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QUARTERLY PROGRESS REPORT

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APHIA*plus* WESTERN KENYA

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Prepared for
Dr. Maurice Maina
United States Agency for International Development Kenya
c/o American Embassy
United Nations Avenue, Gigiri
PO Box 629, Village Market
Nairobi 00621
Kenya

Prepared by
PATH's Country Office in Kenya
ACS Plaza, 4th Floor
Lenana
PO Box 76634-00508
Nairobi 00100
Kenya

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ABBREVIATIONS

AAC	area advisory council
AGYW	adolescent girls and young women
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
APHIA	AIDS, Population, and Health Integrated Assistance
APR	annual program review
ART	antiretroviral therapy
ARV	antiretroviral
ASDSP	Agricultural Sector Development Support Programme
ASRH	adolescent sexual and reproductive health
ASSIST	Applying Science to Strengthen and Improve Systems
BEmONC	basic emergency obstetric and newborn care
CBO	community-based organization
CCC	comprehensive care center
CD4	cluster of differentiation 4
CEmONC	comprehensive emergency obstetric and newborn care
CHMT	county health management team
CHV	community health volunteer
CHW	community health worker
CLTS	community-led total sanitation
CMAM	community-based management of acute malnutrition
CME	continuing medical education
COP	country operational plan

CRH	county referral hospital
CU	community unit
CTX	cotrimoxazole
DHIS	District Health Information Software
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe
DPT	diphtheria, pertussis, tetanus
DQA	Data Quality Assessment
DR–TB	drug-resistant TB
EBI	evidence-based intervention
EID	early infant diagnosis
EmONC	emergency obstetric and newborn care
EMR	electronic medical record
EMTCT	elimination of mother-to-child transmission
FP	family planning
GBV	gender-based violence
GIS	**g**eographic information system
HBHCT	Home-based HIV counseling and testing
HCW	health care worker
HCWM	health care waste management
HEI	HIV-exposed infant
HH	household
HIV	human immunodeficiency virus
HMT	health management team
HTC	HIV testing and counseling
HTS	HIV testing services
ICF	intensified case finding

ICT	information and communication technology
IPC	infection prevention and control
IPT	isoniazid preventive therapy
KAVES	Kenya Agricultural Value Chains Enterprises
KSh	Kenya shilling
LIP	local implementing partner
LMIS	logistics management information system
MACEPA	Malaria Control and Elimination Partnership in Africa
M&E	monitoring and evaluation
MCC	Male Champions of Change
MCH	maternal and child health
MIYCN	maternal, infant, and young child nutrition
MNCH	maternal, newborn, and child health
MOH	ministry of health
MPDSR	maternal and perinatal death surveillance and response
MSP	Male Sexual Partner
MTCT	mother-to-child transmission
MUAC	mid-upper arm circumference
NACS	nutrition, assessment, counseling and support
NASCOP	National AIDS & STI Control Programme
NDCs	nutritional demonstration centers
OLMIS	OVC Longitudinal Management Information System
OPV	oral polio vaccine
OVC	orphans and vulnerable children
PE	peer educator

PEPFAR	US President's Emergency Plan for AIDS Relief
PHDP	positive health, dignity, and prevention
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PPR	program performance report
PSSG	postnatal-specific psychosocial support group
PT	proficiency testing
RDTs	rapid diagnostic tests
RH	reproductive health
RMNCH	reproductive, maternal, newborn and child health
RTK	rapid test kit
SAM	severe acute malnutrition
SAPR	semi-annual program review
SASA	Start Awareness Support Action
SDP	service delivery point
SD-SB	single delivery, single birth
SGBV	sexual and gender-based violence
SIMS	Site Improvement Monitoring Systems
SOP	standard operating procedure
STF	service tracking form
STI	sexually transmitted infection
SCHMT	subcounty health management team
TB	tuberculosis
TOT	trainer of trainer
TWG	technical work group

UBT	uterine balloon tamponade
USAID	United States Agency for International Development
USG	United States Government
VL	viral load
VMMC	**v**oluntary medical male circumcision
VSLA	village savings and loans association
Y6Q3	Year 6 Quarter 3

EXECUTIVE SUMMARY

The AIDS, Population and Health Integrated Assistance (APHIA) *plus* Western Kenya Project is a United States Agency for International Development (USAID)–funded project that is being implemented from January 2011 to December 2017. The project is being implemented by a consortium led by PATH and composed of the Elizabeth Glaser Pediatric AIDS Foundation and 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 (HCWs) and improving infrastructure of health facilities.
- Helped empower communities and promote sustainability through support for local community-based organizations (CBOs).

In Year 6 Quarter 3 (Y6Q3), the period under review, the project continued to align its activity support to the President's Emergency Plan for AIDS Relief county prioritization based on the HIV burden and UNAIDS 90-90-90 goals.[1] In line with this and as outlined in the project's Year 6 work plan, Homa Bay, Kisumu, Migori, and Busia were categorized as Scale-Up to Saturation counties; Nyamira, Kakamega, and Kisii as Aggressive Scale-Up counties; and Vihiga and Bungoma as Sustained counties.

During the reporting quarter, the project supported HIV testing and counseling (HTC) of 544,198 clients. This brings the total number of clients counseled and tested from October 2015 to September 2016 to 1,633,426 against a country operational plan (COP) 2015 target of 897,463 (182 percent achievement). The number of clients testing HIV positive for the reporting period was 6,831, bringing the total number of HIV-positive clients from October 2015 to September 2016 to 26,572 against a COP 2015 target of 30,167 (88 percent achievement).

During the reporting quarter, 31,218 pregnant women were counseled and tested for HIV, of whom 1,617 (5 percent) tested positive. Maternal prophylaxis was provided to 1,552 women (96 percent of those tested positive), and 1,577 infants (97 percent) received prophylaxis. This brings the total to 129,788 (54 percent) clients with known status out of a COP 2015 target of 239,886 and 6,720 (72 percent) HIV-positive identified out of the targeted 9,362. A total of 6,506 pregnant women and 6,537 infants have been issued prophylaxes from October 2015 through September 2016 period.

During the reporting quarter, a total of 6,220 (82 percent of positives) HIV-positive clients were enrolled in care, while 10,884 were initiated on antiretroviral therapy (ART). This translates to achievements of 102 percent of new clients enrolled into care and 107 percent of clients initiated on ART from October 2015 to September 2016 period against COP 2015 targets. At the end of the reporting period, 103,599 clients were actively enrolled in care and 102,261 became active on treatment, against the COP 2015 targets of 108,720 and 97,847, respectively.

[1] An ambitious UNAIDS treatment target to help end the AIDS epidemic. By 2020, 90 percent of all people living with HIV will know their HIV status. By 2020, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90 percent of all people receiving antiretroviral therapy will have viral suppression.

Through HIV prevention services implemented during the reporting period, a total of 15,175 clients accessed voluntary medical male circumcision (VMMC) services, bringing the total number reached from October 2015 to September 2016 to 47,733, against a COP 2015 target of 42,821 (111 percent achievement). Behavioral interventions of the project reached 4,373 fisherfolk with evidence-based interventions (EBIs) during the period under review, bringing the October 2015 to September 2016 performance to 18,361, which represents a 126 percent achievement against the COP 2015 target.

Within the reporting period, a total of 165,253 orphans and vulnerable children (OVC), 90.8 percent of the 181,991 enrolled in the project, were supported with a range of services. The performance for the quarter translates to an achievement of 85.5 percent against the COP 2015 target of 193,145. Cumulatively, 181,559 (99.6 percent) of the 181,991 enrolled OVC have been tested for HIV. Of these, 5,742 were HIV positive and the project has achieved 100 percent linkage and enrollment on ART.

A total of 27,715 mothers completed four antenatal care (ANC) visits in the quarter under review, bringing the total from October 2015 to September 2016 to 106,545, against a target of 81,411 (131 percent achievement). In addition, a total of 41,242 mothers delivered under skilled birth attendants in the reporting quarter, bringing the total from October 2015 to September 2016 period to 156,580, against a target of 149,329 (105 percent achievement).

On the Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) initiative, the project enrolled a total 31,467 (92.0 percent) out of 34,264 adolescent girls and young women (AGYW), an increase of 5,263 from the previous quarter. In Kisumu, 15,493 (79.0 percent) of the target were enrolled into program and 15,974 AGYW (109.0 percent) in Homa Bay County. Enrollment was highest for AGYW aged 10 to 14 years old at 6,736 (104.0 percent) and 13,928 (99.9 percent) for 15 to 19 years old. During the reporting period, the project supported 34 mains safe spaces and 136 satellite safe space in the supported wards.

I. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

Subpurpose 1. Increased and expanded quality HIV services

HIV testing and counseling (HTC) services

The project continued to provide direct service delivery support to all the 533 project-supported sites. Focus was on capacity-building of HTC service providers on the HIV testing services (HTS) algorithm, quality improvement and assurance, technical assistance to HTS service providers, and support for technical work groups (TWGs) on rapid test kit (RTK) commodity management to ensure RTK commodity security. Capacity-building was done through provider mentorship, supportive supervision, and facility-level, issue-based continuing medical education (CME). The project deployed 530 HTS service providers as a task-shifting strategy to enhance provider-initiated testing and counseling (PITC) services. Priority placement for HTS service providers targeted sites in Scale-Up to Saturation counties, where all the facilities were allocated an HTS service provider, with the high-volume facilities having more than one service provider. The coverage in the high- volume sites included the wards, outpatient departments to include special clinics, laboratories, maternal and child health (MCH) and nutrition clinics, and comprehensive care centers (CCCs). In the Aggressive Scale-Up and Sustained counties, the HTS providers were deployed in high-yield facilities. Out of 530 HTS service providers, 100 providers were specifically tasked with the responsibility of accelerating children's testing at the various entry points, and 130 service providers specifically supported community testing in Homa Bay County. The project also supported focused HTC outreach services targeting key and priority populations: sexually active young women and orphans and vulnerable children (OVC) during the reporting period.

The testing strategies in the Scale-Up to Saturation counties included universal coverage of PITC in all high- and moderate-yielding sites, testing of family members of people living with HIV (PLHIV), and focused outreach activities targeting key and priority populations. The project specifically adopted the community-testing strategy for Homa Bay County and enhanced identification of eligible first-time HIV testers to yield higher new HIV positives through targeted family testing of index clients at all facilities in Scale-Up to Saturation and Aggressive Scale-Up counties. This was done by identifying all index clients within a facility and documenting all family members' HIV status. The index client's family members of unknown status were line listed and invited to come to the facility for HTC services. In addition, targeted HTC outreach was supported to reach family members who are not able to come to the facility for testing.

The project strengthened targeted testing approaches with use of data to prioritize testing of populations with the highest HIV positive yield and particularly reached out to index client's sexual partners as opposed to only the index-client contacts and family members. The project continued utilizing the snowballing approach to reach out to the social networks of the newly diagnosed positive clients. The project supported the distribution of 1,330 proficiency testing (PT) panels to providers for Round 15 and received 1,029 (77 percent) satisfactory results. The project supported corrective measures for all unsatisfactory results received in Round 15 and further enrolled a total of 2,300 HTS providers for PT Round 16, now awaiting panel distribution. The providers enrolled include all new HTS providers, prevention of mother-to-child transmission (PMTCT) nurses, and health care workers **(**HCWs) at the CCCs who will provide HIV confirmatory retesting before antiretroviral therapy (ART) initiation.

The HTS performance for period October 2015 to September 2016 is shown in Table 1 below:

Table 1. HTC achievements for October 2015 to September 2016.

Indicator	COP 2015 Target	Y5Q4 (Oct—Dec 2015)	Y6Q1 (Jan-–Mar 2016)	Y6Q2 (April-–June 2016)	Y6Q3 (July-–Sept)	Totals	% achievement
Number of clients counseled and tested for HIV	**897,463**	247,379	337,008	504,841	544,198	1,633,426	182%
Number of clients testing HIV Positive	**30,167**	5,314	6,833	7,594	6,831	26,572	88%

Note: HIV testing and counseling; COP, country operational plan; Y, year; Q, quarter**.**

During the reporting quarter, a total of 544,198 clients were counseled and tested. This brings the total to 1,633,426 clients counseled and tested against the country operational plan (COP) 15 target of 897,463, translating into 182 percent achievement. A total of 6,831 clients among those counseled and tested turned HIV positive in the reporting quarter, bringing the total to 26,572 clients against a COP 15 target of 30,167. This translates to 88 percent achievement. The project demonstrated a quarter-on-quarter improvement in clients reached with counseling and testing with corresponding improvement in HIV-positive absolute yield in the first three quarters from 5,314 to 6,833 to 7,594 and a slight drop to 6,831 in this reporting quarter. This drop in HIV-positive yield is attributed to the accelerated community testing in Homa Bay County during the reporting quarter. In addition to the HTS offered in the reporting quarter, a total of 30,304 mothers accessed counseling and testing services in PMTCT settings, with 703 of these mothers newly testing HIV positive. In total, 574,502 clients received counseling and testing services in the reporting period, of whom 7,534 clients were HIV positive. Those linked to treatment in the reporting period were 6,220, a linkage rate of 83 percent.

County HTC performance

The county HTS performance for the period Y5Q4-Y6Q3 is shown in Table 2.

Table 2. HTC county-level performance counseling and testing, Y5Q4-Y6Q3.

County	HIV Counseling and Testing						
	COP 2015 Target	**Y5Q4**	**Y6Q1**	**Y6Q2**	**Y6Q3**	**Total**	**% Achievement**
Scale-Up to Saturation Counties							
Homa Bay	215,468	23,377	52,163	76,474	113,179	265,192	123%
Kisumu	53,818	12,465	19,619	32,306	53,090	117,480	218%
Migori	74,300	26,501	44,108	43,212	48,978	162,799	219%
Busia	23,485	12,037	17,116	28,963	24,698	82,814	353%
Subtotal	367,071	74,380	133,006	180,955	239,945	628,285	171%
Aggressive Scale-Up counties							
Nyamira	290,689	53,002	69,427	115,167	111,810	349,406	120%
Kisii	37,433	8,775	11,557	24,137	20,020	64,489	172%
Kakamega	108,941	63,180	65,668	94,716	94,407	317,971	292%
Sub---total	437,063	124,957	146,652	234,020	226,237	731,866	167%
Sustained Counties							
Bungoma	58,498	29,712	34,032	50,518	46,236	160,498	274%
Vihiga	34,829	18,330	23,318	39,348	31,780	112,776	324%
Subtotal	93,327	48,042	57,350	89,866	78,016	273,274	293%
All counties	897,463	247,379	337,008	504,841	544,198	1,633,426	182%

Note: HTC, HIV testing and counseling; COP, country operational plan; Y, year; Q, quarter.

The project achieved counseling and testing COP 15 targets in all the nine supported counties with Homa Bay and Nyamira counties undertaking accelerated testing activities after semi-annual program review (SAPR) 2016 to ensure catch-up and meet COP 15 targets. These accelerated testing activities included community testing in Homa Bay and targeted HTS outreaches in Nyamira.

The HTS county level performance for HIV positive in period Y5Q4-Y6Q3 is shown in Table 3.

Table 3. HTC county-level overall performance HIV positive, Y5Q4-Y6Q3.

County	HIV Positive						
	COP 2015 Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	%Achievement
Scale-Up to Saturation Counties							
Homa Bay	9,195	538	1,023	869	976	3,406	37%
Kisumu	2,777	526	738	827	826	2,917	105%
Migori	3,285	530	1,041	821	694	3,086	94%
Busia	688	204	331	455	305	1,295	188%
Subtotal	15,945	1,798	3,133	2,965	2,801	10,704	67%
Aggressive Scale-Up counties							
Nyamira	6,187	695	756	978	878	3,307	53%
Kisii	744	93	123	218	133	567	76%
Kakamega	4,330	1,608	1,481	1,855	1,672	6,616	153%
Subtotal	11,261	2,396	2,360	3,051	2,683	10,490	93%
Sustained Counties							
Vihiga	1,278	477	539	620	546	2,182	171%
Bungoma	1,682	643	801	951	801	3,196	190%
Subtotal	2,960	1,120	1,340	1,571	1,347	5,378	182%
All counties	30,167	5,314	6,833	7,594	6,831	26,572	88%

Note: HTC, HIV testing and counseling**;** COP**,** country operational plan; Y, year; Q, quarter.

For HIV positives in COP 15 period, three of the four Scale-Up to Saturation counties achieved greater than 90 percent COP 15 targets with Busia at 188 percent, Kisumu 105 percent, and Migori 94 percent. Homa Bay had the lowest performance at 3,406 (37 percent) positives against the COP 15 target of 9,195. In Homa Bay County the project aimed at achieving universal testing coverage and community testing through Home-Based HIV Counseling and Testing (HBHCT), a hallmark approach, in addition to health-facility testing.

Through HBHCT in Homa Bay, the project mapped all households in the 42 project-supported community units (CUs) that completely cover the population catchment in both supported subcounties. Through community testing, 144,088 individuals were reached with 811 (0.60 percent) testing positive while of the 121,104 reached through facility testing, 2,595 (2.10 percent) tested positive. A total of 265,192 individuals were tested against an estimated population of 244,503[2]. The numbers tested being higher than the estimated population could be attributed to retesting of individuals who reported any form of exposure and retesting during the postnatal period in line with the current guidelines. A mop-up exercise will continue in the following quarter to reach out to individuals who were not reached with testing by the end of September 2016. The absolute HIV-positive yield in Homa Bay was 538, 1,023, 869, and 976 positives through the four quarters with a constant proportionate yield of 0.86 percent month-on-month in this reporting quarter when community testing activities were being carried out.

For the Aggressive Scale-Up counties, only Kakamega (153 percent) met HIV-positives targets. Although Nyamira (53 percent) and Kisii (76 percent) did not meet their targets, they demonstrated improved month-on-month HIV-positive absolute yield. The project continued to support focused targeting of new testers, key and priority populations, positive-partner testing, and contact testing, particularly sexual partners and the use of snowball sampling, which all enhanced the identification of positive clients. All

[2] CBHIS - MOH 516, Kasipul and Kabondo Kasipul subcounties

the hot spots (15) were identified within the 6 subcounties of Nyamira-Kisii (including tea zones and factories), and these were reached with testing services. This improved the identification of new positive clients, which contributed to the improved month-on-month absolute yield. The Sustained counties of Bungoma (190 percent) and Vihiga (171 percent) met HIV-positive COP 15 targets.

Homa Bay county-specific interventions

The testing strategy in Homa Bay County was universal testing coverage, and this was achieved through complete coverage in both the facility (PITC) and community settings (HBHCT). The county demonstrated an upward trend in testing achievements quarter-on-quarter with 23,377, 52,163, 76,474, and 113,179 through the quarters. This was a 123 percent achievement of the COP 15 target of counseling and testing. This improved achievement has been realized as a result of interventions put into place in the county.

Some of the interventions are as follows:

1. The project supported 100 percent coverage of HTS providers at all facilities with the placement of 58 HTS providers and ensured all key service-delivery points in each facility, including MCH departments, inpatient and outpatient departments, TB clinics, nutrition services, and laboratories had HTS providers deployed. In addition, the HTS providers worked during weekends and public holidays in all high-volume sites to ensure eligible individuals attending the facility are reached with HTS services to reduce missed opportunities. In addition, a team of 130 HTS providers were specifically tasked for HBHCT, with 60 in Kasipul and 70 in Kabondo-Kasipul subcounties.
2. Community testing was supported through use of the community strategy structures by mapping the 42 community units that cover the two supported subcounties. Five hundred and forty-six (546) villages were enumerated with 51,051 households having 244,503 individuals. This population was targeted for HIV testing through facility and community testing to achieve universal testing in Homa Bay County. The project engaged 607 community health volunteers (CHVs) within these CUs to guide the household mapping and testing. The community testing included outreaches that targeted churches, market centers, funeral gatherings, community postnatal-specific psychosocial support groups (PSSGs), and any other gathering within the mapped areas.
3. The project team adopted a team approach to having integration of HTS services in all program areas, including reproductive health, voluntary medical male circumcision (VMMC), TB, nutrition, and OVC programming. This involved all the project staff, including monitoring and evaluation (M&E) teams who supported HTS reporting in all program areas and the geospatial mapping of the population catchment to enable community testing.
4. Data Quality Improvement meetings were held every two weeks in all facilities to discuss the testing uptake trends, positivity rate, linkages cascade, and quality of services offered to inform focus areas for quality improvement.
5. Strengthening of index-client contact testing was supported with an aim of enhancing improved identification of eligible individuals, particularly in pediatrics. This was done by ensuring line listed contacts of unknown status were tested at a facility or in the community, updating the index client's contact forms at the facility, and providing documentation in the client file for contacts tested during community and facility testing.
6. Performance review meetings were held at facility, subcounty, county, and project levels to review the data, as well as the strategies and progress made. These meetings also addressed challenges experienced in linkages of HIV-positive clients from community outreaches. This informed the Bring Back the Positives initiative by the cross-functional linkages team at the facility and subcounty, which saw a marked improvement in linkages of clients testing HIV positive.

7. The project supported the strengthening of the existing RTKs commodity TWGs to ensure accuracy and timeliness in consumption, forecasting, and quantification reporting of RTKs and commodity security in the Health Commodities Management Platform and District Health Information System (DHIS) 2 platforms. The TWGs, in addition, supported the equitable allocation and distribution of project-procured consumables (e.g., Jik, gloves and cotton wool) and reporting tools to ensure uninterrupted service provision.
8. Weekly project review meetings at Homa Bay County comprising the project technical teams and M&E county teams. This was to track the progress on HBHCT, Test and Treat linkages, and uptake ART and viral load (VL) testing, among others. Challenges were shared and addressed for the common aim of achieving the set goals.
9. Mapping of all the hot spots was done and prioritized services for these populations with moonlight outreaches was supported, as shown in Table 4.

Table 4. Moonlight outreaches supported in Homa Bay County, Y6Q3.

Homa Bay County	Location		Counseling and Testing	Positives	Linked	Positivity Rate
	Hot spots for moonlight	1,000 streets	347	3	2	0.9%
		Virgin Lake and Cool Base Bar	1,083	2	1	0.2%
	Markets	Oyugis and Kadongo	1,292	7	4	0.5%
	Churches	Agoro, Oyugis and Kadongo	852	5	5	0.6%
Total			3,574	17	12	0.5%

Note: Y, year; Q, quarter.

A total of 3,574 individuals were reached with testing in hot spots, with 17 turning HIV positive (0.5 percent positivity) and 12 linked to care (71.0 percent linkage rate).

The project made every effort to ensure patients with confirmed HIV infection were linked to treatment. This was initiated by the HTS providers who provided information on the benefits of early initiation, encouraged disclosure and awareness of the need to discuss the HIV status with a trusted friend or relative, and addressed barriers to linkage at the time of providing a test and to continuing after test results are provided.

The project employed the following strategies to ensure linkage to treatment:

1. Referral and physical escort of HIV positives to the facility of their choice by the HTS providers and handed over to CCC team.
2. Completion of the triplicate standard referral tool (to capture telephone number and physical address) and client locator form immediately.
3. Use of the linkage registers to document the linkage outcomes of each positive client, including facility to which linked, enrollment number, and, for those deferring enrollment, follow-up dates for home visits.
4. Immediate involvement of the peer educators (PEs) for those clients who defer enrollment. They work with the CHVs or the community PEs for subsequent follow-up of these individuals.
5. Establishment of patient support structures (e.g., psychosocial support groups for continuing psycho-social support) and patient treatment literacy for HIV-positive clients.
6. For HBHCT, tester accompaniment of clients who are ready for initiation to the health facility (escorted referral by HTS providers).

7. Immediate testing of ALL index-client contacts at the facility or community level; this is to encourage disclosure and family support (with consent).
8. Monthly facility linkage meetings with the HTS providers, who each accounted for HIV positives they identified and linked to treatment.

County HTS performance in children and adolescents under 15 years old (pediatrics)

The county HTS counseling and testing performance in pediatrics below 15 years old for the Y5Q4-Y6Q3 period is shown in Table 5.

Table 5. Pediatrics HTS performance, HIV counseling and testing, Y5Q4-Y6Q3.

County	Pediatric HIV Counseling and Testing						
	COP 2015 Target	**Y5Q4**	**Y6Q1**	**Y6Q2**	**Y6Q3**	**Total**	**%Achievement**
Scale-Up to Saturation Counties							
Homa Bay	31,017	4,330	11,074	15,739	22,634	53,777	173%
Kisumu	14,358	2,419	4,143	4,383	7,437	18,382	128%
Migori	20,026	3,137	6,367	3,457	8,326	21,287	106%
Busia	3,523	2,949	3,868	4,053	3,330	14,200	403%
Subtotal	68,924	12,835	25,452	27,632	41,727	107,646	156%
Aggressive Scale-Up counties							
Nyamira	41,782	13,433	17,101	21,883	21,253	73,670	176%
Kisii	4,784	1,187	2,139	3,623	3,004	9,953	208%
Kakamega	30,440	14,308	15,211	15,164	15,108	59,791	196%
Subtotal	77,006	28,928	34,451	40,670	39,365	143,414	186%
Sustained Counties							
Vihiga	5,224	3,510	5,462	6,292	5,070	20,334	389%
Bungoma	15,,977	3,938	4,699	4,554	6,467	19,658	123%
Subtotal	21,201	7448	10,161	10,846	11,537	39,992	189%
All counties	167,131	49,211	70,064	79,148	92,629	291,052	174%

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

For the pediatric counseling and testing, the project reached 92,629 in the reporting quarter, bringing the overall total to 291,052, a 174 percent achievement against the COP 15 target of 167,131. All the nine counties achieved the pediatric counseling and testing COP 15 targets with Kisii (208 percent), Kisumu (128 percent) and Migori (106 percent) showing tremendous improvement in uptake from SAPR 2016.

The county HIV positives performance in pediatrics below 15 years old for the Y5Q4-Y6Q3 period is shown in Table 6.

Table 6. County pediatrics HIV positive, Y5Q4-Y6Q3.

County	Pediatric HIV Positive						
	COP 2015 Target	**Y5Q4**	**Y6Q1**	**Y6Q2**	**Y6Q3**	**Total**	**%Achievement**
Scale-Up to Saturation Counties							
Homa Bay	620	41	101	98	127	367	59%
Kisumu	287	32	64	57	64	217	76%
Migori	400	44	43	78	79	244	61%
Busia	70	14	18	44	30	106	151%
Subtotal	1,377	131	226	277	300	934	68%
Aggressive Scale-Up counties							
Nyamira	836	63	34	79	73	249	30%
Kisii	96	3	3	15	13	34	35%
Kakamega	610	132	113	170	133	548	90%
Subtotal	1,541	198	150	264	219	831	54%
Sustained Counties							
Bungoma	319	43	62	98	85	288	90%
Vihiga	104	43	37	57	47	184	177%
Subtotal	423	86	99	155	132	472	112%
All counties	3,341	415	475	696	651	2,237	67%

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

The total pediatric HIV positives for the reporting quarter was 651, bringing the overall total to 2,237, a 67 percent achievement against the COP 15 target of 3,341. There was a noted improvement in absolute pediatric HIV positive in the second SAPR 2016 period with 1,347 (696+651) vis-à-vis 890 (415+475) in the first period.

The overall pediatric HIV-positive COP15 target was achieved in Vihiga (177 percent) and Busia (151 percent) with achievements in other counties, such as Kakamega (90 percent); Bungoma (90 percent); Kisumu (76 percent); Migori (61 percent); Homa Bay (59 percent); Kisii (36 percent) and Nyamira (30 percent) vis-à-vis COP 15 targets. The very low performance in Nyamira and Kisii (Masaba South Subcounty) is attributed to the generally low HIV prevalence in Nyamira County and Masaba South Subcounty.

The project strengthened pediatric testing through targeted testing in settings with high yield, namely in-patient wards, households with HIV positive parents, OVC settings, and areas with malnourished and TB-infected children. This was enabled by the dedicated pediatric HTS counselors placed at all pediatric entry points at high-volume/high-yield sites, allocation of pediatric HIV-positive targets at all entry points, optimization weekend and school holiday testing at pediatric service delivery points, and optimizing testing of pediatric contacts of index clients. The project will continue to support these interventions in subsequent quarters.

Index clients contacts testing

The project embraced index client contact testing through contact notification as a strategy to find new HIV cases. The project supported line listing of all index-client contacts at the CCC and tracing made to

reach these clients and offer HIV counseling and testing at both the facility and community settings. The achievements for this strategy are shown in Table 7.

Table 7. Summary of the index-client contact outcomes by county, Oct 2015 to Sept 2016.

	County	Contacts Counseled and Tested	HIV Positive	Number Linked	% Linkage	Positivity Rate
1	Bungoma	4,092	387	379	98%	9%
2	Busia	1,309	510	493	97%	39%
3	Kakamega	1,118	70	64	91%	6%
4	Kisii	1,927	40	38	95%	2%
5	Kisumu	2,580	56	45	80%	2%
6	Migori	3,585	66	66	100%	2%
7	Nyamira	5,558	58	56	97%	1%
8	Vihiga	524	3	3	100%	1%
-	Homa Bay*	N/A				
-	**Total**	**20,693**	**1,190**	**1,144**	**96%**	**6%**

*With universal testing the index-client contacts were tested alongside the general population and thus not disaggregated by index-client entry point.

A total of 20,693 index-client contacts were tested from October 2015 to September 2016 with 1,190 turning out HIV positive, and 1,144 (96 percent) were successfully linked. This was an average 6 percent positivity rate across the counties. The high positivity rate in Busia 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 being invited to test in the health facility and thus skewed to clients already seeking health services. Other counties tested both at the facility and in the community, with the latter possibly reaching non-contacts. 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. Kakamega and Vihiga Counties did not quite optimize index-client contact client listing and tracing, and more deliberate efforts are being supported to improve this aspect.

HTS among key populations and OVC

During this reporting period, 564 (M 239; F 325) fisherfolk were effectively referred for HTS services, out of whom 22 (M 8; F 14) tested positive, translating to about 4.0 percent positivity rate. Cumulatively, between October 2015 and September 2016, a total of 1,921 fisherfolk were tested for HIV, out of whom 120 were positive, translating to a positivity rate of 6.0 percent. All 22 fisherfolk who tested positive during this reporting period were enrolled in care and treatment services.

The project continued to support OVC counseling and testing through project-supported community-based organizations (CBOs). The county breakdown for OVC counseling and testing and HIV positive for annual program review (APR) 2016 period is shown in Table 8.

Table 8. OVC counseling and testing and HIV positive, October 2015 to Sept 2016.

County	OVCs Tested	HIV positive	Linked
Migori	5,202	84	84
Bungoma	2,399	1	1
Nyamira	2,780	2	2
Kakamega	4,477	22	22
Busia	4,913	7	7
Vihiga	1,296	3	3
Kisumu	3,108	13	13
Total	**24,175**	**132**	**132**

Note: OVC, orphans and vulnerable children.

A total of 24,175 OVC accessed HTC services from project-supported sites in the APR 2016 period with 132 testing positive (a positivity rate of 0.5 percent). All the HIV-positive OVCs were linked to care and treatment.

Linkage to care and treatment services

The total number of HIV positive clients from HTS entry points linked to care and treatment services was 6,220 (83 percent) of the total 7,534 positive clients identified during the reporting period. A total of 24,173 (81 percent) of the 29,725 positives identified were linked to care and treatment from October 2015 to September 2016.

