USAID | KENYA
FROM THE AMERICAN PEOPLE

USAID KENYA/APHIA*PLUS* NAIROBI-COAST HEALTH SERVICE DELIVERY PROJECT
QUARTERLY PROGRESS REPORT

USAID KENYA (APHIA*PLUS* NAIROBI - COAST HEALTH SERVICE DELIVERY PROJECT)
FY 2015, Q2 PROGRESS REPORT

15th May, 2015

Award No: (USAID/KENYA RFA NO: 623-10-000009)

Prepared for Ms. Jerusha Karuthiru
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
The Watermark Business Park, Karen, Fountain Court, 1st Floor
Ndege Road, off Langata Road
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 | Facebook | Twitter

DISCLAIMER

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF PHOTOS

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
APHIA*plus*	AIDS, Population and Health Integrated Assistance People-Centered Local Leadership Universal Access and sustainability
ART	Antiretroviral Therapy
ARV	Antiretroviral (Drugs)
BCC	Behavior Change Communication
CaCx	Cancer of the Cervix
CASCO	County HIV/AIDS and STI Control Office
CBHIS	Community Based Health Information System
CBO	Community Based Organization
CCC	Comprehensive Care Center
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHRIO	County Health Records Information Officer
CHS	Community Health Strategy
CHU	Community Health Unit
CHW	Community Health Worker
CME	Continuous Medical Education
COPE	Client Oriented Provider Efficiency
CPGH	Coast General Provincial Hospital
CSA	Community Self-Assessment
CSI	Child Status Index
CU	Community Unit
CYP	Couple Years of Protection
DBS	Dry Blood Samples
DHIS	District Health Information System
DQA	Data Quality Analysis
DTC	Diagnostic Counseling and Testing
EBI	Evidence based Initiative
EBI	Evidence Based Behavioral Intervention
EID	Early Infant Diagnosis
FBO	Faith Based Organizations
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GIS	Geographic Information System
GoK	Government of Kenya
HAART	Highly Active Anti-Retroviral Therapy
HCW	Health Care Workers
HEI	HIV Exposed Infant
HES	Household Economic Strengthening
HH	Household
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Health Management Team
HRIO	Health Records Information officer
HTC	HIV Counseling and Testing
ICF	Intensified case finding
IGA	Income Generating Activity
IP	Implementing Partner
IPT	Intermittent Preventive Therapy
ITN	Insecticide Treated Net
IUCD	Intrauterine Contraceptive Device

IYCF	Infant and Young Child Feeding
KAP	Key Affected Populations
KARHP	Kenya Adolescents Reproductive Health program not in this report
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supply Agency
KEPH	Kenya Essential Package for Health
KGGA	Kenya Girl Guides Association
LIP	Local Implementing Partner
LLITN	Long Lasting Insecticide Treated Net
LOC	Locational OVC Committee
MNCH	Maternal and Child Health
MDH	Mbagathi District Hospital
MDR	Multi-Drug Resistant
MNCH	Maternal, Newborn and Child Health
MOA	Ministry of Agriculture
MOH	Ministry of Health
MSM	Men who have Sex with Men
MSW	Male Sex Workers
MT	Metric Tons
MTCT	Mother to Child Transmission
MVA	Manual Vacuum Aspiration
MYSA	Mathare Youth Sports Association
NARESA	Network of AIDS Researchers of Eastern and Southern Africa
NASCOP	National AIDS and STI Control Program
NGI	Next Generation Indicators
OJT	On-the Job Training
ORT	Oral Rehydration Therapy
OVC	Orphans and Vulnerable Children
PAC	Post abortion Care
PCR	Polymerase Chain Reaction
PE	Peer Educator
PEMA	People Marginalized and Aggrieved
PEP	Post Exposure Prophylaxis
PHO	Public Health Officer
PI	Pathfinder International
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PPH	Post-Partum Hemorrhage
PSI	Population Services International
PTA	Parents and Teachers Association
PWID	People who Inject Drugs
PwP	Prevention with Positives
QI	Quality Improvement
RH	Reproductive Health
RRI	Rapid Results Initiative
SAPTA	Support for addiction prevention and treatment in Africa
SGC	Small Group Communication
SILC	Saving and Internal lending for communities
SMS	Short Message System
SP	Sulphadoxine-Pyrimethamine
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SC	Sex Workers
TA	Technical Assistance
TB	Tuberculosis

TBA	Traditional Birth Attendants
TOT	Trainer of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medical Male Circumcision
VSL	Voluntary Savings and Loans

I. APHIA*PLUS* NAIROBI-COAST HEALTH SERVICE DELIVERY PROJECT- EXECUTIVE SUMMARY

Since its inception in 2011, USAID/APHIA*plus* Nairobi-Coast Health Service Delivery Project has partnered with the Ministry of Health (MoH) and a select number of local implementing partners (LIPs) as primary stakeholders, to strengthen provision of integrated health services as a subset of the larger USAID/Kenya health system strengthening efforts. The Project focuses both on provision of improved quality, expanded integrated package of health services as defined by the Kenya Essential Package for Health services (KEPHs) and the means by which service implementation data and information is managed and utilized for improved program implementation. The overall goal is to realize and accumulate outcomes resulting in better performance which, in turn, will result in a quality package of service delivery for all Kenyans -responsive to - health sector programming priorities of Zone 2. The Project works with various partners to enhance capacity of facilities and community-based service providers to provide integrated high impact interventions and holistic systems strengthening. Working with Counties, sub-counties, facility and community levels of the health service provision system in Kenya, the Project continued to facilitate strengthening facility-community linkages and referral mechanisms thus ensuring communities access to improved quality integrated health services and products.

This report presents APHIA*plus* Nairobi-Coast Health Service Delivery Project's performance for the first quarter: Jan-Mar, 2015 and covers the Project's achievements across all the sub-components of the 2 key result areas (Result Areas 3 and 4 of the USAID Kenya, 2012-2015 Implementation Framework) as stipulated in the Project's Strategic Goal for health "*Sustained improvement of health and well-being for all Kenyans*". The report has 16 sections (I- XVI) organized by key programmatic areas: Result Area 3, which covers the core services package as defined by Kenya Essential Package of Health Services (KEPHs), i.e. HIV and AIDS, TB, Maternal and Neonatal Child Health (MNCH), Malaria, TB, WASH; the Social Determinants of Health; Result area 4, and finally contributions/support to health systems strengthening (Result areas 1 and 2). Within each area, project performance is reported based on the program defined key indicators

Under the section on contributions to health systems strengthening, the report documents how the Project implementation strategies and activities have endeavored to contribute to increased availability of services by addressing geographic, socio-cultural, economic, legal/regulatory barriers impeding access to healthcare, with special focus on the poor and 'hard to reach' populations residing in the urban slums and hard to access rural areas, and key populations. Towards that end, the report outlines the activities undertaken during the quarter to mitigate the effects of behavioral, social and structural barriers and constraints to the access and utilization of integrated quality health services. The main report concludes with the financial management report section, PMP matrices, the schedule of subsequent events and future activities which constitute part of the annexes which should be read side-by-side with the narrative report. The report further illuminates on the status of implementation of different activities and strategies aimed at increasing availability of services that address geographic, socio-cultural, economic, legal/regulatory barriers impeding access to care and treatment, with special reference to poor and "hard to reach" populations.

In this reporting period, the Project continued to build on, and scale up, activities across all six counties that define Zone 2 (Kilifi, Kwale, Lamu, Nairobi, Mombasa, and Taita-Taveta). With commitment to continuity and sustainability of service delivery, the Project focused on supporting targeted interventions at both the facility and community levels to improve communities' uptake of services by focusing on sustaining gains made in the previous quarter for HIV prevention, care and treatment while ensuring support to enable access to HIV counseling and testing (HCT) services for those that needed them. Efforts were made to prevent new infections especially among young children by increasing access to HIV counseling and testing and strengthening the quality of services. The Project continued to concentrate efforts on integrated approaches to elimination of mother to child transmission of HIV (eMTCT) further reducing the number of children getting infected before, during and after delivery. In the reporting quarter, the Project registered significant strides in implementing the new HCT algorithm building on efforts made in previous quarters in capacity building of staff. The revised ART guidelines were scaled up in a phased approach, with more staff being trained and efforts being made to ensure a complete shift to option B plus, initiating more patients to treatment using the cut off of CD4 count 500 cell per ml, initiating all children below ten years on HAART and ensuring that those already on HAART got a baseline and annual viral load test. The Project also continued to put particular emphasis on finding children and linking them to key services such as HCT, care and treatment, TB diagnosis and treatment and psychosocial support. Health system strengthening activities in support of patient access and retention to HIV and TB services remained the pinnacle of support. In order to improve HIV diagnostics and monitoring in the six counties, the Project continued to support lab networks for CD4 through nodal sites.

With regard to improving MNCH services the Project continued to build on and scale up RH/FP, MNCH, Nutrition and Malaria activities across all the six counties as per the priority interventions defined in the six-month extension work

plan. The Project focused on supporting targeted interventions at both the facility and community levels to improve community use of, and access to, quality integrated services while minimizing intense direct support due to Project close out.

RH/FP Mentorship, OJT, sensitizations and support supervision focused on long acting reversible and permanent contraception, integration with HIV services and compliance to USG FP legislative and policy requirements.

MNCH support focused on addressing the common causes of maternal and neonatal mortality. In Mombasa, Kilifi and Nairobi support focused on BEmONC, -increased use of focused antenatal care services (completion of 4 FANC visits), skilled delivery attendance and post-natal care services. In coastal counties –the Project focused on prevention of malaria in pregnancy nutritional assessment counselling and support for pregnant women, children under five years and TB/HIV co-infected clients.

Under gender and other-cross-cutting issues, the Project continued to strengthen community-based services targeting increased health service access for girls and women and increased prevention and response efforts against GBV. The Project focused on: strengthening GBV coordination working groups through update and exchange meetings; promotion of healthy images of manhood (HIM) through sensitization sessions; promotion of health treatment literacy integrated with GBV sensitizations; facilitating and supporting to increase community awareness and engagement for improved access to service by women and children by supporting the facility-community referral linkages and sensitizations. Targeted sessions were held in Nairobi, Mombasa and Lamu counties for girls and boys sensitizations on FP/RH, HIV/AIDS and GBV for men and maintenance and strengthening of GBV safe spaces and shelters. The Project continued supporting GBV Working groups with shelters/safe spaces monthly meetings; forums for women on laws of marriage and succession and the Women's Enterprise Fund; and - provision of legal aid services by CREAW in supported districts. Support was provided to Kenyatta National Hospital Gender Violence Recovery Centre with GBV coordination, community outreaches and provision of psychosocial support services.

As a continuation of activities from the previous quarter, Result Area 4 interventions focused on strengthening households' economic capacities, improving food production, farming, post-harvest management skills and techniques to enhance the capacities of targeted households and communities to adopt healthy nutritional practices. School and community-based educational structures were strengthened to ensure improved educational access, retention and completion for orphaned and vulnerable children (OVC) while at the same time strengthening the literacy skills of caregivers. Access to safe water, sanitation, and hygiene practices were improved for the marginalized, poor, and underserved children and communities in the Zone.

To ensure sustainable impact and continued improvement of service delivery, the Project continued to work on its health systems strengthening strategy fully cognizant of eventual exit. During the quarter, the Project worked towards sustainability by: 1) fully aligning with national policies and strategies; 2) ensuring that technical assistance added real value and 3) referring to complex systems when dealing with systems issues; 4) building grassroots networks for service delivery through CHWs, LIPs and Facility referral networks. Interventions to ensure a continuum of service delivery included strong linkages between health facilities and the communities and vice versa.

Detailed explanation and descriptions of various activities undertaken, challenges faced and suggested recommendations, for Project activity implementation are outlined in the respective sections of the main report. In the coming quarter, the Project will focus on supporting the key identified priority transition interventions and activities that describes the 3-months (May-July, 2015) extension work plan to strengthen systems for service delivery, increase county ownership, and support to MOH structures in finalizing various tools under review to facilitate full operationalization and institutionalization of the New PEPFAR MER Strategy and Guidance Note on DATIM

Table 1, 2 and 3 here below summarizes the cumulative Project performance, including this quarter, for the indicators under the two strategic objectives. The Project performance surpassed most of the service delivery targets.

Table 1: APHIAplus Nairobi-Coast Project: Summary Performance Table, Result Area 3

rvice ea	Indicator	Yr. 1 Targets	Y1 Ach.	Yr. 1 % Ach.	Yr. 2 Targets	Y2 Ach.	Yr. 2 % Ach.	Yr. 3 Targets	Y3 Ach.	Yr. 3 % Ach.	Yr. 4 Targets	Y4 Ach.	Yr. 4 % Ach.	Yr. 5 Targets
MTCT	PMTCT/C&T	126369	130963	104%	172,000	186,035	108%	195,000	177,728	91%	188,202	207,813	110%	74,100
	Mother prophylaxis	6793	5618	83%	7,600	8,009	105%	9,000	5,931	66%	6,308	6,193	98%	2,484
	# of 4 ANC visits	80106	57126	71%	112,216	84,183	75%	95,000	77,121	81%	82,225	89,066	108%	30,219
	# of deliveries with a skilled birth attendant (SBA)	82604	70322	85%	97,220	93,684	96%	105,640	99,397	94%	55,475	62,761	113%	35,734
MMC	#of males circumcised	52	169	325%	4,060	3,128	77%	2,421	3,168	131%	131,056	103,345	79%	500
C	# counseled and tested	669428	549379	82%	600,000	594,617	99%	594,253	510,447	86%	204,006	399,936	196%	130,056
V	ART New clients	8472	10227	121%	10,900	11,288	104%	12,050	9,778	81%	68,496	76,071	111%	3,920
	ART Current clients	69053	48382	70%	61,180	53,543	88%	70,500	52,828	75%	62,574	65,645	105%	62,466
	# of TB Patients Tested HIV	10500	8040	77%	15,000	13,645	91%	15,200	12,466	82%	116,796	83,087	71%	45,661
NCH	# of children under five receiving Vitamin A	401710	262094	65%	236,748	376,252	159%	420,000	176,982	42%	222,403	144,784	65%	108,988
	# of children less than 12 months of age who received DPT3	30463	57000	187%	128,468	146,191	114%	100,000	124,092	124%	138,273	108,361	78%	54,729
	# of children who have received measles vaccine by 12 months	113926	129557	114%	146,034	147,008	101%	165,000	136,106	82%	139,037	110,827	80%	54,074
	# of children <1 year fully immunized	105059	74367	71%	123,723	140,438	114%	156,700	135,284	86%	121,344	212,019	175%	55,847
	# of Long Lasting Insecticide Treated Nets (LLITN) distributed	59776	215191	360%	250,000	245,412	98%	250,000	79,426	32%	183,255	205,249	112%	35,425
	FP - CYP	66375	197032	297%	260,000	320,369	123%	375,000	310,923	83%	198,085	282,253	142%	128,755

Table 2: Summary Table: County-Level Performance- Year5, Jan-Mar, 2015

		NAIROBI COUNTY PERFORMANCE			MOMBASA COUNTY PERFORMANCE			KWALE COUNTY PERFORMANCE			KILIFI COUNTY PERFORMANCE			TAITA TAVETA COU PERFORMANCE	
	Indicator	Yr 4 Targets	Jan-March 2015	% Ach.	Yr 4 Targets	Jan-March 2015	% Ach.	Yr 4 Targets	Jan-March 2015	% Ach.	Yr 4 Targets	Jan-March 2015	% Ach.	Yr 4 Targets	Jan-March 2015
MTCT	PMTCT/C&T	16,755	17,009	102%	11,847	10,151	86%	6,007	6,428	107%	6,113	7,267	119%	2,117	2,418
	Mother prophylaxis	690	708	103%	336	302	90%	100	162	162%	206	211	102%	76	75
	# of 4 ANC visits	9,901	8,884	90%	5,788	4,875	84%	3,896	3,849	99%	3,148	3,319	105%	1,268	1,747
	#of deliveries with a skilled birth attendant (SBA)	12,901	9,883	77%	6,704	6,544	98%	4,192	4,438	106%	2,569	3,034	118%	2,221	2,393

MMC	# of males circumcised	-	-		-	-		-	-		-			-	-
TC	# counseled and tested	32,100	35,951	112%	22,877	25,851	113%	12,114	13,942	115%	10,414	11,663	112%	8,009	8,694
V	ART New clients	1,091	1,855	170%	1,248	922	74%	600	630	105%	602	615	102%	53	52
	ART Current clients	13,293	15,441	116%	6,195	5,230	84%	4,005	4,114	103%	6,033	6,165	102%	2,067	2,042
/HIV	# of TB Patients Tested HIV	10,878	9,712	89%	5,407	4,544	84%	3,466	3,424	99%	3,080	3,249	105%	32	32
NCH	#of children under five receiving Vit. A	38,914	34,745	89%	14,275	12,266	86%	9,160	9,345	102%	3,218	3,288	102%	1,537	1,519
	#of children less than 12 months of age who received DPT3	13,002	13,394	103%	6,716	6,555	98%	4,767	4,710	99%	6,839	6,988	102%	2,506	2,476
	# of children who have received measles vaccine by 12 months	16,624	17,521	105%	6,975	7,651	110%	4,090	4,534	111%	2,683	2,741	102%	1,267	1,252
	# of children <1 year fully immunized	14,500	13,839	95%	10,332	10,574	102%	5,027	5,263	105%	2,235	2,284	102%	1,689	1,669
	# of Pregnant women supplied with LLITNs	881	786	89%	15,338	15,804	103%	3,002	3,183	106%	2,729	2,788	102%	1,824	1,802

Table 3: APHIAplus Nairobi-Coast Health Service Delivery Project: Summary Performance For Result Area 4

	Indicator	Yr. 1 Targets	Y1 Ach	Yr. 1 % Ach.	Yr. 2 Targets	Y2 Ach.	Yr. 2 % Ach.	Yr. 3 Targets	Y3 Ach.	Yr. 3 % Ach.	Yr. 4 Targets	Y4 Ach.
Result Area 4.1	Households trained on VSL	3745	10560	282%	23,000	10,933	48%	27,083	19,674	73%	12,975	17,119
	Households initiated an IGA	0	0	0%	53,000	53,256	100%	3,097	44,973	1452%	8,931	14,830
	CBOs linked to MFI	0	0	0%	2,262	2,360	104%	577	783	136%	374	389
	#of children trained on basic financial literacy	300	322	107%	2,105	620	29%	1310	1,224	93%	1,607	2,215
Result Area 4.2	#of farmer groups formed	0	0	0%	1,000	949	95%	1,300	1,561	120%	645	314
	# of producer organizations formed & linked to marketing networks	0	0	0%	75	75	100%	75	224	299%	92	72
Result Area 4.3	# of supported schools with children's health and/or rights clubs	272	276	101%	340	375	110%	500	832	166%	566	471
	#of individuals reached through theatre sessions on safe water and hand washing	27000	5596	21%	50,000	75,506	151%	0	11,987	166%	27,303	30,098
Result Area 4.4	Liters of drinking water disinfected with USG-supported, point-of-use treatment products	125000	229282700	183426%	101,000,000	105,890,700	105%	125,000,000	295,971,740	237%	30,000,000	22,813,68

	# of households with functional pit latrines	20000	48381	242%	65,000	45,329	70%	50000	112,056	224%	23,662	94,509
	#of functional GBV working groups supported	6	4	0%	15	12	80%	25	18	72%	17	26
Result Area 4.5	#of male champions networks supported	12	1	8%	5	5	100%	6	46	767%	8	21
Result Area 4.6	# of special events supported (MOYA youth week, Malezi Bora/BF weeks	4	5	125%	18	27	150%	20	44	220%	30	22

II. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

This section highlights the qualitative achievements of the Project, during the quarter in each project result area. Outputs and effects/outcomes of priority interventions and activities supported by the project are highlighted.

RESULT 3: INCREASED USE OF QUALITY HEALTH SERVICES, PRODUCTS AND INFORMATION

Result area 3 focuses on realization of increased access and use of quality health services, products and information through increased availability of, and corresponding demand for, an integrated package of quality high-impact interventions both at community and health facility levels. In pursuit of this result, the Project continued to support MOH structures and other key GoK departments, to strengthen the ability of facility and community based services to provide an integrated package of high impact interventions (HIP) at all tiers of health care. The Project worked with various partners to enhance capacity of facilities and community-based service providers to deliver integrated high impact interventions through intensification of actual service provision, system strengthening and quality improvement activities. Working through Counties, sub-counties, facility and community levels of health service delivery system in Kenya, the Project continued to facilitate strengthening facility-community linkages and referral mechanisms thus ensuring effective and reliable access and availability of health services and products. Priority for the year has been on improving the quality and coverage of the continuum of care for integrated HIV and AIDS/TB, RH/FP, MNCH, nutrition, and malaria services in all six counties. Though the various activities are tracked through selected indicators, the overall thrust of the Project traverses across them.

