The Global Fund to Fight AIDS, Tuberculosis and Malaria

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

SECTION I: Executive Summary of Proposal

Table I.a

<table>
<tr><td>Proposal title (Title should reflect scope of proposal):</td><td colspan="4">Kenya National Proposal to Address and Reduce the Impact of HIV/AIDS, Tuberculosis and Malaria.</td></tr>
<tr><td>Country or region covered:</td><td colspan="4">Republic of Kenya</td></tr>
<tr><td>Name of applicant:</td><td colspan="4">Joint Inter-Agency Coordinating Committee (JICC)</td></tr>
<tr><td rowspan="5">Constituencies represented in CCM (write the number of members from each Category):</td><td></td><td>Government – Health ministry 2</td><td></td><td>UN/Multilateral agency 2</td></tr>
<tr><td></td><td>Government – Other ministries 6</td><td></td><td>Bilateral agency 7</td></tr>
<tr><td></td><td>NGO/Community-based organizations 4</td><td></td><td>Academic/Educational Organizations 1</td></tr>
<tr><td></td><td>Private Sector 1</td><td></td><td>Religious/Faith groups 1</td></tr>
<tr><td></td><td>People living with HIV/TB/Malaria* 1</td><td></td><td>Other (please specify): 1 (Professional Orgs.)</td></tr>
<tr><td>If the proposal is NOT submitted through a CCM, briefly state why:</td><td colspan="4"></td></tr>
</table>

* According to national epidemiological profile/characteristics

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund[**]:

Table I.b

Component(s) (mark with X):			Amount requested from the GF (USD thousands)					
			Year 1	Year 2	Year 3	Year 4	Year 5	Total
	X	HIV/AIDS	16,772.88	19,948.93	24,447.51	30,308.34	37,576.44	129,054.10
	X	Tuberculosis	2,452.61	2,214.78	2,193.83	1,871.46	2,032.98	11,232.73
	X	Malaria	4,604.49	5,922.39	6,913.69	7,730.19	8,416.05	33,586.79
		HIV/TB						
		Total	**23,830.98**	**28,089.1**	**33,558.03**	**39,913.99**	**48,030.47**	**173,422.57**
Total funds from other sources for activities related to proposal								**121,536.95**

NOTE: The total of $173,422,570 is requested from the GTFATM to meet the needs of GAPS opened by the activities proposed for all three components. Earmarked funds of $121,536,950 are required, IN ADDITION to those requested.

Please specify how you would like your proposal to be evaluated[***] (mark with X):

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

[**] If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.
[***] This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief Proposal Summary: Overall Goals, Objectives And Broad Activities Of Each Component, Including Expected Results And Timeframe For Achieving These Results:

HIV/AIDS COMPONENT: The overall goal of the HIV/AIDS component is to prevent the spread of HIV in Kenya and minimize its impact on Kenyans. Three primary objectives have been identified as ways to assure reaching the overall goal:

- 1) PREVENTION and ADVOCACY, through scaling up existing Voluntary Counseling and Testing (VCT) services;
- 2) CARE, through a scaling up of comprehensive services that includes screening and diagnostic and treatment for TB and other opportunistic diseases and STIs, accompanied by the provision of appropriate drugs and ARV therapy targeting pregnant women, their infants and partners, as well as limited numbers of medically-eligible PLWHAs;
- 3) INSTITUTIONAL STRENGTHENING of the National AIDS Control Council (NACC) and local entities in PACCs, DACCs, CACCs, NGOs, CBOs and other stakeholders from the civil society.

In order to ensure effective implementation of the above objectives continued development of the health system in ways that will ensure an orderly and effective expansion of VCT, PMTCT Plus and limited provision of ARV therapy programs is required. Therefore, capacity building will target human resource development and ensure an adequate, predictable level of trained personnel capable of staffing the expansions on a dedicated basis. Staffing patterns have been developed through experience of existing VCT services, and personnel requirements for PMTCT Plus and ARV therapy activities have been well thought out in the design and development of the five existing locations where a wide range of screening, treatment and care is already delivered to AIDS patients, including pregnant women and other PLWHAs, and those in need of post-exposure prophylaxis (PEP), such as victims of sexual assault and health care workers. Laboratory and other system-wide screening and diagnostic requirements, plus overall logistics support, will be required for each health center to which VCT and PMTCT clients are referred, and from which they can expect to receive comprehensive services. Initially, Provincial General Hospitals will all be brought up to a required level of standard, followed by District hospital improvement in areas of dedicated staff, laboratory capabilities that will allow for necessary screening and diagnostic and treatment services, and availability of basic drugs for STIs, TB and OIs. Finally, as NACC facilitates and coordinates implementation of the national AIDS control system, each AIDS Control Unit (ACU) within all ministries, and the overall decentralized system flowing from the Provincial AIDS Control Committees (PACCs) through District AIDS Control Committees (DACCs) to community-based activities, NACC will require human resource training and office logistic supports that could include basic furniture, and private, confidential settings where effective counseling can take place. Additional capacity building will target implementing partners that include NGOs and CBOs.

Expected results from the prevention and advocacy objective will include:

- VCT services that extend beyond those currently offered at 75 locations serving more than 60,000 individuals annually, to 350 locations (averaging five locations in each of Kenya's seventy districts), serving over 1,000,000 clients by the end of the five year duration of this proposed action plan;

- Placement of new VCT locations, to be determined by analyses of community demographic characteristics and HIV prevalence, thereby placing new VCT services where there is high likelihood of reaching target populations without symptoms but with some reason to seek counseling and testing.

The intention is to identify individuals at a very early stage of infection, with those new clients who are not infected learning of their status at the earliest possible time in order to empower them to change their behaviour and prevent them and/or their partners from becoming infected. VCT services represent the gateway to a range of counseling, treatment and care for opportunistic infections and other diseases, and

result in a greater proportion of Kenyans knowing their sero status (currently, less than 10% of those infected know their status) by receiving their results in a timely manner (nearly always on the same day of being tested, often within thirty minutes).

- Clients will receive counseling, and, depending on the results of voluntary testing, be referred to medical facilities where more comprehensive screening and diagnoses can take place.

- Medical facilities will provide treatment, care and support from an expanded number of dedicated providers who will have been recruited and trained as part of the infrastructure development necessary for successful scale-up of existing locations where VCT, PMTCT Plus and ARV therapy services are provided.

- ARVs initially made available to those pregnant women who are HIV positive and/or have AIDS, and are medically eligible for PMTCT Plus. (It is estimated that approximately 1,050,000 women in Kenya are pregnant at any given time.) Infants and partners will also be enrolled in the PMTCT Plus programs.

- Individuals needing post-exposure prophylaxis (PEP), such as victims of sexual assault and health workers exposed because of work-related injuries will receive ARV therapy according to guidelines developed for such occurrences.

- Planned, methodically implemented systemic infrastructure strengthening will take place;

- Medically eligible target populations will be included in the ARV program, including TB positive AIDS patients and health workers. Recipients of the existing projects of MSF and USAID will also adhere to eligibility criteria developed by the government. The ARV Task Force will identify other groups for inclusion according to eligibility criteria now under development. The ARV Task Force will identify other groups for inclusion according to eligibility criteria now under development.

Emphasis will be placed on scaling up all three aspects of VCT, PMTCT Plus and ARV therapy in coordination with systemic capacity building. This proposal targets each Provincial General Hospital for capacity building and being made capable of providing a comprehensive range of high quality services recommended in the recently made available Guidelines for VCT Services and ARV Therapy. (AIDS-specific Attachments # 1 & 2) In addition, a standardized ARV regimen for Kenya has been completed. (See AIDS-Specific Attachment # 3) Some of those hospitals already are fully capable of providing such services while others will be targeted for rapid strengthening.

- There will be a cadre of dedicated, appropriately trained personnel, including Physicians, Clinical Officers, Nurses, Pharmacists, Counselors, Family Health Workers and Outreach Workers.

- Necessary logistics support, including laboratory facilities and test kits necessary for timely diagnosis, and tools and personnel dedicated to data collection, management and reporting requirements, will be provided.

- Private, appropriate locations for effective counseling, and an overall capability to provide guidance and training to District and Community health personnel will also be part of the overall system strengthening so that services offered at the Provincial level will be replicated in the Districts, and eventually made available in the Communities.

- Institutional support for NACC will be tailored to allow NACC to continue to undertake its role of facilitating and coordinating ACUs to further develop their multi-sectoral activities at Provincial, District and Community levels. NACC will also be enabled to further drive activities into the PACCs, DACCs and CACCs, and to support activities of implementing partner NGOs and CBOs.

TB COMPONENT:

The overall goal of this proposal is to increase the coverage and quality of DOTS services that will benefit TB patients, people living with HIV/AIDS, minority groups such as orphans, women, prisoners and the community at large. The main objective is to expand the availability of high quality TB services through partnership with community, private sector, and public sector organizations that will achieve a case detection rate of 70% and maintain a high treatment success rate of 80% by the year 2005. The current five-year development plan does not provide sufficient answers to the ongoing crisis of tuberculosis and TB-HIV. However, it is widely recognized that additional efforts are needed for the foreseeable future in order to lift the TB program to the same level as the pre-HIV era, or better. The overall goal of the National Leprosy and Tuberculosis Programme (NLTP) strategic plan (See TB-Specific Attachment # 1) to reduce morbidity and mortality by tuberculosis in Kenya cannot, without additional assistance, be reached by 2005.

In addition to continuing to implement the NLTP five-year plan, there are other major areas identified by all implementing partners that require prompt attention. These include: Expand and decentralize diagnostic and treatment services; Develop and Implement an Urban TB control strategy; Develop and implement joint TB-HIV/AIDS program activities; Develop and implement a TB communication strategy; and, strengthen monitoring and evaluation of specific objectives and indicators. Expected outcomes of continuing implementation of the NLTP development plan and the proposed activities described in this proposal to GFATM, include adhering to the global targets of TB control, namely: Achieve and sustain 70% case detection rate of TB cases; Achieve and sustain 80% cure rate; and, Contain MDR TB at less than 3% in treated and untreated TB cases.

MALARIA COMPONENT:

The overall goal of the Malaria Component is to scale-up effective interventions to reduce morbidity and mortality associated with malaria among the Kenyan population.

The Malaria Component incorporates five specific objectives:
1: To increase the percentage of pregnant women and children under five sleeping under ITNs to 40%, in at least 40 districts by 2007;
2: To increase the number of pregnant women accessing IPT to 20% in at least 40 districts by 2007;
3: To improve case management and effective treatment of malaria;
4: To improve the drug distribution system for efficient malaria prevention and treatment;
5: To improve community access to information about malaria control and prevention.

Activities designed to achieve objective 1 include implementation of a voucher subsidy scheme targeting pregnant women and children under five and improving the efficacy of ITNs through the promotion of regular net re-treatment. Objective 2 will be addressed by scaling-up the use of IPT. Objective number 3 will be achieved through two broad activities: by training health staff and community resource persons in IMCI and shopkeepers in good drug dispensing practices; and through the purchase and distribution of anti-malarial drugs to peripheral health facilities. Objective 4 will be addressed through a consultative review and consequent revision of the current drug stock distribution system, together with the training of health facility workers, store keepers and district health management teams. Objective 5 will be achieved through three broad activities: the establishment of ITN advocacy groups; an IEC campaign on malaria prevention and treatment;

and inter-personal communication at the community level, through community-based organizations, networks and operations.

The expected results of these activities include: improvement in malaria case management at both the health facility and community levels; improved ownership and appropriate use of ITNs by pregnant women and children under five; and increased use of IPT among pregnant women. Other expected results include no drug stock-outs in peripheral health facilities, improved awareness of malaria prevention and the seeking of early treatment by communities. Quantitatively, by 2007 these results will be:

- A reduction in the percentage of outpatient attendance attributed to malaria from 30% of all outpatient attendance to 20%.
- A reduction in the percentage of admissions to health facilities attributed to malaria from19% to 13%
- A reduction in under fives malaria hospital admissions from 145,000 to 100,000.
- A reduction in the percentage of severe malaria cases from 19% to 15%.
- A reduction in the percentage of inpatient deaths of all ages attributed to malaria from 26% to 18% in sentinel districts
- A reduction in the number of deaths among children under five attributed to malaria from 34,000 to 23,000.
- A reduction in the percentage of inpatient deaths among children under five years attributed to malaria from 27% to 19% in sentinel districts
- A reduction in the number severe malaria and anaemia cases during 1st pregnancies from 6,000 to 4,000.
- A reduction in the number of low birth weight babies due to malaria associated maternal anaemia from 4,000 to 2,800.

The main development partners in addressing malaria in Kenya include the World Bank, UNICEF, WHO, EU, ADB, DFID-EA, DANIDA and Sida. NGOs including AMREF and PSI are also involved in this process, together with GoK ministries including the Ministry of Education, the Ministry of Culture and Social Services and the Office of the President.

- **Beneficiaries and Their Expected Benefits from Each Component:**

HIV/AIDS COMPONENT:

Kenya's overall population of 30.8 million will benefit from the proposed set of objectives, with specific impact on knowledge and practices of the 6.3 million youth who comprise the 15-24 year population segment; 600,000 individuals treated annually for STDs; the more than 1,050,000 women seen in antenatal clinics annually, who can be tested and treated for HIV, TB, STDs, and other OIs, and referred to treatment and PMTCT programs; more than 60,000 infants who can be prevented from becoming infected through peri-natal transmission from their infected mothers, and the infants' fathers; medically-eligible PLWHAs within the approximately 60,000 health care workers in both public and private delivery systems and those PLWHAs who are also TB positive; more than 2.2 million Kenyans now infected who will have increased access to voluntary counseling and testing, including the receipt of prevention information and condoms, when requested, and referral to screening and diagnostic and treatment locations, care and support; NGOs and CBOs comprised of and dedicated to providing Home-Based Care to PLWHAs; hundreds of institutions

and organizations and tens of thousands of individuals responsible for facilitating, coordinating and delivering the overall range of services down through the system to the community level.

TB COMPONENT:

The principal beneficiaries are all TB patients including those currently not diagnosed and their families. Organizations that play essential roles in the management of health services in communities are among the beneficiaries and these include community-based organizations and local networks of care, support and private sector health service providers. Also to benefit from the support of this fund are population groups hard-hit by HIV/AIDS and poverty, focusing on minorities that include women, orphans, and prisoners, among others. Difficult to reach groups will also benefit. The nation as a whole will benefit indirectly from the resulting longer life expectancy, increased productivity, and conservation of limited resources.

MALARIA COMPONENT:

Beneficiaries of the Malaria Component include all sectors of Kenyan society. Special focus is placed upon individuals who are particularly biologically vulnerable. These include pregnant women and children under five. Expected benefits to pregnant women and children under five, will be protection from malaria afforded by access to ITNs through the introduction of a voucher subsidy system. Benefits to pregnant women and their new born children include a reduction in severe and complicated malaria cases, a reduction in anaemia and a reduction in the number of low birth weight babies. The expected benefits accruing to children under five will be a reduction in morbidity and mortality due to malaria. For the population as a whole, there will be a reduction in the number of deaths resulting from malaria, a reduction in the constraints placed by morbidity on productivity, leading to overall poverty alleviation.

Key Synergies Of This Three-Component Proposal Will Include:

- Capacity building at all levels of Kenya society in terms of human resource development, with special attention paid to the counseling, testing and general health care delivery system;
- Strengthening and expansion of the national laboratory capabilities required for testing and diagnosis;
- Enhanced procurement capacity that emphasizes absorptive capacity and the ability to maximize efficiencies and cost effectiveness when buying, securing and distributing essential drugs, test kits, reagents, and drugs, including those used for opportunistic infections (OIs) as well as anti-retro viral drugs (ARVs);
- Data management capabilities that will overarch all three components;
- Financial management systems that will adhere to strict requirements of transparency and timely reporting;
- Monitoring and Evaluation methodologies that will combine tracking of basic, actual programmatic outcomes that can be compared to targeted outcomes on both financial and programmatic targets;
- Complementary services between HIV/AIDS and TB components will directly add efficiencies and therefore programmatic value of one to the other, with especially promising improvement of client care;
- Community-based Health Officers currently providing IEC services and materials on behalf on one epidemic will be utilized to provide the same or similar services to all three epidemics.

SECTION II: Information about the applicant

Table Iia

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal *(Guidelines para. 14–15)*	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines para. 24–25)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines para. 24 and 26)*	
Sub-national CCM	Sub-national proposal *(Guidelines para. 27)*	1–9 and 11
Non-CCM	In-country proposal *(Guidelines para. 28–30)*	12 – 16
Regional Non-CCM	Regional proposal *(Guidelines para. 31)*	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines para. 32)

Country Coordinating Mechanism (CCM), (Refer to *Guidelines paragraph 72–78)*

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	Yes
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:** The CCM has added members from the NGO community, Private Sector and other groups previously not included.	

1. **Name of CCM**

   Joint Inter-Agency Coordinating Committee (JICC)

2. **Date of constitution of the current CCM**

   6th February 2002

3. **Background and Process of Forming the CCM**

   The CCM is not a new mechanism, and is comprised of an Interagency Coordinating Council (ICC) for each epidemic. The CCM is made up of Government of Kenya officials, representatives from the donor community, local and international NGOs, and representatives from the private sector, faith-based organizations and the civil society. The members were chosen from among collaborating institutions

working with both the Ministry of Health and the National AIDS Control Council.

3.1 Work Previously Done, Programmes Implemented and Results Achieved

The CCM has met regularly since its inception in order to monitor the on going processes and requirements of the Global Trust Fund so that the CCM's proposal(s) meet(s) the required level of excellence for successful submissions. Furthermore, the CCM continues to refine its internal policies and procedures in order to make them more inclusive to Civil Society constituents, NGOs/CBOs, and other stakeholders, information and other resources for programme implementation and development. The CCM has taken steps since the Round I submission to assure improvement in the proposal development processes so that its submission for Round II funding reflects the wide-ranging efforts toward clarity, inclusiveness and transparency.

4. Organizational processes

The Chairperson of the CCM is the Permanent Secretary of the Ministry of Health. The CCM Secretariat includes the ICCs on HIV/AIDS, TB and Malaria, each of which has subcommittees focused on specific aspects of each disease. Meetings are scheduled monthly, with minutes of each meeting widely distributed to all members. Development of processes designed to reach out to all interested parties within the Civil Society and other interested constituent groups is a primary focus of the CCM, complemented by solicitation of input from all sectors within Kenya.

5. Mode of operation of the CCM

The CCM meets monthly for the purpose of reviewing progress reports from the ICCs, to deliberate on current requirements of the GTFATM, to monitor the development and finalization of the CCP, and to ensure that appropriate mechanisms are in place and that broad participation of the public sector and the Civil Society. An open, transparent process is employed, votes are democratically taken during the meetings, and discussion is open and encouraged. Minutes of meetings are distributed to all members and available to all stakeholders. (Examples of Minutes are seen in General Attachment # 1)

6. Plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required

There are plans to develop a set of criteria for performance evaluation, and to continue to reach out to all stakeholders, including CBOs. Annual general meetings will be convened to receive reports on the implementation and delivery of the National Strategic Plan. Close working relationships with other implementing partners will be consistently strengthened.

7. **Members of the CCM** (*Guidelines para. II.16 – 22)*:

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Office of the President (Government Sector)	Dr. Sally Kosgei	Permanent Secretary and Secretary to the Cabinet		
Main role in CCM				
Representing the Cabinet Office				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Office of the President (Government Sector)	Mr. Z K.A. Cheruiyot	Permanent Secretary		
Main role in CCM				
Representing the Office of the President				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health (Government Sector)	Prof. Julius S. Meme	Permanent Secretary		
Main role in CCM				
Chair of the JICC				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Education (Government Sector)	Prof. I. C. Kiptoon	Permanent Secretary		
Main role in CCM				
Representing the Ministry				

Table II.7

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Finance and Planning (Government Sector)	Mr. Joseph Kinyua	Permanent Secretary		
Main role in CCM				
Representing the Ministry				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health (Government Sector)	Dr. Richard O. Muga	Director of Medical Services		
Main role in CCM				
Co-Chair of ICC on HIV/AIDS representing the Ministry of Health				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
University of Nairobi (Academic institution)	Prof. L. S. Otieno	Principal		
Main role in CCM				
Representing the academic sector				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Kenya Medical Research Institute (KEMRI) (Government Sector)	Dr. Davy Koech	Director		
Main role in CCM				
Representing research institutions				

[*] E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
National AIDS Control Council (NACC) (Government Sector)	Dr. Margaret Gachara	Director		
Main role in CCM				
Representing Multi-sectoral HIV/AIDS Partners				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Japan International Cooperation Agency (JICA) (Bilateral agency)	Mr. Masaaki Otsuka	ResidentR epresent-ative		
Main role in CCM				
Representing development partners				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
UNAIDS (UNDP, ILO, UNICEF, UNDCP, UNESCO, UNFPA, WFP, WHO (multilateral agencies)	Dr. Coulibaly Sidiki	UN HIV/AIDS Theme Group Chair		
Main role in CCM				
Representing UN bodies on HIV/AIDS				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
WHO	Dr. Peter Eriki	WHO - WR		
Main role in CCM				
Representing UN Bodies on TB and Malaria				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
World Bank	Dr. Makhtar Diop	Country Director		
Main role in CCM				
Representing Development Partners				

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
German Development Corporation	Dr. Henri van den Hombergh	Health Sector Coordina-or		
Main role in CCM				
Representing development partners				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Department for International Development	Ms. Marilyn McDonagh	Health Advisor		
Main role in CCM				
Representing development partners				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
CDC (Bilateral agency)	Dr. Lawrence Marum	Medical Epidemiolo-gist		
Main role in CCM				
Representing development partners				

- E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
USAID (Bilateral agency)	Ms. Janet Paz-Castillo	Chief, Office of Population and Health		
Main role in CCM				
Representing development partners				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
SIDA (Bilateral agency)	Ms. Maria Stridsman	Counselor Develop-ment Assistance		
Main role in CCM				
Representing development partners				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
SUPKEM (Religious group)	Mr. Abdulaltif Shaban	Director General		
Main role in CCM				
Representing religious organizations				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
CARE (NGO)	Mr. Gituro Wainaina	Regional Coordina-tor		
Main role in CCM				
Representing NGOs				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Kenya MedicaL Association (Professional organization)	Dr. William Lore	Represent-ative		
Main role in CCM				
Representing professional bodies				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
AMREF (NGO)	Dr. Mette Kjaer	Head, Kenya Country Office		
Main role in CCM				
Representing NGOs				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Kenya AIDS NGOs Consortium (NGO)	Mr. Allan Ragi	Director		
Main role in CCM				
Representing NGOs				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Kenya Association of Manufacturers/Private Sector Business Council (Private Sector)	Mr. Chris Kirubi	Chairman		
Main role in CCM				
Representing the private sector				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Network of People Living with AIDS (NEPHAK)	Mr. Rowlands G. Lenya	Director		
Main role in CCM				
Representing people living with AIDS				

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	Alternate Chair/Vice-Chair
Name	Prof. J. Meme	Dr. Richard O. Muga
Title	Permanent Secretary Ministry of Health	Director of Medical Services
Address	P O Box 30016 Nairobi	P O Box 30016 Nairobi
Telephone	254-2-717077	254-2-717077
Fax	254-2-713234	254-2- 715239
E-mail		dms@insightkenya.com
Signature		

9. Contact persons for questions regarding this proposal

Table II.9

	Primary contact	Second contact
Name	Prof. J. Meme	Dr. Margaret Gachara
Title	Permanent Secretary Ministry of Health	Director National AIDS Control Council
Address	P O Box 30016 Nairobi	P O Box 61307 Nairobi
Telephone	254-2-717077	254-2-250 558
Fax	254-2-713234	254-2-2711 231
E-mail		Gachara@iconnect.co.ke

SECTION III: General information about the country setting

18. Actual and Potential Disease Burden of HIV/AIDS, TB and Malaria

HIV/AIDS:

The Kenya Ministry of Health (MOH), in conjunction with the National AIDS Control Council (NACC) and in collaboration with and support of major stakeholders, in 2001published a sixth edition of "AIDS in Kenya", in which national data for the year 2000 relevant to the epidemic have been expertly summarized, referenced and discussed, and from which the following information has been extracted and referenced by page number. The document is included as AIDS-specific Attachment # 4.

