KENYA COORDINATING MECHANISM (KCM)
OVERSIGHT VISIT REPORT

BUSIA COUNTY

23RD to 27TH November 2020

Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ACF	Active Case Finding
AMREF	Africa Health Africa
BCC	Behavior Change Communication
BCTRH	Busia County Teaching and Referral Hospital
CHMT	County Health Management Team
COG	Council of Governors
DRTB	Drug Resistant Tuberculosis
DSTB	Drug Sensitive Tuberculosis
DST	Drug Sensitivity Testing
GF	Global Fund
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Service
ICU	Intensive Care Unit
KCM	Kenya Coordinating Mechanism
KP	Key Population
KRCS	Kenya Red Cross Society
LLIN	Long Lasting Insecticide Nets
MDR	Multi Drug Resistance
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
SR	Sub Recipient
TB	Tuberculosis
TPT	Tuberculosis Prevention Treatment
VMMC	Voluntary Medical Male Circumcision

1. Introduction

On the 23rd to 27th November 2020 the Kenya Coordinating Mechanism (KCM) for Global Fund (GF) has been scheduled to conduct an oversite visit in Busia County, Kenya. The KCM team was comprised with the secretariat, KCM members from malaria, KP, COG and informal sector. There was also a delegation from the GF implementing PR from Kenya Red Cross Society (KRCS) and Amref Health Africa in Kenya (Amref) for the Non-State PR and National Treasury as the state PR. The team was to work with the health department within the county facilities that handle the main concerned diseases of TB, HIV and Malaria. The county teams were to provide guidance for KCM to reach its targeted mandate meant for the oversite visit within the county. The SRs for both Non-State PRs were also represented to showcase their utilization of the GF funding allocation meant for them.

2. TORs, Purpose and Objectives of the Oversight visit

The overarching purpose of oversight is to ensure that grants from the Global Fund are implemented as planned and are yielding targeted results, and further that challenges and bottlenecks are identified and resolved, and verifiable results are achieved within agreed timelines.

Specific objectives of the oversight visit were to:

1. Establish HIV, TB and malaria commodity security status and progress made in strengthening supply chain systems
2. Establish progress made in implementation of COVID-19 Support and mitigation of COVID-19 effects.
3. Establish bottlenecks and challenges affecting GF grant implementation and recommend solutions and strategies to improve grant performance.
4. Engage with stakeholders and beneficiaries and share information/ experiences regarding GF programming in Kenya

3. Findings

3.1. Summary of Activities Undertaken

Activity	Facility/ Place Visited
Courtesy Call to the Honorable Governor	Busia County Referral Hospital Boardroom
Meeting with CHMT	Busia County Referral Hospital Boardroom
Site Visit to Busia County Referral Hospital	HIV/TB/ Malaria Service Delivery Points; Pharmacy Stores; Laboratory; Youth Friendly Centre
KRCS Implementing HIV Programme - Show case Key Population and HIV Prevention for general population	WOFAK Office
Site Visit to Holy Family Nangina Mission Hospital County Referral Hospital	HIV/TB/ Malaria Service Delivery Points Show Case ACF, Contact tracing and Treatment Interrupters tracing Visit Beneficiaries – MDR TB patients, DS TB patient, MDR Champions Success Stories

3.2. Busia County Government Entry Meeting

The Kenya Coordinating Mechanism (KCM) for Global Fund (GF) team held a meeting with the County Health Management Team (CHMT) at Busia County Referral Hospital Board Room. The meeting was opened by HE the Deputy Governor of Busia County, and the session was chaired by Chief Officer for Health Medical Services. The team briefed the CHMT members on the functions of KCM and its members. The CHMT were taken through the objectives, methodology and program for the 5-day visit.

The Deputy Governor gave his opening remarks and welcomed the team to Busia County. As part of the opening remarks, he highlighted that, 30% of the county budget is allocated towards Health which is not sufficient considering the county is at the Kenya-Uganda border point. He elaborated that handles a heavy traffic of about 1500 interborder tracks per day and a lot of human movement between Uganda and Kenya. This presents, a high number of truck drivers, turn boys and their associates in the County who seek health services while on transit thus posing a challenge both in terms of resources allocation and increase in health risk of infections in the county particularly COVID-19 and HIV. For example, 40% of patients attended to in the County referral hospital are foreigners or people on transit. The Deputy governor further pointed out to the challenge of delay of disbursement of money from the national government. He informed the team that all salaries for the county workers had been paid up to date but some allowances had not been paid due to delay in disbursement of money from the national government.

3.2.1. Updates from the County Health Management Committee

There are 7 sub counties in Busia County with a population of approximately 992,279 inhabitants. The following were the updates provided on HIV, TB, Malaria, Pharmacy commodities and COVID-19 in the county.

A. TB Status

The County Tuberculosis and Leprosy Coordinator (CTLC) provided comprehensive feedback on TB situation in the county. In Busia County there are 171 TB treatment facilities, with 54 private facilities, 14 Faith Based Organization Health facilities and 103 public facilities. Each of the 7 sub counties has a Sub-county Tuberculosis and Leprosy Coordinators (SCTLC), 4 of the sub counties have a GeneXpert sites while 3 sub counties depend on sample networking to transport samples to the GeneXpert sites.

There has been a drop in the drug susceptible TB cases notified for the year 2020, reporting 38.1 % compared to last year, due to poor health seeking behavior of the general population, COVID-19 pandemic challenges and inadequate staff to conduct ACF. The treatment outcome for TB stands at 82.7% which is below the target of 90%. This was attributed to high death rate of 12% (Majority of deaths occurring within one month of diagnosis). Late diagnosis has been identified as a major contributor to the death late.

Drug Resistant (MDR) - An increase in cases of DR TB has been an increase with 14 cases diagnosed within the year. The diagnosed cases mostly consist of contacts of truck drivers. The increase in DRTB cases is associated with increase of samples being subjected to culture and DST under the sentinel surveillance currently ongoing in the county.

Under TB/HIV the co-infection rate has dropped and is currently at 34%, ART and TPT uptake targets of 905 have been archived and the County is currently performing at above 98%, through contact tracing and management initiatives.

Isoniazid Preventive Therapy (IPT) - The targets (IPT Ratio of 1:3) of children under the age of 5 years, contacts of bacteriologically confirmed TB patients initiated on IPT has been achieved in the County. However, there were reported cases of low stock levels for TPT commodities.

