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# USAID KENYA AND EAST AFRICA
# Afya Kamilisha
## COP18/ FY19 ANNUAL WORKPLAN


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Submitted by: **Jhpiego Corporation**
Sub-contractors/Implementing partners: **LVCT Health, Amethyst Technologies LLC, Cloudburst Group**
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# ACRONYMS LIST

| | |
|---|---|
| AGYW | Adolescent Girls and Young Women |
| AMELP | Activity Monitoring, Evaluation, and Learning Plan |
| ANC | Antenatal Care |
| ASSIST | Applying Science to Strengthen and Improve Systems Program |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| AWP | Annual Work Plan |
| BMGF | Bill & Melinda Gates Foundation |
| CASCO | County AIDS & STI Coordinator |
| CCC | Comprehensive Care Clinic |
| CDC | U.S. Centers for Disease Control and Prevention |
| CHESS | County Health Systems Strengthening |
| CHMT | County Health Management Team |
| CME | Continuing Medical Education |
| CO | Contracting Officer |
| COP | Chief of Party |
| COR | Contracting Officer's Representative |
| CQI | Continuous Quality Improvement |
| CRP | Community Own Resource Person |
| DBS | Dried Blood Spot |
| DCOP | Deputy Chief of Party |
| DC | Differentiated Care |
| DCM | Differentiated Care Model |
| DDL | Development Data Library |
| DREAMS | Determined Resilient Empowered AIDs-Free Mentored Safe |
| DR TB | Drug Resistant Tuberculosis |
| DQA | Data Quality Assessment |
| EBI | Evidence-informed Behavioral Intervention |
| EID | Early Infant Diagnosis |
| eLMIS | Electronic Logistics Management Information System |
| EMMP | Environmental Mitigation and Monitoring Plan |

| | |
|---|---|
| EMR | Electronic Medical Record |
| eMTCT | Elimination of Mother-to-Child-Transmission |
| FMP | Family Matters Program |
| FP | Family Planning |
| GBV | Gender-Based Violence |
| GOK | Government of Kenya |
| HCBF | Healthy Choices for a Better Future |
| HEI | HIV-Exposed Infant |
| HIGDA | Health Informatics Governance and Data Analytics Activity |
| HIV ST | HIV self-testing |
| HMIS | Health Management Information System |
| HP+ | Health Policy Plus |
| HR | Human Resources |
| HRH | Human Resources for Health |
| HRIO | Health Records and Information Officer |
| HRSA | Health Resources and Services Administration |
| HSDSA | HIV Services Delivery Support Activity |
| HSS | Health Systems Strengthening |
| HTS | HIV Testing Services |
| ICF | Intensified Case Finding |
| ICT | Information and communication technology |
| IEC | Information and Education Communication |
| iHRIS | Integrated Human Resource Information System |
| IRIS | Immune Reconstitution Inflammatory Syndrome |
| IPC | Infection Prevention and Control |
| IPT | Isoniazid Preventive Treatment |
| IPV | Intimate Partner Violence |
| KAIS | Kenya AIDS Indicator Survey |
| KASF | Kenya AIDS Strategic Framework |
| KEMSA | Kenya Medical Supplies Agency |
| KHQIF | Kenya HIV/AIDS Quality Improvement Framework |
| KQMH | Kenya Quality Model for Health |
| KSCSS | Kenya Supply Chain Systems Strengthening Project |
| LIP | Local Implementing Partner |
| MCH | Maternal and Child Health |
| MDT | Multidisciplinary Team |
| M&E | Monitoring and Evaluation |
| MOH | Ministry of Health |
| MTB/RIF | Mycobacterium Tuberculosis/Resistance to Rifampicin |
| NACC | National AIDS Control Council |
| NASCOP | National AIDS and STI Control Programme |
| NHRL | National HIV Reference Laboratory |
| OCAT | Organizational Capacity Assessment Tool |
| ODK | Open Data Kit |
| OI | Opportunistic Infection |
| OPD | Outpatient Department |
| OTZ | Operation Triple Zero |
| OVC | Orphans and Vulnerable Children |
| PAS | Performance Appraisal System |
| PBB | Program-based budgeting |

| | |
|---|---|
| PCR | Polymerase Chain Reaction |
| PE | Peer Educator |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PHDP | Positive Health, Dignity and Prevention |
| PITC | Provider-Initiated Testing and Counseling |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PO | Program Officer |
| PrEP | Pre-Exposure Prophylaxis |
| PSB | Public Service Board |
| PSSG | Psychosocial Support Group |
| PNS | Partner Notification Services |
| QA | Quality Assurance |
| QASP | Quality Assurance Surveillance Plan |
| QI | Quality Improvement |
| QIT | Quality Improvement Team |
| RDT | Rapid Diagnostic Test |
| RTK | Rapid Test Kit |
| SASA | Start Awareness Start Action |
| SAB | Social Asset Building |
| SCASCO | Sub-County AIDS & STI Coordinator |
| SCHMT | Sub-County Health Management Team |
| SDTA | Service Delivery Technical Advisor |
| SGBV | Sexual and Gender-based Violence |
| SMS | Short Message Service |
| SOP | Standard Operating Procedure |
| SIMS | Site Improvement Monitoring Systems |
| SLMPTA | Strengthening Laboratory Management Toward Accreditation |
| SPO | Senior Program Officer |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TB LAM | Tuberculosis Lipoarabinomannan |
| TOT | Training-of-Trainers |
| TWG | Technical Working Group |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| USAID/KEA | Unites States Agency for International Development in Kenya and East Africa |
| WHO | World Health Organization |
| WIT | Work Improvement Team |

# 1.0 INTRODUCTION

This annual work plan (AWP) details the activities that will be carried out by Jhpiego and its sub-contractors — LVCT Health, Amethyst Technologies, and Cloudburst Group — during the second year of the United States Agency for International Development (USAID)/ Kenya-funded five-year contractual agreement for the Afya Kamilisha formerly, HIV Services Delivery Support Activity (HSDSA). Afya Kamilisha is working in the nine counties in Eastern and Central Kenya: *Embu, Kiambu, Kirinyaga, Kitui, Meru, Murang'a, Nyandarua, Nyeri* and *Tharaka Nithi*. Afya Kamilisha is working towards building the capacity of the county and sub-county leadership to increase access and coverage for HIV prevention, care and treatment services towards meeting and exceeding the 90-90-90 goals.

Afya Kamilisha will empower the nine target counties to focus HIV testing services (HTS) on those individuals most likely to be infected using highly effective strategies such: as index client tracing, targeted provider-initiated testing and counseling (PITC), and innovative methods such as HIV self-testing (HIV ST) for partners and exposed children. Once identified, the Project will work with HTS counselors, peer educators (PE) and community resource persons (CRPs) to ensure that HIV-positive clients are personally escorted and linked to treatment and care. The Project will support healthcare workers to adopt "test and treat," so that newly identified clients — as well as already-identified HIV-positive clients not yet on treatment — are provided consultations on the same day of diagnosis and rapid initiation of antiretroviral therapy (ART) regardless of CD4 count or World Health Organisation (WHO) staging. Clients who start ART will receive adherence counseling from healthcare workers and PEs to ensure optimal viral suppression. The Project will strengthen laboratory networks and their interactions with facilities so that clients on ART are able to access viral load testing and receive their results in a timely manner. For those clients who are stable on ART, Afya Kamilisha will enable counties to offer differentiated models of care that best suit the needs of the clients, including multi-month scripting and/or community-based ART refills for stable clients. Clients who are not virally suppressed on ART and/or clients newly diagnosed with HIV and presenting with advanced disease will receive facility-based intensive clinical management until they meet the criteria for stability. Facility, sub-county, and county levels of the health system will be strengthened across the six WHO health system building blocks, with a focus on human resources for health (HRH), health financing through budgeting and planning, commodity management, health management information systems (HMIS) strengthening, and quality assurance/ quality improvement to ensure provision of a comprehensive package of HIV services to clients. The Project will ensure that members of priority populations - especially adolescent girls and young women (AGYW) - who are HIV-negative, remain HIV-negative by helping health facilities and communities to offer a combination prevention package of evidence-based behavioral, structural and biomedical interventions, including oral pre-exposure prophylaxis (PrEP) and in accordance with national guidelines. Adolescents who are HIV positive will receive Project support through interventions tailored specifically to their unique situation, needs, and challenges.

Afya Kamilisha will employ a humanistic and holistic approach rooted in the right to health to enhance gender-sensitive and transformative programming. The Project will prioritize efforts to achieve gender equality and women's empowerment as per the USAID gender policy, with a focus on reducing gender disparities in access to, control over and benefit from resources; reducing gender-based violence and mitigating its harmful effects on individuals and communities; and increasing the capability of women and girls to realize their rights, determine their life outcomes, and influence decision making in households and communities. Afya Kamilisha will work with men, women, girls, and boys to mitigate the gender effects on care-seeking behavior towards attainment of the global 90-90-90 targets by 2021.

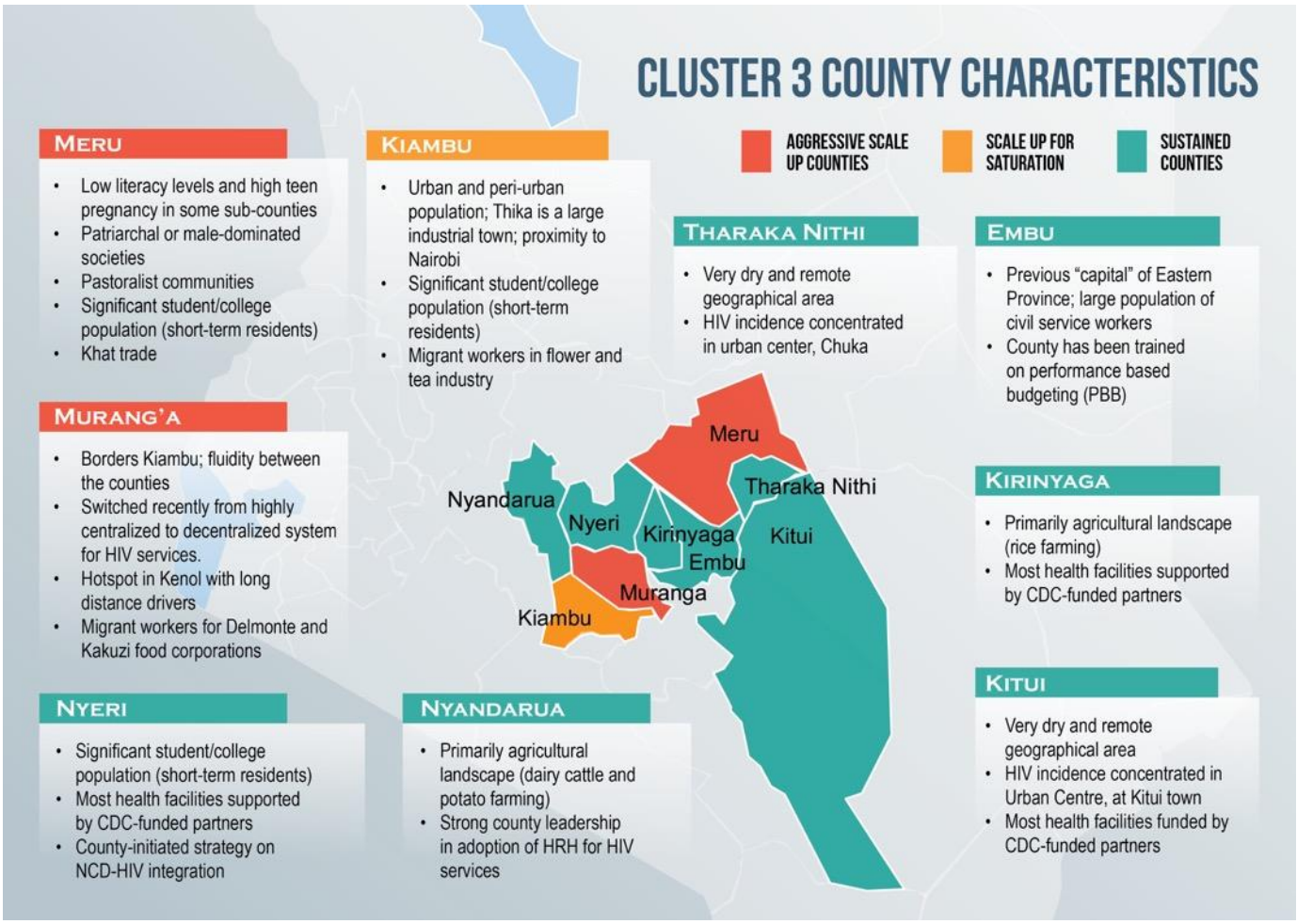
## 1.1 AFYA KAMILISHA BACKGROUND AND COUNTY CONTEXT

Kenya has seen a decline in overall HIV prevalence from 10.5% at the height of the epidemic in 1996 to 5.6% in 2014[1]. From the start, Kenya enacted a strong response to the epidemic — led by the National AIDS and STI Control Programme (NASCOP) and the National AIDS Control Council (NACC) with support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund and the Bill & Melinda Gates Foundation (BMGF) — that embraces and operationalizes new evidence-based best practices in HIV prevention, care and treatment as they become available. Yet, there remain close to 78,000 new HIV infections each year[2], and more than 1.5million people living with HIV (PLHIV) in Kenya, 830,000 of whom are women[3]. While 900,000 PLHIV are on ART, an estimated 600,000 remain untreated[4].

The Government of Kenya (GOK) recently committed to achieving the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 goals by the year 2021: with 90% of all people living with HIV knowing their HIV status, 90% of all people with diagnosed receiving sustained antiretroviral therapy (ART), and 90% of all people receiving ART being virally suppressed. Key elements are in place to achieve this goal: a national strategy, the Kenya AIDS Strategic Framework (KASF); evidence-based prevention, care and treatment policies and guidelines; and numerous public, faith-based organizations and private health facilities that provide comprehensive HIV services, complemented by outreach and community-based services. Nonetheless, critical challenges remain. While Kenya has a generalized epidemic, there are significant disparities in HIV prevalence in different geographical areas of the country. Approximately 90% of PLHIV are concentrated in just 27 of the 47 counties in Kenya, with five counties contributing 49% of PLHIV. With this in mind, PEPFAR and the GOK pivoted their approach in Kenya, reallocating resources to geographic areas most in need. Counties in Kamilisha (Figure 1) include those categorized as for "aggressive scale-up," where HIV interventions need to be actively increased to achieve epidemic control (Meru and Murang'a), "scale-up for saturation" (Kiambu)," or "sustained," where HIV interventions need to steadily continue (*Embu, Kiambu, Kirinyaga, Kitui, Meru, Murang'a, Nyandarua, Nyeri and Tharaka Nithi*).

[1] Kenya AIDS Strategic Framework (KASF 2014/15 – 2018/19, National AIDS Control Council (NACC).
[2] UNAIDS Prevention Gap Report, 2016.
[3] Kenya AIDS Response Progress Report, March 2014, NACC.
[4] Ministry of Health, National AIDS & STI Control Programme. Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya 2016. Nairobi, Kenya: NASCOP, July 2016.

**FIGURE 1: KAMILISHA COUNTY CHARACTERISTICS**




## 1.2 PROJECT FRAMEWORK:

*Project Goal*: To increase access and coverage for HIV prevention, care and treatment services towards achieving the 90-90-90 targets. The Project objectives are as follows:

- *Objective 1:* Increased availability and use of combination prevention services for priority populations
- *Objective 2:* Increased use of targeted HTS
- *Objective 3:* Improved linkage to treatment for individuals newly testing positive for HIV
- *Objective 4:* Increased uptake of and adherence to quality HIV treatment services
- *Objective 5:* Follow-up of clients receiving care and treatment services, including laboratory and logistics support.
- *Objective 6:* Strengthened institutional capacity and accountability for the management, facility and county HIV response in the nine Kamilisha counties

**FIGURE 2. PROJECT FRAMEWORK**


The Project Framework graphic (Figure 2) visually presents Afya Kamilisha's overall goal, outcomes, key interventions and guiding principles. It maps the pathway to increase access and coverage of HIV prevention, care and treatment services and contribute to achieving the 90-90-90 targets. To realize this goal, the Kenyan health system must have strong elements to develop a sustainable response throughout the country. The five pillars represent these critical elements, and within each pillar are the key interventions and actionable approaches that will lead to the expected Project results. The foundation, underlying all interventions and objectives, is the Project's sixth objective to strengthen institutional capacity and accountability for county coordinated HIV response.

Kamilisha has laid out a set of guiding principles that will permeate all aspects of the Project and result in assisting the GOK in achieving meaningful impact on HIV in Kenya.

This COP 18 AWP outlines specific technical activities to be undertaken under each Project objective, as well as the overall project management necessary to effectively achieve the objectives. The AWP directly corresponds to the FY 19 annual budget (submitted in tandem for USAID's review and approval).

## 1.3 PROJECT PARTNERSHIP

Jhpiego will lead an experienced team—comprised of LVCT Health, a local organization; and Amethyst Technologies and Cloudburst, U.S.-based small businesses – to effectively and efficiently achieve project objectives (Table 1).

**TABLE 1: Partnership Roles and Responsibilities**

| Organization | Roles and Responsibilities |
|---|---|
| **Jhpiego** | Jhpiego is providing overall technical and management leadership of the Project and leading Objectives 1, 3, 4, 5 and 6. |
| **LVCT Health** | LVCT Health is leading Objective 2, contributing to Objective 3, and leading GBV prevention and treatment interventions across all objectives. |
| **Amethyst Technologies, LLC (U.S. small business)** | Amethyst Technologies is leading implementation of SIMS and laboratory QA under Objective 6, as well as quality assurance (QA) of laboratories under Objective 5. |
| **Cloudburst Group (U.S. small business)** | Cloudburst Group is leading the development of the Kamilisha Environmental Mitigation and Monitoring Plan (submitted with this AWP) and will ensure compliance with environmental and monitoring mitigation measures including capacity building of all sub-grantees. |

Drawing on the consortium's experience, extensive network in cluster 3 counties and technical expertise, the project will build capacity and transition ownership to county and sub-county leadership by enabling them to effectively plan and budget activities, efficiently use and leverage resources, and deliver high-quality HIV services.

# 2.0 TECHNICAL STRATEGIES – NARRATIVE

## OBJECTIVE 1: INCREASE AVAILABILITY AND USE OF COMBINATION PREVENTION SERVICES FOR PRIORITY POPULATIONS

In the County Operational Plan (COP) 17, Afya Kamilisha initiated implementation of the DREAMS program in Biashara and Ngoliba wards in Kiambu County. The project focus was on recruiting and training enumerators, conducting girl roster mapping, community resources mapping, identifying and enrolling eligible females into the AGYW program, laying the foundations for providing services to the most vulnerable, plus provision of primary services. By end of Q4 of COP 17, a total 7,394/7980 (93%) AGYW had been enrolled in the program, all of whom are active with 6,559 receiving the combined minimal package of care. Afya Kamilisha identified and enrolled 47/157 (30%) eligible AGYW for pre-exposure prophylaxis for HIV prevention (PrEP) in the project link health facilities.

In COP 18, Afya Kamilisha plans to reach 6,134 eligible AGYW with defined packages of services through the following strategic approaches: Equip more safe spaces as avenues for all services to the AGYW, Continuous capacity building to the mentors to improve quality in the delivery of the social assets building sessions as laid out in the Adolescent Girls Initiative in Kenya (AGIK) curriculum, Demand creation for the AGYW initiative; Provision of age appropriate services to AGYW and their male sexual partners; Strengthening the inter and intra communication between parent/caregivers and the AGYW; and Mobilising the community to be champions against all forms of violence in the community. Success will be anchored on continuous stakeholder involvement and ownership of the interventions—including ownership from the beneficiaries themselves. A total of 90 mentors will be deployed in Biashara and Ngoliba wards to manage cohorts of 60-80 girls supporting them in social assets building (SAB), mentorship, and linkage to services. They will also provide a coordination point for the delivery of the EBIs, biomedical and structural interventions.

Efforts in COP 18 will be concentrated on sustaining the gains made in COP 17 (Year 1), by ensuring that the layering of services is adhered to. Using data from the DREAMS data base, the Project will ensure that the AGYW remain active in the program, have completed all the sessions in the primary interventions, and are provided with the appropriate secondary interventions. Further activities will concentrate on providing the contextual level interventions of parenting and care giver programs, community mobilizations and norms change and reducing risk of the AGYW's male sexual partners. These will be achieved through the activities described below:

### ACTIVITY 1.1 STAKEHOLDER ENGAGEMENT ON HEALTH MATTERS FOR AGYW AND DREAMS INTERVENTION

In COP 18, the project will targets 6,134 AGYW with the combination prevention services. DREAMS success will be anchored on increased stakeholder involvement and participation in the project design, implementation and monitoring. The stakeholders that were engaged during program implementation in the first year will be continually engaged to monitor and provide corrective actions during implementation. The main stakeholders to be engaged are from the national government representatives, relevant county and sub county line ministries and partners (MoH, MoE, MoGSS etc), Ward, community leaders (chiefs, religious leaders, and heads of institutions, local administration, parents, local media, CBOs and youth groups) will also be sensitized to ensure ownership and representation. Afya Kamilisha will align with existing government initiatives like the ward administrators, village elders and the *Nyumba Kumi* initiative to increase community participation

Kiambu County has an adolescent technical working group (TWG) that brings together representatives from all the County departments and key partners working on adolescent programs discuss adolescents unique needs. Afya Kamilisha will be part of this TWG to ensure that the DREAMS work is part of the County overall agenda of improving the health of AYPs.

Afya Kamilisha will establish one Community Advisory Boards (CAB) in each ward. These CABs will be the community participation and monitoring arm of the DREAMS intervention. The Boards will serve as a forum that both communicates and promotes DREAMS in the community but also receives feedback about implementation and resolves any conflicts that may arise. The CABs will be constituted by local leaders, representative of parents, representatives of local organizations and religious institutions, Afya Kamilisha and CASEOVC staff, and most importantly, representatives of the AGYW themselves. The Project will support the Community Advisory Boards to meet at least two times per year.

## ACTIVITY 1.2 EMPOWER ADOLESCENT GIRLS AND YOUNG WOMEN (AGYW) TO REDUCE THEIR RISK FOR HIV AND VIOLENCE

### Activity 1.2.1 Social asset building for vulnerable AGYW through mentorship and safe spaces model

Social Asset Building remains the core of the DREAMS initiative, with the main purpose of ensuring the AGYW are empowered to adjust and live with the daily challenges they face in their living environment. From Year I activities, the project has recruited and trained 90 female mentors. The project will also maintain the existing safe spaces from where the 90 mentors will continue to provide mentorship to the AGYW. The safe space will also be a coordination point for the delivery of the EBIs and other biomedical and structural interventions. Each mentor will work with about 60 AGYW grouped in age cohorts of 20 -25 to define the list of assets each AGYW is eligible by using the SAB Toolkit. The mentors will deliver them the SAB through regular sessions at the safe spaces where participants receive social support, information, and services (and/or links to services such as health care). The focus is on building sustainable individual protective assets such as self-esteem, problem- solving abilities, confidence, and social networks that support increased education and economic participation. Afya Kamilisha will endeavor to link socially isolated girls both to higher status adult female mentors who can serve as advocates on their behalf and to community institutions and services. The mentors will be taken through refresher training to build their skills on household visitation and defaulter tracing activities. They will then be required to visit their AGYW at home specially to follow up on those who are lagging behind in participating in the group sessions or have defaulted on key services eg PrEP.

### Activity 1.2.2 Implement Evidence-Informed Behavioural Interventions (EBIs)

DREAMS is responding to the alarming fact that every day, about 1000 AGYW are infected with HIV in sub-Saharan Africa. The Kenya HIV estimates 2015, reports that 3.97% of AGYW aged 15-24 are living with HIV. Reasons for this rising epidemic among the adolescents and young people are incorrect perception of their risks of HIV; limited knowledge of sexual behaviour that expose them to HIV such as failure to use condoms during the first sexual intercourse; failure to resist forced sex from partner; and having sexual intercourse under influence of alcohol or drugs among others. Afya Kamilisha will implement the age appropriate EBIs that have proved to address the contributing reasons for HIV infection among the adolescents and young people. Specifically, the project will support implementation of Health Choices For a Better Future (HCBF), My Health My Choice (MHMC) and SHUGA 11. In order to deliver these curricula-based interventions, the project will recruit and build capacity of an additional 20 community facilitators per EBI. Once facilitators are trained, they will be supported to conduct weekly sessions to deliver the EBI with fidelity ensuring that every AGYW completes the required number of sessions. In addition, all EBI facilitators will be equipped with condoms, demonstration models, referral forms, and trained to use these effectively. The Activity will also elect condom dispensers in the community hot spots.