Kenya, in 1999, declared HIV/AIDS a national disaster and public health emergency as a result of:

- Kenyan deaths by AIDS of more than 1.5 million individuals since 1984;
- Current HIV infections of more than 2.2 million. (Pages 1-2)
- 1.2 million children under the age of fifteen years (4.5% of Kenya's total population of 30.8 million) orphaned through the death of their mother (Page 15)
- National adult HIV prevalence of 13.5%, leading to approximately 300,000 new HIV infections, 200,000 new AIDS cases, and at least 180,000 deaths annually. (Pages 1-2,6)
- One of every eight adult rural Kenyans and one of every five adult urban Kenyans infected. (Introduction, page vii)
- Life expectancy at birth having declined from 65 years to 46 years currently. (Page 13)

According to Ministry of Health (MOH), since 1986 more than 75% of all AIDS cases occur in adults between the ages of 20 and 45, with peak ages of female infections appearing between 25-29, and for males between 29-34. Most HIV infections in Kenya (80%) are transmitted through heterosexual contact. Because the virus is more easily transmitted when one or both sexual partners is infected with a sexually transmitted disease (STD) such as syphilis, chancroid or herpes, all of which cause genital ulcers, there is urgency associated with reducing the relatively high levels of STD's in Kenya. The ratio of HIV infections between males and females is about one to one. However, young women between 15-24 years of age are more than twice as likely to be infected than males in the same age group. (Page 11) Specific geographical areas suffer from extraordinarily high prevalence rates. For example:

- 35% of pregnant women using antenatal sites in some areas, including Busia, Chulaimbo, Kisumu, Mbale, Meru, Nakuru and Thika;
- 10-20% of pregnant women are infected at other sites that include Kakemega, Kisii, and Kitale, amoung others; (Page 3)

The National AIDS and STD Control Programme (NASCOP) within the MOH, through regular HIV surveillance at 32 sites throughout Kenya, has estimated that specific sub-groups of Kenya's population are more highly infected than the overall population. Especially hard hit have been:

- Adults 20-49 years that represent the population segment most economically productive, with illness and death at these ages causing serious economic and social burdens to families and society.
- 80% of Kenya's population lives in rural areas, where there are an estimated 1.5 million infected. (Page 6)
- 90% of Kenya's adult rural population works in the agricultural sector that accounts for 30% of total GDP and 70% of national export earnings.

- Children under 5 years include nearly 100,000 cases resulting from mother-to-child HIV transmission, and between 30%-40% of all infants delivered by infected mothers become infected themselves. (Page 7)

The broad impact of Kenya's HIV/AIDS epidemic can be seen by the following sector-specific information:

- Kenya's health workers experience a high rate of AIDS deaths, reducing the health system's overall response capability;
- Approximately half of all available hospital beds in Kenya are utilized by only 25% of Kenya's HIV/AIDS patients;
- Kenya's education sector is at risk of dissolving because its teachers are dying from AIDS faster than they are being replaced, and its students are dropping out either to care for sick and dying parents or surviving younger siblings, or because they can no longer afford school fees;
- Corporations and firms within Kenya's private sector absorb average HIV/AIDS-related costs per employee of approximately US$ 120, representing about 8% of company profits;
- The average firm in Kenya will be experiencing total annual HIV/AIDS costs in excess of US$403,000 by 2005.

Kenyans, addressing the above conditions as best they can, face another epidemic that compounds the HIV/AIDS epidemic …

TUBERCULOSIS:

Tuberculosis is a major threat to health in Kenya. In the 1995 national tuberculin survey the annual risk of tuberculosis infection was calculated at a very high 1.2%. The case notification rate has steadily increased from 54 per 100,000 in 1991 to 248 per 100,000 in 2001. The peak age groups are 20 to 30 years for females and 25 to 35 years for males. There has been only one HIV sera-prevalence survey among TB patients in Kenya. This survey, done in 1994 by the National Leprosy and Tuberculosis Programme (NLTP), found a national HIV prevalence of 40% in new TB patients. It is now estimated that 50% of TB in Kenya is HIV associated.

Kenya is among the 22 TB high burdened countries that contribute to 80% of the total TB cases reported all over the world. These countries form the DOTS expansion group of Stop TB partnership. In the last decade, the number of TB cases registered and put on treatment in Kenya increased from 14,599 cases in 1992 to 73,017 cases in the year 2001. Over the past five years an average annual increase of 16 % for all forms of TB has been observed. Still, according to WHO projections, the NLTP is only registering between 45 and 50% of the estimated incidence, significantly below the targeted 70%case detection rate.

MALARIA:

Kenya's Malaria disease burden is illustrated by the 20 million Kenyans (70% of the population) living in malarious areas and at risk of infection (National Malaria Strategy 2001, Malaria-specific Attachment # 1). Each year, an estimated 6,000 primigravid women suffer from malaria-associated anaemia, 4,000 babies are born with low birth weight as a result of maternal anaemia and 34,000 children below the age of five years die from malaria. This disease burden has a draining effect upon Kenyan health resources as 30% of all outpatient attendance and 19% of inpatient admissions are due to malaria (National Malaria Strategy 2001). Malaria also widens the gap in prosperity between countries with the disease and those without. It has significant, measurable, direct and indirect costs that place major constraints on economic development in Kenya.

Among the direct costs of malaria is the high personal and public expenditure necessitated by prevention measures and treatment. Indirect costs of malaria in Kenya include: loss of productivity and income

associated with illness and death; loss of working days and/or absenteeism from formal employment and in cases of death of a family member, the loss of future lifetime earnings.

The linkage between Kenya's malaria burden, poverty, and economic development is dramatic and unmistakable. It is estimated that around 20 million Kenyan people (more that half the population) are regularly infected with *P. falciparum*. This means that almost every household is affected by the suffering and economic hardship caused by malaria. When a family member suffers a malaria episode, households' resources have to stretch to the expenditure of transport of the patient, consultation costs and drugs. This is estimated to amount to US $20 each year for the clinical management attacks. Given that 53% of Kenya's rural population subsists below the poverty line (National Economic Survey 2001, General Attachment #3), the clinical management of malarious episodes presents an overwhelming financial burden to the rural population. Malaria associated morbidity is responsible for a significant decrease in productivity and in Kenya, it is estimated that 170 million working days are lost each year as a result of malaria. The negative economic impact is most severe on agricultural productivity and the livelihoods of poor rural farmers, especially in epidemic-prone districts (National Malaria Strategy 2001) School attendance and learning are also disrupted by childhood episodes of malaria. It is estimated that nationally, approximately 4million school days are lost annually due to malaria, which can rise to 10 million during years of epidemic outbreaks.

19. Kenya's Current Economic and Poverty Situation

Kenya's current population is estimated at 30.8 million with a GDP per capita of 25,094 Kenya Shillings (US Dollars $320). About 56% of the total population (16 million) earn less than $1.00 per day and live in poverty. Kenya's rural population carries a disproportionate share of poverty, at 83%. Groups hardest hit are social categories that never existed before, such as child-headed households in which both parents have died, and large numbers of homeless street children. Women have suffered more adversely from poverty, including lower school enrollment rates and higher dropout rates for girls, and women are especially susceptible to damaging social and cultural practices, and discriminatory attitudes. An overall budget deficit, as a percentage of GDP, stands at 3.1%. This condition is attributed, in part, to withholding of donor support from the development partners, and to an economy struggling against the effects of the HIV/AIDS, TB and Malaria epidemics. Kenya's epidemics have exerted a considerable negative impact on her Human Development Index (HDI), causing it to deteriorate from 0.531 in 1990 to 0.514 in 1999. (General Attachment #2)

The economy recovered slightly from the negative growth of 0.2% in 2000 to 1.2% last year due to favourable weather conditions with a positive impact on the agriculture and power sectors, and from increased demand for information and communication services, combined with favourable tax reforms. (General Attachment # 3, Economic Survey 2002, Attachment #4,Poverty Reduction Strategy Paper [PRSP] 2001-2004). Kenya's major development priority is to reduce poverty through measures outlined in the country's PRSP, which has provided suggestions for strengthened social sector responses to economic and social development for Kenya over a five-year period. Factors that hampered full economic recovery included a decline in saving, poor infrastructure, a trade imbalance leading to a balance of payment deficit, economic responses to emergencies and disease, high poverty levels and donor fatigue, among other factors. (See Table 1 - Economic Indicators)

Table 1 – Economic Indicators

YEAR	1999	2000	2001
Population	29.5 Million	30.2 Million	30.8 Million
Growth of GDP at constant prices	1.4%	-0.2%	1.2%
Trade balance	-$1,074,892,307	-$1,452,266,667	-$1,827,153,846
GDP Per capita	USD 1.53	USD 1.45	USD 1.42
Debt service charge as % of GDP	4.2%	4.3%	1.8%

20. Kenya's Current Political Commitment in Responding to the Epidemics

The Government's commitment to Kenyans' health is expressed in the Health Policy Framework Paper of 1994 (General Attachment # 5), in which is expressed the overall goal, " To promote and improve health status of all Kenyans through the deliberate restructuring of the health sector to make the health services more effective, accessible and affordable". The government is a signatory of several international treaties, including the Alma Ata Declaration on implementation of PHC and the Cairo International Conference on Population and Development. The Government also released the National Health Sector Strategic Plan for 1999-2004 (General Attachment # 6), whose vision is "Create an enabling environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Kenyans". One of the main objectives of the national plan is to enhance equity, quality, accessibility and affordability of health care through better targeting of resources to the poor. The resources are to be redirected to the areas that provide maximum benefits to the majority of the vulnerable groups who form a big proportion of the society. In this regard Malaria, Tuberculosis and HIV/AIDS control are priority disease programs in this plan.

The ministry of health has continued to provide approximately 25% of all anti-TB drugs through budgetary allocation, which has contributed significantly to maintain constant drug availability in the country. To address the gap on drug supply, Kenya negotiated and was awarded a World Bank loan of 2.2 million dollars through the District Aids and Reproductive health (DARE) project. More support was requested and received from the Global Drug Facility (GDF). The average annual growth of the Government's contribution to the sector is a reflection of its commitment towards supporting health services in the country. MOH's recurrent budget during the financial year 2001/2002 accounted for about 7% of the Government's total expenditure. Out of the recurrent budget 70% covers curative services and 21% supports PHC activities. Out of this 70%, 67 % is directed towards supporting personnel emoluments, while approximately 21% are used for the purchase of drugs and supplies, leaving 9 % available for operations and maintenance. While donor funding represents only 3% of the overall expenditure on health by the various contributors, it accounts for over 90% of the development budget i.e. the budget for capital expenditure, grants and any credits to the government.

Health Sector Reforms are part of the wider economic reforms being implemented by the Kenya Government in all sectors to stimulate economic growth and reduce poverty and unemployment. In the recent past actions and efforts have been undertaken in difficult times and are key towards targeted and consistent healthcare services provided in Kenya. In line with these broad government policies, the Ministry

of Health, in collaboration with her development partners, developed a five-year National Health Sector Strategic Plan which covers the period 1999-2004.This document provides operational guidelines for Kenya's Health Policy Framework Paper of 1994. The reform agenda aims to promote and provide quality curative, preventive, promotive and rehabilitative health care to all Kenyans, with key strategies including development of alternative financing options, human resource development, strengthening drug and medical supplies and equipment procurement and logistics systems, as well as health support systems, governance and service delivery at all levels. Implementation of health sector reform aims at strengthening the delivery of health services at the district level through a policy of decentralization. The Government is fully committed to decentralizing the authority for decision-making, resource allocation and management of health services to district and facility levels, thereby allowing for greater participation of communities in providing health services and implementing essential clinical and public health packages. Other health services provision gains include participation and co-operation with the private sector, Non-Governmental Organizations, Donors, other Government ministries, research and training institutions, and religious organizations.

The Government established the National AIDS Control Council (NACC) in November 1999 through Legal Notice No. 170 of 26 November 1999 (AIDS-Specific Attachment #5), to oversee all HIV/AIDS matters in the country. The Council has in place the Kenya National HIV/AIDS Strategic Plan 2000-2005, (AIDS-specific Attachment # 6) whose overriding theme is "social change to reduce HIV/AIDS and poverty". The Plan addresses five priority areas for the control of HIV/AIDS, as well as mechanisms for mitigation of the socio-economic impact of the epidemic. Other supportive policies include the Sessional Paper No. 4 of 1997 (AIDS-specific Attachment #7), providing a policy framework to guide all partners in the nation's response to the challenges of HIV/AIDS. Other indications of political commitment include the Condom Policy, National Guidelines on VCT, National Home Based Care Programme and Service Guidelines, Blood Safety Guidelines and Guidelines on the Antiretroviral Drug Therapy in Kenya, and the PMTCT Guidelines. (AIDS-Specific Attachments # 8 through #11) A draft Bill on issues related to HIV/AIDS is to be taken to Parliament before the end of the year 2002. This was recommended after a Task Force looking into the legal issues related to HIV/AIDS handed its report to the Attorney General on 19th July 2002. Parliament have spearheaded massive, nation-wide social mobilization through the formation of Provincial AIDS Control Committees (PACCs), District AIDS Control Committees (DACCs), and Constituency AIDS Control Committees (CACCs), designed to emphasize community-based activities through CBOs and individuals. Active participation of the Members of Parliament during the launching of these committees catalyzed open discussion about HIV/AIDS at the community level.

21. Percentage of Total Government Budget Allocated to Health (USD)

21.1 Total budget allocated to Health:

2001/2002 = 3.9%
2002/2003 = 5.4%

FISCAL YEAR	MOH	TOTAL GOK
2001/2002	US$ 148,842,659	US$ 3,770,660,487
2002/2003	US$ 194,669,215	US$ 3,577,310,030

References: Government Printed Estimates 2001/2002 and 2002/2003,

21.2 National Health Spending for 2001/2002

Table III.21.2

	Total national health spending Specify year: **2001/2002** (USD)	**Spending per capita** (USD)
Public	149,000,000	4.94
Private	131,000,000 (est.)	4.34 (est.)
Total	280,000,000	9.27
From total, how much is from external donors?	25, 200,000 (9%)	0.83

21.3 Earmarked expenditures for HIV/AIDS, TB and Malaria:

SECTORS	**EARMARKED EXPENDITURES (USD)**			
	2000/01	**2001/02**	**2002/03**	**2003/04**
Ministries		2,169,885	2,462,949	2,520,410
Health		51,004	53,716	54,217
Total GOK		2,220,889	2,516,665	2,574,627
ACUs		-	2,270,200	2,540,400
CIA		-	11,000,000	10,000,000
UNDP		-	884,614	1,256,410
External Donors		54,478,981	63,142,434	60,050,513
Total External		54,478,981	77,307,248	73,847,323
Private Sector		-	19,231	-
Total		56,699,870	77,326,479	76,421,950

Source: Mokoro Report on Financing Framework, PIP KHADRE Project
NACC MTEF Budgets

Table III.21.3

Total earmarked expenditures from government, external donors, etc. Specify Year:	**In US dollars:**
HIV/AIDS	76,421,950
Tuberculosis (2001/2002)	22,000,000
Malaria (2002/2003)	23,115,000
Total	121,536,950

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives*, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)**:

Kenya has not qualified for the HIPC initiative, to date.

* HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank
** Optional for NGOs

22. National Programmatic Context

22.1 Kenya's Current National Capacity (state of systems and services) in Response to HIV/AIDS, TB and Malaria

Kenya's current national capacity in response to HIV/AIDS, TB and Malaria includes several important elements. The HIV/AIDS epidemic is addressed primarily through two government entities: 1. The National AIDS Control Council (NACC), an entity established by Parliament, located within the Office of the President, and mandated to coordinate and supervise all HIV/AIDS activities within Kenya, as well as to mobilize resources and develop and promote policies; 2. The National AIDS and STD Control Programme (NASCOP), located within the federal Ministry of Health. Both NACC and the MOH are focused on a health system that utilizes the country's political subdivisions as the bases for decentralizing service provision from the national level to the eight Provinces, and from Provinces through the 70 Districts to the community level, where local health facilities might be found under the auspices of District Health Offices, NGOs and/or CSOs. At the Provincial level are the Provincial General Hospitals (PGH), of major importance in their capacity as providers of comprehensive screening, diagnostic and treatment services, drugs, care and support. In urban areas there are other large providers of comprehensive care that complement the PGHs, and also serve as institutions of higher learning, training health care professionals and others in the helping professions. NASCOP is a Division under the Department of Promotive and Preventive Health, overseen by the Director of Medical Services, who is also a Member of NACC and a technical advisor in the MOH. The role of NASCOP/Ministry of Health is to implement the technical areas of intervention, treatment, blood-safety, and prevention of mother to child transmission of HIV, and to assist the MOH and NACC to mainstream HIV/AIDS in its planning, and human resource allocation. NACC focuses on its mission, which is to ' Provide policy and a strategic framework for mobilizing and coordinating resources for prevention of HIV transmission and provision of care and support to the infected and affected people in Kenya.' NACC, with a Chairman appointed by the President, is the national coordinating body responsible for delivering the HIV/AIDS Strategic Plan. In fact, it is much more in that it acts as a partnership body in which representatives of Ministries, NGOs, Civil Society, Donors and implementing partners are brought together for the common purpose of facing the AIDS epidemic head on, mobilizing all necessary resources - local, national and international - to be successful.

In addition, the National Leprosy and Tuberculosis Programme (NLTP) was launched by the GoK in 1980, combining the Kenya Tuberculosis Programme, established in 1956, with several leprosy control projects in Western, Coast and Eastern provinces that had been operating since the early seventies. The National Malaria Strategy (NMS), developed between 1998-2000 as a consensus strategy of the GoK, stakeholders, donors and other partners, provides principle approaches to effective, evidence-based interventions. Health Sector Reform provides the framework and financing mechanisms for improved district-led support to prevention and curative services.

Within MoH there is an adequate number of existing health personnel for the delivery of health services. These health staff members, however, require additional training in malaria prevention and control. At the country level, there is adequate capacity for training health workers to upgrade their knowledge and skills in malaria control. GoK funds are channeled through district treasuries and supplemented by funds from the Facility Improvement Fund that are generated through cost sharing. Funds from the World Bank, Sida and DANIDA are channeled directly to the districts. This proposal seeks supplementation of the funding gap in the Malaria Component by the Global Fund to provide additional training. This will improve the absorption capacity of funds available at district level and enhance the implementation of malaria interventions.
The types of interventions include: training of health workers and CORPs in key packages (such as IMCI and Focused ANC); scaling-up the use and ownership of ITNs; provision of 1st and 2nd line anti-malarial drugs; and the initiation of the use of IPT in pregnancy.

Complementing the governmental structures in place are many supports provided by NGOs, donors, private providers, and the corporate sector, all necessary for Kenyans to receive essential, life-saving drugs and services. Perhaps most prominent among structures in place to address HIV/AIDS is the Technical Working Group (TWG), comprised of approximately thirty representatives of all stakeholders. This group is technically expert in all aspects of the epidemic, meets monthly to review national and international trends related to HIV/AIDS, and provides overall guidance to the GoK. Of particular import is the Joint AIDS Programme Review (JAPR) undertaken by the senior decision makers of MOH and other Ministries, NACC, donors and other stakeholder organizations. The outputs of the first annual JAPR was forward looking, consensus-based, and provided expert guidance to all parties involved with programme implementation. The draft Logical Framework Matrix that resulted from the ten-day exercise conducted between May 20-31st, 2002, provides the way forward for virtually every aspect of Kenya's National HIV/AIDS Strategic Plan, 2000 - 2005. The final report and collective outputs of the 2002 JAPR are available as AIDS-Specific Attachment # 12.

International development partners, while providing less than 10% of recurrent GoK health care expenditures, provide approximately 90% of development expenditures for health. Despite continuing support from all of the sources mentioned, the proposed objectives of this GTFATM submission will require significant additional resources to fill gaps in additional human resource requirements, system-wide strengthening of screening, diagnostic and treatment services, including laboratory requirements, and counseling, testing, care and support facets, as well as provision of test kits and drugs necessary for implementation. Kenya's overall structures are in place, and her capacity to absorb additional resources is available through its institutional framework that includes universities, training institutes, strong political and social commitment and the unrealized potential of religious organizations, NGOs and CBOs, the corporate sector and other units within the civil society. Breaking out of the seeming intractability of poverty has been the primary objective of Kenya's Poverty Reduction Strategy Paper (PRSP) and its Medium Term Expenditure Framework (MTEF), both of which offer the policies and rationale that Kenyans will deploy against poverty, which directly and negatively impacts on the health status of all Kenyans.

NOTE: Over the months during which this proposal was developed, extensive outreach was made to all members of Kenya's civil society, resulting in meetings with individuals representing more than 150 public and private sector organizations, organized labor, faith-based foundations and organizations, and educational institutions. Technical guidance was offered to many in order to facilitate the development of proposals that were submitted to the three disease-specific Interagency Coordinating Committees (ICCs) that, together, constitute the JICC, Kenya's CCM. As a result, more than two hundred separate proposals were received, processed and considered for inclusion in Kenya's CCP that was developed to meet the three primary objectives of the HIV/AIDS component, and the five objectives each of both TB and Malaria components. A summary of received NGO proposals revealed budget requests totaling an approximate $200 million, leading the CCM to develop an appropriate process to be used in evaluating the proposals. A generous proportion of the overall CCP budget has been designated for annual allocation to NGO participation.

Kenya's NGO community submitted a wide range of proposed activities by which services and care can be delivered to the infected and affected, in urban and rural communities. The Kenya AIDS NGOs Consortium (KANCO), for example, a consortium of more than 700 NGOs operating throughout Kenya, developed a joint proposal with 45 of its members proposing activities that included home based care, peer education, and monitoring and evaluation, among others. Other NGOs proposed activities such as training of health care providers, programs that reach youth, both in and out of school, and supplying nutritional support to those in need. Orphans and other vulnerable children are the subjects of numerous proposals, as are widows and widowers. Finally, as an example, production of IEC materials in local languages has been proposed, along with dissemination methods appropriate to specific locales.

The consolidated budget request in Kenya's proposal incorporates budget requests for activities that will be implemented by implementing partners. The partners' proportionate allocation of Kenya's overall grant, should a grant become reality, can be seen in Table V.33. *PLEASE SEE AIDS-Specific Attachment # 13 for a summary discussion of NGO proposals received.*

In addition, the Malaria component received fifteen proposals that were submitted by the publicly advertised deadline of 13 September for review and consideration. Given the manageable number of documents, proposals were reviewed by the Department of Malaria Control, together with the WHO/MoH consultant. Proposed activities are summarized in the accompanying attachment to the Malaria component, were very broad and included community awareness-raising and mobilization; supporting increased use of ITNs, especially among the biologically vulnerable; and training of health professionals, opinion leaders and school children in malaria prevention and control. Several innovative approaches were presented, including voucher subsidies to increase ITN coverage among vulnerable groups. Crosscutting initiatives were presented to address malaria concurrently with other diseases, such as HIV/AIDS. Many of the NGO proposals incorporated objectives to actively include marginalized and disadvantaged groups such as orphans, urban slum dwellers and people living with HIV/AIDS. The theme of social inclusion and equity was apparent in activities aimed at empowering women, girls and youth and alleviating poverty. Please see Malaria-Specific Attachment #2 for a list of proposal submissions and a summary of their characteristics.

Given the scope of the objectives of the Malaria Component, some of the NGO-proposed activities were more appropriate for incorporation than others. Activities concerned with vector control, for example, are not among the selected priority areas for support from the Global Fund. The proposal submitted by Moi University, due to its focus on epidemic forecasting through the establishment of a regional forecasting centre, stands alone in that its scope does not converge in any way with the Malaria Component of the GFATM Proposal. The JICC (the CCM for Kenya) has agreed that proposals and activities not suitable for incorporation into the GFATM Proposal, will be channeled through GoK for consideration for alternative funding sources, and or set aside for consideration in another proposal in Round III or later calls for proposals.