The team was also updated on the TB in HCW where there was 1 HCW diagnosed with TB. It was recommended that the county conducts frequent screening of HCW from the current semiannual to quarterly.

Currently there is a scale up of ACF activities within the community and in the facilities and ACF is currently contributing 30% of cases through the support of AMPATH and Amref. The county is also planning to undertake targeted ACF outreaches to find the missing TB cases in the county to improve on the case notification. Amref is also supported 10 high burden facilities to carry out quarterly ACF meetings to review the performance of ACF. Linkage assistants supported through the TB grant in 3 high burden facilities have also been instrumental in supporting ACF processes and enhancing patient linkage.

The lost to follow up cases reduced to below 5%, this has been achieved through support of the partners in the county. Amref has supported HCWs (TB Nurse/ Clinicians) with airtime to enable them call patients who fail to come for their medication further CHVs are supported to carry out physical treatment interrupters tracing for patients who can't be traced on phone.

B. HIV Status

There are 186 care and treatment sites for HIV in Busia County, currently the prevalence of HIV is 8.9% at a positivity rate of 4.3%.

The following are the HIV/STI prevention strategies by the county;

- HIV Testing Services (HTS), care and treatment
- Prevention of Mother to Child Transmission (PMTCT)
- Pre-Exposure Prophylaxes(PrEP)
- Post-Exposure Prophylaxes (PEP)
- HIV Sexual Transmitted Infections
- Behavior Change and Communication
- Voluntary Medical Male Circumcision
- Key Population Program

Overall, the positivity rate for the 7 sub counties combined is 5.1%

Challenges

- The treatment success rate of clients in Busia County is at 87% which is below target the target of 90%. The subcounty of Bunyala and Samia have been experiencing flooding affecting care and treatment
- Children under 2 years are not suppressed due to poor/inconsistent care giving skills by the parents/guardians. Currently adolescent suppressing rate is at 73%
- There have been stock outs of dual test kits thus affected testing of expectant mothers for HIV and syphilis
- The county has achieved 93% virus suppression in the general community against a target of 95%. New Infections in adults and the youth has increased
- The recording and reporting tools are not in sync with each other to provide adequate information for decision making
- Under key population, the people who injecting drugs (PWID) and transgender do not have partner support
- The CHVs are currently not receiving their stipends, due to withdrawal of partners
- There is need to train more HCW on PMTCT

Way Forward

- Continuous sensitization on PREP for Key populations
- Ongoing Health education for school and out of school programs for adolescents
- Strengthen community LIPS by advocating for support across the county with frequent joint support supervision
- Scale up mentorship on STEFS management and male involvement at PMTCT
- Addressed gaps on ART commodities
- Encourage/promote teamwork among CCC staffs

- Prompt update of the EID website once children started on ART

C. Malaria Status

In Busia County the overall test positivity rate (TPR) is 46%. There are 184 community health units (CHUs) out of which 105 CHUs receive Global Fund support.

The county has 60% microscopy coverage for malaria diagnosis. Currently there is an ongoing Kenya Malaria Indicator Survey funded by the Global Fund.

The county is now in the third year after the last mass net distribution exercise and there is need to replace LLINs which have undergone attrition in order to protect vulnerable populations from malaria.

Achievements

There is strong leadership at the county and strong partnership involvement.

Challenges

- COVID-19 has affected health seeking behavior of the population
- Inadequate infrastructure and equipment
- Shortages in staffing particularly at sub county facilities and dispensaries
- CHVs are demotivated

D. COVID 19 Status

To date 72,803 tests have been undertaken in Busia out of which 2,122 were positive giving a positivity rate of 2.9%. Out of the total tests 70% were truck drivers yielding in 1,496 positives giving a positivity rate of 2.2%. There were 1,138 HCW tested with 71 testing positive giving a positivity rate of 6.1%. 214 were prisoners with a test positivity rate of 20.6%. There were 328 positive cases from the general population out of which 13 were food handlers. Currently there are 10 COVID patients admitted out of which 9 are confirmed and 1 suspected. There is a surveillance team linking up the positive cases for follow up and CHVs to monitor home based care patients.

The county has a COVID isolation center at ALUPE with a bed capacity of 300, however 180 bed are available for occupancy. The county is in the process of procurement to ensure the 300-bed capacity has been achieved.

The BCTRH has an ICU with a bed capacity of 15, but currently with 4 beds. It has been equipped with oxygen.

Challenges

- Lack of testing Kits
- Inadequate sample collection kits & PPEs due to long county procurement processes
- Lack of standard reporting tools

- No airtime for contact tracing
- Shortage of staff
- Poor data management and lack of equipment

- **COMMODITIES**

Insufficient PPEs due to the lengthy procurement process in the county

TB/ HIV

The county utilizes the monthly allocation tool for TB & HIV commodities that is linked to the Kenya Health Information System (KHIS). This platform has helped to improve reporting rates.

Currently the county has between 1 to 3 months of stock for TB & HIV commodities except for Pyridoxine which is out of stock.

There have been frequent changes in the treatment guidelines without proper guidance on how to handle stocks held at the facilities.

There are 88 ordering sites for HIV commodities in the county.

MALARIA

There are over 3 months of stock for malaria commodities. Distribution of LLINs in Kirinyaga county has been done and plans put in place to kick start distribution in 27 endemic counties.

3.2.2. Youth Friendly Visit at Busia County Referral Hospital on 23rd November 2020.

Introduction

After the morning briefing the KCM together with implementing Non-State PRs (KRCS and Amref Health Africa), KCM representatives from informal sector and Key Populations constituencies were tasked to visit the youth friendly center within Busia County Referral Hospital. However, it came out clear that there's no youth center within the facility as a stand-alone center but their issues are integrated at the sexual and gender-based violence desk and at the sexual reproductive center. The team got an opportunity to visit and interact with the (SGBV) desk personnel which comprised of medical social worker, psychological counsellor and clinicians. The team captured very pertinent issues saturated on sexual exploitation and abuse mostly for children below the age of majority. However, the adult cases were also mentioned during the briefings.

Particularly the SGBV Centre deals with physical, sexual and psychological violence to the young and adult depending on the case presented before them. These include:

- Sexual assaults

- Rape
- Defilement
- Wife and husband bartering

After having a candid discussion with the people at the gender desk it came out strongly that in the month of October 2020 the cases reported were very high amid COVID-19 up to 36. However, it was also mentioned that the lowest cases that can be reported are 6 per week.

