USAID
FROM THE AMERICAN PEOPLE

USAID *AFYA PWANI*

QUARTERLY PROGRESS REPORT

JULY- SEPTEMBER 2018

This publication was produced for review by the United States Agency for International Development. It was prepared by Dr Eileen Mokaya, Chief of party, *Afya Pwani*.

USAID *AFYA PWANI*

FY 2018 Q3 PROGRESS REPORT

1st July 2018 – 31st September 2018

Award No: Aid-615-C-16-00002

Prepared for Mr. Vincent Ojiambo
United States Agency for International Development/Kenya
C/O American Embassy
United Nations Avenue, Gigiri
P.O. Box 629, Village Market 00621
Nairobi, Kenya

Prepared by
Pathfinder International-Kenya
Lavington, James Gichuru Road, Hse # 158
P. O. Box 1996 – 00502 Karen
NAIROBI, KENYA
Office : +254-20-3883142/3/4
Mobile : +254-733-618359/+254-722-516275
Fax : [+254 20] 2214890
www.pathfinder.org

ACRONYMS AND ABBREVIATIONS

ADR	Adverse Drug Reactions
AIDS	Acquired Immune Deficiency Syndrome
AMSTL	Active Management of Third Stage Labor
ANC	Antenatal Care
APH	Antepartum Hemorrhage
APHIA	AIDS, Population and Health Integrated Assistance
APHIA*plus*	AIDS, Population and Health Integrated Assistance-People-centered, local universal access and sustainability
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASRH	Adolescent Sexual Reproductive Health
AYLHIV	Adolescents and Youth Living with HIV
AYSRH	Adolescent and Youth Sexual Reproductive Health
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric and Newborn Care
BFCI	Baby Friendly Community Initiative
BMI	Body Mass Index
BTL	Bi-Tubal Ligation
CASCO	County AIDS and STI Control Officer
CBD	Community Based Distributor
CBP	Community Based Promoter
CBROP	County Budget Review and Outlook Paper
CCC	Comprehensive Care Center
CD4	Cluster of Differentiation 4
CDC	Center for Disease Control and Prevention
CDCS	Country Development Cooperation Strategy
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHS	Community Health Strategy
CHV	Community Health Volunteer
CLTC	County Leprosy and Tuberculosis Coordinator
CLTS	Community Led Total Sanitation
CME	Continuing Medical Education
CNC	County Nutrition Coordinator
COP	Chief of Party
COR	Contracting Officer Representative
CPGH	Coast Provincial General Hospital
CSB	Corn Soy Blend
CQI	Continuous Quality Improvement
CU	Community Unit

CWC	Child Welfare Clinic
CYP	Couple Years Protection
DBS	Dry Blood Samples
DCOP	Deputy Chief of Party
DDIU	Data Demand and Information Use
DISC	Drop in Support Centre
DOT	Directly Observed Therapy
DQA	Data Quality Assessment
DWH	Data Warehouse
EBI	Evidence Based Interventions
EID	Early infant diagnosis
EMTCT	Elimination of Mother to Child Transmission
EmONC	Emergency Obstetric and Newborn Care
EMR	Electronic Medical Records
FANC	Focused Antenatal Care
FBO	Faith Based Organization
FBP	Food By Prescription
FCDRR	Facility Consumption Data Report and Request Form
FMAPS	Facility Monthly ARV Patient Summary
F&Q	Forecasting and Qualification
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender-Based Violence
GOK	Government of Kenya
HAART	Highly Active Antiretroviral Therapy
HC	Health Center
HCSM	Health Commodities and Services Management
HCW	Health Care Worker
HEI	HIV Exposed Infant
HFMC	Health Facility Management Committee
HINI	High Impact Nutrition Interventions
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Health Management Team
HPT	Health Products and Technology
HRIO	Health Records Information Officer
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
HVF	High Volume Facility
IFAS	Iron and Folic Acid Supplementation
IMAM	Integrated Management of Acute Malnutrition

IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention Control
IPT	Isoniazid Preventive Therapy
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
KAIS	Kenya AIDS Indicator Survey
KeHMIS	Kenya Health Management Information System Project
KEMSA	Kenya Medical Supplies Agency
KEPI	Kenya Extended Programme on Immunization
KHSSSP	Kenya Health Sector Strategic and Investment Plan
KHQIF	Kenya HIV Quality Improvement Framework
KP	Key Populations
KQMH	Kenya Quality Model for Health
LTFU	Lost to Follow Up
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
M&E	Monitoring & Evaluation
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Review
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
M2M	Mother 2 Mother
NACS	Nutritional Assessment Counselling and Support
NASCOP	National AIDS and STI Control Program
NCD	Non-Communicable Disease
NDMA	National Drought Management Authority
NGO	Non-Governmental Organization
OI	Opportunistic Infection
ODF	Open Defecation Free
OJT	On Job Training
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OTP	Outpatient Therapeutic Therapy
OVC	Orphans and Vulnerable Children
PAC	Post-Abortion Care
PBB	Program Based Budgeting
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHASE	Personal Hygiene and Sanitation Education
PHPD	Positive Health Dignity and Prevention

PHO	Public Health Officer
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PNC	Post-Natal Care
PNS	Partner Notification Services
POC	Point of Care
PPH	Post-Partum Hemorrhage
PRC	Post-Rape Care
PrEP	Pre-exposure Prophylaxis
PSS	Psychosocial Support Service
PT	Proficiency Testing
QA	Quality Assurance
QI	Quality Improvement
RED	Reach Every District
RH	Reproductive Health
RTK	Rapid Test Kits
RUTS	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SCASCO	Sub County AIDS Control Officer
SCHMT	Sub County Health Management Team
SCLTC	Sub County Leprosy and Tuberculosis Coordinator
SCHRIO	Sub County Health Records Information Officer
SDGs	Sustainable Development Goals
SI	Strategic Information
SIMS	Site Improvement Monitoring System
SLTS	School Led Toy
SMS	Short Message Service
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SW	Sex Workers
SWG	Sector Working Group
STI	Sexually-transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TOT	Trainer of Trainers
TWG	Technical Working Group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government

VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medical Male Circumcision
VL	Viral Load
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WIT	Work Improvement Team
WRA	Women of Reproductive Age
YFS	Youth Friendly Services
YLHIV	Youth Living with HIV
YPLA	Young Person with Living with AIDS
3Ps	Pathfinder International, Plan International and Palladium Group

Qualitative Impact

At the end of the last quarter of the financial year, *Afya Pwani* remained on course towards achieving most of its APR targets. The project tested 138% (455,481 out of 330,959) of its testing targets and reached 97 % (9,134 out of 9,391) of its HIV positive identification targets with Mombasa and Kilifi Counties exceeding their targets at 154% (3,383 out of 2,196) and 117 % (2,746 out of 2,356) respectively.

In addition, out of the target of 8,971 for the newly on ART, *Afya Pwani* achieved 7,871, an 88% performance while those currently on ART was at 89% (48,074 out of 54,074). The project also improved in VL uptake from 85% in FY 17 to 99.6% in FY 18, with suppression rates also improving from 81% to 85% in the same period. Among the main key strategies that contributed to the above results include: optimization of targeted testing strategies like a PNS and risk assessment for HTS clients, male involvement through male champions, capacity building of health care providers on ART services, case management through mentor mothers and peer educators, strengthening adherence counselling, deployment of facility based staff in facilities with critical staffing gaps in HIV service areas and strengthening support systems for PLHIV through support groups and care givers for children and adolescents, having functional multi-disciplinary teams and viremia clinics as well as implementing differentiated care service delivery. *Afya Pwani* also scaled up Non-MER interventions achieving most of the FY 18 targets e.g. PNS (60 out of 74 facilities), DSD (51/74 facilities), Viremic clinics and case management (70/50 facilities), adolescent friendly clinics/OTZ (36/30 facilities) and male friendly clinics 14/31 facilities).

In PMTCT, the project achieved 98.1% of its COP PMTCT STAT target (102,007 of 103,951 pregnant women knowing their HIV status during their 1st ANC visit). This was a good milestone considering that the go-slow by various cadres of HCWs not to offer HTS services within the PMTCT SDPs. A total of 3,274 pregnant women were identified HIV positive with 3,196 getting initiated on HAART during their first ANC visit (97.6% uptake). A total of 3,212 initial polymerase chain reaction tests were processed representing 98% of an estimated 3,274 HIV-exposed infants (HIV-positive pregnant mothers used as crude proxy) in the year. This, however, was a 70% achievement of the COP target of 4,594. Overall, HEI positivity in *Afya Pwani*'s supported sites stood at 3.1% with 102 infants having acquired HIV vertically during the reporting period.

In RMNCH/FP services implemented in Kilifi County, *Afya Pwani* recorded significant improvement across all key indicators. The project reached 46,562 new ANC clients in year 2 compared to 29,221 in the previous year. Fourth ANC clients almost doubled to 71% (22,006 out of 30,785) compared to 37% (13480 out of 30,785) in the previous year with skilled birth attendance increasing to 97% (32,331 out of 33,351) in year 2 from 64% (19,819 out of 30785) in Year 1. On the other hand, FIC improved to 91% (36,829 out of 40,628) in the financial year 2018, up from 60%(22,771 out of 37,760). Uptake of FP tremendously increased from CYP of 64,280 in year 1 to 114,394 in year 2. These successes were realized because of the implementation of robust community awareness, advocacy and demand creation activities that included: maternity open days, mama groups, community dialogues, edutainment, engagement of opinion leaders/male champions/TBAs/CHVs as agents of change, introduction of Community Based Distribution and enhanced male involvement. *Afya Pwani* also sought to improve quality of services provided through

regular support supervision, supported MPDSR sessions, central trainings on different areas of MNCHFP, CMEs, mentorships and OJT based on identified skills gaps.

Investments by *Afya Pwani* through WASH services, contributed to improvement in increasing access and adoption of good water, sanitation and hygiene practices that are continuously contributing to the prevention and control of diarrheal diseases to children under five years of age and other community in priority Sub Counties. In the reporting period, a total 0f 7,510 beneficiaries (M-3679, F-3831) gained access to safe water with the project cumulatively reaching 23,817 (M-11,888, F-11,929) during year two of the implementation period. In addition, a total of 1,932 people gained access to improved sanitation facilities (latrines) at household level following construction of 322 new latrines in the various CLTS triggered villages. During the reporting quarter, a total of 24 different villages are at different stages of CLTS verification stages after self-claim. To enhance the community actions on hygiene and sanitation behavior change, the project conducted various trainings for HCWs, CHVs, school board of members' committee representatives as well as artisans as detained in the report herein. All these incorporated regular dialogues to reinforce the desirable hygiene practices at household and schools level. To ensure nutrition services were scaled up, the project supported 29 out of a target of 67 (43%) facilities to attain BFCI guidelines compliance by the end of the September 2018 up from 22 (33%) in February 2018. This achievement is attributed to targeted trainings and sensitization sessions for HCWs, CHVs, joint support supervision, community sensitization sessions at both health facilities and at community level for nutrition services.

Constraints and Opportunities

During the reporting period, several challenges were encountered in engaging with the CHMTS and facilities for improved access and provision of quality service delivery of HIV and MNCH/RH/FP/WASH and Nutrition. A detailed description of these challenges, opportunities and mitigation measures covering the period between July to September 2018 are described at the end of the respective outputs sections.

Quantitative Impact

Table 1 below is the detailed quantitative program performance for quarter 4.

Table 1 *Afya Pwani* Performance Summary Table July- September 2018

Indicator	Technical Area	Cascade Age bands	Q1	Q2	Q3	Q4	Total achiev' FY18	% Achiev	FY 18 Targets
Number of individuals who received HIV Testing Services (HTS) and received their test results.	HTS_TST	<15 (Coarse)	7,967	7,194	8,908	9,923	33992	106%	31,949
		>=15 (Coarse)	100,537	107,026	105,361	108,565	421489	141%	299,010
		Total	108,504	114,220	114,269	118,488	455481	138%	330,959
Number of individuals who received HIV Testing Services (HTS) and received their test results (Positive).	HTS_TST_Pos	<15 (Coarse)	127	160	124	141	552	70%	786
		>=15 (Coarse)	1,988	2,165	2,235	2,191	8579	100%	8,605
		Total	2,115	2,325	2,359	2,332	9131	97%	9,391
	Computed Indic 1	Positivity <15	2%	2%	1%	1%	2%		2%
		Positivity >=15	2%	2%	2%	2%	2%		3%
		Positivity Total	2%	2%	2%	2%	2%		3%
Number of adults and children newly enrolled on antiretroviral therapy (ART)	TX_NEW	<15 (Coarse)	108	158	133	144	543	62%	874
		>=15 (Coarse)	1,610	1,854	1,954	1,910	7328	91%	8,097
		Total	1,718	2,012	2,087	2,054	7871	88%	8,971
	Computed Indic 2	Linkage <15	85%	99%	107%	102%	98%		111%
		Linkage >=15	81%	86%	87%	87%	85%		94%
		Linkage Total	81%	87%	88%	88%	86%		96%
Number of adults and children with HIV infection receiving antiretroviral therapy (ART).	TX_CURR	<15 (Coarse)	3205	3429	3468	3557	3557	82%	4,360
		>=15 (Coarse)	42,610	43,711	43,759	44,517	44,517	90%	49,714
		Total	45,815	47,140	47,227	48,074	48,074	89%	54,074
Numerator: Number of pregnant women with known HIV status at first antenatal care visit (ANC1) (includes those who already knew their HIV status prior to ANC1). **Denom: Number of new ANC clients in reporting period**	PMTCT_STAT	Denominator	24,754	29,447	24,830	24,795	103,826	95%	109,486
		Numerator	24,732	29,338	24,745	24,666	103,481	95%	109,486
		Known Positives	485	585	475	483	2,028	77%	2,628
		Newly Tested Positive	284	386	315	264	1,249	60%	2,085
		Total Positive	769	971	790	748	3,278	70%	4,713

Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy.	PMTCT_ART	New on ART	274	368	302	251	1,195	47%	2,562
		Already on ART	486	580	474	485	2,025	100%	2,032
		Total on ART	760	948	776	736	3,220	70%	4,594
	Computed Indic 3	PMTCT Positivity	3%	3%	3%	3%	3%		4%
		ART Uptake - New Pos	96%	95%	96%	95%	96%		123%
		ART Uptake - All Pos	99%	98%	98%	98%	98%		97%
Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	PMTCT_EID	0<=2 Months	466	484	482	538	1970		
		2<12 Months	234	248	239	312	1033		
		Total Tested	700	732	721	850	3003	65%	4,594
Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age. Excludes confirmatory testing	PMTCT_HEI_POS	0<=2 Months	7	13	3	10	33		
		2<12 Months	12	23	22	24	81		
		Total Positive	19	36	25	34	114	36%	318
ART initiation and age at virologic sample collection.	PMTCT_HEI_POS_Initiated_ART	0<=2 Months	5	13	3	10	31		
		2<12 Months	12	22	21	22	77		
		Total Initiated ART	17	35	24	32	108	42%	255
	Computed indic 4	HEI Positivity	3%	5%	3%	4%	4%		7%
		HEI ART Uptake	89%	97%	96%	94%	95%		80%
Numerator: Number of adult and pediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and /or supporting laboratory results within the past 12 months. **Denominator:** Number of adult and pediatric ART patients with a viral load result documented in the patient medical record and /or laboratory records in the past 12 months.	TX_PVLS: Suppressed	**<15 (Coarse)**				2,407	2,407		
		>=15 (Coarse)				35,739	35,739		
		Total				38,146	38,146		
	TX_PVLS: Denominator	**<15 (Coarse)**				3,472	3,472	80%	4,360
		>=15 (Coarse)				41,230	41,230	83%	49,714
		Total				44,702	44,702	83%	54,074
	Computed indic 5	**Suppression <15**				69%	69%		
		Suppression >=15				87%	87%		
		Suppression Total				85%	85%		
4th ANC			2,263	5,487	7,487	7,471	22,708	74%	30785
Skilled Birth Attendance			5,003	8,238	10,025	9,542	32,808	98%	33351
Fully Immunized Children(FIC) under 1 year			9,532	11,081	9,332	9,131	39,076	96%	40628
PNC Infants receiving Postpartum care within 2-3 days			6,107	9,135	11,639	9,858	36,739	95%	38482
Total Underweight			3,890	6,676	9,140	9,700	29,406	171%	17153

II. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

SUB-PURPOSE 1: INCREASED ACCESS AND UTILIZATION OF QUALITY HIV SERVICES

Output 1.1: Elimination of Mother to Child Transmission (eMTCT):

During the reporting period July – September 2018, *Afya Pwani* supported provision of comprehensive eMTCT package focused on improving early antenatal care (ANC) coverage, strengthening ART integration into maternal child health (MCH) clinics, early identification of HIV and Syphilis-infected pregnant and lactating women, prompt provision of highly active antiretroviral therapy (HAART) for HIV infected mother baby pairs and infant prophylaxis, improving early infant diagnosis services, and strengthening retention among maternal and HIV-exposed infant cohorts. During the period, the project supported eMTCT services in 240 PMTCT (69 in Kwale, 25 in Mombasa, 55 in Taita Taveta, 64 in Kilifi and 27 in Lamu) Counties.

a) Early Identification of HIV-positive pregnant women and increase for demand services

i) Demand creation for testing

Health talks and Education:

To optimize HIV testing among pregnant and lactating women, health care workers in the MCH department conducted health education sessions in all the *Afya Pwani* supported sites. These health talks were conducted at the health facility waiting bays and MCH targeted pregnant and breastfeeding women aimed at improving awareness on HTS (at ANC, labor and delivery, PNC, and CWC) and early ANC visits before 20 weeks of gestation, literacy and psycho-social empowerment, male involvement, HIV status disclosure, nutrition, eMTCT, HIV prevention, birth preparation, patient rights and gender rights among other interventions.

In Kilifi County, 4,217 pregnant women and mothers of children under 5 years from various facilities were reached with PMTCT messages during the health talks, personal hygiene, exclusive breast feeding (EBF), HIV testing, individual birth plans, early initial ANC visit. During the health talks importance of honoring clinic appointments was emphasized. 20 CHVs conducting door-to-door household visits were done to provide health talks (one-on-one) ensures message reaches the right target and direct referrals to facility, including escorting where necessary. Similarly, sensitizations forums were conducted to emphasize the need for registration into the National Health Insurance Fund's (NHIF) "Linda Mama" programme and the importance of male partners in ANC including accompanying women to ANC clinic. A total of 15 health talk sessions were conducted at Lamu County Hospital, Mpeketoni Sub County Hospital, Witu Health Centre and Hindi dispensary reaching 211 clients (M-18, F-193). The key messages passed during the health talks included: starting ANC early in the first trimester, adherence to all medications, importance of testing for HIV together with partner at the 1st ANC, repeat test in 3 trimesters, during labor and delivery, facility delivery, and post-natal testing for mothers as well as infants especially at post-natal clinic.

The health talks sessions are conducted daily at the facility waiting bays in all the supported facilities where a total number of 4,856 (M-1,698; F-3,158) were reached with the messages. In Taita Taveta County, beneficiaries from various facilities were also reached with PMTCT messages during the health talks. The health talks were also extended in the labor and delivery departments especially on breastfeeding and male involvement. To this end, a total number of 43 men were reached with the information and tested; with two of them turning positive, an improvement compared to the previous reporting period. In Mombasa County, 12 health education sessions were supported by *Afya Pwani* during the reporting period focusing mainly on ANC profiling, planned parenthood, HIV/Syphilis prevention, care and treatment, nutrition and HAART monitoring during the reporting period. The sessions also emphasized the need for registration into the

National Health Insurance Fund's (NHIF) "Linda Mama" programme and the importance of male partners involvement in ANC including accompanying women to.ANC clinics

TBAs as birth companions:
During the period under review, TBAs in eMTCT within *Afya Pwani*'s implementation catchment (especially in Kwale and Kilifi Counties) were sensitized on PMTCT and enrolled as birth companions for early ANC referrals hence early HIV testing. As such a total of 120 TBAs from Msambweni, Samburu, Gombato, and Kinondo Health facilities in Kwale County were trained. Going forward they will be able to mobilize and escort the pregnant women to the facilities with transport refund as a token for every referral.

In the same period, 50 CHVS (M-18, F-32) were sensitized for two days on the importance of early identification, referrals/ escorting pregnant women for early ANC and HIV testing. The CHVs were from; Ng'ombeni, Vyongwani, Matuga, Magodzoni, Mwaluphamba and Shimba hills. In Taita Taveta County, two TBAs were engaged in Njukini to escort mothers for early ANC services uptake from the community; going forward more TBAs will be engaged to create demand for the eMTCT services.

Community dialogues and sensitizations:
Low ANC coverage in Taita Taveta County has necessitated mobilization of early ANC visits and HTS in the community. Strategies implemented to improve coverage include; community sensitization meetings, use of male champions and mentor mothers. Facilities involved were Moi CRH, Mwatate SCH, Taveta SCH, Ndovu HC and catchment areas from the grantees. A total of 158 clients were referred for early ANC visits and HTS, two of whom turned positive and linked for PMTCT services.


Dialogue with young mothers Bodoi, Kilifi County

Dialogue sessions on the importance of early ANC attendance to reduce missed opportunity for early initiation of e-MTCT services were organized and held. As a result of this, 158 different referrals were made to improve access to early ANC services and consequently testing. Between July and Sept 2018, the project supported a total of 256 pregnant women attending 17 community dialogues in Kilifi County targeting pregnant women, adolescents and youths reaching community members with information on early ANC, skilled delivery, male involvement and importance of knowledge of HIV status. During the reporting period, *Afya Pwani* also supported a community open day at Gede during which 11 pregnant women were referred for 1st ANC services and tested for HIV. 12 community sensitization meetings and mobilization exercises for pregnant women were also done in Bodoi, Bomani, Nguruweni. These were done in partnership with grantees and CHVs.

Facility in-charges meetings:
Facility-in-charges' meetings have proved to be a key strategy in inculcating buy-in and ownership on services at facility level. Further, these meetings have helped to re-energize and refocus teams following the conclusion of the protracted nurses' industrial action which adversely impacted on the uptake and access to ANC and PMTCT services for five months. To strengthen efforts and cases made for PMTCT and ensure none of the push is lost, *Afya Pwani* supported a meeting with the County and Sub County Reproductive health coordinators to deliberate on eMTCT performance in Kwale County. The poor performing indicators were discussed, and a way forward was agreed on to organize a training on PMTCT guidelines, integration of family

planning in PMTCT and the pregnancy intention, screening and contraceptive tool. In addition, plans were also made to have the team benchmark on open maternity days in Kilifi County and implement the same in Kwale. In Kilifi and Mombasa Counties, the CHMT was supported to hold facility-in-charges' meetings in Kilifi South and Malindi Sub Counties where discussions on strategies for increasing pregnant women's uptake for ANC services and HIV testing, provision of quality care and treatment services during ANC and PNC visits were put across.

Male involvement in PMTCT:

According to a baseline study conducted at the inception of *Afya Pwani*, male involvement was identified as one of the main hindrances to access and utilization of ANC services in the project supported Counties. To mitigate against this, *Afya Pwani* supported targeted interventions to promote achievement of universal access to ANC and PMTCT services.

In Mombasa County, the project deliberately, targeted male partners of PMTCT clients in a bid to improve their involvement in elimination of vertical HIV transmissions. Pregnant women enrolled in the PMTCT programme were encouraged to come with their male partners during subsequent clinic visits for dialogue sessions and general response to concerns on PMTCT. Supportive disclosure and HTS were also addressed. A total of 66 male partners attended these dialogue days. Tudor Sub County hospital had the highest turnout where 22 men attended the PMTCT sessions with their partners. Other facilities that implemented this strategy during the reporting quarter include; Jomvu and Kisauni with 12 and 8t men attending respectively. These sessions are a promising practice that will not only have the men meaningfully involved in the elimination of vertical HIV transmissions but also a forum for disclosure and an opportunity to be engaged as male champions for PMTCT. Some PMTCT clients shared their experiences on how they find it difficult to disclose their HIV status to their partners, but with such forums, they are assisted to disclose.

Additionally, the program through the support of HIV Free Generation (HFG) identified and trained 20 male champions in Mombasa County, who were deployed in Likoni Sub County to promote male involvement in PMTCT. Going forward, the project hopes to scale up and have more male partner involvement in all 24 sites offering PMTCT services in Mombasa County. The 20 male champions identified were trained to mobilize community members to access services and encourage male partner involvement. To this end, three mothers reported that their partners offered to accompany them to attend ANC and also had a couple HIV testing as a result of the initiative.

In Kilifi County, pregnant women were encouraged to come with their male partners during subsequent clinic visits for health education and those on PMTCT had their concerns on PMTCT addressed.

Additionally, 22 male champions were identified, trained and deployed to promote male involvement in eMTCT. Male champions are persons who are community champions in various health related issues such as HIV and were deployed in the following facilities; Lungalunga, Kikoneni, Vitsangalaweni, Msambweni, Diani, Kinondo, Gombato, Kwale, Tiwi, Mkongani, Kinango, Samburu, Mazeras, Shimba hills, Mwaluphamba, Msulwa, Matuga, Ng'ombeni, Vyongwani, Magodzoni, Waa, and Mazumalume. This resulted to 107 of the 168 partners in Lungalunga, 37 of 79 in Vitsangalaweni, two community sensitization meetings for men were conducted in Msambweni Sub County targeting men in Mwabungo and Kiuzini villages where a total number of 72 men were reached with messages on HIV status knowledge, accompanying their pregnant women for testing, family testing and importance of prevention messages such as condom use. The following facilities had a high uptake of male partners tested in ANC. In Moi Voi hospital of Taita Taveta County, following enhanced activities by male champions during the month of September,31 men were tested in the maternity out of which 1 of them was identified HIV positive in comparison with the month of August where only 6 men were tested in the maternity.

ii) ANC testing and retesting in 3rd trimester, labor & delivery and postnatally

According to the national guidelines on use of antiretroviral drugs for treating and prevention HIV in Kenya of 2018, all pregnant women (unless know HIV positive) should be offered a HIV test during their 1st ANC visit and if negative the test should be repeated in 3rd trimester, at labor and delivery, six weeks postnatally and six monthly there after until complete session of breast feeding. To this end *Afya Pwani* continued to support the deployment of HTS counselors to offer HIV testing and counselling services within the MNCH settings as per the national PMTCT guidance

In Mombasa County, *Afya Pwani* continued to support CPGH, Tudor, Likoni and Port Reitz facilities with HTS counselors (one counselor each at MCH) with the objective of improving early identification of HIV positive pregnant and breastfeeding mothers and HEIs. These counselors compliment efforts by CHVs and mentor mothers who play a vital role in creating demand at the waiting bays on the importance of HTS among pregnant women and their families. In Kilifi, the project supported Sabaki, Adu and Ngomeni, Kilifi County Hospital, Mtwapa, Malindi SCH, Mariakani SCH, Baolala, Rabai and Ganze Health centers with temporary HTS providers at various times during the reporting period to cope with high 1st ANC clients following advocacy meetings with pregnant women during maternity open days. They also provided HTS services within the MCH to reduce missed opportunities for testing in the CWC and the maternity centers and with the objective of improving early identification of HIV positive pregnant and breastfeeding mothers and HIV exposed Infants. In Taita Taveta, *Afya Pwani* supported a HTS counselor in Moi Voi, Mwatate and Maungu health center. In Mombasa County, the project supported deployment of temporary HTS providers to Mrima and Likoni Catholic at varying times of the reporting period based on need.

During the reporting period, a total of 24,920 pregnant women sought 1st ANC services in all *Afya Pwani* supported facilities out of whom 24,374 got to know their HIV status in all PMTCT settings **(see table below).** This performance (24,374) represents 22% of the *Afya Pwani*'s annual PMTCT STAT target of 109,486. 264) women were newly identified as HIV positive against an annual target of 2,085 woman representing a 12% achievement. A total of 24,374 out of 24,920 first ANC clients (98%) tested HIV negative during their first ANC while 480 were already known positives.

Table 2 PMTCT summary achievements for July to Sept 2018 versus COP 17 annual targets

Indicator	COP 17 Target	July 17-Sept 18	% Achieved
Number of sites	240	240	100%
Number of pregnant women with known status	109,486	24374	22%
Number of HIV positive pregnant women identified	4,713	744	16%
Number of pregnant women known to be HIV positive (known positives)	2,628	480	18%
Number of newly identified HIV positive pregnant women (new positives)	2,085	264	13%
Number of HIV infected pregnant women on HAART	4,594	715	16%

Across the five *Afya Pwani* supported Coastal Counties, performance and achievement against the annual PMTCT STAT target during the reporting period shows varying trends with Mombasa at 99% (6595 /6599),

Kilifi at 99% (9436/9533), Kwale at 94% (5236/5597), Lamu at 99% (979 /985) and Taita Taveta at 96% (2128 /2206).

Table 3 PMTCT STAT summary achievements for July to Sept 2018 by County

SNU	COP PMTCT STAT Target	Achievement	% Achievement
Kilifi	40,721	9436	23%
Mombasa	32,590	6595	20%
Kwale	23,243	5236	23%
Taita Taveta	9,912	2128	21%
Lamu	3,020	979	32%
Afya Pwani	**109,486**	**24374**	**22%**

The project takes note that it is becoming increasingly difficult to identify new HIV positive pregnant women with most having known their HIV status as shown by the increasing number of KPs seen. Of the 744 positives enrolled in the PMTCT program, 65% of the clients were known positives (480). *Afya Pwani* also supported the various CHMTs to distribute job aids and the HEI/EID testing algorithm in MNCH settings. Reporting tools such as the national MOH 731 reporting tools were also distributed.

b) Improving HAART uptake for pregnant and breastfeeding mothers

In 2016, the MOH transitioned from Option B^+ to 'Anza Sasa' Strategy which is aimed at initiating all HIV positive pregnant and lactating women on HAART immediately upon confirmation of their HIV status and which seeks to eliminate vertical transmissions of HIV by 2021.

In line with the MOH's "Anza Sasa" Strategy and to optimize HAART uptake among all HIV positive pregnant and lactating women, *Afya Pwani* continued to strengthen the capacity of facilities to provide HAART at 1st ANC in all its supported sites. All project supported Counties reported good uptake of maternal HAART among pregnant women who were identified to be HIV positive as shown in the figure below. For example, in Taita Taveta and Mombasa Counties, as soon as a client is identified HIV positive or is a pregnant known positive, they are immediately linked to a mentor mother for further peer counselling, support and continuous follow up, this has helped the Counties sustain 100% uptake. Kilifi County recorded the lowest maternal HAART uptake rate of 93% with 18 HIV positive pregnant women missing out on HAART initiation during their first ANC. Eight missed opportunities for ART uptake, in Matsangoni (2), Malindi (3), Baolala (1), Watamu Dispensary (1), Ganda dispensary (1), due to some clients declining and others opting for referrals to other facilities outside the County. The clients who have declined are on follow up with the mentor mothers actively making sure they are enrolled to care and treatment.

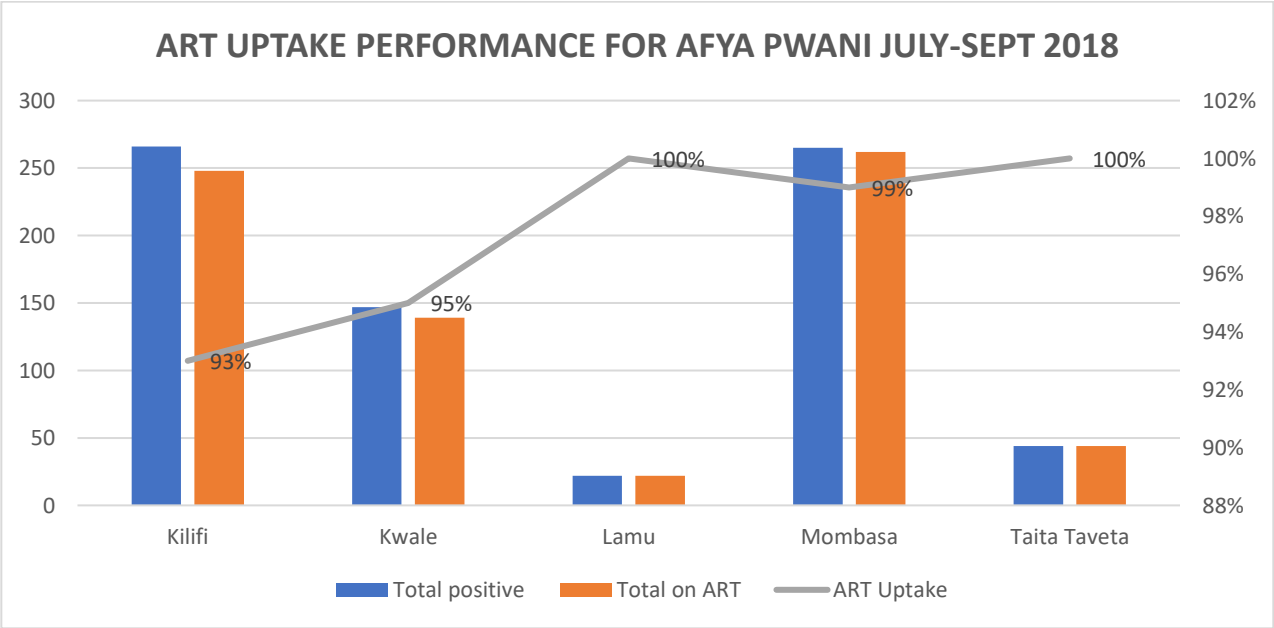


Figure 1 Maternal and Infant Prophylaxis uptake by county, Oct 17 to Sept 2018

During the reporting period, all *Afya Pwani* PMTCT facilities were supported to continuously account for missed opportunities with mentor mothers and CHVs facilitated to conduct home visits to trace and bring back mothers and their infants. The project supported County Health Management Teams (CHMTs) to facilitate correction of data on successfully traced clients on HAART on DHIS2 and account for all missed opportunities. Continuous mentorship, age specific PMTCT support groups, provision of ARV commodities in integrated MCH settings as well as support for commodity consumption, forecasting and reporting were supported in Counties during the reporting period.

To optimize ART initiation among pregnant and breastfeeding women, *Afya Pwani* supported CHMTS and health facilities through the following interventions:

i) Human Resources for Health (HRH)

Afya Pwani continued to strengthen the health systems of various supported Counties through human resources for health (HRH) in high-volume public, private and FBO sites through placement of nurses, clinical officers (RCOs), laboratory and pharmaceutical technologists to enable mitigate the challenge of staff shortages. This especially benefited four Counties (except for Lamu County which is centrally supported) to cope with the increased client need after the prolonged nurses' industrial action that affected ANC/PMTCT/child welfare clinic (CWC) services for five-months in the beginning of the reporting period. To this end, the project supported Mombasa, Kwale, Taita Taveta and Kilifi Counties with 284 staffs of various cadres. *(See Annex VI: Afya Pwani HRH Status Support)*

ii) Integration of ART into MCH

To further strengthen ART uptake and adherence to treatment among HIV positive pregnant and breastfeeding mothers, *Afya Pwani* supported integration of ART into the MCH department in 20 ART sites out of the targeted 24 sites in Mombasa County. The project also continued to build the capacity of HCWs to provide quality, integrated and updated PMTCT care as per the revised 2016 ART and PMTCT guidelines. In addition, *the* project also supported 35 service providers to ensure provision of quality ART services to HIV infected children. Scale up of PMTCT integration into MCH in the same facilities was emphasized. HCWs were also mentored on the algorithm for VL monitoring among the pregnant mothers and HEI follow ups. In the reporting period, Kilifi County reported a total of 11 facilities with full integration out of the 93 supported

facilities i.e. KCH, Malindi, Matsangoni, Mtwapa, Muyeye, Mariakani, Gongoni, Gede, Rabai, Sabaki and Oasis health centers.

In Kwale County, 12 high volume facilities also integrated ART in to MCH to offer one-shop HIV services for both breastfeeding and pregnant mothers. These are Msambweni, Kwale, Kinango and Lungalunga hospitals, Samburu, Tiwi, Kikoneni, Diani, Mazeras, MacKinnon, Ndavaya and Kinondo health centers. Technical support was offered to the nurses on ART initiation and monitoring via viral load testing through mentorship and OJTs. Plans are in place to continue supporting facilities with challenges be able to integrate ART into MCH. To further strengthen integration mentorship was done to integrate FP services in PMTCT and CCC service delivery points (SDPs) and introduced the pregnancy intention, screening and contraceptive use tool in six facilities; Msambweni, Kwale, Kinango, Lungalunga, Kinondo and Diani, it's advisable to have the tool incorporated in the IQ care.

In Taita Taveta County, five high volume facilities (Moi Voi, Mwatate, Wesu, Taveta and Ndovu) have fully integrated ART in MCH. Joint discussions with the CHMT and SCHMTs have been conducted to ensure all health centers providing PMTCT are fully integrated by the end of the first quarter of FY19. Lamu County Hospital, Mkunumbi dispensary, Mpeketoni Sub County Hospital, Muhamarani Dispensary, Mapenya Dispensary, Shella dispensary and Hindi dispensary have fully integrated ART into MNCH out of the 15 supported ART sites. The integration of ART into MNCH in other facilities including Witu Health Centre which is one of the high-volume facilities was affected mainly by the frequent changeover of staff within departments and transfers to other facilities. The newly posted staff in MNCH department have limited knowledge on PMTCT as such on job training is ongoing to capacity-build the providers and ensure ART is fully integrated into MCH.

iii) Capacity building (trainings, CMEs, mentorships and OJTs)

Following a joint supportive supervision and a comprehensive PMTCT needs assessment conducted by CHMTs through the support of *Afya Pwani*, it was evident that glaring gaps existed among HCWs' knowledge of the 2016/18 national ART guidelines. Most (54%) of the HCWs stationed in PMTCT service delivery points (ANC, L&D, Maternity, CWC and PNC) had not been trained in PMTCT in the last six years.

In response this, the project supported five CMEs on eMTCT guidelines in Taita Taveta County specifically in Moi CRH, Taveta SCH, Mwatate SCH, Mgange Nyika, Wesu SCH and Ndovu HC where the health care workers trained included medical interns in Moi Voi County hospital. Other cadres of HCWs trained included clinicians, nurses, nutritionists, lab technicians, pharmacy technicians and counselors. During the CME, the health workers were taken through importance of dual HIV and syphilis testing, HIV testing algorithm, provision of maternal ART, maternal viral load monitoring and testing, prophylaxis for HEI, infant HIV testing as well as infant nutrition, EID and infant prophylaxis for exposed infants. The expected outcome from the CMEs will be improved quality eMTCT services provision to the ANC mothers thus creating demand for the others to come for the services. *Afya Pwani* PMTCT focal person also continued to support facility based HCWs in the MCH, CWC, labor and delivery departments through OJTs and mentorships especially in all high-volume facilities during the quarter on adult and pediatric ART. Project staff supported and facilitated on- job training (OJT) and mentorship of health service providers on the provision of the standard package of care to PMTCT clients. These sessions were utilized to empower the staff on the different aspects of PMTCT such as nutrition, immunization, skilled birth attendance and male involvement other than the normal HIV related issues. Information, education and communication materials were printed and issued to the facilities to enhance quality care.

The *Afya Pwani* PMTCT technical team continued to support facility-based HCWs in the MCH, CWC, labor and delivery departments through CMEs, OJTs and mentorships especially in all high-volume facilities during the Quarter on adult and pediatric ART. In Mombasa County, the project mentored health workers in the 15 facilities on the need to monitor facility PMTCT cascades. Facilities were mentored on how to check facility

PMTCT dashboards for validity, accuracy and completeness to enable facilities correctly track PMTCT indicators. In addition, the project technical team continued to support facility-based PMTCT review meetings which continue to play a vital role in helping facility staff to track and monitor progress for each indicator as well as highlighting key areas for improvement. The facility-based eMTCT review meetings were held at Mikindani, Likoni, Port Reitz, Ganjoni and Tudor SCH. The project also provided mentorship to 17 health care workers from eight supported sites to improve HIV testing uptake and eMTCT outcomes in Mombasa County. HCWs were mentored on the current PMTCT guidelines and provided with assorted job aids on PMTCT. Kilifi County supported sensitization on eMTCT guidelines in Magarini Sub County where 35 healthcare workers were taken through importance of dual HIV and syphilis testing, HIV testing algorithm, provision of maternal ART, maternal viral load monitoring and testing, prophylaxis for HEI, infant HIV testing as well as infant nutrition, EID and infant prophylaxis for exposed infants. The expected outcome from the CMEs will be improved quality eMTCT services.

In partnership with the CHMT, *Afya Pwani* supported Kilifi eMTCT technical team to have a quarterly eMTCT taskforce meeting where progress and achievements of PMTCT of the County were shared and action plans drawn to improve overall quality of PMTCT in the health facilities.

Further, the project supported facility-based monthly PMTCT cascade review meetings in the 20 facilities; Mariakani, Ganze, Gotani, Malindi, KCH, Gede, Gongoni, Mtasangoni, Mtwapa, Muyeye, Gongoni, Rabai, Bamba, Marereni, Marafa, Chasimba, Vipingo, Oasis Medical, Gede, where facility staff were able to track and monitor progress for each indicator as well as highlight key areas for improvement. In Kwale County,the project supported four CMEs on PMTCT guidelines in Mazeras, Lungalunga, Vanga and Kikoneni reaching 90 (M-49, F-51) healthcare workers. This is expected to ensure complete implementation of the PMTCT guidelines especially recommendations for testing and retesting in ANC, L&D and PNC, treatment monitoring using viral load, improve EID testing within two months and early infant feeding. Mentorship, CMEs and OJT at the facility level was done in the supported facilities on HTS in PMTCT, use of ART in PMTCT and infant prophylaxis, viral load monitoring, management of clients with high viral load, Adherence counselling, disclosure processes, early infant diagnosis, Management of positive HEI including baseline viral load sample collection

iv) Case management and patient escorts

To ensure all pregnant and lactating women identified to be HIV infected are immediately and effectively started on treatment and reduce the missed opportunities, the project continued to utilize facility-based HTS providers and mentor mothers as patient escorts from point of testing to MCH for HAART initiation to ensure all the identified mothers are linked to care. The project also designed, printed and distributed referral forms utilized to refer women from the testing to the enrollment point in cases of outreach services. The referrals forms are regularly analyzed to monitor the proportion of identified pregnant and lactating women initiated into HAART. Delays between referral and initiation on HAART were analyzed and clients not ready for enrolment followed up with further counselling prior to starting treatment.

To achieve near perfect linkage to HAART for HIV positive pregnant and lactating women, client escorts i.e. HTS counsellors, peer educators, mentor mothers and other service providers were engaged to physically escort clients to the ART room if it was different from the testing room. Efforts have been made in all *Afya Pwani* supported PMTCT facilities to have the same health worker offer pre-test counseling, testing, post-test counseling and HAART initiation. The Project also ensured the availability and utilization of linkage registers at all facilities and community testing points. Same day enrolment into treatment was emphasized during review meetings and facility mentorship visits. *Afya Pwani* has also strengthened pre-test counseling by doing continuous supervision and refresher trainings to HTS providers to ensure that a minimum package of messages is passed during counseling. In addition, all the newly identified HIV positives pregnant and lactating women were introduced to mentor mothers as a 'significant other' to promote linkage, retention

and adherence to treatment. In cases where clients chose to receive ART from another site, physical escort by peer educator was done if nearby and referral note, and contacts given for far away facilities.

To further strengthen case management, phone call follow-up was done to ascertain if the client reached the enrolment facility or not. Linkage rates were also discussed in facility and Sub-County review meetings and challenges addressed facilities. Phone call follow up was done to ascertain if the client reached the receiving facility or not. Linkage rates were also discussed in facility and Sub-County review meetings and challenges addressed

During the reporting period, the project also continued to support mentor mothers in the delivery of individualized PMTCT services through task shifting, defaulter tracing and case management of mother/baby dyads in 23 VHV and HVF facilities in Mombasa County, 25 in Kwale County, 12 in Kilifi County and five in Taita Taveta County.Atotal of 27 support groups for mothers supported by PIPs met monthly where a total of 72 support group sessions were conducted in Kwale, Msambweni, Diani, Mkongani, Tiwi, Lungalunga, Vitsangalaweni, Kikoneni, Kinango, Mazeras, Shimba hills, Gombato, Ng'ombeni, Taru, Kinondo and Samburu health facilities reaching 465 mothers.

c) Enrollment and retention of HIV-positive pregnant women and HIV-exposed infants

i) Case management (engagement of mentor mothers)

To increase retention of HIV positive pregnant women and HEI infants into care, *Afya Pwani* supported training of mentor mothers and MCH nurses on the importance of mother-baby pair follow up

for the first 24 months of life, initiation onto infant prophylaxis as well as the feeding options for infants. The project also conducted OJT and mentorship for health service providers on: enrollment into care and retention of all HIV positive pregnant women, strengthening defaulter tracing mechanisms as well as HEI registers and cards. By equipping health service providers with information on the above and the necessary skills sets to be able to provide these services, the project ensured that the HIV positive pregnant women were properly enrolled and retained in care and that HEI received the appropriate services as well.

In addition to supporting provision of capacity building for health service providers, *Afya Pwani* staff also worked closely with mentor mothers and HTS providers at the facility level providing them with necessary support supervision to enable them provide high quality peer support for women with infants, ensuring that mother-baby pairs are retained on care and adhere to treatment and are able to access services when needed, ensured all pregnant and breastfeeding women who turn out to be HIV reactive are linked to treatment and other support services including Positive Health and Dignity Prevention (PHDP) sessions; where monthly PMTCT support group meetings were organized and facilitated by the Project to reach these vulnerable and marginalized clients where clients received positive health messages on prevention reinfection of their spouses, the importance of proper nutrition, as well as good hygiene to help clients adhere to their treatment plans.

Cognizant of the l role that support groups play when it comes to enrollment and retention of the mother-baby pair on treatment, *Afya Pwani* also supported the establishment of eMTCT support groups have been established to provide the necessary psychosocial support services (PSS) as well as to help in the follow up of mother-baby dyads to improve enrollment and retention.

In Taita Taveta County, the project equipped health service providers and facilities with airtime and transport to conduct defaulter tracing for HIV positive mothers and children who had missed appointments in their respective CCC clinics as part of efforts to improve enrollment and retention of HIV positive pregnant women and HEI on treatment. There was a total of 23 support groups organized in the reporting quarter in Taita Taveta.

A mentor mother from Kwale hospital conducting a physical defaulter tracing

In Kilifi County, *Afya Pwani* supported 12 mentor mothers as case managers in the delivery of individualized PMTCT services through task shifting, defaulter tracing and case management of mother and baby pairs in Mariakani, Rabai, Oasis, Mtwapa, Chasimba, Ganze, Bamba, Matsangoni, Muyeye, Marafa. Mentor mothers increase community communication and mobilize clients for services and increase demand creation in PMTCT services by providing health talks. In Kwale County, the mentor mothers conducted ono-on-one counselling to the 58 newly diagnosed and 91 Known positives clients. They supported 27 psychosocial support groups reaching 465 mothers also assisted in health talks on various topics. The mentor mothers also participated in tracing 89 of the 107 defaulters via phone and physically and successfully brought them back to care.

ii) HEI graduations

Mariakani HEI graduation

To celebrate the milestones and motivate current PMTCT clients, the project supported HEI graduation ceremonies in Mwatate, Taveta and Wundanyi Hospital of Taita Taveta County. For instance, in Kilifi County, a HEI graduation was conducted at Mariakani Hospital where 10 infants together with their guardians were congratulated on their infants achieving a negative outcome at the end of the HEI program.

iii) Defaulter Tracing

Low cost phones for nomadic PMTCT clients in Samburu

Retention of all mother infant dyads on care is one of the gold standards for any successful PMTCT programme. To ensure good retention, *Afya Pwani* continued to aggressively support defaulter tracing mechanism during the reporting period. To this end the project continued to utilize a weekly community dash boards to track mother-baby pairs who missed appointments, tracking missed appointments, support group sessions and health education sessions. The weekly tracking has improved client follow up and reporting including prompt response to missed appointments. Clients who miss their appointments are immediately listed from the appointment diaries and entered in the client follow up register and appropriate follow up interventions

started that include phone calls, SMS reminders or home visits by mentor mothers. During the reporting period, *Afya Pwani* supported all 21 Sub-County AIDS & STIs coordinators (SCASCOs) and RH coordinators[1] with airtime to facilitate follow ups of all pregnant and lactating women who may have defaulted and/or LFTU.

In Lamu County, all the 33 supported PMTCT sites established defaulter tracing mechanisms. *Afya Pwani* printed and distributed three defaulter tracing registers in the high-volume facilities (Lamu County Hospital, Mpeketoni Sub County Hospital and Witu health Centre). As a pilot, through the PIPs programme, Samburu SCH in Kwale County was supported to pilot provision of cheap low-cost phones to needy, unreachable and nomadic clients who the facility does not have a means of reaching. This will not only motivate the client but will also facilitate remission of transport to such clients on their scheduled clinic days to ensure they do not miss clinics due to transport challenges.

iv) Strengthen psychosocial support services

Afya Pwani continued to strengthen psychosocial support services. Through this, a total of 42 mentor mothers were supported throughout its catchment facilities. The mentor mothers play a key role in establishing Psychosocial Support Groups (PSSGs) for pregnant and lactating mothers living with HIV through which patient literacy and peer support is done. As a result, the project has also developed a Standard Operating Procedure (SOP) for conducting PSSG meetings to standardize the contents of the group meetings and ensure quality. Support groups as an intervention also address the psychosocial needs of PMTCT clients through sharing of experiences, encouraging disclosure, reducing stigma and discrimination, improving self-esteem, enhancing patients' coping skills, psychosocial functioning, supporting medication adherence and improved retention in HIV care.

As a pilot, through the PIPs programme, Samburu SCH was supported to pilot provision of cheap low-cost phones to the needy, unreachable and nomadic clients who the facility does not have means of reaching. This will not only motivate the client but will also facilitate remission of transport to such clients on their scheduled clinic days to ensure they do not miss clinics due to transport challenges. In Kilifi, a total of 12 mentor mothers played a key role in establishing support groups for pregnant and lactating mothers living with HIV through which patient literacy and peer support is done. A total of 15 PMTCT support groups in Kilifi where a total of 122 support group sessions were conducted in various facilities.

In Taveta Sub County Hospital in Taita Taveta County, two PSSGs were conducted which focused on risk behavior change, importance of disclosure and adherence to highly active antiretroviral therapy (HAART) for mother and prophylaxis for HEI. Taveta in quarter four was the facility with the highest number of defaulters totaling to 21 clients. This was seen especially for clients who came from far towns or across the border. The County recently modeled a referral directory capturing contacts of facilities in the County and outside, with the hope that complete follow up will be done and phone transfer out information can also be used to reduce such numbers of defaulters.

In Lamu County, three mentor mothers were recently recruited and deployed in the three high volume facilities (Lamu County Hospital, Mpeketoni Sub County Hospital and Witu health center) through Global Fund support. The three mentor mothers were oriented and mentored on eMTCT using eMTCT guidelines during support supervision supported by *Afya Pwani* to ensure eMTCT services are provided according to the standard guideline.

[1] Matuga, Msambweni, Kinango, Lungalunga, Mvita, Nyali, Kisauni, Likoni, Jomvu, Changamwe, Voi, Mwatate, Wundanyi, Taveta, Lamu East, Lamu West, Kilifi North, Kilifi South, Malindi, Kaloleni, Rabai, Magarini and Ganze

d) Improving Quality of eMTCT services

i) Strengthen Continuous Quality Improvement (CQI)

All through the reporting period, *Afya Pwani* provided site-level capacity-building support including orientation of HCWs on the PMTCT guidelines. The orientation was done mainly via OJTs, joint support supervisions and mentorships, monthly County and Sub-County eMTCT data quality assessment, data review meetings, focused onsite and offsite mentorships and CMEs to promote uptake of HIV counseling and testing services (HTS) among pregnant and breastfeeding women. In addition, the project supported quality and work improvement teams (Q/WITs) within MCHs and strengthened case management for all HIV infected pregnant and lactating women through the placement and support of mentor mothers and case managers in all VHV and HVFs.

In Mombasa County, *Afya Pwani* supported QI training for 42 HCWs from all 24 PMTCT facilities[2].These facilities were further supported to conduct CQI meetings and activities throughout the reporting period. All the facilities were supported in identifying QI gaps and earmarking them for improvement in the next implementation period. For instance, in Port Reitz SCH, the team identified low uptake of partner testing in ANC as a challenge during their root cause analysis (using the fish bone diagrams). The facility identified patient knowledge on availability and importance of couple testing as being low, long waiting time and negative staff attitude as the main hindrances to male involvement. The team suggested variety of change ideas including strengthening and targeting daily health talks on couple testing, change of patient flow among others. The project supported Mariakani, KCH, Gede and Malindi facilities to conduct PMTCT CQI meetings in Kilifi County. All the facilities were supported in identifying QI gaps and earmarking them for improvement in the next implementation period. In Kwale County, *Afya Pwani* supported the RH coordinators from Sub Counties to conduct positive HEI audits in eight facilities; Msambweni, Kinondo kwetu Mwangulu, Vitsangalaweni, Kwale, Vyongwani, Lutsangani and Samburu that had received positive PCR results. Such audits were meant to understand issues that lead to the infants being infected and try to address such challenges in future. The preliminary findings are of the 11, six did not attend ANC and one attended but did not take ART, and two admitted to mixed feeding. Two in Kwale hospital and one in Msambweni were diagnosed in the pediatric ward.

In the period under review, USAID conducted a SIMs assessment in four facilities namely Kinango, Samburu, Kwale and Ukunda Catholic. All the facilities scored above 90% in ANC testing, maternal and infant prophylaxis uptake, treatment monitoring using viral load, HEI follow up and availability and documentation in the registers. Areas of improvement noted were TB cascade and IPT initiation, Integration of Family planning and preconception care in PMTCT and CCC, Community facility linkages and appointment systems.

Afya Pwani also supported four facilities, Mariakani, KCH, Gede and Malindi to conduct CQI meetings and activities. All the facilities were supported in identifying QI gaps and earmarking them for improvement in the next implementation period. In Taita Taveta, the project supported the CHMT and SCMT to do a stock taking count for all clients and infants in the PMTCT program

ii) Data demand and information use (DDIU)

In Quarter 4, *Afya Pwani* prioritized PMTCT DDIU in all supported HVFs with a total of 68 health care workers (M-27, F-41) in Lamu County mentored and trained on the job on maternal cohort analysis (MCA) and HEI cohort analysis (HCA), HEI registers, HEI card documentation, enrollment and retention of HIV-Positive pregnant women, HIV exposed infant follow up and early initiation of HAART to infants confirmed HIV positive. The HCWs were also orientated on the HEI audit tools to enable them to audit all HIV positive

[2] CPGH, Likoni, Port reitz, Bamburi, Mvita, Tudor, Kongowea

children with the aim of finding out contributory factors to the positive results to prevent recurrence. Within the reporting period no positive infants were reported in all the project supported sites in Lamu.

In Kwale, Mombasa, Kilifi and Taita Taveta Counties, the project supported RH coordinators from 16 Sub Counties to conduct positive HEI audits in facilities that had received positive PCR results. There were 27 positive infants that were audited with the view of using data to understand possible factors and issues that could have led to the infants being vertically infected with HIV and institution of remedial actions to prevent future transmissions. A comprehensive report on the audits was shared using the designated template to USAID in Quarter IV and results also used to validate HEIs on the NASCOP EID website.

