OVC, of whom 26,285 were receiving three or more services.

A primary mandate of A2C 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. A2C, through the life of project, provided training to 6,432 individuals including health care workers, community organizations, and government staff. In addition to the training, numerous 'Continuing Medical Education' (CME) sessions were held with health care workers.

Challenges and Lessons Learned

- Upon start-up of its predecessor project, and due to diverse needs and existing programs in the province, A2C was not always able to establish comprehensive clinical and community-based programs in the same locations. Over time, the project was able to re-align interventions geographically to address this gap. Strong linkages between community and facility-based services provided the population served with continuum of care, hence better access to services. Where A2C co-located its facility- and community-based interventions most comprehensively, synergies were created for better quality of care as well.
- Stand-alone community-based activities have limited impact or sustainability. Establishing communications and joint activities between different cadres of community volunteers contributed greatly to a strong continuum of care and to energizing community-based partners. For example, enabling volunteers addressing home-based care and OVC support to link with youth and drama groups as well as volunteers implementing school-based prevention programs generated cross-referrals, better scale-up of activities of mutual concern and resulted in an informal support system for the volunteers themselves in their work.
- Providing a full package of support at facility level (training, CMEs, strengthening of supportive supervision, improving use/reporting of data, lab networking support, linkages to community programs, etc.), backed by district- and/or provincial-level support to management and supervision, is essential to achieve improvements in service delivery.
- Training workshops draw scarce health care providers away from understaffed health facilities and can be a costly approach to skills improvement. The continuous medical education approach employed by A2C, which used short, regularly scheduled updates at the local level on diverse topics, was both well-accepted among service providers and a cost- and time-efficient way to update clinical skills.
- Scaling up HIV treatment as well as early infant diagnosis, cannot be achieved without widening access to laboratory facilities, even within a context of limited resources. Lab networking was an effective approach that helped expand both treatment and EID services to more lower-level facilities without the need for costly investments in advanced labs at lower levels.
- Central Province has a large workforce in commercial agriculture and industrial production. Many workers are immigrants to the province with little family and social support. Education and health services for workers in the workplace are often minimal. A2C found that workplace programs are an important avenue for reaching men and can serve as links to much-needed health information and services.
- Investing in already-sustainable NGO partners with strong capacity is an effective means of scaling up both community level activities as well as clinical services. Such partners are also ideally positioned to initiate new approaches. Examples included subgrantee scale up of mobile and moonlight VCT services.

- Stigma against PLHIV in Central Province remains relatively high, creating multiple barriers to prevention, care, and treatment activities at all levels. A2C made progress in breaking down this stigma both directly via extensive messaging in street theater and through its advocates – who joined drama groups to raise awareness – as well as indirectly, by streamlining stigma reduction throughout training for clinical and community cadres. This multi-pronged approach is essential to reach all elements of society.
- The GoK adopted a community strategy for delivery of health services but did not allocate sufficient resources to make this a reality, creating expectations for projects such as A2C to support the strategy’s roll out, despite the financial cost. While it was difficult to fully meet the needs that the strategy created, success was achieved in places where A2C was able to support initial training activities and regular technical assistance, even without ongoing financial support to CHWs.
- High turnover of district medical officers remained a challenge throughout the implementation of the project, as most were young doctors serving for a few months before proceeding for further studies. A2C had to build the capacity of each new partner, and it took time for each new district medical officer to understand the mandate of A2C and what is expected from GoK as a major partner. In some cases, because of limited understanding of the mandate of A2C, new officers did not contribute as expected as the head of the health team in the district, in supervision, and guiding health care workers towards the achievement of the set objectives. Developing good working relationships between project staff and other DHMT members helped to offset, if not resolve, this challenge.
- Uncoordinated competing implementers in the province posed numerous challenges. For example, A2C and a CDC partner had a similar mandate. At times, information or perceptions about each project’s approach or policies was used by counterparts in the province to negotiate for specific support. On some occasions, this drove a wedge between the two agencies, and often caused inefficiencies.
- Clarity on resource allocations between NGO and government partners is difficult to achieve, due to differing and changing systems of budgeting and budget management, yet sharing of such information is key to maximizing limited resources. Management of expectations from the GoK counterpart remained a challenge as some of their needs fell outside the mandate of the project. For instance, supporting general curative services at the hospital was their greatest need, but as A2C’s mandate focused on HIV/AIDS, TB, RH/FP, and MCH, it was unable to assist to the extent desired by the GoK counterpart.
- In terms of project management, an early lesson learned was that it was important for staff from the consortium members to shed their organizational identities and embrace A2C under one leadership for successful implementation of the project.

Recommendations

- Future projects should further strengthen the linkages between community and facility based services. Challenges to achieving this must be considered from the design phase, in terms of: (1) understanding established projects and activities on the ground which may impede synchronization of a comprehensive facility-community approach, and (2) ensuring sufficient funding for an approach that creates synergies between community and facility (and district) levels.
- Government support the implementation of the community strategy in all districts in the province will also enable projects to contribute in complementary ways.
- Lab networking should be mainstreamed into government systems and co-funded with the government for sustainability. Presently, CD4 tests can only be done in larger

facilities, yet the clients receiving care in lower-level facility need this service as part of treatment monitoring. The same concept applies to EID.

- Workplace programs should be scaled up, especially in hospitals, as stigma remains high among health workers living with HIV. In general, there are ample opportunities for attaining wide coverage through the workplace in Central Province.
- Programming for youth is most effective when it involves not only facility-based but also community-based components and creates linkages between these components.
- More can be done to address HIV treatment and care into pre-service education. This will partially alleviate the challenge of high turnover of health staff and associated re-training in project areas.
- Consider greater emphasis on simple, low-tech, low-cost CME approaches as well as distance and e-learning as technologically appropriate, to reduce the cost in money and time for in-service training.
- Support groups should be strengthened since they are effective for prevention with positives (PWP).
- Donors can play a key role in improving the impact of projects through support to central level systems strengthening: training, supervision, HR systems, MIS, M&E, etc.
- All members of government and the development community need to place strong emphasis on establishing and maintaining open communication and smooth coordination among donor-funded projects to create greater efficiencies and best use of resources.

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

Provincial Situational Analysis in Year 2009

When A2C started implementing independently following the split of APHIA Nairobi/Central, 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). A2NC was mandated to support PMTCT at the District Hospitals in Gatundu, Thika, and Nyandarua Districts whereas all other districts excluding Nyandarua were supported by NARESA through CDC funding. 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 in the province/district levels. HIV treatment, as in previous years under APHIA Nairobi/Central, was supported in most major health facilities by the CDC-funded ICAP Project, such that A2C largely supported lower level facilities for this service, with a few exceptions.

Counseling and testing services built upon the successes of A2NC with strong partnerships with existing partners and the DHMT/PHMTs to improve service linkage and integration as well as mobile services. DHMT/PHMTs were supported to implement and supervise services at all levels of service provision directly through project activities and through a funded MOU with the PDMS and PDPHS. Lessons learned were applied to improve services and were shared at stakeholders' forums for replication at other partner levels.

1.1: Expanded Availability of HIV/AIDS Prevention, Care, and Treatment Services

Strengthening Prevention Services – PMTCT

A2C was broadly mandated to provide HIV/AIDS prevention, care, and treatment services in Central Province. However, in the area of PMTCT, areas of support were clearly divided by the USG agencies. A2C took over from Elizabeth Glaser Foundation all their supported sites at the award of this project. These included PMTCT sites in Thika District Hospital, Gatundu District Hospital, Nyahururu District Hospital, and Ol Kalou District Hospital. In Thika and Gatundu, Pathfinder through its CDC-funded project supported the remainder of public sector facilities. In other districts, NARESA under CDC was the PMTCT partner.

In Nyandarua South and North Districts, the lower level facilities (levels 2 and 3) had not started implementing and keeping records for PMTCT because health care workers (HCWs) had not yet received training in PMTCT at the start of the project period. One of A2C's successes in PMTCT was its expansion of PMTCT services throughout both Nyandarua districts.

During the project period A2C trained 664 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. Grants were provided by A2C to Christian Medical Mission Board (CMMB) and Christian Health Association of Kenya to further strengthen PMTCT in the faith-based organizations, and Gold Star Network (through Family Health International) in private facilities.

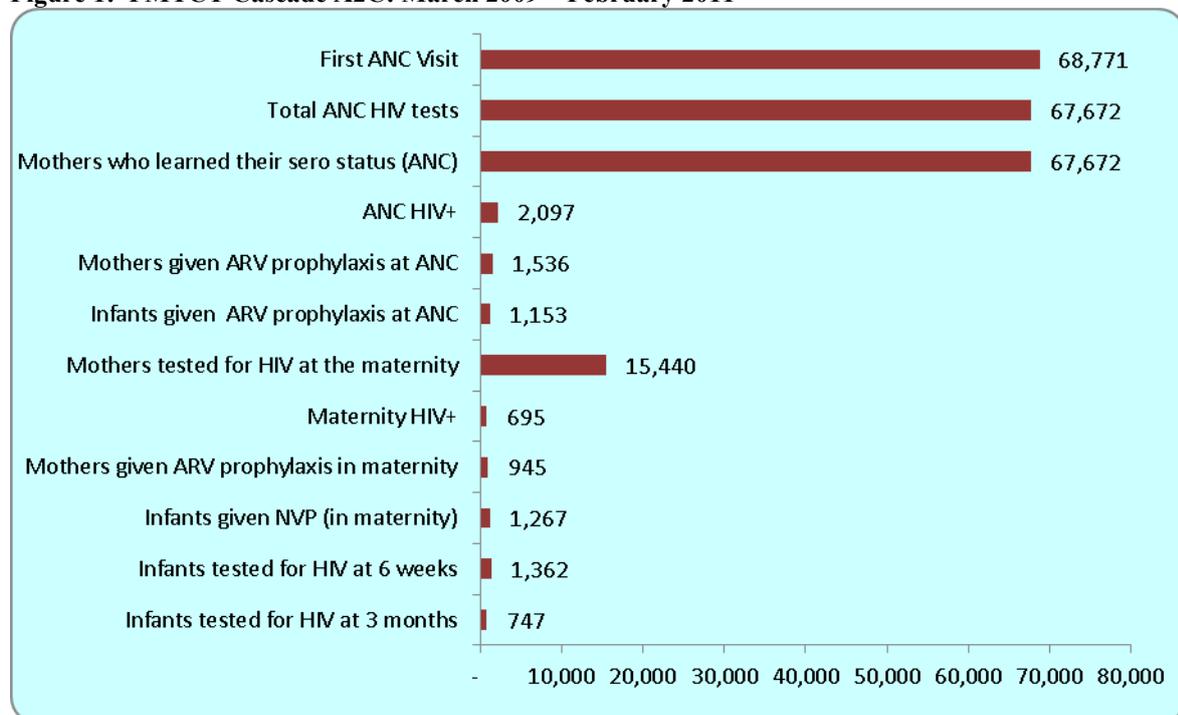
EID sensitization was provided to HCWs in the whole province to enable infected exposed infants to access ART services early in life as a requirement of the national guidelines. A2C clinic

site coordinators (CSC) offered technical assistance and supportive supervision in collaboration with DHMTs to assist in improvement of data management. The facilities were also supported with tools for the same. IYCF trainings were offered to further strengthen PMTCT through recommended practices of infant feeding like exclusive breast feeding. A2C's support to lab networking was established to ensure transport of DBS samples to the district hospital level for onward transport to the Nairobi testing center. This activity, which also benefited treatment clients, made EID possible. By seconding motorcycle riders to the districts under the DASCOS's supervision, management capacity and ownership was also strengthened.

All mothers who tested positive at the PMTCT supported sites were given Nevirapine (NVP) 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, dissemination and sensitization on new (current) guidelines, supportive supervision and technical assistance offered to the HCWs. Mothers who had previously tested positive but not been put on prophylaxis were also offered ARV prophylaxis at the maternity. According to the most recent government guidelines for PMTCT, AZT is used as prophylaxis 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. This regimen is referred to as the more efficacious regimen. A2C provided support to roll out this regimen through training and dissemination of the new guidelines. Drug distribution was also facilitated by A2C especially in areas like the Nyandarua, which face major challenges, such as rough terrain, vast distances between facilities, and poor road networks and infrastructure.

PHMT and DHMT buy in and 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 living with HIV in Central Province.

Figure 1: PMTCT Cascade A2C: March 2009 – February 2011



Strengthening Prevention Services - Counseling and Testing

KAPC was subcontracted to train counselors in Central Province as the number of counselors trained during the A2NC was not adequate to meet the service needs in the province and many VCT sites were closed due to lack of service providers at the facilities. Nurse counselors were frequently required to serve shortages in other departments of health facilities, leaving the VCT further handicapped in terms of staffing.

A2C trained lay VCT counselors affiliated with implementing partners organizations supported under Result Areas 2 and 3. These served on a voluntary basis at the VCT sites. In other areas, the gap in staff was filled by lay VCT counselors that were employed under A2C through the Capacity Project. In total, A2C was able to support 83 VCT sites in the province by the end of the project. However, as the Ministries of Health shifted their strategy away from VCT to PITC, and this led to a reduction of testing in VCT sites countrywide.

Figure 2: Number of Individuals Who Received Counseling and Testing for HIV and Received Their Test Results: March 2009 - February 2011



Also, the Ministries of Health began advocating for national accelerated counseling and testing exercises (Rapid Response Initiatives – RRI), and A2C strongly supported these activities in Central Province. The support for the RRIs included provision of consumables, support for logistics in hiring and transportation of tents and chairs, hiring of temporary counselors, refresher trainings of counselors, and support to P/DHMTs for supervision of the activities.

The objective was to sensitize the public during these 21 to 33-day periods of the need to test for HIV and to counsel and test as many clients as possible. During this period, drama groups supported by A2C and local administration played a major role in community mobilization. The most notable success was the FIFA World Cup RRI (June 11 – July 11, 2010), which saw increased counseling and testing of men, with nearly 49% male participation. The main objective was to reach as many men as possible at the places where they'd be frequenting to watch football matches. A2C also provided extensive support in mobile outreaches, logistics for test kit availability, and moonlight VCT through Hope World Wide Kenya (during RRI and throughout the project period) and other local partners.

KAPC was also supported by A2C to conduct trainings in pediatric psychosocial support, adherence counseling, couples' counseling in PMTCT, and VCT. Targeted for training were HCWs, CHWs, peer educators, and PLHIV, who assisted in improving counseling activities at the facilities level. Their participation and training allowed for task shifting, which alleviated staff shortages. Trained volunteers were used to support counseling services at the health facilities.

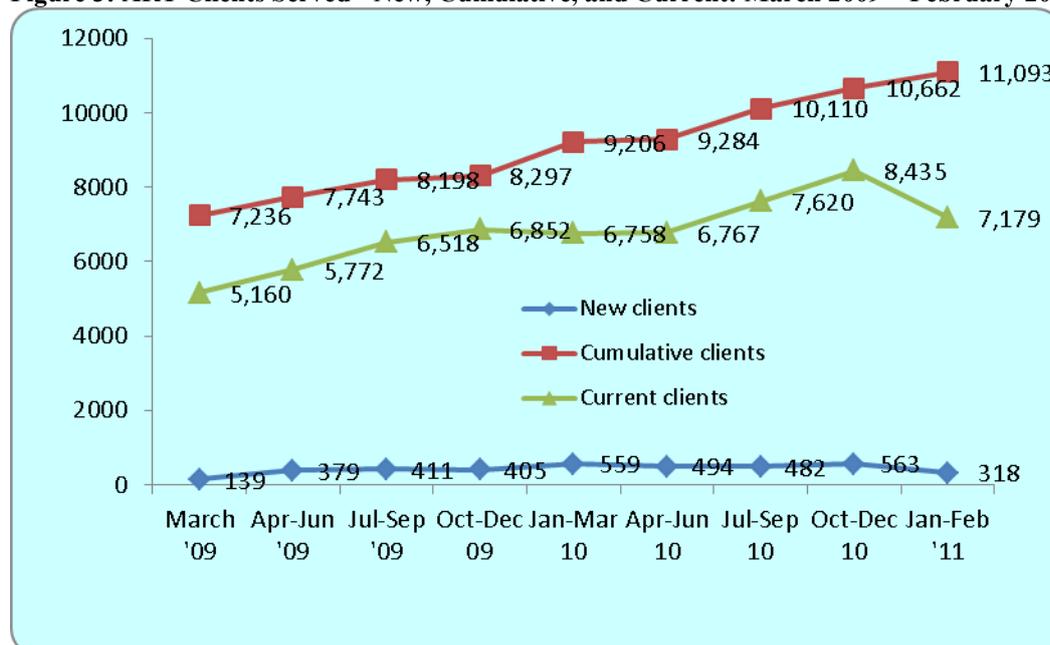
Care and Treatment:

Through A2C support, the province noted an increase 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, only 14 facilities were supported under A2C, most of which were level 3 facilities. The total number of facilities supported by the end of the project period was 45. Initially, 7,236 patients were on treatment, but the number rose by end of project to 11,093 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. By the third year of the project, A2C had added two level 4 facilities, Tigoni DH and Maragua DH, to the supported sites. Clients referred from VCT, PMTCT, DTC, PITC, and TB clinics were enrolled into care and treatment.