22.2 The Main National And International Agencies Involved In National Responses To HIV/AIDS, TB And Malaria, And Their Main Programmes**:

HIV/AIDS:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period) Millions - US Dollars
Government of Kenya	Government	Direct Support: • Salaries • Development and recurrent budget Indirect Support: Not quantifiable	321 Million recurrent; NACC/OP 50 million
IDA/WB	Multilateral	Community initiatives – comprehensive HIV/AIDS	76 over 5 years
USAID	Bilateral	Comprehensive HIV/AIDS	72.8 over 4 years
CDC	Bilateral	Comprehensive HIV/AIDS Prevention Research	31 million over 5 years 6 million over 5 years
EU	Multilateral	Advocacy and Prevention	5.0 for 1 year
JICA	Bilateral	Comprehensive HIV/AIDS	20 over 5 years
DFID	Bilateral	Comprehensive HIV//AIDS, Care and support	37.8 over 4 years
GTZ	Bilateral	Reproductive Health and HIV/AIDS	3.6 over 5-6 years
DANIDA	Multilateral	HIV/AIDS Advocacy and Prevention	5.8 over 4 years
CARE Kenya	NGO	Behavior Change & Prevention	0.43 over 3 years
UNAIDS	Multilateral	Comprehensive HIV/AIDS, Strategic Plan re Law and Ethics	2.6 over 4 years
World Food Program	Multilateral	Nutritional support, care	6.0 over 5 years
UNFPA	Multilateral	Adolescent Reproductive Health and HIV/AIDS	5 over 2 years
UNICEF	Multilateral	PMTCT	3.0 over 1 year
UNDP	Multilateral	Management and coordination	.57 – 1 year
MSF-Spain	NGO	Treatment and care for infected and affected	1.17 for 2 years
MSF-France	NGO	Treatment and care for infected and affected	1.48 over 2 years
Private Sector	Private – Unilever	Awareness creation	.02 for 1 year

TUBERCULOSIS:

Name of Agency	**Type of Agency**	**Main programs**	**Budget** in US$
Government of Kenya	Government	*Direct* Support: • Salaries • Drugs (WB Loan) • Development and recurrent budget *Indirect* Support: Not quantifiable	Government contribution to NLTP -US$ 14,700,000 -45 million RHZ tablets (estimate US$ 1.5million) -US$ 225,000
USAID: JSI/DELIVER FHI/Impact	Bilateral Government through NGO's	*Direct* support of the NLTP: transport, supervision and drug distribution by deliver *Indirect* support through combined HIV/AIDS and TB program activities in urban TB initiatives in Nairobi, Mombassa, Kakamega and Nakuru	US$ 1.5 million US$ 3.6 million
CDC	Bilateral Government	Direct support of core NTLP activities such as laboratory equipment, EQA, recording & reporting and operational research	US$ 4 million over 5 years
WHO	Multilateral	Direct support to community DOTS, TB-HIV collaboration + TA	US$ 210,000 (2003 only)
GDF	Multilateral	For 2003 only 12,000,000 EH 400,000 S 2,200,000 RH	Estimated US$ 500,000
World bank	Multilateral Through DARE project	Combined HIV/AIDS/TB program which includes Drug supply (RHZ)	Included in GoK contribution
CIDA/KNCV	Bilateral Government/ NGO	Direct support of Core NTLP activities such as provision of transport, laboratory supplies, capacity building and Technical assistance	US$ 1.6 million

MALARIA:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period) Millions - US Dollars
Government of Kenya	Government	Direct Support: • Salaries • Development and recurrent budget Indirect Support: Not quantifiable	169 million recurrent
IDA/WB	Multilateral	Community initiatives – comprehensive HIV/AIDS	76 over five years
CDC	Bilateral/ Government	Comprehensive Malaria and Research via KEMRI	10 over five years
DFID	Bilateral	Comprehensive Malaria Strategy	7.5 over five years
WHO	Multilateral	Malaria Control Activities	3.0 over five years
JICA	Bilateral	Supporting Infrastructure Development	6.0 over five years
Community (CBIs)	NGO	CBO Malaria Control Activities	10.0 over five years
PSI	NGO	Social Marketing of ITNs	27.0 over five years

22.3 Major programmatic intervention gaps and funding gaps that exist in Kenya's current response to HIV/AIDS, TB and Malaria (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

The main programmatic intervention gaps in Kenya's current response to the three epidemics include the following:

- Human resources are stretched beyond reason and staff are given additional duties when crises appear rather than new staff being hired and dedicated to specific epidemic-related work;
- Diagnostic and treatment requirements of the system do not meet the requirements of appropriate screening, diagnosis and treatment, and therefore, the system needs to be strengthened nationally;
- VCT locations where confidentiality is a key to using the services lack privacy and must be physically improved;
- Distribution of drugs and commodities is using a system that does not meet minimum standards of efficiency, security or record keeping and reporting;
- National levels of poverty have kept the poor (over half the nation's population) from accessing education and health sectors, which lack adequate resources, including teachers.

Overall, the financial gaps currently facing all three epidemics amount to well over $145 million, although even that level of shortfall is subjective, and takes into account levels of care that would be considered inadequate in any developed nation. The activities described in this proposal are complementary and additive to the successful interventions currently underway.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X):	X	**HIV/AIDS**
		Tuberculosis
		Malaria
		HIV/TB

24. Summary of the component

HIV/AIDS:

Focusing on Kenya's disease burden arising from the HIV/AIDS epidemic (see Section III, paragraph 18), allows for development of the rationale for the overall goal, selected objectives within that goal, related activities and their expected results, and implementation plans with implementing partners. Experience in Kenya and elsewhere shows that while there are many strategies and interventions that can be deployed for controlling HIV/AIDS, that same experience has shown that prevention, a primary component of any national strategy, is best effected through concurrent implementation of several strategies and interventions. **Prevention**, through Voluntary Counseling and Testing (VCT) services that include behaviour change strategies through appropriate prevention education, condom-use promotion and condom availability, referral to health facilities that provide TB and STD screening and treatment, coupled with opportunistic infection (OI) treatment and prophylaxis, and appropriate triage to PMTCT services - **together** - are many times more cost effective than either providing hospital treatment for AIDS patients or trying to prevent the spread of the virus with antiretroviral (ARV) therapy. However, providing PLWHAs with ARVs is seen as a primary responsibility for Kenya, and is, indeed, included in this proposal as a separate **CARE** objective with specific activities. A proper combination of activities, therefore, drives the rationale for the HIV/AIDS component of this Kenya proposal. The overarching goal, 'Social Change to Reduce HIV/AIDS and Poverty, can be found in Kenya's National HIV/AIDS Strategic Plan 2000-2005 (KNSP), page 1. (AIDS-Specific Attachment #6). This same document presents priority areas for addressing the epidemic from which have been selected the three objectives that form the bases of our submission to the GTFATM.

OBJECTIVE 1: Reduction of HIV Prevalence in Kenya through Prevention and Advocacy: Scaling up Existing VCT Services

Broad activities associated with Objective 1 will include: Formulation, harmonization and dissemination of appropriate messages advocating for greater utilization of VCT services. Until 2001, VCT services were almost non-existent in Kenya. In 2001 and 2002 there were rapid scale-ups in both health facilities and in 'stand alone' VCT sites, with support from a variety of partners. As of August 2002 there were approximately 75 locations, and the total number of projected clients utilizing those services through the end of 2002 is expected to approach around 65,000. Though this is a very positive achievement, that

number represents only a tiny fraction of Kenya's total population. At most VCT sites, an average of 20% of clients are HIV+. It is estimated that approximately 2.2 million Kenyans are already HIV+. Therefore, the 65,000 who will have learned of their serostatus in 2002 only represents .03% of all HIV+ Kenyans. It is therefore very clear that a major expansion of VCT services is urgently required in Kenya. Expected results of that scale up will include demand-creation messages produced for wide dissemination through radio and television, accompanied by brochures to be produced in appropriate, local languages and distributed by district and community-based health information officers. Clients tested for HIV in VCT sites and receiving results in a timely manner, usually within an hour of being tested, nearly always on the same day, will approach 1,000,000 over the five-year duration of this project. Implementing partners will include NACC, NASCOP, Ministry of Tourism and Information, ACUs within each Ministry, NGOs, CSOs and faith-based groups.

OBJECTIVE 2: Provide Treatment, Continuum Of Care And Support Through Expansion Of Existing PMTCT and ARV Services

Broad activities associated with this objective will include strengthening the following: Clinical management and nursing care of those infected with HIV/AIDS; System-wide capacity building for the provision of screening, and diagnosis and treatment of STIs, OIs, and TB, a continuum of care, and social services provided by NGOs, CBOs and family members. Expected results from these activities will include increased numbers of the following: Identified PMTCT centers, initially focusing on the Provincial General Hospitals, and subsequently at District and Community health centers; Types and distribution of providers of counseling, treatment, care and support services; Regional facilities stocked with opportunistic infection drugs and ARVs, and reporting a low number of stock-outs during previous 12 months, or no stock-outs at all; and Provision of ARV therapy to eligible PLWHAs, including pregnant women, their infants and partners, TB+ individuals, and health care workers. Those target populations have been identified as an important starting point for the government's scale-up of activities that will be the responsibility of both public and private sector health care providers, NGOs, CSOs and corporations that provide services to employees. As the cost of ARV drugs continues to drop, the ARV Task Force, comprised of medical experts representing NASCOP, NACC, donors, implementing partners and both public and private health systems, will identify ways to expand services that are equitably accessed by all who need them.

OBJECTIVE 3: Management And Coordination Through Institutional Capacity Building

Activities to be undertaken in order to fulfill Objective #3 will include the design and development of various training programs necessary for the creation of demand for VCT and PMTCT services and monitoring and evaluation of the progress of the services. Expected results include a growing number of individuals from NACC and stakeholders organizations, including NGOs and CSOs, trained to effectively market VCT and PMTCT services to communities at and below the District level and within all DACCs and CACCs. In addition, monitoring and evaluation of the expanded services, and their utilization trends, will be strengthened.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year)**:**	January / 2003	**To** (month/year)**:**	December / 2007

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Table IV.26.1

Goal:	To prevent the spread of HIV in Kenya and minimize its impact on Kenyan society.	
Impact indicators *(Refer to Annex II)*	**Baseline** Year: 2002	**Target** (last year of proposal) Year: 2008
Reduced HIV prevalence among priority target groups	**13%***	9%

***Source: Ministry of Health Sentinel Surveillance, 2001(unpublished), General Attachment #7**

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

OBJECTIVE 1: Reduction of HIV Prevalence in Kenya through Prevention and Advocacy: Scaling up Existing VCT Services

Expected results would include prevention programs produced for dissemination through radio and television, accompanied by brochures to be produced and distributed; an increase in the number of VCT locations from 75 currently to over 350 by project end in December 2007; a dedicated cadre of VCT counselors recruited and trained; substantial numbers of test kits utilized for nearly 1 million Kenyans who will know their serostatus, thereby preventing tens of thousands of HIV transmissions; referrals of individuals with AIDS, and their partners and children who are eligible for ARV therapy and care.

OBJECTIVE 2: Provide Treatment, Continuum Of Care And Support Through Expansion Of Existing PMTCT Services and ARV Therapy

Expected results from these activities will include increased numbers of the following: locations where PMTCT+ services and ARV therapy will be available, including a comprehensive set of services such as screening for STIs, diagnostic and treatment services for TB and other opportunistic infections, a continuum of care and support over time; eligible pregnant women and their spouses (estimated at 10% of spouses, initially); health care providers recruited and trained, resulting in increased numbers of dedicated staff at health facilities where PMTCT services and ARV therapy are made available; regional facilities stocked with opportunistic infection drugs and ARVs, resulting in a low number of stock-outs reported during previous 12 months, or no stock-outs at all.

OBJECTIVE 3: Management and Coordination Through Institutional Capacity Building

Expected results include increased uptake of VCT services at urban and rural sites due to increased awareness; availability of counselors in all health facilities, and increased uptake of PMTCT services generated by advocacy from district medical health officers and other medical personnel, and CSOs, NGOs and religious organizations. In addition, there will be increased capability of individuals within PACCs, DACCs and CACCs to coordinate, support, facilitate and motivate VCT service usage at all levels.

Table IV.27

Objective1:	**Reduction of HIV Prevalence in Kenya through Prevention and Advocacy: Scaling up Existing VCT Services**				
Outcome/coverage indicators	**Baseline**	**Targets**			
	Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	**Year 4: 2006**
Percentage of people reporting utilization of VCT services	**1**	5	10	15	20
Percentage of people living with HIV who know their sero-status	**1**	5	10	15	20
Average number of VCT sites per district	**1**	2	3	4	5

Objective 2:	**Provide treatment, continuum of care and support through expansion of existing PMTCT services and ARV therapy**				
Outcome/coverage indicators	**Baseline**	**Targets**			
	Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	**Year 4: 2006**
Percentage of spouses accessing ARV treatment; symptomatic HIV+	**5**	10	15	20	25
Number of women and eligible partners receiving treatment in public sector services	**1,000**	1,985	4,013	7,675	12,139
Number of regional facilities stocked with opportunistic infection drugs and ARVs and reporting no stock outs in previous 12 months	**2**	8	8	8	8

Objective 3:	**Management and Coordination (Institutional Capacity)**				
Outcome/coverage indicators	**Base-line**	**Targets**			
	Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	**Year 4: 2006**
Number of PACC, DACC, CACC, CSO, NGO and other community personnel trained on how to support and advocate for VCT and PMTCT campaigns	**0**	**40 ACU 18 PACC 140 DACC, NGO, CBO and others**	80 ACU 36 PACC 280 DACC, NGO, CBO and others	80 ACU 36PACC 280 NGO, CBO, & DACC	80 ACU 36 ACC 280 CBO, NGO & DACC
Coverage of PMTCT and ARV services	**0**	**10**	20	30	40
Number of quarterly M &E reports indicating success of programmes in place	**0**	**1**	2	3	4

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

OBJECTIVE 1: Reduction of HIV Prevalence in Kenya through Prevention and Advocacy: Scaling up Existing VCT Services

BROAD ACTIVITIES

1. Scale up VCT services

Kenya currently has about 75 VCT sites, mostly in the urban areas. The number of VCT locations will be scaled up to approximately 350 locations in order to make VCT services more accessible, especially in the rural areas. VCT is recognized as a key prevention strategy and the need to scale up to prevent further HIV infections is critical.

Output: Increased access to VCT services for the Kenyan population.

2. Formulate, disseminate and harmonize appropriate messages for a VCT campaign advocating behavior change among specific target groupsSupport Development of NGO- and CBO-generated Activities

Proper messages for behavior change are very important to help prevent the spread of the virus. Future efforts will focus on having them motivate consumers to personal action, and harmonizing the existing messages and materials. Specific target groups will include: Youth between 15-24 years, primarily in school; Adults between 25-49, primarily in workplaces; Religious groups; Cultural groups.

Output: Number of HIV/AIDS prevention programs produced and broadcast on radio and TV, as well as brochures produced and distributed.

3. Institutionalize a cadre of dedicated counselors in GoK health facilities

Currently there is no civil service position of 'Counselor'. Therefore, other health care workers, especially nurses, are trained as counselors, diverting them from their nursing duties. It would be greatly preferable to allow nurses to be nurses and have a separate cadre of counselors dedicated to counseling at VCT sites.

Output: GoK to set standards for counselors and have a cadre of counselors as part of civil service.

4. Training of counselors

With the commissioning of more VCT sites, there will be a need to train additional counselors to serve in VCT locations. There will be three counselors per location working flexible hours to accommodate clients' schedules and maximize utilization of the VCT sites.

Output: Availability of qualified, dedicated counselors in each VCT site with a steady increase as more sites are established.

5. Increase referral and motivation/collection of information and distribution of IEC materials and commodities

Public health technicians, NGOs and CSOs are instrumental in advocating VCT services within communities. In order to carry out this task effectively, there will be a need to motivate them by equipping them with motorbikes for use in disseminating information about all three epidemics throughout the districts, as well as providing an allowance to enable them to carry out the additional tasks effectively.

Output: Better distribution and dissemination of IEC materials and information at the district and community levels**.**

Objective 1:	Reduction of HIV prevalence in Kenya through Prevention and Advocacy: Scaling up Existing VCT Services				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline (Specify year) 2002**	**Targets Year 1 2003**	**Year 2 2004**	**Responsible/ Implementing agency or agencies**
Scale up VCT services	Number of VCT sites	75	125	200	NASCOP, NGOs
Formulate, disseminate and harmonize appropriate messages for a VCT campaign advocating behavior change among specific target groups; support development of NGO- and CBO-generated activities	Number of HIV/AIDS prevention programs produced and broadcast on radio and TV, as well as production and distribution of brochures and other IEC materials; radio talk shows, school-based programs, etc.	TV – 52 Radio – 52 Newspapers Billboards Brochures: 500,000	TV – 883 Radio – 1503 Newspapers 167 Billboards 100 Brochures: 1,000,000 School-based programs: 20	TV – 1412 Radio – 2405 Newspapers 267 Billboards 160 Brochures: 2,000,000; School-based programs: 50	NACC, NASCOP, Ministry of Tourism and Information ACU, Civil Society, religious organizations; NGOs and CBOs
Institutionalize 'Counselors'	GoK to approve of cadre as part of civil service	0	Set Standards	Develop Guidelines	MOH
Training of VCT counselors	Number of VCT counselors trained to serve in new sites	225	150 additional	225 additional	NASCOP, NGOs
Increase referral and motivation/collection of information and distribution of commodities	Number of public health technicians with adequate transport/logistics support (motorbikes/fuel etc) training sponsored annually to build the capacity of partners	0	125	200	MOH, DHMTs

OBJECTIVE 2: PROVIDE TREATMENT, CONTINUUM OF CARE AND SUPPORT THROUGH EXPANSION OF EXISTING PMTCT SERVICES and ARV THERAPY

BROAD ACTIVITIES

1. Provide long-term ARVs for new mothers and 25% of spouses

In 2002, an estimated 45,000 pregnant women in Kenya will learn their HIV status and have access to a comprehensive package of PMTCT services, including provision of nevirapine, safer antenatal and delivery practices, and appropriate infant feeding counseling. Present resources will allow the continued expansion of PMTCT, but resources are not available for ARVs for these pregnant women and their husbands who do learn their HIV status. By providing access to more ARVs, more parents are likely to seek counseling and testing and lives of parents who are HIV infected can be prolonged to reduce the problems of poverty, disability, and death of young parents who leave behind young orphans. In addition, other eligible PLWHAs, including TB+ individuals and health care workers and their spouses will receive ARV therapy. Scale up of these services will commence at a measured level initially, while systemic strengthening takes place at Provincial General Hospitals and other large urban referral medical centers.

Output: Increasing numbers of medically eligible people reporting access to improved treatment and care.

2. Post exposure prophylaxis (PEP) for victims of sexual assault and occupational injuries

Post exposure prophylaxis for health care workers and victims of sexual assault offers a cost effective prevention of HIV infection. Though recommended, the Ministry of Health has only been able to provide this service in limited quantities due to resource constraints. Uptake of these services is likely to be low initially, but should increase as health workers are more willing to be tested before commencing treatment, and rape victims learn about the availability and effectiveness of PEP.

Output: Increased number of rape victims and health workers accessing treatment.

3. Training of health workers

It is anticipated that with the expansion of PMTCT services, there will be a need to train health workers on the regimens to be used, eligibility requirements and program administration, among other issues.

Output: Increasing number of health workers trained.

4. Provide ARV therapy to TB-positive PLWHAs, and health workers

Persons who have TB and AIDS, along with medically eligible health workers, will be motivated to utilize comprehensive services made available through scaling up the government's current activities. The provision of ARV drugs will be a part of the service.

Output: Increased number of people receiving treatment.

Objective 2:	**Provide treatment, continuum of care and support through expansion of existing PMTCT services, and ARV Therapy**				
Broad activities	**Process/Output indicators**	**Baseline**	**Targets**		**Responsible/Implementing agency or agencies**
		(Specify year) 2002	**Year 1 2003**	**Year 2 2004**	
Provide long term ARVs for new mothers and 10% of spouses	Number of women and spouses receiving ARV treatment in public hospitals	1,000	New mothers: 1985 Spouses @ (10%): 100	New mothers 4,013 Spouses (10%): 400	MOH
Post exposure prophylaxis for rape victims and for occupational injuries	Number of rape victims and occupational injuries receiving prophylaxis	0	Rape victims 1000 Health workers 600	Rape victims 2000 Health workers 1200	MOH
Training of health workers	Number of health workers trained in clinics	0	600	1200	MOH NACC
Provision of ARV therapy to TB+ PLWHAs and health workers	Number receiving from among the target group	0	Health workers: 1,200 TB+: 1,200	Health workers: 1,600 TB+: 1,700	MOH

OBJECTIVE 3: MANAGEMENT AND COORDINATION THROUGH INSTITUTIONAL CAPACITY BUILDING.

BROAD ACTIVITIES:

1. Design and develop training programs for Training of Trainers to advocate the national campaign on VCT.

As the country rolls out a national VCT campaign all the way to the community level, NACC's role will be to create demand for VCT services through its existing structures (Ministerial ACUs, PACC and DACCs). This calls for training of staff in these institutions to equip them with the necessary skills to sensitize their target populations on the need to access VCT services. A series of workshops is anticipated for trainers who will in turn train others in their respective units.

Output: Staff trained to sensitize target populations about the VCT services, and to motivate them to utilize VCT services.

2. Training of VCT Counselors to serve in MOH, Mission and NGO health facilities and NGO-operated VCT sites

With the anticipated National VCT Campaign rollout, there will be need for additional counselors to respond to staff concerns at ACU, PACC and DACC level. A series of workshops is therefore anticipated to update and enrich skills and knowledge of counselors.

Output: Counselors who are current in their knowledge of techniques for assisting NACC staff

3. Training of Ministry of Health personnel at the district level and local levels to create demand for PMTCT services.

It has been noted that these personnel interact with patients who come for other services at medical health facilities. They will be trained to talk to patients about PMTCT services and to encourage pregnant mothers to enroll with their spouses. The number of women receiving treatment is expected to increase every year. The proposal targets 5% of the eligible women, and 10% of their spouses.

Output: MOH personnel trained in ways to motivate eligible women and their partners to utilize PMTCT services

4. Monitoring and Evaluation of the progress of the existing programs

As the government scales up VCT, PMTCT and other ARV services, there will be need to monitor and evaluate the success, constraints and lessons learned in the programs. Two consultants will be hired to undertake this task in the nine provinces. Quarterly reports will be expected.

Output: Quarterly M&E reports designed to identify programs successes and challenges

Objective 3:	**Management and Coordination (Institutional Capacity)**				
Broad activities	**Process/Output** **Indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline** **(Specify year) 2002**	**Targets** **Year 1** **2003**	 **Year 2** **2004**	**Responsible/Implementing** **agency or agencies**
Design and develop training programs for Training of Trainers for the national VCT campaign	Number of personnel trained, disaggregated by organization, type and purpose of training	**0**	40 ACU 18 PACC 140 DACC, NGOs, CBOs and others	80 ACU 36 PACC 280 DACC, NGOs, CBOs and others	NACC, ACUs, PACCs, DACCs, NGOs, CBOs and religious organizations, amoung others
Training of counselors to serve in the ACUs, PACCs, DACCs, NGOs and CBOs	Number of counselors trained to scale up VCT in the various units	**0**	40 ACU 18 PACC 140 DACC and NGOs, CBOs	80 ACU 36 PACC 280 DACC, NGOs, CBOs	NACC, ACUs, PACCs, DACCs, NGOs, CBOs, Religious organizations
Training of Medical Officers of Health, Clinical Officers, Nurses and employees of CBOs and NGOs to create demand for PMTCT Plus services	Percentage of postpartum mothers accessing PMTCT Plus services	**5**	5	5	NACC, MOH, civil society and CSO implementing partners
Monitoring and Evaluation of the progress of VCT and PMTCT Plus services	Number of positive quarterly reports	**0**	1	2	NACC, MOH, Independent Consultants

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programs such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

This proposal intends to build on the existing multi-sectoral approach to fight HIV/AIDS adopted by the government of Kenya in 2000 as exemplified by the National HIV/AIDS Strategic Plan. The proposal then will facilitate the delivery of the strategic plan within the priority areas:

1. Scale up HIV community initiatives.
2. Scale up HIV/AIDS activities in the public sector.
3. Scale up HIV/AIDS activities in the private sector.

This strategic plan is also linked to the PRSP that identifies HIV/AIDS as a poverty and developmental issue.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries, such as people living with HIV/AIDS:

The HIV/AIDS component is designed to involve NGOs, CBOs, and religious organizations that provide VCT and health services to the infected and affected; organizations of PLWHAs will be implementing partners, and therefore individuals who are HIV+ and/or have AIDS will necessarily be involved.

29.2. Community participation:

In a national call for proposals, the Kenya CCM put advertisements in local and national dailies inviting all members of the civil society, including NGOs and CBOs, to submit proposals for consideration as implementing partners. The response to the call for proposals was so positive that more than 200 proposals were received from local, national and international NGOs, CBOs and CSOs, faith-based organizations, organized labor and the corporate sector. The process of determining which organizations will be contracted with will be transparent and open, and will be undertaken by a committee comprised of representatives from the donor community, implementing partners, technical working groups, MOH and NACC. Many of the activities of NGOs and CBOs will be implemented in grassroots communities where government capabilities are not robust but where total participation of the community in which the activities are to be implemented can make projects successful. (Please see AIDS-Specific Attachment # 13 for an extended discussion of the CCM's policy and actions at openness, inclusion and transparency during the process of developing this proposal.) Also, please see discussion at end of question 22.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):

The proposal targets youth and adult population segments of both genders, including youth in and out of school, workers at their work places, and spouses and children in work place or community-based settings. Acknowledging that reproductive health issues are of paramount importance, special attention will be paid to young women between 15-24 who are infected at a rate more than twice that of men of the same age. Men's health and behaviour are of extreme importance because of their higher rates of infection and their ability to infect their partners and younger women, coupled with

their importance in the work place. Therefore, equal importance will be given to both men and women, albeit with unique approaches to each gender.