Challenges

- Lack of community awareness on SGBV issues
- Reluctance on arresting the perpetrators of violence since most survivors of violence since they don't report the cases.
- Settlement of cases outside the court where parents/guardian receives money from perpetrators.
- Lack of enough staff to support in follow up of cases.
- Lack of resources to follow up on the perpetrators. This include the logistical constraints to facilitate the movement of people supporting the survivors of SGBV to access justice
- Reporting method also give the perpetrators the leeway to challenge the complainant since the family members have not come to understand relevant terminologies to report different type of sexual violence.
- The survivors and the family of survivors have been reluctant to follow up the cases to the latter and made perpetrators walk scot free of which it exposes other individual of risks of experiencing more violence
- The threat to the SGBV survivors is very high which leads to some cases collapsing, hence some of the perpetrators are relatives to the survivors of SGBV. This was actually one of factors that was seen to fuel violence among young girls

Recommendations

- Establishment of safe space to the survivors of violence in order to regain confidence that might have compromised the occurrence of violence
- Proposed paralegal training to enhance basic legal knowledge to the health care in order to help the survivors of violence access justice in the corridor of law
- Linkages and synergies with other relevant department and partners by mapping the civil society organizations that offer legal support to the community.
- Establishment of a youth friendly center that is a one stop shop offering wholistic behavioral, biomedical and structural interventions that prevent further spread of communicable and non-communicable among youth
- Intensifying tracking of the SGBV survivors for follow up and support in order for perpetrators to face the law and the survivor to acquire justice.
- Establishing working relationship with other partners inclusive of law enforcement, law firms at pro bono agreement and other local leaders to ensure perpetrators are brought to book and cases followed up to conclusion.
- Lobbying and advocating for discussion of highly reported cases of GBV to the county and national law makers. This may help the county to formulate the by-laws that discourage the occurrence of SGBV among young people

Lessons learnt

- The SGBV cases are being treated as offense against an individual instead of offense against the state and therefore the elders sit and settle the matter at the alternative dispute resolution (ADR). However, this practice works so unfairly and cruelty to survivor of SGBV with long term psychological torture.
- Post care program of the survivor of SGBV is also wanting since there are many cases that have not been concluded since the survivors and their relatives have not been showing up to finish the procedure of reporting.
- There is a gap in reporting different cases surrounding SGBV, for instance one can report rape to the minor instead defilement and vise-verse. This calls for basic legal training across the health care workers that deals with SGBV and also sensitize indigenous on how to report correctly.

3.2.3. TB/HIV/Malaria Report – Busia County Referral Hospital at service Delivery point

Malaria

- Diagnosis takes place in the outpatient department (OPD) where most of the patients are walk-ins.
- Patients first report to the reception where registration takes place before moving to the triage area where vitals are taken. After the triage the patient moves to the clinician who takes history and order the necessary tests
- Microscopy is the test done to most patients for diagnosis
- There are no measures in place to assess patient satisfaction with services offered – No exit questionnaires and no suggestion box
- The consultation rooms are made of bedsheets presenting a major deficit in patient privacy and challenge in IPC since patients/staff can move in the room from any direction at any time

TB Services (TB Clinic)

- TB screening and diagnosis happens at all departments including OPD, MCH, Special clinics, inpatients among others.
- Patients diagnosed for TB in any department are referred to the chest clinic for initiation of treatment and follow up.
- Treatment Interrupters tracing mechanism is in place in the facility – All Appointments are entered into appointment diaries. Patients who fails to come for scheduled appointment are given a call within 24 hours asking them to come for their medication. Those who fail to come 3 days after the call are traced physically by the CHVs. Support for airtime to call and physical tracing is provided through Global fund TB grant.
- Indicator performance – Case finding has declined due to COIVID-19 related stigma and reduction in daily hospital visits.
- Contact screening of all bacteriologically confirmed patients and children under the age of five is carried out by the HCWs and the CHVs. This is recorded in the Contact management register.

- The facility is currently managing 8 DRTB patients. Out of the 8 patients, 7 are on social support, are registered for NHIF and are receiving monthly stipend of KES6000 per month from Global fund TB grant.
- Most of the DRTB patients are on community-based care and DOT is done by a DOT Worker who delivers drugs to the patient at home and supervise the patient while taking the drugs. The DOT worker also receives transportation facilitation of KES 6,000 per month.
- Baseline tests required before initiation of DRTB drugs are done at Lancet and supported by partner.
- Monthly multidisciplinary (MDT) meeting to review DRTB patient progress are done. During the meeting the patient is reviewed, given an opportunity to give feedback on progress and satisfaction with services. The findings of the MDT meeting are recorded in the patient logbook. Logbooks are however currently not enough.
- Measures to assess and address patient satisfaction has been put in place – There is suggestion box in the department and exit interview are carried out.
- GeneXpert utilization is low, there has been a decline in number of samples referred for testing due to COVID-19.
- Peripheral facilities referring samples for GeneXpert to this facility lacks fridge and cooler boxes to store samples awaiting transportation and therefore can only collect samples when the rider is available. The rider is not available on a daily basis but picks the specimen on specific days.
- GeneXpert had two broken down modules which were repaired by Caroga. It took time for the repair to be done since Caroga was repairing other machines in other Counties and therefore a request, if the County biomedical engineers can be trained on basic maintenance of the machines.
- Some drugs are out of stock including; Isoniazid 100mg, Pediatric RH, Pyridoxine and Isoniazid syrup.
- Shortage of nutritional supplement for patients - RUTF

HIV

- HIV testing takes place in all the service delivery points including; OPD, MCH, Special clinics, inpatient among others.
- All patients diagnosed with HIV are linked to the CCC for initiation of treatment and follow up. Test and treat initiative have been implemented in the facility and all the patients are on ART.
- The facility has a total of over 6,000 HIV infected patients on follow up among whom 442 are PMTCT mothers.
- Integration of ANC/HIV, TB/HIV has been done very well but there is shortage of staff and sometimes when ANC staff is not available, the ANC mother are sent to the CCC to collect their medications.
- Currently the facility identifies about 35 new HIV infected persons per month and all of them are linked to treatment – Linkage to treatment is at 100%.
- Prior to ART initiation thorough patient preparation is carried out through a literacy program in place where adherence counselling and health education is done
- Viral suppression is currently at 94% and the facility target to reach 95%.
- Challenge with viral suppression among the adolescence, currently at 84%.

