Support Towards Expanded Prevention Services (STEPS)

END OF PROJECT REPORT

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Contact person:	Dr. Lilian Otiso –Director of Programs, Principal Investigator lilian.otiso@lvcthealth.org Dr. Philip Masaulo – Project Director, STEPS Philip.masaulo@lvcthealth.org
Authorizing Official:	Francis Kamau francis.kamau@lvcthealth.org
Date of submission	

CONTACT INFORMATION:
P.O Box 19835-00202, KNH,
NAIROBI, KENYA: +254 020 2646692, Website: www.lvcthealth.org: Email: enquiries@lvcthealth.org

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List of Abbreviations

AAC	Area Advisory Council
AIDS	Acquired Immune Deficiency Syndrome
AGYW	Adolescent Girls and Young Women
ALHIV	Adolescent Living with HIV
APNS	Assisted Partner Notification Services
ART	Antiretroviral Therapy
AYP	Adolescent and Young People
CAB	Community Advisory Board
CACC	County AIDS Control Council
CBO	Community-Based Organizations
CBT	Constituency Development Fund
CCC	Comprehensive Care Clinic
CDF	Constituency Development Fund
CHV	Community Health Volunteers
CHRIO	County Health Records Information officer
CMA	Case Management Approach
CLHIV	Children living with HIV
CALHIV	Children & Adolescent living with HIV
CPARA	Case Plan Achievement Readiness Achievement tool
CPIMS	Child Protection Information Management Systems
CP	Child Protection
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CT	Cash Transfer
DARAJA	Bridging Access to comprehensive health services for key and Priority Populations
DCOP	Deputy Chief of Party
DCS	Department of Children Services
DDIU	Data Information Use
DTG	Dolutegravir
DREAMS	Determined Resilient Empowered AIDS-free Mentored and Safe
EBI	Evidence-based Behavioral Interventions
ECD	Early Child Development
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
FAM	Finance and Administration Manager
FBO	Faith-Based Organization
FC	Financial Capability
FF	Fisher Folk

FMP	Family Matters Program
FSW	Female Sex Worker
GBV	Gender-Based Violence
GoK	Government of Kenya
HCBF	Healthy Choices for Better Future
HEI	HIV-Exposed Infants
HH	Households
HVA	Household Vulnerability Assessment
HIV	Human Immunodeficiency Virus
HIVST	HIV self-test
HTS	HIV Testing Services
IEC	Information Education and Communication
IGA	Income Generating activity
IMC	International Medical Corps
IPV	Intimate Partner Violence
IRDO	Impact Research and Development Organization
IT	Information Technology
J2SR	Journey to self-reliance
JFFLS	Junior Farmers Field and Live School
KENPHIA	Kenya Population-based HIV Impact Assessment
KEPOTE	Kenya Network of Positive Teachers
KHIS	Kenya Health Indicator Survey
KHPQS	Kenya Health Partnerships for Quality Services
KQMH	Kenya Quality Model for Health
KP	Key Populations
KYEOP	Kenya Youth Employment Opportunity Program
LAAG	Local Area Advisory Groups
LIP	Local Implementing Partners
LMIS	Local Market Information System
LSTM	Liverpool School of Tropical Medicine
LTFU	Lost to Follow up
LIVES	Listen, Inquire, Validate, Enhance safety, Support
M & E	Monitoring and Evaluation
MFI	Micro Finance Institutions
MHMC	My Health My Choice
MDT	Multi-Disciplinary Team
MOAL&F	Ministry of Agriculture, Livestock, and Fisheries
MOE	Ministry of Education
MOH	Ministry of Health.
MOU	Memorandum of Understanding
MOPSY&GA	Ministry of Public Service, Youth and Gender Affairs
MSEA	Micro and Small Enterprise Authority

MSP	Male Sexual Partner
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program
NHIF	National Hospital Insurance Fund
NGO	Non –Governmental Organization
NITA	National Industrial Training Authority
NPV	Non-Partner Violence
OCAT	One Child at Time
OIDP	One-on-one integrated Digital Platform
OVC	Orphans and Vulnerable Children
OTZ	Operation Triple Zero
RT-CQI	Recency Testing-Continuos Quality Improvement
PDSA	Plan-Do-Study-Act
PEP	Post Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHDP	Positive Health and Dignity Prevention
PLHIV	People Living with HIV
PNS	Partner Notification Services
PMTCT	Prevention of Mother to Child Transmission
PP	Priority Populations
PSP	Private Service provider
PVC	Post Violence care
PrEP	Pre-Exposure Prophylaxis
PSS	Psychosocial support
PWID	Person Who Inject Drugs
QI	Quality Improvement
QIT	Quality Improvement Teams
QMT	Quality Management Team
SAPTA	Support for addiction Prevention and Treatment in Africa
S&D	Stigma and Discrimination
SILC	Savings and Internal Lending Communities
SIMS	Site Improvement through Monitoring Systems
SGBV	Sexual and Gender-Based Violence
SDGs	Sustainable Development Goals
SRHR	Sexual Reproductive Health Rights
SMART	Skill for Marketing and Rural Transformation
SNS	Social Network Strategy
SP	Sub-Purpose
SOP	Standard Operating Procedures
SSN	Social safety net
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections

STOC	Small tests of change
STO	Senior Technical Officer
SW	Social Worker
TA	Technical Assistance
TB	Tuberculosis
TOF	Trainer of Facilitators
TOT	TOT- Trainers of Trainers
TVET	Technical and Vocation Training
TWG	Technical Working Group
VAC	Violence against Children
VACS	Violence against Children Survey
VCO	Volunteer Children Officer
VRT	Violence Response Teams
VL	Viral Load
VSLA	Voluntary Savings and Lending Associations
VTC	Vocational Training Centre
WHO	World Health Organization
WIT	Work Improvement Teams
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
YACH	Youth Advisory Committees for Health
YFHS	Youth Friendly Health Services
YLHIV	Youth Living with HIV
YMCA	Young Men Christian Association
YWCA	YWCA-Young Women Christian Association

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Introduction

According to Kenya AIDS Response Report, 2018, six counties in Western and Nyanza regions accorded an increase in HIV prevalence among the population aged 15-64 years. These were; Homa bay 19.6%, Siaya 15.3%, Kisumu 17.5%, Kakamega 3.9%, Migori 13% and Kisii 6.1%. The Project works in 4 of these counties (Kisumu, Kisii, Migori, and Homabay).

HIV infections in these counties are driven by key and priority populations who engage in risky sexual behaviors, including casual and multiple sexual relationships, poor health-seeking behavior, and sharing needles.

During the period October 2016 to September 2021, LVCT Health implemented the STEPS project to provide comprehensive HIV prevention, care, and treatment interventions to key and priority populations in Kisumu, Migori, Kisii, and Homa Bay counties in line with national policy documents. To address the rising HIV infections in the country, the National AIDS Control Council (NACC) prioritized reducing new infections through geographic and population prioritization of interventions through the Kenya National AIDS Strategic Plan (2014-17). Several guidelines have since been developed to inform the HIV interventions, including the Kenya AIDS Strategic Framework (KASF II), Kenya Adolescent Fast Track Plan (2015), HIV testing and counselling guidelines (2018), National HIV anti-retroviral use guidelines 2018 (that defined test and start and pre-exposure prophylaxis) and National Key Populations (KP) guidelines (2014). From the KASF national framework, the counties adopted and came up with County AIDS Specific frameworks (CASF), which address specific issues within their counties

The following were the program objectives to be achieved by September 2021:

1. Supporting optimal identification and linkage of HIV positive individuals
2. Providing comprehensive care and treatment services for KP and PP
3. To expand access to and improve the quality of HIV services to Key and Priority Populations.
4. To increase access to health and social services for AGYW and their families
5. To collaborate with national and county governments to strengthen strategic information systems, policy, and program improvement

Overall Project Achievements against objectives

Strategic Objective 1: Supporting optimal identification & linkage of HIV+ individuals

STEPS project has continued to offer quality HIV testing services (HTS) in line with the National HIV testing guidelines across LVCT Health supported sites in Kisumu, Kisii, Migori, and Homa Bay Counties. The project implemented the strategies relevant to the targeted populations, i.e., key populations (FSWs, MSMs, and PWID) and priority populations (AGYWs and Fisherfolk). Enrolled cohorts received annual HIV testing plus quarterly risk-based retesting for KPs, biannual risk-based retesting for FFx, and annual retesting for AGYW. By the end of the project, a total of 723,173 unique individuals were reached with HTS services, among whom 10,954(1.5%) were identified HIV positive and 10,515 (96%) linked to care and treatment. Among the positives, 3,755 (35%) were identified through index testing, 4,652 (43%) through facility testing, 2,378 (22%) through community testing. Of the positives linked, 7,750 (74%) were effectively linked to receiving ART services within LVCT Dices. The table below shows the distribution by population types.

Table 1: HTS uptake and Linkage by typology

	FSW	MSM	PWID	FFx	AGYW	TG	GP	Total
No. Tested	29,384	8,383	962	32,809	56,493	12	595,130	723,173
No. Tested Pos	4,923	410	181	1,651	215	1	3,573	10,954
% Tested positive	17%	4.8%	18.8 %	5%	0.4%	8.3%	0.6%	1.51%
Linked to LVCT Health DiCEs	3,136	351	101	760	0	0	3,402	7,750 (71%)
Linked to other Facilities	1,593	59	80	792	200	1	40	2,765(29%)
Total Linked	4,729	410	181	1,552	200	1	3,442	10,515 (96%)
% Linked	96%	100%	100%	94%	93%	100%	96%	96%

HIV Testing Services for Key Populations

When the STEPS project began in Oct 2016, a total of 16,739 Key populations (FSW - 13,942, MSM - 2392, PWID - 405) were handed over to LVCT by IMC and IRDO, and since then, a total of 20,186 new Key Populations (FSW - 13,566, MSM - 6,037, PWID - 571 and TG - 12) were mobilized and enrolled into the prevention program. HTS was offered to target those already enrolled (retesting) and those newly enrolled. Services were offered through the 12 LVCT Health-supported drop-in centers (DICEs) and outreach activities in hotspots. By the end of the project, a total of 38,741 KPs were reached with quality HIV testing services, where 72 (0.1%) seroconverted. From the newly enrolled KPs, 817 were enrolled as known positives while 5,443 were newly identified as HIV positive with a positivity rate of 31%. For the clients who seroconverted, the project recorded migration outside the program areas as the main contributor. The project innovatively introduced a 'Travel Pack' to those who plan to be away from the program areas for a long period to mitigate this trend. This included; condoms, lubricants, PrEP, among others. The travel packs were issued to the clients before their travelling by the DiCE staff through peer educators, and the process continued through the lifetime of the project

HIV Testing Services for Fisher Folk

STEPS implemented prevention services to Fisher Folk in two Counties; Kisumu and Migori. The Kisumu Fisher Folk project was implemented in the first year, then later transitioned/transferred to Migori County. The project targeted five wards – Muhuru, Got Kachola, North Kadem, Kanyasa, and Kachieng, in Nyatike Sub-County. Prevention services offered included but were not limited to biomedical services, behavioral services (Evidence-Based Interventions to promote behavior change) as well as Structural (supporting the target population to explore other means of livelihood). The LVCT team worked with CDC to define the package of interventions for the fisherfolk program.

By the end of the project, 32,809 fisher folk received quality HIV testing services, 1,651 (5%) tested HIV positive, and 1,552 (94%) successfully linked into care and treatment.

HIV Testing Services for AGYW

Adolescent girls and young women together with their parents/caregivers were reached with HIV testing services through the DREAMS program in both Migori and Homabay Counties. This was offered as part of the combination prevention interventions to the AGYW in the safe spaces by the HTS providers working in the program. The male sexual partners (MSP) of the AGYW were also reached and offered HTS in their homes and/or in targeted spots. By the end of the project, a total of 56,493 AGYW were reached with quality HIV testing services. HIV testing was conducted for those

newly enrolled as well as annual retesting for those already enrolled. During the project life, a total of 215 individuals were newly identified as HIV positive with a positivity rate of 0.4%. Out of that 200 were successfully linked and enrolled in care and treatment, translating to a linkage rate of 93%. The project, however, recorded 74 seroconversions among the AGYW. Out of the seroconversions, 20 (27%) were newly enrolled girls who seroconverted upon their first re-test after enrollment; 43 (58%) had relocated from the program coverage area and were traced back to the program in liaison with their caregivers but seroconverted upon retest whereas 11(15%) seroconverted after self-stopping use of PrEP.

HIV Case Identification Strategies

In regards to HIV case identification, the program adopted high-yielding strategies targeting those recently exposed to HIV, identifying and linking them to care and treatment. The strategy adopted were as follows:

a) 100% HTS for the newly enrolled KPs/PPs into the program

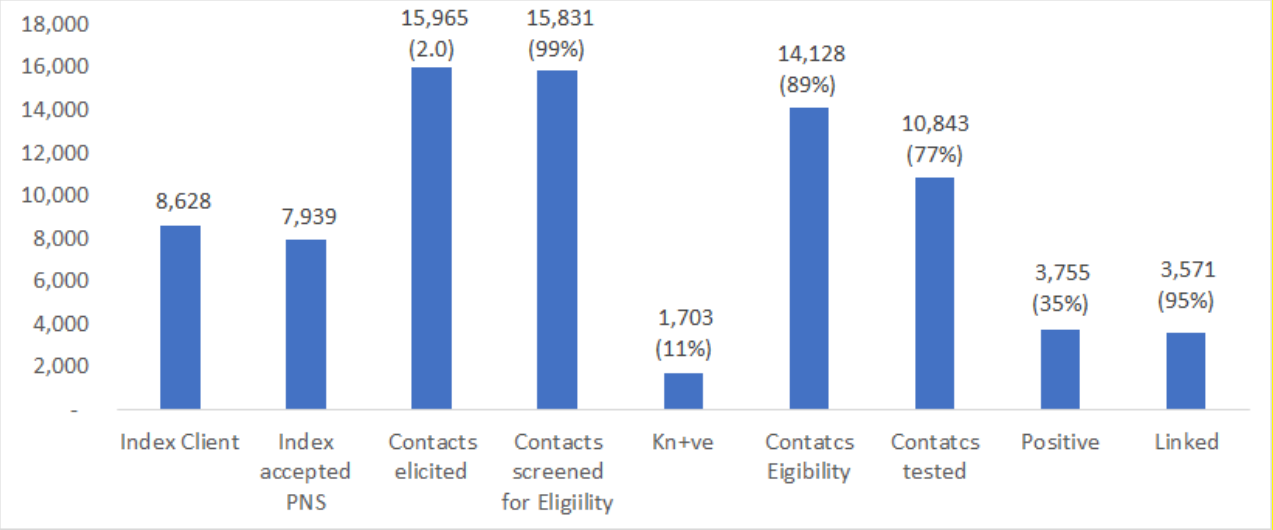
HIV testing was offered to all newly recruited key and priority populations before enrolment into the program. This was meant to establish their HIV status at the point of enrollment and aid in assessing the impact of the prevention project at the end of the implementation. By the end of the program, a total of 5,441 newly enrolled key populations, 1,649 FFx, and 141 AGYWs tested HIV positive, contributing 66% of the total HIV positive clients identified.

b) Assisted Partner Notification Services (aPNS)

Assisted Partner Notification Services (PNS) was offered across all the LVCT Health supported sites, targeting HIV positive and high-risk HIV negative individuals as index clients. In addition, contact elicitation was done to all consenting index clients, targeting their sexual partners, biological children, and injecting drug partners.

