KENYA COORDINATING MECHANISM FOR GLOBAL FUND OVERSIGHT FIELD VISIT REPORT

KWALE COUNTY

November 23rd to 27th November 2020

Contents

Acronyms

CHMT	County Health Management Team
CCC	Comprehensive Care Clinic
CHU	Community Health Unit
CHV	Community Health Volunteer
COVID	Corona Virus Disease
CSO	Civil Society Organization
DNMP	Division of National Malaria Program
GF	Global Fund
KCM	Kenya Coordinating Mechanism
KEMSA	Kenya Medical Supplies Authority
KRCS	Kenya Red Cross Society
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NASCOP	National AIDS and STIs Control Program
NTLLP	National Tuberculosis, Leprosy and Lung Diseases Program
PR	Principal Recipient
SR	Sub Recipient
TNT	The National Treasury
HIV/AIDS	Human immunodeficiency Virus/Acquired Immunodeficiency Syndrome
PTB	Pulmonary Tuberculosis
VMMC	Voluntary Medical Male Circumcision.
USAID	United States Agency for International Development

1.0 Executive Summary

The best feature about Kwale County is that all health services are free. They have attained universal health coverage. Kwale County also covers for commodity stock outs from county coffers driving an agenda of sustainability very intensely.
In this executive summary we present findings by objective of the oversight visit the conclusions and key recommendations.

Objective 1: Establish HIV/TB/Malaria commodity security status and progress made in strengthening supply chain systems

- There were adequate stock levels in the pharmacies
- HIV has Adequate Commodities (ARVs, IO drugs, RTDs, Condoms and Lubricants)
- Malaria commodities and drugs are available in the county
- TB clinic well stocked with commodities

Objective 2: Establish progress made on implementation of COVID-19 Support /Mitigation of C19 effects.

- COVID 19 -PPE supplies to CHVs through AMREF
- Training of Health Care workers on COVID 19 by KRCS

Objective 3: Establish bottlenecks/challenges affecting GF implementation and recommend solutions/ strategies to improve grant performance.

Achievements

- There were adequate stock levels in the pharmacies
- Innovation to start targeted community TB screening and testing was employed.
- Cascading of the 90:90:90 strategy stands at 70% 100%93% Lunga Lunga
    - Assisted Partner Notification Process 35% success in Lunga Lunga
    - Contact tracing through CHVs. This has yield 3% of TB cases reported in Kwale.
    - Social support to DRTB

There are capacity gaps observed

- Understaffed facilities
- Capacity for stock quantification needs building
- When facilities are upgraded to sub county level it would just be nice to match the infrastructure with equal number of skilled staff. Some CCC centers were supervised by 1 clinician – Lunga Lunga

    - Space for pharmacy, and stand-alone TB clinic to avoid infection to other patients
    - GeneXpert machines
- HRH- Few staff. Facilities are over stretched;
    - Samburu Clinical Officer works from 7.30am-8PM
    - Lunga Lunga – 1 clinical officer for the CCC centers
- Inadequate pharmacy store
    - Lunga Lunga uses the old kitchen, Samburu was inadequate as well.
- Equipment: GeneXpert machine is shared between Msambweni and Lunga Lunga and serving far flung lower level facilities is over stretched

Objective 4: Engage with stakeholders/ beneficiaries and share information/ experiences regarding GF Programming in Kenya

- KP program interventions (FSWs, MSM, Transgender and PWID)
- Manual data collection and storage
- Kwale county offers 100% free Medical services
- Engage with stakeholders/ beneficiaries and share information/ experiences regarding GF Programming in Kenya.

Recommendation

- Additional GeneXpert for Kwale County, to make diagnosis more efficient especially for Lunga Lunga and Samburu Sub County hospitals.
- Before then improve the logistics (delivery of specimen and collection of results) is done by the lab assistant. Can explore encamping a boda boda rider to assist.
- Assistance in the formulation of child friendly DRTB drugs.
- National to hasten the process of NHIF to our DRTB clients-Last payment done in July 2020.
- Capacity building of health care workers can be outsourced to the Non-State actors as state has the next 6 months to close the GF project for this allocation

Conclusions

The best feature about Kwale County is that all health services are free. They have attained universal health coverage. Kwale County also covers for commodity stock outs from county coffers driving an agenda of sustainability very intensely.