- The facility has a viremic program in place to support patients who are not virally suppressed; any patient with a viral load that is 400 and above is enrolled in to the program. Interventions give include; Enhanced adherence counseling, psychosocial support and monthly appointments and development of adherence plan.
- Differentiated model of care has been implemented where stable patients are given longer drug refills while unstable patients are seen more often to address their conditions.
- Patient tracing mechanism in place – Patient locator details are documented in patient locator card; all appointments are documented in the appointment's diaries. Patients who miss appointment are given a phone call asking them to come for their medication. Physical tracing is done for all patient who fail to show up after the call.
- Measures to assess and address patient satisfaction has been put in place – There is suggestion box in the department and exit interview are carried out.

Challenges/ Bottlenecks

Challenges/ Bottlenecks	**Way Forward**
Malaria	
The consultation rooms are made of curtains affecting patient privacy and IPC.	The county to facilitate the partitioning of the OPD consultation rooms.
Delay in receiving Malaria laboratory result as a result of workload.	Recruit additional Labaratory staff
Health Care workers at the OPD not provided with enough PPEs – They are given 1 surgical/Medical mask per day. Sanitizers are not enough and run out sometimes. No gowns, no face shield.	Provide adequate PPEs to the Health workers and fast truck procurements
Tuberculosis	
No isolation for DRTB patients	Provide isolation rooms for the TB patients
Peripheral facilities lack cool boxes to transport/ store samples awaiting transport to the GeneXpert sites	Procure cooler boxes/ fridges
Peripheral facilities lack fridge to store samples awaiting transportation and therefore collect samples only when the rider is available leading to missed opportunities.	Procure cooler boxes/ fridges
GeneXpert had 2 broken down modules which were repaired by Caroga. It took time for the repair to be done since Caroga was repairing other machines in other Counties.	Consider training the County biomedical engineers on minor repairs of the GeneXpert machines and only involve Caroga for major repairs.
Shortage of cartridges for GeneXpert	County should ensure timely reporting

Shortage of some drugs – Isoniazid 100mg, Pediatric RH, Pyridoxine and Isoniazid syrup.	-
Shortage of nutritional supplements for patients - RUTF	-
HIV	
Shortage of staff – Most staff are employed by partners presenting a sustainability challenge.	Transition partner supported staff to the county
Cross boarder effect, some patients coming from Uganda – Tracing them becomes a challenge when they interrupt treatment.	Strengthen cross border coordination and have the quarterly meetings for the updates
Need for various players (Partners) supporting the various components in the facility/County to have a forum to discuss and harmonize their work	Map the partners within the county and know who does what

3.2.4. **BCTRH Laboratory V**isit – 23-11-2020

Overview

The Laboratory is headed by Madam Frida and assisted by Madam Linet.

The Laboratory manager gave the team an overview of the laboratory which was constructed and fully equipped with the support from World Bank EPHLN. However, the laboratory is more biased towards Tuberculosis testing although there are other four test (Malaria Lab, TB Lab, Micro Biology Lab, PCR lab and Staining Lab.) being done at the laboratory. The laboratory has 27 permanent staff and 2 casuals.

The laboratory is currently being able to take and process test for COVID19 samples.

The laboratory is a GeneXpert site equipped with a 4 module GeneXpert Machine and they also undertake AFB microscopy. The facility receives samples from 3 other sub counties, Matayos, Nambale, Teso south and Alupe issolation Centre. The sample transport networking is currently supported by AMPATH.

Challenges

i. High sample processing backlog as the facility receives samples from 4 sites
ii. Stock outs of cartridges and falcon tubes
iii. Lack of adequate servicing & maintenance of equipment
iv. Staff shortage and lack of recognition

Observations

i. The current workload is approximately 14,000 per month, with malaria samples accounting for 4,000 and TB 200-400 test
ii. The GeneXpert has an active service maintenance and the challenge is on having a functioning UPS.

iii. The reporting tools for TB are adequate, however MOH 240 reporting tool for malaria is not available
iv. The average turnaround time for tests are; 1hour for malaria and 24-48 hours for TB
v. RDTs are not stocked at the laboratory thus not in use except in exceptional circumstances.
vi. The Laboratory malaria data reporting is done through MOH 706

Recommendations

i. The counties have received a circular authorizing retention of funds generated at the county to be retained and utilized by the county (FIF).
ii. The KCM to recommend to the county to allocate funds for printing of tools and procurement of UPS for the Laboratory GeneXpert Machine
iii. The county to take ownership and establish sustainability mechanism to ensure adequate maintenance of the laboratory equipment.
iv. The county government to increase funding towards the laboratory for procurement of reagents and consumables
v. Promote utilization of laboratory capacity
vi. Hire additional laboratory staff, provide recognition and reward the laboratory staff as well as providing adequate PPEs.

3.2.5. Pharmacy

HIV

The commodities are handled at the CCC, however, there were reported shortages in ART commodities due to the optimization?

TB

Quantification is done monthly, however determining the number of patients is a challenge due to spikes in the number of patients seeking services from truck drivers.

Stock Levels

1. RHZE Patient pack – 30 patient pack
2. RHZ – 60/30/150 pediatric tabs -tablets
3. MDR TB (Cycloserine – 400 Caps, Kanamycin 82 Caps, Clofazimine 900 Caps, Moxifloxacin 400 caps)

Malaria

There are reported stock outs of malaria test kits, there are no stocks maintained for mRDTs.
Stock Levels

1. AI/Lum-6s – 1,440 doses – 2.6 months of stock
2. AI/Lum-24s – 1,170 doses – 2.9 Months of stock
3. RDT Kits – Stocked out

