KENYA COORDINATING MECHANISM FOR GLOBAL FUND OVERSIGHT FIELD VISIT REPORT: MOMBASA COUNTY 19 TO 22 NOVEMBER 2018

For more information on this report, please contact the KCM Secretariat at info@globalfundkcm.or.ke

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EXECUTIVE SUMMARY

Introduction and Background: Overseeing grant implementation is a core responsibility of the Kenya Coordinating Mechanism (KCM) oversight committee. This is done through a variety of activities, including quarterly review of progress reports and field visits. The oversight field visit to Mombasa County took place November 19–22, 2018.

The objectives of the visit were as follows:

- To share technical information and promote linkages and collaboration among KCM, counties, principal recipients (PRs), sub-recipients (SRs), and local communities
- To establish progress made in implementation of Global Fund grants
- To document success stories from beneficiaries and stakeholders and document views on how to strengthen Global Fund programming

Methods: The Oversight Team met with the top county health leadership (County Executive Committee member for health and County Director of Public Health) and conducted a focus group discussion with members of the county health management team. Visits were undertaken to health facilities, wellness centers, hotspots, and the community (households). During these engagements, the Oversight Team and PRs did the following: presentation on KCM overview and Global Fund investments in the county, administration of the county checklist, administration of health facility checklist and filling of the data collection tool, interviews with beneficiaries, and administration of the SR checklist.

At the end of each meeting with the facilities or organizations, brief feedback was provided with key findings and areas for improvement. In addition, contextual information and clarifications around the findings were sought to inform how issues are presented in the final report and avoid misunderstandings or misrepresentations. At the end of the field visit, a debriefing session was also held with the county health leaders and the county health management team. All these interactions were viewed as opportunities for getting to the key issues and mapping an action plan for improving implementation of Global Fund grants in the county.

Key Findings and Recommendations:

Key Finding	Recommendation
1. There is inadequate partner coordination with many parallel programs and lack of clarity on budgets and accountability lines. National and county workplans not aligned.	1. Provide policy and guidance to counties for coordination of implementing partners to maximize on available resources and minimize duplication.
2. There is no standardized implementation of an incentive package for community health volunteers. Stipends are different and implemented ad hoc.	2. Standardize and harmonize CHV stipends.
3. There was a gap in ordering, storage, accountability, and distribution of condoms in	3. Standardize and routinize the system for condom supply.

	Key Finding	Recommendation
	the county. There was also a lack of understanding of the condom supply chain.	
4.	Although there was an adequate supply of GeneXpert machines in the county, they had variable functionality in terms of functional modules and the use of the online reporting system. In addition, there were stock outs of GeneXpert cartridges.	4. Plan an intervention to increase utilization of GeneXpert machines.
5.	There were no dedicated consultation areas or isolation wards for multidrug-resistant (MDR) tuberculosis (TB) patients.	5. Fast track set up of isolation wards for MDR TB cases.
6.	Despite the positive trends in active case finding and decreases in TB cases, there is no apparent special focus on TB detection among health care workers both at the facility level and the community level.	6. Create policy for TB detection for health care workers and institute routine TB screening among them.
7.	There were reports of distribution of short expiry of TB patient packs and stock outs of AL 6s and malaria rapid diagnostic tests.	7. Strengthen procurement and supply management for TB and malaria diagnostics and medicines to ensure sustainable and continuous supply.
8.	Mombasa is still heavily dependent on external donor financing for health. 70 percent of the county health budget is spent on recurrent expenditure with little left for other health activities.	8. Develop strategies for sustainable financing and follow up on sustainability plans for programs and projects.
9.	The County is relying on outdated key populations bio-behavioral data for planning and resource allocation.	9. Fast track the availability of bio-behavioral key populations data nationwide for planning and resource allocation.

Conclusions:

- Mombasa County provides an enabling environment for the implementation of Global Fund grants. The county is committed to the health of its residents, with health remaining a priority for the county as demonstrated by the allocation of county resources to health (Ksh 31.6m for HIV/AIDS, tuberculosis [TB], and malaria) and mobilization of additional resources for health from the private sector (Ksh 35m).
- Mombasa has realized a downward trend in the incidence and prevalence of the three diseases in the last five years, and investments in health need to be sustained to avoid rolling back gains made in the same period.
- Although there are good practices in the area of commodity security in the county, including relevant working groups and regular meetings to discuss issues, more effort is needed in ensuring the availability of important health products and technologies. There

were no reported stock outs of antiretrovirals, but the supply chain for TB, malaria commodities (especially AL 6s and malaria rapid diagnostic tests), and condoms needs to be strengthened to avoid expiries and improve commodity availability, thereby inspiring confidence in the delivery of health care services.

- The coordination of health partners in the county needs further strengthening, including the involvement of Global Fund implementing partners in county planning and budgeting processes to ensure that key county health priorities are being addressed and Global Fund activities are aligned with those priorities.

LIST OF ACRONYMS

ACF	active case finding
AHF	AIDS Healthcare Foundation Kenya
ANC	antenatal care
ART	antiretroviral therapy
CCC	Comprehensive Care Center
CHMT	county health management team
CHS	Center for Health Solutions
CHV	community health volunteer
CMEs	continuous medical education
DIC	drop in center
DICES	Drop in centers
DTG	dolutegravir
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis
eMTCT	elimination of mother to child transmission
HCM	PS Kenya Health Communication and Marketing project
HTS	HIV testing services
IPT	Isoniazid preventive therapy
KAPTLD	Kenya Association for Prevention of Tuberculosis and Lung Diseases
KCM	Kenya Coordinating Mechanism
KEMSA	Kenya Medical Supplies Authority
KESSHA	Kenya Secondary Schools Heads Association
KP	key population
KRCS	Kenya Red Cross Society
MCA	member of county assembly
MCH	maternal and child health
MDR	multi-drug resistant
MFL	master facility list

MP	member of parliament
MOH	Ministry of Health
mRDT	malaria rapid diagnostic test
MSM	men who have sex with men
NACC	National AIDS Control Council
NASCOP	National AIDS and STIs Control Program
OPD	out-patient department
PITC	provider-initiated testing and counseling
PR	principal recipient
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
SR	sub-recipient
TB	tuberculosis
UHAI	Ujinsia, Haki, Afya, Imani
USAID	United States Agency for International Development
WOFAK	Women Fighting AIDS in Kenya

INTRODUCTION

Background Information

Mombasa County lies in the Coast endemic epidemiological zone, where prevalence of malaria is 8 percent. Overall, malaria burden has been decreasing, except for a few hot spots, such as Timbwani, Bofu, Mikindani, and Mtopanga wards, where the incidence is more than 100 cases per 1,000 population. In 2016, there were a total of 71,101 confirmed cases; in 2017, the overall cases decreased to 58,695. In 2017, HIV prevalence was 4.1 percent (HIV Estimates 2018), down from 7.5 percent in 2015 (HIV Estimates 2015). The number of people living with HIV is currently estimated at 41,599, with 1,738 estimated HIV new infections in 2018 (HIV Estimates 2018).

Notified tuberculosis (TB) cases have shown a downward trend since 2010, from 5,980 newly diagnosed cases in 2010 to 3,854 newly diagnosed cases in 2017. Following the 2016 national TB prevalence survey, which indicated that the country is missing 40 percent of TB cases, strategies for facility TB case finding were put into place with noticeable success. TB cases increased by 7 percent from 2016 to 2017 and by 17 percent from Quarter 2 of 2017 to Quarter 2 of 2018. TB case notification stands at 321/100,000 population (2017 data), and on average, there are 30 newly diagnosed drug-resistant TB cases per year.

Terms of Reference and Purpose and Objectives of the Oversight Visit

Grant oversight is one of the core governance functions of the Kenya Coordinating Mechanism (KCM). The role of the KCM Oversight Committee is to ensure that implementation of grants is undertaken as planned, targeted results are realized, and any challenges are addressed in good time. The KCM team conducted an oversight mission in Mombasa County from 19 to 23 November 2018. The purpose of the visit was to strengthen linkages and establish progress made in Global Fund programming in the county and to recommend appropriate interventions for any challenges identified.

The oversight team comprised the following: KCM members; Oversight Committee members; the KCM Secretariat; and representatives from the National Treasury, Amref Health Africa, the Kenya Red Cross Society, the United States Agency for International Development (USAID), the Joint United Nations Programme of HIV/AIDS, HIV, TB, and Malaria Inter-Agency Coordinating Committees, the National AIDS and STIs Control Program (NASCOP), the National Malaria Control Program, the National Tuberculosis, Leprosy and Lung Disease Program, and the County Health Department. (See Annex 1 for the complete list of the oversight mission team.)

Objectives of the Oversight Visits

The objectives of the visit were as follows:

- To share technical information and promote linkages and collaboration among KCM, counties, principal recipients (PRs), sub-recipients (SRs), and local communities
- To establish progress made in implementation of Global Fund grants

- To document success stories from beneficiaries and stakeholders and document views on how to strengthen Global Fund programming

METHODOLOGY

The oversight team met with the top county health leadership (County Executive Committee [CEC] member for health and County Director of Public Health) and conducted a focus group discussion with members of the county health management team (CHMT). Visits were undertaken to health facilities, wellness centers, hotspots, and the community (household). During the above engagements, the following was done:

County-level meetings:

- Presentation by the Oversight Team and PRs on KCM overview and Global Fund investments in the county
- Administration of the county checklist

Health facility, community, and household meetings:

- Administration of health facility checklist and filling of the data collection tool
- Interviews with beneficiaries

Non-state SR meetings:

- Administration of the SR checklist

At the end of each meeting with the facilities or organizations, brief feedback was provided with key findings and areas for improvement. In addition, contextual information and clarifications around the findings were sought to inform how issues are presented in the final report and avoid misunderstandings or misrepresentations. At the end of the field visit, a debriefing session was also held with the county health leaders and the CHMT. All these interactions were viewed as opportunities for getting to the key issues and mapping an action plan for improving implementation of Global Fund grants in the county.

See Annex 2 for the complete itinerary for the visit.

FINDINGS

County Entry Meeting

An entry meeting was held with the CEC and CHMT that included a presentation and discussions on the following: the overall burden of malaria, TB, and HIV/AIDS in the county; the overall situation of HIV/TB and malaria commodities in the county; and proportion of funds mobilized to support HIV/AIDS, TB, and malaria; and identification of areas of strengths and areas in need of improvement.

HIV commodities have been in good supply, and the reporting is done through the DHIS2 platform. The supply for TB commodities has faced challenges, such as short expiry patient packs and technical challenges with the transition of reporting to DHIS, resulting in stock outs. There were challenges in supply of malaria commodities (AL 24s, 18s, and malaria rapid diagnostic tests [mRDTs]) till September 2018. However, a back order was sent for the ordered commodities. There are no challenges with DHIS reporting. Through Amref/Global Fund, the storage conditions in 8 facilities have been improved through the provision of shelves (14), deep freezer (1), computers and UPS (6), air conditioners (10), and wall thermometers (9). Through the COMBO initiative, the county is able to carry out a number of activities, such as data review at the sub-county level, stock taking at the county level, mentorship and support supervision at the sub-county level, and recruitment and training of mentor mothers. The Global Fund is the main source of funding for malaria control activities. The county has maintained a TB treatment success of 89 percent over the last five years. TB infection prevention in the facilities has improved with AIDS Healthcare Foundation Kenya (AHF) support for putting up well-ventilated waiting bays.

