45

THE GLOBAL FUND
To Fight AIDS, Tuberculosis and Malaria
Interim Secretariat

Geneva, 31 January 2002 GFATM/B1/6A

KENYA PROPOSAL TO GFATM

For the use of the Global Fund Secretariat:
Date Received:
ID No:

This form is divided into 3 sections:
SECTION A seeks summary information on the overall proposal, total funding sought and information related to general eligibility criteria, including details of the Country Coordinating Mechanism;
SECTIOB B seeks further detail on the overall proposal, its objectives, how it will be monitored and demonstration of additionality;
SECTION C seeks detail, including budgetary information, separately on each component of the proposal.

SECTION A: OVERVIEW INFORMATION

A.1. Republic of Kenya

A.2. Proposal for additional support to fight AIDS, Tuberculosis and Malaria in Kenya

A.3. Main Components are:

3.1 HIV/AIDS:
- Scale up PMTCT and VCT program
- Increase equitable access to STI and OI prevention and treatment (TB included),
- Increase access to ARV for PLWA in Kenya
- Develop systems to ensure the feasibility of these mainstream activities.

3.2 Tuberculosis
3.3 Malaria

A.4 Additional outcomes expected:

4.1 HIV/AIDS specific outcomes
- The quality of life and length of survival of people living with AIDS in Kenya is improved.
- The incidence of HIV infection in the age bracket 15-24 years of Kenya is reduced.
- Prevalence of HIV infection in the general population is stabilized and shows indications of a downward trend
- The incidence of paediatric HIV-Infections is reduced.

4.2 Tuberculosis specific:

- Case-detection rate increased from 47-70% by end 2006
- 80% cure-rate of tuberculosis achieved
- Sustained uninterrupted supply of high quality anti-TB drugs in all health facilities by end 2006
- Laboratory quality assurance established
- Complete monitoring of drug resistance achieved

4.3 Malaria specific:

- Morbidity and mortality caused by malaria reduced by 30% among the population by 2006
- 80% of the health facilities report uninterrupted supply of quality assured anti-malarial drugs
- 60% of pregnant women and children under 5 years have access to insecticide treated nets (ITNs) by end of 2006.

4.4 Development targets

- Life-expectancy at birth increased from 47 years currently to 53 years by end 2006
- Infant Mortality Rate (IMR) reduced from 62 currently to 53 by end of 2006
- Maternal Mortality Rate reduced by 10% from the current 590/100,000 population by end 2006
- Rolling back the above three diseases of poverty will contribute to the achievement of the Millennium Goals as stated in the Poverty Reduction Strategy Paper (PRSP).

A.4. **Table 1: Total Amount Requested from the Global Fund (US$ millions by year)**

Component	Budget Estimates					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	31.10	31.78	35.14	40.74	40.61	179.37
2	4.31	1.19	1.58	2.28	2.55	11.91
3	13.94	10.14	26.01	25.41	26.75	102.25
TOTAL	**49.35**	**42.68**	**62.73**	**68.43**	**69.91**	**293.53**

A.5. Disease burden:

5.1 HIV/AIDS

- HIV/AIDS has been declared a national disaster and public health emergency in Kenya. About 1.5 million people in the country have died of AIDS, 2 million people are living with HIV, and over 1 million children have been orphaned. The estimated HIV prevalence is 13%.
- In the health sector, the pandemic increases the number of people seeking health services and raises the overall cost of health care.
- Hospital care for HIV/AIDS cases alone in Kenya will rise to US$ 200 million in 2010 from US$ 12 million in 1990.
- The Government is now implementing the third national strategy on HIV/AIDS. There is ample evidence that HIV can be controlled in the country.
- Previous efforts have led to a slow down in the rate of transmission and the prevalence is declining. Through the World Bank-financed Sexually Transmitted Infections (STI) Project, HIV prevalence has been reduced among people with sexually transmitted diseases by 50% and the scope of the national campaign against HIV/AIDS has been expanded to a multisectoral level with the establishment of the National AIDS Control Council. To sustain these efforts, there is need to invest more resources on voluntary counseling and testing and management of HIV.
- **A resource gap of US$ 179.37million for the treatment and control of HIV/AIDS, treatment of STIs, and for surveillance and voluntary counseling and testing has been estimated for the period 2002-6.**

Table 2: HIV/AIDS disease burden at a glance

1.	Total number of people infected with HIV	2,200,000
2	Rural population infected	1,650,000
3	Urban population infected	550,000
4.	National HIV prevalence rate (sentinel surveillance)*	13.9%
5.	Annual new HIV infections	300,000
6.	Annual deaths due to AIDS	180,000
7.	Total deaths due to AIDS since 1984	1,500,000
8	Hospital bed occupancy rate by AIDS patients	50 %
9	AIDS orphans	1,200,000

Source: AIDS in Kenya, 2001.
NB: 1. Total Population of Kenya 29 million (1999 Census).
* Current unpublished data indicates National HIV Prevalence of 13%

