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USAID/KENYA AND EAST AFRICA *AFYA JIJINI* PROGRAM

QUARTER 3 PROGRESS REPORT-YEAR 4 (APRIL-JUNE 2019)

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USAID/KENYA AND EAST AFRICA AFYA JIJINI PROGRAM

FY2019, Y4 Q3 PROGRESS REPORT

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Photo Captions

Front Cover: (1) Afya Jijini's outreach activities aimed at sensitizing the community on HIV testing. (2) Laboratory analysis of blood samples. (3) Maternal health and childcare support to a new mother at a health facility.

Back Cover: Afya Jijini is supporting integrated, holistic and sustainable health systems strengthening Interventions that increase access to quality health care in Nairobi County. *(Photo Courtesy: Craig Thompson/IMA World Health)*.

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ACRONYMS AND ABBREVIATIONS

ACF Active Case Finding
ACT Accelerating Children's HIV/AIDS Treatment Initiative
AGYW Adolescents Girls and Young Women
ALHIV Adolescent Living with HIV
AMSTL Active Management of the Third Stage of Labor
ANC Antenatal Care
AoC Ambassador of Change
APOC Adolescent Package of Care
APR Annual Performance Report
ART Antiretroviral Therapy
AVD Assisted Vaginal Delivery
AWP Annual Work Plan
AYRSH Adolescent and Youth Sexual and Reproductive Health
BCC Behavior Change Communications
BemONC Basic Emergency Obstetric and Newborn Care
BHESP Bar Hostess Empowerment and Support Program
BMI Body Mass Index
CASCO County HIV/AIDS and STI Coordinator
CBD Community-Based Distribution
CBHIS Community-based Health Information System
CCC Comprehensive Care Center
CHA Community Health Assistant
CHAI Clinton Health Access Initiative
CHISP Nairobi City County Health Sector Strategic and Investment Plan
CHMT County Health Management Team
CHV Community Health Volunteer
CLTS Community-Led Total Sanitation
CME Continuing Medical Education
CMLT County Medical Laboratory Technician
CNAP County Nutrition Action Plan
CNTF County Nutrition Technical Forum
COC Continuum of Care
COP Country Operational Plan
COP Chief of Party
CTLC County TB/Leprosy Coordinator
CWC Child Welfare Clinic
CYP Couple-Years Protection
DAC DREAMS Advisory Committee
DBS Dried Blood Spot
DCM Differentiated Care Model
DCOP Deputy Chief of Party
DHIS2 District Health Information System 2
DICE Drop-In Center
DMPA Depot-Medroxyprogesterone Acetate
DOT Directly-Observed Therapy
DQA Data Quality Assurance
DREAMS Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe Women Initiative
EBF Exclusive Breastfeeding Feeding
EBI Evidence-Based Intervention
ECD Early Childhood Development
EID Early Infant Diagnosis
EMMP Environmental Monitoring and Mitigation Plan
EmONC Emergency Obstetric and Newborn Care
EMR Electronic Medical Record
eMTCT Elimination of Mother-to-Child Transmission
EPI Expanded Program on Immunization
FANC Focused Antenatal Care
FBO Faith-Based Organization
FGD Focus Group Discussion
FHOK Family Health Options Kenya
FMP Family Matters Program
FP Family Planning
FSB Fresh Stillbirth
FSW Female Sex Worker
GBV Gender-Based Violence
GoK Government of Kenya
HCSM Health Commodity and Supply Management
HCA HIV Cohort Analysis
HCBF Healthy Choices for a Better Future
HCMP Healthcare Management Plan
HCW Healthcare Worker
HCWM Health Care Waste Management
HEI HIV-Exposed Infant
HINI High-impact Nutrition Intervention
HOYMAS Health Options for Young Men on HIV/AIDS/STIs
HRIO Health Records and Information Officer
HPT Health Products and Technologies
HR Human Resources
HRH Human Resources for Health
HRM Human Resources Management
HSS Health Systems Strengthening
HTS HIV Testing Services
HWWK Hope Worldwide Kenya
HWMP Healthcare Waste Management Plan
ICF Intensified Case Finding
ICT Information Communication Technology
IEC Information, Education, and Communication
IEE Initial Environmental Examination
IFAS Iron and Folic Acid Supplementation
IMAM Integrated Management of Malnutrition
IMCI Integrated Management of Childhood Illness
INH Isoniazid
IPC Infection Prevention and Control
IPD Inpatient Department
IPT Isoniazid Preventative Therapy
IUCD Intrauterine Contraceptive Device
KEMSA Kenya Medical Supplies Agency
KEPI Kenya Expanded Program on Immunization

KHQIF	Kenya HIV Quality Improvement Framework
KII	Key Informant Interview
KMC	Kangaroo Mother Care
KMTC	Kenya Medical Training College
KP	Key Population
KQMH	Kenya Quality Model for Health
KSG	Kenya School of Government
L&D	Labor and Delivery
LARC	Long-Acting Reversible Contraception
LDP+	Leadership Development Program Plus
LGBT	Lesbian, Gay, Bisexual, and Transgender
LMIS	Logistic Management Information Systems
LMS	Leadership Management and Sustainability
LTFU	Lost-to-Follow-Up
M&E	Monitoring and Evaluation
MAM	Moderate-Acute Malnutrition
MAP	Men as Equal Partners
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant TB
MDSR	Maternal Death and Surveillance Response
MDTs	Multi-Disciplinary Teams
MEC	Medical Eligibility Criteria
MHMC	My Health, My Choice
MIYCN	Maternal Infant and Young Child Nutrition
MLKH	Mama Lucy Kibaki Hospital
MMR	Measles, Mumps, Rubella
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MPDSR	Maternal and Perinatal Death Review, Surveillance, and Response
MSW	Male Sex Workers
MTC	Medicine Therapeutic Committee
MUAC	Mid-Upper Arm Circumference
NACC	National AIDS Control Council
NACS	Nutritional Assessment Counseling and Support
NASCOP	National AIDS and STI Control Program
NCC	Nairobi City County
NHIF	National Health Insurance Fund
NHRL	National HIV Reference Laboratory
NPA	Nasopharyngeal Aspirates
NPA/NG	Nasogastric and Nasopharyngeal Aspirate
NTLDP	National Tuberculosis, Leprosy, and Lung Disease Program
ODF	Open Defecation-Free
OI	Opportunistic Infection
OJT	On-the-Job Training
OPD	Outpatient Department
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OTP	Outpatient Therapy
OVC	Orphans and Vulnerable Children
PAC	Post-Abortion Care
PCR	Polymerase Chain Reaction (test)
PEP	Post-Exposure Prophylaxis
PHDP	Positive Health Dignity and Prevention
PHO	Public Health Officer
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
POC	Point-of-Care
POU	Point-of-Use
PPFP	Post-Partum Family Planning
PrEP	Pre-Exposure Prophylaxis
PSM	Patient Self-Management
PSS	Psychosocial Support
PSSG	Psychosocial Support Group
PT	Proficiency Testing
QA	Quality Assurance
QA/QI	Quality Assurance/Quality Improvement
QI	Quality Improvement
QIT	Quality Improvement Team
RDQA	Routine Data Quality Assessment
RED	Reach Every District
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
RRI	Rapid Results Initiative
RTK	Rapid Test Kit
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAB	Social Asset Building
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendants
SCASCO	Sub-County HIV/AIDS and STI Coordinator
SCHMT	Sub-County Health Management Teams
SCMLT	Sub-County Medical Laboratory Technician
SCNTF	Sub-County Nutrition Technical Forums
SCPHN	Sub-County Primary Health Care Nurse
SCTLC	Sub-County TB/Leprosy Coordinator
SGBV	Sexual- and Gender-Based Violence
SIA	Supplemental Immunization Activities
SOPs	Standard Operating Procedures
SMLT	Sub-County Medical and Laboratory Technologist
SRH	Sexual and Reproductive Health
STI	Sexually-Transmitted Infection
STLC	Sub-County Tuberculosis and Lung Disease Coordinator
TA	Technical Assistance
TB	Tuberculosis
TIBU	EMR for TB patient data
TOR	Terms of Reference
TOT	Training of Trainers
TPA	Treatment preparation and Adherence
TWG	Technical Working Group
UCLTS	Urban Community-Led Total Sanitation
UCT	Unconditional Cash Transfer
UHAI Team	An IMA innovation of technical support teams
VAS	Vitamin A Supplementation
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation, and Hygiene
WCD	World Contraception Day
WITs	Work Improvement Teams
WRA	Women of Reproductive Age
YFS	Youth-Friendly Services

EXECUTIVE SUMMARY

The USAID/Kenya and East Africa Afya Jijini Program (hereafter, Afya Jijini) is a five-year $48 million program managed by IMA World Health in collaboration with the Mission for Essential Drugs and Supplies (MEDS), the National Organization of Peer Educators (NOPE), and the Christian Health Association of Kenya (CHAK). It is designed to improve and increase access to and utilization of quality health services in Nairobi through strengthened service delivery and institutional capacity of the county's health systems.

This report gives an account of the results obtained for the period of ***April 1 – June 30, 2019***. It highlights progress and milestones in the implementation of the program, challenges encountered, and provides a strategic outline of interventions being made to achieve the program goals, objectives, and targets.

In quarter three (Q3), Afya Jijini continued implementing the first option year of the contract while advancing the mission of strengthening Nairobi City County (NCC)-level institutional and management capacity to deliver quality healthcare services. Specifically, the project aimed to improve access to and uptake of quality health services in NCC for the most pressing health issues, with a focus in the informal settlements. The program implemented its objectives through three main sub-purposes including:

1. Increasing access to and use of quality HIV/TB services
2. Improving access to and uptake of maternal, neonatal, and child health (MNCH), family planning (FP) and reproductive health (RH), Water, Sanitation and Hygiene (WASH), and nutrition services.
3. Strengthening county and sub-county health systems.

During the quarter, the following marked the key highlights under the sub-components.

Sub-Purpose 1: Increased Access and Utilization of Quality HIV Services

During the quarter, the program intensified interventions aimed at increasing access and utilization of quality HIV services. As progress towards achieving the targets of the first 95, Afya Jijini confirmed the status of 13,012 pregnant women (59% of the target). From this cohort, 262 women were identified as new HIV-positive cases during the quarter while 341 were known positives. Overall, the program initiated 1,746 new clients on treatment during the quarter, totaling to 5,948 patients (86% of the APR target) at the end of the Q3 reporting period. 86% of HIV-positive clients were linked to treatment and initiated on ART on the same day; 132 (8%) were initiated within the first two weeks of testing positive; and 25 (1.5%) were linked after two weeks in the second 95. Retention of ART clients at 12 months was at 76%. Afya Jijini supported 14,055 clients to access and receive valid VL results, out of which 92% were virally suppressed. In prevention, the project-trained Voluntary Medical Male Circumcision (VMMC) teams reached 1,411 clients contributing to 94% of the annual target. Under DREAMS, the project has enrolled a cumulative of 14,634 AGYWs that continue receiving the DREAMs interventions.

Sub-Purpose 2: Increased Access and Utilization of Focused Maternal, Newborn, and Child Health, Family Planning, Water, Sanitation, and Hygiene, and Nutrition Services

In Q2, Afya Jijini provided technical support as per MOH guidelines at the facility levels through mentorship sessions, OJTs, and CMEs aimed at improving the quality of child health care. *Afya Jijini* officers, working closely with the Sub-County EPI coordinators, mentored HCWs on the documentation in the daily activity registers. The program continued to distribute FP guidelines, community family planning manual, Tiarht charts, SOPs, counselling cards, minimum eligible criteria (MEC) wheels, and job aids which offer quick check lists for the HCWs to use during counselling as well as guidance on what to do when providing the services. To improve nutrition in informal settlements, the project supported supervision visits across sub-counties.

The key outcomes of the quarter include 24,915 women received at least 4 ANC visits; 24,405 births conducted by skilled attendants; 26,671 children received full immunization; 21,710 cases of diarrhea treated; 211,211 children provided with Vitamin A supplements; and 33,004 pregnant women were reached with nutrition interventions.

Sub-Purpose 3: Strengthened and Functional County Health Systems

Under health systems strengthening support to the county health department, *Afya Jijini* prioritized annual work planning and budget development; health facility leadership capacity development; health products and technology oversight and facility focused quality improvement interventions. Specifically, the program supported a stakeholders' forum to foster collaboration by Nairobi-based implementing partners and share 2019/2020 AWP priorities. In addition, Pumwani Maternity Hospital was supported to initiate their planning processes by participating in a visioning exercise and SWOT analysis. On HRH capacity development, Afya Jijini hosted a results dissemination workshop with trainees from three Level 4 hospitals and seven health centers.

Apart from receiving technical support on consumption-based forecasting and quantification and commodity distribution, the department also benefited from mentorship on good commodity management practices resulting in improved reporting rates and reduced stock-outs — sustained support to sample networking led to a sustained viral load sample rejection rate of less than 2%. Besides providing technical assistance to quality improvement technical working groups in line with Kenya Quality Model for Health (KQMH), and Kenya HIV Quality Improvement
Framework (KHQIF), the county teams are being supported to hold an award and recognition ceremony for health facilities who demonstrate and provide quality health services as measured by the Kenya Quality Model for Health. The projects developed and being implemented by the work improvement team (WITs) at facilities are yielding positive results and indicated by improved HIV Exposed Infant (HEI) testing.

Key challenges encountered during Q3 included top leadership management changes at the County level, which negatively affected the implementation of project activities; rapid test kit stock outs challenged HTS provision; inadequate supplies of blood and blood products created challenges in managing hemorrhage cases; and availability of Amoxicillin DT since KEMSA withheld supplies due to debts owed by NCC. Continuous collaboration with the County Government, local health facility teams and other development partners was a strategic approach that helped navigate through the challenges in the quarter for improved outcomes.

PROGRAM ADMINISTRATION

No significant constraints or critical issues were encountered in the process of project administration within the year. All key personnel remained during this period, and the program is fully operational.

NEXT QUARTER'S WORK PLAN

All work plan activities were completed on time and submitted to the COR.

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

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

Afya Jijini's eMTCT approach utilizes the global four-pronged approach to Prevention of Mother-to-Child Transmission (PMTCT). In Q3, the program addressed each prong through multiple activities, as detailed in the table below.

Table 1: eMTCT Implementation by Prong (FY19/Q3)

Prong	Activity implementation
Prong 1	Activities 1.1.1 and 1.1.9 provided patient education, HIV testing services (HTS), condom distribution in service areas, use of PrEP and ART in discordant couples, and HIV self-testing and activities targeting HIV prevention in adolescent girls and young women (AGYW) as part of prevention activities.
Prong 2	Activities 1.1.1, 1.1.2, and 1.1.9 provided access to family planning (FP) services through the integration of reproductive health (RH) services in Comprehensive Care Center (CCC) in 12 facilities and client referrals.
Prong 3	Activity 1.1.3 linked and initiated all HIV-positive pregnant and breastfeeding mothers on ART and monitored for viral suppression and retention, and through Activity 1.1.4 tracked HIV exposed infant (HEI) cohorts for eMTCT outcomes and impact.
Prong 4	Activities 1.1.3, 1.1.5, 1.1.7, and 1.1.8 provided lifelong support to the mother and child as the index clients to reach out to other family members for HTS and linkages.

The focus for this quarter was to ensure continuity of quality and sustainable PMTCT services and that SURGE activities and strategies were implemented across facilities. Further, *Afya Jijini* focused on the implementation of assisted partner notification services (aPNS) for PMTCT clients to boost the identification of HIV infected clients. *Afya Jijini* continued to work with 37 facilities to ensure that integration of eMTCT and maternal and child health (MCH) services was maintained.

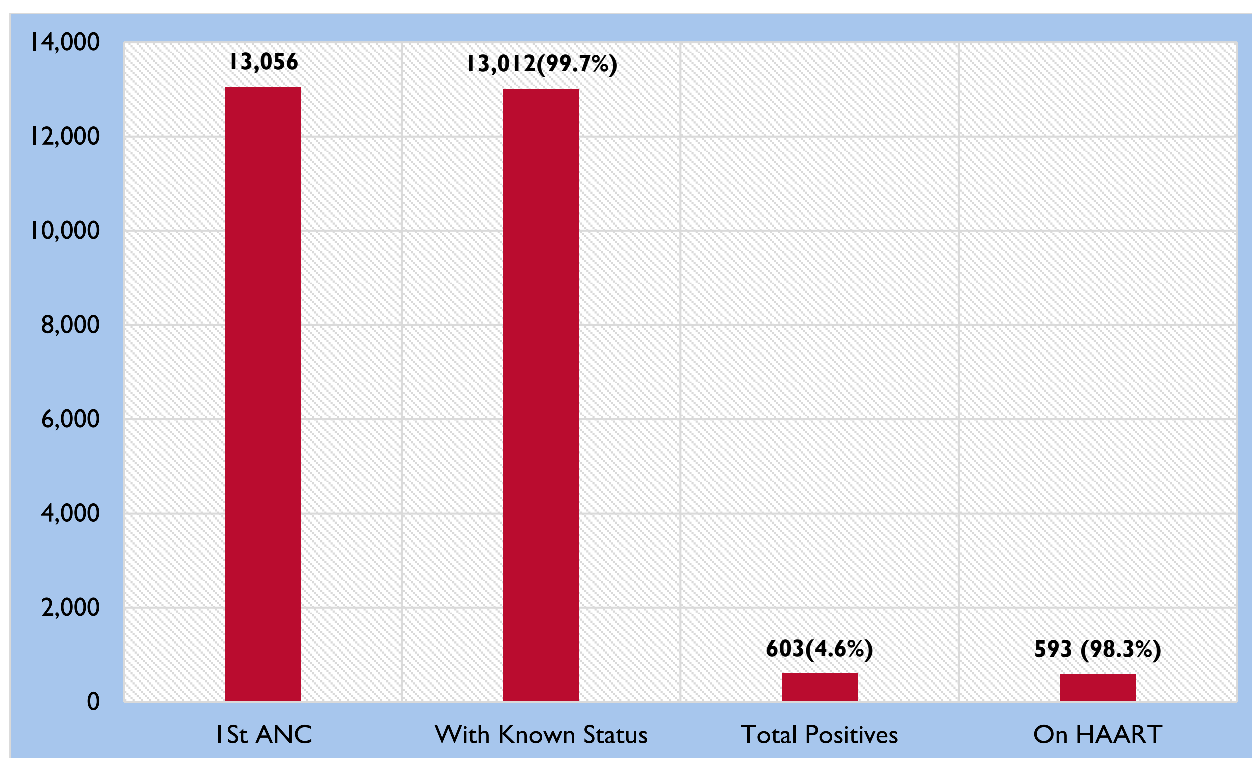

Figure 1: eMTCT at 1st Antenatal Care (ANC) in Q3

Identify 3,059 HIV-positive pregnant women through HIV testing and re-testing

In Y4 Q3, *Afya Jijini*-supported facilities offered HTS to 13,012 women out of the 13,056 who attended first ANC services, translating to a 59% achievement of the PMTCT_STAT[1] target. A total of 341 women already knew their HIV-positive status and were not tested; 262 were newly identified as HIV-positive, achieving 59% of the annual target for identification of HIV-positive pregnant women. *Afya Jijini's* focus during the quarter was to ensure that all first ANC clients with unknown HIV status received HTS through the integrated system for HIV testing implemented across the facilities. Mentorship activities were provided for healthcare workers (HCWs) on HIV testing throughout the quarter by *Afya Jijini's* UHAI[2] teams.

Improve eMTCT-Maternal, Newborn, and Child Health (MNCH) integration

The *Afya Jijini* program team worked to ensure that integration of eMTCT and MCH services was maintained: 21 program supported PMTCT nurses who have been trained on eMTCT service delivery continued to support service integration in high-volume facilities throughout the quarter. *Afya Jijini* managed to integrate PMTCT services into one additional facility this quarter, reaching a total of 37 facilities with PMTCT services integrated into MCH. To increase coverage for first ANC, *Afya Jijini* will continue to work closely with Sub-Purpose (SP) 2 to identify pregnant women and refer them for ANC services and subsequently provide HTS. Facility-based continuing medical education (CME) on integration was conducted this quarter. To ensure that HIV infected women have access to contraception, eight facilities provided RH services within the CCCs. *Afya Jijini* aims to integrate RH services in seven additional facilities.

[1] *Number of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC*
[2] *Swahili name, meaning life---associated with key cluster teams of the Afya Jijini program*

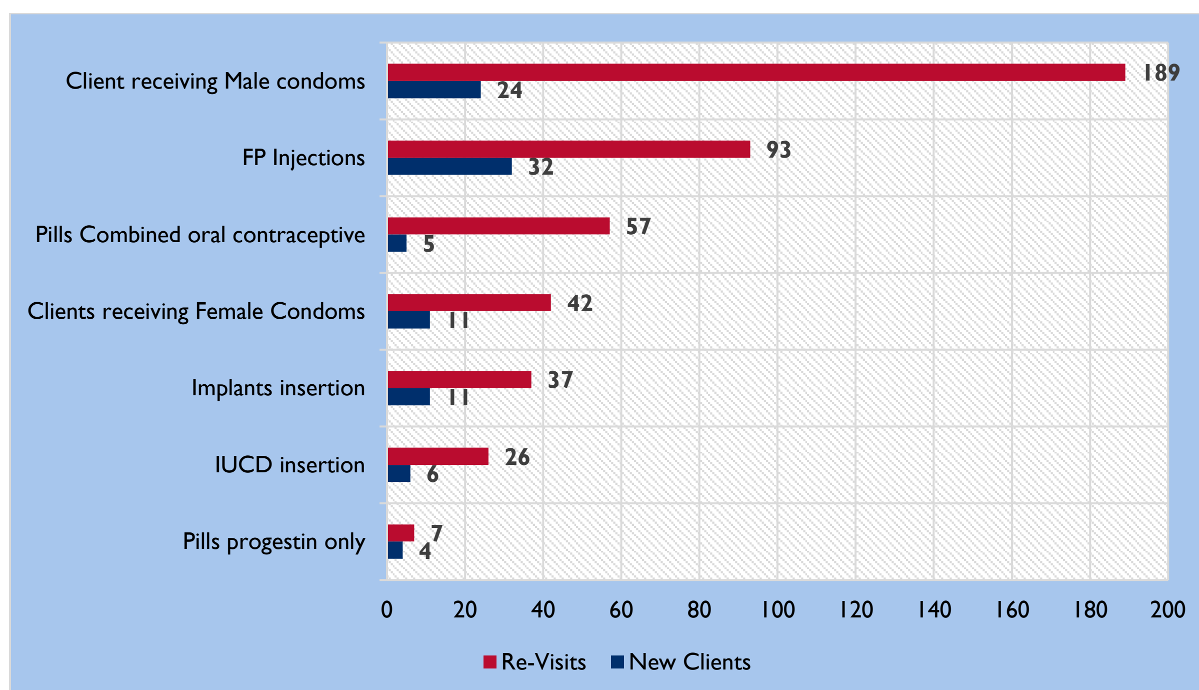

Figure 2: family planning (FP) method mix in CCC

Enroll 2,914 HIV-positive pregnant women on ART and achieve 95% VL suppression

Of the 603 women identified as HIV-positive during the quarter, 593 were initiated on highly active antiretroviral therapy (HAART). *Afya Jijini* supported facilities and enrolled 1,760 HIV-positive women by the end of Q3, achieving 60% of the PMTCT ART target. Stock-outs of Nevirapine (NVP) syrup continued to be experienced in facilities during the quarter. Redistribution was supported to ensure that infants did not miss prophylaxis. Additionally, AZT syrup was provided for breastfeeding infants following recommendations from the National AIDS and STIs Control Programme (NASCOP) as the country waits to receive additional NVP syrup.

Table 2: Viral load uptake

	6 months	12months	24months
Eligible	475	528	431
Viral load tested	319	358	286
Viral load suppressed	93%	96%	92%
Retention in care	90%	88%	87%

Afya Jijini continued to support on-the-job mentorship to build the capacity of nurses and clinical officers to monitor viral suppression and retention of mothers in the program as per the national ART and PMTCT guidelines.

Viremia clinics continued in 17 facilities. Data from these facilities demonstrated that of the 175 clients enrolled for follow-up, 134 (77%) completed three enhanced counseling sessions, of which 96 (72%) were suppressed on repeat VL, with 14 patients switching to the second line.

Support and track HIV-exposed infants (HEI)

Afya Jijini continued to support HCWs in conducting the HEI cohort analysis. In Q3, 553 HEI born during the April – June 2018 cohort were enrolled for follow up, while 501 HEI of the April – June 2017 cohort were enrolled. In the first review (2018 cohort), seven infants were reported as HIV-positive, and 100% of them were linked to care. In the 2017 cohort, nine infants (2%) were identified as HIV-positive, and all were initiated on ART. In Q3, 464 (84%) of infants enrolled were active in follow up at 12 months, while 350 (70%) of infants were active in follow up by 24 months. Facility-based and community-based mentors continued to support retention, identification, and tracking of defaulters and led psychosocial support group (PSSG) activities both at the facility and community levels.

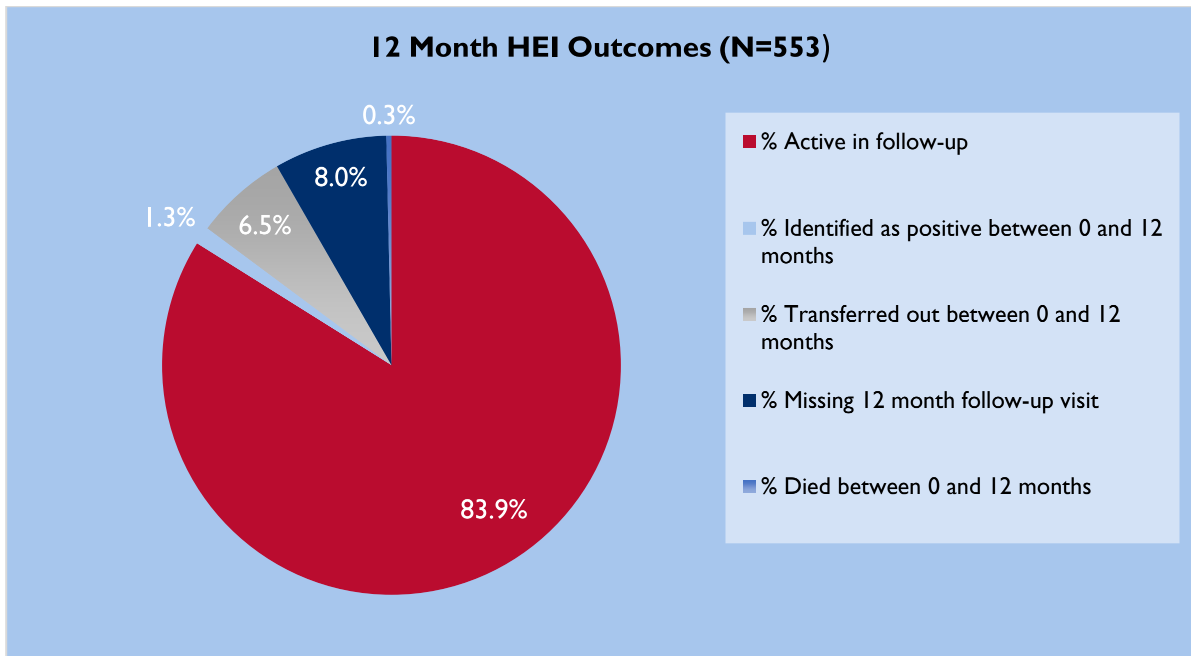

Figure 3: 12 Months of HEI Outcomes

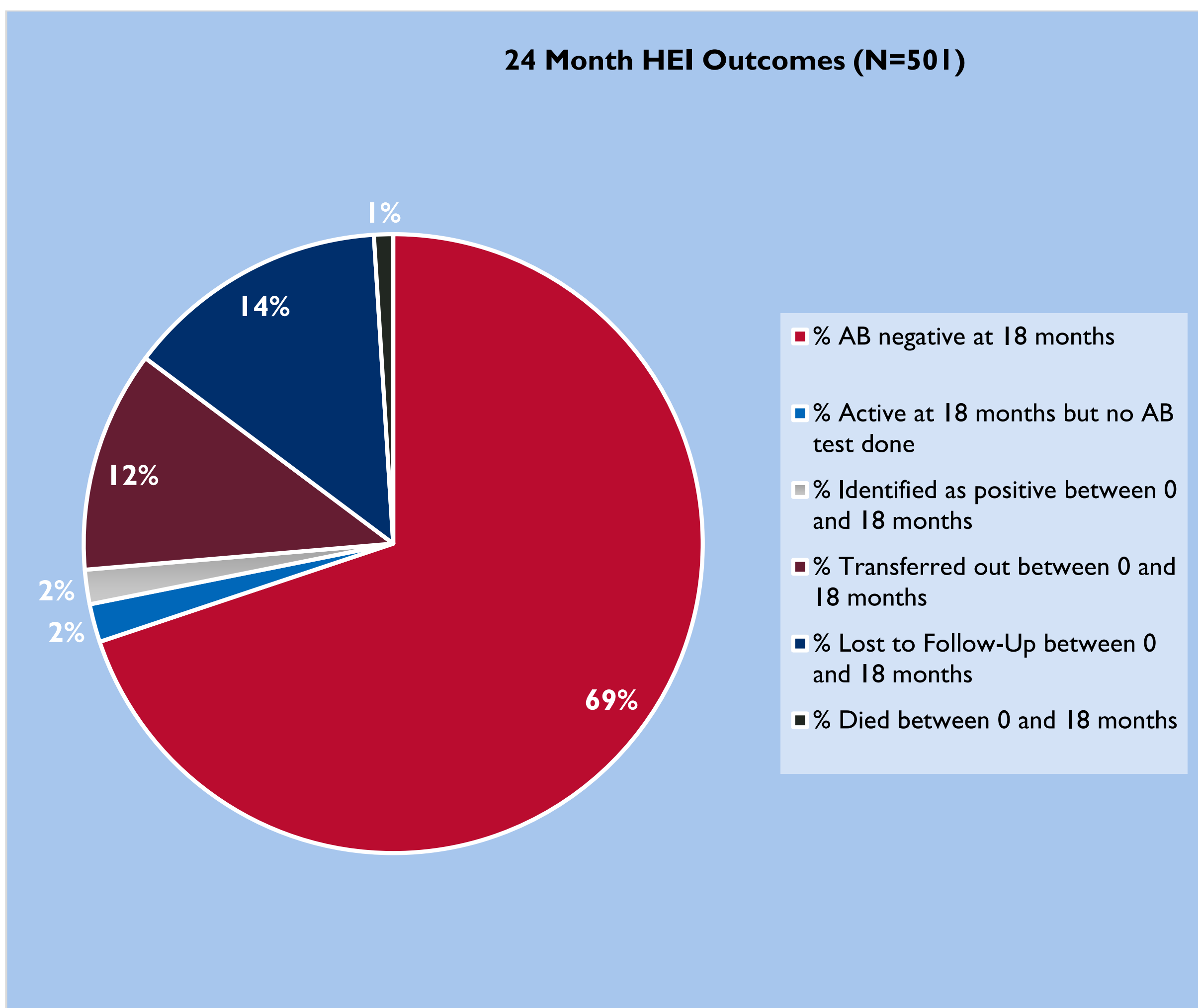

Figure 4: 24 months of HEI outcomes

Increase mother-baby retention in the eMTCT cascade

In Y3, *Afya Jijini* awarded a sub grant to the St John's Community Center (SJCC) to improve retention of the mother-baby pair in 19 *Afya Jijini*-supported facilities that contributed to the highest rates of loss to follow up. SJCC works with 51 facility-based mentor mothers and 28 community-based mentor mothers to provide peer education and PSSGs. Supervision and mentorship activities for mentor mothers continued during the quarter through the *Afya Jijini* UHAI teams and the SJCC program officers. To ensure timely follow-up of mother and baby, on the job training (OJT) was provided on documentation in the mother-baby pair longitudinal registers, defaulter tracing and identification registers, and community linkage registers. In Q3, the mentor mothers provided referrals and linkages for various services to clients.