Quality assurance

Quality assurance activities in HTS are essential to ensure the provision of quality counseling and accurate, reliable HIV testing.

The project employed the following activities to ensure high standard of quality in HTC settings:

- Regular laboratory and point-of-testing site visits by subcounty health management teams (SCHMTs) and project HTS technical teams.
- Proficiency panel tests enrollment and corrective actions undertaken for Round 15 and enrollment for Round 16.
- Rapid HIV testing and DNA Polymerase Chain Reaction refresher trainings.
- Retesting of samples from HTC sites as per the guidelines.
- HIV testing register review.
- Sit-in counselor observation, mentorship, and support supervision for the HTS providers.

The project continued to support use of standard operating procedures (SOPs) that are aligned to the existing HTS national testing and policy guidelines. These are useful for providing guidance on counseling and testing procedures and standardization for comprehensive and consistent HTS services provision at all levels.

In APR 2016 period, the project supported the distribution of 1,331 PT panels to HTS providers during Round 15 as part of external quality assessment support for HIV counseling and testing. Ninety-nine percent (99 percent) of the panels were returned by the providers (1,330/1,331) with support from the project to the National HIV Reference Laboratory for processing and producing results on PT. Through project support, 1,310 results were received by providers with 79 percent reporting satisfactory responses. Corrective measures were undertaken for all providers with unsatisfactory results.

In line with the new national HTS guidelines that requires confirmatory retesting at the CCC, the project has supported an update of the Proficiency Testers database and enrollment of more service providers, including health providers in CCC targeting a total of 2,300 service providers for PT Round16.

RTKs commodity status

The project continued to support the existing RTKs commodity TWGs to ensure accuracy and timeliness in consumption, forecasting, and quantification reporting of RTKs and commodity security in the Health Commodities Management Platform and DHIS2 platforms. This has ensured timeliness in reporting with greater than 90 percent reporting from all sites on RTKs commodities. For the screening test Determine and confirmatory test First Response, the Months of Stock status as at end of September 2016 is shown in Table 9.

Table 9. Months of stock status as at end September 2016.

County	RTK type	Months of stock
Homa Bay	Determine	4
	First Response	6
Kisii	Determine	2
	First Response	11
Kisumu	Determine	2
	First Response	2
Migori	Determine	1
	First Response	4
Nyamira	Determine	1
	First Response	12
Bungoma	Determine	3
	First Response	7
Busia	Determine	5
	First Response	13
Kakamega	Determine	5
	First Response	8
Vihiga	Determine	6
	First Response	9

No stockouts of RTKs were experienced in the reporting quarter**.**

Challenges

1. Some of the newly diagnosed HIV-positive clients opted to seek treatment services at other sites supported by other implementing partners who offer clients incentives for enrollment. This was especially so in some areas in Homa Bay County, contributing to reduced new ART clients started on treatment as compared to the new positives identified within project-supported sites. These clients enrolling in other facilities are documented in the linkages register at the testing facility.
2. Clients reached through community-testing outreaches at markets, camps, and other social gatherings accounted for the majority of HIV-positive clients who were lost to follow-up. These were largely transit clients who were from catchments outside project-supported zones.

3. Manual analysis of bulky daily data generated during the community-testing activity was tedious, and the project will invest in electronic data systems for mapping, data collection, and collation and analysis for timely reporting and decision-making.

Elimination of mother-to-child transmission (EMTCT) of HIV

During the reporting quarter, the project continued support for prevention of mother-to-child transmission (PMTCT) services in 266 health facilities (Nyanza 104; Western 162). The comprehensive support focused on 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 provided site-level capacity-building via focused continuing medical education (CME), mentorships, and support supervision, plus orientations on commodity management and forecasting, as well as data documentation, review, and reporting. The project also supported the county and national review and development of the new EMTCT framework that is scheduled for launch later in the year.

During the reporting quarter, 32,218 pregnant women were counseled and tested (including 914 known positives); 1,617 (5 percent) tested HIV positive while 1,552 women (96 percent of the positive) and 1,577 infants (97 percent of the positive) received antiretroviral (ARV) prophylaxis, respectively (Table 10 below).

Table 10. PMTCT summary achievements, October 2015 to September 2016.

Indicator	COP 2015 Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	%
Number of sites		266	266	266	266	266	
Number of pregnant women with known status	239,886	29,406	34,753	34,411	31,218	129,788	54%
Number of pregnant women HIV-positive	9,362	1,481	1,870	1,752	1,617	6,720	72%
Number of pregnant women known HIV positive		742	984	927	914	3,567	
Number of pregnant women new positive		739	886	825	703	3,153	
Number of pregnant women issued with prophylaxis	9,362	1,434	1,826	1,694	1,552	6,506	69%
Number of infants issued with prophylaxis	9,362	1,443	1,826	1,691	1,577	6,537	70%

Source: ministry of health (MOH) 731, MOH 711. Note: PMTCT, prevention of mother-to-child transmission; COP, country operational plan. Note: PMTCT, prevention of mother-to-child transmission; COP, country operational plan; Y, year; Q, quarter.

The project therefore achieved a total of 129,788 (54 percent) clients with known status against COP 2015 target of 239,886, and 6,720 (72 percent) HIV-positive identified out of the targeted 9,362. A total of 6,506 pregnant women and 6,537 infants have been issued prophylaxes from October 2015 through September 2016 period. The project did not meet its COP target due to the discrepancy between its site coverage, reporting on only 266 retained sites, and the assigned target that was based on earlier supported 606 sites. Optimization of testing at labor and delivery and postnatal clinics continued to be supported by use of dedicated pediatric counselors in all high-volume sites. The dropped sites continue to receive HIV test kits and conduct testing leading to a total Known status of 47,724 and 1,228 positive pregnant women

identified. The project has continued to discuss this with United States Agency for International Development (USAID), leading to an adjustment of COP 2016 target to 163,119.

The project continues to record an increase in known positive clients, reporting 53 percent (3,567 out of 6,720), which is attributed to older clients desiring to have more babies due to the successes of the PMTCT program. Support for family planning (FP)/HIV integration through mentorship and use of reproductive health (RH) coordinators is ongoing with a view to reducing unmet need for family planning.

Table 11. County performance against COP 15 targets.

PEPFAR Category	County	Target- Known Status	Target- Positives	Exp. Pregnancies	Known Status: APR	Total Positives	Maternal Prophylaxis	% Known Status	% Positives	% Coverage: KS Vs Expected pregnancies	% Maternal prophylaxis
Scale-Up to Saturation Counties	Homa Bay	7,186	1,605	7,902	6,433	954	915	90%	59%	81%	96%
	Kisumu	5,034	844	6,217	5,768	749	716	115%	89%	93%	96%
	Migori	15,415	1,164	12,675	13,207	958	939	86%	82%	104%	98%
	Busia	9,946	456	10,545	6,918	315	299	70%	69%	66%	95%
Aggressive Scale-up Counties	Nyamira	39,327	1,061	11,043	8,931	381	371	23%	36%	81%	99%
	Kisii	3,374	152	2,511	1,660	65	66	49%	43%	66%	100%
	Kakamega	96,260	2,479	47,690	42,136	1,749	1,675	44%	71%	88%	96%
Sustained Counties	Bungoma	46,367	997	36,074	32,980	985	976	71%	99%	91%	99%
	Vihiga	16,976	604	14,838	11,755	564	549	69%	93%	79%	97%
Total		**239,885**	**9,362**	**149,495**	**129,788**	**6,720**	**6,506**	54%	72%	87%	97%

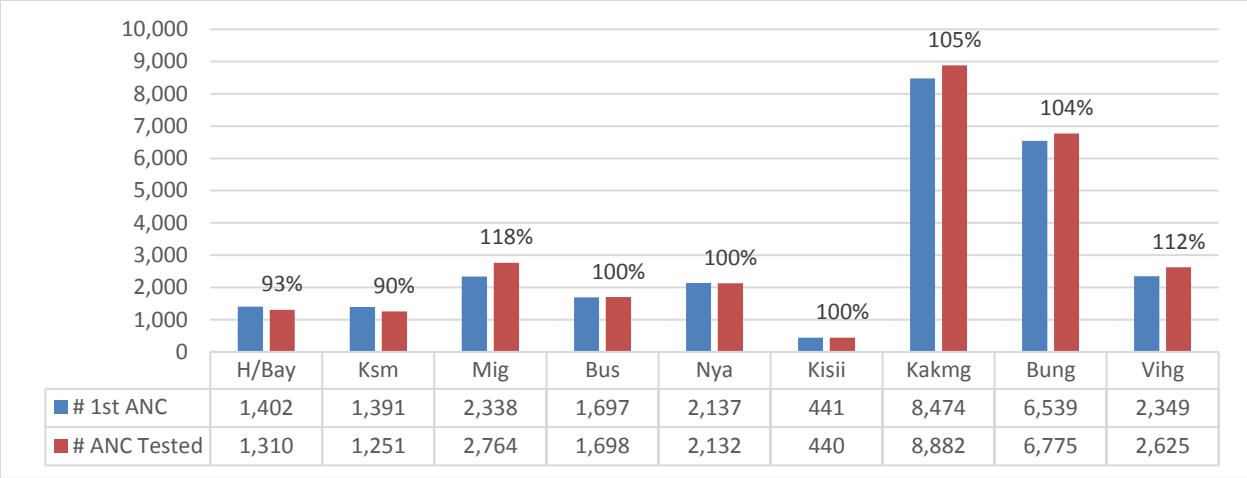
Note: COP, country operational plan.

The variances in county achievement against COP 2015 and expected pregnancies (Table 11 above) show there may be issues with the assigned targets. Only Kisumu County surpassed the APR target by achieving 115 percent of known status, closely followed by Homa Bay, which achieved 90 percent. However, it is reckoned that Kisumu and Homa Bay counties had lower COP targets than their expected deliveries, hence the project worked towards reaching all women. Counties that had many sites dropped like Kakamega, Nyamira, and Kisii were most affected, hence the lower-than-expected performance. Nevertheless, the project aimed to reach all pregnant women in each PMTCT–retained site across all counties through use of EMTCT cascades, referral booklets, activation of customer care desks, and community health volunteers (CHVs) rotating at maternal and child health (MCH) clinics. The project also procured an outreach support package comprising tents, examination couches, folding chairs, and vaccine carriers and distributed it to 13 selected, low-performing subcounties. Successes of these interventions were notable at the facility level. These led to an achievement of 87 percent performance against the expected pregnancies (129,788 out of 145,495). Challenges faced in low-coverage areas includes women not being open with CHVs about their pregnancy status; long distances covered by CHVs, hence inability to reach all targeted households; prohibitive antenatal care (ANC) profile charges by health facilities; in-completed unsuccessful referrals due to women considering too early to begin ANC services; and facility setbacks, like long waiting time. The project continues to sensitize communities on the importance of early nutrition, assessment, counseling and support (NAC) attendance.

PMTCT cascade

In the reporting quarter, counseling and testing uptake for first ANC was 106 percent, maternal prophylaxis was 96 percent, and infant prophylaxis was 97 percent. Figure 1 below shows the PMTCT cascade on uptake of counseling and testing by county for the quarter.

Figure 1. Counseling and testing uptake by county, Y6Q3.



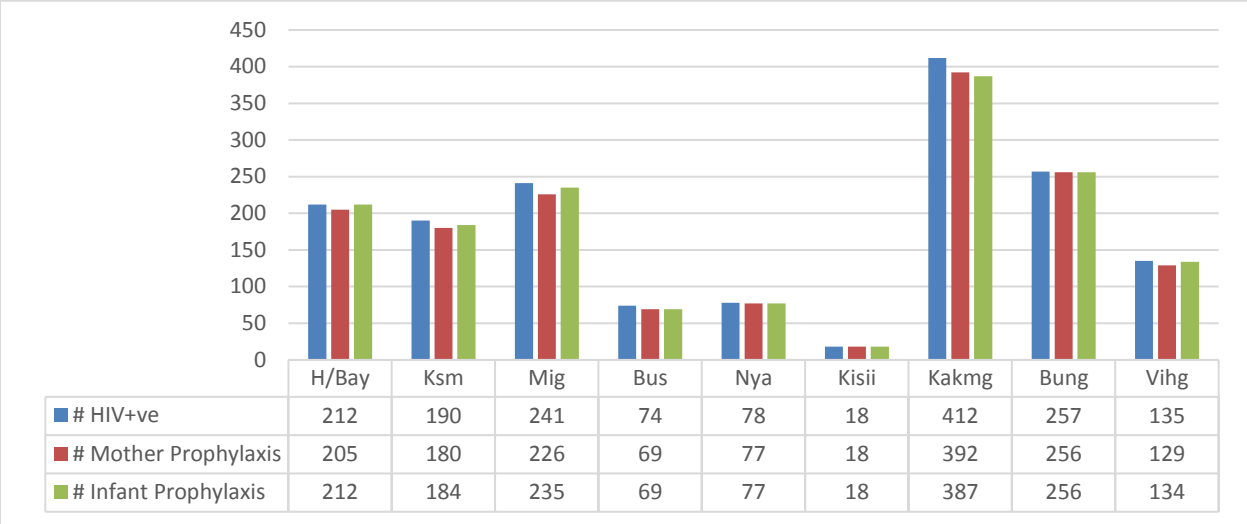
	H/Bay	Ksm	Mig	Bus	Nya	Kisii	Kakmg	Bung	Vihg
# 1st ANC	1,402	1,391	2,338	1,697	2,137	441	8,474	6,539	2,349
# ANC Tested	1,310	1,251	2,764	1,698	2,132	440	8,882	6,775	2,625

Source: Ministry of Health (MOH) 711/MOH 731. Note: ANC, antenatal care; Y, year; Q, quarter.

Access to counseling among women attending ANC services remained high in all the counties during the reporting period. The low testing in Homa Bay and Kisumu is due to known positive clients at ANC who are not eligible for testing. Homa Bay county reported 141 (67 percent) known positives out of the 212 total positives in the reporting quarter, up from 59 percent last quarter. This has been attributed continuously to success in PMTCT. The project has support 16 community mentor mothers in this county to enhance uptake and retention.

Some counties reported higher testing compared to the first ANC visit, especially in Migori and Vihiga Counties due to data discrepancies as the two indicators are obtained from different summary tools, ministry of health (MOH) 711 and MOH 731.The project will continue to enhance reporting and documentation of PMTCT indicators. Figure 2 shows the uptake in prophylaxis by county.

Figure 2. Prophylaxis uptake by county, Y6Q3.



	H/Bay	Ksm	Mig	Bus	Nya	Kisii	Kakmg	Bung	Vihg
# HIV+ve	212	190	241	74	78	18	412	257	135
# Mother Prophylaxis	205	180	226	69	77	18	392	256	129
# Infant Prophylaxis	212	184	235	69	77	18	387	256	134

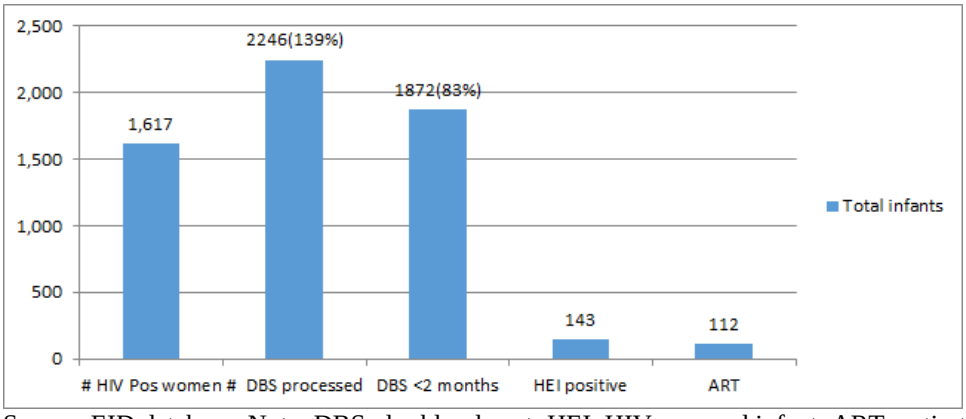
Source: Ministry of Health (MOH) 731. Note: Y, year; Q, quarter.

All counties continue to report high uptake for both maternal and infant prophylaxes. Health care workers **(**HCWs) were supported to continuously account for missed opportunities by PEs conducting home visits to trace and bring back the mothers and their infants. The project supported County Health Management Teams (CHMTs) to enable successfully traced clients on prophylaxes to be reflected in the District Health Information Software (DHIS) retrospectively, hence ensure all missed opportunities are accounted for. Mentorship, PMTCT support groups, provision of ARV commodities in integrated MCH settings, and support for commodity consumption, forecasting, and reporting continued at all sites.

Early infant diagnosis

During the reporting quarter 2,246 polymerase chain reaction tests were processed. This was 136 percent of an estimated 1,617 HIV-exposed infants (proxy from HIV-positive pregnant mothers). This was an increase from the 105% last quarter and is attributed to continued efforts in scaling up EID services. Figure 3 below follows the early infant diagnosis cascade from this reporting period.

Figure 3. Early infant diagnosis (EID) cascade, July through Sept 2016.



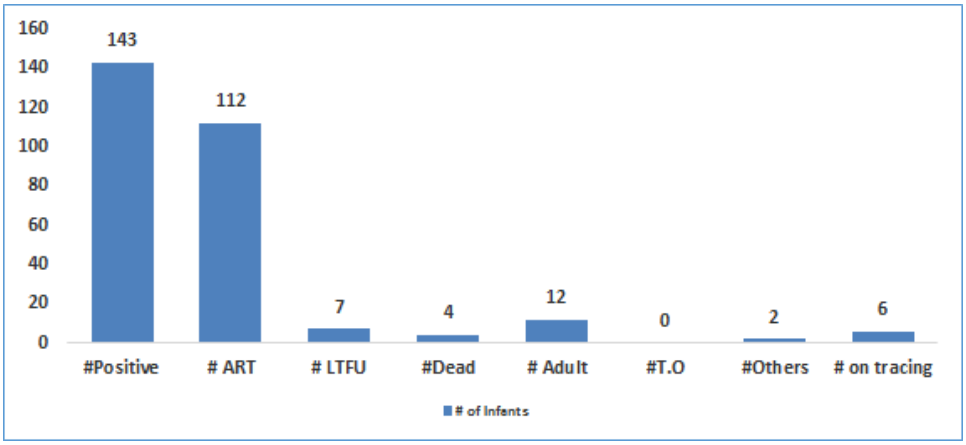
Source: EID database; Note: DBS, dry blood spot; HEI, HIV-exposed infant; ART, antiretroviral treatment.

Of all the tests processed, 1429 (83% percent) were done at the recommended (less than eight-week) period, up from 77% previous quarter. Positivity rate was 6.4 percent overall and 5.0 percent at two months. The project continues to strengthen early identification of infants.

Linkage of positive infants

Out of 143 positives infants identified, 12 were adult samples and 4 infants died before enrolment. A total of 112 out of 127 (88 percent) were initiated on treatment as shown in Figure 4 below. Tracing is ongoing for the remaining 6 positive infants.

Figure 4. Early infant diagnosis (EID) cascade for July through Sept 2016.



Note: ART, antiretroviral treatment; HEI, HIV-exposed infant; LTFU, lost to follow-up; T.O, transfer out.

PMTCT cohort analysis

The project supported PMTCT cohort analysis in all the 266 sites to establish client retention at 3 months, 6 months, and 12 months after enrollment. Viral uptake and suppression levels were also determined. Table 12 below gives the project status.

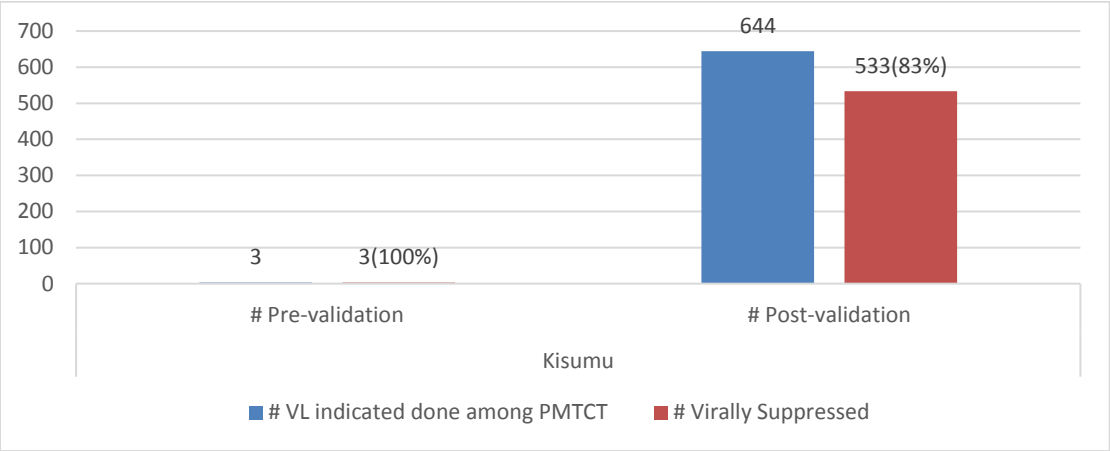
Table 12. Prevention of mother-to-child transmission (PMTCT) cohort analysis.

Indicator	3-Months Cohort			6-months Cohort			12-Months Cohort		
	Apr, May, Jun 2016			Jan, Feb, Mar 2016			July, Aug, Sept 2015		
	KP	NP	Total	KP	NP	Total	KP	NP	Total
Enrolled into Cohort (A)	546	844	1390	520	818	1338	466	782	1248
Transfers in (B)	63	7	70	64	17	81	44	12	56
Transfer Out (C)	20	47	67	36	62	98	27	74	101
Net Cohort (D=A+B-C)	589	804	1393	548	773	1321	483	720	1203
Defaulters	24	49	73	28	27	55	16	22	38
Lost To Follow Up	0	0	0	13	77	90	31	77	108
Reported Dead	0	2	2	1	4	5	2	6	8
Stopped	0	0	0	0	0	0	2	0	2
Alive and Active on Treatment (I)	565	753	1318	506	665	1171	432	616	1048
Viral Load (VL) Collected	410	0	410	380	489	869	235	327	562
Virally Suppressed (VL<1000)	390	0	390	334	407	741	220	298	518
% Retained (I/D*100)	96%	94%	95%	92%	86%	89%	89%	86%	87%
VL uptake	72%	0%	72%	69%	63%	66%	49%	45%	47%
VL Suppression	95%	0%	95%	88%	83%	85%	94%	91%	92%

Retention at 3, 6, and 12-month cohorts was 95 percent, 89 percent, and 87 percent within the project-supported sites and was higher among known positive clients across all cohorts. Viral uptake was, however low, attributed to lack of proper documentation. Suppression levels were recorded at 95 percent, 85 percent, and 92 percent across the 3, 6, and 12-month cohorts respectively. The project has rolled out the use of new viral load (VL) forms to improve proper documentation of PMTCT clients receiving VL.

Following the low VL uptake established during PMTCT cohort analysis, the project undertook some validation of all VL results per site in each county to determine the number of samples belonging to PMTCT clients. This initially was done in Kisumu County with the following results (shown in Figure 5).

Figure 5. Viral load (VL) validation among PMTCT clients in Kisumu County.



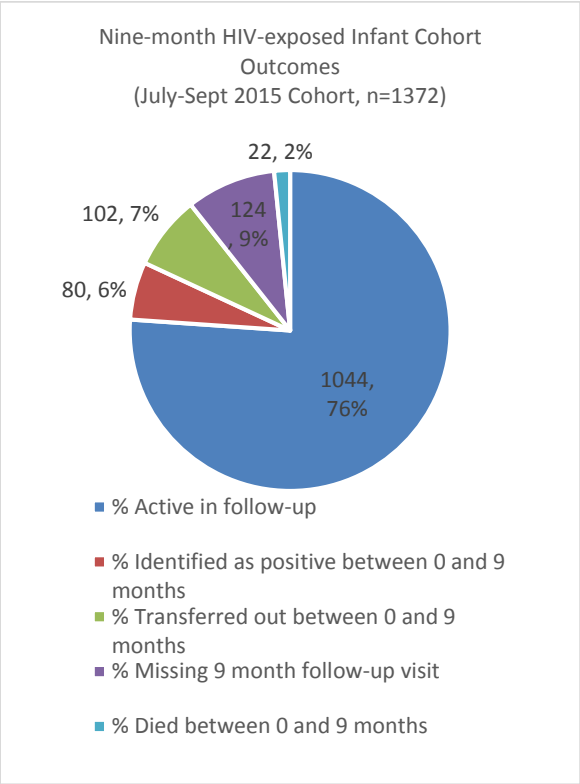
Source: EID/VL website. Note: PMTCT, Prevention of mother-to-child transmission.

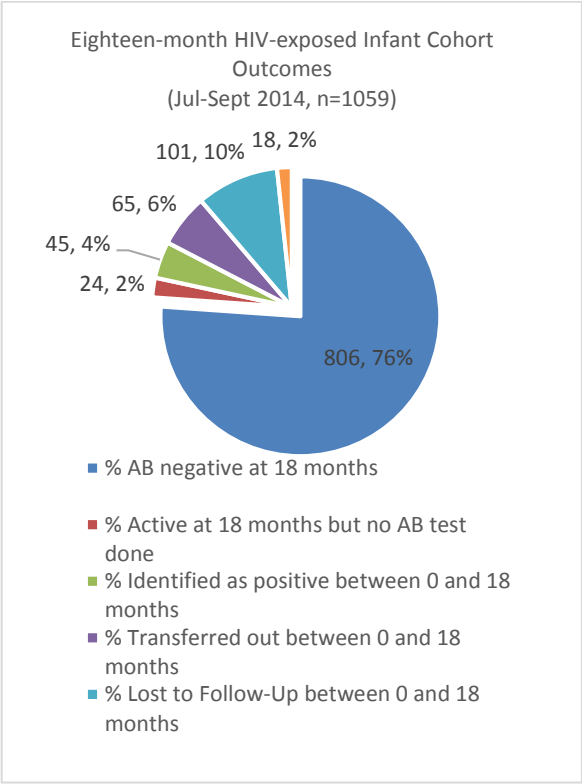
Prior to the validation exercise, Kisumu County only had three clients whose VL had been ascribed as belonging to the PMTCT cohort. After validation, the number of VL taken among PMTCT clients increased to 644 with an 83 percent suppression rate. As a result of this exercise, the project has undertaken a rapid sensitization of HCWs to correctly fill in the requisition forms for the PMTCT cohort. The project has scaled up this activity to other counties while conducting a follow-up of those clients not suppressed to ensure their final outcomes are determined.

HEI cohort analysis

The project conducted HEI cohort analysis for both 9- and 18-month cohort clients from 186 health facilities (Figure 6) to establish the percent active and HIV negative, as well as mother-to-child transmission (MTCT) rates for the two periods.

Figure 6. HIV-exposed infant (HEI) cohort analysis at nine and eighteen months.





Overall, the project attained 76 percent retention and 6 percent MTCT rate among the 9-month cohort clients, and similarly 76 percent retention and 4 percent MTCT rate among the 18-month cohort clients. Retention increased for the 18-month cohort from 71 percent achieved in the previous quarter. This was attributed to the project's continued focus to promote retention of mother-baby pairs by strengthening appointment and defaulter tracing systems, postnatal-specific psychosocial support groups (PSSGs), regular performance meetings with PEs and mentor mothers, as well as capacity-building of HCW and PEs/mentor mothers on maternal, infant, and young child feeding.

HIV care and treatment services

The project supported 511 HIV care and treatment sites in the reporting period. The support focused on the minimum package of HIV care for the pediatric, adolescent, and adult cohorts, including capacity-building, health management information systems, quality improvement initiatives, laboratory support for cluster of differentiation 4 (CD4) and viral load (VL) testing, and linkages to the ART commodities supply chain. The aim was to optimize HIV-positive clients' linkages to care, enrollment into treatment, and ensure adherence and retention to ART. The project also aimed to improve the VL uptake, as well as achieve optimum viral suppression for those on ART.

Adult care and treatment

During the reporting quarter, 7,534 clients (6,831 HTC, 703 PMTCT) tested HIV positive in the project-supported sites. Of these clients, 6,220 (83 percent) were enrolled in care in the July to September 2016 period, bringing a total of 24,173 clients enrolled for the COP 15 period against the year's target of 23,596 (102 percent achievement). Over the year, progressive improvement has been witnessed, with the second quarter exhibiting an upward trajectory with the month of March recording an enrollment of 2,285, which is above the monthly target. This momentum was sustained through to the end of the year with a peak in the month of May, where 2,499 new enrollments were recorded across the project-supported sites. Similarly, the project employed strategies to trace clients who tested positive during the previous quarter through physical tracing and escorted referrals to the facilities for enrollment using lead CHVs and community PEs.

During the reporting period, a total of 10,884 clients were initiated on treatment compared to 4,957 in the April to June 2016 period. This brings the total to 24,458 new clients initiated on treatment in the project-supported sites, translating to 107 percent achievement against the COP 15 target of 22,816. The more-than-double increase in performance in the July to September period was contributed by the adoption of the new ART guidelines of July 2016. Working under the auspices of the Test and Start guidelines following the roll-out of the National ART guidelines in mid July 2016, line listing of 6,557 cotrimoxazole (CTX)-only clients in the current care cohorts identified as at end of June was undertaken with 5,975 (91 percent achievement) of these being initiated on treatment within the three months of July to September. There is currently ongoing follow-up of the remaining 582 clients to ensure all are initiated on ART in the coming months.

The project started off the year with 97,542 current-care clients, and an additional 24,173 were enrolled in the 12 months of the COP 15 period. By the end of the reporting quarter, 103,599 (95 percent) clients were actively enrolled in care, while 102,261 (105 percent) were active on treatment. Table 13 below shows the HIV care and treatment performance of the project for October to September 2016.

Table 13. Summary care and treatment achievements (Oct 2015–Sept 2016).

Indicator	PMP Target	Achievements					
		Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% Achievement
New care	23, 596	5,017	6,089	6,847	6,220	24,173	102%
Current care	108,720	100,229	102,622	105,885	103,599	103,599	95%
New ART	22,816	4,173	4,444	4,957	10,884	24,458	107%
Current ART	97,848	90,524	93,228	96,476	102,261	102,261	105%

Source: Ministry of Health 731. Note: ART, antiretroviral therapy; Y, year; Q, quarter; PMP, performance monitoring plan),

The project achieved 103,599 current-care clients out of the 108,720 COP 2015 target, a 95 percent achievement compared to 89 percent in the APR 2015 period. The project started off the year with 97,542 current-care clients, and an additional 24,173 were enrolled in the 12 months of the COP 15 period. This gives an expected care of 121,715 against the reported figure of 103,599, translating to a crude retention of 85 percent.

On the current ART indicator, the project achieved 102,261 against a COP 15 target of 97,848, translating to 105 percent achievement. Beginning with an APR 2015 baseline of 87,838, a total of 24,458 new ART clients were initiated on ART, giving an expected current ART of 112,296 against a reported figure of

102,261 at the end of the APR 2016 period. This translates to a 91 percent crude retention in the 12-month period, a rate that is in tandem with the project's 12-month cohort retention.

Table 14 shows the reporting quarter's county-level performance compared with the COP 15 targets for new and current clients on care and treatment.

Table 14. County care and treatment achievements against COP 15 targets (Y6Q3).