2.0 INTRODUCTION

2.1 Background Information

The mandate of Kenya Coordinating Mechanism (KCM) is to oversee the overall management of Global Fund grants to fight AIDS, Tuberculosis and Malaria (GFATM). The KCM Oversight team conducted an Oversight visit to Kwale County. The Committee also included selected persons from both PR 1 the National Treasury, Amref, The Kenya Red Cross Society and sub recipients under PR 2 with a focus on special initiatives. The visit was under from 23rd to 27h November 2020. The Oversight team was led by M/s Eva Muthuuri – KCM member and consisted of a team members identified from KCM (Civil Society, Disease specific ICCs, Government Officers, from KCM Secretariat and the KCM Oversight Officer. Annexed as appendix one find details of the team members.

2.2 Purpose

The Kwale County Oversight visit aimed at establishing progress made on implementation of COVID-19 Support /Mitigation of C19 effects ant to identify challenges affecting GF implementation and recommend solutions/strategies to improve grant performance. This was with a specific focus on the grant cycle that started in 2018/2019 with an end period of June 2021.

2.3 Oversight Field Visit Objectives

1. Establish HIV/TB/Malaria commodity security status and progress made in strengthening supply chain systems
2. Establish progress made on implementation of COVID-19 Support /Mitigation of C19 effects.
3. Assess progress made in Construction of KEMSA Warehouse
4. Establish bottlenecks/challenges affecting GF implementation and recommend solutions/ strategies to improve grant performance.
5. Engage with stakeholders/ beneficiaries and share information/ experiences regarding GF Programming in Kenya

2.4 Oversight visit guiding questions

The following tools were developed to facilitate information gathering during the oversight visits:

- Oversight field visit checklist for county health department
- Assessment of progress made on implementation of COVID-19 Global Fund support
- Oversight field visit checklist for sub-recipients (SRs)
- Oversight field visit checklist for MOH Facilities

3.0 Methodology

3.1 Approach

On arrival at every facility the team paid a courtesy call to the facility in charge. The meetings were held in adherence to the MoH Covid 19 guidelines. The general methods of engagement were in form of

- Discussions and Presentations
- Key informant Interviews using standardized tools and questionnaires
- Inspection of Documents and Records and Observation at facility level.
- Conversations with both patients and service providers including Community

The oversight visit was highly participatory and consultative process which was conducted through an in-depth analysis of Programmatic and Financial data and information including site Visits to health facilities and SRs within Kwale County.

3.2 Technical approach

In order to collect data, the team applied the following stepwise approach:

3.3. Step 1: Online training and capacity building of various oversight teams.

These training session s including discussion of the tools, the logistics plans, the oversight action plan and program.

3.4 Step 2: Prior Preparation.

The KCM Secretariat was instrumental in making prior preparations, creating rapport and booking appointments through the County Executive Committee member for Health, the Principal Recipients and their sub recipients, the beneficiaries and community health workers across the cadres. The KCM members were alerted early enough of their engagement so as to adjust their calendars and timelines

3.5 Step 3: Travel and Courtesy call.

The team members arrived Kwale a day prior to the start of the oversight visits. The team arrived Kwale the first meeting was a courtesy call to the Governor Kwale County, Hon. Salim Mvurya while accompanied by the CECMH Francis Gwama and his team of three diseases leads for Malaria, TB and HIV. After meeting the His Excellency Governor Salim Mvurya, we had presentations from the disease leads and PRs as well KCM Secretariat.

Figure 1visiting the County Governor

3.6 Step 4: Formation of over sight sub teams along diseases areas.

Kwale County is vast with very long distances between facilities and sites, during the over site visits the national curfew was still in force. To make best use of time at a facility, allow the health care workers and patients enough time to render and receives service and close in adherence to the curfew and MOH COVID guidelines the team split up into 4 groups.

3.7 Step 5: Focused over sighting.

Each team would ensure they filled the questionnaires from the cardinal points of outpatient department, the lab, the pharmacy and other critical service delivery points. Noting the strengths and bottle necks at each area. Covid 19 was a cross cutting theme for all teams.