Boosting eMTCT focused stakeholder collaboration

Afya Jijini continued to support collaborative activities with the county and sub-county health teams. During the quarter, one stakeholder meeting was held to review eMTCT progress. A PMTCT regional stakeholder meeting supported by NASCOP was also held in the quarter. The purpose of this meeting was to share best practices across counties to improve service delivery of PMTCT to achieve eMTCT.

Strengthening ART linkages for HIV-positive infants

In Q3, the program collected and delivered 594 dried blood spots for initial polymerase chain reaction (PCR) testing at the Kenya Medical Research Institute (KEMRI). Of those, 20 (3.4%) reported as HIV-positive. Treatment was initiated for 16 infants; one was lost to follow-up, and three are actively being followed up. A total of 488 early infant diagnosis (EID) tests were collected for babies under the age of two months, which represents 81% of the HIV-positive women identified during the quarter. *Afya Jijini* continued to emphasize timely initiation of ART for all HIV-positive infants through mentorship of HCWs. Mentorship activities also focused on updating the treatment status of the HIV-positive infants on the NASCOP EID database.

Strengthening family-centered HIV testing and care

PMTCT nurses, HTS counselors and mentor mothers jointly worked to identify sexual contacts of PMTCT clients, making contact through phone calls to increase identification of HIV-infected clients and link them to treatment. During the quarter 404 out of 416 PMTCT clients accepted aPNS. A total of 680 sexual contacts were identified, with an elicitation ratio of 1:1.7, of which 632 were eligible for testing. Of those, 294 (47%) were offered testing services, and 34 HIV-positive individuals were identified positive, and all were linked to care. UHAI teams at *Afya Jijini* will continue to mentor nurses, HTS counselors, and mentor mothers on aPNS, and support will also be provided to test at home for contacts who give consent.

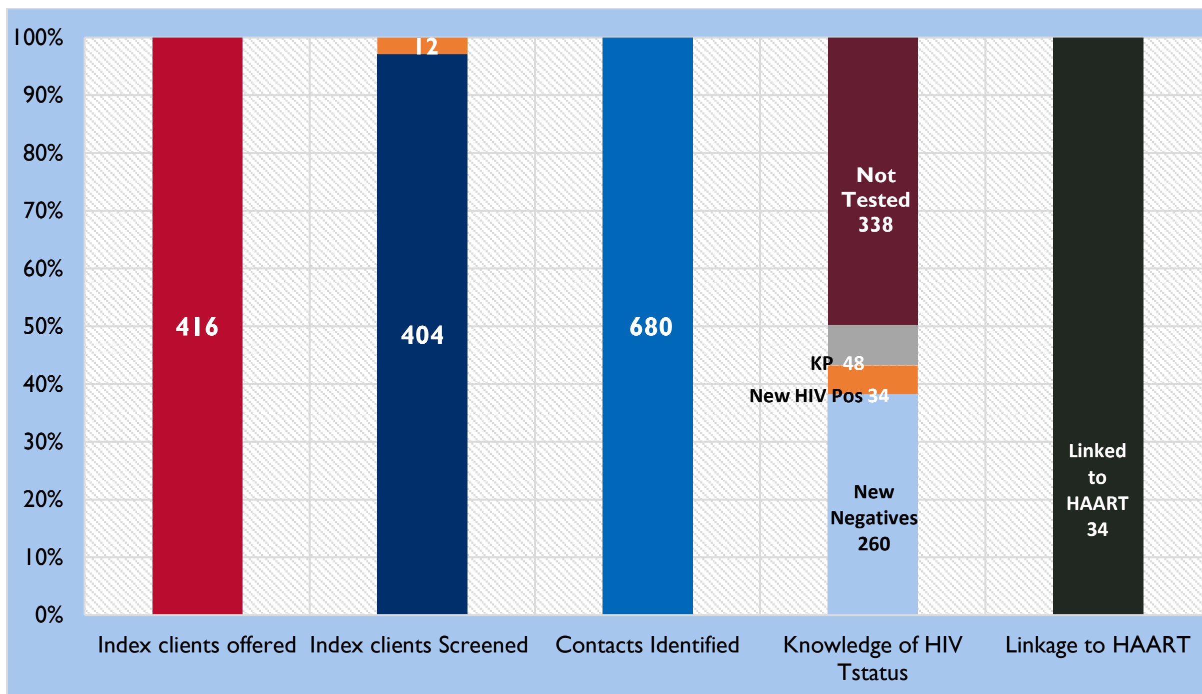

Figure 5: aPNS Cascade in PMTCT

Increasing adolescent-friendly ANC services

During the quarter, adolescent specific PMTCT PSSGs were formed in five facilities, namely Mbagathi, Kayole 2, Kangemi, Kariobangi North, and Kangemi H/C. These groups provided information and education to adolescent mothers to improve viral suppression, increase retention, and prevent MTCT of HIV. A total of seven facilities now have PSSGs for adolescent PMTCT clients.

1.2 Output 1.2 and 1.3 HIV/TB Care, Support, and Treatment Service

Initiating 7,174 new clients on ART

In Y4 Q3, the intensified HIV interventions (SURGE) aimed to improve retention and initiation of newly diagnosed clients to ART. Newly diagnosed patients were counseled and initiated on ART at the site or were transferred out to continue ART services at their site of choice. The intervention of fast-tracking initiation of new clients led to an improvement in the number of clients enrolled on ART on the same day as shown in figure 6 below. A total of 2,083 clients (86% of the target), were diagnosed as HIV-positive, of which 1,713 (82%) were linked to care. Of those, 1,475 (86%) were linked and initiated on ART on the same day; 132 (8%) were initiated within the first two weeks of testing positive, and 25 (1.5%) were linked after two weeks. Altogether, there were 5,948 patients newly diagnosed with HIV at the end of Q3, representing 86% of the annual performance report (APR) target.

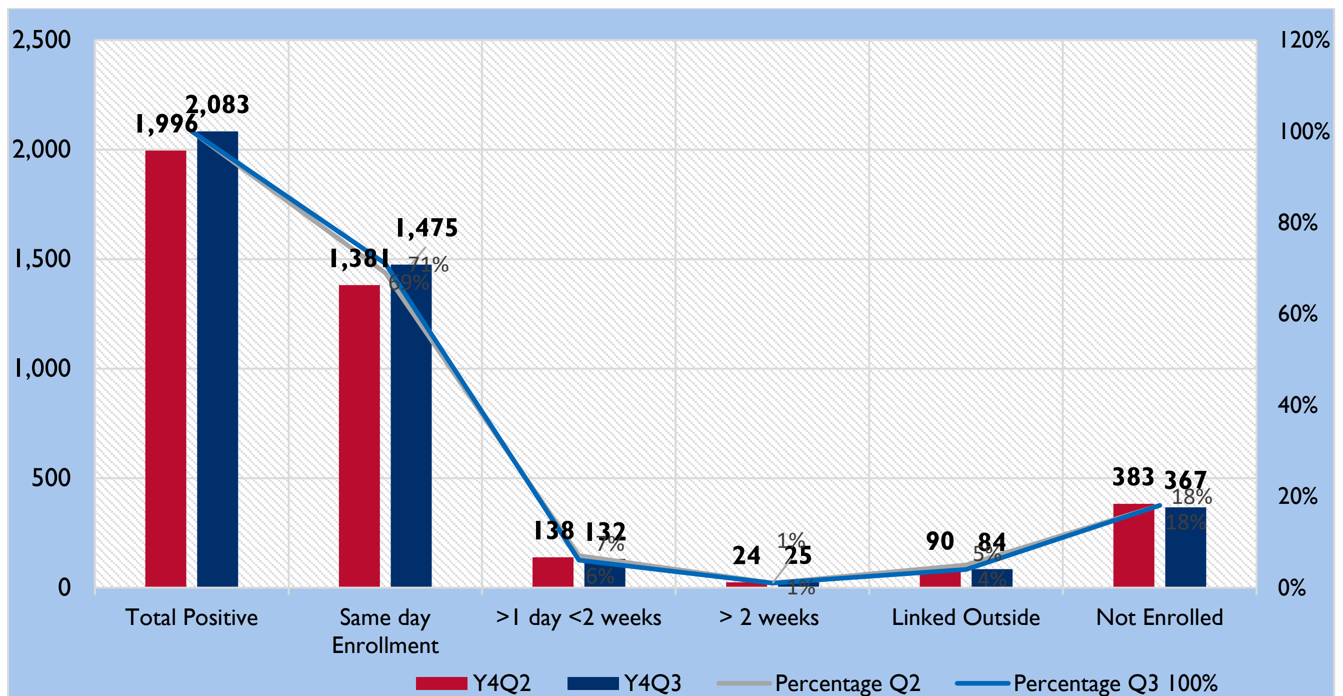

Figure 6: New clients on ART

Of those linked to treatment, 1,632 were enrolled at an *Afya Jijini* testing facility, and 84 were linked to other sites for treatment (including sites that were both supported and non-supported by *Afya Jijini*). This success in linking eligible clients to treatment is attributed to the strategy of enhanced mentorship on same-day enrollment, ART treatment preparation by adherence counselors, peer educators, and clinicians.

Boosting HIV Treatment Adherence Support

To enhance adherence and retention to treatment, *Afya Jijini* continued working through peer educators and adherence counselors to provide monthly population specific PSSGs for new clients on treatment, including pediatric, adolescent, caregiver, and non-suppressed clients. Daily PSSGs and patient self-management (PSM) sessions continued in 22 project-supported facilities, reaching 33,984 clients. The table below provides a breakdown by the different PSSG types that were instrumental in fostering retention to care. During this quarter, the program continued to work with 27 treatment preparations and adherence (TPA) counselors engaged under AMURT (a local sub grantee) to provide support for adherence and retention in the project-supported facilities. The TPA providers received continuous mentorship and on-the-job training on adherence and retention during the quarter.

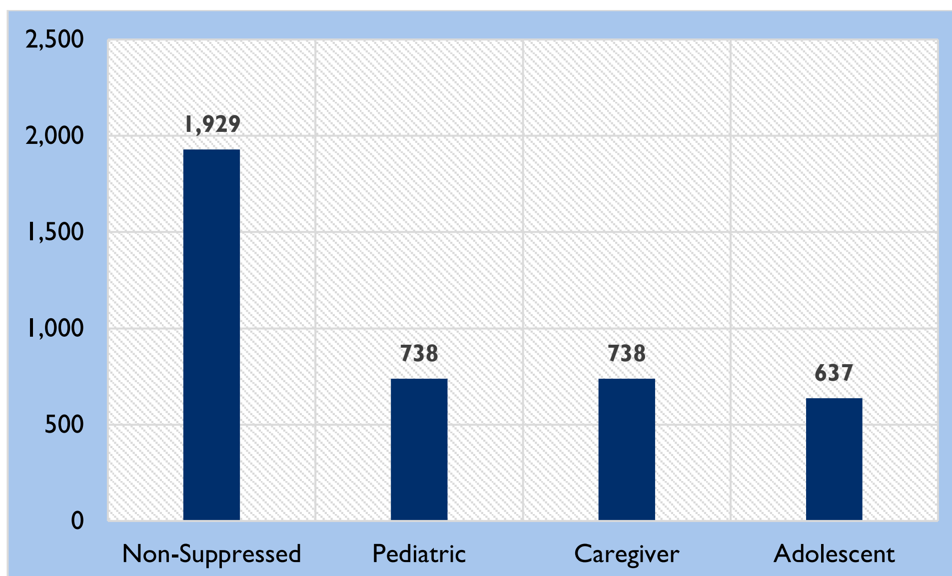

Figure 7: PSSG support Services

Continuous Mentorship on implementation of the New ART Guidelines

Afya Jijini provided mentorship and on-the-job training to 187 HCWs, including clinicians, nurses, TPAs, HTS counselors, peer educators, and mentor mothers on effective implementation of the 2018 ART guidelines and optimization strategies.

Scale-up and support pediatric and adolescent ART

As of the end of Q2, *Afya Jijini* supported 1,296 children (0-14 years) and 3,231 adolescents (15-24 years) in accessing treatment services. Out of the children enrolled, 1,066 had a VL measured with an 87% suppression rate. Out of the adolescents enrolled, 2,652 had their VL measured, and 86% adhered to clinic appointments and ART.

Strengthening HIV defaulter tracing

Afya Jijini continues to conduct defaulter tracing through peer educators for patients who miss clinical appointments. The table below identifies the outcomes of defaulter tracing for Y4Q3.

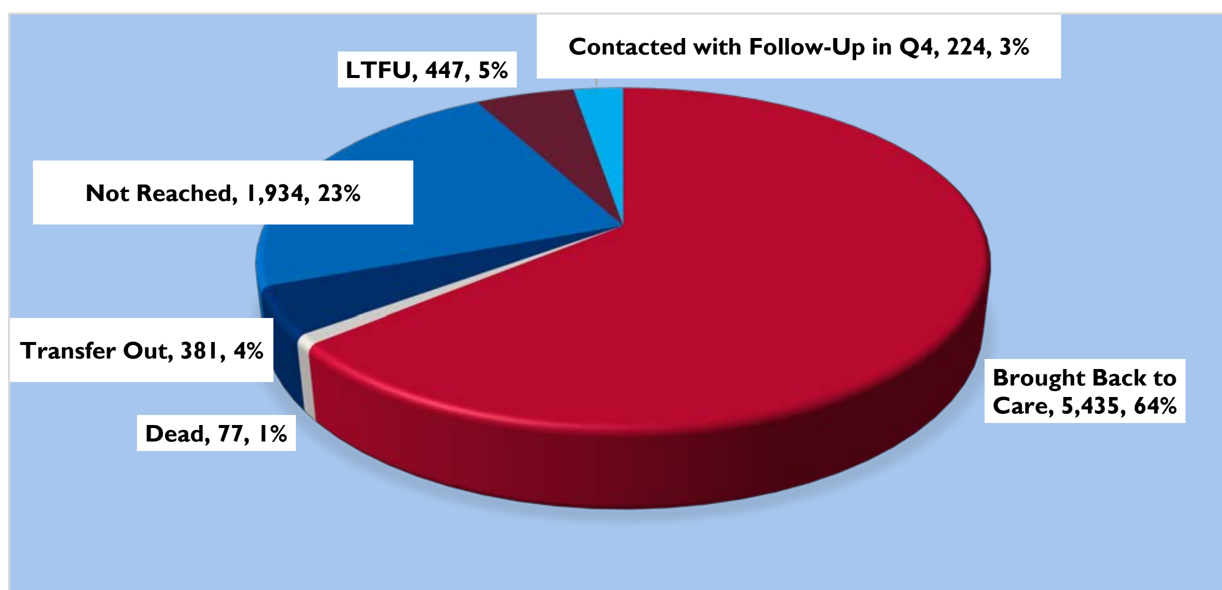

Figure 8: Defaulter tracing (n=8,498)

During the quarter, *Afya Jijini* continued working with WOFAK, a sub grantee, to improve defaulter tracing efforts through chart abstraction and line listing of all active clients and defaulters. The project supported 48 peer educators in project facilities and provided mentorship and OJT on the defaulter management process, including correct documentation in the defaulter tracing registers. The peer educators worked to line list and trace all defaulters through phone and home visits when feasible and documented outcomes in the defaulter tracing register. Job aids and reporting tools such as appointment diaries and defaulter tracing registers were provided to facilities as needed. The technical team from Afya Jijini empowered the peer educators through mentorship on the use of these tools at the facility level to attain the program objectives.

Increase VL uptake and suppression

VL Uptake: The program supported VL testing for 34,182 clients. Enhanced mentorship and OJT was provided to clinicians and TPAs to strengthen implementation of high viremia clinics in 29 facilities. Daily bleeding was conducted throughout Q3, reaching 14,055 clients, with 12,949 (92%) suppressed. Patients without a current VL were line listed and fast-tracked for sample collection through TPAs who conducted phone tracing. Joint supportive supervision and mentorship sessions were conducted by the *Afya Jijini* and sub-county mentors.

Viral Load (VL) Suppression and Review: The program continued to mentor clinicians, PMTCT nurses, and TPAs on the use of the high VL register and clinical summary tools. The program ensured that Multidisciplinary Team Meeting (MDT) meetings across all supported facilities were active and meeting regularly to review clients with un-suppressed VLs. The program sites identified 2,036 patients with non-suppressed VLs during Q3; of those, 1,188 had a repeat VL after undergoing satisfactory enhanced adherence sessions, and 223 of those were switched to second-line therapy.

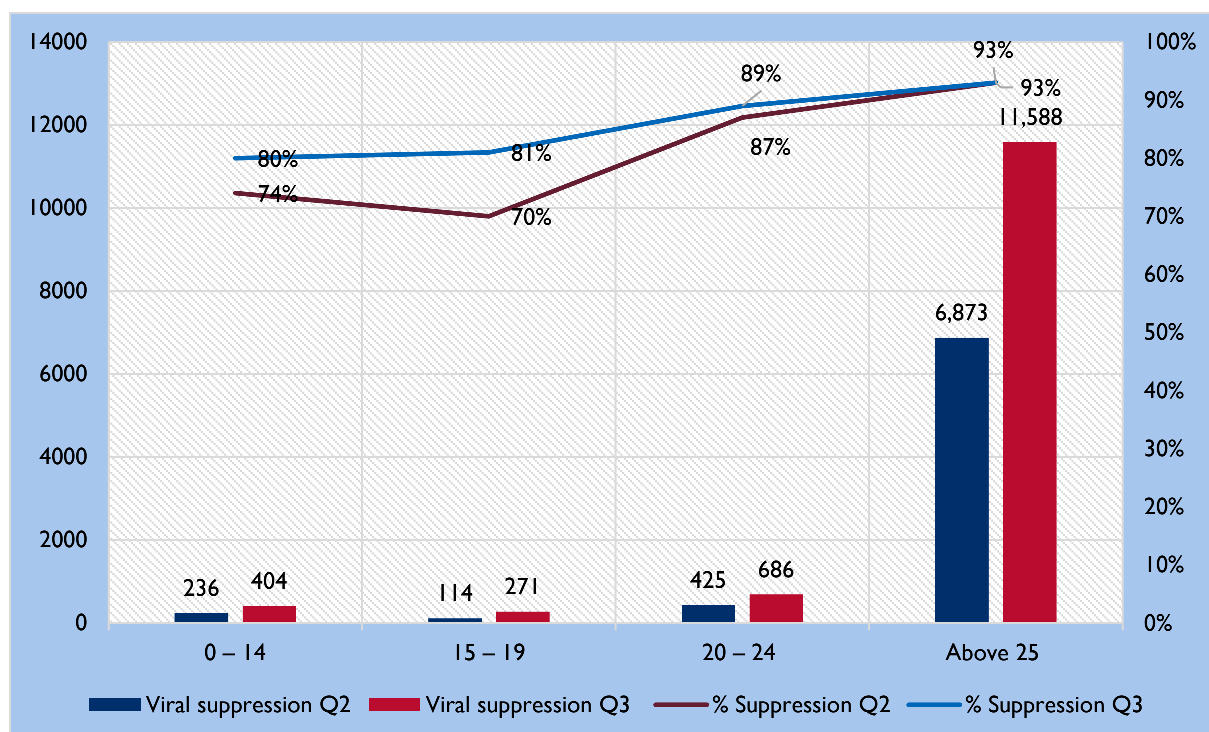

Figure 9: Viral load suppression trend

Treatment optimization

Implementation of Differentiated Care Model (DCM)

Following the guidance from NASCOP about the re-categorization of patients on Tenofovir/Lamivudine/Dolutegravir (TLD) regimen as stable, Afya Jijini supported project facilities to review the DCM processes and align the categorization of patients with the new guidance. As of the end of Q3, *Afya Jijini* supported DCM in 34 facilities, with 8,848 (59%) out of the 14,953 stable patients line listed enrolled on a fast track. Of the 3,126 patients enrolled on a fast track for more than 12 months, 2,982 had VLs done, with 2,889 (97%) achieving viral suppression. A total of 3,309 appointments were scheduled, and

88% kept their appointment. *Afya Jijini* partnered with the county to support the implementation of DCM through the quality improvement (QI) approach. Three facility-based coaching visits at *Afya Jijini*-supported sites were conducted, and one NASCOP-led ECHO session was conducted to support implementation.

Roll-out of early morning clinics targeting male clients

During Q3, the program team intensified the implementation of male-only clinics to reach out to working-class men who prefer attending clinics early in the mornings. A total of 629 men attended the early morning clinics and, through the support of the TPAs and the clinicians, formed PSSGs. The project provided snacks and health education to enable the PSSG members to meet once per month to discuss the unique challenges facing HIV-infected men.

Improve HIV Treatment Stakeholder Collaboration

Afya Jijini supported the regional technical working group (TWG) for HIV by providing monthly data for the video conferencing facilities and sending technical team members to attend the monthly meetings. In addition, *Afya Jijini* partnered with *Afya* HCM, a USAID-funded project, to jointly sensitize the health management team (HMT) members on SURGE interventions. Joint Ministry of Health (MOH) and *Afya Jijini* supportive supervisions were conducted at 10 sites, and quarterly review meetings were held with the SCHMT/CHMT members.

1.3 Output 1.3 is combined with 1.2 above

1.4 HIV Prevention, HIV Testing, and Counseling (HTS), Voluntary Medical Male Circumcision (VMMC), Gender-Sensitive HIV Prevention, and DREAMS

Voluntary Medical Male Circumcision (VMMC)

Q3 activities built on the gains made from the previous half of the fourth year of the program in the integration of VMMC services with other preventive services in county government facilities. *Afya Jijini* continued to support VMMC service delivery in low social-economic communities in Mathare slums, the Ngomongo slums in Korogocho, the Kabiria slums in Waithaka, and the Soweto slums in Kahawa West. To ensure continuity and availability of services during weekends and public holidays, *Afya Jijini* continued support of dedicated teams in each of three facilities: Mbagathi hospital, Railways Training Institute Clinic (RTI), and Biafra medical clinic. During the April holiday, the program supported in-reaches (facility based camps) at Mbagathi hospital and Biafra medical clinic, with most of the clients mobilized through faith-based community organizations within the facilities catchment. Supported facilities in this period provided services during extended hours that included early morning and late evening service delivery, ensuring more clients were reached.

Key Results

In Q3, the project reached 1,411 clients with the VMMC minimum package of care, which includes HTC, Syndromic Screening and Treatment for STIs, provision of male and female condoms and training of their correct and consistent use, promotion of safer sex practices, provision of risk reduction counseling, and active linkages of HIV-positive clients from VMMC sites to HIV care and treatment programs. In total, 94% of the annual target was achieved. Trained health care providers and the lead mobilizer reached a total of 2,211 clients with information, education, and communication through health talks during church services or at project-supported facilities.

Table 3: Summary

Age Groups	10-14	15-19	20-24	25-29	30-49	>50
Number circumcised	807	385	124	59	34	1
Number tested for HIV	87	351	108	53	31	1
Number tested positive	0	1	0	0	0	0

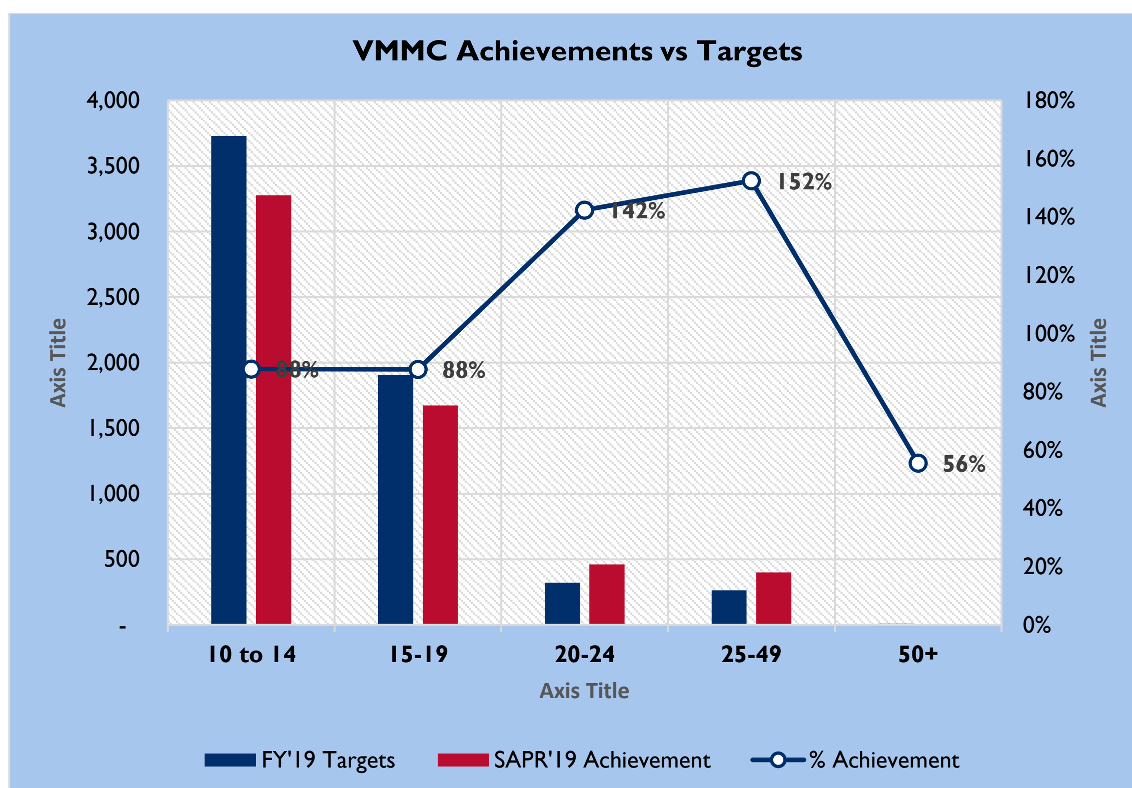

Figure 10: VMMC achievements verses targets

1.4.1 Provide Strategic HIV Testing Services

Increased access to targeted HIV testing at the facility level. In Y4 Q3 at both the facility and community levels, *Afya Jijini* implemented the SURGE strategies aimed at reducing over-testing while increasing the yields and efficiency of testing services. In this quarter, the emphasis was on ensuring that there was a reduction in numbers tested, i.e., targeted testing for increased yields, through stringent use of the risk-based eligibility screening tool to identify those eligible for testing, as well as through index testing and aPNS. The project also continued to work with Partnership for an HIV Free Generation (HFG), a sub grantee mandated with the task of supporting HTS in 10 project facilities.

