



Ministry of Health

A Report on Assessment of Health Facilities Providing Oral Pre-exposure Prophylaxis for HIV in Kenya



March 2018



**JIPENDE
JI PrEP**



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This document contains relevant information on the provision of Pre-Exposure Prophylaxis (PrEP) in Kenya as at March 2018. All reasonable precautions have been taken by NASCOP to verify the information contained in this document.

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ABBREVIATIONS

ADR	Adverse Drug Reaction
AGYW	Adolescent Girls and Young Women
ART	Antiretroviral Therapy
ARVS	Antiretroviral Drug(s)
CASCO	County AIDS and STI Coordinator
CCC	Comprehensive Care Centre
CHAI	Clinton Health Access Initiative
CrCL	Creatinine Clearance
DHIS	District Health Information Systems
DICEs	Drop In Centers
EMR	Electronic Medical Records
FDA	Food and Drug Administration
FDC	Fixed Dose Combination
FSWs	Female Sex Workers
FTC	Emtricitabine
HBsAg	Hepatitis B Surface Antigen
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IPD	In Patient Department
KEMSA	Kenya Medical Supplies Agency
KP	Key Population
LMIS	Logistics Management Information System
LTFU	Lost To Follow Up
M&E	Monitoring and Evaluation
MoH	Ministry of Health

MOS	Months of Stock
MSM	Men Who Have Sex with Men
NASCOP	National AIDS and STI Control Program
OPD	Out Patient Department
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
STIs	Sexually Transmitted Infections
SCASCO	Sub-County AIDS and STI Coordinator
TDF	Tenofovir Disoproxil Fumarate

PREFACE

In 2015, the World Health Organization (WHO) recommended the use of pre-exposure prophylaxis (PrEP) to prevent and reduce the risk of contracting Human Immunodeficiency Virus (HIV) among populations at substantial ongoing risk of HIV infection as part of a combination prevention package. Kenya has been at the forefront of adapting the use of PrEP as part of a combination of prevention therapy for populations at substantial ongoing risks of HIV.

Based on evidence that daily oral PrEP intake significantly reduces the chances of HIV infection, the Ministry of Health (MoH) incorporated implementation of PrEP into the national policies and guidelines related to HIV. These include: The Kenya HIV Prevention Revolution Roadmap - 2013, Kenya AIDS Strategic Framework (KASF) – 2014/15-2019/20 and the Guidelines on use of ARV drugs for treating and preventing HIV infections in Kenya – 2016 and 2018 editions. In 2017, a framework on the implementation of PrEP and the PrEP toolkit were developed to provide guidance on PrEP provision and implementation.

This assessment was informed by the need to document the progress that has been made with regards to PrEP implementation since its inception and official launch in Kenya in May 2017. It further sought to identify the implementation gaps and areas that require action so as to inform further scale up.

ACKNOWLEDGEMENT

This assessment was led by the National AIDS and STI Control Program (NASCOP) of Ministry of Health with support from various partners and the report developed through continued and unwavering support and contributions of various stakeholders.

I wish to recognize Clinton Health Access Initiative (CHAI) for their technical and financial support through the Prevention Market Manager grant, without whom the process would not have taken place. I am grateful for the support and guidance that was offered to the field teams by the County Governments through the County AIDS and STI Coordinators (CASCO) and Sub-County AIDS and STI Coordinators (SCASCO) who were engaged in the data collection process. I also appreciate the effort and the time taken by the management and staff of the 852 facilities who provided the requisite information.

Finally, my special and sincere appreciation goes to the NASCOP and CHAI teams that regularly reviewed and provided technical input towards completion of the assessment report through the oversight and guidance provided by Dr. Irene Mukui.



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EXECUTIVE SUMMARY

Background: Today, PrEP represents an important addition to the HIV prevention strategies which include HIV Testing Services, Risk Reduction Counselling, Voluntary Medical Male Circumcision, Condoms and Elimination of Mother to Child Transmission among others¹. However, its full potential to reduce the HIV epidemic is yet to be realized as its uptake has been slow. As PrEP is a new HIV prevention intervention in Kenya, there is need to identify the progress made in implementation and the extent to which services are available across the counties. The assessment sought to establish the capacity of facilities to offer PrEP and identify areas with gaps.

Methods: A cross sectional assessment was conducted between February and March 2018 in facilities that were reported to be providing PrEP services by county governments and implementing partners. The report presents findings in PrEP service delivery in 852 facilities within 34 counties in Kenya. The facilities ranged from National referral hospitals, County hospitals, health centers, dispensaries and Drop In Centers (DICE's). The thematic areas assessed included: laboratory services, monitoring and evaluation, human resources, commodity security and communication and advocacy.

Summary of findings:

The findings provide vital information on the situation of PrEP uptake and service provision in Kenya and are summarized as follows:

- i) A total of 852 facilities in 34 counties were reported provision of PrEP as at March,2018.
- ii) Sero-discordant couples were the population type that used PrEP more.
- iii) There was suboptimal access to baseline laboratory tests (creatinine and B and hepatitis C) while baseline HIV testing was conducted in most of the clients.
- iv) Majority of the facilities had some trained personnel at the service delivery points where PrEP was offered.

¹ National AIDS & STI Control Programme (NASCOP), Ministry of Health, (2017). Framework for the Implementation of Pre-Exposure Prophylaxis of HIV in Kenya, Nairobi, Kenya: NASCOP

- v) PrEP commodity dispensing was largely conducted through manual tools as opposed to use of electronic platforms such as the ARV dispensing tool (ADT), which has been used in the ART program to streamline and optimize supply chain management.
- vi) There was inadequate availability of the MOH-NASCOP's PrEP monitoring and evaluation tools at the facilities.
- vii) There was limited reach of communication and advocacy activities at the facilities and community level.

The successes and gaps observed are valuable lessons learnt and will be used to design/improve on quality of services and strategies that inform scale up of PrEP nationally. The information will also be used to set priorities and provide guidance on the type of investment needed in the focus areas towards successful implementation of PrEP as outlined in the Framework on implementation of Pre-Exposure Prophylaxis in Kenya.

1. INTRODUCTION

In the last decade, there has been a distinct shift in the HIV prevention landscape, with increasing investment on biomedical strategies to supplement behavioral and structural HIV prevention interventions. One of these approaches is the use of oral PrEP as an additional form of HIV prevention offered as part of combination HIV prevention approaches for HIV negative people at substantial ongoing risk of HIV infection. Pre-exposure prophylaxis provides an important public health opportunity to substantially decrease new HIV infections.

In Kenya, there has been significant progress made in controlling the HIV epidemic; the national HIV prevalence in the country has declined by nearly 50% from a peak of 10.6% in 1995/96 to approximately 4.9% in 2018². This has been due to aggressive implementation of a combination of evidence-based interventions including scale-up of antiretroviral therapy. While the number of new infections has also significantly declined from over 100,000 new infections annually, the country still experiences a large number of new infections estimated at 52,800 in 2017, 49% of which occurred among adolescents and young persons aged between 10-24 years³.

The national guidelines recommend use of PrEP among persons who are at an ongoing risk of HIV acquisition. These include but are not limited to: HIV uninfected persons in HIV Sero-discordant relationship where the HIV infected partner has not been on effective (suppressive) therapy for the preceding 6 months; HIV Sero-discordant couples trying to conceive; individuals whose sex partners are HIV positive or at high risk of HIV infection, sexual partner/s of unknown HIV status and is/are at high-risk for HIV infection (has multiple sexual partners, has had STIs, engages in ⁴transactional sex, or from high HIV burden settings); recent or recurrent sexually transmitted infections; recurrent use of Post-Exposure Prophylaxis (PEP); history of sex whilst under the influence of alcohol or recreational drugs as a habit; inconsistent or no condom use or inability to

² Spectrum report 2018

³ Kenya HIV estimates report 2018

negotiate condom use during intercourse with persons of unknown HIV status and injection drug use where injection equipment is shared⁵.

While oral PrEP acceptability and adoption globally is growing since its FDA approval in 2012 and global WHO recommendation in 2015, uptake has not kept pace with expectations despite clinical practice guidelines supporting its use. To maximize its prevention potential, the public health impact of PrEP requires a two-pronged approach that will lead to: 1) large-scale adoption among eligible populations and 2) identification of current gaps in knowledge and practice among health care providers and users.

Since the launch of the national PrEP implementation framework in Kenya in May 2017, there has been rapid scale up of PrEP service provision in public health facilities across the country. The implementation framework and toolkit for service providers developed to support PrEP implementation provide minimum requirements for service provision and give guidance on how services should be provided.

1.1 Rationale for the assessment

Data collection and reporting for PrEP is relatively low. As a result, there has been little understanding of the status, availability and quality of services being offered across health facilities. NASCOP, sought to understand and establish the scale and status of PrEP services being offered, the populations being targeted, understand how well-equipped service points were in providing comprehensive quality services. The results of the assessment would then inform scale up activities going forward for national and county governments, implementing partners and other stakeholders.

1.2 Objectives

The goal of the assessment was to establish availability of PrEP services and determine the readiness and capacity of facilities to provide PrEP services.

The specific objectives of the assessment were:

⁵ Ministry of Health, National AIDS & STI Control Program. Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya 2018 Edition. Nairobi, Kenya: NASCOP, August 2018. Print.

- To determine the availability of support services - laboratory services and commodities in facilities providing PrEP
- To ascertain availability of M & E tools for PrEP service delivery
- To determine the availability of PrEP trained personnel in facilities providing PrEP
- To determine the availability of IEC materials at PrEP facilities
- Identify gaps and develop solutions to improve service provision for PrEP

2. METHODOLOGY

2.1 Identification of facilities

The National AIDS and STI Control Program (NASCOP) developed and shared a standard excel based template with all counties and implementing partners in the period between October and December 2017 prior to the assessment in order to determine the facilities offering PrEP. A total of 852 facilities were identified across 34 counties which were reported to be offering PrEP services. Thirteen counties indicating zero facilities for PrEP provision were not assessed.

2.2 Design

This was a cross sectional assessment conducted from February to March 2018. Figure 1 outlines the process of the planning, implementation, data analysis and reporting.

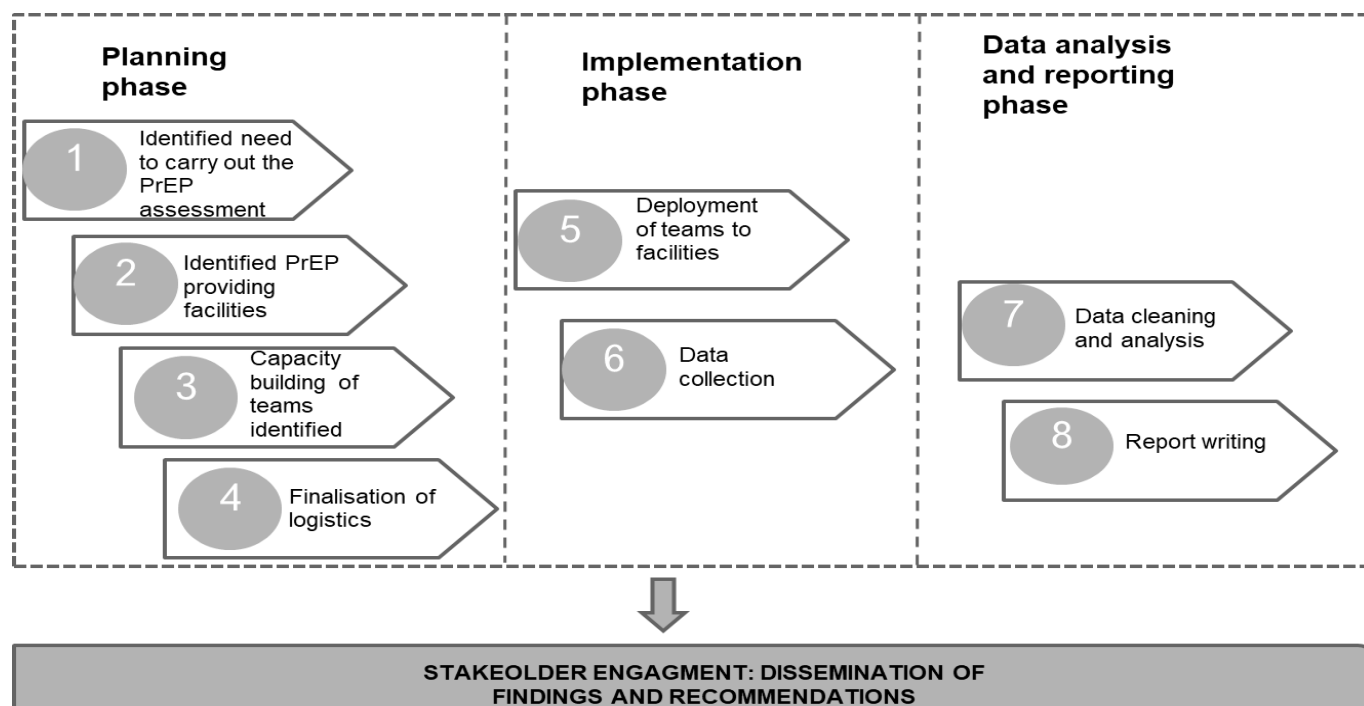


Figure 1: Process of data collection and analysis

2.2.1 Data collection

A GPS enabled electronic tool was developed and piloted prior to the actual data collection. The data collection teams comprising of staff from NASCOP, County Government (CASCO and SCASCO) and CHAI were trained on the data collection processes and tool.

2.2.2 Data analysis process

Data cleaning and analysis was carried out using Tableau Desktop-64 bit-10-5-1, Epi INFO version 3.5.4 and 7.2.2.6 and Microsoft excel.

3. FINDINGS

3.1 Facility Characteristics

Key findings

- Majority of the assessed facilities were Public (government owned) 640 (75.1%).
- Counties considered to have a high HIV burden had more facilities offering PrEP compared to those with low HIV burden.
- By facility level, Health Centre's accounted for the highest proportion of facilities providing PrEP
- Nairobi and Kisumu counties had the highest number of clients on PrEP; 5,445 and 4,880 respectively. Most of the counties had less than 100 PrEP clients.

3.2 Ownership of the PrEP providing Facilities

A total of 640 (75.1%), facilities were Government (public) owned facilities, 92 (10.8%) were Faith Based organizations (FBO's), 78 (9.2%) were Non-Governmental Organizations (NGOs) and 42 (4.9%) were privately owned as shown in Figure 2.

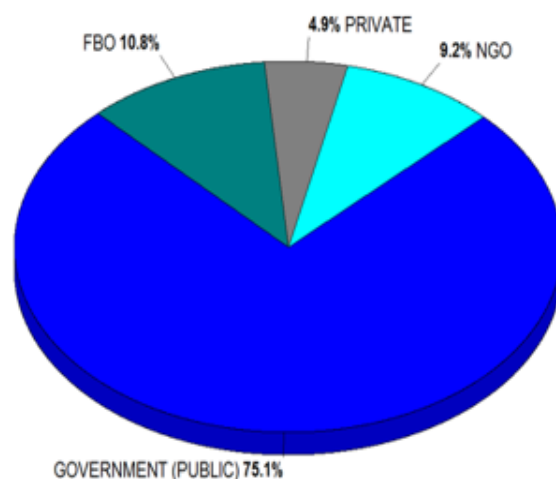


Figure 2: Distribution of facilities providing PrEP by ownership

3.3 Distribution of PrEP facilities by county

A total of 852 facilities were reported to be providing PrEP in 34 counties as at March 2018. Out of these facilities, Siaya County had 139 (16.3%) facilities, Kisumu had 99 (11.6%) facilities, Homabay had 88 (10.3%) and Nairobi had 68 (7.9%) facilities (Figure 3).

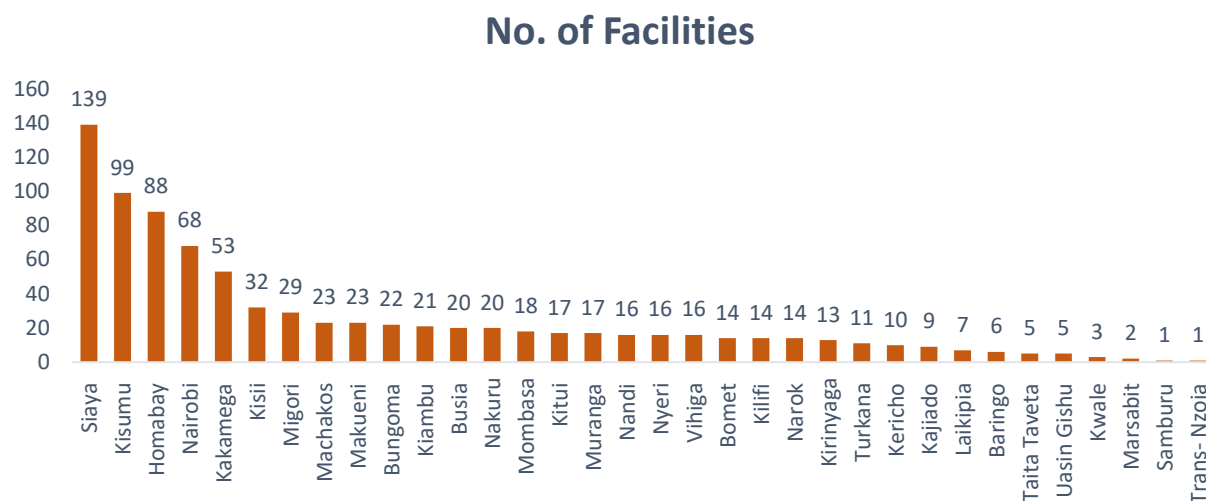


Figure 3: Distribution of facilities providing PrEP by county

A comparison between the county HIV prevalence and distribution of facilities providing PrEP by counties (Figure 4) illustrates that counties with high HIV prevalence had more facilities providing PrEP.