29.4. Social equality issues (*Guidelines paragraph IV.53*):

Issues of social equality, while somewhat overlapping with Gender Equality issues discussed in 29.3, will be approached from policy and legislative frameworks. Efforts at promoting social equality issues through a review of existing laws and their implementation, coupled with harmonizing traditional and civil laws, will lead to drafting and passing legal protections for both genders, in addition to orphans and other vulnerable children, widows, widowers, PLWHAs and other affected individuals.

29.5. Human Resources development:

The proposal describes several capacity building activities among stakeholders at all levels. Of prime importance will be recruitment and training of a project-dedicated cadre of counselors, health workers and care givers, at all levels, including professional and technical staff, family members and the community at large throughout Kenya who provide home-based care, along with significant capacity-building at grass roots levels of society through CBO/NGO strengthening. Program and financial management personnel will also be recruited and trained for assignment to districts and communities targeted for the activities of this proposal. Monitoring and evaluation, as key requirements for long-term success of any program, will require personnel recruited and trained for M&E skills building.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), *(Guidelines para. IV.55),* (1–2 paragraphs):

Antiretroviral Drugs

The Kenya Guidelines on ARV Drug Therapy in Kenya (AIDS-Specific Attachment # 2) stipulates the treatment protocol. It also articulates the need for monitoring change of therapy and adherence to treatment. The preferred regimen consists of two nucleoside analogs and a protease inhibitor or a NNRTI, as recommended by the ARV therapy guidelines.

The Kenya Ministry of Health has formed a technical working group on ARV drugs that monitors the usage and adherence to the protocols. This group, comprised of representatives drawn from civil, governmental, pharmaceutical and stakeholder organizations, has developed a simple guide on ARV therapy for nationwide application. (AIDS-Specific Attachment #3)

Drugs accessed through the GFATM will be administered in the treatment protocols presented below:

Adults and Adolescents:

First Line: D4T + 3TC + EFV
D4T + 3TC + NVP in pregnant women or those likely to become pregnant

Second Line: AZT + DDI + Lopinavir + Ritonavir (Lopinavir and Ritonavir can be substituted by Nelfinavir.)

Children Under 13 Years:

First Line: D4T + 3TC + NVP

Second Line: AZT + DDI (Lopinavir and Ritonavir)

Prevention of Mother to Child Transmission:

First Line: Nevirapine, if mother is not symptomatic;
D4T + 3TC + NVP, if mother shows symptomatic disease

Patients with Tuberculosis:

- Avoid ARVs during intensive phase
- D4T + 3TC + EFV (800 mg/day)

Post-Exposure Prophylaxis:

- Low-risk exposure: AZT + 3TC
- High-risk Exposure: AZT + 3TC + Indinavir

NB: Details on dosages, administration and monitoring follow the 'Guidelines to ARV Drug Therapy in Kenya', a handbook. (See AIDS-Specific Attachment # 19)

Opportunistic Infections Drugs

An flow chart is currently available and in use for clinical management of OIs. Development of policy guidelines is in progress and the 1st draft is in place.

Recommended drugs for Opportunistic Infections are as follows:

Antifungal drugs: Ketoconazole, Griseofulvin, Clotrimazole Shampoo and Miconazole

Antibiotic drugs: Amoxycillin – Clavulinic Acid, Cefuroxime, Ciprofloxacin

Antiviral drugs: Acyclovir

Sexually Transmitted Infection Drugs

A flow chart in the syndromic management of STIs is available and in use. (General Attachment #11). Development of the STI management policy guidelines is in progress and the 1st draft has been completed. Procurement of STI drugs in a kit form is recommended, with each kit containing the following drugs:

- Ceftriaxone injectable
- Spectinomycin injectable
- Benzathine Penicillin injectable
- Norfloxacin Tabs
- Doxcycline Capsules
- Erythromycin
- 1% Tetracycline Ointment
- Water for injection
- A 2001 syndromic management flowchart is available, and guidelines for STI are in draft stage.

HIV/AIDS COMPONENT:

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed (USD)	**Activities**	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Human Resources	Recruitment and Recurrent Salaries	1,115,385	1,784,615	2,453,846	3,123,077	4,015,385	12,492,308
Infrastructure/ Equipment	Systemic upgrade of labs, distribution	814,103	1,228,846	1,275,000	1,321,154	1,751,282	6,390,385
Training/ Planning	Counselors and care givers	334,615	571,346	665,538	759,731	877,962	3,209,192
Commodities/ Products	IEC materials, Guidelines, Policies	10,300,000	9,500,000	9,500,000	10,500,000	11,500,000	51,300,000
Drugs	OI, STI and ARVs	2,885,800	4,745,000	7,655,400	11,074,600	14,882,600	41,243,400
Monitoring and Evaluation	Technical, component-specific	8,308	16,615	17,446	18,277	19,108	79,754
Administrative Costs	FMA manage-ment, TA, capacity building	1,314,671	2,102,502	2,880,275	3,511,498	4,530,107	14,339,052
Total		**16,772,881**	**19,948,926**	**24,447,508**	**30,308,341**	**37,576,449**	**129,054,091**

Please see Attachment "HIV/AIDS Detailed Budget"

__The budget categories may include the following items:__
Human Resources: *Consultants, recruitment, salaries of front-line workers, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *3% of total overhead, programme management, audit costs, etc*
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	**Unit cost** (USD	**Volume** (specify measure)	**Total cost** (USD)
STI Drug Kit	400	12,000	4,800,000
OI Drug Kit	10.41	122,189	1,271,987
ARV	2 (triple therapy per day/per patient)	1,460,000 (4,000 pts for 365 days)	2,920,000
Educational materials			252,750

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

The dollar costs of human resources are immaterial as proportion of total is less than 1%, although the complementary costs are important to effective and efficient management of the overall programmes.

The sustainability of the human resource is assured because the personnel are already government employees and will continue to remain on the payroll after the proposed period is over.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*)**:**

Table V.31.1

	1999/2000	2000/01	2001/02
External Donors			
IDA-KHADREP-ACUs		893,692	2,820,512
KHADREP-NACC		321,041	3,596,154
DFID			6,929,487
UNDP			538,462
CIA (Community Activities)			2,564,103
Total		1,214,733	16,448,718
Public Sector			
GOK/Public Sector			
Planning			
Transport		112,821	61,538
Environment		205,128	6,410
Labour			
Office of the President			19,231
Agriculture			
Lands and Settlement		1,282	7,692
Energy			385
Tourism and Information			38,462
Roads and Public Works			11,538
Home Affairs		89,744	47,436
Foreign Affairs			
Health			51,004
Education			194,872
Total		408,975	438,568
Private Sector			19,231
Total Private Sector		408,975	557,799
Grant Total		**1,623,708**	**17,006,517**

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

32. **Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u>** (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* (%)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Government	76	77	80	80	81	**79**
NGOs / Community-Based Org.	14	13	10	10	9	**11**
Private Sector	2	2	2	2	2	**2**
People living with HIV/ TB/ malaria	4	4	4	4	4	**4**
Academic / Educational Organizations	1	1	1	1	1	**1**
Faith-based Organizations	2	2	2	2	2	**2**
Others (please specify)	1	1	1	1	1	**1**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	**16,772,881**	**19,948,926**	**24,447,508**	**30,308,341**	**37,576,449**	**129,054,091**

*

Please note: The following three sections (VI, VII and VII) are all related to proposal/component implementation arrangements.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

Note: The Following Section VI Is Proposed As Generic To All Three Components, And Is Based On A More Elaborate Mechanism That Has Been Proposed To Meet All Requirements Of The GTFATM. Please See General Attachment # 7. As a result of discussions held within government, a consensus was reached concerning the arrangement as proposed in the PriceWaterHouseCoopers Final Report (Attachment #9). It was agreed that the Permanent Secretary of the Office of the President will be accountable for any funds released to NACC, while the Permanent Secretary of MOH will be accountable for funds released to MOH for TB and Malaria component activities. Furthermore, Figures 1 and 2 of the Final Report will be modified to reflect the consensus. Modified Figure 1 precedes the final report.

33. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),*(1–2 paragraphs)**:**

The Ministry of Finance (the Treasury), which is charged with the responsibility of financial management for the Kenya Government, will enter into an agreement with the Global Fund Secretariat once the Country's proposal is approved. As the Principal Recipient, it will have the overall responsibility of ensuring that funds are disbursed directly to implementers, used for the intended purpose and fully accounted for in line with the requirements of the GFATM. The two ministries responsible for the GFATM are the MOH, for TB and Malaria, and the Office of the President for HIV/AIDS activities.

Through delegated responsibility, the Permanent Secretary of the Ministry of Health is the Chairman of the JICC. The Accounting Officers for the Project will be both Permanent Secretaries of the Office of the President and Ministry of Health. They will ensure that work plans, budgets and activity reports from implementers are reviewed and approved by the respective JICC technical committees (ICCs) before they are consolidated. These committees will have representation from the different implementers. The approved reports will be consolidated in the GFATM Project Co-ordination Unit and signed by the Accounting Officers before they are submitted to the GFATM through the Treasury.

Implementers will include Ministry of Health and its departments down to the Districts, NACC Units and NGOs, CBOs, Private sector, and civil society organizations. They will be responsible for preparing work plans and budgets, and submitting them to the ICCs for review and approval before they are submitted for funding through the JICC. The implementers will also be responsible for

submitting financial and physical reports to the project co-ordination Unit for consolidation and forwarding to the GFATM.

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

The management arrangement is based on existing structures and systems, with enhancements as appropriate. The proposed rationale ensures:

- Equitable and transparent budgeting: The review of implementers' budgets will be conducted by technical committees (ICCs) with representation from various participating groups to ensure fair play and balanced allocation of funds. The GFATM Project Co-ordination Unit will consolidate the approved budgets into a GFATM budget that will be included in the Government Printed Estimates in order to ensure transparency.

- Coordinated Reporting: For effective coordination and monitoring, the project budget will be reflected under the Ministry of Health Development Vote. There will be one overall Accounting Officer for the GFATM. Reports will be consolidated in the GFATM Project Coordination Unit under the Ministry of Health before they are forwarded to the Global Fund. This will facilitate complete accounting and reporting on all project funds.

- Timely release of Funds to Recipients: Funds will be transferred from a Special Account to Implementers Accounts within 7 to 14 days of receipt of request by Treasury. These will initially be based on Budgets and cash requirement forecasts for the first quarter and subsequently on submission of SOEs supported by activity and output indicator reports.

- Strengthening of Existing Systems and Sustainability: To avoid vertical systems and ensure sustainability, the proposed GFATM management arrangement is based on the existing Government systems for donor-funded projects. The only notable new feature in the system is the involvement of Non-Governmental participants in the project. Though not common, this arrangement is already present under the IDA-KHADREP project under the NACC, where 60% of the credit is meant for community initiative activities. As in the KHADREP project the financial management of the funds extended to the Non Government participants will be outsourced.

Strong Internal Controls: The financial management systems contain internal control mechanisms. Payment vouchers are subjected to examination and approval procedures before payments are made. The GoK departments involved with payments approval have adequate segregation of duties to facilitate internal controls. The Financial Management Agent will ensure that participating NGOs have adequate internal control mechanisms.

- Annual Independent Audits: A key control in the overall financial management of the GFATM is mandatory annual independent audits. The PS Ministry of Health will ensure Project financial statements are prepared and submitted for independent audit within three months of close of each financial year. The audited accounts will be forwarded to the GF within six months of the close of the financial year.

- Monitoring and Evaluation: The SOE showing budget versus actual and variance, will be accompanied by an activity report and output indicators providing explanations for deviation from target performance. These will be reviewed by the Project Coordinator and the Treasury before SOEs are submitted for replenishment. .

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

Table VI.35

	First suggestion	Second suggestion
Name of PR	Ministry of Finance/ Government of Kenya	
Name of contact		
Address		
Telephone		
Fax		
E-mail		

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

The Ministry of Finance of Kenya is charged with the overall financial management responsibility of all funds to the Kenya Government. It has existing structures down to the Districts to ensure funds are disbursed and accounted for in a manner that addresses implementers, the Government and the GFATM requirements. Through delegation of authority to Accounting officers in the Government departments, the Ministry can ensure funds are fully accounted for.

To address the Multi-sectoral aspect of the project an FMA has been included to disburse funds to NGOS, CBOS, Private Sector and civil society organizations, and ensure these are fully accounted for. This approach has been used under the World Bank-funded KHADREP project, which is coordinated by the NACC.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

Funds will be disbursed through current, effective existing systems that ensure transparency, timely release and accountability of funds. The Ministry of Finance will receive a funds transfer request, with allocation details from the PS Ministry of Health, and transfer funds directly to the implementers' project accounts in the Districts and Headquarters, and to an NGO/CBO/ Private sector/Civil society account operated by an FMA. The FMA will be responsible for disbursement

of funds to NGO/CBO/Private Sector/Civil organizations, and for ensuring they are fully accounted for.

The Implementers will prepare SOEs, Activity and output indicator reports, certify them and forward them to the GFATM Project Coordination Unit for project level consolidation. NGO, CBO, Private Sector and Civil Society organizations financial and activity reports will be reviewed and consolidated by the FMA, who will submit the consolidated report to the Project Coordination Unit.

The GFATM Project Coordination Unit in the Ministry of Health will be responsible for the consolidation of SOEs, activity and output indicator reports. These will be certified by the PS-Ministry of Health (Chairman of JICC) and forwarded to the GFATM, through the Treasury, on a quarterly basis. The Technical Committees for each component will review semi-annual physical progress and performance indicator reports, approve and forward to the JICC.

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

Linkage with Existing Systems: The project follows existing Government systems for donor-funded projects, and data will be captured in the Government accounting systems as payments are received from the GFATM. The Project Coordination Unit will, however, prepare project specific reports including work plans and indicators that are not normally captured in the Government accounting systems. The Ministry of Health system has been developed with an open interface to facilitate future integration with financial systems currently being developed by the Ministry of Finance.

Independent Auditing Arrangements: Independent annual project audits will be conducted by both the Controller and the Auditor. The PS Ministry of Health will ensure Project financial statements are prepared and submitted for independent audit within three months of close of each financial year. The audited accounts will be forwarded to the GFATM within six months of the close of the financial year. The Audit will be comprehensive and verification of transactions will take place at:

- Ministry Project Co-ordination Units and Ministry's departments, including the District MoH Office and District Treasury, where vouchers will be held;
- NACC and its District Units, where NACC records and supporting vouchers will be held;
- FMA office for funds disbursed to the FMA for NGOs/CBOs/Private Sector and Civil Society organizations.

NGOs with allocations above US $ 20,000 will be required to submit an external audit report. Those receiving up to US$ 20,000 will be audited by the FMA or by a firm subcontracted by the FMA. The Global Fund, the FMA and the JICC technical review committee will have access to the financial management records and supporting payment vouchers of the beneficiaries for periodic reviews/audits.

Build Capacity as Appropriate to Enhance Effectiveness: The project has made provision for the following capacity building measures:

- Hire Accountants (Accounts Assistance) to support the MoH Office at the Districts and strengthen the District Treasury-ERD section

- Provide two computers in each District, one for the MoH office and the second one for the District Treasury External Resources Department.
- Train the staff implementing the computerized Financial Management Systems at the Project Coordination Unit to ensure the systems are effectively implemented.
- Contract the services of a Financial Management Agent (FMA) to manage the funds issued to NGO/CBO/Private Sector/Civil Society organizations.

Note: The Following Monitoring And Evaluation Discussion Is Considered For Short Term Limited M&E Function Of The Financial Management Functionary Of The Overall Project. However, M&E Of Each Component's Technical Implementation Will Be Assigned To Entities With Expertise In The Disease Components.

The JICC will use a monitoring and evaluation framework that will lead to quality outputs, accountability and an effective project. Central to this framework is the principle of consultation and effective participation of all players. A consultative approach is also important because there is need for all the players to understand the form and content of the program approach, proposed activities and deliverables. Monitoring and evaluation will be integrated in all components, phases and activities. The logical framework methodology will be applied. Implementers at the districts will be required to prepare work plans in a standardized format, based on the log frame for each component, to be drawn together in the overall log frame for the project. A computerized database will be developed to capture essential information on the critical path for each component, to enable the Monitoring and Evaluation Technical Committee monitor project progress accurately. Performance will be measured against targets and timeliness of achieving them. Monitoring and evaluation will be performed at two levels:

Short-term monitoring and evaluation will involve identifying specific activities undertaken by each implementer and measuring progress in performing these activities against plan. This will be done on a monthly basis. Each implementer will be required to prepare a detailed work plan for each component showing the activities to be conducted, indicators for each activity and the timeframe. A detailed budget should also be prepared. The budget should be prepared in the form of a cash flow statement to enable JICC to link the budget for a particular month with the activities being carried out during the month.

SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)***:**

Monitoring of prevalence, incidence and impact of HIV, tuberculosis and malaria utilizes several complementary health information systems in Kenya. Trends in HIV seroprevalence are measured in antenatal clinics and among sexually transmitted infection patients in annual sentinel surveillance surveys since 1990 (AIDS in Kenya, 6th Edition, MoH; HIV Surveillance 2001)). These surveys and AIDS case reports are presented by NASCOP. A Behavioral Surveillance Survey (BSS) is being conducted nationally in ten districts in youth (in- and out-of-school), police, female commercial sex workers and transportation workers after preliminary surveys in 1998 (Behavioral Surveillance Survey in Kenya, FHI/MoH 2000). The Demographic and Health Surveys of 1988, 1993 and 1998 included household questions relating to all three diseases (DHS 1998). The DHS of 2003 is expected to include modules for HIV, malaria and tuberculosis and a serosurvey for HIV that will measure HIV

infection in the general adult population and serve as a development indicator for the National AIDS Strategic Plan. The Health Management Information System (HMIS) of the Ministry of Health collects health facility data to monitor reports of malaria cases by age group and gender, sexually transmitted infections, AIDS defining illnesses, and other key indicators of health service delivery using the WHO model of Integrated Disease Surveillance. The National Blood Transfusion Service (NBTS) and the National Public Health Laboratory (NPHL) prepare annual reports on HIV, hepatitis and syphilis infection rates among blood donors. The National Leprosy and Tuberculosis Programme collects case reports and treatment outcomes of all registered TB cases nationally. Special studies of community prevalence of malaria and anemia are conducted regularly in the course of research conducted by the Kenya Medical Research Institute (KEMRI) to monitor trends. These studies are conducted in Bondo District near Lake Victoria in collaboration with the Centers for Disease Control and Prevention and Walter Reed Army Medical Research Institute, and in Kilifi District in collaboration with the Wellcome Trust. In Asembo Bay a demographic and surveillance site has been established to monitor impact of these diseases on the population. Hot spots in the HIV epidemic, including injection drug users, factory workers, and other high risk groups, are evaluated through special behavioral and/or serological studies to better understand the dynamics of the epidemic and to respond programmatically. A landmark recently published WHO/MoH Multicentre Study of three African cities, including Kisumu, provides important population-based data that serve as a baseline for a heavily affected region of the country (AIDS 2001 Supplement). The Joint AIDS Programme Review in May 2002 established a national process to review indicators and progress toward targets for HIV/AIDS. This includes review of non-health studies such as monitoring for the poverty reduction plan (PRSP reports; API; and Education ministry reports).

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.)**:**

A Monitoring and Evaluation Technical Committee is being established which will report to the NACC Technical Working that will review progress toward targets, as will the JICC. Data collection methodologies include sentinel serosurveys for HIV and TB; programme data for VCT and PMCT using central data collection systems; population surveys for the BSS, DHS, and special studies; and integrated disease surveillance and case reporting through the HMIS and NASCOP. Special evaluations and operations research will also be conducted. Management of different health information systems and various studies is the responsibility of various groups, with varying frequencies of data collection as is appropriate and as listed below.

37.3. Timeline:

During the five-year period of this application, the following timeline of activities is anticipated:

- Sentinel surveillance reports: annual; AIDS in Kenya, alternate years
- Behavior Surveillance Survey: 2002,2005
- Demographic and Health Survey: 2003, 2008
- National Leprosy and TB Program reports: annual
- Health Management Information System, continuous, annual reports
- National Blood Transfusion Service: continuous, annual reports
- Demographic Surveillance Site; continuous census, annual reports
- Joint AIDS Program Review: annual review
- National Poverty Reduction Strategy: periodically

37.4. Roles and responsibilities for collecting and analyzing data and information:

The Ministry of Health has responsibility for collecting and analyzing data and disseminating information related to health issues through its various departments. This includes disease reporting

from facilities with the HMIS Department, NASCOP for HIV sentinel surveillance, BSS, AIDS case reports, STI data and special studies, NLTP for TB data, and KEMRI for evaluation of pilot programs and demographic surveillance. WHO collaborates to strengthen HMIS and IDS; CDC collaborates with NASCOP, KEMRI and NLTP in research and program evaluation. The Central Bureau of Statistics (CBS) conducts the DHS in collaboration with Macro International and other partners including CDC, KEMRI, UNFPA and MoH departments. The BSS is coordinated by NASCOP with support and collaboration from CBS, CDC, and FHI. Program evaluation is conducted for many health programs with support and assistance from USAID. WHO, UNAIDS, UNICEF, UNDP and other development partners commission special studies in partnership with MoH and other Ministries. The University of Nairobi, KEMRI and other groups conduct special studies and program evaluations. NACC coordinates, provides technical support and reviews AIDS data from ACUs in line ministries.

37.5. Plan for involving target population in the process:

NACC is a coordinating agency. However, NACC and stakeholders in the implementation of Global Trust Fund will engage in an extensive participatory process, to build ownership for monitoring and evaluation.

There will be a need for each partner to agree on key targets, using simple, structured tools that will be developed as target forms, such that each partner will agree to submit simple, structural reports. NACC will prepare an overall annual monitoring and evaluation plan, and will conduct supervision to ensure quality and timeliness of the monitoring and evaluation products over their indicators.

A comprehensive participatory approach will be conducted which will include key stakeholder interviews through field visits to interview field staff and beneficiaries, and review the monitoring and evaluation system, and the tools that will be developed.

Provincial and district stakeholders consultation meetings will be held to develop the decentralized (provincial and district) monitoring and evaluation strategy that will eventually end up with the development of monitoring and evaluation strategy, systems, procedures and tools.

The major stakeholders to be involved will include MOH and other key ministries, and will also include WHO, UNAIDS and CDC, major NGOs, major research and academic institutions and major PLWHA groups.

The budget for involving the target population is estimated below:

Activity	**KSHS.**
Literature Review	
- Lunch of 3 pax @ KShs. 1,000 x 7 days	21,000
- Transport for 3 pax @ KShs. 500 x 7 days	10,500
Formation of ME Interim Groups	
Monthly meetings	
4 meetings per month x KSHs. 20,000 per meeting	80,000
Provincial consultations workshop	
9 workshops x KShs. 500,000 per workshop	4,500,000

District workshops	
70 workshops x KShs. 400,000 per workshop	28,000,000
National stakeholder meeting to draft M&E Plan	1,400,000
TOTAL	**43,971,500**
USD Equivalent:	**$ 563,767**

NOTE: The above budget has been incorporated into the budget summary of the HIV/AIDS component, within the $24.8 million referred to in Footnote #1.

37.6. Strategy for quality control and validation of data:

Quality control and validation of laboratory data to establish seroprevalence in different populations is conducted in several ways. Sentinel surveillance samples are validated centrally through the NPHL while specimen and data collection is supervised by NASCOP. VCT and PMCT sites use whole-blood rapid testing strategies, but collect a sample of filter paper specimens for central validation at KEMRI or the NPHL, supported by CDC. AMREF has a contract to complete proficiency testing of laboratories and quality control for blood safety. Ethical and scientific review of special studies is conducted through the University of Nairobi, KEMRI and the MoH. The Monitoring and Evaluation Technical Committee of NACC reviews data from many sources.

37.7. Proposed use of M&E data:

These rich sources of data and information are published and disseminated in various reports, some of which are given wide dissemination. For example, 15,000 copies of AIDS in Kenya 6th edition were printed and most have been distributed to health facilities, political leaders, and civil society, serving to educate and advocate for more effective prevention and care programs in addition to reporting surveillance data. Involving health leaders and community members at the community and district level has not, however, been fully exploited. The structure of CACCs and DACCs will allow a broader participation of society groups in an intersectoral response. The NACC log frame for monitoring and evaluation of progress is a useful tool to summarize the indicators to be measured to achieve the National AIDS Strategic Plan objectives.