During the quarter, the project continued working with 74 HTS providers to provide HTS as well as a linkage for all newly diagnosed HIV-positive clients in 42 project-supported sites. As part of the SURGE strategy, these HTS providers received mentorship and on-the-job training on high yielding testing approaches as well as on accurate documentation practices. HIV self-testing continued being implemented in project facilities despite the inconsistent RTK supply. A total of 191 clients were reached with HIV self-testing, with none yielding positive results. Follow-up is ongoing for those clients who did not provide their test results. Monitoring of QI projects continued throughout the quarter, with the supported facilities taking on more projects in line with the SURGE strategy. A total of 36 QI projects were monitored for improvement this quarter. With targeted testing being implemented in Q3, the program reached 80,403 clients with testing services, with 2,083 new positives identified (a yield of 2.6%). This translates to 113% of the annual testing target and 86% of the annual positivity target, respectively. The index testing/aPNS approach enabled the project to reach 3,827 contacts of index clients, out of which 1,491 were tested for HIV and 244 tested positive, translating to a yield of 16.4%.

Table 4: HIV Test Yields by Testing Points (FY19/Q3)			
Testing Point	***Tested***	***Positive***	***Yield***
Inpatient Services	1,993	70	3.5%
PITC TB Clinics	1,072	148	13.8%
PITC PMTCT (ANC Only) Clinics	12,671	262	2.1%
PMTCT (Post ANC 1)	12,267	37	0.3%
STI	130	5	3.8%
VMMC Services	631	1	0.2%
Other PITC	29,392	692	2.4%
Emergency	293	11	3.8%
Pediatric	55	1	1.8%
VCT	20,408	612	3.0%
Index testing	1,491	244	16.4%
TOTAL	**80,403**	**2,083**	**2.6%**

Increased targeted HIV testing at the community level: In Y4Q3, *Afya Jijini* implemented SURGE strategies aimed at improving targeted community testing. The project focused its support for community testing on hot spots that were identified through micro-targeting using the index client as well as through review of program data identifying areas where PLHIV are mostly concentrated. In these areas, a two-layered eligibility approach was used to identify and test only those clients who were eligible for testing to reduce over-testing. The following are the targeted outreach activities that were supported in the quarter:

- Weekend Outreach Events: The program worked with facilities to conduct targeted weekend outreaches focusing on the hot spots and follow-up of identified contacts of index clients. These outreaches were conducted in Bahati HC, Jericho HC, Kahawa West HC, Soweto PHC, Kangemi HC, Dandora 2, Kariobangi North, and Westlands. A total of 12 HIV-positive clients were identified and linked to *Afya Jijini*-supported facilities.
- FBO Engagement: The program worked with INERELA (a grantee mandated to reach the religious community) to conduct targeted outreach events in the identified hot spots in Embakasi East, Embakasi West, and Westland Sub Counties. A total of 2,793 (1,146 females and 1,647 males) people were reached with 1,346 or 48% (508 females and 838 males) being new testers. The testing activities managed to identify 45 clients (27 females and 18 males) as positive, translating to a yield of 1.6%. All clients were linked to *Afya Jijini*-supported facilities. A total of 78 HIV self-testing kits were distributed with none yielding positive results.

aPNS: In Y4 Q3, *Afya Jijini* implemented SURGE strategies aimed at improving the uptake of aPNS and index testing. The project worked to ensure that all newly identified HIV-positive clients received aPNS and that their contacts were followed-up during routine clinical visits. For existing clients, the focus was on ensuring that contacts were elicited and tested for the following categories of index clients: Loss-to-follow-up (LTFUs) and defaulters being brought back to care, clients with high VLs, clients with STIs, and discordant couples and partners of PMTCT clients. The HTS providers continued receiving mentorship on line-listing, elicitation, and follow-up of contacts for testing, and accurate documentation. The project continued sensitizing HCWs on aPNS through OJT at the facilities, with emphasis on contact elicitation from index clients. Airtime and transport allowances were provided to facilities to enable elicited contacts to be traced for testing. The table below represents a summary of aPNS for Q3.

aPNS Cascade	Male		Female	
	<15	**>15**	**<15**	**>15**
Number of index cases offered index testing services	-	881	-	1,860
Number of index cases that accepted index testing services(Screened)	-	831	-	1,735
Number of contacts elicited by age/sex	510	1,642	569	1,106
Known Positives	12	226	13	170
Eligible for testing	498	1,416	556	936
Tested	204	584	257	446
Positive	9	108	17	110
Linked	8	103	17	10

Figure 11: aPNS Summary (Sexual Partners)

Newly diagnosed clients enrolled into care: In Q3, *Afya Jijini* continued supporting testing and linkage to care and treatment of newly identified clients through the HTS/TPA counselors. The project linked 1,802 of the 2,083 positives identified to supported facilities, and an additional 93 clients to other facilities, providing a total linkage of 91%. By working with the TPA counselors, 1,716 clients were initiated on treatment over the same period, representing a linkage to treatment of 82%. Challenges faced in same-day initiation included client unwillingness and lack of knowledge and understanding, and uncooperativeness among facility staff. To address the challenges among the facility staff, the project developed a linkage scope of practice to provide a standard guideline on enrollment of clients both within project facilities and outside facilities. The HTS/TPA counselors were mentored on using the linkage SOP, which included training on same day enrollment to care and treatment, proper follow-up of unlinked clients, and correct documentation on the linkage and treatment preparation registers. An audit of all positives identified in the quarter that were not initiated on treatment was done as shown in the table above.

Figure 12: High-level Results from Audit

New Positives	Number	Percentage
Initiated later on treatment	145	40
On CTX undergoing adherence	18	5
Linked to another facility confirmed	9	2
Linked to another facility await CCC no.	25	7
Gave wrong contacts	24	7
On follow-up	95	26
Awaiting disclosure to partner	5	1
Declined	15	4
In denial	11	3
On TB treatment	7	2
Admitted	3	1
KP	1	0
Died	9	2
Total	**367**	**100**

The project continued working to improve linkage and retention through supporting 27 TPA counselors at 22 high volume sites. The TPA counselors worked closely with the HTS providers at the facilities to ensure that newly diagnosed clients received adequate counseling and treatment preparation and were escorted to the CCC for enrollment. Clients who opted to be enrolled in other facilities were first enrolled in project-supported facilities before being transferred to their facility of choice. Follow-up on the unlinked clients was done by the HTS provider through phone calls every week and the follow-up was documented in the linkage register. This work will continue in the coming quarter.

Internal HTS quality assurance (QA) strengthened. Working in conjunction with the sub-county teams and HFG, the project continued to support facilities to strengthen internal quality assurance in HTS. The HTS providers were encouraged to participate in observed practice sessions and have HIV testing outcomes documented for follow-up action. The HTS providers continued monitoring their QI projects to track improvement. New projects on identification and on linkage were taken up in the quarter as part of the SURGE strategy.

External HTS QA measures improved. During the reporting period, *Afya Jijini* continued to work with the sub-counties to provide corrective and preventative action (CAPA) sessions for those with unsatisfactory results during PT round 19. CAPA sessions were done at facility-level for 53 HTS providers with unsatisfactory results. *Afya Jijini* also continued to work with NHRL to ensure HCWs were enrolled in PT round 20, and that they received the PT panels for reconstitution. Working with the SCASCOs, the project provided counselor supportive supervision sessions in five sub-counties, namely Makadara, Langata, Ruaraka, Kasarani, and Embakasi East. In addition, facility-based counselor supportive supervision sessions were done in Mbagathi Hospital, Kangemi HC, Kayole 2 HC, Kariobangi North and Dandora 2 HC. These sessions were instrumental in providing the HTS providers the opportunity to debrief and share experiences in HTS provision. The project also continued working with the Sub-county Medical Laboratory Technologists (SCMLT) to strengthen RTK supply chain management to ensure that there was no stock out of RTKs at the facility level. This included redistribution and re-allocation of RTKs as needed. This work will continue in the coming quarter.

Scale-up of PrEP services: During the reporting period, the project continued working with the DREAMS project to provide PrEP to 697 AGYWs. To cater to the needs of the general population, the project continued working with the sub-county and other partners to provide PrEP to discordant couples. HCWs received mentorship on PrEP services as well as on ensuring that adequate commodities are available to cater to the increasing need for PrEP during the SURGE period.

Scale-up of condom promotion and contraception use: During Q3, the project continued working to improve the integration of FP with HTS. Job aids, including TIART charts and FP counseling cards, were provided to project sites as needed for HTS providers to offer during services. This will continue in the coming quarter.

Support HIV stigma reduction efforts: In Q3, *Afya Jijini* continued working in project-supported facilities to reduce the stigma and discrimination associated with HIV. Working with AMURT, the project continued to strengthen disclosure and PSSG activities in supported facilities. The project also made job aids on patient rights, stigma reduction, and patient responsibilities available, and ensured that the staff were sensitized to them.

Improve stakeholder collaboration: In Q3, the project participated in an HTS TWG that was organized at the national level to discuss HTS. Key issues highlighted in the meeting were on HIV self-testing, HTS service quality assessment, proposed guidelines review, and commodity management for RTKs.

HIV Prevention: Gender-Based Violence

In Y4 Q1, the program trained key community defenders, such as the sub-county school health teams, which have been critical in providing insight on children and violence. In this reporting period, the program held stakeholder engagement forums on Violence against Children (VAC). Every quarter the school health TWG organizes a meeting that has improved surveillance and referral coordination of sexual and gender-based violence (SGBV) cases among school-going children.

Work with the County and sub-counties to Strengthen comprehensive Post-Rape Care (PRC) chain of custody by improving the networking

For Q3, the project continued to enhance coordination with the county and sub-county teams by spreading survivor management for levels of distress through community-level assessments and referrals among AGYW in Kangemi, Kariobangi, Korogocho and Lunga Lunga, where 98 young mothers were screened by the WHO using the Edinburg Post Natal Depression Scale. Of those screened, 72 (73.5%) scored moderate to severe depression. These young women were offered interpersonal psychotherapy using WHO Group Problem Management Plus as a complimentary intervention for coping with post-traumatic stress due to childbirth. These post-counseling assessments are scheduled in five consecutive sessions before a final evaluation and termination. A series of follow-up sessions in seven other facilities (i.e., Pumwani Hospital, Dandora II, Mukuru Health Centre, STC, Kayole II Health Centre, Mutuini Health Centre, and Waithaka Health Centre) were held and 105 young people 15 to 19 years (53 females and 52 males) were sensitized to enhance the chain of custody within the sub-county and county.

Afya Jijini continued to work with the County and other implementing partners on PRC management and litigation. Five additional police units (Makadara, Buru Buru, Kabete, Kasarani and Viwandani) are coordinating the forensic evidence collection of survivors from the link facilities (Makadara Health Centre, Mama Lucy Kibaki Hospital, Kangemi Health Centre, and Kasarani Health Centre) after the police standard operating procedure (SOP) manual launch earlier in the year (Y4Q2), to complete the chain of custody in GBV survivor management.

Operationalize GBV Clinics

In Y4 Q2, *Afya Jijini* continued to strengthen its mentorship support roles through coordination of county and sub-county GBV focal people. Seven additional GBV facilities (Mukuru Health Centre; Kangemi Health Centre; Pumwani Hospital, Dandora II Health Center; St Joseph the Worker; and Gertrude's Hospital, both main and Githongoro) had direct onsite coaching on PRC recording and forensic evidence collection coordination. The county supported this initiative through coordination of site supervision in 18 health facilities.

Strengthen utilization of SGBV guidelines GBV reporting tool
Through the county and sub-county GBV focal persons, the program continued to emphasize a review of the reporting trends from MOH 705, MOH 364-(A & B), and the SGBV Monthly Summary to address areas of improvement and learning as captured in the District Health Information System 2 (DHIS2) data. While quarterly surveillance and reporting have improved, longitudinal follow-up, which is critical in the whole spectrum of GBV services, still remains a challenge.

DREAMS

Support Strong Community Engagement and Leadership Support for DREAMS Success
In Y4 Q3, *Afya Jijini* continued to leverage positive relationships with stakeholders including the County, Sub-county officials, and other implementing partners for enhanced AGYW cohort enrolment and service layering to achieve saturation of DREAMS sites in Embakasi East and Westlands Sub-counties. Cumulative AGYW served to date stands at 14,634 (2,884 aged 9-14 years; 5,559 aged 15-19 years; 4,982 aged 20-24 years; and 1,209 aged 25 plus). Out of this total, 87 or 1% of AGYW (19 aged 10-14 years; 44 aged 15-19 years; and 24 aged 20-24 years) were co-enrolled with an OVC partner (82 from Nilinde and 5 from COGRI-Lea Toto Program). Partners for HIV Free Generation, a grantee, reached 4,230 AGYW.

Table 5: *Afya Jijini* Y4 Q3 Cumulative DREAMS Achievements

DREAMS Indicators	Target	9-14'	15-19	20-24	24 + years	Total	%
DREAMS new enrollment	5,053	911	1,147	635	-	2,693	53%
Gender GBV	9,658	1,089	1,623	1,007	153	3,872	40%
Community mobilization/norms change	7,726	3,876	3,076	2,480	3,955	13,387	173%
HTS	4,042	556	1,942	1,460	221	4,179	103%
Priority population HIV prevention	1,145	900	1,691	1,987	383	4,961	433%
SAB interventions	5,053	2,250	4,102	3,104	647	10,103	200%
Family Matters Program (FMP)	1,732	121	228	23	-	372	21%
Education subsidies	3,416	487	973	199	25	1,684	49%
Cash transfers	957	-	119	440	95	654	68%
Financial Capability	5,053	956	1,778	1,126	178	4,038	80%
Condom education and promotion	4,042	32	2,346	2,080	417	4,875	121%
Contraceptive method mix	3,234	24	2,043	1,427	238	3,732	115%
PrEP	1,166	-	287	617	109	1,013	87%
Economic strengthening	959	8	370	333	41	752	78%

Activity 1.4.3.1: Empower AGYW (Core Area 1): *Mentorship*: In Y4 Q3, *Afya Jijini* continued to provide mentorship for active girls while also making efforts to narrow the enrolment target of 5,053 at 18 safe spaces (10 in Mukuru and Pipeline; and 8 in Kangemi and Mt. View). A total of 10,103 AGYW (New: 2,693; Maintained: 7,410 girls) (2,250 aged 9-14 years; 4,102 aged 15-19 years; 3,104 aged 20-24 years; and 645 aged 25+ years) were reached with social assets building (SAB) sessions. Beyond the standard curricula, fun activities suggested by AGYWs were carried out (i.e. dancing sessions, team building activities and modelling sessions).

These activities helped with retention of the girls and enabled the project to reach out to other vulnerable girls who were subsequently enrolled in DREAMS this quarter. *Afya Jijini* also continued to line-list AGYW who had not received the full package of services for their cohort, to fast track them for the missing services and prioritize them for secondary and/or contextual services based on individual girl's needs.

In this quarter, Afya Jijini worked with mentors to support formation and strengthening of girl groups. The already existing 372 girl groups (160 Mukuru, 212 Westlands) have identified income generating activities (i.e. soap making where they produce and sell to the locals) and three of them are in the process of registering with the Ministry of Labor, Social Security and Services as a self-help group. This is an innovation that has helped with retention.

In both Mukuru and Westlands, an inter-cluster debate competition on key topics such as the pros and cons of empowering the girl child was carried out where all the clusters were represented by all the girls who emerged as winners during the inter-safe space competition. The project mobilized a total of 300 girls in Mukuru and 300 in Westlands who were drawn from all the 18 safe spaces. These activities were done to improve layering for all the girls who were present with the support of mentors and other service providers to offer services i.e. HTS services, P.V.C. and condom education among others. The AGYW were also given a chance to showcase their talents (i.e. dancing, acting and poetry recitation) based on the different topics/themes that the girls had been taken through during mentorship sessions. During this quarter, 68 mentors (26 from Kangemi and 42 from Mukuru) were taken through financial capability training for five days to take over the responsibility of instructing DREAMS AGYW in lieu of short term volunteers.

Condom promotion and distribution: During the quarter, *Afya Jijini* continued promoting condom efficacy education and distribution to AGYW aged 15-24 and the community at large. This was done through various evidence-based interventions (EBIs) which include MHMC, SASA! and Sister 2 Sister Kenya. During Q3, eight condom dispensers were erected within hotspots in Kangemi. This effort resulted to 4,587AGYW (2,191 15-19 yrs., 1,999 20-24 yrs., 397 25+) Being reached through condom efficacy education, in which a total of 1,056 AGYWs picked 40 female condoms and 10,187 male condoms at the safe spaces, 31,888 male condoms from dispensers totaling up to 42,060.

Evidence-based behavioral interventions (EBI's): In Y4 Q2, HFG continued with implementation of school based EBIs focused on teaching HIV/GBV prevention skills and imparting information on the same to the AGYW aged 9-17 years. Trained facilitators partnered with school health clubs and their patrons to deliver the interventions in schools during the afternoon break. As a result, 508 AGYW, aged 10-14 years 246 were reached with Healthy Choices for a Better Future (HCBF) and 261 aged 13-17 years reached with My Health My Choice (MHMC). In addition, *Afya Jijini* reached the older girls 18-24yrs with sister to sister Kenya Intervention where 1,694 girls were reached bringing the total reached with EBIs to 2,754 AGYW over this reporting period.

Contraceptive method mix

During this reporting period, *Afya Jijini* continued the empowerment of **1802** AGYW. The participants received information at safe spaces in Kangemi and Mukuru on contraception. Contraceptives were accessed by the girls as shown in the table. In Q3, a total of **1101** AGYW aged 15-19yrs and **791** aged 20-24 years were reached with information on contraceptive method mix. DREAMS engaged a clinician in this quarter for AYSRH Education and contraceptive method provision. A total of 40 AGYW in both Mukuru and Kangemi received various contraceptive methods in this quarter. An Evidence Based intervention called Sister to Sister Kenya (S2S) aimed at increasing AGYW confidence and self- efficacy in using both male and female condoms reached 1,694 AGYW.

Table 6: Contraceptive method mix

Contraceptive Choice	15-19	20-24yrs	25 Plus	Total
Oral contraceptives	11	20	0	**31**
IUD/Implant	0	2	0	**2**
Coil	3	3	0	**6**
DMPA	0	2	0	**2**
Condoms	339	411	74	**827**

Pre-Exposure prophylaxis (PrEP) In Y4 Q3, DREAMS accelerated distribution of PrEP information and PrEP uptake in both Embakasi and Westlands (see table below for reach data). The incorporation of findings and suggestions cited by AGYW during FGD discussions conducted in Y4 Q2 on hindrances to uptake and retention bore significant fruits from 21% (Q2) to 87% (end of Q3). Specifically, mentors journeying with AGYWs from mobilization, initiation and post-PrEP follow ups yielded to an increase in uptake with substantial AGYWs going for subsequent refills. In addition, the program engaged an additional clinician in Mukuru with unique soft skills in handling AGYW issues. In the coming quarter, the program will continue using current working strategies, reinforce PrEP retention while incorporating it with other related DREAMS services.

Post-violence care, gender-based violence (GBV)*:* In Year 4 Quarter 3, trauma counselling sensitization continued in both Westlands and Embakasi Sub Counties targeting AGYW who are newly enrolled in DREAMS. *Afya Jijini* moved on to embrace effective referrals and linkage systems through GBV Working Groups in the community to ensure sustainable support to the services of GBV. With the intensified GBV Sensitization services, **3152** AGYW (**818** aged 9-14 years, **1394** aged 15-19 years, **813** aged 20-24 years, and **130** aged 25+ years) were reached in both Westlands and Embakasi South Sub-county.

HIV Testing Services: In Y4 Q3, the project hired four additional HTS providers to support improvement of service uptake among AGYW aged 15-24 years. This saw an increase in the number tested for HIV by 50% in comparison to the number reached in the last quarter. Both Kangemi and Mukuru concentrated on reaching out to the newly enrolled AGYW as well as continued to saturate through line listing of AGYW aged 15-24 years who missed HTS and prioritized them with the services. Among the success stories we have from both sites is that the girls who tested a year ago have come back for re-testing. HIV testing services offered an opportunity for the girls to get other services like condom efficacy education, PrEP information, condom distribution, PrEP and TB screening services as a package offered within the safe space during the session. The major challenge that HTS providers faced during this reporting quarter was RTK stock outs. All seven AGYW who were newly identified positives were linked for care and treatment at Mukuru Health center. There were three known positives who reported that they were already in care and adherent to treatment.

Table 7: targeted age groups

Age group (years)	Tested for HIV	Negative	New Positive	Known positive
9-14	367	366	1	0
15-19	1,076	1,075	0	1
20-24	818	812	4	2
25+	112	110	2	0
Total	**2,373**	**2,363**	**7**	**3**

Activity 1.4.3.2: Interventions to reduce risk of/among AGYW sex partners
During this reporting period, 18 Male Sexual Partner (MSP) Champions from both Embakasi South and Westlands Sub-counties, in collaboration with 6 SASA! Champions and 6 HFG-supported DREAMS volunteer facilitators participated in "Mshirika Afya" which is a Swahili phrase meaning "Healthy Partner". This initiative's objective is to provide peer-led community-based male condom education, demonstration, and distribution on a weekly basis targeting male sexual partners of AGYW. This initiative provided a platform for men to receive health education on correct and consistent condom use aimed at protecting oneself and one's sexual partner so as to contribute towards raising a healthy family. In this quarter, the team distributed 42,060 male condoms through community-based condom dispensers. Under the HFG grant, the project scale-up reached male sexual partners of AGYWs and offered biomedical intervention including HTS and STI screening utilizing a safe-space approach that ensures all interventions are documented and reported appropriately.

Activity 1.4.3.3: Strengthening families. Parental and caregiver program*:*
During this quarter, *Afya Jijini* mobilized a total of 360 parents/caregivers who are currently being taken through the FMP 1 session and a total of 288 parents/caregivers for FMP 2 in Westlands and in Mukuru. The FMP curriculum increases knowledge and provides skills for parents and caregivers to hold conversations relating to sex and sexuality with their girls and help them evade risky behaviors which might put them at risk of getting infected with HIV. Over time, the caregivers/parents are embracing the training and talked a lot about the positive skills they gained and how this has turned their parenting skills around.

Unconditional cash transfer (UCT) program: Unconditional cash transfer (UCT) program: This period saw *Afya Jijini* disburse UCT cash cycles to the girls in Mukuru and Kangemi after the team worked on identification and prioritization process for AGYW who would benefit from. A total of 654 (533 in Mukuru and 101 in Kangemi) AGYW aged 15-24 years received UCT. For Kangemi it was for Batch 1-Cycle 1.

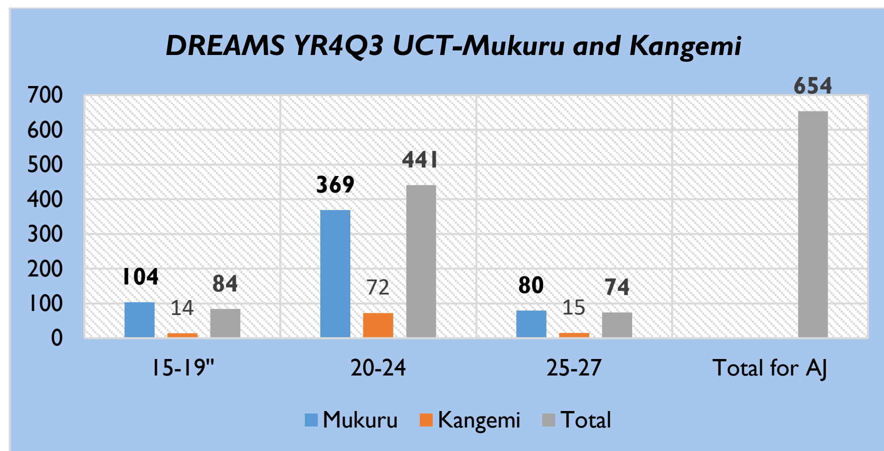

Figure 13: Below depicts the CT disbursement across the age cohorts

Education subsidies program: In Y4 Q3, *Afya Jijini* provided Education Subsidies in the form of school subsidies and dignity kits. In Mukuru, a total of 1,115 girls were reached with ES with 240 girls getting school fees subsidy and 952 receiving dignity kits (one reusable sanitary towel and two free size panties). In Kangemi, a total of 728 girls were supported with an ES: 159 received school fees subsidy while 569 received dignity kits. A further 140 girls have been prioritized for the school fees subsidy in Kangemi and 272 in Mukuru. In total, 1,448 girls have received education subsidy to continue keeping them in school.

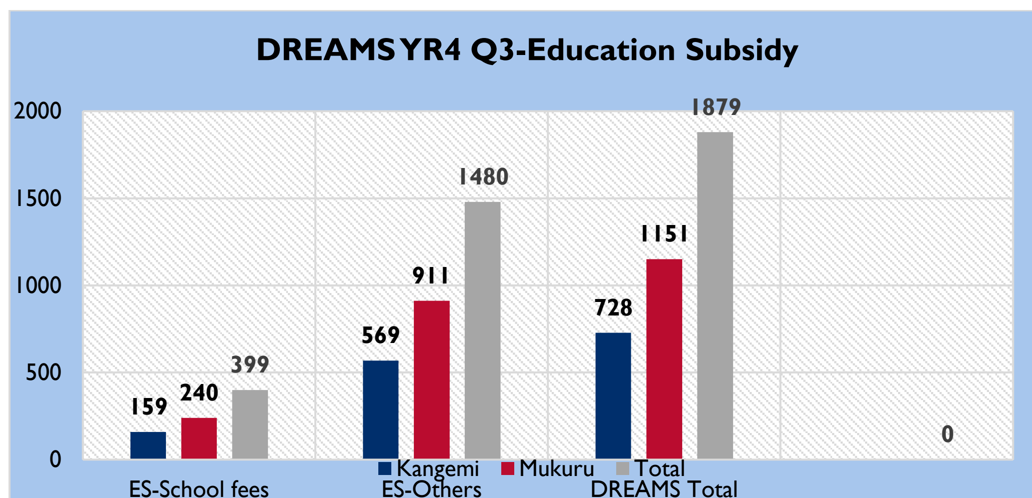

Figure 14: Education subsidy

Activity 1.4.3.4: Interventions to mobilize communities for change

SASA! Intervention: This quarter, HFG resumed implementation of the SASA! program. In Embakasi South and Pipeline Wards-in Mukuru Kwa Njenga their scope of work was limited to only reaching out to DREAMS Girls while in Kangemi Ward their mandate was to include the general population, hence the inclusion of men. Due to continuous and intensive implementation of the SASA! Intervention, positive behavior changes related to gender norms were reported during this quarter in Kangemi Ward with respect to violence against women by men. In Kangemi, some men are not only intervening to prevent Intimate Partner Violence (IPV) incidences in their neighborhood, but also reporting cases of GBV to the local administration. In the coming quarter, *Afya Jijini* will build on this success to involve more men in prevention of violence against women. A detailed breakdown disaggregated by ward and age is illustrated in the table the table below.

Table 8: Interventions summary

DREAMS SASA INTERVENTION SUMMARY											
# Reached Through Activism & Training in Mukuru											
Period in Month;	**Male**					**Female**					
	<10	**10-14**	**15-19**	**20-24**	**25+**	**<10**	**10-14**	**15-19**	**20-24**	**25+**	**Total**
APRIL,											
MAY,	0	0	0	0	0	0	614	737	430	0	**1781**
JUNE.	0	0	0	0	0	0	132	325	193	0	**650**
Sub Total	**0**	**0**	**0**	**0**	**0**	**0**	**746**	**1062**	**623**	**0**	**2431**
# Reached Through Activism & Training in Kangemi											
Period in Month;	**Male**					**Female**					
	<10	**10-14**	**15-19**	**20-24**	**25+**	**<10**	**10-14**	**15-19**	**20-24**	**25+**	**Total**
APRIL,	0	0	75	208	534	0	173	362	330	235	**1917**
MAY,	0	60	24	11	45	0	172	67	41	60	**480**
JUNE.	0	0	0	26	90	0	132	79	109	129	**565**
Sub Total	**0**	**60**	**99**	**245**	**669**	**0**	**477**	**508**	**480**	**424**	**2962**

Combined socio-economic approaches

In the quarter, 2804 girls received Financial Capability training, 697 AGYW 9-14 years, 1325 AGYW 15-19 years, 677 AGYW 20-24 and 105 AGYW 25-27 years. In the same line, Afya Jijini offered entrepreneurship training to help AGYW to incubate small businesses, to improve their sales and help develop new business ideas. A total of 228 AGYW were reached with entrepreneurship training. *Afya Jijini* also supported 124 girls in Kangemi with Vocational Training who recently graduated and were issued with certificates where 70 were in catering, 48 in Cosmetology and six in tailoring.

Economic Strengthening performance

A total of 119 AGYW were linked to employment opportunities. Fifty of these got direct links to employment around Nairobi as a result of confidence building and training on soft skills for employment purposes. Key employers included beauty parlors, Kenya Builders and Jubilee Insurance Company. In Kangemi, four of the AGYW were engaged as DREAMS Program mentors and facilitators in Financial Capability Sessions; another 10 have partnered to supply bread and milk to the parents/caregivers attending the FMP I and II sessions in Kangemi while 7 are supporting Mukuru. The eight AGYW who received the Sales training with Jumia Kenya continue to actively work as sales agents and they receive monthly trainings with the company on how best to close sales.