In compliance with the National and PEPFAR index testing guidelines, STEPS conducted site-level assessments on safe and ethical index testing across all the supported sites, feedback was given to the team for remedial actions. As a result, 3,755 HIV-positive clients were identified through the strategy, contributing 35% of the total positive clients identified during the program life. The graph below shows the PNS cascade:

Figure 1: PNS cascade from project inception



c) HIV Self-Testing Strategy (HIVST)

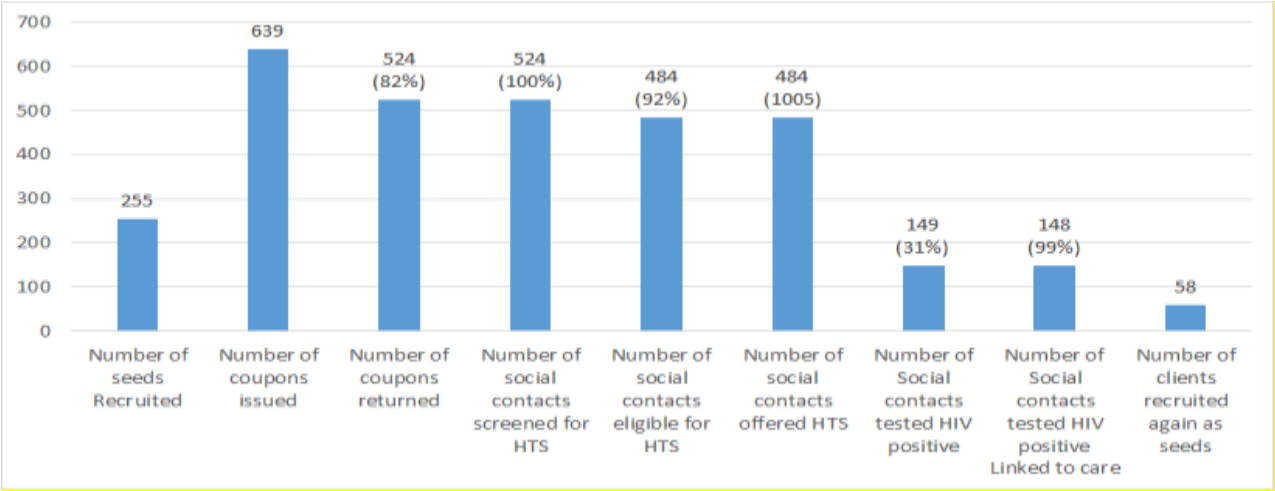
LVCT Health STEPS implemented an HIV self-testing strategy to help reach hard-to-reach populations, especially men and adolescents. The program mentored providers on effective screening in line with the national curriculum focusing on eligibility screening and documentation. As a result, PLHIV with hard-to-reach contacts were screened and issued with HIVST kits. The program also reached men not able to take up routine testing with HIVST kits issuance. The strategies used were directly assisted and unassisted HIVST. Supplies were acquired from the Ministry of Health facilities through redistribution and direct supplies from KEMSA. However, the program faced an acute stock out of commodities in the last FY of the program. By the end of the program, 11,001 HIVST kits were distributed, of which 4,236 were distributed to men and 3,033 distributed to youth and adolescents.

d) Social Network Strategy (SNS)

The program implemented Social Network Strategy (SNS) targeting key populations. The strategy was based on the assumption that people in the same social network share similar risk behaviors for HIV, hence the need to reach and offer HTS to social networks of those tested HIV positive and high-risk HIV negative. STEPS rolled out and implemented SNS from the fourth year of the program (2019/20) after training by CDC. Incentives offered during the implementation of this strategy were non-monetary: Sanitary towels for FSWs, Lubricants for MSM and Hygiene packs (toothpaste, toothbrush, bathing soap, and petroleum jelly) for PWID.

The below cascade gives the SNS achievement.

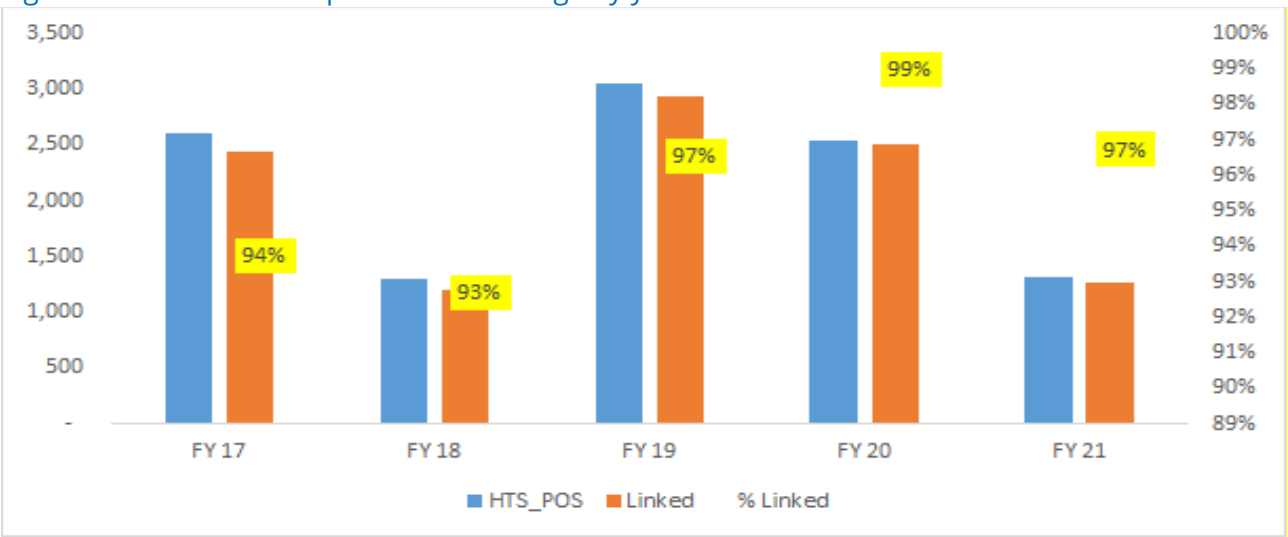
Figure 2: SNS cascade



Linkage into care and treatment

The achievement of the 3rd 95% is dependent on successful linkage into care and treatment for clients who are identified as HIV positive. During the program implementation, STEPS utilized several strategies to ensure effective linkage for clients into care and treatment, including the physical escort of the clients to the CCC of their choice by the HTS providers, phone/physical follow up for those who didn't access CCC on the same day, as well as tracking by the linkage and retention officers. The linkage was done, both intra and inter-facility, depending on the client's choice. By the close of the program, out of the identified HIV positive clients, 10,515 were successfully linked into care, translating to an overall linkage rate of 96%

Figure 3: Number tested positive and linkage by year



Quality Assurance in HTS

The program ensured the implementation of HIV quality assurance programs as per the Kenya National AIDS and STI Control Program's recommendations (NASCOP) for HIV Testing Services. LVCT STEPS strengthened weekly and monthly HTS counselor support supervisions, debriefings, and joint HTS and Laboratory observed practices. Quarterly site support supervisions were conducted by the Ministry of Health officials. The laboratory also assisted in conducting Monthly HIV kits quality-control tests and new HIV batch testing and other rapid test kits quality control processes and tracking of the HIV concordance rates. Laboratory and HTS teams were trained on rapid test kit continuous quality improvement (RT-CQI) and quality champions were identified to scale up implementation of quality HTS services in all sites in the final year of implementation. All HTS providers were enrolled into the national proficiency testing (PT) scheme managed by the National HIV Reference Laboratory (NHRL) with 100% percent participation. All staff trained in HTS services including clinicians and laboratory staff who actively conduct HTS services including retesting participated in the national PT program with corrective action and preventive actions (CAPA) conducted for those with unsatisfactory results. Annual refresher trainings were conducted to update the providers on new emerging issues as well as reemphasize the need to ensure quality in HTS service provision. The failures in round 21 were as a result of the 4 participants working as a group hence recorded wrong results. This was identified as the gap for failure during CAPA and the matter was addressed with the participants.

Table 2: HIV EQA/PT Participation & Performance

PT ROUND	# ENROLLED	# SATISFACTORY RESULT	# UNSATISFACTORY RESULTS	# ROUTE CAUSE ANALYSIS(RCA) DONE	# CAPA DONE
Round 19	134	129	5	5	5
Round 20	167	167	0	N/A	N/A
Round 21	169	165	4	4	4
Round 22	172	168	2	2	2

Implementation of Electronic HIV Testing Services (e-HTS)

All LVCT Health-supported sites/staff were trained on e-HTS and the sites migrated from Afya Mobile to Kenya EMR. So far, 5 (42%) of the sites successfully rolled out and uploaded their data to the server. The remaining 7 sites (58%) were having technical hitches which are being resolved.

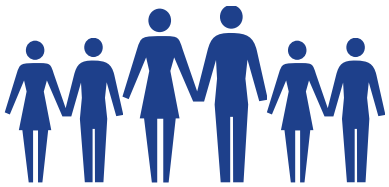
Strategic Objective 2: Providing Comprehensive Care and Treatment services for KP and PP

In a bid to contribute to the 95:95:95 and Kenya's progress towards meeting the vision 2030 target, the program developed a key strategic intervention to ensure 100% of clients identified were started on treatment on the same day of identification or within 14 days from the date of testing positive (for those that declined). The program implemented its activities, observing all the MOH COVID prevention protocols.

In the reporting period, a total of 10,954 clients tested HIV positive. Out of these, 7,750 (71%) clients were enrolled in our DICEs, while 2,765 (25%) were linked to other facilities, the majority being the general population. Key strategies to achieve the test and treat included: Community ART scale-up in Migori and Kisii Counties, Outreach preparation and initiation, tracking pending initiations within 14 days, and extended working hours to ensure all identified clients were enrolled on the same day through physical escort by HTS providers.

10,954

Individuals who tested positive for HIV



Of the 10,954 HIV-positive clients identified, 139 were pediatrics, whereby 96 were linked to Tivoli, the only site that enrolls pediatrics, and others were linked to the nearby health facilities based on preference by the caregivers.

Retention of clients on care and treatment (TX Current)

The program began from a TX Current of 2,879 and closed out with 5,845 clients (5,733 adults and 112 pediatrics) as active clients in the program (TX Current). The program deployed various retention strategies which included: active calling of clients before their appointment dates, mapping of high-risk defaulter clients, prior appointment reminders through the utilization of the USHAURI platform, immediate follow up of clients not turning up for their clinic appointment within 24 hours, and home visits for defaulters after 7 days of missing an appointment. The program engaged client trackers and Community Health Volunteers to help in active community-level tracking of the key population who defaulted or missed appointments. An online google sheet-based tracker was used to ensure timely site-level support was offered and intervention initiated promptly.

The program implemented comprehensive activities to support clients with co-morbidities to access their medication through sending the drugs as parcels, fast-tracking appointments, buddy picking

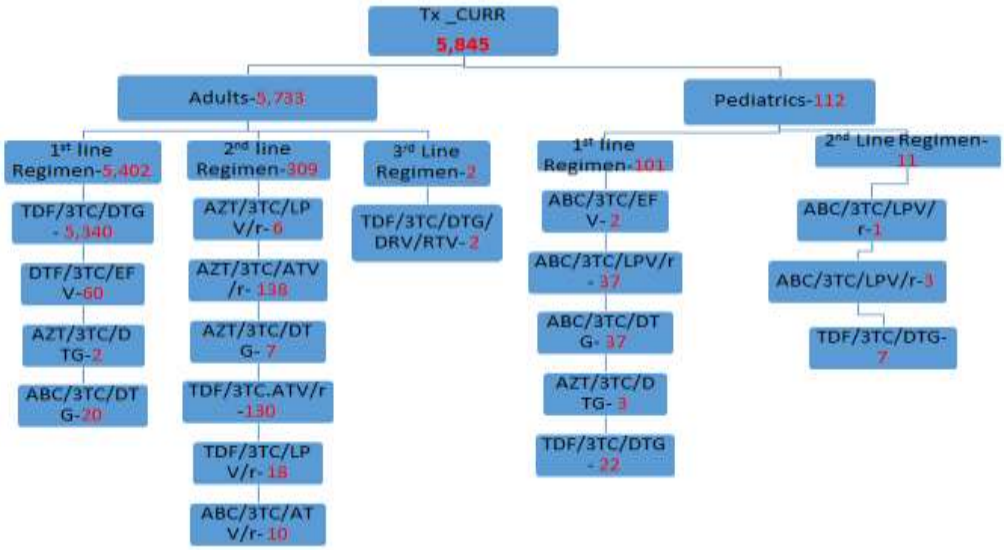
their medications, and offering teleconsultation where necessary. The program also worked closely with other implementing partners to link clients who were unable to travel due to proximity and movement due to challenges like proximity and COVID 19 to access medication through the use of the facilities directories. During COVID-19 restrictions which began in March 2020, clients who requested it had their drugs delivered to them by couriers.

KenyaEMR was instrumental in flagging clients with missed appointments, clients due to viral load, and twinning of the families to allow comprehensive family support among clients accessing care in our facilities. The EMR has also ensured efficient reporting and remote client review and support by the technical teams.

The program also tracked return to care clients and lost to follow-up clients across 11 Dices. Over the period, the program attained a net growth (TX_NET_NEW) of 2,966.

