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AIDSFree
Strengthening High Impact Interventions for an AIDS-free Generation

AIDSFree TECHNICAL IMPLEMENTATION PLAN

CREATING A PUBLIC-PRIVATE ALLIANCE FOR RAPID EXTENSION OF PEDIATRIC HIV CARE AND TREATMENT SERVICES IN KENYA

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ACRONYMS

ART	antiretroviral therapy
BHESP	Bar Hostess Empowerment and Support Program
C&T	HIV care and treatment
CASCO	County AIDS and STI Coordinator
CBO	community-based organization
CDC	U.S. Centers for Disease Control and Prevention
CHAK	Christian Health Association of Kenya
CHW	community health worker
COC	National Clinical Officers Council
CSO	civil society organization
CSR	corporate social responsibility
EID	early infant diagnosis
FBO	faith-based organization
GOK	Government of Kenya
HIV	human immunodeficiency virus
HMIS	health management information system
HTS	HIV testing services
KAPH	Kenya Association of Private Hospitals
KASF	Kenya AIDS Strategic Framework
KEMSA	Kenya Medical Supplies Authority
KEMRI	Kenya Medical Research Institute
KPA	Kenya Pediatric Association
LTFU	loss to follow-up
M&E	monitoring and evaluation
MMAAK	Movement of Men Against AIDS in Kenya
MOH	Ministry of Health
MOU	memorandum of understanding

MTCT	mother-to-child transmission
NASCOP	National AIDS and STD Control Programme
NGO	nongovernmental organization
NNAK	National Nurses Association of Kenya
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHS	private health sector
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PPP	public-private partnerships
PY	project year
QA	quality assurance
QI	quality improvement
RGHC	Redeemed Gospel Health Centre
SHOPS	Strengthening Health Outcomes through the Private Sector
SLA	Service Level Agreement
SW	sex worker
TA	technical assistance
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WOFAK	Women Fighting AIDS in Kenya

EXECUTIVE SUMMARY

In 2014, approximately two million people worldwide were newly infected with HIV—including 220,000 children. While global efforts to scale up HIV care and treatment (C&T) for adults have strengthened access to antiretroviral therapy (ART), access among children and adolescents has lagged behind. In Kenya, for example, an estimated 614,000 children and adolescents (179,770 aged 0 to 14, and 435,224 aged 15 to 24) are living with HIV; of these only 42 percent are receiving lifesaving care and treatment. Although Kenya, like other sub-Saharan priority countries, possesses a diverse and multisectoral health system, private for-profit and not-for-profit health care providers are not yet fully and formally engaged in rapidly scaling access to pediatric C&T.

Beginning in project year (PY) 1, the Strengthening High Impact Interventions for an AIDS-Free Generation (AIDSFree) project consulted with a broad array of Kenyan health stakeholders to develop an approach for mobilizing the private health sector (PHS) to scale up the availability of pediatric C&T services in Kenya. In PY 2, AIDSFree plans to implement a targeted technical model emphasizing the creation of a "Public-Private Alliance for Pediatric HIV and AIDS" in Kenya (the AIDSFree Alliance). The model engages public, private, and community actors to (1) strengthen and formalize public-private engagement for pediatric HIV services via the multisectoral "alliance"; (2) rapidly scale up the supply of, demand for, and access to pediatric C&T services via the private health sector; (3) extend community-based interventions such as supportive case identification, linkage to care, and retention and adherence support in high-burden community settings; and (4) provide a collaborative multisectoral model for expanding public-private pediatric C&T that can be scaled or replicated in Kenya and other high-HIV prevalence settings. This document describes the AIDSFree Alliance model and provides details about the planned implementation in Nairobi and low-income surrounds during PY 2.

1. INTRODUCTION

Pediatric and adolescent HIV remains a significant challenge requiring sustainable solutions that can be adapted and sustained at the country level. There is a need for comprehensive strategies, including prevention of mother-to-child HIV transmission (PMTCT), to prevent new pediatric infections and close the significant global gap in child and adolescent access to HIV testing and care and treatment (C&T) services. As governments and implementers in high HIV burden settings have looked to accelerate and sustain pediatric and adolescent HIV programs, there has been increasing interest in mechanisms to more fully engage private and non-state actors.

At the inception of the Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project, the AIDSFree Pediatric Care and Treatment Team carried out preliminary research on strategies for increasing private sector involvement in care and treatment (C&T) for children and adolescents in Kenya. During project year (PY) 1, the team brought together and worked with a wide variety of stakeholders from government, the private health sector, facilities, and communities engaged in Kenya's HIV response. With these local partners, AIDSFree developed a multisectoral approach, the "Public-Private Alliance for Pediatric HIV and AIDS in Kenya" (the AIDSFree Alliance), aimed at increasing access to and use of pediatric C&T services in Kenya by mobilizing and increasing the capacity of private-sector facilities, providers, and civil society actors.

Research, engagement of stakeholders, and development of the model took place in PY 1. In PY 2, AIDSFree plans to begin its implementation. The project expects to begin operationalizing the model through the collaborative and complementary actions of the public, private, and community sectors. AIDSFree and partners from government, professional organizations, and the private health sector will work with approximately 30 private and non-state health facilities in and around Nairobi to scale up private supply of pediatric C&T services. Participating providers will receive support to obtain sufficient clinical knowledge, technical equipment, supplies, and reporting capacity to expand access to private-sector pediatric C&T services in alignment with national requirements and norms. Community-based organizations (CBOs) and civil society partners will develop linkages between eligible children or families and facility-based services (private AIDSFree-affiliated or otherwise).

The anticipated result will be increased demand for, access to, and use of family-focused pediatric C&T services, and a concomitant enhancement in the health and wellbeing of children and adolescents living with HIV in Nairobi. Ideally, the collaborative relationships developed during these activities will continue to develop organically beyond the duration of AIDSFree's activities, so that all partners contribute to Kenya's ownership of its national HIV response.

Findings from the Kenya public-private alliance approach could be adapted to other country contexts as a way of enhancing multisectoral national responses to HIV and reducing the number of children and adolescents living with HIV worldwide. This document describes the rationale behind expanding private sector involvement in pediatric C&T; outlines the pediatric HIV situation in Kenya; and provides details on the AIDSFree Alliance model and the Kenyan partners who will implement and ultimately sustain the model. It also lays out implementation details, including technical strategies.

Box 1. International Child and Adolescent HIV Targets

In 2014, UNAIDS set the ambitious "90-90-90" targets for HIV treatment by 2020: 90 percent of people living with HIV (PLHIV) knowing their HIV status, 90 percent of PLHIV accessing ART, and 90 percent of PLHIV virally suppressed. While global efforts to scale HIV C&T for adults have achieved significant gains in access to ART, the same is not true for children. Globally, 41 percent of adults living with HIV are accessing ART, whereas only 31 percent of children have the same access (UNAIDS 2014a). One-third of children living with HIV who do not have access to treatment die by their first birthday, and half die before age two. Starting children on ART is extremely effective in reducing morbidity and mortality. Initiating ART in exposed infants before their 12th week of life—can reduce HIV-related mortality by 75 percent (WHO 2015). For children who become infected after birth, the impact of treatment is also magnified and life-saving.

Global Background

Globally in 2014, there were approximately two million people newly infected with HIV, including 220,000 children aged zero to 14. Over 95 percent of all new pediatric infections are in sub-Saharan Africa, even though approximately 73 percent of pregnant HIV-positive women in the region are accessing ART during pregnancy as part of PMTCT (UNAIDS 2014a). Continued increases in the global incidence of pediatric HIV infections are mainly driven by delayed or absent HIV testing among infants and children; high loss to follow-up (LTFU) among HIV-positive women in the postnatal early infant diagnosis (EID)[1] and breastfeeding period of the PMTCT cascade; lack of confirmatory HIV testing among HIV-exposed breastfeeding infants; early sexual debut among adolescents; and sexual abuse of children and adolescents (Sibanda et al. 2013; Hassan et al. 2012; Turan et al. 2011).

Achieving international goals (Box 1) to extend the availability of pediatric and adolescent C&T requires addressing the current barriers to care. There are significant delays in timely diagnosis of children, which makes it critical to increase pediatric case-finding during PMTCT, childhood, and adolescence. Once HIV-positive infants and children are identified, it is equally critical to engage mothers and families to promote pediatric treatment uptake, adherence, and retention

[1] EID offers diagnosis of HIV in infants 4–6 weeks old. EID is critical to ensuring that infants with a positive diagnosis receive timely care and treatment.

in care; locate mother-baby pairs that are LTFU; provide linkages to services for orphans and vulnerable children; and expand access to ART for eligible pediatric and adolescent clients.

A further critical barrier is that children are not and cannot be fully responsible for their own medical care, and depend upon on a parent or guardian to take them to the health center, financially support their treatment, and ensure correct, regular adherence to prescribed treatments. Children who are not attending clinics regularly for other health concerns are especially difficult to reach. Adolescents who are sexually active or are caring for themselves also face barriers, since most countries prevent adolescents under a certain age from seeking out an HIV test or service without the consent of a parent or guardian. In Kenya, adolescents under the age of 15 are prohibited from seeking out an HIV test unless they are emancipated or pregnant. This is a particular challenge in sub-Saharan Africa, where child-headed households are common among families affected by HIV. Furthermore, too often in these types of households, children are vulnerable to sexual violence and/or engage in sex work to support the family.

Box 2. Why Kenya? Strengths and Challenges in the Kenya Context

AIDSFree's work in Kenya builds on strengths identified during PY 1 research. These include:

- Strong interest in the AIDSFree Alliance approach and readiness to participate among a broad range of public and private partners
- A robust and relatively well-organized private health sector individual and umbrella bodies ready to introduce pediatric C&T services
- Motivated and active community-based partners who are already engaged in multiple communities in and around Nairobi, and are ready to strengthen specific focus on pediatric and family-focused outreach
- Existing national legislation that allows for private-sector provision of HIV care, creates precedent for private-sector access to controlled HIV commodities, and permits nurse-midwife or clinical officer task-sharing and prescribing for pediatric ART.

Research has also identified potential pre-implementation barriers, many of which are also found in other settings interested in expanding pediatric HIV services:

- Numerous public and private partners with varying missions and methods of engagement (the goal of the Alliance is to reconcile these varied interests and needs)
- Known challenges at the national level with inconsistent HIV commodity supply and reported delays in diagnostic processing
- Severe HIV stigma and discrimination at the community level that prevents many families or people living with HIV (PLHIV) from seeking care.

Providers in both the public and private sectors also face difficulties in introducing and providing pediatric HIV services. Providers often feel—and often are—unprepared to provide HIV C&T for children. Pediatric treatment regimens are more complex and require more experienced dosing and monitoring of side effects; and acquiring appropriate pediatric medications and formulations can be difficult in resource-limited settings. Furthermore, private-sector providers are often excluded from training on pediatric C&T, and may not have access to supplies available in the public sector.

Sustainable scale-up of pediatric C&T requires engagement of both the private and public health sectors to leverage all possible domestic financial resources, increase the number of providers offering pediatric care, and achieve logistic efficiencies in expanding access to pediatric services. Public-private alliances and formal collaboration offer a very promising approach for enhancing the scale of pediatric treatment in high HIV burden settings where pediatric C&T services are lagging. AIDSFree proposes a public-private collaboration to scale up pediatric C&T services in Kenya by mobilizing private providers and improving the quality of privately delivered care; ensuring the availability of commodities and diagnostic inputs; and generating demand for services through targeted community engagement.

The implementation plan that follows is designed for the Kenyan context (see Box 2), but similar approaches can be pursued in other high-prevalence and high-need contexts. The public-private alliance described in this plan has the potential to significantly improve the availability of pediatric C&T and increase engagement of HIV-positive children in care. AIDSFree will use the activity in Kenya to demonstrate proof of concept for the intervention, which can then be expanded to other areas of Kenya or additional global settings where children continue to bear far too great a burden in the HIV epidemic.

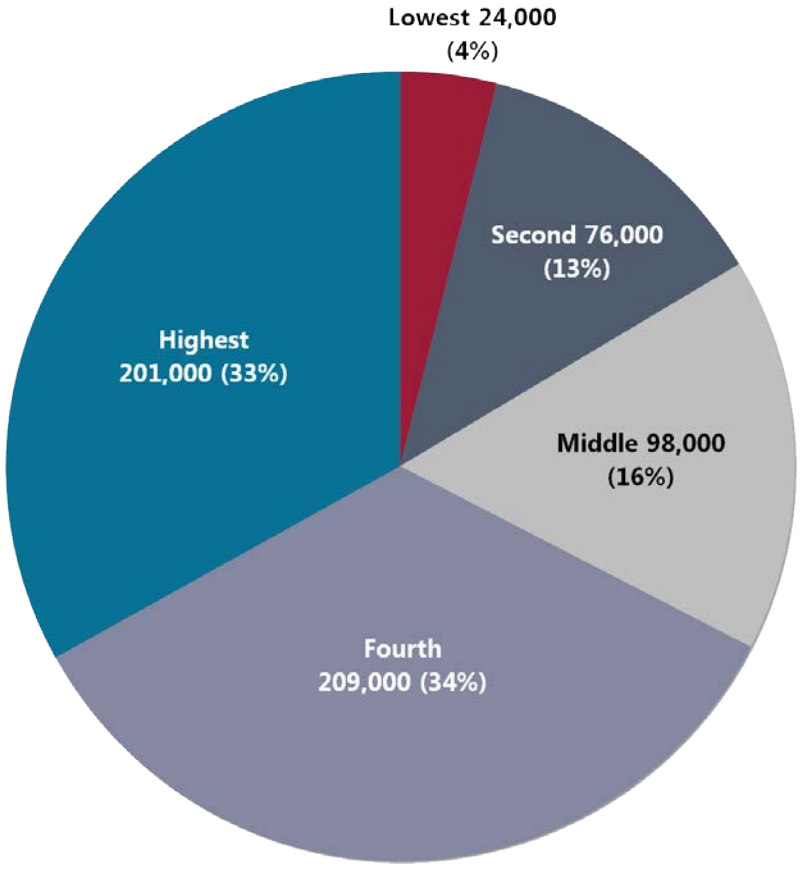
Kenya Situation Analysis

If Kenya is to meet the 90-90-90 goals, there needs to be a rapid scale-up of testing, care, and treatment services among adult, adolescent, and pediatric clients. In 2014, over 100,000 Kenyans acquired HIV, including approximately 13,000 children under age 14. Today there are approximately 614,000 children, adolescents, and young people (179,770 aged 0 to 14, and 435,224 aged 15 to 24) living with HIV in Kenya, and only 42 percent of these are receiving lifesaving C&T (Maisha National AIDS Control Council 2015a; UNAIDS 2014b). Even though there has been great progress in scaling up urban availability of child health services for immunizations (diarrheal and respiratory infections, for example) the same successes have yet to be realized for pediatric and adolescent HIV care. Nairobi has one of the largest population of children and adolescents living with HIV, second only to Homa Bay (49,904 and 11,920, respectively), and only 51 percent are currently accessing ART (Maisha National AIDS Control Council 2015a).

Children in Kenya's high-burden urban areas are underserved even though they are generally surrounded by a large number of public and private health care sites. Interestingly, in many of these urban areas there are more private-sector than public-sector sites providing HIV services. Notably in Nairobi, the WHO 2013 Service Availability and Readiness Assessment Mapping (SARAM) identifies 41 percent of private-for-profit sites (234) and 22 percent of private-not-for-profit sites (90) as ready to provide or already providing HIV services; together these private sites represent 78 percent of all sites providing HIV services in Nairobi (Ministry of Health [Kenya] 2013). Additionally, according to the 2012 Kenya AIDS Indicator Survey (2014), the

majority of HIV infections in urban areas are among those in the fourth and fifth (the highest) wealth quintiles, a large population whose members are more likely to seek health care in the private sector (Figure 1). This indicates the need to engage private providers and their facilities comprehensively to increase the availability and coverage of pediatric and adolescent HIV care in urban areas.

Figure 1. Urban PLHIV in Kenya by Wealth Quintile



Pediatric HIV transmission in Kenya most commonly occurs due to mother-to-child transmission (MTCT) during childbirth or breastfeeding, or may also occur due to sexual transmission as a result of early sexual debut or sexual violence (particularly among adolescent girls). In 2014, UNAIDS estimated that approximately 67 percent of pregnant women in Kenya accessed effective PMTCT treatment (UNAIDS 2015). However, "late cascade" MTCT rates (assessed during the postnatal phase of the PMTCT cascade or upon cessation of breastfeeding) are estimated at 164 percent higher than MTCT rates at earlier points in the cascade—a result of MTCT transmission through breastfeeding and LTFU during the postnatal phases of PMTCT. This is because while HIV-positive mothers may engage in antenatal care, at which point they receive an ART intervention for PMTCT, it is more difficult to sustain their engagement in PMTCT care and EID during the postnatal and breastfeeding periods. Accordingly, it is critical that providers have the resources and procedures in place to track mother-baby pairs and retain them in PMTCT care through the child's first years.

Adolescents and young people aged 10–24 years are high-priority target beneficiaries for pediatric treatment, as outlined in the National AIDS Control Council's *Fast-track Plan To End HIV and AIDS Among Adolescents and Young People* (2015a). The plan also specifically highlights the need to scale services for young girls and women in this age group, given that 21 percent of adult infections (ages 15 to 49) occur among young women between ages 15 and 24. There is also an extreme gap in services for this population. As of 2014, only 25,720 of the estimated 435,224 HIV-positive adolescents in this age group were receiving ART (Maisha National AIDS Control Council 2015a).

Several factors impede children's access to HIV C&T in the Kenyan context:

- *Sexual violence:* Child sexual abuse is a taboo topic in Kenya, but a significant HIV risk factor: 32 percent of girls experience sexual violence before reaching age 18. Low rates of disclosure of sexual abuse, for numerous reasons including fear of punishment and threats by the abuser, leave many providers unaware of the need to test children and adolescents for HIV. While 88 percent of Kenyan girls aged 13 to 17 years who experienced sexual abuse reported that they knew where to go for an HIV test, only 45 percent of them reported ever being tested for HIV (UNICEF 2012) These dynamics indicate the need for increased provider awareness of sexual violence among children and adolescents, and for expansion of provider-initiated testing and counseling particularly targeting girls in the affected age range.
- *Age-related restrictions:* Kenya requires individuals under age 18 (with some exemptions) to obtain parental consent for HIV testing. Ensuring that children who have acquired HIV through sexual violence or early sexual debut are able to access testing, care, treatment, and psychosocial support should be a united effort among stakeholders in both the public and private health sectors.
- *The public-private health divide:* Private-sector providers deliver a significant portion of HIV care and treatment in Kenya, including services for children, but are often omitted from nationally mandated government trainings or other capacity building opportunities for pediatric C&T that are routinely offered to public-sector providers.

