Kenya Afya County and National Support Program: Afya Halisi

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Program Year 4
Annual Work Plan

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Jhpiego in collaboration with
Consortium Partners
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<td>Baby-friendly community initiative</td>
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<td>Emergency, Risk Communication</td>
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<td>IBTCI</td>
<td>International Business and Technical Consultants, Inc.</td>
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<td>IMAM</td>
<td>Integrated management of Acute Malnutrition</td>
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<td>Information Education Communication</td>
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<td>IUCD</td>
<td>Intrauterine contraceptive devices</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>IMNCI</td>
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<td>Modern Contraceptive Prevalence Rate</td>
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<td>Maternal and Perinatal Death Surveillance and Response</td>
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<td>M2MSG</td>
<td>Mother to mother support group</td>
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<td>MIYCN</td>
<td>Maternal, infant and young child nutrition</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>Reproductive Maternal, Newborn, Child and Adolescent Health</td>
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<td>Health in All Policies</td>
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<td>RH</td>
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<td>Sub-County Health Management Team</td>
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<td>SRH</td>
<td>Sexual Reproductive Health</td>
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<td>SOP</td>
<td>Standard Operating Procedure</td>
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<td>Social Analysis &amp; Action</td>
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<td>Sexually Transmitted Infection</td>
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<td>Social Determinants of Health</td>
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<td>Technical Assistance/ Advisors</td>
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<td>TOTs</td>
<td>Training of Trainers</td>
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<tr>
<td>THS</td>
<td>Transforming health systems</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>VAC</td>
<td>Violence Against Children</td>
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<td>VSLA</td>
<td>Village Savings and Loan Association</td>
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<td>WASH</td>
<td>Water Sanitation and Hygiene</td>
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<td>WHO</td>
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<td>WiHCFs</td>
<td>WASH in Health Facilities</td>
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<td>WASH FIT</td>
<td>WASH Facility Improvement Tool</td>
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EXECUTIVE SUMMARY

The US Agency for International Development’s (USAID) Afya County and National Support Program (Afya Halisi) is a five-year project led by Jhpiego and implemented jointly with five local partner organizations. The Project works with the Kenya National Ministry of Health (MOH) and the four focus county governments of Kakamega, Kisumu, Kitui and Migori to deliver county led quality, integrated services in family planning, reproductive, maternal, newborn, child and adolescent health, nutrition, and water, sanitation and hygiene (FP/RMNCAH/WASH) to those most in need. The Project is currently in its third year of implementation and is designed to strengthen the capacity of national, county and sub-county health leaders and health systems across the continuum of the household through the community to health facilities to improve efficiency of the health systems. The Project seeks to strengthen the ability of these leaders and systems to prioritize populations most in need, increase equity, and scale-up evidence-based high-impact interventions and practices to improve quality in a sustainable and self-reliant manner. The Project implementation team has adopted an agile and adaptive approach based on iterative learning in the last three years while fostering multi-sector collaboration, coordination and private sector engagement coupled with increased social accountability towards a total market approach that reduces missed opportunities in service provision and uptake.

In years 1 and 2, the Project worked in 23 sub-counties across the four counties including the Kakamega County Government Teaching and Referral Hospital. In year 3, with the guiding principle of adapting, the Project scaled up its support beyond the initial three sub-counties in Kakamega County, to Butere, Lurambi and Mumias East sub-counties based on the poor performance of the three sub-counties that consequently pulled down the overall county performance. Over the years, the Project has responded to strategic and programmatic shifts from both USAID and the county and national governments, including local contexts, reorienting and realigning activities accordingly to achieve population coverages, improve quality of care and achieving set targets.

In year 4, Afya Halisi will continue to strengthen the capacity of the County and Sub-County Health Management Teams (HMTs) to use RMNCAH scorecard to prioritize support to sub-counties and wards performing poorly for evidence-based differentiated investments that address disparities in resource distribution, improve coverage for underserved, high burden sub-counties, wards, and health facilities to acceptable national goal and standards.

Working under MOH stewardship at all levels of the health system, Afya Halisi continues working to transfer the skills needed to achieve its key objectives to:

1. Increase the availability and quality of FP/RMNCAH and WASH services;
2. Increase care seeking and health promoting behavior; and
3. Increase MOH stewardship of key health program service delivery.

In line with USAID’s Policy Framework of the Journey to Self-Reliance (J2SR), in year 3, Afya Halisi changed its structure of consortium composition from the previous two international NGOs (Jhpiego and Save the Children) and one local NGO (PS Kenya) to one international NGO (Jhpiego) and five local organizations of Anglican Development Services Eastern (ADSE), the Center for the Study of Adolescence (CSA), Kisumu Medical and Education Trust (KMET), Lwala Community Alliance (LCA), and PS Kenya. In year 4, Afya Halisi will continue with the partnership arrangement with Jhpiego as the prime with the three

In year 4, Afya Halisi will continue with the partnership arrangement with Jhpiego as the prime and four LIPs - Anglican Development Services Eastern (ADSE), the Center for the Study of Adolescence (CSA), Kisumu Medical Education Trust (KMET) and Lwala Community Alliance (LCA).
LIPs as sub-awardees. PS Kenya will transition from the consortium end of PY3. Based on the two rounds of organizational capacity assessments that were done in year 3, Afya Halisi will continue to jointly work with the LIPs to implement the capacity building plan to strengthen their management systems based on gaps identified. The scope of work for the LIPs will include community engagement for social behavior change; addressing gender norms; WASH and the broader community health programming including adolescent and youth sexual and reproductive health. Anglican Development Services Eastern (ADSE) is implementing community level activities in Kitui County while the Center for the Study of Adolescence (CSA), Kisumu Medical Education Trust (KMET), and Lwala Community Alliance (LCA) are implementing these activities in Kakamega, Kisumu and Migori counties.

In year 4, the Project will continue to build the capacity of MOH to effectively coordinate RMNCAHN and WASH services. To advance self-reliance and as part of the Project’s transition approach, the Project will continue to work with the County Health Management Teams (CHMTs) to co-create, co-plan, co-budget, co-implement and co-monitor implementation of activities in the respective counties and will use that platform to provide technical assistance and mentor members of the CHMT on a business approach of implementation towards improved efficiency and effectiveness of the health systems for quality and people-centered RMNCAHN services. Emphasis on building of county and sub-county health systems to ensure effective coverage and provision of quality of care will continue to be at the center of focus. With the county governments leading service delivery, the Project will continue working closely with the county and sub-county HMTs to integrate services, using a crosscutting approach that focuses on health promotion, disease prevention, and the delivery of high quality, high impact interventions aimed at ending preventable child and maternal deaths. The expected outcome of this approach is the improvement of RMNCAHN and WASH indicators in line with the country’s aspirations for universal health coverage.

In years 1-3, Afya Halisi supported the identification and development of mentorship teams across all technical areas. In year 3, the Project has been working with the C/SCHMT to map out all mentors developed by Afya Halisi and other partners, standardize their practices and approaches, certify them, and create a repository of mentors to allow proper utilization of skills obtained over the years. The mentorship teams will be essential in ensuring the capacity of health care workers and community health volunteers is built across the various program areas. By utilizing the mentors, the Project will be ensuring that technical sustainability is guaranteed beyond its life. In addition, as part of the implementation of the HPN integrated model in Kakamega County in year 3, the Project is supporting the C/SCHMT to operationalize the integrated supportive supervision model that allows provision of oversight on all technical components at health facilities (both private and public sector) and at the community level. In Y4, the project will scale up this model to the other counties through conducting experiential learnings.

The recent onset of Coronavirus disease 2019 (COVID-19) pandemic, a respiratory tract infection caused by a newly emergent coronavirus, SARS-CoV-2, that was first recognized in Wuhan, China, in December 2019¹, presents a serious challenge to the health systems and to the safety and wellbeing of the Kenyan people. In PY3, Afya Halisi received incremental funding to support the Ministry of Health in implementing responsive actions to the COVID-19 pandemic at national level; Busia and Kajiado counties. The Project revised it’s Y3 work plan to adapt it’s implementation to the COVID-19 context. In PY4, Afya Halisi will continue implementing activities aimed at strengthening the country’s resilience amidst this pandemic. The Project will specifically prioritize working with the county government on the continuity of routine essential health services, particularly reproductive, maternal and child health services.

The Project purposes to continue supporting the counties and sub-counties to effectively plan, budget, and monitor activities— a gap that has been noted by the CHMT in the four focus counties. This is being achieved by co-locating Project staff with the CHMTs and SCHMTs for real-time technical support and as part of the transition process. At the sub-county level, the Project’s Technical Officers and MEL Coordinators will continue to provide the necessary support for planning, budgeting, and coordination of activities. Concomitantly, Afya Halisi will engage and work with the CHMT leaderships to leverage MOH and partner resources and develop outcome-focused and integrated joint work plans and implementation schedules that align to each partner’s planned activities and budgets for various service provision areas in order to ensure transparency, accountability, and performance-based implementation and monitoring.

In year 2, the Project hired 89 Human Resources for Health (HRH) staff for the county governments of Kitui (52), Migori (17) and Kisumu (20). In year 3, the Project advocated with the county governments, up to the highest levels of leadership, to absorb 30% of the HRH staff into their payroll as per the Letters of Agreement (LoA). In June 2020, the Project provided contracts to only 70% (64) of the HRH staff that were included in the Project’s payroll. The Counties continue to face challenges on absorption of the HRH as per the LoAs. For instance, Kitui County lacks a Public Service Board that is mandated with the recruitment of county staff due to the leadership wrangles between the executive and the members of county assembly. In year 4, the Project will continue to advocate with the three counties to absorb the remaining 62 HRH staff being supported by the project.

To strengthen private sector engagement, Afya Halisi will continue to support a structured model of engagement between the Kisumu CHMT and the Kenya Obstetrical and Gynecological Society (KOGS) for continuous quality improvement in the public and private health sectors in the county. The Project will continue to support the CHMT and the association’s leadership to implement the private sector engagement roadmap that was agreed on in year 3 based on the lessons learned from Y3 implementation. In addition, the Project will strengthen the capacity of the CHMTs in the four focus counties to oversee service delivery in the private health sector by streamlining a structured way of engagement between the CHMTs and the private sector health facilities to improve the quality of care and enhance timely and accurate reporting. Strengthening the linkage between the CHMTs and the private sector professional associations will allow them to work more closely together towards a more self-reliant, administrative, and service provision milieu. The CHMTs will provide regular supportive supervision to the private sector as part of the governments mandate to build the capacity of this sector and to ensure compliance and quality of care services.

In year 4, the Project will continue to support the county and sub-county health management teams to review and track county and sub-county level outcome data using packaged information to advocate for additional resources from the county governments and other stakeholders. Additionally, the Project will continue working closely with the CHMTs to build their capacity in development of business case ideas that will be submitted to the private sectors in the various counties, in a bid to tap into the private sector resources.

At the community level, the local implementing organizations will continue to build the capacity of communities using various platforms such as community-based organizations and community health
volunteers on social accountability. The outcome of this will be empowered communities that hold health facilities accountable for basic standards, such as working hours and staffing and county leaders on availability of essential medical commodities and supplies, which will result in ensuring the health system is responsive to community needs.

At the national level, Afya Halisi will continue to work with the Department of Family Health’s Division of Reproductive and Maternal Health (DRMH), Division of Neonatal and Child Health (DNCH) and Division of Adolescent and School Health (DASH) to develop and disseminate evidence-based policies, strategies, standards, and learning resource packages.
J2SR Road Map: Progress on milestones and priorities for year 4

Meaningful Engagement with Local Implementing Partners
To enhance local capacity towards self-reliance, Jhpiego engaged local implementing partners (LIPs) in the implementation of project activities. While the identification of the LIPs commenced in PY2Q2, the process was completed in PY3Q1. Following approval by USAID, Anglican Development Services Eastern (ADSE) was engaged to cover Kitui County; the Center for the Study of Adolescence (CSA) in Kisumu and Kakamega; Kisumu Medical and Education Trust (KMET) in Migori and Kakamega; and Lwala Community Alliance (LCA) in Migori have since been fully brought on board to join Population Services Kenya (PS Kenya) that implements in the four project counties.

Onboarding of Local Implementing Partners:
Inception meetings were held with the four LIPs to agree on the scope of work and co-plan implementation strategies. Besides, the four organizations signed sub-agreements, submitted work plans detailing how activities would be implemented, and completed the recruitment process bringing onboard staff to implement project activities. Jhpiego allocated approximately $2.1million to the five LIPs which represents 20% of year 3 obligation.

Capacity building of the LIPs:
To structure capacity-building efforts for LIPs, an initial organizational capacity assessment was completed for the four LIPs to provide baseline information on the organizations’ capacity. The assessment focused on 5 key capacity areas: leadership and governance; finance and administration; human resource; project management and data visualization and communication. For each capacity area, availability of essential documents, implementation of processes and procedures as well as a graduation criterion were assessed. The findings showed that the four organizations performed well with ADSE scoring 89%, CSA 77%, KMET 85%, and LCA 66%. The best performing areas were human resources, finance, and administration, while the worst-performing was data visualization. The identified gaps for each of the organizations have informed capacity-building strategies, mentoring, and coaching by the Jhpiego technical, finance, and M&E teams. Action plans were jointly agreed upon and signed as part of the commitment to improve the areas of weakness. At the time of the assessment, ADSE and KMET did not have SAM registration in place but Jhpiego assisted the two organizations to obtain DUNS numbers and registration on the https://sam.gov/SAM/ website.

Follow up visits were carried out for the four LIPs to jointly address agreed-upon actions. The follow-up visits provided an opportunity for the Project to mentor and coach the LIPs on areas of weakness. Besides, the Project shared requisite templates such as project charters for the LIPs to adopt and use in developing policies, guidelines, and standard operating procedures that they lacked.

The Project has completed a second organizational capacity assessment for ADSE, KMET, and LCA to assess progress and changes in the organizational capacity of the LIPs. A similar tool used during the initial organizational capacity assessment was used during the second organizational capacity assessment. The findings showed significant improvements in the five capacity areas that were assessed for the three LIPs. Further, the organizations had a better understanding of the Project’s technical areas and scope of implementation.

By the end of March 2020, Jhpiego had successfully conducted a comprehensive training for all the new LIP staff on Afya Halisi technical areas, M&E, finance, grants, administrative and branding aspects. The
training provided a platform to clarify the LIPs' scopes of work, work plans and targets for year 3, details of the Project's strategic shifts, deliverables, and USAID reporting and compliance requirements. Furthermore, the staff was provided orientation on the community scorecard which is the main tool for social accountability implementation in the project. Moreover, the Project conducted a virtual training on report writing for the LIP staff based on identified gaps in the submitted monthly and quarterly progress narrative reports. This has led to improvements in the quality of narrative reports submitted by the partners, less time spent in review of the reports and reduced turn-around time for reimbursement of funds.

In year 4, the project will continue to engage LIPs to address recommendations made during the second capacity assessment and which require more time to address (leadership and governance, procurement, finance and administration, project management, and data visualization pillars). Moreover, the project will empower LIPs to address issues raised on monthly review of invoices and narrative reports.

**Ability to write and submit proposals:**
The Project supported virtual training on proposal development and submission for the LIP staff. The training, which was facilitated by a representative from the Jhpiego Business Unit, aimed at empowering the LIPs to effectively respond to Request for Application/Request for Proposals from potential donors through the submission of robust and quality proposals. The main areas of interest by participants included the development of capacity statements, understanding a call, making the decision to apply, as well as choosing partners for a teaming agreement.

In year 4, the Project will continue to provide tailored support to each of the partners during proposal development and application processes. Some of the LIPs were in the process of developing capability statements and have requested for Jhpiego’s technical inputs. To empower the LIPs to be more competitive, the project will link the LIPs with appropriate institutions for training on donor rules and guidelines to improve their capacity to attract multiple donor funding. Further, the project will work to build the capacity of LIPs to strategically position themselves for funding opportunities through meaningful partnerships with local governments, like-minded organizations, and other government departments.

**Linkage of the LIPs with Health NGOs Network (HENNET):**
In year 3, the Project continued to engage the partners on the importance of HENNET membership. Through the Project’s initiative, ADSE was linked with HENNET for further consultations on membership. CSA was already a member and sits on the board of HENNET at the national level as well as being a member of Bungoma, Busia, and Nairobi counties. The organization will seek to play a bigger role in Kisumu and Kakamega counties. KMET is a member in Bungoma, Kakamega and Kisumu counties and has started the process for national level membership. Lwala Community Alliance (LCA) has been linked with HENNET for further consultations on membership. The project will continue to engage the LIPs to actively participate in HENNET activities and take leadership roles in the network for more visibility.

**Table 1. Progress on Meaningful engagement with LIPs**

<table>
<thead>
<tr>
<th>J2SR Metrics</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to write and submit proposals</td>
<td>Virtual training on proposal development conducted</td>
</tr>
<tr>
<td>Ability to attract funding from multiple sources</td>
<td>To provide tailored TA during proposal development</td>
</tr>
<tr>
<td>Capacity to provide quality health services as per the scope of work</td>
<td>LIPs already implementing health activities at the community level</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>J2SR Metrics</td>
<td>Progress</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Training has been conducted on technical thematic areas</td>
</tr>
<tr>
<td></td>
<td>Training staff on report writing</td>
</tr>
<tr>
<td></td>
<td>Organizational capacity assessment completed</td>
</tr>
<tr>
<td></td>
<td>Action plans for improvement agreed upon and signed</td>
</tr>
<tr>
<td></td>
<td>Follow up visits on the action plans completed</td>
</tr>
<tr>
<td></td>
<td>2nd organizational capacity assessment completed</td>
</tr>
<tr>
<td>Linking partners with HENNET</td>
<td>LIPs at different stages of membership</td>
</tr>
</tbody>
</table>

**Strengthen Coordination and Stewardship of County Governments to Deliver Services**

Afya Halisi’s J2SR roadmap envisions strengthening the counties’ ability to effectively coordinate and manage health programs. As per the approved J2SR roadmap, Afya Halisi Project identified three key deliverables for this objective. Progress of implementation under this pillar is as outlined below;

**Development and operationalization of joint work plans (JWP):**

In collaboration with the CHMTs and other RMNCAH implementing partners, Afya Halisi provided technical and financial support in co-creation of county-level joint work plans in Migori, Kisumu, Kitui, and Kakamega counties. The joint work plans (JWP) for the period FY 2020 highlight the county priorities in line with their annual work plans, and indicate funding by the government and all stakeholders. Under the JWPs, counties have committed resources for training and mentorship, supportive supervision, performance review meetings, data quality assessments, and immunization logistics including vaccine distribution. To align with J2SR, Afya Halisi successfully advocated for the county governments to take over the provision of airtime to health record information officers for uploading data in KHIS. Implementation of the JWP has been monitored quarterly while tracking co-financing by the counties. However, due to the COVID-19 pandemic, the focus county governments shifted their focus to mitigating and preventing the surge of the pandemic. Through a co-creation process, the project in collaboration with the county governments revised the work plan to prioritize activities that are geared towards slowing the spread of the virus while ensuring continuity of services. The summary of county contribution towards co-implementation of activities is as outlined in the section below.

1. **Co-financing of prioritized activities with county governments**

A key outcome of the county level joint work plans is increased county funding of FP/RMNCAH activities. Through the joint work plan framework, the Project has been tracking and documenting the financial and in-kind contributions towards implementation of activities in all the Project supported counties. Some of the activities funded by county governments through the transforming health systems funds (THS) include training and mentorship, supportive supervision, performance review meetings, and facility in-charges meetings. As at the end of PY3 Q3, the project had documented co-financing by the supported counties amounting to US$262,837 for direct activity implementation. County level details of the co-financing are outlined in table 2. This is complemented by in-kind contribution in a co-financing arrangement for the following projects;

- **Operationalization of operating theaters in Kitui County:** In Kitui County, Afya Halisi partnered with the county government in a co-funding arrangement for renovation and operationalization of the operating theatres in Tseikuru and Migwani Sub-County Hospitals. Afya Halisi supported the renovation and equipping of the two operating theaters while the Kitui County government hired and deployed 7 nurses, 2 anesthetists, and 2 doctors together with the necessary commodities and supplies to fully operationalize the theaters to provide comprehensive emergency obstetric and newborn care closer to where women live. As at end of PY3 Q3, the
preparations for operationalization are in final stages. The county is servicing the anesthetic machine in readiness for use and full operationalization is scheduled for end of PY3 Q4. (With funding from USAID Kitui received operation theatre lamps to the following theatres: Ikutha SCH in Kitui South, Kauwi SCH in Kitui Central and Zombe SCH in Kitui East)

- **Operationalization of operating theaters in Migori County:** In Migori County, Afya Halisi supported the renovation of Awendo and Rongo sub county hospital operating theaters which were completed and handed over to the county. Migori county government has provided theater equipment and supplies and will deploy staff to operationalize the theaters. In addition, the project will support a refresher training of deployed staff on operating theater procedures to operationalize the two theaters for comprehensive emergency obstetric and newborn care by end of PY3 Q4. During the year the county built a new theatre in Macalder Subcounty Hospital that was given an operation theatre Lamp with funding from USAID. The project will advocate for the operationalization of this theatre in Y4

II. **Direct funding of county governments for implementation of activities**

Kakamega County, which is one of the three integration pilot counties, is a frontline USAID/KEA Prosper County and has already signed a multi-sectoral MOU with USAID/KEA. As part of the project’s J2SR roadmap, Afya Halisi committed to providing small grants to Kakamega County to strengthen the county’s ability to manage donor resources and position itself for potential direct funding by donors. However, following consultations with USAID KEA, Afya Halisi was advised to discontinue the process of direct funding to the County Government of Kakamega. Instead, another implementing partner, AMPATHPlus will engage in an agreement with the County Government of Kakamega on direct funding to the county government. As part of the MOU with USAID/KEA, Afya Halisi will be among the USAID implementing partners that will support the implementation of the Annexes on Health and Water in the county in Y4.

**Table 2: Progress on the J2SR metrics on strengthening coordination and stewardship of county governments**

<table>
<thead>
<tr>
<th>J2SR Metrics</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of co-designed work-plans with county government</td>
<td>In FY 20, Afya Halisi in collaboration with county governments and other implementing partners co-created 4 county level joint work plans (Kisumu, Migori, Kakamega, Kitui), including an implementation monitoring framework.</td>
</tr>
<tr>
<td>Visibility of funds allocated to health by county governments and other implementing partners</td>
<td>In FY 20; Kisumu County committed US$ 1,155,514 for FP/RMNCAHN services, while Afya Halisi committed US$ 361,007; Migori County committed US$ 1,162,556 with US$ 380,000 from Afya Halisi; Kakamega County committed US$ 1,362,666 with Afya Halisi committing US$ 405,192; and Kitui County committed US$ 9,707,830 (amount inclusive of recurrent costs) with Afya Halisi committing US$ 562,301</td>
</tr>
<tr>
<td>Evidence of co-financing by the county governments</td>
<td>Through tracking of financial and in-kind contribution by counties for implementation of activities, by the end of Q3, co-financing by the counties in FY 20 was as follows; Kisumu US$ 111,684, Kakamega US$ 66,235, Migori – US$ 51,283, and Kitui US$ 33,635. Total US$ 262,837</td>
</tr>
</tbody>
</table>

**Challenges and lessons learned**

A key challenge in the development of FY 20 joint work plans was lack of budgetary allocation by counties for some technical areas in their 2019/2020 budgets which preceded the joint work plans. The most adversely affected technical elements are nutrition, family planning, health promotion, and WASH. To address this challenge, the project participated in the 2020/2021 AVP development to provide technical support for prioritization of all FP/RMNCAHN continuum of care. This will inform the county priorities
for FY 20 and the subsequent year 4 joint work plan. However, in the backdrop of COVID-19, the project resorted to virtual engagements with the C/SCHMTs to review and finalize the 2020/2021 AWPs. Another challenge was the suboptimal transparency by non-USAID implementing partners on their full extent of support to county governments resulting in the displacement of county resources in some cases and a reduction in the total co-financing by the counties. In Y4, the project will continue supporting the CHMTs to provide stewardship of all programs for transparency and accountability including those funded by non-USG support.

Support Engagement of the Private Sector to Leverage Financial and Technical Resources for Health

Private sector engagement is one of the two proven approaches by USAID to accelerate and sustain progress in the holistic approach to institutionalize Journey to Self-Reliance. This engagement envisaged enormous opportunities from tapping into new financial resources for health, to collaborating on innovations that enable breakthrough solutions to difficult problems. In PY3, Afya Halisi rolled out initiatives aimed at promoting the ability of County Government of Kisumu to plan, finance, and implement solutions to its own development needs without the need for foreign assistance. In piloting this approach, Kisumu County was chosen due to its robust presence of the private sector both in health and non-health enterprises. Notably, the project worked with the County Government towards mobilizing technical resources from the private health sector and professional associations, and financial resources from the rich private sector enterprises and individuals in the County. Below is a description of the private sector strategies utilized in PY3 and priorities for the subsequent year.

Scale-up exchange of technical resources between private and public health sector facilities:
In PY3, Afya Halisi worked towards signing of a Memorandum of Understanding (MoU) and subsequent implementing of cross-learning forums between Aga Khan Hospital, Kisumu and Kisumu County Referral Hospital on technically appropriate and contextual management and clinical aspects of health service delivery. Working with the blessing of the County, the project engaged the leadership of the two organizations independently for buy-in and agreement on the twinning agenda. The project working with the County also developed the draft MoU and facilitated several meetings between the leadership of the two health facilities with the objective of establishing an agreement on all clauses of the MoU in readiness for the official signing. It is envisaged that the two health facilities will sign the MoU towards the end of PY3. The delay in signing the MoU between Aga Khan Hospital Kisumu and Kisumu County Referral Hospital was attributed to changes in office holders of Kisumu County Health Management Team, postponement of the meetings to allow the County to respond to covid-19 pandemic, and the healthcare workers industrial strike.

In PY4, Afya Halisi will fast track the cross-learning forums between Aga Khan Hospital Kisumu and Kisumu County Referral Hospital and document the lessons learned and best practices for scale up. The project will also expand the twinning partnerships to other private and public health facilities using evidence on critical process and outcome indicators of care. This will be done through identification of additional public and private facilities that may benefit from twinning partnerships. The project will work with the County to facilitate signing of MoUs and implementation of cross-learning forums in these facilities. Reports from the KO GS mentorship and coaching program indicated gaps in patient assessment, investigations, diagnosis and management in one of the major private facilities in Kisumu. Twinning partnerships between such a private facility and JOOTRH will see improvement in the quality of care provided. In this regard, twinning partnerships are envisaged to benefit both health facilities. To enhance the sustainability of twinning partnerships as a way of improving health services in the county, Afya Halisi will engage the County
department of health in order to come up with a sustainability plan. This will ensure that these partnerships are supported beyond the life of the project.

**Harnessing technical resources from professional associations:**
The growth of the private sector has seen its expertise in various sectors of the economy unequivocally strengthened. Using the same lens and in line the USAID’s vision on Journey to Self-Reliance, Afya Halisi in its third year of project implementation focused on facilitating meaningful engagement between the Kisumu CHMT and local chapters of the health professional associations of Kenya Obstetrical and Gynecological Society (KOGS) and Kenya Pediatrics Association (KPA) to have these two associations play a bigger role in improving the health of women, children and adolescents. The project facilitated two consultative meetings where the professional associations engaged internally among themselves on ways they can contribute more meaningfully to the improvement of RMNCAH outcomes. The outcome of these deliberations was the affirmation on the need for mentorship and coaching program for HCWs in the peripheral facilities. The Project kept the county health leadership informed on the outcomes of these meetings. Afya Halisi identified 4 needy health facilities based on the number of maternal complications, maternal deaths, and perinatal deaths. The project working with KOGS representatives identified four (4) obstetrics and gynecology consultants and agreed on modalities of the facilitation. Afya Halisi also co-developed the necessary tools to document and quantify the impact of this intervention. Subsequently, the project facilitated the piloting of the program in the four (4) health facilities. Despite this progress, the delays occasioned by the onset of the COVID-19 pandemic and HCW industrial action led to the implementation of the mentorship and coaching program for a shorter than anticipated duration.

In project year 4, the project will conclude the first phase of mentorship and coaching program and document best practices and lessons learned for scale-up. The project will work with the County to initiate a second phase of mentorships with a focus on needier public and private health facilities based on similar criteria. Additional health facilities will be selected for support and mentorship and coaching plans agreed on with KOGS mentors. Using the evidence generated from the pilot mentorship and coaching program, Afya Halisi will advocate to the County on the need to institutionalize and sustain the KOGS mentorship and coaching program. Additionally, the project will facilitate engagements between the Kisumu County Department of Health and KOGS members on strengthening RMNCAH services and provide technical support in design of the structured framework or roadmap of engagement going forth. Afya Halisi will take forward initial conversations with the governor and the nominee Health CEC Member to support this process by engaging prominent and trusted health leaders who hail from the county.

**Resource Mobilization from the Private Sector:**
It is without a doubt that the private sector is endowed with a substantial amount of resources that remain untapped. There is a need to catalyze private-sector resources now more than ever to achieve the health goals and objectives as the focus on self-reliance intensifies. In PY3, Afya Halisi embarked on the journey to mobilize financial and non-financial resources from the private sector enterprises and individuals. Earlier on the project year, Afya Halisi engaged the focal persons responsible for resource mobilization on their buy-in and insights on how to carry out the resource mobilization agenda. In order to build the capacity of the health sector in Kisumu County to effectively mobilize resources, Afya Halisi worked with the County to develop a county resource mobilization strategy and roadmap. In working towards this milestone, the project facilitated a workshop, virtual meetings, and a series of small face-to-face meetings in order to develop, review and refine and finalize the roadmap. The project also incorporated the Kisumu CHMT into a LIP zoom training on responding to calls for proposals. A hands-on training and mentorship on concept development and proposal writing was carried out to impart practical knowledge and skills. However, due to COVID-19 pandemic restrictions on large meetings, county forums by the Governor,
Kisumu County to engage private sector players were not convened. Other challenges that affected achievements in this strategy resulted from changes in the CHMT office holders including the CEC, and the COH leading to the loss of gains made with the former office-bearers.

In PY4, Afya Halisi will support the establishment and functioning of the Kisumu County Health Sector Resource Mobilization Technical Working Group (TWG). The project will also support the implementation of the County Resource Mobilization Roadmap through monthly and quarterly review meetings. Afya Halisi will carry out advocacy on resource mobilization targeting key influencers of the County and the Governor Kisumu County. The project will support a forum between the Governor and private sector players in Kisumu where health resource gaps will be highlighted and appeal for support made. Additionally, the project will support mentorship and hands-on support to the select TWG members in developing and submitting concepts for funding and responding to the live calls for proposals.

**Table 3. Summary Progress on Engagement of Private Sector to Leverage Resources for Health**

<table>
<thead>
<tr>
<th>J2SR Metrics</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pairing of Aga Khan Hospital Kisumu and Kisumu CRH for cross-learning</td>
<td>Aga Khan Hospital Kisumu and Kisumu County Referral Hospital leadership engaged by AH independently for buy-in and support the twinning</td>
</tr>
<tr>
<td>Memorandum of understanding between Aga Khan Hospital Kisumu and Kisumu County Referral Hospital</td>
<td>Engagement of the county health leadership on this activity despite the frequent changes in officeholders</td>
</tr>
<tr>
<td></td>
<td>Draft MoU developed, reviewed and refined into a Kisumu County format</td>
</tr>
<tr>
<td></td>
<td>AGHK and KCRH leadership meeting to deliberate on MoU contents - Agreement on most elements of the MoU except on specific areas of partnership in specified departments.</td>
</tr>
<tr>
<td></td>
<td>MoU signing meeting deferred due to the need for Aga Khan Hospital to consult their governance structures, and due to HCWs industrial action affecting identification of specific areas of partnership in KCRH</td>
</tr>
<tr>
<td></td>
<td>Call for the facilities’ leadership meeting once HCWs strike ends</td>
</tr>
<tr>
<td>Harnessing technical resources from the professional associations</td>
<td>Leadership of KOGS and KPA engaged for buy-in</td>
</tr>
<tr>
<td>County roadmap of engagement with professional associations</td>
<td>Meetings between KOGS and KPA and Afya Halisi conducted and county health leadership updated. KOGS agreed to pilot the mentorship and coaching program for HCWs in health facilities that have been jointly identified based on need.</td>
</tr>
<tr>
<td></td>
<td>KOGS identified 4 (4) consultants to lead the first phase of mentorship and coaching and the modalities of facilitation agreed upon with Afya Halisi and the county health leadership.</td>
</tr>
<tr>
<td></td>
<td>Mentorship and coaching program deferred as a result of COVID-19 pandemic and HCWs industrial action. This will take off within the remaining period of this year</td>
</tr>
<tr>
<td></td>
<td>County government, AH and KOGS will co-create formal structure for engagement with the county after generation of evidence from pilot mentorship and coaching.</td>
</tr>
<tr>
<td>Resource Mobilization</td>
<td>Buy-in from the County Department for Health leadership sought</td>
</tr>
<tr>
<td>County roadmap for domestic resource mobilization</td>
<td>Focal person for resource mobilization engaged for input into the process</td>
</tr>
<tr>
<td></td>
<td>A resource mobilization team identified from existing CHMT (Disbanded in PY3Q2 as a result of change in leadership)</td>
</tr>
<tr>
<td></td>
<td>A new team installed after appointment of a new CHMT and oriented</td>
</tr>
<tr>
<td></td>
<td>5-day workshop planned to deliver a resource mobilization roadmap but was canceled on day 2 due to COVID-19 pandemic.</td>
</tr>
</tbody>
</table>
Zoom meetings and small group (less than 10) face-to-face meetings utilized to work on the roadmap focusing on chapter by chapter approach

First draft of the Kisumu County Resource Mobilization Roadmap developed

The first draft will undergo content review, editing, design, production and will be launched by the Kisumu Department of Health in PY3Q4

Implementation of the roadmap to begin in August 2020

<table>
<thead>
<tr>
<th>Number of concept notes submitted to private sector players</th>
<th>Zoom training on “Responding to calls for proposals” done.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of concept notes funded by private sector</td>
<td>Hands-on training on concept development and proposal writing to be done in the remaining period of the year</td>
</tr>
<tr>
<td>County forums convened by the Kisumu County Governor to engage private sector players</td>
<td>Submission of concept notes and proposals to identified resource providers to be done in the remaining part of the year</td>
</tr>
<tr>
<td>To be carried out once COVID-19 situation allows meetings of more than 20 participants to be held</td>
<td></td>
</tr>
</tbody>
</table>

Enhance Social Accountability Across all Levels

The Project consolidated efforts to raise the voices and capacity of citizens to demand greater accountability from the political leadership, health facilities, and health care workers and to improve responsiveness in service delivery. The Project provided technical assistance to the local implementing partners and community-based organizations to implement participatory social accountability and collective action mechanisms aimed at enhancing provision of quality health services at the county, sub-county, ward, health facility and community levels.