### Activity 1.2.3 Provide and link AGYW with appropriate biomedical interventions

Afya Kamilisha implemented the DREAMS package of biomedical interventions including condom education and distribution, PrEP education and provision, violence prevention and post violence care, HTS and appropriate linkage to CCC, education and provision of contraceptive method mix, screening and linkage for STIs, TB and GBV. In COP 17, all the enrolled AGYW were screened for GBV, STIs and TB and linked to appriopriate services.

This was achieved through the concurrent testing and service provision strategy. HTS services were accessed by over 50% AGYW and the eight (8) who were identified HIV-positive were linked to CCC. Fifteen HCPs from the link health facilities were trained on PrEP and by APR they initiated PrEP to 47 clients. The challenge was on getting the male sexual partners to access services. Strategies for reaching mean are further described in section 1.4 in this document.

In COP 18, Kamilisha will continue strengthening health facilities in the target wards to provide youth-friendly services defined as services that are accessible, acceptable and age-appropriate to 6,134 AGYW in response to their needs. About 30 health care providers from facilities serving vulnerable AGYW will be trained on youth friendly services. The project will endeavour to provide HTS to over 80% of AGYW and 20% of the male sexual partners in accordance with the testing guidelines.

AGYW who are HIV- negative and at high risk for HIV acquisition (i.e. AGYW who have HIV-positive partners, a recent STI, a violent partner, engage in sex work etc.) will undergo a risk assessment administered by trained health care providers. Those with substantial ongoing risk indications will be assessed for PrEP eligibility, counselled and educated about its use and the importance of adherence, and finally enrolled on oral prophylaxis. The AGYW on PrEP will be regularly monitored through clinic appointments where they will also be provided with adherence counselling. The partnered with Jilinde, a Jhpiego-led project funded by Bill & Melinda Gates Foundation for access of PrEP guidelines, SOP and algorithms. Afya Kamilisha has ensured that one of the DREAMS program officers has the capacity of providing the biomedical interventions and will regularly mobilise other providers to bring sexual and reproductive health services at the safe spaces. AGYW needing services of psychosocial support groups (PSSGs) for HIV-positive girls, young mother's clubs, and PMTCT support groups will be linked appropriately.

### Activity 1.2.4 Provide and link AGYW to structural interventions and social protection services

Social protection interventions are documented to have consistent effects on biological and behavioral outcomes for the AGYW while keeping them safe from HIV and violence. To achieve maximum results for the AGYW, Afya Kamilisha will support multiple interventions including financial literacy and entrepreneurship, linkage to socio-economic opportunities, and provision of financial support through cash transfers and educational subsidies. In COP 17, 1542 AGYW were provided with educational subsidies including school Levies and form of dignity kits.

Data from the DREAMS database will be analysed to ensure that every AGYW completes the 5 sessions of financial capability training to equip every AGYW with basics of finances and savings. The sessions are designed to enable them to learn how to prioritize and meet their financial needs independently, hence reducing their vulnerability. Furthermore, Afya Kamiisha will provide entrepreneurship skills building focusing on those out of school AGYW aged 15-24 years. These cohorts will undergo another 5-session intervention to build their entrepreneurship skills to start, manage and expand a business. The project will recruit and train approximately 30 facilitators for financial literacy and entrepreneurship and will support them to conduct full sessions in each ward.

In COP18, the Project will also link eligible young women with newly formed entrepreneurship and financial literacy skills to microfinance institutions and other government funding entities, like the UWEZO fund or women's informal cooperatives (known as *chamas*), to expand their options for accessing capital to grow their businesses. Working with the mentors, the Project will also identify successful businesswomen who can provide mentorship to the young women and link eligible AGYW appropriately. AGYW who will require technical skills will be linked to vocational training schools while others may only need linkage to internship opportunities and job placements. The project will strive to collaborate with private companies in the region, and link AGYW for internship and training as part of public-privatepartnership.

For a select number of young women showing considerable vulnerability, Afya Kamilisha will engage them in cash transfer programs, primarily by linking them to existing programs. Typically, cash transfer programs provide unconditional monthly transfers of KES 2000 to eligible young women over the age of 18. Cash will be sent every

2 months through the Mpesa payment system. Before inclusion into the intervention, eligible AGYW and households will have their names run against the single registry by the government to ensure no double payments. Those younger than 18 requiring cash transfers will be linked to the orphans and vulnerable children (OVC) project being implemented in Kiambu by CASE-OVC.

The Project will provide educational subsidies to eligible AGYW in the form of school fees paid directly to the school, uniforms, shoes and books. Afya Kamilisha will work closely with CASE-OVC project to support the enrolment of eligible AGYW in the OVC program. Afya Kamilisha will identify and link AGYW to government bursaries, local charities and religious institutions providing educational support, while again providing highly limited subsidies to those who have no other options.

### Activity 1.2.5 Develop schools as Safe Spaces

In COP 17, Kamilisha, worked with education and community stakeholders to map resources to support DREAMS implementation. Twenty six (26) learning institutions were identified as possible safe spaces. Eight of these have been developed and are in use. To further strengthen the school safe spaces, Kamilisha will identity and orient 20 school-based stakeholders i.e. school heads, school health patrons, school nurses/clinicians, and teachers serving as health club champions on DREAMS program and the mentorship of girls through the safe space. The stakeholders will then be asked to identify additional safe spaces within their respective schools. Depending on the number of adolescent girls per school, the project will allocate r mentors appropriately. The school health matron/nurse/teacher will work with the mentors to schedule meetings and invite them to schools to mentor the adolescent girls. Additionally, health clubs will be strengthened for increased knowledge and life skills transfer through the HCBF EBI for primary and secondary AGYW and through SHUGA II EBI for tertiary institution students.

Innovations that keep girls in school are proven to dramatically reduce their vulnerability to HIV infection and violence.The Project will also collaborate with the Ministry of Health and other partners to provide sanitary pads for school-going AGYW to ensure that menstruation does not create a barrier to school attendance. Afya Kamilisha will also orient schools and the AGYW on proper disposal of sanitary pads. To increase targeted and age appropriate messaging, the Project will partner with the private sector and local artists to work with the schools and set up talking walls with different health and HIV prevention messages.

### Activity 1.2.6 Provide and link AGYW to gender-based violence (GBV) interventions

In COP 17, 4 HCPs from DREAMS link facilities were trained to provide comprehensive GBV services (including access to emergency contraceptives and introduction to family planning services, as needed) to survivors of sexual violence. An additional 6 HCWs will be trained in COP 18 to increase the number of health facilities providing GBV services to AGYW. So far 16 AGYW ages 20-24 have accessed post GBV services Further support for GBV survivors is described under activity 2.8. To mitigate on intimate partner violence, the project will screen for partner violence among AGYW and where needed, link couples to joint intimate partner violence counselling provided by trained staff at health facilities or other safe spaces. The Project will develop and disseminate appropriate information and education communication (IEC) materials for GBV prevention.

## ACTIVITY 1.3 CHARACTERIZE AGYW SEXUAL PARTNERS FOR EFFECTIVE TARGETING FOR HIV PREVENTION

Characterization of the males who are potential sex partners of AGYW will provide information for better targeting of HIV prevention, care and treatment. This activity was initiated in COP 17 and will continue in COP 18 so as to reach all AGYW in orde to help determine the characteristics of male sex partners (MSP); age, occupation, type of relationship/partnership, where they hang out, where sex takes place, motivation in relationships etc. This will then inform strategies of targeting MSP with effective behavioral and biomedical interventions such as condom promotion and provision, HTS, VMMC and ART for the HIV positive. Understanding the characteristics of MSP of AGYW will inform HIV service provision to AGYW e.g. risk reduction and topics to

be prioritized in the safe spaces discussions. Kamilsha will endeavor to learn and incorporate best strategies from the innovation challenge initiative to meaningfully involve boys and men in the empowerment of AGYW.

## ACTIVITY 1.4 STRENGTHEN FAMILIES THROUGH PARENT/ CAREGIVER PROGRAMS

Afya Kamilisha is aware that implementing parenting programs has demonstrated effects on HIV risk behaviors and on protection from sexual violence for the adolescents. Family Matters Program (FMP) aims to reduce sexual risk behaviours among adolescent by giving parents the skills they need to protect and guide their children. By APR, 1200 parents/caregivers of AGYW aged 10 - 17 were oriented on DREAMS program and consented to the enrollment of their girls. Thirty (30) Facilitators were trained on FMP 1 and have started recruiting parents/caregivers for the sessions. In COP 18, another 30 facilitators will be trained to rollout FMP 11. Carrying on from project year 1, Afya Kamilisha will continue to support the joint youth – parent forums for open and honest dialogue to promote two way understanding for the high impact DREAMS interventions eg. PrEP. Opening inter and intra communication for parents and their children has the potential of improving educational and health outcomes. A positive relationship with a parent, caregiver, or other caring adult has a consistent protective factor for young women and adolescent girls against a variety of negative health and social outcomes. Programs that involve parents and caregivers have shown to be very effective in changing HIV related sexual behaviors among all youth (e.g., use of male and female condom, delayed sexual debut, as well as decreased exposure to negative outcomes such as violence and abuse).

## ACTIVITY 1.5 EDUCATE AGYW AND YOUNG MEN AND MOBILIZE COMMUNITIES FOR CHANGE

For social norms to change and vulnerability to be reduced, women, men, boys and girls all play a role. The team has mobilised and sensitised the community for change. This was achieved through identification and sensitization of 30 (20 in Biashara and 10 in Ngoliba) community leaders on the Start Awareness Start Action SASA! an intervention which addresses power imbalances between men and women as well as harmful gender norms. These community activists, who are also gender champions, are leading gender-transformative community dialogues on GBV recognition, reporting and underlying norms that support GBV in order to prevent it. In COP 18, the project will continue to support these community activists to spearhead community dialogues promoting positive community norms. For increased male involvement, the team will map spots frequented by men (football clubs, pool table joints, video joints) and engage them in discussions on the same.

## ACTIVITY 1.6 COORDINATION AND MONITORING OF DREAMS INTERVENTIONS

Afya Kamilisha will support monthly staff review and update meetings for capacity building, quality improvement and documentation. Similarly, bi-weekly planning meetings will be held with the mentors in the safe spaces, and monthly review and update meetings with the pool of EBI facilitators, mentors and SASA! activists. AGYW representatives will be integrated into the meetings as often as possible without compromising confidentiality of other enrolled AGYW.

To ensure continued compliance and alignment with the national and county priorities, the project will support and participate in relevant stakeholder forums and AGYW TWGs at the county and national levels. Similarly, Afya Kamilisha will support the commemoration of key international health days aligned to the DREAMS initiative. The project will ensure availability of stationery, reference and IEC materials.

### ACTIVITY 1.7 NETWORKING AND COLLABORATION

Networks are a critical component of the success of any program especially when the create avenues for collaboration with other programs. Afya Kamilisha will continue to collaborate with the other DREAMS partner on the ground for sharing of experience and best practices as well as technical support to the county. The project will continue collaborationgwith CASE-OVC project in the provision of services to girls ages 9 to 17 years to complement the OVC services and ultimately the goal of achieving the DREAMS age specific layered services and hence empowering AGYW to reduce their risk for HIV infection and violence. As CASE-OVC project recruits and provides OVC services to girls ages 9 to 17 years, they will share the girl's information with Afya Kamilisha to enrol the same girls into the DREAMS program. Additionally, CASE-OVC project will transition girls who are 18+ years to the DREAMS program. Likewise, Afya Kamilisha will refer to CASE-OVC project girls ages 9 to 17 years who are in the DREAMS program and are eligible to be enrolled into the OVC program. The project will work with other DREAMS partners in Kiambu County to form a County DREAMS partners' forum. This forum will as safe space for partners to share best practices, discuss quality improvement issues, share and review data to avoid double dipping amongst the girls and other trouble shoot on arising issues.

## OBJECTIVE 2: INCREASED UPTAKE OF TARGETED HIV TESTING SERVICES

The cascade of HIV care begins with identifying HIV positive individuals who will be subsequently linked to care and initiated on ART to ultimately achieve viral suppression. By APR COP17 the activity has a testing target of 570,743 and 12,445 HIV-positive. By end of Q4 of COP 17, Afya Kamilisha had tested 507,668 of the targeted 570,743 clients and identified 8,184 of the targeted 12,445 HIV-positive clients. In COP18, Afya Kamilisha is targeting to test 498,799 clients, identify 14,792 new HIV positive individuals and link 13,313 (95%) to ART.

In line with PEPFAR priorities, high yielding targeted interventions be the focus for COP 18. These interventions will be implemented across 283 facilities in the nine Kamilisha counties. In counties with high targets e. g *Murang'a, Tharaka Nithi, Kiambu* and *Meru;* PITC will be provided routinely to increase testing coverage. On the other hand, the rest of the counties will focus on PNS and other targeted approaches. The key strategic approaches include: engaging *HTS counsellors* in high volume facilities, *supportive supervision* and *mentoring* of HTS providers. HTS providers will utilize *index client follow-up*, assisted *partner notification services* (PNS), and HIV *self-testing* (HIV ST). Other interventions include risk screening in provider-initiated testing and counselling (PITC) settings. This will be done in antenatal care clinics (ANC), child health units, outpatient departments (OPD), and in-client settings. Other HTS approaches targeting those in need will include HIV testing for adolescent girls and young women (AGYW) in the DREAMS program in Kiambu, and testing for children in OVC program.

### ACTIVITY 2.1 STRENGTHEN HUMAN RESOURCES FOR HEALTH CAPACITY AND SUSTAIN HIGH QUALITY HTS

In COP 17, Afya Kamilisha engaged 128 HTS counsellors across 96 facilities. In COP 18, the project will increase HTS counsellors to 180 and deploy them across the 169 ART facilities. This will ensure that all 169 high volume facilities can rely on having one or more HTS counsellors available to cover all testing areas and to escort clients to the CCC for linkage to treatment. Each counsellor, will test a minimum of 300 clients per month (15 clients per day for 20 working days each month). Roving HTS providers will support facilities with no counsellors, specifially during busy days when many clients show up at these facilities. The deployment of HTS counsellors to the 169 CCC facilities is expected to yield 11,833 HIV positive individuals, 80% of the total COP 18 targets.

#### Activity 2.1.1 Conduct Annual Refresher trainings for HTS providers

Annual refresher trainings will be conducted for 350 HTS providers (180 HTS counsellors, 120 nurses and 50 Laboratory technologists) in line with NASCOP requirements. This will ensure that HTS service providers are updated on National HTS Guidelines, PNS guidelines, self-testing guidelines and national testing algorithms.

### Activity 2.1.2 Conduct monthly HTS providers debriefing meetings

HTS providers will hold monthly review meetings to track facility performance and achievement towards the targets. These meetings will create forums for learning and sharing experiences and capacity building for the teams. During the meetings, counsellor supervisors conduct debriefing and supervision sessions. The sessions assist address HTS providers' burn-outs. The meetings will be held within the facilities and will incorporate other cadres that are offering HTS services.

### Activity 2.1.3 Sensitize HTS counsellors to provide gender responsive services

HTS counsellors need skills and knowledge on gender responsiveness when offering HTS services. They need to understand gender and social norms, social determinants of health, GBV, sex and sexuality, gender-sensitive and rights-based care, couple counselling, and male friendly services. The project sensitized 128 HTS providers by APR COP 17. An additional 52 HTS counsellors, 100 nurses, and 45 lab technologists will be sensitized in COP 18. This will enable the HTS counsellors empower their clients during counselling sessions to address gender inequalities within their relationships such as having an open discussion about risky sexual behavior with their partners, negotiating for safer sex, intergenerational sexual relations, and addressing sexual and gender-based violence when appropriate. Afya Kamilisha will conduct sessions on gender and HIV issues during the monthly meetings based on the gaps identified in the course of provision of services.

### Activity 2.1.4 Sensitize HTS counsellors on adherence counselling

Optimal adherence is key to maximize the benefit of use of ARV for attainment of long-term viral suppression, improve client's health, and reduce transmission of new infections. HTS providers will be sensitized on basic adherence counselling skills so that they can initiate adherence counselling as soon as the client has tested positive. This will be done routinely during the monthly meetings.

### Activity 2.1.5 External and Internal quality assurance (QA) mechanisms.

Internal QA mechanisms such as observed practice by supervisors, client exit interviews, counsellor self-assessment and debriefing meetings between HTS counsellors and supervisors will be held routinely. The project will facilitate HTS service providers from supported sites to participate in all rounds of proficiency testing (PT) – an External Quality Assessment conducted by the national laboratory. This will be followed by supporting sub county medical laboratory technologist (SCMLTs) conducting corrective action and preventive action (CAPA) targeting participants with unsatisfactory performance after every round. SOPs and Job-aids on proficiency testing will be distributed to supported sites.

## ACTIVITY 2.2 SCALE-UP PARTNER NOTIFICATION SERVICES

In COP 17, Afya Kamilisha scaled up PNS services targeting sexual contacts and family members of index HIV positive cases to 120 facilities. Partner notification services, which yielded higher positivity rates in COP 17 at 29% in Q4, compared to the other interventions, will continue to be a major strategy for the project. In COP 18, Afya Kamilisha will scale-up PNS to 169 facilities across the 9 counties and aim to identify 3,192 new HIV positive clients through this strategy. The project will optimize the PNS cascade by improving PNS testing uptake among elicited contacts from 67% to >80% and eliciting contacts of non-suppressing HIV positive patients already on treatment. The project will also utilize the roving strategy whereby PNS-trained HTS counsellors based in the high volume facilities will be attached to proximal smaller volume facilities. They will work in that facility at least one day in the week and will provide PNS services and follow up on linkage to ART for all clients tested in that facility.

The HTS providers will utilize counsellor-supported disclosure to empower clients disclose their status to their partners in a way that ensures their comfort and safety. HTS providers will be provided with phones, airtime and transport to reach out to listed contacts and provide services in places where the clients are most comfortable.

### Activity 2.2.1 Conduct PNS training to scale up facilities providing PNS services

Afya Kamilisha will train the 52 additional HTS providers and 42 nurses and clinicians on PNS for a total of 228, the existing 128 HTS counselors included. The nurses and clinicians will complement the PNS work done by HTS counsellors. This will facilitate the scale up of PNS services to 169 sites by end of COP 18. PNS providers will be mentored to increase elicitation and testing uptake.

PNS providers who are able to expand sexual networks of index clients will be motivated through a result-based approach. They will be expected to identify sexual and social contacts of all newly diagnosed HIV-positive clients, as well as clients already enrolled in care and treatment services. Clinical officers and nurses will be sensitized to elicit sexual partners for PNS during CCC clinical visits and PMTCT sessions.

## ACTIVITY 2.3 IMPLEMENT TARGETED PITC IN OPDS INCLUDING TUBERCULOSIS CLINICS AND INPATIENT

To optimize facility testing coupled with use of eligibility screening tools, HTS services will be offered in all service delivery points in 169 high volume facilities. As at COP 17, the 98 high volume facilities with sessional counsellors contributed to 3,273 (85%) of the HIV positive clients identified. In COP 18, the project aims to identify 8,303 HIV positive clientst through sessional counsellors. The project will support additional counsellors in 169 high volume facilities to cover all service delivery points (Outpatient, Inpatient, ANC, VCT, and TB). To ensure adequate coverage and improved uptake of HTS services, the project will engage an additional 52 trained HTS sessional counsellors (non-clinical) for a total of 180. Departmental heads meetings will be utilized to allocate PITC targets to healthcare workers and review departmental performance. Site and counsellor HTS targets allocation and weekly performance review will be an agenda at the departmental meetings. Health talks will be offered at the OPD, and IEC materials mounted to maximize the utility of waiting time. On job mentorship for health care workers (trained nurses and lab technicians) to provide targeted HTS will be provided continuously to complement the work done by the sessional counsellors. Sensitization for clinical officers will be done through CMEs for them to gain skills in conduct screening and refer symptomatic patients for HTS .The project will establish extra testing spaces through provision of tents at 15 high volume health facilities with inadequate testing space. HTS counsellors working as volunteers within the facility will be utilized to provide HTS services at health facilities to provide additional man power. Afya Kamilisha will ensure that all clients attending tuberculosis (TB) clinics for presumptive or confirmed cases of TB are tested for HIV. Where TB/HIV services are already integrated, Afya Kamilisha will support healthcare workers to ensure ART is initiated as soon as possible. For those sites where services are not integrated, clients testing positive for HIV will be referred to CCCs for ART initiation and subsequent management of HIV.

Though the positivity for inpatient testing is relatively low at 0.7%, HTS providers will visit all the in-patient wards daily, and provide HTS services to all newly admitted clients with unknown HIV status. All identified HIV-positive clients will be initiated on treatment appropriately before discharge. Those willing be started on ART in other facilities will be provided with a referral note. The project aims at identifying 771 HIV positive clients through inpatient testing.

### Activity 2.3:1 Implement strategies for reaching men

In COP 17, 34% (2,791) of the total tested positive clients were male. The project will intensify testing through targeted outreaches and PNS in facilities neighboring hotspots in high burden counties namely; Kiambu, Murang'a and Meru. Known areas, hot spots, or populations of higher HIV prevalence, include: In Murang'a: Kenol, a stopping spot for long-distance drivers and Del Monte and Kakuzi Corporate farms in which house migrant workers and educational institutions. Makuyu Health Centre will provide HIV services to this population. In Meru: Khat trading areas. Kangeta Health Centre and Nyambene District Hospital provide HIV services to this population. In Kiambu, Makongeni town on the Nairobi-Garissa highway, which is home to numerous migrant workers. Makongeni Health Centre will provide HIV services to this population. To ensure that all eligible clients

benefit from this service, HTS providers will visit homes, informal workplaces and social places and provide HTS services to male sexual contacts identified but unable to visit the facility for services. The Project will have 8 high-volume facilities by end of COP 18, offering extended hours and weekend testing and scale up to 21 in COP 18. These health facilities in high burden counties will be staffed with male HTS providers to increase HTS accessibility for men. The project aims to identify 14,792 HIV positive individuals in COP 18, of which 4,728 (32%) will be male >15, and 946 (20%) will be contributed by extended hours/ weekend clinics.

### Activity 2.3.2 Implement strategies for reaching children

As stated in COP 17, June 2018 report, a total of 29,743 children, below 15 years were tested for HIV, with 369 (0.9%) identified HIV positive. In COP 18, the project targets to identify 182 HIV positive children < 15 yearsm, through targeted testing at pediatric clinics, MCH/CWC, pediatric wards, and IMCI Clinics. All children seen at the above clinics and are of unknown status will be tested for HIV. All eligible children of adults receiving HIV service (PMTCT, Care, ART) will be offered HTS service through either facility or home-based index case testing. The project will work at strengthening Early Infant Diagnosis for HIV-exposed Infants; pediatric case finding and also Work with OVC partners in the 9 counties and DREAMS partners in Kiambu county to ensure all eligible children receiving OVC and AYGW prevention services are tested for HIV. Index teens in the adolescents support groups will be encouraged to refer their peers to the facility for HTS services. The project will conduct a retrospective analysis of data for HEI and mothers lost from PMTCT program and work to offer HTS services and appropriate linkage services to contact them and have all their children traced and tested.

## ACTIVITY 2.4 ROLL OUT HIV SELF-TESTING FOR CLIENTS WITH LIMITED CONTACT WITH HEALTH FACILITIES

With guidance from NASCOP and USAID, Afya Kamilisha will utilize trained HTS providers in facilities in the nine counties to roll out self testing. The provider will encourage index clients to distribute self-test kits to their sexual contacts who are not willing to access HTS services at the facility due to barriers like working hours, fear of stigma and discrimination, inability to finance transport, etc. This will mainly be for mothers attending ANC, PNC and FP services, and other high risk clients with partners of unknown status.

## ACTIVITY 2.5 PROVIDE CONDOMS AND SAFER SEX MESSAGES FOR HIV-POSITIVE AND HIV-NEGATIVE INDIVIDUALS

Afya Kamilisha will ensure that male and female condom dispensers are placed strategically within all service delivery points, and that healthcare workers dispense male and female condoms free of charge during one-on-one client interactions. Healthcare workers will also provide education and counselling on STI screening and treatment to both HIV positive and negative clients, and adherence counselling (including the importance of viral suppression for health improvement and reduced transmission risk) to HIV positive clients. The project will provide the facilities with penile and vaginal models to the facilities. These will help the providers to demonstrate condoms during the HTS sessions. The HTS providers will inform clients receiving HTS services about the LVCT Health managed toll-free hotline, 1,190, for additional information and counselling on HIV prevention, sexual and reproductive health issues, safe sex, condom use and other health information. High risk HIV negative clients will be referred to other services including PrEP and VMMC for male clients.

