KENYA ROUND 7 PROPOSAL

in response to

7TH CALL FOR PROPOSALS

Applicant Name	**Country Coordination Mechanism**
Country/countries	**Kenya**
Components included in this Proposal Form	
☒ HIV/AIDS	
☒ Malaria	

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PROPOSAL SECTIONS FOR COMPLETION BY ALL APPLICANTS

ATTACHMENTS

1 Proposal Overview

1.1 General information on proposal

Applicant Type	
☒	**National Country Coordinating Mechanism**
☐	Sub-national Country Coordinating Mechanism
☐	Regional Coordinating Mechanism (including small island developing states)
☐	Regional Organization
☐	Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)		
	Component	**Title**
☒	HIV/AIDS	**Improvement of the quality of life of People Living with HIV and AIDS and reduction of HIV infections**
☒	Malaria	**Scale up of Malaria prevention and treatment interventions**

Currency in which the Proposal is submitted	
☒	**US$**
☐	Euro

1 Proposal Overview

Summary of Technical Assistance Provided During Proposal Preparation		
Section/Component	**Name of organization or organizations providing assistance and type of assistance provided**	**Duration of technical assistance**
☒ Sections 1 to 3B	UNAIDS Technical Services Facility for East Africa – provided funding for the proposal manager to oversee and provide leadership for the proposal development process	50 days
☒ HIV/AIDS component, and/or budget	IntraHealth/Capacity Project - Funded two consultants to develop the HIV and AIDS component proposal IntraHealth/Capacity Project -Co funded the Independent Review Panel to assess the CSOs, FBOs and Private Sector Organisations Expressions of Interest NACC co funded the Independent Review Panel to assess the CSOs, FBOs and Private Sector Organisations Expressions of Interest	62 days 5 days 5 days
☒ Malaria component, and/or budget	Management Sciences for Health – provided funding for one consultants to develop the Malaria component proposal World Health Organisation – funded one consultant to develop the Malaria component proposal	30 days 30 days

Table 1.2 – Total funding summary

Component	Total funds requested over proposal term					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
HIV/AIDS	21,042,109	26,103,803	28,352,985	28,146,620	28,624,266	132,269,783
Malaria	9,977,877	8,006,055	22,032,328	9,134,386	9,863,544	59,014,190
Total all components	**31,019,986**	**34,109,858**	**50,385,313**	**37,281,006**	**38,487,811**	**191,283,973**

1.3 Contact details for enquiries by the Global Fund

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	**Secondary contact**
Name	Dr Mutile Wanyee	Dr Hezron Nyangito

1 Proposal Overview

Title	CCM Secretary	CCM Chairman
Organization	Kenya CCM Secretariat	Kenya CCM
Mailing address	P.O. Box 30016, Nairobi	P.O. Box 30016, Nairobi
Telephone	+254-20-2738704	+254-20-2714467
Fax	+254- 20-2738704	+254-20-2713234
E-mail address	mutilewanyee@yahoo.com	psmoh@africaonline.co.ke
Alternate e-mail address	wanyee@health.go.ke	ps@health.go.ke

1.4 Overview Summary of the Applicant's Proposal

This proposal comprises two components: HIV and AIDS and Malaria. The two components are based on a comprehensive gap analysis and have linkages to on going programmes funded by Global Fund and other partners. The components fit within the national strategic frameworks for HIV and AIDS and Malaria and are aligned to the national strategies for controlling the two diseases.

Both components will be implemented through a partnership of Government and Non-Government Organisations. The Non-Government organisations to implement the proposal were selected using a transparent, objective and open tendering process and are already integrated in the proposal.

The proposal will be managed by two principal recipients: Ministry of Finance for the government institutions and Care International in Kenya for the non-government institutions.

Highlights of the two proposals are presented below:

1. HIV and AIDS component: The HIV and AIDS proposal aims at improving the quality of life of PLWHAs and prevention of new HIV infections. The proposal will provide ARVs, nutrition, OI prophylaxis and counselling and testing services. These core service delivery areas will be supported by strategic communication.

The HIV/AIDS component has four objectives:

1. To scale up and maintain PLWHAs on ART: The proposal will put on ART 20,264 new patients and additional 42,500 patients currently supported by GF Round 2 grant.
2. To increase access to HIV counselling and testing services: 139,611 HIV test kits will be provided to complement the on-going CT programmes by end of proposal term.
3. To increase uptake of HIV prevention and treatment services: This will be achieved through strategic communication aimed at creating demand for the services.
4. To strengthen institutional capacity to effectively implement and monitor HIV/AIDS services: This proposal will address some of the challenges facing Kenya in M&E for HIV/AIDS programmes. The national M&E system and NASCOP M&E sub system as well as programmatic M&E systems for the PRs will be strengthened to improve performance monitoring and reporting on the HIV and AIDS programmes.

2. Malaria component: The Malaria proposal aims at scaling up on-going prevention and treatment services by building on the current successes. The goal of this proposal is to reduce malaria morbidity and mortality. Key objectives to be achieved include:

1. To scale up insecticide treated nets coverage among vulnerable groups
2. To improve malaria case management
3. To promote behaviour change communication for malaria prevention and treatment

1 Proposal Overview

1.6 Previous Global Fund grants/proposals recommended for funding

Table 1.6.1 – Previous Global Fund HIV/AIDS financial support

HIV/AIDS	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	0.00	0.00	
Round 2	26,365,987.00	26,365,987.00	
Round 3	0.00	0.00	
Round 4	0.00	0.00	
Round 5	0.00	0.00	
Round 6	0.00	0.00	
Total	**26,365,987.00**	**26,365,987.00**	

Table 1.6.3 – Previous Global Fund malaria financial support

Malaria	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	0.00	0.00	
Round 2	4,640,447.00	4,640,383.00	
Round 3	0.00	0.00	
Round 4	52,188,969.00	46,998,346.00	
Round 5	0.00	0.00	
Round 6	0.00	0.00	
Total	**56,829,416.00**	**51,638,729.00**	

2 Country Eligibility

2.1 Income Level

World Bank classification of Income level of countries/ economies included in proposal	Country/economy name	
☒ Low-income	Kenya	➔ *Go straight to **section 3A**, Applicant Type*

3A Applicant Type and Eligibility for Funding

Confirmation of Applicant Type

Table 3A – Applicant Type

☒	**National Country Coordinating Mechanism**	➔ *Complete sections 3A.1 and 3A.4 and 3B.1*

3A.1 National Country Coordinating Mechanism (CCM) Applicants

Table 3A.1 – National CCM: overview information

Name of CCM
Kenya Country Coordinating Mechanism

3A.1.1 Mode of operation

The extent to which the CCM acts as a functional partnership between government and other key stakeholders

The Kenya Country Coordinating Mechanism (CCM) was formed in 2001 and, since then, it has evolved into a truly multi-sectoral partnership committee. The CCM's mandate is to discuss, approve and submit proposals to the Global Fund and to monitor, guide and support the implementation of financed projects.

Composition

The membership of the Kenya CCM has evolved over the years in an effort to ensure wide inclusion and participation of stakeholders; starting with an initial number of 36 and currently stabilizing at 26 voting member organisations and 26 alternate organisations. Members are drawn from the Government of Kenya, Development Partners, Non-Government Organisations, Communities, Faith Based Organisations, Private Sector, Professional Associations, Research Sector and Universities. The CCM has taken proactive measures to ensure membership reflects gender balance, representation of rural areas or cities other than Nairobi and at-risk communities.

Each sector selects its representative organisation to the CCM using their selection process. However, the process has to be transparent, inclusive and based on clear criteria.

Structure

The structure of the CCM consists of a Chairperson from a GoK organisation and a Vice Chairperson from non-GoK organisation. The CCM standing and ad hoc committees which implement specific tasks. Standing committees have an indefinite timeframe and ad hoc committees are task oriented and serve for a limited time. The CCM also assigns specific Global Fund related roles and responsibilities to GoK led Interagency Coordinating Committees (ICCs) for Malaria, TB and HIV/AIDS, Health Systems. Kenya CCM has established a secretariat to facilitate the functioning of the CCM. The secretariat facilitating work planning, operationalisation of CCM decisions and information sharing among CCM members.

The diagram showing the interrelations between all actors involved in Global Fund grants in the country is included in the Governance manual annexed to this proposal.

Decision making

The CCM decision making processes and procedures are clearly outlined in the Governance Manual. Decisions are made by consensus wherever possible and, where necessary, by voting. CCM holds four general meetings and special meetings when necessary. In between meetings, decisions are made by the CCM chair following laid down regulations. These decisions are reviewed by the CCM and members have a right to over-rule such decisions. Each representative is accountable to his/her constituency through consultations and reporting.