Universal Health Coverage

The county plans to increase budgetary allocation for health, from 22 percent to 35 percent. There are plans to have level 4 facilities in every sub-county, and there are five facilities under construction in Mtongwe, Shika Adabu, Vikwatani, Marimani, and Chaani to expand access to services as well as strengthen and broaden primary health care services. The county also ensures the availability of essential medicines and medical supplies for health care facilities by conducting annual quantification and allocating funds to procure health commodities (KES 183,450,651 allocated for 208/19 budget). The county facilitates the provision of quality health services training and constitutes quality improvement teams for health care provision at all tiers. To reduce out-of-pocket expenditure, the county plans to increase National Hospital Insurance Fund (NHIF) coverage from 36 percent to 60 percent.

County Health Allocations

Total county budget is 13,591,771,891, with 22 percent allocated to health (3.02 billion). Of the health allocation, 70 percent is for recurrent expenditure such as salaries and wages, 20 percent is for development, and 10 percent is for operations, with preventive and promotive health receiving about 3 percent (MAT, HIV prevention and control—KES 14,215,838; TB control—KES 9,477,225; and malaria control—KES 7,897,687). The amount of non-Government of Kenya funds mobilized for HIV, TB, and malaria activities was reported as KES 35 million.

Partners Support

- USAID/Afya Pwani Project—KES 30 million support for HIV/AIDs service delivery
- AHF—KES 20 Million - support for human resource, service delivery, and infrastructure
- Amref through PS Kenya—KES 356,750 for health facility system strengthening

- LVCT Health has supported 15 public health facilities in integrating LGBT service delivery with 13 HIV testing service providers supplemented and 30 peer educators under PEMA-Kenya

- HealthStrat has supported monthly counselor support supervision for 45 counselors.

Resource Mobilization Strategies

- Lobbying for increased government funding (advocacy meetings with health and finance committee of county assembly)
- Developing the elimination of mother to child transmission (eMTCT) business plan to advocate among influential leaders for commitment toward the elimination of MTCT of HIV by 2021
- Sensitizing partners for increased support (fast track cities, malaria advocacy meeting, a functional eMTCT technical working group to coordinate stakeholders)
- Engaging private sector through public-private partnership
- Tapping into private companies for corporate social responsibility (the department through support from Center for Health Solutions (CHS) held a meeting with private companies to advocate for support for screening of their staff)
- Collaboration with player in diverse sectors, including civil society organizations, faith-based organizations, community-based organizations, the media, and research institutions

Table 1 presents a summary of the key successes and challenges.

Table 1. Key Successes and Challenges

	Key Successes	Key Challenges
Governance, leadership, management, and health financing	• Commitment from county government to health, universal health coverage and community health • Initiative to incentivize community health volunteers (CHVs) by paying an one-off NHIF member of Ksh 6,000 for CHVs in the county • County HIV resource mobilization plan • County has allocated domestic resources for infectious diseases (e.g., 9.47m Ksh for TB)	• Inadequate partner coordination with many parallel programs and lack of clarity on budgets and accountability lines • National and county workplans not aligned • High recurrent expenditure (70% of total health budget) • Inadequate participation by county in Global Fund planning processes
Infrastructure	• 8 facilities renovated by Amref (shelves, deep freezers, computers, UPSs, air conditioners, wall thermometers)	
Commodity security	• Regular commodity security technical working groups • Adequate stocks of ARVs • Integrated support supervision for program commodities conducted	• Issuance of short expiry patient packs for TB drugs and ordered quantities not supplied • Stock out of malaria commodities (AL 6s and mRDTs)

	Key Successes	Key Challenges
Clinical and Lab services	• Adequate GeneXpert machines in county (all four sub-counties) • Increased availability of both preventive and curative services	• Full functionality of GeneXpert machines • Stock outs of GeneXpert cartridges
Data systems and processes	• Data review meetings held to review programmatic performance • Malaria data quality audits conducted • DHIS2 ordering sites training conducted	• Outdated key populations data being used for planning and resource allocation • Delays in rolling out DHIS2 ordering sites trainings

Health Facility Visits

Coast General Hospital

i. Table 2. Clinical Services at Coast General Hospital

Clinic	Observations	Challenges	Recommendations
Comprehensive Care Center (CCC)	• There is good client and service flow at CCC. • There is integration of family planning, pre-exposure prophylaxis (PrEP), cervical cancer screening, STI screening, and management and dermatology services • There are 21 HIV testing points distributed in the facility. • There is good identification of TB and HIV cases from the wards; initiated on treatment and discharged through TB clinic/CCC or a peripheral facility as per client preference. • There is significant support for the CCC (hired staff, phones, airtime, continuous medical education (CMEs), monthly data review). • Implementation of differentiated care using a quality improvement approach is progressing well. • Dolutegravir (DTG) transition progressing well—all new clients are initiated on a DTG-based regimen (including post-menopausal women and women on family planning, with their consent) • Good use of data—July to September 2018 aggregate data presented to the team • Good viral suppression—viremia clinic • Support for CMEs—every Tuesday and Thursday • Support for monthly data review • July to Sept 2018 data • 78% antiretroviral therapy coverage (4,185/5,396)	• Linkage—30% lost due to sub-optimal linkage—working on strategies to improve linkage • Sustainability—good partner support (Afya Pwani) with existence of a memorandum of understanding (MOU) with the county to absorb the staff after 5 years • About 70% VL testing for eligible clients—implementing follow up by cohort • Inadequate CHV support for tracking on defaulters—only 5 CHVs • Poor Isoniazid preventive therapy (IPT) uptake due to patient perceptions—health talks offered	• Improve linkage between the facility and community • Strengthen tracking of clients to enable early identification of lost to follow up as well as follow up to peripheral facilities for discharged clients • Institute sustainability measures—follow up with the county on implementation of the MOU

Clinic	Observations	Challenges	Recommendations
	• 97% timely early infant diagnosis (EID) (n=31)—only 1 child did not receive an EID test at 2 months in the period • 96% antenatal care HIV testing (408/425) • 100% maternal and infant prophylaxis (n=21; 5 new HIV + and 16 known positives) • 74% of clients eligible for viral load (VL) testing in the period received a test with 93% viral suppression (7% constituting repeat VLs and clinical failure)		
TB	• There is good intensive case finding and notification, with increased identification from the inpatient wards. • Treatment is provided for HIV+ identified in wards and discharged through the CCC/TB clinic or to a peripheral facility as per the patient preference. • There is good integration of TB and HIV services.	• Lack of isolation facility for multi-drug resistant (MDR) cases—county has identified Chaani for set up of an isolation facility for MDR cases • Roving HIV testing services (HTS) counselors—HTS counselors are called when client is identified • Reported shortage of cartridges for GeneXpert machines • Ad hoc TB screening for health care workers; yet to be systematized • TB services for PWID still a challenge in spite of a hotspot being right next to the hospital • Community support to confirm referrals to peripheral facilities is inadequate • Lack of tools to document IPT for < 5 year olds—contact register does not support documentation of IPT provision	• Facilitate set up of an isolation ward for MDR TB cases • Station an HTS counselor at the TB clinic • Institute routine TB screening for health care workers
Malaria	• Diagnosis for malaria in pediatrics is done at the maternal and child health (MCH) clinic and the test is offered to all presenting with fever and all positives are admitted.	• Antenatal care services have been separated from pediatric services except for prevention of mother-to-child transmission services	• Evaluate efficiency and effectiveness of separating antenatal care services from MCH

ii. Laboratory Services

The Coast General Hospital has a well-established lab with a functional molecular lab (viral load and early infant diagnosis [EID]), TB lab (**GeneXpert** and **microscopy**), and store.

Tuberculosis Lab

The TB lab has 16 modular GeneXpert machines (and a microscope) donated by Cepheid. At the time of the visit, two modules in the GeneXpert were non-functional despite the machine being serviced in April 2018. The machine was in use until 12 October when they ran out of cartridges and reverted to microscopy. Although they did not have the cartridges, they have tested all their patients using the florescent microscope. Between January and September 2018, 8,103 tests were done using the GeneXpert, out of which 1,084 were positive and 16 were rifampicin resistant. The utilization rates were 86 percent for Quarter 1, 89 percent for Quarter 2, and 106 percent for Quarter 3.

The reporting of GeneXpert is through online real time GeneXpert LIMS; however, the online system has been on and off, and, as a result, the report has been sent through a comments section of the GXLIMS.

Molecular Lab

The facility has two molecular machines (Roche/Cobas and Abbot) for testing viral load and EID For the reference period, the facility has not had any stock outs of reagents; however, since October 2018, they ran short of EID regents for the Roche/Cobas machine. The facility has been using the available reagents for Abbot machine, and hence they have been able to perform all tests required. The facility likes using the Roche because of its closed system functionality, reduced contamination of samples, user friendliness, and accuracy of the results.

Specimen referral for EID, viral load, CD4 and GeneXpert is well coordinated by different partners who support various health facilities (i.e., HealthStrat, USAID/Afya Pwani, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), PS Kenya Health Communication and Marketing (HCM) project, and Kenya Association for Prevention of Tuberculosis and Lung Diseases (KAPTLD).

Laboratory Store

The facility has a well-maintained lab store where staff use bin cards for all receipts and issues of lab commodities based on need and requests. Despite the well-maintained store, the lab is still lacking adequate space to store all lab commodities. There were no expiries observed in the laboratory.

This facility is categorized as level 5 and does not receive mRDTs for testing malaria. They buy their reagents for microscopy testing, however.

Renovation of the Laboratory

The laboratory was renovated by Global Fund through Amref; however, the team observed that some areas in the lab still needed additional workmanship. The paint in some areas was peeling off, some tables had cracks, and there was a pipe that was leaking.

Challenges:

- Two modules (out of 16) for the GeneXpert machine are not working.
- Cartridges for GeneXpert have been out of stock since October 2018.
- There is a stock out of EID reagents for the Cobas platform (Roche reagents).
- Storage space for lab commodities is limited.
- Reporting for dual and self-test kits is not captured in the available tool at the health facility.

Recommendations:

- The TB program should follow up and ensure that the modules that are not working on the GeneXpert machines are repaired. In collaboration with the Kenya Medical Supplies Agency (KEMSA) and Amref, they should liaise with the supplier to fast track delivery of cartridges.
- The President's Emergency Plan for AIDS Relief should fast track the procurement and distribution of EID reagents.
- The facility should identify additional space for the laboratory commodities.
- NASCOP should fast track the printing and distribution of the revised reporting tools.
- AMREF should follow up on the renovation of the county store and ensure that the 10 percent retention fee is not paid until the defects are repaired.

iii. Pharmacy Services (Commodity Status for HIV, TB, and Malaria)

The team visited the pharmacy department and the laboratory to ascertain the stock levels of tracer commodities captured in the field visit terms of reference. Stock status was determined by checking the bin cards at the bulk store, and where discrepancies were noted delivery notes were checked to provide further clarifications. See Annex 3 for a detailed analysis of the stock situation for tracer commodities at Coast General.