1. Those visiting the CCC center and focusing on HIV
2. Those visiting the TB clinic
3. Those visiting the outpatient department to focus on malaria as an integrated service.
4. The community service providers oversight team

3.8 Step 6: Actual data collection.

On arrival at every facility the team paid a courtesy call to the facility in charge. The meetings were held in adherence to the MoH Covid 19 guidelines. The general methods of engagement were in form of

- Discussions and Presentations
- Key informant Interviews using standardized tools and questionnaires
- Inspection of Documents and Records and Observation at facility level.
- Conversations with both patients and service providers including Community Health Workers
- End of day recap and reconciliation by team members and team leads

3.9 Step 7: Ensuring a Logical flow of the Geographic Scope during the visits

Facilities that were in the same direction were visited on the same day for efficiency and effectiveness

- **Day 1** – County Head Quarters and in Kwale town, CHMT visit too. The other visits in the afternoon were in Diani area that included the Diani Health Centre, Ukweli MSM and Teens Watch. Debriefed at Diani.
- **Day 2**- Samburu Sub county Hospital, ADS Pwani, interviewed an MDR Client at the Vigurugani Health Center and Kinango Sub county Hospital. KANCO made a presentation to close the day to the team through a consultative meeting as SRs implementing in the community in Kinango. This facilities are located along the Nairobi- Mombasa highway. That was a long drive from Kwale town. It was the toughest day in terms of distances covered.
- **Day 3** - the KCM oversight team attended a special KCM meeting from morning until later in the afternoon when the technical teams converged to reconcile and write out their team reports.
- **Day 4** - the KCM Oversight team visited Lunga Lunga Sub county Hospital which is a referral hospital and had a consultative meeting with the ADS Pwani, an SR in Kwale County. In the afternoon the teams briefed the CHMT on their findings and recommendations.
- **Day 5 Quality Control -** The team leadership met to crosscheck the completeness, correctness and consistency of the findings and recommendations by various teams. The final reports were collated and edited for completeness according to the KCM guidelines for oversight visit reporting.

  See Annex for Program

4.0 FINDINGS - KWALE COUNTY HEALTH SERVICES

In this section we present findings by disease area and by key objectives, appended to which is a detailed description of findings by site visited and reports by each subgroup.

Section 1: Key findings by Diseases Area

4.1 The Kwale County HIV situational snapshot

In Kwale County the estimated number of People living with HIV (2019) is 16,692 which accounts for an HIV prevalence rate of 2.9%. Being a tourist town, the numbers of Key populations are well documented and presented in the table below that was shared with the team by the CHMT on day one.

Description	Number
Number of sub counties	5
Number of wards	20
Total Population 2019/2020	905,320
Estimated HIV Prevalence *(2019)*	2.9%
Estimated PLHIV *(2019)*	16,692
Estimated number of pg women	35,398
Need for PMTCT *(2019)*	643
Estimated number of FSW	3395
Estimated number of MSM	681
Estimated number of PWID	1736
Total no. of health facilities	152
HTS Sites	124
Care & Treatment sites	100
PMTCT Sites	124
Functional CHUs	171

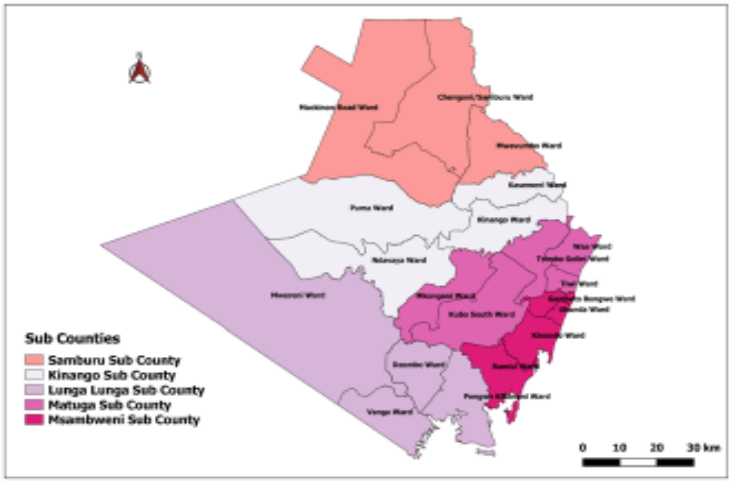

Figure 2 Source - Kwale County CHMT

4.2 Global Fund supported areas

No.	Area	Key activities supported
1.	Leadership/Governance	• Coordination & planning meetings; technical working groups • Supportive supervision
2.	Human Resource	• Hiring/remuneration (data management assistant, lab techs, mentor mothers) • In service trainings for healthcare workers, lay health workers i.e. CHVs, caregivers, peer supporters etc)/Regular technical assistance from national teams
3.	Health Commodities	• Supply of ARVs, diagnostics, other non-pharmaceuticals • TA for forecasting and quantification
4.	Health Information Systems	• Supply of data collection and reporting tools • Target setting, work planning, and performance monitoring • County and regional data review sessions
5.	Service delivery	• Defaulter tracing mechanisms