In partnership with the CHMT, the project supported Kilifi and Mombasa County eMTCT technical teams to hold a quarterly eMTCT taskforce meeting where progress and achievements of PMTCT of the County were shared and action plans drawn to improve overall quality of PMTCT in the health facilities. *Afya Pwani* in Taita Taveta also supported Sub County based monthly PMTCT cascade review meetings where facility staff were able to track and monitor progress for each indicator as well as highlighting key areas for improvement. During the reporting period, *Afya Pwani* also supported the national NASCOP led PMTCT DQA in 10 facilities of Kwale, Taita Taveta, Kilifi and Mombasa Counties. Overall, the scores were good with most of the facilities (80%) scoring over 90% in data concordance between DHIS2, DATIM and MOH 731 reports.

iii) Reward system for best performers

Afya Pwani further supported Mvita Sub County in Mombasa County to develop a reward system for best performing PMTCT sites in identification, linkage, retention, HEI positivity and viral suppression. This initiative has improved staff productivity and commitment and set the pace for positive competition with facilities aiming at improving the quality of care and services. The system has also strengthened ownership and leadership of HIV management and programing by facilities and the Sub County as well.

iv) Partner implemented projects (PIPs)

To ensure quality service provision at PMTCT settings, *Afya Pwani* through partner implemented projects (PIPs), facilitated and supported 19 facilities to hold MDT sessions in Kilifi and Taita Taveta County. In MDT meetings, complex and unsuppressed PMTCT clients were discussed for appropriate interventions including switching to 2nd line regimens and drug dosage adjustments. These efforts were complimented by the joint (with CHMT/SCHMT) support supervision on PMTCT services conducted in 13 facilities reaching 129 HCWs (M-52, F-77). During the supervision, the project provided mentorship and OJT to address linkage gaps, infant prophylaxis, EID, timely viral load uptake, IPT documentation, STI screening, dual HIV and Syphilis testing and use of data for decision making.

v) Supportive supervisions, mentorships, CMEs and OJTs for QI

These supervisions were aimed at building the capacity of HCWs and ensuring provision of the prescribed standard package of PMTCT services as per the national guidelines. During these visits existing, capacity and knowledge gaps among health care workers were identified especially among new HCWs (newly recruited or reshuffled).

During the period under review, *Afya Pwani* supported joint MOH and project support supervision visits to various PMTCT sites in the five counties. The main gap identified through JSS was that HCWs were not trained on eMTCT and not conversant with the latest eMTCT guidelines and yet they are responsible in ensuring all HIV positive pregnant and lactating women and HEIs are offered comprehensive adherence counselling and same day HAART initiation. This mainly resulted from the frequent and ad hoc staff rotations and transfers. Discussions were initiated with the CHMTs through the HSS arm of the project on how to mitigate this challenge. *Afya Pwani* continued supporting the CHMT to conduct regular continuous mentorship to scale up

age specific PMTCT support groups, provision of ARV commodities in integrated MCH settings and support for commodity consumption, forecasting, and reporting in all supported sites.

In Kilifi County, a joint supportive supervision was carried out in eight facilities in an effort to improve uptake of ART among HIV positive pregnant and breastfeeding mothers and to support improvement of quality of care within the PMTCT as per the revised 2016 ART and PMTCT guidelines. In addition to this, *Afya Pwani* HSS in partnership with the County conducted supportive supervision on quality of systems offered within the MCH in eight facilities. During these visits, capacity and knowledge gaps among some health workers were identified and addressed with some health care providers benefiting in TA about the 2018 guidelines. In Taita Taveta, *Afya Pwani* supported joint support supervision to Taveta Sub County in eight facilities namely Taveta, Rekeke, Ndilidau, Njukini, Mata, Challa, Eldoro and Kitobo to assess retention and evaluate HIV testing in the facilities. The County in conjunction with the project team further incorporated HIV services evaluation in their support supervision tool. This in the long run will harness ownership among the CHMT. In Mombasa County, all 24 *Afya Pwani* supported PMTCT sites benefited from joint supportive supervisions by CHMT and project teams while eight of the sites also received joint USAID/CHMT/AP support supervisions through SIMS during the reporting period.

vi) eMTCT taskforce meetings

In Lamu and Mombasa Counties, the project supported four County eMTCT task force meetings attended by CHMT members, PMTCT focal persons and facility in-charges from High volume facilities. During the meeting, it was noted that HIV testing among 1st ANC clients stood at almost 100% in all facilities except retention on PMTCT care at 6 months and viral load uptake among identified HIV positive women who had been on ART for 6 months was low across all facilities. PCRs for EID done for infants by two months of age and infant baseline VL done among the PCR positive infants was also low while ART uptake among confirmed HIV positive infant was 100%. Only Lamu county Hospital was able to present MCA and HCA due to knowledge gap among the HCWs. In response, the *Afya Pwani* technical team in partnership with the Lamu CASCO trained the participants on MCA and HCA.

Additionally, HCWs were trained on how to access and query NASCOP EID and VL website for results including the SMS methods of querying results. This has reduced turnaround time for both viral load and EID results leading to early initiation of HAART among all confirmed HIV positive children and proper monitoring of clients on HAART. In Kilifi County, the project supported one county eMTCT task force meetings attended by CHMT members and PMTCT focal persons in the County. The meetings reviewed eMTCT indicators for the County for period October 2017 through July 2018 with each of the subcounty presenting ANC, maternal and infant cascades. During the meeting, it was noted that HIV testing among 1st ANC client was at almost 96%with some facilities having missed opportunities which were accounted for during the review meeting. There were cases of mothers declining testing within the ANC, shortage of test kits and failure by some nurses to test. PCRs for EID done below for infants by two months of age and infant baseline VL done among the PCR positive infants was also low while ART uptake among confirmed HIV positive infant was 100%.

vii) IQCare EMR pilot at MCH

As part of *Afya Pwani*'s strategy to improve quality of PMTCT services through improved documentation and quality of data, improved data access and real-time decision support, improved reporting and improved appointment management, the project supported the deployment of the IQCare EMR system in MCHs across the supported Counties. The IQCare EMR in a structured and standardized method will improve documentation of procedures and outcomes of the mother baby pairs using the MOH tools. The EMR will greatly improve clinician access to data for real time decision support including monitoring of ANC visits, HIV testing for Index and partners, linkage to care and treatment. Electronic linkage of mother and HEI profile in the EMR will also ensure proper monitoring of HIV exposed infant for the required 24 Months. The management of mother-baby pairs, appointment has already improved in EMR PMTCT sites since the system

has a scheduler for patient bookings and patient contact information is available in the system to facilitate the sending of SMS reminders for ANC and post-natal visits.

Afya Pwani continued to sustain the use of EMR MCH module in Kwale, Mombasa and Kilifi Counties at Kinondo, Tudor, Port Reitz and Kilifi County Hospital during the reporting period. In Taita Taveta County, Afya Pwani supported Moi hospital, Taveta hospital, Mwatate SCH, Buguta SCH and Ndovu HC to reconstruct data for PMTCT clients especially the HEI card into the system. The project further also ensured that routinely used registers such as the ANC and HEI registers are configured in the system as outputs.

e) Improving uptake of early infant diagnosis (EID) for HEIs and viral load monitoring for pregnant and breastfeeding mothers

i) Uptake of early EID for HEIs

HIV exposure status among infants below 18 months should be established at first contact according to the 2018 national ART guidelines. To ensure this happened in all supported sites during the period under review, *Afya Pwani* supported HCWs through sensitizations on EID, initiation of infants on ARV prophylaxis, prompt follow up of HEI for early dry blood spots (DBS) collection, baseline and regular viral load (VL) monitoring of pregnant and breast-feeding women following the national recommendation with an aim of achieving the third '90' of the cascade. The project strengthened HIV screening for all lactating women attending immunization clinics for Penta 1 (six weeks postnatally) in all facilities of the five supported counties to ensure all HEIs are captured and DBS for polymerase chain reaction (PCR) taken.

Afya Pwani further supported S/CHMTs to conduct a comprehensive PMTCT training and capacity needs assessment for health workers (SCASCOs, pharmacists, SCHRIOs and SCMLTs) in all the counties. Joint integrated supportive supervision exercises were conducted in 40 health facilities[3] with emphasis on DBS collection and EID, the provision of ART services to HIV positive pregnant and lactating women and their infants in line with PMTCT guidelines. The health workers were also mentored and sensitized on early infant diagnosis especially the PCR testing algorithm for exposed infants, DBS sample collection, packaging and transportation to the testing laboratory, viral load as well as EID sample collection.

In July-Sept 2018, a total of 940 polymerase chain reaction tests were processed as initial PCR tests. The initial PCR tests done were 52% of 1,798 HIV-exposed infants (HIV-positive pregnant mothers used as crude proxy) in the year. Out of the initial PCR tests done in quarter 4, 65% (608) were done within two months of age as compared to 35 % (332/940) of EID done between 2 and 12 months.

[3] Challa Disp, Njukini HC, Rekeke HC, Mata Disp, Ndilidau Disp, Kitobo Disp, Kimorigo Disp, Eldoro Disp, Kiwalwa Disp, Taveta SCH, Nyache HC, Mbale HC, Kishushe Disp, Sangeroko Disp, Mgange Nyika HC, Mgange Dawida HC, Werugha HC, Mwanda HC, Wesu SCH, Wundanyi SCH, Maktau HC, Bura HC, Dembwa Disp, Mpizinyi HC, Kighangachinyi Disp, Mrughua Disp, Manoa Disp, Mbagha Disp, Shelemba Disp, Msau Disp, Maungu HC, Marungu HC, Kasigau HC, Buguta HC, Sarala HC, Ndovu HC, Tausa HC, Ghazi Disp, David Kayanda Disp and Moi CRH

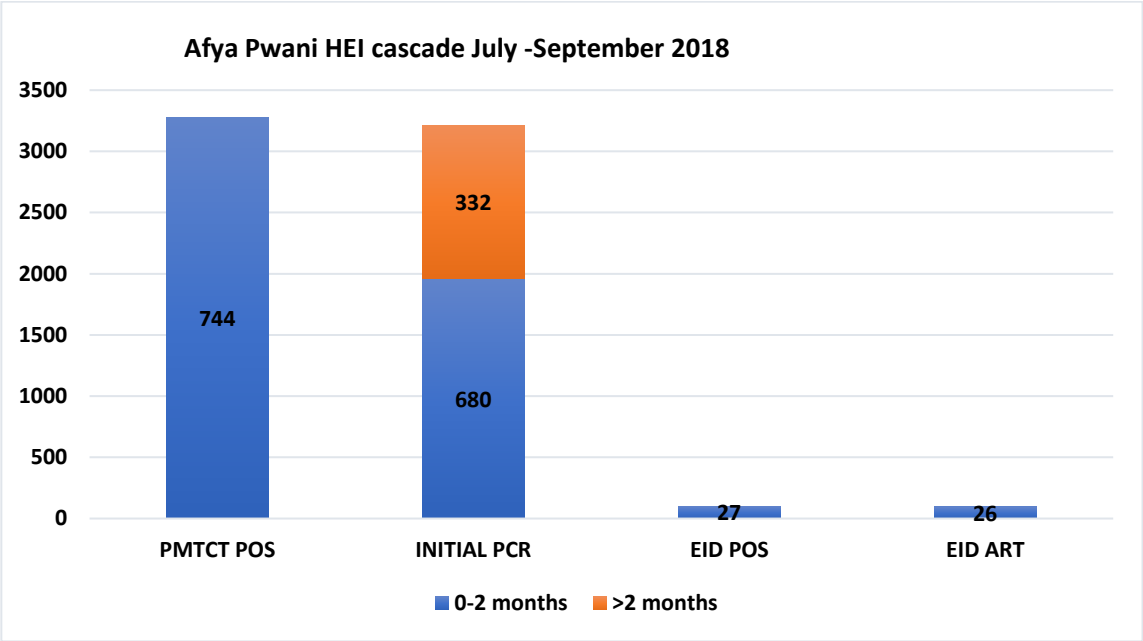


Figure 2 EID Cascade for FY 18 in *Afya Pwani* supported sites

Overall, HEI positivity in *Afya Pwani*'s supported sites stood at 3.1% with 102 infants having acquired HIV vertically during the reporting period out of 3,212 infants receiving an initial PCR test during FY18 as shown in the figure below.

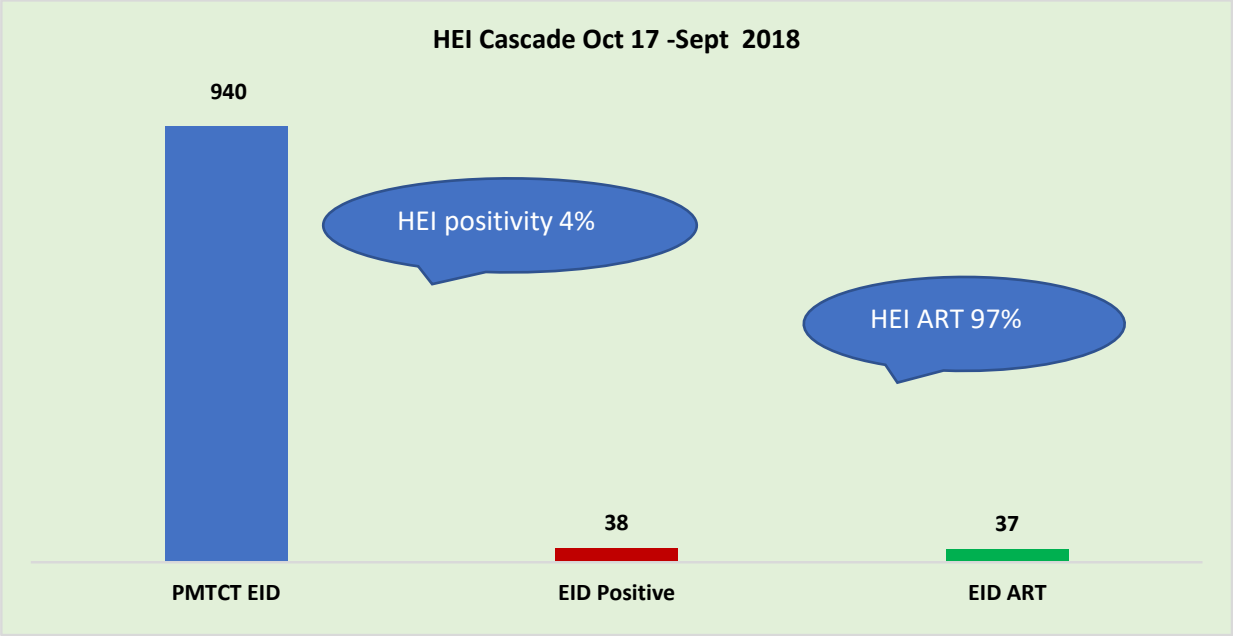


Figure 3 EID positivity for Quarter four in *Afya Pwani* supported sites

HEI positivity in the five *Afya Pwani* supported Counties varied markedly:Lamu 4% (1 infants), Mombasa 2% (7 infants), Kilifi 6% (15 infants), Kwale 5% (9 infants) and Taita Taveta 3.0% (4 infants) respectively as shown in the figure below.

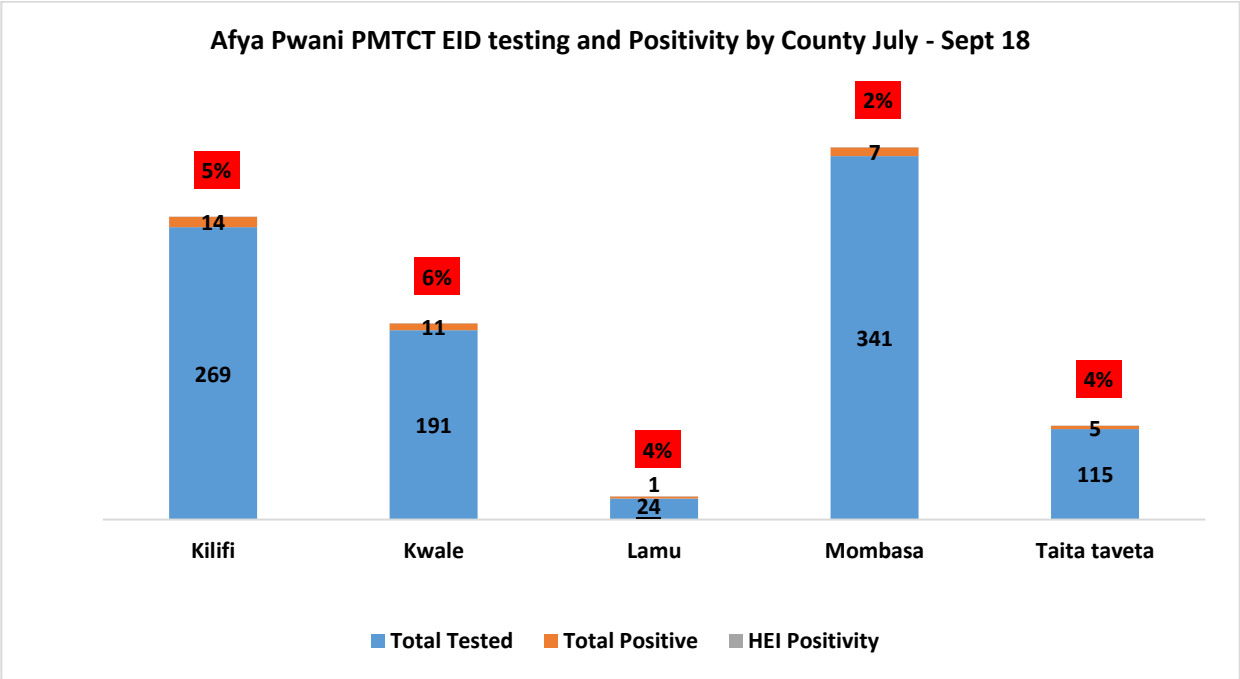


Figure 4 EID Cascade for Quarter four in *Afya Pwani* supported SNUs

During the reporting month, *Afya Pwani* data reported 27 infants below 12 months identified as HIV-positive, according to the EID website, 27 infants were validated, with 4 infants are LTFU. all of whom were validated. All 27 infants (96%) have been initiated on HAART and all HEI positive infants initiated on HAART have been audited through the support of *Afya Pwani* as part of CQI to inform quality improvement subsequently. The infant audits showed that reasons associated with mother-to-child transmission (MTCT) were mainly lack of skilled deliveries (37% of the cases), missed Infant prophylaxis (41%), missed maternal HAART (26%), late PCR tests after two months (70%), lack of attendance to ANC by the mothers (51%) and late attendance among the 49% attending ANC with only 26% of them attending their 1st ANC by week 20 gestation.

Based on the PCR audited data findings, the project will continue to collaborate with County Health Departments and other stakeholders to advocate for early ANC initiation among pregnant women and educate them on PMTCT interventions available including ART and skilled deliveries. The Project will also focus its efforts to improve on the quality of services to ensure that all pregnant and lactating women identified to be HIV positive are all immediately initiated on ART, provided with infant prophylaxis and monitored well for viral suppression to reduce MTCT in the five Counties. Health workers through case management will be supported to account for every HIV positive pregnant and lactating woman to ensure retention in care and adherence to ART, delivery in a health facility and use of the recommended choice of infant feeding, exclusive breastfeeding for infants below six months. Pre-conception screening, counselling and FP services will also be strengthened among known positives to promote informed pregnancy and birth planning. In FY 19, the project will continue to work through the grantees and PIPs to address some of the cultural and religious barriers to early ANC initiation, stigma and discrimination for PLHIV and low skilled deliveries among women especially those living with HIV.

The project also supported an infant mortality audit in Muyeye HC in Kilifi County that reported an infant death. The cause of death was as attributed to delay of ART initiation due to late presentation in inpatient ward having never been tested for HIV before following a home delivery.

Moving forward, *Afya Pwani* will continue to strengthen early identification and referral of HEIs from the community using CHVs and mentor mothers to minimize such cases of delayed identification of HEIs and initiation on ART.

ii) Viral load monitoring for pregnant and breastfeeding mothers

In the period under review, *Afya Pwani* had a total of 2,025 viral load samples taken of which 1,748(86%) were suppressed in the PMTCT settings. In Kilifi County, a total of 391 PMTCT VL samples were collected, 347 were suppressed while 44 samples were unsuppressed, giving a suppression of 88.7%. This is an improvement from the suppression rate of 82.1% in FY1. In Lamu County,a total of 32 PMTCT VL samples were collected in the year, 29 were suppressed giving a suppression rate of 90.6%. Taita Taveta County had 283 viral load samples taken of which 83%(234) of the samples were suppressed. The 17% (49) unsuppressed clients are on close case management follow up by the facility staff and mentor mothers. Kwale County had a total of 344 samples taken,283 were suppressed (82%)and 61 samples were unsuppressed representing 18% of the clients. The unsuppressed clients were discussed in facility MDTs, assigned case managers at the facility and provided enhanced adherence counselling to mitigate against adherence barriers.

f) Strengthen service delivery in private facilities supported by *Afya Pwani*

Despite of the high number of private health practitioners in Mombasa County (84% of all registered health facilities), the project continued to support the Mombasa CHMT through capacity strengthening, supervision, data demand and information use (DDIU) and to strengthen reporting through the DHIS2 with a total of 8 private practitioners supported and attending the Mombasa County eMTCT stock taking meeting. This support was a follow up to the CHMT engagements with private sector which commenced in quarter II. During the reporting period, the project also facilitated discussions with the Mombasa and Kilifi CHMTs on modalities to support registered and practicing private practitioners in the counties to provide quality PMTCT services while at the same time reporting through the MOH DHIS2 platform. An enumeration of all private practitioners in both counties was completed. Because of the engagements, the CHMTs commended drawing up of support plans for the high volume private facilities.

Afya Pwani continued to support County and Sub County HMTs in the distribution of commodities to private facilities providing PMTCT services. The project further supported the Mombasa CHMT to provide TA and supervision to 28 private facilities during the year. As part of the support to private practitioners, the project also expanded its PMTCT training needs assessment to include high volume private facilities. Informed by the finding on this exercise, the project will also support the training of these practitioners in PMTCT as per national guidance in the 1st Quarter of COP 18.

Further, in Taita Taveta and Kilifi Counties, the project supported SCASCOs, HRIOs and SCMLTs with transport to visit six private clinics[4] to conduct mentorship and supported health workers on the need to scale up HTS in PMTCT settings as per the latest recommended algorithm as well as improve linkage to CCC for all those who are identified HIV positive. Clinic staff in the target facilities agreed on physically escorting HIV positive clients to the nearest ART site for enrollment and ART initiation. The project also supported these private facilities with PMTCT, EID, HTS job aids and ART guidelines. In addition, *Afya Pwani* supported four data reviews meetings in all the sub counties in Taita Taveta during which the six private clinics were represented.

Lessons Learned

1. Continuous OJT and mentorship have proven to be an effective strategy to improve the knowledge and skills of service providers; consequently, improving the quality of services offered to eMTCT clients and the boosting of staff morale.

[4] Ndongo Purple, Horesha, Joy medical, Dawida, Mvono, Acode, Oasis Medical Centre and AIC Malanga

2. Health education by volunteers and HCWs at the waiting bays is important as it prepares women in advance for eMTCT interventions and promotes male involvement
3. Strengthened case management through mentor mothers are effective in ensuring retention of mother baby pairs in care and doing defaulter tracing.
4. Mother-baby pair register is an effective tool for longitudinal follow up of mother -baby pairs and it helps to easily identify missed appointments and missed services for immediate follow up. This has improved our retention.
5. Identification of early pregnancies at community level where women are encouraged/linked to care early in pregnancy leads early antenatal clinic attendance hence timely identification of HIV infected pregnant and consequently better maternal and neonatal outcomes. We scaled up targeted PMTCT especially into selected targeted informal settlements
6. Regular facility PMTCT data review meetings and establishment of WITs at MCH at the high- volume sites have greatly improved the quality of the PMTCT program seeing reduction in lab rejection rates of PCR requests and repeat PCR tests mis-captured as initial tests
7. Regular joint supportive supervision plays an important role in improving quality of PMTCT services offered in facilities
8. Partner/male involvement is key in ensuring retention of mother baby pair

Integration of PMTCT in the MCH /FP services improves quality of care offered to PMTCT clients and reduce time clients spend in the facility to receive the basic PMTCT packages of care.

Challenges

What were the challenges encountered during the quarter?	How were these challenges addressed?
Sub-optimal case management due to the limited number of case managers (mentor mothers) the project has engaged and supported across its catchment counties	*Afya Pwani* continued to engage various private corporates during the quarter including Bamburi and Mombasa Cement, Base Titanium to explore possibilities of such supporting more case managers through CSRs. The project will double the number of supported case managers to 65 in FY19
Nurses' go-slow in provision of HIV testing and ART services especially in Taita Taveta, Kwale and Mombasa owing to a memo issued by the KNUN for nurses not to provide HIV testing services.	This has been the biggest challenge in achieving all the indicators in the PMTCT cascade. Lobbying and engagements with relevant stakeholders is ongoing to ensure nurses get back to offering HTS services. Meanwhile, the project engaged temporary HTS providers and engaged lab personnel to ensure HTS is offered at all PMTCT settings.
2010 register versions still in use in most of *Afya Pwani* facilities. The tools and registers have no provision to capture revised PMTCT indicators.	*Afya Pwani* is working with the CHMTs to source for the 2016 register versions and distribute to the sites. Meanwhile, the project has continued to support facilities to innovatively utilize the currently available versions of registers to provide quality PMTCT services.
PMTCT knowledge and capacity gaps and new tools following the frequent	*Afya Pwani* is supported all the five counties to carry out a PMTCT and MNCH capacity needs assessment to inform any training plans in year III. The County Government of Lamu recently supported a

transfers of HCWs and employment of new PMTCT naïve HCWs.	refresher training on new tools. OJT and support supervision in progress to update staff who did not participate in the refresher training.
High staff turnover and change overs through inter-departmental and inter-facility transfers	Advocate for longer staff stays in the facilities and departments to ensure continuity of care Proper handover process implementation will also assist in ensuring provision of quality of care.

Output 1.2: HIV Care and Support Services and Output 1.3: HIV Treatment Services

a) Improving uptake of ART

During the reporting period, 2,054 newly identified PLHIV were started on ART out of the 2,335 that were identified in the period under review, a linkage of 87% for the project.

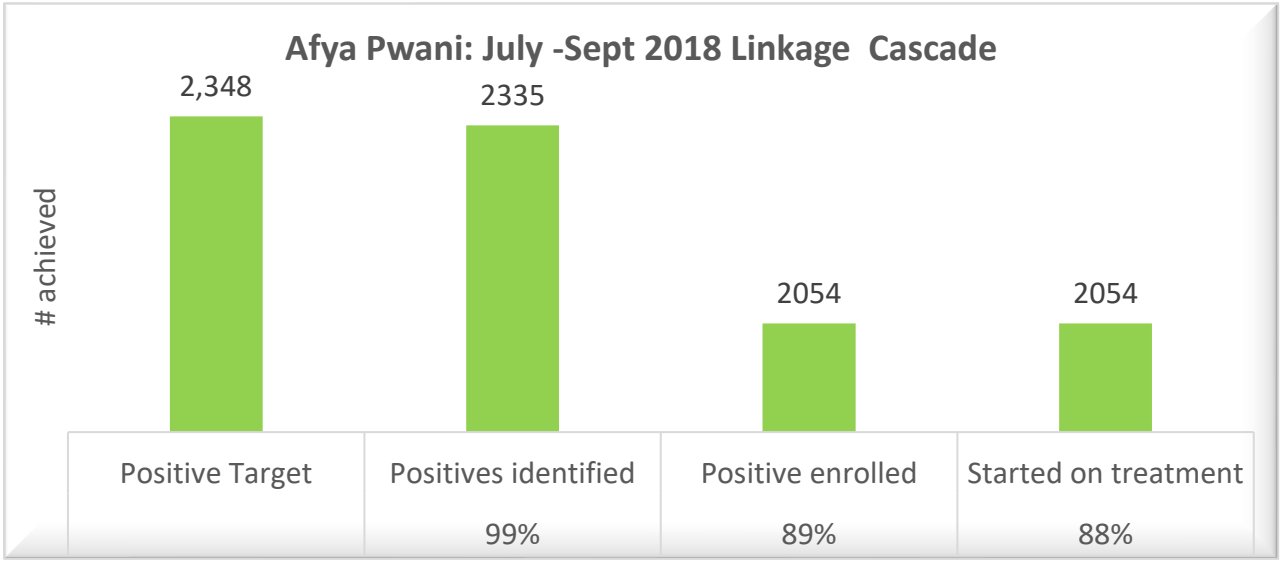


Figure 5 July- Sept 2018 Linkage Cascade

The linkage per County in the concluded Quarter is shown in the chart below; 98%,89%, 86%,89% and 90% in Lamu, Kilifi, Mombasa, Kwale and Taita Taveta respectively.

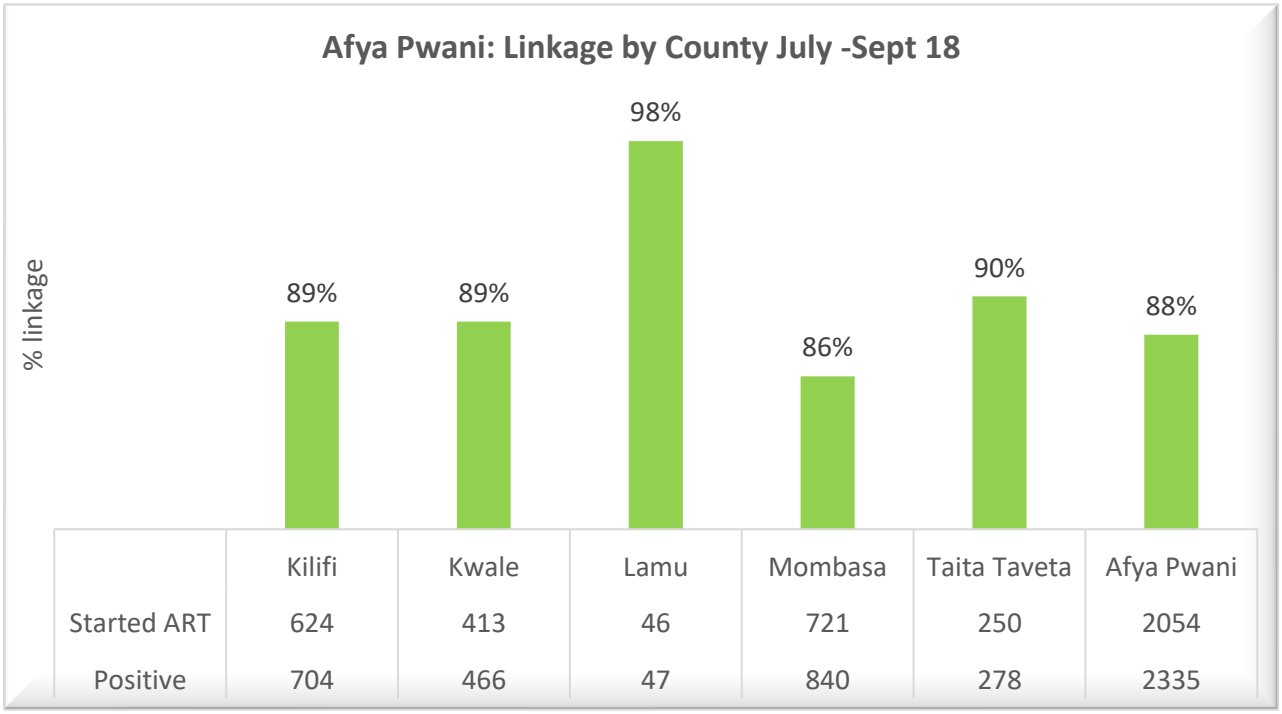


Figure 6 Linkage by County July- Sept 2018

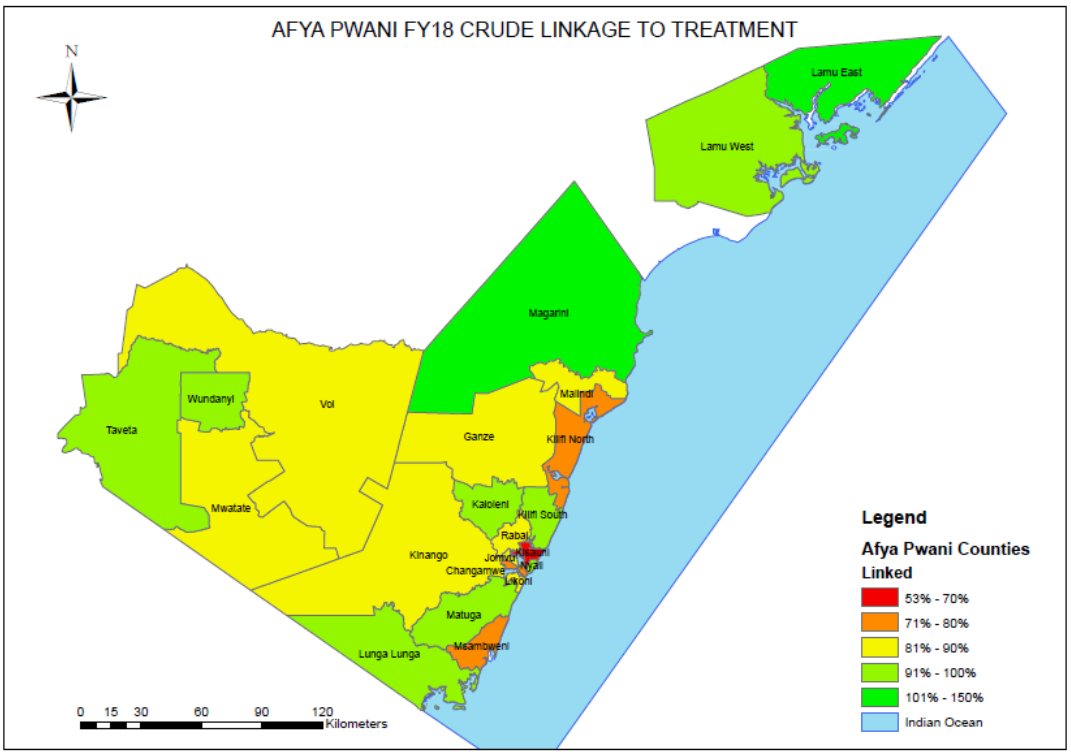


Figure 7 *Afya Pwani* linkage to treatment by Sub County

Overall, linkage among males and females is comparable. However, the linkage for men in Mombasa and Kilifi is significantly higher than that of females and conversely for Taita Taveta and Lamu. Lower linkage for men in Taita Taveta can be attributed to the fact that some of the men identified were on transit, than women due to occupational reasons. In Mombasa and Kilifi counties, the project works with a religious organization and community elders to champion testing for men and consequently linkage.

Table 4 Linkage rate by age and sex

	Positives identified			New on ART			Linkage %		
	Unspecified sex (<10 years)	Females	Males	Unspecified sex (<10 years)	Females	Males	Unspecified sex (<10 years)	Females	Males
Mombasa	16	564	260	26	462	233	163%	82%	90%
Kilifi	33	479	192	42	404	171	127%	84%	89%
Kwale	33	291	141	32	256	125	97%	88%	89%
Lamu	2	26	20	3	28	14	150%	108%	70%
Taita Taveta	4	168	106	6	160	84	150%	95%	79%
Afya Pwani	88	1528	719	109	1310	627	124%	86%	87%

Table 5 Linkage among the different age groups in quarter 4

Linkage per age band July -Sept 2018			
Cascade Age bands	Total Positive	TX-NEW	Linkage %
1-9 (Cascade)	79	98	124%
10-14 (Specific)	51	35	69%
15-19 (Specific)	67	61	91%
20-24 (Specific)	271	221	82%
25-29 (Specific)	471	406	86%
30-34 (Specific)	448	375	84%
35-39 (Specific)	342	285	83%
40-49 (Specific)	416	390	94%
>=50 (Cascade)	181	164	91%

Linkage rates were better among the older age bands with the lowest being among adolescents, 10-14 years. Efforts will be made to work with other adolescents living with HIV to provide peer support in addition to the

targeted professional counselling provided to them to enable them to accept their HIV status and start treatment.

To increase linkage to over 90% , *Afya Pwani* will continue with case management approach where counsellors are responsible for linking identified positives through intense psychosocial and treatment preparation counselling, physical escort to treatment clinics within the health facility, use of expert clients for psychosocial support of newly identified clients for treatment, telephone follow-up of identified clients and use of referral tools registers, directories and referral forms to track and ensure enrolment to treatment. The HTS team will continue to conduct a deep dive of unlinked clients, establish linkage issues for corrective actions.

During the reporting period, select high volume facilities were monitored on linkage and the issues identified were followed with immediate follow up actions.

In the Quarter, 281 newly identified clients had not been linked to ART by the end of September 2018(80 Kilifi, 1 Lamu, 119 Mombasa, 28 Taita Taveta and 53 in Kwale). Forty-eight (48) of the 281 have been started on ART in October,82 still under treatment preparation, 62 have out rightly declined treatment but continued follow up is ongoing with 21 unaccounted for.

Table 6 Linkage July- Sept 2018

Linkage July-Sept 2018 cont.									
	Positives identified	**Started ART**	**Unlinked**	**Linked after Sept 30th, 2018**	**Started ART in another facility**	**Still on treatment preparation**	**Died before starting ART**	**Declined treatment**	**Unaccounted for**
Kilifi	704	624	80	3	41	7	9	14	6
Kwale	466	413	53	14	12	12	7	8	-
Lamu	47	46	1	1	0	0	0	0	-
Mombasa	840	721	119	30	18	10	15	39	7
Taita Taveta	278	250	28	0	11	8	0	1	8
Afya Pwani	**2,335**	**2,054**	281	**48**	**82**	**37**	**31**	**62**	21

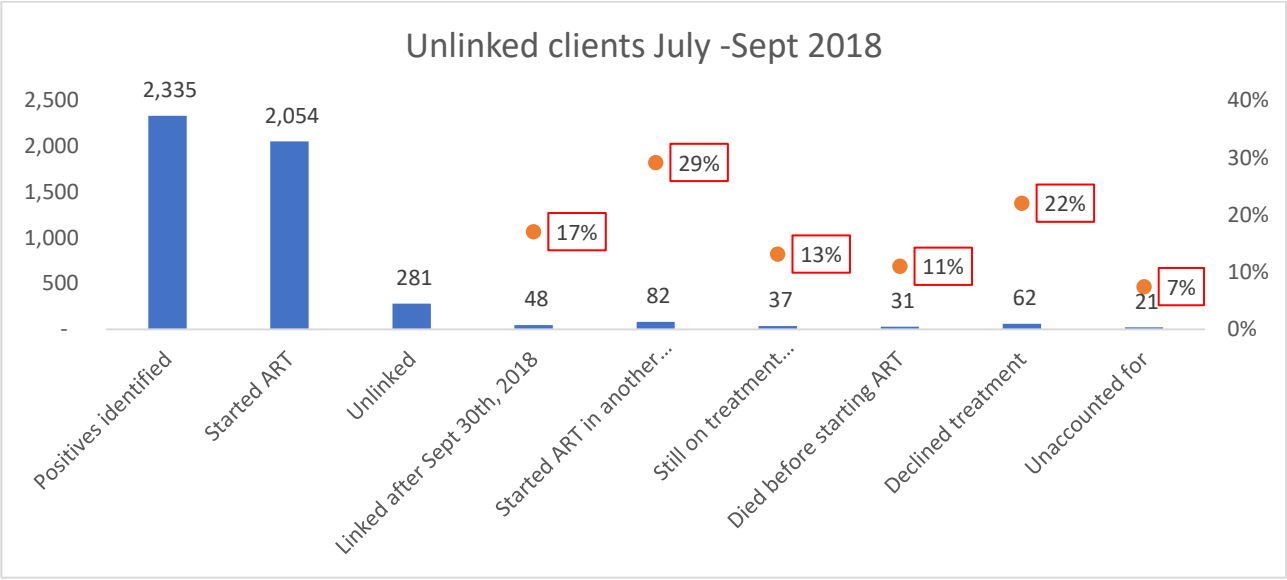


Figure 8 Unlinked clients July- Sept 2018

To achieve the set targets for 2nd 90, *Afya Pwani* has invested heavily in identification of PLHIV and ART preparation of those identified through HTS counselors and enhanced adherence counsellors who have optimized HTS in high yielding service delivery points in addition to engaging peers and HTS counselors to act as linkage facilitators. The capacity of health care workers to provide ART has also been enhanced through mentorship and CMEs across all the supported Counties. In the five supported Counties, *Afya Pwani* is also collaborating with the CHMTs to scale up the use of high yielding HTS modalities like aPNS and self-testing as outlined in the HIV Testing section later. In addition, newly identified PLHIV who decline to start ART are followed up over time, given more appointments for further counselling and any other form of support they may need until they accept their HIV status and agree to start treatment.

b) Improving capacity of health care workers and facilities to provide ART

i) Mentorship and CMEs on ART provision:

Afya Pwani staff in Kilifi County continued to provide targeted mentorship in the six Sub Counties[5] to support early ART initiation for all identified PLHIV. During the period, the project trained 42 mentor health care workers from the seven Sub Counties (M-16, F-26) who have been providing mentorship to service providers on various areas of expertise like clinical care, pharmacy, nutrition, laboratory services, data and reporting to fast tracking attainment 90:90:90.

In Taita Taveta County, the project conducted 10 sensitizations and mentorship sessions on the revised ART guidelines to increase access to ART, where 219 (M-77, F-142) health workers from 34 facilities[6] were reached. The health workers were sensitized on HTS and linkage to treatment and prevention, initial evaluation and follow up for PLHIV, standard package of care for PLHIV, adherence preparation, monitoring and support, antiretroviral therapy in infants, children, adolescents and adults, TB/HIV Co-infection prevention and management as well as antiretroviral therapy for post exposure prophylaxis and oral pre-exposure prophylaxis.

[5] Rabai, Kaloleni, Ganze, Kilifi South, Kilifi North and Magarini

[6] Moi CRH, Taveta SCH, Mwatate SCH, Wundanyi SCH, Wesu SCH, Ndovu HC, Mgange Nyika HC, Nyache HC, Mbale HC, Kishushe HC, Mgange Dawida HC, Bura HC, Marungu HC, Maungu HC, Kasigau HC, Buguta HC, Sagalla HC, Kajire Disp, Tausa HC, Ndome Disp, Ghazi Disp, Miasenyi Disp, Mwambirwa SCH, Msau Disp, Shelemba Disp, Mbagha Disp, Njukini HC, Ndilidau Disp, Kitobo Disp, Challa Disp. Dawson Mwanyumba Disp, Kighombo Disp, Mpizinyi HC, Mahandakini Disp and Chumvini Disp,

In Mombasa County, *Afya Pwani* in collaboration with the CHMT provided technical assistance to 30 service providers (M-11, F-19) from 11 facilities[7] on treatment preparation before start of ART. This was done in targeted facilities that had shown an increased trend of newly identified PLHIV reluctant to be started on treatment. To improve on the knowledge and skills of services providers to provide ART, CME and mentorship sessions on ART guidelines were conducted in 13 facilities reaching 47 service providers (M-20, F-27). Among the topics covered included linkage to treatment, initial evaluation and follow up for PLHIV, standard package of care for PLHIV, adherence preparation, monitoring and support, ART in infants, children, adolescents and adults, TB/HIV Co-infection prevention and management as well as ART for post exposure prophylaxis and oral pre-exposure prophylaxis.

ii) Supportive supervision

The project conducted joint supervision with Lamu CHMT,72 (M-28, F-44) health workers mostly nurses and clinical officers received on job training and mentorship on linkage to increase uptake of care and support services among PLHIV in the supported facilities. All the 15 ART sites[8] were reached. *Afya Pwani* and SCHMT teams in Mombasa conducted joint support supervisions, 76 (M-22, F-44) health care workers received on job training and mentorship on linkage to increase uptake of care and support services among PLHIV in 11 High Volume facilities[9]. In Kilifi County, during joint support supervision, it was noted that some facilities were not providing IPT for pregnant mothers as recommended in the National guidelines. As such, the project supported mentorship in 18 facilities in Magarini and Kaloleni Sub Counties [10] where 47 Service providers (M-15, F-32) were mentored on IPT administration for all eligible pregnant and breastfeeding women who are HIV positive and screening negative for TB to increase uptake of IPT amongst this vulnerable group. In Kwale County, supervision was done at Diani health center, Lungalunga, Msambweni, Kwale and Kinango hospitals, Tiwi and Samburu health centers reaching 16 health workers (M-4, F-12). The emphasis was the screening of TB among HIV positive pregnant women and the provision of IPT. In Taita Taveta County selected CHMT and SCHMT members were supported for joint support supervision, in 56 facilities[11]which focused on ensuring the health workers manage the clients well following the guidelines, viral load monitoring, IPT initiation, management of unsuppressed clients and commodity management with 84 (M-24, F-60) health workers benefitting.

iii) Facility based staff

Among the major hindrance to access to ART services is the shortage of skilled health care providers in supported facilities. To address this gap, *Afya Pwani* has continued to support HRH strengthening across the supported Counties by hiring 2 medical officers, 14 clinical officers, 15 nurses, 4 pharmaceutical technologists, 41 HTS/Adherence counselors, 5 laboratory technologists, 10 HRIOs, 27 mentor mothers and 5 nutritionists.

c) Quality Improvement/Assurance for ART services:

In the reporting period, *Afya Pwani* supported the County Quality Management Unit (CQIT) in Mombasa County to undertake a functionality and maturity index. The index sought to assess the status of QI

[7] CPGH, Tudor, Likoni, Mrima, Shika Adabu, Chaani, Magongo, Likoni Catholic, Mvita, Miritini and Jomvu Model H/C.
[8] Lamu County Hospital, Mpeketoni sub County hospital, Witu health Center, Hongwe Dispensary, Mkunumbi Dispensary, Mapenya Dispensary, Maria Teresa Nuzzo Health center, Hindi Dispensary, Mokowe Dispensary, Pablo Hortsmann Health Center, Shella dispensary, Kiunga Health Center, Faza Health Center, Muhamarani and Kizingitini dispensary)
[9] (CPGH, Ganjoni, Portreitz, Tudor, Mikindani, Likoni, Kongowea, Magongo, Bamburi, Mlaleo and Kisauni.
[10] Baricho, Sosoni, Garashi, Adu, Fundisa, Ngomeni, Mambrui, Marikebuni, Ngomeni, Marafa, Kinarani dispensary, Gotani Health Center, Ribe Dispensary, Mgamboni dispensary, Kambe dispensary, vishakani dispensary, Kombeni dispensary, Lenga dispensary and Chalani Dispensary)
[11] Taveta SCH, Moi CRH, Wundanyi SCH, Mwatate SCH, Ndovu HC, Maktau HC, Bura HC, Mpizinyi HC, Shelemba Disp, Msau Disp, Kwamnengwa Disp, Mwashuma Disp, Modambogho Disp, Shelemba Disp, Msau Disp, Mwambirwa SCH, Challa Disp, Njukini HC, Mahandakini Disp, Chumvini Disp, Rekeke HC, Mata Disp, Ndilidau Disp, Kitobo Disp, Kimorigo Disp, Eldoro Disp, Kiwalwa Disp, Miasenyi Disp, Maungu Model HC, Ndome Disp, Ghazi Disp, Kasigau HC, Buguta HC, Marungu HC, Sagalla HC, Tausa HC, Nyache HC, Mbale HC, Mgange Nyika HC, Werugha HC and Wesu SCH

implementation by assessing among them the existence of QI teams with active QI projects, QI processes include, testing changes, data collection, measurement and analysis, documentation and sharing of key lessons. The project supported the department of health in Mombasa to undertake a quarterly County Quality Improvement Team (CQIT) meeting. The meeting brought together 27 participants from the CQIT, SCQIT as well as the sub county hospital teams. The meeting served as a mid-year review for the QI activities currently being undertaken by the facilities and Sub County teams.

In the same period, *Afya Pwani* facilitated CQI joint support supervisions in Kwale, Kilifi and Lamu. The supervision targeted 22 High Volume Facilities (HVFs)[12]. The program also conducted CMEs in Kwale and Mombasa targeting QITs and WITs. The 89 participants were drawn from Kinango, Kwale and Lungalunga sub county hospitals in Kwale and Ganjoni dispensary in Mombasa. The project provided TA on the implementation of KQMH and development of QI projects. Jointly with the sub county teams, the project also mentored WITs on problem statement, change ideas and indicator definition to enhance QI projects implementation.

i) Cascade review meetings

To ensure that health care workers use data to inform clinical decisions and improve service delivery, *Afya Pwani* has supported facilities to conduct cascades review meetings where they discuss their performance based on the 90:90:90 targets. 55 service providers (M-21, F-29) from eight facilities in Kilifi[13] participated in their facility level review meetings while 11 facilities in Mombasa[14] and 11 health facilities in Kwale[15] held clinical cascade review meetings in the quarter. In Taita Taveta County, 4 clinical cascade review meetings were conducted at the Sub County level.

The project supported Lamu CHMT to conduct one cascade review meeting which was attended by health care workers mostly clinical officers, nurses and lab technicians from high volume facilities (Lamu County Hospital, Mpeketoni Sub County Hospital, Witu health Centre, Faza Sub County Hospital). Key areas addressed in this meeting include 90:90:90 performance with emphasis on identification of positives, initiation of HAART to client identified positive, Retention, Viral load uptake, suppression, issues affecting quality of samples collection at the facility levels, packaging and transportation of samples to the testing laboratory.

ii) Standard package of care for PLHIV (Adults)

Afya Pwani continued its collaboration with the 5 supported CHMTs to ensure that PLHIV in the project supported facilities receive quality services as per the national guidelines. The PLHIVs received PHDP services, specific opportunistic infection screening and prevention, reproductive health services and NCD screening and management, nutritional services, mental health screening, management and prevention of other infections appropriately.

iii) Positive Health, Dignity and Prevention (PHDP) services

Positive Health, Dignity and Prevention (PHDP) helps people living with HIV lead a complete and healthy life and reduce the risk of transmission of the virus to others. PHDP is characterized by its systematic delivery of a range of combination, behavioral, and sociocultural services within local communities. Peer educators provide group and individual counseling, facilitate referrals, and conduct home-based visits. They are HIV-

[12] Kilifi County Referral Hospital, Mtwapa Health Center, Malindi SCH, Gongoni Health center, Vipingo Health Center, Muyeye Health Center, Mariakani SCH, Baolala Health Center, Vitengeni Health Center, Rabai Health Center, Marafa Health Center, Lamu County Hospital, Mpeketoni SCH, Kizingitini dispensary, Mokowe health center, Faza SCH, Diani health center, Kinango SCH, Kwale SCH, Mkongani Health center, Tiwi Health Center, Lunga Lunga SCH, Msambweni County referral hospital.

[13] Ganda, Gede, Matsangoni, Malindi Hospital, Kilifi Hospital, Bamba Sub County Hospital, Mariakani Hospital, Jibana Sub

[14] Magongo, Likoni, Shika Adabu, Port Reitz, Tudor, Ganjoni, Bamburi, Mlaleo, Kisauni and Mikindani County Hospital

[15] Msambweni, Kwale, Lungalunga and Kinango Hospitals, Tiwi, Diani, Kikoneni, Kinondo, Mkongani, Samburu health centers and Vitsangalaweni

positive, whose adherence to treatment and clinical visits is excellent and are trained in the basics of HIV, behavioral risk reduction, treatment adherence and psychological support.

During the period, 2,609 adolescents (M-939; F-1,670) were reached through adolescents' support groups, pediatric support groups and caregiver support groups as well as PMTCT, general support and discordant couples support groups. The project's strategy to utilize the support groups and case management has proved to be effective in improving treatment adherence. During the period, the project intensified the use of caregiver support groups to reach out to guardians of children living with HIV(CLHIV) as a facilitation of adherence, disclosure and family support. 1,035 care givers (M-308, F-727) were reached with information on treatment adherence, good nutrition and disclosure issues. Because of this intervention most caregivers can disclose their HIV status.

In Kwale County, the project works closely with Kenya network of HIV Positive Teachers(KENEPOTE) where schools are regularly sensitized on HIV AIDS information, stigma reduction, adherence to ART, disclosure, care and support for children living with HIV. During the reporting period, the following schools were reached (Gandini Primary, Majengo Primary, Mwache Primary, Vikolani Primary, Makuluni Primary, Miguneni Primary, Shimoni Primary, Mwazaro Primary and Kichaka Mkwaju Primary). There are teachers groups in Kinondo with 36 (M-15,F-21) members, Lungalunga with 30 (M-14, F-16) members, Kikoneni with 20 (M-8, F-12) members and Mkongani with 25 (M-9, F-16) members under this network that collaborate with the project.

Health education sessions were conducted in 15 sites[16] in Kilifi County reaching a total of 6,851 (M-2,678; F-4,173) and 11 Facilities[17] in Kwale County. Additionally, 32 PLHIV support groups, met monthly and conducted 96 sessions reaching 801(M-283, F-518) in Kwale. To reach adolescents in the same County, 7 peer support groups based in Msambweni, Tiwi, Kinango, Mazeras, Samburu, Kwale and Diani meet monthly conducting 15 sessions reaching 107(M-43, F-64) peers. These have helped adolescents living with HIV cope with fear, hopelessness, stigma and discrimination. In Mombasa County, 15 facilities conducted 46 support groups sessions reaching 114 clients (M-41, F-73) who benefited from the PHDP sessions held in the facilities that were guided by 48 CHVs and 8 peer educators with support from *Afya Pwani* staff.

During the period under review, *Afya Pwani* supported men only support groups at Tudor Sub County Hospital, Mikindani, Likoni and Bokole CDF Health Centers reaching 118 men. They shared their experiences, challenges and were more willing to disclose and share amongst other men than within a mixed adult's session. Plans are in place to scale up to more facilities in the coming year. In Kilifi County, similar sessions for men were also conducted reaching 94 men and will be scaled up to other facilities whereas in Kwale County six men support groups were supported in Kinondo, Msambweni, Kinango, Kikoneni, Lungalunga and Gombato, reaching 113 men.

iv) Treatment Literacy sessions

Treatment education teaches people to know how to live with their HIV status, explains how to get access to treatment, offer information on drug regimens, offer support and ideas for adhering to treatment and helping others to do so, emphasizes the importance of maintaining protective behaviors and healthy living, and suggests strategies for overcoming stigma and discrimination and gender inequality. *Afya Pwani* in Mombasa County, sensitized HCWs in 21 Facilities[18] on the importance of treatment literacy sessions to PLHIVs reaching 96 HCWs (M-42, F-54). Peer educators and clinical staff based at the CCC conduct treatment literacy sessions daily for clients at the CCC waiting bays, messages shared are on importance of adherence,

[16] Rabai, Mariakani, Chasimba, Mtwapa, Vipingo, KCH, Matsangoni, Gede, Muyeye, Malindi, Marafa, Mambrui, Gongoni, Marereni, Ganze and Bamba
[17] Kwale, Msambweni, Diani, Mkongani, Tiwi, Lungalunga, Vitsangalaweni, Kikoneni, Kinango, Mazeras and Samburu health facilities
[18] CPGH, Portreitz Reitz, Tudor SCH, Likoni SCH, Magongo HC, Mlaleo CDF, Bamburi HC, Kisauni HC, Utange Disp, Kongowea HC, Ganjoni Clinic, Railways Disp, Mvita Clinic, Mikindani HC, Jomvu Model, Miritini CDF, Bokole CDF, Chaani Disp, Likoni Catholic, Mrima HC, Shikaadabu Disp

condom use, partner testing, family testing, management of opportunistic infections, stigma and discrimination and nutritional information. Kwale County reached 4,320 (M-1,927; F-2,393) PLHIV with various treatment literacy messages in 21 facilities[19] with peer educators.;

v) Retention and defaulter tracing

In the reporting period, *Afya Pwani* added 2,054 PLHIV to those on ART bringing the cumulative number on ART to 48,074, with the expected current on treatment at the end of the quarter being 48,882. The project has guided facilities in ensuring close follow up of PLHIV especially the high-risk ones so that at every moment the facilities can account for their clients. This has been made successful through expansion and strengthening of case management.

Table 7 Retention rates July- Sept 2018

RETENTION Q4 FY18							
	TX_CURR Q3	TX_NEW Q4	Deaths	Transfers out	EXP TX_CURR	TX_CURR Q4	Variance
Kilifi	15863	624	28	70	16389	15890	-499
Kwale	8151	413	7	21	8536	8285	-251
Lamu	1338	46	6	16	1362	1359	-3
Mombasa	17362	721	16	72	17995	17827	-168
Taita Taveta	4513	250	45	118	4600	4713	113
Afya Pwani	47227	2054	102	297	48882	48074	-808

Every service delivery point that is providing ARVs for patients is expected to have a functional system for identifying patients who miss appointments and to guide them to act within 24 hours of a missed appointment. The defaulter tracing process involves patient appointment booking, transfer of missed appointment to follow up register at the end of each day, call clients or treatment buddy within 24 hours. Returnees within seven days to counseled and continue with care. Defaulters are physically traced after prioritization. The follow up details are documented, and outcomes discussed by the facility team.

