KENYA COORDINATING MECHANISM FOR GLOBAL FUND OVERSIGHT FIELD VISIT REPORT TO NANDI COUNTY

FEBRUARY 2022

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ACF	Active Case Finding
AMREF	Africa Health Africa
BCC	Behaviour Change Communication
NCTRH	Nandi 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

INTRODUCTION

On the 7th to 11th February 2022 the Kenya Coordinating Mechanism (KCM) for Global Fund (GF) conducted an oversight visit in Nandi County, Kenya. The KCM team comprised the secretariat, KCM members from malaria, KP and COG. 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. Present also were representatives from MOH divisions of NASCOP, Malaria and Tuberculosis. 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 oversight 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.

BACKGROUND

Nandi county was chosen for oversight visits because of the following reasons as extracted from KCM Minute meetings[1].

- HIV positivity rate
- The PMTCT prevalence rate
- Malaria positivity rates have reduced yet malaria admissions on the rise

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

METHODOLOGY

The Oversight visit guiding questions – see oversight visit Questionnaires

This was an oversight visit not a monitoring visit. The approach varied to suit the objectives of the oversight visit.

1. AREAS VISITED

Activity	Facility/ Place Visited
1. Courtesy meetings with the County leadership	CECM for health, Chief Officer for Health and CHMT (day 1) Governor, Chief Secretary and county health leadership (day 2)
2. Review of HIV, TB, Malaria and COVID-19 service provision and health commodities stock levels	Kapsabet County Referral Hospital (day 1) Kaptumo sub-county hospital (day 2) Kabiyet health centre (day 3)
3. Monitoring visits of the HIV, TB and Malaria Global Fund sub-recipients in Nandi	Family Support Institute (FASI) - KRCS SR for general population Impact Research Development Organization (IRDO) - KRCS SR for key populations Network of People Living with HIV/AIDS in Kenya (NEPHAK) - Amref SR for TB Catholic Medical Missions Board (CMMB): Amref SR for TB
4. Meetings with beneficiaries	Kapkangani health centre - CHVs, beneficiaries of FASI for gen pop
5. Exit briefing meeting with county health leadership and management teams	CECM for health boardroom

2. DATA COLLECTION

Data collection was done articulately and systematically. Each team handled a section of the sampled stakeholders with well laid out targets per day. There was a mutual sharing and exchanging of phone numbers between team members to enhance communication. Each group edited questionnaires with their team leaders at the field level before leaving the sites.

The task was demanding, though, with working hours often spanning 10 hours, from 8.00 am- 6.00 pm and sometimes running into the early night. They were generally welcoming and eager to participate since they had been mobilised earlier In some areas, translation into Kiswahili or the local language was done. Data was collected over a period spanning 5 days.

Ethical considerations of informed consent were followed to the letter, confidentiality and maintaining privacy during interviews and ensuring respondents names were out of the tools were observed.

3. LOGISTICS

Before fieldwork, mapping and routing were done in close consultation via email and phone calls with PRS and SRS. The preparation employed planning tools including a documentation on zones and c contacts of SRS.

Global Fund and partners provided the logistical support of transport. The PRS provided the network of stakeholders on the ground to help in creating the much-needed rapport, acting as a guide to get to meeting venues that were, in many cases, members' homes, MOH offices, and social halls, most conducted in the open spaces to adhere to recommended COVID-19 prevention protocols.

4. LIMITATIONS AND CHALLENGES

This being an oversight visit, only a small sample of health facilities and beneficiaries was visited thus the findings may not be generalisable to the whole county.

FINDINGS FOR EACH SITE VISITED

1. GF SUPPORT TO NANDI COUNTY: JULY 2021 TO JUNE 2021

Category	Estimated Value (Ksh)		
	National Treasury	Non-State Actors	TOTAL
HIV	136,331,255	40,731,857	136,331,255
TB	17,292,831	13,461,464	30,754,295
Malaria	201,266,624[1]	19,885,920	221,152,544
Total	**354,890,710**	**74,079,241**	**428,969,951**

2. COUNTY POLICY LEVEL INTERACTIONS AND OVERSIGHT

a) Entry Meetings
   a. Courtesy call with Hon Governor
   b. Entry Meetings CEC/CHMT

b) Overall disease burden for Malaria, TB and HIV/AIDS in the County

c) Overall situation of HIV/TB and Malaria Commodities in the County

d) Proportion of funds mobilized to support HIV/AIDS, TB and Malaria

e) Global Fund program areas of strengths and improvement.

2.1. ENTRY MEETINGS

Courtesy call on the Nandi County Governor: His Excellency Stephen Sang

The KCM oversight team together with representatives from the three principal recipients and national government MOH had a courtesy call on the Nandi County Governor, the County Secretary, Chief of Staff, the CEC member for Health and some members of the CHMT.

The KCM team leader took the Governor and his team through a presentation highlighting the Global Funds mission and vision, investments in Kenya and the in-country structures (the Local Fund Agent, the KCM management and oversight committees, the KCM secretariat, and the principal and sub-recipients of the Global Fund grant).

The Governor gave a detailed brief of the investments made in health care in Nandi county; including on infrastructure, equipment, human resources for health, health information systems, and health products and technologies. He informed the meeting that ~35% of the county's budget goes to health.

Other best practices highlighted by the Governor included:

- Co-creation of work plans with partners to ensure efficient use of resources and sustainability
- Facility Improvement Fund (FIF) bill approved by cabinet and pending passage by the County assembly

[1] TNT budget is for commodities procurement; Malaria figure includes mass net budget for 2021 and 2024; Non-state budget is for activities implementation

The Governor highlighted the following as areas of concern that require attention by the national and county governments:

- The KEMSA bill restricting procurement of health commodities by counties to KEMSA: with low fill rates by KEMSA, this bill has led to challenges in ensuring availability of health commodities in the counties. The KEMSA board should incorporate county government representation for inclusive decision-making.
- the NHIF: county governments should be involved in the NHIF board to provide their input in policy and decision-making by the body.

1) Meeting with the Health CEC and the County Health Management Team (CHMT)

The meeting was opened by Madam Ruth Koech - the CEC member for health Nandi County, and the session was chaired by KCM oversight chair for the event Dr Victor Sumbi and the CEC Madam Ruth Koech. CEC for Mandera Dr Eda Mahmoud was part of the team and was instrumental in inter county workflow to get the CEC and a meeting with H.E the Governor.

The team briefed the CHMT members on the membership and functions of the KCM. The CHMT were taken through the objectives, methodology and program for the 5-day visit.

2.2. OVERALL DISEASE BURDEN FOR MALARIA, TB AND HIV/AIDS IN THE COUNTY

1.1. Nandi County HIV profile

County	Population (Census 2019)	HIV Prevalence (Spectrum 2020)	No. of PLHIV (Spectrum 2020)	No. on Treatment (DHIS Dec 31, 2020)	Estimated No. of new infections per year (Spectrum 2020)	MTCT transmission rate
Nandi	952,975	3%	18,511	11,162	557	11.4%

Gaps

- Many defaulters among adolescents and young people with inadequate defaulter tracing
- Few mentor mothers supported by NASCOP/County.
- Low uptake of FP and cervical cancer screening due to staff turnover.
- HR Gaps to run CCCs e.g. Kabiyet, Kaptumo.
- Insufficient integration of Key Population services
- Gap between patient testing and ARV initiation

Interventions

Nandi county offer various HIV prevention strategies as listed below: -

- HIV testing, counselling (HTS) and health promotion
- Prevention of mother to child HIV transmission (PMTCT)services
- Voluntary medical male circumcision in selected health facilities within the tea estates where we have non- circumcising communities (27 facilities)

- HIV care and treatment services offered in 36 facilities
- Post exposure prophylaxis services- All ART facilities
- Pre exposure prophylaxis services- All ART facilities
- Key Population program- starting February 2022

1.2. Nandi County Tuberculosis profile

- Nandi County Case finding increased from 629 in 2020 to 716 in 2021
- Robust Contact and defaulter tracing. An increase of 14% in active case finding (2021)
- Co-infection among TB patients at 28%
- Low diagnosis of childhood TB- 4% against a target of 15%.
- Nutritional status: Severely Malnourished - 16% & Moderately Malnourished- 32%. Lack of nutritional supplements has impacted treatment outcomes
- Erratic supply of GeneXpert cartridges (Sep 2021 - Jan 2022). Inconsistent & delays in relay of GeneXpert results to peripheral facilities.
- Commodity insufficiency. Recommended >3 MOS

1.3. Nandi County Malaria Profile

Overall malaria prevalence stood at 1% which accounted for 30,000 outpatient Department (OPD) cases. Main geographic areas of malaria occurrence were Tinderet and Aldai sub-counties bordering the lake endemic zones.