2. AIDSFree PUBLIC-PRIVATE ALLIANCE FOR PEDIATRIC HIV AND AIDS IN KENYA

To help the Government of Kenya (GOK) address the coverage gaps and barriers outlined above, the AIDSFree Pediatric Treatment Team worked with a broad range of public and private stakeholders to develop a comprehensive, multisectoral service delivery model emphasizing the creation of a Public-Private Alliance for Pediatric HIV and AIDS in Kenya (the AIDSFree Alliance). This model, to be implemented in project year 2 (PY 2),[2] is intended to accelerate private-sector provision of quality pediatric C&T services in high-burden areas of Nairobi. The technical strategy was designed to align closely with GOK HIV and public health strategies (see Box 3); complement existing initiatives within in Kenya's public- and private-sector HIV response; holistically address technical gaps; and strengthen proven local initiatives. AIDSFree's activities are also intended to complement, rather than duplicate, other activities by the U.S. Agency for International Development (USAID) and other donors.

Box 3. AIDSFree Alliance and GOK Strategies

The activities conducted through the AIDSFree Alliance model are intended to contribute across multiple strategic directions outlined in the Kenya AIDS Strategic Framework (KASF) 2014/15–2018/19 (Maisha National AIDS Control Council 2015b). The interventions address several strategic directions outlined in the national strategic framework, including:

- *Strategic direction 2:* Increasing the coverage of care and treatment with a particular focus on reducing the loss in the cascade of care
- *Strategic direction 4*: Strengthening community service delivery systems at national and county levels for the provision of HIV prevention, treatment and care services
- *Strategic direction 8:* Strengthening multisectoral and multi-partner accountability to deliver KASF results.

The AIDSFree activity also aligns with and complements other Kenyan initiatives, including:

- NASCOP goals to accelerate HIV treatment (Mukui 2015)
- New targets outlined in the recently announced *Kenya's Fast-track Plan To End HIV and AIDS Among Adolescents and Young People* (2015–2017) (Maisha National AIDS Control Council 2015a)
- The 2012–2015 national strategic framework for eMTCT (NASCOP 2012)
- The National Community Health Strategy (GOK and UNICEF 2010)
- The *Beyond Zero Campaign* to reduce child and maternal mortality, recently launched by the First Lady of Kenya.

[2] AIDSFree PY 2 will operate October 1, 2015 through September 30, 2016.

AIDSFree PY 2 Technical Objectives

The AIDSFree PY 2 technical model focuses on four broad objectives:

Objective 1. Strengthen public-private collaboration, focusing specifically on the rapid extension of pediatric HIV C&T services and uptake

The AIDSFree Alliance model employs public-private partnership (PPP) and multisectoral engagement to combine, leverage, and complement the existing capacity of private sector and community-based health actors in Kenya. The "Alliance" platform is intended to serve as an open and sustainable forum for collaboration in which public and private partners can collectively discuss and take action on issues affecting the scale-up of pediatric C&T during PY 2. Topics to be pursued under the Alliance partnership platform include private provider training and certification; private-sector access to commodities and diagnostics; reporting and supervision; clinical mentorship; and formal integration of private-sector providers into the GOK pediatric HIV response.

Objective 2. Rapidly scale up pediatric C&T services via targeted private health sector providers

AIDSFree will implement a targeted supply-side intervention to strengthen private providers' ability to deliver pediatric HIV C&T services in collaboration with NASCOP and the Kenya Ministry of Health (MOH). Using available epidemiological data and targeting SAID and NASCOP priority counties to guide clinic selection, AIDSFree will work through existing umbrella bodies and associations, such as the KPA, Kenya Association of Private Hospitals (KAPH), National Clinical Officers Council (COC), National Nurses Association of Kenya (NNAK), and others (see Section 3 and Annex C), to identify geographically and clinically appropriate facilities for introduction of pediatric C&T services. Working through partnerships with these entities (to facilitate development of sustainable capacity and local ownership of initiatives to expand private-sector contributions to pediatric HIV care), the team (via the KPA) will deliver ongoing clinical mentorship as part of focused quality assurance (QA) and quality improvement (QI) activities. Participating private facilities will also be required to consistently and accurately report into the national health management information system (HMIS) in order to access publicly provided clinical trainings, commodities, and mentorship. By investing in the expansion of KPA's existing NASCOP-approved pediatric clinical mentorship program, AIDSFree can help ensure that private providers receive clinical mentorship visits that are supportive and nurturing rather than punitive in intent. By emphasizing ongoing provider and facility-level mentorship and support, the AIDSFree technical model seeks to sustainably strengthen the quality and reliability of privately-provided pediatric C&T services.

Private-sector engagement also offers task-sharing opportunities to more fully involve non-pediatrician health providers, such as clinical officers, nurses, and midwives, in delivering

pediatric C&T services. The AIDSFree team has already engaged the COC and NNAK to systematically task-share additional pediatric C&T responsibility with non-pediatrician prescribers as part of the AIDSFree clinical provider and site selection process. The AIDSFree team is also continuing collaborative discussions with partners funded by Emory University and the U.S. Centers for Disease Control and Prevention (CDC) to ensure that the AIDSFree strategy for private-sector pediatric services aligns with and contributes to the implementation of the national task-sharing policy currently under development.

Objective 3. Link the private health sector with community partners to increase demand for C&T in HIV and ART services among HIV-positive pediatric and adolescent clients

In addition to scaling up the private-sector supply of pediatric C&T services in high-priority areas, the AIDSFree team will implement a broad community- and facility-based intervention designed to locate HIV-exposed and HIV-positive children and adolescents; successfully connect them to an appropriate point of care (private or otherwise); and provide ongoing community-based support to ensure adherence and retention in therapy. Providing community-based adherence support and case-management via community health workers (CHWs) has been proven effective in retaining children in ART services (Grimwood et al. 2012; Kim et al. 2012), and has been shown to be more effective than volunteer-centered community-based strategies (Estopinal et al. 2012). Although a recent review found that both volunteer and remunerated CHWs are potentially effective, it argued that "well-trained, supervised volunteers and full-time CHWs who receive regular payment, or a combination of both [types of workers], are more likely to engage the community in grass-roots health-related empowerment" (Singh et al. 2015).

AIDSFree will work with civil society organizations (CSOs) and community health workers (CHWs), emphasizing activities that develop strong referral and retention links among community-based AIDSFree Alliance partners, government, and private sources of pediatric C&T supported by AIDSFree. In doing so, the AIDSFree team will significantly increase the number of HIV-positive children and adolescents accessing care and treatment via an AIDSFree-affiliated community actor or a facility-based private provider.

Objective 4: Mobilize and strengthen the capacity of community-based and civil society actors

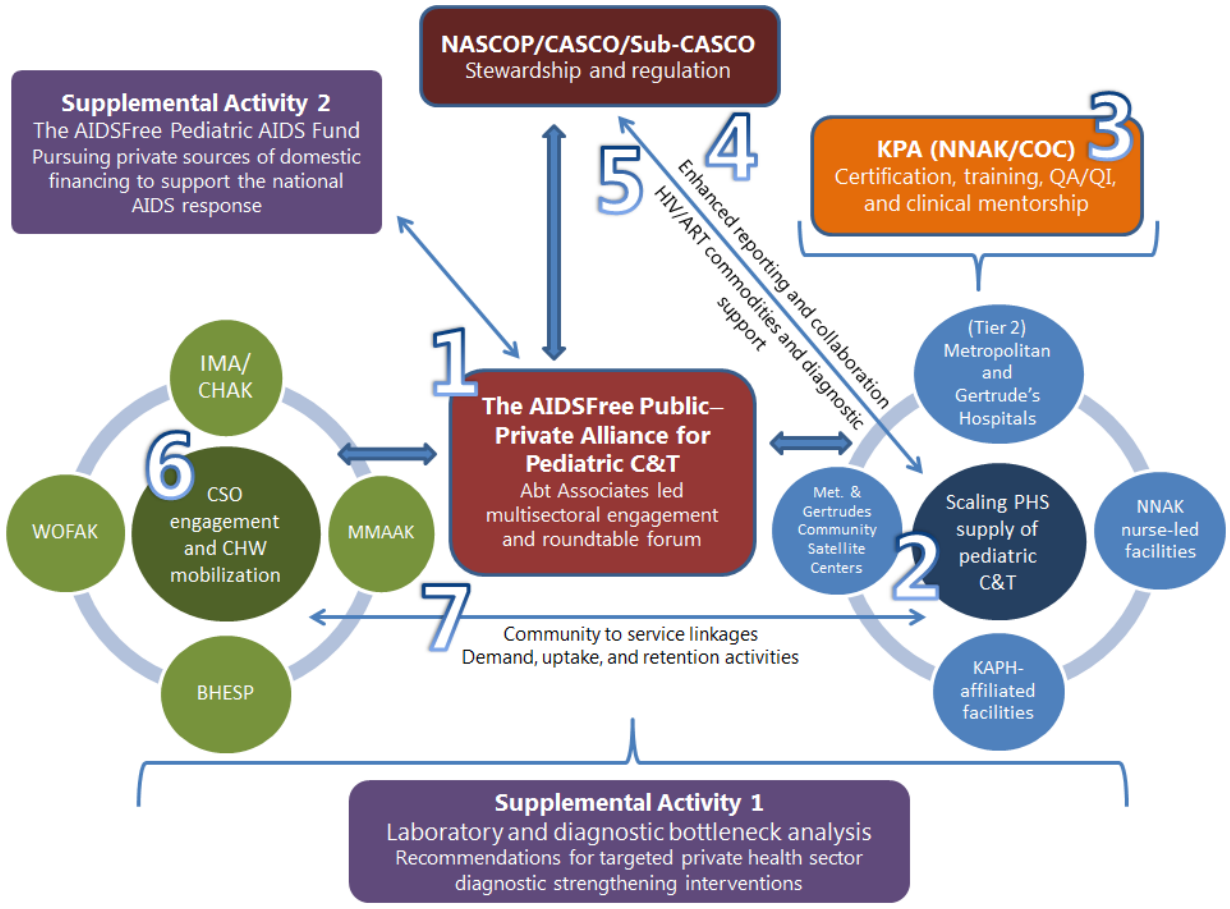
To ensure a holistic approach, the AIDSFree team will work with selected groups of community-based civil society partners to reach pediatric clients and families via outreach methods tailored to their unique needs and barriers. Building the capacity of these partner CSOs and CBOs (and their affiliated CHWs) will support the sustainability of this approach beyond the life of AIDSFree investment, leaving Kenyan partners better prepared to continue providing community-based C&T and family engagement over the long term.

Technical Model and Key Elements

The technical model for AIDSFree PY 2 activities takes a holistic and family-focused approach to scaling up access to, uptake of, and retention in pediatric C&T service. The model is comprised of seven "core" elements (outlined below and depicted in Figure 2) that are meant to address individual technical objectives but also work in harmony. As outlined above, the AIDSFree technical model is designed to align closely with NASCOP's strategic direction, and to contribute across multiple MOH priority areas at national, facility, and community levels, including strategies outlined in national-level HIV programs.

1. Creation of the AIDSFree Public-Private Alliance for Pediatric Care and Treatment, formalized via a memorandum of understanding (MOU) between AIDSFree and NASCOP, and serving as a public-private platform for advancement of pediatric C&T through targeted technical interventions with PY 2 local partners.
2. Scaling up the private health sector's supply of nationally-approved pediatric C&T services, formalized via private facility certifications, provider training, national accreditation, and NASCOP approval to implement pediatric HIV C&T services through identified private points of care.
3. Ongoing clinical mentorship for private-sector pediatric treatment providers through the KPA mentorship program, carried out in collaboration with the NNAK, COC, and KAPH to ensure provider support.
4. Enhanced and consistent reporting by the private health sector to national HIV surveillance via existing HMIS systems, and strengthened formal collaboration between private health sector HIV service providers and national government (NASCOP/CASCO/sub-CASCO).
5. Pursuit of approved private health sector access to nationally-controlled pediatric treatment commodities and HIV-related diagnostic services as part of sustainable public-private engagement.
6. Targeted CSO engagement and CHW mobilization activities, focused on strengthening the capacity of local organizations in high-burden and hard-to-serve communities.
7. Strengthened community-to-facility service linkages, with an emphasis on generating community demand for, access to, and retention in family-focused pediatric C&T services via either private or public service providers.

Figure 2. Elements of the AIDSFree PY 2 Technical Model



USAID has also invested in two supplemental AIDSFree activities aimed at supporting and strengthening the core treatment and community-based intervention outlined above.

Supplemental Activity 1: Laboratory and diagnostic strengthening and bottleneck analysis

The AIDSFree team will closely monitor the provision and availability of pediatric C&T-related diagnostic services delivered by participating private sector AIDSFree Alliance providers in PY 2, including tests such as EID DNA-PCR, CD4, viral load, liver function, blood count, and other HIV- and ART-related diagnostic surveillance and investigation. This activity will also include monitoring service parameters such as specimen collection and commodity availability, rejected samples, turnaround times, and communication of results to clients, among other service quality parameters. The AIDSFree team will use this information during the introduction and ongoing delivery of private pediatric C&T services to identify bottlenecks, reveal specific commodity or diagnostic processing challenges, and inform targeted improvements to strengthen private-sector HIV diagnostic capacity.

Supplemental Activity 2: The AIDSFree Pediatric AIDS Fund

Ensuring that governments and health systems can sustainably cope with the financial and logistic burden of managing a comprehensive national HIV response long term requires identification and mobilization of domestic sources of financing that can supplement and complement public health financing. Many private entities have indeed contributed to national HIV responses under the banner of corporate social responsibility (CSR). However, CSR remains a discretionary investment and relies on the goodwill of private companies and corporations. The AIDSFree team will pursue a new model for generating private sources of financing through "embedded transactional donations" in Kenya's tourism, sporting, academic, banking, and transport sectors. The activity is more fully described on page 29.

Pediatric and Adolescent Target Groups

In PY 2, AIDSFree will use epidemiological evidence and anecdotal reports from providers to reach HIV-exposed or already positive pediatric clients via a family-focused approach.[3] The intervention will specifically target the following high-priority groups:

- **Infants (0–24 months) missed or LTFU during the PMTCT cascade**

  AIDSFree proposes to link closely with existing PMTCT providers at both the facility and community levels to ensure HIV-positive children are successfully transitioned to pediatric C&T upon completion of the PMTCT cascade.

- **HIV-positive children (2–9 years) at school and home**

  AIDSFree will help locate and link HIV-positive children (and their mothers or caregivers) to care through a targeted community outreach strategy to strengthen school- and home-based health care contacts.

- **Adolescents and young people (10–19 years) at school and in "hot spots"**

  AIDSFree plans to reach young people through school and hot spot-based CHW interventions, and by targeting specific risk groups, such as early sex initiators and adolescent sex workers (SWs). Adolescent hot spots targeted in PY 2 will include church activities and school events; roadsides, bridges, and corridor areas; and (for adolescent CSWs) bars, pool halls, taxi ranks and other CSW active areas. All CSO partners currently use community informants who help direct them to current "hang-outs."

[3] The AIDSFree "family-focused" approach seeks to target, support, and involve mothers, fathers, and other family members in the care of HIV-positive children and adolescents. This is to address key barriers to pediatric C&T, such as children's reliance on parents and guardians to access health care and lack of male involvement.

PY 2 Geographic Target Area

As mentioned earlier, HIV-positive children and adolescents are numerous and underserved. Private-sector facilities offer an opportunity to expand young people's access to care, and in many high-HIV burden areas of Kenya, private facilities outnumber available public-sector sites. The 2013 SARAM report indicated that 52 percent of private-for-profit sites across Kenya are already offering or are ready to offer ART services—for example, 41 percent of private-for-profit sites and 22 percent of not-for-profit facilities, or a total of 324 facilities, in Nairobi (Ministry of Health [Kenya] 2013). Taking into account the need for pediatric and adolescent HIV C&T in Nairobi, and the availability of willing private-sector providers, AIDSFree has prioritized Nairobi county and the surrounding area as the geographic focal point for implementation of AIDSFree Alliance activities in PY 2.

AIDSFree Alliance Partners

The AIDSFree Alliance will bring together a wide range of partners from public, private, and community arenas, each offering unique strengths and playing specific roles in operationalizing private-sector provision of pediatric C&T services. Technical support from AIDSFree to these partners will strengthen the sustainability of their engagement with private-sector stakeholders, and will help to propel the continuing expansion of access to pediatric C&T services beyond the project's life.

Abt Associates Inc., an AIDSFree consortium partner, will lead the implementation of all PY 2 activities in Kenya, in close collaboration with the AIDSFree Pediatric Treatment Team lead at JSI Research & Training Institute, Inc. (JSI). The majority of PY 2 activities will be carried out through in-country Kenyan consultants engaged by Abt Associates Inc., and through approved subcontract mechanisms with local partners such as the KPA and other technical implementation partners. The AIDSFree Public-Private Partnerships lead at Abt Associates Inc. will oversee management of the full project, collaborating with a Kenya-based Abt Associates Inc. senior representative as a focal point for in-country management and consultation. As a member of the AIDSFree Alliance, IMA World Health will be separately managing a community component of this technical plan (via engagement with the Christian Health Association of Kenya [CHAK] and their faith-based affiliates) in close cooperation with Abt Associates Inc.

AIDSFree also plans to secure the services of a trusted private sector-focused, Kenya-based advisor/consultant to serve as a resource, PPP advisor, and facilitator to AIDSFree PY 2 partners in the periods between roundtable discussions. This consultant will have demonstrated experience convening public and private health actors in Kenya, will facilitate formal and informal dialogue among AIDSFree partners, and will serve as an advisor and focal point during commodity, reporting, and private-sector service delivery discussions. Such technical support is necessary to ensure a transparent, mutually beneficial, and successful public-private joint effort.

Table 1 below briefly lists the key partners and their roles; more detailed information can be found in Section 3 on implementation, and in Annex C.