M&E data collected will be used to monitor the rate of progress towards the targets developed by using a simple rating scale developed, which will be as follows:

Targets largely attained
Targets partially attained
Targets largely completed/attained

These data will be collated, analyzed and summarized and reports written every six months and circulated to all stakeholders.

The indicators developed will be specific to the project/programme and will include:

Inputs
Outputs that will include increase of NACC capacity, public sector and civil society service, services delivered in communications, prevention, care and support services. The indicator will also involve outcomes such as safer sexual practices, mitigation, capacity and impacts.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in strengthening M&E capacities)	**Resources Required** (USD, 000's)					
		Year 1 2003	**Year 2 2004**	**Year 3 2005**	**Year 4 2006**	**Year 5 2007**	**Total**
Sentinel Surveillance	CDC,UNAIDS, WHO,	200	200	200	200	200	**1,000**
BSS	CDC, FHI		300		300		**600**
DHS	MASRO, USAID, UNDP, CDC	1,500	200[1]				**1,700**
Prevention Activities	CDC, DFID, USAID, UNICEF	200	200	200	200	200	**1,000**
Care Activities	CDC, DFID, UNAIDS, CIDA	200	200	200	200	200	**1,000**
Special Studies[2]	CDC, DFID	100	100	100	100	100	**500**
AIDS in Kenya Dissemination[3]	MOH, NACC	100	50	100	50	100	**450**
Total requested from Global Fund		**633**	**817**	**333**	**617**	**333**	**2,733**
Total other resources available		**1,667**	**433**	**467**	**433**	**467**	**3,467**

[1] Publication of larger volume of reports; provision of provincial level data for planning, advocacy and dissemination at district level.
[2] Injection drug use; epidemic hot spots; blood safety
[3] Dissemination of an additional 30,000 reports through posters, National AIDS day, training institutes, and local CACCs.

SECTION VIII – Procurement and supply-chain management information

39. **Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets** (Refer to *Guidelines paragraph VIII.86*)**.**

Note: It Is The Intention Of The JICC (CCM) That The Procurement Function Will Operate Generically Across All Components Along The Lines Described Below. Kenya Has A Long History Of Utilizing World Recognized Procurement Agents, With Long-Standing Relationships With GTZ And Crown Agents. The Nation's Absorptive Capacity Is Enhanced Through The Use Of Such Organizations, On A Totally Competitive Basis. The Procedure Of Engagement Is Reflected In General Attachment # 8.

The GFATM project will comply with the Government procurement regulations provided in the Exchequer and Audit (Public Procurement) Regulations of 2001 that have been established under the Exchequer and Audit Act by the Government of Kenya under Legal Notice No. 51 of 30th March 2001 (General Attachment # 9). Major project items will be procured centrally at the project level to ensure quality standards are met. The Inter-Agency Coordinating Committee (ICC) for each of the three components will review approved work plans from implementers and develop annual procurement plans. These will be approved by a JICC procurement Committee that will have representation from respective departments, and the NGO/CBO/Private Sector and Civil Society organizations.

Procurement of items will be contracted out to reputable Procurement Agents who will be responsible for management of bids and contracts, and delivery per specific procurement arrangements. The use of Procurement Agents is necessitated by inadequate in-house capacity at the Ministry to effectively manage big contracts. It does not replace the procurement management responsibility of the JICC, and in particular, that of the lead Ministry. The Ministry through the respective ICC and the Ministry's Procurement Officer dedicated to the Project will develop the detailed technical specifications of goods and services, and ensure the GFATM tender committee approves these.

The GFATM tender committee will consist of the Ministerial Tender committee with representatives from the participating implementers. The contracting and management of the performance of the Procurement Agent will be the responsibility of the JICC Procurement Committee that will have representation from each group of implementers.

(i) Procedures (Methods and Thresholds)

Procurement will be on competitive basis except for small or specialized items that would best be conducted through single sourcing. The regulations for selecting a suitable procurement method are provided in part IV of the Exchequer and Audit (Public Procurement) Regulations of 2001. The thresholds for procurement methods are provided in the Second Schedule of the Government Procurement Regulations.

Currently they are as follows (at US$1: K Shs 78):

- Restricted Tendering: US$ 128,200
- Direct Procurement: US$ 2,560
- Request for Proposals: US$ 25,600
- Open Tenders: US $ 25,600

Advertisements period thresholds are as follows:

- National Competitive tenders : 28 days
- International Competitive tenders: 42 days

Open competitive bidding will be observed on all procurements based on the annual procurement plans. It will apply to procurements in excess of US$25,600. A fee will be charged for each bid to meet the costs of document preparation and mailing.

Open international bidding will be utilized when procuring under open national tendering cannot offer an effective competition. During project negotiations, items will be grouped as appropriate and the most suitable mechanisms included in the project agreement. This approach has been observed with the DARE and KHADREP projects implemented by the Ministry of Health and NACC, respectively.

(ii) Quality Assurance

In addition to quantity verification, items will be subjected to technical and quality inspection on receipt. Technical Experts will be involved in the inspection of complex and specialized items to provide quality assurance. Where deemed necessary, and in the absence of local expertise, international experts will be contracted to test and provide necessary quality assurance certification.

Contracting of Procurement Agents and Technical Experts to ensure quality standards are achieved in procurement and inspection of goods is an existing practice. The Ministry of Health deals with highly technical medical supplies and equipment and uses experts in specialized areas as necessary. The values of procurement activities that will be carried out at the Districts under the project are relatively small. They will mainly include office furniture, minor civil works, small service contracts or small procurement of goods and supplies. Minor procurements at the Headquarters and Districts will be carried out by the implementers in a transparent manner that meets Government requirements.

(iii) Procurement Monitoring

A procurement monitoring report showing target versus actual performance will be prepared on a quarterly basis by the selected Procurement Agents in liaison with the Ministry Procurement Officer dedicated to the project. This will be presented to the JICC for review and rescheduling as necessary.

The procurement performance report will show date of accomplishment of major tasks. Depending on the procurement method observed, this may include:

- invitations to tender
- tender evaluations
- contract negotiations and awards
- delivery of goods or services
- payment date
- closure of contract.

In addition to the performance date, the report will reflect the total time taken to complete each identified procurement task. Different formats will be used for services and goods. This monitoring approach is used for the KHADREP and DARE projects and will be tailored to suit GFATM project specific requirements.

Supplier performance monitoring will include:

- delivery versus contract terms
- frequency of supplier defaults
- value of products rejected.

(iv) Procurement Procedures

In order to ensure open competitive tenders, expedited products availability and consistency with National and International Intellectual Property Laws and obligations, we will strictly adhere to PART V of the Public Procurement Regulations which stipulates clearly all the systems under the open national, tendering procurement methods. These include restricted tendering, direct procurement and request for proposals (quotations) procedures.

(v) Existing Arrangements

There is a Procurement team that includes a Procurement Manager, assisted by qualified procurement officers, together with the Procurement Specialist within the Financial Management Agency.

(vi) Quality Assurance

We have existing firms that have been contracted by the Government for purposes of evaluating both the technical and commercial proposals provided by the tendering firms. The contracted firms include M/S Crown Agents and M/S. GTZ. The panel of experts sits to evaluate the technical part based on certain standard protocols clearly laid out for prospective suppliers. Procurement regulations that focus on quality assurance are provided by the Kenya Bureau of Standards, which provides guidance on quality of goods considered for procurement by the Government.

(vii) Distribution System

Distribution of equipment and supplies (IEC materials) is normally *contracted out* to public courier services. Distribution of drugs and other related items is undertaken by (KEMSA), the department within the Ministry of Health that ensures proper storage and distribution to all provincial and district hospitals, including health centers, nationally.

Table VIII.39

Component of procurement and supply chain management system	**Existing arrangements and capacity (physical and human resources)**
How are suppliers of products selected and pre-qualified?	***Pre-qualification of Supplies: Public Procurement Regulation Part III – General Procurement Rules*** Suppliers of products are selected and pre-qualified by a Procurement Committee that follows the open and competitive bidding and tendering process per the Public Procurement Regulations. Competitive bidding is used to obtain best value for money except on isolated cases where sole sourcing might be the most reasonable approach. In such instances the regulations for sole sourcing are complied with.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	The procedures used include: 1. Open tendering 2. Restricted tendering 3. Direct procurement 4. Request for proposals Each of these procedures is described in detail in the Public Procurement Regulations.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	Quality assurance is achieved through: 1. Pre-qualification and monitoring of selected suppliers in terms of product quality, service reliability and delivery time 2. Clear design of technical specifications that address international standards 3. Use of officially published drug list of safe, effective and cost effective drugs. Formal approval procedures shall be observed in procurement of non listed drugs 4. Product technical and quality evaluations on receipt of items, with assistance of experts in specialized cases where deemed necessary.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	The distribution system that is used: 1. For equipment and supplies (IEC materials) - Contracted out 2. For drugs and other related items – undertaken by KEMSA This distribution system has been used effectively on other projects e.g. KHADREP

40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

The World Bank guidelines on selection and employment fully describe the hiring of personnel, contract and training programmes and these are strictly adhered to. From time to time a ***no objection certificate*** from the World Bank is requested before undertaking any implementation within specified thresholds. The public procurement regulations also set out proper guidelines for hiring of consultancy services, which are adhered to.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

The current Government procurement and logistics capability requires significant strengthening in order to be able to respond to the considerable scaling up that will be required in terms of commodity supply. Other stakeholders and health service providers in the private and non-government sectors also need to be provided access to quality commodities at an affordable price through for example long term call down contract arrangements. Accurate and timely information is essential if the commodity supply chain is to be effectively managed and wastage kept to an absolute minimum. Therefore, there will need to be strengthening at the District level in the areas of human resources and electronic systems capacity (infrastructure).

To date neither donors nor the Government have been providing ARVs. There is therefore no pre-existing vertical programme nor a Government procurement or logistics capability to deliver ARVS in a sustainable or secure manner. The WB, DFID and SIDA have previously funded the supply of STI drug kits. These have been procured by a procurement agent and distributed to District level by an international logistics company funded by the donors. This intervention has now ended although the WB does have provision for a further supply of STI kits. This provision does not include a logistical component. There is no other planned procurement by either the MOH or donors to fill the gap.
The Essential Drug Kits contain drugs that can be used to treat opportunistic infections, STIs and also Malaria. These kits, since 1996, have been procured by an agent appointed by the Ministry of Health. They are delivered to the Regional Depots operated by the Kenya Medical Supplies Authority (KEMSA). The KEMSA distribution arrangements to District and sub-district level are sub-optimal. In general, lack of transportation and communication between the levels of the system make distribution, supervision and monitoring of stock levels and consumption difficult causing chronic stockouts. The Ministry of Health information system is also dysfunctional, characterised by a lack of order forms, stock cards, poor supervision and an absence of regular reporting.

NOTE: Please see **General Attachment # 8** **for a description of how the Procurement System will operate should Kenya receive an award from GTFATM.**

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

Products requested from the GTFATM for this component are directly related to the activities described in this proposal, and are therefore required to fill the gaps that the proposed scaled up activities will generate. No similar products have been requested from other providers specifically for these activities.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X):		
		HIV/AIDS
	X	**Tuberculosis**
		Malaria
		HIV/TB

23.1 Provide a brief summary of the component

In Kenya, tuberculosis notification is still on the rise, at the overwhelming average annual increase of 16% over the last decade. The number of patients notified in 2001 was 73,017 corresponding with a notification rate of 248/100,000 population. Although the number of notifications is high, the actual number of TB cases is estimated to be much higher. WHO estimates that only 47% of the TB cases were detected in the year 2000 indicating that the remaining 53% undetected cases continue to transmit TB within the Kenyan community. The current TB epidemic is linked to a rapid growing HIV epidemic. The HIV sera-prevalence among TB patients is estimated to be around 50%. TB is the most common opportunistic infection and the most common cause of death in HIV infected individuals and AIDS patients. Many successfully treated TB patients still die due to HIV related illnesses and a proportion get re-infected with tuberculosis. The DOTS strategy is effective in controlling TB in the absence of HIV. However, in countries with a high TB and HIV disease burden, where strategy is focused on passive case finding, the reservoir of TB infection and disease in the population may not be sufficiently reduced, as is demonstrated by the high annual increase of newly registered TB cases in Kenya. In this situation an dynamic approach towards control

of HIV may have an impact on control the TB epidemic. Although the National Leprosy and TB Control Program survived the initial onslaught of HIV/AIDS, it has severely weakened, especially in the capital city of Nairobi. The current staff establishment and supporting budget is merely enough to run basic services. Several national and international developments have initiated additional new strategies and activities guiding national response to TB and HIV. Current NLTP capacity and resources are therefore under enormous pressure. The NLTP program performance is still adequate in rural and semi-urban area's. Unfortunately this is not true anymore in large urban settings such as Nairobi, Mombassa and Kisumu. The patient load here is rising rapidly and it becomes harder to monitor patients. The treatment success rate of Nairobi has fallen in two years time from 78% to 73%. Nairobi reports an unrealistic low death rate of 3%. However, defaulter and transfer-out rates are high, 13% and 8% respectively, hiding many non-recorded deaths. The general health system and services (council and government) in Nairobi are appalling. Political will and commitment to change this has emerged but will need correct guidance and support. In the meantime a strong growing private health sector is diagnosing and treating more and more TB patients uncontrolled with danger of the emergence of MDR TB. Kenya participates in the "Stop TB" DOTS expansion working group and has an obligation to accelerate DOTS expansion in its own country. This will need additional financial and human resources to support the implementation of new strategies and accelerate existing activities.
Goal The overall goal of this proposal, which is seeking to realize additional plans to the existing five years Development Plan, is to increase the coverage and improve the quality of DOTS services that will benefit TB patients, people living with HIV/AIDS, minority groups such as orphans women, prisoners and the community at large. **Main Objectives** The main objective is to expand the availability of high quality TB services through partnership with community, private sector, and public sector organizations that should achieve a case detection rate of 70% and will maintain a high treatment success rate of 80% by the year 2005. **Beneficiaries** The principal beneficiaries are all TB patients including those who are currently not diagnosed and their families. Organizations that play an essential role in the management of health services in communities are among the beneficiaries and these include community-based organizations and local networks of care and support and private-sector health service providers. Also to benefit from the support of this fund are population groups that are hard-hit by HIV/AIDS, poverty and minorities such as women, orphans, prisoners etc. Difficult to reach groups will also benefit. The nation as a whole will benefit indirectly from the resulting longer life expectancy, more productivity, and the possible resources saved. **Implementing Partners** The Ministry of Health through the NLTP will be the leading implementing agency within a partnership covering the public sector, non-governmental organizations, community-based organizations, and the private sector. The TB-ICC will provide coordinated technical direction during implementation at National level. The District Health Consultative groups will provide co-ordination and guidance at the peripheral level. Organizations that will benefit include, NLTP, KAPTLD, MSF, AMREF, KEMRI, Health Centres and Dispensaries, TB Manyattas, hard to reach communities, Community based organizations, Community based health providers, prisons, Private physicians, Nurses and Clinical Officers

26.1. Goal and expected impact

The overall goal of this proposal is to increase the coverage and improve the quality of DOTS services, which will benefit not only TB patients but also people living with HIV/AIDS, minority groups such as orphans, women, prisoners and the community at large. The current five-year development plan does not provide sufficient answers to the ongoing crisis of tuberculosis and TB-HIV. It is widely recognized that additional efforts are needed to lift the program to the same level as the pre-HIV era or beyond. The overall goal of the NLTP strategic plan to reduce morbidity and mortality of tuberculosis in Kenya will otherwise not be reached by 2005.

Goal: **Increase the coverage and improve (maintain) the quality of DOTS services in Kenya**		
Impact indicators	Baseline	Target **(last year of proposal)**
	Year: 2001	Year: 2007
Case Detection Rate (based on prevalence estimates of WHO)	47%	**70%**
Cure Rate	64% (declining)	**70%**
Treatment Success Rate	79% (declining)	**80%**
MDR TB in previously treated TB	<3% (increasing?)	**<3%**
MDR TB in previously untreated TB	<1% (increasing?)	**<1%**

27. Objectives and expected outcomes

The main objective is to expand DOTS activities and restore quality TB control in all areas. To reach this the NLTP will in the first place continue to implement its current 5 years Development Plan. Additionally, we plan to address the following five major areas that have been identified by all partners as priorities.

These are:

1. Expand and decentralize diagnostic and treatment services
2. Develop and implement an Urban TB Control strategy
3. Develop and implement joint TB and HIV/Aids program activities
4. Develop and implement TB communication strategy
5. Strengthen monitoring and evaluation of specific objectives and indicators

Expected outcomes at end of plan

The outcome of the combination of the original NLTP development plan and the proposed plan that is submitted here adheres to the global targets of TB control.

1. Achieve and sustain 70% case detection rate of TB cases
2. Achieve and sustain 80% cure rate of tuberculosis

3. Contain MDR TB at less than 3% in treated and untreated TB cases.

27.1. Broad activities related to each specific objective and expected output:

Specific objectives and strategies

1. Expand and decentralise diagnostic and treatment services

Strategic decentralization of diagnostic and treatment services will form an important basis of this plan. Diagnostic services will be spread out to more service points based on criteria such as expected suspect TB cases, accessibility and total population, involving community, public-, mission- and private sector.
(1 diagnostic centre/100,000 pop. - 1 centre/ 25 km radius - a minimum of 3 suspect TB cases/week). Treatment services will be available at all Hospitals, Health centres and half of all dispensaries. In remote areas or areas where HC are difficult to reach Community Based organization will be approached and trained to supervise TB treatment. The District Health Consultative Groups (explain) will be the coordinating platform at this level. Community based health service providers will be involved in the early detection of TB suspects by teaching them early signs and symptoms and providing a well functioning referral system for diagnosis and treatment. The successful Manyatta system to treat TB patients from nomadic tribes will also be expanded.

In order to provide care to some remote and hard to reach communities, NLTP plans to partner with AMREF (see annex). The AMREF proposal plans to scale up diagnosis, management and control of TB and HIV in remote, hard to reach areas of Kenya. AMREF plans to work within the established Ministry of Health and Mission infrastructures in Kajiado, Turkana, Marsabit, Moyale districts, and in one AMREF supported health center in a slum area of Nairobi. The overall approach will be to improve basic health care services by introducing and maintaining best medical practices.
In 2002 and thereafter, anti-TB drugs to treat 80,000 patients are provided by GoK and GDF. This proposal will request support for the procurement of anti-TB drugs to treat a total of 88,000 additional TB cases, which will come forward as a result of the new activities, based on an estimated 16% annual increase.

Objective:1	**Expand and decentralize diagnostic and treatment services**				
Outcome/coverage indicators	Baseline	Targets			
	2001	Year 2:	Year 3:	Year 4:	Year 5:
Number (and type) of diagnostic centers	319	**340**	**360**	**380**	**400**
Number (and type) of treatment centers	1022	**1250**	**1500**	**1750**	**2000**
Health facilities in Nomadic areas (Manyattas)	20	**20**	**25**	**35**	**40**
Districts with active/reporting community DOTS participation	2	**10**	**20**	**40**	**60**
Percent of Health facilities with drugs	100%	**100%**	**100%**	**100%**	**100%**

Table IV.27.1

Objective:1	**Expand and decentralize diagnostic and treatment services**				
Broad activities	Process/Output Indicators	Baseline	Targets		Responsible agency
			Year 1	Year 2	
1.1 Train DTLCs	**Number of DTLC trained**	0	**30**	**60**	**NLTP/CU**
1.2 Train provincial laboratory technologist as trainers/supervisors	**Number of Provincial Technologists performing district training**	0	**20**	**20**	**KEMRI/NRL**
1.3.1 Regional training of trainers.	**Number of regional trainers performing district training**	0	**40**	**0**	
1.3 .2 Train District community health trainers	**Number of actively involved providers**	?	**280**	**0**	**DTLC**
1.4 Train CBOs in TB care	**Number of actively involved CBOs**	?	**560**	**560**	**DTLC/PTLC**
1.5.1 Provide transport Hard to reach areas (4x4 WD cars + running cost) CBO (bicycles)	**Number provided**		6 560	**0** **560**	**NLTP AMREF DTLCs**
1.6 Provide laboratory microscopes/ materials	**Number of new diagnostic centers functioning**	0	**21**	**20**	**NLTP PTLC**
1.7 Supervision of Difficult To Reach Communities (DTRC)	**Number of supervisions done by the DTLC in a year**	0	**4**	**4**	**NLTP AMREF**
1.8 Build new identified Manyatta units	**Number of new units reporting**	0	**4**	**6**	**NLTP/CU/NGO**
1.9 Scale up control of TB and HIV in remote, hard to reach areas of Kenya	**Number of Health facilities reporting**	unknown	**11**	**21**	**AMREF/NLTP**
1.10 Procurement of anti-TB drugs to treat 16% additional cases	**% of treatment centers with drugs**	100	**100**	**100**	**NLTP/ JSI/ KEMSA**

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 Estimate	Year 4 Estimate	Year 5 Estimate	Total
Human resources	65,016	68,267	71,682	75,264	79,028	359,257
Monitoring/Evaluation			15,821		16,419	32,239
commodities	22,342	43,760	55,753	61,328	67,460	250,643
Administrative	78,382	71,712	36,745	36,432	41,691	264,961
Infrastructure/ Equipment	793,369	441,813	89,196	123,716	86,974	1,535,068
Training/ Planning	316,077	231,990	258,279	173,439	188,477	1,168,262
Drugs	251,000	292,000	344,000	406,000	482,000	1,775,000
Total	**1,526,186**	**1,149,542**	**871,476**	**876,179**	**962,049**	**5,385,430**

Key:
- Infrastructure/ Equipment consists of activity no. *1.5.1,1.5.2,1.6,1.8*
- Training/ Planning consists of activity no.*1.1,1.2,1.3.1,1.3.2,1.4*
- Drugs are in activity no.*1.10*

2. Develop and implement an Urban TB Control strategy

The development and the implementation of an urban TB control strategy for urban areas, to start with Nairobi, will have its foundation in a strong partnership of relevant partners in the city. The Plan of Action for Nairobi will be developed in close collaboration and after extensive consultation of Municipal authorities, Private Hospital Association, Private sector representatives (physicians and pharmacists), authorities of prison and other uniformed forces and NGO's. Expansion and decentralization of services will provide 30 diagnostic centres and 100 treatment centres by the year 2006 (against 9 diagnostic and 50 treatment centres now). These centres will include public hospitals, health centres and dispensaries, private hospitals, community based DOT provision and private practitioners. Successful implementation, monitoring and evaluation of this ambitious plan can only be done with the assistance of additional human resources. The current team of one PTLC and four (4) DTLCs will increase to a total of four PTLCs and sixteen DTLCS. Each PTLC will be in charge of a section of Nairobi and support four DTLCs, who will be based at key diagnostic centres. A strong advocacy campaign supported by appropriate IEC materials will assist to improve case finding and reduce defaulter rates. The lessons learned from a successful Nairobi project will be used in other major cities.