The program focused on weekly virtual adherence sessions to ensure reduced contact time between the providers and the clients as part of the COVID-19 prevention measures for the ART naïve clients who were starting treatment. Clients with high Viral load were enrolled into viremic clinics. Targeted viremia support groups were offered in clusters of not more than five clients to ensure optimal support and adherence to medication. For clients enrolled in Community ART, this was done during outreach in clusters of 15-20, but at the tail end of the program, the numbers per cluster were reduced to 5 clients because of the COVID-19 restrictions. In addition, family and friend support systems were structured to address the client's unique issues to improve adherence.

Figure 4: Current treatment by regimen



By the end of the Project, there were a total of 5,845 on treatment, out of which 5,733 were adults and 112 children. A majority (94%) of adults on treatment were on 1st line while 90% of children

were on the first line. Only 2 Adults were on the 3rd line and none for children. All clients were on recommended optimized regimens

ART Optimization

The program embarked on a rapid optimization plan following the introduction of the Dolutegravir (DTG) based regimen. Since then, all the clients on Nevirapine (NVP) and Efiverance (EFV) based regimens were transitioned to either DTG or retained on EFV based regimen with strict observation of the Ministry of Health guidelines on pediatric and adult patients ART optimization. This was attributed to the commodity supply chain and patient's preference.

Figure 5: Current ART optimization status by site

Viral Load Cascade

LVCT Health STEPS continued to ensure at least 95% of clients eligible for viral load are bled and achieve viral suppression. It implemented multiple prongs to achieve viral suppression, and these included; targeted viremia psychosocial support groups, Differentiated Service Delivery (DSD) for all typologies, Operation Triple Zero (OTZ) for adolescents in Tivoli leveraging on school holidays, and PapaMama (PAMA) for pediatrics with suspected failure. The Program had 5,134 eligible clients for viral load, and out of which 3,114 (61%) clients were sampled, 2,996 (96%) received their results, where 2,252(75%) had Low Detectable levels (LDL) results

With a cutoff of <1000, the Program recorded a viral suppression of 2,891 (96%) at the end of the reporting period (98% among FSW, 97% among MSM, and 97% among PWID). Viral suppression among adolescents is at 45/50(90%), and pediatrics at 65/75(87%)

Table 3: Viral Load Cascade by population type

	FSW	MSM	PWID	FFx	Gen Pop
Eligible for viral load	1,356	191	51	436	3,100
With Results	786	110	32	247	1,821
With VLS	767	107	31	242	1,744
% Suppressed (<1,000 copies)	98%	97%	97%	98%	96%
<400 copies	754	105	31	240	1,671
% <400 copies	96%	95%	97%	97%	92%
LDL	609	75	23	201	1,344
% With LDL	77%	68%	72%	81%	74%

The program continued to review strategy to achieve scaled-up LDL levels across all populations to ensure progress towards achievement of Undetectable- Untransmittable(U=U) strategy.

High VL patients with copies above 1000 had Enhanced Adherence Counselling sessions (EACs) as part of intensified adherence interventions; they were enrolled into viremia PSSG and provided structured individualized care. This resulted in a re-suppression rate of 71(68%).

Some key strategies to improve viral suppression among adolescents included an adoption model involving the clinical staff to support the families with adherence challenges, a Peer-led attitude change approach, OTZ champions, and continued tapping into technology through the digital platform to support the CALHIV during the COVID 19 period.

Support for Young Key population and adolescents living with HIV

The program offered structured support to adolescents and young people through targeted adolescent PSSGs and OTZ clubs to support them and ensure their unique issues were addressed. This was done in clusters of 10-20 adolescents and later in clusters of 5 adolescents to observe the COVID 19 regulations. The program was able to re-align its service provision based on the young Key population guideline.

PAMA Care for pediatrics

LVCT Health enrolls HIV-positive children in Tivoli Integrated Clinic. Children below 10 years are seen together with caregivers as a family to improve on their retention and treatment outcomes. The ultimate goal is to pair all the children with their caregivers.

Child_ Caregiver Tracking to support Viral suppression for Children <10 years

This was done through the pairing of pediatrics within the program and their caregivers to ensure they attain viral suppression. During the reporting period, the program had 31 pediatrics paired with their caregivers. 81% of pediatrics had both child and caregiver achieving viral suppression, 0% child suppressed caregiver unsuppressed, and 29% child unsuppressed caregiver suppressed. Linkage to OVC was a key strategy to achieving viral suppression among pediatrics in the program. There was an improvement in suppression among children linked to the OVC program at 53% compared to those not linked at 47%.

Differentiated Care Models

The program implemented Differentiated Service Delivery models across 11Drop In Center's. These included multi-month scripting, community ART, and integrating clinical services into psychosocial support group meetings. The program had 3,871 stable clients, out of which 3,492 (90%) were put on six multi-month scripting, and 241 enrolled into community ART programs spread across the three counties.

In the five-year implementation period, STEPS increased the adoption of a fast-track model for ART refills. As a result, community ART stabilized across Kisii, Migori, Muhuru, and Isebania DICEs, with good retention reported across the sites. For instance, Kisii reported 93% VLS, Isebania 98%, Muhuru 98%, and Migori 100% through community ART.

Table 4: Breakdown of clients on DCM by model

	Male	Female	Total
Facility-based Fast Track System for ART Refills (Long appointment >3 months)	1,427	2,065	3,490
Community/Facility ART Groups for ART Refills (OTZ, PAMA)	20	20	40
Healthcare Worker-led Community/Facility ART Groups (KP sites support groups)	50	50	100
Individual Patient ART Distribution in the Community (DCM by location)	87	154	241

KP/PP PLHIV Tracking

The program scaled up PLHIV tracking both for key and priority populations, focusing on clients accessing care and treatment in other facilities. These are clients who joined the program for prevention services while already in care or diagnosed while in the prevention program but linked to other facilities due to distance. The program developed strategies that included utilization of facility directories and follow-up with specific facilities where the clients had access to care. As such, the program managed to track 967 key populations and 87 fisher folks (clients of the PLHIV accessing care in other facilities. The major challenge remained the change of names and wrong unique numbers, which affected tracking.

TB Case Finding

In the five-year implementation period, the program scaled-up intensified case finding and active case finding for both positive and negative clients The program screened 22,783 clients with 260 being presumptive and taken through the diagnostic cascade as per the guidelines, 145(56%) were diagnosed with TB through Gene Xpert, TB LAM or X-ray. Active follow-up was done to all clients to ensure cure or treatment completion across the sites. Clinicians had their capacity built around the identification of presumptive TB cases through proper screening to identify suspects. Integration of TB screening within various departments like HTS rooms, Comprehensive care clinics, and Prevention clinical rooms was implemented to reduce missed opportunities.

TB preventive services (Isoniazid preventive therapy) among the HIV-positive clients accessing care services at the Dices was successful with a total of 4,713 having been initiated on IPT, 4,565 completing treatment, and 148 still on IPT by September 2021. Tracking the IPT status of clients accessing care in other non-program facilities was also a priority within the five-year implementation reporting period.

Essential commodities and supplies

The program supported commodity supplies across the sites to ensure adequate commodities to manage the clients effectively. Clinicians were capacity-built to discern adverse events and report appropriately both electronically and manually to the sub-counties. Quarterly meetings were held by medicine and therapeutic committees.

The program used ARVs Drug Supply Chain Management Tool (ADT) for commodity management across the 10 sites. Data was compared with the Kenya EMR to ensure data consistency between the two systems. The program utilized a pull system for the commodities. The program tracked its stock levels to ensure consistent drug commodity supplies, raise emergency orders as the need arose, and flagged the high stocks of short expiry medications. However, during the final FY, the

project experienced an erratic supply of commodities which affected the adoption of the DSD models and some delays in optimizing eligible clients.

Laboratory Services

The project began with no functional laboratory systems and ever since has put in place robust laboratory structures to support the provision of quality healthcare to PLHIV initiated into care and treatment. A well-structured sample networking system was implemented through an effective hub and spoke model coordinated to support Viral Load, TB GeneXpert and microscopy, EID laboratory tests, DTS, and HIV inconclusive samples across all sites. Over the years, the program strengthened stakeholder collaborations (Ips & MoH) in the rotational shipment of samples to regional testing laboratories and local testing of Prep samples for biomedical laboratory tests, TB GeneXpert, TB microscopy follow-up tests, and CD4 testing. LVCT prevention and treatment Center-Tivoli laboratory was also strengthened as a central hub for LVCT sites in Kisumu County for sample networking, remote login, and other laboratory tests. We used Motorcycle couriers to transport samples from Drop-in centers to central hubs daily for remote login before shipment to regional testing laboratories (see Table 8). In addition, the program used vehicles to ship samples from central lab hubs to regional testing labs twice a week to reduce sample holding time at the central hubs.

Table 5: LVCT Health STEPS Viral Load Sample Network

No. of Drop-in centers	County	Sub County	Hub Supporting	Testing Laboratory
5	Kisumu	Kisumu Central	LVCT prevention center-Tivoli	KEMRI/CDC Kisian
1	Kisii	Kitutu Chache South	Kisii Teaching & Referral Hospital	Walter Reed Project-Kericho
2	Migori	Suna East	Migori County Referral Hospital	Ampath-Eldoret
2	Migori	Nyatike	Macalder	Ampath-Eldoret
1	Migori	Awendo	Awendo Sub County Hospital	Ampath-Eldoret

The program strengthened the mobile laboratory process (Mlab) in all facilities to help improve viral load result access and turnaround time (TAT) and use the national VL/EID dashboard and SMS for clients' results at the facility level. Moreover, the program worked closely with the national systems to supply HIV laboratory commodities like CD4 cartridges for CD4 testing. The overall results turnaround time improved from over 30 days for VL in 2016 to less than 10 days, as shown in Table 6.

Table 6: LVCT STEPS Laboratory Results Turnaround Times

	Viral Load	GeneXpert TB	CD4
TAT (In Days)	10	2	1

Mentorship was done on sample collection to improve on quality samples and reduce rejections to below 1% and remote login improved from 67% to 94%.

Table 7: LVCT STEPS VL samples Remote login & Rejection Rates.

# of VL samples collected	% Remote logged	# & % Sample rejected	% Results received
4038	3825 (94%)	4 (0.17%)	99.88%

In the wake of the COVID-19 pandemic, the laboratory intensified staff sensitization on pandemic related infection prevention & control (IPC) measures, including safe handling of patient samples, especially TB samples. In addition, IPC committees were formed and supported by the laboratory department to effectively strengthen IPC measures in various regions.

Training of HCWs

The program trained health care workers on the new guideline in collaboration with the MOH in the support counties to ensure alignment with WHO and Kenya ART guideline 2018 release. A total of 56 (nurses, clinical officers, Laboratory Technologist, pharmaceuticals, and adherence counselors) were trained.

Strategic Objective 3: To expand access to and improve the quality of HIV services to Key and Priority Populations.

HIV Programming for Key Populations

The STEPS program offered comprehensive HIV prevention services to Key Populations in Kisumu, Kisii, and Migori Counties in Western Kenya. The services were offered through Static (DICES/ Prevention Centers) and outreach models. Mobilization of key populations to access service both at outreach and static DICES were led by trained KP peer educators and outreach workers.

i. Hotspots mapping and size estimation

LVCT Health carried out hotspot mapping and key population size estimation exercise (KPSE) in 2018 in collaboration with NASCOP and the county government 2018. The exercise was carried out by trained program staff and peer educators using standardized data collection forms.

The attached table summarizes the number of hotspots and KP size estimates in Kisumu, Kisii, and Migori counties as published in the NASCOP Key Population Size Estimates report 2018.

Table 8: KP size estimates

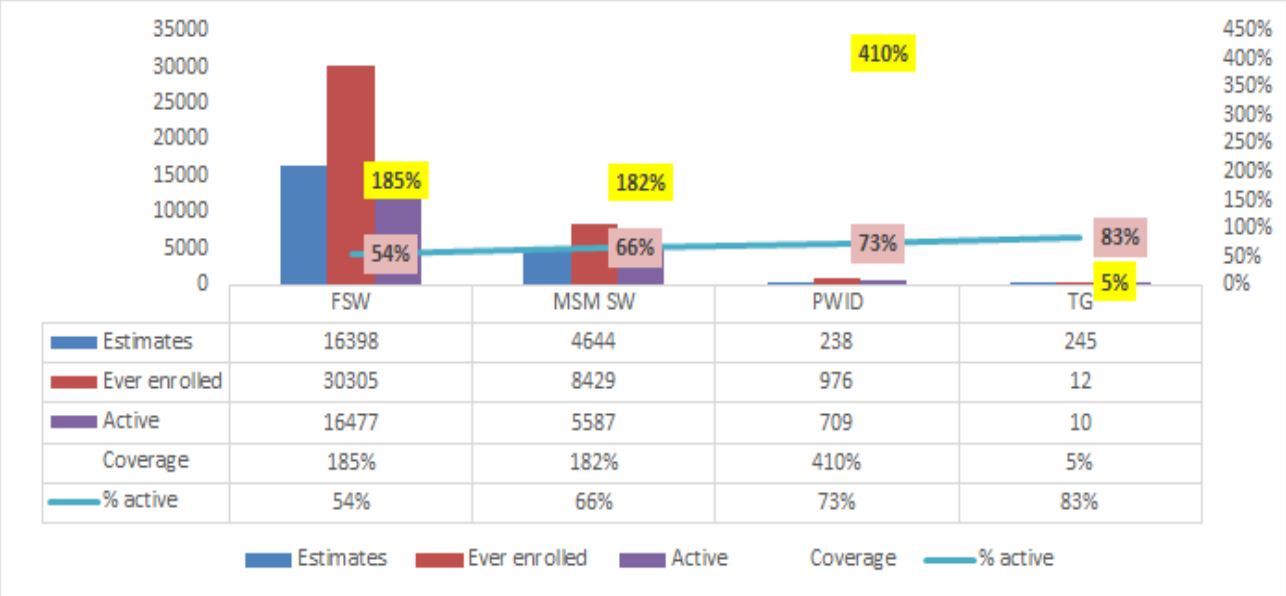
County	Number of Hotspots				Estimated Populations					Total KP estimate
	FSW	MSM	PWID	TG	FSW	MSM	MSW	PWID	TG	
Kisumu	438	313	40	90	5,151	2,492	767	491	228	9,129
Kisii	669	52	5	23	6,538	462	138	36	62	7,236
Migori	603	75	15	51	4,709	559	226	202	183	5,879
Total					16,398	3,513	1,131	729	473	22,244

ii. Service Delivery Approaches

Drop-in centres (DICEs): During the program implementation period, services were delivered through 11 DICEs strategically located near major KP hotspots in Kisumu, Kisii, and Migori counties. Migori has 5 DICES, 1 in Kisii and 5 in Kisumu. All DICEs were equipped with condom and lubricant dispensers, STI treatment and family planning commodities, KP-targeted IEC materials, KP data tools, and other required supplies. Service provision in the centers was delivered by Clinicians, Nurses, HTS providers, Addiction Counsellors, Field Officers, Data Clerks, and Program Technical Officers.

