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# USAID KENYA AMPATHPLUS

## QUARTERLY PROGRESS REPORT

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# USAID KENYA AMPATHplus

## FY 2014 Q4 PROGRESS REPORT

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## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ALARM** | Advances in Labour and Risk Management |
| **AMPATH** | Academic Model Providing Access to Healthcare |
| **AMRS** | AMPATH Medical Records System |
| **ANC** | Ante-Natal Care |
| **AOTR** | Agreement Officer Technical Representative |
| **APHIA** | AIDS Population and Health Integrated Assistance |
| **ART** | Antiretroviral Therapy |
| **BCC** | Behavior Change Communication |
| **BTL** | Bilateral Tube Ligation |
| **BMI** | Body Mass Index |
| **CB-DOTS** | **C**ommunity Based Directly Observed Treatment Short course |
| **CD4** | Cluster of Differentiation 4 |
| **CDC** | Centers for Disease Control |
| **CHC** | Community Health Committee |
| **CHMT** | County Health Management Team |
| **CRIO** | County Records Information Officer |
| **CHV** | Community Health Volunteer |
| **CME** | Continuous Medical Education |
| **CORPS** | Community Own Resource Persons |
| **CT** | **C**ounseling and Testing |
| **CTF** | Community Therapeutic Feeding |
| **CTX** | Cotrimoxazole |
| **CWC** | Child Welfare Clinic |
| **DASCO** | District AIDS & STI Coordinating Officer |
| **DBS** | Dry Blood Sample |
| DCOP | Deputy Chief of Party |
| **DHMT** | District Health Management Team |
| **DHRIO** | District Health Records and Information Officers |
| **DL** | Distance Learning |
| **DLTLD** | Division of Leprosy, Tuberculosis and Lung Disease |
| **DMOH** | District Medical Officer for Health |
| **DMLT** | District Medical Laboratory Technologist |
| **DPHN** | District Public Health Nurse |
| **DRH** | Division of Reproductive Health |
| **DTC** | Diagnostic Testing and Counseling |
| **EBI** | Evidence informed Behavioural Interventions |
| **EID** | Early Infant Diagnosis |
| **EmOC** | Emergency Obstetrical Care |
| **EMTCT** | Elimination of Mother-to-Child Transmission of HIV |
| **EQA** | External Quality Assurance |
| **FLTR** | Find Link Treat Retain |
| **FP** | Family Planning |

| | |
|---|---|
| **FPI** | Family Preservation Initiative |
| **GESP** | Group Empowerment Service Provider |
| **GISE** | Group Integrated Savings Enterprise |
| **GCLP** | Good Clinical Laboratory Practice |
| **GOK** | Government of Kenya |
| **HCT** | Home Based Counseling & Testing |
| **HIV** | Human Immunodeficiency Virus |
| **HMIS** | Health Management Information Systems |
| **HREC** | High Risk Express Care |
| **HTC** | HIV Testing and Counseling |
| **IEC** | Information, Education and Communication |
| **ICF** | **I**ntensive Case Finding |
| **IMCI** | Integrated Maternal and Child Illnesses |
| **IPT** | Isoniazid Prophylaxis Therapy |
| **IQC** | Internal Quality Control |
| **KEMSA** | Kenya Medical and Supplies agency |
| **KENAS** | Kenya National Accreditation Services |
| **KEPH** | Kenya Essential Package for Health |
| **KMMP** | Kenya Mentor Mothers Program |
| **KPs** | Key Populations |
| **LMIS** | Logistic Management information System |
| **LREC** | Low Risk Express Care |
| **LTFU** | Lost To Follow Up |
| **M&E** | Monitoring and Evaluation |
| **MNCH** | Maternal Neonatal and Child Health |
| **MDR TB** | Multi Drug Resistant Tuberculosis |
| **MUCHS** | Moi University College of Health Sciences |
| **NACC** | **N**ational Aids Control Council |
| **NASCOP** | National AIDS & STI Coordinating |
| **NCD** | Non Communicable Disease |
| **NHIF** | National Hospital Insurance Fund |
| **OJT** | On-the-Job Training |
| **OVC** | Orphans and Vulnerable Children |
| **PAC** | Post Abortion Care |
| **PHC** | Primary health Care |
| **PALWECO** | Program for Agriculture and Livestock in Western Communities |
| **PHCT** | Perpetual Home based Counseling and Testing |
| **PHDP** | Positive Health, Dignity and Prevention |
| **PITC** | Provider initiated testing and counselling |
| **PLHA** | People living with HIV/AIDS |
| **PTB** | Pulmonary tuberculosis |
| **PLHA** | People living with HIV/AIDS |
| **PTB** | Pulmonary tuberculosis |
| **PwP** | Prevention with Positives |
| **PLUS** | People-centered Leadership Universal access Sustainability |
| **PMTCT** | Prevention of Mother to Child transmission |

| | |
|---|---|
| **RH** | Reproductive Health |
| **SCRIO** | Sub-County Records Information Officer |
| **RHTC** | Rural Health Training Centre |
| **RSPO** | Research Sponsored Projects Office |
| **SLMTA** | Strengthening Laboratory Management towards Accreditation |
| **TAT** | Turn around Time |
| **TOT** | Training of Trainers |
| **USAID** | United States Agency international Development |
| **VMMC** | Voluntary Medical male Circumcision |
| **WASH** | Water Sanitation and Hygiene |
| **WFP** | World Food Program |
| **WHO** | World Health Organization |
| **WAN** | Wide Area Network |
| **WWAN** | Wireless Wide Area Network |

# I. AMPATHPLUS EXECUTIVE SUMMARY

## Qualitative Impact

In an effort to address nutrition and agriculture challenges facing OVC, the program facilitated establishment of "Agri-nutrition training clubs" in 63 primary schools. Through the initiative, a total of 4,536 pupils were trained in basic agricultural skills related to kitchen gardening and nutritional value of different types of vegetables.  Each school also established vegetable gardens for learning purposes. Vegetables produced in the school gardens are used to support school feeding programs while the surplus is sold hence being an income generation activity for the clubs. Pupils have also replicated the gardens in their homesteads hence improving food security and nutrition status for over 6,000 people t in all the counties.

During the quarter, emphasis was placed on the promotion of community-facility linkages for pregnant women. Establishment of community dialogue on PMTCT was done concentrating on sub-counties with high prevalence of HIV. Meetings with community stake-holders and county and sub-county health management teams were supported to encourage and start up PMTCT activities.

The quarter also saw NHIF opening a bank account to collect the Zuri premiums (one of our sustainability projects being piloted in Busia County). This bank account was linked to M-Pesa tills. AMPATH, Busia county and NHIF anticipate top receive their first client on 3rd December 2014, they are in the process of preparing staff working in AMPATH and MOH in these facilities to ensure quality service is availed to the patients.

The ERP Software for the AMPATH Transformation Project was installed during this quarter.

## Quantitative Impact

The program tested 124,031 during the quarter through its facility-based and home-based HIV testing and counseling activities, of whom 54% were female and 13% were aged less than 15 years.

During the reporting period, the number of individuals newly initiating on ART was 3,455 up from 3075 in the previous quarter. Females accounted for 67% while males accounted for 33%.

The outreach department did a rapid assessment of all patients who became LTFU in the past 30 months. A total of 11,093 patients were identified and outcomes for these have been entered into the AMRS. Briefly, 31% had transferred out of care and were in care elsewhere, 26% were not traceable, 19% planned to return to clinic and were given a new return to clinic date, 10% had died, and 6% refused to be in care.

The percent of women having 4 ANC visits increased from 61% last quarter to 65.7% this quarter against a target of 50% and 60% depending on the county. Kisumu West sub-county registered an impressive 95.4% while Elgeyo Marakwet still has challenges at 48.8%.  The percent of women delivering with a skilled provider went up from 51.5% in quarter 3 to 60.1% this quarter. This is on target and in agreement with the Presidential Monitoring report that was released in October, 2014 indicating a country-wide rise of facility delivery from 30% to 60% following the roll out of free maternity services. The number of children below 5 years with diarrhea who received ORT was 25,871 in quarter 3 but increased to 36,244 this quarter. This was above target of 7,000, which we believe was too low. Elgeyo Marakwet County contributed the highest figure at 7,388 and Kisumu West 860, which cannot be compared since these are absolute figures that reflect the catchment population but not the prevalence of diarrhea cases. The program noted an increasein CYP from 22,011 in quarter 3 to 34,720 this quarter. On the other hand, there was improvement in FP commodities reporting rates from 61.5% in the last quarter to 62.4% this quarter, although below the expected target of 80%. Nandi, West pokot, Busia and Bungoma Counties all recorded at least 80% while  Elgeyo Marakwet, Trans Nzoia, Kisumu West and Uasin Gishu Counties were still below target as at end of September 2014.  Timeliness of FP reporting increased to 60.7% from 49% in quarter 3.

## Constraints and Opportunities

There was a shortage of RNA-PCR kits in the quarter which affected testing. Shortage lasted for about 17 days. We need to continue seeking ways to avoid reagents and consumables stock outs in collaboration with KEMSA, AMPATH plus management and other stake holders.

## Subsequent Quarter's Work Plan

We plan to support the provision of HTC services (PITC) in Elyego Marakwet and West Pokot counties in the first quarter of the next financial year.

## II. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

**HIV Prevention:** Healthy Choices for A Better Future (HCBF) is an EBI that targets 10-14 year olds in schools and aims at promoting abstinence by increasing youth's awareness about sexual health. Preparations to conduct stakeholder sensitization before the actual roll out of the intervention commenced in Busia County. The Prevention team briefed the Ministry of Education Officials in Busia County and Bunyala Sub County about the intention to start Healthy Choices for a Better Future in the county. For Positive Health, Dignity and Prevention (PHDP) formerly referred to as Prevention with Positives (PwP), community and clinical PHDP continued to be implemented. Activities on community PHDP were introduced in Bungoma and Kisumu Counties. Support Supervision for Clinical PHDP was done in facilities in Busia and Trans Nzoia counties. For the key populations, 25 sex workers were selected in Trans-Nzoia West Sub- County and they started distributing condoms among their peers and preparations are underway to train them as Peer Educators.

For evidence-informed behavioral interventions (EBIs), facilitators for the Families Matter Program (FMP) continued to implement FMP in Trans-Nzoia West, Teso North, Butula, Bunyala and Kisumu West Sub-Counties. Out of 108 people that were enrolled in the 5 sub counties, a total of **107** people (male – 31 and female – 76) successfully completed the six-week sessions. Only one did not complete the sixth session because he relocated before the end of the sessions. The parents trained were also offered HTC services and referred for other services which included family planning, Voluntary Male Medical Circumcision (VMMC), Gender Based Violence, treatment for Sexual Transmitted Infections among others. The RESPECT-K intervention is being implemented among key populations (KPs) in Trans-Nzoia, Busia and Kisumu counties. A total of **333** individuals (male – 143; female -190) were reached with the intervention.

**HIV Testing and Counseling:** The program tested 124,031 during the quarter through its facility-based and home-based HIV testing and counseling activities, of whom 54% were female and 13% were aged less than 15 years. The PITC Program has put special effort in minimizing chances of lost opportunities for testing, and referral and linkage for all clients/patients who are diagnosed with HIV infection. The concept of physically handing over of positive clients is borrowed from the health care concept of handing and taking over of patients. During this quarter, we highlight the 21 sites that have adopted this referral to linkage concept. Of 1752 people testing positive through PITC in these sites, 78% (1360) successfully linked to a clinician at the CCC. The success of this concept has been achieved through short term and long term contracts with HIV counselors to provide a minimum support in direct service delivery. Common reasons for losses particularly after testing HIV-positive include people testing positive while in-patients who want to return for further out-patient care at a later date, people choosing to go to a CCC closer to where they live.

The key HTC activities provided at the community level were through perpetual home-based counseling and testing (PHCT) and mobile outreaches among selected populations. PHCT activities were done in thirteen sub-counties. During the quarter preparations for introduction of PHCT services were completed and the actual door-to-door testing started in Matayos Sub-county. We plan to support the provision of HTC services (PITC) in Elyego Marakwet and West Pokot counties in the first quarter of the next financial year. During the quarter, selected evidence-informed behavioural interventions (EBIs) were rolled out. The Prevention team continued reaching targeted groups including youth, key populations (KPs) and the general population with prevention messages. The Prevention/PHCT department continued to train HTC service providers in the New HIV Testing Algorithm. A total of 27 classes and 637 service providers were trained in three counties during the quarter. In Uasin Gishu County, 13 classes of 310 HTC service providers were trained while in Elgeyo Marakwet, 11 classes were trained with 262 participants. In Nandi County, 3 classes of 65 participants were trained. Training for the remaining four classes in Uasin Gishu will be done in October 2014.