3A Applicant Type and Eligibility for Funding

Programme Implementation oversight

The Kenya CCM has developed an elaborate oversight function for the GF grants whose implementation has commenced with the on-going grants. The Principal Recipient is appointed afresh for every GF grant application. CCM plays specific oversight roles to guide grant implementation including ensuring PRs have efficient, transparent and accountable mechanisms for grant management; monitoring and evaluating the PR, approving any major changes to the programme implementation plans proposed by the PR and reviewing reports to be sent to the Global Fund among other roles.

How CCM Coordinates its activities with other national structures

CCM works closely with the National AIDS Control Council and Ministry of Health to develop proposals for Global Fund. Programmatic and financial gaps are identified within the framework of the National HIV/AIDS Strategic Plan and National Malaria Strategy and Business Plan. The interventions and strategies are guided by the National Strategic Plans and policies for specific technical areas. The CCM monitors and evaluates the GF grants within the structures of the national M&E frameworks for HIV and AIDS and Malaria. Officers implementing these M&E systems collect data and report on the utilisation of the Global Fund grants.

3A.4 Functioning of Coordinating Mechanism (CCM, Sub-CCM and RCM Applicants)

3A.4.1 Round 6 Application History

Table 3A.4.1 – Applicant's Round 6 Application History

☒	Applied in Round 6 **and** determined as having met the minimum requirements for Round 6	➔ ***Complete section 3A.4.2 and*** *each of* ***Requirements 3(a), 3(b), 4(a) and 5(a)*** *within sections* ***3A.4.5 and 3A.4.6.***
☐	Did not apply in Round 6 **or** determined ineligible in Round 6	➔ ***Complete*** *sections 3A.4.2 to 3A.4.6* ***inclusive****.*

3A.4.2 Changes in CCM, Sub-CCM or RCM from Round 6 Application

The CCM reviewed of the Global Fund management architecture for Kenya in 2005. The Committee has been and is still continuing to implement the recommendations of the reviews. By the time the CCM submitted the Round 6 Proposal in 2006, it has established a Task Force – referred to as the Transition Team - to lead the process of implementing the recommendations of the reviews. The transition team developed an action plan which was agreed on by the CCM and which is currently being implemented. The following milestones have been achieved through the implementation of this action plan.

Revision of the Governance Manual: The CCM Governance Manual has been revised to streamline the committee's operations. The revised manual provides clear procedures and processes for member selection, PR nomination, decision making and identifies the roles of all stakeholders on the CCM. The CCM has adopted the new manual and is currently operationalising it.

Code of Conduct: A code of conduct for all CCM members has been finalized and adopted by members. The code of conduct includes a statement of conflict of interest.

Development of the CCM website: The CCM has established a website to facilitate communication and sharing of information with members and wider stakeholders. The purpose of the website is to enhance transparency and openness of the CCM operations.

Setting up of the CCM secretariat: The CCM set up a secretariat with staff dedicated to its work. The secretariat is being strengthened to improve its performance.

3A Applicant Type and Eligibility for Funding

3A.4.3 Principle of broad and inclusive membership	
(a) Requirement 1 ➔ Selection of non-governmental sector representatives	
Documentation relied on to support compliance with Requirement 1	**Identify which annex to this proposal contains these documents** *Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.*
☒ Selection criteria for each sector developed by each respective sector	Annex 3: Kenya CSOs Elections for Representatives to the Kenya Country Coordinating Mechanism
☒ Minutes of meeting(s) at which the sector transparently determined its representative	Annex 4: Minutes of CCM meeting of 15 February 2007
☒ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	Annex 3: Kenya CSOs Elections for Representatives to the Kenya Country Coordinating Mechanism
☒ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	Annex 6: Letters of inviting CSOs to participate in the regional and national elections meetings
☒ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM.	Annex 5: Advertisements in print media calling for CSOs meetings
☐ Other: *(please specify):*	

(b) Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1
Two sectors - Non Governmental Organisation, People Living or Affected by HIV/AIDS, TB and Malaria - developed a clear criteria and process for selecting representative organisations to the CCM. The selection process was through direct elections. The criteria and process adopted was developed by the sectors themselves and not dictated to by the CCM. The rules and procedures governing the elections were prepared and adopted by members. The elections procedures and mobilisation of members to participate was done through networks and by advertising in the main print media.

3A Applicant Type and Eligibility for Funding

3A.4.4 Principle of involvement of persons living with and/or affected by the disease(s)

Requirement 2 ➔ People living with and/or affected by the disease(s)

Describe the involvement of people living with and/or affected by the disease(s) in the CM.
(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section).

Three members represent people living or affected by HIV and AIDS and TB on the CCM. Two members represent people infected or affected by HIV and AIDS and one member represents people affected by Tuberculosis. These members were elected by the respective sectors.

3A.4.5 Principle of transparent and documented proposal development processes (Requirements 3, 4 and 5)

As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the CM's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting(s) where the CM decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal. We will also review how, during the program term, the CM will oversee implementation.

Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:

Requirement 3(a) ➔ Process to solicit submissions for possible integration into this proposal.

Kenya CCM developed a transparent and widely communicated process for soliciting submissions from civil society, private sector, faith based organisations and other organisations for integration into this proposal. Guidelines, criteria and application forms for the in-country solicitation of proposals were developed and issued to all interested organisations. The request for expression of interest for inclusion in the national proposal was advertised from 10 May 2007 in the main print media and sent out through civil society networks to reach all regions of the country. The application forms would be downloaded from the CCM website. 429 applications were received by close of deadline 24 May 2007. Details of the review of the submissions are provided in section 4.8.3.

Requirement 3(b) ➔ Process to review submissions received by the CM for possible integration into this proposal.

An Independent Review Panel was constituted to review the submissions received by CCM. The panel reviewed submissions using assessment tools developed based on the pre-determined criteria that were circulated to the applicants at the time of advertising. Steps followed in reviewing submissions are as follows:

(i) Systematic and careful documentation of the receipt of submissions by the CCM. Each organisations signed acknowledgement of receipt of its application by CCM.

(ii) Assessment of the capacity of the organisations to ensure they can implement proposed projects effectively

(iii) Assessment of project proposals to identify projects that fit within the objectives and service delivery areas of Round 7 proposal.

Details of the review process are outlined in section 4.8.3.

3A Applicant Type and Eligibility for Funding

Requirement 4(a) ➔ **Process to nominate** the Principal Recipient(s) for proposals.
The Kenya CCM implemented the principal recipient nomination process laid out in the Governance Manual to identify the principal recipients for the Round 7 proposal. Key steps in the process include setting of criteria for selection of the PR, establishing a PR Nomination Committee, Advertising the request of application for PR from eligible organisations, evaluation of applications and final decision by CCM appointment of the PR(s). The CCM appointed two principal recipients for this proposal – Ministry of Finance for funds for the Government Institutions and Care International in Kenya for Non Government Organisations.
Requirement 4(b) ➔ **Process to oversee/review** program implementation by the Principal Recipient(s) during the proposal term.
The CCM has developed specific processes for overseeing programme implementation as outlined in the Governance Manual. The CCM will monitor and evaluate the PRs, review PR reports before submission to Global Fund, approve major changes in the PR programme implementation work plan and make policy decisions to facilitate grant implementation. The CCM has started operationalising these systems. It has evaluated the PR for on-going grants and recommended ways of improving its performance.
Requirement 5(a) ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in the proposal development process.
Kenya CCM developed a documented process for the development of the Round 7 proposal. The documented process laid out elaborate steps to be followed in engaging stakeholders in proposal development and meeting all GF eligibility requirements. Stakeholder were engagement through the Interagency Coordinating Committee meetings, holding of HIV and AIDS and Malaria stakeholders meeting on proposal development and requesting for proposal submissions from organisations. The CCM also widely advertised the proposal development process through the main print media, Civil Society, Faith Based Organisations and Private Sector networks.
Requirement 5(b) ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in grant oversight processes.
The CCM has structures for broad consultation and input by stakeholders in grants oversight outlined in the Governance Manual. Representatives the sectors constituting the CCM send out information and hold periodic consultative meetings with the sector members to discuss grants management and implementation. The representative members discuss and make decisions on the grant management during the CCM general and special meetings. The members receive, review, discuss and approve the PR reports and implementation plans.

3A.4.6	**Principle of effective management of actual and potential conflicts of interest**	
	Requirement 6 ➔ Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No
	If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**.	