County	New care			Current care		New ART			Current ART	
	Target COP 15	Achieved Y6Q3	% Achieved	Target COP 15	Achieved Y6Q3	Target COP 2015	Achieved Y6Q3	% Achieved	Target COP 15	Achieved Y6Q3
Scale-Up to Saturation counties										
Homa Bay	5,696	2,680	**47%**	16,740	13,127	5,371	2,774	**52%**	15,066	13.023
Kisumu	1,122	2191	**195%**	4,902	6,053	1,114	2,229	**200%**	4,411	6,021
Migori	3,298	2,749	**83%**	12,910	11,853	3,204	2,969	**93%**	11,619	11,790
Busia	619	1,210	**195%**	7,099	6,861	1,055	1,273	**121%**	6,389	6,831
Sub-Total	**10,735**	**8,830**	**82%**	**41,651**	**37,894**	**10,744**	**9,245**	**86%**	**37,485**	**37,665**
Aggressive Scale-Up counties										
Nyamira	3,949	3385	**86%**	15,095	12,863	4,167	3,064	**74%**	13,569	12,257
Kisii	75	650	**867%**	352	1,837	135	543	**400%**	321	1,827
Kakamega	4,956	6,111	**123%**	29,073	27,870	5,373	6,341	**118%**	26,166	27,531
Subtotal	**8,980**	**10,146**	**113%**	**44,507**	**42,570**	**9,676**	**9,948**	**103%**	**40,056**	**41,615**
Sustained counties										
Bungoma	1,848	2,970	**161%**	11,831	12,931	492	3,125	**633%**	10,648	12,844
Vihiga	2,033	2,227	**109%**	10,731	10,204	1,903	2,140	**112%**	9,658	10,137
Subtotal	**3,881**	**5,197**	**134%**	**22,562**	**23,135**	**2,396**	**5,256**	**219%**	**20,306**	**22,981**
Grand total	**23,596**	**24,173**	**102%**	**108,720**	**103,599**	**22,816**	**24,458**	**107%**	**97,847**	**102,261**

Source: Ministry of Health 731, COP 15 targets. Note: COP, country operational plan; ART, antiretroviral therapy; Y, year; Q, quarter.

The Sustained counties of Bungoma and Vihiga surpassed their targets with an overall achievement of 134 percent. These counties had a very modest COP 15 target with Bungoma County surpassing the target by the third quarter, resulting in a 161 percent achievement at the year-end while Vihiga achieved 109 percent. The Aggressive Scale-Up counties of Kakamega, Kisii, and Nyamira together achieved an average of 113 percent against their cumulative target. In this category, Nyamira recorded the lowest achievement of 86 percent, having enrolled 3,385 clients against their target of 3,949. However, this county had one of the least-missed opportunities in linkage of positive clients with 3,385 of the 3,493 positive clients (97 percent) being enrolled to care. Thus, the low achievement is attributed to a higher-than-expected positivity of 2.01 percent that was used to compute the HIV cascade targets, as opposed to 0.34 percent that was actually achieved in the year. Kisii County achieved eight times its COP target, having enrolled 650 clients against a target of 75.

The four saturation counties of Homa Bay, Kisumu, Migori, and Busia together achieved new care enrollment of 8,830 against their cumulative target of 10,735, translating to 82 percent achievement. Homa Bay's target of 5,696 contributes slightly more than half of the total target for the saturation counties, and therefore its low performance of 47 percent (2,680/5,696) had a huge impact on the overall performance in this category; the other three counties overall surpassed their individual targets. Kisumu and Busia largely surpassed their targets, achieving 195 percent each, while Migori followed closely with an 83 percent achievement.

Linkage drill-down and retrospective tracing of unlinked clients will be intensified in the mentioned counties. The facilities have started holding weekly linkage review meetings that are expected to address challenges that may arise in identification, testing, and intra- and interfacility linkages. Optimal utilization of the county facility directories to ascertain complete referrals will be emphasized during supervision, as well as in the mentioned meetings.

HIV care and treatment for children and adolescents below 15 years old

The project continued to support pediatric care and treatment for children and adolescents aged less than 15 years old (pediatrics) through the Accelerating Children's HIV/AIDS Treatment Initiative. Table 15 below shows the project's performance on the pediatric care and treatment indicators through COP 15.

Table 15. Summary project achievement, pediatric care and treatment (Oct 2015 to Sept 2016).

Indicator	PMP Target	Y5Q4 achieved	Y6Q1 achieved	Y6Q2 achieved	Y6Q3 achieved	Total	% Achievement
Pediatric new care	3,222	452	464	629	565	2,110	65%
Pediatric current on care	14,692	9,363	9,434	9,722	9,828	9,828	67%
Pediatric new on ART	3,075	412	408	566	723	2,109	68%
Pediatric current on ART	13,320	8,875	9,049	9,320	9,707	9,707	73%

Source: Ministry of Health (MOH) 711 and MOH 731. Note: Y, year; Q, quarter, PMP, performance monitoring plan)

In the reporting period, 794 HIV-positive pediatric clients were identified through HTC (651) and EID (143 confirmed via website). A total of 565 were enrolled to care in the July to September period, bringing the total to 2,110 clients enrolled in care by end of COP 15 against the annual target of 3,222 (65 percent) achievement. The low performance in the quarter was attributed to lower positivity during the period, evident from the community-based HTS outreaches done especially in Homa Bay. In this county, the project embarked on a testing strategy to ensure universal coverage through mapping all the CUs in the region and testing all eligible clients, including pediatrics; a total 22,634 pediatrics were tested, leading to 127 positives, a positivity of 0.60 percent. This annual performance

of 2,110 is also comparable to previous COP 14 performance of 2,090 pediatric newly enrolled on care.

In the reporting period, 723 pediatric clients were initiated on ARVs compared to the previous quarter of 566. This brings the total to 2,109 clients initiated on ART against a COP target of 3,075 (68 percent). The more than 30 percent increase in new pediatric clients on ARVs from previous quarter was due to the advent of the new Test and Start guidelines that led to mop-up of the clients previously on CTX only. The number of pediatrics not on ART has reduced from 402 in Quarter 2 to 121 in the reporting quarter. This narrowing of the gap has been attributed to strategies employed in the advent of the Test and Treat guidelines. The project is currently tracing the clients that were not initiated during the quarter to ensure all 121 remaining clients on CTX are started on ARVs by the end of the next reporting period.

The project achieved 9,828 pediatric current-care clients, out of the 14,692 COP 2015 target, a 67 percent achievement. On the current ART indicator, the project achieved 9,707 against a COP 15 target of 13,320, translating to 73 percent achievement. Beginning with an APR 2015 baseline of 8,875, a total of 2,109 new ART clients were initiated on ART, giving an expected current ART of 10,984 against a reported figure of 9,707 at the end of the APR 2016 period. This translates to an 88 percent crude retention in the 12-month period.

ART cohort analysis

For the COP 15 period, a total of 19,941 individuals out 21,903 were still on treatment 12 months after initiation on ART. This translates to 91 percent achievement against an expected target of 90 percent. The project's retention mechanisms have been pivotal in the project continuously achieving the more than 90 percent 12-month retention rate. These mechanisms will continue to be strengthened in the COP 16 period with improvements where gaps are noted. The 12-month retention among the children up to 14 years old is 88 percent (2,068/2337). This lower-than-average retention could be attributed to the transitioning of children to the 15+ age group.

Laboratory support

The project continued to provide support to a total of 32 CD4 nodal sites in the quarter. It also maintained linkages for VL processing with the Kenya Medical Research Institute, Alupe-Busia; Kenya Medical Research Institute/US Centers for Disease Control and Prevention, Kisian; and the Walter Reed Program, Kericho.

Viral load (VL) testing

By the end of the COP 15 period, 88,966 out of the eligible 93,228 clients *(current ART as at March 2016,* had received at least one VL. This translates to a 95.0 percent VL uptake compared to 56.0 percent in the previous year. The pediatric uptake was highest at 99.5 percent: 9,011 of the 9,049 eligible children on ART received at least one VL within 12 months, while for the population above 15 years old, the uptake was 95.0 percent. At county level, the highest uptake is exhibited in Vihiga County where 98.0 percent of the eligible clients received at least one VL. The lowest is in Migori at 80.0 percent with the two Kuria subcounties, as well as the low-volume sites across the whole county, acting as major contributors. The distance of the Kuria subcounties to courier services could be a contributor to this low uptake. Homa Bay's relatively low performance of 82.0 percent uptake is mainly contributed by seven facilities that had a below 80.0 percent uptake. Among these are two high-volume sites, namely Kabondo Subcounty Hospital and Matata Nursing and Maternity Home. Efforts since have been made to conduct mop-up of the eligible clients for VLs in these facilities. The most improved county was Bungoma, which previously has had an uptake of less than 50.0 percent but recorded a 91.0 percent in this reporting period.

The total number of tests that were suppressed among the 88,966 VL tests done in the year is 71,908, translating to an 80.0 percent viral-suppression level against an expected 90.0 percent. Among the three cohorts of pediatrics (0 to 14 years old), adolescents (15 to 19 years old) and adults (20+ years old), the suppression levels are at 60.0 percent, 58.0 percent and 82.0 percent, respectively. At county level, the highest suppression levels are seen in Kisumu County with 89.0 percent of the total VL done being below 1,000 copies/ ml. With an equally high VL uptake of 94.0 percent, the pediatric and adolescent cohorts are still recording a 66.0 percent and 58.0 percent suppression, respectively. Migori County's suppression stands at 81.0 percent, followed by Homa Bay at 80.0 percent and Nyamira at 78.0 percent.

Reaching people living with HIV (PLHIV) outside health facilities

In Y6Q3, the project continued supporting the 889 trained community PEs to conduct positive health, dignity, and prevention (PHDP) sessions in all 1,011 PSSGs and 151 children and adolescent clubs (PSSGs) across Nyanza and Western Provinces. A total of 241 health facilities are linked to the PSSGs; 128 facilities in Nyanza and 113 facilities in Western Counties. A total of 24,111 (M 7,600; F 16,511) HIV-positive adults, adolescents, and children were reached with the 13 prevention messages compared to 13,104, 12,498 and 11,981 reached in Y6Q2, Y6Q1 and Y5Q4, respectively.

A child play therapy session in Uriri.

The outreach breakdown is as follows:

i. Children Clubs (PSSGs)—the project facilitated monthly meetings in 89 children clubs, reaching a total of 2,347 (M 944; F 1,403) with services through play therapy, nutritional assessments, and growth monitoring.
ii. Adolescent Clubs (PSSGs)—the project also supported monthly meetings for adolescents on care through clubs reaching a total of 690 (M 251; F 439) with information on adherence, self-care, personal hygiene, and the need for viral suppression.
iii. Adult PSSGs—through adult PSSGs, a total of 21,074 (M 5,758; F 15,316) were reached with information on viral suppression, stigma and discrimination, and human rights, alongside the 13 PHDP messages. As a result, 304 defaulters in Migori, Bungoma, Busia, Kakamega, and Kisumu Counties were traced and brought back to care services.
iv. Discordant Couple Groups—In addition to one discordant couples group formed in Matungu, Kakamega County, in Y6Q2, three more PSSGs were formed in Nyamira and Bungoma Counties in Q3 to address the psychosocial and health needs of discordant couples.
v. Male Champions of Change (MCC)—the project supported Male Treatment Champions, and rights-based approach advocates continued to "advocate" for the provision of quality HIV services at the community and health-facility levels. In Busia, the rights-based approach advocates facilitated the arrest and conviction of a 40-year old man who defiled and infected an adolescent girl with HIV.
vi. Business Activities—the project continued to mentor PLHIV on income generation through village savings and loans associations (VLSAs) for household economic strengthening. Through VSLAs, Tusaidiane, Alemuna, Kotur, and Rarieda Kaloo PSSGs in Busia and Homa Bay continued with group savings and revolving fund activities. In Kuria East, Tushirikiane "A" and "B" PSSGs received a dairy cow and an incubator for hatching chicks by Migori County government to boost their VSLA activities.

TB–HIV coinfection services

The project continued to provide support in implementation of TB–HIV activities in 511 sites through various capacity-building initiatives, including facility CMEs, sensitization and mentorship of HCWs, support supervision, sample networking, and performance review meetings with focus on the "5Is": strengthened Integration of TB–HIV services; Intensified case finding (ICF) among PLHIV and PMTCT clients; Immediate ART for all the TB–HIV coinfected clients; Isoniazid preventive therapy (IPT) for asymptomatic persons and timely management for symptomatic clients through GeneXpert utilization; and Infection prevention and control (IPC), targeting provision of minimum package of IPC in all the project-supported sites. The key achievements for October 2015 to September 2016 are shown in Table 16.

Table 16. Key TB–HIV performance indicators, October 2015 to September 2016.

TB–HIV performance indicators	COP 2015 Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total
Number of TB cases registered		1,528	1,507	1,297	1,317	5,649
Number of TB patients who were counseled, tested for HIV, and received results	6,514	1,487	1,476	1,247	1,276	5,486
Proportion counseled and tested for HIV and received results against COP 15 Target		(23%)				84%
Number of HIV-infected TB patients		524	473	463	435	1,895
Proportion of TB–HIV Co-infection		(35%)	(32%)	(37%)	(34%)	35%
Number of HIV-infected TB patients on Cotrimoxazole		511	468	463	432	1,874
Number of HIV-infected TB patients on ARVs	2,952	476	439	436	420	1,771
Proportion of HIV-infected TB patients on ARVs against COP 2015 target		(16%)				60%
Number of HIV-positive clients screened for TB	86,976	85,454	91,126	96,228	94,101	94,101
Proportion of PLHIV clients screened for TB against COP 2015 target		(98%)	(105%)	(111 %)	(108%)	(108%)

Source: TIBU System data/MOH 711. Note: COP, country operational plan; ARV, antiretroviral; PLHIV, people living with HIV; Y, year; Q, quarter; "TIBU" means "to treat" in Swahili.

During the reporting period, a total of 1,317 TB patients were registered in project-supported sites, where 97 percent (1,276/1,317) of all the clients were counseled and tested for HIV, 34 percent (435/1,276) were co-infected with HIV, and 99 percent (432/435) were initiated on ART (TIBU Data). This brings the total to 5,649 TB patients registered in the period between October 2015 and September 2016. Clients with documented HIV status were 5,486 against a COP 15 target of 6,514, an 84 percent achievement for the APR 2016 period. Overall, 97 percent of all TB clients registered had a known status. For HIV-infected patients initiated on ARVs, the total was 1,771 against a COP 15 target of 2,952, giving a 60 percent achievement in the APR 2016 period.

Integration of TB–HIV services

In the reporting quarter, a total of 1,317 TB patients were registered in project-supported sites. This brings the total to 5,649 TB patients registered in the period between October 2015 and September 2016. The number of clients counseled and tested for HIV was 5,486, which translates to 84 percent achievement against the COP 15 target of 6,514. The low known status uptake compared to the COP 15 target could be attributed to missed opportunities in TB case detection and TB diagnosis at levels of care, including the outpatient and MCH departments. Other contributing factors could be associated with delay in referral of clients within the facility (i.e., focused referral of all presumptive TB clients at the CCCs and referral of suspected TB clients from community to facility). In addition, challenges attributed to the reporting system have been noted, and the project will continue working closely with the sub-county TB coordinators, subcounty health records information officers, and project data clerks to ensure that data from the primary tools (TB4 registers) are collected and analyzed by the tenth of every month and keyed into the TIBU and DHIS systems.

To further improve on TB case findings and PITC provision among registered TB patients at county level, the project will continue to provide capacity-building initiatives to strengthen the use of presumptive TB registers at CCC and MCH clinics. Focus will also be on active case finding in all entry points, especially the inpatient and outpatient departments, with more emphasis on correct use of the ICF cards at the facility and intensified contact tracing for smear-positive clients at the community, school, and household level to ensure that there is timely referral of symptomatic clients to the nearest facilities for diagnosis and possible treatment. The project teams will also support and participate in quarterly TB–HIV technical working group (TWG) meetings and county/facility-based data reviews at all levels.

ART initiation among TB–HIV coinfected clients

In the reporting period, the project initiated 420 clients (97 percent) on ART out of the 435 eligible TB–HIV coinfected individuals. This reflects a continued upward trend in ART initiation from 94 percent in the April to June 2016 period and 38 percent in the pre-SAPR 2016 period occasioned by data discrepancies in the reporting system. This brings the total to 1,796 coinfected clients initiated on ART during the APR 2016 period, a 61 percent achievement against the COP 15 target of 2,952. This low achievement could be attributed to the low number of new TB cases registered during the reporting period.

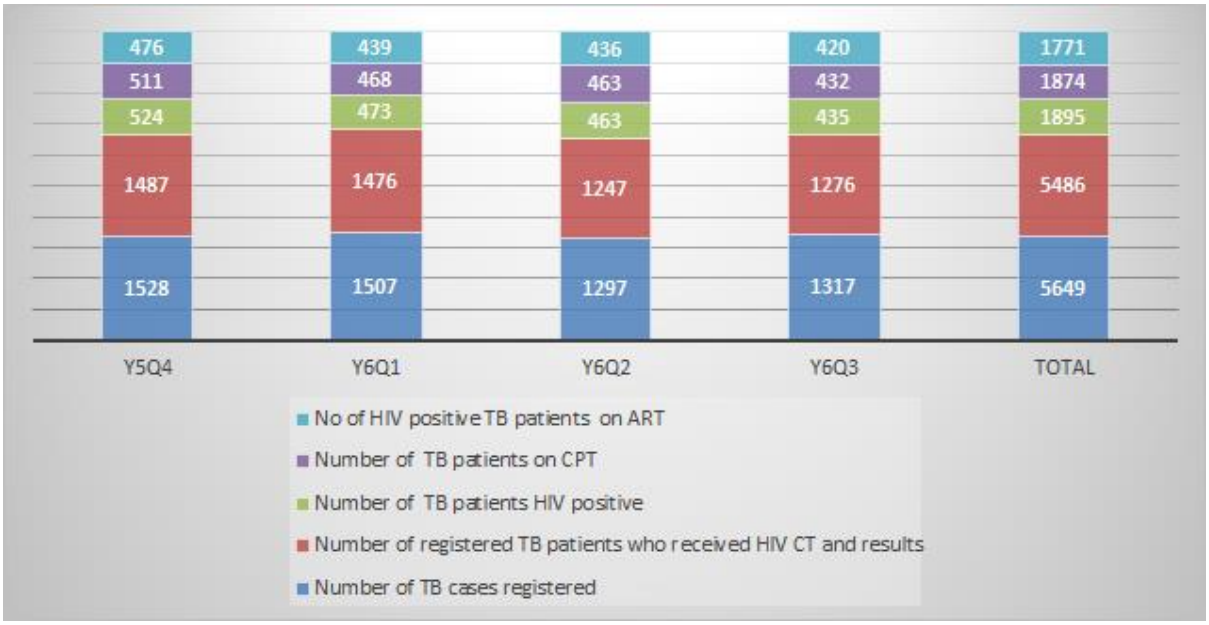
To sustain the TB ART uptake among coinfected clients, the project will continue to provide direct service delivery support—including capacity-building with focus on dissemination of the new ART guidelines and, in particular, on the current Test and Treat policy through sensitization, mentorship, and facility-based CMEs for HCWs at CCC, MNCH, and TB clinics and training of newly employed county health providers with a target of 100 percent ART initiation among the TB–HIV coinfected clients. The project also will support joint TB–HIV support supervision, regular performance review meetings to ensure proper documentation, and reporting of TB–HIV coinfected clients in MOH reporting tools, TIBU system, and DHIS.

Childhood TB–HIV

During the reporting quarter, 147 children were diagnosed with TB, representing 11 percent of the 1,317 identified cases. Of those, 97 percent (143/147) were tested for HIV and 28 percent (41/147) were coinfected with TB–HIV. Of those coinfected, 100 percent (41/41) were on CPT, while 95 percent (39/41) were initiated on ART. For the period between Oct 2015 and Sept 2016, out of a total of 5,649 registered TB patients, children were 506 (9 percent). To scale up on diagnosis of TB among children to the 12 percent National Tuberculosis, Leprosy and Lung Disease Program target, the project continues to support utilization of pediatric ICF cards at all levels, support pediatric TB–HIV capacity, strengthen the use of GeneXpert use through sample networking, support mentorship on pediatric diagnosis, and ART initiation with more focus on newly employed county staff. The project will continue with dissemination and distribution of pediatric TB SOPs.

The overall TB–HIV cascade for Oct 2015 to Sept 2016 is shown in Figure 7.

Figure 7. TB–HIV cascade, Oct 2015to September 2016.



Source: TIBU System data/MOH 711.

Intensified case finding-TB screening

Table 17. TB screening against current-care clients, Y6Q3 and COP 15 target.

County	COP 15 Target	Total Screened for TB	% Compared to COP 15 Target	Current-Care Clients	% Compared to Current Care Sept 2016
Busia	5,679	6,178	109%	6,861	90%
Homa Bay	13,392	12,680	95%	13,127	97%
Kisumu	3,922	5,630	144%	6,053	93%
Migori	10,328	10,809	105%	11,853	91%
Kakamega	23,259	23,953	103%	27,870	86%
Kisii	634	1,748	275%	1,837	95%
Nyamira	11,713	12,087	103%	12,863	94%
Bungoma	9,465	11,474	121%	12,931	89%
Vihiga	8,585	9,542	111%	10,204	93%
Total	**86,976**	**94,101**	**108%**	**103,599**	**91%**

Source: MOH 731 (September 2016). Note: COP, country operational plan; Y, year; Q, quarter.

During the reporting period, 94,101 PLHIV clients were screened for TB against a COP 15 target of 86,976, a 108 percent achievement as shown in Table 17. This translated into 91 percent achievement against the current-care cohort of 103,599 as at end of APR 2016 period. Review of county-level achievement indicates that all counties achieved more than 100 percent TB screening against COP 2015 target apart from Homa Bay County, which scored 95 percent. The project will therefore put more emphasis in Homa Bay County facilities to ensure that all PLHIV are screened for TB and results documented in MOH 731 and DHIS2.

The project will continue to support facility CMEs and sensitization of HCWs to ensure proper/quality utilization of the ICF cards and timely referral for all the Presumptive TB clients, with the aim of improved TB case detection and timely TB diagnosis and treatment among PMTCT and HIV-positive clients. Photocopies of ICF cards in instances of shortage also will be supported to ensure that all files of PLHIV at MNCH and CCC clinics have the ICF cards and are administered regularly during each clinical visit.

The project also will focus on sensitization of HCWs to ensure that asymptomatic clients identified and eligible are initiated on IPT while all symptomatic clients are registered in the Presumptive TB registers. The samples from the symptomatic patients will be subjected to GeneXpert examination through the project-supported sample networking system. Based on GeneXpert results received, clients will be linked and/or referred in a timely manner for treatment and appropriate care.

Isoniazid preventive therapy (IPT)

Table 18. Number of PLHIV on IPT by County (Y6Q1 to Y6Q3)

County	COP 2015 Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% compared to COP 15 target	Current Care, Y6Q3	% against Current Care, Y6Q3
Busia	495	0	1,382	0	52	1,434	290%	6,861	21%
Homa Bay	4,557	1,748	1,267	696	207	3,918	86%	13,127	30%
Kisumu	897	0	1,194	1,202	13	2,409	269%	6,053	40%
Migori	2,638	388	1,175	1,056	1,313	3,932	149%	11,853	33%
Kakamega	3,965	1,145	6,583	1,806	969	10,503	265%	27,870	38%
Kisii	229	0	155	0	152	307	134%	1,837	17%
Nyamira	2,991	377	957	844	402	2,580	86%	12,863	20%
Bungoma	1,479	1,149	1,183	617	25	2,974	201%	12,931	23%
Vihiga	1,626	348	1,928	909	511	3,696	227%	10,204	36%
Total	18,876	5,155	15,824	7,130	3,644	31,753	168%	103,599	31%

Note: PLHIV, people living with HIV; IPT, isoniazid preventive therapy; COP, country operation plan.

In the reporting period, the project initiated IPT in 3,644 PLHIV, bringing the total to 31,753 PLHIV initiated on IPT in APR 2016 period against a COP 15 target of 18,876, a 168 percent achievement. This overachievement could be attributed to the relatively low COP 15 target. This achievement was, however, only 31 percent of the current-care cohort as at end of September 2016.

In subsequent quarters, the project will focus on IPT initiation for all eligible clients among the current-care cohort, with a target of 90 percent initiation. This will be achieved through continued capacity-building initiatives to ensure that all asymptomatic clients are evaluated and eligible clients initiated on IPT therapy. The project will work closely with the National AIDS & STI Control Programme (NASCOP) and the National Tuberculosis, Leprosy and Lung Disease Program to ensure that there is enough supply of IPT commodities across all the project-supported counties. In addition, it also will focus on IPT reporting system to ensure that all clients initiated on IPT are documented in the IPT registers and reported monthly using the new MOH 731 tool by HCWs and DHIS by subcounty health information officers. Reporting for children under 5 years old with a history of contact with smear-positive TB clients will be documented in the IPT registers at the TB clinics and in TIBU by the subcounty TB coordinators.

TB–HIV cohort analysis

Cohort analysis for the 1,664 TB–HIV coinfected clients registered in Y5Q3 showed that 89 percent (1,481/1,664) of reported clients completed their course of TB treatment, 2 percent (35) were lost to follow-up, 3 percent (46) were transferred out to other facilities before completion of treatment, 1 percent (14) reported as failed and were subjected to GeneXpert testing, while 5 percent (87) of the coinfected clients died while on treatment. The project will continue capacity-building approaches in TB–HIV management to immediately initiate all coinfected clients on treatment.

Infection prevention and control (IPC)

During the reporting period, the project continued to support IPC measures, and 82 percent (412/502) sites were able to provide a minimum IPC package of infection prevention and control (well-ventilated waiting bays, triaging of clients, and opening of windows). The project also supported the training of 35 HCWs and 120 community health workers (CHWs) on community-based directly observed treatment for TB. The project will continue to provide support for improved IPC measures, plus IPC and health care waste management (HCWM) committee meetings to ensure that each facility is able to hold an IPC meeting with documentation of IPC plans in facility files. The project will further support the Advocacy, Communication and Social Mobilization activities with focus on reduced TB transmission through training of newly employed county HCWs on community-based directly observed treatment for TB and printing and distribution of IPC posters on cough etiquette and other information, education and communication materials.

Drug-resistant TB (DR–TB) Management

In the reporting quarter, a total of four (4) new multiple DR patients were reported in project-supported subcounties, bringing the total number to 41 DR–TB patients ever on treatment for the life of the project to date. A total of five (5) DR–TB patients completed DR–TB treatment and were discharged from treatment after culture and sensitivity results in the APR 2016 period; one client died, and one client defaulted.

Defaulter tracing for the lost client was done, but the client was not reached because of moving to an unknown location. Contact tracing for all the 4 new multiple DR clients was done, and 28 contacts were screened with none reporting sputum positive. The project will continue with support for DR–TB management through support for clinical review meetings, sample networking for GeneXpert, and DR–TB surveillance through contact tracing. The project will focus on utilization of GeneXpert testing for all DR–TB contacts and training more HCWs on DR–TB to ensure that all eligible clients are screened and resistant clients initiated on treatment.

GeneXpert utilization

The project continued to support GeneXpert utilization through GeneXpert and TB–HIV TWGs, sensitization of HCWs on GeneXpert algorithm and utilization of ICF cards, and sample networking though timely referral of specimens for symptomatic clients from peripheral sites to the GeneXpert sites. During the reporting period, the project supported distribution of Presumptive TB registers to all the 500 CCC sites and 325 MCH clinics for PMTCT symptomatic clients.

The GeneXpert utilization is shown in Table 19 for the supported counties.

Table 19. GeneXpert utilization rate per county, Oct 2015 to Sept 2016.

County	% GeneXpert utilization Y5Q4	% GeneXpert utilization Y6Q1	% GeneXpert error rate Y6Q1	% GeneXpert utilization Y6Q2	% GeneXpert utilization Y6Q3	% GeneXpert error rate Y6Q3
Scale-Up to Saturation counties						
Kisumu	46%	100%	2%	71%	93%	2.4%
Homa Bay	103%	55%	4%	93%	60%	0.8%
Migori	63%	60%	4%	69%	58%	1.4%
Busia	11%	41%	2%	83%	58%	0.7%
Aggressive Scale-Up counties						
Kakamega	48%	62%	4%	43%	74%	2.0%
Nyamira	26%	77%	2%	45%	52%	7.0%
Kisii	35%	64%	2%	67%	92%	2.2%
Sustained counties						
Bungoma	46%	69%	3%	68%	91%	2.0%
Vihiga	24%	49%	2%	0%	27%	9.0%

Source: Source: National Tuberculosis, Leprosy and Lung Disease Program **(**NTLD-P) – Online GX Alert.

GeneXpert utilization improved across the counties apart from Vihiga and Homa Bay Counties. There was also a notable decline in error rates except for Nyamira and Vihiga. The main contributing factors to the low-utilization and error rates are as follows: recurring power blackouts, unsuitable samples, low-sample networking, and internet access, leading to delay in results relay from the GX Alert system to the requesting clinician.

The project will strengthen the use of current GeneXpert algorithms and SOPs through capacity-building initiatives and sample-networking approaches from peripheral sites to the nearest GeneXpert machine. Sensitization of HCWs in facilities with GeneXpert machines will be conducted in order for them to utilize GeneXpert as the first diagnostic test for all Presumptive TB cases in all departments (outpatient, inpatient, MCH, and CCC). The project team will also support GeneXpert/TB–HIV TWG meetings to ensure that any noted error in the machine or shortage of commodities (Falcon tubes and cartridges) are reported in a timely manner to the county teams and national mechanisms for quick resolutions. Through the TWG the project will support all the county medical lab coordinators, their subcounty counterparts, and the Super Users to track and report any interruptions in Internet access, and the project will assist through support for airtime bundles.

School health and community TB activities

During the reporting period, the project supported school health talks in 251 schools. A total of 1,528 pupils and teachers were reached with key messages on TB prevention. Coupled with this was the screening and investigation of contacts of the active TB cases in schools where 14 contacts were screened, leading to two (2) smear-positives for TB who have since been enrolled on treatment.

The CHVs provided health education on TB during household visitation and defaulter tracing initiatives. The community TB activities outputs in the reporting quarter are shown in the Table 20.

Table 20. Community TB outcomes, July to September 2016.

TB Outcome	Jul-16	Aug-16	Sep-16	Total
TB Treatment Defaulters Traced and Referred Back Into Care	5	7	6	18
Clients With Cough Referred for Diagnosis	40	31	59	130
School Health Talks (# of pupils and teachers reached)	945	-	583	1,528
Contact Screening in Households With MDR TB Patients	12	21	32	65

Note: MDR, multiple drug-resistance.

Household contact screening was done in households with multidrug-resistant TB patients, and 65 contacts were screened and samples collected. None were positive. Eighteen (18) clients were defaulter traced and returned to treatment, as well as counseled on the importance of adherence to treatment.

HIV prevention services

Voluntary medical male circumcision (VMMC) services

During the reporting period July to September 2016, the project continued to provide direct service delivery support to 47 project-supported VMMC sites (30 static and 17 outreach) through the provision of consumables, equipment, and reporting tools, as well as supportive supervision and mentorship on VMMC service provision. All the 47 VMMC sites are in the Scale-Up to Saturation counties of Homa Bay, Migori, Kisumu, and Busia Counties. A total of 15,175 men accessed VMMC services across the 47 sites. Of these, 14,823 (98 percent) were counseled and tested for HIV as part of VMMC minimum package of services, 23 of whom turned positive and were all referred and linked for HIV care, treatment, and support. There was one moderate adverse event reported.