During the period, 4 peer educators and mentor mothers identified and tracked clients and mother baby pair respectively who had dropped out of care at key points along the cascade and followed them up by telephone through SMS and calls. Clients who could not be traced successfully via telephone were referred onwards to the CHVs for home tracing. This is done to reduce the number of clients, pregnant mothers or mother-baby pairs who default from care at critical time points in the treatment cascade. Defaulter tracing also helps to identify key factors that lead to defaulting, for program analysis and problem solving. Through this approach, peer educators and mentor mothers can scan through the appointment books/IQ care after every clinic to

[19] Kinondo, Msambweni, Diani, Tiwi, Kwale, Mkongani, Lungalunga, Ng'ombeni, Mwaluphamba, Gombato, Ukunda Catholic, Magodzoni, Shimba Hills, Kizibe, Waa, Lukore, Vitsangalaweni, Kikoneni, Samburu, Mazeras and Kinango.

identify those on missed appointment and subsequently implement defaulter tracing mechanism. The defaulter tracing process for all the Counties is shown below.

Table 8 Defaulter Tracing July- Sept 2018

Defaulter Tracing, July -Sept 2018						
County	**Total missed appointments**	**Traced/returned to care**	**Success rate in tracing back**	**Deaths**	**Transfer out**	**Still on follow up**
Kilifi	1686	1509	90%	28	70	149
Kwale	201	161	80%	7	21	69
Lamu	107	74	69%	6	16	11
Mombasa	1246	1013	81%	16	72	173
Taita Taveta	414	235	56%	12	127	123
Afya Pwani	3654	2992	82%	69	306	525

To further improve retention, three facilities in Mombasa County are utilizing EMR inbuilt SMS platform to remind clients of their missed appointments and encourage them to visit the facility as soon as possible.

vi) Nutrition assessment counselling and support (NACs):

As per the national ART guidelines, every PLHIV should receive Nutrition Assessment Counselling and support (NACs) at every clinical visit. To ensure that nutritional commodities are available for all the needy clients, the project support Sub County nutritionist for Matuga Sub County in Kwale County to re-distribute nutrition commodities to sites In Matuga sub county which were reporting stock out of the same. The facilities that benefitted were: Mkundi, Mwaluphamba, Mwaluvanga, Msulwa and Kibuyuni dispensaries. In Lamu, the project supported the CHMT to mentor HCWs on nutritional services and mental health screening, PLHIVs in all the 15 project supported ART sites have benefited from nutritional assessment, counselling, and support tailored to the individual needs of the patients. 10 BMI wheels were distributed to health facilities. counselling, allocation of nutrition duties and responsibilities, technical guidance and corrective actions. In Mombasa County, the project supported CHMT to mentor HCWs on nutritional services for PLHIVs in 11 sites[20] have benefited from nutritional assessment, counselling, and support tailored to the individual needs of the patients.

Mentorship and OJT was done in 10 facilities[21] in Kilifi and 10[22] in Taita Taveta reaching 20 (M-8, F-12) and 22(M-9, F-13) respectively. Nutrition targeted CMEs were conducted in Kwale, Kilifi and Mombasa Counties reaching 240 (M-54, F-186) health care workers with topics such as anthropometric measurements, Critical Nutrition Practices in HIV and TB being discussed. To enhance coordination for nutrition services, two coordination forums were held in Kilifi and Taita Taveta Counties with 24 (M-10, F-14) and 28 (M-7, F-21) health care workers participating.

[20] CPGH, Portreitz Reitz, Tudor SCH, Likoni SCH, Magongo HC, Mlaleo CDF, Bamburi HC, Kisauni, Utange, Kongowea and Ganjoni
[21] Takaungu, Kadzinuni, Roka Maweni, Tsangatsini, Kinarani, Kakuyuni, Mnarani, Chasimba, Oasis and Jaribuni
[22] Mwashuma HC, Msau, Mwambirwa, Shelemba, Saghainghu and Kiangachinyi Dispensaries, Ndovu, Moi Voi, Mwatate and Taveta

vii) Differentiated care service delivery

Afya Pwani has scaled up the implementation of DSD to reach 51 facilities as shown in the table below, benefitting from multi-month appointments to reduce their burden of attending monthly ART clinics. All facilities shown below are implementing the Facility based Fast Model except Mwatate SH which has implemented the community ART group model with 112 clients organized in 18 groups where clients pick drugs on a rotational basis for each other as well as report on the progress of their group members to the clinicians.

Table 9 Differentiated Care Service Delivery as at September 2018

				At enrollment (before 12 months on ART)		After 12 Months on treatment		
County	Number of facilities	TX Current	Number of clients categorized	Number well	Number with advanced disease	Stable	Unstable	# on multi-months' appointments.
Kwale	13	5479	5735	311	58	1724	2859	1115
Lamu	4	1051	881	118	56	471	236	425
Mombasa	11	17363	13213	959	215	5879	6160	5137
Kilifi	11	11243	5132	708	143	3677	1839	2854
Taita Taveta	12	3451	3097	288	94	1633	1082	1200
Afya Pwani	51	35972	28524	1830	502	11147	9485	9544

viii) Case management approach

To improve quality of care and treatment for HIV patients, the project rolled out case management approach to supplement the patient file case management already being undertaken in the care and treatment of the patients. Priority cohorts which includes all pediatrics, adolescents, PMTCT mothers and the unsuppressed PLHIVs have been enrolled in the model. A total of 63 facilities are implementing case management; 17 in Kilifi County[23], 16 in Taita Taveta[24] and 16 in Mombasa[25]. The case managers received orientation on the concept and they are to report monthly on the progress during the feedback monthly meetings. The excel dashboard helps to characterize the clients and follow them up in a better and targeted way. The project through the grantees and volunteer workforce is improving capacity for a full-fledged roll out and tracking of clients.

d) Standard package of care for adolescents

[23] Mariakani, Gotani, Rabai, Mtwapa, Vipingo, Chasimba, KCH, Matsangoni, Gede, Ganze, Bamba, Muyeye, Malindi, Mambrui, Gongoni, Marereni, Marafa. In Kwale 14 facilities (Kinondo Msambweni, Diani, Kinango, Samburu, Mazeras, Kwale, Mkongani, Tiwi, Lungalunga, Kikoneni, Vitsangalaweni, Gombato and Ukunda Catholic),

[24] (Moi CRH, Mwatate SCH, Wesu SCH, Ndovu HC, Mgange Nyika, Njukini HC, Bura HC, Kitobo Disp, Ndilidau Disp, Challa Disp, Wundanyi, Nyache HC, Eldoro Disp, Modambogho, Rekeke HC and Mbale HC)

[25] (CPGH, Portreitz SCH, Tudor SCH, Likoni SCH, Mvita Clinic, Chaani Disp, Ganjoni; Shikaadabu Disp, Railways Disp, Bamburi HC, Utange Disp, Mikindani HC, Bokole CDF, Magongo HC, Mlaleo CDF, Kongowea HC, Kisauni HC)

i) Adolescent Friendly Clinics/OTZ Clubs:

To provide services tailored for young people and improve on these outcomes, adolescent friendly clinics and recently OTZ clubs have been supported by *Afya Pwani*. Adolescent friendly clinics have been supported in 11 facilities[26] reaching 648 (M-338, F-310) AYLHIV in Mombasa, 6 facilities in Kilifi reaching 152(M-68, F-74), 10 facilities in Kwale reaching 234 (M-104, F-130), one facility in Lamu reaching 30 (M-9, F-21) and eight facilitates in Taita Taveta reaching 155 (M-63, F-92) AYLHIV. The project conducted trainings on APOC and OTZ to improve the quality of services provided to AYLHIV reaching a total of 74 (M-24, F-50) health care workers: in Mombasa 21 (M-1, F-20) in Kilifi 25 (M-11, F-14) and 28 (M-12, F-16) in Taita Taveta. The health care workers were drawn from 21 facilities[27] in Mombasa, 23[28] in Kilifi and 24[29] in Taita Taveta. The health providers were sensitized on the adolescents' package of Care and Operation Triple Zero to build the capacity by enhancing knowledge and skills in delivery of adolescent care and youth- responsive health services while contributing to the HIV strategy. The training was guided by the 2014 APOC guideline and the project will support dissemination in the facilities reached through CMEs to aid in the formation of more OTZ clubs targeting adolescents and Youth within year three.

ii) Adolescent support groups

Peer support groups provide many benefits for adolescents. They can be an important source of psychological support, helping to build confidence, resilience, reducing anxiety and promoting a sense of belonging. Because of their common experiences, they can also help other adolescents living with HIV to cope with fear, hopelessness, stigma and discrimination, and they also learn problem solving skills. Peer support groups are also reliable sources of practical information, motivation and positive reinforcement for adherence to treatment, disclosure, sexual and reproductive health issues and addressing mental health and substance use concerns. In Quarter 4, *Afya Pwani* supported 42 support adolescent groups reaching 1484 adolescents (M-691, F-793).

Table 10 Adolescent Support Groups in Quarter 4

County	No. of groups	No. of adolescents reached
Kwale	8	229 (M-97, F-132)
Lamu	1	30 (M-9, F-21)
Mombasa	12	681 (M-357, F-324)
Kilifi	16	444 (M-197, F-247)
Taita Taveta	5	100 (M-31, F-69)
Total	**42**	**1484 (M-691, F-793)**

[26] CPGH, Mlaleo, Tudor SCH, Jomvu Model, Chaani, Likoni SCH, Mrima and Magongo Health Centre
[27] Railways, Mvita, Kisauni, Mlaleo, Mtongwe, Mikindani, Likoni, Chaani, Jomvu Model, Port Reitz, CPGH Youth Zone, Mbuta, Bokole, Likoni Catholic, Kongowea, Magongo, Tudor, Miritini, Utange and Bamburi
[28] Kilifi District Hospital, Malindi District Hospital, Mtwapa Health Center, Gongoni Health Centre, Vipingo Health Centre, Mariakani District Hospital, Bamba Sub-District Hospital, Gede Health Centre, Marereni Dispensary, Rabai Health Centre, Matsangoni Health Center, Marafa Health Centre, Muyeye Municipal Health Centre, Ganze Health Centre, Ngerenya Dispensary, Takaungu Dispensary, Mambrui Dispensary, Gotani Dispensary, Kakuyuni Dispensary, Vitengeni Dispensary, Marikebuni Dispensary, Adu Dispensary, Sosoni Dispensary, Mtepeni Dispensary
[29] Taveta Sub-County Hospital, Kitobo Dispensary, Njukini Health Centre, Ndilidau Dispensary, Rekeke Model Health Centre, Challa Dispensary, Mwatate Sub- District Hospital, Bura Dispensary Taita, Kwamnengwa Dispensary, Modambogho, Maktau Health Centre, Wesu District Hospital, Wundanyi Sub District Hospital, Mgange Nyika Dispensary, Mbale Health Centre, Moi County Referral Hospital, Tausa Health Centre, Buguta Health Centre, Ndovu Health Centre, Sagalla Health Centre, Maungu Model Health Centre, Kasigau Health Centre

e) Standard package of care for children

i) Caregivers training and sensitization meetings:

Care givers are the backbone of effective HIV care and support for children and adolescents living with HIV. They have a critical role in the prevention and treatment: not just in the home, but also in the community and at school; beyond just caring for the infected child, but also in delivering medicine, adherence and pyscho-social and nutritional support. The trainings across the Counties focused on building the knowledge base and skills of care givers to execute their roles effectively, which includes; talking to the children about their HIV status and taking them for testing, identifying health facilities for treatment and taking the child for health checks and monthly clinical visits to the CCC for ART, ensuring the child has taken medication and eats well, motivating children to take responsibility for illness and treatment, talking to others around the child's life about importance of treatment (e.g. teachers and community workers); Preparing the child to face, respond and protect themselves from stigma. By applying the ELSIE approach at parenting, both parents and child can nurture healthy relationships, involves Empathizing, Listening, Self-control, Influencing and Encouraging. In the concluded quarter, *Afya Pwani* supported caregivers training across all the 5 counties reaching 1035 care givers (M-308, F-727).

f) Treatment Monitoring

i) Viral Load Uptake

As at the end of September 2018, the project had done Viral Loads (VLs) for 46956 clients of the 47,140 PLHIV that were on ART as at March 2018, an uptake of 99.6% with 85% of them being suppressed.

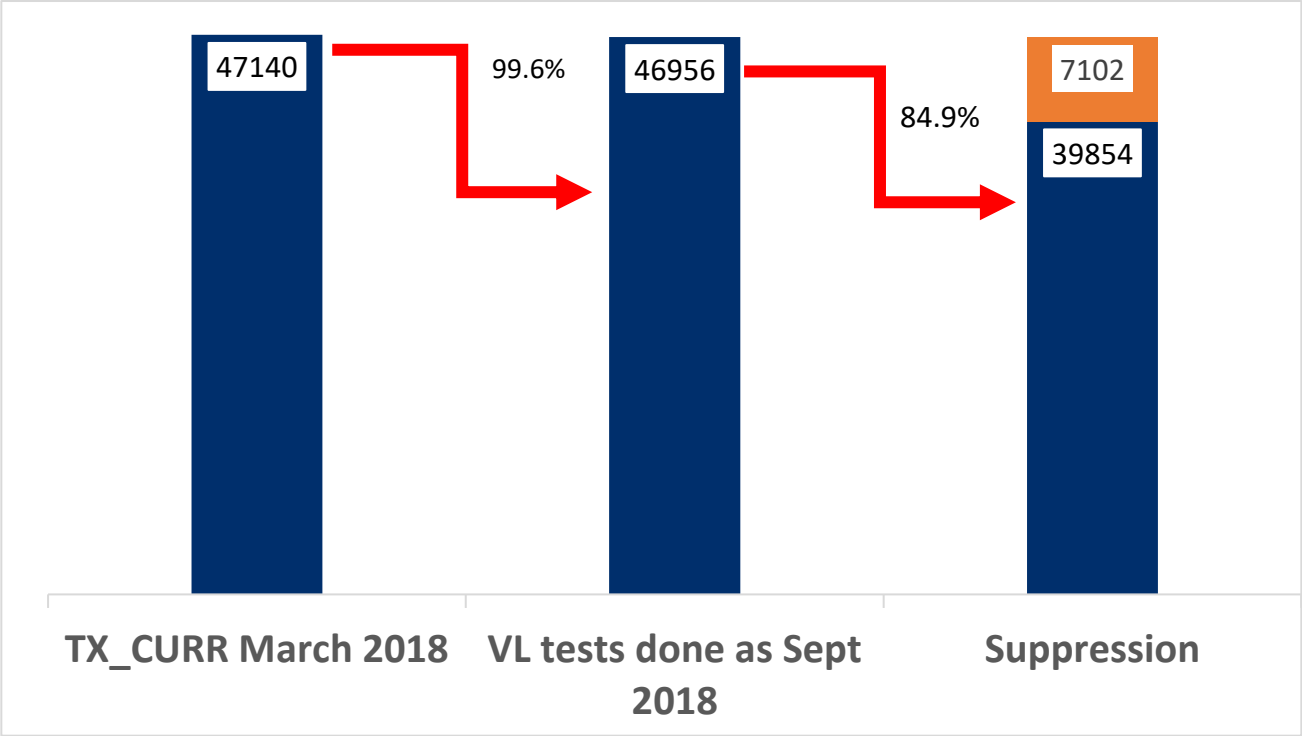
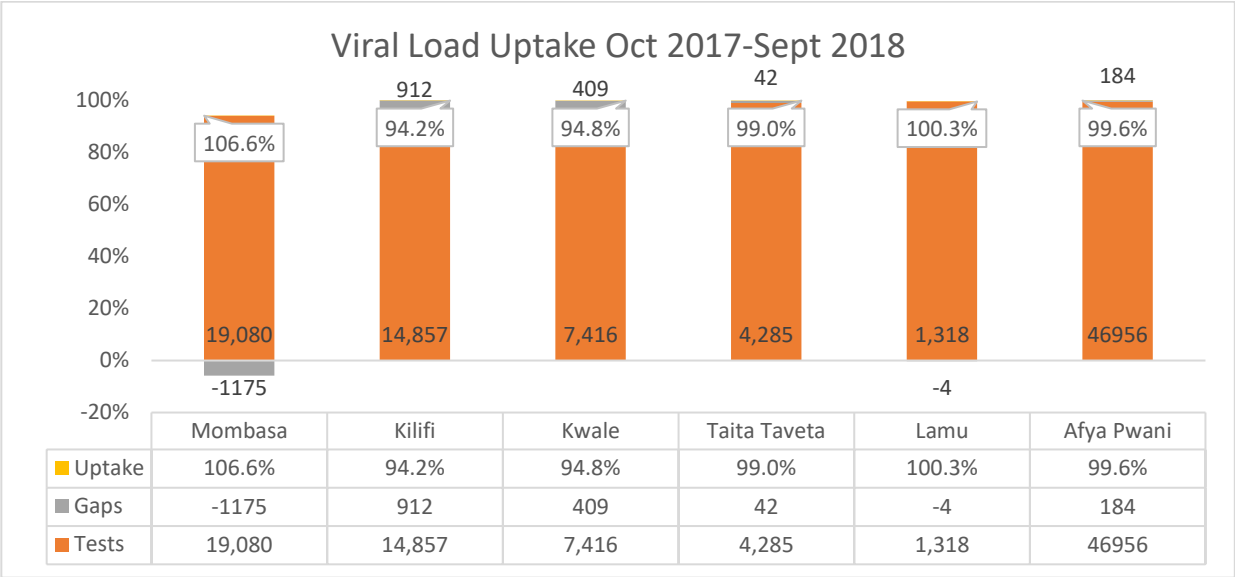


Figure 9 Viral Load Monitoring FY 18.

The uptake for VL in all the counties was above 90% as shown in the chart below.



	Mombasa	Kilifi	Kwale	Taita Taveta	Lamu	Afya Pwani
Uptake	106.6%	94.2%	94.8%	99.0%	100.3%	99.6%
Gaps	-1175	912	409	42	-4	184
Tests	19,080	14,857	7,416	4,285	1,318	46956

Figure 10 Viral load uptake Oct 2017- Sept 2018

To improve on the uptake of viral load among PLHIV, the project supported facilities to line list their clients and those who were due for VL were called for sample collection. Demand creation for VL was done among PLHIV through health education sessions, in support group meetings and one on one counseling sessions with peer educators and clinicians. The importance of Viral Load testing has been a permanent topic in support group meetings supported by the project to not only create demand for VL but also promote adherence through championing VL suppression as a treatment goal for each member of the support group. *Afya Pwani* also did on the job training for health care providers on workers on quality and safe collection, packaging, labeling and transportation of viral load samples in addition to continued support for laboratory networking.

ii) Suppression

Overall, the viral load suppression across all *Afya Pwani* supported Counties is 85%. Kilifi and Mombasa Counties posted suppression rates of 85.7% and 87.4% respectively. Lamu County posted the lowest suppression rate of 76.3% but this is however on an upward trend compared to previous years.

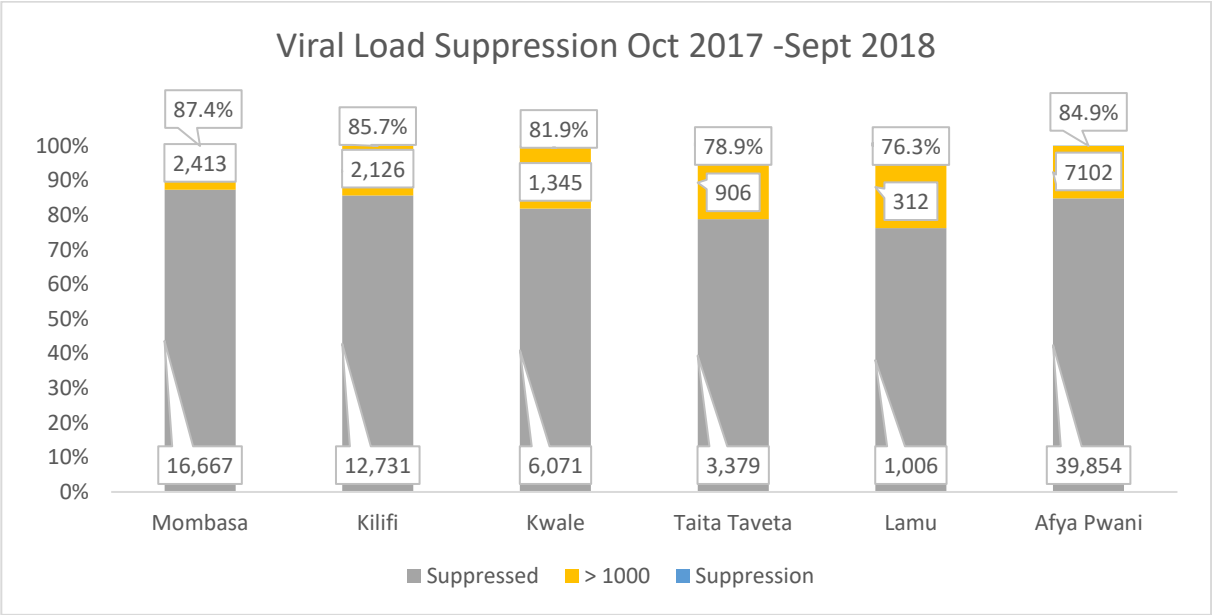


Figure 11 Viral load suppression Oct 2017- Sept 2018

To improve viral load suppression, *Afya Pwani* has supported the functioning of multi-disciplinary teams, unsuppressed PLHIV support groups and viremia clinics.

iii) Multi-disciplinary team meetings

To harness the benefits of all available expertise at the facility to improve clinical outcomes of unsuppressed clients, the project continued to support and guide facilities to conduct multi-disciplinary meetings in all the five supported Counties. In Kilifi County 13 high volume facilities[30] ,13 facilities[31] in Mombasa, 17 facilities in Kwale[32] and 12 facilities[33] in Taita Taveta were supported to discuss the management of both unsuppressed and complicated PLHIV cases in their CCCs.

iv) Viremia Clinics

Afya Pwani has supported the establishment of viremia clinics to provide customized care to unsuppressed PLHIV which are closed linked to support groups for the unsuppressed. As shown in the table below, 17 facilities[34] in Kilifi,16[35] in Taita Taveta, 14 in Kwale[36] , 22 in Mombasa[37] and 5 in Lamu[38] were supported to serve 2655 unsuppressed PLHIV.

[30] Muyeye, Marereni, Bamba, Chasimba, Ganze and Matsangoni Gede, Gongoni, Kilifi, Malindi, Rabai, Vipingo, Mtwapa and Mariakani,
[31] CPGH, Ganjoni, Kisauni, Tudor, Portreitz. Likoni, Kongowea, Bamburi, Magongo, Mikindani, Mlaleo, Chaani and Bokole
[32] Kinondo Kwetu Community Dispensary, Lungalunga SC Hospital, Kinango SC hospital, Tiwi RHTC, Diani Health Center, Samburu Health Center, Msambweni County Referral, Kwale Hospital, Mazeras Dispensary, Kikoneni Health Center, Mkongani and Vitsangalaweni.
[33] Moi CRH, Mwatate SCH, Wesu SCH, Wundanyi SCH
Taveta SCH, Bura HC, Njukini HC, Ndovu HC, Challa Disp, Kitobo Disp, Werugha HC and Ndilidau Disp
[34] Vipingo Health Center, Rabai Health Center, Oasis Medical Center, Mtwapa Health Center, Matsangoni Health Center, Mariakani Hospital, Marereni Dispensary, Marafa Health Center, Muyeye Health Center Malindi Hospital, Kilifi County Referral Hospital, Gongoni Health Center, Gede Health Center, Ganze Health Center, Chasimba Health Center and Bamba Sub County Hospital
[35] Buguta, Bura, Challa, Eldoro, Ghazi, Kasigau, Kitobo, Mbale, Moi, Mwatate, Ndovu, Njukini, Rekeke, Wundanyi, Taveta, Wesu
[36] Msambweni county Referral Hospital, Diani Health center, Vitsangalaweni, Kwale Hospital, Tiwi Health center, Mkongani Health Centre, Lungalunga, Kikoneni, Kinondo Kwetu, Kinango Hospital, Samburu Health center and Mazeras Health center.
[37] Railways, Mvita, Kisauni, Mlaleo, Mtongwe, Mikindani, Likoni, Chaani, Jomvu model, Port Reitz, Bokole, Likoni Catholic, Kongowea, Magongo, CPGH Youth Zone, Mbuta, Tudor, Miritini, Utange and Bamburi Mrima and Miritini)
[38] Lamu Hospital, Mpeketoni Hospital, Pablo Hortsmann, Faza and Hindi Magogoni Health Center.

Table 11 Viremia Clinics and MDTs as at end of Sept, 2018

County	# of facilities with Viremia Clinics	# enrolled in Viremia Clinics	#of clients discussed in MDTs
Kilifi	17	1053	412
Kwale	10	304	337
Lamu	5	98	77
Mombasa	22	874	103
Taita Taveta	16	326	102
Afya Pwani	70	2655	1031

v) Unsuppressed PLHIV support groups:

The Project continued to support service providers to offer psychosocial support to virally unsuppressed clients through a prescribed minimum package of PHDP services to reduce stigma, encourage appropriate disclosure and adherence to treatment. During these sessions, clients were taken through enhanced adherence counselling while assessing the possible barriers to adherence and review psychological, emotional, and socio-economic factors that may have contributed to poor adherence. The support group sessions were conducted on the same day as the clients' Viremia clinic day to encourage attendance of both the sessions appointments to provide psychosocial support to unsuppressed clients, *Afya Pwani* has facilitated support groups for unsuppressed clients that are linked to viremia clinics. The project supported the management of 1498(M-642, F-856), 162(M-73, F-89), 331(M-131, F-200), 405(M-178, F-227) and 600(M-260, F-340) unsuppressed PLHIVs in Taita Taveta, Kilifi, Kwale and Mombasa Counties respectively.

g) Strengthening laboratory services:

i) Improved laboratory commodity management

During the reporting period, the project supported laboratory mentorship and commodity management in nine facilities[39] in Kilifi County in addition to providing technical assistance to Taita Taveta, Mombasa, Kilifi, Kwale and Lamu Counties in Quarterly RTK allocation exercise.

ii) Strengthening the quality of laboratory services:

Afya Pwani supported Quarterly Sub County Laboratory Coordinators meeting for Kwale, Taita Taveta and Lamu Counties. The issues addressed during the meeting included: efficient sample referral networks for both viral load and sputum for GeneXpert, reducing sample rejection rates, proficiency testing and corrective measures for failed testers. The project also conducted laboratory mentorship on continuous quality improvement (CQI), laboratory biosafety, test SOPs, test interruptions, waste management, injection safety, blood safety and appropriate filling of viral load forms in 16 facilities[40]. Mentorship was also offered to 33 health providers (M-19, F-14) on safe collection and transportation of Viral Load samples and blood safety for 16 facilities[41]. *Afya Pwani* conducted OJT and supported mentorship on quality, safe collection and transportation of viral load samples at Tiwi HC, Mgange Nyika and Njukini HC reaching 4(3M,1F) health care

[39] Msambweni SCH, Kinango SCH, Diani Hospital, Tiwi HC, Kwale CRH, Rabai HC, Mariakani SCH, Gotani HC, Chasimba HC
[40] Msambweni SCH, Kinango SCH, Diani Hospital, Tiwi HC, Kwale CRH, Rabai HC, Mariakani SCH, Gotani HC, Chasimba HC, Moi Voi CRH, Taveta SCH, Mwatate SCH, Wesu SCH, Wundanyi SCH, Mgange Nyika HC, Njukini HC
[41] Msambweni SCH, Kinango SCH, Diani Hospital, Tiwi HC, Kwale CRH, Rabai HC, Mariakani SCH, Gotani HC, Chasimba HC, Moi Voi CRH, Taveta SCH, Mwatate SCH, Wesu SCH, Wundanyi SCH, Mgange Nyika HC, Njukini HC

workers and building their capacity on specimen collection, packaging and labeling. The project supported laboratory staff meetings in two Sub Counties of Taita Taveta County where a total of 19 (M-15, F-4) lab staffs attended. Issues addressed included how to avoid RTK stock outs through proper commodity management, efficient sample referral networks for both viral load and sputum for GeneXpert, reducing sample rejection rates, HIV testing discussion to increase uptake and get new positives, proficiency testing and corrective measures for failed testers.

iii) CPGH Molecular Laboratory

Afya Pwani has continued to provide both staffing and logistical support to the CPGH molecular laboratory which conducts the viral load and EID tests for the Coast region. In the concluded Quarter, 23,115 VL tests and 2,695 EID tests were done at the lab as shown in the table below. The laboratory has maintained turnaround time of less than 8 days from sample collection to dispatch of results.

Table 12 EID tests done during the Quarter

Month	Total Samples Received	Rejected Samples	Tested Samples (Including Repeats)	Valid Positive/Negative Results	Positive	Valid Negative Results	Failed Samples/ Results
July	877	6	860	796	37	759	0
August	813	1	902	823	40	783	0
September	862	0	933	866	40	823	0
Total	**2552**	**7**	**2695**	**2485**	**117**	**2365**	**0**

Table 13 Viral load tests done during the Quarter

Month	Received Samples	Rejected Samples	Non-suppressed	Virally Suppressed	Repeats	Total Tests Done (including repeats)
July	7511	9	762	7141	33	7936
August	7386	0	747	6734	112	7593
September	7598	0	523	6964	99	7586
Total	22495	9	2032	20839	244	23115

Viral load tests done during the Quarter

Lessons learnt

1. Proper RTK quantification and forecasting by facilities and working closely with CMLCs and SCMLCs ensures continuous availability of this commodities leading to uninterrupted service delivery.
2. Continuous OJT and mentorship is key to improving knowledge and skills

3. Regular support supervision plays an important role in improving quality of Care and treatment services offered in facilities

4. Empowering service providers to access results from the NASCOP VL dashboard reduces turn-around time and motivates service providers.

5. Having case managers for clients with unsuppressed viral load has shown some improvement in clients adhering to medication.

Challenges

Challenges	How you overcame them
Due to high temperatures within the coast region the machines keep on breaking down due to high temperatures.	*Afya Pwani* has been purchasing the ACs for this Laboratories though the demand has been on a steady rise.
Health care workers are not updated on the 2018 ART guidelines	Planning for training TOT and facility staff in progress.
Knowledge gap on new tools	County Government recently supported Refresher training on new tools. On job training and support supervision in progress to update staff who did not participate in the Refresher training.
Remote facilities cannot access online results due to poor network connectivity.	VL and EID hard copy results will continue to be printed and sent to facilities from the nearby facilities that have printers and by the Lab Network motor rider
In adequate clinical staff in some facilities leading to unqualified health care workers attending to ART clients.	This has so far been addressed by having rotational clinicians attending to clients during clinic days

Output 1.4 HIV Prevention and HIV Testing and Counseling

a) Gender and prevention

During the the reporting period, 73 health providers were trained on the adolescent package of care and Operation Triple Zero in Mombasa, Kilifi and Taita Taveta County. Sensitization sessions on GBV response/management along with stigma and discrimination at facilities were conducted at the following health facilities Ganjoni, Msambweni, Gombato, Lungalunga, Mazeras, Lungalunga and Kikoneni reaching 111 health providers (M-54, F-57).

Male engagement activities centered on leadership by men, demand creation for health services, support to contribute to HTS targets, advocacy for PMTCT and four ANC visits in four Counties (Mombasa, Kilifi, Kwale and Taita Taveta).

Community education and dialogue sessions were conducted aimed at HIV prevention by addressing gender norms, post-rape care services including PEP, stigma, and discrimination including practices that fuel and prevent the spread of HIV and poor uptake of health services reaching 268 people (M-74, F-194). 307 adolescents and youth aged 15–24 years were reached to enhance the access and utilization of the standard package of care for adolescents and youth including SRH services.

One safe space known as *Mahali Pa Usalama* in Tudor Nora for SGBV survivors was identified out of the five pre-qualified potential safe spaces to be strengthened to support more GBV survivors to enhance access to services in the multisector response cascade specifically, legal services, psychosocial support and safety and security.

b) Specific needs of adolescents and young people addressed

i) Adolescents Package of Care and Operation Triple Zero (OTZ) training

In Mombasa County, a three-day training was conducted reaching 21 health care workers (M-1, F-20) within the quarter. The participants represented 20 health facilities namely: Railways, Mvita, Kisauni, Mlaleo, Mtongwe, Mikindani, Likoni, Chaani, Jomvu Model, Port Reitz, CPGH Youth Zone, Mbuta, Bokole, Likoni Catholic, Kongowea, Magongo Tudor, Miritini, Utange and Bamburi. The health providers were sensitized on the adolescent's package of Care and Operation Triple Zero to build their knowledge and skills in delivery of adolescent care and youth- responsive health services while contributing to the HIV strategy. The training was guided by the 2014 APOC guideline and the project will support dissemination in the facilities reached through CMEs to aid in the formation of OTZ clubs targeting adolescents and Youth within year three. Deliberations revealed that because of staff shortages the mainstreamed model[42] (ref: below) offered during separate hours was preferred.

c) Mainstreamed Youth Friendly- Services

> "Whole Facility" model: non-judgmental, privacy and confidentiality. All (or most) health providers and staff offer high quality youth-responsive services as part of routine service delivery. Sometimes with special opening hours for youth. Specific demand-generation strategies for youth.

In an effort to mainstream youth friendly services, 24 health care workers from 23 facilities were trained on Adolescent Package of Care (APOC) and Operation Triple Zero (OTZ). A similar training was also done in Taita Taveta reaching 28 participants from 24 facilities. it is envisaged that OTZ clubs will be established in the first Quarter of year III of the project.

[42] any provider, whether they offer contraceptive services, STI services, HIV treatment and care, maternity services, The mainstreamed YFS model involves all units/departments of a health facility and the staff providing services. The model accommodates provision of other SRH services, primary care services, or any other type of health service are non-judgmental to all young clients, ensure privacy and confidentiality, and offer quality counseling and
referrals to other services if needed.
Additional demand generation strategies are required to attract and retain young clients such as peer educators on site and in the community, tailored IEC materials, publicity of special hours for youth consultations, promotion of the services among young people in the facility catchment area, and engagement with gatekeepers to reduce social barriers to service seeking.

i) Psychosocial support for adolescents and youth (GBV survivors) from the CPGH - GBVRC and the Youth Zone

During the reporting period, the project supported a psychosocial support session for GBV survivors who are adolescents and Youth along with their care givers. The sessions focused on trauma counselling and life skills guided by the GBV Management Manual and the *Tuko Pamoja* Manual (Adolescent Reproductive Health and Life Skills Curriculum). This is due to the growing recognition of the importance of helping young people build mental resilience, from the earliest ages, to cope with the challenges of today's world. Evidence is growing that promoting and protecting adolescent health brings benefits not just to adolescents' health, both in the short- and the long-term, but also to economies and society, with healthy young adults able to make greater contributions to the workforce, their families and communities and society. Out of the 46 participants who attended the sessions on this day there were 20 reported GBV cases that have had the perpetrators executed without the victims escaping, families being bribed, or cases withdrawn due to many reasons. This was made possible with the good will of legal support organizations that work with the CPGH - GBVRC. A total of 46 adolescents and youth survivors 10-24 (M-9, F-37) were reached as well as 55 caregivers aged 25-60 years (M-17, F-38). The Youth Zone has one part time volunteer psychologist who also manages clients from the GBVRC hence, the management of the Youth Zone and the GBVRC through CPGH, plan to make a formal request to the project to support the following aspects of GBV response at CPGH: employ a part time or full time medical officer at the CPGH GBVRC to attend to the increasing number of clients they have and aid in case management, provision of legal support to the survivors and their families, employ a trauma Counsellor and a psychologist. This is due to the service delivery gap they have experienced for a long time now which compromises the quality of GBV response or post-rape care services and may contribute to poor health outcomes among the GBV survivors. Another emerging issue this year per the PGH- GBVRC, is the importance to have tailored interventions at the following areas in Mombasa as they are SGBV hotspots due to the following reasons:

In Kibarani, a number of adolescents are lured into the bush and raped; Mshomoroni and Kisauni: are hot spots and most of the survivors also come from these areas; Miritini & Jomvu: survivors come with cases of defilement, pregnancies and a lot of delinquent behaviors.

Within the quarter, 448 adolescents and youth 15-24years (M-106, F-342) reached with anti-stigma messages and GBV response messages in Mombasa County in Likoni, Shika Adabu and Mrima. Feedback revealed that self and external stigma are the main contributing factors to poor adherence among adolescents and Youth. The perception of HIV as a disease associated with promiscuity by the infected and the fear of taking the drugs for a lifetime makes the adolescents shy away from accessing HTS and contributes to poor adherence. The people were also sensitized on the availability of post-rape care services including PEP at the *Afya Pwani* supported facilities (Likoni, Mrima and Shika-adabu).

Similarly, the project, with the help of trained CHVs and the male champions in partnership with Local Administration have sensitized the community leaders and members on HIV related stigma, discrimination and SGBV response services during the chief barazas in Timbwani and Shonda areas in Likoni Sub County-Mombasa and Maweni, Kididima and Mtwapa in Kilifi South reaching 80 community members (M-45, F-35) during the sensitizations.

During the period, continuous sensitization on AYSRH including SGBV, stigma and discrimination and Youth friendly services conducted as follows: 51 youth based at Mlaleo and Port Reitz Youth friendly centers (M-33, F-18). These orientations contribute to HIV prevention through the community-facility and SGBV management referral system for prevention and management of GBV against vulnerable population groups.

A total of 386 people aged 14-24 years (M-103, F-283) adolescents and youth aged 15 – 24 years were reached with prevention and support messages to enhance the access and utilization of the standard adolescents and youth package of care (APOC) including SRH services. Local implementing partner/grantee -

HIV Free Generation (HFG)- with the help of the S/CHMT have managed to involve both gender norm sensitization meeting and carrying out of the activities at the community level. This has helped progress male involvement on sexual reproductive health issues.

In Kwale County, 30 out of school Youth (M-8, F-22) in Kosovo - Matuga were reached with prevention messages including condom demonstration and harm reduction practices. All participants were voluntarily tested and four turned HIV positive (M-3, F-1) linked to care at Diani Health Center and Ukunda Catholic (Reference HTS report).

See cumulative numbers reached within the Quarter:

Table 14 Summary of young people sensitized

County	Male	Female	Totals	Comments
Mombasa	26	75	101	46 GBV survivors reached through CPGH GBVRC
Mombasa	106	342	448	
Kilifi	45	35	80	(Mombasa and Kilifi)
Kwale				
Taita Taveta				Table name

d) Improving uptake of HIV Testing Services

During the period under review, the project continued to work in closely with County Departments of Health to provide HTS services targeting the most at risk for HIV infection. Heavy investments in high yielding strategies were employed in high yielding facilities in attempts to increase identification of those living with HIV and link them to HIV care and treatment. Monthly facility level, County and program level age and sex disaggregated data analysis was conducted to track progress, identify coverage gaps and initiate quality improvement actions. To this end, the project offered HTS to 118,366 people against a target of 83,882 with Kilifi, Mombasa and Taita Taveta Counties surpassing their quarterly targets. Kwale and Lamu Counties missed their quarterly targets by 9% and 24% respectively mainly due to inadequate number of HTS providers. The project surpassed its overall testing target for the year, reaching 454,526 against a target of 335,366 (135%).

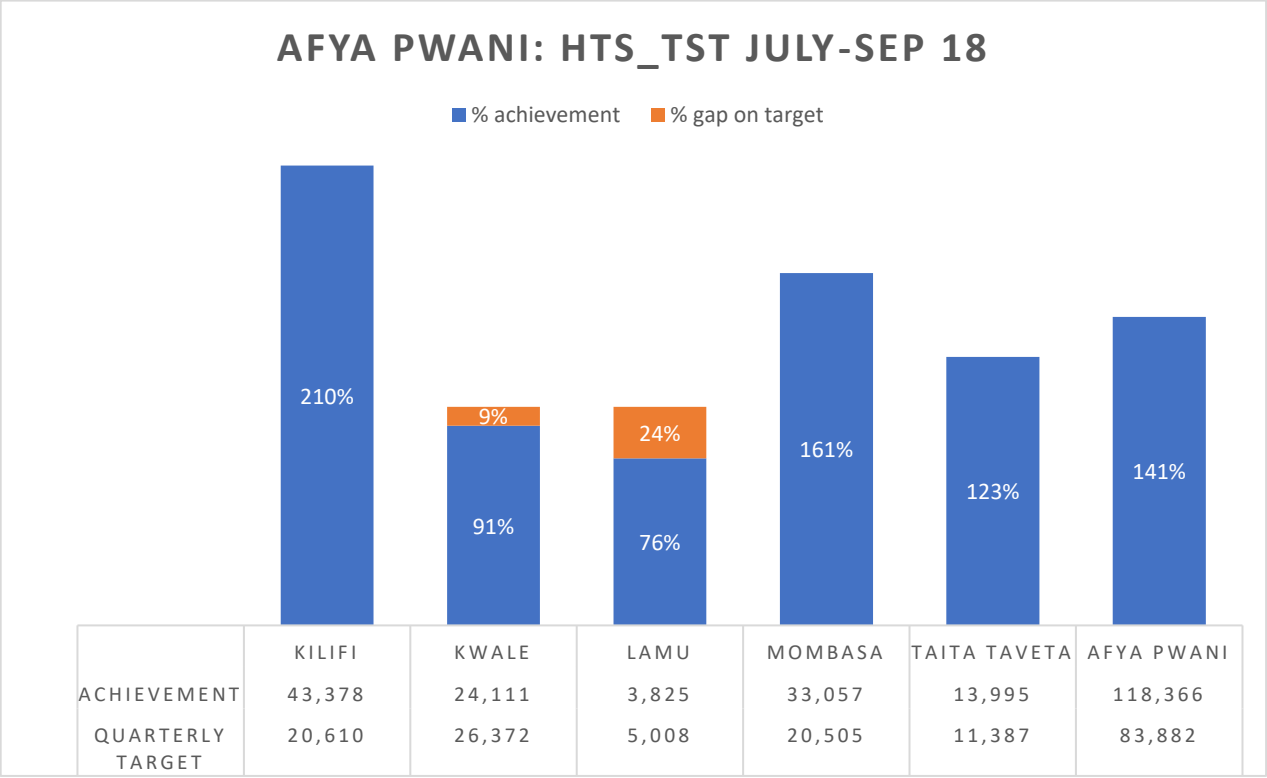


Figure 12 HIV Testing July -Sept 2018

In the concluded period, the project also tested 227% of its target for <15 years and 116% of its target for those above 15 years as shown in the table below.

Table 15 HTS by Age July -Sept 2018

	<15 years			> 15 years		
	Tested	**Quarterly Target**	**% performance**	**Tested**	**Quarterly Target**	**% performance**
Kilifi	3851	2,533	152%	39527	18,078	219%
Kwale	2526	1,844	137%	21585	24,528	88%
Lamu	220	169	130%	3747	4,839	77%
Mombasa	2738	2,854	96%	30319	17,651	172%
Taita Taveta	1546	682	227%	12449	10,705	116%
Afya Pwani	10881	8081	227%	107627	75801	116%

Afya Pwani targets to identify 2,388 people living with HIV on a quarterly basis to reach its annual 90:90:90 targets. In this reporting period, 2,324 PLHIV were identified, a performance of 97%. Of the 2,183 adults (>15 years) to be identified, the project achieved 2,135, a 99% performance rate while only 42% of the target for under 15 years old was achieved as shown in the table below.

Table 16 Identification by Age July -Sept 2018

	<15 years			> 15 years		
	Positives identified	**Quarterly Target**	**% performance**	**Positives identified**	**Quarterly Target**	**% performance**
Kilifi	50	81	62%	640	509	126%
Kwale	46	61	75%	422	764	55%
Lamu	2	4	53%	46	97	47%
Mombasa	36	91	40%	809	498	162%
Taita Taveta	7	17	42%	266	268	99%
Afya Pwani	141	253	42%	2183	2135	99%

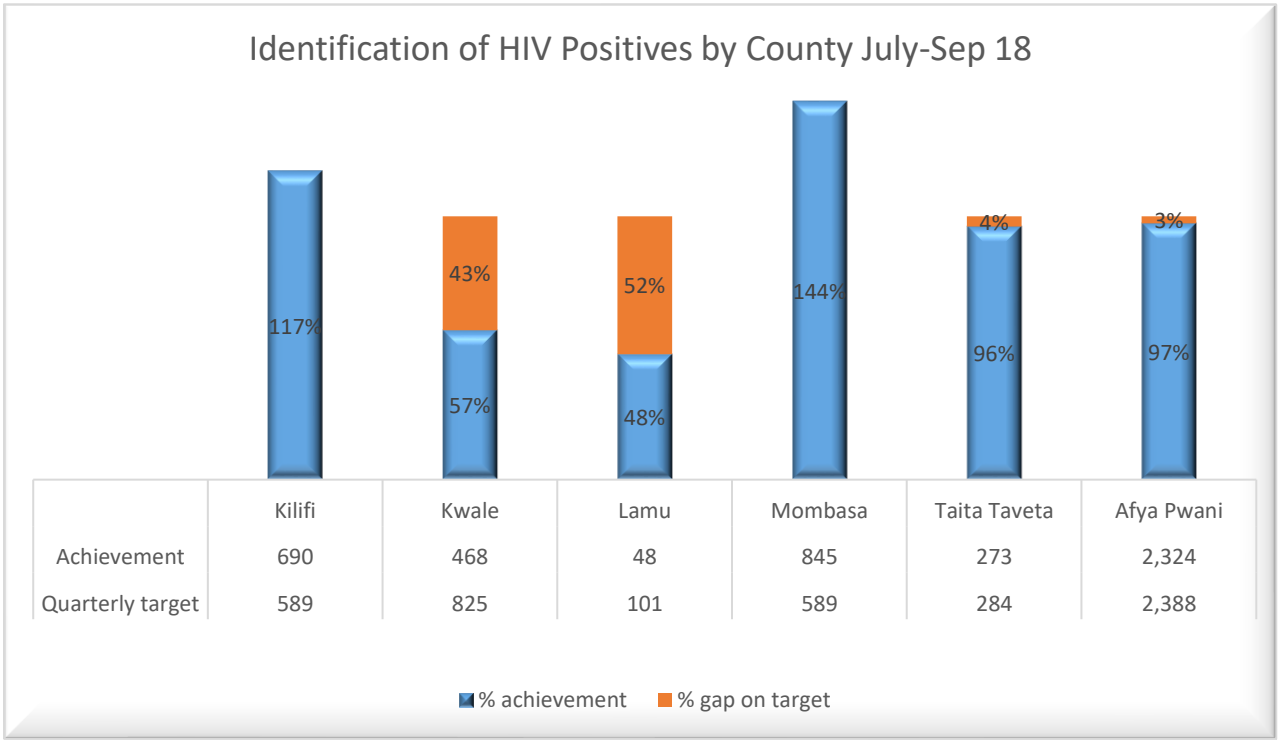


Figure 13 Identification of Positives by County July -Sept 2018

On the other hand, Mombasa and Kilifi Counties surpassed their targets for identification by 44% and 17% respectively with Taita Taveta missing its target by a mere 4% (273 out of 284). Kwale and Lamu Counties achieved 57% and 48% of their quarterly targets for identification of positives respectively. In both Counties, lack of adequate HTS providers contributed significantly to this under performance. In Kwale County, nurses continued to boycott offering HTS services with most testing being done by laboratory technical and lay HTS counselors. Nurses form the bulk of primary clinical care providers who come across most of the patients who would be prioritized for HTS. As such, hence their boycott therefore affects targeted testing hence identification.

i) Yields by Modality

The high yielding modalities are TB clinic and index client testing including a PNS. Other PITC and VCT give high yields in terms of absolute numbers. The project will continue focusing on TB clinic, a PNS as well as optimizing targeted testing in other PITC and VCT to improve on identification of positives.

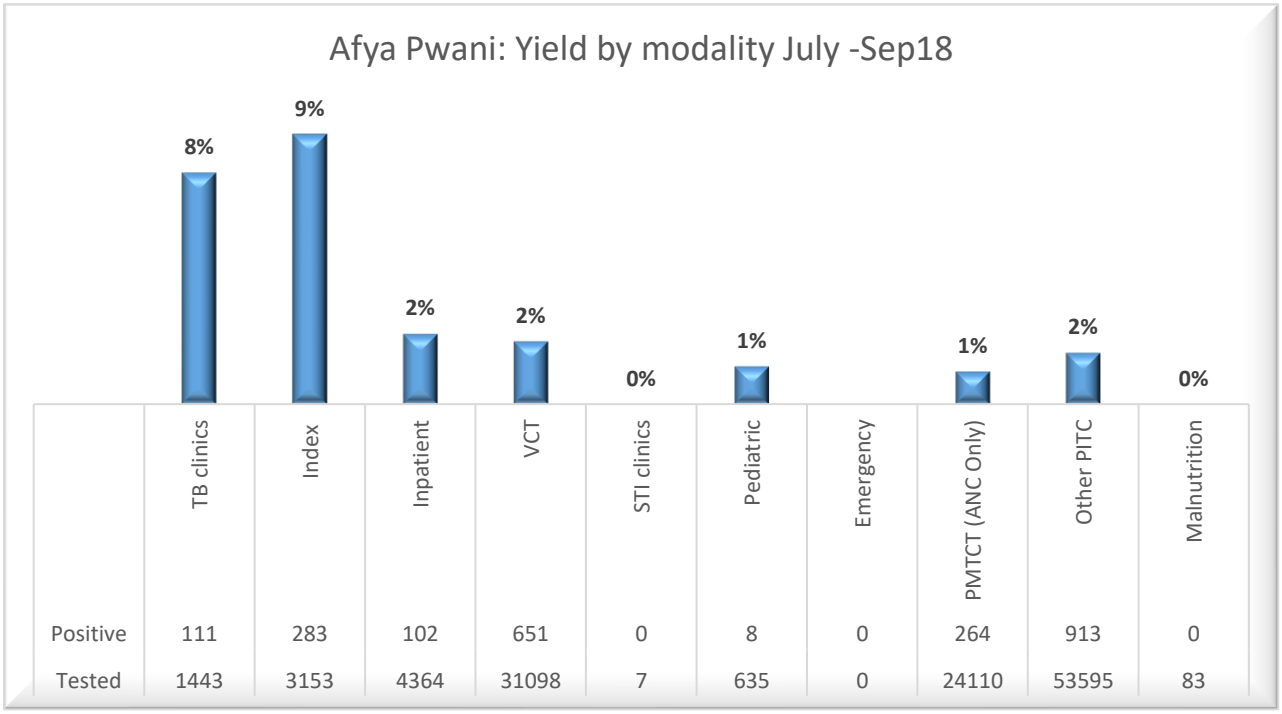


Figure 14 Yields by Modality July- Sept 2018

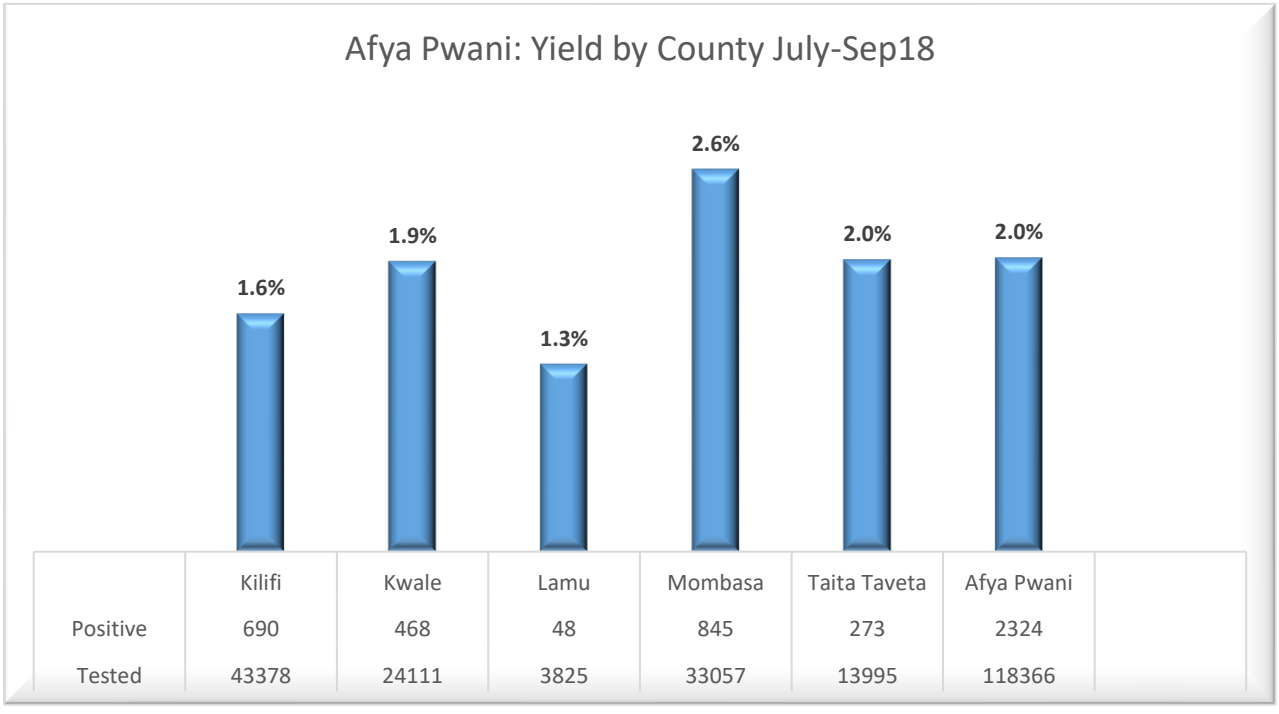


Figure 15Yeild by County July- Sept 2018

In the reporting period, Mombasa, Taita Taveta and Kwale had highest yields partly contributed by large scale adoption of a PNS. Kilifi and Lamu Counties are in the process of scaling up the modality to cover all the high yielding sites.

ii) Facility based testing

The project prioritized facility-based testing in outpatient, inpatient, TB and ANC departments since the departments give high yields in both percentage and absolute numbers especially among individuals aged above 15 years. Targeting was implemented through strict adherence to HTS screening tools in all service points to ensure testing of only individuals likely to be living with HIV and reduce on over-testing for efficiency. To scale up testing and identification, 37 lay counsellors were recruited and deployed to high volume health facilities (13 in Mombasa County, 13 in Kilifi County, 7 in Kwale County and 4 in Taita Taveta County). To create demand for HIV services, through continuous medical education (CME) sessions, HTS providers sensitized clinicians to screen and refer symptomatic patients for HIV testing alongside health talks to patients in outpatient on availability of HIV testing services and recommendation of all eligible patients for HIV test as part of health services to be taken when at the hospital.

iii) Index Client testing

As alluded in the FY 18, Afya *Pwani* scaled up index client testing services targeting newly identified HIV positive clients and virally unsuppressed patients on HAART. The number of HTS sites reporting PNS services increased to 60 in Q4. The program supported PNS sensitization meetings for County CHMTs and facility in charges to enable the teams support and champion PNS implementation as a key strategy to improve identification of PLHIV especially men and young people. The PNS sensitizations led by NASCOP and USAID, reached CHMTs members from Kwale 38 (M-25, F-13), Mombasa 45 (M-19, F-26) and Taita Taveta 32(M-12, F-20) Counties. Additionally, 24 PNS TOTs were trained with 6(M-3, F-3) being from Taita Taveta, 8 (M-3, F-5) from Mombasa, 7 (M-4, F-3) from Kilifi and 5(M-3, F-2) from Kwale County to support cascading of PNS trainings to HTS providers, offers mentorship and act as PNS champions at the county and subcounty levels. In quarter 4, the project supported PNS training for 46 (M-10M, F-36) HTS providers in Mombasa, 72 (M-11, F-61) in Kilifi, 24 (M-12, F-12) in Kwale and 69 (M-33, F-36F) in Taita Taveta County as part of the efforts to implement PNS in all the 296 HTS project sites by end of FY 19. In FY18, index client testing was prioritized as an efficient strategy for increased proportional HIV positives contribution to total positive individuals identified.

Weekly PNS site level performance data was collected and analyzed to identify scale up gaps and inform corrective actions. Significant progress and learning continue in PNS implementation at all levels. Elicitation and test uptake challenges among eligible clients were identified. To address this PNS providers were mentored in presenting a non-judgmental approach towards clients during counseling and elicitation of sexual contacts. HTS program staff and experienced champion PNS providers provided ongoing skills building and support to the newly trained in-experienced PNS providers for scale up. Regular PNS review meetings were held in Mombasa 18 (2M,16F), Kilifi 15(3M,12F) and Taita Taveta 18(M-6, F-12) Counties to offer support to PNS providers involving guided step by step on risk reduction assessment and elicitation of sexual partners. In addition, *Afya Pwani* supported PNS providers with transport and airtime to contact and reach clients who were not able to bring their contacts to the health facilities for testing.