Table 1. AIDSFree Alliance Partners and Roles

AIDSFree Alliance Partner	Role
Government Bodies	
National AIDS and STI Control Programme of Kenya (NASCOP)	Overall regulation and stewardship of the national AIDS response. Primary public-sector collaborator under MOU with AIDSFree to facilitate private-sector scale-up of pediatric C&T.
Nairobi County- and Sub-County AIDS and STI coordinators (CASCO and sub-CASCO Nairobi)	Participation in certification of private-sector facilities for pediatric C&T, provision of CHW curricula, facilitating access to KEMSA and KEMRI commodities and diagnostic processes.
Kenya Medical Supplies Agency (KEMSA)	Provision of publically controlled pediatric C&T commodities; pharmaceutical supply chain.
Kenya Medical Research Institute (KEMRI)	Provision of DNA-PCR, viral load and other pediatric C&T related diagnostic support.
Professional Bodies and Associations	
The Kenya Pediatrics Association (KPA)	Key partner for advancing private facility and provider readiness for pediatric C&T. With AIDSFree, lead private-sector site identification, assessment, and certification process. Carry out NASCOP-approved provider training in pediatric C&T. Implement ongoing pediatric mentorship program among AIDSFree clinical providers.
Clinical Officers Council of Kenya (COC)	Participate in private site identification process; with emphasis on opportunities for clinical officer task-sharing.
National Nursing Association of Kenya (NNAK)	Participate in private site identification process; with emphasis on opportunities for nurse-midwife task-sharing.
Private Health Sector Service Providers	
Kenya Association of Private Hospitals (KAPH)	Participate in private site identification process, represent small and medium KAPH-affiliated private health facilities participating in AIDSFree pediatric C&T activities, and strengthen ongoing KAPH facility reporting activities. Deliver pediatric C&T at approximately 15–20 KAPH-affiliated facilities as part of the PY 2 AIDSFree Alliance supply-side intervention.
Metropolitan Hospital (+ satellite clinics)	Deliver pediatric C&T at the main hospital and approximately three Metropolitan affiliated satellite facilities as part of the PY 2 AIDSFree Alliance supply-side intervention.
Gertrude's Children's Hospital (+ satellite clinics)	Deliver pediatric C&T at the main hospital and approximately five Gertrude's-affiliated satellite facilities as part of the PY 2 AIDSFree Alliance supply-side intervention.

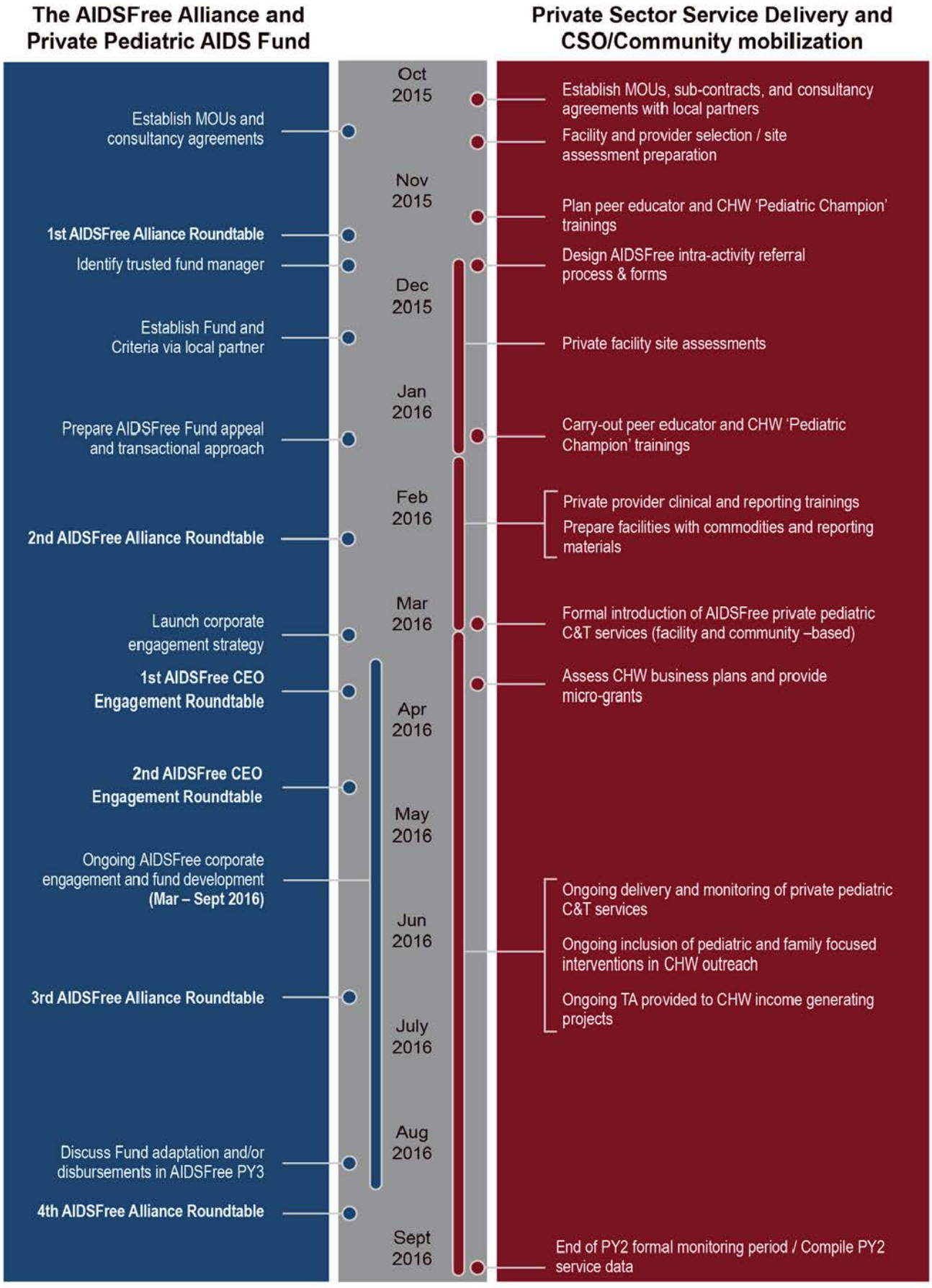
AIDSFree Alliance Partner	Role
Community Actors and Civil Society	
IMA World Health and CHAK Including: the Redeemed Gospel Health Center (RGHC) and the Redeemed Gospel Church (RGC)	Teacher and school-focused interventions emphasizing pediatric HIV case identification, family-focused community-to-facility referrals, mobilization of CHWs through the RGHC, and faith-based community mobilization through the RGC. Also includes a focus on orphaned and vulnerable children (OVC) via the SOS children's village home for children.
Women Fighting AIDS in Kenya (WOFAK)	Training and mobilization of CHW "pediatric HIV champions" to infuse pediatric and family-focused programs into WOFAK CHW activities. Business training for CHW leadership and micro-grants for CHW sustainability.
Men's Movement Against AIDS in Kenya (MMAAK)	Training and mobilization of CHW "pediatric HIV champions" to infuse pediatric and family-focused programs into MMAAK male-focused CHW activities. Business training for CHW leadership and micro-grants for CHW sustainability.
Bar Hostess Empowerment and Support (BHESP)	Training and mobilization of adolescent female sex worker "peer educators" to provide HIV- and STI-targeted outreach to Nairobi's adolescent SWs. Provision of community-to-facility referral to SW-friendly clinical sites.

3. DETAILED PY 2 TECHNICAL IMPLEMENTATION PLAN (OCTOBER 1, 2015–SEPTEMBER 30, 2016)

In PY 2, the AIDSFree team will implement a specific set of technical activities in Nairobi and its surrounds (see the timeline in Figure 3). Activities will address the "core" AIDSFree Alliance objectives described in Section 2 above, as well as those of the supplemental Private Pediatric AIDS Fund and diagnostic strengthening activities also funded for PY 2/PY 3 implementation.

During PY 2, AIDSFree and its Alliance partners will focus on five main activities: (1) convening the Alliance; (2) supporting private facility readiness to deliver pediatric C&T; (3) provider training, mentorship, and support; (4) strengthening commodity access, equipment supply, and reporting; and (5) engaging community and civil society stakeholders. During PY 2 and PY 3, the partners will also focus on creating the Private Pediatric AIDS Fund and strengthening private-sector diagnostic capacity for pediatric C&T via bottleneck analysis (described in Box 4 on page 29).

Figure 3. PY 2 Technical Implementation Timeline



1) Convening the AIDSFree Public-Private Alliance for Pediatric HIV and AIDS in Kenya

Although several private health entities currently deliver PMTCT and pediatric C&T in Kenya (both independently and in partnership with NASCOP), there remain numerous independent private providers, networks, and associations that could be more formally involved in the national HIV response. The AIDSFree Alliance approach in Kenya will work with these groups in PY 2 to:

- Harness the collective capacities of public and private health actors to expand the availability of and access to pediatric and family-focused C&T services via previously unengaged private health providers
- Provide a platform for open and transparent public-private dialogue on the private health sector's delivery of pediatric and adult HIV and ART services
- Serve as a mechanism through which AIDSFree can provide targeted financial investments to strengthen the facility- and community-based activities of AIDSFree's private and civil society partners.

Initial Alliance Activities

AIDSFree will liaise with USAID/Kenya and with NASCOP to determine specific sub-counties and communities to be geographically targeted in PY 2. An Alliance partners' meeting will be hosted in Nairobi in late October 2015 involving AIDSFree, KPA, NNAK, COC, and KAPH. Participants at this meeting will identify a short list of 50 clinics in high-priority geographic areas in and around Nairobi which will be targeted for KPA site assessment. NNAK, COC, and KAPH have already started to review their provider membership lists to identify possible clinics for inclusion. Early criteria for site identification includes: physical location in a high-HIV prevalence area; perceived sufficient human resource and infrastructure; provider interest in providing no-cost/cost-recovery pediatric C&T services; demonstrated high referral rate of HIV-positive children; and existing quality provision of child-focused health services.

Private Provider Recruitment, Motivation, and Cost Recovery

As per similar approaches utilized under the Strengthening Health Outcomes through the Private Sector (SHOPS) project, the AIDSFree strategy for private provider engagement focuses on mobilizing private-sector umbrella bodies and associations to engage and recruit individual private health providers for participation during AIDSFree PY 2. The KAPH, NNAK, COC, Metropolitan Hospital and Gertrude's Hospital administration, and AIDSFree's public-private engagement consultant will use an *AIDSFree Technical Primer for Private Providers* to introduce private practitioners to the project, outline benefits and expectations, and describe the assessment and certification process.

As per ongoing negotiations with NASCOP, the AIDSFree private model will operate under one of two possible structures: a) private providers will deliver a defined core package of pediatric C&T services "at no cost to the client" in exchange for public provision of KEMSA pharmaceutical commodities and KEMRI diagnostic support at no charge; OR b) AIDSFree will help KAPH and other participating providers to develop a Service Level Agreement (SLA) structure with government that defines what private providers can and cannot receive payment for; this could include a contracting component if public financing were made available.

Based on SHOPS experience in other settings, the AIDSFree model is prioritizing option (a) above, asking private providers to contribute overhead and other costs as part of the AIDSFree effort. AIDSFree also assumes that private providers delivering at-no-cost pediatric treatment services will benefit financially by increasing their client caseloads and providing fee-for-service non-HIV services to pediatric clients and family members. This assumption will be formally investigated during AIDSFree PY 3 or PY 4, once pediatric C&T has been introduced by private providers. However, AIDSFree staff in Kenya are currently conducting discussions with NASCOP about the preferred approach, and whether a more robust SLA structure is required for long-term sustainability.

The AIDSFree model assumes the following potential motivations for private provider participation: altruism and desire to contribute toward pediatric ART goals; achievement of CSR or business sustainability aims; and financial benefit through provision of non-HIV services to an expanded client caseload. AIDSFree expects to benefit private-sector participants by enhancing their clinical skills and competence to manage pediatric HIV clients and increased client flows, specifically through:

- KPA site assessment and formal facility certification (sponsored by AIDSFree)
- NASCOP-approved training and formal certification to deliver pediatric HIV services (sponsored by AIDSFree and provided by the KPA)
- Access to NASCOP HMIS materials and systems
- Free and subsidized access to pediatric C&T commodities via PPP with NASCOP
- Free and subsidized access to pediatric C&T diagnostic services via PPP with NASCOP
- Ongoing clinical mentorship and facility-based support (provided via KPA)
- Enhanced client base and expanded opportunities to deliver non-HIV services
- Linkage to demand creation activities carried out by AIDSFree community-based partners
- Achievement of CSR and business sustainability goals.

In return for this support, participating providers will be expected to fully engage in the KPA site assessment process, take part as required in the NASCOP pediatric C&T training, report accurate service data into the NASCOP HMIS system, provide a core package of pediatric C&T (to be defined through AIDSFree/NASCOP negotiations) free of charge to the client, and to provide "non-core" pediatric C&T services (to be defined in service agreements) according to the fee schedule agreed upon. Private providers will further contribute staff time and other defined

indirect costs to offer core pediatric C&T services, and will participate in ongoing KPA mentorship activities to achieve and maintain a high standard and quality of service.

AIDSFree Alliance Public-Private Roundtable Discussions

The AIDSFree Alliance is intended to serve as an informal forum for public-private dialogue on pediatric C&T, and a platform through which AIDSFree can provide targeted technical support to AIDSFree partners for joint public-private action. Thus, in PY 2 AIDSFree does not intend to register the Alliance as a formal entity in Kenya, and will instead operate through the project's partnerships. AIDSFree will host four roundtable discussions during PY 2 to promote effective public-private engagement and contribute to PY 2 service delivery objectives. The first meeting occurred in November 2015, with a focus on re-introducing all public and private AIDSFree partners; reviewing AIDSFree pediatric C&T strategy and activities planned for PY 2 in Kenya; updating participants on the private provider identification process; and initiating dialogue on the process and timeline for securing private-sector access to public-sector pediatric pharmaceutical commodities and diagnostic services.

The roundtable discussions will take place approximately every three months during PY 2. They will include a review of service data to guide multisectoral technical interventions, and will focus on progress in introducing facility- and community-based pediatric C&T services; strengthening community-to-facility linkages; monitoring and reporting; pharmaceutical or diagnostic bottlenecks; and opportunities and challenges. The final roundtable discussion will include a review of AIDSFree Alliance service data, discussion of gaps and successes, and discussion of next steps for PY 3 or other future investment.

2) Supporting Private Facility Readiness

Following identification of candidate facilities, the AIDSFree team will conduct facility-level assessment and certification to introduce pediatric C&T services. The project's PY 2 activities will strengthen existing NASCOP and KPA regulatory mechanisms, provide private providers with formal certification, and ensure that private facilities are integrated fully into the national HIV and AIDS response.

Private Facility Site Assessments

At the outset of PY 2, the AIDSFree team will engage with KPA mentors to physically assess 50 private facilities. Mentors will make one- or two-day site visits to each identified facility to apply a baseline checklist assessing facility suitability and provider preparedness to deliver pediatric C&T services. These site assessments will use portions of the KPA's nationally-approved "HIV Care Mentorship Tools" to determine whether pediatric C&T services can be safely introduced at the facility, assess provider preparedness to attend training and implement care, and identify existing and potential barriers to service introduction (including providers' willingness to provide

services at no cost to clients). The facility's experience with adult HIV services, their ability to easily report service data to government HMIS systems, and availability of adequate infrastructure for service introduction (i.e., locked pharmacy storage, adequate waiting space, cleanliness) will be specifically observed.

Training, Mentorship, and Support

The KPA has recommended training at least two clinicians (pediatricians, nurses, midwives, or clinical officers) at each private facility introducing pediatric HIV services. The team will select 30 facilities (representing 60 separate providers) from among the 50 partner sites assessed by KPA, prioritizing those with existing capacity to rapidly introduce pediatric C&T services during PY 2. The KPA will then certify those 30 facilities for PY 2 implementation, initiate provider preparations for training, and notify KEMSA and KEMRI of the facility's pending introduction of pediatric C&T services. Primarily, the AIDSFree Alliance approach is intended to help formalize private provider participation in national HIV trainings and service delivery. During the provider and facility selection process AIDSFree plans to target opportunities for task-sharing by nurses, midwives, and clinical officers where appropriate. Expanding task-sharing will engage additional health cadres in the delivery of pediatric C&T, expand service options at the community level, and support the national task-sharing policy movement.

3) The National HIV Integrated Training Course

The KPA's leadership has agreed to create a five- to seven-day private sector-focused training curriculum through its NASCOP-certified national HIV trainers, using modules from the *National HIV Integrated Training Course* and other NASCOP training materials (2015). With funds available in PY 2, AIDSFree plans to work with the KPA to host two trainings of 30 clinicians (the typical maximum participants allowed under NASCOP training protocols) to yield a total of 60 pediatric C&T-certified private clinicians. The course will be delivered early in the 2016 calendar year, once facility assessments are completed and providers identified. The KPA/NASCOP training will focus on the clinical skills required for introduction of pediatric C&T services; and the AIDSFree team will add a one-day monitoring and evaluation (M&E) module to reinforce the government's reporting materials and procedures.

KPA Clinical Mentorship

Once clinical providers have completed the national HIV integrated training course and been certified to introduce pediatric C&T services, they will be connected to a local mentor from the KPA mentorship program in their geographic area. The KPA mentorship program includes a baseline site visit shortly after introduction of pediatric services, to ensure that services have been rolled out safely; assess and strengthen providers' quality of care; and determine that necessary commodities and diagnostic inputs are available. Mentors will use the KPA*'s* HIV Care Mentorship Tools (Annex D) and will use the mentorship strategy developed by the Kenya

Paediatric Research Consortium (Annex E). After the baseline visit, providers will receive monthly site visits and/or phone calls from their assigned KPA mentorship team to help with complex cases and provide service QA and QI as the facility scales up its pediatric C&T service platform.