Build the capacity of project and LIP staff on social accountability mechanisms:

The project engaged MOH community scorecard TOTs in training staff including LIPs on the scorecard to advance social accountability, participation, transparency, and accountability among HCWs and community members in the delivery of health services. The training has allowed the staff to co-implement the community scorecard at various levels in the four counties in collaboration with the sub-county community strategy focal persons. Besides, they have continued to support CBOs in the implementation of the tool as a result. The following have since been achieved since the rollout of social accountability:

- A critical mass of organizations established: The project co-implemented the selection of 18 CBOs (Kakamega-8, Migori-10) out of a pool of 85 that were mapped to implement social accountability activities at the community level. The chosen CBOs met the following criteria; involved in community health, participate in community advocacy, have financial control systems, and a record of collaboration with communities within their catchment areas. Besides, they displayed gender diversity, youth, and adolescent involvement, as well as the inclusion of people living with disabilities, and showed great interest and enthusiasm in working with the communities to roll-out social accountability activities. The involvement of CBOs will ensure sustainability for they will continue to implement social accountability activities even after the project transitions. The Project supported the training of 90 community social accountability facilitators (50 male, 40 female) on the use of the community scorecard. The facilitators are expected to work with the health facility management committees to advocate for improved quality of care, promote the establishment of grievance redress mechanisms at the health facilities, promote community participation in the annual budgetary process, and advocate the communities to have a collective voice and demand for better performance at health facility, ward, and county government levels.
Training of community facilitators: Also, the project supported the training of 32 community facilitators chosen from within the community unit structure consisting of women of reproductive age, people with disabilities, youth, opinion leaders, religious leaders among others drawn from across the four counties to facilitate the community scorecard process. Further, the Project is engaging in efforts that are led by KMET to strengthen the coalition of CSOs in addressing FP within the broader umbrella of UHC in Kisumu County.

The project utilizes the community scorecard tool to advance social accountability, participation, transparency, and accountability in the delivery of health services. So far, the project has completed the process in Kitui County and is at the facility level in Kisumu and Migori counties. In Kakamega County, the Project supported a scorecard feedback meeting to review action points agreed upon in PY3Q1. While only key priorities are drawn from community issues for the interface session, other issues are addressed in other social accountability forums that community health committees, service delivery stakeholders, and the health facility management committees will consider. The main issues that have so far been raised are related to ambulance services, laboratory services, availability of drugs, and staff attitude. During the review session in Kakamega County, participants reported that staff attitude had improved leading to more clients seeking services at the facility; the facility had started to provide 24-hour services after employment of 2 additional HCWs; there was the provision of free laboratory services for ANC profiles and free removal of FP implants which were previously charged.

In year 4, the project will continue to support the CBOs to collaborate with the sub-county health management teams in implementing social accountability activities including the community scorecard. Further, the project will empower the CBOs to continue implementing social accountability activities effectively so that the activities can continue beyond the life of the project. Besides, the project will support the documentation of experiences in the implementation of the community scorecard and impact on the quality of services provided in the health facilities.

Strengthening oversight and accountability of facilities and hospitals:
The Project has continued to strengthen the capacity of health facility management committees (HFMCs) to improve functionality and optimize service delivery. The Project has supported the training of 27 HFMCs; three (3) of the HFMCs have already put in place grievance and redress mechanisms to enable community members to provide feedback aimed at improving service delivery in the facilities. The HFMCs also tracked resource allocation during the fiscal year 2020/21 budgeting process and showed commitment to follow through the process to ensure prudent allocation of resources to their facilities.

In year 4, the project will focus on building the capacity of health facility committees and hospital boards to ensure the efficiency and quality service delivery in health facilities. Training will be held for the remaining committees that were not trained in year 3. This will ensure the committees can implement redress mechanisms so that community members can have their issues addressed. Further, the project will continue working with the ministry of health to be involved more in the budget-making process to ensure that health services are prioritized in the budget-making process. At the community level, the project and the ministry of health will engage CHVs and youth champions to participate in the public participation fora to highlight health-related matters for discussion.
Table 4. Summary Progress on Social Accountability

<table>
<thead>
<tr>
<th>J2SR metrics</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of functional HFMCs or HBs as defined by government statutes</td>
<td>Jointly mapped out 164 health facility committees</td>
</tr>
<tr>
<td></td>
<td>Co-facilitated and co-financed training for 27 HFMCs (Kakamega – 15, Migori- 12)</td>
</tr>
<tr>
<td></td>
<td>Co-financed and co-facilitated quarterly review meetings for 10 HFMCs (3 in Kakamega and 7 in Migori)</td>
</tr>
<tr>
<td>Number of facilities with grievance and redress mechanisms</td>
<td>3 out of 4 HFMCs have put in place grievance and redress mechanism structures. Some facilities have placed suggestion boxes at strategic points</td>
</tr>
<tr>
<td>Number of facilities with health facility management committees that develop and utilize community participation tools</td>
<td>Trained 32 community facilitators on implementation of community scorecard (CU structure)</td>
</tr>
<tr>
<td></td>
<td>At different stages in 6 facilities (1 each in Kakamega and Kitui; &amp; 2 each in Kisumu and Migori)</td>
</tr>
<tr>
<td></td>
<td>Use of community scorecard with community members completed in 4 facilities</td>
</tr>
<tr>
<td></td>
<td>Use of community scorecard with HCWs completed in 3 facilities</td>
</tr>
<tr>
<td></td>
<td>2 interface sessions completed (Kakamega-1, Kitui -1)</td>
</tr>
<tr>
<td></td>
<td>10 CBOs in Migori and 8 in Kakamega selected and capacity assessment done.</td>
</tr>
<tr>
<td></td>
<td>Trained 90 CBO facilitators on social accountability</td>
</tr>
<tr>
<td>Number of communities actively participating in the budgetary process</td>
<td>Co-facilitated participation of key community champions in Kisumu, Kakamega, and Migori in public participation forums for county fiscal budgets for FY2020/21</td>
</tr>
</tbody>
</table>

Health Systems Strengthening by Addressing the WHO Building Blocks

Human Resources for Health (HRH)

Transitioning of the Contracted HRH to County Government Employment as per the Letters of Agreement

In year 3, the Project advocated with the county governments, up to the highest levels of leadership, to absorb 30% of the HRH staff into their payroll as per the Letters of Agreement. In June 2020, the Project provided contracts to only 70% of the HRH staff that were included in the Project’s payroll. The other 30% were considered for transitioning by the county governments of Kisumu, Kitui and Migori. In year 4, the Project will continue to advocate with the three counties to absorb the remaining 62 HRH staff being supported by the project.

Increasing efficiencies of existing HRH

In year 3, the Project continued to advocate with counties to regularly utilize the WHO workload indicator of staffing needs (WISN) tool for mapping of existing health care workers in all facilities to enable rationalization of existing human resource in Migori, Kisumu and Kakamega counties. The WISN tool provides objective ways of addressing mal-deployment of HRH by improving rationalization and deployment to the appropriate service areas, and enhancing accountability and motivation of HRH. In year 4, the Project will leverage with HRH Kenya to regularly utilize the WISN tool for rationalization of existing human resource in the focus counties. A summary of the progress of the J2SR metrics is indicated Table 5 below.
Table 5: Progress on Human Resources for Health

<table>
<thead>
<tr>
<th>J2SR Metrics</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of absorption of 30% of the supported HRH staff</td>
<td>In Kisumu, Kitui and Migori counties, the Project successfully conducted joint advocacy sessions with senior county government leadership including the CDH, COH, Health CEC Member, Governor, and the Chairman of the Health Committee at the County Assembly resulting in the commitment by each to absorb 30% of the HRH by July 2020. Due to various reasons, complete transition of the envisioned 30% of the HRH staff to the county governments’ payrolls did not take place. In year 4, the Project will continue to advocate with the three counties to absorb the remaining 62 HRH staff being supported by the project.</td>
</tr>
<tr>
<td>Counties utilizing the WHO workload indicators of staffing needs (WISN) tool to rationalize deployment of staff</td>
<td>The Project continued to engage the counties to implement action plans that were generated in collaboration with the HRH mechanism during the dissemination of the WISN assessment results. Kakamega county committed to expand use of WISN tool to all health facilities to inform staffing norms and rationalization was interrupted by the advent of the COVID-19 pandemic. Migori County has continued to expanded use of the tool to additional health facilities as a result of sustained advocacy efforts. The plan by Kitui County to conduct its WISN assessment in year 3 was interrupted by the COVID-19 pandemic. Afya Halisi will continue to collaborate with HRH Kenya to provide the necessary technical support during the exercise.</td>
</tr>
</tbody>
</table>

Healthcare Financing

In Migori, the regulations to operationalize the County Health Service Act that was co-facilitated and co-financed by Afya Halisi was finalized and printed by the government printer. The Health Services Act has a section that describes the mobilization and utilization of health funds. The Project supported the County Government of Kitui through a co-creation, co-planning and co-financing process to finalize the Kitui Health Services Bill that has sections that stipulate the generation and utilization and ring-fencing of health services funds; implementation of the Community Health Strategy, including the role and utilization of CHVs; and the Health Products Technology Unit. In Kisumu, the Project co-supported the county to develop a draft road map for domestic resource mobilization from the private sector. The road map will be launched in the last quarter of year 3.

Leadership and Governance Capacity of C/SCHMTs

In year 3, Afya Halisi continued to build on earlier advocacy initiatives directed at the MOH leadership in the four focus counties to strengthen planning and coordination for effective delivery of quality services. The Project supported the counties to lead the process of developing of joint work plans, including all implementing partners. Afya Halisi has consistently engaged the county leadership on the various advocacy agenda. The progress of the various advocacy agenda is shown in Table 6 below.
### Table 6. Progress on Advocacy agenda

<table>
<thead>
<tr>
<th>County</th>
<th>Advocacy Agenda</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kitui</td>
<td>Reinstatement of the community program as per national policies and guidelines for implementation of the Community Health Strategy and having it anchored in an appropriate county law.</td>
<td>In year 3, the Project co-facilitated and co-financed a workshop bringing the County Assembly Health Committee, the County MOH leadership and a team of lawyers (The County Assembly legal advisor, the Kitui County Legal Officer and a consultant lawyer) to harmonize the various clauses in the Kitui County Health Services bill. The Project supported the county to integrate community health services into the Bill. Once enacted into county law, it will protect the community health platform against the cyclical changes in political leadership. The bill also has provisions on the health services fund and the Health products and technologies unit. The draft bill was submitted to county executive for approval and submission to the County Assembly.</td>
</tr>
<tr>
<td></td>
<td>Absorption of contracted HRH hires by the county government.</td>
<td>Despite the county government’s commitment to absorb 30% of the HRH staff, that was not possible. However, the Project transitioned 30% of the HRH staff from July 2020. In year 4, the Project will continue to advocate with county government to absorb the remaining 38 HRH staff being supported by the project in the county.</td>
</tr>
<tr>
<td>Migori</td>
<td>Operationalization of the County Health Services Act</td>
<td>In year 3, through regular discussions with the Migori county health leadership, it became apparent that operationalizing the Health Services Act was the county’s immediate priority. Consequently, the Project co-financed and co-facilitated development of regulations to operationalize the County Health Services Act that had been enacted in November 2019. The regulations were approved by the county assembly and printed by the Government printer.</td>
</tr>
<tr>
<td>Kisumu</td>
<td>Domestic resource mobilization from the private sector for health care financing.</td>
<td>In year 3, the Project worked with the Kisumu CHMT to develop the draft road map for domestic resource mobilization from the private sector. The road map will be launched in the last quarter of year 3.</td>
</tr>
<tr>
<td>Kakamega</td>
<td>Finalization of the development of the Health Bill</td>
<td>In year 3, the Project co-financed and co-facilitated the co-creation meetings to develop regulations for operationalization of Kakamega County Health Facility Fund.</td>
</tr>
</tbody>
</table>

**Health Management Information System for Effective Use of Data**

In year 3, the Project collaborated with Tupime Kaunti to generate a fact sheet for Migori County that showed performance trends in key health indicators and priority actions to address the key gaps. In addition, the Project collaborated with Tupime Kaunti in generating a quarterly bulletin for Kisumu County that demonstrated progress in key FP/RMNCAH indicators and recommended responsive actions to accelerating improvement in performance. The Project co-developed ward level RMNCAH scorecards for Kisumu County. These scorecards were used during a consultative meeting between the County Health Executive, the County Assembly and members of the County Public Service Board to advocate.
with the Kisumu County Members of Assembly for increased resource allocation for RMNCAH services, especially for wards with low coverage performance in key FP/RMNCAH indicators.

In year 4, the Project will continue to work with Tupime Kauti and county MOH teams to develop bulletins that will show progression of county performance in key FP/RMNCAH, nutrition and WASH indicators, especially during the COVID-19 pandemic period, and key actions required for enhanced resource allocation and to ensure continuity in essential health service provision.

**Increased Access to Essential Medicines and Products**

In year 3, the Project continued to advocate to the counties to prioritize their budgeting to include making payment of all unpaid KEMSA bills to minimize interruption of supplies of essential medicines, health products and technologies, including FP commodities. This advocacy initiative resulted in Kisumu county even buying essential medicines from the open market when KEMSA did not have life-saving medicines like Oxytocin in stock. The four counties were able to pay their bills to KEMSA on schedule. The Project continued to work with the counties on improving the supply chain system that was catalyzed by the introduction of the integrated supply chain management approach, towards improvement of security of essential life-saving commodities and supplies including those for family planning, maternal and newborn health and vaccines. However, the counties still experienced stock-outs of commodities and supplies at the point of use at different times. In addition, in year 3, the Project collaborated with Afya Ugavi to build the capacity of staff/pharmacists on commodity security and pharmacovigilance. The Project will also continue to advocate for appropriate resources allocation for the line items. In year 4, Afya Halisi will continue to collaborate with Afya Ugavi by building the capacity of health care workers to implement supply chain activities at facility levels as Afya Ugavi continues to implement the integrated supply chain model. The progress of the engagements with the county governments is shown in Table 7 below.

**Table 7. Progress on Increased Access to Essential Medicines and Products**

<table>
<thead>
<tr>
<th>J2SR Metrics</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities reporting zero stock-out of essential commodities</td>
<td>In year 3 The Project has consistently engaged the senior county leaderships, up to the Governor level, to pay their debts to KEMSA to allow them to minimize stock out of essential drugs and commodities. This advocacy has resulted in the counties being able to reduce their debts to an extent they now have regular supplies of essential medicines and commodities.</td>
</tr>
</tbody>
</table>

**Kakamega**

Project year three saw Afya Halisi expand its geographical scope in Kakamega County from the initial three (3) sub-counties to include direct support of an additional three sub-counties in Kakamega County, which include Butere, Lurambi, and Mumias East. This followed a request by County Government of Kakamega to Afya Halisi, based on low population coverage performance and strategic importance of the referral hospitals in these sub-counties to serve a wider population in the county. Consequently, in PY3 from Q2, the Project supported 6 out of the 12 sub-counties in that county, adding to the initial 3 sub-counties of Khwisero, Matungu, and Navakholo.

In PY3, the Project co-financed and co-facilitated the co-creation of regulations for operationalization of Kakamega County Health Facility Fund. The fund creates a facility improvement fund to be administered by the Chief Officer of Health and thus consolidates resources for health within the health department and guards against utilization of resources for health on non-health related expenses. With Kakamega County having been identified as a USAID ‘Prosper’ county and having signed a memorandum of
understanding (MOU) with the USAID, Afya Halisi led a collaborative effort of six implementing partners in the implementation of an integrated model for FP, MNCH, Nutrition, HIV, OVC and Malaria programs. At systems level, the Project co-implemented supportive supervision on integrated supply chain in the focus sub-counties in partnership with the county and other USAID funded mechanisms, co-supported Kakamega County to develop and validate its FP costed implementation plan 2020 – 2025 and co-supported training of members of health facility management committees on budgeting process and financial accountability. The project also provided technical support during the development of the Kakamega County biannual MPDSR report. At service delivery level, Afya Halisi supported targeted mentorships on EmONC, OPL EPI, IMNCI, LARC for newly hired healthcare workers.

In response to the COVID-19 pandemic, Afya Halisi in collaboration with the county government of Kakamega Department of Health, co-planned and co-implemented activities targeted at ensuring continuity of care for women, children and families. The project co-supported dissemination of guidelines for continuity of RMNCH services to HCWs, reprogrammed interventions to align to public health measures on social distancing and handwashing and rolled out toll free lines for adolescents and young people seeking health services.

By end of Q3, PY3 SBA coverage in Kakamega County was 68%, as compared to 56% at project inception, ANC 4 coverage was 58% from 39% at inception and FIC coverage was 77% from 68% at inception.

**Kisumu**

In PY3, Afya Halisi prioritized support for targeted service delivery interventions while building capacity of county leadership and health systems in preparation of a transition of supported activities. As at end of PY3 Q3, the project had supported targeted onsite mentorship and supervision on emergency obstetrics and newborn care (EmONC), operational level immunization (OPL EPI) and long acting reversible contraception (LARC) including postpartum family planning (PPFP). At the community level, the project supported household mapping, identification and referrals of pregnant and lactating women and children for services. The project supported printing of referral tools, monthly meetings for community units and training of community health units on community MNCH modules. Afya Halisi supported systems-level activities targeted at ensuring commodity security, effective referral networks, strong social accountability mechanisms and development of strategic documents. Specifically, the project supported commodity redistribution and review meetings, referral planning meetings, community scorecard trainings and dialogue sessions. Afya Halisi provided technical support for the development of Kisumu County family planning costed implementation plan (CIP).

Private sector engagement was identified as a pillar for support in Kisumu County under the project’s J2SR in PY3. Pursuant to this objective, Afya Halisi participated in the co-creation of a resource mobilization roadmap, twinning partnership for leveraging of technical resources between public and private health facilities and engagement with professional associations such as the Kenya Obstetrics and Gynecological Society (KOGS).

The emergence of COVID-19 pandemic in PY3 Q2 saw the national and focus county governments introduce public health measures targeted at slowing down the spread of the virus. The non-emergency health services were greatly affected by the COVID-19 response measures that were put in place, with some of the health facilities in Kisumu County closing out-patient departments or transferring those services to other health facilities to minimize the spread of COVID-19 pandemic. During the initial weeks of the pandemic, communal and group activities were halted with counties offering support for emergency interventions only. The restrictions occasioned by the public health measures and resulted in a reduction in care seeking by communities, a corresponding increase in home-based deliveries, a rise in the number
of unvaccinated and under vaccinated children and an increase in sexual gender-based violence (SGBV) cases. As a result, the project in concert with the county government through the department of health reprogrammed its interventions to align to the national and county governments’ regulations on prevention and management of the pandemic. The reprogramming was necessitated to ensure that there is continuity of essential health services to the targeted population. In consultation with the focus county health leaderships, the Project continued with implementation of activities that do not require large gatherings of people, while ensuring adherence to the COVID-19 prevention measures. In response to the rise in SGBV cases, the project co-implemented rapid capacity building interventions for HCWs on response and prevention of SGBV. In addition, Afya Halisi co-supported an emergency response platform for adolescents and young people seeking health services by rolling out a toll free line.

Efforts to ensure continuity of services amidst COVID-19 contributed towards attainment of a skilled delivery (SBA) coverage of 76%, fourth antenatal care coverage of 59% (ANC 4) and a full immunization coverage (FIC) of 83% by end of June 2020. Despite these coverages performing sub-optimally in FY 20, this still represents an improvement from the performance at project inception when SBA was at 62%, ANC 4 was at 42% and FIC at 71%.

**Kitui**

In the wake of the disruptions caused by COVID-19, Afya Halisi’s initial support was to ensure continuity of essential RMNCH services. These included the dissemination of Kenya RMNH COVID-19 guidelines, a rapid assessment to document the effect of COVID-19 on healthcare service delivery and infection prevention and control orientation in high volume facilities. As part of this extended support and in line with the co-creation and co-planning approach, the USAID Afya Halisi has supported the county with co-implementation of the response and mitigation activities. The support includes training of 146 HCW and 550 CHVs on COVID-19 prevention, case management, contact tracing and disease surveillance. The Project will support extra training to 100 more HCWs from 8 sub-counties before the end of PY3.

Demand creation activities remain an essential element of service delivery. In Kitui, the Project supported the county health promotion team in the identification and leveraging of social media platforms for FP/RHMNCAH information dissemination. The team also worked closely with the county’s Health Promotion Advisory Committee (HPAC) in the identification of messages for dissemination through these platforms. The platforms identified including; Twitter, Facebook, YouTube and short text message media. In efforts to improve coordination, the county appointed sub-county health promotion officers in PY3.

Consequently, the Project worked provided a technical orientation on the roles of the position in advancing health promotion and supporting community education activities. In the reporting period, the SBC team continued to support the CHPO in planning for implementation of the mass media strategy, including radio talk shows in various radio stations. The team also supported the training of the health promotion team to manage the toll-free helplines FP/RHMNCAH information dissemination and referral/linkage. The toll-free lines are in operation, and a comprehensive analysis of the outputs will be in the annual Project reports.

Inadequate financing for MNH is associated with quality and access gaps in health service delivery. Many health facilities in the county have experienced challenges with financing for FP/RMNCAH and other services. To strengthen health care financing for MNH, the Project, in collaboration with NHIF and MOH, conducted an orientation of 12 HCW from 12 health facilities that conduct deliveries from Mwingi West sub-county on Linda mama financing. The Project has been at the forefront of supporting the initiative to enact the Kitui Health Services Bill, which will allow for direct reimbursement of funds to facilities for operations and development. In another collaborative initiative, the Project worked with the USAID Afya
Ugavi Project to develop sub-county trainers and mentors who will support commodity management at the facility level. This initiative is part of ongoing collaborative efforts between the Afya Halisi and other USG-supported projects.

A large proportion of neonatal deaths in Kitui County are associated with newborn asphyxia. In the county’s largest referral Hospital- Kitui County Referral Hospital, 32 (46%) of neonatal deaths reported in the newborn unit from January to May 2020, 32 were due to newborn asphyxia. Further reports from MNH supervision and MPDSR reviews conducted in the reporting period indicated that most HCP in the county lack knowledge and skills in newborn resuscitation. To address the gaps and promote newborn survival, the Project worked closely with the county’s Division of Neonatal and Child Health to conduct ETAT drills focusing on capacity building of HCP on newborn resuscitation.

Access to safe drinking water in Kitui County has been disadvantaged owing to the limited endowment with water resources. This limitation has resulted in disproportional access to safe water in the sub-counties with a comparatively higher diarrhea disease burden in Mwingi North and Kitui South sub-counties. In PY3, the county collaborated with the Department of Water and Irrigation to rehabilitate five boreholes – three in Kitui South and two in Mwingi North. The five water sources have the potential to provide safe drinking to over 13,000 people. The Project will continue to support the water management committees to manage the water points for posterity.

**Migori**

As part of strengthening county coordination and improving planning of activities, the Project supported the CHMT to conduct a joint work planning session for the FY2019/2021 focus activities. This process that was meant to operationalize the AWP. The joining work planning process was steered by the county health leadership, and the process brought together all the other RMNCAH/Nutrition and WASH partners within the county. This process enhanced visibility of the support that the county is receiving from various development and implementing partners. Afya Halisi has followed through this process of JWP with the county to fulfil their mandate and the county contribution is reflected in the resource mobilization tracker.

For PY3, based on the priorities indicated in the JWP, Afya Halisi implemented IMNCI approach by training a pool of sixteen mentors at county level who subsequently conducted onsite mentorship reaching over 200 HCWs and CHVs. The project also supported EPI cold chain equipment maintenance leading to the revival of 9 facilities that had stopped providing immunization services due to break down of equipment. The project increased utilization of the USAID procured ultrasound machines by training 70 health workers in basic obstetric ultrasonography, thereby benefitting over 200 mothers, thus reducing unnecessary referrals for basic obstetric. Due to the stock outs for IFA, the project catalyzed social accountability for IFA through the community scorecard, leading to identification of barriers to increased utilization of IFA that the project will follow through.

Significant strides have been made in Migori county across the RMNCAH/FP/NUT/WASH components of the project as reflected in the trend of the indicators. However, despite all the gains there are emerging issues that could threaten the continued improvement of health indicators in Migori. The impact of COVID-19 pandemic, reported local transmission and impact to health services, county and sub-county level system weak points and certain context specific gaps in certain sub-counties are the main areas that the project considers critical for support in FY4. The inspiration of Year 4 investments is walking with the county health department to ensure that the investments made in Year 1 to Year 3 are sustained by the county government and communities beyond the project phase. Afya Halisi will in Year 4 continue supporting the county in strengthening its Joint Work Planning with not only USAID IPs but with all
RMNCAH/FP/NUT/WASH partners. Further to this Afya Halisi with take the County Health Act and its regulations to the next level. The project plans to support the county to ring fence funds to the health department through operationalization of the county health fund as envisioned in the county health act. Afya Halisi will also advocate for allocation of funds to infrastructural aspects for medical waste management. The project will also work with the health departments and other health partners so as to establish a synergized support supervision approach for the county.

**National level**

Afya Halisi has continued to support Department of Family Health specifically, the Division of Reproductive and Maternal Health, Division of Neonatal and Child Health and the Division of Adolescent and School Health. Afya Halisi has co-supported the Divisions in the development, review, dissemination of national policies, guidelines and technical briefs. To date, Afya Halisi has co-supported the development of the National Obstetrics and Perinatal Care Guidelines, Quality of Care assessment tool, EmONC mentorship package, Neonatal and Child Health Strategy, M&E framework to monitor FP2020 progress. The Project has also strengthened the M&E capacity of the MOH staff through capacity building of the DNCH team on HIS, revision of RMH and Child health indicators, tools, and registers.

As was envisioned at the start of the project, Afya Halisi has continued to co-support MOH to strengthen internal and external coordination of activities and programs. This has been achieved through the development of terms of reference for the newly instituted structure for coordination (TWGs and Committee of Experts); coordination of partners through the formation of WhatsApp platform and convening of regular meetings to share planned activities for better coordination and synergy. In this current year of PY3, the RH policy was finalized; Afya Halisi has supported the Division of Reproductive and Maternal Health to develop a sensitization package that will be used to disseminate the provisions of the RH policy. The project has continued to participate in several technical discussions including the Child Health Panel of Experts and iCCM TWG Meetings to review the recommendations from the panel of expert's review of pneumonia management under iCCM, and review status of iCCM road map implementation in Kenya; the SRH technical working group a plan for action for teen pregnancy.

With the COVID-19 pandemic, the Project supported the development of dissemination of COVID-19 guidelines for continuity of essential services. In addition, the project worked closely particularly with DRMH and DNCH to continue convening online meetings for stakeholders and partners to discuss performance, share MOH priorities and enhance national and county level coordination. The project co-supported development of annual work plans, national and county dialogues through forums such as stock-taking meetings and regular performance review meetings.
BACKGROUND

Project Goal and Objectives

Afya Halisi seeks to assist the Government of Kenya (GoK) to realize its Vision 2030 goals and USAID/KEA's Development Objective 2 (DO2) of health and human capacity strengthened. Afya Halisi’s vision is that by the end of five years the use of high-quality, county-led FP/RMNCAH, nutrition and WASH services will increase, particularly among the most vulnerable and underserved in four priority counties of Kitui, Kakamega, Migori, and Kisumu. Working hand-in-hand with counterparts at all levels — including county, and sub-county health management teams (S/CHMTs), local implementing organizations, and the private sector - Afya Halisi is working to strengthen the capacity of the health system at all levels.

The Project seeks to strengthen the county and sub-county health leadership to provide stewardship in increasing the availability and use of high quality, county-led integrated services in family planning (FP)/reproductive, maternal, newborn, child and adolescent health (RMNCAH), nutrition, water, sanitation and hygiene (WASH) especially among the underserved and vulnerable populations, through building capacity of its health care workers and communities to identify health priorities and to plan, implement interventions, and monitor activities that to address the specific health challenges for all sectors.

Afya Halisi focuses its efforts on three main results with specific outputs under each one:

Sub-purpose 1: Increased availability and quality delivery of FP/RMNCAH, nutrition and WASH services

Output 1.1: Strengthened FP/RMNCAH, nutrition and WASH service delivery at health facilities, including referral from lower level facilities and communities
Output 1.2: Strengthened delivery of targeted FP/RMNCAH, nutrition and WASH services at community level, including effective referral to mobile and/or static facilities
Output 1.3: Strengthened county health systems for delivery of FP/RMNCAH, nutrition and WASH services

Sub-purpose 2: Increased care seeking and health promoting behavior for FP/RMNCAH

Output 2.1: Increased knowledge of and demand for FP/RMNCAH, nutrition and WASH services
Output 2.2: Improved gender norms and sociocultural practices
Output 2.3: Increased practice of key nutrition and WASH behaviors in target communities

Sub-purpose 3: Increased MOH stewardship of key health program service delivery

Output 3.1: Strengthened coordination, monitoring and evaluation capacity
Output 3.2: Strengthened capacity to develop evidence based policies, strategies and guidelines
Geographic Focus

Kakamega, Kisumu and Migori are three of the 15 counties where the majority of maternal deaths occur, primarily from hemorrhage and pregnancy-induced hypertension. In addition, health outcomes and county government response are exacerbated by the HIV, TB and malaria burden in these three counties. All are HIV "evolve" counties\(^2\), noting high prevalence in Kisumu (16.3%) and Migori (13.3%)\(^3\). Migori (24%) and Kakamega (19%) are two of 20 counties with highest adolescent pregnancy rates. Kitui, the fourth program focus county, plays an important role in achieving Kenya’s goal of ending preventable child and maternal deaths by 2030 because nearly half the population (47% in 2013) is aged 0–14. Stunting affects nearly one of every two children under 5 years old (46%, or double the national rate), with 3.4% acute malnutrition. Vast distances limit access to services, as does the lack of operational facilities (due to inadequate HCWs and equipment) and sociocultural beliefs. Religious sects such as Kavonokya discourage using of modern health care services.

In years 1 and 2, the Project worked in 23 sub-counties across the four counties and in Kakamega County Government Teaching and Referral Hospital. In year 3, the Project scaled up its support to Butere, Lurambi and Mumias East sub-counties. This followed a request by County Government of Kakamega to Afya Halisi, based on low population coverage performance and strategic importance of the referral hospitals in these sub-counties to serve a wider population in the county. Consequently, the Project will continue to work in 6 out of the 12 sub-counties in that county. Afya Halisi will continue to support the 26 sub-counties in the four focus counties; with the Project supporting 6 sub-counties in Kakamega, 6 out of 7 sub-counties in Kisumu, 6 out of 8 sub-counties in Kitui and all the 8 sub-counties in Migori. These sub-counties are home to four million people, of which 993,212 are women of reproductive age (WRA) and 528,614 are children under the age of five years. The Afya Halisi counties have 1,023 health facilities in the 26 sub-counties as shown in the table below. Private health facilities comprise 43% of the total health facilities.

<table>
<thead>
<tr>
<th>County</th>
<th>Public/ MOH</th>
<th>Private</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Kakamega</td>
<td>82</td>
<td>71</td>
<td>153</td>
</tr>
<tr>
<td>Kisumu</td>
<td>112</td>
<td>149</td>
<td>261</td>
</tr>
<tr>
<td>Migori</td>
<td>150</td>
<td>140</td>
<td>290</td>
</tr>
<tr>
<td>Kitui</td>
<td>240</td>
<td>79</td>
<td>319</td>
</tr>
<tr>
<td>Total (%)</td>
<td>584</td>
<td>439</td>
<td>1,023</td>
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Work plan Development Process

The development of the work plan was informed by co-creation meetings between the Project, implementing partners and county governments of Kakamega, Kisumu, Kitui and Migori, to reinforce and build relationships with health county health leadership; foster collaborations; and ensure plans for Afya Halisi year 4 implementation aligns with the needs, intentions, and priorities of the focus counties. In addition to internal staff consultations, data sharing, best practices and learnings generated in the last three years of project implementation, Afya Halisi deliberately co-created and identified priority interventions with the CHMTs and SCHMTs in the four counties, based on prevailing gaps and anchored on existing county platforms to assure sustainability and continued ownership. The co-creation processes were

\(^2\) PEPFAR definition
\(^3\) National AID Control Council, Kenya HIV Estimates Report 2018. October 2018
guided by USAID’s Journey to Self-Reliance (J2SR) principles that call for co-creation, co-financing, co-management, co-implementation, and co-monitoring of programs with the national and county governments, and the need for mutual transparency and accountability with the government. The priority strategies, policies, and interventions of the counties – including county annual work plans for FY2020/21, were taken into account during the work planning process to ensure alignment, buy-in from county teams, and opportunities to build systems for sustainability in line with J2SR and as part of the Project’s transition process.

**County Priorities**

Afya Halisi engaged the leadership of the four counties in identifying specific priority areas that the project could invest based on the gaps currently observed. The priority areas that the project will focus on **intensely** in year 4 in collaboration with the county leadership are indicated below. No partner is currently working on the same, hence it will provide an opportunity for Afya Halisi to leave a legacy statement on the areas. Other priority areas are outlined in the subsequent sections of this work plan.

**Kakamega County**

Project year three (3) saw Afya Halisi expand its geographical scope in Kakamega County from the initial three (3) sub-counties to include direct support of an additional three sub-counties in Kakamega County, which include Butere, Lurambi, and Mumias East. During PY3, through co-planning and co-implementation, the project focused on startup activities aimed at rapidly building the capacity of the new sub-county health teams to plan and implement RMNACH interventions. Kakamega county was also selected for piloting of an integrated RMNCAH and Nutrition, HIV/TB, OVC and Malaria model which is designed to harness synergy of interventions across programs while encouraging collaborations to create greater impact in quality of care and health outcomes. In PY4, Kakamega county will prioritize a scale-up of integration approaches while strengthening the ability of the county health team to effectively implement such an approach. This will be implemented through a county led co-creation of strategies and activities.

Under health systems strengthening, Afya Halisi will support the operationalization of the county health facility fund created under the Kakamega County Health Bill. The fund is intended to ensure availability of resources for health by shifting the management of health resources from the county treasury to the department of health under the chief officer for health. This will safeguard health resources from being utilized on non-health related expenses. In addition, the project will support the co-creation of the county community health services (CHS) bill which is currently in a zero draft. The bill is intended to streamline and anchor community health services within the county laws thereby safeguarding community health services from interference from political office bearers. Currently, the county supports community health services through remuneration of CHVs via stipends. This is however not protected in any county law and risks discontinuation by future county leadership.

In order to address gaps in quality of care at referral health facilities, Afya Halisi will support county led quality improvement initiatives through the utilization of maternal health specialists in onsite mentorships for HCWs providing emergency obstetrics and newborn care.