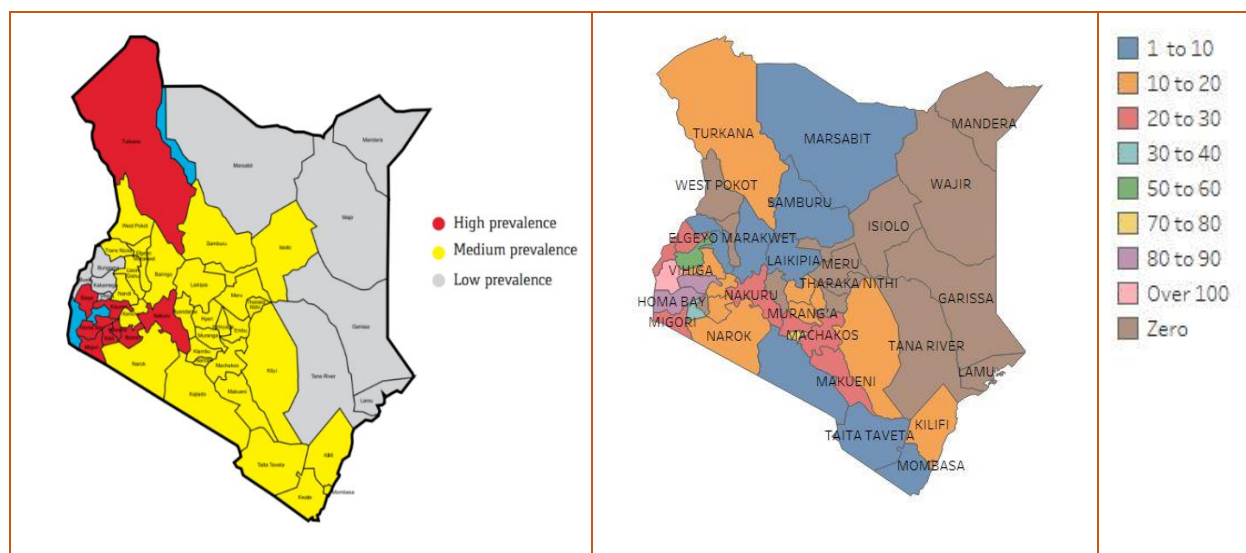


Figure 4 a): Map of Kenya showing HIV prevalence by county in 2013

Figure 4 b): Density map showing distribution of facilities offering PrEP by county

3.4 PrEP providing facilities by level

Of the 852 PrEP facilities, 270 (31.7%) were health centers, 187 (22.0 %) dispensaries, 143 (16.8%) sub-county hospitals and 2 (0.2%) National Referral. The were 152 (17.8 %) mission hospitals and/or private facilities and 50 (5.9%) DICE's (Table 1)

Table 1: Distribution of PrEP offering facilities by level

Level	n (%)
National Referral Hospital	2 (0.2%)
County Referral Hospital	34 (4.0%)
County Hospital	14 (1.6%)
Sub County Hospital	143 (16.8%)
Health Centres	270 (31.7%)
Dispensaries	187 (22.0%)
DICE	50 (5.9%)
Mission and Private	152 (17.8%)
TOTAL	852(100.0%)

The distribution of facilities by level varied from one county to another with counties like Siaya having 72 (26.7%) of their total facilities being health centers and 36 (19.2%) of them dispensaries. Nairobi county had 14 (28.0%) of drop in Centres (DICES) (Figure 5).

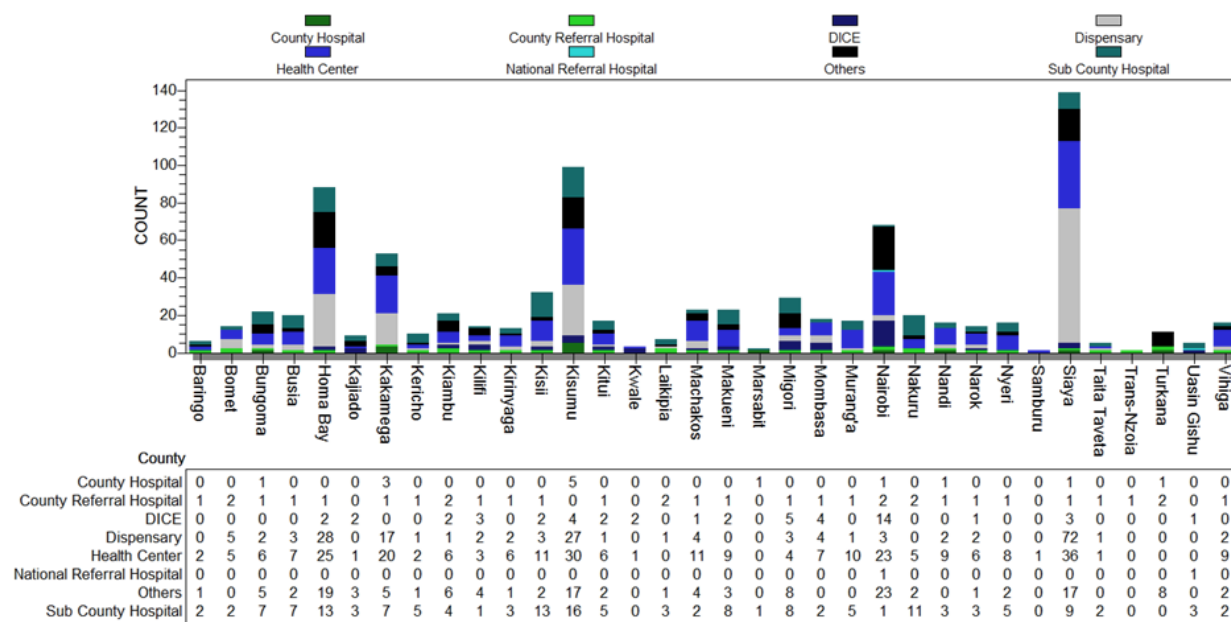


Figure 5: Distribution of PrEP offering facilities by level per county

3.5 Distribution of PrEP clients by county

Nairobi and Kisumu counties had the highest number of clients on PrEP, 5,445 and 4,880 respectively. Majority of the counties assessed had less than 100 clients (Figure 6).

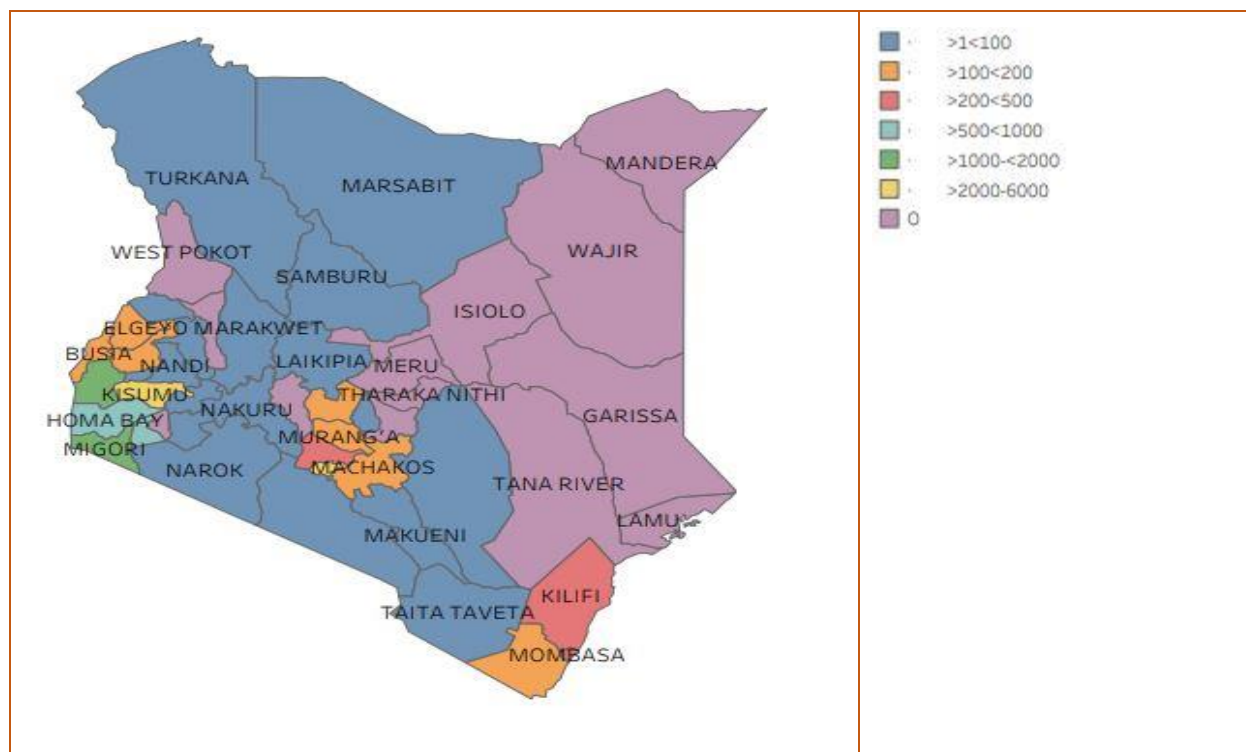
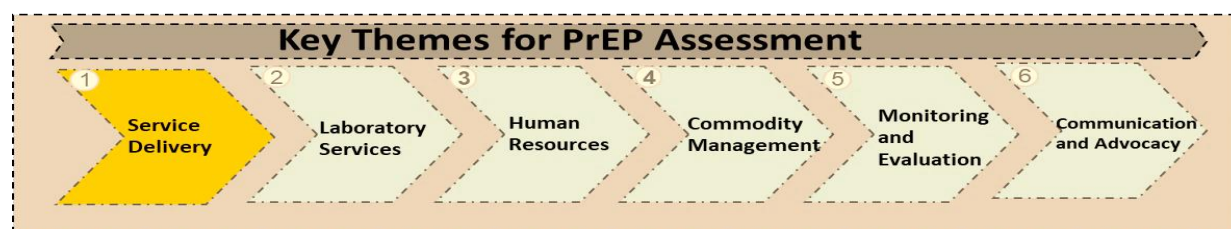


Figure 6: Distribution of PrEP users by County

3.6 Service delivery



To offer PrEP services, a set of minimum requirements that include trained human resources, selection of appropriate service delivery points, access to laboratory testing, availability of commodities among others are necessary. This section outlines the findings from the facilities assessed on the following areas; availability of a PrEP focal person, partner support, availability of other HIV services in the facilities, duration of PrEP delivery within the facilities, service provision points as well as populations receiving PrEP.

Key findings

- 659 (83.9%) of facilities started offering PrEP after the official launch in May 2017
- 691 (60.2%) of facilities assessed were offering PrEP in the CCCs
- Among the 852 facilities offering PrEP, 707 (83.0%) offered PrEP to discordant couples
- 736 (86.4%) facilities reported to have a PrEP focal person
- Implementing partner support for PrEP services was available in 765 (89.9%) facilities

3.7 PrEP focal person

The PrEP focal persons are expected to support coordination and dissemination of information on PrEP services within the facilities and are useful especially where PrEP is provided in multiple service points within the same health facility. Among the facilities assessed, 736 (86.4%) reported availability of PrEP focal person and it the availability varied from county to county (Figure 7)

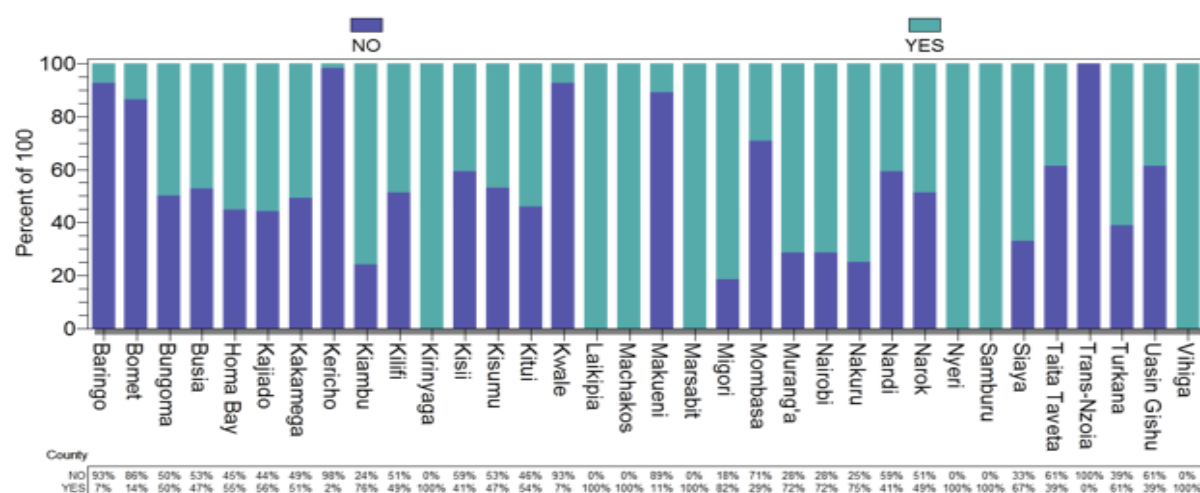


Figure 7: Availability of a PrEP focal person in facilities by county

3.7.1 Availability of Support for PrEP Services by the PrEP Implementing Partners

Partner support in facilities offering PrEP is important as it aids in the implementation of services. A total of 766 (89.9%) facilities assessed reported having a partner supporting PrEP services. The support for monitoring and evaluation was reported in 641(83.8%) of facilities, whereas human resource hiring support was reported in 569 (74.4%) and support for IEC materials in 521(68.1%) facilities (Table 2).

Partner support is available and supports routine components expected for service delivery such as human resource, monitoring and evaluation and information, education and communication.

Table 2: Implementing partners support in facilities

Type of Partner Support Provided	n (%)
M&E tools	641(83.8%)
Hiring staff	569 (74.4%)
IEC materials	521(68.1%)
Provision of equipment and furniture	467 (61.1%)
Laboratory support	38(50.3%)
Others (capacity building, transport allowance, advocacy)	189(22.2%)

A total of 11 counties reported presence of implementing partners in all the facilities assessed, with Kericho and Marsabit counties reporting no partner support in any of their PrEP providing facilities (figure 8).

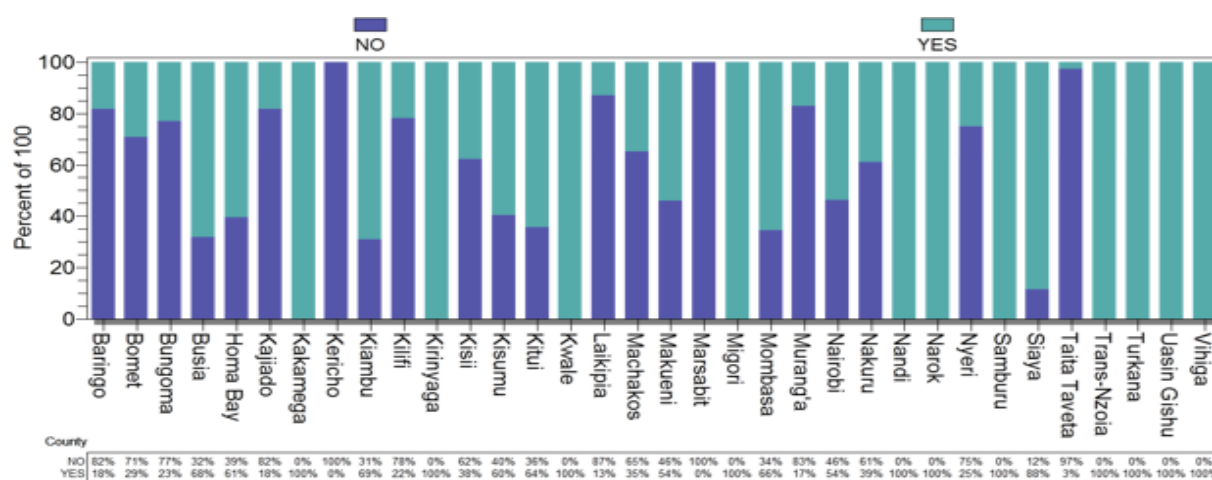


Figure 8: Proportion of facilities with PrEP implementing partners support by county

3.7.2 Availability of HIV services in facilities

Pre-Exposure Prophylaxis is provided as part of combination prevention and we assessed availability of other HIV services in the facilities visited. HIV Testing Services (HTS) were provided in 822 (96.5%) facilities, ART 801 (94.0%) facilities and other services including family planning, distribution of condoms, STI screening, cervical cancer screening, nutrition and gender-based violence screening and management, services for Key populations and VMMC were provided in fewer facilities (Figure 9). Majority of the facilities providing PrEP provided other HIV related services.

