



Centre for Health Solutions - Kenya

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MINISTRY OF HEALTH CHS ANNUAL STAKEHOLDERS MEETING



THEME:
CELEBRATING FIVE YEARS OF EXCELLENCE IN HIV/AIDS & TB SERVICE DELIVERY

MAANZONI LODGE, MACHAKOS | NOVEMBER 12-13, 2015



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Word from the CEO



CHS stakeholders present at the Annual Stakeholders Meeting have played an important role in achieving the results that CHS is celebrating during its fifth year anniversary. It is a pleasure to have present chief executive members of health, county directors of health, chief officers of health, county and sub county health workers, medical superintendents, and representatives from development partners, as well as CHS staff.

This meeting brings together stakeholders working to bring down the burden of HIV and TB in our settings, and provides an opportunity to share and learn from each other's experiences, challenges and best practices. For this reason, CHS has sought to bring together these stakeholders each year since the start of Tegemeza in 2011.

The 2013 stakeholders' meeting focused on devolution, providing an opportunity to discuss expectations for the decentralised form of government. Stakeholders were taken through the new constitutional provisions that would affect health care including the change in roles, what the intentions behind the new constitution were and how health care would be managed to promote better health outcomes.

In 2014, the focus was on strategic information for health systems strengthening with the aim of helping stakeholders understand their role in contributing to the national health information system. The meeting also touched on health care and the law including medical negligence.

2015 is a celebratory year and a time to reflect with our stakeholders, on what the organisation has managed to achieve in the last five years that CHS has been in operation. It is a time to take stock of what we have done, based on what we intended to do when we began.

CHS activities feed into the country's health strategies with targets set in line with national guidelines. CHS seeks to support the strategies of the National AIDS Control Council (NACC) including the Kenya AIDS Strategic Framework (KASF) and aligns its activities to national guidelines provided by the National AIDS and STI Control Program (NASCO). CHS is dedicated to service delivery and has managed its resources effectively, invested in infrastructure, human resource and capacity building, laboratory support, pharmacy support and leadership and governance. This includes hosting courses from University of Washington for staff and health workers. About 1 million Kenyans have been reached through our work, close to Ksh 0.5 billion passed through CHS to the counties, over 300 competent health care workers added into the health system and over 8,000 health care workers supported through training on quality HIV care.

Dr Paul Wekesa
Chief Executive Officer

Keynote address

Dr Nduku Kilonzo, National AIDS Control Council (NACC)



Kenya has managed to reduce its HIV prevalence by more than half. It is however important to recognize that we still have a long way to go. Kenya is committed to being the third country to control HIV after Botswana and Angola. In this regard, the country must step up its efforts to avoid complacency in the fight against HIV.

There are approximately 1.6 million people living with HIV including 200,000 children. Drug users, especially injecting drug users and men having sex with men (MSM), are among those at highest risk for HIV. Women are at a higher risk of HIV, especially when they are younger. Statistics indicate increasing new infections among older people. Each year, there are 74,000 women who are pregnant and HIV positive, which means that there are 74,000 children exposed to HIV every year. Despite this, there has been a huge reduction in transmission of HIV from mothers to children by almost 50 per cent in the last 5-6 years.

There are increased results in testing and counselling; with and 800,000 individuals currently on treatment in Kenya. The number of new infections is still unacceptably high with 100,000 new infections in 2013. Half of these new infections are among married people and those in steady relationships. This is a difficult area to focus on because of our inclination to protect

family unions and matters of trust. We must however address the question of rising infections in marriages.

Thirty per cent of new adult infections occur in people between 15 and 24 years of age, which is one in every three new adult infections. HIV is still a leading cause of death among the youth. This can be attributed to lack of disclosure to avoid stigma, which keeps young people from seeking services, and to poor adherence to treatment... We cannot afford to lose our young people. This must go beyond providing services to ensure young adults are effectively guided on HIV matters.