Following the disbursement of cash transfers, 28 AGYW have opened small scale businesses, and three of these have used the funds to expand their businesses. Notably, one AGYW resumed school with the CT funds. Thirty-two (32) girls were linked with internship opportunities through a partnership with Blessing Institute. This is part of the institution's responsibility to improve the skill level of those who pass through the center. The 11 AGYW who graduated from Vocational Training have either started their own business or have been employed. Three (3) of them have started baking and selling cakes in Kangemi; two have started mobile saloons; and two have been employed as waitresses. In addition, 29 girls enrolled in ICT Training at Kangemi Vocational Training Institute. Two other girls were enrolled at St. Joseph's Vocational Training Center to study mechanics.

The Table below shows the DREAMS socio economic approaches.

Table 9: DREAMS socio-economic Approaches				
	Employment	Vocational Training	Entrepreneurship Training	DREAMS Total
15-19	20	20	126	166
20-24	85	86	94	265
25-27	14	18	5	37
Total	**119**	**124**	**225**	**468**

Cross-Cutting DREAMS Activities

Conduct stakeholder engagement*:* During this quarter, *Afya Jijini* preceded the initial joint engagement meeting with Beacon of Hope, with a follow-on entry meeting with community stakeholders in Deep Sea village of Parklands Ward of Westlands Sub-county. Additionally, the program conducted review meetings with parents who had completed FMP sessions for both Mukuru and Kangemi, to gather views on how the program has improved their parenting skills and attendant short-term gains they already observe.

Partnership with sub- county*:* Within this reporting period, *Afya Jijini* participated in the development of the joint NASCOP-MoH PrEP Quality Assurance Plan for the County. The project also participated in the Westlands Sub-county Security Area Advisory Council, to articulate child protection issues geared towards supporting the Sub-county's GBV response. In addition, the project participated in the Westlands SGBV Stakeholders Forum that was run by the Sub-county SGBV Focal Point, so as to anchor the DREAMS GBV agenda into the larger MoH-led efforts. Additionally, the project also supported Westlands Sub-county HMT to conduct a CME on PrEP and printed tools for service providers.

Sub granting*:* One meeting was held this quarter with Partners for HIV Free Generation (HFG) to assess the progress of both HTS and SASA-AYEP programs. HFG's grant was renewed in March 2019.

Quality Improvement*:* The reporting period saw *Afya Jijini* safe spaces implement quality improvement projects aligned to previously identified performance gaps at each site. These QI projects included work environment improvement, filing and arrangement of the safe spaces, and clear documentation for paper-based tools for better synchronization with the online data base. Performance against these indicators will be evaluated and posted on the talking walls in the next quarter.

1.5 TB/HIV Co-Infection Services

1.5.1 Strategically scale-up model for Active Case Finding (ACF)

This quarter, the project continued to support County TB/Leprosy Coordinator (CTLC) and the Sub-County TB/Leprosy Coordinators (SCTLCs) to strengthen ACF at the facility level. The project supported the training of 60 HCWs on TB LAM (lipoarabinomannan). This is a test, recently introduced by the National TB program, which detects mycobacteria lipoarabinomannan antigen in urine and is given as a bed-side test to very sick patients presenting with CD4 levels of below 200. After the training, TB LAM was rolled out to three project facilities at both the inpatient and CCC departments. The pilot facilities for Nairobi County are as shown in the table below together with several tests done and their results:

Table 10: Pilot facilities			
Name of Facility	Number of Tests Done	Positive Results	% Positivity
MLKH	17	5	29.4
ST Mary's	3	1	33
Mbagathi hospital	10	2	20

Clinicians are expected to do a confirmatory test with GeneXpert, but may also use accurate clinical judgment to initiate TB treatment if the patients are too sick and unable to give sputum samples. The project also supported ACF CMEs at St Mary's Hospital. A total of 30 HCWs were sensitized, and as a result, there was a 14% increase in number of TB cases diagnosed at the facility in Q2 (88) compared to Q1 (64). Missed opportunities were experienced at the out-patient department (OPD) where patients diagnosed by clinical officers and doctors were rescheduled for the start of treatment on a different day instead of same-day initiation.

Another CME was conducted with clinicians on client flow. A temporary register for TB treatment initiation for newly diagnosed patients was placed at OPD, and a nursing officer was tasked to document. The project continued to support cough monitors to fast track coughers at OPD and also to double up on eligibility screeners at some of the SURGE facilities. This quarter a total of 301 patients were presumptive cases in the CCC, 284 were tested with GeneXpert, 63 Smears, and 36 other TB tests including smear test and x-rays were conducted, and 163 were confirmed TB positive.

1.5.2 Strengthening community TB treatment monitoring and defaulter tracing

Nairobi County reported 31 cases lost to follow-up at various facilities in Q3. *Afya Jijini* supported two Focus Group Discussions(FGDs) at Mathare North, where 18 participants consisting of Community Health Volunteers (CHVs) and TB patients, raised the issue of a high defaulter rate among alcohol abusers and street families (this was sited to be due to lack of meals to support drug adherence). Consequently, a CME was conducted for 34 CHVs on defaulter tracing mechanisms. CHVs were mentored on eliciting correct phone numbers from patients and correct documentation on outcome after a tracing attempt. To improve tracking per facility, SCTLCs were also tasked to audit defaulters and within the quarter, a total of seven cases of treatment defaulters were traced and restarted on TB treatment.

1.5.3 Improving IPT

Through cluster teams during SURGE, the project line listed all clients who were not on IPT. A total of 7,419 clients were found not initiated and started on IPT. This quarter a total number of 1,385 patients on HAART were initiated on IPT.

1.5.4 Strengthening TB infection and prevention control

Afya Jijini supported STLC to facilitate 11 TB WITs to conduct an assessment at the facility and review work plans at 11 supported facilities. This activity is designed to mentor facility based HCWs and be able to continuously monitor TB IPC through the integrated WIT meetings.

1.5.5 Boosting TB-HIV integration and provision of immediate ART for TB clients

At Mbagathi Hospital, TB clinic staff were oriented on SURGE and immediate HAART initiation on all co-infected patients. Clinicians were also tasked with ensuring all patients in the wards were linked to care and treatment to reduce missed opportunities. *Afya Jijini* continued to support HTS counselors who have ensured there were no missed opportunities for testing at all 42 project facilities. The figure below is the TB cascade illustrating testing and HAART as of Q3:

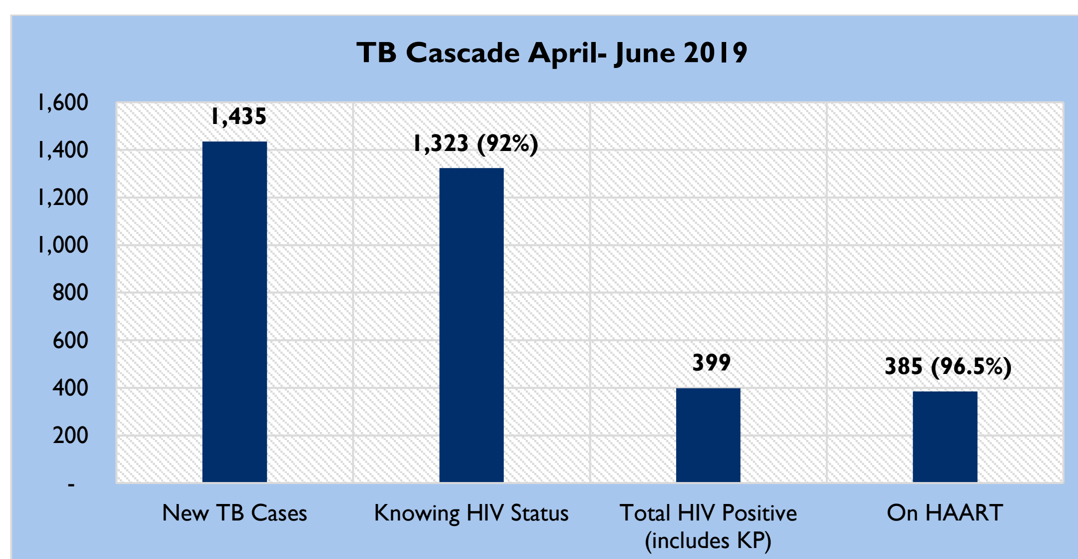

Figure 15: Afya Jijini TB cascade for the period between April and June 2019

1.5.6 Strengthening pediatric TB diagnosis and treatment

Afya Jijini supported SCTLC Kasarani to conduct nasopharyngeal aspirates (NPA/NG) for GeneXpert at Dandora II and Kariobangi HC. A total of 68 HCWs were trained in obtaining sputum from pediatric patients. A total of 13 NPA/NG were conducted during the training, and 3 (23%) were found to be positive for TB. At Westlands Sub-county, *Afya Jijini* supported SCTLC to conduct ACF at Kilele Children's Home. A total of 44 children and 19 support staff were screened, of whom two were found to have x-rays suggestive of TB infection. A total of 112 clients were diagnosed in Q3, which represents 8% of all adult cases diagnosed at *Afya Jijini* facilities. The national pediatric target is 10-15% of the total adult cases diagnosed.

1.5.7 Multi-drug resistant TB (MDR-TB)

Sensitization on MDR-TB was conducted for Dagoretti Sub-county, where a total of 20 HCWs were trained on programmatic management of MDRTB. *Afya Jijini* continued to support programmatic MDR-TB clinical meetings across all the sub-counties. SCTLC were mentored to conduct updated CMEs during the clinical meetings and to continue mentorship of TB clinicians managing MDR-TB clients. A total of one patient was diagnosed this quarter with Rifampicin resistance only, and two had Monoresistant TB. Quarter 3 results of MDR-TB surveillance at the 42 TB/HIV facilities is as stated below:

Table 11: DRTB surveillance at 42 TB/HIV Facilities	
Total previously treated	137
Done for GeneXpert	107
Not done	30
DRTB surveillance	78% (107/137)

1.5.8 Strengthening County TB coordination

The project continued to support county and sub-county monthly meetings to review performance, discuss strategies to improve indicators at facilities and share best practices. This quarter *Afya Jijini* supported and participated in data-driven supervision in collaboration with TB ARC and the county TB teams at MLKH, St Francis Hospital, Mbagathi Hospital, and Jericho HC. *Afya Jijini* supported STLCs to conduct monthly data review meetings of facilities within the Dagoretti, Westlands and Embakasi sub-counties, during which they set targets and revised existing targets according to performance.

2 SUB-PURPOSE 2: INCREASED ACCESS AND UTILIZATION OF FOCUSED MATERNAL, NEONATAL AND CHILD HEALTH, FAMILY PLANNING, WASH, AND NUTRITION SERVICES

2.1 Output 2.1: Maternal and Neonatal Health Services

2.1.1 Strengthening County and sub-county MNH service quality and coordination

In Q3, the program supported the county in planning its quarterly activities. These included the emergency obstetric and newborn care (EmONC) assessment feedback meeting and (EmONC) assessments within the sub-county facilities, which had been previously rescheduled due to the polio campaign. Instead, the classes have been handed off to the sub-counties. The program supported distribution of Maternal Perinatal Death Surveillance Review (MPDSR) reporting tools (MOH-369-PDNF-48, MOH371PDRF-48, and MOH 372 MDRF-20) to all ten sub-counties, including the five largest maternities for the county.

During the quarter, the program supported county-led Integrated Management of Newborn and Childhood Illness (IMNCI) mentorships across the entire county. The sub-county IMNCI mentors identified facilities with the high newborn related morbidities and mortalities, these included Dandora 2 HC, Mutuini HC, Waithaka HC, Mathare North HC, Kahawa West HC, Chandaria HC, Ngong Road HC, Mukuru MMM, Mukuru Ruben, Mukuru HC, Ngara HC, Lunga Lunga HC, and Jericho HC. Each of the ten sub-counties identified the top three burdened facilities and implemented a site-based mentorship, the results of which will be relayed in the next quarter. The county Child Health Coordinator met with mentors for a one-day meeting to draft the mentorship tool, plan for IMNCI trainees follow-up, and participate in a class on Helping Baby Breathe, all of which will be reported on in the coming quarter.

Assorted equipment was purchased through the KEMSA/USAID Medical Commodities Program (MCP) and distributed to NCC facilities according to a schedule that had been shared by *Afya Jijini* and the USAID team. The equipment included 20 fetal Dopplers, 10 resuscitates with phototherapy, 50 infant room warmers, 20

portable ultrasound machines, and neonatal and pediatric ambubags. The program will conduct on-the-job training and mentorship on the correct use of the equipment in the next quarter.

2.1.2 Boosting ANC attendance (uptake and completion of 4+ ANC visits)

In Y4 Q3, *Afya Jijini* had 24,915 clients (90% of the quarterly target) attend their fourth ANC visit, reflecting 61% of the annual target. Emphasis was put on a screening for pregnancy in women of reproductive age (WRA) seeking services at all service delivery points to identify pregnancies early enough and initiate timely ANC. The program advocated for funds from the governor's office for health facilities, which enabled facilities to purchase ANC profile laboratory reagents. OJT and mentorships by program staff continued, reaching 101 HCWs. HCWs were mentored on the need to mobilize mothers to come early for the first ANC. Additionally, 80 HCWs attended the CMEs trainings. PMTCT nurses in high volume sites continued to support RH-HIV integration by ensuring zero missed opportunities for all pregnant women who tested positive in MCH, maternity, and postnatal service delivery points.

During the quarter, CHVs conducted 45,800 household visits to provide appropriate and timely messaging on the importance of completing all four ANC visits. Data collected during household visits revealed that 690 pregnant women completed four ANC visits and gave birth at one of 10 health facilities where the CHVs were linked. In the same period, 1,152 pregnant women at different stages of ANC visits were identified and counseled on the importance of attending all ANC visits for better outcomes, individual birth preparedness, and warning signs during pregnancy and post-delivery. A total of 70 ANC defaulters and another 606 pregnant women were also referred for services to health facilities.

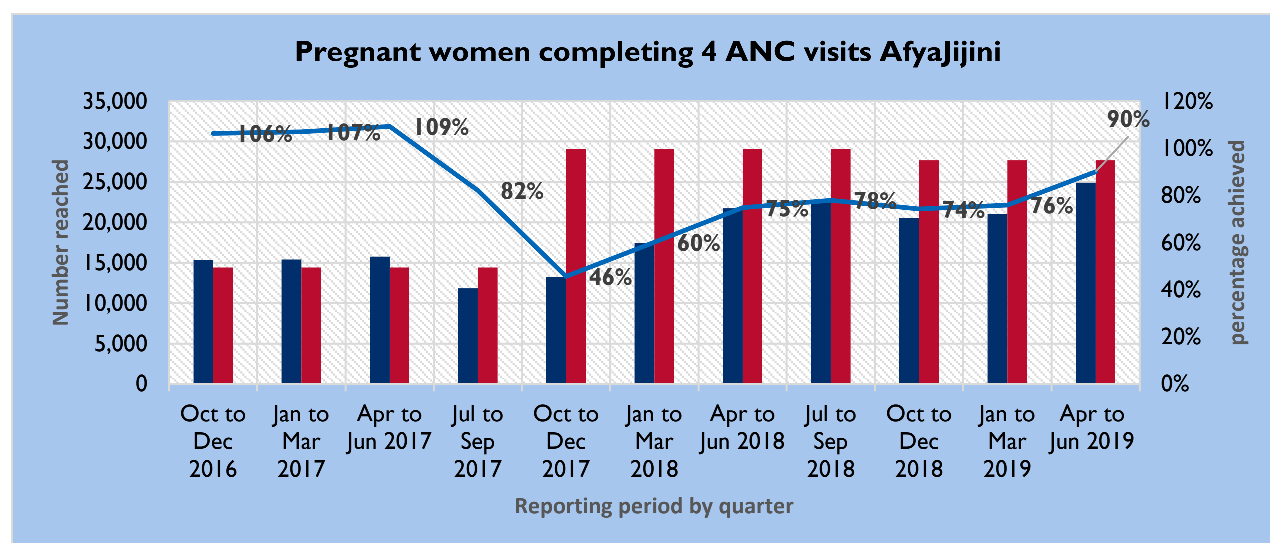

Figure 16: Pregnant women completing 4 ANC visits

Boost Adolescent ANC attendance (uptake and completion of more than four visits)

In Q3, focus group discussions (FGDs) were held in each of the 10 health facilities targeting adolescent and young people's responsiveness to RH services. The preliminary findings indicate that a majority are relatively aware of what RH is about, and most participants had some experience with RH issues that range from unsafe abortions, STIs, painful menses, and pregnancies. A reasonable number of participants had little or no knowledge on RH and where they could access RH services. Instead, they seek help from peers or search the internet for quick solutions. Some willingly visited health centers, and those who did were not comfortable due to the lack of youth-friendly services. They cited stigma and ridicule as barriers. This insight informed the project of the need for attitude change discussions both at facilities and the community, while equally engaging adolescent peers to mobilize and encourage navigation for effective services.

2.1.3 Increasing safe deliveries within NCC

To improve documentation of patient information and labor monitoring in health facilities, a total of 6,000 maternity files were distributed to 18 facilities (Mutuini and Kayole 2 SCHs, Waithaka, Kayole I, Embakasi, Dandora II, Mukuru, Eastleigh, Lang'ata, Bahati, Makadara, Kahawa West, Korogocho, Mathare North,

Ngara, Kangemi and Westlands Health Centres, and Marurui Dispensary). The project also advocated for fund allocation at the facility level to maintain a supply of the files in the future. The challenges have been irregular or non-reimbursement of the National Hospital Insurance Fund (NHIF) Linda Mama claims. The program also supported SCPHNs and facilities to conduct mentorship, CMEs/OJTs on Respectful Maternity Care (RMC), and EmONC signal functions, reaching 276 HCWs on various topics such as postpartum hemorrhage (PPH), newborn resuscitation, assisted vaginal delivery, correct use of partographs, and maternity HIV testing, among others.

Maternity tours during the first ANC visit in 13 public health centers coupled with CHVs' community services led to an increase in in skilled deliveries in health facilities. The 182 CHVs referred 735 women to health facilities for safe attended births. Another 1,210 mothers were referred and linked for Linda Mama enrollment in health facilities. Leadership development program (LDP) coaching activities continued with facilities showing sustained gains in skilled deliveries.

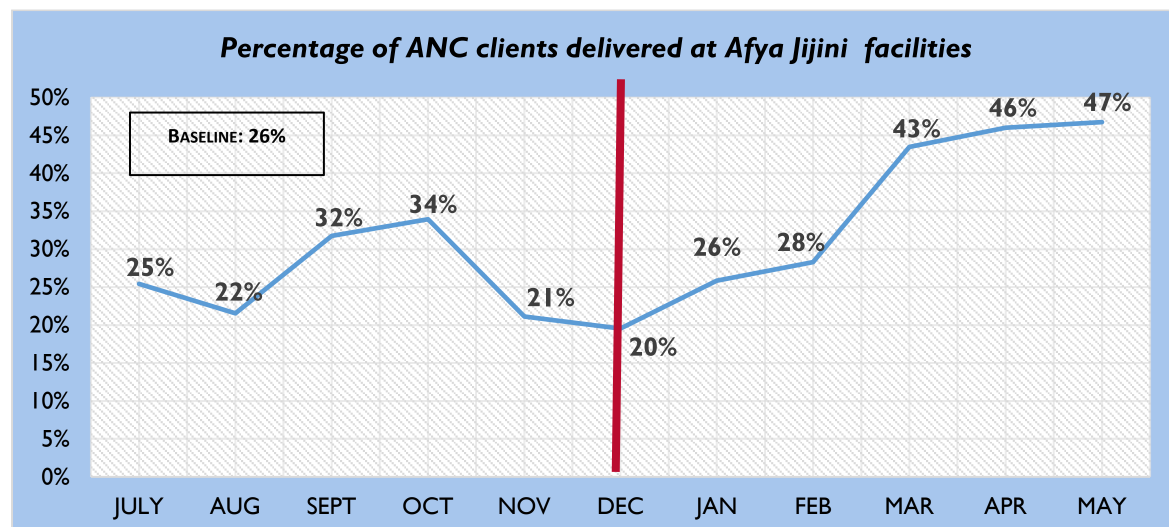

Figure 17: Improved uptake of deliveries in Mathare North Health center; LDP project results for the period July 2018 – May 2019

In Q3, EmONC assessments were conducted in 12 of the 67 maternities supported by the project. Skills gaps identified during the EmONC assessments were rectified through OJTs and mentorships jointly conducted by the program team and sub-county mentors. Although the EmONC feedback for last year's assessment is scheduled for the next quarter, coupled with joint planning and assessment for this year.

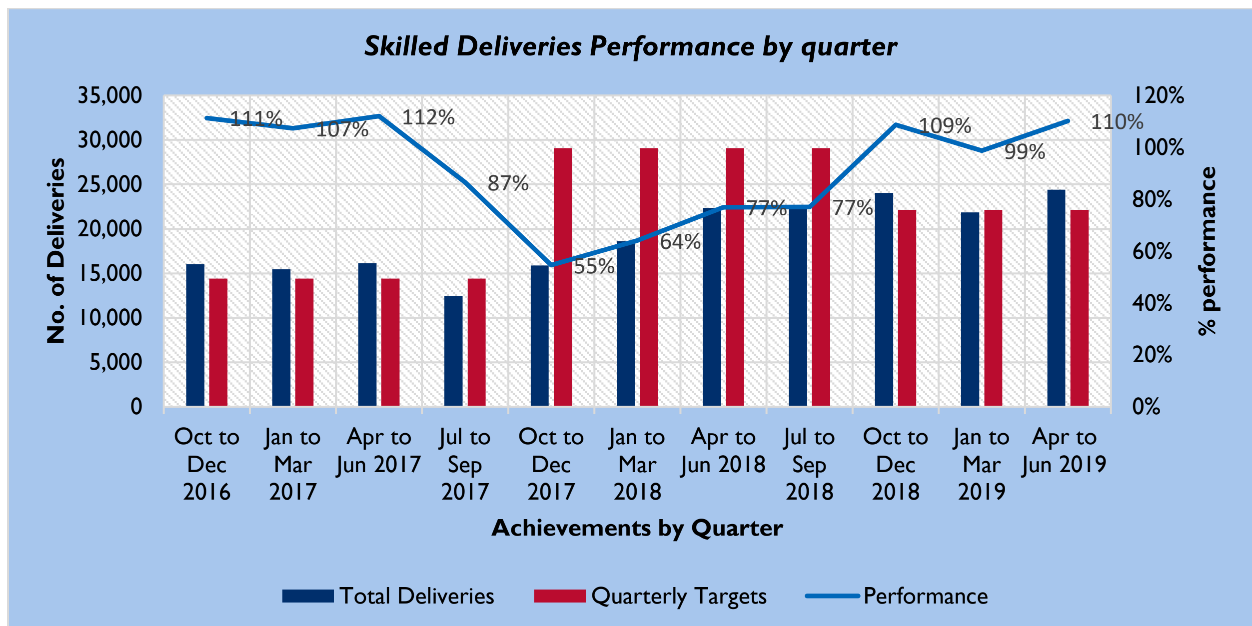

Figure 18: Skilled delivery performance by quarter

During the reporting period, a total of 24,405 deliveries (contributing to 79% of the annual targets) were reported, with a corresponding 100% given oxytocin after delivery. There was no reported case of oxytocin stock out in Q3. There was a slight disparity in the number of deliveries versus administration of oxytocin within one minute, but this was attributed to documentation gaps in the partograph. Project staff, together with the sub-county and facility teams, are addressing documentation accuracy through mentorship sessions, OJTs, and work improvement team (WIT) activities. Of the 2,121 maternal complications reported in the quarter, 339 (16%) of cases were due to PPH as compared to the Q2 contribution of PPH cases, which was 39%. This improvement is attributed to the continued mentorship, OJT and QI activities in the maternities. This quarter all PPH cases were managed using the PPH care bundle, and 82 cases were transfused with blood and blood products. The biggest challenge in managing hemorrhage cases was a late referral from referring facilities and inadequate supply of blood and blood products. Five PPH-related deaths were reported this quarter. There were 642 cases (30%) in which antepartum hemorrhage (APH) contributed to maternal complications. This finding emerged as a key area of programmatic focus for Q4, in which the program will work to enhance early identification of warning signs and ultrasound screenings in the antenatal period and delivery.

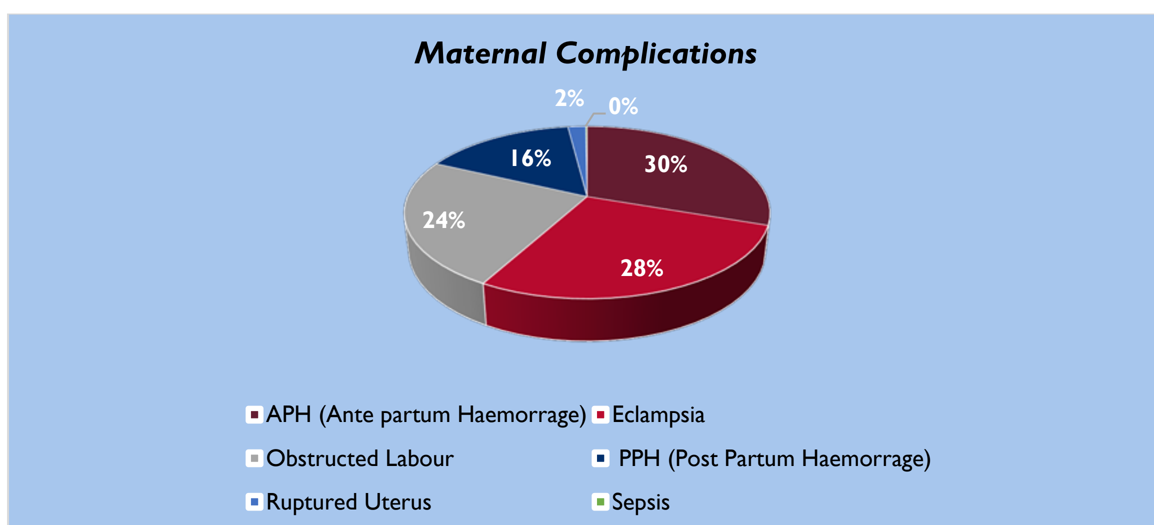

Figure 19: Direct maternal complications reported in Q3

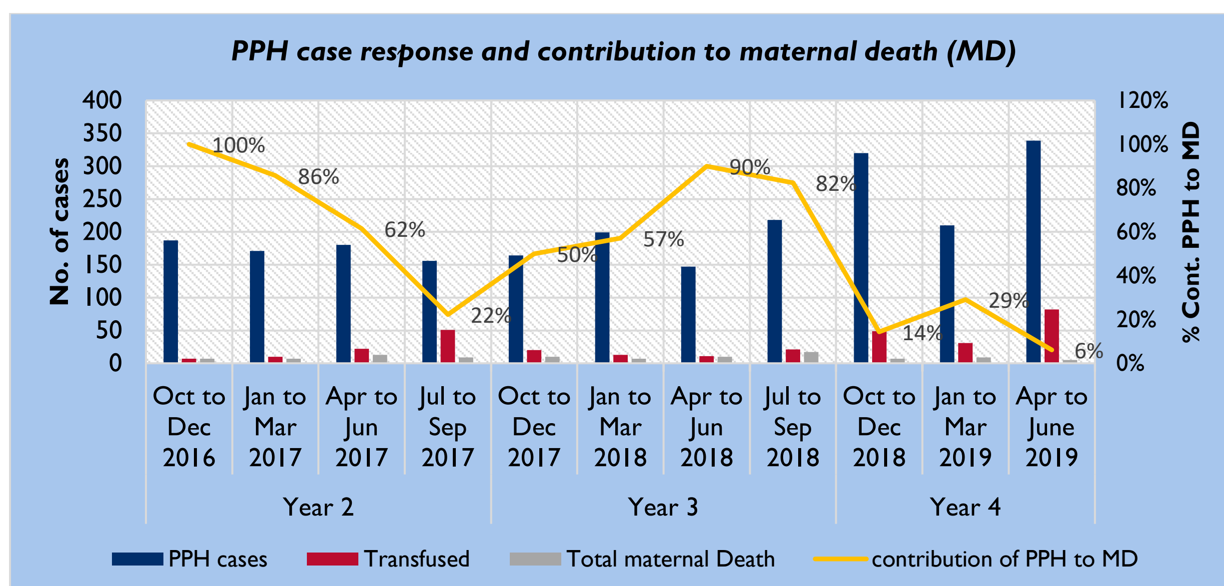

Figure 20: PPH case response

MPDSR activities at health facilities

In Q3, 13 direct maternal deaths were reported in three high volumes facilities. Of the complications, 39% were due to PPH, 8% to abortion, 15% to other indirect causes (HIV and meningoencephalitis), 8% to eclampsia, 8% to the ruptured uterus, and 23% to maternal sepsis. All reported maternal deaths were audited. Findings revealed that the big maternities contributed to nearly all reported maternal deaths: eight (8) (57%) at MLKH, one (1) (7%) at Pumwani Maternity Hospital, and two (2) (14%) at St Francis Hospital, and three (3) (21%) at Mbagathi Hospital.

Perinatal deaths reported in Q3 totaled 870 (468 Fresh Still Birth (FSB) and 246 Macerated Still Birth (MSB) of which 156 were neonatal deaths. A total of 126 of the neonatal deaths were audited, and the findings are as follows: 50 were due to asphyxia, three to neonatal sepsis, and 73 to other reasons including prematurity, respiratory distress syndrome among others. Program staff are focusing on addressing poor maternal and perinatal outcomes in these facilities and surrounding communities by working with the CHMT, SCHMTs, health facilities and community to address some of the first, second and third delays contributing to the occurrence of deaths. Overall, the program reported a facility-based maternal mortality ratio of 56 deaths per 100,000 live births and a perinatal mortality ratio of 35 deaths per 1,000 live births in Q3.

