USAID KENYA/EAST AFRICA

HIV Service Delivery Support Activity – HSDSA Cluster 2 (Afya Nyota ya Bonde)

Quarterly Progress Report
July 2019 - September 2019 (Q4)

Co-creating, Co-planning and Collaborating on Joint Y3 Work-plan with Baringo, Samburu, Kajiado and Laikipia Counties as we Embark on our Journey to Self-Reliance.

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USAID KENYA (Afya Nyota ya Bonde/HSDSA Cluster 2)

FY 2019 Quarter 4 Progress Report
July 1, 2019 – 30 September 2019

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ACRONYMS AND ABBREVIATIONS

AGYW	-	Adolescent Girls and Young Women
ANC	-	Antenatal Care
ART	-	Antiretroviral Therapy
ARV	-	Antiretroviral
AWP	-	Annual Work Plans
AYP	-	Adolescent and Young People
CAG	-	Community ART Groups
CCC	-	Comprehensive Care Centre
CD4	-	Cluster of Differentiation 4
CHMT	-	County Health Management Teams
CHV	-	Community Health Volunteers
CME	-	Continuous Medical Education
CRH	-	County Referral Hospital (former provincial general hospital – PGH)
CRS	-	Catholic Relief Services
CWC	-	Child Welfare Clinic
DATIM	-	Data for Accountability, Transparency and Impact Monitoring
DBS	-	Dried Blood Spot
DQA	-	Data Quality Assessment
DQVF	-	Data Quality Verification Factor
DSD	-	Differentiated Service Delivery (*in relation to ART differentiated care*)
DSD	-	Direct Service Delivery (*in relation to level of effort*)
EBI	-	Evidence-based Behavioral Interventions
EID	-	Early Infant Diagnosis
EMR	-	Electronic Medical Records
FHI 360	-	Family Health International
FP	-	Family Planning
FY	-	Fiscal Year
GOK	-	Government of Kenya
GSK	-	Goldstar Kenya
GUC	-	Grants Under Contract
HAART	-	High Active ART
HC	-	Health Centre
HCA	-	HEI Cohort Analysis
HCMP	-	Health Commodity Management Plan
HCW	-	Health Care Worker
HEI	-	HIV-Exposed Infant
HIV/AIDS	-	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMT	-	Health Management Team
HRH	-	Human Resources for Health
HSDSA	-	HIV Service Delivery Support Activity
HTS	-	HIV Testing Services
HVF	-	High Volume Facilities
ICF	-	Intensified Case Finding
IEC	-	Information Education and Communication
iHRIS	-	Integrated Human Resource Information System
IPC	-	Infection Prevention and Control
IPD	-	In-Patient Department
IPT	-	Isoniazid Preventive Therapy
J2SR	-	Journey to Self-Reliance
JWP	-	Joint Work Plan

KEMRI	-	Kenya Medical Research Institute
KHIS	-	Kenya Health Information System
M&E	-	Monitoring and Evaluation
MCA	-	Maternal Cohort Analysis
MCH	-	Maternal and Child Health
MDT	-	Multidisciplinary teams
MNCH	-	Maternal, Newborn and Child Health
MOH	-	Ministry of Health
NASCOP	-	National AIDs and STI Control Program
NCD	-	Non-Communicable Diseases
OGAC	-	Office of the Global AIDS Coordinator
OJT	-	On-Job Training
OPD	-	Out Patient Department
OTZ	-	Operation Triple Zero
PBB	-	Performance Based Budgeting
PCR	-	Polymerase chain reaction
PEP	-	Post Exposure Prophylaxis
PEPFAR	-	U.S. President's Emergency Plan for AIDS Relief
PGH	-	Provincial General Hospital
PHDP	-	Positive Health, Dignity and Prevention
PLHIV	-	People Living with HIV
PMC	-	Performance Monitoring Chart
PMTCT	-	Prevention of Mother-to-Child Transmission
PNS	-	Partner Notification Services
POC	-	Point of Care
PrEP	-	Pre-Exposure Prophylaxis
PSSG	-	Psychosocial Support Group
Q1, 2, 3, 4	-	Quarter 1, 2, 3, 4
QA/QI	-	Quality Assurance/ Quality Improvement
QIT	-	Quality Improvement Team
RRI	-	Rapid Results Initiative
RTK	-	Rapid Test Kits
SCH	-	Sub-County Hospital
SCHMT	-	Sub County Health Management Teams
SGBV	-	Sexual and Gender Based Violence
SILC	-	Savings and Internal Lending Community
SIMS	-	Site Improvement Monitoring System
SMS	-	Short Message Service
SOP	-	Standard Operating Procedure
STF	-	Suspected Treatment Failure
STI	-	Sexually Transmitted Infection
TA	-	Technical Assistance
TB	-	Tuberculosis
THCS	-	Total Hospitality Consultation Services LTD
TLD	-	Tenofovir/Lamivudine/Dolutegravir
TQA	-	Technical Quality Assessment
TWG	-	Technical Working Group
USAID	-	United States Agency for International Development
USG	-	United States Government
VL	-	Viral Load
VMMC	-	Voluntary Medical Male Circumcision
WIT	-	Work Improvement Team
WRP	-	Walter Reed Project

FY19 QUARTER 4 ACHIEVEMENTS

594,101
Clients tested for HIV

11,816
Clients tested HIV positive

2.0%
Yield Rate

10,618
Newly initiated on ART

90%
ART Linkage Rate

65,772
Clients currently on ART

87%
Viral Load Suppression

108,949
PMTCT clients with known HIV Status

3,287
PMTCT clients initiated on ART

4.0%
EID positivity

19,153
Males circumcised

5,772
TB Patients diagnosed with TB and put on Treatment

EXECUTIVE SUMMARY

The Afya Nyota ya Bonde is a five-year (8th December 2017 – 7th December 2022) contract between the United States Agency for International Development (USAID) and Family Health International (FHI 360) implemented in seven counties in Kenya namely Baringo, Kajiado, Laikipia, Nakuru, Narok, Turkana and Samburu Counties. The Afya Nyota ya Bonde goal is to increase access and coverage for HIV prevention, care and treatment services toward achieving the ambitious United Nations AIDS (UNAIDS) "95-95-95" targets with focused capacity building to bolster county ownership and management of the HIV/AIDS response and epidemic control. The Activity is implemented by a consortium of partners under the leadership of FHI 360 as the prime contractor and three other sub-contractors, namely Catholic Relief Services (CRS), Gold Star Kenya, and Total Hospitality Consultation Services (THCS) Ltd.

In quarter 4 of the financial year (FY) 19, the Activity continued to focus on:1) targeting service delivery where it is needed most using epidemiological and program data to focus support in high-volume facilities and high HIV-yield locations; 2) integration of Anti-Retroviral Therapy (ART) in all health facility departments; 3) scaling up evidence- based interventions and innovations, 4) building county ownership and sustainability by mentoring CHMTs, SCHMTs and other health executives to lead and manage the HIV response; and 5) leveraging resources of other actors including other United States Government (USG) lead agencies. In the quarter, the Activity supported 327 facilities across the seven counties to provide HIV prevention care and treatment services. This report describes annual FY 19 (October 2018 – September 2019) achievements with special highlights on quarter 4 of the fiscal year.

A. Qualitative Summary

Development of Joint Work Plans (JWPs): The Activity continued to support implementation of JWPs with County Health Management Teams (CHMT), Sub-County Health Management Teams (SCHMT) and facility Health Management Teams (HMT). By Q4 of FY 19, a total of 121 JWPs (i.e. 7 CHMT, 34 SCHMT, 80 HMTs) were developed to support the Ministry of Health (MoH) in implementing various activities geared towards improving sustainable quality HIV service delivery and achieving the UNAIDS "95-95-95" goal of epidemic control.

Development of new Sub-Contract: In Q4 FHI 360 completed the sub-contract with Gold Star Kenya (GSK) and fully onboarded the staffs hired under GSK to implement the agreed-on activities in the work-plan. GSK was sub-contracted to engage technical and administrative staffs in Baringo, Kajiado, Laikipia and Narok county field offices as well some technical staff in Nakuru County. FHI 360 was

still responsible for strategic leadership and technical direction for all the seven supported counties, including technical assistance, mentorship and training in implementation of activities.

Changes in Sub-Contract: following the communication on intended funding cuts in FY20, FHI 360 discussed and agreed with CRS to disengage from the partnership with activities previously carried out by CRS to be incorporated within the job descriptions of remaining staffs. These activities included improving client retention, tracking of defaulters and loss to follow up (LTFUs) as well as returning to care for the defaulters. During the quarter, the CRS staffs continued to provide direct implementation of community engagement activities in supported counties.

Evaluation of Grants Under Contract (GUC) Applications: In FY 19, the Activity initiated the process of engaging local partner organizations to implement community HIV services through a GUC mechanism by inviting interested organizations to submit their request for application (RFA). A total of 56 applications from 35 prospective partner organizations were received, with some organizations submitting two or more applications for funding under the GUC mechanism. These applications were evaluated by the internal staff with support from USAID and Nakuru County Department of Health representatives. A total of 10 organizations/applications met the first evaluation criteria and were requested to submit more information for further review. The second review process is yet to happen and is likely to be completed in FY20.

Implementation of Surge: In the fourth quarter (Q4), the Activity continued with implementation of SURGE strategy in 90 priority sites across the seven counties with support from USAID. Implementation of SURGE activities helped increase case identification, improved linkage to ART and helped bring back to care patients who were initially lost to follow up. It also increased uptake of viral load tests while strengthening retention in ART. During the quarter, the Activity continued with daily data-driven "Situation Room Meetings" (SRM) for quick review and learning to improve implementation at project level as well as in all SURGE sites. These SRMs were aimed at reviewing performance of each participating site both in terms of daily achievements against set targets, reporting rates, data quality, and developing site specific action(s) to addressing identified gaps. The USAID team attended some of the review meetings physically and remotely via skype or telephone to provide required technical support for focused implementation. As a result, by 26th September, or Day 100 of SURGE implementation, a total of 95,661 clients were reached with HTS of whom, 3,797 were newly diagnosed with HIV with 3,678 (96%) being started on ART. Assisted partner notification services contributed to 1,218 (32%) of the new positives with a yield of 27%. Overall, the yield increased from 1.7% in Q1 to 2.4% in Q4 of FY19

USAID Assessment of SURGE Implementation Progress: During the quarter, USAID team continued to participate in mentorship and supportive supervision across the different counties. Various sites in Baringo, Kajiado, Nakuru and Turkana were visited. A total of 46 facilities were visited by the USAID team (3 in Baringo, 27 in Nakuru, 9 in Kajiado, and 7 Turkana). Some of the findings included: great leadership, ownership and support for surge activities at the CHMT and facility levels; great commitment and resilience amongst HCWs at the facilities towards surge; reduced overall HIV testing with potential to increase yield; partner notification services (PNS) and index testing were now better understood and were contributing to the great results mentioned above. Testing of eligible index clients was a remaining gap that still needs our focus in the coming quarter. TLD/TLE optimization was scaled up reaching 91% of eligible patients across the supported counties. While management of treatment failure has improved, there are still gaps in documentation of interventions; similarly, time to intervention for patents with suspected treatment failure is taking too long. This needs focus in coming quarter for timely to switch clients to 2nd line regimen, especially for children.

Viral load suppression especially for pediatrics and adolescents across most of the sites is low and needs closer monitoring, individual case management and care giver literacy in order to improve.

Site Improvement Monitoring System (SIMS): By end of Q4, USAID had conducted SIMS in four facilities across three counties of Baringo, Kajiado and Nakuru counties. The individual site scores were as follows; Nakuru Provincial General Hospital (PGH) 81%, Keringet Health Centre (HC) 86%, Molo Sub-County Hospital (SCH) 79%, and Ongata-Rongai SCH 100%. While the average performance was good, some gaps were identified in waste segregation, enrollment of HIV testers in proficiency testing and adequate documentation. To address identified gaps and mitigate reoccurrence, the Activity will continue to work with the respective county departments of health services and the SCHMTs to provide technical assistance, mentorship and on-job training (OJT) to heath care workers (HCW) in the facilities across the counties.

Transition in Narok, Turkana and Laikipia Counties: During the quarter under review, the Activity held meetings in Turkana and Narok Counties to discuss transition of HIV services. This was led by USAID in both Counties. In Turkana County, ANYB was transitioning activities to the USAID funded AMPATHPlus Project while in Narok County, ANYB was transitioning activities to the Walter Reed Project. Both county transition meetings went on successfully as planned with site level staffs and activities fully transitioned to the in-coming partners. The incoming partner in Turkana County was to have follow up discussions with the Diocese of Lodwar and AIC Ministries to agree on how to work together.

In the same period, activities in two sites previously supported by the Center for Health Solutions (CHS) in Laikipia County were transitioned to ANYB. The staffs in those sites were absorbed by ANYB following the same rationalization process that was employed across all counties.

Closure of County Based Offices: in response to reduced funding and in order to reduce program management costs, all the satellite offices were closed in Q4. Given that there will be a very lean team on the ground, keeping such offices operational was not justifiable. The county-based staffs will be co-located with the County Health management Teams or with Health management Teams in high volume facilities. This will lead to more prudent and efficient use of resources and further reduce the above-site project related costs as demanded by the donor.

Monthly Gap Analysis Meetings: The Activity's multi-disciplinary teams (MDTs) continued to conduct monthly data review meetings at the regional offices to review service delivery gaps identified by review from monthly Ministry of Health (MoH)/Activity data. The meetings entailed identification of data inconsistencies, missing reports, among other gaps. Action plans to address the gaps in the areas of PMTCT, HIV care and treatment, TB/HIV, EID and VL services were developed to improve data quality. These reviews have resulted in timely monitoring and reporting of project deliverables, and informed mentorship strategies and on -job training (OJT) of facility-based staff on correct/accurate data capture and reporting.

Trainings of Health Care Workers (HCW): The Activity continued to facilitate various capacity building initiatives for HCWs to improve quality HIV service delivery in health facilities as illustrated in section 6.1.3 of this report.

B. Quantitative Impact

Below is a summary of progress towards the achievement of the Project Performance Monitoring Plan (PPMP) targets. Details are provided in **Section III** of the report.

Table 1: Project Performance Monitoring Plan

PROJECT PERFORMANCE MONITORING PLAN (PPMP)										
Code	Indicator	Baseline	Year 2019 Target	2019 Quarterly Achievements				Cumulative Year Achievements		Percent (%) Achieved vs Year 2019
				Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sep 19	FY 2019	FY 2018	
Objective 1: Increased availability and use of combination prevention services										
1	PP_PREV Percentage of priority population reached with a defined package of services in HIV high burden counties	44622	80%	-	96%	-	99%	97%	54%	97%
2	VMMC_CIRC Number of males circumcised as part of minimum package of MC for HIV prevention program within the reporting period	4086	22033	8468	1443	3083	6159	19153	24264	87%
Objective 2: Increased uptake of targeted HIV testing services										
4	HTC_TST Number of individuals who received HIV testing and counseling services for HIV and received their test results [by age, sex and results, service delivery point at facility level]	800000	446294	145951	166690	151672	129788	594101	874703	133%
5	HTC_TST Positive: Number (Percentage) of HIV+ individuals in each discrete geographic area identified through HIV testing services	21666	9869	2537	3016	3128	3135	11816	13410	120%
6	HTS_SELF Number of individual HIV self-test kits distributed	-	26530	197	849	3415	5609	10070	-	37%
7	Percentage linkage of PLHIV to HIV care and treatment services	15672	95%	89%	88%	90%	92%	90%	88%	90%
8	PrEP_NEW Number of adults and adolescents who have received antiretroviral pre-exposure prophylaxis in the reporting period [PrEP] to prevent HIV infection	-	1332	-	400	233	256	889	405	66%
9	GEND_GBV Number of people receiving post GBV clinical care based on a minimum package [persons provided with PEP by exposure type]	846	11964	157	219	193	178	747	457	6%
Objective 3: Improved linkage to treatment for individuals newly testing positive for HIV										
10	Percentage of patients receiving CD4 on initiation of ART	-	90%	28%		45%		38%	65%	38%
11	Percentage of individuals testing positive for HIV initiated on ART within 2 weeks of identification	-	85%	82%	81%	90%	91%	86%	89%	86%
12	TX_RET Percentage of adults and children with HIV known to be alive and on treatment 12 months after initiation of anti-retroviral therapy	60%	90%	73%	69%	75%	65%	69%	72%	69%
13	TX_NEW Number of adults and children newly enrolled on ART [by age, sex and pregnancy status]	5396	10550	2252	2671	2810	2885	10618	11743	100%
14	TX_CURR Number of adults and children currently receiving ART [by age, sex and pregnancy status]	20073	74756	58868	61586	64155	65772	65772	59747	88%
15	TX_TB (NUM) Number of ART patients were started on TB treatment during the reporting period	-	-	-	654	-	590	1244	1795	-
16	TX_TB (DEN) Number of ART patients who were screened for TB at least once during the reporting period	1	74752	56665	60437	62200	63793	63793	56093	85%
17	TB_STAT Number of new and relapsed registered TB cases with documented HIV status	50	5538	1463	1532	1426	1351	5772	7632	104%
18	TB_ART Percentage of HIV positive new and relapsed TB cases on ART during TB treatment [by sex]	30%	98%	93%	92%	93%	92%	92%	94%	92%
Objective 4: Increased uptake of and adherence to quality HIV treatment positive for HIV										
19	Percentage of supported facilities have adequate staff [>80 Percentage of full-time equivalents are filled] to carry out core HIV service provision	-	45%	14%	49%	48%	51%	41%	22%	41%

PROJECT PERFORMANCE MONITORING PLAN (PPMP)										
Code	Indicator	Baseline	Year 2019 Target	2019 Quarterly Achievements				Cumulative Year Achievements		Percent (%) Achieved vs Year 2019
				Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sep 19	FY 2019	FY 2018	
20	PMTCT_STAT Number of pregnant women with known HIV status [includes women who knew their status for HIV prior to ANC and those who tested for HIV and received their results]	96000	125783	24456	29742	27088	27663	108949	109008	86%
21	TX_NEW Pregnant HIV+ women: Percentage of expected HIV+ women enrolled into care/treatment;	4617	95%	98%	100%	99%	100%	99%	99%	99%
22	PMTCT_ARV Number of HIV positive pregnant women who received ARV to reduce the risk of mother to child transmission [MTCT] during pregnancy and delivery	80	4593	769	942	765	811	3287	3359	71%
23	PMTCT_EID Number of infants born to HIV-positive women who had a virological HIV test done within 12 months of birth	3627	4593	859	856	769	608	3092	4588	67%
24	Percentage of infants born to HIV infected mothers who receive prophylaxis to reduce MTCT	65%	93%	93%	102%	-	-	97%	98%	97%
25	PMTCT_FO Percentage of final outcomes among HIV exposed infants registered in the birth cohort	2933	90%	100%	100%	100%	100%	100%	96%	100%
26	PMTCT_STAT Mother-to-child transmission of HIV rate by 18 months of age in target counties	5%	50%	5%	3%	3%	4%	4%	3%	4%
27	PMTCT_CTX Number of infants born to HIV-infected women who were started on cotrimoxazole [CTX] prophylaxis within two months of birth within the reporting period	3035	4364	577	487	-	-	1064	2399	24%
Objective 5: Long term follow up of patients receiving care and treatment services including laboratory and logistics support										
28	TX_PVLS (DEN)Number (%) of adult and pediatric ART patients with a viral load result documented in the patient medical record within the past 12 months	41591	73926	56637	60939	54210	61009	61009	56220	82%
29	TX_PVLS (NUM) Percentage of ART patients virally suppressed with a viral load documented in the medical records in the past 12 months with a suppressed viral load [<1,000 copies/ml]	90%	90%	83%	85%	89%	87%	86%	84%	86%
30	IMIS Percentage of supported facilities with the necessary commodities required for service provision	12%	45%	70%	78%	94%	94%	87%	87%	87%
31	Percentage of sites reporting their stock status on a timely-monthly basis	76%	45%	60%	87%	94%	94%	83%	57%	83%
Objective 6: Strengthened institutional accountability for the management of community, facility and county HIV response										
32	Number of county AWPs that reflect project activities and activity budgets	-	7	7	5	7	7	7	7	100%
33	Number of sub-counties effectively utilizing program-based budgeting to prioritize health and HIV needs	-	7	39	35	23	33	33	41	471%
34	Number of county governments that progress as measured by the organization capacity assessment tool	-	7	-	-	-	-	-	7	0%
35	HRH_STAFF Number of health care workers [regardless of funding source] at PEPFAR funded facility [with PEPFAR support disaggregated]	644	400	934	963	972	1054	1054	1045	263%
36	Percentage of high-volume facilities that conduct quarterly data review and use forums	49%	80%	51%	33%	58%	80%	55%	58%	55%
37	Percentage of facilities submitting timely, complete and accurate information	98%	95%	80%	91%	96%	98%	87%	92%	87%
38	EMR_SITE Percentage of service delivery points that utilize a patient electronic medical record system	-	80%	9%	19%	93%	96%	55%	21%	55%

C. Personnel Management

FHI 360 experienced several staff changes in FY19. In quarter 4 (Q4) of FY19, the need to down-size the project staffing was communicated based on the proposed Y3 funding. This downsizing reduced

total project staffs from 97 to 54 with Senior Technical Officers reducing from 9 to 4 while the Technical Officer positions reduced from 19 to just 7. An objective criterion was developed to inform the downsizing. During the same period, the Director Monitoring and Evaluation was brought on board but unfortunately, she left after just one month. The Senior Data Manager and DCOP positions was officially approved by USAID and were both filled. The Activity will need to go back to the drawing board on recruitment of the Director, M&E and Senior M&E positions. These are currently under way.

D. Constraints and Opportunities

During Q4 of the FY19, several constraints affected implementation of planned activities including: 1) equipment downtime and reagent stock-outs at Kenya Medical Research Institute (KEMRI)/Walter Reed Project (WRP) Laboratory in Kericho that led to long Turn-Around Time (TAT) of 25 days for Viral Load (VL) sample analysis and relaying of results; 2) conflicts in parts of Kuresoi South and Njoro sub-counties in Nakuru County, and Kainuk and Nakwamoru due to the insecurity along Turkana-West Pokot border that displaced patients, thus affecting their follow up and retention on treatment; and 3) the way DATIM auto-populates data from TB_STAT indicator to HTS_TST (facility) – PITC Modality assumes that all patients were tested in the TB clinic which is not always the case, and this leads to double counting all HIV positive clients since some are captured under OPD and other PITC and then referred to TB clinics, hence false low linkage rates.

