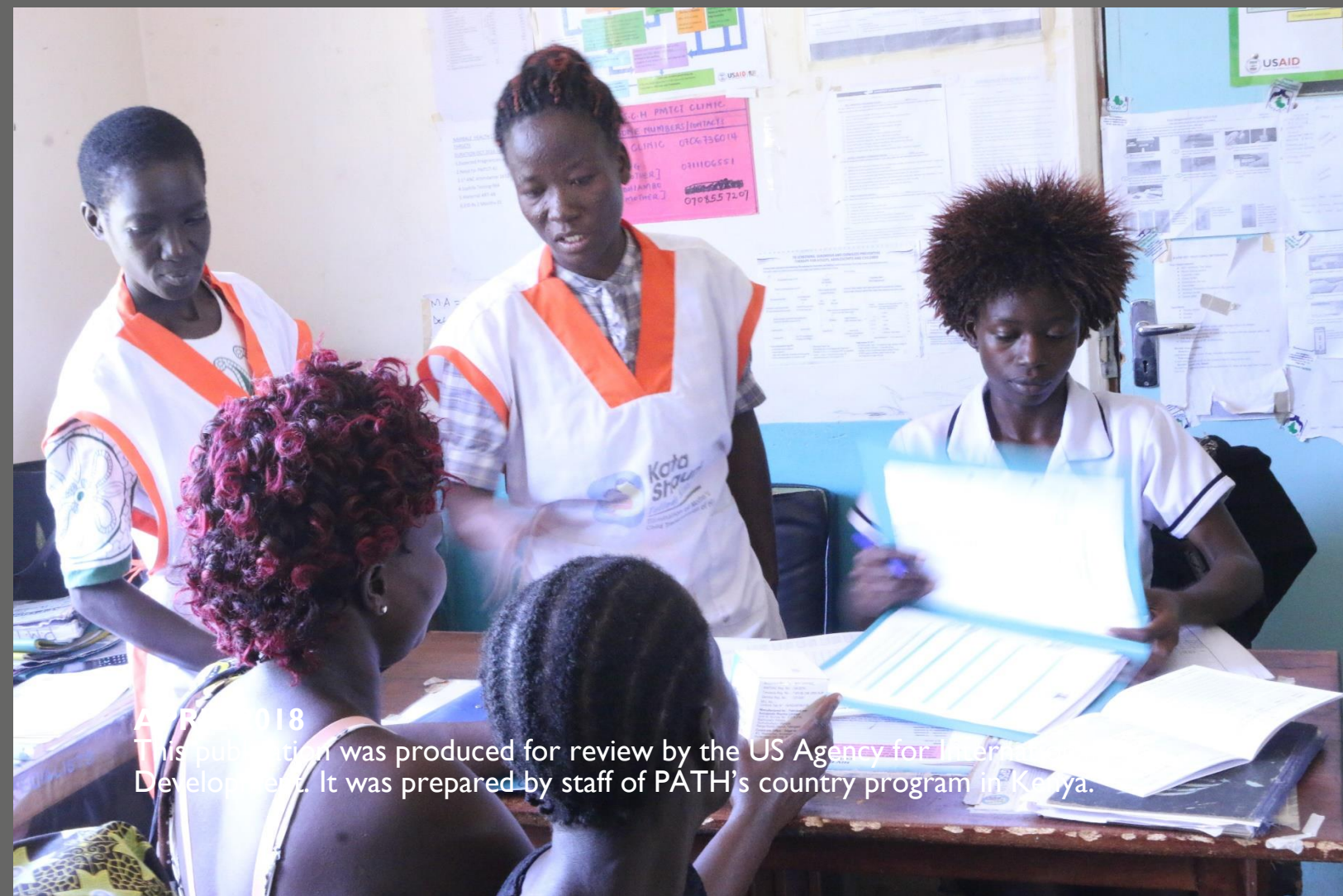




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AFYA ZIWANI (HSDSA CLUSTER I) QUARTERLY PROGRESS REPORT



April 2018

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AFYA ZIWANI (HSDSA Cluster I)

FISCAL YEAR 2018

QUARTER I PROGRESS REPORT

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ABBREVIATIONS

ADT	ART (antiretroviral therapy) dispensing tool
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
CAPA	Corrective Action Preventive Action
CCC	comprehensive care center
CDH	county department of health
CHMT	Council Health Management Team
CHVs	community health volunteers
CME	continuing medical education
COP	Country Operational Plan
CPSB	County Public Service Board
DHIS	District Health Information Software
EBI	evidence-based intervention
EID	early infant diagnosis
EMR	electronic medical records
EQA	external quality assessment
GBV	gender-based violence
HHA	Healthy Heart Africa
HEI	HIV exposed infant
HP+	Health Policy Plus
HRH	Human Resources for Health
HSDSA	HIV Service Delivery Support Activity
HTS	HIV testing services
KEMSA	Kenya Medical Supplies Authority
KHQIF	Kenya HIV Quality Improvement Framework
MCH	maternal and child health

MOH	Ministry of Health
NASCOP	National AIDS and STIs Control Programme
NPHL	National Public Health Laboratory
OJT	on-the-job training
OTZ	Operation Triple Zero
OVC	orphans and vulnerable children
PCR	polymerase chain reaction
PMTCT	prevention of mother-to-child transmission
PNS	partner notification services
PrEP	pre-exposure prophylaxis
PT	proficiency testing
Q	quarter
QI	quality improvement
RDQA	routine data quality audits
RTK	rapid test kit
SAPR	Semi Annual Program Report
SCH	Sub-County Hospital
SIO	Splash Inside Out!
SCHMT	Sub County Health Management Team
STI	Sexually Transmitted Infection
TAT	Turnaround Time
TB	Tuberculosis
USAID	United States Agency for International Development
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

EXECUTIVE SUMMARY

The HIV Service Delivery Support Activity (HSDSA) cluster 1 project is working in five (5) counties of the Nyanza region. Three of the counties are designated scale-up to saturation counties namely Homa Bay, Kisumu and Migori with the other two Kisii and Nyamira aggressive scale up to saturation counties. The US Agency for International Development-funded project is being implemented from October 2017 to September 2022 by PATH working with small business initiatives partner and local implementing partners.

In Year 1 Quarter 2 (January through March 2018), the period under review, the project continued to align its activities with US President's Emergency Plan for AIDS Relief county prioritization based on the HIV burden and continuum of care HIV/AIDS goals of 95-95-95, while strengthening Ministry of Health institutional capacity and accountability for the management of community, facility and county HIV response.

Through HIV prevention services implemented during the reporting period, a total of 589 clients accessed voluntary medical male circumcision services during the reporting period, bringing the total number reached in the Semi-Annual Program Results (SAPR 2018) period to 19,966, against a Country Operational Plan (COP) 17 target of 38,605 (52% achievement). Behavioral interventions reached 1,512 fisherfolk with evidence-based interventions during the SAPR 2018 period under review, against a COP 17 target of 27,000(6% achievement).

The project will implement the DREAMS initiative in 50 wards in the three counties of Homa Bay, Kisumu and Migori. The project as at SAPR 2018 had enrolled 67,942 adolescent girls and young women (AGYW), against a COP 17 target of 91,893, 74% achievement of the project target; all have been entered into the DREAMS database. During the SAPR 2018 reporting period, 67,942 AGYW received services in the 194 safe spaces across the 50 wards. At the end of the reporting SAPR 2018 period, the project enrolled 223 new AGYW (Kisumu 74; Homa Bay 149) for oral pre-exposure prophylaxis (PrEP) in safe spaces, an achievement of 12% against the COP17 target of 1,908. The project will continue to strengthen implementation of PrEP services in order to reach targeted AGYW.

During the reporting quarter, the project supported HIV testing and counseling of 193,638 clients. This brings the total number of clients counseled and tested in the SAPR 2018 period (October 2017 through March 2018) to 351,864 against the COP17target of 1,438,452 (24% achievement). The number of clients who tested HIV positive for the reporting period was 2,494, for a total number of HIV-positive clients in the SAPR 2018 of 4770, against a COP17 target of 29966, a 16% achievement.

During the reporting quarter, 2,157 clients were initiated on antiretroviral therapy, bringing the total to 4148 clients within the SAPR 2018 period, a 26% achievement against the COP17 target. At the end of the reporting period, 49888 clients were active on treatment, against the COP17 target of 62676 (80% achievement).

During the reporting quarter, 9656 pregnant women were counseled and tested for HIV, of whom 813 (8%) tested positive. Maternal prophylaxis was provided to 795 women (98% of those who tested positive), and 788 infants (97%) received prophylaxis. During the SAPR 2018 period, 18130 women

accessed testing services for the prevention of mother-to-child transmission of HIV, against a COP17 target of 49,814 (36% achievement). Among these, 1573 women (9%) were diagnosed HIV positive. Maternal prophylaxis uptake for the SAPR 2018 period was 98% and infant prophylaxis uptake was 97%. For the SAPR 2018 period, maternal prophylaxis performance translates to a 46% achievement against the COP17 target.

The project will accelerate activity implementation in all service areas to ensure the attainment of APR 2018 targets. The project is carrying out various rapid results initiatives in the next quarter including for HIV prevention activities, which had a slow start-up due to various contractual approvals for LIPs required before activity implementation could commence, to ensure the project is on track to attain COP 17 targets.

I. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

ADOLESCENT GIRLS AND YOUNG WOMEN

In the reporting SAPR period, the project enrolled 67,942 adolescent girls and young women (AGYW) against a target of 91,893 (74% achievement). The project used a layering approach to provide a comprehensive package of services to AGYW, as eligible by age cohorts. Under the gender-based violence (GBV)-NORM indicator, 57,595 AGYW had completed SASA sessions for the prevention of violence as at SAPR. Among those completing the sessions, the project worked with linked facilities to provide 1,501 AGYW with clinical post-GBV care. Under PP_PREV, 41,201 AGYW completed evidence-based intervention (EBI) waves in the SHUGA 2, My Health My Choice and Healthy Choices for a Better Future. The project continues to ensure that newly enrolled AGYW receive EBIs as a primary intervention. During the PP_PREV sessions, 43,744 eligible AGYW received condom education and took condoms, while 46,094 eligible AGYW received contraceptive method mix education. Working in conjunction with link facilities, the project supported outreaches for uptake of preventive biomedical interventions. As at SAPR, the project had provided HIV testing services (HTS) to 54,054 AGYW with 179 (< 1% positivity) HIV positive, and all were enrolled in HIV care. The project enrolled 223 new AGYW (18–19 years old: 59 and 20–24 years old: 164) for pre-exposure prophylaxis (PrEP), bringing the total number of eligible AGYW on PrEP as at SAPR to 1,394. The project is closely working with the county government to ensure continued high-quality PrEP programming for AGYW.

The project has been engaged in the reporting quarter on start-up activities to enable counties, stakeholders, and partners understand the new implementation approach to AGYW interventions. Contract negotiations with the donor United States Agency for International Development (USAID) have been ongoing through the reporting quarter, hence slowing down implementation. The project is on the verge of completing these discussions and engaging its local implementing partners to implement accelerated activities to achieve Annual Performance Report targets. For ongoing PrEP recipients, the project has worked with link facilities to ensure continued access to commodities and services.

Fisher folk

In the SAPR period, the project implemented a comprehensive package of interventions for fisher folk in 12 beaches of Kisumu. The interventions implemented included Splash Inside Out! (SIO), which besides disseminating behavioural messages encouraging and empowering fisher folk to reduce behaviours that increase risk of HIV, addresses matters of stigma and gender norms among the fishing communities. As at the end of SAPR, the project reached 1,512 fisher folk, who completed waves of the SIO intervention. This is against the set Country Operational Plan (COP) target of 27,000. Among these, 1,320 were newly tested for HIV with 74 (5% positivity) returning an HIV-positive result and all linked to long-term HIV care and treatment. Additionally, 19 eligible males underwent voluntary medical male circumcision (VMMC), while 42 individuals were screened and treated for sexually transmitted infections (STIs). The project was able to provide 1,659 fisher folk with condoms and condom education. This figure includes 147 fisher folk who were not undergoing the behavioural intervention but came over to request for condoms.

Compared to COP 2016, the new targets for the same locations increased more than fourfold from 5,890 (COP16) to 27,000 (COP17). This may require some discussion on target rationalization, since the targets provided exceed the number of fisher folk population in the project catchment as provided by the Kenya Fisheries Department. The project has been in discussions with USAID on local implementing partner contracting and this delayed implementation in the reporting quarter. The project will embark on accelerated fisher folk implementation interventions in the next quarters to meet Annual Performance Report targets as best as possible. This will include increasing the number of sessions per day per pair of facilitators to two, mainstream biomedical interventions during behavioural sessions, close monitoring and support supervision, and increasing in number of peer educators.

Voluntary Medical Male Circumcision

During the period January to March 2018, the project continued to provide direct service delivery support to all the 36 project-supported voluntary medical male circumcision (VMMC) sites through the provision of consumables, equipment, reporting tools, supportive supervision, and mentorship on VMMC service provision. All the 36 VMMC sites are in the scale-up to saturation counties of Homa Bay, Migori, and Kisumu. During this reporting period, a total of 589 clients accessed VMMC services across the 36 project-supported sites. Those counseled and tested for HIV as part of VMMC minimum package of services were 574 (98%), of whom two (2) turned positive and were both referred and linked for HIV care, treatment, and support. There was no adverse event reported.

As at SAPR, 19,966 clients had accessed VMMC services against a COP 2017 target of 38,605 (52% achievement). Of these clients, 18,916 (95%) were counseled and tested for HIV as part of VMMC minimum package of service, with 22 (< 1% positivity) testing positive for HIV and were all linked into HIV care, treatment, and support in the respective facilities. All the circumcisions were done using the dorsal slit surgical method. The proportion of clients coming back for follow-up within 14 days of circumcision was at 91% (18,207 of 19,966 clients circumcised) with no adverse event reported.

Migori County had 6,238 circumcisions conducted against a COP 2017 target of 9,609 (65%) and Homa Bay County with 12,678 circumcisions against a COP 2017 target of 25,829 (49% achievement). The performance was attributed to successful VMMC outreaches in Migori and Homa Bay Counties. Kisumu County conducted 1,050 circumcisions against a COP 2017 target of 3,167 (33% achievement). Kisumu County's performance was greatly affected by the delayed initiation of VMMC activities in the reporting quarter, given that Muhoroni, the only VMMC project-supported subcounty in Kisumu County, needed additional donor approval prior to rollout of activities. The overall SAPR achievement is attributed to the project support for six weeks of VMMC rapid results initiative campaigns coinciding with school holidays in November/December 2017, across all the fixed and outreach sites.

The table below summarizes VMMC achievement by quarter as at SAPR 2018.

Table 1. VMMCs done as at COP 2017 SAPR.

Qtr	County		Male Circumcisions	% Achievement
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		COP17 Targets	10-14yrs	15-24yr	25+	Total	
Q1	Homa Bay	6,457	6,043	5,481	735	12,259	190%
	Kisumu	792	337	468	224	1,029	130%
	Migori	2,402	2,948	2,710	431	6,089	253%
	Totals	9,651	9,328	8,659	1,390	19,377	201%
Q2	Homa Bay	6,457	96	231	92	419	6%
	Kisumu	792	0	13	8	21	3%
	Migori	2,402	20	78	51	149	6%
	Total	9,651	116	322	151	589	6%
SAPR	Homa Bay	25,829	6,139	5,712	827	12,678	49%
	Kisumu	3,167	337	481	232	1,050	33%
	Migori	9,609	2,968	2,788	482	6,238	65%
	Total	38,605	9,444	8,981	1,541	19,966	52%

The males older than 15 years accounted for 53% all male circumcisions done in the SAPR 2018 period.

To increase demand for VMMC services, the project continued to engage with community structures for social mobilization during VMMC rapid results initiative campaigns and outreaches targeting males aged 10 to 29 years in the community and in educational institutions. Door-to-door, community mobilization by the community health volunteers (CHVs) also ensured that there was a steady stream of clients at the facility level. The project also continued to sensitize women on the benefits of VMMC, enabling them to make referrals, accompany partners for VMMC, and offer support during the healing period. In addition, the project continued to strengthen intra-facility referral by referring for VMMC services eligible men who test HIV-negative from the different facility testing points. The project supported and participated in the national, county, and sub county VMMC taskforce activities for the purposes of coordinating VMMC services in the region.

During this SAPR period, the project continued to provide internal quality assurance through the project's own VMMC Quality Assurance team and external quality assurance through the Sub-County Health Management Team (SCHMT). The project and Ministry of Health (MOH) teams continued to ensure that all clients receive the service using the recommended dorsal slit technique and ensure compliance with World Health Organization (WHO) guidelines on tetanus immunization prior to circumcision using male circumcision devices, Shang Ring, and PrePex.

The project continued with the process of computerizing management of VMMC data, which enables the project to generate VMMC data electronically and perform specific VMMC data disaggregation for reporting and decision-making purposes.

HIV Counseling and Testing Services

During the reporting period, the project continued with direct service delivery support to the 250 project-supported sites. Focus was on HTS optimization strategies with priority for partner notification services (PNS), reaching more eligible adolescents and men with HTS including provision of extended and weekend testing, and ensuring high-quality HIV testing through enrollment for proficiency testing (PT) round 18, among other interventions. The project supported implementation of the various strategies, tracking the outcomes and scaling up the interventions to more sites. This was done through continued mentorship on use of partner notification registers and the accompanying reporting tools and scripts and understanding the testing/retesting guidance specifically for discordant couples in provision of PNS.