Comprehensive outreach: Comprehensive outreach activities were carried out in hotspots located far from the DICES to bring services closer to key populations every quarter to mitigate the barriers of time and distance. Planning of outreach was spearheaded by DICE In-Charges and Field Officers, who worked closely with the peer educators. The hotspot managers (bar owners or managers) provided venues for service delivery at a fee and security officers were hired for night outreaches. The CASCOs and Sub-CASCOs supervised outreach activities and ensured the availability of test kits and quality services. The timing, location, and venues of outreach depended on an analysis of the previous outreaches, feedback from the peer educators and clients, space, security, and typology of the key populations. In the third year of the project implementation, the project classified hotspots based on risk. Thus, most of the outreaches were implemented in high-risk hotspots; those with higher yields for HIV-positive clients, STI cases, and rampant cases of sexual and gender-based violence.

Figure 6: STEPS KP coverage



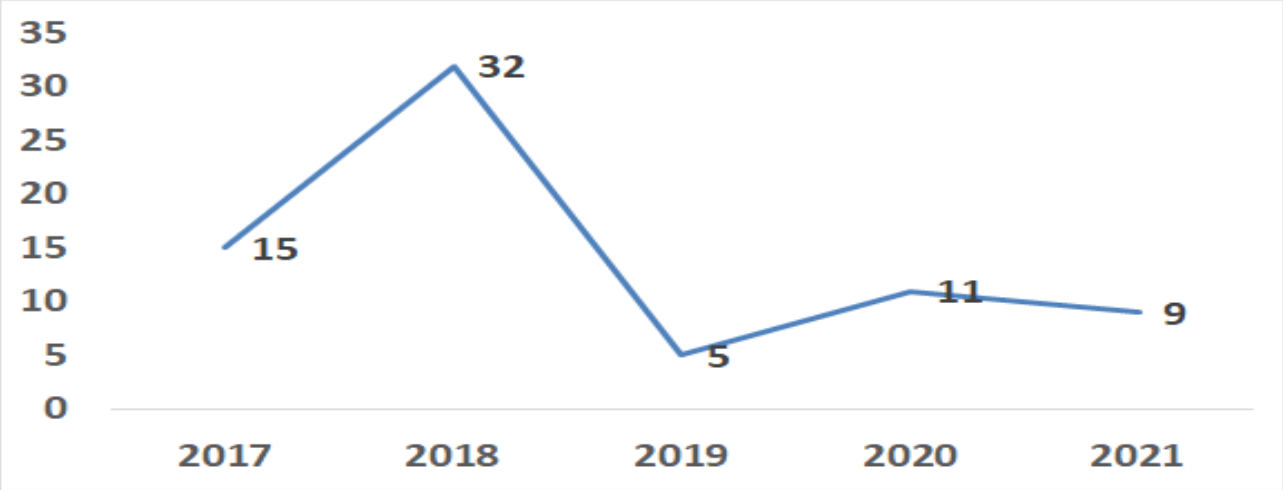
Biomedical Interventions

i. *HIV Testing Services*

HIV testing services were offered to key populations on yearly basis as part of KP prevention and every quarter as per the NASCOP guidelines and also routinely depending on risks and vulnerability.

Through this, the program recorded 72 seroconversions (54 FSW, 17 MSM, 1PWID). Most seroconversions occurred when the clients had migrated out of the project catchment area signaling reduced access to prevention services. The number of seroconversions declined as the program matured as shown in the figure below, particularly with the introduction of the 'Travel Pack'

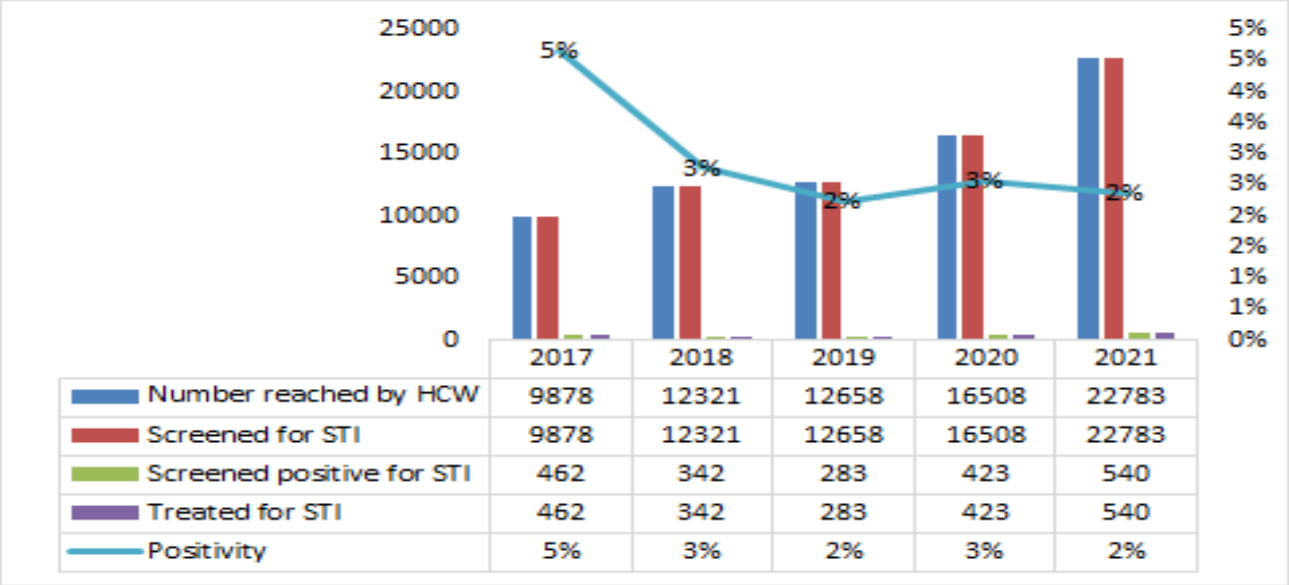
Figure 7: Reducing trend in KP seroconversions



ii. *Regular STI prevention, screening, and treatment*

STEPS aimed to reduce STI incidence and increase access to STI treatment services through the use of a syndromic management approach. At every clinic visit, clients were screened for STIs and those found to be infected were treated at the Dices. Below is a graph showing the STI rates over the five years.

Figure 8: STI positivity over periods



	2017	2018	2019	2020	2021
Number reached by HCW	9878	12321	12658	16508	22783
Screened for STI	9878	12321	12658	16508	22783
Screened positive for STI	462	342	283	423	540
Treated for STI	462	342	283	423	540
Positivity	5%	3%	2%	3%	2%

The most prevalent STIs reported during the years were vaginitis and Urethritis.

iii. *TB prevention, screening, treatment and prevention and management of other co-infections and co-morbidities.*

A total of 22,783 KP clients, both HIV positive and negative, were screened for possible TB infection using the intensified case finding (ICF) tool, and 243 suspects were identified. All of them were referred for screening using gene Xpert, 122 of whom tested positive and were initiated on treatment.

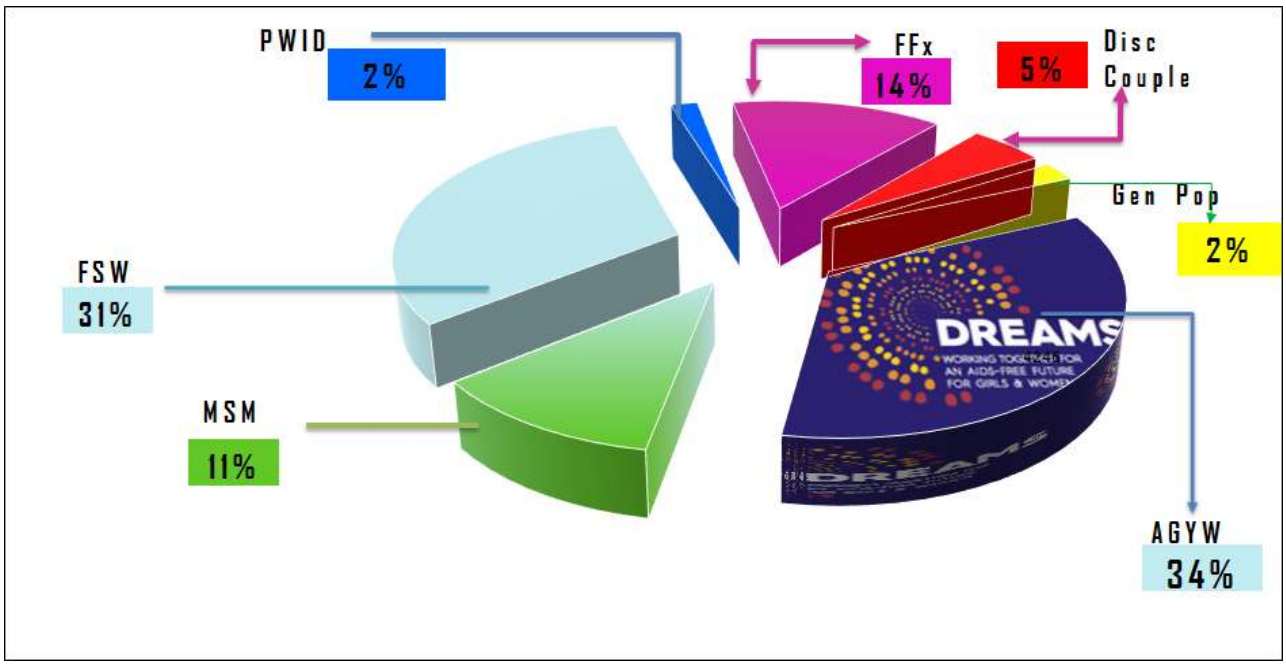
iv. *Post Exposure Prophylaxis (PEP)*

During the period, 1,528 clients eligible were provided and completed PEP. 275(18%) of whom reported sexual violence and 1253 reported condoms burst

v. *Pre-exposure prophylaxis*

PrEP was initiated to 12,348 clients (3,837-FSW, 1,409-MSM, 217-PWID, 4,246-AGYW, 1747-FisherFolk and 892-General Population). Mobilization for PrEP was done through peer educators and mentors. Service providers routinely screened clients for PrEP eligibility. Other activities included: forming PrEP support groups to support retention, identifying PrEP champions at each site, and carrying out focused group discussions that informed clients' preferences in terms of location and time of dispensing PrEP.

Figure 9: PrEP initiation by population type



vi. *Harm reduction for people who inject drugs (PWID)*

The program delivered PWID services through service providers attached to Manyatta, Awendo, Migori, and Kisii DICEs. This involved provision of clean needles and syringes and harm reduction counseling by outreach workers and peer educators. A total of 709 PWIDs continually benefited from needles and syringes.

Four hundred fifty-nine (459) clients were prepared and referred for MAT at Jaramogi Oginga Odinga Teaching and Referral Hospital. Of these, 284 were successfully inducted on MAT, and 126 clients continue to receive MAT services at the end of the project. Other harm reduction packages of services that were offered included provision of condoms, screening, and treatment of hepatitis, provision of care and treatment to HIV positive clients, linkage to livelihood activities, cervical cancer screening and treatment, safe space for relaxation, and education sessions, and overdose management.

vii. *Condoms Programming*

Increased use of condoms was achieved through intensive promotion, demonstration, and distribution to improve primary HIV prevention. Condoms were also distributed through 200 condom dispensers strategically mounted in major hotspots. Monitoring and refilling was done by designated peer educators every week. Condom and lubricant registers were used for recording

and tracking condoms and lubes uptake. All KPs continually received condoms and lubes either at the prevention sites, condom dispensers, or through the peer educators

Evidence-informed Behavioral Interventions (EBI)

Within the period, service providers were trained on Sister-to-Sister intervention, an EBI on condom efficacy among female sex workers. The program reached 823 clients with the intervention. A total of 3219 were identified as high-risk clients during risk screening and were offered RESPECT K (risk reduction counseling and HIV testing).

Alcohol and drug use assessment, counseling, and referral services. A total of 13,538 KPs were screened for alcohol and drug use through the use of a standard CAGE alcohol screening tool where 8,123 who were identified positive for alcohol and drug use were provided with counseling intervention and referred for further alcohol and drug screening and enrolment into the PWID program where necessary.

Structural interventions

Structural interventions promote an enabling environment by addressing the political, economic, and sociocultural factors that are drivers of vulnerability to HIV infection. These interventions are directed at the societal level. They include 100 % condom use program, services to mitigate sexual and gender-based violence, including police violence and arbitrary arrests, services to reduce stigma and discrimination, advocacy interventions for policy/program/service changes, promotion of social cohesion and development of leadership skills and continuous engagement with stakeholders at community, county, and national levels. The implementation of these interventions was well spelled at the program's onset and implemented by various program staff depending on the level of engagement. At the community level, site level staff engaged beneficiaries through quarterly community advisory board meetings; at the program and national levels, program technical staff spearheaded KP TWG meetings and other policy activities county and national levels.

i. Gender-based violence

Within the period, 22,783 KPs were screened for violence, with 10,235 (45%) reporting having experienced a form of violence. 9,760 (97%) physical/emotional and 475 (13%) sexual). All the identified KPs received post-violence services based on the LIVES model's minimum package. 80% per cent of these clients were referred for clinical care, legal support, and trauma counseling.

The programs also managed to build the capacity of all service providers, including peer educators, through facility CMEs, sensitizations, and training on violence identification and response in all the drop-in centers. The violence prevention and response teams (VRTs) and a GBV focal person were identified in the first year as a strategy to respond to violence. The program also ensured program

integration into the HIV setting where 132(100%) of service providers were trained on identifying violence and providing first-line post-violence support known as LIVES (Listen, inquire, empathize, support), a first kind response to survivors of violence. Continuous sensitization of service providers on SGBV through CMEs and online and physical mentorship greatly improved their knowledge and skills to provide post-violence (care). All this was done in line with the standard operating procedures and guidelines.

GBV reported cases increased among Key Populations during the COVID-19 pandemic. The government instituted containment measures to curb the spread of COVID-19, leading to the closure of hotspots; sexual abuse increased, arrests occurred at night during curfew hours. To mitigate this, all peer educators' paralegals were trained to identify violence cases and provide referral and linkage to the DICE for screening and clinical care.