Opportunities: The Activity experienced greater opportunities to collaborate with Palladium Group to institutionalize coverage of Electronic Medical Records (EMR) system implementation at 72 sites to improve data quality and use of the system for patient management. At the same time, the Activity utilized other opportunities that existed such as: 1) collaboration with LINKAGES Project to provide HIV Testing Services (HTS) to clients of female sex workers within the hotspots as well as provision of Pre-Exposure Prophylaxis (PrEP) to the key populations within the Drop-In-Centers (DIC); 2) implementation of surge strategy accelerated achievement of targets with improved achievement on; identification, retention and follow up, viral suppression and ART optimization; and 3) training of HCWs on 2018 new ART guidelines which strengthened quality of service delivery. For orphans and vulnerable children, the Activity has initiated discussions with CASE OVC to ensure inclusion of CLHIV in their support. There's also an opportunity to collaborate better with the cross-border project in order to provide holistic care for populations near the border in Kajiado County.

E. Subsequent Year's Work Plan

Surge strategy produced good results in Quarter Q4 of FY19. The Activity will continue to implement surge strategy in FY 20 with a focus on targeted HTS based on screening outcomes for eligible clients to improve HIV positive case identification particularly through assisted Partner Notification Services (aPNS), improve linkage rate to at least 95% and enhance retention in HIV treatment especially for newly diagnosed patients in the supported sites. The detailed work plan is outlined in section XII of the report. The activity will also focus on optimization of ART among children and adolescents (phase out NVP, LPV/r syrup and introduce LPV/r pellets, introduce DTG for peds/adolescents weighing >20kg and continue scaling up use of DTG among women of reproductive potential. In the coming quarter, the Activity will also scale up operation triple zero (OTZ), scale up continuous quality improvement as an approach to improve quality of care and improve documentation across different indicators. There are three new indicators that have been introduced while three old ones have been revised. The Activity will revise internal data collection templates to reflect these changes while also supporting the counties to improve the Kenya Health Information System (KHIS), the MOH data

system. Once KHIS has good quality data, ANYB will import data from that system for our own reporting. A joint DQA will be done with NASCOP and USAID to assess concordance between DATIM and KHIS. Roll out of EMR will be supported to ensure that most of the data is generated from point of care EMR and the Activity will work jointly with Health IT to transition from IQCare to Kenya EMR> In Q1 of Y3, the Activity will hold a joint planning meeting with the counties, sub-counties and high volume facilities to co-create, co-plan and collaborate on development of a joint work-plan to inform implementation. Deliberate efforts will be made to collaborate better with projects providing complementary services while the Activity will start direct implementation of prevention services for key populations.

I. KEY ACHIEVEMENTS (Qualitative Impact)

OBJECTIVE 1: INCREASED AVAILABILITY AND USE OF COMBINATION PREVENTION SERVICES FOR PRIORITY POPULATIONS.

Activity 1.1: Provide HIV prevention services to fisher folk and other priority populations

In Q4 of FY19, the Activity continued to provide HIV prevention messages using Evidenced Based Intervention (EBI) through stepping-stones curriculum in three major landing beaches of Kalokol, Namukuse and Longech of Kalokol and Kangatotha wards of Turkana Central Sub-County. Afya Nyota ya Bonde conducted refresher training to 10 peer educators on screening for HIV risk, effective delivery of EBI messages, documentation to improve data accuracy, and referral for services. In addition, the Activity also reviewed data collection tools which included referral and screening tools for better data capture and analysis.

During the quarter under review 4,957 fisher folk were reached with HIV prevention messages using steppingstones evidenced based curriculum in the major landing. Consequently, 4889 (99% of annual target) fisher folks were targeted with prevention services of whom 4,806 (98%) received HIV prevention services (HIV testing or referrals for HIV test) plus referral or delivery of other prevention services such as Voluntary Medical Male Circumcision (VMMC), PrEP, Family Planning (FP) and psychosocial support. To improve uptake of testing services, the Activity paired HTS providers with the peer educators during the session and this reduced cases of missed opportunities for those who desired for immediate HIV test after receiving HIV prevention messages. The Activity also ensured complete linkage for all individuals who tested positive by ensuring physical escort to the facilities along the landing beaches where EBI sessions were held.

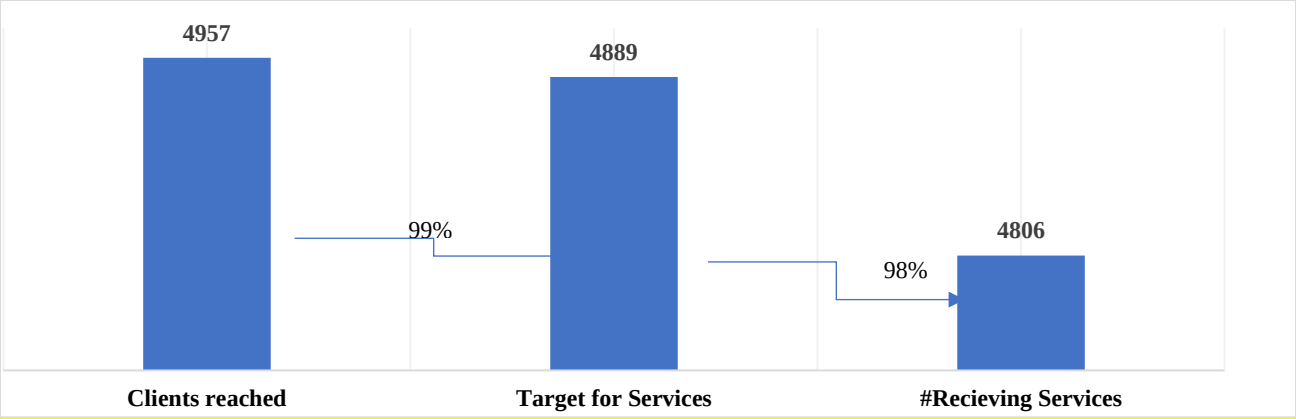


Figure 1: Oct'18 - Sep'19 Fisher-Folk Achievements for Turkana County

Activity 1.2: Promote and provide Voluntary Medical Male Circumcision (VMMC).

The Activity provided VMMC services in Nakuru and Turkana Counties targeting uncircumcised males age 10 years and above. The VMMC services were offered in six static facilities in Nakuru County and five static facilities in Turkana County. This included engagement of temporary VMMC service providers of three teams to compliment the four fulltime teams to provide VMMC services during the accelerated VMMC services especially during school holidays.

During this period under review, a total of 19,153 males were circumcised in Nakuru and Turkana as shown in Figure 2. This was an achievement of 87% against the annual target of 22,033. Nakuru county contributed 25% (4,860) and Turkana county contributed 75% of the overall achievement. Of the annual target for the counties, Nakuru county has achieved 97% of its annual target while Turkana county has achieved 84%. Males aged 15 years and above contributed 60% of the achievements. A further analysis shows that males aged 10-14 years contributed 54%, males aged 15-19 years contributed 32%, and those aged 20-29 years contributed 12%. The achievement in the two counties is attributed to the focused VMMC mobilization efforts through the organized groups in the community, the churches, workplaces, the informal sector and fish landing beaches of lakes Turkana and Naivasha, as well as engagement of additional service providers during school holidays.

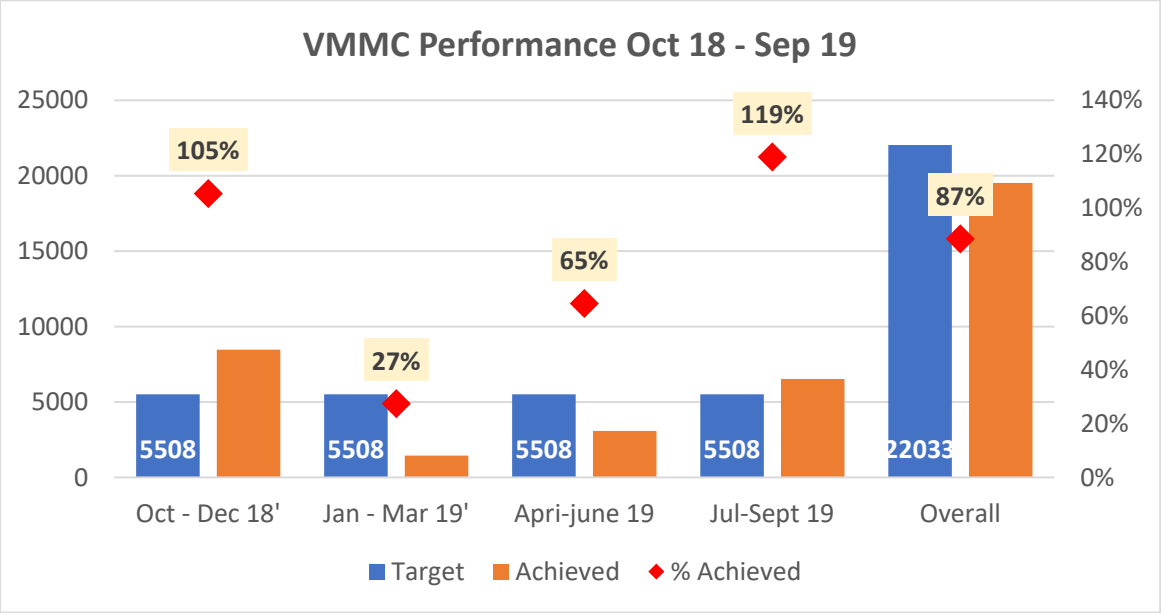


Figure 2:Oct'18 – Sep''19 VMMC Achievement against Annual Targets

The Activity ensured a coordinated approach to provision of VMMC services to ensure safety and prevent any post-operative infections. A total of 18 moderate cases of adverse effects (AE) were reported in both Nakuru and Turkana counties and there was no severe case reported. Most of the AEs encountered were mainly due to delayed healing or swellings due to poor hygiene or general failure to follow post-operative instructions. All encountered AE cases were managed as per the national guidelines. In addition, six HIV positive people were newly diagnosed, and all were linked to care and treatment.

The Activity conducted regular supportive supervision for routine data quality checks, restocking of VMMC supplies, distribution of reporting tools including minor theatre registers. The Activity in collaboration with MoH provided mentorship and on- job-training (OJT) to the service providers to ensure adherence to the guidelines and use of dorsal slit methods in the provision of VMMC.

Activity 1.3: Increase access to PrEP for discordant couples and other high-risk populations

The Activity supported PrEP service provision across the supported sites through mentorship of HCWs, provision of PrEP registers, facilitation of the SCHMT and CHMT to conduct site level support supervision and forecasting, quantification and reporting of commodities. No commodity stock-out was reported in the year. The Activity enhanced PrEP activities during surge implementation period by integration of PrEP eligibility screening into HTS risk assessment tool and mentored HCWs to enhance identification of HIV negative individuals at a substantial risk of acquiring HIV infection. These included HIV negative partners of suspected treatment failure (STF) clients enrolled in viremia clinics and those in a discordant relationship, newly diagnosed mothers in Ante-Natal Care (ANC), and those individual clients with recurrent use of Post-Exposure Prophylaxis (PEP) in OPD. To strengthen reporting, the Activity printed and distributed PrEP registers and Daily Activity Registers (DAR) on need basis.

52,693 individuals were assessed for PrEP and 2522 (4.8%) found eligible. A total of 886 clients were newly initiated on PrEP translating to 67% achievement against the annual target of 1,332. In addition, there are 966 clients who are active on PrEP. Many clients opting for use of condoms largely contributed to the under achievement on PrEP services uptake. Of those not initiated on PrEP, 127 were still in preparation at time of reporting, 76 were referred to non-project facilities, 75 declined PrEP and 1358 indicated they preferred to use condoms and were being followed on continuous behavior change counselling. Figure 3 below shows PrEP cascade for October 2018 - Sep 2019.

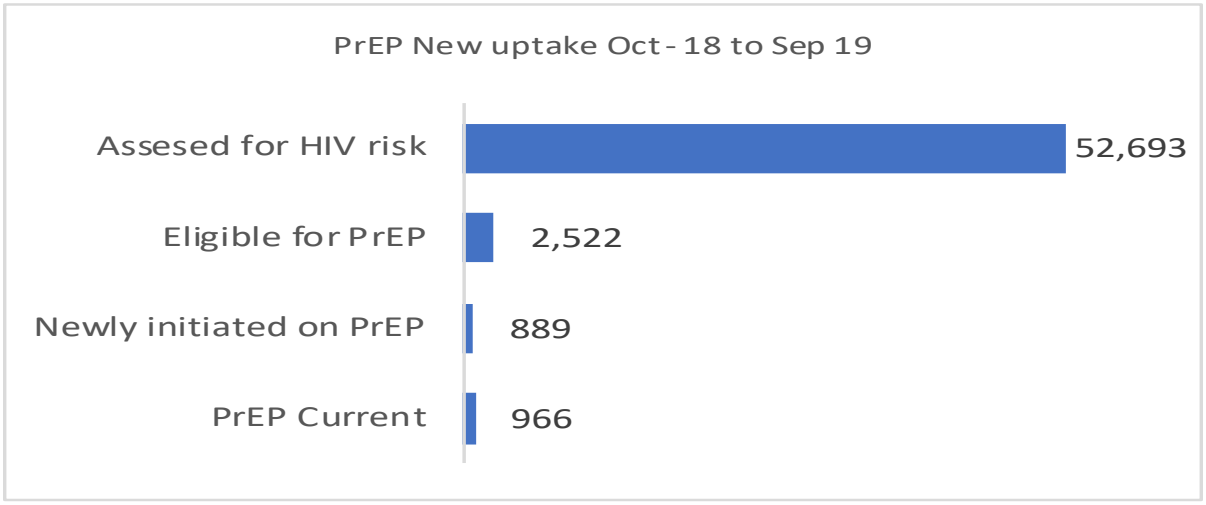


Figure 3: Oct'18 - Sep'19 PrEP Service Uptake

To increase uptake of PrEP in FY20, Afya Nyota ya Bonde will focus on facility optimization by increasing index HIV testing among partners of suspected treatment failure (STF) clients enrolled in viremia clinics, discordant couples, newly diagnosed mothers in Ante-Natal Care (ANC) and those with recurrent use of Post-Exposure Prophylaxis (PEP) in outpatient clinics. The Activity will also re-orient HCW skills in communicating about PrEP to potential clients and patient preparation to address any barriers. The Activity will strengthen PrEP services in drop-in-centers (DICs) targeting key populations and special groups.

Activity 1.4: Sexual and Gender-Based Violence (SGBV) prevention and response

By end of Q4 of FY19, the Activity supported provision of comprehensive package of SGBV services in 62 sites distributed across the seven counties. A total of 747 clients were offered comprehensive SGBV services, which was 6.2% achievement of the annual target of 11,964. Of the 747 reached, 616 experience sexual violence while 131 experience emotional and physical violence. 604 (98%) of those experiencing sexual violence were screened for STI, 421 (70%) were tested for STI and 228 (54%) were treated for STI. 230 (87%) of 263 eligible received emergency contraceptive pill while 462 (75%) of those eligible received Post Exposure Prophylaxis (PEP). 491 (66%) were tested for HIV and three of them tested HIV positive. 162 (90%) of those started on PEP three months (180) prior completed PEP. Documentation is still a challenge and leads to underperformance. This will be improved in the coming quarter.

OBJECTIVE 2: INCREASED UPTAKE OF TARGETED HIV TESTING SERVICES (HTS) OBJECTIVE

Activity 2.1 Increase access to facility based HTS services

At the end of Q4 of FY19, the Activity supported 319 facilities to provide HTS services across the seven counties. Several interventions were employed including training of 658 HCW on new HTS guidelines, orientation of 575 HCWs on assisted Partners Notification Services (PNS), and mentorship of 577 HCWs on HIV self-testing. In addition, the Activity implemented surge strategy to accelerate identification of new HIV positive clients through testing optimization and scaling up of aPNS. This involved orientation of 650 HCWs on surge strategy, including 138 HTS counselors who were oriented on aPNS, eligibility screening, documentation in HTS registers to track strategies/ HTS testing modalities. Further, the Activity oriented Sub-County Medical Laboratory Technologists (SCMLT) to forecast HTS Rapid Test Kits (RTKs) using the Health Commodity Management Platform (HCMP) and commodity TWG meetings for quantification. 152 HTS counselors underwent observed practice sessions. By end of Sep 2019, 594,101 clients were tested for HIV translating to 133% achievement of annual targets. To improve HTS yield and reduce over-testing, the Activity implemented optimized/targeted testing in service delivery points emphasizing aPNS and Index Testing. Figure 4 illustrates HTS achievement per county in FY 19.

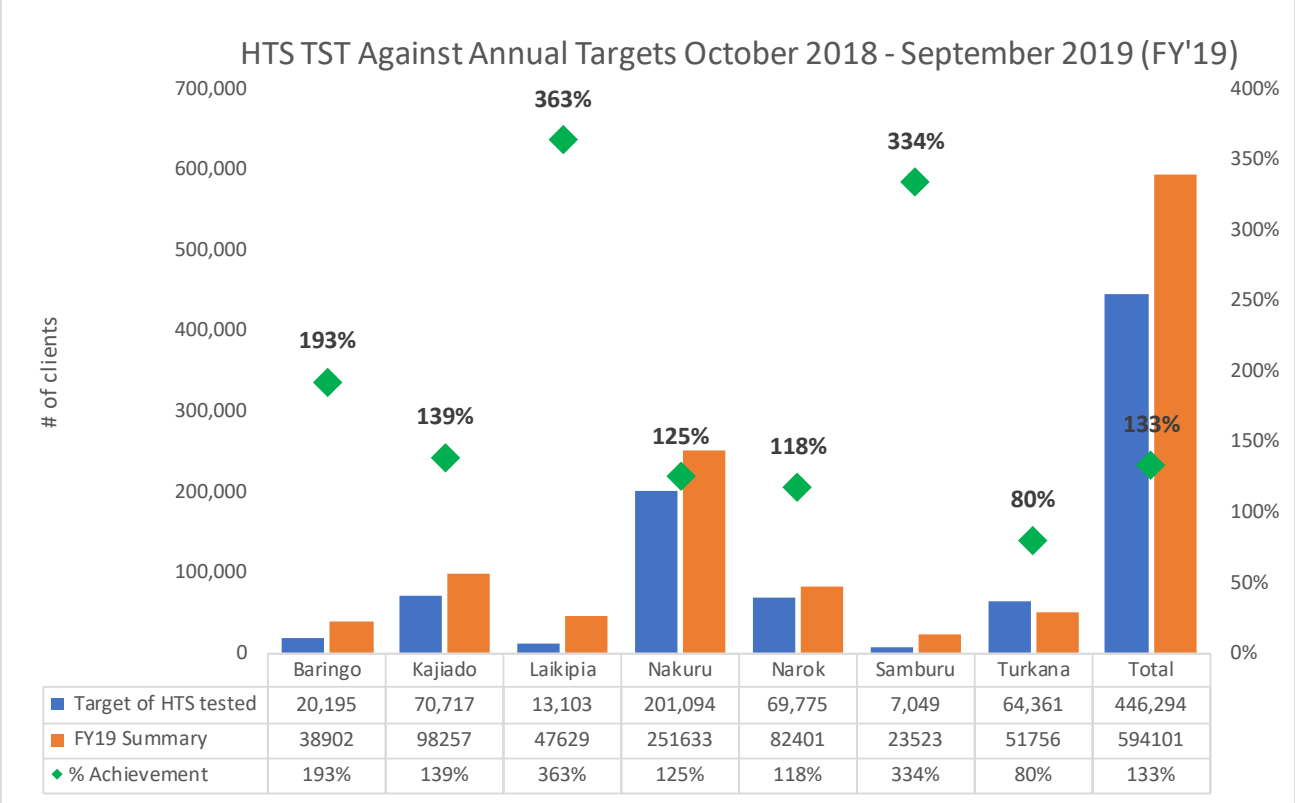


Figure 4:FY19 HTS_TST Performance against Annual target (Oct '18 - Sep'19

Figure 5 below shows a reduction in HIV testing and increase in yield in FY19, compared to high HIV testing and lower yield in FY18.