Malaria Strengths mentioned included:

- Successful mass net campaign in 2021 that led to high coverage in Nandi
- Overall stock levels for all commodities (except RDTs) above max (6 MOS)

Malaria Gaps

- IPTp provision in 2 sub-counties (Aldai and Tinderet) with high malaria transmission was ongoing; however, information on IPTp coverage was not included in the county briefing.
- Inadequate MIS tools required to capture/ report key malaria indicators (e.g. OPD registers and reporting tools, lab tools); MIS tools, where available (e.g. Kabiyiet SCH), were not being filled correctly

2.3. OVERALL SITUATION OF HIV, TB AND MALARIA COMMODITIES IN THE COUNTY

1) Commentary HIV Commodities

A total of 22 types ARVs for adults were in stock see appendix (0) for details and 21 types of Paediatric ARVs see (0). Some HIV commodities not available for instance DBS filter papers, HIV test kits/ Dual Kits, Viral Load testing reagents. EID monitoring, testing and computing 3rd 95% performance at PMTCT difficult. DC affected due to lack of Viral Load reagents. Need to Hire more Mentor mothers to fill the gap of peer support and increase PMTCT Uptake.

2) *Commentary on TB drugs*

The latest county stock status for TB commodities was as below, TB Commodities reporting rate was 49% with 100% reporting on time for 2020

Commodity	Unit of measure	adj. AMC	Latest SOH	MOS
Patient packs	pack	52	262	2
R/H/Z (RHZ) 75/50/150 mg Tablets	pack	841	12,026	14
R/H 75/50 mg Tablets	packs	1,528	1,512	10
Isoniazid (INH) 100mg Tablets	packs	0	0	0
Pyridoxine 25mg Tablets	packs	1,000	3,252	3

3) *Commentary on Malaria Commodities*

Stock status for malaria commodities for the whole county was as below:

Commodity	Unit of measure	adj. AMC	Latest SOH	MOS
All artemether + lumefantrine tabs	Treatments	161,478	2,344,332	14.5
Artesunate Injection 60mg vials	Vials	1,898	19,740	10.4
Sulphadoxine + Pyrimethamine Tabs	Tabs	462	3,974	8.6
Malaria Rapid Diagnostic Tests	Tests	9,179	52,723	5.7
Long lasting insecticidal nets (LLINs)	Piece	18,000	2,000	9

3. SERVICE DELIVERY LEVEL OF INTERACTIONS AND OVERSIGHT

3.1. KAPSABET COUNTY REFERRAL HOSPITAL

The oversight team had a briefing meeting with the hospital management team which shared an overview of HIV, TB, malaria and COVID-19 services offered at the health facility. Highlights are as below:

3.1.1. MALARIA

Findings from the Laboratory, MCH, OPD, Pharmacy.

LABORATORY

The laboratory is ISO: 15189:2012 certified, with a performance of 85% and the team had to sign a non-disclosure agreement (NDA) as a compliance document for any visitors. As routine activity on compliance the Quality Assurance (QA) officer usually convenes a meeting of laboratory staff undertaking Malaria slides to recheck. The laboratory team requested for the recommended 5day malaria training for new staff members to balance off attrition. Slides are stained separately to prevent cross overs or contamination of results. A best practice noted was the Hospital laboratory service areas are digitized and freshly renovated with support from AMREF Global Fund grant.

Gaps noted: *Glycerol is currently out of stock. MOH 505 (IDSR Register) is out of stock- one copy in use being last one*

MCH Clinic: About 2,500-3,000 Clients are seen per month. LLINs distributed per month Antenatal Clinic-230; Child Welfare Clinic - 400; LLINS in stock at the time of visit was 1,900 pieces. Documents currently being used are MOH 405 and Free Net Pack (document used in documenting the receipt and on distribution of nets), Both documents were currently out of stock. Free Net Pack registers will be phased out because LLINs reporting is being integrated into KHIS - Kenya Health Information System tools.

The KCM oversight malaria experts advised the facility to issue nets to children under one during the first immunization visit other than at birth to incentivize clients to bring their babies for vaccination services.

3.1.2. HIV

The team was taken through the comprehensive care clinic (CCC) by the SCASCO who introduced the KCM members. The flow of the discussion was focussed performance based on targets, the care flow, appointment schedules, challenges, exit interviews, inquiries on patients, strategies for defaulter tracing, adherence counselling, groups on differentiated care model (DCM), retention rate, available stocks of commodities, challenges faced by PMTCT and Proposed solutions.

Performance based on targets (OCT 2021-JAN 2022)

INDICATOR	TARGET	PERFORMANCE
Current on care	3,221	2,986
Current on ART	3,221	2,983
Testing		72.9%
Linkage		93%
Targets on the cascade	95-95-95	72.9-92.6-91.6
PMTCT initial testing		1,030
PMTCT positives		41
HEI indicators (< 2 months)		22
HEI indicators (> 2 months)		11

The care flow: Clients are referred to the CCC from the various testing points within the facility. They are received at the CCC by the HTS counsellor for second testing for confirmatory purposes and counselling. The client is then linked to the Peer educator at the facility for enrolment and issuance of CCC number as further counselling is being done.

The new client is then accompanied for blood pressure, height, and weight measurement by the nurse at the CCC. The client is then escorted by the nutritionist before visiting the clinician. The clinician will then request some lab tests, including CD4 tests and any other tests as prescribed. Finally, the client will see the pharmacy to collect the prescribed drugs, and the next clinic appointment will be scheduled in the next two weeks. The old clients queue and are served on a first come, first-served basis.

Appointment schedules: The facility has a maximum of 60 bookings in a day. However, for the old clients, not all of them will go through the entire care flow as they are on differentiated care. This saves time.

Challenges experienced

1. Low-level PrEP uptake at the facility. This has contributed to the knowledge gap by the facility staff on PrEP due to insufficient training.
2. Low level of family planning uptake attributed to high rates of staff turnover (who have been trained on family planning). The facility does yearly staff rotations.
3. Defaulter tracing is tedious, especially for clients coming from far and are not willing to transfer to facilities near them contributed to stigma.

Exit interviews: Exit interviews are administered to clients through questionnaires on a quarterly basis. However, no analysis is done, or reports written on the responses received and the questions in the exit interviews are very general and do not capture the specific issues related to clients accessing CCC services. The team was advised to tailor make the tool to capture key issues that will support analysis for best outcomes.

Inquiries on patients: In regard to the patients that have been admitted, an early morning round by the social workers is done. The admitted patients are then reviewed by the clinicians later on during the day. The newly diagnosed patients are initiated on ART.

Defaulter tracing strategy: Clients are followed up through phone calls immediately they miss an appointment. If clients do not respond appropriately to phone calls, a home visit is done by the community volunteers to trace the client back to care. A line list of defaulters is prepared on a monthly basis to ascertain the workload and request the community volunteers to come and support this. FASI who is a sub recipient of KRCS has been supporting defaulter tracing.

Adherence counselling: General health talks are conducted for 30-40 minutes when clients come for their clinics. A one-on-one talk follows facilitated by the Peer Educators at the facility. From the individual discussions, the peer educator gets to understand the underlying reasons for defaulting and a way forward agreed upon.

Groups on DSM: It was established that the facility has 3 groups on DSM. Each group has 10 members which were started in October 2021. The groups will be observed for the next 6 months until March 2022 to ascertain their stability, which is bases on viral load testing.