The project-supported facilities were facilitated through regular support supervision, planned mentorship, sensitization, and on-the-job training (OJT) with the aim of promoting high-quality HTS and documentation. The project also strengthened escorted referrals, linkages, and follow-up of clients who test HIV-positive to immediately access care services. This was reviewed through monthly linkage meetings held at the sub county level using the Master Facility Linkages Register (and/or new MOH HTS registers that include linkage outcomes) to account for all newly identified HIV-positive clients and the linkage outcomes.

The project deployed 166 HTS non-clinical service providers as a task-shifting strategy to enhance provider-initiated testing and counseling services. The high-volume facilities were allocated more than one HTS service provider, and coverage in the high-volume sites included the wards, outpatient departments (to include special clinics), laboratories, maternal and child health (MCH) and nutrition clinics, and comprehensive care centers (CCCs). The 166 HTS non-clinical service providers were distributed across 123 sites (out of the 250 project sites) covering all high- and medium-volume facilities and some of the strategic low-volume facilities (mostly dispensaries). The sites not covered by project-supported HTS non-clinical service providers are providing HTS through clinical service providers and HTS volunteers under supervision of the project and MOH technical teams.

During the reporting quarter January to March 2018, 193,638 clients were counseled and tested, of whom 2,494 (1.3%) were identified as HIV-positive.

The project is on track on the counseling and testing targets in Kisii (80%) and Migori (59%) against expected SAPR target of 50%. However, Homa Bay (at 13%), Kisumu (at 31%), and Nyamira (at 22%) are below the expected 50% threshold for this reporting SAPR period. The low performance in the three counties is attributed to an almost fourfold increase in COP17 targets for Homa Bay (142,026 in COP16 to 526,533) and threefold increase for Nyamira (216,652 in COP16 to 605,871) in the counseling and testing targets. Kisumu had a 2.5-fold increase in testing targets from 63,004 in COP16 to 155,282. Based on past performance in COP16, when the counties surpassed their testing targets with Homa Bay achieving 157,871, Kisumu at 126,756, and Nyamira at 292,543, the COP17 testing targets are significantly steep and not in tandem with population estimates and/or past performance. This will have contributed to the low performance against COP17 targets this reporting quarter in the three counties.

The project achievements for the SAPR 2018 were 351,864 counseled and tested against COP17 target 1,438,452, a 24% achievement. For HIV-positive, 4,770 newly identified against a COP17 target of 29966, a 16% achievement.

The HTS achievements for adults and pediatrics are in Table 2 and Table 3 below.

Table 2. Overall adult HTS achievement SAPR 2018 period (Oct 2017–March 2018).

County	Overall Testing achievement against target-SAPR					Overall positive achievement against target-SAPR				
	COP 17 Target	Y1Q1	Y2Q2	Total SAPR	% Achieved	Target COP 17	Y1Q1	Y1Q2	Total SAPR	% Achieved
Homa Bay	526533	30873	39542	70415	13%	8410	478	551	1029	12%
Kisumu	136298	21159	21300	42459	31%	7020	496	481	977	14%
Migori	145706	41949	43956	85905	59%	6070	640	712	1352	22%
Kisii	24044	9571	9304	18875	79%	368	99	80	179	49%
Nyamira	605871	53181	79536	132717	22%	8098	563	670	1233	15%
Total	1438452	156733	193638	350371	24%	29966	2276	2494	4770	16%

On identification of the adult HIV-positive clients, only Kisii (49%) nearly met the expected targets of 50%. The rest of the counties underachieved with Kisumu at 14%, Homa Bay at 12%, Migori at 22%, and Nyamira at 15%. Despite the low performance recorded, all the five (5) counties improved in absolute HIV-positive identified this reporting quarter January to March 2018 of 2,494 vis-a-vis 2,276 previous quarter. The proportionate yield for the SAPR 2018 was 1.3%. The COP17 HIV-positive targets for Homa Bay County was increased by 51% to 8,410 from 5,572 in COP16 even though in the preceding year only achieved 32% (1,770) of target in COP16. Likewise Nyamira had a 52% increase in positive targets in COP17 to 8,098 from 5,337 in COP16, having only achieved 37% (1,975) positives in COP16. These steep targets have affected the proportionate performance vis-a-vis targets.

Table 3. Overall pediatric HTS achievement SAPR 2018.

County	Target COP 17	Paediatric Testing achievement against target SAPR				Target COP 17	Paediatric pos achievement against target SAPR			
		Y1Q1	Y1 Q2	Total SAPR	% Achieved		Y1Q1	Y1 Q2	Total SAPR	% Achieved
Scale up to saturation counties										
Homabay	103,179	1,199	1,235	2,434	2%	819	33	58	91	11%
Kisumu	27,199	502	506	1,008	4%	430	16	11	27	6%
Migori	31,709	1,277	1,138	2,415	8%	594	53	46	99	17%
Total	162,087	2,978	2,879	5,857	4%	1,843	102	115	217	12%
Aggressive scale up counties										
Kisii	4,444	188	170	358	8%	27	6	4	10	37%
Nyamira	50,577	1,192	1,157	2,349	5%	598	25	27	52	9%
Total	55,021	1,380	1,327	2,707	5%	625	31	31	62	10%
Grand Total	217,108	4,358	4,206	8,564	4%	2,468	133	146	279	11%

The Pediatrics counseled and tested were 8,564 with 279 (3.3%) turning out HIV-positive for the reporting period October 2017 to March 2018. This is a 4% achievement on counseled and tested (COP 17 target of 217,108) and an 11% achievement on positive (COP17 target of 2,468). The age disaggregated COP17 pediatric targets were derived using the COP16 HIV-positive achievements prorated for pediatric contribution.

For the pediatric HIV positives identified, none of the counties were on track with Homa Bay at 11%, Kisii at 37%, Kisumu at 6%, Migori at 17%, and Nyamira at 9%. The project will aggressively implement the strategies highlighted below and specifically ensure 100% uptake in testing for the elicited contacts in partner notification services (majority of whom are children), testing of orphans and vulnerable children (OVC), malnourished children, and children with recurrent infections like pneumonia and tuberculosis (TB).

The project will pursue several strategies to achieve the steep targets set and work toward a 75% achievement by Q3 reporting period for all HTS reporting targets.

The HTS strategies for meeting COP17 targets by APR include:

- Scale up PNS with focus on elicitation of male sexual partners.
- Provide demand creation interventions through targeted key messaging, involvement of CHVs at the household level, and use of the existing peer and psychosocial groups to mobilize the community with an aim of improving access and uptake in HTS services particularly for PNS related outreaches.
- Optimize HTS at the facility and community settings (for PNS-related and men-focused interventions). Specifically aiming for 100% coverage of all testing service delivery points in the facility (TB clinics, MCH/family planning, STI, outpatient department, inpatient department, medical clinic, gynecology and surgical outpatient clinics, laboratory, nutrition clinics) and providing weekend and extended hours services with a focus on eligible pediatric, adolescent, and male populations.
- Intensify testing among specific target populations including men and adolescents and retesting of key and high-priority populations as per the current guidelines. All the previously mapped hotspots will be revisited and the eligible populations will be retested.
- Utilize existing male-specific facility psychosocial support groups, male peer educators, male champions, and male CHVs to mobilize men for testing.
- Offer expanded testing targeting all men coming to the facility regardless of symptoms of HIV as guided by the expanded HIV testing eligibility decision-making algorithm already distributed. The algorithm allows testing clients verbal reporting of negative results—not verified.
- Support of men targeted outreaches to formal/informal work places informed by PNS data and PNS client characterisation.
- Map out key population (men who have sex with men, injecting drug users, and sex workers) and reach out to elicited sexual partners for testing.
- Utilize more male HTS providers to support male testing as informed by male focus group discussions conducted. Currently, 45 (27%) out of 166 HTS providers supported are men.
- Integrate HTS within non-communicable disease (NCD) hypertension screening platform (Healthy Heart Africa, HHA) in Homa Bay and Kisumu, VMMC, and AGYW DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) implementation in Homa Bay, Kisumu, and Migori.
- Support rollout of HIV self-testing targeting men.
- Institutionalize monthly site-level performance reviews and utilize them as forums to monitor facility performance.

Partner Notification Services

The project intensified PNS to the partners of all people diagnosed with HIV as part of a comprehensive approach to improving HTS coverage. During the reporting quarter January to March 2018, 1,306 index clients were offered PNS; 3,228 contacts were elicited of whom 348 were known positives; 1,655 contacts were tested out of the eligible 2,880 translating into a testing uptake of 57%. Of the ones tested, 140 turned HIV-positive, a positivity rate of 8% with a linkage of 84%. The contribution of adult HIV-positive to all newly identified HIV-positive was 91% (127/140), with proportionate yield of 16% (56/358) among men and 20% (71/348) among female. The linkage to care for all newly identified HIV-positive adult men was 91% this reporting quarter and 82% (58/71) for female. All clients who were not linked are actively being traced to ensure 100% linkage to care.

Table 4. PNS performance January to March 2018

	Kisii	Nyamira	Kisumu	Homa Bay	Migori	Totals
Index clients	104	504	135	292	271	1,306
Total contacts	309	916	368	914	721	3,228
Key populations among contacts reached	23	72	36	149	68	348
Eligible for testing	286	844	332	765	653	2,880
Tested	212	504	158	465	316	1,655
New positives	10	36	27	14	53	140
Linked to care	10	35	19	10	43	117
Testing uptake	74%	60%	48%	61%	48%	57%
Positivity rate	5%	7%	17%	3%	17%	8%
Linkage to care	100%	97%	70%	71%	81%	84%
Proportion of key populations in contacts reached	7%	8%	10%	16%	9%	11%

For Homa Bay County, the aggregate PNS positivity rate at 3%, Kisii at 5%, and Nyamira at 7% is low compared to the aggregate average PNS yield of 8%, with Kisumu and Migori both at 17%. For PNS interventions, the proportionate yield/positivity is higher than across all HTS interventions at 1.3% this reporting quarter even though the absolute numbers are relatively small. Homa Bay County had the

highest proportion of known positives among the elicited contacts at 16%, up from 12% the previous quarter; this could be attributed to the intensive family and community testing done in the previous quarters. The other counties had on average 7%–11% of known positives among the contacts elicited for testing. The project will optimize testing among the elicited eligible contacts and ensure all newly identified HIV-positive clients are offered PNS, given the high positivity rate realized from this strategy. This will be done through the following strategies:

- Use PNS champions from among HTS providers to increase contact elicitation and uptake testing of eligible contacts through mentorship.
- Incentivize testers to elicit three or more sexual partners and mobilize, test, and document the test outcomes.
- Sensitize other service providers like MCH nurses and CCC clinicians to scale up elicitation of contacts and testing of the elicited eligible partners.
- Utilize the non-communicable disease hypertension screening and treatment platform (HHA) to scale-up PNS activities at the sites they are working in.
- Dedicate PNS days (a day in a week) for high-volume sites for follow-up and testing of elicited contacts.
- Take a more proactive approach using service providers to identify sexual partners/contacts and reach out to elicited sexual partners/contacts.
- Engage the PNS sensitized clinical teams at the CCCs to specifically elicit sexual partners/contacts among prevention of mother-to-child transmission (PMTCT) and suspected treatment failure clients.
- Weekly monitoring of PNS outcomes among PMTCT and suspected treatment failure clients.
- Support for airtime, lunch, and transport for providers to facilitate PNS activities.

HTS Optimization Strategies

The project supported weekend testing in 25 high-volume sites during the reporting quarter of January to March 2018, up from 21 sites the previous quarter. The total clients tested were 2,591, of whom 1,131 (44%) were men. Twenty-one (21) clients were diagnosed as HIV-positive, of whom six (6) were men. The overall yield realized from weekend testing was 0.8% with a linkage of 90%. The proportionate yield dropped from 1.7% the previous quarter to 0.8% due to reduced support for HTS providers from 240 to 166 (a 45% reduction) that limited HTS services to alternate weekend coverage to prevent burnout among the HTS providers.

Table 5. HTS weekend coverage January to March 2018.

Weekend Coverage January to March 2018															
County	Sites	Counseled and Tested				Positives				Linked				Positivity	Linkage
		M	F	M	F	M	F	M	F	M	F	M	F		
Hbay	6	21	23	132	123	0	0	3	2	0	0	3	2	1.7	100%
Kisumu	6	8	17	89	125	0	0	0	1	0	0	0	1	0.4	100%
Migori	5	6	7	131	163	0	0	1	5	0	0	1	5	2.0	100%
Nyamira	6	110	128	583	815	0	1	1	6	0	1	1	4	0.5	75%
Kisii	2	7	7	44	52	0	0	1	0	0	0	1	0	0.9	100%
Total	25	152	182	979	1278	0	1	6	14	0	1	6	12	0.8	90%

For extended-hour HTS services, this was provided at 27 sites, an increase from 10 sites the previous quarter, reaching 1,438 individuals with testing, whom 708 (49%) were men. Seventeen (17) individuals tested were identified HIV-positive (eight males and nine females) translating to a positive yield of 1.2% with a linkage of 100%. There was a modest rise from 1% to 1.2% in proportionate yield this quarter January to March 2018 from extended hours service, despite the reduced HTS providers complement that significantly reduced the contact hours during extended testing services.

Table 6. Extended hours coverage January to March 2018.

Extended hours January to March 2018															
County	Sites	Counseled and Tested				Positives				Linked				Positivity	Linkage
		M	F	M	F	M	F	M	F	M	F	M	F		
Hbay	6	28	18	142	138	0	0	4	2	0	0	4	2	1.8	
Kisumu	8	4	5	161	142	0	0	0	3	0	0	0	3	1.0	
Migori	1	0	0	4	10	0	0	0	1	0	0	0	1	7.1	
Nyamira	6	45	43	281	319	0	1	2	2	0	1	2	2	0.7	
Kisii	6	12	7	31	48	0	0	2	0	0	0	2	0	2.0	
Totals	27	89	73	619	657	0	1	8	8	0	1	8	8	1.2	100%

Both interventions—weekend and extended-hours—were geared toward HTS service optimization. The project will continue to support these services to reach at least 50% site coverage by the next quarter.

Targeted Outreaches

The project supported 189 PNS mapped outreaches, to specifically reach out to men sexual partners who declined testing, in spite of a series of PNS approaches employed at the facility level. Of the 12,549 individuals offered testing during these PNS outreach services, 6,848 (55%) were men. Those identified HIV-positive were 161 (1.3% positivity), of whom 65 (40%) were men. The overall linkage of newly identified positives from outreaches was 83% (134/161) and 87% among men (57/65). Among the counties, Migori reported an overall positive yield of 2% from these outreaches, with Kisumu reporting 1.1% and Homa Bay County, reporting the lowest positive yield, at 0.7%. Overall, the project realized a positive yield of 1.3% from these PNS mapped outreaches.

Table 7. PNS outreaches.

County	Number Outreaches	Overall Counseled and Tested	Men Counseled and Tested	Overall Positives	Men Positives	Overall Linked	Men Linked	Overall Positivity	Overall Linkage
Homa Bay	79	3,945	2,429	28	18	27	22	0.7%	96%
Kisumu	74	3,162	1,926	36	14	28	9	1.1%	78%
Migori	23	4,570	1,985	94	32	76	25	2%	81%
Nyamira	12	813	472	2	1	2	1	0.2%	100%
Kisii	1	59	36	1	0	1	0	1.7%	100%
Total	189	12,549	6,848	161	65	134	57	1.3%	83%

During the reporting quarter, Homa Bay and Kisumu counties conducted a series of male-targeted outreaches in collaboration with the Health Heart Africa project. These outreaches targeted the *boda-boda* motorcycle riders, sand harvesters, taxi drivers, cattle sellers, men in drinking dens, and the general

population at market places. In Kisumu County a total of 1,481 eligible individuals (981 M, 500 F) were offered HTS (48% uptake HIV testing) among 3,072 who were mobilized and screened for hypertension. A total of 17 had HIV-positive results (7 M, 10 F), which translates to a positivity rate of 1% among males and 2% among females. Out of the newly identified positives, 14 were effectively linked to care and treatment, translating to 82% linkage to care. The remaining three are being followed up on to ensure enrollment in care. The HHA activities in Homa Bay County mobilized and offered hypertension screening to 6,313 (3,963 M, 2,350 F) individuals, offered HTS to 3,839 (2,450 M, 1,389 F) who were eligible among the total screened. The individuals newly identified positive were 28 (19 M, 9 F), a positivity of 0.8% among males and 0.6% among females. A total of 22 (79 %) were linked for care and treatment services as equal efforts continue toward ensuring 100% accounting for all the positives identified.

Table 8. HHA HTS screening and testing.

Homabay	Male	Female	Total	Kisumu	Male	Female	
Screened	3963	2350	6313	Screened	1917	1155	3072
Tested	2450	1389	3839	Tested	981	500	1481
% Tested	62%	59%		%tested	51%	43%	
Positives	19	9	28	positives	7	10	17
Linked	16	6	22	Linked	6	8	14
Linkage	84%	67%		Linkage	86%	80%	
Positivity	0.8%	0.6%		PR	1%	2%	

Among the challenges affecting HTS optimization are:

- Fewer supported HTS providers are limiting the number of sites offering PNS. Currently only 123 sites out of 250 are supported with providers. To scale up PNS to additional sites will require additional HTS providers to support this service.
- HTS providers burn out due to extended and weekend coverage in addition to routine weekly HTS. Avoiding burnout will require additional HTS providers to allow rotation and adequate rest for HTS providers.
- Risk of intimate partner violence on disclosure of status by index during PNS. This is commonly reported by female index clients who have not disclosed their status but are willing to bring their children to the facility for testing to avoid suspicion among their sexual partners, citing possibilities of violence and family breakups in case of discordance results. Most of these female index clients confess getting into these relationships with a known positive status.
- Follow up of elicited sexual contacts of index clients out of catchment. Will need some form of national referral directory to track and account for the outcomes of these individuals.
- Inadequate counselling skills for contacts elicitation among some HTS providers with no medical background. Additional capacity-building will be supported through MOH and project technical teams and OJT mentorship by PNS champions.
- Reporting of elicited contacts reached months later not provided for in the PNS reporting tools.

