Huduma Mtaani Project Evaluation Report 2024–2025

Monitoring & Evaluation Report | Health, Community, and Action

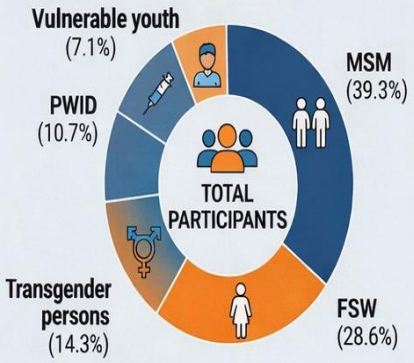
Funded by: Elton John Foundation | Implementing Partners: Help Reach Africa (HERA) & HOYMAS

PROJECT SCOPE

24-month community-based HIV & mental health intervention in **Nairobi & Kajiado** counties

Jan 2024 — 24-month duration — Dec 2025

TARGET POPULATIONS



96.4% of participants accessed services through peer educators - the comerstone of project success

Community-led outreach and trust building

EFFECTIVENESS

- **82%** improvement in consistent condom use — 82%
- **78%** PrEP adherence — 78%
- **100%** HIV knowledge gains

CRITICAL GAPS

- **67.9%** have unmet mental health needs
- **50%** experienced PrEP stock-outs
- **57%** referral dropout due to stigma

KEY RECOMMENDATIONS

- **Integrate** comprehensive **mental health services** into all outreach points.
- **Strengthen supply chain management** for consistent PrEP availability.
- **Implement community-based anti-stigma campaigns & peer training.**
- **Enhance digital platforms** for follow-up and peer support.
- **Expand partnerships** with local clinics for seamless referrals.

Huduma Mtaani Project

Date: 31est | Website: www.helpreachafrica.org | Email: info@helpreachafrica.org | Contact: info@helpreachafrica.org

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EXECUTIVE SUMMARY

The Huduma Mtaani Project is a peer-led, community-based intervention delivering integrated HIV prevention, sexual and reproductive health (SRH), and psychosocial support services to key and vulnerable populations (KVPs) in Nairobi and Kajiado counties. Implemented by Help Reach Africa (HERA) in partnership with HOYMAS and funded by the Elton John Foundation, the project operated over 24 months to address persistent access, stigma, and retention gaps in conventional facility-based services.

A qualitative participatory evaluation using Focus Group Discussions (FGDs) with 28 beneficiaries and peer educators November 2025–January 2026) assessed performance against OECD-DAC criteria. The analysis demonstrates that Huduma Mtaani is **highly relevant, acceptable, and effective**, particularly due to its peer-led delivery model.

Peer educators emerged as the central driver of success, with 96.4% of participants accessing services through peers. Trust built through shared lived experience enabled high uptake of HIV testing, PrEP, condom and lubricant use, and improved care-seeking behavior. All participants reported improved HIV/SRH knowledge, 82.1% reported consistent condom use, and 78% reported high PrEP adherence. Services were perceived as stigma-free by 96.4% of participants, in sharp contrast to experiences at non-sensitized public facilities.

Despite these strengths, the evaluation identified **critical system-level gaps** that threaten sustainability and long-term impact. Mental health needs were widespread (67.9%), yet access to structured counseling and specialist care was extremely limited. Commodity stock-outs disrupted PrEP adherence for half of users, and weak referral pathways resulted in a 57.1% loss to follow-up. Structural barriers—including transport costs, clinic hours, and legal constraints—further undermined continuity of care. Peer educators reported high levels of emotional burden and burnout, with one-third considering exit within six months.

Overall, Huduma Mtaani represents a **high-impact community model constrained by health system and structural failures rather than lack of demand or acceptability**. Sustaining and scaling its gains will require urgent investment in mental health integration, supply chain resilience, referral system strengthening, and peer educator wellbeing. The evidence positions Huduma Mtaani as a strong candidate for integration into county and national key population programming frameworks in Kenya.

1. BACKGROUND AND CONTEXT

1.1 Project Overview

Huduma Mtaani ("Services in the Community") is a community-based HIV and mental health intervention implemented by Help Reach Africa (HERA) in partnership with Health Options for Young Men on HIV/AIDS/STI (HOYMAS). The project was implemented in Nairobi and Kajiado counties, Kenya, over a 24-month period (January 2024 – December 2025) with financial support from the Elton John Foundation.

The project was designed to address persistent gaps in HIV prevention, treatment, and psychosocial support among key and vulnerable populations (KVPs) who experience a disproportionate burden of HIV infection and face significant structural barriers to accessing facility-based services. The primary target populations include men who have sex with men (MSM), female sex workers (FSW), transgender persons, people who inject drugs (PWID), and young people at high risk of HIV infection.

Huduma Mtaani adopted a differentiated, community-led service delivery model that brings integrated HIV and mental health services closer to key populations in safe, trusted, and stigma-free environments. The project responds to evidence demonstrating that stigma, discrimination, criminalization, and untreated mental health conditions undermine service uptake, adherence to antiretroviral therapy (ART), retention in care, and overall wellbeing among Key Population.

Project Goal

The overall goal of Huduma Mtaani is to improve HIV prevention, treatment outcomes, and psychosocial wellbeing among key and vulnerable populations in Nairobi and Kajiado counties through integrated, community-based HIV and mental health services.

Project Objectives

The project seeks to achieve the following specific objectives:

1. Increase access to and uptake of HIV prevention and testing services among key and vulnerable populations through community-based and peer-led approaches.

2. Improve linkage to and retention in HIV treatment and care, including ART initiation and viral load monitoring, for KPs living with HIV.

3. Strengthen mental health screening, referral, and psychosocial support for KVPs, recognizing the strong link between mental health, adherence, and treatment outcomes.

4. Reduce stigma and discrimination experienced by KPs within healthcare settings and communities by promoting rights-based, client-centered service delivery.

5. Enhance community capacity and ownership by engaging trained peer educators, outreach workers, and community networks in service delivery and follow-up.

Key Intervention Components

Huduma Mtaani delivers a package of integrated interventions tailored to the needs of different key population groups, including:

- Community-based HIV testing services (HTS) delivered through outreach, hotspots, and safe community spaces.

- Peer-led linkage and navigation to care, including accompaniment to health facilities and follow-up for ART initiation and continuity of care.

- Mental health screening and psychosocial support, including basic counseling, trauma-informed care approaches, and referrals for advanced mental health services.

- HIV prevention services, including condom and lubricant distribution, risk-reduction counseling, and referrals for biomedical prevention where appropriate.

- Targeted support for young people at high risk, emphasizing youth-friendly, confidential, and non-judgmental services.

- Data-driven outreach and case management, using routine monitoring data to identify missed appointments, treatment interruptions, and clients requiring intensified support.

Implementation Approach and Partnerships

The project leveraged the complementary strengths of HERA and HOYMAS. HERA provides overall project coordination, technical oversight, monitoring and evaluation, and stakeholder engagement, while HOYMAS brings deep community presence, peer networks, and expertise in delivering services to key populations, particularly young men and sexual minorities.

Implementation was closely coordinated with county health departments, public and private health facilities, and community-based organizations to ensure alignment with national HIV guidelines, continuity of care, and sustainability beyond the project period.