4) Connecting Private Providers to County and Sub-CASCO Reporting, Commodity Supply, and Diagnostic Processes

The AIDSFree Alliance model is intended to foster strong and sustainable private-public collaboration for pediatric C&T. In this pursuit, following the facility and provider certification process, AIDSFree will help to establish links between private pediatric C&T providers and their respective county health leadership and sub-CASCO representatives. AIDSFree will also ensure that these representatives are informed of their participation in the AIDSFree activities, and that the private providers are included in short-term commodity supply forecasts. Throughout PY 2, AIDSFree will work with NASCOP representatives and the KPA to ensure that the private-sector facilities receive timely access to essential commodities, drugs, and laboratory services offered through the public-sector response; and that these private facilities are prepared and committed to routinely and accurately report into government HMIS systems. AIDSFree will monitor these processes closely, and will provide targeted TA in partnership with KPA and NASCOP to prepare the 30 facilities for introduction of pediatric C&T in approximately March 2016.

Pharmaceutical Supply Chain

Initially, KEMSA and NASCOP (at the county level) will work with the 30 facilities to develop processes for forecasting, reporting, procuring, and distributing pediatric C&T commodities. NASCOP leadership has confirmed that details for these processes must be determined between each facility and the local KEMSA and county health representatives following facility certification. From the outset of PY 2, AIDSFree will ensure that private providers have been informed of this process and are prepared to work through their umbrella organizations for county-level commodity procurement. AIDSFree will also work with the KPA and NASCOP to facilitate timely and adequate certification with KEMSA, and procurement of KEMSA pediatric C&T commodities. Although AIDSFree does anticipate some challenges in securing private access to public commodities—particularly during periods of public-sector stockout or shortages of pediatric formulations—the benefits of connecting private health providers to the national HIV response and commodity distribution system far outweigh the risks of pursuing other options (such as wholesale procurement of privately-sourced pediatric ARVs).

Laboratory and Diagnostic Processing

Introduction of pediatric C&T will require that AIDSFree PY 2 partners have consistent and reliable access to medical laboratory and diagnostic services for EID DNA-PCR, viral load, CD4, and other HIV-related diagnostic tests. As with pharmaceutical supplies, PY 2 private-sector facilities will obtain access to public HIV-related diagnostic services provided via KEMRI. Again,

specific processes for laboratory sample collection, processing, and results dissemination will be determined at the county level among providers, their associations, KEMRI, and sub-CASCO (as appropriate). Because of bottlenecks reported at the facility level in terms of diagnostic turn-around times and results (particularly in terms of EID DNA-PCR and viral load), the AIDSFree team will closely monitor access to diagnostic services and assess options, if needed, for private-sector laboratory strengthening or outsourcing (for example, to the private Lancet Labs PTY, Nairobi). However, since pediatric C&T services are intended to be cost-exempted, any overhead or direct costs incurred by private facilities for diagnostic or other services will create challenges for cost recovery, so these alternatives will require discussion within the AIDSFree Alliance. This supplemental diagnostic monitoring and strengthening activity is outlined in greater detail in Section 4.

5) Engaging Communities and Civil Society

Increasing the supply of privately-provided pediatric C&T services will certainly increase opportunities and choice for clients. However, evidence suggests the need for significant demand creation, counseling and support, and stigma reduction at the community level to overcome structural, institutional, and behavioral barriers to care (John-Stewart 2013; Kunapareddy 2014; Schenk 2014; Maisha National AIDS Control Council, 2015a). In PY 2, AIDSFree plans to pursue a "whole community—whole family" approach involving a range of civil society engagement and community-based outreach activities. Research shows that such family-centered HIV care models can achieve strong cost and coverage outcomes (Luyirika et al. 2013; Rochat et al. 2011), strengthen medication adherence among adolescents (Lyon et al. 2012), and improve maternal retention in care through co-enrollment (Myer et al. 2014). The AIDSFree approach will support:

- Community-based case identification and enrollment
- Referral and direct linkage to the most convenient private (or public) sources of pediatric C&T
- Family-focused adherence and retention support
- Strengthening of CHW activities through sustainable microeconomic models.

The community engagement model targets key community structures to identify HIV-exposed or -positive children and adolescents (homes, schools, churches and mosques, community child centers, and other child hot spots), with CHWs and civil society organizations of PLHIV playing a central role. The model's broad objectives are to 1) increase community knowledge of pediatric C&T services; 2) increase demand for and access to pediatric C&T services (private or otherwise); 3) engage key community structures and CSOs in expanding the reach and uptake of pediatric C&T services; and 4) strengthen sustained CHW activities in high-priority areas of Nairobi.

Over the course of PY 2 AIDSFree will implement a targeted community-based strategy, using a phased approach that parallels AIDSFree service delivery activities. Early in PY 2, AIDSFree will

convene all community-based partners to develop a community-to-facility referral process, identify CHWs to be trained as "pediatric HIV champions," and consult sub-CASCO representatives on the curricula for pediatric-focused CHW trainings. In partnership with the Bar Hostess Empowerment and Support Program (BHESP), AIDSFree will also identify a cohort of adolescent sex worker "peer educators" to receive training on sensitive HIV outreach. During the second phase, occurring early in 2016, CHW trainings will be held to equip CHW pediatric HIV champions and adolescent peer educators with the knowledge and skills to accelerate community-based outreach. CHW units from Men's Movement Against AIDS in Kenya(MMAAK) and Women Fighting AIDS in Kenya (WOFAK) will be invited to submit micro-income-generating ideas for consideration, and all CBO partners will finalize preparations for formal AIDSFree Alliance service introduction in partnership with other Alliance partners. The third phase, beginning in approximately March 2016, will include the formal launch and monitoring of AIDSFree community-based outreach activities. AIDSFree will then continue to monitor community-level indicators for successes, challenges, and bottlenecks requiring technical intervention.

The project will carry out specific activities with community partners, as detailed below.

IMA World Health and CHAK

IMA and CHAK will implement the whole community—whole family approach in the target areas of Grogan A and Grogan B in Kongocho, Kenya's third largest slum, with an HIV prevalence of 15.1 percent. IMA/CHAK will engage with selected community structures in this area to implement a broad range of community outreach activities including:

Training CHW pediatric HIV champions for outreach through the Redeemed Gospel Health Centre (RGHC)

CHWs at GGHC have received formal basic training and specific HIV support training per MOH guidelines. However, current CHW training on HIV lacks depth on outreach for pediatric HIV specifically.

Working with AIDSFree and other community-based PY 2 partners, IMA and CHAK will train approximately 10–15 CHWs to become pediatric HIV champions within the RGHC CHW network. The training curriculum will be developed in partnership with sub-CASCO and CASCO representatives, and drawn from the existing MOH and NASCOP CHW and pediatric ART training materials. The CHWs will play a key role in sensitively identifying, referring, and following up families of HIV-positive children reported at the church and schools; linking children and adolescents (and their families) to nearby HIV testing services (HTS) and C&T services (such as to the SOS Children's Village Medical Center in Kongocho or to other AIDSFree partner facilities); and providing client follow-up and default tracing in the community.

The champions will be trained as trainers to develop and support the activities of pediatric peer support groups within the community, and to build pediatric- and family-focused psychosocial support, adherence, and nutrition counseling into all RGHS CHW activities. IMA/CHAK plans to provide nonmonetary incentives such as T-shirts, bags, reading glasses, and skills training to encourage CHW participation and support CHW livelihoods. Other options, such as access to savings and credit facilities and provision of airtime (through partnership with mobile telecommunications companies) will also be explored.

Developing "sermon/khutbah" guides and initiating family support groups in partnership with the Redeemed Gospel Church

Many religious leaders lack adequate knowledge, skills, and tools to provide adequate support on pediatric HIV care and treatment. In PY 2, a tool known as a sermon/khutbah guide will be developed to equip both Christian and Muslim religious leaders with key messaging on pediatric HIV and AIDS, and the family's role in securing care for children affected by the disease. The khutbah created by IMA/CHAK during PY 2 will reinforce spiritual counseling for psychosocial support, and will promote family support groups for HIV-positive children and their parents within church and mosque congregations.

Involving schoolteachers at the Korogocho Grogan School

While many schoolteachers have received basic training on health education, including HIV and AIDS, they often lack the knowledge or experience to provide adequate support to students affected by or living with HIV. In PY 2, IMA/CHAK will implement a teacher support program at the Korogocho Grogan School to increase teacher knowledge about pediatric C&T, build skills among student HIV leaders, develop parent counseling, and promote confidential and sensitive case identification and linkage to health services.

WOFAK and the MMAAK

Training CHW pediatric HIV champions for WOFAK and MMAAK outreach

Approximately 10 WOFAK CHWs and 10 existing MMAAK men's peer educators will participate in this training, and after their certification, will infuse pediatric- and family-focused outreach into the activities of their assigned WOFAK "community unit." WOFAK CHWs will mobilize their community units for broad pediatric- and family-focused outreach during AIDSFree PY 2, serving as a key source of case identification in homes, schools and community child hot spots; and providing confidential, supportive referral to private sector clinical partners or other public and private points of pediatric C&T.

Providing seed-funding micro-grants to CHW community units

WOFAK CHWs have successfully promoted access to and uptake of HIV services, but many work as unpaid volunteers or are provided a small stipend (typically funded through donor projects),

an arrangement that may not be sustainable in the long term. AIDSFree plans to use a small portion of PY 2 funding to test innovative income-generation strategies for sustaining the activities of CHWs beyond initial donor investment. These will engage the management committees of community units (groups of about 50 CHWs) at both WOFAK and MMAAK (both organizations that have successfully implemented microenterprise activities in the past). These management teams will be invited to submit a microenterprise idea requiring investment no greater than U.S.$500–1000 for start-up. The business plans will be assessed for viability and USAID compliance, and two or three proposals from each organization will be selected for PY 2 funding. The five or six successful community units receive a seed-funding micro-grant through their respective organizations. AIDSFree will monitor the success of these microenterprise activities in generating revenue for CHW activities during PY 2 implementation, and will connect the successful micro-grant recipients to additional social enterprise venues and donors who can provide long-term business TA.

Providing sustainable business training to CHW community units

As part of the sustainable PY 2 CHW approach, AIDSFree plans to train approximately 30 individuals representing leadership teams of CHW units operating under WOFAK, MMAAK, and RGHC. These individuals would be separate from the CHW pediatric HIV champions, and would target CHW unit managers and financial personnel overseeing the CHW unit's sustainable operations. The training will focus on sustainable business practice, sound financial management, and income generation opportunities. Participants who are implementing microenterprise pilots will receive priority. Businesses involving production of basketry, soap, water wells, bicycle repair, livestock production, and other small-scale businesses have been suggested for CHW implementation. The AIDSFree business training will focus on arming CHW community unit managers with financial tools to sustain the clinical, community, and small-business activities of their units.

Reaching Key Populations

During PY 2, AIDSFree and its community partners will conduct innovative outreach to expand case-finding to reach the most vulnerable and underserved groups.

Case identification and CHW C&T activities at the SOS Children's Village

SOS Social Centre staff and guardians have been trained on basic HIV caregiving, but lack in-depth knowledge of pediatric care and barriers to retaining children in care. In PY 2, to extend support for orphans and street children, CHAK will build the capacity of staff and guardians' knowledge about pediatric HIV, and strengthen their skills in counseling HIV-positive orphaned or otherwise vulnerable children.

Reaching adolescent SWs and children of HIV-positive SWs

In PY 2, AIDSFree plans to work closely with the BHESP to expand the number of adolescent SWs who can function as peer educators with other adolescent SWs in their own social settings. AIDSFree and BHESP will train approximately 30 adolescent members of BHESP to operate as sources of information, peer-to-peer outreach and counseling, and referral to HTS and other services; and to serve as community-based champions for adolescent sex workers. AIDSFree will also train existing BHESP CHWs on identifying HIV-exposed or -positive children of SWs and providing confidential linkage to sex worker-friendly clinical sites, including the PY 2 private-sector partners if appropriate.

Referral, linkage, and retention

Although increasing the supply of pediatric C&T services and extending the reach of community-based interventions will increase access to both pediatric and adolescent C&T services, AIDSFree acknowledges the need for strong and effective linkages between PY 2 facility- and community-based activities. AIDSFree will work with clinical partners to develop a consistent facility-to-facility referral form, so as to promote continuity of care and transmission of all necessary information during physician referrals and transfers for complex case management, laboratory investigation, or other services. AIDSFree and its community partners will also develop a community-to-facility referral form and process to facilitate linkages and track their successful completion.

Box 4. Supplemental PY 2/PY 3 Activity: Creating the Private Pediatric AIDS Fund

The AIDSFree team has received PY 2 funding to pursue an innovative private health financing activity in parallel to the core AIDSFree Alliance activity. This activity will lead to the creation of a Private Pediatric AIDS Fund, using a modest USAID investment in PY 2 to generate a sustainable pool of private funding. In the future, these funds could be released to AIDSFree partners or other public and private institutions through grants or other financial instruments to address pediatric C&T needs in Kenya.

AIDSFree is promoting a transactional donation approach that entails embedding a negligible donation for pediatric C&T within every transaction occurring at selected tourism agencies, safari operators, hotels, grocery or retail outlets, airlines, or perhaps banks. Rather than an "opt-in" approach, in which consumers are asked to make a donation, AIDSFree proposes attempting an "opt-out" model where the donation is made automatically. In PY 2, the AIDSFree team will introduce this model as a proposed sustainable solution to generating private capital for pediatric HIV services, but will also accept any one-off CSR contributions emerging from CEO engagement activities.

The AIDSFree fund will differ from existing funding schemes in Kenya (such as those for chronic disease and adult C&T). The fund will specifically target pediatric and adolescent C&T in the private sector, focusing on increasing access to high-quality services regardless of ability to pay. For instance, private funds could finance demand-side financing mechanisms (i.e., client vouchers), diagnostic or logistic interventions, or CHW activity expansion.

AIDSFree plans to engage a trusted private sector convening body, such as the Kenya Healthcare Federation (KHF) to assist in the design, management, and promotion of the fund: specifically, conducting CEO engagement and testing the transactional donation option with Kenya-based firms. AIDSFree and our local partner will also engage the services of a trusted financial management firm (such as Deloitte, KPMG, or Ernst & Young) to handle the fund, increasing corporate trust in the security of donated funds, and reliable disbursement once the fund evolves into a grant-making platform.

This activity is intended for implementation over two years (PY 2 and PY 3). At that point, the return on investment can be broadly assessed before further AIDSFree investments are made in developing or managing the fund.

PY 2 activities: In PY 2, AIDSFree will focus on securing a local private-sector engagement management partner and trusted fund manager; clarifying the laws, rules, and regulations pertaining to fund start-up in Kenya; and establishing (in consultation with USAID) the process for generating and handling private cost-share, and the eventual grant-making criteria and/or disbursement process in accordance with USAID policies. This partner will be selected based on their ability to promote the fund among local Kenya firms, CEOs, company managers, and foundations. The partner will also receive AIDSFree funding to host two CEO engagement events to discuss pediatric C&T needs, introduce the fund, and further develop the transactional donation strategy with corporate input.

Once AIDSFree has confirmed that funds can be securely donated and transferred in accordance with USAID rules and regulations, the project and its local partners will begin promoting the fund through focused CEO engagement.

4. MONITORING AND EVALUATION

AIDSFree will develop an M&E framework at the outset of PY 2 to guide service monitoring and data-use processes at all levels. The framework will include a set of process and outcome indicators, and will leverage existing Kenyan private- or public-sector data capture tools, which can be adapted as needed to measure and monitor AIDSFree project progress. These indicators will be aligned with the project objectives and key activities as outlined above.

In PY 2, the AIDSFree M&E strategy will consist of three primary components:

1. Monitoring and compiling client and service level indicators at the private facility level

To collect and compile service delivery indicators (See Annex C), AIDSFree will rely on data collected from private-sector facilities participating in the PY 2 supply-side intervention, as well as updated epidemiological data at district and county levels. The AIDSFree team will work closely with each participating provider to ensure that they have sufficient tools and forms for consistent and quality reporting into the NASCOP and MOH HMIS systems; obtain sufficient pre-implementation training on HMIS and reporting; and receive ongoing TA and support to maximize the quality of their routine service delivery reporting. AIDSFree will also ensure that reporting data from AIDSFree PY 2 clinical partners can be appropriately disaggregated by key variables.

Before pediatric C&T services are introduced at private facilities, AIDSFree will collect information on key indicators for the three months prior to the start of the private-sector activities to establish a baseline for the 30 participating facilities. At the end of the implementation cycle, month-to-month and cumulative service indicators will be compiled and fed into planning for ongoing AIDSFree technical activities. Service monitoring will be used in three ways: (1) making decisions about refining the project's objectives, activities, products, and services; (2) documenting expenditure of project resources; and (3) justifying continued or additional funding, particularly when combined with data on care and treatment outcomes.

2. Monitoring and compiling community-based outreach and referral interventions

Abt Associates Inc., IMA World Health, and our PY 2 community-based partners will also measure and document indicators, achievements, and challenges encountered within the CSO and community mobilization components of the AIDSFree PY 2 technical model. The AIDSFree team will monitor the number of community members reached, and will track community partners' reports on the number of pediatric cases receiving a community-based HIV intervention; clients and families referred for care; and existing pediatric ART clients receiving interventions for retention or support.

The M&E component of the AIDSFree community-based model is intended to be a dynamic process that keeps the project on target and AIDSFree PY 2 partners motivated and engaged. All PY 2 M&E activities carried out by AIDSFree are intended to feed directly and continuously into the technical implementation to improve understanding of project successes and barriers, and

to strengthen local capacity and institutional development through consistent use of data for decision making.

3. Monitoring laboratory and diagnostic service availability to reveal technical bottlenecks

USAID has also funded a diagnostic monitoring activity to run in supplement to AIDSFree core service delivery activities. This activity will operate over two years (PY 2/PY 3) and will focus on monitoring laboratory and diagnostic service availability at AIDSFree private-sector clinical locations during and beyond the introduction of pediatric C&T services. AIDSFree plans to secure the services of a local Kenyan health data and research firm to conduct 1) a pre-implementation baseline; 2) monthly provider self-reporting on daily availability of pediatric C&T ARV commodities, HIV rapid diagnostic tests, EID dried blood spot specimen collection kits; 3) monthly provider self-reporting on daily availability of DNA-PCR testing, CD4, viral load, and other pediatric C&T diagnostic services; and 4) measurement of diagnostic turn-around times (both on- and off-site processing), percentage of lost or faulty samples, and proportion of clients who receive their test results.