3.1: INCREASED AVAILABILITY OF AN INTEGRATED PACKAGE OF QUALITY HIGH-IMPACT INTERVENTIONS AT COMMUNITY AND HEALTH FACILITY LEVELS

3.1.2 HIV PREVENTION, CARE, TREATMENT AND SUPPORT

Elimination of Mother to Child Transmission of HIV (eMTCT)

The Project supported activities under eMTCT to ensure transmission reduction of HIV from infected mothers to their infants and ensuring life for the latter.

a) ***Capacity building for eMTCT:*** The Project continued to build the capacity of health workers through on job training (OJT), mentorship and continuous medical education (CME). In Nairobi, 31 HCWs were updated on the rapid advice guidelines during the quarter. The guidelines with supporting job aids and reference materials were disseminated and distributed in 12 high volume facilities[1]. At the Coast, on job training on the rapid advice guidelines was provided to health care workers (45 in total) in 16[2] high volume facilities to build the capacity and increase knowledge of the HCW in eMTCT while strengthening the existing eMTCT workforce.

During this reporting period, post training follow-up was undertaken by the MoH program managers and APHIA*plus* Nairobi-Coast clinical team. All the 18 healthcare workers who had been trained as trainers were mentored and are expected to conduct monthly continuous professional education at their facilities using the already disseminated reference materials.

[1] **Mbagathi District Hospital, St Mary's mission Hospital, Mama Lucy Kibaki Hospital, Makadara health Centre, Kayole 11 Health Centre, Westlands Health Centre, Kangemi Health Centre, Mathare North Health centre, Kahawa west Health Centre, Kasarani Health Centre, St Francis Mission Hospital and Lunga-Lunga Health Centre**

[2] **CPGH, Tudor DH, Shimo Annex HC, Bamburi HC, PDH ….**

Mentorship of health workers in public facilities on DBS collection for EID was supported in 4[3] facilities, reaching eleven service providers. Other areas focused on during the mentorship were HEI follow-up and documentation.

Five CME (reaching 90 health workers) were supported in high volume[4] facilities at the Coast. These CME, focused on the use of HAART among HIV infected pregnant and lactating mothers (option B+).

b) ***EMTCT task force meetings:***

At the Coast, five eMTCT task force meetings (with 86 participants) targeting health workers at their facilities[5] were held. topics discussed included: HIV counseling and testing (HCT) at ANC, option B plus at ANC, Prophylaxis to HIV exposed infants (HEI), DBS and Viral load collection, documentation, and HEI follow up.

In Kilifi County, the first quarter's task force meeting (32 participants from 12 high volume facilities) to review progress made on eMTCT was supported. The task force meetings revealed that some HCWs did not understand all the PMTCT indicators thus leading to inaccuracy in some of the numbers reported. It was resolved that HCW be orientated on all the PMTCT indicators. Also, at the meeting, preparations were made for the national eMTCT stock taking meeting that was held in Nairobi in April 2015.

c) ***Early infant diagnosis (EID)-PCR Testing:***

The table below presents the number of DBS samples collected and analyzed for HIV using PCR.

Table 4-Early Infant Diagnosis (EID)-PCR Testing

REGION	JAN	FEB	MAR	NEGATIVE	REJECTED	POSITIVES	TOTAL
NAIROBI	294	225	202	683	13	25	721
COAST	292	188	300	693	8	79	**780**
TOTALS	586	413	502	1376	21	104	**1501**

From the table above, a total of 1501 EID samples were collected in the quarter, of which 1,376 were negative, 104 positive with 21 rejections giving a positivity rate of 6.92 % and rejection rate of 1.39%. During the reporting period, the Project provided support to review why samples were rejected and redraws done.

To strengthen HEI identification, testing and follow-up of the babies up to 18 months was provided as per the national guidelines. EID OJT was offered in 28 health facilities in Kwale and Taita Taveta Counties, where 108 HCW were reached. The OJT focused on DBS collection for EID, use of HEI register, HEI follow-up guidelines as well as CD4 and viral load sample collection.

The Project supported the CPGH laboratory with airtime and internet bundles to strengthen EID laboratory networking in the region. Calls were made to facilities to collect results or to inform them of a rejected sample and the need to redraw. This has improved the turnaround time for result dispatch back to the facility. Health workers in the ANC clinic were taught how to report online on the progress of HIV positive children on the NASCOP EID website. This was after it was noted that reporting and follow-up of HIV positive infants was low.

d) ***Mentor Mothers:***

In Coast, five facilities[6] in Kilifi County have retained and continue to fund and support mentor mothers to offer quality peer education and counseling to HIV Positive mothers at ANC clinics. Therefore, the Project continued to work with mentor mothers and CHWs to trace and follow-up mothers of exposed children for EID and to return for results.

e) Data:

Out of 49,942 women tested at antenatal, maternity and post-natal wards, 2,638 (5.3%) tested positive for HIV. Those who already knew theirs status were 51,046 of whom, 1,264 (2.3%) were positive. The total number of mothers issued with prophylaxis was 1,679 (i.e 43% of all positive mothers) but this number excluded those who already were on HAART at first

[3] Bamburi HC, Magongo HC, Kwale DH, Mtwapa HC

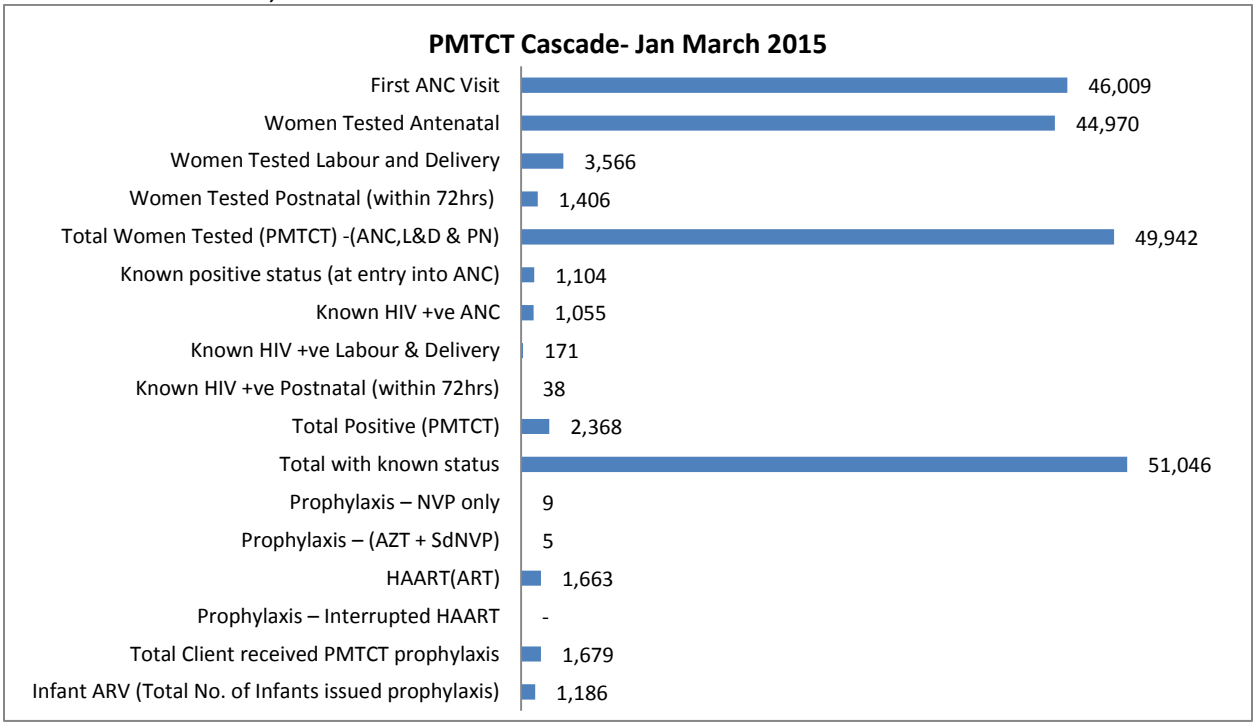
[4] Kilifi County hospital, Malindi Sub County Hospital, Bamba Sub County Hospital, Rabai Health center, Moi Hospital

[5] Diani Health Centre, Lamu Hospital, Hindi Magogoni, Witu Health Center, Mpeketoni Hospital, Wesu DH, Moi DH, Taveta DH and Mwatate SDH,

[6] Mariakani, Kilifi and Malindi County hospitals; Mtwapa and Vipingo health centers

contact. Documentation of infant prophylaxis remains a challenge because health workers are still not issuing this at ANC first visit.

Figure 1-PMTCT Cascade-Jan-Mar, 2015



eMTCT strategies applied included:

1. Consultation with MOH sub-county health teams to ensure that staff trained in eMTCT are retained for at least 6 months at all service delivery entry points to ensure mentorship and quality of care.
2. Feedback and case conference sessions with facility clinical teams on reported cases of transmission, identifying possible causes e.g. health care worker errors made during issuance of prophylaxis.

Lessons Learned included:

1. Case discussion at facility improves quality of care and management of patients.
2. Adherence counselling of patients when emphasized in the implementation of rapid advice helps to minimise defaulting on ARV.
3. Advocacy by mentor mothers reduces resistance to HAART initiation in HIV positive pregnant mothers.

HIV Testing and Counseling (HTC)

Awareness of one's HIV status empowers clients to take precautions that prevent HIV transmission and re-infection.

a) ***Commodity Management*****:** APHIA*plus* Nairobi-Coast Project supported all 6 county medical laboratory technologists with airtime for RTK online commodity reporting, thus ensuring minimal stock outs. No stock outs were reported during the quarter.

b) ***PITC Counsellors:*** APHIA*plus* Nairobi- Coast supported locum counsellors in high volume facilities[7], which reduced missed testing opportunities both in outpatient and in-patient services.

Table 5- Facilities supported with PITC Counselors

Facility	Number Tested	Number positive	Number Linked to Care
Mathare N. Health Center	571	53	53
Mama Lucy Kibaki Hospital	372	8	8
St Mary's Mission Hospital	4492	234	234

[7] Mama Lucy Kibaki hospital, St Mary's Mission hospital, Mbagathi District hospital and Mathare North health centre

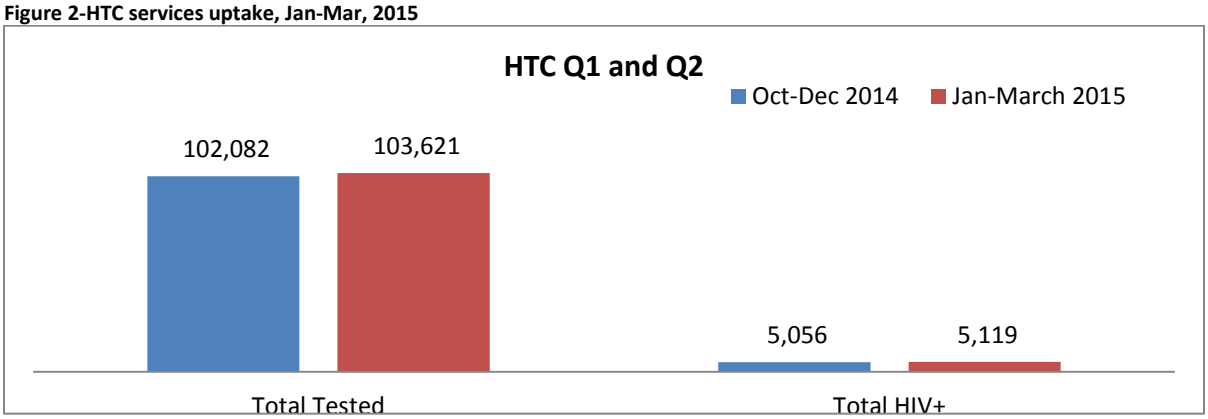
Mbagathi District Hospital	2297	220	220
Total	7732	515	515

c) ***HTC Outreaches:*** In Coast region, during the reporting period, the Project supported 12 integrated outreaches in hard-to-reach areas in Lamu. A total of 225 (87 male and 138 female) clients were counseled and tested for HIV. Four (1.8%) clients tested positive and were linked to the nearest health centre for enrollment into care.

d) ***Support to Counselor Supervision*:** In Nairobi County, supervision sessions were conducted in all the nine sub-counties and 92 Counsellors were debriefed. The sessions focused on building counselor skills to address discordancy and HIV information giving to clients.

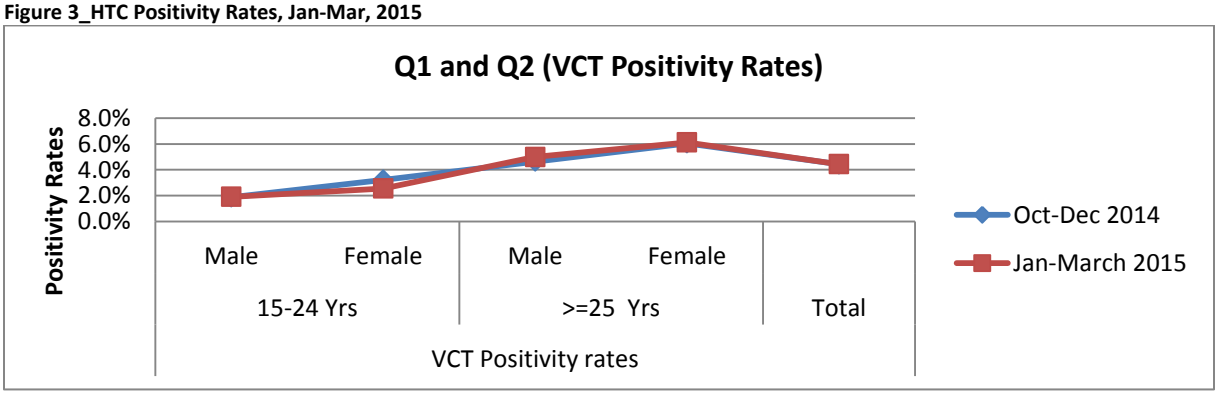
e) ***Data:***

Figure 2-HTC services uptake, Jan-Mar, 2015



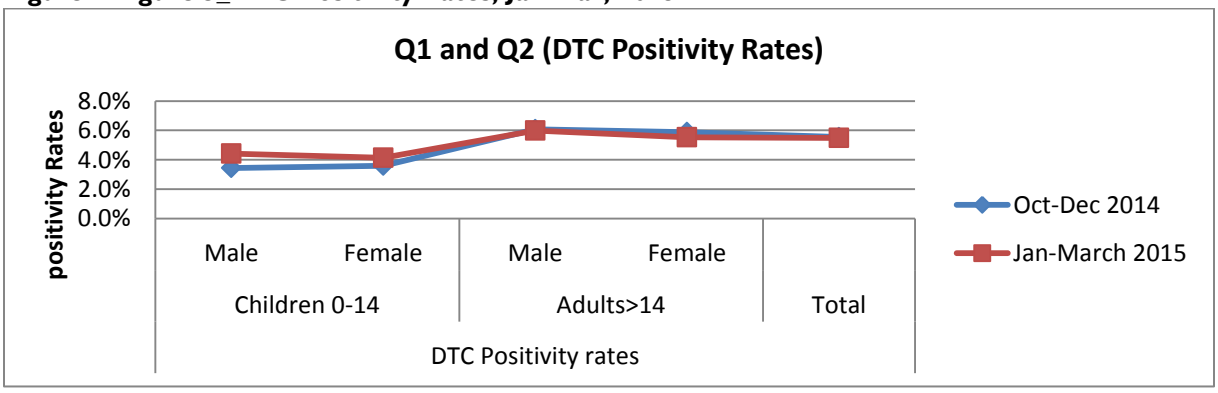
Out of 103,621 clients tested, 5119 (4.9%) were positive.

Figure 3_HTC Positivity Rates, Jan-Mar, 2015



Out of 54,469 clients tested in VCT, 2,418 (4.4%) were positive for HIV.

Figure 4-Figure 3_HTC Positivity Rates, Jan-Mar, 2015



Out of 49,152 clients tested for HIV in DTC, 2,701 (5.5%) were positive. About 7,046 children were tested in DTC with a positivity rate of 4.3%.

Strategies used in HTC included: hiring locum counsellors to undertake targeted PITC of outpatients in high volume facilities.

Lessons Learned: Linkage of clients into care and treatment is more effective in comprehensive care clinics (CCCs) than in stand-alone VCT.

HIV Care and Treatment

The Project continued to support technical assistance on provision of quality HIV care and treatment services as per national guidelines and standards; aimed at retaining clients on care and treatment, monitoring them through available laboratory tests and supporting them for healthier living.

Priority interventions that the project focused on in the reporting period are described below:

a) ***Capacity Building:*** In order to scale up the implementation of the rapid advice guidelines and improve the quality of services provided in ART clinics, the Project collaborated with FUNZO Kenya to train 90 HCWs from supported facilities in Nairobi County. In Coast, one (1) CME on Pediatric HIV management (attended by 56 HCW) was conducted at Moi Hospital.

To improve the quality of services, mentorship and technical assistance was provided in 14 facilities[8]. Mentorship focused on the use of MoH reporting tools and documentation of clients' information in registers and files. Areas that required TA were guided by gaps identified during routine monthly data verification exercise in the reporting quarter, through supportive supervision visits conducted by the program team. For example, at AMURT health centre and STC Casino documentation gaps were identified after the facilities had recruited new staff. Mentorship was offered on basal metabolic index (BMI) taking and recording and CD4/ viral load data on MoH tools.

On-job-training on the new treatment guidelines was provided to health care workers in 38 high volume facilities in Lamu, Kwale and Taita-Taveta reaching a total of 157 HCWs. Areas addressed included: ART eligibility criteria, preferred regime for adults, adolescents and children; HIV/TB co-infected clients, Isoniazid Preventive Therapy (IPT) and laboratory monitoring for PLHIV.

Site assessments (an integrated activity done to access previously non- ART sites to start offering ART) for ART scale up was undertaken. During the site assessment, TA was offered as a follow-up after the rapid advice dissemination to HCWs from these sites, technical assistance and follow up of ART guidelines dissemination was conducted in 12 facilities. This was aimed at imparting skills, building provider's confidence and competency, monitoring of clients and sharing of updates on current ART rapid advice guidelines for HCW not yet oriented. Thirty-four service providers were reached and seven clients were newly initiated on HAART.

b) ***Multi-disciplinary team meetings:*** In Coast region[9], the Project supported multi-disciplinary review meetings involving staff from MCH, CCC, laboratory and maternity. The review panels (comprising 37 participants) discussed eligibility of HIV positive PMTCT mothers and how to strengthen linkages of these mothers from maternity to care and treatment. In Nairobi, a multi-disciplinary team meeting made up of nine staff was held at Kayole II HC to discuss 4 cases of HIV transmission to infants. This measure was undertaken both to ensure that the latter cases were linked to treatment; and also to identify lapses that had resulted in transmission in a bid to prevent repeat occurrences..

Psychosocial Support:

a) ***Client retention*:**

With roll out of the rapid advice guidelines, clients are being initiated on treatment at a relatively high CD4 of < 500 with efforts geared towards client retention as a measure of success in treatment. The activities conducted in this regard included; training on treatment literacy, mini group sessions on adherence at the CCCs and strengthening of psychosocial support groups.

[8] St Francis Community Hospital, STC casino, Kahawa West HC, Staff clinic, Kenyatta University, FHOK, AMURT, Melchidezeck hospital, Westlands HC, Kangemi HC, Kayole II SDH, Mama Lucy Kibaki hospital, Soweto PHC and Reuben center

[9] The Facilities are Coast General Hospital, Moi Hospital and Marungu Health Centre.

Below is the number of clients reached during treatment literacy and mini group sessions:

Table 6- Psychosocial Support service uptake

Activity	No. of Sessions Held	Male	Female	Total
Treatment Literacy Trainings	3	34	138	172
Mini Group Adherence Sessions	62	136	319	455

APHIA*plus* Nairobi-Coast Project continued to strengthen linkage of infected infants to treatment services; as well as reinforce tracing, enrollment and managing adherence of HEI.

b) ***Retention and defaulter tracking for PLHIV on ART:***

To enhance client/patient retention, the Project continued to address client factors (i.e client knowledge, attitude and practices, adherence, partner testing and disclosure, lifestyle, stigma, dependency, socio-demographic information and psychological status); community factors (i.e cultural, religious beliefs and attitudes, community structures and social political issues) and geo physical factors (e.g. distance to point of service, decentralization of services and infrastructure)/client retention.