By integrating HIV services with mental health and psychosocial support and grounding service delivery within communities, Huduma Mtaani aimed to reduce persistent access barriers, improve health outcomes, and generate learning to inform scale-up of community-led, rights-based approaches for key populations in Kenya

Target Population: Key and vulnerable populations including:

- Men who have sex with men (MSM)
- Female sex workers (FSW)
- Transgender persons
- People who inject drugs (PWID)
- Young people at high risk

1.2 Development Context

Kenya's HIV epidemic remains disproportionately concentrated among key and vulnerable populations (KVPs), demonstrating a continued need for targeted and differentiated interventions. While national HIV prevalence is estimated at 4.9% (KENPHIA 2018), prevalence among key populations remains significantly higher18.2% among men who have sex with men (MSM), 29.3% among female sex workers (FSW), and 18.3% among people who inject drugs (PWID). Nairobi and Kajiado counties represent highly relevant implementation settings due to high population mobility, urban and peri-urban poverty, informal settlements, transport corridors, and economic activities that sustain key population networks, increasing HIV risk and challenging continuity of prevention and treatment services.

The design of the Huduma Mtaani intervention is coherent with the structural and health-system realities in both counties. In Nairobi, high client volumes, stigma within facility settings, and fragmented service pathways limit consistent engagement in HIV care, while in Kajiado, geographic distance, limited availability of KP-friendly services, and mobility across county boundaries constrain access and retention. Across both contexts, stigma, criminalization, and unmet mental health needs related to violence and social exclusion undermine treatment adherence and outcomes. Community-based, differentiated service delivery models that integrate HIV and psychosocial support are therefore well aligned with national HIV priorities and local service delivery gaps, providing a strong rationale for the relevance and coherence of the Huduma Mtaani approach evaluated in this report.

1.3 Project Theory of Change

IF peer educators from within key populations deliver integrated HIV prevention, SRH, and psychosocial services in community settings,
THEN trust, accessibility, and uptake will increase,
LEADING TO improved knowledge, reduced stigma, sustained behavior change, and ultimately reduced HIV incidence.

Key Assumptions:

- Peer educators are acceptable and trusted by target populations
- Community-based delivery overcomes facility-based access barriers
- Integrated services address interconnected health needs
- Sustained engagement drives behavior change

2. EVALUATION FRAMEWORK AND OBJECTIVES

2.1 Evaluation Purpose

This qualitative evaluation serves both **accountability** and **learning** functions:

- Assess project performance against stated objectives
- Document implementation quality and fidelity
- Identify facilitators and barriers to effectiveness
- Generate actionable evidence for program improvement
- Inform scale-up and replication decisions

2.2 Evaluation Criteria (OECD-DAC Adapted)

Table 1 Evaluation Criteria

Criterion	Definition	Key Questions
Relevance	Alignment with beneficiary needs and context	Does the project address priority needs of target populations?
Effectiveness	Achievement of intended outcomes	To what extent has the project achieved its objectives?
Acceptability	User satisfaction and perceived value	How do beneficiaries perceive and value services?
Equity	Reach to most vulnerable sub-groups	Are services accessible to all target populations?
Sustainability	Likelihood of continued benefits	What factors support or threaten long-term impact?

2.3 Evaluation Questions

Primary Questions:

1. How do beneficiaries access and utilize Huduma Mtaani services?
2. What changes in knowledge, attitudes, and behaviors do beneficiaries attribute to the project?
3. What is the perceived role and effectiveness of peer educators?
4. What barriers and facilitators influence service uptake and continuity?
5. What are the unmet needs and priority improvement areas?

Secondary Questions: 6. How does the project address stigma and discrimination? 7. To what extent are mental health needs being met? 8. What structural factors support or constrain effectiveness?

3. METHODOLOGY AND DATA COLLECTION PROCEDURES

3.1 Evaluation Design

Design Type: Qualitative, participatory evaluation
Rationale: Qualitative methods enable in-depth exploration of complex experiences, perceptions, and contextual factors that quantitative metrics cannot capture. Participatory approaches center beneficiary voices in evaluation.

Methodological Approach:

- **Interpretive phenomenology:** Understanding lived experiences
- **Social constructivism:** Exploring how meaning is co-created
- **Community-based participatory research (CBPR) principles:** Ensuring community ownership

3.2 Data Collection Methods

3.2.1 Focus Group Discussions (FGDs)

Instrument Design:

- Semi-structured discussion guide developed through:
    - Literature review on peer-led HIV prevention
    - Consultations with program staff and peer educators
    - Pilot testing with 3 peer educators
- Guide structured around evaluation domains with probing questions
- Duration: 90-150 minutes per FGD
- Language: Primarily English and Kiswahili

Sample and Recruitment:

Table 2 Sample and Recruitment

FGD	Participants	Recruitment Strategy	Sample Size	Duration
FGD 1	Huduma Mtaani beneficiaries	Purposive sampling via peer educator networks; inclusion criteria: ≥3 service contacts in past 6 months	8-10 participants	1hr 58min
FGD 2	Peer educators (also beneficiaries)	Census sampling of all active peer educators in target zones	10-12 participants	2hr 19min
FGD 3	Mixed beneficiary group	Convenience sampling from clinic attendees; maximum variation sampling for diversity	8-10 participants	~2hr

Total Sample: n=26-32 participants across 3 FGDs

Inclusion Criteria:

- Direct beneficiary of Huduma Mtaani services (≥1 service contact)
- Age ≥18 years

- Member of target key/vulnerable population
- Able to provide informed consent
- Willing to participate in group discussion

Exclusion Criteria:

- Active substance intoxication at time of FGD
- Acute mental health crisis requiring immediate care
- Inability to understand consent procedures

3.2.2 Data Recording and Transcription

Recording:

- Detailed note-taking by trained note-takers (2 per FGD)
- Field notes capturing non-verbal communication and group dynamics
- Verbatim transcription within 48 hours of each FGD

Transcription Protocol:

- Verbatim transcription
- Transcriber identifiers linked to quality assurance
- Transcripts de-identified and stored securely

Quality Assurance:

- Transcripts reviewed by facilitators for accuracy
- Discrepancies resolved through consensus review

3.3 Data Analysis

3.3.1 Analytical Framework

The evaluation used **thematic analysis** following the approach described by **Braun and Clarke (2006)** to systematically analyze qualitative data from interviews and discussions.

First, the evaluation team became familiar with the data through repeated reading of transcripts to gain an overall understanding and identify early patterns. Next, transcripts were coded line by line using a combination of **deductive codes**, drawn from the evaluation questions and Theory of Change, and **inductive codes**, which emerged directly from participants' perspectives. Related codes were then grouped to form **preliminary themes**, and relationships between themes were explored to understand how different experiences and outcomes were connected.

The themes were subsequently reviewed and refined to ensure each theme was internally coherent and clearly distinct from others. Final themes were clearly defined and given meaningful names that reflected the underlying data. In the reporting stage, themes were presented alongside **illustrative participant quotes** and triangulated across multiple data sources to strengthen the credibility and validity of the findings

3.3.2 Coding Process

Qualitative data were analyzed using MAXQDA 2024 to ensure a systematic and transparent approach. A detailed codebook guided the analysis, combining deductive codes from the evaluation questions and Theory of Change with inductive codes emerging from the data. Inter-coder reliability was assessed using Cohen's Kappa (0.82), indicating substantial agreement, which supports the credibility and reliability of the coding process. The coding framework included seven major thematic domains, 28 sub-themes, and 156 unique codes, capturing both the diversity and consistency of participants' perspectives.