Retention: The facility had a retention rate of 93% as at January 2022. This is attributed to the support from FASI in defaulter tracing. The team anticipates an increase to 95% as per the HIV cascade.

Challenges faced by PMTCT

- Lack of DBS filter papers
- PMTCT mothers lack current VLs due to lack of VL testing reagents
- 2020 cohort HEI positivity rate was at 1/11

Proposed solutions

a) Enhance support groups for young mothers.

b) Improve community sensitization of PMTCT.

Available stocks of commodities

1. DTG single dose - 5 months of stock
2. Cotrimoxazole 960mgs - 2 months of stock
3. Cotrimoxazole 480 mgs – 9 months of stock
4. TDF/3TC/DTG 300/300/50 – 2 months of stock
5. ABC/3TC 120/60 mg – 1.5 months of stock
6. HIV test kits – 0.5 months of stock
7. HIV/Syphilis dual kit – 0
8. Male condoms – 5 months of stock

In early 2021, there were commodity stock outs which were solved by redistribution by various facilities.

Recommendations

1. As soon as viral load testing actively resumes, the facility should embrace the differentiated care model more as a mechanism of aiding clients to keep appointments.
2. It is good for the facility to do a report on exit interviews which can be shared with the partners for support.
3. The facility should enhance more youth friendly services at the facility to aid their retention
4. Recommendation of a suggestion box to capture any concerns that may arise from clients

3.1.3. TB

General observations

- The facility has a chest clinic which is stand-alone with rooms for clinician, SCTLC, pharm tech, CTLC, Nutritionist, and triaging area. The facility is manned by one clinician with support from CHVs and Linkage assistant. The clinician receives support from the TB coordinator only during clinic days.
- The clinic is well ventilated with all IPC measures observed in both triage and consultation rooms. COVID-19 prevention measures have been put in place; hand washing and use of sanitizers.
- Patient charter, IEC and SOPs are placed on the wall to ensure patient knows their rights for health as well as pick current updates on TB prevention, care and treatment

Flow of patients:

- The facility receives patients at triage section and confirms appointments using the patient appointment card. The patients undergo triage and thereafter taken to the clinical room for examination and health education.
- The facility has 2 DRTB Patients who are on month 14 of treatment. They collect their drugs/ medicines at the main pharmacy.

Linkage:

- The facility has a linkage assistant (supported by NEPHAK) who assists in screening of all patients at the outpatient department and refers symptomatic cases to the TB clinic for further screening and examination by the clinician and has worked well for the facility.
- The facility uses 2 CHVs for household contact screening and tracing of treatment interrupters

Drugs

- TPT/ Pyridoxine: The facility has adequate and stock for 10 months
- RHZE: The facility has 1 month of stock
- RH: adequate with almost 10 months of stock. Expiry date December 2022.
- Facility to arrange for redistribution and/or use these drugs for TPT
- DRTB drugs: The practice with ordering of drugs for TB patients is on a need-by-need basis. Once a patient is diagnosed with DRTB, sub county pharmacists in consultation with SCLC make an order which is supplied on 3-monthly. The team noted some extra drugs (Cycloserine, Clofazimine and Levofloxacin) in stock. Staff advised to take the medicines to the main pharmacy store/ back to circulation to prevent expiries.

Laboratory:

- The facility has a 4-module GeneXpert machine. All the modules are operational with the last service documented as October 2021 by Cepheid. The machine utilization rate for 2021 was 49% with GXLIMS utilization at 97%. The machine supports Emgwen and Chesumei sub counties. The cartridges and reagents are adequate with approximately 2 months of cartridges.
- Also available was an LED microscope which had some issues with LED functionality forcing the facility to convert it to Ziehl-Neelsen Staining (ZN).

Challenge:

- The facility reported a lot of documentation. This is currently done by the clinician. There is need for deployment of a nurse to support triaging, patient screening and updating/documentation of recording and reporting tools
- Lack of a functional LED microscopy service/diagnostic tool

Recommendations:

- The facility uses a normal ZN microscope for TB testing but requested fluorescence which is more powerful in performing TB testing. The was caused by breakage of the existing fluorescent microscope
- The facility to consider ordering only enough drugs for the facility to avoid excess stocks
- There is a need to separate sub county drugs from the facility stock/drug. We noted this facility is a central store for Emgwen Sub County hence commodities from Kemsa are delivered here. This means those drugs from Kemsa should go to a facility store and in turn TB clinic make an order for their use.
- The facility requires additional nurse(s) to support the current clinician in the TB clinic.
- Patient Charter of Rights of TB Patients IEC Material to be placed strategically where Patients visiting the facility can interact with like the reception waiting area.

3.1.4. COVID-19

- Commodities available
- triaging available; active testing; handing washing facilities
- Inpatient testing
- Masking among patients and staff.
- Staff trained on COVID-19
- Isolation facility available
- Critical care physician and anaesthesiologist available

3.2. KAPTUMO SUB-COUNTY HOSPITAL

The team was received by the sub-county MOH. Following pleasantries and introductions, the team deliberated on the COVID-19 situation analysis, sub county specific disease demographics, reason for the Oversight Field visit and expected output/outcomes.

The Oversight Field visit team split into two teams: - Team one, reviewed the OPD, Malaria, pharmacy and Laboratory aspects. Team 2 reviewed the HIV, TB Service provision as well as CCC and TB commodity sufficiency. The deductions were as follows: -

3.2.1. TB

Client Flow:

TB Patients screened from all entry points. Assessment of all patients is done at the clinic including walk-in clients.

Patient Related

1. No MDR Clients. No MDR Drugs available. No isolation facility
2. Have monthly clinical meetings at the facility.
3. Assess client satisfaction through in person meetings and exit interviews.
4. No suggestion box available.
5. Patient tracing using 3 CHVs. Use physical addresses and telephone numbers to trace the patients.

GeneXpert Testing Microscopy is done in the health facility. GeneXpert samples processed at Nandi Hills Hospital. Riders transport the samples to the Facility. It takes about 1-2 weeks for results to be received. LMIS- results are conveyed to the CTLC through email who then links the results to the CHV then client

Recommendation: results should be channelled to the clinician in conjunction with the CTLC who then links up with the patient through the CHV.

Drug and commodity status

Stock outs noted were on

1. RHZE especially for any new patients or patients Sero converting positive after 2 months of treatment. Packs available are specific for each patient.
2. Nutritional Supplements

3. PTP -Isoniazid

Coping mechanism

IPT only for PMTCT. Inadequate stocks for the general population.

Challenges/ Bottlenecks

1. No TB Clinician currently serving at the TB Clinic. *Solution*: SCTLC to sit at the clinic on some of the days.
2. Noted a stock out of the GeneXpert cartridges in previous months *Solution*: Ensure adequate stocks are ordered and maintained at the health facility
3. Inadequate RHZE especially for any new patients or patients seroconverting positive after 2 months of treatment or transit patients. Packs available are specific for each patient.

TB Commodities

1. *RHZE – Have 1 MOS*
2. *RHZ- 10 MOS No patient currently available. Hospital advised to re-distribute the medicines.*
3. *Falcon Tubes-Approx. 100 available in hospital*
4. *MDR/Gene expert cartilages/Nutritional Supplements not applicable*

SR Support

1. NEPHAK, etc help in Defaulter tracing, and active case finding through provision of transport and airtime.
2. Global fund provision of sanitizers, masks and gloves appreciated.

3.2.2. HIV

Client flow: Patients screened from all entry points.

Client flow chart available and flow elaborated.

Indicator performance indicators document and up to date in the recording manuals/ documents.

Client Satisfaction assessment

Conduct exit interviews as well monthly client/ caregiver meetings to address anonymous concerns raised by the patients.

No suggestion box available.

Challenges & Bottlenecks

1. 1 Clinician available for service provision. No triaging nurse available. *Recommendation:* Need to add a nurse for screening and triaging purposes.
2. Lack of viral load testing
3. Shortage of DBS filter papers.