Findings:

- The pharmacy at Coast General was well arranged with good lighting and air-conditioning. There were also adequate shelves and pallets for storing commodities. Stock cards were well displayed.
- There was inconsistencies in the filling of the commodity bin card; for instance, the bin card for AL 6s had missing entries on the issues column.
- There was an apparent gap in ordering, storage, accountability, and distribution of condoms. Condoms had not been ordered from the main store for a period of five years. There were pushed deliveries of condoms from AHF at the family planning/maternal and child health clinic, both from the AHF program stocks and government stocks from the sub-county with logistical support from AHF. There was also a lack of understanding of the condom supply chain.

- GeneXpert cartridges were out of stock at the time of the visit. An explanation was sought and given by the central level that a pre-shipping inspection regulation had been introduced, leading to increased lead times and delays in delivery of the commodity.
- Distribution of short expiries, especially anti-malarial in late June 2018, indicated inefficiencies in the pipeline system.
- IPT tools were not able to record some commodities.
- There was a lack of reporting tools for condoms and lubricants.

Recommendations:

- The Chief Pharmacist at the facility should take action in ensuring accuracy of the entries in the bin cards.
- The team led by the Chief Pharmacist should mainstream and work on the condom pipeline to ensure accountability and an understanding at the facility of the condom supply chain: who orders, where from, how often, record keeping, etc.
- Follow up with KEMSA and the National Malaria Program to streamline the distribution of AL.

Likoni Health Center

i. Clinical Services

TB Clinic: Patient Flow

- There is good patient flow from the registration desk to the triage.
- Patients with a cough are seen first and sent for GeneXpert testing.
- Confirmed positive patients are started on treatment.
- There are 8 points where GeneXpert request forms are completed in the health facility (the work load is between 15 to 28 patients per month).
- GeneXpert reagents are available—but for three weeks now no cartridges have been available.
- Four multi-drug resistant (MDR) TB patients are on treatment; two are on a long-term regimen, and two are on short term and in their final stage.
- The MDR patients get 6,000/- every month. The challenge is that some get the money and go drinking or on drugs, hence the money does not serve the intended purpose. There is need to have an ongoing counselling with the MDR patients on how the money can benefit them. The patients need to be educated on income-generating activities.
- There are 34 TB/HIV co-infected in the county, and 29 are from this facility.

Consultation Room—Malaria: Patient Flow

Patients with fever are sent to the consultation room and after history is taken, they are then sent for testing by microscopy. Confirmed positive malaria cases are classified as severe, which are admitted, or uncomplicated malaria, which are given ALs and pain killers.

Tallying is done, and there are about five cases confirmed out of the clinical cases, about 80 percent. There is adequate anti-malarial ALs.

The facility has an active CME program, and when some of the health care workers go for a training, they come and train the others.

Challenges:

- There is no Clinical Officer or Medical Officer for children under five, hence it is difficult to differentiate pediatric and adult cases.
- All Clinical Officers have been trained on malaria case management, but no Medical Officer has been trained. Patients carry their books home and the next visit may change the book, so it is not easy establish a complete medical history for patients.
- There are no referrals from the community health volunteers (CHVs) to the health facilities because the CHVs only do HIV and TB linkages and follow up since this is what they are paid stipends for.
- **Action:** Work with implementing partners who are supporting community interventions and explore how malaria prevention can be taken up by the CHVs.

Comprehensive Care Clinics

By end of October 2018, there were 1,600 active clients, and more than 95 percent are on antiretroviral therapy (ART). Suppression rate is at 90 percent. AHF is supporting counselors. Testing is done at CCC and maternity. Outreaches are done but not regularly. Viral load is done in Coast General.

There sufficient condoms from AHF and National AIDS Control Council (NACC), and these are stored at each point of care.

There are two implementing partners, Pathfinder and Women Fighting AIDS in Kenya (WOFAK), and there seems to be duplication of activities. The county was requested to have a meeting with the partners and align the implementing partners' areas of operation and their support to avoid duplication.

The presence and areas of jurisdiction of the CHVs are not very clear, and there is need for demarcation between those in facility and in the communities. The CHVs' role and areas of work as well as stipends is not very well streamlined, and the community health extension workers (CHEWS) need to take up the management of the CHVs with support from the community strategy team.

Every partner is paying the CHVs differently. There is need for standardization of the stipends for all the CHVs by WOFAK, the Kenya Red Cross Society (KRCS), and the Government of Kenya.

ii. Laboratory Services

TB Laboratory

The facility has had a GeneXpert machine with four modules since 2011, but only three modules were working at the time of the visit. One module broke down just a few weeks before the cartridges stocked out. The facility has not had cartridges since 16 November 2018, and the last test was done on 15 November 2018.

The utilization of the GeneXpert machine was varied from one period to another. The utilization between January and March was 0 percent, mainly attributed to the fact that the machine was out of order for this period (November 2017 to March 2018); however, it was repaired at the end of March 2018. Between April and June 2018, the utilization went up to 73 percent, and the subsequent quarter it went down to 29 percent. This was affected by power fluctuations. The facility has since been supplied with a generator by the county so that when power goes off, the procedures in the lab are not affected.

The facility provides the report through the online system. The results are received through an SMS to the clinician, and a hard copy is generated thereafter. Sometimes the online report differs with the actual number of the test done, especially if the system is not uploading, and in such cases, the information is provided using the comment section of the system.

Target per day for this facility is 12 GeneXpert tests for approximately 22 days, representing approximately 264 GeneXpert tests per month.

Viral Load and EID

The facility does not conduct viral load testing; however, the samples are collected and sent to Coast General hospital. USAID/Afya Pwani provide support for transportation of samples through a rider once every week, and the facility does sample transportation twice a week. One day of the week is supported by the facility through the county government.

Challenges:

- Stock out of GeneXpert cartridges since 16 November 2018
- One faulty module under the GeneXpert machine
- GeneXpert machine lacks a printer

Recommendations:

- Fast track the delivery of already contracted quantities of cartridges through Amref, KEMSA, and the TB program.
- The TB program should follow up and ensure that the GeneXpert module is repaired and is working.
- The facility should liaise with the county to procure a printer for the machine.

iii. Pharmacy Services (Commodity Status for HIV, TB, and Malaria)

The team visited the pharmacy department and the laboratory. Stock status was determined by checking the bin cards and delivery notes for pharmacy, and where discrepancies were noted delivery notes were checked to provide further clarifications. See a summary under Annex 4 of commodity status at Likoni Level IV.

Findings:

- The pharmacy at Likoni Level IV is well lit, aerated, and maintained.
- Bin cards are kept together with items they are meant for, are legible, and are fairly easily navigable.
- Bin card entries are accurate for the most part, aside from some minor mixing up of tablets and patient pack entries as a result of the lack of adequate human resources (student temporary clerks come in to fill bin cards).
- Availability of antimalarials is an issue, with frequent stock outs reported. mRDTs have been received by the facility but are redistributed to lower-level facilities because Level IV facilities use microscopy. There is adequate lab personnel, with the facility boasting five experienced microscopists.
- Most non-malaria commodities have adequate months of stocks, except GeneXpert cartridges, which have similar availability issues as those observed at Coast General (hold up by new pre-shipment inspection rules).

Recommendations:

- Management of malaria commodities needs more concerted effort, including management of short expiry antimalarials.
- Issue of GeneXpert cartridge availability needs to be addressed across the board (for all facilities) to remove upstream supply chain bottlenecks.

iv. CHEWs and CHVs at the Likoni Sub-county Hospital

The facility is supported by 20 CHVs from three Community Units (CUs) (Timbuani—8, Misufini—6, and Kibuyuni—6). Each CU has approximately 50 CHVs, but only a handful are supported by KRCS Global Fund through WOFAK. The CHVs engaged trace the defaulters from the facility to the community, refer new clients to the facility, follow up with prevention of mother-to-child transmission and other antenatal mothers so that they seek antenatal care (ANC) services and deliver at the facility, and conduct home visits. The CHVs are able to reach out to the clients at any time because they come from the same catchment area. They also follow up with the TB defaulters from the facility using the telephone number and physical address provided by patients.

The CHVs engaged have monthly meeting with WOFAK. In addition, they have meetings at the community during which Ministry of Health (MOH) officials participate.

CHVs submit reports every month to the CHEWs using MOH 514 and to WORFAK using the tools provided by KRCS. It was reported that feedback is provided by the CHEW; however, this could not be verified.

The CHVs indicated that they distribute condoms in the line of their duty, but the mechanism and frequency was not very clear, and it was also reported that not all CHVs distribute the condoms.

Challenges:

- The stipend provided is very minimal and CHVs proposed for an increment and standardization.
- Sometimes it is difficult to approach certain patients or clients, and some do not take the visits and follow up lightly, leading to conflict.
- Some of the clients visited by the CHVs expect financial assistance from the CHVs in terms of food and transport to the facility for those who are unwell. Sometimes the CHVs have to use their funds to support such clients.

Noted improvement: CHVs reported that health-seeking behavior has improved over time. People go to the ANC clinic and deliver at the facility (*Linda Mama* has really helped through that support), HIV testing during outreaches has improved, diarrheal diseases have reduced, and finally the community dialogues are well attended because of the engagement and advocacy that has been happening over time.

Likoni Sub-county hospital has three CHEWs, each managing a CU. They supervise the CHVs and compile the report to be uploaded into DHIS2 by the sub-county health information system officer. This could not be verified because none of the CHEWs had the report.

The team noted that the CHEWs are not supported in any way in terms of airtime and trainings, but the CHVs are trained at the beginning of almost all the grants.

CHEWs have one review meeting per month with the CHVs, during which it is expected that they review progress and reports, provide feedback, and plan for the next month. The time is not sufficient.

The county recently recruited CHEWs, but they have not been taken through the community health strategy.

Recommendations:

- The county should support training of CHEWs on the community health strategy and support their airtime for community work.
- KRCS should liaise with their SRs so that the county and the community-based stakeholders support this officer. A total of 10, 6 new recruited and 4 CHVs, can also assist in the distribution of condoms at the community level.

KRCS Wellness Center

The wellness center is managed by a men who have sex with men (MSM) Network HAPA Kenya, which is implementing HIV prevention, treatment, care, and support. The center is housed in a building opposite Mombasa Technical University. The centers offer the following services to MSM:

- Health education
- Promotion of and education on condoms and lubricants
- HIV testing and counseling
- STI screening and treatment
- Offer safe space for the community
- Security and economic empowerment

They are implementing their interventions using the peer hotspot-based outreach model and referral to a Tudor Health Facility because they do not yet have a master facility list (MFL) and have their wellness center fully operational.

They work though peer educator and outreach workers who reach out to their peer with HIV messages and refer for outreaches to get comprehensive services. During this, HIV testing services (HTS) counselors, clinical officers, and nurse are engaged from the public facilities in the county on a locum basis.