**Kisumu County**

In recognition of the significant role played by the private health sector in Kisumu County, the project prioritized support for private sector engagement in PY3 as part of J2SR pivot. Through a co-creation process, the county has developed a resource mobilization plan and a roadmap. In PY4, Afya Halisi will support operationalization of the resource mobilization plan with the objective of enabling Kisumu County position itself for funding opportunities from the private sector and donors. Project support for Kisumu
county has seen a rise in pregnant women seeking antenatal care and skilled delivery services resulting in an increase in antenatal care coverage from 42% in FY 17 to 59% in FY 20 and skilled delivery coverage from 62% in FY 17 to 76% in FY 20. Despite the rise in number of clients seeking facility based services, there has been no corresponding decrease in maternal mortalities in the county, which has fluctuated from 46 maternal deaths in FY 17, 42 deaths in FY 18, 62 deaths in FY 19 and 41 deaths in the FY 20 period ending June 2020. As per Kenya Health Information System (KHIS) data, there was a steady decline of Institutional Maternal Mortality Ratio (IMMR) in Kisumu from 2016 to 2018 as shown in figure 1. However, in 2019 Kisumu had a high IMMR of 173/100,000 deliveries despite its comparatively better health access and availability of maternal and child health specialists.

Despite project investments in training and mentorships of HCWs in EmONC, MNH equipment, support supervision, coordination and commodity security, systemic challenges still persist in Kisumu county, key among them being unstable industrial relations between the County Government and Healthcare workers’ unions. Kisumu county has witnessed nine (10) industrial actions (strikes) that have negatively affected continuity of service delivery since 2017. There has been either a full blown strike, a go-slow or a notice of intention to strike in each of the last 9 fiscal quarters. Maternal death audit findings reveal other system-level challenges like delayed referrals due to lack of fuel for the ambulance and delayed supply of essential lifesaving medicines. Further analysis of maternal mortality data reveals that 66% of maternal deaths were as a result of third delays (delay in receiving appropriate care) with hemorrhage and eclampsia contributing to 54% of all deaths. The main underlying reasons for third delays were delay in diagnosis and management at referral and referring sites, lack of blood and its products, delay in referrals due to lack of fuel for ambulances and inability of medical officers to handle surgical emergencies.

Based on these findings, Halisi proposes interventions targeted at influencing positive actions by the county health leadership while working to improve quality of services at level 4 and 5 referral and referring sites in PY4. The project will institute targeted advocacy for streamlining of referral services, availability of blood and blood products, improvement of industrial relations between HCWs and unions. In order to address delay in receiving appropriate care at health facilities, Afya Halisi will work to institute a county led quality improvement mechanism through establishing linkages between maternal health specialists at referral sites and HCWs at referring sites. In addition, the project will work to develop protocols detailing timelines and standards for emergency obstetrics and newborn care.
Kitui County
The county’s department of health has prioritized the enactment of the Kitui Health Services bill, which will regulate the management of finances resources for health service delivery and guide the restructuring of the community health services. The technical coordination of health functions is vested mainly on the strength of sub-county health management teams. The health department will strengthen both the structure and capacity of these teams, including health finance management by mid-level health managers. The county has prioritized improved access to emergency care by ensuring that the two operating theatres at Migwani and Tseikuru hospitals are functional. To ease the movement of patients and general human traffic, the county and the national government are already improving road networks in southern (Kitui South) and northern (Mwingi North) regions of the county. The county has also prioritized human resource capacity, including new hires and absorption staff paid by the non-state partners and skills development through training and mentorship. With the structured health products and technologies unit, the county seeks to improve health commodity security through advocacy on appropriate resource allocation and quality control.

Migori County
In PY3, Afya Halisi supported Migori county government to enact the Migori County Health Act Regulations. This resulted in operationalization of the act. However, one critical last step is pending and that is the creation of the Health Fund as stipulated in the County Health Act. Afya Halisi will work with the county health leadership to ensure that this fund is created. The fund will enable the health department to take full charge of its budgets and improve efficiency and adherence to county health department budget lines as contained in the approved annual budgets. Further to this the project will support the county in the mid-term review of its 2018-2023 Strategic Plan. To enable greater synergy among RMNCAH partners, the project will support the office of the Chief Officer responsible for coordination of partners to ensure that Joint Work Planning and consequent reviews are institutionalized and routinely utilized for decision making and optimal utilization of resources available from all partners and from the department.

One of the greatest challenges that emerged during the preceding years has been a coordinated and effective way of conducting support supervision. The project will support the county health department to develop a support supervision strategy to enable effective support supervision mechanism and allow for a systematic way of following up support supervisions recommendations.

Other priority activities in Year 4 includes strengthening systems that will facilitate the maintenance and or improvement of the Year 1 to 3 gains through; designation and certification of 5 BFHI hospitals, support MPDSR activities at county and sub county level, Support the county develop a county strategy on commodity management and drug formulary, align the clean clinic approach to the global WASH in Health Care Facilities (WiHCFs) approach and conduct advocacy activities for counties to prioritize infrastructural investments for medical waste management. Activity implementation will be sensitized to the COVID-19 pandemic measures that have put in place since Migori is a high risk county.

Technical Approach and Prioritization
Since inception of the program, Afya Halisi has been implementing in the four focus counties using an equity and needs lens that utilizes an outcome driven approach to identify sub-counties and wards with low performance. The Project has continually built the capacity of Sub-County Health Management Teams (SCHMTs) on use of data visualization dashboards such as the reproductive, maternal and child health (RMNCH) scorecard and quantum geographic information system (QGIS) to better manage, analyze, and use data for performance measurement, monitoring, and decision-making. Using a prioritization matrix (Figure 2), sub-counties and wards performing poorly are identified in collaboration...
with the counties and sub-county health management teams, and an enhanced package of support is provided with the theory that by improving the health outcomes of the unreached and underserved populations, the overall health indicators will improve. For sub-counties and wards performing fairly well, enhanced programmatic effort is geared towards maintaining the good performance and identifying lessons learned and best practices for cascading to the other sub-counties and wards. This approach has enabled evidence-based differentiated investments that address disparities in resource distribution and improved coverage for underserved, high burden sub-counties, wards, and health facilities to acceptable national standards.

In year 3, Afya Halisi outlined context-specific strategic shifts to accelerate the expansion of population coverages for key FP/RMNCAH and nutrition indicators. To achieve these, Afya Halisi co-financed and co-implemented these strategic shifts with the CHMTs and SCHMTs. In year 4, the Project will continue to work closely with the S/CHMTs to focus interventions to the poorly performing, underserved, vulnerable, high need geographic areas or pockets of high burden. The Project will adapt its co-implementation strategy with the focus county governments to intensify support in areas with poor indicators and no partners to improve outcomes while avoiding duplication. In addition, the local implementing partners, will continue to use this score-card to enhance social accountability among community members and local leaders (MCAs and ward administrators) with an aim of accelerating improvement in priority health outcomes across all technical areas.

**Figure 2: Year 4 prioritization for comprehensive and enhanced package of support per sub-county by technical area**

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<thead>
<tr>
<th>County/Sub County/Program</th>
<th>Kakamega</th>
<th>Kisumu</th>
<th>Kitui</th>
<th>Migori</th>
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<td>MNH</td>
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<tr>
<td>Kwisero</td>
<td>Intense</td>
<td>Standard</td>
<td>Maintenance</td>
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| Immunization              |          |        |       |        |
| Child Health              |          |        |       |        |
| Nutrition                 |          |        |       |        |
| Family Planning           |          |        |       |        |
| AYSRH                     |          |        |       |        |
| WASH                      |          |        |       |        |
Technical Approaches

Family Planning (FP)
In the period of implementation, the USAID’ Afya Halisi Project has supported national and sub-national health governments to increase access to quality reproductive and contraception services. In the first two years, Afya Halisi provided support to the four focus counties to realize their FP strategic goals through structural, service delivery and technical assistance support. In the PY3, the focus shifted to system-level engagement, broader engagement of local development partners and advancing USAID’s policy on Journey to Self-Reliance. It is also in PY4 that the country joined the global community to respond to the effect of the COVID-19 public health emergency. Despite the interruptions caused by the pandemic in health care service delivery and all aspects of social welfare, the Project worked with national and sub-national government and non-state actors to ensure that continued access to safe and affordable contraception services. There have been inevitable adjustments to the models of service delivery; however, the global consensus is the need for continuity of quality FP services in public health emergency settings. The Project worked with the MOH to release guidelines on the continued provision of safe contraception services that are adaptive to local contexts and the stage of the pandemic.

In its penultimate implementation year, the Project will seek to sustain the gains made in the past years by broadening engagement of local implementation partners, civil society organizations and private enterprises. This approach fits into Project’s transition plans, sustainability efforts and exit strategy. As part of maximizing resources, the Project will collaborate with other USAID implementing partners like Afa Ugavi, Tupime Kaunti and HRH Kenya; non-USG initiatives like UKAID in Migori, the World Bank supported efforts in the four counties.

In PY 3, the Project instituted co-planning and co-creation processes with both national and county governments and other implementing partners and local communities. Building from past USAID investments, this approach will continue in PY4 through strengthening the capacity of county and sub-county health management teams and technical facilitators to support the provision of quality FP services. Continuous scaling up FP interventions will significantly improve reproductive, maternal and child health outcomes in the four counties and contribute to the country’s goal of ending preventable maternal and child deaths. While the four counties provide the requisite leadership, Afya Halisi will support needed technical support to either sustain or enhance quality FP services.

Adolescent Youth and Sexual Reproductive Health (AYSRH)
Since inception of implementation in PY1 to PY3, the Project has focused on improving access to AYSRH services and information across the four focus counties. This has been achieved through building the capacity of the County and Sub County HMT towards strengthened leadership and stewardship of AYSRH interventions, demand generation activities, and linkage to other programs and line GOK ministries in a multi sectoral approach. These intervention have in turn led to an increase in adolescents accessing services and reduction of teen pregnancies. The support provided by the project to MOH and Local implementing partners included training of service providers on provision of adolescent services, capacity building and whole site orientation targeting high volume sites, targeted service provision sessions and dialogues to adolescents and their key behavioral influencers such as parental and caregivers.

In year 4 Afya Halisi will focus on sustaining efforts made in the first three years of the project; strengthening coordination and leadership of AYP activities by MOH- CHMT and SCHMT and local organizations. The project will collaborate with Mwendo Project, Afa Ziwani’s – Dreams Project and other CSOs towards enhancing service provision to adolescents and young people. Through the CSO’s
network in Kisumu County the project will co-support advocacy efforts for increased funding and budgetary for adolescent health interventions. To address the potential increase in teen pregnancy brought about by the COVID-19 pandemic, the project will sustain the co-created interventions for continuity of comprehensive SRH services and information including county based toll free line, utilization of the virtual spaces for online SRH sessions for information and referral, conducting small group sessions for adolescents and enhancing of parents and caregiver’s interventions.

**Maternal and Newborn Health (MNH)**

In its first two years of implementation, USAID Afya Halisi Project’s focus in maternal and newborn health (MNH) was on increasing access to essential and emergency maternal and newborn care, ensuring quality and dignity in MNH services. This support included training through mentorship of healthcare workers in maternal and newborn care; technical and financial support for maternal and perinatal death review and response; procurement, distribution and orientation on MNCH equipment, HRH support; and expand access to emergency maternal and newborn care. The approach was modified in PY 3 to adapt to the growing maturity of county governments’ healthcare management systems and to respond to the ever-increasing need for self-reliance. There has also been an improvement in the county-level capacity to plan and implement health programs with limited support from the national government. The Project recognized the growing public expectation in universal health rights and clamor for quality maternal and newborn services.

In PY4, Afya Halisi will work with both national and the four counties to sustain gains made in improving MNH indicators, widen the collaboration with other stakeholders to maximize resource utilization and advocate for increased resource allocation to support MNH initiatives. The Project will adopt practical approaches, learning what works, testing and adopting new strategies to ensure USAID investments achieve the desired legacy. To achieve this, Afya Halisi will work with the county government to identify long-lasting solutions to the persistent health care worker strikes and go-slows that have become a common feature in service delivery. The Project will build on the counties’ roll-out of UHC as an opportunity to target quality improvement approaches in 30 high burden facilities in the four counties: 10 in Kisumu, 8 in Kitui and six from Migori and Kakamega. This process will be county-led, recognizing the need for strengthening quality management structures at the county level. The counties will develop quality measurements in line with Kenya Quality Model for Health and apply improvement science to system-level gaps like referral pathways and commodity management.

The Project recognizes the need for increased funding for MNH services in the counties. The aspect of imprudent utilization of health care funds and resources has through various government audits. The Project will work with four counties to strengthen the capacity of mid-level health care managers in planning and financial management.

**Child Health (CH)**

In year 3, Afya Halisi focused on activities at the primary health care level while working closely with the county and sub-county MOH teams to strengthen their capacity to plan and implement high impact interventions in a manner that is effective in their administrative areas, including monitoring and periodic evaluation of achievements. Based on the burden of diarrhea and pneumonia, the project in collaboration with the county successfully co-created an implementation approach for integrated community case management (iCCM) of diarrhea and pneumonia in Migori county. Despite having a higher disease burden for in Kitui and Kakamega counties, there was no county buy in in the implementation iCCM in these counties. In PY3 Q2, with the outbreak of COVID-19 pandemic, the project shifted focus on accelerated
implementation of the strategic shifts targeted at ensuring continuity of child health services in the context of COVID-19 pandemic while documenting strategies that work and those that are ineffective.

Despite progress made in building capacity of HCWs and health systems to deliver county led quality child health services, there are still disparities among the supported sub-counties with fast adopting sub-counties having a stronger capacity. Sub-counties identified for a high intensity support for IMNCI implementation include Muhoroni and Kisumu East in Kisumu County and Kitui Rural sub-county in Kitui County. In PY4, Afya Halisi proposes to intensify support in these sub-counties for IMNCI. In addition, the project will focus on establishing a greater capacity of health management teams at county and sub-county level to plan, implement and monitor child health services through establishment of child health technical working groups. Other systems level support will include, roll out of revised child health tools including the under-five sick child register (MOH 204A) and outpatient summary (MOH 705A) and mainstreaming use of digital platforms to monitor child health commodities. This will be a collaborative effort with Afya Ugavi project and Clinton Health Access Initiative (CHAI). In order to ensure slowdown of spread of COVID-19 and appropriate care for positive children, the project will co-support dissemination of pneumonia management guidelines in the context of COVID-19, with specific focus on triaging of sick under five-year old children.

**Immunization**

In PY3, the project focused on strengthening routine immunization services through co-creation and co-implementation of facility-level micro-plans for immunization and scale-up of the REC approach. Through utilization of data, the project identified locations with a high number of un/under-vaccinated children for intensified support. In order to ensure equity, Afya Halisi in collaboration with the counties identified strategies targeted at communities with a high number of unvaccinated and under-vaccinated children. As at end of June 2020, the full immunization coverage in Kisumu, Kakamega, Migori and Kitui Counties were 85%, 78%, 86% and 84% respectively. Despite a relatively high full immunization coverage across the counties, this performance is still suboptimal to the project target at 90% and the national target at 85%. There are also existing disparities at the sub-county level.

Through a co-creation process, Afya Halisi proposes to support interventions targeted at strengthening the capacity of HCWs and health systems to provide a county led quality immunization services that utilizes the REC approach and ensures equity in a sustainable way. The partnership with supported counties will ensure the counties take up greater roles in planning, financing implementing and monitoring of immunization services. Specifically, Afya Halisi has identified the following elements of immunization for strengthening: **leadership and governance**, the project will build capacity of sub-county immunization coordinators to effectively manage immunization programs through training on the WHO mid-level management (MLM) package; the project will co-support the dissemination and institutionalization of the **e-chanjo platform** which is a logistic management information system (LMIS) for vaccines and supplies; and dissemination of the national **immunization strategy** that is in the final stages of development, to sub-county health teams to update them on new strategies to reach more children. One key shift will be leveraging school enrollment to identify immunization defaulters. The project also proposes to support an annual micro planning and review of facility level immunization plans. The project will prioritize support for catch up immunization activities contextualized per county targeted at reducing the number of unvaccinated and under-vaccinated children that has been exacerbated by the COVID-19 pandemic, to reduce risks of outbreak of vaccine-preventable diseases in the supported counties. In line with this strategy, Afya Halisi will co-plan and co-support measles-rubella supplementary immunization activity (SIA) in select counties under the project support as per the national countywide SIA plan scheduled for October 2020.
Nutrition

Intensification and scale up of implementation of high impact nutrition interventions (HINIs) has a significant impact in reduction of maternal, newborn and child morbidity and mortality. At the community level, Afya Halisi, in collaboration with the counties, is prioritizing HINIs by addressing the behavior drivers and creating social accountability through the LIPs. The HINI being prioritized by the project include promotion of exclusive breastfeeding, promotion of optimal complementary feeding, Vitamin A Supplementation, Iron-folic acid supplementation, management of acute malnutrition, promotion of hygiene practices including hand washing and zinc supplementation for diarrhea management. Zinc supplementation for diarrhea management is integrated with child health. The project will intensify advocacy for commodities from a gender lens.

The Project will continue to target families and communities majorly through BFCl as a strategy for promoting the adoption of behaviors and practices that support optimal MIYCN during the critical first 1,000 days—from a baby’s conception through the second birthday. This is integral to the Project’s nutrition interventions and is at the center of its strategic approach, particularly in the community. Afya Halisi will work through the LIPs at community level in select sub-counties as other sub-counties are transitioned to the county for continued support and sustainability of interventions.

The project will support guidance development to institutionalize VAS for sustainability. Afya Halisi will continue to expand collaboration and linkages with other stakeholders within the county for integration, sustainability, improved livelihoods and transitioning of implementation. Implementation will continue to be county led utilizing mentors developed by the project.

Specific details of nutrition activities to be implemented are outlined in Output 1.1 and 2.3 of the work plan.

Water, Sanitation, and Hygiene (WASH)

The thrust of Afya Halisi’s WASH interventions is geared towards sustaining the gains of year 1 to 3, while undertaking targeted interventions in poor-performing geographic areas, advocacy at county level on priority sustainability WASH financing for medical waste management facilities. In addition, the project aims to support counties strengthen multi-sectoral coordination and collaboration among department of health and water, as well as with other departments and partners. Afya Halisi will build the capacity of County HMTs and SCHMTs to plan, coordinate and oversee facility-level WASH interventions, enforce good hygiene practices such as handwashing with soap and running clean water, and enable facilities to provide outreach for improved WASH in the community. Afya Halisi will continue promoting proven low-cost, high-impact WASH interventions that prevent diarrhea and under-nutrition.

At the community level, Afya Halisi’s WASH interventions will focus on completing the remaining stages of the CLTS protocol; villages that are yet to attain ODF status will be given more attention on follow-ups. The Project has in the last three years worked with CHVs as change agents to promote handwashing, latrine construction and use, and water treatment and storage at household level. While there have been commendable strides on the increase of latrine coverage in Afya Halisi supported villages in Migori and Kakamega, household handwashing facilities installations have lagged behind. In addition to that there are concerns that villages who have attained ODF status are likely to relapse if the households do not invest in durable sanitation facilities construction technologies. The main reasons for households reverting to OD are lack of access to their own latrines (not shared), safe and functioning toilet and young children’s (children above 3 years) defecation practice. In year 4, Afya Halisi’s will not only undertake to support villages increase their latrine coverage but also to construct more durable latrines that will also be safe
and conducive for children above 3 years to use. The project will support **community service delivery structures** to increase the installation and use of hand-washing facilities at household level. In addition, the project will continue working with the County WASH coordinators and the UNICEF supported staff responsible for CLTS reporting to ensure that all Afya Halisi supported villages have accurate data on their CLTS status and data routinely uploaded on the CLTS online hub. In Kitui County as well as Migori and Kakamega, the project will build on the **Sanitation Marketing** gains of Year 3 to ensure sustainable sanitation at the household level. Through empowering of CHVs and artisan with skills on registration as CBO’s, entrepreneurship and financial management skills transfer, the project anticipates that by the end of Year 4 the CU’s will be able to sustain WASH interventions beyond the project. The project will prioritize CU’s that have had historical challenges of relapsing back to OD with ISSB machines to support households construct more durable latrines at a lower cost.

**Leveraging Partnerships**

In year 3, Afya Halisi focus counties received additional support from other partners. The Transforming Health Services by World Bank is funding the county governments to support FP/RMNCAH service delivery. Migori County has many partners supporting family planning activities, in Kakamega and Kisumu Counties, GAVI has engaged KANCO (Kenya Aids NGOs Consortium) to support immunization activities while Clinton Health Access Initiative is supporting child health activities in Migori, Kakamega and Kisumu counties.

In year 4, Afya Halisi will continue to engage and work with the CHMT leaderships to leverage MOH and partner resources and develop outcome-focused and integrated joint work plans and implementation schedules that align to each partner’s planned activities and budgets for various service provision areas in order to promote transparency, accountability and performance-based implementation and monitoring. **Table 9** outlines the list of partners working in Afya Halisi focus counties that the Project will leverage.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Area of operation</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNFPA</td>
<td>Migori, Kitui</td>
<td>• Supports the entire spectrum of RMNCAH focusing on mentorship, support supervision, performance review, quality improvement and training</td>
</tr>
<tr>
<td>TCI (Jhpiego)</td>
<td>71 health facilities in Migori County</td>
<td>• Supports Family planning and AYSRH. Focus on mentorship, support supervision, data review meetings, CHV Review meetings, Program implementation team meetings and outreaches</td>
</tr>
<tr>
<td>CHAI</td>
<td>Migori, Kitui</td>
<td>• Supports child survival interventions in Migori focusing on capacity assessments, training, mentorship and supervision</td>
</tr>
<tr>
<td>World Bank (THS)</td>
<td>Migori, Kitui</td>
<td>• Provides direct funding to the County government to implement priority areas of the AWP.</td>
</tr>
<tr>
<td>DESIP (PS Kenya)</td>
<td>Migori: Private and Faith based facilities</td>
<td>• Supporting FP services in faith based and private health facilities.</td>
</tr>
<tr>
<td>KIWASH</td>
<td>Selected sub-counties in the four counties</td>
<td>• USAID mechanism that is supporting WASH in Likuyani, Lugari and Malava sub-counties (Kakamega County); Kisumu East, Nyakach and Nyando sub-counties (Kisumu County); Kitui West and Mwingi North sub-counties (Kitui County); and Nyatike, Rongo and Suna-West subcounties (Migori County) focusing on CLTS, sanitation marketing and water safety</td>
</tr>
<tr>
<td>Organization</td>
<td>Area of operation</td>
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<tr>
<td>Tupime Kaunti</td>
<td>Kakamega, Kisumu and Migori</td>
<td>• USAID mechanism that works with county governments to strengthen outcome measurement, learning and accountability systems to provide quality data and synthesized information for planning, implementation, policy development and decision making.</td>
</tr>
<tr>
<td>AMPATHPlus</td>
<td>Kakamega and Kisumu</td>
<td>• USAID funded HIV service delivery project in Kakamega County, that supports the county to provide these services. The Project is working with AMPATHPlus in implementation of the HPN Integrated model in Kakamega County. The two mechanisms are collaborating in PMTCT, FP/HIV integration and HTS/SBA integration.</td>
</tr>
<tr>
<td>Afya Ugavi</td>
<td>Kakamega, Kisumu, Kitui and Migori counties</td>
<td>• USAID funded mechanism that provides comprehensive technical assistance to strengthen Kenya’s supply chains for HIV/AIDS, malaria, family planning, and maternal and child health commodities at both the national and county levels of the health system.</td>
</tr>
<tr>
<td>MWENDO</td>
<td>Kakamega, Kisumu and Migori counties</td>
<td>• USAID funded project that aims to ensure that OVC remain healthy, safe, stable and schooled.</td>
</tr>
<tr>
<td>Impact Malaria</td>
<td>Kakamega, Kisumu and Migori counties</td>
<td>• US President’s Malaria Initiative (PMI) global service delivery project to reduce malaria mortality and morbidity.</td>
</tr>
<tr>
<td>Living Goods</td>
<td>Kakamega and Kisumu</td>
<td>• Leverages a powerful combination of catalytic technology, high-impact training, and quality treatments that empower government community health workers. Afya Halisi is working with Living Goods to support in community health services in Kisumu and WASH interventions in Kakamega.</td>
</tr>
<tr>
<td>Options Consultancy Services</td>
<td>Kitui</td>
<td>• Supports health systems strengthening, improving access to quality reproductive, maternal and child health services, and tackling discriminatory gender norms.</td>
</tr>
<tr>
<td>HRH Kenya</td>
<td>Kakamega, Kisumu, Kitui and Migori counties</td>
<td>• USAID funded project that supports strengthening health professional training programs and health workforce management systems throughout Kenya to help the country improve the health of its citizens.</td>
</tr>
<tr>
<td>UNICEF</td>
<td>Kakamega, Kitui and Migori counties</td>
<td>• Support for delayed Malezi Bora campaigns in Kitui; County support for WASH commodities coordination in Migori and Kakamega.</td>
</tr>
</tbody>
</table>
PROPOSED YEAR 3 ACTIVITIES BY SUB-PURPOSE

Sub-purpose 1: Increased availability and quality delivery of FP/RMNCAH, nutrition and WASH services

Output 1.1.: Strengthened FP/RMNCAH, nutrition and WASH service delivery at health facilities, including referral from lower-level facilities and communities.

Activity 1.1.1. Strengthen facility service readiness, quality of care and measurement to increase effective coverage of FP/RMNCAH, nutrition and WASH services

1.1.1.1 Family Planning
In the first nine months of PY3, the Project supported provision of family planning services in 641 health facilities across the four supported counties, an increase by 27 facilities after the Project's expansion into Butere, Lurambi, and Mumias East sub-counties in Kakamega county. At the county level, Migori achieved 79% of the county’s CYP target, Kisumu was at 58% while Kitui achieved 50% of the county’s CYP target. Kakamega added 22,515 CYP to reach 48% of the county’s annual target. Despite the initial disruptions after the confirmation of COVID-19 in Kenya in March 2020, the Project co-created and co-implemented prioritized activities to ensure minimal interruptions in family planning and other essential MNCH services.

At the time of submission of activity plan, Afya Halisi had supported 376 HCWs on RH/FP through in-service training and on-site mentorship, and 3,045 CHVs were providing community FP services in the four counties. The Project collaborated with USAID's Afya Ugavi to strengthen the capacity of healthcare providers on FP commodity management in Kakamega and Kitui counties. The response to the COVID-19 pandemic has pushed the focus of healthcare towards treating affected patients and protecting the further spread of the contagion. The counties have recognized the need for RH/FP service continuity to minimize missed opportunities. Afya Halisi supported the Division of Reproductive and Maternal Health to develop and validate guidelines on the management of RMH services, including FP during this pandemic.

The provision of immediate PPFP is now part of essential post-partum care in health facilities with delivery and family planning services. Past USAID support with the right equipment and continuous mentorship on competency skills by the Project has resulted in increased access and reduce missed opportunities for FP services. In the reporting period, Afya Halisi facilitated the sub-county mentors to conduct LARC and PPFP mentorship in 54 private health facilities in Migori and Kisumu counties, reaching 192 HCWs at the end of Q3 of PY3.

There was no reported violation of US abortion and FP requirements in the period of implementation. The Project continues to provide reminders to the local implementing partners, project staff and government on these provisions.

Afya Halisi recognizes the need for safe, effective, acceptable, and affordable FP methods and services as a key, highly cost-effective life-saving intervention. With a rapidly growing population, counties have realized the need to invest in FP to reduce the adverse social and economic consequences. The MOH has prioritized strategic areas towards universal access to family and meeting the country’s mCPR target of 66% by 20230. The areas are advocacy, commodity security, demand creation and service integration. There is a particular focus on the adolescent, youth and vulnerable populations and creating opportunities.
through public-private partnerships. In PY3, the Project co-supported the development of FP costed implementation plans (CIP) for Kisumu and Kakamega and supported the review of Migori county’s FP action plan. In Kitui, the process of review of the CIP has started with the Project supporting the initiative.

In PY4, the Project will align its support to the county-specific strategies and is mindful of different stages of the S-curve. In their strategic plans, the four counties have all cited gaps in leadership and governance, resource allocation and specialized advocacy efforts in sustaining the existing gains. In year 3, the Project will support the C/SCHMTs to utilize the family planning S-curve to inform context-specific strategies since the counties lie at different stages with varying method mix. For instance, LARC uptake in Migori is over 80%, while in Kitui, it is less than 50%. The counties will provide stewardship in the delivery of FP services at both private and public facilities, addressing the needs of the two entities. The Project will promote multi-sectoral collaboration to identify community platforms that promote positive gender and sociocultural norms and practices, and participatory decision-making. The proposed activities for Y4 include the following:

**Expanding access to quality FP:**
In the first three years of implementation, there has been a considerable expansion of access to FP services in the four counties. Technical coordination and mentorship structures are established at the sub-county level, although with different maturity states. Kisumu, Kitui, and Migori counties have well trained and skilled training teams, while Kakamega will need extra support in setting up mentorship structures. Both Kisumu and Kakamega have had frequent changes in the health management teams that have often affected the continuity of services. Since Kisumu, Kitui, and Migori need minimal support in establishing mentors, the Project will provide technical assistance to the sub-county teams in these three counties. Some of the priority activities for expanding access to high-quality FP services will include:

- **Revitalizing Voluntary Surgical Contraception:** Through Project support, all counties now have teams with the capacity to offer voluntary surgical contraception. The Project will harness the utilization of these surgical contraception teams to reach out to the marginalized and hard-to-reach populations in Kitui and Migori counties. The Project will also work closely with the CHMT and the surgical teams to institutionalize surgical contraception in all level 4 facilities while adhering to guidance from MOH on the provision of elective surgeries during the COVID-19 pandemic.

- In Kakamega, cultural inhibitions have hindered the expanded utilization of FP. The Project, through local implementing organizations, will utilize community-level activities that provide platforms for community dialogue on healthy timing and spacing of pregnancy as well as examining social and gender norms related to fertility.

- **Expand access to and choice of family planning services and HIV preventive through integration in pharmaceutical outlets:** Private pharmacies and drug shops contribute significantly to access to FP, especially for adolescents and youths and particularly during the COVID-19 pandemic. The training package for the provision of FP services by pharmacists in drug stores was not completed in time, as earlier anticipated in PY3. Upon finalization in PY4, the Project will work with the Pharmaceutical Society of Kenya, the Division of Reproductive and Maternal Health and the county government to support the roll-out of the training package in Kisumu.

- **Scale-up of intrauterine hormonal contraception (LNG-IUS):** Levonorgestrel-releasing intrauterine system (LNG-IUS) is a safe, effective and acceptable form of contraception used by over 150 million women worldwide. It also has a variety of non-contraceptive benefits including treatment
for painful menstruation and other uterine illnesses. The Project has been involved in the LNG-IUS introduction in Kisumu and Migori counties. However, the commodity has not been accessible universally in the country owing to a lack of distribution and commodity monitoring channels. In PY3, the Project co-supported a process to revise service delivery reporting tools to include provision for tracking hormonal intra-uterine device methods. The revised standardized national FP training package has also incorporated LNG-IUS in the service package. In PY 4, Afya Halisi will work with the Division of Reproductive and Maternal Health to transition to the mainstream MNCH commodity tracking process.

**Quality of Care:**
In the first two years of project implementation, Afya Halisi strengthened the counties’ capacity to provide high-quality FP services through continuous training support and point-of-care mentorship resulting in a well-trained workforce and equipment needed for quality service provision in the four counties. However, the organization of care and inadequate monitoring of quality remains a critical gap. An assessment of the competency of healthcare workers in 2019 in Kitui revealed that almost 40% of trained staff had no confidence in inserting the intrauterine contraceptive device within the first 48 hours of delivery. This finding points to missed opportunities in providing the full array of contraception methods to all women at all timings. Inadequate counseling for initiation and continuation is a pivotal contributor to the discontinuation of FP method use. The Project will work closely with the CHMTs to strengthen mentorship teams to scale up and intensify appropriate counseling for initiation and continuity of FP use. The Project will also advocate the S/CHMTs to institutionalize oversight and supportive supervision of the health facilities to improve the FP quality of care, including counseling for initiation and continuation to improve uptake and minimize discontinuation.

Project reports indicate that FP commodities stock outs continue to occur in project sites. The Project will continue to work with the USAID Afya Ugavi project and the county governments on systems-level support to ensure the availability of the FP commodities in the health facilities. Afya Ugavi has supported the establishment of Health Products and Technologies Units in the four counties, providing the technical direction on the commodity management in the counties. The Project supported the training of commodity management mentors in the counties in the first three years of implementation. In PY4, Afya Halisi will support the HPTUs, to sustain the technical support of field teams to improve commodity management.

**Service integration:**
The Evidence for Contraceptive Options and HIV Outcomes (ECHO) study did not find any substantial difference in HIV risk among women using the three methods studied. The study demonstrated that women want a range of FP methods for them to make informed choices about their health, including preventing unwanted pregnancies, STI and HIV. The Project will enhance the integration of FP into other health care services like in-patient care, GBV and chronic disease care. Service integration is already in-built in the FP training and mentorship modules. Besides, the counties’ CIPs place a focus on scale-up of FP/HIV integration services, provision of a wide range of contraception options to clients, and also the strengthening of the community-based FP services in line with the community strategy. The Project will co-plan with the counties on offering regular skills updates to help increase the competence and confidence of the providers in delivering quality services in other service delivery areas. These are child health clinics, SGBC care centers, in-patient care units, and through integrated outreaches in hard to reach areas in Kitui and Migori. The Project has also instituted support for infrastructural improvement to enhance client privacy in service delivery areas, a critical element in FP integration.
The provision of immediate PPFP is now part of essential post-partum care in health facilities with delivery and family planning services. Past USAID support with the right equipment and continuous mentorship on competency skills by the Project has resulted in increased access and reduced opportunities for FP services. The Project will work with counties to support regular skills updates to healthcare workers to improve on the current 4% uptake of PPFP in childbirth care facilities. The purpose is to ensure consistent provision of immediate PPFP in 226 facilities – 38 in Kisumu, 67 in Kitui, 76 in Migori and 45 in Kakamega.

1.1.1.2 Adolescent Sexual and Reproductive Health

In the first three years of the project, Afya Halisi conducted high impact activities targeted at increasing access to SRH services and information for adolescents and young people. The supported activities included: primary intervention activities such as capacity building and training of health care workers on the provision of adolescents and youth responsive services, expanded access to SRH services, targeted in reaches and outreaches in hard to reach and urban informal settlements, dialogue session with adolescents and key behavioral influencers to the adolescents such as parents and community leaders, outreaches in institutions of higher learning. Secondary prevention intervention activities included: provision of services to pregnant and post-natal adolescent mothers through young and adolescent mothers club, linkages of adolescent mothers and out of school youth to socio-economic empowerment opportunities, enhancing access retention and return to school and education opportunities- Secondary, Primary, TVET. System Level intervention included: County and Sub County technical working group and steering committees, multi-sectoral stakeholder forums and ward level coordination and advisory forums. These activities have resulted in an increase in contraceptives uptake by adolescents by 61% in the 4 project supported County from FY17 to FY 19., and a corresponding reduction in teen pregnancy rates in Kisumu by 46.3% and 12.6% in Migori County from FY 17 to FY 19.