Training of HCWs in managing HIV positive patients increased their confidence in HIV management and thus motivated them to recruit more patients into treatment. The retention rate increased after the service providers underwent training 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.

The laboratory transport network was a huge boost to the program numbers as more patients became able to access immunological testing. Also, A2C trained HCW and CHW couriers in transportation of specimens to a hub lab, which served a cluster of facilities. As previously noted, motor bikes were also procured in selected districts and riders were hired by A2C to reach all facilities, making transportation of specimen faster and more efficient. This led to better case management due to the ability of HCWs to make timely diagnoses and better monitor treatment of those on ART.

Figure 3: ART Clients Served - New, Cumulative, and Current: March 2009 – February 2011



Integration of Services

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

Service providers at all A2C-supported sites were trained on care and management of the TB/HIV co-infected patient by the end of the project. TB screening took place at the comprehensive care centers (CCCs). Likewise, testing for HIV of TB patients was encouraged in the TB clinic. A2C assisted in compilation of the integrated data at district level. With the scale up of TB Intensive Case Finding (ICF) by NASCOP and DL/TLD, the project supported the provincial roll out to DHMTs, printing, and dissemination of the ICF tools through the PASCO for Central.

At the CCCs, where people living with HIV were managed, those patients who were TB/HIV co-infected were supported with food (Unimix, porridge flour) provided quarterly by A2C. 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 HCWs in CT into FP using the national curriculum. Service providers from facilities throughout 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 the data was properly managed.

The project further supported sensitization of health care workers in the integration of FP into CCCs, meaning that FP services were integrated into CCC services for PLHIV.

Nutritional Support

A2C provided training to service providers in IYCF and nutrition in HIV/AIDS using the national curriculum. Weighing scales with stadiometers were procured and distributed to supported facilities. In addition, pediatric weighing scales were provided to supported PMTCT sites to further strengthen measurement and recording of anthropometric parameters at supported sites.

A2C facilitated support to DHMTs in distribution of multivitamins and IEC materials to facilities as need arose.

Through complementary funding from UNICEF, between August and December, 2009, Pathfinder was able to build on A2C's foundation in the province to introduce a targeted IYCF and Baby-Friendly Hospital Initiative, which strengthened the quality of IYCF and a BFHI for increased infant survival at 16 facilities and surrounding communities. The activity was a good example of how the project boosted its impact and built MOMS/MOHP capacity by adding small but well-placed resources from another donor.

Access to Pediatric HIV Treatment

At the inception of the project, less than 10 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. A2C supported training in basic pediatric ART to 84 service providers through a subcontract with Gertrude's Children's Hospital and provided technical assistance to facilities that were providing pediatric care and treatment through the clinic site coordinators.

Cotrimoxazole was made available to facilities for prophylaxis: all A2C 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, and linkages were made to A2C's OVC program. Further support was provided by training peer educators to provide pediatric psychosocial support through KAPC.

Strengthening Laboratory Support

By August 2009, there were seven hospitals with CD4 machines offering services to HIV-infected patients in public, faith-based, and private health facilities in Central Province. Aphia II Central was mandated to bring HIV services to the most peripheral health facilities in the province without laboratory capacity for CD4 test, liver and renal function test, or even hemoglobin estimation. It became necessary, therefore, to link these rural health facilities to labs in nearby district hospitals to facilitate diagnosis and monitoring of ART treatment. This laboratory transport network helped to improve and support the diagnostic process.

To start the laboratory transport network, service providers from every district attended a one-day sensitization meeting supported by A2C. Afterwards, some A2C 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, A2C procured motorbikes and hired riders to transport the specimens, especially in distant and hard to reach areas with challenging terrain, such as those in the Nyandarua Districts. Specimen collection vacutainers and cool boxes were procured and distributed to support the laboratory transport network.

During the same period A2C supported selected and needy facilities by procurement of hemogram machines. Microscopes were also procured and distributed, and laboratory technicians trained in TB microscopy to improve their skills in TB diagnosis. Linkages were made with KEMRI CDC laboratory to facilitate early infant diagnosis (EID); the dry blood spot specimens (DBS) were transported to the nearest G4S courier point by either the lab personnel or the A2C motorbike riders. A2C supported x-ray networking for HIV-infected patients in all districts. Patients were referred to the nearest level 4 or 5 facilities that had x-ray support through an agreement between A2C and the medical officer in charge of the facility. The facility would provide chest x-ray services to patients through an account that was credited to A2C.

The project supported X-ray services for clients attending supported CCC in the province, by subcontracting private/FOBs and M.O.U.s for government facilities. This improved the diagnosis and treatment of HIV/TB co-infected clients and greatly enhancing TB/HIV collaboration.

Quality Improvement

Quality improvement through performance monitoring as well as use of data for decision making was supported through formal training, CMEs, mentoring, and data reporting and analysis meetings. Focused QI efforts in selected facilities were also brought on board during the course of A2C's implementation. External quality assurance, especially of laboratories where TB was being diagnosed, was implemented with support from A2C and the PTLC office. Supportive supervision was provided by PHMT and DHMT members, who were facilitated by A2C with transport under the PDMS/PDPHS MOU. Technical assistance during the project period was provided by A2C clinic sites coordinators to further strengthen services in all areas supported by

A2C; NARESA mentors complemented this TA with higher-level inputs. Please see the full Quality Improvement section at the end of this report.

1.2: Expanded Availability of FP and MCH Services

Expanding Access

Central Province is vast with poor terrain; the poor road network hampered access to pockets of hard to reach areas like Nyandarua North and South Districts. Service provision to the communities remained a challenge due to poor access to services at level 3 and 4 facilities; some dispensaries were not equipped or lacked trained HCWs to provide FP and RH services. The communities' socio-economic status is mainly in the lower bracket and inability to afford transport alone deters clients from seeking services elsewhere. A2C identified a need for contraceptive technology updates in Nyandarua North and South, and a total of 153 service providers were trained after which they developed implementation work plans. A2C supported the redistribution of commodities from the District Reproductive Health Office (RHO) to these facilities, which further improved access to family planning service.

A2C managed to support expansion of 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 also undertaken by A2C to improve service provision in the province.

During the project period, support to facilities offering RH services that previously received support from A2NC was maintained, with one extra site added. Thus, A2C increased the number of supported facilities from 152 to 153 by close of the project. The total couple year protection continued to rise throughout the project, with a total of 282,474 CYP provided to Central Province through A2C 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 641 HCWs were trained during this period.

Long-term Family Planning

For some time the FP program provided combined oral contraceptives and depo injection, as the two methods were easier to administer. Staff shortage might also have influenced the choice of method by service providers. A2C worked to improve the method mix and quality of services through an 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 (supported by R2) groups as well as HCW provided the health talks.

Long acting methods of family planning were not popular and the trend was still low hence the need to increase the use of IEC materials and peer counselors. 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 normally available and preferred by many clients as they do not have to make a daily decision to take a pill.

FP/HIV Integration

A2C built on previous work done under APHIA II Nairobi/Central, which integrated FP services into PMTCT services and brought VCT and FP services together where possible through continued support to both integrated sites as well as FP clinics.

Antenatal Care

A2C received very limited funding intended for support to ANC services. However, through its PMTCT services support and community level work, the project was able to contribute to strengthened ANC services. The care of a woman during pregnancy depends much on her initiative to seek services. 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 HCWs and regular updates on PMTCT as per the national guideline. Close collaboration with CMMB, which was 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 selected facilities, whereas A2C ensured that all the HCW were trained on Infant and Young Child Feeding (IYCF). A2C also supported CMEs during which the district public health nurses (DPHN) gave updates on focused antenatal care, the five doses of tetanus toxoid schedule, and other immunizations. Health care workers were given targets per district for the number of women who should receive services at antenatal care.

A2C also provided the facilities with blood pressure machines, stethoscopes, thermometers, and other basic clinical equipment.

Maternal and Neonatal Child Health (MNCH)

MNCH is a very important component of the health care service delivery system that is meant to address the MDG 4 and 5. According to the most recent KDHS, Kenya as a country is deteriorating in the attainment of the MDG 4 and 5. Thus, there is an urgent need to scale up MNCH/malaria interventions to address this. In the inception of A2C, from August 2009 very few MNCH activities were undertaken then due to limited funding received by the project for such activities. However, the following was achieved:

- Support for Malezi Bora (Child Week) campaign to emphasize better feeding practices and child health activities.
- Private service providers were trained on FP to facilitate integration of FP services within ANC and maternity settings as well as IYCF to offer pregnant and lactating mothers appropriate nutrition counseling and follow up in PNC as per the national guidelines.

Funds for the MNCH/malaria program became available in mid-2010 and A2C embarked on the following activities:

- One week support for Malezi Bora GoK initiative in all the districts.
- Drama groups staged themes on BCC to promote prevention and treatment of malaria in the five malaria-prone districts.
- Training of 87 health care workers in all levels of the health care system to address emergency basic and comprehensive obstetric/neonatal care.
- Training of 77 health care workers in all levels of health care system in five malaria prone districts in malaria case management in pregnancy and childhood.

- Training of 57 health care workers in all levels of health care systems on IYCF/ counseling.
- Dissemination of training manuals, job aids, knowledge, and essential skills obtained by participants to other staff through CMEs and OJT.

Labor and Delivery

The project received very little funding dedicated to this activity. However, through its general support to RH/FP and HIV/AIDS services, some limited benefits were seen for labor and delivery. During facility needs assessments it was noted that there was still need for more delivery beds in some lower level facilities. At the same time, awareness had been raised on the need to advocate for women to access maternity services to improve deliveries under skilled attendants. A2C addressed the need by procuring and distributing additional delivery beds to selected health facilities under its PMTCT program as part of its overall effort to strengthen PMTCT services. The selection was done in collaboration with the PHMT/ DHMTs. An additional 10 beds were delivered to supported facilities during the month of November 2010. Further to the procurement and distribution, A2C supported trainings on emergency obstetric care, among others, under the MNCH activities implemented in the months of November and December 2010.

Post Abortion Care (PAC)

The historically negative attitude of health care workers towards women in need of post-abortion care has always hindered service uptake. Many HCWs believe that the patients are guilty of an offense and thus delay intervention. In most circumstances, RH services providers at all primary health care levels have conducted manual vacuum aspirations without being aware of the existence of a comprehensive PAC package. PAC has been supported by training 30 service providers and providing them with training with MVA/PAC kits through private funds/other donors, and through follow-up technical assistance. A2C continued to support sensitization of staffs in facilities on PAC.

The project, in collaboration with the Provincial/District RH coordinators, followed up on provision of youth-friendly post abortion care (YFPAC) services (a combination of YFS with PAC) in facilities where the service had been established by A2NC jointly with private funding from Pathfinder International. The facilities were: Tigoni, Thika and Gatundu District Hospitals. Comprehensive, quality PAC services are not yet institutionalized in Central Province and are therefore difficult to maintain without broader support. Thika, Ruiru and Nyeri PGH did continue to provide YFPAC services, and others were continuing to provide PAC broadly. In Ruiru, the YFPAC services link to a wider youth approach with Ruiru partners that is described below. The challenges to maintain YFPAC in Gatundu and Tigoni were related to staffing and space constraints. But, it is important to note that some staff from each District Hospital were trained on YFPAC, such that the activity can be re-invigorated.

Cervical Cancer Screening

Cervical cancer screening was rolled out in the province through training and later dissemination of the same to the districts and later peripheral clinics. The project was able to support monthly cervical cancer screening campaigns in every district, greatly improving the lives of women of reproductive age and impacting greatly on survival rates in cancer of the cervix due to early diagnosis and referral. Sustainability was achieved through procurement of speculums, examination beds, torches, and ingredients that were distributed to facilities after the district campaigns

Youth Friendly Services (YFS)

A2C supported the establishment of YFS in a number of facilities. Staff were trained from each district hospital in YFS and youth friendly desks were established in facilities that did not have adequate space for a youth friendly clinic. Lack of space and staffing are ongoing challenges to implementation, however notable successes included the A2C model in Ruiru and sustained services at Nyeri PGH.

In Ruiru, A2C used a multi-pronged approach to delivering youth-friendly services. Service providers were trained in YFS and YFPAC, and by leveraging private funding from the Kahrl family, a Pathfinder benefactor, as well as the USAID-funded, Pathfinder-led COPHIA Project, A2C was able to renovate and expand the Ruiru Health Centre (later transformed to a Subdistrict Hospital) MCH clinic, including sufficient space for youth activities in a separate waiting area for youth. A2C supported the local youth group, Focus, to build its skills for community outreach, drama presentations, and educational activities, as well as its organizational capacity. Focus conducted extensive street theater activities in Ruiru District, disseminating a wide variety of messages around HIV and AIDS prevention, care and treatment, TB and RH/FP, including YFS and YFPAC. A third partner, situated on the grounds adjoining the health facility, was the Ruiru Bible Baptist Church. RBBC, a long-time, home-based care partner under the COPHIA Project, continued to support HBC, OVC, and HIV prevention activities under A2C. Ruiru Baptist in turn also supported Focus by providing the group with a small office space on the church's grounds. A2C supported Focus to transform the office into a resource center for youth in the community and trained selected members in VCT counseling.

The Ruiru YFS became an important success story with impact in the community. Focus group members continued to staff the YF desk within the health facility and to provide educational talks and theatre to youth waiting for services, in addition to their regularly scheduled outreach work. Health facility staff benefited greatly from the support of the Focus Group. Co-location with the HBC/OVC partner organization greatly facilitated linkages between the different components, including attention to older OVC in need of RH information and services and involvement of younger people in HBC activities.

Men as Partners

Throughout the duration of the project, more men were tested during MVCT outreaches than were tested at VCT sites. This was attributed to the fact that MVCTs find men at their places of work or social activities. Literature shows that men tend to have poor health seeking behavior, including HIV counseling and testing. Innovative approaches like invitation cards to the ANC were piloted with an MoH tool for this purpose, but this initiative had limited success in Central, similar to other sites where it had been tried by Pathfinder's sister PMTCT Project.

Providing 'fast track' service for couples accessing ANC services together, however, was more successful. GoK Rapid Results Initiatives (with A2C support) also had some effect: during the November 2009 HCT RRI, more men than women were tested for HIV in Nyeri PGH. Also, during the FIFA World Cup RRI in June-July 2010 when the campaign targeted men and couples, the proportion of men tested was considerably high at approximately 49 percent compared to women. Notably, the overall number tested surpassed the targets by over 30 percent. It is hoped that with the new project, the province will be able to implement more innovative ideas, such as strengthening the use of the invitation cards to ANC and build on this demonstrated openness of men to be tested

1.3: Reinforced Networking Between Levels of Care and Between Clinical Services and the Community

As the program expanded, linkages between levels of care were established and A2C distributed referral forms to enhance documentation of referrals from facility to facility and between departments in the same facility. The same forms were to be used in the community to record 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 A2C's presence was well established like the southern part of the province and the Nyandarua Districts. As had been planned, A2C supported the government to train more CHWs and established community units around most of the facilities. Health education in supported facilities was offered by peer educators and advocates supported by A2C. The MOH referral tool was employed for community-facility referrals.