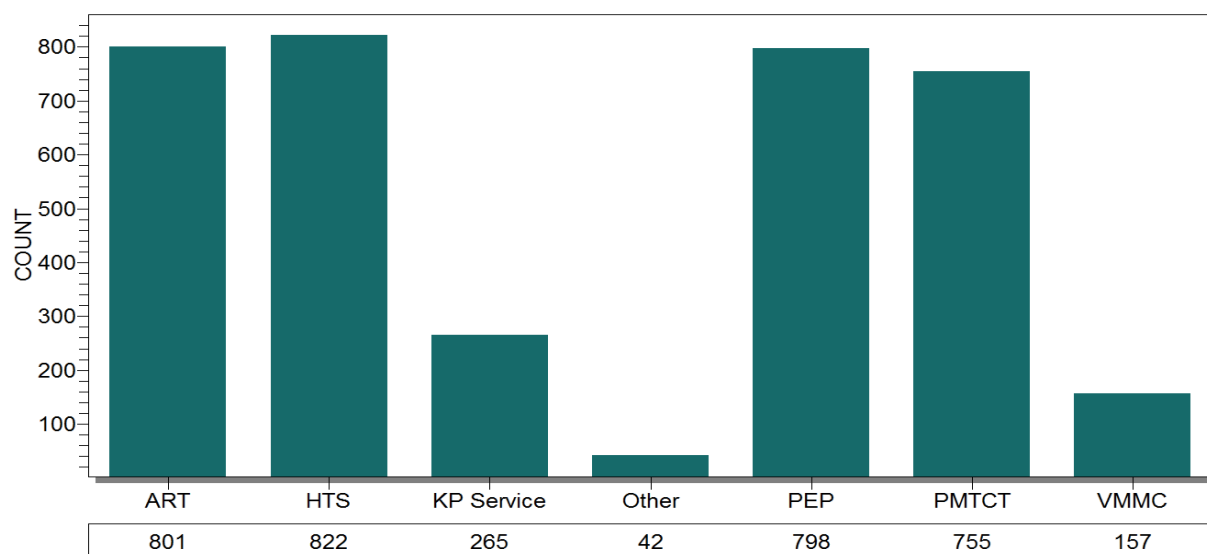


Figure 9: Availability of other HIV services in facilities providing PrEP

3.7.3 Service Delivery Points (SDPs) offering PrEP in the facilities

PrEP services were offered to the clients at different Service Delivery Points (SDPs) located within the facilities. The CCC's were the most common service delivery points 691 (60.2%) followed by PMTCT/ MCH 229 (20%). Others included DICE's 55(4.8%) and OPD 88(7.7%).

The distribution of SDPs within facilities differed across the counties (figure 10).

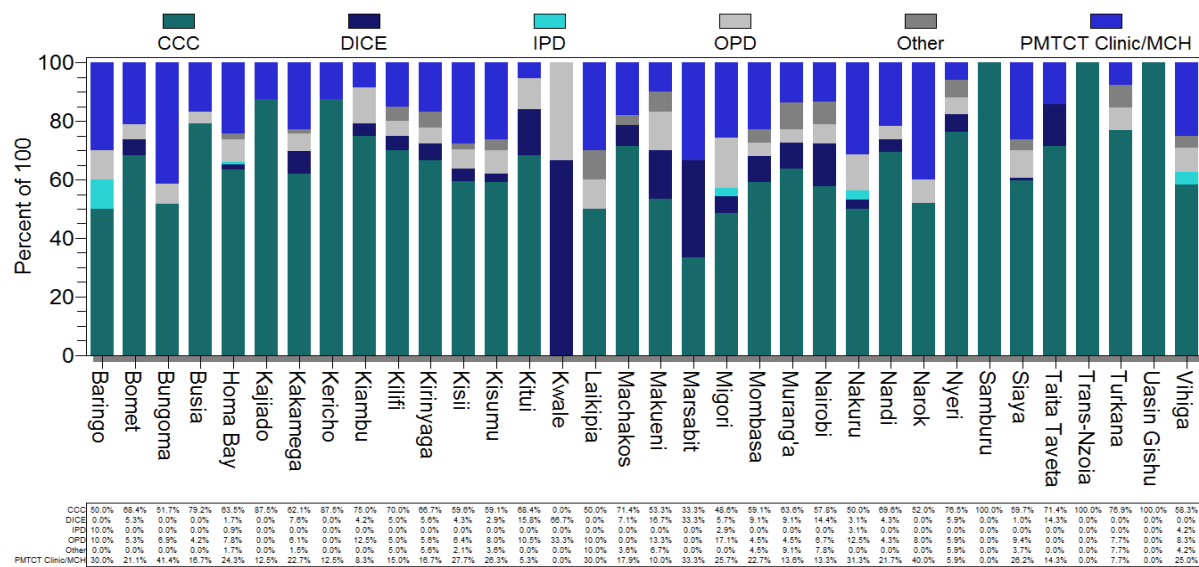


Figure 10: Distribution of service delivery points by county

3.7.4 Duration of PrEP provision in facilities

The implementation framework for PrEP was launched in May 2017 in Kenya. Prior to this, PrEP was mainly provided in a limited scale within demonstration and pilot projects that sought to determine acceptability and feasibility of providing PrEP among different populations.

A total of 659 (83.9%) started PrEP implementation after the launch of the PrEP framework, while 122 (16.0%) facilities commenced following the inclusion of PrEP into the national guidelines in July 2016. Four facilities reported provision during demonstration projects phase. Rapid scale up of PrEP provision has taken place since the national launch of the PrEP implementation framework as noted by the proportion and number of facilities that commenced PrEP provision in mid-2017

3.7.5 Populations receiving PrEP in facilities

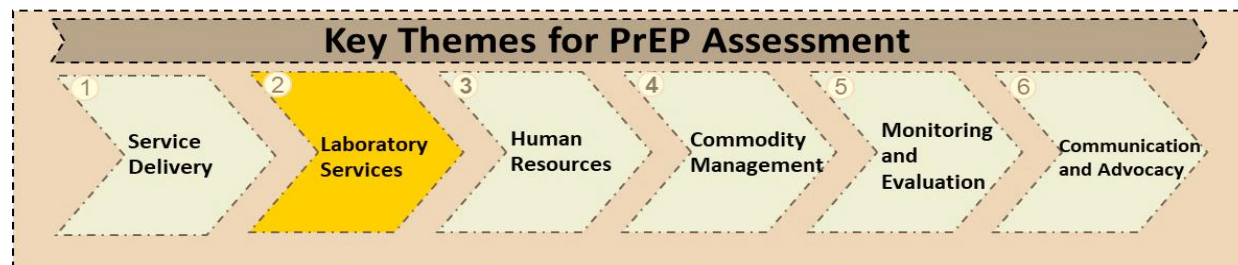
PrEP is provided to all at substantial ongoing risk for HIV infection. A total of 707 (83.0%) of the facilities were offering PrEP to discordant couples, 163 (19.1%) offered to FSWs and 95 (11.2%) to MSM (table 3).

HIV treatment centers commonly referred to as comprehensive care centers (CCCs) were the major service delivery point in most of the facilities assessed. This may explain why majority of the facilities assessed offered PrEP to HIV Sero-discordant couples as they could easily be identified through partner notification system routinely carried out at the CCCs.

Table 3: Key populations targeted for PrEP in facilities

Population	n (%)
Discordant Couples	707 (83.0%)
General Population	256 (30.0%)
FSW - Female Sex Workers	163 (19.1%)
Adolescents & young girls & women	126 (14.8%)
MSM - Men who have sex with men	95 (11.2%)
PWID	31 (3.6%)

3.8 Laboratory Services



Baseline laboratory tests which include a rapid HIV test, Hepatitis B (Hep B) Hepatitis C (Hep C) are recommended before PrEP initiation. A negative HIV test is a requirement prior to PrEP initiation while the other tests recommended should not delay PrEP initiation among eligible clients and efforts should be made to carry out the testing soonest possible. PrEP is contraindicated if baseline Creatinine Clearance $\text{CrCl} < 50 \text{ ml/min}$. The Hepatitis B surface antigen (HBsAg) test is advisable and where the results are negative then Hepatitis B vaccine should be offered and where the findings are positive then Hepatitis B treatment should be considered. Hepatitis C test is advisable especially for PWID and where results present as positive, Hepatitis C treatment should be given.

Key findings

- Majority of the facilities did not have access to recommended baseline tests: creatinine testing was inaccessible in 560 (65.7%) of the facilities, Hepatitis B in 550 (64.6%) and Hepatitis C in 636 (74.6%) of the facilities.
- Baseline testing equipment and reagents were unavailable in a majority of the facilities
- The facilities that had access to laboratory testing carried out most of the tests off – site.

3.8.1 Creatinine Testing

Of the 852 facilities, 292 (34.3%) had access to creatinine testing. Access to creatinine testing varied in the facilities assessed across all counties (figure 11). The facilities assessed in Samburu and Trans-Nzoia counties had no access to creatinine testing.

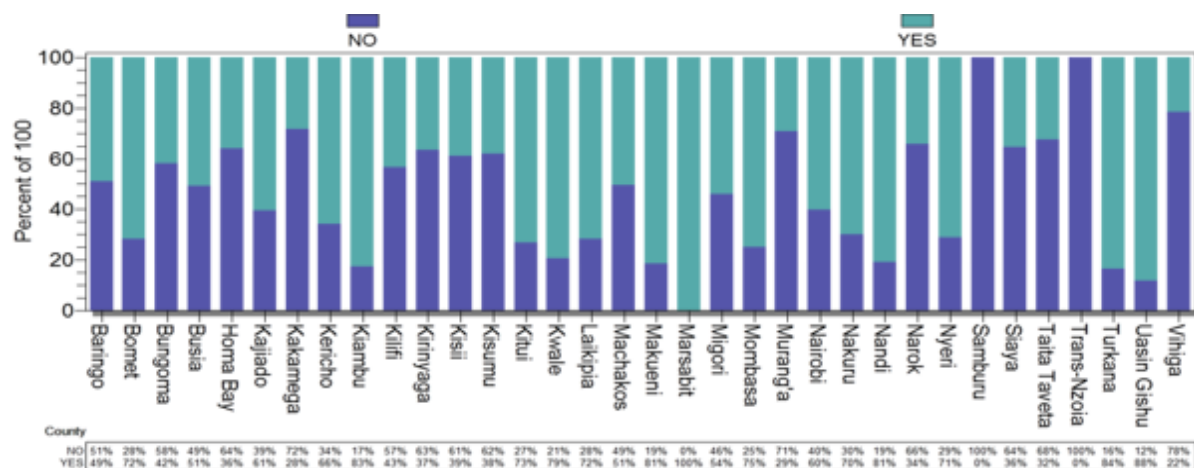


Figure 11: Access to creatinine testing in facilities by county

Among the 292 facilities with access to creatinine testing, 157 (53.8%) had on-site access to testing i.e. they had the equipment and reagents to carry out the test onsite. The distribution of on-site versus off-site testing also varied from one county to another (figure 12).

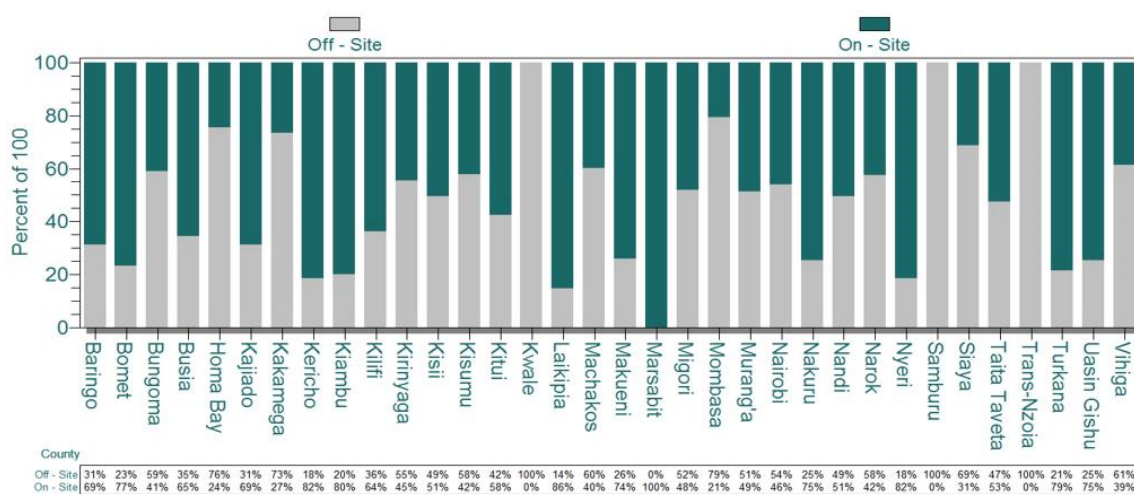


Figure 12: Proportion of facilities that carry out creatinine testing onsite vs offsite

3.8.2 Hepatitis B Testing

There were 302 (35.4%) facilities that had access to Hep B testing among all the facilities assessed. Onsite testing for those that had access to Hep B testing was available in 207 (68.5%) of the facilities but only 203 (67.2%) of the facilities with access had equipment to conduct the test. Access and testing offsite vs onsite varied from one county to another (Figure 13 and 14)

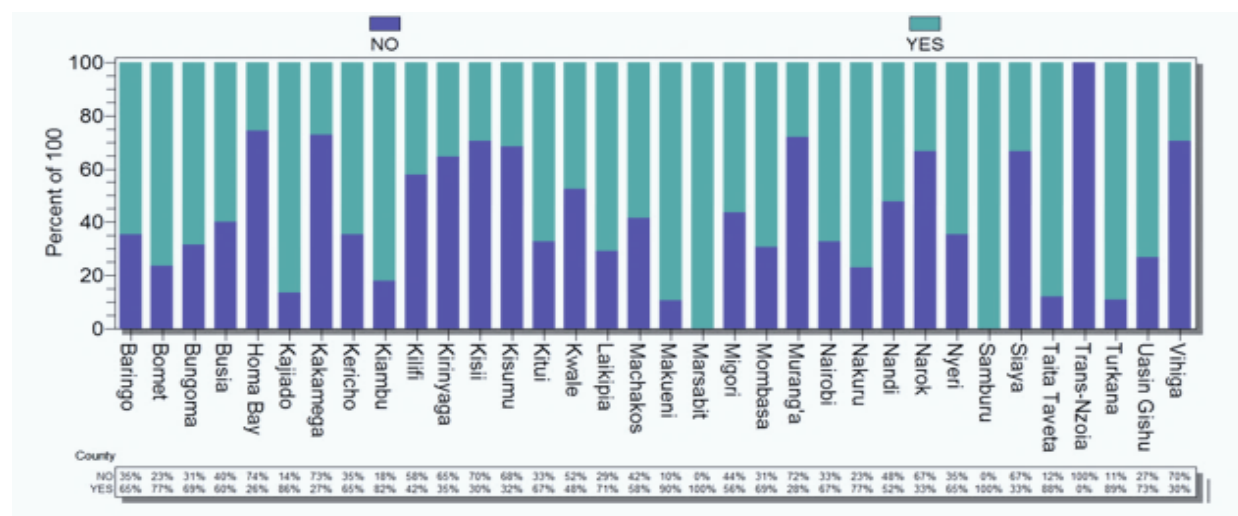


Figure 13: Access to Hepatitis B Testing by county

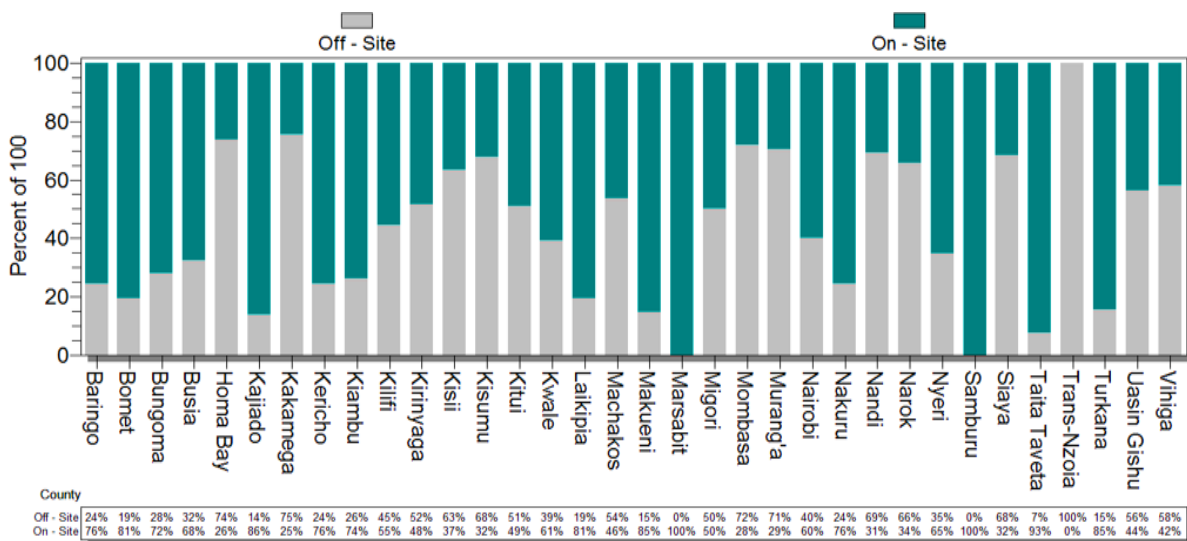


Figure 14: Proportion of facilities that carry out Hepatitis B testing onsite vs offsite

The two facilities assessed in Marsabit and the one facility assessed in Samburu and Trans-Nzoia counties respectively had testing equipment for Hep B. It is important to note that although the facility in Trans- Nzoia County had access to the Hepatitis B testing equipment, testing was done off-site (Figure 15)

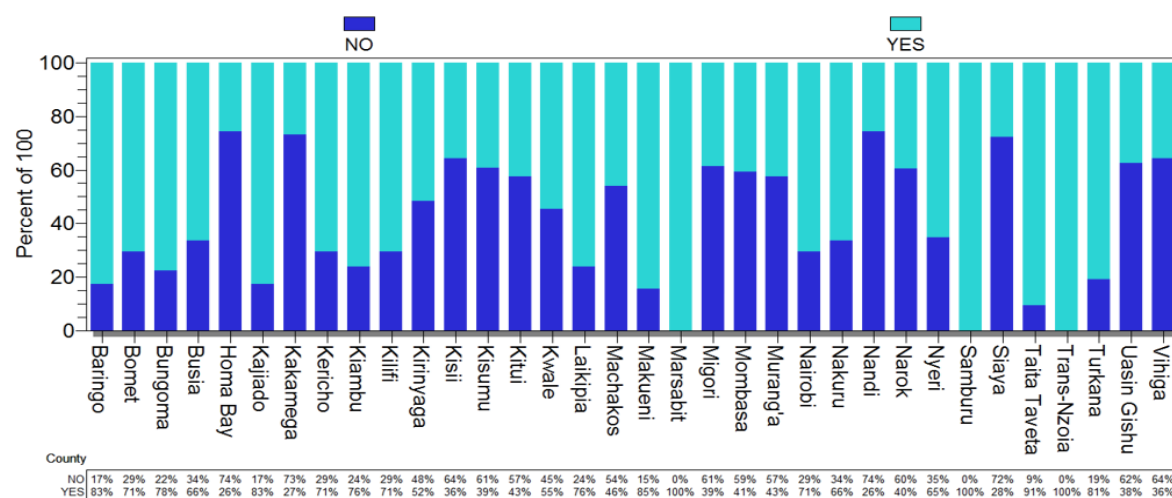


Figure 15: Availability of Hepatitis B testing equipment by county

3.8.3 Hepatitis C Testing

Of the 852 facilities assessed, only 216 (25.4%) reported having access to Hepatitis C antibody testing. Figure 16 shows the distribution of access by county.