Program implementers were also sensitized to a screening of violence at every client visit. Those who screened positive for violence were provided with first-line support (LIVES). The program also participated in quarterly virtual meetings with key KP implementing partners who provide legal support, health, security to KPs. This has fostered good working relationships and improved key populations' referral networks and service access.

As part of improving legal justice for survivors, police officers from the counties were trained on prevention and response to GBV. This was done in collaboration with LVCT health and police headquarters.

LVCT is also a key stakeholder in the Gender technical working group. In 2018, the gender department initiated a plan to develop the Migori county SGBV policy. The project team supported Migori County to develop that policy which is meant to coordinate stakeholders' efforts in prevention and response to gender-based violence.

Low identification of sexual violence due to normalization of violence, especially among the sex workers, remains a gap. To this end, the program intensified the peer educators' sensitization on the importance of reporting.

ii. Community Advisory Board Meetings

Quarterly Community Advisory Board (CAB) meetings were held in all sites that helped in advocating for the rights of KP to demand and access to quality services at the DICEs. The board members consisted of various stakeholders, including police, bar owners, county administration, peer educators' representatives, and members of KP-led CBOs, Key populations, and religious leaders. The boards were instrumental in advocating for the rights of the KPs, promotion of active involvement of key populations in program activities, uptake of PrEP and GBV services, and dissemination of COVID 19 prevention measures and messages. Each of the 11 prevention sites has

a functional CAB. The CABs also play the role of advising LVCT on areas of programming that require improvement. The establishment of CABs was in line with the National Guidelines for HIV programming with key populations in 2014.

iii. Peer education and outreach services

The program worked with 250 KP volunteer peer educators and 40 outreach workers. The peer educators played a central role in mobilizing peers to access comprehensive HIV and health services in DICEs and outreach. The peer educators also offered health education, distribution of condoms, lubricants, needles, and syringes, and distribution of IEC materials and sensitization on prevention of Covid-19. The program peer educator to peer ratio was 1:76 for FSW, 1:40 for MSM, 1:32 for PWID, within the recommended NASCOP peer ratio. All peer educators received support supervision from the program outreach workers and field staff. Peer educator's sensitization and training of peer educators on various topics continued over the years formally and informally during performance review meetings and CME during peer educators' monthly review meetings. Peer educators were also trained on Community quality improvement and to improve the services offered at the hotspots and community level. They were also facilitated to participate in National Peer Conventions, County KP TWG, World AIDS day celebration, and in the formation of IGA groups and CBOs.

iv. Capacity building of staff on key population programming

Program staff has benefited from various training organized by the Program Technical Team, LVCT Head Office, CDC, and NASCOP. These trainings include Key population sensitivity training, Key population technical programming, PrEP, SGBV, SNS, index testing, reduction of stigma and discrimination, client-centered approach, size estimation, and mapping, quality improvement, facilitative supervision, and meaningfully engagement of beneficiaries. Staff were also trained on conversion therapy using material from CDC. This training sought to explain what conversion therapy is and how to prevent it.

v. Meaningful involvement of KP in program planning, implementation, and evaluation.

The program developed robust strategies to promote the meaningful involvement of beneficiaries in program planning, monitoring, and implementation. Key population representatives were supported to participate in County KP TWG meetings. Moreover, Peer educators were supported and participated in World AIDS activities. The project also implemented various strategies to effectively reach out to beneficiaries for their input on the quality of services received from DICEs and outreach. These include quarterly client exit interviews, focused group discussions, participation in CAB meetings, and suggestion boxes mounted in all DICEs. Feedback from all these initiatives was incorporated in various program activities during the program life span.

Moreover, the program carried out an organizational capacity assessment and development for 19 KP-led CSO based in Migori, Kisii, and Kisumu Counties, courtesy of the Key Population Investment fund. Five KP-led organizations were engaged in distributing COVID 19 prevention materials, condoms and food vouchers. The program worked with Nyanza Reproductive Health Society as a sub-grantee and MAT clinic.

vi. Strategic Engagement of Stakeholders

Sensitization of County Health Management Team members: During the five years, the project supported and participated in County Health Management Team meetings in all three counties. The CHMT members were sensitized on KP programming, program achievements, LVCT Health programs in the western region, and quarterly performance review meetings. The project also supported CHMT members with fares and airtime to carry out MOH support supervision to program sites and coordinate county meetings.

Sensitization of Hotspot Managers on the program activities: The program held various sensitization meetings with owners and managers of major hotspots to enhance the collaboration between the hotspot managers and the project. The Hotspots managers played a key role in availing space for outreach, storage of condoms, and mobilizing their staff to access services during outreaches.

Key Populations Technical Working Group Meetings: During the years the STEPS project participated in all quarterly National and County Key Populations TWG and National Harm Reduction technical meetings. The meetings discussed partners' reports, TWG Sub-committees' presentations, DHIS reporting, development of various guidelines, key population size estimation. Other priorities for the meetings were reduction of duplication of activities through the allocation of counties to different donors and implementing partners and implementation of various KP studies, implementation of assisted index testing to Key Populations.

Service provision to Adolescent KP

As part of the rollout of the National Implementation Guidelines for HIV and STI programming Among Young Key Populations (2018) in line with *Fast Track Plan to End HIV and AIDS among Adolescent and Young People,* LVCT Health through the CDC funded STEPS identified 3,587 adolescents and young people of ages 15-19 years from its cohorts enrolled in the prevention centers in Western Kenya to provide differentiated services to them. A total of 2703 FSW, 873 MSM, and 11 PWID were enrolled for comprehensive services in the11 dices in the three counties.

vii. Response to COVID 19 Pandemic

To contain the spread of COVID-19, and continue offering essential HIV services to key populations, the program developed SOPs on how to provide services during outreaches, equipped sites with COVID 19 prevention equipment and supplies, educated service providers and clients on prevention measures, among others. Furthermore, the program assessed vulnerable key populations caused by the closure of hotspots due to COVID 19, distributing food vouchers to 1000 vulnerable KP. It worked directly with KP-led CSOs to mitigate COVID 19 in Kisumu and Migori counties. The services to KP remained throughout the COVID-19 containment process due to the measures put in place.

a) Impact of COVID-19 on HTS

The project continued to offer services to target populations while observing the containment measures as laid down by the Ministry of Health (MoH) from time to time. Areas affected included:

- No targeted outreaches and hotspot testing
- No community-level follow up of index testing contacts (contacts requested to turn up at the facility)
- Reduced number of staff at the facility level
- Low target achievement due to reduced number of staff at the facility at any given time

b) Impact of COVID 19 on Care and Treatment

The COVID-19 pandemic disrupted healthcare services worldwide and had implications for the progression of care and treatment services within the counties. This was made worse with the shortage of commodities, especially drugs that disrupted MMD across the three counties. In addition, there was a challenge in programming for static and CAGs, resulting in erratic trends in TX ML. The program also recorded low presumptive case identification and low TB case identification due to a halt in community TB contact tracing, clients with cough not accessing services due to fear of quarantine, and EACs for viremia clients. As such, the program employed alternative strategies to mitigate these challenges. Some of these measures were a bi-directional approach in screening all clients seen both at the facility and in the community with prompt referrals for further screening. In addition, strengthening CAGs for clients who opted out of facility services, Robust defaulter management strategies like online trackers, and calls to scale up RTT/RTC. The program also supported viremia clients through virtual EACs to ensure satisfactory sessions.

HIV Programming for Fisher Folk in Migori County

LVCT Health STEPS offered a comprehensive health package to fisherfolk in Kachieng, Kanyasa, Got Kachola, North Kadem, and Muhuru Wards in Nyatike Sub-County in Migori County. The project reached 36,475 FFx with a standard package of biomedical, behavioral, and structural interventions

during the period. The project offered HIV prevention services to 6012 FF in Nyando in Kisumu County before transitioning the program to USAID-funded partners in 2018.

FFx program Coverage and size estimates

In 2018, the FF program carried out an FF size estimation exercise along the beaches and landing sites in Migori County. The results revealed 28 beaches and 12 landing sites in Migori County. The overall number of fisher folks was confirmed to be 35,295 and 18, 271 during high peak and low peak respectively.

viii. *Fisher Folk Package of Services*

The program designed and implemented a comprehensive health package for FF comprising the following interventions.

Biomedical Interventions	HTS/ART Services, Condom, STI Screening, STI Treatment, TB Screening, FP Services, VMMC referrals, PrEP, PEP
Behavioral Interventions	Peer Education, Health Education, PHDP, RESPECT K
Structural Interventions	GBV Services, Stigma and Discrimination reduction services**,** Financial Literacy**,** and engagement of stakeholders

ix. *Fisher Folk Peer Education Program*

During the years, STEPS worked with 310 trained peer educators and 30 outreach workers in the five wards, giving us a peer educator to peer ratio of 1:100. The peer educators provided health education and HIV prevention sessions to peers individually and in small groups. They also offered condoms, distributed IEC materials, recruited new peers, mobilized, and referred peers to access biomedical services during outreach and regularly on the beaches/landing sites and in DICEs. Field level data were collected monthly using Peer calendars, condom registers, and outreach workers' monthly summary sheets. In addition, monthly peer educators' meetings were held with program staff to plan and review performance, capacity building sessions, supply of condoms, and submission of reports.

x. *Structural Interventions among Fisher Folk*

a. Reduction of Stigma and Discrimination

The Program sensitized peer educators and service providers on policy to reduce stigma and discrimination related to HIV. The peer educators were able to reach their peers with vital messages to reduce stigma and discrimination.

b. Gender-based violence

STEPS carried out several activities to reduce and mitigate gender-based violence among FF. These activities included community dialogue and advocacy meetings on GBV, beach advisory board meetings to discuss challenges faced by fisher folks and mitigation measures to mitigate them, facility-based CMEs and training were conducted to staff on GBV, sensitization on post violence care during peer educators' monthly review meetings and SGBV. As a result, 9,472 GBV cases were identified, 4 % (419) of the sexual violence. In addition, all the clients received post-violence care services.

c. Financial Literacy

Several FF were offered financial education by Barclays Bank and Kenya Women Finance Trust. The Program was also able to offer more financial information through SILC Model. As a result, some of the Financial Support Groups raised to Kshs 700,000 and invested the savings as many Merry-go-rounds formed.

d. Strategic Engagement with Fisher Folk Stakeholders

A total of 400 local leaders were reached with various orientations, dialogue, and consultation meetings over the years through Beach Management Units (BMU) and other stakeholders Meetings conducted organized by the program, Ministry of Fisheries, and BMU Networks. About 200 BMU leaders in the County participated in these meetings. BMU County leadership, Fisheries Officials, the Director of Fisheries, and the Director of Health participated in the meetings. The FF program also participated in County Health Management Team meetings, Prevention TWG, visited County Police Commander and Director Education. The LVCT Key population has also participated in the ongoing process of development of National Guidelines for HIV and STI programming for Fisherfolk.

Strategic Objective 4: To prevent new HIV infection amongst adolescent girls and young women by use of high impact combination HIV prevention in DREAMS program

LVCT Health STEPS implemented the DREAMS program in 19 administrative wards in Migori and Homabay counties to reduce HIV new infection and unintended pregnancy among adolescent girls and young women (AGYW) aged 9 to 24 years. HIV prevalence remains high in the two counties because of the compounded structural factors that perpetuate poverty and make women and young people vulnerable and at increased risk of HIV. To achieve the desired results, the program used a combination of evidence-based behavioral, structural, and biomedical interventions to address the issues at different levels of the ecological model.

The Homa-Bay County (Gembe and Kaksingri wards) program was transitioned from International Medical Corps (IMC) to LVCT in October 2016, where 15780 AGYW were transitioned. In June 2017, the program expanded to Migori County, covering 5 wards (Wasimbete, Wiga, Ragana Oruba, Kakrao, Wasweta II, Kachieng). In Oct 2018, the program extended to the Kachieng ward in the Nyatike sub-county in the Migori ward and later in Oct 2019 to Got Kachola and Macalder/Kanyarwanda. In October 2020, the program again expanded to 9 more wards; Kaler, North Kadem, Kanyasa, and Muhuri in Migori county and West Kasipul, South Kasipul, East Kamagak, Kojwach, and Kabondo East Wards in Homabay county.