## ACTIVITY 2.6 INTEGRATE GBV PROTOCOLS INTO OUTPATIENT SERVICES

Afya Kamilisha will continue to support fourteen sites which are currently offering comprehensive GBV services (including access to emergency contraceptives and introduction to family planning services, PEP as needed) to survivors of sexual violence. An additional ten sites will be supported in COP 18, to enable the project provide services to clients who experience other forms of violence. The project has developed a data collection tool that

will enable disaggregated data for both physical and emotional violence to be reported. Afya Kamilisha will conduct mentorship and CMES to ensure continuous capacity development for healthcare workers and enable them report all forms of violence. The facilities will be provided with job aids and reporting tools that comply with national guidelines. Social workers, police, and community leaders who have previously been trained and sensitized in GBV prevention will continue providing a strong link for facility and community referrals. Through working with other stakeholders e. g gender officers, children officers ,legal officers and local administration, Afya Kamilisha will ensure that clients who have experienced GBV are referred for social support, legal services, and trauma counselling, depending on their immediate and individual needs.

### PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

To reduce the vertical transmission, early HIV testing and identification of HIV positive pregnant women and screening of all breastfeeding women at all entry points is key to ensure prompt ART initiation, routine VL testing to monitor adherence, and ensure viral supression and thus reduce the risk of MTCT of HIV in this critical period. In addition to synchronizing of Early Infant Diagnosis(EID) with immunizations at Maternal and Child Health(MCH) unit. The antenatal clinic, maternity services and post-natal services provide opportunities for identification of mothers living with HIV and testing of exposed infants for the appropriate interventions. Gaps identified in the first year of implementation include; late ANC1 attendance, low uptake of EID before 8 weeks and lack of integration of ART in MCH units in lower volume sites. The major strategic approaches that will be used in FY19 include; intense mobilization of pregnant women for early ANC, integration of eMTCT services at MCH across the counties, psychosocial support groups (PSSGs), deployment of nurses and mentor mothers in high volume facilities, collection of EID and viral load samples during psychosocial support groups meetings and mentorship and supervision of healthcare workers.

### ACTIVITY 2.7 IMPLEMENT PITC IN ANC, MATERNAL, AND CHILD HEALTH UNITS (MCH)

As of COP 17 Q4 Afya Kamilisha had tested 71,297 of the targeted 77,235 pregnant women for HIV and identified 1,942 positive ones. Meru, Embu and Kiambu contributed 67% of all the pregnant women tested for HIV. In COP 18, Afya Kamilisha intends to reach 67,467 pregnant women at ANC1, identify 2,185 HIV-positive and enrol a minimum of 2,089 on ART. The major strategic approach to achieve COP 18 testing of pregnant women at first ANC will involve; training of 669 nurses to provide HTS in the 223 sites offering ANC services. The project will also deploy HTS counsellors to test women at MCH, postnatal clinic and maternity to reduce the missed opportunities. To increase testing coverage, 669 health care workers will be trained on HTS focusing on dual HIV-syphilis test kits and self-testing rapid kit. The project team and MOH PMTCT county coordinators will conduct on-site mentorship and continuous medical education (CME) for nurses in ANC and maternity wards. HIV positive pregnant mothers will act as a link to family testing and partner notification services (PNS), including testing of exposed infants who are missed at immunization.

In hard to reach area in Murang'a and Tharaka Nithi Counties the project will leverage on Beyond Zero mobile clinics to reach pregnant mothers and link HIV positive women to supported sites. Across the eight counties, the project will identify and test all women who present to labour wards and postnatal clinics with unknown HIV status.

### ACTIVITY 2.8 INCREASE UPTAKE OF TESTING AMONG PREGNANT ADOLESCENT GIRLS AND YOUNG WOMEN (AGYW)

As at the end of COP17 , 30,840 pregnant Adolescents Girls and Young Women (AGYW) were reached with HIV testing services with 486 (1.6%) being identified as HIV positive and 476 (99%) started on ART. Meru (Igembe and Tigania sub-counties), Kiambu and Embu counties contributed to 69% of the AGYW identified as HIV positive.

Currently the project is supporting age-specific PSSGs at Makongeni dispensary in Kiambu County with 15 HIV positive AGYW enrolled and on ART. In COP 18, the project will scale-up age-specific PSSGs, Mentorship and continuous medical education (CMEs) on adolescent package of care in the three Counties of Kiambu, Embu, and

Meru. The project will link HIV positive AGYW in PSSGs where they will be followed up for 24 months to enhance adherence and retention to ART. Currently Kamilisha is offering preconception care at MCH and CCC, family planning and mentorship to health workers at MCH on pregnancy intention screening. In COP 18, key focus will be on the integration of family planning services in all entry points including CCC to ensure positive women are able to be offered family planning as per their choice, preconception care and placement of family planning job aids in all entry points.

## ACTIVITY 2.9 INTEGRATE ART IN MCH ACROSS AFYA KAMILISHA COUNTIES

Afya Kamilisha has 223 PMTCT supported sites. Meru, Embu and Kiambu counties account for the majority (53%) of these sites i.e 55, 36 and 27 respectively. Uptake of maternal HAART and infant prophylaxis is at 98% of the HIV positive pregnant women identified at ANC1. This was due to fully integration of ART in MCH in 153 (69%) sites and continuous mentorship on the same. Twenty (20) sites (9%) are partially integrated while 50 sites (22%) are not integrated. Key challenges hindering integration within the counties include:- infrastructure and inadequate MCH staff hindering complete integration of ART in MCH in 50 low volume sites.

Kamilisha will work with all supported counties, sub-counties and facilities, to fully support ART integration in all supported MCH units including those at FBOs and private facilities to reach 95% ANC1 coverage. The health care providers (HCPs) in all sites will be mentored on ART integration at MCH, ART provided and all HIV positive pregnant women initiated on ART at first contact. In addition to mobilizing positive women during outreaches in hard to reach counties. This will increase the coverage for ANC and identification of HIV positive pregnant women. The newly identified positive women will be monitored using viral load six months after initiation of ART while the known positive pregnant women will receive a viral load test at first ANC visit and six monthly thereafter as per the PMTCT guidelines. The non-suppressed women, will be enrolled in viremia clinic and in PSSGs supported by mentor mothers and trained health care providers to achieve suppression. In addition, the project will use CMEs, mentorship, OJT and supportive supervision to train the nurses and clinical officers in line with the national PMTCT 5th edition guidelines.

To increase male engagement, pregnant women will be encouraged to attend ANC1 with their partners. At the facility the health workers will be sensitized to prioritize couples at MCH. focus will be given to the male partners who attend PSSG meeting to be mentored as mentor fathers in COP 18. The HIV positive pregnant women will be supported and clinic days synchronized in order for the women to be seen with their partner at MCH.

Retention into care and treatment at 12 months for pregnant women has increased to 88% in 2018 compared to 80% in 2017(maternal cohort analysis). 2,228 exposed infants were reached with EID testing across the counties at 12 months. EID before 8 weeks has improved from 53% at SAPR to 84% in quarter 4. Majority (400/577) of the infants were tested in Embu, kiambu and Meru counties 83%,93% and 88% of the infants were tested before 8 weeks respectively. Kamilisha will work towards improving the uptake of early infant diagnosis (EID) and synchronization of Immunization with EID in the 223 supported sites in order to achieve over 85% EID testing before 8 weeks of age.

As of COP 17 Q4, positivity for HEI tested before 12 months was at 3.9%. Most of the infants who turned positive after 2 months had been missed during the strike in 2017. Kamilisha will work towards achieving elimination of mother to child transmission (EMTCT) of HIV with the goal of having transmission rate below 2% before 8 weeks of age and 5% at 18 months in all the 9 counties.

## ACTIVITY 2.10 INCREASE UPTAKE OF EARLY INFANT DIAGNOSIS (EID)

As of COP 17 Q4, 2,228 (102%) of the targeted 2,285 HIV exposed infants (HEI) were reached with testing before 12 months, with 1,613 (72%) receiving the PCR test before 8 weeks of age. The performance was contributed by monthly validation of EID samples and mentorship at the site level. In COP 18, Afya Kamilisha, targets to test 434 HEI by 12 months of age, of whom at least 369 (85%) will receive polymerase chain reaction (PCR) tests before 8 weeks of age. Where feasible, the project will assist the health facilities to carry out birth testing (primarily in scale

up counties of Meru, Murang'a, and Kiambu). EID provision will be scaled up from the 153 sites currently offering the services to all 223 supported PMTCT sites. The project will work towards reducing the primary turnaround time (from collection to testing laboratory) of EID samples to 2 days from the current 7 days. This will be done through coordinated transportation of samples using motorcycle courier (boda boda) services, laboratory networking and strengthening the service provider skills. Kamilisha will leverage on other programs and county government to provide basic equipment and supplies required for HIV counselling and testing to children and their guardians at first contact.

One major gap documented in the EID sample validation report is erroneous filling of the PCR request forms at facility level. To mitigate this, Afya Kamilisha will train all the health care providers on the new EID log and laboratory requisition form. The project has already printed, distributed and mentored Health care workers on the same. Mentorship on the correct use and documentation will continue in YR2. In addition, Monthly validation of EID website data at site level and integration of Immunization with EID will be intensified in COP 18. This will be done by; - conducting EID training targeting the HTS counsellors, nurses and other service providers working in under-five immunization clinics to enable them integrate immunization with EID and test all malnourished under-fives with unknown HIV status as per the national testing guidelines.

## ACTIVITY 2.11 INCREASED UPTAKE OF VIRAL LOAD AMONG PREGNANT AND BREASTFEEDING WOMEN AND BASELINE VIRAL LOAD FOR THE POSITIVE INFANTS

Kamilisha will monitor the progress of pregnant and breastfeeding women using viral load. As reported in Annual Programme Report (APR) maternal cohort analysis 1,487 pregnant and breastfeeding women had a viral load done with a suppression of 93%. Non-suppressing patients will be linked to viremia clinics for case management and follow up of the mother baby pair. In addition, trained mentor mothers and 22 nurses hired by Kamilisha will support SMS reminders, and link all HIV positive mother baby pair to psychosocial support group where monthly line-listing of client due for viral load and EID will be done. HIV positive infants will be done a viral load while sending the confirmatory test.

## ACTIVITY 2.12 ENGAGE NURSES AND MENTOR MOTHERS TO PROVIDE SERVICES AT MCH

Kamilisha will continue to engage 22 nurses to be placed in 22 high volume MCH sites with HRH constraints to augment the County clinical staff in providing services. The HRH staff will contribute highly to will increase MCH coverage and testing uptake to over 98%, support integrated mobile outreaches, bleed HIV positive women viral load and EID during PSSG and collaborate with mentor mothers to increase ART coverage among HIV positive women. In COP 18, Kamilisha will increase the number of mentor mothers (MM) from the current level of 40 to 70, and increase the number of high volume facilities covered by the MM from 38 to 63. Through this investment, initiation of HIV positive mothers on ART, and retention on treatment are expected to be realized. Both cadres of staff will also be utilized to support psychosocial support groups and defaulter tracing for the mother baby pair lost to follow up.

## ACTIVITY 2.13 PROVIDE ASSISTED DELIVERY SERVICES FOR HIV-POSITIVE PREGNANT WOMEN

Afya Kamilisha supported the sites with maternity units with capacity building on; - testing of women with unknown status, provision of ART and safe delivery. As COP 17, APR, Kamilisha supported sites contributed to 32% of the hospital deliveries from HIV positive women, with Meru, Tharaka Nithi and Embu counties contributing 82%, 81% and 76% respectively. Major gaps in hospital deliveries are identified in Igembe and Tigani sub-counties in Meru and in Maara sub-county in Tharaka Nithi County due to the poor infrastructure and vast distance from one site to another. Kamilisha will leverage on the beyond Zero mobile clinics to access hard to reach areas. The project will enhance preconception care for all HIV positive women in MCH and CCC and integrate family planning in CCC and maternity.

HIV positive pregnant women enrolled in psychosocial support groups (PSSGs) have shown to be more likely to deliver in hospital compared to women not enrolled in PSSGs. Data reviewed in Meru county for HIV-positive

women enrolled and those not enrolled in PSSGs , reviewed showed that women enrolled in PSSGs were more likely to deliver at facilities compared to those not enrolled in PSSGs (96% and 60% respectively). Kamilisha will support PSSGs in all 223 ANC sites to ensure timely enrollment of HIV infected women into the groups. In addition, ANC providers will offer intense counseling to HIV infected pregnant women, discuss on ARV prophylaxis for the mother-baby pair and work with them to develop a birth plan that includes a preferred facility for delivery. The project will strive to link all HIV positive pregnant women during the PSSG meetings. In addition, the nurses in MCH and mentor mothers will walk the HIV positive mothers through the maternity and explain the procedure to them so as to allay any fears and misconceptions and encourage them to deliver at the facility.

Meru County has shown an increase in hospital deliveries from 54% in 2016 to 65% in 2017 with the introduction of "Linda Mama" programme, a need-based initiative by the NHIF that covers the costs from antenatal period to delivery. Kamilisha will sensitize the health facilities to ensure all pregnant women receive NHIF card to support through delivery. The project will support ANC providers to send SMS reminders to HIV infected women during their pregnancy to reinforce self-care messages and encourage facility-based delivery.

## ACTIVITY 2.14 ENHANCE ADHERENCE AND RETENTION TO ART FOR PREGNANT AND BREASTFEEDING WOMEN AND THEIR INFANTS

Use of mentor mothers (MM) and psychosocial support groups (PSSG) strategy has shown to improve the adherence and retention among the mother baby pair. In COP 17, Kamilisha supported 96 PSSGs across 84 PMTCT sites for a total of 2500 pregnant and breastfeeding women enrolled. Higher retention rates of 96% was reported for the women enrolled in PSSG and linked to mentor mothers at SAPR. Psychosocial support groups will be increased to cover all sites with more than five HIV positive women with an aim to reach over 95% HIV positive women within the region. The HIV infected breastfeeding women and their partner who are suppressed and adhere to ART will be given a longer period. However, they will be asked to bring the infants for monitoring as per the schedule. At the end of COP 17, 12% of mother baby pair were lost to follow up (EID cohort analysis), with Meru, Embu and Tharaka-Nithi Counties accounting for 14%, 13% and 17% respectively. The project will provide phones and airtime to support the mentor mothers in carry out tracing for all mother baby pair lost to follow up and re-link them back into treatment. Mentor mothers will be supported with Lunch and transport to be able to reach the HIV positive women at community level.

## ACTIVITY 2.15 INCREASE THE QUALITY OF CARE OFFERED TO THE MOTHER-BABY PAIR

To achieve elimination (below 5% MTCT) and infant survival, exposed infants and their mothers must be retained in HIV treatment and care for close monitoring as well as IYC feeding counseling. A PCR positive audit for 149 infants conducted in COP 17 acrose the 9 counties. Major reasons identified contributing to HEI turning positive included: late attendance of ANC leading to delayed initiation on ART, denial mostly for the AGYW group and poor ART adherence/defaulting by mother, inter-facility referrals from private facilities. Kamilisha will target to audit all the HIV positive infant and link them to ART.The project will continue to support County supervision teams, healthcare workers and mentor mothers to review records of mother-baby pair against outcomes on the NASCOP EID website. For cases of seroconversion, the team will use Positive audit tool to identify factors contributing to seroconversion and develop facility specific plans to prevent future transmission.

The project will support the 223 sites mentored on use of SIMs tool to monitor the quality of PMTCT interventions, identify priorities and develop joint action plans with site teams. Subsequently Kamilisha, CASCOs and SCASCOs will use SIMS tools to supervise the sites. In COP 18, Kamilisha will expand the reporting of HCA in DHIS from the current 40 sites to 80 high volume sites to strengthen the monitoring of mother-baby pair.

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

Linkage to treatment is a critical step in the HIV care cascade that ensures that HIV-positive individuals identified are started on treatment on the way towards epidemic control. Afya Kamilisha will advance the second 90 of the 90-90-90 UNAIDS goals by ensuring patients with confirmed HIV infection are linked to treatment.

As of COP 17, the linkage to treatment stood at 74%. In COP 18, the project will link at least 90% of the 14,792 new HIV positive cases targeted for identification, for a total of 13,313. The main strategy to be scaled up by Afya Kamilisha are same day enrolment, deployment of linkage officers, enforcing utilization of the revised HTS register, client escorts, data validation to account for positives identified in the previous periods, phone tracing for the lost clients. Working with Sub county HIV coordinators, project will conduct monthly meetings where all HIV partners will account and validate linkage outcomes for all clients tested in their facilities.

### ACTIVITY 3.1 DEPLOY LINKAGE OFFICERS

Afya Kamilisha will deploy 10 linkage officers in high volume facilities and their role will be to coordinate and track all the referrals within and outside the facility and to provide updated reports on the status and outcome of all referred clients. They will physically escort HIV positive clients from HIV testing points to ART initiation points. The linkage officers will report the weekly and monthly linkage outcomes and also update the MDTs and sub county teams on the linkage progress.

### ACTIVITY 3.2 ENSURE IMMEDIATE LINKAGE TO SERVICES AND RAPID ART INITIATION

Afya Kamilisha will strengthen the strategies that are working and discard the ones that didn't produce the desired results in COP 17 like use of CHVs to link positives identified at the community. In COP 18, the project will implement the following strategies; client escorts to ART initiation and psychosocial support, utilization of the revised HTS registers to capture linkage data and same-day enrolment policies. Afya Kamilisha will hire a Linkage Focal Person in consultation with the facilities whose role will be to coordinate and track all the referrals within and outside the facility and to provide updated reports on the status and outcome of all referred clients as well as ensuring all the new clients get thorough adherence counselling, linking them to PSSG and also ART services. Additionally, the project will support weekly meetings at the facilities and monthly at sub-counties to validate HIV positive clients and linkage outcomes and address the emerging gaps. In the situation where a client opts to access care services at a facility other than the one that provided testing services to them, the Linkage Focal Person will communicate with the receiving facility, track client enrollment over the phone, and document the outcome in the referral and linkage register.

HIV-positive clients identified in other parts of a facility — particularly inpatient wards; will be initiated on treatment by healthcare workers trained in HIV care and treatment. These providers and Linkage Officers will link inpatient-clients for continued follow-up and adherence support after discharge. If the client is unable to make a same day visit after identification, the linkage officer will set an appointment for the client and enter the information in HTS register (Linkage section in the register) for follow up and tracking. Clients testing in non-ART sites will be connected with a Linkage Officer from the CCC of their choice.

### ACTIVITY 3.3 PROVIDE ENHANCED DIAGNOSIS OF TB FOR HIV–POSITIVE CO-INFECTED INDIVIDUALS

As TB remains the largest killer of HIV infected patients, Afya Kamilisha is committed to tackle TB/HIV to produce the greatest impact and reduce morbidity and mortality associated with TB/HIV co-infection. As HIV infection is a life threatening condition in TB co-infected individual (including DR TB), Afya Kamilisha will be in the front line in the nine supported counties within the region of operation in offering collaborative TB/HIV services with the aim of reducing the burden of HIV and TB for individuals and communities. This will be done under a framework of a joint TB and HIV programing engraved in the TB/HIV collaborative activities. Specifically, the activities will

center on establishing mechanisms for joint TB and HIV collaboration, decrease the burden of TB in PLHIV and decreasing the burden of HIV in TB patients. In addition, activities will include synergized program management and better targeting of resources through synergies and efficiencies gained.

### Activity 3.3.1 Intensive and active case finding

HIV is the strongest risk factor for developing tuberculosis (TB) disease in those with latent or new Mycobacterium tuberculosis infection. Screening all PLHIV for TB is paramount for early detection, prevention and treatment of the dually infected patient. By the end of COP 17 Q4, HCW had screened; using clinical algorithm for Intensive TB Case Finding a total of 42,325 (96%) of 44,314 HIV-positive clients currently on care.

### Activity 3.3.1.1 Intensive TB case finding

Afya Kamilisha will strengthen TB screening for all PLHIV clients accessing CCC for ART. This will be achieved by offering quarterly Technical Assistance (TA) and mentorship to HCW on quality TB screening at each clinical visit using the). In addition, peer educators supported by the project through OJT on fast tracking any patient presenting with a cough at the waiting bay for assessment by the clinician. Presumed TB cases will be encouraged to use designated areas for sputum collection, submission to the laboratory. Kamilisha with support facilities to fast-track sputum results. The peer educators will explain to the patient on return date for feedback. Training of HCW on ICF will be integrated in the clinical care training.

To improve efficiency in TB diagnosis and find missing cases, the national TB program is expected to adapt Tuberculosis Lipoarabinomannan (TB LAM) diagnostic method during COP 18. TB LAM will be used to compliment GeneXpert to detect TB, particularly for specific groups of PLHIV with low baseline CD4 count and patients with advance HIV disease. Once officially launched, Afya Kamilisha will support the roll out of TB LAM in focus County CCC's. To ensure successful role out, Kamilisha will collaborate with NTLDP and other HIVTB implementing partners in sensitization of healthcare workers on TB LAM. To optimize the use of the new technology, TB LAM sensitizations will focus on HCW providing care and the laboratory personnel.

### Activity 3.3.1.2 Active TB case finding

Active TB case finding will be done for all clients seeking services in HTS service delivery points using symptom screen in an effort to find missing TB cases. To leverage on existing HTS counsellors, Afya Kamilisha will orientate these counsellors to integrate and strengthen TB screening while offering HIV testing to clients (including linkage to treatment, where applicable) in line with the NTLDP ACF guidelines. Through TA to these service delivery points, the project will offer on job training and mentorship where gaps are identified.

### Activity 3.3.1.3 TB specimen transportation

Afya Kamilisha will support transportation of collected specimen (including sputum) onsite to the nearest Gene Xpert hub through an established laboratory sample networking system used to transport blood for viral load and EID. To ensure timely management of identified cases, Afya Kamilisha will support timely relay of results through GeneXpert Alert and transportation of hard copies of results using the established system. Afya Kamilisha will also support all nine Gene Xpert machines currently within focus counties by procuring service contracts. By the end of COP 17 Q4, utilization of the nine Gene Xpert machines was at an average of 56%, which is 19% below the national target. The project will strive to increase utilization of the Gene Xpert machines by sensitizing health care workers on the indications for Gene Xpert in TB diagnosis (and use in EID and viral load). This will be achieved through onsite CMEs and departmental visits for sensitization. Afya Kamilisha will support facilities that host the hubs to ensure that Gene Xpert remains the first diagnostic screening test for all TB presumptive cases irrespective of their HIV status in line with the national TB program recommendations.

### Activity 3.3.2 TB drug resistant support

To improve management and quality care for dually infected DRTB patients, Afya Kamilisha will offer technical assistance and participate monthly clinical surveillance meetings where HIV co-infected DRTB clients are discussed in a Multi-Disciplinary task force. These activities will be done in collaboration with other partners.

### Activity 3.3.3 Provision of isoniazid preventive therapy

Isoniazid preventive therapy has been shown to reduce TB infection amongst HIV infected persons and prevent progression of dormant TB in this group. Afya Kamilisha has been actively working with facilities and county health management teams in the nine counties of operation to increase IPT uptake amongst PLHIV. Every effort will be made to ensure that PLHIV's who screen negative for TB at patient support sites, will be initiated on IPT after adherence counselling is done. For those who develop active TB while on ART (and may be on IPT), they will be initiated on anti TB medication according to the national guidelines.

By end of COP 17, the project had cumulatively initiated, 44,314 patients on IPT out of 57,038 ever on ART. Afya Kamilisha will work with the supported sites in line listing all patients who have never been initiated on IPT. These patients will be evaluated for IPT eligibility and initiated as soon as possible. HCW in these sites will be oriented on the eligibility criteria for IPT initiation, dosing, toxicity, and monitoring, and on the provision of intensive adherence and follow-up support. Peer educators who have successfully completed IPT will be recruited as treatment champions. To assist target counties in monitoring IPT uptake among PLHIV, Afya Kamilisha will provide TA to strengthen IPT reporting to the DHIS. The project will also support initiation of IPT among pregnant and breastfeeding women in the PMTCT clinics and provide IPT for children under 5 who are exposed to active tuberculosis

### Activity 3.3.4 TB/ HIV integration

Integration of TB and HIV services provides comprehensive care and is convenient to clients seeking both services as the client is assessed holistically. Depending on resources and infrastructure available at service provision sites, two models of integration are available. Some sites are fully integrated (all TB and HIV services are provided under one roof) or partially integrated (patients may be referred for some services in another clinic within the facility). By the end of Q4, 98 facilities are fully integrated while 34 are partially integrated. The project will strive to make sure that services to the clients are seamless at both models by strengthening linkages between clinics.