Technical support to facility and community staff focused on maintaining an appointment diary or daily register, transferring of missed appointment, phone calls, categorization and physical tracing.

Provision of airtime for phone calls for missed appointments and review sessions on defaulter tracing outcomes with health facility staff were supported. In Kilifi County 10 high volume facilities were supported with airtime for defaulter tracing and 22 males and 73 females were traced back to care.

Frontline SMS has also been introduced in Kwale and Mombasa Counties with Port Reitz, Tudor, Kwale, Magodzoni and Tiwi health facilities already using the application. The Frontline SMS in these facilities is being used to remind clients of their appointments.

A PWP advocates' meeting in Taita Taveta County was supported by the Project with the intention of sensitizing support groups on their role in PHDP. At this meeting, data on clients who had defaulted was shared and members were able to account for 16 out of 17 clients who had defaulted and the group was tasked to support their members and get them back to care and treatment.

c) ***Psychosocial support and topical updates for support groups:***

The Project continued to provide technical support to selected support groups, targeting the organizational capacity of the groups in line with the national draft guidelines. Ninety two (92) support groups were provided with monthly mentorship sessions. Areas covered during mentorship included the role of support groups, stages of group development, leadership in support groups, conflict resolution, resource mobilization, monitoring & evaluation, income generating activities (IGAs)/economic strengthening and management of specific populations of PLHIV. The PLHIV advocates attached to health facilities/HCBC desks provided prevention messages at both facility and community levels. Support group TA focused on how to sustain their livelihood activities, and relevant linkages with the GOK to enable them access assistance after e Project exit.

d) Strengthening Orphans and Vulnerable Children (OVC) Support Groups

During routine monthly support group sessions at LIP level, children and their caregivers were equipped with skills on drug adherence, disclosure, proper nutrition, PwP, RH/FP, PEP, and personal hygiene. The Project continued to build the capacity of 1,273 OVC (548 male, 725female) in 57 support groups in strengthening their coping mechanisms. All children in attendance were counseled on behavior change and how to make informed health choices. Parents Clubs of OVC living with HIV were capacity built on parenting skills, income generating activities, drug adherence, nutrition and care for HIV positive children. They were encouraged to continue with VS&L and SILC activities to enable them become economically sustainable at household level.

e) **Rehabilitation of Orphans and Vulnerable Children with Disability**

Treatment for children with epilepsy: During this reporting period, the Project collaborated with the Kenya Association for the Welfare of People with Epilepsy [KAWE] to support 28 [24 Male, 4 Female] children with epilepsy to continue with therapy sessions which led to reduced convulsions as indicated in their medical records. Additionally, caregivers of 7 (3 Male, 4 Female) newly identified children paid for their treatment, increasing the number to 35 [27 Male, 8 Female]. Due

to rehabilitative treatment, all child clients have experienced improved health and eight [8] OVC have been retained in schools.

Sensitization of caregivers on disability issues has reduced self-stigma and improved acceptance of the disabled in households and schools. Further, caregivers have taken responsibility to pay part of their children's hospital bills. Other caregivers of children with epilepsy have started their children on treatment after observing the improved health status of the enrolled children.

f) Support treatment and therapy for OVC with other Disabilities

Caregivers continued to support medical checkups and treatment therapy. A total of 163 (64male, 99female) OVC with disabilities were taken for treatment and therapy sessions at Ruben center, Kayole Health Centre, Mama Lucy Kibaki, Kibera, AMREF center, and St. Francis hospital; this has led to improved condition of the OVC since some of them can now walk, move their limbs resulting in improved health benefits and easy blood circulation. Caregivers have also learned how to perform therapy based on their observations of occupational therapists at the rehabilitation centers and are assisting their children to exercise while at home.

Laboratory

The Project supported linkage of all ART sites to CD4 testing for clients on care and viral load testing for monitoring clients on treatment. APHIA*plus* Nairobi-Coast supported the transportation of DBS, CD4 and viral-load samples and their results between the facilities and hub laboratories.

c) ***Pima CD4 testing:*** To continue giving real time quality services in the facilities under the rapid advice, the Project in collaboration with Ministry of Health and Clinton Health Access Initiative (CHAI) installed Point of Care Machines (PIMA) in Bahati, Uzima and Kangemi health centers in Nairobi, and Diani health centre and Kinango Hospital in Kwale County. Below is the number of samples collected and analyzed for CD4 and viral load:

CD4 Testing

Table 7-County level support for CD4 Testing, Jan-Mar, 2015

COUNTY	JAN	FEB	MAR	TOTAL
NAIROBI	1685	1608	1578	5034
MOMBASA	754	1076	954	2784
KWALE	369	147	339	855
TAITA TAVETA	123	208	87	418
LAMU	27	11	13	51
KILIFI	176	224	248	648
TOTALS	3134	3274	3219	9790

VIRAL LOAD

Table 8- County support for Viral Testing

REGION	JAN	FEB	MAR	TOTAL
NAIROBI	1397	1653	1897	4947
COAST	113	482	611	1206
TOTALS	1510	2135	2508	6153

d) ***Status of Laboratory Reagents:*** To ensure service continuity and avoid expiry of reagents in laboratory stores, the Project supported the re-distribution of 1,500 tests, **CD4% easy count** from Taveta District hospital to Mama Lucy Kibaki hospital and 100 tests CD4/CD3 from Lunga-Lunga health centre to Mathare North health centre. The Project also redistributed reagents for CD4 facscount from Kilifi hospital to Kwale hospital which had experienced a week long shortage.

The Project continued to support the CD4 testing by procuring and distributing of vacutainers to the facilities. In Taita Taveta the Project distributed 200 vacutainers per facility to Mwatate, Moi and Wundanyi hospitals.

DBS Filter papers for EID are inadequate to cover all facilities, and more viral load DBS filter papers are needed for Coast County sites.

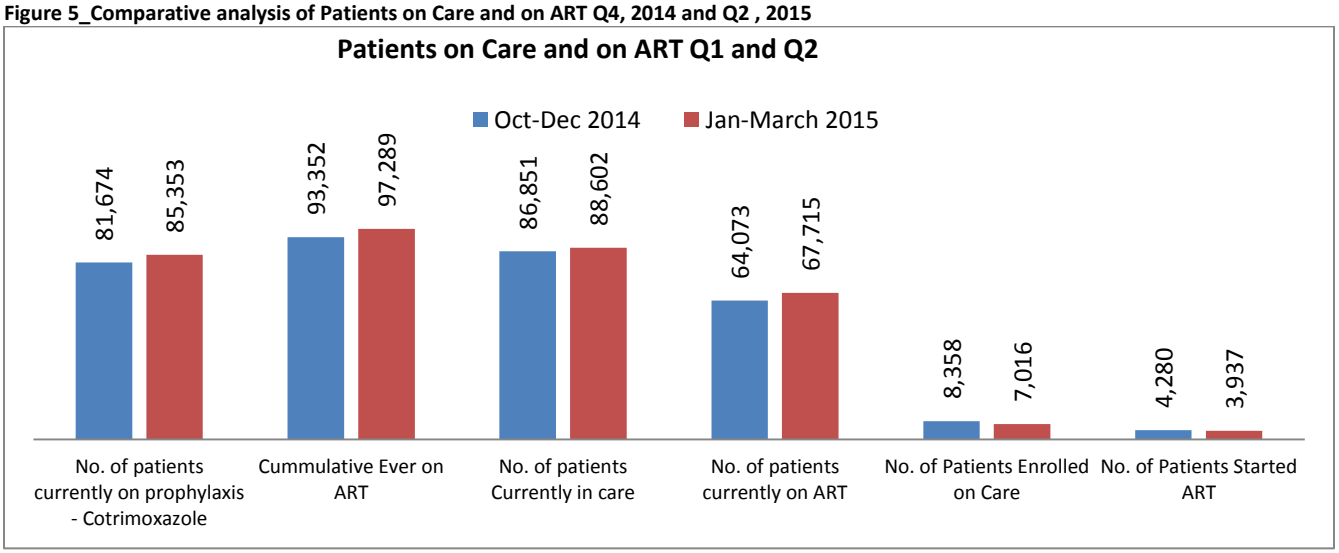
e) ***Monthly ART outreaches*****:** APHIA*plus* Nairobi-Coast continued to support ART outreaches during the quarter in hard-to-reach areas of Lamu and Taita Taveta. Fifteen (15) ART outreaches were supported reaching out to 249 clients on

care and treatment. For purposes of sustainability the management and running of outreaches were handed over to facilities within the catchment area.

f) ***Key Affected Populations (KAPs):*** The Project continued to support linkage and referrals of KAPs to Mama Lucy Kibaki hospital in Nairobi County for counselling and testing of HIV and to other service delivery points for treatment of HIV, STI and general OPD services. Further, during this reporting period a KAPs support group meeting in Nairobi County was supported with 30 participants in attendance.

g) Data

Figure 5_Comparative analysis of Patients on Care and on ART Q4, 2014 and Q2 , 2015



This quarter saw 7,016 patients enrolled on care and 3,937 initiated on ART. The number of patients who accessed treatment was 67,715, an increase of 3,642 from the previous quarter. Retention on care still remains a challenge with a noted increase of 3,679, despite enrolling 7,016. Most patients on care keep their six month appointment where they receive Cotrimoxazole and get a CD4 test since most are healthy.

The key strategy used was scheduled and focused TA based on emerging gaps in service provision as reported by HCWs and CHMT.

HIV /TB Integration

HIV infection significantly increases the risk of progression from latent to active TB. Survival is improved when ART is started early following initiation of TB therapy.

a) ***Capacity Building*****:** In Coast region, APHIA*plus* Nairobi-Coast supported one CME on Pediatric TB and Gene expert where 60 HCW attended. In Nairobi County the Project in collaboration with FUNZO Kenya trained 33 HCWs from the APHIAplus Nairobi-Coast sites; this has increased the number of HCWs with the knowledge on diagnosing and treating TB clients thus improving patient quality of life. Also trained on pediatric TB were two HIV/TB Service delivery managers and a Senior Advisor for HIV/TB.

b) ***Immediate HAART:*** APHIAplus Nairobi-Coast clinical team continued to mentor clinicians on ensuring all TB/HIV co-infected clients are initiated on HAART

c) ***TB active case finding:*** APHIA*plus* Nairobi-Coast clinical teams together with sub-county TB and Leprosy Coordinators (SCTLC) mentored high volume sites which are both tuberculosis diagnostic and treatment sites on ICF, to ensure all HIV positive clients are screened for TB on every visit and outcome documented. In coast region, mentorship on integrated services was provided in 4 facilities and use of ICF cards in the CCC was emphasized. Nine HCW were reached.

d) ***Infection Prevention:*** The Project's clinical team mentored service providers to incorporate cough etiquette education in morning health talks to ensure that clients avoid spreading TB.

e) ***Isoniazid Prophylactic Therapy (IPT)*:** There are 8 facilities[10] offering IPT in Coast region with a total of 118 clients, both PLHIV and under-5 years, exposed to smear positive TB contacts on preventive therapy. Currently IPT drugs in most facilities in Mombasa, Kwale, Taita Taveta, Kilifi and Lamu Counties are out of stock..

While Nairobi County was adequately supplied with isoniazid, there was no pyridoxine. The IPT initiation for Nairobi has therefore been put on hold until further communication from the CTLC.

f) ***TB/HIV Integration***: APHIA*plus* Nairobi Coast has been supporting TB/HIV integration at all supported facilities. Most of facilities are implementing the referral integration model.

g) **MDR TB:** Through Project Lab Networking support, APHIA*plus* Nairobi-Coast continued to support specimen transportation to testing labs for Gene xpert for TB suspects/ clients.

Facilities with clients having Drug Resistant (DR) Tuberculosis continued to receive technical assistance on management of adverse events and infection prevention for HCW and patients. The logistics involved in client sputum sample transportation remains a challenge due to lack of triple packaging materials for safe transportation.

MDR TB patients continue to be followed up at various supported facilities as follows:

Table 9- County support for MDR TB

NO	County/Facility Name	MDR Clients	Treatment Status
TAITATAVETA COUNTY			
1	Sagalla H/C	1	Ongoing
2	Marungu H/C	1	Ongoing
3	Shelemba Dispensary	1	Ongoing
KWALE COUNTY			
1	McNon Road Dispensary	1	Ongoing
2	Eshu Dispensary	1	Ongoing
3	Mamba Dispensary	1	Ongoing
4	Mazeras Dispensary	1	Died
KILIFI COUNTY			
1	Malindi Hospital	4	Continuation phase
2	Mijomboni dispensary	1	Intensive phase (newly diagnosed)
3	Mtwapa health Centre	2	Intensive phase
4	St. Luke's hospital	1	Intensive phase
MOMBASA COUNTY			
	Port Reitz Hospital	2	Ongoing
NAIROBI COUNTY			
	Kariobangi H Centre	1	Ongoing
	Kasarani H Centre	2	Ongoing
	Dandora II H Centre	2	Ongoing
LAMU COUNTY			
1	Lamu Hospital	2	One on Intensive phase, the other in Continuation Phase.

Gene xpert testing by County

[10] **Tudor DH, Likoni DH, Magongo HC, Shimo Annex HC, Bamburi HC.**

Table 10-Gene xpert testing by County

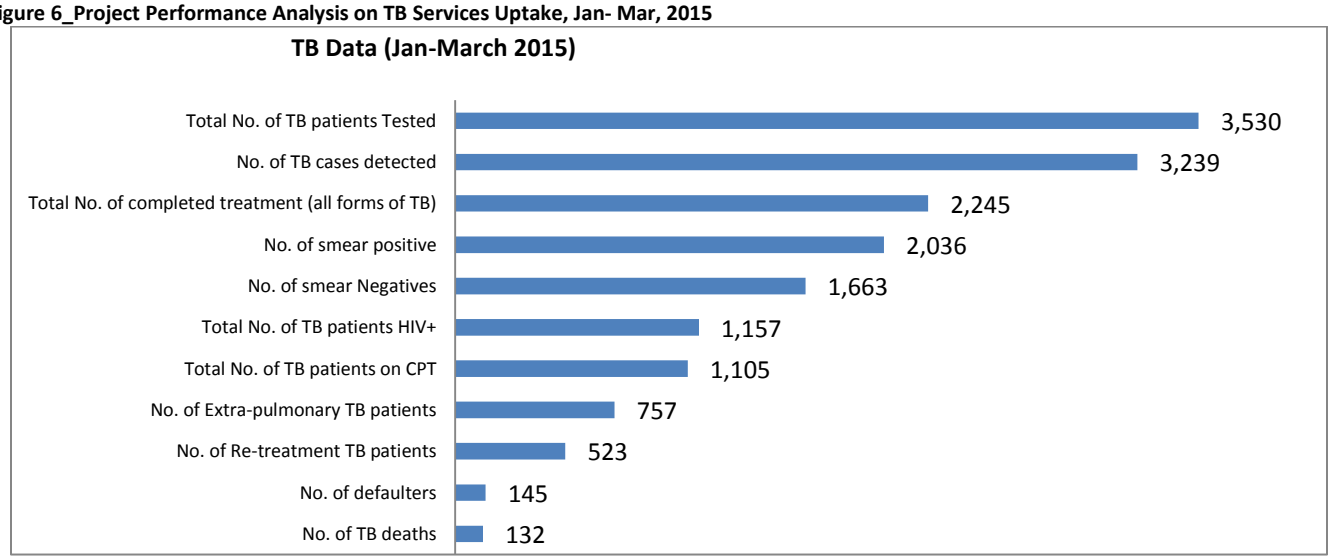
County	Testing Facility	Total tested	TB positive	Rifampicin resistance
Mombasa	CPGH	210	76	3
	Likoni	96	21	1
	Portreitz	0	0	0
Nairobi	Mbagathi	133	45	0
	Rhodes	102	50	1
Kilifi	Malindi	125	41	2
Kwale	Msambweni	144	31	0
Taita Taveta	Moi Voi	172	36	1
Lamu	Mpeketoni	202	15	0
Total		1184	315	8

h) **World TB Day:** WTB day was celebrated in both Nairobi and Coast. In Nairobi, the celebrations were held in Makadara sub-county, marked with a procession distribution of fliers on TB prevention by CHVs and HCWs to over 2,000 community members, and launch of IPT in all CCCs. The CTLC confirmed availability of commodities. In Mombasa, celebrations were conducted at Mvita grounds.

i) ***Laboratory Support:*** The Project supported Mama Lucy Kibaki hospital to equip and set up the TB laboratory. This has decongested Kayole II health center which was previously acting as referral site for sputum analysis. Due to stock out of sputum mugs in Taita/Taveta County this quarter, the Project, working together with the MoH has redistributed 5,000 sputum mugs from Langata health center in Nairobi County to Taita Taveta County at the Coast.

j) Data:

Figure 6_Project Performance Analysis on TB Services Uptake, Jan- Mar, 2015



The Project continued to prioritize TB/ HIV integration by ensuring that TB patients were being tested for HIV in the TB clinic. Out of all the 3,239 TB cases detected 1,157 (35.7%) were HIV positive and 1,105 (95.5%) were started on Cotrimoxazole prophylaxis in the TB clinic. The Project continues to support defaulter tracing.

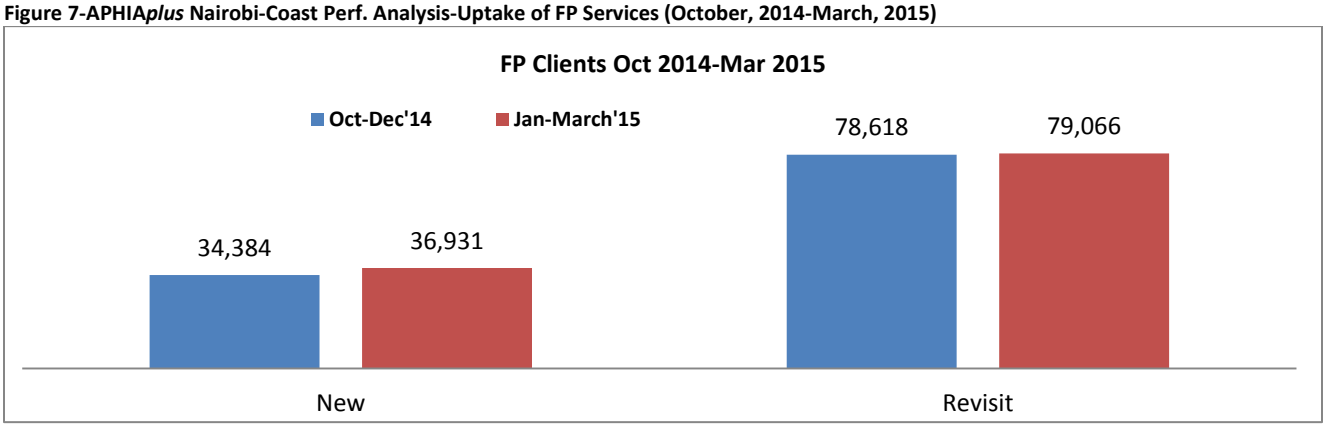
REPRODUCTIVE HEALTH, FAMILY PLANNING AND MNCH

During the period January-March 2015, APHIA*plus* Nairobi-Coast Project continued to provide targeted technical assistance in 388 supported facilities in the counties of Kilifi (108), Kwale (73), Lamu (27), Mombasa (66), Nairobi (59) and Taita – Taveta (55) to strengthen, and continuously improve delivery of quality RH/FP and MNCH services; ensuring integration of services to minimize missed opportunities. The Project continued to scale down direct support due to close out.

FAMILY PLANNING

During the quarter, 36,931 new clients were provided with family planning services compared to 34,384 in the previous quarter. Reported FP revisits were 79,066 compared to 78,618 in the previous quarter - a slight increase in the number of clients seeking contraceptive services compared to the previous Oct-Dec 2014 quarter where FP client numbers are generally low because of the festive period (see figure 1 below).