Linkage to Care and Treatment services

The project made every effort to ensure all clients identified and confirmed HIV infection were linked to treatment. This was initiated by the HTS providers who provided information on the benefits of early initiation, encouraged disclosure and the need to discuss the HIV status with a trusted friend or relative and addressed barriers to linkage at the time of providing a test and continuing after test results are provided. Out of the 2,494 clients identified to be HIV positive, 2157 were effectively linked to care translating to 86% linkage to care in the reporting period Jan-March 2018.

Quality Assurance

The project continued to provide support for external quality assessment (EQA) activities through proficiency testing (PT). The last delivery for round 17 PT were received by the testers at facilities directly from the National Public Health Laboratory (NPHL) through a contracted courier who transported PT panels to the facilities and collected the results. This change in modality using a contracted courier posed a number of challenges to the implementing partners, and since the county medical laboratory technologists (CMLTs)/sub-county medical laboratory technologists (SCMLTs) were not involved, it was difficult to establish the actual numbers delivered, processed, and returned to NPHL.

The project has so far received results for two (2) counties, Kisumu and Homa Bay, from NPHL and relied on these incomplete dataset results as the final feedback for round 17 in the absence of results through the formal MOH structures. Homa Bay County enrolled 232 HTS providers but only received 31/232 (13%) round 17 PT panels. Among the 31 who received PT panels, only 29 testers received feedback, of whom 26 (90%) had satisfactory responses and 3 had unsatisfactory responses. Kisumu County enrolled 77 testers but only 30 (40%) received round 17 PT panels, with 26 (87%) satisfactory responses and 4 unsatisfactory responses. Four among the seven testers with unsatisfactory responses are no longer offering HTS services. The other three providers with unsatisfactory responses consist of two HTS providers and one PMTCT nurse who were supported with corrective action and the Corrective Action Preventive Action (CAPA) log updated. The project will continue support for other EQA activities including sit-in sessions, support supervision, and mentorship and ensure a second tester before treatment initiation confirms all positive results.

Given the highlighted challenges, coupled with the delay in conclusion, of round 17, the NPHL has organized for a meeting with the county and sub county lab coordinators and the implementing partners to appraise on performance operations for the next cycle of PT round 18. In addition, NPHL will introduce the web-based results management system, which is expected to significantly reduce the turnaround time for access to PT reports.

HIV Care and Treatment

The project supported treatment services in 222 sites in the reporting period. The clients newly initiating treatment in the Q2 January to March 2018 period were 2,157, bringing the total initiated as at SAPR 2018 to 4,148 clients against a COP17 target of 15,747, a 26% achievement. This was an improvement from Q1

performance with 1,991 initiated. The project achieved 27% (3,887/14,411) of the adult target and 20% (261/1,336) of the pediatric target. The aggregate linkage rates for the SAPR 2018 period was at 87% (4,148/4,770). The pediatric linkage was significantly better (96%) than adult linkage (87%). The project continues to follow up on clients not linked for care and treatment and is working on using the master facility linkage register to accurately report true linkage as opposed to using aggregate linkage in summary MOH 731 reporting that is a proxy for linkage. In addition, the project is working to strengthen linkage in the facilities reporting less than 90% linkage using peers as care navigators for all clients who turn positive.

Table 9. Overall new and current on treatment summary achievement October to March 2018.

Indicator	SAPR achievements New ART and Current ART					
		Targets	Y1Q1	Y1Q2	Total SAPR	% achieved
New ART	Adult	14,411	1,880	2,007	3,887	27%
	Paediatric	1,336	111	150	261	20%
	Overall	15,747	1,991	2,157	4,148	26%
Current ART	Adult	57,259	44,768	45,727	45,727	80%
	Paediatric	5,417	4,360	4,197	4,197	77%
	Overall	62,676	49,119	49,924	49,924	80%

Across the counties for new treatment, SAPR performance against COP17 targets had Kisii at 74% (170 total new on treatment) achievement and Kisumu (810) at 81% achievement with Homa Bay (859) at 16%, Migori (1,184) at 47%, and Nyamira (1,295) at 17%. Homa Bay, Migori, and Nyamira performance is below the expected 50% mark as at SAPR. Factors affecting the performance include lower identification because of low positivity/yield of 0.6% and 1% in Nyamira and Homa Bay counties respectively. In Kisumu, discordance with new HIV-positive identification target of 8,029 and new treatment initiation target of 994 are not in accord, and this may contribute to the performance noted.

Table 10. Overall new treatment achievements by county October to March 2018.

County	Target COP 17	TX New Overall			
		Y1 Q1	Y1 Q2	Total SAPR	% Achieved
Scale up to saturation category					
Homabay	5,281	385	474	859	16%
Kisumu	994	409	401	810	81%
Migori	2,517	569	615	1,184	47%
Sub Total	8,792	1,363	1490	2,853	32%
Aggressive scale up category					
Kisii	230	93	77	170	74%
Nyamira	6,725	535	590	1,125	17%
Sub Total	6,955	628	667	1,295	19%
Total	15,747	1,991	2157	4,148	26%

The project will continue to implement accelerated activities to improve identification and subsequent initiation on antiretroviral therapy (ART) in the following quarter. These include partner notification services (PNS), engaging non-clinical HTS counselors in active screening of clients eligible for testing at all service delivery points, and strengthening test and treat implementation. Linkage rates are above 80%, so to achieve the targets more effort needs to put in identifying the positives. The project will ensure all contacts of clients in the HIV Patient Support Centers are tested and those positive linked.

Regarding pediatric SAPR performance for new treatment against COP17 targets, Kisii and Kisumu counties are on track with 59% (10/17) and 54% (33/61) achievement respectively. The remaining counties' achievement were below expectation with Nyamira at 10% (51/497), Homa Bay 15% (76/515), and Migori 37% (91/246). The age disaggregated COP17 pediatric targets were derived using the COP16 HIV-positive achievements prorated for pediatric contribution.

Table 11. Pediatric new treatment achievements by county, October to March 2018.

County	Target COP 17	TX New Paeds			
		Y1 Q1	Y1 Q2	Total SAPR	% Achieved
Scale up to saturation category					
Homabay	515	25	51	76	15%
Kisumu	61	16	17	33	54%
Migori	246	39	52	91	37%
Sub Total	822	80	120	200	24%
Aggressive scale up category					
Kisii	17	5	5	10	59%
Nyamira	497	26	25	51	10%
Sub Total	514	31	30	61	12%
Total	1,336	111	150	261	20%

In the reporting quarter, direct service delivery support included capacity-building initiatives including Human Resources for Health (HRH) support for clinical officers, nurses, medical lab technologists, and pharmaceutical technologists; Site Improvement Monitoring System (SIMs); program area-specific support supervision and follow-up; data documentation, reviews, and reporting; commodity management and forecasting, and site-level program support for clinical management of clients.

To ensure complete reporting and high-quality data during the reporting period, the project supported the HIV care and treatment sites with distribution of the new MOH reporting tools in rolling out of the new tools. Data quality assessments at the site level to check consistency of data in the registers and MOH 731 and quarterly data review meetings at sub county level to discuss site- and sub county-level performance were supported. All these interventions augmented with targeted on-site mentorship, continuing medical education (CME), and on-the-job-training for HCWs in the facilities contributed to improved HCW understanding on use of the HIV reporting tools and understanding of indicators. The project also supported the high-volume sites with health records information officers to assist in facility data management and county-based data clerks to support non-routine database management such as test and treat and differentiated care components.

Current ART

For current ART in the reporting period January to March 2018, the project reported a current on ART number of 49,924 against a COP17 target of 62,676, representing an achievement of 80%. This was a net increase of 769 clients from Q1. The project achieved 80% (45,718/57,259) of adult targets and 78% (4,206/5,417) of pediatric targets. With 2,157 new on ART in the reporting quarter, the actual current on ART of 49,924 is below the expected number of 51,276.

The county breakdown for current ART is shown in table below.

Table 12. Overall current on treatment performance by county October to March 2018.

County	Target COP 17	Current ART Achievement			
		Y1Q1	Y1 Q2	Total SAPR	% Achieved
Scale up to saturation counties					
Homabay	19,734	13,691	13,819	13,819	70%
Kisumu	4,189	6,974	7,320	7,320	175%
Migori	15,748	13,226	13,491	13,491	86%
Total	39,671	33,891	34,630	34,630	87%
Aggressive scale up counties					
Kisii	2,319	2,021	2,030	2,030	88%
Nyamira	20,686	13,207	13,264	13,228	64%
Total	23,005	15,228	15,294	15,258	66%
Grand Total	62,676	49,119	49,924	49,888	80%

The county-specific performance for the reporting period had Homa Bay at 70% (13,819) achievement, Kisii at 88% (2,030), Kisumu at 175% (7,320), Migori at 86% (13,491), and Nyamira at 64% (13,264) against expected COP17 target. Kisumu had an over 100% achievement and this was because the COP17 target of 4,189 was 40% less than COP16 target, and as at the end of the reporting period had achieved a current ART of 7,320 (March 2018). Thus the overachievement on this indicator. Homa Bay and Nyamira counties had the lowest performers at 70% and 64% respectively of expected COP17 target for current ART. This was because of the low yield in newly identified HIV-positive individuals discussed under HTS_TST and thus fewer individuals enrolled on treatment than expected. Both Homa Bay and Nyamira have consistently low positivity yields about or less than 1% despite targeted HTS interventions.

Homa Bay has a deficit of 5,915 clients as at end March 2018 to meet the overall COP17 target of 19,734. The county was allocated a new treatment COP17 target of 5,281 with an expected new treatment enrollment of 1,320 every quarter. In this reporting period, the treatment new achievement was 474 (35% of the expected quarterly enrollment), a reflection of the low newly identified HIV-positive, evident from the low positivity at about 1%.

In this reporting period, the pediatric performance for current ART achieved 80% (4,206) against the COP17 target of 5,417. The pediatric current ART county performance had Kisii (170) and Kisumu (502) at more than 100%, and Homa Bay at 64% (1,235/1923), Migori at 74% (1,138/1,541), and Nyamira at 76% (1,157/1,527) against COP17 pediatric targets. The overachievement in Kisii and Kisumu could be attributed to the modest COP17 targets.

The pediatric current ART performance by county is shown in table below.

Table 13. Pediatric current on treatment performance by county October–March 2018.

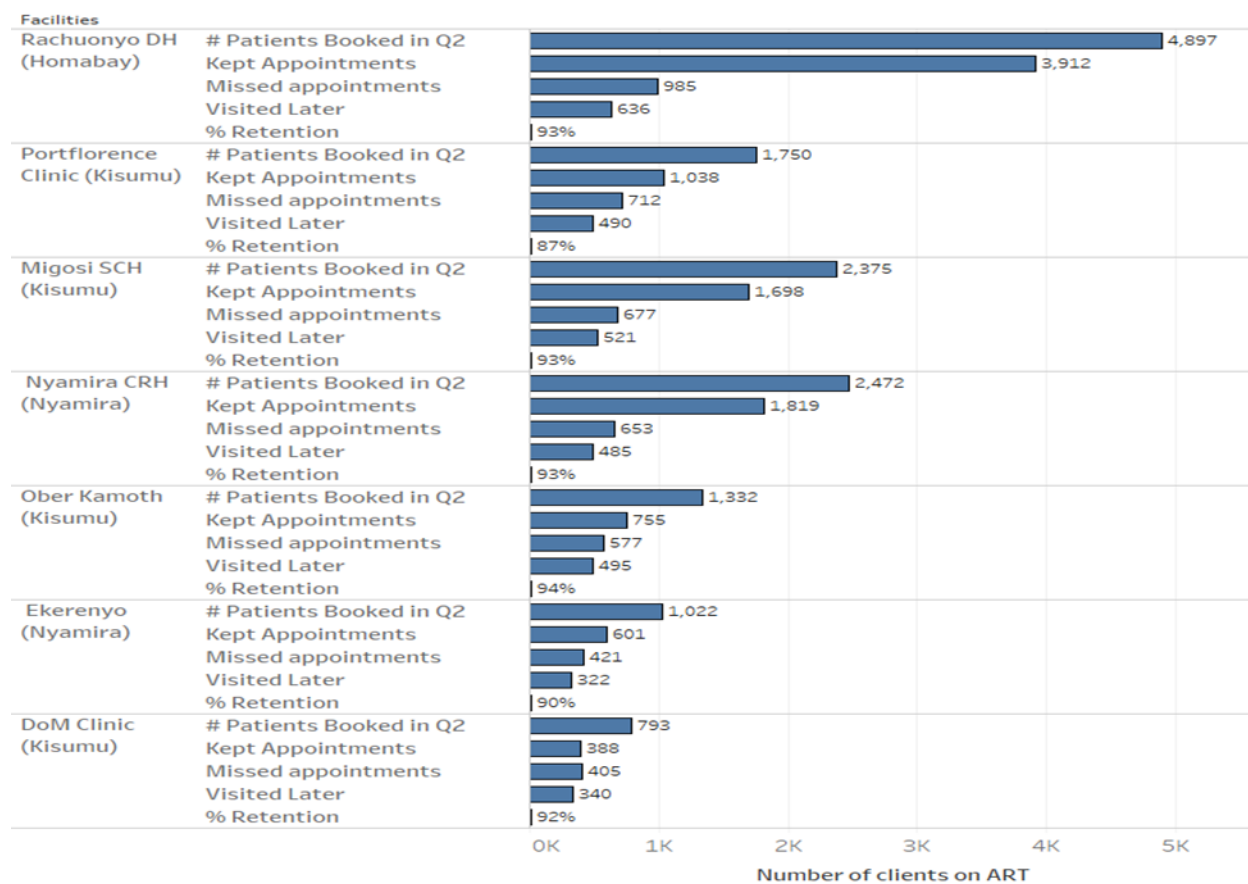
County	Target COP 17	Current ART Achievement Paediatric			
		Y1Q1	Y1 Q2	Total SAPR	% Achieved
Scale up to saturation counties					
Homabay	1,923	1,201	1,235	1,235	64%
Kisumu	256	502	506	506	198%
Migori	1,541	1,277	1,138	1,138	74%
Total	3,720	2,980	2,879	2,879	77%
Aggressive scale up counties					
Kisii	170	188	170	170	100%
Nyamira	1,527	1,192	1,157	1,157	76%
Total	1,697	1,380	1,327	1,327	78%
Grand Total	5,417	4,360	4,206	4,206	78%

Retention In Care and Treatment

During the reporting period January to March 2018, the project analyzed appointment and retention rates from seven high-volume sites using the ART Dispensing Tool (ADT) to determine the retention rates during the reporting quarter. The appointment-keeping cascade and retention is shown in the below figure graph.

Figure 1. Appointment-keeping cascade and retention among high-volume sites January–March 2018.

Appointment Keeping cascade and retention among some high volume sites during the reporting period January- March 2018



Patients Booked in Q2, % Retention, Kept Appointments, Missed appointments and Visited Later for each Facilities.

It's evident the retention rates for most sites were above 90%, with the highest facility, Ober Kamoth, reporting 94% while the lowest-performing Port Florence reported 87%.

The project continues to strengthen appointment management with a focus of ensuring reduced missed appointments through SMS and phone reminders and scheduling the appointments to meet specific needs for clients like suspected treatment failure (viremia) clinics, adolescent, pediatric clinics, mother-baby pair for MCH clinics, and family-based booking for CCC appointments where applicable.

The project during the reporting period, sampled 35 sites with drop in number of current ART for a better understanding of the trend. The sampled sites reported a total current on ART of 33,733 (68% of the project's current on ART) with a net loss of 1,029 clients out of the 1,388 total loss as at SAPR 2018. Of the 1,029 clients, 421 (41%) were transfer outs, 60 (6%) were reported as deceased, 37 (4%) were lost to follow-up, 242 (24%) defaulters, 218 (21%) were adjusted due to previous data errors, and 51 (4%) other reasons. The data shows the defaulter management has improved accounting for less of the losses than the previous quarter (59% in Q1); however, there is need to continue improving the project's defaulter management system with dedicated time especially at the end of the month for multidisciplinary defaulter tracing efforts. The project will review the reasons for the transfers out to inform improvement

in quality of care and client retention. Mortality audits will also be part of regular program reports to identify gaps, if any, in patient management. The project will also use the ADT and electronic medical records (EMR) to more accurately report patient numbers in high-volume sites and identify gaps in the existing Daily Activity Register (DAR) reporting system.

Strategies to improve retention include:

- The project is reviewing the adherence processes with the aim of improving patient preparation and routine adherence. The project will also strengthen mentorship and support supervision of facility and community-based adherence support counselors and standardize adherence support across the supported sites.
- The project will continue to provide a comprehensive package of care for new clients, especially those with advanced disease to improve their retention.
- Follow up of all patients lost to follow-up for the period starting January 2017 and documentation of outcomes. In addition, HIV Service Delivery Support Activity Cluster 1 (HSDSA C1) will document reasons for being lost to follow-up to improve quality of service provision and improve retention.
- The project will develop site-level exit interviews that will inform facility-level service delivery improvement.
- The project will identify clients most at risk of defaulting and develop a more aggressive follow-up system through individualized care, phone and SMS reminders, and enhanced adherence.
- The project will dedicate the last few days of the month for intensive defaulter tracing and updating of Daily Activity Register (DAR) for accurate reporting of retention.