In PY 4, the project will continue implementing AYSRH activities aimed at increasing uptake of contraceptive methods and reducing teen pregnancies that might increase because of the COVID-19 pandemic that has resulted in schools being closed. The Project proposes to conduct the following activities:

Primary Prevention Interventions:
The primary prevention interventions will aim at preventing teen pregnancy and other health consequences, by building implementing behavioral and biomedical interventions. The behavioral interventions will seek to reduce risk by addressing risky behaviors and stimulate uptake of SRH services. The intensive implementation of these approaches leads to multiple outcomes, including increased knowledge, enhanced risk perception, norms, skills, sexual behaviors. The bio-medical interventions, which are mixtures of clinical interventions, will be data-driven focusing on sub-counties, and further at ward and facilities level with Low uptake of SRH services for adolescents and high teen pregnancy numbers. These will include the following:

- **Access to Comprehensive Sexuality Education/Information**: Comprehensive sexuality education (CSE) has been proven to ensure healthy sexual and reproductive lives for adolescents. It provides accurate information on a range of age-appropriate topics; and fosters knowledge, attitudes, values and skills to enable adolescents to develop positive views of their sexuality. In Yr. 4 the project will give technical support and work with C/SCHMT and LIPs to conduct activities that will increase access to comprehensive information targeting adolescents as the primary audience, while at the same time reaching to key behavioral influencers to the adolescents such the parents and caregivers.
• **Adolescent Targeted Dialogue Sessions:** In the 3yrs, the project has support MOH to reach adolescents and young persons through community spaces and the young mothers clubs. In Yr. 4 the project focus will be on building skills and knowledge of the adolescents and young people on prevention efforts and linkage to SRH Services, through the MOH structures at community unit level. The activities will focus on areas with low uptake of services among adolescents and high teen pregnancy cases this include: Butere, Mumias East and Navakholo Sub Counties for Kakamega County, Nyando, Muhoroni, and Nyakach for Kisumu County, Nyatike, Rongo, Suna West and Uriri for Migori County, Kitui East, South and Mwingi North for Kitui County.

• **Parental and Caregiver Interventions:** Parents plan an important part in shaping adolescent’s behavior, With the disruption of the schooling calendar the role of parents and caregivers becomes extremely important in reducing risk and supporting adolescents access information and services. In the 3yrs the project has engaged parents and caregivers through different fora building their capacity on understanding the adolescent and the adolescent period, and effective communication and parenting during this period. In Yr. 4 the project will conduct small group sessions with key community leaders and parents, and seek to foster support among communities and parents for adolescents to access contraceptive information and services. The sessions will cut across the project and will ride on existing structures such as religious a church gathering, community baraza’s, and ward level forums.

• **Engaging Adolescent Boys and Young Men:** In an effort to curb teen pregnancies, the project will adopt male sex partner characterization and mapping. Encouraging young men to reduce their number of partners and concurrency, and uptake prevention and treatment services such as HIV testing, use of condoms, in an effort to reduce teen pregnancy and HIV among both AGYW and young men. Studies conducted including human-centered design and gender analysis done by the project show that young men also have varying views on contraception as well as which partner(s) should be responsible for its use. Limited contraception knowledge reduces young men’s sexual health communication as well as their contraception use. The project will hence support and give technical guidance to MOH and LIPs in conducting Male targeted sessions for SRH messages and prevention services across the project.

• **Digital Health- Virtual platforms (Facebook and WhatsApp):** Digital health interventions help overcome not only health worker shortages, but the disruption of services during this pandemic period and increase access SRH services for young people. In Yr. 3 the project supported the establishment of 6 WhatsApp platforms dubbed “Club Tubonge” and reached 1,361 adolescents and young people with SRH messages through online discussions. In Yr. 4 The project will continue to give technical guidance to MOH and LIPs to harness the digital space where young people are often technology natives as they are growing up in a world that is filled with technology. Social media will provide the project a strong organic channel to address SRH issues, raise awareness and start a real conversation, leading to linkages to services, the platforms will provide information of points of services access and key SRH messages. The project will build the capacity of youth champions on content and effective online engagement of adolescents and young persons, use their social media spaces to push well co-designed SRH messages and initiate discussions. This engagement will run across the four implementation Counties.

• **SMS Volley for SRH Messages and Information:** A significant proportion of adolescents and young people rural areas have analogue phones, as opposed to smartphones, thus will be left out of the online engagement. The project will work with MoH and LIPS to send out structured SMS
messages on a regular basis sent out the relevant target audiences such as pregnant adolescent to disseminate new information and/or serve as reminders for services they are expected to uptake.

- **Adolescent County Based Toll-Free Line:** In Year 3 of the project, the project supported the Counties to set up toll-free lines for adolescents. This intervention was conceptualized on the backdrop of barriers to service uptake experienced by adolescents and young people and greatly exacerbated by the impact of the on-going COVID-19 pandemic. The platform is aimed at ensuring that adolescents and young persons have access to expert comprehensive information regarding their sexual reproductive health needs as well as providing linkage (referrals) for those in need of services to health service provision points. The platform also provides the youth and adolescents an opportunity to express themselves without fear that their privacy and confidentiality will be infringed. In Yr. 4 the project will continue with support for toll-free line as we transition the management of the line to the respective Counties.

- **Access to SRH Services:** The project in its initial 3yrs, has built the capacity of health care workers in delivery of AYSRH services towards improving access to youth-centered services. In Yr. 4, the project shall be guided by data from project score card at Sub County, Ward and facility level to support MOH and LIPs to conduct targeted in reaches and outreaches to expand access to SRH services by the adolescents. The focus will be on areas with low uptake of services among the adolescents and high levels of teen pregnancy.

- **Support CHV’s and Boda Boda as CBD’s (condoms distribution):** In Yr. 3 the project supported community health strategy and health promotion team to set up the condom outlets in Migori (Uriri and Awendo) and Kitui (Kitui East and South) distributing a total of 24,487 male condoms. In Yr. 4 the project will continue to provide technical assistance to MOH and LIP to work with the trained Community health volunteers in community-based distribution of contraceptives (Condoms) and boda boda leaders to provide condoms in their boda boda shades. This shall be implemented across in Sub Counties with the highest teen pregnancy burden in Kakamega (Butere, Mumias East and Navakholo), Kisumu (Nyakach, Nyando and Muhoroni), Migori (Nyatike, Rongo, Suna West) and Kitui (Kitui East, South and Mwingi North).

- **Orienting Community CORPS on SRH Packages (CHVs):** The project has sensitized 154 select CHVs on AYSRH and Life Planning in Kakamega, Kisumu and Kitui Counties. Kakamega County . In Yr. 4 as the project works towards transition and sustainability, the project will work with County Community Health Strategy teams to identify select CHVs per Community unit who will focus on adolescent interventions at community unit level. This will be implemented across the four Counties.

**Secondary Level Intervention:**
This intervention aims at improving access to quality SRH services for pregnant and adolescent mothers who are in need of these services, including ANC, SBA, PNC, PPFP, and nutrition. These will be done through the following;

- **Improve Access to Quality Services to Pregnant and Postnatal Adolescents:** Transition to motherhood for teenage girls has been associated with many challenges. The Project has so far supported the establishment of 144 young mothers’ club (Kitui 13, Kisumu 63, Kakamega 37 & Migori 31), where a total of 2850 young mothers (Pregnant 1127, Lactating 1723) have been reached with different SRH services of ANC, PNC, SBA, PPFP, immunization for children and maternal and infant
nutrition. In year 4, the project working closely with the counties, will strengthen the existing groups towards sustainability, support registration of the groups as self-help groups with the ministry of social services.

- **Support Linkage to Safety Nets (Linda Mama, UHC), Economic Strengthening Opportunities and Return to School**: In reducing risk and transactional sex among out of school adolescent and youths, 47 young mothers were linked to technical and vocational training opportunities (TVET) in Kakamega County, 350 were trained on economic strengthening through collaboration with Partners (Mwendo Project in Kisumu, Kakamega and Migori, Organization of African Youth in Kisumu and Paint a smile CBO in Kakamega. In year 4, the LIPs working closely with the counties, will strengthen the existing groups towards sustainability, support registration of the groups as self-help groups with the ministry of social services. The intervention will target 5 facilities in the focus sub-counties to form the young mothers’ clubs. The selection of the facilities will be guided by data, focusing on facilities that have a proportion of teen pregnancy. The Sub Counties where these facilities are located include Muhoroni and Nyakach (Kisumu), Navakholo, Matungu, Mumias East and Butere (Kakamega), Rongo and Uriri (Migori), Kitui East, Kitui South and Mwingi North (Kitui).

**Structural and System Level Interventions:**
Structural interventions seek to address underlying factors that make adolescents and young people vulnerable to teen pregnancy and HIV infection. The multi-sectoral approach addresses adolescent/youth health by ensuring that interventions address health and social determinants (direct and indirect factors) of adolescent health. Such an approach emphasizes cross-cutting linkages and aims to create synergies between different development sectors. During the 3yrs of the project, the project supported the Counties, to establish County technical working groups and multi-sectoral and stakeholder forums. The project also co-supported Migori County in the development of the County Multi Sectoral action plan to end teen pregnancy in Migori. In Yr. 4 the project focus will be on strengthening the existing structures towards sustainability of effective delivery of adolescent and young person’s services. The activities will include:

- **Dissemination of Policies and Guidelines for Adolescents and Youth Services**: In Yr. 4 the project will support re-dissemination of policy and guidelines in the provision of services to adolescents and young people, this is necessitated by the change of service provider including employment of new staffs, the session will be conducted online for CHMT and SCHMT and Line ministries, and small group sessions for community leaders and administrators. This session will take place across the four supported counties.

- **Supporting County and Sub County AYSRH Coordination Forums**: The Project has supported county stakeholder forums and technical working groups that enhanced coordination of services for the youths. These forums brought together all AYSRH partners, representation of vulnerable groups in the community, youth representations, line ministries, and County and National Government. In year 4, the project will continue to support County coordination forums in all the four implementation Counties, and Sub County Coordination forums in 11 Sub Counties: Muhoroni and Nyakach (Kisumu); Navakholo, Matungu, Mumias East and Butere (Kakamega); Rongo and Uriri (Migori); and Kitui East, Kitui South and Mwingi North (Kitui).
• **Multi-Sectoral County Forums:** In enhancing sustainability of coordination and stewardship of adolescents and young people, the project will support Counties to develop strong advocacy tool based on evidence and data on importance of investing in adolescents and young person’s intervention. The project will also work to provide County-based common platform and concerted effort across different sectors for adolescent development and wellbeing, with measurable results.

**Partnership with other USAID Implementing Partners:**
Afya Halisi project will build collaborative partnerships as a strategy for health improvement for adolescents and youths. The project will work together with other USAID implementing partners Afya Ziwani; Dreams (Adolelescent girls and young women)Intervention, Mwendo Project (OVC), Tupime County and Ampath (HIV Services) to achieve a common purpose. The areas of collaboration will include:

• **Joint Area Advisory Council Meeting:** The area advisory council (AAC) will integrate efforts in improving the coordination of adolescents and young people services and advocacy efforts. The forums (AAC) exercises general supervision and control over the planning, financing and coordination of child protection and rights activities and advise the government on all aspects related to children. Afya Halisi will partner with Tupime County and Mwendo project, in an effort targeted towards strengthening of a functional learning and accountability forum in Kakamega, Kisumu and Migori Counties, the intergration will also strengthen the linkage of vulnerable adolescents to the CPIMs for child protection services. Mwendo project will convene the county level meetings, tupime county will lead in the strengthening of data and information use for decision making while Afya halisi will strengthen the linkage MOH and Childrens services and advocacy efforts for more county allocation to improve service provision to children and adolescents

• **Integration of HIV-Sexual Reproductive Health Services for Young People:** Optimizing utilization of sexual and reproductive health services through integrating HIV and SRH services for this age group is a key step to mitigating the high-risk sexual behaviors. Inadequate linkage of SRH services often leads to missed opportunities for addressing unmet needs of the adolescents and young persons. Afya Halisi will leverage on the adolescent support groups that would be convented by Ampath/Mwendo/Dreams, and utilize the platforms to support the provision of adolescent sexual reproductive health services. The expected outcomes will be increased number of HIV positive adolescents receiving SRH services

• **Economic Strengthening of young mothers:** Economic strengthening is a way of reducing adolescents and youth vulnerability to risky behaviors, economic factors are linked to risky behaviors, poverty and economic insecurity can affect risk by reducing negotiating power within sexual relationships, increasing reliance on transactional sex and sex work, or limiting access to prevention knowledge and service. To address economic drivers of the risky behaviors among the adolescents and young people, Afya Halisi, Dreams and Mwendo project will collaborate in supporting the Savings and Internal Lending Communities (SILC) intervention, and other social-economic approaches to enable the young women to develop their reliable financial services and to support community self-reliance and resilience.

### 1.1.1.3 Maternal and Newborn Health

The Project continued to support counties to strengthen emergency obstetric and newborn care functions in the supported health care facilities. At the end of PY3 Q3, the Project supported 149 (90% of the
Project’s target) health facilities to provide appropriate maternal and neonatal emergency care services in the four counties. The overall coverage for ANC 4 visits at the end of PY3 Q3 was 55% in the project focus counties. The non-emergency services were significantly affected by COVID-19 response measures, with some of the health facilities closing out-patients’ departments or transferring those services to other health facilities to minimize the spread of the COVID-19 pandemic. In response, the Project reprogrammed its activities to respond to the COVID-19 pandemic period. A total of 24,585 births were conducted at health facilities supported by Afya Halisi across the four focus counties, bringing the total to 70,967 as at the end of the PY3 Q3 period.

The Project tracked the average institutional maternal mortality rate (iMMR) in Project supported health facilities from 2018 up to PY3 Q3. In the Project's implementation period, the average iMMR was 140/100,000 deliveries, with a decrease from 209/100,000 deliveries in PY3 Q2 to 175/100,000 deliveries in the PY3 Q3 period. At the county level, Kisumu county had the highest institutional iMMR at 239/100,000 deliveries, and Kakamega had 218/100,000 deliveries in Project supported delivery facilities. In Kitui, the over 90% of maternal mortalities occurred at Kitui County Referral Hospital and a similar proportion in Kakamega County Government Teaching and Referral Hospital in Kakamega. The two facilities receive referrals from all the neighboring sub-counties.

In Kisumu, the Project is advocating for better management of human resources to end the perennial HCW strikes and improve the regional coordination of care and referral pathways as the county is a strategic healthcare referral county for Western Kenya. In all the focus counties, the Project will put efforts into co-supporting the deployment of specialist medical personnel in high comprehensive care facilities, sustenance of supply chain for essential life-saving MNH medicines, and establishment of blood safety systems. The Project has developed a road map to provide advanced mentorship by health specialists to reverse the trend of poor maternal outcomes in Kisumu. In Kitui, the Project supported a meeting between the health department and the county assembly health committee to deliberate on the enactment of a health services bill. The passage of this bill will ring-fence health facility funds and assure payment of stipends to CHVs. The planned Y4 activities include the following:

**Quality of Care:**

Afya Halisi recognizes the need to advance the quality of care from the health systems level to service delivery. The roll-out of UHC in the country was affected mainly by the emergence of the COVID-19 pandemic. While UHC provides a platform to increase access to safe maternal and newborn services, engraving quality measures is an essential aspect of this initiative. The national MOH has been engaged in the WHO Quality of Care Network and subsequently requested the counties to join the network on a wiling-interest basis. Building on past efforts, Afya Halisi will work with the county governments to apply for the national technical support and strengthen the capacities of the county and sub-county teams to plan, coordinate, monitor and report on quality improvement initiatives. To achieve this, the Project the existing quality improvement teams under the Kenya Quality Model for Health (KQMH) platform. Afya Halisi will form a collaborative of 30 health facilities with the highest contribution to MNH indicators: 10 in Kisumu, 8 in Kitui, 6 in Migori and another 6 in Kakamega.

While the Project has supported mentorship across MNH service delivery, there is a need to broaden and improve the mentorship structure. USAID Afya Halisi will work with the national Division of Reproductive and Maternal Health to roll out a national mentorship package. This package will be completed in the first quarter of PY4. The Project will support the training of HCWs on risk assessment, universal precautions and IPC to minimize contraction and spread of COVID-19 in healthcare settings. Enhanced sensitization of CHVs on universal precautions in line with the dissemination of public health
information on COVID-19 while maintaining the government’s guidelines on infection prevention. The Project will advocate for minimal interruptions in core MNH services with the national and county governments. These interruptions are expected in the form of staff redeployment from MNH service delivery points to COVID-19 response.

Access to Essential MNH Services:
Appropriate antenatal care (ANC) reduces maternal and perinatal morbidity and mortality through the detection and treatment of pregnancy-related complications, identification of women and girls at increased risk of developing complications during labor and delivery. The four supported counties have had progress an assessment of performance over the Project’s implementation period notes that the proportion of women who attended at least one ANC visit went up during the program period across all the four counties. Similarly, the proportion of women who attended four or more ANC visits during pregnancy also increased during the program period across all the four target counties. In PY4, the Project will focus on bridging the variations in sub-counties’ performance. In Kitui, despite the relative improvement of 4 ANC coverage from 28% in 2017 to 41% in 2019, the Project will work with local implementing partners and county government to improve antenatal care services in Kitui Central, Kitui East and Mwingi North.

The Project will strengthen the implementation of modified Group ANC to increase ANC coverage in Kisumu and Migori and roll-out in Kitui and the Mumias and Butere sub-counties in Kakamega. The Project recognizes the restrictions on congregated services in the wake of the COVID-19 pandemic. Group ANC will be implemented under the guidance on the state of the pandemic. In PY3, the Project initiated community scorecards to engage communities to contribute and demand quality health services. In PY4, the Project will continue utilizing the available community engagement platforms to increase community participation in influencing improvements in antenatal services in the four counties.

One critical strategy for reducing maternal morbidity and mortality is ensuring that every childbirth process is assisted by a skilled birth attendant, which generally includes a medical doctor, clinical officers, nurses or a midwife. Access to skilled care has improved in the four counties, although there still exist disparities across the sub-counties. In Kakamega, the Project will work with the county government to increase access and utilization of skilled services in Khwisero and Mumias East sub-counties. Kitui has recorded improvement across maternal newborn indicators, but there are still access gaps in three sub-counties, i.e., Kitui East, Mwingi West and Mwingi North. The Project supported five maternal shelters in Kitui. A gap analysis indicated the need to increase maternity waiting homes in hard to reach areas in the county.

Further support for the establishment of maternal shelters in Kitui will be reliant on assurances of human resource support by the county government. Migori county will be a low-effort county in regards to access, the main focus being quality of services. Half of the eight sub-counties have a skilled birth attendance of more than 80%. In Kisumu county, the Project will work with the government to improve access to safe childbirth services in Muhoroni and Nyakach sub-counties. Despite the low coverage of skilled birth care in Kisumu East, the county recognizes the proximity of the sub-county with Kisumu Central that has most of the emergency obstetric and newborn care facilities.

Access to an obstetric ultrasound before the 24 weeks’ gestation to detect any fetal anomalies is an essential aspect of antenatal care as per WHO’s recommendation. Through a collaborative approach in Kisumu county in PY2 and PY3, there was an increase in access to obstetric ultrasound services in Kisumu and Kakamega. The Project co-supported a training of 32 health care workers in Kitui, adding to the 60 trained on obstetric ultra-sound in Kakamega and Kisumu counties. In PY4, the Project will collaborate
with the county governments for quality assurance and support the operational maintenance of this equipment. In Kitui, the Project will transition the support for laboratory support to the county management, after supporting this initiative in PY2 and PY3.

**Access to Emergency Care:**
It is a recommendation that there should be at least 5 EmONC facilities per 500,000 populations, of which at least one should provide all the signal functions of CEmONC. However, having an adequate number of facilities does not necessarily ensure the availability of quality services. Skilled and motivated staff, availability of essential medicines and effective referral pathways are equally important. Kisumu, Migori and Kakamega have adequate referral facilities for counties’ populations. The Project will collaborate with the three counties to focus resources on improving the quality of services in the facilities and improve referral systems. The Project will work with the Kitui county government to operationalize the two comprehensive emergency maternal and neonatal care centres in Tseikuru (Mwingi North) and Migwani (Mwingi West).

**Essential Newborn Care:**
The Project has supported efforts to advance essential newborn care, especially prevention and management of birth asphyxia and prematurity. Project efforts have been predominantly on essential newborn care and prevention and management of birth asphyxia. USAID has supplied equipment and training kits to all the Level IV facilities. In PY 4, Afya Halisi will work with counties and focus efforts in the 30 health facilities to improve newborn outcomes through quality improvement approaches described above. Eighty-five percent of neonatal mortalities occur in these 30 facilities across the four counties. In this transition year, the Project will collaborate with local chapters of the Kenya Paediatric Association to lead mentorship efforts. The Project will support emergency drills, using ETAT+ and EmONC mentors in the high-volume facilities. The Project will collaborate with the national Division of Neonatal and Child Health to strengthen the county coordination structure on neonatal and child health programs. A joint national-county assessment of the status of newborn health services will be conducted to guide learning and improvement. Afya Halisi will continue to advocate for the inclusion of essential neonatal commodities like chlorhexidine for cord care, tetracycline ointment for newborn eye care and vitamin k in the county procurement plans.

**Demand Creation:**
Community educational interventions that focus on the family provides an opportunity to educate the mother and her support network on appropriate care during the antenatal, intrapartum and postnatal periods. The Project recognizes that shortcomings in the supply side of service delivery contribute more to maternal and newborn mortality, demand for health services remains a factor. To build on the PY3 work, the Project will build the capacity of local implementing partners to continue support for demand creation activities. These include creating awareness of existing health services, especially during the COVID-19 pandemic, increase community-facility linkages and enhance social accountability. The interventions are provided in detail in Output 1.2. section.
1.1.1.4 Immunization

In PY3, in order to ensure equitable access to immunization services in line with the REC approach across project supported sub-counties, Afya Halisi utilized a prioritization matrix to identify underperforming sub-counties and targeting these sub-counties with a higher intensity of immunization interventions support. The project in collaboration with the counties identified the following sub counties for high intensity support: Suna East, Kuria East and West, Nyatike and Rongo in Migori County, Khwisero, Navakholo, Shinyalu and Mumias East in Kakamega County, Mwingi West, Mwingi Central, Kitui South and Kitui East in Kitui County and Kisumu-East, Kisumu-West, Nyakach and Muhoroni in Kisumu County. To reduce missed opportunities for vaccination, Afya Halisi supported countywide micro-planning for immunization with the development of facility level micro plans. The project also co-supported EPI focused support supervision and onsite mentorship. Immunization defaulter tracing was supported with a shift to technology based platforms such as SMS reminders coupled with rigorous data review. Through CHV link desks established in the first six months of the program year, Afya Halisi supported CHAs to establish community-facility linkages and follow up for defaulters. Cognizant of the huge contributory role of private sector health facilities to immunization, the project supported the county health team to engage private sector through supervision especially in Kisumu Central Sub-County that has a high number of private clinics not offering immunization services resulting a to a high number of unvaccinated children. To ensure commodity security, the project supported operationalization of vaccine stock management tools, of which dissemination of the e-chanjo tool which is a LMIS was key.

In PY3 Q2, upon declaration of the outbreak of COVID-19 pandemic in Kenya and the resultant reduction in uptake of immunization services among other health services, Afya Halisi through co-creation with the county health teams instituted measures to ensure continuity of services while adhering to public health measures for control of COVID-19. These measures included; scheduling of immunization sessions in small groups to ensure physical distancing and avoiding crowding, rigorous defaulter tracing and referrals through SMS reminders and phone follow ups, dissemination of RMNCH guidelines to HCWs to ensure proper guidance on service continuity during COVID-19 pandemic, dissemination of public health messages through media and key influencers on the need for continued utilization of immunization services and supporting vaccines and immunization supplies collection from the national depot and distribution to supported counties as a stop gap measure to mitigate the effects of limitation of movement during COVID-19.

Through the Afya Halisi’s support, as at end of July 2020, full immunization coverage (FIC) for the project supported counties was as follows; Kisumu 83%, Kakamega 78%, Kitui 83% and Migori 85%. Progressively, FIC for the project supported counties has increased from PY1 to PY3 as follows; Kisumu from 71% to 83%, Kakamega from 68% to 78%, Kitui from 63% to 83% and Migori from 63% to 85%. However, county level coverages continue to mask sub-county disparities. Afya Halisi takes note of this situation and will factor strategies targeted at increasing equity in coverage in order to leave no child unreached with immunization services.

In PY4, the project proposes to shift strategy in immunization programming to focus on systems-level support to enhance ability of county health teams to effectively plan, finance, implement and monitor immunization services. In identifying PY4 strategies for immunization programming, Afya Halisi is guided by the following principles; data driven programming, innovations for reaching the unreached and underserved, county context specific approaches, leveraging collaborations and partnerships to maximize results and focus on sustainability by through county led approaches.

Program data from Kisumu and Migori counties indicate that 30% of all children receiving immunization services do so in private health facilities.During PY1 to PY3 period, Afya Halisi supported private health
facilities through enabling the S/CHMTs to develop capacity of service providers on operational level EPI, conduct support supervision in private facilities and providing private facilities with vaccines and supplies. To sustain gains made in immunization within the private sector, the project will advocate for mainstreaming of county support for immunization in private facilities as part of their immunization program. This will entail inclusion of private facilities in target setting and micro-plan development, support supervision and EPI performance reviews. Through a co-creation process with CHMTs from supported counties, Afya Halisi proposes to support the following systems level activities in PY4.

**Strengthening capacity of Immunization managers to effectively manage immunization programs:** Building on the progress achieved from PY1 to three in strengthening the ability of County and Sub-county EPI coordinators to oversight immunization activities, through a co-creation process, Kakamega, Migori and Kisumu Counties identified training in mid-level management (MLM) as a key gap to be addressed. In PY4, the project will support MLM training for County and Sub-county EPI coordinators to ensure a sustainable transition of immunization activities and safeguard gains made in increasing immunization coverage. In Kitui County, MLM training was conducted in PY3 with funding from the county. The project will focus on continued technical support to refine oversight skills for immunization managers.

**Enhancing commodity security through strengthening use of vaccines stock management tools (e-chanjo):**
One of the persistent gaps in immunization service delivery is frequent stock out of vaccines and supplies at the sub-national level. The focus counties continue to face challenges of securing the continuous supply of essential vaccines, with all project supported counties being affected at some point in PY3. In year 3, Afya Halisi will supported counties to operationalize stock management tools to allow better visibility of consumption patterns and hence avoid stock out situations within the pipeline. The project supported sensitization of EPI coordinators on the e-chanjo platform in Kakamega and Migori Counties. Despite efforts made, there still exists a gap in institutionalization of use of the e-chanjo LMIS. The project proposes to support refresher training of all sub-county logisticians in supported counties on the LMIS.

**Reducing missed opportunities for vaccination:**
In order to sustain and build on the gains made over the years by providing quality immunization services and improve population coverage for immunization services, Afya Halisi will support targeted interventions in a county-specific context aimed at reaching the all children with immunization services. In year 3 Afya Halisi under the leadership of the county and sub-county health management teams will support synthesis and development of micro-plans through sensitizing EPI coordinators and frontline workers on micro plan development and identification of SMART strategies for improving access to immunization. This will be coupled with need-based catch up immunization interventions such as targeted outreaches and campaigns in sub-counties that perennially experience flooding, dilapidated road infrastructure and with poor access to static immunization services due to long distance to health facilities.

Proposed additional approaches for reducing missed opportunities for immunization will include leveraging collaboration with other implementing partners to identify and refer defaulters for immunization. Specifically, in Kakamega County Afya Halisi will leverage collaboration with AMPATHPlus to screen for immunization defaulters in comprehensive care centers. With a near-universal early childhood development enrollment rate (above 95%), ECDs present an opportunity to identify immunization defaulters for linkages with services. The project proposes to advocate for buy in by the counties on instituting policy directives that ensure all children presenting for enrollment are screened for immunization status and referred for services where necessary.
In order to reduce the number of children remaining under vaccinated, Afya Halisi through leadership of the immunization coordinators will spearhead development of facility specific defaulter tracing mechanisms that contextualize existing factors to create a workable, cost effective and sustainable defaulter tracing modalities.

**Cold Chain Management:**
Between PY1 and 3, significant investments in procurement of cold chain equipment in the focus counties from both the ministry and immunization supporting partners have been made. Through co-creation with supported counties, a key gap identified for strengthening is lack of an updated detailed inventory and management to support procurement, redistribution, as well as equipment maintenance. In PY4, the project will leverage on the existing inventory plans to update cold chain equipment inventory including functionality with a view to rationalizing their distribution. To strengthen the capacity of sub-county cold chain technicians, the project will work with the county biomedical engineers to build capacity at sub-county level.

1.1.1.5 Child Health
In PY3, Afya Halisi collaborated with CHAI to implement child health interventions in Migori, Kisumu and Kakamega counties. Whereas CHAI supported trainings and mentorship on ETAT+, IMNCI, and procurement of child health equipment, Afya Halisi focused on empowering child health focal points, as conveners of the TWGs to effectively coordinate and convene the child health TWGs and ensure follow up of action plans. This priority was informed by a longstanding gap in the inability of county and sub-county child health focal persons to provide optimal stewardship and oversight for child health activities. Afya Halisi supported formation of Kakamega County TWG through orientation of county and sub-county focal persons on their terms of reference as outlined by the Division of Newborn and Child Health. At service delivery level, the Project adapted its implementation strategy to intensify support in areas with a higher burden of diarrhea and pneumonia. This support entailed strengthening the capacity of health HCWs to correctly diagnose, classify and initiate appropriate care for sick under five-year olds as per the integrated management of newborn and childhood illnesses (IMNCI) guidelines. These efforts resulted in a significantly proportion of childhood illnesses receiving appropriate management of diarrhea and pneumonia as per the IMNCI guidelines in PY3, with 87% of all cases of diarrhea and 88% of all cases of pneumonia managed appropriately in the project focus sub-counties. Kitui County had the highest burden of diarrhea at 21% followed by Kakamega at 15%, Kisumu at 12% and Migori at 11%. The highest burden for pneumonia was observed in Migori at 8%, followed by Kisumu at 6%, Kitui at 4 % and Kakamega county at 3%. Based on the burden of diarrhea and pneumonia, the project in collaboration with the county successfully co-created an implementation approach for integrated community case management (iCCM) of diarrhea and pneumonia in Migori county. Despite having a higher disease burden, in Kitui and Kakamega counties, there was no county buy in and leadership in the implementation iCCM. In PY3 Q2, with the outbreak of COVID-19 pandemic, the project shifted focus on accelerated implementation of the strategic shifts targeted at ensuring continuity of child health services in the context of COVID-19 pandemic. Afya Halisi co-supported the dissemination of guidelines developed by the Division of Neonatal and Child Health (DNCH) on the provision of child health services during COVID-19 pandemic. Emphasis was placed on the management of childhood pneumonia in the context of COVID through appropriate triaging and screening.

In line with Afya Halisi transition and exit strategy, in PY4, the project will shift focus to approaches that accelerate maturity of county health management teams in readiness to take greater responsibility in management and delivery of quality child health services. In addition to systems strengthening support, at the community level the project proposes to renovate Mumoni spring as a legacy project targeted at
ensuring availability of safe water and reduction of diarrhea burden in Kitui county which has the highest burden amongst project supported counties at 21%.

Given the strong presence of private health facilities in Kisumu and Migori Counties (approximately 30% of health facilities), Afya Halisi will work with the S/CHMTs in the two counties to mainstream support for child health activities in private facilities in the two counties. Specifically, the project will support the S/CHMTs to conduct support supervision and mentorship on IMNCI as part of their routine quarterly schedules. Considering that private health facilities are not part of the KEMSA supply chain, the project will work with the county to advocate for availability of ORS/Zinc co-packs, amoxicillin DTs and antimalarials in private health facilities through supporting them to utilize data to quantify and forecast their stock needs of these commodities.

**Strengthening of Child Health TWG:**
To ensure sustainability of gains made in improving access to and quality of child health services, child health TWG provide a platform for a coordinated leadership and decision making process. In PY3, Afya Halisi supported revitalization of the child health TWG in Kakamega County through re-orientation on the TORs. In Kisumu and Migori Counties, despite having existing TWGs, there has been lack of leadership from the child health focal point with resultant lack of ownership and coordination of child health stakeholders. Kitui county has no child health TWG despite having strong leadership for child health services through the county child health focal point. Based on these contexts, Afya Halisi will co-support various activities targeted at streamlining functionality of the TWGs as per the DNCH TORs for TWGs.

**Strengthening systems-level IMNCI capacity:**
In PY3, Afya Halisi programming under child health was adapted to focus on ensuring continuity of IMNCI services in the context of restrictions occasioned by COVID-19, with the aim of ensuring that critical services such as management of pneumonia, malaria and diarrhea are still available in the background of the pandemic. A rapid assessment of uptake of services during COVID-19 pandemic revealed a drastic decline in the uptake of IMNCI services. In order to ensure continuity of services, Afya Halisi and C/SCHMTs co-supported dissemination of RMNCH guidelines on continuity of care during COVID-19. Subsequently, the SCHMTs were supported to cascade the guidelines to health facilities. Over time, these efforts saw a slow resumption in uptake of IMNCI services. The Project thereafter focused on strengthening IMNCI services with management of pneumonia in the context of COVID being a center area of focus.

Building on progress in year 3, in PY4, Afya Halisi will prioritize system level support aimed at preparing HCWs and facilities to provide IMNCI services and specifically treatment for pneumonia in the context of COVID-19 based on the MOH guidelines and algorithms for triaging of children under five years for COVID-19. To achieve this, the project will support training of IMNCI mentors across the supported counties on the algorithms and guidelines and through a co-implementation approach, the counties will facilitate cascading of these trainings to the peripheral health facilities.

Availability of essential child health commodities such as ORS and Zinc has greatly stabilized with no stock outs reported in all supported sub-counties and health facilities. In order to mainstream monitoring, forecasting and quantification of ORS and Zinc co-packs, Afya Halisi in collaboration with Afya Ugavi in Kisumu and Kakamega will support dissemination of integrated commodity dashboard to sub-county pharmacists with the aim of institutionalizing routine reporting of stocks in order to avert stock outs through timely procurement and redistribution.
As part of building capacity of the child health focal to offer oversight for IMNCI services, Afya Halisi will co-support IMNCI supervision and mentorships targeted at newly hired HCWs.