There was a display of 90-90-90 cascade data at the wellness center, evidence that follow up with HIV clients is happening. The team met with the peer educators who were attending STI sensitization. The peer educators were happy that they are equipped with information to reach out to their peers. They also appreciated the organization for service provision to the beneficiaries. However, they noted that they need to get identity cards to protect them from being harassed and arrested by the police when on duty. PRs requested the SRs to facilitate IDs for all outreach workers and peer educators.

Challenges:

- Lack of a formalized referral system. There is no memorandum of understanding (MOU) to formalize the referral system.

- Access of commodities through KEMSA is a challenge because the center lacks an MFL code

Recommendations:

- Establish an MOU with the link facility to ensure that their clients are treated and feedback provided. A peer educator can be seconded to the facility to help with compliance.
- Provide training and sensitization of link facility staff on MSM to ensure community friendly services are offered.
- Amref SRs implementing TB should provide support in the provision of reporting tools and follow up on TB clients.

- The wellness center should continuously engage the sub-county health management team to get the MFL code.

Human Interest Story: HAPA Kenya River of Life

In 2009, a group of nine gay men who used to meet at their hotspots as peers came to realize that they could also provide services to their peers without discrimination. A number of their peers had tested positive and were not ready to disclose their status. Because they had been trained as peer educators on basic counseling and life skills, they decided to take things a notch higher and register a community-based organization known as HAPA Kenya.

They were optimistic that one day they would get funding. They initially started their meetings hosted by one of their members in his house. Later they rented a small office that could fit only a table and a chair. They even decided to develop an organogram for the organization, which was headed by a director even without salaries, and they reached out to their peers in the hotspot.

This group of peer educators had a vision and applied for funding from different sources. Years later, after operating without funding, they got Ujinsia, Haki, Afya, Imani (UHAI) fund on board to give them a grant to reach 1,500 MSM. Later Kenya Red Cross and Stephen Lewis came on board and funded them to implement HIV prevention, treatment, care, and support activities reaching out to MSM. They moved from the small office and currently occupy a bigger office, which also serves as a wellness center. The peer educators are now employed serving different portfolios as per their academic expertise. One of them is now the director and is leading the organization to greater heights.

The wellness center is considered a safe space for MSM managed by their own community members. The rest is history. The organization has claimed its space among those who implement HIV programs to the key population in Kenya.

HAPA Kenya currently is in the process of acquiring an MFL code that will enable them get access to HIV prevention commodities from the government as well as give the clinic an opportunity to offer health services to its members.

Kongowea Health Center

The KCM oversight team visited the Kongowea dispensary, where an entry meeting with the facility staff was held before the actual exercise. The team were divided in different groups for the exercise and the output is as indicated below.

i. Clinical Services

a. Malaria

There is a good flow of patients from the entry to the exit. Those who present with malaria symptoms are referred to the laboratory. mRDTs were available until end of March 2018, and since then the facility has been doing microscopy, and then it received a few mRDT kits from KEMRI. After malaria is confirmed, a patient is given a prescription to pick drugs from the pharmacy. AL stock has not been consistent, and recently the facility received AL 24s and mRDTs, which are received through a push process.

Daily client flow is about 200, with an average of 7 confirmed malaria cases in a day and sometimes about 15 in a week. This shows that malaria burden is quite high, and the previous month had about 44 confirmed positives. Malaria control efforts are strained due to the presence of an open drainage in the catchment that provides a perfect breeding site for mosquitoes that transmit malaria. Malaria among children under five is lower compared to the adult population.

There are CHEWs attached to the facility, but they do not do testing and treatment at the community level. Mainly, the CHEWs and the CHVs do referrals using the referral forms, and at times they give a note or a phone call to the facility. They also give health talks at the community level. CHVs unfortunately are not using mRDTs at the community level due to erratic stocks and lack of sensitization at the community level because they have not been trained. Amref will be approached to consider providing the training package to the CHVs.

Every month the facility does data review, and based on the disease burden, it determines the topics for the health talks.

CHVs' stipends are paid by KRCS, depending on the affiliation or service they provide. The facility currently has 26 CHVs.

Challenge: Whenever support for stipends come to an end, CHVs lose motivation and thus do not consistently support community referrals and follow up of patients.

b. TB Clinic

When a patient comes through reception, they are taken for triage, and those with suspected TB are referred to the TB clinic, mainly with persistent cough as the main symptom.

The facility does GeneXpert, microscopy and at times requests for x-rays. They have had a shortage of GeneXpert cartridges since mid-September 2018 to date.

The clinic currently has 68 TB clients. It was reported that some private facilities send samples for GeneXpert to be done at the Kongowea Health Center and are charged about 200 for transport. The facility has a rider who supports with deliveries of specimen.

Currently, the health facility has four MDR clients, one of whom is a class 6 pupil. This triggered a mop up at the school as an active case finding (ACF) was done. At the moment the facility does not have any pediatric TB cases. At the facility, there is a school health coordinator who supports with school health program. The facility does not focus much on secondary school, but that is where clients can be found more than at primary school level. They have been to two high schools (Mama Ngina and Sheikh Khalifa) which were sensitized.

Another great achievement as reported by the nurse is health talks with a bias on TB, which was given to secondary school heads from all the 47 counties in the country during the Kenya Secondary Schools Heads Association (KESSHA) forum held in Mombasa. The head teachers inquired whether they can be advised to screen all students during admission or return from holidays.

The facility has also done a screening at the Kongowea Market and received clients, translating to 7–10 percent of the total screened. Co-infected clients are between 10–15 percent of the total.

Best Practices:

- One stop shop for CCC/TB clients, which makes referral easier and is well taken up.
- Data-driven decision making results from monthly data reviews with all the staff and they interrogate the data.
- In terms of infection control, the facility has reduced contact of TB patients with the other patients. All TB clients are served by 9 a.m. before out-patient department (OPD) begin to bring other clients that include pediatric clients, TB clinics moved to Thursday and Friday because there are low workloads on these days and HIV/TB co-infected patients are seen at the CCC every Friday.

Challenges:

- Space is a challenge at the TB clinic.
- Staffing is challenge because they lack a permanent TB nurse.
- Some patients stay far but work at the market nearby hence at times they are lost to follow up clients.
- The facility is not yet a GeneXpert site, so it therefore recommends digital x-rays. Patients are asked to pay for the x-ray when the medical examinations indicate possible TB.
- TB awareness in the community and institutions is quite low.
- Alcohol abuse in the community is rampant, and there is a need for training in substance abuse management and to have a psychologist available.
- Masks are available to staff. There is occasional use but not much uptake.

Recommendations:

- Make use of TB champions (e.g., TB survivors) to support TB advocacy.
- Have a TB support group, a post-treatment group, which will serve as an incentive for the patients, especially those who have had successful treatments.

c. CCC Clinic

Identification of HIV-positive individuals is done through provider initiated testing and counselling (PITC). All patients go through the health talk session depending on the topic of the day. All those tested more than 12months ago are requested to test again for HIV. HIV-positive clients are linked to the CCC for further management. Currently there are 1,300 HIV-positive clients on care and treatment; 1 person refused to be started on ART because he has not disclosed to his wife but is on TB treatment and adhering well. The facility start clients on ART after 15 days and uses the electronic medical record system. The facility has three testing points (HTS room, lab, and HTS tent) with four counselors.

The clinic has not had shortage of ARV and has an adequate supply of condoms. Staff just pick, they do not do requisitions from the Government stores and AHF, and they distribute in the CCC, HTS, and condom dispenser.

Criteria of clients started on DTG include all men who are newly tested HIV-positive, Efavirenz clients who are virally suppressed, and women above 49years.

Differentiated care is being implemented where patients are categorized as stable and non-stable. About 750 are on 3 months' refill, 40 on second line, and no patient is on third line.

Defaulters: The facility has 20 percent defaulter rate, despite having three CHVs attached to the CCC and five CHVs in the community who are linked with the clients. Some of the reasons noted for defaulting include the following: clients do not get time off from their place of work to collect their refill; high stigma from the community; migration, mainly work-related, and loss to follow up because they pick drugs from other facilities (e.g., when the market season changes).

TB/HIV: All the HIV-positive clients are screened for TB. IPT uptake is at 82 percent. It was also reported that the electronic medical record system is not correlating with the hard copy data, and the facility is resolving this with support from Palladium Group.

Challenges in the CCC department:

- No power backup in case of outage, hence they opt to use paper base.
- Limited space and infrastructure; whenever there is a new client, a staff member has to be displaced from his or her working space to create room for the client to be seen.

Key Findings:

- There is good use of data for decision making
- There is good linkage between the TB clinic and the community.
- There is a need to train health care workers on substance abuse.
- Mental health issues are not well addressed, especially for the TB clients. There is a need to have psychological counselors at the sub-county level.
- Community component in malaria is missing—have never trained on malaria.
- There is an erratic supply of mRDTs.
- The clinic has started implementing differentiated care and has an understanding of it.
- TB is integrated with the key populations (KP) program but HIV is not.
- Despite shortages of the cartridges, the TB clinic reverts to microscopy and x-ray.

ii. Laboratory Services

The facility has two laboratory technicians currently offering TB microscopy and malaria testing (microscopy), but at times when they have power surges they use mRDTs. Between January and September 2018, they have not had mRDTs. The mRDTs verified at the facility lab were received from KEMSA in November 2018.

Between January and 12 October 2018, the facility was referring sputum samples to Coast General and Shimo la Tewa for GeneXpert testing through the support of USAID/Afya Pwani. The turnaround time for testing is between two and five days. With the shortage of GeneXpert cartridges, the facility received communication from the county to start conducting microscopy tests for detection of TB. Since then, the facility has been doing microscopy tests for TB using florescent microscope. In the reference period, the new smear positivity rate per month ranged from 9.8 percent to 32.9 percent, and most of the months had above 20 percent.

Viral load and EID samples are also referred to Coast General for testing through the support of USAID/Afya Pwani. The summaries for EID and viral load are done at the end of every month and recorded in the lab register. The turnaround time for EID and viral load testing is between 5 and 14 days.

Challenges:

- The laboratory space is small, and there is not enough space for the equipment in the facility. Due to lack of space, the lab has missed opportunities, including the delivery of a GeneXpert machine that was diverted to Shimo la Tewa, and the expansion of the facility, which was stopped due to shortage of land.
- The facility still uses a biohazard hood instead of the current biosafety cabinet. The hood is an old version that lacks ultraviolet rays and this poses a risk to both the facility lab technologists and the community visiting the facility.
- The facility has not requested the N95 mask and they have not received any from KEMSA.
- The lab needs to be renovated, especially the windows, with preferably sliding windows for infection prevention.
- The facilities do not have power backups and in cases of power shortage, the lab team cannot conduct certain lab tests.

Recommendations:

- The facility requires a power backup possibly a power inverter. The county should provide this support.
- The facility needs to expand the laboratory space to ensure that there is space for all the equipment.
- The facility needs to lobby for a biosafety cabinet from the county or implementing partners.
- The facility needs additional staff to handle the huge number of patients who require lab services.
- The National Malaria program should ensure a constant supply of mRDTs to this facility.

iii. Pharmacy Services (Commodity Status for HIV, TB, and Malaria)

The team visited the pharmacy department and the laboratory. Stock status was determined by checking the bin cards and delivery notes for pharmacy, and where discrepancies were noted

delivery notes were checked to provide further clarifications. Annex 5 summarizes the stock status for HIV, TB, and malaria tracer commodities selected for the Oversight Committee in this facility.