Through project support, CMEs were conducted at the district levels, empowering the service providers with useful knowledge that made it possible for decentralization of HIV services to level 2 because the facilities can continue with care of patients once treatment is initiated at levels 3 and 4 facilities. The project provided chest x-ray support to supported Level 2 sites by paying for the radiograph and reporting of the films. This improved diagnosis capabilities and further management of patients with TB or any other chest-related illnesses.

The Gold Star Network was subcontracted by A2C to support the private providers in expansion of care and treatment services. They were 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 they serve in a private or public facility; they are all empowered through trainings and support supervision. The private practitioners have been reached mainly in major towns in the province.

The community component for clients of private providers was a challenge and thus stigma reduction and psychosocial support was required. Psychosocial support groups were established by GSN support for clients in private facilities and this went a long way in reducing stigma and improving adherence to treatment and care.

Infrastructure improvement

During the project period, A2C supported the improvement of infrastructure for enhanced service delivery through procurement of furniture, equipment, and minor and major renovations. The decision on which facilities to support was entirely led by the P/DHMTs and P/DMSTs with advice from A2C. The following are the activities implemented:

- Procurement and distribution of office/ clinic desks, chairs, computers and printers (for selected DHMTs), and filing and drug cabinets.
- Procurement of cryosurgery machines.
- Procurement and distribution of TVs, D/VCDs, and TV stands for YFS clinics for viewing of education materials
- Procurement and distribution of equipment for Solio Ranch Dispensary.

- Renovations of the Thika DH PAC Ward, Tigoni Laboratory, Murang'a DH PAC Ward, and Mawingu Shalom Dispensary (former IDP Camp). All the renovated sites received the basic equipment/furniture needed for service delivery.

Result 1 Challenges, Lessons Learned, and Recommendations

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). A2C linked the facilities to the district pharmacies where they were able to send their reports on drug consumption and replenish their ARV drug stocks. A2C sourced and redistributed ANC registers as well as the daily activity registers to monitor PMTCT activities at the ANC. Further to that, the Service Delivery Specialist established links with Kenya Pharma and facilitated facilities' access to Kenya Pharma for streamlined availability of ARVs.
- 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 A2C trained 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. It would be advisable to have nutritionists stationed in each care and treatment facility.
- The shortage of staff especially at public facilities hampers service quality as sometimes only one HCW provides all the services at the facility, e.g. FP/RH, MCH/ANC/PMTCT, TB, etc.
- Infrastructure was often quoted by health care workers as a hindrance to implementation of CCC and Youth friendly services. Integration of services was therefore encouraged by A2C and extra furniture was provided to maximize utilization of available space.
- Provision of high quality family planning services, including full method mix, continues to be periodically hampered by stock outs of some methods
- Attracting men to the health facility and engaging them in RH issues is a challenge. Fast tracking services for couples in ANC (for PMTCT purposes) is one approach that has shown some initial success.
- It is important to locate resource centers near the health facility, yet not as part of the facility, to encourage referrals. Locating outside the facility helped the youth group retain their focus on prevention and work at the community.
- Edutainment proved to be a very good mobilization tool and also very successful in passing information to the community members. Likewise education through listening (ETL) proved to be one of A2C's most successful approaches that helped the youth really open up during the sessions.
- Youth friendly services do not require entirely separate clinics for the youth. In Ruiru, the youth desk help reached out to the youth and assisted the youth in navigating through and accessing services at the health facility.
- Introduction and provision of FP and RH services at the resource center was a great success in improving access to these services by the youth.
- Cervical cancer screening and treatment has not been mainstreamed and therefore supplies needed for the activity not supplied through the government system and

depended almost one hundred percent on A2C. However, the larger facilities could support screening as they have a stronger financial base. Rural health facilities, where the bulk of the population access health care, are not able to support the screening on their own. Another challenge is the absence of government registers and reporting tools, which leads to difficulty in capturing the number of screenings done.

- The community-facility referral tool is still not widely or consistently accepted due to design and availability issues.
- Infrastructure was often quoted by health care workers as a hindrance to implementation of CCC and youth friendly services. Integration of services was therefore encouraged by A2C and extra furniture was provided to maximize utilization of available space.

Recommendations

- In view of the chronic staff shortage that exists at the facilities, A2C found it necessary to encourage task shifting in most areas.
- 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.
- Cervical cancer screening should be continued through the APHIAplus projects and be built into their sustainability plans. Cryotherapy is still a relatively new technology; therefore, doctors and other health workers not very familiar with its use. This requires intensive training and sensitization.
- For stronger community-facility linkages, CHW should be based at facilities to strengthen defaulter tracing, support group facilitation and community health talks.
- The MOH can improve facility-community referrals and uptake of services with more attention to the tools, their availability and application.

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

2.1: Expanded and Strengthened Community and Workplace Prevention Formal Workplace Sector

The implementation of workplace prevention program activities was successfully expanded and strengthened during the project life of A2C. Ultimately, the project supported 100 worksites to develop and adopt comprehensive workplace HIV/AIDS program packages. Key activities included company surveys (knowledge, attitude, and behavioral practices), management trainings/sensitization meetings, workplace stigma and discrimination reduction trainings, peer education trainings, and promotion activities. In order to effectively implement the program and ensure cohesive policy development, the Federation of Kenya Employers (FKE) developed reference materials including a peer education training manual; workplace HIV/AIDS coordinators' training guide; and the National Code of Practice on Workplace HIV/AIDS in collaboration with Ministry of Labour, Central Organization of Trade Unions, ILO, and NACC (National AIDS Control Council).

Clustered HIV/AIDS Enterprise Partnership

In April 2009, FKE adopted a new approach, called the Clustered HIV/AIDS Enterprise Partnership (CHEP) network, to address work place HIV/AIDS issues as a holistic and collective responsibility. The objectives of the CHEP network are to increase knowledge on HIV/AIDS dynamics in workplace, influence behavior change at company level and within the companies' sphere of control, reduce stigma and discrimination in workplaces, and leverage HIV/AIDS interventions through collective efforts. Through A2C support, three CHEP Networks (Ruiru, Mt. Kenya, and Nyandarua) consisting of 30 companies in Central Province were formed. Each CHEP network consists of a committee with representation from each enterprise (worksites).

Five company nurses from Ruiru CHEP received training in HBC and PITC to empower them with knowledge and skills to counsel, test, and support the other workers on aspects of HBC. Through linkages to MOMS and MOPHS facilities, more than 500,000 condoms and 60 condom dispensers were distributed to various worksites. Referrals and linkages to health facilities and Gold Star Network were effectively done with 40 companies linked to treatment, care, and support services.

The project supported formation of two PLHIV support groups comprising of 60 members; one for Ruiru CHEP members and another one for the health care workers in Central Province. Support groups offer a social forum within which issues affecting members as HIV positive employees are deliberated. Some of the key issues addressed are ways of helping other workmates to disclose their status, supporting coworkers, and helping each other live positively.

Workforce sensitization was done through the peer educators, who reached 20,200 workers with basic HIV/AIDS information. This also saw workplace HIV/AIDS policy development, review, and implementation in 40 worksites whereby technical support was offered to ensure effective and efficient running of the processes.

Distribution of more than 2,000 HIV/AIDS IEC materials (posters and brochures) to the work sites was conducted in collaboration with DASCOS and DPHOS from the various regions. This

enhanced workers' knowledge and awareness on the program. FKE also distributed technical support materials including posters, brochures, training manuals, coordinators' training guides, and National Code of Practice on Workplace HIV/AIDS to the worksites.

Joint and promotional activities like Youth Tournament in Ruiru CHEP and World AIDS Day were also organized and supported. Through these events, 800 people were reached and sensitized, received counseling and testing, and gained access to distributed IEC materials and peer education sessions.



Peer educators during a training at Bata Company

To amplify and sustain the HIV/AIDS Workplace Program, the project trained 450 peer educators for the worksites. Ninety-nine managers were also trained as facilitators or workplace HIV/AIDS program coordinators in their companies to spearhead the initiative. The peer educator's role is to positively influence the behavior of their peers by providing HIV/AIDS information, acting as a role model, and providing or referring workers for health services or products. Out of those trained, 389 peer educators were also counseled and tested. In addition, 587 senior managers from 21 worksites were sensitized on workplace HIV/AIDS program to enhance institutional buy-in of the program.



Healthy Images of Manhood (HIM) training for APHIA II Central Staff

Healthy Images of Manhood (HIM) training was provided for 34 APHIA II Central staff to give the men adequate knowledge in understanding the negative effects of gender norms and stereotypes on their health and the health of their families.

In addition to the workplace program, the project PLHIV advocates carried out workplace sensitizations to various worksites.³ The

³ Wangige Health Centre, Kenya Women Finance Trust, The Provincial Administration Kibaral, Gatundu Post Office, Muthithi Gardens LTD, Carzan Flowers Ltd. Engineer, Olkalou Water & Sewerage Company, Mabee Flower Farm, Highlands Plants Ltd, Kirinyaga County Council, Nyeri County Council, Ihururu Dairy Workers, Kenya Revenue Authority Nyeri, Nyeri municipal workers, Red Land Roses, KRA Thika, Gachie Police Station, Kenya Women Wangige branch, Kenol Administration Police, Olkalou Police Station, Olkalou Water Supply Office, Primarosa Flower Farm, Mabee Flower Farm, Anima Farm Staff, Kiambu Municipal Council Staff, Sasisni Ltd, Wang'uru County Council, KRA Nyeri, Nyeri Municipal Workers, Nyeri Water & Sewerage Company, Lichi Securities, Loreto Girls School Limuru, Limuru Girl's School, Kiambu Secondary School, Hassana Children's Home Staff, Citymark Security Company, Maragua Municipal Council, GK Prison Kin'gon'go, KRA Nyeri Branch, Nyeri Municipal Council, Kagumo Teachers Training College Non-teaching staff, Nyeri County Council, Olkalou County Council, Olkalou Police Station, Nyabururu County Council, AIC Secondary School Teachers, Muthithi Gardens, Magumu Coffee Plantation, Kebabu Cofee Estate, Vision School of Hair Dressing, Limuru Red Cross, Wida Highway Motel, Sasini Ltd, Kiambu West LATIF Committee, Kiambu CACC, JKUAT, Pollen Ltd, Superfoam, Kenya cuttings, Nazareth Hospital Health Care workers, Tigoni Health Care Workers, Limuru Health care workers, Wangige Health care workers, Gichuru Health care workers, Kiambu Health Care Workers, Delmonte, KRA Thika branch, Thika Teachers, AA Growers, and Thika County Council.

advocates, some of whom were trained as VCT counselors, provided counseling and testing services. The worksites made use of these services with at least half of the sensitized workers willing to learn their HIV status. By training the advocates as VCT counselors, the project met the needs of CT during outreach events, which is a more cost effective approach than taking a mobile VCT to the worksite.

The project also targeted teachers in schools through the “school as worksite” program. Through this approach, the advocates sensitized the teachers in the schools⁴ with the *Chill* program on HIV/AIDS-related subjects.

Informal Workplace Sector

The project-supported PLHIV advocates sensitized persons working in the informal sector. The advocates carried out HIV/AIDS sessions targeting motorbike riders (*boda boda*), *matatu* (public passenger transport vehicles) industry personnel, *jua kali* artisans, charcoal dealers, market stall owners, construction site workers, and barmaids and saloon workers.

Thirty *matatu* drivers and conductors from Karatina, Nyandarua, and Ruiru were trained as peer educators. They were equipped with knowledge on HIV and facilitation skills that enabled them to reach their peers with information and promote health services. They were trained on HIV basic facts, risk perception, condom use and efficacy, VCT, drug use and abuse, TB, stigma, and discrimination. The participants were provided with the PSI workplace/community HIV/AIDS facilitation manuals, Siri job aids, and penile models. The trainers were PLHIV advocates and MOH staff. This training was carried out in collaboration with the FKE workplace program.

2.2: Expanded Preventions Program Targeting MARPS

From March 2009, 14 drama groups that had been trained under A2NC carried out outreach events to high-risk communities in slums, including Majengo and Witeithe in Nyeri; Maina and Manguo in Nyandarua; and Kiandutu, Makongeni, and Witeithe in Thika. The topics addressed included condom use in prevention, stigma and discrimination, VCT and trusted partner myth, and self-risk perception.

To ensure that correct messages were delivered during the outreaches, joint supervisory visits were made by field officers and relevant MOPHS officials (DASCO, DHEO, and NACC representatives) to evaluate the outreaches. To maintain outreach quality, the drama groups and other cadres of volunteers received monthly topical updates on condom use, VCT, PMTCT, and RH/FP.

Education through Listening

Through A2C, 192 community volunteers (102 male and 90 female) were trained on a facilitation technique known as Education through Listening (ETL). Nine four-day trainings were carried out in Nyeri, Kirinyaga, Murang’a North and South, Thika, Kiambu West, Nyandarua North and South. The participants were volunteers who conduct health education in the community, including PLHIV advocates, youth leaders, members of youth groups, and CHWs. ETL training is a shift from the traditional health education to a methodology that is people-centered in order to enhance participatory and productive community dialogue, resulting in behavior change.

⁴ Ngaindeithia, Weru, Rurii, Madaraka, Nyandarua Boarding, Ritaya, Mung’etho, Kiganjo, Ndaragwa, Oljororok, Tumu Tumu, Karatina D.E.B., and St. Joseph Kiangage Primary Schools.

Prison Program

A2C fought HIV/AIDS infection within the prison community (inmates, prison wardens, and their families) in Central Province through: (1) Training peer educators among inmates and staff members; (2) Training inmates in drama and theater skills; (3) Sensitizing inmates, staff, and their families on HIV/AIDS; and (4) Conducting mobile outreach on counseling and testing in all the prisons in the province.

Prison wardens from Nyeri Command and Thomson Falls Prison were sensitized on HIV/AIDS topics such as HIV epidemiology, trusted partner myths, VCT and its role, opportunistic infections and STIs, tuberculosis, stigma and discrimination, and positive living. During one of the workshops, a warden confessed that she had lived fearing that she was HIV positive for 18 years because her last partner had died of AIDS-related complications. She got tested and learned her HIV status that day.

Seventy-nine long serving inmates from Nyeri Main, Muranga, and Thika prisons were trained as peer educators. They were equipped with knowledge to help them to reach their fellow inmates and society at large. After the training the participants were given manuals and penile models for use during sensitization sessions. The sessions focused mainly on HIV basic facts, drug and substance abuse, and MSM. 50 prison wardens were also trained as peer educators with the aim of equipping members of staff with information. Both the inmate and warden peer educators were trained on HBC.



Inmates at Nyeri Main Prison during a peer education training session

Forty-five inmates from Nyeri Main, Murang'a and Thika prisons were trained in HIV/AIDS and theater skills. With this capacity, HIV messages were delivered cost-effectively by inmates instead of hiring outside drama groups from outside.

Overall, A2C reached 3,000 clients in the prison community with HIV counseling and testing services. Those who tested positive were effectively referred for further management.

Transport Corridor Activities – *Matatu* Drivers and Conductors Program

Through a partnership with the *Matatu* Drivers and Conductors Welfare Association (MADCOWA), A2C reached a large number of *matatu* industry personnel at *matatu* termini and through workshops.⁵ These targeted outreaches always included a mobile VCT to test any willing personnel. In addition, 53 *matatu* personnel representing various urban centers in Central Province were trained as peer educators in collaboration with FKE. Through this, the *matatu* program became more sustainable and effective.