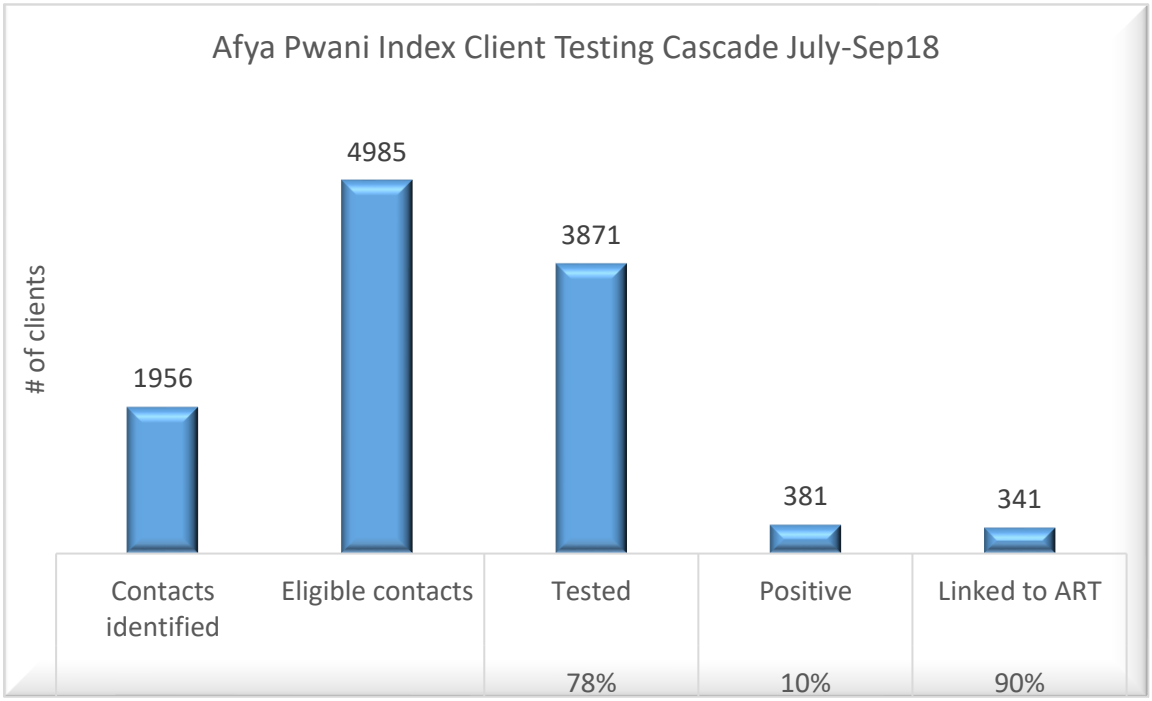


Figure 16 Index Client Testing July- Sept 2018

As evidenced in the chart above, a total of 1,956 newly identified index clients participated in PNS eliciting 5,651 contacts for testing inclusive of children of index clients. Most of those elicited were children below 15 of age (2,181) with males above 15 years eliciting more sexual contacts than females of the same age. Known HIV positive contacts accounted for 10% of the elicited (574 against 5651 of elicited contacts), uptake of HTS among elicited was 74 % (3,871 against 4,985) while HIV positivity among tested was at a high of 10% (381 against 3,871) with a high linkage of 91 % (347 out of 381) which is attributed to disclosure preparation of index client and offering of PNS at ART facilities. Adequate preparation of clients resulting in good linkage rate continues to be scaled up as a best practice for all PNS sites. There was also high yield (15%) of males above 15 years (147 out of 968 tested).

Going forward*, Afya Pwani* will pursue PNS as a strategic approach to identification of men and young people below age 30 years through mentorship of providers, supportive site supervision, printing and distribution of PNS tools as well as weekly reporting and review meetings to maintain sustained scale up, adherence to guidance and timely changes where necessary.

iv) HIV Self Testing (HIVST)

The HIVST is a screening rapid test which involves a client collecting their own oral fluid or blood specimen, performing an HIV test and interpreting their own result. The clients with HIV positive results need to undergo further HIV tests by a trained HTS provider at the health facility. This strategy targets men, sexual partners of index clients, key populations and youth. ANC mothers, PNC mothers. Clients are screened for intimate partner violence (IPV) before kits are issued to them to take to their sexual partners or injecting drug user friends. IPV screening involves screening for physical emotional and sexual violence.

Through HIVST approach, 20 project supported health facilities received 19,200 Oraquick HIVST kits from as follows; five facilities[43] in Mombasa received 8,900 kits, eight facilities[44] in Kwale received 5,500 kits and

[43] kits (CPGH 3500, PDRH 1,700, Tudor SCH 1,000, Likoni SCH 700and Jomvu HC 700
[44] Kwale hospital 1,000, Diani HC 1,000, Msambweni CRH 500, Kinango SCH 700, Lungalunga HC 700, Samburu HC 700, Kinondo Kwetu community clinic 500, and Mazeras HC 400

seven health facilities[45] in Taita Taveta County received 4,800 kits. The project supported HIV self-testing (HIVST) sensitization meetings for County CHMTs and facility in charges to enable the teams support and champion HIV self-testing implementation as a key strategy to improve identification of PLHIV among men, key population groups and young people. The HIV self-testing sensitization meetings were led by NASCOP and reached CHMTs members from Kwale 38 (M-25, F-13), Mombasa 45 (M-19, F-26) and Taita Taveta 32(M-12, F-20) Counties. Further, sensitization to HTS providers was done in Mombasa and Taita Taveta Counties reaching 53 (M-11, F-42) and 114 (M-47, F-65) respectively. The other Counties will carry out HIVST sensitizations for HTS providers in the coming quarter. HTS providers started issuing the HIVST kits in late September after the sensitizations with 175 HIVST kits having been issued in Mombasa and 194 in Taita Taveta Counties. The project will continue to support the rapid scale up of HIVST by offering mentorship to HTS providers and reaching out to men in informal employment such as tuk-tuk drivers, boda boda, matatu drivers and touts and mechanics.

v) Identification of adolescents and young people (15 – 24 years of age) (Datim)

In FY 18, *Afya Pwani* tested 35,452 (M-9173, F-26279) adolescents and young people aged 15- 24 years identifying 338 (M-59, F-279) positive individuals and linking 282 (M-50, F-232) to treatment. Facility based outpatient, Voluntary Counselling and Testing and PNS were the overarching approaches to identification of adolescents and young people. Malindi CRH, Coast PGH, Mariakani SCRH and Matsangoni Health Center offered youth friendly clinic days and weekend testing by trained youth friendly health care providers and including young trained professionals. Sub-grant community-based organizations through community action days mobilized and created demand for the youth friendly services. *Afya Pwani* will collect data and monitor contribution of the targeted services to uptake of services in subsequent reports.

The DREAMS project tested 1260 AGYW in Mombasa County identifying 4 young women living with HIV and linking 2 to HAART.

Table 17 Testing of DREAMS AGYW

AGYW tested by Age Group:	Sub County			Total
	Jomvu	Likoni	Nyali	
9-14	118	182	95	395
15-19	111	293	122	526
20-24	74	189	76	339
Grand Total	**303**	**664**	**293**	**1260**

vi) HIV testing targeting hard to reach men

The ratio of males to females testing is 1:2 across all supported Counties with a similar ratio being seen among those identified to be HIV positive. The yields are comparable among males and females except in Lamu and Taita Taveta where the yields for males are higher than for females. This can be attributed to uptake of PNS in Taita Taveta where male sexual partners of CCC clients have been reached and an increasing population of working men in Lamu County who moved in without their families getting tested.

[45] MCRH 1,000, Taveta hospital 1,000, St Joseph shelter of hope 1,000, Mwatate SCH 1,000, Wesu SCH 1,000 and Wundanyi SCH 200

Table 18 Testing by gender in quarter 4

	Tested		Positives		Yields	
	Females	**Males**	**Females**	**Males**	**Females**	**Males**
Kilifi	29,493	11,431	479	192	1.6%	1.7%
Kwale	15,292	7,222	291	141	1.9%	2.0%
Lamu	2,734	1,034	26	20	1.0%	1.9%
Mombasa	20,413	10,451	564	260	2.8%	2.5%
Taita Taveta	8,485	4,042	168	106	2.0%	2.6%
Afya Pwani	76,417	34,180	1,528	719	2.0%	2.1%

During the reporting period*, Afya Pwani* employed strategies such as testing at flexible hours, offering PNS services at the health facility and the community, issuing HIVST kits to men or to their sexual partners. Extended hours testing involving weekend and after-hours testing was employed to increase testing and identification of men in select high volume health facilities in urban centers and proximal to male dominated (EPZ factories) working environments. In quarter 4 of FY18, eight facilities[46] in Mombasa County offered extended testing services reaching 1,472 clients (883f and 589 M), identifying 39 positive individuals (M-14, F-25) and linking 29 (M-10, F-19) to ART. Three clients (M-2. F-1) out of the 39 identified died at CPGH before initiation on HAART.As alluded in the quarter 4 data review of extended hours testing services did not show significant uptake of services amongst men when compared to women. However, despite the slow uptake, the extended hours strategy will be continued to reach the few who would otherwise not be reached during normal working hours.

Table 19 Extended hours testing performance July-September 2018

Facility	No tested		No positive		No linked	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**
CPGH	598	530	21	11	15	7
Tudor	31	11	2	0	2	0
Likoni	43	22	0	0	0	0
Miritini	3	6	1	1	1	1
Chaani	6	6	0	0	0	0
Malindi	27	14	1	2	1	2
Mariakani	175	0	0	0	0	0
Total	883	589	25	14	19	10

[46] Coast Provincial General Hospital, Miritini CDF health center, Jomvu health Centre, Portreitz Sub county hospital, Magongo health center, Likoni sub county hospital and Mrima health Centre

e) Improving the quality of HIV Testing Services

i) Proficiency testing

Afya Pwani employed proficiency testing, counsellor supervision, on job mentorship, observed practice, job aids provision and strict adherence to the latest HTS guidelines to ensure quality HIV testing Services. During the period under review, the program supported County and Sub County Medical Laboratory Technologists(S/CMLTs), in the 5 Counties to carry out corrective OJT for HTS providers who failed round 17 proficiency testing: Taita Taveta (15M, 27F), Kwale (5M,7F), Kilifi (6M, 10 F) Lamu (3M,2F) and Mombasa 42 (16 F,31F). Among the reasons for unsatisfactory PT results included; failure to follow correct steps indicated in the proficiency testing job aids during reconstitution of the panel, cross contamination during reconstitution, incorrect incubation temperature and procedure, failure to incubate the sample overnight, failure to fill in the results correctly among other reasons. The corrective OJT participants are taken through sample reconstitution and filling in the results using the proficiency testing job aids. In addition, the project supported online enrolment of 380 HTS providers into round 18 of PT testing. The project also supported S/CMLTs to mentor and support HTS providers during online uploading of PT results. Mombasa county 334 (120 Male, 214 Female), Kilifi county 288, Kwale 296 and Taita Taveta 118 (67M,51 F). PT results received for round 18 were received, 87 % of the results were satisfactory: 93 % (329 against 352) in Mombasa, 87 % (198 against 228) in Kilifi, 93% (190 against 204), 66% (103 against 156) in Kwale, and in Lamu 92% (24 against 26) as follows. The project will in the subsequent quarter support PT corrective OJT as corrective action following the below round 18 PT results.

During the period under review, PT round 18 results were released, 87 % (844 against 966), 122 HTS providers received unsatisfactory results. As such, *Afya Pwani* will support the provision of corrective OJT.

Table 20 **Round 18 PT results**

County	Satisfactory results	Unsatisfactory	Total	Percentage Satisfactory (%)
Mombasa	329	23	352	93
Kilifi	198	30	228	87
Kwale	190	14	204	93
Taita Taveta	103	53	156	66
Lamu	24	2	26	92
Total	844	122	966	87

ii) Counselor support supervision and mentorship

During the reporting period, *Afya Pwani* provided support supervision and mentorship on the HTS algorithm and the 5C's (Informed consent, counseling, confidentiality, correct results and connection) principles, HTS optimization, linkage and documentation in health facilities in Mombasa,46 (M-4, F-42), Kilifi 30 (M-5, F-25) Taita Taveta (M-21, F-44) in Kwale 39 (17M, 22F) and 6 (3M,3F) in Lamu County. To ensure compliance with HTS algorithm, quality service provision and heightened performance, the HTS team distributed HTS job aids, offered OJT and mentorship to HTS providers at the health facilities to improve on identification and effective linkage of clients to HAART.HTS providers were encouraged to test clients who meet the eligibility criteria

according to the test retest guidelines to ensure testing clients who are likely living with HIV. Job aids on the HTS Algorithm, screening tools, and linkage tools were printed and distributed to 18 Facilities in Mombasa, 49 facilities in Kwale, 23 facilities in Kilifi and 26 facilities in Taita Taveta and five facilities in Lamu during the reporting period. These job aides were particularly helpful in providing step by step guidance on the HTS protocol to newly employed service providers.

iii) HTS refresher trainings

Afya Pwani in collaboration with Mombasa, Kilifi, Kwale and Taita Taveta Counties offered refresher trainings in HTS guidelines in Mombasa 74 (M-11, F-63), Kwale (M-21, F-26), Kilifi 72 (M-11, F-61) and 94 (M-41, F-53) Taita Taveta. The HTS updates helped counselors to better understand HTS guidelines in relation to target testing and retest recommendation, HTS algorithm and importance retesting clients with reactive results to correct results, emphasis on 5 Cs of counseling, informed consent, confidentiality, correct results and connection. Effective linkage of identified clients was emphasized.

iv) Observed practice

In the reporting period, *Afya Pwani* supported HTS site supervisors to conduct observed practice supervision of all supported facility counsellors. The HTS supervisors sat in during HTS sessions to observe pretest counseling, HIV test preparation and testing, interpretation of results and post counseling for a negative or positive result and identified gaps during the process which they supported the HTS providers to improve on. A total of 32 HTS providers, 14 females in Mombasa and 18 (M-7, F-11) benefited from observed practice in quarter 4, *Afya Pwani* will scale up observed practice in subsequent quarters to improve the quality of HIV counseling and testing offered to clients. The program also supported one-day CME to 45 Clinical officers (M-25, F-20) in Kwale County and 67 (M-30, F-37) on PITC and the HTS protocols to improve their skills and knowledge on HTS and be able to provide HTS services in their consultation rooms.

Lessons learnt

1. Successful PNS implementation requires continuous mentorship by skilled and experienced PNS providers.
2. weekly monitoring and tracking of performance helps to identify performance gaps and facilitates institution of timely corrective actions
3. Optimized testing requires extra testing spaces and extra counselors at the health facilities.

Challenges

Challenges	How they were overcome
Failure of HTS providers to adhere to retesting recommendations and screening clients before testing.	Refreshers were held for HTS guidelines, screening job aids and a tally sheet were printed to guide, and mentorship on their use done to improve on target testing.
Partner elicitation was a challenge for PNS counselors, most counselors only managed to elicit steady partners and children, while in some cases only children were elicited.	This challenge was overcome through continuous mentorship of PNS providers to build their attending skills, understanding of core conditions and 5Cs, additional TOTs who included SCASCOs and counselor supervisors were trained to support PNS providers. More PNS providers were trained during the quarter and regular reviews done.

A total of 41 HTS providers who participated in PT round 18 received invalid results after submitting blank forms online.	The project supported SCMLTs to offer mentorship during submission of online results, SCMLTs will be supported to offer mentorship during subsequent PT rounds. PT online submission guidelines were printed for some facilities; the project will print more guidelines and distribute to all health facilities.
Newly identified clients face barriers to linkage which include economic, personal, cultural and health system. Economic barriers include inability to miss work, high transport costs, migration and food insecurity, fear of stigma is a cultural barrier, heath system barriers include long distance to HIV clinic, inadequate treatment preparation, long waiting times and inconvenient operating hours, personal barriers include young age, fear of HIV disclosure, not trusting HIV test results, fear of HAART side effects, lack of partner support, not feeling healthy	To improve linkage to ART the project attempted to resolve barriers to linkage. Refreshers in HTS guidelines were offered to enable HTS providers understand the importance of counseling and connection. Ongoing OJT and mentorship was provided to HTS providers to improve the quality of posttest counseling. Linkage tools which included locator forms, referral forms were printed and distributed, mobile phones were purchased airtime provided. Linkage directories will be developed or updated in collaboration with S/CASCOs.

Output 1.5: Tuberculosis/HIV Co-infection Services

In the reporting period, the project continued to provide integrated TB and HIV services using the 5 I's approach as the guiding principles providing ART and TB treatment to nearly all clients with TB and HIV co-infection to avert morbidity and mortality among PLHIV.

a) Intensified Case Finding

During the reporting period, *Afya Pwani* continued to focus on increasing access to and utilization of TB/HIV health services including improving coverage of TB screening among PLHIV. In Kilifi County, the project supported mentorship to 15 (M-6, F-9) HCW in eight facilities[47] on TB screening at CCC using the ICF cards for both adult and pediatrics and ensuring proper documentation is done. Through this mentorship, the project team emphasized that all clients who are suspected of having TB to be screened using Gene expert and those found negative are provided with Isoniazid preventive therapy. In addition, the use of the presumptive register was also emphasized to the health care providers. The SCHRIO and SCASCO were supported to conduct a validation exercise on correcting IPT numbers in the DHIS from the supported facilities. Further,60 (M-21, F-29) community health volunteers from 14 facilities[48] were sensitized on community TB so that they may be able to offer health education and early referral of suspected TB cases and active case finding at health facilities to enable early diagnosis of TB during support group sessions.

In Mombasa County, due to the high TB burden in Kisauni Sub County, and with cases coming from schools and hotels among other organizations as reported by the Sub County MOH, *Afya Pwani* supported a one-day TB sensitization and awareness meeting which included managers from hotels, Kongowea markets and schools. A total of 40 (M-26, F-14) attended the meeting. The project team continued to engage CHVs to conduct facility and community based active case searches to help identify more cases of smear positive TB.

[47] Marereni, Gongoni, Marafa, Garashi, Adu, Ngomeni, Mambrui and Marikebuni
[48] Bamba, Chasimba, Ganze, Gede, Gongoni, Kilifi, Malindi, Marereni, Mariakani, Matsangoni, Mtwapa, Muyeye, Rabai and Vipingo

During the quarter of reporting, Mombasa County supported two active case finding activities (ACF) in Kongowea market during which awareness on basic facts of TB, signs and symptoms of TB, treatment and health education was created at the Kongowea social hall. In Lamu County the CHMT oriented 72 health care workers (M-28, F-44) from 11 facilities[49] on TB screening using the ICF Cards during the project supported support supervision activity.

In Taita Taveta County, six cough monitors were supported in Moi CRH, Mwatate SCH, Wundanyi SCH, Wesu SCH, Ndovu HC and Taveta SCH, where a total of 4176 patients were screened for TB, 481 presumptive TB and were documented in presumptive register, 323 specimens were screened using gene Xpert and 14 rifampicin sensitive positive TB cases were identified and put on TB treatment. To increase TB screening and case finding for TB, 192 (84m,108f) health care workers were updated on facility TB intensified case finding from 50 health facilities[50] .

In Kwale County, the project mentored health care workers on the use of ICF tool to screen for TB during each client visit. To raise demand and awareness for TB screening services, a total number of 5,698 CCC clients seeking health services (M-1457; F-4,241) were reached with TB prevention messages during health talks which are conducted at facility waiting bays. In addition, TB prevention messages were shared during PLHIV support group meetings where 1,531(M-534, F-997) were reached in 14 facilities[51]. To improve screening and diagnosis of TB clients, 85 health workers (M-38, F-47) were taken though CMEs on TB diagnosis and management. The CMEs were done at Diani (M-7, F-8) and Samburu (M-14, F-16) and Msambweni (M-5, F-15) and Mkongani (M-12, F-8) health facilities.

i) Gene Xpert Utilization

In Mombasa County, *Afya Pwani* provided mentorship to 48 HCWs (21m,27f) in 22 facilities[52] on the use of Gene Xpert testing which resulted in increased utilization to diagnose cases of TB in project supported sites. A Gene Xpert TWG meeting attended by 30(17m,13f) health care workers in Mombasa was supported to discuss the scale up of Gene Xpert testing for TB diagnosis, to help identify priority arears of need and to come up with working solutions concerning challenges facing optimal utilization of the Gene Xpert machines.

In a bid to enhance utilization of Gene Xpert machines in Lamu County, health care workers from Mpeketoni Sub County Hospital, Lamu Hospital and Faza Health Centre were facilitated to transport sputum specimens for Gene Xpert testing. This initiative has however been slow since the Gene Xpert machine in Lamu broke down. Arrangements were done to ferry the samples to Malindi Sub-County Hospital in Kilifi County with 30 samples being transported and tested in the reporting period.

In Taita Taveta County, TB/HIV TWG meetings for SCHMTs and high-volume facilities representatives were supported to meet and discuss the issues which hinder achievements of the TB/HIV indicators and provision of quality services to the clients. A total of 48 (M-30, F-18) members from the four Sub Counties (Voi, Mwatate, Taveta and Wundanyi) attended. Several issues were discussed as follows and action points developed:

[49] Faza Health Centre, Kizingitini Dispensary, Tchundwa dispensary, Shella Dispensary, Lamu Hospital, Mokowe Health center, Hindi Dispensary, Muhamarani Dispensary, Hongwe Catholic dispensary, Mpeketoni Hospital and Witu Health Centre

[50] Shelemba Disp, Msau Disp, Kwamnengwa Disp, Mwashuma Disp, Saghaighu Disp, Dawson Mwanyumba Disp, Modambogho Disp, Mwatate SCH, Kighombo Disp, Horesha Clinic, Joy Medical Clinic, Mwambirwa SCH, Challa Disp, Njukini HC, Mahandakini Disp, Chumvini Disp, Rekeke HC, Mata Disp, Ndilidau Disp, Kitobo Disp, Kimorigo Disp, Eldoro Disp, Kiwalwa Disp, Taveta SCH, Miasenyi Disp, Kajire Disp, Makwasinyi Disp, David Kayanda Disp, Maungu Model HC, Ndome Disp, Ghazi Disp, Kasigau HC, Buguta HC, Marungu HC, Sagalla HC, Ndovu HC, Tausa HC, Moi CRH, Nyache HC, Mbale HC, Kishushe Disp, Sangeroko Disp, Mgange Nyika HC, Mgange Dawida HC, Werugha HC, Mwanda HC, Wesu SCH, Wundanyi SCH, Mvono clinic and Dawida Clinic

[51] Kwale, Kinondo, Diani, Lungalunga, Msambweni, Kikoneni, Vitsangalaweni, Kinango, Samburu, Mazeras, Tiwi, Mkongani, Gombato and Ukunda Catholic.

[52] Portreitz, CPGH, Likoni, Tudor, Ganjoni, Mvita, Mrima, Bamburi, Kongowea, Utange, Kisauni, Mlaleo, Magongo, Chaani, Jomvu Model, Bokole, Miritini, Mikindani, Mbuta, Shika Adabu, Likoni Catholic and Railways

- Implementation of the policy statements and guidelines on TB/HIV
- Adequate supply of the commodities
- Maintenance of equipment used in TB/HIV service delivery
- Proper data collection, processing, cleaning and validating

Additionally, the project supported a CME reaching 60 (M-26, F-34) health workers on TB diagnosis with the aim of raising their suspicion index for TB.

During the period July -September 2018, the project continued to support logistics of sputum collection and transportation to testing labs a motorbike riders and transport reimbursement in facilities not served by the riders.

b) IPT Coverage

To address low uptake of IPT, six meetings were supported for the SCLTCs, SCASCOs and SCHRIOs in Taita Taveta, Kilifi, Kwale, Mombasa and Lamu. The meetings noted that most of the facilities reported using the interim IPT reporting tool, since there was no official reporting tool, but the SCHRIOs did not do data entries for all facilities in the DHIS 2. Until the utilization of the new HMIS tools, facilities continued reporting using the IPT interim reporting tool and the SCHRIOs did data entry as soon as they receive the reports. Utilization of new reporting tools which has improved documentation and reporting for IPT. Between January and March 2018, project staff worked with health service providers to conduct file reviews following reports that not sites were providing IPT for pregnant mothers as recommended. To address this gap mentorship for 95 (M-61, F-34) service providers from 45 facilities was done on IPT administration for all eligible pregnant and breastfeeding women who are HIV positive and screening negative for TB to increase uptake of IPT amongst this vulnerable groups. Support supervision on IPT was conducted in Lamu, Kilifi, Mombasa and Taita Taveta Counties symptoms reaching 137 (M-56, F-81) health care workers from 30 facilities. Among the action points from the supervisions included line listing of PLHIV eligible for IPT, calling them for uptake and the IPT tools to fill in data.

To improve the capacity of health care providers to offer IPT to eligible clients, *Afya Pwani* conducted CMEs in the five counties focusing on IPT eligibility, documentation and reporting with 182 (M-84, F-98) benefiting. At Malindi Hospital and Gongoni Health Center CME sessions on IPT were conducted reaching a total of 35(M-15, F-20). *Afya Pwani* also conducted CME sessions for health care workers on IPT to under 5s reaching 25 (M-10, F-15) service providers in Malindi, Kilifi, Mariakani, Portreitz, Likoni, Tudor, Kisauni Hospitals and CPGH respectively. This was done as part of efforts to ensure that children of parents with smear positive TB get prophylaxis for TB prevention since they are at a high risk of developing TB due to the Immune suppression. The cadres reached were nurses, clinicians, HRIOs, mentor mothers and community health volunteers working at MCH/PMTCT/CWC and CCC service areas. To improve IPT uptake among pregnant and breastfeeding women, targeted sensitization on IPT provision to 41 (M-15, F-26) health workers providing eMTCT services was done in Malindi, Kilifi, Mariakani, Portreitz, Likoni, Tudor, Kisauni Hospitals and CPGH respectively. In the same period, mentorship on IPT initiation was provided to 25 (M-8, F-17) health care workers from 14 HVFs. Facility based CHVs also provided health talks to raise awareness on IPT amongst PLHIV as part of efforts to increase uptake and adherence of IPT amongst PLHIV. To create more awareness and allay some concerns that some health care workers had on IPT especially those touching on side effects, a TB/HIV collaborative stakeholder's forum was supported in Voi control zone, where 50 (M-28, F-22) health workers attended. The forum also discussed strategies to increase uptake of IPT and gene Xpert utilization in health facilities including using the community barazas organized by local chiefs to sensitize community members on issues of TB, offer screening and collect sputum for gene Xpert for those with cough.

Table 21 IPT Uptake July -Sept 2018

County	<15 Years	>Years
Taita Taveta	51	325
Kilifi	146	500
Mombasa	72	1147
Kwale	20	67
Lamu	4	100
Total	**293**	**2139**

c) Increase uptake of ART among TB/HIV coinfected patients

Through the facility PIPs, Bamba, Chasimba, Ganze, Gede, Gongoni, Kilifi, Malindi, Marereni, Mariakani, Matsangoni, Mtwapa, Muyeye, Rabai and Vipingo were able to conduct CME on TB/HIV management and Integration reaching 76 Participants (M-34, F-42) it is through such integration TB-HIV coinfected clients are tested for HIV, and those testing positives are started on ART the soonest time possible.

HIV infection significantly increases the risk of TB progression from latent to active TB disease; as such integration of HIV/TB health services is a vital component of any HIV care and treatment program aimed at creating sustained and improved health and well-being for its client. During the reporting period, *Afya Pwani* project continued to support mentorship to HCW on the importance of HIV/TB integration. The project mentored 35 of HWs from Vipingo, Gede, Bamba, Marereni, Mariakani, Rabai and Muyeye with an emphasis on 100% testing of HIV for all TB Patients.

d) Integration of TB/HIV services.

In Lamu County, 72 health care workers (M-28, F-44) from Faza Health Centre, Kizingitini Dispensary, Tchundwa Dispensary, Shella Dispensary, Lamu Hospital, Mokowe Health center, Hindi Dispensary, Muhamarani Dispensary, Hongwe Catholic dispensary, Mpeketoni Hospital and Witu Health Centre were capacity built during the project supported CHMT support supervision. The service providers were also oriented on TB/HIV co infection and prevention of TB among PLHIV during the CHMT support supervision to ensure provision of quality TB/HIV services in the facilities. Key areas that were addressed included: Intensive TB case finding which focuses on screening all HIV clients for TB using the Intensive Case Finding (ICF) cards and all TB clients tested for HIV, early initiation of ARV to all TB clients confirmed HIV Positive, triaging for clients who are coughing, open door and window policy as a way of preventing TB infection in facilities, Integration of TB Services in other service delivery points e.g. MNCH and initiation of IPT to HIV clients with no signs of TB. In Kwale County, a CME on TB and HIV integration was supported at Mkongani dispensary reaching 20 health workers (8 males and 12 females) to improve the care of the co-infected clients.

Table 22 TB/HIV Integration July -September 2018

COUNTY	No of TB Clients	No Tested for HIV	% Tested for HIV	No HIV Positive	% TB/HIV Co infected	No Started ART	% Linked to ART
Taita Taveta	159	154	96.9%	39	24.5	36	92.3%
Mombasa	1076	1043	97%	302	30%	295	98%
Kilifi	534	523	98%	137	26%	135	99%
Kwale	604	566	94%	146	26%	144	78%
Lamu	80	80	100%	11	14%	11	100%
Afya Pwani	**2453**	**2366**	**96.5%**	**635**		**621**	**97.8%**

e) Infection Prevention Control

To address the poor coordination and implementation of IPC activities, *Afya Pwani* supported sites the project focused on strengthening TB IPC through the formation and strengthening of functional IPC committee, In the reporting period the project supported IPC Committee meetings in eight facilities at Kilifi Hospital, Gede Health Centre, Matsangoni Health Centre, Rabai Health Centre, Portreitz Hospital, Tudor, Likoni and CPGH.

f) Support to MDR Tuberculosis

MDR TB poses a significant health risk not only to the general population but especially for PLHIV, significant emphasis was placed on trying to identify clients with MDR TB, especially those who also have HIV. In Mombasa County, the project team helped to streamline surveillance activities for MDR TB in collaboration with S/CHMTS, part of these activities involved supporting contact tracing activities. The project also supported sputum sample referral to gene Xpert in the County.

In Kilifi County, the project continued to support surveillance and management of Drug resistant TB. During the reporting period, *Afya Pwani* team supported Kilifi County to have quarterly MDR clinical review meeting, 33 Service providers participated in the review meeting (M-12, F-21). 19 MDR clients were clinical reviewed and plan of management was outlined, In the meeting it was noted some facilities required N95 mask as protective gear.

Kwale County is currently managing eight MDR cases. To facilitate the sharing and improving the quality of services offered to the MDR clients, the project supported MDR clinical review at Tiwi and Mkongani. The other reviews in other facilities will be conducted in the next coming quarter. The clinical review reached 25 health workers (M-12, F-13). To capacity build health workers on the surveillance ad diagnosis of MDR clients, the project supported a CME Msambweni hospital reaching 30 (M-16, F-14).

In Taita Taveta County, six CMEs on MDR TB management were supported reaching 97 (M-43, F-54) health workers drawn from 10 health facilities (Mwatate SCH, Bura HC, Mwashuma Disp, Kwamnengwa Disp, Maktau Disp, Mbagha Disp, Mbale HC, Mgange HC, Wundanyi SCH and Wesu SCH). Four MDR TB clinical review meetings were supported in Mwatate, Wundanyi and Voi TB control zones, where a total of five patients were discussed. Two patients are on intensive phase and one on continuation phase. Contact tracing for the contacts of MDR clients was supported in all the facilities.

Table 23 Drug Resistant Cases on Treatment

County	Intensive phase	Continuation phase	Total DR cases
Taita Taveta	2	2	4
Kilifi	4	16	20
Kwale	3	5	8
Afya Pwani	11	31	42

Lessons learnt

- Continuous OJT and mentorship is key to improving knowledge and skills
- Regular support supervision plays an important role in improving quality of TB/HIV services offered in facilities
- Sensitizing health workers on gene Xpert testing has improved the utilization of the machines.
- The project has learnt that most of the reasons for low uptake of IPT are facility based and not at the higher levels. Commodities are available.
- Rapid adoption of the new NASCOP reporting tools will help address the documentation and reporting issues with IPT and TB data.
- MDR TB clinical review meeting are effective in providing quality care to MDR patients since views and skills of several health care workers are incorporated into the management of the client as opposed to a single clinician.
- Collaboration with both SCASCOs and SCMLTs in joint planning and implementation of the TB/HIV activities is paramount in success of the activities.

Challenges

Challenges	How you overcame them
Breakdown of Gene Xpert Machine in Lamu	Machine was successful repaired early October
IPT data not consistently reported and entries to DHIS2 not done.	The SCHRIOs have been supported in making entries in DHIS2.

Output 1.7: Determined, Resilient, Empowered, AIDS Free, Mentored and Safe (DREAMS) Initiative

a) Enrollment of AGYW

AGYW enrolment of in Mwangala village in Mtongwe

The three-pronged enrollment approach continued in the quarter in reference. First approach involved onboarding OVC girls aged 10-17 years and those that had clocked 18 years from NILINDE OVC project. 418 OVC from the three Sub Counties where *Afya Pwani* is under implementation were successfully identified and enrolled into DREAMS project. It was assumed in this approach that *Afya Pwani* was able to subsume the AGYW above 18 years that had been exited from OVC program through its community-wide enrollment that involved mobilization by the community health volunteers and village elders from the targeted villages. In the second approach that involved mass listing from the pre-assessment conducted by trained enumerators, the strategy changed to identification of the vulnerable AGYW from schools and tracking them back home for enrollment. This was due to difficulties in locating the AGYW from home and was aimed at immediate attachment to a mentor and provision of in-school evidence-based HIV and violence prevention interventions. The most utilized approach was that of enrolling AGYW at the safe space by the mentors. This was able to reach the off-track[53] AGYWs for inclusion. Using the three approaches, an additional 6,741 AGYW were enrolled during the quarter totaling to the current 11,315 AGYW in the UCSF managed DREAMS database.

b) Community Resource Mapping for DREAMS related Services

The DREAMS core implementation team continued with the community resource scan to identify best resources to optimize for the successful implementation of the project. Through this exercise, the project identified safe spaces and mentors through the support of the community members premised on the already secured good will. The following is the status of safe space identification and mentor engagement:

i) Safe Space

These remain the service delivery points for AGYW in the project. During this reporting period, a total of 36 new safe spaces (schools – 23, churches – 2, community halls – 3, community library -1, village elders office – 1, youth friendly centers in a health center – 2 and vocational skills training center - 4) were identified and are in use.

ii) Mentors

Mentors are young women aged 18-35 years, residing in the same community as the AGYW being mentored and having attained a minimum of secondary education. An additional 16 mentors were identified, trained and engaged from the beneficiaries enrolled and already receiving services to put the total number of mentors at 70 as at the end of FY17. The table below shows the distribution of the safe spaces and mentors against AGYW by age cohort served so far.

[53] *Refers to AGYW whose "life paths" are outside articulated national policies with respect to education, the right to a safe childhood, and access to other assets. E.g. girls aged below 17 years who are out of school. This definition is adapted from Population Council's Building Girls Protective Assets Tool Kit*

Table 24 Distribution of the Safe Spaces and the mentors against AGYW by cohort served

Aspects	AGYW age category			Total
	9-14yrs	15-19yrs	20-24yrs	
# of safe spaces	22	20	9	51
# of mentors trained	20	30	20	70
# of AGYW	1,541	1,579	1,105	4,225
Mentor: AGYW ratio	1: 77	1: 53	1: 55	1: 60

c) Delivery of DREAMS Core Package of Services

In the period under review, the project continued enrolling and serving AGWY as per the DREAMS comprehensive package of services. This was made easier by segmenting the groups by age, in school/out of school status, married and unmarried among other segmentations. A schedule of activities was then developed and agreed upon by the AGYW, mentors, facilitators and project staff for buy in and accelerated implementation. The services revolved around evidence-informed HIV prevention and behavioral interventions, provision of HIV Testing Services (HTS), information on biomedical services (PrEP information and services), condom education and commodities, contraception information and services, linkage to biomedical services as well as provision of age specific structural interventions (such as education subsidy, financial capability training and entrepreneurship training). The project also started focusing on services aimed at mobilizing communities to support and protect AGYW; services that strengthen AGYW's families and those that target risk reduction among the male sexual partners of AGYW. These have been discussed below:

d) Empowering Adolescent Girls and Young Women

School-Based HIV and Violence Prevention

For buy in from stakeholders for the implementation of the school-based HIV and violence prevention interventions, the project held a successful stakeholder meeting with Ministry of Education (MOE) Mombasa County Director and his Sub County counterparts, County and Sub County school health coordinators as well as the Directorate of Children Services in Mombasa County to sensitize them on DREAMS initiative and the need to work with schools. The meeting secured the goodwill and support of all stakeholders providing the project volunteers access to schools to offer the intervention to those enrolled. The schools have therefore been very good venues for conducting sessions on Evidence-Based Interventions(EBIs) across all target groups and have occasionally been used as safe spaces. Evidence-based interventions delivered in and out of schools were; Healthy Choices for a Better Future (HCBF), My Health, My Choice (MHMC), Shuga II and Respect-K as explained below:

i) *Healthy Choices for a Better Future (HCBF):* In total 36 facilitators (M–18, F-18) were trained as volunteer facilitators to offer this intervention that targets school going children aged 9 – 14 years. The intervention was mainly implemented in primary schools where majority of the AGYW in that age category are found. A total of 281 adolescent girls and 20 adolescent boys completed the recommended seven sessions.
ii) *My Health, My Choice (MHMC):*36 facilitators (M–18, F-18) were trained as volunteer facilitators to offer this intervention that targets school going teenagers aged 13-17 years. In total 286 AGYW and 49 male peers completed the recommended five sessions. Due to a short and 'heavy' school term, most schools restricted access to the targeted girls hence the low uptake of HCBF and MHMC interventions.
iii) *Shuga II:* In total 24 volunteer facilitators were trained on this intervention (M-11, F-13). The intervention was offered and successfully completed by 690 young women aged 18-24 years in five recommended sessions.

iv) *Respect K:* In total 24 volunteer HTS providers were trained on Respect K (M–1, F–23) with the intervention successfully offered to 255 young women aged 15-24 years during HTS sessions. In these sessions, condoms education and commodities were also offered as part of risk reduction as per the *Respect-K* protocol.

e) Biomedical Interventions for Adolescent Girls and Young Women (AGYW)

i) HIV Testing Services (HTS) and Linkage of HIV positive AGYW to Care

The project mobilized for HTS AGYW across all age groups during the school-based HIV and violence prevention intervention for all interested AGYW in the program. Those who had never tested or were sexually active and had not been tested in the last 12 months were offered the testing services. For AGYW below 15 years who wished to be tested, screening was done by the HTS providers and consent secured from their parents or guardians before testing was conducted. Seven hundred and thirty (730) AGYW were tested and received their results bringing the total at end of FY17 to 1,260. Among those tested, one new case was reported to be HIV positive during the quarter bringing the total to three considering those identified in the previous period. The two cases previously identified have so far been successfully linked to Mrima and Mtongwe Health Centres respectively for HIV care and treatment. The one who was not linked has been handed to the care and treatment team for treatment preparation and enrolment. Below is the number of AGYW tested and received their test as at FY18.

Table 25 Summary of the HTS achievements by Age

# of AGYW who received HTS and received their test results	Annual Target	Q 4 Achievement			Total Achieved
		9-14 yrs.	15-19 yrs.	20-24 yrs.	
Total tested	8,160	249	269	212	730
Tested positive	-	-	1	2	3
# linked to care & treatment			1	1	2

ii) Condom promotion and provision (male and female)

Condom education was provided to additional 988 AGYW aged 15-24 years in the quarter bringing the total number of AGYW aged 15-24 provided with the service to 1229. Condom education was mainly provided at the safe space during MHMC and Shuga II classes as well as during respective counselling sessions.

iii) Expanded and Improved Contraceptive Method Mix (CMM)

The project engaged locum nurses as a strategy to accelerate uptake of these services. These services were offered at the safe space and incase an AGYW wanted a method, the nurse was available to offer it at the safe space or take an appointment for the services at the facility. The services were provided to 394 AGYW aged 15-24. In addition to the education, eight AGYW were individually counselled by the nurses and six of them received contraceptives; pills – 4 and injectables - 2.

iv) Pre-exposure Prophylaxis (PrEP) Information and Services

The project continues to provide PrEP information for AGWY at the safe spaces for those aged 18-24 years by trained nurses and clinicians. It's from these sessions that girls who are at increased risk are screened and referred for PrEP commodities in the nearest health facility. In the quarter, 367 AGYW received PrEP education in various forums with none so far reported to have received any commodities. Moving forward, *Afya Pwani* will identify PrEP Champions to support girls who are interested in the uptake.

v) Post-Violence Care (PVC)

The project identified AGYW who had experienced Gender-based Violence (GBV) in two ways. First, enrolment data was used to identify AGYW who reported having experienced GBV in the last three months

prior to enrolment. Secondly, at Safe Spaces, mentors—through their interactions with the AGYW, continued to actively identify the AGYW who had experienced GBV. In total, 31 AGYW reported having experienced emotional violence and were provided with Psychosocial Support. Two AGYW who reported physical and sexual violence were referred to the Paralegal point persons for legal and other services as appropriate. Follow-up on services provided to the two girls are ongoing. The paralegals work hand in hand with department of children services to pursue justice for the victims.

f) Social Asset Building

To build social assets for the AGYW, *Afya Pwani* supported formation of Social Asset Building (SAB) groups according to their segments. These SAB groups met weekly at their designated Safe Spaces to interact, share, learn together and bond. Due to these interactions, the AGWY began working on various projects within their SAB groups. The project included dance groups (18 AGYW), soccer teams (23 AGYW), singing groups (17AGYW), table banking groups (78AGYW), and theatre groups (17 AGYW). It is anticipated that the SAB activities will enhance and widen AGYW social connections with their peers. These will allow for peer to peer mentorship and strengthened support system among AGYW. So far 4225 AGYW participated in a SAB at least once as the figure shows.

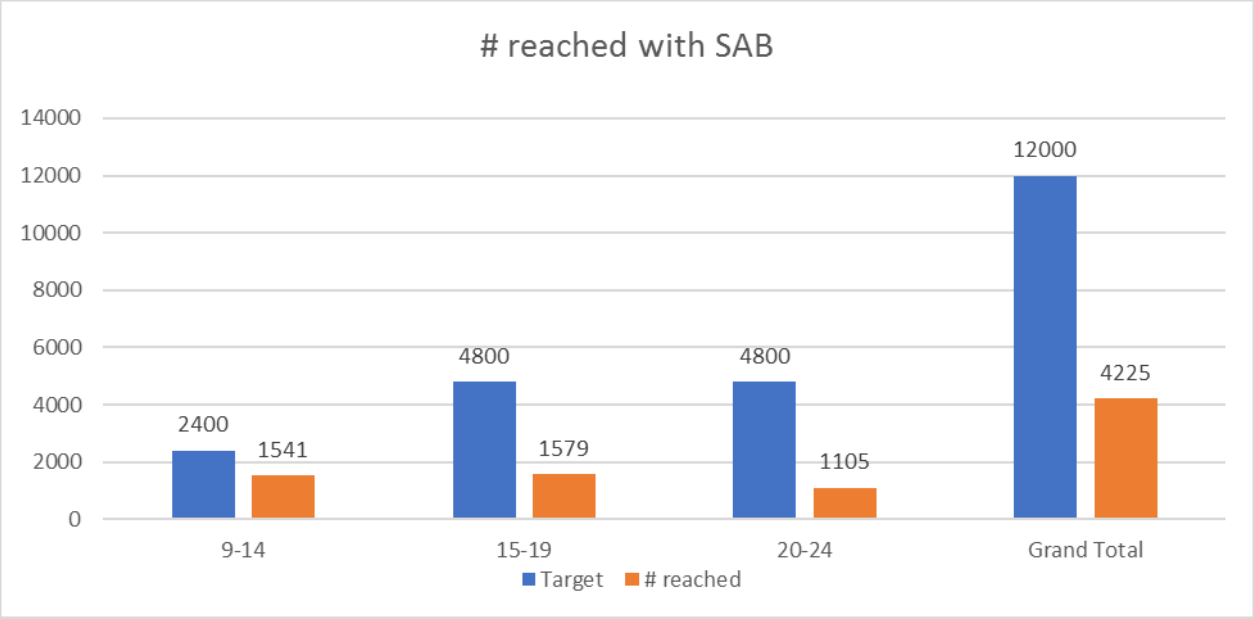


Figure 17 Number of AGYW by age segment who attended SAB activities

i) Community Mobilization and Norms Change

To mobilize community to support AGYW stay away from HIV infections, the project trained 20 volunteers facilitators (M–9, F-11) community members as SASA[54] Community Activists. To this end, a total of 4, 4,020 (M-965; F-3,055) community members were reached with SASA messages. The number reached was 74 per cent of the annual target of 5,402. The breakdown of those reached were as shown in the table below.

[54] SASA stands for Start, Awareness, Support, Action and is an evidence-informed community-level intervention

Table 26 Summary of community members reached with SASA messages by gender

Ward	Male					Female				
	<10	10-14	15-19	20-24	25+	<10	10-14	15-19	20-24	25+
Kongowea	0	2	142	13	88	0	85	195	53	158
Ziwa la Ng'ombe	1	28	32	21	63	2	81	76	37	49
Mikindani	13	27	21	58	204	24	150	57	61	258
Jomvu Kuu	0	0	10	31	52	0	0	53	63	77
Likoni	0	0	49	52	58	0	48	22	58	16
Timbwani	0	0	0	0	0	0	60	184	265	72
Mtongwe	0	0	0	0	0	13	36	72	24	58
Total	**14**	**57**	**254**	**175**	**465**	**39**	**460**	**659**	**561**	**688**

g) Strengthening Families

As part of strengthening families sustain HIV prevention among AGYW, efforts were made towards actualizing two types of interventions. These were parenting/caregiver programs to improve communication between parents and adolescents and through social protection initiatives.

i) Parenting/Caregiver Programs

To improve parent-adolescent communication—especially on sexuality—the project conducted a training on Families Matter Program (FMP) for 18 volunteer facilitators (M–9, F-9). These facilitators identified AGYW aged 10-14 years whose parents were eligible for FMP. FMP sessions have started though none of the parents/caregivers has completed the wave. The ongoing sessions will be completed in the next reporting period.

ii) Social Protection

Cash Transfers:

The project is yet to start providing the cash transfers. This is because of the detailed precautionary and necessary processes to ensure only deserving AGYWs benefit. As such the project has started holding stakeholder consultations on how best to approach it. These consultations are already under and the screening for eligible households should be starting in quarter 1 in FY18.

Educational Subsidies:

To facilitate payouts for education support, a vetting committee comprising of MOE representative, County school health Representative, DCs, Caregiver, AGYW and three *Afya Pwani* staff was formed with substantive terms of reference to guide operations. The committee designed criteria for reviewing and recommending applications for education subsidy. These were mainly AGYW who had recently dropped out of school or were at risk of dropping out. At risk of dropping out were those who had stayed out of school for long periods due to lack of fees, those with high school fees balances, those lacking learning materials or school uniforms. Education subsidies in form of school fee/levy was recommended for 313 AGYW at either primary or secondary level. This was 63 per cent of the targeted 500. It is anticipated that, the support will enhance AGYW school attendance hence averting them the risk of early sexual debut. *Afya Pwani* will continue working with other stakeholder, and GOK to support AGYW education needs to ensure sustainability.
The summary of education support provided to AGYW is presented in the figure below.

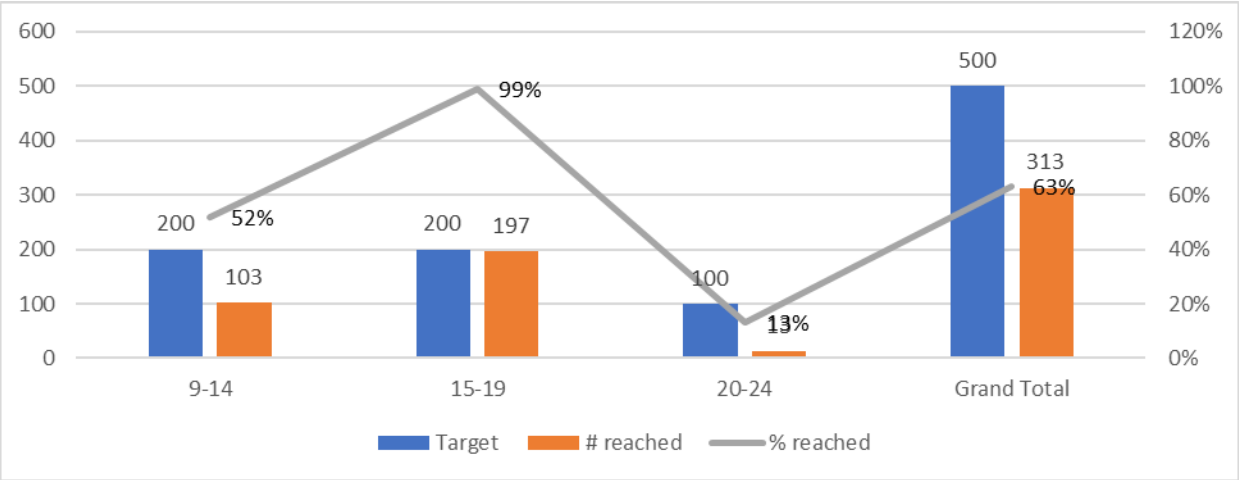


Figure 18 Summary of education support provided to AGYW by age group

Combined Socio-Economic Approaches (CSEA):
The project employed multiple, complementary CSEA during the period. These included financial capability and entrepreneurship training, vocational skills training, and linking AGYW to internship and job opportunities. The project trained 25 volunteer facilitators (M-12, F-13) on entrepreneurship and 37 (M-21, F-16) on financial capability. The summary of the achievements is provided in the table below.

Table 27 Performance in Combined SOCIO-ECONOMIC Approaches

Services Provided	Annual Target	Achieved	% Achieved
Financial capability training	11,515	1,216	11%
Entrepreneurship training	1200	0	0%
Vocational Training	500	162	32%

h) Service Layering within the Minimum Package

i) AGYW service layering for 10-14 Years
In terms of the layering of the AGYW by age specific core package of services, majority of the AGYW aged 10-14 years received between 1 and 2 services as opposed to 3 services recommended for that age category

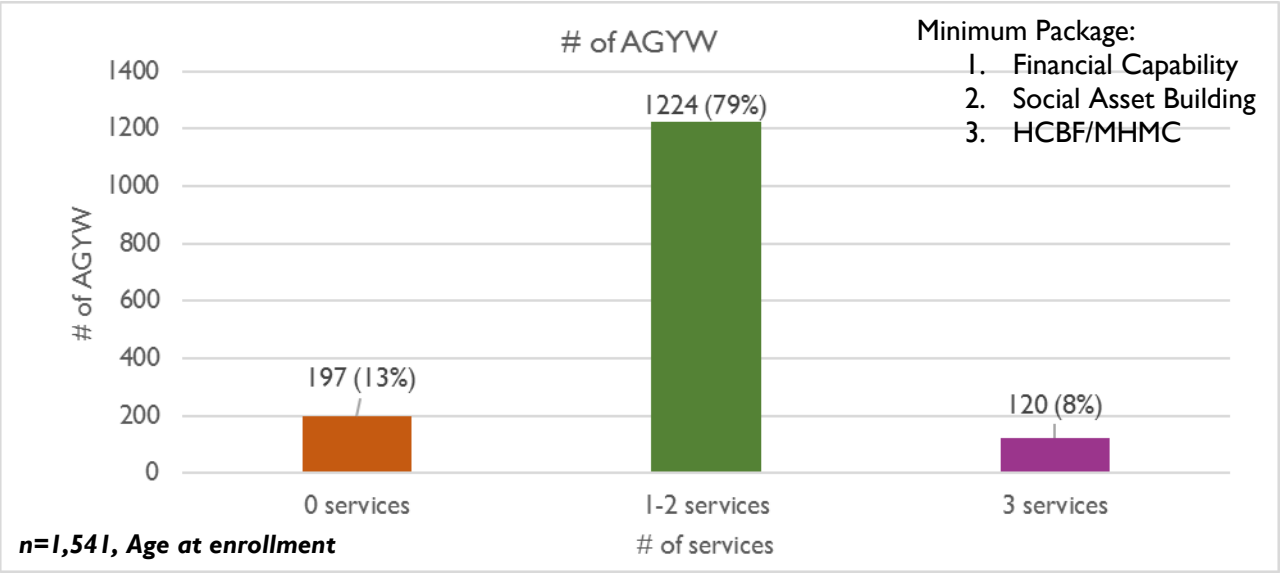


Figure 19 Service layering for AGYW 15-19 years

Service layering among 15-19-year-old AGYW against the seven core services showed very low uptake of services at just 1% of active AGYW. Majority of the active AGYW in the specific age cohort received just 2 services followed by 3-4 services as the figure shows.

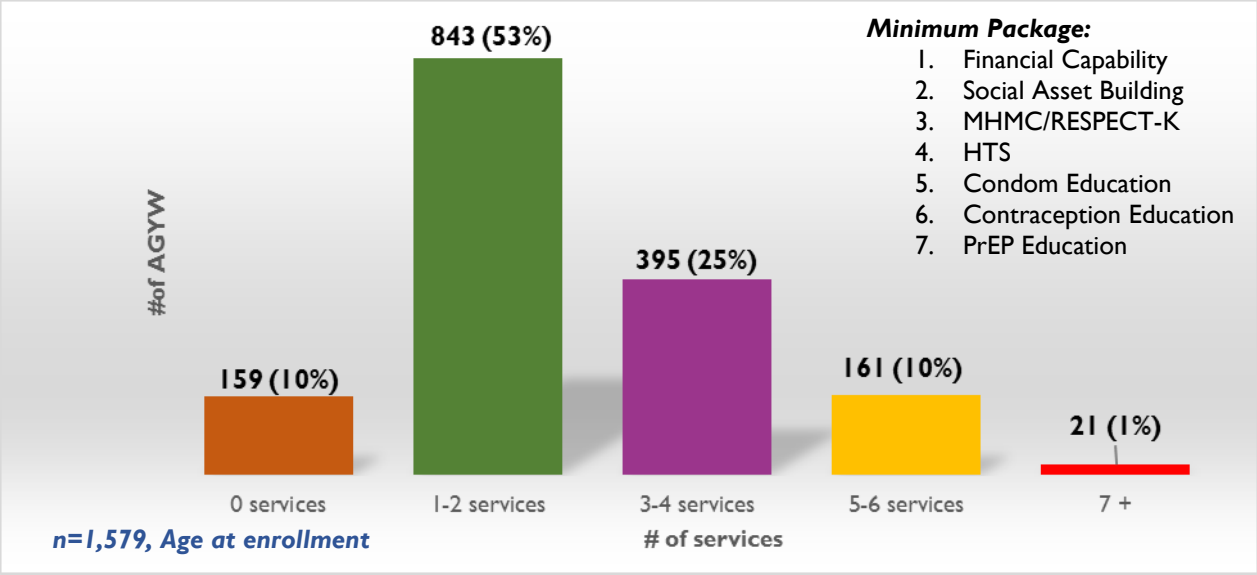
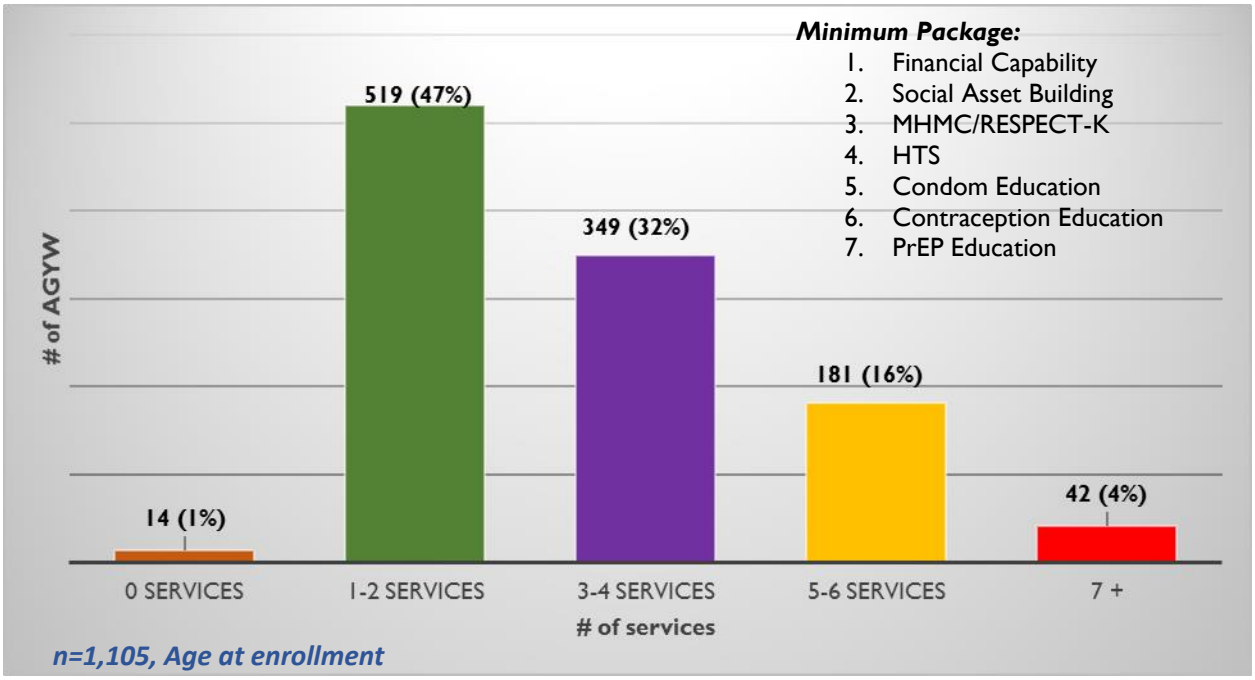


Figure 20 Service layering for AGYW 20-24 years

As for the active AGYW aged 20-24 years, the trend was the same with the most of the active AGYW having received one or two services. Just 4% of the active AGYW had received the recommended seven services as at end of the year as the figure below shows.



i) Decreasing Risk in Male Sexual Partners (MSP)

Characterization of Male Sexual Partners (MSP):

The project sensitized seven program staff and 45 mentors to conduct Male Sexual Partner (MSP) characterization at Safe Spaces. The sensitized mentors began conducting sessions with AGYW at safe spaces and at the end of the quarter, MSP characterization had been conducted with eight SAB groups. The MSP identified included boda boda riders, matatu drivers/touts aged 20-35 years, drug sellers and users 20-40 years as well as class mates aged 15-25 years, Beach boys, sponsors and shopkeepers. Most of these were aged 25-40 years.