5.2 Tuberculosis

- HIV is responsible for up to 40% of new cases of tuberculosis in the country.
- In the last decade, Kenya reported a five-fold increase in tuberculosis cases, from 12,320 to 64,159 or an 18% annual increase of All forms of TB. If this trend is maintained, a cumulative 500,000 tuberculosis cases will be reported in the next five years.
- During the same period, the Case Notification Rate (CNR) increased from 54-218 cases notified per 100,000 population.
- A study of HIV sero-prevalence conducted in 1994 in 17 districts in Kenya showed that HIV was responsible for about 40 per cent of registered TB cases in the country. Presently HIV sero-prevalence in TB cases is estimated at 50-60 per cent. Similarly, in the last decade, the gradual increase in the proportion of cases in age groups 15-44 was noted and correlates with corresponding age groups where high HIV/AIDS prevalence is recorded.
- The Health Sector in Kenya supports efforts to promote the interventions of HIV/AIDS and TB in line with WHO proposals.
- A drug resistance survey is to be conducted in 2002 after which a Plan of Action for multi-drug TB treatment will be published.
- **The resource gap of US$ 11.91 million for improvement in diagnostic services, research and training has been estimated for 2002-2006**

5.3 Malaria.

- Malaria accounts for 30% of outpatient attendance at health facilities in the country. At least 4 million attacks of malaria are expected to occur in 2002 in children alone leading to an estimated 34,000 deaths (or 93 children per day). Complications of malaria like severe anemia and cerebral malaria are frequent and pose a major burden on the health system.
- In 2002, over 16,000 pregnant women are likely to develop severe anaemia and 25,000 women may deliver low-birth weight babies as a result of malaria. Six percent of infant deaths are due to low birth weight caused by malaria.
- Kenya's diverse climate and ecology supports wide variations in the epidemiology of malaria transmission ranging from negligible risks in high altitude areas like Nairobi through to epidemic conditions in the semi-arid and highland areas, and stable transmission along the Indian Ocean and around Lake Victoria.
- **The resource gap for implementing the Malaria Strategy (2002-6) is estimated at US$ 102.25 million.**

A.6. Economic situation:

- The total population of Kenya is estimated at 29 million; GDP per capita is US$ 294; the proportion of the population living on less than US$ 1 per day is 56%; the percentage of GDP allocated to health is less than 10%; Infant Mortality Rate is 62 per 1000 live births.
- The year 2000 was one of the most difficult ones for the Kenyan economy in recent history. The rate of economic growth decelerated for a fifth consecutive year, closing with a negative growth of rate of 0.3 per cent. The deceleration was occasioned by a decline in almost all the key sectors of the economy and was largely attributed to the prolonged drought of 1999-2000, inadequate power supply, deterioration of infrastructure and low aggregate demand. In real terms, the growth rate of GDP declined from 4.6% in 1996 to negative 0.3% in 2000.
- Agriculture is the mainstay of the country's economy accounting for 26% of the GDP while manufacturing accounts for 14%. Tea, coffee, horticulture and tourism are the main foreign exchange earners.
- It is against this background that the high prevalence of HIV/AIDS, tuberculosis, and malaria has a devastating impact on Kenya's economic growth.

A.7 Political commitment

7.1 HIV/AIDS

- National policy on AIDS (Sessional Paper on AIDS) was approved by Parliament in 1997. It provides policy guidance on HIV/AIDS in Kenya to all implementing agencies for the next 10 years and beyond.
- The establishment of NACC in the Office of the Present is a major demonstration of political commitment, as is the participation of Members of Parliament in mobilization and establishment of 210 Constituency AIDS Control Committees.
- The third National AIDS Strategic Plan 2000-5 is in place. Guidelines have been developed to support implementation in all critical areas.
- The President declared AIDS a national disaster in 1999 and structures to implement a multisectoral AIDS strategy have been put in place. Creation of an enabling environment for the participation of the private sector, People Living with HIV/AIDS, and faith-based organizations is demonstrated in the composition of NACC.

Table 3: Estimated HIV/AIDS Funding for Kenya National Strategic Plan for the period 2000-2006

Item	Funding Sources	Cost (US$ millions) estimates	Mode of Disbursement
1	GoK: Recurrent Budget	321.0	Through budget—finance salaries & recurrent expenses of NACC and AIDS Control Units.
2	GoK: Development Loans from World Bank	100.0	Through budget. NACC/OP Direct US$ 50 million, MoH US$ 50 million, US$ 15 million of MoH portion for other health problems, US$ 35 million to HIV/AIDS.
3	DFID	45.0	Direct contracting with implementing agencies.
4	USAID	98.0	Direct contracting with implementing agencies.
5	CDC	46.5	MoH support and contracting with implementing agencies.
6	UN agencies	15.0	Mainly Direct Contracting with implementing agencies.
7	JICA	20.0	Direct contracting with implementing agencies.
8	SIDA	1.0	Through district budget
9	BMZ(Germany)	7.0	Direct contracting
Total		653.6	

- In addition to large amounts of Government resources deployed in the fight against HIV/AIDS, the Government has negotiated additional resources from development partners. Thus, the Government has procured over 300 million condoms through a World Bank loan to support the campaign against HIV/AIDS. The Government borrowed US$40 million from the World Bank for Sexually Transmitted Infections for the period 1995-2000 and another US$100 million from the World Bank for financing the National AIDS Strategic 2000-5. In addition, it has negotiated credit agreements in the form of KHADRE and DARE projects.