Findings:

- There was inadequate space at the drug store in the Kongowea Health Center, but the store was well arranged and items were on shelves or pallets and well-marked. Because of the limited storage space, not all drugs were stored in one central location.
- Bin cards are thoroughly completed. They are legible with minor errors and omissions (e.g., name of TB patient a pack was issued to); however, the bin card for TDF/3TC/EFV had multiple issues to the CCC (run by AHF) in the same month for several months, suggesting that it was being used as a Daily Activity Register and indicative of poor stock control at the CCC pharmacy/store.
- There was excessive stock of RHZ 75/50/150 packs of 100s, with 500 packs expiring by end of September. This was occasioned by distribution of short expiry RHZ from the central level. Further, the stock could not be shared with other satellite facilities because they were similarly supplied with large amounts of short expiry RHZ.
- As noted for Coast General and Likoni Level IV, there were no accountability measures in place for condoms.
- AL 6's were out of stock for the whole year with the lasts receipt being November 15. In the absence of AL 6's, older patient packs are cut up and used for pediatric patients as well. However, there is an adequate stock of AL 24's
- mRDTs were also out of stock for all of 2018, with the facility receiving some on November 15. The facility uses microscopy and has two laboratory technologists trained in malaria microscopy.
- GeneXpert services are not offered at Kongowea Health Center, but specimens are collected on falcon tubes (with support from USAID/Afya Pwani Project) and referred to Coast General hospital. There are adequate supplies of falcon tubes. However, since mid-October 2018, the facility has reverted to using microscopy because the GeneXpert machine at Coast General ran out of cartridges. A circular was issued for facilities to revert to microscopy so as not to interrupt TB diagnostic services.

Recommendations:

- Consider creating an additional storage space (with AC) at the facility.
- Review the quantification and distribution of AL 6's pack at the national level. The frequent stock outs are indicative of under-quantification and/or facilities not getting the quantities they need as per their pediatric patient volumes.
- Put in place accountability measures for condoms.

iv. Meeting with the CHVs

Kongowea Health Center is served by Maguti CU, which has a total of 30 CHVs, and 5 attached to the facility are supported by various partners, such as CHS, USAID/Afya Pwani, and Amref before the engagement of the SR. The roles of the CHVs include: defaulter tracing, contact tracing, health

education on TB, referral, and follow up of referrals. They also follow up on family planning, communicables diseases, and any other ailment where the client requires medical intervention.

Their work is at the community and the facility levels. Because the facility has a shortage of staff, sometimes they assist under triage and help the officer dispensing TB drugs.

Key Findings:

- Stipend payment for the CHVs varied from the different partners. USAID/Afya Pwani pays KES. 5,000, CHS pays KES. 7,000, and Amref pays KES. 840 upon tracing a defaulter or tracing a contact. In addition, it was observed that for a period of time, some CHVs got support from both CHS and AMREF.
- At the time of the visit, only two CHVs were engaged by USAID/Afya Pwani because CHS had come to an end in September 2018. Amref had engaged an SR who was in the process of county entry meeting before start of implementation.
- The CHVs have an in charge who coordinates and collaborates with both the facility and the community. In addition, he ensures that all community documents are kept well for reference purposes.
- Most CHVs are trained on HIV and TB, but only one had been trained on malaria.
- The county plans to provide CHVs with NHIF cover so that they can access health services. They had filled the NHIF forms a month ago, but the provision of the services are yet to be effected. This is a good practice that needs to be emulated by other counties with recomendation of the national Community Strategy Division.

Challenges:

- Some clients provide incorrect phone numbers and physical addresses, making it difficult for the CHVs to track or trace those who are defaulters or conduct contact tracing.
- There is an occasional lack of tools both for collection and reporting; however, during the visit the CHVs had all the required tools.
- Some clients are difficult to reach, and the expectations for the CHVs are very high, both from the community and the facility.
- There is a lack of support for consistent follow up through the county and some partners. The CHVs have engaged the county for consideration as health workforce but this has not been effected.

Recommendations:

- Amref through the SR (KANCO) should fast track the engagement of the CHVs to support Kongowea dispensary.
- There is a need to increase and have standardized CHV stipends to streamline the payments from the different partners through dialogue at the county level.
- More CHVs should be trained on malaria case management at the community level to advocate for malaria prevention at the grassroots level.
- The county should consider payment of stipends for CHVs.

PWID Outreach at Go Down Hotspot

The Reach out Center Trust is a SR of KRCS, and its main objective is to conduct outreaches using the KRCS Mobile Wellness Van. A schedule is shared by the Regional Office that assigns the SRs some days to attend to the hard-to-reach project beneficiaries. This is to expand access to appropriate and free services to the KPs in areas far off from the drop in center (DIC).

The Go Down hotspot injection den has an estimated 350 people who inject drugs (PWID) who are served by four peer educators and one outreach worker. On the day of the visit, service provision was organized at the hotspot with support of the Mobile Wellness Van. The activity reached PWIDs with the following services:

- HIV testing services
- STI screening and onsite treatment
- TB screening and referral.
- Family planning counseling and services.
- Cervical cancer screening.
- Wound management and treatment of minor ailments
- Health education and risk reduction counseling
- Commodity distribution: needles and syringe packages, condoms, water-based lubricants, tourniquet and safety boxes

The services were offered by clinical staff, outreach workers, peer educators, and HTS providers. This is part of ongoing community HIV prevention activities, which are usually cascaded to the routinely done peer education at the hotspot level. Peer educators visit the hotspots at least twice every week to distribute commodities, conduct peer education sessions, and refer KPs appropriately as per their needs.

Visit to the Reach Out PWIDs Town Clinic

The main objective was for the oversight team to experience the outreach services of the Reach Out team

The clinic targets PWIDs from the Mombasa outskirts as well as those within Mombasa. The activities offered are HTC, STI screening and treatment, as well as nutritional support, where lunch is served daily to an average of 100 PWIDs.

They are maintaining a cohort of 2,500 PWIDs, and this has been achieved over the quarters.

The clinic is doing a good job and they are at speed with their targets and funds absorption.

They have an MFL code, which enables them to receive commodities directly from KEMSA, although they have been experiencing shortages and interrupted supply of STI treatment drugs and other pharmaceutical commodities that can be used for minor ailments, including injuries. Injuries are very common among the PWIDs.

Challenges:

- Minimal supply of STI drugs and other pharmaceuticals at the DIC while demand is high.
- Police ambushes at the hotspots, which disrupts service provision.
- Few clients visit the DIC due to the long distance from most of the hotspots.

Recommendations:

- Advocate support from the county government on the essential drugs because the facility has an MFL code. In addition, KRCS should seek support from a pharmaceutical organization that provide drugs a means of social responsibility.
- KEMSA should supply available pharmaceuticals and other commodities under the grant directly to the drop in centers.
- Continue engagement with enforcement agencies to minimize violent encounters with police.

Best Practices:

- Accompanied referrals, which enhance referral and linkage services with support of transport from program
- Political outreaches—Engaging key politicians on harm reduction, through breakfast meetings (members of county assembly (MCAs), members of parliament (MPs), health committee)
- Radio program targeting the larger population
- Nutritional support that motivates and facilitates flow of clients for services
- Rapid response to any client emergency issue at any time (i.e., 24/7)
- Daily service delivery even during weekends and holidays, bringing good outcomes for conditions and enhance commodities distribution

Plenary:

The GF OC field visit team congratulated the PWID Drop in Town Clinic team for the good performance and the achievements.

There was a recommendation to approach the private sector and philanthropists for support, especially for the procurement of the medicines. Resource mobilization is key locally and internationally, and the program should not rely only on the Global Fund grant. The health committees would also be useful in allocating resources for the procurement of medicines for the drop in centers.

The team noted that the distance between the clinic and the outreach is quite far and wondered how many PWIDs reach the clinic. There would be a need to consider a decentralization model (i.e., having clinics as near as possible to the hotspot areas of target [*Maeneo])* in the era of taking services to the people for ease of access.

The Oversight Team noted that stakeholder engagements by counties was a cross-cutting challenge and the implementing partners were experiencing a vacuum in implementation, which sometimes led to duplication of activities by partners.

The Oversight Team went round the clinic and experienced the treatment room and pharmacy, feeding program, and the HTC clinic. These were functional and managed by professional teams. The client flow at the feeding clinic was very high, and the beneficiaries looked quite happy and settled with the support. The HTS clinic tests approximately eight clients per day and the testing is open to all, including those who are not PWIDs.