Linkage of Male Sex Partners to Relevant HIV Prevention Services:

From the Male Sex Partners (MSPs) characterization, two outreaches were conducted where MSP were encouraged to test for HIV. As a result, 12 MSPs tested and 935 condoms were provided. None of the male partners tested HIV positive. Information on VMMC was also provided during the outreaches but no referral was reported.

Table 28 Number of condoms distributed to MSP

Ward	# of sessions with 15-24 years	Most common MSP	Favorite Hangout joint	#MSP Tested	# of condoms distributed to MSP
1.Kongowea	3	Boda Boda riders	Stage	1	288
		Sharobaro	Beach		
		Drivers/conductors	Bars/clubs		
		School boys	Mtaani		
2.Ziwa la Ng'ombe	5	Boda Boda riders	Stage	11	65
		Sharobaro	Mtaani		
		Drivers/conductors	Clubs/bars		

		School boys			
3.Mikindani	3	Boda Boda	Stage		150
		Drivers/Conductors	Mtaani		
		Truck drivers	Bars/clubs/Beach		
4.Jomvu Kuu	2	Boda Boda	Stage		432
		Sharobaro	Mtaani		
		Drivers/conductors	Friends' houses		
		Truck drivers	Clubs/bars		

j) Collaboration and Partnerships

AGYW Engagement:

Afya Pwani created several opportunities to engage AGYW in the project. For instance**16** AGYW were engaged as new mentors. These were allocated segments of AGYW who were younger than themselves to mentor. The project staff also met the AGYW in their Safe Spaces to get their feedback on the project and sought their input and ideas on how the project could be improved. In total, 8 such meetings were held.

Government, Civil Society and Private Sector Engagement:

The project also engaged the community, GOK, civil society and the private sector and sought their support in providing services to AGYW. These stakeholders contributed in various ways to the project as outlined in the table below.

Table 29: List of Partners who supported the Project

Partner	Type of support
MOH (County & Sub County)	Support supervision, capacity building. (*Afya Pwani* also participated in the Mombasa County Adolescent Technical Working Group).
Health facilities: GOK	*Afya Pwani* linked HIV positive AGYW to these facilities for HIV care and treatment. They also provided condoms, test kits and HTS waste disposal.
Mombasa City County (Education Department) Multiple schools	Authorization to work in schools: Use schools as Safe Spaces and deliver HCBF
CAP Youth Entrepreneurship Initiatives (CAPYEI)	Subsidized vocational skills training fees
Generations Kenya	Subsidized vocational skills training fees
Vocational training centers	Use training centers as Safe Spaces and subsidized school fees.
Multiple Churches	Safe spaces
GOK Administration	Safe spaces and meeting halls in social halls
Bamako initiative (CBO)	Use their office for Community meetings venue, plus chairs and tents.
Likoni Community Development Program (LICODEP)	Use their hall as safe space and venue for community meetings

Besides these partnerships, *Afya Pwani* established Program Advisory Committees (PAC) in each ward. The PAC were composed of representatives of AGYW, CHV, village elders/community leaders, youth leaders,

representatives from other CSOs working in the area and teachers. The PACs met quarterly and members gave feedback from the community and input on ways to improve the project. Their input was discussed and incorporated in next quarterly program plans.

Partnership with USAID Kenya:
Afya Pwani worked very closely with USAID Kenya in the year especially in transitioning OVCs from Nilinde to the DREAMs program in Mombasa County.

Key Lessons

Afya Pwani learned several lessons as presented below:

- Plans for childcare are essential in DREAMS since some of the most vulnerable AGYW are mothers. Inability to get childcare support hinders such AGYW from participating in SAB activities as well as attending school/ vocational training.
- Layering of services – Since DREAMS provides need-based services, there is need to be strategic with the services that each AGYW gets exposed to for maximum benefit. Focus will go towards utilizing data more in layering the specific AGYW.
- Improvement in screening for and serving the AGYW with GBV services is a priority and the gender department will be engaged proactively to accelerate this process.
- The DREAMS program should be open to the various kinds of ideas proposed by AGYW as part of their SAB activities. This ensures that the AGYW find ways to stay engaged in the project. Some of the activities that kept the AGYW together included forming of soccer teams, dance groups, singing groups, and theatre groups.
- *Afya Pwani* has noted the need to build the skills of mentors and project staff to better identify and support AGYW who have suffered GBV. Training for mentors on GBV will be held in the next quarter.

Challenges

Challenges	How it was addressed
Some of the information given by AGYW on GBV at enrolment was unreliable. Upon follow up, some of the AGYW changed the story they initially provided. On the other hand, some AGYW suspected to be undergoing GBV were unwilling to disclose for support. Only a few AGYW were identified and received post-violence care.	The project will conduct additional training to equip mentors and project counselors with skills to better identify GBV cases and refer for appropriate PVC services.
Some AGYW were not able to create time to participate in activities at Safe Spaces due to household chores/ responsibilities.	The project will sensitize caregivers & spouses on the importance of allowing the girls to attend the weekly SAB activities.
Implementation of MHMC and HCBF progressed much slower than intended. This was because some boys were unwilling to participate because of perceived sense of inequity in program benefits. They felt that girls were benefitting more from the project than the boys.	Project staff sensitized the boys and young men on why the project was targeting AGYW. And that the interventions were designed to address already existing inequity, with AGYW being disadvantaged. This sensitization will continue in the FY18.
Directive by Education Cabinet Secretary stopping all visits and non-academic activities in schools affected implementation of the in-school EBIs.	The project has planned to have more EBIs sessions the first and second term in the school's calendar, with learners expected to be in school for three months

The project planned to implement two parenting interventions: FMP I for parents of girls aged 9-14 years and FMP II for parents of youth aged 15-19 years. Unfortunately, due to late start in providing services parents of AGYW aged above 14 years were not reached with any parenting intervention.	The project will train FMP II facilitators and engage them to train parents of older girls in FY18.
Some AGYW and their families had high expectations and some parents bordered on abdicating their duties. As a result, some took long to submit documents needed to facilitate fees payments. Others expected the project to fully cater for their children's educational needs.	The project team held sensitization sessions with parents and AGYW to inform them that the project was only meant to offer a "helping hand" but the families needed to continue investing in their girls' education.
Teenage mothers willing to go back to school or vocational training had challenges finding someone to take care of their young children while they attended school.	The project will hold discussions with the AGYW and their caregivers to get the caregiver's support in caring for the children. The project will engage vocational training centers to consider introducing daycare as part of the package.
Low safe space weekly activities attendance among AGYW 20-24	Sensitize AGYW caregivers and husbands to permit girls to attend safe space activities
Low number of MSP willing to test for HIV	The project will identify and train male champions to support in sensitization of MSP
Documentation of SAB is a challenge for the mentors.	A training on documentation in general will be prioritized for the mentors in quarter 1 FY18.
Inconsistencies have been noted with UCSF managed DREAMS database as far as raw service data, raw intervention data and JASPER reports are concerned.	These have been raised with UCSF and action is expected.

SUB-PURPOSE 2: INCREASED ACCESS AND UTILIZATION OF FOCUSED MNCH AND FP, WASH AND NUTRITION

Output 2.1: Maternal, Newborn and Child Health Services

a) Addressing sociocultural barriers to utilization of Maternal and Neonatal Health (MNH) services

i) Engaging Opinion leaders

In response to several socio-cultural barriers affecting uptake of MNCH services in Kilifi County, the *Afya Pwani* team supported meetings with the opinion leaders/gate keepers in Kilifi North, Malindi and Magarini during the reporting quarter. The participants included the provincial administration, Kaya Elders, Imams, Pastors from different denominations, Wazee wa Nyumba Kumi, boda boda riders, Maendeleo ya Wanawake, youth groups as well as CHV representatives. The meeting was coordinated by the area Public Health officers (PHOs) and Community Health Assistants (CHAs). Project staff used this meeting as a platform for sensitizing these opinion leaders on the importance of seeking health care especially for pregnant women and children. Emphasis was also put on the leaders' role in addressing cultural and religious beliefs that negatively affect health seeking behaviors. A total of 120 opinion leaders were engaged.

ii) Religious leaders meeting

An advocacy forum with the opinion leaders and gate keepers at Zowerani chiefs camp in Kilifi North

The *Afya Pwani* project also supported a meeting with the 30 religious leaders in Rabai Sub County within Kilifi County. The main aim of the meetings was to urge religious leaders, who are key stakeholders in the community, to partner with the County Government Department of Health to devise ways of curbing the retrogressive socio-cultural and religious practices that have been actively curtailing access and uptake of health services for communities in Rabai Sub County, with the hope of increasing positive health outcomes for these populations and working to achieve a healthy community. During the meeting discussions focused on addressing cultural and religious barriers to accessing health services. Emphasis was put on early and 4 ANC attendance as well as skilled deliveries which the religious leaders were encouraged to support. Some of the key issues that were addressed head on included but were not limited to the negative effects of 'Mwenye' Syndrome when it comes to women accessing health services and MNCH. Moving forward the Project will organize and facilitate more meetings with other religious leaders in other Sub Counties.

iii) Community Dialogue sessions

To enhance community education and increase demand for MNCH services, *Afya Pwani* also facilitated community dialogue sessions to create awareness and education sessions on MCH during Chiefs Barazas and other community meetings. These community education sessions were also supplemented by health talks that the Project supported at the facility level for the pregnant mothers attending the Ante natal clinics. More specifically, these sessions focused on disseminating key messages on MNCH that included the importance and need for early of ANC, importance of completing 4 ANC visits, skilled delivery and post-natal care as well as maternal and child nutrition. Eight dialogue sessions[55] with expectant mothers were conducted involving 230 expectant mothers. The objective of the session was to sensitize the expectant mothers on ANC attendance and skilled delivery as a way of improving maternal and perinatal outcomes. Additionally, three expectant mothers in attendance were given the 1st ANC services after the sessions.

iv) Male involvement

During the period, *Afya Pwani* trained 60 male champions in Kilifi North and Malindi Sub Counties. The male champions were taken through various issues affecting uptake of health services especially on MNCH where they were told to encourage their fellow men to support their wives during pregnancy. They should facilitate their transport to the facilities and ensure the women don't miss appointments and also promote skilled deliveries as well as acting as role-models in accompanying their wives for health services. Elders were also sensitized on the importance of encouraging positive health seeking behaviors and discouraging negative cultural practices. More specifically, these male champions have been working with chiefs, religious leaders and "Mangwe" (local brew dens) owners to create forums where they can share positive health information with community members who frequent these areas.

[55] Mmangani, Mtondia, Kiwandani, Matsangoni, Rabai, Ganze, Kizingo and Dzikunze

v) TBAs/ CHVs sensitization meetings

These meetings were held to sensitize community members on the available Maternal Neonatal Child Health services within health facilities as well as motivate the community through its structures on the available opportunities and as such reach the target population.

The meetings also sought to reduce the high number of unskilled birth attendance in the communities, address religious beliefs affecting uptake of service and work towards sustaining demand for routine MNCH, increase performance of routine maternal neonatal child health services coverage through mapping, capacity building of household on service demands, capacity building of the health teams to include traditional birth attendants and community health volunteers on advocacy as well as mobilization of communities to fully utilize routine MNCH services and surveillance activities.

Other needs will include behavioral and communication rapid assessments on knowledge, attitude and practices for improving routine MNCH services. The meetings were conducted in facilities[56] in Kilifi North, Malindi and Magarini Sub Counties with 451 people being sensitized.

A health worker from Gongoni HC sensitizing the TBAs and the CHVs on MNCH

A TBA/CHV Sensitization meeting at Marikebuni

b) Increase demand creation for MNH services

i) Scaling up of mama and Binti kwa Binti groups

To increase demand for MNCH services, *Afya Pwani* has continued to support the 'Mama' groups concept in all the Sub Counties. During the quarter under review, *Afya Pwani* established an additional 44 Mama Groups (MG) and Binti kwa Binti (BkB), increasing the number from 28 last quarter to a total of 74 groups by end of Q4. These groups have successfully served as peer support networks for pregnant women encouraging each other to complete ANC visits, deliver within the facility and seek PNC services. *Afya Pwani* supports the MG and BkB groups' monthly meetings where the women get the routine ANC services alongside a comprehensive package of information as requested by the women. In addition, peer to peer education sessions are conducted to enhance peer learning. The project has also lobbied for entrepreneurs to train the

[56] Gongoni, marikebuni and Kamale, Mjanaheri, Marafa and Marereni in Magarini sub county; Jilore, Mkondoni, Kakuyuni,Ganda, Muyeye, Takaye, Gahaleni, Mmagani and Baolala In Malindi Sub counties; and Cowdray, Matsangoni, Mtondia, Mnarani, Kadzinuni, Mavueni, and Takaungu in Kilifi North sub county.

women on income generating activities and entrepreneurship to facilitate the groups with small loans/start-up capital in the next quarter.

An ongoing mama group session

Binti kwa Binti session at Matsangoni health centre

ii) Scaling up maternity open days

Maternity open day at Muyeye HC (60 1st ANC clients were in attendance)

Low literacy levels, long distance from facilities, high cost of services and transport to facilities, poor socio-economic status, inadequate information on importance of early and completion of 4 ANC, cause a lot of delays to access to MNH services. Furthermore, in most health facilities, poor health care providers attitude, long waiting times, user fees for MNH services as well as lack of essential services like ANC profiling result in low utilization of services and unnecessary referrals contributing to more delays in uptake of MNH services. These challenges contribute to the poor maternal and perinatal outcomes recorded in the County. In this quarter, a total of 39 (18 by *Afya Pwani* and 21 by grantees) maternity open days were conducted an increase from 14 conducted in last quarter. Through the maternity open days, 1232 women were reached (508 by *Afya Pwani* and 724 by grantees).

Snacks were provided by *Afya Pwani* to encourage women who said they can't afford a meal before coming to ANC to take anti malaria profylaxis hence stay at home. Demystification of myths and rumors on MNH services was done during maternity open days by giving appropriate information during question and answer sessions. Clients expressed many reasons why they go to TBAs which one of them included lack of hot drinks and showers in many facilities. *Afya Pwani* has addressed some of these challenges by procuring overhead heaters for some facilities that were in dire need e.g. Ganze, KCH and Malindi SC Hospitals. Advocacy with the County for procurement of laboratory reagents was done by the project staff in all facilities through the linda mama program. The SCHMTs and health care providers had meetings to discuss and correct any challenges expressed by clients as well as address other administrative gaps. During the maternity open days, clients who had previous TBA deliveries shared their bad experiences as well as good experiences at facilities, this saw many clients acknowledge the negative consequences of home deliveries and committed to deliver in health facilities. It was noted in these sessions

that a good number of clients were not aware of the availability of delivery services in the new facilities or upgraded ones. The women had an opportunity to be taken round the facility MNH service areas, to see the availability of the services. In facilities that were not aware of Linda mama program that enables free maternity services, *Afya Pwani* in collaboration with the facility staff sensitized the mothers on the program and supported their enrollement in Kilifi North and Ganze Sub Counties. Mama and BKB groups were established after the maternity open day sessions to enhance retention.

c) Improve access to MNH services by optimizing functional existing County health services

i) Increasing ANC service uptake:

During the period under review, *Afya Pwani* reached 11,494 new clients with Focused Ante-Natal Care(FANC) services. This achievement was realized majorly through the maternity open days that emphasized on mobilizing 1st ANC clients, early identification of 1st ANC during the immunization RRI that started in mid quarter 4, continuous sensitization and engagement of CHVs, male champions and TBAs through *Afya Pwani* support as well as community mobilization strategies such as the target-based approach. The project also realized sustenance in number of clients attending at least four ANC clinics during this reporting period, indicating successful retention of clients mobilized during maternity open days, through enrolling them into mama and *Binti kwa Binti* groups. In total 7471 clients attended at least four ANC clinics in quarter 4, compared to 7,423 reached in the previous quarter.

The figure below shows trends in uptake in 1st and 4th ANC over the last four quarters. *Afya Pwani* will scale up implementation of the strategies mentioned above to reach more clients with ANC services. It was noted that most clients start clinic late therefore not able to make four ANC visits as illustrated in graph below; hence the continuous efforts to mobilize ANCs monthly to get them early.

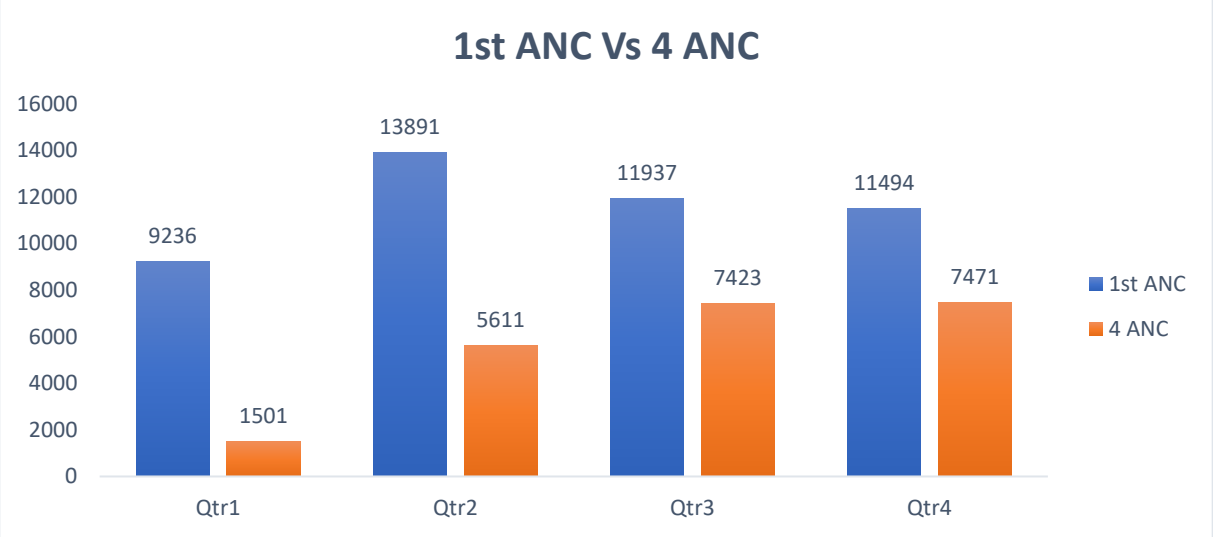


Figure 21 Uptake in 1st and 4th ANC

ii) Increasing skilled birth attendance:

In the period (Jul- Sept), a total of 9,517 skilled deliveries were conducted in the project supported facilities across the seven Sub Counties in Kilifi almost like last quarter's performance of 10,062, while live births were 9732 with still births (141- MSB, 126- FSB) as shown in the second graph below. These high accesses to SBA is mainly attributed to the dialogues sessions during maternity open days which addressed the barriers to SBA such as poor provider attitude, CMEs and creating awareness of availability for delivery services since most clients were not aware of availability of delivery services. The orientation in labor ward during

maternity open days also played significant role in promoting SBA since some clients had never delivered in facilities due to wrong information about labor ward and HCPs, which was addressed. The linda mama project advocacy has also seen many facilities give free MNH services and increase access, which addresses the challenge of high cost of MNH service.

The figure below shows comparison of 1st ANC Vs SBA service uptake showing progressive bridging of the gap between 1st ANC and SBA.

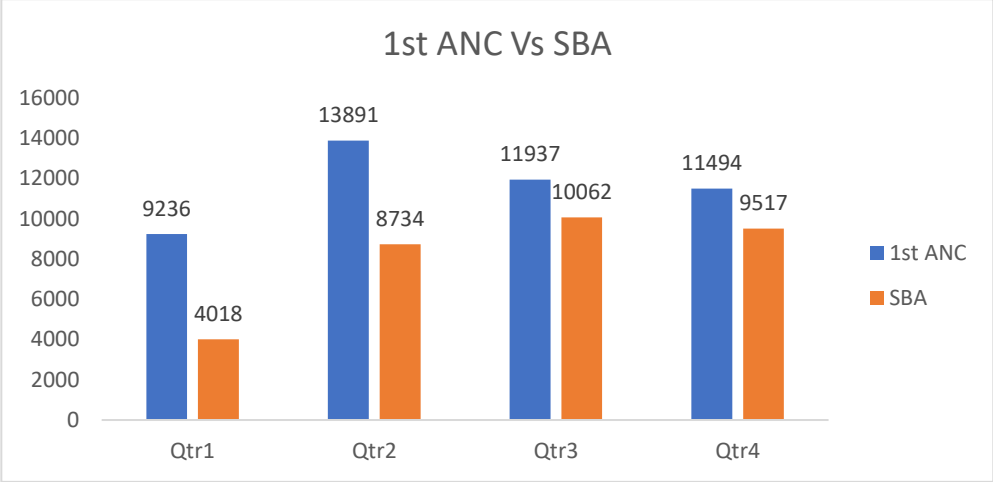


Figure 22 Comparison of 1st ANC Vs SBA

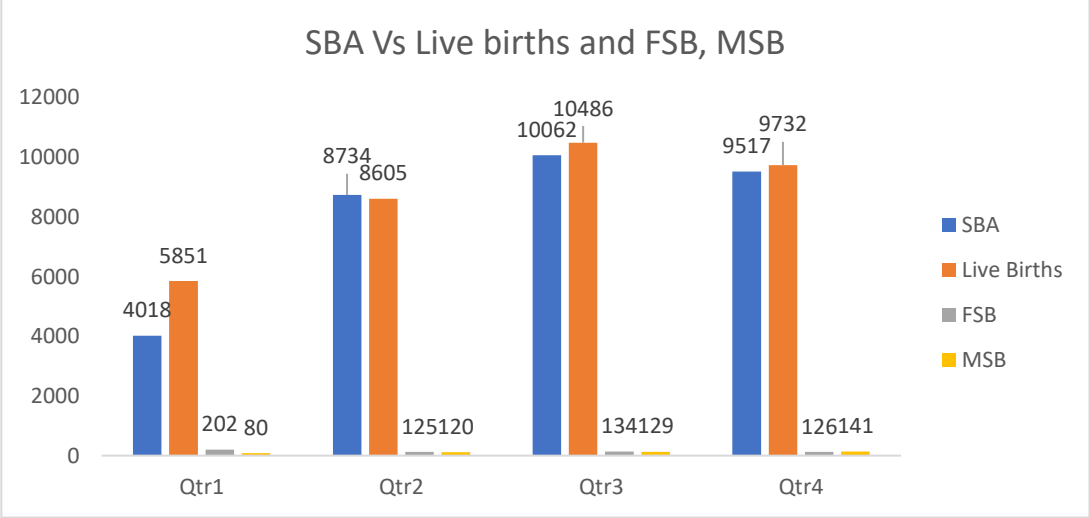


Figure 23 SBA Vs Live births and FSB, MSB

iii) Lab networking for ANC profile

Lack of ANC profiling is one of the key barriers for the uptake of MNCH services as expressed by clients during previous maternity open days. Most facilities in Kilifi lacked laboratory reagents and/or lab personnel in the last three quarters. This quarter, *Afya Pwani* provided technical assistance to the CHMT and successfully advocated for resource allocation for procurement of laboratory reagents for the HVFs which was implemented in this quarter (Jul-Sept) and all the HVF have laboratory reagents. In coming year, the project will procure HB meters for three high volume facilities in hard to reach areas as well as support shipping of

specimen from peripheral facilities to HVFs; this will ensure availability of these services to all pregnant women.

iv) Transport vouchers

To address the challenge on distance the transport voucher system discussions have been under way since year 1 and were finalized in year 2 where the project has supported CHV and TBAs with transport reimbursement to refer clients. The County will also be supported by the project with maintenance of three County ambulances to address the challenge of access due the poor terrain of roads within the County.

d) Strengthen health facility capacity to offer BEmONC/ CEmONC services:

i) Respectable maternity care efforts

Respectable maternity care requires that women deliver under clean, safe and conducive environment, to this end, *Afya Pwani* supported minor renovations based on the recommendations of an assessment undertaken in year 1 in the County's 15 HVFs. Some of the gaps the program has focused to address include painting, partitioning of rooms and plumbing works. Facilities like Matsangoni HC, Mambrui dispensary, Ganze HC, Mariakani, Malindi, and KCH have benefitted from the renovations in quarter 3 and 4. For instance, the newborn unit in Malindi which had been shut down due to leakages and other construction faults, was repaired by redoing the ceiling and roof as well as painting inside and outside the building. The unit is now open and in use. The MCH and maternity wings in Malindi were also painted to give a pleasant look to attract clients since they have not been painted since devolution. Painting has also been done at the KCH Maternal and Child Health and maternity wings. All the above efforts of strengthening health facility capacity to provide BeMONC/CeMONC services has enabled a realization of a tremendous performance of MNH indicators i.e. 1st ANC, 4 ANC, SBA, and PNC. *Afya Pwani* project intends to support more level 4 and some level 2 (not yet gazetted for free maternity fee) facilities with minor renovations since they aren't able to freely access the free maternity reimbursement from county treasury and non-gazettement respectively

BEFORE RENOVATION *AFTER RENOVATION*

Malindi SCh New Born Unit

Malindi SCH Maternity Unit

ii) Equipment support

In the reporting period, the project procured equipment items like resuscitaires, deliver sets, weighing scales and BP machines for distribution to the facilities in need. Additionally, the project has carried out procurement and distribution of plastic water tanks to some priority facilities[57] under WASH to supplement MNCH outcomes.

iii) Blood transfusion services

With lesson learnt from the previous quarters the Project has continues to advocate for construction of a County Blood Transfusion Centre (RBTC). As a result, the county got into partnership with the Danish government and is constructing an RBTC at Malindi SCH. Joint blood drives are also being conducted to enable transfusion services to be provided, especially for pregnant women. In year 3, the project will support blood drives and have blood prescreened, stored and managed by transfusion committees as a stop gap measure as we wait for completion of the RBTC.

iv) CMEs

Participants follow through a CME session on UBT in Malindi SC Hospital

During the reporting period, the project supported 11 CME sessions (two Sub County, nine facility level) reaching a total of 176 health workers with technical insights on MNH in 24 facilities. The Sub County CMEs were done in Ganze (11 facilities) and Magarini (six facilities) Sub Counties to enable primary facilities with one or two HCPs, with similar challenges get updates, since it's not feasible to have a CME for one or two staff. Experienced facilitators were supported to go and facilitate CMEs to enhance quality and impact of CME. Discussion topics were selected depending on the challenges identified in MNCH service areas. These included proper use of partograph, respectful maternal care, management of PET, UBT, management of APH and PPH as well as Active Management of Third Stage Labor (AMSTL). The CME sessions were intended to build health care providers skills and confidence in MNCH service provision to improve maternal and neonatal outcomes.

e) Enhance the provision of quality MNH services

i) Maternal and perinatal death audits

The County MPDSR committee, established with support from the project, conducted three maternal and three[58] perinatal death audits. Cognizant of the fact that some deliveries are still conducted at home, the project is in the process of establishing Sub County level verbal autopsy committees which has started in Bamba and Kilifi South Sub Counties by sensitizing chiefs on verbal autopsy.

In this quarter, nine maternal deaths were reported in Kilifi County. All the deaths were audited to establish causes and remedial measures identified to reduce similar occurrences in future. As for neonatal deaths, a total of 40 were also recorded during the quarter compared to last quarter which had. This reduction can be attributed to the capacity building efforts by the project to health care providers and feedback from the

[57] Adu, Marikebuni,Sabaki, Mambrui, Tsangatsini,Chalani, Bamba,Dida, Dzikunze,Lwandani, Danicha, Maojo, Mtondia, Mutoroni,Kirosa, Braka Jembe.
[58] Kilifi County Hospital, Malindi SCH, Mariakani Hospital

MPDSR committees highlighting causes of maternal deaths and remedial actions to reduce future deaths. The causes of these deaths included: late initiation to ANC delaying identification and management of pregnancy related conditions e.g. anemia which results in poor maternal and perinatal outcomes, lack of blood to manage complications like APH and PPH. The high number of deaths is also associated with improved reporting rates for maternal outcomes, occasioned by increased hospital delivery as evidenced in graphs below.

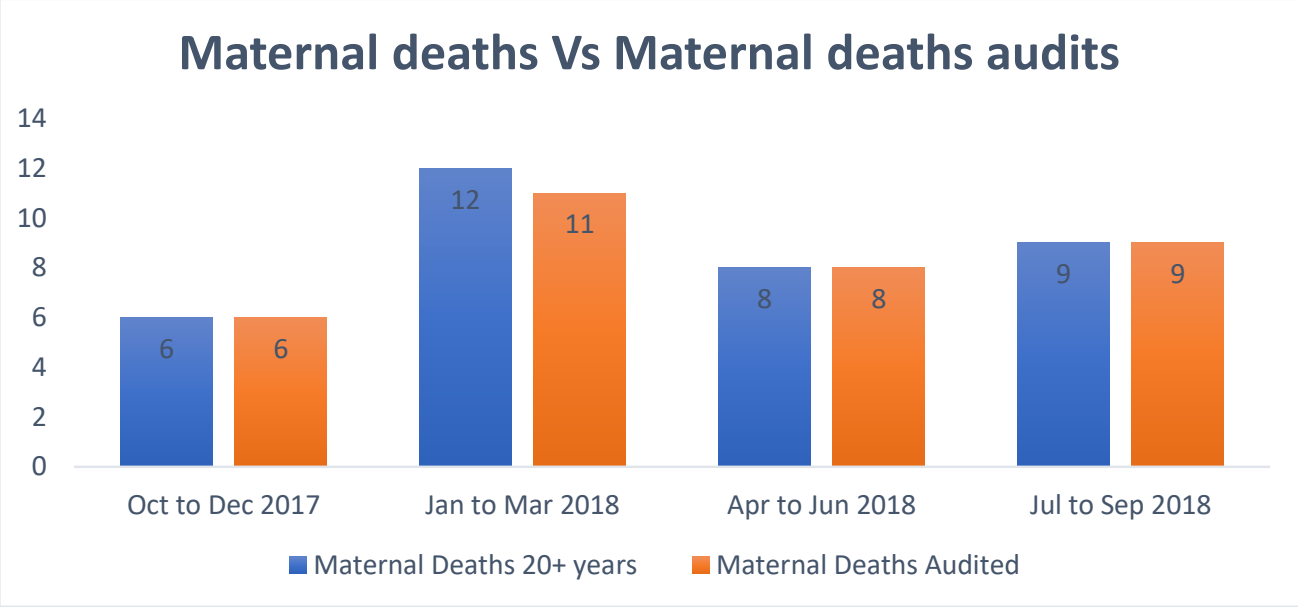


Figure 24 Maternal deaths Vs Maternal deaths audits

In the next quarter, *Afya Pwani* will support blood drives across the County, to help ensure there is a reserve for screened blood to mitigate maternal deaths due to lack of blood. The project will also schedule routine feedback sessions with the S/CHMT to discuss issues captured during routine visits, to help address community and health facility systemic issues that contribute to the deaths e.g. negligence from HCWs

ii) Support supervision

Afya Pwani donated a vehicle to be used for support supervision in the vast Magarini Sub County which happens to have most of the MNCH challenges.

***Afya Pwani* senior driver (in white cap) handing over car keys to the CEC health Dr Anisa and DMOH for Magarini**

f) Strengthen delivery of quality newborn care services

i) Documentation

The understanding of the PNC indicator definition and documentation were realized to be the greatest challenges among HCPs during quarter 2nd hence in this quarter, TA on indicator definition and documentation continued to be emphasized through social media platforms such as WhatsApp, meetings and CMEs. This has a big improvement as illustrated in the figure below.

ii) Advocacy and renovation of New Born Units

Following the projects advocacy for improved newborn health within the County, a new, newborn unit is being constructed in Mariakani SC Hospital. Another one in Malindi has been renovated as explained in the MNH section while the one at KCH is well running albeit for the staffing issues.

These efforts on improving new born clinic services saw the project achieve high numbers of HCPs capacity build as mentioned above and hence an improvement in performance of live births from 9486 against SBA of 10062 in quarter 3 to live births of 9732 against SBA of 9517 in quarter 4.

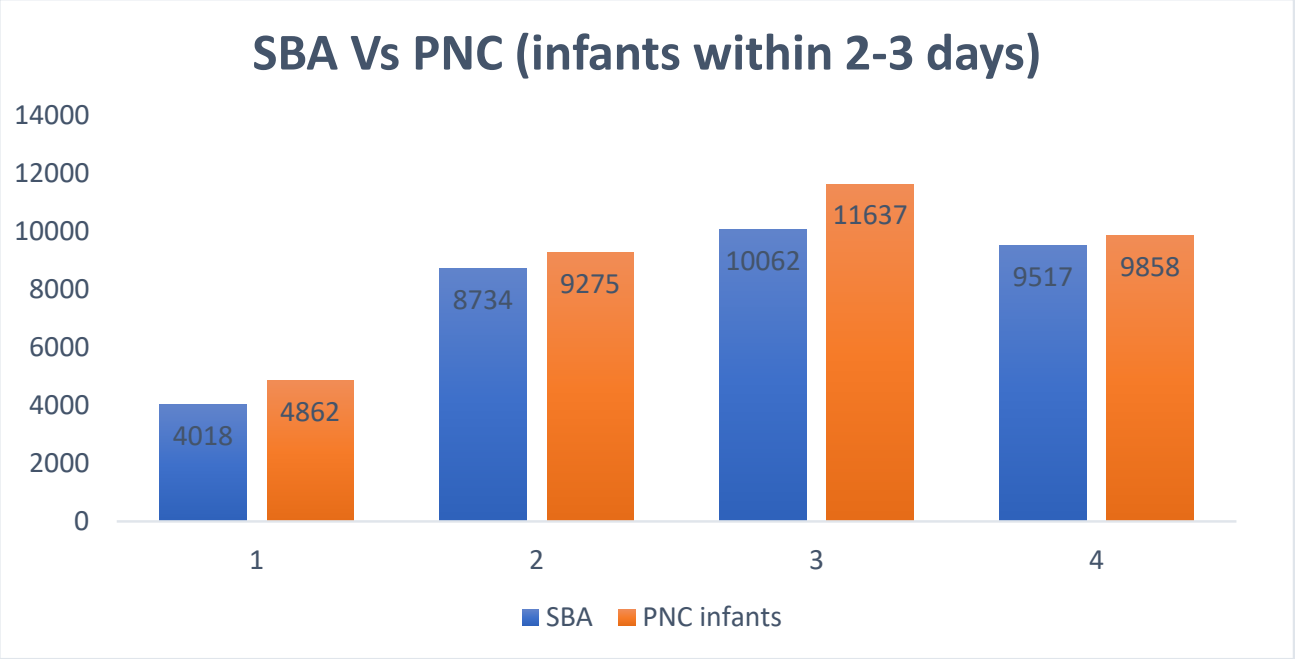


Figure 25 SBA Vs PNS

In the next quarter, the project will also continue providing mentorship for PNC documentation to ensure all HCPs understand the PNC indicator definition and documentation.

Output 2.2: Child Health Services

a) Increase demand for child health services

i) Strengthened Integrated Community Case Management of Childhood illnesses(ICCM)

A participant of the ICCM training (left) taking a client's health background information during the practical session

Kilifi County is vast, and as such many residents either delay or forfeit utilization of health services, including vital child health services hence compromising quality of life for their children. To reduce access challenges for child health services, *Afya Pwani* in quarter 4, scaled up the ICCM[59] strategy in Kilifi County by training 15 (M-2, F-14) Trainers of Trainees (TOTs) drawn from Kaloleni, Kilifi South, Malindi, Ganze and Kilifi North Sub Counties. Initially the County had only four ICCM TOTs- all based in Magarini Sub County, this caused sluggish implementation of the strategy in other areas of the County. The TOTs have in turn trained 61[60] CHVs on case definitions for diarrhea, malaria, pneumonia and malnutrition, recommended community-level interventions, documentation as well as referral systems for the same as per the national guidelines. Post-training, these CHVs were tasked to identify, treat or refer children with diarrhea or fast breathing at community level as well as test eligible children for malaria and treat or refer them to the nearest health facilities. The County in collaboration with *Afya Pwani* is working on a reporting structures for implementation of ICCM.

The following table is an illustration of under 5 children who were reached with diarrhea, pneumonia and malaria treatment at community level during the reporting period.

Table 30 Child health services provided by CHVs at community level

	July- Sept
No of children presenting with fast breathing	242
No of children presenting with diarrhea	227
No of children of receiving Zinc ORS	342
No of children tested for Malaria	274
No of Children receiving Artemether-Lumefantrine	194
No of immunization defaulters identified	467
No of Children referred and accompanied for further health services	1324

All the children with fast breathing were referred to health facilities for treatment. CHVs managed dehydration resulting from diarrhea by administering Zinc and ORS. 274 children presenting with fever were tested for Malaria and those who tested positive (194) were put on Artemether-Lumefantrine. While at it, the CHVs also traced and referred a total of 467 immunization defaulters to nearby health facilities for vaccination. Moving forward, the project will continue advocating for the County to wholly adopt the ICCM strategy including budgeting and commodity management to enhance sustainability.

[59] ICCM strives to deliver treatment interventions closer to the clients in hard to reach areas. This is achieved through capacity building and deploying resident community health volunteers (CHVs) to treat sick children and to mobilize families to seek prompt and appropriate child health services.

[60] 25 Magarini Sub County, 31 Malindi Sub County, 30 Kilifi North Sub County

ii) Engaging community leaders to promote positive child health seeking behavior

Increasing local leaders' involvement in promoting good health seeking behavior has been critical in Kilifi, a County where myths, misconceptions and retrogressive cultural practices often cloud the facts about immunizations. During this reporting period, *Afya Pwani* together with Magarini Cultural Centre, held four advocacy meetings with 90 (M-65, F-25) Kaya elders in Magarini Sub County to advocate for an enabling social environment for clients who need these services. Aware of the role of Kaya Elders to uphold culture and their ability to influence community perception of different cultural practices, the project explained the harm these practices predispose the children to while explaining the need for abiding by the recommended immunization schedules. During these discussions, the elders blamed most childhood deaths on witchcraft but after the sensitization sessions, they were informed of how timely vaccination could protect the children from some of these preventable causes of child mortalities. The Kaya elders unanimously agreed to be champions of immunization by sensitizing communities and referring clients for these services.

The project grantees supported four advocacy meetings with 148 (M-82, F-66) opinion leaders in Malindi, Kilifi North, and Kaloleni Sub Counties to build a case for local leadership in promoting child health. The opinion leaders were urged to serve as role models, empower communities as well as demand for child health services especially in hard to reach areas.

Afya Pwani also engaged Kayaelders, teachers, religious leaders and Chiefs in mobilization, sensitization and referral for child health services. 11 chiefs in Kaloleni Sub County utilized their routine Baraza meetings to empower community members on childhood immunizations reaching up to 647 community members with information. Teachers were equally utilized to refer children in their schools who required these services. For instance, Midodoni primary school offered to be an outreach site for immunization services, where the ECD pupils get routine child health services and immunization defaulters from the surrounding community also get these services.

iii) Awareness creation on child immunization

Afya Pwani in partnership with the project grantees[61] trained tier 1[62] health volunteers and conducted 336 community sensitization meetings in 84[63] villages in Kilifi County. A total of 6,720 (M-1707, F-5018) community members were reached with information aimed at shaping positive beliefs about immunization to enhance uptake. These fora were informed by data from health facilities depicting villages with high immunization defaulter rates. The project purposed to include all community members including fathers and mothers with children under 5 years to emphasize gender roles in ensuring children's wellbeing.

From these engagements, it was observed that the health of children is compromised as parents feel more obliged to fend for the family and hence lack time to routinely visit the facilities for immunizations. The discussions allowed the community to reflect and contextualize the need to ensure their children are fully immunized. CHVs were tasked to refer and accompany the defaulters for services in nearby health facilities. To address the barrier of distance, the project also supported outreaches in hard to reach areas. Additionally, project leveraged on the supported mama group meetings to disseminate information on child immunization and provide child health services during their scheduled meetings.

iv) Door to door campaigns to identify and track immunization defaulters

To enhance retention and completion of children's immunization schedules in the period under review, *Afya Pwani* together with DABASO Community Based Organization and Magarini Cultural Centre conducted door to door campaign in Kilifi North (Gede area) and Magarini Sub Counties. This process aided in identification,

[61] Health Rights Advocacy Forum, Dabaso Tujengane Community Organization, Moving the goal post, Magarini Cultural Centre and AMURT
[62] CHVs, Kaya Elders, Chiefs and Male Champions
[63] 24 villages in Magarini Sub County, 10 in Ganze SC, 13 in Kilifi North SC, 12 in Malindi SC, 10 in Kilifi South SC, 11 in Rabai SC and 4 in Kaloleni

tracing and referral of children under 1year who had defaulted from their immunization schedules (verified using the MOH mother-baby booklet) as well as educate expectant mothers on the importance of ensuring their children are fully immunized. The CHVs visited 1868 households, identifying 512 immunization defaulters who were then accompanied to health facilities for services.

v) Working with TBAs as referral agents for child health services

In Quarter 4, *Afya Pwani* oriented 416 TBAs in Magarini, Malindi, and Kilifi North Sub Counties on child health services including immunization and growth monitoring. These TBAs were further engaged in identification of immunization defaulters, referral of children born at home for PNC and immunization services as well as community education on importance of completing the recommended immunization schedules. To-date the TBAs have referred 2,660 children for immunization services.

b) Strengthen delivery of quality child health services (IMCI to include diarrhea management immunization, malaria, Pneumonia, Ear infections and malnutrition)

i) Supportive supervision

Afya Pwani supported five Sub County Health Management Teams (SCHMTs)[64] to conduct support supervision. In Kaloleni Sub County, the team supported Health Care Providers (HCPs) in 12 facilities[65] to improve quality of service provision and documentation. Specifically, the team conducted spot checks on EPI operational management, cold chain management, ORT corners and record against national standards. Feedback to HCP included mentorship and OJTs on areas that had gaps. In Ganze Sub County a total of 12 facilities[66] were supervised on child health. The team also checked immunization program recording, archiving, reporting, demographic information, core out puts/analysis and evidence of using data for action components. Action points for Ganze facilities were: -

- Facilities with low access & high drop out to identify the said areas & take relevant actions to address the same
- Health facilities to conduct targeted out reaches and in reaches to increase health service uptake in hard to reach areas which will have a positive impact in health facilities indicators performance.
- All health facilities to have focal person for data verification before submission to avoid data discrepancy in all reports moving forward.
- Facilities' yet to update current immunization monitor chart & vitamin A monitor chart, to prepare and display the same immediately.
- Routine preventive maintenance of cold chain equipment's by maintenance officer (Mirihini Disp).

[64] Kaloleni, Ganze, Kilifi South, Magarini, Rabai

[65] Gotani health centre, Ndatani dispensary, Makomboani dispensary, Chalani dispensary, Madzimbani dispensary, Vishakani dispensary, Jibana dispensary, Kinarani dispensary, Kasemeni dispensary, Shangia dispensary, Mgamboni dispensary, Kamkomani dispensary,Viragoni dispensary

[66] Bamba SCH, Ganze Health Centre, Dida dispensary, Jila dispensary, Vitengeni dispensary, Dungicha dispensary, Mwapula dispensary, Jaribuni dispensary, Palakumi dispensary, Sokoke Dispensary,Mirihini Dispensary

In Magarini Sub County, selection of the six facilities[67] were supervised based on previous performance and immunization client retention[68]. Action points for these facilities include completion of immunization permanent register and identification of true defaulters for follow up, defaulter tracing, updating of the summaries and monitor charts, timely updating of stock ledgers, prompt charting the cold chain temperatures, routine health talks to boost immunization uptake, completion of micro planning as well as ensuring availability of service charters to help publicize services. Prompt capacity building sessions for HCP in the six facilities' staff were conducted to enhance their capacity on the respective areas that had gaps. Follow up support is scheduled for October 2018.

ii) Management of Diarrhea in Children under the Age of 5

During the reporting period, a total of 12,642 children under 5 years of age were treated for diarrhea in *Afya Pwani* supported sites as compared to 8,048 of diarrhea cases among people above the age of 5. This showed a reduction of diarrhea cases among under 5 children by 2,309 from 14,949 cases of the previous quarter. This is partly attributed to *Afya Pwani* Water, Sanitation and Hygiene interventions (WASH) coupled with favorable environmental condition in the quarter.

In collaboration with the division of health, *Afya Pwani* worked towards increasing uptake of desirable hygiene promotion practices and behaviors for prevention of childhood diarrhea by promoting water safety improvement practices and enhancing community engagements on hygiene promotion.

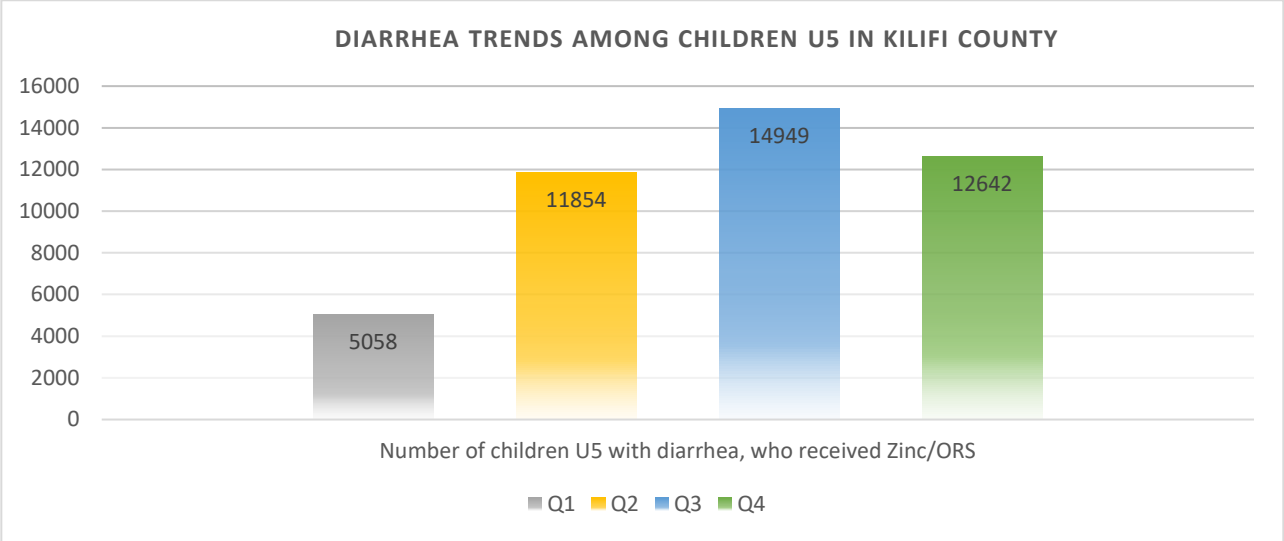


Figure 26: Diarrhea trends among children under 1 year

In addition, the project increased the number of ICCM trained CHVs from 120 to 540 during the reporting period. Under 5 children who manifested with diarrhea, 342, were reached out by CHVs with zinc and ORS at community level before they were referred to health facility, an increase of 61% from 212 in the previous quarter.

iii) World Breastfeeding Week

[67] Mtoroni Dispensary, Marereni Dispensary, Marafa Health Centre, Sosoni Dispensary, Adu Dispensary, Dagamra Dispensary

[68] Mtoroni Dispensary, 29%, Marereni Dispensary 22%, Marafa Health Centre 28%, Sosoni Dispensary 28%, Adu Dispensary 23%, Dagamra Dispensary currently not immunizing due to broken CCE.

In a bid to promote child health, the project supported Kilifi County to mark World Breastfeeding Week 2018 in Gange, Kaloleni and Magarini Sub Counties. During the period key breast feeding messages were passed to the community, accelerated growth monitoring including assessment, counseling and referral for further management as well as integrated outreaches. The theme for 2018 was "Breast feeding: Foundation of life". As a result, 677 under 5 children were reached with growth monitoring, 502 children under 1 year were immunized, 28 pregnant women received ANC, 56 WRA received family planning services, 92 under 5 children received Vitamin A supplementation, 53 received anti-helminthics, 150 received HTS and 24 WRA received cervical cancer screening services in Ganze, Malindi and Kakoleni Sub Counties.

iv) Immunization

During the reporting period, the project maintained its momentum towards reaching all children under 1 year with immunizations in accordance with the national guidelines. A total of 9,131 were fully immunized as compared to 9,311 previous quarter representing a 22% contribution to the annual achievement which stands at 91% (36,829) of the target 40,628; way above the performance of 60% (22,771) for year 1. The high performance is attributable to the before mentioned community advocacy, mobilization awareness campaigns as well as outreach and in-reach activities that project continued to engage in including grantees at community level to create demand for immunization services. In addition, a total of 42 integrated in-reaches were conducted throughout Kilifi targeting Women of Reproductive Age (WRA) with FP services and children who are below five years with growth monitoring and immunizations.

As illustrated in the graph below, there was a significant increase in DPT3 coverage in Kilifi County; 11,931 as compared with 9,673 the previous quarter. This increase is directly attributable to immunization RRI as well as demand creation activities that were conducted in the quarter.

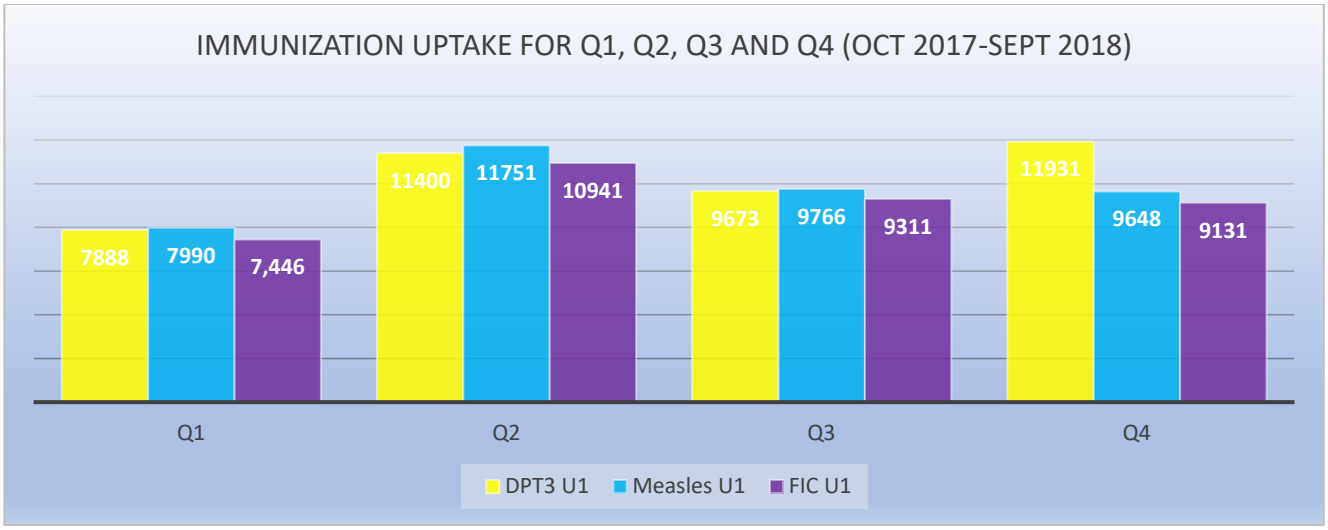


Figure 27 Kilifi County Immunization Uptake for Q1, Q2, Q3 And Q4

Afya Pwani supported an immunization Rapid Results Initiative (RRI) activity that started on 27th August 2018, and ended on 26th October 2018. This was in line with an initiative by His Excellency the President and the Chair Council of Governors who launched and flagged off to the Counties specialized cold-chain equipment, motorbikes and vehicles acquired through cold chain expansion and health strengthening projects to support accelerated action by the Counties in a National Immunization RRI targeting unvaccinated children throughout the country on the 27th of June 2018. In Kilifi County, a mid term review was conducted on 25th September 2018. Main activities during the RRI were to:

- Map areas with the highest number of unvaccinated children (2017 and 2018)

- Intensifying immunization activities at all health facilities daily
- Intensifying outreaches – increase frequency from once a month as per policy to two days a week during the RRI
- Continue to engage local community leadership through facility management Boards to mobilize communities for immunization
- Robust follow up for caregivers of children who have missed vaccination appointments
- Continue to share messages during vaccination sessions on immunization

To reach the RRI target (unvaccinated Children), *Afya Pwani* supported health facilities to line list immunization defaulters from immunization permanent registers into defaulter tracing registers. The project also supported 170 facilities to articulate the importance of a complete defaulter tracing algorithm. *Afya Pwani* also facilitated smooth shipping of EPI commodities for coast region from the national depot in Kitengela to the regional depot at Mombasa. This involved hiring of a track and constant communication between Kilifi County EPI department, the National EPI office, coast region EPI department and the project staff.

Challenges of and Way forward

Challenge	Way forward
Opposition for immunizations by a section of religious leaders in Malindi and Magarini Sub Counties, who eluded that vaccines provided were laced with evil powers which would lure its users into devil worshipping. This rumor led to boycott by community members to allow their children to use these services.	To address this, the project conducted 6 sensitization meetings with the Sub County interdenominational associations from the two Sub Counties to dispel this myth. The reservations and fears held by the religious leaders on immunizations were clarified, and they pledged to disseminate information to their congregations.

Output 2.3 Family Planning Services and Reproductive Health (FP and RH)

a) Increase uptake of FP services

i) Increasing community awareness and demand creation for FP

In quarter 4, *Afya Pwani* conducted 87 targeted community dialogue forums to enlighten communities on the importance of FP and dispel myths impeding uptake of contraceptives. The community dialogues were held with homogenous groups clustered as expectant mothers, mothers with young children, youth and men. Disaggregation of the groups was necessitated by varying levels of understanding and needs of the different community groups. Information disseminated in these forums was customized to suit each group, and testimonials from fellow community members used to dispel the untruths about FP. During the dialogue sessions, community members were sensitized on different family planning methods, advantages of child spacing to the family and informed of where to get the services. From the discussions, it was established that many women wish to delay their pregnancies but either fear the side effects of FP or feel obliged to retrogressive cultural practices which bar utilization of FP. To address the fears held by community members, the project engaged users of FP who gave positive testimonies and health workers who elaborated reasons

for side effects as well as how they can be managed. The community members were encouraged to make informed choices after counselling, instead of opting for a method based on peer referral.

These forums also served to strengthen the community facility linkages as community members provided feedback for reasons of non-use resulting from poor service delivery and areas they felt health workers needed to improve on. The health workers present equally assured the clients on their commitment to improve services to better reach the communities they serve.