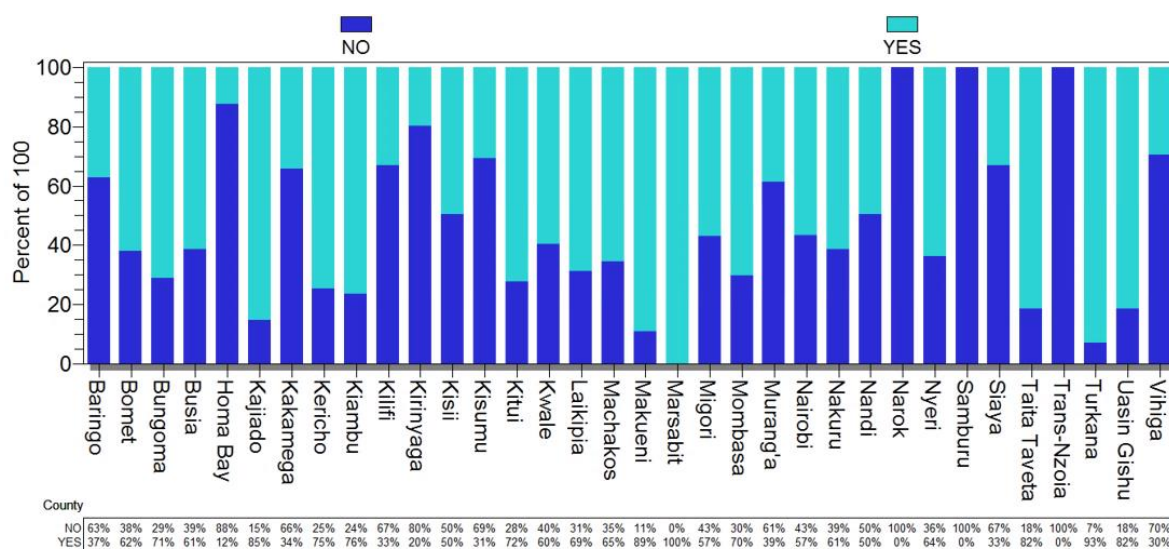


Figure 16: Access to Hepatitis C testing in facilities by county

Of the 216 facilities reporting access to Hepatitis C testing, 122 (56.5%) had onsite testing and in majority of the counties, facilities had access to both onsite and offsite testing. However, the two facilities assessed in Marsabit County had onsite testing while all the facilities assessed in Kwale, Nandi, Narok, Samburu and Trans-Nzoia counties accessed the test offsite.

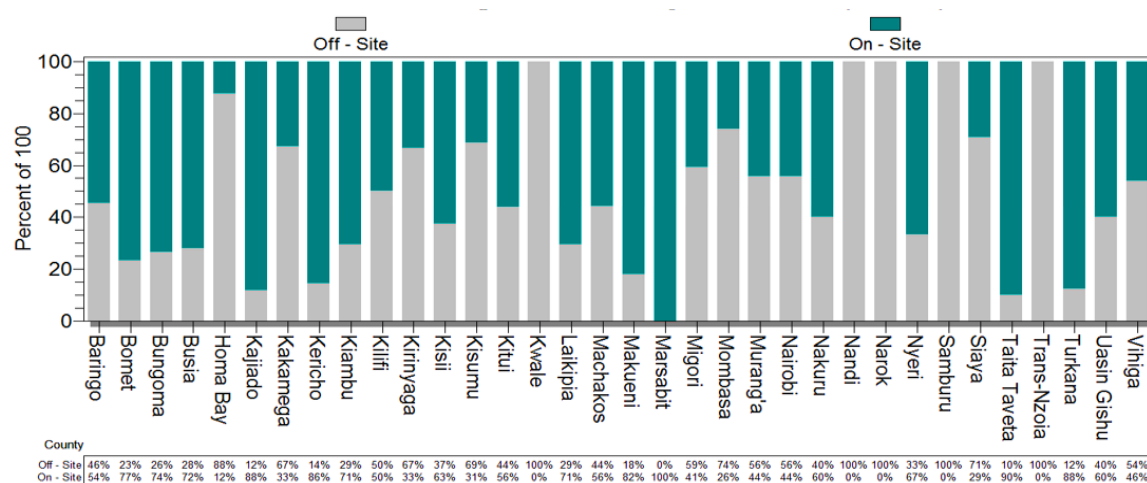


Figure 17: Proportion of facilities that carry out Hepatitis B testing onsite vs offsite

Among the 216 facilities that had access to Hepatitis C testing, 120 (55.6%) had equipment on site to conduct Hepatitis C antibody testing. All assessed facilities in Kwale, Nandi, Samburu and Trans-Nzoia counties had no equipment (Figure 18)

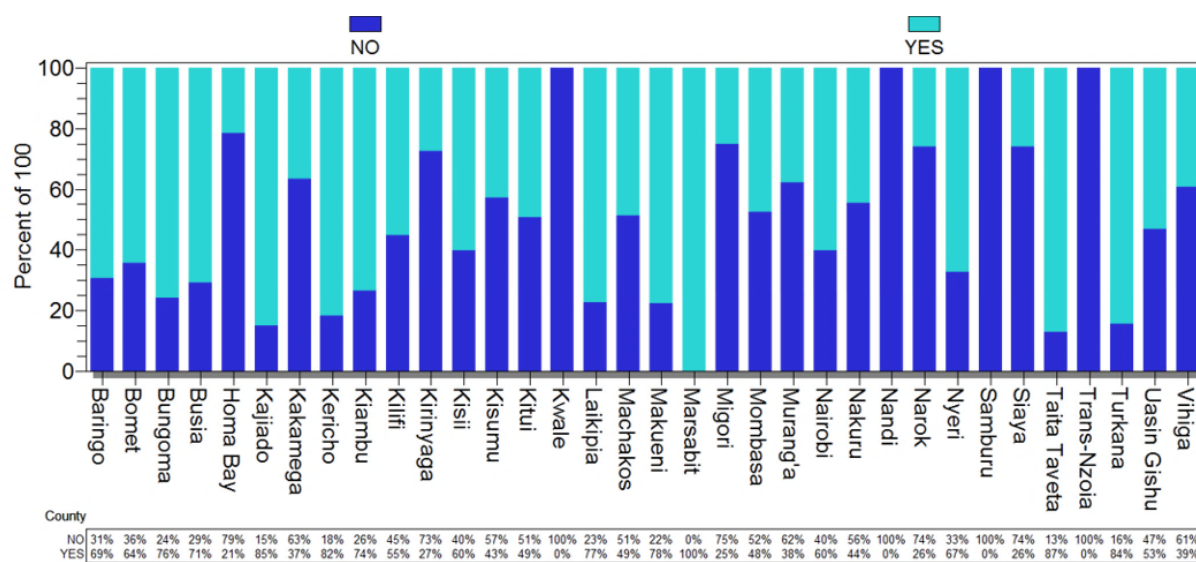
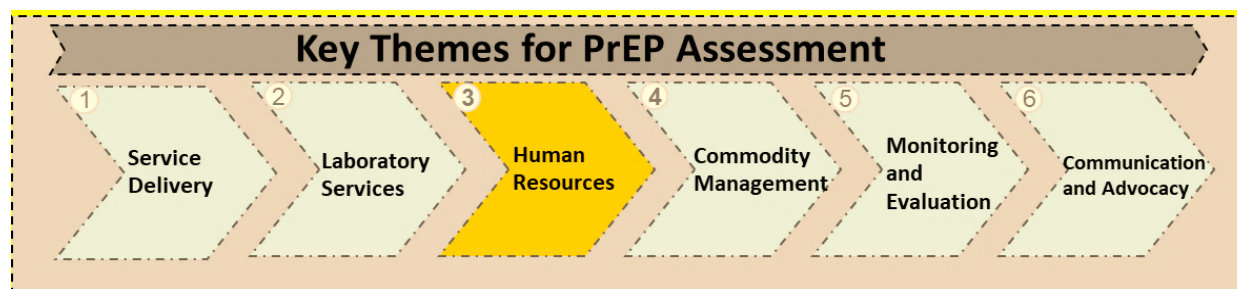


Figure 18: Availability of Hepatitis C testing equipment in facilities by county

3.9 Human Resources for PrEP Service Provision



For provision of PrEP services, adequate numbers of skilled health care workers are needed. The providers should be trained in clinical, counselling and commodity management reporting to ensure that handling, prescription and dispensing of PrEP is done in line with national guidelines. The assessment sought to determine the availability of trained health care workers in facilities providing PrEP. Following the launch of the PrEP implementation framework in May 2017, NASCOP developed a 3-day training package for sensitization of health care workers to provide PrEP. However, as a significant number of facilities had already initiated PrEP service provision even prior to the launch of the framework, implementing partners had developed packages for sensitization of providers in facilities. The assessment sought to determine the availability of trained providers and the type of training undertaken.

Key findings

- 487(57.0%) facilities had at least one health care worker trained on the provision of PrEP
- In the facilities with trained providers, majority; 376 (77.2%) had between 1-3 personnel trained on PrEP
- Of the 487 facilities with trained staff, 333 (63.8%) of the facilities had personnel trained using NASCOP PrEP training curriculum while 119 (22.8%) of the facilities had personnel trained using partner PrEP training curriculum
- A total of 997 staff were trained where 396 (39.7%) of those trained comprised of clinical officers and 16 (1.6%) medical doctors.

3.9.1 Availability of trained personnel

Of the 852 facilities, 487 (57.0%) reported having personnel trained on provision of PrEP. In 333 (68.4%) facilities, the staff were trained using NASCOP PrEP training curriculum while 118 (24.2%) were trained using partner training curriculum and 36 (7.4%) facilities, the staff were trained using both NASCOP and partners training curriculum (table 4).

Table 4: Type of training curriculum by facility

Type of Training	n (%)
NASCOP PrEP training	333 (68.3%)
Partner training curriculum	118 (24.3%)
NASCOP PrEP training and Partner training package	36 (7.4%)

Among the 34 counties assessed, four counties: Kwale, Marsabit, Samburu and Trans Nzoia, had at least one personnel trained in all their PrEP providing facilities. Ten counties i.e. Bomet, Kajiado, Kirinyaga, Laikipia, Migori, Nakuru, Nandi, Turkana, Uasin Gishu and Vihiga had no personnel trained in most of the facilities providing PrEP (Figure 19).

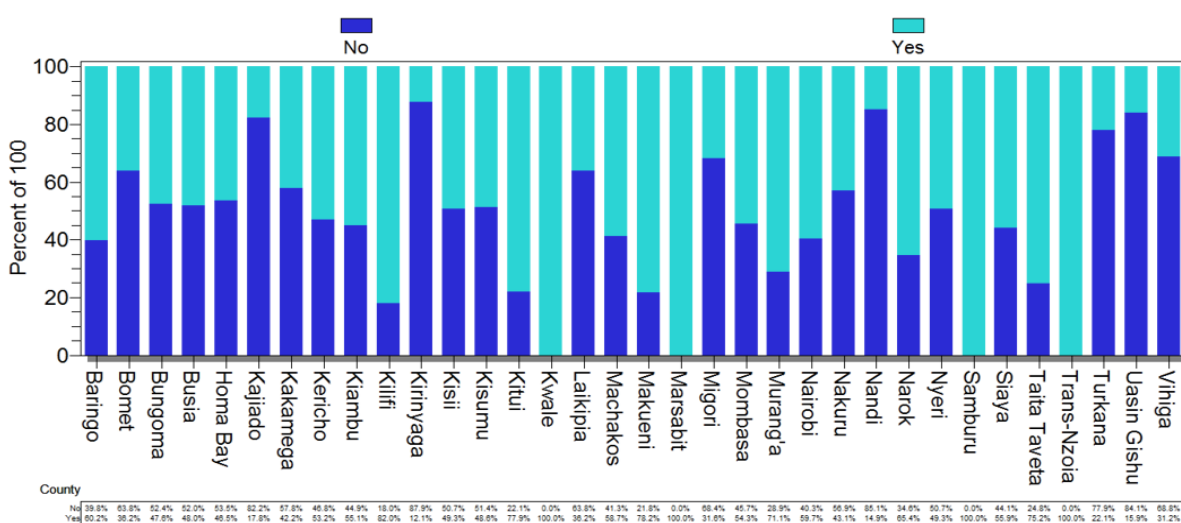


Figure 19: Distribution of facilities with trained personnel by county

3.9.3 Proportion of trained personnel by facility and county

Four hundred and eighty-seven facilities provided data on the number of staffs trained in PrEP of which 376 (77.2%) had between 1-3 personnel trained on PrEP (table 5).

Table 5 : Proportion of trained personnel by facility

Personnel Trained	n (%)
1-3	376(77.2%)
3-6	69(14.2%)
>6	42 (8.6%)
TOTAL	487(100.0%)

In ten counties: Baringo, Bungoma, Kajiado, Kirinyaga, Kwale, Samburu, Taita Taveta, Trans-Nzoia, Uasin Gishu and Vihiga all facilities had 1-3 personnel trained on PrEP while Marsabit county reported 3- 6 personnel trained in all their facilities (Figure 20).

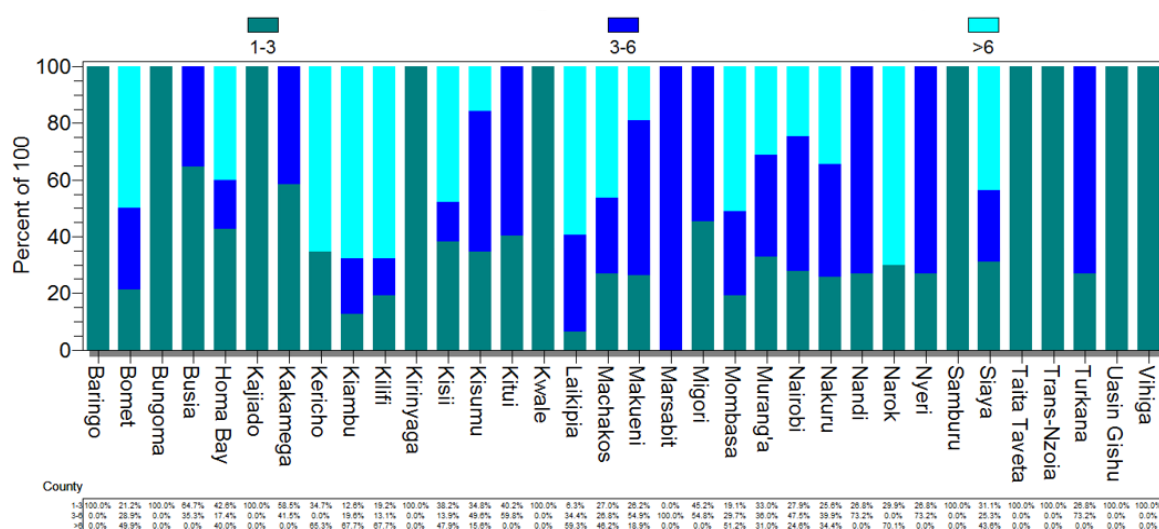


Figure 20: Distribution of number of trained personnel by facilities by county

3.9.4 Distribution of cadres trained on PrEP

There were 997 personnel trained in total and they were distributed as follows; Clinical Officers 396 (39.7%), Nurses 273 (27.4%), Medical Officers 16 (1.6%) and Other cadres which includes Health Records Information Officers, Laboratory Technologists and Social Workers 53(5.3%) (figure 21).