The Kenya Aids Strategic Framework (KASF) lays down a plan for fighting HIV and provides clear guidelines that aim at reducing infections by 75 per cent, AIDS related deaths by 25 per cent, stigma by 50 per cent and increasing domestic financing by 50 per cent. Stigma is a major epidemic and we have a long way to go in fighting stigma and discrimination. The 90:90:90 targets are also incorporated into the KASF. As a country, we are all called to engage counties so that they can invest resources in non-treatment activities including community actions and quality assurance. Counties are expected to include HIV in their performance targets and should be held accountable for it.



Tegemeza Project: Four Years of Excellence

Program Updates

The five-year Centers for Disease Control and Prevention (CDC) funded TEGEMEZA Project is in its fifth year of implementation in Central Kenya; supporting Laikipia, Kiambu, Nyeri, Nyandarua and Nyeri counties. The project that initially supported 194 facilities (44 being care and treatment sites) now supports 105 facilities, 67 of which provide care and treatment (C&T). This follows transition of support for the remaining facilities to counties. Areas of support include HIV Testing and Counselling (HTC), Care and Support, Antiretroviral Therapy (ART), Prevention of Mother to Child Transmission of HIV (PMTCT), Adherence and Psychosocial Support (APSC), laboratory and pharmaceutical service support and health systems strengthening.

CHS is guided by the **KASF 2014-2019** which seeks to reduce new infections by 75 per cent, reduce AIDS related mortality by 25 per cent, reduce HIV

related stigma and discrimination by 50 per cent and increase domestic financing for HIV response by 50 per cent.

The **Revised ART Guidelines 2014** have informed CHS work including the adoption of expanded ART eligibility criteria, use of Gene Xpert technology for TB diagnosis among people living with HIV (PLHIV) and children, provision of Isoniazid Preventive Therapy (IPT) and viral load monitoring.

CHS is working towards the **UNAIDS 90:90:90 targets**, which seek to ensure identification of PLHIV, 90 per cent enrolment of eligible persons on ART, and 90 per cent viral suppression.

The Role of the NACC

The National AIDS Control Council has four primary roles:

1. National level policy and strategy including the national strategic framework and monitoring.
2. This includes providing technical advice on the development of county HIV/sector plans – education, tourism, transport, extractive industries, mining; including definition of plans and goals
3. Partner coordination which involves ensuring all stakeholders align to national goals. Responsibility for the national monitoring and evaluation (M&E) framework. NACC aims to ensure that data on HIV will be available to counties via a dashboard on a day-to-day basis by collating data from different systems including the DHIS, HMIS, commodity and supply data from KEMSA into one system
4. Mobilising resources from the exchequer, development partners and ensuring resources are priority driven

The cost of antiretroviral therapy per person per year is Ksh. 20,000, including viral load testing but excluding research and health care costs. If one million people are on treatment, this means that 20 billion shillings is spent as recurrent expenditure, thus posing significant pressure on the exchequer. In order to promote sustainability, NACC is working towards developing a fund to support HIV care instead of getting funding from the exchequer



Testing

- 924,073 tested including 146,222 children. This figure excludes testing in PMTCT settings
- 21,244 identified as positive including 1,751 children

Treatment



- 20,982 enrolled to care including 1,669 children
- 16,130 initiated on ART including 1,589 children
- 99% of all adults with CD4 <500 cells/mm³ are on ART
- 99% of all children <10 years are on ART
- 89.4% retained on ART at the end of one year
- Viral suppression at 86% (73% among suspected TF cases)
- 5,748 women received ARV prophylaxis for PMTCT and 4,818 infants receiving ART prophylaxis
- 4,152 PLHIV initiated on IPT



TB Care

- 934 adults and 28 children currently on IPT
- 6016 GeneXpert tests done

Health Systems Strengthening



- County engagement: MoUs signed, transition plans agreed on
- Health care workers (HCWs) support: 300 HCWs, 150 volunteers supported
- Over 8,000 health care workers trained
- Residential mentorship: 189 mentored
- E-learning offered at Murang'a District Hospital
- Four Centres of Excellence created at Thika Level 5 Hospital, Murang'a District Hospital, Nyahururu District Hospital and Nyeri Provincial General Hospital