		• Community engagement through dialogues • Support groups for children care givers, adolescents, youth, men etc • Home & community based care (HCBC) • Conducting outreaches/Client referrals & linkage
6	A focus on Key Populations	• Key population program interventions (FSWs, MSM, Transgender and PWID Development of Adolescent comprehensive SGBV and HIV prevention packages and tools/ Recruitment and training of mentor mothers/ Peer led HIV testing services
7	Communication	• Equip for teleconferencing/Mass media through digital platform and interpersonal engagement with fisher folks and motorbike riders
8	Advocacy	• Advocacy forums – CHMT, law enforcers, network of people living with HIV, KPs, Insurance companies, Judiciary, National assembly members

4.3 Challenges, opportunities and Recommendations

No.	Challenge	Opportunities/priority areas/Recommendation
1.	Low identification among males and adolescents and young persons	• Engaging male champions (including local political leaders) • Strengthening collaboration between MoH and Kenya Network of HIV Positive Teachers (Kenepote) • Facility level quality improvement projects focusing on males & AYPLHIV • Scale up of OTZ
2.	Low viral suppression among children coupled with malnutrition	• List households with HIV positive children as beneficiaries of the various food distribution programs/ economic empowerment initiatives outside the department of health • Scale up differentiated service delivery
3.	Low skilled delivery among HIV positive pregnant women and late postnatal care attendance	• Invest in free and open source digital solutions for tracking mothers and newborns across the continuum of care • Increase the number of mentor mothers in the County
4.	Incomplete coverage of key populations	• Identify a sub recipient to offer services to men having sex with men in Msambweni sub county
5.	Data quality issues	• Technical assistance for HCWs in facilities with Kenya EMR • Ensuring adequate supply of the latest versions of data tools • Trainings on data collection, reporting and data use • County led implementation research projects

4.4 Tuberculosis Prevalence Rate

Tuberculosis (TB) is the leading cause of mortality among infectious diseases globally. Kwale county had a mortality rate of 10% among patients diagnosed with Tuberculosis in the year 2019.

Kwale County has four Tuberculosis control zones and its case notification rate is 102/100 000 population with 992 cases diagnosed in the year 2019. Msambweni Sub County is the leading sub county with a case notification rate of 225/100 000 whereby 394 cases were diagnosed in the year 2019, followed by Kinango(256 cases),Matuga (177cases) and Lungalunga(165 cases) respectively. The County defaulter rate has is below 1%

4.5 TB Services delivery

Identification of TB services done is done at OPD by screening using TB ACF card with the 5 questions. Investigations are done in the lab and by Gene Expert. Patents diagnosed with TB are registered in the TB Clinic and started on treatment and managed from the TB clinic.

TB Case finding at Facility level in terms of screening was suboptimal at OPD. Among the people with URTI in OPD which were 324 only 48 were in the TB Lab register which translates to 14%. The team observed some knowledge gap with the service providers in terms of screening and offering support to the OPD teams in terms of OJT and plans to support TB screening and facility ACF.

Generally, the services provided were good, we observed low defaulter rates in both facilities. Diani had 2 lost to follow out of 25 patients. In Samburu we noted that they had no defaulters. The team however noted a high death rate in Samburu at 26%

In terms of access to the Gene Experts, the two facilities visited (Diani and Samburu Health centers) were not Gene Expert sites and therefore they had to transfer their patient's samples to the nearest Gene expert machine. The **main challenges is that the County does not have an organized system of sample transportation**. This poses a challenge in identification and follow up of patinets. For example in Diani Health center the Lab person had taken a personal initiative to deliver and pick results to Msambweni Sub County Hospital while in Samburu an ambulance takes the samples to the to Kiango Referral. This the team observed that in the situation where the facility has no fuel for the ambulance or there is a mechanical problem the samples will not be transported. There is therefore a need to ensure that the County plans and organize an efficient transport system for sample transport network.