For fully integrated sites, the project will provide TA for sustainability of quality services and train staff where changes take place. For the partially integrated sites, the project will train staff on integration and importance of proper referral mechanisms. Peer educators will be sensitized on referrals and supported to escort clients needing additional services in the other clinics. In addition, the project will continue to provide mentorship to these sites to continue offering quality services.

The project will work with the counties in strengthening the use of TB presumptive registers. The presumptive TB registers will be used to capture all patients who present with symptoms or signs suggestive of TB at the CCC. The presumed TB cases will be referred to the lab to establish their TB status and initiated on treatment if found to have TB.

For elimination of mother-to-child-transmission (eMTCT) (described in detail in Objective 4), Afya Kamilisha will work with facilities to ensure integration of TB/HIV services in MCH, and will provide IPT to eligible HIV positive mothers. All pregnant and breastfeeding mothers together with their exposed infants will have TB screening, and clients with active disease will be referred to TB clinic for treatment to prevent TB transmission at the MCH. The Project aims to achieve this through mentoring healthcare workers and mentor mothers to fast track cough clients, and to strengthen inter-facility referral mechanisms for PMTCT mothers with active TB. These mentor mothers will escort the mothers to TB clinics. Babies of mothers with active TB will have IPT initiated at the PMTCT clinics. Clients will have their appointment dates for TB and eMTCT clinics synchronized to improve convenience.

### Activity 3.3.5 Immediate initiation of ART for TB/ HIV infected clients

All Health Care Workers will undergo a refresher training and proficiency testing alongside the HTS counselors who provide HTS to ensure that all presumptive and confirmed TB cases undergo PITC. Those patients who are dually infected will be initiated on ART within 56 days of TB treatment. The project will provide integrated TA to health care workers on management of TB/HIV co infection and provide job aids and SOPs.

### Activity 3.3.6 Infection prevention and control (IPC)

Noso-comial transmission of TB is a risk to PLHIV, staff and visitors to health facilities. To protect healthcare workers, PLHIV, and other clients, the project will support the implementation of IPC measures within key service delivery points, with an emphasis on administrative control measures. These will include policies and practices to reduce risk of transmission of TB (like patient flow in the health facilities) and respiratory protection with personal protective equipment (e.g. N95R masks and disposable filtering face-pieces). Afya Kamilisha will provide IPC mentorship to healthcare workers. The project will provide IPC job aids and SOP available in sites. The Project will strengthen existing IPC committees (and revitalize any dormant committees) by supporting quarterly facility based IPC meetings to monitor implementation and discuss related matters. The IPC committees will be encouraged to identify and assign a focal person who will be responsible for the TB infection prevention in the health facility. In addition, the project will support health facilities in focus counties to develop TB infection control plans and monitor implementation.

The Project will reorient staff on IPC package, capacitate PEs on cough etiquette and need to fast track coughers for assessment. Health care workers will be expected to provide health education sessions on TB infection. Afya Kamilisha will provide IEC materials and posters (cough etiquette and respiratory hygiene). The project will support biannual health care worker screening for TB.

Afya Kamilisha will support laboratories to decontaminate, store, properly package, and transport waste generated in the laboratory for incineration according to the national guidelines and EMMP recommendations.

### Activity 3.3.7 Commodity management

Success of any project is determined by availability of required commodities. Although Afya Kamilisha is not directly involved in procurement and distribution of TB and HIV commodities, the project is cognizant of the importance of commodity security. The project will provide technical assistance on essential commodity management. Staff will be trained on pharmacovigilance and onsite mentorship provided on ordering, storing, issuing and reporting of commodities. The project will monitor stock status of essential TB commodities and report any impending stock outs to responsible the county administrators.

### Activity 3.3.8 TB/HIV program review

The Project will ensure the incorporation of TB/HIV data into monthly data review meetings at the county and mentor health facilities on use of data that generate for decision making and to improve services. It is anticipated that there will be 2 data review meeting every quarter per county except Kitui County. The project will support quarterly TBHIV review meetings at cluster level.

### Activity 3.3.9 Collaboration with MoH

To ensure that services are provided as expected, Afya Kamilisha will work closely with the County MoH by supporting quarterly joint technical assistance to health facilities. Staff will be encouraged to participate in alternative capacity building methods like e learning. Weekly TB echo provides a platform for sharing lessons and discussing complex TB HIV cases. The project will support participation of 16 TB ECHO hubs by providing internet connectivity where this is missing and monitoring participation of staff in these sessions.

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

Treatment with antiretroviral drugs is key to improvement of the health of a HIV positive individual and ultimately viral suppression and epidemic control. Afya Kamilisha will aim at ensuring all the clients identified and linked are initiated on treatment the same day or within two weeks for those who are not ready to start.

By the end of COP 17, 6,033 (62%) of a targeted 9,723 HIV positive individuals were initiated on ART. In COP 18, the project targets to initiate 13,946 new HIV positive individuals on ART. Peer educators (PE) and clinicians will provide ART adherence support, including risk reduction counseling and condom distribution. Health care workers (HCWs ) will receive comprehensive supportive supervision, technical guidance in supply chain management, in-service instruction in QA/ QI, and opportunities for CME.

The major strategic approaches that will be used include; deployment of health care workers (clinical officers and nurses), and lay workers (peer educators and mentor mothers) in high volume facilities, supervision and mentoring as well as deploying roving clinicians in the low volume facilities and establishing more satellite ART site to reduce on the distance covered by the clients to the main ART site. The project will also intensify age and gender specific intervention like operation triple Zero, Male friendly clinics, pediatric specific clinics, scale up viremia clinics, transition of eligible clients to TLD and differentiated care service delivery model. Additionally the project will customize intervention for different geographical regions based on the challenges encountered.

### ACTIVITY 4.1 DEPLOYMENT OF CLINICAL STAFF TO PROVIDE TREATMENT FOR ADULTS, CHILDREN, AND ADOLESCENTS

Afya Kamilisha will deploy 37 clinical officers in high and mid volume facilities to augment the clinical staff in providing ART services across the 9 Counties. The project will work with the 169 supported care and treatment facilities to fast-track all individuals with confirmed HIV sero-positive status into ART treatment (same day initiation or initiation within two weeks of diagnosis). This will depends on whether clients are willing and ready to take ART and adhere to treatment. The project will strengthen categorization of patients at enrolment based on their presentation: those presenting with advanced disease will have intensive evaluation for opportunistic infection (OI) and management, while those presenting clinically well will be fast tracked, coupled with adherence counseling to prepare them for treatment initiation and long-term care. Newly enrolled clients will have baseline CD4 cell count at the time of ART initiation, although these tests will not be a prerequisite for ART initiation. Afya Kamilisha will provide a technical orientation to healthcare workers on HIV treatment updates or new ART regimens as they are introduced by the MOH.

To improve on retention and viral suppression the project will work with all HCWs involved in patient management to ensure from the testing point, the clients gets as much information as possible as well as ensuring adherence counselling happens at every contact. Additionally the project will support age specific clinic appointments and PSSG meetings targeting pediatrics and adolescents and young people as well as men and those who have not suppressed the virus to ensure everyone adheres to treatment. The project will also use colour-coded stickers to identify patients due for viral load in low volume facilities and also utilize EMR systems in the sites where it's functional to flag off patients due for viral load and engage peer educators to call them for bleeding.

#### Adult Treatment:

Afya Kamilisha will provide technical and logistical support to the CHMTs, SCHMTs, and facility health care workers to conduct monthly chart reviews, data abstraction and line-listing of all enrolled clients to identify those not on ART, as well as those due for viral load testing to monitor treatment and to assess suspected treatment failure. PEs will call these clients on phone to return for clinical review and appropriate management. Additionally the project will support the facilities to characterize the defaulters and come up with specific interventions based on the gaps identified.

To ensure male clients are retained into treatment and also achieve maximal viral suppression, the project will do the following:

- Scale up male specific clinics from 25 in COP 17 to 140 care and treatment sites in COP 18.
- Engage male peer educators with well-defined roles,
- Scaling up of male only support groups
- introduce flexi hours to accommodate men's schedule
- Enroll all the stable male clients in differentiated care.

### Pediatric Treatment:

As of COP 17 Q4, 91% (1,433/1,582) of children aged 1-9 years accessed viral load with 988 (69%) suppressing the virus. To improve on viral load uptake and suppression, Afya Kamilisha will ensure at least 95% of children in the supported sites access viral load and 90% suppress the virus. Additionally, the project will provide dosing charts/wheels, and work with the MOH staff to ensure children keep their clinic appointments. Children and their parents/ guardians will be offered special appointment days to attend for clinical assessment and ART refill, ensuring that the special needs in this group are comprehensively addressed. These needs include *growth monitoring, viral load testing, ART dosing, adherence/ pill count, parent/ guardian/ caregiver treatment literacy,* and *disclosure support*. Quarterly appointments for the child and the care giver will be given for those who have suppressed the virus, while on the other hand, more frequent follow-up visits for the non-suppressing clients will be given.

The project will also collaborate with Case OVC for the benefit of children by ensuring that those in need of OVC support are linked and those already enrolled on treatment are suppressed. This support will entail: Identifying OVC enrolled in the project supported ART facilities, monitor their adherence as well as viral suppression, link eligible children for enrollment in OVC program, educate the guardians/care givers on viral load interpretation and share results of their children.

Afya Kamilisha will support children friendly services through orientation and mentorship of health care workers on pediatric ART, establishing children friendly corners and establish age-specific PSSGs. In addition, the project will engage expressive arts therapy counsellors to mentor HCPs and provide services to children with psychosocial problems. The project will work with teachers living with HIV through the Kenya Network of HIV Positive Teachers (KENPOTE) to provide treatment support including adherence counselling to HIV-positive children in school.

Facility MDTs will characterize children suspected of treatment failure together with their guardians/ parents identify and address the root cause of treatment failure. Children suspected of treatment failure will undertake repeat viral load testing after 3 months of good adherence. Those with repeat VL above 1000 copies/ml will receive enhanced adherence counselling and switched to second line treatment.

### Adolescent and Young People Treatment:

The unique needs of adolescents and young people living with HIV calls for innovative and responsive strategies to promote adolescents' HIV status knowledge. By the end of COP 17, adolescents aged 10-19 years had a viral load (VL) uptake of 93% and VL suppression of 66%. However, 58 facilities supported by the project in eight counties had a total of 1,431 adolescents enrolled, with 79% (1,131/1,431) accessing viral load testing and 75% (848/1,131) attaining viral suppression. As a result of the improving trends among the adolescents, the project will scale up the intervention into 70 sites in COP 17 and in 140 ART sites in COP 18.

CHMTs and health facilities teams will be sensitized on adolescent responsive interventions to ensure they are equipped with the necessary skills through mentorships, facility based CMEs and on job training. The Project will utilize the already trained MOH mentors and program officers to provide mentorships to healthcare workers to be able respond appropriately to adolescent needs and to improve on quality of services. Additionally the project will support adolescents' peers in all the high volume facilities who will provide one-on-one and group adherence support.

The project will work with supported facilities to ensure all enrolled AYPs get adequate information on the benefit of enrolling into OTZ clubs and are given an opportunity to join. Through the scale-up, the project aims to increase VL uptake to >95%, and VL suppression to >90%.The project will implement the following adolescent and young person-targeted services:

- Appointments and PSSG aligned to school holidays
- Introduction of flexi hours of operations and weekend clinics to serve adolescents
- Leverage adolescent-responsive technology such as the establishment of WhatsApp groups to bring together adolescents and their providers
- Dedicated clinic days for the adolescents
- Identify and support adolescent champions and motivate them with lunch and transport–during PSSG
- Recognition of OTZ heroes
- Dedicated adolescent corners/spaces
- Monthly Saturday Adolescent Focused Clinic (Saturday Teens clinic)

## ACTIVITY 4.2 ENHANCE TREATMENT LITERACY

Afya Kamilisha will work with all providers involved in patient management to ensure clients get one on one education/counselling as well as a group. The project will also engage professional adherence counsellor who will provide mentorship to the health care providers to be able to provide quality counselling. Additionally HIV education and messaging as well as provision of IEC materials will be incorporated into other activities like morning health talks at the waiting bay, during PSSG meeting and at all patients contacts and will be provided by a trained provider.

## ACTIVITY 4.3 STRENGTHEN ADHERENCE COUNSELING

Adherence preparation, monitoring and support to the client should be tailored based on their level of adherence and the stage of ART initiation and follow up that the clients are now adherent. Adherence counselling will start at the point of diagnosis and continue at the point of initial evaluation and follow up for ART as well as when treatment failure is suspected and/or confirmed and will be a collaborative process between the health service provider and the patient or the care giver. Adherence counselling is a continuous process, provided at every visit/ contact by each member of the MDT. The more PLHIV understand about ART initiation, HIV treatment and long-term effects, the more likely they are to take up and stay on care and treatment. At the facility level, Afya Kamilisha will integrate adherence support into HIV package of service to assist clients on ART initiation and follow up. This package includes at least three adherence support-counseling sessions: Adherence counseling at ART initiation, routine adherence assessments during ART refills, counseling interventions for patients with poor adherence (enhance adherence-counseling sessions). This package is in line with 2016 National ART guidelines and maintains flexibility to meet the needs of individual clients.

The combination of PSSGs, treatment literacy, support to teachers living with HIV, and Peer counselling will play an important role in adherence counseling. Afya Kamilisha will support facilities and LIPs working with PLHIV to identify clients facing similar challenges and cluster them into voluntary, age- appropriate support groups. Examples include mother-baby pairs, adolescents, younger men and older men.

Afya Kamilisha will engage PEs in all CCCs and train them on adherence counselling, after which they will provide the same in group and individual sessions, as well as providing HIV education and leading the facility and community based psychosocial support group. PEs will also link the clients to community-based interventions.

### ACTIVITY 4.4 CONDUCT IN-SERVICE TRAINING AND CME FOR CLINICAL AND NON-CLINICAL STAFF

Afya Kamilisha will foster a continuous learning culture at the facility level by:

- Providing regular updates on the changing ART guidelines like TLD transition
- Integrating regular, in-service training and CME opportunities as core components of building sustainable local capacity
- Building upon existing CME programs in 169 facilities in Afya Kamilisha to integrate priority HIV-topics into standard curriculum rotations
- Ensuring that priority HIV, STI, TB, OI and other updates are shared with facilities
- Incorporating new guidelines and best practices into the continuous learning curricula (e.g., EID at birth and at two months, timing of viral load testing, and diagnosis and management of OIs and STIs)

As part of the overall QI process, Afya Kamilisha will support facilities to integrate in-service training and CME expenses as a recurrent cost in their budgets. Building upon an existing cadre of clinical mentors at target facilities, the project will implement cascade-style training to reinforce priority topics and develop new mentors as programs grow over time. Afya Kamilisha will also expand CMEs to non-clinical cadres (e.g., mentor mothers, PEs, CHVs, HTS counselors and adherence champions). LIPs will provide this through grants with Afya Kamilisha. The Project will coordinate with national mechanisms, such as the USAID-funded Kenya HRH project, to complement and not duplicate training.

### ACTIVITY 4.5 BUILD CAPACITY OF HEALTH FACILITIES TO PROVIDE GENDER RESPONSIVE HIV SERVICES

Guided by the findings of a baseline gender, youth, and social inclusion analysis exercise, Afya Kamilisha will deliberately build the capacity of healthcare workers, HIV providers, CHVs, PEs and other influencers to provide gender responsive services that respond to gender specific risk factors and treatment needs. Sessions on gender will be included during trainings and CME to enable the participants to understand the gender perspective around provision of HIV services. The sessions will equip participants with the knowledge and skills to understand and challenge harmful gender norms and practices e.g. gender dimension in linkage to care and treatment for newly diagnosed clients. In order to ensure buy-in for gender mainstreaming interventions at the facility level, the Project will conduct whole site orientation on gender in health, targeting both clinical and non-clinical staff. The Project will train and develop the capacity of facility gender focal persons to ensure gender responsive HIV services exist that fully consider the needs of men, women, girls and boys. In addition, the Project will strengthen facilities that already offer SGBV services as stipulated in National Guidelines on Management of Sexual Violence in Kenya.

## OBJECTIVE 5: LONG-TERM FOLLOW-UP OF CLIENTS RECEIVING CARE AND TREATMENT SERVICES INCLUDING LABORATORY AND LOGISTICS SUPPORT

Successful viral suppression requires consistent adherence to ART. Maintaining ART adherence is a life-long commitment by PLHIV that requires both internal motivation and external support services, delivered in a targeted and client-centered manner. At the end of COP 17 ,viral load uptake was 89% (38,049 / 42,534) with 85% (32,443 / 38,049) suppressing. In COP 18, the project will aim to achieve the following: 47,196 HIV positive patients retained on ART treatment, with at least 44, 837 of them having updated viral load results documented in their medical records within the previous 12 months, and at least 40,354 attaining viral suppression. The strategic approaches that will be used by Afya Kamilisha include mentorship to HCP on viral load management, scaling up of viremia clinics and PSSG, differentiated service delivery models (DSD), deployment of laboratory staffs and also deploying lay workers who will provide adherence counselling and defaulter tracing.

## ACTIVITY 5.1 ENGAGE LAY WORKERS TO SUPPORT COMMUNITY MOBILIZATION AND LINKAGES

Afya Kamilisha will deploy 210 lay workers who will include 140 peer educators in high volume facilities across the nine counties and their roles will be to offer community PHDP as well as linking the patients to community intervention. In addition, they will also mobilize the communities to seek health services and also trace back the lost clients.

## ACTIVITY 5.2 SUPPORT DIFFERENTIATED CARE MODELS

Afya Kamilisha will build on success of Differentiated Care Model (DCM) implementation in Murang'a County where facilities like Maragua sub-county hospital and Makuyu Health center reduced the number of clients attending clinic per day from 100 to 30 and 25 respectively and scale up implementation from 104 health facilities in COP 17 to 140 sites in COP 18. As at the end of COP17,125 health facilities had categorized patients and in a pool of 41,811 patients ,31,042 (74%)patients were found to be stable and amongst them 19,605(63%) have been put on express clinics. It's worth noting that the number of stable clients fluctuates due to the criterion used in categorization especially if someone misses an appointment and also with ART optimization.

To improve on numbers enrolled into differentiated the Project will continue to build the capacity of CHMTs, SCHMTS, MDTs and HCWs to understand the DCM, implement and monitor the progress in the 140 care and treatment sites. Afya Kamilisha will facilitate the MDTs to continue conducting facility readiness assessment and categorization of patients in preparation for scale up to more sites.The project will continue to support mentorships to HCP and provide job aids to ensure rapid assessment and categorization of the newly enrolled patients. Those presenting well, will be fast tracked and frequent visit for the sick ones.

To improve on community ART distribution, Afya Kamilisha will strive to emulate success in Murang'a County where one facility has established 60 community ART groups with 304 clients enrolled and receiving community PHDP services as they await the Counties to streamline the community ARVs supply system and monitoring. In COP 18, the project will support formation of 60 additional CAGs in Tharaka-Nithi County due to vastness and proximity to ART facilities.The meetings for the groups will be at the community level and the project will ensure the groups are efficiently run by supporting the CHMTs to conduct supportive regular supervisions.

### Activity 5.2.1 Differentiated Care for Children, Adolescents and Pregnant/breastfeeding Women and families

HIV clinic appointments for women who are pregnant or breastfeeding will be integrated with focused ANC visits and with follow-up of the HIV- exposed infant. The project will work with supported facilities to synchronize the appointments for the families with primary goal of enhancing adherence to treatment and viral suppression. Quarterly appointments for the child and the care giver will be given for those who have suppressed the virus, while on the other hand, more frequent follow-up visits for the non-suppressing clients will be given. For the non-suppressed children, the project adopt case management approach where the MDTs will characterize them discuss and address the adherence issues with their guardians/parents come up with a treatment plan.

## ACTIVITY 5.3 SUPPORT INTEGRATED DEFAULTER TRACING

The Project will continue to support the 169 care sites to establish a scheduling system that evenly distributes appointment times throughout the week to avoid long waiting times, and to implement continuous line-listing in which records for all clients on ART are scanned to identify those who have missed appointments for ART refills or viral testing.

The Project will provide the supported sites with appointment diaries and tracing registers to track clients who miss appointments/ ARV refills. Those who miss appointment will be contacted via mobile phone within 24 hours in order to reintegrate client back into care and avoid any interruption in treatment. Information will be filled in the defaulter tracing register to monitor the outcome. Monthly airtime will also be provided to supported facilities for appointment reminders and phone tracing, aiming at early identification and tracking of clients and improving retention rates. Once the defaulters return to the clinic, the trained adherence counsellors will assess for barriers to adherence, review the patients/guardian understanding on ART administrations, address any concern that the patient might be having and reassess for readiness for re- initiation of ART.

## ACTIVITY 5.4 EXPAND VIREMIA CLINICS

Afya Kamilisha will aim at achieving over 90% viral suppression across all the ages however, for those suspected to be failing, a robust mechanism will be applied to ensure they suppress again. The project had scaled up support for viremia clinic from 20 at the time of the Semi Annual Progress Report, to 98 as at the end of COP 17; with 2,524 clients enrolled. Amongst those enrolled, 1446 (57%) re-suppressed the virus and 732 (29%)of the enrolled client switched to second line ART while those failing on 2nd line had the cases summarized, discussed at the facility, County and regional TWG and so far blood samples for five cases have been sent for drug sensitivity test and are awaiting the results.

Building on this, the project scaled up viremia clinics to 98 sites by the end of COP 17. targeting all the suspected treatment failures and to 105 by COP 18. Clients suspected to be failing will be enrolled in viremia clinics and PSSG at the CCC. They will be assigned case managers and their cases discussed in MDT to address any underlying cause, with subsequent repeat of the viral load testing as per national ART guidelines. To improve on documentation, monitoring and follow up, the facilities will be provided with registers where clients' details and interventions will be documented. Additionally, the project will print forms to monitor enhanced adherence and morisky medication adherence scale (MMAS) and ensure they are filed in patient notes for easier reference.

Afya Kamilisha will make job aids on treatment failure and interpretation of viral load results available at all ART service delivery points. Additionally the project has linked level 2 and 3 facilities with the County TWGs where difficult cases are reviewed and the team receive technical assistance from the senior staffs.

## ACTIVITY 5.5 STRENGTHEN LABORATORY SUPPORT TO HIV SERVICES

Laboartory plays a centre role in HIV/AID response. Key areas of laboratory support to the program include strengthening quality assurance by ensuring accurate diagnosis of diseases,support viral load uptake based on the eligibility, resistance testings for the clients failing on 2nd line regimen, PCR for early infant diagnosis, CD4 monitoring, TB diagnosis and identification of TB resistant cases, and strengthening the use of rapid kits for HIV and syphilis testing. In COP 17, laboratory support for HIV related activities included sample collection for viral load testing (VL), PCR for EID, GeneXpert for TB diagnosis and drug resistance testing. The project adopted integrated sample transport mechanism to ensure all samples from 178 sites are transported either to county/sub county referral laboratories and national referral laboartories for analysis and ensuring results are availed in good time to clinicians for clients management. Twenty one (21) laboratory staff were hired in 6 counties to augument MOH staff, informed by the gaps identified in relation to viral load uptake and turnaround times. To ensure continuity of services, the project procured service contracts for 9 Gene Xpert platforms.This will continuously support TB diagnosis and identification of cases early enough for clinical intervention.

### Activity 5.5.1 Engage laboratory staff to strengthen laboratory services

In COP 17 Afya Kamilisha engaged 21 laboratory officers to strengethen HIV related activities which include viral load sample collection, transportation ,packaging and ensuring viral load/PCR results are availed in good time for

clinical intervention. During COP18, the project will continue with the engagement to strengthen quality management, biosafety/biosecurity aspect, scale up on viral load uptake, and improve on inventory management especially for HIV realted commodities and ensure safety standards are maintained at all time. The staffs will also be trained on QA, material management, biohazard waste handling, and lot-to-lot validation testing. Biosafety and biosecurity trainings/annual refresher will be conducted. The staff will work closely with other implementing partners to strengthen lab accreditation process and CQI activities (continuous quality improvement process) in supported sites.

The Project will guarantee sample integrity and quality through on-site training and mentoring of laboratory personnel; training of HCW providers in sample management for VL, Gene Xpert, CD4 and EID.

### Activity 5.5.2 Laboratory sample networking and management

Afya Kamilisha will improve the efficiency of existing laboratory sample referral systems to achieve reduced turnaround time to 2 days from the current 6 days for samples sent to central lab within the county and less than two weeks from the current 15 days for return of results for samples sent to national laboratories for analysis. The project will further support the establishment of remote log-in hubs targeting high volume hospitals to ensure sample accessioning before samples are sent to national referral laboratories for analysis. This will ultimately reduce workload at the national laboratories thus improving on the overall turnaround time (TAT) for return of results. Scale up of SMS notification system for VL and EID results will be achieved in the 2nd year of implementation to ensure timely interventions by clinicians especially to clients with high viremia and PCR positive infants. The project will strengthen the use of Gene Xpert machine platforms in Meru TRH and Nyambene SCH to support multi-disease testing for DNA PCR and TB. This will greatly reduce TAT further by ensuring the results are availed real time for clinical intervention.