Table 3. Summary of Key Findings and Recommendations

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
1	County Entry Meeting	• Plans to increase budgetary allocation for health from 22% to 35% • Plans to increase NHIF coverage from 36% to 60% • Plans to have level 4 facilities in every sub-county; five facilities under construction in Mtongwe, Shika Adabu, Vikwatani, Marimani, and Chaani • DHIS commodity reporting works for HIV and malaria commodities, but technical challenges with reporting TB commodities • Stock outs of TB and malaria commodities		• CEC • CHRIO & CTLC • CHRIO & CTLC	• FY 2019/20 • June 2019 • December 2018
2	Coast PGH	**Clinical services** • Inadequate community linkage to confirm referrals • 30% lost due to sub-optimal linkage of new HIV+ • Good partner support (Afya Pwani) with existence of a memorandum of understanding with the county to absorb the staff after five years • Lack of isolation facility for MDR TB cases • HIV testing not co-located in TB clinic • Shortage of cartridges for GeneXpert machines • Ad hoc TB screening for health care workers • ANC services have separated from pediatric services except for PMTCT services	• Improve linkage between the facility and community • Strengthen tracking of clients to enable early identification of lost to follow up as well as follow up to peripheral facilities for discharged clients • Institute sustainability measures • Facilitate set up of an isolation ward for MDR TB cases • Station a HTS counselor at the TB clinic • Institute routine TB screening for health care workers • Evaluate efficiency and effectiveness of separating ANC services from MCH	In charges at the CCC, TB clinic, MCH and OPD	March 2019
		Laboratory services • Two modules (out of 16) for the GeneXpert machine are not working	• The TB program should follow up and ensure that the modules that are not working on the GeneXpert machines are repaired. In	• Laboratory in charge • KEMSA • AMREF	• March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		• Cartridges for GeneXpert are out of stock since October 2018 • Stock out of EID reagents for Cobas plat form (Roche Reagents) • Storage space for lab commodities is limited • Reporting for dual and self-test kits is not captured in the available tool at the health facility	collaboration with KEMSA and AMREF they should liaise with the supplier to fast track delivery of cartridges. • PEPFAR to fast track the procurement and distribution of EID reagents. • The facility to identify additional space for the laboratory commodities • NASCOP to fast track the printing and distribution of the revised reporting tools. • AMREF to follow up on the renovation of the County store and ensure that the 10% retention fee is not paid until the defects are repaired.	• NASCOP	
		Pharmacy services • The pharmacy at Coast General was well arranged with good lighting and air-conditioning. There were also adequate shelves and pallets for storing commodities. Stock cards were well displayed. • There was inconsistencies in filling of the commodity bin card, for instance, the bin card for AL 6s had missing entries on the issues column. • There was an apparent gap in ordering, storage, accountability and distribution of condoms. Condoms had not been order for a period of five years from the main store. There were pushed deliveries of condoms from AHF at the FP/MCH	• The Chief Pharmacist at the facility to take action in ensuring accuracy of the entries in the bin cards • The team led by Chief Pharmacist to mainstream and work on the condom pipeline to ensure accountability and an understanding at the facility of the condom supply chain: who orders, where from, how often, record keeping, etc • Follow up with KEMSA and the National Malaria program to streamline the distribution of AL.	Chief Pharmacist	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		clinic, both from the AHF program stocks and government stocks from the sub-county with logistical support from AHF. Additionally, there was a lack of understanding of the condom supply chain. • GeneXpert cartridges were out of stock at the time of the visit. An explanation was sought and given by the central level that a pre-shipping inspection regulation had been introduced leading to increased lead times and delays in delivery of the commodity. • Distribution of short expiries especially anti-malarial in late June 2018 indicated inefficiencies in the pipeline system • IPT tools were not able to record some commodities • Lack of reporting tool for condoms and lubricants			
3	Likoni Health Center	**Clinical Services** • GeneXpert reagents are available, but for three weeks now there have been no cartridges. • Four MDR clients are currently receiving treatment. • MDR patients get 6,000/- every month but reports have been made of the support not serving the intended purpose. • There is no Clinical officer or Medical Officer attending to the children under five. • There are no referrals from the CHVs to the health facilities because the CHVs only do HIV and TB linkages.	• Institute ongoing counseling and education on income-generating activities for the MDR patients • Work with implementing partners who are supporting community interventions and explore how malaria prevention can be taken up by the CHVs • Hold a meeting with the county and the partners and align the implementing partners' areas of operation and their support to avoid duplication.	In charges at the CCC, TB clinic, MCH and OPD	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		• Presence and areas of jurisdiction of the CHVs is not very clear and there is need for demarcation between those in the facility and those in the communities. The CHVs' role and areas of work as well as stipends are not very well streamlined. The CHEWs need to take up the management of the CHVs with support from the community strategy team. • There is no uniform payment of CHV allowances—every partner is paying the CHVs differently. • There is likely duplication of activities between two implementing partners (i.e., Pathfinder and WOFAK).	• Standardize the stipends for all the CHVs by WOFAK, KRCS, and the Government of Kenya.		
		Laboratory Services • Stock out of GeneXpert cartridges since 16th November 2018 • One faulty module under the GeneXpert machine • The GeneXpert machine does not have a printer	• Fast track the delivery of already contracted quantities of cartridges through AMREF, KEMSA and TB program. • TB program to follow up and ensure that the GeneXpert module is repaired and is working. • The facility to liaise with the County to procure a printer for the machine.	• Laboratory in charge • KEMSA • AMREF	March 2019
		Pharmacy Services • The pharmacy is well lit, aerated and maintained • Bin cards are kept together with items they are meant for, are legible, and fairly easily navigable • Bin card entries are accurate for the most part, apart from some minor mixing up of tablets and patient packs entries owing to lack of adequate human resources (student temporary clerks come in to fill bin cards) • Availability of antimalarials is an issue with frequent stock outs reported. mRDTs have been received by the facility but redistributed to lower	• Streamline documentation of consumption data and ordering of ALs and mRDTs	Pharmacy in charge	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		level facilities since Level IV use microscopy. There is adequate lab personnel, with the facility boasting five experienced microscopists • Most non-malaria commodities have adequate MOS, except GeneXpert cartridges which are in short supply •			
		Community services • The stipend provided is very minimal and they proposed for an increment and standardization. • Sometimes it's difficult to approach certain patients/clients and some do not take the visits and follow up lightly leading to conflict. • Some of the clients visited by the CHVs expect financial assistance from the CHVs in terms of food and transport to the facility for those who are unwell. Sometimes the CHVs have to use their funds to support such clients.	• The County should support training of CHEWS on community health strategy and their airtime for community work. • KRCS to liaise with their sub recipients so that the County and the community-based stakeholders support this officer. In total 10, 6 new recruited and 4Community health volunteers can also assist in the distribution of condoms at the community level	County Community Strategy lead KRCS CHEW	March 2019
4	Kongowea Health Center (including AMREF TB SR)	**Clinical Services** • RDTs were available until end of March; thereafter has been doing microscopy, then received a few RDT kits from KEMRI. • AL stock has not been consistent. Recently the facility received 24s and RDTs, which are received through a push process. • There are CHEWs attached to the facility, but they do not do testing and treatment at the community level. • CHVs are not using RDTs at the community level due to erratic stocks and lack of sensitization. • Whenever support for stipends comes to an end, CHVs lose motivation and thus do not consistently	• Integration of Malaria, HIV and TB services by CHV • Harmonize CHV stipends • AMREF will be approached to consider provision of the training package to the CHVs • Upscale TB Champions • Institute TB support groups	In charges at the CCC, TB clinic, MCH, OPD and Pharmacy CHEW SCTLC AMREF	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		provide support with community referrals and follow up of patients. • There has been a shortage of cartridges since mid-September 2018. • Facility does not focus much on secondary schools for TB ACF. • Facility is not yet a GeneXpert site, so therefore it recommends digital x-rays. Patients are asked to pay for the x-ray when the medical examinations indicate possible TB. • During a head-teachers meeting, the teachers inquired whether they can be advised to screen all students during admission or return from holidays. • Alcohol use in the community is rampant. • There is a 20% defaulter rate, despite having 3 CHVs attached to the CCC and 5 CHVs in the community.			
		Laboratory Services • The laboratory space is small hence not enough for the equipment within the facility. Due to lack of space the lab has missed opportunities including the delivery of a GeneXpert machine which was diverted to Shimo la Tewa and the expansion of the facility which was stopped due to shortage of land. • The facility still uses biohazard hood instead of the current biosafety cabinet. The hood is an old version that lacks ultraviolet rays and this poses a risk to both the facility Lab technologists and the community visiting the facility. • The facility hasn't requested for the N95 mask and they have not received any from KEMSA. • They need renovation of the lab especially the windows preferably sliding windows for infection prevention.	• The facility requires a power back-up possibly a power inverter. The County to provide this support. • The facility needs to expand the laboratory space to enable them put all the equipment • The facility to lobby for a biosafety cabinet from the County or implementing partners. • The facility needs additional staff to handle the huge number of patients who require lab services	SCTLC/CTLC Sub county pharmacist/County Pharmacist	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		• The facilities do not have power backups and in cases of power shortage, the lab team cannot be able to conduct certain lab tests	• The National Malaria program to ensure constant supply of mRDTs to this facility		
		Pharmacy Services • There was inadequate space at the drug store in Kongowea Health Center, however, the store was well arranged, items were on shelves or pallets and well-marked. Because of the limited storage space, not all drugs were stored in one central location • Bin cards are thoroughly completed. They are legible with minor errors and omissions (e.g. name of TB patient a pack was issues to), however, the bin card for TDF/3TC/EFV had multiple issues to the CCC (run by AHF) in the same month for several months, suggesting it was being used as a Daily Activity Register and indicative of poor stock control at the CCC pharmacy/store. • There was excessive stock of RHZ 75/50/150 packs of 100s with 500 packs expiring by end of September. This was occasioned by distribution of short expiry RHZ from the central level. Further, the stock could not be shared with other satellite facilities because they were similarly supplied with large amounts of short expiry RHZ • As noted for Coast General and Likoni Level IV, there were no accountability measures in place for condoms. • AL 6's were out of stock for the whole year with the lasts receipt being November 15th. In the absence of AL 6's, older patient packs are cut up and used for pediatric patients as well. However, there is an adequate stock of AL 24's • mRDTs are also out of stock all of 2018 with the facility receiving some ON November 15th 2018.	• Consider creating an additional storage space (with AC) at the facility. • Review the quantification and distribution of AL 6's pack at the national level. The frequent stock outs are indicative of under-quantification and/or facilities not getting the quantities they need as per their pediatric patient volumes • Put in place accountability measures for condoms.	NMCP Sub county pharmacist/county pharmacist Pharmacy in charge	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		The facility uses microscopy and has two laboratory technologists trained in malaria microscopy • GeneXpert services are not offered at Kongowea Health Center but specimens are collected on falcon tubes (with support from USAID/Afya Pwani Project) and the specimen referred to Coast General hospital. There are adequate supplies of falcon tubes. However, since mid-October 2018, the facility has reverted to using microscopy since the GeneXpert machine at Coast General ran out of cartridges. A circular was issued for facilities to revert to microscopy so as not to interrupt TB diagnostic services			
		Community Services • Stipend payment for the community health volunteer is varied from the different partners. USAID/Afya Pwani pays KES. 5,000, CHS pays KES. 7,000 and AMREF pays KES. 840 upon tracing a defaulter or tracing a contact. In addition, it was observed that for a period of time, some got support from both CHS and AMREF. • At the time of the visit, only two CHVs were engaged by USAID/Afya Pwani since CHS had come to an end in September 2018. AMREF had engaged an SR who was in the process of County entry meeting before start of implementation. • The CHVs have an in charge who coordinate and collaborate with both the facility and the community. In addition, he ensures that all	• AMREF through the SR (KANCO) to fast track the engagement of the CHVs to support Kongowea dispensary. • There is need to increase and have standardized CHV stipend to streamline the payments from the different partners through dialogue at the County level. • More community health volunteers should be trained on Malaria case management at the community level to advocate for Malaria prevention atthe grassroot level • The County to consider payment of community health volunteers stipends	County Community Strategy lead CHEW/CHVs in charge AMREF	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		community documents are kept well for reference purposes. • Most CHVs are trained on HIV, TB but only one had been trained on Malaria. • The County plans to provide CHVs with NHIF cover so that they can access health services. They had filled the NHIF forms a month ago but the provision of the services are yet to be effected. This is a good practice which needs to be emulated by other counties with recomendation of the national Community Strategy Division • Some clients provide wrong phone numbers and wrong physical address making it difficult for the CHVs to track or trace those who are defaulters or conduct contact tracing. • Occasional lack of tools both for collection and reporting however during the visit the CHVs had all the required tools. • Some clients are very difficult to reach out and the expectations from the CHVs are very high both from the community and the facility. • Lack of support for consistent follow up through the County and some partners. The CHVs have engaged the County for consideration as health workforce but this has not been effected.			
5	KRCS Wellness Center (HIV AIDS Peoples Alliance - HAPA KENYA)	• This is a network of MSMs formed out of a group of former peer educators • Membership is a mix of both HIV positive and negative MSMs • Peer educators have enrolled into NHIF (with premiums are taken out of their salaries) • Are linked to Tudor SCH and Port Reitz Hospital	• MOU with the link facility to ensure that their clients are treated and feedback provided. A peer educator can be seconded to the facility to help in compliance.	CASCO/sub CASCO Link facility in charge KRCS AMREF	March 2019

S/No	Site Visited	Key Findings	Recommendations/Actions	Responsible Person/Entity	Timeline
		• Lack formalized referral system - there is no MOU to formalize the referral system • Lack MFL code- challenges is accessing commodities through KEMSA.	• Training and sensitization of link facility staff on MSM service provision • Amref SRs implementing TB to support in provision of reporting tools and follow up on TB clients		

Exit Meeting with the CHMT

The exit meeting with the CHMT was chaired by Dr. Salma. Dr Salma gave an apology from the CEC and the County Director of Health who could not attend the debrief because of other competing priorities. Other CHMT members were in attendance.