7.2 Tuberculosis

- The Government's commitment to addressing the TB problem is articulated in the Health Policy Framework Paper approved by the Cabinet in 1984 and the National Health Strategic Plan 1999-2004.
- The key interventions are based on the WHO strategy of DOTS. The Government provides 60% of the national TB budget. Through a World Bank loan, the Government has procured additional anti-TB drugs to respond to an increased demand. Other key development partners in the fight against TB in Kenya are the Royal Government of Netherlands, WHO, Global drug Facility and the USA Government through USAID, CDC and other agencies.
- **Resource gap for TB is estimated to be US$ 11.91 million for the period 2002-2006**

Table 4: Estimated Tuberculosis Funding for the period 2000-2006

Item	Funding Sources	Cost (US$ millions) estimates	Mode of Disbursement
1	GoK: Recurrent Budget	49.7	Through budget
2	USAID	5.7	Direct Contracting
3	CDC	5.0	Direct contracting
4	WHO	10.0	Contracting with MoH.
5	JICA	1.0	Through budget.
6	BMZ(Germany)	5.0	Direct contracting.
7	CIDA	2.0	Direct contracting.
Total		78.4	

7.3 Malaria

- Malaria control is identified as a high priority activity in the National Health Sector Strategic Plan. The President has publicly proclaimed total war on malaria. The President also attended the Africa Heads of State summit in Abuja, Nigeria, in 2000 and 2001 and endorsed the Abuja Declaration thus pledging support to Roll Back Malaria in Kenya. The Government has responded to several key obligations of the Abuja Declaration through the removal of taxes and tariffs associated with insecticide-treated net products.
- National Malaria Strategy 2001-2010 and an Inter-Agency Coordinating Committee with clearly defined targets is functional.
- The main development partners are DFID-EA, the World Bank, WHO, DANIDA, SIDA, EU and UNICEF.

Table 5: Estimated Malaria Funding for the period 2000-2006

Item	Funding Sources	Cost (US$ millions) estimates	Mode of Disbursement
1	GoK: Recurrent Budget	169.0	Through budget
2	GoK: development loans from World Bank	2.0	Through budget
3	USAID	4.9	Direct contracting.
4	DFID	37.0	Direct contracting with implementing agencies.
5	WHO	3.0	Contracting with MoH.
6	JICA	6.0	Through budget.
7	Community (CBIs)	10.0	
Total		230.9	

Health Ministry Budget Allocation for 1999-2002, Kenya (Printed Estimates in Kenya Shillings)
(1USD = 78 Kenya Shillings)

1999/2000 Fiscal Year
1/99 Recurrent
Total Government of Kenya Budget Gross was Sh.244,141,700,080.
Allocation to MoH was Sh. 9,627,458,040

1/99 Development (Investment)
Total Government Budget was Sh. 54,120,986,920 out of which 34,135,451,580 was external funding while Sh. 19,985,535,340 was GoK contribution.

Allocation to MoH was Sh. 5,047,337,680 of which Sh. 4,102,727,860 was external funding and Sh. 944,647,820 was GoK contribution.

2000/2001 Fiscal Year
2/00Recurrent
Total Government of Kenya Budget Gross was Sh.270,072,022,752.
Allocation to MoH was Sh. 10,672,191,923.

2/00 Development (Investment)
Total Government Budget was Sh. 38,420,815,667out of which 23,886,133,551 was external funding while Sh. 14,534,682,116 was GoK contribution.

Allocation to MoH was Sh. 3,932,527,800 of which Sh. 3,293,836,280 was external funding and Sh. 638,691,520 was GoK contribution.

2001/2002 Fiscal Year
3/010Recurrent
Total Government of Kenya Budget Gross was Sh.264,906,675,805.
Allocation to MoH was Sh. 10,527,393,800.

3/01Development (Investment)
Total Government Budget was Sh. 41,637,296,447 out of which 26,254,193,746 was external funding while Sh. 15,383,102,701 was GoK contribution.

Allocation to MoH was Sh. 3,539,542,008 of which Sh. 2,997,038,007 was external funding and Sh. 542,504,001 was GoK contribution.

A.8 Links with existing activities

HIV/AIDS, Tuberculosis and Malaria are included in the list of six high priority essential health packages in the National Health Sector Strategic Plan. These diseases hinder Government efforts to alleviate poverty and promote development. Accordingly, multisectoral initiatives and structures have been established as provided for in the Kenya National HIV/AIDS Strategic Plan 2000-2005, National Tuberculosis and Leprosy Strategic Plan 2001-2005 and National Malaria Strategic Plan 2001-2010. The Government also acknowledges the problem posed by these diseases in the Poverty Reduction Strategy Paper (PRSP) in which one of the primary objectives is to enhance equity, quality, accessibility and affordability of health care through better targeting of resources to the poor – geographically and technically – and more efficient use of resources. Details on links are provided in the documents attached.