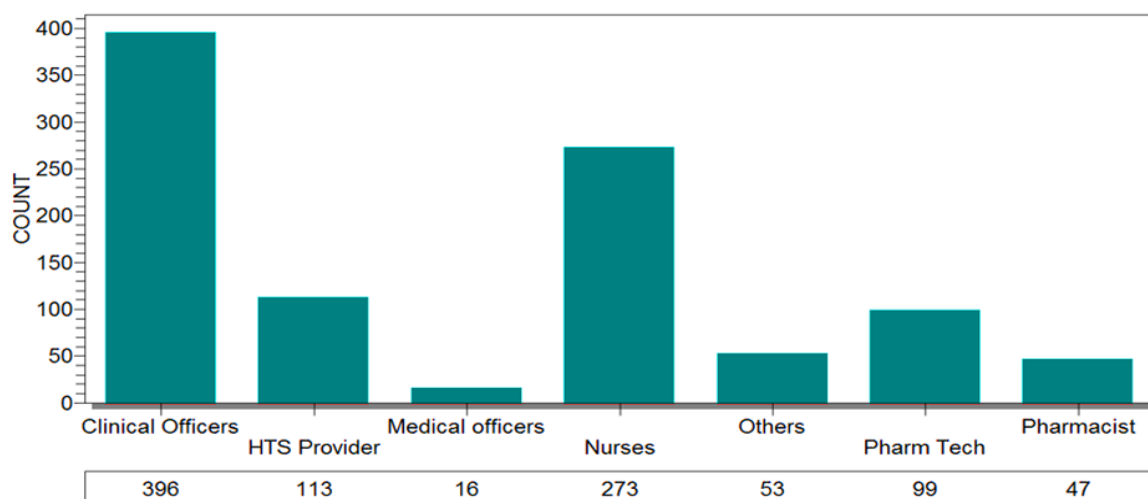


Figure 21: Distribution of cadre trained on PrEP

3.9.5 Proportion of cadres trained and providing PrEP service

Of the 997 trained personnel, 573 (57.6%) were providing PrEP service at the time of assessment. Nurses were 158 (27.8%), Clinical Officers at 130 (23.0%) and Medical Officers had the least proportion trained and providing service PrEP 13(2.3%) (Table 6). Few HIV testing service providers were trained, yet HTS forms the primary entry point for PrEP creating a big gap in the delivery of PrEP services

Table 6: Proportion of cadres trained and providing PrEP service.

Cadre	n (%)
Nurse	158(27.8%)
Clinical Officers	130(23.0%)
Pharm Tech	130(22.7%)
HTS Provider	84 (14.7%)
Pharmacist	58(10.1%)
Medical officers	13(2.3%)
TOTAL	573(100.0%)

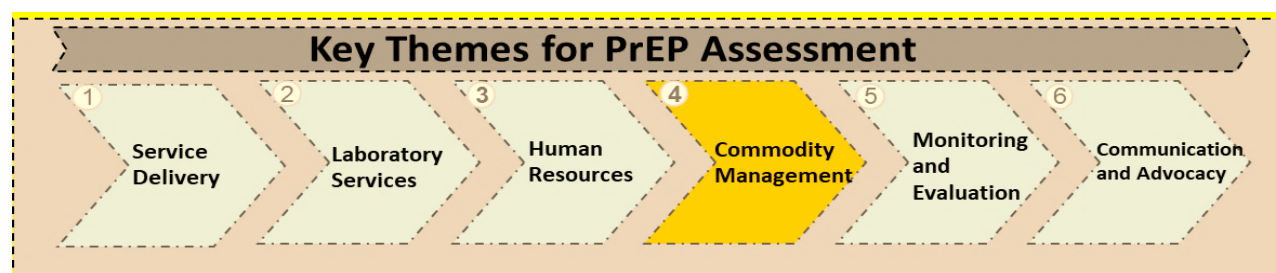
3.9.6 Location of trained personnel

The 573 trained staff who were actively providing PrEP were located at different sites as follows; 221 (38.6%) were located at HIV treatment centers (CCCs), 145 (25.3%) in drop in centers while the outpatient departments had the least number of PrEP trained personnel dispensing PrEP (Table 7).

Table 7: Location of PrEP trained personnel

SDP	n (%)
CCC	221(38.6%)
DICE	145(25.3%)
FP Clinic	76(13.3%)
IPD	71(12.4%)
PMTCT/ MCH	39(6.8%)
Others	17(3.0%)
OPD	4(0.7%)
TOTAL	573(100.0%)

3.10 Commodity Management



Availability and management of commodity supply is critical in the effective provision of PrEP services. In Kenya, PrEP products are defined by the Guidelines for Antiretroviral drugs for Treating and Preventing HIV (2018), which recommends the use of TDF/FTC as the preferred drug, with TDF/3TC and TDF as alternative drugs.

Procurement, warehousing and distribution of HIV commodities is done centrally by KEMSA. Distribution of PrEP products is integrated into the national supply chain pipeline for all ARVS in the country based on monthly reports. The national ARVs supply chain network has classified facilities into three based on facility capacities: Central sites (ART facilities ordering ARVs from KEMSA on behalf of other facilities), Standalone sites (ART facilities ordering ARVs from KEMSA but not for other facilities) and ART satellite sites (ART facilities ordering ARVs from ART central sites). To maintain quality and consistency of services provided by the facility there needs to be trained personnel, and effective commodity management systems

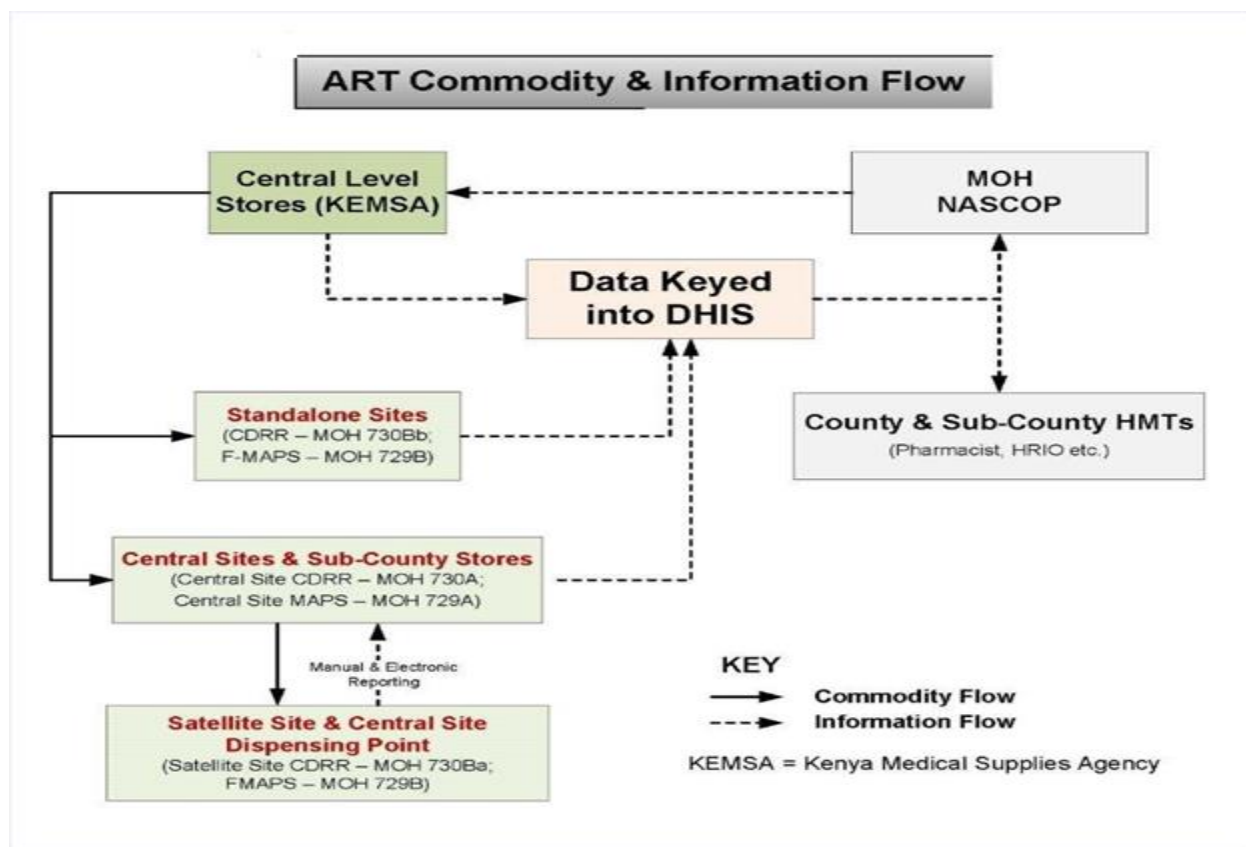


Figure 22: ART commodity and information flow

There are 467 ART ordering sites, 308 central sites, 159 standalone sites and over 3,400 ART satellite sites, based on DHIS mapping data.

The assessment sought to determine availability of ARV medicines for PrEP, the preferred ARVs in use and where dispensing took place.

Key findings

- 714 (87.7%) facilities were dispensing the recommended regimen (TDF/FTC)
- 432 (53.3%) facilities were satellite ARV receiving sites
- 32.2% of facilities had more than the recommended three months of stocks (3 MOS) while 10.1% of the facilities assessed had stock outs
- Electronic ART dispensing tools were found to be in use in 429 (52.4%) of facilities, while the rest 390 (47.6%) were using manual tools

3.10.1 ARVs distribution and supply sources

The sources of ARVs for the 810 facilities that responded were 90 (11.0%) facilities were central sites, 288 (35.6%) standalone sites and 432 (53.3%) satellite sites (Figure 23).

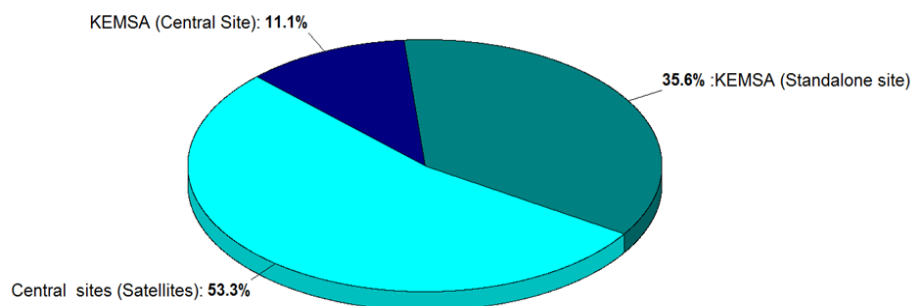


Figure 23: Source of ARVs in facilities assessed

3.10.2 Analysis of sources of ARVs by county

An analysis of the source of ARVs by county is as outlined in the figure 24.

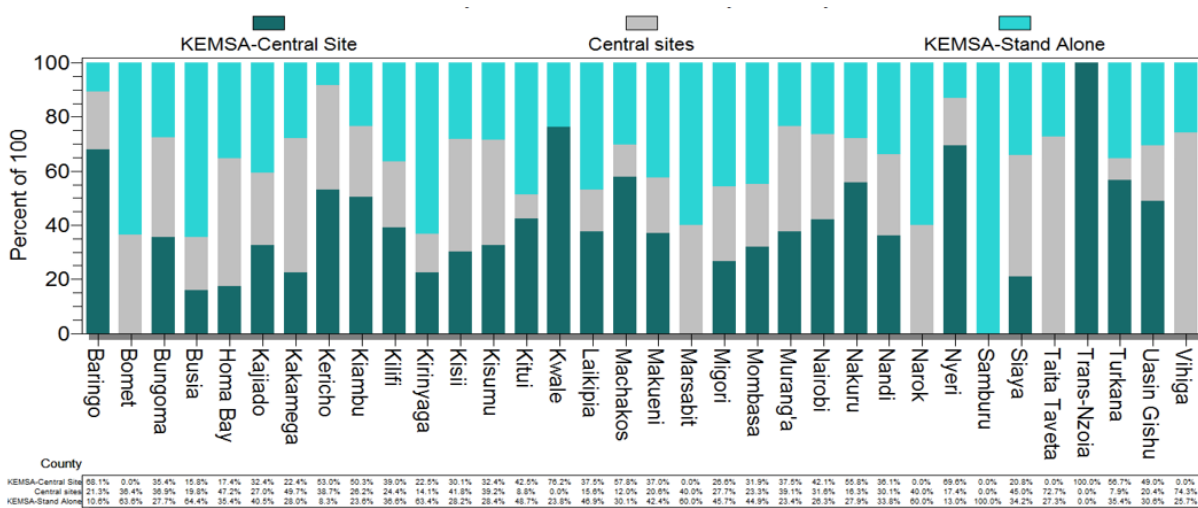


Figure 24: Facility source of ARVs by county

3.10.3 Dispensing points for PrEP

A total of 939 dispensing points were reported from the 852 facilities assessed with some facilities dispensing PrEP at more than one dispensing point.

There were 634 (67.5%) CCC's and 105(11.2%) PMTCT/ MCH clinics. Other dispensing points identified included facility pharmacies, safe spaces, outreaches, and youth friendly services (Table 8). CCC's were the main PrEP dispensing points in the counties, this could be attributed to the fact that discordant couples were the largest population of clients receiving PrEP.

Table 8: PrEP dispensing points for facilities assessed

Where PrEP is dispensed	n (%)
CCC	634(67.5%)
PMTCT/ MCH Clinic	105(11.2%)
OPD	77(8.2%)
DICE	19(2.0%)
FP	10(1.1%)
IPD	1(0.1%)
Others	93(9.9%)
TOTAL	939(100.0%)

The distribution of the various dispensing points by county is as illustrated in figure 25.

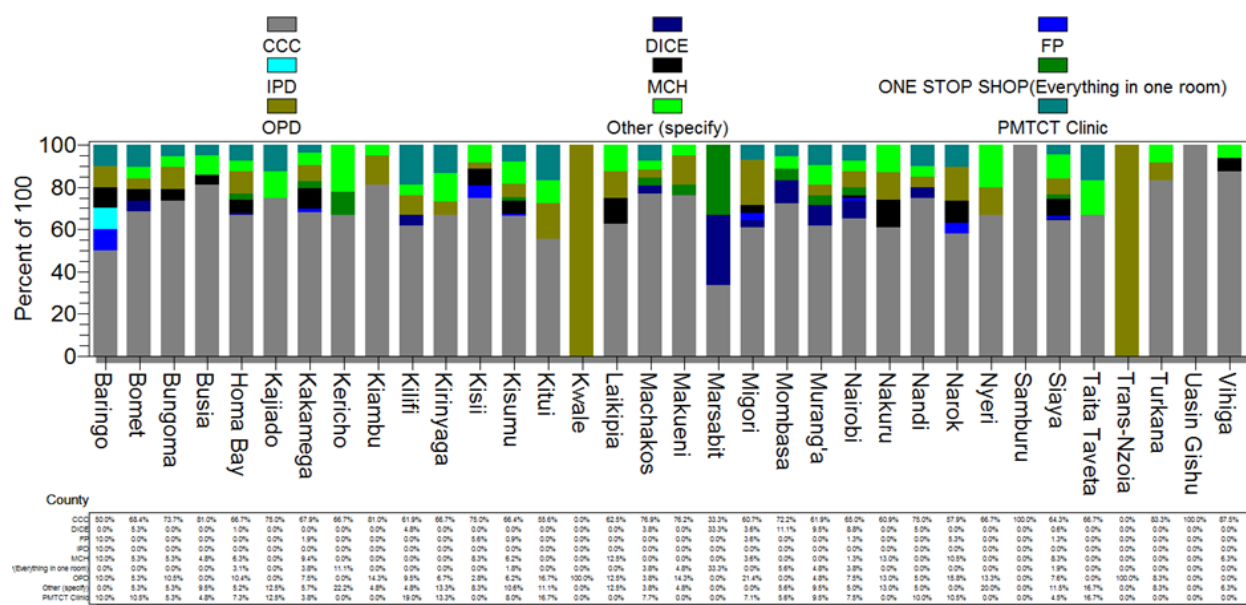


Figure 25: PrEP dispensing points in facilities by county

3.10.4 Antiretroviral medicine stock levels in facilities

The national guidelines for pipeline monitoring of HIV Commodities recommends that facilities should hold a minimum of one month's consumption stock (MOS) and a maximum of three months' consumption stocks for ARV medicines. Of the 833 facilities that responded, 338 (40.6%) had between 0 to 2 MOS while 84 (10.1%) facilities reported to have stock out (Table 9). In majority of the facilities, the recommended MOS were not adhered to. Some of the facilities had excess stock while others had stock outs. It is important to note that there were facilities with stock but no clients.

Table 9: Stock levels in facilities

Months of stocks	n (%)
0-2 months	338(40.6%)
2-3 months	75(9.0%)
3-6 months	114(13.7%)
6-15 months	103(12.4%)
Above 15 months	6.1%
Had client no stock	84(10.1%)
No clients with stocks	41(4.9%)
No clients/No Stocks	27(3.2%)
TOTAL	833 (100.0%)

3.10.5 PrEP regimens dispensed

Of the 814 facilities that provided information on type of ARV regimen used for PrEP, 714 (87.7%) dispensed the preferred TDF/FTC while 92 (11.3%) dispensed TDF/3TC and Eight (1%) dispensed TDF alone (Table 10). Majority of the facilities assessed adhered to dispensing the recommended PrEP regimen as stipulated in the guidelines.

Table 10: PrEP regimens dispensed at facilities assessed

PrEP product being dispensed	n (%)
TDF/FTC	714(87.7%)
TDF/3TC	92(11.3%)
TDF	8(1.0%)
TOTAL	814(100.0%)

3.10.6 Type of PrEP dispensing systems

There were 819 facilities that used PrEP dispensing systems where 390 (47.6%) used manual registers, 157 (19.2%) Web ADT and 122 (14.9%) IQ Care (Table 11). There were different commodity management systems in place, however it was noted that majority of the facilities were using manual registers which poses a challenge with workload management and ability to analyze and disseminate data rapidly.

Table 11: PrEP dispensing systems used

Systems	n (%)
Manual registers	390(47.6%)
Web ADT	157(19.2%)
IQ Care	122(14.9%)
Kenya EMR	79(9.6%)
Access ADT	39(4.8%)
EDDIT	32(3.9%)
TOTAL	819 (100.0%)

The county analysis of the distribution of PrEP dispensing systems in facilities is as shown in Figure 26.

