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USAID KENYA

APHIA*plus* WESTERN KENYA

QUARTERLY PROGRESS REPORT



USAID KENYA

APHIA*plus* WESTERN KENYA

FISCAL YEAR 2017

QUARTER 3 PROGRESS REPORT

JULY 1 through SEPTEMBER 30, 2017

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ABBREVIATIONS

ADT	ART (antiretroviral therapy) dispensing tool
AGYW	adolescent girls and young women
AIDS	acquired immunodeficiency syndrome
AMPATH	Academic Model Providing Access to Healthcare
ANC	antenatal care
APHIAplus Western	AIDS, Population, and Health Integrated Assistance Zone 1
APR	Annual Performance Report
ART	antiretroviral therapy
ARV	antiretroviral
ASSIST	Applying Science to Strengthen and Improve Systems
CAG	community antiretroviral group
CCC	comprehensive care center
CME	continuing medical education
COP	Country Operational Plan
DHIS2	District Health Information Software 2
EBI	evidence-based intervention
GBV	gender-based violence
HCW	health care worker
HIV	human immunodeficiency virus
HRH	human resources for health
HTC	HIV testing and counseling
HTS	HIV testing services
ICT	information and communication technology
IPT	isoniazid preventive therapy
KSh	Kenyan Shilling
M&E	monitoring and evaluation
MCH	maternal and child health

MOH	Ministry of Health
NACS	nutrition assessment, counseling, and support
OVC	orphans and vulnerable children
PCR	polymerase chain reaction
PHDP	positive health, dignity, and prevention
PLHIV	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission of HIV
APNS	assisted partner notification services
PrEP	pre-exposure prophylaxis
PSSG	psychosocial support group
Q	quarter
SACOMEN	Sabatia Constituency Men
SAPR	Semiannual Program Report
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
TB	tuberculosis
TWG	technical work group
USAID	US Agency for International Development
VMMC	voluntary medical male circumcision
Y	year

EXECUTIVE SUMMARY

The AIDS, Population, and Health Integrated Assistance Zone 1 (APHIA*plus* Western) project is funded by the US Agency for International Development. It is being implemented in Western Kenya from January 2011 through December 2017 by a consortium that is led by PATH and includes World Vision.

Since 2011, the project has:

- Contributed to improvements in key health indicators.
- Built the capacity of community-level structures to respond to the needs of people.
- Strengthened linkages between health facilities and communities to facilitate access to HIV care and treatment.
- Enhanced health service quality by building the capacity of health care workers and improving the infrastructure of health facilities.
- Helped empower communities and promote sustainability by supporting local community-based organizations.

In Year 7 (Y7) Quarter 3 (Q3, July through September 2017), the period under review, the project continued to align its activities with the US President’s Emergency Plan for AIDS Relief county prioritization, which is based on HIV burden and the Joint United Nations Programme on HIV/AIDS 90-90-90 goals.¹ In line with this and as outlined in the project’s Y7 work plan, Homa Bay, Kisumu, Migori, Busia, Kakamega, and Kisii were categorized as scale-up to saturation counties; Nyamira and Bungoma as aggressive scale-up counties; and Vihiga as a sustained county.

During the reporting quarter, the project supported HIV testing and counseling of 265,859 clients. This brings the total number of clients counseled and tested in the Y6Q4 to Y7Q3 period (October 2016 through September 2017) to 1,506,670 against the Country Operational Plan 2016 (COP 2016) target of 929,003 (162 percent achievement). This performance exceeds the 100 percent threshold for the quarter.² The number of clients who tested HIV positive for the reporting period was 4,583, bringing the total number of HIV-positive clients in the Y6Q4 to Y7Q3 period to 20,862; this is against a COP 2016 target of 30,734, a 68 percent achievement.

During the reporting quarter, 17,371 pregnant women were counseled and tested for HIV, of whom 1,068 (6 percent) tested positive. Maternal prophylaxis was provided to 1,053 women (98 percent of those who tested positive), and 1,033 infants (97 percent) received prophylaxis. Within the Y6Q4 to Y7Q3 period, 108,270 women accessed testing services for the prevention of mother-to-child transmission of HIV; this is against a COP 2016 target of 163,919 (66 percent achievement). Among them, 5,758 women (5 percent) were diagnosed HIV positive. Maternal prophylaxis uptake for the Y6Q4 to Y7Q3 period was 97 percent; infant prophylaxis uptake was

¹ An ambitious Joint United Nations Programme on HIV/AIDS treatment target to help end the AIDS epidemic. By 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90 percent of all people receiving antiretroviral therapy will have viral suppression.

² The 100 percent threshold is the expected performance for all indicators as of the end of the quarter. Indicators that had results greater than 100 percent against the COP 2016 target performed well, whereas indicators that had results less than 100 percent against the COP 2016 target did not meet the expected target.

also 97 percent. For the Y6Q4 to Y7Q3 period, maternal prophylaxis performance translates to a 61 percent achievement against the COP 2016 target.

During the reporting quarter, 4,132 clients were initiated on antiretroviral therapy. This brings the total to 19,791 clients initiated on antiretroviral therapy within the Y6Q4 to Y7Q3 period, a 51 percent achievement against the COP 2016 target. At the end of the reporting period, 110,013 clients were active on treatment, against the COP 2016 target of 120,374 (91 percent achievement).

Through HIV prevention services implemented during the reporting period, a total of 13,502 clients accessed voluntary medical male circumcision services during the period. This brings the total number reached in the Y6Q4 to Y7Q3 period to 46,209, against a COP 2016 target of 44,618 (104 percent achievement). Behavioral interventions reached 3,733 fisherfolk with evidence-based interventions during the period under review. This brings the total for the Y6Q4 to Y7Q3 period to 12,660, against a target of 13,738 (92 percent achievement).

The project implemented the DREAMS project in eight sub-counties of Kisumu and Homa Bay counties, covering 34 wards. Working with 341 trained mentors, 588 facilitators certified in evidence-based interventions, 510 DREAMS Ambassadors, and qualified service providers from 40 link health facilities, the project delivered age-appropriate DREAMS interventions to 62,310 adolescent girls and young women as at the end of the reporting period. Through its engagement with the community, the project has established 196 safe spaces where adolescent girls and young women (AGYW) receive interventions.

I. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

Subpurpose 1. Increased and expanded high-quality HIV services

HIV testing and counseling services

During the reporting period, the project continued to provide direct service delivery (DSD) support to the 537 project-supported sites. Focus was on building the capacity of HIV testing and counseling (HTC) service providers to use assisted partner notification services (aPNS), use family testing registers in establishing index contacts testing site coverage, use the partner notification register and the accompanying reporting tools and scripts, understand the testing/retesting guidance in line with the test-and-treat guidelines, among others. The project continued to orient HTC service providers on the use of master facility linkage registers and their role in tracking HIV-positive individuals to determine the linkage outcomes over a period of one year. Other efforts were directed to quality improvement and assurance, technical assistance to HIV testing services (HTS) providers, and support for technical work groups (TWGs) on rapid test kit commodity management to ensure rapid test kit commodity security.

In the quarter, the project management and technical teams continued to provide site-level mentorship in all HIV service delivery components. In HTS, the areas assessed included understanding of the allotted site-level identification COP 16 targets; HTC services optimization strategies to include extended-hour, weekend, and 24-hour testing; evidence of support for outreaches that target men; availability of screening tools; evidence of screening for eligibility before testing; and the positive yield in service delivery points based on computation of positivity rates over time. The feedback from the team visits informed high-priority interventions and also formed a basis for follow-up and subsequent mentorship by the project and site staff on areas with gaps. Capacity-building was done through provider mentorship, supportive supervision, and facility-level, issue-based continuing medical education (CME).

The project supported a training of trainers for four project staff in assisted aPNS. These staff in turn trained a total of 513 services providers: 9 project staff, 475 HTS providers, 12 nursing staff, 8 counselor supervisors, and 9 county and subcounty health management team members across the nine project-supported counties. The project deployed 523 HTS providers as a task-shifting strategy to enhance provider-initiated testing and counseling services. The project prioritized the placement of HTS service providers in scale-up to saturation counties. Each facility in these counties was allocated an HTS service provider; the high-volume facilities were allocated more than one service provider. In the high-volume sites, HTS service providers were placed in the wards; outpatient departments, including special clinics; laboratories; maternal and child health (MCH) clinics; nutrition clinics; and comprehensive care centers (CCCs). In the aggressive scale-up and sustained counties, the HTS providers were deployed in high-yield facilities. Out of 537 sites across the project-supported counties, the 523 HTS service providers were distributed across 380 sites, which translates into 73 percent site coverage. The remaining 27 percent of sites were mainly clinics that were supported by roving teams and identified focal persons.

To increase HIV testing among men, the project continued to leverage the Healthy Heart Africa (HHA) project thus integrating Hypertension screening with HIV testing in Homabay and

Kisumu counties. In line with this the project supported sensitization of HTS service providers on hypertension screening. A total of 29 HTC service providers from 19 facilities across the two subcounties of Homa Bay County and 15 HTC service providers from 14 facilities in Kisumu County were sensitized. The counselors were taken through a practical session where they learned how to take blood pressure using a digital blood pressure machine, how to document blood pressure in the hypertension screening register, the steps of client referral, when to make a referral, and what needs to be documented in the referral forms. This improved hypertension screening services, specifically during moonlight activities when trained community health volunteers are absent.

The HTS performance for the period from October 2016 to September 2017 is shown in Table 1 below.

Table 1. Overall project HIV testing and counseling performance, Y6Q4 to Y7Q3, compared with COP 2016 targets.

Indicator	COP 2016 target	Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	Percent achieved
No. of clients counseled and tested for HIV	929,003	407,378	428,523	404,910	265,859	1,506,670	162%
No. of clients testing HIV positive	30,734	4,880	5,677	5,722	4,583	20,862	68%

Source: Ministry of Health 731 (reporting form).

Note: COP, country operational plan; No., number; Y, year; Q, quarter.

During the reporting quarter of July to September 2017, a total of 265,859 clients were counseled and tested, of whom 4,583 were identified as HIV positive. Cumulatively, by Annual Performance Report (APR) 2017, a total of 1,506,670 clients were counseled and tested; this was against the target of 929,003, a 162 percent achievement. A total of 20,862 clients among those counseled and tested were identified as HIV positive. This was against a target of 30,734, a 68 percent achievement.

There was a significant decline in the number of individuals counseled and tested during the last three quarters—from 428,523 in January to March 2017, to 404,910 in April to June 2017, and down to 265,859 in July to September 2017. The number of HIV-positive individuals identified increased slightly from 5,677 in January to March to 5,722 in April to June; this then dropped to 4,583 in the reporting period of July to September. The drop in the July to September period was attributable to a 45 percent reduction in the number of tests done in that period and this was largely due to an ongoing nurses strike and the country’s general elections in August, which led to interruption of services.

The project’s HIV testing trends over time demonstrated that the absolute yield in numbers improved with an increase in number of individuals tested. The highest number of HIV-positive individuals identified in COP 2016 was recorded in the month of May 2017 at 2,285, with a concomitant high number of individuals tested of 162,296.

County HTS performance

The county level performance on HIV testing and counselling for the period from Y6Q4 to Y7Q3 is shown in Table 2 below.

Table 2. County-level HIV testing and counseling, Y6Q4 to Y7Q3, compared with COP 2016 targets.

County	HIV testing and counseling						
	COP 2016 target	Y6Q4	Y7Q1	Y7Q2	Y7Q3	APR 2017	%
Scale up to saturation county							
Homa Bay	142,026	56,799	41,642	36,199	23,201	157,841	111%
Migori	85,964	43,782	48,688	48,002	42,780	183,252	213%
Kisumu	63,004	29,128	35,568	41,095	20,965	126,756	201%
Kisii	7,646	14,582	14,873	11,377	7,052	47,884	626%
Kakamega	296,897	101,523	101,191	112,696	80,639	396,049	133%
Busia	61,441	16,407	20,496	16,230	12,943	66,076	108%
Subtotal	656,978	262,221	262,458	265,599	187,580	977,858	149%
Aggressive scale-up county							
Nyamira	216,652	82,757	96,256	75,555	37,885	292,453	135%
Bungoma	29,551	36,762	37,369	34,298	23,815	132,244	448%
Subtotal	246,203	119,519	133,625	109,853	61,700	424,697	172%
Sustained county							
Vihiga	25,822	25,638	32,440	29,458	16,579	104,115	403%
Grand total	929,003	407,378	428,523	404,910	265,859	1,506,670	162%

Source: Ministry of Health 731 (reporting form).

Note: COP, country operational plan; Y, year; Q, quarter.

The county level performance on HIV positive identification for the period from Y6Q4 to Y7Q3 is shown in Table 3 below.

Table 3. County-level identification of HIV-positive individuals, Y6Q4 to Y7Q3, compared with COP 2016 targets.

County	HIV-positive						
	COP 2016 target	Y6Q4	Y7Q1	Y7Q2	Y7Q3	APR 2017	%
Scale up to saturation county							
Homa Bay	5,572	478	477	466	349	1,770	32%
Migori	3,257	718	537	677	662	2,594	80%
Kisumu	3,485	706	544	624	529	2,403	69%
Kisii	108	148	105	105	92	450	417%
Kakamega	10,764	1,622	1,424	1,852	1,455	6,353	59%
Busia	878	270	219	258	233	980	112%
Subtotal	24,064	3,942	3,306	3,982	3,320	14,550	60%
Aggressive scale-up county							
Nyamira	5,337	541	607	522	348	2,018	38%
Bungoma	297	604	652	706	571	2,533	853%
Subtotal	5,634	1,145	1,259	1,228	919	4,551	81%
Sustained county							
Vihiga	1,036	429	476	512	344	1,761	170%
Grand total	30,734	4,880	5,677	5,722	4,583	20,862	68%

Source: Ministry of Health 731 (reporting form).

Note: COP, country operational plan; Y, year; Q, quarter.

The project has achieved the counseling and testing targets in all six scale-up to saturation counties, namely Busia (108 percent), Kisumu (201 percent), Homa Bay (111 percent), Kakamega (134 percent), Kisii (626 percent), and Migori (213 percent). All the other supported aggressive scale-up and sustained counties equally surpassed their counseling and testing targets against the expected target of 100 percent.

On the identification of the HIV-positive individuals, only Busia (112 percent) and Kisii (417 percent) among the six scale-up to saturation counties met the expected targets. Migori (80 percent), Kisumu (69 percent), and Kakamega (59 percent) were all below the 100 percent target. Homa Bay recorded a 32 percent achievement, an improvement from 26 percent in the previous quarter. Homa Bay County registers an average of 146 HIV-positive individuals monthly, with a positivity rate of below 1.5 percent in almost all testing strategies employed. In this reporting quarter, the county reported 349 HIV-positive individuals, which was down from 466 HIV-positive individuals reported in the previous quarter. There was alarming significant decline in the month of August 2017, when only 82 HIV-positive individuals were identified; this was the lowest number of HIV-positive individuals identified in the entire 12 months and could largely be attributed to the National General Elections in addition to an ongoing Nurses strike. The total number of individuals tested in Homa Bay County similarly had a corresponding drop from 36,199 for the period April to June to 23,201 for the reporting period July to September 2017; this led to a slightly improved positivity rate from 1.3 percent to 1.6 percent respectively

Among the two aggressive scale-up counties, Bungoma (853 percent) surpassed the HIV-positive target, whereas Nyamira (37 percent) did not meet this target. Bungoma's overachievement could be attributed to fairly modest targets allocated for period compared to expected performance. On the other hand, Nyamira is a predominantly low-HIV prevalence county, with

an average positivity rate of 0.7 percent throughout COP 2016 and therefore could not achieve set targets. The best-yielding strategy for focus in the county is aPNS, which realized a positive yield of 10 percent among partners and 4 percent among children within a month of implementation. Vihiga, a sustained county, surpassed the expected HIV-positive target (170 percent) and this could also be attributed to modest targets assigned to it.

Overall, the project improved the positive yield from 1.3 percent in the first semester of the year (October 2016 to March 2017) to 1.6 percent in the second semester (April to September 2017). This was marked with a steady rise in the positivity rate from 1.3 percent in April, 1.4 percent in May, 1.5 percent in June, and 1.7 percent in July, August, and September 2017. The achievement was attributed to consistent review and optimization of workable county-specific strategies at both community and facility settings, including rolling out and scaling up aPNS, optimizing index client contact testing, testing in mapped hot spots, conducting outreaches that target men, scaling up extended HTC services, and providing weekend and 24-hour testing.

County-specific HTS optimization for identification of males

Each county optimized the existing opportunities to reach more men with testing services. The project recorded an average positive yield of 2 percent from a series of outreaches done across the nine project-supported counties. A total of 10,537 individuals were offered testing services: 6,054 (57 percent) were men; 234 were identified HIV positive, of whom 127 (54 percent) were men. Substantial positive yields were realized from the informal workplaces (3 percent), formal workplaces (2 percent), hot spots (3 percent), and community index contacts (2 percent). The fishing community, who were reached through beach testing, and *bodaboda* (commercial motor-cycle) riders, who were routinely targeted for outreaches, each recorded a 1 percent yield. The other approaches that were employed to reach men were extended-hours testing, weekend coverage, call-back hotlines, and express testing services (they were exempted from queuing for services) for men and couples seeking testing services.

Table 4 below shows a summary of the outcomes from the targeted outreaches for men from July to September 2017.

Table 4. Outcomes of targeted outreaches for men, July to September 2017.

Target population	C&T total	C&T male	HIV+ total	HIV+ male	Total linked	Linked male	Total positivity	Male positivity	Total linked	Male linked
Deceased index client households	166	79	4	1	4	1	2%	1%	100%	100%
Informal workplace	791	541	22	14	10	5	3%	3%	45%	36%
Fishmongers	943	571	9	7	7	5	1%	1%	78%	71%
Hotspots	5,449	2,721	147	73	111	54	3%	3%	76%	74%
Formal workplace	1,243	897	20	15	14	11	2%	2%	70%	73%
<i>Bodaboda</i>	1,249	922	17	12	16	11	1%	1%	94%	92%
Community index contact testing	696	323	15	5	14	5	2%	2%	93%	100%
Total	10,537	6,054	234	127	176	92	2%	2%	75%	72%

Note: C&T, counseled and tested.

Optimization of HTS in Homa Bay County

The project continued to prioritize Homa Bay County in all interventions aimed at identifying HIV-positive individuals. However, the county still performed below the project average in positive yield. Previously, during COP 2015, the county implemented universal community testing which resulted in a very low proportionate yield of 0.6 percent. By the Semi-annual Program Report (SAPR) in COP 2016, the county reported an average yield of 1 percent; there was a modest improvement to an average of 1.4 percent by APR 2016. The highest yield reported in COP 2016 was 1.5 percent in the months of May and July, when the project optimized community index contacts testing and targeted outreaches for men, respectively. In the reporting period of July to September 2017, the project ensured uninterrupted HTC services in the county through a series of intensified targeted outreaches for men amidst disruptions from the health care workers' industrial action and general elections. Cumulatively, 69 targeted outreaches for men were conducted, which reached a total of 2,556 individuals, of whom 1,709 (67 percent) were men; 12 out of the 2,556 individuals tested turned out HIV positive, an overall positivity rate of 0.7 percent. The target populations reached during these outreaches included *bodaboda* riders (with a recorded a positive yield of 0.9 percent), those reached in moonlight outreaches (0.2 percent), those reached in *chang'aa* (local brew) dens (0.8 percent), taxi operators (0.3 percent), and those reached through testing at Seventh-Day Adventist church camps (1.3 percent). For a five-month period starting in May 2017, outreaches that targeted male *bodaboda* riders were organized in conjunction with Healthy Heart Africa project. The testing services through mapped out sheds and bases reached a total of 988 riders, of whom 10 had HIV-positive results. This translates to a positivity rate of 1 percent. Seven (7) of the 10 identified as HIV positive were men.

The best positive yields in Homa Bay were realized through the aPNS done in September 2017, at 29 percent among sexual partners and 10 percent among children. Index contacts testing for the period from July to September 2017 recorded a 1.9 percent positive yield. See Table 5 for a summary of all results.

Table 5. Targeted outreaches for men, organized in collaboration with the Healthy Heart Africa project, Kasipul and Kabondo, July to September 2017.

Indicator	Population type						Total
	<i>Bodaboda</i> riders	Moonlight outreach - Oyugis town	Seventh-Day Adventist camps	<i>Chang'aa</i> dens	Cattle sellers (Korogo, Ringa, and Oyugis)	Taxi, ajua and pool games	
# of outreaches	13	6	5	4	5	36	69
# counseled & tested	330	485	154	131	190	1,266	2,556
# positive	3	1	2	1	1	4	12
# linked to treatment	3	1	2	1	1	3	11
Positivity rates	0.90%	0.20%	1.30%	0.80%	0.50%	0.30%	0.70%

Note: Activities done in Korogo, Ringa and Oyugis; Ajua games.

Optimization of HTS in Kisumu County

A total of 125 targeted outreaches for men were conducted in Kisumu County, which reached 5,877 individuals with testing, of whom 3,217 were men. Ninety-seven (97) individuals tested HIV positive, with a positivity rate of 1.7 percent; of them, 52 were men (54 percent). The overall linkage was 80 percent, and the linkage among men was 77 percent. The workplace testing in Kisumu County recorded a best yield among all populations at 3.3 percent, with the beaches recording the lowest yield at 1.1 percent. The low positivity among the fisherfolk was attributed to the consistent community testing services offered along the beaches, coupled with the intensified behavior change communication interventions. Other populations were offered testing in the rural urban slums and through moonlight testing, which both realized a 1.6 percent positive yield. Consequently, given the diversity of outreaches and continued integration with the Healthy Heart Africa platform, Kisumu County maintained its average yield of 2 percent in both semesters of the APR 2017. See Table 6 for a summary of Kisumu County's results.

Table 6. Targeted outreaches for men, organized in collaboration with the Healthy Heart Africa project, Kisumu County, July to September 2017.

Indicator	Population type						Total
	Workplace - Tuuffam, Kodiaga, fish markets	Moonlight outreach	Rural urban slums	Beaches - Usoma, Paga, Ogal, Rare	Integrated with HHA	Men only	
# of outreaches	6	18	86	5	10		125
# counseled & tested	276	752	4,003	187	659	3,217	5,877
# positive	9	12	64	2	10	52	97
# linked to treatment	5	9	55	2	7	40	78
Positivity rates	3.30%	1.60%	1.60%	1.10%	1.50%	1.60%	1.70%

Note: Activities done in Tuuffam, Kodiaga, and beaches of Usima, Paga, Ogal and Rare.

Pediatric HIV testing

For the reporting period from July to September 2017, 36,534 pediatric clients were counseled and tested; 299 of those tested turned out HIV positive. Cumulatively, the project recorded a total of 260,861 pediatric tests against a COP 2016 target of 118,786, a 220 percent achievement. The overall number of pediatric HIV-positive individuals identified was 1,662, which was a 37 percent achievement of the target, with a proportionate yield of less than 1 percent. All the nine project-supported counties met the expected pediatric counseling and testing targets by APR 2017. Table 7 provides the county-level performance in counseling and testing.

Table 7. Pediatric HTS performance, Y6Q4 to Y7Q3.

County	HIV testing and counseling						
	COP 2016 target	Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	%
Scale up to saturation county							
Homa Bay	30,592	11,360	7,888	6,696	4,687	30,631	100%
Migori	18,647	7,022	6,940	6,823	3,765	24,550	132%
Kisumu	13,353	4,777	6,291	6,990	2,326	20,384	153%
Kisii	1,798	2,325	3,394	2,604	1,114	9,437	525%
Kakamega	10,292	16,083	19,612	21,912	14,461	72,068	700%
Busia	7,344	2,300	3,212	2,502	2,142	10,156	138%
Subtotal	82,026	43,867	47,337	47,527	28,495	167,226	204%
Aggressive scale-up county							
Nyamira	19,874	15,821	20,311	15,874	3,709	55,715	280%
Bungoma	13,279	4,376	7,178	6603	2799	20,956	158%
Subtotal	33,153	20,197	27,489	22,477	6,508	76,671	231%
Sustained county							
Vihiga	3,607	4,593	5,606	5,234	1,531	16,964	470%
Grand total	118,786	68,657	80,432	75,238	36,534	260,861	220%

Note: COP, country operational plan; HTS, HIV testing services; Q, quarter, Y, year.

In identifying the HIV positives, only three counties achieved the expected targets, namely, Bungoma (386 percent), Busia (192 percent), and Kisii (114 percent). Kakamega (99 percent) nearly hit the 100 percent expected pediatric target. The other five counties of Homa Bay (11 percent), Kisumu (14 percent), Migori (31 percent), Nyamira (42 percent), and Vihiga (86 percent) did not meet the 100 percent expected by APR.

The county performance in identifying HIV-positive pediatric clients under 15 years old for the period from Y6Q4 to Y7Q3 period is shown in Table 8.

Table 8. County performance in identifying HIV-positive pediatric clients, Y6Q4 to Y7Q3.

County	HIV counseling and testing						Total	Percent achievement
	COP 2016 target	Y6Q4	Y7Q1	Y7Q2	Y7Q3			
Scale-up to saturation counties								
Homa Bay	1,507	58	55	34	25	172	11%	
Migori	819	58	82	69	44	253	31%	
Kisumu	1,017	24	58	33	31	146	14%	
Kisii	29	11	7	7	8	33	114%	
Kakamega	450	96	132	133	85	446	99%	
Busia	38	21	18	21	13	73	192%	
Subtotal	3,860	268	352	297	206	1,123		
Aggressive scale-up counties								
Nyamira	356	42	40	41	26	149	42%	
Bungoma	59	48	57	79	44	228	386%	
Subtotal	415	90	97	120	70	377		
Sustained counties								
Vihiga	188	44	39	56	23	162	86%	
Grand total	4,463	402	488	473	299	1,662	37%	

Note: COP, country operational plan; HTS, HIV testing services; Q, quarter, Y, year.

The project has witnessed a reduction in the number of pediatric clients identified as HIV positive quarter by quarter, from 488 in January to March, 473 in April to June, down to 299 in the reporting period of July to September. In the months of July, August, and September 2017, Homa Bay County identified 8, 3, and 13 HIV-positive pediatric clients respectively, while Kisumu identified 14, 14, and 3 HIV-positive pediatric clients respectively. The low performance in pediatric identification for Homa Bay, Kisumu, and Migori counties was partly attributed to the target computation, as derived from the overall identification targets: Homa Bay was allocated 27 percent, Kisumu 29 percent, and Migori 25 percent of overall identification targets. Busia and Kakamega counties, which performed better, had pediatric targets of 4 percent each.

The project continued to optimize testing among eligible children, as envisaged in the accelerated children testing (ACT) initiative. The children of index contacts were mobilized; and they were readily available at community and facility settings. The project worked closely with the growth monitoring and promotion volunteers in the facility nutrition departments to screen and offer HIV testing to all malnourished children at the MCH and tuberculosis (TB) clinics. The project also intensified contacts testing; leveraged psychosocial support groups (PSSGs; the contacts of index clients were invited to PSSGs and tested if eligible); and tested eligible orphans and vulnerable children (OVC).

Assisted partner notification services

The project continued to strengthen assisted partner notification services (aPNS) as an effective way to reach sexual partners specifically, many of whom are undiagnosed and unaware of their HIV exposure, and may welcome support and an opportunity to test for HIV. This testing modality also, secondarily, elicits children of index clients that are eligible for testing. All the HTS providers in the high-priority counties of Homa Bay, Kisumu, Migori, Busia, and Kisii were trained in aPNS. Kakamega County trained 95 percent of HTS providers; a few HTS

providers were replaced after individual appraisals, which are routinely done to examine and evaluate an employee's work. Nyamira County trained 100 percent of HTS providers almost immediately after 78 HTC service providers had transitioned to the county. Bungoma trained 70 percent and Vihiga 60 percent of their HTS teams. The project supported each site by printing and providing them with aPNS registers, sets of aPNS steps and scripts (phone call scripts, home-visit scripts, invitation notes, referral slips, partner elicitation forms, intimate partner violence screening tools, tips and scripts for telling a partner about one's HIV status), and monthly reporting aPNS summary tools. See Table 9.