Table 21. VMMC Quarterly performance by County as at APR.

County	Male circumcisions done						
	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	Target	%
Homa Bay	12,072	1,717	4,789	7,088	25,666	23,673	108%
Migori	4,238	380	1,952	2,709	9,279	9,077	102%
Kisumu	1,478	121	727	694	3,020	3,631	83%
Busia	3,269	138	1,677	4,684	9,768	6,440	152%
Total	**21,057**	**2,356**	**9,145**	**15,175**	**47,733**	**42,821**	**111%**

Note: VMMC, voluntary medical male circumcision; MC, male circumcision; APR, annual program review.

As at APR, a total of 47,733 clients had accessed VMMC services against a COP 15 target of 42,821, an 111 percent achievement as shown in Table 21. Ninety percent (42,945) of these clients were counseled and tested for HIV as part of VMMC minimum package of service, 74 of whom turned positive and were effectively linked to HIV care, treatment, and support. There was one moderate adverse event reported during the period. All except Kisumu County achieved more than the expected 100 percent. Busia County achieved 152 percent of their target owing to the influx of clients seeking male circumcision services in the month of August 2016, which coincided with the circumcision period around this part of the country. Kisumu County achieved 83 percent, a performance which can attributed to the low number of sites supported in that county. The project is working with the SCHMT to identify and support underserved health facilities within Muhoroni subcounty. The 100+ percent overall achievement is attributed to the project support for intensive six weeks of VMMC Rapid Results Initiative activities in the month of November and December 2015 and the

eight weeks of accelerated VMMC campaigning which coincided with school holidays in April and August across all the 47 sites and outreach sites. A total of 38,258 clients were reached, contributing to 80 percent of all circumcisions done during this reporting period. The highest uptake of VMMC services over time remains clientele aged 10 to 24 years old (26,421), 55 percent of the total, followed by under 14 years old at 13,188 (28 percent). The project and MOH teams continued to ensure that young adolescents with immature penile anatomy receive the service using the recommended dorsal slit technique.

To increase demand for VMMC services, the project continued to work with community structures for social mobilization during routine and high-volume VMMC services, targeting males aged 10 to 29 years old in the community and in educational institutions, HIV-negative men in discordant relationships, and men who test negative at different testing points within the facilities. In order to get services even closer to the clients, the project provided mobile and outreach services across the four counties. The project also 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 has continued to support quality assurance initiatives by supporting the MOH teams to conduct continuous supportive supervision and mentorship and supporting monthly data review meetings, conducting Data Quality Assessment (DQA) and Site Improvement Monitoring Systems (SIMS). The project also supported the training of 158 healthcare providers—108 on full VMMC service provision, 47 on dorsal slit method of male circumcision, and 3 Shang Ring male circumcision device. This was to improve their surgical skills on male circumcision, including circumcision using dorsal slit method for clients aged 10 to 14 years old whose penile anatomy are still immature and circumcision using the Shang Ring device in readiness for rollout of Shang Ring active adverse event surveillance in Homa Bay County.

Priority populations

The project continued supporting two local implementing partners (LIPs), Kenya Red Cross Society and Western Region Christian Community Services to implement evidence-based interventions (EBIs) targeting fisherfolk from 12 beach management units in Kisumu and 5 in Busia Counties, respectively. The support included capacity-building through mentorship and trainings, support supervision, data documentation, reviews and reporting, tracking of commodity consumption and forecasting, and financial management support.

Using the combination prevention approach as recommended by NASCOP, the project used Splash Inside Out to reach out to the fisherfolk and link them to appropriate services, both biomedical and structural. The intervention aimed at increasing demand for HIV prevention, care and treatment, and support services. The following main activities were carried out during the Splash Inside Out sessions: peer education on HIV and sexually transmitted infection (STI) prevention, risk assessment at the individual level, risk-reduction plan and skills building, promotion of condom use, demonstration and distribution, promotion and access to HIV and STI services, promotion of VMMC, screening for drug and alcohol abuse, and tracking of effective referrals for service uptake.

The following activities were carried out during the quarter: Splash Inside Out refresher trainings for 85 (M 45, F 40) PEs and PHDP for 53 (M 16, F 37) PEs, peer education, outreaches, and referrals for service uptake.

As a result of the project support, 4,373 fisherfolk were reached through one-on-one and small group sessions in Kisumu and Busia counties. Out of those served, 1,434 were effectively referred for various services at link facilities. Between October 2015 and September 2016, the project reached 18,361 fisherfolk, hence realizing 126 percent achievement of the COP 2015.

Table 22 below indicates the number reached during the reporting period.

Table 22. Fisherfolk performance, Y5Q4–Y6Q3.

County	2015 COP Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% Target Achievement
Busia	6,328	1,977	1,427	1,804	2,083	7,291	115%
Kisumu	8,268	1,574	2,435	4,771	2,290	11,070	133%
Total	14,596	3,551	3,862	6,575	4,373	18,361	126%

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

The overachievement of the COP 2015 target was attributed to effective targeting and proper packaging and delivery of health information services by the PEs. Moreover, the refresher trainings, constant mentorship on data documentation, and support supervision to PEs and link health facilities also necessitated the remarkable performance by the LIPs.

Biomedical interventions

During this reporting period, 1,434 out of the 4,373 fisherfolk reached during one-on-one and small-group sessions were effectively referred for uptake of various health services. Table 23 below summarizes the essential package of services referred for and received.

Table 23. Essential package of services referred for and received.

Month	County	Biomedical services						Structural services				
		HTC	STI	VMMC	TB	CaCx	EC/FP	GBV	A&D	PSS	FSS	LA
Jul'16	Busia	36	4	0	3	2	6	1	0	0	0	1
	Kisumu	119	34	47	51	119	140	18	16	4	10	8
Aug'16	Busia	31	1	7	3	2	13	0	1	0	0	1
	Kisumu	174	9	26	24	25	47	13	5	19	3	2
Sep'16	Busia	28	1	0	1	0	6	0	0	0	0	0
	Kisumu	176	16	13	31	27	50	9	18	14	16	3
Total		**564**	**65**	**93**	**113**	**175**	**262**	**41**	**40**	**37**	**29**	**15**

Note: HTC, HIV testing and counseling; STI, sexually transmitted infection; VMMC, **v**oluntary medical male circumcision; EC/FP, Emergency Contraception/family planning; GBV, gender-based violence; CaCx, Cancer of the Cervix; A&D, Alcohol and Drug Abuse; PSS, psychosocial support; FSS, Financial Support and Sustainability, LA-Legal Advice.

During this reporting period, 564 (M 239; F 325) fisherfolk were effectively referred for HTS out of which 22 (M 8; F 14)) tested positive, translating to about 4 percent positivity rate. Cumulatively, between October 2015 and September 2016, a total of 1,921 fisherfolk were tested for HIV, out of which 120 were positive, translating to a positivity rate of 6 percent. All the 22 fisherfolk (M 8; F 14) who tested positive during this reporting period were enrolled on care and treatment and linked to PHDP services.

HTS outreaches

The project conducted 5 outreaches (Kisumu-2 and Busia-3) during this reporting period, reaching 230 (M 101; F 129) fisherfolk with HTS, 2 (M 1; F 1) tested positive and were enrolled on care and treatment.

Networking and collaboration

The project continued networking with the department of health at county and subcounty levels to ensure that those reached also access and use health services at link facilities. These services included the following: access, distribution and use of condoms, HTS, enrollment in HIV care and treatment, VMMC (93 were circumcised), FP, gender-based violence (GBV), and STI treatment. Further, four legal aid clinics were conducted in Busia County reaching 243 (M 128; F 115) fisherfolk focusing on land, child protection, and GBV.

Gender mainstreaming and integration

The project continued to strengthen gender mainstreaming and 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 using project Start Awareness Support Action (SASA) and facility-level GBV response services. The key activities implemented in the APR period were as follows: orientation and training of CHVs, paralegals, girl mentors, and youth leaders as SASA facilitators; orientation of MCCs; commemoration of national and international days; and protection and legal services to GBV survivors. The project also supported supervision and CMEs in health facilities to strengthen post-violence care service provision.

Addressing male norms and behaviors

In the reporting quarter, the project continued to implement community-level activities to explore negative gender norms that impact on access to and utilization of health services by both men and women using SASA Approach. As a catch-up strategy, the project accelerated SASA implementation through capacity-building and engagement of a wide range of community members (e.g., paralegals, CHVs, MCC, PSSGs, children and adolescent clubs, girl mentors, and religious leaders.

Through the project-trained MCC, areas perceived to have a high level of male dominance were targeted with SASA interventions to enhance positive gender norms. During these sessions, SASA posters and experiences of MCC were used. Adolescent girls and young women (AGYW) in and out of school, were also reached with asset-building skills to address their norm-related risks and vulnerabilities through mentors. In addition, children, adolescents, and adults in organized psychosocial support groups were also reached with SASA messages to reduce their risks and vulnerabilities to GBV and stigma and discrimination through rights empowerment.

Other targeted facility- and community-level education activities for norm change included use of SASA posters by health care providers to facilitate exploration of negative gender norms during health talks, SASA sessions by paralegals on human rights, and community involvement in GBV prevention.

A total of 41,620 people were reached with information using SASA strategies compared to 538/ Y6Q1, 15,902/Y6Q2, and 14,508/Y6Q3, giving an APR reach of 72,568 (106 percent) against COP 15 target of 68,450, as shown in Table 24 below.

Table 24. Gender norms performance, Y5Q4–Y6Q3.

County	COP 2015 Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% Achievement
Bungoma	7,326	0	978	2,130	5,537	8,645	118%
Busia	9,077	0	3,334	2,244	3,107	8,685	96%
Kakamega	15,276	312	45	1,811	15,993	18,161	119%
Vihiga	11,656	0	5,334	195	1,894	7,423	64%
Homabay	828	0	1,129	338	447	1,914	231%
Kisumu	7,845	226	553	853	3,387	5,019	64%
Nyamira	4,672	0	1,992	1,435	1,099	4,526	97%
Migori	11,770	0	2,537	5,502	10,156	18,195	155%
Total	**68,450**	**538**	**15,902**	**14,508**	**41,620**	**72,568**	**106%**

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

Gender-based violence (GBV) care services

In the reporting period, the project continued to support integrated GBV care services both at the facility and community level. At the facility level, 32 health facilities in both Nyanza and Western Regions conducted supportive supervision and CMEs on post-rape care service provision and sexual and gender-based violence (SGBV) screening at the point of care, reaching a total of 98 HCWs. The project orientated data clerks at the facility level to facilitate SGBV reporting, particularly on DHIS. To address reporting gaps for other forms of violence (physical, emotional, and economic), which do not have reporting tools, the project issued hard cover books to health facilities to enable them to capture the data/information. As a result, a total of 494 survivors of sexual violence were reached with services in Y6Q3, compared to 352, 350, and 231 reached in Y5Q4, Y6Q1, and Y6Q2, respectively, giving a total reach of 1,427 against COP 15 target of 1,362 (105 percent) as per Table 25 below.

Table 25. GBV performance, Y5Q4–Y6Q3.

County	COP 2015 Target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% Achievement
Bungoma	196	92	83	32	31	238	121%
Busia	138	11	6	24	48	89	64%
Kakamega	220	89	73	78	130	370	168%
Kisii	8	14	8	0	0	22	275%
Vihiga	126	45	73	47	36	201	160%
Homabay	201	23	29	4	16	72	36%
Kisumu	118	0	2	32	136	170	144%
Nyamira	146	64	54	0	73	191	131%
Migori	209	14	22	14	24	74	35%
Total	**1,362**	**352**	**350**	**231**	**494**	**1,427**	**105%**

Note: GBV, gender-based violence; Y, year; Q, quarter.

A total of 371 survivors of sexual violence received post-exposure prophylaxis while 39 were linked to legal, police, psychosocial, and protection services. In Kisumu, the project also facilitated the process for two HCWs to provide clinical reports for two SGBV cases that were revived through advocacy by the gender TWG. One case was concluded during the quarter. The project also continued to support the five GBV recovery centers—Nambale District Hospital, Kakamega Referral Hospital, Butere District Hospital, Kegonga District Hospital, Alupe Subcounty Hospital—to continue

offering comprehensive post-GBV care services. The project noted low reporting rates in Migori, Homa Bay, and Busia Counties; and to improve on this, strategies such as active case finding through GBV screening at the point of care and community-level GBV awareness using SASA were employed. The project will continue supporting more community-level case finding activities to ensure that all forms of violence are reported and, should clients opt to go for services outside the project-supported facilities, completed referrals documented.

At the community level, the project supported sensitizations for GBV prevention, protection, and accountability through trained paralegals, HCWs, PEs, and MCC. In addition, the project continued to engage in active case identification through screening, both at the community and facility levels, and referrals of survivors to safe houses identified by the gender TWGs in Kisumu and Kakamega. In Kisumu, the gender TWG supported communities to understand the legal and policy context in relation to violence against women and girls, while in Kakamega, Kisumu, Vihiga, and Homa Bay, the health management teams (HMTs) were facilitated to hold consultative meetings to develop county-specific SOPs for SGBV management. The process of SOP development is on course.

Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) Interventions

The APHIA*plus* Western Project continues to implement the DREAMS project in 34 wards (29 in Homa Bay County and 5 in Kisumu East Sub-county) for the reporting period. The focus was on continued development of the systems for implementing the project and, also, on provision of services to the adolescent girls and young women in the four sub-purposes, namely:

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

The following activities took place:

- During the period under review, the project enrolled a total 31,467 (92.0 percent) out of 34,264 AGYW, an increase of 5,263 from the previous quarter. In Kisumu, 15,493 (79.0 percent) of the target were enrolled into program and 15,974 AGYW (109.0 percent) in Homa Bay County. Enrollment was highest for AGYW ages 10 to 14 years old at 6,736 (104.0 percent) and 13,928 (99.9 percent) for ages 15 to 19 years old; however, the project is working on the process of de-enrolling the least of the most vulnerable AGYW to ensure that enrollment is sustained at the program target.
- Enrollment of AGYW ages 20to 24 years old stands at 10,803, an increase of 2,426 compared to last quarter. Strategies including peer talks by enrolled AGYW, door-to-door sensitization of young women and their spouses, and sensitization through churches contributed to the increase in yield.
- Compared to last quarter, enrollment in Homa Bay has picked up at an average of 109 percent against 71 percent reported last quarter. This can be attributed to the fact that Homa Bay is largely rural, coupled with the intensive community mobilization conducted before and after the Girl Roster exercise. Kisumu County reported an increase from 76 percent to 79 percent in relation to last quarter's enrollment figures.

Table 26 shows enrollment status per cohort.

Table 26. DREAMS enrollment status.

Age	Homa Bay			Kisumu			Total		
	Target	Achieved	% Achieved	Target	Achieved	% Achieved	Target	Achieved	% Achieved
10 -14	2,373	2,974	125	3,971	3,762	95	6,344	6,736	106
15 - 19	6,137	7.079	115	7,823	6,849	88	13,960	13,928	100
20 - 24	6,137	5.921	96	7,823	4,882	62	13,960	10,803	77
Total	**14,647**	**15,974**	**109**	**19,617**	**15,493**	**79**	**34,264**	**31,467**	**92**

An additional 64 mentors have been recruited to ensure the ratio of mentor to girls is maintained at 1:60. These additional mentors will be trained in the first quarter of the second year with the aim of improving efficiency in service delivery. The mentors facilitated linkages with AGYW and their caregivers to receive direct service through parental / caregiver programs, education support, and a combination of socioeconomic approaches, in addition to access to clinical services and behavioral interventions.

1. Empowering girls and young women

Interventions in this section include HIV abstinence activities, other HIV prevention activities, condom promotion and prevention, HTS, pre-exposure prophylaxis, post-violence care, expanded and improved contraceptive method mix, and social asset building. The project supported the training of facilitators of EBIs, including for My Health My Choice (MHMC), Healthy Choices for a Better Future, Family Matter Program, and SHUGA. The project also supported the sensitization of 71 CHVs on Contraceptive Method Mix.

HIV testing services

DREAMS put in place mechanisms to ensure the efficient provision of biomedical services to AGYW in the safe space. Via consultation and partnerships with the MOH in Kisumu East Sub-county and Homa Bay County, the project identified 34 link facilities to be matched with safe spaces in each ward. Currently the project is working in 34 mains safe spaces and 136 satellite safe spaces in the supported wards. Further, the project negotiated with service delivery partners, especially in Homa Bay, to have access to the supported service providers. Forums were held to determine DREAMS need for mobilized AGYW and mechanisms of involving the service providers on an outreach basis. In Kisumu and Homa Bay, therefore, DREAMS managed to have the MOH procure HTS commodities with AGYW targets in their procurement and distribution plans.

All these efforts led to DREAMS project achieving 22,273 AGYW accessing HTS against a target of 30,458. Of those tested, 77 girls returned a seropositive result, 75 of whom were enrolled into treatment. A reported lack of readiness to start treatment and coming to terms with the new HIV status explains the low margin of treatment enrollment for the AGYW. DREAMS continues to work with the girls to achieve total enrollment. Two girls are undergoing pre-treatment adherence counseling from Kajulu and Karachuonyo North Wards.

School-based HIV and violence prevention

Working in partnership with the ministry of education, the project reached AGYW and boys in schools with HIV and Violence Prevention interventions, including Healthy Choices for a Better Future and SASA. In select schools, the head teachers requested My Health My Choice to be conducted with the girls to stem cases of pregnancies in school. The project-developed comics were a popular and effective way of dealing with masculinity norms and preventing violence as the students reported being able to identify with the scenarios shown and learning concepts that improve respect for women and reduce violence.

Increased contraceptive method mix and condom promotion and provision

Working in partnership with the MOH and, specifically, the department of reproductive health in the counties, the project facilitated access to contraceptive education and subsequent in-situ uptake of contraceptives and/or referral for insertables at the health facilities. The safe space has proven to be a good forum for AGYW to have their questions on contraception answered, share experiences, clarify attitudes, and take up the contraceptives. In anecdotal testimonies, AGYW have expressed being comfortable addressing contraceptive issues at the safe space rather than at the clinics, particularly because they are not mixed with older women, and also because they have ample, focused time with the service providers.

Condolympics session in Gwassi

The project realized that due to not being allowed information on contraception, in-school AGYW—who are also sexually active—were keen to come to the safe space for these sessions. For this reason, access to the education was given to all eligible girls and thus, went beyond the COP target.

The project continued to promote and provide condoms to the AGYW and their male sex partners. Condom promotion is infused in several of the interventions that the project supports, including the EBIs and the contraception session, where DREAMS promotes condoms for dual protection against HIV and unintended pregnancy. PATH's Condolympics is proving a popular and effective way of engaging AGYW to overcome attitudinal issues about condoms and prevention. See Table 27 below for summary of achievements.

Table 27. Achievements in HIV Prevention, Condom Promotion and Provision and Contraceptive Method Mix.

Indicator	Target	Reached
School-Based HIV Prevention	16,851	14,723
Condom Promotion and Provision	23,267	23,189
Contraceptive Method Mix	13,958	**17,976**

Note: AGYW, adolescent girls and young women.

Social asset building

The project works to build various assets in the AGYW to prepare them to effectively deal with life's shocks and experiences. These include social, economic, literacy, and health assets. Via several evidence-informed behavioral interventions, the project has continued to build the health assets of the AGYW. My Health My Choice and SHUGA sessions are ongoing and form part of the package for health education. The safe spaces provide continued opportunity for girls to build their social assets, making friends and building important life networks. The project supports games and other social, team building activities to help in this regard. In the reporting quarter, the project managed to call for volunteers to donate useful but no longer used books to the safe spaces, an initiative which subsequently realized a donation of 100 books to safe spaces in the Nyalenda slums.

Post - violence care

During the reporting period, the project continued to strengthen the provision of post violence care services to AGYW both at the facility and community levels. At the facility level, the project supported supervision and CMEs on SGBV management and reporting to 9 major referral facilities,

reaching a total of 59 HCWs. The project also supported the reprinting and distribution of SGBV reporting tools (MOH 363, MOH 364, and MOH 365) and SOPs to all the subcounty hospitals in Homa Bay that lacked the reporting tools. During the CMEs, HCWs were also orientated on SGBV screening to enhance case identification at the point of care. The HCWs were also given SGBV screening tools for documentation. At the community level, 26 paralegals were identified to support case identification, escorted referrals to facilities, and follow-up of legal redress. In addition, the project identified other GBV actors in the communities to "add a voice" through vibrant anti-GBV advocacy forums, particularly to facilitate legal redress while GBV screening services continued at the safe spaces. The project also reprinted Liverpool VCT's GBV pocket guides and posters (What to do when raped) for the individual girls. In Rangwe, Homa Bay, the project collaborated with the health facility to build capacity of the police officers in GBV response and supported the establishment of a gender desk at Rangwe Police Station.

DREAMS Ambassador at a stakeholders meeting

As a result, a total of 153 AGYW—10 to 14 years old (12), 15 to 19 years old (44), and 20 to 24 years old (74)—received post-GBV services. Of these cases, 51 were sexual while 102 were physical/emotional. A total of 20 survivors of sexual violence (39 percent) received post-exposure prophylaxis, while those who reported late received other services, such as counseling, STI screening, and social support referrals. Nine (9) cases were reported to the police for legal redress. The project recorded high GBV case reporting among AGYW aged 15 to 19 years old and 20 to 24 years old compared to the 10 to 14 years old cohort. Some of the gaps identified in relation to the low reporting rates, especially among those aged 10 to 14 years old, were erosion of cases by the police and perpetrators who were mainly close relatives to the survivors, threats from relatives of perpetrators, disappearance of perpetrators, and the communities' reluctance to seek legal redress.

To remedy the gaps in GBV response, the project has identified 26 paralegals who will support case identification, escorted referrals to facilities, and follow-up of legal redress. In Kisumu, the paralegals already have begun active GBV case identification, and this is expected to expand to Homa Bay in Year 2. In addition, the project will work with the vibrant Kisumu gender TWG to strengthen the other peripheral gender TWGs in addressing GBV cases.

2. Mobilizing communities

Interventions in mobilizing communities include community mobilization and norms change and school-based HIV and violence prevention.

The project has continued to work with communities to improve AGYW access to the available community resources and to ensure that critical stakeholders get the opportunity to work with AGYW to gain increased confidence and utilization of the resources. As a result of the community resource mapping exercise, the project has worked with government and civil society organizations to make girls dream again about their future.

Communities continue to support the project with safe spaces, resource persons, and opportunities for the benefit of girls. By engaging the communities, girls have increased their awareness of their rights and also have given back to the community by offering services (e.g., at the police stations). Equally, the project continues to involve the AGYW through DREAMS Ambassadors to engage community stakeholders in meetings where AFYW matters are concerned. The project encourages AGYW to attend TWG meetings, planning meetings for international days, and periodic project review meetings. All this is intended to increase the social assets of the AGYW and ensure that their points-

of-view are considered in decision-making.

Norms change

The project supported norm change activities aimed at mobilizing communities for positive norm change to create an enabling environment for AGYW to achieve their dreams. The project-trained SASA activists continued to conduct community-level norm change sessions to reduce risks and vulnerabilities of AGYW to GBV and HIV infection. During these sessions, SASA posters and Maswala Krucial comics were used to trigger exploration and discussion on GBV response. The AGYW continued to discuss the cross-generational sexual relationships norm, where young girls have sexual relationships with older married men for economic gains ("Sponsor"), as a negative norm that affected them in achieving their dreams. As a result, the project reached 5,165 AGYW aged 10 to 14 years old, 10,975 AGYW aged 15 to 19 years old, and 7,423 AGYW aged 20 to 24 years old, giving an annual reach of 23,566 (69 percent) against COP 2016 target of 34,264. In addition, 10,413 people from the general community/population also participated in SASA sessions to promote norm change. The project also incorporated SASA in all the sessions involving the male partners of the AGYW while girls were linked to other relevant services.

3. Strengthening families

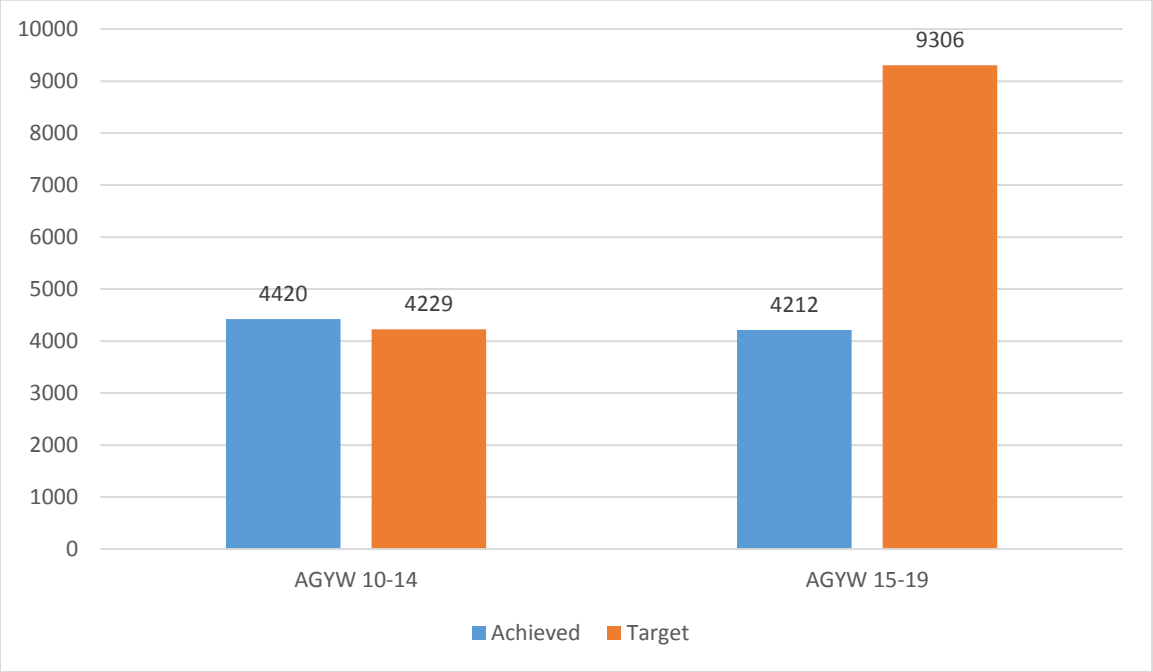
Parenting/caregiver programs

DREAMS continued to apply a family-centered approach to mitigate the impact of HIV through parental and caregiver programs. Aimed at supporting improved parental skills and communication, the project facilitated caregivers of 3,352 adolescent girls aged 10 to 14 years old and 3,407 aged 15 to 17 years old to improve knowledge of HIV risks for young people, positive parenting, effective adult-child communication on sexuality, and sexual risk reduction. Collectively, the project has supported the training of 4,420 caregivers of AGYW aged 10 to 14 years old against 4,229 and 4,212 for aged 15 to 19 years old against the target of 9,306. Some of the parents trained have reported enhanced communication with their girls as is indicated in one mentor's feedback below:

"Some of the parents, after going through parental skill training, have come back to me and reported improved relationship with their girls," narrates Pauline Odhiambo, a mentor in Got Nyabondo in Kajulu Ward". She recounts how, after training, a parent asked her to accompany him to disclose to his children aged 10 and 14 years old of their HIV status, something he previously did not have the courage to do.

Figure 8 below provides a summary of the number of AGYW reached through parental skills training in the period under review.

Figure 8. Number of AGYW reached through parent/caregivers programs.



AGYW were helped to identify child day centers where they can leave their babies for care when they attend school or colleges. Furthermore, each safe space set aside a corner where babies of AGYW are left under the care of a mentor as their mothers attend EBI sessions or other safe space activities.

Education subsidies

Based on the priority needs of AGYW identified during enrollment and vulnerability assessment, the project facilitated targeted education support to address barriers to enrollment, attendance, and progression of the most in-need AGYW. Cumulatively, 676 AGYW aged 10 to 14 years old were provided with solar lamps to enhance night studies in preparation for the national examinations set to begin early next quarter. Additionally, 1,441 AGYW aged 15 to 19years old and 891 aged 20 to 24 benefitted from education subsidies provided by the project. Learners' packages, which include sanitary pads, pants, soaps, shoe polish, and body oil, were distributed to 1,083 of the most in-need AGYW aged 15 to 19 years old to reduce their vulnerability and predisposition to engage in transactional sex to meet their basic sanitary needs. In order to build employability and venture into business, 133 AGYW aged 15 to 19 years old were supported with trainings on career and job readiness.

Another 83 AGYW aged 15 to 19 years old and 338 aged 20 to 24 years old were facilitated to acquire ICT skills to enhance their ability to access information through email and internet and to build networks, including creation of access to markets and the ability to keep business records, besides friendship building.

Table 28 represents the distribution of AGYW who benefitted from education subsidies provided by the project.

Table 28. AGYW beneficiaries of education subsidies.

County	10–14	15–19	20–24	Total
Homa Bay	241	817	496	1,554
Kisumu	435	624	395	1,454
Total	676	1,441	891	3,008

Access to combination socioeconomic approaches, AGYW 10 to 24 years

In the effort to support AGYW and their families to be more resilient to financial shock, the project supported 2,184 AGYW aged 15 to 19 years old and 492 aged 20 to 24 years old through participatory identification and targeted training. The combination socio - economic approaches package provided by the project includes provision of small stock to enhance food security and asset building, provision of solar lamps, and youth-friendly peer discussions.

The socioeconomic support activities are summarized as follows:

1. A total of 34 AGYW aged 20 to 24 years old were trained via Training of Trainers (TOTs) on VSLAs, which will be cascaded to target other AGYW after the completion of trainings on financial capability.
2. A total of 1,137 AGYW benefitted from solar lamps, which have the capability of charging phones levied at a fee to bring income to the AGYW and reducing the energy cost from lighting.
3. An additional 1,047 were supported to participate in youth-friend peer discussion for the purpose of networking, friendship building, experience sharing, and learning new skills, including tie-and-dye techniques. Several groups (chamas) have been formed by AGYW aged 20 to 24 years old from their safe space besides the EBI sessions. For instance, AGYW at Kagwa safe space meet every Thursday, when each member contributes a minimum of Kshs 20, used to buy food stuff for members while others can borrow to start or expand small businesses. Membership to the group is voluntary.

The project facilitated training of 68 facilitators on financial capability, and cascade of the training among the AGYW is ongoing to build their capacity on financial resource management.

The project also sponsored six TOTs for Entrepreneurship Training by ASPIRES, (a consultant contracted by USAID to provide technical support on financial capability and economic strengthening in DREAMS). The training will be cascaded to facilitators and AGYW aged 15 to 24 years old who will have completed FC training in the next quarter. Targeted AGYW include those already engaged in businesses ventures with the aim of skills building on management of small businesses.

Building on existing networks and support of stakeholders, the project facilitated quarterly stakeholders meetings to review progress, development of joint plans, and feedback. The project continued to work on building the capability of CBOs for effective implementation and monitoring. Stakeholders' forums on cash transfer will be conducted in the next quarter for awareness creation and buy-in. Preparatory activities, including sensitization and identification of CT beneficiaries, has been done awaiting confirmation from single registry.