Plans to integrate health services

Facility has plans to integrate the CCC services to the general health services in the health facility. The facility has already integrated chronic disease care provision with those of CCC.

ART adherence and defaulter tracing

The SR supporting HIV Programming- FASI is very key in cascading the active case finding and defaulter tracing.

Treatment and retention to care levels: the facility has an active differentiated care model-

Which Supports groups meeting monthly.

Patients pick their drugs at the facility or use the 2 CUs available to deliver the medicines.

Have an active Operation triple Zero (OTZ)- that supports AYP Clientele.

Client satisfaction Assessment:

Have monthly support group meetings where they mainly respond to anonymous issues raised.

Conduct exit interviews.

Recommendation: They introduce the use of the suggestion box to assess client satisfaction.

ARV Commodity sufficiency

1. DGT- approximately 1 MOS
2. Septrin – approximately 1 MOS
3. DTF/3TC/DTG- approximately 1 MOS
4. ABC- approximately 3-MOS
5. HIV Test Kits- available
6. Male and female condoms available.

3.2.3. MALARIA

This health facility is within a high malaria transmission area in Nandi County.

Case Loads: Data was unavailable

Test Positivity: In Oct 2021, out of 219 microscopy tests done for under 5 years, 8 were +ve; out of 437 tests above 5 years 9 were positive. Severe Malaria: 1 case was reported. The patient recovered

Cases of empirical treatment was reported at OPD based for patients with negative microscopy results.

Malaria diagnosis: Microscopy is done at the facility, but since there is no standby generator, when power is off, RDT is done.

Commodities were available; however, stock outs of AL12 and AL6 were noted. AL24s available (19 packets of 30). Stock bin cards S3 updated. Injectable AL available (1,410 vials). IPTp was being carried out and SP tablets were available for the same.

Challenges:

1. Training need for newly recruited Health workers
2. CHVs not paid by NMCP for the 2021 LLIN distribution
3. Tools for reporting inadequate.
4. Treatment of Malaria based on clinical symptoms

5. Data unavailable for caseloads at health facility due to incorrect/ inadequate filling of the OPD registers

3.3. KABIYIET HEALTH CENTER

The oversight team paid a courtesy call to the facility health management team at the health center. Members of the sub-county HMT, and one member of the CMTH were in attendance. Findings and recommendations for the service delivery points visited are outlined below.

3.3.1. HIV

HIV CASCADE

First 95

Indicator	Annual Target	Quarter target	Achieved	% achieved quarter	% achieved annual
Testing	2,022	506	1,112	220%	55%
Identified positives	53	13	181	123%	30%
Linkage			16	88.8%	
Leakage			2	11.1%	

Second 95

Indicator	Annual Target	Quarter Target	Achieved	% achieved quarter	% achieved annual
Treatment new Peads	5	1	2	200%	40%
Treatment new Adults	62	15	17	113%	27%
Treatment current Peads	25		21	84%	
Treatment current Adults	460		416	90%	

Client flow

The four testing points at the facility includes use of a Provider initiated testing and counselling (PITC) at the outpatient, Casualty for all patients being admitted, PMTCT at MCH and at the labour and delivery room and VCT.

Newly Diagnosed clients

In the event, a client tests positive from any of the HTS points mentioned above, the HTS counsellor writes a referral note to the health records desk where the necessary enrolment forms and clients documents are issued. He /She is then referred to the clinician who enrols the client by filling the relevant forms and providing the client with a unique number. This is followed with The clients being then linked to the peer educator for counseling on adherence issues. He is also referred to a nutritionist for nutrition advice before the clinician reviews and prescribes then sends them to the pharmacy for drugs dispensation.

The KCM team recommended that the client visit the Peer Educator first before visiting the clinician's desk for enrolment and clinical review. However, the fact that the PE and the clinician shared a room, it was technically difficult for this to happen.

Old clients

The clients come directly to the record department for registration before proceeding to the nutrition department for vital signs taking. Ideally, this is a nursing procedure that is not available at the CCC. The clinician then clinically reviews the clients before they proceed to the pharmacy for drugs dispensation. The old clients rarely see a peer educator unless they were defaulters, have issues with adherence or have a high viral load.

In regard to the Differentiated Care Model, 257 (59%), clients had been placed. These clients have cards written "express' and go directly to the pharmacy for their drugs. Out of the current 437 clients on ART, 20 or fewer clients are seen in a day.

At the MCH clinic, for PMTCT, for new mothers testing of vital signs is done before proceeding to the MCH nurse for HIV testing. If they turn positive, they are referred to the PEs for adherence counselling and a file is opened by the nurse for enrolment into care.

Exit Interviews for clients

Apart from the HTS team that has questionnaires, exit interviews are done orally and no questionnaire is administered. The clients are asked if they were satisfied with the services offered, including time taken within the facility, and if they were contented with the services. The oral feedback is then given to the teams on what the clients are happy or not happy about.

How does the facility enhance adherence and defaulter tracing?

When clients miss appointments, the PEs start by calling them to determine why they missed the appointment. In the event they fail to show up after 3 phone calls then the PEs visits their homes and ensure they are counselled and taken back to the facility to continue with the treatment. Defaulter tracing is done if the clients fail to come back to the facility after 30 days of the missed appointment.

The facility had a total of 48 defaulters from October 2021 to the end of January 2021 where 27 clients had not been traced. The defaulting is associated with stigma at the family and community level with a majority of the young adults between the age of 20-24 being the most defaulters. The retention as of December 2021 was 100%.

Strategies to reduce defaulting at the facility

1. Working with caregivers and requesting peers to help also support especially for paediatrics and adolescent clients
2. There is poor attendance of support groups at the facility, especially with young adults and adolescents. There is a need to engage community adolescents' treatment supporters to enhance attendance
3. Training of caregivers to support the adolescents living with HIV.
4. Formation of a WhatsApp group for young adults and adolescents.

Success story

The facility had 60 to 70% retention rates in earl 2021. They started attaching case managers to new clients up to six months of being in care. This close follow up ensures that new clients are not lost.

During the viraemia clinic, the facility engaged champions (i.e. clients who have previously had high viral load and suppressed) to support in adherence discussions and support other clients with adherence issues.

Challenges

1. The facility does not have a nurse at the CCC to support nursing services.
2. There is limited space hence a room is shared between PE and clinician and a nurse at the MCH.
3. Sharing of medical equipment –SP02, blood pressure Machine from one department to another.
4. Shortage of commodities hence interfering with DCM (Last year from October 2021).
5. There is no examination couch to examine patients hence the clinical officer has to take the patients to the outpatient department to access examination coaches.
6. There are no youth-friendly sites but the facility has Operation Triple Z (OTZ) meetings on the weekends targeting adolescents and young people living with HIV.

PMTCT Challenges

1. Lack of resources-DBS filter papers
2. Mothers requesting for 3 months medication yet -all PMTCT mothers are unstable, and can only be given a maximum of one slide
3. Clients come from far to access PMTCT services
4. The MCH PMTCT room is small as clients come even without appointments. The same room is also used for family planning, ANC and PMTCT.
5. Clients giving wrong telephone numbers making it hard to track them

3.3.2. TB

Office space and posters

- The facility is fully integrated for TB/HIV (under one roof) though the space is squeezed. This compromises on the safety of the clinicians. Plans are in place to shift to a spacious room. The facility uses an EMR to capture its data. Updated monthly facility charts, IEC materials and treatment algorithms are well displayed on the wall.

Patient flow -The facility patient flow happens in 2 ways:

- The first flow of patients starts from the OPD where they are screened by clinicians at OPD and those who present with TB symptoms are requested to provide sputum for diagnosis at that point. Upon receiving results, the clients are linked to the chest clinic with support of a linkage assistant. This is the best practice to ensure everyone is engaged in active case finding
- The second flow is for patients who are coming to collect drugs. These groups go directly to the chest clinic and are queued at the triaging area. They are either directed to the clinician or pharmacy room for the service.