Table 9. County-level partner notification services cascade of testing, positive, and linkage disaggregated by sex and age

County	Gender	# index clients offered PNS	# Contacts identified		# Known positive		# Tested for HIV		# Newly tested HIV positive		# Linked to care		# Tested for HIV through CSD		Positivity rates		Linkage rates	
			<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs	<15 Yrs	15+ Yrs
			Nyamira	Male	24	18	49	0	1	20	38	1	1	1	1	0	0	5%
	Female	34	19	52	0	3	21	38	2	4	2	4	0	4	10%	11%	100%	100%
Kisii	Male	9	2	10	0	1	2	8	0	1	0	1	0	0	0%	13%	-	100%
	Female	14	2	13	0	1	2	12	0	1	0	1	0	1	0%	8%	-	100%
Vihiga	Male	43	75	88	2	11	44	30	3	6	1	5	3	9	7%	20%	33%	83%
	Female	72	55	55	1	0	45	28	7	13	5	12	1	9	16%	46%	71%	92%
Bungoma	Male	53	79	95	2	15	49	55	4	8	3	7	17	22	8%	15%	75%	88%
	Female	95	93	60	2	19	52	17	2	4	0	3	11	15	4%	24%	0%	75%
Busia	Male	37	29	22	0	10	28	6	1	2	1	2	0	1	4%	33%	100%	100%
	Female	24	28	34	3	7	22	19	0	3	0	3	0	2	0%	16%	-	100%
Homa Bay	Male	0	0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-
	Female	0	0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-
Kakamega	Male	344	277	262	17	60	149	114	22	32	8	29	18	27	15%	28%	36%	91%
	Female	251	253	362	9	59	159	146	15	37	7	35	16	37	9%	25%	47%	95%
Migori	Male	44	22	45	0	4	13	29	7	8	7	3	1	3	54%	28%	100%	38%
	Female	62	23	53	0	4	21	39	3	14	3	8	0	7	14%	36%	100%	57%
Kisumu	Male	76	84	53	1	13	59	40	2	10	2	9	0	3	3%	25%	100%	90%
	Female	59	72	66	5	14	53	32	2	9	2	9	0	1	4%	28%	100%	100%
Project Total	Male	630	586	624	22	115	364	320	40	68	23	57	39	65	11%	21%	58%	84%
	Female	611	545	695	20	107	375	331	31	85	19	75	28	76	8%	26%	61%	88%

Note: APNS, partner notification services; Yrs, years (of age).

Overall, the project reported a positivity rate of 24 percent among sexual partners and 10 percent among pediatric clients through the aPNS testing modality. A total of 1,346 index clients were offered aPNS (664 male; 682 female); this elicited 1,269 children under 14 years old and 1,425 sexual partners. By the reporting period, 791 children (62 percent) and 675 (47 percent) sexual partners who had been elicited through various aPNS approaches were tested. Homa Bay County reported a positive yield of 29 percent among partners; Migori reported 32 percent; Kisumu reported 26 percent; Busia reported 25 percent; Kakamega reported 26 percent; and Vihiga reported 33 percent. The lowest yields were in Kisii (10 percent) and Nyamira (7 percent). The project will work with the HTS providers to ensure that the already elicited individuals are offered testing with the approaches agreed on and as guided by the index clients.

In addition the project will ensure the following ongoing activities are accomplished:

- Train the remaining HTS providers, CCC teams, facility in charges, county/subcounty counselor supervisors, and other key players to support the process.
- Continue on-job-trainings, mentorship, and support supervisions for the aPNS implementing teams as immediate follow-up after trainings; address gaps; and reinforce any areas with gaps.
- Ensure that all HIV-positive individuals identified are offered aPNS services and linked to treatment, all elicited contacts are reached with testing services, and new HIV-positive individuals are captured as secondary index clients and equally offered aPNS.
- Based on the county prevalence and site-positive targets, apportion a percentage of expectation yield from aPNS as a modality to ensure optimization of this strategy.
- Identify champions who will support other HTS providers in elicitation, documentation, and reporting; have meetings with the champions with site reports to discuss the agreed upon deliverables.
- Hold site-level meetings to review progress, analyze the yield, and make decisions; this will inform subcounty aPNS review meetings.
- Provide site-level CME in all high-volume sites to support the health care workers (HCWs) who may not have been trained.
- Ensure accurate and complete aPNS registers; support the timely use of the aPNS register in reporting; and ensure aPNS registers are available.
- Use innovations such as WhatsApp® as aPNS platforms to share experiences, provide support, and encourage teams.

Index clients contacts testing

The project continued to support testing index client contacts who were identified through contact notification as a strategy to find new HIV cases. This was done by line-listing all index client contacts at the CCC, tracing these clients, and offering them HIV counseling and testing at both the facility and community settings. The achievements for this strategy are shown in Table 10.

Table 10. Summary of the index client contact outcomes by county, July 2017 to September 2017.

County	Contacts tested	Contacts HIV positive	Contacts enrolled in HIV care	Positivity rate
Homa Bay	1,045	20	20	1.9%
Kisumu	665	51	50	7.7%
Migori	6,593	94	80	1.4%
Nyamira	325	11	11	3.4%
Kisii	160	4	4	2.5%
Busia	715	26	26	3.6%
Bungoma	1,462	44	42	3%
Kakamega	2,317	199	142	8.6%
Vihiga	147	29	23	19.7%
Total	13,429	478	398	3.6 %

A total of 13,429 index client contacts were tested from July 2017 to September 2017; 478 turned out HIV positive and 398 (83 percent) were successfully linked. The average positivity rate was 3.6 percent across the counties. The high positivity rate in Vihiga can be attributed to the fact the most of the index client contact tracing and testing only happened within the facility setting, with the contacts invited to test in the health facility. This skewed the results to include only clients who were already seeking health services. Other counties tested both at the facility and in the community, with the latter possibly reaching noncontacts, as was the case for Migori County. The overall achievement was dependent on the willingness of the index client to provide correct locator information and the ability of the service providers to locate the contacts. With the rollout of assisted aPNS, we expect to have a better focus given the separate documentation for assisted PNS.

Other HTS optimization strategies

The project extended the HTS optimization strategies to more sites this reporting quarter by offering extended hours services in 32 sites, up from 12 at the end of the last quarter, and weekend coverage in 48 sites, up from 15 sites at the end of the last quarter. Twenty-four-hour testing was only offered at Rachuonyo Sub County Hospital in Homa Bay County in the month of July 2017. However, due to a reduced flow of patients to the facility at night during the ongoing nurses strike, the services were temporarily terminated and the responsible HTC service providers re-allocated to other testing modalities. A total of 98 clients were reached (55 Male; 43 Female) through weekend and/ or extended hours testing in the hospital, with no HIV-positive clients identified. The overall outcomes of the optimization strategies across counties are shown in Table 11 below.

Table 11. County-level HTS optimization strategies cascade of testing, positive, and linkage disaggregated by sex

County	# of sites	Strategy	Counselled & Tested			Positives			Linked		
			Male	Female	Total	Male	Female	Total	Male	Female	Total
Homa Bay	5	Weekend	175	139	314	4	1	5	4	1	5
	3	Extended	59	47	106	0	0	0	0	0	0
	1	24 hrs	55	43	98	0	0	0	0	0	0
Kisumu	4	Weekend	78	80	158	2	4	6	2	4	6
	1	Extended	408	208	616	8	3	11	6	3	9
Migori	5	Weekend	259	332	591	3	4	7	3	4	7
	1	Extended	13	7	20	1	0	1	1	0	1
Nyamira	7	Weekend	60	190	250	0	1	1	0	1	1
	5	Extended	29	42	71	0	1	1	0	1	1
Kisii	2	Weekend	141	118	259	1	1	2	1	1	2
	1	Extended	14	18	32	1	0	1	1	0	1
Bungoma	3	Weekend	160	115	275	1	2	3	1	2	3
	6	Extended	172	117	289	2	4	6	2	4	6
Busia	3	Weekend	46	66	112	2	1	3	2	1	3
Vihiga	3	Weekend	67	65	132	0	0	0	0	0	0
	1	Extended	9	23	32	0	0	0	0	0	0
Kakamega	19	Weekend	674	706	1380	10	12	22	8	10	18
	20	Extended	216	236	452	3	2	5	2	2	4
TOTAL	51	Weekend	1,660	1,811	3,471	23	26	49	21	24	45
	38	Extended	920	698	1,618	15	10	25	12	10	22
	1	24 hours	55	43	98	0	0	0	0	0	0

Both weekend and extended-hour testing HTC services (which were offered between 5 p.m. and 10 p.m) realized a similar positive yield of 1.4 percent. A total of 3,196 individuals were reached through weekend testing, of whom 1,500 (47 percent) were men. Of the individuals tested, 46 were identified as HIV positive, 22 (48 percent) of whom were men. Separately, extended services reached a total of 1,329 individuals, of whom 56 percent were men. Thirteen (68 percent) out of 19 who were HIV positive were men. Both strategies enhanced testing services for men during the ongoing health care workers' strike.

The project will further strengthen the targeted testing approach and embrace provider-initiated testing and counseling at the facility setting to reach over 50 percent of outpatient department clients and 100 percent inpatient clients with testing. The project also will further strengthen weekend coverage and offer extended-hour testing to progressively attain 50 percent site coverage in HTS sites.

Focus group discussions that targeted males were held to elicit some of the reasons behind poor health-seeking behaviors among men. The cited reasons included: long hospital queues, sitting alongside mothers and children, the direct and indirect costs charged by the health facilities, lack of essential drugs in the facilities, and the health care workers' attitudes toward men. The majority of men therefore opted for over-the-counter medicines and herbs; they resorted to seeking health services only as the last option. The project has taken into account this feedback as it continues optimizing testing among men.

HTS among key populations and OVC

Between July and September 2017, a total of 1,167 (574 Male; 593 Female) fisherfolk were offered HTC services in Busia County. In Kisumu County, 1,007 (518 Male; 489 Female) were tested, and in Busia, 160 (56 Male; 104 Female) were tested; 27 among the ones tested turned out HIV positive, a positivity rate of 2.3 percent. Among the 27 who were HIV positive, 26 (11 Male; 15 Female) were linked to treatment; hence, there was 96 percent linkage. As at APR, 4,359 (2,118 Male; 2,241 Female) fisherfolk were reached during the outreaches and tested for HIV. Seventy-five (40 Male; 35 Female) fisherfolk tested were HIV positive, out of which 74 (39 Male; 35 Female) were successfully linked to care. This translates to 99 percent linkage.

During the reporting period, the project supported testing of newly recruited OVC and other OVC who were already in the program and were eligible for retesting. A total of 2,328 OVC were tested between July and September 2017; 9 tested HIV positive (a positivity rate of 0.4 percent). All of the HIV-positive OVC were successfully linked to care and treatment. Table 12 below summarizes HTC services among OVC.

Table 12. OVC testing July to September 2017, disaggregated by sex and age

Indicator	1–4 years old		5–9 years old		10–14 years old		15–19 years old		20–24 years old		25+ years old		Total		Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Tested	145	134	297	346	497	552	130	131	13	23	7	53	1,089	1,239	2,328
HIV positive	1	1	1	1	0	3	1	0	0	0	1	0	4	5	9
Linked	1	1	1	1	0	3	1	0	0	0	0	1	4	2	9

Note: F, female; M, male.

The National AIDS and STI Control Programme (NAS COP) supported counseling and testing services in institutions of higher learning with an aim of reaching unreached adolescents. Five project-supported counties participated; very low positive yields were achieved as detailed in Table 13.

Table 13. Testing and linkage cascade of the NAS COP rapid results initiative targeting institutions of higher learning, July to September 2017

County	# of institutions	Tested	HIV positive	Linked	Positivity rate
Migori	1 institution	110	1	1	0.9%
Busia	6 institutions	428	0	0	0.0%
Bungoma	3 institutions	1,508	3	3	0.2%
Kakamega	1 institution	3,008	3	2	0.1%
Vihiga	2 institutions	800	2	2	0.3%
Totals	13 institutions	5,854	9	8	0.2%

Quality assurance

The project continued to support the use of standardized operating procedures that are aligned to the existing HTS national testing and policy guidelines. The project ensured that all HTC service providers in all facilities conducted testing according to quality management system principles in order to provide the highest level of quality and accuracy. The project also supported regular laboratory and point-of-testing site visits by subcounty health management teams and project

HTS technical teams, proficiency panel tests enrollment and corrective actions for any unsatisfactory responses, retesting of samples from HTC sites by a second tester as per the current guidelines, sit-in counselor observed sessions, mentorship, and regular appraisals of the HTC service providers to evaluate individual performance.

Key challenges in the reporting period included service delivery disruptions due to an ongoing nurses' strike and the general elections that were held in August. The nurses' strike that began in June 2017 has continued to paralyze services; over 60 health facilities have closed as a result. Patient flow reduced significantly in the open health facilities. To ensure continued HTS, the project employed the following measures: redeployed HTC service providers from the closed facilities and nonfunctional service delivery points to support testing services in private and faith-based facilities, supported targeted outreaches for men at the already mapped-out hot spots in the community setting, offered extended hours and weekend testing in all high-volume sites; and supported APNS.

Elimination of mother-to-child transmission of HIV

During the reporting quarter, the project continued support for PMTCT services in 346 health facilities (Nyanza 128; Western 218). 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 HCWs to carry out targeted ANC outreaches and strengthened referrals from communities to the facilities. Site-level capacity-building was done via support supervision and mentorship; monthly zonal elimination of mother-to-child transmission of HIV meetings; focused onsite and offsite mentorships; CME; on-the-job trainings to promote uptake of counseling and testing among pregnant and breastfeeding women; orientations on commodity management and rapid test kit forecasting; allocation meetings at county level; data documentation, review, and reporting; as well as county stock-taking forums. The project also supported the county-level elimination of mother-to-child transmission of HIV TWG/business planning meetings. Human resource support was given to private and faith-based organization sites to enable them to cope with the service need during the nurses' strike that affected the Ministry of Health (MOH) sites.

During the reporting quarter, 17,371 pregnant women were counselled and tested for HIV at ANC only, including 705 reported as known positives. Of the pregnant women counseled and tested, 1,068 (6 percent) tested HIV positive; 1,053 women (98 percent of those who tested positive) and 1,033 infants (97 percent of those who tested positive) received antiretroviral (ARV) prophylaxis. Overall, for the October 2016 to September 2017 period, the project reached 108,270 pregnant women with HIV testing services, of whom 5,758 tested positive. Table 14 below shows the achievement for the four quarters of COP 2016 in comparison to the targets.

Table 14. PMTCT summary achievements, October 2016 to September 2017, against COP 2016.

Indicator	COP 2016 Target	Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	% Achievement
Number of sites	346	346	346	346	346	346	100%
Number of pregnant women with known status.	163,919	27,002	37,085	26,812	17,371	108,270	66%
Number of pregnant women that are HIV positive.	9,145	1,337	1,919	1,434	1,068	5,758	63%
Number of pregnant women known to be HIV positive		792	1,195	924	705	3,616	
Number of pregnant women new positive		545	724	510	363	2,142	
Number of pregnant women issued with prophylaxis.	9,145	1,272	1,866	1,388	1,053	5,579	61%
Number of infants issued with prophylaxis	9,145	1,273	1,853	1,393	1,033	5,552	61%

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

Note: COP, Country Operational Plan; PMTCT, prevention of mother-to-child transmission; Q, quarter, Y, year.

The project recorded the lowest performance during the reporting quarter (July to September)—11 percent against an expected quarterly achievement of 25 percent. Performance in the other quarters of COP 2016 was 16 percent in Q1, 23 percent in Q2, and 16 percent in Q3. Out of the four quarters, the project performed better in Q2 due to pregnancy mapping, escorted referrals, and ANC outreaches in all counties, as well as optimal operation of all the health facilities. The extremely low performance witnessed in Q4 was mainly due to the nurses' strike that disrupted implementation of ANC services in the MOH sites in all counties.

Kisumu and Homa Bay performed better than the other counties due to the contribution from the high-volume private facilities and availability of project-supported staff in the MCH clinics. The remaining counties were affected by the zero performance reported from the high-volume MOH sites. Some of the high-volume sites that were affected include the following: Kakamega County General Hospital had a drop from 199 clients in May to 92 clients in July; Bungoma County Referral Hospital had a drop from 355 clients in May to 8 clients in the July-September quarter; Isebania Subcounty Hospital and Kuria Subcounty Hospital had zero reports throughout the July-September quarter. Nyamira County had the lowest performance compared to all the other counties; this was largely because of their high COP target (25,160), which was double the expected pregnant women (13,641), as well as the industrial action taken by all HCWs in the county in solidarity with the striking nurses. In Nyamira County, MCH clinics in all the high-volume sites—including Nyamira County Referral Hospital, Keroka Subcounty Hospital, Manga Subcounty Hospital, and Borabu Subcounty Hospital—were not functional and filed zero reports for pregnant women tested for HIV in ANC during the entire July-September quarter.

Out of the 346 project supported PMTCT sites, 70 (20 percent) were fully operational and able to provide PMTCT services; the majority of them were private and faith-based organization sites. There were 247 (72 percent) sites that were semi-operational and mainly provided care-and-

treatment services (MCH services closed); the majority of these were staffed by project-supported clinicians. There were 27 (8 percent) sites that were totally closed down, and these were mainly dispensaries staffed by nurses; most of these were in Nyamira county.

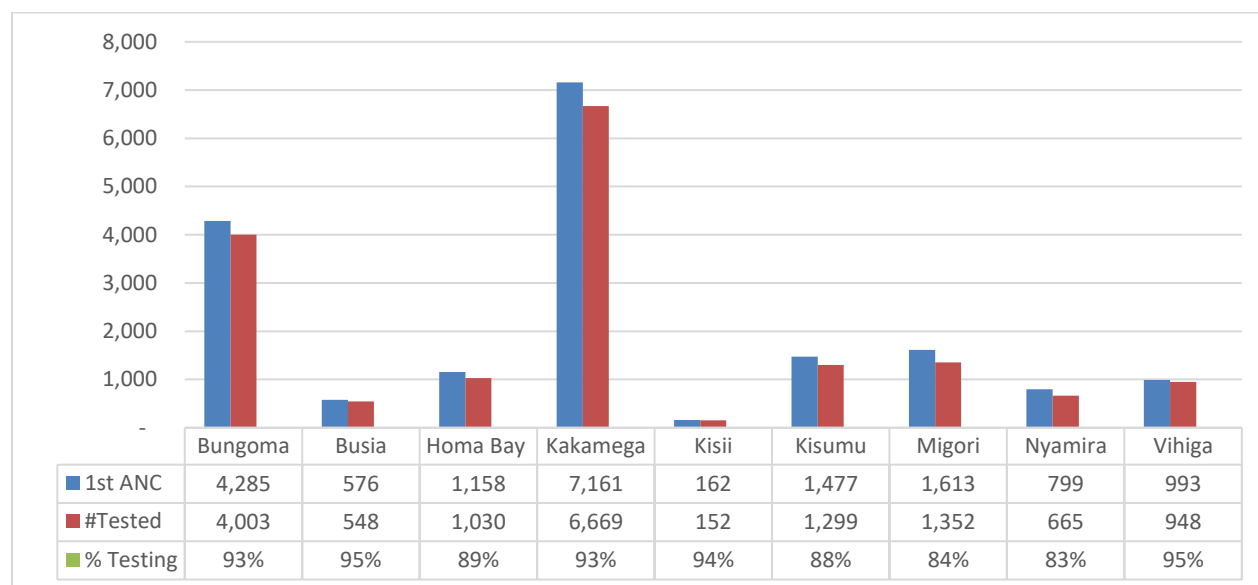
Performance for HIV testing of pregnant women against the COP 2016 target at county level was as follows: Nyamira reported 36 percent; Vihiga reported 60 percent; Bungoma reported 62 percent; Migori reported 69 percent; Kakamega reported 71 percent; Kisii reported 73 percent; Homa Bay reported 99 percent; Busia reported 119 percent; and Kisumu reported 123 percent.

The project continued to record an increase in known positive clients, reporting 66 percent (705 out of 1,068), which was attributed to older clients desiring to have children due to the success of the PMTCT program and the ability of project-supported clinicians to provide services to known positive (KP) at the first ANC visit during the ongoing strike. Support for family planning/HIV integration through mentorship and use of reproductive health coordinators has continued, with a view to reducing unmet need for family planning. However, this was affected by the prolonged nurses' strike.

PMTCT cascade

In the reporting quarter, counseling and testing uptake during the first ANC visit was 91 percent, uptake of maternal prophylaxis for those testing positive was 98 percent, and uptake of infant prophylaxis was 97 percent. Figure 1 below shows the PMTCT cascade on uptake of counseling and testing by county for the reporting quarter.

Figure 1. Counseling and testing uptake by county, Y7Q3.



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

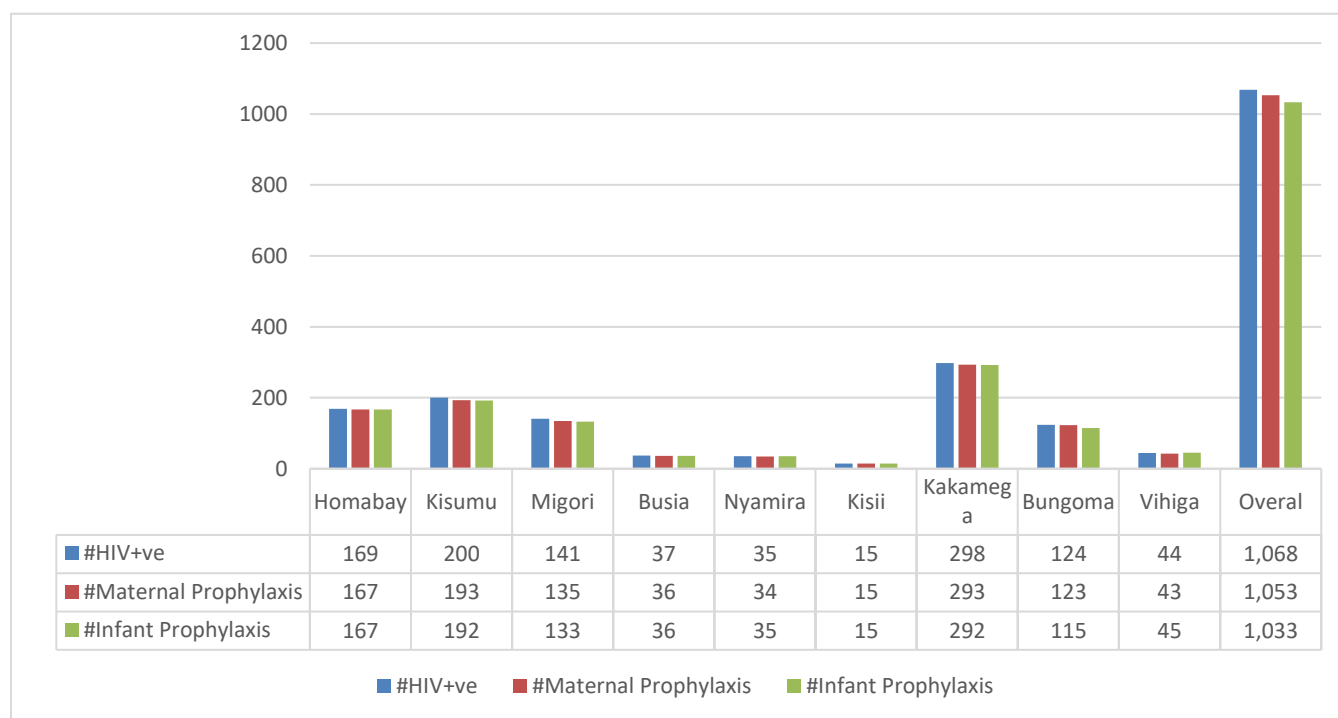
Note: ANC, antenatal care; Y, year; Q, quarter.

Access to counseling and testing among women attending ANC services was above 90 percent in five out of the nine supported counties. There was lower performance of 89 percent in Homa Bay, 88 percent in Kisumu, 84 percent in Migori and 83 percent in Nyamira; this was mainly attributed to health care workers strike which led to clients presenting for ANC visits not

receiving HIV testing in the MCH departments. The women who missed counseling and testing were listed. Follow-up is ongoing to ensure that they are all traced back to be tested and documented.

All counties continued to report high uptake for both maternal and infant prophylaxes, as shown in Figure 2 below, except for Bungoma and Migori counties, which reported low uptakes of infant prophylaxis of 93 percent and 94 percent respectively, with this attributed to sites which were affected by the nurses’ strike. HCWs were supported to continuously account for missed opportunities by peer educators conducting home visits to trace and bring back the mothers and their infants. The project supported county health management teams to include the successfully traced clients on prophylaxis in the district health information system, the District Health Information Software 2 (DHIS2). Hence, they were able to account for all missed opportunities. The project continued the following activities at all sites: mentorship, PMTCT support groups, provision of ARV commodities in integrated MCH settings, and support for commodity consumption, forecasting, and reporting.

Figure 2. Maternal and infant prophylaxis uptake by county, Y7Q3.



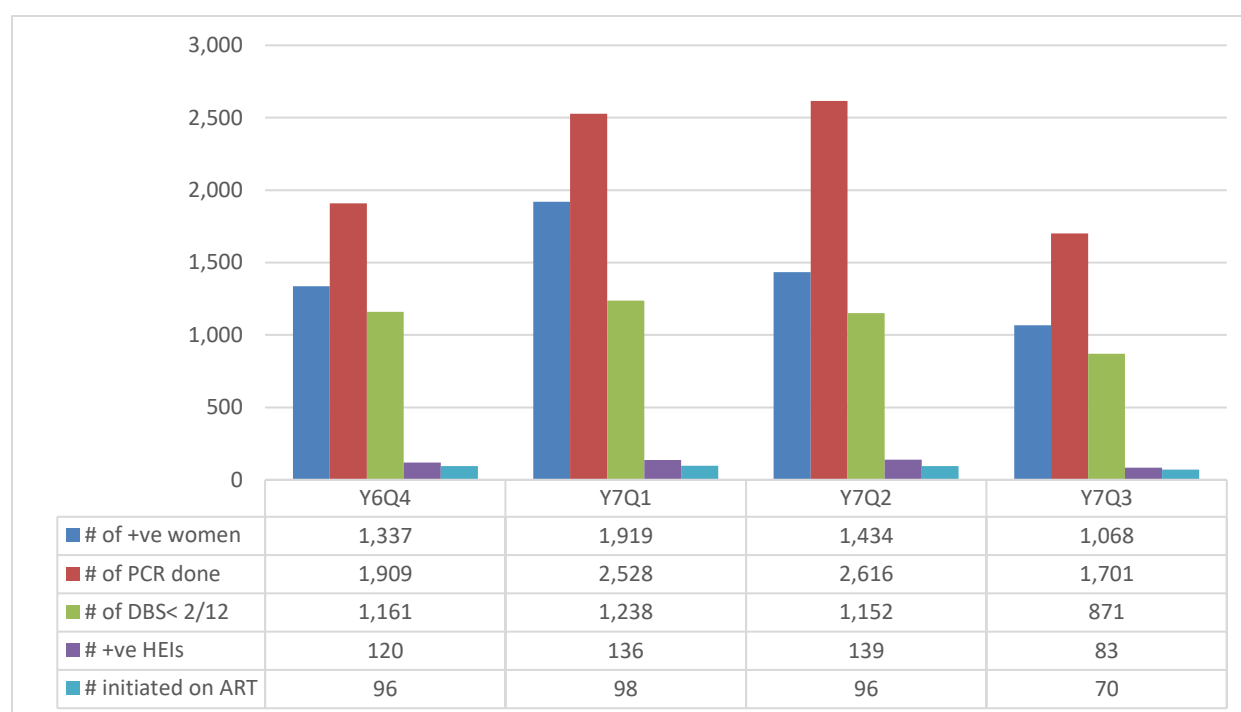
Source: Ministry of Health (MOH) 731.
 Note: HIV+ve, HIV positive; Y, year; Q, quarter.

Early infant diagnosis

During the reporting quarter, 1,701 initial polymerase chain reaction (PCR) tests were processed. These tests were done for 160 percent of an estimated 1,068 HIV-exposed infants (proxy for HIV-positive pregnant mothers) in the quarter. The higher than expected performance is as a

result of reporting of some of the repeat tests as initial tests. The project continued with human resources for health (HRH) support and mentorship to the PMTCT sites, with an aim of scaling up the uptake of early infant diagnosis services. Of the initial 1,701 PCR tests done in the quarter, 51 percent (871) was done for children within 2 months of age. This was a slight improvement from the 44 percent achieved in the last quarter. The project will continue to support HCWs to provide health education to clients on the importance of accessing the first PCR when a child is 6 to 8 weeks old, in order to improve on this indicator. Figure 3 below shows the early infant diagnosis cascade for this reporting period in comparison to the previous quarters.

Figure 3. Early infant diagnosis cascade, October 2016 to September 2017.



Source: National AIDS and STI Control Programme early infant diagnosis database.