The turnaround time for results is generally good but of concern is that the GX alert was noted not to be working efficiently since getting lab results online is a challenge out f 5 samples taken about 3 of them are returned through the online system.

The facilities we visited showed a lower Treatment success rate Diani Health Center had 67% while Samburu had 57% as compared to the County average which is 83%.

4.6 TB Commodities

All the individual patient packs were available in the facilities visited with adequate buffer stock. The bin cards and the commodity consumption registers were generally being well utilized and well

updated. We noted Stock out of INH and pyridoxine. The Challenge of storage of TB medicines was noted in Samburu health center

Despite the fact that GF did not procure Nutrition commodities, they were available with the support of UNICEF since this is an ASAL County and once available it provides nutrition support for all clients.

4.7 Challenges

- Challenge with storage of TB medicines
- Knowledge gap challenge for TB service providers
- No organized Lab transport network in the County - Challenges with accessing Gene expert and the lab transport network
- TB Commodity status challenge - The stock out of Pyridoxin and INH
- County mortality data - The county reported 10% death rates while observation during a visit to Samburu health center noted a 26% death rate

4.8 Recommendations

- The MDR patient visited to be used as a TB champion to share his story and be able to encourage others. To be used in advocacy and network support group.
- The facility to get a cabinet for storage of TB medicines
- Facility CMEs on Active TB screening at OPC and data use
- Work on organizing and support the Lab transport network and allocate resources for the same
- National TB program to follow up and fast track the availability
- Need to conduct mortality audits

4.9 Malaria

Malaria is the leading causes of Morbidity and Mortality in Kwale County. According to the DHIS data, it is the number five cause of morbidity among children under five and number two among the people over five years (DHIS data). The Malaria cases have been on the increase for the last two years rising from 145,110 cases in 2019 to 209,135 in 2020(44% incidence)

- Matuga sub-county is leading with 81,429 confirmed malaria cases, Lungalunga SC follows with 46,790, Kinango SC with 45,656 and lastly Msambweni SC with 35,260 confirmed cases
- In 2019 confirmed malaria cases per Ward was:
    1. Mkongani Ward -20,829
    2. Kubo South Ward- 14,467,
    3. Kinondo Ward - 12,652,
    4. Tsimba /Golini Ward - 12,369
    5. Pongwe/kikoneni-12136.
- This year confirmed malaria cases per Ward was:
    1. Pongwe Kikoneni Ward is leading - 19,930

2. Tsimba Golini Ward - 19,090
3. Mkongani Ward -18,451 cases
4. Kubo South fourth - 17,574
5. Kinango Ward -17262 cases.

4.10 Global Fund Supported Activities

Global fund has continued to support to Kwale County to implement Malaria control activities which include;

a. Supply of malaria commodities through KEMSA
b. Malaria case management training of health workers 200 HCW trained in 2017 and 2019
    a. In 2017 trained 80 HCWs and 2019 we trained 120 HCW through consultancy.
    b. This year we will train 100 HCWs on Management of malaria in pregnancy.
c. Malaria data quality audit through the GF sub recipient.
d. Malaria supportive supervision
e. Malaria entomological surveillance
f. Monitoring of in-patient and outpatient quality of care

4.11 Achievements

i. The health facilities are stocked with malaria commodities although the county complained that malaria commodity was funded from the county treasury due to delays in delivery.
ii. The county was prepared for mass net distribution
iii. Management of suspected malaria cases as per guidelines:
iv. Routine Net Support Supervision.
v. Carry out bi-annual Out-patient Quality of care surveys and In-patient Quality of care surveys.
vi. Quarterly; ordering procure, distribute and re-distribute mRDTs and ACTs (Antimalarial drugs) Through the Office of CPF and CMLTC.

4.12 Challenges

i. Processing of orders for Malaria commodities by KEMSA has previously taken a bit long period.
ii. The Malaria control towards elimination Kwale is dependent on the interventions in the other malaria endemic counties.
iii. Lack of LLINS for the Boarding institutions.
iv. Few staffs trained on malaria case management trainings are usually done as a block e.g. 360 HCWs for South Coast
v. Malaria commodity (mRDTs and ACTs) out of stock
vi. Few partners support for Larvae Source management
vii. The Irrigation areas and where we have large water bodies hence breeding areas for mosquitoes.