The oversight team made a summary presentation of the key findings that will form part of the final report. From the presentation, the key areas of discussion are as summarized in the table as follows.

Table 4. Key Concerns, Responses and Way Forward Discussed With Mombasa County at Exit Meeting

	Issue	Concern	Response	Way Forward/Action Point/By Who
1	Condoms requisition from KEMSA	Oversight team noted that there was no requisition of condoms although there was adequate supply	The chief pharmacist indicated that the condoms requisition, distribution, and documentation plan was not very clear, and he further indicated that Mombasa had a lot of condoms in the stores that have been requested by the implementing partners.	NASCOP to provide further insights on the condom requisition and documentation requirements.
2	CHVs	Implementing partners are engaging CHVs differently with varying stipends ranging from KES. 2000 to KES. 7000	The county will discuss and see how the CHVs' stipends can be standardized, including discussions on how the county can take them up and pay their stipends, as is happening in other counties. In addition, the country will ensure that the CHVs are engaged in a broader way at the community level because they are key in prevention and primary health.	Engage the community strategy team and other partners who have funds for community systems strengthening.
3	Coordination of implementing partners	There was notable duplication of interventions by partners. The County was concerned that some partners come with authority from the national government and felt that the County could not push back/ not likely to ask such partners questions. The County was encouraged to hold all partners accountable.		The county to make plans for regular stakeholders meetings. NACC to share the HIPORS report for FY 2017/18 with the CEC and offer more guidance to counties on partner coordination. Need to hold partners accountable on what they have been funded to do and how much.

The chair of the meeting thanked the KCM oversight team and she indicated that they will be waiting for the full report for implementation. She noted that it is always good to have an external eye conducting oversight because they are likely to bring out very pertinent details that may have been overlooked by the county routine oversight visits.

The KCM oversight team lead thanked the county MOH leadership for welcoming the oversight team and providing the team with county staff to take the team around.

In general, the Chair noted that the oversight team noted there was good work going on in Mombasa County, especially as far as Global fund grant was concerned. There was no shortage of TB, malaria, and HIV commodities in the county. She acknowledged the hard work that was portrayed by the health care providers in the county.

The meeting was officially closed by the chair, and the KCM oversight visit officially wrapped up.

CONCLUSION

The Global Fund KCM oversight committee field visit to Mombasa County sought to fulfill the following objectives:

- To share technical information and promote linkages and collaboration among KCM, counties, PRs, SRs, and local communities
- To establish progress made in implementation of Global Fund grants
- To document success stories from beneficiaries and stakeholders and document views on how to strengthen Global Fund programming

The objectives of the field visit were realized through a series of activities, including in-briefing, feedback meetings, and an out-briefing with county leaders and health officials at several levels; review of existing health performance data from the county and Global Fund implementing partners; and panel discussions and key informant interviews with health facility staff offering clinical and non-clinical services and members of the community who are designated to benefit from those services.

The following conclusions were drawn from the visit:

- Mombasa County provides an enabling environment for the implementation of Global Fund grants. The county is committed to the health of its residents, with health remaining a priority for the county, as demonstrated by the allocation of county resources to health (Ksh 31.6m for HIV/AIDS, TB, and malaria) and mobilization of additional resources for health from the private sector (Ksh 35m).
- Mombasa has realized a downward trend in the incidence and prevalence of the three diseases in the last five years, and investments in health need to be sustained to avoid rolling back gains made in the same period.
- Although there are good practices in the area of commodity security in the county, including relevant working groups and regular meetings to discuss issues, more effort is needed in ensuring the availability of important health products and technologies. There were no reported stock outs of ARVs, but the supply chain for TB, malaria commodities (especially AL 6s and mRDTs), and condoms needs to be strengthened to avoid expiries and improve commodity availability, thereby inspiring confidence in the delivery of health care services.
- The coordination of health partners in the county needs further strengthening, including involvement of Global Fund implementing partners in county planning and budgeting processes to ensure that key county health priorities are being addressed and Global Fund activities are aligned with those priorities.

ANNEX 1: LIST OF PARTICIPANTS

Name	Organization
1. Ms. Faith Ndungu	KCM Member, NGO Constituency, **Team Leader**
2. Mr. John Bernon	KCM Member, Bilateral Partners/U.S. Government
3. Mr. Peter Njane	KCM Member, Key Population
4. Dr. Abdinasir Amin	MICC-OC Member, **Coordination of Report Writing**
5. Ms. Margaret Mundia	KCM Secretariat
6. Dr. Caroline Olwande	UNAIDS
7. Ms. Carol Ngare	NACC
8. Ms. Margaret Ndubi	The National Treasury
9. Ms. Christine Mbuli	National Malaria Control Programme
10. Mr. Michael Nduri	Amref Health Africa, Kenya-Malaria Grant
11. Mr. Titus Kiptai	Amref Health Africa, Kenya-TB Grant
12. Dr. Kipruto Chesang	PEPFAR/CDC
13. Mr. Abdille Farah	NLTP
14. Ms. Maria Cecilia	GIZ/IHAA
15. Ms. Christine Mbuli	NMCP
16. Ms. Khalda Mohamed	KRCS
17. Dr. Bob Agwata	NASCOP

ANNEX 2: ITINERARY

THE KENYA COORDINATING MECHANISM PROGRAM : OVERSIGHT VISIT MISSION: MOMBASA COUNTY: 19 TO 23 NOVEMBER, 2018		
Day/Time	**Activity/Event/Tentative Discussion Points**	**Venue**
Sunday, 18 Nov, 2018	**Travel to Mombasa**	
Day 1: Monday 19 Nov, 2018 09.00 am–10.00 am	**Courtesy call on the Hon. Governor** • GF support to the county • Objectives of the visit • Question and answer session	**County Headquarters**
10.00 am–noon	**Meeting with CEC/COH and CHMT Members** • Overview of KCM and Global Fund • Presentation on GF investments and achievements by PRs, the National Treasury, Amref Health Africa, and KRCS • County feedback on GF Support (HIV/TB/malaria) ▪ HIV/TB/malaria burden ▪ Overall situation of HIV/TB/malaria commodities. ▪ Performance of GF sub-recipients in the county ▪ GF-supported trainings ▪ GF-supported commodities and equipment • Question and answer session	**CHD Offices**
01.00 pm–02.00 pm	**Lunch break**	
2.00 pm–4.30 pm	**Site visit—COAST PGH** • Progress on the renovation of county pharmacy store • Availability of HIV/TB/malaria commodities • Status: Health care worker's trainings MDR/ART/TB/malaria case management • Availability and functionality of GeneXpert machine/ microscopes/laboratory supplies • Adherence to HIV/TB/malaria guidelines • Data quality for HIV/TB/malaria programs • Status of support for DQA and support supervision • Linkage between facility HF/community	**Mombasa**
5.00 pm–5.30 pm	Recap of Day's Activities	
Day 2: Tuesday 20 Nov, 2018 9.00 am—1.00 pm	**Site visit—Likoni Level 4 Hospital** • HIV/TB/malaria outpatient and diagnostic services • Situation and management of GF commodities and equipment • Status: Health care worker's trainings MDR/ART/TB/malaria case management • Status of support for DQA and support supervision by Amref Health Africa • Reporting tools, data quality, and use of DHIS • Linkage between HF and community	**Likoni**
1.00 pm–2.00 pm	**Lunch break**	

THE KENYA COORDINATING MECHANISM PROGRAM : OVERSIGHT VISIT MISSION: MOMBASA COUNTY: 19 TO 23 NOVEMBER, 2018		
Day/Time	**Activity/Event/Tentative Discussion Points**	**Venue**
2.00 pm–5.00 pm	**Visit to KRCS—home visit/wellness center** • Completeness of service packages for KPs • Assess quality of services DICES • Availability of commodities (STI drugs, condoms, lubricants) • Feedback from community members. • Completeness of service packages for KPs • Feedback from community members • AYP program	**Wellness Center**
Day 3: Wednesday 21 Nov, 2018 9.00 am—1.00 pm	**Site Visit—Kongowea Health Center** • HIV/TB/malaria outpatient and diagnostic services • Situation and management of GF commodities and equipment • Status: Health care worker's trainings MDR/ART/TB/malaria case management • Adherence to HIV/TB/malaria guidelines • Data quality for HIV/TB/malaria programs • Status of support for DQA and support supervision by Amref Health Africa • Reporting tools, data quality, and use of DHIS • Linkage between HF and community	**Kongowea**
1.00 pm–2.00 pm	Lunch	
02.00 pm–4.30 pm	**Amref TB** • Review CHV activities for TB under Amref (tracing defaulters, contact tracing) • Status of training for CHVs and CHEWs • Meeting with CHVs and CHEWs • Visit to beneficiaries-MDR (NHIF support, monthly social support**)**	**Kongowea Health Center**
2.00 pm–5.00 pm	• Debrief meeting with the CEC, Health	**CHMT Office**
Day 4: Thursday 22 Nov, 2018 8.00 am–1.00 pm	**Visit to KRCS SR** • Completeness of service packages for KPs • Assess quality of services DICES • Availability of commodities (STI drugs, condoms, lubricants) • Feedback from community members • Completeness of service packages for KPs • AYP programs	**Wellness Center**
2.00 pm–4.00 pm	Debrief CHMT	
Day 5: Friday 23 Nov, 2018	**Departure for Nairobi**	

ANNEX 3: STOCK STATUS OF TRACER COMMODITIES AT COAST GENERAL HOSPITAL (JANUARY TO SEPTEMBER 2018)

S/NO	Commodity Name	Receipts + Balance Brought Forward from Jan to Sept 2018	Issues Jan to Sept 2018	Months of Stocks	Expires	Rating	Comments
Malaria	AL 6s	600 pcs	180	0	420	0%	The facility was using other packs like the AL 18s.The facility received 600 short expiry in June 2018. Data for January to June were missing due to entries in multiple bin cards. The last BBF was for October 2017.
	AL 24s	1,020	660	8	0	80%	Commodity was within range
Malaria	RDTs-Kits	0	0	0	0	N/A	The facility does not stock RDTs kits due to government policy where LV3 and above facilities do not receive this commodity because they are expected to use microscopy.
TB	RHZE	221	89	7	12	100%	The facility is a central site and until recently was serving other satellites like Mvita and Kongowea.
	RHZ 60/30/150 (peads)	0	0	0	24	0%	The facility ordered in 2017 and 24 packs of the drugs expired in the facility and they did not order thereafter. The facility explained that in case of TB case for a child they will order.
	INH 300 (100s)	2,869	2,300	3	0	50%	
	GeneXpert	123	109	0	0	0%	There is stock out of the gene cartridges due to introduction of pre-shipment inspection.
HIV	TDF/3TC/EFV-300/300/600mg	14,395	12,149	1	0	10%	The country's new guidelines recommends change from TLE to TLD and currently facilities are transitioning to TLD and hence the formulation is being phased out.
	TDF/3TC/DTG 300/300/50mg	0	0	N/A	0	N/A	This is a new drug and the facility received its first stocks of 724 packs in October 2018 and hence months of stock cannot be determined yet.
	ABC/3TC 120/60mg	3,302	2,705	2	0	30%	The facility issued to other facilities.
	Male condoms	0	0	0	0	0%	The facility has not ordered since October 2015 as per KEMSA records. But facility has been receiving condoms from AHF at MCH/FB through the CCC and hence covering for the clients' needs. The team noted an apparent gap in ordering, storage, accountability, and

S/NO	Commodity Name	Receipts + Balance Brought Forward from Jan to Sept 2018	Issues Jan to Sept 2018	Months of Stocks	Expires	Rating	Comments
							dispensing and distribution of condoms.
	HIV test kits (determine)	15,780	13,180	2	0	30%	
	Dual test kit (HIV/syphilis)	900	150	10	0	100%	The test kits started to be utilized after the trainings in June 2018.This kit is expiring on March 2019. Quick action to be considered should the consumption remain low.