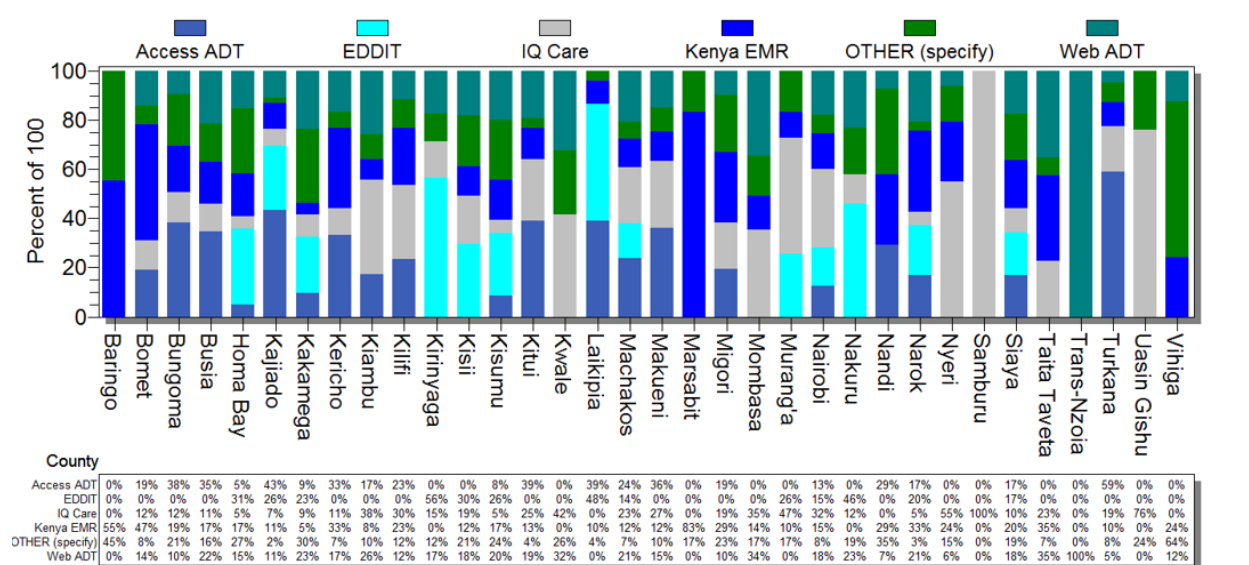


Figure 26: PrEP dispensing software in facilities by county

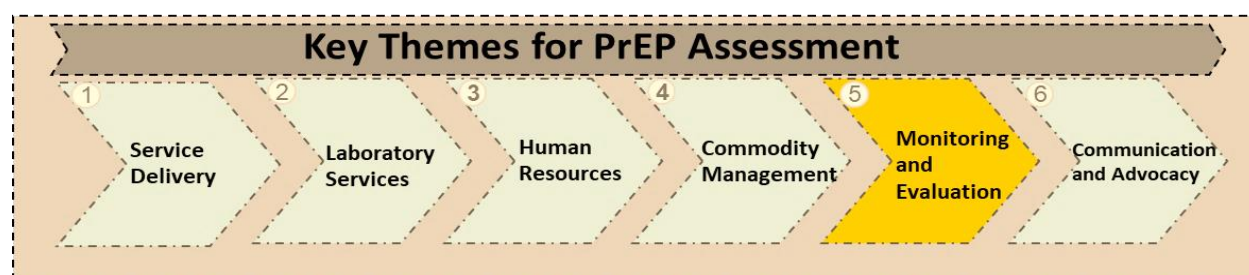
3.10.7 Proportion of personnel dispensing PrEP trained

A total of 471 personnel was dispensing PrEP of which 354 (75.2%) were trained on PrEP while 316 (67.1%) had undergone a 3 -5-day pharmacovigilance training (Table 12).

Table 12: Proportion of personnel dispensing PrEP trained on pharmacovigilance

Personnel Dispensing Trained on PrEP	n (%)	Personnel Trained on pharmacovigilance	n (%)
YES	354(75.2%)	YES	316(67.1%)
NO	117(24.8%)	NO	155(32.9%)
TOTAL	471(100.0%)	TOTAL	471(100.0%)

3.11 Monitoring and Evaluation



Monitoring and evaluation provides information on how well the PrEP program is being implemented. It entails the process of data collection, analysis, documentation and dissemination. These processes require tools (either manual or EMR) to aid in effective and efficient data management therefore standardizing reporting for PrEP data elements across the country. The national program developed and disseminated various tools to facilities to facilitate reporting for PrEP.

Some of the M&E tools in use are:

- LMIS tool - Used to collect data for commodities to aid in proper planning of supply of commodities;
- PrEP Clinical Encounter record - Used for recording information of all PrEP package services offered to a client at the initial, and subsequent visits;
- Pharmacovigilance tools - Used to report Adverse Drug Reactions (yellow form) and poor quality of drugs received (pink form) in the facility;
- PrEP register - A longitudinal register for recording PrEP users' clinical visits. It is an important source document for reporting into the DHIS and other studies that require monitoring progress on PrEP;
- The Rapid Assessment Screening Tool – Used to stratify a client's risk of HIV acquisition and aid in determination of PrEP eligibility;
- PrEP Summary Tool - Used to aggregate monthly PrEP client data for reporting.

The assessment focused on checking availability of the various M&E tools for PrEP in the facilities and client specific information through chart reviews.

Key findings

- There was sub-optimal distribution of the M&E tools across all the counties
- There was a decrease in the number of Clients ever started on PrEP (24,862) and those currently on PrEP (17,532) as at February 2018.
- The use of EMR's was sub optimal in facilities assessed with only 179 (22.8%) facilities using them
- From the PrEP client files assessed, there were more female PrEP clients in the age bracket of 15 –40 years while male clients were more from the age group of 40 years and above.
- There were 1,765 (82.6%) active PrEP clients from the files assessed with 4 (0.2%) of the total client files assessed being of Sero-converted patients.
- The highest number of PrEP clients 731 (34.2%) discontinued PrEP after one month

3.11.1 LMIS tools

Of the 852 facilities assessed, 502 (58.9%) reported availability of the LMIS tool. The county distribution of the tools is shown in figure 27.

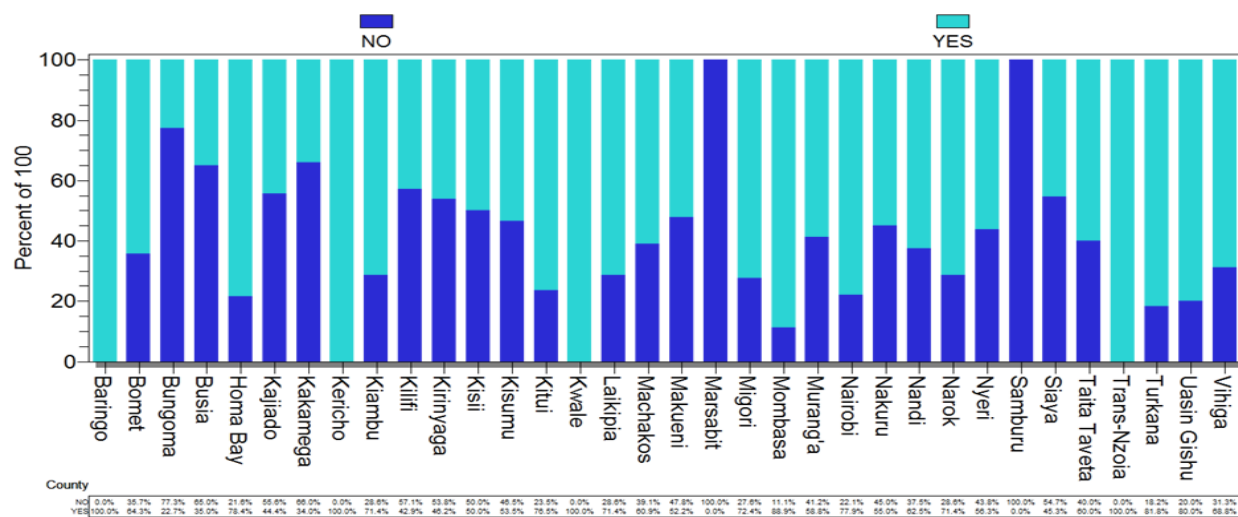


Figure 27: Availability of LMIS tools in facilities by county

3.11.2 Clinical encounter forms

More than half, 576 (67.6%) of the assessed facilities had the clinical encounter form. The county distribution of the tool is as illustrated in Figure 28.

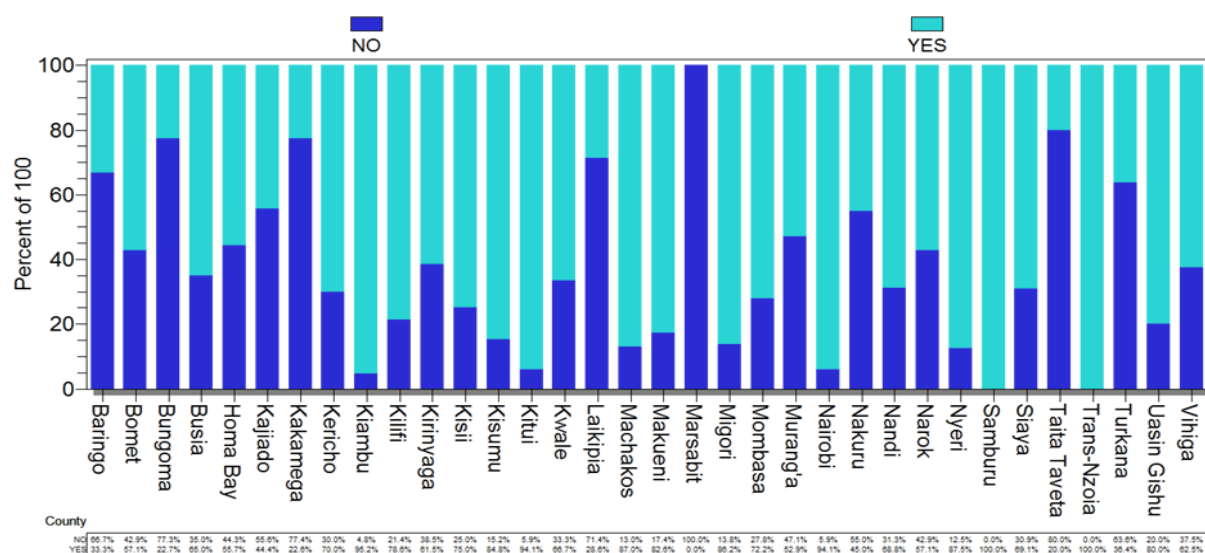


Figure 28: Availability of clinical encounter form

3.11.3 Pharmacovigilance tools

Of the 852 facilities, 698 (81.9%) reported availability of the pharmacovigilance reporting tool. The distribution of the tool in facilities in the counties is as illustrated in figure 29.

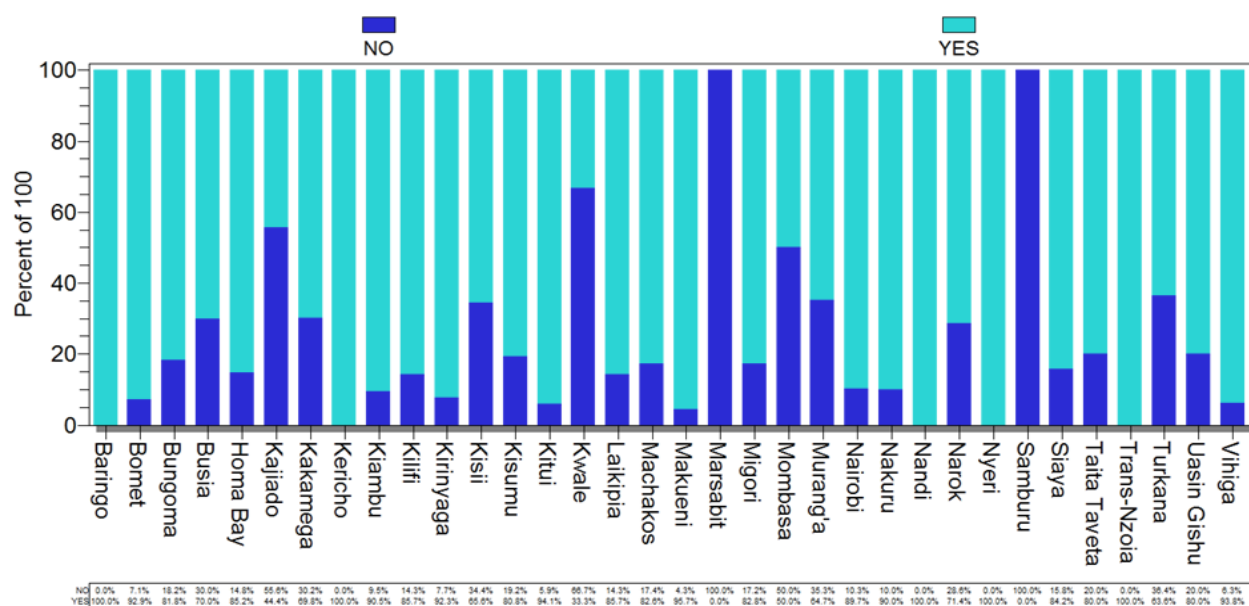


Figure 29: Availability of pharmacovigilance tools in facilities by county

3.11.4 PrEP register

The registers were available in 369 (43.3%) of the facilities and the distribution per county also varied (Figure 30).

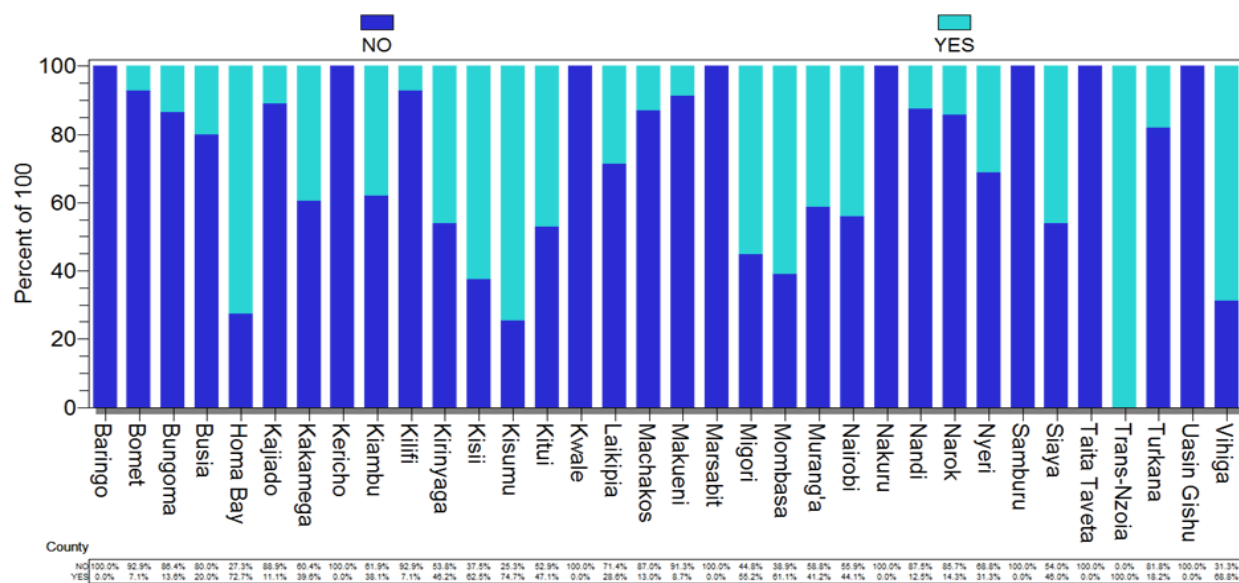


Figure 30: Availability of PrEP register in facilities by county

3.11.5 Rapid assessment screening tool

Of the 852 facilities assessed, 429 (50.4%) reported availability of the Rapid Assessment Tool. The distribution of the tool in the counties is as illustrated in figure 31.

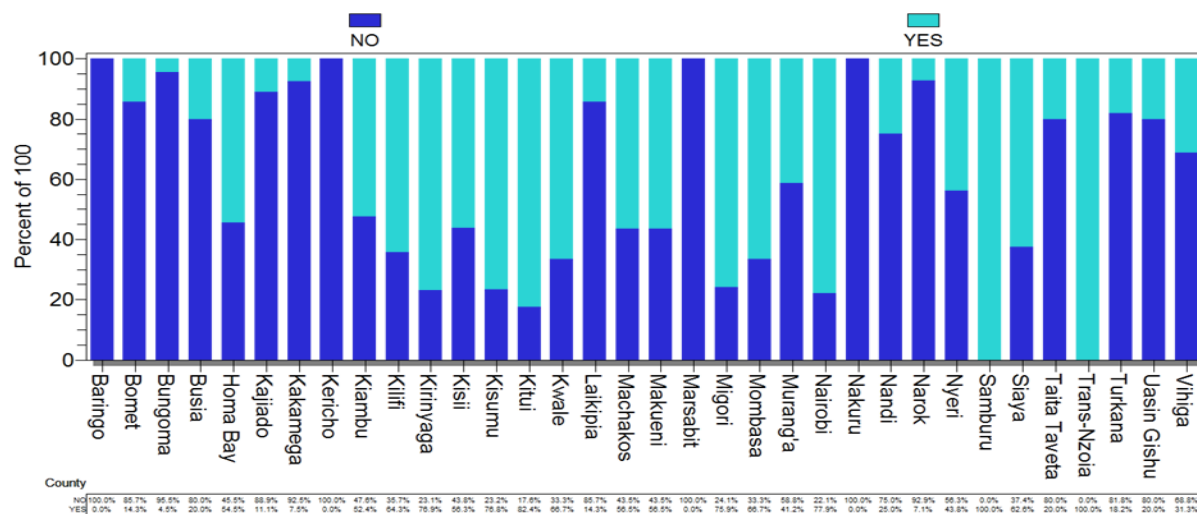


Figure 31: Availability of rapid assessment screening by county

3.11.6 PrEP summary tools

The PrEP Summary Tool was available in 369 (43.3%) of all the facilities. Similarly, in most of the counties, tools were not readily available (figure 32).