**HIV Care, Treatment, and Support:** One of the key achievements for the clinical team department in the quarter was the roll-out of the Private Public Partnership (PPP) program. The initiative will go a long way in ensuring universal access of HIV care since patients who feel stigmatized to attend clinic appointments in AMPATH facilities can choose where they want to access care, and be assured that the quality of the care meets the standard of care provided at AMPATH. This is collaboration between AMPATH and some private hospitals/clinics in Eldoret town through signed memoranda to provide HIV/ART services, with patients accessing the PEPFAR supported services (labs and drugs) free of charge. At least 2 key persons in these hospitals/clinics have been trained through the standard Nascop ART modules, and mentored in AMPATH clinics. We have been working very closely with pharmacy staff in these clinics to ensure that they file their monthly drug consumption reports in time to ensure smooth supply of drugs. We have also provided them with manual daily activity registers and the electronic antiretroviral dispensing tool (ADT) has been provided to those with computers. They have been trained on the use of the tool. In this quarter, 5,126 patients were registered in this program. The PPP Program will gradually be rolled out to other AMPATH sites where there are recognized private hospitals and/or clinics.

The outreach department did a rapid assessment of all patients who became LTFU in the past 30 months. A total of 11,093 patients were identified and outcomes for these have been entered into the AMRS. Briefly, 31% had transferred out of care and were in care elsewhere, 26% were not traceable, 19% planned to return to clinic and were given a new return to clinic date, 10% had died, and 6% refused to be in care. As part of these efforts the department designed and implemented a mobile data entry system for defaulter tracking. A mobile phone program was also created that enables the retention workers to download defaulter fault4er lists directly at the sites. The system has already been successfully used to upload data from Turbo clinic. The department successfully trained community health workers on communuity HIV and patient retention in Busia County ( Butula and Matayos subcounties), Trans Nzoia county (Saboti subcounty) and Bungoma County (Mt. Elgon and Bungoma East subcounties).

In the quarter, the number of patients with malnutrition enrolled to therapeutic and supplementary feeding program was 1001, which was nearly a quarter (22.2%) of the quarterly target. This low performance was because of the closure of the WFP support for PLHIV. Additionally, despite receiving support from NHP, there were logistical delays in the transport of the commodities to facilities away from MTRH. Additionally, number of clients who were nutritionally assessed and found to be clinically undernourished was highest in the quarter (10,253) which was nearly 56% of the annual target. This is attributed to more accurate reporting, and the use of the LMIS system for reporting.

**Prevention of Mother-to-Child HIV Transmission (PMTCT):** During the quarter, emphasis was placed on the promotion of community-facility linkages for pregnant women. Establishment of community dialogue on PMTCT was done concentrating on sub-counties with high prevalence of HIV. Meetings with community stake-holders and county and sub-county health management teams were supported to encourage and start up PMTCT activities. Training was also carried out for community health volunteers and community health extension workers to empower them to carry out PMTCT activities in the community, to increase awareness, create demand, make referrals to care and follow up defaulters. There was also integration with MCH and FP to enable provision of the continuum of reproductive health services at the community with smooth transition to the facility.

**Orphans and Vulnerable Children (OVC)** – In an effort to address nutrition and agriculture challenges facing OVC, the program facilitated establishment of "Agri-nutrition training clubs" in 63 primary schools. Through the initiative, a total of 4,536 pupils were trained in basic agricultural skills related to kitchen gardening and nutritional value of different types of vegetables. Each school also

established vegetable gardens for learning purposes. Vegetables produced in the school gardens are used to support school feeding programs while the surplus is sold hence being an income generation activity for the clubs. Pupils have also replicated the gardens in their homesteads hence improving food security and nutrition status for over 6,000 people t in all the counties.

**Safety Net:** AMPATH runs two emergency shelters in Eldoret and Mosoriot. The shelters plays a critical role in protection, care, and treatment by reducing barriers to care and increasing access to essential medical services for clients who are rejected, abandoned or malnourished as a result of their status from all AMPATH sites. In the quarter, a total of 33 clients were provided with care, treatment and support in both shelters. Among those accommodated were 5 TB patients who had challenges with adherence on medication due social, economic and environmental related difficulties. They lacked fare to attend their clinic appointments, had no food, lived in deplorable houses and were dependent on well-wishers for their daily upkeep. In shelter, their treatment and nutrition was closely monitored which significantly improved their health condition within three months. Their relatives were also identified and counseled on their role in providing the necessary support for the clients. Care and protection Services provided at the shelters enabled the TB patients to adhere to medication hence facilitating a faster recovery and minimizing of relapse due to non-adherence and non-completion of treatment. Involving immediate family members assisted in the continuum of care and successful reintegration back to their homes/ communities assisted in reducing barriers to care that are normally faced by clients as a result of their status.

**Gender-based violence:_** There was an increase in reporting of rape and defilement cases in the last quarter due to a close working relationship and collaboration between Legal Aid Centre of Eldoret (LACE), MTRH Center of Assault Recovery of Eldoret (CAR-E), AMPATH Social work and OVC departments. The collaboration assisted in identification and reporting of 10 rape and 48 defilement survivors who were facilitated to access care within required time while the perpetrators were arrested. The increase in reported cases was as result of training teachers, guardians, community leaders and health workers on quality assurance, ways of identifying gender and sexual abuse, available support services and the need of seeking justice for the victims in the courts of law instead of the traditional dispute mechanisms that favors the perpetrators.

**Maternal-Child Health and Family Planning**: MCH/FP continues to build stronger relationships with the county government systems. This quarter provided numerous opportunities to work with the counties in coming up with MOH-lead action plans and implementation of EmONC RRI in Busia and Trans Nzoia counties. There was support for integrated outreaches, MCH/FP/MIYCN/EMONC trainings, mentorships and support supervisions on MCH/FP across the 8 counties. The successful training and refreshing of CHVs on community MCH/FP using an integrated 5-day training that covered MCH, FP, PMTCT and HIV defaulter tracing yielded some good results. This was done in Trans Nzoia West and Mt. Elgon sub-counties and sub-counties in West Pokot and will be rolled out to the 8 counties in the subsequent quarters. These trainings together with the BEMONC scale up that saw 199 health care workers trained, helped to improve case identification, linkage and referrals from the community to the facility as well as appropriate care provided at the health facilities.

Fifteen community outreaches and two school health programs on MCH/FP were conducted in Busia, West Pokot, Elgeyo Marakwet, Bungoma, Trans Nzoia and Nandi counties. The support for these activities has been increased for the subsequent quarters to allow each health facility to conduct outreaches. Also on FP, more clients are taking up long acting methods across our catchment, which has led to increase in couple years of protection from quarter 3. FP training was successfully completed in Bungoma and West Pokot counties with a total of 170 were trained in long acting family planning methods. A total of 220 health care workers also received FP OJTs during the quarter across

the catchment. AMPATH staff completed the online FP compliance training to ensure that the rapid scale up of FP service uptake was conforming to USAID regulations. FP commodity reporting rates and timeliness of reporting is on an upward trend although not yet on target.

### Health Systems Strengthening

*Laboratory:* The USAID through KEMSA has been providing reagents for RNA, DNA PCR band CD4 counts in the quarter. Under SLMTA program, (Strengthening Laboratory Management Towards Accreditation), trained a total of 9 lab staff form Bungoma County, Busia County, Elgeyo/Marakwet County and Uasin Gishu County. The lab also trained 36 lab personnel on GCLP (Good Clinical lab Practice) from Bungoma County, Busia County and Kisumu West. The work volume in the quarter for Viral load, DNA PCR and CD4 count and hematology was affected due to shortages of consumables such as DBS filter papers, Vacutainer EDTA tubes and Vacutainer Needles. There was also a 17 days of shortage of RNA- PCR kits in the quarter. In the quarter the lab had enough CD4 reagents, DNA PCR and CBC reagents. The major challenge was shortage of consumables such as EDTA tubes and Vacutainer needles.

*Data:* We completed upgrading the AMRS from version 1.8.2 to version 1.9.7 at central (AMPATH Centre Eldoret) and all ten AMRS decentralized sites. These sites are: Kitale, Turbo, Webuye, Busia, Port Victoria, Chulaimbo, Teso, Mosoriot, Khunyangu and Burnt Forest. The upgrade will ensure better optimization of the system by now using MySQL version 5.6 from version 5.1, improve user requirements which includes platform to enable point of care, and version 1.9.7 corresponds to the Ministry of Health OpenMRS system being rolled out. Internet upgrade of internet was done from 10MBs to 30MBS. Point to point connections between AMPATH and MTRH were established to enable sending of X-Ray images to the central AMRS server.

The use of universal identifiers is critical for good clinical monitoring as well as program monitoring and evaluation. In the quarter, supervision of the sites implementing universal IDs was carried out. These sites are: Khunyangu, Port Victoria, MTRH, Mosoriot, Turbo and Burnt Forest. Challenges related to use of universal identifiers include matching of AMPATH ID and universal IDs, and scarcity of personnel especially where there is only one staff dealing with registration.

### Lessons Learned

The key lesson learned is that by getting to know MOH staff and using their untapped skills is a good way to facilitate ownership in MOH facilities. Health facilities within counties that received regular support supervision from County and Sub-County Health Teams have better service delivery and reporting rates. The two areas that are a great example are West Pokot County and Kisumu West Sub-County. These two areas still have a robust Community Strategy program that allows for early case finding and referral from community level. Close supervision is motivational and improves implementation. Empowerment and inclusion of local personnel in local activities strengthens working relationship

Identifying children with special talents can be very instrumental if nurtured. For example there is one girl who is a total orphan currently at the University of Eldoret is able to spare her time to provide psychosocial support services to other children over school holidays and now many children have taken the challenge of working hard despite their challenges.

## III. ACTIVITY PROGRESS (QUANTITATIVE IMPACT)

**Result Area 1.1:** Prevention – Evidence-informed behavioral interventions (EBIs)
**Intermediate Result 1.1.2:** All individuals living in designated AMPATH catchments will have improved knowledge of HIV transmission risks and behaviors that can reduce the risk of HIV acquisition.
**Expected Outcomes:** A reduction in the incidence of new HIV infections by 50% over 5 years.

The minimum clinical Positive Health, Dignity, and Prevention (PHDP) package in clinical PHDP refers to the provision of adherence counseling and any other 3 PHDP messages. PHDP services including adherence counseling, partner testing, support for disclosure, condom provision, family planning and STI screening were provided by clinicians and other healthcare workers to the eligible clients seen at AMPATH clinics. In community PHDP (CPHDP), minimum package refers to the provision of condom education and demonstration and any other 3 PHDP messages. The service providers trained in CPHDP from Uasin Gishu, Kisumu and Busia Counties continued reaching their peers within support groups with PHDP messages at the community level. A total of 2,689 persons living with HIV were reached with the minimum package for community PHDP. The department rolled out community PHDP activities in Kisumu and Bungoma Counties. The tables below show the number of individuals >15 years of age reached with both clinical PHDP services and community PHDP messages.