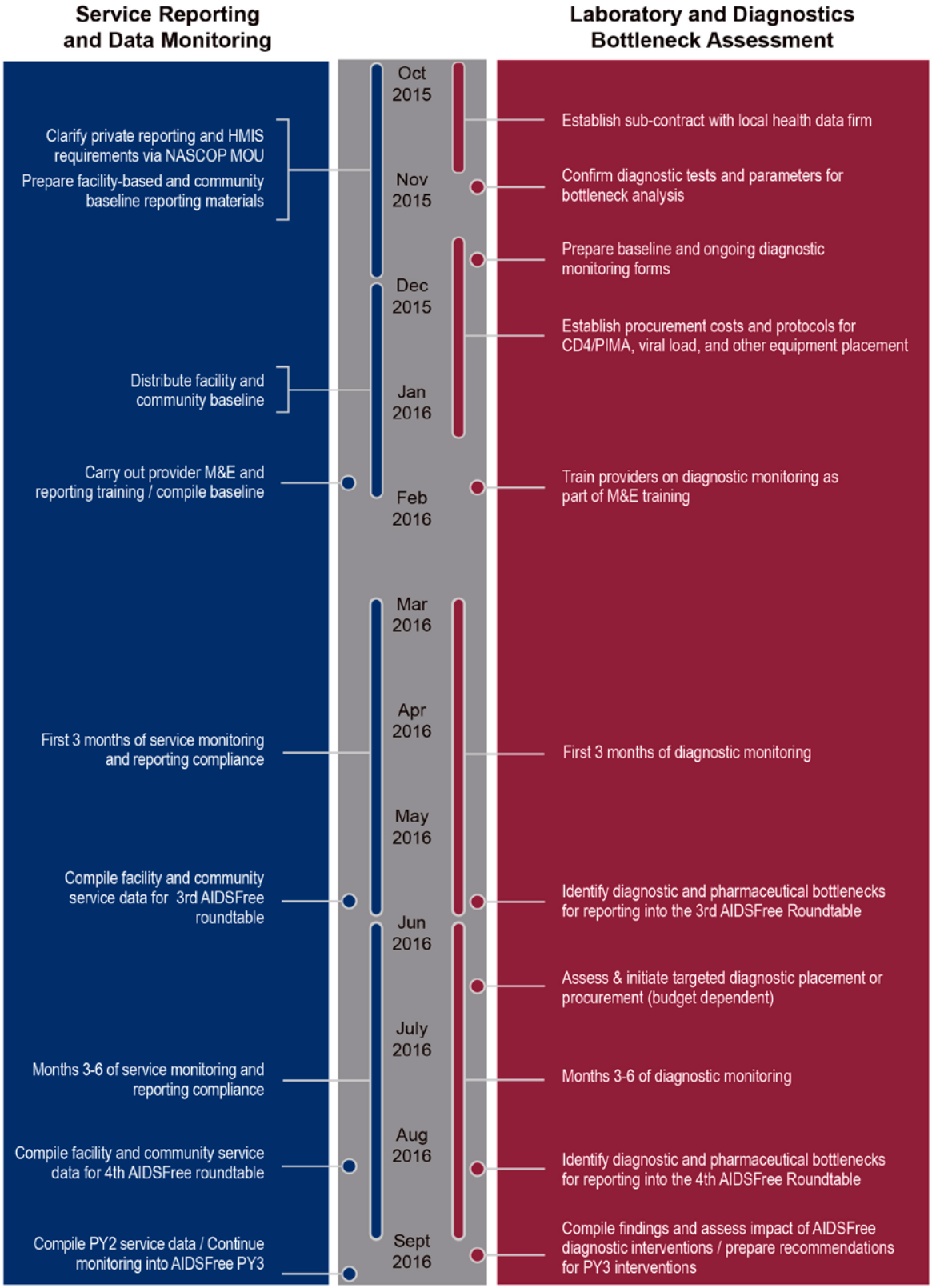
This monitoring activity will help to identify specific commodity shortages, diagnostic service availability, processing times, and results dissemination. During roundtable events and at other times as needed, AIDSFree and its partners will discuss bottlenecks in specific regions or at specific clinics, and Alliance members will help address laboratory or diagnostic challenges. Specific barriers or bottlenecks in diagnostic services observed in PY 2 will help AIDSFree develop recommendations for strengthening private-sector diagnostic services in PY 3.

4. AIDSFree reporting

AIDSFree will report to USAID/Kenya and USAID/Washington on a quarterly and annual basis and at other times as requested. As part of each reporting cycle, the project management team will assess whether service delivery and community-based AIDSFree PY 2 activities are on track to achieve desired results, making technical adjustments to program implementation as necessary. Thus, AIDSFree's PY 2 M&E strategy will emphasize routine use of data throughout project implementation. Reporting will be through the AIDSFree Progress and Annual Reports as well as through regular updates to the relevant USAID teams in Kenya and in Washington, with some indicators (e.g., numbers trained, service delivery statistics) available on a quarterly basis. The Clinical Advisor will enter HIV and AIDS service provision data for PEPFAR's Data for Accountability, Transparency, and Impact system, to facilitate prompt review and use of project data. In addition, AIDSFree will share data with all PY 2 partners as part of the AIDSFree Alliance roundtable discussions, and will develop feedback mechanisms so that private clinics can see the value of reporting and assess their own performance against that of other network clinics, and against annual targets.

Figure 4 illustrates a projected M&E timeline for AIDSFree Alliance activities in PY 2.

Figure 4. PY 2 M&E Timeline



5. CONCLUSIONS AND ADAPTABILITY TO OTHER CONTEXTS

In Kenya, as in many high-prevalence countries globally, a significant number of HIV-positive pediatric and adolescent clients are either unaware of their HIV status or are not being directed to appropriate C&T services, despite the general availability of both private- and public-sector HIV services in many urban areas. Stakeholder engagement in Kenya during AIDSFree PY 1 revealed the need to directly engage Kenya's private health sector to collaboratively involve them in the national HIV response, and to formalize their contributions to pediatric C&T. AIDSFree has proposed a PY 2 technical model that aims to be truly multisectoral by promoting public-private dialogue and collaboration; increasing provision of pediatric C&T services by the private sector; and extending into the community through the actions of local faith-based and civil society actors. The overall intent of the PY 2 model, to be implemented initially in Nairobi and low-income surrounds, is to increase pediatric and adolescent clients' demand for, access to, and use of high-quality pediatric treatment services.

Stakeholder engagement in Kenya revealed several enabling factors and potential barriers that may affect AIDSFree PY 2 implementation. Enabling factors include the country's robust private health sector; legislation allowing private-sector provision of HIV care; and strong interest among all stakeholders to pursue a multisectoral approach to pediatric C&T. While initial research also revealed barriers—including significant national-level challenges to establishing a reliable supply chain and reported delays in HIV-related diagnostics—the AIDSFree Alliance approach is designed to provide a public-private forum to build on strengths and address gaps and barriers.

The AIDSFree Alliance model provides clear incentives to promote and motivate the participation of diverse partner and client groups. Private health providers and CSO actors benefit from access to AIDSFree-sponsored government trainings; access to KEMSA and public pediatric HIV commodity inputs and KEMRI diagnostic support; and increased client volumes through AIDSFree community outreach. The public sector will also benefit through increased availability of pediatric C&T services from AIDSFree private-sector partners and formal collaboration with private health sector umbrella organizations. Private providers will receive training on routinely reporting to the government's national HIV surveillance systems, and ongoing quality assurance and improvement support through KPA will work to strengthen the multisectoral national HIV response. Most importantly, clients will benefit from community-based outreach, retention, and adherence support provided by AIDSFree community partners, as well as the increased choice of providers made available to them via AIDSFree CSO and CHW outreach activities.

AIDSFree is pursuing its PY 2 activity in Kenya to immediately scale up supply of, demand for, and access to pediatric C&T services in the high-burden area of Nairobi and its surrounds. However, the Nairobi activities are also intended to demonstrate options for strengthened public-private engagement for advancing pediatric HIV services in other high-HIV prevalence settings. AIDSFree hopes that PY 2 implementation in Kenya will demonstrate how a public-private alliance model can achieve rapid technical gains in extending pediatric C&T services. Thus, the project will focus on revealing barriers, opportunities, and lessons learned during PY 2 implementation. AIDSFree anticipates that its PY 2 activities in Kenya will offer a clear model for expanding pediatric C&T to the private sector—a model that can be shared with implementers and governments seeking to replicate such an approach in other settings.

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ANNEX A. SERVICE AVAILABILITY AND READINESS ASSESSMENT MAPPING (SARAM) 2013 AND KENYA PREVENTION ROADMAP

County	Estimate of Children with HIV	HIV Service Readiness Index	HIV Readiness by Ownership (%)				HIV Service Readiness Index #	HIV Readiness # by Ownership				HIV Readiness Total by Ownership (%)			
			Public	Private Not for Profit	Private for Profit	Other		Public	Private Not for Profit	Private for Profit	Other	Public	Private Not for Profit	Private for Profit	Other
Bomet	3,589	78%	78%	79%	83%	50%	87	74	9	2	1	86%	11%	3%	1%
Bungoma	5,086	76%	81%	75%	56%	75%	107	74	15	13	5	69%	14%	13%	4%
Homa Bay	19,370	84%	88%	77%	82%	63%	151	106	32	11	3	70%	21%	7%	2%
Kakamega	9,452	80%	82%	92%	72%	80%	183	98	32	50	4	54%	18%	27%	2%
Kericho	2,324	76%	74%	79%	87%	83%	132	98	19	13	2	74%	14%	10%	2%
Kiambu	4,256	66%	69%	70%	62%	33%	228	61	61	105	1	27%	27%	46%	0%
Kilifi	3,507	62%	71%	65%	53%	69%	123	62	15	43	5	50%	12%	35%	4%
Kisii	7,715	90%	91%	98%	79%	100%	126	91	21	13	2	72%	16%	11%	2%
Kisumu	16,326	85%	91%	80%	71%	75%	131	81	30	15	5	62%	23%	11%	4%
Machakos	4,135	64%	74%	60%	53%	70%	163	95	21	48	1	58%	13%	29%	1%
Migori	10,705	83%	83%	79%	84%	100%	140	90	28	20	1	64%	20%	14%	1%
Mombasa	6,870	50%	63%	48%	46%	52%	147	30	18	87	9	21%	12%	60%	6%
Muranga	2,881	66%	77%	71%	65%	0%	121	82	23	28	0	67%	19%	23%	0%
Nairobi	12,894	48%	75%	56%	41%	45%	417	74	90	234	17	18%	22%	56%	4%
Nakuru	7,898	60%	79%	70%	72%	65%	190	100	56	73	7	52%	29%	38%	3%
Siaya	15,568	63%	87%	89%	81%	63%	98	103	20	9	3	105%	20%	9%	3%
T. Nzoia	3,574	43%	75%	72%	51%	100%	59	39	16	32	1	66%	27%	54%	2%
Turkana	5,736	48%	66%	70%	67%	0%	65	62	19	10	0	95%	29%	15%	0%
U. Gishu	3,677	52%	77%	63%	56%	33%	76	69	16	16	0	91%	22%	21%	0%

* Sourced from the 2013 SARAM, the readiness here indicates the basic requirements to provide services such as infrastructure, amenities, basic equipment, and standard precautions for infection control, diagnostic tests, medicines, and commodities. Information on readiness is based on four domains: 1) standard precautions, 2) basic amenities, 3) basic equipment, and 4) essential medicines.

ANNEX B. ILLUSTRATIVE AIDSFree PY 2 FACILITY- AND COMMUNITY-BASED INDICATORS

The indicators below illustrate the facility- and community-based indicators AIDSFree will monitor during PY 2, based on PEPFAR's Monitoring, Evaluation, and Reporting (MER) Guidance and the Strategies for Pediatric and Adolescent Case Findings. The final indicators list will be determined in consultation with USAID, and will be consistent with indicators as reported in the government's HMIS system and with partners' existing indicators as reported to USAID.

Illustrative Service Delivery Indicators

- Number of children >2 and <20 years of age who received an HIV test, disaggregated by age, sex, and type of site where the testing was provided
- Number of children >2 and <20 years of age who tested for HIV and were found positive, disaggregated by age, sex, and type of site where the services was provided
- Number and percent of infants who received an HIV test within 6, 12, 18, and 24 months of birth (the EID indicators), disaggregated by sex and type of site where the testing was provided
- Number and percent of infants who received an HIV test within 6, 12, 18, and 24 months of birth (the EID indicators) and were found positive, disaggregated by sex and type of site where the testing was provided
- Number of children <20 years of age who were provided with a minimum care service, disaggregated by age, sex, and type of site where the service(s) were provided
- Number of HIV-positive children <20 years of age who received a minimum of one clinical service, disaggregated by age, sex, and type of site where the service was provided
- Number of children <20 years of age who receive cotrimoxazole prophylaxis, disaggregated by age, sex and type of site where the service was provided
- Number of children <20 years of age who were found to be HIV positive and provided with care services and retained in care, disaggregated by age, sex, and type of site where the service(s) were provided
- Number of children <20 years of age who are newly enrolled in HIV treatment, disaggregated by age, sex, and type of site where the service was provided
- Number of children <20 years of age who currently receive HIV treatment, disaggregated by age, sex, and type of site where the service was provided
- Number of children <20 years of age who receive HIV treatment and are found to be virally suppressed, disaggregated by age, sex, and type of site where the service was provided

- Number of stockout(s) disaggregated by commodity (rapid test kits, cotrimoxizole, etc.) and type of site
- Number of cases of sexual abuse detected and reported
- Number of pregnant women accessing services with a community health worker
- Number of persons <20 years of age referred to clinic.

Illustrative Community-based Indicators

- Number of CHWs active in the catchment area
- Number of pediatric-focused outreach activities carried out by pediatric HIV champions and their respective CHW units
- Number of outreach activities delivered to adolescent SWs by AIDSFree-trained adolescent peer educators
- Number of HTS services provided in a community setting
- Number of HIV-positive pediatric clients/families referred for facility-based care
- Number of completed HIV-positive pediatric referrals
- Number of loss to follow-up tracking interventions provided by CHWs
- Number of children linked to services for orphans and vulnerable children.

ANNEX C. ORGANIZATIONAL PROFILES OF PUBLIC AND PRIVATE AIDSFree ALLIANCE PARTNERS

AIDSFree has chosen a public-private alliance approach for PY 2 implementation in an attempt to harness the comparative capacities and strengths of a broad range of public, private, and community-based actors. Key partners for PY 2 implementation were identified during detailed in-country stakeholder dialogue during AIDSFree PY 1, and were selected based on their unique responsibility, role, and/or contribution to the Kenyan HIV response. The following is a brief organizational history and description of strengths and capacities various partners bring to the AIDSFree Alliance.

Government Leadership

The AIDSFree Alliance activities require the involvement of government regulators and parastatal bodies, who play key roles in the management, stewardship, regulation, and oversight of Kenya's national HIV response. To ensure that all private-sector engagement activities align with government protocol and priorities, AIDSFree will work with the following public-sector partners during PY 2 implementation:

NASCOP (including CASCO and sub-CASCO Nairobi)

NASCOP operates as a division within the Ministry of Health and is tasked with technical coordination of HIV and AIDS programs within Kenya. NASCOP is currently implementing priority interventions as outlined in Kenya's *National HIV and AIDS Strategic Plan III* (KNASP III), and administers activities in partnership with respective county and sub-county AIDS and STI Coordinators (CASCOs and sub-CASCOs). The AIDSFree team has liaised with NASCOP and the Nairobi CASCO to pursue agreement in principle on the proposed AIDSFree Alliance and private-sector engagement strategy. Both government bodies have indicated a strong willingness to collaborate, and a national-level MOU has been proposed between AIDSFree and NASCOP to apply in all high-priority counties of Kenya and facilitate interaction with multiple CASCOs and sub-CASCOs over the lifespan of the project.

The Kenya Medical Supplies Authority (KEMSA)

KEMSA is a state corporate entity and government authority mandated by Parliament to procure, warehouse, and distribute drugs and medical supplies for prescribed public health programs and, under their new business model, support county governments to establish and maintain appropriate supply chain systems for essential drugs and medical supplies (Kenya

Medical Supplies Authority 2015). Through AIDSFree's partnership with NASCOP, county-level HIV leadership, and the KPA, there is precedent and expectation that private facilities can be granted access to nationally controlled pediatric HIV commodities such as EID test kits, pediatric ARVs, and other essential pediatric C&T inputs through KEMSA. Such an agreement would be formalized during the development of an MOU between NASCOP and AIDSFree.

The Kenya Medical Research Institute (KEMRI)

KEMRI is a state corporation established in 1979 with a mission to improve human health and quality of life through research, capacity building, innovation, and service delivery. KEMRI currently serves as primary diagnostic services provider to Kenya's Ministry of Health, and will be another essential PY 2 partner in facilitating private provider access to specific pediatric HIV diagnostic testing and monitoring services. The MOU with NASCOP will clarify permissions and processes to enable private-sector providers to access public-sector resources for pediatric C&T, including medical laboratory and diagnostic support, specifically DNA-/RNA-PCR and viral load services.

Professional Bodies and Associations

AIDSFree plans to partner with several professional bodies and associations to help identify high-priority and established private-sector providers and health facilities where pediatric C&T can safely be introduced. The AIDSFree team will work through these partners to assess, certify, support, and mentor new private pediatric providers as a means of fostering sustainable public-private mentorship and collaboration, which will then continue beyond the life of AIDSFree activities. These local partners include:

The Kenya Pediatrics Association (KPA)

The KPA is a non-profit and non-partisan organization of pediatricians and pediatric practitioners established in 1968. The association's mandate is to guide and lead comprehensive child health care delivery in Kenya by promoting best practice in pediatrics training, research, policy formulation, and member capacity building. The KPA is viewed as a primary and essential AIDSFree partner in PY 2, in that their existing certification and mentorship programs can yield rapid scale-up of pediatric C&T services as certified and equipped private-sector points of care, within the parameters of existing NASCOP- and KPA-approved approaches. KPA can conduct rapid site assessments of private health facilities using its existing checklist; certify facilities to introduce pediatric C&T; deliver pediatric and related modules of the NASCOP-approved National HIV Integrated Training Course (NHITC) and certify identified private prescribers; and offer hands-on mentoring and remote support to new pediatric C&T facilities and providers through the KPA clinical mentorship model (NASCOP 2015).