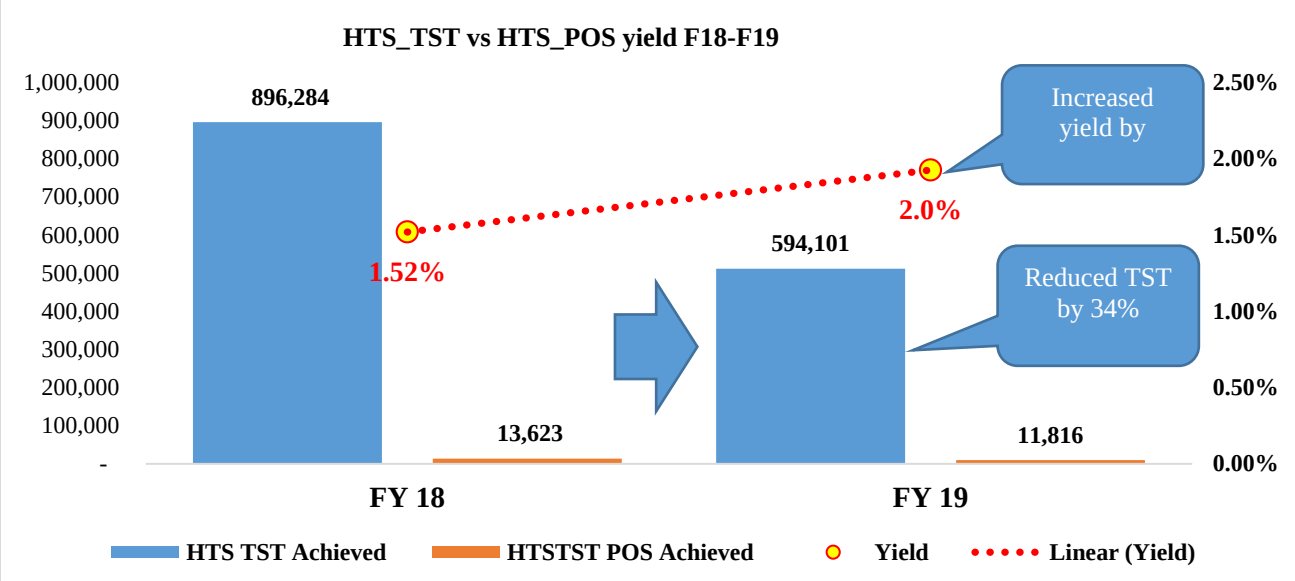


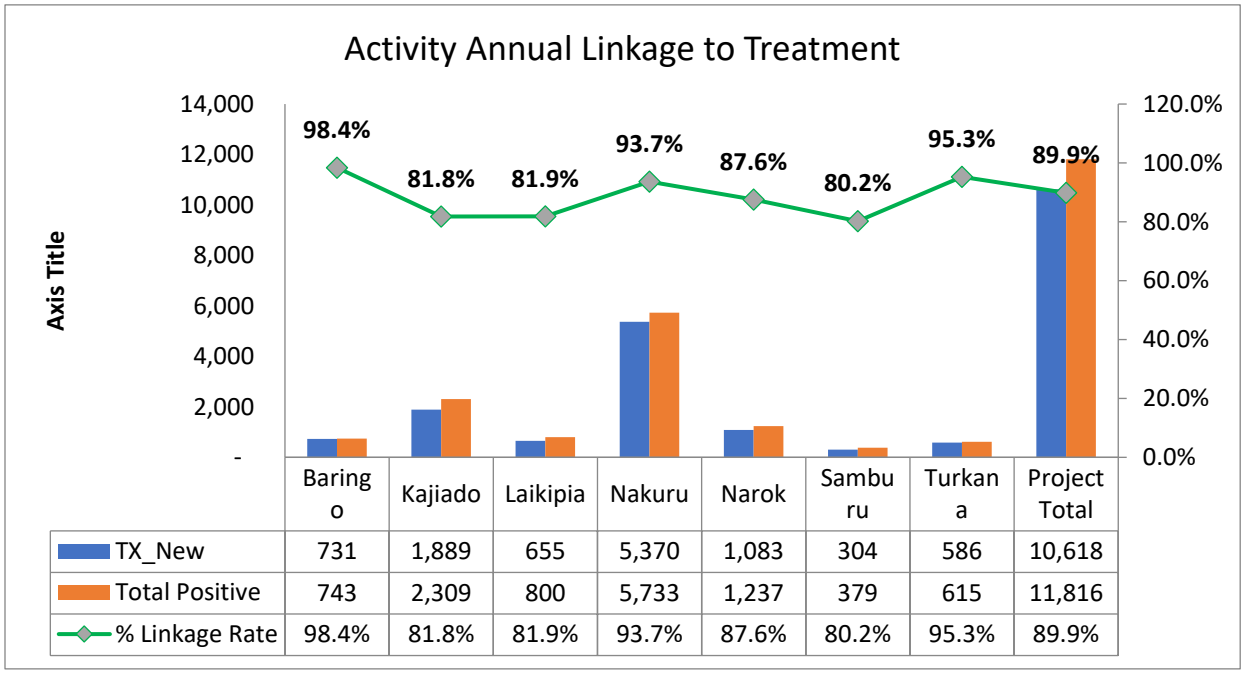
Figure 5: Comparative Analysis of reduced HIV testing and increased yield in FY19 compared to high HIV testing and low yield in FY18

Figure 6 shows the HIV positive achievements per county against targets. Overall, the Activity over-achieved the set targets for HTS_POS for the period Oct 2018 to Sep 2019. There was improved identification in quarter 3 and 4 of FY19.

County	Target of HTS_POS (DATIM Target)	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	FY19 Summary	% Achievement
Baringo	411	169	157	201	216	**743**	**181%**
Kajiado	1,962	506	588	564	651	**2,309**	**118%**
Laikipia	198	143	242	191	224	**800**	**404%**
Nakuru	4,518	1,228	1,457	1,569	1,479	**5,733**	**127%**
Narok	1,575	287	324	336	290	**1,237**	**79%**
Samburu	139	69	83	101	126	**379**	**273%**
Turkana	1,066	135	165	166	149	**615**	**58%**
Project	**9,869**	**2,537**	**3,016**	**3,128**	**3,135**	**11,816**	**120%**

Figure 6:Achievement of HTS_POS against targets by County Oct 2018- Sep 2019

Of those who tested HIV positive, 10,618 (90%) were initiated on ART. Figure 7 below shows linkage by county



	Baringo	Kajiado	Laikipia	Nakuru	Narok	Samburu	Turkana	Project Total
TX_New	731	1,889	655	5,370	1,083	304	586	10,618
Total Positive	743	2,309	800	5,733	1,237	379	615	11,816
% Linkage Rate	98.4%	81.8%	81.9%	93.7%	87.6%	80.2%	95.3%	89.9%

Figure 7: Linkage by County Oct 2018-Sep 2019

Overall, the linkage rate for the Activity was 90% with best linkage in Baringo County while the worst linkage was in Samburu County. In the coming quarter, more effort will be put in patient preparation, individual case management and tailor-made care for each patient to improve linkage and retention.

From the data analyzed by end of Oct 2019, HTS index testing had the highest yield at close to 20% with 13% contribution to ALL new patients put on treatment. While other PITC HTS contributed the highest absolute numbers started on ARRT, the positivity was only 1.7%. other important entry points to HIV care included PMTCT and VCT with a contribution of 10% each while positivity in the TB clinic was high at 13%. These areas need more targeting to ensure no missed opportunities. Table 2 below provides more details on testing modality, yield and contribution to TX_New.

Table 2: Testing and HTS positivity/yield by Modality

Testing Modality	# Tested	# Positive	Contribution to TX New	Percentage Yield (%)
HTS - Emergency Ward	2,873	52	0.4%	1.8%
HTS - Index Testing	7,726	1,517	12.8%	19.6%
HTS - Inpatient Services	37,885	781	6.6%	2.1%
HTS - Malnutrition clinics	329	3	0.0%	0.9%
HTS - Other PITC	361,422	6,076	51.4%	1.7%
HTS - Pediatric Services	3,057	28	0.2%	0.9%
HTS - PMTCT (ANC Only) Clinics	106,850	1,220	10.3%	1.1%
HTS - STI	2,784	33	0.3%	1.2%
HTS - TB Clinics	5,125	681	5.8%	13.3%
HTS - VCT	57,812	1,207	10.2%	2.1%
HTS - VMMC Services	2,546	6	0.1%	0.2%
PITC-PMTCT POST ANC1	5,692	212	1.8%	3.7%
Total	**594,101**	**11,816**	100.0%	2.0%

Table 2: Testing and HTS positivity/yield by Modality

Intensify identification of HIV-positive children (under 0-9yrs):

A total of 24,222 children under 10 years of age were tested for HIV, excluding Early Infant Diagnosis (EID) through Polymerase Chain Reaction (PCR) testing in by end of Q4 2019. Of those tested, 523 (2.2%) new HIV positive children were identified. A total of 456 (87%) children were initiated on ART.

Intensify identification of HIV-positive adolescents (10-19 years).:
During this financial year, 88,991 adolescents aged 10-19 years were tested for HIV, with 527 (0.6%) receiving positive results; 87% of these were linked to ART. These achievements are attributed to the on-job-training (OJT) and mentorship, integration of adolescent and youth friendly services in high-volume facilities, as well as engagement of 59 adolescent champions across the seven counties. The Activity will aim to increase linkage rate to 100% amongst this population in FY20 by implementing the best practices experienced in FY19.

Activity 2.2 Index /sexual network/ family testing at the facility and community level
The Activity mentored 575 HCWs on aPNS across the seven counties, out of whom 169 were HTS counselors to scale up aPNS through optimizing screening of index clients, elicitation skills and testing approaches for the eligible clients. The aPNS mentorship also focused on proper documentation using the new aPNS tracking log and categorization of clients by type of index including: newly identified HIV positives and known positives, TBHIV patients, PMTCT Clients, patients with suspected treatment failure (STF), discordant couples or lost to follow up returned to care to increase elicitation. As a result, 1,297 HIV positive clients were newly identified through PNS from the 11,009 contacts elicited with an elicitation ratio of 1:1.5. Of the contacts elicited, 9,522 were eligible for testing, 4,791 (50%) were tested. Of those tested, 1,297 (27%) tested HIV positive and 1,263 (97%) were linked to ART as shown in Figure 8 below.

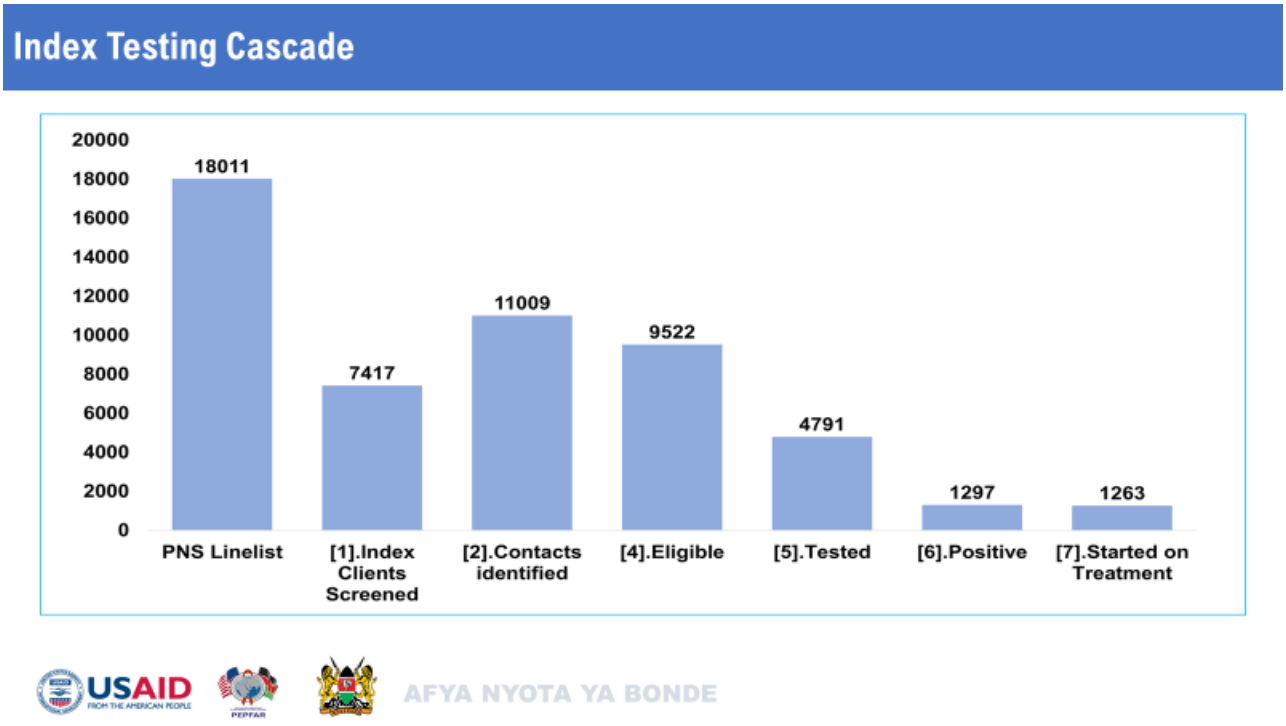


Figure 8: PNS Cascade for Oct'18 - Sep'19

The Activity will continue to scale up the implementation of aPNS through enhancing multi-elicitation of contacts by ALL service providers and through buddy mentorship programs where aPNS champions will be assigned to oversee the implementation in collaboration with the rest of the MDT. For newly diagnosed clients, PNS counsellors and clinicians will be assigned to ensure that elicitation and testing of the sexual contacts and biological children is done. This will include line listing of all the newly diagnosed clients into the new aPNS tracking log. For Known Positives (KPs), PNS champion have been assigned to work closely with the facility MDTs (i.e. clinicians, nurses, mentor mothers, mentor fathers, etc.) to ensure multi-elicitation of sexual networks by all providers as per the various client categories such as suspected treatment failures (STFs), PMTCT mothers, discordant couples and TB patients as well as Sexually Transmitted Infection (STI) clients. During the period under review, all the seven supported counties received HIV self-testing (HIVST) kits which were distributed to 307 facilities. A total of 577 HCW were trained and mentored on HIV self-testing. This included distribution of reporting and documentation registers with an aim of reaching out to the targeted population. Of the 10,070 kits were issued to clients reaching 38% of the set target.

Activity 2.3. Increase HTS among pregnant and breastfeeding women

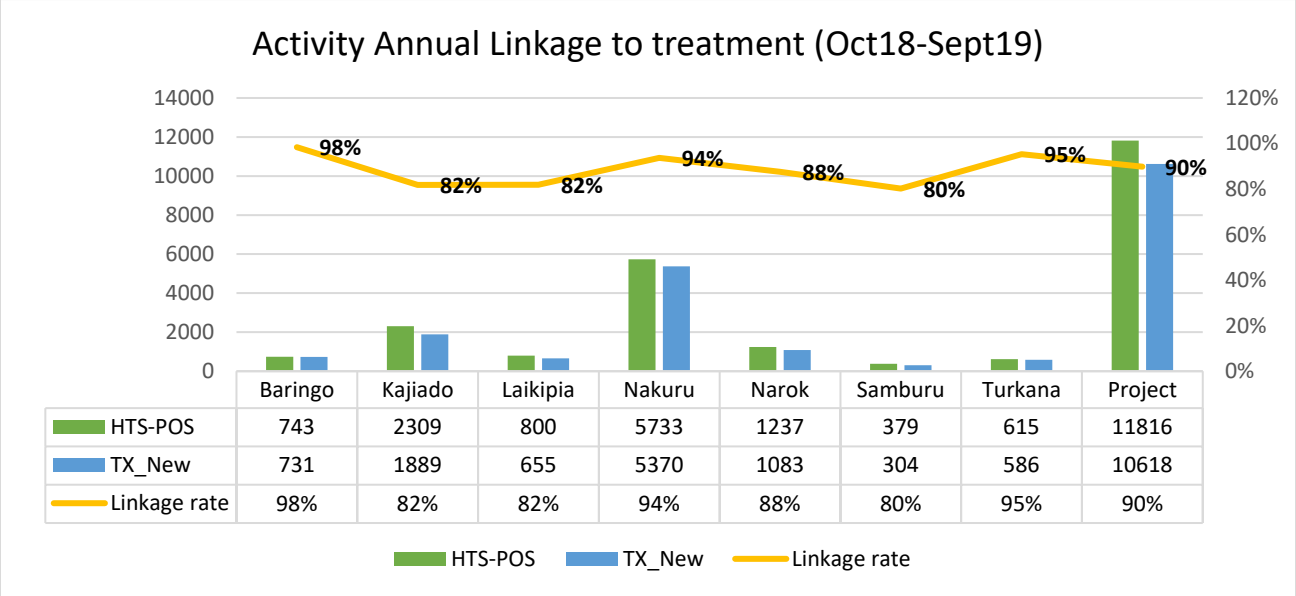
By end of Q4 of FY 19, a total of 108,989clients had their HIV status known, including 1786 known positives in ANC translating to an achievement of 72% against the annual target of 125,783. A total of 1205 mothers had HIV positive results and were immediately linked and initiated on ART; 1,457 male partners were tested at the Ante-Natal Clinic (ANC) clinics with 1.2% (18) testing HIV positive HIV. The Activity engaged 63 Community Health Volunteers (CHVs), 99 mentor mothers and 39 mentor fathers as community MNCH/PMTCT champions to enhance ANC/Post Natal Care (PNC) HTS uptake, linkage to care and treatment, adherence support, as well as facilitate case management and male involvement in PMTCT. In addition, the Activity continued to strengthen the 41 family clinics within ANC settings. In the subsequent quarter, the Activity will encourage pregnant mothers to bring a friend who they suspect to be pregnant in order to improve coverage. Additionally, the CHVs engaged by the counties will be utilized to refer women who may not be attending ANC to access services.

Activity 2.4 Link HIV-positive clients to care

A total of 10,618 clients were newly initiated on ART by end of Q4 in FY19, out of the 11,816 individuals newly diagnosed HIV positive in the year, giving a crude overall linkage rate of 90%. The linkage rate for the respective counties were as follows: Baringo 98%, Kajiado 82%, Laikipia 82%, Nakuru 94%, Narok 88%, Turkana 95% and Samburu 80%. The Activity will align implementation of surge strategy to improve linkage rate to above 95% by identifying sites with the most unlinked patients, line listing the patients, assign case managers to contact them for linkage. Additionally, treatment preparation will be intensified to ensure newly diagnosed patients are ready for life-long ART. A case manager will also be assigned for each new client to walk with them for the first 6 months to ensure they settle better into life-long ART.

OBJECTIVE 3: IMPROVED LINKAGE TO TREATMENT FOR INDIVIDUALS NEWLY TESTING HIV POSITIVE

In Q4 of FY19, the Activity continued scaling up key indicators on the journey to self-reliance in line with Country Operation Plan (COP) 18. This included increasing the number of individuals initiated on treatment and reaching out underserved populations such as pediatrics, adolescents, youth, and Adolescent Girls and Young Women (AGYW) who are largely hindered by varied barriers towards optimal access and linkage to treatment. By the end of that quarter, a total of 11,816 people had been newly diagnosed with HIV of which 3,135 (27%) were diagnosed in Q4 alone. The SURGE strategy implemented from Q3 and continued in Q4 contributed largely to this achievement. By the end of Q4, the Activity initiated 10,618 new clients on ART against an annual target of 10,550 in the 198 ART sites across the seven counties translating to a 101% achievement. 2,885 (27%) of all clients initiated on ART were reached in Q4. The overall linkage rate improved from 89% in Q1 to 92% in Q4. Overall, 90% of newly diagnosed clients were initiated on ART. The improvement is attributed to implementation of various strategies key among them test and start, engagement of linkage facilitators and case managers on enrollment, tracking client level linkage data, follow-up and monitoring of early retention to address any gaps in real time.
Figure 9 below summarizes the Activity's FY19 linkage rate across the seven counties.



	Baringo	Kajiado	Laikipia	Nakuru	Narok	Samburu	Turkana	Project
HTS-POS	743	2309	800	5733	1237	379	615	11816
TX_New	731	1889	655	5370	1083	304	586	10618
Linkage rate	98%	82%	82%	94%	88%	80%	95%	90%

Figure 9: Oct'18 - Sept'19 ART Linkage Rate Per County

Figure 9 shows Afya Nyota ya Bonde linkage rate before surge and during surge implementation period.

Activity 3.1: No-missed-opportunity approach to ART enrollment

The less than 90% linkage rates in Kajiado, Laikipia, Narok and Samburu counties in FY19 was largely attributed to: 1) more HTS sites identifying patients compared to ART sites hence distance from ART sites; 2) geographical and communication challenges limiting follow-up of clients for

linkage into treatment – these being significant in the vast rural pastoralist communities in Samburu, Laikipia and Narok counties; 3) facilities where the project only reports HTS and not ART in DATIM 4) religious and cultural beliefs; lack of disclosure and increased stigma; and 5) non-stringent follow-up of clients identified in the inpatient wards. Mentorship on updating of the locator information on the client locator forms is ongoing with regular follow up at every patient encounter. A total of 184 service providers were trained on psychosocial support, 2,406 on ART, 1,033 on Differentiated Service Delivery (DSD). In addition, assorted job aids and SOPs were distributed to all supported facilities to address acceptance, disclosure, self-stigmatization and beliefs in a respectful manner to social and cultural sensitivities. The Activity also engaged CHVs from selected link facilities and community units (CUs) to better educate and address societal values to acceptance, reduce stigma and create a supportive environment to positive living. These efforts have led to establishment of 232 community ART groups by the activity.

During the reporting period, the Activity further put in place the following strategies to improve linkage to ART; Scale up of test and start, intensive tracking of unlinked clients, daily accounting of new HIV positive clients not linked in the 90 surge sites with weekly tracking in non-surge facilities, and tasking follow-up and management of treatment initiation barriers to the entire team. The clients who were not linked within a specific duration were put on active follow-up list towards definitive linkage outcomes with challenging cases escalated to alternate team members with a good rapport with the patients for further management actions. All newly initiated clients on ART were assigned case managers for closer follow up and addressing of emerging barriers to linkage. As a result, 10,618 (101%) clients were newly initiated on ART against an annual target of 10,550. The reboot counties (i.e. Nakuru, Kajiado, Samburu, Narok and Turkana) started 9,583 clients on ART, being 96% of all new on ART whereas while the sustained counties of Laikipia and Baringo started 1,035 clients on treatment.

In addition, the Activity intensified linkage efforts and case management for clients identified in the inpatient - being one of the areas noted to have lower comparable linkage rates, by tasking specific case managers to follow-up on all clients identified in the IPD and ensure 100% linkage. This was aimed at increasing early ART initiation. Table 3 shows TX_NEW achievements per county

Table 3: Oct'18 - Sep'19 TX_New Achievement per county against DATIM Annual Target

County	Target of New on ART (DATIM Target)	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	FY19 Summary	% Achievement
Baringo	416	167	162	199	203	731	176%
Kajiado	2,113	397	498	463	531	1,889	89%
Laikipia	236	132	161	163	199	655	278%
Nakuru	4,919	1,123	1,363	1,455	1,429	5,370	109%
Narok	1,462	244	278	300	261	1,083	74%
Samburu	156	59	63	64	118	304	195%
Turkana	1,248	130	146	166	144	586	47%
Project	10,550	2,252	2,671	2,810	2,885	10,618	101%
Scale-up Counties	9,978	2,026	2,446	2,547	2,564	9,583	96%
Sustainance Counties	572	226	225	263	321	1,035	181%
High Volume sites	9,590	1,909	2,166	2,363	2,422	8,860	92%

Females aged 30-34 accounted for 12% of all new clients initiated on ART – being the highest for the female population, whereas males aged 30 – 34 years accounted for 6.5% being the highest for the male population. This most likely account for the groups with notable risk exposure and make for a case for better targeting to close the gap of unmet need. Children accounted for 4% (434), AYPs (10-24 years) accounted for 16% (1,688), AGYW accounted for 13% (1,395) of all new patients on ART. Linkage rates among children, AYPs and AGYW was 120%, 91% and 92% respectively. These linkage rates show good progress towards the activity's goal of increasing linkage to treatment of these populations of interest by minimizing associated barriers. Overall, females had better linkage compared to males across all age sets. This needs further analysis to identify the barriers or contributing factors. To reduce missed opportunities for ART initiation, the Activity will continue to enhance patient preparation at time of diagnosis, assign a case manage to each new client, provide escorted referrals, call patients in the immediate post initiation period to address any stress issues the patient may be going through and ensure that the patients feel comfortable to call or come to the facility any time they have a problem or just need to talk. Efforts will be put in place to engage communities to improve care seeking behaviors to reduce the delays in seeking HIV care.