The project will utilize an innovative approach of using motor cycle riders (locally referred to as boda boda) to transport specimens from the facilities to the central laboratories, especially in counties with challenging road infrastructures. This will be done in coordination with the Counties and facilities. The drivers will be trained on sample handling and transportation. Dispatch and collection logbooks will be used to track specimen movements. The project will continue to adopt integrated sample transport model where all samples from a facility are transported at once to central hubs. Remote log in of samples will be done using the established hubs for all samples from both County and Sub county laboratories and peripheral sites before there are sent to national referral laboratories. DBS samples for Viral load and EID will then be sent via courier services to national referral laboratories. For the counties doing plasma for viral load testing, the project will support transportation of samples from central hubs to national referral laboratories for analysis. This will be achieved through collaboration with other implementing partners using the same central sites to leverage. The use of boda boda is expected to greatly reduce primary delays from the current 6 and 8 days for EID and viral load results respectively to less than 2 days for both, reduce transport costs, and minimize skilled man-hours wasted during sample transportation by the laboratory staffs. Afya Kamilisha will facilitate transportation of DBS samples for Viral load,PCR for EID and plasma samples for suspected treatment failure cases from Peripheral sites to the nearest courier services where they will then be transported to national referral laboratories for analysis using prepaid courier service by the national partner.

The project will collaborate with PS Kenya and Clinton Health Access Initiate (CHAI) to establish printing hubs for viral load, EID and Gene Xpert results at the sub county level that will be availed to peripheral sites in a timely manner for clients' management.

Afya Kamilisha will avail printing material for the results and airtime provision for mobile network communications. The Project will support printing of SOPs developed by the sites, sensitization and dissemination of job aides coming from the national program; availing sample collection log books.

### Activity 5.5.3 Laboratory quality assurance

QA procedures for rapid HTS, including validation of HIV test kits will be implemented starting with 50 high volume facilities in Year 2, then scaled up to 97 supported sites in Year 3. Afya Kamilisha will build internal capacity to cascade lot-to-lot validation testing for all county facilities receiving rapid diagnostic tests (RDTs). In the event of validation failures, the Project will support coordination with the national level to resolve the quality issues. Subsequent supportive supervision for QA/ QI will be conducted, including adherence to storage protocols for unexpired test kits.

Afya Kamilisha will work closely with county health laboratory teams to scale up on proficiency testing targeting service providers not currently participating. Afya Kamilisha will facilitate the distribution of PT panels 3 times a year to supported sites. This will be followed by supporting SCMLCs to conduct corrective action and preventive action (CAPA) for HTS service providers with unsatisfactory performance.

Kamilisha will support maintenance services for nine Gene Xpert machines to ensure minimal interruptions in TB diagnosis throughout the project lifetime. Documentation of EQA for Gene Xpert and HIV testing will be ensured in the supported sites. Afya Kamilisha will collaborate with Univeristy of Maryland to strengthen SLMTA (Strengthening Laboratory Management Toward Accreditation) process in six high volume sites and continuous quality improvement (CQI) in fifteen lower volume facilities. The Project will support monthly QI meetings targeting sites undergoing the process. This will ensure quality gaps identified are addressed promptly.

## ACTIVITY 5.6 EXPAND VIRAL LOAD TESTING AND RESULTS REPORTING

Adherence to ART for viral suppression goes hand in hand with routine viral load testing. In Afya Kamilisha counties, the proportion of viral load testing for clients on ART as the end of COP 17 was 89%. The viral suppression among those tested stood at 85% with pediatrics aged 0-9 years having a suppression of 69%, adolescents 10-19 years at 66%, while those above 20 years had a suppression rate of 85%. To report results, providers need to download them from the NASCOP VL website and transfer them to the clients' records, with results generally communicated to clients during their next routine appointment. Currently, gaps all along this system inhibit the timely processing and communicating of viral loads.

The project will support the scale up of viral load testing to achieve at least 95% of all the clients on ART have an updated VL result in their medical records. It will also target a viral suppression rate of at least 90% of HIV positive clients on treatment. Afya Kamilsha will collaborate with the counties to enhance access to viral load testing by ensuring constant availability of viral load commodities, training the laboratory staff on sample collection and handling interpretation of results, and proper disposal of generated waste. Afya Kamilisha will support facilities to increase adherence and client retention through SMS appointment reminders for viral load testing, clinical appointment and ARV pickups, with clinical visits and ARV pick less frequent (every 3–6 months) for stable clients on ART. The Project will share site level targets, work with the supported health facilities to restructure client flow, obtain blood samples directly at the CCC instead of referring the clients for phlebotomy, and take advantage of PSSG to obtain blood samples from eligible clients.

Facilities will be supported to transport laboratory samples to the county/ sub county hospital laboratories for CD4 (at those sites where point of care CD4 is not available) and Gene Xpert analysis and national laboratories for PCR and viral load testing through integrated sample transport system to reduce on cost and address the primary delay. To reduce the results' turnaround time, the Project will mentor facilities on the use of the NASCOP Viral Load and EID website to obtain clients' results. Afya Kamilisha will adopt the use of technology by introducing bulk SMS alert system to notify healthcare workers and clients of results with high viral load, ensuring interventions can be made on a timely manner, without unnecessary delay. Clients will be given consent forms to fill before enrolled into alert system. Peer educators will be engaged to contact clients with detectable viral loads to actively follow them for closer monitoring.

Afya Kamilisha will support the continued use of viral load assay to monitor clients on ART and to detect and diagnose treatment failure in supported Public, private and FBO health facilities. Afya Kamilisha will utilize experienced clinical mentors/trainers at the counties and health facilities as well as Project officers to provide onsite training and consultation on complex cases. In addition, the Project support facility monthly MDTs to discuss viral load uptake and cases of high viral load and treatment failure, as well as other issues related to management of HIV and HIV service delivery.

The success of viral load testing depends on the availability of functional equipment and adequate stocks of consumables - Vacutainer tubes, DBS filter papers for site using DBS for viral load sample collection (Meru and Tharaka Nithi), cryo vials, plasma preparation tubes for the sites using plasma (Embu, Kirinyaga, Nyeri, Nyandarua, Kiambu and Murang'a) - necessary to draw and transport samples to the processing central laboratories. While these supplies are normally provided through National reference Laboratories KEMRI, KNH and NHRL), Afya Kamilisha will monitor the management of supplies through equitable allocation of the forecasted commodities to facilities, timely distribution, and regular documentation and submission of consumption reports.

## ACTIVITY 5.7 STRENGTHEN SUPPLY CHAIN MANAGEMENT CAPACITY AND COMMODITY LOGISTICS

Afya Kamilisha will continuously address some of the gaps in commodity management cutting across both laboratory and pharmaceutical products with an aim of achieving improved health outcomes in the zones. This will be achieved through a collaborative efforts with all key actors from public, faith-based and private institutions to ensure continuously and adequate availability of antiretroviral drugs, TB, nutrition and laboratory commodities in the health facilities. This will be achieved through the strengthening of the technical capacity of the Counties, the Sub-Counties and the health facilities in supply chain management and commodity security. County commodity security technical working groups (TWGs) will be facilitated to promote best practices in forecasting and quantification of the supplies. The project will continue to support counties and sub counties in uploading health commodities reports in the DHIS2 and HCMP platforms on monthly basis .The support will include procuring of data bundles on monthly basis for Sub county pharmacist and SCMLTs to aid in reporting. It is expected that through these efforts, there will be continuous and uninterrupted supplies of health commodities throughout the year. To boost on quality of data further, the project will print and distribute commodity reporting tools (MOH 643 &706) to supported sites and mentorship done to ensure the data is well captured.

### Activity 5.6.1 Commodity accountability

To promote proper management of drugs, the project will support facility level mentorship programs to empower staff on the use of ARV dispensing tool and other electronic systems available for drug management. Afya Kamilisha will work in partnership with NASCOP to generate and review periodic regimen data of clients under care in the program to inform decision making. The project will work together with county pharmacists to mentor HCPs on DHIS commodities reporting and ensure that it is being implemented. There will be mentorship of HCPs on rational prescribing and good dispensing practices in all supported sites. Afya Kamilisha will continue to support County commodity technical working groups (TWGs) in all counties, whose role will include forecasting and quantification, strengthening of commodity buffering and supporting transition of commodity support to county governments through quarterly meetings. Clear TORs will be formulated specific to each county to ensure the county have a system of engaging National program on issues touching on commodities.

### Activity 5.6.2 Drug safety

To ensure patient safety, quality assurance measures will continue to be enhanced in the supported health facilities and the counties. Adverse drug reaction reporting will be promoted through CMEs and on-site mentorships. Pharmacovigilance in all facilities will be strengthened through county based sensitisation circuits, CMEs and OJT during joint support supervision. This will ensure availability of safe, high quality and efficacious commodities. An

effective reporting system for pharmacovigilance will further improve documentation and analysis of adverse drug events.

### Activity 5.6.3 Adoption of technology in commodity management

The project will continue to promote the use of technology such as the WhatsApp to link the health facilities, the CHMTs, NASCOP and other stakeholders in the sharing of updates to mitigate shortages in supplies and to also share new technical information from the national to county level. When stock-outs occur, Afya Kamilisha will support stop gap measures to facilitate redistribution of commodities and essential medicines between facilities, particularly CD4 reagents, RTKs, EID/VL consumables and Gene Xpert cartridges and cartridges. Project Officers will participate in each county-level group to monitor decision-making around commodities re-distribution. Afya Kamilisha will incorporate supply chain management functions into the site improvement through monitoring system (SIMS) QA standards to ensure maintenance of adequate commodity stock levels. This will be achieved by ensuring the sites use up-to date stock cards/bins for monitoring drugs usage on daily basis .This will consequently ensure proper and accurate projects of drugs on monthly basis. For long-term measure, the Afya Kamilisha will support Counties and sub counties teams to use commodity consumption data to guide facilities with low stock levels for prior mitigation before stock out arises. County set targets for all program areas will be merged with commodity quantification and projection data. This will ensure the drawing rights allocated by the national program to the counties merges with the expected targets to reduce on overstocking or understocking especially on HIV testing kits.

### Activity 5.6.4 Quality aspect in commodity management management

Afya Kamilisha will support commodity review meetings and commodity data audits at the county and sub-county levels to strengthen and streamline data quality and ensure the reporting of the health commodities in the DHIS2 and HCMP portals.

## OBJECTIVE 6: STRENGTHENED INSTITUTIONAL CAPACITY AND ACCOUNTABILITY FOR THE MANAGEMENT OF COMMUNITY, FACILITY AND COUNTY HIV RESPONSE

Afya Kamilisha will continue to strenghthen the institutional capacity of the the 9 county departments of health to plan, finance and sustain high quality HIV services delivered through efforts across the HIV cascade as enumerated in Objectives 1-5. The project will further continue to advocate for a steady movement towards full government ownership of HIV services through domestic funding. As at COP 17 at Annual Progress Report, the project conducted organisational capacity assessment in 3 counties across 8 management domains, deployed and supported 74 clinical and 482 lay staff to enhance service delivery, supported quarterly targeted supportive supervision in all the 9 counties, assisted 6 counties to include HIV services in their AWPs, supported RTK allocation in 8 counties, establishment of eLMIS in 9 sub-counties, conducted DQAs for ARVs in one county and established EMRs in 90 care and treatment sites.

In COP 18, Afya Kamilisha will support counties to coordinate HIV partners to ensure optinmal use of available resources, conduct OCA in the remaining 6 counties and support continuous monitoring of OCA action plans in all the 9 counties, support the 74 HRH staff to improve productivity, conduct atleast 180 facility level SIMS focused support supervision visits, advocate for increased domestic allocations to HIV in the county budget, train 246 MoH staff on Continous Quality Improvement (CQI), expand the use of EMRs to 100 care and treatment sites and 80% for POC, scale up eLMIS to the remaining 8 counties, expand DQA to include ARVs, ARV consumables and HIV commodities in 8 other counties. To achieve these results, Afya Kamilisha will employ the following strategies:

a) Strengthen health stakeholder collaboration for leveraging resources,
b) Routinely assess and improve organizational capacity of the nine county governments,
c) Support County and Sub County HMTs in their oversight role
d) Identify HRH gaps in staffing and provide capacity
e) Support contract staff and transition them to counties
f) Provide In-Service training to address identified healthcare work performance gaps
g) Strengthen county planning and budgeting for HIV service delivery
h) Ensure effective use of HMIS
i) Support QA and QI to improve client outcomes
j) Incorporate Gender Mainstreaming

### ACTIVITY 6.1 STRENGTHEN HEALTH STAKEHOLDER COLLABORATION FOR LEVERAGING RESOURCES

Afya Kamilisha will partner with other health stakeholders and the county directors of health to conduct bi-annual County Health Stakeholders' forums (CHSF) to share experiences and leverage resources. It will also seek technical expertise from USAID-supported national implementing mechanisms, complementing their efforts at the county, sub-county and facility levels for partner collaboration, alignment and coordination. The forums will be used to review and update the county health stakeholder maps that were done in the first year. Kamilisha will coordinate joint inter-stakeholders' activities e.g. World AIDS Day and TB days. Table 1 shows the existing USAID national mechanisms.

**TABLE 2: Collaboration, Alignment and Coordination**

| Implementing Mechanism | Proposed synergies and collaboration with Kamilisha |
|---|---|
| HRH Kenya Project | **The HRH Kenya Project is working with national and county-level leaders to improve health workforce management. In Kamilisha, the HRH Kenya Project will provide technical assistance on HRH assessments and translation of national strategies and policies to the county level.** |
| Health Policy Plus (HP+) Project | **HP+ implements strategies to increase health financing and promote domestic resource mobilization. With Kamilisha, HP+ will support efforts to develop program based budgeting (PBB) as a core competence among S/CHMTs.** |
| Health Informatics Governance and Data Analytics Activity (HIGDA) | **HIGDA contributes to the development of a strengthened, unified and integrated HIS system for Kenya. HIGDA will support Kamilisha on the use of health and geospatial data analytics, and strengthening the use of information communication technology platforms to improve data management.** |
| World Bank | **The Multi Donor Trust Fund (MDTF) will provide technical asssistance to counties for Planning, Budgeting, Monitoring and Reporting (PBMR).** |

## ACTIVITY 6.2. ROUTINELY ASSESS AND IMPROVE ORGANIZATIONAL CAPACITY OF THE NINE COUNTY GOVERNMENTS

Afya Kamilisha will continue to keep county governments progressing towards increased ownership of HIV service delivery. To measure this progress, the Project will mentor the counties to continue with self-assessment to identify their strengths and challenges and establish capacity-building goals over time using the OCA tool. OCA will assist the counties in solution finding as an ongoing and learning process for sustainability as opposed to periodic events. Key assessment areas include leadership and governance, quality, human resources for health, planning and budgeting, and health information management. Following initial assessments done in Year 1, Afya Kamilisha will work with counties to develop individualized action plans based on results. Kamilisha will facilitate annual follow-up assessments and reviews in close collaboration with county officials, laying the groundwork for continued regular self-assessment after the project ends. Leadership and management updates for C/SHMT teams will continue as recommended by the OCAT assessment report.

## ACTIVITY 6.3. SUPPORT COUNTY AND SUB COUNTY HMTS IN THEIR OVERSIGHT ROLE

To facilitate counties in their oversight role, Afya Kamilisha will assist CHMTs and SCHMT to conduct quarterly site supportive supervision and strengthen feedback and follow-up on action plans. The project will print and provide the supervision teams with a standard SIMS tools for uniform and comprehensive assessment of service delivery at the facilities (see *Activity 6.9*).

## ACTIVITY 6.4 IDENTIFY HRH GAPS IN STAFFING AND PROVIDE CAPACITY

Kenya has experienced perpetual HR shortages in the health care sector. In Year 1, Afya Kamilisha deployed 74 clinical staff to address staffing shortages that had negatively impacted service delivery. Under COP 18, Afya Kamilisha will continue to work with each county to determine their current staffing patterns—mapping out areas of HRH concentration and less covered catchment areas. Then, following the Kenya HRH Norms and Standards Guidelines and collaborating with the HRH Kenya Project, the Project will work with each county to estimate actual staffing needs and compile into larger staffing plans that include hiring and redeployment. The current deployment in COP 18 stands at 81 clinical staff in addition to 482 lay workers who include mentor mothers and peer educators. To stem shortages in remote rural locations, Afya Kamilisha will advocate for county officials to

provide non-monetary incentives (e.g., free housing, output-based incentives) to recruit and retain healthcare workers in less desirable locations.

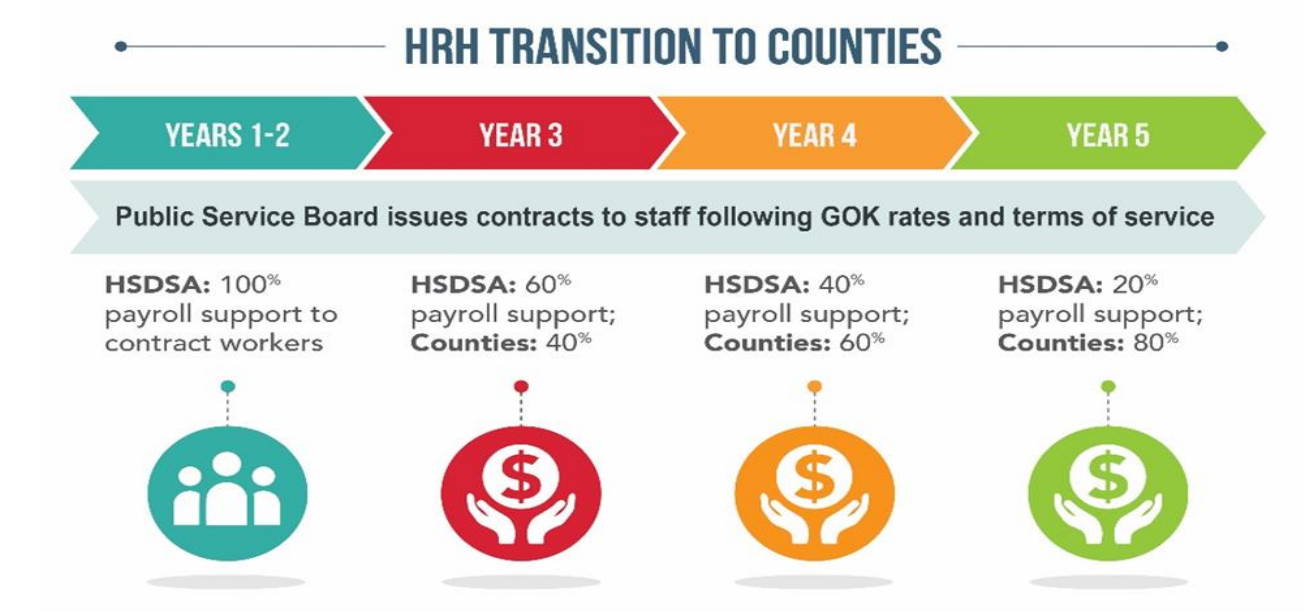
The Integrated Human Resource Information System (iHRIS) developed under the USAID Capacity Kenya and FUNZO Kenya projects is in place in Afya Kamilisha couties. All have been trained on the two basic modules. Kiambu, Murang'a, Tharaka Nithi and Meru trained on the advanced modules that produce dashboards. However, many county and facility committees do not update iHRIS frequently enough to effectively use its data to inform decisions on the ground. In COP 18, Afya Kamilisha will work to reinvigorate this system in the target facilities, integrating the dashboard data into regular management review meetings to support evidence based decision making.

## ACTIVITY 6.5. SUPPORT CONTRACT STAFF AND TRANSITION THEM TO COUNTIES

Afya Kamilisha will continue carrying out its commitment of supporting salaries and stipends for contract workers helping to provide HIV services in targeted counties. The goal is to have the MOH gradually take over these positions beginning Year 3 of implementation and absorb them into the government system. However, under devolution the responsibility for hiring and deployment of healthcare workers has shifted to the counties, presenting challenges in budgeting and staff management. In the previous project, APHIA*PLUS* KAMILI, Kiambu, Murang'a, Nyandarua, Tharaka Nithi and Embu absorbed most of the contracted staff, but other counties are yet to do so.

In COP 18, Afya Kamilisha will take a more sustainable approach to filling HR by engaging the Public Service Boards (PSBs) to review county staffing plans in line with their hiring and contracting guidelines. The PSB will issue contracts following GOK rates and terms of service. While PSB issues the contract, Afya Kamilisha will provide funding for payroll support. By following the GOK donor-supported health care provider contracting guidelines for hiring staff, Afya Kamilisha will develop the county and facility ownership of these staff right from the start. Simultaneously, Afya Kamilisha will negotiate with county officials the transition of these workers to the permanent county payroll. In Year 1, Kamilisha sensitized the PSB and the County health teams on the anticipated model of transition. Figure 3 below shows the anticipated absorption of the HRH over the life of the Project.

Figure 2: **HRH absorption by Kamilisha Counties**




## ACTIVITY 6.6 PROVIDE IN-SERVICE TRAINING TO ADDRESS IDENTIFIED HEALTHCARE WORK PERFORMANCE GAPS

The field of HIV medicine is rapidly changing with new drugs, technologies and evidence-based approaches. To ensure that clients receive the highest quality of care, healthcare workers will receive updated information and refresher trainings on a routine basis. In COP 17, Afya Kamilisha trained 1,520 on various topics. In COP 18, Afya Kamilisha will strengthen locally managed systems by supporting 45 CHMT members to be trained as ToT's who will in-turn train the sub-county teams and build a pool of experts to provide CMEs, on-the-job training and mentorship to healthcare workers providing HIV services. Afya Kamilisha will work with SCASCOs to conduct annual in-service training needs assessments and develop training schedules to address shortcomings in line with MOH training policy and procedures.

The training topics will be selected in-line with the guidelines, required updates in HIV service delivery and in reference to the MOH County training needs assessment of 2015. The topics will range from leadership and management, commodities, clinical updates as discussed throughout this contract and other emerging needs.

As with the transition of HRH, Afya Kamilisha will initially financially support some in-service training, but will facilitate a deliberate shift to county leadership by the end of the project. The project will also strengthen performance appraisal systems (PAS) for current HIV providers. A well-structured PAS is critical for staff motivation and accountability—ensuring that healthcare workers are providing respectful, gender-sensitive, quality services. It is notable that Nyeri County has already embraced the PAS in renewing the staff contracts for the HRH staff as they transitioned to Afya Kamilisha. The project will further support facilities and counties to use GOK-approved PAS assessment tools and scoring criteria and will support the rollout of the electronic version as HRH Kenya completes it.

## ACTIVITY 6.7 STRENGTHEN COUNTY PLANNING AND BUDGETING FOR HIV SERVICE DELIVERY

Currently, funding for all public health initiatives rests with county governments. To allocate their overall funding, counties and sub-counties go through a lengthy, multi-layered work planning process where activities are proposed, vetted, budgeted and approved. This process has not always been consultative, leading to uncoordinated activity-based planning. Health Records and Information Officers (HRIOs) lead the development of AWPs at sub-

county level—in many cases single-handedly. At times, these plans do not align with national and county HIV strategic plans, and often are not reviewed against service delivery data, leading to the same set of activities being requested year after year. In COP 17, Afya Kamilisha supported 5 counties to intergrate HIV in their Annual Work Plans (AWP). In COP 18, the project will continue with efforts started in the first year to address C/SCHMT's capacity gaps in AWP development, enabling them to understand the county and MOH planning cycle and tools. Afya Kamilisha staff will provide technical support to CHMTs to ensure critical input from sub-counties in preparing and revising County Health Investment and Strategic Plans and AWPs.

Using MOH TOTs, the project will collaborate with the USAID supported HP+ and the World Bank (RMNCAH TA MDTF) to build capacity on AWP development teams in 9 counties, targeting a total of 15 persons in each county. Capacity strenghthening in this area will largely focus on supporting counties to effectively transition from line item budgeting Program Based Budgeting (PBB) which is a key requirement under the Public Finance Management Act (PFM Act 2012). PBB promotes accountability for public resourcesby ensuring every shilling invested in HIV (among other programs) is tied to specific outcomes. Afya Kamilisha will further leverage on the above partnerships to strengthen capacity in other critical skills such as public generating evidnce such as the County Health Accounts, public expenditure reviews (PERs) to strengthen advocacy efforts.