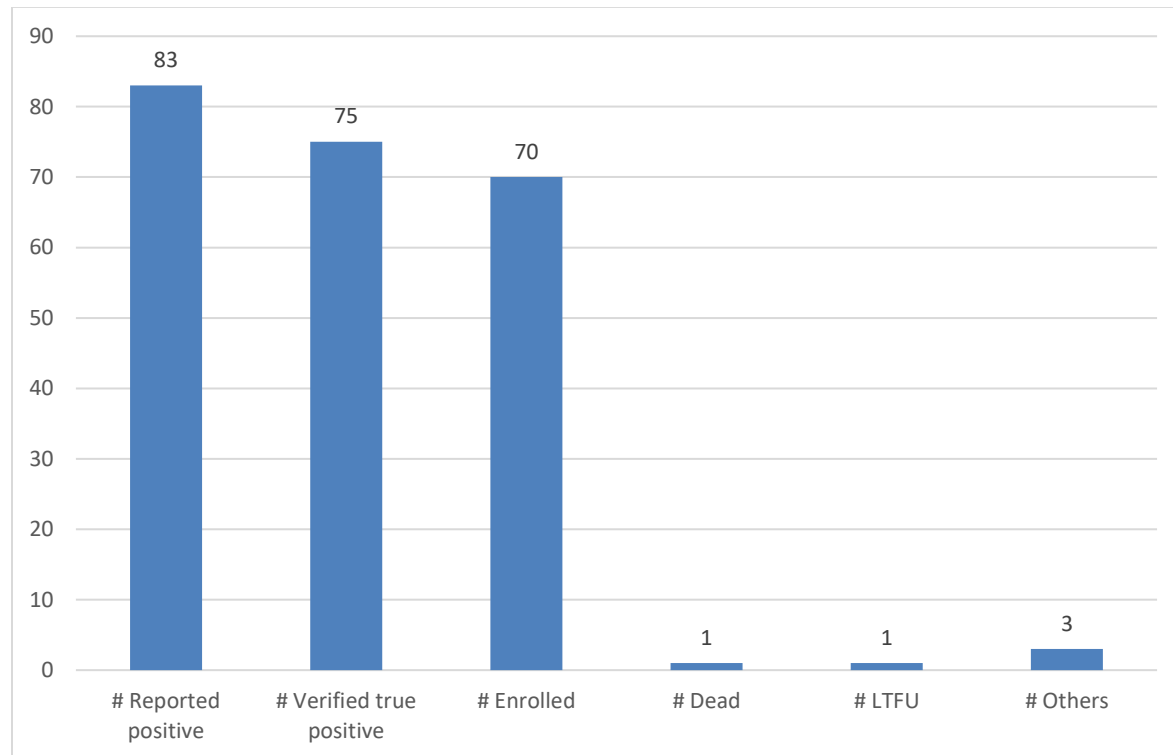
Note: +ve, HIV positive; ART, antiretroviral treatment; COP, Country Operational Plan; DBS, dry blood spot; HEI, HIV-exposed infant; PCR, polymerase chain reaction; Q, quarter.

Compared to the October 2016 to June 2017 period, the July to September 2017 period that had 1,701 PCR tests done, reported fewer tests quarter on quarter (2,616 in Q1; 1,909 in Q2; and 2,528 in Q3). This reduction was due to the validation of the National AIDS and STI Control Programme early infant diagnosis website that was done during the quarter to separate the initial PCR, repeat PCR, and confirmatory PCR; this was in line with the revised early infant diagnosis algorithm. Of all the tests processed, 871 (51 percent) were done at the recommended period when a child is less than 8 weeks old. During the reporting quarter, the overall positivity rate among children at 18 months was 3.3 percent (83/1,701) and the positivity rate among those at 2 months was 2.1 percent (18/871). The project will continue to support health education on early identification of infants through the first PCR when a child is 6 to 8 weeks old.

Linkage of HIV-positive infants

During the July-September quarter, the project reported a gross figure of 83 infants (4.9 percent) who were identified as HIV positive, according to the National AIDS and STI Control Programme early infant diagnosis website. Further validation of these results showed that the initial PCR positive results were 75 (3.3 percent), which is lower than the 115 of the last quarter. Of these, 70 infants have been enrolled into treatment, 1 infant died before enrollment, 1 was lost to follow-up, while 3 were reported as other reasons such as decline (see Figure 4).

Figure 4. Linkage status of HIV-positive infants, Y7Q3.



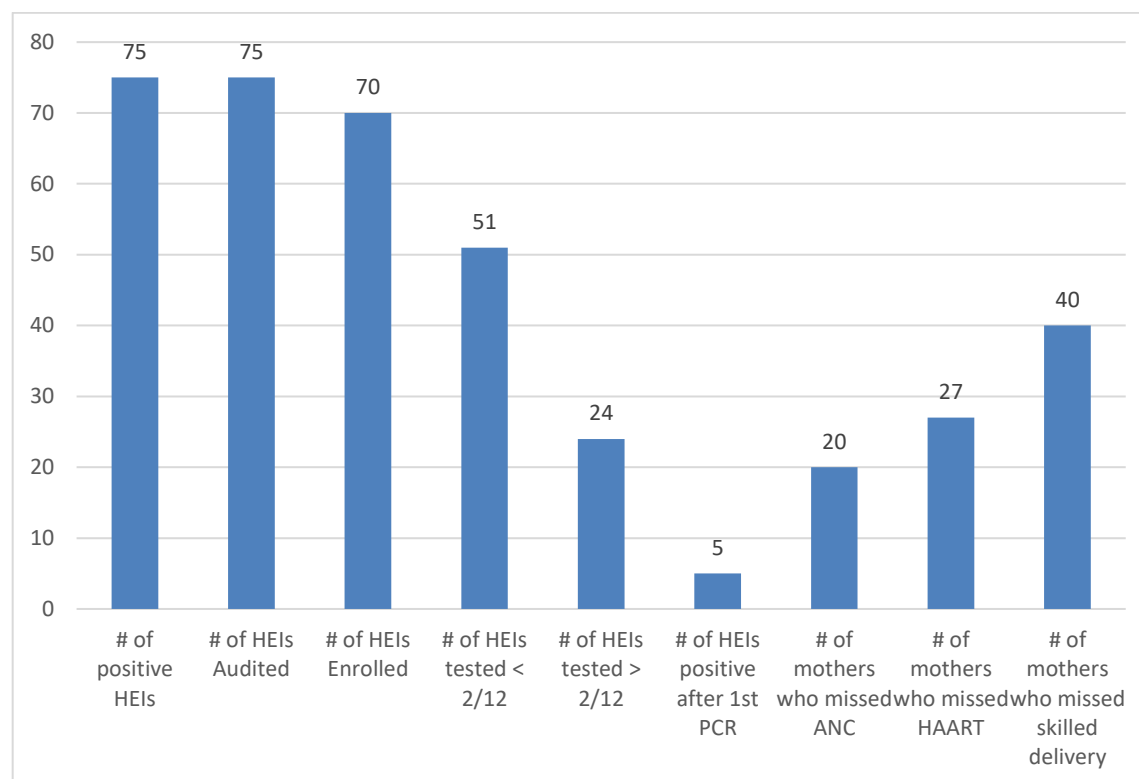
Source: National AIDS and STI Control Programme early infant diagnosis website.

Note: LTFU, lost to follow-up; Q, quarter; Y, year.

The project supported the facility (Kwisero Health Centre) to conduct mortality audits for the infant who died. These audits identified the cause of death to be late identification after the child was 2 months old. The project will strengthen early identification and referral of HIV-exposed infants from the community using community health volunteers.

The mother-to-child transmission audits showed that reasons for mother-to-child transmission were mainly lack of skilled deliveries (40 out of 75), missed prophylaxis (27 out of 75), late PCR tests after a child reached 2 months of age (24 out of 75), and lack of attendance in ANC by the mothers (20 out of 75). The high number of missed opportunities for skilled delivery, prophylaxis, ANC attendance, and early infant diagnosis was attributed to the prolonged nurses' strike affecting MCH and maternity services in MOH facilities. (See Figure 5.)

Figure 5. Outcome of mother-to-child transmission audits, July to September 2017.



Note: ANC, antenatal care; HAART, highly active antiretroviral therapy; HEI, HIV-exposed infant PCR, polymerase chain reaction.

PMTCT cohort analysis

A PMTCT cohort analysis was conducted in all PMTCT-supported sites to establish client retention at 3 months, 6 months, and 12 months after enrollment. Viral uptake and suppression levels were also determined. Retention within the project-supported sites for the 3-month cohort was 84 percent, for the 6-month cohort was 80 percent, and for the 12-month cohort was 84 percent. Retention generally was higher among known positive clients at 90 percent compared to the new positive clients at 84 percent. The viral load uptake is being strengthened through on-the-job training, mentorship on the registers, and real-time dispatch of results in all supported sites. Suppression levels were recorded at 92 percent in the 6-month cohort and 85 percent in the 12-month cohort. Table 15 below illustrates the quarter's performance.

Table 15. Maternal cohort analysis (MCA) outcomes for cohorts attaining months 3, 6 and 12 as at September 2017

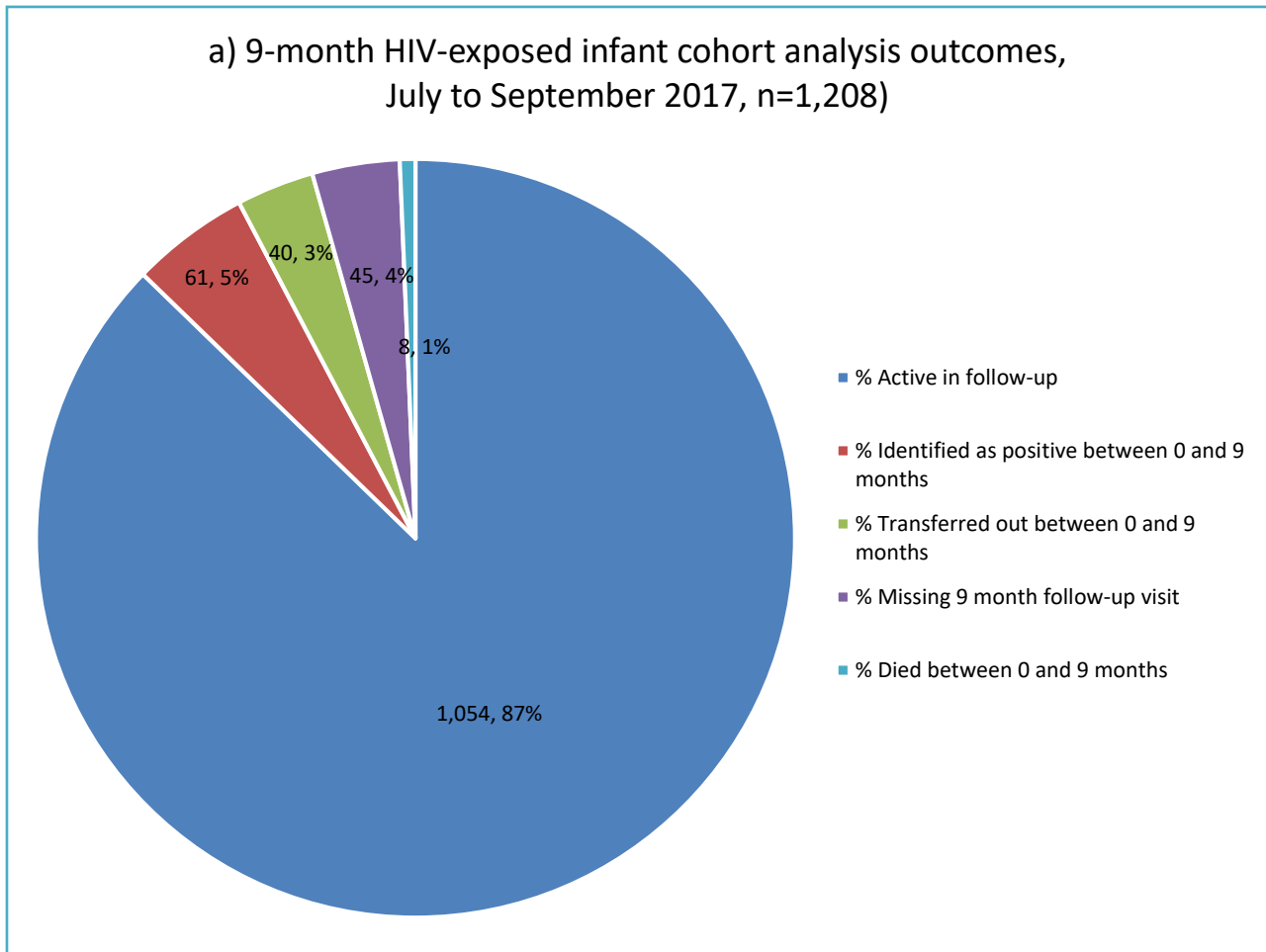
	Indicator	3-months Cohort			6-months Cohort			12-months Cohort		
		KP	NP	Total	KP	NP	Total	KP	NP	Total
A	Enrolled into cohort	455	417	872	609	527	1,136	515	579	1,094
B	Transfers in (T.I)	76	7	83	93	10	103	88	30	118
C	Transfers out (T.O)	9	23	32	22	40	62	29	50	79
D	Net cohort (A+B-C)	522	401	923	680	497	1,177	574	559	1,133
E	Defaulters	21	37	58	5	26	31	13	32	45
F	Lost to follow up (LTFU)	0	0	0	15	39	54	23	76	99
G	Reported dead	1	1	2	2	6	8	6	2	8
H	Stopped	0	3	3	4	3	7	13	7	20
I	Alive and active on treatment	500	360	860	654	423	1,077	519	442	961
J	% Retained (I/D*100)	96%	90%	93%	96%	85%	92%	90%	79%	85%
K	Viral load collected	236	54	290	526	302	828	461	336	797
L	Virally suppressed (VL<1000)	201	44	245	437	242	679	401	269	670
M	% Supressed (L/K*100)	85%	81%	84%	83%	80%	82%	90%	80%	84%

Note: I/D, alive and on treatment/ net cohort; L/K, virally suppressed/viral load collected, * refers to multiplication.; KP, known positive; NP, new positive, VL, viral load test

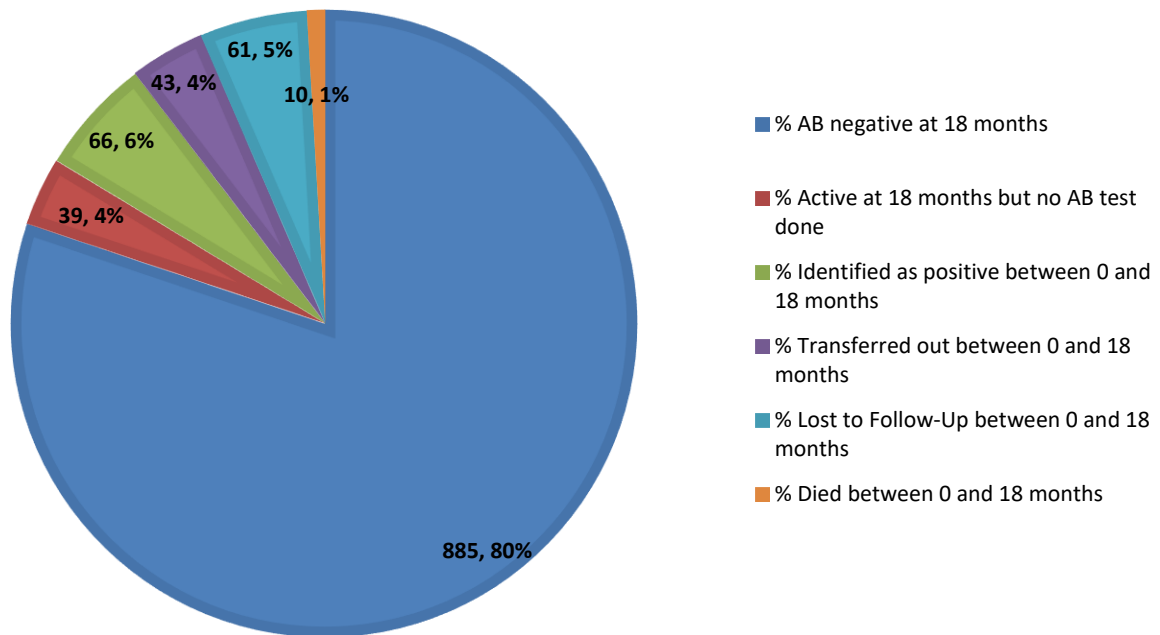
HIV-exposed infant cohort analysis

HIV-exposed infant cohort analysis was conducted during the reporting period for both the 9-month-old and 18-month-old cohort clients in all PMTCT-supported sites. The primary goal was to establish mother-to-child transmission rates and the percentage retained/active in follow-up. Results are shown in Figure 6a and 6b below.

Figure 6a. HIV-exposed infant cohort analysis outcomes at 9 months, and 6b. HIV-exposed infant cohort analysis outcomes at 18 months.



b) 18-month HIV-exposed infant cohort analysis outcomes, July to September 2017, n=1,104



Overall, the project’s retention rate among the 9-month-old cohort was 87 percent, with a 5 percent mother-to-child transmission rate. For the 18-month-old cohort, the retention rate was 80 percent and the mother-to-child transmission rate 6 was percent. Retention and mother-to-child transmission rates across the 9-month-old and 18-month-old cohorts generally improved. This improvement can be attributed to the project’s continued focus on promoting retention of mother-baby pairs by strengthening appointment and defaulter tracing systems; PMTCT PSSGs; quality improvement team meetings with clinicians, peer educators, and mentor mothers; and capacity-building of HCWs and peer educators/mentor mothers on maternal, infant, and young child feeding. In addition, routine mother-to-child transmission/mortality audits created opportunities for corrective actions on gaps identified. HIV-exposed infant graduation held in the supported facilities also made a difference. Moving forward, we will embrace the strategies that made the facilities perform well.

Community PMTCT interventions to improve coverage

The project continued to work with community units to ensure that no pregnant woman missed PMTCT interventions. Focused community interventions geared towards improving coverage of PMTCT services were supported, including PMTCT-focused community outreaches, household mapping of pregnant women, and escorted referrals by community health volunteers to the nearest link health facility. The pregnant women received comprehensive PMTCT services; those who were found to be HIV positive received both maternal and infant prophylaxis. However, clinics were closed due to the nurses’ industrial act, which interfered with the interventions in most areas. Therefore, even though mobilization and demand creation continued,

many of the women could not access ANC services in facilities and outreaches could also not go on.

Escorted referrals by community health volunteers

Transport reimbursements were supported to enable the community health volunteers refer pregnant women to facilities. This was done in all counties that targeted pregnant women who had delayed going to their first ANC visit despite being referred by a community health volunteers. In the quarter under review, a total of 135 sites received support for escorted referrals. A total of 2,045 pregnant women were successfully escorted to the facilities, and they received PMTCT services; this was 26 percent of the 7,811 pregnant women who accessed first ANC services. The escorted referrals' percentage contribution to first ANC moved up to 34 percent in the 226 sites that did receive referrals in the year 2017. See Table 16.

Table 16. Results of escorted referrals for 1st ANC by community health volunteers in project supported sites in the year 2017

County	# of sites receiving escorted referrals	# effective 1 st ANC escorted referrals	Sites 1 st ANC annual performance	Percentage contribution of CHV referrals to facility 1 st ANC performance in Year 7
Homa Bay	31	1,216	3,934	31%
Kisumu	6	1,302	5,176	25%
Migori	23	1,195	5,957	20%
Kisii	7	935	1,631	57%
Nyamira	42	3,409	4,841	70%
Busia	23	1,582	4,506	35%
Bungoma	42	936	2,751	34%
Vihiga	22	480	2,177	22%
Kakamega	30	1,297	5,224	25%
Total	226	12,352	36,197	34%

Note: ANC, antenatal care.

Focused/targeted ANC community outreaches

The program still endeavored to reach the pregnant women in hard-to-reach areas through the use of facility data to support targeted/focused ANC/PMTCT outreaches. This was done in six counties that were struggling to meet their coverage targets. In the quarter under review, a total of 1,573 pregnant women were reached in 92 sites, with 17 new HIV-positive women identified and 15 known HIV-positive women; all of the HIV-positive women accessed prophylaxis. Overall, in the year 2017, a total of 233 outreach sites were supported by the project, which reached 2,913 pregnant women with HIV testing services. This resulted in 43 new HIV-positive pregnant women and 15 with known HIV-positive status, all 58 of whom received maternal and infant prophylaxis. See Table 17.

Table 17. Outcomes of PMTCT-focused or ANC-focused outreaches in project-supported sites, January to September 2017.

County	Total # of outreaches supported	# of pregnant women tested in outreach	# of HIV positive	Percent HIV positive	# of known positive	# received maternal prophylaxis	# received infant prophylaxis
Bungoma	45	635	3	0.5	4	7	7
Kakamega	121	1,642	34	2.1	0	24	24
Vihiga	11	195	3	1.5	1	4	4
Migori	32	255	3	1.2	10	12	12
Nyamira Kisii	24	186	0	0.0	0	0	0
Total	233	2913	43	1.5	15	58	58

Community mentor mother initiative in Homa Bay

The project continued to provide support to and facilitate 17 community mentor mothers within 346 villages in Homa Bay County to conduct follow-ups for PMTCT mothers and their HIV-exposed infants. During this quarter under review, 744 mothers were reached with health education and counseling on the importance of accessing the comprehensive package of care for PMTCT; 35 of the women were newly diagnosed for HIV and thus referred to the mentor mother, while the rest were part of the older cohort that was on follow up. To strengthen adherence and retention to care, 243 clients were visited at home to identify barriers to adherence and intensify benefits of PMTCT to the mother and child, as well as family members. As a result, 343 mothers were enrolled into community PMTCT PSSGs, where risk factors were discussed in depth. Most of the mothers agreed to adhere to the advice to reduce chances of transmitting HIV to their infants. In addition, 12 mothers were referred for partner testing, and 10 PMTCT mothers assisted in having their children tested. During the quarter, 75 HIV-exposed infants graduated and 25 mothers were referred for community-related socioeconomic services.

HIV care and treatment

A total of 4,132 clients were initiated on treatment in the July to September 2017 period. This brought the cumulative total to 19,791 clients initiated on treatment in the COP 2016 period, a 51 percent overall achievement against the year's target of 38,511. In comparison with the HIV-positive clients identified, 84 percent (4,132/4,946) were transitioned to ART within the quarter and 86 percent (19,791/23,004) were transitioned to ART overall for COP 2016. Among the pediatric clients, 305 were initiated on treatment within the quarter and a total of 1,644 clients put on treatment in COP 2016 period, against a target of 3,160, which translates to 52 percent achievement. See Table 18.

Table 18. Summary project achievement in care and treatment, October 2016 to September 2017.

Indicator		COP 2016 target	Achievement					% achievement
			Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	
New ART	Overall	38,511	4,764	5,546	5,349	4,132	19,791	51%
	Pediatric	3,160	391	473	475	305	1,644	52%
Current ART	Overall	120,374	101,557	105,601	107,916	110,013	110,013	91%
	Pediatric	13,240	9,466	9,971	10,196	10,251	10,251	77%

Note: ART, antiretroviral therapy; PMP, performance monitoring plan; Q, quarter; Y, year.

The gap in ART optimization among the HIV-positive clients identified was attributed to missed opportunities in linkage and other individualized client medical reasons. During the period July to September 2017, 84 percent (4,132/4,946) were linked. In COP 2016, 86 percent (19,791/23,004) were linked. The number of clients linked varied across the counties due to different reasons, including clients opting to enroll in sites not supported by APHIAplus, clients declining ART, and co-infected TB patients delaying ART. By and large, the overall and pediatric new treatment targets were not met following the low yield in identification witnessed across the quarters, in spite of the efforts put in place to improve the yield. Some counties were apportioned high targets, and the positivity rates were very low.

The six saturation counties of Homa Bay, Kisumu, Migori, Busia, Kakamega, and Kisii contributed to 68 percent (13,408/19,791) of the total achievement of COP 2016 targets. Among the six counties, only Kisii County managed to meet and surpass its targets by initiating 461 clients (181 percent achievement) against a COP 2016 target of 254. This county had modest targets allocated to it; by Q2, it had achieved COP 2016 targets. See Table 19.

Table 19. New on ART treatment achievements per county against COP 2016 targets, October 2016 to September 2017

County	COP16 target	New ART					
		Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	% achieved
Scale-up to saturation counties							
Homa Bay	5,568	448	464	438	321	1,671	30%
Kisumu	4,203	371	590	530	423	1,914	46%
Migori	4,415	476	621	553	535	2,185	49%
Kakamega	11,561	1,389	1,680	1,740	1,348	6,157	53%
Kisii	254	101	155	111	94	461	181%
Busia	2,365	225	287	273	235	1,020	43%
Subtotal	28,366	3,010	3,797	3,645	2,956	13,408	47%
Aggressive scale-up counties							
Bungoma	1,935	642	664	700	511	2,517	130%
Nyamira	6,609	681	663	528	365	2,237	34%
Subtotal	8,544	1,323	1,327	1,228	876	4,754	56%
Sustained category							
Vihiga	1,601	431	422	476	300	1,629	102%
Grand total	38,511	4,764	5,546	5,349	4,132	19,791	51%

Note: ART, antiretroviral therapy; COP, Country Operational Plan; Q, quarter; Y, year.

Homa Bay County had an overall achievement of 30 percent (1,671/5,568). The targets apportioned to the county were relatively high compared to the general yield reported by the project in the county over time. Being a focus county for the country and for the project as well, the project undertook several activities to improve the yield as outlined in the HTS section above and subsequently initiate the clients identified on ART. These activities included targeted community outreaches in hot spots, implementation of assisted APNS, and informal and formal workplace testing. However, the desired yield still was not achieved.

Kisumu County managed to put 423 clients on ART in the July to September 2017 period, an overall achievement of 46 percent (1,914/4,203). Kisumu County had demonstrated potential to achieve more in terms of yield and transitioning clients to ART in its past achievements: the county initiated 371 clients on treatment in Q1, 590 in Q2, and 530 in Q3. However, Kisumu never managed to achieve its new treatment targets. The county met its testing target, achieving 201 percent (63,004/126,756), but the year's yield was low at 1.9 percent against a calculated positivity target of 3.0 percent. Linkage was equally a challenge, overall at 79 percent; this was primarily occasioned by clients opting to enroll in non- project supported sites. The county was seriously affected by an unsafe political environment during reporting quarter, and health care workers in Kisumu could not work effectively. This impacted negatively on the results as well.

Migori County shared similar challenges as Kisumu. It managed to initiate 535 clients on treatment in the July to September 2017 period and 2,185 clients cumulatively in COP 2016; this translates to 49 percent achievement against a target of 4,415. The county as well had shown potential to achieve the targets from the quarterly trends; Q2 (January to March 2017) had been the best, during which 621 clients were put on treatment.

Kakamega County had the bulk of the project's target 30 percent (11,561/38,511). The project therefore put deliberate effort and focus there. The county had a relatively fair share of HRH staff coverage, and as a result it demonstrated good momentum and progress. However, it experienced a drop in the reporting period of July to September 2017, similar to the scenario in other counties. In Q1, the county initiated 1,389 clients on treatment; 1,680 in Q2; 1,740 in Q3; and 1,348 in Q4. The county attained an overall achievement of 53 percent (6,157/11,561). It was 47 percent shy of achieving the new treatment target, which also appeared high, beginning with the HIV positive target; the calculated positivity target for COP 2016 was 4.0 percent, and the county achieved 1.6 percent positivity. The nurses' industrial strike and unfavorable political environment were attributed to the shortfalls in achieving the targets.

In **Busia County**, the new treatment target apportioned to the county was higher than the HIV positive target. It surpassed the HIV positive target for COP 2016, posting a 112 percent (980/878) achievement, though for new the treatment target, it achieved 43 percent (1,020/2,365). Comparing the yield and clients put on treatment, it attained 104 percent (1,020/980) achievement, with the surplus of clients initiated on treatment originating from COP 2015 period and referrals from other non-supported sites in the region. The county was also affected by the cross-cutting challenge of the nurses' strike and political unrest, which impacted the county's performance in COP 2016 period.

Among the aggressive scale-up counties of Bungoma and Nyamira, Bungoma surpassed the COP 2016 target by achieving 130 percent (2,517/1,935), a modest target that was achieved by Q3.

Nyamira County posted a low achievement of 34 percent, having initiated 2,237 clients on treatment against the COP 2016 target of 6,609. The target for Nyamira was quite high compared to positivity rates that had been witnessed in COP 2015 and even COP 2016 where positivity was 0.34 percent and 0.7 percent, respectively, against a calculated positivity target of 2.0 percent. Nyamira also had myriad of challenges with perennial strikes since the beginning of the year, which involved doctors and later, nurses, clinical officers, pharmacy technicians, and laboratory technicians. Amidst the strike, most of the supported sites suffered due to low project HRH staff coverage. This impacted negatively on HIV services.

Vihiga County was the only supported county in the sustained category. It surpassed its targets with an overall achievement of 102 percent (1,629) against a COP 2016 target of 1,601.

With regard to pediatric performance at the county level, Kakamega and Kisii counties managed to meet and surpass their targets, achieving 131 percent (473) and 119 percent (31) against their COP 2016 targets of 362 and 26, respectively, which were relatively modest. Vihiga achieved 91 percent (154/170) and Busia 84 percent (82/98), almost meeting their COP 2016 targets. However, they were not able to sustain the momentum in Q4 due to interrupted services following the nurses' strike. The achievements for the remaining counties were as follows: 69 percent (238/347) in Bungoma, 56 percent (178/318) in Nyamira, 34 percent (190/564) in Migori, 24 percent (171/725) in Homa Bay, and 23 percent (125/550) in Kisumu. See Table 20.

Table 20. County pediatric new ART treatment achievements against COP 2016 targets, Y7Q3 and APR period.