This quarter, 21 MPDSR committee meetings were supported by technical program staff at 11 facilities. The program also supported the distribution of 193 MPDSR tools to the 10 sub-counties, including the five largest maternities. Due to MPDSR under-reporting in Starehe Sub-County, which attributed to high staff turnover especially in the private facilities, the program supported a one-day MPDSR sensitization meeting for 26 participants from Gurunanak Hospital, Lengo Medical Clinic, Mariakani Cottage Hospital, South B Hospital Limited, Ngara Health Centre, Radiant Pangani Clinic, Ladnan Hospital, and Huruma Nursing Home.

The team also participated in the county MPDSR forum, during which a report of Nairobi County MPDSR for the period July 2017 to June 2018 was shared. A key report highlight was the 165 maternal deaths, of which 158 were audited. Kenyatta National Hospital contributed the largest proportion of the deaths. Only 24 maternal death review reports were uploaded to DHIS-2, cited as one of the major gaps in MPDSR reporting. Of the 24 death reports that were uploaded, the major cause of death was hemorrhage, mainly as a result of the unavailability of blood and blood products. The first delay was attributed to some of the maternal deaths. There was also a need for the establishment of ICU facilities in the county hospitals for effective management of critically ill women in the peripartum period. Regarding client education at ANC, meeting participants proposed that a video with key messages be played in the waiting bays of health

facilities. The program will advocate the hospital management to make the required electronic equipment for client messaging available at waiting bays.

Community MPDSR: In the three sub-counties with the highest maternal death burden, the program worked with 182 CHVs to educate the community and refer pregnant women to facilities to strengthen the community-health facility interface and address first and second delays through verbal autopsies. The project sensitized 30 community MPDSR committees from Embakasi West and linked them to Kayole 1, Kayole 11, Mama Lucy Kibaki Hospital, Kariobangi South, Umoja 11, and Molem. This was a targeted sensitization activity in response to the high burden of maternal and perinatal deaths in that sub-county.

Volunteers gave health talks at the households of 1,152 pregnant women to address the first and second delays and improve maternal and child health outcomes. These volunteers offered15 sessions in 10 health facilities educating pregnant women on warning signs during pregnancy and the importance of seeking medical care immediately upon noting any danger signs during the antenatal, delivery and post-delivery periods. This effort was to prevent maternal and perinatal deaths in the community in subsequent quarters.

Quality Improvement in maternities

WIT activities continued in maternities to improve documentation, patient monitoring, and the general quality of services.

Table 12: Improvements in maternities

Facility	WIT project	Baseline score	Score at the end of Q3 (mid evaluation)	Target score at 6 months
Ngara H/C	To increase skilled deliveries	8%	38%	74%
Guru Nanak Hospital	To improve the completeness and accuracy of partograph	5%	78%	94%
Westlands HC	To increase skilled deliveries	10%	39%	78%
Mutuini	To improve the completeness and accuracy of partograph	5%	20%	60%
Mukuru Reuben	To improve documentation of patient maternity files	10%	55%	90%
Kayole I HC	To improve the retesting of mothers in delivery	0%	70%	100%
St. Mary's Hospital	To improve 4-hourly BP monitoring on partograph	50%	79%	90%
MLKH	Accurate documentation on partograph	5%	47.5%	90%
Pumwani	To improve waste segregation practices in the labor ward	4.7%	4.7%	50%
St Francis	Accurate documentation of information in the patient file and HIV testing in maternity	0 %	54%	100%

2.1.4 Improving HCW attitude through training and coaching

In Q3, the *Afya Jijini* sub-contractor, Health Right International (HRI), continued with RMC activities to address staff attitudes in the five largest hospitals (Pumwani Maternity, Mbagathi County, MLKH, St. Mary's Mission, and St. Francis Community Hospitals) and six health centers (Mathare North, Makadara, Mukuru HC, Mukuru Reuben HC, Kayole I HC, and Eastleigh HC). A patient feedback book was established at each facility's maternity to capture patients' compliments and complaints. The project also supported a three-day training for 34 HCWs and a two-day training for 25 CHVs on RMC. Following this training, a total of 1,136 women from the community were sensitized on their rights during childbirth and how to report disrespect and abuse (D&A) cases.

At the community level, seven cases of D&A (mainly with abusive language) were reported and addressed at the linked health facility. In the same period, RMC sensitization was offered to 34 pre-service nurses at St. Francis Community Hospital's School of Nursing and 35 in-service nurses at Pumwani Maternity Hospital.

Client exit interviews were conducted at two health facilities, Mukuru HC and Makadara HC. Fifty (50) randomly selected clients were administered questionnaires. Some of the key issues highlighted by clients included long wait times, insufficient staff to attend to clients, frequent stock-out of vaccines and medicines, and unclean environment. The feedback was shared with facility health management, who had already addressed some of the concerns. To address wait times, clients are served on a first-come, first-served basis if not requiring emergency or priority care. Unclean environments at these health facilities are also being addressed.

2.1.5 Improve uptake and provision of PNC at target health facilities

In Q3, program staff continued to mentor HCWs on timely documentation of PNC care within 48 hours in maternities. A total of 57 HCWs from 11 facilities were mentored and another 70 trained through CMEs on accurate documentation of PNC services by working with the SCPHNs. The program also addressed the gaps in PNC documentation and distribution of PNC registers. WITs are specifically improving PNC documentation. In this quarter, 12,352 newborns (51% of total deliveries in the quarter) received PNC care within 48 hours.

Kangaroo mother care (KMC): Prematurity and low birth weight are major contributors to newborn mortality, and KMC is one key intervention supported by the program to address poor newborn outcomes. Program staff continued mentoring HCWs on KMC. A total of 325 premature, low birth weight babies were admitted to KMC, of which 333 were discharged home alive (to note, some babies from the previous quarter were discharged this reporting period). Four (1%) babies died while undergoing KMC. *Afya Jijini* plans to follow up with the babies in the community using the program's community model for KMC. This quarter, the program also procured and distributed 16 rolls of cloth material to make approximately 800 Kangaroo Mother Care tharis (wraps) for Mama Lucy Kibaki Hospital (12) and St. Mary's (four) Hospitals. The tharis will be used to maintain premature and low birthweight newborns in KMC position.

This quarter 182 CHVs identified 559 newborns and offered PNC messages to mothers on warning signs for the newborn and mother after delivery in the following units: Bahati, Riumbaki, Ribakia, Maringo,Hamza, River Bank, Umoja Pioneer, K.C.C, Kariobangi South Korogocho A, Soweto Kongo, Kisumu Ndogo, Ngomongo, Matopeni, Bridge, Umoja Pioneer and Jada. The CHVs also mapped and referred 217 mother/baby pairs for postnatal services.

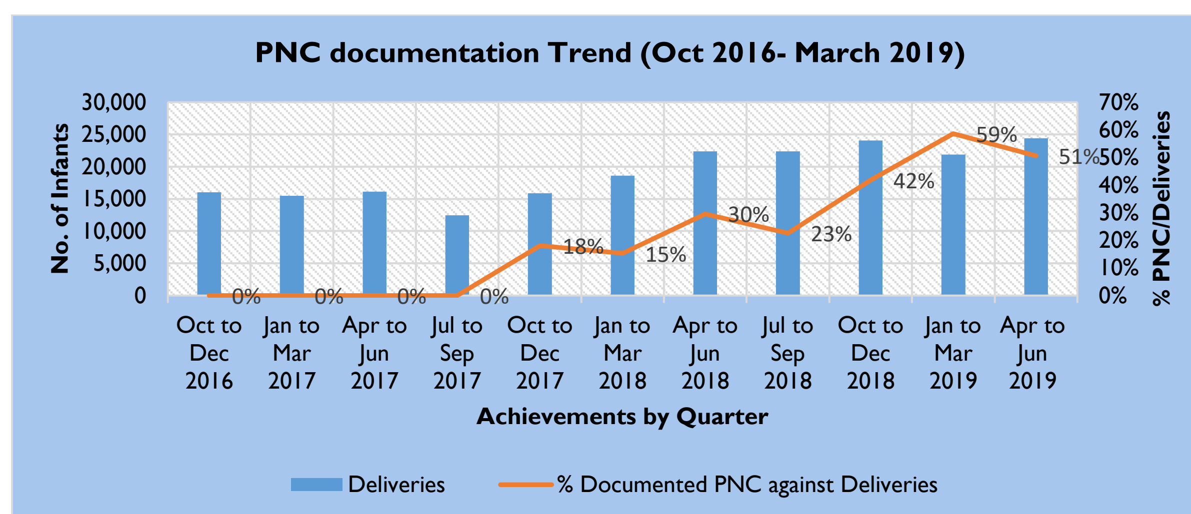

Figure 21: Afya Jijini Quarterly PNC Performance against Target

Table 13: Quality Improvement in PNC				
Facility	**WIT project**	**Baseline score**	**Score at the end of Q3 (mid evaluation)**	**Target score at 6 months**
Kangemi HC	Documentation of the postnatal register	0	35%	100%
Waithaka HC	Accurate and complete documentation of postnatal register	0	70%	100%
Mutuini HC	Accurate and complete documentation of postnatal register	5%	60%	100%

2.1.6 Scaling-up gender-sensitive approaches to Maternal and Neonatal Health

Following sensitization of 47 CHVs on male engagement in Q2, 10 male/female champions were recruited through community participation in Q3 to support male involvement in MNCH at 10 facilities where CHVs are linked. As a result, 362 couples were recruited and sensitized on danger signs during pregnancy and the need for individual birth plans. The program also developed information, education, and communication (IEC) materials and reporting tools to use during health sessions. In the same period, 102 *We Men Care* factsheets were distributed to the champions to be used during engagement activities and health education sessions for couples. A total of 363 men were offered HIV testing, 398 were screened for hypertension, and 254 were screened for obesity. Through couple engagement, 1,489 received ANC messaging, 78 women were supported by their male partner for skilled delivery, 70 women received PNC, and 84 received FP.

2.2 Output 2.2: Child Health Services

In Q3, 25,833 (103% of Q3 target) children under one year of age were reached with diphtheria-tetanus-pertussis 3 (DTP3) (103% of Q3 target), 25,505 (100% of Q3 target) were reached with measles vaccines, and there were 26,671 (105% of Q3 target) fully immunized children (FIC). A total of 9,424 cases of pneumonia among children under five were diagnosed and treated with antibiotics, and 21,610 cases of diarrhea were treated with zinc and oral rehydration salts (ORS) at health facilities.

Availability of amoxicillin DT remained a challenge for the county since KEMSA withheld supply to Nairobi County due to unpaid debts owed to KEMSA. Consequently, caregivers were forced to purchase medications from medicine shops outside the facilities. The HSS team continues to advocate for unbroken supply chain management, but this is tied to financial support from the county.

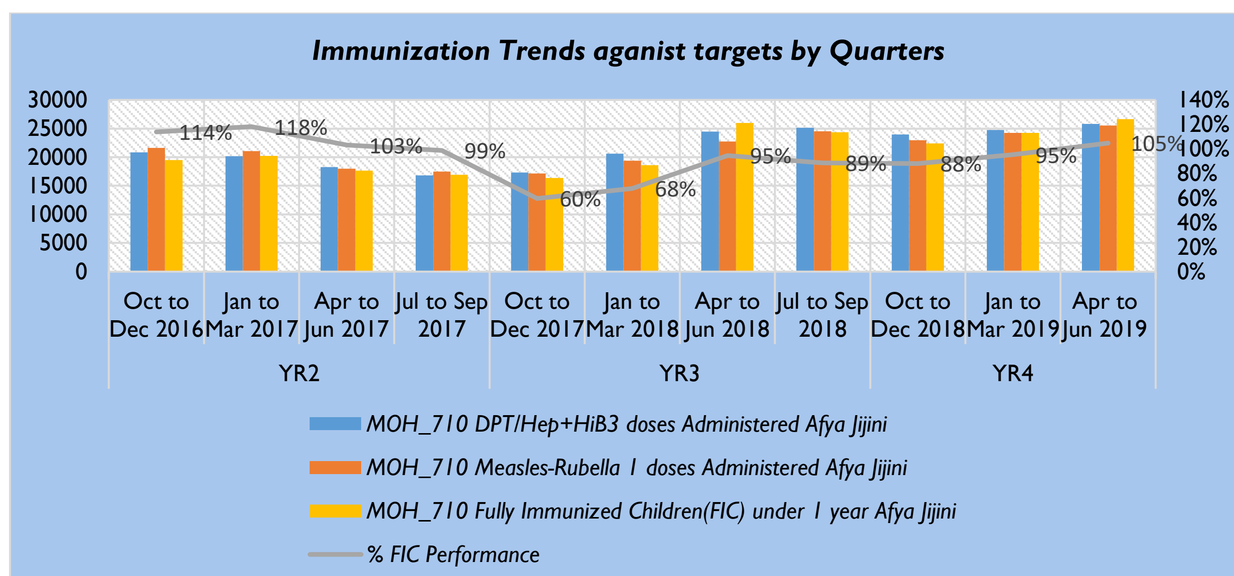

Figure 22: Immunization achievement

2.2.1 Strengthening County and sub-county planning/supportive supervision for child health

During Q3, the program supported a county data review meeting for child health indicators. All 10 sub-counties shared experiences and best practices in reaching children under 5 and improving immunization coverage. Documentation gaps were also noted in the data presentation, and the decision was made to address these by providing close supervision, mentorship, and a data quality audit. Vaccine shortages experienced during Q2 were addressed through re-distribution of available buffer stocks in the county. Towards the end of Q3, there was a shortage of polio vaccine, and this was being addressed by the National Vaccines and Immunization Unit. The program supported a one-day PCV 10 switch sensitization meeting for sub-county depot managers and SCPHNs for three sub-counties (Makadara, Kamukunji and Embakasi West).

As noted in Activity 2.1.1, the program provided logistical and technical support to three sub-counties during the expanded program on immunization (EPI) microplanning meetings: Embakasi East, Ruaraka, and Embakasi West. In the same period, the program supported sensitization meetings in these three sub-counties on the changes in dosage packaging for PCV 10. EPI outreach at Ng'ando slums in Dagoretti sub-county was launched by the CHMT and reached children with immunization services, contributing to a reduction in drop-out and missed opportunity for immunization. Prompted by a data review that showed low coverage of measles II vaccination for children, Makadara sub-county conducted an immunization outreach event and active case finding for malnutrition at seven ECD and daycare centers. A total of 54 children were reached with immunization services in ECD centers. A total of 118 CHWs received mentorship on cold chain management, ledger book usage, documentation, reporting, defaulter tracing of children lost to follow-up, use of appointment diaries and permanent register completion.

Program staff participated in a pneumonia report dissemination forum for a research study done by Save the Children in three counties: Wajir, Bungoma, and Nairobi. The qualitative research sought to explore the adequacy of policies and guidelines on pneumonia, as well as knowledge, practices and community member and CHV understandings of the WHO pneumonia management strategies (protect, prevent, and treat). Based on the findings it was recommended that pneumonia and child health programming should be context and county-specific in order to bring services to hard-to-reach populations such as immigrants and children under five.

2.2.2 Improving facility child health service provision

As a result of the gaps recognized during the integrated supportive supervision in Q2, an IMNCI mentorship plan was developed and executed in all 10 sub-counties in 13 facilities by sub-county mentors. A total of 73 health providers from 13 facilities were mentored on the new IMNCI guidelines by the mentors using guideline checklists. The focus of the mentorship plan was to assess and manage sick children under 5. Guidelines were distributed during the mentorship activities. A trainee follow up/supportive supervision activity has been planned for the next quarter. Program staff also supported the Sub-counties in providing OJT to 118 health providers on various areas including improving documentation gaps in MOH registers for child health.

2.2.3 Strengthening knowledge and uptake of infant and child health services at the household- and community-level

In Q3, program-supported county and sub-county EPI trainers facilitated a three-day EPI training attended by 61 of the 289 total CHVs. Volunteers were equipped with information on the current immunization schedule in the mother-child booklet and identification of missed opportunities and defaulter tracing. This training will help CHVs to further reduce the number of children who default on immunization. This quarter CHVs mapped 45,800 households, reaching 5,094 children under five years of age with health talks to their caregivers. The CHVs gave health talks to caregivers on the importance of immunization, exclusive breastfeeding for six months, complimentary feeding up to two years, handwashing during four critical times, and appropriate and timely referral when warning signs of pneumonia and diarrhea or any other condition that cannot be managed at community-level arise. CHVs referred 1,145 children for immunization and traced back 177 children who had defaulted from immunization.

2.3 Output 2.3: Family Planning Services

In Q3, *Afya Jijini* worked with 183 facilities and 289 CHVs to provide FP services to 111,852 WRA, of which 59,841 were new clients, and 52,011 were previous clients. The program achieved 98,890 (102% against the quarterly target) couple of years of protection (CYP) this quarter, of which long-acting reversible contraception (LARC) contributed 58%. In the same period, provision of adolescent-targeted FP through Binti Shujaa continued. A total of 7,651 adolescents received FP services at health facilities. This quarter there were stock-outs of some FP commodities including the single-rod implants and IUCDs. The newly launched subcutaneous injectable, Sayana Press™, has not yet been supplied to facilities by KEMSA even as sensitization of sub-county managers on the new injectable formulation occurred in Q2. There were also stock outs of the reporting tool, Facility Consumption, and Data Report (FCDRR). The program supported the distribution of copies of the tools to sub-county stores for issuance to facilities as they submit monthly reports.

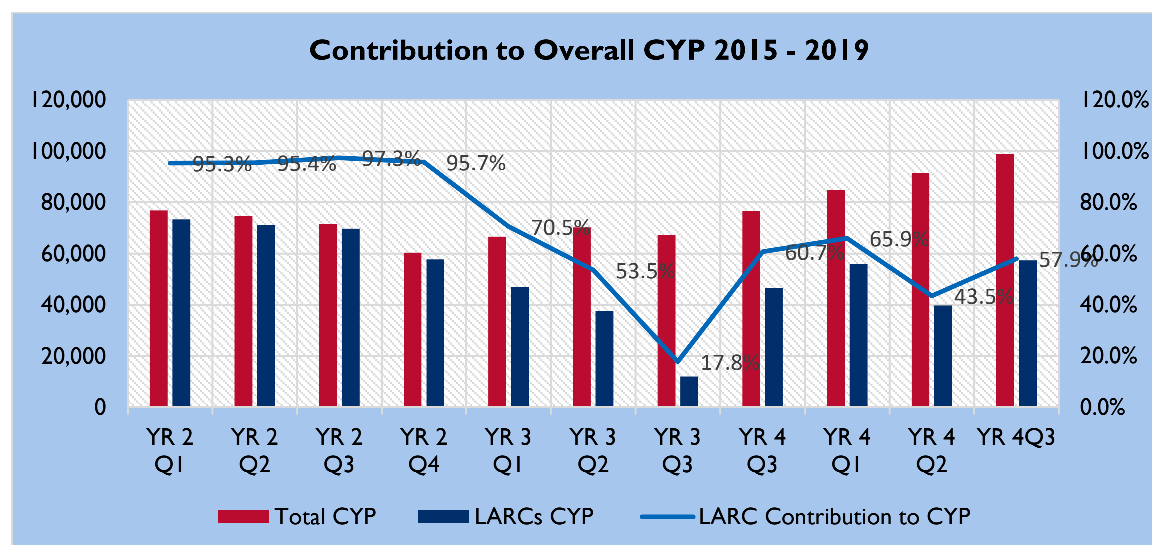

Figure 23: Quarterly CYP performance and LARC contribution

Contribution of LARC in Q3 improved slightly due to improved community sensitizations; improved uptake of FP among adolescents; integration of FP at other service delivery points such as CCCs, maternities, child welfare clinics and PMTCT clinics; redistribution of FP commodities, especially at the county TWG forum; and improved documentation and reporting.

2.3.1 Strengthening County and sub-county FP coordination and service delivery

In Q3, *Afya Jijini* provided logistic support for the in-charges' meetings at Makadara and Embakasi East sub-counties where re-sensitization to US FP and abortion compliance was conducted, reaching 114 facility in-charges and SCHMT members. The program noted an improvement in reporting of F-CCRR; 89.2% in Q3, up from 31.2% reported in Oct–December 2015.

The program also supported quarterly TWG meetings that brought together members who support RH/FP from the county, sub-county and implementing partners. Among the topics discussed were the quarterly performance at the sub-county level, the availability of commodities within sub-county stores, best practices in FP, and the need to create more demand to bridge the unmet needs in FP within the counties.

2.3.2 Improving access and quality of facility-based FP services

This quarter, the program supported facilities by redistributing commodities, especially IUCDs, between and within sub-counties to ensure minimal interruption of services. Program officers also mentored health providers in maternities to provide modern FP methods. The program also distributed 12 sets of counseling cards, seven MEC wheels (2016), and 14 Tiahrt charts to facilities that had integrated FP into maternities.

FP uptake among adolescents and youth

The 20 Binti Shujaa volunteers continued mentoring adolescent girls within the community and reached 387 new girls with FP messages and referrals to Bahati, Dandora 2, and Makadara Health Centers for FP services. One referral was for SGBV services. Nine AGYWs were reintegrated in school. Adolescent

support group meetings were held in Bahati and Dandora II Health Centers to dispel fears among adolescent mothers related to access to services at health facilities. FGDs with adolescents were also held at ten health facilities to discuss ways to improve service delivery and attract adolescents to health facilities. Analysis of the FGD findings is still on-going. A total of 7,651 adolescent girls received a modern contraceptive in Q3.

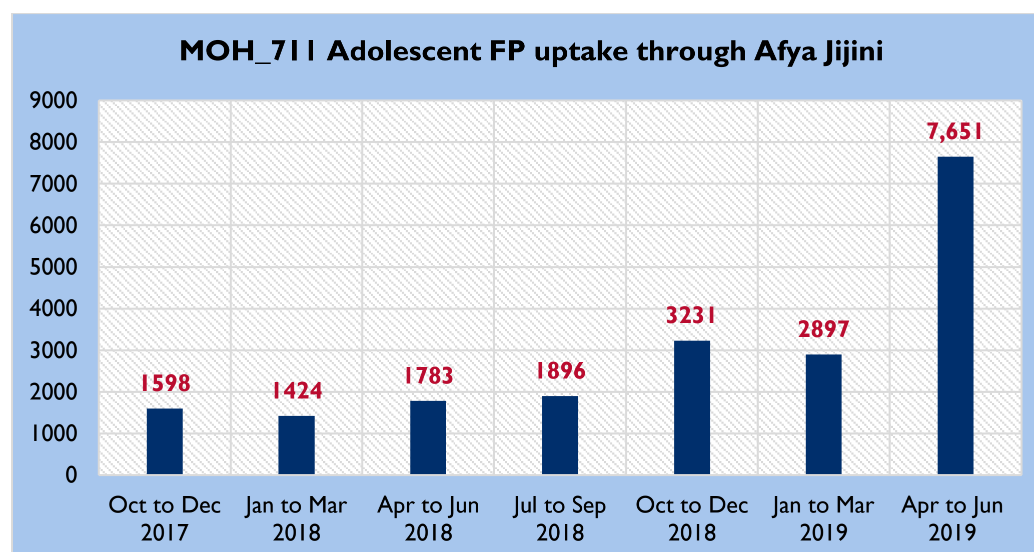

Figure 24: Quarterly FP uptake among adolescents at facilities offering the Binti Shujaa model

Integration of RH/HIV services

Twelve facilities (compared to 9 reported in Q2) continued offering FP-related services in the CCCs and at PMTCT service delivery points as a result of OJT/mentorship on FP services, distribution of FP registers, and re-distribution of FP commodities and equipment. A total of 103 new and 1,485 re-visit clients who were HIV positive were reached with modern FP methods in facility CCCs and PMTCTs. Inadequate infrastructure remains a key challenge for optimal integration of FP in most CCCs. HIV testing by program HTS counselors continued in MCH department, FP rooms and labor and delivery, and postnatal wards in the HVFs and health centers that had counselors. Immediate PPFP services increased, and 13 (19%) facilities currently provide services to postpartum women in maternity wards. Slow uptake has been mainly due to the small number of trained staff in maternities, frequent change-over/turn-over, high workload, and the change in the training curriculum at the national level from single modules to a three-modular training.

Table 14: FP uptake in CCC/PMTCT

	New Clients	Re-Visits	Total
Pills - progestin only	2	71	73
Pills - combined oral contraceptive	5	96	101
Emergency contraceptive pill	0	0	0
FP injections	16	103	119
IUCD insertion	0	61	61
Implants insertion	12	147	159
Sterilization Bilateral Tubal Ligation (BTL)	0	0	0
Sterilization vasectomy	0	0	0
Client receiving male condoms	68	965	1,033
Clients receiving female condoms	0	42	42
TOTAL	103	1,485	1,588

2.3.3 Strengthen household and community access to FP messaging and commodities

A total of 289 CHVs supported by the program continued to share information on FP at the household level and during dialogue days. During household mapping, CHVs reached 45,800 households with FP

messages. CHVs also doubled up as CBDs and distributed a total of 15,391 condoms, 211 cycles of pills to FP clients, and referred 1,188 WRA for LARC services.

2.3.4 Gender-Sensitive FP approaches

47 program supported CHVs reached 1,604 men, of which 985 were couples. The services offered to the men included messaging on HTS, FP, and other MNCH services. Of those, 288 were offered FP services as couples, 971 were tested for HIV, and 1,544 were offered other MNCH services such as ANC, PNC, and skilled delivery.

2.4 Output 2.4: Water, Sanitation, and Hygiene (WASH) Services

2.4.1 County-level WASH support

Improving collaboration and networking

To build the capacity of the county and strengthen networking and collaboration, project staff participated in stakeholder meetings within the county and sub-counties. Meetings were also held with USG and other relevant partners to pursue areas of collaboration and learning.

Afya Jijini also participated in a forum organized by the county on WASH diseases and emergency preparedness. During the forum, an action plan was developed to aid in preparedness and response to the current cholera epidemic. A contingency plan was developed, and *Afya Jijini* was requested to provide a Point-of-Use (POU) water treatment product to 2,600 households within the affected informal settlements.

Capacity building on WASH and reporting

Afya Jijini supported the County Public Health Department in improving reporting of public health activities using the MOH 708 tool in DHIS-2. This was one of the action points that came out of the training on DHIS-2 the previous quarter and has resulted in improvement in reporting rates by over 50%. Also, for the first time, performance data is now available in the national reporting platform.

To improve data availability and reporting by Nairobi County on Urban Community-Led Total Sanitation (UCLTS), the project supported data collection in "villages" in the county. This data will be used by the county for planning and monitoring of progress made towards implementation of the methodology, as well as an advocacy tool as evidence of open defecation in Nairobi County.

Improving collaboration and networking

In addition to participating in the county forum on WASH diseases and emergency preparedness, *Afya Jijini* collaborated with the county and the World Bank's Transforming Health Systems for Universal Care Project (THS-UCP) to sensitize 115 HCWs on healthcare waste management. Key highlights from the meeting included discussions on public health facilities without incinerators to provide subsidies to the big hospitals for the cost of fuel to assist in waste disposal and the THS-UCP project to support health facilities in the disposal of waste, prioritizing those with high accumulation of waste.

2.4.2 Sub-county and facility-level WASH support

This quarter, *Afya Jijini* supported the provision and distribution of 187 posters to improve knowledge of WASH in health facilities. These IEC materials offered messages on handwashing and critical handwashing moments, safe handling of water, and proper disposal of feces. To promote infection prevention and control (IPC) in health facilities, the project supported CME sessions in twenty health facilities. Forty-eight (48) CHWs in two sub-counties (Embakasi West and Kamukunji) were sensitized on healthcare waste management, personal protection, and handwashing.

Supporting functional Oral Rehydration Therapy (ORT) corners

The project continued providing technical support to health facilities to manage diarrhea. Support was provided to health facility health workers and volunteers (WASH Champions) who are involved in diarrhea management and functioning of ORT corners in 30 health facilities. Capacity gaps in ORT corners and diarrhea management in health facilities – such as messaging on prevention and control of diarrhea for children under 5, documentation, and referrals – were addressed during the provision of technical support.

During facility visits, performance reviews were performed to analyze project progress, discuss difficulties and successes, and document/report on project deliverables. Capacity building also occurred during these sessions to improve service delivery in health facilities. The table below shows the number of children who visited the 30 health facilities and were beneficiaries of health education and promotion during the reporting period. During the reporting period, some facilities experienced stock-out of ORS and zinc. The project provided logistical support for redistribution of these commodities from Lang'ata sub-county to facilities in Starehe sub-county. A total of 21,710 children with diarrheal episode were treated with ORS and zinc.

2.4.3 Implement and scale UCLTS in Nairobi's informal settlements

Pre-triggering and triggering activities

Afya Jijini and the Sub-county Public Health Department undertook a pre-triggering visit and triggering in a village in Embakasi North Constituency in Kasarani Sub-County (Kanyama village). This increased the number of villages triggered with support of the project from 39 in Y4Q3 to 40. As a result, 1,000 households will have access to proper sanitation facilities.