A total of 2876 (M-1,229; 1647F,) community members were reached with information during the dialogues.

ii) Promoting FP through edutainment

Magarini Cultural Centre conducted 5[69] FP edutainment sessions in Magarini Sub County. The Centre uses trained Kaya elders and reformed TBAs to compose and execute educative entertainment. During the edutainment session, various educational entertainment activities (songs, dance and drama) were utilized to mobilize and educate community members on the importance of FP. The songs and drama were tailored to local context to make them more relevant, evoke emotions, stimulate discussions and show ultimate consequences of both healthy and unhealthy behaviors to the audience. On average 500 community members were reached with FP information through these forums and 76 women served with FP methods.

iii) Promoting post-partum FP through Mama Groups

During this reporting period, *Afya Pwani* utilized existing mama and binti kwa binti as avenues to share information with expectant women as a preparatory step for post-partum FP. During the Monthly mama group meetings, the project team worked with the health providers to educate the women on the family planning methods, emphasizing the importance of FP to the mother and child. The project also encouraged the women to start FP discussions with their partners early enough, to have adequate time to negotiate for acceptance especially for those who were against FP.

Progressively, more members of the groups are taking up FP immediately after delivery as illustrated in the figure below.

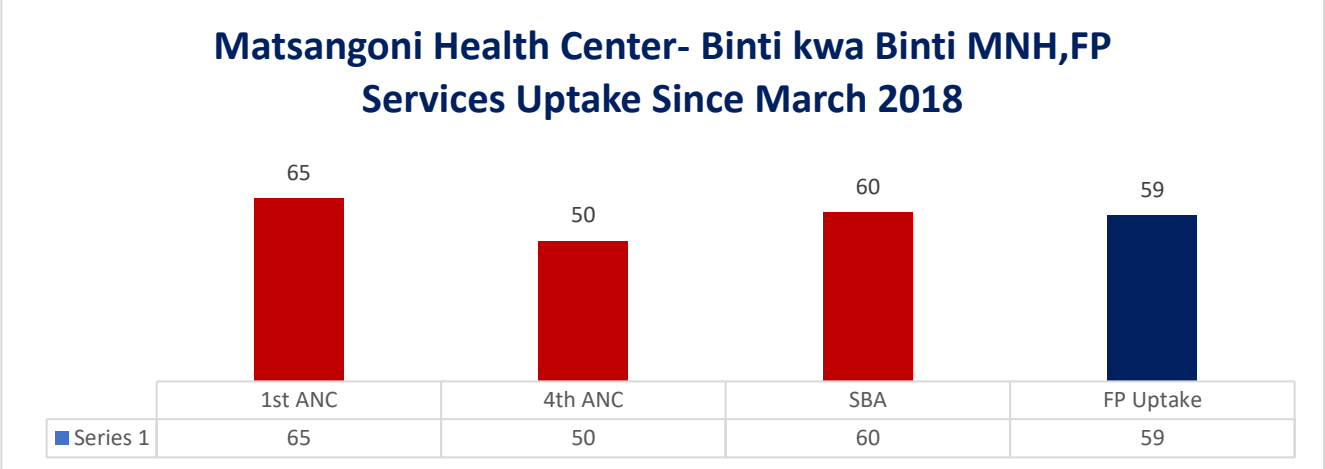


Figure 28 Uptake of post-partum FP in Ganze HC

iv) Engaging Community leaders as champions for FP

During the reporting period, *Afya Pwani* together with its grantees engaged 680 community leaders, in advocacy sessions aimed to avert harmful cultural beliefs and practices that hinder uptake of family planning.

[69] Fundi-issa, Kipangajeni, Sosoni-Majengo, Sabaki-Shella and Mwangatini

Communities in Kilifi County continue to uphold retrogressive practices which debase a woman's power to decide how many and how often she would wish to give birth. Often, women are forced to compromise their fertility intentions to save their marriages. In addition, family planning is still castigated based on its perceived side effects and myths. It's against this background that *Afya Pwani* initiated discussions to influence and achieve buy in from respected opinion leaders such as religious leaders, administrative representatives, village elders, Kaya elders, youth and women group leaders etc. Building a case around the growing economic crunch facing the country, these advocacy sessions sought to evoke debates on population management as a means for survival and development hence the need for FP. Progressively the leaders changing their hard stand on FP and encouraging their constituents to plan their families. Consequently, 12 Chiefs in Kilifi North, Kaloleni and Magarini Sub Counties invited the *Afya Pwani* team to their community Barazas to educate community members on FP.

Advocacy meeting with religious leaders in Ganze Sub County

The project intensified engagement of religious leaders to get a common understanding on the concept of FP. 12 advocacy sessions were held with 246 leaders from different denominations including Muslim leaders, sensitizing them on the importance of child spacing while arguing for reason in the interpretation of "go ye and fill the earth". Most of the participants viewed delayed conception as a sin but could not back it with evidence. After in-depth and continuous deliberations, the leaders agreed that there is indeed need for contraception and child spacing. Many of them, even those who were adamant about family planning made positive statements of support for FP.

"The instruction to fill the world was not meant for one individual, it is a shared responsibility, so let us plan our families, give birth to the number of children we can comfortably raise and leave space for others to contribute in filling the world", said one Pastor.

In Kaloleni Sub County, the Chairman of the religious leaders' association further requested for a comprehensive training session for the leaders to facilitate them in passing correct information to their congregation. The association also agreed to incorporate FP education during marital couple counselling sessions. In Ganze and Magarini Sub Counties, two pastors have since referred 80 clients for FP services in Ganze health Centre (20) and Sabaki dispensary (48) respectively.

v) Increasing male involvement in Reproductive Health

The period under review, *Afya Pwani* continued to engage men at three intersecting levels: as clients, as equal partners and as advocates of change. Working with 157 RH male champions across the County, the project reached 2,897 men including motor riders -who are the main perpetrators of teenage pregnancy- with information on safe sex and contraception. The champions also visited local drinking dens and fishermen beach units where men frequent to be able to reach as many men as possible. As a result, the champions successfully referred 121 couples and 209 women for FP counselling and services. Couple counselling for FP

have been instrumental in encouraging men to become more actively involved in decision-making about family planning with their partners.

Additionally, the project through its grantees conducted 15 "men only" dialogue meetings in Magarini and Ganze Sub Counties where uptake of FP was low. These forums sought to enlighten men about FP, dispel myths and misconceptions as well as create an understanding of low male involvement in RH. From the discussion, it was evident that men wish to space their children, however lack adequate access to information and services. The men also expressed concern with side effects experienced by their spouses after using contraceptives. Taking into account the views and concerns shared, the project team explained possible reasons for adverse side effects and the wide range pf FP method mix to choose from in the event one is not suitable. The 12 participants who complained of adverse side effects experienced by their spouses were referred to health facilities for further counselling and services. The project also distributed 3267 condoms during these gatherings.

vi) Empowering TBAs as FP advocates

TBAs are often provide pregnancy care, deliveries and post-natal care for the mothers. *Afya Pwani* has continuously engaged the TBAs, dissuading home-based ANC and delivery services and instead encouraged the TBAs to serve as change agents and birth companions- whereby TBAs accompany or refer their clients to health facilities. In quarter 4, the project introduced FP promotion as an additional responsibility to the TBAs it works with. The project sensitized 214 TBAs on FP, in anticipation that, as the TBAs visit their clients pre- and post-delivery, they can as well provide effective counselling for FP and even refer for services. The TBAs were actively engaged in community sensitization and referral for FP. In total 1070 clients were referred for FP services. Moving forward, the project will continue strengthening the capacity of the TBAs to be able to distribute pills and condoms at community

vii) Community based distribution (CBD) of FP

During this reporting period, *Afya Pwani* supported the roll out of CBD of FP in Kilifi County, reaching a total of 10,042 clients with FP services at community level. Implementation of CBD in the county was aimed enhancing awareness, access and utilization of FP at community level. The project trained 38 CBDs in Kaloleni and Ganze Sub Counties this quarter. Considering this was the first attempt to implement CBD in the County, rolling out of actual dispensation especially for pills was slow. The County lacked structures to monitor commodity dispensation as well as document results for CBD. There were also doubts on CHV capacity to assess clients before giving pills. To address this, in quarter 4 (July- September) the project supported consultative meetings with the County Health Management team to set CBD qualifications, identified a standard training curriculum and developed reporting tools for CBD. The trained distributers could give pills and condoms. To-date a total of 251 clients have received pills and 207 clients given condoms. To ensure adequate client assessment for suitability of pills and other FP methods, the trained CBD are only limited to give pills to continuing clients and advised to refer all new clients for adequate counselling and assessment.

Moving forward in Y3, the project will continue strengthening capacity of the distributers as well as monitor to measure impact of the same.

viii) World contraception Day.

During the reporting period, *Afya Pwani* supported World Contraceptive Day (WCD) activities in Kilifi County. This year's theme was "*It's your life, it's your choice",* with the following sub-themes: *1) Know your body 2) Know your partner and finally 3) Know your options*." Project staff actively participated in planning meetings with the Kilifi CHMT and 25 other stakeholders supporting the event, including but not limited to: *Afya Pwani* Staff, National Council for Population and Development (NCPD), and Kenya Youth Muslim Development Organization (KYMDO). Stakeholders developed a WCD budget, planned for pre-event activities and D-day activities which included service provision and awareness/demand creation. The WCD pre-events was held in the Sub Counties where 12 in-reaches, three BTL camps, seven community dialogues, six advocacy meetings and five outreaches were conducted.

The main WCD event was celebrated in Gotani, Kazungu Kambi Stadium, in Kaloleni Sub County, an area with poor FP indicators in Kilifi County. The function was officiated by the County Executive Committee Member of Health (CEC) for Kilifi County; other esteemed guests included but were not limited to Kilifi County Youth and Gender CEC, Kilifi County Director for Health, Deputy District County Commissioner for Ganze Sub County, Kiifi CHMT and SCHMT members, Kilifi Kenya Medical Training College (KMTC) principal and students, health workers, CHVs and community members. During these celebrations, about800 community members were reached with positive FP information; 32 clients accessed FP services (Implants- 15, IUCD- 3, Pill-s 9, injectable - 5); cervical cancer screening done for 42 clients. Lastly, a total of 26 clients accessed HTS with one testing HIV positive.

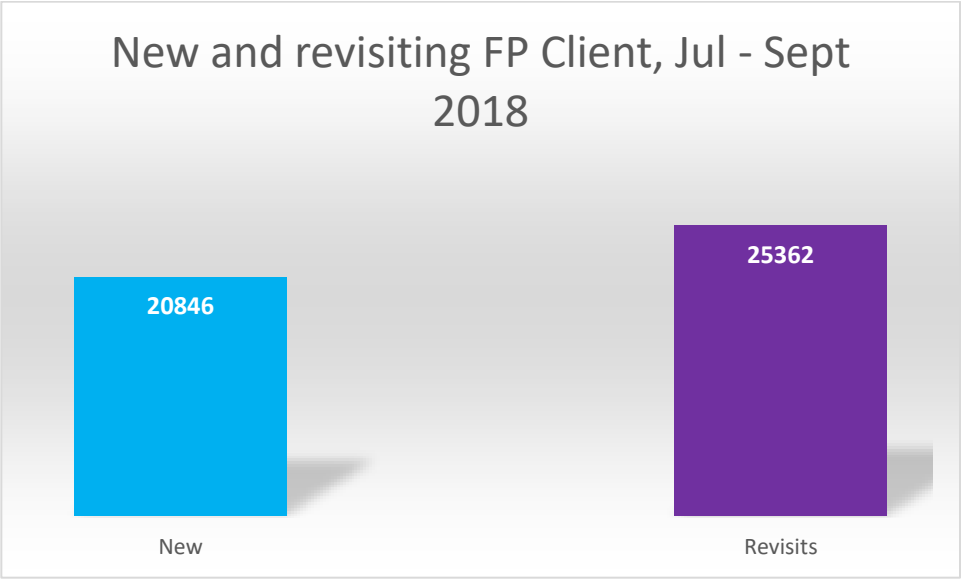


Figure 29 New and revisiting FP clients – Quarter 4

Tremendous success in uptake of FP services in Kilifi County over the reporting period during which the number of WRA who accessed FP services were 46,108 as compared to 34,705 in the previous quarter and 11,637 clients same period the previous year. The upward and steady trend in the graph above can be attributed to the demand creation activities that the project has been implementing over the quarter and to in reaches that were supported by *Afya Pwani* during this period. The project will continue supporting more in reaches in the quarter, ensuring FP compliance as recommended by USG regulations on voluntarism, informed choice of FP method and consent so that clients access the FP method of their choice. The figure below shows FP method mix *in Afya Pwani* supported sites in quarter 4. The table below also provides more information on the actual numbers of clients who received FP counselling and the full range of FP methods.

Trends in FP Method Mix from Oct 2017 to Sept 2018

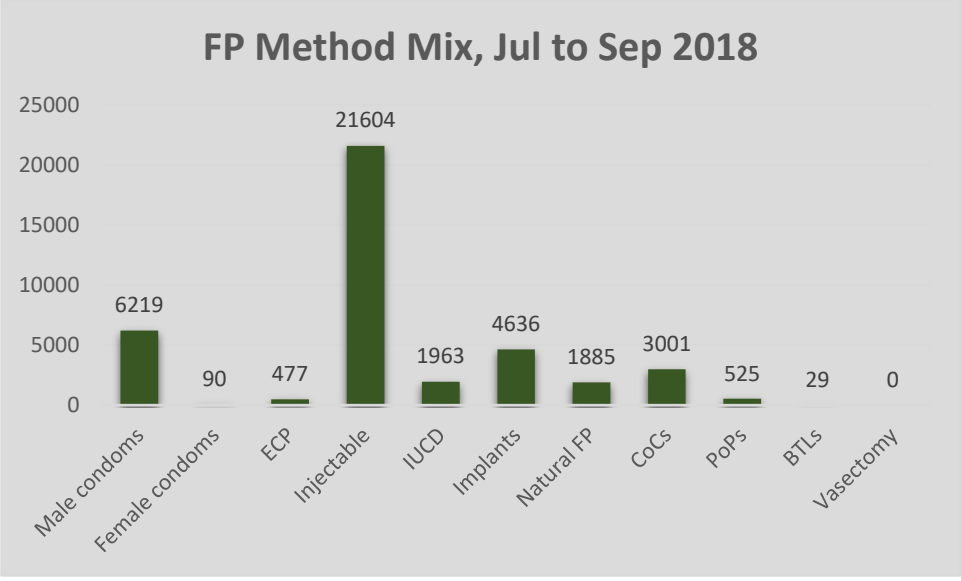


Figure 30 Method Mix, July to Sept 2018

In the period under review, nearly half of FP clients preferred injectable contraceptive as compared to other modern methods of FP. (21,604 of 46,108). This is attributable to its popularity in the community due to the perceived secrecy (that once administered, leaves no evidence). This also points to high level of stigma in the community associated with FP use and the need for discretion among FP clients experience the effect of '*Mwenye Syndrome'*. In the coming quarter, the Project will maintain its comprehensive counseling and continue to accommodate clients' choice as per the national guidelines. Advocacy, demand creation and awareness creation will also be upheld in order to raise community participation and uptake of FP services.

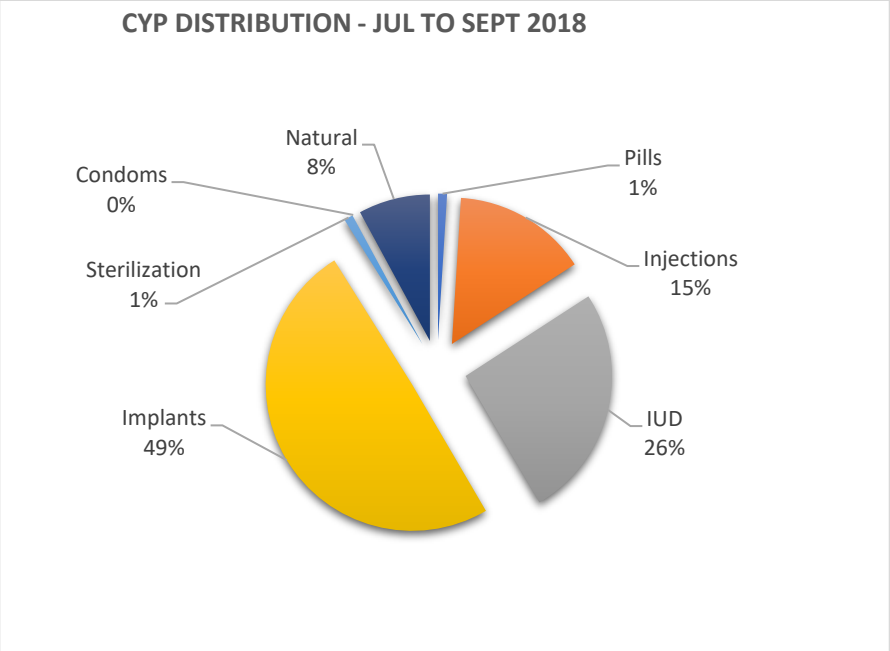
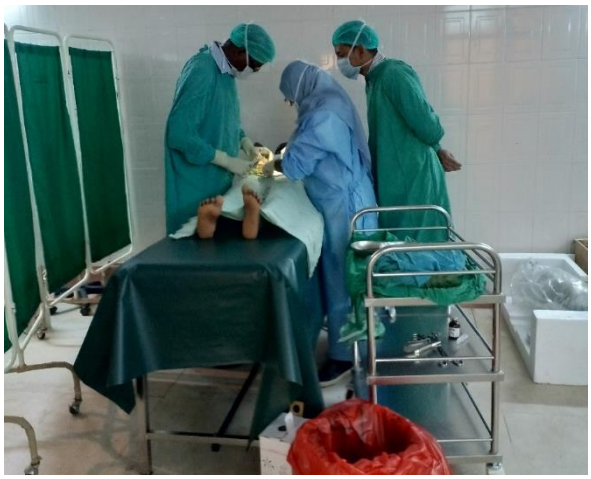


Figure 31 CYP trend in Kilifi County

Figures above shows the trend in CYP for October 2017 to June 2018.

During the period under review, implants (49%) were by far the highest contributor to CYP, followed by IUDs (26%) and injections (14%).

b) Improve the quality of FP services provision



County Gynecologist demonstrated BTL procedure to a MO at Bamba SCH

During the reporting period, *Afya Pwani* conducted mentorship sessions for 52 (M-24, F-28F) HCP who were previously trained on Long Acting Reversible Contraception (LARC) and six others who were trained on BTL. Four BTL camps were organized at Bamba HC, Kilifi County Referral Hospital (twice) and Malindi SCH, that translated to at least 10 clients accessing permanent methods of FP. The purpose of this mentorship was to fine tune skills and knowledge that was acquired during the trainings. As a result, four nurses, two clinical Officers and three medical officers were mentored, most of whom will continue practicing under minimal supervision. At least 42 out of the 60 LARC trained staff are now competent and can work on their own with

regular support from the RH coordinators. In the next quarter, the project will mentor more HCP to champions in FP.

In addition, *Afya Pwani* continued to support HCP in Kilifi county to maintain compliance to the USAID FP compliance legislative policy, ensuring volunteerism and informed choice approach to FP services. In this regard, the above-mentioned staff were taken through FP compliance lessons. At least 50 Tiahrt Charts were distributed to 42 facilities as IEC materials for FP counseling.

c) Strengthen youth friendly services to increase uptake of FP

i) Capacity building of health service providers and CHVs on RH/FP

Three trainings were conducted for youth peer educators on Community Based Distribution of family planning commodities. Youth were drawn from 3 Sub Counties namely Kilifi North (M-3M, F-20), Kilifi South (M-10, F-11) and Magarini (M-17, F-11). In the period Jul-Sept 2018, these peer educators have been engaged to reach out to young people through sports. For instance, during the International Youth Day they managed to reach approximately 650 young people (M-230, F-420) with messaging on contraceptive use. Subsequently, the young people took up contraceptive services as follows: 224 men and women were successfully referred for FP services, 7,200 male condoms, four female condoms, and 30 Oral Contraceptives were distributed. In Matsangoni, the peer educators identify young people in the villages and refer them for services at the heath facility where they have a black book where they write details of the referred young person. An additional 30 youth peer educator from Rabai Sub County were trained and 11 MTG registered girls from Ganze Sub County with the aim of equipping them with knowledge to and skills of community-based health education and promotion of positive reproductive health messages. Additionally, 40 peer educators were engaged and through them, Pwani university managed to reach 863 youth with FP education and 103 youth with contraceptives. Pwani University also managed to identify, educate and link to clinics 465 pregnant mothers to health facilities. Three youth forums were organized to sensitize youth on the importance of having safe sex, reporting SGBV cases and seeking family planning services. The sessions were held at Mambrui, Marereni and Ngomeni where 82 youth (M-48, F-34) attended. The CBDs were able to distribute 480 pieces of male condoms.

A five-day YFS training was conducted from 17th-21st September 2018 targeting Heath Care Workers offering services to young people. All the 16[70] facilities factored in the AYSRH framework had representation and participated in the training. Additionally, these facilities were supported with guidelines for provision of adolescent friendly services in Kenya and job aids including the adolescent cue cards to aid in offering contraceptive counseling to the young people. The training resulted in development of action points to be implemented in the respective facilities that were trained. A total of 20 Health Care Workers from 16 facilities were trained.

ii) Adolescent contraception

During the reporting period, more adolescents chose to practice contraception. At least 688 adolescents aged between 10 and 14 took a contraceptive method compared to only 13 in the previous quarter. This success is attributable to community and CBD conducted by youthful CBDs that were trained the previous quarter as well as the YFS training that targeted HCP.

[70] These are Mtwapa Health Center, Rabai Health Center, Gongoni Health Center, Mariakani Sub-County Hospital, Kilifi Sub-County Hospital, Chasimba Health Center, Malindi Sub-County Hospital, Bamba Health Center, Vipingo Health Center, Matsangoni Health Center, Gede Health Center, Marereni Dispensary, Ganze Health Center, Vitengeni Health Center, Gotani Health Center and Oasis Medical Center (a private facility)

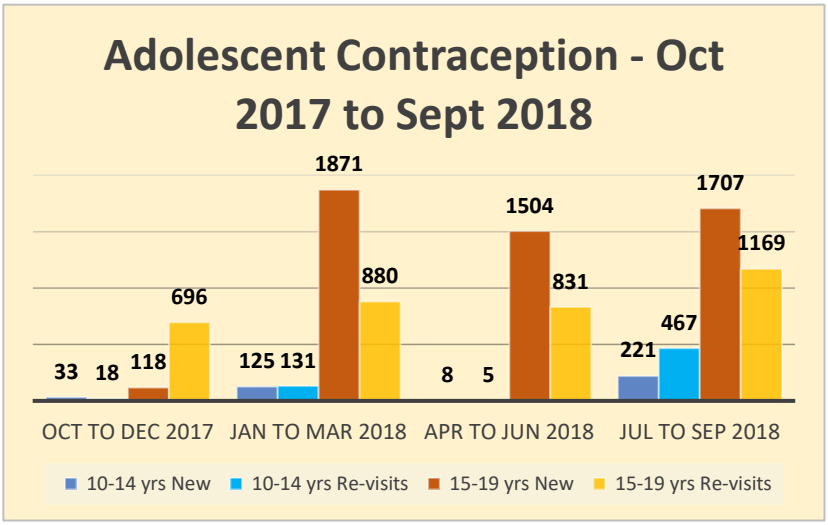


Figure 32 Adolescent contraception - Oct 2017 to Sept 2018

e) Family Planning Commodity Reporting

Commodity Management Supportive Supervision covering all aspects including child health and FP was carried out in five facilities namely Mariakani SCH, Gotani Heath Center, Rabai RHTC, Chasimba Health Center and Bwagamoyo Dispensary. OJT on various aspects of commodity management e.g. inventory maintenance for Vitamin A Capsules, Zinc/ORS copacks, FP commodities, etc and also accurate summarizing of the pages of the FP register wa done. Job aids were distributed. Redistribution of various commodities was done e.g. Combined Oral Contraceptives were moved from Gotani Health Centre where there was an excess to Mariakani SCH. Subcounty Pharmaceutical Facilitators continued getting airtime support to upload commodity reports into DHIS 2.

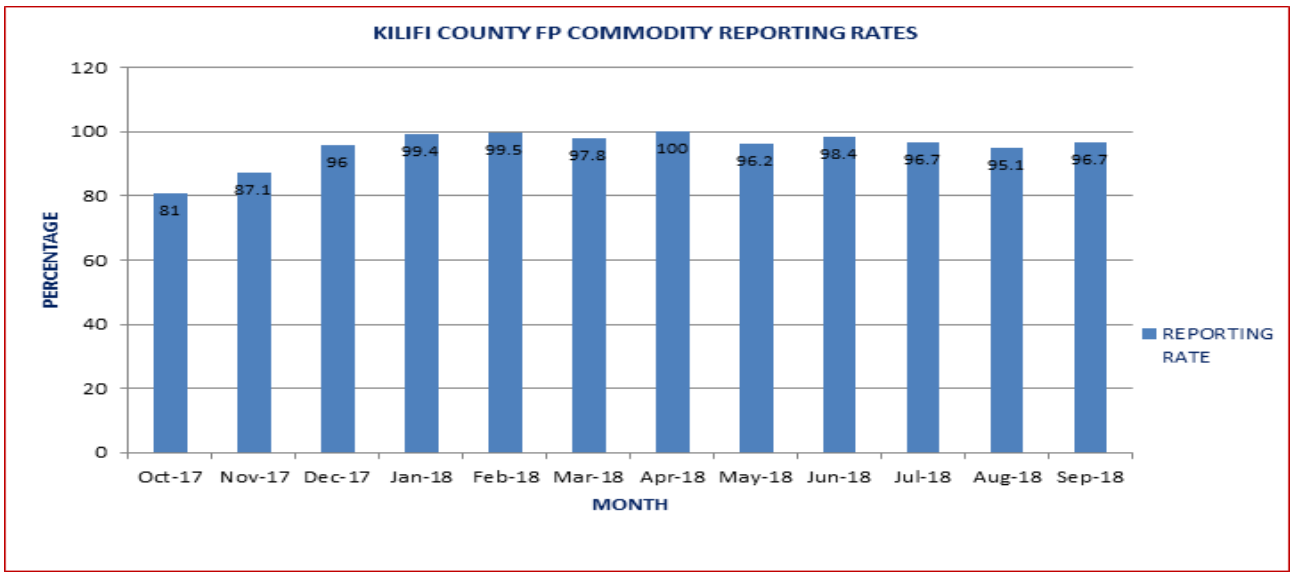


Figure 33 PF commodity reporting rates in Kilifi County

Output 2.4 Water, Sanitation and Hygiene (WASH)

a) Improved access to Water for drinking, domestic and animal use

In an effort to improve access to water for drinking and domestic use, the program successfully completed the installation of 5,000 litre capacity storage tanks and pipeline extensions in seven health facilities and one primary school, tallying to a total of eight high volume institutions[71] thus improving water storage systems. The installations included minor rehabilitation, storage tank installation and guttering for rainwater harvesting in health facilities within priority sub counties of Ganze, Kaloleni and Magarini. A total of 9,642 (M-4,734; F-4,908) beneficiaries were reached in quarter 4 through these interventions

The rehabilitations and pipeline extensions installations for to the 9,642 beneficiaries reached in quarter four disaggregated by gender through interventions at health facilities and primary schools is summarized in the table below:

Table 31 Summary of facilities benefiting from interventions for improved access to water by *Afya Pwani*

Name of Institution/Facility	Males	Females	Total
Adu Dispensary	735	765	1500
Fundi Issa Dispensary	274	286	560
Sabaki Dispensary	955	995	1950
Bamba Sub County Hospital	931	969	1900
Chalani Dispensary	539	561	1100
Zowerani Dispensary	245	255	500
Marekebuni Dispensary	619	646	1265
Shangia Primary school	436	431	867
Total	4734	4908	9642

b) Low access and uptake to sustainable sanitation within the Program area

i) Scaling up of Community led total sanitation (CLTS) and School led total sanitation (SLTS) interventions

Improving access to sanitation at both community and institution level ensures that the project beneficiaries' lives are safe and healthy environment through with proper disease transmission interruption measures. The promotion of safe use of sanitation facilities for safe disposal of feaces through the CLTS approach as the key strategy under *Afya Pwani* that contributes to the realization of the rural ODF Kenya roadmap by 2030 and consequently coupled with improved access to safe water and hygiene practices reduce diarrheal diseases especially among children and mothers. After CLTS triggering at village

[71] Sabaki Dispensary, Adu dispensary, Fundi Issa Dispensary, Chalani Dispensary, Bamba Sub County hospital, Zowerani Dispensary, Marekebuni Dispensary and Shania Primary School.

levels, follow up and review meetings with communities on the progresses of CLTS is key to ensuring the pace is maintained towards ODF achievement and subsequently improve the sanitation coverage. Sustainable access to sanitation services in the program remains a key issue that is now being address through the innovations around sanitation marketing. The roll out of the sanitation marketing strategy has taken off and is closely being monitored and progress will be reviewed from time to time to ensure an active sanitation supply chain through the local entrepreneurs.

At the same time school-based sanitation and hygiene promotion interventions contribute to uptake of sanitation practices among school going children and allow children to act as sanitation and hygiene improvement agents within their communities and more specifically at their homes. This is realized through the school led total sanitation approach whereby schools are triggered to ensure Open defecation free environments within their schools. Parents and children work together to ensure total sanitation is achieved in schools. During the Quarter four implementation phase, the program accomplished the following:

Support the post-triggering follow-ups and Verification

To track the progress realized within the triggered villages, *Afya Pwani* project staff also incorporated review meetings at each Sub County level to assess the progress made in regard to the implementation of CLTS within triggered villages. These meetings were also apt platforms for the *Afya Pwani* team to provide TA and supportive mentorship for identified CLTS champions from the triggered communities, who have and will continue to play a pivotal role in helping their communities improve access to and use of improved sanitation at the community level. During the quarter under review, follow ups were conducted in Kaloleni, Mwahera, Jaribuni and Vitengeni wards.

A total of 322 new latrines had been constructed by the communities in Kololeni, Mwahera, Jaribuni and Vitengeni wards. This resulted to increased access to basic sanitation facility to 1,932 (M-946, F-986) people for quarter 4. Because of the routine follow up on the villages triggered in those wards, the communities have presented a total of 16 villages[72] that are set for Sub County Public Health Officers v and third-party verification in quarter 4.

Table 32 The 16 villages presented for SCPHO varication

Village	No. oh HH	No. of Latrines
Darajani	41	41
Nzovuni	49	45
Mihuhuni	33	25
Mchekenzi	53	53
Ngamani	46	38
Mwele	24	24
Spaki	24	24
Koromio	18	16

[72] Darajani, Nzovuni, Mihuhuni, Mchekenzi, Ngamani, Mwele, Spaki, Koromio, Jibidishe, Sosoni, Sinikumbe, Kakanjuni, Majengo A, Majengo B, Jaribuni, Katsangani

Jibidishe	31	29
Sosoni	29	25
Sinikumbe	32	27
Kakanjuni	47	40
Majengo A	96	90
Majengo B	84	79
Jaribuni	61	59
Katsangani	31	31

ii) Initiation of Sanitation marketing

During Quarter 4, *Afya Pwani* worked with communities to implement sustainable sanitation for improved sanitation services. The availability of enabling environment that promotes the implementation of an effective, affordable and sustainable sanitation scale up strategies that address both the needs in the supply and demand side as well as overcoming the technical challenges of latrine construction remains key in ensuring success of the sanitation interventions. In the reporting period, the program continued with the sensitization efforts of the community members as part contribution towards the Kenya 2030 ODF road map. To achieve the improved sanitation demand creation, the project undertook a sanitation marketing and sanitation business skills development training targeting Community Health Volunteers and local artisans. A total of 38 (M-24, F-14) individuals benefited from the training and are now part of sanitation marketing entrepreneurs and promoters of sustainable access to improved sanitation at the community

The training involved demonstrations on installation of Makiga interlocking soil stabilized block making machine, demand creation concept of the artisanry and a general business model to the product and services offered by the above group. The trained artisans are supporting communities to manufacture of Interlocking stabilization blocks for upgrading of latrines at health facilities and subsequent scale up in villages.

iii) Support construction and rehabilitation of sanitation and waste management

Gongoni six-door VIP latrine

The project had planned to construct eight-door sanitation facilities in the year to improve access to sanitation to the beneficiaries in high volume health facilities and schools. The project was able to successfully construct six-door sanitary block at Gongoni health facility in quarter 4. The completed water borne toilet block has incorporated the disability component in the design to ensure inclusion. The construction works has increased access to improved sanitation to over 1900 people (M-931, F-969).

c) Uptake of desirable Hygiene promotion practices and behaviors for prevention of childhood diarrhea

i) Promote water safety improvement practices

Point of use water treatment is key in ensuring household water quality and goes a long way in diarrheal disease prevention among household members and children under 5. *Afya Pwani* program is in the front line in ensuring household water quality for the target communities.

During quarter 4, the project purchased and distributed 18,500 Aqua tabs and 21,120 purr sachets for water treatment at the point of use (POU) in Ganze, Magarini and Kaloleni through trained WMC members, HFMC members, artisans and community based CLTS promoters and public health workers. As such, a total of 581,200 liters of water was treated at point of use during the quarter four review period.

Despite the quarter being characterized by heavy rains, the project worked closely with the county government and PHOs to control under five diarrheal cases as there were floods experienced within the county. As a result of the natural calamities of flooding, the general under five diarrheal trends for the county was on an upwards trend in terms of the cases reported. The project scaled up sanitation and hygiene promotion messages in the affected areas to curbing diarrheal cases.

ii) Enhance community engagements on hygiene promotion

To enhance the community actions on hygiene and sanitation behavior change, the project incorporated regular dialogues to reinforce the desirable hygiene practices at household level by supporting the community hygiene champions in carrying out regular dialogues and engagements with communities. During Q4 community dialogues on hygiene promotion were supported at Dida and Jaribuni villages. The dialogues involved practice on handwashing and installation and use of tippy taps. The attendance for the dialogue sessions was 175 (M-85, F-90) for both Dida and Jaribuni villages. Similarly, the project undertook a hygiene promotion drive through the community-based promoters in Ganze Sub County. This is part of the larger scale up to ensuring routine safe hygiene practices at the community. A total of 48 (M-24, F-14) people attended the sensitization in Ganze and are expected to be part of the change agents to support with more installation of tippy taps. The 'tippy tap' has economic, efficient, adaptable and convenient benefits to users as it keeps main water source safe from germs and reduces the chance of bacteria transmission as the user touches only the soap.

iii) Implementation of school hygiene and sanitation promotion interventions

Improved practices among school children has a positive effect on their health and that of their families. School led total sanitation (SLTS) approach is an effective way of ensuring all school environments and their catchments become safe and clean to minimize disease transmission. This is part of the comprehensive school health approach that the project is using to ensure uptake of good hygiene and sanitation practices among school going children who are good change agents at the household level and influencing behavior change. Involving teachers, parents and pupils in the promotion of sanitation and hygiene in schools creates culture of ownership and sustainability of school hygiene promotion.

During the Quarter, *Afya Pwani* disseminated health messages through the SLTS approach in schools within Kaloleni and Magarini Sub Counties. In Magarini Sub County Health messages were disseminated

in eight schools[73] reaching a total of 608 boys and 646 girls. In Kaloleni, 10 schools[74] took part in the dissemination of hygiene promotion behaviors reaching a total beneficiary of 2012 boy and 2206 girls.

A total 5472 (B-2620, G-2852) pupils participated in the school led total sanitation triggering on hygiene and sanitation dissemination. The roll out of the SLTS has resulted into installation of hand washing station (Tippy tap) in the schools and improved sanitation. The primary targets, that is the school children, are particularly influential in ensuring their parents put up latrines and related hygiene facilities for promoting sanitation. Through these concerted efforts it is anticipated that the prevention of diarrheal illnesses among school children can be realized over the project period.

Table 33 Summary of SLTS roll out

Sub County	Primary School	Boys	Girls	Total
Magarini Sub County	Baraka Jembe	55	43	98
	Thethesa	173	146	319
	Mtoroni	125	128	253
	Mogole	36	46	82
	Yedhi	23	31	54
	Mwaeba	102	159	261
	Fundi Issa	45	62	107
	Mambrui	49	31	80
Total		**608**	**646**	**1254**
Kaloleni Sub County	Shangia	310	255	565
	Migundini	238	325	563
	Chanagande	23	31	54
	Chalani	14	14	28
	Walea	0	185	185
	Miyani	24	33	57
	Baraka	510	478	988
	Misufini	394	351	745
	Makomboani	242	301	543
	Kizurini	257	233	490

[73] Barakajembe pri (B55, G 43) Thethesa pri (B173, B146), Mtoroni (128G, 125 B) Mtoroni (87G- Girls targeted topic Menstrual Health Management - MHM), Mogole (B36, G 46) Yedhi (B 23, G31) Mwaeba (B 102, G 159) Fundi Issa (B 45, G 62) Mambrui (B 49 G 31)
[74] Shangia pri (310B, 255G) Migundini (238B, 325G) Chanagande (23B, 31G) Chalani (14B, 14G) Walea(185g) Miyani (24B, 33G) Baraka pry (G478 B510) Misufini (G 351, B394) Makomboani (B242, G301), Kizurini (257B, 233G)

Total		**2012**	**2206**	**4218**
Total direct beneficiaries		**2620**	**2852**	**5472**

The project further held a reflection and consultative meeting bringing together all the school health implementation teams from the respective areas where *Afya Pwani* is implementing the school led total sanitation. The meeting where 40 (M-30, F-10) participated, brought together the teachers, public health officers from the target sub counties to reflect on the progresses made so far in School Led Total Sanitation(SLTS) promotion activities and deliberate on sustainable uptake of hygiene and sanitation practices at school level. The key deliberations from the meeting for enhancing sustainable school hygiene interventions are as follows:

- Strengthening the school health clubs and formation of the same for those who still do not have.
- Peer to peer communication in hygiene behavior change promotion
- Involvement of the BOMs and Parents for sustainability, especially for construction projects
- Hygiene open days in schools involving parents, and other community members
- Creating competition among schools.
- Joint support supervision from the education and public health officers

Challenges:

Challenges Encountered	**Recommendations**
Collapsing pit latrines due to weak soil structure	Promote use of ISSB
Water contamination due Flooding experienced in previous quarter	Enhanced hygiene promotion and use of water treatment products
Opportunities	
Willingness of the community to use locally available resources	

Output 2.5 Nutrition

a) Strengthening the Sub County capacity to support/lead the provision of Nutrition Services

To strengthen County, Sub County and other stakeholders to support nutrition services, a sensitization meeting was conducted in Malindi sub county on Baby Friendly Community Initiative. (BFCI) where 32 (M-18, F-14) participants attended. This was awareness creation on Maternal Infant and Young Child Nutrition (MIYCN) policy, that demands understanding by health workers from all levels.

During the reporting period, a planning meeting was conducted for Malezi bora week at KCH involving all stakeholders[75]. The importance of this activity is that it enhances/promotes uptake Vitamin A supplementation to children under five as this activity is carried out in ECCD centres within the community.

[75] Xxxx List stakeholders here

To improve on documentation of nutrition activities, 10 CHVs, one nutrition officer and two PHOs attended a review meeting on anthropometric assessment, defaulter tracing, case finding, and referrals conducted in Kilifi south. During the meeting it was observed that there is an improvement of birth weight over a period of 10 months from 66% to 76%.

b) Strengthening the Health facility capacity to provide Nutrition Services

To strengthen health workers performance on nutrition service improvement, a joint supervision involving *Afya Pwani* and Ministry of health was conducted in Takaungu, Mavueni and Mnarani dispensaries for the reporting period. The Nutrition component focused on providing feed back to health facility in charges on implementation of the MIYCN policy.

A rapid assessment on the implementation of the policies indicate that the above facilities are at different levels of implementation (79.5% (Takaungu), 79.5% (Mavueni) and 74.4% (Mnarani). In quarter four Continuous Medical Education(CME) sessions were conducted in Killifi South (Mtwapa, Vipingo), Kaloleni (Mariakani), Magarini (Marafa, Gongoni), Kilifi North (Gede, Matsangoni, KCH) and Ganze (Bamba) Sub Counties. This was necessitated by quarter 2 training on baby friendly community initiative where one key action point was to brief all health care workers in the facilities on the Baby Friendly Community Initiative(BFCI) guidelines. This has enhanced their active participation during implementation. Six health facilities carried out briefing sessions, where 227 (M-90 F-137) health care workers benefited from the training this is in addition 30 (M-8, F-22) who benefited in Q4.

c) Support relevant community structures and groups to enhance nutrition services at community level

i) Facilitate integrated community outreach services in communities

During the reporting Quarter, *Afya Pwani* has supported ministry of health in Kilifi County by supporting several child survival interventions, including various operation initiatives, to improve the health of children in Kilifi sub county. These include the expanded program on immunization, the integrated management of childhood illnesses initiative, the infant and young child feeding program, a micronutrient supplementation program, deworming and vitamin A. An assessment to identify malnourished children was also conducted in Kilifi south by CHVs in Mapawa, Mtomondoni, Mwendo Wa Paya and Shimo la Tewa villages, where current data on Size (length/height) and weight at birth for children born in the five years prior to the case finding was noted. Based on the CHVs assessment, 2% of children born were small at birth, 2% were smaller than average, and 84% were average size. The key action points agreed for remedying the situation was to scale up nutrition and maternal health care information sensitization at the community level as well as strengthening further the referral mechanisms to linked facilities as well as nutrition information education in targeted /affected locations.

The Table below represents the findings of the CHVs follow-up, conducted at Mapawa, Shimo La Tewa village, Mwendo Wa Panya village and Mtomondoni village.

Table 34 Findings of the CHVs follow-up

Data element	Under 6 months	Male 6-59 month	Female 6-59 months	5 years
Beneficiaries at the beginning of the month	1	6	10	5
New admission cases	0	1	4	1
Old admission, returns, defaulters	0	1	1	0
Total admission	1	8	15	6
Discharged cured	0	2	2	0
Discharged defaulters	0	0	0	0
Total at end month	**0**	**2**	**2**	**0**

To improve the quality of health of pre-school age children the project conducted joint outreaches to children at early childhood centres to do deworming for the children. As a result of this, 18,165 boys and 16153 girls drawn from Rabai, Kaloleni, Ganze and Magarini were dewormed and given Vitamin A supplementation. This activity was conducted by frontline health workers in conjunction with community health volunteers. The activity targeted hard to reach locations within the county, was accompanied by health talks to the children to enable them to understand appropriate hygiene practices at an early age.

ii) Support Mama groups to promote good nutrition practices in the Community

To improve on knowledge and skills to mothers on nutrition status improvement, a PD Hearth session was conducted in Kaloleni to rehabilitate 11 malnourished children. The children were enrolled to the session based on moderate malnutrition.

During the session mothers and their children were taken through feeding protocols utilizing the local available foods. The mothers prepared meals and fed their children during the sessions in addition to health talks on appropriate feeding practices and encouraged to replicate the same at their homes. Close monitoring will be done for a period of 45 days after which it will be determined if the children will be graduated based on their status then

d) Improved household's food security and nutrition initiatives in target communities.

An assessment on performance of the shed net in Gongoni health Centre was undertaken during the quarter in collaboration with the Ministry of Agriculture. It was noted that leaching (leakage of nutrients) of the plants nutrients due to excessive water that collected in the shade net resulted in slowed crop development affecting its performance. The shed net is designed to allow 75% light during hot season but during rainy season due to cloud cover, it allowed less than 75% light thus inhibiting the growth of most crops planted i.e. kale, spinach, tomatoes, onions, egg-plant and okra. The Shade net efficiency increased during hotter months.

Enhancing the efficiency of the shade net will be collaboration with the agricultural extension workers to determining the right quality seeds to be planted as well as the required precipitation levels. Engagements with the meteorological department would be key especially in prediction of the right planting seasons.

In addition, random spontaneous check on the status of the kitchen gardens was undertaken in specific homes in Mariani (five Households) and Gongoni villages (three households) to observe the replication of the kitchen gardens in homesteads. Encouraging observations were made on the uptake of the kitchen gardens as a nutrition intervention in the community. Households have accessed vegetables on a continuous basis for the last 1 year after the initial trainings.

i) Training women on extraction of coconut oil to improve household food security and dietary diversity.

To strengthen and diversify household food security initiatives, through support of grantees, 13 women from Kilifi South were empowered with skills on extraction, storage and inspection of coconut oil. Most families use coconut milk as food additive as opposed to the coconut oil. Whereas there is available raw material for production of the oil, families lacked the skill to enable them to extract the coconut oils for domestic use. This was informed by the knowledge gap on this activity as affirmed by the sub grantee.

ii) Pilot cross-sector community driven approaches to improve household food security and dietary diversity.

To improve on food security at community level, 14 PMTCT mothers in Mtepeni facility catchment were empowered through training on how to prepare kitchen gardens. The participants were taken through benefits and establishment of a kitchen garden.

At the same time the project conducted Nutrition education on maternal Infants and Young child nutrition to 60 women in Vipingo health facility catchment. The health talk focused on importance of exclusive breastfeeding of infants up to six months, positioning and attachment. Mothers were demonstrated on correct positioning and attachment techniques.

To monitor growth of children within the program area, 10 CHVs carried out anthropometric assessment referrals, active case finding and defaulter tracing in Mtwapa facility catchment. This activity was conducted within community units where common nutritional conditions were identified as- underweight, poor feeding practices and stunting.

Table 35 Actions taken per community unit

Community Unit	Cases identified	Action Taken
Mtwapa	2	CHVs referred child to Mtwapa health facility
Becharo	5	CHVs referred child to Mtwapa health facility
Barani	4	CHVs referred child to Mtwapa health facility
Kwa Mwaritwa	1	CHVs referred child to Mtwapa health facility
Sokoni	9	CHVs referred child to Mtwapa health facility
Mkwajuni	3	CHVs referred child to Mtwapa health facility
Mkwajuni Kijijini	5	CHVs referred child to Mtwapa health facility

Mtomondoni	9	CHVs referred child to Mtwapa health facility
Goa	5	CHVs referred child to Mtwapa health facility
Total	**43**	

To pilot cross sector community driven approaches towards improvement of household food security and dietary diversity, 10 CHVs (Women) were trained on how to make liquid soap from affordable ingredients to help improve on their income.

Thirty(30) mothers were trained on making liquid soap both for home use and for sale to be financially stable. Sixty(60) PMTCT mothers were trained on economic empowerment on how to make star soft.

Conclusion

The July-September period of year 2 program interventions saw to improvement in service delivery within the *Afya Pwani* communities. Increased provision of WASH and Nutrition services within the high-volume health facility catchment communities has gained momentum and will ensure that the beneficiaries access various health services from the respective health facilities in an intergraded manner and thus help address the service needs.

There is significant access to improved sanitation and water access within the project targeted institutions and high-volume facilities. This milestone is significant especially for support the MNCH interventions at health facility level where water supply and sanitation needs have been supported in the health facilities served during the reporting period.

Improvements in access to sanitation in communities continue to be realized. More communities are achieving ODF status with more communities claiming to be ODF meaning that the demand creation for sanitation campaign through the CLTS is effective. More ODF communities mean reduced environmental contamination and thus reduced diseases transmission. The program has planned for quality control for the CLTS villages so that celebrations can be done. This accomplishment coupled with the improved hygiene practices and improved water safety has positive attributions to improved health status of target communities. Reduction in diarrheal illness is an indicator to this result.

Improved Nutrition services also continue to be realized within the programme area. With the support of the capacity development on the key nutrition areas of BFHI and IYFC for health care workers and community health volunteers, the implementation of the IYCF guidelines is expected to hit the 80% target mark in the subsequent quarters of the program.

Close support supervision visits to the health facilities have seen improvements in implementation of nutrition policies and strategies and this will be will be enhanced in the subsequent quarters. The further support for communities to benefit from small gardens and crop production approaches and support with inputs at household level is working positively to improve food security situation for communities.

SUB-PURPOSE 3: STRENGTHENED AND FUNCTIONAL COUNTY HEALTH SYSTEMS

Output 3.1 Partnerships for Governance and Strategic Planning

a) Strengthen planning and budgeting process in the sector

i) Capacity strengthening of facility PBB and AWPs[76] for FY 2019/20

During the Quarter 4, *Afya Pwani* Health Systems Strengthening (HSS) and service delivery teams jointly provided support to the health departments of Lamu and Kilifi Counties to undertake support supervision at facility-level. The aim of this activity was to provide a deeper understanding of facility level challenges and health sector's performance in general. The activity included Focus Group Discussions (FGDs) to identify challenges and best practices in the High-Volume Facilities (HVFs)[77].

From these supervision exercises, it emerged that Counties employed different approaches in addressing health governance challenges affecting effective implementation of healthcare in the devolved system. To ensure predictability of financial flows into the health sector, Kilifi, for instance, is at the initial stages of implementing the recently enacted Kilifi County Health services improvement fund Act, 2016[78]. The Act, through established structures and mechanisms, allows level 3 and 4 facilities to retain a given proportion of generated revenues for utilization at the source. This is envisaged to improve the predictability of financial resources from County treasury to the health department and health service delivery at facility level.

To support the implementation of this new policy, *Afya Pwani* also assessed the facilities' capacity to implement the requirements of the Act. Out of the (13) facilities assessed, 77% demonstrated functional management structures with budgeting and planning roles. These functions are undertaken in line with the existing planning and budgeting guidelines. In most facilities, in-charges demonstrated adequate knowledge and the authority to make decisions to expend available resources. However, sustained and regular support supervision from the County departments to facilities is still inadequate. The project in year 3 will provide mentorship to strengthen the capacity of facility in charges and management team in preparation of facility plans and financial management to, improve allocative efficiency and accountability for facility funds.

The assessment further revealed that most respondents from the facilities had limited understanding of the budget process and subsequently their roles in the overall County planning process. This disconnect in facility and County planning continues to cause challenges of equitable resource allocation by the department to facilities. Consequently, facility AWPs annual work plans (AWPs) for these facilities are prepared as a formality upon request from the department. Further, the centralized budget process with minimal authority at the facility level also emerged as a major bottleneck to health service delivery at the facility level. This challenge was equally observed in Lamu County. In view of the emerging gaps, *Afya Pwani* support in year 3 will focus on strengthening the capacity of health facility and Sub County levels managers in planning and budgeting for FY 2019/20.

In the quarter ending September 2018, *Afya Pwani* conducted a sensitization to enhance Hospital Management Teams's (HMT) understanding of the new annual work plan template, data generation, analysis, and information use to inform planning. The project provided Coast Provincial General Hospital

[76] PBB: Program based budgeting; AWP: Annual Work plans

[77] Kilifi County Referral Hospital, Mtwapa Health Centre, Malindi Hospital, Gongoni dispensary, Vipingo Health Centre, Muyeye Health Centre, Mariakani SCH, Baolala Health Centre, Vitengeni Health Centre, Lamu County Hospital, Mpeketoni Sub County Hospital, Kizingitini dispensary and Faza Health Centre

[78] Kilifi County Health Department, 2016 https://www.kilifiassembly.go.ke/images/HEALTH-HFIF_BILL-CLEAN-FINAL.pdf

(CPGH) HMT with TA in the development of the FY 2018/19 AWP. In the new planning cycle for the FY 2019/20, the project will assist the hospital to align its planning with the health department's budget cycle to ensure inputs from the hospital are incorporated in the overall health sector County plans for Mombasa.

ii) Development of County Health Sector Strategic Plans for 2018-2022

Afya Pwani has been supporting development of County Strategic and Investment Plans for the implementation period 2018-2022 in four Counties; Kilifi, Kwale, Taita Taveta, and Mombasa. During the quarter, Mombasa and Kilifi Counties received support to undertake review meetings with stakeholders to validate the plans pending the launch and dissemination of the same upon final approval by the health committees. Similarly, the project provided TA to Taita Taveta and Kwale in the ongoing development of the County-specific strategic plans.

b) Strengthen stakeholder coordination and collaboration

i) County health stakeholders' forums

In this reporting quarter, *Afya Pwani* supported health stakeholders' forums in Kilifi and Mombasa. In Kilifi, the project supported the department of health to appoint new leadership for the stakeholders' forum secretariat in line with ToRs. In addition, the project supported the County to undertake quarterly consultative forums and in documenting resolutions arising therefrom.

The project further supported the Mombasa department of health in developing the terms of reference and formation of the Monitoring and Evaluation (M&E) Technical Working Group to strengthen the management's capacity to measure outcomes, analyze and utilize data to inform decision making. This has contributed immensely to guiding the development of a comprehensive M&E framework for tracking the programmatic strategies, objectives and implementation of planned activities. The project also supported the department to convene a meeting to discuss how to develop and strengthen monitoring and evaluation development processes in the County. In year 3, *Afya Pwani* will continue supporting the TWG's advocacy efforts for increased investments to strengthen the M&E/health information system in the County.

Output 3.2: Human Resources for Health (HRH)

a) HRH planning strengthening at the County

In the period July to September 2018, *Afya Pwani* supported the departments of health in Mombasa and Kwale Counties to roll-out of performance appraisal systems. During the processes (undertaken under the leadership of HRH stakeholder committees and guidance of CPSB), each County was guided to select a performance appraisal champions for their respective health facilities and Sub Counties. The champions were later sensitized on the revised appraisal tool, performance targets and indicator setting.

b) County HRH assessment and staffing data analysis

In partnership with HRH Kenya Mechanism, the project participated in a workshop where new HRH norms and standards were being developed. The new guidelines are based on the WHO Workload Indicators of Staffing Needs (WISN) tool. A national technical experts' steering committee was also constituted with *Afya Pwani* as a member to drive the technical aspect of the process.

c) Recruitment of Facility Based Contract Health Workers

Following the recruitment and deployment of facility-based health workers in the previous quarters, the project in collaboration with the County Public Service Boards (CPSB's) focused on the assessment of the health workers' performance. In Mombasa however, the project supported the CPSB during the process of advertising and shortlisting potential candidates for interviews scheduled for October 2018. The project also undertook a human capital audit for the facility-based staff to verify and ascertain the existing number of facility-based staff and the workers' qualifications including validity to provide health services for their respective cadres.

d) IHRIS skills building for High Volume Facilities.

In this quarter, *Afya Pwani* collaborated with HRH Kenya in assessing HRH data capture on IHRIS in HVFs in the five Counties. The projects held joint consultative meetings with IHRIS focal persons in the HVFs and the County health departments to strengthen their capabilities to manage the system. As part of continuous TA, the project, jointly with HRH Kenya also supported Kwale to maintain and use data from IHRIS system for HRH management.

Output 3.3: Health Products and Technologies (HPT)

a) Strengthen County commodity management oversight and planning

During the period, *Afya Pwani* supported the health commodities security TWG in Taita Taveta and Mombasa to undertake quarterly TWG meetings. In Taita Taveta, the TWG developed a short-term plan for the 2018 calendar year. The plan outlined commodity management priorities including forecasting and quantification (F&Q), KEMSA supply planning, commodity management support supervision and commodity disposal execution among others.

Further, following development of the android phone-based stock status reporting platform in the previous quarters, the project supported the Commodity Security TWG in Mombasa to scale up and pilot the tool in 37 facilities in the County. *Afya Pwani* also trained 41 health workers and provided access rights to facilitate monthly data entry for selected tracer commodities.

The figure below illustrates the information the tool will generate for tracking stock status for health commodities in Mombasa. It shows that, only one ART commodity was understocked with about a month of stock. If optimally used, this tool will improve supply planning for the selected tracer commodities. Importantly, it will provide the County health management team (CHMT) with real time access to commodity data for improved decision making.