Adherence Support

Adherence support continued to be provided to all clients enrolled on treatment in order to enhance their health outcomes. Several adherence strategies continued to be supported. These include flexible clinic appointment days during weekend and paediatric/adolescent/male clinics, family appointment days, SMS reminders for appointment keeping and medication adherence, ART literacy sessions for newly enrolled clients, health education, adherence counselling for all clients, support group meetings, Directly Observed Treatment (DOT) for clients with identified adherence challenges and a treatment supporter ('buddy') system.

Adherence Support for Paediatrics and Adolescents

The project focused on paediatrics and adolescent adherence support through peer-to-peer buddy support system, targeted adolescent literacy session on HIV self-management and DOTs for adolescents with identified adherence challenges. In addition, supported case management approach for paediatrics and adolescents with adherence issues and follow-up of adolescents in boarding schools through support of teacher champions. The project worked with facility teams on appointment management harmonization to accommodate school calendar and minimize missed appointments.

All counties continued to fast-track implementation of Operation Triple Zero (OTZ) strategy which aims to improve adherence and viral suppression amongst the adolescents. The facility teams including clinicians, HRIOs, Adherence Support Counsellors (ASCs) and peer educators (PEs) were sensitized on OTZ strategy. In the reporting quarter, 34 OTZ clubs were established at all high volume facilities with 607 adolescents enrolled and shown below.

Table 14. Operational OTZ Clubs March 2018

HSDSA C1 County	# of OTZ Clubs Established March 2018	# of Adolescents Enrolled
Homa Bay	12	195
Kisii	1	15
Kisumu	6	95
Migori	4	78
Nyamira	11	224
Total	34	607

Data source: Facility OTZ Records

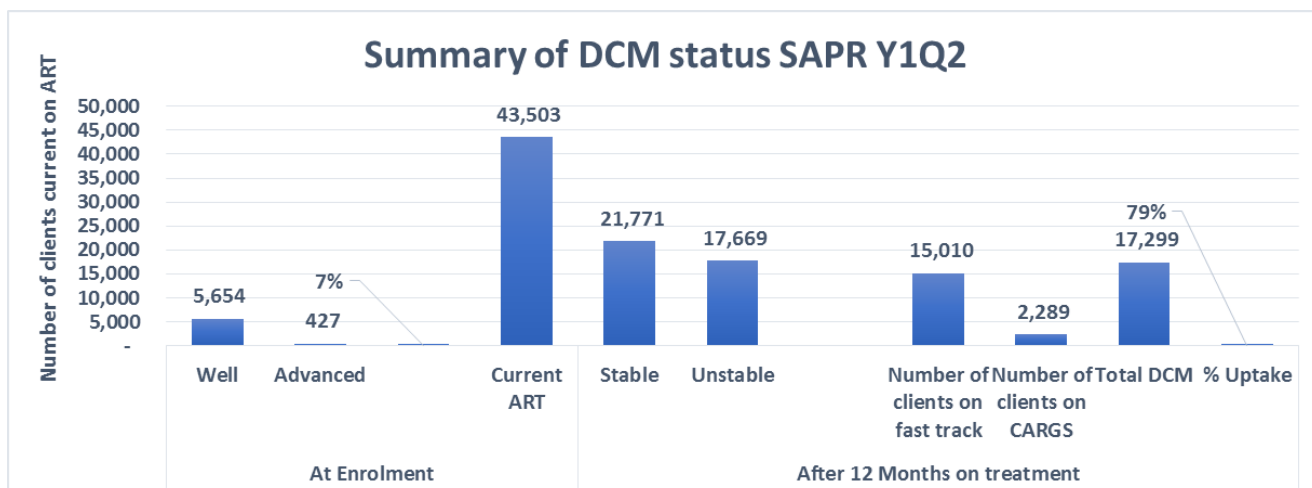
The project will continue to scale-up OTZ clubs to ensure all 59 high and mid volume health facilities have at least one OTZ club to cater to the adolescents by APR 2018.

Differentiated Model of Care

The project supported implementation of differentiated care for eligible clients on ART. Based on program data analyzed, out of the 222 supported sites, 128 (58%) are implementing differentiated care with planned scale up to 80% of the sites in the next two quarters. With an eligible current ART as at March 2018 of 43,503, 21,771 were stable thus eligible for differentiated care. A total 15,010 were enrolled on facility fast track and 2,289 on community ART refill groups for a total of 17,299. The overall uptake among eligible stable clients on ART was 79% (17,299/21,771). This was an improvement from 67% as at December 2017. The project will continue to strengthen uptake and reporting of differentiated care in the subsequent quarter.

Figure 2 shows outcomes of differentiated care implementation.

Figure 2. Outcomes of differentiated care implementation.



*Data source Facility Records Including DAR

Positive Health Dignity and Prevention (PHDP) Interventions

During the reporting quarter, the facilities continued to form and/or strengthen PSSGs at both community and facility levels. The HCWs and peer educators use the PSSGs as vehicles for disseminating key PHDP messages which were aimed at enhancing the members' adherence to appointments and ART and coping with the HIV infection. The project supported HCWs, peer educators' logistics and stipends during their engagement with PSSGs, and provided refreshments for PSSG members during meetings. The PLHIV enrolment in four counties as at March 2018 is shown in table below

Table 15. PLHIV Enrolment in PSSGs March 2018

	Current ART March 2018	PLHIVs enrolled facility PSSGS	PLHIV enrolled community PSSGS
Homa Bay	13,819	4315	1077
Kisii	2,030	418	59
Kisumu	7,320	2272	261
Migori	13,491	2565	998
Nyamira	13,264	2060	576
TOTAL	49,924	11,630	2,971

Data Source: Peer educator logs

To date, 11,630 clients actively attended facility PSSGs while 2,971 attended community PSSGs where key PHDP messages were disseminated. Community PSSGs has improved retention, defaulter tracing and eased formation and running of community ART refill groups (CARGs). The project will accelerate enrolment of PLHIV into PSSGs in the coming quarters.

Laboratory Support

During the quarter under review, 41 HCWs received mentorship and on-the-job training in laboratory services. Areas covered included minimizing missed opportunities for both viral load and early infant

diagnosis (EID) sample collection, proper documentation of recording tools for viral load and EID, proper documentation of request forms, and developing of lab standard operating procedures. Laboratory staff received assorted job aids to enhance self-centered learning.

In the laboratory department, the project is working closely with GIS and FHI on implementing the laboratory quality management system (LQMS) and Strengthening Laboratory Management Towards Accreditation (SMLTA). Rachuonyo sub-county laboratory, which is undergoing accreditation, has had an internal audit and scored 182 translating to two stars. In Q3, the project will support both county and sub-county EQA meetings for GeneXpert proficiency testing and sputum microscopy. These meetings will form the basis of conducting facility corrective and preventive measures using a standardized CAPA tool.

Working closely with the Elizabeth Glaser Pediatric AIDS Foundation, two point-of-care viral load-testing machines have been placed in Rachuonyo SCH and Nyamira CRH, and the program is riding on the existing HSDSA Cluster 1 sample-networking model. Nyamira CRH did 123 sample with 35 facilities sending in its samples. Rachuonyo SCH analyzed 137 samples with 12 facilities sending in its samples. Turn-around-time (TAT) is one day for the spoke facilities and one hour for the hubs, a significant reduction from the previous TAT. The project will work to scale up utilization of this testing modality for optimal throughput.

The project has continued to support the Rider Led Sample Networking (RLSN) model. This model has increased efficiency by reducing facility sample transportation TAT and improving results delivery TAT to supported facilities. All supported facilities have identified a viral load focal person who ensures results are entered into the viral load or EID tracking log and patient individual files. Viral load and EID tracking logs are used to calculate TAT.

CD4 Testing

The project continued to support 11 CD4 nodal testing sites across the five counties. Eight-hundred eighty-one baseline CD4 samples were networked and processed during the quarter against 2,157 clients newly enrolled into care, translating to 41% coverage. Out of the CD4 done, 98 (11%) of all samples tested had a CD4 of less than 100 cell/mm and were further subjected to the serum *Cryptococcus neoformans* antigen (CrAg) test, and six were positive and were put on treatment.

During the quarter under review, six out of the 11 CD4 nodal sites had CD4 reagents. The remaining five nodal sites that are having BD FACS and Partec machines did not receive CD4 reagents from Kenya Medical Supplies Authority (KEMSA). This greatly affected CD4 uptake in those regions.

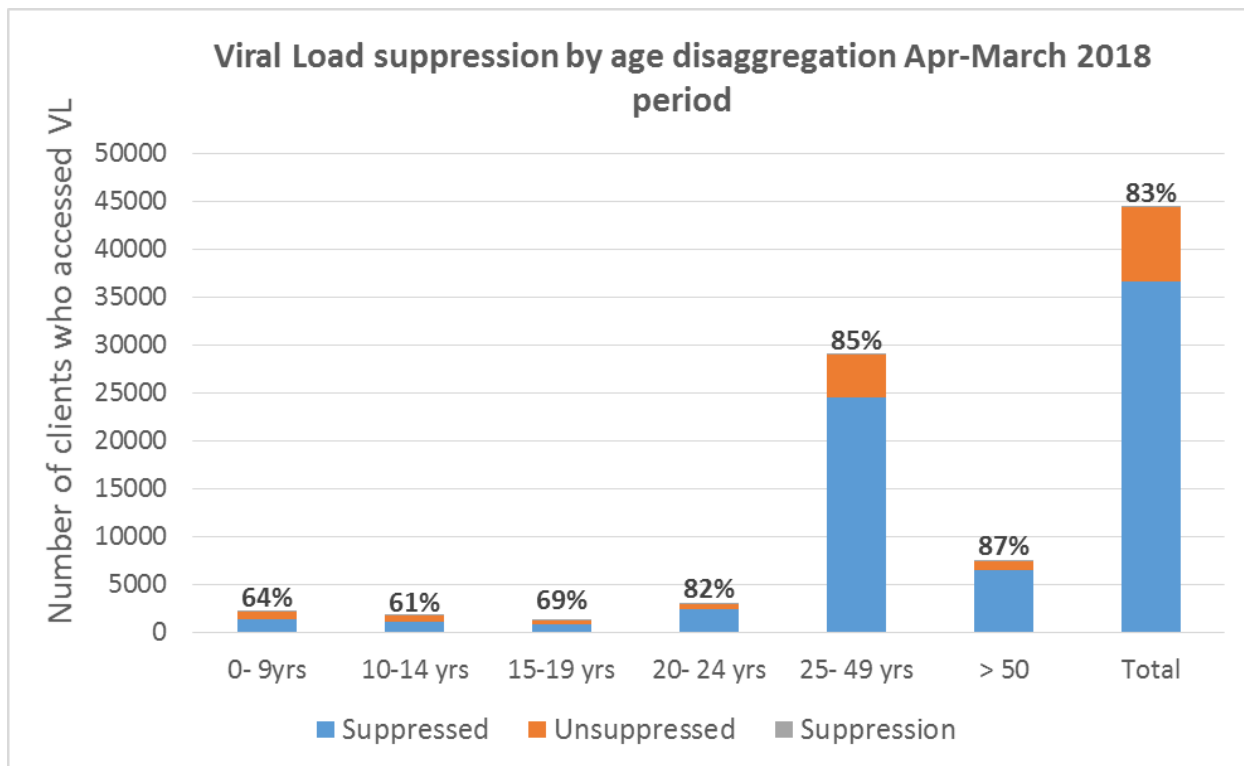
Viral Load Testing

The project supported viral load (VL) sample networks in the five supported counties to the three testing laboratories: KEMRI Alupe, Walter Reed Kericho, and Kisian Kisumu. Viral load samples analyzed were 45,000 against a target of 48,364, translating to 93% coverage for VL testing uptake. Pediatric samples were 4,362 (10%) and 39,298 adults (90%).

Viral load testing by gender had 31,146 female samples, 13,755 male samples, and 99 samples with no data documented. Overall suppression at reporting stood at 83% (April 2017–March 2018). Disaggregated by age, viral suppression was highest in the 25-49 years old cohort at 85% and lowest among the pediatric 10–14 years old cohort at 61%.

The graph Figure 3 shows viral suppression by age cohorts as at end SAPR 2018 reporting period.

Figure 3. Viral suppression by age cohorts as at end SAPR 2018 reporting period.



Suppression of the pediatrics and adolescents is being addressed through strengthened adherence and disclosure counseling, enrollment in pediatric psychosocial groups, working with trained providers on pediatric HIV services and scale up of Operation Triple Zero (OTZ) clubs to reach all adolescents supported by the project. Across gender, suppression rates were male 80% and females 83%. The project will work to strengthen the viremia clinics by having viremia clinics for target population that is pediatrics, adolescents, and males. Psychosocial support groups for high VL clients will be supported in all high and medium volume sites.

The overall county-specific suppression for the same period had Homa Bay at 85%, Kisii 78%, Kisumu 85%, Migori 82%, and Nyamira at 79%. The age disaggregated county suppression rates is as shown in table 16 below.

Table 16. County viral suppression rates by age cohorts

Proportion Viral Suppression (%) Jan-March 2018	0-14 Years	15-19Years	20+ Years
	Pediatrics	Adolescents	Adults
Homa Bay	73%	79%	87%

Kisii	67%	65%	80%
Kisumu	68%	77%	90%
Migori	63%	66%	84%
Nyamira	52%	59%	80%
Total	63%	69%	85%

The adults were generally better suppressed than the adolescents and paediatrics age groups across the counties.

The project has further identified the sites with particularly low suppression rates for more support. The project is undertaking a viral load quality improvement collaborative activity that is looking at the processes in management of suspected treatment failure. This will improve management of treatment failure clients and standardize best practices across the program.

The VL testing uptake achievement was made possible by increasing the number of sub hubs from 11 in the last quarter to 14 sub hubs. The project has continued to support the Rider Led Sample Networking (RLSN) model. This model has increased efficiency by reducing facility TAT to 5 days. This has, however, been affected by challenges in the testing laboratories. All the 14 sub hubs are doing remote login for their spokes. During this reporting quarter, 68% (150/222) of the project-supported facilities are doing remote login, an improvement of last quarter, which had 40% (87/220) of the facilities doing remote login. The project supports weekly distribution, to all facilities, of high VL client list. The client names are then line listed in the suspected treatment failure register and the client called back for enhanced adherence counseling. The project has supported the use of the SMS short code 20027 to reduce results TAT through mentorship and distribution of Standard Operating Procedures (SOPs) in all supported sites.

The project experienced some challenges during the reporting quarter in reaching males with viral load testing services and overall VL testing coverage. This was mainly in low-volume sites, which did not have project-supported HRH hires resulting in missed opportunities for VL testing. This is being addressed through use of roving clinicians to support the low-volume sites during their clinic days to provide services but also support capacity-building to ensure no missed opportunities. The project supported some more mop-up activities in the quarter and this will continue in the upcoming quarter.

Elimination of Mother-to-Child Transmission of HIV

During the reporting quarter, the project supported PMTCT services in 137 health facilities. The comprehensive support focused on improving antenatal care (ANC) coverage, strengthening identification of HIV-infected women, providing highly active antiretroviral therapy (ART) and infant prophylaxis, improving early infant diagnosis services, and analyzing retention among maternal and HIV-exposed infant cohorts. The project supported health care workers to carry out targeted ANC outreaches and strengthened referrals from the community to the facilities. Site-level capacity-building including providing technical mentorship on implementation of PMTCT guidelines was conducted. Focused on-site mentorship to low-level facilities was also conducted by sub county mentors. Eliminating mother-to-child transmission (EMTCT) review meetings were also conducted to review monthly achievements against the

target, and low-performing facilities were identified for joint targeted mentorship with the SCHMT. Other issues discussed during the site visit and meetings included documentation and data review and reporting before submission to the sub county.

During the reporting quarter, 9,656 pregnant women had known HIV status at ANC only. The total number pregnant women turning HIV positive were 812. Out of these, 581 (72%) were known positives and 231(28%) were newly tested positive. Maternal prophylaxis was issued to 795 HIV positive women (98% of the total positive) while 788 infants (98% of the total positive) received antiretroviral (ARV) prophylaxis. Table 17 below shows the achievement for the reporting period (January–March 2018) against the COP 2017 targets.

Table 17. PMTCT summary achievements, January–March 2018.

Indicator	COP 2017 Target	Q1 (Oct– Dec 2017)	Q2 (Jan– March 2018)	Total	% Achieved
Number of pregnant women with known status	49,814	8,434	9,656	18,090	36%
Number of pregnant women that are HIV positive	3,423	762	812	1,574	46%
Number of pregnant women known to be HIV positive (known positives)		541	581	1,122	
Number of pregnant women new positive		221	231	452	
Number of pregnant women issued with prophylaxis	3,423	755	795	1,550	45%
Number of infants issued with prophylaxis	3,423	735	788	1,523	44%

Source: Ministry of Health (MOH) 731, MOH 711. Note: PMTCT, prevention of mother-to-child transmission; COP, Country Operational Plan.

The project reached 18,090 clients with known status in SAPR 2018 against the COP 2017 target of 49,814, which is a 36% achievement and was lower against the expected target of 50%. Of the COP17 target of 3,423 HIV-positive clients, the project identified 1,574 (46% against COP 17 target) in SAPR 2018, with 452 (28%) new positives and 1,122 (72%) known positives. A total of 1,550 pregnant women and 1,523 infants were issued prophylaxis in SAPR 2018 an achievement of 45% and 44% respectively against COP17 targets.