Kamilisha will continue to advocate for inclusion of sub-county medical officers into the AWP planning process to support HRIOs and for overall increases of HIV resources. The 9 counties will be assisted to conduct bi-annual AWP reviews integrated into health stakeholder forums.

## ACTIVITY 6.8 ENSURE EFFECTIVE USE OF HMIS

Currently data in the county health systems limits accurate utilization in decision-making and tracking the project's responsiveness. Electronic Medical Record (EMR) systems on the other hand promises to provide more robust, client-centered information. EMRs are however not universal system in Afya Kamilisha, and is currently implementing EMRs in 91 out of the possible 140 care and treatment sites; 71% (64/91) of them are functional. Afya Kamilisha will facilitate continuity and efficiency of the EMRs, allowing data to be directly keyed into the EMR by clinicians in real time during client visits. Afya Kamilisha will ensure full functionality of the EMR systems as well as increase the service delivery points connected to the system to include the MCH for PMTCT services, outpatient for HTS and the TB clinics apart from the CCC that are already connected. This will give a comprehensive collection of the data required. Capacity building of the users and advocacy through the county governments will also be done. CHMTs and Project staff will use data generated by the HMIS to inform annual target setting and decision making.

Afya Kamilisha will support quarterly supportive supervision visits aimed at strengthening capacity of healthcare workers to implement evidence-based M&E activities (i.e. indicator definitions, DQA, filing system, data storage, documentation of reporting tools, computer/database literacy, data analysis, timely ordering of reporting tools/updated version of DHIS-2 databases and timely compilation of site reports). To address this, the project will continue working with health facilities to improve the reliability, timeliness, validity, completeness and precision of the data by instituting checks and supervision from the county and sub-county to identify problem areas and provide on-site instruction in data quality improvement. Afya Kamilisha will support S/CHRIOs to follow-up on missing reports through SMS and phone calls.

Afya Kamilisha will work with facilities to analyze client exit interviews in order to assess client satisfaction. S/CHMTs will conduct quarterly Routine Data Quality Assessments (RDQAs) using the national DQA guidelines and tools with support from the project. Facilitation of data feedback mechanisms to sub-county and facility managers for decision-making will improve service delivery across the cluster. Kamilisha will also facilitate biannual county data review meetings with stakeholders (a subset of the health stakeholders' forums), where high performing facilities will be recognized, and those with challenges identified and supported.

Finally, the project will continue liaising and synergizing with other implementing partners to ensure that adequate infrastructure and technology are in place to support data transmission.

## ACTIVITY 6.9 SUPPORT QA AND QI TO IMPROVE CLIENT OUTCOMES

During the first year of implementation, Afya Kamilisha conducted an Organizational Capacity Assessment (OCA) baseline assessment in Murang'a, Meru and Kiambu counties. Some of the key findings from the baseline showed that the three counties had mechanisms to ensure participation of external stakeholders for QA/QI activities, there was a strong compliance with National level HIV policies (Standards and Guidelines), and the counties effectively engaged in External Quality Assessment (EQA)/ PT. Nevertheless, some of the key weaknesses identified were lack of capacity on QA/QI across the zone, inactive Quality Improvement Teams (QITs), poor documentation, low utilization of data for decision making, and lack of dedicated personnel and budget for QA/QI implementation. Additionally, the project conducted a gaps identification and analysis for QIT/WIT, SIMS & DQAs for site level monitoring of quality interventions. The project has 137 (48%) of the possible 283 sites have ever had quality improvement / work improvement teams (QITs/WITs) out of which 61 sites have an Active QIT/WITs. About 53 (18%) health facilities have conducted SIMS for the year and 126 DQAs. The activities planned therefore for COP 18, will be informed by these gaps.

In COP 18 Afya Kamilisha will build capacity of 215 MOH and S/CHMT CQI through training and mentorships, currently the project has about 61 active QITs. Afya Kamilisha establish and strengthen 76 more QIT/WITs to have a total of 137 high volume facilities across the counties and support utilization of the Kenya Quality Model of Health (KQMH) and the Kenya HIV Quality Framework (KHQF) across the sites. The project will identify 20 KQMH champions who will travel to facilities still in need of QITs and WITs and mentor them through the establishment and roll-out of this model. QITs will conduct routine assessments of their facility's performance against the national HIV/AIDS framework and standards.

Afya Kamilisha will integrate key principles of CQI into facility based Continous Medical Education so that a wider group of providers within each facility is familiar and dedicated to CQI for improved quality aspects. The county and sub-county levels will provide quarterly external assessments, assist facilities to develop action plans, and address identified gaps. Supervisory checklists will also augment information from other data sources, and will be used to track quality improvement.

In Year 1, Afya Kamilisha conducted SIMS in 53 health facilities. Five of these were carried out externally by the donor. Remedial actions have been followed up as appropriate. In COP 18, the project will develop and utilize an automated Site Improvement Monitoring System (SIMS) assessment tool in 115 (40% of the total supported sites) during supportive supervision with program team leaders, the senior management, county and sub-couty health management teams. These will produce dashboards that clearly articulate key findings from the SIMS assessment, what needs to be followed up, and the various action points and timelines. This way, quality of service provision related to Care and Treatment, TB/HIV, PMTCT, HTS, Commodity Management, and HRH, will be addressed on an ongoing basis. The automated system will enable Afya Kamilisha to follow up and address adverse findings from the SIMS and appropriate remedial actions will continuously be taken and documented. Afya Kamilisha will ensure that the S/CHMT use the SIMS tool for all their support supervision activities.

Across all the program implementation areas, the project will develop key quality indicators and avail progress charts to track them in order to improve quality and ensure Data Demand and Information Use (DDIU) across board. In close collaboration with MER, the Afya Kamilisha will facilitate county and sub-county teams to review performance data and identify gaps to initiate QI activities across the region as well as support participation in QI and external quality assessments. Ultimately, quarterly assessment and problem solving will become a core responsibility of S/CHMTs.

Afya Kamilisha will liaise with implementing partners to ensure that adequate infrastructure and technology are in place to support data transmission. Part of accurate and timely reporting is expanding the use of EMR, currently the project has 90 health facilities implementing EMR, however in COP 18 Afya Kamilisha will expand the use of

EMR to at least 100 (60% of the current supported care and treatment sites), allowing data to be directly keyed into the system by clinicians, point of care (POC) in real time during client visits, this will greatly enhances quality of data, improve reporting and encourage data demand and information use. Afya Kamilisha will continue providing EMR trainings and linkage to DHIS2. In order to enhance quality, continuous capacity building on indicator definitions and DQAs will be done, refer to M&E Section 4.0.

## ACTIVITY 6.10: GENDER MAINSTREAMING

Activity 1: Afya Kamilisha will train all the Project staff on gender mainstreaming and integration. This will equip them with knowledge and skills to offer support to health facilities, LIPS and CRPs in designing and implementation of gender responsive interventions. In the project quarterly reports all programs will report on activities carried out on gender integration.

Activity 2: Afya Kamilisha will conduct a gender integration sensitization targeting the MOH and MOG (Ministry of Gender) teams in all the 9 counties that we are supporting. The objective of this intervention is to capacity build the MOH teams on being gender aware of the existence inequalities in accessibility of health services, identify the gender norms that affect health seeking behavior for HTS, linkages and adherence and come up with strategies that will bridge the gap. At the same time ,this activity will build the capacity of the Gender Coordinators in the counties to participate fully in gender integration in HIV interventions within our scope of work.

Activity 3: Gender program will conduct site supportive supervision using the Gender Service Delivery Standards-Quality Assuarance Tool and strengthen feedback and follow-up on action plans to ensure facilities are offering Gender responsive services.

# 3.0 PROJECT MANAGEMENT

Led by Jhpiego, the Afya Kamilisha project, including LVCT Health, Amethyst Technologies and Cloudburst, continues to build capacity and transition ownership to county and sub-county leadership by enabling them to effectively plan and budget activities, efficiently use and leverage resources, and deliver high-quality HIV services. As described in 1.3 Project Partnership, primary partner Jhpiego will provide overall technical and management leadership for the project and serve as the point of contact with USAID. Jhpiego will lead implementation under Objectives 1, 3, 4, 5 and 6. LVCT Health will lead Objective 2, contribute to Objective 3 and support GBV prevention and treatment interventions across the project. Amethyst Technologies will lead implementation of SIMS and QA of labs under Objective 4 and 6. Cloudburst will lead the development of the Afya Kamilisha EMMP and will ensure compliance with environmental monitoring and mitigation including capacity building of all sub-grantees.

## 3.1 THE PROGRAM TRACKING TOOL (PTT) FOR EFFICIENT MANAGEMENT

For effective use of technology, Jhpiego introduced the use of a Program Tracking Tool (PTT) which is a web-based system and designed to assist in the management of projects in line with the Project Management framework to achieve the desired outcome on scope, budget and schedule of an activity. All program staff and management will effectively utilize the system to keep track of the project's progress. This has been designed to be used by all staff whose profiles have been activated and given different levels of permission into the system. The URL to the system is: https://jptt.jhpiego.org.

The Activity will ensure continuity of this system, which has been designed to keep track of the following:

- Work plan – Project activities
- Activity Budget and Expenditure
- Procurement plan, items procured
- Transport & flight expenditure
- MERL targets versus actual achievements

While providing timely alerts on;

- Overdue activities
- Activities below target
- Over and under expenditures
- Procurement timelines reminders
- Overdue procurements
- Process approval alerts and reminders

The system provides various dashboards customized for every user depending on the permission granted to them in the system; -

- Country Leadership: Granted exclusive view of all projects and their performance details
- Project Leadership: Granted exclusive view of the project details and its performance
- Project Team: Granted exclusive view to their activities, all operations in the system where the users are involved

## 3.2 STAFFING

Afya Kamilisha is led by Dr. Robert Nyanga, the Chief of Party (COP), and a team of key personnel including:

- Dr. Regina Mbayaki, Deputy Chief of Party (DCOP) and Service Delivery Technical Advisor (SDTA)
- Mr. Aaron Mulaki, Health Systems Strengthening (HSS) Advisor
- Mr. Paul Munyao Musya, M&E Specialist
- Mr. Peter Mugambi**,** Director of Finance and Administration

Other Jhpiego project staff adding up to a total of 50 are available to implement the project in COP 18. Jhpiego's home office support, STTA and partner staff will all be available. See Organogram and Staffing List in Annex 2 for more details. The Project's primary office will be located in Juja town, Kiambu County. Project staff will be embedded with MOH counterparts and local partners in Kiambu, Murang'a, Nyeri, Nyandarua, Kitui, Meru, Tharaka Nithi, Kirinyaga and Embu.

## 3.3 REPORTING

The Project will comply with all programmatic, M&E and financial reporting requirements, in accordance with the Afya Kamilisha contract and USAID rules and regulations. The Chief of Party, in collaboration with key personnel, will compile and submit reports to USAID and maintain constant communication with the USAID contract team for permissions, concurrence, programmatic updates and knowledge sharing. The Director of Finance and Administration and Finance Manager will work together with the headquarters Finance Administrator and Compliance team to review and verify all materials prior to submission, ensuring that they do not include financially sensitive information, and the Administration Manager will check conformity to branding requirements.

Kamilisha will follow the Delivery Schedule for Reports/ Performance Objectives as detailed under section F.5 of the fully executed contract. According to the schedule, Afya Kamilisha will complete and submit the Annual Work Plan within 30 days before the end of the fiscal year. Afya Kamilisha will also submit quarterly performance reports, GIS and activity location data, and quarterly financial reports within 30 days after the end of the fiscal quarter. PEPFAR indicator reporting will be completed on a semi-annual basis within 30 days at the end of quarters 2 and 4, and the PEPFAR expenditure reporting will be completed by October 31, 2019. Afya Kamilisha will report foreign taxes by April 16 and submit an annual report of government property in the Project's custody by the last day of the contract year (December 12, 2019). Finally, Kamilisha will submit the small business subcontracting report within 30 days of the close of each period, and the drafted annual performance report 30 days before the end of the fiscal year.

## 3.4 GRANTS UNDER CONTRACTS

Kamilisha will issue small grants to local implementing partners (LIPs) to implement specific aspects of the project such as: creating demand for HTS, linking communities with health facilities, providing psychosocial support to PLHIV, supporting retention in care and adherence to treatment, and AGYW. Afya Kamilisha's approach to grant making will emphasize capacity building, leadership skills, continuous performance monitoring and financial accountability, as well as capacity to comply with USAID-rules and regulations including the newly reinstated Mexico City Policy. The grant award process will include assessment of each grantee's institutional capacity, identification of capacity needs and corrective actions needed to reduce risk, determination of level of monitoring required and deployment of staff resources to manage overall grantee risk reduction, gender and cultural assessment and development of sub-recipient audit plan. We will provide training and capacity building to mentor grantees in good stewardship of United States Government funds and compliance to branding and marking requirements and environmental management

# 4.0 MONITORING AND EVALUATION

Kamilisha has developed an Activity Monitoring Evaluation and Learning Plan (AMELP) to accompany the COP18 project workplan, detailing the proposed Project's logical framework, the components of management information system that monitors progress towards achievement of the results, key M&E implementation gaps and proposed approaches to address these gaps and the Project's critical assumptions during implementation. The AMELP includes the project's indicators for each objective in the framework, showed the data sources and described how this will be collected, collated, analyzed and presented to inform performance. The matrix summarizes the planned M&E activities while an M&E strategy spells out the proposed approaches to deliver on the planned activities. The AMELP will endeavor to track activity inputs, outputs and achievements to inform performance outcomes over the contract's life. Kamilisha will review the AMELP and incorporate guidance from the Contracts Officer Representative (COR) in line with the contract document.

# 5.0 ACTIVITY MATRIX

**Strategic Objective 1: Increase availability and use of combination prevention services for priority populations**

**Output:**

- 6134 eligible AGYW reached with a defined package of services in Kiambu county

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Oct - Dec'18 | Jan - Mar '19 | Apr - Jun '19 | Jul - Sep '19 | |
| 1.1 | >80% of vulnerable AGYW reached with a defined package of services in HIV high burden counties. | 150 County, 150 sub county, 100 MOE, 100 community leaders and gate keepers sensitized | Project Reports | Stakeholder engagement forums | 400 leaders | Jhpiego | X | | | | |
| 1.2 | | 8 Quarterly meetings held | Project reports | Community DREAMS Advisory Board meetings | 8 | Jhpiego | X | X | X | X | |
| **1.2 Empower AGYW to reduce their risk for HIV and violence** | | | | | | | | | | | |
| 1.2.1 | >80% of vulnerable AGYW reached with a defined package of services in HIV high burden counties. | 40 safe spaces operational | Project reports | Support the running of safe spaces | 40 | Jhpiego | X | X | X | X | |
| 1.2.1 | | 90 mentors engaged | Project reports | Conduct weekly mentorship sessions | 90 | Jhpiego | X | X | X | X | |
| 1.1.2 | | 30 facilitators each for HCBF, MHMC and SHUGA II trained | Program reports | Recruit and train facilitators | 90 | Jhpiego | X | X | | | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Oct – Dec'18 | Jan - Mar '19 | Apr - Jun '19 | Jul - Sep '19 | |
| 1.2.3 | PP_PREV | 6134 AGYW reached with combination prevention services | DREAMS database | Conduct HCBF, MHMC and SHUGA sessions | 6134 | Jhpiego | X | X | X | X | |
| 1.2.3 | PREP_NEW | 30 HCWs trained | MOH/DREAMS data base | Train HCWs on AGYW friendly services | 638 | Jhpiego | | X | | | |
| 1.2.3 | | AGYW provided with PrEP, HTS, | DREAMS data base/MOH | Provide biomedical interventions | | Jhpiego | X | X | X | X | |
| 1.2.4 | 80% of vulnerable AGYW reached with a defined package of services in HIV high burden counties. | 500 AGYW supported with educational subsidies | DREAMS data base | Provision of educational subsidies | 500 | Jhpiego | X | X | X | X | |
| 1.24 | | 800 AGYW receiving bi monthly cash transfer | DREAMS data base | Initiate cash transfer | 800 | Jhpiego | X | X | X | X | |
| 1.2.4 | | 30 facilitators trained | Program reports | Train 30 facilitators on financial literacy and entrepreneurship | 30 | Jhpiego | X | | | | |
| 1.2.4 | | 2500 AGYW trained | DREAMS database | Provide financial literacy and entrepreneurship sessions | 2500 | Jhpiego | | X | X | X | |
| 1.2.4 | | 100 AGYW linked | DREAMS database | Linkage to MFI institutions | 100 | Jhpiego | | X | X | X | |
| 1.2.4 | | 100 AGYW trained | DREAMS database | Pilot provision of vocational training, | 100 | Jhpiego | | | X | X | |
| 1.2.4 | | 100 Small enterprises started | DREAMS database | Provide startup capital | 100 | Jhpiego | | X | X | X | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Oct – Dec'18 | Jan - Mar '19 | Apr - Jun '19 | Jul - Sep '19 | |
| 1.2.5 | 80% of vulnerable AGYW reached with a defined package of services in HIV high burden counties | 15 schools with talking walls | Program reports | Develop schools as safe spaces | 15 | Jhpiego | | X | X | | |
| 1.2.5 | | 3000 AGYW provided with dignity kits | Program reports | Provide dignity kits for select AGYW | 1000 | Jhpiego | | X | X | X | |
| 1.2.6 | | 100 people sensitized | Program reports | Sensitize police, community and opinion leaders on gender and (S)GBV | 100 | Jhpiego | | X | | | |
| 1.2.6 | | 100 AGYW linked | DREAMS data base | Referral and linkage for S(GBV) services | 100 | Jhpiego | | | | | |
| 12.6 | 80% of vulnerable AGYW reached with a defined package of services in HIV high burden counties | 6 forums conducted | Program reports | Conduct male engagement dialogue fora on GBV, IPV, HIV prevention, gender norms, empowering young women etc. | 6 | Jhpiego | x | x | x | | |
| 1.3 | | MSP characterized | Program reports | Mapping and characterization of MSPs | | Jhpiego | X | X | X | | |
| 1.3 | | 100 MSP know their HIV status | Program reports | Promote HTS among MSP | 100 | Jhpiego | X | X | X | X | |
| 1.4 | | 30 facilitators trained | Program reports | Train facilitators on FMP I and II | 30 | Jhpiego | | | X | | |
| 1.4 | | 1000 Parents and care givers reached | DREAMS database | Conduct FMP I and II sessions | 1000 | Jhpiego | | | | X | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct - Dec'18 | Jan - Mar '19 | Apr - Jun '19 | Jul - Sep '19 | |
| 1.5 | | 40 community activists trained | Program reports | Recruit and train SASA! community activists | 40 | Jhpiego | X | X | | | |
| 15 | | Weekly community dialogue meetings | Program reports | Conduct community dialogue meetings with SASA! CAs to address positive community gender norms | | Jhpiego | | X | X | X | |
| 1.6 | | Monthly review meetings for Facilitators, mentors and program staff held | Program reports | Coordination and Monitoring of DREAMS | | Jhpiego | X | X | X | X | |
| 1.6 | | TWGs and stakeholder forums attended | Program reports | Participate in relevant national and county AGYW TWG and stakeholder meetings | | Jhpiego | X | X | X | X | |
| 1.6 | | Participation in conferences, and national health days supported | Program reports | Participation in International and National health commemoration days | | Jhpiego | X | X | X | X | |
| 1.6 | | Reference materials availed | Program reports | Supply of IEC, Stationery, reporting and tracking tools, Bags, referrals registers, Manuals and handbooks | | Jhpiego | X | X | X | X | |

**Strategic Objective 2: Increased uptake of targeted HIV Testing Services**

**Outputs**:

- 498,799 individuals tested for HIV
- 14,792 new HIV positive individuals identified

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 2.1 STRENGTHEN HUMAN RESOURCES FOR HEALTH CAPACITY AND SUSTAIN HIGH QUALITY HTS | | | | | | | | | | | |
| 2.1.1 | HTS_TST | Annual refresher trainings conducted for HTS providers (300 providers) | MOH | conduct Annual Refresher trainings for HTS providers | 300 | LVCT Health | | | x | x | |
| 2.1.2 | HTS_TST | 180 HTS counsellors attending a monthly debriefing meeting | MOH | conduct monthly HTS providers debriefing meetings (12 meetings per county) | 96 | LVCT Health | x | x | x | x | |
| 2.1.3 | GENDER-GBV | 180 HTS counsellors sensitized on gender responsive services | Activity Reports | sensitize HTS counsellors to provide gender responsive services | 180 | LVCT Health | x | x | | | |
| 2.1.4 | HTS_TST | 180 HTS counsellors sensitized on basic adherence skills | Activity reports | sensitize HTS counsellors on adherence counselling | 180 | LVCT Health | x | x | | | |
| 2.1.5 | HTS_TST | 3,300 HTS providers participate in internal and External QA | NHRL reports | conduct external and Internal quality assurance (QA) mechanisms. | 3,300 | LVCT Health & Amethyst | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 2.2 SCALE UP PARTNER NOTIFICATION SERVICES | | | | | | | | | | | |
| 2.2.1 | HTS_TST | 100 providers trained in PNS | Training reports | Conduct PNS training to scale up facilities providing PNS services | 498,799 | LVCT Health | x | | | | |
| ACTIVITY 2.3 IMPLEMENT TARGETED PITC IN OPDS, INCLUDING TUBERCULOSIS CLINICS AND INPATIENT | | | | | | | | | | | |
| 2.3.1 | HTS-TST POS | New HIV positive clients identified (reaching men with testing services). | MOH | Implement testing strategies for reaching men e.g flexi hours, outreaches to male dominated areas | 6,034 | LVCT Health | x | x | x | x | |
| 2.3.2 | HTS-TST | Testing strategies implemented to reach children | MOH | Implement strategies for reaching children e.g. *testing CWC clinic, family testing for PLHIV* | 2,278 | LVCT Health | x | x | x | x | |
| 2.3.3 | HTS-TST | Remaining prevalence, men and children identified through Partner Notification Services | MOH | Partner Notification Services to Identify remaining prevalence, men and children | 15,947 | LVCT Health | x | x | x | x | |
| 2.3.4 | HTS-TST | 180 HTS counsellors engaged | Program reports | Implement targeted PITC in all outpatient and inpatient SDPs | 498,799 | LVCT Health | x | x | x | x | |
| ACTIVITY 2.4 ROLL OUT HIV SELF-TESTING FOR CLIENTS WITH LIMITED CONTACT WITH HEALTH FACILITIES | | | | | | | | | | | |
| 2.4.1 | HTS-SELF | Clients with limited contact with health facilities provided with HIV self-testing services | MOH | HIV self-testing services for clients with limited contact with health facilities | - | LVCT Health | x | x | x | x | |
| ACTIVITY 2.5 PROVIDE CONDOMS AND SAFER SEX MESSAGES FOR HIV-POSITIVE AND HIV-NEGATIVE INDIVIDUALS | | | | | | | | | | | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| 2.5.1 | HTS_TST | 286 HTS facilities providing condoms | MOH | Provide condoms and safer sex messages for HIV-positive and HIV-negative individuals. | 498,799 | LVCT Health | x | x | x | x | |
| ACTIVITY 2.6 INTEGRATE GBV PROTOCOLS INTO OUTPATIENT SERVICES | | | | | | | | | | | |
| 2.6.1 | GENDER-GBV | 24 facilities conducting quarterly CME on GBV | MOH | Integrate GBV protocols into outpatient services | 17,600 | LVCT Health | x | x | x | x | |

**eMTCT**

- 67,467 pregnant women reached with testing at first ANC
- 2,089 HIV-positive pregnant women receive ART to reduce risk of MTCT during pregnancy and delivery
- 434 exposed infants tested for PCR before 12 months of age
- 85% of children born to HIV infected mothers receive an HIV test before 8 weeks of age (through DNA polymerase chain reaction – PCR testing)