A.9 Profile of the Country Coordinating Mechanism (CCM)

1. **Name of the CCM**: Joint Inter-Agency Coordinating Committee (JICC)
2. Date of Constitution of the current CCM: 6th February, 2002
3. Organizational structure:

3.1 Members of the Joint Inter-Agency Coordinating Committee:

a) Government: Permanent Secretary (PS)-Health, Chairman; PS-Office of the President (OP) (Cabinet); PS-Education; PS-Finance & Planning; DMS; Principal, University of Nairobi Medical School; Director, KEMRI, and Director, NACC).
b) Donors & UN agencies: UNDP, Department of International Development, UK (DFID), The World Bank, United States Agency for International Development (USAID), Japan International Cooperation Agency (JICA), German Development Co-operation (GDC-GTZ), World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations AIDS Programme (UNAIDS), Center for Disease Control (CDC), and Swedish International development Agency (SIDA).
c) Civil Society, People Living with AIDS, Private Sector and Prevention Network of People Living With HIV/AIDS in Kenya (NEPHAK), Kenya Medical Association (KMA), Kenya Association of Manufacturers (KAM), Kenya AIDS NGOs Consortium (KANCO), Catholic Secretariat, CHAK, AMREF, CARE and SUPKEM.
d) Secretariat: Director of Medical Services (DMS), Chairman/Head of Secretariat; Head Research, Quality in Health Care, Health Legislation and Policy; Head National AIDS/STD Control Programme (NASCOP)/TB, Head of Malaria Programme, Head of TB Programme, Head of Planning Unit, MoH; and Director/NACC).

3.2 Joint ICC links with HIV/AIDS-ICC (HICC), TB-ICC (TICC) and Malaria-ICC (MICC), the latter three provide the agenda for JICC and report to it.

Membership:

a) HIV/AIDS-ICC; Director, National AIDS Control Council (NACC), Convenor, Head NASCOP/TB, PS-Health, PS-OP, DMS, UNAIDS, WHO, United Nations Development Programme (UNDP), The World Bank, USAID, DFID, SUPKEM, KAM, FKE, University of Nairobi (UoN), NEPHAK, KANCO) and Kenya Medical research Institute (KEMRI), JICA, KMA, CDC, UNICEF, GDC-GTZ..
b) TB-ICC (DMS –Convenor, PS-Health, PS-Finance & Planning, Head NLTP, Kenya Medical Research Institute (KEMRI), WHO, CDC, The World Bank, USAID, GDC-GTZ, MSF, Kenya Association for prevention of TB & Lung Diseases, Aga Khan Health Services, Canadian International Development Agency (CIDA) KAM and KEMRI.
c) Malaria-ICC (DMS-Convenor, PS-Health, PS-Finance, PS-Education, Head of DOMC, JICA, WHO, DFID, UNICEF, Danish International Development Agency (DANIDA), African Medical Research Foundation (AMREF), CARE-Kenya, Mission for Essential Drugs (MEDS), Federation of Pharmaceutical Manufacturers, KAM, KEMRI, and CDC.

3.3 At the district level, the JICC will be represented by District Health Consultative Group (DHCG) whose membership will include the following:

DMOH—Chairman; Medical Superintendent, District Hospital; three representatives of NGOs and Community Based Organizations; one representative of PLWH, DASCO, DTLC; one representative of District Development Committee (DDC); one representative of the District AIDS Coordinating Committee (DACC); one representative of the District Health Management Board; two representatives of Traditional Medical Practitioners; one representative of the Private Sector, one representative of Religious/Faith–Based Organizations. DMOH office will provide the Secretariat.

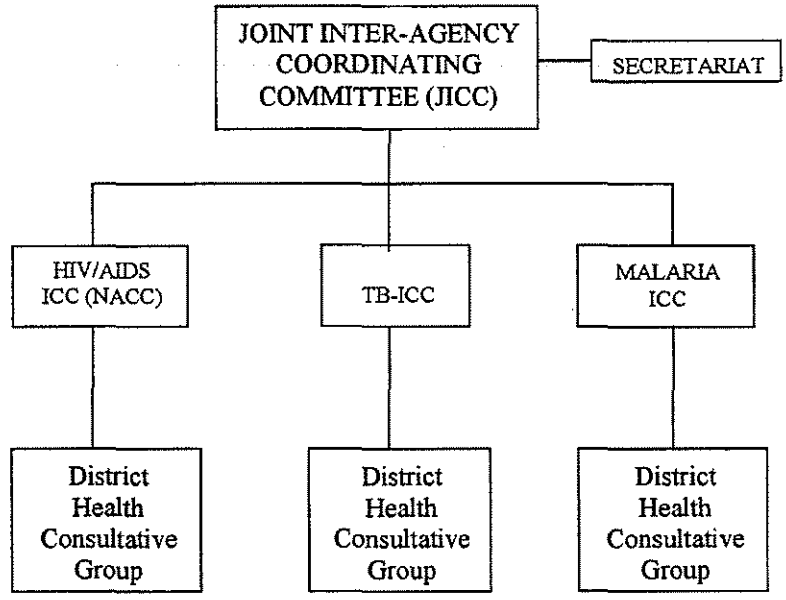
3.4 Frequency of meetings: JICC will meet quarterly while HIV/AIDS-ICC, TB-ICC, Malaria-ICC, DHCG will meet monthly.

4 Major functions and responsibilities of the CCM:

- Advise the Government and implementing agencies on all matters related to GFATM and health sector policy and strategy.
- Exchange of knowledge and information on health sector priorities and challenges.
- Review Country proposals to GFATM
- Commission periodic evaluation of implementation plans.

- Advise on policies and strategies including operational guidelines and work plans on HIV/AIDS, Tuberculosis and Malaria.
- Advise the Ministry on resource mobilization, disbursement and accountability for HIV/AIDS, TB and Malaria control funds.