Post-triggering monitoring and follow up

The project collaborated and partnered with CHMTs and SCHMTs to implement the UCLTS approach to address sanitation in informal settlements. The aim was to decrease the number of informal settlement populations practicing open defecation and increase those scaling-up sanitation. To support triggered villages and ensure the progress of villages towards being open defecation free (ODF), the project facilitated 36 post-triggering monitoring and follow-up field visits in triggered villages. The primary objectives of these field visits were to determine and document progress towards ODF status and to offer capacity building and support to leaders and officers involved in the implementation of the UCLTS approach. *Afya Jijini*, together with the sub-counties, intensified engagement with landlords as key stakeholders in the promotion of sanitation in informal settlements. During the quarter, the project supported the internal assessment of Gitwamba village by Kasarani sub-county, the first village to have ODF claims in the county. Based on the results of the internal assessment, the county, following CLTS protocol and guidelines, plans to proceed with the next stage of the process to verify the claims.

Capacity building for sub-counties in UCLTS

The project continued providing OJT to sub-county WASH focal persons, public health officers (PHOs) and community leaders in all ten sub-counties to strengthen UCLTS implementation. These sessions were conducted during meetings and monitoring visits. OJT contributed to improved knowledge, skills, and quality of facilitation during triggering and post-triggering monitoring and follow-ups.

2.4.4 Community-based WASH support activities

Community sensitization on WASH

Afya Jijini partnered with Nairobi County on improving WASH awareness within informal settlements through action and dialogue days. During these events, community members were sensitized on necessary and adequate sanitation practices and ways of making water safe for prevention of diseases, including correct and consistent handwashing. Demonstrations were also conducted on how to make leaky tins using locally available materials for use in handwashing. During these community events, over 1,000 households were reached by CHVs and CHWs, with an estimated 7,000 people reached with WASH messages through health talks and demonstrations.

Promoting environmental sanitation through clean-ups

The project supported six sub-counties to undertake 38 clean-up and sanitation action days that reached 30,287 people with WASH messages. These sessions were conducted in informal settlements, including the "triggered" villages. Communities developed plans to improve waste management. The clean-ups were also used as an opportunity to advocate on environmental sanitation. World Environment Day was also marked during the review period.

Promoting WASH-friendly ECDs, day-care centers, and schools through community outreach

To improve sanitation and hygiene health-seeking behavior of children, caregivers (teachers and parents) and communities in informal settlements, the project supported the implementation of the ECD model and Small Doable Approach (SDA-includes activities such as health education, proper sanitation at ECD centers,

and handwashing techniques). *Afya Jijini* hosted WASH sensitization events in four sub-counties where the project is also supporting community nutrition interventions through volunteers. Target beneficiaries in these sub-counties were reached with messages on hygiene, drinking water quality, and safe disposal of excreta (all aimed at preventing diarrhoea in children under 5). CHVs also distributed IEC materials (posters) on handwashing in ECD centers.

Supporting access to clean drinking water and household water treatment technologies
Most informal settlements have illegal water connections that are easily damaged and contaminated, hindering residents' access to clean and safe water. Many residents in informal settlements rely on outside vendors for sources of water. To improve the use of water treatment technologies and provide safe water in the informal settlements, *Afya Jijini* procured 312,000 Aquatabs™ (67mg) for Point-of-Use (POU) treatment of 6.2 million liters of water for sub-counties and health facilities. These products were distributed to community members in "triggered" villages, benefitting an estimated 31,200 households, ECD and daycare centers, institutions, and 30 health facilities to benefit children with diarrhea. Also treated were community water points using chlorine granules, procured by the project in Y1, for dosing of community and school water tanks. To promote water quality, the project partnered and supported sub-counties to undertake water sampling and testing in informal settlements. The samples were used for bacteriological analysis and testing of residual chlorine using rapid test kits. The results of the water sample testing then informed the actions and interventions to be undertaken, including lobbying the Nairobi Water and Sanitation Company to increase chlorination level or promoting the use of POU water treatment products.

Promoting handwashing at the community level
The project promoted handwashing during all project-supported activities and interventions. As an example, during UCLTS follow-up visits and sanitation dialogues, information on good handwashing practices was included as one of the capacity building subjects for leaders and community members. Emphasis was placed not only on the importance of handwashing but also on the critical times to wash hands. IEC materials on handwashing, provided both by the project and by county government, were also distributed.

2.5 Nutrition Services

2.5.1 County-level nutrition support

Coordination alignment: During the quarter *Afya Jijini* participated in a County Nutrition Technical Forum (CNTF), the main purpose of which was to evaluate the follow-up on the Data Quality Assessment (DQA) that was carried out the last quarter, where the reporting rate for eight of the Sun-counties improved. Other areas of discussion included the alignment of the County Nutrition Action Plan (CNAP) document (2019-2023) with the draft National Action Plan. Concerning the CNAP, one of the key areas of focus suggested for NCC was a clear strategy on micronutrient support and indicators.

In addition, the Kenya Red Cross, together with Nutrition Department Units, is currently developing guidelines on nutrition in emergencies after which there will be an MOU with Nairobi County to provide capacity building for health workers. For this, *Afya Jijini* provided inputs and will participate in the validation meeting.

To track the defaulter rate for the integrated management of acute malnutrition (IMAM) program, the county created a social platform to monitor defaulters on a weekly basis in order to respond to the causes of defaulting at the facility level. It was further noted that a data audit should be done monthly before new data entry, and sub-counties were encouraged to know their catchment populations including an understanding of the most vulnerable within that population. An aspect of a TB-nutrition linkage was discussed, and it was agreed that all children screened for SAM were also to be screened for tuberculosis.

A coordination meeting was held to the kick-off of the new ECD/day-care platform to the new sub-counties. Representatives from the county, sub-county (the MOH, CHS, and school health focal persons), and other nutrition implementing partners from Makadara (Bahati area), Kamukunji (California area), and Kasarani (Ruai, Njiru, Kasarani Dandora 1, and Kariobangi) attended the meeting. An action point and timeline for each sub-county were developed, with the primary goal being engaging the 50 CHVs to implement the GMP/HINI activities at 753 ECDs/daycare centers.

Sub-county support: At the sub-county level the project continued to support SCNTF, and during the period under review, Westlands and Embakasi East sub-counties carried out SCNTF. Westlands shared a briefing on the routine DQA that was recently done following the discrepancies in reporting data in the last quarter. Incomplete MOH 704 tools and lack of primary data were noted as the major challenges. Facility representatives were advised to ensure all their reporting tools were completed. Two CMEs to follow up on MOH 733B and 409 A&B were suggested and planned by the team.

At Embakasi East, improved referrals and linkages between the facility and the community were noted and attributed to the teamwork between the SCHMT and health facilities, as well as inter-departmental involvement at the facilities. The sub-county reported the significant role of mentorship for one nutritionist who supports Rueben and Soweto PHC and the valuable impact of HR support.

Some key challenges noted by the two sub-counties, which was also a challenge in the county, were an erratic supply of nutrition commodities, inadequate storage space for nutrition commodities, and unavailability of functioning anthropometric equipment**.** In meetings, the Sub-County Disease Surveillance Officers reminded the nutritionist that malnutrition is one of the diseases monitored weekly, and hence they should report weekly. The sub-county pharmacist emphasized the need for commodity management and urged everyone to take responsibility for this task.

Nutrition weeks: To improve the use of nutrition services by mothers and children among the targeted population in the community and at supported facilities, *Afya Jijini,* in collaboration with the Malezi Bora County, offered nutrition activities in May through the county nutrition department. This year's theme was "Strengthening maternal and child health services to attain universal health coverage." NCC directed activities offered at Malezi Bora targeted children under five years, pregnant and lactating mothers, and adolescents, with the objective to accelerate nutrition services such as de-worming, vitamin A/IFAS/micronutrient supplementation, growth monitoring and promotion, and active case finding at the facility and community levels.

The project convened a meeting with the county, sub-county, nutrition implementing partners, and multi-sectorial departments to plan the nutrition weeks. Some of the strategies discussed included mobilization using CHVs, use of the media and the SCNO to pass the information to local radio stations in their sub-counties, and door-to-door and church campaigns. *Afya Jijini* was tasked to provide logistics for vitamin A supplementation and de-wormers to ensure availability during the nutrition weeks at all service delivery points in the community and facilities.

The project also supported the Malezi Bora launch at Kibagare in Westlands sub-county. The launch was made visible by a roll-up banner, a street banner, and 400 t-shirts. Also, 25 CHV mobilized for the launch to ensure a high turnout. A total of 156 mothers attended and were taken through maternal and infant young child feeding practices and their children screened for GMP.

Partners Coordination Support: Afya Jijini continued to collaborate with other nutrition implementing partners in the county to ensure impact and coverage in targeted communities and avoid duplication of the work that had happened during Y4 Q3. The project collaborated with Concern Worldwide (CWW) to ensure ACF was well monitored. *Afya Jijini* supported two SCHMT members per sub-county and CWW supported three CHWs in all 10 sub-counties. In Starehe sub-county, the project supported logistics during the five days of activity and Comitato Collaborizione Medica (CCM) provided scissors to cut the vitamin A, water, and sanitizers. There was also a coordination meeting held with the Action Foundation, a local organization that provides holistic development opportunities to children and young people with disabilities in informal settlements. *Afya Jijini* explored the possibility of linking Action Foundation to the county and sub-counties' teams for joint activities and support to the disability centers in the slums.

2.5.2 Facility-based nutrition strengthening activities

Ensuring growth monitoring and nutrition assessments. The project continued to support over 25 facilities to ensure correct nutrition assessments were done and with proper documentation, as gaps in nutrition assessments were found following the last quarterly report. Technical support was provided on the use of anthropometric tools, MOH tools, and the calibrating of all anthropometric tools in those facilities. A total

of 68 HCWs from Jumuia Hospital, Huruma Lions, and Westlands and Riruta H/C took a CME on the MOH 713, 410 A and B and 734 reporting tools; the use of the BMI wheel and adult MUAC tape; and IMAM.

Capacity building: Afya Jijini collaborated with PATH to support sensitization on the dissemination of the MIYCN policy at Pumwani Maternity during BFHI training for Pumwani paternity staff. The project provided 55 copies of the policy document, and 50 HCWs were trained on the new policy contents.

Strengthening Nutrition Assessment and Counseling Services (NACS): The project provided CCC service delivery points with a bathroom scale at the Ngong Road, Kangemi, and Dandora II health centers. These improved NACS by reduced waiting time. The project also provided adult MUAC tapes to supported facilities and BMI wheels to CCC sites. As a follow-up, all CCC were provided nutrition notes for proper documentation of patient files, and inputs were initiated during Q3 of this year.

Further strengthening facility HINI provision: The project continued to support facilities to prevent stock-outs of IFAS to ensure mothers maintain access to them. The project also conducted daily nutrition education and counselling at facilities on EBF, complementary feeding, and maternal nutrition. Additionally, mothers are taught about cost-effective nutrition interventions during three community conversations that took place in Embakasi East, Dagoretti, and Westlands. The project further supported re-distribution of micronutrient powders (MNPs) from depots to 15[3] facilities to ensure continuity of supplementation for children aged between 6-23 months. CHVs were sensitized and given MNPs to give to caregivers within the community to increase coverage to a total of 4,500 children. A close follow-up was done to ensure VAS data were submitted and entered in DHIS2. This was done by the *Afya Jijini* team, SCNO, and SCHRIO since documentation of VAS as the reporting rates are sometimes low. During Y4Q3, a total of 33,004 pregnant women received IFAS at their first ANC visit as detailed in the figure below:

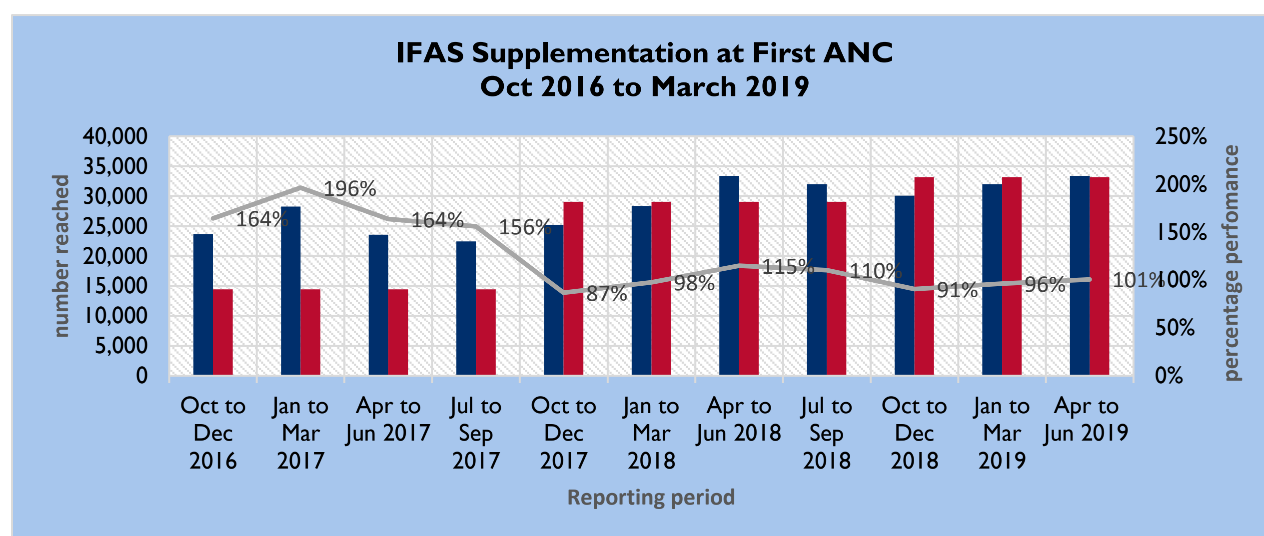

Figure 25: IFAS supplementation at first ANC (Oct 2018-March 2019)

Strengthen IMAM at priority health facilities. During the reporting period, there was an erratic supply of nutrition commodities which led to an increase in defaulter cases. Though the re-distribution approach worked to a certain extent, it did not fully cover all the needs of essential nutrition commodities required in the management of SAM and MAM cases. The project supported the logistics of redistribution of commodities from Makadara H/C to Bahati, Kaloleni, and Jerusalem; and from Huruma Lions to South B Clinic, STC Casino, Ngara and Ngaira H/C; and from Dandora 11 to Njiru and Kasarani H/C.

2.5.3 Community-based nutrition support activities

Active case finding (ACF): Quarterly ACF through MUAC screening, vitamin A supplementation, and deworming were supported. The project supported 30 CHVs, five HCWs, and two SCHMTs per sub-county to conduct this activity for five days in May. In April, Makadara and Kamukunji sub-counties were supported to conduct the activity for three days. The team visited 993 ECDs/daycare centers, 222 churches,

[3] *Makadra, Lungalunga, Jeruselem, Sweto PHC, Kaloleni, Njiru, Kasarani, Dandora I, Dandora II, Mukuru h/c, MMM, Rebuen, Mathare North and aba ndogo H/C.*

and 91,820 households, totaling 219,134 under five children reached, of which there were 49 SAM cases and 642 MAM cases. The projected made 500 copies of MUAC tally sheets and 400 copies of vitamin A and de-worming tally sheets per sub-county to be used during ACF.

Table 15: MUAC screening data

	<115mm		115-125mm		125-135mm		>135mm		EDEMA		TOTAL	
Sub-county	M	F	M	F	M	F	M	F	M	F	M	F
Westlands	4	4	50	58	1459	1426	6989	6706	0	0	8572	9384
Ruaraka	2	5	25	46	1370	1888	8156	8373	0	0	9554	10372
Dagoretti	2	3	11	11	744	799	4627	5107	0	0	5383	5896
Makadara	4	6	22	23	2365	2374	5269	6464	0	0	7659	8849
Kasarani	10	14	14	33	1931	2449	15488	15904	0	0	17146	18,106
Emb. East	4	2	56	56	374	393	9271	9608	0	0	9705	10,059
Emb.West	5	4	46	59	471	515	8660	9869	0	0	9182	10,447
Langata	0	2	59	51	1	2	15,810	17,637	0	0	16237	17637
kamukunji	4	11	26	38	597	1100	3904	4384	1	0	4513	5658
Starehe	14	35	290	352	3660	3712	13862	12239	1	1	17287	16948
TOTALS	**49**	**86**	**599**	**727**	**12972**	**14658**	**92036**	**968991**	**2**	**1**	**105778**	**113356**

Vitamin A supplementation (VAS): The project supported VAS in all10 sub-counties through deployed CHVs. 30 CHVs and seven Community Health Workers (CHWs) were supported per sub-county to carry out this activity. A total of 187,912 under five children were supplemented during the outreach. During the quarter, a total of 211,211 children received VAS, equivalent to 131% of the annual target of 312,438 children.

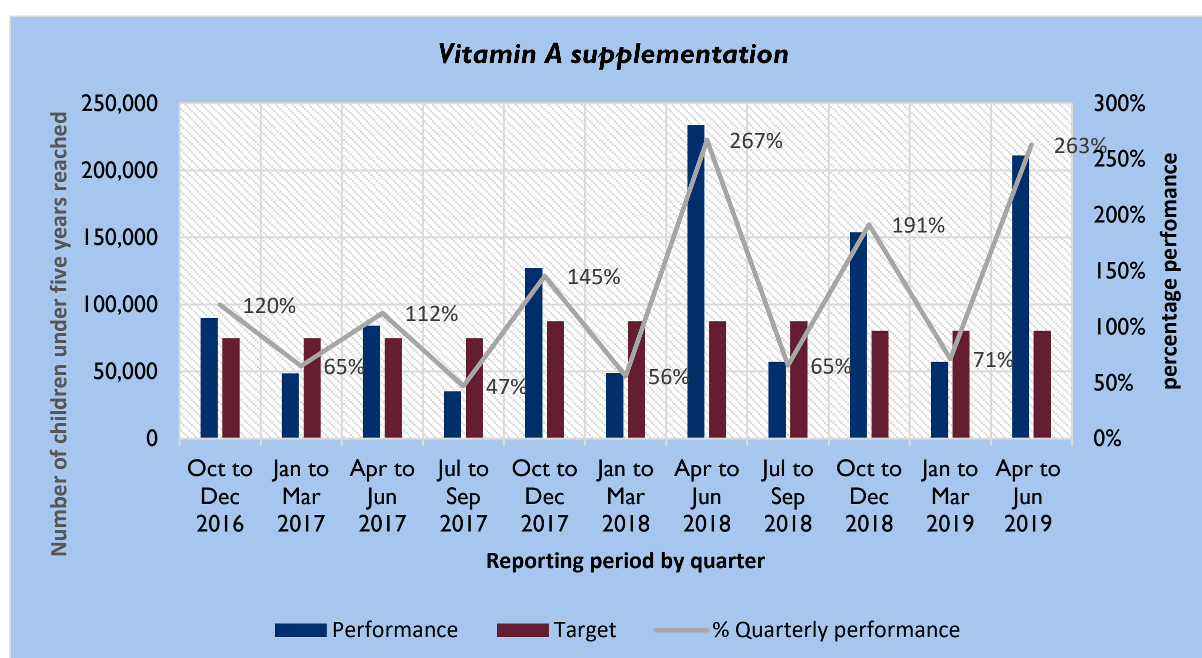

Figure 26: Vitamin A supplementation

De-worming. To ensure continuity of availability of de-worming medication in the facilities and during community activities, the project provided logistic support for the redistribution of de-wormers from the

depot to all ten sub-counties. A total of 144,205 children under five were dewormed during ACF.

Community conversation: Community conversations were supported during the reporting period in three areas: Westlands Kibagare, Mukuru, and Dagoreti sub-county. Five CHVs were supported in each sub-county to conduct mobilization. During the event, mothers were provided with milk and bread. In Mukuru, the focus was on care during pregnancy, nutrition assessments for children under 5, EBF, and complementary feeding. Based on discussions with mothers, the majority of the pregnant women were going to their first ANC visit after the first trimester, and most of the mothers had low knowledge about the significance of IFAS. It was also noted that there were a lot of myths and misconceptions surrounding breastfeeding. Mothers who had practiced EBF shared their experiences on exclusively breastfed babies compared to those not exclusively breastfed. As a result of these discussions, 103 children under 5 were assessed using MUAC screening, and weight and height measurement. One SAM and six MAM cases were identified, 24 children under 5 were given vitamin supplementation, and 12 de-wormed. A total of 153 mothers participated in the conversation. Cross-cultural engagement was done in Dagoretti sub-county, thus reaching a total of 107 mothers. In Kibagare, 210 mothers were reached.

Community-Based Nutrition – The ECD Model: After the inception meeting in April, the CHAs and community strategically identified 50 CHVs in the four sub-counties: 10 in Makadara, 10 in Kamukunji, 10 in Langata, and 20 in Kasarani. The CHVs were first given a refresher training on GMP and hygiene promotion and then provided with identification badges, introductory letters, reporting tools, and branded bags and t-shirts to use during the visits. Six data review sessions were held since May 2019. Key behavior changes that the daycare centers embraced following advice from CHVs included: warming food for children during the lunch hour, changes in diet, and improving food diversity at the daycare and ECDs centers. During the reporting period 54,917 children were screened with MUAC tape and 13 SAM and 88 MAM cases identified.

3 SUB-PURPOSE 3: STRENGTHENED AND FUNCTIONAL COUNTY HEALTH SYSTEMS

During the quarter under review, the county experienced top leadership management changes that negatively affected the implementation of project activities. Despite this challenge, *Afya Jijini* continued to collaborate with the County government and partners at all levels to strengthen the health system to improve the quality of service delivery. The project has adopted a partnership approach that enables the county to provide the required stewardship for the sector. The county was supported to lead and implement the following priority interventions: planning, budgeting, stakeholder management, performance management, effective HRH, and commodity management.

3.1 Output 3.1: Partnerships for Governance and Strategic Planning

3.1.1 Stakeholder Consultative forum

During Q3, the county was supported both technically and financially to prepare and hold a stakeholders' forum. During this forum, which attracted more than 150 partners including more than 20 implementing partners, the county was hailed for its effective stewardship of the forum after mentorship from Afya Jijini. In this meeting, the county re-emphasized the need for all partners to continue using existing engagement frameworks to foster closer collaboration amongst partners and with the government to enhance efficiency and synergy against a backdrop of declining resources. In addition, the county took the opportunity to share with all stakeholders the 2019/2020 Annual Work Plan (AWP) priorities to guide partners' in forwarding planning and support to the county. The forum further provided a platform for the partners to share their activities and identify areas for potential collaboration with other partners. The county also received TA from Afya Jijini to develop a stakeholders' report with clear recommendations on the way forward.

Annual Work Plan (AWP) 2019/2020 Development

Medium Term Expenditure Framework (MTEF): During the same period, the project assisted the county in gathering relevant financial and expenditure information to facilitate expenditure review to inform the next MTEF development of which is due to commence on 30th August 2019. The draft expenditure review report is due for finalization in the fourth quarter. During the forthcoming MTEF cycle, the program will support the MTEF TWG in preparing both the MTEF report and health financing advocacy tools for engagement with various stakeholders including the Members of County Assembly Health Committee and County Treasury

Strategic planning for County Referral facilities: During Q3, the project jump-started the development of Pumwani Maternity Hospital (PMH) planning processes by taking the hospital management team (HMT) and the Board through a visioning process as well as a detailed SWOT analysis. A situation analysis is ongoing and due to be completed in Q4. In tandem with PMH, the project also provided technical support to other referral hospitals in their quest to develop a strategic plan as part of the health systems strengthening interventions. These hospitals included Mbagathi Hospital, St Mary's Hospital, and St Francis Community Hospital, whose draft plan is due for validation.

Pumwani Maternity Hospital Team during strategic planning visioning process

3.2 Output 3.2: Human Resources for Health

3.2.1 County/Sub County-level HRH strengthening

County HRH TWG: To improve HRH management, the county was supported to convene an HRH TWG meeting during which the County Training Needs Assessment (TNA) and Work Councils were discussed. The training needs assessment report will be used by the county to inform training decisions for improved service delivery. *Afya Jijini* was represented in the health department HRH training guideline review and finalization workshop. The document is intended to establish in-service training coordination and management mechanisms. The project also supported the county to prepare and successfully host the Nairobi Metropolitan Inter-cluster HRH TWG and stakeholders' forum. During this forum, partners supporting HRH shared the status of their HRH support. From this forum, HRH issues identified for follow-up were as follows: advocacy for the community health workforce as key to accelerating the realization of universal health coverage; HRH costs by the program to inform investment considerations in County health budget; scale-up of HRH leadership and development. Counties are expected through County specific technical working groups expected to consider and plan for the implementation.

HRH transition plans: The project has continued to monitor finalization of the HRH transition plan. The process has stalled since there was no membership at the County Public Service Board. In the review period, a new board was established and is awaiting vetting and Gazettement after which negotiations will resume at the beginning of Year five.

3.2.2 Health facility level HRH strengthening

Leadership Development Program Plus: To strengthen leadership capacity at the facility level, the county was supported to implement the Leadership Development Program Plus (LDP+). During the quarter, an LDP+ results dissemination workshop was held, and the cohort of trainees graduated following site-level six month-long post-training coaching and mentoring. The participating teams were drawn from three-level 4 hospitals and seven health centers. Presentations from the teams demonstrated that post-training follow up coaching and mentoring fixes training content with participants and improves the quality of service delivery.

Table 16: Teams achievements about their selected measurable result

Facility	Target for Post-LDP Project	Results
Mathare North Health Centre	Increase percentage of ANC clients delivering at the facility from 26% to 35%	36%
Waithaka Health Centre	Reduce immunization dropout rate for Measles from 50% to 10%	9%
Bahati Health Centre	Increase monthly average deliveries from 43 to 76	69
Westlands Health Centre	Increase monthly average deliveries from 58 to 73	54
Mbagathi Hospital	Reduce the percentage of neonatal sepsis in babies admitted to NBU from 8.4% to 6%	7.3%
Mukuru Health Centre	Increase monthly average deliveries from 62 to 70	54
Pumwani Maternity	Reduce the Percentage of SBAs from 1% to 0.5%	0.6%
Ngara Health Centre	Increase monthly average deliveries from 40 to 69	53
Mama Lucy Kibaki Hospital	Increase the percentage of PNC at two weeks from 16% to 30%	29%
Dandora II Health	**Increase monthly average deliveries from 31 to 50**	**48**

HIV provider optimization for performance and productivity: To accelerate HIV/AIDS epidemic control interventions in select surge sites, the project reorganized project hired HIV providers to include task re-allocation/task shifting, dedicating staff for eligibility screening, JD revision and development of a weekly check-in/performance management tool). In addition, the project customized tools to conduct annual HRH optimization performance and productivity in select 'surge' sites.

Table 17: Tabulation on sites focused for the study

Facility	Type of Assessment				
	Rapid site-level health workforce assessment	Employee engagement	Health worker productivity	Provider skills and competency assessment	Client flow
Cluster 1					
Mama Lucy Kibaki Hospital	✓	✓	✓	✓	✓
Mbagathi Hospital	✓	✓	✓	✓	✓
St. Francis Mission Hospital	✓	✓	✓	✓	✓
St. Mary's Mission Hospital	✓	✓	✓	✓	✓
Makadara Health Centre	✓	✓	✓	✓	
Lunga Lunga Health Centre	✓	✓	✓	✓	
Jericho Health Centre	✓	✓	✓	✓	
Cluster 2					
Kayole II Health Centre	✓	✓	✓	✓	
Kariobangi Health Centre	✓	✓	✓	✓	
Mukuru MMM	✓	✓	✓	✓	
Mukuru Health Centre	✓	✓	✓	✓	
Kahawa West Health Centre	✓	✓	✓	✓	
Mathare North Health Centre	✓	✓	✓	✓	
Cluster 3					
Westlands Health Centre	✓	✓	✓	✓	
Ngong Road Health Centre	✓	✓	✓	✓	
Ngaira Health Centre	✓	✓	✓	✓	

3.3 Output 3.3: Health Products and Technologies (HPT)

3.3.1 County and Sub-county level HPT strengthening

Targeted Support Supervision: In Y4 Q3, the program continued to support sub-county pharmacists to carry out supportive supervision in facilities within their jurisdiction. Two sub-counties (Makadara, Embakasi East) were supported and eight hospitals were visited[4]. They included; Coptic hospital, Jamaa hospital, Makadara Mercy Sisters dispensary, Metropolitan hospital, Mukuru Health Centre (HC), Mukuru Reuben HC, Mukuru MMM HC and Soweto Kayole HC.

Sub County Commodity Technical Working Groups (TWG). Embakasi East Sub County was supported to hold their TWG meeting during the quarter. The agenda of the meeting was; review of the TWG TORs, TWG work plan 2019-2020 and formulation of tracer commodity list. They adopted the TWG TORs and the work plan. They tasked the sub county pharmacist to continue working on the tracer list

Sub County Commodity Technical Working Groups (TWG): Embakasi East Sub County was supported to hold their Commodity TWG meeting during the quarter during which the TWG's TOR was adopted, and 2019-2020 work-plan developed.

Quantification and allocation of RTKs: In Q3, Afya Jijini continued to support quarterly quantification and allocation of laboratory commodities including: Rapid HIV Test Kits (RTKs), GeneXpert commodities, CD4 and viral load commodities. The coordination is done through the office of the County Medical Laboratory Coordinator (CMLC). This involved monthly tracing of commodities and preparation of quarterly requisitions to NASCOP and the National TB program for supply of HIV and TB commodities respectively.