PMTCT/RH



- 99% of women receiving HAART for PMTCT
- 92% HIV exposed infants (HEI) received ARVs from 0-6 weeks; 82% exclusively breastfed; 94% tested with PCR and 91% eligible HEI tested with 1st antibody (AB) test between 0-9 months and results available (October 2013-September 2014 birth cohort).
- 83% AB negative in October 2012-September 2013.
- Integrated RH services, (LTC methods, cervical cancer screening)
- 67 HIV clinics offering short term FP in CCC
- 43 clinics offering long term FP and cervical cancer



Identification and Linkage

- CHS developed a linkage register that is being adopted for national use
- CHS offers linkage support through HTC and linkage officers

Tegemeza Beyond 2015

As CHS implements the 5th year of the Tegemeza project, there is commitment to promote the quality of care across supported counties. This will be achieved through:

- Scaling up identification, linkage and enrolment of children and adolescents LHIV
- Strengthening retention and viral suppression
- Increasing GeneXpert utilisation and IPT uptake
- Streamlining of the viral load testing and result transmission system
- Continued engagement with counties and facilities in regard to transition and sustainability as the project closes



Financial Updates

CHS sub-granting mechanism

CHS signed its first sub-grant with the Ministry of Health's Provincial Medical Office (PMO) in 2011, with initial funding of Ksh. 21 million. This was part of the funding received through the ICAP-funded MCAP project. CHS later began funding counties under the devolved system of government and has so far channelled Ksh. 480million through the Ministry of Health (MoH) systems to date.

In order to promote effective response to health needs, CHS invested resources in understanding the operational needs of MoH systems and thus ensure that effective and efficient resource management mechanisms were adopted. This resulted in the adoption of a sub-granting funding mechanism that ensured timely disbursement of funds to sub recipients and effective management of funds to enhance accountability. A monthly reporting system was adopted for monitoring to ensure that County Health Management Teams (CHMTs) had adequate liquidity for program implementation. The roving accountant monitoring mechanism was also retained and improved and this played a great role in ensuring good audit outcomes and rating.

21 million
to
480 million

Human resource support

The level of staffing through CHS support to the counties has increased from 246 in 2011 to 306 in 2015. Approximately 80 per cent of funding to county sub recipients is dedicated towards meeting human resource and associated costs.

In order to manage the human resource component better, CHS invested in a payroll software that ensured improved efficiency in salary processing and sought to improve leave planning and

management through on-site monitoring and support. CHS seeks to ensure compliance with Kenya Revenue Authority (KRA) regulations through submitting tax returns. The application of the newly established KRA iTax system however remains a challenge across the CHS supported counties and is yet to be effectively used.

Equipment and infrastructure support

Assets and hospital furniture worth Kshs 25 million have been acquired to date to improve the quality of health services to patients and communities across the CHS supported counties. CHS has also undertaken the improvement of 13 health facilities at a cost of Kshs 74 million including: Ruiru District Hospital, Gatundu District Hospital, Murang'a District Hospital, Thika Level 5 Hospital, Kihoya Dispensary, Nyeri PGH, Ol Kalou District Hospital, and Engineer District Hospital among others.

Making proper use of the equipment supplied and use of the repaired facilities will ensure that the milestones achieved through the Tegemeza project benefit the counties beyond the life of the project. Accordingly, users have the role of safeguarding these assets and ensuring that they are used for intended purposes. Counties are called upon to own the equipment and to maintain it for efficiency.

Beyond 2015

CHS has elaborate plans to enhance sub-award management. These include:

- Investing in technology to improve operational efficiency at the sub recipient level
- Continued capacity building of staff for proper management of resources to enhance accountability and foster transfer of skills to MoH for sustainability of programs
- Continued collaboration with MoH as lead partners in project implementation



TB ARC Support

National Highlights on TB

Kenya is among the 22 countries that contribute 80 per cent of the global TB burden and is ranked 4th highest in prevalence in Sub-Saharan Africa. 60 people die daily from TB, mostly because a significant number of cases go unidentified.