Table IV.27

Objective:2	**Develop and implement an Urban TB Control strategy**				
Outcome/coverage indicators	Baseline	Targets			
For Nairobi	Year:	Year 2:	Year 3:	Year 4:	Year 5:
Reporting private hospitals	3	**4**	**7**	**9**	**10**
Reporting private practitioners	0	**10**	**20**	**30**	**30**
Number of diagnostic centres	9	**15**	**20**	**25**	**30**
Number of treatment centres	50	**60**	**75**	**90**	**100**
Nairobi notification rate	600	**700**	**800**	**900**	**1000**
Nairobi cure rate/success rate	60/73%	**62/75%**	**65/78%**	**78/80%**	**70/80%**
Nairobi death rate*	3%	**5%**	**5-10%**	**5-10%**	**10%**
Nairobi defaulter rate	13%	**10%**	**8%**	**5%**	**<5%**

* *Related to insufficient feedback on treatment outcome of patients. A realistic death rate is an indicator of an efficient and true reporting and recording system.*

Table IV.27.1

Objective: 2	Develop and implement an urban TB control strategy				
Broad activities	Process/Output Indicators **(indicate one per activity)**	Baseline (Specify year)	Targets Year 1	Year 2	Responsible/Implementing Agency or agencies
2.1 Planning workshop	**Nairobi Plan of Operations available City TB committee**	0	**1**	**0**	**NLTP/ FHI /MALTESSER PMO Nairobi**
2.2 Support City TB Committee meetings	**Number of meetings**	0	**4**	**4**	**NLTP/ PMO Nairobi**
2.3 Deploy 3 additional PTLC	**PTLC functioning**	0	**3**	**0**	**NLTP / MoH MoH City commission**
2.4 Deploy 12 additional DTLC	**DTLC functioning**	0	**12**	**0**	**NLTP / MoH MoH City commission**
2.5.1 Train 12 DTLCs	**DTLCs trained**	0	**12**	**0**	**NLTP**
2.5.2 Train 3 PTLC at the international IUATLD course	**PTLC trained**	0	**3**	**0**	**MoH/ NLTP IUATLD**
2.5.3 Train 4 PTLCs MPH course	**PTLCs trained**	0	**2**	**2**	**MoH/NLTP**
2.6 Provide transport PTLC (small car)	**Vehicles available**	0	**3**	**0**	**NLTP /JSI**
2.7 Provide transport DTLC (public transport cost)	**DTLC with Regular transport refunds**	0	**12**	**12**	**NLTP /JSI**
2.8 Supervision (fuel/allowances)	**Number of centers supervised**	56	**79**	**102**	**NLTP**
2.9 Develop guidelines/ training curriculum on TB control in private sector	**Guidelines used in training of private sector staff**	0	**2000**	**2000**	**NLTP KAPTLD**
2.10 Train (private) practitioners	**Number of practitioners trained**	0	**120**	**120**	**NLTP KAPTLD**
2.11 Train pharmacists	**Number of pharmacists trained**	0	**120**	**120**	**NLTP KAPTLD**
2.12 Support CBOs providing TB services	**Number of actively collaborating CBOs supported by NLTP**	0	**8**	**16**	**NLTP KAPTLD**

Objective 2:

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 Estimate	Year 4 Estimate	Year 5 Estimate	Total
Infrastructure/ Equipment	146,460	30,560	30,560	30,560	30,560	268,700
Training/ Planning	106,314	76,134	36,801	16,134	16,134	251,517
Commodities/ Products	16,680	18,192	19,976	22,080	24,565	101,493
Monitoring and Evaluation	24,240	24,240	24,240	24,240	24,240	121,200
Total US $	**293,694**	**149,126**	**111,577**	**93,014**	**95,499**	**742,910**

Key:

- Infrastructure/ Equipment consists of activity no. *2.3,2.4,2.6,2.7,2.12.4,*
- Training/ Planning consists of activity no.*2.1, 2.5.1, 2.5.2,2.5.3, 2.2, 2.10, 2.11, 2.12.1*
- Commodities/products consists of activity no.*2.9.1,2.9.2,2.12.2,*
- Monitoring and evaluation consists of activity no.*2.8.1,2.8.2,*

3. Develop and implement joint TB and HIV/AIDS program activities

To respond to the dual epidemic of TB and HIV, a shared strategy that addresses TB and HIV is vital. NLTP, NASCOP and other partners will explore and stimulate potential synergies between NLTP and NASCOP objectives and activities.

A collaboration of NLTP, KEMRI and NASCOP will carry out baseline surveys in one district in each province to map out available services and networks and to plan joint activities. Simultaneously, the communication between TB and HIV/AIDS units at national and peripheral level should be formalised. At each of the districts, newly established TB/HIV working groups are mandated with the co-ordination and monitoring of the joint activities. TB case finding will be intensified by actively screening HIV infected persons for TB at VCT and MTCT centres. VCT services are rapidly expanding in Kenya. Through the development of a transparent referral system, suspected HIV positive patients and suspected TB patients should be able to access the best possible diagnostic services and care package available in the district. This should include quality counselling and testing to anyone who desires HIV test and subsequent access to care and prevention activities.

The plan aims at improving the referral system by strengthening referral from home to hospital, revision and dissemination of procedures concerning TB notification and compliance to community, public and private sectors. It will also encourage referral of patients from VCT centres to health-care providers and care networks in the community. The program also aims to provide IPT to as many as possible eligible HIV positive patients. Successful models of HIV-TB joint collaboration will be scaled up stepwise to the other districts.

Objective:3	**Develop and implement joint TB and HIV/AIDS program activities**				
Outcome/coverage indicators	Base-line	Targets			
	2001	Year 1	Year 2	Year 3	Year 4
Number of active districts with TB-HIV working groups	0	**10**	**40**	**70**	**72**
Number of TB patients referred for DCT	0	**7200**	**28800**	**50400**	**59472**
Number of VCT clients referred for TB screening	0	**7200**	**28800**	**50400**	**59472**
Number of VCT clients on IPT	0	**1,000**	**4,000**	**7,000**	**10,000**

Table IV.27.1

Objective:3	**Develop and implement combined TB-HIV control activities**				
Broad activities	Process/Output Indicators	Baseline	Targets		Responsible/Implementing Agency or agencies
		2002	Year 1	Year 2	
3.1 Perform baseline surveys in districts	**Number of district surveyed**	0	**10**	**30**	**NLTP / NASCOP / KEMRI**
3.2 1Establish TB/HIV working groups in districts	**Number of active working groups**	0	**10**	**30**	**NLTP / NASCOP / KEMRI**
3.2.2 Support TB working group meetings	**Number of meetings**	0	**40**	**120**	**NLTP / NASCOP / KEMRI**
3.3 Establish district TB/HIV coordinating committees	**Number of active committees**	0	**10**	**30**	**NLTP / NASCOP / KEMRI**
3.4 TB Screening of All HIV positive clients	**Number of HIV clients screened for TB**	0	**7200**	**28800**	**NLTP / NASCOP / KEMRI**
3.5 DCT for TB patients	**Number of TB patients screened for HIV**	0	**7200**	**28800**	**NLTP / NASCOP / KEMRI**
3.6 Develop training curriculum addressing TB-HIV	**Training guide developed, distributed and used.**	0	**2000**		**NLTP / NASCOP / KEMRI/ CDC**
3.7 Train selected health staff in TB-HIV	**Number of staff trained**	0	**100**	**300**	**NLTP / NASCOP / KEMRI/CDC**
3.8 Establish monitoring system	**Records – reports (see indicators)**	0			**NLTP/NASCOP**
3.9 Isoniazid preventive therapy	**Number of Patients on IPT**	0	**4000**	**6000**	**NLTP / NASCOP / KEMRI**

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 Estimate	Year 4 Estimate	Year 5 Estimate	Total
Human Resources	10,000	30,000	30,000	0	0	70,000
Infrastructure/ Equipment	0	0	0	0	0	0
Training/ Planning	111,000	342,000	497,000	314,000	341,000	1,605,000
Commodities/ Products	15,000	45,000	45,000	0	0	105,000
Drugs (INH)	0	0	0	0	0	0
Monitoring and Evaluation	0	0	0	0	0	0
Total	**136,000**	**417,000**	**572,000**	**314,000**	**341,000**	**1,780,000**

Key:

- Human resources consists of activities no.*3.1.1*
- Infrastructure/ Equipment consists of activity no. *3.4*
- Training/ Planning consists of activity no.*3.2.1,3.3,3.6,3.5,3.8*
- Commodities/products consists of activity no.*3.2.2,3.7*
- Drugs are in activity no.*3.10 & 3.11*
- Monitoring and evaluation consists of activities *3.9.1,3.9.2&3.9.3*

4. Develop and implement advocacy and IEC strategy

Advocacy and health education are important for creation of awareness for policy makers, health workers, patients and the community at large in the control of TB. The plan seeks to sensitize the general population to come early to the health facilities together with their close contacts for diagnosis and treatment. It will also embark on changing negative societal behavioral attitudes and misconceptions including stigma towards tuberculosis and clarify the parallel and difference between TB and HIV/AIDS. Religious, political and peer leaders will be sensitized so that they in return raise community awareness. The NLTP intends to develop a national strategy on advocacy in collaboration with WHO, that should incorporate referred strategies.

Table IV.27

Objective:4	**Develop and implement advocacy and IEC strategy**				
Outcome/coverage indicators	Baseline	Targets			
(Refer to Annex II)	Year:	Year 2:	Year 3:	Year 4:	Year 5:
Number (and variety) of messages presented	3	**10-15**	**10-15**	**10-15**	**10-15**
Number of staff trained in communication	0	**5**	**10**	**15**	**20**
World TB day commemorated	1	**1**	**1**	**1**	**1**
Annual TB conference	0	**1**	**0**	**1**	**0**
TB education championship	0	**1**	**1**	**1**	**1**

Table IV.27.1

Objective:4	Develop and implement communication strategy				
Broad activities	Process/Output Indicators	Baseline	Targets		Responsible/Implementing agency or agencies
		(Specify year)	Year 1	Year 2	
4.1 Planning workshop	**Workshop held**	0	**1**	**0**	**NLTP / Div. Health education of MoH**
4.2 Train relevant health staff in communication	**Number of NLTP staff trained in communication**	0	**100**	**0**	**NLTP /AMREF**
4.3 IEC message conveyed	**Variety of messages presented**	0	**5**	**5**	**NLTP /WHO**
4.4 social mobilization	**Number of barazas** **Child to child TB championship**	0 0	**700** **1**	**0** **0**	**Provincial administration/ NLTP** **NLTP/ Min.of Education**
4.5 Annual TB conference	**Number of participants**	0		**400**	**NLTP / KEMRI/partners**

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Infrastructure/ Equipment	101,500	232,834	101,500	232,834	101,500	770,168
Training/ Planning	189,568	142,034	165,034	130,034	165,034	791,704
Total	**291,068**	**374,868**	**266,534**	**362,868**	**266,534**	**1,561,872**

Key:

- Training/ Planning consists of activity no.*4.1,4.2,4.4.1,4.4.2.1,4.4.2.2*
- Administrative costs in activity no.4.3.1,4.3.2,4.3.3,4.3.4,4.3.5,4.4.3 & 4.5

5. Strengthen monitoring and evaluation of specific objectives and indicators.

Monitoring and evaluation of all these additional activities and the recording and reporting of indicators is crucial for a successful analysis of this plan. This proposal will be implemented within the framework of the NLTP and therefore benefit from the existing monitoring and evaluation mechanisms. The NLTP routinely collects data every quarter and this will form part of the report to the JICC. Funds will be released in quarterly tranches according to the Workplan. The current NLTP set up will be maintained and further enhanced by its entrenchment in the DHMTs and PHMTs
To co-ordinate and supervise activities presented in this plan, the Central Unit of NLTP at the Ministry will appoint a co-ordinating officer with solid public health back-ground and experienced in control of tuberculosis. An important new aspect of the monitoring is the involvement of institutions and individuals of the private sector and the community, which will require careful planning and sensible approach. Operational research activities will be encouraged. The NLTP in collaboration with KEMRI and CDC will develop research agenda for the coming years. The program will also develop a reliable and international acknowledged MDR surveillance system in collaboration with KEMRI and an accredited supra-national reference laboratory.

Table IV.27

Objective 5	**Strengthen monitoring and evaluation of specific objectives and indicators**				
Outcome/coverage indicators	Baseline	Targets			
	Year 1:	Year 2:	Year 3:	Year 4:	Year 5:
MDR rates	?				**<3%**
Number of operational research activities	2	**3**	**4**	**4**	**4**
Annual TB management meeting	1	**1**	**1**	**1**	**1**

Table IV.27.1

Objective: 5	Strengthen monitoring and evaluation of specific objectives and indicators				
Broad activities	Process/Output Indicators	Baseline	Targets		Responsible/Implementing agency or agencies
		(Specify year)	Year 1	Year 2	
5.1Deploy additional Public health specialist	**Deployment of Public Health specialist**	0	**1**	**0**	**MoH / NLTP**
5.2Support operational research activities	**Publication of research findings**	0	**3**	**3**	**MoH / NLTP**
5.3MDR surveillance	**Surveillance data available and reported by year 2**				**MoH/ NLTP/ KEMRI**
5.4 Annual TB management meeting	**Minutes/report**	0	**1**	**1**	**NLTP/Partners**

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 Estimate	Year 4 Estimate	Year 5 Estimate	Total
Human Resources	36,000	36,000	36,000	36,000	36,000	180,000
Operational Research	100,000	100,000	100,000	100,000	100,000	500,000
Administrative costs	10,000	15,000	20,000	20,000	20,000	85,000
Infrastructure/Equipment	87,300	130,950	196,425	196,425	196,425	807,525
Drugs	0	0	0	0	0	0
Commodities	38,000	38,000	38,000	38,000	38,000	190,000
Total	**271,300**	**319,950**	**390,425**	**390,425**	**390,425**	**1,762,525**

Key

- Human resources refers to 5.1
- Operation research refers to 5.2
- Drugs refers 5.3
- Commodities 5.4

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

This has been explained in chapter 22.3

29. Brief description of how the component addresses the following issues:

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

Approximately half of all HIV positive individuals (1million) in Kenya are infected with tuberculosis. It is estimated that 30% (300.000) of them will develop TB disease sometimes in life span. Early identification and appropriate treatment of individuals with TB disease will not only reduce the transmission of TB in the general population, it will also improve the quality of live of many HIV infected individuals and possibly extend survival. Preventing reactivation of possible TB infection in HIV positive individuals with Isoniazid Prophylactic Treatment is another important contribution to improve life quality and survival.

29.2. Community participation:

The community is recognized as an important partner in extending DOTS services throughout the country. The involvement of community volunteers and leaders in early detection of tuberculosis and appropriate treatment under observation as presented in this proposal will be evident. Furthermore, NLTP strategy on communication will primarily target community members. Community targeting messages related to identification of suspect TB, correct supervised treatment and TB-HIV will appear in different media and will hopefully enhance community participation.

29.3. Gender equality issues:

The NLTP recognises that women are a marginalized population in Kenya, which is mainly related to a disproportionate lower socio-economical status. Inequities in access to care and the disproportionate effect of the HIV/AIDS epidemic on women are two areas, which are addressed in this proposal. Decentralisation, community involvement and a joint TB-HIV approach will contribute to more equity in case detection and therefore treatment.

29.4. Social equality issues:

The TB burden is disproportionate high among poor people. The links between disease, inequity and poverty are recognized and discussed. Kenya has produced a Poverty Reduction Strategy Paper aiming at poverty reduction, which also includes combating communicable diseases, such as tuberculosis. To enhance TB control and in line with international agreements, anti TB treatment to all TB patients diagnosed and treated within the existing control system is free of charge.

29.5. Human Resources development:

A dedicated staff of Doctors, clinical officers, Nurse, Laboratory technologists and public health officers and technicians at various levels undertake the core functions of NLTP. These staff has various qualifications, ranging from Masters degrees, Basic medical degrees, diplomas and certificates in designated fields. Besides these qualifications the staff have under gone training in Tuberculosis and leprosy control in Arusha (IUATLD course) Tanzania and Addis Ababa, Ethiopia respectively. NLTP plans to maintain high calibre staff by routinely recruiting doctors and sending those without MPH for training in the country and where possible abroad. The doctors will also be given special training in Tuberculosis and Leprosy control, through the IUATLD course in Arusha and ALERT course in Ethiopia respectively. The Kenya Medical Training College trains clinical officers in chest and skin diseases in Nairobi. This is a post basic diploma course and produces 15 graduates every year. The graduates are deployed as District Tuberculosis and Leprosy coordinators, forming a backbone of tuberculosis and Leprosy control. NLTP will continue to support this course. With the resurgence of tuberculosis, NLTP recognizes the need of Health workers (Doctors, Clinical Officers and Nurses) to diagnose and manage tuberculosis without problems. To satisfy this need, NLTP organizes training for Health workers at the district conducted by PTLCs and DTLCs with support from Central unit. The training conducted through lectures, role-plays and practical focuses on diagnosis and treatment of TB. Like wise, the Laboratory workers undergo Refresher training in Sputum smear microscopy every year.
NLTP recognizes the need to incorporate TB control in teaching curriculum of doctors, clinical officer and nurses and has made this recommendation to the institutions. To address all these needs the NLTP is participating in the TBCTA Taskforce training initiative that is exploring ways of developing solid multi-year Human Resource Development plans.

29.6. Description of drugs and treatment regimen used in NLTP

The NLTP of Ministry of Health Kenya, applies the WHO/IUATLD recognized DOTS strategy in management of tuberculosis. The five elements of DOTS are strictly applied under varying geographical and socio-cultural conditions in the country. Diagnosis of tuberculosis is by sputum smear microscopy through a net work of over 300 laboratories. Treatment is by Rifampicin containing fixed dose combinations. The drugs used are Rifampicin, Isoniazid, Pyrazinamide, Ethambutol and Streptomycin. The regimens used in Kenya are as follows:

1. Category 1(Smear Positive PTB) 2EHRZ/6EH
2. Category 2(Retreatment PTB cases)2SHRZE/1HRZE/5RHE
3. Category 3(Smear Negative and Extra pulmonary TB) 2RHZ/6EH

Treatment is observed at least in the initial 2 months of the 8-month treatment period. Prognosis of the patient is monitored by sputum examination at 2, 5, and 8 months and this is recorded in various records and registers. Routine culture and where indicated sensitivity is done on all Retreatment cases as a surveillance to Multi-Drug Resistant Tuberculosis.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 Estimate	Year 4 Estimate	Year 5 Estimate	Total in US dollars
Human Resources	111,016	134,267	137,682	111,264	115,028	609,253
Infrastructure / Equipment	1,027,129	603,323	316,181	350,701	313,959	2,611,293
Training/ Planning	722,959	792158	957,114	633607	710645	3,816,483
Commodities/ Products	92,022	144,552	158,729	121,408	130,025	647,136
Drugs	251,000	292,000	344,000	406,000	482,000	1,775,000
Monitoring and Evaluation	24,240	24,240	40,061	24,240	40,659	153,439
Operation research	100,000	100,000	100,000	100,000	100,000	500,000
Administrative costs	124,240	124,240	140,061	124,240	140,659	1,120,129
Total	**2,452,606**	**2,214,780**	**2,193,828**	**1,871,460**	**2,032,975**	**11,232,733**

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Estimated added TB cases for 2003 are 12,800. The estimated number of clients to be referred for IPT is 1000. Transport will be provided to 6 difficult to reach districts, and 3 PTLCs in Nairobi

TableV.30.1

Item/unit	**Unit cost for 1,000** (USD)	**Volume** (specify measure)	**Total cost** (USD)
RHZH : 4FDC Tablets	40	3,200	128,000
EH: 2FDC Tablets	25	4,100	123,000
H: 150 mg tablets	15	360	9,000
4x4 vehicles Suzuki 4x4 vehicles Toyota Land cruiser hardtops	32,000 40,000	3 6	96,000 240,000
Microscopes Safety cabinets(Hoods)	1,333 667	21 20	27,993 13,340
Lab. Equipment(Assorted materials for the Bactec) refer 5.3.2			87,300
Total cost for 2003			**752,626**

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

NOTE: The detailed budget has been presented throughout this section.

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* **(%)**	**Year 1**	**Year 2**	**Year 3 Estimate**	**Year 4 Estimate**	**Year 5 Estimate**	**Total**
Government	78	79	87	86	85	**82**
NGOs / Community-Based Org.	18	17	8	9	10	13
Private Sector	0	0	0	0	0	0
People living with HIV/ TB/ malaria	0	0	0	0	0	0
Academic / Educational Organisations	4	4	5	5	5	5
Faith-based Organisations	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	**2,452,606**	**2,214,780**	**2,193,828**	**1,871,460**	**2,032,975**	**11,232,733**

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**		
		HIV/AIDS
		Tuberculosis
	X	**Malaria**
		HIV/TB

24. Provide a brief summary of the component **(Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):**

In response to the high level of morbidity, mortality and deprivation associated with the high endemicity of malaria in Kenya (set out in Section III, part 18), MoH has developed a National Business Plan, incorporating 19 malaria control activities. The Malaria Component of this proposal to the Global Fund identifies five activities from the Kenya Business Plan, that will address two priority areas for scaling-up malaria control activities. These areas include all sectors of society and make special provision for biologically vulnerable groups, namely pregnant women and children under five.

Priority 1- Social marketing of ITNs, incorporating subsidies for vulnerable groups.
Recent research in Siaya district of Kenya (CDC/KEMRI 2001) confirm findings from the Gambia (D'Allessando 1996) that insecticide treated nets (ITNs) may confer some protection against malarial infection among pregnant women. In order to significantly increase ITN use among vulnerable groups, thereby reducing malaria-associated morbidity and mortality, awareness must be raised about the protection nets provide and access to them must be improved. PSI, supported by DFID, is in the process of awareness-raising, demand creation and promotion of the appropriate use of ITNs through social marketing throughout Kenya,

with a focus in poor, rural endemic areas. The initial experience of PSI in social marketing ITNs in Kenya illustrates the efficacy of these techniques in increasing demand for ITNs. Between January and July 2002, actual sales of ITNs exceeded projections by over 200% nationally (PSI Semi-annual report 2002). With additional funding from the GFATM, this programme will be expanded through partnerships with other NGOs and community groups, to reach a greater proportion of these rural and at-risk communities. In neighbouring Tanzania, a voucher system that was piloted and effectively improved the access of marginalized people to ITNs, is due to be scaled up by PSI. In order to ensure that Kenya's most vulnerable groups gain access to ITNs, a targeted subsidy voucher system will be established. This is a new and innovative approach in Kenya and will draw upon the experience and expertise of PSI in neighbouring countries. Through the use of the proposed voucher system, by 2007 at least 40% of pregnant women and children under five in at least 40 districts will be provided with subsidized ITNs.

Priority 2 - Provision of effective anti-malarial drugs, IPT targeting pregnant women and implementation of IMCI

Research has demonstrated that malaria infection in pregnancy has a negative impact on maternal and child health and well being. There is evidence that in malaria endemic regions, such as many areas of Kenya, pregnant women are more likely to be infected with *P. falciparum* than non-pregnant women. As a consequence, they are more likely to be anaemic, resulting in a greater risk of pregnancy-related mortality and morbidity (Meek & Schulman 1998). Malaria in pregnancy also impacts upon foetal development and neonatal health. Up to 5% of neonatal mortality and 30% of preventable low birth weight are understood to result from maternal malaria in endemic regions (Child Health Research Project 1999). Studies in Kenya and elsewhere, however, have demonstrated a significant reduction in the incidence of malaria-associated anaemia in pregnancy, following the administration of two IPT doses of SP in the second and third trimesters (Praise *et al* 1998; Shulman *et al* 1999). An additional benefit of the use of IPT in pregnancy is a reduction in the incidence of low birth weight infants. (Malaria-Specific Attachment 3: KEMRI/CDC 2001; NMS 2001-10).

MoH in partnership with JHPIEGO, is currently building capacity among service providers in 15 districts of Kenya. With additional funding from the Global Fund, this will be expanded to an additional 25 districts over the next five years.

MoH's newly introduced Integrated Management of Childhood Illnesses (IMCI) strategy, with support from WHO and the World Bank, has trained health workers and community health workers in three districts in case management at two levels; at the health facility and the community level. In partnership with WHO, DFID, UNICEF and USAID, MoH will scale-up coverage by 10 districts each year and health facilities in those districts will subsequently be equipped with supplementary IMCI drugs to support these activities. In this way, by 2007 at least 60% of health workers in 40 districts will have been trained. Of the health facilities with trained workers, 100% will have IMCI drugs. At the community level, by 2007, at least 15% of households will be practicing IMCI activities.

Health facilities currently receive anti-malarial stocks from two main sources. These are through GoK supply channels and from donors including ADB, Sida and DANIDA. At the rural health facility level, anti-malarials should be received monthly as part of the national

drug kit received by all facilities regardless of the degree of local malaria endemicity. Current supplies of anti-malarials, however, are grossly inadequate in highly endemic areas, with monthly supplies being exhausted within days of their receipt. Due to logistical problems at the district level, many health facilities do not receive their allocated monthly supply kits on time. With GFATM support, this supply gap will be addressed to ensure that by 2007, 80% of rural health facilities in at least 40 districts will have no anti-malarial stock-outs over a two-week period in any given month. At the district level, the supply gap is not perceived to be problematic as a cost-sharing mechanism, the Facility Improvement Fund, is used to supplement any shortfalls in supply.

Currently, SP, Amodiaquine and Quinine are used as 1st and 2nd line anti-malarials, in accordance with MoH guidelines. Parasite resistance of up to 30% to SP has, however, been detected in focal areas of Kenya (EANMAT 2001). Given this situation and that WHO recommends that countries with significant levels of parasite drug-resistance adopt the use of combination therapy (WHO 2001), MoH is in the process of information gathering, with a view to reviewing national drug policy and the potential benefits of various drugs for use in combination therapy in the Kenyan setting.

The National Malaria Strategy will be translated into activities at the district level through implementation of the Business Plan and address the two Malaria Component priority areas. This business-style approach will forge new partnerships through franchising and contracting with the private sector and collaboration and partnerships with NGOs such as PSI and Cry for the World Foundation. This will expand the scope of district level malaria control operations beyond the District Health Management Team (DHMT) programme of action.