3.3. WOFAK SR Visit (24 Nov 2020)

Site Visited	Key Findings	Recommendations/ Actions	Responsible Entity	Timeline
Nangina Mission hospital	Pharmacy • All the TB Commodities were available in the store as the pharmacy was only for dispensing. However, the nutrition supplement especially plumpy nuts, fortified flour and ISO meal for children are not available. • Supply is done monthly and the facility had one month of supply. • The HIV commodities including ARVs were available and had never been out of stock. • Supply is 3 months depending on consumption. • Dual kits (HIV/syphilis are not available and have been out of stock • Cartilages are also out of stock	• The facility is envisioning for a one stop shop where comprehensive services and treatment can be offered • The facility is in dire need of biosafety cabinet to ensure low or zero contamination. • Support in additional microscopic and human resource	Donors	2021
	Laboratory • The facility is ISO Accredited with a scope of 15189 and has 5 technical staff who run day and night shifts • They have an automated machine for bio-chemistry parameters. They also run Hematology tests, TB Microscopy, Malaria Microscopy and Stool analysis. ▪ They started testing for Sickle cell. Currently with 157 clients diagnosed and under management. ▪ The facility is the 2nd referral unit in Busia especially during HCP industrial actions. ▪	• Support with an equipped unit for growing and maintaining microbiological cultures • Support with GeneXperts • Provision of DQA tools at the laboratory level • Quarterly quality management trainings for laboratory personnel • Work with partners and counties for support and get elevated to a center of excellence	MOH Nangina mission hospital	Immediately

Site Visited	Key Findings	Recommendations/ Actions	Responsible Entity	Timeline
	Viral Load Tests ▪ Samples are referred to Alupe, which is 60kms away, twice in a week with a turnaround time (TAT) of 5 days. ▪ 160 viral load tests were managed in October 2020 with a viral suppression of 50% (below 1000 copies). ▪ General suppression rate of 96% Malaria Microscopy ▪ They are the bulkiest tests done in the lab ▪ There is need for an additional microscope to meet demand and to improve TAT ▪ Need for additional 2 laboratory staff due to workload TB ▪ Their main Lab is used for microscopy for AFB smear. ▪ They also conduct follow ups ▪ They refer GeneXpert tests at Port Victoria for lack of equipment. Coved ▪ They do not test unless during emergencies. They refer the samples to either Alupe or Busia referral hospital Challenges • Lack of reagents and blood bags during screening of blood for sickle cell	• Support to sensitize communities on uptake of Anti-TB drugs • Provision of nutritional supplement especially plumpy nuts, fortified flour and ISO meal for children • Support with a reproductive health package for all patients • Pick up Linda Mama initiative for deliveries, ANC and Post Natal		

Site Visited	Key Findings	Recommendations/ Actions	Responsible Entity	Timeline
	• Community require sensitizations on blood donation • Inadequate PPEs (Lab coats, masks, gloves) • Lack of GeneXpert PHARMACY - Team members capture stocked levels on the KCM tool Service deliver points CCC Services flow • Waiting bay: weighing of patients • Triage interface: Have an automated system • Consultation Rooms: Patients are seen by different clinician based on need (Pediatrician, TB contact clinician who pairs up as a PMTCT contact clinician, Lead clinician on care and treatment). Care and Treatment • Currently having 2576 patients on HIV care. • Using *differentiated care model* which is client centered • They have two Community ART Groups (CAGs); one from Siaya, the other from Uganda. • They have reduced defaulter rates since they have longitudinal model for follow ups (social worker makes follow ups on missed appointments, calls and links with CHVs)			

Site Visited	Key Findings	Recommendations/ Actions	Responsible Entity	Timeline
	• CHVs support in DOTS. 60 CHVs are supported by Wofak, while 22 are supported by the program TB • Impact Research supports a link assistant for TB clinic • Sputum collection is done and delivered to the lab for referral to Port Victoria • For negative results, clinical treatment is done by performing an Xray to the patients • If GeneXpert test is positive, contact tracing follows. Tests on patients are then repeated after every 2, 4, and 6 months. • Gastric Aspirate Test is done to 7 years old and below • Have had 3 MDR Patients and currently managing one • There are four under 5 TB positive patients • They also perform Active Case Finding at the facility • DOTs done by CHVs or HCP • MDR patients receive a stipend of Kshs. 6000 from Impact Research Development Organization which is supported by Amref • CHVs are supported with stipends by Komesha TB which motivates them Youth Friendly Centre			

Site Visited	Key Findings	Recommendations/ Actions	Responsible Entity	Timeline
	• They have and Operation Tripple Zero (OTZ) for youth and adolescents with an objective of zero missed appointments, zero missed pills and zero viral load. • Mwendo program supports children and adolescents. They meet on Saturdays under an adolescence mentor and clinician. Reproductive Health Package • There have one for PLHIV only • They conduct active cervical cancer screening to all women of reproductive age and any other patient requesting for a screening. Challenges - Small congested CCC structure with limited space hence affecting confidentiality - Health care problem by health care providers; This is where patients are wrongly dragonized at local facilities and by the time of referral their health has deteriorated and some die. - The process of referring advanced cervical cancer patient - Legal linkage of assaulted GBV client			

REPORT FOR DAY THREE OVERSIGHT EXERCISE DATE: 24th November 2020

a. Visit to Nangina Mission hospital

The team paid a courtesy call to the MOH in charge Dr Berly Anyango and her team members. The team lead Dr Iscar gave a brief overview of the visit emphasizing that the KCM team has come to provide oversight and not intimidate the facility workers. She indicated that since Global funds support in commodities on HIV, TB and malaria, it's imperative to know if the facility have been receiving the same. The key focus is on any stock out, any challenges they are facing, successes, lessons learnt and key recommendations.

Successes

- Systems tracking for the patients MDR TB patients managed at home followed up and non has died.
- Health care workers not exposed to TB due to the conducive working environment.
- Established club for adolescents living with HIV ALHIV) between ages 10 to 19 years to assist adolescents to adhere. The clubs are known as 0z which focuses on 0 missed appointments, 0 missed pills and 0 viral detection. The facility organizes annual OTZ camps and have competitions during the camps.
- Death rate related to TB, HIV and TB/HIV are zero.
- Staff have been trained on gender-based violence and are able to offer services to GBV victims.

b. WOFAK VIST-SR

The SR is implementing treatment care and support (TCS) and general populations module (GP) in 4 sub counties in Busia county. The SR has trained and engaged 475 CHVs and is working with 48 facilities spread in all the 4 sub counties. The total budget for the implementing period i.e. January 2018 to June 2021 is Ksh 55,617,108. The amount received in the last disbursement is Ksh 17,592, 692.Propotion of funds received is 100%. The number of adults and children living with HIV who receive care and support services outside facilities in the program is 7550 (79%). Total target is 9500 clients while **average programmatic performance** 80.5%