4.13 Recommendations

i. KEMSA to process the order for malaria commodities on time.
viii. Regular refresher training on malaria case management
ix. Scale up the best practice like Mashuja Campaign. (Demand generation through schools)
x. In future malaria control activities should be factored in program based financing.
xi. Create a Global fund; funding system for Malaria, TB and HIV in the Counties.
xii. Scale up train of communities to increase their participation in malaria prevention especially in the Malaria leading Sub-counties and Wards.

4.14 Global Fund Support in COVID ERA

PPE supplies to CHVs through AMREF

They are given supplies of re-usable masks, gloves and sanitizers to CHV doing community activities.

Capacity building

- COVID 19 -PPE supplies to CHVs through AMREF
- Training of Health Care workers on COVID 19 by KRCS

Media communication Support

Different media houses have been used to pass COVID 19 messages and invite the public to screen.

Section 2: Findings by Objectives set for the oversight visit

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Achievements

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- Cascading of the 90:90:90 strategy stands at 70% 100%93% Lunga Lunga
    - Assisted Partner Notification Process 35% success in Lunga Lunga
    - Contact tracing through CHVs. This has yield 3% of TB cases reported in Kwale.
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There are capacity gaps observed

    - Understaffed facilities
    - Capacity for stock quantification needs building
    - When facilities are upgraded to sub county level it would just be nice to match the infrastructure with equal number of skilled staff. Some CCC centers were supervised by 1 clinician – Lunga Lunga
    - Space for pharmacy, and stand-alone TB clinic to avoid infection to other patients
    - GeneXpert machines
- HRH- Few staff. Facilities are over stretched;
    - Samburu Clinical Officer works from 7.30am-8PM
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- Inadequate pharmacy store
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Objective 4: Engage with stakeholders/ beneficiaries and share information/ experiences regarding GF Programming in Kenya

- KP program interventions (FSWs, MSM, Transgender and PWID)
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- Additional GeneXpert for Kwale County, to make diagnosis more efficient especially for Lunga Lunga and Samburu Sub County hospitals.
- Before then improve the logistics (delivery of specimen and collection of results) is done by the lab assistant. Can explore encamping a boda boda rider to assist.
- Assistance in the formulation of child friendly DRTB drugs.
- National to hasten the process of NHIF to our DRTB clients-Last payment done in July 2020.
- Capacity building of health care workers can be outsourced to the Non-State actors as state has the next 6 months to close the GF project for this allocation

6.0 Conclusions

The best feature about Kwale County is that all health services are free. They have attained universal health coverage. Kwale County also covers for commodity stock outs from county coffers driving an agenda of sustainability very intensely.

1) Generally, the commodity security status is good except shortages in Septrim, Pyridoxine and INH
2) Attempts to prevent and mitigate the effects of Covid-19 have institutionalized however there is room for more improvement.
3) Beyond the provision of GF commodities, consideration should be made to fund programs that promote community rights and gender and the health facility to better support treatment success reduce incidences of SGBV especially among children
4) More detailed discussions in the appendix of the report

7.0 Lesson learned

1) The GF has invested significantly to the response of HIV, Malaria and TB in Kwale County. However more interventions are required.
2) There were notable delays in delivery on medicines for up to 3 months in the beginning of the year due to Covid -19 challenges.
3) The CHVs supporting the mainstream health workers in the sites visited. Supported by
4) Partner contribution to access of health care is significant for all he facilities and was recorded in all facilities.

8.0 Appendices-

Appendix 1: Summary of Key findings by Facility Visited

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	Diani Health Centre				
	COVID 19 Patients and clinicians are observing COVID-19 protocols and the clinicians were trained by KRCS	Keep up the effort	County and partners	All through	Good
	Malaria 2.The patients get to the facility very late and hence late diagnosis	Sensitize the community on the importance of accessing health care on the early onset of feeling unwell	County/Partners	3 months	Input into SBCC
	Malaria Lab 3. Lack of proper mechanism of picking samples for GeneXpert and collecting results	Getting a system in place and use of the ward transport(motorbike) put in place to ensure efficient picking and collection of samples and results in a timely manner	County/Partners	3 months	Discussed with CHMT
	Malaria Pharmacy 4. The following Malaria commodities were available and the amount of time stock could last ;AL/Lum-6s' –	Keep up the effort	County/KEMSA/partners	All through	Good