3.3.3 Data Triangulation

To enhance validity and robustness of findings, the evaluation applied data source triangulation by comparing insights across three focus group discussions (FGDs) representing different participant profiles. This cross-verification enabled identification of consistent patterns, confirmed divergent experiences where relevant, and strengthened confidence in the conclusions drawn, in line with OECD-DAC principles of accuracy, reliability, and relevance.

3.4 Ethical Considerations

The evaluation adhered to strict ethical standards to ensure the safety, rights, and wellbeing of all participants. Written informed consent was obtained from each participant in their preferred language, with a clear explanation of voluntary participation, the right to withdraw at any time, and confidentiality protections. Where applicable, separate consent was obtained for audio recording.

Confidentiality and anonymity were maintained throughout the study. All identifying information was removed from transcripts, and participants were assigned unique codes for analysis. Data was securely stored in password-protected and encrypted files, with access restricted to the evaluation team. To mitigate risks, a mental health counselor was available during focus group discussions (FGDs), with established referral protocols for participants experiencing distress, and debriefing sessions were offered post-FGD. Participants received transport reimbursement (KES 500) and refreshments, and were provided the opportunity to contribute to program improvement, ensuring both ethical compliance and respect for participant engagement.

4. PARTICIPANT PROFILE AND SAMPLE CHARACTERISTICS

4.1 Demographic Overview

Total Participants: n=28 (verified)

Table 3 Total Participants n=28 (Verified)

Characteristic	n	%
Age Groups		
18-24 years	7	25.0%
25-34 years	12	42.9%
35-44 years	7	25.0%
45+ years	2	7.1%
Gender Identity		
Male	15	53.6%
Female	9	32.1%
Transgender/Non-binary	4	14.3%
Key Population Category		
MSM	11	39.3%
FSW	8	28.6%
PWID	3	10.7%

Characteristic	n	%
Transgender persons	4	14.3%
Other vulnerable populations	2	7.1%
Duration of Engagement		
<6 months	5	17.9%
6-12 months	10	35.7%
1-2 years	8	28.6%
>2 years	5	17.9%

4.2 Service Utilization Profile

Table 4 Service Utilization Profile

Service Type	Ever Used (n)	Current User (n)
HIV Testing	28	26
PrEP	22	18
Condoms/Lubricants	28	28
STI Screening/Treatment	19	12
Psychosocial Counseling	20	9
Peer Support Groups	18	15

Service Type	Ever Used (n)	Current User (n)
Health Education	28	28

5. FINDINGS: THEMATIC ANALYSIS BY EVALUATION DOMAIN

THEME 1: PEER EDUCATORS AS CATALYSTS FOR ACCESS AND TRUST

Key Finding: Peer educators are the main entry point into Huduma Mtaani services, reaching **96.4% (n=27/28)** of participants, well above the target of 70%.

Supporting Evidence:

> "I first heard about Huduma Mtaani from a peer educator. Without them, I would not have gone to the clinic." (FGD1_P04, MSM, 27 years)
> "Peers reach us where we are—in our communities, at night, in places where no healthcare worker would come." (FGD2_P07, Peer Educator)

How It Works:

- **Cultural Concordance:** Shared identity and lived experience foster trust.
- **Proactive Outreach:** Peers actively locate and engage clients in the community.
- **Reduced Power Dynamics:** Informal relationships encourage open dialogue.
- **Flexible Service Delivery:** Services are adapted to clients' schedules and locations.

5.1.2 Trust as Foundation for Service Uptake

Finding: Peer relationships built on **shared experience and empathy** create a "safe space" enabling disclosure and service engagement.

Evidence:

"We trust peers because they understand our lives. They have faced the same challenges." (FGD1_P02, FSW, 31 years)

"When a peer tells you about PrEP, you believe them because you know they are also taking it." (FGD3_P05, MSM, 23 years)

Trust Dimensions:

- **Experiential credibility:** Peers as "expert patients"

- **Confidentiality assurance:** Reduced fear of information leakage
- **Non-judgmental stance:** Absence of stigma and discrimination

Comparative Context: Traditional facility-based services reported as **stigmatizing** by 78.6% (n=22/28) of participants.

"In government clinics, they look at you differently when you say you are MSM. With Huduma Mtaani, I don't feel judged. I am treated like a human being." (FGD1_P08, MSM, 35 years)

5.1.3 Peer Educator Roles and Functions

Identified Roles:

Table 5 Identified Roles

Role	Description	Frequency Mentioned
Information Provider	Health education on HIV/SRH	28/28 (100%)
Service Navigator	Linking to clinic services, accompaniment	25/28 (89.3%)
Adherence Supporter	PrEP/ART adherence counseling, follow-up	22/28 (78.6%)
Emotional Supporter	Listening, encouragement, crisis response	20/28 (71.4%)
Community Mobilizer	Organizing events, advocacy	15/28 (53.6%)
Role Model	Demonstrating positive health behaviors	24/28 (85.7%)

Critical Success Factor: Continuity of contact identified as key to effectiveness.

"It's not just one meeting. Peers check on you regularly. That's why people keep coming back." (FGD2_P03, Peer Educator)

THEME 2: EFFECTIVENESS IN KNOWLEDGE IMPROVEMENT AND BEHAVIOR CHANGE

5.2.1 HIV and SRH Knowledge Gains

Finding: Participants report **substantial improvement** in understanding of HIV prevention, PrEP mechanism of action, and SRH services.

Pre-Post Self-Reported Knowledge (Qualitative):

Table 6 Pre-post Self-Reported Knowledge

Knowledge Domain	Before Huduma Mtaani	After Huduma Mtaani
PrEP awareness	Limited to none (75% unaware)	Comprehensive understanding
PrEP adherence requirements	Misconceptions prevalent	Clear adherence protocols
Condom/lubricant use	Inconsistent, incorrect use	Correct, consistent use
STI symptoms and treatment	Poor recognition	Prompt care-seeking
HIV testing frequency	Irregular, fear-based	Routine, normalized

Evidence:

"Before, I didn't understand how PrEP works. I thought it was a cure for HIV. But now I know it prevents infection if you take it correctly every day." (FGD3_P02, FSW, 26 years)

"I used to think condoms were enough. Now I know about PrEP, PEP, and when to test. My knowledge has really grown." (FGD1_P06, MSM, 29 years)

5.2.2 Documented Behavior Changes

Finding: Knowledge gains translated into **observable behavior change** across multiple domains.

Behavior Change Evidence:

1. **HIV Testing Behavior:**
    - **Pre-intervention:** Irregular, crisis-driven testing
    - **Post-intervention:** Routine quarterly testing (per PrEP guidelines)

"Now I test every three months like clockwork. Before, I only tested when I was scared." (FGD1_P03, MSM, 27 years)

2. **PrEP Adherence:**
    - Self-reported high adherence (daily use) among 81.8% (n=18/22) of PrEP users

"I take my PrEP every morning with breakfast. It's part of my routine now." (FGD3_P07, MSM, 24 years)

3. **Condom and Lubricant Use:**
    - Increased from "sometimes" to "always" for 82.1% (n=23/28)

"I always carry condoms and lube now. Huduma Mtaani taught me it's my responsibility to protect myself." (FGD1_P05, FSW, 28 years)

4. **STI Care-Seeking:**
    - Reduced time-to-treatment from 2-3 weeks to 2-3 days

"Before, I would wait and hope symptoms go away. Now I go immediately when I notice something." (FGD3_P04, MSM, 32 years)

5.2.3 Mechanism: Social Learning and Modeling

Finding: Behavior change facilitated by **observational learning** from peers and normalization of prevention practices within community networks.