TB is highly prevalent among people living with HIV, with 35 per cent of the 89,000 TB cases identified in 2014 being co-infected with HIV. The proportion of TB cases in children identified is lower than the target to notify 10-15% of cases. The national treatment success rate target of 90% has not been achieved, however TB data has improved.

TB ARC Support

The Tuberculosis Accelerated Response and Care (TB ARC) activity is a five-year USAID-funded activity supporting the national TB program to expand access to quality-assured TB services across all Counties for all forms of TB.

CHS works in a consortium with other partners including PATH - Advocacy, communication and community TB partner, TangazoLetu - ICT partner, Kenya AIDS NGOs Consortium (KANCO) - Informal private sector engagement and Kenya Association for the Prevention of Tuberculosis and Lung Diseases (KAPTLD) - Formal private sector engagement.

Through TB ARC, CHS supports the TB program to provide reliable leadership and coordination of TB services in Kenya, scale up new programme areas, adoption and scale up of globally proven TB interventions and technology driven programming and monitoring.

TB ARC Support Highlights

National level

- Launch of TB strategic plan 2015-2018, highlighting the key approaches to address TB in the country
- Support for the World TB Day in March
- Support for the launch of National IPT roll-out plan, as a way to prevent TB among people living with HIV and children under five who exposed to TB
- 1st National TB Prevalence Survey where the true number of cases of TB in the country will be identified

County level support

- Provide County TB and Leprosy Coordinators (CTLCs) with logistical support
- Bi-annual support meeting where data from TB counties is analysed and coordinators learn best practices
- Support CTLCs, CMLTs and sub-county TLCs to conduct routine supervisions, not only to collect data but also to provide mentorship to health care workers at facility level
- Orientation of incoming officers and training county pharmacists on commodity management
- Maintaining vehicles allocated to TB program activities
- Installation of GeneXpert machines across various health facilities, a great improvement from the previously used sputum microscopy and a breakthrough for multi-drug resistant TB (MDR TB) diagnosis. This has improved the turnaround time for testing, efficiency, accuracy, specificity and sensitivity
- GeneXpert sample transportation from facilities to the National TB Reference Laboratory (NTRL)
- Support for GX Alert – an online GeneXpert reporting system. TB ARC provides support through providing modems and data bundles
- Quality assurance



MDR-TB

Despite the reducing TB cases, the cases of MDR TB are increasing every year. The number increased from 166 in 2011 to 260 in 2014. This is of great concern due to the difficulty in treatment, long treatment period (20 months), significant expenses on the patients and adverse drug reactions. In this regard, TB ARC

- Provides social support to enable patients access health facilities for treatment
- Supports directly-observed therapy (DOT) nurses in community based care
- Supports base line lab testing through Lancet Labs

TB/HIV

- Coordination of partners to support HIV coordinating bodies
- Harness partner strengths to address TB/HIV activities
- Distribution of IPT M&E tools

Formal and informal sector

Through KANCO and KAPTLTD, TB ARC engages formal and informal sectors to identify TB cases and refer them appropriately while ensuring that the sector is linked to the national TB system

M&E

- Printing of M&E tools including TB registers, IPT registers
- Distribution to counties where implementing partners are tasked with the distribution to health facilities
- Provide TB coordinators with tablets and airtime to promote case notification and surveillance
- Quarterly data review meetings where different counties review data, verify and report
- Data quality assurance missions

Remarks from CDC representative, Dr Elly Odongo – CHS Activity Manager

“CHS is doing exceptionally well in fulfilling the mandate of the Tegemeza Project. The commitment of CHS staff is commendable and the positive results from project implementation are notable. The results being observed where CHS works are quite impressive based on reviews and site visits conducted by CDC.

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Excellence in TB/HIV Service Delivery: Best Practices

The last five years have been characterised by constant innovation to promote the quality of care at supported facilities. This has been achieved through identifying challenges in service delivery within the facility settings and working towards developing solutions to address the challenges. These innovations have successfully enhanced service delivery and led to improved indicators of health in Central Kenya. Various presentations made during the meeting showcased some of the best practices and their outcomes, thus presenting ideas for benchmarking at other facilities.