Site Visited	Key Findings	Recommendations/ Actions	Responsibility Entity	Timeline
WOFAK KRCS SR	▪ Proportion of funds - 100% received ▪ The turnaround time between when funds are requested by SR, review and disbursement by PR is 8-14 days. ▪ Financial performance – All the funds have been liquidated 100% ▪ Disbursement request, addendum budgets, notification by PR, work plan, financial reports- the confirmation was made through sharing bank statements for proofs. Soft copies to be shared with KCM members. ▪ Timeliness in disbursement and notification from PR- confirmation, bank statements. Timeliness on the submission of reports to confirm delays ▪ Every quarter SRs do quarterly request and one-month buffer followed by reviews against work plans. ▪ Q3 –report 5th of every month and PR expects that in October reports is send with disbursement request. The review is done for 5 days and if there are no issue proceed to disbursement. ▪ There are minimal incidences of delays of disbursement. KRCS system ensures all SR have monies except when SR has questionable costs. They are advised to clear until you clear on time however it does not take a month. Turnaround time is 14 days however PR sends an email to SRs in advance. There is a clear commitment from PR. ▪ WOFAK do not have delayed funds and have strong internal control. In quarter 3 financial period absorption rate was at 32%. The low absorption was attributed to scale down of implementation, i.e. CHV training and subsequent CHV stipends. ▪ Following the RRI activities held in October, absorption rate stands at 59% following the activities that had huge chunks such as CHVs HCBC trainings that had been	▪ There is need to put in place mechanisms through realignments of budgets since any organization that does not utilize funds will lose the fund. ▪ Share acceleration plan with KCM oversight team- CHMT presence will support the SR in case of unforeseen challenges. ▪ SRs to consider identifying ideas for the CHVs- SR to check what IGA for CHVs to pool and assist them to manage suggestion made soap making training. ▪ Psychosocial support to address issues on mental health for AYP- drugs and substance abuse, teenage pregnancy, suicidal tendency, basic counseling skills to CHVs ▪ Staff medical cover- advised to confirm with the insurance company package for Covid-19 management ▪ Weekly business continuity plan w –phone number & next of kin's number ▪ Staff rota in the regions -Kilifi, Msa, Bsa- not all staff in the office ▪ Provision of PPEs	WOFAK	25th Nov 2020

Site Visited	Key Findings	Recommendations/ Actions	Responsibility Entity	Timeline
	completed and CHVs stipends payments for the newly trained. Trainings and stipends could not be scaled down due to outbreak of COVID-19 that interrupted some of the activities. The trainings were held after authorization by County. ▪ The SR has got structured way of funds flow ▪ Activities being carried out are RRI plans ending 30th November,2020, whereby SRs with unmet targets will be distributed by KRCS to other SRs in different regions. KRCS planned for RRI plan, trainings. ▪ WOFAK recruit CHVs through community strategy. CHVs already training on basic modules and attached to CUs are profiled by the Sub County focal person through the community units in relation to health gaps within the community units. ▪ KRCS has supported 1754 face masks & 877 (250mls) hand sanitizers, Ksh 1.4 m for sensitization of 81 local administrators, 50 CHAS, 150CHVs, 120 support group leaders, 60 AYPLHIV, 255 clients sensitized on Covi-19. Sensitizations were carried out in 3 sub counties Bunyala (floods), Matayos & Teso North as border counties ▪ **AMREF** supported with 60 boxes surgical masks, 800 re-usable masks, 60 (500mls) hand sanitizers, 60 boxes glove and Kshs, 430,000 for sensitizations of 28 CHVs & 28 CHAS in Bunyala and Butula sub counties.	▪ Laptops and extra bundles to ensure staffs can efficiently work from home ▪ Virtual household visits by CHVs ▪ Issue of quality, re-alignment of budgets to respond to C-19 targeting schools' teachers & children, hand wash facilities, sensitization of village elders and gate keepers, provision of PPEs since the launch "***No Mask No service campaign.*** ▪ Need to address gaps addressed such as perception that Covid-19 funds were has been misappropriated ▪ Doing things differently- let the partnership continue and let the partnership with CEC, Chief Officer occasionally to make a difference to be enhanced. ▪ Let's learn lessons from HIV implementation for COVID-19. ▪ Psychosocial support component is key in COVID-19 mitigation and control.		

C MEETING WITH CHVs

The meeting to get the feel of the work done by CHVs and feel free to discuss work done. The CHVs shared their experiences as follows;

CHV 2- The CHV explained that she meets clients either in-house or outdoor. She seeks permission to engage and begin with introductions followed by reason for visit. She then discuss health issues, probe on adherence and request for clinic card to confirm next appointment. They also ask for VL. In case of high VL and if there are other challenges the CHVs discuss adherence, pill count, storage. They also give time for the client on any concern or issue to discuss and eave contacts behind and clients too.

CHV 3- In the event of visiting a new client who may be facing stigma reason for visit and notify relative. She seeks permission for duration to take after introduction. She asks them who else knows their status as well as discordant issues and importance of partner testing and dual protection.

Success story –by a client

Mulwandaa.

I really appreciate the CHV without the CHVs intervention I would be dead. I was sick together with my child. The CHV hosted us, paid transport & accompanied me to hospital and took care for the child. Am continuing with my ARVs and she regularly visits me. The nurse can attest the sorry state I was in the past since I was unable to walk up but the CHV supported me up-to when I gain strength. She is like a mother to me. My family stigmatized me and isolated the items I used.

CHV: The client did not attend ANC clinics neither delivered in hospital and the child was 5 months old without any immunization at the time of contact and enrollment.

Recommendations

- Intensify on bringing pregnant women to facility so that this can be celebrated when they graduate 24 months.
- Identification and prompt referrals of HEI to avoid losing them.
- Intensity testing as the WAD is close as an pre activity for the D DAY

3.3.1. Awareness creation of SGBV for men-by-men activity in Mudoma center, Samia Sub county.

The area chief requested to have a session with men to address the rising cases of defilement, rape, wife battering and widows being denied their properties by the in-law. The chief mentioned that the cases being reported to his office were worrying and he felt that such

information would be crucial to the people of this area. Since gender-based violence was not discussed by many in this community because it is considered not necessary yet it has great repercussion for the people of this community. Members present during the session included the SCCSFP, the ward CHA, chief, village elders, KCM members, AMREF, KRCS and WOFAK staff. The participants wanted to know why men were targeted. A WOFAK staff member explained that in most cases men are the perpetrators of the above mentioned. During the meeting, the facilitator dwelt much on session 3 of the training manual on masculinities and engaging men. The facilitator explained the objectives of the session as to enhance men's knowledge of gender-based violence and the spread of HIV and STI. The meetings other objective is imparting knowledge to men so that they become change agents in mitigation of SGBV and the spread of HIV & AIDs. Physical, economic, Psychological and Cultural violence were amongst topics discussed.