Enrolment process: Enumeration of girls within the coverage area was determined using the girl roster and then analyzed for vulnerability and eligibility for DREAMS enrollment. A household visit was then conducted to enroll eligible AGYW. The AGYW were also identified through community & stakeholder referrals where identified AGYW were screened for eligibility before enrolment. All enrolled AGYW were characterized based on vulnerability. For instance, survivors of abuse (physical or sexual), those pregnant, those with multiple sexual partners, those living with disability, child-headed families, food-insecure households, those undergoing intimate partner violence (IPV) to enhance reach with relevant services. Cumulative enrollment stood at 68,084 AGYW by the end of the reporting period. The cumulative number of AGYW who exited from the project stood at 12,443. A total of 7,636 AGYW graduated from the project after completing the required primary, secondary, & contextual interventions and acquiring the protective assets, thereby reducing their risk of HIV infection. A total of 55,677(82%) AGYW are active as of the end of the project, as highlighted below

Table 10: Enrollment by ward

Ward Name	Achieved
East Kamagak	1777
Gembe	906
Got Kachola	3008
Kabondo East	3117
Kachieng	3689
Kakrao	6140
Kaksingri West	1081
Kaler	1367
Kanyasa	1684
Kojwach	1970
Macalder	2835
Muhuru	2262
North Kadem	2318

Figure 2: Exits-A total of 12,443 exits

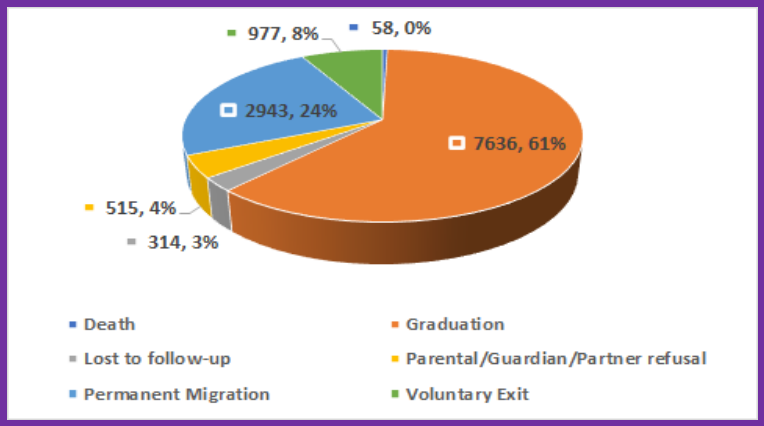


Figure 3: Inactive- a total of 305 inactive

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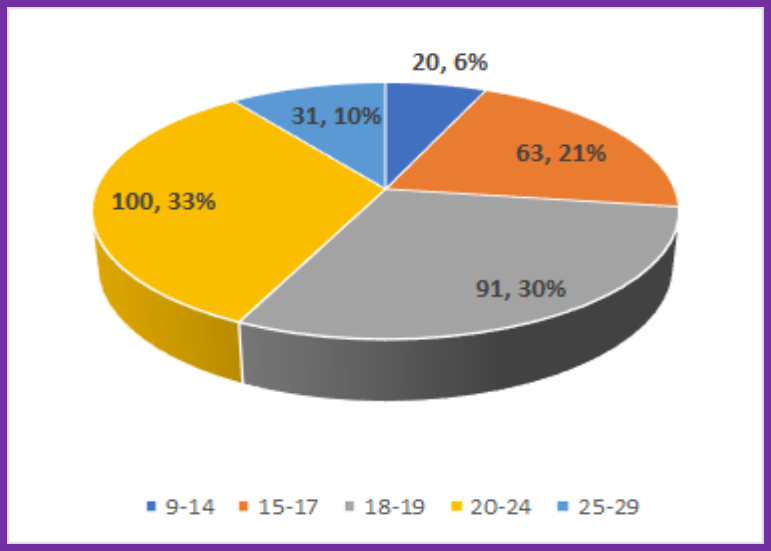


Ragana-Oruba	5756	
South Kasipul	2787	
Wasiambete	4295	
Wasweta	3433	
West Kasipul	2595	
Wiga	4657	
Total	55,677	

DREAMS Intervention Package

DREAMS employs a client-centred approach with different intervention categories (empowering girls and young women, mobilizing communities, strengthening families, and decreasing risk in male sexual partners). The AGYW is always at the center. DREAMS requires the implementation of multiple interventions that target different risk factors or behaviors that may lead to HIV acquisition. Different biomedical, behavioural, and structural interventions are recommended to provide services to target the key vulnerabilities for change. Table 1 details the four main engagement categories and the group of interventions associated with each category.

Table 9: DREAMS interventions package

Category	Intervention
1. Empower Girls and Young Women	• Social Asset Building • HTS with linkage to care for the positive • Condom promotion and provision (male and female) • Pre-exposure Prophylaxis (PrEP) • Expanded and improved contraceptive method mix • Post-violence care

2. Mobilize Communities	1. School-based HIV and violence prevention • Community mobilization and norms change
3. Strengthen Families	• Parenting/Caregiver Projects • Social protection: Education subsidies & combined socio-economic approaches
4. Decrease risk in sex partners	• Characterization of male sexual partners (MSP) • MSP Outreaches and linkage to HTS, VMMC, and ART

Figure 10: Cumulative Summary of Key Achievements

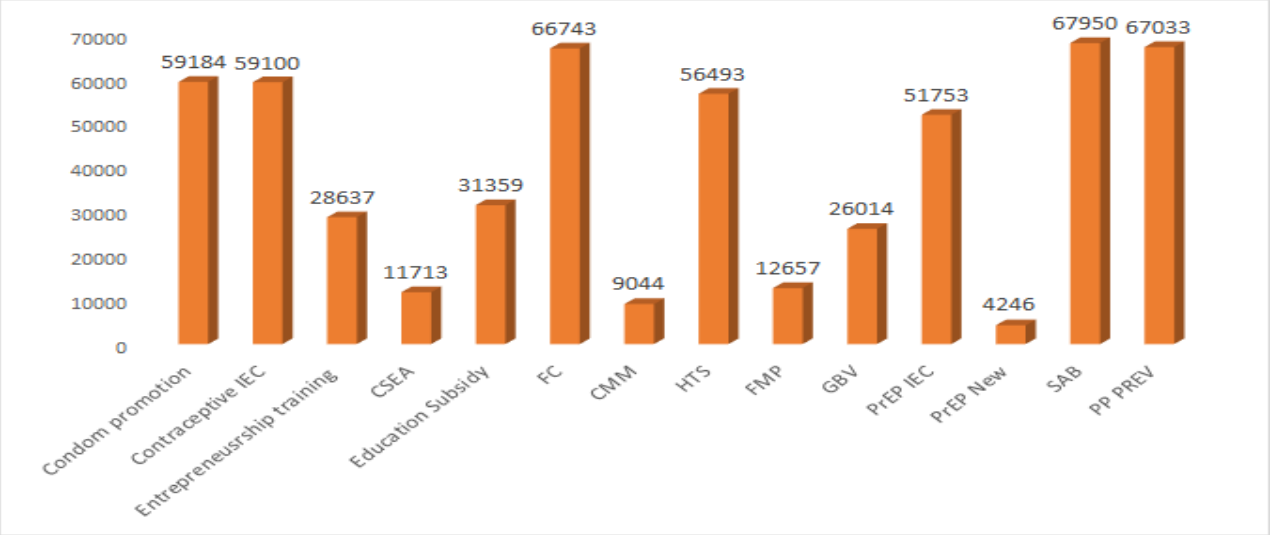
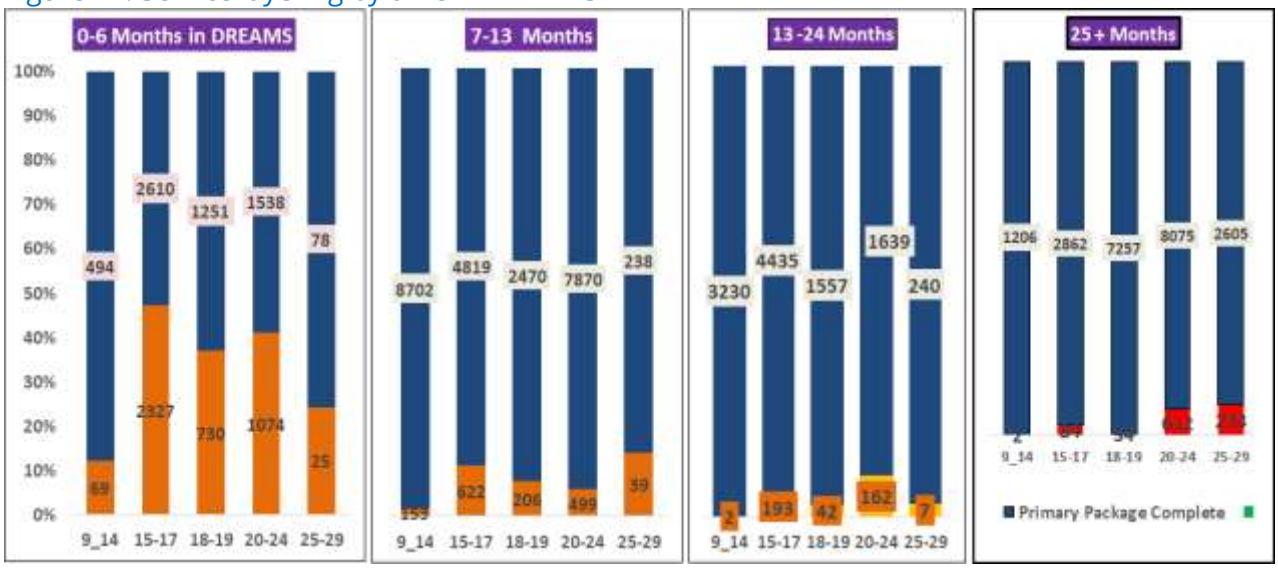


Figure 11: Service layering by time in DREAMS



53,194(88%) AGYW were fully layered by receiving a primary level package of services

Empower Girls and Young Women

Interventions in this category enable AGYW to build protective assets: health, human, financial, physical, and social assets. These include biomedical interventions (HTS, PrEP, contraceptive method mix, STI screening, treatment, and referrals), condom education and provision, violence prevention, and post-rape care. The project used the following approaches to deliver friendly health services to AGYW:

Social Asset Building (SAB) Social asset building (SAB) was utilized through a combination of weekly structured small group sessions in the safe spaces moderated by trained mentors and service providers. SAB provided a platform where AGYW received services and built their cognitive, health/human, economic and social protective assets of the DREAMS ecological model.

Enrolled AGYW mapped out community spaces considered safe (where they could express themselves freely) for their 2-hour, weekly meetings. AGYW was segmented based on their age categories (10-14, 15-19, and 20-24 years), marital status, schooling status, and geographic location. A curriculum on health and life skills, the girl-centered approach by the Population Council, was used by mentors to facilitate SAB sessions. At the same time, national guidelines and facilitation manuals guided other service delivery. A reward system of quarterly acknowledging the mentor's efforts fostered positive competition and improved performance.

During this period, the project established 1,206 Safe spaces based in schools, churches, health facilities, chief camps, and homes of trusted community members and was managed by 680 mentors. A total of 67,950 AGYW attended safe space sessions. This was attributed to improved supervision and monitoring of mentors' engagement with AGYW, effective follow-up, and weekly tracking of inactive AGYW. Mentors, service providers, and field officers also carried out the door-to-door follow-up, especially during the COVID-19 limitations on group gatherings.

Safe space activities

Condom education and demonstration at safe space session

Dignity Pack distribution at the safe space

HIV Testing Services (HTS): - During the period under review, a total of 56,493 AGYW were tested with 215 testing HIV positive and 200 (93%) enrolled on ART. Of the 215 AGYW who tested positive, 141 were new enrolments, 74 were seroconversions, and follow-up was done where most of the predisposing risk factors were: multiple sexual partners, inconsistent condom use, new sexual partner, and sex in exchange for money and material. Follow-up and supervisor counseling was done where most AGYW receive supportive disclosure, debriefing counseling, and social support all of them linked for care and treatment.

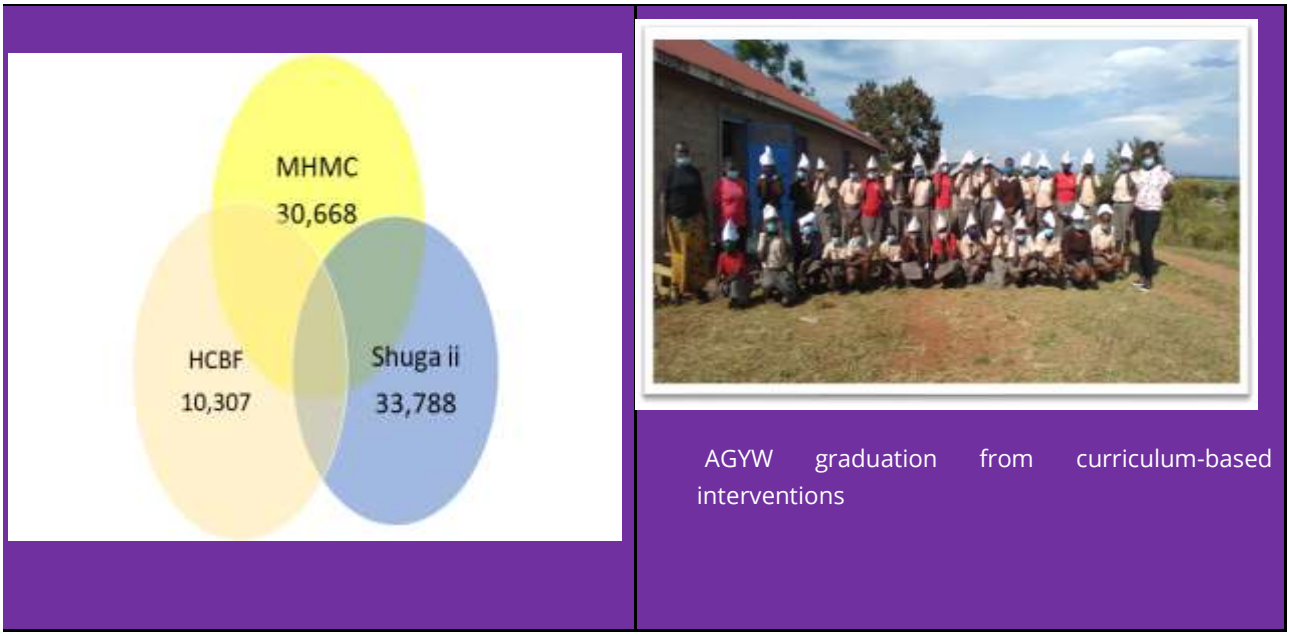
The project also reached 572 AGYW with known HIV-positive status with relevant services.

Table 11: AGYW HIV testing services by year

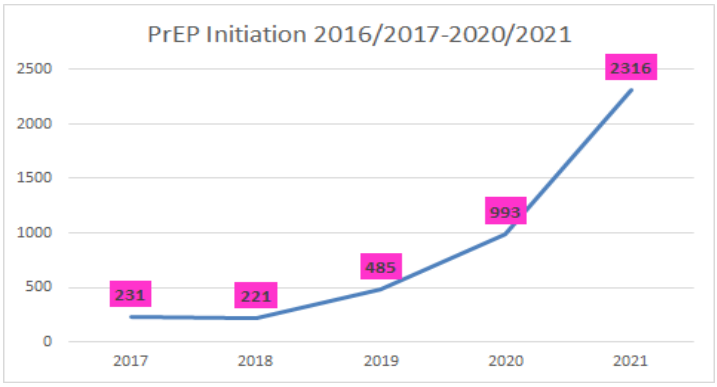
Indicator	2017	2018	2019	2020	2021
# Active AGYW	15,144	26,157	30,408	40,071	65,285
#AGYW Screened for HIV	15,101	25,956	29.995	39,861	64,121
#AGYW Eligible for HTS	13,957	14,176	14,372	24,633	32,901
#AGYW Tested	13,957	14,176	14,372	24,633	32,901
#Known positive	181	262	374	163	306
#Newly testing positive	23	63	37	42	50
#Linked to care	22	60	36	40	42

PP-PREV/ School-based HIV and violence prevention: The interventions targeted both girls and boys with curriculum-based sessions delivered in small groups. These included Health choices for a better future (HCBF) targeting girls aged 9-14, My Health My Choice (MHMC) targeting adolescents aged 13-17 years, and SHUGA II targeting those aged between 18 and 24 years. A total of 67,033 AGYW were taken through the interventions by trained facilitators. The project reached 7,894 non-AGYW with various forms of school-based HIV and violence prevention

Figure 12: School-based HIV and violence prevention



Pre-Exposure Prophylaxis (PrEP): During the project life, a total of 4,246 AGYW were initiated on PrEP with 1,213 of these retained on PrEP after 3 months. 51,753 AGYW received PrEP education/IEC. All staff and service providers were trained on PrEP to scale up delivery of PrEP education and risk assessment at every encounter with AGYW and as a result, a total of 49,351 AGYW were screened. Some of the challenges with PrEP initiation are fear of stigma and community perception of the pills as ARV as well as fear of Intimate Partner Violence. The Project has intervened through sensitizing the community with the help of community advisory boards and change agents to demystify myths and misconceptions as well benefits and importance of PrEP. The program has also identified PrEP champions who are AGYW peers to help with PrEP adherence.