4. Decreasing HIV risk among sex partners of AGYW

By the end of the reporting period, the project had managed to determine the typical male sex partners of the AGYW of the ages between 15 and 24 years. Using the Male Sexual Partner (MSP) characterization tool, the AGYW identified and ranked the common partners that they have. The identified MSP varied form ward to ward and may be summarized as follows:

- Transport industry workers (boda boda/tuk-tuk drivers and matatu crew).
- Local entrepreneurs (kiosk owner, mitumba vendor, fishermen, MPESA clerks, DJs).
- Casual workers (masons, sugarcane cutters, sand harvesters, herdsmen, watchmen).
- Teachers, civil servants, policemen, school mates.
- Relatives of girl's friends (brother, cousin, uncle, etc.) and boys at household.
- Revelers at disco matanga/social gatherings.

The reasons for engaging in sex with the men also varied, of which the main one was transactional to get money for basic needs (food, fees, rent, capital for business, etc.). Being "in love," being under the influence of alcohol, having fun, being married, and maintaining a relationship were also common reasons for sex.

Save for fellow students and some casual workers, all the other male sex partners were generally older than the AGYW, falling in an estimated age range between 20 and 30 years old for the 15- to 19-year-old cohorts and between 20 and 50 for the 20- to 24-year-old cohort.

Subsequent to the profiling, the project used the MSP intervention planning tool to design strategies to facilitate males' uptake of high-impact interventions of condoms, HTS and ART, and VMMC. The project worked with organized boda boda associations, beach management units, schools, and local administration to mobilize men for services, which also included violence prevention via SASA. Boda boda bases, schools, sand harvesting centers, beaches, "pool" joints, homes, and chief's barazas were all venues of intervening with the MSP.

By the end of the reporting quarter, the project attained the following reach under interventions for MSP (see Table 29 below).

Table 29. Number of MSP reached with services

Reducing Risk in Male Sex Partners **(Part)**	# of MSP Tested	**5,659**
	# of MSP_HIV +ve	**35**
	# of MSP HIV+ve Started on Rx	**21**
	% MSP HIV+ve Started on Rx	**60%**
	# of MSP taking VMMC	**951**
	# of MSP Reached with SASA Intervention	**3,477**

Note: MSP, male sexual partner, VMMC, **v**oluntary medical male circumcision; SASA, Start Awareness Support Action.

Men who tested positive for HIV and sought to delay enrollment reported being not ready to start treatment and, in other cases, suggested that they required further tests to "confirm" status. However, there are those who flatly refused enrollment and even absconded completely. The MSPs, especially, the boda bodas, tended to shift their bases after a positive HIV test, while general chauvinism and a lack of predictable catchment for the men hamper follow-ons. The project continues to work with health facilities and AGYW partners of the males to increase their uptake of services.

OVC services

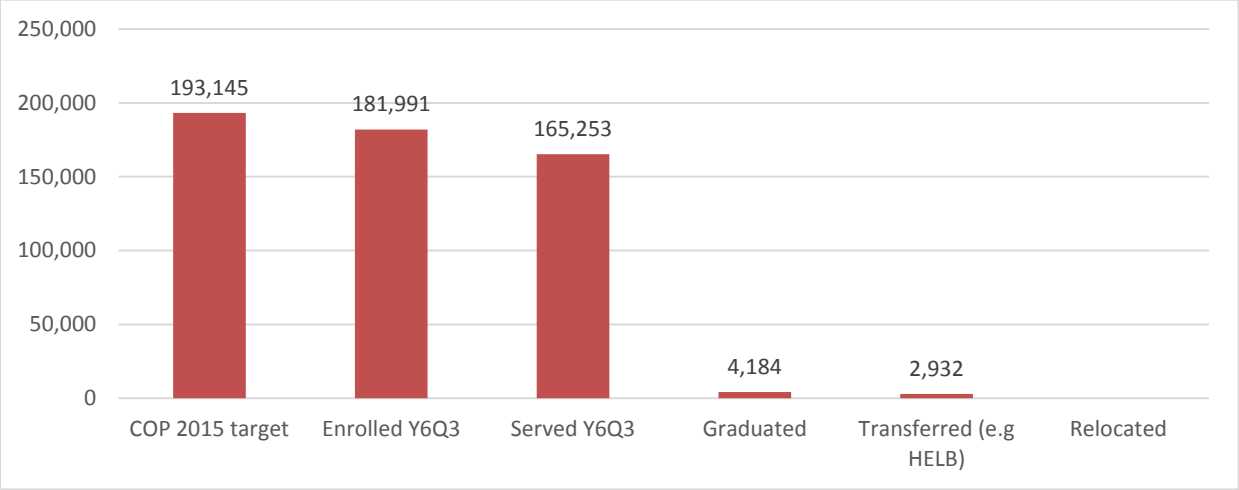
During the Y6Q3 reporting period, the project continued to implement activities that support improved child outcomes; these activities were done at the county, community, household, and child levels. The areas of focus included access to health and social services, capacity-building of the community and household, and strengthening of child welfare systems. The project also continued to build the capacity of the 76 implementing CBOs across the ten counties to strengthen support to OVC and their households.

Increased access to health and social services for OVC and their families

OVC served

In Y6Q3, 165,253 (85.6 percent) OVC were served in the ten counties, against the COP 2015 target of 193,145. There were 181,991 OVC enrolled by the project as at end of Y6Q3. There were 16,738 OVC who were not served; they were targeted to receive school uniforms and livestock (goats)[3] in the next reporting period. The reduction in the number of OVC enrolled is attributed to the exit and graduation of 13,863 OVC from the program between April and September 2016. The reasons varied, including the following: 4,184 OVCs exited the program as a result of improved socioeconomic capabilities of their caregivers; 2,932 OVC graduated, joined university and tertiary colleges, and linked to other forms of support outside the project (including the Higher Education Loans Board); the remaining 6,747 OVC had permanently relocated for varied reasons, including search for entrepreneurship opportunities in major towns. The details are in Figure 9 below.

Figure 9. OVC performance, Y6Q3.



Note: HELB, Higher Education Loans Board; COP, country operational plan.

In the October–December 2016 reporting period, the project plans to enroll new OVC to replace those who exited the program and to contribute to the COP 2016 target.

In the reporting period, the project was able to generate the prioritized needs from the previous quarter (Y6Q2), as documented in the service tracking forms (STFs) that formed the backdrop of targeted service provided during the reporting period. Details of the OVCs served in each of the ten counties are documented in Table 30 below.

[3] Uniforms and goat procurement was being finalized at the time of reporting hence and targeted for distribution in October to December 2016 period.

Table 30. Number of OVC served per county in Y6Q3.

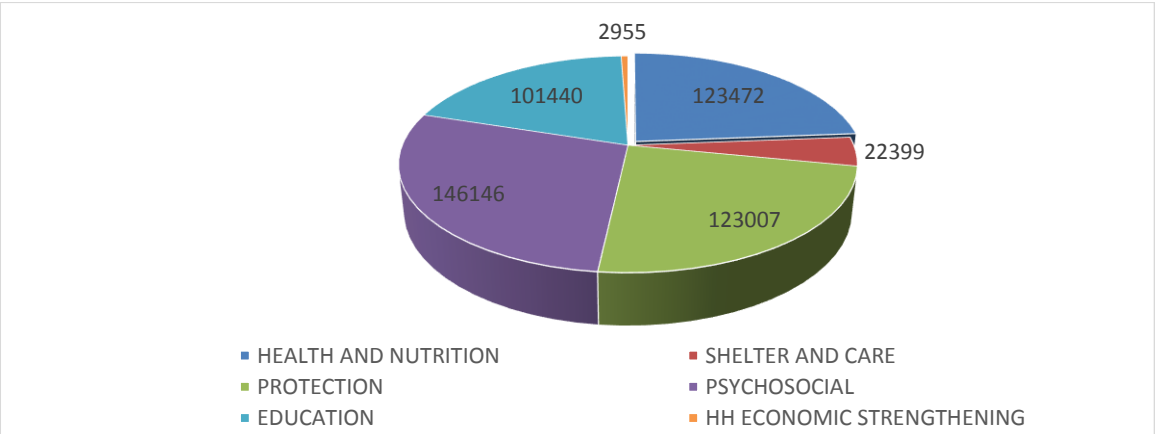
County	COP 2015 Target	Y6Q3 served	Female	Male	% served Y6Q3	% served Y6Q2	% served Y6Q1
Scale up Counties							
Siaya	14,383	12,051	5,888	6,163	83.8	94.4	97.5
Kisumu	25,717	23,601	12,038	11,563	91.8	99.2	97.3
Migori	23,580	19,360	9,252	10,108	82.1	95	89.2
Busia	19,163	17,113	8,499	8,614	89.3	93.7	98.9
Homa Bay	44,615	31,828	15,015	16,813	71.3	89.6	99.6
Aggressive scale up							
Kakamega	31,505	29,119	14,927	14,192	92.4	99.2	104.3
Kisii	2,467	2,365	1,195	1,170	95.9	90.6	91.4
Nyamira	3,272	3,090	1,485	1,605	94.4	101.7	104.7
Sustained Counties							
Bungoma	19,786	18,114	9,078	9,036	91.5	104.9	108.2
Vihiga	8,657	8,612	4,312	4,300	99.5	92.8	101.2
Total	**193,145**	**165,253**	**81,689**	**83,564**	**85.6**	**96.8**	**99.2**

Source: OVC Longitudinal Management Information System, July–Sept 2016.

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

Increasingly, more children (101,440) were served with educational support, which included scholastic materials and school fee subsidies, as seen in Figure 10. Education support is one of the most recurring high-priority and critical needs for children of school-going age. Over 50 percent of the children (88,716 of 176,295 school-going children) in the reporting quarter requested the same support. The project in the next period will focus on strengthening the economic resilience of the households/caregivers to sustainably take care of these services.

Figure 10. Number of OVC served per domain.



Note: HH, household.

OVC access to health services

A total of 85,374 (170.9 percent) OVC received HIV services (including HIV counseling and testing, enrollment in ARV programs, among others) in the reporting period, against a COP 2015 target of 49,964 as shown below in Table 31. The overachievement was a result of enhanced community

outreaches, including during weekends and holiday periods, and support to each CBO to have a link volunteer in the facilities, which ensured bi-directional referrals and intensified sensitization. A total of 1,300 (F 703; M 597) OVC tested positive for HIV in the reporting period; all were enrolled into ARV treatment programs.

A total of 181,559 OVC (99.8 percent) out of the 181,991 enrolled children have been tested for HIV. The project is near 100 percent mark due to intensified outreaches during weekends and school holidays. Integrated sessions, in which testing is done alongside other activities that target children (e.g., career camps and mentorship sessions), have also enhanced the reach. The project supports a total of 5,742 OVC who are HIV positive and all of them (100%) are enrollment in ART programs. The use of peer educators (especially for the adolescent cohort), escorted referral for the children testing positive, and ensuring continued follow-up by the link volunteers and caregivers in PSSGs have supported these effective linkages. Most counties were able to achieve their targets, and some even surpassed targets because of increasing demand for the services. Migori showed under achievements in the data generated in the OVC Longitudinal Management Information System (OLMIS) at the time of reporting (end of quarter). This was a result of delays in updating the testing dates in the upgraded system; these have now been updated.

Table 31. OVC access to HIV services.

County	COP 2015 target	Total tested	% progress toward target
Scale-Up to Saturation Counties			
Kisumu	12,230	17,883	146.2
Busia	3,429	11,724	341.9
Homa Bay	11,144	15,148	135.9
Siaya	6,343	7,418	116.9
Migori	5,889	3,863	65.6
Aggressive Scale-Up Counties			
Kakamega	5,010	14,614	291.7
Kisii	1,629	2,325	142.7
Nyamira	570	2,516	441.4
Sustained Counties			
Bungoma	2,763	5,822	210.7
Vihiga	957	4,061	424.3
TOTAL	49,964	85,374	170.9

Source: OVC Longitudinal Management Information System, July–September 2016.

Note: COP, country operational plan; OVC, orphans and vulnerable children.

Nutrition

During the reporting period, a nutrition assessment was conducted of 5,502 children under five years old, out of the current 8,193 in the project. There were 89 (M 48; F 41) severely malnourished children who were referred to health facilities for therapeutic management. Caregivers of 563 OVC (M 256; F 307) who were moderately malnourished were provided with nutrition counseling. Nutrition assessment for all OVC has been initiated and will be completed in the next quarter. The project is in the process of procuring therapeutic feeds for community management of malnutrition to ensure severely and moderately malnourished children (aged six months–nine years) and adults receive prompt support once screened. This support is expected to reach the OVC starting next quarter (October–December 2016). A total of 76 community based organization leaders, ten project staff, and six MOH nutritionists have been trained in readiness for therapeutic food management, distribution, and monitoring of the impact and benefits to children.

Child protection

The project continued to increase access to other social protection services for the OVC and their households. Through a support mechanism to conduct community outreaches on birth registration, OVC were supported to register for and receive birth certificates. This included providing the Department of Civil Registration with transport to the various locations and paying for the late registration fee. A cumulative total of 126,228 (69.7 percent) had birth registration by the end of the quarter; 3,001 who were supported in the quarter are waiting to receive the certificate. The project provided other social protection services, including: 37,616 OVC are in households with active national hospital insurance fund, and 9,674 OVC households are benefiting from the Government's cash transfer program. A total of 76 OVC were supported with shelter repair in the quarter; cumulatively, the project has supported 1,748 OVC with shelter repairs since 2011

Education

The project's education strategy aims to enhance access to school and ensure successful completion by providing an enabling environment. The project collaborates with the Ministry of Education in addressing OVC educational needs in the following areas: school fees subsidy, scholastic materials, mentorship, and the county coordinating working group. In this reporting period, a total of 1,253 (M 776; F 477) OVC, out of 3,521 OVC who sat for Kenya Certificate of Secondary Education in 2015, were admitted into university. This represents a 70 percent increase from the 700 OVC who were admitted into university during the same period last year. An additional 2,673 were supported to enroll in vocational trainings.

To support retention, regular attendance, and examination preparation of highly vulnerable OVC in schools, the project procured and distributed health and scholastic materials, including sanitary pads (for females), geometrical sets, pens, pencils, and school bags. This benefitted 86,687 OVC. The CBOs, through linkages and other different resources, also provided educational support to 990 OVC during the reporting period.

Impact of village savings and loans association

Christine,* who is from Bukonoi community-based organization in Bungoma County, joined a village savings and loans association (VSLA) in 2015. She is now reaping the benefits of being in a VSLA. She has so far enjoyed a share-out of KSh 23,000/- from the first saving cycle. She has taken three loans in the amounts of KSh. 30,000/-, KSh 25,000/-, and KSh 100,000/-. This has enabled her to open a shop, buy a plot where she is farming onions and tomatoes, start a second-hand clothes business, and buy a dairy animal. All this has enabled her to diversify her sources of income, which she is using to pay school fees for two orphans and vulnerable children under her care as well as to meet her household's needs. Christine has also increased her assets, including a television and household items.

*not her real name

On strengthening systems to streamline and support OVC in schools, the Big Heart Secretariat (one of the sustainable initiatives for providing scholarship funds that the project started in 2015) has since January 2016 to September 2016 paid school fees for 222 OVC worth KSh 2.8 million; 42 OVC received funds to pay for their school fees in the reporting period. The scholarship fund also received a boost from the Kenya Community Development Fund, which pledged to support capacity-building on sustainability and fundraising strategies. The Secretariat was later transformed into an endowment fund.

Capacity of households and communities strengthened to protect and care for OVC

The project's main focus on economic strengthening is to transfer, protect, and grow assets of target households to increase their resilience and reduce their economic vulnerability. This is being achieved through a set of interventions that include provision of indigenous poultry to the highly vulnerable, promotion of savings groups, training on energy-saving technologies, value chains, and entrepreneurship skills for the low vulnerable households. Linkage to other livelihood service providers has leveraged the project efforts in building the target households' resilience.

Promotion of savings groups

VSLAs continue to be a key economic strengthening intervention in the project area. The project invested in training 209 community-based trainers on VSLAs; these trainers mobilize, train, and monitor the VSLAs. This has contributed to an increase to the 742 total number of groups trained as well as the amount saved per group. The project aims to strengthen the VSLA growth to a mature level based on the share amounts. The project supported 754 active VSLA that had a total of KSh 46,951,280 circulating as loan among the members, benefiting 45,326 OVC. Details are in Table 32.

Table 32. VSLA progress per county in Y6Q3.

County	# of new VSLA	Total # of active VSLA	Membership of active VSLA			OVC benefiting			Total cash circulating
			M	F	T	M	F	T	
Bungoma	19	92	429	1,133	1,562	1,718	2,097	3,815	4,674,006
Busia	26	69	271	968	1,239	837	1,234	2,071	2,943,976
Migori	18	146	816	2,799	3,418	4,659	5,067	7,587	8,509,060
Nyamira	7	11	106	204	310	641	739	1,375	1857720
Kisii	2	1	10	10	6	17	16	33	11,090
Homa Bay	0	128	5,715	4,094	9,809	10,449	9,329	19,778	8,779,242
Siaya	17	88	122	1,710	1,832	1,859	1,761	3,620	7,994,837
Kisumu	17	106	750	2,057	2,807	856	1,064	1,920	10,094,217
Kakamega	21	105	106	308	455	1,748	1,990	3,738	1,605,368
Vihiga	1	8	46	342	388	499	890	1,389	481,764
Total	128	754	8,371	13,625	21,826	23,283	24,187	45,326	4,695,1280

Note: F, female; M, male; OVC, orphans and vulnerable children; VSLA, village savings and loan association.

Other income-generating initiatives

To address overall livelihood support, including nutritional needs, among the highly vulnerable households, the project supplied 1,086 highly vulnerable households with 6,100 local poultry in Homa Bay, Bungoma, Kisumu, and Busia counties. More of this distribution will be done in Y6Q4.

An additional 343 OVC HHs were supported with 376 bags of orange-fleshed sweet potatoes. In addition, 100 moderately vulnerable households in Bungoma were supported with 400 kg of sunflower seeds, which they could use to produce oil for sale and at the household level.

Impact story of local poultry

Milka* from Bungoma County received 4 four local poultry from the project in 2013. Using the techniques taught through the project, she raised enough poultry, which she sold to buy dairy goats. To-date, she has consolidated income from dairy goats to purchase a dairy cow. She pays fees for her niece, who is an orphan and vulnerable child; provides for her family's basic needs; is a member of a village savings and loans association; and is ready to graduate.

A total of 4,651 (M 1,341; F 3,070) OVC from moderately and low vulnerable households benefited through energy-saving technologies, value chains, and greenhouse farming. They generated an income of KSh 2,814,120 from sale of value chain, energy saving and greenhouse produce/products, which was used to acquire productive assets, including goats and dairy cows. The project has continued to scale up value chains initiatives in Homa Bay, Kakamega, Kisii, and Bungoma. Caregivers were mobilized to join groups, and it is from this platform that skills are transferred, joint market is solicited, and they get value on their investments.

In Mount Elgon Subcounty, caregivers in Bukonoi CBO have joined efforts to carry out horticulture farming, focusing on onions and tomatoes. The bulking is done at the farm, and the caregivers sell crops as a group to mitigate the effects of middlemen who undermine individual farmers. A group of 24 farmers generated an income of KSh 2,687,000, with each member getting an average of over KSh 100,000 as income from Q1 to Q3. Most of them are able to sustainably provide for their families.

Transition and sustainability

During the reporting period, the project continued to focus on the sustainable economic and social resilience of the households through building the capacity of 76 CBOs that are taking care and supporting the OVC in the project. The project built on the achievements of the last quarter, during which 717 HHs graduated. An additional 60 HHs graduated in Migori—increasing the number of HHs that have graduated thus far to 4,184 OVC. In addition, the project has supported CBOS to develop strategies to boost household economic resilience, hence increasing the number graduating. These strategies include CBOs mobilizing local resources from partners, including the Ward Development Fund and Constituency Development Fund, and well-wishers to fund the CBOs' scale-up activities. Training and linking more households to VSLA, as well as initiating income generating activities among caregiver groups, link caregivers to microfinance institutions (e.g., the Kenya Women Finance Trust, One Acre Fund, and banks aimed at accelerating economic growth).

Strengthened child welfare and protection systems at county level, and improved structures and services for effective responses in targeted counties

The project continued to partner with the Department of Children Services across the ten counties. In Siaya County, the project is supporting the rollout of the national Child Protection Information Management System. A total of 185 volunteer trainers of trainers (TOTs) in quality improvement were trained in liaison with the Department of Children Services. These TOTs have been instrumental in supporting the DQA in the July–September 2016 period across the 76 CBOs as they cascaded the skills to other volunteers.

To support data quality at the CBO level and continuous mentorship on the use of OLMIS, the project recruited and assigned three M&E personnel in the period July–September 2016 and continued to support 46 data clerks who are assigned to CBOs. The support included on-site mentorship on the use of the OLMIS, understanding of OVC indicators, and data validation. The project was able to upgrade the OLMIS to meet the United States Government (USG) reporting requirements; capacity-building of CBO and project users on OLMIS will continue in the October–December 2016 period.

Subpurpose 2. Increased access to and utilization of focused maternal, newborn, and child health; family planning; water, sanitation, and hygiene; and nutrition services

Reproductive health, family planning, and maternal and neonatal health services

The project provided support for reproductive health; family planning; as well as maternal, newborn, child health, and adolescent health to 755 sites. The focus of this support was on improving ANC service uptake, skilled deliveries, postnatal care, (i.e., newborn care, child immunization, family planning, and PMTCT). Additionally, the project provided support to strengthen maternal and perinatal death surveillance and response (MPDSR) processes. The project continued to support initiatives aimed at meeting the demand for FP services. These initiatives included RH camps and integrated MNCH/FP outreaches in hard-to-reach areas, with a focus on special groups, including very poor women in informal settlements/slums, the poorly educated, and young people/adolescents.

The project provided reproductive, maternal, newborn, and child health (RMNCH)/FP tools to capture data; conducted RH camps and MNCH outreaches in hard-to-reach areas for scale-up of services; built the capacity of capacity-building HCWs and CHVs on RMNCH/FP for improved knowledge; provided SOPs/guidelines (Tiahrt charts) and job aids to facilitate service deliveries; and ensured quality of care through technical assistance, supportive supervision, data reviews, and integration of FP services. Continuous support was provided to FP commodity TWGs to sustain reporting rates above 80 percent, as well as to advance respectful maternity care. The project enhanced demand creation for RMNCH/FP services through community mobilization and sensitization in dialogue days, provision of community-based distribution of community FP methods by CHVs, as well as referral of clients by CHVs to health facilities for services.

The project conducted RMNCH/FP advocacy with the county team to strengthen county government RMNCH/FP financing. It also worked closely with the county governments to provide appropriate coordination for RMNCH/FP services. This was further enhanced by the formation of RMNCH TWGs with a focus on improved coordination for RMNCH services.

Table 33. RH/FP/maternal and neonatal health performance, Y5Q4–Y6Q3.

Service area	Indicator		PPR 2016 target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% achievement
Maternal and neonatal health	Number of health workers trained in FP/RH with USG funds (HCWs)		432	0	288	448	37	773	179%
	Number of women who received at least 4 ANC visits (4 plus ANC visits)		81,411	27,436	24,439	26,955	27,715	106,545	131%
	Number of deliveries with a skilled attendant in USG programs		149,329	39,064	37,587	38,687	41,242	156,580	105%
	Number of babies who received postnatal care within 2 days		143,416	39,178	34,829	39,402	41,236	154,645	108%
	Number of facilities that provided appropriate lifesaving maternity care BEmONC and CEmONC	BEmONC	27	25	25	34	40	40	148%
		CEmONC	20	18	18	23	26	26	130%
Family planning	Couple-years protection in USG-supported programs.		432,633	172,093	159,612	150,820	178,079	660,604	153%
	Total number of CHVs trained in FP counseling and services through USG-supported programs		5,453	5,453	6,410	6,410	6,567	6,567	120%
	Number of USG-assisted service delivery sites that provided FP information and/or services			755	755	755	755	755	
	Number of SDPs that reported stockout of any contraceptive commodity offered by the SDP at any time			755	755	755	755	750	
	Number of additional CHVs who provided FP information and/or services		144	66	891	0	157	1,114	774%
	Number of referrals for FP services made by CHW in USG-supported programs			9,199	6,617	12,271	5,361	33,448	

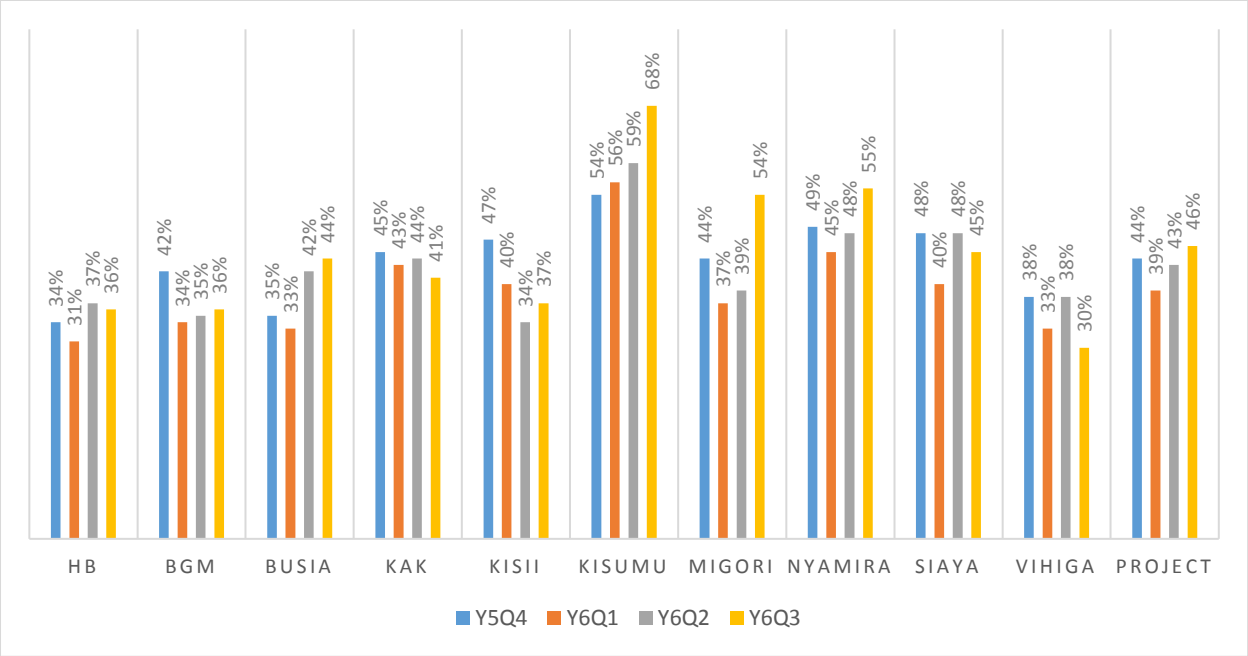
Note: ANC, antenatal care; BEmONC, basic emergency, obstetric, and neonatal care; CEmONC, comprehensive emergency obstetric and neonatal care; CHV, community health volunteer; CHW, community health worker; FP, family planning; HCW, health care worker; PPR, program performance report; Q, quarter; RH, reproductive health; SDP, service delivery point; SD-SB, single delivery, single birth; USG, United States Government; Y, year.

Training of HCWs and CHVs

A total of 773 HCWs and 6,567 CHVs underwent update/refresher trainings on FP/RH, as of the end of Y6Q3 as shown above in Table 33. The trainings covered cervical cancer screening, commodity management, emergency obstetric and newborn care (EmONC), use of uterine balloon tamponade (UBT), FP legislative compliance regulations, long-acting and reversible contraceptive methods, respectful maternity care, and MPDSR.

Antenatal care

Figure 11. Proportion of pregnant women attending at least four ANC visits.



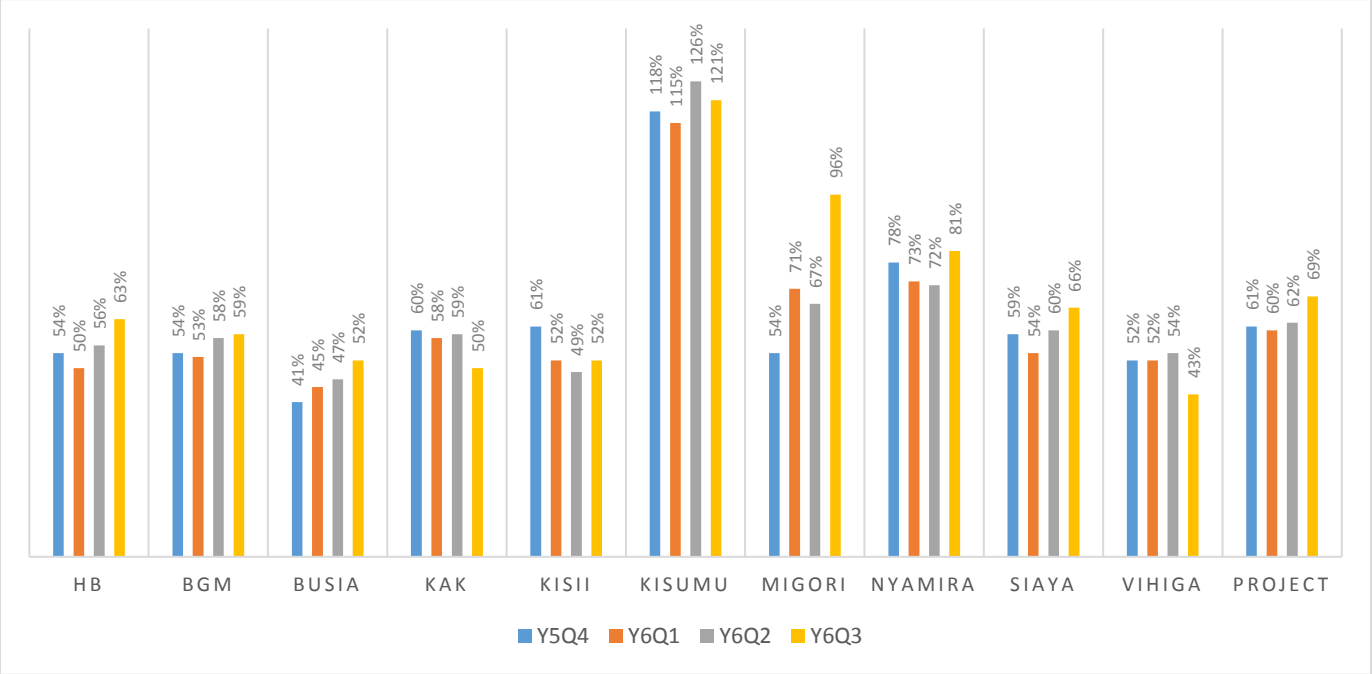
Note: BGM, Bungoma; HB, Homa Bay; KAK, Kakamega; Q, quarter; Y, year.