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	750 doses MOS 9 Months; AL/Lum-24s – MOS 6 Months; RDT – N/A				
	MDR TB 1. The patient was diagnosed as MDR TB in February 2020 and was started on treatment immediately. He has adhered well to medication. He receives DOTS by CHV and being followed up by the TB specialist from the County Referral hospital. He was 40Kgs when he started medication and he is now 78Kgs. He is not receiving nutritional support but he gets social support of Ksh 6,000 from AMREF.	To be selected as a TB champion to share his story and be able to encourage others in advocacy and network support group.	County TB program and IPs	Within 3 months	Good
	TB Pharmacy • Challenge with storage of TB medicines • TB Commodity	The facility to get a cabinet for storage of TB medicines National TB program to follow up and fast track the availability	Facility TB clinic lead and the in charge of the facility		Discussed with CHMT

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	status challenge, stock out of Pyridoxine and INH				
	TB staff Training Needs Knowledge gap challenge for TB service providers	Facility CMEs on Active TB screening at OPC and data use	SCTLC to plan for County and National TB programs		Discussed with CHMT
	TB Lab Challenges with accessing GeneXpert and the lab transport network	Work on organizing and support the Lab transport network and allocate resources for the same	County and National TB programs	Continuous	Discussed with CHMT
	TB County mortality data. The county reported 10% death rates while observation during a visit to Samburu health center noted a 26% death rate	Need to conduct mortality audits	National TB program Facility, SCTLC and county teams	Continuous	Discussed with CHMT
	HIV CCC/Youth Friendly Inadequate staffing at the CCC.	Increase staffing at the CCC center Train support groups in IGAs for sustainability and motivation	County and Partners	Continuous	Discussed with CHMT
	Overdependence on donor support for support groups hence demotivated clients				

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	SAMBURU				
S/No	**Outpatient** 1.There is an established link between the facility and community for linkage and support of clients	**Best practice**	County and Partners	Continuous	Discussed with CHMT
	TB Currently there is follow up of 3 MDR clients ,1 had passed on in the month	Best practice	County and Partners	Continuous	Discussed with CHMT
	Health education is carried out on all the 3 diseases including HIV, TB and Malaria	Best Practice	County and Partners	Continuous	Discussed with CHMT
	CHVs and champions: The SR facilitates payment of stipends to CHV, linkage assistant and MDR champion with linkage assistant being paid 5000/= and MDR champion 4000/=	Best practice	County and Partners	Continuous	Discussed with CHMT
	Challenges: No job Aids to assist in information sharing –this Includes IEC materials	Avail job aids	County and Partners	Continuous	Discussed with CHMT

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	1 MDR champion serving the county and hence cannot reach all the beneficiaries	Invest in more champions	County and Partners	Continuous	Discussed with CHMT
	Distance and wide coverage of the county possess a risk as the stipend provided cannot sustain transport associated costs	Invest in more champions	County and Partners	Continuous	Discussed with CHMT
	Myths and cultural belief systems on causes of disease trends hinders health education efforts	Invest in consistently communication to clarify values	County and Partners	Continuous	Discussed with CHMT
	Malaria				
	Outpatient/Malaria 1.Record keeping was not as per the standards-No Bin cards were in place for the Als	Standardize record keeping, storage and offer capacity building to the pharmacy staff	County and Partners	Continuous	Discussed with CHMT
	Storage of commodities was not per the standards	**Storage cabinets**	County and Partners	Continuous	
	3.There is shortge of Staff and hence overstreched especially clinicians and in the laboratory	Increase the number of staff especially the county	County and Partners	Continuous	Discussed with CHMT

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	TB				
	2.Challenges with accessing GeneXpert and the lab transport network	create a sustainable mechanism for sample and results pick up for GeneXpert	Facility TB clinic lead and the in charge of the facility	Continuous	Discussed with CHMT
	Challenge with storage of TB medicines	The facility to get a cabinet for storage of TB medicines	County and National TB programs	Continuous	Discussed with CHMT
	CCC/Youth Friendly 1. Privacy –the facility shares premises with physiotherapy department and hence many a times the safe space of CCC is not observed. Furthermore, the facility location does not support privacy of the clients. Space – the CCC is congested and does not have enough room to offer services as required. This has led to mix up of GPs and CCC clients who are in turn exposed to Stigma and grapevines which can affect adherence.	Work on organizing and support the Lab transport network and allocate resources for the same Relocate the CCC/TB clinic to a more private location as the hospital has vast grounds. Proper storage of the medicine considering the privacy of clients and climate. Define and recognize the Adolescents and Young People accessing services at the facility CHWs should be facilitated to be able to work Increase male engagement HIV programs at community Provide nutrition supplements to patients	County and ADS-Pwani County County/ Partners	1 Month Continuous Immediately Consider in financial year/ next funding	Consider in financial year/ next funding Consider in financial year/ next funding Consider in financial year/ next funding