Commercial Sex Workers

The Improving Prevention Education and Services for Sex Workers (IPESS) subproject targeted one of the most inaccessible high risk populations, female sex workers and their clients. Specific project activities included: providing counseling and testing (CT) services through mobile, workplace, and moonlight VCT; providing STI treatment for sex workers and their clients; sensitizing stakeholders (sex workers, bar owners, bar hostesses, bar managers, and pimps); training sex workers as peer educators; providing HIV BCC and OP messages to sex workers,

⁵ The workshops mainly covered the following sessions: Basic Facts about HIV/AIDS, Trusted Partner Myth and Self Risk Perception, Condom Self Efficacy, Stigma & Discrimination, STI's, Drug Abuse and TB

their clients, and other most at risk populations; setting up functional condom dispensers; distributing condoms; linking sex workers to economic support groups and psychosocial support groups; providing sex workers and PLHIV with livelihood skills support; supporting sex workers to join or initiate support groups; and distributing anti-stigma messages.

Accomplishments

- 12,889 sex workers and clients underwent voluntary HIV counseling and testing.
- 69,737 sex workers and their clients were sensitized on prevention messages.
- 309 sex workers were trained in peer education, 202 linked to psychosocial support and 75 to safety nets.
- 392,497 condoms were distributed and 23 condom dispensers mounted at the hotspots.
- 280 stakeholders sensitized.
- 13 support groups for sex workers formed.
- 263 sex workers and their clients provided with STI treatment.
- 45 sex workers provided with alternative livelihood skills support.

Youth Activities

Chill Club Program

Following the initial approval from the Ministry of Education during APHIA II Nairobi/Central, the project continued to implement the Chill Program. The curriculum⁶ had been adapted from the Kenya Adolescent Reproductive Health curriculum in 95 schools in the province. Chill sessions were participatory as a result of the facilitation methodologies used by the youth leaders, which made the pupils open up. This was done through interactive games and role plays. One-day stakeholder review meetings to discuss program achievements, challenges, gaps, and recommendations were held annually at the district level and brought together Ministry of Education officials, head teachers, Chill Club patrons, parent and teachers association representatives, youth leaders, and the program beneficiaries.

Table 2: Children in Chill Club Program: April 2009-February 2011

Total Number of Children Benefited from the Chill Club Program in Primary Schools April 2009-Feb 2011		
KGGA and Chill Clubs	Chill Clubs Only	KGGA Only
204,459	14,179	190,280

Based on lessons learned under the first phase of the project, youth leaders received training on basic counseling skills conducted by the Kenya Association of Professional Counselors. They were able to counsel the Chill Club members and other adolescents on diverse issues, such as dysfunctional families, boy-girl relationships and sexual exploitation, parent-child relationships, resisting peer pressure, and how to avoid drugs and substance abuse.

Chill graduation events known as chill fun days were held in all districts that had the Chill Program running in Nyeri, Thika, and Olkalou Clusters. The objective was to celebrate successful completion of the weekly sessions that started at the beginning of the year and to

⁶ The following are the topics contained in the Chill curriculum: values, life cycle, adolescence and puberty, reproductive systems, reproduction myths, healthy relationships, communication, parent/child relationships, friendships, love, infatuation and romantic relationships, cross-generation relationships, introduction to gender, gender stereotypes, sexuality and behavior, self-esteem, assertiveness, 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, and facts and myths about STIs.

provide a forum for Chill Club members from all the schools in each district to meet and interact. Activities included team building games that included messages based on the Chill ARH and life skills curriculum. Other activities included creative performances by the students, quiz games, and dance competitions. The events were graced by local opinion leaders; A2C and PSI staff; and district representatives from the Ministry of Education (MOE), Ministry of Health, Ministry of Culture and Social Services, and the Children's Department.

Essay writing and art competitions were held in 2009 and 2010 with all the 95 chill schools participating. In 2009, the essay topic was 'The challenges I face as an adolescent trying to chill (abstain) from sex.' Several serious challenges were raised by students in their essay write-ups, including peer pressure, access to internet pornography and media influence among others while in 2010 the topic was 'Things I do that help me to chill.' The writers of the best essays were awarded book vouchers.

Sanitary towel training was continued in schools targeting girls in classes 6-8. This intervention was carried over from a linkage made under A2NC between the Chill Program and the project's OVC work, where the activity began. These sessions were facilitated by the youth leaders. The training covered basic hygiene and how to make, use, and clean the alternative/improvised sanitary towels. The pupils were encouraged to share what they learned with other girls. Lack of hygienic sanitary towels is common among girls from poor families, particularly from rural areas. Several girls use unhygienic materials such as pieces of cloth, tissue papers and pieces of blankets which lead to infections. In addition, cases of absenteeism are common among girls during menses. This initiative was lauded by teachers, parents, and Ministry of Education officials in the region.

In December each year, youth leaders reached adolescents who had undergone circumcision with information on adolescent sexual reproductive health and life skills. These adolescents are at risk of HIV infection and other STIs due to a cultural practice known as *kubura mbiro*, which means 'to wipe away the soot' in the local dialect. The boys are encouraged by their peers to engage in sex to legitimize their passage into manhood. They were reached in camps organized by faith-based organizations where they spent about eight days during the healing process.

School Drama Outreach

Twelve community theater groups from seven districts underwent training on sexual adolescent reproductive health, life skills, and theater skills using the Chill curriculum. The drama groups were trained to enable A2C reach schools that were not being served by either the "Chill" program, KGGGA Adolescent Reproductive Health Program, or similar programs in the region. The community theater groups reached a wider audience because, unlike the Chill Program, which targets only class seven students, they are reaching class five to eight students. The outreach began in June 2009. Some of the topics addressed through skits, memory verses, song, and dance were: cross-generational relationships, teenage pregnancy, drug and substance abuse, resisting peer pressure, and being assertive. The response from the students and teachers was very positive and in most schools the level of participation was high.

OVC Outreach

Youth leaders reached OVC with life skills and sexual and reproductive health messages. The sessions were organized by A2C in collaboration with the implementing partners supporting OVC activities (Shandumu, Olkalou Fountain of Hope, and Upendo Community Based Organisation). The topics covered included sexuality and behavior, HIV/AIDS and STIs, drugs and substance abuse, resisting peer pressure, sexual exploitation, and rape and gender violence. The youth leaders used innovative ways to break the ice and engage participants, such as

energizers and the education through listening (ETL) facilitation methodology. Overall, the sessions were very participatory. It was noted that the OVC had a lot of misconceptions and myths regarding HIV/AIDS. They could name the drugs that are commonly used and abused by their peers such as glue, unprocessed tobacco, cigarettes, and low-end alcohol known as 'keg.' They attributed drug use among youth to peer pressure, the need to belong and associate with peers (*kuwa kimoja*), and stress relief. Thus, the sessions served to educate the OVC, dispel myths, and offer healthier alternatives to certain types of behavior. Excerpts of questions asked by OVC are summarized below.

The following questions arose during the OVC outreaches:

- Do people who are born again get infected with HIV?
- After one is infected with HIV, how long does a person live?
- Is it true that an old person infected with HIV can be cured after having sexual intercourse with a virgin?
- Is it true that HIV infection is caused by witchcraft?
- What should you do if you once had symptoms of an STI but they just disappeared without treatment?
- If you bathe with water used by an HIV positive person, can you be infected?
- How can you live positively with HIV?
- Do condoms prevent HIV transmission? How safe is a condom?
- Can a girl become pregnant before having her first menstrual period?

HIV Free Generation Activities

Seven youth groups participated in the G-amini Annual Talent Explosion (GATE) Festival, which is one of the youth groups being coordinated by HIV Free Generation. GATE is a youth initiative that enhances the use of theater as a tool for behavior change communication by identifying, recognizing, nurturing, and promoting talent and creative excellence in communicating HIV prevention, care, and treatment messages. It brought together community-based youth groups from various parts of Kenya that are utilizing theater to promote behavior change communication in their respective communities. The GATE Festival is drawn from the G-Amini philosophy of the G-PANGE initiative, which gives youth the opportunity to choose a philosophy that encompasses all aspects of youth life with specific emphasis on skills development, social networking, career opportunities, excellence in sports, the arts, and leading a healthy life. The festival was held from March 19-20, 2010, at Kenyatta University. The Central Province youth groups received seven awards, winning in the categories of best play, best song, most creative script, best and the second best open category, second best choral verse, and third position for solo verse.

Youths between 15 and 24 years of age were reached through the MTV Shuga movie. This movie targets young people by provoking them into assessing their sexual relationships vis-à-vis protecting themselves from HIV infection. It also addresses the stigma and the challenges faced by young people living with HIV. The screening of the movie was followed by either intensive small group discussions or outreach sessions for wider audiences in secondary schools and tertiary institutions. Out-of-school youths were also targeted in video dens. Some of the take-home messages the youths identified were VCT, condom use, and resisting peer pressure and stigma. The learning institutions that were reached include Jomo Kenyatta University of Agriculture and Technology, Mount Kenya University, Kenyatta University and Ruiru Campus, Nyeri Technical Institute, and Nyandarua Institute of Science and Technology.

Adolescent Reproductive Health Program

Through support from A2C, KGGA reached 343,389 individuals with abstinence and/or being faithful messages. The project trained 5,345 individuals to promote HIV/AIDS prevention through abstinence and/or being faithful and reached 97 schools with abstinence messages.

Patrol Leader trainings were held in all three phases and reached 180; they aimed at training patrol leaders in both primary and secondary schools to be peer educators. This served to help the patrol leaders reach their peers in schools and the community at large as well as help the guide leader in implementing the project in their respective schools. The following topics were covered during the training: self-esteem and being a good friend, taking care of common illnesses, understanding feelings of attraction, communication skills for protection, talking to helpful adults, making decisions for yourself, responding to negative peer pressure, understanding HIV transmission and prevention, reducing stigma and discrimination, preventing rape, and avoiding drugs and alcohol. In addition, 73 guide leaders underwent a TOT refresher training aimed at refreshing the already trained TOTs on life skills and HIV/AIDS.

Essay competitions were held in the year 2009 and 2010 with the theme of both competitions being “Abstinence is the Best Choice” with awards in terms of school fees/book vouchers being presented to the best three contestants. Certificates were also awarded to all who participated. A total of 130,684 youths participated in the competitions.

In 2010, KGGA held a rally attended by 4,886 students. The theme of the rally was “Abstinence Is the Best Choice,” and the students presented songs, poems, and skits on the theme.

2.3: Reinforced Networking between Communities and Clinical Services

A2C supported community theater groups to solicit support for services supported by the project at various health facilities. The demand for services was created through skits and verses based on services the project was offering. For example, if A2C was supporting VCT services at Kahembe Dispensary, the local theater group in the region would do skits on VCT and make the community aware of the service, as well as make referrals to the health facility.

Collaboration within Communities

The project partnered with Kenya Volley Ball Association and conducted two volleyball tournaments in Nyeri. These tournaments were an opportunity to reach out to spectators with OP messages through dramatized items on stigma and discrimination, VCT, and condom use. Counseling and testing services were offered during the tournaments.

The youth groups also held talent shows and sporting activities in their respective towns. The activities were used as forums to showcase the different talents the youths had and also provide an opportunity to reach the youth with prevention messages through dramatized items and through the Shuga movie. In addition, counseling and testing services were provided.

Partner Collaboration

Advocates conducted sessions in A2C-supported health facilities to reduce stigma and provide more information on HIV/AIDS related topics such as VCT, PMTCT, and condom use.

Result 2 Challenges, Lessons Learned, and Recommendations

Challenges and Lessons Learned

- Demand for services for sex workers (such as trainings, counseling and testing, and outreach) surpassed expectations, so the program developed innovative strategies – including a peer-led approach and hot spot testing and counseling – that required little funding.
- There were occasional commodity shortages (of condoms and test kits) from government sources, so A2C had to encourage the sex workers to build a culture of buying the condoms in the market through heightening their risk perception.
- Stigmatization and marginalization are linked to sex workers but not their clients. To address this, the program carried out anti-stigma campaigns among the clients and health workers not to stigmatize sex workers when they seek services and to promote a sex worker friendly environment that enables sex workers to access health services.
- There is improved access to health services by sex workers through reduction of stigma by health care providers and promotion of ‘sex worker friendly’ health centers that are accessible, acceptable, and affordable.
- Sex workers faced violence and harassment by clients and police officers. A2C held sensitization forums and meetings to reduce these harmful practices. Due to the illegality of the trade, forging partnerships and network with police and justice ministries is crucial.
- Incorporation of drug and substance abuse as an intervention to target sex workers has increased risk perception and helps curb rate of HIV/STI infection. Alcohol and drug abuse is common among sex workers, which increases their risk of HIV/STI infection. The program incorporated drug and substance abuse sessions during trainings and workshops, which resulted in sex workers becoming more knowledgeable about the link between drug abuse and HIV/STI infection. Many sex workers in the program reduced their consumption of alcohol and became more responsible for their general health and wellbeing. They also continued to serve as role models for their peers in support groups.
- Building of self-esteem of FSWs increases their uptake of alternative livelihood means beyond sex work. Harsh economic times and low literacy levels left many lower class sex workers with a decreased capacity to negotiate for safe sex. A2C increased their self-esteem during workshops, improved their knowledge on options of alternative livelihood means, and strengthened linkages to safety nets. As a result, several sex workers started small businesses that supplement their income, reducing their need to go to the streets. Other sex workers learned to be more assertive in condom negotiation.
- Targeting clients of sex workers has certainly enabled sex workers to negotiate condom use more easily.
- Promoting a peer-led approach in the intervention increases solidarity and ownership of implementation by sex workers.
- Sex workers face a lot of harassment and assault from their clients. Since they are practicing an illegal business, their clients are in a powerful position to deny them their pay and commit physical abuse. The police also incarcerate sex workers arbitrarily and often sexually abuse them when they seek assistance. There is therefore a great need for advocacy on their rights.
- There was a stock out of the male condoms at KEMSA and most GoK health facilities and this affected condom distribution during outreaches. Free GoK female condoms continued to be inaccessible due to stock out, putting women who would like to use them at a disadvantage.

- Missed testing opportunities: The demand for counseling and testing by people who wish to be tested immediately after an outreach is not always met due to the unavailability of testing kits.
- Insecurity was a challenge as several towns experienced tension resulting from the killings conducted by an outlawed sect and vigilantes. Some drama outreaches had to be rescheduled and HTA night outreaches suspended in the affected areas.
- The uptake of HIV counseling and testing and disclosure among health care providers are still low despite the continuous HIV/AIDS sensitization and education.

Result 2 Recommendations

- Linkages between workplaces and facilities that offer youth friendly services should be established because there are very many workers who are young. Where possible, youth friendly services should be established in worksites.
- All workplace CHEP networks should aim to be registered as CBOs to enable them to mobilize resources.
- Support groups should be strengthened since they are effective for prevention with positives (PWP).
- There is need to incorporate RH/FP information and services in the workplace program. This can be achieved with the implementation of the Healthy Images of Manhood methodology.
- Promote the social marketing of condoms, as well as subsidized female condoms and water-based lubricants, as a way of encouraging condom use.
- There is need to develop strategies to enable sex workers to improve their safety with non-commercial partners.
- Train more sex workers as community health workers and HIV testing and counseling counselors, including equipping them with basic counseling skills and on prevention with positives (PWPs), to help them effectively serve their peers.
- Enlighten sex workers on their rights to curb cases of harassment and GBV by both police and clients.
- Support the establishment and management of drop-in service centers (DiSCs) for sex workers.
- Develop and distribute tailored IEC materials for sex workers.

Result 3: Improved And Expanded Care And Support For People And Families Affected By HIV/AIDS.

Introduction

The Home and Community Support (HCS) component was implemented to enhance improved and expanded care and support for people and families affected by HIV/AIDS. It was designed based on the past experience of both the COPHIA and APHIA II Nairobi/Central projects. The overarching aim of the project was to strengthen integration between HIV/AIDS prevention and care; respond to the complex needs of PLHIV, OVC, and caregivers; promote prevention; reduce stigma; and engage communities in mitigating HIV/AIDS impact, ultimately reducing morbidity and easing the burden of HIV/AIDS on vulnerable households and over-extended health care systems.

The HCS worked with NGOs/CBOs/FBOs and the two Ministries of Health, the NACC, NASCOP, Ministry of Agriculture and Livestock and other public and private institutions. Activities were implemented through CHWs, their supervisors, implementing partners, and project staff. This report highlights the activities undertaken between March 2009 to February 2011, key achievements, challenges, and lessons learned.