Activity 3.2 Increase ART uptake among HIV Positive Children

In the period under review, a total of 2,406 HCWs were mentored on comprehensive ART guidelines including management of HIV in children, 2,034 HCWs on PMTCT and trained 184 counselors on pediatric psychosocial support. In collaboration with NHP*plus*, the Activity provided nutrition support towards better uptake of ART and retention in therapy, with 482 HCWs mentored on management of acute malnutrition. The Activity further supported pediatric clinic corners, clinic days and enhanced pediatric play group sessions across the 7 counties. A total of 434 children were initiated on ART in FY19 against 361 newly diagnosed HIV positive, giving a linkage rate of 121%. The above 100% linkage is attributed to <1 year children diagnosed through DNA PCR and started on ART. This is attributed to having 72 specific pediatric clinics, 31 facilities offering family clinic days, weekend clinics offered by 26 facilities, and afterhours clinics

offered by 19 facilities. The Activity supported pediatric psychosocial support groups (PSSG) across the seven counties.
The Activity also focused on regimen optimization for this age group towards more palatable and easily tolerable first line regimens to improve uptake of ART in this age group. This has led to 2,269 pediatric being active on ART by end of Q4 in FY19.

Activity 3.3: Increase ART Uptake among HIV Positive Adolescents

The Activity implemented various strategies focused on empowering adolescents to champion their right to treatment, service delivery options and support structures, and strong networks and initiatives to improve adherence to ART. As a result, there are a total of there are 78 functional adolescent stand-alone clinics, 18 youth friendly centers, 79 facilities offering youth responsive services, 26 facilities offering weekend clinics, and a further 19 offering extended hours' clinics. The Activity also continued to support AYP support groups with a focus establishing Operation Triple Zero (OTZ) clubs towards zero missed appointments, zero missed drugs, and zero viral load. In line with this, a total of 30 service providers were trained on OTZ and rolled out the services in 9 facilities in the month of September in Nakuru county. In addition, the Activity supported 59 adolescent champions across the seven counties who have been essential in increasing uptake of ART in this age group, providing peer/buddy support, stewardship of the support groups, case management, early and long-term retention in ART, as well as improving VL suppression. As a result, 457 adolescents (10-19) were newly initiated on ART against 526 newly identified HIV positive in the year, representing a linkage rate of 87% compared to 83% reported in FY18. As at APR, there were 4,290 adolescents currently on ART with 2738 of them being beneficiaries of standalone adolescent clinics while 1991 benefited from the youth responsive clinics/services. The 12 months retention rate for adolescents in support groups was 95% compared to 73% in the general adolescent subset. The viral suppression rate on the other hand was 78% compared to 74% for the general adolescents as at June 2019. The Activity will scale-up AYP support groups to increase coverage in FY20.

Activity 3.4: TB/HIV co-infection services

Early identification, treatment and prevention: In FY19, the Activity continued to support TB identification and treatment services in 198 sites across the seven counties towards the targets to end TB epidemic in the country through accelerated response and care championed by NTLD program. This involved the implementation of case finding, TB/HIV co-infection evaluation, provision of IPT and TB treatment for those diagnosed with TB and ART initiation for those co-infected with HIV. By the end of Q4, a total of 5,988 TB people with active TB were identified through active case finding in the health facilities, translating to a 109% achievement against the annual target of 5,503. Of the TB patients identified, 5,772 (96%) had documented HIV status representing an 104% achievement against the annual target of 5,538, out of which 1,333 were HIV positive (23% co-infection rate).Of the 1,333 TB/HIV co-infected clients, 93% (1,246) were on ART during TB treatment which translates to 82% achievement against the annual target of 1524. Figure 11 below shows the TB/HIV cascade

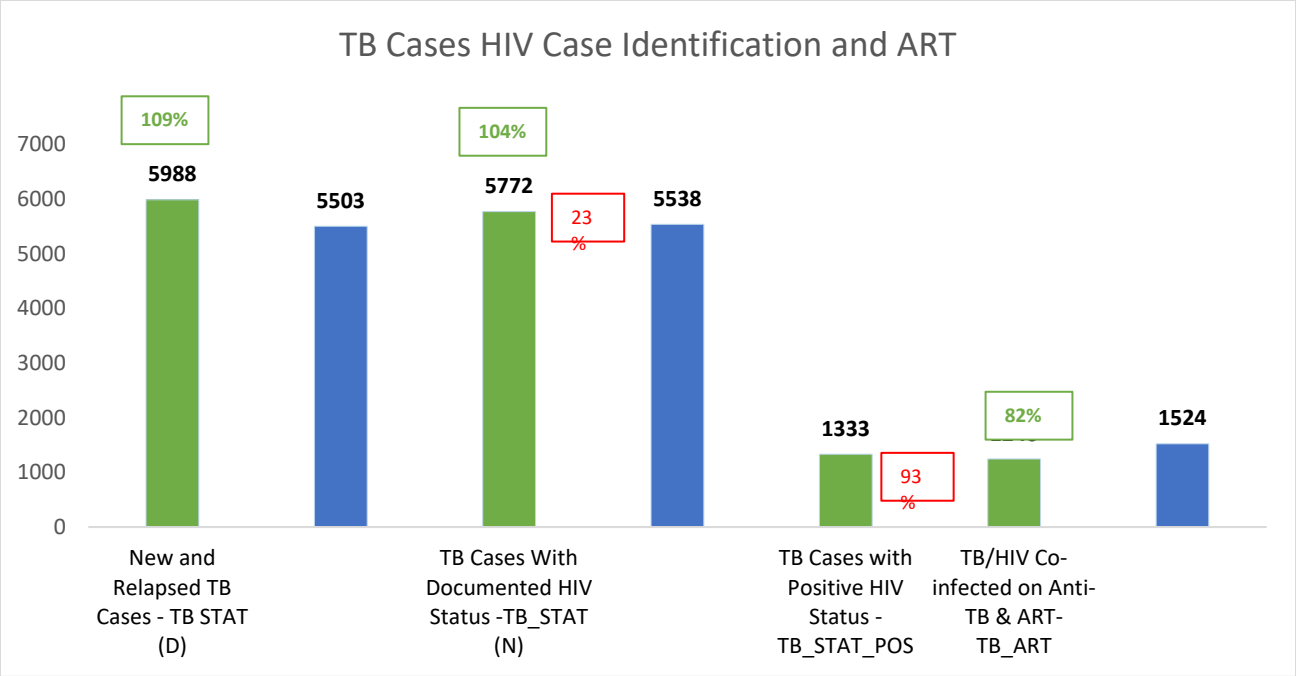


Figure 10: Oct'18 -Sep'19 TB_STAT and TB_ART Cascade

In the period Oct 18 to Sept 19, the Activity focused on intensified TB case finding amongst HIV positive clients receiving ART in the supported facilities. As a result, 63,793 clients were screened for TB in their last clinic visits across the seven counties which is 97% of all clients who are currently active on ART (65,772). In the period ending June 2019, a total of 956 (1.5%) PLHIV had a positive TB screen, out of which 775 (81%) had a sample sent for diagnosis of active TB infection. Of these samples, 348 had a smear only assay while 427(56%) were assayed using GeneXpert. Key to note is that only 45% clients screening positive had a GeneXpert done. Amongst the 775 samples assayed, 526 returned positive at 68% TB positivity rate amongst those assayed and 55% amongst those screened positive. Of the initial 62,200 screened for TB, 956 were initiated on TB treatment, 430 from a clinical diagnosis and 526 from sample positive results. The number of ART clients completing a course of TB preventive therapy (IPT) in the reporting period was 8407 representing 82% achievement of the 10,203 targets.

In the same period, there were 173 sites offering TB/HIV integrated services, benefitting 18,764 clients; with mentorship of 1,994 HCW's on TB care and 751 on commodities including TB commodities management. To address data quality issues, the Activity continued to support SCMLT and other key facility personnel on data verification and upload to the TIBU system to ensure timely accurate and quality data, as well mentorship on reporting IPT on Kenya Health Information System (KHIS), commodity reporting and adherence to SOPs.

Expanding intervention to increase screening and diagnosis of TB

In FY19, a total of 20,390 GeneXpert samples were processed in the Activity supported laboratory hubs compared to 23,791 in FY 18. The TAT for relaying of results was 48 hours which was a comparatively better TAT down from an average of four days. This is attributed to improved access of GeneXpert results processing made possible by the enhancement of capacity of various centers to process these results and through coordination for effective transportation of samples

and results across the supported sites. The GeneXpert machines utilization rates for each county compared to the national target of 80% was as follows: Nakuru 65%, Narok 69%, Kajiado 69%, Laikipia 72%, Turkana 31%, Baringo 57% and Samburu 39%. Underutilization in all the counties is attributed to stock out of cartridges experienced in all the GeneXpert hubs and equipment downtime in some sites. In order to improve uptake of GeneXpert, the Activity will continue to provide mentorship and CMEs to HCWs to improve the use of GeneXpert algorithm for TB diagnosis, documentation and laboratory sample networking as well as improved commodity reporting through the GXLIMS platform. Additionally, the Activity will work closely with CHMLTs/SCMLTs and Lab focal persons to co-plan, co-create interventions in order to move towards sustainability

Activity 3.5 Reach children with TB screening and diagnosis.

The Activity actively screened and evaluated children for TB infection through enhancing capacity of 1,031 HCW's on diagnosis and managing of TB including sputum induction and use of clinical symptoms to start TB treatment among children. SOPs, current TB guidelines and job aids highlighting GeneXpert algorithm on management of TB in children were also provided to further support self-learning. The Activity further supported various laboratories to facilitate TB screening and diagnosis amongst children through provision of additional lab personnel, clinical screening tools, tuberculin skin test, radiography and sample assays to screen and diagnose TB. In addition, the Activity collaborated with the national TB program and TB ARC to provide easy to use pediatric formulations including fixed dose combination anti-TB drugs and dispersible ethambutol. Mentorship of HCW was conducted to facilitate scale up of tuberculin skin test to aid diagnosis especially in children, improve index contact tracing by ICF for symptomatic children of index clients and children living with HIV. As a result, 583 children were screened for TB in FY19, out of which 349 were diagnosed with TB. In addition, 96 facilities implemented integration of TB services into MCH and pediatric wards. Since children, especially those below 5 years are unable to produce sputum, the Activity will continue to emphasize clinical diagnosis to ensure there are no delays in initiating TB treatment for those likely to have TB.

Activity 3.6 Link HIV-positive and TB clients with nutritional assessment.

In FY19, the Activity continued offering nutrition services in all the 198 supported ART sites with nutritional assessment highlighted as part of the standard package of care for PLHIV with requisite documentation in every clinical visit. A total of 14 nutritionists across the seven counties were facilitated to provide nutritional assessment and counselling services (NACS) to all PLHIV and TB clients at every clinical visit as well as offer mentorship to HCWs on promotion of good dietary practices, proper documentation in all relevant tools. The Activity also collaborated with NHP*plus* to access therapeutic supplementary feeds for PLHIV and TB clients. In addition, 482 HCWs were mentored on diagnosis, management and prevention of acute malnutrition, and facilitated to refer and follow-up patients.

OBJECTIVE 4: INCREASED UPTAKE OF AND ADHERENCE TO QUALITY HIV TREATMENT SERVICES

Activity 4.1 Health Commodities

The monthly ARVs allocation model at the county level is working well and demonstrated increased data ownership and interrogation among the subcounty pharmacists and county pharmacist. All supported counties were able to do ARV allocations at county level. During this reporting period, the Activity facilitated commodity security TWG quarterly meetings in five counties except Baringo and Narok. The Nakuru county TWG was co-facilitated by NASCOP and the Activity team. Items discussed and reviewed included KHIS ARV commodity reporting rates, data sets allocation, data quality, forecasting and quantification with focus on months of stock levels and RTK/FP/Malaria/TB/Essential Medicine and Medical Supplies (EMMS) commodity stock status. ART optimization progress, pharmacovigilance and environmental mitigation were also discussed. The TWGs noted that improved ART/RTK/FP KHIS reporting rates have resulted in uninterrupted availability of commodities and sustained service delivery. There was noted short expiry stocks of RTKs. However, the stocks of LPV/r 200/50mg, Nevirapine suspension and anti-TB drugs RHZ were adequate and facilities have started to build their stocking levels with the start of receiving back orders from KEMSA. During the Nakuru County TWG meetings, the Activity in collaboration with NASCOP facilitated counties on upgrading ordering sites as a follow-on action to strengthen the devolved ARV supply chain allocation platform. There were adequate commodities in the facilities to facilitate ART optimization.

There was continued engagement with KEMSA on post ART commodity supply in Nakuru county. KEMSA/Afya Nyota ya Bonde jointly visited 10 ten ordering sites for supportive supervision where HCWs were mentored on commodity management and excess commodities were redistributed. In addition, 375 HCWs from 126 facilities across the seven counties were reached with mentorship sessions on health commodities management focusing on ART optimization, stock control management, storage, timely reporting, and use of web ART Dispensing Tool (ADT) in 38 facilities. Ninety two percent (92%) of the 38 Web ADT systems were upgraded to version 3.4. The Activity also provided all the SCMLT and Sub-County Pharmacists with data bundles for monthly commodity reporting on KHIS and HCMP. This has resulted in an average reporting rate of 98% of MoH 730A and improved MoH 730B reporting rate from an average of 87% to 93% as shown below in Figure 11.

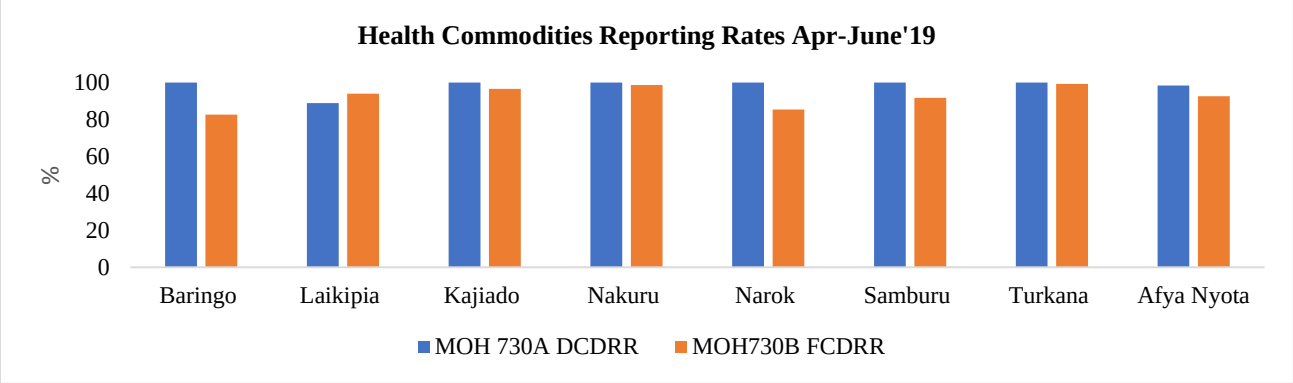


Figure 11:Health Commodity Reporting Rates for July-Sep 2019

As at the end of the reporting period, 91% of ART beneficiaries eligible for ART optimization had been transitioned. Facilities and sub-county Pharmacists continued to report on pharmacovigilance. During the quarter, one suspected ADR case on metronidazole was reported from Ololulunga sub-county hospital to Pharmacy and Poisons Board (PPB). There were no ARV-related Adverse Drug Reactions (ADRs).

ART Optimization by Regimen- 84 sites

Regimen Type		Clients on this Regimen at the End September 2019			
Adult ART 1st Regimen Line		Male	Female	Total	% Total/Tx_Curr
AF2E	TDF + 3TC + DTG	8471	13074	21545	52.8%
AF2B	TDF + 3TC + EFV	1152	14178	15330	37.5%
AF4B	ABC + 3TC + EFV	31	65	96	0.2%
AF4C	ABC + 3TC + DTG	14	26	40	0.1%
AF1D	AZT + 3TC + DTG	29	90	119	0.3%
AF1A	AZT + 3TC + NVP	163	473	636	1.6%
AF2A	TDF + 3TC + NVP	33	101	134	0.3%
AF2F	TDF + 3TC + LPV/r (*1L Adults <40kg*)	4	7	11	0.0%
AF4A	ABC + 3TC + NVP	1	5	6	0.0%
AF1B	AZT + 3TC + EFV	43	118	161	0.4%
AF2D	TDF + 3TC + ATV/r	476	751	1227	3.0%
AF5X	Any other 1st line Adult regimens	0	0	0	0.0%
AF2G	TDF + 3TC + RAL (*PWIDs intolerant to ATV*)	0	0	0	0.0%
AF2H	TDF + FTC + ATV/r	0	0	0	0.0%
Grand Total		10417	28888	39305	96.2%

91% on Current optimized regimen

Data Source: 84 sites
Period: as at September 2019

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Figure 12: Figure 13 highlights optimization progress- sample from 84 sites.

Figure 13 below shows KHIS reporting rates on HIV/FP/Malaria program commodities that fosters service integration.

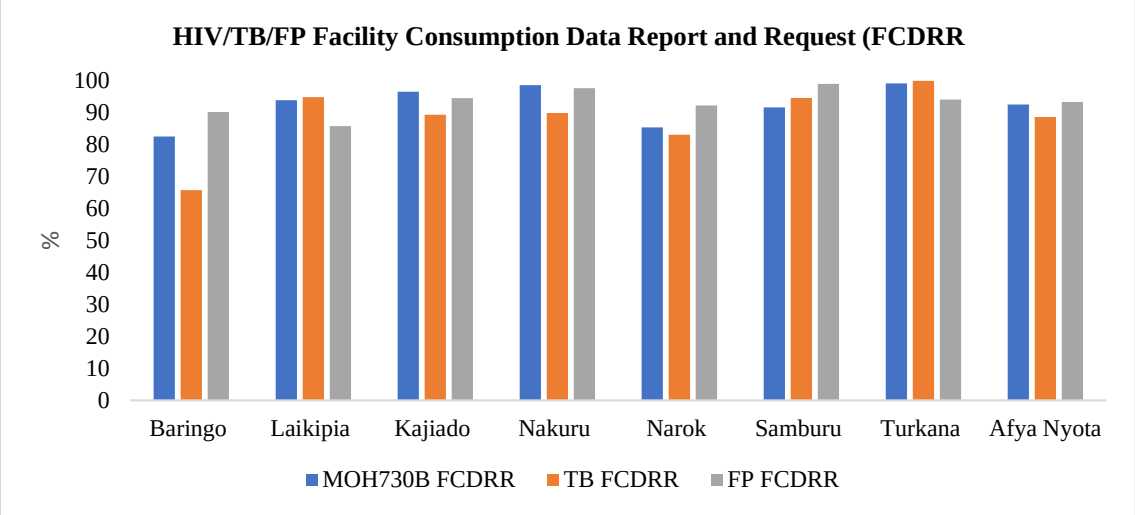


Figure 13: April - June 2019 HIV/FP/Malaria Commodity Reporting Rates per County

In collaboration with KEMSA/NASCOP, Clinton Health Access Initiative (CHAI) and other implementing partners, the Activity will continue to strengthen the capacity of HCWs to ensure real time forecasting and quantification, as well as work with county Health Records Information Officers (HRIOs), sub county pharmacists and KEMSA/NASCOP field officers in supporting monthly commodity allocation and reporting.

Activity 4.2 Laboratory Services and Networking

Afya Nyota ya Bonde continued to collaborate with National Public Health Laboratory Services (NPHLS) and FHI 360 CDC Laboratory Systems Strengthening (LSS) program in supporting External Quality Assessment (EQA) activities in 21 facilities within the Activity's area of coverage.

Activity 4.2.1 Strengthen lab networking and services

The Activity continued to facilitate shipment of CD4, Early Infant Diagnosis (EID), and Viral Load (VL) samples from the 194 ART sites to 14 laboratory hubs and three referral laboratories for analysis. At the same time, the Activity's MDTs across the seven counties mentored 280 HCWs on patient lab monitoring focusing on EID and VL algorithm as per the 2018 ART guidelines, use of VL for monitoring ART patients, timely reporting including submission of commodity reports through HCMP. During this reporting period, Nakuru and Narok counties experienced a 25 days delayed TAT of VL sample analysis and relay of results due to equipment down time and reagent stock outs at KEMRI/WRP Kericho Laboratory. However, the TAT for sample analysis and relay of results is still long (i.e. 15 days). This is because the laboratory had a long backlog of samples that has since ben cleared. TAT is expected to improve in the coming quarter. 61,009 (93%) of patients currently on ART received a viral load test. Of these, 87% were virally suppressed. 1064 clients consented to receive EID (175) and VL (889) results via SMS. Table 4 shows the number of samples shipped in the period April -Sep 2019.

Table 4: Number of samples Shipped in April - Sep 2019

COUNTY	CD4	GeneXpert	EID	Viral Load
Baringo	477	3,372	333	3,206
Kajiado	947	2,609	1,120	9,836
Laikipia	368	1,562	377	4,707
Nakuru	2,073	9,896	2,300	36,784
Narok	521	1,367	505	4,008
Samburu	132	1,111	62	1,006
Turkana	105	473	228	1,462
Total	**4,623**	**20,390**	**4,925**	**61,006**

Activity 4.2.2: Devolution of TB, EID, VL and CD4 tests

During the period under review, the Activity continued to work closely with UNITAID-EGPAF Point of Care Program in Turkana county to improve EID service uptake in the county. Effective July 2019, the UNITAID program has transitioned the POC EID Program in Kenya to Turkana

County Government which will take over the management of the POC EID program with the support from NASCOP and other stakeholders.

The Activity improved EID PCR online upload of results from the testing hubs through provision of data bundles to the laboratories to facilitate data upload to the NASCOP website. In the subsequent periods, the Activity will improve EID PCR online upload of results from the testing hubs through provision of data bundles to the laboratories to facilitate data upload to the NASCOP website. In addition, the Activity will continue to provide mentorship, OJT and supportive supervision to HCWs to create demand and improve utilization of 16 GeneXpert machines across the seven counties.