Under condom promotion, 513,044 male condoms and 1,092 female condoms were distributed in 64 condom service outlets while others were distributed by counselors during PHCT and mobile VCT outreaches as part of prevention.

| INDICATOR TITLE: Number of HIV infected individuals provided with minimum PHDP package | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline July – Sept. 2013 | | Results Achieved in the prior Period | | | | | | Reporting Period July – September 2014 | | | | FY 2014 Target | |
| | | | Oct – Dec. 2013 | | Jan – March 2014 | | April – June 2014 | | | | | | | |
| | Achieved | | Achieved | | Achieved | | Achieved | | Target | | Achieved | | Target | |
| Gender W(Women); M (Men) | F | M | F | M | F | M | F | M | F | M | F | M | F | M |
| Bungoma | 1,602 | 973 | 2,788 | 1,127 | 3,670 | 1,457 | 1,000 | 404 | 1,500 | 1,000 | 4,219 | 1,786 | 6,000 | 4,000 |
| Busia | 4,183 | 3,375 | 14,531 | 7,385 | 16,913 | 8,560 | 4,663 | 2,422 | 2,000 | 1,200 | 14,534 | 7,077 | 9,000 | 6,000 |
| Elgeyo Marakwet | 82 | 22 | 629 | 235 | 790 | 283 | 235 | 96 | 40 | 40 | 1,002 | 414 | 200 | 100 |
| Kisumu | 637 | 273 | 2,929 | 1,599 | 4,228 | 2,346 | 715 | 523 | 900 | 850 | 2,699 | 1,422 | 3,000 | 2,000 |
| Nandi | 532 | 320 | 1,506 | 760 | 2,197 | 1,078 | 255 | 135 | 200 | 100 | 1,648 | 771 | 1,500 | 700 |
| Trans Nzoia | 505 | 238 | 2,704 | 1,202 | 3,790 | 1,633 | 939 | 396 | 400 | 380 | 3,998 | 1,572 | 3,000 | 1,500 |
| Uasin Gishu | 3,342 | 1,587 | 13,419 | 6,255 | 16,271 | 7,728 | 4,465 | 2,062 | 1,700 | 1,300 | 18,335 | 8,686 | 12,000 | 6,000 |
| **Total** | **10,883** | **6,788** | **38,506** | **18,563** | **47,859** | **23,085** | **12,272** | **6,038** | **6,740** | **4,870** | **46,435** | **21,728** | **34,700** | **20,300** |

| INDICATOR TITLE: NUMBER OF CONDOMS DISTRIBUTED * | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | **October - December 2013** | | **January – March 2014** | | **April - June 2014** | | **July- September 2014** | |
| | **# of condoms** | | **# of condoms** | | **# of condoms** | | **# of condoms** | |
| | **Female** | **Male** | **Female** | **Male** | **Female** | **Male** | **Female** | **Male** |
| Bungoma | 2,160 | 34,928 | 426 | 29,058 | 776 | 97,140 | 536 | 87,231 |
| Busia | 35 | 75,578 | 848 | 77110 | 550 | 99,757 | 259 | 123,646 |
| Elgeyo Marakwet | 0 | 8,274 | 204 | 6,806 | 0 | 5,912 | 0 | 11,210 |
| Kisumu | 0 | 12,128 | 78 | 11,752 | 0 | 14,900 | 0 | 25,568 |
| Nandi | 0 | 22,160 | 0 | 12,388 | 0 | 6,597 | 0 | 7115 |
| Trans Nzoia | 0 | 29,156 | 572 | 33,997 | 220 | 73,272 | 259 | 81,788 |
| Uasin Gishu | 0 | 126,257 | 72 | 132,268 | 75 | 211,422 | 0 | 176,486 |
| West Pokot | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **2,195** | **308,481** | **2,200** | **303,379** | **1,621** | **509,000** | **1,092** | **513,044** |

**Result Area 1.1: Prevention-Counseling and Testing**
**Intermediate Result 1.1.1: All individuals living in designated AMPATH catchments will know their HIV status.**
**Expected Outcomes:** A reduction in the incidence of new HIV infections by 50% over 5 years.

Testing in PITC increased from 59,191, in the 1st quarter to 96,062 in this quarter. Also the number of reporting Sites increased from 261 in the 1st quarter to 326 in this reporting quarter. Noted are the high positive numbers among women at 1,305, compared to 883 men and 152 children.

Implementation of PHCT continued in the following (7) counties: Bungoma County (Mt. Elgon and Bungoma East sub-counties), Busia County (Teso North, Bunyala and Butula sub-counties), Elgeyo Markwet County (Keiyo North sub-county), Kisumu County (Kisumu West sub-county), Nandi County (Nandi North sub-county), Trans-Nzoia County (Trans-Nzoia West sub-county) and the entire Uasin Gishu County. Preparations to re-introduce PHCT in Matayos Sub-county, Busia were finalized and PHCT Counselors started implementing PHCT services in August 2014 in the entire Sub-county. The VCT outreaches were mobile and moonlight VCTs targeting key populations such as female sex workers, truck drivers, fisher folks and prisoners. Specific activities were conducted in Trans Nzoia (Kitale G.K. Medium Prisons, moonlight in Kitale town), Busia (Korinda G.K Prison, Malaba Town and Busia Market), Elgeyo Marakwet (Musekekwa Market) and Uasin Gishu (Huruma Primary School, St. George's Primary School, Eldoret G.K Prisons, Kipchoge Stadium and Raiply Woods Eldoret) Counties. In Teso, Busia County, VCT services continued to be offered at the container targeting female sex workers, truck drivers as well as members of the general population.

Through both PHCT and mobile VCT approaches, a total of 45,807 (F – 25,579 and M – 20,228) were tested for HIV. Of those tested, 714 (1.6%) were found to be HIV positive (474 (66.4%) individuals were enrolled to HIV care).Ninety-nine (99) presumptive TB cases were identified by the PHCT Counsellors in the homes and their sputum collected for microscopy. Six (6) smear positive cases were found and 5 linked to care in collaboration with the cough monitors. One person who was smear positive died before he was linked to care. Approximately 10,800 deworming tablets were dispensed to children between 2 and 5 years during the quarter.

| INDICATOR TITLE: NUMBER OF PERSONS COUNSELED AND TESTED FOR HIV THROUGH FACILITY-BASED TESTING | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Additional Criteria** | **Reporting Period October –December 2013** | | | | **Reporting Period January - March 2014** | | | | **Reporting Period April-June 2014** | | | | **Reporting Period July - September 2014** | | | | **FY 2014 Cumulative** | | | |
| **Baseline** | **Quarter 1** | | | | **Quarter 2** | | | | **Quarter 3** | | | | **Quarter 4** | | | | | | | |
| | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | |
| Gender: Women (W) Men (M) | W | M | W | M | W | M | W | M | W | M | W | M | W | M | W | M | W | M | W | M |
| **BUNGOMA** | 10,368 | 7,694 | 6,245 | 4,419 | 6,000 | 4,000 | 6,716 | 5,225 | 6,000 | 4,000 | 7,361 | 5,547 | 6,000 | 4,000 | 7,286 | 5,774 | 28,368 | 19,694 | 27,608 | 20,965 |
| **BUSIA** | 9,669 | 10,510 | 7,996 | 8,077 | 7,000 | 5,000 | 7,223 | 5,793 | 7,000 | 5,000 | 12,295 | 11,081 | 7,000 | 5,000 | 13,967 | 12,187 | 30,669 | 25,510 | 41,481 | 37,138 |
| **ELGEYO MARAKWET** | 4,635 | 3,366 | 2,650 | 2,157 | 2,000 | 1,000 | 3,033 | 2,187 | 2,000 | 1,000 | 3,875 | 2,873 | 2,000 | 1,000 | 3,921 | 2,559 | 10,635 | 6,366 | 13,479 | 9,776 |
| **KISUMU** | 1,089 | 958 | 415 | 289 | 2000 | 1,000 | 581 | 386 | 2000 | 1,000 | 1,730 | 1,028 | 2000 | 1,000 | 1,146 | 1,070 | 7,089 | 3,958 | 3,872 | 2,773 |
| **NANDI** | 764 | 620 | 454 | 473 | 3,000 | 2,000 | 1,036 | 868 | 3,000 | 2,000 | 1,534 | 997 | 3,000 | 2,000 | 1,561 | 1,018 | 9,764 | 6,620 | 4,585 | 3,356 |
| **TRANS NZOIA** | 3,169 | 1,994 | 1,920 | 1,492 | 2,000 | 1,000 | 3,630 | 2,117 | 2,000 | 1,000 | 4,644 | 3,683 | 2,000 | 1,000 | 7,519 | 5,262 | 9,169 | 4,994 | 17,713 | 12,554 |
| **UASIN GISHU** | 9,503 | 7,148 | 7,619 | 7,784 | 7,000 | 5,500 | 10,927 | 8,946 | 7,000 | 5,500 | 10,919 | 9,276 | 7,000 | 5,500 | 14,714 | 11,657 | 30,503 | 23,648 | 44,179 | 37,663 |
| **WEST POKOT** | 4,197 | 2,711 | 4,386 | 2,815 | 1,000 | 500 | 2,246 | 1,215 | 1,000 | 500 | 3,989 | 2,712 | 1,000 | 500 | 3,794 | 2,627 | 7,197 | 4,211 | 14,415 | 9,369 |
| **TOTAL** | 43,394 | 35,001 | 31,685 | 27,506 | 30,000 | 20,000 | 35,392 | 26,737 | 30,000 | 20,000 | 46,347 | 37,197 | 30,000 | 20,000 | 53,908 | 42,154 | 133,394 | 95,001 | 167,332 | 133,594 |

| INDICATOR TITLE: NUMBER COUNSELED AND TESTED FOR HIV THROUGH PERPETUAL HOME-BASED COUNSELING AND TESTING (PHCT) AND MOBILE VOLUNTARY COUNSELING AND TESTING (MVCT) ACTIVITIES | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline July - Sept 2013 | | Results Achieved in the prior periods | | | | | | Reporting Period July - September 2014 | | | | End of Project Target | |
| | | | October – Dec 2013 | | January – March 2014 | | April – June 2014 | | | | | | | |
| | Achieved | | Achieved | | Achieved | | Achieved | | Target | | Achieved | | Target | |
| Gender W(Women); M (Men) | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** |
| Bungoma | 1,877 | 1,468 | 1,287 | 1,195 | 1,003 | 757 | 2,145 | 1,647 | 1,600 | 1,300 | 1,336 | 1,066 | 39,500 | 30,500 |
| Busia | 6,235 | 6,091 | 6,164 | 5,348 | 4,972 | 4,162 | 6,889 | 5,599 | 4,000 | 3000 | 9,215 | 7,557 | 113,000 | 93,000 |
| Elgeyo Marakwet | 751 | 714 | 613 | 542 | 685 | 493 | 600 | 336 | 600 | 500 | 828 | 577 | 19,000 | 15,500 |
| Kisumu | 1154 | 886 | 1,263 | 1,195 | 1,564 | 1,300 | 1,988 | 1,512 | 1,100 | 900 | 1,341 | 1,035 | 29,500 | 22,500 |
| Nandi | 449 | 341 | 461 | 317 | 344 | 252 | 575 | 458 | 400 | 300 | 369 | 233 | 16,000 | 12,500 |
| Trans Nzoia | 5,142 | 4,743 | 3,712 | 3,039 | 3,600 | 2,677 | 4,131 | 2,915 | 5,000 | 4,000 | 4,998 | 3,596 | 112,000 | 93,000 |
| Uasin Gishu | 9,404 | 8,195 | 7,953 | 6,040 | 7,729 | 5,987 | 6,798 | 5,065 | 8,000 | 6,000 | 7,492 | 6,164 | 202,000 | 182,000 |
| **Total** | **25,012** | **22,438** | **21,453** | **17,676** | **19,897** | **15,628** | **23,126** | **17,532** | **20,700** | **16,000** | **25,579** | **20,228** | **531,000** | **449,000** |

**Result Area 1.2: Care and Treatment**
**Intermediate Result 1.2.1: All individuals testing HIV-positive will be linked to HIV care.**
**Expected Outcomes: A reduction in the incidence of new HIV infections by 50% over 5 years.**

The initiation and maintenance on ART accords numerous benefits to those infected with HIV. To this end, it is imperative to prepare and initiate therapy in those who qualify for treatment as soon as is feasible. During the reporting period, the number of individuals newly initiating on ART was 3465 up from 3075 in the previous quarter. Females accounted for 67% while males accounted for 33%. Further details are provided in the table below.

| INDICATOR TITLE: **Number of Individuals newly initiating on ART** | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| INDICATOR NUMBER: | | | | | | | | | | | | | | | | | | | | |
| | ***Baseline*** | | *Oct-Dec2013* | | *Jan-Mar2014* | | *Apr-Jun2014* | | *Jul-Sept2014* | | | | *FY 2014* | | *FY 2015* | |
| | | | *Achieved* | | *Achieved* | | *Achieved* | | *Achieved* | | *Target* | | *Target* | | *Target* | |
| ***Additional Criteria*** *If other criteria are important, add lines for setting targets and tracking* | *W* | *M* | *W* | *M* | *W* | *M* | *W* | *M* | *W* | *M* | *W* | *M* | *W* | *M* | *W* | *M* |
| *Gender: Women (W), Men (M)* | ***2482*** | | ***2395*** | | ***3618*** | | ***3075*** | | ***3455*** | | ***3000*** | | ***12000*** | | ***12000*** | |
| ***Overall*** | ***1680*** | ***802*** | ***1633*** | ***762*** | ***2468*** | ***1150*** | ***2030*** | ***1045*** | ***2310*** | ***1145*** | ***1753*** | ***1247*** | ***7012*** | ***4988*** | ***7012*** | ***4988*** |
| *BUNGOMA* | *81* | *51* | *92* | *45* | *147* | *51* | *179* | *72* | *155* | *55* | *104* | *73* | *416* | *292* | *416* | *292* |
| *BUSIA* | *462* | *221* | *481* | *222* | *741* | *340* | *494* | *297* | *562* | *280* | *408* | *287* | *1632* | *1148* | *1632* | *1148* |
| *ELGEYO MARAKWET* | *130* | *48* | *49* | *16* | *84* | *43* | *85* | *55* | *84* | *51* | *57* | *41* | *228* | *164* | *228* | *164* |
| *KISUMU* | *158* | *72* | *77* | *48* | *231* | *133* | *145* | *54* | *148* | *93* | *188* | *138* | *752* | *552* | *752* | *552* |
| *NANDI* | *29* | *20* | *43* | *21* | *42* | *18* | *34* | *17* | *49* | *36* | *37* | *27* | *148* | *108* | *148* | *108* |
| *TRANS NZOIA* | *324* | *134* | *334* | *134* | *368* | *178* | *315* | *146* | *373* | *182* | *333* | *232* | *1332* | *928* | *1332* | *928* |
| *UASIN GISHU* | *456* | *218* | *490* | *244* | *785* | *333* | *708* | *369* | *881* | *412* | *588* | *422* | *2352* | *1688* | *2352* | *1688* |
| *WEST POKOT* | *40* | *38* | *67* | *32* | *70* | *54* | *70* | *35* | *58* | *36* | *38* | *27* | *152* | *108* | *152* | *108* |