3.1: Expanded Home and Community Support Program

The HCS activities were designed to address two NACC priority areas as presented in the Kenya National HIV/AIDS Strategic Plan (KNASP II): to improve the quality of life of people infected and affected by HIV/AIDS and to mitigate the social economic impact.

3.1.1 Capacity Building

A2C built the capacity of various cadres through training and mentorship to enhance their knowledge and skills in the provision of home and community support services. Given particular attention were the community health workers and their supervisors. Leaders of implementing partners and health providers were also targeted.

GoK Community Strategy Training for CHWs

A2C supported the MoH to roll out of the community strategy, during which CHWs identified through participatory processes were trained. A total of 2,600 CHWs were trained from 52 community units in the province. CHWs were equipped with skills and knowledge to function as link persons between communities and the health system.

The training covered the following topics: developing and maintaining household registers; data collection, collation on chalkboards, and its use for dialogue at household and village levels; and educating and motivating the community on key household practices based on an agreed communication strategy. Other competencies built included safe motherhood; IMCI; adolescent health; screening for chronic conditions; immunization; family planning; antenatal care; disease surveillance; treatment of malaria; prevention and control of HIV/AIDS and STIs; monitoring TB treatment; promoting school health; providing first aid treatment for minor illness and injuries; referring patients to health facilities; mobilizing communities and their leaders on level one services to take appropriate action; and facilitating and participating in planning, implementation, monitoring and evaluation of level one services.

Treatment Literacy and Defaulter Tracing Training

With improved and accessible services for PLHIV, there has been an increase in their general health and also an increase in the uptake of ARVs. This has led to a shift in the needs of PLHIV, with more demand on treatment and adherence education, education on positive living, and prevention with positives. Further it was noted that there were high levels of defaulting within the communities. Major reasons given for defaulting included belief in ‘divine healing,’ stigma (the clients feared being seen taking medication or even going to facilities), and side effects. A2C organized trainings on treatment literacy and defaulter tracing in Thika, Nyandarua, and Nyeri districts targeting support group members and CHWs. The trainees included people on ARVs and those not on ARVs. Among the topics covered were ARV regimes, side effects of ARVs, and opportunistic infections.

During the training one of the support group members remarked, “I thank God that I came for the training at this time. I had already decided that I would stop my drugs due to the discomforts I was getting and especially at night such that I could not sleep. I now know the reason and I know that I can discuss the side effects with the in charge at the CCC. I cannot imagine what could have happened if I had stopped.”

Follow ups conducted after the trainings indicate that the clients have taken the initiative to monitor each other’s compliance with treatment regimens. Support group meetings were also used as forums for following up on adherence.

Training on Rights-based Approaches

PLHIV play a significant role in advocacy and prevention and there is need to strengthen their capacity to address their own issues and be actively involved in their community. A2C therefore organized training for PLHIV on rights-based approaches. PLHIV were trained from Thika, Nyeri and Nyandarua districts. The PLHIV were from various support groups linked to the IPs working with A2C. The participants were equipped with skills to advocate for their rights and also educate their communities on issues such as adherence, positive living, and nutrition. In one of the trainings, participants from three districts recommended establishing a network of PLHIV in Central Province. They asserted that levels of stigma were still high in the province and more effort was needed to address this.

Healthy Images of Manhood (HIM) Approaches Training

Gender issues continue to play a significant role in HIV management. The HIM training was organized to equip the participants with knowledge and understanding of the influence of gender on efforts to improve health and the importance of addressing reproductive health and family planning along with HIV/AIDS. The 30 participants trained were CHW ToTs from Thika, Nyeri and Nyandarua District, who then cascaded the training to their counterparts. The participants recommended that more HIM trainings should be rolled out on the ground, especially in the rural areas where gender stereotypes are entrenched.

Stigma reduction trainings

Stigma and discrimination are major barriers in the fight against HIV/AIDS. One of the institutions identified to have high levels of stigma is school. A2C therefore targeted teachers who are patrons of Chill Clubs for training on stigma reduction so that they would have the knowledge and skills to create awareness about the issue. Teachers were trained from Nyeri, Thika, and Nyandarua districts. A key outcome of one of the trainings in Nyandarua district was the formation of the Nyandarua Teachers Anti -Stigma Advocates. A committee was established to set meetings and strategize on how members would organize their outreaches.

3.1.2 Leaders Engagement

Community Leaders

Community leaders played a significant role in the success of the project. Acting as gate keepers of the community, they influence the uptake of services within the community. A2C conducted sensitization meetings targeting various levels of community leaders to address pertinent HIV issues such as stigma reduction, importance of referrals and linkages, and sexual reproductive health issues, among others. More than 500 leaders, including the local administration, religious leaders, provincial and district administration, and CACC representatives were reached.

Religious Leaders' Involvement

Religious leaders hold substantial influence in decisions their congregation and society in general make. HIV/AIDS is one of the greatest challenges facing humankind and the contribution of religious leaders to promoting understanding and treatment is sorely required. Unfortunately, in most instances, their influence has been negative. In the treatment literacy and defaulter tracing trainings undertaken, religion was cited as a major cause of defaulting. It is against this background that A2C in partnership with KENERELA organized a three-day HIV advocacy meeting for religious leaders from different denominations drawn from Nyeri, Thika, and Nyandarua districts.

During the training, one of the trainees commented, "I am so ashamed by the way I have been making moral judgment on PLHIV. Why have I been so ignorant? Why had someone not brought such training before? I will dedicate the rest of my years to advocate for the rights of PLHIV to at least cover for the years I have condemned them. God have mercy."

An outcome of the training was the formation of regional advocacy units, through which the religious leaders created awareness among their colleagues.

3.1.3. Provision of Home Based Care

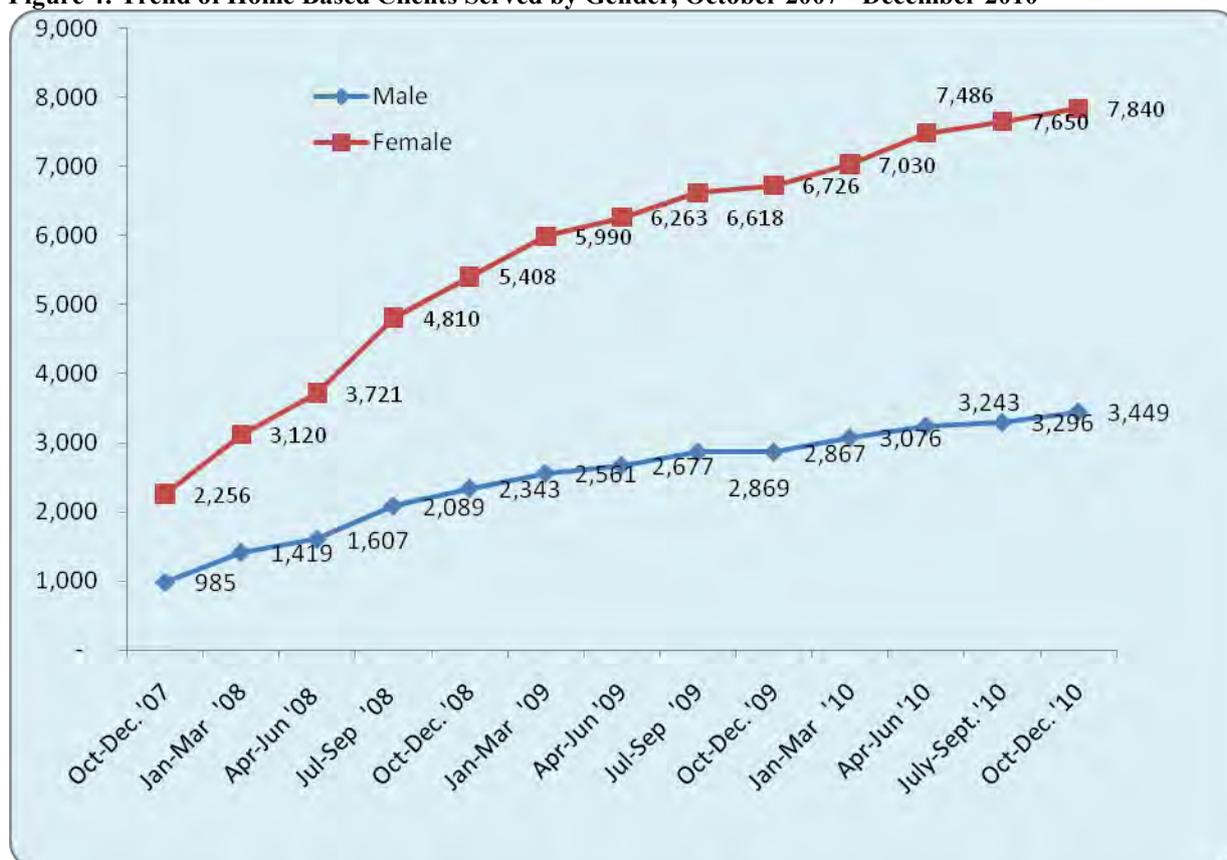
In facilitation of HBC services to clients, A2C supported CHWs and their supervisors with token allowances and home based care kits. Numbers served through HBC recorded consistent increase during the program, rising from 8,551 in March 2009 to 11,289 in December 2010, which is a 32 percent increase. The proportion of client deaths on the other hand recorded a declining trend from 1.2% over the same period. Clients were also referred for other services such as PMTCT, FP, and treatment of OIs, thereby according them a chance of holistic wellness beyond HIV/AIDS. The table below summarizes these positive outputs and outcomes.

Table 3: Summary of Home-based Care April 2009-December 2010 Central Province

Activities/Services	Apr-Jun '09	July-Sept. '09	Oct-Dec. '09	Jan-Mar '10	Apr-Jun '10	July-Sept. '10	Oct-Dec. '10
No. of new clients served	1,169	1,026	1,042	1,079	998	722	650
Clients who have died	95	96	84	64	70	74	44
Number of Caregivers	12,189	12,763	12,503	13,593	15,337	14,567	14,837
No. of home-base clients (males)	2,677	2,869	2,867	3,076	3,243	3,296	3,449
No. of home-base clients (females)	6,263	6,618	6,726	7,030	7,486	7,650	7,840

Activities/Services	Apr-Jun '09	July-Sept. '09	Oct-Dec. '09	Jan-Mar '10	Apr-Jun '10	July-Sept. '10	Oct-Dec. '10
Number of New ARV Clients	269	446	291	248	207	164	149
Number of clients currently on ARV	6,626	7,256	7,477	8,000	9,117	8,795	9,280
Number of ARV clients Defaulters	172	214	192	174	113	84	310
Referral cases for VCT	367	363	332	259	284	275	372
Referrals for treatment of OIs	2,657	3,147	2,686	2,477	2,608	2,297	1,975
Referral for FP	1,258	1,393	2,167	2,253	2,433	2,433	2,057
Referral to support groups	3,366	3,880	4,013	4,306	4,702	2,431	2,030
Referral for PMTCT	173	926	231	149	166	173	624
Condoms distributed	240,060	273,854	298,048	320,395	309,822	237,487	202,874

Figure 4: Trend of Home Based Clients Served by Gender, October 2007 - December 2010



The program continued to support more HBC clients each quarter. The number of female clients doubled that of male clients, as shown in figure 14 above. HIV prevalence among men is lower compared to women, which contributed to a lower number of men enrolling for care. Furthermore, CT uptake among men has been low; hence lower chances of men knowing their HIV status.

3.1.4. Nutrition and Food Security

Nutrition is a key aspect of ensuring enhanced health status of PLHIV. Food stress was one of the contributing factors for defaulting in treatment. In order to improve the health status of PLHIV and their families, A2C undertook activities that would enhance nutrition education and food security for their households. In collaboration with the Ministry of Agriculture and the Ministry of Livestock and Fisheries, various groups were trained on skills to enhance their nutritional status as well as income. Below is a table of trainings conducted to promote nutrition and food security.

Table 4: A2C Nutrition and Food Security Trainings

Training	Number of trainees
Fish farming skills training	360
Poultry keeping	98
Rabbit keeping	50
Kitchen gardening	200

The trainings were mainly for support groups linked to the IPs working with A2C. To ensure sustainability of projects initiated by the groups trained on fish farming, they were linked to the GoK Economic Stimulus Program, which offered them fingerlings and continuing technical support on fish farming. Nutrition education was also covered in all the trainings, and PLHIV were encouraged to start and maintain kitchen gardens.



A pond constructed for a support group in Othaya.

3.1.5 Support Groups

Support groups for PLHIV provide forums for experience sharing and learning. A2C supported the establishment of 80 support groups linked to A2C-affiliated IPs. Due to intensive capacity building offered by A2C, the groups have had a positive impact on health-seeking behaviors of PLHIV. This has resulted in better adherence to ARVs and reduced IO rates. Better health, in turn, has enabled PLHIV to initiate and sustain IGAs since they are physically strong and psychologically stable. Some groups have written proposals that have been funded through Total War Against AIDS (TOWA) funds, a positive outcome of A2C capacity building.



Mwihoko Support Group sourced TOWA funds and has been engaged in rabbit keeping, closely working with MOA.

HBC Skills Orientation

HBC skills are meant to facilitate referral and promote care, support, and treatment of clients at the community and facility levels. Additionally, they facilitate identification of focal points within health facilities through which CHWs can refer clients and seek technical assistance.

Due to the high demand for HBC services, the HBC team, in collaboration with DPHOs, DPHNs, IP, and support group officials, conducted HBC orientation for support groups, service providers, and caregivers. In total, 360 (165 male and 195 female) caregivers, clients and health care providers from Nyeri, Muranga North and South, Kirinyaga, Nyandarua North and Kiambu received orientation on HBC skills.

Orientation on Disclosure

To reduce the challenges of disclosure of HIV status by parents, guardians, and spouses to their children and others close to them, A2C supported a two-day disclosure skills orientation for 180 clients, caregivers, and guardians linked to IPs in Thika, Nyeri, and Nyandarua. The participants were taken through the importance of disclosure, to whom, how and where to disclose. Members reported that it was easier for them to disclose within support groups but not at the family level. The members who had been able to disclose their status shared with the others how they overcame the challenge. In a later training, one of the guardians who had participated in the disclosure training had this to say.

“The skills I got during the disclosure training really helped. I was able to go back and talk to my 13-year-old son. What shocked me is that he had for long suspected that I am HIV positive but did not know how to ask me. I felt like a heavy load had been lifted from my shoulders. We have become closer and are able to talk even about sexual issues something that we could not do before.”

IP Leaders’ Monthly Reporting Meetings

Throughout the life of the project, A2C supported monthly IP leader’s meetings during which the leaders submitted activity data to A2C, provided program updates, and shared IP experience. Feedback on the previous month’s performance was also given during those forums.

HBC Stakeholders Meeting

HBC stakeholders meetings were held on quarterly basis in Thika, Nyeri, and Nyandarua districts. Key issues that emerged during these meetings were:

- Need for more involvement of health care providers in co-ordination and supervision of HBC services.
- Importance of strengthening referrals and linkages.
- Importance of reporting and using the correct tools for reporting.
- Enhancement of skills in resource mobilization.

Institutional Capacity Building

A2C provided technical and financial support to the 21 IPs through which the program implemented HBC activities. Institutional capacity gaps were identified and the IPs trained on financial management, program management, proposal writing, and resource mobilization to address identified capacity gaps. Trainings targeting the CHWs and their supervisors also increased knowledge and skills within the IP organizations.