3.3.2 Strengthening facility-level commodity management (inventory management and commodity security)

Support Supervision: In Y4 Q3, 11 facilities[5] were visited by our supply chain specialist for supportive supervision and mentorship. During the visit, the facilities were assessed for their level of inventory accuracy, and the results showed a score between 0 and 83%. Six facilities scored zero while the rest scored 50% (3), 67 % (1), and 83 % (1). This analysis showed that general inventory management in most visited facilities is poor, and more investment is still required.

Installation of storage shelves and cabinets. The storage capacity assessment initiated in Y4 Q1 was concluded in Y4 Q2. Based on this assessment report, in Y4 Q3, 66 storage shelves and 11 cabinets were purchased and placed in seventeen facilities.

Redistribution of commodities: The program supported the redistribution of HIV and TB commodities to mitigate interruption of HIV and TB service delivery. The commodities redistributed include HIV Test Kits, HIV Self-Test Kits, and TB and GeneXpert commodities.

Inventory Management: Afya Jijini provided technical support to facilities on proper commodity management practices. Mentorship on commodity management was provided to the medical laboratory technologists and other healthcare workers on documentation and commodity management cycle (e.g., receiving, storage, issuing, and preparation of consumption reports). This has resulted in sustained improvements in commodity reporting.

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[4] Coptic hospital, Jamaa hospital, Makadara Mercy Sisters dispensary, Metropolitan hospital, Mukuru Health Centre (HC), Mukuru Reuben HC, Mukuru MMM HC and Soweto Kayole HC

[5] Mama Lucy Kibaki hospital, Ngaira health centre, St. Mary hospital, Mbagathi hospital, Ngong road HC, Kangemi HC, STC Casino HC and Kayole 2 HC.

3.3.3 Strengthening facility-level commodity management (information systems)

Printing and distribution of commodity management tools. During the quarter, to improve commodity documentation, 20 ART Daily Activity Registers (DARs) were delivered to Makadara Sub County and ten booklets each of the Facility Consumption Data Report and Request (F-CDRR) and Facility Monthly ARVs Patient Summary (F-MAPS) were delivered to Ruaraka Sub County.

Monthly commodity security reports. In Q3, the project continued to disseminate commodity security reports at the end of each month. The reports highlighted the stock status of the various ART and Family Planning commodities. Staff at the facility level knew the months of stock available in the pipeline and thus were able to make informed decisions during the prescribing and dispensing processes.

ART and Family Planning commodities monthly reporting rates. The reporting rate of ARVs had improved remarkably since September 2018, when all sites were trained on DHIS2 reporting. Support for sub-county pharmacists with airtime every month has also been associated with this improvement. The sub-county pharmacists have also taken over-reporting of family planning commodities leading to the good reporting rates.

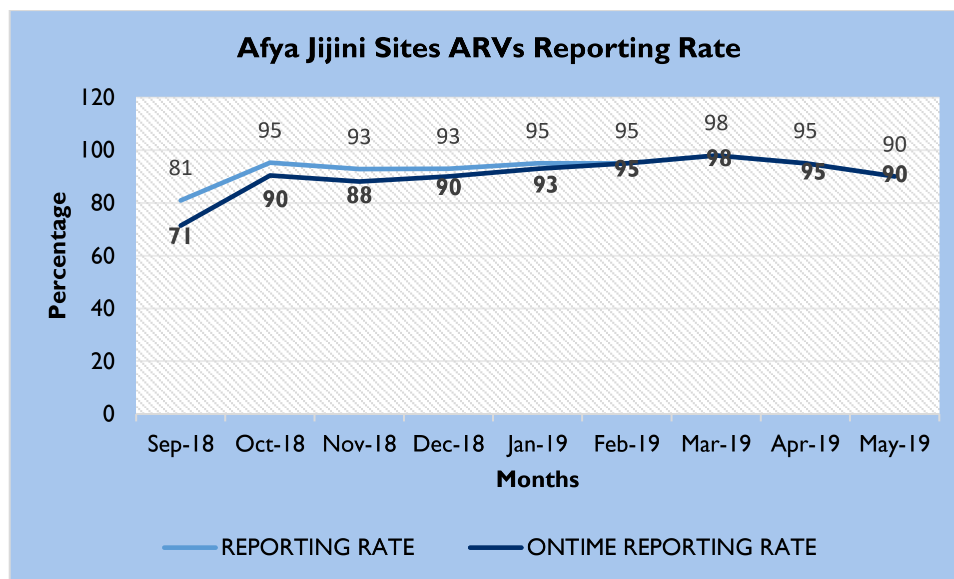

Figure 27: ARVs reporting rates for program sites

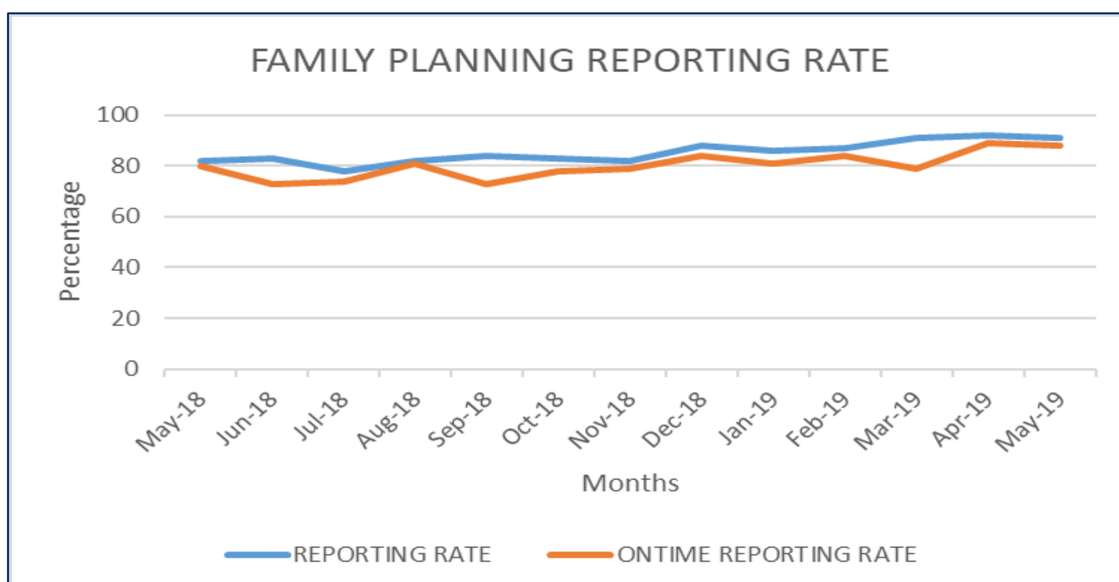

Figure 28: Family Planning Reporting Rate

Collaboration with related USAID and donor-supported HPT projects. Worked jointly with the National TB Program (NTP) and the Center for Health Solutions (CHS) to develop TB Sample Referral System. In partnership with the National HIV Reference Laboratory (NHRL), the program continued to support HIV DREAMS recent study, which is supported by the University of California San Francisco (UCSF).

3.3.4 Strengthening facility-level commodity management (patient safety)

Continuous Medical Education (CME). The program supported the Embakasi East Sub-county Pharmacist to carry out pharmacovigilance CMEs in two hospitals (Mukuru Health Centre, Mukuru Reuben Dispensary) during the quarter. Thirty-three staff from these two hospitals benefited from the CME that covered the importance of pharmacovigilance, the role of HCWs, and reporting procedures. This is expected to translate into improved service delivery at the facility level.

Environment Monitoring and Mitigation Plan (EMMP). During the reporting period, the program supported adherence to laboratory biosafety and biosecurity, and infection prevention control (IPC) standards as prescribed in national and international standards. During the quarter, 48 medical laboratory technologists were offered Biosafety/biosecurity refresher training. Certification of biosafety cabinets and safety hoods was done to ensure the safety of the users (healthcare workers) and the environment.

3.3.5 Strengthening facility-level commodity management (QA)

Pharmaceutical Care Plan, CME. A CME event was carried out at Mama Lucy Kibaki Hospital to improve the quality of pharmaceutical services at the hospital, particularly for patients in chronic care, such as patients on ART. A Clinical Pharmacist at the hospital sensitized all the pharmacy staff and members of the medicines and therapeutics committee on the implementation of a pharmaceutical care plan.

Coordination of laboratory services. The project supported the County Medical Engineers TB equipment's assessment report dissemination meeting. The meeting was attended by the County Health Services Director, County and Sub-county Laboratory, TB, and Medical Engineering Coordinators, and implementing partners. The TB equipment assessment report was presented which pointed out that there was a need for a well-coordinated mechanism for repair and maintenance of laboratory equipment by the users (Laboratory), facility in-charge (for financing), and medical engineers. The County Health Director clarified that the laboratory should be apportioned budget for equipment repair from the facility budget.

Laboratory Support Supervision and mentorship. In the quarter under review, the program supported the SCMLCs to do support supervision using SIMS supervision tool.

Laboratory sample networking. *Afya Jijini* supported sample networking from the supported care and treatment facilities to the referral laboratories. This included strengthening the sample referral system and results in information management. *Afya Jijini* participated in quarterly review meetings with KEMRI and the National HIV Reference Laboratory referral laboratories to review performance on a sample referral system. This resulted in objective feedback to the testing laboratory, implementing partners, and facilities.

Sample rejection rate. During the reporting period, the VL sample rejection rate was sustained within the acceptable limits of less than 2%. The reduced rejection rate was due to continuous mentorship and corrective action at the facility level.

Result Turn-around-time (TAT) for viral load and early infant diagnosis (EID). Viral load (VL), TAT over the last six months, was within the expected ten days. There was increased EID TAT in May and June due to delayed testing at KEMRI referral laboratory during the holidays.

Scale-up of GeneXpert Utilization. *Afya Jijini* supports scale-up and utilization of TB GeneXpert testing in six facilities. In this quarter, the project did a CME on Genexpert for TB diagnosis at Gertrude's Children Hospital. The aim was to sensitize the Laboratory and CCC health care workers to scale up utilization of Genexpert for TB diagnosis.

3.3.6 Collaboration with related USAID and donor-supported HPT projects

Worked jointly with the National TB Program (NTP) and Center for Health Solutions (CHS) to develop TB Sample Referral System. In partnership with the National HIV Reference Laboratory (NHRL) the program continued to support HIV DREAMS recency study which is supported by the University of California San Francisco (UCSF).

3.3.7 Environment Monitoring and Mitigation Plan (EMMP)

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3.3.8 Laboratory strengthening activities

Coordination of laboratory services: Afya Jijini supported county Medical engineers TB equipment's assessment report dissemination meeting attended by County health services director, County and sub county Laboratory, TB, and Medical engineering coordinators and implementing partners to disseminate TB equipment assessment report. The research established that there was need for well-coordinated mechanism for repair and maintenance of laboratory equipment by the users (Laboratory), facility in-charge (for financing) and medical engineers. In addition, it is critical to allocate budgetary funds for TB equipment repair at facility level.

Laboratory Support Supervision and mentorship: In the quarter under review, the program supported the SCMLCs to do support supervision using SIMS supervision tool.

Laboratory sample networking: *Afya Jijini* supported sample networking from the supported care and treatment facilities to the referral laboratories. This included strengthening the sample referral system and results in information management. *Afya Jijini* participated in quarterly review meetings with KEMRI and the National HIV Reference laboratory referral laboratories to review performance on a sample referral system. This resulted in objective feedback to the testing laboratory, implementing partners, and facilities.

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Scale up of GeneXpert Utilization: *Afya Jijini* supports scale up and utilization of TB GeneXpert testing in six facilities. In this quarter, the projected did a CME on Genexpert for TB diagnosis at Gertrude's Children Hospital, the aim was to sensitize the Laboratory and CCC health care workers to scale up utilization of Genexpert for TB diagnosis.

3.4 Output 3.4: Strategic Monitoring and Evaluation Systems

3.4.1 Build County capacity to monitor and evaluate priority health service delivery areas effectively

Collaborate with relevant stakeholders to review progress. Health Delivery Areas (SCHRIOS, M&E TWG):

During the reporting period, the project partnered with other PEPFAR funded projects in service delivery in scale-up of new strategies which included mHealth – roll out of ushauri and mLab in partnership with USAID's Kenya Health Management Information System (KeHMIS) program; University of California, San Francisco (UCSF): Supported DREAMs data management and USAID's Health IT program in Management of Family Health reports. The aim of this collaboration is to of improving the quality of reports through National HIS systems and information informed clinical management of patients.

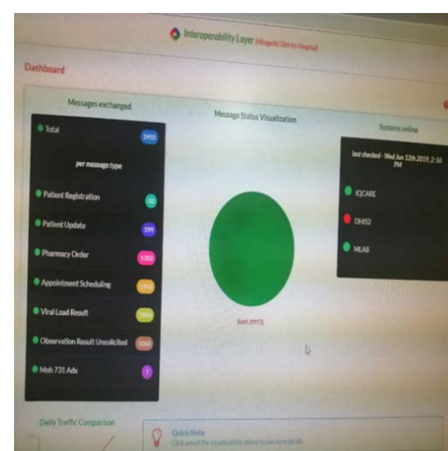
Support quarterly Sub-County data quality assurance (DQA) and RDQA at health facilities:

During the reporting quarter, the project supported a county DQA process in review of Family Health indicators, HIV care and treatment and Public health where facilities compared reports at different levels of aggregation (MOH registers, Facility Summary Forms DHIS2) in all ten sub-counties. The exercise was aimed at informing areas that require more emphasis and inform the variance on the quality of reports in the system. Some areas that were highlighted that requires strengthening will include; data discrepancies, incomplete documentation and lack of controls checks before submission of data to the next level.

Train CHMT, SCHMT Members and HCW from High volume facilities on use of national HIS platforms:

Afya Jijini worked with the county, sub-county and mHealth teams to conduct OJT to service providers in Mbagathi, Westlands HC, MLKH, Lunga Lunga HC, Makadara HC and STC on mLab and Ushauri respectively with the aim of reducing the Turn-around time (TAT) for laboratory results from the National HIV Reference laboratory to the facility, and to effectively monitor drug adherence and appointments keeping. Topics covered included; tracking laboratory results, appointment scheduling, defaulter tracing, seeking patient consent to receive SMS reminders and informative health messages. This has worked in Mbagathi Hospital and Westlands Health Center with over 2000 and 1000 VL updated by the end of Q3 respectively.

AJP staffing during OJT



Screenshot of IL dashboard at Mbagathi Hospital.

Support sub-counties and high-volume facilities with airtime for uploading data to DHIS2

Afya Jijini continued to support monthly data upload to DHIS2 in 10 sub-counties within Nairobi County. This has been achieved by providing 11 temporary data clerks who work four days every month to ensure complete and accurate reporting. This has greatly improved the availability of reports on time and reduced the delayed submission of reports in DHIS2. Similar support was extended to Pumwani Maternity Hospital with facility receiving bundles due to their erratic connectivity on site. A case example of improved reporting rates is demonstrated by Community CHEW summary below where all Community units are reporting 100% as below.

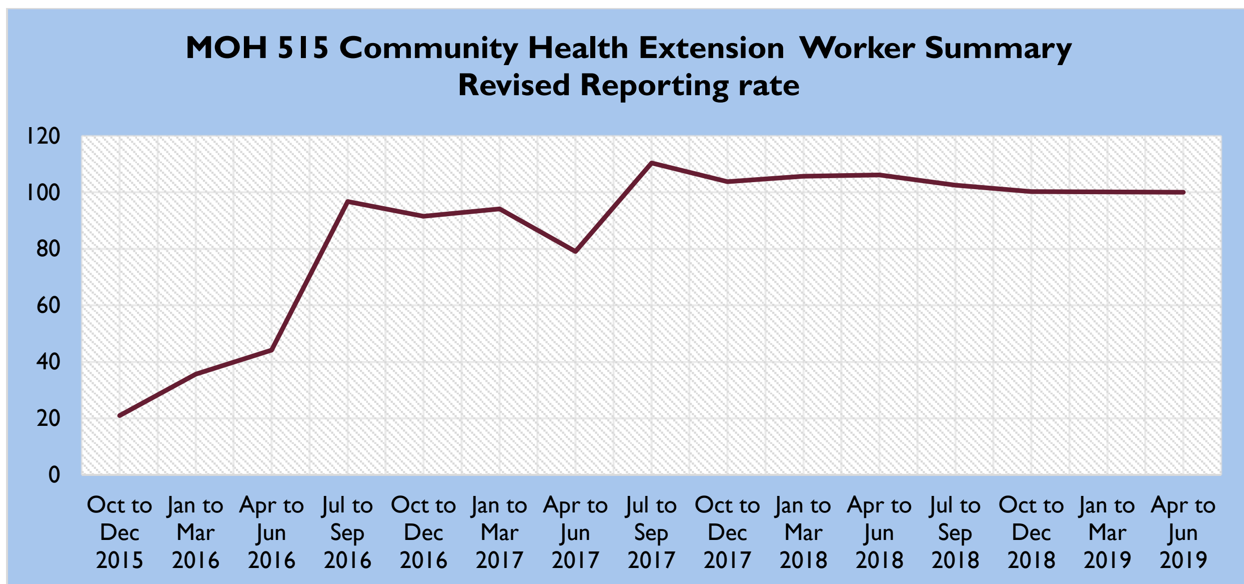


Figure 29: Reporting rate

Carry out supportive supervision and Data review forums to sub-counties and facilities on service delivery data: The project also supported the same sub-counties to conduct data review meetings to address reporting gaps and share best practices across the various program areas. The team continues to support the 23 surge sites to collect and submit surge data using an ODK tool daily as a way of monitoring and tracking facility performance. To achieve this, the program has institutionalized the following with the support of facility in charges at the site level; Result based work plan that is reviewed every week; facility-level QI charts displayed on process indicators for monitoring progress, facility and individual level target setting. This has drastically increased the demand for data for decision making.

During the quarter, the project conducted a TB/HIV data review meeting for Kasarani sub-county health management team. The key areas were on optimization of DHIS 2 reporting system to improve reporting rates and commodity management by adopting Push Method in supply, capacity building, continuous support supervision, and reinforce quarterly data assessments.

Afya Jijini Collaborative Fora: The project supports TB stakeholders meeting for Ruaraka Sub County for SCTLCs and TB focal point persons. The gaps identified were meant to strengthen IPT uptake among children under five years, utilization of presumptive registers at the CCC and PMTCT, active case finding roll out to other departments, TB defaulter tracing and documentation, increase TB uptake at the CWC by line listing children through contact tracing and IPT initiation.

3.4.2 Improve facility-level data collection and use

Strategic EMR scale-up to 29 program-supported C&T sites to full EMR functionality: During the quarter, the project supported the rollout and installation of the PMTCT Module of IQcare to an additional 5 sites (St. Marys Mission hospital, Westlands Health center, Kangemi Health center, Lunga Lunga Health Center and Mathare North Health center) with service providers oriented on how to use and navigate through the module while attending to patients. The project further supported the roll-out of E-HTS (Afya Mobile) to 7 sites (Mama Lucy Kibaki, Mukuru Health Center, Westlands Health center, Mbagathi health center, Amurt Hospital, Melchizedek hospital and Lunga Lunga health center.) to facilitate paperless capture of HIV Testing Services (HTS) data, linkage and partner notification services.

In collaboration with m-Health, the project was able to install the interoperability layer that enables receipt of results from the national HIV reference lab and update patient's records in EMR as well as send text for adherence (T4As) SMS reminders for appointments to improve adherence and reduce cases of default. Currently, this is an ongoing exercise, and patients have to provide consent to have messages sent to their phones for the next appointments. This will be done through the M-Lab and Ushauri platform, respectively.

The project also continued to support upload of EMR Data into the national data warehouse with 24 sites able to upload a total of 23,650 records. Of this 69 % were considered complete (the existence of the data elements in the active on art client record set) with an accuracy (measure of whether the data elements conform to specified ranges & domain of predefined values) level of 87% as shown in the images below.

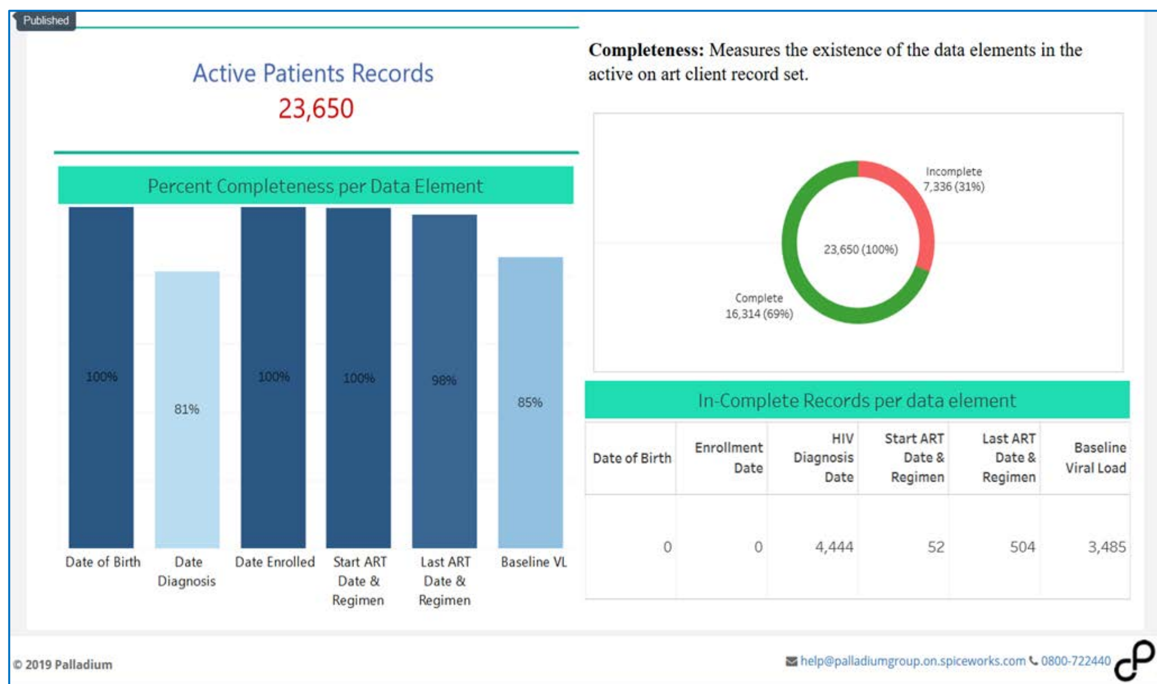


Figure 30: Completeness score of Afya Jijini records in the national data warehouse

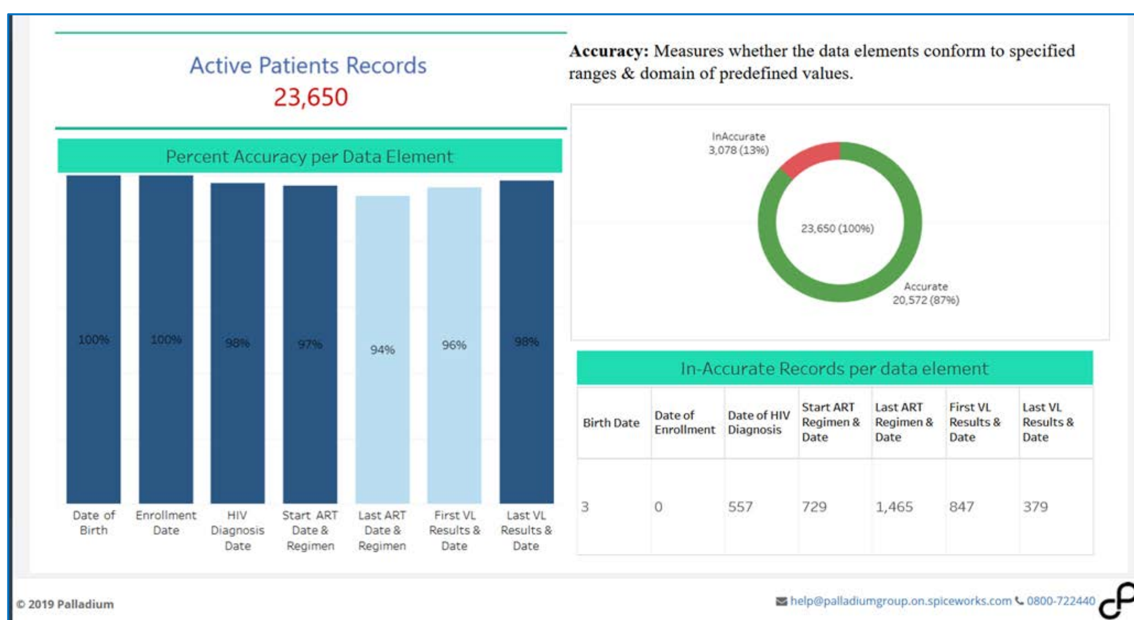


Figure 31: Accuracy score of Afya Jijini records in the national data warehouse

The project also supported Mbagathi Hospital to connect the PMTCT department with the main CCC for ease of service delivery between the two service delivery points. Other areas of improvement that were strengthened during this reporting quarter focused on Family Health program level data collection tool; sensitization of M&E assistants based at facility on use of MPDSR ODK tool and data verification processes in DHIS2. Process indicators to be monitored included; new born care, chlorhexidine availability and Kangaroo Mother Care (KMC).

Develop and implement a service performance dashboard to inform/facilitate decision-making
The M&E department also provided support to sites to be able to monitor and review daily and weekly performance during the SURGE period. This was done by developing customized data collection tools (on excel and ODK platforms), populating and updating surge dashboards to display weekly performance against targets. Further, the project continued to support updating of the existing facility dashboards in order to improve use of data for decision making for service delivery. Some of indicators monitored include: identification of positives through eligibility screening, retention, attrition, TLE and TLD optimization and aPNS cascade.

The project supported WITs at the CCC to design a quality improvement project on "Optimization" of all clients eligible for optimization are regularly reviewed. This was enforced from the NASCOP's circular on the stability of optimized clients to reduce the number of daily appointments to decongest the clinics.
Further, the project assisted clinicians and HTS councilors in eliciting contacts for PNS through regular data reviews using data generated from the line lists; targeting new positive clients, defaulters brought back to care, STI clients and those in viremia clinics.

Capacity building of HCWs to strengthen M&E technical areas: During the quarter, the team continued to offer technical support at for both surge and non-surge sites to enhance proper documentation, especially on eligibility screening and aPNS. The team also provided mentorship on documentation in ANC, maternity and PNC registers; especially on HTS to minimize missed opportunities throughout the cascade of care. To strengthen retention, the team developed a questionnaire to be administered to clients brought back to care. This was done after characterization of the LTFU and defaulter on follow up to assist in understanding who is most likely to fall out of treatment and put in measures to avert the losses.

Support routine M&E activities: As part of routine M&E support to facilities, the M&E team supported sites in setting up eligibility screening desks and tally sheets to help in daily data collection of patients screened, as well as reporting of daily reporting for selected surge indicators. Data collection and reporting tools were also printed and distributed; they included eligibility screening registers and tally sheets for outpatient departments, line listing registers, appointment diaries, and defaulter registers. The team also provided mentorship and technical support on the proper use of these tools.

3.4.3 Strengthen and integrate community-based health information systems (CBHIS)

Community RDQA: During the quarter the project supported QRDA processes in two sub-counties Embakasi East and West. Where 38 and 18 Community units respectively, were assessed. The findings unearthed the following; Report in DHIS2 were matching, and the MOH 515 CHEW Summary; Community with WIT meetings were functional, and this has improved data capture and reporting. Action points taken an to be implemented in the next quarter includes; frequent support supervision to ensure that continuous mentorship; Need to update the villages and Community units in CBHIS to obtain the correct denominators; the need for the county to allocate budget for community tools to overcome erratic supply of registers.

Support distribution of community reporting tools to 10 sub-counties: The program provided MOH registers by photocopying and distributing through the CHAs and CSSFPs offices MOH 513, 514, and 515. One hundred referral tool photocopies were also supplied to the following sub-counties: Westlands, Dagoretti, Embakasi West, Kasarani, Makadara, Kamukunji, and Kasarani. In total, more than 17,500 assorted photocopies have been distributed to various CUs in the respective sub-counties. The project has procured new revised CBHIS registers and reporting tools which has been finalized.

Sustainability plan-Journey to Self-Reliance

In Y5, *Afya Jijini* will work with the CHMT to advocate for allocation of resources and finances dedicated to M&E and ICT activities. The program will continually build the capacity of SCHMTs and facility health management teams and HCWs in DDIUs, data analysis, and reporting. To promote evidence-informed decisions, *Afya Jijini* will work with the County and Sub-counties to institutionalize data use through data sharing forums, data reviews at all levels, best practice sharing, conference presentation, and exchange learning visits. For example, although NCC has not consistently held quarterly M&E TWG forums to discuss key emerging issues that are affecting the county over the past few years, in Y4 the County institutionalized an EMR coordination desk, prioritized HMT freshers TOT training on EMR, with the goal of cascading these skills to the facility level and integrate EMR supportive supervision tool.

3.5 Output 3.5: Quality Assurance/ Quality Improvement systems

3.5.1 Support to county level QI teams

County QA/QI TWG: During the reporting period, the county was supported to hold a QA/QI TWG meeting. During this meeting, sub-counties and stakeholders deliberated on the progress of implementation of the county 2018/2019 QA/QI work plan. The stakeholders also shared their QA/QI activities for the previous quarter and plans for the next quarter. Notable achievements included self-assessments and posting of results onto DHIS2 by all the 147 facilities previously trained on KQMH.