The National Nurses Association of Kenya (NNAK)

Established in 1968, the NNAK is a professional association representing all cadres of nurses in Kenya's 47 counties, with a mandate to promote positive health outcomes among the population through the improved socioeconomic security and welfare of nurses. AIDSFree has engaged the NNAK's Pediatric Nurses Chapter (KNPC) and Private Nurse Practitioners Chapter (PNP) to help identify opportunities for enhanced task-sharing of pediatric C&T services to Kenya's private nurses and midwives, and to strengthen links between the NNAK and KPA as contributing members of the AIDSFree Alliance.

The Clinical Officers Council of Kenya (COC)

Since 1989 the COC has operated in Kenya to organize and represent Kenya's vast cadre of hospital attendants, assistants, assistant medical officers, and certified clinical officers. COC has agreed to help AIDSFree to develop task-sharing opportunities for clinical officers to deliver pediatric C&T, and to identify private facilities led by clinical officers in AIDSFree geographic and high-priority areas. COC will also benefit from stronger ties to KPA's mentorship program and continued collaboration with the NNAK under the AIDSFree Alliance.

Private Health Sector Service Providers

The specific private facilities selected to participate in AIDSFree in PY 2 will be identified in consultation with USAID/Kenya, NASCOP, and the Nairobi CASCO, with collaboration from NNAK, COC, KAPH, and our other clinical partners. The AIDSFree team will target Nairobi and its low-income surroundings according to epidemiologic priorities, and will work with local partner organizations to identify existing and new private-sector providers who could introduce pediatric C&T services in those areas.

Private Referral Hospitals

AIDSFree's PY 2 service delivery plan focuses on smaller community-based C&T, but there is a need to strengthen links between these facilities and larger referral hospitals. AIDSFree has identified two private hospitals with sufficient inpatient and specialist care, diagnostic capacity, and emergency services to serve as focal referral facilities and sources of clinical leadership within the AIDSFree Alliance. These would be equivalent of level 4 or 5 health facilities within the MOH facility classification system.

Metropolitan Hospital Nairobi

Metropolitan Hospital is a comprehensively equipped private-for-profit hospital located in the eastern Buru Buru sub-county with inpatient capacity of 125 beds, offering 24-hour emergency and surgical care, maternity and primary health care, and extensive laboratory services (including on-site X-ray, CT scan, ultrasound, and established outsourcing to KEMRI for dried blood spot DNA-PCR investigation, as well as Lancet Labs PTY Ltd and Nyumbani Diagnostic Laboratory for

other diagnostic investigations). Metropolitan Hospital also operates a free-to-client NASCOP-approved HTS clinic and a comprehensive care clinic (CCC) for adult and pediatric HIV services, which currently serves 587 PLHIV on ART (including 32 children between 6 months and 15 years of age), and is primed for strengthening and expansion. The Metropolitan CCC and their experienced clinical staff can serve as a model and mentor to newly-engaged private clinics participating in the AIDSFree Alliance. The hospital's existing ties with private insurance companies and corporate clients could be leveraged to help families or clients who need care beyond the free HIV interventions (HTS, counseling, CD4 and viral load testing, and ART prescribing/dispensing) available to ART clinic clients. AIDSFree's diagnostic strengthening and bottleneck analysis might include considering Metropolitan Hospital for CD4 or viral load placement contracts as part of the recommendations or low-cost AIDSFree-financed interventions.

Gertrude's Children's Hospital Nairobi

Gertrude's Children's Hospital, based in Muthaiga, Nairobi, is the one of the few pediatric-focused hospitals in East and Central Africa. The hospital, established in 1947 and registered as a private institution in Kenya, offers both primary and specialized health services to over 300,000 pediatric outpatients and 5,000 inpatients annually (Gertrude's Children Hospital 2015). In 2010, the Board of Trustees also established the Gertrude's Hospital Foundation ("The Foundation") to advance charitable projects and to promote community access to child health services in the Republic of Kenya (Gertrude Hospital Foundation 2015). In 2012, as part of expanding the hospital's service package and advancing the Foundation's mission, Gertrude's Hospital and several of their affiliated satellite centers introduced PMTCT at the CCC Sunshine Clinic (providing pediatric-focused HIV and ART services). Like Metropolitan Hospital, Gertrude's CCC is primed for strengthening and expansion, and could serve as a referral point, clinical model, and mentor to affiliated satellite centers (discussed below) and other private providers participating in the AIDSFree PY 2 Alliance.

Kenya Association of Private Hospitals (KAPH)

Most of the private providers and facilities who participate in the AIDSFree Alliance's PY 2 activities are expected to come through AIDSFree's planned partnership with KAPH. KAPH was registered in 2003 as a national association of medium and small private hospitals and health care facilities. With over 360 members across Kenya, KAPH brings together numerous practitioners holding a license with the Kenya Medical Practitioners and Dentist Board, or the Nursing Council of Kenya (NCK). As an added advantage, KAPH encourages member to hold National Hospital Insurance Fund (NHIF) accreditation. Although KAPH facilities operate largely as private for-profit enterprise, membership entails a commitment to KAPH's central focus of providing affordable quality health care to all Kenyan's as a contribution to the Government's "Health for All" policy. KAPH participation in the AIDSFree Alliance facilitates stronger representational and regulatory links between multiple private health facilities and NASCOP/CASCOs as part of AIDSFree pediatric C&T effort. Although AIDSFree envisions that the majority of participating KAPH-affiliated clinics will be small- or medium-size community-based points of care, larger affiliated facilities with inpatient and diagnostic capacity may also be identified for participation; these will be assessed for referral and diagnostic participation by Abt Associates Inc./AIDSFree and the KPA as part of the site assessment process.

Community-based Private Health Facilities

Consistent with PEPFAR 3.0's epidemiological emphasis, USAID/Kenya's county prioritization, and NASCOP's strategic pillars, AIDSFree plans to rationalize the strategic inclusion of diverse community-based private points of care and involve pediatrician-, nurse-, midwife-, and clinical officer-led facilities in the strategic scale-up of private-sector pediatric C&T provision. Those community-based facilities, in both middle and low-income areas, will be identified from the following:

KAPH-affiliated Small and Medium-sized Private Facilities

AIDSFree envisions strategic introduction of pediatric C&T services at several KAPH-affiliated facilities identified in consultation with KPA, NNAK, and the COC. Such facilities would be assumed appropriate to receive a KPA site assessment, and the providers in charge would be known to the KPA or other professional associations as a prepared clinician.

Metropolitan Hospital and Gertrude's Satellite Centers

Metropolitan Hospital has five satellite centers capable of site-level pediatric C&T assessment and service delivery; these will be included in the clinic identification and assessment process. Gertrude's Hospital has eleven fixed location[4] satellite outpatient and diagnostic clinics, nine of

[4] Gertrude's hospital satellite clinics are located in Lavington, Thika, Nairobi West, Ongata Rongai, Pangani, Kitengela, Embakasi, Donholm, Komarock, BuruBuru, and Mombasa.

which are not currently providing pediatric C&T and will be considered for site selection (including one mobile unit set to begin operations in Nairobi in early 2016). All of these will be included in the facility selection and assessment process for possible introduction of pediatric C&T services in PY 2.

Community-based Civil Society Partners

The AIDSFree community-based strategy (outlined in Section 3) emphasizes the involvement of a broad range of CSOs, pediatric-focused CHWs, local faith-based groups, and traditional leadership focused on helping HIV-exposed or -positive children and their families reach confidential and accessible pediatric C&T on an ongoing basis.

In PY 2 AIDSFree, through Abt Associates Inc., plans to engage with the following established community-based partners:

IMA World Health and the Christian Health Association of Kenya (CHAK)

Founded in the 1930s, the Christian Health Association of Kenya (CHAK) is one of the most recognized FBO networks in Kenya. CHAK works closely with government through PPP mechanisms and has a broad mandate to facilitate the role of the Church in health care and healing. The CHAK secretariat serves as a technical support organization to their total membership of more than 500 health institutions drawn from 43 church denominations across Kenya, including 23 hospitals, 53 health care centers, 364 dispensaries, 58 churches/church organizations, 24 community-based health care programs, and 10 schools of nursing. The CHAK secretariat provides members with a core package of advocacy, lobbying, representation to government, health system strengthening interventions, program development, resource mobilization, and capacity building. Through its members, CHAK provides comprehensive HIV and AIDS prevention, care, and treatment services which include both pediatric and adult ART, PMTCT, HTS, post-exposure prophylaxis (PEP), and management of HIV-related opportunistic infections. CHAK also has deep roots in communities through a network of over 200 religious leaders who play an influential role in health-seeking behavior; and a network of over 1,000 CHWs who provide home-based care, psychosocial support, spiritual counseling, adherence counseling for PLHIV, and behavior change communication. Recently, CHAK also integrated a human rights framework into their HIV and AIDS program to combat stigma and promote the rights of PLHIV in the community.

In PY 2, AIDSFree plans to engage CHAK to assist in implementation of the "whole community—whole family" approach focused on supportive case identification and enrollment, referral and linkage, retention, and adherence for pediatric HIV treatment. AIDSFree will leverage CHAK's existing community networks to address the gaps and barriers to pediatric C&T in selected high-burden communities and in child hot spots. The AIDSFree team envisions this being a strong opportunity to 1) increase community knowledge of pediatric treatment services;

2) increase demand for pediatric treatment services; and 3) effectively engage key community structures and CSOs in pediatric care and treatment for sustainability.

CHAK's Community Partners

Redeemed Gospel Health Centre (RGHC)

The RGHC is a faith-based health facility (affiliated with CHAK) providing a broad range of primary health care and HIV services, including HTS and PMTCT, that fulfils the social ministry of the Redeemed Gospel Church. RGHS also works with a network of CHWs who extend basic health care into the community. RGHC affiliated CHWs perform a broad range of activities including preventive counseling, health education, behavior change communication, and health promotion; as well as screening, treatment, and referral for a range of diseases. Their HIV-specific services for PLHIV include home-based care, retention support and follow-up, and psychosocial support for PLHIV.

Redeemed Gospel Church

Religious networks such as the Redeemed Gospel Church serve as deep-rooted support systems within the community. Through preaching and spiritual counseling, religion plays an influential role in changing sociocultural behaviors.

SOS Children's Village

The SOS Children's Village is the largest institution providing orphan care in Nairobi's Grogan communities, supporting orphaned and neglected children via partnerships with the SOS Social Centre and an SOS Medical Centre. The SOS Social Centre focuses on raising awareness of HIV, facilitating support groups for those affected and providing nutrition and education bursaries for children. It also addresses the issue of street children. The SOS Medical Centre provides basic health services to the local community. It also includes an HIV clinic providing HTS and ART, which serves as the main referral point for pediatric and adult C&T for RGHC and the surrounding community.

Women Fighting AIDS in Kenya

Women Fighting AIDS in Kenya (WOFAK) is a national nongovernmental organization (NGO) operating across 10 counties in Nairobi, Coast, Nyanza, Western and Rift Valley regions. Registered in 1994 by a group of mostly HIV-positive women, the organization has progressively expanded its scope of operations to include provision of comprehensive community-based care and support to women, youth, and children living with or affected by HIV. In 2013 alone the organization provided community or home-based care to 16, 882 HIV-positive or otherwise vulnerable clients; and provided comprehensive care and support services to 8,183 children (including HIV counseling, care, and nutritional support). As a civil society leader, WOFAK also has experience in training the leadership of other CBOs on sound financial management, good governance, and M&E. In addition, WOFAK has implemented several innovative income-

generating projects that support the training and sustained mobilization of CHWs for WOFAK's community-based activities.

In PY 2 AIDSFree plans to engage WOFAK and the sub-county CASCO to train a cadre of community health workers to perform as pediatric HIV champions within their organizations and integrate pediatric- and family-focused outreach into their CHW units' existing outreach activities. In addition, AIDSFree plans to provide a small amount of funding to support seed-funding micro-grants to established WOFAK "community units" (typically comprised of 50 CHWs) so they can pursue USAID-compliant small-scale income-generating opportunities. This could offer an opportunity to strengthen WOFAK's CHW income-generation model, which could sustainably fund ongoing mobilization for pediatric outreach beyond the initial AIDSFree investment.

Movement of Men Against AIDS in Kenya (MMAAK)

The MMAAK, a national NGO of people living with and affected by HIV, was established in 2001 in partnership with Metropolitan Hospital to integrate and enhance male involvement in the fight against HIV. MMAAK is the only organization in Kenya that specifically targets men to address HIV. The organization's activities focus on engaging men as fathers in supporting women and children during antenatal care; maternal, newborn, and child health; and HIV care. MMAAK helps men cope with their own HIV status, empowers them to support their positive wife or child, and conducts community outreach to encourage HIV prevention and stigma reduction. In Kenya, several AIDSFree partners report that a mother's fear of disclosure to her partner often prevents HIV-positive children from receiving or consistently accessing the care they need. As such, MMAAK is primed to support AIDSFree in reaching men and fathers to help link and retain HIV-positive children and families in care. AIDSFree plans to include existing MMAAK CHWs in the planned Pediatric HIV Champion training described above. Selected MMAAK CHW units will also receive seed-funding micro-grants to sustain their community outreach and operations.

Bar Hostess Empowerment and Support Program (BHESP)

The BHESP is an organization for and by sex workers, women having sex with women (WSW), and women using drugs in Kenya. Established as an informal association in 1998 by a group of these vulnerable women, the BHESP's mission is to advocate for rights and recognition, facilitate provision of quality health services, advance human rights awareness, and provide legal services and economic empowerment to sex workers and other vulnerable women in Kenya. In addition to providing legal support to their members, supportively engaging law enforcement, and advocating on behalf of SWs and vulnerable women, BHESP operates a comprehensive HIV and general health program with support from The Global Fund to Fight AIDS, Tuberculosis and Malaria and the Kenyan Red Cross. The NGO operates two fully equipped Wellness Centers offering primary health care and HIV testing, as well as 10 satellite drop-in centers offering

discreet on-site health interventions for key populations in highly-populated urban areas. BHESP also operates a mobile wellness van to link key hot spots and the BHESP drop-in/wellness centers.

The cornerstone of BHESP's work is peer education and community outreach. Peer educators have been empowered to provide the entire portfolio of HIV testing, prevention, infection, risk management, and vulnerability mitigation. BHESP's peer educators, who focus on education about sexually transmitted infections including HIV, have demonstrated high efficacy in reaching out directly to vulnerable girls and adolescents to connect them to ongoing support and care. In PY 2, AIDSFree plans to work closely with BHESP to train a cohort of HIV peer educators from BHESP's existing membership of adolescent SWs to reach adolescent SWs "peer-to-peer" and link them to HIV prevention, care, and treatment services that they might otherwise be afraid or unwilling to access. AIDSFree will also work through BHESP's community and peer outreach strategies to identify HIV-positive SWs with children at home who have not been assessed for or enrolled in HIV care, and link them to the services they need.

ANNEX D. HIV CARE SERVICES MENTORSHIP TOOLS

MINISTRY OF HEALTH

HIV CARE SERVICES MENTORSHIP TOOLS

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- Social Workers .....

MENTORSHIP SITE VISIT ASSESSMENT

PREAMBLE

Mentorship site visit for Paediatric HIV:

This allows a mentor or a team of mentors to spend time (1- 5 days) at a (low level) health-care facility to give confidence to the local staff by giving guidance in patient management including harmonized management systems in the institution.

Approach:

Sites that are suitable for this activity are where staff have had theoretical training as well as clinical mentorship attachment.

An initial visit to the identified site is made and a base-line assessment carried out. This involves an assessment of health providers' skills, knowledge and practices. The institution's service delivery chain, systems and processes especially linkages of entry points to Paediatric HIV care and the CCC are evaluated.

The mentors specifically assess:

- Whether HIV services have commenced and if not tries to identify bottlenecks and constraints. Possible solutions are discussed with the local teams
- Linkages of Paediatric HIV care with other hospital services (points of entry to care).
- Actual patient care:-checks on knowledge and expertise in all aspects of management of HIV by local healthcare personnel including diagnosis, staging, ART treatment decisions, and monitoring.

The objective of the baseline assessment is to enable the mentors identify gaps and weak areas. A work plan that addresses the site's specific requirements is then designed. This may include mentors working side by side with the local healthcare providers for several clinical sessions. In this way the mentees learn by observation and instruction. A debrief is carried out at the end of such a clinical session in order to clarify and/or emphasize on challenging clinical issues.

This process is repeated until the local healthcare personnel are fully confident to work on their own. Afterwards the mentor/s keeps contact with the site to address any emerging issues. Sharing of new information on HIV is encouraged.

Mentored sites must be visited regularly and encouraged to grow until they are confidently running on their own.

Mentor description:

- Must have undergone the Comprehensive HIV management course and the TOT.
- Clinical mentors may be Pediatricians, medical or clinical officers.
- Mentors from other clinical disciplines like counseling, pharmacy, nutrition, records and laboratory are also included
- Must be actively involved in management of Paediatric HIV patients and up-to-date with current developments in HIV.

BEFORE THE VISIT

In preparation for the visit, the institution to be visited should be notified well in advance. The site should also be informed on the areas of assessment in order to facilitate a smooth evaluation. The relevant staff and departments should be asked to prepare and be available to assist in the exercise.

Contact with the institution should be done by the head of the mentorship team.
The local medical officer of health and his health management team should be notified and involved in order that they become immediately aware of their institution's short-comings that may be identified. They are expected to lead in the design and implementation of the action plan.
The provincial or district ART services co-coordinator (PASCO or DASCO) as well as any NGO partners in HIV programs should be informed and invited to participate in the exercise. They will play a crucial role in the implementation of the action plan to be agreed on at the end of the assessment.

DURING THE VISIT

The team of mentors should ideally be multi-disciplinary including:

- Clinician
- Pharmacist
- Laboratory Technician/Technologist
- Counselor
- Nurse
- Social Worker
- Nutritionist

When only one mentor is available then it is desirable that he or she is a clinician.

The following procedure has been found helpful when the mentors arrive at the institution.

1. The mentors should first report to the Hospital administration for introduction and statement of the purpose of their visit which in summary is:
   - to assess HIV services at the institution;
   - to identify and help bridge gaps in knowledge practice and systems with a view to optimizing services and helping the institution achieve its full potential in this important field.

2. Identify a staff member from the institution to help with the assessment for example a clinician working in the Paediatric CCC. This person takes the mentors round the institution introducing them and helping them gather information.