3A Applicant Type and Eligibility for Funding

3A.4.7 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM operations? *Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.*	☒ Yes *provide details below* ☐ No *go to section 3B.1*
If yes, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in Section 3A.4.7 of the Guidelines for Proposals. **Applicants must ensure that the amount requested is included in the detailed component budget** (section 5.1) **in a separate identifiable budget line.**	
This proposal request USD 60,000 annually for the first two years of the programme to support the CCM secretariat. This amount is within the limit recommend by CCM and is also within the timeframe recommended for CCM. Kenya CCM has not requested for funding for the secretariat in the past. The cost categories for this request are also within those recommended by CCM.	

3B.1 Coordinating Mechanism Applicants *(CCM, Sub-CCM and RCM)* membership and endorsement

3B.1.1 Leadership of the Coordinating Mechanism

Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information
(Not applicable to Non-CCM and Regional Organization Applicants)

	Chair	Vice Chair
Name	Dr Hezron Nyangito	Rev. Fr. Vincent Wambugu
Title	CCM Chairman	CCM Vice Chairman
Organization	Kenya CCM	Catholic Secretariat
Mailing address	P.O. Box 30016, Nairobi	P.O. Box 13475,00800, Nairobi
Telephone	+254—20-2714467	+254-204443133
Fax	+254- 20-2713234	+254-204442910
E-mail address	psmoh@africaonline.co.ke	health@catholicchurch.or.ke
Alternate e-mail address	ps@health.go.ke	

3A Applicant Type and Eligibility for Funding

3B.1.2 Membership information of CCM, Sub-CCM or RCM

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of CCM, Sub-CCM or RCM		
Sector Representation		**Number of members representing the sector**
☒	Academic/educational sector	1
☒	Government	7
☒	Non-Government Organizations (NGOs)/community-based organizations	3
☒	People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria	3
☒	Private sector	2
☒	Religious/faith-based organizations	4
☒	Multilateral and bilateral development partners in country	4
☒	Other *(please specify):* Professional associations	1
☒	Other *(please specify):* Research sector	1
	Total Number of Members	**26**

3B Proposal Endorsement

3B.1.3 CCM, Sub-CCM and RCM proposal endorsement

Level 1 Endorsement

Level 1 endorsement	Check this box **only** if the CCM, Sub-CCM or RCM has completed the membership details and **members have signed Attachment C** to the Proposal Form	☒

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
Section 3A: Applicant Type and Eligibility for Funding		
Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants)		
3A.1.1 (CCM), 3A.2.1 (Sub-CCM) **or** 3A.3.1 (RCM)	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors).	Annex 1: CCM Governance Manual Annex 2: CCM Code of Conduct
Documentation describing compliance with the minimum Coordinating Mechanism requirements (sections 3A.4.3 to 3A.4.6 inclusive):		
Minimum Requirement 1	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	Annex 3: Kenya CSOs Elections for Representatives to the Kenya Country Coordinating Mechanism Annex 3A: Nomination of CHAK CCM representative Annex 4: Minutes of CCM meeting of 15 February 2007 Annex 5: Advertisements in print media calling for CSOs meetings Annex 6: Letters of inviting CSOs to participate in the regional and national elections meetings
Minimum Requirement 3(a)	- solicit submissions for possible integration into the proposal.	Annex 7: Advertisement of Request for Expression of Interest
Minimum Requirement 3(b)	- review submissions for possible integration into the proposal.	Annex 8: Criteria for establishment of the Independent Review Panel Annex 9: Expression of Interest assessment tools Annex 10: Report of the Independent Review Panel for EoIs
Minimum Requirement 4(a) and 4(b)	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation.	Annex 11: Advertisement of solicitation of applications for PR Annex 12: Minutes of the CCM meeting of 20 June 2007
Minimum	- ensure the input of a broad range of	Annex 13: Invitation letter for HIV and AIDS

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
Requirement 5(a) and 5(b)	stakeholders in the proposal development process and grant oversight process.	stakeholders to attend the proposal development meeting Annex 14: Invitation letter for malaria stakeholders to attend the proposal development meeting
3A.4.6 – Minimum Requirement 6	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	Annex 1: CCM Governance Manual Annex 2: CCM Code of Conduct
Regional Organization Applicants:		
3A.5.1	Documents that describe the organization such as statutes, by-laws (official registration papers) and a summary of the main sources and amounts of funding.	N/A
Non-CCM Applicants:		
3A.6	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	N/A
3A.6.2 b	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	N/A
3A.6.3 *(if submitted for a country where no CCM exists)*	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	N/A
Section 3B: Proposal Endorsement		
3B.1.3 ***Level 1 Proposal***	Minutes of the meeting at which the	**Attachment C to the Proposal Form**

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
Endorsement *(CCMs, Sub-CCMs and RCMs)*	proposal was developed and CCM endorsed..	
3B.1.3 (***Level 2 Proposal Endorsement =*** *Sub-CCMs and RCMs only)*	Documented evidence (including minutes of the CCM meetings) that all national CCM(s) have reviewed and endorsed the proposal.	N/A
3B.2.1 (***Level 2 Proposal Endorsement*** *Regional Organizations only)*	Documented evidence that the national CCMs have reviewed and endorsed the proposal.	N/A
Other documents relevant to sections 1 to 3B attached by Applicant:		
1.6	Previous Global Fund grants performance	Annex 15: Kenya CCM Action to Improve Performance of the Global Fund Grants
3A.4.5	Documentation of proposal development process	Annex 16: Kenya Round 7 Proposal Development Process

4 Component Section *HIV/AIDS*

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CACC	Constituency AIDS Control Committees
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control (US)
CHAK	Christian Health Association of Kenya
CHEW	Community Health Extension Workers
COBPAR	Community Based M& E system
COMBI	Communication for Behaviour Change
CORPS	Community Owned Resource Persons
CSO	Civil Society Organization
CSW	Commercial Sex Worker
CT	Counselling and Testing
DHMT	District Health Management Team
DHSF	District Health Stakeholders Forum
DOMC	Division of Malaria Control
DTC	Diagnostic Testing and Counselling
DFID	Department for International Development (UK)
DMS	Director of Medical Services (MOH)
ERS	Economic Recovery Strategy
FBO	Faith Based Organization
FDC	Fixed Dose Combination
GoK	Government of Kenya
GIPA	Greater Involvement for People with AIDS
GSC	Grant Score Card
HBC	Home Based Care
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immuno-deficiency Virus
ITN	Insecticide Treated Net
ICC	Inter-Agency Coordinating Committee
IDU	Injection Drug User
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult Illnesses
IVM	Integrated Vector Management
JAPR	Joint HIV/AIDS Programme Review
JICA	Japan International Cooperation Agency
KHADREP	Kenya HIV/AIDS Disaster Response Project
KDHS	Kenya Demographic Health Survey
KEBS	Kenya Bureau of Standards
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KEMRI	Kenya Medical Research Institute
KCS	Kenya Catholic Secretariat
KNASP	Kenya National HIV/AIDS Strategic Plan
MARP	Most at Risk Population
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health

MSM	Men who have Sex with Men
MTEF	Medium Term Expenditure Framework
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Programme
NHIF	National Health Insurance Fund
NHSSPII	National Health Sector Strategic Plan
NGO	Non- Governmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PME	Participatory Monitoring and Evaluation
PLA	Participatory Learning Action
PRA	Participatory Rural Appraisal
PRSP	Poverty Reduction Strategic Paper
PSCMC	Procurement and Supply Chain Management Consortium
PSM	Procurement and Supply Chain Management
R2	Global Fund Round 2
RDT	Rapid Diagnostic Test
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach (for health)
TB	Tuberculosis
TA	Technical Assistance
TOT	Trainers of Trainers
TOWA	Total War Against Aids (WB/DFID/GoK)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WB	World Bank

4 Component Section *HIV/AIDS*

4.1 Requested proposal term for this disease component

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	July 2008	June 2013

4.2 Disease specific component executive summary

4.2.1 Executive summary

The goal of this project is to improve the quality of life of people infected by HIV and AIDS and to reduce HIV infections. Based on analysis of gaps in the national response to HIV and AIDS, the proposal mainly focuses on sustaining antiretroviral treatment and scaling up prophylaxis for opportunistic infections. It also seeks to expand prevention services to most-at-risk-populations (MARP) and underserved areas. Kenya currently has a GF Round 2 grant which provides ARVs for 42,500 patients, cotrimoxazole for 183,000, scaling up of VCT clinics, and many prevention and training activities. The R2 programme is scheduled to end in December 2008, and this proposal intends to continue the services provided by R2, while adding a few key strategic interventions such as nutrition, strategic communication, and support to M&E programs.