Source: DHIS2, 2015-2016

Comparing the number of pregnant women completing the fourth ANC by expectant pregnant population, the project achieved 46 percent in Y6Q3, which is an improvement from the 43 percent achieved in Y6Q2 (see Figure 11 above). The performance for Kisumu County could be contributed to by pregnant mothers in non-project supported health facilities who prefer to receive 4th ANC services in project supported health facilities such as Kisumu county hospital and Jaramogi Oginga Teaching and Referral Hospital. Comparing pregnant women completing the fourth ANC by program performance report (PPR) target as of the end of Y6Q3, the project achieved a total of 106,545 as at end of the reporting period, against a PPR target of 81,411 (131 percent achievement of the target). The achievements were attributed to mapping of pregnant women by CHVs in the community and observed referrals of the same to antenatal clinics. CHVs further supported the services by carrying out quarterly updates of data on pregnant women in their catchment areas and making household follow-ups for ANC attendances. The project also supported health care worker trainings on EmONC and focused antenatal care, and CME for improved knowledge and skills. Additionally, the project supported data reviews for decision-making, supportive supervision, mentorships, and on-the-job trainings for health care providers.

Skilled birth attendance

Figure 12. Proportion of skilled birth attendance.



Note: BGM, Bungoma; HB, Homa Bay; KAK, Kakamega; Q, quarter; Y, year.

Source: DHIS, 2015-2016

A total of 41,242 mothers delivered under skilled birth attendance in the reporting quarter, bringing the total number during the period to 156,580, against a PPR target of 149,329. This translates to 105 percent achievement. The achievement was largely attributed to enhanced demand creation through community mobilization and sensitization, training of traditional birth attendants on the importance of skilled births, rewarding traditional birth attendants on every pregnant woman referred for skill births, and conducting health facility tours for pregnant women to view the maternity setups in terms of friendliness. The achievement was also as a result of free maternity services; improved advocacy on respectful maternity care; training of HCWs on EmONC, focused antenatal care and emergency neonatal care which improved their skills; integrated supportive supervision and data reviews and use for decision making.

As shown in Figure 12 above, skilled deliveries in the project catchment population was at 69 percent in the reporting quarter with Kisumu, Nyamira, and Migori performing better than other counties. The performance of Kisumu County could be contributed to by pregnant mothers in non-project supported health facilities who prefer to deliver in project supported health facilities such as Kisumu county hospital and Jaramogi Oginga Teaching and Referral Hospital.

Scale-up of emergency obstetric and neonatal care services

During the year, the project continued to work with the county/subcounty teams to improve the package of minimum services for mothers and newborns in the basic emergency obstetric and newborn care (BEmONC) focus counties of Nyamira and Busia. The key program elements included building of clinical competencies, commodity procurement, and a continuous quality improvement process. Following an EmONC facilities assessment, comprehensive emergency obstetric and newborn care (CEmONC) sites increased from 23 to 26 facilities drawn from both Nyanza and Western regions. The added CEmONC sites include: Dream Land Hospital and Khalaba Medical Clinic from Bungoma County and Avenue Hospital from Kisumu County. Following the BEmONC assessment carried out in both Nyamira and Busia counties, the number of BEmONC sites increased from 34 to 40 sites (29 in Busia and 11 in Nyamira), translating into 148 percent achievement. The

main challenges that restrict the BEmONC sites' progress in Nyamira County are lack of manual vacuum aspiration kits for manual removal of retained products of conception, inadequate vacuum extractors for assisted vaginal delivery, and lack of anticonvulsants due to inconsistent purchase by the health facilities, which leads to stockouts. However, the Director for Health for Nyamira County has pushed the manual vacuum aspiration kits agenda in the next budget; this is geared toward increasing the number of BEmONC sites in Nyamira County. In Busia County, all the health facilities had MVA kits.

Uterine balloon tamponade initiative

The project, in conjunction with the Kisumu Medical Education Trust, continued to support lower-level health facilities with competency-based trainings on the use of the UBT as a complementary strategy to address postpartum hemorrhage. Other strategies included managing PPH like removal of retained products of conception and administration of uterotonics, ligations of bleeding blood vessels. In Year 5, the initiative was rolled out in Kakamega, Migori, Homa Bay, Nyamira, Siaya, and Busia counties.

Cumulatively, a total of 1,321 service providers have trained on UBT through the project support. In the reporting quarter, 5 cases of postpartum hemorrhage were successfully managed using UBT kits at lower-level health facilities. This brought the total to 84 cases of postpartum hemorrhages successfully managed using UBT kits since the project began supporting the rollout of UBT in 2013.

Respectful maternity care

The project continued to champion the reproductive health rights of the pregnant woman as enshrined in Chapter 4 of the Constitution of Kenya (2010), which addresses the fundamental rights of all citizens. Respectful maternity care discussions are mainstreamed in all RH, MNCH, and FP activities to remind the HCWs and other service providers of the rights of the pregnant women. A total of 294 HCWs were reached with update trainings through the project support in the reporting quarter.

Maternal and perinatal death surveillance and response

The project continued to support health facilities to conduct MPDSR. MPDSR committees continued to identify deaths, collect data, analyze the information, and respond to the findings with recommendations and actions. A total of 22 maternal and 89 neonatal mortalities occurred and were audited. Twenty-two (100 percent) maternal deaths and 10 (11 percent) neonatal mortalities were audited within 24 hours, and 79 (89 percent) neonatal deaths were audited within two weeks. The main direct causes of maternal deaths identified through the MPDSR process were: antepartum hemorrhage, postpartum hemorrhage, eclampsia, and sepsis. The most common causes of neonatal deaths were complications associated with prematurity, asphyxia, and delays (family related) in reaching the health facility for care. As an ongoing strategy to prevent maternal and perinatal deaths, the project is putting more effort toward early identification of pregnant mothers and referrals to health facility for care. Health education on pregnancy risk factors in community dialogue days is also strengthened to disseminate the information. Health facilities are being supported to address the common causes of maternal and neonatal deaths. This is done through CMEs, usage of partographs during labor, and support of facility referrals to prevent delays associated with labor.

Family planning services

The project continued to support activities aimed at meeting the demand for FP services, where the clients have access to the method they want and choose to use. In the reporting quarter, a total of 5,361 FP clients were referred by CHVs for FP services. Additionally, 37 HCWs and 157 CHVs received updates/refresher training on FP/RH.

Couple-years of protection

In Q3, the project achieved a couple-years of protection of 178,079, bringing the number to a cumulative total of 660,604, against a COP target of 432,633 (153 percent achievement). The achievement could be attributed to continued updates to HCWs, enhanced use of CHVs to refer clients for FP, sustained support for RH/FP camps, improved FP commodity management and reporting, and improved county support through FP TWG compliance monitoring.

The project continued to monitor FP compliance at all levels. FP project staff continued to keep watch on compliance concerns. The project will continue to systematically address FP compliance at facility and community levels through CME, as well as through county and subcounty supportive supervision visits. No cases of violation or potential vulnerability were noted in the reporting quarter.

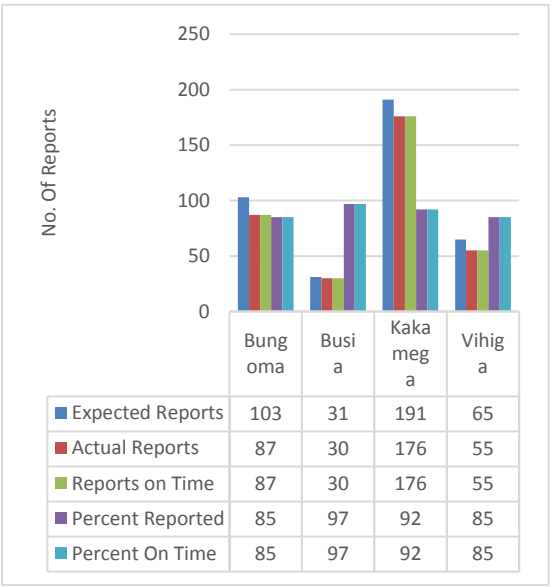
FP commodity reporting

The FP commodity reporting rates have been sustained at a high level across all counties as a result of the project's investment in training HCWs and FP project staff on FP commodity management. Additionally, the project supported commodity TWGs, supportive supervision, mentorships, and on-the-job trainings. At the end of the quarter, all Nyanza and Western region counties achieved FP commodity reporting rates above 80 percent as shown in Figure 13 to 15 below. A total of 255 HCWs received training on commodity management in the reporting quarter.

Figure 13 below summarizes the FP commodity reporting status as at the end of September 2016.

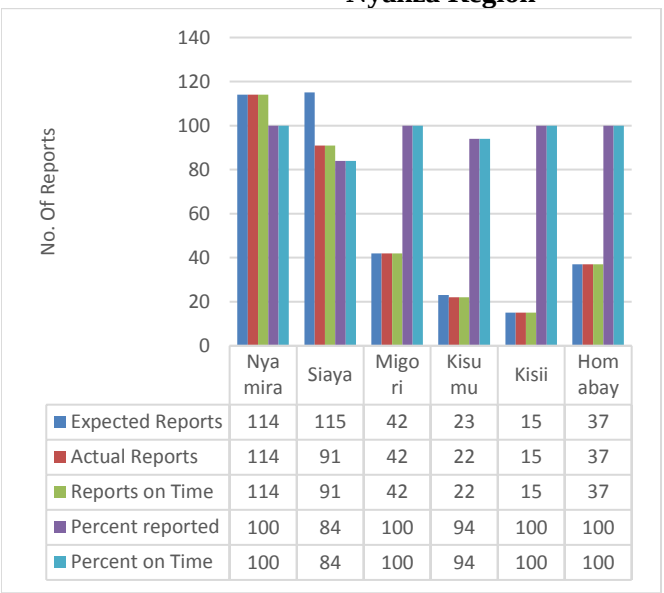
Figure 13. FP commodity reporting rates by county, September 2016.

Western Region



	Bungoma	Busia	Kakamega	Vihiga
Expected Reports	103	31	191	65
Actual Reports	87	30	176	55
Reports on Time	87	30	176	55
Percent Reported	85	97	92	85
Percent On Time	85	97	92	85

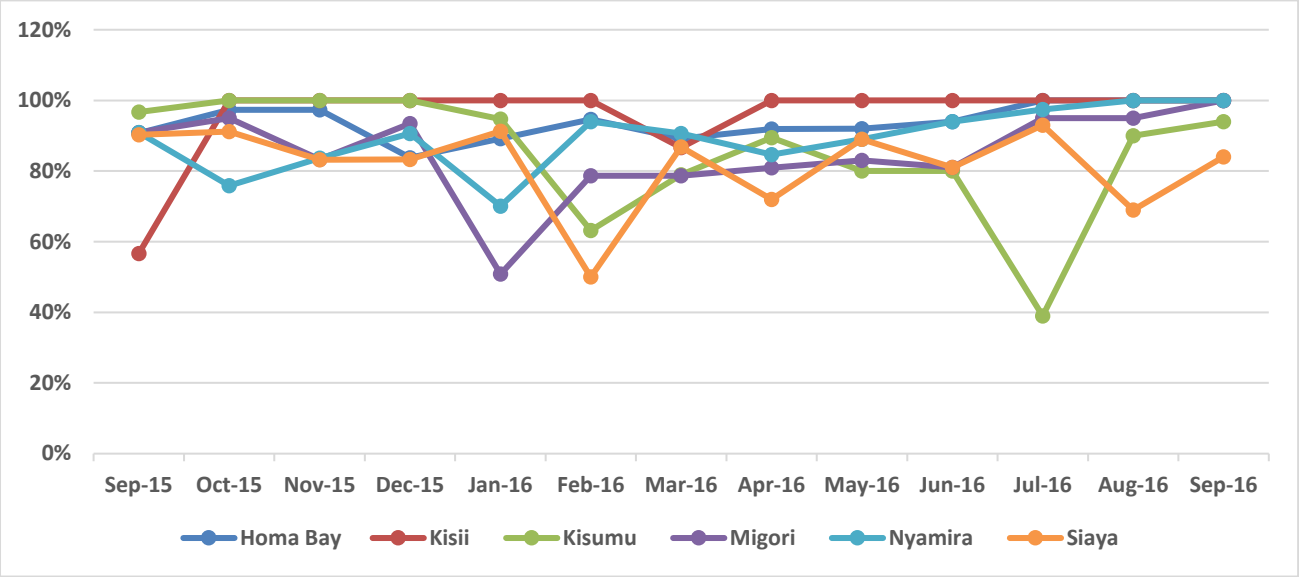
Nyanza Region



	Nyamira	Siaya	Migori	Kisumu	Kisii	Homabay
Expected Reports	114	115	42	23	15	37
Actual Reports	114	91	42	22	15	37
Reports on Time	114	91	42	22	15	37
Percent reported	100	84	100	94	100	100
Percent on Time	100	84	100	94	100	100

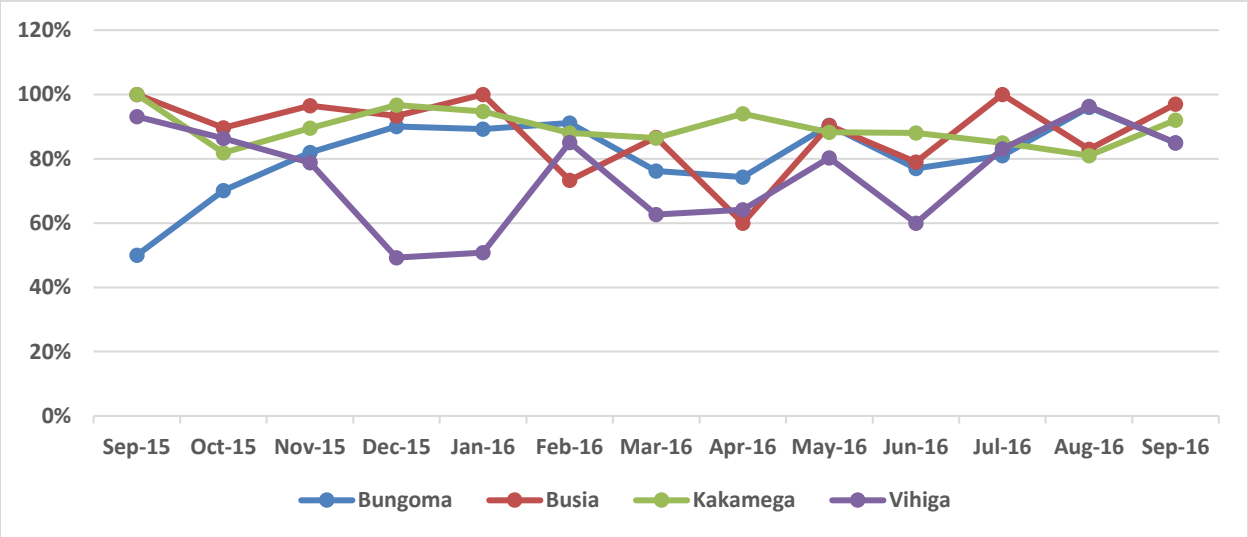
Source: District Health Information System 2, October 2016.

Figure 14. FP commodity reporting timeliness for Nyanza region, September 2015–September 2016.



Source: District Health Information System 2, October 2016.

Figure 15. FP commodity reporting timeliness for Western Region, September 2015–September 2016.



Source: District Health Information System 2, October 2016.

Child health services

The project has continued to support MOH teams to provide high-quality child health services in 755 health facilities and at community level. The main focus was on improving immunization coverage across all counties and managing common childhood illnesses, including diarrhea and pneumonia. The project continued to work closely with the MOH and county government structures to provide appropriate coordination and partnerships for improved service provision, as well as to develop and disseminate the relevant SOPs, policies, and guidelines. Quality-of-care issues were also addressed through technical assistance, supportive supervision, data reviews, and capacity-building of health care workers and CHVs. Table 34 below shows the performance on key child health indicators for the October 2015 to September 2016 reporting period.

Table 34. Performance on the child health indicators, Y5Q4–Y6Q2.

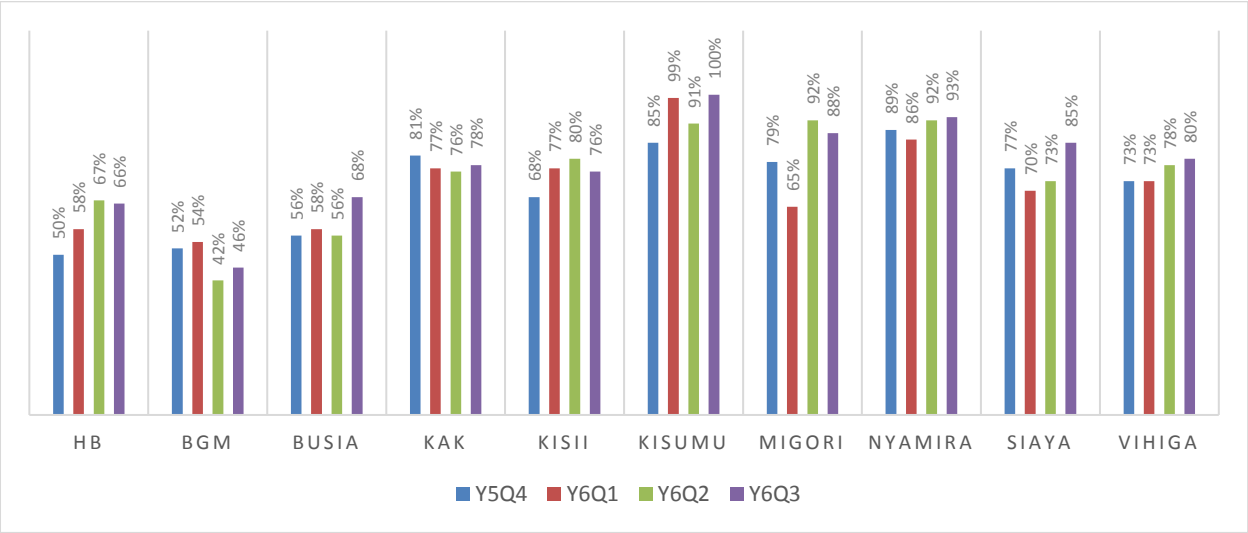
Indicator	PPR 2016 target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% achievement
Children aged less than 12 months fully immunized.	135,528	44,649	43,887	43,559	45,941	178,036	131%
Children aged 12 to 23 months who received third dose of DPT.	180,503	46,452	43,661	42,427	46,466	179,006	99%
Children aged 12 to 23 months who received measles vaccine by the age of 12 months.	174,880	44,822	46,115	44,325	49,597	184,859	106%
Children who received the third dose of pneumococcal conjugate vaccine by the age of 12 months.	170,866	44,797	45,146	42,235	46,271	178,449	53%
Children aged less than 12 months who receive three doses of OPV, excluding birth polio.		34,814	51,416	41,070	45,682	172,982	
Children aged less than five years with diarrhea, who received ORT, defined as receiving oral rehydration solution.	175,598	44,683	23,661	37,009	34,293	139,646	80%
Pneumonia cases in children aged less than five years.		10,014	15,295	16,374	15,116	56,799	

Note: DPT, diphtheria, pertussis, and tetanus vaccine; OPV, oral polio vaccine; ORT, oral rehydration therapy; PPR, program performance report ; Q, quarter; Y, year.

Immunization

As shown in Table 34 above, the project is on track toward achieving PPR 2016 targets for immunization services. However, comparing fully immunized children achievement against proportion of children aged under one year, the overall coverage is lower than achievements against 2016 PPR targets, as shown in Figure 16 below.

Figure 16. Proportion of children under one year old fully immunized.



Note: BG, Bungoma; HB, Homa Bay; KAK, Kakamega.

Kisumu, Vihiga, Nyamira, Migori, and Siaya counties reached coverage rates of 80 percent and above, as shown in Figure 16. Homa Bay, Bungoma, Busia, Kakamega, and Kisii counties had coverage rates slightly lower than 80 percent. The low coverage for Bungoma County was attributed to lack of solo shots for administration of Bacille Calmette-Guérin (BCG) vaccines to newborns. Through support from the project, solo shots were collected from KEMSA commodity supply unit in Nairobi and brought to Bungoma County. The project will follow up with the poorly performing counties, especially Bungoma and Busia, to address emerging challenges so as to improve their performance.

Diarrhea prevention and management

The total number of children aged under five years treated with oral rehydration solution (and zinc) for diarrhea was 80 percent of the PPR 2016 target. This could be attributed to improved reporting by service providers as a result of strengthened use of the oral rehydration therapy register, as well as on-the-job training and CME of HCWs. So far, the project has supported the provision of oral rehydration therapy registers to all 755 health facilities to strengthen reporting. CHVs continue to provide health education at household level, as well as to report on households without access to clean water or sanitation facilities. The process of improving access to a clean and safe water supply for those in dire need of it is ongoing. To enhance community knowledge on waterborne diseases, the project continued to use CHVs under its support to provide health education on diarrhea prevention and various methods of water purification at the household level. Community-led total sanitation (CLTS) also continues to be rolled out in targeted communities through MOH teams.

Pneumonia prevention and management

The project continued to support activities aimed at improving HCWs' and CHVs' skills in diagnosing and treating pneumonia cases with antibiotics. In the reporting quarter, a total of 96 HCWs were trained on integrated management of childhood illnesses for improved knowledge on diagnosing and treating pneumonia cases with antibiotics. In the reporting quarter, a total of 15,116 pneumonia cases were managed successfully with antibiotics, as compared to 15,374 cases managed in Q1. This brings the cumulative total of pneumonia cases managed with antibiotics to 56,799. Through mentorship and sensitizations, the project has also continued to empower CHVs to make timely identification of pneumonia and to refer cases to link facilities. Additionally, the project has continued to support CHVs in providing health education, with emphases on addressing indoor air pollution, improving nutritional practices, and ensuring that children aged under five years are fully immunized.

Water, sanitation, and hygiene services

The project continued its effort to increase access to improved water sources, sanitation, and hygiene for the target population by training and sensitizing the water user committees and individuals on WASH issues. In this regard, a further 152 were reached, making a total of 777 individuals trained so far. The subcounty Public Health Officers were supported to conduct supportive supervision and maintenance, take ownership, and ensure sustainability of the protected springs. The project made efforts, and out of 296 villages triggered through the CLTS process, 215 were finally certified as open defecation free as shown below in Table 35.

Table 35. WASH performance table, Y5Q4–Y6Q3.

Indicator	PPR 2016 target	Y5Q4	Y6Q1	Y6Q2	Y6Q3	Total	% Achievement
Number of people in the target area gaining access to improved drinking water supply	72,000	143,220	55,000	68,000	68,000	68,000	94%
Number of individuals trained to implement improved sanitation methods	200	81	358	186	152	777	389%
Number of people in target areas gaining access to improved sanitation facilities	70,000	69,300	75,075	77,060	144,950	144,950	207%
Number of communities certified as ODF	250	140	140	156	215	215	86%

Number of people in the target area gaining access to improved drinking water supply

A total of 68,000 (94 percent), out of the targeted 72,000 people, continued to gain access to improved drinking water supply through the project's support. They accessed the water from the 68 springs protected through the project support. The project supported public health officers and public health technicians to sensitize and supervise the communities and water user committees of those water facilities for purposes of ownership, maintenance, and sustainability. The project, working with MOH officials and communities, has identified ten more springs to be protected in the next quarter.

Number of people in target areas gaining access to improved sanitation

During this reporting period, the project supported the follow-up of 296 villages through the CLTS process. A total of 215 (Nyanza 172; Western 43) villages have been certified as "open defecation free," using the current MOH protocol for certification. From the efforts of CLTS, a total of 144,950 people accessed improved sanitation as at end of the reporting period. In institutional setups, the project provided 80 handwashing facilities and 50 safe water drinking facilities to all the centers of excellence/high-volume sites.

The subcounty Public Health Officers, the ward public health officers, together with lead CHVs and village champions made household visits and provided health education on access to improved sanitation. The project facilitates the CHVs to meet monthly to conduct dialogue/action days and report on the progress.

Villages certified as open defecation free as a result of USG assistance

During this reporting period, 215 of the 296 villages that had been triggered on CLTS in the last quarter were moved to open defecation free internal certification, bringing the total to 446 villages (231 villages were certified in the previous years). A further 146 were newly triggered during the quarter and will be followed through the CLTS process for certification as open defecation free.

Number of individuals trained to implement improved sanitation methods

To enhance the capacity of the health care workers and other community members on water, sanitation and hygiene, the project further supported the training of 152 individuals on improved sanitation methods, making a total of 777 individuals trained (389 percent).

Nutrition services

In the reporting period, the project continued supporting and strengthening nutrition-specific interventions (high-impact nutrition interventions) that target mother and child. These included sensitizations on maternal, infant, and young child nutrition (MIYCN), training and mentorship on integrated management of acute malnutrition, and support for micronutrient supplementation. Of key focus in the MIYCN activities were strengthened messages on maternal nutrition and appropriate infant feeding practices, which include breastfeeding within one hour of delivery, exclusive breastfeeding, and appropriate complementary feeding. Integrated management of acute malnutrition activities aimed to prevent the occurrence of malnutrition and improve treatment of the same. The micronutrients of focus were vitamin A supplementation, iron folic acid supplementation, and education on the importance of zinc supplementation in diarrhea.

The project also supported nutrition-sensitive interventions through nutrition demonstration centers (NDCs). These interventions were meant to address food and nutrition security for PLHIV in various project supported PSSGs. Nutrition assessment, counseling, and support (NACS) for PLHIV were also supported during the period, with great improvement being realized. The improvement realized was made possible by mentoring on the use of the nutrition tool by NASCOP, acting on Site Improvement through Monitoring System exercise findings, and using nutrition volunteers in high-volume sites. In the next reporting period, the project will give more focus to on-site mentorship, which is a proven approach to sustained improvement in performance.

The project supported training and the start of Positive Deviance/Hearth programs in Nambale and Ugunja, which had reported high numbers of malnutrition in the previous year at 8 percent and 9 percent respectively. Positive Deviance/Hearth programs aim to demonstrate that caregivers from poor backgrounds can actually bring up children with good nutritional status by using locally available foods. Already, 14 hearths were established in both subcounties.

The project's performance on key nutrition indicators compared to PPR 2016 targets is shown below in Table 36.

Table 36. Targets versus performance of key nutrition indicators.

Indicator	PPR 2016 Target	Y5Q4		Y6Q1		Y6Q2		Y6Q3		Total	%
		M	F			M	F	M	F		
Number of people trained in child health care and nutrition.	1,035	459	576	127	217	113	191	59	131	1,873	181%
Number of HCWs trained in child health care and nutrition.		274	228	60	104	44	94	59	131	994	
Number of CHVs trained in child health care and nutrition.		185	348	67	113	69	97	0	0	879	
Number of children under five years of age reached with USG support.	432,515	445,892		486,776		504,920		561,069		1,065,989	247%
Number of children under five years of age who are underweight.	38,398	11,786		17,216		15,900		17,042		32,942	86%
Number of children under five years of age who received vitamin A from USG-supported facilities.	346,012	180,467		155,008		414,845		202,437		617,282	178%
Number of facilities with established capacity to manage acute malnutrition.	260	292		313		313		315		315	121%
Number of children who are wasted.	17,919	3,830		5,628		6,357		7,093		13,450	75%

Note: CHV, community health volunteer; HCW, health care worker; PPR, program performance report; Q, quarter; USG, United States Government; Y, year.

People trained on child health and nutrition

A higher number for this indicator was realized during Malezi Bora periods and World Breastfeeding Week, during which MIYCN sensitizations were supported. Integrated management of acute malnutrition trainings focused on areas with high numbers of undernutrition reported and with fewer facilities that are able to manage malnutrition. These trainings will continue based on specific indicator performance and any emerging updates.

Children reached with USG support

This indicator uses growth monitoring as a proxy because this is the entry point to all nutrition services. Performance for the period was assessed through the number of under-five children whose growth were monitored in the las 6 months, also to minimize on double counting. The children reached were high due to the large area of coverage by the project, which also translates to a higher population reached with nutrition services. Other contributing factors included referrals by CHVs for GMP, less missed opportunities at the CWC desk due to use of growth monitoring volunteers, improvement in documentation and use of CHANIS. High number of children were also reached during the Malezi bora activities. The project supported training of CHVs on CMAM and MIYCN, which saw them actively engage in active case finding of children with malnutrition using the MUAC

tapes and referring them to facilities for management. Mothers with EBF difficulties were also taught and referred accordingly.

Underweight and wasted children

Among all children whose growth were monitored, the percentage of children under the age of five years who were underweight was 3 percent and wasting was at 1 percent. This is despite the increased number of children whose growth were monitored in Y6Q3 due to the ongoing nutrition assessment for OVC. The project aims to further reduce the proportion of children who are underweight and wasted by strengthening support on high-impact nutrition interventions and nutrition assessment, counselling and support.

Vitamin A supplementation

The indicator performance was assessed through the number of children 6-59 months supplemented with Vitamin A in the last 6 months since it is a biannual exercise. High achievement for this indicator was realized during Malezi Bora activities in May 2016, which were done at health facilities and early childhood development centers. Routine supplementation was also supported through various initiatives. The project in liaison with MOH nutritionists included Vitamin A supplementation messages in every nutrition continuous medical education and strengthened use of tally sheets at every administration point to avoid missed opportunities especially over the weekends. The project also monitored the community indicator on how many children had not been supplemented and followed up on referrals. The project continues to support nutrition mentorships and documentation of Vitamin A supplementation as a focus area since it has been a challenge and has not always been emphasized as other EPI activities. The project supported the printing and distribution of Vitamin A supplementation monitoring charts which are in use in all project supported health facilities. The indicator has the same challenges similar to growth monitoring since many under-five children stop visiting health facilities after immunization hence are hard to reach unless through accelerated activities such as Malezi bora. The project is also on course in strengthening documentation by making sure it's done alongside other immunization services than waiting to tally later. More children are targeted for Vitamin A supplementation during the second round of Malezi bora in October/November 2016.

Facilities able to manage malnutrition

The project supported IMAM activities in the region with 315 facilities being able to manage malnutrition. This was achieved through CMEs, OJTs and mentorships. The project identified nutrition mentors who provide integrated management of acute malnutrition mentorships at the site level. The indicator was assessed by use of HiNi OJT tool and facilities were categorized as per the set criteria with many facilities retaining the status quo over a long period of time. A facility can change status by not meeting one of the outlined criteria and therefore the results are subject to change based on prevailing challenges at the time of assessment. However, as much as this performance was realized, challenges and gaps existed mostly in inpatient therapeutic feeding where commercial feeds were not available in the last two reporting periods. During the shortage period, many facilities administered locally available feeds. A few health facilities cited challenges of delayed funds from the county government hence not able to purchase commodities for local preparation of feeds. In such cases, the clients were referred to higher level facilities where the commodities were available. Another gap was on inadequate knowledge especially in health facilities that had new staff and many were taken through the IMAM package and provided on-site mentorships. The project also continues to engage facility administrators by involving them in IMAM sensitizations so that they can provide support where commodities need to be availed either through purchase or transportation.

Centers of excellence support

The process of identifying centers of excellence started in Y6Q2. The project targeted all the subcounty hospitals. All the counties have already developed SOPs for all nutrition service areas. Reviewing, printing, and signing of the same are in progress.

Positive Deviance/Hearth initiative

The program established 14 hearths with 108 malnourished children. In the first, second, and third assessments, the children progressively added weight between 0 g and 2000 g. However, 8 (7 percent) dropped out of the program, 4 (4 percent) did not add weight, and 12 (11 percent) lost weight due to illnesses experienced in the follow-up period.