3. The mentors and their team should visit the CCC, MCH, and Maternity (Labour Ward), Paediatric Ward, TB Clinic VCT and the outpatient emergency services.

4. When the assessment of the institution is completed, mentors can then split up to asses

their particular disciplines i.e.

- The clinical mentor will sit at the CCC with local clinical staff and carry out the individual assessments using forms provided.

The mentor observes the local personnel as they attend to several patients Mentors are also expected to inspect several samples of patients' records in order to make a fair assessment of the clinicians' ability to manage various categories of Paediatric HIV patients and the quality on patient notes.

Mentors should be careful in the way they handle this part of the assessment (and indeed all the mentorship activities) in order not to erode patient confidence in the clinicians. Above all the mentors should build a good rapport with the clinicians being mentored so that they are regarded as equals.

5. When the assessment exercise is over, the mentors gather the local team and PASCO/DASCO/partners to discus the findings and make a proposal for an action plan addressing the identified short-comings. Each proposed activity in this plan should have a named person taking responsibility and a time frame within which to do the task. A forum (scheduled follow-up meetings) should be established in order to review progress.
6. A copy of the assessment and action plan is left at the institution and the original copy remains with the lead mentor in order to help with reporting and co-ordination of subsequent mentorship visits.

AFTER THE VISIT

The lead mentor compiles a comprehensive written report of the visit. The report incorporates:

- name of site and date(s) on which the visit was conducted
- the list of mentors who conducted the site visit and their cadre
- list of hospital personnel, PASCO, and any regional Partner representative present during the exercise.
- an overview of individual areas visited within the site and how integrated they are – outpatient, MCH, Labour ward, Paediatric ward, Laboratory, Nutrition centre, Pharmacy and TB Clinic.
- overview of the hospital staff.
- capacity and resources: - staffing, equipment, systems and processes.
- Summary of numbers of patients on care and treatment; both adult and Paediatric.
- the action plan developed for the site highlighting the gaps/bottlenecks with the proposed solutions. The report is submitted to the KPA office and is shared with all the stakeholders.

CHECK LIST

The lead mentor should ensure that he/she takes adequate copies of:

- KPA site assessment tool
- health providers evaluation forms
- National treatment guidelines
- Baylor Dosing chart cards

DOs & DONTs OF MENTORING

The mentor must always:

- ensure that they give constructive criticism to the mentee and in a positive way
- give feedback in a way that both the strengths and weaknesses of the mentee are captured; building on the mentees strengths and identifying areas of improvement.
- leave the mentee feeling honored and inspired.

The mentor must not:

- Openly criticize the mentee in front of patients or junior staff.
- Use unacceptable language.

NATIONAL MENTORSHIP PROGRAM

SITE ASSESSMENT FORM.

Date of Visit:

Province:

District:
District Code:

Facility Name:
Year the ART program started ……
Facility category (Central, satellite, stand alone):
Satellite sites under this facility

Facility Representative: (MOH, Med sup, CO or Matron)
Name/Position)
(Phone):
(Email):
(Fax):
(Signature

Officer in-charge of HIV Services/Clinic	(Name/Position): (Phone): (Email): (Fax): (Signature):
PASCO/DASCO	(Name/Position): (Phone): (Email): (Fax): (Signature
NGO/Partners e.g APHIAs **Representative**	(Name of NGOs/Partners (Name of contact person/Position): (Phone): (Email): (Fax): (Signature

Mentors Name	Designation	Signature

1. GENERAL DATA

HIV Services available in this facility

- **ART (adult and pediatric)**
- **PMTCT**
- **FP**
- **PITC**
- **PWP**
- **Others (specify)** .....
  .....
  .....

STATISTICAL DATA

	GRAND TOTAL	Adults	Children (0-14yrs)	
1. Total in CCC	Cumulative ever enrolled			
	Currently active			
2. Total on ARV'S	Cumulative ever enrolled			
	Currently active			
3. No. On second line ART				
4. Average monthly enrolment (Total last 3months divide by 3)				
5. Average monthly lost to follow up and transfers* and transfers				

* Lost to follow-up is 3 months

2. ENTRY POINTS TO CARE

Number of patients newly testing HIV Positive

	Month 1		Month 2		Month 3		Monthly Average		*Average Prevalence	
Entry point	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**
1.ANC a) HIV +ve / Total Number Tested b) Testing rates No tested / Total attendance	.....									
2.Labour Ward a) Deliveries with known HIV status / Total deliveries b) HIV +ve / Total deliveries	....									
3. EID a). PCR positive / Number tested b). Spoiled samples / Lost results										
4. Ward..... a). Number tested / Total admission b) HIV +ve / Total Number Tested	.....									
Ward..... a). Number tested / Total admission b) HIV +ve / Total Number Tested										
Ward..... a). Number tested / Total admission b) .HIV +ve / Total Number Tested										

	Month 1		Month 2		Month 3		Monthly Average		*Average Prevalence	
Entry point	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**
Ward…… a). Number tested Total admission b) HIV +ve Total Number Tested										
Ward…… a). Number tested Total admission b) HIV +ve Total Number Test										
Ward…… a). Number tested Total admission b) HIV +ve Total Number Tested										
5. MCH Universal testing of sick Children/PITC a). Number tested Total attendance b). HIV +ve Total Number Tested	…… ……									
6. OPD (PITC) a) Number tested Total attendance b) HIV +ve Total Number Tested	…									
7. TB Clinic a) Number tested Total b) HIV +ve Total Number Tested	……									

Entry point	Month 1		Month 2		Month 3		Monthly Average		*Average Prevalence	
	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children
8. VCT a) Number tested / Total attendance HIV +ve / Total Number Tested	.....									
9. PEP Services a). Number tested / Total attendance. b) HIV +ve / Total Number Tested	.....									
10. .Any other testing area e.g dropping points for MARPs *(Most at Risk Populations)*										
Total monthly average from all entry points.										
Linkage of Entry points to CCC : average monthly enrolment in CCC over average total positive in all entry point									*% Linkage*	

3. HIV SERVICES INFRASTRUCTURE

Requirement	Yes	No	Comment
1. CLINIC SPACE: • Adequate room for Waiting area-open consultation and counseling • Child friendly facility • Adequate ventilation to support Infection control • Smooth Patient flow • Sanitation facility for staff and patients			
2. EQUIPMENT: • Weighing Scales adults • Paeds			
• Tape measure • muac tape/ • height board			

Requirement	Yes	No	Comment
• Thermometer			
• ENT Diagnostic Set			
• Torch • Spatulas			
• BMI wheel			
• Bp Machine			
3. JOB AIDS • National ART Guidelines			
• ART Clinical Manual			
• OI manual			
• Paediatric Dosage Wheel/Chart			
• Infant Diagnosis Algorithm			
• WHO Staging Charts Adults: • Paed:			
4. RECORDS: • Record staff			
• CCC patient card(MOH 257) Blue card • MOH 258 Yellow Card			
• Pre-ART Register (MOH 361A • ART Register (MOH 361B)			
• Monthly cohort Summary (MOH 711A/B)			
• Patient appointment diary			
• Timely reporting			

<u>Comment:</u> -Patients Seen per Clinic Day (Average)
No of clinicians per clinic day
Clinic days per week for adults
Clinic days per week for paediatrics

4. DIAGNOSTIC INVESTIGATIONS

Not Available	Available but inconsistent	Available and consistent	Available, consistent & with quality control
0	1	2	3

Score on a scale of 0-3 Assess competence in the following areas:-

Capacity	Score	Average monthly tests	*Comment e.g type of test and equipment*
1. Haemogram/ Hb			
2. Liver Function Test Capacity(ALT,AST)			
3. Hepatitis B SAg			
4. Hep C antibody			
5. Renal Function Tests Venous lactate Lipid profile Fasting blood sugar			
6. CD4%			
7. CD4 count			
8. Viral Load			
9. DBS(DNA PCR)			
10. TB Smear Capacity			
11. Access to TB smear cultures			
12. Access to VDRL testing			
13. Lab networking			
14. Standard Operating Procedures			
15. Lab records			
10. X-ray services			

5. PHARMACY

1. Is the facility a Central site ☐ Stand alone ☐ Satellite ☐
2. If a Central site, how many satellites do you support……
3. Patient data

Data item	Paediatrics	Adult
No. Ever enrolled on care		
No. currently on care		
No. ever started on ART		
No. currently on ART		

Items	Yes	No	Comment or Description
Drug inventory system 1. Reporting tools i. CDRR- (OIs, ARVs) ii. Monthly patient summary			
• Receiving i. Delivery notes/invoice			
• Storage records i. Bin cards ii. Expiry tracking iii. Temperature monitoring			
• Issuing i. S11 or equivalent ii. DAR or equivalent			
Standard Operating Procedures and Job Aids 1. Requesting 2. Receiving 3. Storage 4. Issuing a. To patients b. To departments c. Satellites 5.Medication use counselling			
Adequate stocking (Between 1-3 months) i. Paediatric-ARVs ii. Adult-ARVs			

Items	Yes	No	Comment or Description
Any "stock Outs" experienced in the last 3 months • State reason • Did patients miss drugs?			
Point of dispensing ARVs • CCC • OPD pharmacy • Any other (specify) Is space for drug counseling available?			
Adherence monitoring and patient tracking system. • Patient Diary • Pill Count • Any other			
Storage i. Is storage space adequate ii. Is the storage practice good (storage guidelines) iii. Is cold chain storage available			
Method of data collection (dispensing, storage, etc) i. Manual ii. Electronic a. ADT b. Any other			
Pharmacy staff available 1. In the facility i. Pharmacist ii. Pharm Tech iii. Any other (specify) 2. For ART management i. Pharmacist ii. Pharm Tech iii. Any other (specify			

Do you collect and report on these data to the National office?

ARVs ADRs and side effects		
Regimens change		
Reasons for change		

1. When did you do the last physical stock count? .....
2. How often do you do physical stock count? .....
3. How do you manage your short expiry drugs (less than 6 months)
4. In the last 6 months, have you had any expired and damaged drugs? .....
5. How do you manage your expired and damaged drugs?
6. Have you experienced and loss/damage of drugs through wrong handling? (check records)
7. How do you distribute drugs to Satellites sites? Describe
8. Any challenges experienced in distribution?

1. Have **site** staff attended any **in-service** training programs for HIV/AIDS Pharmaceutical management? **Yes** ☐ **No** ☐

2. If you answered '**YES**' to question **12 above,** identify the training programs.

Name of course and training source	# of staff trained	# of training hrs

6. COUNSELLING SERVICES

Requirement	Yes	No	Comment
1. Trained Counselors			
2. Counseling Space			
3. Privacy			
4. Counseling Tools (e.g.) Play equipment for and material for children. Information, Education and Communication materials. (IEC)			
5. Support groups Adults Adolescents Children.			

7. NUTRITIONAL SUPPORT SERVICES

Requirement	Yes	No	Comment
1. Registered Nutritionist/HCW trained in nutrition			
2. Assessment tools/Equipment • Stationmaster or height meter / Length Board • Weighing scale(Paediatric /Adult) • Tape measure			
3. Counseling Tools and Materials • National Nutrition and HIV guidelines • Growth Monitoring charts • BMI calculators/Wheels • Nutrition Counseling Cards • Nutrition Wall charts • Other IEC materials • Food demonstration kit 4. Provision for Nutrition Supplements • FBP • Therapeutic feeds(F-75, F100,Plumpynut)			
5. Provision for Replacement Feeding			
6. Provision for Breastfeeding support			
7. Reporting tools/Registers			

STAFF

Indicate the number of staff working at the facility

CADRE	No. working in the CCC	No. with relevant HIV training
Consultants(specify)		
Medical officers		
Clinical Officers		
Nurses		
Counselors		
Pharmacists		
Pharmaceutical technologists/technicians		
Laboratory technologists/ technicians		
Nutritionists		
Records officer		
Social workers		
Volunteers(specify)		

CONCLUSION OF SITE ASSESSMENT

IDENTIFICATION OF NEW HIV CASES AND THEIR LINKAGE TO CARE

	Recommendations	Action plan		
		How	Who	When
ANC				
LW				
WARDS				

	Recommendations	Action plan		
		How	Who	When
OUTPATIENT				
MCH				
EID				
TB CLINIC				
VCT				
PEP				
OTHERS				

SUMMARY OF FINDINGS	RECOMMENDATIONS	ACTION PLAN		
		HOW	WHO	WHEN
Clinic space Waiting space Consulting room Child friendly facilities Counseling rooms Nutrition room Sanitation facilities				
Equipment				
Job aids				
Records				
Pharmacy				
Laboratory				

HIV SERVICES INFRASTRUCTURE

PERSONELL/STAFFING

CADRE	TRAINING NEEDS	RECRUITMENT NEEDS	ACTION PLAN		
			HOW	WHO	WHEN

INDIVIDUAL ASSESSMENT FORMS

CLINICIANS ASSESSMENT FORM

Name of Clinician: - _____

Designation: - _____

Date: - _____

Name of Mentor: - _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	**1**	**2**

General Clinician Evaluation (To be completed for clinicians in CCC)
Score on a scale of 0-2 Assess competence in the following areas:-

	Competence Score				Average score
	Patient 1 A/C	**Patient2 A/C**	**Patient 3 A/C**	**Patient 4 A/C**	
1. History taking: HIV symptoms, diagnosis & progression. Drug family & social history. Symptoms enquiry.					
2. Interpretation of vital and clinical signs					
3. WHO Clinical Staging					
4. Clinical diagnosis, prophylaxis and treatment of OIs and STIs.					
5. Appropriate use of laboratory tests for patient management including use of CD4 and VL where available					
6. Decision making on ARV eligibility. Correct ART prescription.					
7. Identification and management of ART side effects, toxicity and failure.					
8. Chronic care model – (Review of trends in the blue card, clinical notes, side effects, family situation ,disclosure, follow up of last visit , case summaries of transfers and referrals etc);					
9. Communication and implementation of PWP messages and interventions as appropriate					
10. Adherence review (self assessment, prescription reconciliation with pill count, appointment keeping)					
Total Score					

Results and action

Total score below 10 - Retrain and then mentor
Total score 10-15 - Mentor
Total score above 15 - CME

COUNSELLORS ASSESSMENT FORM

Name of Counselor:- _____

Designation: - _____

Date: - _____

Name of Mentor: - _____

Grading

Not Done or Incorrect	Acceptable	Good
0	1	2

Assess Competence in	Competence Score				Average
	Patient 1	Patient 2	Patient 3	Patient 4	
1. COUNSELLING SKILLS Ensures privacy and confidentiality					
Pre & Post Test Counseling • Communicates with client/guardian with respect (both verbal & non-verbal communication.					
Invites and answers questions respectfully					
2. HIV KNOWLEDGE • Assesses the client/guardians knowledge of HIV.					
• Provides correct key information on HIV.					
3. APPROPRIATE USE OF DRUGS • Use of appropriate counseling guidelines or protocols.					
• Assesses and Discusses risks reduction measures.					
• Appropriate obtaining of assent or consent.					
4. DISCLOSURE COUNSELING • Assesses readiness & encourages disclosure. • Helps/caregiver through the process of disclosure. • Uses appropriate tools & techniques for disclosure e.g. role plays with dolls, narratives & stories etc. • Addresses issues of perception knowledge and fears. • Supports coping with disclosure.					
5. ADHERENCE COUNSELING. • Importance of Adherence • Meaning of Adherence • Enquires on & supports on good adherence practices (Establish routine/calendars/alarm clocks/diaries/ treatment buddies) • Drug taking history. • Pill Count					
Total Score					

Results and action

Total score below 5 - Retrain and then mentor
Total score 5-7.5 - Mentor
Total score above 7.5 - CME

LAB TECHS ASSESSMENT FORM

Name of Laboratory Technician /Technologist _____

Designation: - _____

Date: - _____

Name of Mentor: - _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	1	2

	Competence Score				Comment
	Test 1	Test 2	Test 3	Test 4	
1. HAEMATOLOGY (Haemogram, WBC differential counts.					
2. IMMUNOLOGY CD4 counts & percentages					
3. VIROLOGY DBS HIV Rapid & Elisa antibody tests Viral load Hepatitis B Hepatitis C					
4. BIOCHEMISTRY Liver function tests Renal function tests Serum lipids Lactic acid					
5. MICROBIOLOGY & MICOLOGY ZN smears Indian Ink stains Bacterial cultures & constrains					
Total Score	**(Total Score Over 5)_____**				

Results and action

Total score below 5 - Retrain and then mentor
Total score 5-7.5 - Mentor
Total score above 7.5 - CME

NURSE ASSESSMENT FORM

Name of Nurse: - _____

Designation: - _____

Date: - _____

Name of Mentor: - _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	1	2

	Competence Score				Average
	Patient 1	**Patient 2**	**Patient 3**	**Patient 4**	
1. TRIAGE:- • Accurate observations: temperature, weight, height, respiration, pulse, BP • Supervision of non-professional HCWs carrying out measurement of VS					
• Rapid clinical assessment.(check vital signs, assess symptoms and signs)					
2. APPROPRIATE ACTION:- • Emergency signs? Other patient needs Manage and refer to relevant discipline					
3. Baseline assessment of new pts with HIV					
4. Identification, management and referral of pts with OIs					
5. Pt education and preparation for ART including lab tests					
6. Follow up of stable pts on ART including scheduled lab tests					
7. Identification and referral of pts experiencing ARV drug toxicities or treatment failure					
8. Counseling Skills:- • Medication Use Counseling • PITC • Disclosure support • Continued counseling of pts					
9. Prevention with Positives • (Condoms promotion Family planning Reproductive health plans)					
10. General management of clinic and staff					
Total Score					

Results and action

Total score below 10 - Retrain and then mentor
Total score 10-15 - Mentor
Total score above 15 - CME

NUTRITION SERVICE PROVIDER ASSESSMENT FORM

Name of Nutrition service provider:- _____

Designation:- _____

Date:- _____

Name of Mentor:- _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	**1**	**2**