The Kenya National HIV and AIDS Strategic Plan sets out the control strategies and targets for the national response up to 2010. This strategic plan provides the framework for harmonization of all interventions in the country. The main HIV control strategies include prevention; treatment and care with emphasis on ART, nutrition and care; and mitigation of the social economic impact of HIV and AIDS through mainstreaming HIV and AIDS interventions in all sectors and addressing the impact on OVCs. Kenya has made significant progress in its HIV and AIDS response efforts. Currently, there are over 144,000 people on ARVs in the country. The prevalence of HIV infection has reduced from 13% in 1994 to 5.9% in 2005. This proposal will contribute to attaining the KNASP target of 75% of patients on treatment by 2010. Kenya's prevention goal is to reduce the prevalence rate from 5.9% to 4.5% by 2010.

The proposal has following objectives and Service Delivery Areas:

Goal	Objectives	Service Delivery Areas
Improved quality of life for people living with HIV and AIDS in Kenya and reduced HIV infections	Objective 1: To scale up and maintain PLWHAs on ART	SDA 1.1: Treatment: Antiretroviral treatment and monitoring
		SDA 1.2: Prophylaxis and opportunistic infections
	Objective 2: To increase access to HIV testing and counseling services	SDA 2.1: Counseling and Testing
	Objective 3: To increase uptake of HIV prevention and treatment services	SDA 3:1: Behaviour change communication – mass media
		SDA 3.2: Behaviour change communication – community outreach
	Objective 4: To strengthen institutional capacity to effectively implement and monitor HIV/AIDS services	SDA 4.1: Information system & operational research
		SDA 4.2: Strengthening of civil society and institutional capacity building*
		Service delivery*
		Human resources*
		Procurement and Supply management*

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**Activities in human resources, service delivery, and procurement and supply management are not listed as SDAs because they have been integrated in other parts of the proposal.*

The Global Fund is an important partner in the coordinated strategy to fight HIV and AIDS in Kenya. Kenya also receives significant financing from PEPFAR, the World Bank, DFID, the United Nations, and several other donors. The CCM collaborated on this proposal with all partners to ensure that the proposal addressed the most urgent gaps in Kenya's response. Partnership between the government, donors, and civil society is strong and well-coordinated in Kenya.

The main beneficiaries are PLWHA who will be provided with treatment services and most-at-risk populations (MARPs) who will be targeted for strategic communications messages, including youth, CSWs and their clients, MSMs, IDUs, long distance truckers and prisoners. Activities in this proposal will be carried out by 34 civil society organizations in addition to government implementers, highlighting that active and close collaboration in the fight against HIV/AIDS.

In preparing this proposal efforts have been made to address weaknesses identified in previous submissions (Rounds 5 and 6).

Earlier challenges to Kenya's programme implementation have been addressed. The CCM confidently believes that this proposal represents the most pressing gaps in Kenya's programme, and that Kenya has the experience and ability to successfully implement this programme.

4.3 National program context for this component

4.3.1 Indicate whether you have any of the following documents and if so, please attach them as an annex to your proposal:

☒	National Health Sector Development/Strategic Plan[1]
☒	National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costings**[2]
☒	Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards)[3]
☒	Most recent evaluation reports/technical advisory reviews **directly relevant to the proposal**[4]
☒	National Monitoring and Evaluation Plan (health sector, disease specific or other)[5]

4.3.2 Epidemiological and disease-specific background

(a) In table 4.3.2 below: (i) identify the total population of the country/countries; **and** (ii) then provide current estimates of the stage of the disease in the listed specific population groups.

[1] The Second National Health Sector Strategic Plan (NHSSP II, 2005-2010)
[2] Kenya National HIV/AIDS Strategic Plan, 2005/6- 2009/10
[3] National ART Strategy, National Communication Strategy, National Nutrition Guidelines
[4] Kenya HIV/AIDS Data Booklet, December 2006
[5] National HIV/AIDS M&E framework

4 Component Section *HIV/AIDS*

Table 4.3.2 – Estimated disease prevalence within key population groups

Population	Estimated number	Year of estimate	Source of estimate
(i) **Total Population** (all ages)	34.6 Million	2007	Kenya 1999 Population and Housing Census; Analytical Report on Population Projections Volume VII
(ii) **Current estimates on the stage of the disease in the following population groups**:			
Total people living with HIV *(adults and children)*	1,276,000	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)
Women living with HIV >15 years	675,000	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)
Pregnant women living with HIV	85,000	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)
Children (0-14 years) living with HIV	156,000	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)
AIDS related deaths per year	115,000	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)
AIDS related deaths per year	115,000	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)
Orphans (0-17 years)	1,193,000 (HIV related) 2,400,000 (total)	2005	Kenya HIV/AIDS Data Booklet Dec 2006 (National HIV Sentinel Surveillance and Kenya Demographic Health Survey)

(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons for their use. Any data on drug resistance should also be included (where relevant).

HIV prevalence

Kenya faces both a generalized and a concentrated HIV and AIDS epidemic that continues to have a devastating impact on all sectors of society. National estimates indicate that the adult HIV prevalence rate stood at 5.9% in 2005. An estimated 1.3 million people are living with HIV and AIDS in Kenya, while an estimated 1.5 million people have died from AIDS-related illness since 1984 when the first case was detected. National prevalence declined significantly from a peak of about 10% in the 1900s to around 5.9% in 2005[6]. This trend is supported by data from national surveys which document changes in behaviour tending towards fewer partners, less commercial sex, greater condom use and later age at first sex. The number of children living with HIV and AIDS is estimated to be 156,000.

[6] Kenya HIV/AIDS Data Booklet, National AIDS Control Council, December 2005.

The table below shows the number of people living with HIV and AIDS by age, gender and location:

National HIV estimates for 2005

	Prevalence	Number HIV+
Adults 15-49		
Total (Range)	5.9% (5.0%-6.8%)	1,024,000 (870,000 – 1,180,0000)
Male	4.0%	349,000
Female	7.7%	675,000
Urban	9.6%	438,000
Rural	4.6%	586,000
Adults 50+		96,000
Children 0-14		156,000
Total		**1,276,000**

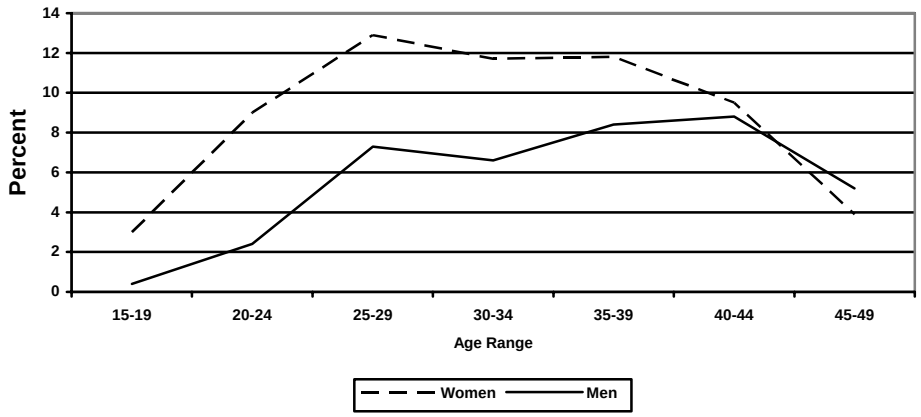
Source: Kenya HIV/AIDS Data Booklet, 2006

Prevalence was estimated at 8.7% for women and 4.6% for men in 2003 (KDHS). The prevalence has changed to 7.7 % among women and 4.0% among men by 2005. With regard to the youth, age 15-24, the HIV prevalence was estimated at 4.5 %(KDHS 2003) dropping to 2.6% in 2005. HIV prevalence declined from 6% in 2003 to 4.5% in 2005 for girls and from 1% 2003 to 0.8% in 2005 for boys. This data shows that HIV prevalence has continued to decline in Kenya among all age groups. However, gender disparities are pronounced even within the declining trend. The gender difference is most pronounced among young people; in the 15-24 age range, female prevalence is nearly five times higher than male prevalence (see Figure 1). Prevalence rates also show significant regional and rural/urban variations, with average urban prevalence (10%) nearly twice that in rural areas (5-6%).