Activity 4.2.3 Laboratory quality and accreditation

The FHI 360-CDC laboratory services strengthening program and Afya Nyota ya Bonde supported 21 facilities in implementation of laboratory quality management systems and Continuous Quality Improvement (CQI) in four counties. Two of the facilities have undergone assessments by the conformity accreditation body – KENAS.

Activity 4.3 Prevention of Mother-to-Child Transmission of HIV

In this financial year (FY19), 109,326 clients attended the 1st ANC clinic, out of whom 108,949 (99.7%) clients had their HIV status known in ANC translating to 87% achievement against the annual target of 125,783. Among the 108,949clients whose HIV status was determined, 3319 were HIV positive. Of the3319women who were HIV positive at ANC, 3287 (99%) received ART to reduce the risk of mother to child transmission, whereas the rest 32 are actively on a follow-up to have them initiated on ART. This translates to achievement of 72% of the annual target of 4,593. 184 women were initiated on ART in the post-natal period. Table 5 shows county specific PMTCT testing achievement against the annual targets.

Table 5: Oct'18 – September '19 PMTCT_STAT Achievement against Annual Targets

County	Target of PMTCT_STAT (N)	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	FY19 Summary	% Achievement
Baringo	10980	1903	2,191	2,069	1,958	**8,121**	**74%**
Kajiado	25531	5618	6,825	6,284	6,016	**24,743**	**97%**
Laikipia	11072	1567	2,241	2,022	1,930	**7,760**	**70%**
Nakuru	50999	10668	12,281	11,261	12,046	**46,256**	**91%**
Narok	14102	3011	3,794	3,500	3,443	**13,748**	**97%**
Samburu	6475	992	1,170	1,007	1,310	**4,479**	**69%**
Turkana	6624	697	1240	945	960	**3,842**	**58%**
Project	**125,783**	**24,456**	**29,742**	**27,088**	**27,663**	**108,949**	**87%**

Figure 14 below shows maternal cascade for the period Oct18-Sep19.

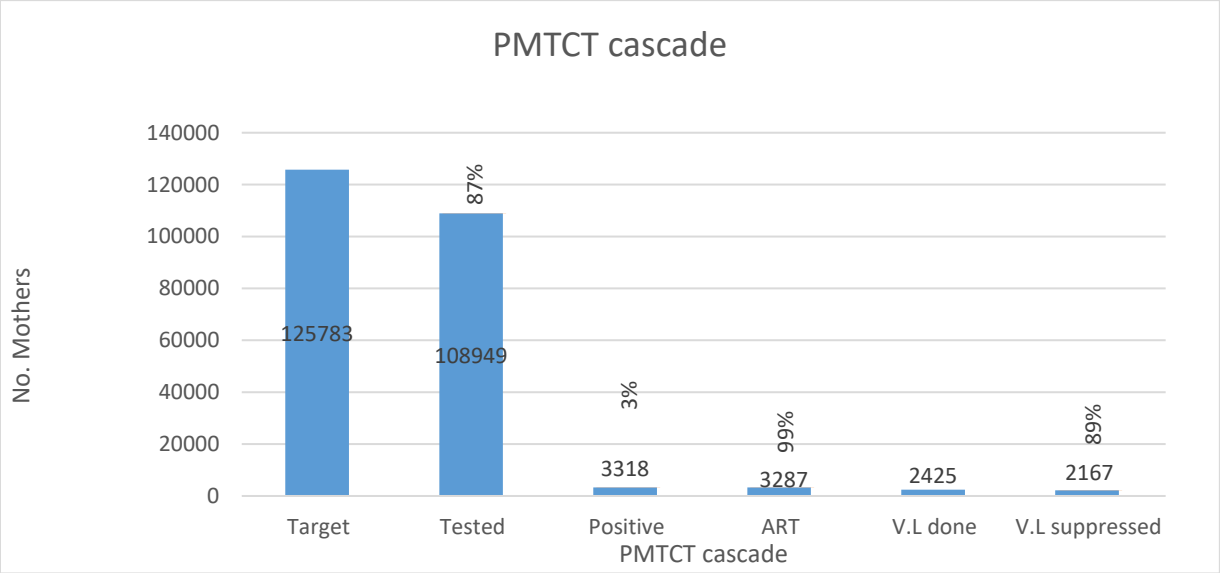


Figure 14: Oct'18 - September'19 PMTCT Maternal Cascade

Activity 4.3.1 Increase uptake of PMTCT services including EID

At the end of Q4, a total of 3,319 women were identified as HIV infected translating to a positivity of 3%. Of these, 3,287 (99%) received ARVs to reduce mother to child transmission of HIV. The Activity reports data from 229 of the 800 PMTCT sites in the seven counties. This, therefore, means that the target of 125,783 is unlikely to be met from the reporting sites. Narok and Kajiado counties have 97% PMTCT STAT achievement while Turkana County had a much lower achievement at 58%

Activity 4.3.2 Increase uptake of EID services by two months:

In the period under review, a total of 3,104 infants aged 0-12 months of age were enrolled for EID follow up. Of those enrolled, 2,386 (77%)) had their initial PCR done at 2 months of age and below, while 718 (23%) had their PCR done at 2-12 months of age. The infants testing at <2 months of age had a positivity of 1.9% while those testing at >2 months of age had a positivity of 5.6% (>3x of those being reached earlier). This requires concerted efforts to ensure at least 90% of the infants are reached earlier to improve outcomes. The Activity will focus of pregnancy intension assessment among women of reproductive age attending comprehensive care clinics and will also intensify screening at immunization clinics to reach those being missed at ante-natal care. Targeted outreaches in hard to reach areas will also be done aiming at reaching pregnant women earlier. Linkage to care and treatment is also low for infants testing HIV positive and will be an area f focus in the coming quarter.

Figure 16 shows HEI testing uptake for different ages for HIV exposed infants.

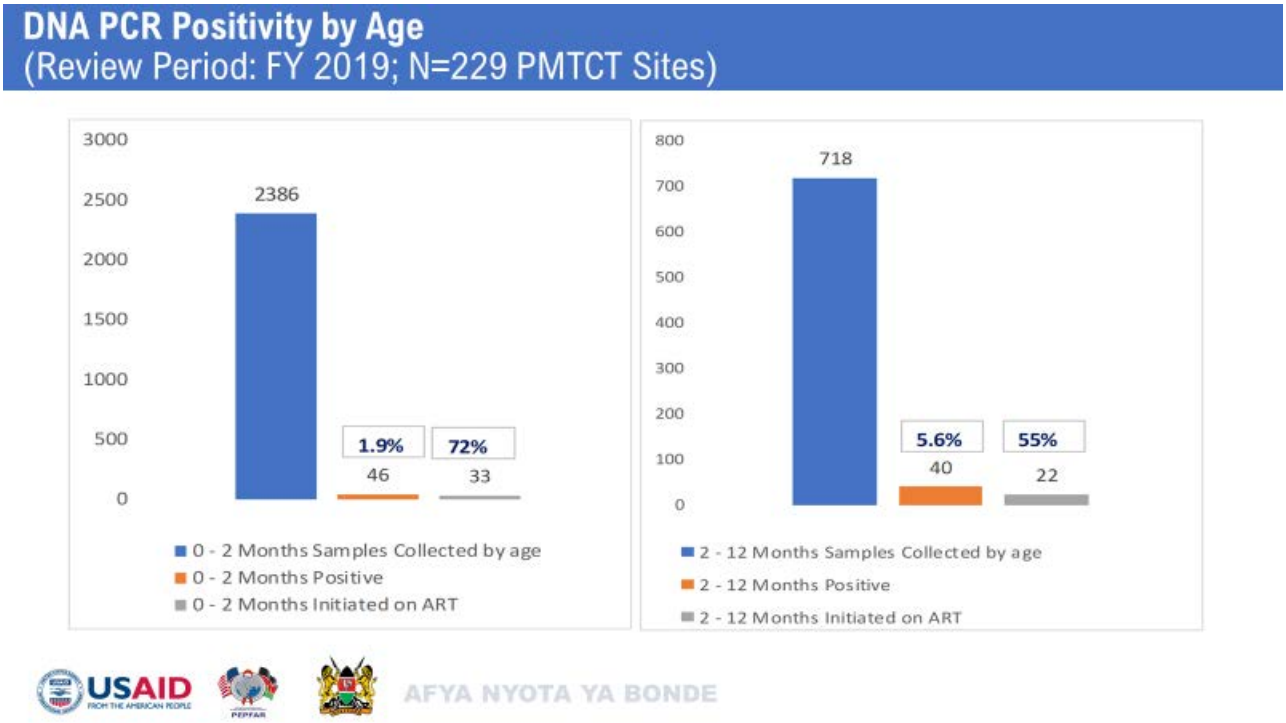


Figure 15: Oct'18 - Sep'19 HEI Testing and Positivity by age

There were 166 HEI who had a positive PCR result in FY19 across the testing cascade. A total of 133(80%) were initial PCR, 13(8%) were 2nd PCR and 20(12%), were 3rd PCR testing positive. Of the 166 PCR positive HEI, 159(96%) had a validation outcome, of whom 7(%) had a death outcome, with 3(2%) adult samples. Of the remaining 156 eligible for enrolment, 126(81%) were enrolled and initiated on ARVs. Nakuru county contributed to 45% of the overall positives while Samburu county was the least contributor at 2% of the overall total positive tests. The rest of the counties' distribution was 20(12%) from Baringo county, 24(14%) from Kajiado, 13(8%) from Laikipia, 19(11%) from Narok, and 7% from Turkana. The Activity will focus on a deeper EID audit for the death and positive outcomes especially among the 38 High burdened facilities identified.

Activity 4.3.3: Improve retention of mother-baby pairs

There were 1,008 HEIs who were enrolled from 124 facilities between October 2017 and June 2018. Of these, 887 (88%) received infant prophylaxis within 0-6 weeks, and 834 (83%) received virologic test within the recommended 6-8 weeks out of which 31 (4%) tested HIV positive. A total of 781(88%) of the eligible 885 HEI were exclusively breastfed by 6 months of age, and 795 (79%) of the remaining 1001 were retained on active follow-up at 12 months. In addition, 39(4%) of the retained HEI were PCR positive by 12 months follow up outcomes. Figure 17 below shows the 12 months' cohort follow up outcomes.

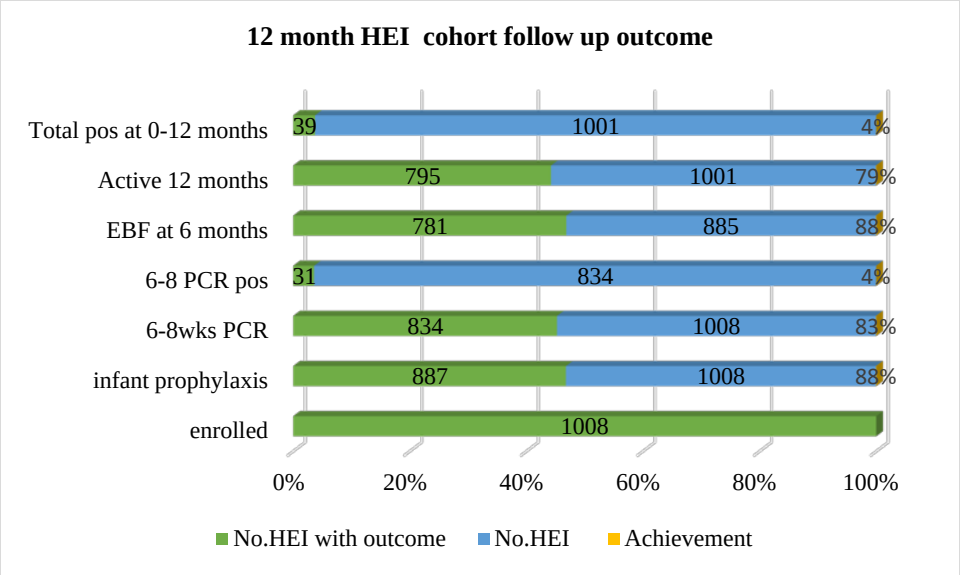


Figure 16: HEI Cohort Analysis Outcome at 12 months

877 HEI were enrolled for the 24 months follow up in 124 health facilities between October 2016 and July 2017. Among the 877 HEI enrolled and analyzed in the 10 cohort monthly reports, 576 (66%) exited with an HIV negative outcome, while 8(1%) were active but missed 18 months' antibody testing. Only 31(3%) were HIV infected at the exit, with 110(12%) having transferred out,129(15%) were LTFU and 23(3%) died. Overall the 24 months' cohort had a 67% retention rate inclusive of those who were active but not tested. This is below the 80% expectation. The Activity will endeavor to improve retention of the mother-baby pairs during the 24 months follow up period in order to improve the HEI outcomes.

Maternal Retention: During the period under review, there were two categories of cohorts reviewed (i.e. 12 months and 24 months' maternal cohort outcomes). A total of 1,253 mothers were followed up under the 12 months' cohort whereas 1,111 mothers were followed under the 24 months' cohort. Details of the outcomes are shared in the Figure 25 below. At 12 months' cohort, 77% (968) of the 1,253 mothers enrolled were retained. Of those retained, 89% (861) had VL tests done with 91% (783) achieving viral suppression. The retention rate below 95% was as a result of transfer outs and LTFUs among the cohorts. The 24 months' cohorts had a retention rate of 66% (729), out of which 94% (682) had a VL tests done with 93% (637) VL suppression rate. In both cohorts, there was notable low retention rate which was attributed to transfer outs and LFTUs across the supported counties, in both supported and non-supported facilities. To address this attrition, the Activity will enroll the PMTCT mothers to support groups, assign case managers for mothers with difficulties at home separate adolescent mothers and form age specific support groups for these mothers. This is expected to improve the mental health and psychological outcomes for these mothers to help them cope with living with HIV. The Activity has established 31 family clinics, integrated ARVs into MCH among 103 facilities with a total of 5,994 beneficiaries. At the same time, 89 PMTCT support groups with 2,695 beneficiaries were facilitated to hold support group sessions across the seven supported counties. The Activity will focus mentorship on retention within the 37 high burden facilities contributing to highest PMTCT loss to follow-up rates through strengthening mentor mother program, focused community

retention strategy, HEI graduation celebration, and mother-to-mother buddy system in support groups.

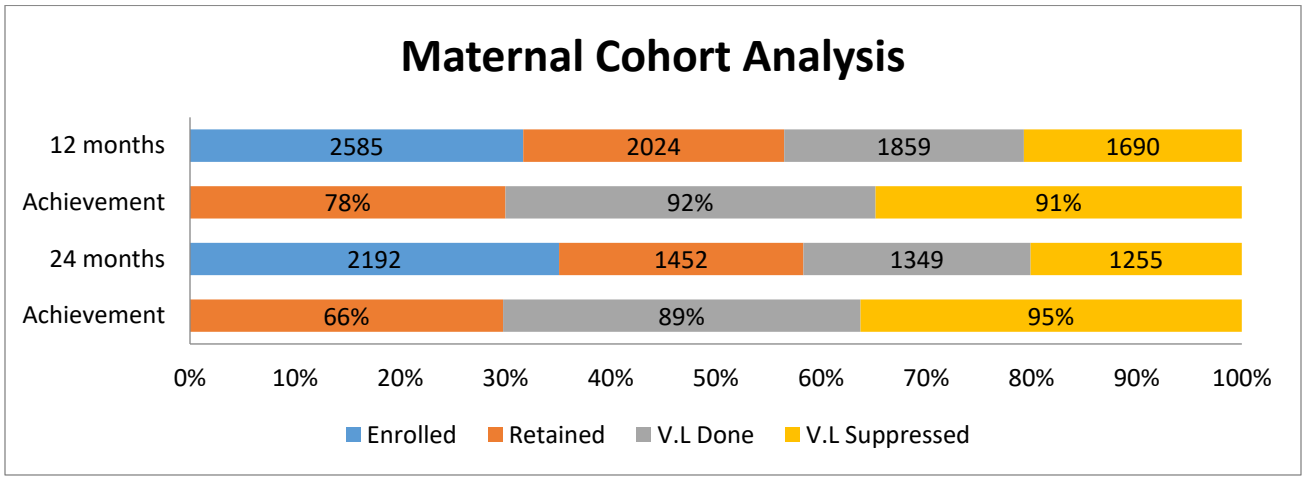


Figure 17: Maternal Cohort Analysis

Activity 4.3.4: PMTCT for Adolescent Girls and Young Women (AGYW)

Figure 19 below shows the number of pregnant women served by end of Q4 in the reporting period. Of concern is the high number of adolescent girls who got pregnant and became mothers when they are still children themselves. Of the 109,281 women seeking ANC services, 15,156 (14%) were aged 10-19 years. It's important to note that the new positives were much higher than known positives in the 15-19-year-old, signifying the HIV exposure risk among these adolescent girls. The Activity will engage the county gate keepers to address the high rate of teenage pregnancy to reduce MTCT rates and to keep girls in school.

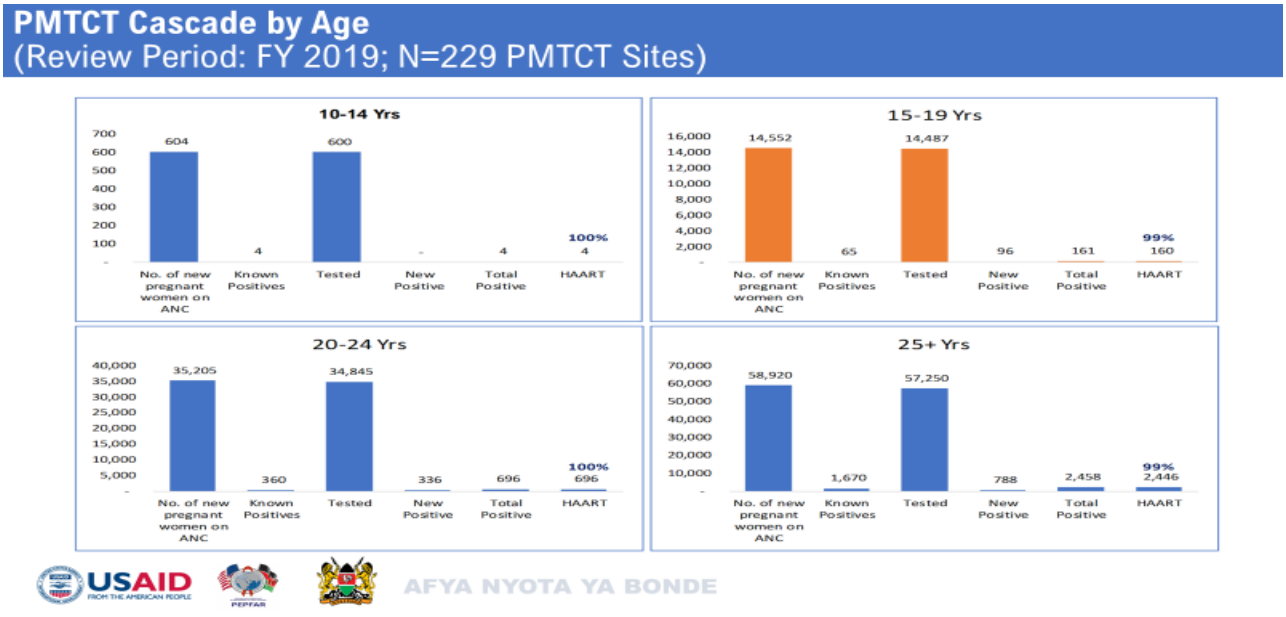


Figure 18: PMTCT Cascade by age Oct 2018- Sep 2019

OBJECTIVE 5: LONG-TERM FOLLOW-UP OF PATIENTS RECEIVING CARE AND TREATMENT SERVICES INCLUDING LAB AND LOGISTICAL SUPPORT

There were 65,772 PLHIV who were active on treatment in all the 194 ART sites by the end of Q4, out of whom, 10,618 were newly initiated on treatment as shown in Figure 20. This represents 88% achievement against the annual target of 74,756.

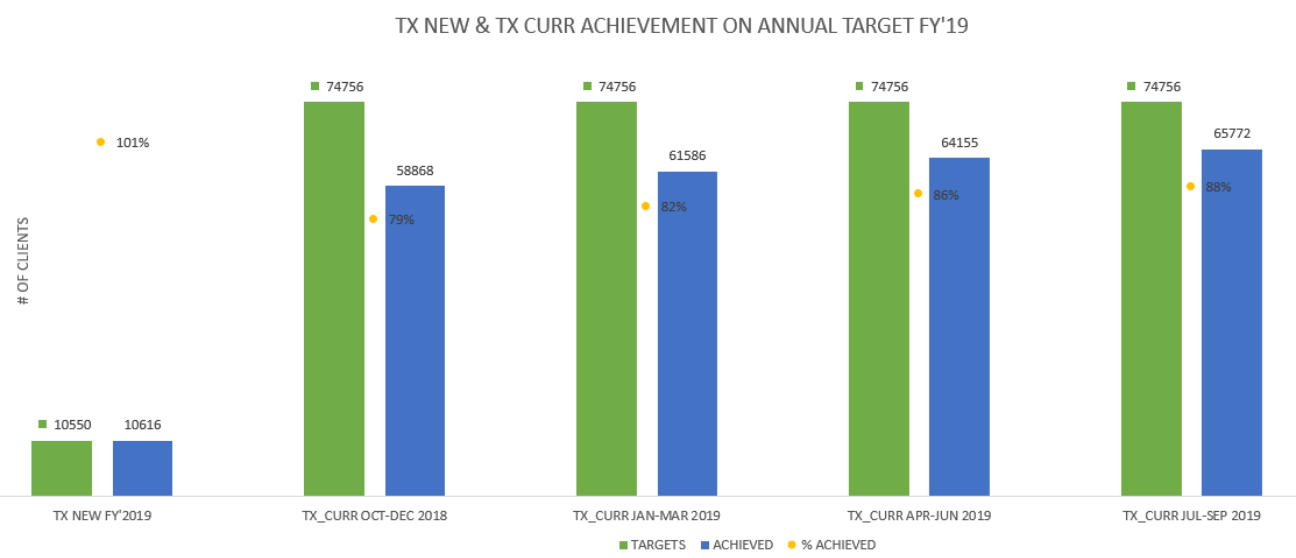


Figure 19: Achievements of New and Current on ART Against Annual Targets

The five reboot counties (Kajiado, Nakuru, Narok, Samburu and Turkana) contributed 86% 56442) clients currently on ART. Of the 65,772 clients who were on ART by end of Q4, 66% (43,640) were females. Figure 19 illustrates age distribution of clients currently on ART.