	Competence Score				Average
	Patient 1	Patient 2	Patient 3	Patient 4	
1.NUTRITIONAL ASSESSMENT • Classification of nutritional status					
• Height for Age					
• Weigh for Age					
• Weight for Height					
• BMI					
• MUAC					
2.INFANT FEEDING ASSESSMENT(breastfeeding ,replacement feeding, complementary feeding mixed feeding)					
3. **ASSESSMENT OF FOOD INTAKE.** • 24 hour recall assessment.					
4.**COUNSELING:-** • Basic Balanced Diet • Therapeutic Diet • Recommendation for opportunistic infections with regard to diet. • Dietary recommendation during OIs. • Ability to plan for the patient's diet with what is affordable & available to the patient. • Food-drug interactions • Benefits of good nutrition on successful ARV Therapy.					
5.INTERVENTIONS Supplementary feeding Referral to • clinician for treatment of nutrition deficiencies • Social worker or Community health care worker. Follow up assessment					
Total Score					

Results and action

Total score below 10 - Retrain and then mentor
Total score 10-15 - Mentor
Total score above 15 - CME

PHARMACIST ASSESSMENT FORM

Name of Pharmacist or Pharmtech: _____

Designation:- _____

Date:- _____

Name of Mentor:- _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	1	2

Asses Competence in	Competence Score.				Average
	Patient 1	Patient 2	Patient 3	Patient 4	
1. Dispensing :- • Counter checking doses					
• Check on drug interactions					
• Appropriate formulations					
• Correct quantities					
2. Drug administration, counseling and demonstration.					
3. Side Effects counseling & enquiry					
4. Monitoring Adherence:- • Pill count					
• Re-fill Appointment diary.					
5. Inventory management					
Requesting					
Receiving					
Storage					
Total Score					

Results and action

Total score below 5 - Retrain and then mentor
Total score 5-7.5 - Mentor
Total score above 7.5 - CME

RECORDS CLERK ASSESSMENT FORM

Name of Records Clerk _____

Designation: - _____

Date: - _____

Name of Mentor: - _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	1	2

	Competence Score				Average
	Patient 1	Patient 2	Patient 3	Patient 4	
1. **AVAILABILITY AND COMPLETENESS OF THE RECORD.** • Pre-ART Register(MOH 361A)					
• ART Register(MOH 361B)					
• Patient CCC Card(MOH 257)					
• Monthly Summary Sheet					
• Cohort Register					
• Patient Diary					
2.BACK UP • Back-up for important data					
3.TIMELINESS OF SENDING DATA ON WARDS TO NASCOP					
4. IDENTIFIES AND TRACKS DEFAULTERS					
5FILES PATIENTS NOTES AND REPORTS					
Total Score					

Results and action

Total score below 5 - Retrain and then mentor
Total score 5-7.5 - Mentor
Total score above 7.5 - CME

SOCIAL WORKERSASSESSMENT FORM

Name of Social Worker _____

Designation:- _____

Date:- _____

Name of Mentor:- _____

Grading:

Not Done or Incorrect	Acceptable	Good
0	1	2

	Competence Score				Average
	Patient 1	Patient 2	Patient 3	Patient 4	
1.Social assessment and history taking					
2.Facilitation of financial support					
3.Counseling (Trauma, adherence, supportive)					
4.Referrals					
5.Facilitation of support groups (children caregivers)					
6.Defaulter follow-up					
7.Client/relative follow-ups					
8.Home Placement					
9.Home Visits					
10.Repatriation					
Total Score					

Results and action

Total score below 10 - Retrain and then mentor
Total score 10-15 - Mentor
Total score above 15 - CME

MENTEE LOG BOOKS

Clinical

Skills/knowledge	Pt 1 IP NO/ SIG/ DATE	Pt 2 IP NO/ SIG/ DATE	Pt 3 IP NO/ SIG/ DATE	Pt 4 IP NO/ SIG/ DATE	Pt 5 IP NO/ SIG/ DATE	Pt 6 IP NO/ SIG/ DATE	Pt 7 IP NO/ SIG/ DATE	Pt 8 IP NO/ SIG/ DATE	Pt 9 IP NO/ SIG/ DATE	Pt 10 IP NO/ SIG/ DATE
History taking and examination										
Review of immunization status, growth and development in children										
Diagnosis and WHO Staging										
clinical diagnosis, prophylaxis and treatment of OI's										
use of laboratory tests for patient management										
Decision making on ARV Eligibility										
Timely initiation of ART;accurate prescription										
Monitoring:clinical, laboratory for failure and s/e										
chronic care model										
referrals /consultation										
Management of specific OI's including bacterial pneumonia, TB, PCP, Cryptococcal meningitis, KS, Toxoplasmosis, skin conditions										
communication of PWP messages and interventions										
6. *Adherence review indicators on non-adherence (self assessment, prescription reconciliation with pill count, appointment keeping)*										

Skills/knowledge	Pt 1 IP NO/ SIG/ DATE	Pt 2 IP NO/ SIG/ DATE	Pt 3 IP NO/ SIG/ DATE	Pt 4 IP NO/ SIG/ DATE	Pt 5 IP NO/ SIG/ DATE	Pt 6 IP NO/ SIG/ DATE	Pt 7 IP NO/ SIG/ DATE	Pt 8 IP NO/ SIG/ DATE	Pt 9 IP NO/ SIG/ DATE	Pt 10 IP NO/ SIG/ DATE
Identification and management of treatment failure										
1. Initiation of ART in patients with abnormal baseline laboratory tests and co-morbidities • TB/HIV co-treatment • Pre-existing anaemia (Hgb < 7g %) • Viral Hepatitis										
Identification and management of ART common side effects and toxicities • Drug rash . Intractable side effects • Hepatitis .Lactic acidosis • CNS side-effects Lipodystrophy • Peripheral Neuropathy										

Laboratory

Skills/knowledge	Pt 1 IP NO/SIG/DATE	Pt 2 IP NO/SIG/DATE	Pt 3 IP NO/SIG/DATE	Pt 4 IP NO/ SIG/DATE	Pt 5 IP NO/SIG/DATE	Pt 6 IP NO/SIG/DATE	Pt 7 IP NO/SIG/DATE	Pt 8 IP NO/SIG/DATE	Pt 9 IP NO/SIG/DATE	Pt 10 IP NO/SIG/DATE
1. Haemogram/ Hb										
2. Liver Function Test Capacity(ALT,AST)										
3. Hepatitis B SAg										
4. Hep C antibody										
5. Renal Function Tests Venous lactate Lipid profile Fasting blood sugar										
6. CD4%										
7. CD4 count										
8. Viral Load										
9. DBS(DNA PCR)										
10. TB Smear Capacity										
11.Timely reporting										
12.Quality control										
13.Equipment maintenance										
14.Lab SOPs										
15.Lab records										

Nutrition

Skills/knowledge	Pt 1 IP NO/SIG/DATE	Pt 2 IP NO/ SIG/DATE	Pt 3 IP NO/SIG/DATE	Pt 4 IP NO/ SIG/DATE	Pt 5 IP NO/SIG/DATE	Pt 6 IP NO/SIG/DATE	Pt 7 IP NO/SIG/DATE	Pt 8 IP NO/SIG/DATE	Pt 9 IP NO/SIG/DATE	Pt 10 IP NO/SIG/DATE
7. **Classification of nutritional status**										
a. **ANTHROPOMETRIC ASSESSMENT** (First assess the availability of the anthropometric equipments)										
• Height for Age										
• Weigh for Age										
• Weight for Height										
• BMI										
• BMI for Age										
• MUAC										
B.BIOCHEMICAL (first assess availability of nutrition and HIV tool kit or guidelines)										
Haemoglobin										
Triglycerides										
• Lipase										
oedema										
buggy pans										
sunken eyes										
Parlor										
d. **DIETARY ASSESSMENT**										
24 hour recall assessment.										
Food frequency										

Skills/knowledge	Pt 1 IP NO/SIG/DATE	Pt 2 IP NO/ SIG/DATE	Pt 3 IP NO/SIG/DATE	Pt 4 IP NO/ SIG/DATE	Pt 5 IP NO/SIG/DATE	Pt 6 IP NO/SIG/DATE	Pt 7 IP NO/SIG/DATE	Pt 8 IP NO/SIG/DATE	Pt 9 IP NO/SIG/DATE	Pt 10 IP NO/SIG/DATE
8. Infant Feeding assessment(Assess availability of infant feeding counseling card)										
Exclusive breastfeeding										
replacement feeding										
mixed feeding										
complementary feeding										
3.Nutrition Diagnoses • normal										
• Failure to thrive										
• Wasting										
• Underweight										
• Stunting **4 Nutrition intervention (Assess availability of nutrition and HIV counseling card)**										
Nutrition Counselling (CNP) Peroidic nutritional assessment										
• Increased energy need(Ability to counsel patient with what is affordable & available to the patient.)										
• Maintaining high level of sanitation										
a. Nutrition Counselling (CNP) Peroidic nutritional assessment										
• Increased energy need(Ability to counsel patient with what is affordable & available to the patient.)										
• Maintaining high level of sanitatio										
• Practicing positive living behaviours										
• Physical activity or exercises										

Skills/knowledge	Pt 1 IP NO/SIG/DATE	Pt 2 IP NO/ SIG/DATE	Pt 3 IP NO/SIG/DATE	Pt 4 IP NO/ SIG/DATE	Pt 5 IP NO/SIG/DATE	Pt 6 IP NO/SIG/DATE	Pt 7 IP NO/SIG/DATE	Pt 8 IP NO/SIG/DATE	Pt 9 IP NO/SIG/DATE	Pt 10 IP NO/SIG/DATE
• Plenty of clean safe water (8 glasses)										
• Prompt treatment for all OI and manage sympotoms with dietary practices										
• Drug- food interactions and diet related side-effects										
Vit A supplementation for infants not breastfeeding										
b. Supplementary feeding										
c. Therapeutic feeding (F75, F100 or plumpy nut)										
5. Data management (Assess availability of nutrition and HIV register)										
Availability of tools										
Data collection procedure										
Data entry										
Interpretation										
Data consumption and feedback.										
6.Referral and Follow up										
To clinician for treatment of nutrition deficiencies										
• To social worker.										
• To community										
• Return date										

MONITORING AND EVALUATION MENTEE LOG BOOK

Name: **Designation:** **Station:**

Skill /knowledge given by mentor.		Mentors name/signature/date
The data management system	Blue card	
	Pre-ART Register	
	ART Register	
	ART monthly summary sheet	
	Cohort monthly summary sheet	
	MOH 711A/B	
Completeness of Records	Blue card	
	Pre-ART Register	
	ART Register	
	ART monthly summary sheet	
	Cohort monthly summary sheet	
	MOH 711A/B	
Accuracy of data	Blue card	
	Pre-ART Register	
	ART Register	
	ART monthly summary sheet	
	Cohort monthly summary sheet	
	MOH 711A/B	
Consistency of data	Blue card	
	Pre-ART Register	
	ART Register	
	ART monthly summary sheet	
	Cohort monthly summary sheet	
	MOH 711A/B	
SOPs followed in data management	Data security & confidentiality	
	Filing & storage	
	Data recording	
	Data validation	
	Reporting	
	Data back-up	
	IT Support	
Electronic records		
a) Computer skills	Basic computer literacy skills*	
	Electronic software(EMR)	
b) Data Entry	Electronic record keeping with	
	Completeness	
	Accuracy	
c) IT Support	Antivirus	

Pharmacy

MENTEES LOG BOOK

Mentee's Name: _____

Activity	Demonstration done (Yes/No)	Proficient/ skilled Yes/No	Comments	Signature of Mentee & Date	Name of mentor	Signature of Mentor & Date
ART Policies, SOPs, Job Aids						
Requesting & Quantification						
Receiving						
Storing						
Issuing						
Rational use: Dispensing& Medication Use Counselling						
MTP-Problem solving and action plan development						

In order to be certified as having completed the Mentorship Program the mentees must demonstrate proficiency through direct experience in the following areas:

1. ART Policies, SOPs, Job Aids 1 hour
2. Requesting & Quantification- 1 day
3. Receiving- ½ day
4. Storing- 1 day
4. Issuing- ½ day
5. Rational use (Dispensing& MUC)- 2 days
6. MTP-Problem solving and Policies updates'- 2 hours

MENTORS CHECKLIST

CLINICAL MENTORS CHECKLIST.							
• *History taking and examination*							
• *Review of immunization status, growth and development in children*							
• *Diagnosis and WHO Staging*							
• *clinical diagnosis, prophylaxis and treatment of OI's*							
• *use of laboratory tests for patient management*							
• *Decision making on ARV Eligibility*							
• *Timely initiation of ART;accurate prescription*							
• *Monitoring:clinical, laboratory for failure and s/e*							
• *chronic care model*							
• *referrals /consultation*							
• *Management of specific OI's including bacterial pneumonia, TB, PCP, Cryptococcal meningitis, KS, Toxoplasmosis, skin conditions*							
• *communication of PWP messages and interventions*							
• *Adherence review indicators on non-adherence (self assessment, prescription reconciliation with pill count, appointment keeping)*							
Identification and management of treatment failure							
• Initiation of ART in patients with abnormal baseline laboratory tests and co-morbidities o TB/HIV co-treatment o Pre-existing anaemia (Hgb < 7g %) • Viral Hepatitis							
Identification and management of ART common side effects and toxicities • Drug rash . Intractable side effects • Hepatitis .Lactic acidosis • CNS side-effects Lipodystrophy • Peripheral Neuropathy							

LABORATORY MENTEES LOGBOOK AND MENTORS CHECKLIST

Skills/knowledge	Pt 1 IP NO/SIG/DATE	Pt 2 IP NO/ SIG/DATE	Pt 3 IP NO/SIG/DATE	Pt 4 IP NO/ SIG/DATE	Pt 5 IP NO/SIG/DATE	Pt 6 IP NO/SIG/ DATE	Pt 7 IP NO/SIG/DATE	Pt 8 IP NO/SIG/DATE	Pt 9 IP NO/SIG/DATE	Pt 10 IP NO/SIG/DATE
1. Haemogram/ Hb										
2. Liver Function Test Capacity(ALT,AST)										
3. Hepatitis B SAg 4. Hep C antibody										
5. Renal Function Tests Venous lactate Lipid profile Fasting blood sugar										
6. CD4%										
7. CD4 count										
8. Viral Load										
9. DBS(DNA PCR)										
10. TB Smear Capacity										
11.Timely reporting										
12.Quality control										
13.Equipment maintenance										
14.Lab SOPs										
15.Lab records										

PHARMACY

Mentor's Checklists

The mentee is proficient in the following under commodity management:

1. Procedures
2. Record keeping

Activity	Yes	No	Comments
ART Policies, SOPs, Job Aids			
Requesting & Quantification			
Receiving			
Storing			
Issuing -To the patients -To departments -To satellite sites			
Rational use: Dispensing& Medication Use Counselling			
MTP-Problem solving and action plan development			

Overall comments

Mentor's signature…… **Date……**

Mentee's signature…… **Date……**

ANNEX E. KENYA PAEDIATRIC RESEARCH CONSORTIUM MENTORSHIP METHODOLOGY

KENYA PAEDIATRIC RESEARCH CONSORTIUM (KEPRECON)

MENTORSHIP METHODOLOOGY

FACILITY SITE ASSESSMENT

Mentorship site visit for Paediatric HIV allows a mentor or a team of mentors to spend time (4 days) at a (low level) healthcare facility to give confidence to the local staff by giving guidance in patient management including harmonized management systems in the institution.

Approach

Sites that are suitable for this activity are where staff have undergone theoretical training in the management of paediatric HIV as well as an offsite clinical mentorship attachment.

An initial visit to the identified site is made and a base-line assessment carried out. The National HIV care services mentorship tool is used for this activity. The process involves an assessment of health providers' skills, knowledge and practices. The institution's service delivery chain, systems and processes especially linkages of entry points to Paediatric HIV care and the CCC are evaluated.

The mentors specifically assess:

- Whether HIV services have commenced and if not tries to identify bottlenecks and constraints. Possible solutions are discussed with the local teams
- Linkages of Paediatric HIV care with other hospital services (points of entry to care).
- Actual patient care:-checks on knowledge and expertise in all aspects of management of HIV by local healthcare personnel including diagnosis, staging, ART treatment decisions, and monitoring.

The objective of the baseline assessment is to enable the mentors identify gaps and weak areas. A work plan that addresses the site's specific requirements is then designed.

One facility site assessment will be conducted for fifty (50) facilities. Of the fifty, only 30 facilities that need further mentorship to improve on their knowledge and skills will be identified using the National HIV care services mentorship tool.

MENTORSHIP COURSE

The Kenya Paediatric Research Consortium (KEPRECON) will offer one (1) training of trainers and mentorship course for 30 healthcare workers. A senior mentorship team comprising representatives from KEPRECON and the county will be formed. KEPRECON will begin by developing the mentoring skills of

the 30 participants identified from the 2 comprehensive paediatric HIV management courses. They will undergo a 3 day training of trainers and mentorship course to become facility mentors. The KEPRECON/County mentorship team will support the facility mentors to train other health workers through mentorship sessions while ensuring proper identification and management of paediatric HIV.

MENTORSHIP SITE VISITS

The mentorship site visits will be conducted in all facilities from which participants were trained in the mentorship course. The team will comprise 2 KEPRECON representative and 2 county HIV focal person. At the end of the mentorship, participants will receive the mentorship training certificates.

The KEPRECON and county mentors will work side by side with the facility healthcare providers for three (3) clinical sessions (one every 2 months for six months). In this way the mentees will learn by observation and instruction. A debrief is carried out at the end of such a clinical session in order to clarify and/or emphasize on challenging clinical issues. Targeted continuous medical education sessions are conducted based on difficult cases that have been encountered by healthcare workers at the facilities and patient files are reviewed. This process is repeated until the local healthcare personnel are fully confident to work on their own. Afterwards the mentors maintain contact via email with the site to address any emerging issues. Sharing of new information on HIV is encouraged.

Each facility mentor will be allocated at most 5 mentees in their respective facilities. The facility mentors will schedule regular mentorship sessions with the mentees.

Once a group of mentees has successfully gained competencies and skills in the management of paediatric HIV, they will be expected mentor other health workers in the facility. This will form a mentorship cascade that will ensure continuous and sustainable trainings in the facility. Facility mentors will progress to be champions and provide mentorship leadership at the facility level. There will only be one champion per facility who will be selected from among the facility mentors.

At the end of the six months, an evaluation of the services offered will be conducted using the mentorship tool. The key indicators will therefore be the general data on diagnosis of HIV in the facility, linkage to care and uptake of treatment at facility levels.

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