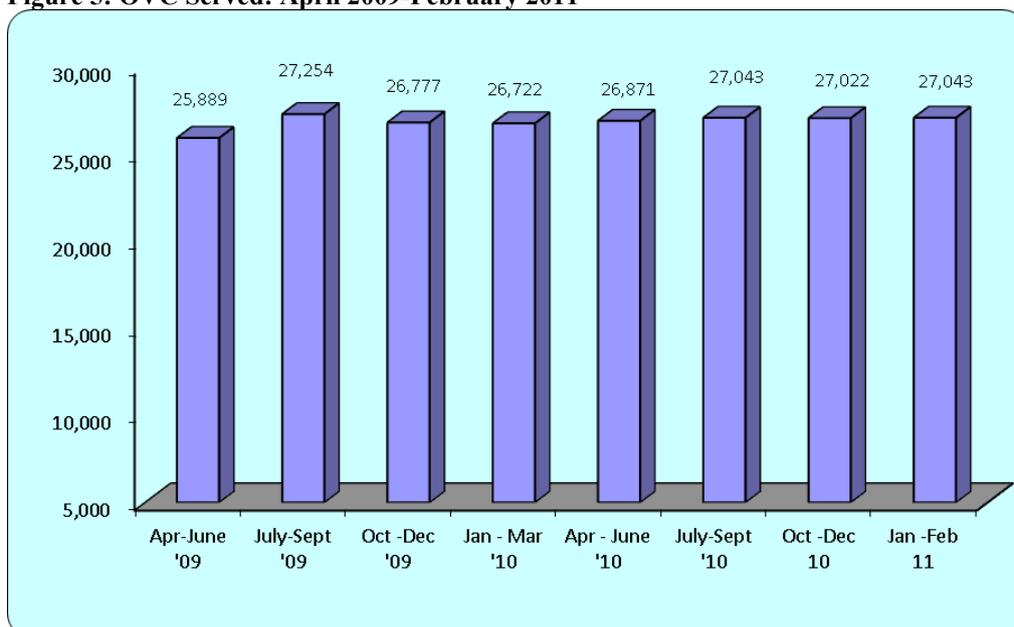
Sustainability Initiatives

A2C incorporated sustainability strategies in the technical support it provided to IPs. One of the organizations, Vision Garden, was able to organize a fundraiser to construct a youth training center in Ngoru-Mukurwe-ini. Vision Garden now holds its trainings in the center, thus saving money that would have been spent on renting meeting venues. A2C's support to renovations on a basic structure previously built by the Brothers of St. Joseph Self Help Group enabled this highly effective grantee to own a large building with community meeting space to be hired out locally for community meetings or training activities as a long-term source of income.

3.2: Expanded Support for OVC

A2C mitigated the suffering of orphans and vulnerable children (OVC) on a wide scale in Central Province, consistently reaching more than 27,000 children with services. The need was great, as the number of children orphaned by HIV in Kenya was estimated at 650,000 and projections indicated that by 2010, 15.4% of all children under age 15 will have lost one or both parents. Project activities were designed with the need to provide OVC with educational and economic support, nutrition and food security, social protection, and emotional development support.

Figure 5: OVC Served: April 2009-February 2011



A2C scaled up and strengthened the technical and institutional capacity of IPs, AACs, and VHCs to provide OVC support in a fully integrated manner. The project provided the majority of OVC with at least three long-term services and ongoing short-term services as needed out of the seven service areas.

OVC Care and Support Package

Access to Health Services

APHIA II Central strengthened referral links with supported health facilities by training service providers in pediatric PSS, play therapy, and home based care (HBC). In total, 1,035 (735 female and 300 male) CHWs received specific OVC psychosocial training to enable them to address the emotional needs of OVC enrolled by IPs. Each CHW was allocated between 15 to 30 OVC who receive visitation at least once per month, and 14,589 households were visited over the life of the project. Household visits allowed the CHWs to observe the emotional state of the child, provide counseling, and conduct a household needs assessment. CHWs would then follow the progress of the family against the seven core service areas and make appropriate referrals. These screenings helped IPs identify HIV-positive children in need of specialized health and social support.



An Upendo CBO CHW assists Peter Mwangi in using his new wheelchair, which was donated by APHIA II Central.

One community health worker in each of the 29 IPs was trained in pediatric child counseling and linked to the respective DASCO. As a result of this training, the IPs supported therapeutic groups for HIV+ children to live positively and adhere to treatment. Five children's support clubs were formed and remain operational. The members meet regularly over the weekend with close monitoring of CHWs and youth leaders. Religious leaders and youth leaders in churches have also been trained on handling of children, thus ensuring project continuity.

CHWs also provided special RH services for adolescent OVC, including sanitary towels, YFS referrals (for prevention, FP, VCT, STI), and PEP and YFPAC. During the project period, more than 80 percent of enrolled OVC received medical screening, immunizations, and three monthly de-worming exercises and vitamin A supplementation. Thirty OVC were referred for hospital admission and 15 received support for specialized medical examination.

To reduce the occurrence of eye-related conditions associated with poor indoor lighting (exposed paraffin wick lamp), 5,500 households were supported with improved light sources. Follow-up medical screening showed a reduction in eye conditions due to that intervention. Skin conditions, ringworm, and malnutrition were consistently reduced by medical personnel working with IPs to access OVC with outreach medical camps during school holidays.

The general wellbeing and hygiene of all enrolled OVC was strengthened through the provision of a bi-annual hygiene pack that included towels, bathing and washing soap, hair combs/brushes, toothpaste, and tooth brushes.

Psychosocial Support

Under this core service area, A2C aimed to improve the psychosocial wellbeing of OVC through ensuring that the children were happy with their thoughts, feelings, and actions while feeling

connected to others in healthy and meaningful ways. A2C provided TOT capacity building to 180 caregivers on psychosocial support, journey of life, and nutrition using the Regional Psychosocial Support Initiative training curriculum and manuals. Paralegal support and child counseling trainings were also undertaken.

Life skills camps for adolescent youth reached 550 youths. Key PSS messages reached 380 guardians, which improved the health and emotional status of OVC.

The project provided bonding forums for more than 12,000 children during school holidays. These forums incorporated messages about child participation, self-awareness and esteem, gender, human growth and related development, drugs and substance abuse, HIV education and prevention, child protection, and risk reduction.

Education

A2C supported over 85 percent of enrolled OVC in the following age groups with educational support:

Table 5: OVC Supported by Age and Gender

0-5 years		6-10 years		11-15 years		16-18 years		above 18	
M	F	M	F	M	F	M	F	M	F
2,986	2,865	4,805	4,445	3,545	4,258	1,791	1,836	318	259

The table shows that 23,042 supported OVC received education access support either at the level of early childhood education, primary, secondary, or post-secondary. A2C supported 2,692 OVC to access early childhood education. A rapid assessment undertaken by Child Fund Kenya, an A2C partner, found that only about 20 percent of children attending early childhood education centers were OVC. The main reason was that the privately or community-owned centers charged levies ranging from 200 to 5,000 shillings per term (3 months). These fees were out of reach for most low-income households. Advocacy via the provincial director of education set a levy limit at 700 shillings per term, which enabled A2C to increase its support to needy OVC. Participating centers recognized the special needs for OVC with targeted learning and teaching materials as well as outdoor recreational facilities.

More than 17,000 OVC were enrolled in various primary schools. The children were supported with school supplies including school bags, uniforms, and water tanks. About 3,500 supported OVC were secondary school students. Linkages with both private and public entities enabled A2C to access 364 scholarships (USAID/ PEPFAR), while 287 OVC have received short term scholarship support from the Constituency Bursary Fund.

Approximately 2,000 targeted girls were supported with counseling/menses education and sanitary towels to increase their retention in school. A lack of sanitary towels was found to be a significant cause for girls' absenteeism. Follow up on supported girls showed a significant increase in class attendance.

One hundred twenty-five (75 female and 50 male) older OVC received post-school skills training in vocation centers: Mugutha Vocational Centre, Ruiru Baptist Vocational Centre, Karundas Catholic Institute, and Karatina Youth Polytechnic. The students received two years of skills training in trades like carpentry, metalwork and welding, plumbing, masonry, electrical wiring, tailoring, and grooming services. The project purchased start-up kits for the older OVC who undertook vocational training in preparation for employment. The trained youth formed support groups to work together as they launched their new careers and opened small businesses.

Food Provision and Nutrition Education

A2C alleviated hunger among all 27,043 enrolled OVC with food provisions especially during the periods of food stress and shortage. All 14,589 OVC household received provisions for all children and caregivers. During period 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 children under the age of five consistently received supplemental nutrition support every quarter.

To increase the availability of food within households, A2C undertook capacity building for all IPs to seek alternative supplemental food sources, including dairy goat raising, rabbit farming, chicken rearing, organic farming, and traditional food farming of foods more drought resistant than maize and beans. This was undertaken with the collaboration of the Ministry of Agriculture and Livestock.

Community health workers supported the guardians and OVC in nutrition counseling through training and key messages delivery during home visits. Implementing partners established demonstration farms, and households established and maintained 1,368 kitchen gardens.

More than 600 households were trained on organic farming in collaboration with the Ministry of Agriculture. Linkages to Ministry of Agriculture, Ministry of Fisheries, and Ministry of Livestock were made and OVC guardians were supported with seeds, bee hives, fish ponds, and poultry from the ministries. The project noted that poor yield in some households was the result of poor farm tools, so A2C provided 600 sets of fork *jembes* (hoes) and *jembes*.

Child Protection

A2C held consultative and plenary meetings with the provincial children's officer, youth, gender, MOA, and other key children's resources including the 11 area advisory councils (AACs) to develop joint working and field monitoring/QA strategies. The project supported training on the development of minimum standards for OVC, and all the district children's officers in the province attended. In addition, the volunteer children officers in the greater Nyandarua District were trained.

A2C also trained and worked with 287 paralegals supported by CHWs and IPs to address stigma and legal rights issues of OVC. Trained community paralegals provided legal assistance to address case of abuse. Several cases were brought to the courts in collaboration with IPs, children's officers, and the children and gender desk within police station – all of which received capacity development to protect children during the project period.

Each of the 29 implementing partners identified a rescue center in the locality that can accept abused children. These rescue centers/children homes received training on child protection and child status index, among other topics. A2C also provided shelter materials to the centers to improve the living conditions of the children.

In Kenya, having a birth certificate is a requirement to access basic services like school admission. However, many OVC do not have a birth certificate and this impedes their ability to receive an education and become productive members of society. The application process can be challenging, requiring registration, a fee, and sometimes travel to a district center. To overcome this obstacle, A2C supported OVC to acquire birth certificates through IPs.

Shelter and Short-term Relief

During the project period, A2C provided all enrolled children with shelter materials to improve their living environments and reduce disease. Materials provided included bedding (blankets and mattresses), water containers, mosquito nets, clothing, water purification materials, lanterns, towels, bath and washing soap, hair brushes, and skin oil. In addition, 40 households were renovated or built to provide OVC with their own living environments where none was previously available, and 20 toilets were constructed. Specialized support like house renovation or sanitary improvements focused specifically on OVC-headed households and those with HIV-positive members of the household.



Children at the Watu wa Maama Children Centre in Thika East District express their appreciation after receiving blankets.

Livelihood Capacity Building

In collaboration with IPs, 34 people received training on income generating activities, monitoring, and data collection tools. The trained individuals became the point people in their CBOs for the establishment and management of village saving and loans groups. A2C reached 2,658 clients through 126 saving groups. A further two youth groups with a combined membership of 70 received training on voluntary saving and lending. The village savings and loan groups aim to lend money for members to start small businesses and improve local economic conditions.

The guardians supported by the project formed working groups and are implementing different activities. The group membership is between 15 to 25 members, based on locality. To date, 26 guardian groups have been formed and they are still involved in animal husbandry (rabbit rearing, poultry farming, bull rearing, and sheep rearing), farming, and tree nurseries. A2C provided the groups practicing farming with *jembes* (hoes) to achieve higher yields.

One hundred twenty families whose OVC were enrolled in the St. Joseph program benefitted from the daily goat project and revolving fund. The children now have regular access to nutritious goats' milk, and project proceeds enable the guardians to save money and provide for the needs of their families.

Success Story

Kinamba Group supported via Shining Star has a membership of 15 guardians who are rearing sheep. The group meets every Sunday in a group member's house. Each member contributes 10 shillings for a children's welfare fund, 15 shillings for snacks, and 50 shilling for group shares. The 10 shillings contributed for children's welfare is saved and only accessed in dire circumstances like illness. The 50 shillings is usually loaned out to a member and the borrower pays back the total with interest. Ann Njeri Njenga, an OVC guardian, noted that the loan from the group enabled her to pay her son's school fees. The group hopes to increase its savings to improve loaning startup capital to group members and to be able to sponsor their OVC in secondary schools.

The above was reported in the quarter report of July –September 2009. Ann Njeri joined a guardian support group after she attended training with other guardians. She can now afford to send her son to secondary school through the support of the group. The group is also involved in sheep rearing.

3.3: Reduced Stigma and Establishment of Safety Nets for PLHIV and Their Families

To reduce HIV/AIDS-related stigma and discrimination and protect the human and social assets of those infected and affected by HIV/AIDS, the project funded 29 local implementing partners to implement promising approaches towards stigma reduction. Some of the approaches included:

- Empowering PLHIV ready to go public as champions against stigma;
- Conducting anti-stigma sessions during public meetings and support group meetings;
- Engaging the religious leaders in the campaign as the majority believed HIV is a punishment from God;
- Sensitizing communities on the basic facts about HIV/AIDS to dispel myths and misconceptions; and
- Training CHWs, workplace peer educators, youth leaders, and other volunteers to enable them to mainstream stigma in all their outreaches and sessions.

On safety nets for PLHIV, the project provided linkages for economic strengthening with various GOK ministries for the households affected. These activities included fish farming, poultry keeping, rabbit keeping, and organic farming.

Result 3 Challenges, Lessons Learned, and Recommendations

Challenges and Lessons Learned

- The diversity of needs within the community could not all be addressed by the project. However, by partnering and networking, many of the non-health needs were addressed.
- Some of the organizations were overly dependent on the project for financial and technical support; their ability to function as independent organizations is questionable.
- Information dissemination to clients through support groups is very effective.
- Enhancement of knowledge on legal and human rights issues in the community is key to addressing issues of gender-based violence and other human rights abuses
- The majority of PLHIV require more support in disclosure, prevention with positives, and treatment literacy.
- Adolescents living with HIV really need to be empowered on HIV prevention, treatment, and care and support.
- Demand for OVC support and services in Central Province was greater than the project was able to provide.
- Secondary school costs, even with government subsidy for tuition, remain the single most stressful item for OVC in secondary schools. More support is needed to support vulnerable OVC to finish their education; too many are forced to drop out due to the cost of secondary school.
- Support to primary schools with items like desks and water tanks or sanitation projects will enable IPs to lobby for reduced school costs for OVC.
- Religious leaders can be powerful advocates for stigma reduction, acceptance of PLHIV, counseling and testing, and medical treatment. Training is an effective way to inform religious leaders and encourage them to provide educational messages that refute myths and misconceptions about HIV.

Recommendations

- For sustainability purposes it is important for the IP organizations to diversify their funding sources.
- Empower PLHIV in HIV prevention treatment care and support through information.
- Stigma levels are still high in some areas of Central Province. This should continue to be a priority for APHIAplus. For example, the project should streamline in all trainings to service providers as well as volunteer cadres, incorporate related messages in all community outreach, and build the capacity of role models such as our PLHIV advocates.
- Target adolescents living with HIV. HIV-positive youth groups exist in Nairobi, but this is only feasible in locations with large numbers of HIV-positive people. In Central, a feasible strategy might be through integrated youth programs that encompass community elements where youth are reached with strong linkage to facility elements.
- The community strategy is a laudable approach that enables health programs to reach even the hard-to-reach areas. Support for its national roll-out is warranted.
- Involvement of more church leaders to reduce stigma and refute myths would be valuable.
- More prison managers and school teachers should be equipped with skills in HIV management. There is a higher prevalence and/or risk of infection in prisons. Schools should be targeted for teacher involvement/buy in to peer education programs and to meet the special needs of children either living with HIV or in households affected by HIV.

4.0: Monitoring and Evaluation

Monitoring and evaluation of APHIA II Central activities was carried out by the project's M&E team composed of the M&E specialist, a data manager, and one data officer. Occasionally, the team was assisted by the temporary employment of two data clerks. The team worked closely with project partners including the GOK, the private sector, and the FBO sector. By the end of the project, the team was monitoring data monthly from 201 health facilities and 29 implementing partners. The M&E Unit provided complete and accurate data to project staff for use in programmatic decision making and reporting, working closely with the project result areas to assist in evaluation and analysis of performance.