Nutritional support

- The facility is reported to be stocked out of RUTF and FBF from 2019. The only support offered to patients is Vitamin A both at the beginning and end of treatment

- They have a weighing scale which only records the weight, height taken aside then calculate BMI. They reported that their modern Anthropometric machine spoiled hence reverted to the current one.
- *They have a total of 11 patients below BMI of 18.5 (SAM = 3, MAM = 8) for 2021*

Recording and report

- They have all recording and reporting tools; stamps for screening, ACF tools, treatments cards, treatment registers, commodity reporting tools and EMR.
- The registers are filled with few documentation gaps noted in contact management registers; listing done but missing screening data. *Recommendation made to facility to ensure screening of contacts are done by clinician through contact invitation*

Care and treatment

- Almost 95% of their patients are bacteriologically confirmed. They are treating actual TB.
- In terms of workload for 2021, a total of 25 patients were started on treatment (bacteriologically confirmed were 22, clinically diagnosed one (1) and extra pulmonary TB one (1)). Among the 25 patients, only one was a child of age 12yrs. *Recommendation: There is need to strengthen childhood TB diagnosis by exploring all diagnostic options*
- On treatment outcomes, they had 90% cure rate with 100% TSR. There was no incident of death or LTFU reported for January – June 2021

Drugs and Medicine

- Supply Chain Management;. Currently they have zero patient packs at the central store and only three (3) packs at the chest clinic. *Recommendation: Need for pharmacists to make emergency order to the national program for patients packs, mapping of facilities be done at the allocation tool to correct the mess in future (Done)*

Challenges

1. Prolonged shortage of geneXpert cartridges
2. Shortage of Pyridoxine
3. Non supply of nutritional food support. Affects patient care and outcomes
4. Lack of support to cascade ACF activities to peripheral facilities (funds to conduct sensitization meetings)
5. wrong mapping of facilities in KHIS and TB allocation tool impacting on drug shortages

3.3.3. MALARIA

Malaria services are integrated in the health system and therefore offered at multiple service delivery points. The KCM team visited these points and documented the key gaps and opportunities.

Maternal and Child Health Clinic

The MCH clinic provides services to mothers attending the antenatal clinic (ANC) and children brought to the child welfare clinic (CWC). LLINs are issued to ANC mothers usually on their first visit as well as children at birth and, for those who did not get an LLIN at birth, during their first immunization visit. The MCH clinic had ~4 months of stock of LLINs as well as all the required registers. Information was being captured as expected; the facility staff had improvised a tool to help them to summarize data from the daily registers. No issues or challenges were identified at this service delivery point.

Pharmacy Department

The oversight team visited the pharmacy to assess availability of malaria commodities and commodity data capture and reporting.

Multiple gaps and challenges were identified at this service point:

- stock records were missing for some commodities e.g. AL 6s
- for commodities with stock records available, there were not updated resulting in high variances between the stock records and actual stock on hand
- the monthly malaria summary reports were inconsistent and at least 54 LLINs could not be accounted for in the previous two months
- injectable artesunate consumed was enough for ~40 patients, however, the average number of severe malaria cases at the facility, according to the clinician at the OPD, averages between 1 and 10 per month. This points to either improper record keeping, pilferage of this commodity or both.
- injectable artesunate in stock (96 vials, enough for ~24 patients) is expiring in June 2022 some of it will need to be redistributed if it won't be used up by then.

It was also established that the pharmacy had been visited by the county pharmacist during supportive supervision on January 17, 2022 and the same gaps had been flagged but the health facility did not seem to have addressed them.

Outpatient Department: The department had the latest outpatient registers (MOH 204A and B). However, the column for capturing malaria testing data was blank. This means that the health facility cannot accurately report data on suspected malaria cases and numbers tested and treated for malaria. The work flow at OPD has not been set up to allow for capturing of this data in the OPD registers.

Laboratory Department: The laboratory department reported that they carry out parasitological malaria diagnosis both by microscopy and rapid test kits. RDTs use was done to mop up excess RDTs issued to lower level health facilities e.g. Kapkeringon and Kapkagaron dispensaries each received 1,800 RDTs and they conduct ~25 tests per month each.

4. SUB-RECIPIENT AND COMMUNITY LEVEL OVERSIGHT INTERACTIONS

a. Proportions of fund received
b. Proportion of funds utilized
c. Timeliness in disbursement of funds from PR-SR-SSR
d. Expenditure patterns
e. Timeliness in Implementation of activities
f. Programmatic performance rating – average score
g. Link facility support supervision
h. Proportion of CHVs supported
i. Completeness in reporting
j. Availability of commodities

k. CHVs sustainability strategy

l. Success stories/view from beneficiaries as annex

Beneficiary testimony

Tom, a PLHIV realised his status and was very worried despite regular counselling by the community volunteers. One day, he got a girlfriend. He advised her to visit clinic for HIV testing. When the results came out positive, the girl left him immediately never to come back. The boy got stressed and decided to stop taking drugs. When the CV was still trying to trace him, she found him lying helplessly in the bush and feeling abandoned, not loved. The CV did counselling to him and she managed to bring him back to care. After some months of stability, the boy got another girlfriend who was also a PLHIV and they have been staying together happily encouraging each other. They are now planning to officiate their union and are proudly inviting the health facility staff. They were also requesting that other youths to join the ceremony and witness that HIV is not a killer disease but like any other disease, when drugs are adhered, people will live a normal happy life.

Further discussions with the beneficiaries brought out the following issues;

1. The PLHIVS testified that they had been receiving drugs from the facilities both ARVs and other supplements required.
2. They also testified that they had received vigorous follow up from the community volunteers that had aided them to adhere to treatment.
3. It also came out clearly that the beneficiaries had not enrolled on any health insurance scheme including NHIF. Also, they were not members of any economic empowerment group like 'Chamas' or income generating activities like table banking.
4. The beneficiaries were requested to be good ambassadors to other PLHIVs and encouraged to continue adhering to treatment.

4.1. FASI: KRCS SR HIV (KEY POPULATIONS)

The visit to FASI was informative. They are new to Nandi County. They began implementing the new grant that was signed in July 2021. FASI is implementing 2 key modules: treatment and support specifically to trace defaulters and bringing them back to care and ensuring PMTCT - ensuring pregnant mothers access services. They are meeting the targets 109% in quarter one for the ARV defaulter tracing. For PMTCT they are awaiting the revision of the strategy. Other cross cutting issues include HIV testing Modules and stopping teenage pregnancies as well as fighting GBV. They will promote training in legal rights, GBV reporting, and prevention and know your rights campaigns. They have good linkages with CHVs. On resource mobilization they are in discussion with KRCS to implement the COVID 19 grant. They are guided by the principles of co-creation, co-location and co-implementation to ensure ownership at the county level and sustainability post the grant. Their finances are in good order and have a committed team in place. working in 17 facilities in Nandi County and working with CHVs to trace defaulters and have monthly meetings with CASCO

Their budget for Nandi County is 14.4 million so far they have expensed 1.7 million translating to 12 % absorption for quarter 1. The requisition period took 20 working days, and the second requisition took 7 working days. For COVID not doing anything. They have identified and engaged pro bono lawyers and paralegals to assist in human rights and gender issues

Challenges: Office space. They wish to be hosted at the MOH offices or the health care center.

4.2. IRDO: AMREF SR TB

Background: Started grant implementation in the month of January 2022 with the County Entry Meeting. This was a new county for KP Programming under the GF program.

No Activities were slotted for Q1 and Q2. This was because Nandi was one of the new counties in the GF program and IRDO was contracted to begin implementation in Q3 of the program i.e. January 2022. This was as per the KRCS performance framework and thus, no time was lost nor targets not achieved during the period.