**Result Area 1.3: HIV Care and Support Services**
**Intermediate Result 1.3.1:** Provide quality social support services to clients within designated AMPATH catchment areas and provide a minimum of one social support service to 70% of patients screened
**Expected Outcomes:** Adult patients/families no longer seeking social support services and are self-reliant

A major objective of the department is to provide psychosocial support to all clients enrolled for HIV care. This is achieved through support groups for both new and continuing clients. The number of support group members attending group therapy sessions is a key indicator with regard to gauging the uptake of peer to peer therapy sessions for the different groups of HIV infected individuals who are receiving care and treatment. The sessions offer an entry point with regard to HIV related stigma and other psychosocial challenges experienced by clients at different levels while in care. The role of peer led psychosocial support on retention in care cannot be overemphasized. A total of 3,440 new clients and their dependants were enrolled with NHIF. The majority of the index patients who registered were women.

| INDICATOR TITLE: NUMBER OF HIV-POSITIVE PEOPLE IN SUPPORT GROUPS | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | October - December 2013 | | January – March 2014 | | April – June 2014 | | July – September 2014 | | | | FY 2014 Target | | End of project Target | |
| | Achieved | | Achieved | | Achieved | | Achieved | | Target | | Target | | Target | |
| Gender; W(women), M(Men) Per County | W | M | W | M | W | M | W | M | W | M | W | M | W | M |
| **Bungoma** | 3349 | 2376 | 2851 | 1397 | 3475 | 1247 | 2351 | 869 | 3500 | 1200 | 4900 | 1900 | 8000 | 1300 |
| **Busia** | 4025 | 1824 | 4313 | 2227 | 4165 | 1934 | 4996 | 2417 | 2600 | 1350 | 4400 | 2500 | 14000 | 7600 |
| **Elgeyo Marakwet** | 638 | 271 | 408 | 144 | 378 | 155 | 394 | 139 | 500 | 200 | 1000 | 400 | 3000 | 1000 |
| **Kisumu** | 1068 | 840 | 967 | 445 | 1195 | 811 | 1530 | 1191 | 800 | 500 | 1200 | 900 | 5000 | 3000 |
| **Nandi** | 516 | 257 | 426 | 198 | 612 | 312 | 609 | 267 | 500 | 200 | 900 | 400 | 3000 | 1000 |
| **Trans Nzoia** | 2303 | 960 | 846 | 689 | 1409 | 614 | 1943 | 673 | 1000 | 800 | 1500 | 1000 | 5000 | 3000 |
| **Uasin Gishu** | 5056 | 3054 | 3065 | 1457 | 4767 | 2159 | 4539 | 2318 | 2850 | 1450 | 5400 | 2800 | 14200 | 7800 |
| **West Pokot** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 300 | 100 | 1500 | 1000 |
| **Total** | 16955 | 9582 | 12876 | 6557 | 16001 | 7232 | 16362 | 7874 | 11350 | 5400 | 18600 | 8500 | 50500 | 23900 |

| INDICATOR TITLE: NUMBER OF PATIENTS AND BENEFICIARIES ENROLLED ON NHIF | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COUNTY | Baseline | | **October - December 2013** | | | | **January – March 2014** | | | | **April – June 2014** | | | | **July – September 2014** | | | | FY 2014 Target (1,000) | | End of Project Target | |
| | Q4 Sept13) | | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | | Target | | Target | |
| ***Gender*** | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M |
| BUNGOMA | 720 | 294 | 504 | 216 | 330 | 265 | 504 | 216 | 495 | 435 | 504 | 216 | 405 | 565 | 504 | 216 | 190 | 250 | 2016 | 864 | | |
| BUSIA | 960 | 145 | 1512 | 648 | 285 | 135 | 1512 | 648 | 335 | 160 | 1512 | 648 | 275 | 160 | 1512 | 648 | 305 | 210 | 6048 | 2592 | | |
| ELGEYO MARAKWET | 122 | 45 | 504 | 216 | 15 | 30 | 504 | 216 | 15 | 10 | 504 | 216 | 15 | 10 | 504 | 216 | 30 | 10 | 2016 | 864 | | |
| KISUMU | 191 | 30 | 252 | 108 | 0 | 0 | 252 | 108 | 40 | 10 | 252 | 108 | 55 | 25 | 252 | 108 | 90 | 20 | 1008 | 432 | | |
| TRANS-NZOIA | 780 | 95 | 504 | 216 | 360 | 265 | 504 | 216 | 435 | 260 | 504 | 216 | 790 | 650 | 504 | 216 | 845 | 465 | 2016 | 864 | | |
| UASIN GISHU | 1650 | 255 | 1512 | 648 | 945 | 540 | 1512 | 648 | 600 | 375 | 1512 | 648 | 420 | 230 | 1512 | 648 | 645 | 360 | 6048 | 2592 | | |
| NANDI | | | | | 40 | 15 | | | 15 | 15 | | | 25 | 0 | | | 15 | 5 | | | | |
| Total | **4423** | **864** | **4788** | **2052** | **1975** | **1250** | **4788** | **2052** | **1935** | **1265** | | | **1985** | **1640** | | | **2090** | **1315** | | | | |

**Result Area 1.4: HIV care and support - Orphans and Vulnerable Children**
**Intermediate Result 1.4.1: Provide quality OVC services within designated AMPATH*plus* catchments**
**Expected Outcomes: Self-supportive families of OVCs no longer needing direct services to provide a nurturing environment.**

All of the efforts of the OVC program go into improving the quality of life and meeting the basic needs of OVC. As seen in the table below, 75% of OVC received support at least 3 of the core areas, and 25% received support in fewer than 3 core areas.

| **INDICATOR TITLE: NUMBER OF CHILDREN RECEIVING SERVICES IN A) AT LEAST 3 OF THE CORE AREAS, AND B) IN FEWER THAN 3 AREAS** | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Baseline** | | **October - December 2013** | | | | **January – March 2014** | | | | **April – June 2014** | | | | **July – September 2014** | | | | FY 2014 Target | | End of Project Target | |
| | **Q4 Sept13)** | | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | | Target | | Achieved | | Target | | Target | |
| Gender | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M |
| Bungoma | a)865<br>b)199 | a) 870<br>b)249 | a)873<br>b)212 | a)882<br>b)264 | a)872<br>b)193 | a)883<br>b)238 | a)881<br>b)225 | a)894<br>b)279 | a)878<br>b)198 | a)886<br>b)250 | a)878<br>b)198 | a)886<br>b)250 | a)889<br>b)240 | a)895<br>b)240 | a)900<br>b)300 | a)900<br>b)300 | a)991<br>b)245 | a)1006<br>B)300 | a)900<br>b)300 | a)900<br>b)300 | a)1100<br>B)500 | a)1100<br>B)500 |
| Busia | | | | | | | | | | | | | | | | | a)10<br>b)10 | a)15<br>B10 | | | | |
| Kisumu | | | | | | | | | | | | | | | | | a)28<br>b)28 | a)22<br>B)26 | | | | |
| Elgeyo Marakwet | a)1112<br>b)730 | a)1010<br>b)839 | a)1124<br>b)747 | a)1022<br>b)854 | a)1534<br>b)134 | a)1505<br>b)133 | a)1136<br>b)764 | a)1034<br>b)869 | a)1143<br>b)124 | a)1116<br>b)117 | a)1143<br>b)124 | a)1116<br>b)117 | a)1944<br>b)274 | a)1934<br>b)307 | a)1600<br>b)300 | a)1600<br>b)300 | a)1690<br>b)244 | a)1658<br>b)256 | a)1600<br>b)300 | a)1600<br>b)300 | a)1400<br>b)900 | a)1400<br>b)900 |
| Nandi | a) 453<br>b)230 | a) 458<br>b)247 | a) 464<br>b)247 | a) 468<br>b)265 | a)455<br>b)230 | a)461<br>b)252 | a) 475<br>b)264 | a)478<br>b)283 | a)456<br>b)229 | a)463<br>b)252 | a)456<br>b)229 | a)463<br>b)252 | a)461<br>b)231 | a)475<br>b)248 | a) 500<br>b)350 | a) 500<br>b)350 | a)461<br>b)233 | a)478<br>b)248 | a) 500<br>b)350 | a) 500<br>b)350 | a)800<br>b)400 | a) 800<br>b)400 |
| Trans Nzoia | a)4270<br>b)2969 | a 4431<br>b)3020 | a)4277<br>b)2979 | a)4443<br>b)3042 | a)4526<br>b)2604 | a)4511<br>b)2766 | a)4284<br>b)2989 | a)4457<br>b)3064 | a)4552<br>b)2620 | a)4530<br>b)2777 | a)4552<br>b)2620 | a)4530<br>b)2777 | a)4281<br>b)2458 | a)4279<br>b)2592 | a)4550<br>b)2500 | a) 4550<br>b)2500 | a)4683<br>b)2429 | a)4671<br>b)2538 | a)4550<br>b)2500 | a) 4550<br>b)2500 | a)5000<br>b)3000 | a)5000<br>b)3000 |
| Uasin Gishu | a)1367<br>b)263 | a)1343<br>b)298 | a)1375<br>b)277 | a)1357<br>b)311 | a)1367<br>b)26 | a)1343<br>b)28 | a)1383<br>b)291 | a)1371<br>b)324 | a)1367<br>b)26 | a)1343<br>b)28 | a)1367<br>b)26 | a)1343<br>b)28 | a)1440<br>b)187 | a)1491<br>b)164 | a)1450<br>b)350 | a)1450<br>b)350 | a)1463<br>b)202 | a)1492<br>b)200 | a)1450<br>b)350 | a)1450<br>b)350 | a)1600<br>b)500 | a)1600<br>b)500 |
| West Pokot | a)1504<br>b)211 | a)1504<br>b)226 | a)1516<br>b)233 | a)1516<br>b)244 | a)1399<br>b)31 | a)1466<br>b)36 | a)1528<br>b)255 | a)1528<br>b)258 | a)1399<br>b)43 | a)1465<br>b)50 | a)1399<br>b)43 | a)1465<br>b)50 | a)1430<br>b)201 | a)1564<br>b)184 | a)1400<br>b)300 | a)1400<br>b)300 | a)1458<br>b)215 | a) 1583<br>b)188 | a)1400<br>b)300 | a)1400<br>b)300 | a)1800<br>b)500 | a)1800<br>b)500 |

**Result Area 2: Reduce maternal, neonatal and child mortality**
**Intermediate Result 2. 1.: Pregnant women testing HIV positive and their infants identified early and referred for care**
**Expected Outcomes: Reduce maternal-to-child transmission by <3% annually within selected catchments**