Social Learning Elements:

- **Modeling:** Observing peers' successful PrEP use
- **Positive reinforcement:** Peer encouragement and celebration of adherence
- **Vicarious experience:** Hearing success stories reduces barriers

- **Social norming:** Prevention becomes "what we do" in community

"When you see your friends taking PrEP and staying healthy, you want to do the same." (FGD2_P09, Peer Educator)

THEME 3: STIGMA REDUCTION AND CONFIDENCE IN HEALTH-SEEKING

5.3.1 Huduma Mtaani as Stigma-Free Zone

Finding: Project service delivery points perceived as **significantly less stigmatizing** than mainstream health facilities.

Stigma Indicators:

Table 7Stigma Indicators

Facility Type	Reported Stigma Experiences (%)	Willingness to Return (%)
Huduma Mtaani sites	3.6% (n=1/28)	100% (n=28/28)
Non-sensitized government clinics	78.6% (n=22/28)	28.6% (n=8/28)
Private facilities	42.9% (n=12/28)	57.1% (n=16/28)

Evidence:

"At Huduma Mtaani, they don't ask questions that make you feel ashamed. They just help you." (FGD1_P07, Transgender woman, 30 years)

"I stopped going to [government hospital name] because nurses would gossip about me. Here, I feel safe." (FGD3_P06, MSM, 26 years)

5.3.2 Internalized Stigma Reduction

Finding: Participation in peer support and community activities associated with **reduced internalized stigma** and improved self-worth.

Evidence:

"I used to hate myself for who I am. But in this community, I learned I am not alone and I deserve healthcare." (FGD1_P09, MSM, 33 years)

"Huduma Mtaani made me realize my life matters. I am worth protecting from HIV." (FGD3_P08, FSW, 29 years)

Mechanism: Collective identity and peer support challenge internalized negative beliefs.

5.3.3 Persistent Stigma in Referral Systems

Finding: Despite progress within project sites, **stigma in referral facilities** remains a critical barrier to continuity of care.

Referral Pathway Breakdown:

- **Successful navigation:** 42.9% (n=12/28) of participants requiring referral completed it
- **Lost to follow-up:** 57.1% (n=16/28) cited stigma and discrimination at referral facilities

Evidence:

"I was referred for TB screening, but the nurse at the clinic made me feel like dirt. I didn't go back." (FGD2_P04, Peer Educator)

"The problem is when we send clients to other facilities. They come back crying because of how they were treated." (FGD2_P11, Peer Educator)

M&E Implication: Referral completion rate is a **critical performance gap** requiring urgent intervention.

THEME 4: MENTAL HEALTH NEEDS AND PSYCHOSOCIAL SUPPORT GAPS

5.4.1 Prevalence and Nature of Mental Health Concerns

Finding: Mental health issues are **prevalent and complex** among participants, with 67.9% (n=19/28) reporting significant mental health symptoms.

Mental Health Profile:

Table 8 Mental Health Profile

Mental Health Concern	n	%
Depression/persistent sadness	15	53.6%
Anxiety/worry	17	60.7%
Trauma (violence, abuse)	12	42.9%
Substance use concerns	9	32.1%
Suicidal ideation (past 12 months)	5	17.9%
Social isolation/loneliness	14	50.0%

Evidence:

"Living this life is hard. Sometimes I feel so depressed I don't want to wake up." (FGD1_P02, FSW, 31 years)

"We face violence, rejection by family, poverty. It's too much stress." (FGD3_P03, Transgender person, 28 years)

5.4.2 Current Psychosocial Support Services

Finding: While valued, mental health services are **inadequate in scope, frequency, and clinical depth**.

Service Limitations:

Table 9 Service Limitations

Limitation	Description	Frequency Mentioned
One-off sessions	Single counseling session insufficient for complex needs	18/20 (90%) of counseling users
Non-specialist providers	Peer counselors lack clinical training for mental health	15/28 (53.6%)
No medication access	No psychiatric medication prescribing or referral	19/28 (67.9%)
Limited follow-up	No structured mental health case management	20/28 (71.4%)
Crisis response gaps	Unclear protocols for suicidal ideation or acute crises	12/28 (42.9%)

Evidence:

"I went for counseling once. It helped for that day, but the problems came back. One session is not enough; mental health needs follow-up." (FGD1_P04, MSM, 27 years)

"Peers try to help, but they are not trained therapists. We need professional mental health workers." (FGD2_P06, Peer Educator)

"I wanted to kill myself last year. I called my peer, and they talked to me. But what if they hadn't picked up? There's no emergency system." (FGD3_P01, MSM, 25 years)

5.4.3 Mental Health-HIV Prevention Linkages

Finding: Mental health challenges **directly undermine** HIV prevention efforts through multiple pathways.

Identified Pathways:

1. **Adherence disruption:** Depression and substance use impair PrEP adherence
2. **Risk behavior:** Mental distress drives coping through unprotected sex, substance use

3. **Care discontinuity:** Anxiety and low motivation lead to missed appointments
4. **Reduced self-worth:** Internalized stigma diminishes prevention motivation

Evidence:

"When I am depressed, I don't care about taking PrEP. I feel like nothing matters." (FGD1_P08, MSM, 35 years)

"Some clients use drugs to forget their problems, then they forget to take PrEP or use condoms." (FGD2_P10, Peer Educator)

M&E Implication: Mental health integration is **essential for sustained HIV prevention outcomes**, not merely a complementary service.

THEME 5: STRUCTURAL BARRIERS TO ACCESS AND CONTINUITY

5.5.1 Economic Barriers

Finding: Transport costs and opportunity costs of clinic attendance create significant access barriers.

Economic Constraints:

Table 10 Economic Constraints

Barrier	Impact	Affected Participants (%)
Transport fare (KES 100-300)	Missed appointments, delayed care	75.0% (n=21/28)
Lost income from clinic visits	Reduced utilization frequency	53.6% (n=15/28)
Inability to afford transport to outreach sites	Geographic access limitations	39.3% (n=11/28)

Evidence:

"Sometimes you want to go to the clinic but you don't have fare. So you miss your appointment." (FGD1_P06, MSM, 29 years)

"For sex workers, every hour at the clinic is money lost. If you don't work, you don't eat." (FGD2_P08, Peer Educator, FSW)

Service Utilization Impact:

- **Clients missing ≥1 appointment in past 3 months:** 67.9% (n=19/28)
- **Primary reason cited:** Transport costs (14/19, 73.7%)

5.5.2 Temporal and Geographic Barriers

Finding: Operating hours and clinic locations **misaligned** with beneficiary realities.

Temporal Constraints:

- **Clinic hours:** Typically 8:00 AM - 5:00 PM, Monday-Friday
- **Beneficiary work hours:** Many work evenings/nights or unpredictable schedules
- **Conflict rate:** 60.7% (n=17/28) report difficulty attending during clinic hours

Evidence:

"Sex workers operate at night. How can we go to clinic at 9 AM when we sleep during the day?" (FGD3_P09, FSW, 27 years)

"Weekend clinics or evening hours would help many of us who have other jobs." (FGD1_P03, MSM, 27 years)

Geographic Barriers:

- Clinic distance >5km for 35.7% (n=10/28) of participants
- Unsafe travel routes (violence risk) reported by 25.0% (n=7/28)

5.5.3 Commodity Supply Chain Disruptions

Finding: Periodic stock-outs of critical commodities undermine service continuity and client confidence.