The overall goal of the Malaria Component is to scale-up effective interventions to reduce morbidity and mortality associated with malaria among the Kenyan population.

<u>Objectives</u>
The Malaria Component incorporates five specific objectives:
1: To increase the percentage of pregnant women and children under five sleeping under ITNs to 40%, in at least 40 districts by 2007;
2: To increase the number of pregnant women accessing IPT to 20% in at least 40 districts by 2007;
3: To improve case management and effective treatment of malaria;
4: To improve the drug distribution system for efficient malaria prevention and treatment;
5: To improve community access to information about malaria control and prevention.

<u>Activities to realize these objectives:</u>
Activities designed to achieve objective 1 include implementation of a voucher subsidy scheme targeting pregnant women and children under five and improving the efficacy of ITNs through the promotion of regular net re-treatment. Objective 2 will be addressed by scaling-up the use of IPT. Objective number 3 will be achieved through two broad activities: by training health staff and community resource persons in IMCI and shopkeepers in good drug dispensing practices; and through the purchase and distribution of anti-malarial drugs to peripheral health facilities. Objective 4 will be addressed though a consultative review and consequent revision of the current drug stock distribution system, together with the training of health facility workers, store keepers and district health management teams. Objective 5 will be achieved through three broad activities: the establishment of ITN advocacy groups; an

IEC campaign on malaria prevention and treatment; and inter-personal communication at the community level, through community-based organizations, networks and operations.

Expected results

The expected results of these activities include: improvement in malaria case management at both the health facility and community levels; improved ownership and appropriate use of ITNs by pregnant women and children under five; and increased use of IPT among pregnant women. Other expected results include no drug stock-outs in peripheral health facilities, improved awareness of malaria prevention and treatment measures among communities.

How these activities will be implemented and involved partners

These activities will be implemented through a series of collaborations and partnerships between GoK, multilateral and bilateral agencies, NGOs, community groups, faith-based organizations and the private sector. PSI, MoH and other partners will use social marketing and a voucher subsidy system to enable pregnant women and children under five to access ITNs. MoH in partnership with JHPIEGO and AMREF, will enhance the access of pregnant women to IPT by expanding focused ANC services. The IMCI strategy will be implemented by MoH, in collaboration with WHO, DFID, UNICEF and various NGOs to improve case management at the health facility and community level. MoH in partnership with AMREF and Merlin will train health facility staff trainers, supervisors and trainers of CORPs in IMCI. MoH will carry out shopkeeper training in co-operation with WHO, AMREF and KEMRI, to improve the use and access to appropriate, quality anti-malarial drugs. The purchase and distribution of anti-malarials to peripheral health facilities will be implemented by MoH, and access to these drugs will be through peripheral health units and Bamako Initiative sites. A review and revision of the current stock distribution system will be undertaken in consultation with agencies such as DFID, JICA and USAID to improve drug distribution. MoH will address the logistical problems inherent in the current anti-malarial drug distribution system, by training district health management teams, health workers and store keepers in logistics and drug supplies management to enable them to manage stocks more effectively. To improve community access to malaria control and prevention information, WHO has supported MoH to establish ITN advocacy groups. These groups are composed of MoH, NGOs, including PSI, AMREF and World Vision, faith-based organizations, government departments and extension workers. Awareness-raising and public education through the Information Education and Communication (IEC) mass media campaign will be carried out by a partnership incorporating PSI, AMREF, UNICEF, WHO, MoH and USAID. Inter-personal communication at the community level will be implemented by MoH and partners including MAP, AMREF and the Ministry of Culture and Social Services, through community based organizations, networks and operations.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year)**:**	January 2003	**To** (month/year)**:**	December 2007

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

*Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.***

*Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.***

*Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.***

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

The overall goal of the Malaria Component is to scale-up effective interventions to reduce morbidity and mortality associated with malaria among the Kenyan population.

Malaria Disease Burden in Kenya

Of the Kenyan population, 70% (20 million people) live in malarious areas and are at risk of infection (National Malaria Strategy 2001). Each year, an estimated 6,000 primigravid women suffer from malaria-associated anaemia, 4,000 babies are born with low birth weight as a result of maternal anaemia and 34,000 children below the age of five years die from malaria (MoH 1998). This disease burden has a draining effect upon Kenyan health resources as 30% of all outpatient attendance and 19% of inpatient admissions are due to malaria (National Malaria Strategy 2001). Malaria also widens the gap in prosperity between countries with the disease and those without. It has significant, measurable, direct and indirect costs that place major constraints on economic development in Kenya.

Among the direct costs of malaria is the high personal and public expenditure necessitated by prevention measures and treatment. Indirect costs of malaria in Kenya include: loss of productivity and income associated with illness and death; loss of working days and/or absenteeism from school and formal employment and in cases of death of a family member, the loss of future lifetime earnings.

Linkage between Kenya's malaria burden, poverty, and economic development

It is estimated that around 20 million Kenyan people (more than half the population) are regularly infected with *P. falciparum*. This means that many households are affected by the suffering and economic hardship caused by malaria. When a family member suffers a malaria episode, households' resources have to stretch to the expenditure of transport of the patient, consultation costs and drugs. This is estimated to amount to US $20 each year for the clinical management of attacks. Given that 53% of Kenya's rural population subsist below the poverty line (National Economic Survey 2001), the clinical management of malarious episodes presents an overwhelming financial burden to the rural population. Malaria associated morbidity is responsible for a significant decrease in productivity and in Kenya, it is estimated that 170 million working days are lost each year as a result of malaria. The negative economic impact is most severe on agricultural productivity and the livelihoods of poor rural farmers, especially in epidemic-prone districts (National Malaria Strategy 2001). School attendance and learning are also disrupted by childhood episodes of malaria. It is estimated that nationally, approximately 4million school days are lost annually due to malaria, which can rise to 10 million during years of epidemic outbreaks.

Expected impacts

The expected impact of the planned activities will be a reduction in the number of severe malaria cases, a reduction in the number of hospital admissions due to malaria and a reduction in the malaria death rate, leading to an overall reduction in the crude death rate. Interventions targeting vulnerable groups such as pregnant women and children will lead to a reduction in maternal, infant and under five mortality rates. The expected overall reduction in morbidity (including fever, anaemia, low birth weight, and severe and complicated cases) resulting from these planned activities will reduce outpatient attendance, and is expected to be particularly marked among targeted groups such as under fives, pregnant women and non-immunes.

In economic terms these activities will lead to reduced household spending on malaria treatments, enhanced agricultural productivity, enhanced economic growth and a consequent reduction in poverty levels in Kenya.

Goal: Reduction of morbidity and mortality associated with malaria by 30% of the current levels by 2007 **Impact Indicators***	**Baseline****	**Target (last year of proposal) 2007**
No. of deaths attributed to malaria (children 0-4yrs)	34,000 (MoH-1998)	23,000
Expected malaria admissions (0-4 yrs) p.a.	145,000	102,000
% of inpatient deaths under five years attributed to malaria	27%	19%
% of inpatient deaths of all ages attributed to malaria	26%	18%
No. of severe malaria & anaemia episodes during 1st pregnancy	6,000	4,000
No. of low birth weight babies due to anaemia	4,000	2,800
% of outpatient attendance attributed to malaria	30%	20%
% of admissions to health facilities attributed to malaria	19%	13%

*Additional surveys planned for 2003 will serve both to verify the above baseline figures and provide additional indicators for which statistics are not currently available ** Source: National Malaria Strategy 2001, unless indicated otherwise.

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective)

Deleted:

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 1: To increase the percentage of pregnant women and children under five sleeping under ITNs to 40%, in at least 40 districts by 2007

For the purpose of this proposal, pregnant women and children under five are identified as biologically vulnerable groups. MoH is adopting two interventions to specifically address these at risk groups. The first strategy, outlined in this objective, is to promote the use of insecticide treated nets (ITNs). Over a five-year period, five million subsidized ITNs will be made available through a voucher scheme to 40% of pregnant women and children under five, in at least 40 districts. Five million net re-treatment kits will also be made available. The outcome of this objective (together with that of the awareness-raising campaign outlined in objective 5) will be increased ITN coverage of pregnant women and children under five.

Objective 1	**To increase the percentage of pregnant women and children under five sleeping under ITNs to 40%, in at least 40 districts by 2007**				
Outcome/coverage indicators (for targeted areas)*	**Baseline****	**Targets**			
	2001	**2004**	**2005**	**2006**	**2007**
% of children under five sleeping under a mosquito net	15%	20%	30%	45%	60%
% of children under five sleeping under ITNs	4%	6%	10%	20%	40%
% pregnant women sleeping under a mosquito net	12%	15%	25%	40%	55%
% pregnant women sleeping under ITNs	3%	5%	10%	20%	40%
% of households owning at least one mosquito net	22%	30%	40%	50%	60%
% of households owning at least one ITN	8%	12%	20%	30%	40%

* Surveys planned during 2003 by Population Services International (PSI) amongst others, will provide verification of the baseline data as well as additional indicators aimed at assessing the efficacy of the adopted strategy. ** Source Ministry of Health 2002.

Objective 2: To increase the number of pregnant women accessing IPT to 20% in at least 40 districts by 2007

The second intervention adopted by MoH to address malaria in pregnancy, is the provision of Intermittent Presumptive Treatment (IPT) with two doses of Sulphadoxine Pyrimethamine (SP), which will be accessed through antenatal clinics (ANCs). Benefits of IPT include a reduction in malaria episodes and associated anaemia, and a reduction in low birth weight babies. By 2007, 20% of pregnant women in at least 40 districts will be accessing IPT through ANC services.

Objective 2	**To increase the number of pregnant women accessing IPT to 20% in at least 40 districts by 2007**				
Outcome/coverage indicators	**Baseline**	**Targets**			
	2001	**2004**	**2005**	**2006**	**2007**
% of pregnant women who have accessed IPT from ANC services during pregnancy	4%	6%	10%	15%	20%

Source: MoH 2002.

Objective 3: To improve case management and effective treatment of malaria

Promoting effective intervention measures, notably treatment of fever cases within 24 hours of onset and treatment of 1st line drug failures, will involve both access to effective drugs and skill development of health care providers. Training of health workers, community resource persons (CORPs) and shopkeepers will be supplemented by a public education campaign (set out in objective 5). As an immediate measure to address the shortage of drug supplies at the peripheral level, with funding from the GFATM, districts will be supported with supplementary drug supplies. (Long-term improvement in distribution and stock management at the district level is addressed under objective 4). The expected outcome of objective 3 is improved skills in the recognition of fever due to malaria and appropriate treatment within 24 hours of onset, both at the community and health facility levels.

Objective 3	**To improve case management and effective treatment of malaria**				
Outcome/coverage indicators	**Baseline**	**Targets**			
	2001	**2004**	**2005**	**2006**	**2007**
Proportion of under fives with fever receiving anti-malarial treatment within 24 hours of onset	2%	3%	5%	7%	10%
% of febrile people taking anti-malarials within 24hours of fever onset	2%	5%	10%	15%	20%
Proportion of under fives with uncomplicated malaria correctly managed at GoK health facilities*	64%	70%	75%	80%	85%

Source: MoH (2002).

Objective 4: To improve the drug distribution system for efficient malaria prevention and treatment

Frequent anti-malarial stock-outs at peripheral health facilities impede the continuity of malaria prevention and treatment. This is a consequence of poor stock management capacity and poor logistical co-ordination between national, regional, district and peripheral health facilities. With support from the Global Fund, MoH will address these issues and by 2007, 70% of health facilities will not experience stock-outs of anti-malarial drugs. The Kenya Medial Supplies Agency is currently being established to improve drug procurement and stock management. This objective targets the distribution network at district-level, where improved supply and management of essential drugs will enhance the efficiency of malaria prevention and treatment.

Objective 4	To improve the drug distribution system for efficient malaria prevention and treatment				
Outcome/coverage indicators	**Baseline**	**Targets**			
	2002	**2004**	**2005**	**2006**	**2007**
% of health facilities reporting no stock-outs	25%	30%	40%	55%	70%

Source: MoH 2002.

Objective 5: To improve community access to information about malaria control and prevention

Mass media campaigns, using a combination of strategies, including radio, television, print media, community performances of plays, songs and concerts are being undertaken to raise community awareness of malaria prevention and control. Messages incorporate information about the use of ITNs and their re-treatment, IPT and the benefits of early treatment of fever.

With support from the Global Fund, these strategies will be scaled-up to enhance ongoing awareness-raising campaigns. Through these channels, MoH will introduce the proposed ITN voucher subsidy system for pregnant women and children under five. A public information campaign will be launched to widely disseminate and reinforce information about access to subsidized ITNs. Specifically men and household heads will be targeted in an effort to support behavioural change, whereby women and under fives will be given preferential use of ITNs within the home. Pregnant women, mothers and other caretakers of

children under five will be targeted to receive information about ITN use, net re-treatment and IPT.

Objective 5	To improve community access to information about malaria control and prevention				
Outcome/coverage indicators	**Baseline**	**Targets**			
	2001	**2004**	**2005**	**2006**	**2007**
% of pregnant women aware of the voucher system	0	40%	50%	60%	70%
% of households receiving campaign messages from at least one source every 6 months to support objectives 1-3	<5%*	20%	30%	40%	50%
% of people self-medicating with appropriate anti-malarials within 24hours of fever onset	Data undergoing MoH analysis	10%	15%	25%	40%

***Source: MoH 2002

27.1. Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

> Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.
>
> Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.
>
> For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

Objective 1: To increase the percentage of pregnant women and children under five sleeping under ITNs to 40%, in at least 40 districts by 2007

<u>Broad activities</u>

1. **Implementation of a voucher subsidy scheme targeting vulnerable groups**

PSI is currently using social marketing as a strategy to create demand nationally for subsidized ITNs, available through commercial outlets. This ongoing strategy aims to increase ITN coverage to 40% of all pregnant women and under fives, over a period of five years. With support from the Global Fund, a voucher system will be introduced, to meet the gap between the PSI subsidy and the cost of the ITN to the consumer. In this way, access to ITNs by pregnant women and children under five will be enabled. First and second time pregnant women will receive vouchers for ITNs through ANC. During EPI vaccination, children under five, who may not have received an ITN via their mother's ANC visits, will receive vouchers for their own nets. Vouchers for net re-treatment kits will also be distributed for the under fives, when they receive their measles vaccination at nine months of age. Vouchers will be redeemed through the commercial sector, which includes PSI kiosks.

Health workers and shopkeepers will be trained in the management of the voucher scheme and mechanisms will be developed to ensure voucher security and control for effective implementation of this scheme. Sentinel surveys will also be conducted to monitor access to and utilization of ITNs by pregnant women and children under five. In this way, in the first year (2003) of implementation, an estimated 550,000 ITNs and a similar number of re-treatment kits will be distributed to the target group through the voucher scheme. This will be expanded to approximately 750,000 in the second year, increasing to 1.6 million ITNs by 2007.

2. Net re-treatment

Health workers and Community Resource Persons (CORPs) are being trained to encourage communities to undertake regular re-treatment of nets. WHO has already initiated this process in two districts, and this will be expanded to eight districts in the first year, in partnership with NGOs and CBOs working at the community level. With support from the Global Fund, by 2007, at least 40 districts will have a net re-treatment rate of at least 25%.

Objective 1:	**Objective 1: To increase the percentage of pregnant women and children under five sleeping under ITNs to 40%, in at least 40 districts by 2007**				
Broad activities	Process/Output indicators **(indicate one per activity) (Refer to Annex II)**	Baseline	Targets		Responsible/Implementing agency or agencies
		2001	2003	2004	
Distribution of ITNs to pregnant women & children <5 through voucher scheme	**Number of ITNs accessed through the voucher scheme**	**0**	**200,000**	**400,000**	**MoH, PSI**
Distribution of ITNs to children attending EPI, through voucher system	**Number of ITNs accessed through the voucher scheme**	**0**	**150000**	**350000**	**MoH, PSI**
Distribution of re-treatment kits through voucher system	**Number of re-treatment kits accessed through the voucher scheme**	**0**	**350,000**	**750,000**	**MoH, PSI**
Training of CORPs and Health Workers on the voucher scheme	**No. of CORPs and Health Workers trained in the voucher system.**	**0**	**2,000**	**2,000**	**MoH, PSI**

Objective 2: To increase the number of pregnant women accessing IPT to 20% in at least 40 districts by 2007

Broad activities

1. **Scaling-up the use of IPT**

The main strategy for the prevention of malaria in pregnancy is the administration of SP during the 2nd and 3rd trimesters of pregnancy. This is currently being implemented by MoH, in partnership with JHPIEGO and AMREF, through focused ANC services in 15 districts. With support from the Global Fund, this will be expanded to a further 25 districts. Activities to implement IPT will include training of District Health Management Teams (DHMTs), supervisors, health facility staff and traditional birth attendants (TBAs). SP drugs will be supplied to ANCs, where they will be accessible by pregnant women. Pregnant women will be encouraged to seek ANC services through the integrated publicity campaign proposed under objective 5.

Objective 2:	**Objective 2: To increase the number of pregnant women accessing IPT to 20% in at least 40 districts by 2007**				
Broad activities	Process/Output indicators **(indicate one per activity) (Refer to Annex II)**	Baseline	Targets		Responsible/ Implementing agency or agencies
		2001	2003	2004	
Scaling up the use of IPT	**No. of districts implementing Focused Ante Natal Care (FANC)**	**15**	**25**	**40**	**MoH, JHPIEGO, AMREF**

Source: MoH 2002.

Objective 3: To improve case management and effective treatment of malaria

Broad activities

1.Training of health facility staff and community resource persons (CORPs) in IMCI and shopkeepers in good drug dispensing practices.

MoH is using the IMCI strategy to improve malaria case management. This currently involves two levels of training in IMCI in seven districts. At the institutional level, this incorporates the training of trainers, supervisors, and health staff and t the community level involves trainers of CORPs and CORPs themselves. With funding from the GFATM, MoH will build capacity for 10 additional districts each year to train health facility staff trainers, supervisors and trainers of CORPs in IMCI. The actual training of health workers at peripheral facilities and CORPs will be undertaken through existing MoH and partners' programmes. Shopkeepers will also be trained in good drug dispensing practices to enable them to stock and dispense appropriate, quality anti-malarial drugs in the correct dosages.

2. **Purchase and distribution of anti-malaria drugs to peripheral health facilities**

Health facilities' ability to treat patients presenting malaria symptoms is dependent upon an adequate supply of anti-malarial drugs to the periphery. At present, MoH is using SP, amodiaquine, quinine and IMCI drugs to treat fever cases. With support from the Global Fund, additional drugs will be procured and districts supported in managing distribution to peripheral health units and Bamako Initiative sites will be supplied with seed anti-malarials. This will enable communities to access affordable and effective anti-malarials within walking distance of their homes.

Objective 3:	To improve case management and effective treatment of malaria				
Broad activities	Process/Output indicators **(indicate one per activity) (Refer to Annex II)**	Baseline	Targets		Responsible/Implementing agency or agencies
		2001	2003	2004	
Training of district TOTs and supervisors	**No. of trainers and supervisors trained in IMCI.**	**140**	**340**	**540**	**MOH, AMREF**
Training of CORPS trainers	**No. of CORPS trainers trained in IMCI**	**0**	**70**	**240**	**MOH, Merlin, AMREF**
Training of shopkeepers	**No of shopkeepers trained good drug dispensing practices.**	**350**	**1550**	**2250**	**MOH, AMREF**
Procurement and supply additional IMCI drugs to districts	**No. of districts with facilities with adequate IMCI drugs.**	**7**	**17**	**27**	**MoH**
Procurement and supply additional anti-malarial drugs to peripheral centres	**No of districts reporting no stock-outs**	**25%**	30%	40%	**MoH**

Source: MoH 2002.

Objective 4: To improve the drug distribution system for efficient malaria prevention and treatment

Broad activities:

1. **Consultative review and revision of the current stock distribution system**

With support from the GFATM, a review of the drug distribution system will be undertaken. The main purpose of this review will be to identify supply bottlenecks and factors contributing to stock-outs of anti-malarial drugs in peripheral health facilities. It will identify possible solutions, such as capacity-building initiatives, to improve the drug distribution system. This review will be carried out in a consultative manner, in partnership with stakeholders, including agencies such as DFID, JICA and USAID. Recommendations from this review will form the basis of interventions for improvement of the drug distribution system.

2. Training of health facility workers, store keepers, and district health management teams

To address the logistical problems inherent in the current anti-malarial drug distribution system, district health management teams, health workers and store keepers will be trained in logistics and drug supplies management to enable them manage stocks more effectively. Training will be structured to improve drug stock management skills in order that the recommendations of the distribution system review can be implemented. With funding from the Global Fund, training will commence in 10 districts in the first two years.

Objective 4:	To improve the drug distribution system for efficient malaria prevention and treatment				
Broad activities	Process/Output indicators **(indicate one per activity) (Refer to Annex II)**	Baseline	Targets		Responsible/Implementing Agency or agencies
		2001	2003	2004	
Review of the drug distribution system	**Recommendations for improvement of anti-malarial drug distribution system finalized**	**0**	**1**	_	**MoH (HSR)**
Training of DHMTs, health workers and store keepers	**Number of districts with trained DHMTs, health workers and storekeepers**	**0**	**3**	**7**	**MoH**

Objective 5: To improve community access to malaria control and prevention information

Broad activities

1.Establishment of ITN advocacy groups

WHO has supported MoH to establish ITN advocacy groups in 15 districts in Kenya. These groups are composed of MoH, NGOs, faith-based organizations, government departments and extension workers and act as coordinating bodies, which promote the use of ITNs through information dissemination. Specific activities of the ITN advocacy groups include: holding stakeholders meetings to establish ITN groups at national, district, divisional and local levels, conducting workshops to develop joint work plans and share responsibilities; and conducting seminars on net insecticide treatment. Support from the Global Fund is requested to assist MoH to establish ITN advocacy groups in an additional 25 districts.

2. Information, education and communication (IEC) campaigns on malaria prevention and treatment

Mass media campaigns will be conducted through television, radio, print and folk media to educate the community on the prevention and treatment measures being undertaken by MoH and partners. Specific activities will include the development and distribution of posters, brochures and leaflets; development and dissemination of guidelines on case management,

job aides for IPT, voucher scheme, and net treatment; development and broadcasting of TV and radio spot messages; and the formation of drama and folk media groups to disseminate information to gatherings and audiences.

3. **Interpersonal communication at the community level, through community based organizations, networks and operations.**

With support from the Global Fund, information on malaria prevention and treatment will also be disseminated through more direct, inter-personal communication strategies. This will involve community groups coordinating activities including house-to-house campaigns, meetings, gatherings and conducting workshops and seminars for opinion leaders.

Objective 5:	To improve community access to malaria control and prevention information				
Broad activities	Process/Output indicators **(indicate one per activity) (Refer to Annex II)**	Baseline	Targets		Responsible/Implementing Agency or agencies
		2001	2003	2004	
Establishment of ITN advocacy groups	**No of districts where ITN advocacy groups established**	**15**	**25**	**40**	**MoH, PSI, AMREF, World Vision**
IEC campaign for prevention treatment of malaria	**% of households receiving targeted messages through mass media**	**<5%***	**40%**	**60%**	**MoH, PSI, ECPO**
Inter-personal communication at community level through local CBOs	**% of individuals who have received information through CBO networks.**	**0**	**30%**	**45%**	**MoH, MAP**

*Source: MoH 2002

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (Guidelines para. III.41 – 42),(2–3 paragraphs):

Between 1998 and 2000, the Government of Kenya led a process of consultation with partners and stakeholders from the public, private, NGO and donor community to reach consensus on development of a National Malaria Control Strategy. The National Malaria Strategy document (2001–2010) provides an institutional framework to co-ordinate stakeholders' efforts, strengthen partnerships and focus national commitment.

The National Health Sector Strategic Plan (1999-2004) provides the framework for decentralized health services. Malaria prevention and treatment have been identified as

priority packages within this NMS Strategic Plan, the Kenya Health Policy Framework (1994), and the National Interim Poverty Reduction Paper (2000–2003).