Good project monitoring and evaluation, however, extends far beyond merely collecting and reporting data. APHIA II Central provided a wide range of support in the province in order to fulfill its broad mandate of assisting to build the capacity of the MOH M&E system. The team worked closely with provincial and district MOH staff, liaising regularly with the provincial health records information officer (PHRIO), the district health records information officers (DHRIOs), the provincial AIDS and STI coordinator (PASCO), and the district AIDS and STI coordinators (DASCOs).

Support for M&E was provided the province in a number of ways. Capacity building was provided district HMIS staff, health facility staff, and community implementing partners in the form of formal training, CMEs, and TA. The project supported the training of health care workers on the ART tools while wider audiences were reached through a number of CMEs. Training was facilitated by NASCOP TOTs with the support of A2C. Eleven temporary data clerks were deployed at the DHRIOs offices to assist the districts in data collection and reporting. This also ensured timely reporting and improvement of data quality.

TA was provided at regular intervals through joint visits to facilities by project and MOH staff. Registers were examined and on-the-job training provided on maintenance of registers. NACC encourages all community organizations in the country to register and to submit an activity report to the constituency HIV/AIDS control coordinator on a quarterly basis. The M&E team built the capacity of service providers and implementing partner representatives' on data management during trainings and orientation meetings to improve the use of data generated through the service delivery points.

At the request of NASCOP, all A2C projects initiated the reconstruction of patient data at a number of health facilities throughout Kenya. The objectives of the exercise included (a) ensuring that all patient files are maintained according to national guidelines, (2) supporting MOH efforts to transfer all patient records to MOH data registers, (3) assisting the MOH to achieve a reliable set of data with which to conduct important cohort analyses. It is only through the latter that the government would be able to more accurately evaluate the impact of the efforts being expended on the HIV/AIDS campaign. Sound data would allow deeper analysis of the impact of ARVs on the epidemic as well as enable analysts to assess more accurately the trends of drug adherence, drop outs, deaths, and other important indicators.

To this end, A2C supported a training of 37 TOTs on data reconstruction and subsequently a training of 30 data reconstructors from selected sites on data reconstruction for 20 health care workers and district health records officers. In Central Province, data reconstruction was performed in the following 15 health facilities, representing the public, private, and faith-based sectors.

Table 6: Data Reconstruction in Health Facilities

Name
Kiganjo Health Center
Kahembe Health Center
Ndaragua Health Center
Silibwet Dispensary
Wanjohi Health Center
Mary Help of the Sick
Mulumba Mission Hospital
Munyu Health Center
Ngoliba Health Center
IAP Mangu Hospital
Maragua District Hospital
Lari Health Center
Mary Immaculate Hospital
Narumoru Catholic
Mugunda Hospital

Measure Evaluation held a training on Child Status Index in 2010, which was attended by the data manager and one community development facilitator. The attendees then held several meetings to sensitize staff and area advisory councils on the importance and use of the CSI tool in assessing the wellbeing of OVC in their scope of work.

The introduction of a new PEPFAR-supported unit, the APHIA Evaluation Team, helped all APHIA II projects to focus more sharply on the M&E needs of the GOK and MOH. By the end of the A2C project, the subject of data use by districts had been clarified with considerable

support provided through the projects to districts for the use of their data. The District Data Demand and Information Use tool (DDIU) was presented at a workshop for district health records information officers (DHRIOs) and district HIV/AIDS coordinating officers (DASCO) in August 2010 by the M&E specialist for the APHIA II evaluation with the support of APHIA II Central.

A2C supported M&E in the province through the data sharing and data feedback sessions held with the district health management teams (DHMTs). Data sharing sessions were also held with clusters of implementing partners during which the topics of data management, collection, and reporting were discussed.

The A2C M&E team, together with representatives of the DHMTs, carried out a number of data quality assessments using the USAID tool, Rapid Data Quality Assessment (RDQA). The exercise entailed tracing an individual client through the trail of register entries to ascertain the accuracy of entry. A client was tracked from entry to the clinic through care and treatment in the comprehensive care clinic for HIV-positive individuals. A particular indicator was used for the tracking exercise. Through a small number of such tracking exercises, the quality of data entry at the site could be reasonably assessed.

5.0: Institutional Capacity Building (ICB)

Senior Alignment Leadership Development Program (LDP) Training of DHMTs in Central Province to Strengthen MOPHS/MOMS Capacity (Feb 16, 2009, Nyeri)

As a follow up to the work of the CAPACITY project, Management Sciences for Health (MSH) trained 30 senior provincial MOPHS and MOMS service providers/administrators affiliated with APHIA II Central. Participants were DHMT members from Central Province's 11 districts who undertook in-depth environmental scans of RH/HIV management initiatives from earlier LDP courses. For implementation of district assignments and also to facilitate buy-in, the DMOH were involved in the training and were expected to spearhead district activities.

The course exposed participants to eight principles of management and leadership through group work and assignments so that they gained knowledge and skill in several areas: (i) developing a mission and vision, (ii) identifying challenges, (iii) root cause analysis, (iv) priority matrix use, (v) planning of resources, (vi) stakeholders involvement, (vii) implementation of district based activities, and (viii) monitoring and evaluation of activities. The LDP course also provided trainees with basic practices of leading and managing.

Training on Subgrant Finance Management for APHIA II Central Finance Managers (April 27-30, 2009, Nyeri)

With the initiation of new partners and grants to APHIA II Central's portfolio in 2009, ICB support was planned within the first six months of the grants cycle to improve project design and financial and programmatic reporting. Pathfinder developed a tailored four-day financial management course for APHIA II Central finance managers. The training curriculum was derived from USAID/APHIA II Central's financial reporting documents. The training reached 38 staff from IPs in two categories: (i) 10 IPs already receiving grants and TA from APHIA II Central and (ii) potential partners whose proposals to APHIA II Central were at advanced stages of grants processing.

The course exposed participants to principles of financial management through group work and assignments. They gained hands-on knowledge and skill/orientation on USAID's standard provisions, financial reporting requirements, and reporting forms (timesheets, purchase orders,

assets management, and cash books). Training outcomes included improved financial reporting by A2C subcontractors and IPs in terms of their grantee financial reports (GFRs). The training was followed by on-site support from a mix of APHIA II Nairobi and Central staff drawn from grants, finance and administration, ICB, and program departments to ensure that subgrantees establish solid systems for grants management.

A2C designed the subgrant finance management course to build the capacity of current subgrantee and subcontractor staff for better grants management in the short term. Long term, A2C's capacity building strategy aimed to improve government of Kenya (GOK), subcontractor, local clinic, and community-based implementing partner potential and ability to use resources effectively and maintain gains in performance with gradually reduced levels of external support.

Training on Subgrant Finance Management for APHIA II Central Non-finance Managers (Aug 31-Sept 3, 2009, Nyeri)

A2C's Subgrant Finance Management for Non-finance Staff training was conducted as recommended by finance managers trained in April 2009. Participants included 27 A2C participants from 13 IPs. These were mainly sub-grantees, though some of the participants were from CBOs with the potential of becoming IPs. The workshop aimed to ensure that IP finance managers receive more support from their CEOs and program counterparts, minimizing potential liabilities that arise from non-compliance with USAID regulations. The training outcome was improved financial reporting by all IPs to A2C.

With the completion of this round of training, most of the IP and PIP finance and non-finance managers then in APHIA II Central's program had received introductory training on basic financial management and compliance with various USAID rules and regulations. The training team recommended (i) further discussions with IPs be undertaken by A2C program and finance staff to clarify and reinforce concepts learned; (ii) A2C program and finance staff follow up with each IP as they implement their post-training action plans and give necessary technical support; and (iii) to hold a refresher workshop in 2010, funds permitting.

Finance Management Technical Assistance for APHIA II Central Grantees

A2C grants management staff followed up with 13 grantees to clarify and reinforce concepts learned through on-the-job TA, which helped IPs implement their subgrant action plans developed during previous training.

Financial Management TA

Following training in financial management in 2009, A2C provided on-site support to ensure that grantees used effective systems to manage their grants. However, the Kenya Girl Guides Association (KGGA) experienced some financial management challenges, such as timely submission of Grantee Financial Reports (GFRs). Compounding this situation, A2C staff noted questionable costs during regular monitoring visits. To mitigate this problem:

1. A2C changed KGGA's status to a partner implemented project (PIP) and appointed the local audit firm of Carr, Stanyer and Gitau to assess the books, do bank reconciliations, and prepare quarterly reports for July 2008-January 2010. Once the books were prepared and financial reports regularized, questioned costs were determined for KGGA and terms of refund negotiated and agreed. In the interim, because KGGA ARH program operations were deemed good by A2C staff, only staff salaries were paid until Pathfinder International HQ approved the budget, workplan, and MOU. The process began in late April 2010 and continued through September 2010.

2. KGGA committed to strengthen its finance department by recruiting a new, more qualified accountant. In the interim, KGGA HQ's Financial Management Specialist and Treasurer were more actively engaged in review of financial documents prior to submission to APHIA II Central.

Capacity Building Training

To address identified training gaps in A2C-affiliated GOK health service providers (PHMT & DHMT) and local IPs and CBOs/FBOs, A2C staff developed terms of reference and sent out expressions of interest to several management training institutions for two types of ICB training courses:

- a. **Board roles and responsibilities, leadership, and governance** (management training institutions consulted by A2C: AED, the Poverty Eradication Network; MSH Kenya; Premise; and CORAT)
- b. **Project design, proposal writing, and resource mobilization training** (management training institutions consulted by A2 C: AMREF, Capacity Africa Training Institute, and MSH Kenya)

A2C met with the USAID-funded MSH Kenya Leadership, Management and Sustainability Project (LMS) on October 14, 2010, to explore potential collaboration. The requested capacity building trainings in the areas of leadership and governance, resource mobilization, and proposal writing and project management were part of the APHIA II Nairobi and Central projects' exit strategy. MSH Kenya did not have regularly scheduled courses in those areas, but rather provided targeted TA to partner organizations based on their needs. The LMS project already had, or was in the process of developing tools, to address the areas APHIA II Central were interested in.

MSH regretted that given its current activities, it was unable to provide TA during the October-December 2010 quarter. MSH indicated interest in continued networking to explore areas of future collaboration should Pathfinder be successful in its bids for APHIAPlus. Going forward, areas for future potential collaboration with MSH include: leadership training; governance training for hospital committees; governance and leadership training for community health committees; and induction and mentorship programs for newly hired managers.

6.0: Subgrants

A2C funded 21⁷ subgrants during the life of the project. Out of these 12 were implemented through the formal subgrant mechanism and nine were managed as partner implemented projects (PIPs). PIPs are projects implemented by a local partner with project costs handled by the Pathfinder Country/Central Office directly.

The various subgrantees implemented activities in programmatic areas including ART, PMTCT, FP, RH, TB, VCT, HB, OVC, PTC, AB, and OP. Specific subgrantee activities and their impact are described in the result area sections of this end-of-project report.

⁷ A2C funded 21 implementing partners through subgrants and PIPs during the life of the project. In addition, A2C directly supported eight other implementing partners through program coordinators, providing technical assistance, training, and commodities as needed. Thus, the total number of A2C implementing partners as listed in the PMP is 29. The eight additional implementing partners include: Faith Children's Center, Gatha CBO, Kaloscop CBO, Kimorori CBO, Nyakio Women's Group-Mweiga, Othaya Children Fund, Sacred Heart Endarasha, and Umoja CBO.

Successes

Providing subgrants to various local organizations has led to success in implementation of the A2C project. Additionally, the subgranting mechanism encouraged institutional capacity building, making it possible for the subrecipients to manage donor funds. Some successes include:

- Through support to sub-recipients, the project was able to reach most of the targets for the grant period.
- A high level of accountability was experienced during the project, reflecting value-for-funds through the subgranting mechanism.
- Average achievement rate for subgrants stood at 88 percent by the end of the project period.
- Support was directed towards ensuring sustainability through promotion of income generating activities. This saw many subgrantees strengthen their capacity to continue with or without funding.
- Supported the streamlining of job descriptions. Technical assistance was given to the PIPs in refining staff contracts and setting up basic human resources guidelines.
- A2C offered non-formal technical assistance in policy formulation and documentation for various subgrants and PIPs.

Challenges and Lessons Learned

- Late submission of reports, and challenges to a few of the sub-grantees to report accordingly and keep good books of account. This, in turn, affected implementation negatively.
- High staff turnover in most of the sub-grants, including changes in top management, was a challenge.
- Some of the subgrantees took long to respond to information requests required for subagreement modifications, which caused a delay in the signing of extension agreements. This delay further affected implementation.

Recommendations

- Partnerships through subgranting need be as prioritized as direct programming. This would help keep subgrants at a good level of progress with direct program work. Aspects of capacity building and institutional support need be conducted more systematically and under regulated guidance. This would improve subgrant efficiency levels.

Table 7: A2C Subgrantees and PIPs

Name	Funding Mechanism
Mugutha Women Group	Subgrant
Ruiru Bible Baptist Church	Subgrant
IAP	Subgrant
St. Joseph HIV/AIDS Self Help Group	Subgrant
Karatina Home Based Care & Counselling	Subgrant
Saikaka CBO	Subgrant
Shandumu CHWs	Subgrant
Hope World Wide Kenya	Subgrant
Christian Health Association of Kenya	Subgrant
Catholic Medical Mission Board	Subgrant
African Wildlife Foundation	Subgrant
Our Lady of Lourdes Mwea Catholic Mission	Subgrant
Kenya Girl Guides Association	PIP (Nov 2009-Dec 2010)

Name	Funding Mechanism
	Subgrant (May-Oct 2009)
Shining Star CBO	PIP
Engineer Broad Vision	PIP
Children & Youth Empowerment Centre	PIP
Ministry of Public Health & Sanitation	PIP
Ministry of Medical Services	PIP
Central Province Prisons AIDS Control Unit	PIP
Vision Gardens Home Based Care & Counselling	PIP
Eagle Neema Self Help Group	PIP

7.0: Quality Improvement

Highlights

In June 2009, a mid-term review was conducted of the APHIA II Nairobi and APHIA II Central projects by Pathfinder International headquarters staff. The evaluation team recommended that the project focus on quality, content of programs, and quality improvement of clinical and community services for increased effectiveness and standardization. Another challenge cited by the evaluation team was lack of any systematic tools for or use of supervision data or other attempts to directly observe or assess quality of services/care, either in facility or community services. The evaluation team thus recommended that the project hire a quality improvement expert to support staff, systems, facilities, and local implementing partners, and work with the MOH on quality. Areas of focus were to include client provider interaction, client satisfaction with service provision, holistic care, counseling, patient flow systems, client rights, reducing stigma and discrimination, and effective and evidence-based prevention messages and strategies. In addition, the QI expert would assist project staff in the development/adaptation and institutionalization of quality assessment tools, and assist staff in implementation of the tools for supervision and coaching of facilities and IPs.

The quality improvement advisor (QIA) was recruited and started work on February 1, 2010. She was mandated to provide technical leadership in quality improvement across Pathfinder programs in Kenya, with special emphasis on APHIA II Nairobi and APHIA II Central and work in collaboration with project directors, deputies, and team leaders in the development/adaptation of program strategies and approaches to ensure and improve the quality of clinical and community services.

During the period February 2010 – February 2011, the QIA provided technical assistance for the following project initiatives:

Technical Assistance to Teams on QI

The QIA supported building the capacity of the teams to manage quality, as well as helping the teams to learn lessons from their successes and challenges and create opportunities to celebrate and document the successes. In this regard, the QIA held capacity building sessions with the team through meetings, discussions, and field visits to address different aspects of quality as follows:

- **Introduction to quality concepts:** The teams were engaged in a session on quality in which various topics were discussed including definition of quality, quality assurance, and quality improvement; dimensions of quality; principles of quality assurance; application

of the systems view to managing quality; and definition, characteristics and sources of standards. The discussion focused on the application of this knowledge to the project setting towards improving the quality of program operations and interventions.