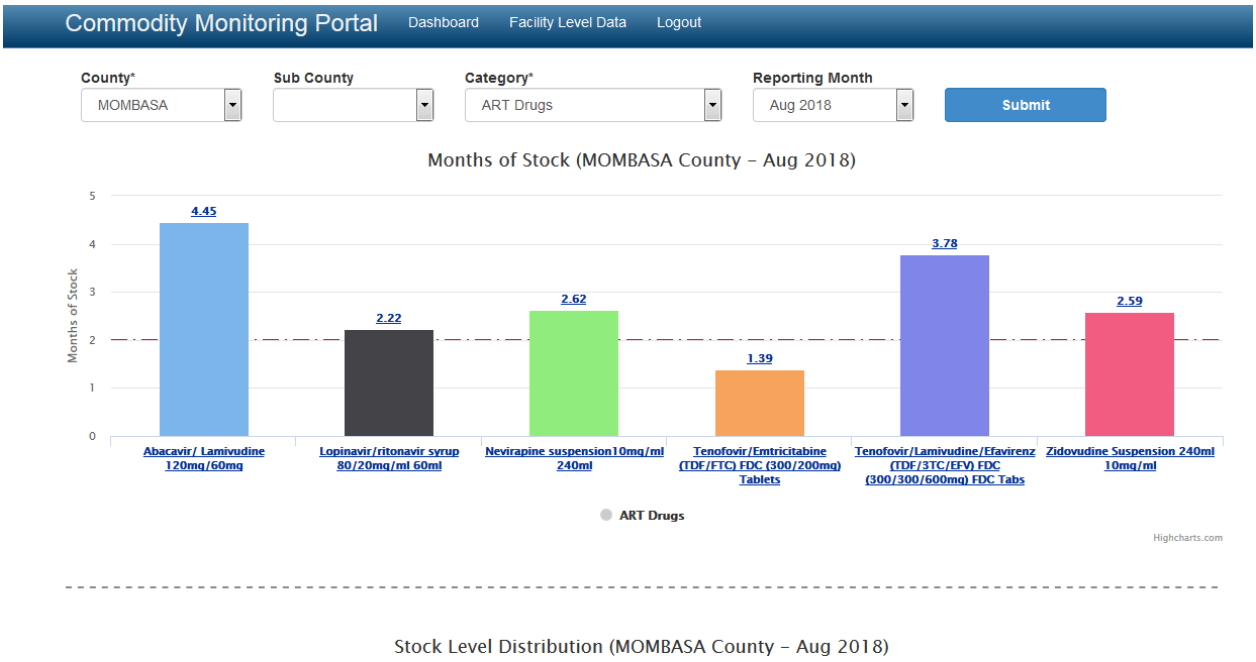


Figure 34 ART Commodities Stock Level Mombasa – Aug 2018

b) Strengthen Pharmacovigilance

As part of the project's continued pharmacovigilance support, *Afya Pwani* trained 55 health workers on pharmacovigilance through a CME at CPGH. The training which was co-facilitated by the hospital pharmacist covered pharmacovigilance systems in Kenya, structure and flow of information in the pharmacovigilance system and ADR monitoring within the same system. The health workers, from different cadres, were also sensitized on the tools for reporting ADRs and poor-quality medicines including online reporting through the Pharmacy and Poisons Board (PPB) and the new Dolutegravir updates/guidelines from NASCOP.

In addition, the project assisted the facility to analyze EMR data to identify high risk patients currently on the Dolutegravir-based regimen. Following the analysis, a plan was developed to facilitate follow up and for some patients, switching to Efavirenz-based regimens.

c) Improve commodity data quality at Facility Level

The project envisaged to scale up the pharmacy dispensing module to 15 additional ART sites in the second year of project implementation. As such, the project deployed supply chain module in Gede Health centre, Kwale hospital and Lamu hospitals bringing the total of facilities with the module in the five Counties to 21. As observed in other facilities, SCM use is expected to enhance patient monitoring and improve commodity data monthly reporting.

The table below presents commodity reporting rates for the five Counties for the Jun-Aug 2018 period. Positive trends were observed in four of the five Counties, improvements that have been attributed to strengthened commodity oversight provided by the CS-TWGs as well as facility mentorship efforts and SCM in select facilities.

Table 36 Commodity reporting rates June-August 2018 Source: DHIS2 8th Oct 2018

Commodity reporting rates June-August 2018				
		FP FCDRR	ART FCDRR 730A	MOH 643
Aug-18	Mombasa	96	94	94
	Kilifi	95	78	69
	Kwale	90	88	95
	Taita Taveta	85	100	94
	Lamu	77	100	46
Jul-18	Mombasa	98	89	98
	Kilifi	96	89	59
	Kwale	92	88	95
	Taita Taveta	99	75	95
	Lamu	74	100	8
Jun-18	Mombasa	96	78	82
	Kilifi	96	89	67
	Kwale	88	88	99
	Taita Taveta	88	50	97
	Lamu	84	100	8

Additionally, in Quarter 4, 14 facilities[79] were visited for commodity management supportive supervision. The visits were done jointly with SCHMT members. On the job training on various aspects of commodity management for example proper inventory management, good storage practices, logistics management information systems and pharmacovigilance was done to 72 health workers from different cadres[80], 29 male and 43 female. Job aids were also distributed during the visits where missing to further equip the health workers with knowledge and skills on good commodity management in the different departments[81] handling commodities. Four of those facilities were being visited for the first time in a shift of strategy towards visiting smaller volume facilities as the high volume become stable in commodity management.

[79] Bwagamoyo Dispensary, Chasimba Health Centre, Diani HC, Gotani HC, Kinango SCH, Kwale SCH, Mariakani SCH, Mazeras Dispensary, Msambweni CRH, Matsangoni HC, Rabai RTHC, Kijanaheri Clinic, Samburu HC, Shimba Hills HC, Tiwi RHTC, and Ukunda Catholic Dispensary

[80] Pharmaceutical Technologists, Pharmacists, Nurses, Registered Clinical Officers, Nutritionists, Laboratory Technologists, Laboratory Technicians and Support

[81] Pharmacy, Medical Stores, Comprehensive Care Clinic, MNCH/FP Clinic, Nutrition Clinic, TB Clinic and Laboratory

This will be scaled up in year 3 to ensure the medium and small volume facilities are at par with the high-volume facilities. High volume facilities will continue being visited but less often.

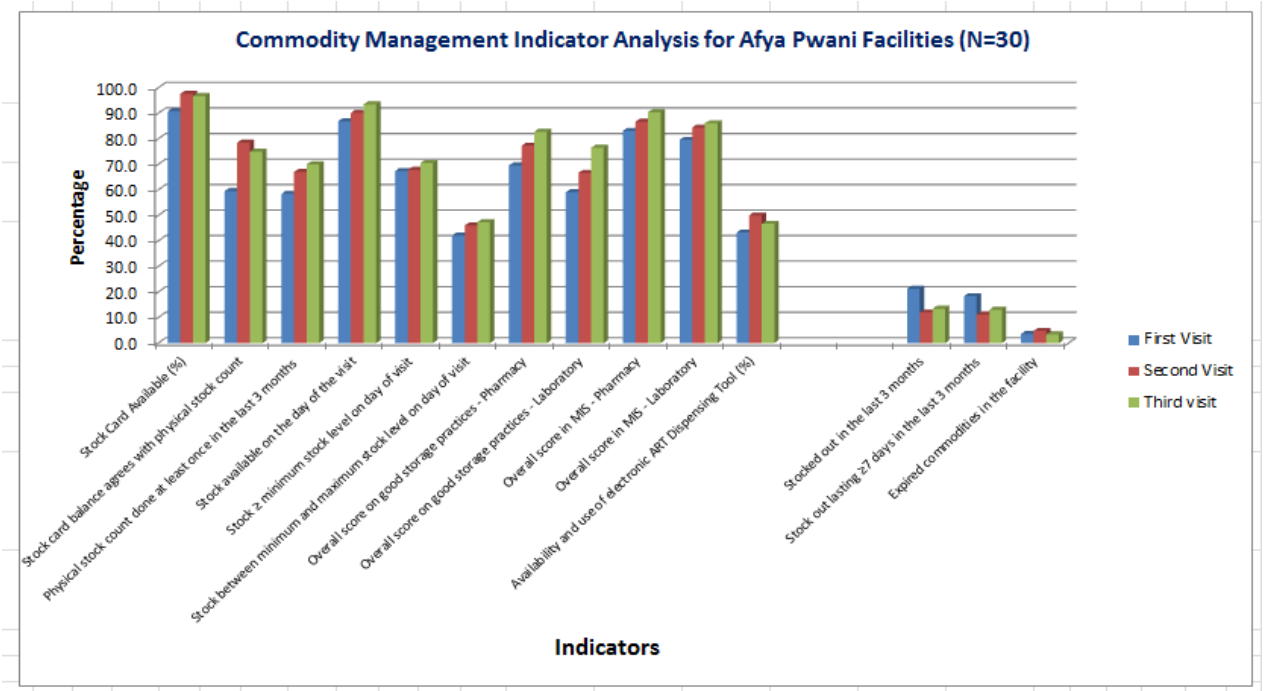


Figure 35 Comparative Commodity Management Indicator Analysis for Afya Pwani Facilities Visited Thrice in FY 17 and FY 18 (N=30)

In the figure above, indicators that are supposed to increase over time are on the left side while the ones supposed to decrease over time are on the right side. Availability of stock cards seems to have increased by the second visit and then decreased during the third visit. This was occasioned by varying the tracer list in FY 18 (Year 2) to include more FP commodities and to include Vitamin A 200000 IU capsules. The latter was discovered to have been very poorly managed previously to the extent where there would be a dispute between departments about where the inventory should be. In some facilities it was agreed that it be kept in the Pharmacy Store but most settled on the Nutrition Department as the primary department that should maintain the inventory. Most facilities didn't have any inventory for the commodities, but it was started during the visits and will be captured in subsequent visits. The same affected stock cards with the recorded balance agreeing with physical stock since the denominator is the total number of tracer items whether there is a card or not. The other indicators generally showed a steady increase which shows that the visits are bearing fruit in the improvement of commodity management practices. Malaria RDTs which is a Lab tracer item was mostly out of stock after a batch expired in June 2017 and that caused the slight increase in stock outs during the third visit. Some Counties also suffered some sporadic stock outs of FP commodities e.g. Kwale County. Expiries increased slightly (mainly due to the Malaria RDTs) and then reduced after a mop up of expired commodities by KEMSA MCP.

Sub County teams continued being supported with airtime to upload commodity reports into both DHIS 2 and HCMP. Commodity redistribution was also supported especially during the support supervision visits for example moving Isoniazid 300mg from Mariakani Sub County Hospital to Chasimba Health Centre, Combined Oral Contraceptives from Gotani Health Centre to Mariakani Sub County Hospital, Tenofovir/Lamivudine/Efavirenz FDC tablets from Mariakani Sub County Hospital to Malindi Sub County Hospital, etc. WhatsApp groups were extensively employed in redistributing commodities among facilities

especially short expiry products. The *Afya Pwani* Commodity Management Advisor was included in the HTS WhatsApp groups and this is used to enquire on availability of HIV Test Kits and mitigate shortages or stock outs before interruption of services. This was done in Bamba Sub County Hospital in Kilifi County where they had run out of First Response, Mackinnon Road Dispensary in Kwale County where they had run out of both Determine and First response, Kibuyuni Dispensary in Kwale County where they had donated all their test kits to other facilities for lack of a tester and then a HTS Counsellor as deployed by *Afya Pwani*, etc.

All the five Counties of Mombasa, Kwale, Kilifi, Taita Taveta and Lamu were facilitated and given technical assistance by *Afya Pwani* during the allocation of HIV Test Kits at the end of Quarter 4. Proper quantification and allocation in Quarter 3 ensured that there were enough stocks in most facilities and this will be sustained to ensure the achievement of the first 90 in the response against HIV/AIDS.

Other emerging issues:

- There was USAID SIMS conducted in seven facilities in Kwale and Mombasa Counties. This informed the decision to henceforth focus on smaller facilities too as opposed to High Volume only. Commodity Supportive Supervision will be scaled up in Year 3 to reach every facility using SCHMTs and spread the gains across all the Project facilities.
- There were fruitful meetings with KEMSA MCP officers who had come to mop up expired commodities and conduct some mini DQAs in Mombasa County on use of HIV commodities.
- The *Afya Pwani* HPT Department was represented at the AIDS 2018 International Conference in Amsterdam, Netherlands during the week of 22nd to 28th July 2018. There was a poster presentation named, "Increasing availability and access to life saving ART commodities through improved inventory management and forecasting using a scored supportive supervision checklist: Case study of five coastal Counties in Kenya."

d) Build the capacity of S/CHMTs and facility staff for good commodity management

To further strengthen commodity management practices, *Afya Pwani* supported S/CHMTs to undertake health commodities support supervision at facility level in Kilifi (11), Kwale (14), and Lamu (7). The exercises identified commodity management gaps and provided a basis for intervention by S/CHMTs. In the three Counties, the project utilized USAID's SIMs tool and FP supervision checklists. Findings from the supervision in Taita Taveta were disseminated during the CS-TWG quarterly meeting to inform decision making. These gaps included poor documentation of commodity transactions, lack of reporting tools for ART program and lack of pharmacy personnel.

Output 3.4: Monitoring and Evaluation Systems

a) Strengthen M&E oversight in all the 5 Counties for effective continuous monitoring, decision making and planning.

The department of health in Mombasa has made significant progress in strengthening monitoring and evaluation (M&E) oversight structures over the project implementation period. To sustain this progress, *Afya Pwani* provided TA to the department in the development of the health sector's M&E framework and in defining indicators for tracking performance This SI intervention was only undertaken in Mombasa in this quarter. *Afya Pwani* will continue supporting implementation of the framework while focusing on performance tracking and data use in health planning, implementation and financing. Strengthening performance monitoring is expected to enhance accountability and prudent use of the allocated

resources.

b) Strengthen the use of data collection tools including EMR to enhance patient management and ease reporting

i) Facility Based EMR support

Afya Pwani has achieved key milestones in EMR implementation by ensuring operationalization of 51 EMR sites. These gains are attributed to among them the project's continuous development to enhance responsiveness of IQCare to HIV service delivery needs. Currently, of these sites 20% are paperless, 70% are hybrid while 15% are retrospective. The project also introduced EMR in new department such as pharmacy (21 facilities), HIV testing (3 facilities), Maternal and Child Health (3 facilities). Importantly, the project strengthened the capacity of health workers on EMR use for ease of patient records accessibility.

To sustain the gains achieved through EMR use, the project continued providing routine IQCare support and troubleshooting reaching over 50 facilities across the five Counties during this quarter. This support focused on: computer hardware maintenance (6 facilities), network repair (6 facilities), on the job capacity building (27 facilities) and IQCare/IQTools upgrade (24 facilities). In Samburu and Kikoneni health centers; the project's newest EMR sites, follow up was conducted on a weekly basis to ensure completion of legacy data migration. Further support was provided to facilitate patient case management using line listed longitudinal data to improve patient outcomes particularly on viral suppression, differentiated care, nutrition management and patient retention in HIV care and treatment.

As shown in the figure below, sustained EMR support has strengthened patient management and reporting, with 11/12 (91%) facilities in Mombasa currently using the EMR for both functions. Concurrence of current on ART data in the IQCare and DHIS2 systems also points to significant progress in EMR use for effective patient management amongst the health workers.

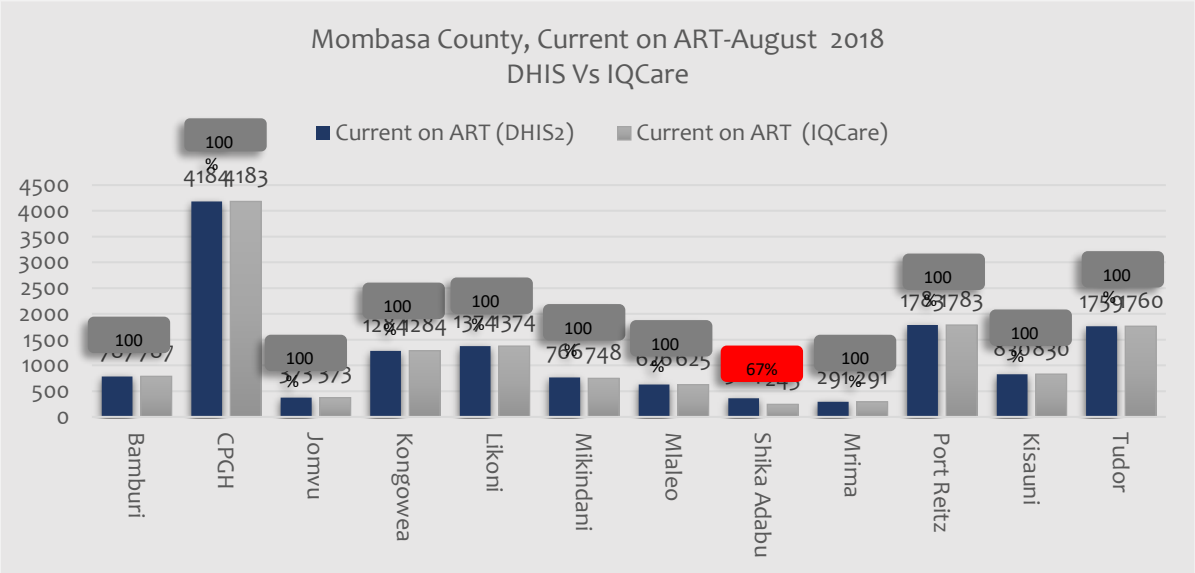


Figure 36 Comparison of Current on ART Data on IQCare and DHIS2 - Aug 2018 for All EMR Sites in Mombasa County

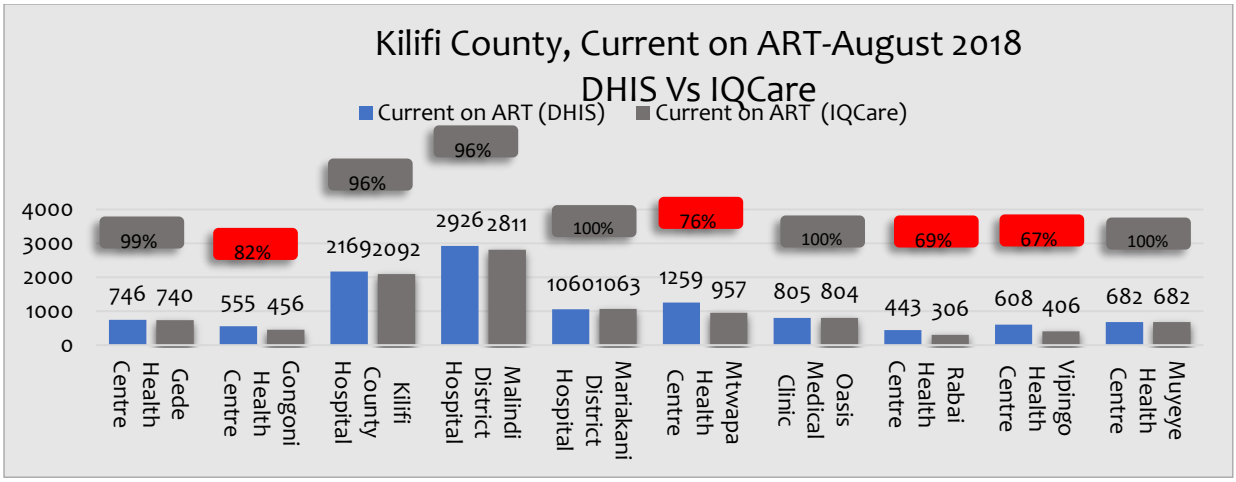


Figure 37 Comparison of Current on ART Data on IQCare and DHIS2 - Aug 2018 for All EMR Sites in Kilifi County

Whereas the project's technical support on EMR implementation has been standard across the five Counties, uptake of the same remains varied as shown in figure above. This is largely attributed to County leadership and support, power supply and health worker attitudes towards EMR use.

ii) MHealth Tools/EMR for HIV Testing Services

Advancements in EMR development and deployment have largely focused on the 2nd 90 and 3rd 90's in the HIV care and treatment cascade over the past project implementation period. This has left a gap in innovative electronic documentation and reporting of HIV testing and linkage data. To mitigate this, *Afya Pwani* commenced development and piloted the android-based version of IQCare during this quarter. The application, *AfyaMobile* aims at facilitating HIV testing data collection to support efforts towards the 1st 90 by catering for the roving HIV testing health care workers. To fast track adoption of this new solution, the project will provide tablets and wireless routers for data collection and real time syncing of collected data to the IQCare servers.

The application, currently being piloted at Muyeye Health Centre in Kilifi County is anticipated to improve HTS service provision by improving efficiency of HTS eligibility assessment, ease partner identification and line-listing, auto-generation of PNS, HTS and linkage registers. This will further build up to the project's efforts to improve linkage of HIV clients positive.

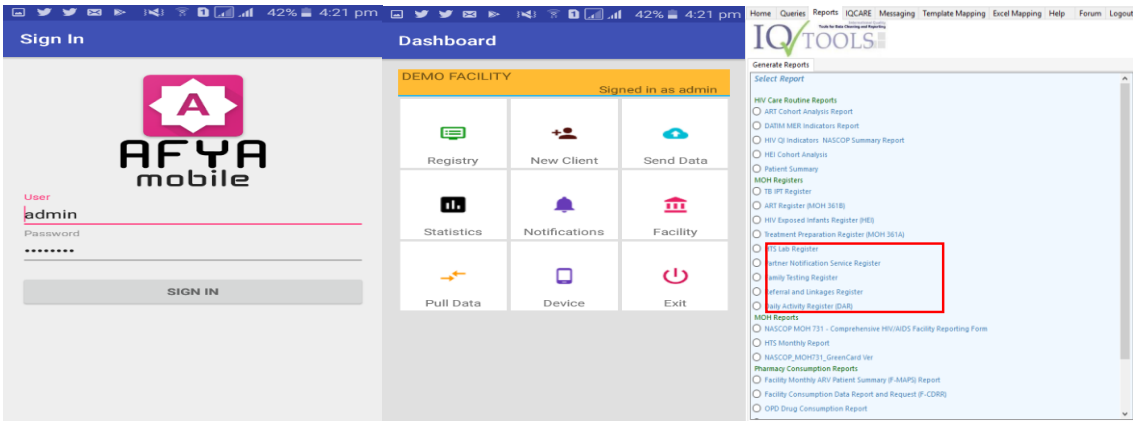


Figure 38 Screenshot of the AfyaMobile Android-based EMR Application

c) Institutionalize data use at facility and S/CHMT levels for decision making

i) Data review tool and scoring pilot

Afya Pwani continues to support the five Counties with the aim to improve data quality and sustain a culture of data use. During this quarter, the project piloted the previously developed facility data review template in more than 12 HVFs. The template has simplified the process of data analysis and provided a standardized approach for conducting data review meetings across all facilities. Importantly, this tool places great emphasizes on the importance of performance reviews at facility level and therefore equips health workers particularly facility in-charges, with a tool to track performance of health service delivery. The tool has also triggered interests in data and information use at facility, Sub County and County management level. Potentially the tool is expected to facilitate effective performance tracking and provide a basis for evidence-based interventions for improved service delivery.

Below is a sample data review dashboard for Port Reitz Sub County Hospital for quarter April to June 2018. The dashboard which illustrates how this tool works, indicates an average score of 85%. The facility is doing exceptionally well with linkage to care, viral suppression for both males and females, management of HIV in the TB clinics which are all at 100%. Testing at ANC is at 97% while one-year retention is at 88%. ART coverage is at 65% while TB screening is documented at 49%. The facility's performance in infant prophylaxis, Maternal HAART and initial PCR are all at 100%. As shown in the data review tool, it is easy to identify gaps for appropriate intervention for instance, provision and documentation of isoniazid to ensure quality service to patients. The figure below presents similar performance data for Gede Health in Kilifi.

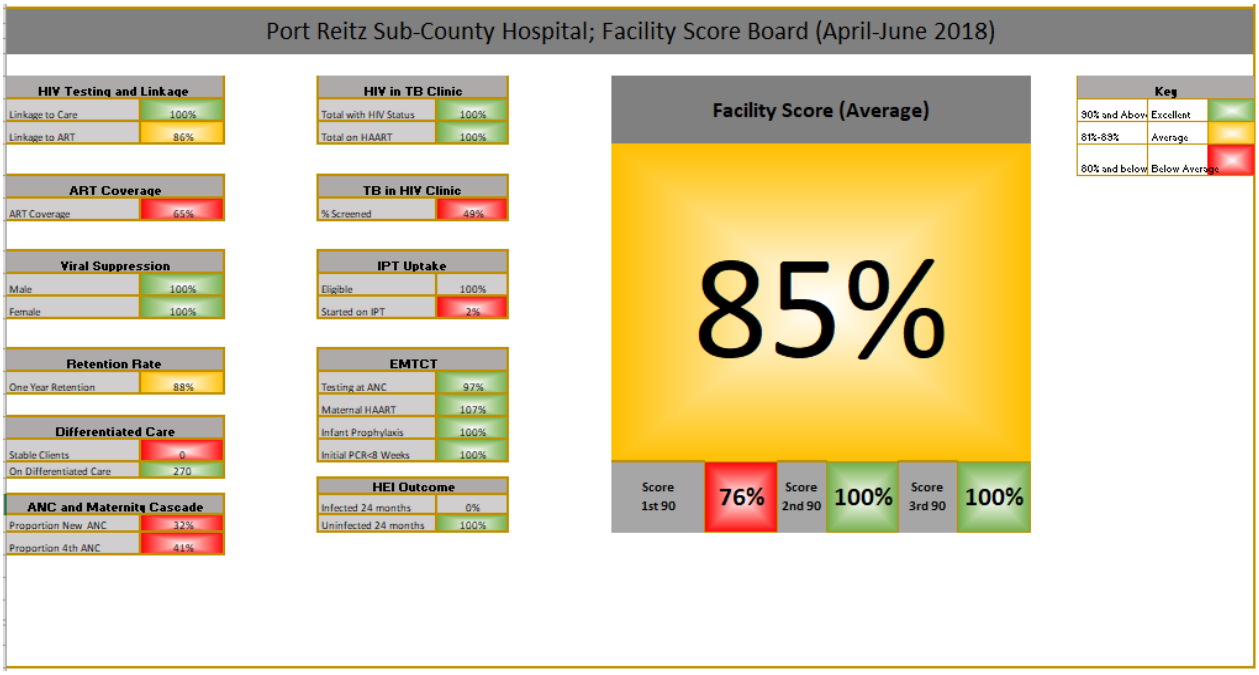


Figure 39 A screenshot of the facility data review tool dashboard; Port Reitz Sub County Hospital - Mombasa

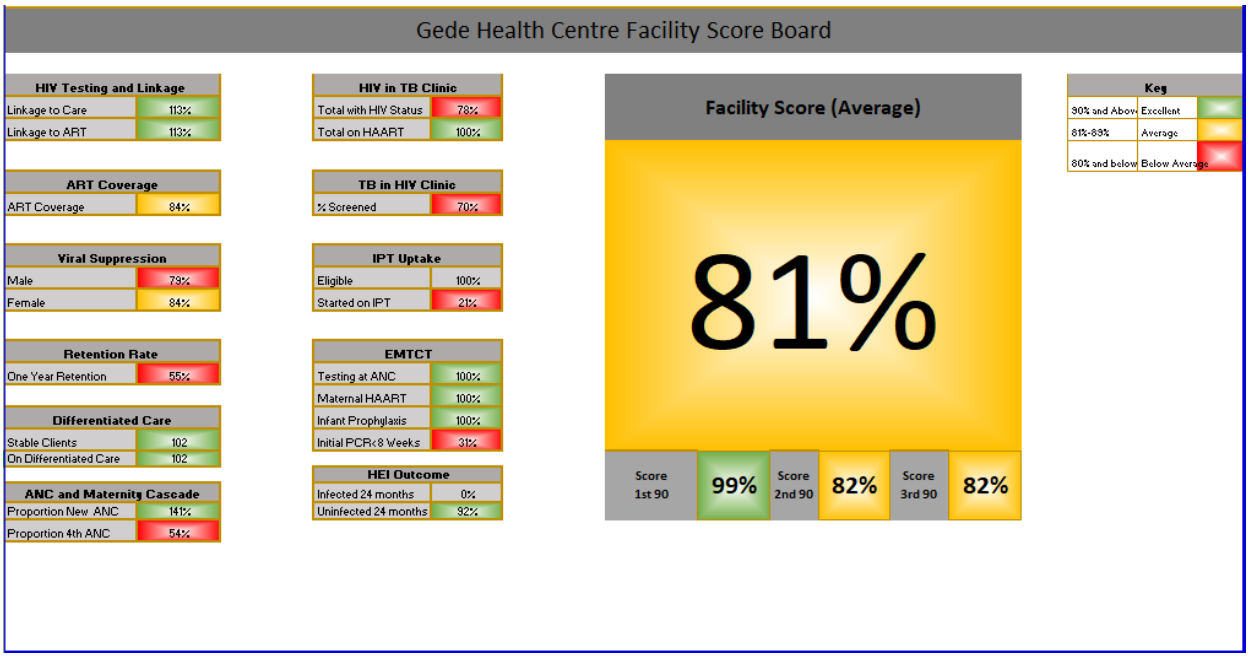


Figure 40 A screenshot of the facility data review tool; Gede HC- Kilifi

Going forward, the project will support facilities to undertake routine analyses and comparison of indicator(s) on all programme areas and overall facility performance over a period of one year to strengthen evidence-based decision making at facility and Sub County levels.

Output 3.5 Quality Improvement

a) Strengthening QI at County and Sub County levels

In the period Jan-Mar 2018 Quarter, *Afya Pwani* supported the County quality management unit (CQIT) in Mombasa County to undertake a functionality and maturity index[82]. The index sought to assess the status of QI implementation by assessing among them the existence of QI teams with active QI projects, QI processes including testing changes, data collection, measurement and analysis, documentation and sharing of key lessons. The maturity index scores placed sampled facilities on different levels of QI execution.

After the previously conducted baseline index and follow up QI interventions at facility level, the project supported the CQIT to undertake a midline maturity index for the same facilities. As shown in the graph below, 10 of the 12 facilities have recorded general improvements in the functionality of the QI teams. Nine of the 12 facilities were ranked at 2**,** two at 1.5 while only one facility's performance declined. As a follow up, *Afya Pwani* will support the CQIT to host a County level learning platform to facilitate sharing on QI implementation across facilities. The activity which aims to assess progress over a one-year period will allow facility QI teams to score to 2.5 and above.

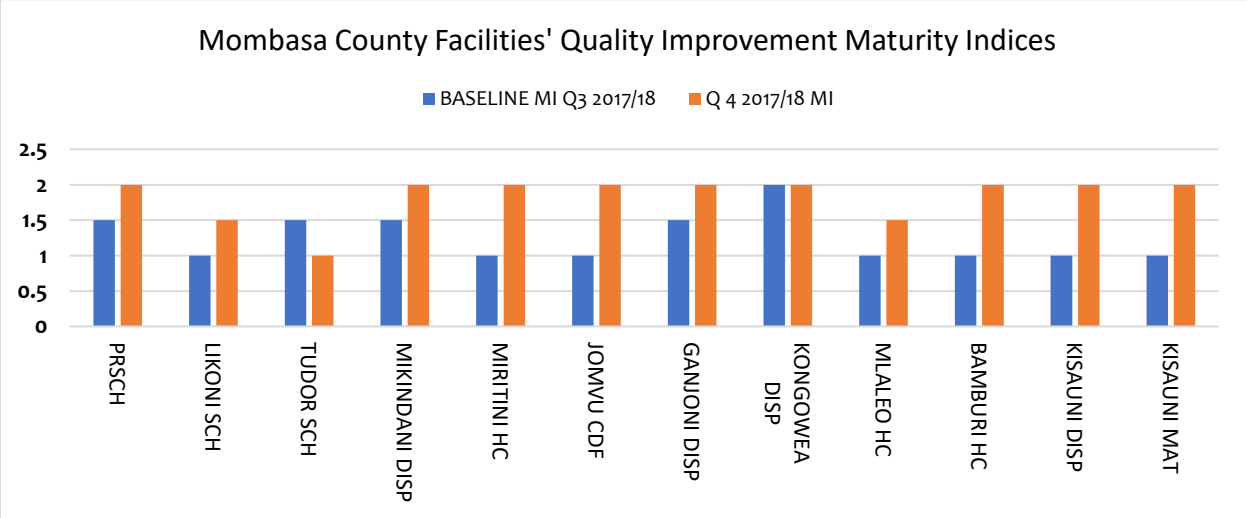


Figure 41 Mombasa County Facilities' Quality Improvement Maturity Indices

At the same time, the project supported the department of health in Mombasa to undertake a quarterly County quality improvement team (CQIT) meeting. The meeting brought together 27 participants from the County and Sub County QIT as well as the Sub County hospital teams. The meeting served as a mid-year review for the QI activities currently being undertaken by the facilities[83] and Sub County teams[84].

[82] See annex 1: Maturity index tool

[83] Likoni Sub County hospital, Tudor Sub County hospital, Port Reitz Sub County hospital, Ganjoni dispensary, Bamburi Health centre, Kisauni Dispensary, Kisauni MAT clinic, Mlaleo Health centre, Kongowea Dispensary, Miritini CDF Dispensary, Mikindani Dispensary, Jomvu model health centre

[84]

During the meeting, Sub County and facility QI teams outlined implementation progress including successes and challenges.

The figures below highlight progress made by Mvita and Likoni Sub County QITs. Following the project's QI interventions which commenced in February 2018, the Sub County QITs projects recorded improvements including on IDSR reporting rate and facilities using IMCI guidelines as demonstrated by correct classification and management of diarrhea cases respectively. However as shown in figure 10 representing the percentage of correct classification and management of pneumonia in Likoni Sub County as per IMCI, the improvement was noted in classification but not management of the cases due to unavailability of Amoxyl for treatments as per the guidelines in the facility level.

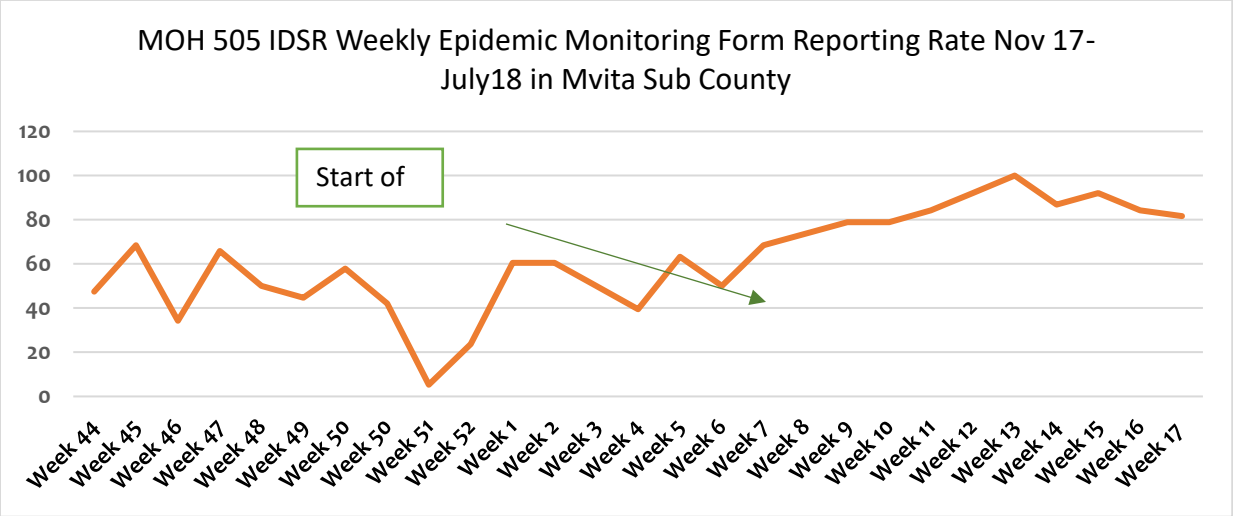


Figure 42 Mvita Sub County MOH 505 IDSR Weekly Epidemic Monitoring Form Reporting Rate Nov 17- July18

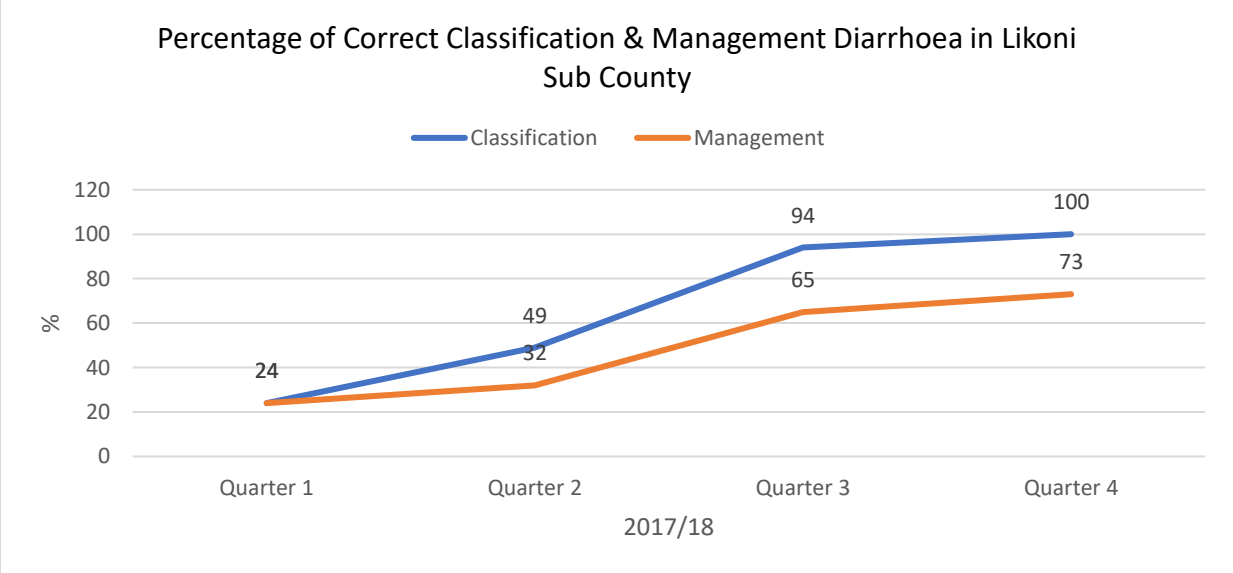


Figure 43 Percentage of Correct Classification & Management Diarrhoea in Likoni Sub County

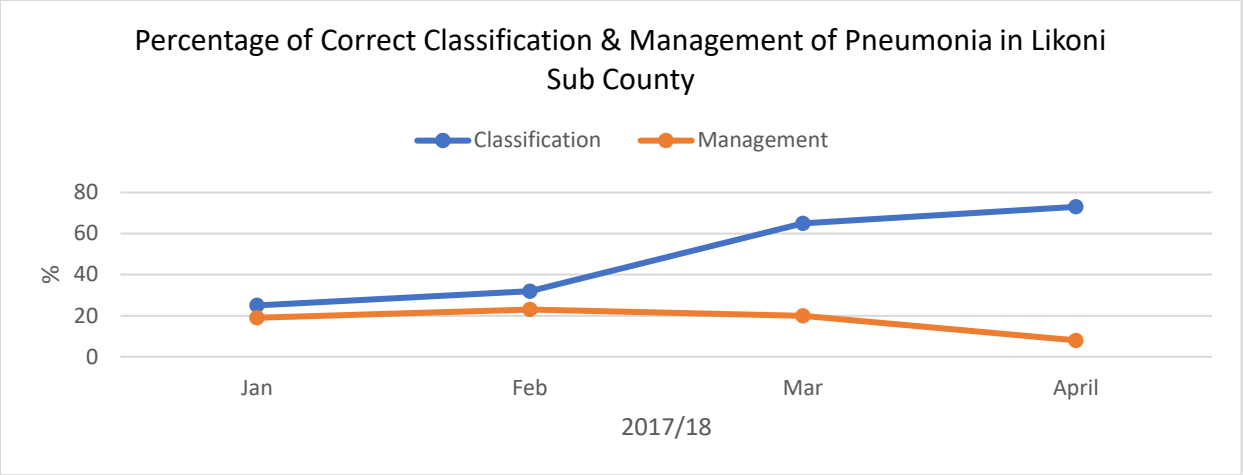


Figure 44 Percentage of Correct Classification & Management of Pneumonia in Likoni Sub County

b) Strengthening QI at Facility Level

In the same period, *Afya Pwani* facilitated a Health Systems Strengthening focused joint support supervision in Kwale, Kilifi and Lamu Counties. The supervision targeted 22 high volume facilities (HVFs)[85]. During the supervision visits, the project provided each facility with TA and mentorship on the quality of care using the SIMS tool. This exercise provided QIT and WIT with evidence on gaps for appropriate QI interventions/projects. In Kilifi, the project also facilitated development of a draft support supervision tool for use in MNCH programming. This tool captures the County's MNCH priority areas and will therefore assist County and Sub County teams in developing strategies for improving quality of care offered at facility level.

In addition to the support supervision, the project conducted one KQMH training in Mombasa. The four-day training brought together 31 health workers from the CPGH CCC, MCH, maternity, lab, outpatient, youth and adolescent clinic and Tudor SCH CCC. Subsequent to the training, the facility identified and commenced implementation of QI projects.

Afya Pwani also conducted CMEs in Kwale and Mombasa Counties targeting QITs and WITs. The 89 participants were drawn from Kinango SCH (29), Kwale SCH (24) and Lunga SCH (28) in Kwale County and Ganjoni dispensary (7) in Mombasa County. The project provided TA on the implementation of KQMH and development of QI projects. Jointly with the Sub County teams, the project also mentored WITs on problem statement, change ideas and indicator definition to enhance QI projects implementation.

A review of the ongoing facility QI projects in Mombasa showed noteworthy progress and points to the progressive improvements in QI implementation in the project-supported facilities. Data for HIV testing at six weeks in the MCH department in Mikindani HC for the period July 2017 and July 2018 shows a steady increase in number of mothers being tested for HIV in the facility as shown in the figure below. Similarly, the number of hospital deliveries in Miritini CDF for the same period has grown following the initiation of QI projects aimed at reversing the poor performance observed earlier in the period. Similarly, the VL coverage and VL suppression rates for Kisauni dispensary have improved as indicated below.

[85] Kilifi County Referral Hospital, Mtwapa Health Centre, Malindi SCH, Gongoni Health center, Vipingo Health Centre, Muyeye Health Centre, Mariakani SCH, Baolala Health Centre, Vitengeni Health Centre, Rabai Health Center, Marafa Health Center, Lamu County Hospital, Mpeketoni SCH, Kizingitini dispensary, Mukoe health center, Faza SCH, Diani health center, Kinango SCH, Kwale SCH, Mkongani Health center, Tiwi Health Center, Lunga SCH, Msambweni County referral hospital.

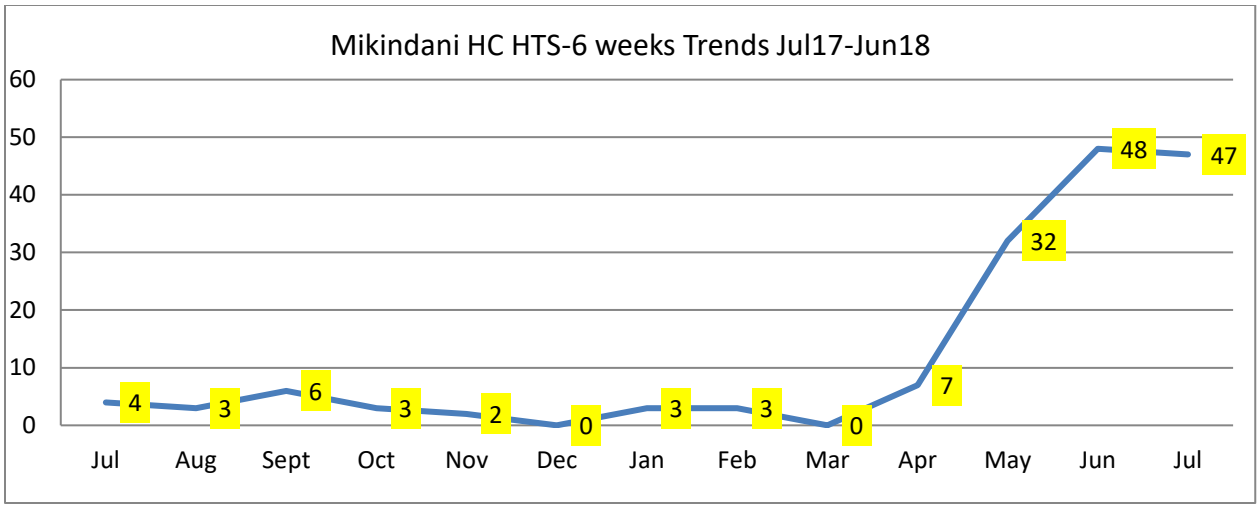


Figure 45 Trends for MCH HIV Testing at 6 weeks - Mikindani HC Jul 2017 - Jul 2018

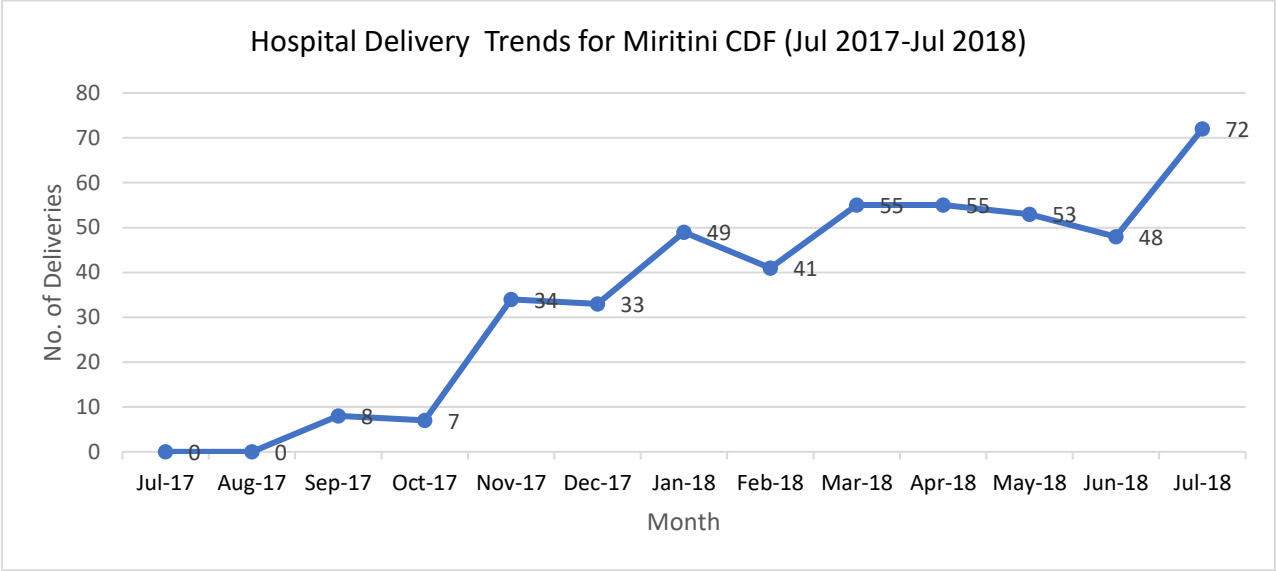


Figure 46 Hospital Delivery Trends for Miritini CDF (Jul 2017-Jul 2018)

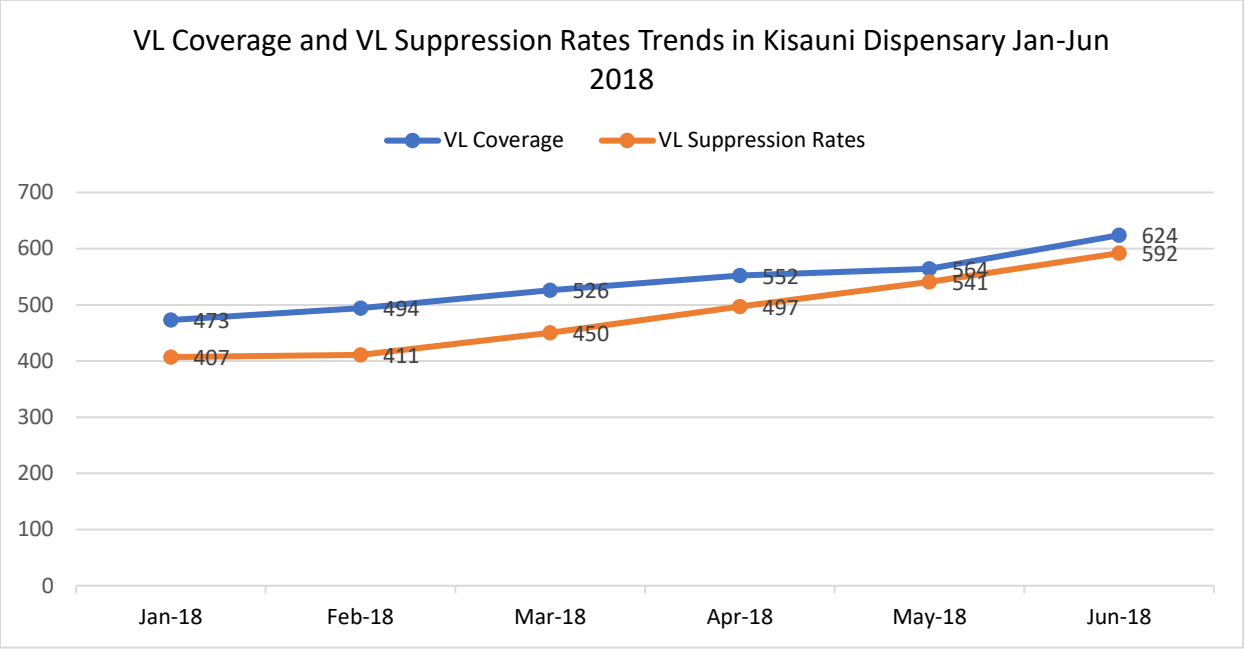


Figure 47 VL Coverage and VL Suppression Rates Trends in Kisauni Dispensary Jan-Jun 2018

Challenges and Opportunities

Challenges Encountered	Recommendations
Limited understanding of the planning and budgeting processes among HMT.	Cascade sensitization planning and budgeting to facilities to respond to the planning cycle process. Build capacities of HMT in planning and budgeting to align with the overall County planning and budgeting process
Lack of dedicated planning and budgeting entity at the facility level.	Advocate for the establishment of planning and budgeting unit in high volume facilities especially CPGH
Centralization of planning, budgeting, and financial management.	Advocate for de-centralization and financial management to the departmental and planning, budgeting to facility level. Enhance departmental linkages with the County treasury for open sharing of information on resource allocation, revenue collected and expenditure tracking.
There is a weak support from the County for facility based EMR and IT systems in terms of	To sustain the gains made in deployment of electronic systems and provision of strategic information management, Counties are beginning to appreciate and

provision of technical assistance and provision of hardware and software troubleshooting support	IT support for facility systems and the project in collaboration with the IT counterparts from the Counties are working together to ensure sustainability of the systems.

III. ACTIVITY PROGRESS (QUANTITATIVE IMPACT)

Please see Attachment II for the full performance summary tables.

IV. CONSTRAINTS AND OPPORTUNITIES

These have been described under respective output sections.

V. PERFORMANCE MONITORING

During the quarter, efforts by MEL were directed towards DATIM data collection and reporting, data quality improvement, capacity building on use of EMR, data reviews and performance monitoring. Priority was also given to MoH staff capacity building, SIMS and joint PEPFAR/NASCOP nationwide DQA for HIV services.

Key Achievements

i) Compliance to donor Reporting:

During the quarter, the project supported monthly data collection to enable timely reporting in DATIM and DHIS2. The project supported multi-pronged efforts to ensure compliance in reporting requirements by USAID. On monthly basis, the MEL team provided support for DHIS data entry for various reports and supported CHMT and SCHMT teams with monthly airtime and internet bundles to access and use data in DHIS. Further, the project collected and entered program data in DATIM and JPHES for both HIV and RHMNCAH services respectively. Data collected was analyzed on monthly basis at both county and project level and shared with respective program teams to inform decision making.

ii) Data Quality Audit and Data Quality Improvement

During the quarter, the project continued to support DQAs in across the supported counties. Routine facility data verification and validation checks were carried out for all reportable indicators. This has improved data consistency between DHIS2, DATIM, MOH 731 and source registers to over 98%. Overall, in the quarter, the reporting rate for *Afya Pwani* in DHIS2 was 95% for MoH 711 and 96% for MoH 731.

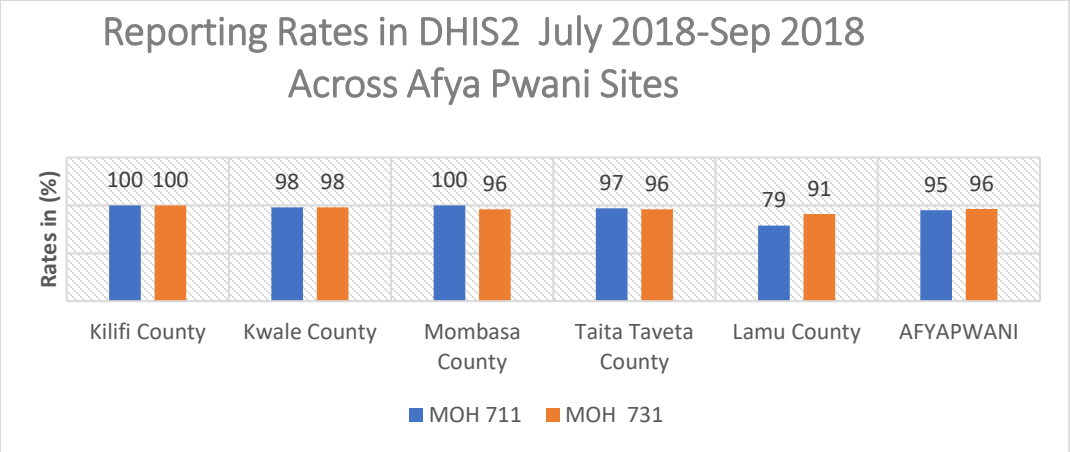


Figure 48 Reporting Rates in DHIS2 July- Sept 2018

iii) Capacity Building on M&E

Capacity building was supported through mentorship and On Job Training (OJT) to facility staff with the focus on use of revised HIV tool. CMEs and OJTs on documentation and reporting were done in Miritini CDF, Mlaleo CDF, Wesu SCH, Taveta SCH, Rekeke HC, Eldoro Mission Dispensary. Further, TA was provided during DATIM data verification, facility reviews and supervision visits.

iv) Data Review and Performance Monitoring

The project supported facility data review meetings for 10 high volume facilities in Mombasa while the other facilities participated in sub-county data review meetings. The review meetings were done using the standard data review tool developed by *Afya Pwani* and which has received a lot of support from the CHMTs. Through the review meetings, various gap emerged, and corrective action plans were developed. In Likoni SCH, for instance, the facility come up with a corrective action plan for addressing erratic numbers for current on ART. The facility also line listed all clients on ART while documenting the active ones with a view of establishing actual clients current on ART. As result facility and can now correctly report on the actual clients on ART.

In Taita-Taveta County, the project supported sub county review meetings in all the four sub counties; Voi, Mwatate, Wundanyi and Taveta, where treatment cascades were reviewed and discussed highlighting the gaps and corrective action plans. In the county, the facilities that have fully embraced the new data review tool include Taveta sub county Hosp, Moi, Mwatate and Maungu HC. The project plans to continue working with the facilities to develop internal Data Quality Improvement plans in the coming period.

Also, across the five Counties supported by Afya Pwani, PIPs facilitated selected high-volume facilities to conduct monthly data reviews to discuss their reports and performance. This enabled them to make informed decisions in day to day provision of HIV services. Defaulter tracing activities, physical escorts of clients, and weekend provision of services are some of the interventions that have benefited from these regular data and performance review meetings.

v) EMR implementation

Across the supported Counties, the department continued to support mentorships and offer TA to MOH staff on the utilization of EMR. The support focused on use EMR green card and generation of line lists for

clients due for viral load, PMTCT clients and missed appointments among others. This has significantly boosted EMR data use and demand among health workers.

vi) Data and Information Use

During the period, the project enhanced utilization of data at County, Sub County and facility levels through various approaches developed by the project in the past. At facility level, the project supported updating of progress charts and dashboards. Using dashboards, the facilities can track performance of early warning indicators and identify red flags early in advance to develop corrective action plans. It worth noting that all high-volume facilities supported through PIPs have adapted structured data review meetings and have utilized the findings to improve data quality and address programmatic gaps. These facilities include Msambweni County Referral Hospital, Kilifi County Referral Hospital, Coast Provincial General Hospital, Moi County Referral Hospital, and Mwatate Sub County Hospital among others where HIV cascades are being reviewed using standardized dashboards to inform decisions on how to address issues of identification, linkage, retention and suppression.

vii) Other activities

In the period under review, the MEL team supported joint PEPFAR and NASCOP nationwide DQA in the five supported Counties and participated in SIMS assessment by USAID in Kwale, Kilifi and Mombasa**.**

Key Challenges and Recommendations

1. Shortage of revised HIV tools across the supported counties especially DAR, treatment preparation registers and ART cohort register. The project recommends fast-tracking the production of the tools by NASCOP and continue with focused OJT and mentorship on the utilization of the tools.
2. Slow uptake of eLearning on revised HIV tools. The project recommends routine supportive supervision by NASCOP to the office CHRIMs to enhance buy in.