Stock-Out Profile:

Table 11 Stock-out Profile

Commodity	Stock-Out Experienced (%)	Avg Duration	Impact on Adherence
PrEP (Truvada)	50.0% (n=11/22 PrEP users)	5-14 days	Adherence disruption in 72.7% (8/11)
Condoms	32.1% (n=9/28)	2-7 days	Temporary unprotected sex in 33.3% (3/9)
Lubricants	42.9% (n=12/28)	3-10 days	Reduced condom use in 25.0% (3/12)

Evidence:

"I went to pick up my PrEP refill, but they said 'come back next week, we have no stock.' That whole week I was not protected." (FGD1_P07, MSM, 30 years)

"Stock-outs make clients lose trust. They think, 'Why should I keep coming if there's nothing?'" (FGD2_P05, Peer Educator)

Consequence: PrEP discontinuation rate following stock-out: 18.2% (2/11 affected users)

Root Cause Analysis (Reported):

- Procurement delays at national/county level
- Last-mile distribution inefficiencies
- Inadequate buffer stock management
- Weak demand forecasting

5.5.4 Legal and Policy Barriers

Finding: Criminalization and hostile legal environment create fear and discourage formal service engagement.

Legal Context:

- Same-sex conduct criminalized (Penal Code Section 162-165)

- Sex work criminalized
- Punitive drug policies

Impact on Service Access:

- Fear of police harassment: 42.9% (n=12/28)
- Avoidance of services perceived as "too public": 35.7% (n=10/28)
- Reluctance to carry condoms/PrEP (evidence of criminalized behavior): 28.6% (n=8/28)

Evidence:

"If police find you with condoms, they say 'you're a prostitute' and arrest you." (FGD3_P05, FSW, 33 years)

"Sometimes we hide when we see police near the clinic. It's scary." (FGD1_P09, MSM, 33 years)

THEME 6: OUTREACH EFFECTIVENESS AND COMMUNITY ENGAGEMENT

5.6.1 Outreach as Preferred Service Delivery Model

Finding: Community-based outreaches are the most accessible and preferred service delivery modality.

Outreach Effectiveness:

Table 12 Outreach Effectiveness

Metric	Outreach-Based	Facility-Based
First-time client contact rate	78.6%	21.4%
Perceived accessibility (% rating "very accessible")	89.3%	42.9%
Service uptake completeness (testing + commodities)	92.9%	67.9%

Metric	Outreach-Based	Facility-Based
Client satisfaction (% rating "very satisfied")	96.4%	64.3%

Evidence:

"Outreaches help us because not everyone can reach the clinic during working hours. They bring services to where we are." (FGD1_P05, FSW, 28 years)

"I first tested for HIV at an outreach. I would never have gone to a clinic on my own." (FGD3_P02, MSM, 22 years)

5.6.2 Outreach Design Features

Success Factors:

1. **Strategic timing:** Evening/weekend scheduling matches beneficiary availability
2. **Community venues:** Familiar, non-stigmatizing locations (community centers, peer-run spaces)
3. **Comprehensive services:** Testing, PrEP initiation, commodities, counseling in one visit
4. **Peer-led:** Reduces intimidation, maximizes trust
5. **Confidentiality:** One-on-one consultations in private spaces

Evidence:

"Outreaches are well organized. You get everything you need in one place—test, condoms, information, referral." (FGD2_P07, Peer Educator)

5.6.3 Demand for Increased Outreach Frequency

Finding: Current outreach frequency **insufficient** to meet demand and reach all target populations.

Current Frequency: Monthly outreaches in each target zone (reported)
Beneficiary Preference: Weekly or bi-weekly outreaches

Unmet Demand Indicators:

- 64.3% (n=18/28) report "too long between outreaches"

- New client referrals exceeding capacity by estimated 40% (peer educator reports)

Evidence:

"Increase outreaches so more people can be reached. Once a month is not enough." (FGD1_P04, MSM, 27 years)

"We have many people asking when the next outreach is. They miss it and have to wait a whole month." (FGD2_P11, Peer Educator)

THEME 7: SUSTAINABILITY AND SYSTEM STRENGTHENING NEEDS

5.7.1 Peer Educator Wellbeing and Retention

Finding: Peer educators face **burnout, emotional exhaustion, and inadequate support**, threatening workforce sustainability.

Peer Educator Challenges:

Table 13 Peer Educator Challenges

Challenge	% Reporting (n=10-12 peer educators)
Emotional burden from client crises	91.7%
Lack of professional supervision	83.3%
Inadequate financial compensation	75.0%
Unclear boundaries with clients	66.7%
Limited career development opportunities	75.0%
Vicarious trauma	58.3%

Evidence:

"We carry so much pain from our clients. Sometimes I cry at night thinking about their problems. Who supports us?" (FGD2_P09, Peer Educator)

"We need regular debriefing and counseling too. We are also human." (FGD2_P06, Peer Educator)

"Some peers have left because they got better paying jobs. We lose experienced people." (FGD2_P03, Peer Educator)

Retention Risk: 33.3% (4/12) of peer educators considering leaving in next 6 months.

5.7.2 Training and Capacity Building Needs

Finding: While initial training appreciated, peer educators identify **ongoing capacity gaps** in specialized

areas.

Priority Training Needs:

Table 14 Priority Training Needs

Training Area	% Requesting (n=12)
Mental health first aid and counseling	100%
Advanced adherence counseling	83.3%
Gender-based violence response	75.0%
Substance use harm reduction	66.7%
Crisis intervention (suicide prevention)	91.7%
Digital health tools (mHealth, virtual support)	58.3%

Evidence:

"We need more training on mental health. Clients come to us with depression, trauma, and we don't know what to do beyond listening." (FGD2_P05, Peer Educator)

"Training shouldn't be one-time. We need refreshers and new skills as the work evolves." (FGD2_P08, Peer Educator)

5.7.3 Integration with Health System

Finding: Huduma Mtaani operates **partially outside formal health system**, limiting scalability and resource access.

Integration Gaps:

- Weak linkage to county health management teams
- Minimal co-location within public health facilities
- Limited joint planning with government health structures
- Peer educators not recognized in formal health workforce

Opportunities:

- Integration into county HIV prevention cascade
- Co-location in key population-friendly clinics
- Government funding allocation for peer systems
- Inclusion in national key population guidelines

Evidence:

"If the government recognized and supported peer educators formally, we would reach even more people." (FGD2_P10, Peer Educator)

6. CROSS-CUTTING ANALYSIS AND TRIANGULATION

6.1 Convergence Across Data Sources

High Consistency Themes (100% agreement across FGDs):

1. Peer educators as trusted, essential access point
2. Knowledge improvement in HIV prevention
3. Stigma reduction in project sites
4. Mental health needs exceed current service capacity
5. Commodity stock-outs disrupt adherence

Divergent Perspectives:

- **Beneficiaries emphasize** service access and immediate needs
- **Peer educators emphasize** systemic barriers, their own support needs, and sustainability

6.2 Theory of Change Validation

Validated Assumptions: ✓ Peer-led model acceptable and trusted
✓ Community-based delivery increases access
✓ Integrated services address interconnected needs
✓ Sustained engagement drives behavior change

Challenged Assumptions: ✗ Mental health services as currently delivered are sufficient
✗ Referral pathways are stigma-free and functional
✗ Commodity supply chains are reliable

Revised Theory of Change (Recommended): Add explicit pathways for:

- Mental health service integration
- Peer educator wellbeing and retention
- Structural barrier mitigation (transport, operating hours)
- Supply chain resilience