County	COP16 target	New ART quarterly achievements					
		Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	% achieved
Scale-up to saturation counties							
Homa Bay	725	47	53	43	29	172	30%
Kisumu	550	17	45	43	20	125	46%
Migori	564	41	54	49	46	190	49%
Kakamega	362	109	138	143	84	474	53%
Kisii	26	11	7	6	7	31	181%
Busia	98	20	28	27	7	82	43%
Subtotal	2,325	245	325	311	193	1,074	47%
Aggressive scale-up counties							
Bungoma	347	52	61	80	45	238	69%
Nyamira	318	58	48	42	30	178	56%
Subtotal	665	110	109	122	75	416	63%
Sustained county							
Vihiga	170	36	39	42	37	154	91%
Grand total	3,160	391	473	475	305	1,644	52%

Note: APR, Annual Performance Report; ART, antiretroviral therapy; COP, Country Operational Plan; Q, quarter; Y, year.

The achievement realized in the quarter as well as all year for COP 2016 was attributed to engaging contracted staff in the health facilities across the project-supported sites and placing more staff in the saturation and aggressive scale-up counties. The ongoing nationwide nurses' strike impacted negatively on the gains made and on service delivery, especially in the Tier 1 and Tier 2 facilities, which were mainly staffed by nurses. The project hired locum clinicians (clinical officers and nurses) to bridge the gap and ensure continuity of services. Focus was put toward improved testing, especially in the high-yield sites, and mapped hot spots where targeted outreaches were conducted. The project worked toward improving linkages of the clients who tested HIV positive. The nonclinical counselors and peer educators served double duty as linkage officers; they were responsible for all clients who tested positive in a facility. Subsequently, clinicians at the patient support center initiated clients on treatment promptly, as per the guidelines. ART enrollment strategies, including facility performance tracking, were used to assess gaps and opportunities that existed in the facilities. Performance-based incentives were maintained to motivate the health care providers to achieve targets.

Current ART: Number of adults and children currently receiving antiretroviral therapy.

During the July to September reporting period, the project achieved 110,013 current on ART against a COP 2016 target of 120,374, translating to a 91 percent achievement. During the same period, the performance against target among males was 87 percent (33,778/39,046) and among females was 94 percent (76,235/81,330).

In the reporting quarter, the project started from a baseline of 107,916 (current on ART in June 2017) and reported 4,132 new ART enrollments, resulting in an expected current on ART of 112,048. Against this, a current on ART of 110,013 was realized in September 2017, indicating a net loss of 2,035 in the Y7Q3 reporting period.

For the APR period (October 2016 to September 2017), the project began with a baseline of 102,148 at the end of September 2016 and initiated 19,791 new ART clients on ART in 12 months. This resulted in an expected current on ART of 122,047, against the reported figure of 110,013 at the end of the September 2017. The overall net loss was 11,926. This translates to 90 percent crude retention in the 12-month period (110,013/121,939).

Table 21 provides a county level detail on the performance of this indicator per quarter of the COP 2016, against target.

Table 21. County current on ART treatment achievements against COP 2016 targets, Y7Q3 and APR period.

County	COP16 target	Current ART				
		Y6Q4	Y7Q1	Y7Q2	Y7Q3	% achieved
Scale-up to saturation county						
Homa Bay	18,836	13,182	13,238	13,314	13,567	72%
Kisumu	6,936	6,049	6,545	6,809	7,035	101%
Migori	11,981	11,766	12,344	12,638	12,999	108%
Kakamega	34,295	27,182	28,824	29,638	30,386	89%
Kisii	1,905	1,730	1,874	1,850	1,981	104%
Busia	6,971	6,792	7,061	7,171	7,278	104%
Subtotal	80,924	66,701	69,886	71,420	73,246	91%
Aggressive scale-up county						
Nyamira	17,804	12,444	12,613	12,835	13,055	73%
Bungoma	11,886	12,558	12,927	13,348	13,405	113%
Subtotal	29,690	25,002	25,540	26,183	26,460	89%
Sustained county						
Vihiga	9,760	9,854	10,175	10,313	10,307	106%
Grand total	120,374	101,557	105,601	107,916	110,013	91%

Note: APR, Annual Performance Report; ART, antiretroviral therapy; COP, Country Operational Plan; Q, quarter; Y, year.

In the category of scale-up to saturation, which has the six counties of Homa Bay, Kisumu, Migori, Kisii, Kakamega, and Busia, the overall achievement was 91 percent (73,246/80,924) against the cumulative target in this category. This category contributed to 67 percent of the overall target. Four out of the six counties achieved above 100 percent, and Kakamega and Homa Bay achieved 89 percent and 72 percent respectively. These two counties had deficits of 3,909 and 5,269, respectively, to achieve the overall targets by APR 2017.

In the category of aggressive scale-up, the overall achievement was 89 percent (26,460/29,690) against the cumulative target in this category. This category contributed to 25 percent of the cumulative target. Bungoma achieved 113 percent, and Nyamira achieved 73 percent against set targets. The only county in the sustained category, Vihiga, achieved 106 percent (10,307/9,760) against the expected target.

The overall deficit of 10,361 in the current on ART was largely due to three out of the nine counties that the project supports, namely Homa Bay, (38 percent), Kakamega (28 percent), and Nyamira (34 percent). Factors that contributed to the achievement deficit include a lower than

expected identification of new HIV-positive clients for enrollment in ART in the last 12 months, the lowest occurring during the reporting quarter against target with a treatment new achievement of 365 in Nyamira; 1,348 in Kakamega; and 321 in Homa Bay. The counties showed an obvious decline in overall performance from the COP 2015 period. In Nyamira, the total new enrollment declined by 73 percent (2,237/3,064) from the COP 2015 period achievement of 3,064. Homa Bay registered a decline of 60 percent (1,671/2,774).

The yield of new positives from testing among eligible clients was equally low at 0.7 percent in Nyamira and 1.0 percent in Homa Bay, as compared to other counties that had an average yield of positives of 2.0 percent and above. Besides that, the targets allocated to these counties doubled in comparison to COP 2015 (11,561 in Kakamega and 6,601 in Nyamira, in comparison to 5,373 and 4,168 respectively in COP 2015).

Kakamega was allocated an increased target for new ART initiation of 11,561, up from 5,373 in the COP 2015 period. Thus, the expected monthly new ART enrollment target was 963; Kakamega currently achieves an average enrollment of 500 monthly. In the reporting quarter, it reported a low enrollment of 1,346 (47 percent of the expected quarterly enrollment). Homa Bay was allocated a COP 2016 target of 5,568 for new enrollment. Thus, the county has a monthly target of 464; it currently achieves an average of 150 monthly. It has experienced lower enrollments against target, as evident from the overall low positivity in the county of 1 percent against an expected 4 percent, which was used in deducing the COP 2016 targets. In the reporting quarter, the county reported a low new ART enrollment of 321 (24 percent of the expected quarterly enrollment).

In addition, all the counties faced challenges during the industrial action when doctors went on strike in the months of December 2016 to February 2017. They are still facing challenges currently with the nurses' strike that has been ongoing for five months. For example, in Nyamira, 20 percent of facilities were closed during the strike, as these facilities are largely small dispensaries supported by MOH staff. In an effort to continue services, the project referred clients from closed sites to nearby supported sites to receive their ARV refills. In the month of August, 90 percent of project-supported clinical staff in Nyamira county were absorbed by the county government leading to a shortfall in staff supporting HIV services in these facilities. The shortfall was exacerbated by the absorbed staff immediately joining their counterparts in the strike. The project embarked on a recruitment drive to replace the staff. The project is training them to ensure they continue to offer high-quality HIV services.

In Homa Bay County, 6 out of the 42 sites (70 percent of the overall county target for current on ART in the two subcounties that the project supports) were similarly affected during the strike; uptake of services were affected in these sites.

Regarding the pediatric current on ART performance, during the reporting period, the project achieved 10,251 against a COP 2016 target of 13,240, translating to 77 percent achievement. Within the quarter, the project began with a baseline of 10,196 clients on ART in July 2017 and added 112 new on ART, resulting in an expected September current on ART of 10,308. However, the reported figure as at September 2017 was 10,251. Table 22 provides county-level performance against the COP 2016 targets.

Beginning with an APR September 2016 baseline of 9,707, a total of 1,644 new ART clients were initiated on ART in 12 months, resulting in an expected current on ART of 11,351, against

a reported figure of 10,251 at the end of the September 2017 period. This translates to 90 percent crude retention in the 12-month period (10,251/11,350). The 10 percent nonretained pediatric clients may be attributed to those that transition to the greater than 15-year-old age group in the year.

Table 22. County pediatric new on ART treatment achievements against COP 2016 targets, Y7Q3 and APR period.

County	COP16 target	Current ART				
		Y6Q4	Y7Q1	Y7Q2	Y7Q3	% achieved
Scale-up to saturation counties						
Homa Bay	2,127	1,193	1,240	1,244	1,264	59%
Kisumu	790	437	485	500	512	65%
Migori	1,379	1,090	1,136	1,246	1,210	88%
Kakamega	4,005	2,604	2,832	2,836	2,970	74%
Kisii	264	167	185	185	187	71%
Busia	768	566	579	571	543	71%
Subtotal	9,333	6,057	6,457	6,582	6,686	72%
Aggressive scale-up counties						
Nyamira	1,453	1,187	1,195	1,204	1,209	83%
Bungoma	1,296	1,198	1,216	1,307	1,228	95%
Subtotal	2,749	2,385	2,411	2,511	2,437	89%
Sustained county						
Vihiga	1,158	1,024	1,103	1,103	1,128	97%
Grand total	13,240	9,466	9,971	10,196	10,251	77%

Note: APR, Annual Performance Report; ART, antiretroviral therapy; COP, Country Operational Plan; Q, quarter; Y, year.

In the category of scale-up to saturation counties, the overall achievement was 72 percent (6,686/9,333) against the cumulative target in this category. Most counties were below 80 percent, with only Migori County achieving 88 percent. Homa Bay and Kisumu achieved 59 percent and 65 percent respectively. These two counties had deficits of 863 and 278 respectively in order to achieve the overall current target. The average achievement of new children on treatment month to month in these counties was 10 and 15 respectively.

In the category of aggressive scale-up, the overall achievement was 89 percent (2,437/2,749) against the cumulative target in this category. Bungoma was on track in its current ART, with an achievement of 95 percent, and Nyamira achieved 83 percent. The only county in the sustained category, Vihiga, achieved 97 percent (1,128/1,158) against the expected target.

Strategies to improve retention include the following: increasing efforts to improve ART preparedness of clients who are newly starting ART, including frequent messaging around enhanced adherence; actively tracking newly enrolled clients to ensure that they meet their appointments regularly through reminders via short text messages or calls two days prior to the appointment; strengthening implementation of the differentiated care model to reduce workload in high-volume sites and offer ample time to see unstable clients, which lead to improved retention of clients on ART; managing appointments within three weeks of the month, with active defaulter tracing in the last week to ensure clients who missed appointments all make their appointments within the reporting month.

Laboratory support

The project continued to provide support to 32 CD4 nodal sites in the quarter. It also maintained linkages for viral load processing with Kenya Medical Research Institute (KEMRI) Alupe- (Busia), KEMRI/US Centers for Disease Control and Prevention (CDC) (Kisian), and the Walter Reed Program (WRP), Kericho.

CD4 uptake and networks

The summary of the CD4 baseline uptake over the quarter is shown in Table 23. A total of 24 CD4 nodal sites supported the network of CD4 samples from peripheral facilities in the 9 counties. A total of 2,715 CD4 samples were networked and processed during the quarter as baseline and/or for diagnostic purposes. From the CD4 done over the period, 354 had a CD4 of less than 100 cell/mm³ and were further submitted to a CRAG test.

During the quarter, 5 nodal sites with PIMA POC machines had reagent stock outs while one broke down during the period. However, the project utilized the rider led sample network system to facilitate secondary networking for the samples. BD installed back up CD4 machines (BD Presto) at Kakamega CRH and Bungoma CRH.

Table 23. CD4 tests done July to September 2017 by county

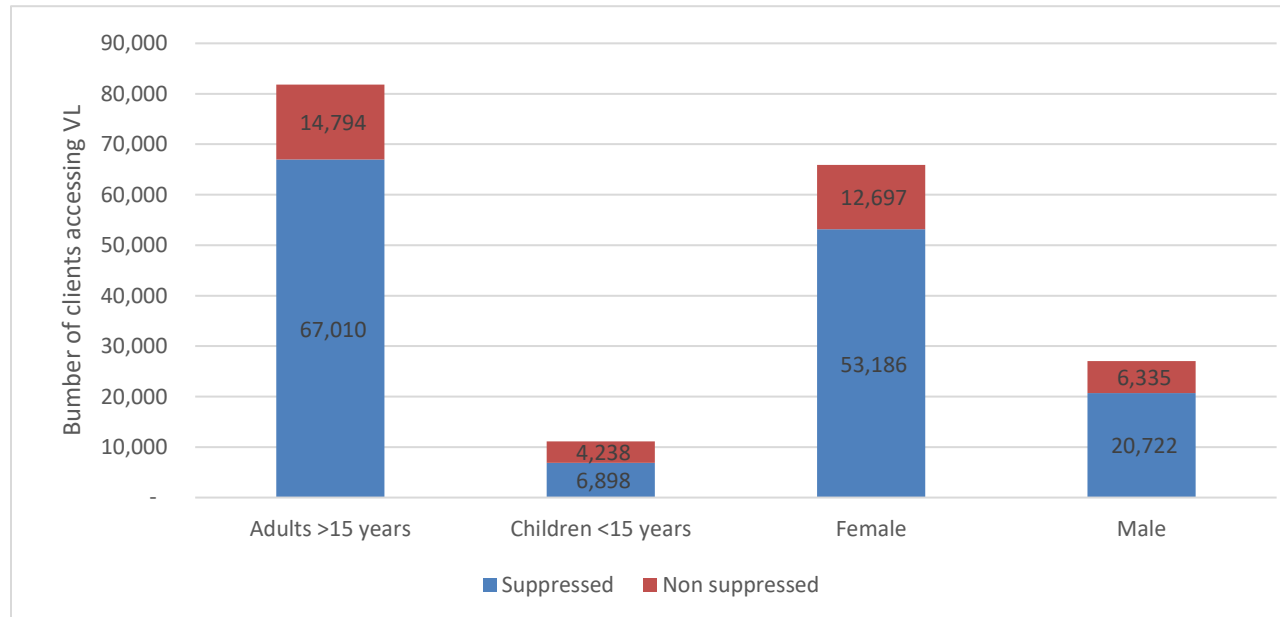
County	Tests done	CD4 <100
Kisumu	320	34
Migori	140	5
Nyamira	280	45
Homa Bay	285	50
Kisii	25	3
Bungoma	331	29
Busia	303	40
Kakamega	761	108
Vihiga	270	40
Total	2,715	354

Viral load uptake and suppression

During the reporting period in COP 2016 (October 2016 to September 2017), a total of 92,940 viral load tests were done against the project target of 105,601 (current on ART in March 2017), translating to 88 percent uptake. This is an improvement compared to the previous reporting period, during which a total of 88,389 tests were done, which translated to 77 percent uptake. Of the total tests done, 71 percent (65,883) were among females and 29 percent (27,057) were among males as depicted in Figure 7 below. According to various justification categories 5.4% (4,985) were targeted confirmatory repeat viral load tests, 1.3% (1,329) baseline, 0.34% (375) pregnant mother, 0.42% (741) breastfeeding mother and 5.5% (5,111) had no data. Due to delays in processing samples at the processing labs, the project still had an additional 1,339 pending samples yet to be processed with 44% (585) in Walter Reed Project/Kericho lab, 37% (490) in Alupe/KEMRI in Busia, 19% (262) in Kisian/KEMRI/CDC lab in Kisumu. The project

experienced some challenges in documentation of the viral load request forms following the transition from the previous lab request version of the form (September 2014 version) to the latest (October 2016 version) and led to poor documentation in some justification categories

Figure 7. Overall performance of viral load suppression, October 2016 to September 2017.



Note: VL, viral load; Yrs, years of age.

Across the counties, the highest achievements were in Busia and Kisii, with coverage of 97 percent and 103 percent respectively; the lowest achievement was in Nyamira, with 82 percent. The shortfall in Nyamira was occasioned largely by the closure of some of its sites during the ongoing nurses’ strike, as 20 percent of its sites are supported by MOH staff. In response, the project initiated a rapid results initiative, using available staff from other sites to line-list the clients who were due for their routine viral load tests; the staff made efforts to reach these clients. This exercise reached approximately 80 percent of eligible clients, thus the lower than expected performance.

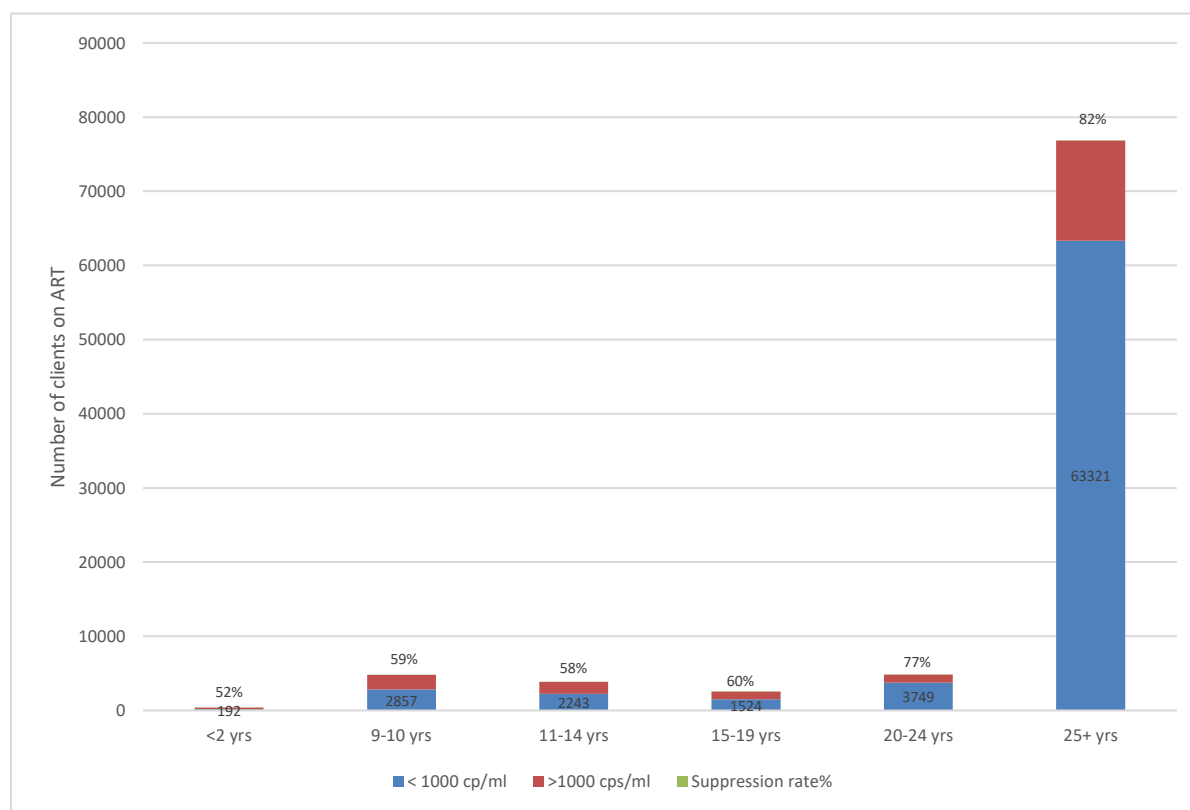
Regarding viral suppression the project achieved a suppression rate of 80 percent (73,908) with a non-suppression of 20 percent (19,032). Among the various age groups the highest suppression was among clients above 25 years at 82 percent while the lowest was the age group of 2 years and below at 53 percent. The pediatric age group of 2 to 9 years old and adolescents 15 to 19 years old achieved 59.3 percent and 59.9 percent respectively.

Table 24. County summary of viral load uptake and distribution category

County	Total VL done	Routine VL done	Targeted VL done	Not documented
Bungoma	11,383	10,145	350	888
Busia	6,664	5,267	359	1,038
Homa Bay	11,794	10,701	913	180
Kakamega	25,733	23,180	1,606	947
Kisii	1,774	1,403	46	325
Kisumu	5,763	5,443	320	-
Migori	10,475	9,534	468	473
Nyamira	9,999	9,409	354	236
Vihiga	9,355	7,762	569	1,024
Total	92,940	82,844	4,985	5,111

Across the counties, the highest performances were in five of the nine counties—namely, Kakamega, Homa Bay, Migori, Kisumu, and Busia, which each had averages of 80 percent suppression rate. The lowest performing county was Kisii, which had a 75 percent suppression rate. Table 24 shows the county-level viral load done per justification.

Figure 8. Viral load suppression by age distribution.



Note: ART, antiretroviral therapy; Yrs, years of age.

In the next reporting period, the project will employ various strategies to improve performance, including the following: sharing to facilities the weekly summaries of high viral load logs through the program teams, to ensure the respective files and cases are discussed within the week in the multi-disciplinary (MDT) meeting. Similarly, following the release of the revised ARV

formulation guidelines, which require the transition of clients previously on an inferior regimen to the recommended optimal regimens, the project will sensitize the clinical staff on the same to improve adherence of and viral suppression among clients. To improve documentation, the project will strengthen the use of remote log-in of samples at laboratory sub-hubs to minimize the poor documentation that was experienced during the COP 2016 period.

Differentiated model of care

The project embraced the differentiated model of care in all the supported counties, following the recommendation by the National AIDS and STI Control Programme after the release of the Kenya HIV treatment guidelines in 2016. In the period from October 2016 to September 2017, the project enrolled a total of 24,827 clients on the differentiated model of care, 20,054 of whom were on the facility fast track model and 4,773 of whom were on the community ART refill groups model.

The performance as at September 2017 translates to 24 percent (24,827) achievement against 102,188 clients current on ART, as at September 2016, who are eligible for differentiated care. Comparing the performance with the proportion of line-listed stable clients, the project attained a 64 percent (24,827/ 39,081) achievement. The performance was varied across the counties, as demonstrated in Table 25 below.

Table 25. Summary of county-level performance on enrollment of clients on the differentiated model of care, as at September 2017.

County	Current on ART as at September 2016	No. of stable clients stable line-listed	No. of clients started on fast track	No. of clients in CARGs	Total clients on DMOC to date	Proportion on DMOC against current on ART	Proportion on DMOC against line-listed clients
Nyamira	12,257	2,901	2,073	370	2,443	20%	84%
Kisii	1,827	569	302	39	341	19%	60%
Bungoma	12,884	4,138	1,577	984	2,561	20%	62%
Kakamega	27,531	10,876	5,086	1,253	6,339	23%	58%
Vihiga	10,073	4,639	3,000	375	3,375	34%	73%
Migori	11,790	5,177	1,728	764	2,492	21%	48%
Homa Bay	12,974	6,112	3,639	714	4,353	34%	71%
Busia	6,831	2,145	1,173	135	1,308	19%	61%
Kisumu	6,021	2,524	1,476	139	1,615	27%	64%
Total	102,188	39,081	20,054	4,773	24,827	24%	64%

Note: ART, antiretroviral therapy; CARG, community ART (antiretroviral therapy) refill group; DMOC, differentiated model of care; No., number.

Other direct service delivery support provided by the project include capacity-building initiatives for the health care workers, nonclinical counselors, and peer educators; program area support supervision and follow-up focusing on client referral and linkage to ART initiation and other HIV services; support for data documentation, reviews, and reporting; site-level program support for clinical management and documentation by both health care workers and peer educators.

Nutrition assessment, counseling, and support

In the reporting period, the project focused on promoting good nutrition as part of a minimum standard package of care in HIV management through various activities. These included sensitization in Nyamira, Kisii, and Kisumu counties of 61 peer educators on nutrition assessment, counseling, and support (NACS) and 21 mother mentors on infant feeding in the context of HIV. These activities were aimed at improving the quality of NACS for PMTCT mothers on maternal nutrition and infant feeding. The project's nutrition team also partnered with the HIV counseling and Healthy Heart Africa teams to increase the demand for HIV testing services through noncommunicable disease outreaches. Given the role nutrition plays in noncommunicable diseases, nutrition status screening and services were major preferences of the public; these services attracted large numbers who also accessed HTS. Performance review for NACS was also supported for seven counties (Kakamega, Vihiga, Busia, Bungoma, Homa Bay, Kisii, and Nyamira). The project supported the Kisumu Nutrition Technical Working Group and a County Nutrition Action Plan development meeting for Busia County. To improve on pediatric HIV testing and linkage, growth monitoring volunteers were deployed in high-volume facilities and MCH and nutrition clinics to do nutrition screening and referral of the severely acute malnourished children or those experiencing persistent weight loss.

In the reporting period, 81,341 (79 percent) people living with HIV/AIDS (PLHIV) from most of the ART sites were reached with NACS. This was an improvement from the previous quarter's 52 percent reached. This can be attributed to a performance review meeting supported during the quarter, in which all the nutrition volunteers were given targets to reach all the PLHIV with NACS in every visit.

During this period, 6,579 PLHIV were given food supplementation, which included fortified blended flours. The fortified blended flour shortage witnessed in the previous quarter was resolved in this reporting period. There is a current shortage on ready-to-use therapeutic foods in most facilities, but the project is hopeful that this will be resolved soon to address the current gaps in management of severe acute malnutrition.

Nutrition integration with noncommunicable diseases and HTS

Outreaches targeting noncommunicable diseases were carried out in Kisumu and Kakamega counties, where nutrition status screening was a key service and referrals were done for HTS. Table 26 shows the outcome of the exercise.

Table 26. Contribution of the non-communicable disease outreaches to the testing cascade, July to September 2017

Month	Number reached	Number tested	Number positive	Percent positivity	Hypertension		Diabetes	
					Males	Female	Male	Female
July	314	183	9	5	21	0	8	1
August	211	91	4	1.9	21	0	1	2
September	189	104	4	4.4	17	3	6	0
Total	714	378	17	3.8	59	3	15	3

Growth monitoring and promotion (GMP)- HIV testing services linkage

The project supported HIV case-finding for pediatric clients through anthropometric and clinical screening at the MCH and nutrition clinic; those identified were then referred for testing. Table 27 shows how many referrals were done in Chwele, Bungoma District Hospital, and Uriri. Due to the nurses' strike, the activity has slowed down.

Table 27. Contribution of GMP to the testing cascade, July to September 2017

County	Number referred for testing	Positives	Percent positivity
Bungoma	28	5	17.9
Migori	111	2	1.8
Total	1,928	33	2

Positive health, dignity, and prevention interventions targeting PLHIV

During this quarter, the peer educators continued to disseminate key positive health, dignity, and prevention (PHDP) messages to PSSG members at facility and community levels; these messages were aimed at improving the lives of PLHIV through stigma reduction and provision of comprehensive care services. PHDP services that were provided included condom distribution and demonstration of use, adherence counseling, sexually transmitted infection (STI) screening, TB screening, among others. There were 3,917 newly enrolled clients who were counseled on adherence, the importance of ART, and how to cope with the HIV burden. During this quarter, 23,913 clients participated in facility PSSGs and 25,518 participated in community PSSGs, where key PHDP messages were disseminated; these participations rates were great improvements from the previous quarter. The quarter also saw 1,762 clients referred from the facility to the community to continue with the continuum of care—an increase from 1,228 of the previous quarter.

The project supported the establishment of 204 new PSSGs. This increased the number of community PSSGs under project support to 1,062, which was up from 858 in the previous quarter; thereby the community PSSG membership grew from 14,401 last quarter to 25,518. The groups have continued to provide a forum for the PLHIV to meet to discuss key messages on PHDP. The groups also refer those in need of services to service providers. Out of the total enrolled of 25,518, 8,211 received condoms, which was up from the 5,550 who received condoms in the previous quarter. Referrals were also made for different services, including 4,744 for family planning; 588 for gender-based violence (GBV) screening; 5,111 for STI screening;

and 822 for nutrition assessment at the facility level. Tables 28 and 29 below provide a regional level performance.



Hero book writing and play therapy at Bumula and Tongaren children’s clubs.



APHIAplus staff and a health care worker interacting with the youth during an adolescent psychosocial support group meeting at Bumula Health Center in Bungoma County.

Table 28. PHDP interventions at facility and community levels July to September 2017

Indicator	Nyanza	Western	Total
No. of PLHIV attending facility PSSGs	15,757	8,156	23,913
No. of PLHIV referred from facility to community PSSGs	533	1,229	1,762
No. of active community PSSGs	517	545	1,062
No. of group members in community PSSGs	17,499	8,019	25,518

Note: No., number; PLHIV, people living with HIV/AIDS; PSSG, psychosocial support group.

Table 29. PHDP services provided at the community level, July to September 2017

Indicator	Nyanza	Western	Total
No. of PLHIV (aged 15 years and older) enrolled in PHDP sessions	7,070	8,469	15,539
No. of PLHIV (aged 15 years and older) completing all sessions	4,804	5,096	9,900
No. of PLHIV (aged 15 years and older) provided with information on adherence	5,841	8,469	14,310
No. of PLHIV (aged 15 years and older) provided with condom	3,241	4,970	8,211
No. of PLHIV (aged 15 years and older) referred for family planning	3,389	1,355	4,744
No. of PLHIV (aged 15 years and older) referred for GBV screening	1	587	588
No. of PLHIV (aged 15 years and older) referred for STI screening	1,161	3,950	5,111
No. of PLHIV (aged 15 years and older) referred for nutrition assessment	30	852	882

Note: GBV, gender-based violence; No., number; PHDP, positive health, dignity, and prevention; PLHIV, people living with HIV/AIDS, STI, sexually transmitted infection.