Innovations and success stories

The department supported facilities to carry out in depth analysis of data and preparation posters, some of which were accepted and presented in the 2018 National HIV Conference at Movenpick Nairobi. The titles of the posters presented were:

1. Going beyond basic categorization to improve HIV care among clients
2. Improving HIV/AIDS patient outcomes using EMR decision support tools and automated reporting
3. The Male Involvement Factor in Family Planning among Women of Reproductive Age in HIV Care" under the Achieving zero MTCT rates, what does it take? track.
4. Helping Children Accept their HIV Status: The Game Changers" under the Communication strategies for reaching adolescents and youth with HIV information track
5. Improving County HIV services using Geographic Information System (GIS)
6. "Illustrating retention in a non EMR site using longitudinal colorations excel sheet.
7. Making personalized attention count" Appreciation of Case Management by USAID *Afya Pwani* in Taita Taveta County

VI. PROGRESS ON CROSS CUTTING THEMES: GENDER AND YOUTH

a) Gender and systems strengthening

The team has made efforts at ensuring the project has a voice at County and Sub County levels on matters of youth and gender by participating and contributing in County forums well as being part of existing and established relevant TWGs for synergy and leveraging of resources among stakeholders. As such, *Afya Pwani* participated in the quarterly County gender TWG which has resulted in the development of the Kilifi County Gender policy actively facilitated by the County gender office. During the quarter, the project also supported the quarterly meeting with the gender stakeholders meeting that had a SWOT analysis conducted resulting in an agreement to have a more coordinated approach on gender matters. The stakeholders agreed to have four components SGBV, legal and rights, male engagement and women empowerment under the gender stakeholders' forum that is coordinated by the gender CEC with *Afya Pwani* coordinating the male engagement docket. Further to this, the project together with select members of the gender stakeholders' forum participated in reviewing the County Integrated Development Plan (CIDP) that saw the incorporation of gender and rights issues in the document.

The project equally participated in the AYSRH stakeholders meeting where the issue of high teen pregnancies was discussed resulting in establishment of the Kilifi County AYSRH TWG that has since developed a TOR. The TWG met and deliberated around Kilifi County's Maternal, Neo-natal and Child Health Bill - 2017 due to the gap of adolescent and youth issues including nutrition in the bill. The meeting conclusively agreed that the bill would be referred to as the Maternal Neonatal Child Health Adolescent and Youth Bill - 2018.

Capacity building focused on communities and health providers through collaborations with trained County and Sub County health teams, health care providers and community health structures as agents of demand creation for SRH services across various platforms within the quarter through continuous medical education, edutainment, dialogues, forums and sensitization sessions.

b) Community sensitization and capacity building

Community education and dialogue sessions conducted aimed at HIV prevention by addressing gender norms as well as post-rape care services such as PEP, stigma and discrimination which includes practices that fuel and prevent the spread of HIV and low uptake of health services including other SRH services such as FP. The project supported three survivor support groups within the quarter in Mombasa, Kilifi and Malindi. Further to this, one safe space known as 'Mahali Pa Usalama' in Tudor Nora for SGBV survivors was identified out of five pre-qualified potential safe spaces. This space is to be strengthened to support more GBV survivors to enhance access to services in the multisector response cascade specifically, legal services, psychosocial support and safety and security. A total of 448 adolescents and youth 15-24years (M-106, F-342) were sensitized on the availability of post-rape care services including PEP, health rights, access to health services, anti-stigma messages and GBV response referral pathway in, Likoni, Shika Adabu and Mrima, Mombasa County. The perception of HIV as a disease associated with promiscuity by the infected and the fear of judgement and taking ARVs for a lifetime makes the adolescents shy away from accessing HTS and other SRH services

Similarly, the project with the help of trained CHVs and male champions in partnership with local administration have sensitized the community leaders and members on the available SGBV response services including the multisector coordination process involved. HIV related stigma- discrimination, referrals and access points were also discussed during the chief barazas in Timbwani and Shonda areas in Likoni Sub County-Mombasa as well as Maweni, Kididima and Mtwapa in Kilifi South reaching 80 community members (M-45, F-35). The cumulative numbers of people reached through sensitization meetings within the quarter was 629 (M-177, F-452). The program supported the mobilization and facilitation of 14 community education sessions in Changamwe and Mvita Sub Counties through the following 14 community units: Changamwe, Chaani, Kipevu, Mburukenge, Majengo, Shimanzi, Engilani/Kuze, Mwembe Tanganyika, Tononoka Kaloleni, Muoroto, Kadherbhouy and Kaa Chonjo; reaching 502 community members (M-90, F-412). The sessions were facilitated by Community Health Extension Workers (CHEWs). The community was engaged through inquiries on the high SGBV cases in the community. Participants shared varied opinions on why cases are not adequately reported and the challenges experienced through SGBV response networks. Among the participants were survivors who voluntarily shared their real-life experiences with the community members urging them to advocate for anti-GBV and to always report and assist any GBV survivors. The challenges discussed in the forums included lack of support from some local authority leaders in anti-GBV interventions. Engaging men to challenge retrogressive and harmful masculinity norms. Late and low reporting rates of rape and defilement cases at the police can be attributed to culture and fear of stigmatization of the survivors. In most cases, those who report do not follow up either for complete trauma counselling sessions or legal procedures. Lack of goodwill from the police and local administration remains one of the reasons women fail to report on violence meted against them. The police are sometimes reluctant to respond and post-response, survivor fatigue sets in due to the financial implications of the lengthy legal procedures.

c) Targeted community dialogues on HIV related stigma, discrimination and SGBV

Part of community interventions to increase uptake of SRH services including post-rape care services saw the program support three community dialogue sessions reaching 131 people (M-69, F-62). The dialogues were planned by the Sub County community strategy focal teams and the CHEWS after identifying health issues to be addressed in the respective community units namely: Shimanzi, Soko mjinga and Kadzonzo villages. It was noted that there's minimal involvement of husbands in maternal health care. From the dialogues, men were encouraged to be proactive in the health of pregnant women and mothers and the value of their contribution in positive health outcomes in the community.

In Kilifi County, Pwani University conducted six dialogue sessions to establish perceptions around contraceptives, skilled deliveries and HIV as well as sensitize the youth and community on HIV, MNCH and FP thus creating awareness and demand for available services. The populations were students from Pwani University, Kilifi College of Accountancy, Thiyani tailoring school, boda boda vendors, religious leaders and village ambassadors to address FP uptake, GBV response structures, MNCH services HIV Stigma and discrimination reaching 160 people.

The project team conducted geographical mapping and resolved to conduct sensitization meeting at Ramada area since six cases of SGBV were reported at Adu Dispensary. The forum targeted female high school students from Ramada secondary. This was possible through counselling of students, breastfeeding and weaning mothers to take a family planning method to avoid unplanned pregnancies. 44 people (M-1, F-43) were reached.

d) Behavioral interventions aimed at changing gender norms

Mae, a service provider at KCH's GBVRC talking to pupils from Fumbini primary on key messages on sexual violence and GBV response services available

Six school-based sensitizations were conducted to reach young people with requisite information on sexual violence prevention including LVCT hotline 1190 for SRH information and childline-116. The sensitizations were done to over 800 students, school heads and teachers in Basi, Konjora, Fumbini, Kiwandani, Mkwajuni and Mnarani primary schools. The sessions were useful for instance; a student followed the facilitators after a session and disclosed that they had been violated by their father when they were young. Further appointments were made with the girl where it emerged that the girl got infected with an STI as a result and had suffered with the infection for years.

The girl is in the healing process after treatment and counselling. *Afya Pwani* supported similar interventions in efforts to reduce stigma and discrimination among adolescents and young adults in accessing SRH services targeting them at learning institutions by engaging the Kenya Network of HIV positive teachers (KENEPOTE) to conduct the school–based interventions. A total of 634 students at the following seven schools reached: St. Mary's, Kwa Shee, Bomu, Bahari, Kwa Jomvu and Greenfield Primary schools as well as Tudor high school. The discussions covered were comprehensive HIV/AIDS prevention among adolescents and young people, SRH rights, stigma and discrimination, sexual and gender-based violence including defilement, the GBV response cascade of services as well as pre and post exposure prophylaxis as a prevention strategy.

e) Integrating gender, youth and rights through quality improvement

Quality improvement efforts have been supported within the component through facility-based continuous medical education on health rights, GBV management and youth responsive services. Within the quarter, 173 health providers (M-77, F-96) were reached through CMEs with the participants being from the following facilities: Ganjoni and Jomvu Model (Mombasa 25pax – M-8, F-17), Gombato, Kikoneni, Msambweni, Mazeras, and Lungalunga (Kwale 86pax – M-46, F-40); Mariakani, Matsangoni and Gotani (Kilifi 62pax – M-23, F- 39). Additionally, the health care workers were sensitized on the Human Rights Based Approach to service delivery, patients' rights, equity and non-discrimination in service provision. Further discussions focused on completeness in provision post-rape care services and other support services in the continuum of care such as psychosocial support, safety and security and legal services. Youth responsive services were also discussed in form of rights based and mainstreamed youth-friendly services approaches in service provision to adolescents and youth in terms of accessibility, appropriateness, effectiveness, acceptability and equitability in provision of AYSRH services. A setback

was the shortage of PRC forms at the Reproductive Health and Maternal Services Unit (RHMSU) in health facilities. In response to the gap, *Afya Pwani* was given soft copies and rights to support in printing and managed to distribute to the following sites: Kilifi County Hospital, Malindi, Mtwapa, Vipingo, Mambrui, Gongoni, Matsangoni, Bamba, Jomvu Model, Ganjoni, Rabai, Ganze, Vitengeni and Mariakani.

i) Adolescents Package of Care and Operation Triple Zero (OTZ) training

One of the facilitators, Mr. Dimba illustrating a point during the APOC training in Kilifi

Adolescents and youth face many challenges due to the physical, mental and emotional changes that they experience as they grow. They struggle dealing with the rapid growth occurring in their bodies and issues around their self-esteem hindering adherence to drugs especially for adolescents who are HIV positive thus resulting in poor health outcomes. To ensure that they receive optimal HIV care, skills on dealing with the adolescents become instrumental. Different approaches have been used based on new knowledge that is always emerging in the HIV field and when this happens, equipping health care workers with this information is vital. The Adolescent Package of Care (APOC) is one of the approaches to address the challenges faced by the adolescents as it offers comprehensive and friendly services to all adolescents irrespective of their HIV status. A three-day training was conducted separately for three Counties: Mombasa[86], Kilifi[87] and Taita Taveta[88] reaching 21, 25 and 28 (M-24, F-50) health care workers respectively within the quarter. The health providers were sensitized on the APOC and Operation Triple Zero (OTZ) to build the capacity by enhancing knowledge and skills in delivery of adolescent care and youth responsive health services while contributing to the uptake of SRH services. The training was guided by the 2014 APOC guideline and the project will support its dissemination in the facilities reached through CMEs to aid in the formation of OTZ clubs targeting adolescents and youth within year three. Deliberations revealed that because of staff shortages the mainstreamed model [89] offered during separate hours was preferred. The OTZ clubs will be established in the first quarter of year III of the project.

[86] Mombasa County - Railways, Mvita, Kisauni, Mlaleo, Mtongwe, Mikindani, Likoni, Chaani, Jomvu Model, Port Reitz, CPGH Youth Zone, Mbuta, Bokole, Likoni Catholic, Kongowea, Magongo Tudor, Miritini, Utange and Bamburi

[87] Kilifi District Hospital, Malindi District Hospital, Mtwapa Health Center, Gongoni Health Centre, Vipingo Health Centre, Mariakani District Hospital, Bamba Sub-District Hospital, Gede Health Centre, Marereni Dispensary, Rabai Health Centre, Matsangoni Health Center, Marafa Health Centre, Muyeye Municipal Health Centre, Ganze Health Centre, Ngerenya Dispensary, Takaungu Dispensary, Mambrui Dispensary, Gotani Dispensary, Kakuyuni Dispensary, Vitengeni Dispensary, Marikebuni Dispensary, Adu Dispensary, Sosoni Dispensary, Mtepeni Dispensary

[88] Taveta Sub-County Hospital, Kitobo Dispensary, Njukini Health Centre, Ndilidau Dispensary, Rekeke Model Health Centre, Challa Dispensary, Mwatate Sub- District Hospital, Bura Dispensary Taita, Kwamnengwa Dispensary, Modambogho, Maktau Health Centre, Wesu District Hospital, Wundanyi Sub District Hospital, Mgange Nyika Dispensary, Mbale Health Centre, Moi County Referral Hospital, Tausa Health Centre, Buguta Health Centre, Ndovu Health Centre, Sagala Health Centre, Maungu Model Health Centre, Kasigau Health Centre

[89] any provider, whether they offer contraceptive services, STI services, HIV treatment and care, maternity services, The mainstreamed YFS model involves all units/departments of a health facility and the staff providing services. The model accommodates provision of other SRH

ii) Mainstreamed Youth Friendly- Services

> "Whole Facility" model: non-judgmental, privacy and confidentiality. All (or most) health providers and staff offer high quality youth-responsive services as part of routine service delivery. Sometimes with special opening hours for youth. Specific demand-generation strategies for youth.

Participants presenting their work in one of the sessions during the YFS training in Watamu, Kilifi

Interventions to increase access and uptake of SRH services include training Community Based Distributors (CBDs) who are peers of adolescents and youth so they can be empowered to provide services including education and referrals in the community to those who do not have access to SRH services including FP services. A total of 74 youth peer educators were taken through a three-day training on Community Based Distribution of family planning in a bid to increase access of contraceptive use among young people by making the commodities more accessible to the youth through their peers. These were from three Sub Counties: Kilifi North (M-3M, F-20), Kilifi South (M-10M, F-11) and Magarini (M-17, F-11). The peer educators have been engaged to reach out to young people through sports for instance, during the International Youth Day they managed to reach approximately 650 young people (M-230, F-420) with messaging on contraceptive use and available services. Subsequently, the young people took up contraceptive services as follows: 224 men and women were successfully referred for FP services, 7,200 male condoms, four female condoms and 30 oral contraceptives were distributed. In Matsangoni, the peer educators identified young people in the villages and referred them for services at the heath facility where documentation (a black book) is supported. An additional 30 youth peer educator from Rabai Sub County were trained including 11 MTG registered girls from Ganze Sub County with the aim of equipping them with knowledge and skills of conducting community-based health education and promotion of positive reproductive health messages. Additionally, 40 peer educators were engaged and through them, Pwani university managed to reach 863 youth with FP education and 103 youth with contraceptives. Pwani University also managed to identify, educate and link to clinics 465 pregnant mothers to health facilities. Three youth forums were organized to sensitize youth on the importance of protected/safe sex, reporting

services, primary care services, or any other type of health service are non-judgmental to all young clients, ensure privacy and confidentiality, and offer quality counseling and
referrals to other services if needed.
Additional demand generation strategies are required to attract and retain young clients such as peer educators on site and in the community, tailored IEC materials, publicity of special hours for youth consultations, promotion of the services among young people in the facility catchment area, and engagement with gatekeepers to reduce social barriers to service seeking.

SGBV cases and accessing family planning services. The sessions were held at Mambrui, Marereni and Ngomeni where 82 youth (M-48, F-34) attended. The CBDs distributed 480 pieces of male condoms.

Efforts to being youth-responsive led to a five-day youth friendly services training conducted from 17th-21st September targeting heath care workers offering services to young people. This was necessitated by the fact that there is a new and improved training curriculum for capacity building health workers with topics such as mental health included in the curriculum bearing in mind the challenges young people face yet health care workers are not equipped with this information. The training was facilitated by three of the nationally recognized facilitators. All the 16[90] facilities factored in the AYSRH framework

had representation and participated in the training. Additionally, these facilities were supported with guidelines for provision of adolescent friendly services in Kenya and job aids including the adolescent cue cards to aid in offering contraceptive counseling to the young people. The training resulted in development of action points to be implemented in the respective facilities that were trained. A total of 20 health care workers from the 16 facilities were trained.

iii) Psychosocial support for adolescents and youth (GBV survivors) from the CPGH - GBVRC and the Youth Zone

Psychosocial support is a critical component of post-rape care services for GBV survivors. This helps address the post-GBV trauma and other possible outcomes such as pregnancies, HIV infection, justice for the survivor among other factors. The project supported a psychosocial support session on a Saturday for GBV survivors who were adolescents and youth along with their care givers. The sessions focused on trauma counselling and life skills guided by the GBV management manual and the Tuko Pamoja Manual (Adolescent Reproductive Health and Life Skills Curriculum). This is due to the growing recognition of the importance of helping young people build mental resilience, from the earliest ages, to cope with the challenges of today's world. Evidence is growing that promoting and protecting adolescent health brings benefits not just to adolescents' health, both in the short- and the long-term, but also to economies and society, with healthy young adults able to make greater contributions to the workforce, their families and communities and society. A total of 20 reported GBV cases were reported out of the 46 participants who attended the sessions on that day have had the perpetrators executed without the victims escaping, families being bribed or cases withdrawn due to many reasons. This was made possible with the good will of legal support organizations that work with the CPGH - GBVRC. Forty-six adolescents and youth survivors 10-24 (M-9, F-37) were reached as well as 55 caregivers aged 25-60 years were also reached (M-17, F-38). The Youth Zone has one part time volunteer psychologist who also manages clients from the GBVRC hence, the management of the Youth Zone and the GBVRC through CPGH, plan to make a formal request to the project to support the following aspects of GBV response at CPGH: employ a part time or full time medical officer at the CPGH GBVRC to attend to the increasing number of clients they have and aid in case management, provision of legal support to the survivors and their families, employ a trauma Counsellor and a psychologist. This is due to the service delivery gap they have experienced for a long time now which compromises the quality of GBV response or post-rape care services and may contribute to poor health

[90] These are Mtwapa Health Center, Rabai Health Center, Gongoni Health Center, Mariakani Sub-County Hospital, Kilifi Sub-County Hospital, Chasimba Health Center, Malindi Sub-County Hospital, Bamba Health Center, Vipingo Health Center, Matsangoni Health Center, Gede Health Center, Marereni Dispensary, Ganze Health Center, Vitengeni Health Center, Gotani Health Center and Oasis Medical Center (a private facility)

outcomes among the GBV survivors. Another emerging issue this year per the PGH- GBVRC, is the importance to have tailored interventions at the following areas in Mombasa as they are SGBV hotspots due to the following reasons: In Kibarani: a lot of adolescents are lured into the bush and raped; Mshomoroni & Kisauni: are hot spots and most of the survivors also come from these areas; Miritini & Jomvu: survivors come with cases of defilement, pregnancies and a lot of delinquent behaviors. The hotspot mapping conducted by the GBVRC will be followed up in the following year and quarter to provide the cascade of SRH services to other unreported cases and enhance uptake of SRH services especially among the adolescents and youth.

f) Provision of recovery and HIV prevention services for survivors of SGBV Provided

i) Establishment of psychosocial support groups for child and adult SGBV survivors

During the quarter, two survivor support groups run concurrently while meeting consistently for sessions in Malindi and Kilifi. The support groups were divided into adult and child survivors with a bias towards child survivors since they experience most violence per the data at GBVRC. Thirty survivors and care givers were taken through a comprehensive model of trauma counseling known as the Trauma Focused Cognitive Behavioral model. In the next quarter, the project will support more survivors through a five-week trauma counseling program. These sessions are instrumental bringing about healing and champions who further this dialogue in their respective areas.

Establish safe spaces for GBV survivors and networks for prevention and management of GBV for vulnerable populations

ii) Safe Spaces

Safe spaces are part of the GBV response services to remove survivors from an abusive situation or space to provide safety, security and psychosocial support. This will help improve adherence to the trauma counselling sessions and other follow-up services hence improving quality of care to the survivors as well as address post rape care service gaps reaching more survivors with the cascade of GBV response services specifically health, psychosocial support, legal, safety and security services. In the quarter under review, the identification process of safe spaces entailed preliminary visits to five spaces as follows: Okoa Sasa in Utange, Wema Center in Utange, Calvary Zion Orphanage in Shanzu, Mahali Pa Usalama rescue Center in Tudor Nora and the Child Welfare society of Kenya in Tudor. Mahali Pa Usalama qualified for possible partnership after the project staff visited them a second time and the following were the findings: it is a referral healing center in the coast region for trafficked and abused children founded in 2008 and is owned, run and managed by Sisters of Our Lady of Charity of the good Shepherd (the Catholic Archdiocese of Mombasa). They counsel, empower, educate, aid in the healing process of child GBV survivors and restore a sense of dignity to them as well and so far, have assisted 1,500 survivors since 2008. An MOU has been drafted pending required approvals.

iii) Response Networks

Within the quarter, a GBV response network was formed to facilitate referrals and support of SGBV survivors in Kisauni Sub County to health facilities where survivors can access post-rape care services. SGBV network members were from Bamburi ward, Mtopanga ward, youth office Kisauni and children office Kisauni as mobilized by the Sub County public health officer. Groups represented were community

health workers, community health volunteers, volunteer children officers, youth affairs, and Family matters. Two SGBV response network meetings conducted in Kisauni with the help of the community focal person and the CHVS. 10 CHVs (3F and 7M) were recruited to act as the main contact people through whom GBV cases would be referred. Two defilement cases from Kashani area were reported at Kisauni police station through the CHVs, then to the GBVRC at CPGH after which they're forwarded to the children's officer. Three coordination and feedback meetings were supported by the project within the quarter, two in Mombasa and one in Taita Taveta. In Kilifi County, 21 community health volunteers (M-7, F-15) were trained on case referral systems. Subsequently, a response network of 13 organizations was formed where all SGBV cases in Ganze Sub County would be reported and referrals made to the health facilities where the survivors would receive post-rape care services. A total of four girls have so far been referred to Bamba Sub County hospital for the PRC services. A feedback meeting was held with 51 CHVs (M-20, F-31) from Malindi Sub County where progress on referrals made were reported. The discussions were centered on what worked well, case identification at community level, referral, follow up of the survivors, and successful completion of these cases. Challenges shared included harmful traditions and practices such as marrying off children due to pregnancy almost equated to punishment for pregnancy out of wedlock. A success story was shared of a school girl who had been impregnated by a peer and had dropped out of school but through the efforts of one of the CHVs the child of the school girl received the required immunization vaccines. The school girl was encouraged to return to school post-delivery and has since been reinstated back to school.

iv) Screening CCC clients for Gender-based Violence and Intimate Partner Violence

All females aged 15-49 years and emancipated minors accessing HIV care services should be screened for IPV as part of the standard package of care for PLHIV in the 2018 ARV guideline. Part of the identification process of these patients entails basic screening questions that have been found to be acceptable to patients and healthcare workers if the provider has a respectful attitude and assures the client of confidentiality.

Within the quarter, Taita Taveta County through Njukini CBO has conducted GBV screening in seven sessions for virally unsuppressed clients who require differentiated care and frequent assessment of their progress through the PHDP profile hence, addressing their non-adherence issues aiming at viral suppression. The seven sessions were held as follows: Chala – 3 sessions, Njukini – 3 Sessions and Ndilidau - 1 session reaching 102 unsuppressed clients. The issues addressed revolved around; family testing, GBV response messages among other PHDP Messages. Assessment of HIV status of household members especially children and partners is done and appointments set for HIV testing. The sessions are conducted in tandem with recommendations from MDT meetings being conducted at the three health facilities.

v) Male Engagement

Male engagement in decisions regarding access to health services in many parts of the coastal communities remain low. *Afya Pwani* is cognizant of this and has made concerted efforts at bringing the men on board to address health barriers. During the period under review, men were engaged to contribute to the identification, referral and engagement of partners of expectant mothers during and post- pregnancy contributing to early ANC and HTS by the expectant mother and her partner/spouse. In Taita Taveta County, male champions conducted sensitizations on the importance of attending all ANC visits and the contribution of their partners in elimination of mother to child HIV transmission. The

communities in various villages were reached as follows; in Chala, Njukini, Ndilidau, Chumvini and Mahandakini at a total of 92 people (M-11, F-81). It was evident during the discussions that men are still reluctant to access HTS services; 4 pregnant women were identified and referred for ANC services and through one of the committed male champions, 127 households were reached with HIV prevention information, stigma reduction and anti-discrimination messages. In the following cadres of are engaged to mobilize men: community health volunteers, community mentor mothers, traditional birth attendants and male champions. The role of the male champions is purposely to identify expectant women and their male partners within the community, initiate health talks and discussions, provide referrals for ANC visits and/or escort them for ANC and PMTCT services.

In Kilifi County, Male champions were engaged to advocate for uptake of family planning and male inclusion in health matters of their families in the communities they represent. Male champions from Ganze had community level engagement and discussed the rising cases of teen pregnancies and sexual violence reaching men and women with this information. Two feedback meetings were held in Magarini Sub County for the men to access their monthly progress, success and challenges encountered in September. Four male champions managed to conduct five sensitization forums targeting polygamous families reaching 121 people as follows: Adu-25, Mambrui-23, Ngomeni-26, Pumuani-27, and Sabaki-20. They utilized these sessions to address SGBV especially on the girl child rights while a similar meeting was conducted by male champions from Kaloleni Sub County to discuss and review male involvement in MNCH/FP services offered within the Sub County. It was noted that men still dominate decision making regarding their partners seeking MNCH/FP services within the health facilities in Kaloleni. However, following their endeavor to sensitize fellow men about the importance of MNCH/FP services, there was some change of the situation where some men had started encouraging, discussing and supporting their partners to seek the services at the health facilities. One Focus Group Discussion was conducted with the participation of 15 men at Shangia dispensary in Kaloleni Sub County with the support of facility-in charge, Health Care Workers and Public Health Officer. Among the topics discussed were; knowledge and understanding of Family Planning and Reproductive Health, male involvement in seeking health services and information, perception of men on uptake of family planning methods as well as perceptions around accompanying their partners for Family planning and ANC services. The emerging issues ranged from the fear of being tested in the presence of their spouses, not having time to seek health services due to work, negative perceptions towards FP uptake among other factors affecting their active participation in health matters. The men were also sensitized on the importance of accessing quality MNCH/FP services, and consequently discuss with and allow their women to access available services based on the right information.

g) Increased access to youth appropriate MNH information and services

Within the reporting period, the project focused on increasing access and utilization of MNH services for women and children in Kilifi County. *Afya Pwani* recognizes that young women aged 24 years and below have different needs from women above 24 years resulting in clustering them into two groups hence binti kwa binti group and mama groups respectively. These groups are useful as the respective members receive education on different health aspects including preparedness pre-delivery, during and post-delivery including social aspects to it where young women conduct table banking hence encouragement and empowerment to achieve planned goals including going back to school. The project has established a positive relationship with National Gender Affirmative Action Fund (NGAAF) with names of young girls

who want to go back to school being forwarded to the officer concerned in NGAAF who had committed that the girls will be taken back to school as soon as funds are available since they have been included in the system. The binti kwa binti groups have realized remarkable results in skilled deliveries, new ANC visits, 4 ANC visits and contraception uptake. They have also been instrumental in ensuring that the young mothers bring the children to the health facilities for the requisite health services. In addition, eight CHVs and 22 Students from Pwani University were trained on Focused Ante Natal Care (FANC), skilled delivery and Post Natal Care to enable them identify, educate and refer young mothers for ANC services. Subsequently, a total of 465 young pregnant mothers were identified and referred for ANC services to KCH, Mtondia Dispensary, Mnarani Dispensary, Ngerenya Dispensary and Kiwandani Dispensary. Another 18 CHVs were engaged from Vipingo, Oasis and Mtwapa health centres in Kilifi County to identify adolescent girls for FANC/PNC resulting in 569 girls being referred. Empowerment of adolescents/young pregnant women working through the USAID *Afya Pwani* grantees and County AYSRH stakeholders. A total of 58 young mothers 30 (15-19years) and 28 (20-24years) in Vipingo and Mtwapa health centers in Kilifi South respectively were sensitized on the importance of personal hygiene, exclusive breast feeding, knowing their HIV status, developing an individual birth plan, early ANC visits, honoring clinic dates and encouraging their partners to accompany them to the clinic. The sensitization was done by the CHVs and mentor mothers with guidance from nurses at Vipingo and Mtwapa hospitals. Eighteen (M-3, F-15) from Vipingo and Mtwapa Health Centers were engaged to escort at least one pregnant adolescent girl/young woman each month for 1st ANC visit attendance and subsequent visits and follow ups. This initiative undertaken to ensure that a woman achieves at least 4 ANC visits, delivers at the facility, ensures that the child is reviewed within two days post-delivery and receives required immunizations.

h) Increased demand for child health services for young mothers

Afya Pwani has been supporting child defaulter tracing to ensure that children born of young mothers are not left behind and efforts have been put to follow up on these children. Through Pwani University, one home delivery was identified by a CHV who then referred the young mother to the hospital for Post Natal Care (PNC). A total of 20 immunization defaulters who are young mothers were identified and linked back to care in Kilifi North.

i) Advocacy and Key Stakeholder Meetings

The project has continued to ensure that adequate ORS, Zinc, Dispersible Amoxil tablets and nutritional supplement are available at supported facilities and that there is adequate stock on the same. These have not only been utilized by the general population but by adolescent and teen mothers. For the 16[91] select facilities where adolescent and youth services are to be strengthened, these requisite drugs are also available and accessible to them.

j) Strengthened youth friendly services to increase uptake of FP

Various AYSRH interventions to increase uptake of SRH services by adolescents and youth (9-24 years) were conducted within the quarter to enhance access and utilization of the standard package of care for

[91] These are Mtwapa Health Center, Rabai Health Center, Gongoni Health Center, Mariakani Sub-County Hospital, Kilifi Sub-County Hospital, Chasimba Health Center, Malindi Sub-County Hospital, Bamba Health Center, Vipingo Health Center, Matsangoni Health Center, Gede Health Center, Marereni Dispensary, Ganze Health Center, Vitengeni Health Center, Gotani Health Center and Oasis Medical Center (a private facility)

adolescents and youth. The interventions included capacity building of health providers through trainings and CMEs, focus group discussions to address barriers in accessing FP services, ANC visits, PMTCT, SGBV school- based and community dialogue sessions, post-rape care services, support group sessions and referrals for services. A total of 74 health providers were trained on the adolescent package of care and Operation Triple Zero in Mombasa, Taita Taveta and Kilfi with a focus on enhancing youth-responsive services at *Afya Pwani* supported health facilities. CMEs on GBV management, youth responsive services, rights-based approaches in service provision along with stigma and discrimination at facilities were conducted in Mombasa, Kilifi and Kwale reaching 173 health providers. Further to this, 20 health providers participated in a five-day training on Youth Friendly Services targeting the 16 facilities central in the Kilifi AYSRH strategy. Male engagement activities centered on leadership by men through encouraging positive masculinity practices, demand creation and referral for health services, contribution to HTS targets, advocacy for PMTCT as well as four ANC visits in four Counties (Mombasa, Kilifi, Kwale and Taita Taveta).

In the previous quarter Apr-Jun, *Afya Pwani* supported the refurbishment of a youth center at Matsangoni Health Center and aptly named it*, 'youth space my space'* implying that the youth require a platform to access health information and services and this can be anywhere they feel safe to access those services providing a space for young people to meet and discuss their issues. The youth in the area have in this reporting quarter utilized the space as an avenue for information sharing and knowledge dissemination as well as referral for health services. The project further supported a whole site CME at the facility where 43 staff were taken through youth friendly services and discussed strategies of retaining the young people in the space that has been created for them. A total of 36 actual referrals for health services have been made through the youth space for instance, ANC, FP and HIV testing.

Adolescent cue cards were shared and discussed with health care workers from 11 facilities that include Bamba, Kakuyuni Dispensary, Mtepeni, Vipingo, Mambrui, Marikebuni, Mariakani, Ngerenya, Sosoni, Adu and Gotani health center. These health care workers were part of participants attending an Adolescent Package of Care (APOC) training. Additionally, other facilities were supported with the National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya (2016) that include Marereni dispensary, Vitengeni HC and Gede HC. Other guidelines were distributed during a YFS training to select facilities including Gotani, Oasis medical, Bamba HC, Kijanaheri clinic. These were given out together with the National Adolescent Sexual RH policy implementation framework which the participants were encouraged to refer to while planning for and implementing youth appropriate services. AYSRH focused job aids that were printed adapted from the tool "Thinking outside the separate spaces" were also distributed and mounted in eight facilities i.e. KCH, Malindi, Mambrui dispensary, Matsangoni HC, Gongoni HC, Gede, Dzikunze and Kijanaheri Medical clinic. Targeted outreaches were conducted to reach young people with correct information on contraceptives. A build up activity was done to commemorate the World Contraceptive Day on 26th September, *Afya Pwani* with Pwani University supported an event with youth in and out of college in Kilifi North. The youth were given an opportunity to get correct contraceptive information and HIV testing services. Consequently, services offered during the event were as follows: 52 young people were counseled, given consultation on FP services and methods; seven took up Combined Oral Contraceptives (COCs), four Progesterone Only Pills (POPs), three implanon, two Depo, 10 female condoms were issued and seven were booked for implanon removal at KCH. Additionally, 38 youth were tested with one 15-year-old testing HIV positive and linked to care.

In Marereni Sub County, four youth sports/edutainment sessions were conducted at Gongoni, two sessions in Marereni and Kanagoni to reach adolescents and youth aged 9-24 years with messages on safe

sex and SGBV response. The sport-for-change sessions brought over 1000 youth on board and created demand for male and female condom utilization for safe sex to curb unplanned pregnancies as well as sensitized the youth on SGBV issues. Community Based Distributors (CBDs) supported in distributing condoms to the youth and a total of 3,168 pieces of male condoms were distributed with 79 young women being referred to health facilities to access various short term and long term family planning methods. All the women received different FP methods and the data can be confirmed at the facilities on the FP registers.

k) Support AY friendly forums at community level.

During the quarter, a community dialogue was conducted by Pwani University with students from the university, Kilifi College of Accountancy and Thiyani Tailoring School to address factors contributing to low consumption of FP commodities among the youth. A total of 112 youth were reached with information of contraceptives; the different methods as well as their advantages and disadvantages to enhance informed decision making while taking up FP methods. This also acted as a Q&A session to clarity and demystification of myths and misconceptions around FP utilization.

Two Focus Group Discussions were held in Ganze and Bamba wards respectively in Ganze Sub County targeted the youth mobilized by the CHEWs in charge of the areas within the locality. The purpose of the FGD was to assess perceptions of young people on contraceptives, teen pregnancies and barriers to utilization of reproductive health services. During the session, it was clear that majority of pregnant teenagers do not get access to health services due to shyness linked to walking around the community and getting seen by others who may criticize and mock them. It was noted that some are bound to stay in-doors by their parents until their due dates or some are sent to their grandparents' homes until they deliver thus, the need for more sensitization among the girls.

l) Advocacy and lobbying for AYSRH

Low uptake of contraceptives among the youth continues to be a concern in Kilifi County as the youth shy away from taking up AYSRH services resulting in high teen pregnancy rates. This has been recognized as a challenge from the County leadership and there have been concerted efforts aimed at addressing this issue. It was unanimously agreed that there is need to establish a taskforce that will address these issues in a unified approach hence the formation of an AYSRH taskforce. *Afya Pwani* is a member of the taskforce that has since seen the development of ToRs for engagement and a subsequent meeting to amend the Kilifi Maternal Neo natal Child Health Act 2016 so that it includes adolescent and youth health. After much deliberations and inclusion of adolescent, youth and nutrition issues, it was agreed that the bill would be referred to as the Maternal Neonatal Child Health Adolescent and Youth bill 2018.

m) Advocacy through special gender activities

In discussions and dialogues with youth, they expressed the need to be provided a platform where they can express their frustrations and be heard by people that can influence decision making. The International Youth Day, commemorated on 11th August, was a good platform for the youth to utilize and express themselves. The project therefore supported youth from seven Sub Counties in Kilifi to participate in an inter-generational dialogue with their leaders during the International Youth Day with the theme Safe spaces for youth. The youth engaged with CECs, National and County Youth Directors and the Member of Parliament for Kilifi North - Hon. Owen Baya where they deliberated and discussed matters

regarding making spaces for the youth safe and agreed on ways to have the youth more involved and productive including ensuring more transparent feedback mechanisms and purposeful involvement of the youth on matters affecting them.

VII. GRANTS

Grants Award and Management

As provided in the *Afya Pwani* contract, the project received approval from USAID to fund 20 local organizations to support in implementation of demand creation, effective linkage and defaulter tracing activities at community level. During the quarter ending September 30,2018, the project continued to work with these grantees to support the implementation of activities as per the approved *Afya Pwani* Year 2 work plan. With approval from USAID, the project finalized formal contracting and disbursement to two organizations i.e. Women Fighting ADS in Kenya (WOFAK) and Ananda Marga Universal Relief Team (AMURT) to implement the HIV Care & Treatment in Mombasa & Kwale and MNCH/FP grants in Kilifi Count in Kilifi County. These organizations were selected to replace The German Foundation for World Population (DSW) which was closed out due to the board's decision not to impose the requirements of the standard provision RAA29- Protecting Life in Global Health Assistance on their global activities.

Grantee Reporting and Compliance

In compliance to the grant agreement terms and conditions, the project noted timely submission of both financial and program reports by the grantees. During the quarter ending September 30, 2018, the project was able to facilitate the disbursements to grantees to enable them conduct planned activities for the quarter. Cumulatively for the annual period October 2017 to September 2018, the burn rate against the grantee budget obligation is 74 %. The financial reports and documentation submitted by the grantees relating to program expenses is generally reasonable, allocable, allowable and in accordance with applicable cost standards (2 CFR 200, Subpart E—Cost Principles) except for one grantee, Strengthening Community Partnerships and Empowerment (SCOPE) whose expenses were questionable in line with the above cost standards and grant agreement terms & conditions. A detailed review is on-going by Pathfinder's internal audit department to ascertain the way forward on the eligibility and acceptability of the grantee's reports by the project, an update will be provided in the next quarterly report.

Capacity Building of Local Implementing Partners (Grantees)

To strengthen the capacity of grantees to deliver quality services in the respective thematic areas, *Afya Pwani* facilitated one grantee quarterly review meeting per County in Mombasa, Kilifi, Kwale & Taita Taveta Counties during the reporting period. In these meetings, grantee performance for the period was reviewed and feedback provided on how the grantees can fast track activity implementation and to address specific performance gaps to contribute to the overall project performance. Additional support was provided virtually to all grantees and through program monitoring visits to three grantees noted to have a low burn rates to help them re-align their activities and provide support in fast tracking activity implementation as the financial year comes to an end. Additionally, a sensitization workshop on PNS testing modality was done to six grantees implementing HIV Care & Treatment in Kilifi County reaching 15 project staff and HTS counsellors attached to these grantees.

To enhance sustainability of the grantees and project interventions, *Afya Pwani* provided technical support to two grantees; AMURT and HIV Free Generation (HFG) to write innovative concept notes in

response to the call for proposals by the Global Fund Tuberculosis Project dubbed '*Kenya Innovative Challenge TB* Fund' for Mombasa County.

If successfully granted, the award will help to complement efforts of the *Afya Pwani* project in the County specifically in improving the TB co-infection services outcomes for the project and the County.

***Afya Pwani* Partner Implemented Projects (PIPs)**

As outlined in the approved *Afya Pwani* Grants Manual and approved Year 2 workplan, the project has continued to provide support to select facilities as 'Partner Implemented Projects' (PIPS) that are administered through Memoranda of Understanding(MOU) signed with the facilities which allows the project to directly pay for all allowable costs. The project identified 36 facilities [92]to be supported under this mechanism. Signing of MOUs for 35 facilities was completed in the quarter ending June 2018. In this reporting period, the project signed off the MOU that was pending with Coast Provincial General Hospital in Mombasa County. The activities implemented by these facilities are largely focused on addressing the gaps identified in provision of quality care & treatment service delivery to clients and complemented the support provided by the *Afya Pwani* staff and community grantees. Details of the specific activities implemented under this mechanism are described under sub purpose 1 and 2 of this report.

Grantee Contribution to The Project Outputs

The project noted accelerated activity implementation by the grantees in the respective thematic areas because of their familiarity with the geographical areas of implementation and better understanding of the project interventions coupled with the on-going support from the *Afya Pwani* team. With support from the project, grantees were able to implement activities to compliment *Afya Pwani* interventions and contribute to the overall *Afya Pwani* targets in sub purpose 1 and 2 as highlighted in Annex IV below.

VIII. PROGRESS ENVIRONMENTAL MITIGATION AND MONITORING

Please see Appendix I which contains the detailed Environmental Mitigation and Monitoring Report (EMMR) for the April- June 2018 quarter.

IX. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

a) SIMS assessment

During quarter 4, USAID carried out a SIMS assessment between 13th and 17th August 2018 in 3 Counties of Kwale, Mombasa and Kilifi. The facilities sampled were: Ganjoni dispensary, Kongowea H/C, and Tudor SCH in Mombasa, Msambweni CRH, Kwale SCH and Kinango SCH in Kwale County and Gede Dispensary in Kilifi County. Mombasa and Kilifi County facilities scored between 84 and 91% whereas Kwale County scored an average of 62% a marked improvement from the score in year 2 of between 32 and 45% across facilities. This score notwithstanding, Afya Pwani worked with the County on a fast tract corrective action plan dubbed Kwale RRI that was officially launched by the County Executive Committee Member (CECM) for Health on the 4th October 2018. The key focus of the RRI for Kwale is to focus on gaps and consolidating the gains made in the 90:90:90 agenda and corrective action plan for the SIMS report as attached

b) Data Quality Assessment

[92] PIP facilities; Mombasa County- 7; Kwale County-11, Taita Taveta County 4 and Kilifi County-14

NASCOP with support from the Global Fund and in Conjunction with Stakeholders conducted a national wide HIV program DQA covering over 300 sites between 17th and 28th September 2018. A total of 31 sites were sampled from the five *Afya Pwani* supported project Counties (Mombasa-10, Kilifi-8, Kwale-5, Taita Taveta-5 and Lamu-3 sites). Assessment teams composed of NASCOP, CHMTs, USAID and CDC visited all the High-volume facilities across the five Counties among them CPGH, BOMU, Kwale Hospital, Moi Hospital Voi, Kilifi County Referral Hospital and Malindi SCH. There were varying levels of data concurrence between DHIS2 and DATIM across the facilities with overall performance was generally good (above 90%) for most *Afya Pwani* supported sites with only one site in Kilifi county i.e. Malindi SCH that had a concordance rate of 84% hence requiring data audit. The general recommendations were as follows: HTS and ART had the highest concordance rates but PMTCT data needed corrective actions around documentation of Infant prophylaxis especially for Mombasa and Kilifi County. The project was tasked to upscale capacity building in HIV service delivery and quickly scale up EMR to saturation and work with Counties for ownership of the EMR systems for better documentation, reporting and patient outcomes.

c) Training on Assisted Partner Notification Services (aPNS)

The project led by NASCOP and USAID conducted sensitization on aPNS to 115 (M-56, F-59) CHMT members from Kwale, Taita Taveta and Mombasa in July, 2018 which resulted in greater buy in for the testing modality and lay a solid foundation for scale up to facilities. As follow on to sensitizations, in partnership with AMPATHPLUS and LVCT, the project conducted ToT training in the last week of August for 24 (M-13, F-11) trainers of trainers. Additionally, on a PNS to 211 (M-66, F-145) health care workers from facilities.

d) Testing of Orphans and vulnerable children.

Afya Pwani collaborated with NILINDE to offer HTS to 72 orphans and vulnerable children who were screened and found to have been on a high risk for HIV infection.

X. PROGRESS ON LINKS WITH GOK AGENCIES

a) Support supervision and Performance Review Meetings

Afya Pwani continued to enhance collaboration with the county governments in enhancing the quality of service delivery. Joint support supervisions were conducted with SCHMT across the five Counties with actions plans for follow up being developed. In Kwale, Kilifi and Taita Taveta Counties, performance review meetings were conducted that were attended by the County Executive Committee members (CECs) for Health and the Directors for Health Services in addition to the relevant County Program Officers.

b) HIV Prevention, Care and Treatment Scientific Conference 2018, 9th -11th September 2018

The project supported 18 MOH and project staff from all the five supported Counties to participate in the conference and presented seven posters in collaboration with the CHMTs from Kwale and Taita Taveta.

c) Midwives Association of Kenya Conference in Kilifi

Afya Pwani partnered with Kilifi County government to host the above conference at Pwani University on 14th -16th August 2018 by supporting 100 mid wives to participate as well sharing a presentation on maternity open days as a best practice.

d) PMTCT Regional Stock Taking Meeting in Malindi

Afya Pwani partnered with the respective five County governments of Taita Taveta, Kwale, Mombasa, Kilifi and Lamu to host a regional PMTCT stock taking meeting in Malindi between 27th and 29th August 2018 bringing together over 54 CASCOs, HRIOs and RH Coordinators to take stock of their PMTCT performance for the period July 2017 – June 2018.

XI. PROGRESS ON USAID FORWARD

As provided in the *Afya Pwani* contract, the project received approval from USAID to fund 20 local organizations as grants under contract to support in implementation of demand creation, effective linkage and defaulter tracing activities at community level. During the quarter ending September 30,2018, the project continued to work with these grantees to support the implementation of activities as per the approved *Afya Pwani* Year 2 work plan. With approval from USAID, the project finalized formal contracting and disbursement to two organizations i.e. Women Fighting ADS in Kenya (WOFAK) and Ananda Marga Universal Relief Team (AMURT) to implement the HIV Care & Treatment in Mombasa & Kwale and MNCH/FP grants in Kilifi Count in Kilifi County. These organizations were selected to replace The German Foundation for World Population (DSW) which was closed out due to the board's decision not to impose the requirements of the standard provision RAA29- Protecting Life in Global Health Assistance on their global activities.

XII. SUSTAINABILITY AND EXIT STRATEGY

The project continues to engage the Counties in trainings, mentorship and OJTs to collaboratively but independently run health services management and service delivery effectively. The project also built the capacity of counties to review their performance by conducting data review meetings in Mombasa, Kilifi, Kwale, Lamu and Taita Taveta Counties as a sustainability strategy to ensure continuity of quality services.

XIII. SUBSEQUENT QUARTER'S WORK PLAN

In quarter 1 of FY 19, *Afya Pwani* will focus on consolidating and scaling up strategies and interventions that were effective in years 1 and 2 while shedding off the ineffective ones.

For sub-purpose 1, the project will partner will counties to scale up PNS after the series of trainings that have been conducted in Q4. While *Afya Pwani* has made tremendous progress in scaling up Non-MER interventions among them: PNS, DSD, Case management, Viremic clinics, OTZ and male friendly clinics. In quarter 1 of year 3, the project aims to further scale up and saturate these adjunctive interventions of the Non-MER to support attainment of the MER indicators. With the recent release of the training curriculum for the Revised ART guidelines of 2018, *Afya Pwani* will prioritize refresher trainings for health care workers and scale up the uptake of optimized ART regimen as clients on ineffective regimen will be switched to preferred effective regimen. The project will also strengthen the capacity of facilities to offer HIV services through hiring more facility-based staff especially clinicians, nurses and adherence counselors to improve the VL suppression rate from 85% to the target of 90% by the end of FY 19. For PMTCT, the project will start the implementation of the pre-elimination agenda for Malindi Sub County in Kilifi county as well focus in training a critical mass of health care workers to offer PMTCT services to avoid missed opportunities for testing or ART among pregnant, post-natal and breastfeeding women as well as HIV exposed or infected infants. Further the project will continue to support HCWs deployment in the MCH/PMTCT SDPs to offer quality PMTCT services while supporting demand creation activities for ANC

These are outlined below:

A CHAMPION OF CHANGE

Cornelius Karaba is a resident of Palakumi in the distant ward of Bamba, Ganze Sub County in Kilifi County. He works as a motorbike rider popularly known as boda-boda which a common feature among commuters in the region.

When not transporting clients, Karaba spends most of his time at the local *boda-boda* stall or at his favorite *"mangwe"* (local drinking den) to catch up with his friends on current affairs before heading home. It was during one of his trips with a client, that he heard about the male champions group meeting that is supported by USAID's Afya *Pwani* project. Out of curiosity, he opted to stay back to understand more about the meeting.

The meeting sought to establish male perspective on family planning. A heated debate ensued. Some men suspected ulterior motives about the project while others claimed family planning encourages promiscuity, and others were for it. This discussion left him yearning to learn more. He realized how little he knew about family planning, so he followed one of the facilitators and engaged on a one-on-one

discussion on the various options available to him and his wife. He got to understand the benefits of family planning and was referred to Bamba Health Centre where he could receive accurate information about the health benefits of family planning, high-quality counseling and a full range of methods that he can use. Armed with this information, he approached his wife about taking up a contraceptive method as part of keeping their family to size. The couple who currently have 8 children, chose implant.

Cornelius and a fellow male champion preparing for a sensitization session in Kilifi County.

Like many areas in Kenya, women in Kilifi County face a myriad of challenges in accessing and fulfilling their sexual and reproductive health rights. This situation has made them unable to access quality reproductive health services. The deeply engrained *"Mwenye syndrome*[93]*"*, has also compromised their ability to make decision on fertility intentions.

Karaba is now one of the male champions advocating for family planning in the region, thanks to *Afya Pwani* project that is enabling mothers especially the rural poor have access to quality maternity and family planning services.

The self-proclaimed champion says that for a long time, women have borne the responsibility for pregnancy, childcare, domestic chores including farming, in a region that has chosen a patriarchal route. He says that such grueling and potentially dangerous workload on women, paves the way for health complications and in most cases has had devastating domino-effect on children and families.

Karaba, the talkative boda boda guy is not alone on this important journey of cutting down the myths around family planning. Through *Afya Pwani* trainings, other 157 male champions have been trained in the region, a major milestone towards promoting awareness on reproductive health s among men, improve spouse communication on issues of sexuality, reproductive health and family planning as well as encourage couple counselling for family planning services.

A male champion educating fellow men on family planning options.

The community forums and informal meetings such as the "mangwe get together" are today a perfect sanctuary for people like Karaba and others who did not have basic knowledge on sexual reproductive health. The forums have helped reach more than 10,000 men with messages on family planning and reproductive health services. Because of these outreach activities, 1,570 men have taken the role of accompanying their wives for family planning services, a norm that was unheard of in the County. The male champions also report a

[93] A cultural perception, that positions men as the sole decision makers in all family matters including health

growing number of men allowing their wives to take up contraceptives.

Convinced of the growing positive outcomes of the male champions involvement, Esther Mwema, Kilifi County Reproductive Health (RH) Coordinator, officially adopted the concept from *Afya Pwani* and issued a directive to all health facilities in the County to train and mentor reproductive health male champions.

"We are now seeing more men accompanying their wives for family planning services in our health facilities unlike in the past," She says.

She notes that the Contraceptive Prevalence Rate in the County has now significantly increased from 32% (KDHS 2014) before *Afya Pwani* begun, to 42.9% in 2018, according to a survey by PMA 2020.

Karaba says through their pillow talks, he has learned that his wife always wanted to delay getting pregnant, but the thought to discuss with him, always sent shivers down her spine as she feared he would divorce her. "*That statement left me feeling like a monster, because I often pushed her to give me more children*", he says.

His experience underscores the difficulty many women face in talking with their spouses and partners about their desire to plan their families in a safe and healthy manner. But now, through the education and support efforts of *Afya Pwani*, many couples are jointly a setting a clear path for their families' future.

BEATING ALL ODDS

Hamisi, 34 (not his real name) lives in Kombani area of Kenya's County number 002. Kwale County is one of the country's favourite tourist destination due to its spotless white beaches that extend as far as the eye can see; only ending at the point where the water kisses the clouds and the hills that form part of County.

Hamisi lives with his sister after his parents separated while he was still young to contemplate enough the different pieces that hold the world together He grew up without his parents until 2008 when he learnt that they had died of HIV.

Hamisi life was not easy thereafter. It completely changed! The death of his parents made him live in a neglected life. He had no one to provide basic needs. To make it even worse, he had to drop out of school. He started taking drugs.

"I started using heroine at the age of 16 years, I was introduced by my best friend who had dropped from class six. I started by using cigarettes, then bhang and eventually later graduated to heroine. After smoking for two years, I started injecting heroin into my body for a period of 9 years, I used all my money in drugs even though I earned this money doing odd difficult jobs like moving all day round collecting scrap metals." He says.

Hamisi could not resist the peer pressure and slowly by slowly he found himself deep in the world of drugs. During that time, he was at the prime of his life and very energetic. But instead of using the energy to better himself, he had diverted all the attention to heroine. He would use all the income and savings he made to buy drugs.

One thing that a drug does to your system is that it interferes with your judgment. You are not able to think properly, and you do not take anything seriously. You live a care free life with your biggest worry being where you will get money to purchase your next package. Hamisi had reached the tipping point of this life. It was until early this year, (February 2018) when Hamisi finally took the bold step and decided he needed help. Acceptance is usually the first step that most drug abusers are usually so afraid to take. But little do they know that it is usually the first step to healing and recovery.

When he walked to the Kombani Mat clinic, he had already made up his mind. That he was going to leave behind his bad life and take in whatever help he would he given in that centre.

First, he was empowered on the importance of taking a HIV test. The counsellor took him through sessions that helped him accept his HIV status.

When he took the test, he had made his mind and was ready for the results. He also recognized that the support of the HTS counsellor who took him through the pre-test and post-test sessions and it was easy for him to agree and accept the results.

"The pre-test and post-test sessions made me easy to accept my status. The counsellor took me to Kombani dispensary to start ART support where I enrolled for care and support." He says.

Just like others who have been reached by the USAID funded *Afya Pwani* project, Hamisi is adhering to counselling and ART treatment at the local health dispensary. He is also, a committed member of the support group in the health centre where he attends counselling as in his journey of reform.

"I am no longer afraid to disclose my HIV status. Life has meaning now," says Hamisi on the side-lines of a key population support group for PLHIV which meets on monthly basis at the office.

THE PASSIONATE PEER EDUCATOR

Margaret Wakio, 46, walks out of her three-roomed brick house every morning with a mind fixated at changing her corner of the world. And this exactly is what she has been doing for the last 15 years.

To get to her house, you will have to go through the winding murram roads of Kirongwe village in Mwatate, Taita Taveta County.

Since 2003, Margaret alias *Maggie wa CCC as* she is known by many of her friends and within the Comprehensive Care Clinic at Mwatate Sub County hospital, has been crisscrossing her community wearing different hats and fighting a scourge that the country desperately needs to win.

"I started out as a volunteer HIV/AIDS campaigner after I lost my husband to HIV related infections leaving me with three children. I got tired of seeing people suffer from the disease and the stigma that came with it," she says.

She recalls that her husband only revealed about his status three weeks prior to his death. This triggered her into making a bold decision of getting tested as well.

Shockingly, she tested positive. She immediately started ART and disclosed her status to her immediate family. Luckily, they were supportive despite the stigma that was associated with the disease.

However, after some time it was discovered that she had a reproductive health problem after a routine cervical cancer screening. She was later diagnosed with cervicitis after a biopsy was done at Moi Referral Hospital.

Treatment was administered, and she fully recovered. Afterwards, she found it prudent to disclose her status and sensitize her community on the importance of seeking HIV testing services due to the complications she encountered after knowing her status at the tail stages where opportunistic infections had cropped in.

At first, her community was not receptive to her. They stigmatized her and despite the setback she decided to grab every opportunity that came along to disclose her status to motivate and empower other people living with HIV. After some time, the stigma started fading as some community members started to embrace her. This was the beginning of her journey to becoming a peer educator.

Since then, *Mama wa CCC* has been at the forefront in diffusing stigma for people living with HIV.

Maggie loves her work and her biggest dream is to have a HIV free generation.

"I conduct home visits and private counseling sessions in a bid to raise awareness about HIV and support the less knowledgeable about the disease," she says.

Her visits to the unsuppressed clients and defaulters are on routine basis, her good rapport has enabled her walk with them in their journey while mitigating the barriers like belief in spiritual healing and she counsels them on individual needs. Her key messages to her clients are guided with the standard package care like drug adherence.

The mother of three, believes that a HIV infected person can live a normal life as long as they adhere to treatment.

Mentor mothers in Mwatate now look up to her in creating awareness and reaching out to those people living with HIV.

"What keeps me going? The fact that I am contributing to a free HIV world and understanding in my own little way," she says.