Figure 7-APHIA*plus* Nairobi-Coast Perf. Analysis-Uptake of FP Services (October, 2014-March, 2015)



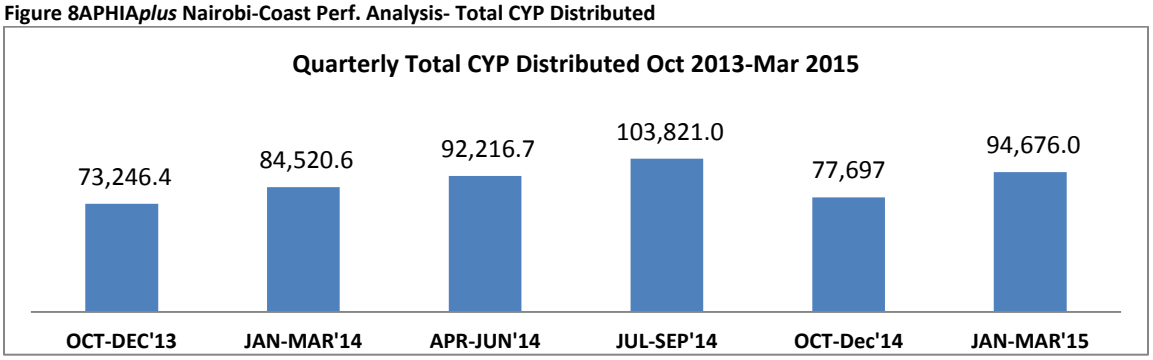
Injectable contraceptives (followed by implants, pills, condoms and IUCDs) continued to be the modern contraceptive methods of choice for most of new clients. While ensuring availability of the full range of methods, the Project continued to provide TA on counseling and informed choice so that clients voluntarily consent to use FP methods of their choice. The table below shows number of clients (new and revisits) who accessed family planning methods.

Table 11-Clients Accessing FP methods

Family Planning		New Clients	Re-visits	Total
PILLS	Microlut	1,210	1,783	2,993
	Microgynon	3,654	11,409	15,063
INJECTIONS	INJECTIONS	14,766	57,416	72,182
I.U.C.D.	Insertion	2,257	876	3,133
IMPLANTS	Insertion	9,619	2,560	12,169
STERILIZATION	B.T.L.	94	0	94
	Vasectomy	10	0	10
CONDOMS	No. of Clients Receiving	4,517	4,352	8,870
All Others: (Specify)		804	670	1,474
TOTAL NO. OF CLIENTS		36,931	79,066	115,987
REMOVALS	IUCD	511	Implants	2,394

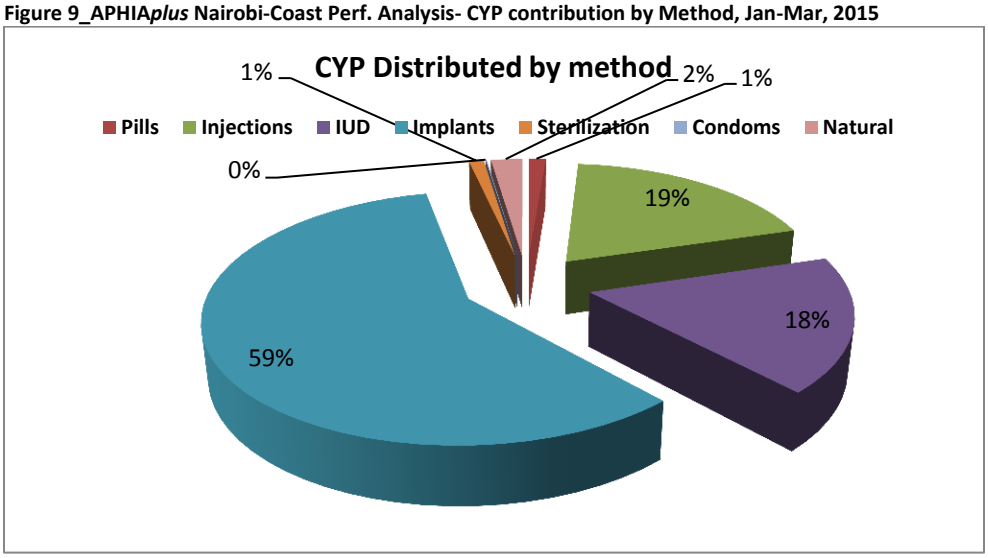
During the reporting period, contraceptive options provided to clients in Project supported sites contributed to an achievement of a CYP of 94,676; an improvement from the previous quarter's 77,697. Figure 2 shows trends in quarterly CYP achievements over time. The Project's investments in TA, focusing on long acting reversible and permanent methods of contraception has resulted to these sustained trends in CYP.

Figure 8APHIA*plus* Nairobi-Coast Perf. Analysis- Total CYP Distributed



Long acting reversible methods of contraception (Implants and IUDs) continued to contribute the most to the CYP achievements as shown in figure below. This is a commendable trend and the Project will continue providing TA to maintain this achievement while ensuring supported facilities adhere to the USG legislative and policy requirements of family planning.

Figure 9_APHIA*plus* Nairobi-Coast Perf. Analysis- CYP contribution by Method, Jan-Mar, 2015



The following activities were supported during the quarter:

a) Capacity building of service providers

Project staff continued to provide targeted capacity building through provision of TA, mentorship and on job training (OJT) to address emerging gaps identified (included FP compliance, HIV in FP integration, data use and timely commodity consumption and reporting) during support supervision, mentorship visits and quarterly providers review meetings.

During the TA sessions, the quality of counselling on the full range of family planning methods was emphasized to ensure clients make informed choices. The Project staff also reviewed with HCW on the USG legislative and policy requirements on FP.

OJT sessions focusing on long acting reversible contraception were supported in 20[11] high volume health centers. In addition, OJT on mini-laparotomy bilateral tubal ligation was supported at Mariakani sub-County hospital and Mwatate hospital in Kilifi and Taita-Taveta Counties respectively. The SCHMTs in Mombasa, Kilifi and Kwale were also supported to conduct facilitative supervision to facilities where the DPHNs sensitized health providers on Contraceptive Technologies Updates (CTU), Infection Prevention Practices (IP) and commodity reporting. To effectively support the transition from

[11] **Vipingo, Bamba, Matsangoni, Gede, Rabai, Mtwapa, Gongoni, Njukini, Challa, Mwatate, Sagalla, Ndovu, Tiwi, Diani, Shimba-Hills, Kongowea, Mlaleo, Mpeketoni, Witu, Faza.**

Implanon classic to Implanon NXT, five Nairobi based Project staff were trained through the Reproductive Health and Maternal Health Services Unit (RHMSU) in collaboration with JHPIEGO.

b) Outreaches and FP camps

During the reporting period, the Project supported 4 RH/FP outreaches/camps for provision of integrated HIV and RH/FP services which included HTC, family planning and cervical cancer screening. The following services were provided as shown in table below

Table 12_Supported Outreaches and FP camps

Health facility	Number screened for Cancer	Number given LAPM	Number done BTL
Mpeketoni Sub County Hospital	42	23	0
Lamu County Hospital	21	17	0
Mwatate SDH	45	15	6
Mariakani Hospital	92	45	7

c) Youth Friendly Services (YFS) at facility

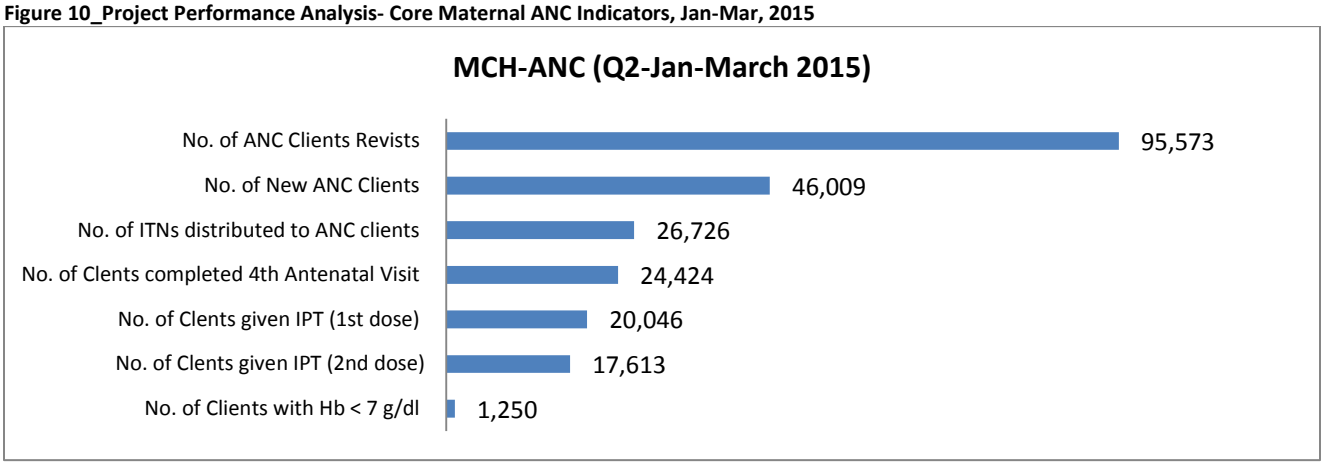
The Project continued to support provision of youth friendly services in 75 high volume facilities (Nairobi=33 and Coast=42). Targeted capacity building and technical assistance of health workers on provision of youth friendly services was provided through support supervision and regular review meetings. The project also supported in distribution of the C-word job aids to youth friendly sites and a one day refresher session for youth in Tiwi health center on contraceptives. During this quarter, APHIA*plus* Nairobi-Coast staff consolidated YFS service delivery in 40 service delivery points[12]

Emerging APHIA*plus* Nairobi-Coast led AYSRH Initiative - Using Mobile Phone Technology to Increase Uptake of YFS at Kenyatta University (KU). Development of mobile App content by KU students with APHIA*plus* Nairobi-Coast TA continued at a reduced pace this quarter due to project close-out.

MATERNAL AND NEWBORN HEALTH (MNH)

This reporting quarter, 46,009 new and 95,573 revisit ANC clients, were seen in the Project supported sites compared to 38,616 new and 85,196 revisit clients in the previous quarter. Clients who completed 4 focused ANC visits were 24,424 compared to 21,791during the Oct-Dec 2014 reporting period. Additionally, 17,613 clients received IPT 2 dose for malaria prevention as shown in graph below.

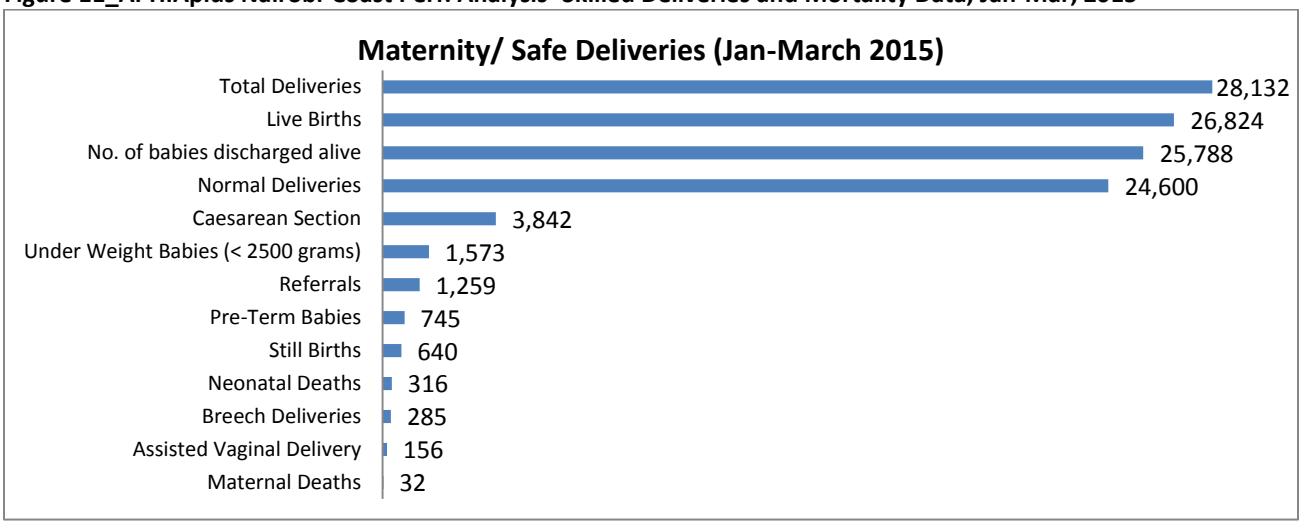
Figure 10_Project Performance Analysis- Core Maternal ANC Indicators, Jan-Mar, 2015



The Project continued to support provision of safe deliveries by skilled attendance. A total of 28,132 deliveries under skilled attendance were reported in Project supported facilities compared to 25,899 deliveries in the previous reporting period. A consistent increase in the numbers of clients seeking skilled delivery attendance has been noted since the announcement of free maternity services

[12] **YFS sites in Nairobi County: 22 public, private and FBO health facilities in 9 Nairobi sub counties. At the Coast: 18 public health facilities in 5 counties.**

Figure 11_APHIAplus Nairobi-Coast Perf. Analysis- Skilled Deliveries and Mortality Data, Jan-Mar, 2015



Highlights of key activities for the quarter were as follows:

a) Capacity Building

The Project continued to work with the sub-counties to provide targeted technical assistance and capacity building on various topics according to emerging needs. These included newborn resuscitation, management of APH and PPH, AMTSL and use of partograph. At community level, CHWs were sensitized on the importance of early ANC attendance, completion of 4 FANC visits and skilled delivery attendance so that they keep reminding and following up pregnant women.

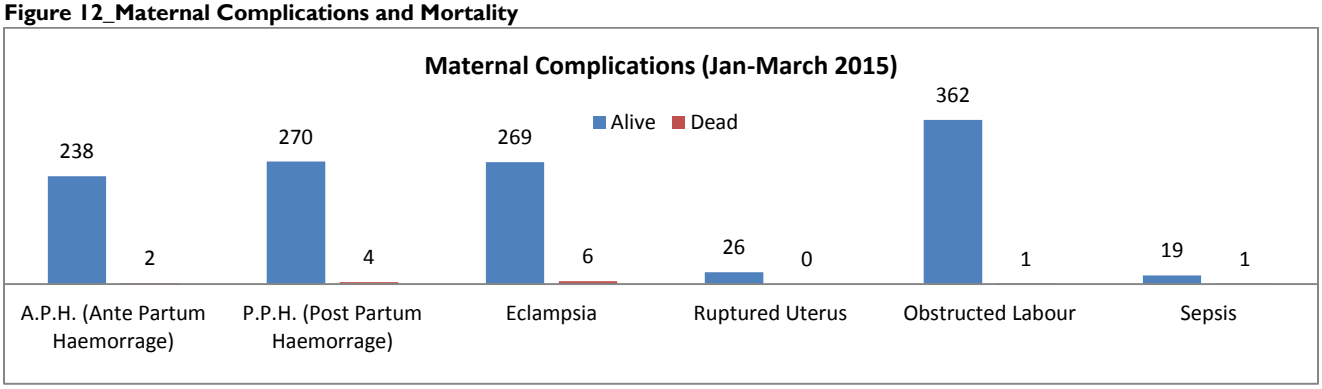
b) Emergency Obstetric and Newborn Care (EmONC)

The Project continued to provide TA and mentorship in BEmONC sites in Nairobi, Kilifi and Mombasa Counties where 51 facilities were targeted. In collaboration with FUNZO Kenya, health workers from the target facilities in Kilifi and Mombasa were trained on BEmONC. The Project also printed and distributed assorted BEmONC job-aids to supported facilities. Follow-up training, mentorship and targeted TA will continue to be supported. In Nairobi County, Project technical officers updated incoming sub-County health management team members and facility in-charges on the status of EmONC based on survey findings.. Health management teams were encouraged to lobby for availability of intravenous antibiotics in labor wards as this was found to be a glaring gap.

c) Maternal and perinatal Deaths Audits

Maternal complications during labor and delivery were as a result of obstructed labor, post-partum hemorrhage, eclampsia and ante-partum hemorrhage. Consequently, in the Project supported sites; there were 32 reported maternal deaths. The Project supported maternal death review meetings to discuss causes of mortality and develop preventive actions to minimize future mortality. The maternal death audits revealed that the commonest causes of mortality were eclampsia, post-partum hemorrhage, ante-partum hemorrhage and sepsis.

Figure 12_Maternal Complications and Mortality



CHILD HEALTH

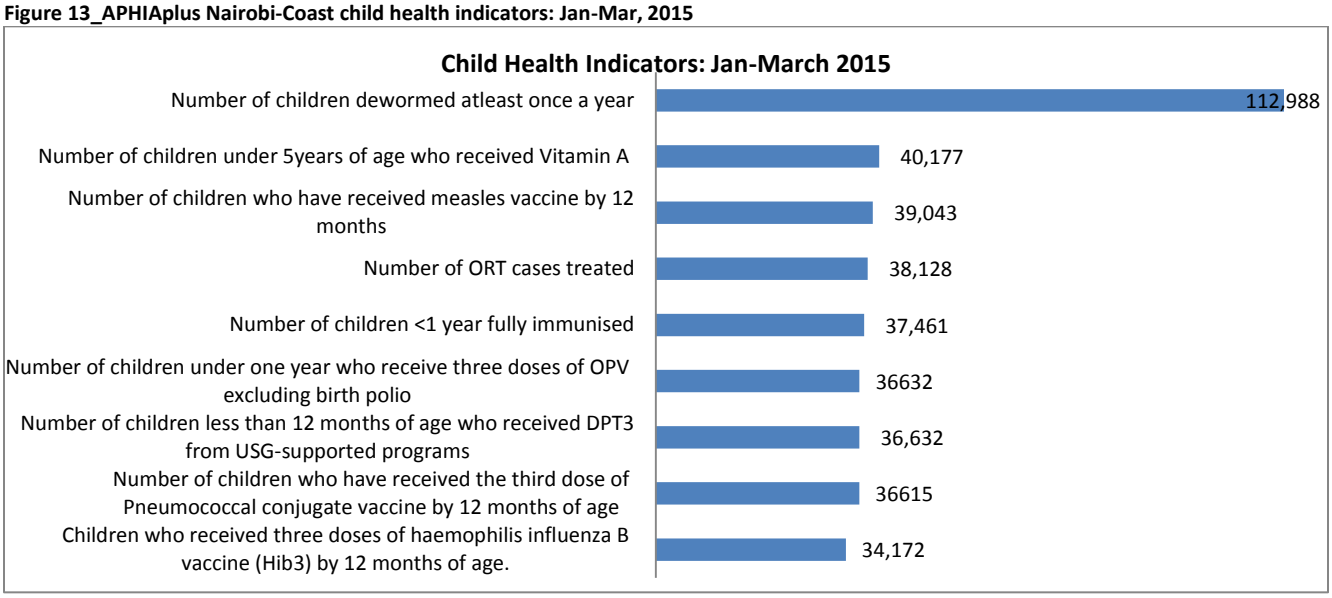
During this reporting period, the Project continued to provide TA and support to ensure that facilities reported according to national guidelines providing both curative and preventive services to children. Through the supported community units, the CHVs continued to mobilize mothers to take children to health facilities for services, and also trace and refer back immunization defaulters.

a) Immunization

During the period, the Project contributed to immunization of 36,632 children with pentavalent 3 compared to 35,283 in the previous quarter. Measles vaccinations by 1 year were administered to 39,043 children as compared to 31,236 during the last quarter. Additionally, 36,615 children were immunized with 3 doses of pneumococcal vaccine compared to 35,539 during October-December 2014 period.

Figure below captures in detail the immunization cascade and other services provided to children less than 5 years of age which presents the project's achievement for the reporting quarter.

Figure 13_APHIAplus Nairobi-Coast child health indicators: Jan-Mar, 2015



The Project provided TA, support supervision, and capacity building in target setting and documentation.

To ensure all facilities had consistent stocks of vaccines, support for re-distribution of vaccines to 11, 4 and 10 health facilities in Kilifi, Kwale, and Lamu counties were supported respectively.. The Project also supported immunization outreaches for hard-to-reach populations in Lamu County.

b) Management of diarrhoea

All supported health facilities have fully functional ORT corners that provide ORS and Zinc to children with diarrhoea. The Project provided technical assistance and reminders during support supervisory visits to ensure ORT corners continue to be functional and that all cases of diarrhoea seen and managed at the facilities were documented in the ORT register. A CME on management of diarrhoea was also supported at Moi County Referral Hospital where 55 health workers (33 female and 23 male) were reached.

c) Support for Deworming and Vitamin A supplementation; To increase survival rates and help OVC reach age appropriate milestones, 4,874 OVC [2,505 Male, 2,369 Female] were dewormed, of whom 1,631 [720 Male, 911Female] received Vitamin A supplementation from the sub-County nutritionist.

d) **Growth Monitoring**; Community based outposts aided in surveillance and identification of malnutrition among under-fives reaching 735 OVC (278 male, 457 female). In HAKI group 3 underweight cases were identified, referred to Mbagathi Hospital and enrolled into the Supplementary Feeding Program [SFP]. In Progressive Care Coalition, 50 OVC were identified, referred and enrolled for SFP to Dandora I health center. In addition, sensitizations on the effects of poor feeding were provided to the OVC caregivers to provide information on the importance of proper feeding. Facilitators used food-charts to illustrate nutrients required by the body to grow and develop. To ensure that OVC receive a balanced diet, the use of locally available and affordable food was emphasized by facilitators..