PreP initiation session at the safe space

Condom education and provision: AGYW aged 15-24 years (59,184) were targeted with condom education and provision where 24,060 eligible AGYW were provided with condoms during sessions at the safe spaces and outreach activities.

Contraceptive Method Mix: Towards reducing unplanned pregnancies, a total of 59,100 AGYW aged 15-24 years were taken through contraceptive method mix information and education sessions. After screening, 39,861 AGYW were counseled and 9,044 were provided with various family planning services both at the safe spaces and through referral at the local link facilities.

STI Screening and treatment: During the reporting period, 54,082 AGYW were screened for STI with 665 screening positive, and all were referred to MoH facilities where they received treatment. Out of the 665 who tested positive, 210 were initiated on PrEP. STI prevalence was found to be much common among girls at the shores of Lake Victoria

Post Violence Care: One of the goals of the DREAMS program is to keep girls safe. The project has been doing this through routine GBV screening of AGYW and the Provision of post-violence services. A total of 50,775 AGYW were screened for GBV with 26,014 AGYW reporting having experienced a form of violence (25,100 physical/emotional, 914 sexual). All the identified AGYW received post GBV services based on the minimum package using the LIVES model.

The project carried out continuous capacity-building sessions to service providers and the community volunteers on LIVES to support in the identification, response and reporting.

Table 12: DREAMS GBV summary

Indicator	2017	2018	2019	2020	2021
#AGYW Screened for GBV	15,101	25,956	29,995	39,861	64,121
# AGYW Eligible for PVC	748	761	9,470	14,918	4,473
#AGYW referred/offered services	748	761	9,470	14,918	4,473
# Physical/emotional violence supported	712	714	9,310	14,272	4,401
# AGYW with sexual violence support	36	47	160	646	72

#Offered and completed PEP	1	6	1	2	1

Mobilize Communities

Community mobilization and norms change: This is a community mobilization strategy geared towards changing community gender norms which are implemented through the SASA (Start, Awareness, Support, and Action) approach which is designed to address the core drivers of violence against women and HIV as well as the imbalance of power between women and men, girls and boys. The project has been implementing the Start phase of SASA and is now in the process of transitioning to Phase 2. During the reporting period, 161 change agents managed to reach 41,254 community members through Local activism by employing innovative approaches to counter the COVID 19 containment measures.

Figure 14: SASA activism: Kaksingri West Change Agents having a build-up activity on 16 Days of Activism in Nyakiamo Stadium during the Suba Annual

SASA training session

SASA Activism session at the community

Strengthening Families

Interventions in this category are aimed at building families' abilities to foster positive values, improve cross-generational communication between caregivers and AGYW, improve livelihood options and enhance resilience. These include:

Education Support: *T*his target vulnerable school-going AGYW with school fees subsidy (secondary school), sanitary towels/dignity packs (primary and secondary), stationery given to candidates (primary and secondary), and school uniform (primary). The intervention aims to keep girls in school and reduce the risk and vulnerabilities associated with missing items such as dignity packs and stationery. During the reporting period, 31,359 AGYW benefited from education subsidy with 10,810 benefiting from school fees. The project procured dignity packs and textbooks which have been particularly of benefit to AGYW during the COVID-19 school's closure period where 4,638 AGYW benefited. 411 AGYW was also linked to scholarship opportunities through the county bursary.

Figure 15: Education subsidy by year

Stationery distribution session during the COVID 19

Cash transfer: A total of 1,202 and 1,982 households received cash transfers in 2017 and 2018 respectively through Mpesa, a mobile money transfer service. Cash transfer was offered to vulnerable AGYW households. Selection criteria included poor households defined by food insecurity, critically ill caregivers, child-headed households, and orphaned AGYW, the deplorable state of housing among other vulnerabilities. Cash transfer was offered to support AGYW and their families in important and regular expenditures to spur consumption smoothing. The intervention was offered in line with the Government of Kenya's (GOK) cash transfer programs standards and DREAMS Kenya cash transfer SOP.

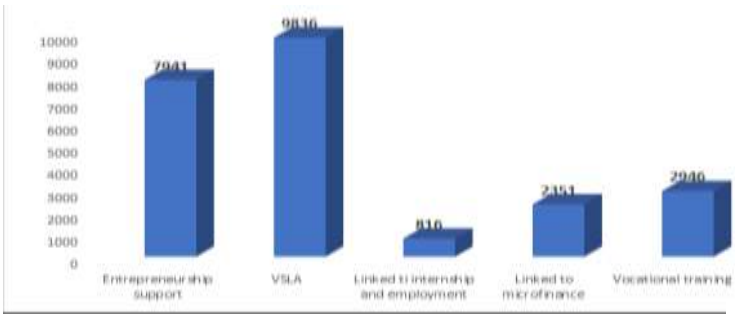
Combined Social Economic Approaches: Economic strengthening is a social protection component that comprises a portfolio of need-based interventions to reduce the economic vulnerabilities of AGYW. The interventions included financial literacy, entrepreneurship training, vocational training, business start-up funding, linkage to employment and internship opportunities, markets linkage, linkage to voluntary saving and loaning groups, and microfinance.

LVCT Health used the five components which align to OGAG FY22 focus priorities that included (i) Market assessment, (ii)Tailored training to develop financial literacy, marketable skills, an entrepreneurial mindset, and soft skills, e.g. communication skills and positive self-concept (iii) Actual bridge to employment for wage employment or starter packs/other support for small businesses for the entrepreneurial pathway, (iv) Savings groups (only if AGYW are earning an income) and (v) Facilitating access to and acceptance in social and business networks.

A total of 11,713 AGYW were reached with combined social-economic approaches during the reporting period towards improving their livelihoods through entrepreneurship support, linkage to extension services, while others were linked to microfinance, internship, and employment opportunities. The project also supported 2,946 AGYW by paying fees in TVETs for various courses, including tailoring, welding, hairdressing, and catering. A total of 66,746 AGYW completed financial

capability training, and 28,637 completed entrepreneurship training within the reporting period under review.

Figure 16: Combined Social Economic Approaches



Rearing of chicken through VSLA

Financial capability (FC): This is a primary intervention targeting all enrolled AGYW. During this project period, 66,746 AGYW completed financial capability training.

Figure 17: Financial capability completion by year

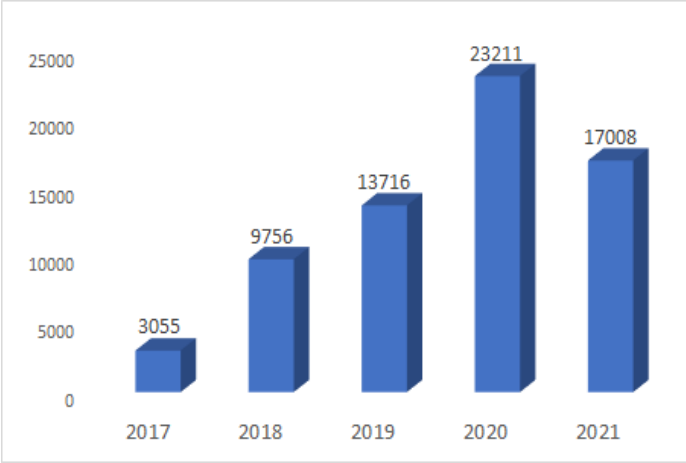
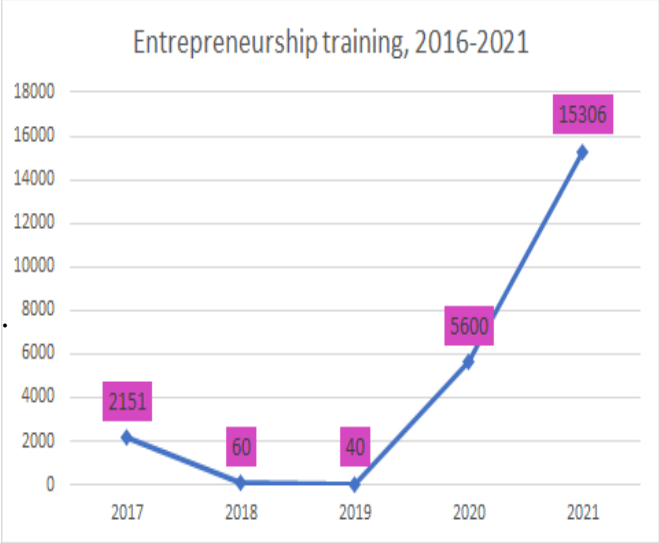


Figure 1Ongoing FC session at the safespace

Entrepreneurship training: This is a secondary intervention geared towards building AGYW business skills. During the period under review 28,637, AGYW were reached with Entrepreneurship training 2,721(10%) having started businesses.

Figure 18: Entrepreneurship Training achievement by the year



Entrepreneurship training at Kaksingri Ward

Parenting/Caregiver Projects: This is implemented through the Families Matter Program with FMP I targeting AGYW aged between 9 and 14 years while FMP II targets AGYW aged between 15 to 19 years. A total of 12,657 caregivers were reached during the reporting period resulting in improved relations between AGYW and caregivers. The caregivers demonstrated this by responding positively to their role in educating their children on Adolescent and Sexual Reproductive Health and violence prevention and response. There is an increasing need to ensure that all caregivers of adolescent girls in the DREAMS project are reached with FMP intervention

Table 13: FMP achievement

County Name	# Reached with FMP I	# Reached with FMP II
Migori County	4353	10,219
Homa Bay County	472	2,349
Total	4,825	12,568

Decrease Risk among male sexual partners

During the reporting period, a profile of AGYW's Male Sexual Partners (MSP) was developed through feedback sessions with AGYW. Money for food, school fees, sanitary towel, pocket money,

underwear, and other essential items were key drivers for AGYW to engage in transactional sex, at times without the use of protection with some AGYW reporting to engage in sex "just for leisure". The top five identified sexual partners were motorcycle (*Bodaboda)* riders, classmates, teachers, brothers-in-law, and fishermen.

Table 14: Summary of achievement during MSP outreaches.

Indicator	Achieved	MSP outreach
# MSP tested	13,511	
# Testing Positive	5	
# Linkage to care & treatment	4	
# Referred for VMMC	0	
# Screened for STI	13,511	
# STI Positive	12	
# Treated for STIs	12	

DREAMS County Engagement and partnerships

County engagement STEPS continued to engage with stakeholders in both Migori and Homabay Counties, including participating in technical working groups (TWG). LVCT health supported the development of The Migori county Multisectoral action plan to improve the wellbeing of adolescents and youth in Migori county, Migori Gender policy document, Youth Policy document, and Child protection policy (currently in the final review stage). The organization also supported various thematic events, including World AIDS Day, 16 Days of Gender Activism, Homabay County's Mama County Says Mentorship Event and Stakeholder Forums.

Community Advisory Board (CAB) The Board acts as a structure for community feedback about DREAMS implementation. They comprise key community gatekeepers and government officials, including the area chief, Area Education Officer, Children's officer, Ward Admin, Religious leaders,

caregiver representative, AGYW representative, and DREAMS staff representatives from all partners working within the area. In addition, each ward has a CAB that meets quarterly. Extraordinary CAB meetings are convened with varying membership focusing on the specific vetting during the vetting of school fees and vocational training applications.

One to One Integrated Digital Platform (OIDP) LVCT Health hosts a toll-free platform for youth for Bulk SMS services, Call-Ins, WhatsApp chats, and tele-counseling on SRH and HIV services general information as required. Bulk SMSs were sent to AGYW, Mentors, Change Agents, and even caregivers for correct messaging and information on various topics, including COVID 19, violence prevention, HIV prevention, and reminders on safe space schedules

Miss Tourism Homabay County Edition is an annual county and national event that seeks to strengthen the country's Tourism strengths through the participation of talented young ladies exhibiting a passion for marketing the counties locally and internationally. LVCT Health, in partnership with Homabay county government and other sponsors, supported the Miss Tourism Homabay event under the department of Culture and Heritage with the year's theme as "ENHANCING TOURISM, CULTURE & ENTREPRENEURSHIP". A total of 10 AGYW participated in the event, with 4 progressing into the finals.

World Aids Day (WAD) WAD is celebrated every 1st of December of every year. During the period under review, the DREAMS program participated in planning the event in Migori and Homabay counties and particularly had AGYW participating at Nyakiamo Stadium, in Suba south sub-county Kaksingri ward. During the event 10, AGYW presented skits that portrayed a message on how communities can unite for an HIV free generation through standing up for girls and vulnerable children in the society

Lessons Learnt/Best Practices

1. The involvement of community advisory boards (CAB) enabled community ownership and participation in the program designing, planning, implementation, and evaluation. CAB members also assisted in the identification of the most vulnerable AGYW to benefit from Social Protection interventions.
2. Strengthening of VSLA activities motivated young women who were previously inactive in their safe spaces and also promoted togetherness and cohesion among community members, as even non-DREAMS beneficiaries were allowed to join for sustainability.
3. Adoption of integrated service deliver improved achievement of service layering
4. AGYW Focused Group Discussions (FGDs) provided an interactive and objective feedback forum for the organization to improve on service delivery and retention in the safe spaces
5. Timely payment of school fees and distribution of dignity packs motivated safe space attendance for school-going AGYW throughout the year.