Nutrition demonstration centers

The community and facility peer educators continued to work together to establish nutrition demonstration centers that act as learning centers for the clients enrolled in ART, particularly new clients. Various locally available and nutritious food crops such as pumpkins, crotalaria, cow peas, spider plant, black nightshade, kales, and others are planted and harvested. They are shared with some deserving cases at the facilities. Clients, including PSSG members, are encouraged to replicate the same in their kitchen gardens at home. During this quarter, 70 nutrition demonstration centers were established and 1,167 kitchen gardens were replicated. Therefore, 6,046 household members benefitted from this intervention, as indicated in Table 30 below.

Table 30. Nutrition demonstration centres, replication kitchen gardens and benefiting households in July to September 2017

County	# of nutrition demonstration centers	# of kitchen gardens	# of household members benefiting
Bungoma	23	245	1,228
Busia	6	350	1,295
Kakamega	12	482	2,892
Vihiga	12	36	351
Nyamira	10	40	240
Kisii	7	14	40
Total	70	1,167	6,046



A nutrition demonstration center at Mautuma Subcounty Hospital.



A kitchen garden at Matete.

Village saving and loaning association

Support groups continued to improve their economic status by running village saving and loaning associations in their respective groups. For instance, In Kakamega County, the Eshimuiya PSSG attached to the Eshihongo facility in Navakholo reported to have KSh (Kenyan Shillings) 15,000/= in loans in circulation among members. The group is also involved in goat keeping as an income-generation activity. Through these income-generation activities, members were able to raise school fees for their children. By the end of September 2017, the group had a total of KSh 10,000 in circulation. In Bungoma County, 778 (342 Male; 436 Female) members from 36 PSSGs were actively engaged in village saving and loaning associations, with loans worth KSh 962,270 circulating among them.

In Busia County, the Asiape PSSG, which is linked to Alupe Subcounty Hospital, had KSh 40,000 in loans circulating; KSh 17, 000 had accumulated as interest, which was collected and deposited in the group bank account. In Nambale subcounty, the Tusaidiane PSSG loaned out KSh 130,000 to members for investing into small businesses, which helped them earn a living; members used some of the profits to pay school fees and cater for other basic household needs. Finally, the Kotur Alemna and Nanderema PSSGs from Teso South and Samia subcounties had KSh 135,000 in loans circulating among members (Teso South, KSh 85,000; Samia, KSh 50,000).

The Nyachichi PSSG in Nyamira County reported to have KSh 235,000 in circulation as loans to members. Additionally, the members have been able to lease land to sell Napier grass, as well to keep goats for sale. The Esani PSSG, through loaning members, has been able to improve the

members' lives since they acquired livestock such as goats. The members sold the goats and thus were able to purchase dairy cows as a sustainability measure.

In Kisii County, Masimba Mercy, Obomo, Ndemi, and Upendo PSSGs members take a total of Ksh 3,600 as loans on a monthly basis, which total to Ksh 14,000. The loaning systems have been able to improve the lives of the members in that they have been able to pay fees, improve businesses, and save aside welfare to help during family emergencies.

It is worth noting that the Geibamanya post test network in Kisii County are involved in church and *barazas* as sensitization sessions to advocate for testing, knowing HIV status, and reducing stigma. This has led to a testing outreach, which identified three HIV-positive clients, who were linked to Masimba and Gesusu subcounty hospitals.

TB–HIV co-infection services

The project continued to support implementation of TB–HIV services through the “5 I’s” strategy of intensified case finding; integration of TB–HIV; immediate ART for all TB–HIV co-infected clients; isoniazid preventive therapy (IPT) initiation for eligible asymptomatic clients to improve IPT completion rates; and infection prevention and control. Other key deliverables during the quarter were improved GeneXpert® utilization through the rider-led sample networking mechanism, capacity-building initiatives, clinical review meetings for multidrug-resistant TB clients, and joint support supervision with county and subcounty teams. The project focused on improving TB case finding through implementation of the active case finding approach. The project deployed 274 cough monitors in high-volume facilities, where staff were tasked to screen all symptomatic clients in all entry points at the facility (i.e., outpatient department, inpatient department, CCC, MCH clinics) and at the community through public *barazas* and the motorcycle stages while the riders wait for their customers.

Out of the 508 supported sites, 218 (43 percent) continued to provide the complete integration model of care; 181 (35 percent) provided the partial integration model; and 112 (22 percent) provided the cross-referral model.

TB–HIV performance

In Y7Q3, a total of 1,317 TB patients were registered in project-supported sites. This brings to a total 4,680 registered TB patients for the entire APR period. Out of these, 4,513 (96 percent) were counseled and tested for HIV; 1,607 (36 percent) were identified as TB–HIV co-infected; 1,588/1,607 (99 percent) were initiated on cotrimoxazole preventive therapy; and 1,527/1,607 (95 percent) were put on ART.³ Table 31 puts these performance indicators into perspective against the respective COP targets while Figure 9 provides a graphical view.

³ Data source: TIBU reporting system.

Table 31. Key TB–HIV performance against COP 2016 targets.

TB–HIV performance indicators	COP 2016 targets	Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total
Number of TB cases registered		1,269	694	1,400	1,317	4,680
Number of TB patients who were counseled, were tested for HIV, and received results	7,309	1,238	674	1,337	1,264	4,513
Proportion counseled and tested for HIV and received results against COP 2016 target						62 percent
Number of HIV-infected TB patients		473	264	441	429	1,607
Proportion of TB–HIV co-infection						99 percent
Number of HIV-infected TB patients on cotrimoxazole		469	258	438	423	1,588
Number of HIV-infected TB patients on ARVs	2,564	454	246	420	407	1,527
Proportion of HIV-infected TB patients on ARVs against COP 2016 target						60 percent
Number of HIV-positive clients screened for TB	120,374	91,539	101,305	100,689	104,389	104,389
Proportion of PLHIV clients screened for TB against COP 2016 target		(105 percent)				87 percent

Source: TIBU System data/MOH 711.

Note: ARV, antiretroviral; COP, country operational plan; MOH; Ministry of Health; TB, tuberculosis; PLHIV, people living with HIV; PMP, Performance Monitoring Plan.

When compared to the COP 2016 target of 7,309, the project’s performance for the entire APR period for TB patients accessing HTS was 62 percent (4,513/7,309). This low performance could be attributed to the lower than expected number of registered TB patients during the APR period, declining number of TB cases notified, and the health care workers’ strike, which led to closure of some peripheral facilities. The project’s strategy during the reporting quarter was deployment of 274 cough monitors to high-volume facilities to improve active case finding at all levels of care (i.e., outpatient department, inpatient department, CCC, and MCH clinics). The cough monitors approach in active case finding was started in the month of August 2017; by the end of September 2017, a total of 1,099 TB patients were diagnosed with TB. This indicates that the cough monitors approach contributed 83 percent (1,099/1,317) to TB case identification during the quarter.

To further improve on the TB case finding trends, the project will continue to work closely with the facility and subcounty teams. The project will focus on the current approaches of cough monitors and rider-led sample networking mechanisms to ensure that active case finding is intensified across all the facility entry points and the communities.

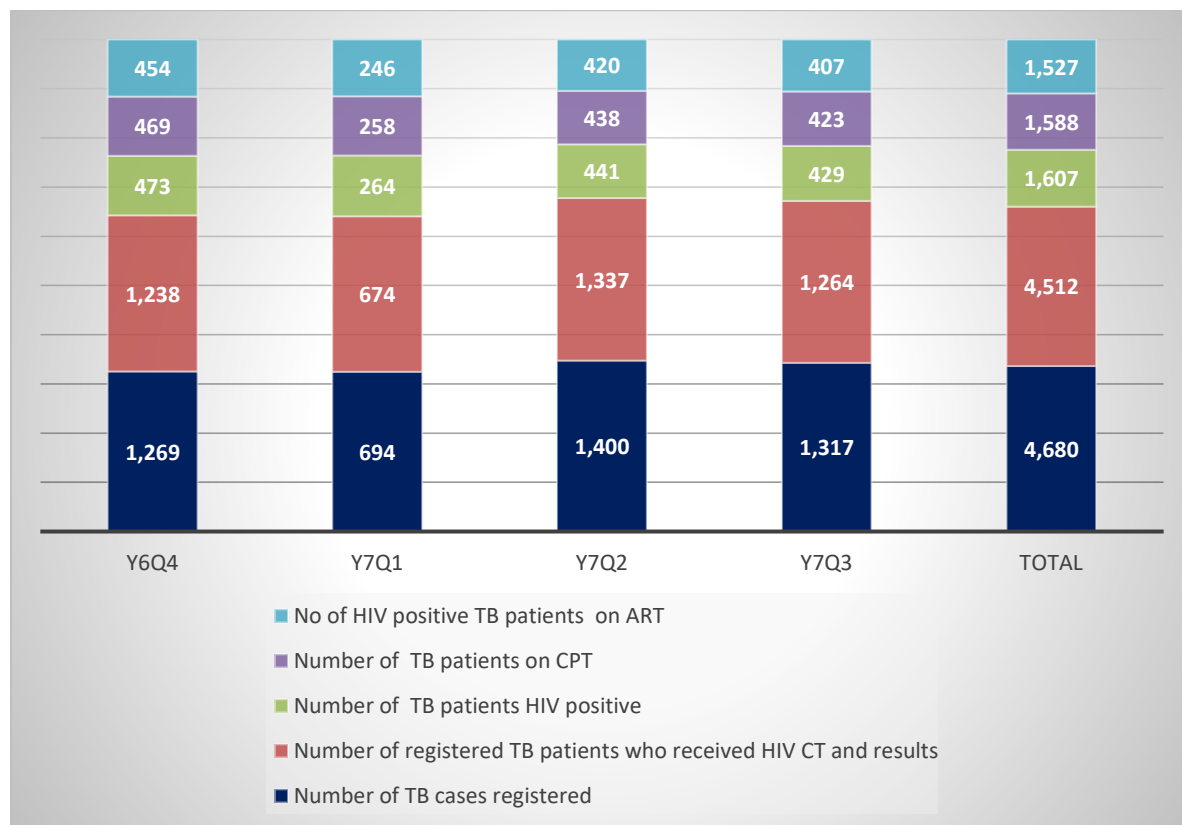
ART initiation among TB–HIV co-infected clients

During the reporting period, 407 of the 429 TB–HIV co-infected clients were initiated on ART. Further analysis of the 22 clients (5 percent) who were not on ART during the reporting period indicated that the clinicians in the reporting sites decided to hold ARV initiation based on

clinical assessment, awaiting stability as outlined the Kenya ART guidelines. Eight (8) of these clients had been registered in the last week of the reporting quarter. Detailed analysis for these clients will be documented in subsequent quarters. The county-specific ART uptake showed that Migori County was at 100 percent, Nyamira and Kakamega at 98 percent, Busia at 95 percent, Vihiga at 93 percent, Homa Bay at 92 percent, Bungoma at 91 percent, and Kisii at 83 percent. The low performance in Kisii was attributed to the low numbers: five out of the six HIV-positive clients, 83 percent, were put on ARVs, and only one client was not initiated due to clinical judgment. The project supports only one subcounty in Kisii County, where a total of 24 TB cases were reported.

For the entire APR period, 1,527 of the 1,607 co-infected clients were put on ART. This translates to 95 percent ART uptake. As compared to the COP target of 2,564 TB–HIV co-infected clients to be put on ART, the project achieved 60 percent ART performance. The low performance of this indicator against the target could be attributed to the low case finding among the identified clients and the health care workers’ industrial action. To further improve on ART uptake, the project will continue to focus on improved case finding through the cough monitors approach, dissemination of ART guidelines, and support for capacity-building initiatives. The project will also support regular performance review meetings to ensure that there is proper documentation and reporting across all the supported counties.

Figure 9. TB–HIV cascade, Y6Q4 to Y7Q3.



Source: TIBU System data/MOH 711.

Note: ART, antiretroviral treatment; CPT, cotrimoxazole preventive therapy; CT, counseled and tested for HIV; MOH, Ministry of Health; Q, quarter; TB, tuberculosis; Y, year.

Childhood TB–HIV

The proportion of children diagnosed with TB during the APR period was 11 percent (514/4,680), of which 98 percent (503/514) were tested for HIV and 28 percent (143/514) were co-infected with TB–HIV. All the 143 co-infected children were put on cotrimoxazole preventive therapy, and 96 percent (137/143) were initiated on ART. In subsequent quarters, the project will continue to support capacity-building initiatives of HCWs and cough monitors through the use of the current pediatric guidelines and standardized operating procedures, to ensure that there is no missed opportunity of TB diagnosis among children. The project will use GeneXpert for all symptomatic children. The project will also strengthen the rider-led sample networking system to ensure that specimens from all symptomatic children are timely transported to the nearest GeneXpert site. On ART initiation among the co-infected children, the project focus will be to improve the uptake from the current 96 percent to 99 percent through facility-based CME and HCW mentorship on ART guidelines.

Intensified case finding—TB screening

During the reporting quarter, the project achieved 87 percent (104,389/120,374) of the total ART clients screened for TB through the use of a symptom-based intensified case finding screening tool. Further analysis showed that a total of 14,266 ART clients had a specimen sent for GeneXpert examination (GX-LMIS data); a total of 292 clients on ART developed TB, all of whom were started on TB treatment. The project team will do further clinical review for the 292 to ascertain why they developed TB while on ART (e.g., review their viral loads and ART adherence).

Table 32. Tuberculosis screening among antiretroviral therapy clients, Y7Q3.

County	No of ART Clients	No Screened for TB	% ART Clients screened for TB
Busia	6,971	7,094	102%
Homa Bay	18,836	13,014	69%
Kisumu	6,936	6,827	98%
Migori	11,981	12,671	106%
Kakamega	34,295	28,338	83%
Kisii	1,905	1,917	101%
Nyamira	17,804	12,106	68%
Bungoma	11,886	12,699	107%
Vihiga	9,760	9,723	100%
Total	120,374	104,389	87%

Source: MOH 731.

Note: ART, antiretroviral therapy; TB, tuberculosis.

Table 32 provides the county level performance on TB screening. In this, Busia, Migori, Bungoma, Kisii and Vihiga counties achieved over 100 percent TB screening among the ART clients. Kisumu County was at 98 percent, Kakamega at 83 percent, Homa Bay at 69 percent, and Nyamira was at 68 percent. The low performance in counties with below 80 percent TB

screening could be attributed to the health care worker strike, especially in Nyamira County, where the majority of the supported facilities were closed.

To ensure improved and sustained quality of TB screening, the project will continue capacity-building initiatives through sensitization of HCWs and cough monitors. The aim is to ensure that all clients are screened for TB, and the symptomatic clients are registered in the presumptive TB registers and their samples subjected to GeneXpert test. The cough monitors approach will also assist the facility teams in active case finding and documentation of all screened clients. The rider-led sample networking system will also support timely submission of specimens to the GeneXpert sites and relay of hard copy results to the clinicians. The project teams will continue to work closely with the subcounty health management teams and health record information officers/data clerks to ensure that TB screening is documented as per the National Tuberculosis, Leprosy and Lung Disease Program and National AIDS and STI Control Programme guidelines.

GeneXpert diagnostic system utilization

As shown in Table 33 below, there was a slight drop in the GeneXpert utilization rate across all the supported counties, from 83 percent to 81 percent, with an error rate 2.1 percent. The drop could be attributed to the health care workers' strike during the reporting quarter. In subsequent quarters, the project will continue supporting active case finding activities through the cough monitors and rider-led sample networking mechanisms to ensure that there is improved GeneXpert utilization. Sensitization of HCWs on the GeneXpert algorithm will also be conducted across all the counties with keen/major focus on PLHIV and children.

Table 33. GeneXpert utilization rates per county, Y7Q2 to Y7Q3.

County	Percentage of GeneXpert utilization Y7Q2	Percentage of GeneXpert error rate Y7Q2	Percentage of GeneXpert utilization Y7Q3	Percentage of GeneXpert error rate Y7Q3
Kisumu	98%	1.2%	95%	2.00%
Homa Bay	86%	3%	82%	3.50%
Migori	83%	2%	80%	1.40%
Busia	89%	3%	75%	1.90%
Kakamega	91%	2.5%	85%	2.40%
Nyamira	82%	3%	78%	2.20%
Kisii	72%	2%	71%	1.80%
Bungoma	93%	2%	91%	2.10%
Vihiga	54%	3.5%	75%	2.60%
Average percent	83%	2.4%	81%	2.10%

Source: National Tuberculosis, Leprosy and Lung Disease Program Online GX Alert.

Note: Q, quarter; Y, year.

TB preventive therapy

The project continued to support implementation of IPT initiatives in all of the project-supported counties, with the aim of having all asymptomatic co-infected clients initiated on IPT and analyzing the IPT outcome among the clients who were initiated on the therapy six months earlier. During the reporting period, the IPT completion rate improved, with an overall

achievement of 95 percent (18,448/19,521) as compared to 86 percent in the previous quarter. The project in the next quarter will continue to hold IPT performance review meetings with all the counties, with specific focus on counties that achieved a less than 90 percent IPT completion rate. To ensure that IPT documentation and completion improve, the project will also support capacity-building and mentoring initiatives for HCWs and pharmacy staff on accurate documentation in IPT registers and timely ordering of IPT tablets and other commodities. Table 34 shows the IPT completion rate at county level.

Table 34. Proportion of antiretroviral therapy patients who completed a standard course of TB preventive therapy (isoniazid preventive therapy).

County	Completed IPT					Expected to complete IPT after 6 months					Percent completed IPT		
	Female		Male		Total	Female		Male		Total	<15 yrs	15+ yrs	Total
	<15 yrs	15+ yrs	<15 yrs	15+ yrs		<15 yrs	15+ yrs	<15 yrs	15+ yrs				
Migori	145	1567	112	725	2549	171	1880	143	981	3175	82%	80%	80%
Homa Bay	59	678	61	265	1063	60	680	61	271	1072	99%	99%	99%
Kisii	26	367	33	126	552	27	378	35	131	571	95%	97%	97%
Nyamira	47	1114	54	402	1617	49	1156	58	409	1672	94%	97%	97%
Kisumu	36	299	18	119	472	36	299	18	121	474	100%	100%	100%
Kakamega	338	3720	235	1473	5766	355	3899	257	1502	6013	94%	96%	96%
Bungoma	57	905	58	302	1322	65	955	73	317	1410	83%	95%	94%
Vihiga	161	1724	154	869	2908	196	1975	189	1017	3377	82%	87%	86%
Busia	73	1114	88	468	1743	79	1204	93	508	1884	94%	92%	93%
Total	942	11,488	813	4,749	17,992	1,038	12,426	927	5,257	19,648	89%	92%	92%

Data source: Ministry of Health District Health Information System.

Note: ART, antiretroviral therapy; IPT, isoniazid preventive therapy; PEDS, pediatric clients; TB, tuberculosis; Yrs, years of age.

TB–HIV cohort analysis

The cohort analysis for 1,335 TB clients registered one year earlier (Y6Q3) showed that 89 percent (1,188/1,335) of the reported clients completed their TB course treatment; 2 percent (28) was lost to follow-up; 4 percent (53) was transferred out to other facilities before completion of treatment; 1 percent (12) reported as failed and were subjected to GeneXpert testing, srug sensitivity testing (DST), and culture; and 4 percent (54) of the clients died while on treatment. The project will focus on improving TB outcomes with reduced death rates through early detection of TB by cough monitors and timely treatment initiation.

Drug-resistant TB management

In Y7Q3, a total of six new drug-resistant TB patients were reported in project-supported subcounties. This brought the total number of drug-resistant TB patients on treatment at project-supported sites to 62. Contact tracing for the six new clients was conducted at household level, and a total of 21 contacts were screened; none was found to be mycobacterium tuberculosis (MTB) positive. One multidrug-resistant TB patient in Malava subcounty was identified and

referred by one of the cough monitors during community visit. Cohort analysis of the four drug-resistant TB patients who were started on treatment two years ago indicated that 75 percent (3/4) were cured and 25 percent (1/4) defaulted from treatment. A defaulter tracing report of the patient who was lost to follow-up indicated that she had travelled to Mombasa and refused to take the medication. The project will continue to support drug-resistant TB management through regular clinical review meetings and drug-resistant TB surveillance, including contact tracing and transport of samples for GeneXpert through the rider-led sample networking approach.

Infection prevention and control

During the reporting quarter, 91 percent (462/508) of all the project-supported sites were able to provide a minimum infection prevention and control package (i.e., well-ventilated waiting bays, triaging of clients, and opening of windows). All of the 462 sites were able to develop an infection prevention and control plan that used information, education, and communication materials. In subsequent quarters, the project will support regular health talks by cough monitors at facility and community levels to ensure that there is minimal transmission of TB among HCWs, other patients, and visitors to the facility

Community TB care

In Y7Q3, the project supported outreaches and school health talks in 19 schools that had reported TB cases. A total of 947 pupils and students were screened for TB, and 7 children were newly diagnosed with TB from the following subcounties: Awendo, Borabu, Masaba South and North. All were initiated on treatment. The cough monitors also visited various communities and market places, including motorcycle parking areas where one rider was diagnosed with TB through GeneXpert examination.

HIV prevention services

Voluntary medical male circumcision services

During the reporting period of July to September 2016, the project continued to provide direct service delivery support to 39 project-supported voluntary medical male circumcision (VMMC) sites through the provision of consumables, equipment, and reporting tools, as well as supportive supervision and mentorship on VMMC service provision. All of the 39 VMMC sites are in the scale-up to saturation counties of Homa Bay, Migori, Kisumu, and Busia.

A total of 13,502 men accessed VMMC services across the 39 sites in the four counties. As part of the VMMC minimum package of services, 13,396 (99 percent) were counseled and tested for HIV, 29 of whom turned out HIV positive; they were all referred and linked for HIV care, treatment, and support. Sixty-one percent (8,202) of the clients circumcised were aged 15 years and older. This compares to the last quarter, during which 7,137 out of 11,794 (61 percent) clients circumcised were aged 15 years and older. In addition, 85 percent (11,452) came back for follow-up review within 14 days of circumcision. There was no moderate or severe adverse event reported during the period under review.

Table 35. VMMC quarterly performance by county as at APR 2017.

County	Target	Male circumcisions done					Percent achieved
		Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	
Homa Bay	28,282	8,495	2,723	6,726	9,388	27,332	97%
Kisumu	5,830	1,825	401	1,191	755	4,172	72%
Busia	2,228	2,627	237	1,473	886	5,223	234%
Migori	8,278	4,132	473	2,404	2,473	9,482	115%
Total	44,618	17,079	3,834	11,794	13,502	46,209	104%

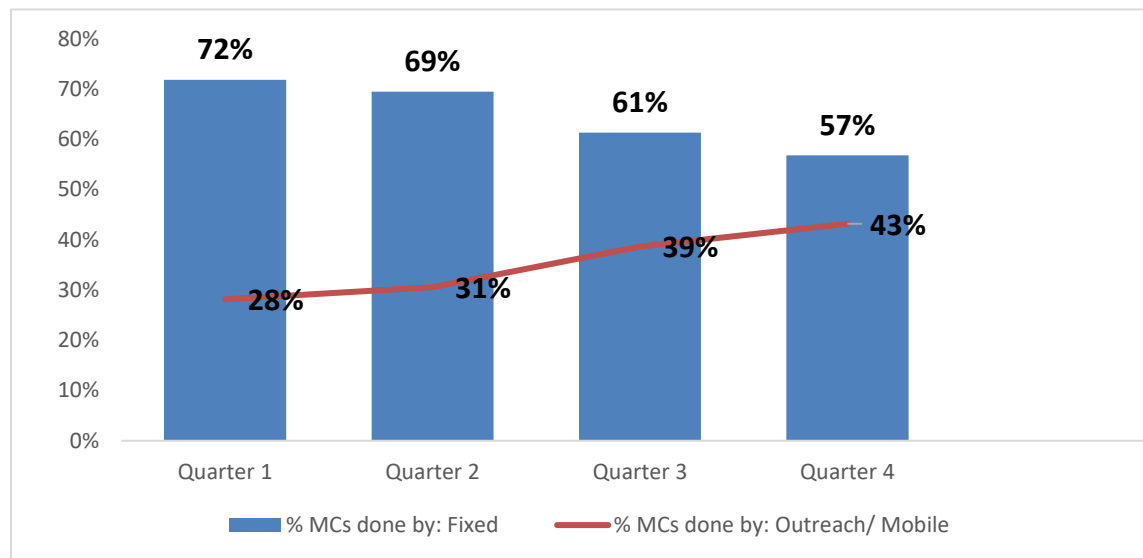
Note: APR, Annual Performance Report; Q, quarter; VMMC, voluntary medical male circumcision; Y, year.

As at APR 2017, a total of 46,209 clients had accessed VMMC services against a COP 2016 target of 44,618, a 104 percent achievement. Ninety-eight percent (45,496) of these clients were counseled and tested for HIV as part of the VMMC minimum package of service; 118 of these clients turned out HIV positive and were effectively linked to HIV care, treatment, and support. There was one severe adverse event reported during the period.

Table 35 provides a county-level achievement of the targets. Busia and Migori counties surpassed their annual targets by 234 percent and 115 percent respectively. Homa Bay County managed to conduct 27,332 circumcisions, against a COP 2016 target of 28,282, (97 percent achievement). Kisumu County managed 4,135 circumcisions against a COP 2017 target of 5,830 (72 percent achievement). Overall achievement is attributed to the following interventions: For six weeks during the reporting period, the project supported an accelerated VMMC campaign that coincided with school holidays in July and August 2017 across all the fixed and outreach sites. The project also supported a six-week rapid results initiative in November to December 2016 and a four-week accelerated VMMC in April 2017, which coincided with school holidays. In addition, the project expanded its support for VMMC outreaches in up to 31 facilities, bringing the number of sites supported to 70. The outreaches contributed to 28 percent (4,806), 31 percent (1,171), 39 percent (4,559), and 43 percent (5,831) of circumcisions done in Q1, Q2, Q3, and Q4 respectively. On average, VMMC outreaches contributed a total 16,367 circumcisions (35 percent) to the overall project's VMMC achievement. A total of 36,139 clients were reached with services during the November to December 2016 rapid results initiative and the April and August accelerated VMMC campaign. These interventions contributed to 78 percent of all circumcisions done during this reporting period. The highest uptake of VMMC services was among clientele aged 10 to 14 years at 40 percent (18,700), followed by clientele aged 15 to 29 years at 32 percent (14,609).

Figure 10 shows that there is a lot of untapped potential in VMMC outreaches, as demonstrated by the increasing number through the quarters of clients who were circumcised through this strategy.

Figure 10. Proportion of male circumcisions by facility type.



Note: MC, male circumcision.

Busia County’s set target was much below the demand for services in the county, whereas in Migori County, the project enjoyed immense monopoly in VMMC service provision in the October to December period, a period when there was a slow transition between the other VMMC implementing partners in the county that resulted in a huge influx of clients seeking VMMC services in the project-supported sites. In addition, Q1 coincided with a circumcision period for a small Luhya subtribe living in Uriri subcounty, Migori County. This influx catapulted the project’s county performance to 50 percent of its annual target by end of that quarter. Kisumu and Homa Bay, which had relatively high targets, called for more outreach and mobile VMMC services. These outreaches, however, were affected by the intermittent health care workers’ strike that led to the closure of most of these outreach sites. Kisumu County was the most affected, as some of the few identified outreach sites remained closed.

The project used multifaceted strategies to mobilize clients for services. To increase demand for VMMC services, the project continued to engage community structures in social mobilization for VMMC rapid results initiatives and outreaches that targeted males aged 10 to 29 years in the community and in educational institutions. Door-to-door community mobilization by the community health volunteers 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 to VMMC appointments, and offer support during the healing period. The project continued to support and participate in the national, county, and subcounty VMMC taskforce activities for the purposes of coordinating VMMC services in the region. The project continued with the process of computerizing the management of VMMC data. This system enables the project to generate VMMC data electronically and to disaggregate VMMC data for reporting and decision-making purposes.

The project continued to support quality assurance initiatives by supporting the MOH teams to conduct continuous supportive supervision and mentorship, as well as supporting monthly data review meetings and conducting data quality assessments and the site improvement through monitoring system. The project supported the training of 100 health care providers on full

VMMC service provision. The aim was to improve their surgical skills in male circumcision, including circumcision using the dorsal slit method for clients aged 10 to 14 years, whose penile anatomy is still immature. The project also supported the training of 112 community health volunteers on VMMC demand creation to equip the mobilizers with the right information for VMMC communication. In addition, the project and MOH teams continued to ensure that young adolescents with immature penile anatomy received the recommended dorsal slit technique of circumcision.

Priority population

In the July to September 2017 period, the project continued to support two local implementing partners (LIP), the Kenya Red Cross Society and Western Region Christian Community Services, to implement comprehensive HIV prevention interventions using the combination prevention approach. The approach incorporates behavioral, biomedical, and structural interventions that were delivered through two evidence-based interventions (EBIs). The EBIs implemented during the review period included Splash Inside Out and PHDP. These interventions continued targeting fisherfolk in 17 beach management units—12 beach management units in Kisumu and 5 beach management units in Busia. The EBIs implemented are independent of the DREAMS interventions.