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 2.7 IMPLEMENT PITC IN ANC, MATERNAL, AND PAEDIATRIC/ CHILD HEALTH UNITS | | | | | | | | | | | |
| 2.7.1 | PMTCT_STAT | 669 Healthcare workers trained on PITC and EID in ANC and child health unit | MOH | Conduct refresher training on PITC and EID in ANC and child health units. | 67,467 | Jhpiego | | X | | X | |
| 2.7.2 | PMTCT_STAT | 99% of clients tested at first contact HTS counsellors | MOH | Placement of HTS counsellors to assist in MCH testing | | Jhpiego | X | X | X | X | |
| 2.7.3 | PMTCT STAT | 669 health care providers working in MCH trained on Dual HIV-syphilis and self-test kits | MOH | HTS Training on Dual HIV-syphilis and self-test kits | | Jhpiego | | X | | | |
| 2.7.4 | PMTCT STAT | On-site mentorship and CMEs held in at ANC & Maternity in 223 sites | MOH | On-site mentorship and continuous medical education (CME) for nurses in ANC and maternity wards at 223 facilities | | Jhpiego | X | X | X | X | |
| 2.7.5 | PMTCT STAT | Women with unknown status identified and tested at labor & delivery and post-natal clinics | MOH | Identify and test all women presenting with unknown HIV Status at labor & delivery wards and postnatal clinics | | Jhpiego | X | X | X | X | |
| ACTIVITY 2.8 INTEGRATE ART IN MCH ACROSS AFYA KAMILISHA COUNTIES | | | | | | | | | | | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| 2.8.1 | PMTCT_ ARV | 918 nurses in maternity and ANC Sensitized on eMTCT intervention through CMEs | MOH | Conduct facility CMEs on integration of ART in MCH | 2,089 | Jhpiego | X | X | X | X | |
| 28.2 | PMTCT_ ARV | Orientation on MCA, HCA and HEI audit conducted | MOH | HEI Audit/HIV positive pregnant mother's cohort analysis orientation | | Jhpiego | X | X | X | X | |
| 2.8.3 | PMTCT_ ARV | 223 facilities with ART in MCH clinics | MOH | Integrate ART in all supported MCH units | 223 | Jhpiego | X | X | X | X | |
| 2.8.4 | PMTCT_ARV | Mentor mothers' monthly meetings held in 9 counties | MOH | Conduct mentor mothers' monthly meetings for 65 mentor mothers | 108 | Jhpiego | X | X | X | X | |
| 2.8.5 | PMTCT_ ARV | HIV positive mother baby pair enrolled in psychosocial support group | MOH | Conduct 150 monthly psychosocial support groups meetings | 150 | Jhpiego | X | X | X | X | |
| 2.8.6 | PMTCT_ EID | 223 PMTCT sites have EID and positive infants data validated | MOH | Conduct quarterly County EMTCT EID validation meetings | 2,089 | Jhpiego | X | X | X | X | |
| 2.8.7 | PMTCT_ ARV | 25 Mentor mothers trained | MOH | Conduct mentor mother training | 25 | Jhpiego | | X | | | |
| 2.8.8 | PMTCT_EID_POS | <5% MTCT by eighteen months of age<br>95% PMTCT clients enrolled in care and treatment | MOH | Defaulter tracing (physical and airtime) | <5% | Jhpiego | X | X | X | X | |
| 2.8.9 | PMTCT_STAT | 9 counties, conduct quartely EMTCT technical stock-taking meetings | MOH | Conduct quartely EMTCT technical stock-taking meetings | 36 | Jhpiego | X | X | X | X | |
| Activity | MERINDIC | | Data | | TARGET | Response | Quarterly Timelines | | | | |

| | | OUTPUT | | ACTIVITY | | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 28.10 | PMTCT_ STAT | 95% of the pregnant women counseled and tested | MOH | Conduct community outreaches in hard to reach areas(72 outreaches) | 72 | Jhpiego | X | X | X | X | |
| 2.8.11 | PMTCT_STAT | 95% PMTCT clients enrolled in care and treatment | MOH | EMTCT staff monthly project meetings | 2,089 | Jhpiego | X | X | X | X | |
| 2.8.12 | PMTCT _ARV | All the 223 sites utilizing the updated EMTCT job Aids at MCH | MOH | Printinting of the EMTCT Job Aids for 223 sites | 223 | Jhpiego | X | X | X | X | |
| ACTIVITY 2.9 PROVIDE ASSISTED DELIVERY SERVICES FOR HIV-POSITIVE PREGNANT AND BREASTFEEDING WOMEN | | | | | | | | | | | |
| 2.9.1 | PMTCT_STAT | 1,115 maternity staff sensitized on respectful maternity care | MoH | Sensitization of maternity staff on respectful maternity care | 1,115 | Jhpiego | X | X | X | | |
| ACTIVITY 2.10 ENGAGE NURSES AND MENTOR MOTHERS TO PROVIDE SERVICES AT MCH | | | | | | | | | | | |
| 2.10.1 | | 22 nurses deployed to 20 high volume facilities at MCH | | Deploy 22 nurses in 20 high volume facilities at MCH | 22 | Jhpiego | X | X | X | X | |
| **Total** | | | | | | | | | | | |

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

**OUTPUT**

- 13,964 newly identified HIV positive individuals linked to care
- ≥80% of individuals testing positive for HIV being initiated on ART within two weeks of identification

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 3.1 DEPLOY LINKAGE OFFICERS | | | | | | | | | | | |
| 3.1 | TX_NEW | ≥80% of individuals testing positive for HIV being initiated on ART within two weeks of identification | Project reports | Deploy 6 linkage officers | 13,946 | LVCT Health | x | x | x | x | |
| ACTIVITY 3.2 ENSURE IMMEDIATE LINKAGE TO SERVICES AND RAPID ART INITIATION | | | | | | | | | | | |
| 3.2.1 | TX_NEW | ≥80% of individuals testing positive for HIV being initiated on ART within two weeks of identification | MoH | Ensure immediate linkage to services and rapid ART initiation | 13,946 | LVCT Health | x | x | x | x | |
| | | | | Weekly facility meeting to discuss on linkage | 13,946 | LVCT Health & Jhpiego | x | x | x | x | |
| | | | | Monthly subcounty linkage and positive audit meetings | 636 | LVCT Health & Jhpiego | x | x | x | x | |

Strategic Objective: 3.4 PROVIDE ENHANCED DIAGNOSIS OF TB FOR HIV–POSITIVE CO-INFECTED INDIVIDUALS
Output: Annual Targets:

- 53,779 clients screened for TB.
- 100% TB patients reported with a documented HIV status
- 100% of TB/HIV co-infected patients initiated on ART
- 10,983 PLHIV complete IPT

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET USAID Contribution | Responsible Party | Quarterly Timelines Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.4.1.1 | TX TB | 1. 169 Health facilities provided TA on quality TB screening | MoH | 1. Provide TA on quality TB screening to health facilities | 100% | Jhpiego | x | x | x | x | |
| | | 2. 140 peer educators provided OJT | | 2. Provide OJT to 140 peer educators on fast tracking coffers at waiting bays | | | | | | | |
| | | 3. 338 HCW sensitized on TB LAM | | 3. Sensitize HCW on TB LAM | | Amethystst | x | x | x | | |
| 3.4.1.2 | TB STAT | 320 HTS counsellors Sensitized on TB ACF | MoH | Sensitize HTS counsellors on TB ACF | 100% | LVCT health | x | x | x | x | |
| 3.4.1.3 | TB STAT | 169 health facilities supported to transport specimen to GX hubs | MoH | Support sputum transport network in 9 Counties | 100% | Jhpiego | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| 3.4.2 | TX TB | Participate in at least 90 meetings in 9 counties | MoH | Care and treatment program officers participate in HIV drug resistant TB clinical review meetings | 100% | Jhpiego | x | x | x | x | |
| 3.4.3 | TB PREV | 169 health facilities have line list of PLHIV clients not started on IPT | MoH | Line listing PLHIV clients not started on IPT | | | | | | | |
| | | 169 health facilities recording IPT data accurately | MoH | Provide TA on recording of IPT data in MoH 731 | 100% | Jhpiego | x<br>x | x<br>x | x | x | |
| 3.4.5 | TB_ART | 169 sites provided SOP's and job aids | MoH | Printing and distribution of SOPs and job aids | 100% | Jhpiego | x | | x | | |
| 3.4.6 | | 9 counties trained on IPC<br>77 IPC committees formed<br>77 IPC plans developed<br>30 IPC committees meet quaterly<br>169 sites provided SOP's and job aids | MoH | Conduct IPC trainings in counties<br>Support formation of IPC committees<br>Support development of IPC plans<br>Support IPC committee meetings<br>Print and distribute job aids and SOPs | 100% | Jhpiego/ cloudburst | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| 3.4.7 | | 48 monthly TB/HIV data review meetings<br>9 TBHIV cluster review meetings. | MoH | Support monthly TBHIV data review meetings<br>Support cluster TB/HIV Quarterly review meetings | 100% | Jhpiego | x | x | x | x | |
| 3.4.8 | | 27 TA on TBHIV activities provided to 9 counties<br>16 TB ECHO hubs participate in eLearning sessions | | Conduct joint supportive supervision and TA visits<br>Support participation in TB ECHO sessions | 100% | Jhpiego | x | x | x | x | |

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

**OUTPUT:**

- 13,964 newly identified HIV positive individuals initiated on ART
- 53,809 adults and children CURRENTLY receiving antiretroviral therapy (ART), (TX_CURRENT)
- 2,089 HIV-positive pregnant women receive ART to reduce risk of MTCT during pregnancy and delivery
- 2,185 exposed infants tested for PCR before 12 months of age
- 85% of children born to HIV infected mothers receive an HIV test before 8 weeks of age (through DNA polymerase chain reaction – PCR testing)

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 4.1 ENGAGE CLINICAL STAFF TO PROVIDE TREATMENT FOR ADULTS, CHILDREN, AND ADOLESCENTS | | | | | | | | | | | |
| 4.1.1 | TX_CURR | 37 clinical staff deployed in high volume facilities | Project reports | deploy clinical staff to provide treatment for adults, children, and adolescents | 37 | Jhpiego | x | x | x | x | |
| | | MDT meetings held in 169 care and treatment sites | | Support Monthly MDTs in 169 care and treatment sites | 169 | Jhpiego | x | x | x | x | |
| | | Operation triple zero meetings held in 140 | | Support quarterly OTZ meetings in 140 care and treatment sites | 140 | Jhpiego | x | x | x | x | |
| | | OTZ heroes in 140 care and treatment facilities recognized | | Support Annual recognition of OTZ heroes | 140 | Jhpiego | | | | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| | | Paediatrics PSSG in 169 care and treatment sites | | Support Monthly Paediatrics PSSG meetings in 169 sites | 169 | Jhpiego | x | x | x | x | |
| | | Male friendly clinics and PSSG held in 140 sites | | Support quarterly male friendly clinics and PSSGs | 140 | Jhpiego | x | x | x | x | |
| | | Chart reviews conducted in 169 facilities by MOH and project staffs | | Support Monthly mentorship and chart reviews by MOH and program officers | 169 | Jhpiego | x | x | x | x | |
| | | Printing of enhanced adherence forms | | Print and distribute enhanced adherence forms | 169 | Jhpiego | x | | | | |
| 4.2 ENHANCE TREATMENT LITERACY | | | | | | | | | | | |
| 4.2.1 | TX_CURR | Treatment literacy provided to clients in all supported sites | Project reports | Provide treatment education and support to address potential barriers to adherence. | 169 | Jhpiego | x | x | x | x | - |
| ACTIVITY 4.3 STRENGTHEN ADHERENCE COUNSELLING | | | | | | | | | | | |
| 4.3.1 | TX_CURR | 90% patients are retained in care and treatment | Project reports | Train HCP on adherence counselling | 169 ART sites | Jhpiego | x | x | x | x | - |
| ACTIVITY 4.4 CONDUCT IN-SERVICE TRAINING AND CME FOR CLINICAL AND NON-CLINICAL STAFF | | | | | | | | | | | |
| 4.4.1 | TX_CURR | Inservice training for cinical and non-clinical staff conducted in all supported sites | Project reports | Conduct in-service training and CME for clinical and non-clinical staff | 169 Care and treatment sites | Jhpiego | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 4.5 BUILD CAPACITY OF HEALTH FACILITIES TO PROVIDE GENDER RESPONSIVE HIV SERVICES | | | | | | | | | | | |
| 4.5 | TX_CURR | Capacity of HCWs in 169 ART sites built (in gender responsive HIV services) | Project reports | Build capacity of HCWs in supported health facilities to provide gender responsive HIV services | 169 | Jhpiego | x | x | x | x | |

**STRATEGIC OBJECTIVE 5: LONG-TERM FOLLOW-UP OF CLIENTS RECEIVING CARE AND TREATMENT SERVICES INCLUDING LABORATORY AND LOGISTICS SUPPORT**

**OUTPUT:**

- 53,809 adults and children currently receiving antiretroviral therapy (ART) (TX_CURR)
- 9,134 patients are retained within the system at 12 months after initiating ART
- 44,837 patients on ART receive annual VL testing and results filed in their medical records
- 40,354 patients on ART are "virally suppressed"

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 5.1 DEPLOY LAY WORKERS TO SUPPORT COMMUNITY MOBILIZATION AND LINKAGES | | | | | | | | | | | |
| 5.1 | TX-CURR | 140 ART sites provided with lay workers | Project reports | Deploy lay workers to support community mobilization and linkages | 140 ART sites | Jhpiego | x | x | x | x | |
| 5.2 | TX_NEW | 100% of the newly enrolled clients provided with treatment literacy | Project reports | Support treatment literacy to all the newly enrolled clients | 13,946 | Jhpiego | x | x | x | x | |
| ACTIVITY 5.2 SUPPORT DIFFERENTIATED CARE MODEL | | | | | | | | | | | |
| 5.2.1 | TX_CURR | 140 ART sites supported to provide DMC | Project reports | Support differentiated care models | 140 ART sites | Jhpiego | x | x | x | x | |
| | | | | Train HCP on Differentiated care | | Jhpiego | x | x | x | x | |
| | | | | Train Lay workers on DMC | | Jhpiego | x | x | x | x | |
| | | | | Sensitize clients and create demand for DCM | | Jhpiego | x | x | x | x | |
| | | | | Conduct facility assessment for community ART distribution | | Jhpiego | x | x | x | x | |
| | | | | Support categorization of stable and unstable clients | | Jhpiego | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 5.3 SUPPORT INTEGRATED DEFAULTER TRACING | | | | | | | | | | | |
| 5.3.1 | TX-_RET | 90% patients are retained within the system | MOH | Support integrated defaulter tracing | 169 ART sites | Jhpiego | x | x | x | x | |
| 5.3.2 | TX-_RET | 90% patients are retained within the system | Project reports | Provide an avenue for community to facility linkages to those who need | 169 ART sites | Jhpiego | x | x | x | x | |
| 5.3.3 | TX-_RET | 90% patients are retained within the system | Project reports | Print and distribute appointment diaries | 169 ART sites | Jhpiego | x | x | x | x | |
| 5.3.4 | TX-_RET | 90% patients are retained within the system | Project reports | Print and distribute defaulter tracing registers | 169 ART sites | Jhpiego | x | x | x | x | |
| 5.3.5 | TX-_RET | 90% patients are retained within the system | Project reports | Provide peer educators and CHVs transport while conducting physical tracing | 140 ART sites | Jhpiego | x | x | x | x | |
| 5.3.6 | TX-_RET | 90% patients are retained within the system | Project reports | Provide airtime for defaulter tracing | 169 ART sites | Jhpiego | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 5.4 EXPAND VIREMIA CLINICS | | | | | | | | | | | |
| 5.4.1 | TX-PVLs | Over 90% patients are virally suppressed | Project reports | Scale up viremia clinics in care and treatment sites | 105 | Jhpiego | x | x | x | x | |
| | | | | Support Monthly clinics and PSSG for Suspected treatment failures | 105 | Jhpiego | x | x | x | x | |
| | | | | Printing of high viral load registers | 105 | Jhpiego | x | | | | |
| | | | | Printing and distribution of job iads on management of suspected treatment failure | 105 | Jhpiego | x | | | | |

## STRATEGIC OBJECTIVE 6: STRENGTHENED INSTITUTIONAL CAPACITY AND ACCOUNTABILITY FOR THE MANAGEMENT OF COMMUNITY, FACILITY AND COUNTY HIV RESPONSE

**OUTPUT:**

- Nine county annual work plans (AWPs) reflect project activities and activity budgets
- 30 sub-counties effectively utilizing PBB to prioritize health and HIV needs
- 3 county governments progress as measured by the organization capacity assessment tool
- Conduct OCA in 6 counties
- Supporting 75 clinical and 199 lay workforce for delivery of HIV services
- 85% of the health workforce delivering HIV services have undertaken an HIV related update in the last 12 months
- Train 214 HCPs & MOH on QA/QI
- Conduct SIMS in 240 (85% of the total) supported sites
- Strengthen and revive at least 100 established QIT/WITs
- Identify 20 KQMH champions for continuous mentorship
- Conduct Quarterly External Assessments at C/SC levels
- Integrate principles of QI in all CMEs accross the program areas

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 6.1 STRENGTHEN HEALTH STAKEHOLDER COLLABORATION FOR LEVERAGING RESOURCES | | | | | | | | | | | |
| 6.1.1 | N/A | 6 counties conduct annual Health Stakeholders' Forums | Project Reports | Support annual County Health Stakeholders' Forums to improve partner collaboration | 12 CHSF | Jhpiego | x | | | x | |
| ACTIVITY 6.2. ROUTINELY ASSESS AND IMPROVE ORGANIZATIONAL CAPACITY OF THE NINE COUNTY GOVERNMENTS | | | | | | | | | | | |
| 6.2.1 | N/A | Baseline OCA conducted in 6 Counties | Project Report | Conduct baseline OCA in 6 counties | 6 counties | Jhpiego | | x | | | |
| 6.2.2 | N/A | 3 counties conduct progress as measured by the OCA and identified challenges followed up | | Provide technical assistance and coordinate annual self- assessments by CHMTs | 3 counties | Jhpiego | | | | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| 6.2.3 | N/A | 36 CHMT staff sensitized on leadership and management in 6 counties | Project Reports | Conduct leadership and management sensitization for S/CHMT teams as per the OCA recommendations (one meeting) | 36 CHMT staff | Jhpiego | | x | x | | |
| 6.2.4 | N/A | 5 CHMT/SCHMTs Supported per county to conduct quarterly site support supervision (SIMS) to Kamilisha supported sites (Includes Kitui) | Project Reports | Conduct quarterly C/SHMT supportive supervision and mentorship in 9 counties | 4 SS events per county | Jhpiego | x | x | x | x | |
| 6.2.5 | N/A | HSS team conduct weekly technical site visits and attend C/SCHMT meetings | Project Reports | Kamilisha HSS team conduct weekly technical site visits and attend C/SCHMT meetings | 9 Counties | Jhpiego | x | x | x | x | |
| ACTIVITY 6.3 IDENTIFY HRH GAPS IN STAFFING AND PROVIDE CAPACITY | | | | | | | | | | | |
| 6.3.1 | N/A | 1 PSB/MOH meetings to support the HRH component on staffing | Project Reports | Conduct PSB/MOH meetings to support the HRH component on staffing in 9 counties | 9 Counties | Jhpiego | | x | | x | |
| 6.3.2 | N/A | HRH payroll for the clinical and lay staff supported | Project Reports | Support the HRH payroll for the clinical and lay staff | 9 Counties | Jhpiego | x | x | x | x | |
| 6.3.3 | N/A | HRH performance appraisal for 9 counties | Project Reports | Support HRH appraisal process for the 9 counties | 9 Counties | Jhpiego | x | x | x | x | |
| ACTIVITY 6.4 PROVIDE IN-SERVICE TRAINING TO ADDRESS IDENTIFIED HEALTHCARE WORKER PERFORMANCE GAPS | | | | | | | | | | | |
| 6.4.1 | N/A | 45 MOH Personnel trained on iHRIS | Training Logs | Support counties to track personnel training through iHRIS | 9 Counties | Jhpiego | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| 6.4.3 | N/A | Quarterly Supportive supervisions for HRH Staff | Project Reports | Support the MOH team to conduct supportive supervision for HRH Staff | 9 Counties | Jhpiego | x | x | x | x | |
| 6.4.3 | N/A | Semi-Annual HRH staff review meetings | Project Reports | Conduct semi-annual HRH staff review meetings | 9 Counties | Jhpiego | x | x | x | x | |
| ACTIVITY 6.5 STRENGTHEN COUNTY PLANNING AND BUDGETING FOR HIV SERVICE DELIVERY | | | | | | | | | | | |
| 6.5.1 | | 100 AWP development team member trained in PBB | Training Logs | Train AWP development teams on Program Based Budgeting (20 x 5 counties) | 100 trained | Jhpiego | | x | x | | |
| 6.5.2 | N/A | 9 counties consolidate their 2019/20 AWP | Project Reports | Assist 9 counties to Consolidate 2019/20 County AWPs with Kamilisha activities reflected | 9 Counties | Jhpiego | | | x | | |
| 6.5.3 | N/A | 9 counties conduct county level bi-annual AWP performance reviews | Project Reports | Assist County Annual AWP/ Strategic Plan Performance Reviews in 9 counties | 9 Counties | Jhpiego | | | x | | |
| 6.5.4 | N/A | 9 counties conduct quarterly HIV TWG meetings | Project Reports | Assist 9 counties to conduct quarterly HIV TWG meetings to review HIV response progress and make necessary adjustments | 9 Counties | Jhpiego | x | x | x | x | |
| ACTIVITY 6.6 ENSURE EFFECTIVE USE OF HMIS | | | | | | | | | | | |
| 6.6.1 | N/A | 2 Bi-annual trainings of facility and S/CHMTs on EMRs | Project reports | Conduct user trainings and support on HIS systems. | 9 Counties | Jhpiego | x | x | x | x | |
| 6.6.2 | N/A | 2 Bi-annual review meetings on EMRs and DQAs for HFs and S/CHMT | Project reports | Conduct bi-annual review meetings on EMRs and DQAs | 9 Counties | Jhpiego | x | x | x | x | |

| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 6.7 SUPPORT QA AND QI TO IMPROVE CLIENT OUTCOMES | | | | | | | | | | | |
| 6.7.1 | N/A | 159 high volume facilities mentored on CQI in relation to HIV service provision (Includes 2 for Kitui) | Project Reports | Support QI/QA mentorship circuits in high volume facilities | 9 Counties | Jhpiego | | x | x | x | |
| 6.7.2 | N/A | 159 High volume facilities to have QIT & WIT committees and mentorship circuits (includes 2 sites for Kitui) | Project Reports | Support high volume health facilities to strengthen QIT & WIT committees and conduct mentorship circuits | 159 QITs | Jhpiego | x | x | x | x | |
| 6.7.3 | N/A | Support 5 CHMTs/SCHMT per county to conduct quarterly site support supervision (SIMS) to Kamilisha supported sites (Includes Kitui) | Project Reports | Conduct quarterly joint site support supervision visits with the C/SHMTs in order to enhance QA/ QI and external quality assessments | 9 Counties | Jhpiego | x | x | x | x | |
| 6.7.4 | N/A | Support S/CHMT to address gaps identified and weaknesses in operating QA procedures (3 per county) | Project Reports | Address gaps identified and weaknesses in operating QA procedures | 9 Counties | Jhpiego | x | x | x | x | |
| 6.7.5 | N/A | 215 MOH trained on QA/QI and development of workplans | Training Logs | Train MOH on QA/QI, development of work plans and QITs | 215 MOH | Jhpiego | x | x | x | x | |
| 6.7.6 | N/A | Distribution of progress charts to help track quality indicators and support data demand and information use. | Project Reports | Capacity building on DDIU and Quality Indicators | 9 Counties | Jhpiego | x | x | x | x | |