The county PMTCT known status performance is shown in table 18

Table 18. PMTCT_STAT summary achievements by county, by October 2017-March 2018 reporting period.

County	COP 17 Target	Achievement	% Achievement
Homa Bay	6,493	3,071	47%
Kisii	1,848	895	48%

Kisumu	5,202	3,138	60%
Migori	13,467	5,735	43%
Nyamira	22,639	5,251	23%
Total	49,814	18,090	36%

At the county level, the performance against the COP17 target for the SAPR 2018 period was Homa Bay at 47% (3,071/6,493), Kisii at 48% (895/1,848), Kisumu at 60% (3,138/5,202), Migori at 43% (5,735/13,467), and Nyamira at 23% (5,193/22,639). Nyamira County was not on track to meet the SAPR 2018 target. This was largely attributed to the high COP17 target (22,639) set. If measured against the expected pregnant women from the PMTCT retained sites (at 10,660), the performance for the reporting period against the COP17 target would be at 49% (5,251/10,660).

To improve the proportion of ANC clients with known status during the quarter, the project facilitated MOH roving mentors to the medium and low facilities to provide technical mentorship and provision of services especially in Nyamira where we have acute shortage of HRH. The project strengthened escorted referrals by CHVs of ANC mothers identified in the community not attending ANC services and/or defaulted ANC appointments to the project supported sites in targeted regions and facilities with low uptake.

Challenges faced during the reporting period included client charges for ANC profile testing in the private and faith based facilities limiting universal access to PMTCT services and also retention up to the forth ANC visit. The other challenge witnessed is limited support of robust CHVs' referral to do ANC mapping and referral, which led few mothers referred by CHVs to the facilities. Homa Bay, despite being on track, had a drop in the month of March 2018 because of industrial action in the county. Sites with project staff, however, recorded attendance and provision of PMTCT-HTS services.

During the reporting period (January to March 2018), 812 HIV-positive pregnant women (581 were known positive and 231 new HIV positives) were identified with 72% known positives. For SAPR 2018 period this was a 46% (762 for quarter 1 and 812 for quarter 2) achievement of COP17 target of 3,423 HIV positive pregnant women. The county achievement for the SAPR period was Homa Bay 50% (450/898), Kisii 42% (29/69), Kisumu 66% (410/617), Migori 53% (485/912) and Nyamira 22% (200/917)

In the reporting quarter period, 795 HIV positive pregnant women were put on ARV prophylaxis. The SAPR performance against the COP 2017 target for ARV prophylaxis was 45% (1,550/3,423) with county level achievements as follows: Homa Bay 50% (448/898), Kisumu 51% (406/791), Kisii 43% (30/69), Migori 52% (478/912), and Nyamira 21% (195/917).

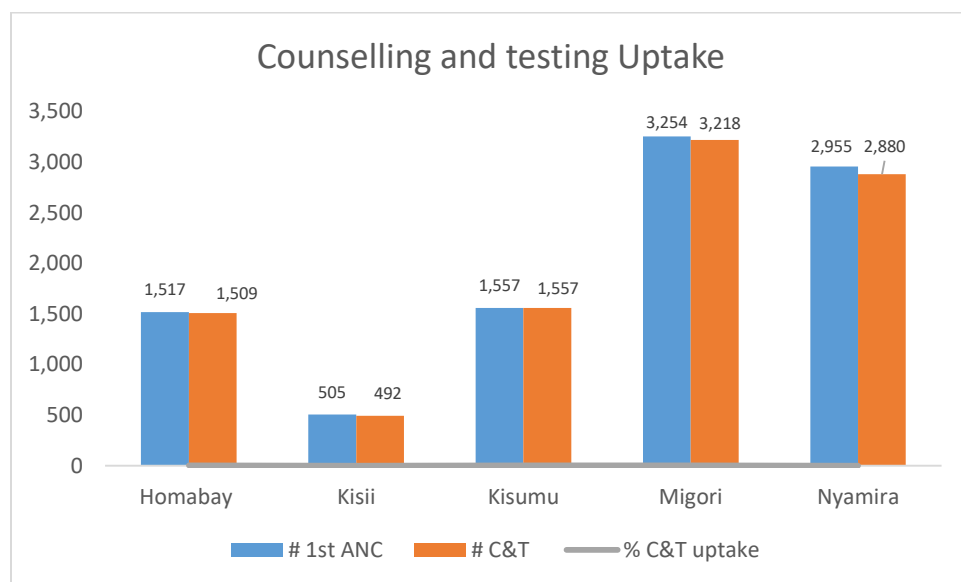
The project as at SAPR 2018 period recorded a high number of known positive clients, reporting 72% (1,122 out of 1,574 positives identified), which is attributed to known positive clients desiring to have children due to the success of the PMTCT program and improved quality of life with good viral suppression. Support for family planning /HIV integration through mentorship and use of reproductive health RH coordinators has continued with a view to reducing unmet need for family planning.

Through use of MOH 731, the project was able to disaggregate the results to include both known positives at entry and newly infected positives at ANC.

PMTCT Cascade

In the reporting quarter, 9,788 first ANC clients were reached and 9,598 accessed HIV counseling and testing, translating to an uptake of 99%; both maternal prophylaxis and infant prophylaxis were at 98%. Figure 4 below shows the PMTCT cascade on uptake of counseling and testing by county for the quarter.

Figure 4. Counseling and testing uptake by county, January to March 2018.

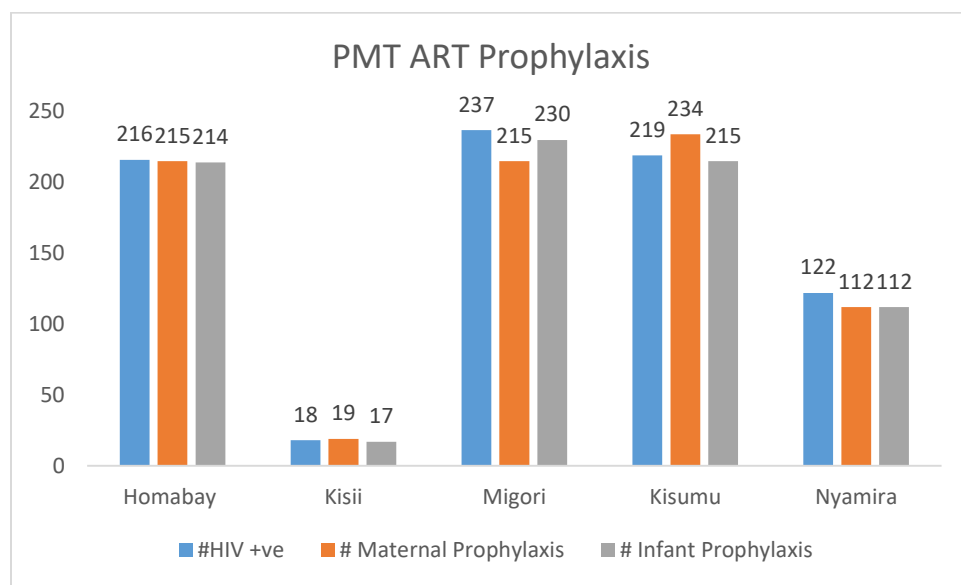


Source: Ministry of Health (MOH) 711/MOH 731.

Overall access to counseling and testing among women attending ANC services was 98%, with Kisumu reporting the highest performance of 100%; Homa Bay and Migori County at 99 % was an improvement from last quarter where they both had a low performance of 89%. Nyamira and Kisii reported 97% performance, a drop for Nyamira, which was at 98 % last quarter. The good performance was because there was no stock out of rapid test kit (RTK) commodities. In addition, mentorship on RTK quantification and forecasting has improved the stock level of test kits. The pregnant women who missed counseling and testing have been line-listed and are being followed up on to ensure they are traced back to be tested and documented.

Figure 5 shows the maternal and infant prophylaxis uptake of the PMTCT cascade.

Figure 5. Maternal and infant prophylaxis uptake by county, January to March 2018.



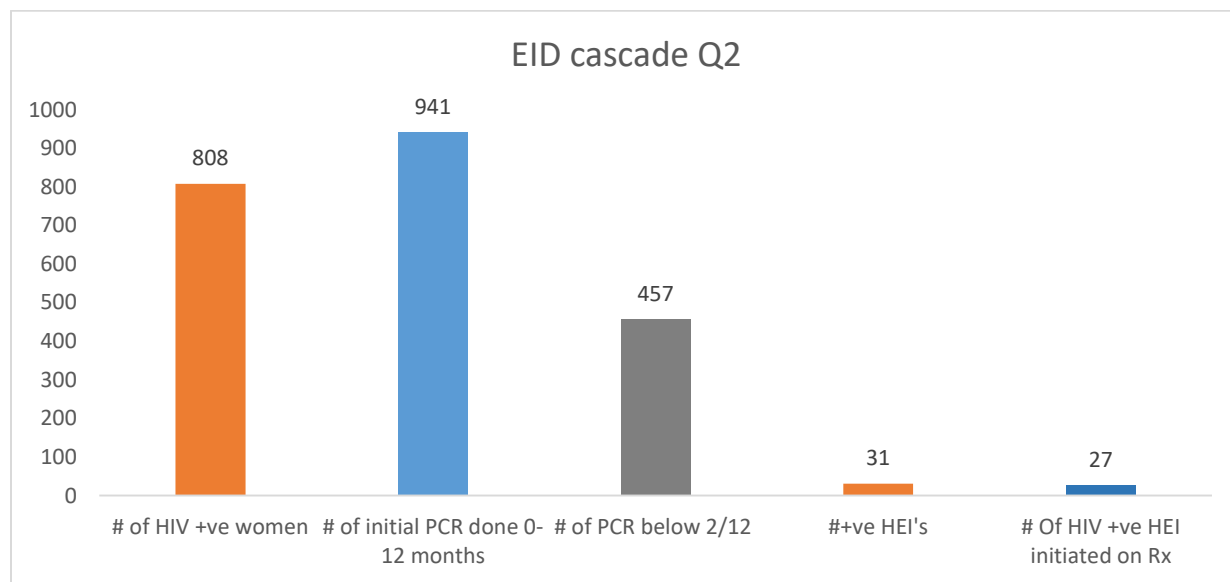
Source: Ministry of Health (MOH) 731.

All counties reported impressive uptake for both maternal and infant prophylaxes as shown at above 95%, except Kisii, which had an infant prophylaxis of below 95%. Health facilities were supported to continuously account for missed opportunities and to tailor a package of follow-up for these mothers. Peer educators and community mentor mothers conducted home visits to trace and bring back the mother-baby pairs who missed ART prophylaxis and did not honor their follow up visit. The project supported county and sub county health records information officers to update the District Health Information Software (DHIS) once clients were successfully traced, accounting for all missed opportunities. Mentorship, PMTCT support groups, provision of ARV commodities in integrated MCH settings, and support for commodity consumption, forecasting, and reporting were supported in all the supported sites.

Early Infant Diagnosis

During the January to March 2018 reporting period, a total of 941 HIV exposed infant (HEI) initial polymerase chain reaction (PCR) tests were done for early infant diagnosis (EID), of which 890 (95%) were done within 12 months of age, an increase from 807 the October to December 2017 period. As at SAPR (50% achievement), 1,697 initial virologic tests were done between 0–12 months of age, translating to 50% of the 3,428 target for COP17. Testing below two months of age was at 52% (457/890), which was similar to the October–December 2017 period, which was at 53% (433/807). County performance on EID testing below two months in the period January–March 2018 was at Homa Bay 63% (135/211), Kisii 54% (14/26), Kisumu 60% (110/183), Nyamira 52% (79/153), and Migori 39% (124/317).

Figure 6. Early infant diagnosis (EID) cascade, January–March 2018.



Source: EID database.

This low uptake of PCR testing below two months of age is due to various factors, such as poor documentation of age at sample collection and late sample collection due to lack of skills to draw a PCR sample by the providers from the infant. The project provided site-level technical mentorship and OJT on sample collection and identification. For Migori, moving forward, the project will built the capacity of health care workers in MCH to collect EID samples. The project will also sensitize the staff in all the counties on the new PCR sample collection request form and EID tracking log, which will now address issues of sample labeling. The mentor mothers and peer educators will remind the mothers, through SMS and phone calls, on the sample collection date to improve early EID.

Disaggregation of the virologic testing within 12 months by county was as follow: Homa Bay at 45% (407/898), Kisii at 81% (56/69), Kisumu at 61% (374/610), Migori at 64% (594/934), and Nyamira at 29% (266/917). Despite two counties not meeting the expected SAPR performance, the number of exposed infants accessing virologic HIV tests improved month on month in the reporting quarter. This is attributed to continuous mother-infant pair follow-up, capacity-building of staff through CME and OJT, EMTCT review meetings on early identification, and follow up and harmonization of Kenya Expanded Programme on Immunization (KEPI) immunization dates with PMTCT HEI follow-up clinic days to avoid multiple clinic

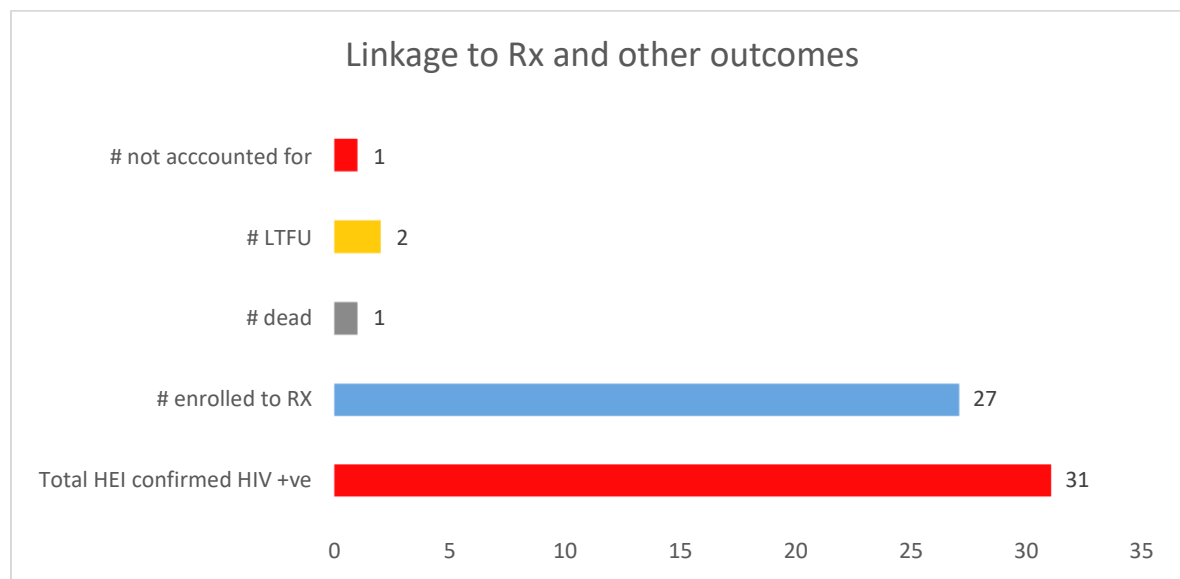
visits by the mother. Homa Bay performance was affected partly by the health care worker strike in the March, which affected the whole PMTCT cascade. Nyamira’s low performance is attributed to COP17 targets that are significantly higher than the expected pregnant women population estimates for the PMTCT retained sites, and this has a performance impact across the PMTCT cascade of identification and EID testing.

Linkage of Positive Infants

The project reported 31 infants as HIV-positive, according to the EID website, and this was validated. Of these, 27 (87%) have been enrolled on treatment, 1 infant died before enrollment, 2 were lost to follow-up, 1 is still being traced pending initiation. The infant not accounted for was from Migori (Giwembe dispensary); follow-up is being done to enroll the infant on treatment and update the outcome online. There was an improvement on infants accounted for and enrolled on treatment compared to last quarter, which was at 67%.

The results of linkage of the HIV positive infants is shown in the figure below.

Figure 7.1 Linkage status of HIV positive infants, Q1 (Jan–March 2018).



Source: National AIDS and STIs Control Programme (NASCOP)/EID website.

PMTCT mortality and HEI positivity audits

The project supported the facility, Kuria SCH, Migori County, which reported one infant death, to conduct a mortality audit. The audit revealed that the infant died of pneumonia and severe dehydration due to chronic gastroenteritis. Unfortunately, the mother accessed treatment late when the child was in critical condition. More information revealed that the mother was a chronic defaulter even during ANC. She was contacted by phone when the PCR results were received but she declined to attend clinic. When she was traced physically, she promised to come to the hospital but she did not honor her appointment. The

project through mentor mother as case managers will help such mothers to accept their status and adhere to their own treatment and appointment keeping.

HEI positivity audits were supported for 30 infants of 31 identified in the quarter and the results are shown in Figure 8.

Table 19. Outcome of HEI positivity audits, January to March 2017.