During the reporting period, the project provided essential direct service delivery support and technical assistance to two local implementing partners in order to achieve specific HIV outcomes amongst fisherfolk. These included capacity-building through mentorship and refresher trainings, support supervision, data documentation and validation, performance review and reporting, tracking of commodity consumption, and forecasting and financial management.

The main Splash Inside Out and PHDP activities that were implemented during the period included conducting refresher Splash Inside Out trainings for 60 peer educators (38 Male; 22 Female) and a PHDP refresher training for 25 peer educators (6 Male; 19 Female). Under behavioral interventions, peer education was conducted at individual and small-group levels. The rest of the activities conducted included risk assessment; risk-reduction counseling and skills building sessions; condom promotion, demonstration, and distribution; screening for STIs, TB, and drug and alcohol abuse; and delivery of 13 key messages through PHDP. The immediate outcome of behavioral interventions was the mobilization of fisherfolk for the uptake of biomedical and structural services under the prevention, care, and treatment continuum.

Behavioral interventions for priority population

The fisherfolk participating in splash inside out and PHDP sessions were escorted by peer educators to link referral facilities to take up the essential package of health services. Some fisherfolk were mobilized for integrated outreaches where they received essential health services. The essential health package included HTS, STI treatment, HIV and TB care and treatment, VMMC, reproductive health/family planning, emergency contraception, postexposure prophylaxis, and tracking of effective referrals. The project tracked completed HTS referrals through facility linkage registers, thus ensuring uptake of care-and-treatment services among the fisherfolk who tested HIV positive.

In the July to September period, 3,733 fisherfolk were reached through one-on-one and small group sessions in Kisumu and Busia counties. Out of those served, 883 referrals were effectively made for various biomedical and structural services. Cumulatively, between October 2016 and September 2017, the project reached 12,660 fisherfolk; hence, the project realized 92 percent achievement of the COP 2016 target (96 percent in Busia and 87 percent in Kisumu).

Busia recorded improved performance against the COP 2016 target. This was due to proportionate allocation of the 60 peer educators to their LIP target of 7,848, which led to a monthly target of 11 fisherfolk per peer educator. However, Busia did not perform optimally because some fisherfolk who were reached did not complete the required minimum of four messages splash inside out sessions; these were not eligible for reporting.

Performance in Kisumu County fell short of the expected COP 2016 target due to a number of reasons: Twenty-five peer educators dropped out, which affected overall output in Q2. Data cleaning was conducted during the Q1 of COP 2016 in order to eliminate double entries that had been made by the local implementing partner. In addition, low numbers were reached in August 2017, since some peer educators were engaged in the electioneering campaigns and so did not meet their targets. Despite not achieving the COP 2016 target, there was tremendous improvement in Kisumu, particularly from June 2017, due to motivation of the peer educators through timely payment of stipends and close monitoring and supervision by the project staff. In addition, three peer educators who had been dropped due to funding were able to voluntarily assist in conducting one-on-one Splash Inside Out sessions to fisherfolk, which boosted the numbers reached. Table 36 below illustrates the numbers reached during the APR between October 2016 and September 2017.

Table 36. Fisherfolk reached with HIV prevention services, October 2016 to September 2017.

County	COP 2016 target	# reached Oct–Dec 2016	# reached Jan–Mar 2017	# reached Apr–Jun 2017	# reached Jul–Sep 2017	# reached Oct 2016–Jun 2017	Percent of target achieved
Busia	7,848	2,136	2,222	1,559	1,612	7,529	96%
Kisumu	5,890	1,028	615	1,367	2,121	5,131	87%
Total	13,738	3,164	2,837	2,926	3,733	12,660	92%

Note: COP, Country Operational Plan.

Biomedical and structural interventions for priority population

Between July and September 2017, a total of 2,641 were referred among the 3,733 fisherfolk who had been reached during one-on-one and small group sessions; the fisherfolk who were referred received the essential package of service. As at the SAPR between April and September 2017, a total of 4,773 fisherfolk were referred out of the 6,659 fisherfolk who had been reached. Cumulatively, between October 2016 and September 2017, a total of 6,581 fisherfolk were referred and received the essential package of service out of the 12,660 fisherfolk who had been reached. Table 37 below indicates the uptake of essential services through effective referrals between October 2016 and September 2017.

Table 37. Uptake of essential services by fisherfolk through referrals.

Period	County	# Reached	Complete referrals for biomedical services						Complete referrals for structural services			
			HTS	STI	VMMC	TB	CaCx	EC/FP	A&D	PSS	FSS	LA
Oct 2016 to	Busia	4,358	238	2	0	1	12	14	0	0	0	0
Mar 2017	Kisumu	1,643	834	92	70	89	106	190	71	27	12	3
Apr to Sept	Busia	3,171	1,419	6	4	34	39	38	5	0	1	6
2017	Kisumu	3,488	1,376	244	169	150	464	508	58	63	48	50
Total		12,660	3,867	344	243	274	621	750	134	90	61	59

Note: A&D, alcohol & drug abuse; CaCx, cervical cancer; EC, emergency contraception; FP, family planning; FSS, family support services; GBV, gender-based violence; HTS, HIV testing services; LA, legal aid; PSS, psychosocial support; STI, sexually transmitted infection; TB, tuberculosis; VMMC, voluntary medical male circumcision.

HTS service uptake by fisherfolk

Between July and September 2017, a total of 2,666 fisherfolk out of the 3,733 reached were newly tested/referred for HTS, out of which 46 tested HIV positive; this translates to a 1.7 percent positivity rate. All of the 46 who tested positive were successfully linked to treatment; hence, there was 100 percent linkage. There were also 307 known positives who were reached during the quarter; they had already been on treatment in health facilities within the wards where the local implementing partners operate.

Between April and September 2017, a total of 4,258 out of the 6,659 fisherfolk reached were newly tested/referred for HTS, out of which 84 tested positive (1.9 percent positivity rate); they were all linked to treatment. Out of those reached, 445 were known positives on treatment.

Cumulatively, between October 2016 and September 2017, a total of 6,352 out of the 12,660 fisherfolk reached were newly tested/referred for HTS, out of which 131 tested positive, a 2 percent positivity rate; they were all linked to treatment. The project also reached 549 known positives who were already on treatment during Splash Inside Out's one-on-one and small group sessions during the year.

Table 38 and Table 39 below illustrate the utilization of HTS between October 2016 and September 2017.

Table 38. HTS service uptake by fisherfolk, October 2016 to September 2017.

Period	County	Number Reached	Newly Tested/Referred	New Testing Positive	Known positives	Missed opportunities including those declining referrals
Oct-Dec 2016	Busia	2,136	607	5	26	407
	Kisumu	1,028	588	35	33	1,503
Jan-Mar 2017	Busia	2,222	681	5	21	1,520
	Kisumu	615	218	2	24	373
Apr- Jun 2017	Busia	1,559	966	4	26	567
	Kisumu	1,367	626	34	112	629
July-Sep 2017	Busia	1,612	1,255	12	8	349
	Kisumu	2,121	1,411	34	299	411
Total		12,660	6,352	131	549	5,759

Table 39. HTS service uptake by fisherfolk, October 2016 to September 2017.

Period	County	Number Reached	Newly Tested/Referred	New Testing Positive	Known positives	Missed opportunities including those declining referrals
Oct 2016 to Mar 2017	Busia	4,358	1,288	10	47	1,927
	Kisumu	1,643	806	37	57	1,876
Apr to Sept 2017	Busia	3171	2221	16	34	916
	Kisumu	3,488	2037	68	411	1040
Total		12,660	6,352	131	549	5,759

All of the 549 known positives were on treatment in link health facilities within the eight wards where the local implementing partners operate (six in Kisumu and two in Busia).

HTS outreaches

Between July and September 2017, there were 760 missed opportunities for HTS among the 3,733 fisherfolk reached. In order to address the missed opportunities, the two local implementing partners organized and conducted 20 integrated outreaches in Kisumu (16) and Busia (4). In Busia, 1,167 (574 Male; 593 Female) fisherfolk were tested. In Kisumu, 1,007 (518 Male; 489 Female) were tested, with 27 positives, a 2.6 percent positivity rate while in Busia 160 (56 Male; 104 Female) were tested with no positive. Overall, twenty-seven individuals (12 Male; 15 Female) out of the total 1,167 (574 males, 592 females) tested between the two counties returned HIV-positive results, translating to a 2.3 percent positivity rate. Twenty-six (11 Male; 15 Female) of them were linked to treatment; hence, there was 96 percent linkage.

Between April and September 2017, the two local implementing partners conducted 32 outreaches in Kisumu (25) and Busia (7), where 1,791(942 Male; 849 Female) fisherfolk, including the missed opportunities, were tested for HIV. Out of them, 37(18 Male; 19 Female)

tested positive, translating to a 2 percent positivity rate. Among those testing positive, 36 (17 Male; 19 Female) were linked to treatment, translating to 97 percent linkage. As at APR, there were 5,759 missed opportunities for HTS among the 12,660 fisherfolk reached. The local implementing partners organized 68 outreaches where peer educators mobilized their peers, including those who had missed the opportunity, to access HIV testing. There were 4,359 (2,118 Male; 2,241 Female) fisherfolk reached during the outreaches and tested for HIV. Of them, 75 (40 Male; 35 Female) tested HIV positive, out of whom 74 (39 Male; 35 Female) were successfully linked to care. This translates to 99 percent who were linked to care.

Condom distribution among Fisherfolk

Condom distribution was also done as a component of the comprehensive care package. As a result, a total of 111,611 condoms were distributed to 11,076 (5,054 Male; 6,022 Female) fisherfolk through 1,192 outlets in Kisumu and Busia counties, as indicated in Table 40 below.

Table 40. Condom distribution to fisherfolk, October 2016 to September 2017.

Period	County	Number of condom outlets	Number of condoms distributed	Number of individuals receiving condoms		
				Male	Female	Total
Oct 2016 to Mar 2017	Busia	310	35,152	1,615	1,402	3,017
	Kisumu	177	13,942	666	825	1,491
	Sub total	487	49,094	2,281	2,227	4,508
Apr to Sept 2017	Busia	356	30,085	1,341	1,684	3,025
	Kisumu	349	32,432	1,432	2,111	3,543
	Sub total	705	62,517	2,773	3,795	6,568
Project total		1,192	111,611	5,054	6,022	11,076

Structural interventions for Fisherfolk

Between October 2016 and September 2017, the project collaborated with the Children's Legal Action Network, to support seven legal aid clinics in Busia County. The legal aid clinics reached (169 Male; 129 Female) fisherfolk. Fisherfolk were sensitized on sexual and gender-based violence (SGBV) and its mitigation, property rights, among other issues. Consequently, one of the lawyers who participated in the clinics supported 13 individuals in handling cases related to land, child protection, and gender-based issues at a subsidized fee. Fifteen groups were also linked to microfinance institutions and other devolved funds, from which they accessed loans and other funds to expand and/or diversify individual businesses. The groups also continued with table banking, hence improving the members' economic safety nets. In Kisumu County, one group from Nduru Beach was linked to financial institutions, such as the Kenya Commercial Bank, where members were trained on financial management. This built their capacity in record keeping and business diversification.

Networking and collaboration for priority population interventions

The local implementing partners continued to collaborate with the MOH to deliver services, as well as to create demand through peer educators for such services such as condom distribution, demonstration of condom use, HTS, enrollment in HIV care and treatment, VMMC, family planning, GBV prevention, and STI treatment. Other partners included the government of Kenya's department of social services, Kenya Commercial Bank, and other microfinance institutions, which provided financial support to the fisherfolk in order to expand/diversify their businesses. Finally, the Children's Legal Action Network collaborated with the Western Region Christian Community Services in Busia to address SGBV, human rights, and property rights that affect the fisherfolk.

Challenges and way forward in priority population interventions

- There were incomplete referrals for the various biomedical services. To counter these, the local implementing partners organized for integrated outreaches to reduce the missed opportunities and intensify referrals during the first encounter at splash inside out sessions;
- There was poor understanding of some of indicators, which resulted in over-reporting. The project supported data validation and verification exercise, as well as support supervision and mentorship on reporting.
- The general election affected the number of fisherfolk reached, especially in August, since some of the peer educators were engaged in electioneering activities.
- The nurses' strike affected uptake of essential services, since some facilities were closed. Some referrals were made to health centers and hospitals, and some sought services in private facilities.

Gender mainstreaming and integration

The project continued to strengthen gender integration activities in service delivery to facilitate access to and utilization of health care services by both men and women through community-level norm change interventions and community- and facility-level GBV response services. The key activities implemented in the reporting quarter were as follows: community-level education to challenge existing negative gender norms and prevent GBV, police orientation to strengthen legal redress for GBV cases, CME and updates on GBV for HCWs, legal aid facilitation, and support for and collaboration with the gender TWGs to strengthen both facility- and community-level GBV response services.

Addressing male norms and behaviors

The project continued to implement community-level activities to explore and reduce negative gender norms that increase GBV, as well as impact access to and utilization of services. These activities aimed to prevent GBV and create demand for clinical services. The activities carried out to change norms were joint meetings with police and HCWs to improve linkages for GBV reporting and legal redress, and community-level dialogues on gender and GBV in churches, schools, and chief's *barazas*. The project continued to use the SASA! approach . A total of 3,590 people were reached with norm- and behavior-changing information in Y7Q3.

Post-GBV services

The project continued to support integrated post-GBV care services both at the community and facility levels. This led to achievements of 1,101 for the quarter and 7,448 for the APR reporting periods, as shown in Table 41 below.

Table 41. Post gender-based violence (GBV) care services, October 2016 to September 2017.

COP 2016 targets	Y6Q4	Y7Q1	Y7Q2	Y7Q3	Total	Percent achievement against COP
6,889	1,385	2,305	2,673	1,101	7,448	108%

Note: COP, Country Operational Plan; Q, quarter; Y, year.

Community-level Post GBV services

At the community level, the project continued to provide platforms for community conversations to happen with the aim of challenging gender norms and cultural practices that perpetuate GBV. These included community dialogue sessions, stakeholders' forums, and sensitization meetings. During these meetings, GBV active case identification was also done through screening by skilled members (e.g., HCWs and paralegals). The project also collaborated with the relevant gender TWGs in organizing community-level sensitizations on GBV in all counties in preparation for the general elections. During the meetings, the existing policies and legal contexts were reviewed in relation to violence against women and girls and violence against children. In Kisumu, the project supported the gender TWG in identifying and linking GBV survivors during the post-election period.



Kisumu Women's member of parliament—elect Rosa Buyu addresses the Kisumu gender technical working group meeting.

Facility-level post-GBV services

In the reporting period, the project continued to support integrated GBV care services both at the facility and community levels. At the facility level, 16 health facilities in both Nyanza and Western regions conducted supportive supervision and CME on post-rape care service provision and SGBV screening at the point of care; these reached a total of 42 HCWs. The project continued to strengthen documentation of physical violence cases in the outpatient department registers and the use of counter books in capturing other forms of GBV (nonsexual). To address gaps in postexposure prophylaxis completion, the project conducted a one-day meeting for 51 facility-based peers educators and paralegals from high-volume facilities on following up postexposure prophylaxis clients. Quarterly SGBV data review meetings and updates were also held in all the counties; these were led by the health records and information officers. In addition, the project supported debrief sessions for HCWs who offer postviolence care services. Based on

the lessons learnt from the meetings that were held between the police and HCWs in Kisumu and Nyamira counties in Y7Q2 to strengthen collaboration and linkage for legal redress, the project supported similar meetings in Kakamega and Vihiga counties. As a result, a total of 1,101 (99 Male; 1,002 Female) survivors of violence (228 from sexual violence and 873 from other GBV) received clinical services in Y7Q3, compared to 2,673 in Y7Q2; 2,305 in Y7Q1; and 1,385 in Y6Q4. This translates to an APR reach of 7,448, against the COP 2016 target of 6,889 (108 percent) (see Table 42 below).

Table 42. Survivors of gender-based violence (GBV) reached with services, Y6Q4 to Y7Q3

County	COP 2016 Targets	Y6Q4 (GBV- Sexual & Other)	Y7Q1 (GBV- Sexual & Other)	Y7Q2 (GBV- Sexual & Other)	Y7Q3 (GBV – Sexual)	Y7Q3 (GBV- Other)	Total	% Achievement
Bungoma	860	192	261	230	60	261	1,004	117%
Busia	803	136	89	117	11	81	434	54%
Homabay	690	106	156	134	7	107	510	74%
Kakamega	986	211	627	596	60	104	1,598	162%
Kisii	302	60	112	186	11	36	405	134%
Kisumu	677	146	122	257	5	44	574	85%
Migori	800	188	352	368	23	138	1,069	134%
Nyamira	788	227	403	468	44	53	1,195	152%
Vihiga	983	130	183	317	7	49	686	70%
Total	6,889	1385	2305	2673	228	873	7,448	108%

Note: COP, Country Operational Plan; GBV, gender-based violence; Q, quarter; Y, year.

A total of 208 survivors of sexual violence were tested for HIV; 184 received postexposure prophylaxis; 121 received STI treatment; and 66 were linked to legal, police, psychosocial, and protection services. The project also supported the rescue of 24 girls aged between 11 and 15 years from violent/hostile environments and linked them to safe shelter houses. Two (2) safe shelter houses in Kakamega and Kisumu counties were supported with dignity packs and food to maintain the rescued girls. A total of 21 cases proceeded to court, 2 were concluded and 19 are on going. In Vihiga, the paralegals reported a number of cases of threats to known witnesses, many defiled children being moved away from their homes, and parents/guardians changing phone contacts to avoid follow-up.

Notably, the number of cases of GBV that are managed at the project-supported health facilities dropped as a result of the ongoing nurses' strike, since most of the middle-level and small facilities are managed by nurses who also offer postviolence care services.

DREAMS interventions

DREAMS works to help girls become determined, resilient, empowered, AIDS-free, mentored, and safe young women. It seeks to prevent new infections among adolescent girls and young women between the ages of 10 and 24 years in the HIV high-burden counties.

In COP 2016 period, the APHIAplus Western Kenya project implemented the DREAMS project in eight subcounties, two in Kisumu and six in Homa Bay, which covered 34 wards. Working

with 341 trained mentors, 588 EBI-certified facilitators, 510 DREAMS Ambassadors, and qualified service providers from 40 link health facilities, the project delivered age-appropriate DREAMS interventions to 62,310 adolescent girls and young women (AGYW) as at the end of COP 2016 period. Through its engagement with the community, the project has established 196 safe spaces where AGYW receive interventions. The project also implemented interventions during the reporting period targeting the identified, typical male sex partners of the AGYW.



The Ogande Safe Space in Homa Bay East ward, where adolescent girls and young women receive HTS.

AGYW enrollment and exits

By the end of the reporting period, the project had enrolled 62,423 AGYW into the program out of the targeted 72,344 as shown in Table 43. In Q4, using the girl roster records and the vulnerability criteria for identifying AGYW at the highest risk of HIV acquisition, the project enrolled a total of 28,911 AGYW. The enrollment, which represented an 86 percent achievement against the target, was, however, hampered by the hostile environment caused by electioneering issues. In both Kisumu and Homa Bay counties, a few DREAMS mentors were treated roughly after being accused of buying ID cards. To ensure the safety of DREAMS staff and volunteers, the project halted recruitment and activity implementation for the duration of the elections, when the environment was not conducive to project activities. The project also adopted other age-clarifying documents (e.g., birth certificates, baptismal cards, and school leaving certificates). To find new AGYW, the project relied on the girl roster records and list of OVC in the catchment areas.

Table 43. Enrollment of AGYW against targets, by county and age cohort.

County	COP target (10–14 years old)	Reach (10–14 years old)	COP target (15–19 years old)	Reach (15–19 years old)	COP target (20–24 years old)	Reach (20–24 years old)	COP target	Total reach	Percent
Homa Bay	4,854	5,014	13,058	13,177	13,058	9,873	30,970	28,064	91
Kisumu	8,140	7,973	16,617	14,982	16,617	11,404	41,374	34,359	83
Total	12,994	12,602	29,675	27,299	29,675	20,880	72,344	62,423	86

Note: AGYW, adolescent girls and young women; COP, Country Operational Plan; GBV, gender-based violence; Q, quarter; Y, year.

A total of 20,066 AGYW had received the optimal number of interventions (more than 6) as at the end of Q3. Therefore, the project reduced the level of effort on this cohort to concentrate on the newly enrolled AGYW. As at the end of the reporting quarter, the project had provided a total of 46,467 AGYW (75 percent) with more than four services. Of all the enrolled AGYW, 708 AGYW exited the program. The majority of exits were a result of relocation and loss to follow-up, and a few voluntarily chose to leave the program. Those leaving the program cited their reason as no longer being interested in it. A total of 26 AGYW (4 aged 10 to 14 years, 7 aged 15 to 17 years, and 15 aged 18 to 24 years) died of various causes, including murder, road accident, post-abortion complications, death while giving birth, and illnesses. By the end of the reporting quarter, 61,715 AGYW out of the enrolled 62,423 (99 percent) had received social-asset-building interventions. The remaining number consisted of those who were enrolled late, as the project came to a close in COP 2016 period ; these AGYW will receive services in the next quarter.

Services to the AGYW were categorized into four subpurposes, namely:

1. Empowering girls and young women.
2. Mobilizing communities.
3. Strengthening families.
4. Decreasing HIV risk among sexual partners of AGYW.

Details about the services are provided below.

1. Empowering girls and young women

Under this category of interventions, the project delivers interventions that empower AGYW to reduce their risk of acquiring HIV. These interventions include biomedical interventions (HTS, enrollment to treatment, pre-exposure prophylaxis [PrEP], condoms, contraception, postviolence care, and STI screening and management), EBIs, and social-asset-building interventions. The project works directly with the county health management teams to ensure high-quality service delivery of the biomedical interventions. The project also supports, where appropriate, the training of MOH officers in the delivery of services. For PrEP, the project trained a total of 77 health care providers.

HIV testing services

By the end of the quarter, the project had provided HTS to 45,000 of the 62,423 (72 percent) AGYW enrolled. Besides those who were provided with HTS, 11,442 newly enrolled AGYW reported having been tested and having known their status within three months prior to the date of their enrollment. As of September 30, 56,442 of 62,423 (91 percent) AGYW know their status. There were 490 AGYW who tested HIV positive; 404 (82 percent) of them were linked to treatment. Those AGYW who were not enrolled were still in different stages of counseling; one absconded from the project altogether. The HTS that was provided suffered from the industrial action in a few areas, but still there was optimal access to link facility service providers to serve the AGYW. Together with HTS and as appropriate, AGYW accessed condom education and commodities. A total of 41,128 AGYW received condoms. As a result of education on the contraceptive method mix, 3,039 AGYW received individual contraceptive counseling. Out of these, 23 took up oral pills, 76 received injections, 97 received implants, and 2 received an intrauterine contraceptive device. See breakdown of service uptake in Table 44 below.

Table 44. Achievement of interventions to empower AGYW.

Empowering intervention	Project achievement	COP target (applicable)	Percent achievement
Total enrolled	62,423	72,344	86%
HTS provided	45,000	62,423	72%
Knew status past 3 month prior to enrollment	11,442	-	-
Total number of AGYW who knew status	56,442	62,423	91%
Enrollment Tx	404	490	82%
PrEP education	5,697	-	-
PrEP initiation	1,188	6,232	19%
Condoms	43,281	-	-
Contraception education	37,869	-	-
Individual contraception counseling	3,039	-	-
Contraceptive uptake	198	-	-
EBI	38,979	62,310	
Postviolence care	1,445	11,422	13%
Social asset building	62,423	62,310	99%

Note: AGYW, adolescent girls and young women; COP, Country Operational Plan; EBI, evidence-based intervention; HTS, HIV testing services, PrEP, pre-exposure prophylaxis; Tx, Treatment.

PrEP

At the end of the quarter, the project had enrolled 1,188 (550 in Kisumu and 638 in Homa Bay) eligible AGYW on PrEP against a target of 6,232 (19 percent). Furthermore, the project continued to provide PrEP education to AGYW aged 18 to 24 years, which reached 5,697 AGYW. In the reporting quarter, a total of 418 (304 in Kisumu and 114 in Homa Bay) clients were enrolled. Seven clients were discontinued on PrEP in Kisumu (3 due to reduced risk, 1 due to inability to adhere, and 3 out of their voluntary choice). Those who discontinued due to lowered risk or by choice continued on PrEP for 28 days after their last exposure. Seven AGYW were restarted on PrEP. In Homa Bay, one AGYW stopped due to reduced risk and one declined to give a reason for stopping. An (1) AGYW was restarted on PrEP after she was reassured and

counseled on PrEP side effects. The project continued to work closely with the MOH to ensure high-quality PrEP provision. The project has supported training of MOH staff on PrEP. The project continued to promote other HIV prevention methods and contraception to be used in combination with PrEP.

EBI

The project continued to implement age-appropriate EBIs for eligible AGYW both at the safe spaces and in schools. At the end of the reporting period, 38,979 AGYW had completed all the EBI waves, and 36,347 AGYW, the majority of whom were newly enrolled, were in different stages of the various EBI sessions. The project worked with trained and certified facilitators and teachers to implement My Health, My Choice; Healthy Choices for a Better Future; and Shuga 2. In an effort to ensure complete opportunities for HIV prevention and protection from unintended pregnancies, the project continued to provide condom education, condom distribution, contraceptive method mix education, and referrals to eligible AGYW. These were embedded in the appropriate EBI.



Adolescent girls and young women participate in an evidence-based intervention session at Obino Safe Space in Kisumu East.

Post-violence care

The project provided direct support to AGYW survivors of GBV through facility-level CME, community-level (safe space) health education, and commemoration of national and international events such as the 16 Days of Activism Against Gender-Based Violence, International Women's Day, Menstrual Hygiene Day, and Day of the African Child. In addition, active case identification of GBV survivors was done through GBV screening exercises at the safe spaces. During GBV screening sessions, health care workers were involved to offer clinical services to the girls who might have encountered any form of violence (past or present). At the same time, AGYW were referred for other GBV services outside of clinical management (e.g., medical and legal information and economic empowerment).

In January 2017, the project trained 34 paralegals (one per ward) to facilitate effective referrals to the police and legal aid. The paralegals conducted medicolegal clinics to educate AGYW on their rights and GBV prevention while also ensuring that AGYW survivors of GBV had comprehensive documentation from health facilities and other service delivery points to enhance litigation. Furthermore, 48 police officers and local administrators from Kisumu and Homa Bay were sensitized on gender/GBV and the services offered by DREAMS project. This sensitization aimed to strengthen referrals for legal redress. As a result of the medicolegal sensitizations, 67 AGYW reported cases of indecent acts in the APR period. Prior to the awareness sessions, a number of AGYW considered indecent acts (e.g., touching private parts) to be “normal.”

A total of 1,445 AGYW (185 in the 10- to 14-year-old age group, 661 in the 15- to 19-year-old age group; and 599 in the 20- to 24-year-old age group) received post-GBV service, an APR reach of 13 percent. In Kisumu, 475 survivors (5 of sexual violence and 470 of physical/emotional violence) were reported and received clinical management. In Homa Bay, a total of 970 (6 of sexual violence and 964 of physical/emotional violence) were served. Of these cases, 11 were related to sexual violence and 1,434 were related to physical/emotional violence. All of the 11 survivors of sexual violence received postexposure prophylaxis, STI screening, and social support referrals. Eight cases were reported to the police for legal redress; two were concluded with penalties of life imprisonment; and six were still in court pending ruling. The project recorded high GBV case reporting among AGYW aged 15 to 19 years and 20 to 24 years compared to those in the 10- to 14-year-old cohort. Most of these cases were physical/emotional in nature and involved intimate partners.

The project will continue to sensitize the AGYW and communities at large on GBV prevention and response. The project will also continue to strengthen collaboration with the paralegal network in Homa Bay to add a voice through vibrant anti-GBV advocacy forums. GBV screening will also continue both at the community and at the facility levels.

2. Mobilizing communities

The project continued to engage community members to create safe environments for AGYW to thrive and also reduce the impact of risk-increasing norms. By implementing SASA! and holding community forums, the project worked with parents and young men to clarify norms and values. Innovatively, the project held several sessions with the parents and guardians of AGYW to provide feedback on the DREAMS project and to further encourage them to support the AGYW’s participation in HIV prevention initiatives.

School-based HIV and violence prevention

AGYW participated in school-based HIV and violence prevention sessions reaching a total of 13,023 AGYW in COP 2016 period.

3. Strengthening families

The interventions in this category seek to strengthen families economically, as well as build the capacity of parents and guardians to parent positively.

Programs for parents/caregivers of AGYW aged 10 to 19 years

The project facilitated training of caregivers of AGYW aged 10 to 17 years using the Families Matter! Program 1 (FMP 1) curriculum. The aim was to improve family interactions, improve knowledge on HIV risks for young people, and promote positive parenting and adult-child communication on sexuality and sexual risk reduction. A total of 2,583 out of a target of 4,229 (61 percent) caregivers received and completed the FMP 1 intervention. As at the end of the reporting period, 680 caregivers were in different stages of the FMP 1 curriculum. As the FMP 2 curriculum is still unavailable, the project established caregiver stakeholders’ dialogue sessions, which are held at the safe spaces monthly. Through these dialogue sessions, where matters of adolescent sexuality and parent-child communication are dealt with, the project reached a total of 8,102 caregivers of AGYW aged 13 to 17 years.