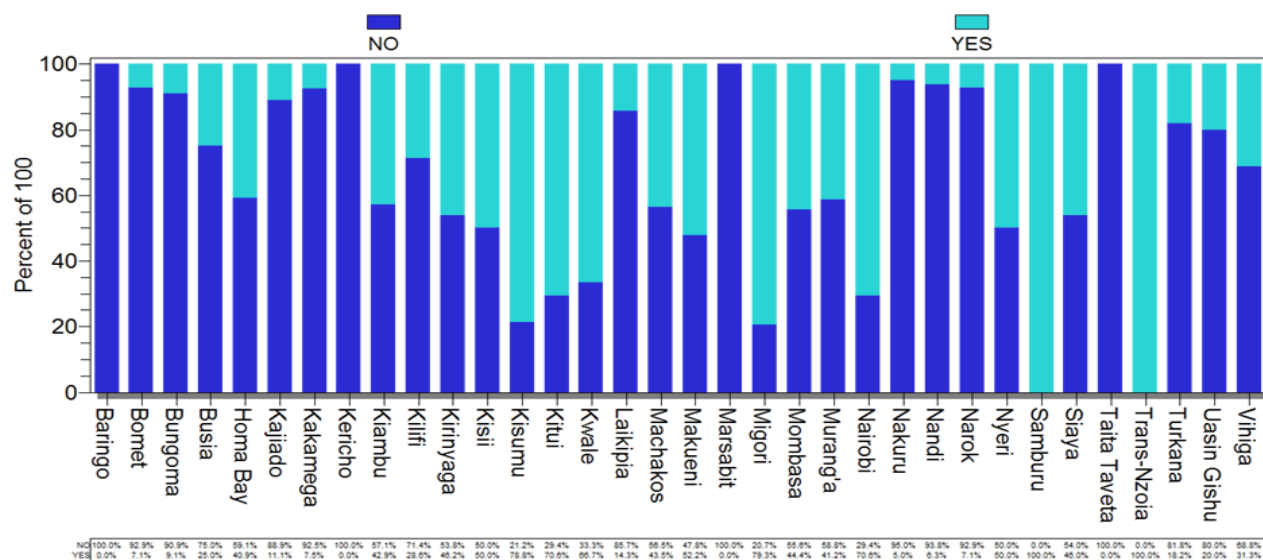


Figure 32: Availability of PrEP summary tools

3.11.7 Clients ever started on PrEP

The total number of clients ever started on PrEP as at the end of February 2018 in the 852 facilities assessed was 24,862. Nairobi county reported the highest numbers with 8,971 followed by Kisumu county 5,807. Majority of the counties assessed had less <100 clients registered (figure 33).

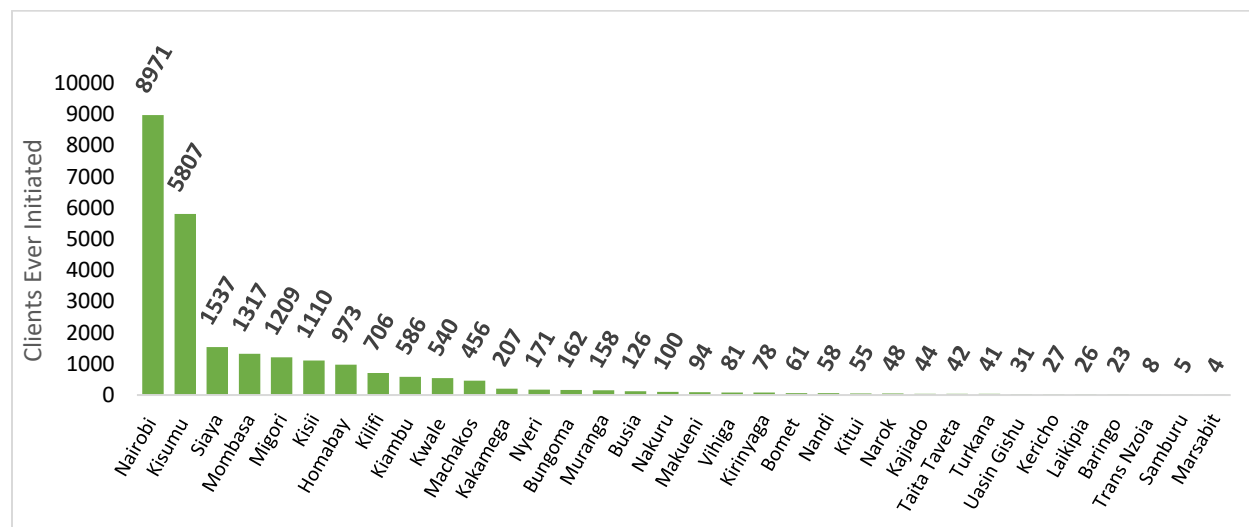


Figure 33: Clients ever started on PrEP

3.11.8 Clients currently on PrEP and active

Clients active on PrEP were defined as any client who had not exceeded 90 days passed their last appointment. As at February 2018, the total number of clients on PrEP was 17,532. This number was significantly lower in comparison to those who had ever started on PrEP (figure 33) as had significantly reduced in majority of the counties. Case in point is Nairobi county whereby those started as previously mentioned were 8,971 and those currently on PrEP were 5,445. The same trend was seen in Kisumu county. However, in some counties the numbers remained constant (figure 34).

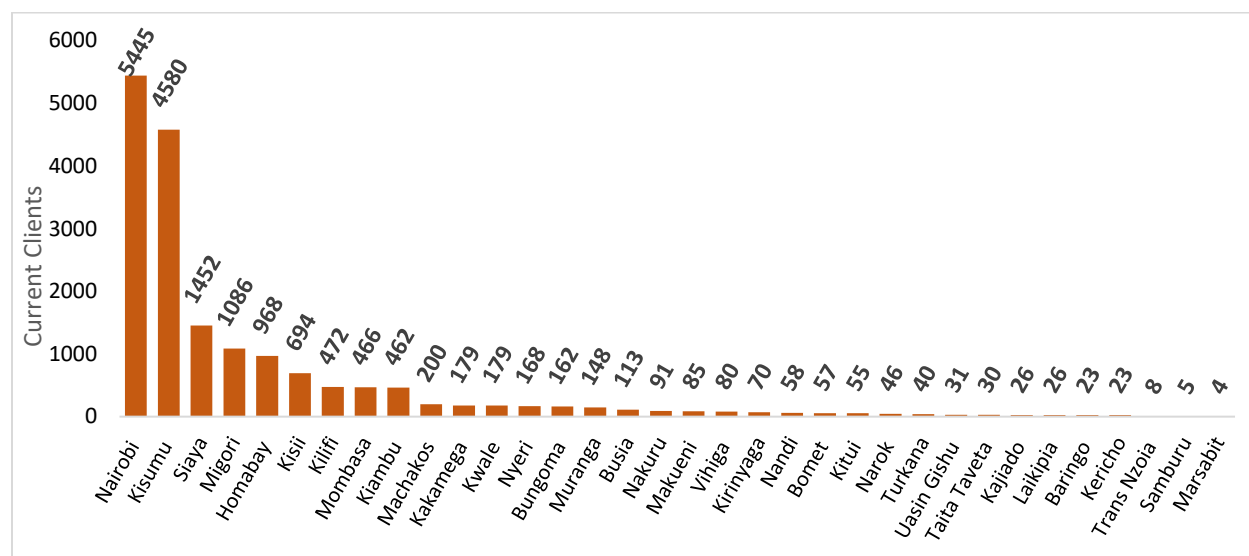


Figure 34: Clients on PrEP

3.11.9 Proportion of facilities using EMR's

One hundred and seventy-nine (21.0%) of the facilities reported to have an EMR while the other 607(71.2%) of the facilities were using paper-based reporting systems. The use of EMR's is important in data management as it ensures real-time availability of information to support decision making. However, EMR for data and commodity management uptake across all counties was notably very low as majority of the facilities were using manual systems.

3.11.10 PrEP client specific information

This section outlines the findings from 2138 PrEP client files reviewed at the facilities. Four files per facility were randomly selected. The findings were categorized as per the levels of facilities as shown in table 13.

Table 13: Levels of facilities where 2138 client files were assessed

LEVEL	n (%)
Health Center	696(32.6%)
Dispensary	449(21.0%)
Mission and Private	378(17.7%)
Sub County Hospital	309(14.5%)
DICE	195(9.1%)
County Referral Hospital	75(3.5%)
County Hospital	22(1.0%)
National Referral Hospital	14(0.70%)
TOTAL	2138(100.0%)

i. Gender and age distribution

Majority of the client files assessed were of female PrEP clients 1,227 (57.4%) and most 658 (30.8%) of the clients both male and female were aged 24- 30 years (figure 35).

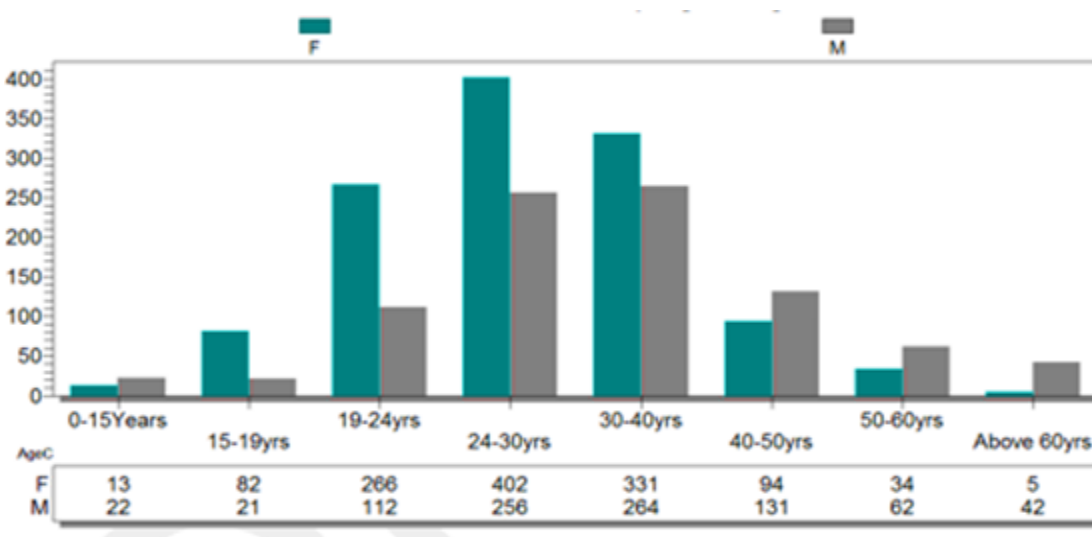


Figure 35: Age distribution of PrEP patients from patient files assessed

ii. Clients PrEP status

A total of 1,765 (82.6%) were active on PrEP while 4 (0.2%) had seroconverted (Table 14) at the time of the assessment.

Table 14: Current status of PrEP patients

Status	n (%)
Active	1,765(82.6%)
Self-discontinued	141(6.6%)
LTFU	82(3.8%)
Defaulted	76(3.6%)
Clinician-discontinued	40(1.9%)
Other	30(1.4%)
Sero-converted	4(0.2%)
TOTAL	2138(100.0%)

iii. Duration on PrEP

The continuation rates on PrEP was varied, 731 (34.2% were on PrEP for one month while 7 (0.3%) clients were on PrEP for 12 months and 2 (0.1%) had been on PrEP for more than 24 months (Figure 36). Continuation rates on PrEP were notably low with majority of clients discontinuing after the first month this may be attributed to multiple factors such as; change of client's risk pattern, LTFU and lack of tools / system for appointment management.

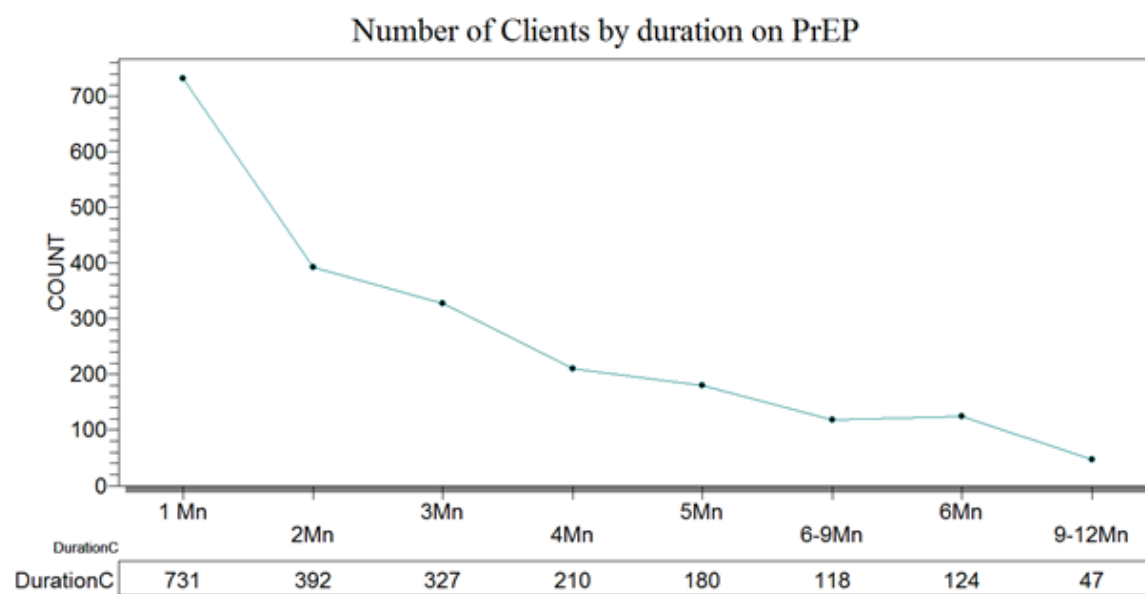


Figure 36: Number of clients by duration on PrEP

iv. Laboratory tests conducted

The files were also reviewed for documentation of baseline laboratory testing for creatinine, Hepatitis B and Hepatitis C. There were 1,882 (88.0%) files with no record of Hepatitis B test while 1,998 (93.5%) had no record of Hepatitis C tests (Table 15).

Table 15: Client files showing creatinine, Hepatitis B and Hepatitis C testing records

	Creatinine Number	Percent	Hepatitis B Number	Percent	Hepatitis C Number	Percent
No	1832	85.7%	1882	88.0%	1998	93.5%
Yes	306	14.3%	256	12.0%	140	6.5%
Total	2138	100.0%	2138	100.0%	2138	100.0%

Documentation of creatinine testing was also analyzed by county as shown in figure 37.

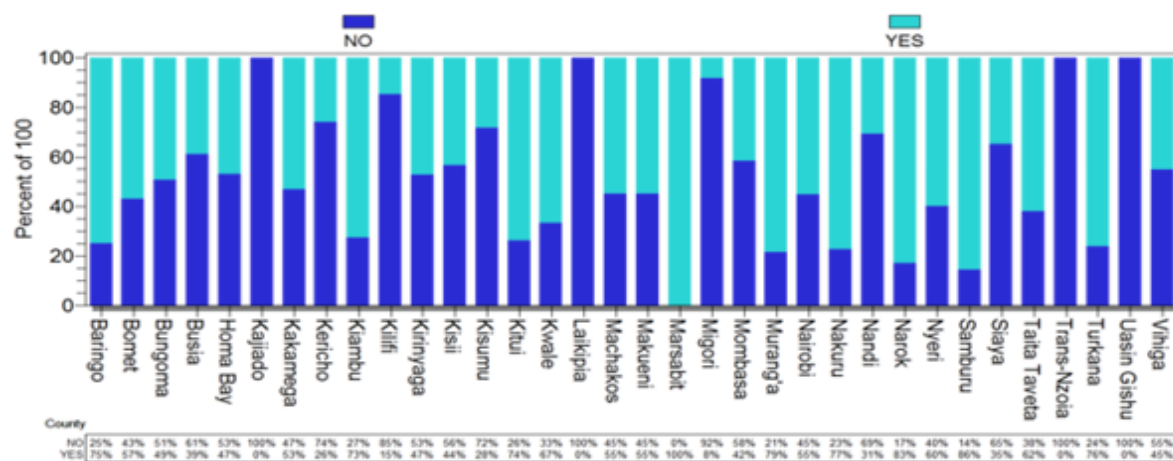


Figure 37: Creatinine testing in the facilities by county

Documentation of Hepatitis B Testing was also analyzed by county indicates that in five counties there were no records of Hepatitis B (figure 38).

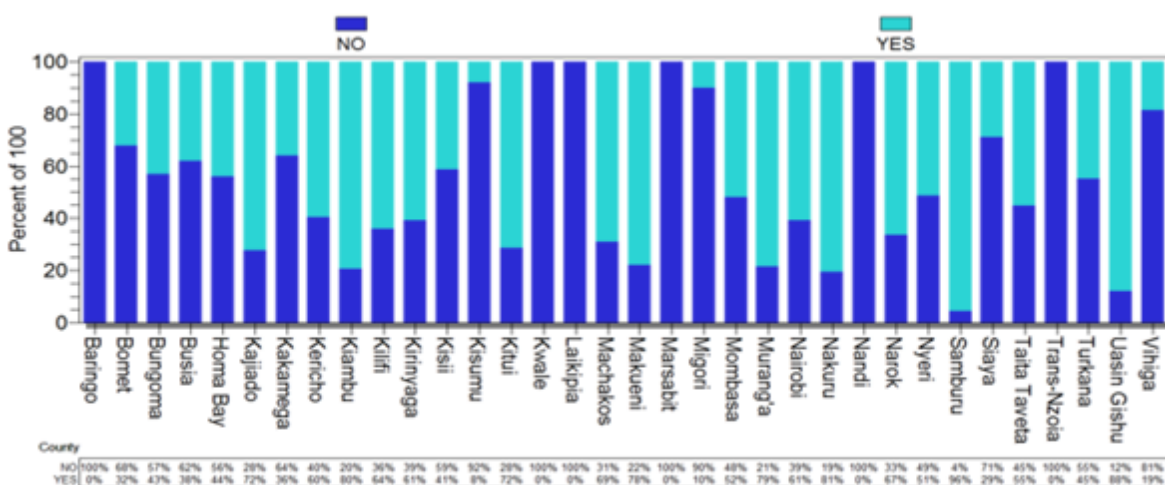


Figure 38: Hepatitis B testing in facilities by county

In fourteen counties (figure 39) there was no documentation for Hepatitis C test in any of the client's files.