County	Total HEI positives in the quarter	Total HEI audited	#of HEI with initial PCR within 2 months	#of HEI with initial PCR >2months	Mother who missed ART prophylaxis	Infants who missed ART prophylaxis	#of mothers who never attended ANC visit	# of mothers who missed skilled delivery
Homabay	9	9	9	0	3	3	2	2
Kisii	1	1	1	0	0	0	0	0
Kisumu	5	5	5	0	2	0	1	2
Nyamira	4	4	4	0	2	2	1	1
Migori	13	8	4	4	3	2	0	5
Total	32	27	23	4	10	7	4	10

The MTCT audits showed that reasons for mother-to-child transmission (MTCT) were mainly lack of skilled deliveries (37% of the cases), missed infant prophylaxis (26%), missed maternal prophylaxis (37%), late PCR tests after two months (15%), and lack of attendance to ANC by the mothers (15%). The high number of missed opportunities for skilled delivery may probably be the limitation of all facilities not conducting 24-hours maternity. PCR testing beyond two months is attributed by the mothers who were identified late at postnatal and some had adherence issues and defaulted on treatment. Mentorship support and follow up of this mothers by the mentor mother and community volunteers is being strengthened to ensure the mother receives an initial PCR within 2 months and skilled delivery as appropriate. The County eMTCT TWG will also be reviewing this two indicators moving forward and highlight the poor performing facilities and do targeted mentorship

PMTCT Cohort Analysis

PMTCT cohort analysis was conducted in all PMTCT-supported sites to establish client retention at 3, 6, 9 and 12 months after enrollment. Viral uptake and suppression levels were also determined. Retention at 3-, 6-, and 12-month cohorts was 96%, 96%, and 100%, respectively within the project-supported sites and generally higher among known positive clients at 96% compared to the new positive 91% at 12 months retention. Viral load uptake and suppression was varied across cohorts, the uptake at 6-month cohort was 79% and 80% at 12-month cohort. The low uptake is attributed to lack of proper documentation in a few sites and some missed opportunities. This is being strengthened through OJT, mentorship on the registers, and real-time collection of samples and dispatch of results in all supported sites. Suppression levels were

recorded at 93% and 94% in 6- and 12-month cohorts, respectively. Table 16 below illustrates the quarter's performance.

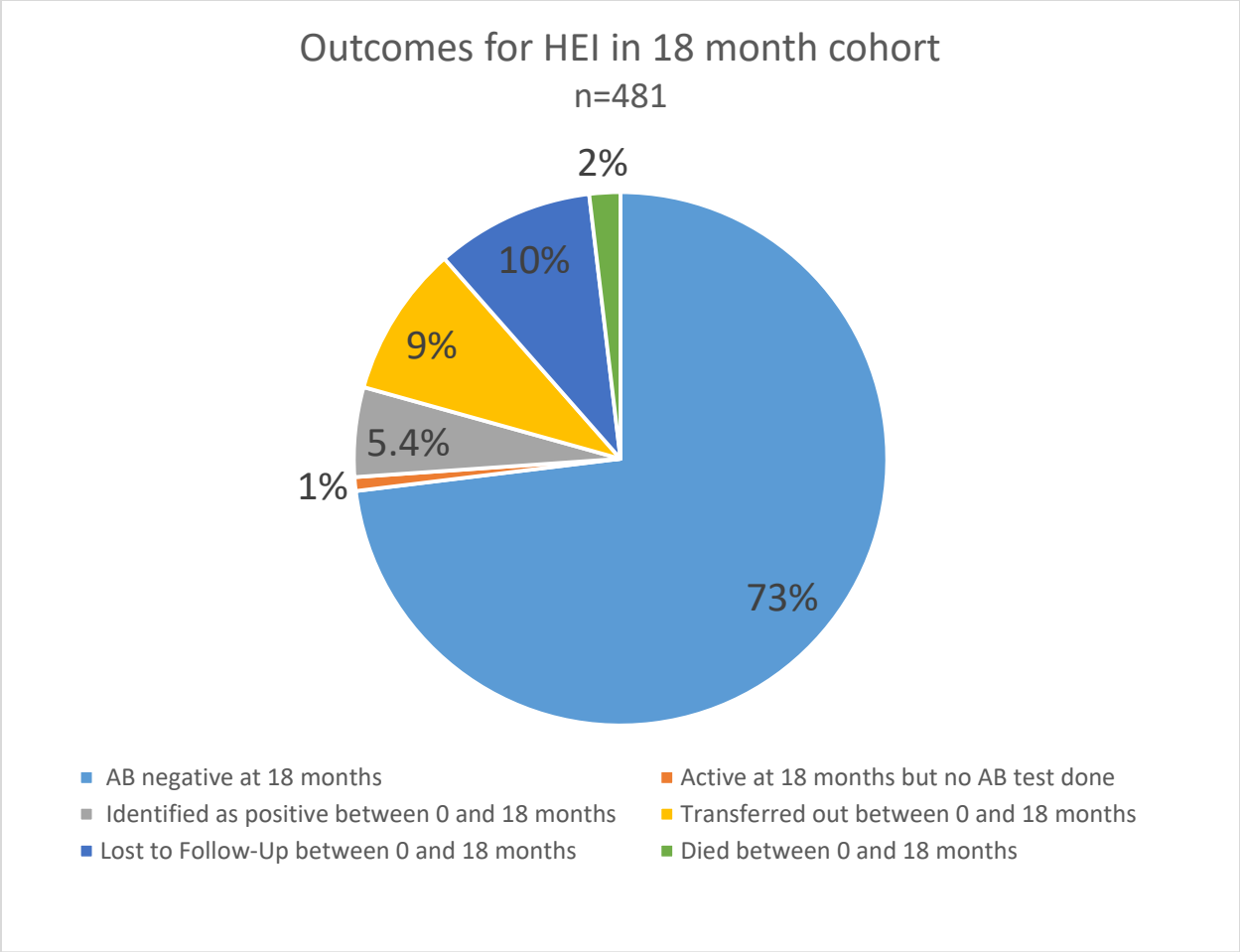
Table 20. PMTCT Cohort analysis, October to December 2017.

Indicator	3M Cohort			6M Cohort			9M Cohort			12M Cohort			24M Cohort		
	KP	NP	Total	KP	NP	Total	KP	NP	Total	KP	NP	Total	KP	NP	Total
Enrolled into cohort	255	186	441	211	163	374	248	171	419	271	269	540	207	247	454
Transfer in (T.I)	41	0	41	32	2	34	36	4	40	35	3	38	31	11	42
Transfer out (T.O)	6	3	9	10	14	24	14	19	33	16	36	52	29	35	64
Net Cohort	290	183	473	233	151	384	270	156	426	290	236	526	209	223	432
Defaulters	5	13	18	6	4	10	1	5		5	6	11	6	6	12
Lost to follow up (LTFU)				2	8	10	5	14		6	13	19	19	33	52
Reported Dead	1	0	1	0	1	1	0	0		1	0	1	1	0	1
Stopped	0	0	0	0	0	0	0	0		0	2	2	2	3	5
Alive and active on treatment	284	170	454	225	138	363	264	137	426	278	215	493	181	181	362
Viral load collected and results available	191	0	191	191	95	286	0	0	0	222	176	398	172	165	337
Virally suppressed (VL<1000)	181	0	181	180	85	265	0	0	0	210	165	375	160	162	322
% Virally suppressed	95%	0	95%	94%	89%	93%	0	0	0	95%	94%	94%	93%	98%	96%
%Retained	98%	93%	96%	97%	91%	95%	98%	88%	100%	96%	91%	94%	87%	81%	84%

HEI Cohort Analysis

During the reporting period, HEI cohort analysis was conducted for the 18-month cohort clients in all PMTCT supported sites. The primary goal was to establish MTCT rates and the percent retained/active in follow-up as demonstrated in the chart below.

Figure 8. HIV-exposed infant (HEI) cohort analysis at eighteen months (January to March 2018).



Overall, the project’s retention rate among the 9-month cohort was 85% with a 4% MTCT rate while the same indicators for the 18-month cohort were 80% and 2% MTCT rate. Retention and MTCT rates across the 9-month and 18-month cohort was relatively good. This performance can be attributed to the project’s continued focus to promote retention of mother-baby pairs by strengthening appointment and defaulter tracing systems; PMTCT psychosocial support groups; quality improvement team meetings with clinicians, PEs, and mentor mothers; and capacity-building of HCWs and PEs/mentor mothers on maternal, infant, and young child feeding. In addition, routine MTCT/mortality audits created opportunity for corrective actions on gaps identified. HEI graduation held in the supported facilities also made a difference. To maintain the momentum, the project will embrace the strategies that made the facilities exhibit good performance.

TB/HIV co-Infection Services

In the reporting period, the project supported various TB/HIV related activities. The project participated and supported the NTLF led clustered quarterly review meetings, supported TB data collection and verification and conducted mentorship support supervisions with the sub county TB leads in line with the 5Is TB/HIV collaborative activities. The project continued to support the Gene Xpert sample networking in all the five counties and provided support for clinical follow up of MDR TB patients. The project has 24

cough monitors in the supported counties, their main role being facility active case finding, support TB infection control measures at sites and support TB defaulters tracing. The highlight in the reporting quarter was support for the World TB day in all the supported counties. In line with this year's theme 'Be a leader, unite for a TB free generation', the project supported the county and sub county leadership in various activities commemorating the day including conducting TB screening in all the supported sub counties.

TB/HIV performance

During the reporting period October 2017 to March 2018, 940 TB clients were newly identified in the supported sites. Of the 940 TB clients identified, 930 (99%) were tested for HIV, of whom 335 (36% co-infection rate) were HIV positive. All the 335 TB/HIV positive clients were put on CPT prophylaxis with 329 (98%) put on HAART.

Compared to the COP 17 targets, the project achieved 48% (940/1,961) registered clients during the reporting period; 49% (930/1,897) clients with documented HIV status; 40% (335/839) TB/HIV co-infected clients identified and 39% 329/839) initiated on ART as shown in the table below

Table 21. Key TB-HIV indicators performance

TB/HIV performance indicators	COP 17 Targets	SAPR 2018 Achievement	% Achievement
Number of TB cases registered	1,961	940	48%
No. of TB patients who were counseled, tested for HIV, and received results	1,897	930	49%
Number of HIV-infected TB patients	839	335	40%
Number of HIV-infected TB patients on ARVs against the COP target	839	329	39%
Number of HIV-positive clients on treatment screened for TB	62,595	48,027	77%

(Data Source - TIBU).

The project will continue to support in intensive case finding at all service delivery points especially in the outpatient and inpatient departments. The project has 24 cough monitors placed at high volume sites across the counties. The cough monitors act as the point persons to enhance active case findings in the facilities they support and provide monthly reports that are part of facility and program data review meetings.

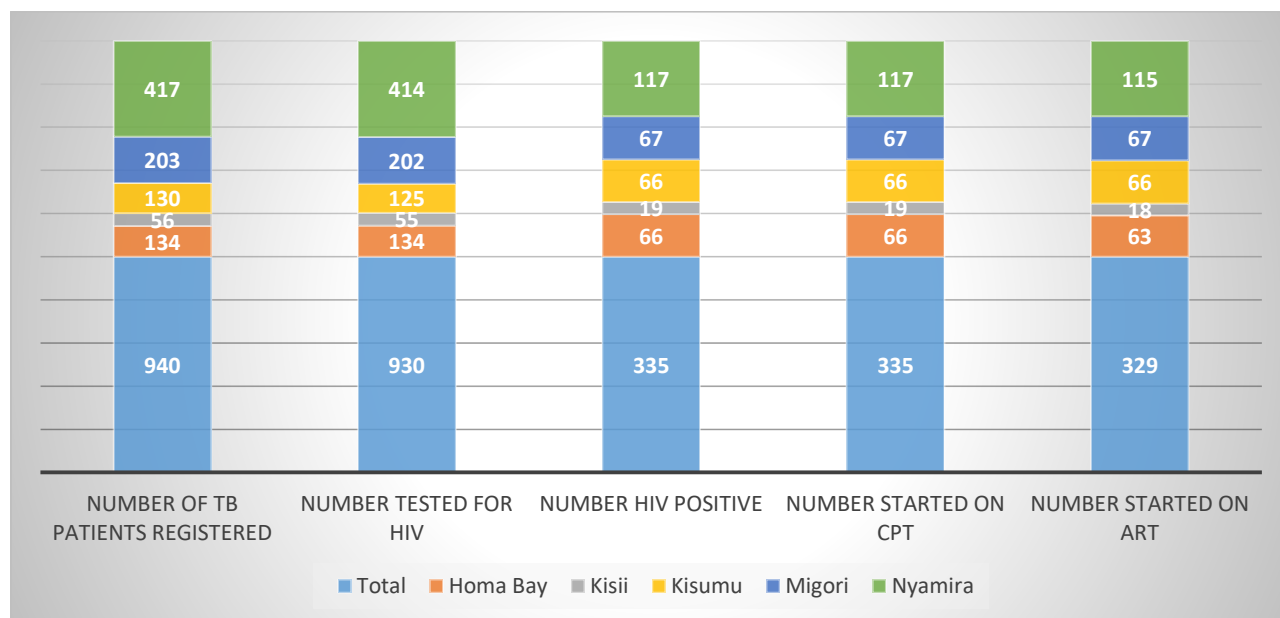
To strengthen HIV testing in TB setting, the project will support optimization of HIV testing in the TB clinics with focus on index client testing and PNS with the aim of ensuring all partners of TB clients both HIV positive and negative are tested for HIV. The project will enhance data review of TB indicators as part of the monthly facility data reviews.

ART initiation among TB/HIV co-infected clients

During the six month period, a total of 335/335 (100%) TB/HIV co-infected clients were started on co-trimoxazole preventive therapy (CPT) while 329/335 (98%) were started on ART. As compared to the COP 17 target, the project achieved 39% (329/839) ART initiation among the identified TB/HIV co-infected clients. The project reported a co-infection rate of 36% (335/935).

County analysis of the TB/HIV co-infection showed Kisumu has a co-infection rate of 53% way above the national average of 35% (2017). Homa Bay has a co-infection rate of 49%, Kisii 35%, Migori 33% and Nyamira 28%. The county TB/HIV cascade is shown in the graph below.

Figure 9: TB/HIV cascade for October 2017 to March 2018



During the reporting period, Homa Bay achieved 46% of the TB identification target with 95% of the TB/HIV clients being initiated on ART. Kisii achieved 53% of the targets with 95% initiated on ART. Kisumu achieved 66% of the target with 100% initiated on ART. Migori achieved 43% of the target with 100% initiation. Nyamira achieved 42% of the target with 98% initiated on ART. Six clients were reported as having not been started on ART however on follow up all had been subsequently started on medication. The project is working with the respective SCTLCS to update the data on TIBU. The project continues to work with the SCTLCS on regular facility support supervision and accurate updating of client information in TIBU.

Intensified case finding-TB screening among the population on ART

In the reporting period of January to March 2018, the project screened 96% (48,099/49,924) of the HIV clients active in care for TB during that period. All counties reported screening rates of over 95%.

Table 22: TB screening Jan-March 2018

County	Current on ART March 2018	Screened for TB March 2018	% Screened
Homa Bay	13819	13191	95%
Kisii	2030	1919	95%
Kisumu	7320	7090	97%
Migori	13491	13080	97%
Nyamira	13264	12819	97%
Total	49,924	48,099	96%

Of the 48,099 that were screened for TB, 9,575 (428 among newly enrolled and 9,147 among existing on ART) had a positive screen. Of these, 8,702 (91%) received a bacteriological test with 270 (3%) confirmed to have TB disease. The mode of diagnostic test used for the 8,702 clients was as follows: 10% (876/8,702) had smear only sample, 85% (7,393/8,702) had a GeneXpert test done and 5% (433/8,702) had other test done including X ray.

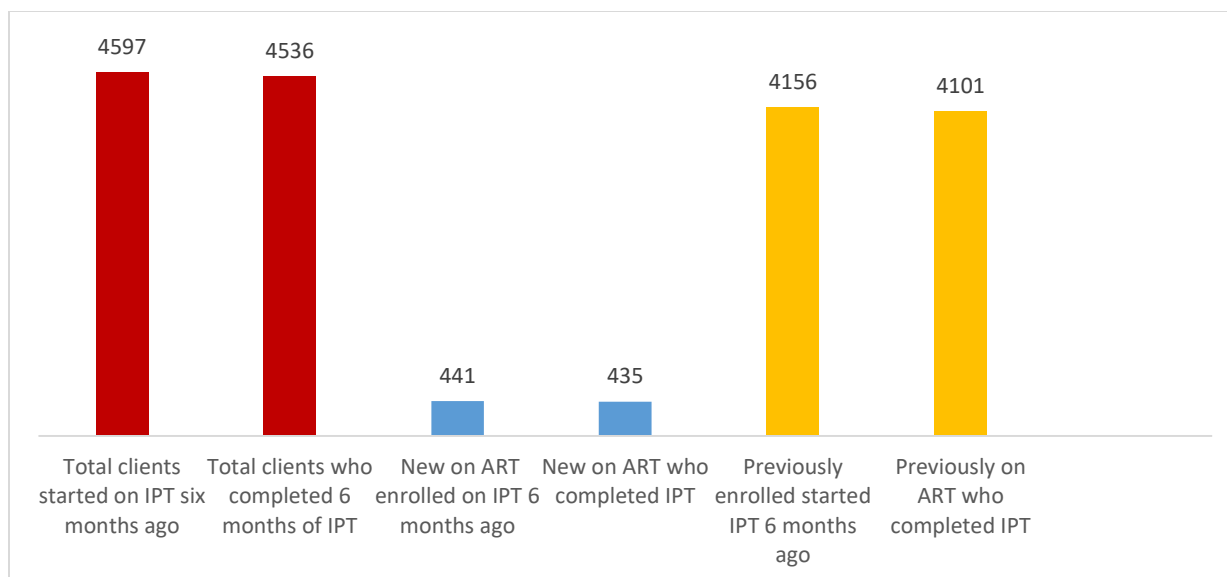
The project has identified five sub counties with screening less than 95% and a few facilities with particular low screening rates. The main challenge identified was incorrect reporting of the data. This is being remedied through support supervision and monthly data review meetings. In addition, the project is conducting regular mentorship to improve the quality of TB screening and TB screening data across all the sites.