Prevalence rates may begin to flatten as more patients survive on ART. E. Gouws et al[7] estimate that 82,369 new infections occurred in Kenya in 2005. 30.1% of these occurred in low-risk populations, supporting the view that this is both a generalized and concentrated epidemic.[8]

Figure 1: HIV Prevalence by Age and Sex (KDHS 2003)

[7] E Gouws, P J White, J Stover and T Brown, Short term estimates of adult HIV incidence by mode of transmission: Kenya and Thailand as examples,
Sexually Transmitted Infections 2006;**82**(suppl_3):iii51-iii55; doi:10.1136/sti.2006.020164
[8] D. Wilson, *HIV Epidemiology: Draft Review of Recent Trends and Lessons*, 2007.
[9] *The Demographic Impact of HIV/AIDS*, Epstein, 2004
[10] Guidelines for Antiretroviral Drug Therapy in Kenya, 3rd Edition, Ministry of Health, December 2005.



AIDS related deaths

The number of AIDS deaths has been increasing rapidly as a result of the rise in new infection in the mid-1990s. The annual number of adult AIDS deaths reached about 135,000 in 2003. This number reduced marginally to 115,000 in 2005. AIDS deaths in Kenya have a profound and increasing societal and economic impact; the total death rate from all causes among adults 15-49 years has more than tripled since 1990. It is estimated that 1.7 million children under 18 are orphans, about half due to AIDS. As the cumulative total of AIDS deaths rises, the impact of these deaths on society will become increasingly severe. Already, life expectancy in Kenya has dropped from 60 years in 1993 to about 47 years in 2004 due to HIV/AIDS[9].

Determinants of the epidemic There are a number of factors driving the HIV and AIDS epidemic in the country. Among these factors is high levels of poverty and unemployment that lead to high levels of transactional sex. Increased movement of people within the country and in the transnational transportation corridors which exposes many people to multiple sex partners and commercial sex work. Lack of behavior change is another factor, especially in rural communities. There also appears to be an increase in injecting drug use in the country, which if unchecked could also become a significant driving factor of the epidemic.

Most-at-Risk Populations The MARPs include, but are not limited to, married discordant couples, commercial sex workers, orphans and other vulnerable children, young people, migrant workers, uniformed services, and survivors of rape and sexual violence. Vulnerability also has important geographical and cultural dimensions with rural populations and the urban poor being most vulnerable due to low social status and reduced access to services.

Some of the MARPs identified in the national strategic plan are as follows:

Discordant couples: The most at risk group in Kenya are sero-discordant couples. It is estimated that over 400,000 married couples in Kenya are discordant.

Commercial sex workers (CSW) and their clients: The sex industry is one of the key factors driving the spread of HIV infection. In Nairobi, approximately 50% of new HIV cases are transmitted by sex workers or the clients of sex workers.

***Young people*:** In Kenya, the HIV and AIDS prevalence rate among young girls aged 15-24 is 5.8%, compared to 1.2% for young men in the same age range (KDHS 2003).

Others: Other vulnerable groups include the 2.4 million orphans and vulnerable children(OVC), migrant workers and survivors of rape and sexual violence. Other groups that are growing in significance include injecting drug users (IDUs) and men who have sex with men (MSM).

Sexual behaviour change: General trends show positive sexual behaviour change with variations among women and men and the youth. Abstinence, safe sex and delayed sex debut are more pronounced in women than in men. About 30% of the men have had sex by age 15 compared to 14.5 % women of same age. Similarly 84.4% of men engaged in higher-risk sex compared to only 30% of women. The table below shows trends in sexual behaviour between 1993 and 2003 based on KDHS.

Trends in selected national sexual behaviour change indicators

Indicator	**1993**	**1998**	**2003**
15-19 year olds who had sex by age 15			
Women	15.8	15.0	14.5
Men	-	31.7	30.9
Median age at first sex (years)			
Women (20-49)	16.8	16.7	17.8
Men (20-54)	-	16.8	17.1
Had more than one sex partner in the last 12 months (%)			
Women	-	4.2	1.8
Men	-	24.1	11.9
Used condom at last higher-risk sex (%)			
Women	-	15.1	23.9
Men	-	42.5	46.5

Source: Kenya Demographic Survey – 1993, 1998, 2003

Treatment regimens

The national guidelines for antiretroviral therapy[10] provide standard antiretroviral drug regimens recommended for use in Kenya. The recommended standardized first line regimen for adults and adolescents is: Stavudine (d4T) or Zidovudine (AZT)+ Lamivudine (3TC)+ Nevirapine (NVP) or Efavirenz (EFV).

Kenya is considering gradually phasing out Stavudine (d4T) and replacing it with Zidovudine (AZT) due to adverse effects of Stavudine and as recently advised by the WHO. A decision has not yet been taken. The guidelines recommend fixed dose combinations (FDC) as preferred formulations for the initial combination treatment in the standardized regimens, where available. The preference for the FDC is based on the fact that, as single drugs, they simplify procurement, drug logistics management, and allow for an increased adherence to treatment. Purchases through the Global Fund and government channels have given priority to FDCs. PEPFAR has been using single dose formulations, but will soon be changing to FDCs for first line drugs.

The recommended standardized national second-line drug regimens for adults and adolescents are: Didanosis (ddl)+ Abacavir (ABC)+ Lopinavir/ritonavir{LPV/r} (Kaletra) *or* Tenofvir (DTF)+ Abacavir+ Lopinavir/ritonavir{LPV/r} (Kaletra). Apart from the standard regimens, the guidelines also recommend alternative regimens for adults and adolescents that could be used due to various reasons such as toxicity, intolerance or co-infections.

HIV drug resistance

The extent of HIV drug resistance is Kenya is not known because a threshold survey has not yet been conducted. There are plans to carry out a threshold survey in the next twelve months.

4.3.3 Disease-prevention and control initiatives and broader development frameworks

(a) Describe, comprehensively, the current prevention and control strategies for the disease, together with planned outcomes.

The National Response to HIV and AIDS in Kenya is guided by the Kenya National Strategic Plan 2005/2010. It provides the overall framework for coordination and implementation of strategies for

controlling HIV and AIDS. The other strategic plans are linked to this plan.

The goal of the KNASP 2005/06-2009/10 is to reduce the spread of HIV, improve the quality of life of those infected and affected and mitigate the socio-economic impact of the epidemic. The plan defines three key priority areas in the response to HIV and AIDS as: (1) prevention of new infections, (2) improve the quality of life of people infected and affected by HIV and AIDS, and (3) mitigation of socio-economic impact.

Prevention of New Infections

HIV and AIDS prevention strategies focus on expanding key prevention interventions such as sexual behaviour change, counselling and testing, condom promotion, treatment of sexually transmitted infection (STI), prevention of mother to child transmission of HIV, safe blood and post and exposure prophylaxis. Prevention strategies are also oriented towards targeting particular population groups that are at higher risk of HIV infection. Groups that are particularly vulnerable include commercial sex workers and their clients, injecting drug users, discordant couples, women and young girls, migrant workers, prisoners and uniformed services (police, military personnel).

The main prevention outcomes anticipated in the KNASP include the following:

- Less than 10% of girls and 20% of boys have sex before age of 15
- Condom use at most recent high-risk sex in 15-24 age range from at least 40% for women 65% for men
- At least 85% of women and 85% of men in age 15-15 identify ways of preventing sexual transmission of HIV/AIDS
- Less than 23% of infants born to HIV+ mothers will be HIV+

Improvement of the Quality of Life of People Infected and Affected by HIV/AIDS

Key strategies for improving the quality of life of people infected by HIV include increasing availability and access to HIV and AIDS treatment and care, and protection of human rights. Treatment and care includes antiretroviral therapy, treatment of opportunistic infections and nutrition support. Human rights protection addresses issues of discrimination, stigma, property rights and provision of a supportive environment for PLWHAs to exercise their rights.

The expected outcomes by 2010 include:

- At least 75% of those appropriate for treatment will receive ART
- At least 75% of people 15-49 years will express accepting attitudes towards PLWA
- 85% of people with TB and HIV will receive ART before the end of TB treatment
- The nutritional status of PLWA will be at least as good as that of non- infected people in the same community

Mitigation of social and economic Impact

This priority area addresses issues relating to the wider impact of HIV and AIDS on society. Specific strategies include policy advocacy to ensure a supportive environment, development and implementation of mitigation programmes targeting communities, care and support for orphans and other vulnerable children (OVC) and empowering people infected and affected by HIV and AIDS to cope with the impact of HIV and AIDS.