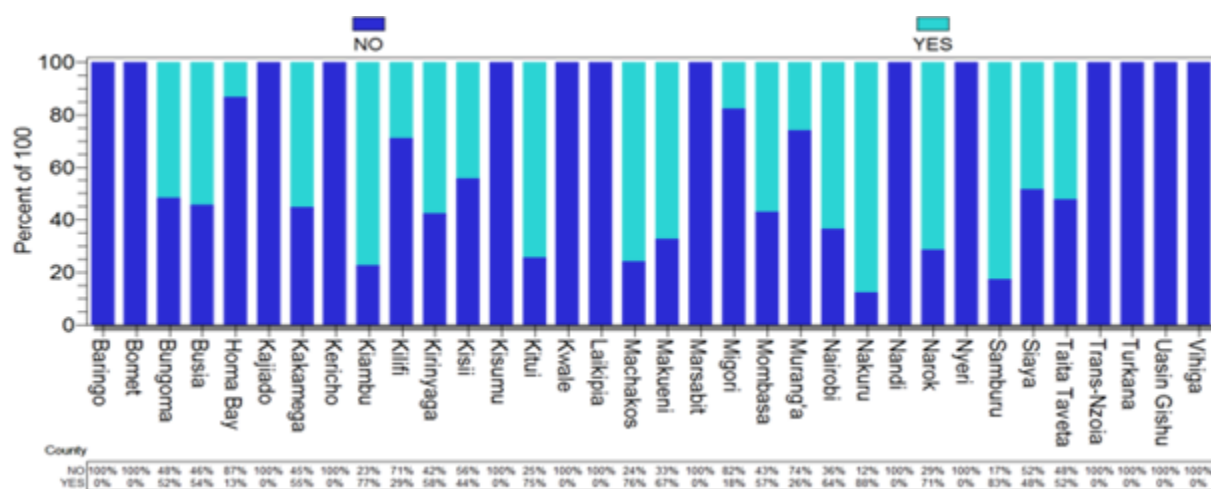


Figure 39: Hepatitis C testing in facilities by county

v. Eligibility

Documentation of PrEP eligibility in the patients file is very vital in the delivery of PrEP and it was noted that a majority 1,964 (91.9%) of the clients had their eligibility for PrEP documented in their files.

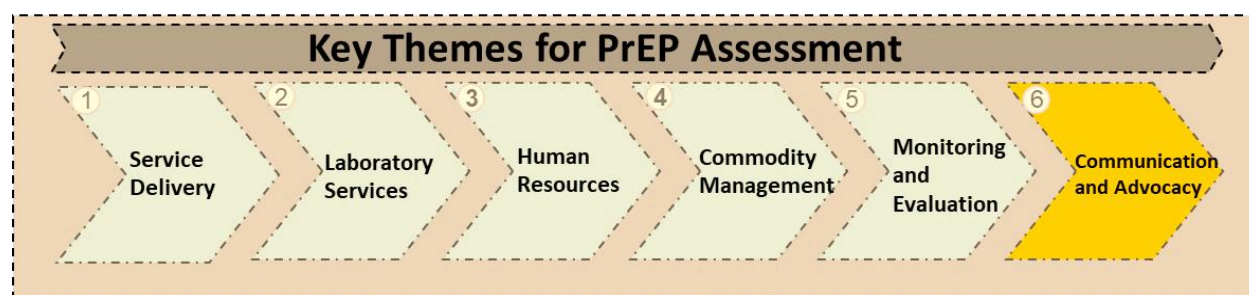
vi. Client follow up mechanism

Various client PrEP follow mechanisms were available in the 783 facilities. A total of 655 (83.7%) were using phone calls while 254 (32.4%) of the facilities generated lists of defaulters. Support groups were the least used follow up mechanism (Table 16).

Table 16: Client follow up mechanisms in the facilities

Follow up mechanism	n (%)
Follow-up phone calls	655(83.7%)
Generate list of defaulters	254(32.4%)
CHW Training	144(18.4%)
SMS Reminders	136(17.4%)
Other	115(14.7%)
Support Group	90(11.5%)

3.12 Communication and Advocacy



Communication and advocacy are key in understanding different dynamics around HIV prevention. It is used by various stakeholders such as service providers, policy makers and community members to encourage positive behavior change and gives information on how to access HIV health services with the objective of increasing knowledge on PrEP services, creating a positive perception and increasing demand for PrEP among target audience. This can be achieved through various strategies such as:

- Media campaigns
- Community mobilization
- Routine capacity building of service providers
- Distribution of targeted IEC materials such as pamphlets and brochures

The assessment focused on checking the availability and documentation practices for communication and advocacy activities.

Key findings

- 543 (63.7%) of the facilities assessed did not have IEC materials
- 443 (52.0%) of facilities assessed did not carry out demand creation within the facilities
- 420 (49.3%) of facilities assessed did not carry out demand creation activities in their communities
- 625 (73.4%) of the facilities had no documentation of the demand creation activities

3.12.1 Availability of IEC materials

Of the 852 facilities, 309 (36.2%) of the facilities had IEC materials. Various counties did not have PrEP IEC materials (figure 40).

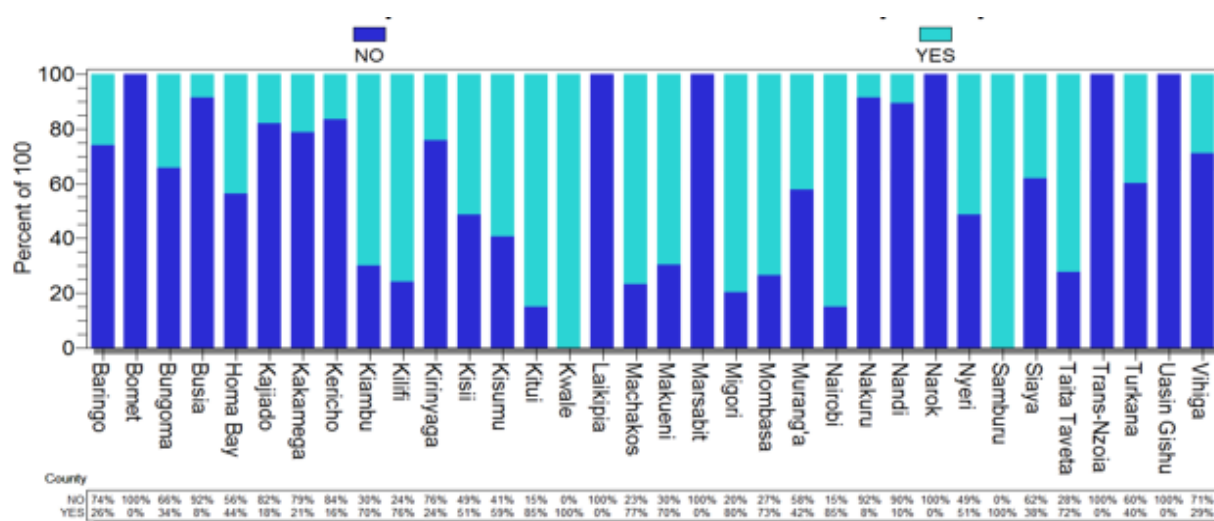


Figure 40: Availability of PrEP IEC materials in facilities by county

3.12.2 PrEP demand creation activities within facilities

Of the 852 facilities, 409 (48.0%) of the facilities carried out demand creation activities. There were no demand creation activities in Baringo county while Trans-Nzoia reported to have conducted demand creation activities in all its facilities (figure 41). One of the objectives of communication in implementation of PrEP is to increase the demand of PrEP among target audience. The assessment revealed that approximately 50% of the facilities assessed had IEC materials and also reported engaging in demand creation activities. This may be attributed to lack of skills in communication and advocacy, lack of resources to conduct demand creation activities and lack of IEC materials.

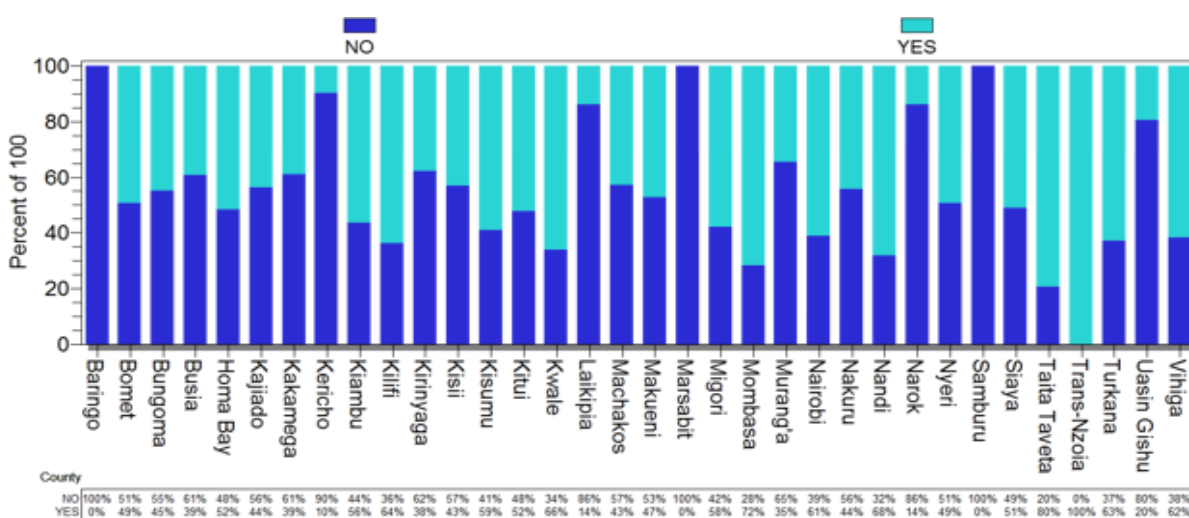


Figure 41: Availability of activities about PrEP education in facilities by county

3.12.3 PrEP Demand Creation within the community

Of the 852 facilities, 432 (50.7%) had carried out demand creation activities within the community. The figure 42 indicates the availability of demand creation activities within the communities in the counties.

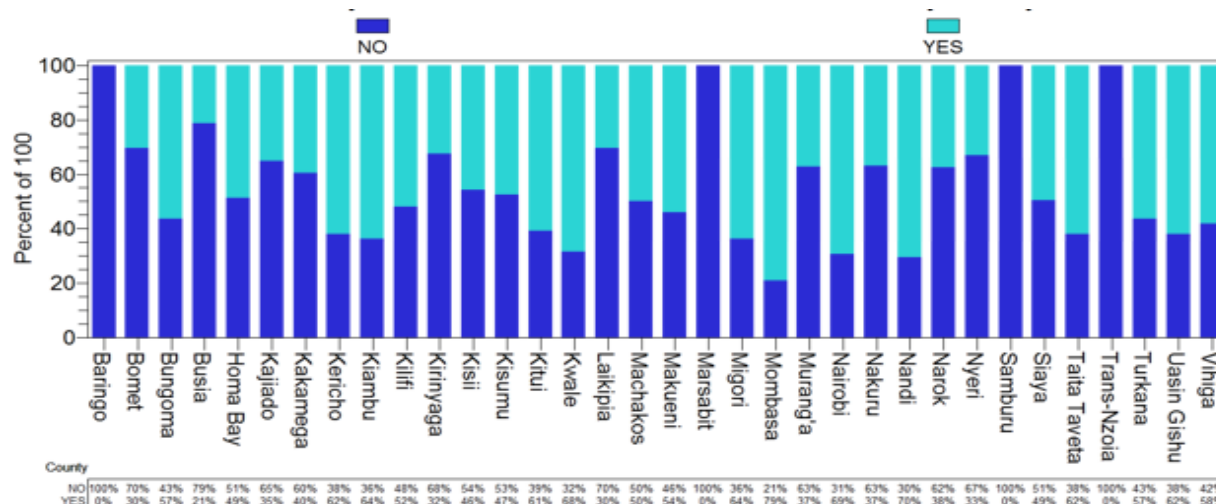


Figure 42: Availability of demand creation activities in facilities by county

3.12.4 Availability of data

Of the 852 facilities, 227 (26.7%) of the facilities reported to have availability of data for communication and advocacy activities. Poor documentation practices at the facilities on communication and advocacy activities has led to lack of availability of data on the same. This could be attributed to lack of skills and tools to aid in the process of documentation.

Poor documentation practices at the facilities on communication and advocacy activities has led to lack of availability of data on the same. This could be attributed to lack of skills and tools to aid in the process of documentation. The documentation at county level also varied from county to county (figure 43)

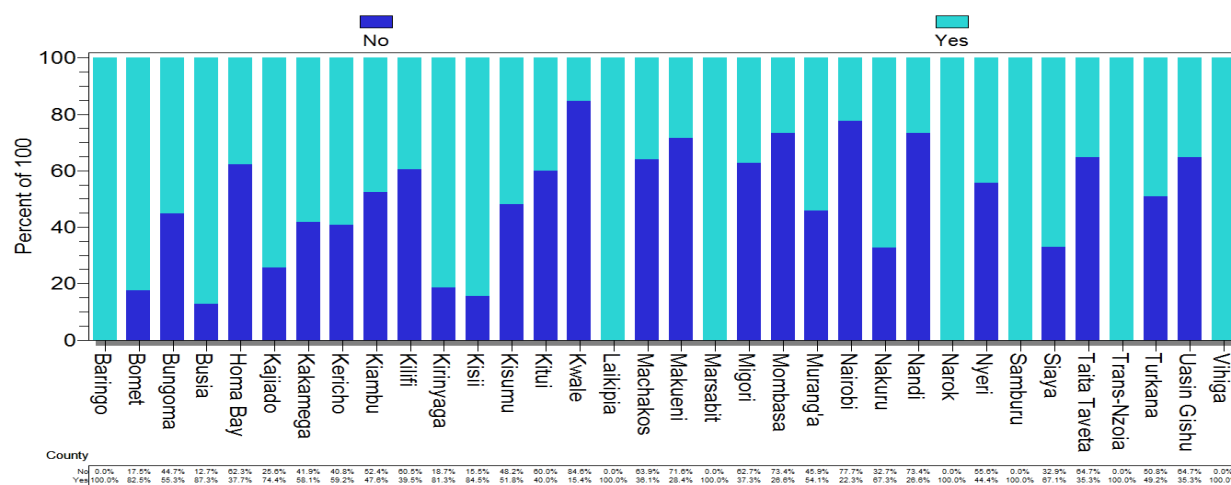


Figure 43: Availability of data Discussion

4. CONCLUSION

PrEP services were readily available in all the sites assessed in the 34 counties. However, the capacity to provide PrEP services varied from one facility to the other across the country.

Generally, there is need to address the gaps identified such as sub-optimal access to laboratory services for baseline creatinine, Hepatitis B and Hepatitis C testing, stock outs that was reported in a few of the facilities, lack of tools M&E tools and capacity building on PrEP and the minimal demand creation and advocacy with regards to PrEP in communities and facilities.

5. RECOMMENDATIONS

Based on the findings and gaps that were identified at the various levels of care, key recommendations for National, county and facility levels are as follows;

5.1 National level recommendations

1. Capacity building of county and facility personnel on PrEP systems, tools and process to improve PrEP service delivery
2. Develop a PrEP communication and advocacy strategy to provide guidance to the counties and facilities on demand creation messages and IEC for potential PrEP clients
3. Printing, distribution and dissemination of PrEP monitoring and evaluation tools
4. Design and integrate module for PrEP on Electronic Medical Record (EMR) and disseminate to PrEP providers
5. Standardization of the PrEP training curriculum module
6. Streamlining of partner support to avoid duplication of effort within facilities in PrEP service delivery
7. Establishing an adherence and retention model for PrEP clients to enhance follow up
8. Develop strategies to integrate all prevention strategies
9. Invest in electronic dispensing software

5.2 County level recommendations

1. Disseminate communication and advocacy strategies to the facilities offering PrEP to increase PrEP uptake
2. Ensure availability and consistent use of national PrEP monitoring and evaluation tools in facilities and capacity building on the use PrEP tools
3. Deployment of module on PrEP on EMRs and dispensing tools at facilities to improve documentation and reporting to improve on PrEP implementation
4. Streamlining of partner support to avoid duplication of effort within facilities in PrEP service delivery
5. Cascade trainings to facilities with personnel not trained on PrEP service delivery
6. Cascade the use of combination prevention strategies at the facilities
7. Frequent redistribution of commodities in facilities within the counties

5.3 Facility level recommendations

1. Provide information to potential PrEP clients at the facility and carry out demand creation activities in the community.
2. Ensure appropriate use of PrEP M & E tools for Service delivery and reporting.
3. Integrate the use of EMRs on PrEP service delivery
4. Ensure personnel dispensing PrEP are trained on PrEP service delivery
5. Integrate prevention strategies when offering solutions to PrEP

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A Report on Assessment of Health Facilities Providing Oral Pre-Exposure Prophylaxis for HIV in Kenya



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