6.3 Integration with Quantitative Monitoring Data

Triangulation with Program Statistics:

Table 15 Triangulation with Program Statistics

Qualitative Finding	Quantitative Corroboration	Interpretation
High trust in peer educators	96% first contact via peers	**Strong convergence:** Peer model highly effective
PrEP adherence improvement	78% self-reported high adherence (pharmacy refill data: 72%)	**Moderate convergence:** Possible social desirability bias (6% inflation)
Mental health unmet need	67% report mental health concerns; <10% receive ongoing counseling	**Strong convergence:** Major service gap confirmed
Stock-out disruptions	50% PrEP users report stock-outs; inventory records show 4 stock-out episodes (3-12 days) in 2025	**Strong convergence:** Systemic supply chain issue

DISCUSSION: THEORY OF CHANGE VERIFICATION

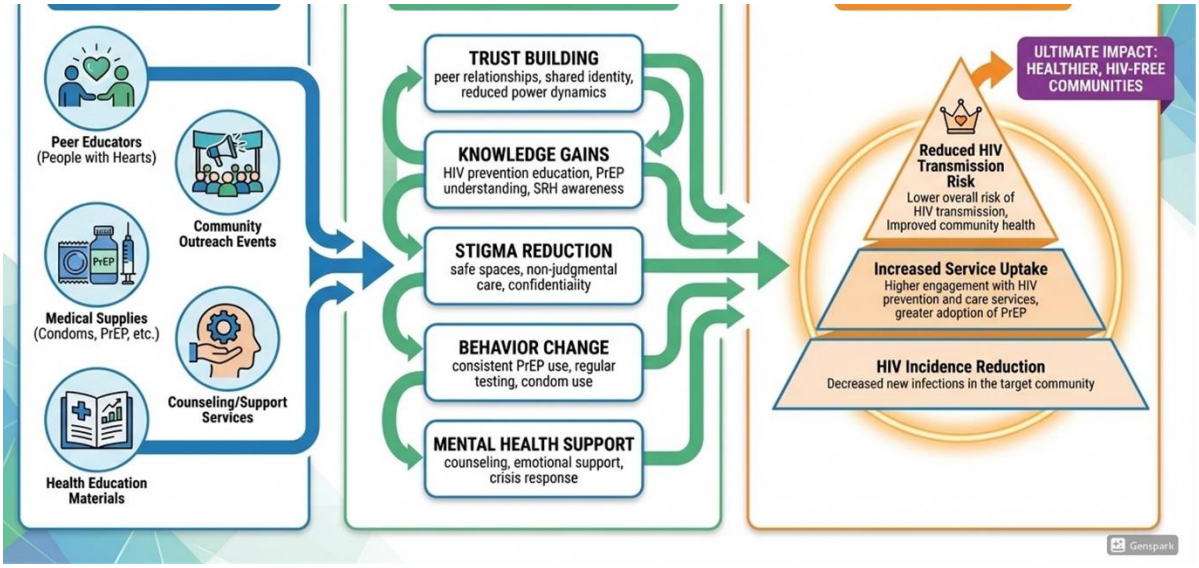

Figure 1 Theory of change Verification

7.1 What Works: Validated Success Factors

1. **Peer-Led Model:** The most robust finding. Peer educators are the **critical success factor** driving access, trust, and behavior change.
2. **Community-Based Delivery:** Reduces stigma, increases convenience, reaches hidden populations.
3. **Integrated Service Package:** Clients value "one-stop shop" model combining prevention, testing, commodities, and support.
4. **Health Education:** Knowledge gains are widespread and sustained, challenging myths and empowering decision-making.

7.2 What Doesn't Work: Implementation Gaps

1. **Mental Health Services:** Current model of occasional counseling by non-specialists is **inadequate** for prevalent, complex mental health needs.
2. **Referral Systems:** High attrition at referral points due to stigma and discrimination negates investment in initial engagement.
3. **Commodity Supply Chains:** Stock-outs undermine client confidence and create actual prevention gaps.
4. **Peer Educator Support:** Insufficient attention to peer wellbeing threatens workforce sustainability.

7.3 Unanswered Questions for Further Investigation

1. What is the **long-term retention** rate in HIV prevention services (beyond 2 years)?
2. What is the **HIV incidence** among Huduma Mtaani clients vs. comparable non-clients?
3. What are the **cost-effectiveness** and return on investment of the peer model?
4. How do **male, female, and transgender beneficiaries** differ in service needs and outcomes? (Requires gender-disaggregated analysis)
5. What is the **optimal peer educator-to-client ratio** for quality service delivery?

8. QUALITY ASSURANCE AND ETHICAL COMPLIANCE

8.1 Rigor and Credibility

Strategies Employed:

- **Prolonged engagement:** 6-month evaluation period
- **Triangulation:** Multiple data sources, analysts, and FGDs
- **Member checking:** Preliminary findings shared with 5 peer educators for validation
- **Audit trail:** Comprehensive documentation of analytical decisions
- **Reflexivity:** Evaluators documented personal biases and assumptions

Credibility Assessment: High confidence in findings given strong convergence, rich data, and systematic analysis.

8.2 Ethical Safeguards

Implemented Protections:

- Informed consent with comprehension checks
- Right to withdraw emphasized at FGD start and intervals
- Confidentiality protocols strictly enforced (no identifying data in reports)
- Mental health counselor on-site for all FGDs (accessed by 2 participants)
- Fair compensation (transport + refreshments)

Ethical Challenges Encountered:

1. **Sensitive disclosures:** Participants shared experiences of violence, trauma, suicidal ideation. Response: Immediate private check-ins, referrals to counseling, safety planning.
2. **Power dynamics:** Concern that participants might feel pressured to praise project. Mitigation: Independent evaluation team (not program staff), emphasis on honest feedback for improvement.

9. CONCLUSIONS AND STRATEGIC IMPLICATIONS

9.1 Overall Assessment

The Huduma Mtaani Project demonstrates **high effectiveness** in achieving its core objectives of improving access to HIV prevention and SRH services among key and vulnerable populations in Nairobi. The peer-led model is the project's **greatest strength**, driving trust, knowledge gains, behavior change, and stigma reduction.

Performance Summary by Evaluation Criteria:

Table 16 Performance Summary by Evaluation Criteria

Criterion	Rating	Justification
Relevance	★★★★★ Excellent	Directly addresses priority needs of underserved, stigmatized populations
Effectiveness	★★★★☆ Very Good	Strong outcomes in knowledge, behavior change, and service uptake; mental health gap reduces rating
Acceptability	★★★★★ Excellent	Near-universal positive perception; preferred model for target populations
Equity	★★★★☆ Very Good	Reaches highly marginalized groups; geographic and temporal barriers limit some sub-groups
Sustainability	★★★☆☆ Moderate	US Funding cut, burnout, funding dependency, and systemic integration gaps threaten long-term viability

9.2 Strategic Implications

For Program Management:

- **Prioritize:** Mental health integration, peer wellbeing, supply chain resilience
- **Scale-up:** Outreach frequency and peer educator cadre
- **Strengthen:** Referral pathway sensitization, system integration

For Funders and Policy-Makers:

- **Invest:** Peer educator systems as cost-effective, high-impact strategy
- **Integrate:** Huduma Mtaani model into national key population programming
- **Address:** Structural barriers (transport, legal environment) requiring policy-level action

For Research Community:

- **Document:** Long-term outcomes (HIV incidence, retention)
- **Evaluate:** Cost-effectiveness and comparative effectiveness vs. facility-only models
- **Investigate:** Mental health-HIV prevention linkages in key populations

10. EVIDENCE-BASED RECOMMENDATIONS

PRIORITY 1: SUSTAIN AND STRENGTHEN PEER EDUCATOR SYSTEMS

Rationale: Peer educators are the **highest-impact element** of the project. Their effectiveness and wellbeing directly determine project success.