Planned outcomes under this priority area include:

- Increased understanding by policy makers and planners of impact of HIV and AIDS, particularly for vulnerable populations and sectors
- National policy on mitigation developed and explicitly reflected in GoK policy and finance processes, including the Economic Recovery Strategy, the Medium Term Expenditure Framework and annual national budget

- Percentage of orphans in school will be at least 90% of the percentage of non-orphans in school in the age range 10-14
- Impact of HIV and AIDS on livelihood and security in Kenya quantified and effective counter measures will be designed and implemented

Key achievements of the national response

In 1999 the Government of Kenya (GoK) declared HIV and AIDS a national disaster and established the National AIDS Control Council (NACC). Various stakeholders are involved in implementation the multisectoral response to the epidemic, including government, civil society, the private sector and development partners.

Substantial progress has been made in scaling up prevention, treatment, care and impact mitigation interventions in the country. Some notable achievements of the programme are as follows:

- Increase in the number of people declaring their sero-status
- Number of voluntary counselling and testing (VCT) centres in the country has increased from about 30 in 2003 to over 600 at end of 2006
- Total of 200 PMCT sites have been established; and
- Six regional blood transfusion centres and three satellite centres have been established, with 100% testing of blood supplies
- The number of people on ART from about 5,000 in 2003 to around 140,000 by March 2007
- National mechanism for coordinating the KNASP has been strengthened and improved, including successful, broad-based annual Joint AIDS Programme Reviews
- NACC institutional framework has been restructured to focus on the constituency as the delivery point for HIV and AIDS programmes, and NACC has undergone a fundamental institutional review whose recommendations are currently being implemented
- District Technical Committees have been formed to act as oversight boards for constituency AIDS control committees (CACCs)
- Substantial resources have been allocated to mitigation initiatives countrywide. For example, 21% of financing under the World Bank supported KHADREP project was used for mitigation.

Despite the substantial progress made a number of obstacles and constraints still remain and need to be addressed. They include the following:

- IEC materials not locally adapted to local language and situation
- Vulnerable groups do not have access to condoms especially in rural areas
- Inadequate youth-friendly support services
- Inadequate VCT sites
- Appropriate drugs for opportunistic infections not readily available
- Lack of food and nutritional supplements for people living with HIV/AIDS
- Lack of test kits for HIV/AIDS in health facilities
- Inadequate financial resources, infrastructure and institutional capacity of implementing agencies.

Major Partners

A range of development partners are involved in providing financial and technical assistance to the national response to HIV and AIDS in Kenya. They include:

(i) PEPFAR

PEPFAR is the largest funder of HIV and AIDS programs in Kenya, providing over $200m per year. Although the PEPFAR program is five years long and expires in 2008, it is expected to be reauthorized, and Kenya expects to continue to be a PEPFAR focus country. PEPFAR's goal is

to provide ARVs for 169,000 Kenyans by the end of 2008. The program also has a significant budget for prevention programs.

(ii) The Global Fund

The Global Fund Round 2 HIV and AIDS program aims at scaling up voluntary counselling and testing services to reach 1 million people over 5 years. It also provides the full range of care services including ART. In addition it seeks to carry out institutional capacity building of government and civil society structures that respond to HIV and AIDS in order to support the scaling up of voluntary counselling and testing, care and support service. The lifetime budget is US$106 million. Phase 2 of the grant is $70m, and is currently underway. The Global Fund also is also supporting two TB programs with large TB/HIV components. Round 5 is a $19.9m program with a focus on TB/HIV services. Round 6 is a $9.2m program focused on strengthening primary healthcare for the effective delivery of TB/HIV care.

(iii) World Bank/DFID/GoK TOWA

The TOWA program (Total War Against HIV and AIDS) is anticipated to begin in mid-2007. The project includes an $80m IDA loan from the World Bank, a $33m grant from DFID, and a $2m contribution from the Government of Kenya, over a period of four years. $28m is for governance and management, while the remaining budget will go to NGO grants, public sector mainstreaming activities, and the procurement of essential commodities (condoms, bed nets and TB drugs).

(iv) Clinton Foundation/ DANIDA/ UNITAID/MSF

The Clinton Foundation supports 2nd line ARVs for the adults and drugs for the children. US$ 13 million is committed in 2007/8. The CF uses UNITAID to purchase paediatric ARVs, with a goal of supporting 20,000 children in 2007. The Foundation provides some programmatic support, but most of its resources go to drug procurement and laboratory support. The Foundation also has a three year, $17m agreement with DANIDA to support 1,120 nurses and clinical offices that are deployed in rural districts with high disease burden.

(v) United Nations Agencies

The UN system provides substantial technical assistance and some financial support aimed at building national capacity to respond to HIV and AIDS. They are particularly involved in assisting the country to set up robust systems for planning, implementation, monitoring and evaluation national efforts. They support the country in adapting international standards and programs to the national context. The UN also has an important role to play in facilitating partnerships between different stakeholders and provide early warning of impending or anticipated problems.

(vi) Others

Family Health International has a program to integrate private sector health providers more closely into the national fight against HIV and AIDS. JICA has continued to support NASCOP in two areas; VCT site development and M&E systems development. During the proposal period JICA will provide about 2 million test kits in 2007/8 and also assist in the roll out of the M&E system to health facilities. JICA support for M&E is mostly in the area of training, not equipment or human resources. The French Cooperation is providing M&E technical support to the Global Fund Principal Recipient at the MOH. Academic institutions in Kenya also provide technical support, medical research, and operations research.

(b) Describe how these disease prevention and control strategies fit within broader developmental frameworks such as Poverty Reduction Strategies, a Health Systems Strengthening Strategy, the Highly-Indebted Poor Country (HIPC) Initiative, and/or the Millennium Development Goals, **emphasizing how the additional support requested in this proposal is aligned with developmental frameworks relevant to the country context**.

The Socio-Economic Impact of HIV/AIDS

4 Component Section *HIV/AIDS*

HIV and AIDS has major economic and social impact on individuals, families, communities and on society as a whole. In Kenya, as in other countries in sub-Saharan Africa, AIDS threatens personal and national well-being by negatively affecting health, lifespan, and productive capacity of the individual; and critically, by severely constraining the accumulation of human capital, and its transfer between generations. Research across many severely affected, low income countries clearly demonstrates that HIV and AIDS is the most serious impediment to economic growth and development in such countries.

Several studies have suggested that HIV and AIDS undermines development across all sectors of the economy and society, though further research is required to quantify the impact. Major challenges include:

- The productivity of the agriculture sector, upon which the majority of Kenyans rely for their livelihood, is undermined by negative impacts on the supply of labour, crop production, agricultural extension services, loss of knowledge and skills and at a personal level the trauma associated with death. Consequences include reduced household and community food security and decline in the nutritional and health status of smallholders and their families. Commercial agriculture, a major source of employment and foreign earnings, is detrimentally affected by increasing health costs as well as protracted morbidity and mortality of key workers.
- Educational services suffer as teachers are lost to AIDS and children drop out of school as parents die and household incomes fall. The health service loses trained staff and has to cope with the increasing burden of HIV-related infections.
- The direct cost and social problems associated with caring for increasing numbers of orphans, coupled with existing high poverty levels place severe burdens on family and societal structures.

In addition to these direct effects on production and social services, there is a growing realisation that HIV and AIDS may undermine the long-term revenue base of the economy, and so reduce Government's capacity to provide the infrastructure and social services essential for long-term economic growth. Studies in countries severely affected by HIV and AIDS suggest that the impact of HIV and AIDS on public finances is large and growing. This provides an additional argument, particularly relevant for the Ministries of Finance and Planning, for greater investment in an expanded response across all sectors.

Economic Recovery Strategy (ERS)

The principal national development framework for Kenya is the **Economic Recovery Strategy**. Poverty reduction, driven by economic growth, is the central objective of Kenya's Economic Recovery Strategy. The impact of HIV and AIDS on economic growth and development, coupled with the direct impact of increased mortality and morbidity on the lives of the poor, makes HIV/AIDS a uniquely corrosive threat to poverty reduction efforts. The ERS also prioritizes improving the health of the poor as a means to economic development.

The ERS also serves as a framework for translation and application of international commitments made by Kenya in the areas of HIV/ADS control and health development. The attainment of the **Millennium Development Goals (MDGs)** for Kenya is one such commitment embedded in the ERS. National development strategies in the ERS contribute to the achievement of the MDGs and in particular those related to health, specifically: Goal 1- Eradication of extreme poverty and hunger; Goal 4-Reduce child mortality and Goal 3- Combat HIV and AIDS, Malaria and other diseases. These strategies provide a framework through which Kenya implements programs that address the MDG goals. Kenya is also a signatory to the **Abuja Declaration** on HIV and AIDS, Tuberculosis, Malaria and Other related Diseases, June 2001 as well as to the goal of **Universal Access** to HIV and AIDS prevention, treatment and care by 2010.