Currently there are many players in the Kenyan health sector that operate on annual plans, including, GoK, NGOs, religious organizations, the private sector and civil society. To date, the efforts of malaria control activities by MoH and other implementing partners have been fragmented and uncoordinated. To implement the National Malaria Control Strategy, MoH, together with partners and with support from RBM/HQ and AFRO, has developed 13 district-integrated plans of action and six divisional plans. These plans have been consolidated into a single National Business Plan, in which the JICC has identified priority activities that require support from the GFATM. The Business Plan identifies malaria activity coordinating mechanisms and will bring on board implementing partners including JHPIEGO, PSI and AMREF to participate, particularly in areas of their expertise. PSI has been supported by DFID to carry out social marketing of ITNs nationally, with a focus on rural, endemic areas. Nets are currently accessible at the community level through commercial outlets at subsidized prices. In order to further target especially vulnerable groups directly, with support from the Global Fund, a national voucher system will be implemented in order that these groups will access ITNs at an even greater subsidy. These activities identified for GFATM support will assist the scaling-up of effective interventions that will be rolled out to the districts through the National Health Sector Strategic Plan.

Significant resources for the implementation of interventions are now being mobilized to finance the operational plans of all stakeholders and the strengthening management systems. There are, however, substantial gaps in the resource packages available to partners. To guarantee optimization of operational plans and scale-up interventions in support of the National Malaria Strategy, additional resources are required. This proposal, therefore, is made to request additional resources to address the funding gaps in the priority activities set out in section 24 and complement scaling-up of interventions currently being undertaken by all partners.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

Within the GoK malaria control programme there are no specific strategies targeting people living with HIV/AIDS (PLHA). With support from the Global Fund, a number of partners will target PLHA for malaria prevention. The activities of several of the NGOs included in the Malaria Component directly involve PLHA. Among these, International Community for the Relief of Starvation and Suffering (ICROSS) targets PLHA for special inclusion in malaria prevention activities. Through social marketing and use of vouchers, ICROSS will scale-up ITN coverage of PLHA from 4,500 to 27,000 in the next six years. It will also ensure that this particularly vulnerable group is adequately supplied with anti-malarial drugs. Aid Africa Concern (AAC) will expand its activities that centrally involve PLHA in accessing ITNs. Empowering Community Perceptions Organization (ECPO) will scale-up its malaria control activities that include children orphaned by AIDS, who will also receive ITNs through the proposed voucher system. The Christian Children's Fund (CCF) currently works with orphaned children and youth in their integrated HIV/malaria projects and will expand their support groups and counseling of PLHA as part of ongoing malaria activities.

29.2. Community participation:

Together with NGOs and multilateral organizations, GoK supports community level Bamako Initiative projects, in the local production and distribution of ITNs and provision of 1st line anti-malarials. MoH's shopkeeper training programme, community awareness campaigns, school health programmes and stakeholder forums will be expanded to encourage community awareness-raising and participation in malaria control. AMREF will expand up its "Neighbour to Neighbour" strategy, which directly involves the community in disseminating sound information about malaria control and treatment throughout villages. Guided area competitions, involving villages composing songs, short plays and poems about malaria prevention and control, bring smaller communities together in sociable and entertaining activities. AMREF will strengthen village health committees and parent–teacher associations to engage communities in the selection of key malaria control behaviours for promotion. Merlin will strengthen training of CHWs, TBAs and other community members, to scale-up local participation in malaria activities. Additionally, Merlin will extend its promotion of insecticide re-treatment of nets. World Vision Kenya (WVK) will scale-up its community mobilization and health education campaigns and address malaria through local community groups. In this way, ITN committees will be formed to establish local net treatment stations. Coverage of CCF's six-monthly community net re-treatment days and local ITN production will be also expanded. The National AIPCA Health and Welfare Organization (NAHWO) will strengthen advocacy of malaria prevention and appropriate treatment within the community, by expanding the training of community-based health workers in the surveillance and intervention of untreated local malaria cases. The Kenya Red Cross Society's (KRCS) well-developed community volunteer network will be scaled-up to expand social mobilization to encourage communities to benefit from local BI community pharmacies for the management of suspected malaria and other illnesses. KRCS also involves the community in RBM activities through social marketing of ITNs and advocacy through IEC materials.

29.3. Gender equality issues (Guidelines paragraph IV.53):

GoK will expand its initiative to promote youth-friendly services, which target and empower female youth in IPT and other reproductive health services. It also encourages male advocacy of prompt female treatment in cases of suspected malaria. In Bungoma district, AMREF is promoting female development by encouraging women and youth groups in managing 40 ITN distribution outlets. Participatory approaches will be used to identify appropriate roles for women in planning interventions. Women and out-of-school youth will form the principal focus of KRCS's integrated club activities. NAHWO will expand its policy of preferentially recruiting women as CBHW and mobilization of local women's groups on malaria control and woman-to-woman dissemination of information about malaria. Scaling-up of these activities will further promote female autonomy and support gender equity. Merlin will contribute to female empowerment by training mothers and child carers in malaria diagnosis and treatment. Certain NGOs are also addressing the common situation of men using households' single ITN. PSI will expand its media campaign that promotes the use of ITNs among pregnant women and children. CCF will scale-up addressing gender inequality in ITN protection, by expanding its programme of ensuring each home has a minimum of three nets. It will also expand its campaign of female genital mutilation awareness-raising,

which is integrated with malaria activities. CCF will also expand its malaria coverage gender bias, which currently targets 60% females in its activities and scale-up its Girl Child project.

29.4. Social equality issues (Guidelines paragraph IV.53):

By scaling-up ongoing activities in slum areas of Nairobi, AAC will specifically address malaria control, prevention and treatment among the displaced and disadvantaged urban poor. Community health workers and their supervisors will be trained to meet the needs of this excluded group. The Kenya Red Cross and NAHWO will expand their community-based support of marginalized people to access health and welfare support during illness. CCF will scale-up its integrated health activities among the youth of marginalized groups in both urban and rural areas using games and mass media campaigns. The Kenya Red Cross will simplify and translate into variety of Kenyan languages its posters, brochures and fliers on malaria to include all communities in RBM initiatives. PSI, on the basis of its experience in social marketing ITNs nationally, will address the inclusion of disadvantaged groups, particularly pregnant women and children under five, in malaria prevention by developing a voucher subsidy system to ensure net coverage. Working in partnership with community groups and other NGOs including BI, PSI will develop increased subsidies on ITNs through the proposed voucher system. GoK and certain faith-based organizations will make public facilities available to support the initiation of a voucher system to subsidize ITNs.

29.5. Human resources development:

GoK supports NGO training of HWs in arid and semi-arid lands, private and mission hospitals through MEDS. In line with the National Malaria Control Strategy, AMREF will train shopkeepers, tutors, school inspectors and education officers to develop skills in identifying malaria and correctly dispensing appropriate medication and advice to the communities they serve. Schools will use folk media to further disseminate malaria control information. NAHWO will expand existing community-based seminars and workshops for training CBHWs. CBHWs will then train the community to further disseminate information about malaria prevention and control, including the treatment of nets. Health workers are also trained in IPT by AMREF. AAC will scale-up its activities to provide training in business administration and financial systems among the urban poor. As a part of their malaria activities, ECPO and CCF will expand training of orphaned children in malaria control and facilitate child-to-child information dissemination. CCF will scale-up training of its national staff, project personnel, stakeholders, collaborators and shopkeepers in National Malaria Strategy, expanding BI coverage and counselling. AMREF, in partnership with other stakeholders including MoH, ICIPE and NGOs, Merlin, WVK and PSI, will train clinicians and laboratory technicians, Bamako Initiative staff, shopkeepers and teachers in national guidelines for malaria control. JHPIEGO, working in partnership with MoH and other NGOs, will build upon its experience of disseminating national guidelines on the use of IPT and will strengthen the skills of DHMT and DTC trainers. In the private sector, Syngenta Ltd, having trained over 500 MoH Public Health Officers to date, will continue to assist in the process of training trainers to incorporate communities in rolling back malaria. Syngenta has committed to community-based training in insecticide treatment of nets and working in partnership with MoH on a malaria awareness-raising campaign. ICROSS will train community health workers and traditional healers in the special provision of malaria control services to PLHA.

Additionally, PLHA themselves will be trained in health promotion and the prevention of malaria.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), (Guidelines para. IV.55), (1–2 paragraphs):

Anti-malarials for case management.

According to national guidelines, SP is the 1st line treatment drug, given as a single dose in cases of uncomplicated malaria. For treatment in cases of failure of the 1st line drug, Amodiaquine is the 2nd line treatment drug, taken for three consecutive days. Quinine is the 1st line treatment drug for severe and complicated malaria, administered parenterally until the patient is able to take oral preparations.

Anti-malarials for IPT

SP is the drug of choice for the prevention of malaria during pregnancy. This is administered as an intermittent presumptive treatment (IPT), given as a single oral dose during the 2nd and 3rd trimesters.

Ensuring rational use of anti-malarials

To ensure adherence to national guidelines on case management and IPT, a reviewed version of the current guidelines will be disseminated to all health workers. Health workers will be given regular updates on the rational use of drug therapies set out in the guidelines.

Monitoring of resistance

The quality of drugs in use will be determined by the National Quality Control Laboratories through batch testing of samples collected from commercial outlets and GoK procured stocks. To determine levels of parasite resistance to 1st and 2nd line treatment drugs, drug sensitivity testing will be carried out annually in each of the eight sentinel sites, by the East African Network on Monitoring Anti-malarial Therapy (EANMAT). Reports from monitoring activities will be used to make decisions on drug policy changes and choices of appropriate drugs for malaria treatment

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to Guidelines paragraph V.56 – 58):

Table V.30

Malaria Budget By GF Categories Figures in thousands of USD						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Totals**
Human Resources	120.00	-	-	-	-	120.00
Infrastructure/Equipment	-	-	-	-	-	-
Training/Planning	1,965.90	2,181.90	2,343.90	2,343.90	2,190.30	11,025.90
Commodities/Products	943.00	1,993.00	2,693.00	3,443.00	4,193.00	13,265.00
Drugs	835.00	835.00	835.00	835.00	835.00	4,175.00
Monitoring & Evaluation	140.00	140.00	140.00	100.00	100.00	620.00
Administrative Costs	600.59	772.49	901.79	1,008.29	1,097.75	4,380.89
Totals	**4,604.49**	**5,922.39**	**6,913.69**	**7,730.19**	**8,416.05**	**33,586.79**

The budget categories may include the following items:
Human Resources: Consultants, recruitment, salaries of front-line workers, etc.
Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.
Training/Planning: Training, workshops, meetings, etc.
Commodities/Products: Bednets, condoms, syringes, educational material, etc.
Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.
Monitoring & Evaluation: Data collection, analysis, reporting, etc.
Administrative: Overhead, programme management, audit costs, etc
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	**Unit cost** (USD)	**Volume** (specify measure)	**Total cost** (USD)
1st line anti malarials: SP	20 per tin of 1000 tablets	5 million doses (15,000 tins)	300,000
2nd line anti-malarials: Amodiaquine	15 per tin of 1000 tablets	1 million doses (9000 tins)	135,000
Quinine IM/IV	125 per 1000 ampoules	2,000,000 ampoules	250,000
IMCI kits	1,500 per kit	150kits	225,000
Vouchers for ITNs	2 per package	350,000	700,000
Vouchers for net re-treatment	1 per package	350,000	350,000
Guidelines	1.6 per copy	5,000	8,000
IEC materials	0.5 per copy	20,000	10,000

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

Human resources contribute less than 1% to the total budget.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (Guidelines para. V.62)**:**

Table V.31.1

	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Domestic (public and private)			3,950,584	1,884,533	1,880,895	1,722,325	1,722,629
External			600252	600252	600252	600252	600252
Total			**4,550,836**	**2,484,785**	**2,481,147**	**2,322,577**	**2,322,881**

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

Please see Malaria-Specific Attachment #4, "Detailed Budget"

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage (Refer to Guidelines para. V.63):

Table V.33

Resource allocation to implementing partners* **(%)**	**2003**	**2004**	**2005 (Estimate)**	**2006 (Estimate)**	**2007 (Estimate)**	**Total**
Government	40%	38%	37%	37%	38%	
NGOs / Community-Based Org.**	60%	62%	63%	63%	62%	
Private Sector	0.0%	0.0%	0.0%	0.0%	0.0%	
People living with HIV/ TB/ malaria	0.0%	0.0%	0.0%	0.0%	0.0%	
Academic / Educational Organizations	0.0%	0.0%	0.0%	0.0%	0.0%	
Faith-based Organizations	0.0%	0.0%	0.0%	0.0%	0.0%	
Others **(please specify)**	0.0%	0.0%	0.0%	0.0%	0.0%	
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in thousands of USD	4,604.49	5,922.39	6,913.69	7,730.19	8,416.05	33,586.79

*These figures are extrapolated from the overall detailed budgets, apportioning a percentage of individual budget lines to different implementing partners. **Includes faith-based organizations.

*** If there is only one partner, please explain why. Please note: The following three sections (VI, VII and VII) are all related to proposal/component implementation arrangements.**

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. **Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), (Guidelines para. VI.64),(1–2 paragraphs)**:**

NOTE: These arrangements are discussed in SECTION VI of HIV/AIDS Component and are generic to the overall proposal.

SECTION VII – Monitoring and evaluation information

37. **Outline the plan for conducting monitoring and evaluation including the following information**, (1 paragraph per sub-question).

    37.1. **Outline of existing health information management systems and current or existing surveys providing relevant information** (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (Guidelines para. VII.76)**:**

The MoH Health Management Information System (HIMS) collects data on routine activities from all health service delivery points. These data are reported monthly to the central level and analyzed annually. At present the HMIS is not operating optimally and the annual reports for recent years have often been published late. There is also a lack of functional feedback of analyzed data to peripheral health units. Monitoring and evaluation data for district RBM activities are collected from four sentinel sites, representative of different malaria epidemiological zones. Data collection methods for M&E currently include: clinical audits; health facility surveys; community surveys and district malaria situation analyses. Information on parasite sensitivity to 1st and 2nd line anti-malarials in use is conducted annually in eight sentinel sites by EANMAT. Other partners including AMREF, KEMRI and CDC are also undertaking similar activities in other areas of Kenya.

The Kenya Demographic and Health Survey is conducted every five years and provides health statistics on mortality and fertility rates, patterns of utilization of health services and common diseases that are perceived by the community to be of public health importance.

    37.2. **Suggested process, including data collection methodologies and frequency of data collection** (e.g., routine health management information, population surveys, etc.)**:**

	M&E Activity	Type of Data	Source	Frequency	Remarks
1	Disease burden	Morbidity & mortality	Health facility	Monthly reports	Returns from peripheral health below 60% in most districts
2	Community surveys	ITN utilization rate Case management at HH level IPT use	Community	Once	Baseline concluded 2001, Repeat in 2004
3	Health facility audits	Categories of facilities Types of services offered Quality of services.	Health facility	Once	Baseline concluded 2001, Repeat in 2004
4	Anti-malarial drug sensitivity tests	Resistance levels	Health facility in sentinel sites	Annual	Data used for making decisions on choice of drugs for use.
5	Anti-malarial drug quality analyses	Quality of 1st & 2nd line anti- malarials in use	Health facility & commercial outlets	Annual	National drug quality control laboratories
6	District level operations Monitoring	District implementation levels. HMIS functioning levels Capacity-building at district level	Health facility	Bi-Annual	Conducted by central level divisions
7.	Audit of district operations	Effectiveness of operations Efficiency service delivery	Health facility	Quarterly	Conducted by the provinces
8.	Structured evaluation of planned activities	Programme achievements	Health facility & community	Biennial	Central level through independent evaluator
9	Demographic surveys	Mortality rates, common diseases Fertility rates Utilization of health services	Community	5 years	Conducted country wide

37.3 Timeline:

	M&E activity	Type of data	Timeliness				
			2002	2003	2004	2005	2007
1	Routine data collection on disease burden	Morbidity & mortality					
2.	Community surveys	ITNs utilization rate Case management at HH level IPT use					
3.	Health facility audits	Categories of facilities Types of services offered Quality of services.					
4.	Anti-malarial drug sensitivity tests	Resistance levels					
5.	Anti-malarial drug quality analysis	Quality of 1st & 2nd line anti-malarials in use					
6	District level operations monitoring	District implementation levels. HMIS functional levels Capacity building					

7.		District level operations auditing	Effectiveness of operations Efficiency service delivery
8.		Structured evaluation of planned operations	Programme achievements
9		Demographic surveys	Mortality rates, common diseases Fertility rates Use of health services

37.4. Roles and responsibilities for collecting and analyzing data and information:

The Central Bureau of Statistics conducts demographic health surveys every five years. As part of this process, health data, specifically on malaria control and prevention behaviours, are collected for the nation as a whole. Health data concerning malaria are also collected at service delivery points by public, faith-based and private health institutions including, AMREF, Kenya Red Cross, ECPO, NAHWO, CCF, WVK and JHPIEGO. Under MoH regulations, all such data should be forwarded to the central level. The most active institutions adhering to this process are the public and faith-based organizations. District headquarters should receive monthly reports from all health facilities within the district, from which reports are compiled and forwarded to the Health Management Information System at central level for analysis. However, the rate of data submission by peripheral institutions varies between 40 and 60% at present.

Using RBM M&E surveys (household surveys, health facility and service provider audits) data on the level of implementation of malaria control activities are collected by the central level divisions, in collaboration with partners including the Welcome Trust Laboratories, universities and private research organizations such as Research Solutions and Informatica. As DOMC has not developed the capacity for M&E data analysis, MoH contracts out this responsibility to competent partners and institutions. Analyzed M&E data are fed back for use to MoH and disseminated to other concerned partners and stakeholders. The Integrated Disease Surveillance and Response Unit will collect data from health institutions on the incidence of selected diseases of public health importance, especially those associated with epidemics and diseases targeted for elimination.

DOMC through EANMAT is responsible for testing the sensitivity of *P. falciparum* to 1st and 2nd line anti-malarial drugs and disseminating the information to partners and stakeholders. The National Drug Quality Control Laboratories, in collaboration with DOMC, tests the quality of 1st and 2nd line anti-malarial drugs in use and informs MoH of its findings.

37.5. Plan for involving target population in the process:

Community members actively collect information on malaria control activities in their own communities. This is stored in registers maintained at health outlets, including: community pharmacies forming part of the Bamako Initiative; records of consultations kept as a legal requirement by traditional healers; and records tracking commodities maintained by community health workers.

Community pharmacies will be scaled-up to provide additional sources of information on community-based malaria control activities. Communities will also be actively involved in in-

depth surveys, both in the data collection process and in providing information through focused group discussions, household surveys and exit interviews carried out as clients leave health outlets.

37.6. Strategy for quality control and validation of data:

Quality control will be carried out through the adoption of established generic data collection tools that will be adapted by key MoH divisions for local application. Some of the data collection processes, such as focused group discussion, will use locally developed tools, appropriate for individual communities. The overall data collection process will be standardized to ensure that all partners use the same tools and procedures to produce data of consistent quality. Data management will be strengthened at the district level through capacity-building to improve the quality of data collection methods, data storage and retrieval, and the timeliness of monthly reporting. Data received at the central level will then be analysed using internationally recognized statistical methods and packages.

37.7. Proposed use of M&E data:

M&E data will be used for policy formulation, planning and re-planning processes and to improve management efficiency. Health audit data will provide information on the quality of services provided by health outlets. Community survey data will be used to determine the impact of malaria control activities on target groups. Health data from the five-yearly demographic surveys will be used to provide information on malaria control knowledge, attitudes and practices, together with the level of access to and utilization of health services.

Data generated by drug sensitivity testing carried out by EANMAT will be used to review drug policy on the most appropriate 1st and 2nd line anti-malarials to be recommended nationally.

Epidemiological data from epidemic detection sites will be correlated with meteorological data to predict potential epidemic outbreaks. In this way, the country will be prepared for the early detection of epidemics and in a position to mobilize epidemic containment measures.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may Help in Strengthening M&E capacities)	**Resources Required** (USD)					
		Year 2002	**Year2003**	**Year 2004**	**Year 2005**	**Year 2007**	**Total**
1. Expansion of the RBM M&E sentinel sites from 4 to 8	DOMC/Welcome Trust/KEMRI						**122,000**
2. Drug quality testing	NQCL						**77,284**
3. Drug sensitivity testing and policy review	EANMAT/ KEMRI/ universities						**256,412**
4. Baseline data collection at the district level	DFID/WHO/ private sector						**269,231**
5. Training central staff in development of data collection tools & use of statistical packages	WHO/Welcome Trust/KEMRI						**83,077**
Training district staff in data management	WHO/Welcome Trust AMREF						**301, 731**
6. Vector resistance monitoring	KEMRI/ICIPE/ Universities/PSI						**76,923**
7. Strengthening district capacity to process HMIS data	Welcome Trust/ AMREF/WHO						**144,230**
8. Establishment of M&E networks	KEMRI/ICIPE/ Universities/ Welcome Trust/ Meteorological Department/PSI AMREF						200,000
Combined research to support M&E	KEMRI/ ICIPE/Universities /AMREF/Welcom e Trust						670,769
Total requested from Global Fund		**0**	**0**	**0**	**0**	**0**	**0**
Total other resources available		**67,308**	**808,356**	484,433	**442,895**	442,895	**2,201,655**

SECTION VIII – Procurement and supply-chain management information

39.Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to Guidelines paragraph VIII.86)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified? - Calls for tender are advertised in print media locally and internationally. Bidders are invited to attend the public tender opening session, after which tenders are submitted to the MoH tender board for evaluation	- Departments requiring bulk items such as rural health facility drug kits, microscopes & laboratory reagents provide specifications and quantities to the MoH for tendering - Items are procured centrally through a competitive tendering system, operated by the Treasury and MoH ministerial tender boards, stored and distributed by KEMSA to district depots. Districts then distribute to the peripheral health units - Small quantities of nets, net treatment kits, supplementary drugs, & IEC materials are procured by divisions through quotations.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations? The MoH Tender Board evaluates bidders' samples, letters of appointment as distributors, product literature, price & delivery time of the items: The Tender Board also gives recommendations for potential bidders. MoH Tender Board recommendations are verified by the Treasury Tender Board that awards tenders to appropriate bidders.	- Tender Boards incorporate secretariats composed of senior technical specialists, supplies officers & finance officers. Departments requiring items also form part of the Tender Boards. The Secretariat convenes meetings and invites members to deliberate on the tender documents
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective? Items such as drugs must be registered by the Drug and Poisons Board after successful trials of their efficacy. Storage period of the items are specified and specifications for equipment are given to ensure safety, effectiveness and durability	Tender bids are submitted with samples and literature for evaluation by the technical specialists to ensure they conform to national specifications and standards. Batch samples from supplied items may be submitted to the Kenya Bureau of Standards for efficacy testing.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply? The receiving body KEMSA, distributes bulk supplies to district depots. The districts distribute supplies to the peripheral health facilities. Product diversion is minimized by carrying out annual audits of products received. A schedule of deliveries to the depots minimizes interruption of supplies.	External auditors conduct regular physical audits on received products & issuance records & a report to the ministry accounting officer.

40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

NOTE: A generic procurement methodology will be utilized for all components, and is referenced as General Attachment #10.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

General Attachment #10 discusses required systemic strengthening of procurement, and the budget for same is included in the HIV/AIDS component.

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (Guidelines para. VIII.88):

The Kenyan National Malaria Control programme has no outstanding applications for products from any other sources.

Table VIII.42

Programme name	**Contact person (with telephone & email information)**	**Resources requested (R) or granted (G)**	**Timeframe and duration of request or grant**

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

As the Kenyan National Malaria Control programme has no outstanding applications for products from any other sources, the Global Fund will be the primary source of support for anti-malarial products. In this proposal, support is requested from the Global Fund for 1st and 2nd line anti-malarials for case management, IPT drugs for malaria in pregnancy and supplementary drugs for IMCI.

Malaria specific documentation:	Attachment #
1. Situation analysis	1
2. Baseline data for the tracking of progress	-
3. Country strategic plan to Roll Back Malaria, with budget estimates	-
4. Result oriented plan, with budget and resource gap indication (where available)	1
General documentation:	**Attachment #**
JICC (CCM) Minutes	1
National Economic	2
National Health Sector Strategic Plan	5
Proposed Fiduciary Arrangement	6
Procurement Guidelines	7
Legal Notice	8
HIV/AIDS specific documentation:	**Attachment #**
Guidelines for VCT	1
Guidelines for ARV Therapy	2
Standarized ARV Regimen for Kenya	3
AIDS in Kenya	4
Legal Notice # 170	5
Sessional Paper No. 4 of 1997	7
National Condom Policy & Strategy	8
National Home-Based Care & Service Guidelines	9
National Guidelines on Blood Transfusion in Kenya	10
Clinical Guidelines for MTCT	11
JAPR Final Report	12
NGO & Civil Society in Kenya	13
HIV/AIDS Detailed Budget	14
Strengthening testing Capabilities	15
TB specific documentation:	**Attachment #**
NGO Proposals	2
Budget Justifications	3
Malaria specific documentation:	**Attachment #**
Malaria Detailed Budget	2
NGO Proposals	3