**Scale up and sustainability of ETAT+:**
In PY4, Afya Halisi will continue to build the capacity of ETAT+ TOTs through refresher trainings. This will ensure continuous availability of county level capacity for ETAT+ who will then cascade capacity building of service providers in high volume level IV and V facilities. With the paradigm shift of enhancing the capacity of C/SCHMTs to take up service delivery for sustainability, the framework for improving basic pediatric protocols (BPP) and ensuring that they institutionalize pediatric quality of care (PQOC) will be undertaken by the management teams. Afya Halisi will work with the C/SCHMTs to ensure that the standards for PQOC are assessed and follow up through the action plans. This will be implemented in all the focus counties. As previously planned in PY3, Afya Halisi will support outpatient emergency management simulations and drills in level 4 and level 5 facilities and ensure an up to date emergency tray in these health facilities.

**Scale up and sustainability of iCCM:**
Based on PY3 programmatic experience, implementation of iCCM has faced unique challenges across the focus counties. In Kakamega county, Afya Halisi trained 40 CHVs from four CUs in Navakholo sub-county in PY2. Despite these CUs being functional and providing other services, CHVs were not able to access ORS and Zinc due to lack of county buy in. The county leadership expressed reservations on the practicability and efficacy of the model. This resulted in a shift in focus of iCCM implementation to Migori County. In Migori county, 60 CHVs from 6 CUs trained on iCCM in PY2 were supported to implement the approach in Rongo, Awendo, Uriri and Nyatike sub-counties. The CUs were supported to conduct data review meetings, submit reports and conduct support supervision. Evidence shows a shift in the burden of diarrhea from Nyatike to Kuria West and Kuria East sub-counties. In Kitui County, 4 CUs in Mwingi North and Kitui South were trained in iCCM. However, implementation of iCCM in Kitui County faces bottlenecks occasioned by lack of a CHS framework that clearly defines the county level coordination structures, supervision, accountability and sustainability. In PY4, Afya Halisi will refocus on advocacy to define the coordination structures for child health activities including community-level implementation with a focus on sustainability. This will be done in concert with CMMB who are also implementing community-level child health activities.

**Child Health and PMTCT Integration:**
In PY4, Afya Halisi in collaboration with six USAID implementing partners piloted an integrated FP, MNCH, HIV, OVC and Malaria model of implementation in Kakamega County. The model aims at ensuring a comprehensive approach to care for women and children while increasing efficiencies and synergy. In the integration model, opportunities for linkages to care between comprehensive care centers and MCH are actively sought and utilized. This model will be evaluated in end September 2020 and positive lessons documented. Afya Halisi will seek to scale up interventions that enhance immunization coverage, HTS and linkage to care for children in the supported sub-counties in Kakamega County.

### 1.1.1.6 Nutrition
Afya Halisi’s supports nutrition interventions in Migori and Kakamega counties. Afya Halisi will intensify follow up in already existing BFCI and BFHI CUs for improved practices and certification while HINI mentorship will be supported in sub counties scaled up in year three as older sub counties are transitioned to integration for sustainability. During the year, focus will be on system strengthening, integration, improvement of practices and sustainability as outlined below;
Improving Breastfeeding Knowledge and Practices of Health Workers and Mothers:
As at end of PY3, a total of 11 hospitals were implementing BFHI; 3 in Kakamega and 8 in Migori. Though none have been certified, there has been notable improvement in knowledge and practices from the county assessments conducted on BFHI. The current BFHI scores for the various hospitals range from between 40% to 76%. Within the last quarter of PY3, MCRH doubled their previous score to 62%.
In PY4, the project will intensify follow up and mentorship on BFHI for the hospitals that scored over 60% to have the hospitals certified as baby-friendly while supporting the remaining facilities to improve their performance through focused mentorship. In these hospitals, the Project will work through the LIPs to support household messaging on breastfeeding by the CHVs integrated with other community-level activities. The project will utilize the county and sub-county BFHI trained mentors based in their facilities and also support cross-learning from hospitals within the counties. The project will then support the county to have national-level staff conduct BFHI external assessment for the hospitals scoring more than 80% for certification. Staff from the certified hospitals will subsequently, support the progress for the remaining hospitals within the county.

Improve Capacity of Facilities to Implement High Impact Nutrition Interventions (HINI)
Implementation:
Through interventions that the Project has supported from inception of the program, one of the HINI indicators, exclusive breastfeeding has increased from 63% to 77% in Kakamega and 76% to 92% in Migori from 2017 to 2020; while initiation of breastfeeding within an hour of delivery improved by 8% to 92% and by 4% to 99% for Kakamega and Migori counties respectively, over the same duration. The project has improved capacity of staff and health facilities to implement HINI. To determine facility capacity, the project used the HINI Capacity assessment tool for assessment and OJT HINI handbook for mentorship. This mentorship was based on the HINI capacity assessment results that were conducted at the end of each year. From these analyses, a scorecard depicting facility and sub-county performance for each of the HINI indicators was developed.
Among newborns, 20% in Lurambi and 14% in Mumias East and Butere are not initiated on breastfeeding within an hour of delivery, yet they were delivered within the various health facilities within the sub-county. Exclusive breastfeeding is still lagging behind in Mumias East and Butere. These sub-counties are also among the new sub-counties where the project will intensify mentorship for HINI indicators. Migori is performing well on initiation and exclusive breastfeeding, as they all scored green. For the previous 11 sub-counties, after capacity assessment in PY 3 quarter four, any remaining gaps will be supported for mentorship. The sub-counties will also be supported to mentor any facility with new staff who have not been trained. The project will work with the county to plan on integration of HINI into other exiting support like supervision. The Project will prioritize IFA mentorship in Mumia East and Khwisero in Kakamega, and Kuria West, Nyatike, Suna East and West in Migori. Beside, the Project will focus on advocacy for procurement and rational distribution of IFA in Migori.

Improved Coverage of Micronutrient Supplementation:
Vitamin A supplementation will continue being a county driven process including both Malezi bora and routine supplementation. In line with the J2SR, the Project will continue to support expanded population coverage for Vitamin A supplementation through the LIPs at community level. However, household-level supplementation and reaching children in EYE centers are not sustainable ventures due to the heavy resources implication for support, based on previous models of implementation. The project working with the county therefore plans to integrate and orient CHAs and CHVs to conduct VAS at household level as part of their routine activities during household visits. During the first semester (October), the project will only support supervision for CHAs and sub county teams as CHVs supplement integrated with household visits. In the second semester, the project will reduce the level of support for supervision. In
addition, the project with the county will develop county guidance for supplementation at household level integrating COVID regulations. This is to ensure sustainability of the exercise, without external support. The county will ensure provision of commodities through KEMSA and UNICEF. The project will continue its advocacy agenda on integration to ensure that deworming is integrated with VAS.

The project will integrate sensitization of VAS and IFAS for CHAs and CHVs in PY3 Q4. Once CHAs have been sensitized, they will in turn sensitize CHVs during the CHV review meeting. CHVs will then be required to support messaging for pregnant women at household level during home visits. The county will also work with the LIPs to ensure messaging at household level in BFCI CUs on importance of IFAS and early ANC attendance. Zinc supplementation for children with diarrhea among under-fives, will be integrated with child health. The project will continue with advocacy for IFA as a gender issue as the pregnant women are denied access to what they need that’s critical for both the life of the mother and the baby. SBC strategies will also be employed in engaging the TBAs to embrace and counsel mothers on IFA benefits to increase utilization.

**Integrated Management of Acute Malnutrition (IMAM):**
As at the end of PY 3, the Project supported 153 IMAM sites; Migori (80) and Kakamega (73) inclusive of both private and public facilities. Over the three years of implementation, the project reduced malnutrition from 3% to 1% in Migori and 3% to 2% in Kakamega county. The project achieved this through supporting IMAM capacity assessment integrated with HINI and subsequently IMAM mentorships based on capacity gaps as identified during the assessments.
In year 3 quarter 4, an IMAM capacity assessment will be integrated with HINI to determine the progress in capacity of the mentored facilities. Mentorship will continue in the 3 focus sub-counties of Butere, Lurambi and Mumias East, based on gaps. For the older sub-counties, based on assessment results, some facilities will be mentored but focus will be on transitioning IMAM and integrating into other MOH activities for sustainability. Focus will also be on mentoring the newly recruited staff in the IMAM sites.

With the prevailing situation, the project foresees an increase in malnutrition cases due to increased household food and nutrition insecurity, as a result of COVID and poor agricultural production. The project will support the county to review malnutrition data from KHIS 2 to monitor the trends. Any pockets emerging will be targeted for family/mother led MUAC and referred to the facilities for management as staff capacity had been built through mentorship on IMAM. The project will, however, not scale up any sites for IMAM.

**Institutionalizing CNAP at County Level:**
Within the life of the project, the project supported both counties of Migori and Kakamega with their CNAP development. The Project provided both technical and financial support during the development and validation of the action plans together with other partners and stakeholders. Migori CNAP was finalized and launched and is in use. Migori county CNAP review that was scheduled was postponed due to COVID-19. The project also supported Kakamega county to finalise their CNAP. In PY4, the project will support the launch and dissemination of Kakamega CNAP after it has been signed. In Migori, the project will support progress review of CNAP and involve all stakeholders to support various components and discuss integration for sustainability while supporting the county to work with local partners. Besides, the project will support the counties to develop county nutrition fact sheet. The process for Migori had been initiated by AVCD but is yet to be finalized. The project will support finalization of the process. In Kakamega, the project will initiate and support the process. The counties will use the fact sheet to share snapshot of county nutrition situation, and advocacy.

**Collaboration with Feed the Future partners and other multi-sectoral players:**
From inception, Afya Halisi has collaborated with various partners. In Kakamega the project collaborated with Sustainable Organic Farming and Development Initiative (SOFDI) in Khwisero in PY1 to train Mother to mother support groups (M2MSGs); Kenya Crops and Dairy Marketing Systems (KCDMS) in BFCI training in PY2; Anglican Development services Western (ADSW) to establish a demonstration garden in Matungu (BFCI); and Hellen Keller international in PY 3 in VAS. In Migori, the project collaborated with Nutrition health Program (NHP) Plus in IMAM review in PY 2, Community mobilization against desertification (CMAD) to support establishment of linkages with nutrition-sensitive sectors by supporting the establishment of kitchen gardens in Awendo and Rongo, 3 Way Care to train BFCI M2MSG members on soap making in PY 3. In PY4, the project will continue the collaboration with the existing partners as well as identifying new partners. The project will integrate gender by continuing to facilitate women’s access to IGAs as well as enhancing their roles in agriculture.

1.1.1.7 WASH

From Year 1 to Year 3, Afya Halisi project invested in establishing implementation structures, capacity building of CHVs and HCWs. Towards the end of Year 2 and during Year 3, the project infused within its programming approaches and strategies that were geared towards ensuring that the project and county governments co-planned, co-financed, and co-monitored WASH interventions. In Year 4, Afya Halisi will support county and sub-county led WASH interventions at both facilities and community levels as indicated below:

**WASH at Healthcare Facilities:**

Afya Halisi carried out facility assessments in years 1 and 2 to identify gaps in WASH infrastructure, skills, knowledge and practice at health facilities. To close this gap, the Project initiated WASH activities in healthcare facilities in Kitui, Migori and Kakamega counties by building the capacity of county and sub county health management teams (C/SCHMTs) who in turn trained HCWs. In addition, the Project printed infection prevention and control guidelines and procured WASH supplies which included waste management bins and heavy-duty hand gloves. In years 1 to 3, the project supported minor repairs of 126 sanitation facilities in the three focus counties. This has led to improved access to sanitation services for patients and facility staff.

In year 4, Afya Halisi will support county governments of Migori, Kitui and Kakamega in guiding its investments in health facilities by introducing the new approach of WASH in Health Facilities (WiHCFs). This approach utilizes WASH Facility Improvement Tool (WASH FIT). The prioritization of this tool is geared to support the county governments comprehensively identify the WASH gaps at health facilities, facilitate prioritization of investments to be made and also to routinely track the progress towards improved WASH at their health facilities. This will ensure that beyond the project life that the county governments will have at their disposal not only a tool for assessments but a tool that can be used for resource allocation and advocacy. The project will support the county government in conducting WASH FIT in priority High Volume Facilities primarily county and sub county hospitals. The project in Year 4 will drastically reduce the number of health facilities that shall receive WASH infrastructural support. The project will limit investments to renovation of only 10 sanitary facilities and installation of 6 water tanks across the 3 supported counties.

**Support advocacy activities for funding of Medical Wastes Management infrastructure:**

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During Year 1 and 2 of the project, Afya Halisi supported Kakamega and Migori to develop comprehensive waste management plans. In order to translate plans into actual funding, Afya Halisi engage the county leadership though advocacy in prioritizing medical waste management infrastructure notably incinerators based on the developed plans and findings of the WiHCFs assessments. The project targets to engage the county governments to include in the FY 2020/21 budget allocation for incinerators in their budgets.

**Supporting county multi sectoral WASH forums:**
One of the outstanding gaps is the strengthening of coordination between water and health departments at county level. There still exists silos approach towards WASH by the two county departments in Kitui county as compared to Kakamega and Migori counties. The project will strengthen coordination through convening of stakeholder forums via online platform, thus allowing for county and partner organization interactions during the pandemic phase.

**Output 1.2: Strengthened delivery of targeted FP/RMNCAH, nutrition and WASH services at community level, including effective referral to mobile and/or static facilities**

**Strengthen Community Health Platform:**
The Project using data-driven methodology that prioritizes programming sites with an equity and needs-based lens selected 55 CUs in the additional sub-counties (Butere and Lurambi) in Kakamega County bringing the total number of CUs supported by the project to 275. The CUs were supported to implement activities such as dialogue sessions, defaulter tracing, household visits and to sensitize community members on the importance of adopting behaviors that promote good health. The presence of the CUs is expected to lead to improvement of performance in the wards. Since year 1, 152 CHAs, 598 CHCs, and 2,264 CHVs were trained on the CHU basic modules across the four counties to enhance the capacity to offer community health services. In year 3, the project supported refresher training for 1542 CHVs on MNH technical modules based on the need to address specific concerns in the community.

The 275 CUs will continue to receive enhanced support in year 4 through the LIPs. The project will support CHAs and CHEWs to coordinate CU activities to be as effective as possible to allow CHVs to carry out their roles and at the same time take care of their business. The project will also focus on empowering the CHVs economically to continue with their roles in providing health services at the community level beyond project support. The CUs having VSLA in place will be linked with organizations that can support various entrepreneurial activities. Also, CUs which are not yet registered with the department of social services will be assisted to do so thereby being able to submit proposals to donors for various activities they are involved in. This will also allow them to access credit if need be. Besides CHVs who are not yet registered with NHIF will be supported to do so ensuring they could access health services if need be. The project will also focus on activities that improve the data reported at the community level. Data quality assessments as well as mentorship and coaching for CHAs and CHVs on effective reporting will be supported. Besides, there will be a focus on documenting various interventions and their impact on the uptake of health services as well as the quality of services provided. Documentation on the small group dialogue sessions, the community scorecard, database for pregnant women, and newborns will be prioritized.

**Supportive Supervision for Improved Quality of Services:**
Supportive supervision remains an integral part of ensuring the quality of services provided by CHVs. Enhanced supportive supervision lead CHAs to accompany CHVs during household visits to ensure the
services provided are of good quality. Community members also have had an opportunity to provide feedback on the services they receive from CHVs and what adjustments they would wish to receive. In year 3, 142 CUs received supportive supervision reaching 1,018 CHVs.

In year 4, the project will support the sensitization of SCHMTs, CHEWs, and CHAs on effective supportive supervision so that services provided at the community level are of quality and accountability is ensured. Further, the project will jointly undertake quarterly supportive supervision with SCHMT. SCHMT supervision will focus on community facility linkage to ensure there is continuity in the continuum of care and services.

**CU Sustainability and CHV Retention:**
In addition to 153 CHVs from 8 CUs trained on Village Savings and Loaning (VSLA) intervention in year 2, seventeen (17) more CUS were trained in year 3 reaching 1,200 CHVs. The intervention provides CHVs to have a revolving fund, where they are advanced money in groups that they manage themselves. In year 4, the VSLA initiative will continue to be delivered by the LIPs and priority will be given to CHV as part of the larger sustainability plan to reduce attrition and enhance performance. The focus, however, will be to support the CUs in mobilizing local resources through savings and linking them to organizations that will continually build their capacity in various income-generating activities as well as advance to funds important in implementing their projects. The CUs having VSLA in place will be linked with organizations that can support various entrepreneurial activities. Besides, the project will encourage the CUs to register with the department of social services and identify enterprises that they can engage in as they continue with volunteer work. While most of the CUs are registered as self-help groups, only a few are registered as CBOs. The project will support 70 which are not registered at all, 21 CUs in Kitui whose membership changed in year 3 and therefore require to be registered afresh. For those registered as self-help groups, they will be encouraged to register as CBOs. This will also allow them to access credit if need be as well as write proposals and attract funding from various sources. The CHVs will be taken through training on basic bookkeeping and entrepreneurship across the four counties for better management of their projects. Moreover, the project will encourage the CHVs in the project supported CUs to register on NHIF to improve their capacity to access health services. To motivate the CHVs the project will support the annual trophies/awards for best performing CU and CHVs.

The Project will continue to utilize sub-county level WhatsApp groups as a platform to enable CHAs provide feedback to CHVs on performance of specific indicators, enable CHVs to seek advice from each other, share experiences and engage in discussions. This approach has helped to foster behavior change through the translation of awareness and knowledge to practice. Besides, the project will utilize virtual meetings for coordination with county and sub-county health management teams as well as community TWGs even post COVID-19. Virtual sensitization sessions will be held with CHAs and PHOs to address issues of concern as well as provide necessary updates.

**Household Visits Covering All Thematic Areas:**
In year 3, the Project continued to support CHVs to visit households in line with the guidelines of implementing community activities in the context of COVID-19. The guidelines provide for CHVs to visit households in counties where there is no community transmission. They wear masks during such visits, communicate with the community members outside the house, ensure social distancing and regular hand washing as well as the use of sanitizers. During the year, priority was given to households with pregnant women, newborns, lactating mothers, and sick community members. Close monitoring was also done for community members most vulnerable to COVID-19 including those above 60 years and those with underlying conditions. To standardize messaging during household visits, the Project supported the printing of the authorized CHV job aids for use by CHVs.
Besides, the project supported the counties in the development of a database for all pregnant women and newborns in supported CUs for follow up through household visits or SMS. In Kisumu County, the project in collaboration with the CHMT co-created an online database for mapped pregnant women which allows continuous updating by CHAs. The information is used for tracking and following up pregnant women to ensure they attend ANC and deliver at the health facility. It has made it easy for CHVs and health workers to identify home deliveries and make referrals as soon as possible. Besides the information has been used to identify defaulters and refer them for missed services. The database was used to inform authorities on community members likely to be requiring ambulance services as well as exemption from curfew requirements. The information is important for effective planning by the health facilities for it provides information on the likely due date and location where the clients live.

In year 4, the Project will continue to work with SCHMTs to ensure the database is utilized effectively for tracking pregnant women and newborn for timely services. The Project will continue to standardize messages provided during household visits by providing IEC materials customized to address predisposing factors in each community. The messaging at the household level will integrate key messages in the scope of the Afya Halisi project and specifically on FP, AYSRH, WASH, nutrition, gender, and child health. Household mapping will be carried out in line with MoH guidelines and community maps updated every six months, highlighting pregnant women, adolescents (especially pregnant), newborns, children under five, circumcisers, and TBAs. While the intensity of household visits will depend on members’ vulnerability, CHVs will be encouraged to visit each household at least once in a quarter. Priority will be provided to households with pregnant women especially adolescents, service defaulters such as immunization, children within their first 1000 days of life; specific-high risk or high-need times (within two days of home delivery for PNC to mother and newborn, or during the period of sickness/malnutrition for a child, pregnant and lactating woman). The CHVs will track the mapped pregnant women and newborns to ensure they access services on time. The Project will continue to explore home pregnancy testing by CHV if project partnership with the private sector on donations of pregnancy kits goes through.

**Maternal and Perinatal Death Surveillance and Response:**
Community autopsy committees established in year 1 and 2 coordinated discussions of 3 maternal deaths and 8 perinatal deaths. In year 4, the committees will be strengthened to continue coordinating verbal autopsies at the community level as well as agreed-upon action plans.

**TBA Mapping and Role Re-designation:**
In year 3, 24 TBAs were sensitized on the importance of ANC and SBA and provided with basic MNH information as they were being re-designated as birth companions. In year 4 TBAs who have been re-designated as birth companions will continue to be involved in accompanying pregnant women for ANC and SBA as well as tracing defaulters.

**Community Dialogue Sessions for all Thematic Areas**
The Project has continued to support targeted and small community dialogue session as a platform to initiate and sustain meaningful community conversations targeting demand creation and behavior change. CHAs and lead CHVs trained in year 2 on effective facilitation of dialogue sessions led the sessions. Project staff worked closely with MOH staff to follow up and implement public health actions agreed on during dialogue days. One hundred and twenty-four (124) sessions were held during the year reaching 3,088 community members with health information in different thematic areas. Issues raised in a session and which often were to do with myths and misconceptions were discussed during follow up sessions. Due to the critical role played by men in decision making on issues of maternal and child health, the Project
supported 7 men-only sessions reaching 91 participants who agreed to support their spouse and create awareness among other men.

In year 4, the LIP staff together with MOH staff will coordinate the dialogue sessions and ensure consistency of messaging from the health facility to the community. More CHAs and lead CHVs will be empowered to effectively facilitate the sessions while the SCHMTs will continue to monitor the sessions for quality and effectiveness. Each dialogue session will be guided to achieve a specific desired outcome and participants will be encouraged to reach out to their neighbors and friends with information obtained in the sessions. Community champions for various thematic areas will continue to be developed to participate in the community dialogue sessions and other community fora. In Kakamega County, the community dialogue will be tailored to address the high teenage pregnancy and GBV in Khwisero, Mumias East, and Navakholo. In Kitui County, the dialogue sessions will address access to family planning; in Migori, the sessions will be tailored to address GBV and nutrition especially in Kuria West that has the highest number of underweight children in the county; and in Kisumu, the sessions will address high teenage pregnancy in Kisumu Muhoroni and Nyando sub-counties.

Utilize Community Support Groups for Demand Creation:
In year 3, the Project continued mapping and engaging existing groups and individuals from priority target groups across all the project sites. In some places, the Project formed new ‘mother to mother’ support groups, groups for pregnant/adolescent mothers, adolescent boys and young men, and male champions who were key in the dissemination of key messages around ANC, SBA, FP, nutrition, gender, child health, and WASH. The champions will work closely with CHAs to create awareness and promote the uptake of health services. In year 4, the Project will continue to map circumcisers in Kakamega and Kuria with the aim of re-designating them as the voice of influence on positive health-seeking behaviors in the community. The circumcisers will undergo an orientation on gender-sensitive delivery and messaging on FP/RMNCAH services.

Conduct Integrated Outreaches, including for Hard-to-Reach Populations:
In year 3, the CHVs were supported to mobilize community members for outreaches. Community mobilization continues to be a critical process in ensuring that the hard-to-reach populations are reached with services. The Project has identified wards with high DPT III dropout rates in all four counties and will provide contextualized services to reach these populations.

In year 4, the Project, in liaison with MOH, will continue to support integrated outreaches and in-reaches for RH/FP, CH, immunization, nutrition, and WASH. Data will be the key determinant of where the outreaches of when and where to hold them. After every outreach, a critical analysis will be undertaken to ensure the yield is worth the investment while maximizing efficiencies. The SCHMT and facility teams will continue to review the outreach services including site selection to ensure that there is maximum yield. Outreaches will continue to be integrated, including FP services. The Project procured Health Wagons that will continue to be used for some of the outreaches in all four counties. The Project will prioritize sub-counties with poor access uptake of FP services and those with pockets that cannot easily access services. In Kitui County, the project will conduct targeted FP outreaches to reach populations with difficulty in accessing services due to the terrain; this approach will be coupled with a CBD program (once the framw in Kitui West, Kitui South and Mwingi central sub-counties with the highest number of teenage pregnancies and a relatively high proportion of facilities not offering FP.
**Scale-up Community Based Distribution (CBD):**

In year 3, the Project provided refresher training for 133 CHVs on FP technical module and CBD to strengthen the implementation of community FP activities based on need. The CHVs were involved in providing information on family planning and referring community members for services in the health facilities. During the year, 16 CUs began providing CBD bringing the total CUs involved in the community-based distribution of family planning commodities to 53. Besides, 21 CHVs from 2 CUs were trained on iCCM and provided with stopwatches, MUAC tapes, and patient recording forms and began to provide ORS and zinc at the community level.

In year 4, the Project will continue engaging MOH to put in place frameworks that allow CHVs to engage in community distribution and ensure that commodities are available for distribution. Further, the project will support the capacity building of CHVs, provision of reporting & ordering tools, as well as supervision for effective CBD. The trained CHVs will continue the distribution of FP commodity refills in line with the National FP Guidelines and under the supervision of CHAs/ CHEWs. iCCM will be prioritized in East and West Kuria sub-counties of Migori County. Besides, the Project will continue to work with the counties to scale up CBD in addressing the gap in FP uptake as a result of COVID-19 restrictions and fear. CHVs will particularly be involved in refills and referring new clients for counseling and commencement of FP uptake.

The Project will continue to advocate with counties to buy-in on the roll-out of the DMPA-SC in the community. This will be rolled out in year 3 targeting at least one sub-county in each of the four focus counties upon approval. Training of DMPA-SC TOTs will be carried out at the county level, the TOTs will be involved in cascading skills to the CHAs and CHVs. Intensive mentorship and supervision will be undertaken to ensure the correct provision of the method.

**Strengthen Community-Facility Linkages, Referral Mechanisms, and Accountability:**

In year 3, the Project continued to support CHVs to coordinate defaulter tracing and referrals through CHV desks as well as share tasks at the link facility. Further, the Project supported the convening of CU monthly reporting and feedback meetings at the health facilities to strengthen community-facility linkages. Besides, social accountability activities were infused into the CU structure with 32 community facilitators trained to implement community scorecards. Moreover, the 6 community scorecard processes were implemented through the CU structure providing a link for community members to engage with health facilities on the improvement of quality of health services.

In year 4, the project will empower CHVs to coordinate social accountability activities at the community level and engage with the health facility committees on the improvement of quality of health services for community members. The project will continue to support CHVs to coordinate defaulter tracing and referrals through the CHV desks in the health facilities. Monthly reporting and feedback meetings will continue to be held in the health facilities to facilitate feedback from the community to the health facilities and an opportunity for health workers to build the capacity of CHVs in areas of need. Besides, the project will engage communities that are early adaptors to engage in health advocacy. Communities will be encouraged to take part in public participation in budgets and bills such as health. They will also be encouraged to send representatives to health committees (i.e. health facility management committees).

**Strengthen Use of Community Based Health Information System for Decision Making:**

In year 3, the Project supported mentorship of CHAs and CHVs as well as PHOs on CBHIS reporting tools and indicator definitions and interpretations. Emphasis was on the use of data and information for action, data quality improvement, and lessons learned. In Kitui County, where project supported CUs
were allowed to start reporting, data quality assessments were held in 6 CUs. The assessment revealed
gaps in CHVs’ understanding of important indicators and reporting, availability of necessary tools, as well
as the need for household mapping to update the CU data.

In year 4, the Project will continue to support continuous mentorship and coaching for CHAs and CHVs
to improve the quality of reporting. Talking walls displaying performance in different indicators will be
generated to enable CHVs to consider the data at a glance. Further, the project will continue to support
the convening of monthly community-facility meetings in liaison with SCHMT to review linkages,
completeness of data, reporting, and generation of scorecards. These meetings will provide opportunities
to build the capacity of volunteers in various technical areas. The meetings will promote the interpretation
of the scorecards to facilitate planning for the following month. Community data will be triangulated with
facility data to identify the key focus areas for the subsequent month, particularly the poor performing
indicators. In Kitui County, the use of community data will be key in determining the sites for community
outreaches and wards where more CBDs need to be trained to cover the need for FP. In the other three
counties, the community data will be used to determine villages where the CHVs need to redouble their
efforts in reaching unvaccinated children or defaulters. In Kitui County, the project will support the
formation of work improvement teams at the community level, training of QI coaches and work
improvement teams, implementation and learning event.

**Strengthen Adolescent and Youth-Centered Services in the Community:**
Building on the community health strategy structures, the LIPs working with the sub-counties management
teams will support community-based dialogues sessions with key behavior influencers e.g. ‘boda boda’
riders, religious leaders, parents, etc., to build community acceptance and support for AYSRH information
and services. The Project will support community health assistants to ensure quality delivery of SRH
information sessions by the CHVs and youth champions. The sessions will also include livelihood training
conducted by CHAs for groups of AYPs.

In-school health, the Project will work with teachers-HCW teams to deliver integrated health messages
and services to the pupils and students. Outreach initiatives with local education institutions with large
youthful populations like Masinde Muliro University of Science and Technology (MMUST) in Kakamega,
Rongo University, Maseno University, Kisii University in Migori and South Eastern University in Kitui.
Events will include school programs such as school sports events, school drama, and music festivals.

Communication intervention using a multi-media approach will be employed to get information to young
people and influence positive attitude and behavioral change in respect of health-seeking behavior. The
Project will target young urban populations through the use of social media platforms like Facebook pages
Twitter and Instagram profiles of key peer influencers to share AYSRH messages. The specific activities
and messages will be determined at the community level to ensure youth appeal, local relevance as well
as cultural sensitivity. Findings from a human-centered design approach will be used to develop SBC plans
targeting specific sub-populations.

**Output 1.3: Strengthened county health systems for delivery of FP/RMNCAH,
nutrition and WASH services**
In Year 4 of implementation, Afya Halisi will continue to collaborate with the national level support
mechanisms including HRH Kenya, Tupime Kaunti, and Afya Ugavi to jointly address the key health system
strengthening (HSS) gaps identified in the counties and sub-counties and work with the counties to
implement high impact interventions across the service areas. Interventions will be put in place at the
county, sub-county, facility and community level to address the key issues as in the facility specific TA
plans. In Year 4, the Project will continue to build on the previous years and working with the counties to, make investments in HSS for an effective and efficient response for sustainable health service delivery. The Project will work with the CHMTs to strengthen TWGs for the various technical areas (FP, Reproductive Health, CH, WASH, County Nutrition Technical forums), with the recommendations used to influence and guide policy, standards and guidelines.

Assess and Improve Leadership and Governance Capacity of CHMTs and SCHMTs
The Project will build on the co-creation conversations with the four focus county senior leadership and management teams on various advocacy needs and furthermore empower the top county leadership and CHMT on SMART advocacy. Additionally, the Project will empower the county and sub county management teams to strengthen planning, coordination and monitoring for effective delivery of county led quality services. The Project will continue to engage with the county leadership in Kisumu, Kakamega and Kitui that have different models of UHC which are being operationalized to identify challenges and successes as experienced from the communities and possible solutions and roll out. In Migori County, the Project will support development of a contextualized UHC plan borrowing lessons learnt from implementing UHC in Makueni and the four pilot counties.

Strengthen Health Workforce
In Year 4, the Project will continue to strengthen the capacity of the CHMT to rationalize health care workers' deployment and retention and continue to advocate for progressive absorption of the HRH staff during the counties recruitment by the Public Service Boards. The project will collaborate with HRH mechanism to support the counties to develop a five-year health care worker’s plan. The plan will include advocacy for efficient management of the HRH including hiring the right and essential cadres of health care workers, the instrument of engagement that produces maximum output, their equitable deployment based on need and priorities, their regular performance appraisals, regular communication and social welfare management.

The Project will build on the gains made and lessons learned as a result of the 89 HRH brought on board in Year 2 in Kitui, Migori and Kisumu counties. The project will continue to advocate with the three counties for the delivery of the LOA on the remaining 62 HRH being supported by the project.

The management of HRH in-service training is a challenge that is continually voiced by the counties. Afya Halisi will continue to work with the HRH mechanism to build the capacity of the CHMT to track the various trainings, deployments, utilization of the skills gained as a result of the trainings, and also to shift the thinking of the staff on the effective models of training that ensure self-reliance and sustainability.

Health Management Information Systems (HMIS) for Effective Use of Data
Afya Halisi will build on achievements in Years 1-3 and co-plan, co-finance, co-implement and co-monitor with the Ministry of Health to strengthen existing health management information systems (HMIS). In Year 4, Afya Halisi will build on achievements in the last three years of project implementation and strengthen the capacity of MOH and local implementing partners (LIPs) to achieve strong and sustainable HMIS and monitoring, evaluation and learning (MEL) systems for reporting and tracking progress towards achievement of FP/RMNCAH, nutrition and WASH goals and key health outcomes in project focal counties and at national level, in the context of the COVID-19 pandemic.

In Years 1-3, the Project used adaptive programming and collaborating, learning and adapting (CLA) approach to inform targeted and tailored implementation of interventions in the focus counties, and at national level. In addition, Afya Halisi enhanced utilization of data at project level through comprehensive and granular data review meetings and strengthened the capacity of the County and Sub-county Health Management Teams (HMTs) to use the RMNCAH scorecard to identify sub-counties and wards
performing poorly for evidence-based differentiated investments to improve coverage for underserved, high burden sub-counties, wards, and health facilities to acceptable national goal and standards. In Year 4, the Project will continue to use the CLA approach and granular data review meetings to inform targeted and tailored implementation of priority interventions in underperforming areas, make strategic shifts and expand what is working well, drop what is not working well, and document and disseminate best practices and lessons learnt to MOH and other partners for cross-learning.

In Year 4, Afya Halisi will leverage both technical and financial resources with other implementing partners such as Tupime Kaunti to strengthen health management information systems at county and sub-county levels, including at national level. During the work planning process, Afya Halisi co-created with Tupime Kaunti to agree on leveraging resources in the focus counties of Kakamega, Kisumu and Migori where Tupime Kaunti works. The partners agreed that Afya Halisi will focus its support on these key MEL activities at sub-county levels whereas Tupime Kaunti will focus its support at county level.

To advance self-reliance and as part of the Project’s transition approach, Afya Halisi will premier and focus at strengthening capacity of HMIS and providing technical assistance at county and sub-county levels, while the CHMTs and SCHMTs and technical officers will cascade the MEL interventions to HCWs, CHVs and local actors at health facility and community levels. Whereas MEL activities will target all Project supported service areas, more focus and intensity will continue to be in Kitui County where Afya Halisi is the key implementing partner providing support in strengthening MEL systems for FP/RMNCAH, nutrition and WASH services.

In Year 3, the Project adjusted its strategies to ensure use of adaptive and safe monitoring, evaluation and reporting of FP/RMNCAHN and WASH services, in the context of COVID-19 pandemic. For instance, the Project worked with MOH to co-plan and co-implement MEL activities that do not involve large groups of people, with observance of the containment and prevention measures against COVID-19 pandemic. In Year 4, the Project will continue to work with MOH to ensure continued implementation of MEL and reporting activities in line with the government’s containment and prevention measures against COVID-19.