OBJECTIVE 6: STRENGTHENED SUPPORT FOR FACILITY AND COUNTY MANAGEMENT OF HIV RESPONSE

Activity 6.1: Human Resources for Health (HRH)

6.1.1. Identify HRH gaps and conduct joint recruitment and deployment

In the July/September quarter, the Activity worked closely with the subcontracted HRH manager, THCS and the CHMTs to recruit additional facility-based HRH and provide capacity building to address priority capacity gaps to bridge the critical HRH gaps in HIV/AIDS services delivery across the seven supported counties. The Activity worked closely with the CHMTs in the quarter to recruit 83 additional temporary staff (i.e. 81 HTS councilors, and 2 Systems developers) to meet the urgent HRH gaps required to implement the surge strategy from May to September at the selected priority surge sites. The capacity building activities are outlined in *section 6.1.3*. Table 7 below outlines the HRH support per county per cadre.

Table 6: July – Sept 2019 HRH Support by County per Cadre

HRH_CURR	Cadre Numbers by County- July - Oct 2019							
Cadre	BARINGO	KAJIADO	LAIKIPIA	NAKURU	NAROK	SAMBURU	TURKANA	Grand Total
Adherence Counselor	5	9	4	24	3	5	7	57
Data Clerk	1		1	13	1	2	5	23
Health Records & Information Officer	3	1	4	14	2	1	2	27
HTS Counselor	12	7	20	37	16	5	24	121
Hygiene Assistant				4			4	8
Laboratory Technologist	2	4	3	10	3	3	6	31
Nurse	8	6	6	44	10	6	16	96
Nutritionist	2	2	3	3	3	1		14
Pharmaceutical Technologist	3	4	2	14	3	2	1	29
Registered Clinical Officer	4	16	10	50	4	3	8	95
Social Worker								
VMMC Surgeon							6	6
Clinical Mentor	1		1	5	1	1	1	10
Facility Staff Sub Total	**41**	**49**	**54**	**218**	**46**	**29**	**80**	**517**
Adolescent Champion	5	11	7	25	6	3	2	59
CHV	8	13	6	16	8	4	10	65
Expert Client/Link Desk/Defaulter Tracer	8	17	5	44	10	6	12	102
Community Mobilizer							2	2
Mentor Father	5	8	2	19	1	1	2	38
Mentor Mother	6	21	7	42	12	3	9	100
Lay Staff Sub Total	**32**	**70**	**27**	**146**	**37**	**17**	**37**	**366**
Facility & Lay Staff Sub Total	**73**	**119**	**81**	**364**	**83**	**46**	**117**	**883**
Data Clerk - Temps								
HTS Screener	6	11	9	45	4	6		81
Systems Development Volunteers				2				2
Temporary Staff Sub Total	**6**	**11**	**9**	**47**	**4**	**6**	**0**	**83**
Grand Total	**79**	**130**	**90**	**411**	**87**	**52**	**117**	**966**

The Activity expanded the quarterly HRH touch base meetings to include discussions on the J2SR and plans for year 3. Through this engagement process, more counties continued to ratify the HRH county Letters of Agreements (LoA), with four counties (i.e. Laikipia, Nakuru, Samburu and Turkana counties) currently issuing HRH contract letters and Baringo and Kajiado agreeing to issue the contract letters from October 1st, 2019 while the Activity continues to manage the contracted HRH staff payroll systems.

6.1.2 Capacity for Health Managers in Leadership, Management and Sustainability (LMS).

The Activity anticipated to implement this intervention, including conducting organization capacity assessment for the county governments departments of health through a sub-contract, Deloitte in FY 19. However, this did not happen because the Activity was not able to sub-contract Deloitte as earlier anticipated due to budgetary constraints. The Activity provided limited TA to support development of county AWPs using the Program Based Budgeting (PBB) format.

6.1.3 Provide In-Service Training/Continuous Medical Education

In Q4, the Activity supported various capacity strengthening initiatives targeting HCWs and community-based workers across the seven counties. This is included on-site and off-sites capacity strengthening activities sch as; orientations, trainings, CMEs and mentorships as shown in Table 7 below. The key topics covered during the trainings, CMEs and mentorship sessions included on adult and pediatric ART management using the new 2018 ART guideline, ART optimization and

appointment management, PMTCT, DSD, HTS with focus on index testing/ aPNS, dual and self-testing, PreP, updates on PMTCT guidelines, SGBV and quality reporting of SGBV cases, IPT and documentation in presumptive register, TB/HIV in pediatrics and TB ACF, HIV and nutrition, HIV pathology and virology, VL monitoring, adherence and counselling, among others.

Table 7: July – Sept 2019 Capacity Strengthening Initiatives

Afya Nyota Ya Bonde Afya Nyota Ya Bonde		July - September 2019 (Q4)							
Item #	Capacity Building Activities	Baringo	Kajiado	Laikipia	Nakuru	Narok	Samburu	Turkana	Grand Total
	Type of Training								
1	Number of HCWs Trained on Diagnosis, Management and Prevention of Acute Malnutrition (CMAM)	6	92	37	85	92	3	0	315
2	No of Counsellors Trained in Pediatric and Adolescent Psychosocial Support	6	1	3	3	1	2	0	16
3	Number of HCWs oriented on OTZ				40				40
	Training Sub Total	**12**	**93**	**40**	**128**	**93**	**5**	**0**	**371**
	Type of CME								
	Number of CMEs Conducted	0	59	18	53	59	4	17	210
1	Number of HCWs Reached Through CMEs	314	97	76	171	97	82	94	931
	Sub Total - CMEs	**314**	**97**	**76**	**171**	**97**	**82**	**94**	**931**
	Type of Mentorship								
1	Number of HCWs Mentored On 2018 ART Guidelines	44	109	63	124	91	43	13	487
2	Number of HCWs Mentored On PMTCT	39	105	53	128	93	45	13	476
3	Number of HCWs Mentored on HIV Self Testing (HIVST)	5	117	62	107	91	29	31	442
4	Number of HCWs Mentored on Dual Testing	8	121	55	116	91	35	16	442
5	Number of HCWs Mentored On HTS	32	119	52	107	91	26	23	450
6	Number of HCWs Mentored On aPNS	39	100	36	101	92	19	13	400
7	Number of HCWs Mentored On RH/HIV	13	18	41	10	5	7	13	107
8	Number of HCWs Mentored On TB	34	110	49	105	92	23	13	426
9	Number of HCWs Mentored on PreP	31	122	44	103	92	21	0	413
10	Number of HCWs Mentored on ART Optimization	38	121	46	111	92	29	26	463
11	Number of HCWs Mentored On DSD	35	122	48	106	93	23	13	440
12	Number of HCWs Mentored on Commodity Management	23	102	48	93	93	10	26	395
13	Number of HCWs Mentored on Comprehensive SGBV Services	3	92	42	96	92	14	0	339
14	Number of HCWs Mentored on Adolescent Package of Care (APOC)	8	104	41	89	92	7	0	341
15	Number of CHVS Mentored on Community Mobilization, HTS, Mentor Mother Approach and Community MNCH/PMTCT	6	11	37	12	3	10	14	93
16	Number of CHVs Mentored on Early Identification of Pregnancy and Use of Referral Directories	5	61	75	122	53	77	14	407
17	Number of HCWs Mentored on Adolescent Package of Care and Integration of Adolescent and Youth Friendly Services	5	104	24	88	91	7	0	319
18	Number of HCWs Mentored On PMTCT, MCA, HCA & PMTCT Reporting Tools	24	103	49	93	91	12	12	384
	Sub Total - Mentorships	**392**	**1741**	**865**	**1711**	**1438**	**437**	**240**	**6824**
22	**Grand Total Capacity Building Activities**	**718**	**1931**	**981**	**2010**	**1628**	**524**	**334**	**8126**

The outcome of these capacity building efforts is improved knowledge and skills among HCWs that is reflected in improved service delivery outputs and outcomes including increased PNS testing, increased same day linkage to ART, increased defaulters/LTFU tracing and re-initiation to treatment, efficiency in HIV testing and increased HIV positive yield, synchronizing VL and EID sample collection with the clients' appointments, timely reporting, and improved linkage of ART and PMTCT sites to the lab network.

Activity 6.2: County Planning and Budgeting

Activity 6.2.1 Provide Technical Assistance to Improve Annual Work Plans, county budgeting and health financing

The Activity continued to provided TA support for the implementation of the county health Annual Work Plans (AWPs 2019/2020) linked JWPs at facility, sub county and county levels. The JWPs define the specific activities that ANyB supports in line with each county's AWP. This is expected to refocus joint teamwork efforts for improved facility, sub-county and county level health service delivery and health management. Table 9 below shows a summary of JWPs supported in the reporting quarter.

Table 8: July – Sept 2019 Activity Supported JWPs

County	CHMT	SCHMT	HMTs (High Volume Facilities)	Total Supported Points
Baringo	1	6	8	15
Kajiado	1	5	12	18
Laikipia	1	3	14	18
Nakuru	1	11	27	39
Narok	1	4	12	17
Samburu	1	3	9	14
Turkana	1	3	10	14
Total	**7**	**35**	**92**	**122**

In Q4, the Activity focused on implementation of surge activities at County, sub county and facility levels in line with the approved JWPs budgets. Laikipia (3 SCHMTs, 7 facilities) and Samburu (3 SCHMTs, 9 facilities) counties, were oriented and supported with TA to start implementing surge activities. This brought the total number of health management and service level sites implementing surge to 7 CHMTs, 35 SCHMTs and 92 surge sites to enhance their capacity towards development of CHMT, SCHMT, facility specific surge workplans for improved implementation of surge activities. surge micro plans. This included use of county, sub-county and facility specific data for planning and improvement of service delivery and overall performance.

Activity 6.3: Health Management Information Systems

The Activity provided M&E support to 182 health facilities in Q1, 315 in Q2, 237 in Q3 and 234 in Q4 across the seven counties. The specific activities included; provision and dissemination of standard HIV data collection and reporting tools to improve complete, accurate, timely data collection and reporting at facility level, mentorship and routine site visits, data verification and review, gap analysis meetings and data quality assessments (DQA). Support was also provided for electronic medical records (EMR) and KHIS. Further details are provided in the sections below.

Activity 6.3.1 Strengthen complete, accurate and timely data collection and reporting at sub county facility and community level

The Activity continued to support the production and distribution of MoH standard HIV data collection and reporting tools to 315 supported sites to address gaps in supply and ensure complete, accurate and timely data collection. Targeted mentorship continued on correct and accurate use of the tools reaching 2194 service providers in the supported regions. In addition, the Activity alongside SCHMTs reviewed monthly reports to assess completeness and correctness before entry

to the KHIS and further followed up on missing reports as well as engaging with service providers to make corrections for reports that had gaps.

Implementation of Electronic Medical Records (EMR): The activity continued supporting the implementation of EMR with the aim achieving 90% of TX_Curr reporting from the EMR. Working in collaboration with Palladium, the EMR partner, the Activity upgraded the Kenya EMR system and IQCare versions from version 16.2 to version 17.0 and version 1.0.0.6 Patch2 to 2.0.0, respectively, in all the EMR supported sites. By the end of Q4, the activity had 15 EMR sites using the system as POC up from 4 sites in FY18 registering more than double increase. The Activity also deployed the interoperability layer between EMRs and the pharmacy Web ADT in three sites (Nakuru PGH, Naivasha SCH and Molo SCH) to increase efficiency of use of the system for client management and reduce the documentation gaps resulting from double documentation on both EMR and hard copy prescriptions. The plan is to have the interoperability layer deployed to all the EMR sites with ADT and using the system as POC by end FY 2020.

Table 9: Oct'18 – Sep'19 EMR implementation status by county

Quarterly EMR implementation status per county									
	Baringo	**Kajiado**	**Laikipia**	**Nakuru**	**Narok**	**Turkana**	**Samburu**	**Total**	**Achieved**
No of ART sites	17	24	19	80	20	20	17	197	197
# of facilities with EMR installed	10	14	12	16	9	8	3	72	37%
# of functional EMR *(last 6 months retrospective data updated in EMR)*	10	2	1	10	0	4	0	27	38%
EMR Mode of Use									
No. of facilities using EMR Point of Care (POC)	4	0	1	10	0	0	0	15	21%
No. of facilities using EMR for retrospective data entry (RDE)	6	11	9	10	7	6	3	52	72%
No. of facilities with stalled EMR	0	3	2	0	2	2	0	9	13%
# of health facilities generating accurate and complete MOH 731 from the EMR	10	2	1	10	0	4	0	27	38%
# of health facilities reporting to DATIM from the EMR	10	2	1	10	0	4	0	27	38%
# of EMR facilities with EMR champions	10	8	2	6	8	0	0	34	47%
# of health facilities EMR DQA conducted	0	6	0	11	0	2	0	19	26%
# of sites reported to the national data warehouse *(Sept 2019)*	10	11	9	13	2	0	1	46	64%
# of facilities conducting EMR review meetings within the quarter	3	5	0	3	2	0	0	13	18%
# of HCWs mentored on use of EMR	23	10	30	20	0	0	22	85	

Implementation of the pilot phase of using the HEI follow up module of the EMR is on course and with the release of IQCare Version 2.1.1, the activity is going to start the pilot phase of PMTCT modules to facilitate achieving a full POC use of EMR. The activity rolled out the use of Afya Mobile in Nakuru PGH and Naivasha SCH for eHTS and is working towards paperless documentation of HIV testing services for the two sites.

Activity 6.3.2: Strengthen data analysis, dissemination and use of data at all levels of service delivery

In FY19, the Activity supported 84 facilities, 24 SCHMTs, four CHMTs to conduct data review meetings to assess performance of selected indicators from Baringo, Kajiado, Laikipia, Nakuru, Narok, Samburu and Turkana Counties. During the process 231 HCWs were mentored on performance monitoring of various indicators including linkage, VL suppression rate, 12-month retention on ART, defaulter tracing and TB screening uptake. Performance monitoring charts were provided to the supported sites to chart and track performance progress. The use of PMCs has progressively improved data use at site level with facilities being able to chart and track progress of performance towards indicator targets.

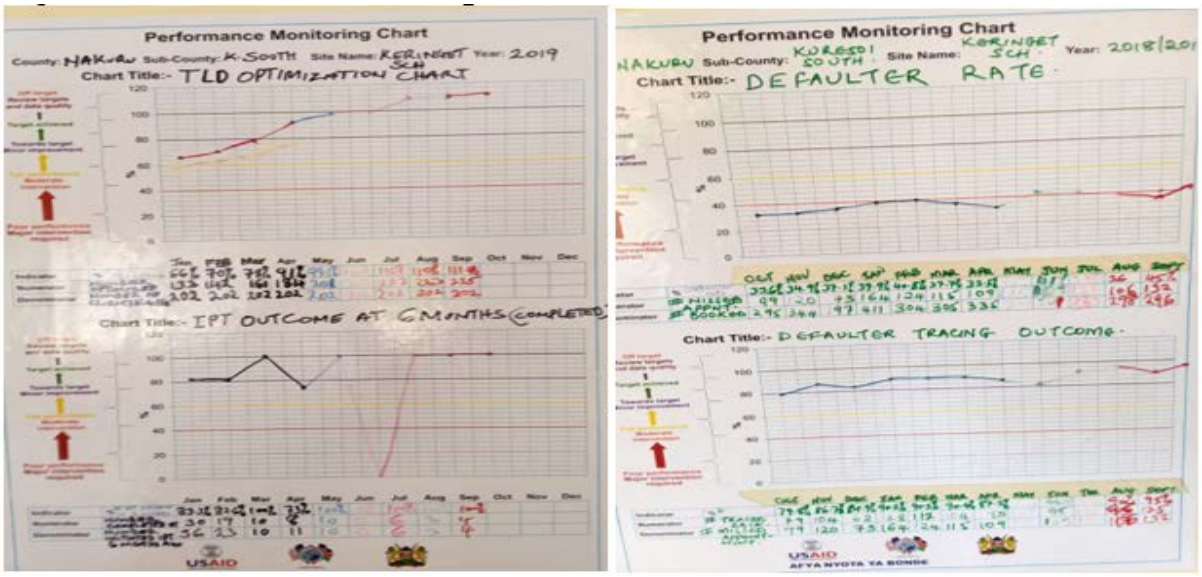


Figure 20: PMC charts

Activity 6.3.3: Institutionalize DQA systems and practices at all points of service delivery

The activity continued to conduct data quality assessments (DQA) to ensure that the data reported both to the national reporting platform and DATIM are within the required data quality range of ±5% margin of error. The three indicators audited i.e. HTS_POS, TX_NEW and TX_CURR registered a data quality verification factor of below ±5% as shown in Figure 21 below. The variance registered were majorly as result of counting errors and documentation in multiple documents that some were missed during aggregation. The reports with variances were corrected and submitted for entry both to KHIS and DATIM.

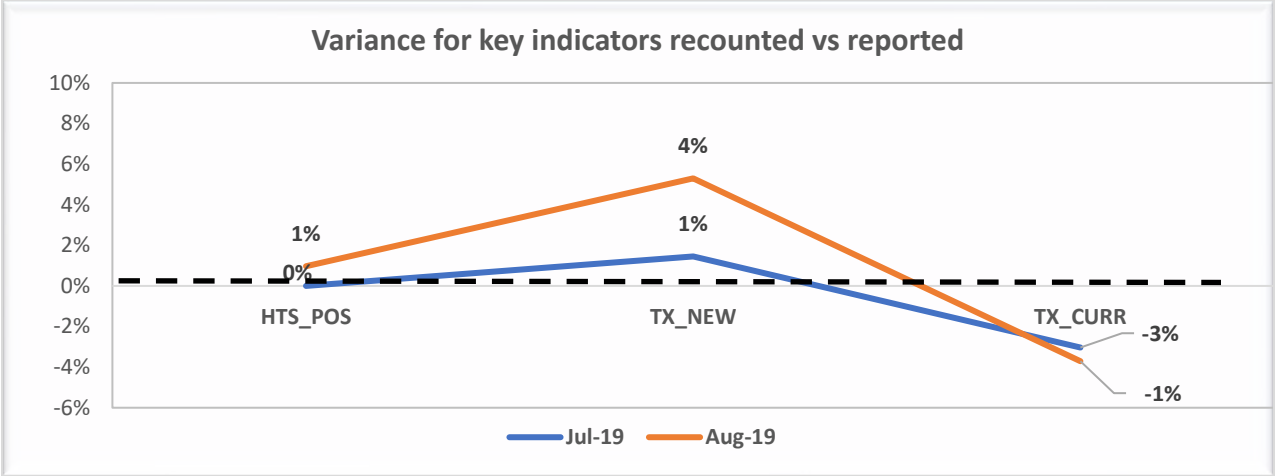


Figure 21: Variance for key indicators

Activity 6.4 Quality improvement (QI)

The Activity continued to support QI activities in the high-volume facilities and at sub county levels. These included supporting development and review of annual QI workplans for high facility and sub county QI teams, orientation and mentorship of HCWs on various CQI topics and processes, quarterly QI review meetings for sub county QITs, monthly review meetings for facility Work Improvement Teams (WITs), development and review of facility performance monitoring charts and review of overall progress made in the implementation of the QI workplans. Other QI efforts included supporting various HIV care and treatment services TWG meetings.

Table 10: Institutional strengthening activities

Item#	Institutional Strengthening (IS) Activities	Baringo	Kajiado	Laikipia	Nakuru	Narok	Samburu	Turkana	Total
	M&E								
1	Number of High-Volume Facilities implementing EMR	27	33	20	31	27	7	9	154
2	Number of Facilities that Conducted Data Review Meetings Held (With Minutes) In the Quarter	18	53	32	48	47	13	27	238
3	Number of Facilities that Conducted a DQA In the Reporting Quarter	3	2	0	2	2	0	0	9
	CQI								
1	Number of Facilities that have A QIT/WIT	10	19	16	19	17	5	9	95
2	Number of Facilities that f QIT/WIT Meetings Held (With Minutes) In the Quarter	16	30	15	28	28	4	5	126
	IS TWGS/ Forums								
1	Number Of **eMTCT** Technical Working Groups Meetings (With Minutes) Heald In the Quarter	2	0	7	0	0	0	0	9
2	Number Of **HIV/TB** Technical Working Groups Meetings (With Minutes) Heald In the Quarter	0	0	0	0	0	0	0	0
3	Number of **HRH** Technical Working Groups Meetings (With Minutes) Heald In the Quarter	0	0	0	0	0	0	0	0

4	Number of **HPT Management** Technical Working Groups Meetings (With Minutes) Heald In the Quarter	0	0	0	0	0	0	0	0
5	Number of **CHSFs** meetings (With Minutes) Heald In the Quarter	0	0	0	0	0	0	0	0

Activity 6.4.1: Provide TA for the design, planning and evaluation of QI activities:

The Activity supported a total of 85 WITs at facility level to hold 121 QI review meetings to review their QI workplans and develop priority actions for the subsequent meetings before scheduled review meetings. The key service areas identified with quality gaps included HIV self-testing, aPNS, PrEP, SGBV, client retention, IPC practices, waste management, EMR utilization, TB/HIV co-infection, and ART optimization amongst others. The facilities prioritized indicators to be tracked for quality improvement and developed action plans for implementation. Notable improvements were indicated on data quality, HTS with fidelity, rate of ART linkage within same day and improving suppression rates.

Activity 6.4.2: Improve HCWs compliance to evidence-based standards of HIV Care

The Activity supported 9 TWGs meetings (2 in Baringo, 7 in Laikipia) focusing on eMTCT to address outstanding eMTCT technical challenges and issues. In conducting VMMC activities, the Activity maintained the equipment and procedure sterility standards in surgical room per WHO and NASCOP requirements with no moderate adverse events in the quarter. Two success stories/effective practices from Narok County titled: *Journey towards current on care and HTC Escorted referrals for linkage to ART* are under review.

Activity 6.4.3: Implement comprehensive capacity building for QITS, WITs.

In addition, 30 HCWs at Ongata Rongai HC, Kajiado continued to receive QI CMEs on improving viral suppression by prompt action on the detectable viral loads conducted in partnership with the CHMT and the Laboratory African Regional Collaborative (LARC). As a result, the facility won an award as LARC champion in Kajiado county for 2019.