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	2. The ARVs are stored together with other drugs in the general pharmacy. 3.Due to space the facility does not have the required youth friendly services 4. CHWs not getting supported to do their work. **Community Health Service** 1. Engagement of CHVs commenced in 2018. 2.428 out of 442 CCC clients have been linked to CHVs 3.Viral suppression at the facility is above 90% 4.CHVs Stigma among the patients still high 5.Gender inequity- Inadequate participation of men in HIV programs 6. Lack of nutritional	Provide bicycles for mobility			

Summary of Key Findings and Recommendations					
S/No	**Key findings**	**Recommendations/actions**	**Responsible Person/Entity**	**Timeline**	**Remarks**
	supplements to support patients. 7.Vastness of households hence reaching all is challenge				

Appendix 2 OVERSIGHT FIELD VISIT TEAM

Community Subgroup

Ms. Eva Muthuuri	KCM member / Team Lead
Mr. Titus Kieta	Amref HA
Ms. Margaret Mundia	KCM Secretariat

HIV sub group

Ms. Joyce Auma	KCM member AYP
Ms. Rose Kaberia	Oversight Committee HIV Constituency
Mr. Sam Gachau	KRCS

TB sub group

Ms. Zilpha Samoei	KCM Alternate FBO
Dr. Peter Kimuu	TNT
Ms. Rita Wanjiru	KANCO
Ms. Mary Nyagah	NLTB
Ms. Jackline Mburu	Amref HA

Malaria Sub Group

Dr. Bob Agwata	Malaria Program
Mr. Antony Miru	TNT
Ms. Josephine Mwaura	KCM Secretariat
Ms. Lucy Wanjiku	KCM and Report writing Coordination lead

Annex 3: ITINERARY

THE KENYA COORDINATING MECHANISM OVERSIGHT MISSION: KWALE COUNTY 23RD TO 27TH NOVEMBER,2020		
Day/Time	**Activity/Event/Tentative Discussion Points**	**Venue**
22nd November, 2020	Travel	
23rd November,2020 09.00am-10.00 am	Courtesy call on the Hon. Governor • Introduction • Purpose / Objectives of the visit.	**County Headquarters**
10.00am to Noon	**Meeting with KWALE 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. ✓ UHC Pilot Experiences Question and Answer session	**CHD Offices**
01.00 pm-02.00pm	Lunch break	
2.00pm- 4.30pm	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	**Ukweli- MSM Network**
5.00pm – 5.30 pm	Recap of Day's Activities	
24th November5,2020 Morning	• 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 • ADS Pwani – meeting with the SR at Lunga Lunga S/C Hospital (SR to mobilize 5 men from the	**Lunga Lunga Sub County Hospital**

	general population to demonstrate SGBV discussions and linkages)	
25th November,2020 9.00am to 1.00pm/ 2- 5pm	• KCM MEETING • Drafting reports in sub groups	
25th November,2020 2.00PM- 4.30PM	Visit Sub county 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 • TEENSWATCH CENTER(PWIDs): SR to mobilize 5 young KPs, peer educators, outreach workers and a few parents	Diani Health Center
26th November 8.30am- 1.00 pm	Through Vigurugani Health Center- MDR client Interview. 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 KANCO to also show case what they are doing under the HIV grant	**Kenyan AIDS NGOs Consortium (KANCO)** **Site – Kinango Sub County Hospital**
2.00pm to 4.00pm	Debrief CHMT	
27th November,2020	**Departure**	

Appendix 5: Photos

Figure 3Excellency Mvuria welcomes the team to Kwale County

Figure 4Team listening to Gov Mvuria

Figure 5 Briefing from Kwale County Malaria Cordinator - Elizabeth Chomba