HIV Testing and Counselling (HTC)

Nyeri Provincial General Hospital in Nyeri County developed an innovative approach to promote linkage and referral following HTC. This was achieved through development of a document to track all clients referred to the CCC following diagnosis, maintaining the client escort systems, capturing patient details on the linkage register, promoting same day enrolment, follow up of clients enrolled in different sites through phone calls, tracking and instituting return to care package for patients with missed appointments, directly linking patients from other sites with the HTC referral tool without the need to retest them and referring in-patient clients to the comprehensive care centre (CCC) a day before discharge. A monthly comparison of the CCC referral register with data from HIV testing points was done to establish

referral success, which indicated 94 per cent referral success rate of newly diagnosed patients between July 2014 and June 2015. 64 per cent of those referred have been enrolled into care.

In order to accelerate HTC uptake, **Nyakianga Health Centre** in Murang'a County undertook daily health talks on HIV testing, routine documentation of HTC registers and referral/linkage register, physical client escort to testing point, generation of HTC coverage, positivity and linkage charts, presentation of HTC performance data during meetings and discussion of action points following identification of poorly performing indicators. This resulted in increased uptake of testing and consequently linkage into care, assigning health care workers to test at each service delivery point, increased acceptance of testing following health talks and accelerated testing of children and adolescents. Based on the data collected between 2011 and 2015, the number of people tested increased from 977 to 3,135. The data also showed 100% linkage to care.

Care and Treatment

ART failure remains a significant challenge in the treatment of HIV and **Thika Level 5 Hospital** in Kiambu County, sought to optimise health outcomes for clients failing ART treatment. To achieve this, routine viral load monitoring was intensified following the roll out of ART guidelines and strategies to support patients failing 1st and 2nd line ART were developed. Clinicians make use of the clinical ART failure algorithm and viral load testing algorithm to identify suspected ART failure and request for a viral load test. Based on the viral load results, patients with high viral loads are identified and called by the adherence-counselling nurse and taken through intensive adherence counselling. Monthly clinical monitoring is done and viral load test repeated after every three months of excellent adherence to confirm viral suppression. This is used to determine the need to substitute or switch the ART. Following these interventions, all active clients on ART have received their viral load reports, 387 clients with



viral load of >1000cp/ml have been identified, 172 are going through adherence counselling, 209 clients have been switched to second line treatment and 98 per cent of clients have achieved viral suppression. As a result, ART failure cases have been minimal.

Endarasha Health Centre in Nyeri County sought to improve health outcomes among children living with HIV by delaying disease progression and preventing mortality. This was done by ensuring that: facility staff were regularly updated on ART guidelines, all HCWs were oriented on CCC activities, job aids and guidelines for paediatric care were available, paediatric and adolescent clinics were set up, paediatric psychosocial support groups and care givers support groups were established and that members met on a monthly basis. This has ensured that all eligible children are put on ART and that all staff can effectively handle children and adolescents on ART. The facility has a retention rate of 95 per cent and full disclosure has been done to 18 children. One adolescent has also been trained as a peer educator.

At **Mount Kenya Sub-County Hospital** in Nyeri County, care and treatment outcomes were improved through promoting linkage to ensure that all clients who tested positive were escorted to the CCC, client counselling to promote adherence done, clinical and psychosocial assessment of clients done, service integration, improved record keeping and client follow-up and support through client tracing by peer educators. This has resulted in 90 per cent linkage to care, 100 per cent TB screening in 2015 compared to less than 40 per

cent in 2011, 100 per cent WHO staging compared to 60 per cent in 2011, increased adherence with over 90 per cent retention compared to less than 50 per cent in 2011 and close to 100 per cent CD4 and viral load monitoring.