II. ACTIVITY PROGRESS (Quantitative Impact)

This section presents a quantitative description of the key achievements at the end of Q4 of FY19 reporting period. All PPMT tables have already been submitted alongside the respective quarterly reports.

III. CONSTRAINTS AND OPPORTUNITIES

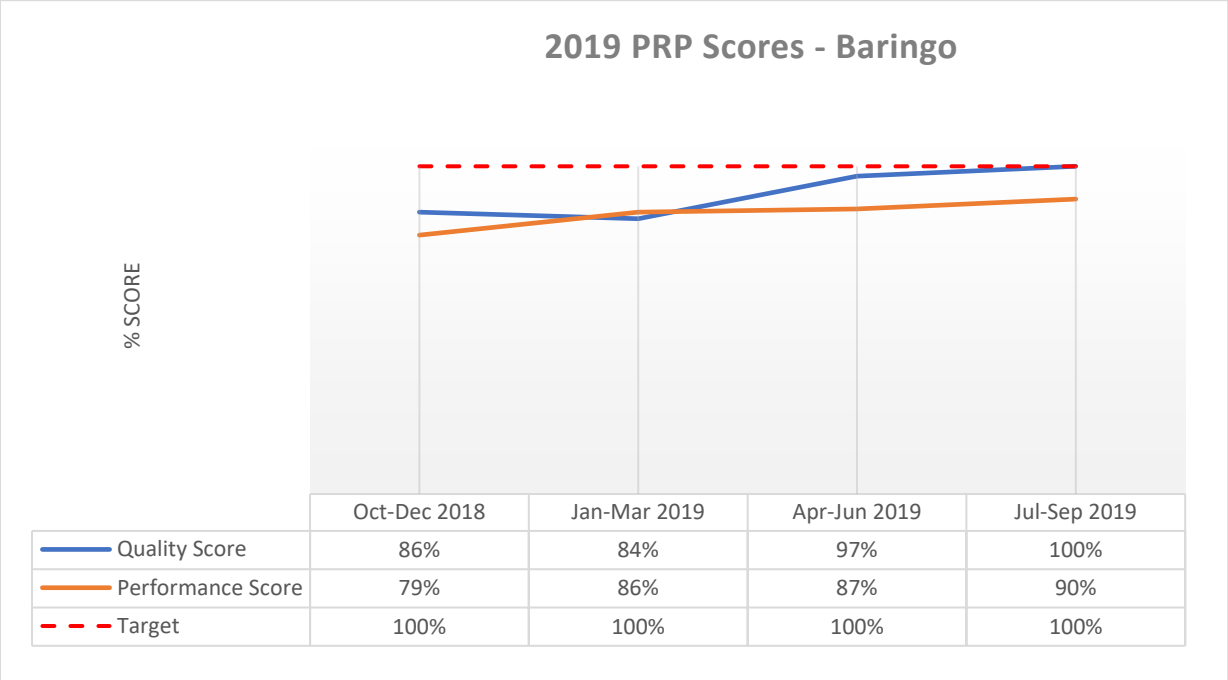
During the FY19, several constraints affected implementation of planned activities as shown below.

- The Kenya Medical Research Institute (KEMRI)/Walter Reed Project (WRP) Laboratory in Kericho experienced equipment down time and reagent stock-outs for a long period of time. This has a significant negative effect on Viral Load (VL) sample analysis for Afya Nyota ya Bonde supported facilities from Narok and Nakuru counties in terms of long and delayed Turn Around Time (TAT) of up to 25 days for sample analysis and relaying of results. The KEMRI/WRP Laboratory WRP has since resumed operation after receiving reagents from Kenya Medical Supply Agency (KEMSA) and addressing equipment downtime issue. However, the TAT for sample analysis and relay of results is still long (i.e. 15 days). This is because the laboratory had a long backlog of samples that is still being processed.
- The way DATIM auto-populates data from TB_STAT indicator to HTS_TST (facility) – PITC Modality: TB assumes that all patients were tested in the TB clinic which is not always the case. This leads to double counting of all HIV-positive clients since some are captured under OPD or other provider-initiated testing and counselling (PITC) points and then referred to the TB clinic. This lowers the linkage rates.
- Conflicts in parts of Kuresoi South and Njoro sub-counties in Nakuru County that displaced patients, thus affecting their follow up and retention on treatment. In Turkana County, clients were unable to access services at Kainuk and Nakwamoru due to the insecurity along Turkana-West Pokot border, leading to low service uptake.
- The drought in Turkana also continued to affect service delivery in Turkana especially the HIV prevention component with the community members giving priority to food distribution meetings rather than HIV prevention sessions and therefore the situation was not ideal for the community meetings.
- The Activity does not report data from all 800 PMTCT sites across the seven counties, and therefore the reported achievement seems low despite the 99.9% ARV uptake for those identified HIV positive in the supported sites. The Activity only supports and reports PMTCT service uptake in 229 (28.6%) PMTCT sites across the seven counties.

IV. PERFORMANCE MONITORING

During the reporting period, the Activity conducted routine performance monitoring activities including tracking of reporting rates in KHIS2, DATIM, IMIS, Surge, High Frequency Reporting and Early Warning Systems, tracking availability and use of standard recording and reporting tools, monthly data quality assessments, utilization of performance monitoring charts and implementing performance reimbursement plan for SCHRIOs across the seven supported counties. The results assisted the Activity to measure improvements, identify areas that need strengthening and form the basis for provision of technical support and mentorship.

To measure reports consistency and reporting rates, the performance of the SCHRIO's across the Counties continued to be monitored through the PRP. As shown in the graph below, the quality and consistency performance scores improved from an average of 86% to 100% and 79% to 100% respectively between Q1 and Q4. This achievement was attributed to the activity team providing focused mentorship to the facility staff and provided continuous feedback to the SCHRIO's on their performance. The Activity team will continue with the targeted mentorship to ensure the scores reach over 95%.



	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019
Quality Score	86%	84%	97%	100%
Performance Score	79%	86%	87%	90%
Target	100%	100%	100%	100%

Figure 22: PRP scores - Baringo

During the quarter under review, the Activity monitored the KHIS2 reporting rates for 10 data set reports (F-CDRR, MOH 731 (ART, PMTCT, HTS, VMMC and PEP), HCA, MOH 643, MOH 364 and MOH 731 PrEP plus) from supported counties. An improvement was noted across all the indicators between Q1 and Q4 as from an average of 58% to 73%. However, HCA reporting rates dropped from 62% to 51% and this was due some facilities erroneously being allocated datasets thus increasing the denominator. In the next quarter, the activity team together with the CHRIO and SCHRIOs will follow up to correct the error.

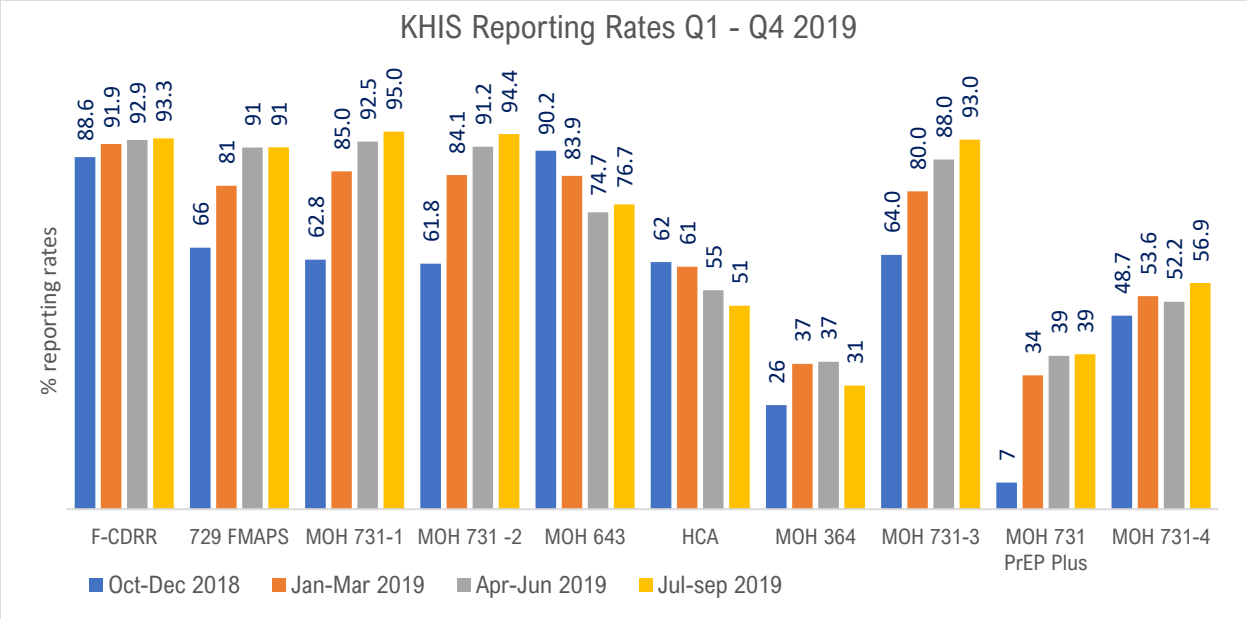


Figure 23: KHIS reporting rates

Result area	Details	Activity Area	Source of Information	Turkana	Baringo	Kajiado	Narok	Laikipia	Nakuru	Samburu	Total
Availability of standard tools	# of facilities & community IPs received standard tools	NASCOP HIV standard tools	Tools distribution list	24	14	51	7	25	130	22	273
		Project customized tools		20	15	37	13	30	100	9	224
		HC1		0	0	0	0	0	0	0	0
		Others (specify)		0	0	0	0	0	0	0	0
		# of HCWs newly trained on the revised NASCOP M&E tools	Training registration form	0	0	0	0	0	0	0	0
		# of HCWs refreshed on use of the revised NASCOP M&E tools		0	0	30	0	0	20	0	50
		# of peer educators trained on use of community tools		0	0	15	0	15	0	0	30
Provision of technical assistance	# of health care facilities visited for	Mentorship	Site visit form	16	14	23	19	30	110	22	234
		Support supervision		16	0	23	19	1	67	9	135
		Data verification before submission to SCHRIO		12	27	10	27	3	52	22	153
		EMR assessment/support	ODK Supervision tool	0	0	11	0	11	11	0	33
	# of health care workers mentored on	Standard reporting tools	Mentorship form	26	49	30	28	115	43	26	317
		Use of PMC charts		8	16	32	28	90	27	30	231
		Use of DHIS2		3	0	5	2	15	0	0	25
		EID & VL dashboards		0	0	3	11	10	2	0	26
		Data analysis and use		8	19	21	2	115	34	0	199
		Others (specify)		0	0	0			0	0	0
Data quality	# of facilities where DQA was conducted	Tools assessment	M&E checklist	0	14	12	6	3	26	0	61
		Facility systems assessments		0	0	12	6	0	27	0	45
		Chart abstraction		0	0	0	0	0	21	0	21
		Data verification between reported and source documents		6	14	12	6	0	24	0	62
	# of gap analysis meetings held	Project level	Gap analysis meeting minutes	0	1	1	2	2	9	1	16
		Health facility level		0	0	5	0	0	6	0	11
		Sub county level		0	0	0	0	0	3	0	3
Data use	# of facilities that conducted data review meeting	Monthly	Data review meeting minutes	0	3	5	3	6	22	1	40
		Quarterly		0	1	5	3	0	7	0	16
		Facility [Monthly]		11	10	15	6	12	43	3	100

Result area	Details	Activity Area	Source of Information	Turkana	Baringo	Kajiado	Narok	Laikipia	Nakuru	Samburu	Total
	# of data review meetings held	Facility (Sub quarterly)		0	0	0	6	0	5	0	11
		Sub-county [Quarterly]		0	0	2	0	2	3	0	7
		County [Quarterly]		0	0	0	0	1	1	0	2
	# of M&E TWG meetings held	County	TWG meeting minutes	0	0	0	0	0	0	0	0
		Sub county		0	0	0	0	0	0	0	0
	PMC	# of facilities with up -to - date charts *(last month of the quarter updated)*	PMC use facility assessment form	13	15	12	19	20	46	6	131
		# of facilities with evidence-based documentation on data use (either on data use handbook or minutes)		0	3	5	2	6	20	0	36
		# facilities with evidence of improved performance through PMC use and data review meetings *(share trend of at least of the indicators for each subcounty reported here)*		0	15	3	2	6	5	3	34
				0	0	0	0	3	0	3	6
		# SCHMT with evidence of improved performance *(share trend of at least of the indicators for each subcounty reported here)*		0	0	0	0	0	0	0	0
EMR	Functional EMR	No of ART sites	EMR assessment report	19	11	21	17	18	80	17	183
		# of facilities with EMR installed		8	11	14	8	12	16	3	72
		# of functional EMR *(last 6 months retrospective data updated in EMR)*		6	10	11	4	11	10	0	52
	EMR Mode of Use	No. of facilities using EMR Point of Care (POC)	EMR assessment report	0	4	0	1	2	10	0	17
		No. of facilities using EMR for Retrospective data entry (RDE)		6	7	11	5	9	6	3	47
		No. of facilities with stalled EMR		2	0	3	2	1	0	0	8
		# of health facilities generating accurate and complete MOH 731		4	10	2	1	4	10	0	31
		# of EMR facilities with EMR champions		0	10	8	8	2	6	0	34
		# of health facilities EMR DQA conducted	EMR DQA report	1	0	6	0	0	11	0	18
		# of HCWs mentored on use of EMR	Mentorship form	0	23	10	0	30	20	22	105
		# of sites reported to the national data warehouse *(last month of the quarter)*	NDW Spot	0	10	11	2	9	13	1	46
		# of facilities conducting EMR review meetings within the quarter	EMR review report	0	3	5	2	0	3	0	13

Table 11 M&E Data Summary (Jul - Sep 2019)

V. PROGRESS ON GENDER STRATEGY

Building on gender analysis that was conducted in FY18, the Activity focused on implementation of activities with a gender lens that gave equal opportunities for men, women, children and the youth equal opportunities to participate and benefit from service delivery; whilst collecting sex disaggregated data with indicators in the Activity's M&E plan measuring transformative change over time. Special HIV care and treatment clinics (i.e. male clinics, pediatric and adolescent) were supported across the seven counties to increase access to HIV care and treatment services for men, children and youths. At the same time, the Activity continued to engage lay treatment workers (i.e. mentor mothers, mentor fathers and adolescent champions) to facilitate increased up take of services. The Activity also continued to provide SGBV services to the populations being served across the seven counties. The Activity's planned training on gender and social inclusion in FY19 for all staff, HCWs and managers, and key community stakeholders did not take place due to the urgent need to implement SURGE strategy to accelerate achievement of results.

VI. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

In FY19, the Activity monitored application and adoption of best practices of medical waste management and disposal procedures in all the supported facilities across the seven focused counties to avoid potential negative environmental impact that may arise as a result of poor waste management. This was done through: 1) conducting regular monitoring visits to Activity sites, and working with CHMTs and SCHMTs, to assure possible, that supported facilities have adequate SOPs and capacities to handle, label, treat, store, transport and properly dispose medical waste; 2) provision of color-coded bins for waste segregation and ensuring that highly contagious wastes are segregated in red color-coded bins and disposed through incineration or microwave and shredding techniques; 3) timely management of expired medicines and commodities; 4) facilitating facility-based IPC meetings and TB risk assessment; 5) capacity building of HCWs of IPC measures. As a result, there are 112 facilities that have instituted IPC committees across the seven counties.

VII. PROGRESS ON LINKS TO OTHER USG PROGRAMS

The Activity worked closely with the following USAID programs and other USG agencies during the financial year under review (FY19):

- **Afya Uzazi:** The Activity continued to collaborate with Afya Uzazi to reach out to pregnant and breastfeeding women and children under 5 years in supported Afya Uzazi supported Sub-counties of Nakuru and Baringo. At the same time, Afya Uzazi supported the implementation of SURGE activities by participating in joint surge site support supervision with support from the MoH teams.
- **AMPATH*plus*:** The project continued to work closely with the AMPATH*plus* to facilitate EID and VL samples analysis, especially for Activity supported PMTCT and ART sites in Baringo county. In addition, the Activity collaborated with AMPATH*plus* to train HCWs on PNS and HIV Self Testing services.
- **FHI 360 CDC Laboratory Systems Strengthening Program**: In addition to continued support to select facilities in the SLMTA process, the Activity collaborated with the FHI 360 CDC lab program in joint mentorship and support supervision on in infection prevention.

- **HRH Kenya:** The Activity collaborated with HRH Kenya in co-hosting of the quarterly HRH County stakeholders' forums, establishment of and co-hosting of County HRH TWG meetings, and trainings of county's on utilization of iHRIS.
- **LVCT Health:** The Activity the Activity collaborated with LVCT Health to train HCWs on PNS and HIV Self Testing services.
- **NHP*plus*:** The Activity continued to work with the national mechanism such as NHP*plus* to provide nutrition and food supplements to the Activity supported ART sites in Samburu, Narok, Nakuru, and Baringo Counties.
- **Palladium:** The Activity continued to work with palladium to provide technical support to all the seven project supported counties on EMR system including supporting system upgrading.
- **PS Kenya:** The Activity collaborated with PS Kenya in ensuring the effective functionality of computers and printers installed for EID/VL remote login in five laboratory hubs across the focus counties. In addition, PS Kenya continued to provide data bundles for the computers and printers to facilitate uploading of EID/VL samples from the facilities.
- **Walter Reed Project:** The Activity worked closely with Walter Reed Project to facilitate EID and VL samples analysis, especially for facilities in Nakuru and Narok counties.
- **TB ARC:** Afya Nyota ya Bonde continued to involve TB ARC in shipment of sputum for MDR TB and samples for baseline laboratory investigations.
- **CASE OVC:** The Activity collaborated with CASE OVC to ensure improved retention to care for some of the HIV positive OVC, as well as ensuring improved VL test uptake and suppression for HIV positive OVC who are on ART.
- **LINKAGES Project:** Afya Nyota ya Bonde collaborated with Linkages program to reach out to Key Population in Nakuru and Narok counties with HIV testing services, including supporting the implementation of surge activities in the region especially testing of clients of sex workers within hotspots in Nakuru county.
- **UCSF Global Programs for Research and Programs**: Afya Nyota ya Bonde collaborated with UCSF Turkana county to train HCWs on the revised NASCOP M&E HIV tools. UCSF supported two master trainers who co-facilitated the trainings together with the MOH and the Activity staff.

VIII. PROGRESS ON LINKS WITH GOK AGENCIES

In FY19, the Activity worked closely with the following key government line ministries and departments to achieve key objectives and results:

- **KEMSA:** Afya Nyota ya Bonde continued to engage with KEMSA in coordinating ordering and distribution of commodities to the facilities in the seven supported counties.
- **KEMRI Molecular Biology Laboratory**: The project continued to work closely with the referral laboratory to facilitate EID and VL samples analysis.
- **Ministry of Health:** The Activity collaborated with the MoH in ensuring quality services are provided to both public and private health facilities. This was done through the Joint Work Plans, mentorship, orientations, support supervisions, capacity building and strengthening referrals through the link desks to enhance referrals from CHVs from community to facility, facility to community and facility to facility. In addition, the Activity involved the MoH in daily data-driven review meetings to assess progress towards achievement of the 95-95-95 targets.

- **NASCOP:** The Activity participated in the NASCOP regional TWGs to deliberate on quality service delivery and clinical review for cases.

IX. PROGRESS ON USAID FORWARD

N/A

X. SUSTAINABILITY AND EXIT STRATEGY

To ensure ownership of the Activity's initiatives by the County Departments of Health, Afya Nyota ya Bonde continued to engage with the leadership of all the seven county governments to develop and sign Letters of Agreement (LOA). This was aimed at advocating for the county governments to issue contract letters to the Activity supported HRH staff, agree on remuneration rates for each of the HRH cadres, and develop transition plans for the HRH staffs to the county government. This was followed by regular county-specific Activity driven quarterly HRH meetings to discuss progress. As a result, all the seven counties agreed and adopted HRH remuneration rates as proposed by the Activity, and four counties (Nakuru, Laikipia, Samburu and Turkana counties) issued employment contract letters to the contracted HRH staffs whilst the Activity continues to pay remuneration of these HRH until such a time when the county will be ready to absorb them. The Activity is in advance discussion with Baringo and Kajiado counties to issue HRH contract letters, which is anticipated to materialize at the start of FY20.

Further, the Activity worked closely with the MoH teams in the counties and sub-counties to conduct onsite joint mentorship and OJTs including CMEs to improve the capacity and skills of HCWs to provide quality sustainable HIV care and treatment services. In addition, the Activity also held joint surge data-driven review meetings with MoH teams to ensure ownership of surge activities to accelerate achievement of targets and sustain service delivery gains. As a result, Nakuru CASCO or his representative chaired the daily data-driven "Situation Room Meetings" which were aimed at reviewing performance of each participating site both in terms of daily achievements against set targets, reporting rates, data quality, and developing site specific action(s) to addressing identified gaps. The office of CASCO also spearheaded the site level SURGE supportive supervisions which has assured continuity of surge activities.

XI. SUBSQUENT QUARTER WORK PLAN

Planned actions for July – September 019	**Actual status this quarter**	**Explanations for Deviations**	**Planned actions for October- December 2019**
Program Management			
Finalize YII work-plan and Budget	Done		Develop Joint Work-Plans and Budget with the Counties
Fast-track the GUC processes	On-going		Continue surge activities in all sites
Submit quarterly DATIM report/ Conduct performance review meeting	Done		Submit quarterly DATIM report/ Conduct performance review meeting
Plan, coordinate and manage implementation of surge activities	On-going		Recruitment of staff (i.e. CoP, Senior M&E Officer, and Director M&E) to fill vacant positions.