5 Major strategies to enhance CCM's role and functions in the next 12 months:
- Strengthen the Secretariat to ensure meetings are regular.
- Review terms of reference.
- Promote networking and partnership.
- Establish a dollar account for all monies received from the Global Fund. Disbursements from the fund account will be against approved work plan endorsed by JICC.



A.10. The total number and composition of members of CCM

People living with HIV/AIDS	1
NGOs/Community-based organisation	4
Private Sector	1
Religious/Faith groups	3
Academic/Educational Sector	1
Government Sector	7
Others (Donors & UN agencies)	11
TOTAL	28

A.11. Signatures:

Members of the Country Coordinating Mechanism (CCM) sign below to endorse this proposal. Endorsement of this proposal does not imply any financial (or legal) commitment on the part of the partner, ag

Signature:
Chair of C inistry of Health.
Chair Nam
Professor Julius S Meme, Permanent Secretary, Ministry of Health, Afya House, Cathedral Road, Nairobi. Tel. 254-2-713395, Fax 254-713234 Email: ps@insightkenya.com

KANCO

CHAK

CATHOLIC SECRETARIAT

A.12. In case the Gl
Name:

Title/Address: Dr. R
Tel.No.: 254-2-71865
E-mail:dms@insig

JICC Member Signatures

Agency/Organization	Name/Title	Date	Signature
GOVERNMENT OF KENYA			
PS-OP (Cabinet)			
PS-Health			
PS-Education			
PS-Finance & Pla			
Director of Medica Services			
Principal, UoN Me School			
Director, KEMRI			
Director, NACC			
DFID			
The World Bank			
USAID			
JICA			
[redacted] GDC-GT			
WHO			
UNICEF			
UNAIDS			
CDC			
SIDA			
UNDP			
NEPHAK			
SUPKEM			
CARE			
KMA			
AMREF			
KAM			

LIST OF ABBREVIATION OF SIGNATURES AS PER PARAGRAPH A11

PS – OP CABINET	PERMANENT SECRETARY – OFFICE OF THE PRESIDENT (SECRETARY TO THE CABINET)
PS HEALTH	PERMANENT SECRETARY MINISTRY OF HEALTH
PS – EDUCATION	PERMANENT SECRETARY MINISTRY OF EDUCATION
PS – FINANCE & PLANNING	PERMANENT SECRETARY MINISTRY OF FINANCE AND PLANNING
DMS	DIRECTOR OF MEDICAL SERVICES
PRINCIPAL, UON	PRINCIPAL MEDICAL SCHOOL, UNIVERSITY OF NAIROBI
KEMRI	KENYA MEDICAL RESEARCH INSTITUTE
NACC	NATIONAL AIDS CONTROL COUNCIL
DFID	DEPARTMENT FOR INTERNATIONAL DEVELOPMENT
WB	WORLD BANK
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
JICA	JAPAN INTERNATIONAL COOPERATION AGENCY
GTZ	GERMAN TECHNICAL
WHO	WORLD HEALTH ORGANISATION
UNICEF	UNITED NATIONS CHILDREN FUND
UNAIDS	UNITED NATIONS PROGRAMME ON AIDS
CDC	CENTRE FOR DISEASE CONTROL
SIDA	SWEDISH INTERNATIONAL DEVELOPMENT AGENCY
UNDP	UNITED NATIONS DEVELOPMENT PROGRAM
NEPHAK	NETWORK FOR PEOPLE LIVING WITH AIDS IN KENYA
SUPKEM	SUPREME COUNCIL OF KENYAN MUSLIMS
CARE	CARE KENYA
KMA	KENYA MEDICAL ASSOCIATION
AMREF	AFRICA MEDICAL RESEARCH FOUNDATION
KAM	KENYA ASSOCIATION OF MANUFACTURERS
KANCO	KENYA AIDS NON-GOVERNMENTAL ORGANISATIONS CONSORTIUM
CHAK	CHRISTIAN HEALTH ASSOCIATION – KENYA
CS	CATHOLIC SECRETARIAT

SECTION B: OVERALL PROPOSAL

B.1 Summary of overall proposal

- HIV/AIDS, Tuberculosis and Malaria are among the six major diseases that together contribute up to 70% of the disease burden in Kenya. They curtail the Government's development programme by reversing previous gains in poverty reduction and well being of the people of Kenya. Efforts to contain the spread of HIV/AIDS, Tuberculosis and Malaria have been severely constrained by lack of resources to scale up implementation of cost-effective interventions nationwide. Where nation-wide implementation of a cost-effective intervention was feasible like in the management of sexually transmitted infections financed by the World Bank and other partners, HIV prevalence among people with sexually transmitted diseases declined by 50%.

- During the period 2002 – 6, we are applying for a total of US$ 293.53 million additional funds against an estimated commitment of US$1.2 billion by Government, civil society, private sector, donors and community based organizations for HIV/AIDS, Tuberculosis and Malaria activities in Kenya. The Government of Kenya is committed to sustaining the proposed funding levels contained in this proposal.

- In the first year, we are applying for US$49.35million to finance commodity imports (US$25.2 million), NGOs and CBOs proposals (US$11.5million), and the rest for programme support.

- Regular health services and systems performance assessments will be undertaken using the Kenya Health Standards Master Checklist to ensure that the additional investments strengthen the national health care system.