Health Service Delivery Awards (HSDA): In Y3, Nairobi County designed and implemented an award and recognition mechanism for health facilities, based on the quality of health services, in Nairobi County with support from *Afya Jijini* and other partners. The project further facilitated the county to assess facilities using Kenya Quality Model for Health (KQMH) checklists to rank facilities and determine the best-performing facilities at each level. This innovation has been identified as a key motivator to facilities to improve quality of care. The County will hold the second annual HSDA ceremony on 8th August 2019 with the support of *Afya Jijini* and other implementing partners.

3.5.2 Strengthen facility-level QI coordination and processes

Capacity building: In collaboration with the Sub County QI Focal Persons (SCQIFPS), the project continued to build the capacity of HCWs in QI implementation through training, facility-based QI CMEs, coaching, and mentorship. The technical support provided during the quarter focused on building the capacity of HCWs to implement health priority interventions. The team also strengthened performance measurement in 23 'surge' facilities through weekly performance review, root cause analysis, and identification of effective change ideas to improve performance.

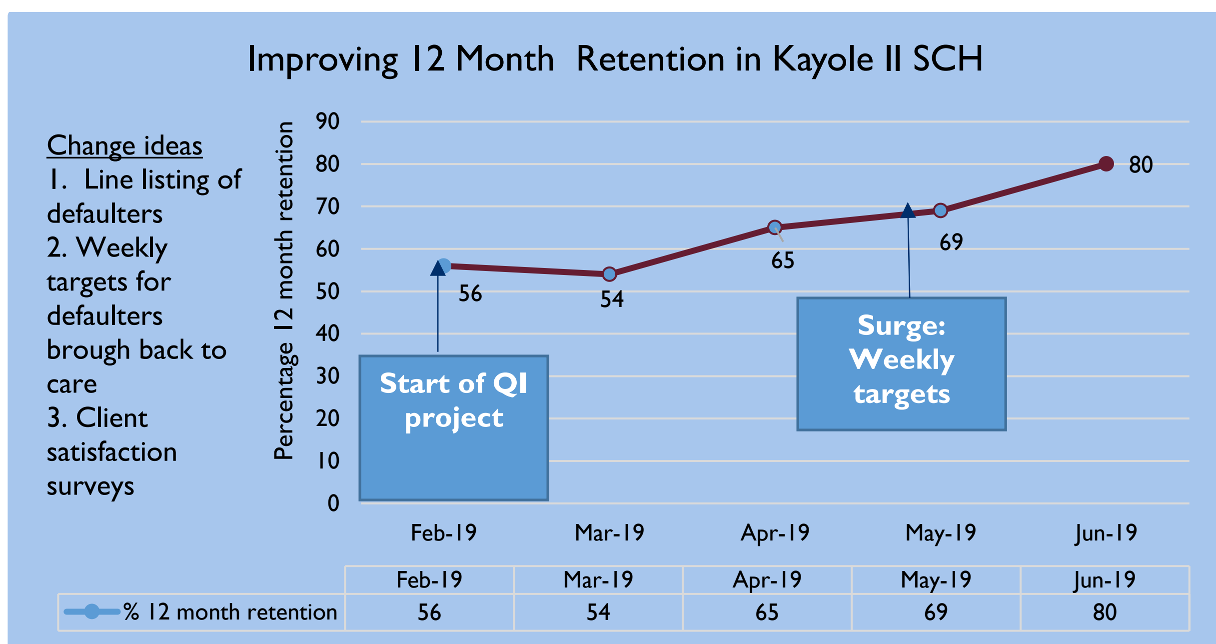
During the quarter, the project also provided technical and logistical support to sensitize 74 HTS counselors on QA/QI and the use of QI principles to review their performance, identify gaps and implement QI projects. In addition, the project conducted one facility-based QI CME in Kariobangi North Health Centre where 23 HCWs were reached. The CME focused on building a positive attitude for service delivery and improving client satisfaction, which is expected to improve retention of clients in the CCC and overall patient satisfaction.

QI coaching and mentorship: Working in close collaboration with the SQIFPS and SCASCOS, the project technical team continued to provide coaching and mentorship to 52 HIV and 61 MNCH WITs. This support was critical to the implementation of the surge strategy started in May 2019. The teams were able to improve surge indicators along the 95 95 95 cascades as illustrated in the facility QI success story below.

Facility QI success story: Kayole II surge QI success story

In February 2019, the CCC WIT in Kayole II Health Centre identified a gap in retention, 56%, of clients in care during a routine review of HIV quality indicators. The team set a goal to improve the retention of clients from 56% in February to 95% by September 2019. The team then conducted a root cause analysis to identify the causes of poor retention of clients in care. The team identified poor documentation of follow up of defaulters as the main root cause of poor retention. To address this, the team developed a line list of all defaulters and set weekly targets for the peer educators to be traced back to care and document all outcomes on the list. The team also began conducting regular client satisfaction surveys to provide additional information on user experience and areas of improvement. Furthermore, the team reviewed the progress of tracing defaulters back to care and documentation of outcomes weekly. Through these efforts, the team was able to improve retention from 56% in February to 80% in June 2019.

Figure 32: Improving retention at Kayole II health center



	Feb-19	Mar-19	Apr-19	May-19	Jun-19
% 12 month retention	56	54	65	69	80

3.5.3 Strengthen sub-county level QI coordination and processes

Coordination of facility QI coaches: The project has been supporting the development of sub-county-specific QI annual work plans. The main activity in these plans is bi-annual sharing of QI best practices by peers. During the quarter, *Afya Jijini* provided technical and logistical support for sub-county QI best practice sharing meetings in five sub-counties: Embakasi West, Embakasi East, Dagoretti, Westlands and Langata. The SCHMT also identified the best three facilities in each sub-county for award and recognition at the sub-county level, which motivates the teams to continue in their improvement efforts.

3.5.4 Strengthen community-level QI processes

In Y4 Q3, the DREAMS program continued to implement QI at the community level in 18 safe spaces, with all safe spaces having identified gaps for improvement through QI. During the quarter, coaching and mentorship meetings were conducted with the DREAMS technical team and field assistants from all safe spaces in Kangemi. In Y4 Q1, the team identified uptake of PrEP among DREAM girls, which was at 11% at the end of Q1, as the main quality indicator to be monitored in all safe spaces. Implementation of this QI project has continued throughout Q2 and Q3. The teams were guided to conduct a root cause analysis to identify barriers to PrEP uptake among AGYWs and developed a change package to address the root causes. Each safe space was also issued with a QI performance monitoring chart to monitor the progress of PrEP uptake against set targets. As a result, PrEP uptake has improved from 11% in Q1, 29% in Q2 to 87% by the end of the quarter.

4 CONSTRAINTS, LESSONS LEARNED AND OPPORTUNITIES

Challenges

High expectations: the program works with the county government and other industry stakeholders in implementing all components. In some cases, there are high expectations of providing financial support in terms of facilitation fees, and if not met, may hinder the execution process.

Lessons Learnt

Surge Implementation: The initial focus of surge for the technical team has been on identification of HIV+ clients and linkage to ART, with emphasis on client retention in care and viral suppression. Moving forward, we have learnt the need to focus more on implementing an "integrated surge" that includes the other components of care.

Data Quality Assessment: during this period of surge implementation, data is collected and entered into the surge dashboard daily. At facility level, data is entered into the registers by the facility staff. It is cleaned and abstracted by the M&E assistants who submit reports per facility to the Afya Jijini's technical program representative. This approach enhances data accuracy and timeliness.

Capacity building of health workers is critical in achieving the set targets and objectives at facility level. Afya Jijini, through the LDP+ program, trained and mentored Nairobi City County Health Workers that targeted key facility leaders. All trainings are followed-up by site-based coaching/mentorship to reinforce skills. It emerged that the LDP+ approach is very effective in enabling hospital teams to achieve measurable results within a limited timeframe, addressing priority challenges identified by the hospital staff and mobilizing human and material resources to implement evidence-based action plans.

Partnership for success: The successful implementation of the program depends on close collaboration with the sub-county and county leaders in the health department, *Afya Jijini's* implementing partners, national governments, and other development partners. These players all have competing priorities and therefore require a time-consuming consultative approach to achieve synergies and ensure stakeholder buy-in. This represents both an opportunity and a constraint, but overall, the success of *Afya Jijini* to date owes a lot to the high-level partnerships developed with partners.

Focus Group Discussions (FGDs) are effective feedback mechanism in program implementation: During the quarter, the program held three focus group discussions with DREAMS AGYWs, TB and MNCH as a way of establishing effective and meaningful engagement with the various target audiences. Afya Jijini established that such forums are very effective in getting face to face feedback, as participants feel valued and it promotes ownership of the issues facing them in communities. In the subsequent quarter, we will carry more of these forums as effective platforms of disseminating program outcomes.

5 PERFORMANCE MONITORING

Afya Jijini's M&E and the technical team heightened surveillance and tracking of HIV positive patients in 23 care and treatment sites with the effort of monitoring the epidemic in Nairobi County. The strategy was cascaded to sub-grantees, county/Sub HMT, health facility and community staff in the effort of identifying new positives and start them on treatment.

Besides, quarterly supportive supervisions, data quality checks, and mentorship conducted in the quarter with the following key areas of focus in the last quarter:

- Weekly monitoring and Tracking of HIV care and treatment cascade for selected indicators.
- IHRIS cleaning & data verifications
- M&E review meetings with sub-grantees to review progress
- Deliverable guidance, support, review, and approval

5.1 Outcomes of activities

- Improved demand for data use at facility.
- Improved data quality & timely reporting by partners.
- Facility level work planning and monitoring of results.
- Strengthen leadership capacity at the facility level, through implementation of LDP Plus programs.
- Improved partner collaboration and coordination.

5.2 Outlook for next quarter

- Routine verification of M&E data from partners.
- Implementation of EMR (PMTCT, Afya Mobile, in care and treatment sites.

6 PROGRESS ON GENDER STRATEGY

In this reporting period, Afya Jijini's activities focused on gender inclusion, eliminating new HIV infections and preventable deaths among the most vulnerable (mothers, children, and adolescent girls and young women (AGYW) aged 10-24, and socially excluded populations) in Nairobi City County.

In this implementation period, a design challenge with the Young African Leaders Initiative (YALI), Civic Leadership Cohort for 2019 engaged stakeholders to come up with proposed solutions targeting AGYW for Afya Jijini which have been integrated into our routine activities.

The program accelerated initiatives targeting adolescent clients on AYSRH in response to feedback collected during FGDs with AGYWs across four sub-counties. The FGDs indicated a need for mental health screening, addressed using the Edinburg Post Natal Depression scale and WHO Depression Anxiety Scale. Both the FGDs and the mental screenings instigated follow up on ART retention through viral load tracking and networking.

In Q2, USAID facilitated a Training on Strategies for Trauma Awareness and Resilience which has emphasized the role of GBV in debriefing HCWs who perform Violence against Children screening and case management.

PEPFAR Strategic Areas that Afya Jijini is advancing:

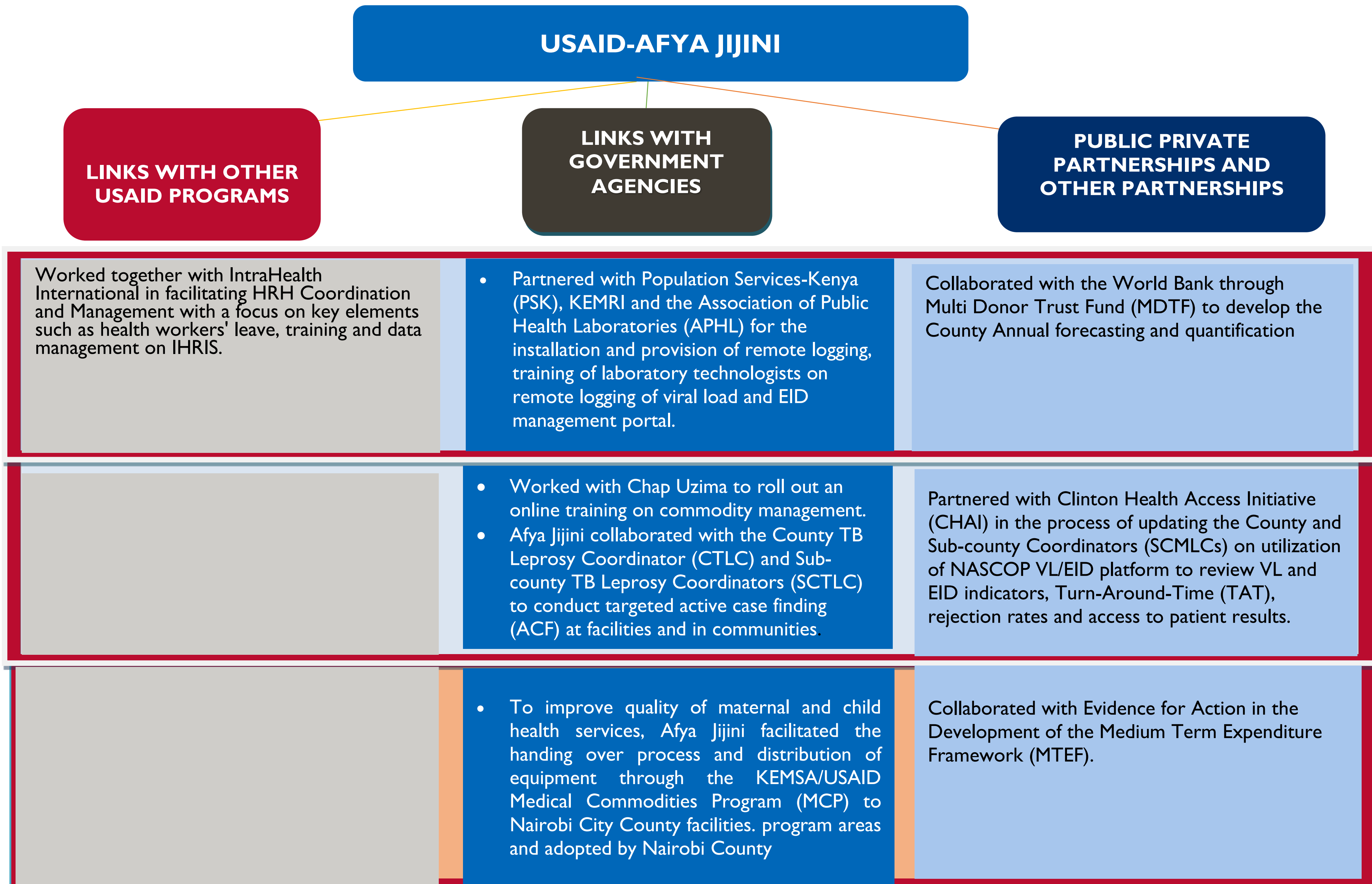
1. *Provide gender-equitable HIV prevention, care, treatment and support.*
2. *Implement gender-based violence (GBV) prevention and response services.*
3. *Implement activities to change harmful gender norms and promote positive gender norms.*
4. *Increase gender equitable access to income and productive resources including education (related to the Determined, Resilient, Empowered, AIDS-Free, Mentored, Safe (DREAMS) activities.*

7 PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

This quarter, Afya Jijini supported the provision and distribution of 187 posters to improve knowledge of WASH in health facilities. These IEC materials offered messages on handwashing and critical handwashing moments, safe handling of water, and proper disposal of feces. To promote infection prevention and control (IPC) in health facilities, the project supported CME sessions in two health facilities. Forty-eight (48) CHWs in two sub-counties (Embakasi West and Kamukunji) were sensitized on healthcare waste management, personal protection, and handwashing.

In the next quarter, *Afya Jijini* will adhere and be sensitive to environmental safety during implementation. To achieve this, the medical laboratory technologists will be trained on biosafety and biosecurity, and those eligible for a refresher will participate in a refresher trainings. Injection safety practices will adhere as stipulated in the national guidelines. At the same time, waste will be segregated to mitigate any possible individual or environmental arm. Samples will be transported by the use of triple packaged couriers to avoid spillage. Facility staff will be sensitized on adherence to safety precautions including: use of PPEs and waste segregation and disposal. Mentorship will be done on the management of hazardous laboratory material, both biological and chemical. SOPs and job aids on management of biological spillage will be provided. Technical guidance on access to PEP following occupational exposure will be offered.

8 PROGRESS ON LINKS WITH OTHER USAID PROGRAMS AND GOK AGENCIES



9 PROGRESS ON USAID FORWARD

Through Afya Jijini's grants under contract (GUC) program, the program is currently engaging with nine local partner organizations. These grantees are engaged in direct technical assistance activities across the spectrum of Afya activities including implementing Respectful Mothers Care and supporting DREAMS implementation. The partners implement evidence-based interventions that contribute to the achievement of USAID and PEPFAR annual targets and are provided close technical coaching and capacity strengthening support to ensure effective implementation of the activities. The local organizations AJ currently sub-grants to include the following: Women Fighting AIDS in Kenya (WOFAK), St. Johns Community Center (SJCC), Partnership for an HIV Free Generation (HFG), HealthRight International (HRI), Kujenga Maisha East Africa (KUMEA), Ananda Marga Universal Relief Team (AMURT), Kenya Council of Bishops (KCCB), International Network of Religious Leaders Living with or Personally affected by HIV (INERELA+ Kenya), and Gertrude's Children's Hospital.

In addition, Afya Jijini sub-contracts with three local organizations. These include the Christian Health Association of Kenya (CHAK), Mission for Essential Drug Supplies (MEDS), and National Organization of Peer Educators (NOPE). These three organizations with IMA form the core implementation consortium. In addition to leading key components of the project, IMA supports the sub-contractors with capacity building in the form of mentorship, technical assistance, and monitoring.

10 SUSTAINABILITY AND EXIT STRATEGY

Afya Jijini's approach to sustainability is to design and implement health interventions that can be taken over within a finite time by county governments, local communities (direct beneficiaries), and other partners then paid for subsequently as a manageable cost of doing business. By working with Nairobi County to institutionalize best practices in service delivery and health systems strengthening such as the performance appraisal system, the Nairobi County Government is gradually getting responsive to the needs of its target population. Both the LDP+ facility-based programs and the QIT approaches at the facility and sub-county level have instilled a sense of ownership towards improved quality services. *Afya Jijini* is working with the County Public Service Board and the County Health Department to prepare to transition administration of program supported staff to NCC as part of the transition. These discussions will continue into Q4.

11 GLOBAL DEVELOPMENT ALLIANCE

No GDA implemented so far.

12 SUBSEQUENT QUARTER'S WORK PLAN

	ACTIVITY	J	A	S	IMPLEMENTATION NOTES
0	**Program Management and Administration**				
0.1	Contracts Management				Continuous monitoring and evaluation of subcontracts to ensure successful completion in line with Program goals
0.2	Deliverable reports from partners				Support the documentation and ensure sustained quality of reporting
0.3	Financial Reports				Included in the quarterly reports
0.4	Staffing				Maintain and obtain approval for new staffing as activities increase
0.5	Budgeting				Review and make adjustments as necessary
0.6	Compliance Reviews				Continued reviews on program adherence to compliance components as outlined in the contract
1	**Sub-Purpose 1: Increased Access and Utilization of Quality HIV Services**				
1.1	of Mother-to-Child eMTCT				Focused identification, linkage, treatment of pregnant and breastfeeding mothers, their sexual partners and HIV Exposed Infants
1.2	HIV Care and Treatment Services				Targeted retention and treatment of HIV infected clients using the SURGE strategy; roll out community testing and referral systems with a focus on men and young adults
1.3	Integrated with 1.2 above				
1.4	HIV Prevention Services				Targeted identification and linkage of HIV infected clients using the SURGE strategy
1.5	TB HIV coinfection				Scale up of Isoniazid preventive therapy and introduction of mortality review meetings for all patients who die while on TB treatment
2	**Sub-Purpose 2: Increased Access and Utilization of Focused MNH, CH, FP, WASH, and Nutrition Services**				
2.1	MNH Services				Conduct EmONC feedback meetings and EmONC assessments Focused respectful maternity care at high volume facilities, KMC support for five high volume facilities, IMNCI mentorship, We Men Care model for male engagement in MNCH in 10 selected facilities, distribution of maternity files, job aids and guidelines
2.2	Child Health Services				Targeted outreaches for CWC services to improve FIC, ICCM and IMNCI mentorship, EPI training for private providers
2.3	FP Services				Targeted Adolescent intervention; Binti Shujaa, Mathare Youth Sports Association (MYSA) engagement to improve RH service utilizations, distribution of SOPs, job aids, and FP guidelines, Mentorship, Community-based distribution, outreach support, PPFP training, scale up FP integration in CCC and maternity.
2.4	WASH Services				

3	Sub-Purpose 3: Strengthened and Functional County Health Systems				
3.1	Strengthen governance and strategic planning and monitoring processes				-continue supporting county and facility strategic plan and annual work-plan development and implementation -continue supporting stakeholder engagements -support budget analyses for advocacy and resource mobilization.
3.2	Human Resources for Health				-Ongoing support for HRH coordination mechanisms (HRH Advisory Committees at Hospital and Sub County level) -Continue supporting leadership development program plus at the facility level -Roll out leave and Performance appraisal in IHRIS
3.3	Health Products & Technologies - Supply Chain Management and Laboratory Strengthening				Convene Sub-County and County Commodity Security Technical Working Group Review Commodity Management SOPs and print SOPs manual Carry out OJT and mentorship on inventory management Complete County Forecasting & Quantification for health commodities
3.4	Strategic Monitoring and Evaluation				Conduct Quarterly DQA; Conduct data sharing and review meetings; EMR support; Nairobi County M&E Plan review and finalization; Support community information reporting
3.5	Quality Improvement Systems				
3.5.1	strengthen county level QI coordination				Support quarterly QI TWG and facility assessments for the Nairobi County Health Service Delivery Awards
3.5.2	Strengthen facility level QI implementation processes				Ongoing support for facility-based QI team meetings
3.5.6	Strengthen sub-county QI coordination				Support each sub-county to hold QI coaches meetings and conduct support supervision
3.5.7	Strengthen community QI implementation				Support the DREAMS project in the implementation of QI in all safe spaces
4. Gender Development					
4.1	Implementation of Afya Jijini Gender strategy				Collaborate with stakeholders to execute quick win activities towards promoting attitude change of the young adolescents towards the uptake of health-seeking behaviors.
4.2	Support Male inclusion interventions				Avail information, education and communication materials that support the increase of men in the uptake of health services as clients, change agents and partners.
4.3	Facilitating men and women's meaningful engagement in Psychosocial Support Groups at facility levels and in the community				Special training and mobilization to increase gender participation, uptake and scale-up of psychosocial groups at facilities.
5. Monitoring & Evaluation					
5.1	Periodic sub-grantees evaluations				Involving all partners
5.2	Quarterly M&E specialists meetings				To review and strengthen performance
5.3	Partners training in M&E Systems				Continuous activity
5.4	Data validation, entry and management				Data validation, entry, and management, are continuous activities to ensure data integrity and reliability

5.5	Surveys				To monitor and review program targets and achievements
5.6	Data collection, analysis, and sharing of lessons learned and new knowledge				Collaboration, learning, and adaptation within the program cycle to increase overall effectiveness.
6. Collaboration, Learning, Adoption, Knowledge Management, and Communications					
6.1	Abstracts Development				Continuous sharing of Afya Jijini's lessons learned and best practices in academic platforms to contribute to the scientific body of knowledge in the health sector through abstract presentations and journal submissions.
6.2	Branding and Marking				Continuous review of branding and marking compliance in liaison with the Mission's DOC team, identification of new strategies of enhancing Afya Jijini's visibility. Refresher training and capacity building for both staff and partners on USAID and PEPFAR branding and marking plans.
6.3	Photography, videos, snapshots, site visits, and success stories				Conduct site visits to document progress through photo and video coverage, training and capacity building of partners on photography and video for social change, develop intervention snapshots to be included in quarterly reports, online portals and success stories for wider distribution
6.4	Documenting Afya Jijini success stories through traditional and social media, field visits and case studies				Continuously to highlight the program legacy messages and successful interventions.
6.5	Support industry-oriented events (forums and national conferences) and executing awareness campaigns				TB and WASH activations in schools and hospitals, collaborating with corporate organizations to implement CSR initiatives targeting the program health objectives.
6.6	Deliberate collaboration				-Promote deliberate collaboration with other USAID funded Program s, development partners, county and national governments and stakeholders in the health sector. -Participating in the monthly USAID's Communications Technical working group meetings and events.
6.7	Development of IEC and training manuals and business plans				Development and Design of communication materials for continuous information dissemination
6.8	Dissemination of Afya Jijini Knowledge reports to stakeholders				Research findings, case studies, reports, policy briefs and analyses dissemination across various channels.

13 FINANCIAL INFORMATION

14 ACTIVITY ADMINISTRATION

14.1 Constraints

No constraints or critical issues were encountered in the program administration.

- Obligated funds were sufficient to support planned activities.
- Excellent working relationships were maintained with the USAID Mission, national, and county level Government agencies and other implementing partners.
- No major changes in project management, implementation, or approach are anticipated for the coming year.

14.2 Personnel

No constraints or critical issues were encountered in project personnel or administration. All key personnel remained, and the program is fully operational.

14.3 List of Deliverables

The publications produced, submitted to USAID and disseminated during the quarter included:

- Performance Monitoring Plan

15 GPS INFORMATION

Attached separately.

16 SUCCESS STORY

Included below. A separate PDF attachment of the same provided.

BREASTFEEDING TO IMPROVE CHILD HEALTH

"One of the most common breastfeeding myths I encountered was that it makes the breasts saggy. I also heard that when you practice exclusive breastfeeding for a long period, you will suffer from dizziness and weight loss."

Mercy Atieno and her daughter

"We were taught that breastfeeding a child for the first six months ensures the baby receives much-needed nutrients and antibodies which give immunity to common childhood illnesses. Furthermore, it also helps in creating a strong bond between the mother and child."

Mercy Atieno is a 20-year-old mother from the Dandora informal settlement in Nairobi County. She is a single parent and a Binti Shujaa program mentor who is passionate about training other adolescent girls and young women (AGYW) on improved child health through optimal breastfeeding practices. She is inspired by her own experience as a new mother, and remembers the fear instilled in her by her peers and community about various breastfeeding myths.

There are several reasons why young women prefer to use baby formula over breastfeeding. Atieno's peers, mostly young mothers, avoid breastfeeding with the uninformed notion that their breasts will remain firm and appealing to the public. Some young women do not like children making a mess of their breasts and clothes. Other young mothers opt to buy packets of milk for feeding due to the stigma of breastfeeding.

Although Atieno opted to breastfeed, without a job or a stable source of income, she could barely feed herself after delivery. Within the first week her body was weak, she lost her appetite, and was consistently dizzy. She struggled to produce a sufficient supply of milk and almost gave up. During this time, Atieno's mother stepped in and offered support. She advised Atieno to eat a balanced diet and to visit her local health center where a nutritionist enrolled Atieno in a supplementary feeding program. She was given fortified blended flour (FBF) for lactating mothers that restored her breastmilk levels to normal. It was through this visit that Atieno was enrolled in the Binti Shujaa program in July 2018. Binti Shujaa (meaning "Young Heroines"), is an initiative to train and mentor Youth Champions to offer comprehensive sex education sessions that equip AGYW with essential maternal and child health skills. In Nairobi County, the USAID/Kenya and East Africa Afya Jijini Program implements Binti Shujaa in collaboration with designated health facilities.

Atieno attended a one-week training with curriculum on antenatal and post-natal care services for mothers and children, including information on child growth and development, breastfeeding after birth, and HIV testing services for mothers and their partners. It was during the training that breastfeeding myths were challenged by providing the young mothers with evidence-based research on the significance of optimal breastfeeding practices, the benefits of childhood development, and development of prenatal skills. Lactating mothers were given demonstrations on positioning and attachment while breastfeeding, as well as proper handwashing before handling the baby to avoid cross-contamination from mother to child. From the training, Atieno and the other mothers learned about the need for exclusive breastfeeding in the first six months.

Mercy Atieno is now a champion and mentor mother to other young women. She coaches her peers on breastfeeding and other sexual and reproductive health issues of concern in her community. She educates young mothers on the importance of breastfeeding a child for the first six months. She challenges myths like the fear of sagging breasts and reminds her peers of the utmost importance of the health of their children. She teaches her peers that breastfeeding gives much-needed antibodies to the baby and facilitates healthy weight gain, improving a baby's overall health. Atieno has since mobilized other young women to participate in the program through channels like WhatsApp, SMS short messages, phone calls, and door-to-door visits. Her greatest achievement was when the 2019 cohort of 200 young women - 20 of whom she had mentored for the last eight months - held their graduation ceremony and celebrated the successful completion of the Binti Shujaa curriculum. She advocates at health facilities for counseling of new mothers on the importance of prenatal care, antenatal care, and personal hygiene. She is passionate about childcare mentorship and would like to see more mothers trained on how to take better care of their children, especially through breastfeeding and proper nutrition. She believes in the impact that more training on optimal breastfeeding practices will have on AGYW in her community.

"The County has made significant strides towards promoting exclusive breastfeeding," ***Diana Njeri Mureithi, Kasarani Sub-County Nutrition Officer said.*** *"We have lined up facility-based training, health workers' sensitization, and community dialogues to encourage conversations and reduce stigma among young women during the Breastfeeding week in August 2019."*

KENYA

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