A parent practices communication with her daughter as part of the Families Matter! Program 1.

Increased access to cash transfer for AGYW aged 15 to 24 years

The identification and enrollment of beneficiaries in the DREAMS cash transfer initiative continued during the reporting period. This was in consideration of the increase in the targeted AGYW from 6,205 to 13,189. To this end, a total of 1,681 new AGYW and their families were enrolled in the DREAMS cash transfer initiative, with the aim of increasing their access to money in emergencies and building their asset base to cope with family economic vulnerabilities. While the purpose of the DREAMS cash transfer is to assist the households to meet basic needs, 11 AGYW reported that they used their funds to start businesses. To date, the project has managed to enroll 3,790 AGYW in the cash transfer initiative as shown in Table 45.

The project continues to work with the government agencies to ensure that only eligible households receive the cash transfer and that there is no double dipping.

Table 45. AGYW that benefited from Cash transfer

County	COP 2016 target	Y7Q3 reach	Total reach	Percent reach
Kisumu	7,385	921	2,264	31%
Homa Bay	5,804	760	1,526	26%
Total	13,189	1,681	3,790	27%

Note: COP, Country Operational Plan; Q, quarter; Y, year.

Increased access to education support for AGYW aged 10 to 24 years

The objective of education subsidies in DREAMS is to increase education attainment for all AGYW after needs assessment. To retain AGYW in school, a total of 3,140 AGYW (1,396 in Homa Bay and 1,744 in Kisumu) were reached with education subsidies (see Table 46). Of this number, 115 AGYW (11 aged 10 to 14 years, 90 aged 15 to 19 years, and 14 aged 20 to 24 years) were supported with school fees. All AGYW who received school fees were supported

with the learners' package,⁴ with the aim of reducing their predisposition to engaging in risky sexual behavior.

Cumulatively, the project has supported a total of 18,037 (3,537 aged 10 to 14 years; 10,551 aged 15 to 19 years; and 3,949 aged 20 to 24 years) AGYW with education subsidies.

Table 46. AGYW beneficiaries of education subsidies.

County	AGYW (aged 10 to 14 years)	AGYW (aged 15 to 19 years)	AGYW (aged 20 to 24 years)	Total
Homa Bay	163	1,110	123	1,396
Kisumu	281	1,069	394	1,744
Total	444	2,179	517	3,140

Combination socioeconomic approaches for AGYW aged 10 to 24 years

The project continued to provide a comprehensive package of economic strengthening services to grow the AGYW capacity to generate income and reduce their vulnerability to HIV infection. This included the provision of financial capability and entrepreneurship trainings to eligible AGYW. The project decided to initially provide the trainings to the 15- to 24-year-old cohort, as they were more eligible for the entrepreneurship training that is a follow-on from FC. Table 47 below shows the achievements of the project in reaching the AGYW.

Table 47. AGYW reached through combination socioeconomic approaches

Age	Financial capability training	Target	Entrepreneurship training
10–14 years	987	12,994	83
15–19 years	22,608	29,675	472
20–24 years	17,533	29,675	734
Total reach	41,128	72,344	1,289

In the period under review, the project supported AGYW to engage in income-/asset-growing activities that boost their self-esteem. Increasingly, AGYW have expressed enthusiasm in the ability to learn new ventures, including basketmaking, soapmaking, weaving, and baking, among many other activities that are performed at the safe spaces across the program areas. A number of AGYW who were supported to attend vocational training raised funds and initiated a mat-weaving enterprise.

Additionally, 60 AGYW (7 aged 15 to 19 years and 53 aged 20 to 24 years) who were trained as facilitators for the various EBIs continued to earn income from facilitation; this was in addition to the 171 trained in the previous quarters. Another 56 (28 aged 15 to 19 years and 28 aged 20 to 24 years) were supported to gain vocational skills, and 16 were linked to internship opportunities where they not only practiced their skills and earned some income but also got the opportunity to expand their network.

⁴ The learners' package includes basic sanitary items, including sanitary towels, pants, soap, a geometrical set, toothpaste, and a toothbrush.

Sixteen AGYW (3 aged 15 to 19 years and 13 aged 20 to 24 years) were reported to have started small enterprises, for instance hairdressing. Additionally, 285 AGYW who were trained on entrepreneurship developed business plans, some of which the project will support with start-up kits. Two county-level business plan vetting committees, led by the county directors of youth in Kisumu and Homa Bay, were constituted in the reporting quarter. This later resulted in roundtable meetings among the project staff, AGYW, and representatives from the Department of Gender and Social Services, all of whom agreed to assist the AGYW in group formation and registration to place the AGYW at a better place to receive funds from other agencies, including the government.

4. Reducing risk in male sexual partners

During the reporting period, the project continued to work to reduce risk in male sexual partners. In each of the 34 wards, the project conducted a male sexual partner characterization, which identified and ranked the typical male partners of AGYW aged 15 to 24 years. Interventions were then tailored to reach those specific cohorts of males, providing them with condoms, HTS, and VMMC. The project also invested in implementing violence-reduction interventions with the men. By the end of the reporting period, the project had successful referral to and uptake of VMMC by 812 males. The project also provided HTS via supporting outreaches to males. A total of 4,656 males were tested for HIV, with a yield of 39 who were HIV positive. Among them, 31 were linked to treatment and 3 absconded from their areas. Five males were still undergoing counseling for treatment enrollment as at the end of the reporting period.

DREAMS new HIV infections

The project conducted a desk review of available data for a total of 28,035 in the cohort of girls enrolled prior to October 2016. Of this cohort, 21,502 (77 percent) reported ever receiving an HIV test with a negative result at enrollment; 332 (1 percent) had an HIV-positive result; 103 declined to disclose their status; and 6,098 had not received an HIV test.

HIV testing done between April and September 2016 indicated that 27,703 of the 28,035 females eligible for testing 23,892 were tested, and 104 (0.4 percent) were identified HIV positive; 3,935 were not tested in the period. In the period from October 2016 to September 2017, 27,599 females in the project were eligible for HIV testing; 17,419 were tested for HIV and 23 (0.1 percent) identified as HIV positive. The overall HIV prevalence of the AGYW in the project is at 1 percent (490 out of 45,000) of those who have received and HIV test and know their status.



DREAMS young women aged 20 to 24 years in Kar Geno show off the chairs for hire that they purchased as an income-generation activity. The group is registered.

Quality of implementation

The project ensured that all interventions were implemented through updated standard operating procedures, which personnel have been trained on. The project supported the training of various cadres of facilitators and mentors to provide high-quality delivery of interventions. All EBI facilitators were trained and certified. Embedded monitoring and support supervision visits, complete with the execution of an internal Site Improvement Through Monitoring System, helped the project to maintain quality.

In biomedical services, the project worked closely with the MOH, drawing the HTS, CMM, and PrEP services providers from the link facilities. The project also supported training of MOH staff, especially on PrEP, and participated fully in the county health management team TWGs for HIV and AIDS, PrEP, adolescents, and reproductive health.

Collaboration and Networking for DREAMS implementation

The project has managed to create and support the necessary environment for the implementation of DREAMS. Through stakeholder mobilization and sensitization, the project has been able to set up safe spaces and utilize available community resources to implement interventions. Intervention implementation has been enabled by working with local administration, community-based organizations, faith-based organizations, parents, and teachers to identify AGYW and safe spaces and also to directly deliver some interventions, including mentorship. The barriers to effective implementation have always been the political disturbances and difficulty to recruit and retain the older cohort of young women.

During the reporting period, the project continued to tailor its interventions to fit the needs of 20- to 24-year-olds. Furthermore, the project continued to use its innovative tools (e.g., comics,

Condolympics, and activities suggested by AGYW, such as fashion shows and exchange programs) to attract and retain AGYW. On the whole, the project operates at over 80 percent level of implementation.

Subpurpose 2. Increased access to and utilization of malaria prevention and treatment services

Malaria prevention and treatment services

Linkage and coordination

In Y7Q3, the project continued to arrange for joint partner planning meetings. One meeting for malaria implementing partner linkage and coordination was successfully held, which brought together APHIA*plus*, Population Services Kenya, University Research Co., PIMA, Malaria Care, Kenya Civil Society Strengthening Program, AIRS, Maternal and Child Survival Program, and Palladium (Tupime Kaunti). There were 12 participants (9 Male; 3 Female).

Other activities jointly done were a data review meeting organized by the Kenya Civil Society Strengthening Program, which reached 63 HCWs, and a data review meeting organized by Chemonics International, which reached 64 HCWs. The project provided supportive supervision, which was jointly co-supported by KANCO. The total number of facilities visited was 92 and 285 HCWs (131 Male; 154 Female) in Nyanza, and 117 (34 Male; 83 Female) HCWs in Western were reached.

During this quarter, the main milestones for linkage were the review of the support supervision Tool and bringing together of the CMCCs for reviewing activities and joint planning aimed at strengthening advocacy for the malaria work that is supported by the US Agency for International Development (USAID) in the region.

A number of activities planned by the project, such as supportive supervisions, stakeholder forums, and technical working group meetings, continued to be jointly attended by other USAID malaria program implementing partners in the area at County and Sub County levels. During the meetings, it has been noted that the joint approach has many advantages, mainly cost-cutting, show of partnership, and reduced waste of time when every partner was supporting the same activity at different times/places; hence, there was a reduction in duplication of service to the partner, MOH. The malaria program implementing partner meetings were held in Busia and Kisii to include all malaria program implementing partners in the region.

Malaria supportive supervision

The project supported all six counties in Nyanza, which reached a total of 42 Sub Counties and 103 health facilities. As a result of this support, 489 HCWs (136 Male; 353 Female) were provided on-the-job training/mentorship on malaria management. Mentorship and on-the-job training were provided based on the gaps in knowledge and skills that had been identified in malaria case management (see Table 48 below).

Table 48. Health facilities and health care workers reached.

County	Total Sub Counties	Sub Counties supported	Number of health facilities reached	Number of health care workers reached		Total reached
				Male	Female	
Kisii	8	2	19	25	36	61
Nyamira	9	1	6	12	3	15
Homa Bay	5	3	38	53	41	94
Migori	8	1	15	24	21	55
Siaya	6	3	21	13	197	210
Kisumu	6	1	4	9	55	64
Total	42	11	103	136	353	499

A joint support supervision meeting funded by KANCO was attended by other partners, including APHIAplus technical officers. Based on the support supervision tool that was reviewed, the findings still indicated challenges in high malaria positivity rates; irregularity in the artemether-lumefantrine dosage schedule; inadequate advocacy, communication, and social mobilization materials in a number of facilities; and inconsistent availability of the outpatient tally sheets (MOH 705A and MOH 705B). These were addressed through mentorship and on-the-job training during the visits. Another corrective measure that was put in place was holding feedback sessions with all staff; this assigned responsibility for making desired changes to all staff. Topics that were emphasized were the role of data for decision-making at the local levels and the responsibility of HCWs to tabulate summary data at facility levels to indicate trends. These findings made in the supervision visits have remained challenges for the malaria program for some time now. The nurses' strike during the quarter worsened the situation and made project support incomplete.

The project seized the opportunities to distribute information, education, and communication materials, as well as the current malaria guidelines, to most of the facilities. The HCWs were urged to continue monitoring malaria trends in their respective areas by charting findings and periodically alerting the Sub County malaria control coordinators on the levels reached.

To address the challenges, the project, in consultation with Tupime County, will work toward supporting data review meetings. The focus will be on gaps identified during supportive supervision visits and recommendations for strengthening clinical skills through practice, as recommended by the TWGs and the national malaria guidelines.

Malaria stakeholder forums at county and Sub County levels

The project continued to support County and Sub County malaria stakeholder forums in all the ten Counties, which reached a total of 1,293 as shown in the Table 49 below. Out of these, 320 participants were from Nyanza counties (128 Male; 192 Female), and 973 (456 Male; 437 Female) from Western counties. The forum comprised representatives from sustainable water

and sanitation programme and the malaria program implementing partners.. During the meetings, each malaria program implementing partner was usually given time to present the project role, activities undertaken, areas of operation, and planned activities for the next quarter. The issues, gaps, and challenges that were identified were discussed, and recommendations were made on how to solve them locally first. The project continued to follow up on the identified gaps to address with the respective partners in each region. Action plans were drawn, and roles and responsibilities were outlined and reviewed in subsequent meetings.

Table 49. Showing coverage distribution by County for stakeholder forum meetings

County	Number of sub counties	Sub counties reached	Participants reached		Total reached
			M	F	
Migori	8	2	34	59	93
Kisii	9	1	8	17	25
Nyamira	5	0	123	79	202
Homa Bay	8	0	0	0	0
Kisumu	6	3	33	42	75
Siaya	6	4	36	74	110
Vihiga	5	5	111	100	211
Kakamega	4	4	118	74	192
Busia	4	4	97	104	201
Bungoma	6	6	141	148	289
Total	61	29	578	618	1,293

Malaria TWG meetings

Malaria TWG meetings were held in nine sub counties in Nyanza, which reached 104 members (43 Male; 61 Female). In Western, malaria TWG meetings were held in all the four Counties, reaching 345 members (211 Male; 134 Female) from the 18 Sub Counties as indicated in Table 50. The gaps that had been identified during the Supportive Supervision meetings and stakeholders' forum were followed up by the TWGs, supported by the project.

Among other issues, the respective TWGs recommended that data collection tools be availed and improved. Malaria Care and Tupime Kaunty, the partners that handle the quality of malaria case management and diagnosis to improve data quality assessments will address the challenges identified; more importantly, a partner will follow up on the key malaria indicators.

Table 50. Participants reached through TWG meetings.

County	Total Sub Counties	Sub Counties reached	Number of participants		Total reached
			Male	Female	
Migori	8	0	0	0	0
Kisii	9	1	5	9	14
Nyamira	5	0	0	0	0
Homa Bay	8	1	8	5	13
Kisumu	6	4	16	26	42
Siaya	6	3	14	21	35
Vihiga	5	5	48	48	96
Bungoma	10	6	21	41	62
Kakamega	12	5	44	40	84
Busia	7	4	21	29	50
Total	76	29	177	219	396

Subpurpose 3. Strengthened and functional county health systems

Human resources for health services

In the July to September period, the project supported 564 HRH contracted by counties to support HIV service delivery in the project-supported sites in nine counties, as shown in Table 51. The project directly engaged an additional 1,645 long- and short-term contract staff to enhance the implementation of the 90-90-90 strategy and to bridge the gap in COP 2016 target achievements (Table 52).

Table 51. HRH county-contracted staff establishment, by county, as at the end of Y7Q3.

Cadre	Homa Bay	Kisumu	Kisii	Migori	Nyamira	Bungoma	Busia	Kakamega	Vihiga	Total
RCO	8	9	4	19	0	15	14	39	19	127
Data clerk	10	5	4	14	0	2	0	0	11	46
HTC counselor	54	15	18	39	28	34	18	22	21	249
Laboratory technician	1	0	0	5	0	3	2	9	4	24
Nurse	3	2	1	1	0	1	4	28	0	40
Nutrition officer	2	0	1	3	0	2	2	3	1	14
HRIO	0	0	1	0	0	3	10	47	0	61
Pharmacy technician	0	0	0	0	0	0	2	1	0	3
Total	78	31	29	81	28	60	52	149	56	564

Note: HRIO, health records and information officer; HRH, human resources for health; RCO, registered clinical officer.

Table 52. HRH project-contracted staff establishment, by county, as at the end of Y7Q3.

Cadre	Homa Bay	Kisumu	Kisii	Migori	Nyamira	Bungoma	Busia	Kakamega	Vihiga	Total
ASC	12	6	3	13	14	14	7	40	12	121
Mentor mother	18	3	0	6	4	4	4	11	4	54
Peer educator	54	32	14	65	91	151	106	347	147	1,007
RCO	14	7	1	3	6	10	2	27	2	72
Data clerk	6	4	1	8	4	11	4	1	0	39
HTC counselor	0	10	0	12	9	16	9	140	7	203
Laboratory technician	5	4	1	0	6	7	6	5	1	35
Nurse	11	10	1	5	5	8	3	12	3	58
Nutrition officer	4	5	1	6	5	5	6	10	4	46
HRIO	0	0	0	0	1	0	1	1	0	3
Pharmacy technician	1	3	0	0	2	0	1	0	0	7
Total	125	84	22	118	147	226	149	594	180	1,645

Note: ASC, ; HRIO, health records and information officer; HRH, human resources for health; HTC, HIV testing and counseling; RCO, registered clinical officer .

The project had a memorandum of understanding (MoU) with the county governments that defined the managerial and supervisory roles of the project and the county government. Part of the arrangement in the MoU was that the county would absorb the contract staff at the end of COP 2016 into the ministry of health payroll. Two counties (Nyamira and Busia) successfully did. The other eight counties faced budgetary constraints and were not able to cater for any new staff in their payroll. One main reason was the inflation of the health personnel wage bill, which arose from the resolution of the nurses' and doctors' industrial actions after the signing of collective bargaining agreements. Under the circumstances, the project was able to retain the staff on short-term contracts to the end of the project.

Experience from working with the county has shown that it is good practice to engage staff to work together, since this provides a long-term focus and solution to HRH. However, because the devolved systems were at its first term, it was challenging to work with some of the counties where the structures and roles within the government were not fully operational. Government bureaucracy tended to slow down implementation, especially when it came to supervision of the contracted HRH staff, appraisal, disciplinary issues, and communication. Under the circumstances, better results were achieved through HRH that had direct contracts with the project.

The main challenge experienced during the reporting year was the doctors' and nurses' industrial actions. The nurses' industrial action, in particular, had more severe impacts on the project; it resulted in reduced patient flow and nondelivery of maternity and primary health care services, such ANC and immunizations. We were not able to meet our PMTCT-related targets, especially those related to known status. Our contracted HRH did continue to offer services, so that all HIV patient care centers where they were present retained their patients on follow-up and enrolled new ones. They also supported other services like ANC, immunization, maternity, and other outpatient services whenever called upon. However their efforts were not enough to mitigate the effects of the strike.

Health care financing

The project continued to implement performance-based incentives to health facilities, which are based on their performance in the following service areas: linkage to care, ART initiation, PCR at six to eight weeks, PCR-positive clients put on ART, and net gain for current on ART and viral load suppression efforts. The incentives were most effective during the rapid results initiative periods of February to June 2017, when it motivated the staff to work harder to bridge the gaps that had been identified. The last payment for COP 2016 period was processed; bringing the total payments to just under US\$150,000 for the period. Most health facilities continued to make use of these incentives to support the HIV service infrastructure and health care worker motivation. Illustrative usage is as shown in Table 53.

Table 53. Illustrative use of performance-based incentives to health facilities, Y7Q3.

Health facility	Amount received	Item procured/PBI disbursement used on	Cost of item
Likuyani	23,832	Stationery	7,890
		Motivation of staff	6,300
		HP black cartridges	3,800
		Modem	2,500
		Casio calculator	1,550
		Transport home visit	1,792
Kabondo Sub County Hospital	165,420	Staff Tea	54,876
		Staff Incentive	44,376
		Repair of autoclave machine	29,584
		Hospital sign board and water dispenser	19,718
		Extension cables to CCC	10,000
		Stationery	6,866

Commodity security

Support to improved supply chain logistics and commodity management

The project supported all 55 ART reporting sites (47 central and 8 standalone sites) to submit monthly reports to the Kenya Medical Supplies Authority logistics management information system. The project achieved an 89 percent reporting rate in the quarter. Table 54 below shows the reporting rates per county. The reporting sites increased by three from the previous quarter, with the project having supported the upgrade of two central sites and one standalone site in Kakamega and Kisumu counties.

Table 54. Central and satellite ART commodity sites' reporting rates, July to September 2017.

County	Central ART sites	Satellites supported	Satellites reporting	Average reporting rate
Busia	4	32	28	88%
Homa Bay	3	34	34	100%
Kisumu	3	24	24	100%
Migori	4	47	42	89%
Kakamega	16	171	152	89%
Kisii	1	14	14	100%
Nyamira	5	104	75	72%
Bungoma	7	85	79	93%
Vihiga	4	43	44	100%
Standalone sites	-	8	7	89%
Total	47	562	500	89%

Note: ART, antiretroviral therapy.

Some of the satellite facilities that were staffed by nurses continued to experience challenges in reporting during the strike; hence, the optimal reporting rate was not obtained in some counties. This affected facilities in Migori, Nyamira, Kakamega, Busia, and Bungoma. One standalone site failed to report, which resulted in an 89 percent reporting rate for this category.

To support quantification, ordering, storage, and inventory management, the project supported all of the 55 ART ordering sites through continuous off-site mentorship and on-the-job training on good commodity management practices. The project also supported procurement of ART reporting tools daily activity register (DAR) for ARVs and OIs, facility consumption data report and request (FCDRR), and FMAPs across all supported sites to improve on documentation and reporting for ARV drugs.

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

In the quarter, the project continued to support all of the nine counties to hold monthly commodity TWG meetings to coordinate commodity management and reporting. Under the project's auspices, the redistribution of off-schedule drugs like plain Zidovudine tablets, Dolutegravir, Amphotericin B, and PrEP commodities, as well as short-expiry drugs, was undertaken in various counties, including Kisumu, Kakamega, Migori, Nyamira, and Homa Bay counties. The project provided support in carrying out supportive supervisions at county and subcounty levels to help monitor commodity management challenges at the health facilities. Identified gaps were addressed through mentorship and on-the-job training, which also aimed to strengthen pharmacovigilance reporting among the health care workers.

The project continued to strengthen multidisciplinary teams at facilities to discuss suspected treatment failures and continuous monitoring of adverse drug reactions in patients.

The project worked with the Clinton Health Access Initiative to conduct training on introducing the web-based ART dispensing tool (ADT) in all reporting health facilities. The project and the Clinton Health Access Initiative also supported the installation. The tool, besides managing drug inventory, patients' records, and dispensing, also has capability to generate current patients' viral

load from the National AIDS and STI Control Programme website. Table 55 shows the progress made in installing the web-based ADT versus the project's target.

Table 55. Web ART dispensing tool coverage per county.

County	Facilities targeted for web ADT	Facilities using web ADT
Busia	5	3
Homa Bay	6	4
Kisumu	9	6
Migori	9	4
Kakamega	22	12
Kisii	2	1
Nyamira	8	4
Bungoma	7	3
Vihiga	8	3
Total	76	40

Note: ADT, ART (antiretroviral therapy) dispensing tool.

The best practices during the reporting period included procurement of packing envelopes for express clinic clients, use of ADT for patient appointment management, and retrieval of viral load results. The project contingency plan for the general election included supplying ordering sites with four months of ARV stock from the Kenya Medical Supplies Authority and supplying clients drugs for longer durations to cover the time of the election. The challenges experienced during the period included the health care workers' strike affecting monthly reporting rates, the shortage of pharmacy technicians to ensure continuous utilization of the ADT tool, and the stockout of opportunistic infections (OI) drugs from the Kenya Medical Supplies Authority (i.e., Dapsone and Acyclovir).

Strategic monitoring and evaluation

During the reporting period, monitoring and evaluation (M&E) activities helped to strengthen data management and reporting systems. M&E activities included mentorship to enhance the capacities of project collaborators and MOH systems to improve data quality; report at county, subcounty, facility, and community levels; and strengthen the reporting process and use of DREAMS databases. The activities undertaken were in line with the M&E strategic areas of implementation. 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

Key challenges in the reporting period included service delivery disruptions due to an ongoing nurses' strike and the general elections that were held in August. The nurses' strike that began in June 2017 has continued to paralyze services. For example, over 60 health facilities have closed as a result. Patient flow reduced significantly in the open health facilities. To ensure continued service provision i.e. HIV testing service provision, the project employed the following

measures: redeployed HTC service providers from the closed facilities and nonfunctional service delivery points to support testing services in private and faith-based facilities, supported targeted outreaches for men at the already mapped-out hot spots in the community setting, offered extended hours and weekend testing in all high-volume sites; and supported assisted partner notification services.

IV. PERFORMANCE MONITORING

Strengthening MOH systems, structures, and capacity of personnel to collect and use data

Strengthening health care worker capacity on reporting tools, indicators, and data use

The project continued to strengthen its support for onsite mentorship on health management information system reporting tools across the nine supported counties. A total of 398 HCWs (20 in Vihiga, 136 in Kakamega, 13 in Homa Bay, 50 in Migori, 11 in Kisumu, 73 in Bungoma, 95 in Nyamira and Kisii) were mentored in the reporting period. This brings the total to 1,948 HCWs mentored in the Y6Q4 through Y7Q3 period. The support targeted gaps that were identified during site improvement through monitoring system visits, monthly data review meetings at project level, quarterly data review meetings at the subcounty level, and routine data quality assessments at the site level. The focus was on addressing reporting challenges in the use of MOH 731, MOH 711, the daily activity register, the ART register, the SGBV register, ANC register, and HIV-exposed infant cohort analysis.

The project continued to use the online web-based system; 62,423 records of AGYW who were receiving services were uploaded in the system. Onsite mentorship on the use of the data tools and web-based system was done for all the 34 supported administrative wards. The mentorship targeted mentors and ward staff who engage with girls at the ward level; the focus was on the updating of service uptake forms.

Improving data quality

Facility data quality audit

In the reporting period, the project liaised with data clerks at the health facility level to conduct data quality assessments in ninety nine (99) project-supported high-volume health facilities during the months of July to September 2017. The data quality assessments built on previous similar audits that have been carried out by the project since April 2014. These audits focused on comparison of data from source registers—monthly reporting on MOH 731 and DHIS2 by facilities.

Generally, the results showed continued improvements in data consistency in the follow-up period of July to September 2017 (see Table 56 below). These results were due to the project's continued onsite mentorship on the use of MOH 731 and support from data clerks assigned to the high-volume health facilities. The project will continue to carry out the data quality assessments to identify gaps in data quality and to develop data quality improvement plans to address gaps.

Table 56. Data quality audit comparisons for care and treatment, Y6Q4 to Y7Q3.

Indicator	Month	Verification status (between source registers and MOH 731)			No. of facilities
		No. of variation	Over-reported MOH 731	Under-reported MOH 731	
No. of individuals currently on ART	16-Apr	86%	11%	3%	63
	16-May	87%	11%	2%	63
	16-Jun	92%	8%	0%	63
	16-Jul	86%	8%	6%	87
	16-Aug	88%	8%	3%	86
	16-Sep	97%	0%	3%	34
	16-Oct	89%	4%	7%	104
	16-Nov	92%	2%	6%	102
	17-Jan	99%	1%	0%	85
	17-Feb	99%	0%	1%	85
	17-Mar	98%	0%	2%	86
	17-Apr	93%	3%	4%	117
	17-May	94%	4%	2%	121
	17-Jun	94%	4%	2%	112
	17-Jul	90%	3%	7%	99
	17-Aug	91%	4%	5%	99
17-Sep	92%	2%	6%	99	
No. of individuals currently on care	16-Apr	86%	11%	3%	64
	16-May	87%	10%	3%	62
	16-Jun	89%	9%	2%	63
	16-Jul	79%	13%	8%	87
	16-Aug	88%	8%	4%	84
	16-Sep	97%	0%	3%	34
	16-Oct	91%	3%	6%	104
	16-Nov	92%	3%	5%	102
	17-Jan	93%	6%	1%	86
	17-Feb	93%	5%	2%	85
	17-Mar	98%	2%	0%	86
	17-Apr	92%	4%	4%	115
	17-May	92%	6%	2%	119
	17-Jun	94%	4%	2%	111
	17-Jul	89%	3%	8%	99
	17-Aug	90%	5%	5%	99
17-Sep	91%	2%	7%	99	
No. of individuals currently on cotrimoxazole	16-Apr	87%	11%	2%	62
	16-May	86%	11%	3%	62
	16-Jun	87%	11%	2%	64
	16-Jul	79%	10%	10%	87
	16-Aug	85%	9%	6%	87
	16-Sep	94%	6%	0%	34
	16-Oct	89%	6%	5%	104
	16-Nov	92%	4%	4%	102
	17-Jan	95%	4%	1%	82
	17-Feb	90%	7%	3%	82
	17-Mar	95%	1%	4%	85
	17-Apr	93%	4%	3%	116
	17-May	94%	4%	2%	120
	17-Jun	95%	4%	1%	112
	17-Jul	91%	3%	6%	99
	17-Aug	91%	5%	4%	99
17-Sep	92%	3%	5%	99	

Source: Data Cross-Check Summary Report, 2016–2017.

Note: ART, antiretroviral therapy; MOH, ministry of health; No., number; Q, quarter; Y, year.

DREAMS data quality audit

During the reporting period, an accelerated data verification was done on a weekly basis and quality assessments were conducted during visits to the safe spaces. These exercises included checking for availability of standard tools, and confirming the consistency, accuracy, and completeness of information documented on the DREAMS enrollment form, service uptake, referrals tool, MSP planning and monitoring tools, and EBI registers. Chart abstraction was done during the visits to monitor the quality of services offered to the AGYW and layering of services for individual girls.