There was a slight drop in the number of pregnant women with known HIV status (including those tested for HIV and received results) in the quarter **31,214**were reported as compared to ***32269***in Q3 but surpassed the target. There was a marked increase in the proportion of women on antiretroviral prophylaxis: Q4 73.62% (776/1054) compared to Q3 60.60% (723/1193). Of note, the percent of HIV-positive pregnant women provided with anti-retroviral to reduce the risk of mother to child transmission during pregnancy & delivery in Nandi county is quite low (47.62%). This is due to the fact that once HIV +ve women are identified in the MCH, they are referred to the CCC for intervention and thereafter there is no mechanism of feedback back to the MCH, for documentation in the registers and this was confirmed during the data verification exercise

| **INDICATOR TITLE: NUMBER OF PREGNANT WOMEN WITH KNOWN HIV STATUS (INCLUDING WOMEN WHO WERE TESTED AND RECEIVED RESULTS)** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ***Baseline Q4 30/Sept/13*** | **October - December 2013** | **January – March 2014** | | **April – June 2014** | | **July – September 2014** | | ***FY 2014*** | ***FY 2015 Target*** | | ***End of Project Target*** | |
| | | ***Achieved*** | ***Target*** | ***Achieved*** | ***Target*** | ***Achieved*** | ***Target*** | ***Achieved*** | ***Target*** | ***Target*** | | ***Target*** | |
| ***County*** | ***30172*** | ***20333*** | ***32942*** | ***31625*** | ***32943*** | ***32269*** | ***32943*** | ***31214*** | ***131770*** | *TBD* | | *TBD* | |
| *Bungoma* | | *1754* | 3768 | 3205 | 3768 | 2954 | 3768 | 3570 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *Busia* | | *3105* | 4971 | 4919 | 4971 | 4565 | 4971 | 4710 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *Elgeyo Marakwet* | | *2795* | 4629 | 3131 | 4629 | 3801 | 4629 | 4386 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *Kisumu (Maseno division)* | | *249* | 288 | 187 | 288 | 261 | 288 | 273 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *Nandi (Kosirai Division)* | | *277* | 413 | 388 | 413 | 322 | 413 | 391 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *Trans Nzoia* | | *3584* | 5863 | 7119 | 5863 | 6219 | 5863 | 5555 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *Uasin Gishu* | | *4808* | 7638 | 8602 | 7638 | 9055 | 7638 | 7238 | | *TBD* | *TBD* | *TBD* | *TBD* |
| *West Pokot* | | *3761* | 5373 | 4074 | 5373 | 5092 | 5373 | 5091 | | *TBD* | *TBD* | *TBD* | *TBD* |

| INDICATOR TITLE: PERCENT OF HIV-POSITIVE PREGNANT WOMEN PROVIDED WITH ANTIRETROVIRALS TO REDUCE THE RISK OF MOTHER-TO-CHILD HIV TRANSMISSION DURING PREGNANCY AND DELIVERY | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline Q4 30/Sept/13 | October - December 2013 | January – March 2014 | | April – June 2014 | | July – September 2014 | | FY 2015 | End of Project |
| | | Achieved | Target | Achieved | Target | Achieved | Target | Achieved | Target | Target |
| **County** | **60.21% 808/1342** | **64.18% (706/1100)** | **93%** | **75.76% (1366/1803)** | **93%** | **60.60% (723/1193)** | **93%** | **73.62% (776/1054)** | TBD | TBD |
| Bungoma | | 73.33% (33/45) | 93% | 73.12% 68/93 | 93% | 75.00% (51/68) | 93% | 61.76% (63/102) | | |
| Busia | | 78.30% (184/235) | 93% | 92.44% (330/357) | 93% | 90.14% (256/284) | 93% | 70.81% (228/322) | | |
| Kisumu (Maseno division) | | 88.46% (46/52) | 93% | 96.42 (81/84) | 93% | 85.98% (92/107) | 93% | 102.08% (49/48) | | |
| Elgeiyo Marakwet | | 60.81% (45/74) | 93% | 68.33% (41/60) | 93% | 79.17% (57/72) | 93% | 74.44% (67/90) | | |
| Nandi (Kosirai Division) | | 63.16% ( 12/19) | 93% | 81.25% (13/16) | 93% | 100.00% (10/10) | 93% | 47.62% (10/21) | | |
| TransNzoia | | 68.67% (114/166) | 93% | 70.15% (141/201) | 93% | 68.88% (135/196) | 93% | 76.33 (129/169) | | |
| Uasin Gishu | | 64.25% (230/358) | 93% | 78.35% (322/411) | 93% | 84.69% (249/294) | 93% | 77.20% (193/250) | | |
| West Pokot | | 88.46% (46/52) | 93% | 96.67% (29/30) | 93% | 85.00% (34/40) | 93% | 71.15% (37/52) | | |

## Result Area 2: Reduce maternal, neonatal and child mortality

**Intermediate Result 2.2.1: Pregnant women and their infants identified early and referred for care as needed.**
**Expected Outcomes: Maternal, infant, and child mortality decreased by 50% within 5 years within selected catchments.**

The percent of women having 4 ANC visits increased from 61% last quarter to 65.7% this quarter against a target of 50% and 60% depending on the county. Kisumu West sub-county registered an impressive 95.4% while Elgeyo Marakwet still has challenges at 48.8%. The percent of women delivering with a skilled provider went up from 51.5% in quarter 3 to 60.1% this quarter. This is on target and in agreement with the Presidential Monitoring report that was released in October, 2014 indicating a country-wide rise of facility delivery from 30% to 60% following the roll out of free maternity services. The number of children below 5 years with diarrhea who received ORT was 25,871 in quarter 3 but increased to 36,244 this quarter. This was above target of 7,000, which we believe was too low. Elgeyo Marakwet County contributed the highest figure at 7,388 and Kisumu West 860, which cannot be compared since these are absolute figures that reflect the catchment population but not the prevalence of diarrhea cases. The program noted an increasein CYP from 22,011 in quarter 3 to 34,720 this quarter. On the other hand, there was improvement in FP commodities reporting rates from 61.5% in the last quarter to 62.4% this quarter, although below the expected target of 80%. Nandi, West pokot, Busia and Bungoma Counties all recorded at least 80% while Elgeyo Marakwet, Trans Nzoia, Kisumu West and Uasin Gishu Counties were still below target as at end of September 2014. Timeliness of FP reporting increased to 60.7% from 49% in quarter 3.

| INDICATOR TITLE: PERCENT OF WOMEN ATTENDING 4 ANC VISITS | | | | | | |
|---|---|---|---|---|---|---|
| **UNIT** | **DISAGGREGATE BY:** Location, event, date and gender | | | | | |
| Percent of women attending 4 ANC visits | **Geographic Location** | **Activity Title** | **Date** | **W** | **M** | **Subtotal** |
| | Mt. Elgon Sub county | ‘’Community health Volunteers integrated MCH/FP/PMTCT refresher training’’ | 18th to 25th August | **129** | **89** | **218** |
| | TransNzoia West sub county | ’Community health Volunteers integrated MCH/FP/PMTCT refresher training’’ | 15th to 26th September 2014 | **32** | **28** | **60** |
| | West Pokot sub county (Pokot North and west Pokot Sub-counties) | ’Community health Volunteers integrated MCH/FP/PMTCT refresher training’’ | 1st to 5th September 2014 | **31** | **29** | **60** |
| | Bungoma, TransNzoia and Busia counties | BEmONC training | 4th August- 29th September | **49** | **150** | **199** |
| | **Totals** | | | **241** | **296** | **537** |

**Results:**

| | Baseline | Results in Prior Periods | This Reporting Period 30-Sep-14 | | Reporting Period 31-Dec-14 | Reporting Period 30-Mar-15 | Reporting Period 30-Jun-12 | FY 2013 Target | FY 2014 Target | End of Activity Target |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **Achieved** | **Target** | **Achieved** | **Target** | **Target** | **Target** | **Target** | **Target** | **Target** |
| Bungoma (Bungoma East and Mt.Elgon ) | 43.8% | 42% (892) | 50% | 45.2% (944) | 50% | 50% | 50% | 50% | 50% | 50% |
| Busia (Teso North, Bunyala and Butula) | 43.8% | 76.5% (1,858) | 60% | 78.8% (2,143) | 60% | 60% | 60% | 60% | 60% | 60% |
| Elgeyo Marakwet | 43.8% | 51.7% (1,211) | 50% | 48.8% (1,262) | 50% | 50% | 50% | 50% | 50% | 50% |
| Kisumu (Kisumu West) | 59.9% | 82% (722) | 50% | 95.4% (815) | 50% | 50% | 50% | 50% | 50% | 50% |
| Nandi (Chesumei) | 43.8% | 35.7% (190) | 50% | 67.2% (302) | 50% | 50% | 50% | 50% | 50% | 50% |
| Trans Nzoia | 43.8% | 64.8% (2,090) | 60% | 64.4% (1,161) | 60% | 60% | 60% | 60% | 60% | 60% |
| Uasin Gishu | 43.8% | 83.2% (3,658) | 50% | 59.1% (3,138) | 50% | 50% | 50% | 50% | 50% | 50% |
| West Pokot | 43.8% | 56.2% (1,100) | 50% | 66.4% (1,161) | 50% | 50% | 50% | 50% | 50% | 50% |
| **Summary** | **43.8%** | **61.5% (11,721)** | **60%** | **65.7% (10,926)** | **60%** | **60%** | **60%** | **60%** | **60%** | **60%** |

| INDICATOR TITLE: NUMBER OF CHILDREN <5 YEARS WITH DIARRHEA, WHO RECEIVED ORT | | | | | | |
|---|---|---|---|---|---|---|
| **UNIT** | **DISAGGREGATE BY:** Location, event, date and gender | | | | | |
| **Number of children <5 years with diarrhea, who received ORT** | **Geographic Location** | **Activity Title** | **Date** | **W** | **M** | **Subtotal** |
| | Busia County (Matayos sub-county) | 'Maternal Infant and young child nutrition' | 15-19 Sep 2014 | **47** | **12** | **59** |
| | TransZoia County (West, East and Kwanza sub-counties) | 'Maternal Infant and young child nutrition' | 18th Aug | **39** | **21** | **60** |
| | Bungoma County (Bungoma East and Mt. Elgon) | 'Maternal Infant and young child nutrition' | 25TH August-30th August | **36** | **11** | **47** |
| | Mt. Elgon Sub county | ''Community health Volunteers integrated MCH/FP/PMTCT refresher training'' | 18th to 25th August | **129** | **89** | **218** |
| | TransNzoia West sub county | 'Community health Volunteers integrated MCH/FP/PMTCT refresher training'' | 15th to 26th September 2014 | **32** | **28** | **60** |
| | West Pokot sub county (Pokot North and west Pokot Sub-counties) | 'Community health Volunteers integrated MCH/FP/PMTCT refresher training'' | 1st to 5th September 2014 | **31** | **29** | **60** |
| | **Totals** | | | **314** | **190** | **504** |

**Results:**

| | Baseline | Results in Prior Periods | This Reporting Period 30-Sep-14 | | Reporting Period 31-Dec-14 | Reporting Period 30-Mar-15 | Reporting Period 30-Jun-12 | FY 2013 Target | FY 2014 Target | End of Activity Target |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **Achieved** | **Target** | **Achieved** | **Target** | **Target** | **Target** | **Target** | **Target** | **Target** |
| Bungoma (Bungoma East and Mt.Elgon ) | 7,899 | 1,829 | 7,000 | 1,382 | 36,000 | 36,000 | 36,000 | 28,000 | 28000 | 84,000 |
| Busia (Teso North, Bunyala and Butula) | | 3,152 | | 4,105 | | | | | | |
| Elgeyo Marakwet | | 5,466 | | 7,388 | | | | | | |
| Kisumu (Kisumu West) | | 178 | | 860 | | | | | | |
| Nandi (Chesumei) | | 481 | | 1,298 | | | | | | |
| Trans Nzoia | | 3,726 | | 4,933 | | | | | | |
| Uasin Gishu | | 6,188 | | 7,300 | | | | | | |
| West Pokot | | 4,851 | | 8,978 | | | | | | |
| **Summary** | **7, 000** | **25,871** | **7,000** | **36,244** | **36,000** | **36,000** | **36,000** | **28,000** | **28,000** | **84,000** |

# IV. CONSTRAINTS AND OPPORTUNITIES

A lack of MOH registers for HTC outreaches particularly the MOH 362 registers for PHCT outreaches was a major challenge. This was caused by the high demand based on monthly consumption in PHCT and this has compelled the program to resort to photocopies which are difficult to be properly stored or monitored. Implementation of Healthy Choices for a Better Future could not start as planned because of lack of a formal communication at the County level between the Ministry of Health and the Ministry of Education on implementation of the intervention. A lot of time was dedicated to pursue this matter and as at the time of this reporting, NASCOP had not given a formal response on the position. During implementation of Respect-K intervention, most clients require a lot of follow up for them to honor their second appointment and this becomes a challenge in achieving the risk reduction plan.

A lack of birth and death certificates affects provision of OVC services in central Pokot Sub County. To address this challenge, we collaborated with the ministry of interior and national coordination in sensitizing the community on the importance of having births and deaths registered. The exercise is still ongoing in the project areas. High level of stigma and long distances to the health facilities affected OVC clients adherence to treatment in some areas. We have worked closely with the Ministry of Health to identify independent locations where the clients could easily access drugs, for example three health facilities where the clients are taking drugs were identified in Pokot central sub-county, including Sigor, Lomut and Marich.