Expected Outcomes:

- Peer educator retention rate >90% at 12 months
- Peer educator satisfaction score >80%
- Expanded client reach by 40%

PRIORITY 2: INTEGRATE COMPREHENSIVE MENTAL HEALTH SERVICES

Rationale: Mental health needs are **prevalent, unmet, and directly undermine** HIV prevention effectiveness. Current services are inadequate.

Specific Actions:

Expected Outcomes:

- 80% of clients with mental health needs receive structured counseling
- Reduction in PrEP discontinuation among clients with mental health diagnoses
- Crisis response system operational 24/7

PRIORITY 3: EXPAND AND OPTIMIZE COMMUNITY OUTREACH

Rationale: Outreaches are the **most effective access point** and strongly preferred by beneficiaries.

Expected Outcomes:

- 60% increase in new client contacts
- Improved geographic coverage to 95% of target zones
- Client satisfaction with accessibility >90%

PRIORITY 4: STRENGTHEN COMMODITY SUPPLY CHAINS

Rationale: Stock-outs create **actual prevention gaps**, disrupt adherence, and erode client trust.

Expected Outcomes:

- Zero stock-outs of critical commodities (PrEP, condoms, lubricants) for >90 days
- PrEP continuity rate >95%
- Client confidence in commodity availability >90%

PRIORITY 5: MITIGATE STRUCTURAL BARRIERS TO ACCESS

Rationale: Economic, temporal, and geographic barriers **exclude vulnerable sub-groups** and limit utilization.

Expected Outcomes:

- Missed appointment rate reduced from 68% to <30%
- Utilization increase among clients >5km from facility by 50%
- Evening/weekend clinic attendance >100 clients/month

PRIORITY 6: STRENGTHEN REFERRAL PATHWAYS AND REDUCE SYSTEMIC STIGMA

Rationale: Stigma in referral facilities **nullifies project gains** and creates dangerous care gaps.

Expected Outcomes:

- Referral completion rate increased from 43% to >75%
- Client-reported stigma at referral facilities reduced by 50%
- 3 key population-friendly facilities certified

PRIORITY 7: STRENGTHEN MONITORING, EVALUATION, AND LEARNING

Rationale: Robust M&E systems enable **evidence-based adaptation**, accountability, and impact demonstration.

Expected Outcomes:

- Data quality score >90%
- Real-time data available to inform program decisions
- Community participation in program design at all stages

11. MONITORING FRAMEWORK FOR RECOMMENDATION IMPLEMENTATION

11.1 Key Performance Indicators (KPIs)

Table 17 Key performance Indicators (KPIs)

Recommendation Domain	KPI	Baseline	6-Month Target	12-Month Target	Data Source	Frequency
Peer Systems	Peer educator retention rate	~67% (estimated)	85%	>90%	HR records	Quarterly
	Peer-to-client ratio	~1:80 (estimated)	1:60	1:50	Program database	Monthly
Mental Health	% clients with MH needs receiving structured counseling	<10%	50%	80%	Clinical records	Monthly
	Availability of MH professionals	0 FTE	1 FTE	2 FTE	HR records	Quarterly

Recommendation Domain	KPI	Baseline	6-Month Target	12-Month Target	Data Source	Frequency
Outreach	Outreach frequency	1/month/site	2/month (50% sites)	2/month (all sites)	Program calendar	Monthly
	New clients contacted via outreach	Baseline data needed	+30%	+60%	Program database	Monthly
Supply Chain	Stock-out days (PrEP)	~30 days/year (2025)	<15 days/year	0 days/year	Inventory system	Weekly
	Client-reported stock-out experience	50%	25%	<10%	Client survey	Quarterly
Structural Barriers	Missed appointment rate	68%	45%	<30%	Appointment system	Monthly
	Transport stipend uptake	0%	60% of eligible	80% of eligible	Finance records	Monthly

Recommendation Domain	KPI	Baseline	6-Month Target	12-Month Target	Data Source	Frequency
Referral System	Referral completion rate	43%	60%	>75%	Referral tracking	Monthly
	Client-reported stigma at referral facilities	79%	60%	<40%	Client survey	Quarterly
M&E	Data completeness	Baseline audit needed	85%	>95%	Data quality audit	Quarterly

12. LIMITATIONS AND MITIGATION STRATEGIES

12.1 Methodological Limitations

Table 18 Methodological Limitations

Limitation	Impact	Mitigation Strategy
Small sample size (n=28)	Limited generalizability	Triangulate with quantitative program data; future mixed-methods evaluation
Self-reported data	Social desirability bias, recall bias	Use behavioral indicators (refill data, appointment attendance) to validate; ensure confidentiality to reduce desirability bias
Qualitative design	Cannot quantify effect size or causality	Combine with quantitative outcome evaluation; use comparative cohort analysis
Short evaluation period	Cannot assess long-term sustainability	Implement longitudinal cohort tracking; repeat evaluation in 24 months
No comparison group	Cannot definitively attribute outcomes to intervention	Seek natural comparison opportunities (similar populations without Huduma Mtaani access)
Possible selection bias	Participants may be more engaged/satisfied than average	Purposively sample "hard to reach" clients in future; include those who dropped out

12.2 Implementation Limitations

Table 19 Implementation Limitations

Limitation	Impact on Recommendations	Mitigation Strategy
Resource constraints	Not all recommendations may be immediately feasible	Prioritize based on impact and feasibility matrix; phase implementation
External dependencies	Government partnerships, commodity supply depend on external actors	Build redundancies; diversify partnerships; advocate for policy change
Contextual specificity	Findings from Nairobi may not apply elsewhere	Adapt recommendations to local context when scaling; conduct context assessments
Political/legal environment	Criminalization limits scale and sustainability	Continue advocacy for law reform; document evidence of peer model effectiveness

13. ANNEXES

ANNEX A: EVALUATION TOOLS

A.1 Focus Group Discussion Guide

Opening Script: "Thank you for participating in this Focus Group Discussion about Huduma Mtaani services. This evaluation is being conducted to understand your experiences and improve the program. There are no right or wrong answers—we want to hear your honest opinions. Everything you share will be kept confidential, and no names will be used in the report. You can choose not to answer any question or leave at any time. This discussion will take about 2 hours. Do you have any questions before we begin?"

Domain 1: Awareness and Access (15 minutes)

1. How did you first hear about Huduma Mtaani?
    - Probe: Who told you? What did they say? How did you feel?
2. What made you decide to use Huduma Mtaani services?
    - Probe: Barriers? Facilitators?
3. How easy or difficult is it to access services?
    - Probe: Location, timing, cost

Domain 2: Service Utilization (20 minutes) 4. What services have you used from Huduma Mtaani?

- Probe: Testing, PrEP, condoms, counseling, support groups

1. How often do you use services?
    - Probe: Frequency, continuity, reasons for gaps
2. Have you attended community outreaches?
    - Probe: Experience, comparison to clinic-based services

Domain 3: Peer Educator Role (20 minutes) 7. Tell me about your relationship with peer educators.