Afya Halisi will align its MEL activities to the priorities of the four focus counties and support co-implementation of the following MEL strategies in Year 4; strengthen HMIS and MEL systems for MOH and local implementing partners; strengthen capacity of MOH in planning, budgeting and monitoring; strengthen use of data and information for action; strengthen data quality; and implement project learning agenda, and focus on documentation of project achievements, best practices and lessons learnt as part of the close out process. Further details on the Project’s support in strengthening HIS is included in the MEL section.

**Access to Essential Medicines and Other Health Commodities at County and Sub-County Levels**

Whereas there has been considerable effort to improve the supply chain system especially with the introduction of the iSCM to improve the constant availability of essential lifesaving commodities and supplies including family planning, there are still challenges with stock-outs of commodities and supplies at different times. The Project will build on the achievements already made in the previous years on the sensitization of health care workers on quantification, forecasting, and reporting. The Project will build on the progress that was made in collaborative work with Afya Ugavi in commodity management in Year 3 and continue to support the county and sub-county management teams to provide oversight to supply chain and commodity management for quality health care delivery in the county and sub-counties. The
Project will build on the use of the dashboard that was developed for quantification, and strengthen the capacity of the sub-counties to roll it out and continue.

The Project will also continue to advocate for appropriate resources allocation for the line items. In Year 4, Afya Halisi will continue to collaborate with Afya Ugavi by building the capacity of health care workers to implement supply chain activities at facility levels as Afya Ugavi continues to roll out the iSCM.

**Health Care Financing**

Despite the many positive strides made in the financial management of county health systems since devolution, the counties still suffer from weak financial management and accountability. There is also evidence of sub-optimal utilization of the NHIF and Linda Mama Program social healthcare financing initiatives. Afya Halisi will use a multi-pronged approach to strengthen counties' public financial management systems to improve fiscal discipline, efficient resource mobilization, and utilization. The Project will work with counties through the Public Expenditure and Financial Accountability Framework to assess the administrative, financial management, and capacities of health facilities.

The Project recognizes that apart from the national treasury, county governments receive funds and support from different other sources for implementing health services. In year 4, Afya Halisi will continue to work with the counties to build on the principles of co-planning, co-funding, co-implementation and co-monitoring. In Migori and Kitui counties, Afya Halisi will continue to advocate and co-support the operationalization of the 4 comprehensive obstetric and newborn care (CEmONC) facilities. Despite the many positive strides made in the financial management of county health systems since devolution, the counties still suffer from weak financial management and accountability. There is also evidence of sub-optimal utilization of the NHIF and Linda Mama Program social healthcare financing initiatives. Afya Halisi will use a multi-pronged approach to strengthen counties' public financial management systems to improve fiscal discipline, efficient resource mobilization, and utilization. The Project will work with counties through the Public Expenditure and Financial Accountability Framework to assess the administrative, financial management, and capacities of health facilities.

The Project recognizes that apart from the national treasury, county governments receive funds and support from different other sources for implementing health services. Afya Halisi will work with the counties to match funds to deliver on the Project's mandate. Through this approach, the county will identify specific activities for co-funding and both parties will demonstrate commitment and evidence of the co-support. In year 3, activities that the Project will not comprehensively support without matching funding commitments from the county governments include field supportive supervision, training of HCWs, procurement of commodities and supplies, redistribution of commodities, and data and performance review meetings. In Migori and Kitui counties, Afya Halisi will support the operationalization of comprehensive obstetric and newborn care (CEmONC) facilities whose theatres were renovated with support from USAID in year 3. The project will also continue to advocate for the opening and operationalization of 8 additional CEMONC facilities: 3 in Kitui (Zombo SCH, Kauwi SCH, Ikutha SCH), 1 in Migori (Macalder SCH), 2 in Kakamega (Mumias West SCH and Navakholo SCH), 2 in Kisumu (Lumumba SCH and the new KCDH maternity theatre). The advocacy will focus on the facilities with theatres that received operation theatre lamps through support from USAID.
Sub-purpose 2: Increased care seeking and health promoting behavior for FP/RMNCAH, nutrition and WASH

Output 2.1: Increased knowledge of and demand for FP/RMNCAH, nutrition and WASH services

Data-driven decision-making, co-creation, strategic investments and synergistic partnerships with the national, county governments and the people of Kakamega, Kisumu, Kitui and Migori counties reflect the Afya Halisi evolutionary journey that has positively impacted and transformed the healthcare landscape in the said counties. Conceived as a health system strengthening mechanism, over the years, the project has made insightful investments that have enhanced the capacity of healthcare systems to effectively, efficiently and sustainably deliver services to its target populations. To date, the project has been able to achieve the following since inception;

- **Improved capacity to design, develop and implement SBC Interventions** - In the spirit of J2SR, the project pursued a Trainer of Trainers (ToT) approach to training county and sub-county MoH staffers in SBC. Following an SBC gaps analysis exercise conducted towards the end of PY2 (Aug 2019), 90 MoH and 27 LIPs’ officers were directly trained by Afya Halisi in PY3 in fundamental SBC concepts and skills such as: Human-Centered Design (HCD), Interpersonal Communication Framework, Community Facilitation Techniques (ETL - Education Through Listening), SBC Quality Assurance/Improvement (QA/QI), Handling Mass & Social Media, Supportive Supervision, and Documentation of Human Interest/Success stories. It is reassuring to note that the ToT approach has already borne fruit. In July of 2020, county and sub-county MoH mentors cascaded the SBC training to 274 CHEWs/CHAs who are currently coaching CHVs in effective SBC techniques.

- **Development of Policy frameworks** - In PY3, the project worked with the county governments of Kakamega, Kisumu, Kitui and Migori to revise (the expired) National Health Communication Guidelines and contextualized the framework to address emerging concerns. When operationalized, the revised County Health Communication Guidelines (CHCG) will give structure to SBC/Health promotion by defining the standards of quality and providing guidelines for the design, development and implementation of SBC/Health Promotion interventions.

- **Improving measurement and quality of SBC** – In PY3, Afya Halisi supported the development of AYSRH SBC Reporting Tool for use in the Schools’ Program and also the SBC Quality Assurance/Quality Improvement (SBC QA/QI) tool.

- **Technical assistance in the design, development and implementation of SBC interventions** - In PY3, Afya Halisi offered both technical and materials support to counties in the development and implementation of SBC interventions. An example can be drawn from the projects technical support for the Kisumu Emergency Communication (ECC) Center and the rollout of Toll-free Helplines in Kakamega, Migori and Kitui counties. The project provided technical assistance in the development of ECC/Helpline Protocols, Reporting Tools and trained the ECC/helpline operatives in elements of Customer care, Basic Counseling Techniques and Value Clarification. The project also provided technical and material assistance in the development and production of IEC materials used market the interventions such as e-flyers, banners and posters.

In response to the restrictions occasioned by COVID-19 emergency measures, Afya Halisi introduced the counties to enabling technological tools such as Zoom/Teams conferencing solutions, social media and document sharing/archiving platforms such as Google Drive and WeTransfer. These technologies
ensured continuity in programming amid the COVID-19 lockdown and are both effective and (cost)efficient.

- **Coordination & Governance** – The project supported 10 interpersonal HPAC (Health Promotion Advisory Committee) meetings and 4 virtual HPAC meetings in PY3 to discuss matters pertinent to SBC. The HPAC is the only recognized coordination mechanism for SBC in Afya Halisi supported counties. The forum brings together government departments/agencies, implementing partners and private sector players involved in health promotion and public health activities in line with the global standard of HiAP (Health in All Policies) that seeks to address Social Determinants of Health (SDH). The forum is responsible for the development of the County Health Communication Guidelines and also the Materials Review workshops that vetted IECs in use (per county) and made recommendations for amendments and adoption into the approved County IEC Compendium (CIC).

- **Telling our story** – Afya Halisi supported the training of MoH and LIPs operatives in the documentation and writing of Human Interest/Success Stories in PY3. In addition, the project provided technical assistance in the development and publication of the Kitui County WASH Bulletin. By partnering with AFP-trained journalists, the project has managed to publish/broadcast over 15 human interest stories that illustrate the outcomes of Afya Halisi’s interventions in conjunction with the MoH in the four supported counties.

Going into PY4, the project through LIPs will pursue a strategy of consolidating gains and building on its achievements over the past three project years to fully transition the SBC and demand creation functions to the county and sub-county governments. Afya Halisi’s support to counties is firmly anchored on the principles of sustainable programming as underscored by the J2SR paradigm. PY4 is a transitional period, where the county and sub-county systems, strengthened over the past three years, are expected to fully kick in and take up the mandate of stewarding the design, development and implementation of effective SBC and demand creation interventions. Below are highlights of key SBC approaches and activities to be implemented in PY4

**Support context-specific strategies for healthy behaviors:**

- **Coaching and Mentorship** - Through the support of Afya Halisi, 90 MoH mentors (HPOs, PHOs and CHSFPs) in the Afya Halisi supported counties/sub-counties were trained in the SBC discipline and are adequately equipped to cascade down SBC skills and techniques to lower levels of the health pyramid.

  The project will provide technical support in the analysis of data and supportive supervision reports to identify the skills gaps among the CHVs/CORPs and provide technical assistance in the development of training plans to bridge the said gaps. To mitigate against the perennial shortage of resources that negates classroom learning, the MoH mentors will rely on coaching, mentorship, on-job training and intensified supportive supervision as the primary vehicles for skills strengthening.

- **The Entrenchment of SBC QA/QI practice** - During recent co-creation meetings with LIPs, counties and sub-counties officials, the Afya Halisi fronted SBC QA/QI approach was endorsed as one of the most effective and novel approaches to measuring and improving the quality of facilitation of community SBC sessions. In PY4, Afya Halisi will use its influence to advocate for the entrenchment of SBC QA/QI process as standard practice in SBC interventions. In order to objectively evaluate the quality of facilitation of a community SBC engagement, a mentor will sit in and directly observe the session being conducted by a CHV/CORP and fill out the structured SBC QA/QI tool which is based on the Likert scale. Thereafter, the mentor will add up the overall score and is required to provide prompt feedback to the facilitator(s). The process is aimed at improving the facilitation technique of the CHV/CORP and any adverse concerns are escalated for further action such as training, updates or orientation to
address the observed skills gap(s). Improving quality of facilitation of SBC sessions leads to better outcomes e.g. increased referrals & conversions (product/service uptake & behaviour change).

- **Operationalize Policy Frameworks** - In PY3, Afya Halisi supported the development of a number of policy frameworks that served to strengthen and give structure to Health Promotion function by defining the standards/quality of the common SBC interventions. The flagship policy document developed in PY3 with support from Afya Halisi is the “County Health Communication Guidelines”. In addition to the standards and quality prescriptions, the policy also provides guidelines on how to implement and measure SBC interventions.

In PY4, Afya Halisi will support the MoH in production, dissemination and operationalization of the said policy framework. The HPAC mechanism will be crucial to the operationalization of the said guidelines. In part, the Terms of Reference of the HPACs decree that, it is the only organ at county & sub-county level mandated to:
  a) Support the Health Promotion Department in the implementation of relevant policies, guidelines & strategies at county and sub-county levels; and
  b) Support HPU in the regulation of Health Promotion initiatives including regulation of training standards and vetting of IEC materials before they are released into communities.

- **Strengthening measurement, reporting and generation of evidence to support efficacy of SBC interventions** - In PY3, Afya Halisi supported Kisumu and Kakamega counties in the development of an AYSRH SBC tool for the Schools’ Program. The tool was endorsed by both MoH and Ministry of Education officials in both counties as the approved standard for capturing SBC data during the school sessions. The rollout of this tool was however greatly hampered by the country-wide shut-down of schools in response to the COVID-19 pandemic.

In PY4, the project intends to engage the Health Promotion function and other entities/partners that conduct SBC activities to consolidate the myriad of SBC data capturing tools in use within counties into one harmonized standard tool for SBC reporting. Further to this, the project will support the county in rationalizing and developing protocols for management of SBC data. The tool will also be forwarded to the national custodians of the DHIS2 platform, which is the universally accepted repository for health sector data, for debate, adjustment, and in time, inclusion on the platform.

Even though the DHIS2 is not a comprehensive repository of SBC (Health Promotion) data, county and sub-county HPOs, PHOs and CHSFPs have strongly expressed the need to be oriented on the platform to approach it from a point of understanding.

Lack of evidence to support the efficacy of SBC interventions is one of the greatest challenges causing sub-optimal investments in health promotion and public health (preventive) initiatives. SBC practitioners have the daunting responsibility of building a body of evidence to support preventive and promotive approaches to health programming. To this end, in PY4, Afya Halisi will provide technical assistance to select county officials who’ve expressed the wish to carry out Operations Research with the SBC arena.

During the co-creation process, the MoH officials expressed the desire to write abstracts that meet global standards and submit them to international conferences as their contribution to growing the knowledge on SBC and the Health Promotion profession as a whole. In PY4, Afya Halisi will orient a select group of MoH officials in the skill of writing abstract targeted for international conferences.
backed by empirical evidence, that’s guaranteed to spur decision-makers into action. Human interest stories have an effective way of emotionally engaging decision-makers, leading to favorable decisions.

In PY4, Afya Halisi will continue to provide technical support to MoH in the writing of such stories in support of SBC interventions. Quality pictorials, together with human interest stories, will yield even greater impact. As part of its technical support to MoH, the project will orient a caucus of mentors in the art of photography. The mentors will then be supported to cascade down the skills to lower levels of the health pyramid. In a world where more and more people are getting their news from social media/internet, its incumbent on the project to strengthen the capacity of the MoH to tell their stories, especially on social media.

- **Advocacy and improved planning for Resource Mobilization for promotive/preventive health activities** - It is common knowledge that within the healthcare continuum, health promotion and public health (prevention) interventions are grossly underfunded. The COVID-19 pandemic has provided evidence around the efficacy and benefits of preventive approaches. In PY4, Afya Halisi will work with CHPOs, CPHOs and CCHSFPs to develop advocacy strategies for the engagement of decision-makers in an effort to increase the budgetary allocation for promotive/preventive health activities.

Additionally, the project thematic leads will work with their MoH counterparts to rationalize their health area priorities and workplans and package the same in the recommended AWP template. The project will allocate resources to support strategic AWP forums that will enable it to plug into the process and articulate its advocacy agenda.

**Create demand for services**

Support for the revision of SBC/IEC materials to reflect the emerging realities of the COVID-19 pandemic

The pandemic has greatly impacted traditional health programming and rendered useless a significant number of protocols and IECs. Invariably, IEC materials, guidelines and protocols must be revised to accommodate emerging realities occasioned by the novel COVID-19. In PY4, Afya Halisi will work with counties to review protocols and IEC materials that need to be revised to accommodate the emerging realities.

Engender the use of technological catalysts to increase SBC coverage and impact - COVID-19 has forced health programmers to innovate and find solutions outside their normal comfort zone. The COVID-19 restrictions to public gatherings have greatly constricted available interpersonal settings/channels that permit safe interactions of persons and/or groups. Catalytic technologies such as conferencing platforms and video calling apps provide viable and cost-efficient alternatives for reaching target populations, cut-off (marginalized) by the COVID-19 restrictions. Virtual dialogues, supported by unrestricted access to information and online shops can lead to significant conversions (behavior change and/or product/service uptake). Technologies such as Social Media platforms are popular, cost-efficient, easy to deploy and maintain.

In PY4, Afya Halisi will support the counties in the deployment and operationalization of catalytic technologies that will improve safety (infection prevention), expand reach, enhance quality of engagement and increase the impact of SBC interventions.

Strengthen Emergency, Risk Communication and Community Engagement (ERC & CE) function - During a crisis or an emergency such as the on-going COVID-19 pandemic, the need for a well-thought-out Risk Communication Plan cannot be discounted. Prompt dissemination of accurate, reliable and credible information may be the difference between losing or saving many lives. The multiplicity of factors and complexity of setting up an effective Emergency & Risk Communication response requires meticulous planning skills and in-depth knowledge of all the elements of the process.
In PY4, Afya Halisi will partner with WHO (World Health Organization) to develop an Emergency, Risk Communication and Community Engagement (ERC & CE) Strategy for Kisumu County. The lessons learned during the Kisumu process will be shared with the other counties.

**Strengthen Coordination and Governance (include Social Accountability and Integration)** – Strong and effective coordination mechanism are a hallmark of good governance. Coordination encourages the systematization of best practices like joint work-planning, gender mainstreaming, social accountability and inclusion of marginalized populations. In situations where a number of partners are operating in the same locale, programmatic vices like double-counting and duplication of effort (which leads to wastage) are minimized through appropriate coordination. When necessary, the partners may be called upon to pool their resources, optimize synergies and deliver healthier outcomes which may not have been possible with scattered effort. Issues of contribution and attribution can also be amicably discussed and determined at such forums.

The Afya Halisi supported HPAC forums have served the important role of coordination and governance and delivered tangible results in the project supported counties. Through these forums, SBC partners have, among other things, managed the following:

- Developed County Health Communication Guidelines
- Mapped of SBC Partners in supported counties and developed comprehensive databases of SBC partners
- Carried out Materials’ Review workshops, vetted available in-county IECs resources and developed a compendium of recommended IECs
- Served as a learning platform for sharing lessons learned across counties/sub-counties

In PY4, the project will gradually cede the control and management of the HPACs to the relevant county departments. The transition will include the transfer of functions and reduction of financial/technical support to the mechanism. During the transition, Afya Halisi will mentor the incoming stewards on Social Accountability in order to ensure continuity of the function before the project life.

**Output 2.2: Improved gender norms and sociocultural practices**

**Gender Integration**

In year 3, the project continued to support the County Department of Health aimed at sustaining the gender integration continuum, gender transformative programming, and provider behavior change. More so, the project scaled up capacity building and deepening of commitment on Gender Integration, Social Inclusion and (S)GBV prevention/response to County Department of Health, County Department of Gender, LIPs and Gender/GBV actors as part of J2SR. However, during the period there was emergence of COVID-19 which continued to compound existing gender disparities and offered an opportunity for GBV to thrive. Therefore, the project focused on reviewing gender/GBV approaches and activities in the context of COVID-19 pandemic in order to respond to Gender/GBV emerging concerns including increased reporting of SGBV/IPV.

In year 1 and 2, the Project designed and conducted a gender analysis, developed gender module, integrated gender in FP/RMNCAH/Nutrition and WASH and built the capacity of Project staff and health care providers. Gender module aimed at building capacity to address gender-based inequities and inequalities that sustained lack of or utilization of FP/RMNCAH/Nutrition and WASH services. Gender analysis established that gender roles, social norms, socio-cultural practices across the four counties continue to impede uptake of modern contraceptives (specifically in Kitui and Kakamega), utilization of SBA in the four counties, immunization (in Kitui), and healthy child nutrition (Kakamega and Migori).
Timely initiation of exclusive breastfeeding in Kitui and Kakamega, continued occurrence of female genital mutilation in Migori, and teenage pregnancies in Kakamega and Migori as a result of existing socio-cultural practices that normalize gender-based violence (GBV) including child marriages.

Informed by the gender analysis conducted in year 2, the Project identified and empowered local champions on strategies for better engagement with communities to address social norms and challenge harmful social-cultural practices. These champions included adolescent boys and girls, male and female opinion leaders, religious leaders, CHVs, among others. Interactions held with providers and community members in years 1 and 2 revealed gender inequalities through male dominance in household decision making towards the uptake and utilization of FR/RMNCAH/ WASH/Nutrition services. In year 3, project established gender steering to support in gender integration and SGBV prevention and response in the project thematic areas. Additionally, the project focused on advocating with the County management team and LIPs to identify gender focal persons at the County, Sub County, facility and community level to promote gender mainstreaming/integration, (S)GBV prevention/response.

In year 4 and sustaining the gains in gender integration, overarching implementation across community inventions will be undertaken through the LIPs. The Project focus will be on building capacity and mentorship LIPs on gender transformative approaches, promote gender-transformative interventions across thematic areas in the context of COVID-19 pandemic, embracing social inclusion, promoting quality services through social accountability mechanisms and inclusion of gender/GBV in Q1 structures, capacity strengthening of service providers, LIPs, and C/SCHMT on gender-sensitive and response programming, and continued gender advocacy at national, county, SC level as part of transition and sustainability approach. In year 3, Afya Halisi leveraged on the gains made in year 1 and 2 to roll out gender transformative interventions at the community and facility level. At the community level, LIPs continued to engage with community health committees to conduct gender-transformative education and behavior change communication with couples, existing community-level social networks and gender multi-sectorial ward level boards. There was also engagement of male and female champions as community-level change agents to facilitate discourse on community and individual level transformation of gender norms and harmful gender practices. The above approaches will be sustained in year 4 but COVID-19 pandemic considerations will be integrated. The Project’s gender integration will continue to focus on the gender transformative approaches to improve the quality of care by ensuring respectful, gender sensitive care, and promoting interpersonal communication, joint-decision making and equitable relations across the continuum of care. All previously discussed community-level activities will be implemented using a gender-transformative approach that acknowledges and examines harmful gender norms and their impact on service uptake. These interventions will not only increase knowledge of the benefits of services, but will work with individuals, couples, and communities to break down social and cultural barriers impeding the use of these services.

During year 3, COVID-19 pandemic emergence impacted on social interaction and gender practices. COVID-19 did not only compound the existing gender inequalities but also reduced opportunities for socialization, services access and utilization due to curfew, travel restrictions and economic strengthening activities. The Project does recognize the adverse socio-economic and health-related outcomes associated with COVID-19 including the loss of livelihood by both men and women; increased care burden placed on women in the household and community; closure of schools thus increasing the vulnerability of girls to harmful traditional practices such as FGM/C and early marriage, in addition to teenage pregnancies; delayed or hindered access to SRH and GBV related services due to restrictions in movement. In year 4, the project will continue to integrate gender-sensitive and responsive approaches aimed at promoting
gender-sensitive normative care in the context of COVID-19 and reduce gender inequalities/vulnerabilities. The project will implement the following approaches in PY4;

**Implement County Specific Gender Integration Strategies**

*High impact gender interventions:* In year 4, the Project will mentor and supervise LIPs to carry out targeted advocacy on social inclusion, gender-responsive care, GBV, and eradication of harmful socio-cultural practices that impede access to FP/RMNCAH. Through the leadership of county gender focal persons’ county focused gender action plans will be implemented. The implementation plans will focus on high impact evidence-based interventions to help address the gender-related barriers to FP/RMNCAH, proper nutrition and WASH behaviors in the four counties. Men engagement as champions will be scale-up in Kuria to address FGM. Well in Kutui men involvement as partners will well focus on promote promoting FP uptake and reduction of IPV among women who access FP services.

*Gender-integrated and responsive service package:* The project will engage trained GBV/IPV mentors to mentor, promote and sustain GBV integration in FP/RMNCAH under the leadership of gender focal persons. Following dissemination and adoption national IPV screening package in health facilities the project will provide mentorship to mentors/HCW to strengthen early IPV identification, management and/or referral among women and girls accessing FP and ANC services. More so, the Project will work closely with the LIPs to strengthen IPV screening and mentorship on focused male engagement in family planning package that was developed and disseminated in year 2 and 3 respectively. Targeted mentorship on gender quality delivery standards and GBV QA tool will be enhanced through technical support to Gender Focal Persons aimed at promoting gender sensitive normative care and comprehensive quality Post GBV Care.

**Utilize community platforms to promote positive gender and sociocultural norms and practices, including equitable decision-making**

In years 2 and 3, the project supported the establishment of Ward gender multi-sectorial boards to address gender norms on FP/RMNCAH, Nutrition and WASH. LIPs, utilized existing community platforms such as community based organizations, male association groups, youth clubs, community barazas, market forum, learning institutions, and religious forums address the socio-cultural practices and barriers to uptake of FP, SBA and timely initiation of breastfeeding. These platforms are informed by county disparities in terms of gatekeepers, prevalent norms and practices, and perceptions towards certain implementation approaches. For example, in Kakamega, it was established that women lack the autonomy to decide when to initiate breastfeeding, and what should be eaten at the household level. In Migori, negative provider attitude delayed FP initiation for adolescents. In Kitui, women were found to be more likely to take up FP/RH or CH services if offered in privacy without the involvement of their male partners. Women reached in Kitui through the immersion process also stated that their religion does not allow for them to use FP methods, but their receptiveness to this information will be more positive if is given in same-sex groups, as opposed to mixed-gender groups. Consequently, the Project will continue provide intensive support and mentorship to LIPs in an effort to ensure gender sensitive and responsive approaches are utilized in the identification of community platforms that will drive change in norms and behavior. The project will work with LIPs drawing from lessons generated in Year 1-3 to enhance their reach to the wider constituents served by community units linked to the health facilities supported by the Project. The following are examples of how this will be implemented:

- *Implement Community Scorecard as a Tool for Social Accountability:* The project will build capacity of LIPs through mentorship and technical support to work directly with communities to conduct dialogues to challenge gender and social-cultural norms, as informed by Project and county
priorities. LIPs to champion social accountability and collective action mechanisms aimed at enhancing provision of quality gender sensitive and responsive service delivery, advocacy, and community level interventions. In Migori, the Project will work with the LIPs to address issues around immunization, FGM, GBV and early child marriage especially in Kuria, Nyatike and Awendo. In Kisumu and Kakamega, the LIPs will engage men, women, girls and boys, including boda riders, male circumcisers, fisherfolk, gold miners, and religious leaders among others. In Kisumu and Kitui, the LIPs will be required to roll out strategies to enhance the utilization of FP and child health with a focus on the underserved population (including PWDs) and those in hard to reach areas. The Project will develop a gender transformative programming package to be utilized by the LIPs in implementing activities across the gender integration continuum.

- **Strengthen Community Gender Multi-Sectoral Advisory Boards:** In collaboration with the counties, the project in year 3 supported set up multi-sectoral gender Community multi-sectorial Boards comprised of local leaders, representative of community members, representatives of local organizations and religious institutions, health workers, CHVs, and local administration and meet regularly to provide feedback on the quality GBV interventions and guidance on the social protection support structure to be put in place by the county for survivors. The project will build the capacity of Gender focal persons/LIPs to provide support and offer mentor CABs intensified efforts to address harmful practices as informed by service delivery data on uptake of FP, SBA, immunization, proper WASH and nutrition behaviors. More so, to support in strengthening post medical interventions such as economic strengthening, psychosocial services.

- **Targeted Small Group Sessions:** The LIPs will collaborate closely with sub-county community focal persons to convene small group sessions. Topics of discussion and target audiences for these groups will be informed by the gender analysis study. The Project will work with the SCHMTs and LIPs to develop and disseminate appropriate messaging on the targeted accelerator behaviors to guide LIPs to facilitate these sessions. In an effort to sustain the impact of these groups, the LIPs will link these groups, where appropriate, to existing economic and life skills empowerment programs to address barriers that enhance gender inequalities in relationships and/or at the household level. In Year 4, the LIPs will leverage the male and female champions trained in Years 1-3 to champion issues that affect FP, SBA, AYSRH, and immunization services.

- **Community Dialogues:** In Year 3, the LIPs at the community level convened thematic dialogues in relation to addressing gender based inequities to uptake and utilization of FP/RMNCAH/Nutrition and WASH services. The dialogue formed fora where communities discuss gender norms and FP/RMNCAH, WASH and nutrition, and provide avenues for enhanced accountability mechanisms on quality of services offered across different levels of care. The LIPs will utilize the Social Analysis & Action (SAA) approach to facilitate communities dialogue, reflect, and take up individual and community actions that support more equitable gender norms and positive FP/RMNCAH, WASH and nutrition behaviors. In year 4, Project in collaboration with the LiPs and SCHMT teams, generate community scorecards as informed by the community perception and response to the quality of services offered by facilities. Dialogue sessions will be informed to strengthen data use for demand creation, behavior change and quality improvement.

- **Gender Technical Working Groups and Collaboration with other Partners:** In Year 4, the Project engagement at TWG level will be to contribute towards advocacy on SGBV policies implementation, involvement in the development of county gender priorities in the AWP process, and networking/advocacy with other implementing partners.
Build capacity of HCWs, CHVs and champions to discuss gender norms and sociocultural beliefs and provide gender-responsive services
In Year 1 to 3, the Project made deliberate efforts to integrate a gender module in all FP/RMNCAH, nutrition, and WASH trainings conducted at county, sub-county, facility and community levels to ensure that participants understand the gender perspectives of the training subject and their role in challenging the harmful gender norms and practices. More so, in year 3 the project focused on building capacity of C/SCHMTs & Community strategy team on gender transformative approaches aimed at promoting gender sensitive planning and budgeting, enhancing understanding of gender perspectives in at the health facility and community level.

Build the Capacity of County and Sub-county Mentors on GBV First-line Response:
In year 3, the project built the capacity of service providers as GBV/IPV first-line responders in Kakamega, Kisumu, Kitui and Migori Counties to equip them with knowledge and skills in the management survivors including sexual violence (Violence Against Children). In year 4, the project through the leadership of County gender focal persons with offer mentorship and technical support to the mentors to scale up cascade of the training to providers at sub-county and county referrals hospitals in Kisumu and Kakamega as well as promote quality of GBV services through adoption of QA tool.

Gender Transformative Programming of LIPs and S/CHMT:
In year 3, the project-oriented and mentored LIPs/SCHMTs on gender-transformative programming. To sustain the gains so far made in promoting gender transformative approaches, the project with mentor county gender focal person to provide continuous mentorship of SCHMTs and LIPs, on high impact gender-transformative interventions, as informed by emerging evidence.

Mentorship of S/CHMT on GBV and Community Scorecard:
In Year 2 and 3, the project developed the capacity of Sub County level mentors in gender-responsive and quality care, including male engagement and GBV as well as implementation a community SCHMT led community scorecard process as an approach to promote social accountability of services offered sub-counties of Kakamega and Kisumu. In Year 4, the Project will strengthen the capacity of the C/SCHMT to scale up this model in Kakamega, Kitui, Kisumu and Migori counties to promote gender-sensitive programming in FP/RMNCAH/Nutrition and WASH.

Gender-responsive Client Health Education, Quality Care and COVID-19:
In year 2 and 3, the Project piloted Jhpiego’s Gender Sensitive Service Delivery Standards, rolled out a Community Score Card (CSC) process and strengthened the capacity of LIPs and SC community health focal persons to conduct CSC as an approach to obtain user perceptions on the quality of service and improve service delivery with a focus on quality, efficiency, accessibility, and accountability across different levels of care. In year 4, the project will offer technical support and mentorship to gender focal persons and LIPs to strengthen the utilization of social accountability as an approach to provide community members with a platform where they can provide vital feedback to health care providers on the quality of services provided at the facility level. The Project will through the LIPs, will continue to disseminated messages on how COVID-19 is affecting women and girls in terms of access to SRH and GBV services. In collaboration with the gender department, gender focal persons and GBV actors the project messages on community-level response to GBV cases.
Develop/print GBV IEC, Service Delivery Algorithms and Data Tools:
In year 2 and 3, the project developed, printed and disseminated GBV IECs, service delivery standards and data tools. This was aimed at raising awareness on available post SV, IPV and Violence Against Children (VAC) services adapt existing national IEC/literacy materials. In year 4, the project will build capacity and mentors gender focal persons to maintain quality of GBV services through adherence to set standards.

Strengthen county forums to improve gender equity and response to gender discrimination in relation to RMNCAH, Nutrition and WASH
In Years 1 to 3, the Project provided technical support to Migori, Kisumu and Kakamega towards domestication of the national SGBV policy framework. The project will continue to engage with the county led Gender Working Group (GTWG) with a key focus on policy development, and provision of technical support towards the development of gender/SGBV policy implementation plans and inclusion of emerging issues such as COVID-19. Additionally, offer technical support to Kitui County TWG on gender policy formulation. The Project will continue to build the capacity of LIPs to engage in advocacy within the GTWG.

Gender Based Violence (GBV)
In year 2 and 3, the project implemented GBV prevention and response activities informed by the County AWPs, the gender analysis and emergence of COVID-19. In Kisumu and Kakamega Counties, the project supported training of the HCWs as chaperones to manage SGBV among adolescents and children survivors, training of county and sub county mentors on first-line GBV LIVES response, orientation of HRIOs on GBV documentation/reporting, sensitization of HCWs, police, community leaders and children officers to strengthen GBV prevention/response including medico-legal services as well as printing of SGBV/IPV data tools, dissemination and mentorship on documentation/reporting. Additionally, the project supported printing and dissemination of IPV Charts, algorithm on SGBV, Dos and Don'ts of SGBV and client flow path for SGBV survivors to offer a guide in management of survivors. Support supervision and mentorship on GBV/IPV was conducted under the leadership of gender focal person which enabled identification of gaps and action planning. In year 2, the project supported CDoH to strengthen the delivery of GBV services to child and adolescent survivors through training of providers (at facility and community) on case identification, referral and management, rehabilitating a child/adolescent-friendly waiting bay/holding area for children during treatment in Nyando County Referral Hospital and Kakamega County Referral Hospital.

In Kitui and Migori Counties, there was orientation on GBV/IPV LIVES targeted facilities. The orientation aimed at equipping the HCWs with knowledge, skills and attitudes on GBV/IPV as first line responders. IPV occurrence as a result of female partners accessing secretly modern contraceptive especially implants without consulting their male partners was reported in Kitui and Migori and therefore the need for continued capacity building through mentorship.

GBV Collaboration and partnership was strengthened through quarterly Gender TWG/GBV stakeholder for a conducted to strengthen referral mechanisms and service utilization in the two counties. Establishment and support of gender multi-sectorial boards at the ward, sub-county, and county-level was carried out aimed at addressing gender norms and SGBV prevention/response. However, there is need to strengthen GBV prevention/response especially during the COVID-19 pandemic. Therefore, in year 4 and in an effort to promote J2SR, the project will build capacity and deep commitment of CDH, CDoG and GBV stakeholder in GBV prevention/response.
Targeted community awareness on GBV prevention/response will be carried informed by GBV data especially during 16 days of gender activism. Leveraging on the existing community structures such as community strategy survivors’ identification, referral, linkages, follow up, retention into care and community re-integration will be enhanced. The project will seek to strengthen collaboration and partnership with stakeholders such as children department, police, DPP, Judiciary, GBV actors, CSOs and other projects such as Muendo project in promoting positive justice outcomes for the survivors in Kisumu and Kakamga Counties. More so enhance linkages to post clinical/medical management such as economic strengthening activities, psychosocial services. Comprehensive quality Post GBV care will be enhanced during the period through sustained integration of SGBV in QITs, WITs and ensuring the quality standards of the GBV service are maintained. Under the leadership of CHRIIO, the project will scale up GBV data review to inform decision making, planning and implementation of SGBV interventions. Counties will be supported with TA to implement a GBV mentorship package on enhanced first line response to be rolled out in health facilities by the S/CHMT. Targeted boys, young men and adult men as champions in promote GBV prevention/ response.