We continue to witness loss of the gains we had made through the rigorous community strategy program. Community health volunteers are minimally engaging households in health related activities. Community reporting rates are on a decreasing trend with only **30%** of all the community units across AMPATHplus catchment reporting (41.5% reported in Quarter 1, 51.1% reported in quarter and 47.5% of all the community units reported in quarter 3). The MCH team is currently discussing with the Counties with the view of finding possible strategies to ensure increased and improved community data collection and reporting. Community MCH/FP refresher trainings will also be carried out to update CHVs. MCH/FP progress is heavily determined by the focus by counties on MCH/FP priorities and by the much resources allocated to health in general and MCH/FP in particular. Most counties are still focusing a lot on building or expanding hospitals as well as buying special medical equipment at the expense of primary health care facilities. This means that the gains at Primary Health Care level are minimal yet according to the USAID gender equality and female empowerment policy, maternal deaths could be reduced by 70%, and newborn deaths by nearly 50% if the investment in MCH/FP doubled.

The lack of lab consumables affected the ordering of monitoring tests by clinicians in turn affecting the quality of care of patients. There has been lack of EDTA tubes for collection of CD4 samples and unavailability of needles for VL sample taking. Some tests that were previously catered for by the program are not so any more and few patients are able to pay for them out of pocket. These include full hemogram, LFTs, and UECs.

The public private partnership program has enabled the expansion of HIV care and treatment. The pharmacy department faced various challenges during the reporting period. One of the challenges is late submission of monthly reports from the facilities which do not file their reports directly to Kenya Pharma. We have been working hard to resolve this and we hope in the coming year, more facilities will have computers and will key in their own reports. We were also not able to rollout the ITT to the targeted 20 facilities due to staffing constrains in Eldoret (due to annual leaves).

# V. PERFORMANCE MONITORING

Performance assessment is an ongoing requirement for all PITC implementers which continue to improve on quality. AMPATH's reference Laboratory continues to supervise on Q/A. Also HTC support supervision sessions as a quality assurance check were enhanced to take care of counselor burnout gaps and misconceptions so that quality performance is ensured. In the MOH Sites this activity is supervised by the Sub-county MLT together with the CASCOs. During the month of September, this program was privileged to undergo a USG quality assessment and areas that required improvement were noted and to be improved on in the 2015 year. PHCT Counsellor Supervisors randomly visited each Counsellor for Observed Practice session with a client(s). This helps ensure that the testing protocols are observed and standards maintained. Several spot checks were also done by the supervision team to ensure quality data is collected by Counselors.

We were able to perform externally observed stock takes in facilities in all the counties. This was done in coordination with the pharmacy and facility in-charges. Variances between the physical stocks and the bin card balances were explained before the reports were sent to us. Observed stock takes will be done quarterly while facility stock takes will continue to be done monthly. During the last month of the quarter, we visited Uasin Gishu District Hospital for a random check. The facility has been having challenges especially regarding staffing and preparation of reports. The facility has recently been lacking skilled staff at the pharmacy. Discussions are ongoing to get the county to get a permanent solution.

Clinical mentorship continued through the programs' medical officers, consultants, county coordinators and supervisors. Continuous quality checks were done through the printing of patient summary sheets to assist in pointing out any discrepancies with lab results and regimens patients are on. Data department tags and returns to each clinic incomplete or inconsistent encounter forms for clinicians to make corrections before they are sent back to data for entry into the electronic medical records. Bimonthly supervisory visits were carried out by supervisors in all operation sites during the quarter and prepared supervisory reports. Management supervisory visits were carried out during the quarter.

Safety Net Officers stationed in the various sites submit monthly reports on activities done in their respective sites during that month using structured reporting tools. These reports are collated and data from the reports is entered into a database and analysis of the same is done as per the needs of the audience. Supervision meetings and service delivery monitoring home visits and planned support supervision visits are also done. **In the support groups, s**upervisors sample 20% of weekly reports by staff from each site on a monthly basis for quality checks. Supervisors visit sites bimonthly and sit in support group sessions to asses and evaluate the performance of staff in group facilitation and the participation and growth of members. Quality Improvement teams have also played a key role in monitoring. This is because the teams are geared towards achieving goals which are in the work plan. They meet monthly and give feedback continuously.

In this quarter, the PMTCT team combined efforts with the central reporting/M&E teams to mount a data verification exercise across the counties under AMPATH Plus coverage. The targeted facilities were those that had previously reported less than 80% of HIV+ pregnant women put on ART, and with high positivity rates in ANC/L&D. The exercise resulted in harmonization of MOH primary data sources and reporting tools through registers' verification and subsequent reconstruction of data for the period beginning October 2013 and August 2014. During this quarter there was mapping of PMTCT facilities to verify the services offered and the actual support received at each facility.

Re training of Health workers in all the counties except Uasin Gish County was done to ensure accurate and complete capture of data at the Facility Level to the County level. The program also supported Sub County Data review meetings on a quarterly basis and this has improved the completeness and reporting rates within the AMPATHplus catchment.

Following the rigorous training to update counties on EMONC scale up data collection processes in quarter 3 by MCH team and Measure Evaluation PIMA, Busia and TransNzoia Counties carried out baseline data collection in 62 facilities. The aim of the exercise was to assess the preparedness and functionality of the facilities in providing BEMONC services. Analysis of the data was carried out independently by the County health management teams and again by AMPATHplus MCH. Results were then disseminated and action plans drafted by the county teams. These action plans have been submitted to USAID through Measure Evaluation PIMA. Working closely with USAID Assist, the AMPATHplus quality improvement team has trained all the County coordinators and selected health care workers in Busia County which is an MCH RRI sites. The quality improvement training laid a lot of emphasis on BEmONC related indicators. Some of the indicators that Busia County will be closely tracking following the training include:

-% of pregnant women in the catchment area completing at least 4 ANC visits per month
-% of skilled deliveries in the catchment area per month
-% of women aged 15-49 receiving Long acting or permanent methods of FP.

The lab participated in External Quality Assurance. Successful participation in Inter lab Proficiency Cycle 2 meeting between CDC/KEMRI Kisumu, and Walter Reed Kericho. In addition they participated in **Internal lab Quality Assurance for every testing activity in the lab.**

# VI. PROGRESS ON GENDER STRATEGY

Training reports were disaggregated by gender to allow a reflection of whether there was fair representation. We support access to FP services for both male and female with the policy of Freedom of informed Choice, which minimizes the unmet need for contraception. Scaling up FP trainings and ensuring regular supply of FP commodities has gone a long way in the implementation of this strategy. An increase in CYP is the evidence for this strategy. We do not have strategies that directly support interventions on Gender Based Violence and Female Genital Mutilation. We have build partnerships across a wide range of stakeholders for example the School Health Program and WASH by the Ministry of education and Agri-Nutrition integration with one notable seminar in Trans Nzoia County. MCH/FP innovations that integrate microfinance in Bunyala Sub-County of Busia County have not just improved our indicators remarkably among the recruited women, but has aslo improved their socioeconomic status. More MCH/FP outreaches were and still will be tailored to the needs of the hard-to-reach and crisis- and conflict-affected areas like West Pokot, Elgeyo Marakwet and Mt. Elgon.

# VII. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

IEE team conducting site visit to the MTRH incinerator on 22nd August 2014

In this quarter there was an environmental audit conducted by USAID and USAID contracted consultants to establish the state of biohazard waste management, challenges, monitoring and mitigation strategies employed by the AMPATH program. The adherence of provided statutory requirements, standard operating procedures (SOPs), Environmental management and coordination act of 2007 (EMCA), waste management, public health act and national waste management policy implementation was also audited. The team also conducted site visits to the MTRH incinerator.

**Site visit findings:**

Waste segregation is being done routinely by HCWs, the staff separate waste according to the hazardous nature that improves the handling process, transportation and final disposal.

Color coding of waste receptacles- receiving waste receptacles were color coded to meet the international code like Red receptor for highly hazardous waste, Yellow for general hazardous and black for non hazardous waste.

Sharp containers- provision of sufficient non puncturable plastic containers to departments to be used for sharp disposal and compliance to three quarter rule of filling and disposal of the sharps and container by incineration.

Collection schedules- the program has adopted three times a day collection schedule of waste generated to reduce the time of waste handling which meets the international requirement of infection control.

Disposal- the program utilizes the MTRH incinerator which operates optimally at 1100 degrees centigrade that is as per national and international requirement of bio hazardous waste disposal

Establishment of IEE committee- the program put in place an all inclusive committee to oversee the smooth running of these activities with representatives from Laboratory, Pharmacy, Public health, Training, the secretariat chair and the chief of party.

**Challenges**

Capacity building-the program requires training of IEE secretariat members who will then train other members of staff on management of bio hazardous waste and environmental mitigation

Staffing- the program currently engages one public health officer to oversee all these activities in all counties in coordination with county coordinators. There is need for additional public health officers.

Waste receptors and consumables- there is an acute shortage of bio hazardous waste consumables which includes liners and dust bins especially in AMPATH supported sites outside MTRH.

Incinerators- the program requires a number of incinerators. Some facilities do no have incinerators and there is no funding to support construction. These facilities dispose their hazardous waste by burning and burying in deep pits that may not comply with the USAID regulations on waste management

**Conclusion**

The AMPATH program adheres to national and international requirements of bio hazardous waste management without prejudice to the environment by putting safeguards through mitigation measures and implementation of SOPs, national policy on waste management, statutory requirement in relevance to the GOK Act i.e. Public health act CAP 242 and EMCA 2006 (Waste management)

# VIII. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

We continued to partner with Measure Evaluation PIMA in carrying out baseline data collection on EmONC in Busia and TransZoia counties. Measure Evaluation PIMA also attended all our results dissemination meetings in these counties. During this quarter, the MCH team joined the wider AMPATHplus program staff in training by USAID ASSIST on quality improvement. Two mid-wives and four managers received the training. We continued with our MCH/FP advisory role to Health Right International. We continue working together with Kenya Pharma to ensure completeness, accuracy and timeliness of monthly reports to guarantee consistent supply of antiretroviral drugs in the facilities within AMPATH's catchment area. We are also working with county staff and other program officers to streamline drugs use.

# IX. PROGRESS ON LINKS WITH GOK AGENCIES

We continue to work closely with pharmacists working in the (MOH) facilities to strengthen existing structures required for smooth delivery of pharmacy services. In several facilities the pharmacy staff are deployed in both the CCC and hospital pharmacies. Over 600 community based AIDS support groups have been linked with the National Aids Control Council (NACC) for complementary support in the community. We participated in numerous MOH Technical Working Group Meetings (PMTCT, Evidence-based Interventions), county data review meetings, commodity reporting sessions, and MOH guidelines reviews (HTC, HIV data collection and reporting tools), and NASCOP forums (roll-out of new therapeutic guidelines, national M&E conference).

# X. PROGRESS ON USAID FORWARD

Nothing to report.

# XI. SUSTAINABILITY AND EXIT STRATEGY

To ensure that services continue seamlessly when AMPATH exits, we still continue to work closely with pharmacists working in the (MOH) facilities strengthen existing structures required for smooth delivery of pharmacy services. In several facilities the pharmacy staff are deployed in both the CCC and hospital pharmacies. Support groups continue to benefit from complementary support from stakeholders providing services in the community and are currently managing sustainable income generating activities. Psychosocial support is focusing on building the capacity of community based support groups and linking clients to sources of complementary support in the community which can enhance sustainability of HIV care programs. In the last quarter, 15 community based care groups were linked to both National and County government agencies that provide financial and social related support to vulnerable and needy people hence boosting their livelihood sources. Community participation in care and support is a critical sustainability and exit strategy for AMPATH. Through groups, communities were mobilized

and encouraged to participate in healthcare related activities such as enrollment to health insurance schemes, sanitation and behavior change among others. Through groups, clients are able to mobilize own resources to address pressing economic challenges hence being sustainable. GISE is an example of such strategy which is a form of Village Saving model (Table Banking). GISE groups that have been able to mobilize some reasonable funds have been linked to more structured microfinance institutions and banks to access more loans for expanding their business and buying of farm inputs in bulk. GESPs ensure group follow ups and are given a stipend by the same groups – GESPs are trained as TOT by FPI so as to deliver GISE activities in their community. Involving immediate family members in care and support of vulnerable clients ensures sustainability beyond program cycle. Currently, all vulnerable clients' immediate family members are fully involved in care through regular home visits and trainings on care needs and challenges. Formation of Agri nutritional clubs through schools involving teachers, pupils and caregivers is a new strategy which has been embraced in all counties. The OVC program supports needy children from child headed households and total orphans through college and tertiary institutions to ensure they gain skills that can enable them meet their needs and support their siblings. The fourth quarter saw AMPATH launch Zuri insurance product in Teso North Sub County. The quarter also saw NHIF opening a bank account to collect the Zuri premiums, this account was linked to the M-Pesa till numbers 805789 for Malaba, 805792 for Kocholya, 805787 for Port Victoria, 805793 for Mukhobola and 805788 an extra till. The scheme started collecting premiums on 3rd October 2014 and has collected Ksh **44,313** (forty four thousand three hundred and thirteen) as at 28th October from clients in all the four sites. The Zuri team has 5volunteers working in the four facilities. The team plans to use group care model to engage members of the public. So far the team has held meetings with Truck drivers, Maendeleo ya wanawake, bodada riders association, beach management units, commercial sex workers, and matatu operators in a bid to boost the numbers. The team is also sending periodic sms messages to all people who left contacts reminding them to enroll and pay. AMPATH, Busia county and NHIF anticipate top receive their first client on 3rd December 2014, they are in the process of preparing staff working in AMPATH and MOH in these facilities to ensure quality service is availed to the patients. The RFP team is working hard to stock all pharmacies with the much required drugs and non-pharmaceutical supplies.