No activities were slotted for Q1 and Q2

Work plan and budget-

- Total budget- 39,471,182
- Amount budgeted- 5,141,994
- Amount received- 7,000,000 (including one month buffer)
- Request placed on 20th January 2022.
- Funds received on 4th Feb 2022.
- Commitments- for January activities- 41,687
- Expenditures- None
- *Date of last Disbursement submitted by SR*- Friday 4th February

Challenges & Lessons learnt

Challenges	Lessons Learnt
Perceived stigma among the general population against the key population	Need for concerted efforts to work with the county government
Need to integrate drop-in Centre (DIC) within the County Hospital or set up in the town center or having fabricated containers to host the DIC.	Need to actualize the resource mobilization plan in Nandi County

Work Plan/ Gantt Chart

Activities conducted between January 2022 to date: 5 activities done including the County entry meeting, hot spot mapping, Training 33 peer educators, salaries, Local travels, Sub-county entry meeting and outreach.

21- activities to be accomplished as per the work plan. Most Activities are on schedule 75%- *Explanation* PR disbursed the Q3 allocation on February 4th. SR managed to implement some of the activities in the month of January.

They will work with peer educators and Outreach workers who are currently undergoing training. PE/ OW to sign contracts and begin work on 21st February 2022. Sites identified/ Tools to be availed by KRCS/SR. SR yet to sign COVID-19 contract.

4.3. NEPHAK: AMREF SR TB

The meeting started at 10.00 am in attendance were CHVs and link assistants from various facilities. The NLTP officer from the facility was present along with the team from NEPHAK and Amref Health Africa to welcome the KCM members.

The meeting started with an introduction and explaining the roles of CHVs. They indicated that they have received training from various partners including AMPATH. Some of the modules include how to collect samples, and how to trace defaulters. They have very good linkages with the facilities who linked them with the clients testing positive. The key role was defaulter tracing and contact tracing. They had success rates in meeting targets in finding defaulters who were returned to full TB treatment. They had a good flow of services between the community and health facility.

In terms of data, the information coming from the CHVs was well linked into the facility and uploaded into the DHIS system. There was no external support available to them except from Global Fund.

Some of the challenges raised by the CHVs included movement and transport to trace the defaulters. They are reimbursed once and sometimes call back may be necessary. A reported incidence of 1 case of a patient who tested smear positive and the family refused to take up treatment. They reported this as alaw breaking incident. Most of the defaulters are alcoholics requiring nutritional support which was not available. They flagged two cases of a alderly man living in abject poverty and with no source of income and his smear positive and broken family, abandoned by wife and left with 3 children who are currently scavenging for food on the streets. This case requires critical support from the PR and SR as well as the county social security system. The second case is a key population smear positive person who defaulted on treatment and because of stigma was chased away from home. This requires support.

We had a case of the MDR client showcased. A woman of childbearing age, under 5 baby and clearly suffering marital problems. She has completed 16 out of 18 months of treatment. Both she and her baby are MDR and are both on treatment. She is HIV negative though. She is enrolled into the NHIF system and she doesn't have any nutritional support. She is receiving a monthly stipend of 6,000 shillings each for herself and her baby which does not come regularly and can delay for 3 months.

Challenge

She is currently working in a restaurant. The team flagged this as a high risk to the general public because her last sputum status was unclear and she had recently relocated to Nandi from her marital home in Kakamega.

Best practice

The team flagged out those 3 cases and will follow up with the county authorities during the CHMT exit meeting.

NEPHAK had a flow chart for facility SOPs. Standard Operating Procedures and Data verification of CHV reports by sub county TB coordinator.

On Covid 19

They indicated that they have received support in terms of sanitizers, masks and gloves and they have a distribution system to facilities on a quarterly basis.

There is oxygen support to 10 facilities. Out of which 2 facilities received liquified oxygen. All this funding was under NFM 2 grant under NFM 3 grant, covid financing is yet to be released. KCM and AMref may need to revise or reallocate. There were few CHVs who were not yet trained. Specifically those new CHVs recruited under the NFM 3 grant.

challenges raised by the SR

for NANDI county they have received 17 million but have only managed to absorb 4.7 million the rest of the money not absorbed because they are awaiting approval from the PR and balances due to activities still unspent.

The CSS TWG was still being constituted and consultants were yet to be hired to carry out the activities for network strengthening among other activities.

For the period July to December 2021 the budget for Nandi County was 24.9 million and in that period they received 17 million kes. The expenditure for the period July to December 2021 was 4.7 million.

4.4. CMMB: AMREF SR MALARIA

Background

They have been in existence for more than 100 years and have worked with local and global partners delivering health solutions through proven, cost-effective models. Their interventions are community-based, community-driven, and long-term. They are committed to the women and children we serve.

CMMB Implements Malaria activities in Kericho, Nandi and Nyamira counties.

In Nandi county- implement activities in Tinderet and Aldai with 48 CUs (480 CHVs) linked to 48 health facilities. They basically deal with malaria in pregnancy activities. that include engagement of CHVs to conduct intermittent treatment in pregnancy, orientation, reporting, supervision and monthly meetings.

The project started in July 2021. However, activities in Nandi County started in November with entry meeting and CU functionality assessment. Functionality assessment of CHUs was conducted by the project to determine their status. The engagement of the identified CUs was completed in December 2021.

Budget:

	Total Budgets
Contractual Budget	91,784,774
Yr 1 Budget Jan 2021- December 2021	18,516,428
Last funds request	16,735,223.65
Last funds disbursement	16,735,223.65
Funds utilization (Burn Rate) (Based on Y1 Budget)	43%

- Proportion of Funds received from Total budget (C/A)- 18%
- Proportion of Funds received from budget for the period (C/B)- 90%
- Date when Last disbursement request was submitted by SR 21/9/2021
- Date when funds were received by the SR 27/9/2021
- Time/Days taken for the SR to receive funds (E-D) – 7 days
- SR Expenditure /Cash expended- 7,196,146
- SR Commitments – No commitments

Results versus targets for all the programmatic indicators.

Indicator	Target	% Achievement against target
# of CHMT/ SCHMT members oriented on MIP	18	100% (18/18)
# of CHEWs oriented on MIP	96	0%
# of CHVs oriented on MIP	480	0%
# of pregnant mothers referred by CHVs for ANC	3,360	0%

Timelines in implementation of planned activities July – December 2021.

The following activities have been conducted in the county.

- Entry meetings (County and sub counties)
- Supervision for CUs in December 2021. This was to pave way for the
- Orientation of CHAS/CHVs was not done due to the above activities which were to pave way for orientation.

According to the SR, most of the activities on schedule 70% (2 out of 3) of the activities were implemented

Linkage of CHV work with Health Facilities (Support supervision of CHVs)

The SR is supporting the training of community health volunteers and the facility team (CHAS/facility in charges) on implementation of MIP activities. They also conduct monthly meetings to review activities together with the county/facility team. They will also support county and sub county teams to conduct support supervision and provide on job training. In addition, the planned review meeting together with CHVs/CHAS/Facility in charge and sub county team will actually help in addressing challenges. This will improve linkage and coordination of activities. The CHVs report to the health facilities through CHAs and reports are populated monthly in KHIS.

CMMB has technical staff who have a good understanding of the project implementation and key indicators for reporting.

Resource mobilization strategy – This is at organization level; the organization does not have a resource mobilization document but components are embedded in strategic plans. They are in the process of reviewing the plan. They also have a resource mobilization functional team for the entire organization and country team.

Income generating activities (IGAS) for the CHVs- the organization does not have IGAs in Nandi. They have had discussions with CHVs/ women groups in other counties like Kitui. They started in 2019 and worked with 11 groups by providing seed funding. They have been able to give them money and all managed to repay back the money. The fund is revolving.

Quarterly activity reports: The organization shares quarterly reports with the PR on a quarterly basis.

COVID-19

CMMB received fund and supported 350 CHVs with PPEs (Masks and gloves) to enhance CHVs safety during HH visits for CCMm and Enhancing referrals for CCMm by CHVs

Best Practices and Lessons Learnt

- CHVs are integral in CCMm: Very few cases of complicated malaria reported.
- Close monitoring, mentorship and continuous OJT for CHVs and the CHEWs especially those newly recruited.

- Strong linkage between CHVs and link HFs can greatly improve malaria indicators
- Redistribution of antimalarial and mRDTs as a mitigation measure for stock outs at CHU level.