Kisumu County priorities include: scale up of comprehensive quality post GBV care services provision, survivors follow up and linkage to post medical care intervention, strengthening multi-sectorial approach to SGBV prevention/response, targeted capacity building of HCWs/CHVs in aimed at strengthening management of survivors, identification, referral and linkage of survivors, targeted awareness creation at the community level to address late reporting of survivors for Post GBV Care services. Kitui County priorities include provider capacity building on GBV/IPV service provision, community education on GBV, strengthened referral and linkage to care, and age and sex appropriate service delivery. Kakamega County focus areas include; scale up of comprehensive post GBV care services, roll out of a county SGBV policy and development of implementation strategy, advocacy on county resource allocation for GBV response, IPV screening in health facilities, Quality of (S)GBV services, trauma counselling, enhanced provider capacity to offer SGBV services. In addition, school health engagement to address teenage pregnancies and sexual abuse in schools; functionality of the county Gender Violence Recovery Centre and targeted community engagement on GBV and integrate gender in county quality improvement mechanisms. Migori County will focus on targeted capacity building on GBV prevention/response, multi-sectorial approach to GBV/IPV prevention/response.

In year 3, the emergence of COVID-19 did not only compound the existing gender inequalities but also increased the vulnerability of women, girls, men and boys to varied forms of gender-based violence. However, women, girls and children are major receipts of GBV in such circumstances. GBV during the period can be attributed to the increased tension within the households. In Kenya, children Department, Ministry of health and media reports highlight the increased reporting of various types of GBV reported through existing hotlines, police stations and health facilities. The GBV occurrences are associated with some of the measures put in place to curb the spread of COVID-19 in the country thus negating the gains so far made towards the enhanced access to GBV prevention and response services/information. Despite the existence of GBV related policy frameworks and service delivery mechanisms, reports indicate that individuals who experience GBV reported late for medical interventions, survivors had limited access to social support, counselling, treatment-related services, referral and follow up services. COVID-19 remains a challenge a therefore, the project will continue to integrate capacity building of LIPs, HCWs and GBV actors in dissemination of the GBV management guidelines, referral pathways in the context of COVID-19. The project aims to carry out sensitizations on GBV and COVID-19, dissemination of guidelines on GBV management in the context of COVID-19. The following GBV activities will be conducted in PY4:

**County GBV Advocacy Agenda:**
The project will in Year 4 continue to engage with the Kisumu and Migori county Gender Technical Working Groups (TWGs) in order to sustain the gains made towards the development of SGBV policies in both counties. The project will offer technical support in development of the SGBV policy implementation plans. In year 4, The Project will support both Kisumu and Migori counties in disseminating the gender/GBV policies to stakeholders on approval and launch respectively. Advocacy efforts will be sustained through engaging the county governments to have dedicated resource allocations towards GBV prevention and response. The Project and working with other GBV actors in TWG/Multi-sectorial fora will use WhatsApp and other available online platforms to provide information on the impact of COVID on SRH/Gender outcomes; identify areas of support required by CHWs and LIPs who are involved in rolling out project gender/GBV related interventions; and share best practices on approaches that are found to work as regards mitigating gender inequalities associated with COVID-19.

**Strengthen GBV response and prevention mechanisms in schools, health facilities and community:**

KHIS reports indicates gaps in SGBV cases management including timely reporting for post GBV care services. Other gaps include quality of service provision, limited cohort follow up of SGBV survivors, lack of services completeness and quality of data reported. In Year 4, the project will focus on strengthening quality of services offered to SGBV survivors including follow up, referral and linkages to post Clinical management interventions. Additionally, the project will focus on targeted community engagement to create awareness on timely reporting.

**Mentorship of trained CHVs as Case Chaperone’s for Survivors:**

The mentorship of trained CHVs as case chaperone’s for survivors will be carried out through the support of gender focal persons to ensure coherent and coordinated service delivery for survivors. The Community link desks in supported high volume facilities will play a key role in identifying ways through which CHVs can support survivors to navigate the facility to receive appropriate and timely services. The project will develop a training package for the case advocates in liaison with the CHMTs. The CHVs will also strengthen follow-up of survivors including children and adolescents to remind them of scheduled hospital clinical monitoring and counseling sessions. Through the leadership of gender focal person, monthly meetings will be held between the project team, CHVs and providers attending to GBV cases at the two facilities to monitor gaps in client flow and mechanisms through which these can be addressed. Working with County Gender Focal Person and LIPs In Migori, the project team will continue to advocate for utilization of existing community-based protection mechanisms that are in existence to protect women and girls from FGM and child marriage during the COVID-19 pandemic. More so, the Project will work with CDoH and CDoG the gender departments to disseminate county-specific GBV referral directories through LIPS and community platforms to enhance effective linkage and referral of GBV cases across sectors during the COVID-19 pandemic. Advocacy on Comprehensive Post GBV care for the survivors will be accelerated to promote uptake and utilization of services.

**Create “Safe Spaces” in Learning Institutions:**

Due to COVID-19 school-level intervention were interfered following the closure of schools. However, abuse of learners in schools and learning institution is a key gap in most schools, with most violations happening either in the toilets, classrooms or playgrounds. The teacher to student ratio poses a challenge on the extent to which teachers can closely monitor the pupils, especially in primary schools. Teachers in certain instances are reported as perpetrators of these violations. Hence there is need to engage both learners and teachers to make schools a violence-free zone, and educate them on how to handle GBV cases when identified. The project appreciates the circumstance the schools will be operating in during the COVID-19 pandemic and in an effort to create dialogue with learners and teachers when the schools
reopen on gender norms and GBV prevention, the project will identify six primary schools in Matungu sub county with an aim of creating a safe and enabling school environment (adaptation of the Good school’s toolkit- from Uganda). Matungu SC has high incidences of teenage pregnancies. This good school toolkit seeks to create schools as safe zones free from any form of violence. Lessons drawn from Matungu will be utilized to inform GBV prevention and response interventions rolled out by LIPs in schools. The key activities will include holding meetings with the county Education offices for ownership; train teachers and student leaders to facilitate sessions using the Good Schools Toolkit; visit to schools every term to assess progress made in creating safe spaces in schools; and adapting, printing and disseminating IEC materials in the targeted schools.

**Strengthen County, and Sub-County Level GBV Focused M&E Approaches:**

In Year 3, the project supported printing and dissemination of SGBV data tools and delivery standards. Orientation of the HRIOs on GBV data tools and reporting was carried out. In year 4, the project will mentor the HRIOs to enhance quality SGBV data reporting in the KHIS, reporting on the gender/GBV indicators for monitoring and reporting during the COVID-19 pandemic and post-crisis.

**Output 2.3: Increased practice of key nutrition and WASH behaviors in target communities**

**Promote and support key nutrition and WASH behaviors in target communities:**

In PY3, the project has worked with KMET and Lwala to implement nutrition at community level including; BFCI, VAS, family MUAC, BFHI, review meetings and establishing linkages. Lwala supported the implementation of community level activities in Rongo while KMET supported Kuria West, Kuria East, Suna West and Nyatike in Migori; and Navakholo, Matungu and Khwisero in Kakamega county. The project has implemented directly in 3 sub counties each in Kakamega and Migori counties. The project has scaled up BFCI implementation from zero to 70 CUs implementing BFCI by end of PY 3 in Kakamega county while in Migori an additional 38 CUs were trained to bring the total to 66. The project supported BFCI trainings for health workers and CMSG, CMEs, mentorships and assessments that led to progress in BFCI. In addition, small group sessions, cooking demonstrations and supportive supervisions have been conducted. The project also used HCD and gender analysis findings to guide implementation at community level. These were factored during implementation and small group sessions were used to address the negative cultural practices and gender-related issues that emerged.

The project improved hygiene and handwashing practices by leveraging and integrating nutrition with WASH. This was done during cooking demonstrations, health education and also when teaching mothers how to make soap as an IGA. The project integrated MIYCN in COVID messaging to M2MSGs during the soap making and BFCI scale up trainings.

In PY4, the Project will continue supporting service delivery at community level through the two LIPs while transitioning the other sub-counties (where the project has implemented directly) to the Ministry by the end of PY 4. The LIPs will continue supporting all community-level activities in their areas of focus. The project will continue using the findings from gender analysis and HCD to enrich its implementation. The project will not scale up any CUs in PY 4 but enhance mentorship and follow up for the existing CUs. The project will support self-assessments and external assessment for those that score over 80% from county assessment. As BFCI is implemented, the focus will be on maternal nutrition, exclusive breastfeeding and complementary feeding. Progress has been made in breastfeeding but challenges still exit in complementary feeding and maternal nutrition for both health workers and CHVs. The Ministry will support household visits by CHVs, cooking demonstrations at community level and health education.
during M2MSG meetings. Children 2 – 5 years will be reached through VAS, deworming, and GMP. Pregnant and lactating adolescents will be reached during home visits by CHVs with all support and where numbers permit, a group will be formed to cater for them also linking them to various sources of livelihoods.

**Improve Water Sanitation and Hygiene Practices:**
The project has been implementing WASH activities in Kitui, Kakamega and Migori since PY1. These activities are geared towards increasing access to improved WASH practices at community level and facilities. Afya Halisi prioritizes the integration of WASH in other components of the project, particularly in child health, nutrition and community service delivery platforms. In year 4, the project will continue to integrate WASH with the other technical areas, particularly the community platform that works with community volunteers to undertake finalization of CLTS follow-ups, verification of villages and most importantly intensify Sanitation Marketing in villages that have perennially recorded relapses to Open defecation (OD) status. In PY4, the project will focus on the following areas:

- **Increase access to safely managed drinking water services:** During year 1 to 3, Afya Halisi in collaboration with county water and health departments has been able to support the rehabilitation and protection of 58 water points. The selection criteria of the water sources to be rehabilitated included diarrheal diseases burden, viability, risk of contamination, beneficiary population, and potential for sustainable management by beneficiaries. Water sampling and quality analysis was undertaken for the protected water sources and water management committees trained on basic operation and maintenance as well as on critical aspects of management of the water facilities they are responsible for. To manage the protected water sources, the Project has supported the training of 55 water management committees during the first three years of the project.

- **Scale Community-Led Total Sanitation (CLTS) Approach:** The CLTS approach is a community-wide approach to sanitation where rural communities are inspired and empowered to stop open defecation and will be implemented in the sub-counties identified for enhanced/intensive support (those with low proportion of villages certified ODF). Through the support of the Project, 335 villages (142 in Kakamega and 193 in Migori) were verified as ODF by PY3Q3. In Year 4, the project will support the follow-up and verification of pending villages yet to be verified as ODF in Kakamega and Migori counties. In addition, the project will support MOH to conduct ODF certification, celebration, and signage of ODF certified villages. In consultation with the sub-county PHOs, the project will conduct a 10% quality assurance of the verified villages. The Project has implemented CLTS methodology in Migori and Kakamega counties by training PHOs and CHEWs on CLTS. One of the gaps that still exist especially in villages that are yet to be verified as ODF is data collection, collation, and posting on the CLTS online hub. In Year 4 the project will give particular attention to supporting the sub-county and county teams in Kakamega and Migori on online reporting. Afya Halisi will work closely with the county WASH coordinators and Unicef’s Sanitation M&E Extender, to ensure that all CLTS investments are properly and consistently uploaded on the CLTS online platform. The Project will also continue to integrate WASH with other technical/thematic areas for maximum health benefits. WASH has integrated well with the community platform, community volunteers undertake

- **Support Post ODF Activities for Sustainability:** In order to minimize ODF attained villages from relapsing back to OD, Afya Halisi in Year 4 will concert its efforts in Sanitation Marketing approach. This will be focused in villages that have reported collapsed latrines in the course of the previous years of the project implementation. In Kitui which was already declared ODF,
The project will continue to engage the SCHMT to carry out periodic assessments to ensure the ODF status is maintained. In Year 1 to 3, the project trained artisans to make improved toilet slabs and appropriate sanitation technologies in the wards that they come from. The Project has learned that some of the reasons that cause relapse of villages back to OD include the type of materials used for construction of latrines, shared latrines and use of latrines by children above 3 years. In Year 4, Afya Halisi will invest in procuring 10 Interlocking Stabilised Soil Block (ISSB) machines to supported targeted villages to produce cheap blocks for improving the durability of their latrines. Particular attention will be given in promoting latrine construction types that will encourage children above 3 years to use latrines and not to have fears on the use of latrines. Through the LIP supported volunteers, demand creation strategies will be applied during community market days to create community awareness and display sanitation products in order to raise demand for improved sanitation and to encourage children above 3 years to use latrines. In order to ensure sustained engagement of villages way beyond the project life, Afya Halisi will work closely with the Counties Community Health Strategy Focal persons and the office of Social Services to register the CU’s and train the CU members on critical sustainability of groups skills. These skills will include; resource mobilization and financial management. This is geared towards enabling the project supported CU’s who have demonstrated commitment to health service delivery to be able to access resources from different funding bodies including the county governments that they work in as well as be able to manage the finances that they will be able to generate. The ISSB machines’ support for improved latrines will also be used for income generation beyond the project life.

Sub-purpose 3: Increased MOH stewardship of key health program service delivery

The 2010 constitution devolved the health function to the counties, except for the national referral facilities and development of the health policies and regulations. The 2017 health act further indicates that the roll of the National Government is to develop health policies, laws and administrative procedures and programs in consultation with county governments and health sector stakeholders and the public. Since inception of the Afya Halisi, the Project has been supporting the Department of Family Health, specifically the Division of Reproductive and Maternal Health, the Division of Neonatal and Child Health and the newly created Division of Adolescent and School Health to achieve its mandate of providing technical stewardship to counties and other stakeholders. With the onset of COVID-19 pandemic, Afya Halisi received incremental funding in March 2020 to support the Department of Disease Surveillance and Epidemic Response, the Public Health Emergency Operation Center and the Division of Community health to strengthen their capacity to respond to the pandemic through the development of key guidelines and roll out to the counties.

Output 3.1: Strengthened coordination, M&E capacity

Afya Halisi has continuously supported the Department of Family Health to provide effective leadership and coordination in health policy, standards and guidelines development and dissemination. For the past 2.5 years, the Project has been able to support the Divisions to link up with the Department of quality standards to development quality of care standards for the maternal and child health programs. To strengthen national and county government coordination, the Project support the national level stock-taking meeting and the maternal health consultative meetings; forums that brought together the county and national leadership to discuss the performance of the Maternal health programs.
The Project has supported improving coordination for policy, planning, monitoring and evaluation through supporting the three Divisions to set up coordination structures with clear terms of reference particularly for the revised technical working groups and committee of experts. Afya Halisi is a member of the technical working groups including the Reproductive Health, Newborn and Child Health, and the Adolescent and School Health; and the Newborn and Child Health strategic committee. In addition, the project supported formation and institutionalization of the Monitoring and Evaluation sub-committees within the DRMH and DNCH.

One of the major challenges the national MoH continues to face is strengthening partner coordination to enhance synergy and reduce duplication of efforts. Afya Halisi has supported coordination of the key partners working in RH and NCH through formation of a WhatsApp platform to enhance communication and coordination of activities that are implemented by the various partners. In addition, the Project instituted bi-monthly meetings with the key partners including USAID to review the progress of implementation and discuss emerging issues with a view of presented a concerted front to the Ministry of Health.

In Y4, the project will continue co-planning, co-implementing and co-monitoring of activities at national level while planning for transition of this support to the national Government. The proposed activities are drawn from the national level priorities as outlined in the finalized 2020/2021 annual work plan for the respective Divisions. These activities have been firmed up following a series of discussions with the Ministry of Health and other partners.

Development of M&E framework for the DNCH and DASH:
Monitoring and evaluation of health systems, programs, and interventions is critical to assess progress, identify problems, and facilitate change to improve service delivery and reach the desired outcomes. Kenya uses the DHIS system to track the trends of utilization and coverage of service statistics for the various programs. However, most programs including the RH and NCH lacks a monitoring system for assessing interventions, process outcomes and activities that are key to achievement of the desired outcomes. With the strategic pivot of self-reliance, most development and implementing partners are increasingly demanding monitoring and evaluation so that they can determine whether there is return on investment. The Division of Neonatal and Child Health and Division of Adolescent and School Health are in the process of developing their strategic plans to operationalize the National Neonatal Child and Adolescent Health Policy that was launched in 2018.

Through a co-creation process, Afya Halisi will co-support the development of the M&E framework that describes the indicators used to measure the implementation of the strategies for the two Divisions based on the five-year strategic plan that would have been developed. The M&E framework is critical because the two divisions coordinate Child and Adolescent Health services across the Ministry, since these components are covered by various programs such as NASCOP, Immunization, Reproductive and Maternal Health. The M&E frameworks will service as a guideline to how the programs are supposed to work by laying out the components of the strategic plan and the order or the steps needed to achieve the desired results. Afya Halisi envisions that the M&E framework will increase the understanding of the program’s goals and objectives, defines the relationships between factors key to implementation, and articulates the internal and external elements that could affect the program’s success.

Dissemination of Revised Tools and Registers:
In PY3, Afya Halisi supported the revision of the health system indicators for the Department of Health as part of a sector-wide process. The revision was occasioned by the revised National Health Sector Strategic Plan 2018-2023 and the roll of the Universal Health Coverage that required updating of the indicators and data elements used for tracking performance. Additionally, there has been global revision
of guidelines and service provision standards that the country has adopted/adapted hence the need to revise the data capture tools. The Department of Health Information System has finalized printing of the tools and is in the process of distribution to the various counties. Following this printing, Afya Halisi supported the development of an orientation package for the dissemination of the revised MOH reporting tools. The tools were revised to align with the current pieces of evidence in various RH and Child Health service delivery indicators. In PY4, the Project will work collaborate with other stakeholders including HealthIT Project and county governments to disseminate the revised MOH monitoring and reporting tools in the 47 counties.

**Technical support for review of RMNCAH scorecard to include new indicators:**
In PY3, Ministry of Health reviewed the existing RMNCAH scorecard that has been in existence for the last five years. Worthwhile to note, several indicators have continued to perform exemplary, for instance ANCI coverage that is almost universal, which begs the question whether there is need to continue tracking the indicator in the score card. A sub-committee was established to revise the 26 indicators in the scorecard. Afya Halisi is part of the sub-committee and has been involved in the initial discussions. In PY4, the Project will continue participating in this discussions with a view of finalizing the list of the 26 indicators that are in the RMNCAH score card, to also align with the revised indicators that HIS would have rolled out. Once finalized, the Project will support roll out of the revised scorecard in the four focus counties to the ward level since this scorecard is the main tool used for social accountability with leaders at ward level.

**Support Performance Review:**
The Project will support the three Division to hold bi-annual performance reviews of the annual work plan. The review meetings will either be held virtually or in small manageable groups in line with the government’s regulations on COVID-19 prevention and control. In PY3, the Project supported the conceptualization of a committee of experts to guide technical directions at the Division. This CoE includes maternal and newborn care experts who regularly review implementation strategies. The Project will support the CoE's quarterly meetings and any other forum as needed.

**Support Development of Annual Work plan meeting 2021/2022:**
The project will co-support the development of the 2021/2022 annual work plan. The development will be done from the various program level to the Division. Afya Halisi will continue coordinating with all the major partners supporting the Divisions to ensure there is a harmonized support by preventing duplication of efforts has has been done in the past. The Project will also support the Divisions to engage with the Finance department to ensure the development of the AWP aligns with the Government’s cycle.

**Strengthen Coordination and Partnership:**
The Department of Health do not have a resource mobilization structure, which has resulted with non-state partners influencing the financing of critical operations at the Division. The unstructured nature of these efforts also meant that documentation was not well maintained. Coordination of the funding elements for the Division needs a well-developed resource mobilization structure. It is for this reason that the Project will work with stakeholders to develop a resource mobilization and tracking strategy in line with the strategic directions of the Project.

**Strengthen commodity security:**
Commodity security exists when every person can obtain and use quality essential health supplies whenever he or she needs them. In the devolved system, the counties have the mandate to manage most of the healthcare commodities. This decentralization has resulted in fragmented systems with frequent
reports of MNCH commodity stock-outs in the counties. In PY4, the Project will collaborate with other stakeholders particularly Afya Ugavi to support technical forums and quarterly commodity security update meetings at the Division.

Output 3.2: Strengthened capacity to develop evidence-based policies, strategies and guidelines
The Department of Family Health’s mandate includes collating evidence based service delivery practices globally and regionally and based on this information develop context specific policies and guidelines for the country. Since inception of the Project, Afya Halisi has supported development of key guidelines, training package and dissemination to the counties. In Y3, the Project is currently supporting the Division of Reproductive and Maternal Health to develop a sensitization package for the RH Policy and dissemination to key GoK departments, stakeholders and counties. The Project in the process of supporting development of key technical guidelines and training package such as the national EmONC mentorship package, PAC guidelines, FP training guidelines and finalization of the School health policies. With the COVID-19 pandemic, the Project participated in the development of RMH guidelines for continuity of essential services.

Division of Reproductive and Maternal Health
The confidential inquiry into maternal deaths in Kenya 2014, 2015 and 2016 reported the attributable causes of maternal deaths out of 1335 audited cases to be; haemorrhage which is on decline comparing the proportions for the years 2014 (39.7%), 2015 (37.2%) and 2016 (33.6%) though still the leading cause of maternal mortality. There was a rise of cases of hypertensive disorders as a cause of maternal deaths 2014 (15.3%), 2015 (17.1%) and 2016 (18.8%), a rise of cases of pregnancy-related infection attributed to maternal deaths 2014 (9.7%), 2015 (4.8%), 2016 (8.5%) and a decline in maternal deaths due to abortive outcomes from 8.3% (2014) to 5.7% (2016). In PY4, the Project will collaborate with DRMH and other stakeholders to provide technical leadership to the country to achieve the Division’s goal of preventing needless maternal and neonatal deaths. This collaboration will be in line with the annual work plan, that USAID Afya Halisi supported to develop. The following activities will be prioritized in PY4;

Development and dissemination of RMNH Guidelines in COVID-19 Settings:
Afya Halisi participated in the technical drafting, virtual dissemination and printing of hard copies of the revised guidelines. The guide offers practical considerations of both preventive and clinical aspects for safe continuity of quality RMNH services amid the COVID-19 pandemic. The Project will support revision of the guidelines when new information on COVID-19 emerges.

Development of a national EmONC Mentorship package:
In the current year (PY3), Afya Halisi co-supported the DRMH to develop a national EmONC mentorship package. The harmonized EmONC training package that has been in existence since 2016 was pilot tested in the three counties of Kisii, Migori and Kakamega. However, the country lacked a harmonized approach for EmONC mentorship, with several partners using different training curriculum and methodologies. Afya Halisi engaged a consultant to facilitate multiple stakeholder workshops and build consensus among these stakeholders to develop a harmonized national EmONC mentorship package. EmONC mentorship to build on EmONC training already conducted as a way to enhance or maintain the clinical practice for those trained and practicing skilled birth attendants. Mentorship provides an opportunity for mentees to enhance competencies in managing obstetric and newborn emergencies.
This process is in its final stages with the final mentorship package expected to be finalized by September 2020. In Y4, Afya Halisi will support finalization of the EmONC mentorship package and dissemination at national and county levels.

**Support roll-out of MNH Quality of Care Standards:**
The Project is a member of the National Technical Working Group that was established to support this activity. The Division of RMH piloted the tools in Kiambu and finalized the assessment tools. In PY4, the Project will support the roll-out of the standards in the four supported counties and leverage on Smile for Mothers PPH Project that is being implemented by Jhpiego. To advance the quality of care, USAID Afya Halisi will support the roll-out of the QoC assessment tools in the four focus counties.

**Finalization and Dissemination of National Guidelines for Quality Obstetric and Perinatal Care:**
The Project will work with and other stakeholders to finalize and roll-out the national guidelines for quality obstetric and perinatal care. At the time of submission of the work plan, the Division was in the final stages of technical review and stakeholder analysis of the EmONC package. The package includes a process to update the county and sub-county mentors on the mentorship approaches, set up teams and provide an evaluation framework on the effectiveness of the standardized mentorship process. In PY 4, the Project will work with other stakeholders to roll out this package in a phased implementation approach.

**Development of Standardized FP Training Package:**
The Project worked with other stakeholders to revise and harmonize training materials for FP technical Modules I and II. Module I covers the provision of short and long term contraception in the intervals periods while Module II is on the provision of immediate post-pregnancy family planning. The Project has provided inputs into the roll-out of Module III that covers the standardized provision of voluntary surgical contraception. In PY4, the Project will collaborate with DESIP and Engender Health under the stewardship of MOH to co-support the finalization of Module II and III. Following the finalization of the training package, the Project will support the reorientation of the national level ToTs on the training package and dissemination at county level.

**Revitalize Voluntary Surgical Contraception:**
Voluntary surgical contraception services have been conducted in the country for decades. However, the country has not had a standardized training curriculum for permanent FP methods. The Division has finalized a curriculum on FP permanent methods. In PY4, Afya Halisi will work with the Division and collaborate with other stakeholders to strengthen the capacity of trainers and supervisors for the delivery of quality surgical permanent methods of contraception under the new standardized training curriculum.

**Develop FP standards based on KQMH:**
The family planning program within DRMH has expressed a need to develop FP standards based on the Kenya Quality Model for Health Standards. Quality of Care within the family planning services has consistently featured as a gap since the country does not have standards that can guide and assess the quality of services offered. With the increase in the modern contraceptive prevalence rate, there is need to ensure that the FP services that are offered in the facility as of the required quality to enhance continuation of use, address discontinuation, system level. The country has invested well in the development of quality of care frameworks in improving maternal and neonatal health. Similar efforts are needed to advance the quality of Family Planning services in the country. Through the KQMH framework, the Project will support the development of FP standards to fit into the revised FP training packages.
Division of Neonatal and Child Health

Kenya has made progress in improving maternal and newborn health outcomes. The under-five mortality rate has reduced from 74 deaths per 1,000 live births in 2008 to 52 per 1,000 live births in 2014 while the infant mortality has also had a corresponding reduction from 52 to 39 deaths per 1,000 live births over the same period. Unfortunately, neonatal mortality rate has continued to exhibit the slowest rate of decline from 31 to 22 deaths per 1,000 live births over the same period. The majority of all neonatal deaths (75%) occurs during the first week of life, specifically within the first 24 hours. Preterm birth, intrapartum-related complications (birth asphyxia or lack of breathing at birth), infections and birth defects cause most neonatal deaths. Significant progress remains to be made before Kenya achieves Every Newborn Action Plan’s goal of a neonatal mortality rate below 10 deaths per 1,000 live births by 2035.

The Division of Neonatal and Child Health provides technical leadership in five areas; Newborn, Nurturing Care, case management, Community and Strategic information. The Project is part of the technical working group and committee in these programs. The Division continues to support scale up of proven newborn and child health interventions specifically Kangaroo Mother Care, Chlorhexidine, Essential Newborn Care and appropriate treatment of childhood illnesses specifically pneumonia and diarrhea. The Division has initiated the process of development of its strategic plan to operationalize the NCAH Policy that was launched in 2018. With the onset of COVID-19, the Division developed and disseminated Guidelines on The Management of Paediatric Patients During Covid-19 Pandemic. In PY4, the Project will collaborate with DNCH and other stakeholders to provide technical leadership to the country to achieve the Division’s goal of reducing child mortality. This collaboration will be in line with the annual work plan, that USAID Afya Halisi supported to develop. The following activities will be prioritized in PY4;

Support Development and Dissemination of NCH Strategy:
In PY3, the Ministry of Health initiated the development of the NCH strategy to operational the NCAH policy. This activity was co-supported by all partners including UNICEF, Save the Children, PATH, KEMRI, KPA and Afya Halisi. A consultant hired by UNICEF was on boarded, and a taskforce developed to spearhead this process. Afya Halisi supported preliminaries meetings to develop a road map for the development of the strategy, supported desk review of available resources on newborn and child health. County engagement meetings were planned and scheduled weeks before the Government provided guidance pertaining to COVID-19 pandemic which included avoiding large gatherings. The planned county meetings had to be rescheduled to allow review of the roadmap with the current context. In PY4, Afya Halisi will continue to support this process, particularly hold county engagement meeting for the Eastern cluster, and participate in county level discussion for the Western Region. Once the guidelines have been finalized, the Project will support dissemination of the strategy to its focus counties of Kakamega, Kisumu, Kitui and Migori.

Review Kenya Action Plan for Prevention of Pneumonia and Diarrhea (KAPPD):
Launched 10 years ago, the Global Action Plan for the prevention and control of Pneumonia and Diarrhea (GAPPD) is a global commitment aimed at reducing morbidity and mortality from pneumonia and diarrhea in children under five years old. The overall goal of GAPPD is to end preventable childhood deaths due to pneumonia and diarrhea by 2025. The global target for pneumonia mortality rate for under-fives as envisaged in GAPPD is 3 deaths per 1000 live births by 2025. GAPPD provides an integrated framework of key interventions proven to effectively prevent and treat childhood pneumonia and diarrhea. Although effective interventions have been well established, they are not always promoted together to achieve maximum benefit. Evidence shows that pneumonia and diarrhea must be addressed in a coordinated manner since the determinants of these diseases are often the same, hence preventive strategies and delivery platforms via health facilities and communities are similar. The action plan proposes a cohesive
approach to ending preventable pneumonia and diarrhea deaths by bringing together critical services and interventions to create healthy environments, promote practices known to protect children from disease and ensures that every child has access to proven and appropriate preventive and treatment measures.

Kenya is a signatory to the Global Action Plan for prevention and control of Pneumonia and Diarrhea. Based on GAPPD, the country has adopted the Kenya Action Plan for Prevention of Pneumonia and Diarrhea (KAPPD), which is the national blueprint towards accelerated action in the reduction of child mortality. In 2018, Kenya’s under-five mortality rate due to pneumonia was 6 per 1000 live births, contributing to 15% (9000) of all child deaths. Over the last 10 years, the country has made investments on interventions aimed at addressing the burden of pneumonia and diarrhea. Despite progress made, the country is not on target to meet the global target, with an average annual rate of reduction in pneumonia mortality of 6% between 2000 and 2018. At this rate, Kenya is expected to reach the 2025 GAPPD target in 2029. To fast track progress towards the global target, DNCH has prioritized a review of KAPPD to take stock, align strategies and make course corrections based on available data and lessons learnt in the recent years. Of specific focus will be introduction of multi-sectoral approaches and prioritization of interventions for low income households, who bear the greatest burden of pneumonia. Through a co-creation process, Afya Halisi proposes to provide technical and financial resources to the DNCH in the review of KAPPD, including development of a costed implementation plan for high impact interventions.

**Review of Basic Pediatric Protocol:**

The first edition of the basic pediatric protocols was inspired by the World Health Organization (WHO) Book, “A Pocket Book of Hospital Care for Children” (2005 Edition). The protocols have subsequently been updated based on specific and up to date reviews of emerging new research evidence and technologies using the GRADE approach. Current protocols were revised in 2016 in line with WHO's revised classification and treatment of childhood pneumonia at health facilities. The revisions included changing the recommendation for the first-line antibiotic and re-defining the classification of pneumonia severity. However, there still persists gaps in standards of care for newborns due to limitations in content on sick newborn and low access to specialized care by pediatricians and neonatal nurses. Other existing newborn guidelines are too detailed and are often not read. The DNCH has identified these gaps in standards of care and has prioritized revision of the pediatric protocols to include content beyond Kangaroo mother care (KMC), newborn resuscitation, neonatal sepsis and respiratory disorders to include ventilation support. In addition, the division intends to introduce new contents to the protocols to include other common conditions such as metabolic disorders, transfusion guidelines, congenital disorders, care for mothers with babies in newborn units and appropriate referral for sick newborns. Afya Halisi proposes to partner with the DNCH in reviewing the basic pediatric protocols aimed at improving quality of care for sick newborns through development of effective, practical and easy to use protocols.

**Conduct Assessment On the Status of Newborn Care in The Country:**

The DNCH has rolled out proven intervention across the country, however uptake has been sub-optimal. KDHS data still indicates the progress towards reduction of neonatal mortality is slower compared to post-neonatal mortality rate. The recently released Kenya facility assessment indicates glaring gaps in provision of newborn health service. Further, the 2019 National Health research agenda has listed newborn health has the leading program area for the Implementation of the Research-for-Health Priorities. Despite this, the country lacks a clear report on the status of newborn care in the country. The DNCH

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6 Grading of Recommendations, Assessment, Development and Evaluations
DNCH plans to identify technical assistance gaps in the management and treatment of newborn, particularly during this COVID-19 pandemic period. Afya Halisi will co-support this process that has begun in PY3, through recruitment of a consultant who will develop the assessment tools. The Project will support data collection in the four focus counties.

Development of Newborn Care Mentorship Package:
With the rising prevalence of COVID-19 cases in Kenya, the uptake and adherence to the COVID-19 newborn care clinical guidelines is critical for newborn survival. The activity is desired in order to establish technical assistance gaps in newborn care and not only support design but also institutionalizing a cost-effective mentorship programme for sustained quality service delivery in all newborn units. Kenya lacks clear mentorship package for essential newborn care. Based on the findings identified in the assessment report, Afya Halisi will support the development of the newborn care mentorship package for the country. The development of this mentorship package is in response to the need for having one training package that can be used across the country in enhancing the capacity of health care workers to provide essential newborn care during this COVID-19 pandemic and beyond.

Division of Adolescent and School Health
The Division of Adolescent and School Health is a newly formed Division that was crafted from the former Neonatal Child and Adolescent Health (NCAHU). In PY3, the Project supported the Division to set up its operation including development of the PY3 AWP which was derived from the NCAHU’s AWP. The Project met the leadership of the two Division’s –NCH and ASH to review how the two divisions will implement past activities that had been conducted under the prevision Division of NCAHU. The Project also supported the establishment of the DASH’s offices including set up of the office for the Division head. The following proposed activities for PY4, have been identified from a co-creation process with the Division and other stakeholders;

Development of the Adolescent Health Strategy:
Afya Halisi will work with the Division of Adolescent and School Health to develop the Adolescent Health Strategy. The strategy will operationalize the Neonatal, Child and Adolescent Health Policy that was developed by the Division of NCAHU which has since been divided into-DNCH and DASH. The Project will co-plan with the Head, DASH to establish a multi-sectoral adolescent health taskforce consisting of the various Departments with MOH that have components of Adolescent Health (RMH, NASCOP, Mental Health, Nutrition), Ministries of Education, and Youth, Sport & Culture; and National Council for Population and Development to oversee the development of the strategy under the stewardship of DASH. Routine meetings will be conducted to define the scope of the strategy. Afya Halisi will support the recruitment of a national consultant to lead in the design and development of the strategy. The Project will support writing workshops for the strategy and a validation meeting to finalize. Afya Halisi will co-support the launch and dissemination of the strategy. Other partners who will co-support the activity include WHO and UNICEF.