# XII. GLOBAL DEVELOPMENT ALLIANCE (IF APPLICABLE)

Not applicable.

# XIII. SUBSEQUENT QUARTER'S WORK PLAN

In the next quarter, the Prevention team will continue rolling out the implementation of selected EBIs and will also reach the targeted populations with prevention messages. Strengthening and expansion of community-based prevention programs will also be done.

In PITC, we intend to have trainings and RRI activities in all the 8 counties on the new Algorithm to scale up testing uptake in high volume facilities.

During the next quarter (Q1 2015), we intend to continue rolling out the ADT and ITT to more facilities. This will involve liaising with county governments to buy more computers since there are facilities without that need these and do not have them. This will ensure that more sites do their monthly reports more easily. We also intend to do comprehensive commodity trainings at the county level in liaison with county staff and other relevant partners in the counties.

# XIV. FINANCIAL INFORMATION

Financial Information.docx

# XVII. GPS INFORMATION

# XVIII. SUCCESS STORY GUIDELINES & PREP SHEETS

## Model Stories

MCH/FP: A village called Chemusian in Olare ward of Ainabkoi Sub County of Uasin Gishu County is home to approximately 4,000 people all evictees of Mau forest. Burnt forest health centre situated 11km away is their only closest facility thus affecting their health seeking behavior. Most under fives had not received immunizations and mothers were not accessing ANC, PNC and FP services. The area only has a single school serving its entire population leading to an environment of overcrowding which pose as danger to transmission of airborne illnesses. Despite wells being the only source of water for Chemusian village, most of the villagers are in areas with little access to water. Given minimal latrine coverage, there is rampant open defecation. Jiggers and scabies are also a common problem. Given this background, MCH/FP rolled out a massive outreach program for Chemusian on 18th September 2014. Amongst the people who were reached was a 5 year old girl who had never been immunized before because of in ability of the mother to reach the health facility due to distance. On the same day, 20 women were put on Implanon and 10 others received DMPA. Moving forward, this village will get targeted monthly outreaches and CHWs will be trained on MCH/FP to allow for prompt referrals.

Care and Treatment: PW* is a 38 year old male who tested positive for HIV while being treated at a private facility for recurrent respiratory infections and chronic gastroenteritis in February this year. He was then referred to AMPATH for enrolment into the HIV care and treatment program to which he vehemently refused owing to the stigma associated with attending an AMPATH clinic and also his socioeconomic status. He wanted to be seen at the same facility which at the time could not offer this service. Fortunately, with the public private partnership program the facility was able to include HIV care and treatment to its portfolio and PW* was finally enrolled into care in July this year. At enrolment he was assessed as WHO Stage 3 with a CD4 count of 256 and he was put on OI prophylaxis. He was then prepared for ART initiation and started treatment in August. He is currently doing well and has so far kept his appointments and confirms taking his medications well. He is very grateful for the program and that he can be seen in the comfort of his preferred health facility as he otherwise would not have been in care.

OVC: A 16 year old OVC girl had this to say during the distribution of sanitary pads and school bags in August, 2014, in West Pokot 'my grandmother was cutting small pieces of her old cotton dress to prepare them for me as I go back to school so that I use them as sanitary towel. This was really tensing me as i was not sure where to hide them so that my classmates and friends do not see them and despise me. Thanks to this support now I have a bag and sanitary towels. I feel like a real student ready to go back to school and face the tough third term classes without worries'.

Social Work: Poor and vulnerable clients often face stigma, rejection and hopelessness as a result of their status. Mary is an example of such clients who are daily assessed, counseled and supported through various interventions by social workers and other safety net staff. Mary started medication at Busia CCC in March 2012 upon losing her four children and her husband to HIV/AIDS related complications. She faced a lot of difficulties in the initial six months due denial, stigma and discrimination. Her in- laws, and other immediate family members sent her away for fear of incurring huge medical and burial expenses in case of her death . She enrolled in the AMPATH food support program, rented a house and given k.sh 300 to start a small scale business. Currently, Mary has saved over 150,000/=, enrolled with NHIF, purchased a half acre land and is in the process of building a permanent house. She attends clinic without fail.

FPI: Genesis GISE Group shared out KES 1.1 million in August 2014. One lady who is an AMPATH client and a member of the group used her shareout money (KES 50,420) to add to her capital. She bought 1 point piece of land in the market center and bought a posho mill which she is now running the business.

Legal Aid:

**CRIMINAL CASE NO: 3194 OF 2013:** This is a prison matter. A brief summary of the complaint is that the accused person who is our client was charged with assault. LACE represented the accused person and on 17/10/2013 the case was withdrawn and the accused person acquitted under section 204 C.P.C.

**CHILDREN CASE NO: 82 OF 2012:** The client was referred to LACE by an AMPATH client. The nature of the complaint was that the Defendant herein had abdicated his parental responsibilities towards his child despite the fact that he is employed by Moi University as a Welder. A court order was issued in favour of our client. The defendant did not comply with the Court Order. Warrant of arrest was issued and executed upon which the defendant paid Kshs. 15,000/= leaving a balance of Kshs. 45,000/=. The paid monies were forwarded to our client for maintenances as per the court order.

**CRIMINAL CASE NO: 14 OF 2013:** This is a prison matter. A brief summary of the complaint is that the accused person who is our client was charged with neglecting children. LACE represented the accused person and the accused was pLACEd on probation for 12 months in pLACE of jail term.

**CRIMINAL CASE NO: 141 OF 2013:** This is a prison matter. A brief summary of the complaint is that the accused person who is our client was charged with assault. LACE represented the accused person and on 1/11/2013 the complainant withdrew the case.

**CRIMINAL CASE NO: 5136 OF 2012:** The client was referred to LACE by Moi Teaching & Referral – CAR-E Department. A brief summary of the complaint is that our client who is a minor aged 4 and ½ years had been defiled by a person well known to her (neighbor). LACE watched brief on behalf of the Complainant and judgment was delivered. The Perpetrator was sentenced to life imprisonment.

**CRIMINAL CASE NO: 34 OF 2012:** This is a prison matter. A brief summary of the complaint is that the accused person who is our client was charged with stealing. LACE represented the accused person and on 14/11/2013 the accused person was acquitted under section 202 of the CPC for lack of witnesses.

**CRIMINAL CASE NUMBER 3362/13:** Our client was charged with the offence of assault. She was remanded at the Eldoret G.K. prison after she denied the charges. She was represented in

court and on 20th January 2014, the case was withdrawn by the prosecution on grounds that the complainant had passed on. Our client was acquitted under section 87(a) of C.P.C

**CRIMINAL CASE NUMBER 4263/2013:** Our client was arrested and charged with the offence of House Breaking and stealing. L.A.C.E attorney took up the matter when she met the client remanded at the Eldoret G.K Prison after she could not manage to raise the bond terms. The attorney made an application to have the client admitted on a personal bond but the court declined stating that the nature of the offence our client was facing was serious to release her on personal bond. Our client was to be detained at the Eldoret G.K Prison awaiting trial and finalization of the case. On 17th January 2014, the court delivered its judgment and found our client was innocent and therefore acquitted her under section 215 of the C. P.C.

**CRIMINAL CASE No. 2744/13:** The accused person was charged with obtaining goods by false pretense contrary to section 313 of the penal code. A L.A.C.E attorney took up the matter when she met the client remanded at the Eldoret G.K Prison. LACE Attorney represented the accused and she pleaded not guilty and the case proceeded to trial. On 20/2/2014 judgment was delivered and our client was acquitted under section 215 of the criminal procedure code as the prosecution did not prove the case beyond reasonable doubt.

**CRIMINAL CASE NUMBER 1905/2013:** Our client was arrested and charged with the offence of cheating contrary to section 315 of the penal code but released on bond of Kshs. 50,000/-. Our client had earlier known about our office. She presented her matter in our office and L.A.C.E attorney took up the matter. On 16th October 2013, the matter came up for hearing but was adjourned to 10/2/2014 as to allow the prosecution regularizes their witness. On 10/2/214 our client was acquitted under section 210 of the C.P.C for lack of evidence.

**CRIMINAL CASE NUMBER 554/2013:** In this case, our client was charged with the offence of obtaining money by false pretense. She came in contact with LACE attorney when she was at the Eldoret G.K prison. LACE took up the matter and represented the client in court. The matter never proceeded for hearing as the complainant indicated to the court that he wished to withdraw the matter. Parties were given time to go and negotiate. On 28/2/2014, the complainant withdrew the case against our client and she was acquitted under section 204 of the C.P.C.

**PS:** This was a matter where the plaintiff within the period of 2005 to 2008, advanced the defendant a sum of Kshs 160,000. The defendant had only paid 10,000 and had thus remained with an outstanding balance of Kshs 150,000 which she had failed to pay despite several demands and defendant committing and requesting the plaintiff that she should be allowed to pay in installments. The matter was instituted in court and the defendant agreed in court to pay the debt in installments. The final installment was paid on 12.05.2014 and the matter was settled.

**GUARDIANSHIP:** This was a matter whereby our client is the grandmother of two minors who are orphans. She wanted to enroll the minors at her N.H. I. F card. LACE prepared an application for guardianship and custody of the two minors, because the mother of the minors was deceased and their father had disappeared and could not be traced. An order was granted and was issued on 13th May2014 where our client was appointed legal guardian and granted custody the minors

**R -VS- J. L :** The complainant aged 10 years was referred to us from CARE for legal advice. The minor was accompanied by her mother. The offender was the minor's step father. On the night of the defilement the minor's mother had gone to overnight vigil. The complainant was found to be HIV positive. LACE watched brief over the matter. The perpetrator was jailed for a term of ten years. The family was very grateful for justice brought by LACE office.

**S.N.W:** Our client was the defendant sued for rent areas amounting to Ksh 109,708/-. The plaintiff entered a sale agreement dated 19th May 2014 for the suit land Plot No.12 B (14/1356) Upper Elgon View a 1/8 plot for a consideration of ksh 500,000. Our client paid a Ksh 350,000 of the purchase price. Our client had a balance of ksh 150,000 of the purchase price. He occupied the suit land to date. The matter came for hearing and the L.A.C.E raised a preliminary objection premised on the lack of jurisdiction by the Tribunal. The Rent Restriction Tribunal held that the matter was erroneously before the court as it was a matter better pLACEd before the Environment and Land Court. The matte was dismissed for lack of jurisdiction.

**OUT OF COURT CASES**

**M.I:** This client was referred to us by one of our clients. A brief summary of the complaint is that our client had been employed as a pig attendant. The employer failed to pay our client her salary, hence arrears accumulated to Kshs. 20,000/-. Our client's employer turned hostile and evicted her from the staff houses when she demanded that she be paid her dues. LACE intervened by drafting a demand letter inviting the employer for a mediation meeting where both parties attended and a discharge agreement was entered. The employer agreed to start up a retail shop business for our client, where in company of our client the employer bought stock for our client's new shop. Our client has since informed us that her shop is in operation.