- Aware of the fact that the Global Fund may not provide all the resources to finance the resource gap for all cost-effective interventions in Kenya, the Government and its key development partners, representatives of the private sector, civil society and affected community submit this proposal for additional resources to finance largely commodity import support and limited programme support for a selected high priority cost-effective, economically feasible, sustainable and culturally acceptable interventions.

- The overall objective is to reduce the disease burden associated with HIV/AIDS, Tuberculosis and Malaria in Kenya.

- In HIV/AIDS, the objectives are to:
  (a) 50% of persons living with AIDS have access to improved therapeutic and palliative care, including equitable access to ARVs, drugs for OIs and STIs
  (b) 75% of young people aged 15 – 24 years have access to services which promote risk reduction and positive behavior change
  (c) Survival of people with HIV increases from average of 5 years at present to 10 years
  (d) 80% of pregnant women with HIV infection have access to services to prevent mother to child transmission (PMCT) and HIV specific post-natal care

  Specifically we intend to ensure (a)sustained uninterrupted 100% availability of quality drugs for treatment of STDS, (b) uninterrupted availability of drugs for treatment of opportunistic infections in 75% of hospitals in Kenya and (c) 300,000 people in Kenya have access to ARV by year 2006.

- In Tuberculosis the objectives are to:
  a) Increase case-detection rate from 47% to 70% by the end 2006.
  b) Achieve 80% cure-rate of tuberculosis by the end of 2006.
  c) Have uninterrupted supply of high quality anti-TB drugs in all health facilities by the end of 2006
  d) Fully establish laboratory quality assurance by the end of 2006
  e) Achieve complete monitoring of drug resistance by the end of 2006.

- In malaria the objectives are to:
  a) To reduce morbidity and mortality caused by malaria by 30% among Kenya's population by the 2006.
  b) Ensure prompt access to quality assured efficacious and affordable drugs to guarantee effective case management in 60-80% of febrile events at all-levels of care by end of 2006.
  c) To improve access to insecticide-treated nets to ensure that at least 60% of Kenya's pregnant women and children aged under five years have access to use of insecticide treated nets (ITNs) by the end of 2006.

- With regard to development targets linked to Kenya Poverty Reduction Strategy Paper (PRSP) the objectives are to:
  a) Increase life expectancy at birth from 47 years currently to 52 years by the end of 2006.
  b) Reduce infant mortality rate (IMR) from 62 per thousand population to 53 by the end 2006.
  c) Reduce Maternal Mortality Rate by 10% from the current 590 per 100,000 population by the end 2006.
  d) Move closer to achieving the Millennium Goals spelled out in the Poverty Reduction Strategy Paper (PRSP) by rolling back these three diseases of poverty.

- The Ministry of Health will be the main executing agency. Implementation will be through Government and other partners. The Joint Inter-Agency Coordinating Committee and its associated sub-committees, the HIV/AIDS-ICC (HICC), the TB-ICC(TICC), the Malaria-ICC (MICC) and District Health Consultative Group (DHCG) will review and endorse the annual work plan and monitor implementation through regular supervision and monitoring including commissioning of special studies to assess impact of interventions.

- It is estimated that 30 million people in Kenya will benefit directly from the proposed activities. The greatest beneficiaries will be poor people who currently have limited access to health care and who suffer high morbidity associated with HIV/AIDS, Tuberculosis and Malaria.

- Major health components:
  1. HIV/AIDS
  2. Tuberculosis
  3. Malaria
- The benefits that accrue from reduced disease burden associated with HIV/AIDS, Tuberculosis and Malaria in Kenya are expected to increase life-expectancy, reduce infant mortality, reduce maternal mortality and thus contribute to the achievement of development targets of Kenya's PRSP and improved well being of the people of Kenya.

B.2 Programmatic monitoring and evaluation

JICC will discuss and endorse quarterly reports based on an approved annual work plan. There will be annual programme review meetings to review progress and strengthen partnership with other health stakeholders and policy-makers. JICC will commission annual studies/surveys to assess the impact of the programme or specific interventions. There will be regular assessment of health services and systems performance. Detailed logical framework for the three disease components are contained in the respective strategic plans attached to this proposal.

B.3 Financial management

- JICC will review and endorse proposals from local implementing partners and NGOs. Disbursement of funds from the special Account will be against justified proposals and approved work plans. A US Dollar Account will be opened with a stable Commercial Bank in Nairobi. All grants from GFATM Fund will be deposited into this account. Quarterly Financial Statements will be presented and endorsed by JICC.
- We are considering a number of financial disbursement options: 1. Improved GAVI disbursement mechanisms already in operation in Kenya, 2. The World Bank financed DARE project disbursement mechanisms and 3. subcontracting the services of an internationally recognized Financial Management Agency (FMA) to strengthen the Financial Management System of the Ministry.

- Expenditures under this fund will be audited by the Controller and Auditor-General every 12 months.

The Civil Society, non-governmental organizations and the private sector will access the GFATM funds by submitting proposals to JICC through respective ICCs and DHCGs which will review them to determine their responsiveness to key strategic documents whose implementation additional funds are being sought to support. The main obstacles that constraint flow of funds to implementing agencies and lack of or delay in accounting for disbursed funds are well understood in Kenya and will not be allowed to frustrate the implementation of this programme. It is expected that the agreed financial management option must address this issue. Financial Status Report will be a permanent agenda item in JICC meetings. GoK procurement procedures will be used. Where necessary procurement agents (e.g , GTZ, Crown Agents, Charles Kendall Partners Limited) will be contracted by the Ministry.