Nutrition demonstration centers

In the reporting quarter, the project continued to support the replication of kitchen gardens from the already established NDCs to improve the food and nutrition security of PLHIV. Between Y5 and Y6, the project supported the creation of 205 NDCs across Nyanza and Western regions to facilitate nutritional education for PLHIV. During the reporting period, a total of 9,812 households replicated kitchen gardens, benefitting approximately 47,200 household members. The project continued to collaborate with the agricultural extension officers and nutritionists to give technical guidance to PSSGs in managing NDCs and kitchen gardens. Through the kitchen gardens, PSSG members have been able to improve their nutritional status and household economic status. In Alupe-Busia County, Bahatika PSSG was able to produce and sell cassava stems (Mihogo) as seeds to the community and to the Ministry of Agriculture.

Nutrition assessment, counseling, and support

The project continued to support NACS during the reporting period. An improvement in performance was recorded at 64 percent of the total clients in care. This is a result of ongoing mentorship and project support for nutrition volunteers at high-volume facilities. This support will continue with the aims of ensuring that every client receives nutrition services at every visit and that documentation is well done. Mentorship will focus on facilities without nutrition personnel to ensure continuity of nutrition services.

Food supplementation for OVC

In preparation for food supplementation for OVC, the project supported meetings for CBO directors to discuss the intended exercise. Mass nutrition assessment for OVC by nutritionists, CHVs, and CBO representatives is going on in all of the 76 CBOs—an exercise expected to end in early November.

Malaria prevention and treatment services

Malaria performance review/stakeholders' forums

The project supported a total of 5 out of the 10 counties to conduct malaria stakeholders' forums (Nyanza 4; Western 1), involving 16 subcounties. Stakeholders involved included PS Kenya, the Kenya Red Cross, the Malaria Control and Elimination Partnership in Africa (MACEPA), MEASURE Evaluation PIMA, University Research Company, the Kenya NGO's Alliance Against Malaria, Africa Indoor Residual Spraying, National Malaria Control Programme, IMPACT, and other subrecipient partners of the Global Fund to Fight AIDS, Tuberculosis and Malaria in the region. Malaria stakeholders' forums for the remaining subcounties have been planned for Y6Q4.

During the stakeholders' meetings the TWGs came up with specific gaps, challenges, and timed resolutions respective to their regions. Coordination between outpatient department, laboratory,

pharmacies, and other units within the facilities that do malaria testing was encouraged across the subcounties. As a follow-up to the challenges, the project supported CME, mentorship, and data review meetings to address the gaps.

Coordination and linkage/technical working group forums

Currently, the project is working toward bringing together partners/players that are implementing malaria programs. The collaboration will mainly manifest during the joint data review meetings and regional quality improvement stakeholders forums that are conducted with support from partners. The subcounty HMTs are encouraged to make consultations and approach the project for support.

During this quarter, the project supported TWG meetings in Nyanza. In Western, these meetings were supported by other partners—like MEASURE Evaluation PIMA, MCSP, Kenya NGO's Alliance Against Malaria, University Research Company, and MalariaCare—in collaboration with the project. Moving forward, the project will identify actionable points for improvement and link with an identified partner for specific areas of support. The project has worked with Population Services Kenya and the MOH to gather print and electronic media materials for use in the region in the next quarter to enhance malaria advocacy and uptake of malaria interventions.

Moving to the extension period, the project is not expected to directly support malaria case management, malaria rapid diagnostic test trainings, CME, and mentorship; instead it will liaise with the respective partners on coordination and linkage. The program's main focus will be on support supervision, stakeholders' forums, TWGs, performance and data reviews, as well as support for county and subcounty annual operation plan/annual work plan processes.

Health care workers' training and mentorship

In order to enhance the capacity of health workers to timely and accurately diagnose, treat, and report on malaria, the project supported malaria case management trainings, malaria CME, and mentorship of the HCWs by the SCHMTs in the high-volume facilities within the ten counties in the region. These activities were usually guided by the gaps identified and findings reached during support supervision, as well as by recommendations from the TWGs.

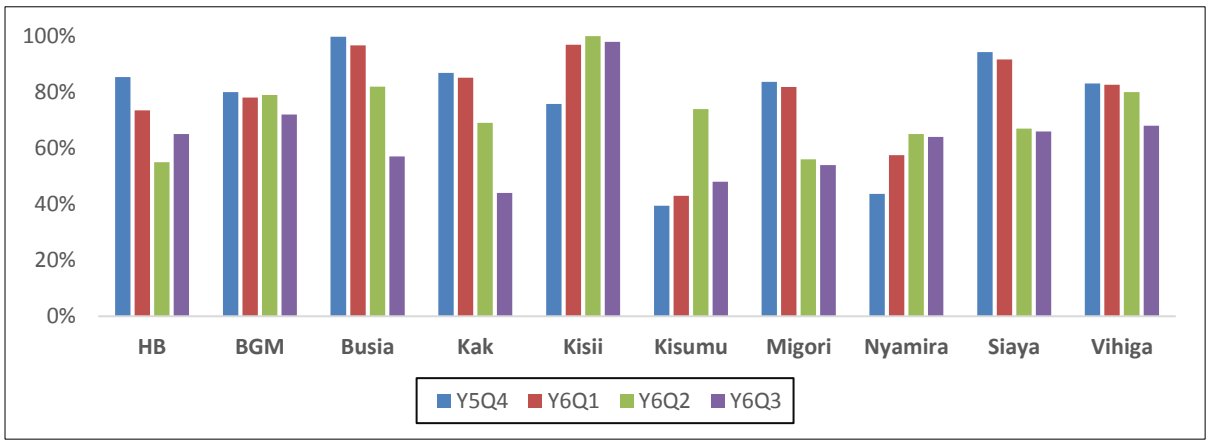
In malaria case management, 30 subcounties were covered, reaching a total of 908 HCWs (Nyanza 182; Western 726). These HCWs were trained using the current MOH case management training guidelines and standards.

In CME and health facility mentorships, 299 (Nyanza 168; Western 131) facilities in 47 subcounties and 3,554 HCWs in the region were reached (Nyanza 1,519; Western 2,035).

Surveillance and malaria tracking

The project did support malaria-epidemic preparedness and response in the epidemic-prone subcounties. The established sentinel sites continued to provide reliable surveillance data, site mentorship, and specific support supervision for the sites. The sites continued to monitor malaria trends in their respective areas and to provide alerts to the county and subcounty malaria control coordinators.

Figure 17. Proportion of confirmed malaria cases by county, Y5Q4–Y6Q3.



Source: DHIS2.
Note: BGM, Bungoma; HB, Homa Bay; Kak, Kakamega; Q, quarter; Y, year.

Figure 17 above shows inconsistency in the testing pattern, which probably can be attributed to perennial malaria commodities stockouts. In an effort to reverse this, the project has consulted with malaria implementing partners whose mandate includes malaria case management to take this up. This will become clearer as the new dispensation is rolled out and clarified during the next malaria implementing partners' joint planning meeting in November 2016.

Subpurpose 3. Strengthened and functional county health systems

Human resources for health services

Having completed the engagement of the human resources for health (HRH) in the previous quarter, the project focused on building their capacity for the optimal provision of quality services. Similarly, the project also filled in some of the HRH gaps with some 239 direct hires that included 32 clinical staff, 2 medical laboratory technologists, 53 nutrition officers, 8 data clerks, one HRIO, 14 nurses, 117 HTC counsellors, one pharmaceutical technologist and 11 social workers. These will complement the work of the 764 recruited through the county mechanisms. The project, working with the USAID Funzo project, facilitated the staff to undergo an e-induction course as per MoH requirements for new hires. The breakdown of the staff placements per county is shown in Table 37 below.

Table 37. HRH establishment by county by end of Y6Q3

Cadre	Scale-up to saturation counties				Aggressive scale-up counties			Sustained counties		Total
	Homa Bay	Kisumu	Busia	Migori	Kisii	Kakamega	Vihiga	Bungoma	Nyamira	
Data Clerks	11	5	1	14	4	0	0	3	14	52
HRIOs	0	0	11	0	1	48	11	3	5	79
Nurses	4	3	4	2	1	39	0	5	10	68
MLTs	3	0	2	5	0	18	4	5	5	42
HTC Counsellors	56	14	19	39	28	22	20	36	111	344
Nutritionists	2	1	2	3	1	13	1	2	3	28
Clinical Officers	11	10	14	20	4	30	20	18	6	133
Pham Tech	0	0	2	0	0	11	0	0	0	13
Social Workers	0	0	0	0	0	5	0	0	0	5
Total	**87**	**33**	**54**	**83**	**39**	**186**	**56**	**72**	**154**	**764**

In the coming quarter, the project will work with the county teams to conduct appraisal for all the staff working in the project supported facilities. Discussions with the counties' departments of health on the staff transition plans will continue to be held.

Strategic monitoring and evaluation

During the reporting period, 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, including rollout of the revised HIV reporting tools; data quality improvement; reporting at county, subcounty, facility, and community levels; and strengthening of the OVC reporting process and use of the OLMIS. 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

Constraints and challenges experienced during the reporting period included the following:

1. Some of the newly diagnosed HIV-positive clients opted to seek treatment services at sites that are supported by other implementing partners that offer clients incentives for enrollment. This

was especially so in some areas in Homa Bay County, which contributed to reduced new ART clients started on treatment, as compared to the new positives identified within project-supported sites. The clients who enrolled in other facilities were documented in the linkages register at the testing facility.

2. Clients reached through community-testing outreaches at markets, camps, and other social gatherings contributed to the majority of HIV-positive clients who were lost to follow-up. These were largely transit clients who were from catchments outside the project-supported zone.
3. It was tedious to manually analyze bulky daily data that were generated during the community-testing activity. The project will invest in electronic data systems for mapping, data collection and collation, and analysis for timely reporting and decision-making.

IV. PERFORMANCE MONITORING

Enhancing availability and capacity to use reporting tools at all levels

During the reporting period, the project collaborated with the MOH at the county and subcounty levels to provide support in addressing MOH reporting tools shortages in the ten project-supported counties. The project supported photocopying and distribution of key MOH reporting tools, including daily activity registers, blue cards, yellow cards, ICF (pediatric and adult) cards, MOH 731, and the new MOH 711A. The above support contributed to the availability of the reporting tools and to improvements in updating patient records and data quality at the facility level.

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

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

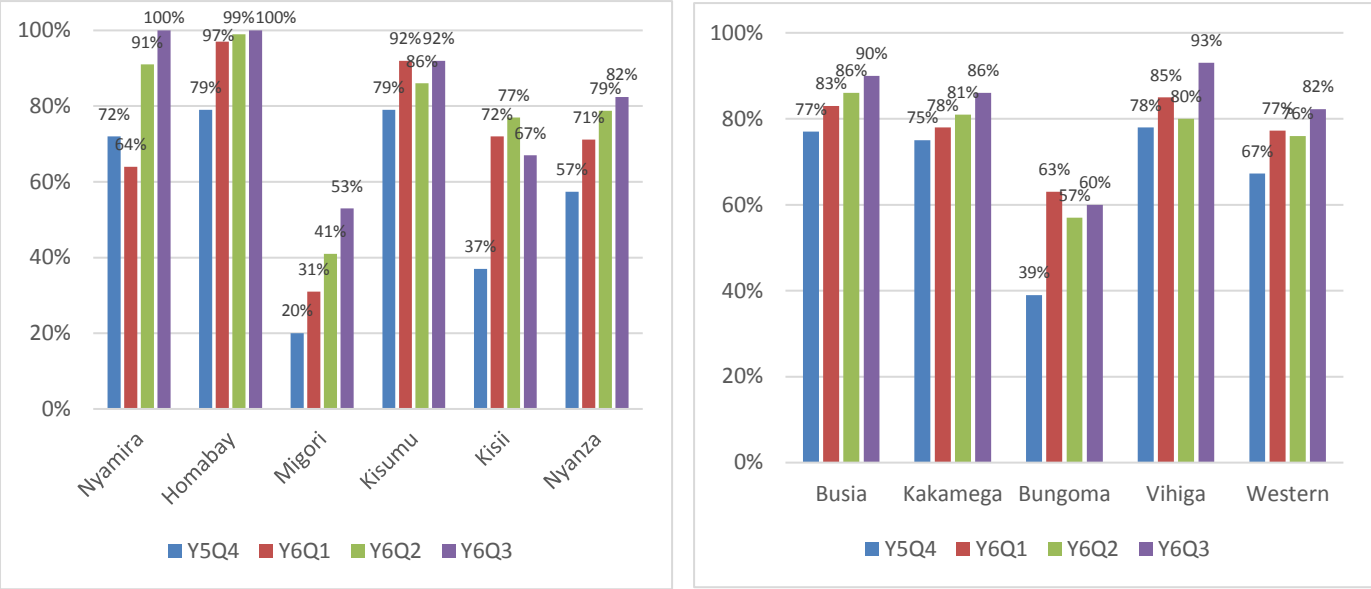
During the reporting period, NASCOP introduced the revised HIV reporting tools. The rollout began with training of master TOTs at the national level, which was followed up by training of TOTs at the county and subcounty levels. The project supported the training of CHMT and SCHMT members as TOTs from project-supported counties during the reporting period. A total of 77 CHMT members (12 in Kakamega, 8 in Bungoma, 3 in Busia, 7 in Homa Bay, 16 in Kisumu, 6 in Nyamira and Kisii, 13 in Vihiga, and 12 in Migori) were trained on the revised tools. In the next reporting period, the project will support training of HCWs from project-supported health facilities on the revised tools. The aim of the trainings is to improve the knowledge of HCWs on the use of the revised tools and to ensure improved quality of reported data through correct filling and transfer of data from facility registers to summary tools.

The project continued to strengthen its support for on-site mentorship on health management information system reporting tools across the ten supported counties. A total of 569 HCWs (106 in Vihiga, 252 in Kakamega, 12 in Homa Bay, 44 in Migori, 15 in Kisumu, 15 in Busia, 90 in Bungoma, and 35 in Nyamira and Kisii) were mentored on reporting tools in the reporting 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 subcounty level, and the USAID-facilitated DQA conducted during the quarter. The focus was on addressing reporting challenges in MOH 731, MOH 711, daily activity register use, HEI cohort analysis, and the HTS service summary tool.

The project also continued to mentor HCWs in HIV care and treatment sites on the use of MOH 733B (nutrition services summary tool) for collecting routine data on NACS services. The project monitored the use of MOH 733B at the health-facility level through quarterly reporting rates (from Y5Q4 to Y6Q3; see Figure 18). To improve the relatively low reporting rates in Migori County, the project followed up with the subcounty HRIOs on reporting the data into DHIS2. The support will continue in the next reporting period, with more focus on strengthening reporting in Bungoma and

Migori counties. This will ensure that the health facilities have adequate MOH 733B tools and that they use them for reporting data on NACS services.

Figure 18. MOH 733B reporting rate by county, Y5Q4–Y6Q3*



*Source: MOH 733B, 2016 (District Health Information System 2).

During the quarter, the project strengthened the capacity of additional community health extension workers and CHVs to use community based health information system reporting tools in order to improve their reporting rates. A total of 61 community health extension workers and CHWs (46 in Nyamira and 15 in Homa Bay counties) were trained on the revised MOH 513, 514, and 515. Thereafter, the team prepared work plans for rollout at the CU level in the next reporting period.

The project also conducted on-site mentorship on the use of the DREAMS reporting tools to M&E staff in local implementing partners for five administrative wards in Kisumu East subcounty, and 16 out of 29 wards in Homa Bay County. The mentorship contributed to proper documentation of services provided to individual AGYW, better management of the DREAMS database, generation of monthly reports, and completion of the performance monitoring plan and project dashboards. Monthly reports from all the wards were reviewed during monthly data review meetings with the aim of identifying gaps in reporting and strengthening understanding of DREAMS reportable indicators. In the reporting quarter, the reporting rate for all the DREAMS indicators was at 100 percent.

The project also conducted DREAMS SIMS in five wards in Kisumu County (Kisumu East subcounty) and ten wards in Homa Bay County (one ward in each subcounty). During SIMS, the project conducted chart abstraction to assess the quality of services and discussed findings with the LIPs. The gaps identified during the visits were documented and follow-up visits were made to monitor the progress.

Improving data quality

Facility data-quality audit

During the reporting quarter, the USAID project management team conducted a DQA for the project. The audit team reviewed reported data for indicators in HTC, PMTCT, treatment, TB–HIV, and OVC program areas. The period covered was July to September 2015 and January to March 2016.

The DQA showed that the project has an elaborate M&E structure, and its systems have in place robust capacity-building initiatives for M&E staff. The audit also revealed the following: The project needs to strengthen and to conduct on a monthly basis the implementation of facility-level data-quality verifications. The project also needs to conduct an analysis of results and provide feedback to the facilities to address gaps.

To address the audit findings, the project developed a data quality improvement plan, which included continued implementation of DQAs on key indicators in HTC, PMTCT, care and treatment, and TB service areas. The project, in liaison with data clerks at health facility level, conducted DQAs in 87 project-supported high-volume health facilities during the months of July to August 2016. The DQA built on previous similar audits that have been carried out by the project since April 2014. These audits focus on comparison of data from the source registers—monthly reporting on MOH 731 and DHIS2 by facility.

Generally, the results showed continued improvements in data consistency in the follow-up period of July to August 2016 (see Table 38). These results were due to the project's continued on-site mentorships on the use of MOH 731 and to the support from the data clerks assigned to the high-volume health facilities. The project will continue to carry out the DQAs to identify gaps in data quality and to develop data quality improvement plans to address gaps.

Table 38. Data-quality audit comparisons for care and treatment, Y5Q3–Y6Q3.*

Indicator	Month	Verification status (between source registers and MOH 731)			Number of facilities (N)
		No variation	Over-reported in MOH 731	Under-reported in MOH 731	
Number of individuals currently on ART	Sep-15	92%	6%	2%	53
	Oct-15	82%	11%	7%	55
	Nov-15	90%	8%	2%	51
	Jan-16	91%	7%	2%	60
	Feb-16	94%	4%	2%	62
	Mar-16	94%	4%	2%	61
	Apr-16	86%	11%	3%	63
	May-16	87%	11%	2%	63
	Jun-16	92%	8%	0%	63
	Jul-16	86%	8%	6%	87
	Aug-16	88%	8%	3%	86
Number of individuals currently on care	Sep-15	89%	7%	4%	53
	Oct-15	83%	13%	4%	53
	Nov-15	91%	8%	1%	53
	Jan-16	89%	8%	3%	59
	Feb-16	92%	6%	2%	60
	Mar-16	92%	5%	3%	61
	Apr-16	86%	11%	3%	64
	May-16	87%	10%	3%	62
	Jun-16	89%	9%	2%	63
	Jul-16	79%	13%	8%	87
	Aug-16	88%	8%	4%	84
Number of individuals currently on cotrimoxazole	Sep-15	89%	7%	4%	54
	Oct-15	88%	8%	4%	51
	Nov-15	93%	7%	0%	54
	Jan-16	88%	6%	6%	58
	Feb-16	91%	5%	4%	58
	Mar-16	91%	5%	4%	60
	Apr-16	87%	11%	2%	62
	May-16	86%	11%	3%	62
	Jun-16	87%	11%	2%	64
	Jul-16	79%	10%	10%	87
	Aug-16	85%	9%	6%	87

*Source: Data Cross-Check Summary Report, 2015–2016.

Note: ART, antiretroviral therapy; MOH, ministry of health.

OVC data-quality audit

The USAID DQA that was conducted during the reporting period identified gaps in OVC programming and reporting that needed to be addressed immediately. The project developed a data-quality improvement plan to address the gaps in the 76 project-supported CBOs. To address the gaps, the project assigned an M&E staff member to be the M&E focal person for the OVC program. The project also recruited two M&E officers to support OVC M&E work in Nyanza and Western regions. The project updated the OVC program and M&E staff on OVC program guidelines, reporting tools, and indicators.

To strengthen the knowledge of CBO staff on OVC programming and reporting, the project resensitized the 76 CBOs (OVC desk persons, data clerks, lead community home visitors, and CHVs) through a TOT approach on OVC guidelines, case management plans, and correct filling of OVC STFs, caregiver STFs, and annual summary benefit forms especially on priority needs assessed and services provided to the OVC, both directly or indirectly. Building on the above resensitization, the project supported the 76 CBOs (OVC desk persons, data clerks, lead community home visitors, and CHVs) through CBO cluster meetings to review the OVC services that were provided (directly and indirectly) and documented in the STFs and annual summary benefit forms; the CBOs also reviewed the OVC priority needs documented in the STFs. The data for the period of July to September 2016 was reviewed for accuracy, completeness, and consistency. The results were reported through OLMIS in the July to September 2016 period. The 47 data clerks assigned to the 76 project-supported CBOs continued to provide support in the filing of OVC records, and in entry and validation of OVC data in OLMIS at the CBO level.

DREAMS data-quality audit

During the reporting quarter, the project supported a DQA in DREAMS safe spaces. The exercise included checking the availability of standard reporting tools. The DQA checked for consistency, accuracy, and completeness of information documented on the DREAMS enrolment forms, service uptake forms, referral tools, MSP planning and monitoring tools, and EBI registers. The DQA also assessed the use of the tools and database to generate project reports. Facility-based data verification was conducted for DREAMS PMTCT indicators. On-site data verification was done for facilities visited, and a desk review was conducted to ensure consistency with the data reported in DHIS2. The LIPs developed data-quality improvement plans to address identified gaps.

Quarterly data review meetings at subcounty level

The project continued to support quarterly data review meetings in all project-supported subcounties. A total of 468 HCWs (95 in Migori, 70 in Homa Bay, 35 in Kisumu, 30 in Busia, 218 in Bungoma, and 20 in Vihiga) were reached during the data review meetings. The HCWs were composed of clinical and data management staff. During the meetings, facility-level data for HTS, care and treatment, PMTCT, RMNCH, and VMMC were reviewed. Key gaps in performance and data quality were discussed and strategies formulated for data-quality improvement at the facility level. During the meeting, HCWs from CCC, HTS, MCH, and laboratory departments reviewed the data.

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.

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 158 HCWs (10 in Busia, 32 in Vihiga, 12 in Nyamira, 15 in Homa Bay, 29 in Migori, and 60 in

Kakamega) participated in the bimonthly meetings. Through the process, data entry inconsistencies in DHIS2 were identified and corrected by SCHRIOs. This contributed subcounty health information officers to an improvement in the quality of data in DHIS2.

Strengthening the use of OLMIS

During the reporting period, the project held a meeting with the Measure Evaluation PIMA team to review, and sensitize project staff on, the USG OLMIS. Building on the meeting, the project developed an action plan to support the project's transition to the USG OLMIS. Through Measure Evaluation PIMA's support, the project installed the OLMIS. In the next quarter, sensitization of project staff and CBO leaders will be a high priority to ensure a smooth transition and use of the new OLMIS.

To enhance the use of OVC reporting tools and OLMIS, the project trained 76 CBO directors, 76 OVC desk persons, and 47 data clerks on the tools and system. The project also continued to provide on-site mentorship on the use of OLMIS to CBO OVC desk persons and data clerks.

Strengthening the use of VMMC M&E system

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

Strengthening HIS and M&E coordination and collaboration structures at county levels

Strengthening county M&E TWG meetings

The project has continued to support all the ten counties to have functional M&E TWGs. During the reporting quarter, the project supported M&E TWG meetings carried out in Busia, Bungoma, and Migori counties. The meetings were useful in ensuring that there was coordination of M&E activities and collaboration among partners at county level. The meetings served as platforms for learning and sharing best practices in the counties.

Progress on site improvement through monitoring system

During the reporting quarter, the USAID team carried out a SIMS exercise in project-supported health facilities in Busia County. Details of the results and actions are included in Annex V.

V. PROGRESS ON GENDER STRATEGY

The project continued to respond to the existing gender inequality gaps through facility- and community- level interventions. At the facility level, the project-supported capacity-building of HCWs on management of SGBV through CME and on-the-job training. To improve active GBV case-finding, the project also built the capacities of HCWs to provide screening services at the point of care. In partnership with other actors and the county-level gender TWGs, the project offered other nonclinical services such as legal aid, protection, and family integration. The project continued to work with paralegals to support legal awareness clinics to improve GBV awareness and response. In addition, HCWs received updates on the new RMNCAH guidelines. The project also supported health facilities to report SGBV data on the DHIS. The project fully migrated GBV reporting from MOH 731 to the DHIS during Y6Q2.

At the community level, the project supported community awareness creation activities to enhance demand creation for GBV services, as well as address power relations and imbalances that prevent

people from seeking care and treatment services. The project used Project SASA as a systematic community-level intervention to address gender norms in the context of HIV and GBV prevention and response. Community-level GBV awareness and response sessions were facilitated by trained SASA activists/facilitators drawn from the CHW fraternity, paralegals, PLHIV, Male Champions of Change, and youth groups. SASA posters were also reprinted to facilitate community-level discussions during VMMC mobilizations, HTC, FP, and MNCH activities. In addition, the project supported commemoration of "international days," such as the International Day of the Girl Child.

VI. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

APHIA*plus* continued to support counties to integrate HCWM into their programmed activities. The project facilitated sensitization and planning meetings in three counties, namely Kisumu, Busia, and Kakamega. The meetings targeted members of county and subcounty HMTs. A total of 83 participants from all the project-supported subcounties attended the meetings. Key deliverables from these meetings were subcounty action plans that integrate HCWM activities, especially support supervision and monitoring by the public health officers. The project expects that the implementation of the subcounty action plans will complement the project activities and expand the project reach.

Health facilities across all the project-supported counties received a supply of color-coded bins and matching bin liner bags. This is aimed at strengthening segregation and immediate storage of infectious waste from HIV service delivery points. At each facility, the areas of focus were the laboratory, CCCs, and MCH clinics. A total of 4,833 waste bins and 1,159,920 bin liner bags were supplied to 537 health facilities. The supply of the HCWM commodities and the provision of job aids and guidelines on management of infectious waste are expected to significantly improve waste handling within the project sites. Reports from the counties where SIMS were conducted show improvements in the overall score on HCWM compared to previous visits.

Secure storage and final disposal of infectious waste still remain challenges to the project due to lack of the necessary HCWM infrastructure in the majority of the facilities in the various counties. The project continued to provide technical support, as well as leverage county resources, to install or repair existing medical waste incinerators, provide disposal pits, and secure waste storage areas within facilities. Two counties, Kakamega (Likuyani Subcounty) and Migori (Uriri Subcounty) installed a new incinerator each in the respective subcounty hospitals. Other lower-level facilities provided pits. The project had in the previous quarter earmarked five facilities to rehabilitate existing incinerators. This activity is still pending approval. This activity will be implemented in the coming quarters as soon approval is granted. This will contribute further to improving final disposal of infectious waste in that target sites.

VII. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

During the reporting period, the project collaborated with the following USAID national mechanisms.

Applying Science to Strengthen and Improve Systems project

Collaboration with the Applying Science to Strengthen and Improve Systems (ASSIST) project continued in this quarter, in line with the 2016 work plan activities that related to quality improvement. The project continued and scaled up support in quality improvement by supporting quality improvement team meetings in the region. County TWGs on quality improvement were

supported across the zone. Quality and work improvement team meetings were supported 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. The two projects jointly supported the training of 76 participants from Kakamega County on the Kenya Quality Model of Health. Each team prepared quality improvement work plans and selected indicators to begin working on. Support was also provided to the Vihiga County quality improvement review meeting. The team embarked on tracking and reporting their quality improvement themes over time (run charts).

The ASSIST project assigned project officers to support Busia, Homa Bay, and Migori who started in September. These officers cover the areas of TB–HIV, malaria, and RMNCH. They are expected to catapult these counties in quality improvement frameworks.

One Acre Fund

APHIA*plus* Western Kenya partnered with One Acre Fund in supporting caregivers with inputs and solar lamps on soft credit across the project area. The project is also working with other USAID-funded partners Academic Model Providing Access to Healthcare (AMPATH) and ICAP in providing HIV testing and counseling and linkages to care and treatment.

Measure Evaluation PIMA

The APHIA*plus* Western Kenya project collaborated with Measure Evaluation PIMA on strengthening the use of OLMIS. The Measure Evaluation PIMA team oriented the APHIA*plus* project team on the USG OLMIS. The teams worked together to develop a transition plan for APHIA*plus* to use to roll out the USG OLMIS. Implementation of the roll-out plan is in progress and will continue in the next reporting period.

The project also collaborated with Measure Evaluation PIMA in planning for the OVC outcomes survey that will assess nine key indicators. In planning meetings, APHIA*plus* and Measure Evaluation PIMA agreed on information that the project will provide and support that will be required during implementation of the survey.

VIII. PROGRESS ON LINKS WITH GOVERNMENT OF KENYA AGENCIES

The project has strengthened partnerships with national and county government agencies on the areas of food security, health, education, and protection for OVC. During the reporting quarter, partnerships with county health departments enabled the project to continue supporting HIV testing services for OVC.

In addition, area advisory councils at the local and county levels were supported to strengthen child protection initiatives. OVC households were linked to the departments of children, civil registration, and vital statistics, as well as the national hospital insurance fund for the acquisition of cash transfer, birth registration certificates, and medical insurance cover.

During the reporting quarter, the project conducted collaborated engagements with the Ministry of Education to strengthen OVC's and AGYW's access to, and retention in, schools. This was done through school fees support and the promotion of adult education through consultative meetings and support supervision.

The project partnered with other departments as indicated in Table 39 below.

Table 39. Project partners based on program and linkage area.

GOK agency	Component	Area of linkage
Ministry of Health	Nutrition HIV testing and counseling WASH	• Growth monitoring for children aged under five years • HIV testing and counseling • Referrals for OVC treatment • Care and treatment for HIV-positive OVC • Safe water • WASH HIV integration
Ministry of Education	Education	• OVC school fees support through bursaries • School fees vetting • Monitoring and capacity-building of school boards of management • Supervision of adult learning centers • Biannual forums for county education boards
Ministry of Labour, Social Security and Services (Children's Department)	OVC and child protection, education, social protection	• AAC support and addressing crucial agendas during meetings • Supervision and periodic accreditation of CBOs • Capacity-building of CBOs • Cash transfer to OVC HH • Linkages for economic strengthening for PLHIV and CHVs
Ministry of Agriculture, Livestock and Fisheries	Food security and nutrition, and household economic strengthening	• Capacity-building of caregivers of OVC • Promotion and monitoring of 4K clubs • Technical support to greenhouse operators • Technical support in nutritional demonstration centers for PLHIV
Ministry of Interior and Coordination of National Government (Kenya Police)	Education, OVC, and child protection	• Follow up on disaster preparedness in schools Membership on AACs
Constituency Development Fund	Education	• School fees support for OVC

Note: AAC, area advisory council; CBO, community-based organization; CHV, community health volunteer; GOK, Government of Kenya; HH, household; HIV, human immunodeficiency virus; OVC, orphans and vulnerable children; PLHIV, people living with HIV; PMTCT, prevention of mother-to-child transmission; RMNCH, reproductive, maternal, newborn, and child health; WASH, water, sanitation, and hygiene.

IX. PROGRESS ON USAID FORWARD

The 76 project-supported CBOs that coordinate service provision for OVC continued to receive support for building institutional capacity and linkages to other partners. This was done to complement their efforts and resources toward scaling up support for OVC. During the reporting quarter, the project enhanced public-private partnership through the 'Busia Big Heart' initiative, Presidential bursary and Constituency bursary fund that enabled mobilizing of extra school fee support to OVC during the reporting period. The CBOs were also facilitated to carry out exchange programs as part of regular peer mentorship, with the hope that such activities would help steer growth.