Within the context of implementation of the ERS the government has increased the allocation to the health sector from 9% to 11.5% of total budget with a plan to progressively increase annually. The National Health Sector Strategic Plan II 2005-2010 (NHSSP II) is the health sector's strategy to implement the ERS and is operationalized through the Annual Operational Plans. HIV and AIDS is a high

priority in NHSSP II. A key strategy for implementation of the NHSSP II is the Sector Wide Approach (SWAP) to health development, which was recently adopted and which emphasizes harmonization of development efforts in line with the **Paris Declaration on Aid Effectiveness**. The NHSSP II also puts emphasis on community involvement in implementation and health promotion.

The Kenya National HIV and AIDS Strategic Plan 2005-2010 (KNASP), which serves as a framework for HIV and AIDS strategies contained in this proposal is consistent with and contributes to both the ERS and the NHSSP II. Therefore, interventions contained in this proposal are an integral part of Kenya's overall national development efforts.

(c) Describe how this proposal seeks to: (1) use, to the extent that they exist, country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

1. Use of national systems

Planning and Budgeting

Planning and Budgeting in Kenya takes place within the framework of the Medium Term Expenditure Framework and the Economic Recovery Strategy. The planning and budgeting process in the MTEF starts with input from the districts. All health programmes are captured in the district workplan and submitted to the Ministry of Health where they are aggregated before being submitted to the Ministry of Finance for consolidation into the National Budget. Disease programmes are prepared by the respective National Control Programmes in the Ministry of Health and submitted to Ministry of Finance. This proposal will be integrated into the MTEF planning cycle at the macro level. As the activities included in this proposal are all drawn from the KNASP, it will also utilize the same systems for planning and budgeting The proposal is aligned with the Paris Declaration on Aid Effectiveness.

Procurement and Supply Management

Government procurement systems, with technical assistance as needed, will be used to procure the drugs, commodities and equipment proposed in this proposal. The Public Procurement and Disposal Act 2005 and the Procurement Regulations of 2006 govern procurement of health products. The regulations require that health products be procured through competitive tendering process. Procurement and supply of health products is managed by Kenya Medical Supplies Agency (KEMSA). As described in section 4.10 of the proposal, KEMSA will be responsible and accountable for all procurement and distribution, in collaboration with technical partners as determined by the CCM and the Global Fund. Under the current guidelines NASCOP shall prepare procurement plans which shall be approved and procurement orders will be prepared and presented to KEMSA for tendering.

Monitoring and Evaluation

Monitoring and evaluation of the services to be provided under this proposal will use the existing national M&E framework and systems. All indicators used in this proposal are consistent with those of the KNASP and the systems for data collection will also be used to collect the necessary information for the purpose of this proposal. The national M&E framework for HIV/AIDS is managed by the National AIDS Control Council. The proposal will also use the M&E sub systems in MoH/National AIDS and STI Control Programme (NASCOP). The proposed programme will also be reviewed jointly with other programmes during the annual Joint AIDS Programme Review (JAPR).

Auditing

The programmes proposed will be audited by Kenya National Audit office will be responsible for audit of the public programmes. Services provided by non-government organizations will be audited by private sector audit firms on behalf of the Kenya National Audit Office.

2. Harmonization and alignment of partners to country cycles for reporting , budgeting, financial management and Procurement

This proposal enhances the alignment of partners to country cycles by using existing reporting, budgeting, financial management and procurement systems. All GoK, CSOs, and FBOs implementing this proposal will be required to align the budgeting, financial management, procurement and reporting cycles to the country cycles and procedures. Implementation of programmes contained in this proposal will also be part of the coordination mechanism under the Sector Wide Approach (SWAp), although there are no immediate plans to include Global Funds in the common funding mechanism.

4.3.4 National health system

(a) Briefly describe the main health systems constraints related to this component by focusing on the strengths, weaknesses, opportunities and threats of the health system.

Kenya has a fledgling health system which has scored many achievements, but also continues to face many challenges. At the national level, the MoH is responsible for oversight of all health services including those covered in this proposal. District Health Management Boards and Teams provide leadership for health service delivery. At the community level, health facility management teams are responsible for oversight. NACC and NASCOP spearhead the fight against HIV and AIDS. The country has developed the Kenya National HIV and AIDS Plan, which provides the roadmap to fight the disease. MoH has expanded the human resources capacity for delivery of HIV and AIDS services over the last five years. The analysis of the key strengths, weaknesses, opportunities and threats of the health system in Kenya in relation to the delivery of this proposal is focused on four areas: Governance, Human resources, infrastructure and systems.

Strengths

- The health sector enjoys political support at the highest level in this country. The ERS identifies the sector as a priority sector for economic recovery, sustained development and poverty reduction, and the Vision 2030, to be launched soon, will also recognize the health sector as a key area. Consequently the budget allocations to the sector have increased over the last five years and currently 11.5 % of government expenditures are allocated to the sector. The Government is committed to achieving the 15% target set at the Abuja declaration.
- Donor support to the sector is significant, especially in development expenditures. PEPFAR, the Global Fund, the Clinton Foundation, the World Bank and DFID are supporting HIV and AIDS Programmes. MoH provides overall governance for health service delivery in the country at all levels.
- At the national level, the MoH is responsible for oversight of all health services including those covered in this proposal. District Health Management Boards and Teams provide leadership for health service delivery. At the community level, health facility management teams are responsible for oversight. NACC and NASCOP spearhead the fight against HIV and AIDS. The country has developed the Kenya National HIV and AIDS Plan, which provides the roadmap to fight the disease. MoH has expanded the human resources capacity for delivery of HIV and AIDS services over the last five years. Kenya has developed a fairly elaborate health delivery infrastructure at national, provincial and district levels. There are 4,912 (Economic Survey, 2006) public health facilities in the country, comprising hospitals, health centres and dispensaries. These facilities are available to offer HIV/AIDS related services such as CT, PICT, PMTCT and ART treatment. There are currently 347 ART clinics in the country providing treatment services to the PLWHAs and 800 VCT centres.
- The national and district health planning systems are well developed and provide HIV and AIDS implementers the opportunity to mainstream programmes within the MTEF budget. HIV and AIDS programmes are integrated in the budget and expenditure systems as line items within the respective ministries.

- Funds for implementation of the HIV and AIDS interventions flow efficiently to the programmes and are accounted for.
- The procurement and supply chain that delivers health commodities is fairly well developed in Kenya and comprises of a number of actors including the Kenya Medical Supplies Agency (KEMSA) which serves mainly the public sector, the Mission for Essential Drugs and Supplies (MEDS) service the faith-based community and a host of other NGO and private sector channels.
- Kenya has an active and engaged civil society. The sector is represented in the CCM and ICCs. It participates in all of the major national interventions against HIV and AIDS.

Weaknesses

- One of Kenya's biggest challenges is its shortage of trained health care workers, and their inadequate distribution. The country's health facilities, especially in the rural areas, are inadequately staffed and often lack the skills necessary to provide health services. Sixty (60%) percent of all health professionals (65,000) are deployed in urban areas, creating a disparity in underserved rural areas. Eighty percent of Kenyans live in rural areas. This imbalance in health workers has serious implications on access to health services including HIV and AIDS.
- The governance structures, especially the DHMB, the DHMTs and the HMTs, are still being strengthened, undermining their capacity to provide leadership in planning, resource mobilization, utilization, accounting and reporting, and monitoring and evaluation of programmes.
- In some parts of the country people travel between 50 to 200 kms to access a health facility. These people do not receive quality HIV/AIDS services. In addition, many of these facilities are not well maintained and require substantial renovations, further undermining service delivery.
- Management and reporting systems are sometimes weak resulting in an inability to effectively monitor implementation of some donor funded programs.
- Kenya has recently struggled with procurement of HIV and AIDS medicines, and faced procurement delays in its Round 2 programme. Although the country's storage and distribution capacity is good, there are significant challenges in procurement of drugs and health commodities.