Challenges and Mitigation Measures

Challenge	Mitigation
Stock outs of commodities	Redistribution of few kits and ALs available Advocacy at the county level to follow up with KEMSA
Demotivated CHVs over lack of stipend payment by the County Government	Follow up on the Community Health Strategy Bill
Some CHVs lacked referral forms to document their community case referrals	Follow up with Amref and the County for provision of these.
Most CHUs, especially in the Fringe counties are either non-functional or semi functional	Discussions with CHMTs and Amref on improving the functionality of the CHUs
Ill preparedness of most facilities in the fringe sub-counties for the MIP interventions based on the anticipated demand created from CHUs	Continuous engagement with the counties on possibilities of improving the same

Nandi County malaria coordinator: confirmed that they have closely worked together with the SR on implementation of the activities. Their collaboration has been smooth.

4.5. FASI: KRCS SR HIV (GENERAL POPULATION)

The team visited Kapkangani Health Centre and paid a courtesy call to Dr Kemboi who is the facility in charge. Later the team had a meeting CHEWs, CHVs, and some of the beneficiaries supported through FASI which is a KRCS SR

The following key issues were discussed:

- Community section of the data collection tool
- The process of tracking clients
- Reasons for defaulting
- Support from FASI to community volunteers
- Suggested recommendations from community volunteers on defaulter tracing
- Beneficiary testimonies
- Community section of the data collection tool

At Kapkangani Health Centre, the commodities used included first aid kits and community reporting tools including the MOH 100 which are referral tools. The CHEWs however indicated that they have some challenges in referral tools as well as airtime to reinforce tracking of defaulters.

The process of tracking clients: In regard to the clients due for a clinical visit, a prior call to remind them of their appointment is done. In the event that the client does not show up at the end of the appointment date, a follow up call is made to find out the challenge. If this attempt fails, further follow up is made through the treatment supporters if they are available. If those attempts still don't yield any result, a home visit is conducted at the community through the community volunteers engaged.

For the frequent defaulters, more adherence counselling and support by Peer educators is done. To avoid the issues of clients giving wrong contacts, client contacts is gathered before testing is done, when the client is relaxed and honest. Within the period of October 2021 and January 2022, Kapkangani health centre had listed a total of 97 defaulters and managed to bring back 47 clients.

Reasons for defaulting

1. Family conflicts affect stability of the clients as some get separated and they relocate.
2. Discordant couples who have not disclosed to their partners are not always free to take their drugs and attend clinical visits if their partners are not around.
3. Pill fatigue
4. Alcoholic clients tend to forget their clinical visits
5. Some clients are still in denial and highly stigmatized
6. Religious influence especially among women
7. Change of intimate partners yet disclosure is not taking place

Support from FASI (sub-recipient KRCS) to community volunteers

1. FASI has provided transport reimbursement to community volunteers after tracing has been done and it is performance based.
2. FASI has issued a line-listing tool to the facilities to aid in establishment of the defaulter tracing workload for specific months.

3. FASI has motivated community volunteers through transport reimbursements when called for meetings.

Suggested recommendation from community volunteers on defaulter tracing include CVs requested for identification tags which includes T shirts, bags, umbrellas so as to be easily identified at the community and Training on treatment literacy so as to gain knowledge and skills on how to handle defaulters.

KRCS explained that they are awaiting the finalization of the treatment literacy materials by NASCOP for the training to take place before the end of the quarter or early next quarter

SUMMARY OF RECOMMENDATIONS

1. RECOMMENDATIONS TO KCM AND PRS

1. Need for inclusion of counties in the boards of KEMSA & NHIF to address counties' concerns and priorities in commodities procurement and health financing respectively: KCM
2. Expedite delayed outstanding 2021 mass net distribution payments to CHVs, health workers and other services providers: DNMP
3. Strengthen surveillance to determine causes of fever of non-malaria origin
4. Print and provide job aids for diagnostics: TNT & DNMP

2. RECOMMENDATIONS TO NANDI COUNTY

2.1. HIV

1. County to redistribute HIV test kits/ dual kits while restricting for MCH use
2. County to enhance adolescent/ youth-based services by strengthening their support groups & provision of youth friendly services
3. The county to support health facilities by engaging CHVs to do home visits for defaulter tracing
4. County to engage partners/ NASCOP for more mentor mothers
5. Capacity build and retain staff for FP and cervical cancer screening at the CCC
6. The county should address HR Gaps in the CCC by engaging more clinicians & nurses
7. County to provide a container and a site accessible to KPs while KRCS will do the refurbishment to ensure it is KP friendly.

2.2. Malaria

1. Capacity building of healthcare workers in malaria case management. MOH Nandi/ partners
2. Strengthen support supervision by county and sub-county health management teams to address gaps in case management, commodity management, data capture and reporting etc. MOH Nandi/ partners
3. Strengthen surveillance to determine causes of fever of non-malaria origin. MOH Nandi
4. Assess stock levels of short expiry inj artesunate and redistribute any excesses to the lake endemic counties there is a shortage. Nandi MOH/ County Pharmacist

2.3. TB

1. County to support nutritional supplements for malnourished patients
2. Redistribution of excess stocks (Rifampicin 75 mg/ Isoniazid 50mg)
3. TB Commodities should at least be > 3 MOS Strengthen reporting from facilities
4. Installation of GeneXpert machine at Aldai (Kaptumo)
5. Relay of GeneXpert results to be streamlined.
6. Deployment of nurses to chest clinics

7. Strengthen childhood TB diagnosis by exploring all diagnostic options
8. County to support ACF sensitizations at peripheral facilities

APPENDICES

1. EXTRACT FROM KCM MEETING MINUTES

KENYA COORDINATING MECHANISM OVERSIGHT FIELD VISIT SITES: FEBRUARY TO JUNE 2022

NO	ACTIVITY	DATES	SITES		JUSTIFICATION	JUSTIFICATION
			TEAM 1	TEAM 2		
1.	Oversight Field Visit 1 & 2	7th to 11th February ,2022	Kisii	Nandi	Kisii Underweight-13.7/ N-11.0 HIV/AIDS Positivity rate 254,815 yet only 11,467 had successfully been stated on ART PMTCT- Prevalence @ 5.8/N 8.5 Malaria Positivity rate& admissions has increased	Nandi HIV/AIDS Positivity rate 124,889. 5,237 had successfully been stated on ART PMTCT- 10.5/N8.5 Malaria Positivity rate have reduced Malaria Positivity rate. Admissions on the rise at 4,000/N 174,966
2.	Covid 19 Specific Oversight Field Visit 3 & 4	21st to 24th March 2022	Nakuru	Narok	Nakuru Disease burden Considerable Investments made around Oxygen and disease prevention.	Narok Disease burden Considerable Investments made around Oxygen and disease prevention.
3.	Covid 19 Specific all letters c Oversight Field Visit 5 & 6	19th -21st April 2022 Counties near Nairobi:	Kiambu	Embu	Kiambu Disease burden Considerable Investments made around Oxygen and disease prevention.	Embu Disease burden Considerable Investments made around Oxygen and disease prevention.
4. •	Oversight Field Visit 7&8	23rd to 27th May 2022	Taveta	Isiolo	Taveta: Far to reach & ASAAL Counties Taita HIV Prevalence-6.3% /N- 5.9% Manage malaria positivity/admission rates. TB Incidence 73/N 79.	Isiolo; TB Prevalence has been on the rise. 339/N 208 HIV - 16,983 positive testing. ART - 1,250 Malaria cases 23,892/N20,252 per 100,000 people.