Prevention of Mother to Child Transmission (PMTCT)

The provision of PMTCT services at **Othaya District Hospital** in Nyeri County initially saw challenges including cumbersome procedures and movements due to separate service delivery points, with women queuing for long periods with their children. They would also need to make frequent clinic visits for different needs. To address this challenge, PMTCT services were integrated within the mother and child health (MCH) setting to include ART and early infant diagnosis (EID) services to create a one-stop shop and scheduled appointment diaries to ensure that women came in less frequently. Psychosocial support groups were also introduced to provide women with information on HIV and enable them to share their experiences with the help of a mentor mother. Defaulter tracing via telephone and physical tracking was also introduced. This led to increased adherence, better appointment keeping, moral support for the women, improved coverage of testing, maternal and infant prophylaxis, EID services and improved data management and reporting.

The phase-out of the roving clinician model triggered the adoption of a sustainable approach towards sustainability of PMTCT services at **Kangari Health Centre** in Murang'a County. Following the exit of the clinician, a sustainable model was arrived at where all nurses were mentored on PMTCT/RH services and documentation. Buy-in and support



from facility management was sought, intensive one-on-one mentorship and facility CMEs to build capacity of nurses was conducted. The Clinical Officer in charge and the CCC Clinician provide clinical support when needed. This intervention has led to sustained performance in PMTCT/RH services for antenatal, postnatal clients, ownership of HIV and PMTCT/RH services by the facility staff and greater teamwork. The facility recorded three per cent MTCT rates by December 2014. All women and children in the PMTCT program have been enrolled on ART.

TB Management

Gatundu Level 4 Hospital in Kiambu County was selected as one of the pilot sites for the provision of IPT, with their first patient being enrolled in May 2013. To promote IPT implementation, the Hospital conducted buy-in meetings with health management teams, sensitised multidisciplinary teams (MDTs) and HCWs on IPT, introduced IPT registers and provided mentorship on its use, mentored the hospital Pharmacist on INH commodity management, educated patients on benefits of IPT and tagging of patient files. As a result, 71.3 per cent of patients (806 adults and 61 children) have been initiated on IPT since 2013. This has reduced cases of TB co-infection in the clinic. There were only 15 co-infected patients in 2015 compared to 40 in 2014.



Prior to 2012, Murang'a County had not had a case of MDR TB and treatment of the first patient was therefore quite challenging. The patient experienced numerous side effects and staff did not have adequate capacity to manage MDR TB. To address this, the hospital increased the frequency of consultations, a clinical review team comprising of DOT Nurse, SCTLIC, Physician, Nutritionist, Pharmacist, Laboratory Technician and a Social Worker was set up and review meetings for the patients were scheduled. Reviews are done monthly and 13 patients currently under review have had good outcomes. Four out of the five patients undergoing treatment for MDR TB have successfully been cured with one death.





Adherence and Psychosocial Support

Jomo Kenyatta University of Agriculture and Technology CCC in Kiambu County aimed to improve the impact of the adolescent psychosocial support group. To achieve this, they created specific clinic days for adolescents, requiring adolescents to come unaccompanied by guardians to create a sense of responsibility, aligning clinic days to school holidays, training an adolescent peer educator, adopting SMS communication with adolescents and using an anonymous 'ask question' strategy to communicate. This resulted in the formation of two active adolescent psychosocial groups, whose members are all on HAART. Disclosure is also at 100 per cent and only one adolescent is on 2nd line ART. Viral load testing has been done for all 22 adolescents and viral suppression has been observed. There is improved knowledge on HIV and adherence, with all the adolescents keeping their appointments during 2015. Some of the adolescents with sexual partners have also disclosed their status to them.

Alcohol dependency was playing a negative role in adherence and treatment outcomes at **Kirogo Health Centre** in Murang'a County. To curb this challenge, the health facility put in place systems to support alcohol cessation for CCC clients. The PLHIVs are followed up from the time of enrolment and offered counselling by HCWs and peer educators. Through reviewing PLHIV charts, use

of the CCC appointment diary, defaulter tracing register, baseline psychosocial assessment forms, support group and treatment literacy registers, the CCC was able to follow up the performance of the affected individuals. To improve the program, training on treatment literacy and adherence counselling was done among peer educators and HCWs with particular interest in alcohol cessation support. The results were improved adherence at 98%, with 95 per cent of the 18 clients enrolled ceasing alcohol consumption. Viral load suppression has improved and so have disclosure patterns.