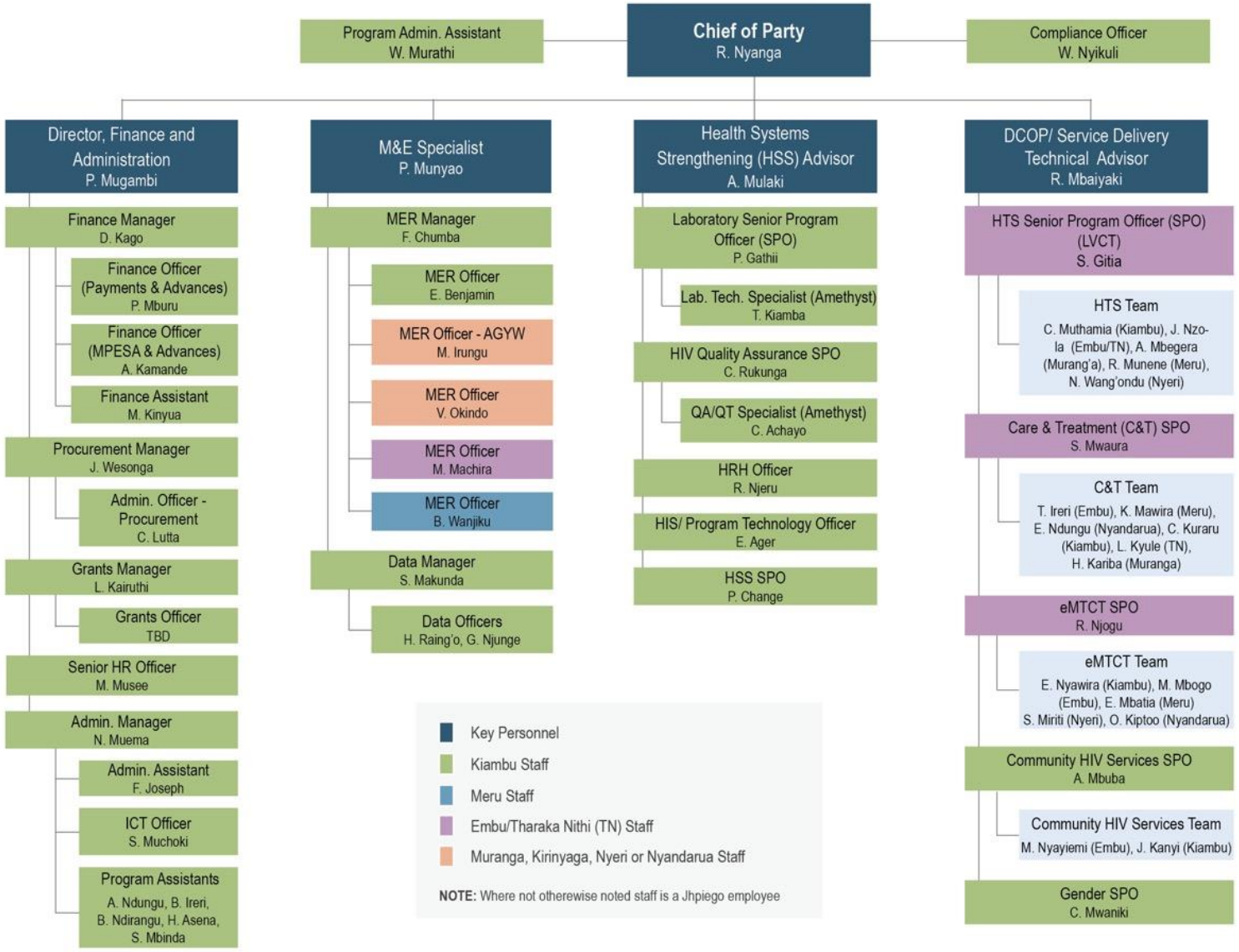
| Activity Ref | MER INDICATOR | OUTPUT | Data Source (Ministry/Other) | ACTIVITY | TARGET | Responsible Party | Quarterly Timelines | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | USAID Contribution | | Oct – Dec '18 | Jan – Mar '19 | Apr – Jun '19 | Jul – Sep '19 | |
| ACTIVITY 6.8 TRAIN PROJECT STAFF & GOK ON GENDER MAINSTREAMING | | | | | | | | | | | |
| 6.8.1 | N/A | 50 MOH & MOG sensitized on Gender integration | Training Logs | Conduct Gender integration sensitization for MOH & MOG | 9 Counties | Jhpiego | | x | | | |
| 6.8.2 | N/A | 62 staff trained on Gender Mainstreaming | Project Reports | Conduct Gender integration sensitization for Afya Kamilisha staff | All Program Staff | Jhpiego | x | | | | |
| 6.8.3 | N/A | Semi-Annual Supervisions on Service Delivery Standards | Project Reports | Conduct Semi-Annual Supervisions on Service Delivery Standards | 9 Counties | | | x | | x | |
| | | | | | | | | | | | |

## ANNEX 1. Environmental Monitoring and Mitigation Plan

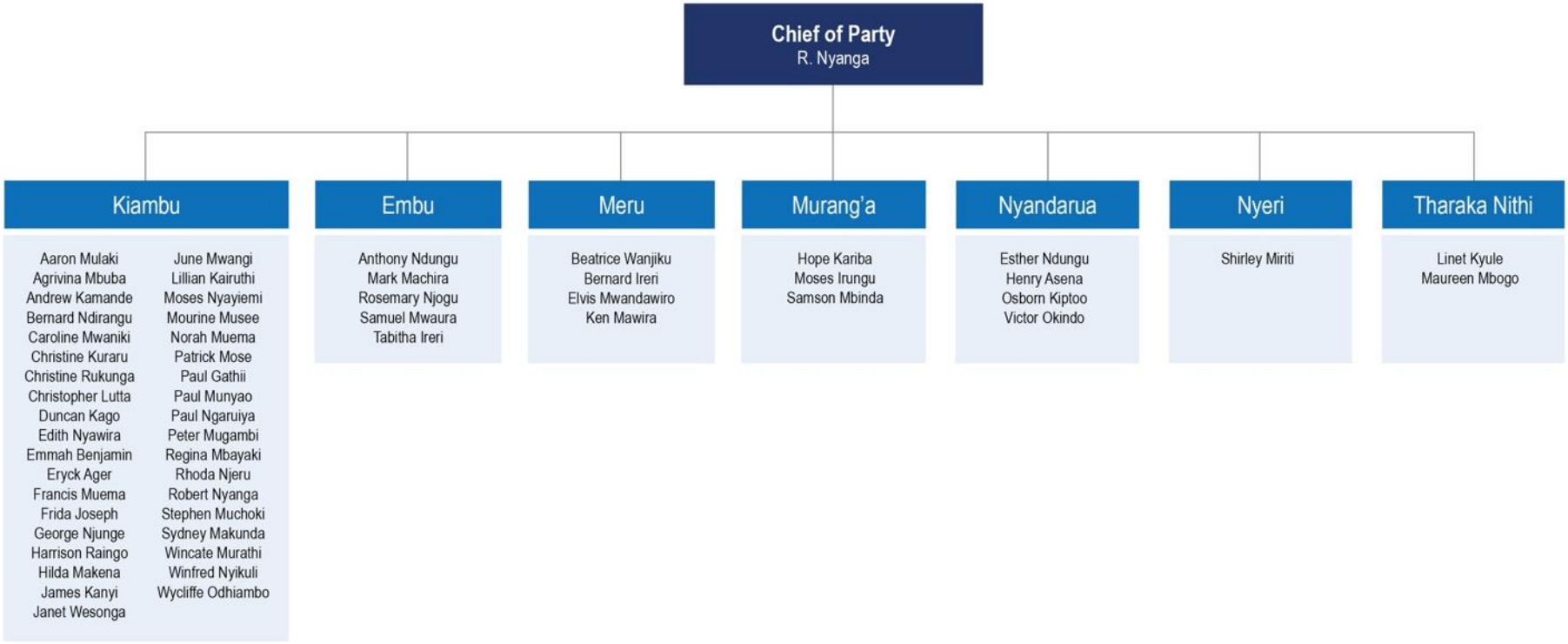
Environmental compliance oversight will be provided by the Cloudburst Group. Working closely with the Project implementation team, Cloudburst has developed the Environmental Mitigation and Monitoring Plan (EMMP) and will ensure its implementation. The complete EMMP is submitted as a stand-alone document along with this AWP.

# ANNEX: ORGANIZATIONAL CHART AND STAFFING PLAN MATRIX

## I. PROJECT ORGANIZATIONAL CHART



# II. COUNTY STAFFING BREAKDOWN



# III. STAFFING PLAN

| No. | Title | Name |
|---|---|---|
| | ***Jhpiego Key Personnel*** | |
| 1. | Chief of Party | Dr. Robert Nyanga |
| 2. | Deputy Chief of Party/Senior Technical Advisor | Dr. Regina Mbayaki |
| 3. | Health Systems Strengthening Advisor | Aaron Mulaki |
| 4. | M&E Specialist | Paul Munyao Musya |
| 5. | Finance and Administrative Director | Peter Mugambi |
| | ***Jhpiego Long-Term Local Staff*** | |
| 6. | Care and Treatment Senior Program Officer | Samuel Mwaura |
| 7. | Care and Treatment & PMTCT Program Officer (Murang'a) | Hope Kariba |
| 8. | Care and Treatment Program Officer (Embu & Tharaka Nithi) | Linet Kyule |
| 9. | Care and Treatment Program Officer (Meru) | Ken Mawira |
| 10. | Care and Treatment Program Officer (Kiambu) | Christine Kuraru |
| 11. | Care and Treatment Program Officer (Nyandarua) | Esther Ndungu |
| 12. | Care and Treatment Program Officer (Embu) | Tabitha Ireri |
| 13. | TB/HIV Senior Program Officer | June Mwangi |
| 14. | PMTCT Senior Program Officer | Rosemary Njogu |
| 15. | PMTCT Program Officer (Kiambu) | Edith Nyawira |
| 16. | PMTCT Program Officer (Embu & Tharaka Nithi) | Maureen Mbogo |
| 17. | PMTCT Program Officer (Meru) | Elvis Mwandawiro |
| 18. | PMTCT and Care & Treatment Program Officer (Kirinyaga/Nyeri) | Shirley Miriti |
| 19. | PMTCT and Care and Treatment Program Officer (Nyandarua) | Osborn Kiptoo |
| 20. | Community HIV Senior Program Officer | Agrivina Mbuba |
| 21. | Program Officer-Differential Service Delivery | Moses Nyayiemi |
| 22. | Program Officer-DREAMS | James Kanyi |
| 23. | Gender Senior Program Officer | Caroline Mwaniki |
| 24. | Laboratory Senior Program Officer | Paul Gathii |
| 25. | HIV QA Senior Program Officer | Christine Rukunga |
| 26. | Human Resource for Health (HRH) Officer | Rhoda Njeru |
| 27. | HSS Senior Program Officer | Patrick Mose Change |
| 28. | MER Manager | Felix Chumba |
| 29. | MER Officer (Embu) | Mark Machira |
| 30. | MER Officer- DREAMS (Murang'a) | Moses Irungu |
| 31. | MER Officer (Kiambu) | Emmah Benjamin |
| 32. | MER Officer (Meru) | Beatrice Wanjiku |
| 33. | MER Officer (Nyandarua) | Victor Okindo |
| 34. | Data Manager | Sydney Makunda |
| 35. | Data Officer | Harrison Raingo |
| 36. | Data Officer | George Njunge |

| No. | Title | Name |
|---|---|---|
| 37. | Compliance Officer | Winfred Nyikuli |
| 38. | Finance Manager | Duncan Kago |
| 39. | Finance Officer II | Paul Ngaruiya |
| 40. | Finance Officer | Andrew Kamande |
| 41. | Finance Assistant | Makena Kinyua |
| 42. | Grants Manager | Lilian Kairuthi |
| 43. | Grants Officer | Wycliffe Odhiambo |
| 44. | Administrative Manager | Norah Muema |
| 45. | Senior HR Officer | Mourine Musee |
| 46. | Administrative Officer-Procurement | Christopher Lutta |
| 47. | Information, Communications & Technology (ICT) Officer | Stephen Muchoki |
| 48. | Program Technology Officer | Eryck Ager |
| 49. | Administrative Assistant | Fridah Joseph |
| 50. | Program Assistant (Embu) | Anthony Ndungu |
| 51. | Program Assistant (Kiambu) | Bernard Ndirangu |
| 52. | Program Assistant (Nyandarua) | Henry Asena |
| 53. | Program Assistant(Murang'a) | Samson Mbinda |
| 54. | Program Assistant (Meru) | Barnard Ireri |
| 55. | Procurement Manager | Janet Wesonga |
| | ***LVCT Long-Term Local Staff*** | |
| 56. | HTS Senior Program Officer | Stella Gitia |
| 57. | HTS Program Officer (Kiambu) | Carol Muthamia Mutiso |
| 58. | HTS Program Officer (Embu/Tharaka Nithi) | James Nzola |
| 59. | HTS Program Officer (Nyeri/Nyandarua) | Anne Mbegera |
| 60. | HTS Program Officer (Meru) | Richard Munene |
| 61. | HTS Program Officer (Murang'a & Kirinyaga) | Nancy Wang'ondu |
| | ***Amethyst Technologies Long-Term Staff*** | |
| 62. | Lab QA Specialist - Amethyst Technologies | Titus Kyalo |
| 63. | QA/QI Specialist/Program Lead – Amethyst Technologies | Carolyne Achayo |
| | ***Jhpiego STTA and Home Office Support*** | |
| 64. | Senior Program Officer | Elizabeth Kizzier |
| 65. | Gender Advisor | Myra Betron |
| 66. | Technical Advisor, HIV Prevention, Care and Treatment | Silvia Kelbert |
| 67. | Finance Advisor | Douglas Mwendwa |
| 68. | MERL Advisor | Anthony Gichangi |
| 69. | ICT & HMIS Advisor | Simeon Wasonga |
| 70. | HIV TB Specialist | Joseph Sitienei |
| 71. | Graphics Designer | Gideon Mureithi |
| 72. | Communications Manager | Catherine Ndung'u |
| | ***LVCT STTA and Home Office Support*** | |
| 73. | Executive Director | Wanjiru Mukoma |

| No. | Title | Name |
|---|---|---|
| 74. | Director of Operations | Joshua Olang |
| 75. | Regional Manager | Cleophas Ondieki |
| 76. | Grants & Accounts Manager | Sanny Njenga |
| 77. | Human Resource Manager | Grace Koome |
| | ***Amethyst Technologies STTA and Home Office Support*** | |
| 78. | M&E Specialist | TBD |
| 79. | Technical Director | TBD |
| 80. | Operations Manager | Charles Hamidu |
| 81. | Chief Executive Officer | Kimberly Brown |
| | ***Cloudburst Group STTA and Home Office Support*** | |
| 82. | Subject Matter Expert | |
| 83. | Technical Analyst | |

# IV. QUALITY ASSURANCE SURVEILLANCE PLAN

**Overview:** This quality assurance surveillance plan (QASP) outlines the management functions and QA procedures that will be utilized jointly by USAID/KEA and Jhpiego as the lead organization for the Afya Kamilisha project. In COP 18, this QASP will facilitate maximizing of performance, programmatic programmatic and management efficiencies and cost-effectiveness, as well as throughout the life of the project. It will be used by USAID/KEA to enforce the inspection and acceptance clauses of the contract. Table 3 includes key performance monitoring information, including: 1) assessment area, 2) methods and frequency and sources of assessment/surveillance, 3) performance standards, 4) quality level achieved, and 5) person(s) involved in assessments.

This sampling guide is illustrative and can be modified at any time by USAID/KEA in coordination with Jhpiego based on new or changing factors that may have bearing on the Project's performance. At a minimum, the QASP is reviewed and updated on an annual basis, together with the project annual plan and AMELP.

## TABLE 3: QASP SAMPLING GUIDE

| Assessment Area | Methods, frequency & sources of assessment/ surveillance | Performance Standards | Quality Level To Be Achieved | Person(s) Involved in Assessment |
|---|---|---|---|---|
| Technical progress | USAID/Contractor Technical Progress Review Meetings: Quarterly/Monthly: Contractor Presentation Materials, and Meeting Minutes | • Quarterly Performance monitoring per objective against core indicators in AMELP<br>• Quarterly progress assessed against milestones in AWPs<br>• Quarterly qualitative and quantitative analysis of progress against objectives and results completed<br>• Quarterly lessons learned, good practices and success stories identified<br>• Project and activity location data recorded | • On track to achieving 100% of quarterly targets for key indicators and milestones | COR<br>COP, DCOP, M&E Specialist, HSS Advisor |

| Assessment Area | Methods, frequency & sources of assessment/ surveillance | Performance Standards | Quality Level To Be Achieved | Person(s) Involved in Assessment |
|---|---|---|---|---|
| Reporting (Monitoring, technical and financial) | Written Feedback on Reports and Report Review Meetings: Quarterly: Written Reports, Written Feedback on Reports, Revised Report and Meeting Minutes | • Timely submission and completeness of the following reports provided monthly<br>  ○ Early Warning Indicators (EWIs)<br>  ○ Non-MER indicators<br>• Timely submission and completeness of the following reports provided quarterly within 30 days after the end of quarter (30th January, 30th April, 30th July and 30th October 2018):<br>  ○ Quarterly performance reports<br>  ○ Quarterly financial reports<br>  ○ GIS and activity location data<br>  ○ Small business subcontracting report entered into eSRS<br>• Timely submission and completeness of the PEPFAR program expenditure report due 30 days *after* the end of the project year (31st October)<br>• PEPFAR Indicator Reporting every 30th of the 7th month and at contract year end<br>• Timely submission and completeness of the following annual reports due 30 days before the end of the contract year or on the last day:<br>  ○ Annual performance report<br>  ○ Report on EMMP<br>  ○ Annual report of government property in contractor's custody (last day)<br>• Timely submission and completeness of:<br>  ○ Datasets to DDL (30 days after dataset has been used)<br>  ○ Foreign taxes report (Due June 30th)<br>• Completeness of all reports above<br>• Response to written feedback on annual reports within 60 days of receipt of comments from USAID | • 95% of performance standards achieved | COR and USAID / KEA Office of Financial Management<br>CO, COP, DCOP, M&E Specialist, Director of Finance and Administration |
| Other management feedback | USAID/contractor communication: reviewed quarterly: emails/letters | • Acknowledgement of request within 2 days<br>• Response to request within agreed upon timeline | • 100% of performance standards achieved | COR, CO, COP, DCOP, Director of Finance and Administration |
| Quality of services and data at supported sites | 100% site visit for SIMS and RDQA during the life of the project: sites visited according to agreed site visit plan | • Data reported by project for each site verified<br>• Use of data visualization techniques verified (i.e., talking walls)<br>• 30% of EMR sites (90) implementing Point of Care (POC) and progress at 5% increase annually, facility QI results reviewed<br>• SIMS dashboards and reports<br>• DQA Reports | • 100% of performance standards achieved | COR, M&E Specialist, DCOP, COP, HSS Advisor, project long-term staff as requested |
| Progress against proposed | Work plan and budget review meetings: quarterly: Meeting minutes and JPTT generated | • Expenditure against planned quarterly budget<br>• Proposed feedback/edits on work plan addressed within 60 days of receipt<br>• Progress of activities assessed against timetable in AWP | • At least 80% of planned budget | COR, CO, COP, DCOP/SDTA, |

| Assessment Area | Methods, frequency & sources of assessment/ surveillance | Performance Standards | Quality Level To Be Achieved | Person(s) Involved in Assessment |
|---|---|---|---|---|
| work plan and budget | dashboards of progress against work plan and expenditure against budget | • Progress of activities assessed against annual gender and youth action plan | for that quarter spent, and no overspent for that quarter | Director of Finance and Administration |
| Milestone achievement | Milestone achievement review meeting; annual: annual report | • Milestones achieved<br>• Proposed feedback/edits to milestones and work plan addressed within 60 days of receipt | • 90% of milestones achieved<br>• 100% timely response to feedback | COR, COP, DCOP, M&E Specialist |

***Method for Random Site Inspection Sampling*: In each county, minimum of five sites will be selected at random in a way that no two sites are from the same sub-county (supervisory area) unless there are less than five sub-counties within the county. USAID can determine whether additional sites should be added based on technical progress and will make the final determination of sites to be visited.

**Checklists**: To document surveillance, the checklist below will be used, which is illustrative of the various assessment:

| Assessment Area | Performance Standards | Quality Level Achieved | Met/Did Not Meet Performance Expectations | Comments |
|---|---|---|---|---|
| Technical progress | Performance per objective against core indicators in AMELP | | | |
| | Quarterly progress assessed against milestones in AWPs | | | |
| | Quarterly qualitative and quantitative analysis of progress against objectives and results completed | | | |
| | Quarterly lessons learned, good practices and success stories identified | | | |
| | Project and activity location data recorded | | | |
| | | | | |
| | | | | |

| Assessment Area | Performance Standards | Quality Level Achieved | Met/Did Not Meet Performance Expectations | Comments |
|---|---|---|---|---|
| Reporting (Technical and financial) | • Timely submission and completeness of the following reports provided monthly<br>o Early Warning Indicators (EWIs)<br>o Non-MER indicators | | | |
| | Timely submission and completeness of the following reports provided quarterly within 30 days after the end of quarter:<br>o Quarterly performance reports<br>o Quarterly financial reports<br>o GIS and activity location data<br>o Small business subcontracting report entered into eSRS | | | |
| | Timely submission and completeness of the PEPFAR program expenditure report due 30 days *after* the end of the project year | | | |
| | Timely submission and completeness of the following annual reports due 30 days before the end of the contract year or on the last day:<br>o Annual performance report<br>o Report on EMMP<br>o Annual report of government property in contractor's custody (last day) | | | |
| | Timely submission and completeness of:<br>o Datasets to DDL (30 days after dataset is used)<br>o Foreign taxes report (Due April 16th) | | | |
| | Response to written feedback on annual reports within 60 days of receipt of comments from USAID | | | |
| Other management feedback | Acknowledgement of request within 2 days | | | |
| | Response to request within agreed upon timeline<br>Completeness of response to request | | | |

| Assessment Area | Performance Standards | Quality Level Achieved | Met/Did Not Meet Performance Expectations | Comments |
|---|---|---|---|---|
| Quality of services and data at supported sites | Data reported by project for each site verified | | | |
| | Use of data visualization techniques verified (i.e., talking walls)<br>○ 50% of EMR sites (90) implementing Point of Care (POC) and progress at 5% increase annually<br>○ Facility QI results reviewed<br>○ SIMS dashboards and reports<br>○ DQA Reports | | | |
| | Use of EMR, among the facilities currently using EMR, verified | | | |
| | Facility QI results reviewed<br>SIMS results reviewed | | | |
| Progress against proposed work plan and budget | Expenditure against planned quarterly budget | | | |
| | Proposed feedback/edits on work plan addressed within 60 days of receipt | | | |
| | Progress of activities assessed against timetable in AWP | | | |
| | Progress of activities assessed against annual gender and youth action plan | | | |
| Milestone Achievement | Annual Review meeting on Milestones achieved | | | |
| | Proposed feedback/edits to milestones and work plan addressed within 60 days of receipt | | | |

*Additional Comments/Concerns Discussed during Review of Assessment area of note:*

**Decision Table**: In the unlikely event that the project has not achieved expected performance standards, Jhpiego will immediately use the 'Decision Table' to: 1) identify challenge(s), 2) understand the causative factor(s), 3) determine corrective action required, 4) specify person(s) responsible, and 5) set a deadline by which the corrective action must be taken. These elements will be used to guide the management discussion internally within the project and jointly with USAID/KEA to define and remedy the challenge in short order.

TABLE 4: **DECISION TABLE**

| Performance Areas | Acceptable Quality Level | Level Achieved | Causative Factors | Unsatisfactory Performance due to Contractor, Government or Other | Action Required | Person Responsible to Conduct Action | Date Action Req. By |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**How USAID and contractor personnel will work together**: USAID representatives and project representatives will review the performance om a regular basis. For site inspections, project staff in the closest geographic proximity to the sites will accompany USAID as requested. The project team will provide all required reports and M&E data. The project team will collaborate with USAID to determine the performance areas to be assessed, the details of the surveillance protocol, and the sites/geographies to be included in inspections and evaluations. USAID will be responsible for completing the monitoring forms (i.e., checklist) to evaluate Afya Kamilisha's performance in meeting all requirements.

**How the team will treat data used to measure performance**: USAID and Kamilisha will treat all data used to measure performance as per current USAID policies and procedures. For example, PEPFAR indicator reports will be public, but quarterly finance and technical performance reports will be considered confidential. Any information that is not covered by a current USAID or Kamilisha policy will be considered confidential and only shared between USAID and Kamilisha.

**How the team identifies ways to improve efficiency and reduce risk**: During technical performance review meetings, USAID and Afya Kamilisha will identify all areas of potential risk by reviewing performance at or below 90% of the performance standards in the sampling guide and understanding the causes for low performance, so that potential solutions can be identified and Jhpiego can agree on the course of action. Afya Kamilisha will also identify all areas of risk that are outside of the project's control (i.e., professional strikes, elections, etc.) and discuss solutions and whether targets need to be revised based on these external risks.

**How disputes will be resolved**: Afya Kamilisha and USAID shall exert good faith efforts to resolve all issues that may arise in connection with the award agreement, its formation and implementation, in an amicable, equitable and mutually acceptable manner. In the event that any such issue shall not be so resolved, either USAID or Afya Kamilisha, upon written notice to the other, may request that all unresolved matters be referred to senior management officers within their respective organizations. Such officers will meet or otherwise confer at least once with the intent to negotiate a good faith resolution or to determine if other dispute resolution procedures that are less expensive or time consuming should be utilized. Neither Afya Kamilisha nor USAID may institute litigation relating to any dispute under the agreement until the consultations described above have been conducted and concluded without an acceptable result. Afya Kamilisha shall comply with the principles and guidelines stated in FAR 52.233-1 (Disputes) and FAR 52.203-13 (Contractor Code of Business Ethics and Conduct) in all dispute resolution, whether between prime contractor and subcontractor or between prime contractor and the U.S. Government.


USAID
SHORT TERM METHODS
PERMANENT METHODS