- **Follow up on the best practices initiative implementation:** During the meetings the teams shared their achievements and challenges on the prioritized initiatives/activities. Solutions/ways forward were agreed upon to ensure continuity in implementation of the selected activities. Progress of prioritized initiatives was tracked as documentation of achieved milestones in preparation for follow-up documentation on best practices/lessons learned as the projects came to a close. In addition, the result teams submitted progress tracking dashboards on milestones achieved under each initiative.

Adaption and Modification of the Facilitative Supervision Tool

The QIA in collaboration with the PHMT Nairobi adopted and modified the MOH's Division of Reproductive Health Facilitative Supervision Tool. The revised tool was then introduced to participants in a five-day facilitative supervision training conducted in April 2010. The training in Central Province targeted the new DHMT members from the former Nyandarua districts. During the training, a one-day practical session on application of the revised facilitative supervision (FS) tool was conducted. Feedback from the pilot of the revised FS tool was gathered from the training participants and was later incorporated into the tool. The final Facilitative Supervision Tool was disseminated to the project's service delivery specialists and clinical site coordinators.

In addition, QIA supported the coaching and on-the-job training of some DHMT and the A2N and A2C service delivery/Result 1 teams on the FS tool. However the FS tool could not be immediately implemented in Central Province due to various challenges. Following dialogue meetings with Division of Reproductive Health and Central Province PHMT members the revised FS tool was implemented in the Nyandarua districts.

Development and Adaption of TB Intensified Case Finding Tools

The QIA in collaboration with the Nairobi PHMT – the offices of the PASCO, PTLC and point person at NASCOP and DLTLTD developed a TB Intensified Case Finding (ICF) register and reporting tool to capture information gathered and summarized from the service provider adult and pediatric TB ICF tool to the district level and eventually to the province. The project supported a sensitization and dissemination workshop in Central Province, where 71 DHMT members (DHRIO, DPHN, DTLC, and DASCO) were sensitized and oriented on the new tool. The agreed way forward was for all CCC sites within the province to implement the new TB ICF tools following the sensitization workshop for CCC staff, with selected health facilities being focal sites for monitoring and feedback to the province and national level on the service provider uptake of TB screening, utilization of the tools, trend change in provincial TB screening, and case detection within CCC setting.

Job Aids and IEC Materials

During the project period, the QIA liaised with Clinton Foundation, Pathfinder CDC PMTCT project, and John Hopkins University and was able to source and distribute various job aids and resource materials to the three Pathfinder-led APHIA II projects. Items sourced and distributed to the Result 1 teams included pediatric wheels; pediatric dosing charts; pediatric frequently asked questions on fixed dose combinations; early infant diagnosis algorithm charts; FP Tiaht charts; global handbook for FP providers; and ANC, labor and delivery and postnatal HIV counseling and testing flip charts.

In addition, the QIA and service delivery specialists sourced and identified job aids and IEC materials from the MOH and ICAP. The materials identified included WHO staging and treatment regimens for both adults and children, PMTCT and IYCF charts for service providers and clients, job aids for cervical cancer screening, HIV counseling and testing job aids, FP job aids for service providers and CBDs, and FP IEC materials for clients.

Documentation

The QIA worked with the APHIA II Central outreach team to identify project successes and learn from these successes for better programming in the future. The teams were able to identify potential successful interventions and to assign themselves responsibilities to prepare presentations in response to a call for abstracts from NASCOP.

The 6th National HIV Care and Treatment Consultative Forum on “Strengthening Health Systems for Universal Access to HIV Care and Treatment” took place at the Kenyatta International Conference Centre (KICC) from October 6-8, 2010. Three presentations from APHIA II Central were accepted by NASCOP: one oral presentation by the service delivery team on “Improving access to CD4 testing” and two poster presentations by the behavior change communication team: “Beyond on pool tables, Integrating community and facility youth friendly services activities at Ruiru Health Centre” and “Ruiru Cluster HIV/AIDS Enterprise Partnership (CHEP) network, HIV workplace program.”

In addition, the QIA supported the compilation of tools, IEC materials, and job aids that were developed under APHIA II Nairobi Central, APHIA II Nairobi, and APHIA II Central. The compilation of materials can be used as a reference for other USAID and/or Pathfinder projects in Kenya and globally.

Review of Mentorship Program

The QIA and the UNITID fellow undertook a review of the mentorship program in Nairobi and Central provinces. For Central Province, the review involved an analysis of mentorship reports for the period March – May 2010.

Highlights of the analysis included reduction in the quality of reports submitted to the project and a general lack of continuity in the mentoring process. The later was attributed to high staff turnover and mentees not being available on site for mentorship due to the lack of a schedule. The minutes of the meeting were shared with the project’s senior management team. Key recommendations that could be applied in the APHIAplus project included:

- Create a roadmap of what the program will accomplish and what outcomes will result.
- Develop a minimum set of competencies (learning objectives) that mentees of each component should exhibit by the end of the mentorship.
- Develop an M&E framework that involves the use of key performance measures with appropriate tools to measure performance – use of national/appropriate guidelines, clearly articulated benchmarks and manageable steps, and clear deliverables at each step.
- Introduction and orientation of the mentors to the DHMT and facility staff, ensuring that all parties are aware about the presence and role of the mentors.
- Develop a visit schedule, reporting guide, and report summary sheet to aid reporting and report utilization to encourage analysis, feedback, adaptation, and support.
- Ensure a continuous monitoring and feedback process including an interconnection of the supervision and mentoring teams.

Reflection/After-action Review Exercise

During the quarter, the quality improvement advisor supported the APHIA II Central Result 2 (BCC) and 3 (HCS and OVC) teams carry out reflective/after-action review (AAR) exercises during the project close-out period. An AAR exercise is a discussion of an event/program/project that focuses on performance standards and enables professionals to discover *what happened, why it happened, what could have been done differently, and how to sustain strengths and improve on weaknesses*. An AAR is a useful exercise as it can serve as the basis for reflective/experiential learning from successes and failures, support a continuous learning culture, and fuel the desire to find and use best practices and innovative approaches. An AAR promotes learning from experience, team work through improved communication, and feedback within the team and improved understanding of team performance. Overall, it helps people think about how best to work together to produce better results.

The questions posed for discussion during the AAR exercise for both teams included:

- What did the team set out to do?
- What actually happened?
- What are the five things the team did well? What makes these things successful? How did the team members know they were successful (provide evidence)?
- What are the three to five things the team did not do well? Why? How did team members know that they did not work well (provide evidence)?
- What process was followed in implementation of the activities? Were any standards or guidance provided?
- What five things would the team do differently?
- What are the key challenges the team has faced and how would team members have addressed them? How could the challenges have been prevented?
- What are some of the unintended outputs and/or outcomes?
- What are the sustainability measures in place?

The exercise provided staff with the opportunity to review their experience, conclude on their experience under the two APHIA 2 projects, and provide recommendations that could guide the APHIA Plus project design at start up.

Performance Monitoring Plan

APHIA II - CENTRAL PROVINCE - PERFORMANCE MONITORING PLAN (PMP)

1 MARCH 2009 - 28 FEBRUARY 2011

PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Yrs 1-3 Target	Total Achievement (Yr1-Yr3)	% Achievement
Prevention -Abstinence and/or Being Faithful										
2.1	Number of individuals reached through community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	140,500	190,654	258,000	263,297	110,000	77,607	508,500	531,558	105%
2.2	Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	1,160	1,684	1,500	1,420	828	45	3,488	3,149	90%
5.1	Number of targeted condom service outlets (Fixed sites or distribution on fixed schedules)	45	291	75	386	75	386	75	386	515%
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	233,200	446,172	400,000	671,850	168,000	172,848	801,200	1,290,870	161%
5.3	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	185	95	250	480	105	-	540	575	106%
Prevention - Medical Transmission/Injection Safety										
4.1	Number of individuals trained in medical injection safety	9	30	15	25	6	0	30	55	183%
Prevention of Mother-to-Child Transmission										
1.1	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	102	106	120	105	120	106	140	106	76%
1.2	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	18,667	20,492	32,000	44,198	13,300	18,704	63,967	83,394	130%
1.3	Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	770	550	1,360	1,340	571	585	2,701	2,475	92%
1.4	Number of health workers trained in the provision of PMTCT services according to national and international standards	60	256	120	360	40	48	220	664	302%

APHIA II - CENTRAL PROVINCE - PERFORMANCE MONITORING PLAN (PMP)

1 MARCH 2009 - 28 FEBRUARY 2011

PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Yrs 1-3 Target	Total Achievement (Yr1-Yr3)	% Achievement
Counseling and Testing										
9.1	Number of service outlets providing counseling and testing according to national and international standards	73	102	75	90	75	83	75	83	111%
9.2	Number of individuals who received counseling and testing for HIV and received their test results	21,600	50,253	60,000	202,407	25,000	141,009	106,600	393,669	369%
9.3	Number of individuals trained in counseling and testing according to national and international standards	40	100	80	240	90	90	210	430	205%
HIV/AIDS Treatment/ARV Services										
11.1	Number of service outlets providing ART services according to national or international standards	27	34	38	45	38	45	38	45	118%
11.2	Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	245	929	500	1,939	210	881	955	3,749	393%
11.3	Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	3,500	8198	4,000	10,110	4,210	11,093	4,210	11,093	263%
11.4	Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	3,000	6,518	3,500	7,620	3,710	8,435	3,710	8,435	227%
11.5	Number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	15	236	60	134	15	10	90	380	422%
Palliative Care (including TB/HIV care)										
6.1	Total number of service outlets providing HIV-related palliative care (including TB/HIV)	56	87	59	48	59	48	59	48	81%
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)	5,872	13,488	11,079	16,427	15,248	17,810	15,248	17,810	117%
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	100	1,960	170	1,224	70	86	340	3,270	962%

APHIA II - CENTRAL PROVINCE - PERFORMANCE MONITORING PLAN (PMP)

1 MARCH 2009 - 28 FEBRUARY 2011

PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Yrs 1-3 Target	Total Achievement (Yr1-Yr3)	% Achievement
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).	36	44	38	46	38	46	38	46	121%
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)	237	467	275	371	302	396	814	1,234	152%
7.3	Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed). (Subset of 6.3)	30	426	50	649	20	38	100	1,113	1,113%
Orphans and Vulnerable Children										
8.1	Number of OVC served by an OVC program	27,000	27,254	27,000	27,043	27,000	27,043	27,000	27,043	100%
8.1a	Number of OVC served by Primary Direct OVC programs		26,203		25,640		26,285	-	26,285	
8.1b	Number of OVC served by Supplementary Direct OVC programs		1,051		1,403		758	-	758	
8.2	Number of individuals trained in caring for OVC (CORPS, providers, caretakers)	24	1,153	24	801		380	48	2,334	4,863%
Strategic Information										
13.1	Number of local organizations and service points provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS)	155	229	166	242	166	242	166	242	146%
	Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	15	37	24	32	10	20	49	89	182%
Other/Policy Development and System Strengthening										
14.2	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	29	25	30	35	30	35	30	35	117%
14.3	Number of individuals trained in HIV-related institutional capacity building	9	65	24	79	10	115	43	259	602%
14.5	Number of individuals trained in HIV-related stigma and discrimination reduction	50	915	150	513	30	369	230	1,797	781%
14.6	Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment	35	1,894	120	535	50	927	205	3,356	1,637%

APHIA II - CENTRAL PROVINCE - PERFORMANCE MONITORING PLAN (PMP)

1 MARCH 2009 - 28 FEBRUARY 2011

PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Yrs 1-3 Target	Total Achievement (Yr1-Yr3)	% Achievement
NON-PEPFAR ILLUSTRATIVE INDICATORS										
IR.1: IMPROVED AND EXPANDED FACILITY-BASED HIV/AIDS, TB, RH/FP, MALARIA & MCH SERVICES										
IR 1: Expanded availability of HIV/AIDS prevention, care and treatment services										
	Number of service outlets providing PEP	17	33	34	45	34	48	34	48	141%
	Number of individuals trained in pediatric HIV treatment	6	108	15	23			21	131	624%
	Number of service outlets renovated & equipped to facilitate provision of comprehensive services	5	4	5	6		9	10	9	90%
Sub-Result 1.2: Improved & Expanded Facility-based HIV/AIDS, TB, RH/FP, Malaria and MCH Services										
	Number of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MCH services	58	63	120	115	120	115	120	115	96%
	Number of service outlets expanding contraceptive method mix	80	153	166	152	166	152	166	152	92%
	Number of service outlets with youth friendly services	4	3	12	5	17	5	17	5	29%
	Number of service outlets whose stock levels ensure near-term availability	138	138	166	142	166	142	166	142	86%
	Number of service providers trained, by type of training and service provider	23	311	90	833	38	775	151	1,919	1,271%
	Couple years of protection (CYP) in USG-supported programs	-	98,036	-	115,193	-	69,245	-	282,474	-
Sub-Result 1.3: Reinforced networking between levels of care and clinical services and communities										
	Number of service outlets that provide/serve CCCs that are linked to community-based care networks/clusters	27	34	29	45	29	45	29	45	155%
	Number of implementing partners provided orientation on the referral system/clusters and networks	29	29	30	35	30	40	30	40	133%
IR.2: Improved & expanded civil society activities to increase healthy behaviors										
	Number of implementing partners supported to implement quality HIV/AIDS prevention programs	29	29	30	35	37	35	37	35	95%
IR2.1: Expanded community and workplace prevention programs										
	Number of workplace/worksites with trained health workers (peer educators, depot holders, etc.)	30	32	60	42	90	42	42	116	276%

APHIA II - CENTRAL PROVINCE - PERFORMANCE MONITORING PLAN (PMP)

1 MARCH 2009 - 28 FEBRUARY 2011

PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Yrs 1-3 Target	Total Achievement (Yr1-Yr3)	% Achievement
	Number of workplace/worksites that have HIV/AIDS workplace policies and programs	22	25	45	33	45	33	45	33	73%
	Number of workplace/worksites with appropriate referral and access to clinical services	22	20	45	25	45	25	45	25	56%
	Number of workers/family members served and/or referred, by type of service and/or referral	50		70	180	30	-	150	180	120%
Sub-Result 2.2: Expanded prevention programs targeting most-at-risk populations										
	Number of informal sites reached with HIV/AIDS prevention messages	26	72	60	62	86	68	86	68	79%
IR.2.3 Reinforced networking between communities and clinical services										
	Number of village health committees (VHC) established	13	21	18	24	3	24	21	24	114%
	Number of VHCs linked to health facilities	13	21	18	24	3	24	21	24	114%
IR.3: Improved & expanded care & support for people & families affected by HIV/AIDS										
IR 3.1: Expanded home and community support programs										
	Number of community leaders who attended sensitization workshops	250	851	500	246	250	120	1,000	1217	122%
	Number of people trained in IGA and linked to micro-credit institutions	250	370	300	949	200	82	750	1401	187%
	Number of individuals provided home-based care		9,487		10,946		11,289	-	11,289	
IR 3.2: Expanded support for OVC										
	Number of Implementing Partners supported to provide care and support to OVC	29	29	32	31	32	31	32	31	97%
IR.3.3 Reduced stigma & establishment of safety nets for PLWHIV & their families										
	Number of community-based anti-stigmatization advocacy/campaign events conducted	640	1797	1100	2,548	460	370	2,200	4,715	214%
	Number of individuals trained/sensitized towards PLWHIV, by type of training and individual (paralegals, CORPS, health workers, etc.)	1,915	41,464	5000	16,798	2,100	1,980	9,015	60,242	668%
	Number of community-based paralegal clinics established and linked to paralegal aid organizations	8	21	16	9	16	9	16	9	56%

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1 MARCH 2009 - 28 FEBRUARY 2011

PEPFAR Indicator	Indicator	Yr 1 Target	Yr 1 achievement	Yr 2 Target	Yr 2 achievement	Yr 3 Target	Yr 3 achievement	Yrs 1-3 Target	Total Achievement (Yr1-Yr3)	% Achievement
	Number of rescue centers for victims of violence established	2	2	3	2	6	2	6	2	33%
	Number of PLWHIV/OVC caretaker support groups formed and linked to other services as appropriate	10	7	15	15	15	15	15	37	247%