- Proceeds from this Fund will be used to strengthen the Ministry's logistics Management System to increase efficiency and effectiveness. Where critical, the Ministry will contract the services of a logistics management agency to ensure timely and equitable access to drugs and commodities by all implementing agencies for their clients.

B.4 Table 4: Statement of Budget Requirements, Financial Commitments and Unmet Needs 2002
(US$ Millions)

	Budget Categories							
	Human Resources	Logistics and supplies	Training & Supervision	Outreach Services	Commodities or products*	Data & information systems/ Research & Monitoring	Others (NGOS, ...O&M)	TOTAL
BUDGET REQUIREMENTS								
Financial Commitments by Source								
Government	30.0	2.50	1.50	0.50	30.0	0.01	20.0	84.51
Civil Society	7.0	1.00	0.50	0.50	9.0	0.01	7.0	25.01
Private sector	3.0	0.25	0.25	0.10	1.0	0.01	2.0	6.61
Donors	0.2	0.20	10.00	0.01	2.5	0.20	3.0	16.11
Other (community voluntarism)	3.0	1.25	0.50	0.10	0.1	0.10	2.0	7.05
Total Commitments	**43.2**	**5.20**	**12.75**	**1.21**	**42.6**	**0.33**	**34.0**	**139.29**
Unmet Needs	----	3.00	2.50	1.33	25.2	5.82	11.5	49.35

*including drugs
NB: Assumptions: 1. Civil Society, NGOs, Faith-based Organizations and the private sector contribute 30-40% of total annual health expenditures in Kenya. 2. Out of pocket expenditures on health in Kenya is about 50% which are community contributions through fundraisings (harambee) and participation in the implementation of community-based health projects as volunteers. 3. Part of the contribution by Civil Society masks donor contributions because donors do finance civil society directly. 4. Civil Society receive a proportion of their resources from individual contributions and there are significant self-sacrifices and voluntarism in the sector. 5. These figures are estimates.

B.5 Duration

Beginning and end dates:

From: May 1 2002 To: June 30, 2006

Period to be covered by this request for financing:

From: 2002 To: 2006

SECTION C: MAJOR COMPONENTS

1. HIV/AIDS COMPONENT: 70% of all the additional funds required will finance drugs and commodity import for treatment of STDs, opportunistic infections, prevention of mother to child transmission, and post-exposure prophylaxis. The remaining funds will be used to support scale up VCT services, logistics, training, research and monitoring as well as support to NGOs and CBOs youth and orphan related activities.

2. TUBERCULOSIS COMPONENT: The additional support will mainly be used to expand diagnostic services, training, logistics and research.

3. MALARIA COMPONENT: Additional resources will mainly be used to provide drugs for malaria treatment, provide ITNs to pregnant women, logistics and research.

This proposal recognizes that during the implementation period, there will be additional external investment in the health sector – the proposed GoK/DFID Malaria Project, the proposed GoK/EU Districts Health Services & Systems Project, Pipeline Kenya-World Bank Pharmaceutical Project, among others.

C (i) HIV/AIDS Component

C.1 Description

- HIV/AIDS in Kenya is a national disaster and a public health emergency. HIV prevalence among adults rose from 5.3 per cent in 1990 to over 13 per cent in 1999. It is estimated that about 1.5 million people had died of AIDS as of June 2000 from the early 1980s when the pandemic was first detected in the country.

- In Kenya HIV is transmitted in over 90 per cent of the cases by sexual contact and about 10 per cent through mother-to-child transmission. Around 80-90 per cent of the infections are in the 15-49 year age group while 5-10 per cent occur among children under five years of age. In addition, seroprevalence among pregnant women attending antenatal clinics range between 6-17 per cent in low prevalence areas and 25-30 per cent in high prevalence ones. Most AIDS-related deaths occur between ages 25 and 35 for men and 20 and 30 for women.

- The HIV/AIDS burden on the health sector is two-fold: it increases the number of people seeking health services, and it raises the overall cost of health care. It is estimated that hospital care for all HIV/AIDS patients would rise to Ksh. 3.7 billion in 2010 from Ksh 480 million in 1990, using a low cost scenario; the high cost scenario projects it to rise to Ksh. 11.2 billion by 2010. Sessional Paper No.4 of 1997 on HIV/AIDS in Kenya estimates the direct and indirect cost of treating a new HIV/AIDS patient at Ksh. 573,240.

The following major activities in the implementation of the National HIV/AIDS strategy are not adequately funded at present and thus are proposed for additional support:

- Provision of drugs and commodities: Additional resources are needed to procure drugs for STIs and OIs, ARVS (for PMCT, post-exposure prophylaxsis, and treatment) and home based care kits
- Scale up voluntary counseling and testing (VCT) services for both HIV prevention and for early entry into care; procurement of HIV test kits and provision of IEC materials and youth-friendly services
- Training, logistics, and systems development to support implementation of the above activities
- Monitoring, evaluation, and operational research to assess progress in meeting these objectives and outcomes

The people involved

Include the Government of Kenya (GOK), Non-Governmental Organizations, Churches, Private Sector, People living with HIV/AIDS (PLWA), Communities, scholars and bilateral agencies.