2. ARVS STOCK STATUS

Adult ARVs

Adult ARVs	Pk size	Quantity	AMC	MOS
Abacavir (ABC) 300mg Tablets	60s		8	0.0
Abacavir/Lamivudine (ABC/3TC) 600mg/300mg FDC Tablets	60s	518	183	2.8
Atazanavir/Ritonavir (ATV/r) 300/100mg Tablets	30s	991	749	1.3
Darunavir (DRV) 600mg Tablets	60s	1	2	0.5
Dolutegravir (DTG) 50mg tabs	30s	823	215	3.8
Efavirenz (EFV) 600mg Tablets	30s			0.0
Lamivudine (3TC) 150mg Tablets	60s		2	0.0
Lopinavir/ritonavir (LPV/r) 200/50mg Tablets	120s	239	95	2.5
Nevirapine (NVP) 200mg Tablets	60s	56		0.0
Raltegravir (RAL) 400mg Tablets	60s			0.0
Ritonavir (RTV) 100mg Tablets	60s	5	1	5.0
Tenofovir (TDF) 300mg Tablets	30s			0.0
Tenofovir/Emtricitabine (TDF/FTC) FDC (300/200mg) Tablets	30s	301	150	2.0
Tenofovir/Lamivudine (TDF/3TC) FDC (300/300mg) Tablets	30s	791	425	1.9
Tenofovir/Lamivudine/Dolutegravir (TDF/3TC/DTG) FDC (300/300/50mg) FDC Tablets	30s	18	70	0.3
Tenofovir/Lamivudine/Dolutegravir (TDF/3TC/DTG) FDC (300/300/50mg) FDC Tablets	90s	4246	2211	1.9
Tenofovir/Lamivudine/Efavirenz (TDF/3TC/EFV) FDC (300/300/400mg) FDC Tablets	30s	1228	197	6.2
Tenofovir/Lamivudine/Efavirenz (TDF/3TC/EFV) FDC (300/300/400mg) FDC Tablets	90s	48		0.0
Tenofovir/Lamivudine/Efavirenz (TDF/3TC/EFV) FDC (300/300/600mg) FDC Tablets	30s		2	0.0
Zidovudine (AZT) 300mg Tablets	60s			0.0
Zidovudine/Lamivudine (AZT/3TC) FDC (300/150mg) Tablets	60s	523	206	2.5
Zidovudine/Lamivudine/Nevirapine (AZT/3TC/NVP) FDC (300/150/200mg) Tablets	60s	137	1	137.0

Paediatric ARVS

Paediatric ARVs	Pk size	AMC	Qty	MOS
Abacavir/Lamivudine (ABC/3TC) 120mg/60mg FDC Tablets	30s	307	1537	5.0
Abacavir/Lamivudine/Dolutegravir (ABC/3TC/DTG) 60mg/30mg/5mg FDC Tablets	60s		0	0.0
Abacavir/Lamivudine/Lopinavir/ritonavir (ABC/3TC/LPV/r) 30/15/40/10mg FDC Tablets	120s		0	0.0
Dolutegravir (DTG) 10mg Dispersible Scored Tablets	90s		15	0.0
Darunavir (DRV) 150mg Tablets	240s		4	0.0
Darunavir (DRV) 75mg Tablets	480s		0	0.0
Darunavir (DRV) susp 100mg/ml (200ml Bottles)	200ml		0	0.0
Efavirenz (EFV) 200mg Tablets	90s	4	181	45.3
Etravirine (ETV) 100mg Tablets	60s		0	0.0
Lamivudine (3TC) liquid 10mg/ml	240ml	3	20	6.7
Lopinavir/ritonavir (LPV/r) 100/25mg Tabs	60s	69	370	5.4
Lopinavir/ritonavir (LPV/r) 40/10mg Caps(Pellets)	120s		0	0.0
Lopinavir/ritonavir (LPV/r) liquid 80/20mg/ml (60ml Bottles)	60ml	51	169	3.3
Nevirapine (NVP) Susp 10mg/ml (100 ml Bottles)	100ml	265	1318	5.0
Nevirapine (NVP) Susp 10mg/ml (240 ml Bottles)	240ml	6	12	2.0
Raltegravir (RAL) 100mg Chewable Tablets	60s		0	0.0
Raltegravir (RAL) 25mg Chewable Tablets	60s		0	0.0
Ritonavir liquid 80mg/ml (90ml Bottles)	90ml		0	0.0
Zidovudine (AZT) liquid 10mg/ml 240ML	240ml	29	203	7.0
Zidovudine (AZT) liquid 10mg/ml 100ML	100ml	3	20	6.7
Zidovudine/Lamivudine (AZT/3TC) FDC (60/30mg) Tablets	60s		124	0.0

3. PROGRAM

Time	Activity/ Event/ Tentative/ Discussion Points	Venue
Noon	February 6, 2022: Travel Day	Nairobi - Kapsabet
	DAY 1: February 7, 2022	
09h00 – 10h00	Courtesy call on the Hon. Governor • Introduction • Purpose / Objectives of the visit.	County Headquarters
10h00 – 12h00	Meeting with NANDI CECMH/COH & CHMT & Partners • Introduction/ Welcome Remarks • Presentation by CHMT about 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 Center	Kapsabet/ Nandi County Referral Hospital
17h00 – 17h30	Recap of Day's Activities	
	DAY 2: February 8, 2022	
Morning	Visit KRCS SR implementing HIV Programme -show case 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	FASI for Gen Population IRDO for KP
Afternoon	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 the Laboratory/Visit youth Center	Kaptumo Sub County Hospital
	DAY 3: February 9, 2022	
09h00 – 13h00	Visit Amref Health Africa SR implementing TB Programme - showcase TB Active case finding, Visit Beneficiaries / MDR Client /meeting with CHVs	Nandi County Referral Hospital Discussion meeting with NEPHAK

Time	Activity/ Event/ Tentative/ Discussion Points	Venue
	Discuss measures in Place to Control Spread of COVID 19/Mitigate it effects Meet CHV's, Linkage assistants and MDR clients	representatives – SR at the facility.
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 the Laboratory/ Visit youth Centre	Kabiyet Health Center
	DAY 4: February 10, 2022	
09h00 – 13h00	Visit Amref Health Africa SR implementing Malaria Programme - showcase 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	Visit to CHA's or CHVs orientation session on MIP Discussion with Catholic medical Missions Board (CMMB) representation
14h00 – 17h00	Report writing	Allen's hotel
	DAY 5: February 11, 2022	
09h00 – 11h00	Exit Debrief CHMT	Allen Hotel

4. LIST OF PARTICIPANTS

	Name	**Organization**
1.	Mr. Titus Kiptai	Amref Health Africa (PR2 – Malaria)
2.	Jackson Mwangi	KCM
3.	Dr Mahmoud Eda	KCM
4.	Ms. Rosemary Kasiba	KCM
5.	Ms. Eva Muthuuri	KCM
6.	Dr Victor Sumbi	KCM Oversight Committee
7.	Ms. Margaret Mundia	KCM Secretariat
8.	Ms. Josephine Mwaura	KCM Secretariat
9.	Anthony Miru	TNT
10.	Feisal Mohamed	TNT
11.	Mr. Irungu Maina	KRCS (PR2 – HIV)
12.	Ms. Sophia Njuguna	KRCS (PR2 – HIV)
13.	Ms. Rael Too	KRCS (PR2 – HIV)
14.	Francis Ngugi	KRCS (PR2 – HIV)
15.	Mr. Paul K.Kiptoo	MOH/ DNMP
16.	Mr. Francis Onditi	Amref Health Africa
17.	Mr. Timothy Kandie	MOH/ DNTLD-P
18.	Dr. Kibisu Amadiva	MOH/ NASCOP
19.	Dr Newton Omale	MOH/NASCOP
20.	Ohaga Spake	IRDO
21.	Hilary Ngeso	CMMB
22.	Salome Ngii	CMMB
23.	Mary Chichole	CMMB
24.	Laban Talam	MOH Nandi county
25.	Jane Samoei	MOH Nandi county
26.	Irene Berenge	MOH Nandi county
27.	Priscah Tero	MOH Nandi county
28.	Dr. Andrew Kisang	MOH Nandi county
29.	Philip Kogo	MOH Nandi county
30.	Ruth Koech	MOH Nandi county
31.	Lillian Boit	MOH Nandi county
32.	Ezekiel Kisorio	CHRIO
33.	IRDO	

	Name	Organization
34.	FASI	
35.	Sheila Jepchirchir	KRCS