Dissemination of the School Health Policy:
The Kenya national School Health Policy was first launched on in the year 2009 that majorly focused on values, life skills, child rights & responsibilities, nutrition and special needs. A shift in the policy and legal environment led to the need for change in the approaches in the delivery of the school health interventions. This led to the revision of the School Health Policy 2018 to address the emerging issues including age appropriate comprehensive sexuality education (AACSE) among other reproductive health concerns. The policy has been developed with significant contribution from DASH, Ministry of Education
and other stakeholders. Finalization of the policy has been hampered by lack of consensus among different stakeholders over the delivery of sexuality and reproductive health education. In PY4, Afya Halisi will support the development of a sensitization package of the policy and facilitate dissemination to stakeholders at National and County level.
MONITORING, EVALUATION, AND LEARNING

In line with J2SR, Afya Halisi will work with the Ministry of Health to co-plan, co-finance, co-implement and co-monitor MEL interventions in order to strengthen existing health management information systems (HMIS). In Year 4, Afya Halisi will build on achievements in the last three years of project implementation and strengthen the capacity of MOH and local implementing partners (LIPs) to achieve strong and sustainable HMIS and monitoring, evaluation and learning (MEL) systems for reporting and tracking progress towards achievement of FP/RMNCAH, nutrition and WASH goals and key health outcomes in project focal counties and at national level, in the context of the COVID-19 pandemic.

In Years 1-3, the Project used adaptive programming and collaborating, learning and adapting (CLA) approach to inform targeted and tailored implementation of interventions in the focus counties, and at national level. In addition, Afya Halisi enhanced utilization of data at project level through comprehensive and granular data driven review meetings and strengthened the capacity of the County and Sub-county Health Management Teams (HMTs) to use the RMNCAH scorecard and QGIS to identify sub-counties and wards performing poorly for evidence-based differentiated investments to improve coverage for underserved, high burden sub-counties, wards, and health facilities to acceptable national goal and standards. In Year 4, the Project will continue to use the CLA approach and granular data review meetings to inform targeted and tailored implementation of priority interventions in underperforming areas, make strategic shifts and expand what is working well, drop what is not working well, and document and disseminate best practices and lessons learnt to MOH and other partners for cross-learning.

In Year 4, Afya Halisi will leverage both technical and financial resources with other implementing partners such as Tupime Kaunti to strengthen health management information systems at county and sub-county levels, including at national level. During the work planning process, Afya Halisi co-created with Tupime Kaunti to agree on leveraging resources in the focus counties of Kakamega, Kisumu and Migori where Tupime Kaunti works. The partners agreed that Afya Halisi will focus its support on these key MEL activities at sub-county levels whereas Tupime Kaunti will focus its support at county level.

To advance self-reliance and as part of the Project’s transition approach, Afya Halisi will premier and focus on strengthening capacity of HMIS and providing technical assistance at county and sub-county levels, while the CHMTs and SCHMTs and technical officers will cascade the MEL interventions to HCWs, CHVs and local actors at health facility and community levels. Whereas MEL activities will target all Project supported service areas, more focus and intensity will continue to be in Kitui County where Afya Halisi is the key implementing partner providing support in strengthening MEL systems for FP/RMNCAH, nutrition and WASH services.

In Year 3, the Project adjusted its strategies to ensure use of adaptive and safe monitoring, evaluation and reporting of FP/RMNCAHN and WASH services, in the context of COVID-19 pandemic. For instance, the Project worked with MOH to co-plan and co-implement MEL activities that do not involve large groups of people, with observance of the containment and prevention measures against COVID-19 pandemic. In Year 4, the Project will continue to work with MOH to ensure continued implementation of MEL and reporting activities in line with the government’s containment and prevention measures against COVID-19.

Afya Halisi will align its MEL activities to the priorities of the four focus counties and support co-implementation of the following MEL strategies in Year 4:

- Strengthen HMIS and MEL systems for MOH and local implementing partners
Strengthen capacity of MOH in planning, budgeting and monitoring
Strengthen use of data and information for action
Strengthen data quality
Implement project learning agenda, and focus on documentation of Project achievements, best practices and lessons learnt as part of the close out process.

Strengthen HMIS and LIPs’ MEL Systems
In Years 2-3, Afya Halisi provided technical assistance in the revision of HMIS reporting tools at national level. In addition, the Project provided technical support in the development of a training package for the revised Division of Neonatal and Child Health (DNCH) indicators. Training of HCWs on the revised MOH reporting tools was postponed due to COVID-19 pandemic. The roll out of the reporting tools at county level will transcend to Year 4. Afya Halisi will strengthen the capacity of MOH county and sub-county HMTs including HMIS mentors and local implementing partners on use of the tools, including technical updates on the indicator definitions, while ensuring observance to prevention measures against COVID-19. In addition, the project will work with the county MOH teams to co-support HMIS mentors, developed in the last three years, to provide targeted on-site mentorships to the HCWs and CHVs on use of the revised tools, with more focus in the high volume health facilities as well as based on gaps identified during the integrated county and sub-county supportive supervision visits.

In order to ensure compliance to USAID reporting requirements, the Project strengthened the capacity of the LIP staff on USAID reporting guidelines, interpretation of national and custom performance indicators, and data flow and use for performance and outcome monitoring. In Year 4, the Project will provide targeted technical updates to the LIP staff on USAID reporting requirements and indicators, based on identified gaps during performance review meetings.

In Year 3, to ensure sustainable strengthening of HMIS and align with J2SR, Afya Halisi successfully advocated for the county governments to take over the provision of airtime to health record information officers (HRIOs) for uploading data in the Kenya Health Information System (KHIS). In addition, the Project supported the training of HRIOs in focus sub counties on use of KHIS. The improved knowledge of the HRIOs enabled them to ensure sustained high reporting rates for the main MOH reporting tools (MOH 711, MOH 710 and MOH 705) for capturing FP/RMNCAH, nutrition and WASH data in KHIS. Given the roll-out of the revised MOH reporting tools, the Division of Health Informatics System will upgrade KHIS to a version that aligns to the revised reporting tools. In Year 4, the Project will co-support orientation of the HRIOs on the revised version of KHIS and KHIS Tracker and Event Capture for uploading audited facility maternal and perinatal forms.

In Year 3, to ensure the availability of the revised MOH reporting tools, the national MOH in collaboration with the World Bank and Global Fund printed the revised version of the reporting tools for use in health facilities and community units across the county. In addition, Year 3, the Project worked with the county MOH teams to conduct a gap and forecasting analysis of GBV reporting tools in the focus counties. The Project co-supported the focus counties to print the reporting tools, that included the PRC form, SGBV register and monthly summary report for use by HCWs to adequately capture GBV cases, care and linkage services offered in health facilities. In Year 4, to ensure sustained availability of all the MOH reporting tools in the focus counties, the Project will use the county M&E TWGs as well as the monthly co-creation meetings with the focus county health leaderships to engage and advocate the MOH to make commitments and allocate adequate resources for printing of reporting tools in areas where there are gaps. The project will support MOH in collection and reporting of non-DHIS data only for indicators that are not in the mainstream MOH reporting tools such as EmONC and WASH data.
Strengthen Capacity of MOH and LIPs in Planning, Budgeting and Monitoring

In Years 1-3, Afya Halisi co-supported the development of MOH annual work plans (AWPs) in Migori, Kisumu, Kakamega and Kitui counties. The AWPs were useful in guiding the planning, implementation and monitoring processes in MOH at various levels. However, there still exists inadequate capacity in leveraging resources among partners during the planning and implementation processes, and efficiently and effectively tracking expenditures and co-monitoring of activities in the AWP. To address these gaps and ensure institutionalized processes of activity budget tracking and outcome driven activity implementation and monitoring, Afya Halisi will in Year 4, co-plan with MOH to develop and consolidate the 2021/2022 AWPs at sub-county level, including consolidation of Kitui County AWP. Tupime Kaunti will support the consolidation of the AWPs at county level in Kakamega, Kisumu and Migori. Afya Halisi will use the opportunity of the AWP development process to sensitize the SCHMTs from the focus sub-counties on outcome and priority driven annual work planning, leveraging of resources among partners, program based budgeting and tracking of activity implementation and expenditures.

In Year 4, Afya Halisi will co-plan with the focus county governments as well as collaborate with Tupime Kaunti to support biannual stakeholder fora to review progress in implementation of priority health interventions in the AWP, status of achievement of the county health outcome targets, strategic interventions for enhanced resource allocation, in addition to dissemination of best practices and lessons learnt. Afya Halisi will support one stakeholder forum in each of the focus counties, including Kitui, while Tupime Kaunti will support the additional stakeholder forum in the focus counties.

Whereas Kisumu, Kakamega and Migori counties have developed M&E frameworks to support tracking implementation of the County Health Sector Strategic and Investment Plan (CHSSIPs), County Integrated Development Plans (CIDPs) and AWPs, Kitui County has not. In Year 3, Afya Halisi advocated and co-created with the Kitui county health leadership on the import of a county M&E framework. In Year 4, the Project will leverage on the Kitui County TWG fora, and use the platform to co-plan with the county government and other implementing partners to co-develop and disseminate the County M&E framework, to guide in monitoring progress in achievement of the goals and objectives of the Kitui CHSSIP, CIDP and AWPs.

Strengthen Use of Data and Information for Action

In the last three years, the Project built the capacity of the CHMTs and SCHMTs in the focus counties on data analysis, with focus on enhanced use of visualization tools such as Quantum Geographic Information System (QGIS) and RMNCAH scorecards. These tools have been useful during quarterly data review meetings conducted at sub-county levels, especially in granular data and identification of areas with gaps for targeted and tailored focus and support, and adaptive programming. However, gaps still exist among the CHMTs and SCHMTs on outcome-level data granulation up to ward and health facility levels, generating actions to address identified gaps, and follow ups on implementation of the action plans. In Year 4, the Project will work the focus CHMTs and use the quarterly sub county data review meetings fora as a platform to provide technical updates to SCHMTs on use of these data visualization tools for enhanced data use for decision making.

In the last three years of implementation, the Project supported sub-county quarterly data review meetings to review performance and progress towards achievement of health outcome targets at sub-county, ward and health facility levels. In Year 3, the Project worked with the focus county governments

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to successfully co-finance the implementation of the quarterly sub county performance review meetings. In addition, due to the COVID-19 pandemic, the Project co-supported the blended use of small group meetings and virtual platforms to conduct the performance review meetings. Additionally, the review meetings were focal in exemplifying the effect of COVID-19 pandemic in provision of essential FP/RMNCAH, nutrition and WASH services and informed tailored, accelerated and rapid results initiatives to reach the underserved with the services. An informal learning activity co-implemented by the Project in Year 3 to evaluate the role of data use in provision of FP/RMNCAH, nutrition and WASH services in Kakamega and Migori counties showed that consistent sub-county data and performance review meetings contributed in reducing the gap between 4th ANC visit and skilled birth attendance coverages. In Year 4, while the Project will co-plan and co-finance the sub-county quarterly data review meetings while adhering to the containment and prevention measures against COVID-19, Afya Halisi will robustly advocate the focus county health leaderships to fully finance the implementation of the quarterly review meetings in order to sustain the activity. The project will also provide technical assistance to the SCHMTs to enhance institutionalization of follow-up on action plans agreed on during the review meetings in order to address gaps hindering attainment of expected health outcomes.

In Years 1-3, the Project worked with the county MOH teams and Tupime Kaunti to co-create and generate bulletins for Migori and Kisumu counties. In addition, the Project is co-creating with the MOH teams in Kakamega and Kitui counties to generate bulletins that encapsulate progress in priority health outcomes in the counties as well as key actions to improve and fast-track achievement of the health outcomes. In Year 4, the Project will co-create, co-plan and co-produce the bulletins with MOH in the four counties, with focus on generation of tailored information for action, as well as showing what is the problem, priority actions to address the problem, and the consequence of not addressing the problem.

**Strengthen Data Quality**

In Years 1-3, the Project worked with the MOH to conduct routine data quality assessments (RDQAs) on FP/RMNCAH and nutrition indicators in targeted health facilities and community units (CUs) to address data quality gaps and enable use of timely, complete and accurate data for reporting and programmatic decision making. The data quality findings in Year 3 showed that more focus and targeted efforts was needed to improve documentation of data on adolescents presenting with pregnancy; babies who received postnatal care within two days of childbirth; under five diarrhea and pneumonia cases that are appropriately managed; sexual and gender based violence cases; and FP commodity reporting, particularly concordance between commodities and service delivery data in KHIS. Institutionalization of self-driven data quality assessments and data review meetings at health facility and CU levels was still a gap. In Year 4, the Project will work with Tupime Kaunti and the focus county MOH teams to co-plan and co-finance targeted data quality assessments with focus in high volume health facilities, that represent 80% of the Project’s data. Afya Halisi will also robustly advocate the focus county health leaderships to fully finance the implementation of the data quality assessments in order to sustain the activity.

In Years 1-3, the Project co-supported the focus sub county MOH teams to conduct mentorship sessions to HCWs in targeted health facilities to address identified data quality gaps. The health facilities reached were identified as part of follow ups on the data quality improvement plans. In Year 4, in order to institutionalize self-driven data quality assessments at health facility and community unit levels, the Project will co-support the HMIS mentors to provide targeted on-site mentorships to the HCWs and CHVs in high volume health facilities, and link CUs, on use of data management and reporting SOPs and guidelines, generation and follow-ups of data quality improvement plans, and holding of structured facility level data review meetings to review facility performance and identify frequent data quality gaps for corrective and follow-up actions.
In Years 1 and 2, the Project addressed data quality issues in KHIS through collection of MOH reporting tools on FP/RMNCAH and nutrition services and entry of the data in the project database, and identified data discrepancies through comparison with data reported in KHIS for respective indicators and follow-ups with SCHRIOs for correction in JHIS. In Year 3, in order to advance self-reliance, the Project transitioned from collection of the MOH reporting tools and parallel entry into the Project’s database and focused on strengthening quality of data in KHIS through validation and triangulation of various related indicators in order to identify quality gaps. The Project also provided virtual technical assistance to the S/CHRIOs on use of SOPs to triangulate and check on errors and outliers for related indicators in KHIS. For example, this included comparison of immunization antigens i.e. Penta 3 and OPV 3, infants receiving PNC services within 0-48 hours and live births, and FP commodities dispensed and FP services received. The health facilities with errors were flagged out and follow ups done to ensure corrections were made at health facility level and cascaded to SCHRIOs to make changes in KHIS. Due to these support, the reporting rates for the FP/RMNCAH and nutrition reporting tools in KHIS improved to 100% for the main reporting tools (MOH 711, MOH 710 and MOH 705) in the four focus counties as at end of Year 3 quarter 3. In Year 4, the Project will co-plan and co-implement with SCHRIOs in the focus sub counties to validate and triangulate various related FP/RMNCAH, nutrition and WASH indicators in order to identify data quality gaps. In order to ensure sustained and timely verification of data in KHIS, the Project will orient SCHRIOs in the focus sub counties, through blended use of small group meetings and virtual platforms, on use of the SOP and checklist for data validation and triangulation.

In Year 3, in order to ensure enhanced quality WASH data in the focus counties of Kakamega, Kitui and Migori, the Project developed minimum standards to guide quality assurance and reporting of data for WASH interventions. In addition, the Project worked with MOH to provide updates to county and sub-county PHOs and targeted HCWs and water management committees in the focus counties on use of WASH reporting tools, interpretation of WASH indicators and validation of WASH data. In Year 4, in order to assure sustainability, the Project will provide updates to the sub-county PHOs and WASH Officers, through use of virtual platform, on use of the minimum standards to guide quality assurance and reporting of data for WASH interventions.

**Implement Project Learning Agenda**

In Years 1-3, the Project implemented various learning agenda as shown in Table 10 below. The Project also implemented the gender analysis, and Kitui baseline assessment, the findings of which informed the design of the Project’s strategic approaches.

**Evaluation of Dynamics of Contraceptive Use, Discontinuation and Method Switching in a bid to address quality of family planning services in Migori and Kitui Counties, Kenya**

In PY2 and PY3, Afya Halisi has been implementing this implementation research that is aimed at Exploring the Dynamics of Contraceptive Use, Focusing On Reasons of Contraceptive Discontinuation Among Previous Users in Migori and Kitui Counties. The two counties were selected based on their modern CPR and contraceptive method mix. Migori County has mCPR of 44.3 percent with LARC methods uptake contributing to 85% of the method mix while Kitui County has a mCPR of 55.1 percent with short term methods uptake contributing to 53.8% of the method mix. This activity involved conducting a formative assessment on barriers and enablers for quality contraceptive services that are aimed to reduce discontinuation and enhance continuation. The study aims at expanding the knowledge gap on strategies to enhance continuation and satisfaction of use of contraceptives among current users to avoid discontinuation among users who are in still in need of contraception. Based on the formative assessment, the project identified and implemented activities to strengthen quality of care. The second phase of the study involved enrolling 1,016 women in a longitudinal study. The aim of this sub-study is to follow the women for 24 months to track their contraceptive use dynamics and promote continuation in instances where the women show
intention to discontinue while still in need of a method. In PY3, the project successfully enrolled 1,041 women at baseline, and have conducted 3 and 6 months follow up with the clients.

In PY4, the project will conduct the 12 month follow up; analyze the data to understand the dynamics of contraceptive discontinuation. Findings of this learning agenda will inform the family planning quality of care standards that will be developed by the DRMH. The Project will develop a study report and prepare abstract manuscripts for dissemination at conference and scientific journals respectively.

**Effectiveness of a combined approach towards Improving Utilization of Adolescent Sexual Reproductive Health Services in Kisumu and Kakamega Counties, Kenya**

The 2015 ASRH policy for Kenya advocates for working with Ministries of Education and Health among other line ministries, inclusion and participation of young people, political arms and others stakeholders for the success of ASRH programs (Kenya, 2015)). To actualize the 2015 policy, the Ministry of Health outlined four service delivery models for ASRH in Kenya which include: a) Community based: Services and information are offered to adolescents within the community/non-medical settings b) Clinical based: Services and information are offered to adolescent within/based on health facility setting c) School based: Services and information are offered to adolescents within the school setting. d) Virtual based: Services and information are offered to adolescents within the virtual space or digital platforms. In PY3, the project rolled out the implementation research by identifying barriers and facilitators for uptake and utilization of ASRH services in Kisumu and Kakamega Counties. A study implementation team was set up in the two counties of Kisumu and Kakamega. Implementation of study activities have been ongoing in the two counties, though the COVID-19 pandemic has disrupted the planned school health activities.

In PY4, the project will conduct end line assessment of the AYSRH learning agenda in the first quarter (November-December 2020). This end line assessment will involve household and client exit interviews in Kakamega and Kisumu. The Project will conduct analysis of the findings, and develop a final study report that will be disseminated nationally and at county level. The Project will develop policy briefs to highlight our findings and the implication of implementation of the four models. The study investigators will develop abstracts and manuscripts for submission to conference and journals.

In addition, the Project conducted a Programmatic Review whose objectives included, to measure project achievements since inception; determine the effect of project investments on health outcomes in the focus counties; identify areas of project strategy modification and prioritization; inform Year 4 project work planning and budgeting; and determine the Project’s alignment to USAID’s Journey to self-reliance (J2SR). The findings of the Programmatic Review were used to inform tailored design and prioritization of activities and strategic shifts in the Year 4 work plan, as well as to advance and catalyze the Project’s approach to J2SR.

In Year 4, Afya Halisi will continue with implementation of the two learning agenda on Evaluation of the dynamics of contraceptive discontinuation and method switch among women of reproductive age (WRA) in Migori and Kitui counties; and Effectiveness of a combined approach towards Improving Utilization of ASRH in Kisumu and Kakamega counties. The Project will also focus on documentation of Project achievements, best practices and lessons learnt since Year 1 as part of the Project’s close out process. Table 4 shows the project learning activities to be continued and implemented in Year 4.
**Table 10: Project Learning Agenda**

<table>
<thead>
<tr>
<th>Technical Area</th>
<th>Learning Question(s)/Activity (ies)</th>
<th>Methodology</th>
<th>Formal or Informal</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP</td>
<td>Evaluation of the dynamics of contraceptive discontinuation and method switch among WRA in Migori and Kitui counties, Kenya</td>
<td>Mixed methods, cross-sectional</td>
<td>Formal</td>
<td>Started in Year 2. Ethical approval obtained and first round of data collected, specific interventions implemented. Activity to continue in Year 4.</td>
</tr>
<tr>
<td>AYSRH</td>
<td>Effectiveness of a combined approach towards Improving Utilization of ASRH in Kisumu and Kakamega counties, Kenya</td>
<td>Mixed methods, cross-sectional</td>
<td>Formal</td>
<td>Started in Year 2. Ethical approvals obtained and first round of data collected, and specific interventions implemented. Activity to continue in Year 4.</td>
</tr>
<tr>
<td>Cross cutting</td>
<td>Documentation of Project achievements, best practices and lessons learned.</td>
<td>Desk review</td>
<td>Informal</td>
<td>To be implemented in Year 4.</td>
</tr>
</tbody>
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**Streamline Project’s internal monitoring, documentation, reporting and accountability mechanisms**

In Year 4, to ensure continuity in implementation of the Project’s planned activities, achievement of targets, and reporting of reliable and valid results during the COVID-19 pandemic period; the Project will continue to reinforce its monitoring, verification, documentation, reporting and accountability mechanisms, including use of digital platforms, as outlined below;

Verifying/monitoring status of activity implementation
- **Virtual project meetings for senior leadership team, technical team and county based meetings:** The Project will hold weekly meetings for the senior leadership team and bi-weekly meetings for project technical team, and county based staff. The Project will use these virtual meetings to provide key updates, monitor progress in implementation of planned activities and engagements and discuss and address emerging issues and challenges.
- **Generation of weekly and monthly individual staff activity work plans:** Project staff, including local partners, will develop individual weekly and monthly activity work plans and update progress of implementation in the Project’s online Microsoft SharePoint. The staff will also provide updates on progress, and lessons and challenges being experienced in implementation of the activities during the virtual bi-weekly county staff meetings.
- **Use of Afya Halisi online J2SR activity tracker to document and monitor progress in implementation of J2SR pillars:** In Year 3, the Project developed an online activity tracker in Microsoft SharePoint to document and track progress in implementation of the J2SR milestones and metrics. In Year 4, the Project will continue to use the tracker to document progress in implementation of the J2SR milestones and metrics, strategic shifts, and challenges and lessons learnt during co-implementation.

Documentation and reporting of results/outcomes
- **Completion of activity reports and monthly progress reports:** The Project staff will continue to document activity reports for all implemented activities and attach photos to the reports as evidence of implementation. All activity and collated monthly progress reports will be uploaded in the Project’s knowledge management portal. These reports will be reviewed and used in programmatic decision making, and collated in the Project’s quarterly reports. The quarterly reports will be disseminated to...
few select CHMT members, due to the COVID-19 preventive measures, for accountability and ownership of the reported results.

- **Use of weekly bulletins:** The Project will strengthen use of the weekly bulletins to document high level summary project achievements and engagements, both at national and county levels. The Project will use the weekly bulletins to document updates on COVID-19 pandemic and the effect on continuity in uptake and coverage of essential health services.

- **Documentation of success and lessons learnt stories:** The Project, through its communication team, will strengthen documentation of both success and lessons learnt stories during the COVID-19 pandemic period. The communication products will include stories, photos and video clips that show interventions that are working well, those that are working well, and the need for continuity of essential health services during the pandemic period.

**Ensuring staff accountability on reported results**

- **Weekly travel and activity tracker:** In Year 3, the Project staff used the weekly travel and activity tracker to track progress in implementation of planned activities. In Year 4, the Project will bolster use of the online weekly travel and activity tracker for staff to document activities implemented during the week and their contributions to the work plan, and planned activities for the subsequent week. All staff will be expected to account for their time and indicate time taken per day to complete the tasks.

- **Capture of GIS information for activities implemented through the Project’s support:** The Project will capture geo-coordinates of activities implemented with the Project’s support. This information will provide validity to the implemented activities. In addition, the Project developed an application that is installed into Android phones and used for capturing geo-coordinates of co-implemented activities. In Year 4, the Project will strengthen use of this application to enable capturing of the activity geo-coordinates.

- **Use of photos and uploading in Project’s knowledge management platform:** As part of documentation and generation of evidence for co-implemented activities, Project staff will be required to work with MOH to take photos of activities and engagements co-implemented through the Project’s support. These photos will be uploaded in the Project’s knowledge management platform, as well as used in documentation of the Project’s achievements as part of the Project’s close-out process.

**Improving Project Visibility**

In year 3, to improve Afya Halisi’s visibility, the Project implemented the following strategic interventions; strengthened use of information products for action; strengthened publication of manuscripts, peer reviewed articles and abstract/poster presentation in conferences; and revitalized its branding. In year 4, the Project will continue to implement the interventions to further strengthen its visibility as described below.

**Strengthen use of information products for action**

In year 3, the Project collaborated with Tupime Kaunti to generate a fact sheet for Migori County that showed performance trends in key health indicators and priority actions to address the key gaps. In addition, the Project collaborated with Tupime Kaunti in generating a quarterly bulletin for Kisumu County that demonstrated progress in key FP/RMNCAH indicators and recommended responsive actions to accelerating improvement in performance. The Project also co-developed ward level RMNCAH scorecards for Kisumu County, which were used during consultative meetings between the County Health Executive, the County Assembly and members of the County Public Service Board to advocate with the Kisumu County Members of Assembly for increased resource allocation for RMNCAH services. In year 4, the Project will continue to work with the county MOH teams to develop bulletins that will show
progression of county performance in key FP/RMNCAH, nutrition and WASH indicators, especially during the COVID-19 pandemic period, and key actions required for enhanced resource allocation and to ensure continuity in essential health service provision.

**Strengthen publication of manuscripts, peer reviewed articles and abstract/poster presentation in conferences**

In the last three years, a number of project staff produced manuscripts which were published in peer reviewed journals, in addition to abstracts and poster presentations made in national and international conferences. In year 3, the Project provided targeted support to Project staff in identification and review of relevant topics to ensure increased publication of manuscripts, peer reviewed articles and abstract/poster presentations in conferences. These manuscripts are at an advanced stages of development. In year 4, the Project will provide support to the staff to finalize and publish the manuscripts in targeted peer reviewed journals.

**Revitalized branding**

In year 3, Afya Halisi fortified its branding efforts with focus on ensuring that renovations, materials and equipment supported by the project were adequately branded as per USAID regulations. In year 3, the Project supported the renovation of operating theatres at Awendo, Rongo, Tseikuru and Migwani sub county hospitals which were completed and handed over to the county governments of Migori and Kitui. The Project ensured that these renovations were properly branded to increase its visibility. In addition, the Project ensured that all the partners in the consortium used the Project logo in all project supported activities, events, PowerPoint presentations and reports. In year 3, the Project mapped its supported health facilities without signages and service charters, which will be supported with signages that have the Project’s logo in year 4 to increase the Project’s visibility.

**Increased engagement at the county level and positive visibility in local and national media outlets**

In year 3, in close collaboration with USAID KEA, the Project engaged with the senior county health leaderships to co-create and track progress of the Project’s priority legacy interventions in the focus counties. These fora were pivotal in profiling the Project and sustaining its visibility at the county and national levels. In year 4, the Project will continue to hold the virtual co-creation meetings between USAID and the focus county governments to co-plan, co-finance, and co-monitor the co-implementation of the legacy interventions to nurture its relationships with the county and national level health leaderships and citizens and ensure sustainable achievement of RMNCAHN and WASH outcomes in the focus counties. Afya Halisi will continue to track its interventions that are reported in local and national media as part of documenting its achievements and profiling USAID’s visibility and impact on RMNCAHN outcomes in the focus counties.

**Project Management**

Afya Halisi has implemented flexible management systems that nimbly adapt to the unique needs of the counties and sub-counties, identifies and capitalize on cost efficiencies, and ensures robust financial management and compliance. In Year 4, the Project will continue to have only one international NGO and five local implementing partners (LIPs) in alignment with the Journey to Self-Reliance (J2SR). The consortium team have considerable experience working together and have established principles and roles for implementation as a cohesive Project, each bringing their technical expertise to the fore. Under Afya Halisi, Jhpiego is leading interventions in reproductive, maternal and adolescent health, FP, child survival and gender at facility and community levels, as well as newborn health at national, county and sub county level. In Year 4, Jhpiego will continue to support capacity building and capacity...
strengthening at county and sub-county level in RH/FP, MNH, AYSRH, CH gender, WASH and nutrition. Jhpiego will also continue to manage the overall project and M&E efforts.

**Staff Roles and Structure:** The Afya Halisi technical approach in Year 4, which aligns to the J2SR has determined the restructuring of the Project’s management and staffing structure. Office locations, staff composition and staff deployment have responded to the J2SR alignment as well as specific epidemiological needs of counties and sub counties with an eye to cost containment and providing tailored technical support to counties and sub-counties depending on their FP/RMNCAH predict WASH needs. The detailed organogram is included below and depicts the staffing structure, staff locations and relationship between all partners. In Year 2, the Project incorporated Child Safeguarding Policy adopted from Save the Children, annexed in the Project’s Operational Manual, all staff, signed their commitment to child safeguarding. In Year 4, staff will go through updates on the same to ensure that they continue to adhere to child safeguarding.

**Location:** Afya Halisi staff have co-located with the county governments in Migori and Kakamega for real-time technical support to the CHMTs and SCHMTs. The co-location has allowed the Project to shut down the privately leased offices in these two counties, freeing up resources that have been ploughed back to implementation of activities. The Project retained the Kisumu office that is more central to allow improved coordination between the four counties and Nairobi based activities. The Kisumu office also hosts the support teams of operations and administration, the COP, M&E Specialist, and Senior Finance and Administration Manager. The DCOP is based in Nairobi and will oversee the technical implementation in the three counties of Kakamega, Kisumu and Migori, and national level. In Kitui, the government does not have sufficient staff to accommodate the Project staff but with the restructuring that the Project went through in year 3, staff have moved into a smaller and more cost-effective leased office in Kitui town. The resources that have been freed by these management changes were ploughed back to programming.

Each county team is supervised by a County Manager who also doubles up as the senior technical liaison with the CHMTs and provides technical oversight and program management for implementation of the scope of work outlined in the work plan and annual Task Order in each county. The County Manager reports to the DCOP and is responsible for the overall quality of implementation of integrated services in each county.

The Project has placed Technical Officers (TO) in cluster sub-counties in Kisumu, Kitui, Migori and Kakamega counties to liaise with the SCHMTs on implementation of activities in the facilities including provision of technical support on budgeting, planning and coordination of activities in the sub-counties. The TOs are co-located with the SCHMT to facilitate teamwork and coordination. The skill sets vary based on the needs of each county. The DCOP liaises between the Department of Family Health (DFH) and the Project, looping in the appropriate technical support based on need. Three MEL Officers sit with the SCHMTs to provide support to the county HRIO to ensure timely, complete and accurate reporting to DHIS. In addition, they collate non-DHIS data that the Project has obligation to report such as WASH data. The senior MEL Officers are based in Migori, Kakamega and Kitui counties.

One Program Officer sitting in Kitui supports the national, county and sub county teams including HRH with program related support.

The WASH specialist and Migori County Manager liaises with the CHMT, SCHMT and LIPs to implement WASH activities at both the facility and the community in accordance with the national guidance and ensure compliance with USAID rules and regulation.
In alignment to the J2SR, a Private Sector Coordinator (PSC) is leading the private sector initiatives including the twinning of public-private hospitals and engagement of professional associations of KPA and KOGs.

The Project has five Program Assistants who provide driving services and clerical services to the Project. To cover the gap left by the few PAs, technical staff drive themselves using pooled vehicles to travel to the sub-counties as need arises.

The Project has on-boarded an additional four LIPs for community programming to address community health services including SBC, gender, nutrition and WASH.

**Project Personnel Management in the Context of COVID-19 Pandemic:** To optimize the functionality of the Afya Halisi team to carry out work in the COVID-19 environment, the Project’s frontline health care workers are still working at health facilities, while adhering to the Government’s directives of social distancing, use of facemasks, washing hands often and other preventive measures. The Project leadership is using online platforms to continue engaging with the county and national MOH leadership on emerging priorities. The Project Senior Leadership Team communicates through email, WhatsApp, telephone calls and Microsoft Teams meetings daily, and sometimes more than once a day, based on programmatic, management and administrative issues on follow up. At county level, the Project implementation team in collaboration with the county government, have prioritized carrying out activities that do not involve large gatherings, while practicing all COVID-19 preventive measures to sustain the RMNCAHN gains while making every effort to flatten the curve. These activities are co-planned and co-implemented with the counties. The Project leadership has rolled out a weekly tracker to monitor performance of staff on key deliverables; and holds weekly staff meetings to review project priorities and progress in activity implementation. The majority of Afya Halisi staff continue to work in the counties, and engaging with the CHMT. Project staff are required to develop individual weekly and monthly activity work plans and provide weekly updates on the progress of implementation through an online tool on the Project’s Microsoft SharePoint.

**Project Oversight:** To continue to effectively manage this project, two steering committees has been established.

**Project Advisory Committee:** This committee has been constituted and comprises
- USAID representative
- Head, Department of Family Health
- CEC Members of Health or designates (e.g. County Officers of Health or County Directors of Health (Migori, Kakamega, Kitui and Kisumu)
- Country Directors or a designated representative for Jhpiego
- Chief of Party, Afya Halisi

**Project Steering Committee:** This committee was constituted in Year 1 with a goal of providing oversight in the operation of the Project to ensure the Project deliverables are met and resolves any conflicts that might arise from the consortium. The committee meets on a biannual basis. The committee comprises:
- Country Directors/Chief Executive Officer or a designated representative for Jhpiego, ADSE, CSA, KMET and LCA
- Chief of Party, Afya Halisi
• Deputy Chief of Party, Afya Halisi
• Finance and Administration Manager
• In attendance, could be M&E Specialist, Afya Halisi, depending on the agenda

Contracts for Construction, Renovation and Equipment: In Year 2, Afya Halisi jointly identified priority facilities to be renovated to increase the number of facilities able to provide CEmONC services ultimately improving access to essential services. Four facilities in Migori and Kitui were identified and the renovations were completed and handed over to the two county governments in year 3. A request for renovation of an additional 22 health facilities was made by Afya Halisi. Jhpiego follows procedures outlined in the Jhpiego Procurement Manual and solicitation for bids and equipment quotations. Abiding by vendor selection processes to promote free and fair competition and reduce fraud, Jhpiego selects vendors that provide the best value for money. Jhpiego will continue to follow the due process of ensuring substantial involvement of the USAID AO and AOR in construction and renovation activities and will comply with requirements under M22 – Limiting Construction Activities (August 2013).
Organogram