Planned actions for July – September 019	Actual status this quarter	Explanations for Deviations	Planned actions for October- December 2019
Finalize staff rationalization in line with reduced scope in year III.	Done		
Initiate the transition of activities in Turkana and Narok counties.	Done		
Service Delivery and HSS			
Expand implementation of intense surge activities to 90 facilities across the seven counties.	Done		Continue to focus on the DATIM indicators and achievement of 90-90-90 targets. Mentorship and supervision to continue this quarter. Continue the quality focus of TQA and SIMs assessments in the high- volume sites. Accelerate efforts of optimized
Reorient HTS counselors on PNS in all counties to carry out the service effectively and link clients to ART with focus on surge facilities. Identify PNS counselors' champions. Facilitate MDT/SCHMT joint support mentorship and supervision	Done		Review and monitor facility surge micro-plans implementation to assure achievement of targets.
Scale-up of age and sex specific friendly services and clinics to all the ART sites. Redeploy case managers/volunteers to optimize early retention and adherence in line with surge strategy.	On-going		Conduct QI trainings for Activity staff and QITs focusing on the KHQIF.
Hold quarterly HRH meetings with the County Governments and finalize year 3 facility-based HRH rationalization	Done		Continue to scale up differentiated care by disseminating patient literacy materials through supports/health education sessions; orient staff, HCWs/case managers/volunteers on different DSD model and sustain use of
Continue to support regular QI review meetings at Sub County and high-volume facilities	On-going		Sustain monthly high-volume facilities and quarterly Sub county QI review meetings.
Intensify prevention activities with fisher folk communities in Turkana through implementing "SURGE" activities to accelerate VMMC service uptake in Turkana county, including joint supervision with MoH teams to improve data quality management and reporting	Done with 107% of targets achieved in Q4		
Continue to support commodity security RTKs allocation, HIV care and treatment, and PrEP TWGs	Ongoing. seven counties held quarterly RTKs allocation		Conduct aPNS orientations for the Activity staff, SCASCOs, and the facility service providers
Continue to support SGBV and post rape care interventions within health facilities and community.	Ongoing		Review implementation JWP activities to ensure alignment of overall resource envelopes for CHMTs, SCHMTs and HMTs to surge activities.
Conduct QI trainings for Activity staff and QITs on QIT. Conduct Mentorship Sessions for MDTs. Document and disseminate success stories and effective practices	On-going		Train/Orient HCWs on commodity with focus on sue of Web ADT system, VMMC, QI, and SGBV
Strengthen HTS identification of positives by scaling up facility optimization, index/PNS testing in line with surge strategy.	Ongoing		Continue to support commodity security RTKs allocation, HIV care and treatment, and PrEP TWGs
			Onboard the Key Populations partners and implement KP activities
Monitoring and Evaluation (M&E)/Strategic Information			
Orientate MDT on the revised DQA protocol for implementation and Build capacity of 327 MOH and project M&E staff on data analysis and use	Done	Priority given to surge activities	Orient the HSDSA staffs and HCWs on new MER 2.4 indicators

Planned actions for July – September 019	Actual status this quarter	Explanations for Deviations	Planned actions for October- December 2019
Build capacity of M&E staff on data analysis and use	Ongoing	None	
Engage one system developer and two interns to rationalize reportable elements in the Surge real time reporting systems	Done	None	Hold quarterly EMR review meetings with stakeholders (CHMT, SCHMT and Health IT) at facility level to transition from IQCare to Kenya EMR
Hold quarterly EMR review meetings with stakeholders (CHMT, SCHMT and Palladium)	43 done	None	Provide TA to 61 EMR sites.
Provide TA to 28 EMR sites	28	None	Conduct EMR DQA in 61 sites.
Conduct EMR DQA in 45 sites	16 done	Other 29 sites provided with EMR TA	Conduct 6 county field supervision visits for field staff to review data recording, collection and reporting
Visit at least three counties to provide technical support	Not done	High demand of M&E attention	Administer of M&E Checklists at 83 high volume sites
			HMIS mentorship to 654 for facility Staff
			Facility data Review Meetings at 83 high volume sites
			Conduct 28 data review meetings at Sub-county level
			Conduct monthly gaps analysis reviews and document outcomes.

XII. FINANCIAL INFORMATION

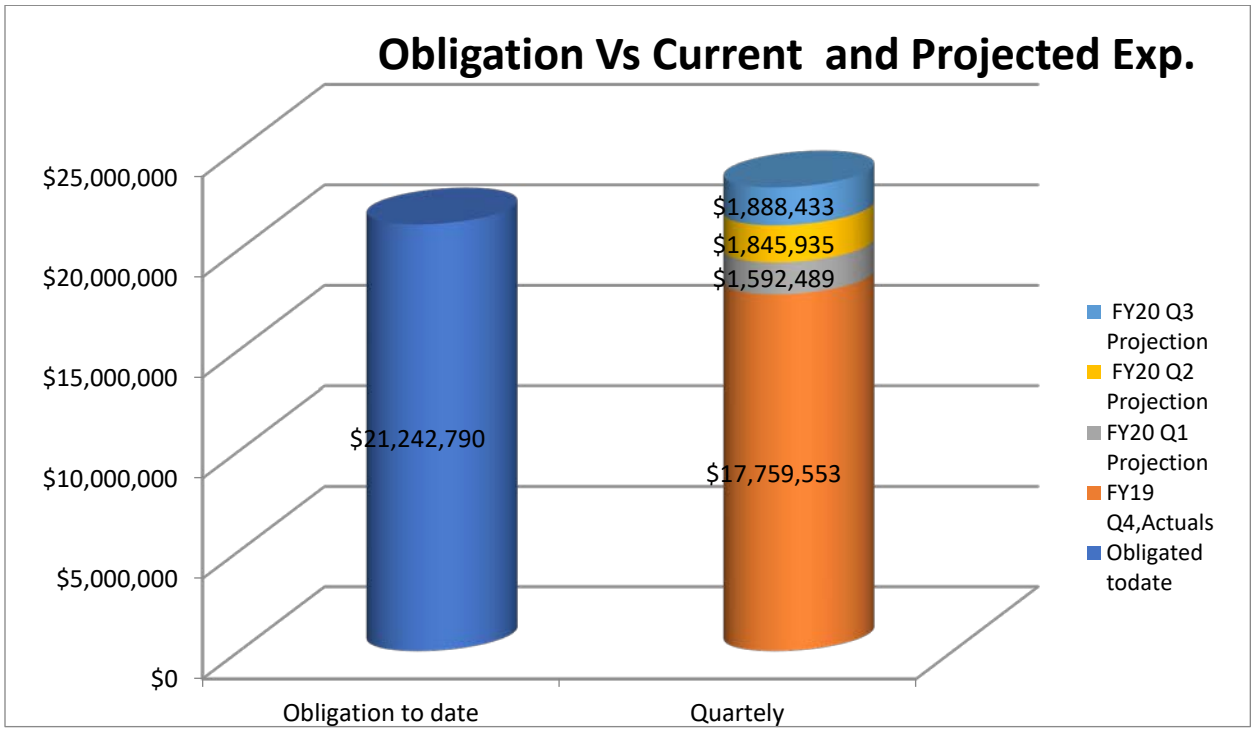


Figure 24: HSDSA: Obligations vs. Current and Projected Expenditures

Note: the information used as an example in Chart 1 is **a snapshot** at the time of a given report and should include the most recent reporting period and the upcoming three reporting periods. These data should be constantly updated by the management staff of the project, and the AOR/COR should always be familiar with the financial conditions. This should not be a chart that is made solely to enter into the Quarterly Report; keeping track of the financial condition of the project is one of the most important functions of project management on both the part of USAID and the project team implementing the Award. This is intended to serve as a valuable management tool for both parties.

Table 12: HSDSA: Budget Details
T.E.C: $ 84,610,261
Cum Obligation: $ 21,242,790
Cum Expenditure: $ 17,759,553

		Dec.17-Sept.19	Oct-Dec.19	Jan-Mar.20	Apr-Jun.20
CLINs	Obligation	FY 2019 Q4 Actual Expenditures	FY 20 Q1 projected Expenditures	FY 20 Q2 projected Expenditures	FY 20 Q3 Projected Expenditures
	$ 21,242,790	17,759,553	1,592,489	1,845,935	1,888,433
CLIN 001	Direct Costs	8,141,403	529,063	587,847	587,847
CLIN 002	Subcontracts	6,441,977	769,454	769,454	794,454
CLIN 002a	*Small Business Subcontracts*	*45,034*	*25,000*	*25,000*	*50,000*
CLIN 002b	*Other Sub Contracts*	*6,396,942*	*744,454*	*744,454*	*744,454*
CLIN 003	Grants Under Contracts (GUC)	0	0	166,667	150,000
CLIN 004	Indirect Costs	2,896,797	224,637	252,632	252,944
CLIN 005	Total Fixed fee	279,376	69,335	69,335	103,188
	Total	17,759,553	1,592,489	1,845,935	1,888,433

Budget Notes (Listed below are assumptions, major changes, estimations, or issues intended to provide a better understanding of the numbers)

Salary and Wages	Salaries for the coming quarter will reduce due to the reduction in staffing as a result of staff rationalization in the project.
Fringe Benefits	Fringe benefit rate will be applied to salaries as per approved award.
Travel, Transport, Per Diem	Travel expenses will increase due to increased trips to project areas as implementation is accelerated in the coming quarter to the project sites.
Equipment and Supplies	Reduced supplies and equipment procurement due to staff rationalization.

Subcontracts	Only 2 Subcontractors will be reporting in the coming quarter due to the close out of CRS.
Other Direct Costs	Accelerated project activities including CMEs, orientation, trainings and meetings will be expected in the coming quarter.
Grants Under Contract	In the coming quarter we expect GUC process to conclude and on board KP partners.
Overhead	
G&A	Calculated as per Award conditions.
Material Overhead	

		Dec.17-Jul.19	Aug-Sept.19	Oct-Dec.19	Jan-Mar.20
CLINs	Obligation	FY 2019 Q3 Actual Expenditures	FY 2019 Q4 projected Expenditures	FY 2019 Q4 projected Expenditures	FY 2020 Q1 Projected Expenditures
	$ 21,242,790	15,369,517	1,843,807	1,519,877	1,632,587
CLIN 001	**Direct Costs**	7,227,576	709,472	483,297	483,297
CLIN 002	**Subcontracts**	5,349,834	879,716	730,131	769,039
CLIN 002a	*Small Business Subcontracts*	*47,784*	*0*	*0*	*38,907*
CLIN 002b	*Other Sub Contracts*	*5,302,050*	*879,716*	*730,131*	*730,131*
CLIN 003	**Grants Under Contracts (GUC)**	0	0	50,000	116,721
CLIN 004	**Indirect Costs**	2,523,121	199,669	197,992	200,738
CLIN 005	**Total Fixed fee**	268,986	54,950	58,457	62,792
	Total	**15,369,517**	**1,843,807**	**1,519,877**	**1,632,587**

Budget Notes (Listed below are assumptions, major changes, estimations, or issues intended to provide a better understanding of the numbers)

Salary and Wages	Salaries for the coming quarter will remain the same.
Fringe Benefits	Fringe benefit rate will be applied to salaries as per approved award.
Travel, Transport, Per Diem	Travel expenses will increase due to increased trips to project areas as a result of close out of Turkana and Narok counties and well as surge activities increase in other counties.
Equipment and Supplies	No major Procurement of equipment is expected.

Subcontracts	Sub contracts will increase in the coming quarter due to the expected close out of CRS and end of FY charges.
Other Direct Costs	Accelerated project activities including trainings and meetings will be expected in the coming quarter.
Grants Under Contract	No costs expected under GUC
Overhead	
G&A	Calculated as per Award conditions.
Material Overhead	

XIII. ACTIVITY ADMINISTRATION

Personnel: FHI 360 experienced several staff changes in FY19. In quarter 4 (Q4) of FY19, the need to down-size the project staffing was communicated based on the proposed Y3 funding. This downsizing reduced total project staffs from 97 to 54 with Senior Technical Officers reducing from 9 to 4 while the Technical Officer positions reduced from 19 to just 7. An objective criterion was developed to inform the downsizing. During the same period, the Director Monitoring and Evaluation was brought on board but unfortunately, she left after just one month. The Senior data Manager and DCOP positions was officially approved by USAID and were both filled. The Activity will need to go back to the drawing board on recruitment of the Director, M&E and Senior M&E positions. These are currently under way.

Contract Modifications and Amendments: Request to sub-contract WI-HER was submitted to USAID; awaiting approval. Additionally, a request to include key population activities was submitted to USAID and it's also awaiting approval**.**

XIV. SUCCESS STORY

Optimizing Access to ART through Community Distribution Points (Community ART Groups)

John and his wife were diagnosed with HIV in 2013. For years they used to travel the whole day from their home on the shores of lake Turkana to Namukuse Dispensary for their monthly check-ups and to get their drugs. But this has changed after the health facility allowed them to receive the medication right in their village as part of a decentralized, differentiated service delivery model known as community ART groups (CAGs) delivery of HIV care and treatment. The facility, with one nurse and three lay workers, has adapted this proven approach to local conditions to beat the odds to retain nearly all the clients enrolled for antiretroviral care since 2017, achieving a viral load suppression rate of 89% at September 2019 for the 196 clients.

When he fell ill in 2013, John made numerous trips from his home in Lokwarin village on the shores of Lake Turkana to hospitals in the county Capital, Lodwar, in search of treatment.

When he could no longer afford the costly trips, he decided to visit Namabusi dispensary, halfway between his home and Lodwar. It was here that he was counselled and tested for HIV. The results came out positive.

"I told my status to my wife and she accepted to be tested," says John. His wife was also found to be HIV-infected and the couple started antiretroviral treatment.

Above: Jane Mabuka, nurse in charge at Namukuse dispensary with community health worker. Below: A view of Namukuse dispensary

The journey from John's village is no mean feat. A return trip costs Sh1,000 by motorcycle taxi, which many cannot afford. For them, the only option is to simply walk over long stretches of sandy ground, braving the scorching sun and dust from numerous dwarf dunes for hours.

John and his wife were determined. They never missed their monthly appointments for medical checks and to collect their ARVs, eventually achieving viral load suppression. But not everyone always made it.

"We realized that some of the new people in our group were dropping out," says John, who had emerged as a champion for the group.

Due to the high transport costs which most people cannot regularly afford, some people simply walked for hours braving the scorching sun and dust for mini dunes that dot the parched landscape. Others did not make it to the health facility and skipped their appointments, missing out on important health checks and ARV refills. Some stopped treatment altogether.

"We realized that some of the new people in our group were dropping out," says John, who has emerged as an energetic champion for the group. O*pinion leader and HIV advocate Joseph Akurne "Hokee*".

"Defaulting on treatment was a big problem a few years back and there were many deaths," says Jane Mabuka, the nurse in charge at Namukuse.

Through consistent clients like John and local community health workers, Jane and her team of three lay health workers tried to reach HIV patients who interrupted treatment. But not all could be reached because of they are spread over a vast area and some migrate frequently in search of fish. In mid-2018, a team from USAID's Afya Nyota ya Bonde briefed Nancy and her team about the community-based ART approach. To Jane, taking ARVs to the community made perfect sense.

"I sensitized the support groups (of people living with HIV) and asked if they could be willing to get ARVs delivered to them in the community," says Jane. "I told them to go home and think about it."

John was among the first support group leaders to take up the idea. "We were many from my village, so I approached the hospital and asked if they could allow us to collect medicine for one another other and they agreed," says John.

But there was one condition. For the approach to work, the nurse asked HIV patients to form a strong group that would promote peer and psychosocial support. In John's case, there was no group. Individuals networked informally with other people living with HIV people who they met in the support group at the dispensary. Back home, John sought the advice of Joseph Akurne "Hokee", an influential community leader. Joseph has been living with HIV for over 10 years. Because he openly talks about his HIV status and is engaged in HIV educating the community about it, many people turn to him for help.

With the help of the local community health volunteer (CHV), Purity Lokope, Hokee and John mobilized clients they knew to form a support group. It took two months for them to bring together 15 members for the first meeting of the group. CHV Purity, who has been trained in HIV care and serves as the link between the community and the health facility, prepared the group and informed nurse Jane that they were ready to receive ARVs. Satisfied that the group was in place, Jane dispensed and packed ARVs for each member clearly labeled into a small box that was handed to John to deliver.

Given it was the first time this was being done, a lay treatment worker from the facility accompanied John to the village to explain to the group how to distribute the medication.

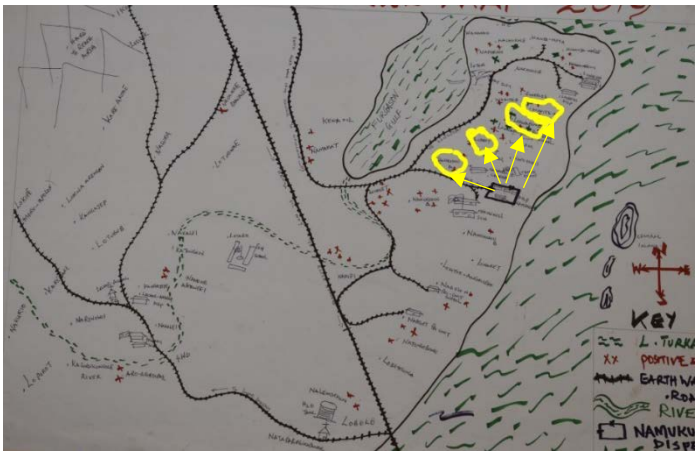
Today, the process is routine:

- The group sets a date for their meeting to coincide with when ARVs are collected and delivered.
- Members meet at the home of the person who collects the ARVs
- The meeting starts with members sharing experience and advising one another on how to cope with common challenges. The CHV, who has been trained on HIV home-based care, also contributes to the discussions.
- The CHV notes any members who need medical consultation and refers them to the dispensary.
- The box with ARVs is opened and each member given their bottles.

The peer-led support group has increased members confidence to talk openly about HIV and support one another to address their information and social needs.

"If a member does not show up for a meeting, the whole group visits the person at home to find out what the problem is," says Purity. "They encourage the person to remain on treatment. If the person is sick, they assist with household chores." - Nurse Jane agreed

Based on the experience at Lokwarin, the Namukuse team has helped support groups start community ART distribution points at Lopokorito, Nawakodou and Wadite (*See map*). These areas were among those found to have the highest number of HIV clients defaulting on treatment during mapping the facility conducted for an accelerated campaign to bring defaulters back to care.

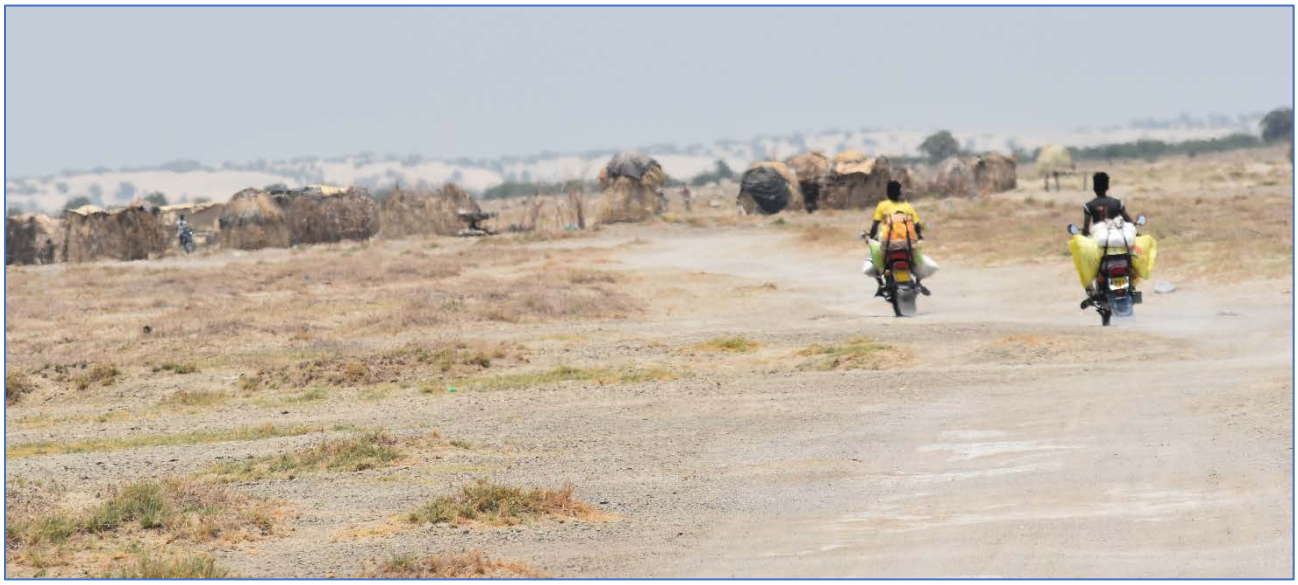


Additionally, the Namukuse team has opened two other sites initiated by the facility under a model lay health care providers. Unlike in the community model, the providers deliver the ARVs to clients who meet at selected sites in areas that had a high proportion of treatment defaulters. This approach is tailored for clients in mobile communities such as fishermen or pastoralists.

What started as a strategy to harness community networks in hard-to-reach areas to deliver ARVs has brought many other benefits. Home visits have helped to resolve other problems. For instance, fewer patients collect ARVs and store them without taking because the peers monitor and encourage them to continue taking the medicine. The group is also addressing alcoholism, blamed for treatment interruption, by many clients. Involving clients' in managing their HIV treatment and the strong bond created also helps in long-term retention of clients on care. It also relieves pressure on poorly staffed health facilities.

Congestion and the client load at health facility has reduced because of less frequent refills for clients as visits and appointment dates for most clients are spaced out. This allows more time for quality consultation for clients who need close monitoring and intensive adherence counselling. According to the facility in charge, there is potential to scale-up community ART distribution to 17 additional sites, nine of which are peer-led and 8 health care worker-led.

About Namukuse Health Dispensary



Residents transport goods on the road from Nakumuse to Lokwarin village on the shores of Lake Turkana. The village is one of four functional community ART distribution sites.

Namukuse Dispensary is in Kangatosa Ward along the western shores of the lake Turkana, about two hour's drive from Lodwar town. The facility catchment covers 30 villages, inhabited by mainly by pastoralist and fisherfolk communities.

The dispensary is 11 kilometres from Kolkol, a bustling trading center that hosts one of the region's largest fish markets, across very rough terrain characterized by mini-sand dunes. Patients visiting the health facility either walk or ride on motorcycle taxis, the only means of public transport.

The facility, one of 28 ART sites in Turkana Central sub-county, has a catchment population of just over 4,000. It is managed by a nurse assisted by a HIV counsellor, who is also a patient attendant and helps in keeping records, and two expert patients.

Besides the comprehensive care clinic for HIV, the facility provides other services such outpatient, HIV testing, maternal and child health, family planning, nutrition, antenatal and postanal care.