The facilitator sort to explain to the men present in the meeting how socialisation creates gender differences which results in others feeling superior to others, results in others feeling superior to others, results in others feeling superior to others, results in others feeling superior to others thereby infringing on their rights. He discussed the issue of sex where women are not allowed to negotiate matters relating to sexuality. In so doing when such men are infected, they will eventually transmit the virus to such women

Some cultures in traditional communities makes both male and female prone to HIV & AIDS especially inheritance where one is dictated to inherit the wife of the diseased bother regardless of their HIV status. In such a scenario one is exposed to the virus but since cultures state otherwise one cannot defy the odds.

Especially during the COVID-19 period more gender violence's was reported and this was due to depression, stress, and economic inflation.

The facilitator further stated that the African up upbringing of children in society makes the female sex inferior to males. He asked why certain roles are preserved for certain sexes. e.g., cooking to be a preserve of women and not men where he asked what happens to men if they cook. Does this change their sex? This leads to physical abuse by men if women do not prepare food for them, hence GBV

In African settings, it is perceived to be right for a man to marry more than one woman but women cannot. This gives men chances of having multiple sex with other women, making their spouses vulnerable to HIV especially when such sex is done unprotected.

Through this has not been articulated well in the society, women have experienced rape in their matrimonial unions which go unreported due to lack of legal in the law. Once one part especially the female part does not consent to sex it qualifies to be rape and in such there can be bruises leading to the spread of HIV & AIDS and sexual transmitted infections (STIs). This prompted a heated debate where men were asking how possible it was for a husband to rape their own spouses, they linked this with the Beijing protocols terming it un-African.

Physical abuse is also a form of gender-based violence. In this case men are the main perpetrators because they feel more masculine than men. Men have also turned out to be victims of physical abuse and do not report this as they feel ashamed and some said they have never known they could report when abused. The facilitator taught them to know their rights.

KCM observation

- Include law makers when developing laws to govern the community.
- Community policy should be key as this keeps the community in place.
- The community should be able to identify responsible dockets to address in case of an incident. This can be achieved if people are imparted with proper knowledge.

Recommendations/Way Forward

- Men felt that the knowledge imparted was so important that the session needs more time where it is done inform of a training then members are given information.
- Men felt that more empowerment is required to change the mind set of men who are perceived to be the most perpetrator of GBV.
- Authorities dealing with GBV should tighten their nuts by bringing culprits to book as this would instil fear among the perpetrators.
- Some retrogressive cultures should be addressed by bringing cultural leaders and key informants such as Village elders, Chiefs, assistant chiefs, and religious leaders on board to learn on the dangers of GBV and educate the community after acquiring knowledge.

3.4. Holy Family Nangina Mission Hospital (24 Nov 2020)

3.4.1. Meeting CHVs, Linkage Assistants, MDR Champions & Beneficiaries of Global Fund Tuberculosis - Amref/ IRDO

Community Health Volunteers (CHVs) highlighted the activities implemented in the community and outlined the support provided by Amref through IRDO.

Contact Screening by CHVs

- The CHVs carry out household visits for contact screening of all bacteriologically confirmed TB patients and children under the age of 5 diagnosed with TB.
- All contacts who have suggestive symptoms of TB and children under the age of 5 are refer to the facility for further evaluation and initiation of IPT.
- Data on contact, referral and IPT is documented in the TB contact screening forms, patient referral form (MOH 100) and Contact management register (CMR). These tools are printed and distributed by Amref through IRDO.
- CHVs are supported with a stipend of KES 840 per household visited.

- In the household the CHVs provide health education, assess the general living conditions (Ventilation) and advice accordingly before carrying out TB screening and referral of all presumptive patients and all children under 5 years

- Challenges – Sometimes CHVs visit households and fail to find the family members despite prior arrangements with the index clients and the CHV is forced to visit one household more than once depleting the support provided.

- The CHVs requested if they can be supported with airtime for calling clients to plan household visits.

- CHVs reported that they were provided with PPEs, Gloves and Sanitizers by Amref/IRDO to ensure service continuity during COVID-19

Treatment Interrupters Tracing by CHVs

- Patients interrupting treatment are traced by the CHV who are supported with KES 840 for lunch and transport for every patient traced.

- Tool for management of patient interrupters including patient interrupter tracing form and appointment diaries have been printed and distribute by IRDO/Amref.

- Airtime support to the healthcare worker at the chest clinic enables the clinician to call the patient interrupting treatment and only send the CHVs to trace the patients if calling fails to work.

- Interruption is low in the facility visited and only one patient has been traced in the last 2 months.

Linkage Assistant

- Linkage assistant engaged by Amref/ IRDO to support ACF processes to address the gaps in linkages within the facility described his work in the facility and the support provided.

- The linkage assistant supports the clinician in the OPD department to fast-track coughers, link them to laboratory services and escort patients diagnosed with TB to the TB clinic for initiation of treatment.

- The linkage assistant also provides health education to the patients on TB and demonstrates how to produce quality sputum for TB test.

- A Linkage assistant is provided with a support of KES 5,000 per month to facilitate this work

Data Flow

- Data from all data sources including TB4 register, presumptive register and CMR is entered into the TIBU system.

- ACF data is summarized in ACF departmental and Facility summaries that are submitted to the Subcounty and uploaded in the DHIS-2.

- PR2 requests data from TIBU on need basis.

Meeting the Beneficiaries

MDR TB Patient

- The team met with one DRTB patient and 4 DSTB patients
- The DRTB patient - an elderly woman of 18 months (about 1 and a half years) injection free regimen - expressed her satisfaction with the services provided in the hospital.
- All drugs have been available for free to the patient except for pyridoxine which is out of stock. The patient has developed peripheral neuropathy and currently needs a high dose pyridoxine of about 150 mg per day. This high dose is too expensive for the patient to buy privately.
- The patient had been receiving KES 6,000 social support from Amref and supporting her for food and transport costs to the hospital when necessary.
- The patient has used some of the money to buy and rear chicken at home.
- A DOT worker supported by Amref deliver drugs to the patient at home to ensure the patient does not visit the facility all the times.
- The patient is also enrolled for NHIF as part of social support.