Capacity-building for the implementing partners has worked as an avenue of ensuring household enhanced economic resilience. During the reporting quarter, 79 HHs graduated from the project after achieving self-sufficiency. They are now champions for training others.

X. SUSTAINABILITY AND EXIT STRATEGY

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

Institutional sustainability seeks to transition services and responsibility at the household and CBO levels. At the CBO level, capacity-building through exchange visits, quarterly review meetings, and supportive supervision was carried out, which has resulted in strengthened networks, stronger linkages for resource mobilization, and enhanced governance and management of these organizations. In Y6Q3, VSLAs continued to generate income for households. A total of 754 groups that were supporting 45,326 OVC benefitted from KSh 47 million in circulating funds at the community level. These groups use these funds for loans and starting small businesses.

A total of 4,043 HHs graduated from the US President's Emergency Plan for AIDS Relief (PEPFAR) support this reporting quarter from among 24,045 HHs that were identified for transition by the end of Y6. Strategies to support HHs that are still in the highly vulnerable and moderately vulnerable levels to move toward resilience are in place. These strategies includes clustering HHs into Watano and Wakumi groups, direct support, VSLAs, support with small stocks, linkage to microfinance, and capacity-building.

In addition, caregivers continued to engage in farming and small business enterprises. They benefitted from the addition of productive assets that were supported by funding from the VSLAs and microfinance institutions. The project supported 1,086 highly vulnerable households with 6,100 local improved poultry as productive assets during the reporting quarter. Other highly vulnerable OVC households, which the project previously supplied with indigenous chickens for rearing in 2013, have continued to grow and multiply their assets, thereby reducing their economic vulnerability and enhancing their resilience.

Caregivers previously trained as artisans in energy-saving technologies continued to install rocket stoves and promote alternative energy-saving devices, such as solar lamps and fireless cookers, within their communities as income-generating activities. Caregivers trained on value chains continued to grow their income (e.g., 55 out of 242 caregivers in Bungoma County were ready to graduate from project support). These initiatives are being promoted to equip caregivers to accumulate and develop productive assets, promote environmental conservation, and provide for their children with minimal external support.

XI. GLOBAL DEVELOPMENT ALLIANCE (IF APPLICABLE)

Not applicable.

XII. SUBSEQUENT QUARTER'S WORK PLAN

The progress on planned activities during the reporting period is described in Table 40.

Table 40. Planned activities during the reporting period.

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.	Completed planned activities for the quarter.	Not applicable
SUPPORT FACILITY-BASED CME FOR ART AND PMTCT ON A QUARTERLY BASIS.	Completed planned activities for the quarter.	Not applicable
SUPPORT THE LABORATORY-NETWORKING MODEL (CD4, EID, BIOCHEMISTRIES, HEMATOLOGY, AND VIRAL LOAD).	Completed planned activities for the quarter.	Not applicable
SUPPORT ART PMTCT REPORTING TO MEET APR TARGETS.	Completed planned activities. Targets met and surpassed.	Not applicable
SUPPORT ACCELERATED ART ENROLLMENT AND RETENTION ACTIVITIES	Completed planned activities. On track for all APR targets.	Not applicable
SUPPORT KQMH QI BASELINE ASSESSMENTS AND REASSESSMENTS IN SITES, AS WELL AS LEARNING SESSIONS AND COACHING.	Completed planned activities for the quarter.	Not applicable
SUPPORT FACILITY ART/PMTCT DEFAULTER TRACING SMECHANISMS (DIARIES, PEER EDUCATORS, AIRTIME, AND SMS REMINDERS).	Completed planned activities for the quarter.	Not applicable
SUPPORT FACILITY PLHIV SUPPORT GROUP MONTHLY MEETINGS (INCLUDING PEDIATRIC, MALE, ADOLESCENT, PMTCT, GENERAL CCC).	Completed planned activities for the quarter.	Not applicable
SUPPORT HIV COUNSELING AND TESTING AT ANC AND MCH CLINICS OF PREGNANT MOTHERS AND MOTHER-BABY PAIRS.	Completed planned activities for the quarter.	Not applicable
PROVIDE HCW MENTORSHIP ON EMTCT.	Completed planned activities for the quarter.	Not applicable
SCALE UP INTEGRATED MCH MODELS OF PMTCT CARE.	Completed planned activities for the quarter.	Not applicable
SUPPORT NONCLINICAL COUNSELORS.	Completed planned activities for the quarter	Not applicable
SUPPORT DR-TB PATIENTS TO ACCESS TREATMENT.	Completed planned activities for the quarter.	Not applicable
OVC services		
Support community-based trainers in VSLA.	Ongoing	Not applicable
Strengthen CBO capacity in private and public partnership for resource leveraging and financial support.	Ongoing	Not applicable
Strengthen locational area advisory councils to promote awareness on children's welfare programs.	Ongoing	Not applicable
Support highly vulnerable households with productive assets.	Ongoing	Not applicable

Conduct meeting with education stakeholder to evaluate and review school fee subsidy provision guidelines.	Ongoing	Not applicable
Coordinate retesting of OVC within the 10- to 19-year-old age cohort.	Ongoing	Not applicable
Follow up cascading of parenting skills to caregivers.	Ongoing	Not applicable
Conduct household graduation.	Ongoing	Not applicable
Support destitute OVC with shelter repairs	Ongoing	Not applicable
Combination prevention interventions		
Quarterly community team meeting	Completed	Not applicable
Implementation of EBIs at the Safe Spaces	Waves completed/continuing	Not applicable
SASA training	Completed	Not applicable
SASA implementation for norm change (DREAMS counties)	Ongoing	Not applicable
Enroll DREAMS girls	Completed in all counties	Not applicable
Conduct psychosocial support group meetings, PHDP sessions, Peer Educator sessions for high-priority and key populations, focused monthly meetings, and dialogue and action days for community units.	Continuous activities	Not applicable
Provide post violence care services.	Ongoing	Depends on the needs of the girls and on their locations
Distribute SASA posters and GBV materials, including reporting tools.	Completed	Monthly/quarterly activity
Train community peer educators on Eban for discordant couples.	Postponed	Awaiting revised curriculum
Conduct monthly meetings to review uptake of all services, and conduct verbal autopsy.	Completed	Not applicable
Conduct community mapping exercise for pregnant mothers.	Ongoing (quarterly basis)	
Household HTS	Completed in some wards	

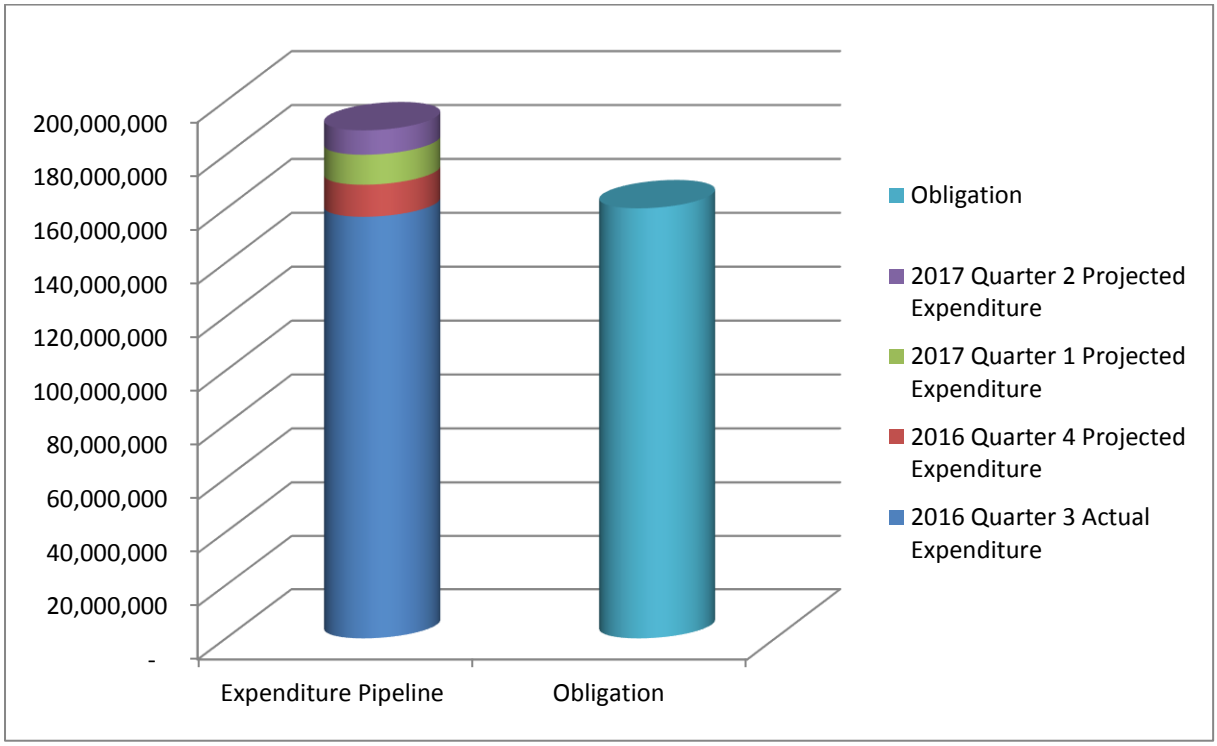
Note: ANC, antenatal care; APR, annual program review; ART, antiretroviral therapy; CBO, community-based organization; CCC, comprehensive care center; CD4, cluster of differentiation 4; CME, continuing medical education; DR–TB, drug-resistant tuberculosis; DREAMS, Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe; EBI, evidence-based intervention; EID, early infant diagnosis; eMTCT, elimination of mother-to-child transmission of HIV; GBV, gender-based violence; HCW, health care worker; HIV, human immunodeficiency virus; HTC, HIV testing and counseling; HTS, HIV testing services; KQMH, Kenya Quality Model of Health; MCH, maternal and child health; OVC, orphans and vulnerable children; PHDP, positive health, dignity, and prevention; PLHIV, people living with HIV; PMTCT, prevention of mother-to-child transmission; QI, quality improvement; SASA, Start Awareness Support Action; VSLA, village savings and loans association**.**

XIII. FINANCIAL INFORMATION

Cash flow report and financial projections (pipeline burn-rate)

The project's obligations and financial projections are shown in Figure 19 below.

Figure 19. Obligations versus current and projected expenditures (USD), Y6Q3.



Note: Q, quarter; USD, US dollar; Y, year.

Budget details

T.E.C: USD 179,378,387

Cum Oblig: USD 160,146,289

Cum Expenditure: USD 157,002,485 (including accruals of USD 1,183,366)

Obligation	2016 Quarter III Cum Expenditures	2016 Quarter IV Projected Expenditures	2017 Quarter I Projected Expenditures	2017 Quarter II Projected Expenditures
$160,146,289.00	$157,002,485.00	$11,898,383.92.00	$11,129,706.00	$9,052,909.00

Salary and Wages	$14,900,479.35	$937,431.00	$1,294,196.00	$1,294,196.00
Fringe Benefits	$4,493,390.70	$303,727.00	$415,342.90	$415,342.90
Travel, Transport, Per Diem	$11,397,234.35	$700,450.00	$812,450.00	$820,450.00
Equipment	$873,469.74	$0.00	780,373.07	$0.00
Contractual	$312,112.53	$120,000	$120,000.00	$120,000.00
Supplies	$13,845,919.87	$990,321.00	$980,480.00	$748,120.00
Other Direct Costs	$90,385,403.26	$6,478,092.82	$4,599,640.00	$3,580,000.00
Overhead	$20,794,475.23	$2,368,362.10	$2,127,223.83	$1,534,799.90

Note: Cum, Cumulative; USD, US dollar.

Budget notes

The budget notes are outlined in Table 41.

Table 41. Budget notes.

Salary and wages	This is expected to increase in Quarter 1 of 2017 as PATH takes over service delivery activities
Fringe benefits	Fringe benefits are the constant ratio against all salaries and wages (payments of provident fund, social security, and medical premiums are included in the fringe pool)
Travel, transport, per diem	This is expected to increase in Quarter 1 of 2017
Equipment	The project intends to buy new laptops in Quarter 1 of 2017
Contractual	The project is expected to continue supporting facility performance-based incentives
Supplies	This continues to stabilize
Other direct costs	This continues to stabilize
Subgrants	No new subawards are anticipated in the coming quarters
Overhead	Calculated as per award conditions
G&A	Calculated as per award conditions
Material overhead	Calculated as per award conditions

New subaward details

No now subawards are expected in the next quarter.

XIV. PROJECT ADMINISTRATION

Critical issues and constraints

The efficiency of the project's operations support equipment and vehicles continues to go down due to aging, wear and tear, and time lapse.

Personnel

There were no major changes in personnel during the quarter.

XV. GPS INFORMATION

Please see the GPS information sheet in the attachment.

XVI. SUCCESS STORIES

Success story 1: From zero to hero—achieving household socioeconomic sustainability.

Margaret Odira, aged 56 years, is no ordinary widowed mother of seven. Hers is yet another "zero to hero" story. She recently achieved a low household-vulnerability status, a qualification a caregiver of an OVC household achieves when their socioeconomic position adequately improves so that they are able to support their various determinants of health, including household food security, access to health services, and access to high-quality education for their children.

When she talks about her life back in 2008, when she first joined the Aphia II Nyanza project under the Dago Dala Hera community-based organization, Margaret says that she was desolate, hopeless, and disoriented. She had just lost her husband at that time; he had been the sole breadwinner for her family. As is common in such a situation, the young family's savings was depleted by the costs of taking care of the ailing member.

Margaret was set to return to Nairobi with her children to start life afresh. However, the Angungo caregiver support group encouraged her to stay in the village and take care of her children. They raised concern that such a move would place her children's inheritance at risk. The caregiver support group offered her comfort and encouragement. "Eventually my eyes opened to an alternative, which I can now confess to have been the best option," Margaret reflected.

Activities of the caregiver support group included growing enough subsistence crops to feed the family throughout the year. Margaret described the household food security drives made among the APHIA*plus* supported households, saying, "I learnt to estimate the amount of food my family would need to be well-fed throughout the season. . . . It was also stressed that each household was to keep a productive kitchen garden to supplement the family dietary requirements and also grow fruit trees." Indeed, her homestead is lined with avocados, mangoes, guavas, and berries, as well as blue-gum timber trees.

Margaret's first son in now a medical doctor, and her daughter is a nurse. These were benefits of APHIA*plus* support in terms of fees paid to schools to improve access to, retention in, and completion of the education cycle for children from vulnerable backgrounds.

As testament to her good work, Margaret's grain store is brimming with sacks of maize harvest. She plans to sell off surplus of her maize, the proceeds from which will go into putting a finish to her new, larger house. "I got the initial capital to start off building this house from my VSLA share-out proceeds with which I bought the corrugated iron sheets," Margaret said. She has a well-deserved pride in her new modern house, which stands majestically next to her old, small gable-roofed house.

"I have become a development champion in my village because I'm keen to implement all lessons I learnt through this project," Margaret commented, referring to the recent graduation ceremony held in honor of the ten other caregivers under Dago Dala Hera. She promised, "I will go out of my way to guide other caregivers who are struggling with such issues as I had passed through."

Success story 2: A discordant relationship—the power of psychosocial support groups in Nyamira County.

Rose (not her real name) was orphaned at a very young age. She ended up in an early marriage because her mother could not afford to pay her school fees. Widowed at the young age of 24 years in 2005, she did not think much about her HIV status then. Her life changed in 2008 when she decided to have an HIV test. The result showed that she was HIV-positive. Immediately, she rushed home and took her children to be tested too. Two of her children tested HIV positive. She and her children (a 16-year-old boy and 14-year-old girl) are currently taking antiretroviral medications.

In 2012, she met a man who agreed to marry her. She disclosed her HIV status to him, and he agreed to take an HIV test with her. The test results showed that he was HIV negative. He still agreed to marry her despite her seropositive HIV status. They have stayed together since 2012. "My husband is very supportive to our children. He supports us all to adhere to the HIV drug regimen by reminding us to take drugs on time. . . . It is the love and support of my husband that has helped us remain strong and focused," said Rose.

Rose is a member of the Misani Couples Support Group in Nyamira North. The support group was started in June 2016 to bring together discordant couples that are attached to Esianyi Health Centre. The members meet regularly with the support of their community peer educator to share experiences, challenges, and how they can support one another. Rose is now 35 years old and a mother of four children, two boys (16 and 7 years old) and two girls (18 and 14 years old).

Community psychosocial support groups are formed by community peer educators with the support of facility peer educators. The members are people living with HIV who have enrolled in HIV care clinics and are receiving prophylaxis treatment or antiretroviral therapy treatment. The facility peer educators and community peer educators are people living with HIV who have disclosed their HIV status, are adhering to treatment, and are free to help others cope with some of the challenges people living with HIV/AIDS face in their daily lives.

Discordant couples are those in which one partner is HIV infected and the other is not. A couple is defined as two persons in an ongoing sexual relationship. Each of these persons is referred to as a "partner" in the relationship.

Through the discordant psychosocial support groups, couples embrace and support each other. Members are taught using the community prevention with positives (cPWP) 13 key messages about infection prevention, condom use, disclosure, alcohol and substance abuse, as well as income-generating activities. This has greatly improved relationships between spouses.

"Joining the discordant couple support group has helped us as a family and my husband to understand the challenges couples face, to keep the marital fire burning, and to adhere [to treatment]. We thank APHIAplus Western Kenya for the support," Rose said.

Success story 3: Celebrating sunrise at St. Mark's Dispensary, Lela.

Rose Adhiambo, at 20 years old, started experiencing labor pains in the morning at around 7 a.m. Together with her husband, she had already made up her mind that, should labor come, she would have her first baby at St. Mark's Dispensary. This informed decision was influenced during her antenatal care clinic at St. Mark's Dispensary. In her own words:

> During ANC clinic, the nurses there were very friendly. They taught on how to tell when due. And I should always be ready with a packed bag with baby stuffs and available means of transport. My husband and I waited for labor to progress. I was not worried because I did not feel anything abnormal depending on what I was taught during my clinic. I was feeling backache and pain in my stomach. It would come and go. My husband and I felt it was time to visit the hospital. We picked the already packed bag and headed to the clinic. This was around 5 p.m. On arrival, the nurses welcomed us. They took me to the room where they used to check me during clinics. They checked me and said I was almost [in labor]. They briefed me on what I should expect and how I should handle the situation. I complied, and within 15 minutes, there she was, my baby girl! I was so excited together with my husband. After delivery, I ate and felt stronger. I left the hospital at around 6 p.m. I was advised to check on bleeding and visit any nearest hospital should anything happen.

When she was asked if she would recommend any mother to deliver at the facility, her response was, "Why not? I myself gave birth to a healthy baby girl right here. However, the Government should provide enough space for delivery and some drinks to the mother who just delivered. I would also wish a nurse to work at night to ensure mothers can rest at least overnight."

Nurse-in-charge Ms. Mary Musula of St. Mark's shared the same sentiments. She said the following:

> I was worried, should any complication occur. But I am happy the labor progressed on well and a LFI score 9/1, 10/5, 10/10 was brought to the world with [a] weight of 2,600 grams. The facility is facing many challenges in regards to maternity services, such as [lack of] linens, sanitary towels, baby blankets, baby cots, Resuscitaire, meals, staffing, and delivery couch, and even delivering space. Despite the challenges, the staffs are committed to offering service. So far, we have [had] four babies delivered in this facility. I would be happy when the staff house completes, as we will be able to have at least a staff on call during the night. I want to thank the subcounty Reproductive Health Coordinator, Ms. Nailantei Kileku, with support from APHIA*plus*, for the support and motivation that has enabled us to develop [a] positive attitude towards service delivery despite the challenges. The celebration today will go a long way in encouraging moms to deliver here. There is hope that the performance will improve with the involvement of all stakeholders.

ANNEXES & ATTACHMENTS

Annex I. Schedule of future events, Y6Q4

Date	Location	Activity
November	Kisumu/Homa Bay	Annual review DREAMS team meeting
October–December 2016	Homa Bay and Kisumu	Implementation of EBIs at the Safe Spaces
October–November 2016	Kisumu (for both Homa Bay and Kisumu teams)	Data entry—enrollment forms
October–November 2016	Homa Bay and Kisumu	PrEP rollout
October–December 2016	Kisumu and Homa Bay	Cash transfer rollout
October–December 2016	Kisumu and Homa Bay	School fees payment
October–December 2016	Kisumu and Homa Bay	Financial capabilities and entrepreneurship

Note: DREAMS, Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe; EBI, evidence-based intervention; PrEP, pre-exposure prophylaxis.

Annex II. List of deliverable products

None

Annex III. Targeted testing strategies and yield by county, October 2015–Sept 2016

County	Location	Strategy/site	Counseling and testing	Positives	Linked	Positivity rate
Migori	CBOs	OVCs	5,202	84	80	1.6%
	CCC	Index clients	3,585	66	66	1.8%
	Hotspots	Bars	312	8	8	2.6%
	Hotspots	*Boda boda* (motorcycle)	625	17	17	2.7%
	Integrated outreaches	RH	21,287	500	444	2.3%
	Workplace	Sony Sugar Company	387	8	8	2.1%
	SAYW	Dede, Awendo	1,682	7	7	0.4%
	Church	Israel Roho	230	2	2	0.9%
	Prisons	Kehancha GK Prison	54	0	0	0.0%
Nyamira	Hotspots	Tea Buying Centre	1,320	8	8	0.6%
		Keroka Block B Bar	46	1	1	2.2%
		Magwagwa Centre	126	2	2	1.6%
		Mokomoni Centre	204	2	2	1.0%
	Outreaches	Integrated RH	6,859	54	52	0.8%
	CCCs	Index contacts	5,558	58	56	1.0%
	Higher learning institutions	Kisii campus, St. Anne College, and Kiabonyoru Girls	532	3	3	0.6%
	CBOs (OVCs)	Manga and Umoja	3,091	1	1	0.1%
	Special clinics	TB clinics	17	4	4	24.0%
	Tea factories	Kipkebe	48	0	0	0.0%
		Sotik	86	2	2	2.3%
		Nyaramba	96	3	3	3.1%
		Nyankoba	106	4	4	3.8%
Kisii	Higher learning institutions	Keroka Technical	101	0	0	0.0%
	Tea factory	Kiamokama	53	2	2	3.8%
	CCCs	Index contacts	1,927	40	38	2.0%
	Special clinics	TB clinics	10	2	2	20.0%
	Outreaches	RH integrated	2,600	23	23	0.9%
	Hotspots	*Boda boda* riders	84	0	0	0.0%
		Kiamokama Bar	82	2	2	2.4%
		Kiamokama Tea Centre	68	2	2	3.0%
		Masimba bar	15	1	1	6.7%

Note: CBO, community-based organization; CCC, comprehensive care center; GK, Government of Kenya; OVC, orphans and vulnerable children; RH, reproductive health; SAYW, sexually active young women; TB, tuberculosis.

Annex IV. Homa Bay community testing

Sub County	CU Name	Linked Facility	No of Villages	Total No of House Holds	Total Population	Number Tested in Community	No HIV + Positive	Positivity Rate
Kabondo Kasipul	Kakangutu East	Othoro	15	1198	5261	3336	80	2.40%
Kabondo Kasipul	Kakangutu West	Kauma	15	1246	6094	2488	12	0.48%
Kabondo Kasipul	Kakelo Dudi A	Ober	15	1247	5311	2383	21	0.88%
Kabondo Kasipul	Kakelo Dudi B	God ber	15	1146	5726	1200	5	0.42%
Kabondo Kasipul	Kakelo Kamroth	Omiro	15	1970	9821	7070	32	0.45%
Kabondo Kasipul	Kakumu	Kabondo SDH	10	530	2639	2491	43	1.73%
Kabondo Kasipul	Kamuga	Atemo	15	1458	6250	3761	24	0.64%
Kabondo Kasipul	Kasewe A	IDF	15	1463	6744	3898	11	0.28%
Kabondo Kasipul	Kasewe B	IDF	15	1475	6898	2479	4	0.16%
Kabondo Kasipul	Kawere	Ober	10	959	4338	1332	11	0.83%
Kabondo Kasipul	Kilusi	IDF	10	422	2229	894	7	0.78%
Kabondo Kasipul	Kodumo East	Atela	15	1311	8174	2793	18	0.64%
Kabondo Kasipul	Kodumo West	Masogo	15	1047	4826	2660	5	0.19%
Kabondo Kasipul	Kojwach East	Kimonge	15	1371	7483	5401	19	0.35%
Kabondo Kasipul	Kokwanyo East	Tala	14	1596	7195	4567	21	0.46%
Kabondo Kasipul	Kokwanyo West	Kokwanyo	13	1363	6193	6993	9	0.13%
Kabondo Kasipul	Kowidi	Kabondo SDH	10	916	4633	4457	71	1.59%
Kabondo Kasipul	Lower Kodhoch	Kabondo SDH	10	614	2770	2491	44	1.77%
Kabondo Kasipul	Miriu	Got Kamondi	15	1411	7581	3693	26	0.70%
Kabondo Kasipul	Rongo Pala	Othoro	15	1129	4936	2156	54	2.50%
Kabondo Kasipul	Upper Kothoch	Kabondo SDH	10	781	3850	3518	61	1.73%
Kabondo Kasipul		Nyawango Disp				65	1	1.54%
Kabondo Kasipul		Jawabu Medical Clinic				30	0	0.00%
Kabondo Kasipul		Awach Disp				0	0	#DIV/0!
Kabondo Kasipul		Kasewe Disp				1228	7	0.57%
	Subtotal					71384	586	0.82%
Kasipul	Kachien North	Nyalgosi Dispensary	12	1345	7518	3569	28	0.78%
Kasipul	Kachien South	Nyalgosi Dispensary	11	969	5121	1024	1	0.10%
Kasipul	Kachieng B	Agawo Dispensary	10	1174	5615	2348	14	0.60%
Kasipul	Kachieng A	Swindon	11	952	4863	9025	3	0.03%
Kasipul	Kadel Kamidigo	Ombek Dispensary	15	1413	6680	7154	7	0.10%
Kasipul	Karabach		13	1291	6250			
Kasipul	Kamiyawa A.	Ragwe	10	760	3661	2798	8	0.29%
Kasipul	Kamiyawa B	Ongamo	10	452	2124	1369	7	0.51%
Kasipul	Kamuma	Rachuonyo DH	15	2089	12079	7089	23	0.32%
Kasipul	Kanyango	Rachuonyo DH	15	1554	7305	4128	15	0.36%
Kasipul	Kasimba	Rachuonyo DH	7	1112	4643	3596	12	0.33%
Kasipul	Kokal	Rachuonyo DH	15	1651	7136	5264	14	0.27%
Kasipul	Kawere East	Koywech Disp	12	1315	5709	4539	17	0.37%
Kasipul	Kawere West	Simbiri Nan Bell	15	1580	6640	3044	18	0.59%
Kasipul	Kawino	Yala Disp	14	1352	5735	1692	1	0.06%
Kasipul	Kotieno Kochich	Nyangiela HC	15	1221	5960	2240	26	1.16%
Kasipul	Kotieno Konuong	Mangima HC	13	1265	6139	2709	23	0.85%
Kasipul	Nyalenda	Nyalenda Nursing Hc	15	1867	8469	4472	14	0.31%
Kasipul	Obisa	Matata	24	1764	8215	2978	11	0.37%
Kasipul	Sino	Sino Kagola	11	1272	5689	3651	8	0.22%
	Sub total					72689	250	0.34%
	Total					144073	836	0.58%

Note: DH, district hospital Disp, dispensary; HC, health centre; IDF, Integrated Development Facility; SDH, sub-district hospital.

Annex V. Status site improvement through monitoring system in project-supported health facilities, 2016

Domain	Element assessed	Health facility/facilities	USAID ratings (September 2016)	Project rescore (October 2016)	Immediate action	Long-term action
All facilities	HIV QM/QI activities	Sio Port, Nangina, and Nambale	Yellow	Light green	Revamped the QM/QI initiatives and organized for meetings; facilities have been sensitized on involvement of external stakeholders such as the SCASCO	Facilities to undertake at least one QI project per 6 months with assessment to ascertain the results of the QI interventions
	Waste management	Nangina, Sio Port, Alupe, and Amukura	Yellow	Yellow	The project has identified model facilities that will be used as waste networks for the project, with the contiguous facilities depositing their wastes therein	Facilities to seek support from the county government on open pit fencing and mechanisms for incineration of hazardous waste.
	Data quality assurance	Nangina	Yellow	Dark green	Provision of the guidance in doing DQA has been done. One DQA undertaken	Sensitize all staff on the DQA; routinely conduct DQAs
Commodities management	Supply chain management	Nangina, Amukura, and Sio Port	Yellow	Dark green	Facilities have been primed to always make timely orders of the ARVs, as well as CTX	Continued CME for any new staff
Care and treatment for general population	ART register	Nambale	Red	Dark green	The health care workers were appraised on complete documentation of the fields in the registers	
	HIV testing of pediatric contacts of index clients	Amukura and Nambale	Yellow	Light green	Availed index client contact tracing forms; updated the forms with the contacts	Follow-up of those that are not yet tested is ongoing
	Isoniazid preventive therapy	Lukolis, Amukura, Alupe, and Nambale	1 Yellow and 3 Red	Yellow	Staff resensitized on the need for IPT. Commodities are now available for use.	Continually work with the national team to provide commodities
PMTCT-ANC	ANC register	Sio Port	Red	Dark green	Staff were sensitized on the completion of the register. Data reconstruction was undertaken	

	Isoniazid preventive therapy	Sio Port and Nambale	Red	Yellow	Staff re-sensitized on the need for IPT. Commodities are now available for use.	Continually work with the national team to provide commodities
	ART monitoring	Sio Port	Red	Dark green	Line list of clients without a VL done; called for VL; results availed.	Quarterly VL mop-up weeks to be done
PMTCT-HEI	EID	Nangina	Yellow	Dark green	The PCR results for the infants have been availed and entered in the registers	Project to support follow-up of any results delaying
	CTX for HEI	Lukolis	Red	Dark green	Documentation by the HCWs addressed	
HTC	Site-level HIV proficiency testing	Sio Port	Yellow	Light green	Availed the enrollment documentation for the one officer that had not indicated their enrollment status	
Laboratory	Quality management system	Lukolis and Nangina	Red	Yellow	Linked up with the geographic information system team on the mentorship of these sites for accreditation	
	Test SOPs	Lukolis	Red	Dark green	SOPs were availed	
	Results and information management	Nangina	Red	Dark green	SOPS were availed	
	Quality testing monitoring	Lukolis and Sio Port	Yellow	Dark green	SOPs availed and implementation started	
	Testing interruptions	Nangina	Yellow	Dark green	The interruptions were addressed	
	Lab biosafety	Amukura	Yellow		Staff undertook a CME on biosafety	

Note: ANC, antenatal care; ART, antiretroviral therapy; ARV, antiretroviral; CME, continuing medical education; CTX, cotrimoxazole; DQA, data quality assessment; EID, early infant diagnosis; HCW, health care worker; HEI, HIV-exposed infant; HIV, human immunodeficiency virus; IPT, isoniazid preventive therapy; PCR, ; QI, quality improvement; QM, quality management; SCASCO, subcounty AIDS and STI Coordinator; SOP, standard operating procedure; VL, viral load.