Challenges/Gaps in DREAMS

- Scarce TVET institutes across DREAMS wards especially in the rural wards to link willing AGYW
- Poor data sharing between implementing partners and County especially MOH
- Controlled attendance in safe spaces due to Covid-19 measures

Strategic Objective 5: To collaborate with national and county governments to strengthen strategic information systems, policy, and program improvement

Monitoring and Evaluation

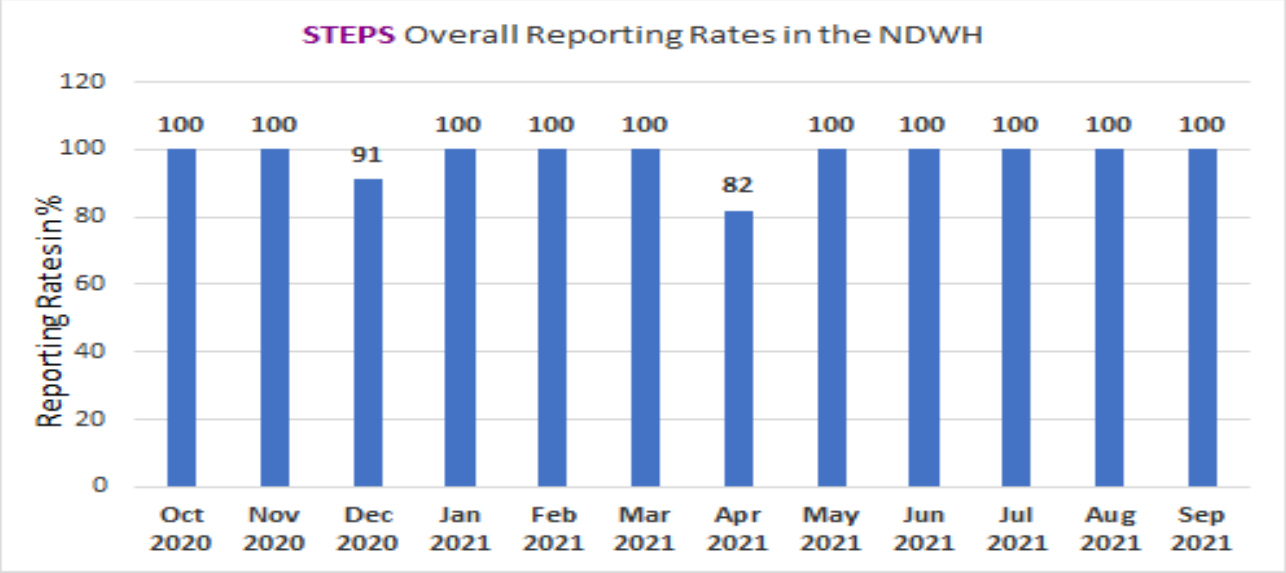
Reporting mechanism to stakeholders

LVCT Health reported every month to KHIS using MOH 731, MOH 711, MOH 731B, MOH 731Plus, MOH 365, and FCDRR reports through the sub-county HRIOs in the respective sub-counties of implementation for entry into KHIS. The 3 PM reporting system was used monthly to submit donor reports. In addition, NASCOP KP quarterly reports were submitted for all the quarters of implementation to NASCOP regional coordinators and also shared with the respective County AIDS and STI Control Officers in the counties of implementation. Low reporting rates in reporting KP data through KHIS were noted in the first quarter with the main setback being the capacity of SCHRIOs in handling KP data. The data officers took up the responsibility of building their capacity and currently all the sites have updated data in the system.

Functional Electronic Medical Records (EMRs); LVCT STEPS was among the few chosen IPs in Kisumu County to pilot the migration toolkit from IQcare to KenyaEMR on 01st Jul 2020. KenyaEMR was then deployed to other sites in September, having transitioned from the IQ Care system. All cadre of site staff were trained on different modules and offered regular support to improve system use. By working closely with Palladium, LVCT Health has endeavored to transition all its prevention sites to KenyaEMR. Technical assistance was also provided to LVCT Health HMIS focal person. Prevention data, initially captured in the LVCT 360 prevention system (an internally built prevention system) was transitioned in December 2020 to KenyaEMR as both systems are open-source. This made it easier to track individuals' services longitudinally and provide comprehensive services.

All 12 sites are currently practicing Point of Care in service delivery, with 50% of them implementing a paperless system. Facilities upload data every week to the National Data Warehouse (https://dwh.nascop.org). The security of data is guaranteed by the use of firewalls and practice expiry of passwords. Users are assigned roles based on their cadre and the scope of access to modules is defined by the user roles.

1. **Interoperability Layer (IL) -** LVCT STEPS sites are using the IL to exchange viral load results directly from the National VL lab through the M-Lab gateway.
2. **Ushauri**- LVCT STEPS sites are using Ushauri systems to send appointment reminders to clients to improve client retention and manage adherence.
3. **eAIR** Module- 2 sites (Manyatta and Anza Mapema) are actively using eAIR to transmit MoH 731 directly into DHIS2. The eAIR has eliminated the manual reports data entry errors and improved on turnaround time. LVCT continues to work closely with Palladium, CHRIO & SCHRIO to have this component fully operational in all DiCEs.
4. **AfyaStat**: -User and super user training were conducted to the HMIS and HTS point persons by Palladium. A pilot was done in Naselica Dice and rolled out to other Dices planned for October 2021
5. **National Data Warehouse-** All LVCT STEPS sites consistently upload quality data on weekly basis and by the 5th of every month using the DWAPI software



WebADT is primarily used at the pharmacy for commodity dispensing and accountability. It's currently used in all Care and treatment sites in generating commodities reports e.g FCDDR, FMAP reports.

Data Quality: To improve the data quality, sites conducted monthly data spot checks, quarterly data verification, monthly site-level data verification, chart abstraction, and quarterly SIMS. SCHRIO were included in the quarterly data verification

Performance Monitoring: Monthly performance reviews were conducted at the regional level with technical advisors and the management team to evaluate and track performance. Each DiCE and ward have a dashboard for tracking key performance indicators against site-level targets and was used to review performance every month. The program also developed online trackers by program

area for daily monitoring of achievement towards targets. Monthly progress presentations are backed up in the LVCT Data Management Centre.

Standard Operating Procedures (SOPs)

The project endeavored to have SOPs in all program areas to guide quality and timely service delivery to beneficiaries. These are arranged by program area and filed inside a box file which is located inside the data room. Soft copy versions are backed up within the LVCT document center. Data SOP elaborates on procedures for data collection, storage and filing, reporting, quality, and sharing with roles of each party well defined

Stakeholder's engagement: County and Sub-county health teams were involved in the support supervision visits on a semiannual basis. The M&E teams also participated in the Kisumu, Kisii, and Migori M&E TWG meetings

Capacity Building: Data officers were trained on how to be super users in KenyaEMR by palladium. The site team were trained on the use of KenyaEMR, and continuous mentorship did to service providers on how to operate the system

Continuous capacity building has also been done to all the LVCT Health sites on data management processes including the use of available systems. This has improved the quality of data reported from the sites and reduced the back and forth experienced in the previous reporting periods concerning data issues.

Data Archiving

Data in KenyaEMR, prevention, and care treatment, were uploaded in the national data warehouse and backed up in the LVCT Datacenter. The site in charge signed off serialized client files updated the inventory list and archived them in the approved store in lockable drawers. DREAMS service received, and enrolment datasets were downloaded from the DREAMS database after the last services provided and backed up in the LVCT data center, restricted access. Program reports were segregated by year and month and backed up within the LVCT data center

Continuous Quality Improvement (CQI)

Continuous quality improvement focuses on strengthening institutional quality management systems to improve efficiency in the delivery of quality services to clients in the LVCT HIV prevention centers and ensures better outcomes through effective use of routinely generated data in assessing processes and outcomes and guiding improvement plans and interventions.

Structured quality management system

Two Quality management committees, in the southern and Kisumu regions, were formed. These committees, given oversight by the CQI coordinator, utilized the guiding principles of Quality

Improvement (Good Infrastructure, Leadership; Teamwork; Client focus; Performance Management; Monitoring Indicators; System/process focus; Dissemination/shared learning) and methodologies as a basis for improvement of service delivery. Work improvement teams (WITs) were formed across all sites (12 Dices, 2 FFx sites, and 19 DREAMs wards). The program also endeavored to form 10 community work improvement teams to oversee the general quality of services offered at community levels

Monthly CMEs in quality improvement were also conducted in 33 sites to build the capacity of the teams in the implementation of quality improvement activities.

Apart from the Kenya HIV Quality Improvement framework, 56 coaches for community QI were also trained on KQMH quality standards for community health services. Outreach workers, Pes, and peers were also trained on community QI. There was 10 Community WIT (5 in Migori, 4 in Kisumu, 1 in Kisii) formed with 100% implementation of QI.

Performance review, Measurement, and Analysis.

A performance measurement plan was developed, and structures were put in place to help monitor performance. These included:

- Monthly QMT monitoring meetings and progress review based on the work plan
- Regional CQI progress review as presented in M4 western region
- Development and operationalization of CQI performance management tools
- Weekly performance review on the key performance indicators

Monthly data review meetings at sites were conducted to strengthen data demand information use (DDIU). The team identified and implemented 45 quality improvement projects or small test of change (STOCs) in sites using PDSA and 6S models. All the STOCs were successfully completed. Chart abstractions and client feedback interviews were done at the site level to identify gaps and a service improvement plan was developed and reviewed

Quality management for program evaluation

Internal site improvement monitoring system (SIMs) was conducted in the 33(100%) sites. The team also supported follow-up of RDQA, SIMs, Technical team visits, and external support supervision action points. Areas for improvement were identified and action plans were developed to address the gaps.

Supervision and Mentorship.

The routine internal supervision was done to all the sites to ensure that the sites are on track with targets achievements, strategies implementations as well as documentation of outcomes. The supervisory team did group as well as individual mentorship and helped the team follow up on the

areas that needed improvement. External supervisions were also done by the Subcounty/County MOH, IRDO, and NASCOP teams.

Annual Quality Management Work plan

Based on a quality assessment by the QMT (Program Strengths and Weaknesses), work plans were developed to guide the implementation of the Quality Management Plan and to help the HIV Services QMT achieve its objectives.

Client Exits/Satisfaction Analysis and Feedback

During this period, the quality management team implemented the SOPs for conducting and utilization of client feedback. Client exit interviews were done and feedback was analyzed and shared with staff and clients on the progress. This greatly improved client involvement and participation in programming.

Figure 19: Client feedback analysis

Strengthened County collaboration and engagement in quality improvement

LVCT participated in the QI TWGs at the county level and also Kenya Quality Management Awards. We managed to enroll our sites in the KQMH (Kenya Quality Model for Health) platform

LVCT Health Ward Offices a blessing for AGYW

Lucy is a 21-year-old young woman raised in Migori County. She is married and blessed with three children. Yet, like many young women in the area, she struggles to make ends meet. Her husband is a casual laborer who depends on odd jobs and counts what the day brings his way, with some days not being too successful. This has meant that they have the pain of some nights watching their children sleep with rumbling stomachs. I acknowledge the DREAMS program for supporting me to achieve all this. May God enable many women in the informal settlement to access such opportunities through DREAMS," says Lucy.

"I am an empowered woman, and I cannot wait to see how far I will go. My desire to enroll in a diploma course in social work and community development is a dream I believe will come to pass and enable me to get employed in even higher positions. My gratitude goes to the DREAMS project
When LVCT health took over the Macalder ward from the previous partner and scaled up enrolment to cover the informal settlements, Lucy was among the vulnerable young women enrolled in 2020. By then, she had resorted to selling sukuma wiki (kales) at Osiri market to supplement the family income. As a result, she would manage an average daily profit between Kshs. 150 to 200. Lucy actively participated in safe space activities. When an advertisement for an office assistant position was placed, with priority given to AGYW, she jumped at the opportunity and was among the three shortlisted for the job. She beat her competitors in the vetting process to become the first Office Assistant of the newly established ward office.

She also benefited from financial capability, entrepreneurship training, and her monthly stipend as an office assistant. As a result, she decided to expand her sukuma wiki business to a mini shop where she sells groceries and dry grains.

Recommendations

During the 5-year life of the project, we learned a lot from documented best practices, mid and end-term evaluations, and innovations. Some of the recommendations include;

- Inter-partner working relationship to client health management hence the good outcome
- Conducting MSM summit to enable in snowballing and enrolling more into the program
- Mapping and saturation of High-Risk Hotspots for GBV cases and HIV positivity
- Pairing of HTS providers with peer educators for high yields in positivity
- Strengthening innovative approaches in identifying new positives among this population could be important given that most sexual contacts contacted had HIV positive results.
- Efforts in raising awareness of PNS should highlight motivations for uptake and the positive impact of PNS while addressing the barriers for uptake.
- Providing PNS to known HIV-positive contacts who are already in care can identify new positives among PNS contacts.
- Program managers need to address staffing and logistics matters for efficient and effective delivery of PNS (work pressure and support for tracing contacts-airtime etc.).
- HTS services providers need more supportive supervision in the delivery of PNS.
- Complete a study on the costing of PNS to provide critical information for PNS scale-up
- Improve documentation of PNS in the registers – especially for clients who reject PNS, the frequency of contact follow-up. This may be done by migrating PNS documentation into an Electronic Medical Records database.
- Scale-up of SNS as an effective strategy in the identification of new positives
- Scale-up DSD to reach more clients on ART
- Support the establishment of satellite colleges to reach AGYW in zones that have no existing TVETs.
- Make full payment of vocational training fees to vulnerable AGYW undertaking TVET courses
- Prevention and response to gender-based violence (GBV) need a multi-sectorial approach involving all community, health, security, and legal justice sectors. A clear referral system is key in ensuring survivors of violence receive quality services without delay.

Conclusion

HIV Prevention among Key and Priority population is key to achieving HIV epidemic control. KPs and PP remain the main drivers of new HIV Infections in Kenya; therefore, investing in programs aimed at preventing HIV among them remains a top priority for the country.

LVCT Health STEPS used evidence–proven strategies to achieve the Project's goal and its objectives. These included combination HIV prevention strategies (biomedical, behavioral, structural) and effective HTS strategies (PNS, SNS) to identify new positives. Proven DREAMS strategies included social asset building (SAB), Economic strengthening interventions, and financial capability training. Beneficiary and community engagement was key to the success of the project, in addition to working with KP Led CSOs to meaningfully engage members.

We carried both Mid-line and End-term evaluations to assess the effectiveness of HTS testing strategies. The main outcome of the evaluations was that PNS and SNS remained key effective strategies in the identification of new positives. The evaluation also looked at the barriers and facilitators of effective PNS implementation. Lessons learned from this can be used to scale PNS and inform policymakers.

Lessons learned and best practices learned from the STEPS project have been widely shared with other implementing partners to adopt and will be used in the new Vukisha project. Therefore, we hope you will find lessons from this report beneficial for adopting or sharing across learning forums.