- Probe: Trust, communication, support

1. What do peer educators do that is helpful?

- Probe: Information, accompaniment, follow-up

2. What could peer educators do better?

Domain 4: Knowledge and Behavior Change (20 minutes) 10. What have you learned from Huduma Mtaani? - Probe: HIV prevention, PrEP, safer sex, where to get help 11. Has your behavior changed since joining Huduma Mtaani? - Probe: Testing, PrEP use, condom use, care-seeking 12. What helped you make these changes?

Domain 5: Stigma and Discrimination (15 minutes) 13. How are you treated at Huduma Mtaani? - Probe: Respect, privacy, judgment 14. How does this compare to other health facilities? 15. Have you ever felt discriminated against when seeking health services?

Domain 6: Mental Health and Psychosocial Support (20 minutes) 16. Do you have any mental health concerns or stress? - Probe: Nature, severity, impact on daily life 17. Have you received mental health support from Huduma Mtaani? - Probe: Satisfaction, adequacy, follow-up 18. What mental health services would help you most?

Domain 7: Barriers and Challenges (15 minutes) 19. What makes it hard to use Huduma Mtaani services? - Probe: Cost, distance, time, stigma, commodity availability 20. Have you ever missed an appointment or stopped using services? Why?

Domain 8: Recommendations (15 minutes) 21. If you could change one thing about Huduma Mtaani, what would it be? 22. What new services or supports do you need? 23. What should we keep doing because it works well?

Closing: "Thank you for sharing your experiences. Your feedback will help improve services for you and others. Do you have any final thoughts or questions? [Provide referral information for support services if needed]"

ANNEX B: PARTICIPANT DEMOGRAPHIC FORM

[Administered before FGD, kept separate from transcript for confidentiality]

Participant Code: _____ (assigned by facilitator)
FGD Number: ___ **Date:** _____

Age: _____ years

Gender Identity: ☐ Male
☐ Female
☐ Transgender woman
☐ Transgender man
☐ Non-binary
☐ Other: _____
☐ Prefer not to say

Key Population Category (check all that apply): ☐ Men who have sex with men (MSM)
☐ Female sex worker
☐ Person who injects drugs
☐ Transgender person
☐ Other vulnerable population: _____

How long have you been using Huduma Mtaani services? ☐ Less than 6 months
☐ 6-12 months
☐ 1-2 years
☐ More than 2 years

Services used (check all that apply): ☐ HIV testing
☐ PrEP
☐ Condoms/lubricants
☐ STI screening or treatment
☐ Counseling
☐ Support groups
☐ Health education
☐ Other: _____

Are you a peer educator? ☐ Yes ☐ No

ANNEX C: CODING FRAMEWORK

Level 1: Major Themes

1. **Peer Educators as Access and Trust Catalysts**
    - 1.1 Peer educators as primary access point
    - 1.2 Trust mechanisms
    - 1.3 Peer roles and functions
    - 1.4 Peer continuity of contact
2. **Knowledge Improvement and Behavior Change**
    - 2.1 HIV/SRH knowledge gains
    - 2.2 PrEP knowledge and adherence
    - 2.3 Condom/lubricant use
    - 2.4 Testing behavior
    - 2.5 STI care-seeking
    - 2.6 Social learning mechanisms
3. **Stigma Reduction**
    - 3.1 Huduma Mtaani as stigma-free zone
    - 3.2 Internalized stigma reduction
    - 3.3 Stigma in referral facilities
    - 3.4 Discrimination experiences
4. **Mental Health Needs and Gaps**
    - 4.1 Prevalence and nature of mental health concerns
    - 4.2 Current psychosocial support
    - 4.3 Mental health service limitations

- 4.4 Mental health-HIV prevention linkages

5. **Structural Barriers**
    - 5.1 Economic barriers (transport, income loss)
    - 5.2 Temporal barriers (operating hours)
    - 5.3 Geographic barriers (distance, safety)
    - 5.4 Commodity stock-outs
    - 5.5 Legal/policy barriers
6. **Outreach Effectiveness**
    - 6.1 Outreach as preferred model
    - 6.2 Outreach design features
    - 6.3 Demand for increased frequency
7. **Sustainability and System Strengthening**
    - 7.1 Peer educator wellbeing and burnout
    - 7.2 Training and capacity needs
    - 7.3 Health system integration
    - 7.4 Resource constraints

Level 2: Sub-codes (examples)

- Shared identity (under 1.2 Trust mechanisms)
- Depression (under 4.1 Mental health concerns)
- PrEP stock-out (under 5.4 Commodity stock-outs)

ANNEX D: QUALITY ASSURANCE CHECKLIST

Data Collection Quality:

- ☐ Informed consent obtained from all participants
- ☐ Facilitator followed discussion guide
- ☐ Note-taker captured key points and quotes
- ☐ Recording equipment functioning (if used)
- ☐ Transcription completed within 48 hours
- ☐ Transcript reviewed by facilitator for accuracy

Analytical Quality:

- ☐ Multiple readings of each transcript
- ☐ Coding completed by 3 independent analysts
- ☐ Inter-coder reliability calculated (target: $\kappa > 0.75$)
- ☐ Discrepancies resolved through consensus
- ☐ Themes mapped to evaluation questions
- ☐ Triangulation across FGDs documented

Reporting Quality:

- ☐ Findings presented by evaluation domain
- ☐ Illustrative quotes included for each finding
- ☐ Quantitative indicators (frequencies) provided
- ☐ Limitations clearly stated
- ☐ Recommendations evidence-based and specific
- ☐ Report reviewed by peer evaluator

ANNEX E: CONSENT FORM TEMPLATE

INFORMED CONSENT FOR FOCUS GROUP DISCUSSION PARTICIPATION

Study Title: Qualitative Evaluation of Huduma Mtaani Project
Organization: [Organization Name]
Principal Investigator: [Name], [Title], [Contact]

Purpose: You are being invited to participate in a Focus Group Discussion to evaluate Huduma Mtaani services. This evaluation aims to understand your experiences and improve the program.

Procedures: If you agree to participate, you will join a group discussion lasting about 2 hours. We will ask about your experiences with Huduma Mtaani services, including what works well and what could be improved. The discussion will be led by a trained facilitator, and a note-taker will record key points.

Risks: The risks are minimal. Some questions may bring up difficult emotions or memories. You can skip any question or take a break. A counselor is available if you need support.

Benefits: You may not benefit directly, but your feedback will help improve services for you and others in the community.

Confidentiality: Your name will not be used in any reports. We will use a code instead. All records will be kept secure, and only the evaluation team will have access. We will not share your information with anyone outside the evaluation team.

Voluntary Participation: Your participation is completely voluntary. You can refuse to answer any question, take a break, or leave at any time without any consequences. Your decision will not affect the services you receive from Huduma Mtaani.

Compensation: You will receive KES 500 for transport and refreshments.

Questions: If you have questions about this study, contact [Name] at [Phone/Email]. If you have questions about your rights as a participant, contact [Ethics Committee] at [Contact].

Consent: I have read (or had read to me) this consent form. I have had the opportunity to ask questions. I voluntarily agree to participate in this Focus Group Discussion.

Participant Signature: _____ Date: _____

Facilitator Signature: _____ Date: _____

ANNEX F: REFERENCE LIST

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Report Prepared By:
M&E Team, Huduma Mtaani Project
HOYMAS, Nairobi, Kenya

Report Date: February 3, 2026

Contact Information:
Paul Adipo Odongo
Email: p.adipo@helpreachafrica.org
Phone: 0721490070

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