The project will improve the quality of TB screening by adopting the national TB prevalence survey recommendation to expand the TB symptomatology screening questions and increased mentorship and supervision. The project will also increase the use of Gene Xpert as the first diagnostic tool to 100%. In addition, to improve accuracy of the reporting and quality of screening, the facilities will report the cascade in the presumptive TB register at all service delivery points on a monthly basis for comparison with TIBU data and updating. This will be done in collaboration with the SCTLCS.

Isoniazid Preventive Therapy

During the reporting period, the project continued to support provision of IPT as part of the minimum package of care for all eligible HIV+ clients in the supported facilities. Of the 4,599 HIV positive clients started on IPT between April and September 2017, 4,536 (99%) completed IPT prophylaxis.

Figure 10. IPT Cascade Outcomes



Data Source: - Facility IPT register summarized into a project IPT addendum reporting tool).

The county IPT completion rates were Homa Bay county 98%, Kisii 100%, Kisumu 100%, Migori 97% and Nyamira 100%. The project is working to improve long-term follow up and reporting of IPT outcomes beyond six months through mentorship on regular updating of the IPT register and monthly reporting of outcomes beyond 6 months. The project is also working to establish the accurate numbers of clients ever initiated through chart abstraction and review of the IPT register and will subsequently update the DHIS2. This will be done in the next quarters.

Gene Xpert Testing

In the reporting period, the project continued to support five GeneXpert machines at 5 testing hubs namely Kuria SCH, Manga SCH, Nyamira CRH, Masaba SCH and Rachuonyo SCH. The support included providing technical support to the hubs, supporting service contacts, and laboratory networking from the spokes to the hubs using the rider led sample networking (RLSN) system. The results for GeneXpert are shown in table below.

Table 23: GeneXpert utilization

County	Facility	Total Test Done	Utilization Rate	Error Rates
Migori	Kuria SCH	414	43%	10 (4%)
Nyamira	Manga SCH	651	68%	36 (6%)
	Masaba SCH	585	61%	11 (2%)
	Nyamira CRH	548	57%	15 (3%)
Homa Bay	Rachuonyo SCH	497	52%	26 (5%)

Source: NTL-D-P – Online GX Alert.

The utilization rates are below the nationally recommended 80% and error rate above the recommended less than 4% in Manga SCH and Rachuonyo SCH. Kuria SCH utilization was significantly affected by constant power interruption necessitating the temporary relocation of the machine to Migori CRH. The machine has been returned to Kuria and the project is working with the county team to source for solar powered

back up for uninterrupted service provision. The high error rate in Rachuonyo and Manga SCH was due to a malfunctioning module with frequent power interruptions contributing to the high error rates. The malfunctioning module has been fixed and looking to long-term stable power solutions with the county. In the coming quarter, the project will renew the service contracts for all the supported machines and support super user EQA training in all the supported hubs. As the project works to scale up active case finding, GeneXpert networking will be enhanced to reduce the turnaround times (TAT) making GeneXpert the first TB diagnostic tool for all TB cases. Turnaround times (TAT) will be monitored on a weekly basis and corrective measures instituted promptly.

Drug-resistant (DR) TB management

The project continued to support MDR TB treatment through clinical meetings and tracing of contacts of MDR TB clients. During the quarter, eleven (11) clients continued on MDR TB treatment, Nyamira (6), Kisii (1), Migori (2), Kisumu (1) and Homa Bay (1). Two clients died during the period, one in Migori and a newly identified client in Nyamira.

Infection prevention and Control (IPC)

The project supported implementation of facility infection prevention and control activities as part of the TB 5Is collaboration. Technical support was provided to ensure the minimal administrative, environmental and use of personal protective equipment are in place. For the 59 high and mid volume facilities with functional infection committees, the project is working to incorporate TB infection prevention and control into the facility infection prevention and control committee. This will ensure TB infection prevention and control is practiced in all service delivery points.

Commodity Security

Improving supply chain logistics and commodity management

The project continued strengthening of county and subcounty supportive supervision teams to improve reporting rates and high-quality reporting. The project supported 22 ART reporting sites (18 central and 4 standalone sites) and submit monthly reports to KEMSA LMIS system, achieving a 94.3% reporting rate in the quarter. Support was provided for off-site mentorships and OJT on good commodity management practices (to improve on quantification, ordering, storage, and inventory management).

Table 24. Central and satellite ART commodity sites' reporting rates, January to March 2018.

County	Central ART sites	Satellites supported	Satellites reporting	Average reporting rate
Homa Bay	3	32	32	100%

Kisumu	3	16	16	100%
Migori	6	44	34	77.3%
Kisii	1	14	14	100%
Nyamira	5	100	98	98%
Standalone sites	-	4	4	100%
Total	18	210	198	94.3%

Support for county technical oversight and coordination for commodity management and patient safety.

In the quarter, the following support was provided:

- Quarterly commodity technical working groups meetings for Nyamira and Migori.
- Continuous county supportive supervision visits across all counties.
- Redistribution of off-schedule commodities (e.g., Zidovudine suspension and LPV/r pellets) across facilities in Migori, Nyamira, and Homa Bay counties.
- Continuous mentorship and OJT on commodity management, pharmacovigilance, and use of Web ADT.
- Assessment by the SCHMT to upgrade Dede dispensary to ART ordering site.
- Mop up of expired ARV drugs in Kuria West subcounty.
- Quarterly RTK allocation meetings in Nyamira and Migori County.
- National RTK management review workshop by KEMSA across all the counties.

Table 25. County reporting rates of RTK commodity, January to March 2018.

County	Number of subcounties reporting	Average reporting rate
Homa Bay	2	90%
Kisumu	2	97%
Migori	4	99%
Kisii	1	100%
Nyamira	5	99%

Source: Health Commodity Management Platform.

Web ADT Tool

Currently the project supports 18 central ordering ART sites, 12 of which have functional Web ADT. In commodity management, the tool supports generation of reliable monthly drug consumption report and monthly patient summary report (FCDRR and FMAPS) for submission to KEMSA. Additionally, we have four standalone ART ordering sites that all have functional Web ADT to support monthly generation of FCDRR and FMAPS.

At the central ordering sites, Web ADT tool also allows accurate management of commodity transactions including amount of ARV supplies received from KEMSA, amount issued to each satellite site, expiry tracking for each ARV drug as well as stock level of each commodity hence giving early warning when stock is below average monthly consumption.

Human Resources for Health Support

In the reporting period, the project worked with the county departments of health (CDHs) and the County Public Service Board (CPSB) in four counties of Migori, Homa Bay, Nyamira, and Kisii toward regularizing the contracting process with the CPSB. Currently, 294 health workers have undergone suitability tests conducted under the tripartite arrangement. The suitability testing process sieved out staff who did not meet the minimum requirement for the positions, and it provided an opportunity to onboard staff who were engaged under locum. For the vacant positions, the CPSB started a recruitment process to fill the positions. In the meantime, the contract staff are on PATH temporary short-term contracts to allow for continuity of services and the CPSB to complete the contracting process in consultation with the CDHs and the project to enable issuing the contracts with effective May 1, 2018.

In the process of engaging the counties on the contracting process, a number of unique issues emerged as shown below:

- In Kisumu County, there is currently a legal and political standoff between the CPSB and the County Executive. It was therefore not possible to engage the CPSB in the contracting process. The Chief Officer for Health, Kisumu, signed contracts for all partner-supported health care workers in Kisumu County.
- In Nyamira County, the county health leadership led by the CEC Health and Chief Officer Health, proposed to have the HRH staff contracted at lower payment terms compared to the SRC recommended rates for all cadres. They based this request on the fact that the county needs more health care workers deployed to support the subcounties and facilities supported by the project. The modalities and supporting documentation for this arrangement between the CDH and the CPSB will be finalized in next quarter. The table below gives a summary of health workers contracted by county.

Table 26. Clinical and non-clinical staff contracted by CPSB and CDH.

County	RCO	KCHRN	HRIO	MLT	Pharm Tech	HTS Providers	Total	Status of Contracting
Homa Bay	17	17	17	2	2	40	95	Recruitment process completed. To be contracted from 1/5/2018.
Kisii	3	3	3	1	1	10	21	County engagements ongoing.

Kisumu	13	13	13	2	3	15	59	Completed.
Migori	19	11	15	4	4	30	83	Recruitment process completed. To be contracted from 1/5/2018.
Nyamira	12	12	12	4	5	71	116	Recruitment process ongoing. To be contracted from 1/5/2018.
Total	64	56	60	13	15	166	374	

During the reporting period, the project conducted a workload-based staffing needs assessment for HIV and AIDS service delivery. The objective of the assessment is to determine the HIV/AIDS staffing levels and staffing gaps in the 59 high- and mid-volume facilities in all five HSDSA C1 supported counties. The data from the assessment will also contribute to the project's reporting on the PEPFAR HRH STAFF indicator.

The assessment process involved drafting of the design and tools and obtaining appropriate approvals and field testing tools. The project held meetings in each county to brief county managers on the HRH assessment and obtain their approval and support for the process. As of March 31, data collection was completed in 45 facilities and data entry commenced. It is expected to be completed in the coming quarter, and data analysis will be done and ready for a draft report presentation to HSDSA C1 project leadership.

The HSDSA C1 project requires that all HRH staff be recruited and deployed as per the MOH donor-contracting model where HRH are hired through the tripartite approach involving the County Public Service Boards (CPSB), MOH, and HSDSA C1. In line with this, the project held engagement meetings with CHMTS in all five (5) counties and oriented them to the recruitment approach. To lay the foundation for further discussions and agreements on transitioning service delivery staff from project support to county employment, the project shared information on numbers and distribution of staff allocated by the project with CHMT members and CPSBs. The project further supported counties in the design of staff suitability evaluations and interviews. Through these activities, HSDSA C1 has set the foundation to define the HRH transition terms with counties as part of the county MOUs. The project awaits further guidance from USAID on the MOU process.

As part of strengthening data driven decision-making, the project participated in the Lake Basin HRH Stakeholders forum convened by the HRH Kenya Project. The forum covered issues of using iHRIS as a decision-making tool and experience sharing by all five counties on HRH management. In the next quarter, the project will use the forum report to develop a joint follow-up support plan with HRH Kenya to ensure strong coordination between the projects in achieving improved iHRIS capabilities and use at the county,

Sub County, and facility levels. The project will use the results of the workload-based staffing needs assessment to provide HRH data to further support counties in the preparation of evidence-based staffing plans.

In the reporting period, the project engaged the deputy CASCO and lead mentor for Migori County to discuss the National AIDS and STIs Control Programme (NASCOP) Mentorship model in order to identify mentorship gaps in two sub county hospitals (Isebania and Kuria SCH). The process involved chart reviews and registers audits alongside facility comprehensive care team. Gaps identified included incorrect documentation in MOH tools, staff not oriented on current HIV NASCOP guidelines, and lack of mentorship by SCHMT. A mentoring plan was deduced with the deputy CASCO and lead mentor for implementation. The concept was replicated in Kisumu, and Homa Bay counties, leading to the C/SCHMTs conducting 21 mentoring visits to high- and medium-volume sites to mentor staff across five counties.

In the reporting period, the project undertook an institutional capacity assessment in three out of five counties toward identifying accredited training institutions with the capacity to provide in-service training for HIV services. The assessment sought to check for readiness by the institutions to offer HIV courses, availability of learning infrastructure, history of in-service training, current HIV courses offered, and accreditation status of the training institutions. The assessment was done using a checklist that captured the above-mentioned parameters. The assessment will be completed in the next quarter, and eligible training institutions engaged to offer in-service training for HIV services. Preliminary findings from the three counties are provided in the table below.

Table 27. Training institution capacity to offer HIV in-service training.

Capacity measure	Kisumu Medical Training College (MTC) (main campus)	Kisumu MTC (Lake Victoria campus)	Homa Bay MTC	Migori MTC
Readiness of faculty	Yes 26 resident and 31 visiting lecturers	Yes 21 resident lecturers	No 7 resident lecturers	No 5 lectures
Training institutions infrastructure	Adequate 12 lecture halls 14 office spaces 1 functional library Wi-Fi Internet connections	Adequate 10 lecture halls 11 office spaces 1 functional library LAN Internet connections	Inadequate 7 lecture halls 8 office spaces 1 library not fully equipped Internet connection	Inadequate 8 lecture halls 7 office spaces 1 library not fully equipped Internet connection

HIV course	Last training conducted in 2012	None	None	None
In-service training program	Available Pediatric nursing Anesthesia	Available Medical laboratory sciences	None	None
Accreditation status	Accredited Ministry of Health and the	Accredited Ministry of Health and the	Accredited Ministry of Health and the	Accredited Ministry of Health and the

In the reporting period, the project in discussion with the care team updated CME topics for rollout across HSDSA C1 supported facilities. The process involved a review of topics in the ART guidelines and the Kenya ARV curricula 2016 as included in Kenya Standard Package of Care. Gaps identified requiring updates were missing appointments, failure to take drugs as prescribed, and violence from caregivers at home. Based on these findings, the project updated the Sexual Gender-Based Violence and Optimization Triple Zero (OTZ) CMEs.

The project went beyond the updates and supported the OTZ CME in Kisumu County, reaching 21 facility staff from three health facilities with the objective of decreasing HIV exposure among infants. In the same reporting period, the project supported the rollout of the Suspected Treatment Failure CME sessions in five facilities, reaching 128 staff across the five counties.

The project supported sub-county hospitals in Kisumu, Homa Bay, and Migori to participate in web-based continuing medical education and case management sessions (ECHO) via Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) once a week throughout the quarter. The topics covered included:

- Osteopenia and HIV Infection
- Management of Diabetes Mellitus in HIV Infection
- Management of High Viral Load
- Drug Induced Liver Injury in the Setting of Isoniazid Preventive Therapy
- Management of TB/HIV in Children
- Management of Hypertension in HIV Infection

Table 28. Health facility staff participation in the ECHO CME sessions.

Facility	County	Number attended
Migosi Sub County Hospital	Kisumu	19

HSDSA Homa Bay Office (Rachuonyo Sub County Hospital, Matata Hospital, Kabondo Sub County Hospital)	Homa Bay	19
Uriri Sub County Hospital	Migori	17
SONY Medical Center	Migori	12
Awendo Sub County Hospital	Migori	16

Strengthening County Planning and Budgeting Processes

During the reporting period, the project supported consolidation of AWP and budgets in Kasipul and Kabondo Kasipul sub counties in Homa Bay County. The process brought together the two sub counties to a central point for three days, which ended with each sub county producing a costed work plan to be shared with Homa Bay County for consolidation. While Health Policy Plus (HP+) already trained four PBB TOTs in Homa Bay County, they indicated that they still need additional support to better support the sub counties to generate costed AWP aligned to PBB template.

In the same period, the project reached out to the other four counties and have planned support for sub county AWP/budgeting for Nyamira, Kisii, Migori, and Kisumu to take place in the next quarter.

In the reporting period, the project undertook county entry engagements in all the five counties to introduce the project formally to the counties and sub county health teams. The project technical team made a comprehensive presentation of the project objectives and activities, allowing the CHMTs and SCHMTS to ask questions during the plenary session. The key areas that the county teams sought clarifications on were (1) nutrition not supported in the HSDSA project, (2) need for an MOU between the project and county health department, and (3) need to streamline engagement and transition of contracted health workers.

Quality Improvement

The project sensitized the CHMT and the SCHMT from Homa Bay County, Kisii County, and Nyamira County on quality improvement (QI) approaches including QI collaboratives. Thirteen QI coaches were also nominated during this meeting, who will coach and mentor QIT/WIT at the facilities to institutionalize QI. The project collaborated with the counties and identified viral suppression as a key priority area for a QI collaborative. Thirty-one facilities across the five counties with low viral suppression in the last year were identified to participate in the viral load collaborative (see table below of sampled sites). A change package and a set of indicators have also been developed in consultation with the counties for the collaborative. During the reporting period, the project supported Homa Bay County in harmonizing the QI baseline survey/assessment tools used by different implementing partners in the county. The final tool has been adapted by the county for annual QI assessments to document QI maturity of the sub counties and facilities.

Table 29. Facilities participating in the viral load collaborative.

County	Facility	County	Facility
Homa Bay	Omiro Dispensary	Nyamira	Manga SCH

Homa Bay	Godber Health Centre	Kisumu	Airport Dispensary
Homa Bay	Ombek Health Centre	Kisumu	Migosi Health Centre
Homa Bay	Kabondo Sub District Hospital	Kisumu	Ober Kamoth Health Centre
Homa Bay	Othoro Health Centre	Kisumu	Port Florence Community
Homa Bay	Kokwanyo Health Centre	Kisumu	Ojolla Dispensary
Homa Bay	Ober Health Centre	Kisii	Masimba Sub-District Hospital
Homa Bay	Nyangiela Health Centre	Kisii	Gesusu Sub-District Hospital
Homa Bay	Rachuonyo District Hospital	Kisii	Ibacho Sub-District Hospital
Nyamira	Masaba/Keroka District Hospital	Migori	Nyakuru Health Centre
Nyamira	Nyamusi SDH	Migori	Kuria District Hospital
Nyamira	Tinga Health Center	Migori	Dede Dispensary
Nyamira	Ekerenyo SDH	Migori	Uriri Health Centre
Nyamira	Nyamaiya H/C	Migori	Awendo Sub District Hospital
Nyamira	Nyamira Dist. Hosp.	Migori	Isebania Sub District Hospital
Nyamira	Kijauri SCH		

The project conducted QI baseline assessments in 48 high- and mid-volume facilities. The results from this will be shared with the counties. The project will support the counties in developing QI action plans based on the findings in the next quarter. In the reporting period, onsite mentorship on the Kenya HIV Quality Improvement Framework (KHQIF) was conducted in seven high-volume facilities. These facilities conducted the KHQIF indicators review, which the Work Improvement Teams (WITs) will use in developing CQI action plans for improving service delivery and patients' outcomes.