Visions Garden Community Based Organisation in Nyeri showcased their community support model aimed at enhancing adherence among PLHIV, done through the formation of support groups to provide psychosocial support and economic empowerment. To promote economic empowerment among PLHIV, Visions Garden adopted a voluntary savings and loaning scheme through the concept of table banking. The CBO invited members of the community to join the scheme and currently has 77 members, 40 of whom are PLHIV and has accumulated a floating amount of Kshs 2,010,048. Through the CBO, members have been trained on different income generating activities (IGAs) including basket weaving, poultry and rabbit keeping, farming, soap making, sale of second-hand clothing and baking. This has resulted





in better adherence since they have enough money to cater for clinic visits.

At **Kangema Sub District Hospital** in Murang'a County, community support systems were adopted to improve adherence. This was based on the fact that the clients spent more time at the community level than at the hospital setting and empowering PLHIV to support other HIV positive clients would play a significant role in reaching them. To achieve this, 12 peer educators were trained and mentored on treatment literacy and community groups were formed. Treatment literacy classes were began at the CCC and six of the treatment literacy groups that graduated after the training were linked to the larger community umbrella group. The community groups participated in community mobilisation activities and the trained peer educators and graduate PLHIV had a chance to participate in local radio discussions on HIV. Out of the 161 clients enrolled, 85% have gone through treatment literacy and 62% have graduated and been linked to community-based support groups. As a result, 2,000 people received community prevention with positive (PWP) messages, 2,500 people were reached through community mobilisation, over 3,000 people were reached through radio, 150 support group members have disclosed to their partners and all clients maintained over 90 per cent appointment keeping. Through strengthened private partnerships, 150 clients were trained on IGAs and given poultry and goats to boost their activities.

Mukurwe-ini CCC in Nyeri County had a significant challenge of poor pre-ART and ART retention of clients and inability of the facility to meet national targets. To address this, the facility set targets to

achieve over 90 per cent retention, over 95 per cent counselling of clients attending the clinic and 100 per cent adherence counselling for all newly enrolled and transferred in clients. 36 habitual defaulters were identified, their files tagged and SMS and phone reminders used for these clients. There was intensified defaulter identification and follow-up, adherence counselling and daily review of all HIV patients admitted and improved linkage between the health facility, the public health department and Vision Garden CBO. All newly enrolled clients were also enrolled in literacy classes. As a result, 90 per cent were successfully counselled on every visit and all clients enrolled in treatment literacy classes over the eight months. 120 are currently undergoing classes, 320 have completed classes and 200 have graduated. Pre-ART retention is at 100 per cent while ART retention is at 95 per cent.

Cognisant of the fact that discordant couple relationships faces significant challenges, **Nyahururu District Hospital** in Laikipia County, formed the Neema discordant couple support group. This began by development of treatment literacy materials for discordant couples psychosocial support package of care followed by an MDT meeting to sensitise CCC staff on the purpose of the group and sharing of the package. Discordant couples were identified and after communication with the individuals, a first meeting was conducted. Quarterly meetings were agreed upon and synchronised with their clinic appointments, where structured treatment literacy classes were given at every meeting. The use of phone reminders sent in advance ensured that couples attended the meeting. As a result, 20 discordant couples have graduated after completing literacy classes, 100 per cent





retention for index partner achieved, all index clients initiated on HAART, testing of negative partners done according to national guidelines and children testing and disclosure to family members done. In addition, members have reported better relationships and there is evident sexual partner support. The graduate group has also registered with the Ministry of Social Services and members are engaged in economic empowerment activities.