ANNEX 4: STOCK STATUS FOR TRACER COMMODITIES IN LIKONI SUB-COUNTY HOSPITAL (JANUARY TO SEPTEMBER 2018)

Commodity Name	Receipts + Balance Brought Forward from Jan to Sept 2018	Issues Jan to Sept 2018	Months of Stocks)	Expires	Rating	Comments
AL 6s	0	0	0	0	0%	Using other weight bands. No AL6s.
AL 24s	390	120	2.0	60	60%	All remaining AL24s expired in June and supplies arrived in November 2018.
RDTs-Kits	0	0	0.0	0	0%	Level 4 does not received RDTs because they use microscopy.
RHZE	452	197	2.2	0	30%	
RHZ 75/50/150	97	45	3.4	0	50%	RHZ 60/30/150 Paed: No longer being used.
INH 300mg	1,300	800	34.9	0	50%	
GeneXpert	2,300	2,000	1.4	0	10%	Currently out of stock due to pre-shipping.
TDF/3TC/EFV 300/300/600	16,690	5,730	5.72	0	80%	
TDF/3TC/DTG 300/300/50	0	0	0.0	0	0%	
ABC/3TC 120/60	1,395	1,400	3.3	0	80%	
Male condoms	4,320	864	36.0	0	50%	
HIV test kits (determine)	8,900	5,700	5.2	0	80%	
Dual test kit (HIV/syphilis)	925	275	4.7	0	80%	

ANNEX 5: STOCK STATUS FOR TRACER COMMODITIES AT KONGOWEA DISPENSARY (JANUARY TO SEPTEMBER 2018)

S/NO	Commodity Name	Receipts+ Balance Brought Forward from Jan to Sept 2018	Issues Jan to Sept 2018	Months of Stocks	Expires	Rating	Comments
Malaria	AL 6s	0	0	0	0	0%	Stock out. Using 24s and breaking them.
	AL 24s	210	130	6.2	0	100%	Ok
	RDTs-Kits	0	0	0.0	0	0%	Out of stock for malaria RDTs. Microscopy used.
TB	RHZE	319	228	0.0	0	0%	Stocked out at end of Sept for a brief period. Received in October (54) and November (54).
	RHZ 75/50/150	2600	1500	0.0	500	0%	Issued to other facilities (Maweni and Ziwa La Ngombe). As of November, 400 in stock, which they received in October.
	INH 300mg	1040	640	5.6	0	60%	
	GeneXpert	0	0	0.0	0	0%	Facility refers samples for GeneXpert.
HIV	TDF/3TC/ EFV 300/300/ 600	8,913	7,117	2.23	0	30%	TLD new product. All months. 0. First receipt Oct 4 of 75 and November 216.
	TDF/3TC/ DTG 300/300/50	0	0	0.0	0	0%	TLD new product. All months. 0. First receipt Oct 4 of 75 and November 216.
	ABC/3TC 120/60	669	584	1.6	0	10%	Received 48 in Oct and 80 in November.
	Male condoms	0	0	0.0	0	0%	21,600 received in November. Nothing received in Jan–Sept from MOH but received AHF.
	HIV test kits (determine)	4,900	4,000	1.7	0	10%	Received 200 in November.
	Dual test kit (HIV/ syphilis)	1,650	100	15.5	0	100%	Advised the facility to consider re-distribution before

S/NO	Commodity Name	Receipts+ Balance Brought Forward from Jan to Sept 2018	Issues Jan to Sept 2018	Months of Stocks	Expires	Rating	Comments
							product expires (March 2019).

ANNEX 6: SUCCESS STORIES

Success Story: Household Visit to a HIV Discordant Couple

Beneficiary: Married female age 24, a mother of 2 (7 year old and a 3 year old). The lady is in a discordant relationship.

Linked Facility: Likoni Sub-County Hospital

CHV Linked to Her: S. M. C; Community Unit, Likoni Sub-County Hospital

Access to, Availability of, and Adequacy of HIV and TB Services

The client was diagnosed with TB (through x-ray) and HIV in July 2018 at Coast General Hospital and on discharge was referred to Likoni Sub-County Hospital. The client had been sickly since March 2018, which led to the admission in July 2018.

She has been accessing her TB drugs and ARVs at Likoni hospital since 13 August, 2018 and is on a two-week appointment and drugs for close monitoring. She is linked to a CHV who has been visiting her weekly since August 2018. She started her treatment when she was bedridden (at 30 kgs) but is now strong and can go on her own for her drugs and clinic appointments.

The client has disclosed her status to her husband and confesses that her husband has been supporting as well as her treatment buddy. The husband is on PrEP.

Recommendations:

- The client is not in any health insurance and has not been trained or started an income-generating activity.
- The team recommends for the client to be linked to an income-generating project and training as well as be encouraged to enroll in a health insurance scheme.

Success Story: Case of an MDR TB Client

The team managed to meet Mr. O, age 23 years who is an MDR TB patient who has been getting services from Kongowea Health Center. He was diagnosed in 2016. Earlier he had been to the facility and was misdiagnosed for pneumonia and his lungs were greatly affected. One day while at work his condition persisted, and he was referred to Kongowea Health Center for further diagnosis. He was given anti-TB drugs and by the fourth month he felt a bit better. However, a month after the treatment regimen, he experienced the same symptoms. He had to return to the facility and was put on a daily injection. He was asked to fill in some form and he got registered with NHIF.

For about one and a half years, Mr. O was very ill and could not attend the clinic. The clinician had to provide the service from his home. He was started the treatment for MDR TB on 14 July, 2017.

Regarding financial support, Mr. O confirmed to have received the monthly M-Pesa payment but could not confirm whether he received payments for all the months because sometimes the

payments were erratic and he lost track. The cause of delay for payment was attributed to delayed submission of IDs of the patient. However, that was sorted and since April 2018, the M-Pesa payment has been consistent.

Before he became too ill, Mr. O had been a fruit vendor around the Kongowea Market. Due to the side effects of the drugs, he became very weak and could no long work. He confirmed that the 6,000 monthly support has come in handy for him, and he uses it mainly for food because he has been staying at his uncle's house. The uncle has been very supportive to him in enhancing drug adherence.

The team thereafter encouraged him to save some money from the 6,000 to re-invest into an IGA that would support him economically. He was also advised to join a support group that would enable him attain psychosocial support. From his earlier business, he attested to have been earning an average of 13,000/-.

Mr. O confirmed that he has been tested for HIV, and he voluntarily disclosed his HIV status.

At some point in the course of his treatment, the nurse confirmed that Mr. O experienced a psychotic attack after he took drugs one time and did not have a meal that night, only to react the following morning after taking his next dose.

On the facility side, the nurse informed the team that they have several staff who provide counseling; however, the psychological counselor is called only when there is need as because he travels around the county.

It was also confirmed that the family with whom Mr. O. was staying had no signs of TB, and thus no samples were taken. The aunt has since returned to her reserve home in Ukambani after Mr. O's health condition improved.

The jovial Mr. O promised to re-start his business next time he gets his M-Pesa payment. He is very grateful for the financial support and committed to adhere to treatment. He cheerfully confirmed to have gained weight, from 46kg to 56.3kg, a great improvement courtesy effective drugs and positive living.

Likoni Home Visit—Young Woman Newly Diagnosed With HIV

The team met Ms. X, a young woman under 25 years of age, at her residence in Likoni who lives in a one-room rental in a large compound with other families. Ms. X lives alone, away from her parents and relatives in Central/Eastern Kenya (Nairobi and Meru Counties). Ms. X worked at the local parish until mid-2017 when she started feeling weak. Her initial encounter with the health system and subsequent management focused on symptomatic relief, but after several consultations with multiple doctors and a referral to Nairobi (Aga Khan Hospital), she was diagnosed with HIV.

Ms. X started taking ARVs (Efarvirenz) in August 2017. She takes her daily dose at night, as recommended, to minimize side effects. She gets her ARVs from a health facility near her residence, a motorbike ride away. Since distance is not an issue, Ms. X can readily access health services.

Ms. X complains of overall malaise, joint weakness, dizziness, and difficulty standing up and remaining on her feet. Although she cooks and cleans for herself, she does not eat well. She was initially choosy on her diet, eating what she could at a time, but she is starting to eat regular foods like Ugali, more consistently.

Ms. X does not have an income of her own, and she is not on NHIF cover. Her expenses are met by her mother (food and rent). The ARVs have really helped her improve her overall health and well-being. She was previously bed-ridden but is now more ambulatory.

It appears that Ms. X has not yet come to terms with her status. She keeps it a secret, and has only confided in a few trusted relatives. She is unwilling to discuss whether she had partners so they can also be encouraged to take the test and know their status. Ms. X is not part of a psychosocial support group except the occasional meeting. She was recently introduced to a group but has not started attending the meetings. Her main wish is to be productive and take part in an income-generating activity. Ms. X currently complains of lower back pain. It is not clear whether this is a co-morbidity or part of a spectrum of symptoms for her condition or an adverse drug reaction.

Recommendations

- Review Ms. X to see how well she is tolerating her current ARV regimen.
- Provide more comprehensive information to Ms. X on her condition, how to take care of herself, side effects of medications, etc.
- Help Ms. X get an NHIF cover so her co-morbidities can be treated under the NHIF cover (e.g., lower back pain).
- Consider putting her on nutritional supplements and providing nutritional support until she is stronger. Her BMI threshold excludes her from eligibility for nutritional supplements, but the team would recommend that an exception be made.
- Connect Ms. X with peers struggling with the same issues so she can come to terms with her condition, process her emotions, and bounce back to be a productive member of the community.