Health informatics: electronic medical records (EMR) and ART dispensing tool

HSDSA Cluster 1 project has continued to support 40 facilities that were furnished with KenyaEMR built on top of OpenMRS platform, whose primary partner was I-TECH Kenya. Thirty-four facilities, out of 40 (85%) have achieved point-of-care usage of the system. Only 18 (44%) of facilities have achieved EMR data concordance threshold. Mentoring and OJT on data use to support EMR for clinical decision-making at the facility level. Support supervision, technical support, hardware maintenance, and data mining have been done and will continue to be offered to the county and sub county management, clinical team, and health records staff. KenyaEMR system currently supports HIV testing services, care and treatment (pediatric, adolescent, and adult) services, antenatal care and maternity services, early infant diagnosis, and HIV/TB services. The system also allows for uploading of monthly data to NASCOP national data warehouse for data visualization.

Eleven facilities in Nyamira County, four facilities in Migori County, two facilities in Kisumu County, and one facility in Kisii County have already achieved the required data quality threshold and are awaiting launch by the department of health in the respective counties to paperless mode.

The project also has continued to support 17 health facilities that host the ART dispensing tool through software upgrade with core features to manage commodities and reporting and direct transmission of viral load results from the NASCOP website where the results are synchronized with patient data in the

system. More so, the project conducted OJT at the facility levels. Given the shift to the Electronic Dispensing and Inventory Tracking Tool, Web ADT, developed by the Clinton Health Access Initiative (CHAI).

Challenges encountered in the rollout of EMR include frequent power outages, inherent system gaps within the EMR platform, high staff turnover at the facility, and hardware malfunction. These are being addressed in consultation with EMR implementation partners Palladium under KenyaEMR and KenyaIT.

Table 30. EMR implementation summary.

County	Number of EMR supported sites	Number of sites					
		Stage 1 (Deployment and migration)	Stage 2 (Work flow)	Stage 3 (Data quality, concordance and point of care usage)	Stage 4 (Electronic reporting)	Stage 5 (Sustainability)	Stage 6 (Paperless operations)
Homa Bay	4	0	0	2	1	1	0
Kisumu	4	0	0	1	1	2	0
Kisii	2	0	0	0	1	1	0
Migori	10	0	1	0	4	5	0
Nyamira	20	0	1	1	11	7	0
Total	40	0	2	4	18	16	0

Table 31. Reporting data concordance (paper MOH 731 vs. EMR 731).

% Data Concordance	No of Sites
90%–100%	18
80%–89%	5
70%–79%	6
Below 69%	10 (some facilities not able to report due to power outages)

Lessons learned from EMR support

- Team synergy is key in achievement of our deliverables.
- County entry engagements provided an opportunity for streamlining the tripartite arrangement in the contracting of the project supported health workers.
- Continues mentorship leads to optimal results.
- Ownership and accountability contributes to a functional EMR.

Generally, the majority of facilities scored low percentages due to the following issues:

1. Not all patient records are updated in the system.
2. A discrepancies in monthly reports, specifically for the following indicators: enrollment in care, started on ART, current in care, and current on ART.
3. Lack of viral load results updated in the system.
4. Incomplete patient records in the system—i.e., ART start date, date confirmed HIV positive, entry point, undocumented lost to follow-up, etc.

Strategic monitoring and evaluation

During the reporting period, M&E activities continued to strengthen data management, data use and reporting systems. M&E activities included training Health Care workers on the revised M&E Tools, distribution of the new tools and assessment of the shortages/gaps in the distribution and availability of the new tools. The project also undertook mentorships to enhance the capacities of MOH systems, including mentorship for the revised HIV reporting tools; data quality improvement; reporting at county, Sub County, facility, and community levels. Details on the strategic M&E activities are included in the Performance Monitoring section.

II. ACTIVITY PROGRESS (QUANTITATIVE IMPACT)

Please refer to the performance data tables in the attachment.

III. CONSTRAINTS AND OPPORTUNITIES

IV. PERFORMANCE MONITORING

1.1. Enhancing availability and capacity to use reporting tools at all levels

During the reporting period, the project collaborated with the MOH at the county and sub county levels to provide support in addressing MOH reporting tools shortages in the ten project-supported counties. The project supported photocopying and distribution of key MOH reporting tools, including daily activity registers, blue cards, yellow cards, ICF (pediatric and adult) cards, MOH 731, and the new MOH 711A. The above support contributed to the availability of the reporting tools and to improvements in updating patient records and data quality at the facility level. The project also conducted gender youth and social inclusion analysis. The analysis collected qualitative data that will be used to investigate specific gaps that exist between males, females and youth with respect to availability, access, utilization and quality of health services including HIV/AIDS prevention, care, and treatment. The analysis will enable the project to determine how it addresses and responds to gender dynamics and inequalities in technical programming, policies and practices.

1.2. Capacity-building of MOH systems, structures, and personnel on data collection and use

1.3. Strengthening capacity of HCWs on reporting tools, indicators, and data use

During the reporting period, NASCOP introduced the revised HIV reporting tools. The project supported the training of facility health care workers who work with the tools. A total of 546 HCW's (106 in Homa Bay, 65 in Kisumu, 269 in Nyamira and Kisii and 106 in Migori) were trained on the revised tools. The aim of the trainings is to improve the knowledge of HCWs on the use of the revised tools and to ensure improved quality of reported data through correct filling and transfer of data from facility registers to summary tools. The project also supported sensitization of the new tools through on-site mentorship for the new 731 as well as the revised registers and cards.

1.4.Improving data quality

Facility data-quality audit

The project, in liaison with data clerks at health facility level, conducted DQAs in 41 project-supported high-volume health facilities during the months in the quarter. The DQA built on previous similar audits that have been carried out by the project. These audits focus on comparison of data across three data points (namely registers, MOH731summaries and DHIS2) to assess and document data consistency.

EMR Routine Data Quality Audit

The project conducted routine data quality audits (RDQAs) for 36 facilities out of 40 (90%). RDQA activity did not take place in four facilities due to power outages that affected four facilities in Kisumu, Nyamira, Homabay, and Migori. The results from Routine data quality audit information is shown in the table below.

Table 32. Routine data quality audit (RDQA) information.

County	% Average RDQA Score	No of Site RDQA Conducted
Kisumu	83%	3
Homa Bay	71%	3
Nyamira	81%	19
Kisii	88%	2
Migori	75%	9

V. PROGRESS ON GENDER STRATEGY

VI. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

Supportive supervision visits were conducted in all supported counties for waste management and disposal by the program technical team working with SCHMT.

VII. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

In the reporting period, the USAID HSDSA Cluster 1 project reached out to Human Resource for Health (HRH) Kenya and USAID Health Policy Plus (HP+), to discuss and plan collaboration on HRH strengthening

and program-based budgeting (PBB) respectively. The project will work collaboratively with these two mechanisms at SCHMT level in the next quarters. .

Collaboration with the PALLADIUM group continued in the quarter in the area of Electronic Medical Records (EMR). The two projects worked towards improving the utilization of the EMR systems through conducting routine data quality assessments (RDQAs), support supervision, review meetings as well as the migration of the existing EMR to the upgraded version 22. In the coming quarters, the service delivery partner is expected to support all the EMR activities apart from review meetings which PALLADIUM will continue to support.

VIII. PROGRESS ON LINKS WITH GOVERNMENT OF KENYA AGENCIES

During the reporting quarter, the project was able to hold entry engagement meetings with all the five counties to introduce the HSDSA project and obtain buy-in from the counties.

In the SAPR 2018 period including the reporting quarter,

- The project continued to partner with the MOH in supporting service-delivery activities at the health facility and safe spaces. This included conducting capacity-building activities, such as trainings, orientations, and mentorships for mentors and paralegals, and providing biomedical services.
- The project collaborated with the Ministry of Education to provide safe spaces in some selected schools as shown in Table xx. The project also supported quarterly stakeholder and gender TWG meetings in the two counties.

➤ Table xx Other ministries and departments with which the project collaborated.

Government of Kenya agency	Component	Area of linkage
Ministry of Health	Biomedical services	<ul style="list-style-type: none"> • Facilitation of trainings • Provision of biomedical outreach and referral services for AGYW
Department of Youth and Gender, Children Services, Youth Enterprise Development Fund	Social-asset building	<ul style="list-style-type: none"> • Safe spaces for girls • TWGs for gender • Stakeholders' forum • Cash transfer • Loans for AGYW
Ministry of Education, Science and Technology	Education	<ul style="list-style-type: none"> • Safe spaces • School fees
Ministry of Internal Security (Kenya Police)	Security and accountability	<ul style="list-style-type: none"> • Post-GBV care for AGYW/accountability—legal support • Security at safe spaces

Provincial Administration		• Bursaries
County Government		

Note: AGYW, adolescent girls and young women; GBV, gender-based violence; TWG, technical work group.

IX. GLOBAL DEVELOPMENT ALLIANCE (IF APPLICABLE)

Not applicable.

X. SUBSEQUENT QUARTER'S WORK PLAN

Table 33. Work plan activities, statuses, and explanations.

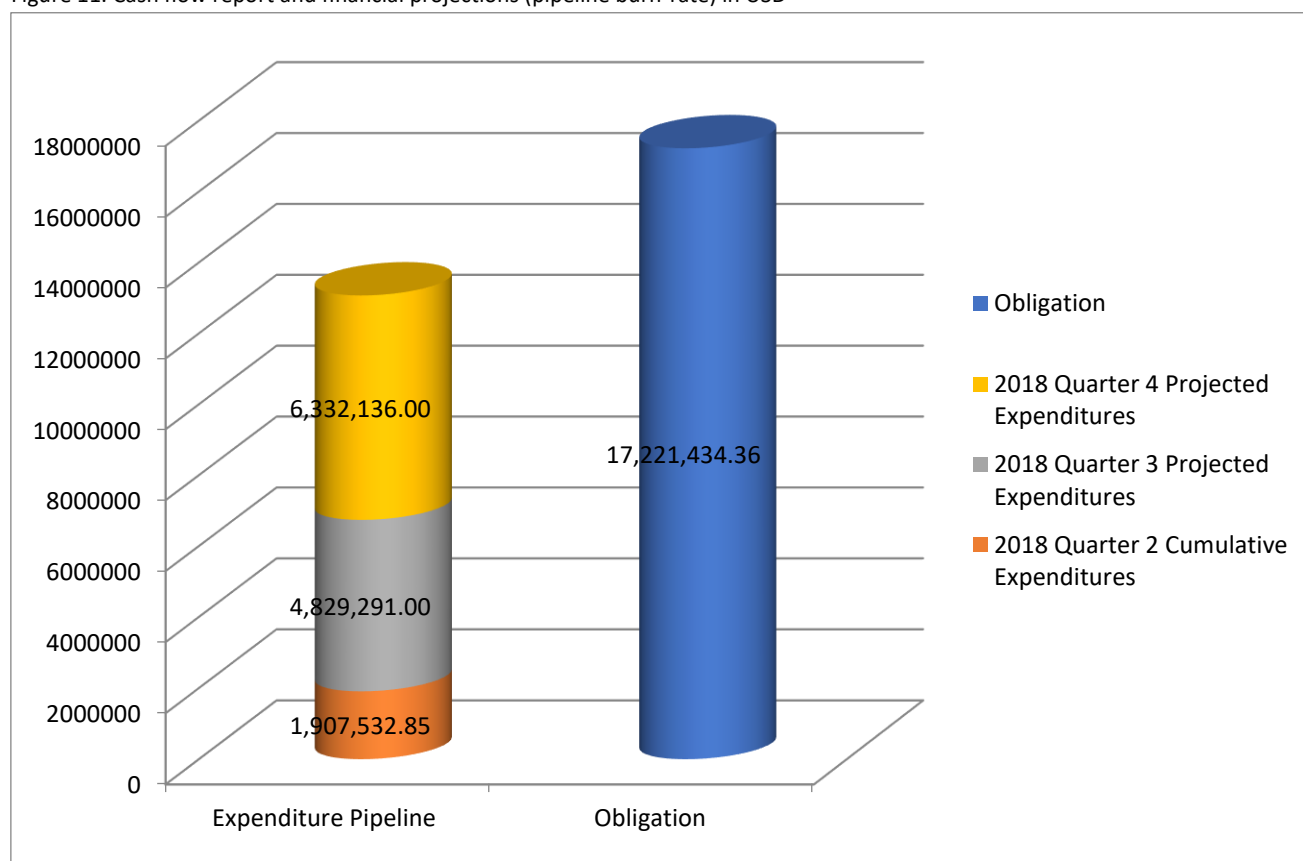
Planned activities from previous quarter	Actual status this quarter	Explanations for deviations
Increased and expanded high-quality HIV services		
SUPPORT FACILITY MENTORSHIP ACTIVITIES BY THE MENTORING TEAMS FOR ART, PMTCT, HTC, LAB, AND PHARMACY.	Fully accomplished in this quarter.	
TRAIN HEALTH CARE WORKERS ON THE REVISED ART GUIDELINES	Fully accomplished in this quarter.	
SUPPORT FACILITY-BASED CME FOR ART AND PMTCT ON A QUARTERLY BASIS.	Fully accomplished in this quarter.	
SUPPORT THE LABORATORY-NETWORKING MODEL (CD4, EID, BIOCHEMISTRIES, HEMATOLOGY, AND VIRAL LOAD).	Fully accomplished in this quarter.	
SUPPORT ART PMTCT REPORTING TO MEET COP 17 QUARTERLY TARGETS.	Fully accomplished in this quarter.	
SUPPORT ACCELERATED ART ENROLLMENT AND RETENTION ACTIVITIES	Fully accomplished in this quarter.	
SUPPORT RDQA FOR EMR	Fully accomplished in this quarter.	
SUPPORT FACILITY ART/PMTCT DEFAULTER TRACING MECHANISMS (DIARIES, PEER EDUCATORS, AIRTIME, AND SMS REMINDERS).	Fully accomplished in this quarter.	
SUPPORT FACILITY PLHIV SUPPORT GROUP MONTHLY MEETINGS (INCLUDING PEDIATRIC, MALE, ADOLESCENT, PMTCT, GENERAL CCC).	Fully accomplished in this quarter.	
SUPPORT HIV COUNSELING AND TESTING AT ANC AND MCH CLINICS OF PREGNANT MOTHERS AND MOTHER-BABY PAIRS.	Fully accomplished in this quarter.	

Planned activities from previous quarter	Actual status this quarter	Explanations for deviations
PROVIDE HCW MENTORSHIP ON EMTCT.	Fully accomplished in this quarter.	
SUPPORT NONCLINICAL COUNSELORS.	Fully accomplished in this quarter.	
SUPPORT DR-TB PATIENTS TO ACCESS TREATMENT.	Fully accomplished in this quarter.	

XI. FINANCIAL INFORMATION

Figure 11 below shows the project cash flow and financial projections.

Figure 11. Cash flow report and financial projections (pipeline burn-rate) in USD



Source: Project financial records, March 2018

1.5. Budget details

T.E.C: \$77,873,573.00

Cumulative Obligation: \$17,221,434.36

Cumulative expenditure

Actual \$1,907,532.85

Accrual \$570,248.00

Total \$2,477,781.00

Table 34. Actual expenditure details

Obligation	FY18 Quarter II cumulative expenditures	FY18 Quarter III projected expenditures	FY18 Quarter IV projected expenditures
\$17,221,434.36	\$1,907,532.85	\$4,829,291.00	\$6,332,136.00
Personnel	\$613,881.97	\$720,743.00	\$720,743.00
Consultants	\$0.00	\$79,430.00	\$38,500.00
Travel and Transportation	\$84,616.46	\$609,235.00	\$761,543.00
Other Direct Costs	\$707,719.29	\$2,555,415.00	\$3,422,850.00
Overhead	\$407,803.13	\$864,468.00	\$1,080,585.00
Fixed Fee	\$93,512.00	\$0.00	\$307,915.00

Source: Project financial records, March 2018

Budget notes

Table 35. Budget notes

Personnel	This is expected to increase from the next quarter as the project plans to onboard additional staff to support AGYW activities.
Consultants	The project plans to engage a consultant to undertake organizational capacity assessment in Quarter III.
Travel and transportation	This is anticipated to increase from next quarter due to expected rise in activity level.
Other Direct costs	More expenditure on AGYW activities will see this rise significantly from next Quarter with key areas being Sub-contractors reimbursements, cash transfers and school fees payments
Overhead	Calculated as per contracts terms and conditions.
Fixed Fees	Earned as per contract terms and conditions.

XII. ACTIVITY ADMINISTRATION

Personnel

During the reporting period, there were no changes on the project's key personnel. The project expects a substantive Chief of Party and M&E specialist in the next quarter.

Contract amendments

None

Sub-contractors

The subcontracts for Initiatives and AMREF were fully executed during the reporting period. An approval to subcontract HFG, ACE Africa, Kenya Red Cross, ICL and NOPE was also received from USAID.

Other significant approvals from USAID.

Purchase of seven project vehicles at \$266,700

Purchase laptop computers for staff at \$139,257

XIII. GPS INFORMATION

Please see the GPS information sheet in the attachment.

XIV. SUCCESS STORIES