ADOLESCENTS AND YOUNG WOMEN SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (ASRH&R))

Adolescent mothers: The Project supported 13 adolescent mothers from Waithaka health center through 8 sessions facilitated by nurses and the OVC contact person. Adolescent and Sexual Reproductive Health [ASRH] manual, JOL and TOL models were used for psychosocial support to help them cope with early age motherhood issues. Topics covered included; Nutrition, Reproductive Health and Family Planning, Gender Based Violence and Economic empowerment to enable them continue accessing affordable credit among them. Outcomes of this activity included mothers reporting uptake of modern contraceptive methods and engaging in Voluntary Savings & Loan [VS&L] and Income Generating Activities [IGAs] leading to improved livelihoods.

NUTRITION

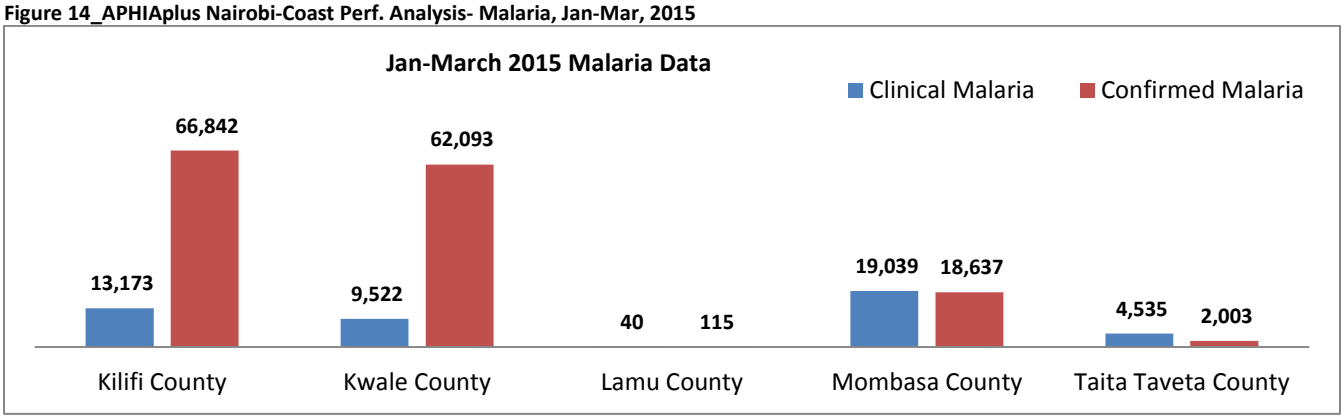
During the period under review, the Project continued to provide TA on nutritional assessment counselling and support (NACS for children and TB/HIV infected clients) to ensure early diagnosis, management and strengthened linkages to FBP and other nutritional support programs both at community and facility level. The Project also supported re-distribution of nutrition commodities, IFAS job aids and tablets.

MALARIA

The Project continued to provide targeted TA especially in prevention of malaria in pregnancy. Commodity redistribution was also supported to avoid stock-outs of nets, AL and RDTs. At the Coastal counties, ANC clients continue to receive IPT1 and 2 for prevention of malaria in pregnancy. Twenty thousand and forty six (20,046) and 17,613 clients received IPT 1 and 2 respectively. In addition, 26,726 pregnant women and 41,211 children under 5 years were provided long lasting insecticide treated nets.

The trends for confirmed cases of malaria have continued to increase; more malaria cases were reported in Kilifi, Kwale and Mombasa counties as shown in figure below.

Figure 14_APHIAplus Nairobi-Coast Perf. Analysis- Malaria, Jan-Mar, 2015



3.2: INCREASED DEMAND FOR AN INTEGRATED PACKAGE OF QUALITY HIGH-IMPACT INTERVENTIONS AT COMMUNITY AND HEALTH FACILITY LEVELS.

The Project continued to support demand creation for Youth Friendly Services (YFS) in 9 select health facilities (Mlaleo, CDF, Shimo La Tewa Health Clinic, Portreiz Hospital, Mtwapa Health Centre, Rabai Hospital, Tiwi Health Centre, Magondzoni Health Centre, Sagalla Health Centre and Njukini health Centre). Youth CBOs continued to conduct Shuga screenings and conduct Small Group Communication (SGCs) sessions within and around these facilities. They addressed Sexual and Reproductive Health (SRH) issues and made referrals to the sites. They also manned youth desks and in some cases, Youth Resources Centre's (YRC's) based in the facilities. At the youth desks and YRCs, they received referrals, they reached the youth visiting the facility with SRH information, they offered peer counseling, distributed IEC materials and condoms and also escorted youth to SRH service points. All these efforts resulted in increased uptake of SRH services among youth, HTC services and condoms. In total, 200,000 condoms were distributed at the youth desks or YRCs and during Shuga sessions. In Nairobi, the youth desks at Dandora II, Kangemi, Kasarani and Mukuru Rueben health centers continue to create avenue for services access to young people. A total of **2,311** young people (333 males and 1,978 females) accessed various services offered at the facilities including family planning, VMMC, HTC, ANC, IEC materials and condoms.

PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT)

Photo: 1-PMTCT Support group meeting

Mentor mothers retained by the Project conducted sessions to educate and support HIV-positive pregnant women and mothers in PMTCT programs through individual, couple, and group sessions. Four (4) PMTCT support groups were supported in Kilifi County through provision of technical support on support group guidelines given during the sessions. As a result of the KMMP interventions, Kilifi County Hospital is expecting to graduate 91 HEIs in April 2015 up from 68 in the previous year.

Psychosocial support and topical updates for support groups:

Photo: 2-Adu Discordant Support Group members shares a meal during their monthly meeting

The Project continued to provide TA to targeted support groups in line with the national draft support guidelines. A total of 92 support groups were provided with mentorship sessions during monthly visits. Areas covered during mentorship sessions included the role of support groups, stages of group development, leadership in support groups, conflict resolution, mobilization, monitoring & evaluation, resource (IGAs)/economic strengthening and income generating activities populations of PLHIV. The PLHIV management of specific facilities/HCBC desks also provided advocates attached to health the facility and community levels. prevention messages both at support groups focused on how to Technical assistance for activities, and linkages with relevant government agencies to enable them access quality sustain their livelihood assistance after the exit of the APHIA*plus* Nairobi-Coast program. PW advocates' meeting in Taita Taveta County sensitized support groups on their role in supporting of PHDP. Sharing of data on the number of clients who had defaulted was also discussed and members were able to account for 16 of 17 clients.

mHealth

Reports continue to be submitted and CHEWs are using the same for decision making purposes after funding for Mhealth activities ended last quarter. TA was provided to CHEWs and CHVs as needed by project staff.

HIV CARE AND TREATMENT

Client retention

The introduction of the new ART guidelines has led to an increase in the number of clients initiated on treatment. Efforts on client retention have been intensified to ensure reduction in the number of defaulters. During the quarter, in Nairobi County, 172 people (34 male and 138 female) were trained on treatment literacy. A further 455 attended the 62 mini-group adherence sessions aimed at reducing the number of ART defaulters. In Nairobi, Positive Youth Initiative (PYI) through the Movement of Men against AIDS in Kenya (MMAAK) managed to conduct four peer support group sessions for youths and men infected and affected with HIV and AIDS. In total, 20 YLHIV and 36 MLHIV were reached with sessions to empower them to live positively, prevent HIV transmission/re-infection and encourage disclosure.

The Kenya Network of Women with AIDS (KENWA), Little Sisters of St. Francis and Redeemed Gospel Church Development Program, conducted PWP sessions through their support groups. Collectively these organizations reached 437 people (348 female and 89 male) with sessions on disclosure, condom use and partner testing. Little Sisters of St Francis conducted a HTC outreach in Marurui and Njathaini (Nairobi) where 200 people were counseled and tested, 15 tested HIV positive, and 15 were enrolled for support group and referred to the CCC.

Defaulter Tracing

To enhance client/patient retention, the Project continued to address client factors (i.e. client knowledge, attitude and practice, adherence, partner testing and disclosure, life style, stigma, dependency, socio-demographic information and psychological status); community factors (i.e cultural, religious beliefs and attitudes, community structures and social political issues) and geo physical factors (i.e. distance to point of service, decentralization of services and

infrastructure)/client retention. Technical support to facility and community staff comprised TA on maintaining an appointment diary/daily register, transferring of missed appointments, phone calls, categorization, physical tracing were done. Provision of airtime for phone calls for missed appointments and review sessions on defaulter tracing outcomes with health facility staff were supported. In Kilifi County, 10 high volume facilities were supported with airtime for defaulter tracing. As a result, 22 males and 73 females were traced back to care.

Frontline SMS has been replicated in additional facilities especially in Kwale and Mombasa Counties with Port Reitz, Tudor, Kwale, Magodzoni and Tiwi health facilities benefitting from installations. The service provides personalized client services leading to improved quality of care for CCC clients and thus improved retention.

3.1.3: SUPPORT TO COMMUNITY STRATEGY

Community units have been conducting meetings and dialogues to promote ANC, MNCH, skilled birth attendance and demand creation for services at the facility. Formation and support of 15[13] facility based CHW desks at various facilities has played a key role especially on referrals, linkage and defaulter tracing. Facility based CHVS (community desk and CHVs assisting at the CCCs) were paid monthly allowances and supported to trace defaulters; 38 CHVs from 15 facilities benefited.

CHVs and CHAS feedback meetings: CHVs and CHAs continued to hold monthly meetings to share reports and work plans, best practices and challenges. A total of 3,424 CHVS (1,377 men and 2,047 women) attended the monthly sessions in 82 community units. Through capacity building, the 82 CHVs groups have organize themselves and registered as CBOs with operational bank accounts. CHV CBOs have embraced resource mobilization which has led to success of 55 CUs who have been funded for different projects while 25 CBOs have submitted their proposals for funding to development partners and are awaiting feedback.

3.3: INCREASED ADOPTION OF HEALTHY BEHAVIOR

During regular household visits, CHWs continued to sensitize OVC and their caregivers on sound hygiene and health practices, such as water treatment, hand washing with soap, use of pit latrines, and clearing of bushes to reduce breeding of mosquitos. The 350 (201 female, 149 male) OVC trained in previous quarter on behavior change and communication, Evidence Based Behavioral Interventions (EBIs) which included Shuga screenings, Healthy Choices II and Family Matters! Program continued to make healthy and informed choices with regard to their sexuality. In addition, the 30 caregivers previously trained on Family Matters! (a program which helps parents to communicate with their children on behavior change issues), continued to cascade the acquired skills to other caregivers.

3.3. 1 In and Out of School Youth

Healthy Choices II (HC II) for a Better Future

The Project continued with implementation of Healthy Choices II for a Better Future and reached 664 (329 male, 335 female) youth aged between 13 and 17 years. This EBI's goal is to prevent pregnancy, STIs & HIV among adolescents by adopting safer behaviors. HC II aims to delay sexual debut, promote secondary abstinence or practice safer sex by providing knowledge and skills on correct and consistence condom use, how to handle peer pressure and encourage knowledge of one's HIV status. The program was implemented in Kilifi and Mombasa Counties.

In Nairobi County, HCII facilitators mobilized and recruited participants from the community and informal schools within three sub-counties namely; Kasarani, Makadara and Embakasi. They were taken through the eight modules of the intervention, and awarded certificates upon completion. The activity helped to increase knowledge and skills of the adolescents to make healthy sexual decisions and avoid risky sexual behavior; reaching 1,088 (470 male, 618 female) adolescents.

Photo: 4-HC II session in progress

Photo: 4-HC II certification and graduation ceremony

Families Matter! Program (FMP)

The Families Matter! Program (FMP) was implemented in Nairobi, Mombasa and Kilifi Counties reaching 1,564 (380 male, 1, 184 female)

Kangemi, Kasarani, Kariobangi, Mathare

parents or caregivers of 9-12 year old pre-adolescents. FMP is evidence based behavioral intervention that promotes positive parenting and effective parent-child communication. The goal of the program is to reduce sexual risk behavior among adolescents, delay the onset of sexual debut and equip parents or care givers to be their children's sex educator. During the sessions, parents or caregivers learned about adolescent sexual risk behavior and its consequences as well as the importance of shaping their children's values and beliefs. They also had a session in which they practiced talking about sex with their pre-adolescents children in a bid to demystify myths and misconceptions. The parents and guardians who attended the sessions were given information and equipped with tools to deliver primary prevention to their children to help them reduce sexual risk behaviors, including delaying sexual debut among the adolescents. Among the tools they were equipped with include; parenting skills, parental monitoring, positive reinforcement and effective communication.

Shuga screening and small group sessions

During the quarter, the Shuga movie was screened and small group communication sessions conducted reaching 2,214(1,173 male, 1,041 female) youth ages 15 to 24 years in Coast region. Topics covered included correct and consistent condom use, multiple concurrent partnerships, risk perception, transactional sex, stigma and discrimination, gender based violence, parent-child communication and alcohol use and abuse. Sessions were facilitated by youth peer educators and were carried out in the community and in facility based Youth Resource Centers. In Nairobi, out of the 398 (186 male, 212 female) young people reached during the quarter, 128 of them underwent counselling and testing, while 28 were referred for RH/FP services.

Photo: 5-FMP session in progress

3.4 INTERVENTIONS WITH KEY POPULATIONS

APHIA*plus* Nairobi-Coast continued to support Local Implementing Partners (LIPs) and CBOs through Pathfinder Implemented Projects (PIPs) to carry out activities aimed at increasing access to quality health services, products and information by the Key Populations in Nairobi, Mombasa, Kilifi, Kwale and Lamu counties. The Project provides services to key populations using the combination prevention model focusing on providing bio-medical, behavioral and structural intervention at the individual, community and society levels. Only six DISCs were supported in Mombasa, Kwale and Kilifi counties due to limited funds.

3.4. 1 Female Sex Workers (FSW)

During the quarter, the Project worked with 30 FSW peer educators and reached total 671 FSW with individual and small group level sessions. A total of 554 FSW accessed HTC services in the 2 supported DISCs. A total of 60 were new testers and 20 who tested HIV positive were linked to care and treatment. A total of 34 accessed cervical cancers screening and 72 accessed various FP services in the drop in service centers. A total of 42 FSW and clients and their clients accessed STI screening and treatment.

Men who have sex with Men and Male Sex Workers (MSM/MSW)

During the January-March 2015 quarter, 456 MSM were reached with individual and small group level sessions. A total of 158 MSM accessed HTC services, 14 were new testers and one tested HIV positive. A total of 8,342 water based lubricants were distributed to MSM during sessions.

People Who Inject Drugs - PWID's & People Who Use Drugs - PWUD's

A total of 647 PWUD (534 male and 113female) and 450 PWID (392 male and 58 female) were reached with behavioral or harm reduction messages and information during the quarter. A total of 731 PWU/ID accessed HTC and 30 who tested HIV positive were linked to treatment. As of February 28th 2015, 1,164 PWID (915 male and 249 female) continued to be beneficiaries of the NSEP program. During the quarter, 27 PWID accessed STI treatment, 26 befitted from nutrition support and 15 screened for hepatitis. The table below is a summary of harm reduction commodities distributed to the key population through peer educators, outreach workers and DISCs during the quarter

Table 13_No. harm reduction commodities distributed to the key population through peer educators, outreach workers and DISCs during the quarter

	Commodity	Quantity
1.	Male Condoms	683, 778
2.	Female condoms	8, 370
3.	Water-based Lubricants	760
4.	Alcohol patches	129,678
5.	IEC Materials	247
6.	Distilled water vials	129,678
7.	Bleach packets	151,146
8.	Cotton sachets	141, 038

Other Structural Interventions for Key Populations

a. Supervision of Peer Education activities

As part of quality assurance, peer educators conducted 12 monthly meetings for feedback and topical updates - held by the 5 CBOs in January and February 2015. During the quarter, CBO coordinators made a total of 20 visits in their respective CBOs to monitor peer educators' working in the community. APHIA*plus* Nairobi-Coast staff made 5 supervision visits to peer educators in the community and DISCs.

b. Support Groups

The Support groups formed earlier by SW and MSM Peer Educators continued to meet in the reporting period. No treatment default was reported among members of these support groups during the quarter.

c. Support Supervision/Mentorship Visits/Technical Assistance to LIPs and MoH

In the period under review, the Key Population department collaborated with their Service Delivery counterparts to conduct support supervision in several health facilities in Kwale, Mombasa and Lamu counties.

The facilities visited included Bokole CDF, Port Ritz, Mbuta Model and Shimo Annex in Mombasa County; Mpeketoni, Pablo Horstman, Mokowe, King Fahd and Hindi in Lamu County; and, Ukunda Dispensary, Tiwi and Magodzoni in Kwale County. Visits were made to ensure that service provision to the general population, youth and key populations were aligned to national guidelines.

RESULT 4.0 – SOCIAL DETERMINANTS OF HEALTH ADDRESSED TO IMPROVE THE WELL-BEING OF TARGETED COMMUNITIES AND POPULATIONS

4.1 Marginalized, poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs.

4.1.1 Voluntary savings and loans (VS&L) and SILC

During the reporting period, Community Based Trainers (CBTs) continued to supervise 545 VS/L/SILC groups with 8,695 (1,739 male, 6, 956 female) OVC caregivers through regular monthly forums. The caregivers in VSL/SILC groups managed to cumulatively save Kshs. **12,365,209** and borrowed Kshs **20,286,056**. VS&L and SILC methodologies provide simple savings and loan facilities to caregivers who are not able to access formal financial services. Social funds accumulated help members to meet emergency needs and act as a safety net for their households.

Table 14-VSL/SILC Quarterly Summary

Cluster	Total membership	No of groups	Cumulative savings (Kshs)	Cumulative value of loans (Kshs)
Lamu	324	25	447400	651200
Kaloleni	543	28	124835	133420
Mombasa	1021	102	840,009	1,762,953
Taita Taveta	1090	61	1,732,250	2,563,212
Upper Kilifi	1492	89	855,081	1,057883
Lower Kilifi	2136	129	1043618	942784
Malindi	1563	61	2411323	2,611,341
Kwale	526	50	657243	785037
Nairobi	4692	263	4,253,450	9,778,226
TOTAL	**13,387**	**808**	**12,365,209**	**20,286,056**

In this reporting period, the Project was not able to support additional caregivers IGAs due to budgetary constraints. However, 960 OVC households previously supported to expand their IGAs continued to benefit and have reported improved business performance and increased income. Some of the key IGAs supported by the project included livestock rearing (goat keeping, poultry), crop farming (vegetables, maize and beans) cooked food vending in the villages, fruit vending, soap making, tailoring and dressmaking. Other IGAs include roadside kiosks, sale of second-hand clothing, charcoal selling, and grocery Banda's amongst others.

During the quarter, 263 groups comprised of 4,692 caregivers in Nairobi County continued to circulate money from cumulative savings of Kshs. 9,778,226. Loans awarded to members supported basic needs for their children such as nutritional support, payment of school fees and levies and provisions for scholastic materials, thus ensuring consistent school attendance and house rent among others. In total, 27,188 children [13,428 Male, 13760Female] benefited from this scheme.. A total of 7 OVC living with epilepsy benefited through loans acquired from VS&L. Caregivers have been able to strengthen and/or initiate IGAs using the loans awarded, changing the status of their households. Members have even secured property through VS&L; for instance one group of caregivers of children with disability from Dandora purchased 5kg gas cookers for 5 members after sharing savings at the end of the cycle in the month of January 2015 a caregiver shared the following during a meeting: *"Cooking meals takes me a very short time with gas compared to charcoal. I prepare food in time for my family and manage to be punctual for the VS&L and support group meetings.''* .

4.1.2 Aflatoun

Through AFLATOUN clubs, children are empowered to make informed decisions on how to spend money, prepare their own plans, budgeting, execute the plans and evaluate their performance. The Project continued to provide technical support to 14 primary schools previously trained on Aflatoun methodology. This has adequately equipped the children with saving skills and enabled them to make informed choices and responsible use of resources.

To build sustainable structures for AFLATOUN clubs a review meeting was held with the patrons of 25 clubs. They resolved to have a uniform ways of training children on social, financial and entrepreneurial skills, their rights and responsibilities and assisting them initiate and manage these clubs. The patrons agreed that the Rights of the Child and health clubs would be merged together to operate under AFLATOUN as most of their activities cut across. The team also took time to plan for the Educational tour that took place on 6th Feb 2015 at Nairobi National park with 30 pupils and 3 patrons participating. The objective of the tour was to motivate the club members, create an environment for them to interact and share as well enabling them to appreciate the conservation efforts carried out by the wild life department. The club membership stands at 480 pupils who continue recruiting and planning the year's activities.