The data quality assessment also assessed the proper utilization of the tools and use of database to generate project reports. Facility-based data verification was conducted for PMTCT DREAMS indicators with the support of MOH staff. Mentorship was provided for staff working in PMTCT-supported sites on the tally sheets and summary tools that capture PMTCT data for the DREAMS project. Onsite data verification was done for facilities visited and desk review conducted to ensure consistency of data in DHIS2. Review of records for AGYW started on PrEP was done to check on completeness of information. The project also supported mentorship on the use of PrEP reporting tools at safe spaces and health facilities.

Quarterly data review meetings at the subcounty level

The project continued to support quarterly data review meetings in all project-supported subcounties. A total of 723 HCWs (29 in Vihiga, 48 in Busia, 47 in Kisumu, 125 in Migori, 352 in Kakamega, and 122 in Nyamira and Kisii) were reached during the data review meetings. This brings the total to 1,687 HCWs reached in the Y6Q4 through Y7Q3 period. HCWs included clinical and data management staff. During the meetings, facility-level data on HTC, care and treatment, PMTCT, and VMMC were reviewed. Key gaps in performance and data quality, including missed opportunities in service provision, were discussed and strategies formulated for data quality improvement at the facility level.

The project continued to support 92 health records and information officers (8 in Migori, 5 in Kisumu, 10 in Nyamira, 7 in Siaya, 5 in Homa Bay, 2 in Kisii, 13 in Bungoma, 7 in Busia, 25 in Kakamega, and 10 in Vihiga) with monthly airtime to ensure timely, complete, and accurate entry of health service delivery data into DHIS2.

Each of the 34 wards was supported by a data clerk who updated information in the system with information from bimonthly data review meetings that were facilitated by the project at ward level to review performance. The project continued to support the management of the DREAMS database, generation of monthly reports, and completion of the Performance Monitoring Plan and project dashboards. Monthly reports were reviewed with the aim of identifying gaps in reporting and enhancing understanding of the DREAMS reportable indicators, frequency of reporting, and data flow by the local implementing partners.

Bimonthly meetings to review DHIS2 data

During the reporting quarter, the project supported bimonthly meetings to review consistency of data reported in DHIS2 against facility summary reports (MOH 731 and MOH 711A) and project data. The indicators reviewed were for HTC, PMTCT, and care-and-treatment programs. A total of 145 HCWs (31 in Busia, 12 in Kakamega, 9 in Bungoma, 18 in Migori, 48 in Vihiga, and 27

in Nyamira) participated in the bimonthly meetings. A total of 307 HCWs were reached through bimonthly meetings to review data consistency in the Y6Q4 through Y7Q3 period. Through the process, data entry inconsistencies in DHIS2 were identified and corrected by subcounty health records and information officers. This contributed to improvement in the quality of data in DHIS2.

Strengthening use of the VMMC M&E system

The project continued to strengthen the use of the VMMC M&E system. Twelve data clerks assigned to Busia, Kisumu, Homa Bay, and Migori continued to support entry of VMMC data into the M&E system at the site level.

Meaningful use of information and communication technology infrastructure

To enhance meaningful use of information and communication technology (ICT) infrastructure for data management and reporting at facility, subcounty, and county levels, the project delivered a set of computers, printers, UPS, Cisco routers, access points, and dongles to support 11 sites and respective county health management team and subcounty health management team offices in the high-priority counties of Kakamega, Nyamira, Bungoma, Busia, and Kisii. The aim was to strengthen clinical management of patients and administrative management of the health facilities. During the reporting period, the project installed the computers, printers, UPS, Cisco routers, access points, and dongles in respective sites. This brings to total 21 high-volume health facilities in eight high-priority counties that were supported with the ICT infrastructure. The high-priority counties included Homa Bay, Kisumu, and Migori. The project will monitor use of the ICT infrastructure with an aim of making the sites model ICT sites and centers of excellence in the provision of service delivery, data management, and use of electronic medical records at points of care. To ensure adequate capacity to manage the ICT applications, the project also supported training of health care workers from the high-volume health facilities on the use of these systems in a way that contributes to the outcome of meaningful use of ICT infrastructure for data management and reporting.

V. PROGRESS ON GENDER STRATEGY

The project continued to strengthen its response to the existing gender inequality gaps at the community and facility levels. At the community level, the project continued to provide platforms for community conversations to happen, with the aim of challenging gender norms and cultural practices that perpetuate GBV and HIV. These were done through community dialogue sessions, stakeholders' forums, and sensitization meetings. GBV screening was integrated in the sensitization meetings. The project also collaborated with gender TWGs in organizing community-level sensitizations on GBV, with an emphasis on policies on violence against women and girls and violence against children. Survivors of GBV were also referred to the community-level safe shelters for protection services. To strengthen linkages in GBV response between health facilities and the police department, joint meetings were held between police officers and HCWs. The project used the SASA! approach for all the community-level interventions.

At the facility level, the project continued to support capacity-building of HCWs on management of SGBV through CME and on-the-job training. HCWs were facilitated to conduct GBV screening at the point of care as a strategy to identify cases. In addition, the project supported data review meetings for HCWs and records officers to strengthen reporting of SGBV in DHIS2 and other GBV (nonsexual violence) in the outpatient department registers. Debrief sessions were also held for HCWs who offer postviolence care to reduce burnout as well as enable them to share experiences. Other nonclinical services that were offered by other project-supported actors, such as paralegals, peer educators, and community health volunteers, were legal aid, protection, referrals, and family integration.

VI. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

Highlights for this reporting period included the commissioning of renovated waste disposal units and training MOH and project staff on health care waste management. Other activities involved supportive supervision, mentorship and technical assistance aimed at strengthening the capacity of project-supported facilities to safely handle and dispose of hazardous medical waste. A total of 19 facilities in seven counties—namely, Migori, Homa Bay, Bungoma, Busia, Nyamira, Kakamega, and Vihiga—were visited during the quarter.

Waste disposal units that incorporate the De Montfort incinerator were commissioned and commenced operating at Cheptais, Sio Port, Lumakanda, Kabondo, and Awendo subcounty hospitals. Each of these facilities received two sets of personal protective equipment for use by the incinerator operator to improve safety. Additionally, they were supplied with working tools and sand buckets for fire safety. Operators and their supervisor, the public health officers, were trained on record keeping. Each facility received a waste register and operation record file. This is expected to strengthen documentation and tracking of infectious waste from point of generation to disposal. All of these facilities are now incinerating safety boxes from other health facilities within their respective subcounties. This ensures safe disposal of infectious waste even in health facilities with no onsite waste disposal units.

Assessment of health facilities without adequate secure storage for infectious waste and disposal pits was carried out in eight project-supported sites in Bungoma and Busia. This was in preparation to support fencing pits and secure waste storage areas. The project will continue to cover more facilities in all of the other project-supported subcounties.

Training and mentorship sessions were conducted in four counties—Vihiga, Kakamega, Bungoma, and Homa Bay. A total of 126 MOH and project staff were trained on health care waste management as follows: Malava Subcounty Hospital in Kakamega had 58 participants, Vihiga County Referral Hospital trained 28, and Bungoma County trained 40. The training, which was integrated into infection prevention and control, covered key steps in health care waste management, including segregation and disposal, as well as health and safety. The participants comprised clinicians, medical laboratory technologists, and other staff who provide HIV care in project-supported facilities. In Kabondo Subcounty Hospital in Homa Bay, 15 staff undertook incinerator operation training. This training focused on standard operating procedures for waste disposal units that incorporate a DeMontfort incinerator, routine maintenance, and health safety. Supportive supervision and mentorship were carried out during the visits to all the

18 facilities. Areas identified for strengthening were segregation and safe treatment and disposal of infectious waste. It was observed that most health care facilities lacked incinerators for disposal of waste. The majority of facilities transported safety boxes to other facilities for incineration and burned infectious waste. Follow-up action on these issues was included in the next quarter's activities.

Due to the ongoing nurses' strike, the health care waste management training activities and mentorship planned for county, subcounty, and facility levels could not be conducted for the second consecutive quarter.

VII. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

Applying Science to Strengthen and Improve Systems project

Collaboration with the Applying Science to Strengthen and Improve Systems (ASSIST) project continued on the quarter even as this project wound up their activities in this quarter, in line that related to quality improvement. The project consolidated the quality improvement work that had been initiated in the previous years including supporting quality improvement team meetings in the region; county TWGs on quality improvement; as well as quality and work improvement team meetings jointly at the facility-management and departmental levels. In the high- and medium-volume facilities, the projects supported coaching sessions, during which the periodic review was done of the Standards of Care according to the Kenya HIV Quality Improvement Framework.

VIII. PROGRESS ON LINKS WITH GOVERNMENT OF KENYA AGENCIES

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 57. The project also supported quarterly stakeholder and gender TWG meetings in the two counties.

Table 57. 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) Provincial Administration County Government	Security and accountability	<ul style="list-style-type: none"> • Post-GBV care for AGYW/accountability—legal support • Security at safe spaces • Bursaries

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

IX. PROGRESS ON USAID FORWARD

The project continued to build the capacity of 15 community-based organizations that provide services to DREAMS beneficiaries/AGYW through trainings, mentorship, and support supervision. The project continued to work with six local implementing partners (nongovernmental organizations) as a strategy of building local capacity to implement interventions targeting AGYW. The project provided both financial and technical support to the local implementing partners to enable them to deliver targeted interventions to girls with high vulnerability. Project-trained mentors and facilitators regularly reach out to AGYW with repeat prevention and risk-reduction messages, condom promotion, and referrals for biomedical service, including social protection services in the two counties of Homa Bay and Kisumu.

X. SUSTAINABILITY AND EXIT STRATEGY

The project continued to ensure that sustainability remained at the core of its interventions. The focus continues to be within three key areas: institutional sustainability, household and community resilience, and environmentally sustainable production systems.

XI. GLOBAL DEVELOPMENT ALLIANCE (IF APPLICABLE)

Not applicable.

XII. SUBSEQUENT QUARTER'S WORK PLAN

Progress against planned activities during the reporting period is outlined in Table 58 below.

Table 58. Subsequent quarter's work plan.

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.	Was not fully accomplished in this quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
TRAIN HEALTH CARE WORKERS ON THE REVISED ART GUIDELINES	Was not fully accomplished in this quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT FACILITY-BASED CME FOR ART AND PMTCT ON A QUARTERLY BASIS.	Was not fully accomplished in this quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT THE LABORATORY-NETWORKING MODEL (CD4, EID, BIOCHEMISTRIES, HEMATOLOGY, AND VIRAL LOAD).	Was not fully accomplished in this quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT ART PMTCT REPORTING TO MEET APR TARGETS.	Was not fully accomplished in this quarter. Quarter's target were not met.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT ACCELERATED ART ENROLLMENT AND RETENTION ACTIVITIES	Was not fully accomplished in this quarter. Targets not met	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT KQMH QI BASELINE ASSESSMENTS AND REASSESSMENTS IN SITES, AS WELL AS LEARNING SESSIONS AND COACHING.	Was not fully accomplished in this quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT FACILITY ART/PMTCT DEFAULTER TRACING MECHANISMS (DIARIES, PEER EDUCATORS, AIRTIME, AND SMS REMINDERS).	Was not fully accomplished in this quarter. Some of the clients missed their appointments.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT FACILITY PLHIV SUPPORT GROUP MONTHLY MEETINGS (INCLUDING PEDIATRIC, MALE, ADOLESCENT, PMTCT, GENERAL CCC).	Was not fully accomplished in this quarter. Some of the clients missed their appointments and PSSG visits in the facilities.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation

Planned activities from previous quarter	Actual status this quarter	Explanations for deviations
SUPPORT HIV COUNSELING AND TESTING AT ANC AND MCH CLINICS OF PREGNANT MOTHERS AND MOTHER-BABY PAIRS.	Was not fully accomplished in this quarter. Some of the clients missed on being attended to at the clinics.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
PROVIDE HCW MENTORSHIP ON EMTCT.	Was not fully accomplished in this quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
SUPPORT NONCLINICAL COUNSELORS.	Completed planned activities for the quarter	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation with the closure of entry points such as OPD & MCH
SUPPORT DR-TB PATIENTS TO ACCESS TREATMENT.	Completed planned activities for the quarter.	Health Care Workers strike that was witnessed in July to September 2017 hindered full implementation
DREAMS		
PrEP: identify more beneficiaries	Ongoing	Identified AGYW's put on PrEP as required
Cash transfer: continue payments	Ongoing	A continuous process. Increasing the numbers.
School fees payment: verify beneficiaries	Done	N/A
Financial capabilities and entrepreneurship training	Ongoing	N/A
Vocational training	Ongoing	N/A
NHIF registration: monitor usage and payments	Done	N/A
Village saving and loaning association training	Ongoing	Not a one-off activity
Parental skills training	Ongoing	Not a one-off activity. Also awaiting Families Matter! Program curricula

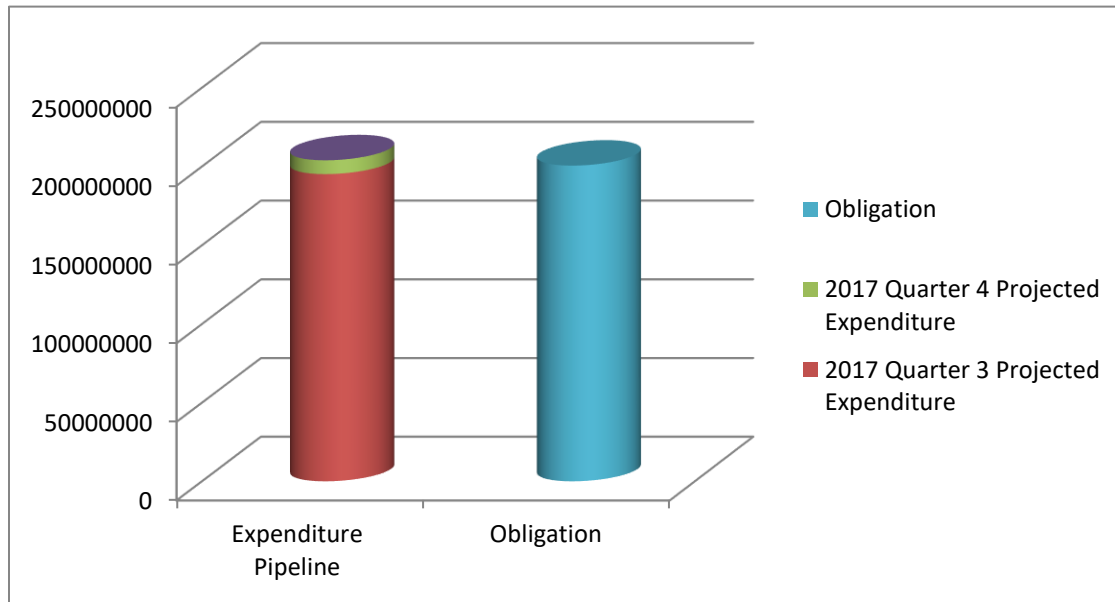
Note: AGYW, adolescent girls and young women; N/A, not applicable; NHIF, national hospital insurance fund; PrEP, pre-exposure prophylaxis.

XIII. FINANCIAL INFORMATION

Project cash flow and financial projections

Project cash flow and financial projections are highlighted in Figure 11 below.

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



Budget details

T.E.C: \$216,065,090

Cumulative obligation: \$200,575,061.41

Cumulative expenditure

Actual \$195,187,582

Accrual \$ 1,073,658.

Total \$196,261,240

Table 59. Actual expenditure details.

Obligation	Quarter 3 2017 cumulative expenditures	Quarter 4 2017 projected expenditures
\$200,575,061.41	\$195,187,582.08	\$8,768,449.43
Personnel	\$19,682,092.16	\$1,319,082.00
Fringe benefits	\$5,984,323.35	\$422,106.00
Travel	\$13,836,867.40	\$487,111.20
Equipment	\$836,863.76	\$0.00
Supplies	\$16,669,962.49	\$751,426.60
Contractual	\$644,186.29	\$41,403.63
Other direct costs	\$110,414,894.20	\$3,776,118.00
Overhead	\$27,118,392.43	\$1,971,202.00

Source: Project financial records, September 2017.

Table 60. Budget notes.

Salary and wages	This has stabilized and should remain the same in the next quarter.
Fringe benefits	Fringe benefits are a constant ratio against all salaries and wages (payments of provident fund; social security; medical premiums are included in the fringe pool).
Travel, transport, per diem	This is expected to come down in the next quarter as the project heads towards closure.
Equipment	No purchase of equipment is anticipated in the next quarter.
Contractual	The project will continue to implement performance-based incentives up to the end of Quarter 3.
Supplies	This has consistently stabilized.
Other direct costs	Other direct costs are anticipated to stabilize from Quarter 3.
Overhead	Calculated as per award conditions.
G&A	Calculated as per award conditions.
Material overhead	Calculated as per award conditions.

New subaward details

None.

XIV. ACTIVITY ADMINISTRATION

Personnel

During the reporting period, there were no changes in the project's key personnel.

Contract, award, or cooperative agreement modifications and amendments

The project sent an incremental obligation request to USAID.

XV. INFORMATION FOR ANNUAL REPORTS ONLY

Not applicable.

XVI. GPS INFORMATION

Please see the GPS information sheet in the attachment.

XVII. SUCCESS STORIES

Community antiretroviral drug refills in Banja Health Center

Helen Kadesa, the only clinician in-charge at the Banja Health Center comprehensive care center in Vihiga County, is a happy and relaxed individual. Ordinarily, she would be busy seeing patients; sometimes, she has more than ten clients on a single day. However, on the day of our visit in August this year, Helen had just three appointments, all in the morning, so she had enough time to host us in the afternoon.

Banja Health Center is one of the facilities that has successfully implemented the community antiretroviral refill model, a form of differentiated model of care in which clients who are stable and do not need regular assessment by a clinician set up a community group. Each member takes a turn in collecting drugs for the rest.

Members of the group are given clinical appointments and six-month prescriptions for drugs. Banja Health Center has 216 clients on antiretroviral treatment, with 80 listed as stable clients (i.e., clients whose viral loads are low and who adhere to treatment).

Helen manages six community antiretroviral groups (CAGs), each with six individuals. Each CAG member only comes to the facility twice in a year.

At each visit, a CAG member not only collects medication but also undergoes routine half-yearly checks of their CD4 count, viral load, and other vital signs. CAGs generate huge savings for the clients who no longer have to spend money and time coming to the health facility. The clinician too has a lighter load. “I have time now to pay more attention to clients who are not yet stable and need my services,” says Helen.

Before being enrolled into the community antiretroviral refill groups, the health facility carried out a line-listing exercise through which stable patients were identified. The criteria used were as follows: clients had to have been on treatment for more than six months, be free of any opportunistic infection, not be pregnant or lactating, and have completed isoniazid preventive therapy for the prevention of tuberculosis. Helen reports:

In this facility, since April 2017, we graduated some of the clients we had on express management—those who [were] above 18 years old and had not missed any monthly appointment since being initiated into care at least in the past 12

APHIAplus WESTERN'S HEALTH IMPACT

Community antiretroviral refill groups

The AIDS, Population, and Health Integrated Assistance Zone 1 (APHIAplus Western) project, through staff supported by health facility comprehensive care centers, identified people living with HIV/AIDS who are stable and enrolled them into community antiretroviral groups (CAGs) of six members each. Through rotation, each member of a CAG visits a facility to collect medication for his/her peers in the CAG and receive a health checkup at least twice a year. CAGs are innovative, time-saving, and cost-saving model for people living with HIV/AIDS who do not need to visit a hospital regularly. For clinicians, CAGs have enabled task-shifting, providing the officers with opportunities to focus on patients who need more attention.

months. They had to have a BMI [body mass index] higher than 18.5, [have] an undetectable viral load, not [be] pregnant or breastfeeding, and be free from any opportunistic infections. In addition, they will have had gone through isoniazid prevention therapy (IPT) to ensure they are free of the risk of TB.

The CAGs meet once a month for members to get their drugs and to provide each other psychosocial support. When that month's "courier" gets the drugs, the group has the meeting on the same day; members sign the prescription sheet that they received with their medicines upon receipt of their medication. If, for one reason or another, a member is not present, their drugs are returned to the facility by a peer educator/adherence counselor on the same day. When CAGs meet, members are able to offer each other peer-to-peer monitoring. Members say that if they see any of the group members looking unwell or showing signs of mental stress, they rally around the member and bring the individual to the facility.

Being in the CAG comes with the responsibility of ensuring that not only are you well but the other five members in your CAG are responding well to treatment. So motivated are the members that they see themselves as role models.

"We tell our friends in the community, work hard so you can also be in a CAG and for medicines to be brought to you at home. There is no need to go to the hospital each month," says a confident CAG member.

Being in a CAG is a status symbol. It rebuilds the self-assurance and confidence of individuals whose HIV status had turned them into pariahs.

In all of Vihiga County, there are 42 active CAGs; a majority of their members are women. At Banja Health Center, the male members of the group are outnumbered six to one. The APHIAplus project seeks to know why. Charles, one of the members tells us, "*Unajua wanaume wako na kichwa ngumu tu; hata kitu kizuri wataleta maneno mengi* (You know men are stubborn; even a small thing, they will query and have issues with)." Helen Kadesa adds that even when it comes to testing for HIV, there are usually more women accessing the service.

At a Banja CAG meeting, we asked the men present to look into their own personal experience and suggest what would make men improve their health-seeking behavior. None of them could come up with a strategy. Even the men seemed to have given up on the obstinacy of their fellow males. As they recounted their personal testing experiences, it was clear that they were a unique lot. Each one of them expressed a personal initiative that took them to the testing center and the stoicism with which they received their HIV status. Each had a story about how they disclosed their HIV status to their partner. Surprisingly, of the five males present in the Banja CAG meeting, all were in discordant relationships; each one said that they had tremendous support from their partners. Two have had children since testing and knowing their status. They had children with full support of their partners. This was testimony to the success of prevention, because neither their partners nor their children had been infected.

It is groups such as these that truly illustrate the fact that HIV is no longer the death sentence it was in the past: it is a chronic illness just like any other.

A men-only support group that is determined to help men access HIV care

It has been widely documented that men have poorer health-seeking behaviors compared to their female counterparts. The Kenya AIDS Indicator Survey, for example, showed that 79 percent of women were more likely to have had a HIV test compared to just 60 percent for men. This is the situation that John Ogwimba Amusavi is working hard to change.

John is an APHIA*plus* Western adherence counselor at Vihiga County Hospital. He acknowledges how difficult it is for men to seek health care. He says that, compared to women, men are unlikely to go to hospital unless they are in dire need. He believes that in order to increase uptake of HIV services, men need to have a champion—a peer that they can relate to and openly talk to about their conditions and situations.

John is the chairman of Sabatia Constituency Men (SACOMEN), a male-only support group. John started the group one year ago by reaching out to fellow men who came to the comprehensive care center (CCC) in Vihiga Hospital for treatment. The group currently has 20 active members, all of whom are older than 18 years. The men are champions; they provide counseling support to fellow men in Sabatia, Vihiga County, and encourage men who do not know their HIV status to get tested.

“I would reach out to one man at a time and invite him to become a member of SACOMEN. As their numbers grew, the men would split up and in turns would talk to other men at the CCC and in the community,” John said.

In 2009, John, who was working as a salesman in a company in Nakuru, was tested and found to be HIV positive. “I had suffered [from] TB, which was resolved after about six to seven months. I got malaria later and was treated and when I got sick again. I was tested for HIV. I could not accept that I was positive; I could not believe nor accept it. I was demoralized. My sister was the first person I told, because I needed her help in disclosing to my wife. Eventually, my wife and I were tested together, and she was HIV negative,” says John.

John says that as a man living with HIV, he was lonely and did not have anyone to confide to, largely due to stigma. It is something that he wanted other men not to experience.

The SACOMEN support group provides counseling to men, which helps to improve treatment adherence. Members also discuss and share experiences, including drug side effects and how to address them.

“It is important that people are told about the possible side effects beforehand so as to know what to expect and how to manage it,” says John. The county has 19,381 people living with HIV, with 10,000 of them on treatment.

SACOMEN sustains itself by carrying out other activities such as poultry-keeping, and banana and vegetable growing. John says:

We do not do these activities to generate income; rather, [we do them] for our livelihoods. We discovered that any sort of business or income-generating activity, as opposed to bringing us together, it impacted on the group negatively.

At one time the group nearly dissolved. Table-banking has not worked either; it made us argue and segregated us.

The USAID-funded APHIAplus Western project has in the last seven years recruited and trained HIV-positive peer educators to provide their peers with awareness and education about HIV and prevention. They are also trained in facilitation skills so that they can assist their peers to understand their risk and develop risk reduction strategies.

John, who responded to an advert for a peer educator, was interviewed and recruited by APHIAplus Western. He has undergone multiple trainings by the APHIAplus partner Elizabeth Glaser Pediatric AIDS Foundation. John has transitioned from being a peer educator to being an adherence counselor. He was trained in counseling, and his main role is to ensure that clients adhere to their medication and maintain low-risk behavior, such as use of condoms.

“Many men I speak to find it easier to relate to me because I also take [ARV] drugs. I am one of them. They see me, and they see that it is not the end of the world,” remarks a cheerful John.

A peer counselor determined to help young people overcome HIV-related stigma and pursue their dreams

Hellen Nyaboke believes that three deaths and one HIV infection would have been averted had there been less HIV-related stigma. She argues that because stigma leads to fear of disclosure of HIV status, it hinders access to HIV testing and treatment. Hellen’s mission is to empower young people to deal with HIV-related stigma so that they can benefit from the widely available treatment and pursue their dreams.

Hellen is a youth peer educator with the USAID-funded APHIAplus Western project at Keroka/Masaba Subcounty Hospital in Nyamira County. She runs the adolescent HIV support group catering to 87 young persons aged 15 to 23 years. Hellen is 24 years old.

Hellen tested HIV positive four years ago when she was when she was in form three. She says that it was a traumatizing moment for her. She recalls, “Our science teacher told us that anyone who had not taken an HIV test in the last one year should presume himself or herself HIV positive.”

Hellen says that she and her friends felt relatively confident that they would be confirmed negative. In her case, she already had a boyfriend, a man who worked in a hotel in Keroka town. Never in her wildest dream did she imagine she could have put herself at risk of being infected. They nonetheless gathered courage and took the test.

“I was very devastated when I turned positive. I did not know what to do, especially how to tell my parents. I was afraid of how they would react,” she said.

Today, Hellen has a positive view of things. She has overcome the fear and trauma and now wants to help other girls like her to answer the many questions one asks themselves when they test positive.

Hellen runs a support group that meets once a month during the school term and twice a month when schools are closed. The facility has adopted a “dedicated day” model of youth-friendly center service. The youth come to the facility to access services over the weekends.

“This support groups gives young people a chance to learn more about HIV and how to live positively. They share challenges and encourage one another. We are also ambassadors for HIV testing,” Hellen says.

Recalling her time in school and the self-stigma that almost made her drop out of school, Hellen has made the schoolgirl and college girl the focus of her work. Hellen says:

I know what they go through. For me school, was no longer exciting. Every time the teacher talked about HIV, I felt like she was just talking about me. I felt like crying every time they would talk about how people with AIDS suffer, because it felt like they were just telling me what was coming. For the most part, I had to hide my drugs from my classmates. I would only take my medicine after everyone falls asleep—sometimes inside my blanket.

According to the National AIDS Control Council, Nyamira County has 24,357 people living with HIV, with 22 percent being young people aged 15 to 24 years and 6 percent being children under the age of 15 years. The county has an HIV prevalence of 6.9 percent and is among counties that have a prevalence higher than the national average of 5.9 percent

The APHIA*plus* Western project supports the delivery of HIV services in nine counties, including Nyamira County, where young people such as Hellen have been trained and deployed to help improve service uptake among young people affected by HIV.

ANNEX A. SCHEDULE OF UPCOMING EVENTS

The scheduled activities for Quarter 4 of 2017 are included in Table 61 below.

Table 61. Schedule of upcoming events in Y7Q4.

Date	Location	Activity
October to December 2017	Kisumu and Homa Bay	PrEP: identification of more beneficiaries
October to December 2017	Kisumu and Homa Bay	Cash transfer: continuance of payments
October to December 2017	Kisumu and Homa Bay	School fees payment: verification of beneficiaries
October to December 2017	Kisumu and Homa Bay	Financial capabilities and entrepreneurship training
October to December 2017	Kisumu and Homa Bay	Vocational training
October to December 2017	Kisumu and Homa Bay	NHIF registration: monitoring of usage and payments
October to December 2017	Kisumu and Homa Bay	Village saving and loaning association training
October to December 2017	Kisumu and Homa Bay	Parental skills training
October to December 2017	Kisumu and Homa Bay	Enrollment of additional girls

Note: NHIF, national hospital insurance fund; PrEP, pre-exposure prophylaxis; Q, quarter; Y, year.

ANNEX B. LIST OF DELIVERABLE PRODUCTS

None.

ANNEX C. ACTIVITY IMPLEMENTATION RESULTS TABLES

None.