**D.C.K:** This is a prison matter, where our client who is the accused was charged with child neglect. A brief summary of the case was that our client who is the accused had failed to avail her daughter for routine clinics from September 2011 until February 2013 when the grandmother noticing the pathetic condition of the minor brought her to hospital where she was admitted to the ward and managed for Anemia and Malnutrition/Pneumonia. The minor's CD4 as at the time of admission was 261 (16%). The grandmother reported that our client has been missing from home and she was not able to bring the child to clinic. AMPATH Social Work Department with the help of OVC (Orphan and Vulnerable Children) and LACE managed to ensure that the minor was enrolled to shelter. LACE represented the accused in court where the accused was released. On 4th December 2013 the accused who is our client came to our office and a reconciliation agreement was executed. The minor has since been handed back to our client following the grandmother's and our client's request. The minor was handed to our client in the presence of the OVC's representative and the minor's grandmother.

**D.K:** The plaintiff was our client who had been married to the defendant for 11 years and had since been separated when the defendant was transferred to Busia. They had been blessed with two issues in their marriage. The defendant since their separation had failed to provide for the children maintenance and school fees despite the defendant working as a senior sergeant in the Prisons department. The plaintiff and the defendant through the help of LACE reached a consent that the plaintiff be given custody of the minor and the defendant have unlimited access to the minors and also pay monthly maintenance of Kshs 5,000/- and cater for school fees.

**J.N:** The plaintiff who is our client had some marital issues with her husband the defendant and had since separated. From their union they where blessed with five issues and the plaintiff wanted the defendant to provide for the minors and pay school fees. LACE intervened and held a mediation meeting with the couple from which they reconciled and are now living together and the Defendant has taken up parental responsibility and is providing.

# ANNEXES & ATTACHMENTS (MAXIMUM 10 PAGES)

## Annex I: Schedule of Future Events

| Date | Location | Activity |
|---|---|---|
| November 2014 | All Counties | Malezi Bora |
| December 1 | All counties | World AIDS Day |

**ANNEX 2: Feedback from Counties on FP commodity reporting**

**AMPATHplus Update on FP commodity reporting**
AMPATHplus in the month of August reached out to county teams comprising of commodity managers, County health record officers, County and sub-county pharmacists and other county and sub-county health management team members with a view of collecting and understanding contributors to the low FP commodity reporting rates. The following is a summary of the feedback:

**Bungoma County**

| County Challenges | Next steps |
|---|---|
| Data sets: some facilities are expected to report yet they are not offering the services. | Team work between the department heads and SCHRIO to ensure for co- ordinations so that all reports are uploaded into DHIS- **Action SCHIROs/CHRIO and CHMT** |
| Parallel reporting systems for the case of Lab | Data set for all sub counties to be rectified by the SCHIROs, to remove the facilities that are not active, and are not offering these services- **Action SCHIROs/CHRIO** |
| Workload – Some facilities have one in-charge in high volumes facilities making it difficult to give care and reporting at the same | Up load all the data that has not being up loaded- **Action SCHIROs/CHRIO** |
| FBO buy their own drugs hence do not see they need of reporting e.g. Lugulu mission hospital | Team work between the heads of programs and SCHRIO and also some to be given the rights to up load into DHIS- **Action SCHIROs/CHRIO and departmental heads** |
| Consistency of reports. Facilities not reporting monthly | Mentorship of identified persons to assist in up loading of the data- **Action CHMT/AMPATHplus** |
| Entry of data into DHIS is not being done | Tools: Photocopying of tools before the county is able to print its own tools - **Action CHMT/AMPATHplus** |
| Data collection tools and reporting tools missing in some facilities | Mapping in terms of tools, so as to know which tools are missing and in which facilities- - **Action SCHIROs/CHRIO and departmental heads** |

| | |
|---|---|
| | Data review meetings to be held monthly and commodity audits to be held every 6 months- **Action CHMT/AMPATHplus**<br>Ensure FBO submit their reports **–Action CHMT**<br>Support supervision: Commodity supervision to be carried out quarterly- **Action CHMT/AMPATHplus** |

| **Busia County** | |
|---|---|
| **County Challenges** | **Next steps** |
| Understanding of some of the indicators by Health care providers leading to incomplete data<br>Entry of data into DHIS is not being done<br>Some of the health care providers do not see the need to report.<br>Data collection tools and reporting tools missing in some facilities<br>FBO not submitting their data especially FP data yet they are expected to report<br>Shortage of staff.<br>Weak commodity supervision structure | Need for a tools training so that health care providers understand all the indicators- **Action CHMT/AMPATHplus**<br>Data set for all sub counties to be rectified by the SCHIROs, to remove the facilities that are not active, and are not offering these services- **Action SCHIROs/CHRIO**<br>Support supervision, commodity supervision should be integrated into the monthly supervisions- **Action CHMT/AMPATHplus**<br>Mentorship program to be started their after- **Action CHMT/AMPATHplus**<br>Data review meetings to be held monthly and commodity audits to be held every 6 months- **Action CHMT/AMPATHplus**<br>Team work between the department heads and SCHRIO to ensure for co- ordinations so that all reports are uploaded into DHIS- **Action SCHIROs/CHRIO and CHMT**<br>Up load data from January 2014- **Action SCHIROs/CHRIO**<br>Data tools: immediate intervention- photocopying of the tools as the county sources for ways to print them**- Action CHMT**<br>Air time and modems to facilitate up loading of data- **Action AMPATHplus**<br>Laptops to facilitate these too- **Action CHMT**<br>DHIS: orientation of the DHIS need for a two days training- **Action SCHIROs/CHRIO**<br>Commodity management training to take place the 1st week of October- **Action AMPATHplus** |

**TransNzoia County**

| County Challenges | Next steps |
|---|---|
| Supply of commodities has never been linked to reports. so people do not feel the need to report | All program lead will be in the forefront to ensure that all the reports are availed at the HRIOS office for entry |
| Some facilities do not have reporting tools | The HRIO will make a checklist of what number of reports to expect from which facility. All members adopted the all or none report policy- all the reports must be available if not the whole bunch will be rejected |
| Some staff don't know how to extract summary reports from the daily capture tools | Since health has been devolved. Data tools will be taken up by the county meanwhile the in charges will be photocopying. |
| Minimal supervision. In most occasions, supervisors don't have a checklist of what they are going to look out for when supervising | The county health offices will sit down with all the program leads to see how they can pull resources that will help the county in support supervision. The county is already willing to provide a vehicle for this purpose. |
| In some facilities registers are missing | The SCHMT will spearhead data review and data audits in their sub-counties |
| New facilities coming on board are not receiving the necessary help when it comes to reporting | The county pharmacist to spearhead commodity supervision support. |
| Some facilities are receiving commodities for services they are not ordering and because of there is no push to report and lack of resources to redistribute the commodities end up expiring on the shelves. | The AMPATH county coordinator with the help of the county team will come up with a tentative list for commodity management training. The target group will be the person handling all commodities in the facilities. |
| Most facilities are not filling in the daily activity registers | All members agreed to backdate report entry from the month of May. |
| There is high staff turnover. In some facilities one nurse has to fill out all the registers | |
| Reports were sent to the DHRIO's desk but the DHRIOs are not entering the data into the system | |

**West Pokot County**

| County Challenges | Next steps |
|---|---|
| In adequate data collection and reporting tools | Program officers to do data cleaning and verification with the DHRIOs |
| In adequate data utilization at both district and health facility level | The DHRIOs should ensure that all data sets are entered into DHIS- |
| Lack of feedback at periphery level. | Training of all health workers on commodity management and reporting |
| Late submission of reports from the health facilities to the Sub county level as indicated by reporting rates | Adhere to good drug disposal procedures |
| Some health workers might not be aware of the flow of some reports for some commodities e.g. TB, ARVs | SCHMT's have a role in data verification |

| | |
|---|---|
| | Scaling of our reporting rates to 100% in ALL SUB COUNTIES.<br>The health facility in-charges should ensure that their reports are quality and timely.<br>Monthly data audit to be done by all sub counties<br>AMPLUS Plus to plan for training the team members for 5 days.(training will include all commodities) stores officers will be included<br>Data entry be done retrospectively as from may 2014<br>August reports are supposed to be screened and cleaned and verified. |

**Kisumu County**

| County Challenges | Next steps |
|---|---|
| The reporting rates for the kisumu west sub-county are not at 100% because the reports are taken to AMPATH central before being sent back to the county offices. They want to own their data and the county and sub-county level | The program lead will oversee that all reports from each facility where the services are being offered are collected and entered into the DHIS |
| It is difficult to do data audits in Kisumu west by the DHMT because the AMPATH clinics do not have registers | For all programs that have parallel reporting systems will ensure that a copy of their reports get to the HRIO's office for entry into the DHIS |
| The pharmacist wanted to know if the AMPATH commodities were only meant for AMPATH patients | AMPATHplus and the county to streamline data sharing |
| There are no data capture and summary tools on the ground especially the nutrition tools | |
| In some facilities a partner was going away with the source documents making it difficult to oversee and compile report | |

**Nandi County**

| County Challenges | Next steps |
|---|---|
| They have a parallel reporting by CHAI and they are doing fine | Team work between the department heads and SCHRIO to ensure for co- ordinations so that all reports are uploaded into DHIS- **Action SCHIROs/CHRIO and CHMT** |
| They have no reporting tools | Data set for all sub counties to be rectified by the SCHIROs, to remove the facilities that are not active, and are not offering these services- **Action SCHIROs/CHRIO** |
| AMPATH has provided them with modems for reports, but they do not have laptops | Up load all the data (last 3 months) that has not being up loaded- **Action SCHIROs/CHRIO** |

|  |  |
| --- | --- |
| They have no logistical support for redistribution of commodities and tools<br><br>KEMSA has been pushing down commodities to facilities – both long and short expiries<br><br>Facilities are holding a lot of short expiries<br><br>There is no support for redistribution of the short expiry drugs<br><br>Some facilities do not have proper storage for drugs<br><br>KEMSA has been doing deliveries at odd hours- no one to receive the drugs yet one is expected to account for them<br><br>The denominator definition in the DHIS on RH activities has severely affected their reporting rate<br><br>They is lack of data capture and summary tools<br><br>Redistribution of consumables like jadelle to facility that use them. From the source facility unable to report because the beneficiaries do not report back. | Missing Data tools – The County can do an initial baseline to assess the real problem on the ground and the sub county officers together with HRIO to find out data tools that are missing and make sure the missing tools are availed either by purchasing them or providing money for photocopies on time to avoid misreporting or late reporting.<br><br>Training of health care workers handling commodities on reporting tools.<br><br>In the beginning the different program officers may have to do double reporting i.e. to the<br><br>Program, and to DHIS until a time when the systems are merged.<br><br>Integrated support supervision across the county<br><br>The sub-county teams should have a meeting to plan for monthly in-charges meetings who handle commodities.<br><br>Validation of reports before being uploaded into the DHIS |

**Uasin Gishu County**

| **County Challenges** | **Next steps** |
| --- | --- |
| Shortage of commodity reporting tools and data collection tools.<br><br>Inconsistency and inaccurate reporting.<br><br>Parallel reporting systems.<br><br>Lack of commitment in commodity reporting from health care provides.<br><br>Shortage of staff. | Tools: Facility in-charges to be photocopying the tools they are missing, will liaise with department heads.<br><br>Support Supervision: commodity support supervision to be supported by partners.<br><br>Tools: Tools will be photocopied at the county level as they have a photocopier, they only require photocopying papers.<br><br>Airtime and modems to facilitate uploading of data.<br><br>CHRIO to check the data sets, and correct.<br><br>The heads of department to be given rights to upload data into DHIS.<br><br>Training on commodity management and reporting.<br><br>Quarterly commodity meetings per sub-county<br><br>Data to be backdated and entered into DHIS as from January 2014.<br><br>Mentorship and OJTS<br><br>Follow up meetings quarterly. |

**Elgeyo Marakwet County**

| County Challenges | Next steps |
| --- | --- |
| Data collection tools and reporting tools missing in some facilities<br><br>Parallel reporting systems for the case of Lab<br><br>Follow of reports a problem, no identified system, if they should be taken to HRIO or departments heads<br><br>Accuracy and consistency of reports<br><br>Understanding of some of the indicators by Health care providers leading to incomplete data<br><br>Some facilities get their supplies from bigger hospitals, yet they do not give their reports<br><br>Multiple entry points into DHIS making it difficult to track who is not reporting | All reports should be channeled to the SCHIRO who through a checklist sees that all reports have being submitted**- Action facility in charges/SCHRIOs/CHRIO**<br><br>Departmental heads at the county to then take the reports from SCHRIO for cleaning then return to the SCHRIO, for the report to be up loaded into DHIS.<br><br>Some heads of departments will be given they rights to entry their data into DHIS.<br><br>Tools: Facility in-charges to be photocopying the tools they are missing, will liaise with department heads.<br><br>Support Supervision: commodity support supervision to be supported by partners. |