4.2 Improved Food Security and Nutrition for Marginalized, Poor and Underserved Populations

4.2.1 Caregivers' sensitization on good nutrition

During the monthly meetings for caregivers such as support groups, parents clubs, VS&L/SILC groups and community barazas, caregivers were sensitized on good nutrition, proper farming methods and proper storage. Moreover, CHVs

continued to sensitize caregivers during regular household visits. Caregivers are equipped with knowledge on nutrition education, utilization of traditional high value foods, planting drought resistance crops, kitchen gardening, proper storage, preparation and use of modern farming methods to improve productivity and increase yields.

4.2.2 Improved food security for OVC households

In collaboration with MOALF, OVC caregivers continued to practice group farming using water collected in water pans, kitchen gardening and gunny sacks. Through planting drought resistant crops such as millet, maize, green grams, cassava and cowpeas, caregivers were able to maintain food banks which they have been using during the drought season. The county governments in coast region have been emphasizing to the communities on expanding coconut farming which has high commercial value for its products and by products.

OVC caregivers in 15 LIPs who previously received Uwezo and TOWA funds have continued to benefit from livelihood activities they had started such as group farming, fish farming and livestock keeping. Through this support, 1,400 OVC caregivers are able to provide nutritional and well-balanced diet to their children. It has resulted in improved OVC health status, reduced risk of malnutrition, improved school attendance and performance. A total of 41,822 OVC (21,137 male, 20,685 female) OVC were reached with nutritional support services during this reporting period. Seven households at Children Hope Foundation [CHF] have continued to practice gunny bag farming, 10 have kitchen gardens that provide for nutritional supplementation and in Kibera 65 households have established gunny sack gardening after demonstrations on how to grow vegetables on a small space created within the slum set up. This has enabled the caregivers supplement food to more than 260 OVC. Additionally, in MOCASO, 93 OVC benefitted through supplementation of nutritional support from gunny sack produce.

Through networking, three[14] LIPs carried out greenhouse farming. Two additional green houses were donated by Amiran Organization to Joshua Orbit International [JOI] and St. Francis. At JOI, 453 OVC benefited from a hot meal with vegetables from the green house and created employment for four caregivers. At St. Francis, the produce was sold generating Kshs. 150,000 which in turn supported 200 OVC (100 in the support group with treatment costs, 100 with emergency needs such as payment of school levies).

Through leveraging, LIPs distributed food to OVC caregivers; 324 beneficiaries from UZIMA and LCPC received direct food support that included some maize flour, rice and cooking oil. MIP supported 3,000 Vulnerable children from 4 schools, with a mid -morning snack supplied by Proctor and Allan Company. As a result of this private sector nutritional support, children remain alert in class and participate in play according to an ECD teacher from St. Catherine center.

Contact farmer's feedback meeting-

During the quarter, contact farmers continued to hold dialogue sessions with their respective farmers groups to share topical updates and address issues affecting them. Farmers were able to discuss experiences and were able to sensitize members on culture of saving by recruiting them in SILC Groups. A total of 18 Contact farmers' feedback meetings were held, with a total of 2,503 farmers (1,238 Male, 1,265 Female) from 973 farmers groups attended the meeting. Contact farmers reported to have reached to 33,567 group members (13,429 Male, 20,138 Female) with messages on food production. Contact farmers continued to sensitize and mobilize members to register as members of 16 formed cooperative societies. This resulted in registration of 4,629 community members whose composition includes CHWs, contact farmers, members of producer organization, PLHIV support group members, OVC care givers and youth group members. County agricultural officers used this platform to sensitize and encourage farmers to prepare their farms as they waited for the long rains and to use certified seeds and fertilizer for maximum output.

4.3 Marginalized, poor and underserved groups have increased access to education, life skills, and literacy initiatives through coordination and integration with education programs

4.3.1 Education support

A total of 50,070 OVC (25,436 male, 24,634female) OVC were supported to access education services. The project supported 636 OVC with school uniforms based on a needs assessment. Through leveraging the Conrad N. Hilton grant and other partners 2,026 OVC at ECD level were supported with TOM's shoes. CHVs continued to conduct regular follow ups in schools to monitor their children's progress. Through households' visits, child right clubs and caregivers meetings, CHVs and education officers sensitized caregivers of both primary and secondary candidates on career choices. Forty OVC from Grace

[14] **Joshua Orbit International , NOFI, ST. Francis**

Care group schooling at Kifaru primary School, in Nairobi, benefited from a hot meal during school days supplemented with green vegetables from the school garden. Further, 14 needy OVC took home vegetables for supplementation of weekend meals. To ensure transition of OVC from primary to secondary schools, 450 caregivers were sensitized on available opportunities. With respect to education, 238 OVC benefited from secondary school support from individuals, foundations and institutions.[15] The OVC are now enrolled in secondary schools and are attending lessons without interruptions.

Through leveraging support from other ChildFund initiatives specifically - Mukuru Integrated Program [MIP] and Nairobi Integrated Program [NIP] school levies for ECD centers and primary attendees were paid for 1,575 OVC ; as well as fees and exam registration for 56 OVC in form four. This has enhanced student school attendance, retention and competition.

4.3.2 Sensitizations on available opportunities for secondary /vocational OVC bursaries and scholarships

Photo: 6-Sensitizations on available opportunities for secondary

Through monthly feedback meetings and community barazas, 1,342 (536 male, 806 female) caregivers were sensitized on available bursary and scholarships opportunities for their children to ensure enrollment, retention, progress and completion of education. Through linkages 721(288 male, 433 female) OVC were supported by county government bursaries and private partners' scholarships such as Equity bank, Kenya Commercial Bank, Jomo Kenyatta Foundation and Kengen to access education.

4.3.3 Child friendly schools

Children have been empowered to advocate for their rights in schools through 340 child rights clubs previously formed. Feedback from club patrons, teachers and parents indicated improved discipline among the children, increased participation in school activities and positive behavior change. During club debate sessions, children acquire various skills such as leadership, informed decision making, critical thinking and advocacy for their rights.

Advocacy and sensitization of OVC on child rights and protection; Community Health Workers [CHWs] sensitized caregivers on child rights and Gender Based Violence [GBV] issues during home visits. Mukuru Ruben Centre carried out a paralegal training for 9 CHW's in collaboration with Wangu Kanja Foundation, and reached 999 OVC with messages on child rights and GBV. In Makadara 5,565 children were sensitized on child rights and responsibilities. Topics discussed include; child abuse, sexual abuse, child exploitation, child neglect, drug trafficking and substance abuse. Children are more aware of their rights and responsibilities.

Birth Certificates:

APHIA*plus* Nairobi-Coast, in collaboration with the Department of Civil Registration and LIPs assisted 146 OVC acquire birth certificates required to register for national exams.

4.3.4 Social Protection

Link OVC/children with disability to government cash transfer programs

Photo: 7-Disability assessment at PCC

The Project in collaboration with Mama Lucy Kibaki Hospital conducted disability assessments for 19 OVC [9 Male, 10 Female] at Progressive Care Coalition. The process to register them at the National Council for Persons with Disability [NCPWD] is ongoing. Through the Cash Transfer [CT] program, 97 [69 Male, 28 Female] OVC from CII, Deep Sea, Mitumba and MOCASO were enrolled. This has helped caregivers meet some daily needs OVC needs such as education, medication, food and nutrition.

[15] *Wings to Fly, Kenya Commercial Bank, Family Bank, Cooperative Bank, Nairobi Chapel Church and individual sponsors, CDF ,JKF Hope World Wide, OVC CT, Micato Safaris, ST. Mary's Viwandani*

Health insurance; Mukuru Integrated Program has initiated a medical scheme accessed through medical cards provided to 1,831 OVC to receive treatment for minor ailments and immunization services at St. Mary Immaculate Clinic. Through this health care service, the OVC have safety nets in event of illness allowing caregivers to focus on other basic needs.

Support targeted OVC with PSS

CHWs continued to carry out visits to OVC households using the Essential Package Cards [EPC] (leveraged from CHNF), JOL and TOL skills. A total of 76, 926 OVC [38,012Male, 38,914Female] were reached with this service during the quarter.

Support Coordinators meetings

APHIA*plus* Nairobi-Coast held 10 meetings to review the general performance of LIPs. Key strategies identified for sustainability to support OVC were; VS&L, IGAs, linkages, CHW groups for cohesiveness at the LIPs and utilization of OLMIS system for quality data, among others. Challenges discussed included; CHW drop out, uncooperative caregivers due to lack of direct provisions and vocational support for those who did not transition to secondary schools. LIPS were encouraged to continue leveraging OVC support and sensitized on available opportunities.

4.4: Increased Access to Safe Water, Sanitation and Improved Hygiene

The 105 schools previously supported with water tanks, have continued to access safe drinking water and to benefit from good sanitation. In addition, 87 primary schools that were separately supported with hand washing vessels in the previous period, reported improved hygiene. CHVs continued to sensitize caregivers on the importance of using treated water and locally available methods of water treatment such as boiling.

Sensitization of Girls on Menstrual management and provision of sanitary towels; in collaboration with LIPs, the Project supported sensitizations of 2,701 adolescent girls (aged 13-18 years) on menstrual management. Topics covered included; phases of the menstrual cycle, sanitary towel use and disposal as well as personal hygiene during menses. HAKI group, Kivuli, St. Johns' community center and Waithaka HC supported a total of 1,257 girls with sanitary towels. The girls expressed gratitude for continued support which enabled regular school attendance, concentration in class during their menses and personal hygiene.

4.5 Strengthened Systems, Structures and Services for Protection of Marginalized, Poor and Underserved Populations

4.5.1 Training on Journey of life and Tree of Life

In this reporting period, the Project supported Local Implementing Partners [LIPs] and Ministry Of Health [MOH] nurses to facilitate 60 sessions comprising of 1761 (728 Male, 1033 Female) children in Nairobi. Using Journey Of Life [JOL] and Tree Of Life [TOL] models as well as Prevention with Positives [PwP] manual, age-appropriate topics were discussed which included; drug adherence, HIV reinfection, nutrition, opportunistic infection, peer pressure, personal hygiene, sexuality, stigma and discrimination. As a result, caregivers noted that OVC adhered to drugs and have improved interpersonal skills. Additionally, the facilitators reported positive attitudes among the children, increased self-worth and motivation to succeed in life due to the influence of their peers who also attended the sessions.

During the same reporting period, 11 OVC contact persons were trained on the Tree of Life in Taita Taveta County. This was in addition to the 112 contact persons previously trained. This tool has been used by contact persons and CHVs during psychosocial counseling sessions and it helps children to open up spaces and opportunities to tell, hear, and explore stories of hope, shared values, connections to those around them and those who are not (e.g. through death) but have made a contribution to their lives. Children targeted by the Tree of life tool include, child right clubs, those affected by conflict, HIV/AIDS, extreme poverty and other types of vulnerabilities. A total 67,550 OVC (34,090 male, 33,460 female) were reached with psychosocial support services during the January –March 2015 quarter.

4.5.2 Capacity Building

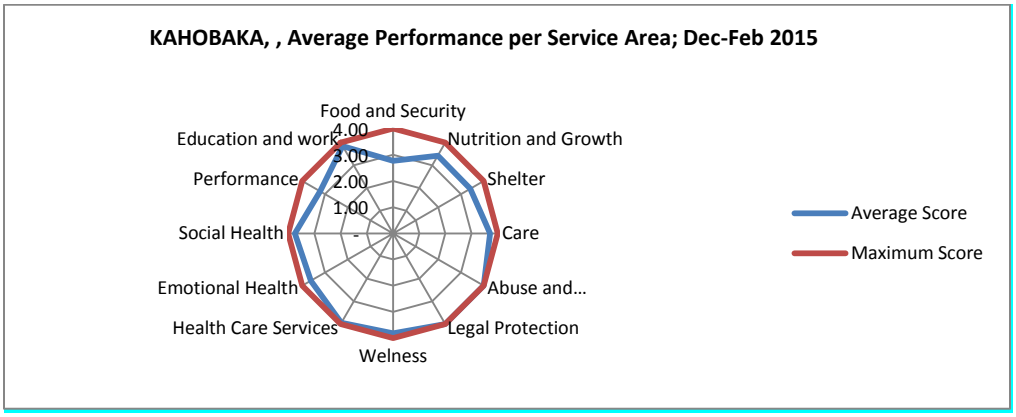
The Project provided continuous technical support in OVC documentation, OLMIS data entry, data collection, report writing and resource mobilization skills to 123 LIPs serving OVC in Coast region. CHVs and OVC contact persons were supported to conduct monthly feedback meetings during the reporting period. 11 LIP contact persons in Taita Taveta County were trained on the Tree of Life tool to equip them with knowledge on how to address children's psychosocial needs.

Vocational Skills training and start up kits. Leveraging from other partners, Joshua Orbit international and Equity bank trained ten OVC in baking and supported them with bakery equipment. They are now self-employed and market their

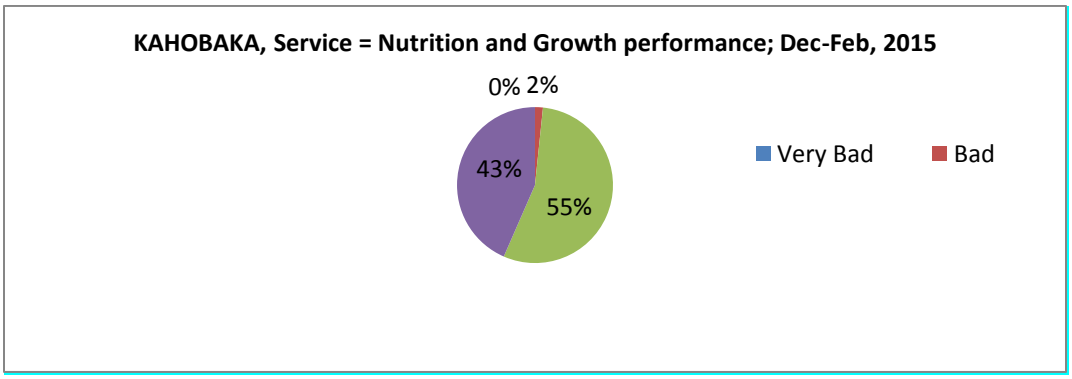
produce to schools and surrounding communities. This initiative has enabled OVC to become independent and support other dependents in their families.

Support quarterly Area Advisory Council [AAC] Meetings; during this reporting period, the Project supported two Area Advisory Council meetings in Makadara and Njiru. Makadara AAC carried out a chief's baraza to voice issues affecting children in the Sub County, and visited 6 schools adversely affected by the recruitment of children into crime by gangs [Gaza group] and sensitized children on their rights and protection. Njiru AAC team collaborated with Department of Civil Registration [DCR] and obtained birth certificates for 75 OVC with priority given to those joining ECDs and class 8 as a requirement for enrolment and examination registration respectively.

Support LIP's to carry out Child Status Index (CSI); A 14% sample of 824 OVC from KAHOBAKA was used to carry out the CSI study after assessments at the household level. The sample was entered into a data template for analysis to find out how the children were performing in the service areas.
The results were analyzed as shown below:



From the above representation, the chart indicates that the OVC are well protected from abuse and exploitation, they are legally protected, and having healthcare services. This has been achieved through caregiver networking and training. Food and nutrition are yet to score optimally as shown in the graph below;



Some of strategies responsible for the above accomplishments include:

1. Use of Local Administration to get men to attend Families Matter! Program Session.

During the implementation of the Families Matter! Program, it was observed that participation of male parents or caregivers has been low. Their participation is critical since the program aims to equip parents or caregivers with knowledge and skills on how to talk with their adolescents about sex. The Project therefore employed a strategy of mobilizing men through the local administration and as more men began to attend, the mobilization strategy shifted to word of mouth. A notable increase in the number of men attending the sessions was observed.

2. **Family Therapies** – MEWA successfully conducted family therapies for families of 29 PWUDs clients who were admitted in the MEWA Rehab Centre. Family therapies are conducted to secure a safe environment for final reintegration of the rehabilitated drug user back into the community. During family therapies, the client and his/her immediate family,

are counseled together in order to show the family that the client is now a new person. The therapies mend the relationship between the client and his/her family so that he/she can be admitted back by his/her kin.

3. **Needle and Syringe Exchange Program (NSEP)** – The NSEP being implemented by MEWA, TOP and ROCT has been scaled up from the pilot phase to include Gongoni, Marereni, Watamu, Kikambala, Changamwe, Ukunda and Msambweni areas. The program is led by NASCOP and NACADA with support from UNODC. Outreach workers recruit and link PWIDs with the program as part of harm reduction interventions. UNODC procures required commodities which are then distributed by NASCOP and NACADA to MEWA, ROCT and TOP. The three NGOs then distribute the commodities to PWIDs. NASCOP also coordinates the waste management of used commodities where the three NGOs pick up used needles and syringes. The latter are incinerated by in Malindi Sub County hospital, Kilifi County hospital and Coast General hospital respectively.

4. **OVC QI strategy;** QI teams are used to develop approaches to resolve challenges faced by respective LIPs, monitor services given to the children and follow up service areas identified for improvement.

5. **OVC support groups**; the forum has provided a platform for sharing issues among adolescent mothers and children living with HIV who adhere to drugs and have a positive outlook on life .

- **Networking and linkages**; community leaders, relevant line ministries, and government departments collaborations have helped identify and deliver appropriate services to communities/OVC, i.e. MOH, MOE and the Department of Children's Services, NCPWD, KAWE etc. for acquisition of birth certificates, treatment and rehabilitation of children with disability, and educational support.

6. Implementing EBI's through Community Units (CUs)

Implementation of the three EBI's allows beneficiaries to benefit from standardized messages. Starting the Families Matter! Program within the same CUs where HC II is being implemented has allowed the program to get more people into the program because parents with children who are in the HC II age bracket (i.e aged 13-17 years) refer them for the sessions. Some of the FMP facilitators are also community based distributors of family planning hence they are able to dispense some commodities to parents/ guardians who attend the FMP sessions.

CONTRIBUTIONS TO HEALTH SYSTEMS STRENGTHENING

Building on previous years achievements, the project continues to pursue a three pronged health systems strengthening strategy that: (i) focus on strengthening health systems (financing, information, human resources, medical products and technologies, governance, and service delivery) to ensure programs are country-owned and sustainable.; (ii) Addresses critical system weaknesses that constrain achievement of outcomes and, (iii) Collaborates and coordinates with the partner country and other development partners to assess, prioritize, test and scale up the system-strengthening actions.

In conducting the technical assistance, APHIA*plus* Mtaani continues to apply a complex adaptive systems perspective, i.e. looking at the health system as a continuously evolving large scale social system in which people are the key drivers and in which building blocks are necessarily interconnected and interdependent. The project will facilitate linkages with other national mechanisms: for human resources for health, renovation, commodity management and logistics system strengthening and health information system management, health communication, leadership and institutional capacity building.

The Project has continued to build on, and align its activities and programs to GOK strategies and priorities. The focus remains on ensuring that Counties contribute optimally to better health outcomes by providing high quality technical assistance to respective health teams through application of a systems perspective, as promoted by the Global Health Initiative (GHI) principles. GHI puts people-centered services first while also facilitating synergistic interactions of the different inter-connected building blocks. This has been realized through continuously improving on linkages with national mechanisms: i.e the Capacity Bridge for human resources for health (HRH), HCSM for commodity management, logistics system strengthening and Afya Info for health information system management. High impact Interventions (HIIs) that strengthen the service delivery system as described in KHSSP 20012-2017 and in County Health Strategic Plans, have continued to be prioritized with TA. The KHSSP 2012-2017 clearly identifies investments in access and quality of service delivery and how these remain major focuses for sector investment efforts. KHSSP 2012-2017 also identifies investments that relate to health service organization and management addressing issues of supportive supervision, strengthening

referral care, functioning of outreach services, facility management of care delivery, within community and facility management of care.

With County Health Strategic Planning adopted, support to counties has now been focusing on tracking AWP implementation. Increased access and continuous quality improvement are the stated ways by which investments are ultimately translating into expected outcomes. Throughout the different programmatic interventions, the following service delivery support strategies were prioritized for support in the reporting quarter.

Strengthened joint quarterly supportive supervision: S/CHMTs invested in building a stronger supportive supervision system: through orientation sessions, OJT and coaching, adaptation or development of supervision tools, documentation of visits and coupled with financial support for travel to different facilities. The project has maintained support to such supportive supervision activities and post-training follow up of service providers and S/CHMTs to plan, manage, supervise, and monitor facility based service delivery. Project staff have participated in supportive supervision and in provision of technical support on HIV/TB, RH/FP, MNCH, SGBV, Nutrition, Malaria and WASH. In addition, attention has also focused on strengthening support supervision for community activities.