C.2 Objectives and indicators

Table 7. Specific Objectives and targets for 2006:

1. 50% of persons living with AIDS have access to improved therapeutic and palliative care, specifically:
   - Uninterrupted supply of drugs for STIs and OIs in 75% of hospitals and health centres
   - Uninterrupted supply of palliative care drugs in 50% of community home based care programs
   - 50% of PWAs meeting national clinical criteria for HAART have accessed treatment

2. Incidence of HIV infection in the age bracket 15 – 24 is reduced from 13% to 9%.
   - 75% of young people aged 15- 24 have access to services which promote risk reduction and positive behavior change
   - 50% of young people 15 - 24 know their sero-status
   - 25% of youth target groups have received HIV preventive services at least once
   - Uninterrupted supply of STI drugs and condoms in health facilities serving youth
   - Post-exposure prophylaxis available in hospitals and health centers.

3. 80% of pregnant women with HIV have access to services
   - At least one health facility per 10,000 target population offer comprehensive PMCT services
   - PMCT Plus: 50% of HIV+ mothers who received peri-natal PMCT services and meet national clinical criteria access HAART

Specific objectives	Indicator	2001	2002	2003	2004	2005	2006
1. Increased survival	Facilities with supply of STI, OI drugs	40%	45%	50%	60%	70%	75%
	Palliative care drugs in HBC	5%	10%	20%	30%	40%	50%
	Access to HAART	2%	10%	20%	30%	40%	50%
2. Reduced incidence in 15-24 age group	Access to youth friendly services	5%	20%	35%	50%	65%	75%
	Knowledge of sero-status	5%	15%	25%	35%	45%	50%
	PEP for special groups	1%	5%	20%	30%	40%	50%
	Supply of STI drugs and condoms	50%	65%	75%	85%	90%	100%
3. PMTCT	Services per target population	1 facility per 60,000	1 facility per 50,000	1 facility per 40,000	1 facility per 30,000	1 facility per 20,000	1 facility per 10,000
	Access to PMTCT+	1%	5%	10%	20%	40%	50%

C.3 Programmatic monitoring and evaluation plans

The successful management and implementation of the activities outlined will depend heavily on effective monitoring and evaluation.

1. Monitoring will take place at various levels of programme management and implementation and will involve identification of key indicators in each priority area. Regular monitoring will ensure that obstacles and constraints are identified early and addressed and that programme impact is maximized. The NASCOP management unit will be responsible for the overall monitoring of progress against the Strategic Plan. However, this will require that the stakeholders and implementing partners to take responsibility for data gathering at the mirco-level. The mechanism for conducting joint monitoring activities will be through regular and review meetings and reports, among other approaches.

2. Evaluation will mainly focus on outcome or effect and impact indicators that have been in-built in the plan at the objective and output levels. In addition, issues regarding programme management, including financial management and co-ordination will be evaluated specifically to assess the extent to which they contribute or not to achieving programme objectives. Information for evaluation will be obtained from monitoring activities such as regular reporting, supervision reports and monthly, quarterly and annual reports. There will be need to undertake a mid-term evaluation at the end of the year 2003 or at the beginning of the year 2004. Summative evaluation should take place around June – July 2006. The results of the midterm and summative evaluation will be measured of the achievement. There may be need to conduct baseline surveys during the first six months of launching the plan. The broader lessons that will be drawn from the evaluation exercise will assist in redesigning, modifying, or maintaining particular strategies and activities in preparation for the subsequent phase of the programme.

C.4 Duration

Beginning and end dates:

From: May 2002 To: June 2006

Period to be covered by this request for financing:

From: 2002 To: 2006

C.5 Implementation plans including resource allocations by partners 2002-6 (HIV/AIDS)

Table 8: Implementation plans and resource allocations by partners for HIV/AIDS 2002-6 (US$ Millions)

	Budget Categories (please fill in according to your plan)							
Financial Commitments by Source	Human Resources	Logistics and supplies	Training & Supervision	Outreach Services	Commodities or Products*	Data & Information Systems & Research and Monitoring	Other NGOs/ (O&M)	**TOTAL**
BUDGET REQUIREMENTS								
Government	150	5.0	15.00	10.50	150.00	10.50	80.0	421.00
Civil Society	40	2.0	1.5	1.5	1.00	0.03	30.0	76.03
Private sector	10	0.5	0.5	0.3	0.7	0.03	7.0	19.03
Donors	1	5.0	90.50	5.5	5.0	3.00	210.00	320.00
GFATM	–	2.5	15.11	17.2	113.0	12.06	19.5	179.37
TOTAL	201.00	15.0	122.61	35.00	269.7	25.62	346.5	1015.43
**Including drugs*								

*including drugs
NB: Assumptions: 1. Civil Society, NGOs, Faith-based Organizations and the private sector contribute 30-40% of total annual health expenditures in Kenya. 2. Out of pocket expenditures on health in Kenya is about 50% which are community contributions through fundraisings (harambee) and participation in the implementation of community-based health projects as volunteers. 3. Part of the contribution by Civil Society masks donor contributions because donors do finance civil society directly. 4. Civil Society receive a proportion of their resources from individual contributions and there are significant self-sacrifices and voluntarism in the sector. 5. These figures are estimates.