Laboratory Services

Karatina Sub-County Hospital in Nyeri County previously faced various challenges including long turnaround time and poor quality CD4 results, commodity stock-outs, poor ART patient monitoring and lack of a specimen referral system and support leading to delayed ART initiation and care and treatment. To address these challenges, various measures were put in place including: supply of viral load buffer stock to ensure uninterrupted viral load collection, addition of a laboratory technologist to improve turn-around time, supply of automated pipettes, support in annual calibration and maintenance of automatic pipettes, supply of biochemistry and haematology analysers, HB metre and centrifuge, development of testing standard operating procedures, support in Laboratory Sample Networking (LSN), on-job trainings and increased meetings between lab management, hospital management and partners. County Medical Laboratory Technicians are also provided with airtime and bundles to ensure upload of MOH 643 and MOH 642 reports on the online platform. As a result of these interventions, turn-around time for CD4 and Chemistry tests have reduced from two days to less than one day, CD4 sample rejection has gone down from

4 per cent to 0.8 per cent, there is an improved specimen referral system for viral load and sputum cultures/GeneXpert, improved quality of results, uninterrupted testing service and improved online reporting rates which have led to better stock management.

Pharmacy Services

J M Kariuki Hospital in Nyandarua County aimed at ensuring sustainable provision of pharmacy services. In this relation, all staff working in the pharmacy were given equal opportunities for training and updates, on-job trainings were done for those who did not attend the trainings, rotation was done and support provided to ensure all the relevant reports were done accurately and on time and regular meetings with the satellite sites were conducted to ensure timely and accurate reporting. This resulted in motivation of staff, facility ownership of CCC Pharmacy services, enhanced data management systems, improved and uninterrupted quality pharmacy service provision, timely reporting by the satellite sites and the facility and knowledge of Web ADT by all staff. Pharmacovigilance reporting is done online and there are no reported stock outs of ART commodities.

Monitoring and Evaluation

There are numerous tools for data aggregation and many indicators for reporting, whose completion often leaves staff with little or no time for review and use of the data to make decisions. To improve performance, it was necessary for **Nyakianga Dispensary** in Murang'a County to simplify this process and to track specific indicators through use of charts. To achieve this, performance



indicators requiring regular review are identified, charts generated from a dashboard of selected indicators from MOH 731, MOH 711 and CPAD, discussion on performance done during MDT meetings, action plans for poorly performing indicators generated and facility performance presented during sub county/county data review meetings. Based on these interventions, the facility's performance over the years can be seen at a glance, there is increased ease in identification of poorly performing indicators, excellence can be easily identified, action plans can be effectively generated to improve or sustain performance and data interpretation skills by health workers has improved.

Warazo Health Centre in Nyeri County has exhibited best practices in monitoring and evaluation and was recognised for excellent performance in 2012. To achieve this, data sharing targeted at all HCWs in the CCC and the facility has been a core practice in promoting data management and information use. The facility adopted a template for dissemination of data, which is obtained from C-Pad and validated using MoH registers, and also ensures that monthly data was shared during multidisciplinary team meetings. The data sharing is followed by action plans to improve or sustain services. The facility has 'talking walls' with graphical data for referencing. Based on these actions, the facility has ensured effective appointment management to reduce overcrowding, enhanced case management by ensuring all patients receive services such as CD4 and viral load testing on time and improved ease in determining logistical requirements such as lab reagents and drugs.

Capacity Building

Through a committee comprised of CHS and **Murang'a County Referral Hospital** staff, a curriculum was developed for the Residential Mentorship Program and site selection done including mentor selection, training material and logistics support. Mentees in various cadres are identified and invited for the mentorship program. The program involves a one-week placement, where mentees are paired with mentors. Pre and post mentorship evaluation is also conducted and there is ongoing on-site mentoring and follow-up by CHS Program Officers. The total number mentored under the program include: 63

Registered Clinical Officers, 57 Nurses, 31 Data Clerks and Health Records Information Officers, 12 Pharmacy Technicians, 4 Pharmacists, 13 Laboratory Technicians and 5 Social Workers.



ASM 2015 in Pictures







Centre for Health Solutions - Kenya

Preferred Partner for Health Solutions



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