Strengthened referral care: The Project helped strengthen linkages between levels of care by supporting counties, sub-counties and facility management committees to strengthen and institutionalize established community desks under the project at facilities and having community health workers based in facilities for referral between CHUs, Primary Care Units and Hospitals. MOH referral tools have continued to be provided at community desks and to CHVs. The Project also focused efforts in strengthening linkages between health facility committees and the Community Health Committees/CHUs for referral. This action has resulted in increased demand for health services. The strategy for strengthening referrals also relies on identification, documentation and dissemination of best practices within existing review meetings and stakeholder forums.

Functioning outreach services: The project supported health facilities to conduct integrated mobile clinics that brought critical services to poor and underserved areas especially in Lamu, Taita Taveta Kwale and Kilifi counties. This has created enhanced uptake of HIV related services. Supported CHUs and attached CHVs continue to facilitate the formation of/strengthening of support groups which act as channels for key services targeting children, adolescent and young women, pregnant women, youth, KPs, men and women.

Strengthened facility management of care delivery: While a national mechanism will support technical training, all other capacity building measures: on-the-job training, Continuous Medical Education (CMEs), whole site training, and orientation sessions continue to be supported by the project. Clinical guidelines can be disseminated through these capacity building activities. In the reporting quarter, on a need-based basis, facility management committees were sensitized or oriented on the relevant management topics: supervision, relationship with CHUs, data use, referrals.

Mentorship: Strengthened quality improvement management and compliance with professional standards: Mentorship is essential to maintaining strong clinical case management capability at facility level. The multi-disciplinary mentorship team (made up of adult ART, paediatric ART, HTC, laboratory, pharmacy, and HMIS, RH/FP and nutrition specialists) works with the county and sub-county mentors in line with the national guidelines on mentorship for HIV services in Kenya (2008). Based on the agreed mentorship strategy with each county, identified sites now have institutional and sub-county mentors who underwent capacity building through coaching.

The mentorship strategy is two tiered: (i) the master mentors of the multi-disciplinary mentorship team provide intensive mentorship to a team of sub-county mentors. The program areas covered are as described above. (ii) The collective of sub-county mentors who disseminate their skills to service providers hospitals and primary care units. Mentors conducted facility visits and provided hands-on transfer of skills to service providers. The latter happens through one-on-one case management, clinical case reviews and chart reviews. Mentorship teams have supported upward referral of complicated clinical cases and downward referral of stable cases. Mentorship teams continued to work with the SCHMTs to ensure dissemination of the national protocols and best practices in HCT, ART and RH. This effort supports decentralization of care and treatment services to lower level facilities and to private facilities. Further to this, mentorship meetings, grand rounds and sharing forums were also supported. Mentorship teams conducted routine grand rounds to support in-patient quality management of HIV. During such rounds they reviewed cases of patients admitted with HIV-related OIs. Skills lab will be identified that will serve as centers of excellence and hub for on-job-training. The mentorship teams continue to adapt the

HIV mentorship principles and apply them to MNCH, RH/FP and TB; and thus institutionalize mentorship beyond HIV service areas.

Strengthened implementation of the Kenya Quality Model of Health (KQMH): The dissemination of KQMH has ensured that all sub-counties and facilities now apply the same framework for continuous quality improvement. The QI Teams and the regular application of the PDA cycle remains the core quality improvement strategy.

The continuous quality improvement approach is currently fully data driven working for the CAPA process and engages managers and service providers in a continuous process of shifting the focus to outcomes for which DHIS provides the data. Client feedback sessions on quality of services have been supported through client exit interviews and focus group discussions at community and facility settings. Exchange visits to model sub-counties for facility staff, CHVs, IPs and S/CHMTs have been supported. Laboratory networks have also been supported to increase their efficiency

Strengthened Health Leadership and Governance: The health sector Leadership and Governance investment area addresses three objectives: improved health stewardship, appropriate systems of health governance and consolidation of partnership arrangements. *Strengthened stewardship* has been achieved largely through technical and financial support to the select supported counties on AWP reviews and development and through needs based mentorship, technical support or OJT on health programs or health systems management to CHMT and SCHMT managers.

With regard to strengthened health governance, as part of quality improvement processes, this quarter, the Project focused on prioritizing and addressing client perspectives on governance issues through client satisfaction surveys using My Check and CAPA tools. The Project supported SCHMTs in organizing stakeholders meetings at sub-national levels (County and Sub-Counties), through the now institutionalized quarterly sub-county meetings as well as key technical working groups. The purpose of this project technical support has been to provide a forum where formal and informal actors involved in decision-making are able to define expectations, verify performance; and implement the decision.

Strengthened partnership arrangements are critical for program implementation. Currently, county and sub-county health stakeholders' fora represent important opportunities to optimize partner contributions under county leadership. Equally important, the project has continued to facilitate community dialogue days under the community strategy to help CHUs coordinate with partners and strengthen f provision of Tier-1 health services.

In the reporting period, 27 QI teams in Coast region were represented best practices learning forums convened in collaboration with URC and the Department of Children Services. All LIPs in the region have been able to provide improved quality services to OVC as a result of knowledge and skills acquired on improving quality of OVC services as evidenced by reports and best practices presented during regional learning forum. The LIPs continued to use materials they were supported with for quality improvement such as minimum quality standards services for OVC, Child Status Index booklets (Swahili version), child rights materials, change idea booklets and Nick's story books on HIV/AIDS.

Human Resources for Health (HRH): The project continues to support critical staff positions in the Project supported health facilities on temporary employment basis. The project has 13 Health Records Information Officers (HRIOs) and Data Clerks spread across supported High Volume facilities in Nairobi, Mombasa, Kilifi and Taita Taveta. Additionally, the Project has 8 Locum Counselors who work for 6 days a month at various supported facilities. The 8 Locum Counselors at stationed at Mama Lucy Kibaki Hospital (2) and at Mathare North Hospital in Nairobi and at Moi Hospital (3), Wundanyi Sub District Hospital (1) and Wesu District Hospital (1) at the Coast.

In Nairobi, the supported facilities with HRIOs are Mbagathi District Hospital, Dandora I, Casino and St. Mary's Hospital. In the Coast region, facilities supported with HROs are Taveta District Hospital, Tudor District Hospital and the Coast Provincial General Hospital. The Project also supports roving HRIOs in various facilities on a need-to basis.

In collaboration with FUNZO, the national mechanism responsible for training of health workers, the Project has continued to coordinate with CHMTs, CHMT, SCHMTs and supported health facility in-charges the needs assessment for new training, following up with FUNZO on the implementation of training programs , and ensuring post-training follow up of trainees.

Health Products and Technologies (HPT): To maintain a regular supply of these inputs, effective public commodity supply management is important. Health Commodity Security committees have been formed with support from HCSM. The project continued to support some of the county and sub-county meetings as they are ideal fora for addressing commodity management problems in counties. As such, in the reporting quarter, the project supported S/CHMTs with transport for either distribution or redistribution of antiretroviral drugs, contraceptive commodities and vaccines. This has gone a long way towards creating demand for services and improving quality. During integrated supported supervision and during review meetings, attention is paid to the use of the logistics information system and the data from the LMIS.

III. ACTIVITY PROGRESS (QUANTITATIVE IMPACT)

The Project Performance Monitoring Plan Matrix (i.e. **see Annex II and Annex III for Summary Project PMP Matrix and Consolidated County PMP Matrix respectively**) details the key indicators that APHIA*Plus* Nairobi-Coast Health Service Delivery Project tracks routinely. The indicators are numbered and organized by Project specific objectives. For each indicator, a definition, baseline values, quarterly and end-of-contract targets (where applicable), and data sources are identified in the key indicator table (KIT) which disaggregates a number of core project indicators by age and sex.

IV. CONSTRAINTS AND OPPORTUNITIES

HIV/TB	
Not all service providers were reached with the new rapid advice guideline; thus need for more training.	The Project provided feedback to the County Management team and has engaged FUNZO Kenya in discussions to train more providers on the new Guidelines
Some HIV positive mothers are refusing to take HAART arguing that their CD4s are still high.	Continue with advocacy and use PMTCT support group for treatment literacy.
Very long turnaround time to getting EID results from CPGH due to high work load in the virology lab.	Two additional Laboratory technologists and one data clerk were provided to support the CPGH though this is not a long term solution
Data capture of PMTCT clients on HAART was erroneous due to HCW not understanding the indicators	TA and mentorship on correct documentation continues to be provided.
Delays in receiving the viral load results from the testing Labs especially at CPGH	Data clerks have been hired to facilitate lab result dispatch. Arrangements are underway to have locum staff in the laboratory.
DBS filter paper supplies inadequate	Follow up ongoing with KEMRI -CDC
Very low detection rate of paediatric clients	CME will be supported to build capacity of HCW on diagnosis of childhood TB.
Nurses and clinicians are ill equipped with diagnostic tools	APHIA*plus* Nairobi-Coast to ensure equipping clinicians with sputum apparatus and commodities that aid in diagnosis
DEMAND CREATION AND ADDRESSING SOCIAL DETERMINANTS OF HEALTH	
Long dry spell in the region has affected food production leading to decreased food security	Increased sensitization on planting of drought-resistant crops and use of conservation farming methods
Access to health care for OVC due to long distances to health facilities	There is need to support the MOH to carry out regular health outreaches at community level.
Continued harassment of KAPs by police officers	A program to sensitize law enforcement agents on the rights of KAPs is being scaled up after the initial sensitization of senior police officers
OLMIS Installation: It was not easy to hire someone to enter data even after installation of the program at the IP level due to resource constraints. Minimal data was entered into the system.	Contact persons and LIP coordinators were encouraged to take the initiative and find innovative ways of carrying out this activity.
High expectations from the caregivers as relative to available services provided/supplies	Implementing Partners encouraged to diversify sources of support

High expectations by the ECDs	ECDs encouraged to continue sourcing other donors support
During the Shuga sessions, there was high demand for HIV counselling and testing, exceeding the capacity of the one counsellor present	Those who did not get a chance to access the service were referred to a nearby facility of their choice
Group IGAs & VSL support groups for PLHIV did poorly this quarter with four of them breaking up as a result of client payment default.	Clients are now being taught and encouraged to start small IGAs individually and these have been fruitful with most doing well when they manage their small-scale businesses.
Due to increased demand for maternity ward utilization inadequate beds.	The project is fundraising for various maternities delivery/maternity beds especially for Makadara, Kayole.

V. PERFORMANCE MONITORING

The Project performance monitoring tasks are grounded and guided by the M&E Technical strategy of the program which places particular emphasis on improved health metrics, by strengthening data demand and information use for improved evidence informed decision making and strategic program positioning (implementation science) using a blend of complexity aware and Outcome Mapping M&E approaches. The Project's robust performance monitoring system enables timely monitoring of performance by tracking the relevant service statistics and periodic analyses of outputs towards outcomes and monitoring its contribution towards supporting the GoK/MoH structures to achieve both the sub-national and the national health priorities.

The Project has continued to support the GoK systems and structures on HIS to generate quality data and information for decision making. This has been through working with and supporting the Division Health Informatics and M&E, Community Health Services Unit, NASCOP and NACC structures both at the national and county levels with design and effective roll-out of strategies to streamline data capture, analysis and reporting for improved program management. The key objectives under this program thrust remain as follows: i) Monitoring project performance in increased use of quality HIV prevention, care and treatment, TB/HIV, MNCH reproductive health and FP services; ii) Monitoring project performance in demand creation efforts and initiatives for increased access to improved quality integrated health services at community levels; iii) Monitoring performance in addressing social determinants for health among orphans and vulnerable children (OVC), home-based care clients and other vulnerable target populations; iv) Measuring the program's contribution to achieving the Ministries of Health and GHI/PEPFAR/USAID objectives; v) Strengthening the capacity of County and sub-county medical health teams, health facilities and community level services providers to record, and use data to plan, manage and improve services; and vi) Supporting the project knowledge management initiatives to ensure that best practices are documented and knowledge products are developed and disseminated targeting the different audiences.

The current M&E system, comprising of three sub systems - the Routine Health Information System –RHIS (captures Facility Based data reported via the DHIS2 Platform, and the Community Based information that comes both through the CBHIS-MCUL data base and plus COBPAR for the LIPs reports), OLMIS sub systems and TraiNet) – continuously get strengthened and expanded in a participatory manner involving the Sub-County Health Management Teams (S/CHMTs) and community-level partners. The M&E system focuses on activities and results achieved at the community, facility and sub/County levels. M&E results guide project management and program improvement. The program M&E system uses the standardized MOH/GoK tools to assess progress against targets. Quarterly reviews of performance data by program managers are the basis for direct feedback on performance, contributing to keeping the program on track and strengthening data quality.

In the reporting quarter, the Project focused on strengthening the capacities of the primary partners (SDPs and LIPs in data capture and routine process monitoring systems for improved quality and integrity of the data reported using integrated facility service statistics databases (KePMs, ODS/KITs, DHIS2, My Check, MCUL, OLMIS and TraiNet) and promotion of innovation to streamline data capture and reporting systems and information utilization for improved decision making as per the demands of the New PEPFAR MER Strategy Guidance that has also seen the birth of the new Data Capture and reporting platform DATIM- "**Data for Accountability, Transparency and Impact".** This was accomplished by adopting a wide range of capacity strengthening strategies and approaches: conducting on-site field performance monitoring and technical assistance missions by the Research and Metrics (RMU) teams to review progress with activity implementation; reviewing adequacy, timeliness and completeness in data capture and reporting; and more particularly strengthening the LIPs M&E systems to ensure collection of high quality data both at static facilities, and during satellite community outreaches.

Highlights of the supported activities under Strategic Information include but are not limited to: Strengthening work plan implementation status and work flow- work plan reviews jointly with Measure Evaluation PIMA project at the county levels; strengthening coordination of activity implementation and reporting through facilitation of communication (Air-time and data bundles to all the sub-county and county-level MOH core teams) to support the data value chain, including referral systems; supporting the Div. Health Informatics, NASCOP and the Div. CHS to develop/refine M&E/HMIS tools and user guides/standard operating procedures to support roll-out a more integrated DHIS2 platform that takes on board the additional data disaggregation by PEPFAR; Strengthening Data Quality Improvement (Data Quality Audits (RDQAs, DQAs, in-depth onsite data verifications (OSDVs); Field Performance Monitoring and Technical Assistance Missions (Desk-level Technical Assistance to HFs, MOH Structures, LIPs; Joint Supportive Supervision by County and sub-county teams (S/CHMTs); and strengthening sub-county and County broad-based stakeholders' data review structures and processes cum feedback and action planning meetings (monthly); DHIS2 data cleaning and support hosting of frequent data review meetings; Strengthening the institutionalization of Facility Multi-Disciplinary Team data review meetings for facility and community programs jointly with URC-ASSIST through strengthening data collection efforts, systems and processes at both facility and community levels. The priorities for technical assistance for the quarter are detailed here below:

Capacity Building of MoH/IP systems and structures on data collection and reporting

Under this priority area, the Project has continued to support several activities this quarter aimed at improving how data is captured, analyzed, reported and utilized both at the facility/SDP levels and how that data gets summarized and shared with the other health system levels. Within its efforts to secure sustainability of established systems a number of supportive supervision/ tailor-made on-site technical assistance were provided by under the guidance of the Research and Metrics Technical Hub aimed at adequately equipping LIPs and SDPs with the knowledge and skills to be able to appropriately capture and report health facility data based on the integrated tools and populate the DHIS2 with the full list of health sector indicators were conducted across the zone.

The Project has also continued to support the S/CHRIOs to cascade the remedial sessions to cover service providers with a particular focus on the high volume facilities (HVFs) as per the reading of the to-months extension prepositions and with particular focus on both PMTCT and ART sites.

At the Tier 1 of the Health System, the project has continued to support community health volunteers to record and report on the national tools by: providing on-site mentorship to health providers and information staff at sub-county hospitals and high-volume ART sites; providing on-site TA and mentoring of the health information staff on use of DHIS2 to report CU activities. Peer educators across different implementing partners were also trained on the new health communication data collection and reporting tools to strengthen data collection and reporting. Of critical highlight in this reporting quarter is the technical assistance that project core RMU technical leads continue to support the Community Health Services Unit (CHSU) as members of the CHS TWG at the national level in development of the Community Health Policy, alignment/revision of the community health strategy and development of the Quality Standards for the Community Health Services. These efforts are jointly driven with other GoK partners (UNICEF, Pop Council, World Vision, WHO, World Bank and other USAID national mechanisms, particularly Measure Evaluation PIMA, and Capacity Bridge that is primed by Intra Health International.

Within the reading of the Project's newly reenergized service delivery strategy that prioritized data driven technical assistance, and as part of the continued efforts to strengthen generation of data of integrity, the project M&E technical officers conducted site-level performance monitoring and technical assistance missions to help with the appraisal of activity implementation and offer need-based technical assistance. All these efforts have resulted into improved reporting rates by facilities with respect to MOH 711, MOH 710 and MOH 731 summary data sheets. More efforts, have been put in the reporting quarter and beyond to ensure that the promising practices in terms of reporting rates for MOH 711 are replicated in terms of holistic submission of reports and population of the DHIS2 including inpatient data (MOH 718), Nutrition summary reports, MOH 713/733 and strengthened FP commodity reporting.

Strengthening data demand and information use by project staff, MOH structures

The Project has continued to strengthen the institutionalization of the CAPA "Corrective Action, for Preventive Action" and MyCheck tool as part of the internal project-level real-time performance monitoring systems and supporting the County and sub-county level monthly data clinics facilitated jointly by the S/CHRIOs and the project M&E technical offices with the respective thematic technical area leads instrumentally interrogating the project service statistics trends to help validate results, address challenges and provide narratives for the quarterly project performance.

For high-volume facilities that account for 90% of the project reported data, the project has continued to host/ facilitate multi-disciplinary team monthly data reviews and feedback dissemination meetings aimed at strengthening data demand and information use for improved program management at service delivery levels. Efforts have been aimed at ensuring that M&E take a center-stage in informing and guiding project implementation. The RMU unit has continued to strive to ensure that M&E results are presented in ways that facilitate decision making at the facility, sub/County and project levels.

The RMU supported monthly and quarterly data review platforms have continued to help promote repositioning of data demand and use in informing strategic decision making around activity programming particularly taking full cognizance of the devolved health systems framework.

Highlights of critical interventions prioritized this quarter under the DDIU sub-theme are detailed here under:

a) **Support to the IPs on M&E and reporting**: In terms of routine health statistics, the project continued to support LIPs to submit data during monthly CHV monthly dialogue meetings, where it is cross-checked and summarized by CHEWs before submission to the link facilities with copies to the project Community Coordinators. As part of the routine data flow processes, IP supervisors meet on a quarterly basis to review and analyze data and problem-solve. Grantees submit quarterly narrative progress and financial reports that are jointly reviewed with the service delivery counterparts to determine completeness, accuracy, and consistency with the sub awards contractual obligations.

b) **Field Performance Monitoring Technical Assistance visits:** Technical, management and field program staff routinely visited project sites across the zone to assess progress with activity implementation, provide TA, and hold discussions with stakeholders on project progress and challenges. Most IPs however, continued to receive monthly on-site technical assistance visits to provide tailor-made, need-based and responsive technical assistance and guidance on activity programming, while high volume health facilities receive monthly or more frequent visits to ensure there is uninterrupted coordination of activity implementation and work flow. Findings get shared with S/CHMTs and IPs (during monthly scheduled data review meetings, quarterly). Key emerging issues are discussed with appropriate project's technical theme leaders or IP staff/teams as part of the knowledge management for organizational learning. The project senior management reviews results for informed strategic program decisions.

c) **Program Performance Review Meetings:** The project has continued to support/ co-facilitate Sub/County level program review meetings involving S/CHMTs and IPs are held each quarter at the County level to discuss experiences, best practices, and resolve common problems.

   Similarly, the Project supported quarterly review meetings separately at the sub-county/sub-county levels with the SCHMTs together with the CHRIO, CASCO and their data teams to review data, share interpretations, and address issues and challenges. Reports from these meetings further provide useful information. RMU team played a lead role in ensuring that the project work closely with, and participate in, the County, sub-county and facility Annual Work Plan (AWPs) reviews and action planning processes across the right from facility/community unit levels, Sub-county and consolidated County AWP development, ensuring alignment of project activities with GOK priorities and targets

d) **Monthly and Quarterly Feedback meetings:** In collaboration with program M&E, progress of activities implemented by the CHWs will be tracked through monthly and quarterly feedback meetings targeting the CHWs, LCHWs, CHEWs, FOs, CHCs, HFMCs, DHMTs S/CHMTs and other stakeholders.

e) **Joint quarterly supportive supervision by Field Officers, S/CHMTs:** S/CHMTs continued to receive field logistical support to provide quarterly support supervision to the various facility and CU level activities. This has ensured that the activities being implemented are in line with the GOK guidelines.