Drug Sensitive TB Patients

Four patients drug sensitive TB patients were met and interviewed;

- A woman on a 12-month regimen for TB spine. The patient was not able to walk at the beginning of the treatment and now can walk. All the drugs are available for the patient. The patient was satisfied with the services provided although she still had back pains that had not been resolved completely.
- A mother and her 6-month-old child who are on TB treatment was interviewed. The mother expressed joy and gratitude for the services offered to her and the child. The child had coughed for three months and had sought care in private health facilities before a CHV (supported by IRDO) referred her to the hospital after a home visit. She and her then 3-month-old baby were diagnosed with TB and put-on treatment. The child's appetite and weight subsequently increased and they are both doing well in their third month of treatment. All drugs have been available for the mother and the child.
- The last patient was a young man aged 20 who is on treatment in the facility who expressed satisfaction with services given and reported that he had improved since initiation of treatment. Before being diagnosed with TB, the young man had bought cough syrups from the chemist severally.

MDR Champion

- This is a former MDR patient who adhered to treatment and recovered successfully and is now engaged by Amref to create awareness on TB and DR TB.

- The champion described how he got TB while in Nairobi and had to move together with his family to Busia where he has a small house. He was advised to stay with his family in a small house due to Infection Prevention and Control (IPC) issue. Through social support (KES6000), he was able to buy iron sheets, build a house and was able to follow treatment while staying with his family.
- His work under Amref involves health education in several hospitals within the sub-county and referral of patients with TB symptoms.

Challenges/ Bottlenecks	**The Proposed Way Forward**
No provision for airtime to call clients to plan home visits	Amref to provide airtime to the CHVs carrying out contact tracing and treatment interrupters tracing
The support provided for contact screening and treatment interrupters tracing (KES840) is minimal	
Training for CHVs on TB has taken a long time since it was done.	CMEs and Upcoming COVID-19 sensitization
Shortage of pyridoxine	
Sometimes patients give incorrect locator information or shifts and this presents a tracing challenge.	

4. Annexes

4.1. Program

Day/Time	Activity/Event/Tentative Discussion Points	Venue
22 Nov 2020	Travel	
23 Nov 2020 09h00 – 10h00	Courtesy call on the Hon. Governor • Introduction • Purpose / Objectives of the visit.	County Headquarters
10h00 – 12h00	**Meeting with BUSIA CECMH/COH & CHMT & Partners** ✓ Introduction/ Welcome Remarks ✓ Presentation by CHMT on the situation of GF (HIV/TB/Malaria) ✓ Overview of KCM& Global Fund. ✓ Presentation on GF investments and by PRs, the National Treasury, Amref Health Africa and KRCS ✓ Establish HIV, TB and Malaria commodity status ✓ Discuss Measures in Place to Control spread of COVID 19 / Mitigate its effects. Question and Answer session	CHD Offices
13h00 – 14h00	Lunch break	
14h00 – 16h30	**Site visit County Referral Hospital** – • Courtesy call on the Hospital CEO • Visit HIV/TB/Malaria service delivery points • Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects • Visit Pharmacy store • Visit Laboratory • Visit youth Centre	Khunyangu Sub County Hospital
17h00 – 17h30	Recap of Day's Activities	
24 Nov 2020 Morning	Visit KRCS SR implementing HIV Programme - show case AYP, Key population and HIV prevention for General Population /meeting with CHVs/Visit beneficiaries /PLHIV Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects	WOFAK
Afternoon	Visit Subcounty Hospital • Courtesy call on the Hospital CEO	Holy Family Nangina mission hospital

Day/Time	Activity/Event/Tentative Discussion Points	Venue
	• Visit HIV/TB/Malaria service delivery points. • Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects • Visit Pharmacy store • Visit Laboratory. • Visit youth Centre	
25 Nov 2020 09h00 – 13h00	Visit Amref Health Africa SR implementing TB Programme - show case TB Active case finding, Visit Beneficiaries / MDR Client /meeting with CHVs Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects	TBC
14h00 – 16h00	Visit primary health care Facility • Courtesy call on the Hospital In charge • Visit HIV/TB/Malaria service delivery points • Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects • Visit Pharmacy store • Visit Laboratory. • Visit youth Centre	Amukura Health Center
26 Nov 2020 09h00 – 13h00	Visit Amref Health Africa SR implementing Malaria Programme - show case community case management of malaria /LLIN Mass net distribution / Visit Beneficiaries / /meeting with CHVs. Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects	TBC
14h00 – 16h00	Report writing	
27 Nov 2020 09h00 – 11h00	Debrief CHMT	

4.2. Oversight Visit Team

	Name	Affiliation[1]	Designation
1.	Mr. Chris Lubanga	Amref Health Africa (PR2 – Malaria)	
2.	Ms. Jacinta Kandie	Amref Health Africa (PR2 – Malaria)	
3.	Ms. Lillian Manyonge	Amref Health Africa (PR2 – Malaria)	
4.	Mr. John Mungai	Amref Health Africa (PR2 – TB)	
5.	Dr Ischar Oluoch	KCM	Member: COG
6.	Mr. Ahmed Said	KCM	Member: KP
7.	Ms. Patricia Mwende	KCM	Alt. Member: Informal Sector
8.	Dr Victor Sumbi	KCM Oversight Committee	Member: Malaria ICC
9.	Mr. Kevin Ogola	KCM Secretariat	Member
10.	Mr. Samuel Muia	KCM Secretariat	Coordinator
11.	Ms. Lilian Kongani	KRCS (PR2 – HIV)	
12.	Ms. Sophia Njuguna	KRCS (PR2 – HIV)	Program Quality Manager
13.	Ms. Phirez Ongeri	MOH/ DNMP	
14.	Mr. Silas Kamuren	MOH/ NTLP	
15.		MOH/ CHMT Busia	Deputy CMCC
16.		MOH/ CHMT Busia	County TB Coordinator
17.		MOH/ CHMT Busia	CASCO
18.		IRDO (SR – TB)	
19.		WOFAK (SR – HIV)	

[1] DNMP – Division of National Malaria Program; KRCS – Kenya Red Cross Society; COG – Council of Governors; KP – Key Populations

4.3. Success Stories