Strengthening Health Informatics for Improved Health metrics

The focus of M & E during the quarter was strengthening the quality and integrity of the data reported via the DHIS2 and DATIM platforms in preparing for SAPR '15. This was achieved through strengthened data quality audit, responsive-need based technical capacity building of the MOH structures (new health care workers on the use of HMIS tools, and health care managers of data demand and information use in programming. In order to ensure program preparedness for APR the available data was analyzed and shared with program staff.

The field performance monitoring and technical assistance mission efforts focused on ensuring that the data facilities had reported was a true reflection of the work they had done in respective months. It was also a time to audit the TA support given to the health care workers on the proper manner of documenting services and generating reports. There was a major drawback in documenting and reporting as a result of inter and intra-transfer of health workers especially in facilities that had one staff.

At the background of the support given to the service delivery points, on-site data reviews and validations (OSDVs), data cleaning, data tracking, and data syntheses continued so as to ensure that all decisions at program and health care service delivery points are informed by the data that the program generates.
The Project worked with S/CHMTs and facilities to improve data collection, processing and analysis of service statistics improved program management and coordination of workflow. This has continued to be achieved through quarterly and scheduled monthly data review meetings with the sub-county-level MOH core staff. The project collects routine facility data monthly, through the CHMTs (S/CHRIOs); using standardized MOH tools (i.e. MOH 731/711, 710…) and ensures that both the project and MOH data reported are consistent and accurate. The M&E Technical Officers review data using a criterion such as ensuring that each facility has submitted data and whether the data demonstrates fidelity to all the 12 compendium of data quality. Service outlets are randomly selected for more in-depth onsite data verifications (OSDVs) to determine if client records were appropriately aggregated by making reference to the physical registers.

The Project continued to support OVC documentation through strengthened implementation and institutionalization of the OLMIS system. Further, the support towards ensuring that all LIPs had reporting tools they needed to cover their caseload

A key part of this process has been remedial onsite orientation sessions for the primary partners (MOH structures) on the use of the DHIS2, MNCHUL and EMR platforms and ensuring that data emanating from the Project supported activity sites are appropriately and adequately collected in accordance with New PEPFAR MER Strategy Guidance Note/MOH RHIS standardized indicator definitions. The project has also made instrumental contribution in RHIS tools distribution, ensuring their availability and appropriate utilization both at facility and community levels; and strengthening capacity of MoH structures and systems for effective data collection, data analysis and usage.

Annexes I and II of this report presents the Project Performance Monitoring Plan (PMP) and the Consolidated County-level PMPs which together presents the Quantitative Analysis, detailing the Project M&E two-pronged Technical Strategy of "Building the chain of evidence' which fully captures the project reporting priorities as reflected in the key indicators tables (KIT) that are tracked routinely. The Project disaggregates a number of core PEPFAR/USAID indicators by age and sex.

VI. PROGRESS ON GENDER STRATEGY

The Project continued to strengthen community-based services targeting increasing health service access for girls and women and increasing prevention and response efforts against GBV.

Quarter program activities focused on: Strengthening GBV coordination working groups through update and exchange meetings; promotion of healthy images of manhood through sensitization sessions; promotion of health treatment literacy integrated with GBV sensitizations; facilitating and supporting to increase community awareness and engagement for improved access to service by women and children by supporting the facility-community referral linkages and sensitizations.

Targeted sessions were held in Nairobi, Mombasa and Lamu counties for girls and boys sensitizations on FP/RH, HIV/AIDS and GBV for men and maintenance and strengthening of GBV safe spaces and shelters. There has also been continued support for GBV Working groups with shelters/safe spaces monthly meetings; forums for women on laws of marriage and succession and the Women's Enterprise Fund; and provision of legal aid services by CREAW in supported districts as well as continued support to the Kenyatta National Hospital Gender Violence Recovery Centre with GBV coordination, community outreaches and provision of psychosocial support services.

Community Sensitizations
Community sensitizations on multi-sectoral coordination were conducted through the working groups that also have Trainers of Trainers (TOTs) trained on multi-sectoral coordination. Opportunities for increasing community sensitization that the Project utilized included chiefs barazas and community meetings where gender and rights issues including domestic violence, defilement, early marriages, illegal abortions, child neglect and child labour are addressed at such forums.

International Women's Day celebrations, mobilization and advocacy

The 2015 theme of the International Women's Day was "Empowering Women, Empowering Humanity: Picture it! - by Stepping it Up for Gender Equality". It was aimed at joining governments and activists across the world in commemorating and celebrating women's achievements since the Beijing Conference of 1995. The project supported the celebrations with technical, organizational and service delivery support.

The Project worked with the departments of health, social services, gender and youth to facilitate anti-GBV mobilization, awareness and advocacy; support critical sexual and reproductive health services provision through community groups and health facilities. The Project also distributed exercise books designed with gender-sensitizing child-friendly messages on multi-sectoral response coordination to GBV.

Under Gender and Rights, the Project tracked six key indicators; two of the indicators tracked the structural interventions which aim at strengthening of community level structures through which gender and rights activities, knowledge and sustainable interventions can be implemented. These are number of working groups supported during the quarter (10) and 5 male champion groups.

On service delivery, 420 people (150 males and 270 females) were reached through one-on-one and small-groups targeting gender norms transformations; while 356- 157 males and 199 females- were reached with information and knowledge aimed at preventing and managing GBV and sexual coercion. A total of 363 (126 males and 237 females) were taken through legal and rights protection awareness sessions while a further 57 (12 males and 45 females) were taken through income and livelihood strengthening capacity and awareness building sessions.

VII. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

APHIA*plus* Nairobi-Coast continued to support waste management at the supported facilities by distributing bin-liners to 13 laboratories in Nairobi County. During the WAD activities counsellors in 9 outreach sites were provided with waste bags and safety boxes. At the Coast, the Project continued providing TA to the facility management teams on infection prevention and waste management. Four facilities were provided with bin liners in Mombasa County and outreach teams at Kwale County were supported to incinerate their safety boxes.

VIII. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

APHIA*plus* Mtaani continues to liaise and coordinate with other national mechanisms to ensure quality and continuity of service delivery and strengthened systems. Working with Futures, and ITEC (the two national Mechanisms on EMR) the Project continued to support enhancement, utilization and institutionalization of IQCare system through conduct of a data quality assessment to inform scaled implementation of the I-IQCare system and tools providing need-based desk-level technical assistance, support and mentorship to identified facilities to fully operationalize the system. It also continued to participate in the National RHMSU M&E Technical Working Group that is driving the implementation/roll-out of the RHMNCH Indicator Score card and streamlining of the FP Commodity reporting via the DHIS2 platform under the stewardship of the Division of Health Informatics and M&E

At the county levels, the project continued to strengthen her established collaboration with the USAID/URC-ASSIST project to support implementation of Quality Work Improvement teams in select HVFs conducting training gap assessments and across all the supported 6 counties of zone 2.

Project collaboration with USAID/Intra Health Capacity Bridge Project continues to be strengthened by working together to support the respective counties in establishing and institutionalizing functional County government-led HRH Interagency Coordination Committees (ICC) through participation in the HRH-Technical Working Groups.

The collaboration with Capacity Bridge has also continued to ensure that we work with the Health Records and Information officers stationed at facilities in the six supported counties to build on existing M&E system to track and evaluate progress towards strengthening of RHIS systems in the counties through improved routine data collection, analysis and reporting systems, data quality assurance and data for decision making.

IX. PROGRESS ON LINKS WITH GOK AGENCIES

In the reporting quarter, APHIA*plus* Nairobi-Coast Project was instrumental to the functions of a number of national level Technical Working Groups (TWGs) as highlighted below:

a) APHIA*plus* Nairobi-Coast support to the MOH between Jan-Mar 2015 included:

1. AYSRH Task Force membership reviewing the GOK's ARH & Development Policy of 2003:

A Task Force[16] chaired by the Reproductive & Maternal Health Services Unit (RMHSU)/MOH has been updating the 2003 ARH and Development Policy[17]. On Feb 12, 2015 RMHSU called a stakeholder meeting to share the second draft of the ASRH policy's eight priority SRH concerns[18] and chart a way forward for its implementation.

APHIA*plus* Nairobi-Coast staff participated in this exercise, a follow up to the December 2014 technical writing workshop. Follow up actions included RMHSU taking responsibility for incorporation of stakeholder comments in the final draft; clustering counties, sharing, printing and disseminating the final AYFS policy and development of the implementation plan. The MOH expects to launch the revised national ARH policy targeting adolescents 10-19 years, by mid-2015 to guide AYSRH programming at national and county levels.

2. Maternal and Newborn Health (MNH) Technical Working Group (TWG)[19] participation:

Following devolution of health services to the counties, the national government is revising policies that reflect the changing landscape of MNH in Kenya. On January 28th 2015, as part of the MNH TWG's theme of "strengthening the policy environment", the meeting chair, RMHSU/MoH, presented the GoK's new MNH implementation plan to guide national and county activities.

3. Family Planning Technical Working Group[20] membership: APHIA*plus* staff participated in the MOH's 2015 quarterly FP TWG meeting (Feb 26, 2015). Chaired by the RMHSU, it was noted that under the devolved system, counties needed to procure essential drugs through KEMSA to ensure adequate FP commodities stock.

4. Support to the National AIDS Control Council/MoH, UNICEF, UNAIDS Launch of the Global Social Movement 'All In!' to fast-track the AIDS Response for Adolescents in Nairobi, Kenya:

AIDS is the leading cause of death among adolescents in Africa and the second highest globally. High numbers of new infections among young people below 24 years of age represent a significant economic cost of life liability to governments. In Kenya, 30% of new infections and 17% of AIDS related deaths occur among young person's < 24 years of age, posing challenges for attainment of economic and youth empowerment goals. The launch of the "All In!" campaign to fast track the AIDS response for adolescents was held in Nairobi at KICC on February 17, 2015 and presided over by H.E Uhuru Kenyatta, President of the Republic of Kenya. The meeting was convened by the MoH and led by NACC in partnership with the UN team led by the Executive Directors of UNAIDS and UNICEF. The high level meeting featured senior GoK officials, the US Ambassador to Kenya, UNFPA, WHO, UNESCO, YPLHIV, youth advocates, adolescents and young people, CSOs and stakeholders. Meeting highlights included four presidential directives on the need for i) the MoH and MoE to address stigma reduction in youth; ii) provision of treatment/ARVs for adolescents and youth to prevent new infections; iii) review of the MoE curriculum to address the needs of YPLHIV and both the MoE and MoH to develop a comprehensive program to fast track Kenya's AIDS response. Going forward, the NACC will convene a multisectoral working group to contextualize issues raised by young people and develop a roadmap for Kenya.

b) APHIA*PLUS* Nairobi-Coast support to the National Council for Population & Development (NCPD)/The Presidency-Ministry of Devolution & Planning, State Department of Planning

[16] AYSRH Task Force members: MOH, NCPD, MOE, LVCT Africa, UNFPA, UNESCO, WHO, FHI360, CSA, NOPE, AFIDEP, the Population Council, DSW, SRHA, and Pathfinder/APHIA*PLUS* Nairobi-Coast

[17] UNFPA Kenya supported review and revision of the AYRH policy under the 7th & 8th Country Program of Assistance

[18] i.e. SRH rights; CSE; STIs/HIV; unintended pregnancies; harmful practices (early marriage and FGM); SGBV including child trafficking; marginalized and vulnerable adolescents i.e. those with disability, living in poverty/on the street, displaced and key populations; drug and substance abuse.

[19] MNH TWG members- RHMSU-DFH/MOH (chair); Jhpiego, UNFPA; Pathfinder International; LVCT; FHOK, MCHIP, FCI, DfID, PATH, ACORD International, Concern, Jacaranda Health; AMREF Health Africa; Phillips; PS Kenya; WHO; USAID Kenya OPH; CHAK; the Population Council and PSP4H.

[20] FP TWG members: RHMSU-chair; USAID OPH Kenya, ICL, MSH, MCSP, Population Council, World Vision, CHAI, Futures group, MSD/Merck, DSW, PS Kenya, Bayer Healthcare, FHI360, Pathfinder, Measure Evaluation, Jhpiego, NCPD, FunzoKenya and WHO,

Contribution to the Population Resources Flow and Family Planning Survey Validation Meeting: APHIA*plus* Nairobi-Coast project was amongst 20 organizations including government agencies (i.e. MoH, the Treasury, the Kenya National Bureau of Statistics, University of Nairobi); USAID CAs (Plan International, ADRA Kenya, WVI, , FCI), FBOs (CHAK), CSO's (FIDA Kenya, AMREF Health Africa, MYWO, Red Cross) and private sector organizations (Old Mutual), which contributed to the NCPD/UNFPA led effort to collect data for the 2013 Population Resource Flows and Family Panning Survey. This activity is part of a global initiative to monitor progress in the implementation of the Program of Action adopted at the International Conference on Population and Development (ICPD) in 1994. NCPD coordinated the exercise on behalf of the GoK. The survey examines levels of donor and domestic expenditures on population activities. The information collected will be used for advocacy and resource mobilization.

Participation in Sustainability of Adolescent Sexual & Reproductive Health Programs in Kenya Meeting; Convened by NCPD and funded by ExpandNet, this meeting was attended by 83 youth and professionals drawn from 34 public and private sector organizations[21]. Meeting goal: to build consensus on systematic approaches to successful scaling up and sustainability in ASRH programs. Meeting objectives: sharing of opportunities and challenges in the development of the revised National ASRH Policy; familiarization of participants with international knowledge about successful and sustainable scale-up of ASRH projects; sharing of lessons learned from Kenya on how projects can work in a sustainable and scalable mode and finally, discussion on how best to promote ownership and institutionalization of ASRH programming at national and county levels. Presentations made covered myriad topics including: development Issues in Kenya and the Youth ENGAGE (NCPD); an overview of the National Youth Directorate and Youth Policy (National Youth Directorate); priority areas and challenges in the development of the ASRH policy in Kenya (DRH); sustainable scale up of youth projects – beginning with the end in mind (ExpandNet); donor perspectives on institutionalization and funding of ASRH Programs (UNFPA, USAID, DFID).

Panel presentations included lessons learned in implementing ASRH programs in Kenya led by Pathfinder International/APHIA*plus* Nairobi-Coast- ARH program pioneers, JHPIEGO and PATH. County teams from Machakos, Nairobi, Mombasa and Kisumu presented their perspectives on ownership and institutionalization of youth programs at county level. NCPD's Director General wrapped up discussions and made several recommendations, including the need for i) sustainable scale up of ASRH projects in the context of devolution; ii) GoK and partner support to revise MoH tools to include segregated information by age and sex for YFS data collection and, iii) digital platforms to implement AYFS services. The latter are to be developed and implemented with the input of young persons to ensure their participation, ownership and sustainability.

Participation in NCPD's "Demographic Dividend[22] Opportunities in Kenya" meeting that discussed
the Demographic Dividend Kenya Model results (March 5, 2015). The Kenya, DemDiv model integrates key elements needed for Kenya's demographic dividend based on three inputs: FP, education, and economic policies (financial efficiency, ICT use, imports, labor flexibility, public institutions. Kenya DemDiv outputs include population, employment, investments, productivity, GDP per capita. Kenya's status with respect to the Demographic Dividend were highlighted: **Family planning** based on KDHS, 2008-09: CPR (all methods) 46%; Fertility rate: 4.6 children/woman; **Education-**adults complete an average of 6.3 years of education and **Economic development-** Kenya is **r**anked 96 out of 148 countries for global competitiveness, with a GDP per capita of US$907.

c) Support to UNFPA 's Faith for Life: Ending Preventable Maternal Deaths in Kenya Inter-Religious Consultative Forum:

[21] Adolescent health meeting participants: Chair: NCPD. Others: Jhpiego, PATH, University of Nairobi, RHMSU-MoH, ICL-Africa, PRB, IPPF ARO, FHOK, Population Council, FHI360, SRHR Alliance, KMYA, Ministry of Devolution & Planning/Directorate of Youth Affairs, MoH Machakos, Kisumu, Mombasa and Nairobi; AFIDEP, UNFPA, Pathfinder International, DSW, ExpandNet, National Youth Service, Track 20 (FP 2020 + Tupange); USAID, UNICEF, National Gender and Equity Commission, Center for the Study of Adolescence, APHRC, Nairobi County Council, National Organization of Peer Educators, SIDAREC.

[22] The Demographic Dividend is defined as a temporary opportunity for faster economic growth that begins when fertility rates fall, leading to a larger proportion of working-age adults and fewer younger dependants. The Demographic Dividend has 4 key elements (i) favorable population age structure i.e. large working-age population (15+ years old); small dependent population (0–14 years old); (ii) Investments in education i.e. completion of primary and secondary education; training and skills development for youth (iii) sound economic policies and (iv) good governance.

UNFPA Kenya convened a collaborative multi partner[23] two day meeting in Nairobi to sensitize religious leaders on the status of maternal mortality in the country with a specific focus on the 15 high burden counties**.** The meeting which was opened by H.E. Uhuru Kenyatta, President of the Republic of Kenya, generated much discussion on harmful traditional practices like FGM and child marriage and its impact on maternal and child health. Key strategies that have contributed to improvement of maternal health and specific contributions made by faith based leaders were also shared. The meeting charted the way forward for the role of religious leaders in mobilizing communities to improve maternal health in the 15 high burden counties and adolescent health.

X. PROGRESS ON USAID FORWARD

APHIA*plus* Nairobi Coast provided program implementation mentorship to the LIPs via support supervision, OJTs and review meetings. In the period under review, key CHMT members like CASCOs and CHRIOs were part of support supervision visits to DISCs in Kwale County and PWHR in Kisauni, Mombasa. The LIPs were mentored in quality assurance of services and proper record keeping. The project also held a one-day local implementing partners review meeting that discussed how to improve targeting and programming for the key populations. To further ensure quality of education sessions, coordinators from CBOs made 53 support supervisions to peer education group sessions.

There was continuous technical support and capacity building on OVC documentation, sensitization on OLMIS, and resource mobilization skills in the 123 LIPs serving OVC in the Coast region. The LIPS had an opportunity to share achievements, challenges and the way forward on OVC programming activities. In collaboration with Conrad N. Hilton Foundation grant and MOE, 87 ECD teachers were trained on basic child development and ECD curriculum.

XI. SUSTAINABILITY AND EXIT STRATEGY

To ensure sustainable impact and continued improvement of services delivery, the project continued to work on its health systems strengthening strategy fully cognizant of eventual exit. During the quarter, the strategy made sustainability the key factor and worked towards: 1) full alignment with national policies and strategies; 2) ensuring that technical assistance adds real value and 3) referring to complex systems when dealing with systems issues; 4) building grassroots networks for service delivery through CHWs, LIPs and Facility referral networks and also embarking on preparatory work for project close-out

Interventions to ensure a continuum of service delivery include strong linkages between health facilities and surrounding communities and vice versa. Strengthening linkages has numerous advantages, including reducing the risk of loss to follow-up and defaulter tracing and also improve the efficiency of preventive messages resulting from reinforced and complementary messages between health facilities and the community units. Individuals who test positive are linked to care; women who receive prophylaxis are linked to support groups, and so are patients (youth, women men, orphans or people with disabilities), survivors of GBV, once provided with care, are linked to local empowerment activities, youth who receive vocational training are linked.

Through systematic involvement of all key actors and stakeholders in collecting, monitoring, and using data, results are fully owned by the key constituents of the health system: the health providers and managers at different levels of the service delivery pyramid including the staff of LIPs as part of the continuum of securing sustainability.

Service continuity and the resultant sustainability are critical for any quality service delivery model. APHIA*plus* seeks to promote continuity of services through (i) strengthening of a two way referral system, i.e. between health facilities and community units and vice versa, (ii) strengthening community systems and (iii) strengthening collaboration and coordination. Ensuring continuity of critical services therefore continues to be of paramount importance as we move closest to the end of this follow-on phase. And finally, the project takes full cognizance of the fact that gender equity is a cross-cutting issue for development policies in Kenya, in general and as such, it is mainstreamed in national policies and strategies. The Project addresses gender related issues and mainstreams gender in all the Project thematic components, while emphasizing the principles of human rights, equity, non-discrimination, and stigma reduction.

XIII. SUBSEQUENT QUARTER'S WORK PLAN

See annex IV to this report

[23] **Faith for Life partners: NCPD, Kenya Red Cross, Inter-Religious Council of Kenya, World Vision, World Bank and the UN.**