Opportunities

- Kenya experienced several challenges during the implementation of its Round 2 grant. As a result, there was a concerted effort by donors, civil society and the GoK to strengthen Kenya's response and fix the problems that were occurring. Kenya has now developed very strong partnerships and excellent coordination between partners.
- The HIV and AIDS governance environment has improved due to a revitalized National AIDS Control Council (NACC), and adoption of the SWAp. Through these mechanisms Kenya is more effectively engaging partners, including private sector, in providing services and harmonizing efforts. The SWAp development is at advanced stage of planning, and will improve Kenya's health system.
- The vibrant civil society in the country further supports the multisectoral approach to fighting HIV and AIDS pandemic.
- The high economic growth rate reported in the recent years in the country will provide increased resources for the health sector.
- The Procurement Act of 2005 and the Regulation Act of 2006 were major milestones in improving health product legislation.
- The CCM has also been through growing pains and emerged strong and cohesive, with effective Guidelines.
- Most significantly, most of the major challenges have been addressed, so that Kenya is now in the process of a large scale up of treatment activities. The pace of treatment rollout, with over 144,500 people now on ART, shows that Kenya is now moving quickly to improve the lives of PLWHA.

Threats

- Because of the high HIV rate and Kenya's poverty, the donor community accounts for over 90% of the development expenditure in the health sector. This could create difficulties for the country should the external sources be abruptly reduced or stopped.
- High poverty levels and a weak health system encourage people to resort to traditional health service providers, as they are unable to afford, or do not trust, hospital services.
- Procurement of drugs and commodities has been a persistent challenge, and while it is greatly improved, needs additional strengthening.
- In the face of sporadic outbreaks of other diseases such as cholera and Rift Valley fever, there is sometimes a risk that attention and resources are diverted to address these acute problems.

(b) **Describe the national priorities in addressing these constraints**

The Government of Kenya is determined to address the challenges and weaknesses of the health system with the aim of developing a health system that meets the expectation of all Kenyans. This is being done through progressively increasing the health budget, improving governance, coordination and harmonization of in the health sector and through systematic implementation of the Kenya Essential Package for Health (KEPH). The KEPH provides the operational framework for:

- Improving the human resources management and development. Deployment of existing staff is being rationalized. Gaps in staff numbers and skills are being addressed. A survey of the deployment of the existing staff has been completed and redeployment is in progress. The NHSSP provides for recruitment of staff as soon as the real gaps in staff numbers are conclusively determined.
- Improving funds flow to and reporting by districts and programmes. The ministry of finance is implementing the integrated financial management information system (IFMIS).
- Strengthening procurement and supply management. KEMSA has been undergoing reforms with a view to improving procurement and supply management systems.
- Increasing access to health services by decentralisation and targeting part of its interventions at community level.
- Integration of the different programme intervention (especially at primary levels) towards client.
- Enhancing the promotion of individual and community health.
- Improving quality of service delivery and responsiveness of health workers as well as changing their prevailing attitudes.

The health sector structure has so far been able to sustain testing close to two million clients for HIV annually in the VCT and PMTCT, caring for over 200,000 HIV positive clients and initiating 145,500 clients on ARVs. In continuing the scale-up, the sector is now working on developing HIV interventions including HIV care with ART treatment to the lower level facilities. Nyanza has been one of the first provinces to move in this direction and to demonstrate that this is clearly feasible and more sustainable in the longer term. The adoption of IMAI will further enhance, simplify and standardize the decentralization process as well as facilitate strengthening of lower level facilities to speed up devolution of services to these centres. As the patients are downloaded towards the community, the capacities of the facilities are better enhanced to accommodate the scale up of HIV services.

Other measures being undertaken to address the constraints faced by the sector include initiatives such as the employment of health workers through the Global Fund Round 2, Clinton Foundation and PEPFAR to work at the primary health care level.

(c) **Coordination and Synergies**

Kenya has recently adopted the Sector Wide Approach (SWAp) for health as a vehicle in building a government-led and sustained partnership with various stakeholders in health. In this context various mechanisms are being defined for joint annual planning and reviews, joint monitoring of performance, harmonizing funding arrangements, and common management arrangements. These efforts in the wider health sector are also in harmony with the mechanisms for HIV and AIDS coordination. The TOWA

program is the first step towards an active SWAp, with the WB, DFID and GoK pooling resources.

A health sector coordination framework is in place, composed of the following mechanisms:

The Joint Inter-agency Coordinating Committee (JICC) chaired by the Minister is composed of Permanent Secretaries of other ministries and heads of missions from all major stakeholders (max 20). JICC provides policy guidance on strategic issues of the NHSSP II, including harmonization of planning and M&E. It also coordinate resource mobilization and allocation.

The Inter-agency Coordinating Committee (ICC). ICCs guide and review overall programme management and funding. There are ICCs for HIV and AIDS (chaired by NACC); for Malaria, TB; RH and Child Health, incl. KEPI, (all chaired by the Director of Medica Services), as well as for Health Systems and an ICC for Community Health Services. The ICC for Systems is expected to give special attention to issues of integration and systems development. The ICCs are comprised of representative of stakeholders in the specific programme areas they address. Members are selected on the basis of their experience and expertise in the subject.

District Health Stakeholder Forum (DHSF), chaired by the District Health Management Board is meant to strengthen collaboration between all stakeholders in a district and to provide a platform for discussion and dialogue on health related issues. The DHSF reviews the District Health Plan, as proposed by the DHMT and coordinate the various interventions and contributions from all stakeholders.

Coordination of specific disease programmes therefore takes place primarily through the above mechanisms. The ICCs are comprised of major stakeholders in specific disease programmes. They address various issues regarding the programme such as planning, management, monitoring, financing and coordination. The ICCs relate to the JICC which serves as a forum for overall coordination of health programmes.

In addition, there are internal coordination processes within the Ministry of Health. The National AIDS and STI Control Programme (NASCOP), the National Leprosy and Tuberculosis Programme (NLTP) and the National Malaria Programme (NMP) all report to the head of Preventive Health Service and subsequently to the Director of Medical Services (DMS). The DMS is responsible for overall technical guidance of the programmes and ensuring coordination and complementarity between the programmes

4.3.5 Common funding mechanisms		
(a)	Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes ➔ *answer questions below.* ☒ No ➔ *go to section 4.4*

4 Component Section *HIV/AIDS*

4.4 Overall Needs Assessment

4.4.1 Programmatic Needs Assessment

4.4.1 Overall programmatic needs assessment

(a) **Based on an existing Health Sector Strategic Plan** *(or, if not in existence, an analysis of national/regional goals, together with careful analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies)*, **describe the overall programmatic needs in terms of people in need of these key services**. Please indicate the quantitative needs for three to five main services that are intended to be delivered for this disease component (e.g., provision of first and second line anti-retroviral treatment, or prevention services for specific population groups most at risk of HIV infection). Also specify clearly how much of this need is currently covered (or will be covered) over the proposal term by domestic sources or other donors.

The KNASP 2005-2010 (see section 4.3.3, above) focuses on three primary areas: prevention, treatment and care, and impact mitigation. Kenya has one active Global Fund HIV and AIDS program (Round 2), as well as three TB programmes (rounds 2, 5 and 6) with TB/HIV components. Funding for the Round 2 programme is anticipated to end in late 2008. Kenya will also receive funding from the World Bank/DFID (TOWA), the United States (PEPFAR), the Clinton Foundation, and other donors, and the GoK.

Key interventions in the National Response to HIV and AIDS include prevention of new infections, care and treatment and mitigation of the social economic impact of HIV and AIDS. The prevention programmes comprise of BCC, PMTCT, CT, PEP, condom promotion and STI treatment components.

Treatment and Care

Antiretroviral treatment: It is estimated that there are 263,000 people in need of antiretroviral treatment in 2007, a number that is projected to grow at a rate of 10% annually to reach 423,596 people in 2012. About 55% (144,500) of those in need are currently under treatment through the support of development partner and GoK funding, leaving a gap of 118,500. After taking into account anticipated support from other development partners and local resources, mainly from government, there are gaps that will require to be filled. This proposal is to fill part of the gaps as follows (numbers are lower at first because R2 drugs will still be available); 2008-20,254 people, 2009 – 41,254 people, 2010-2012- 62,754 people.

A recent mission by WHO and UNAIDS concluded that will be a treatment gap of 130,775 people by the end of the current KNASP, taking into account all current and potential funding commitments. Table A below shows the commitments to support ARV drugs in Kenya until 2010.

Table A

	Jun-07	Jun-08	Jun-09	Jun-10	Jun-2011	Jun-2012
Targets	**157,800**	**229,800**	**289,800**	**337,800**	**375,600**	**413,400**
Commitments:						
Government of Kenya	0	24,000	24,000	24,000	24,000	24,000
Global Fund	42,500	42,500	21,500	0	-	-
US Government[11]	70,022	108,236	131,250	126,625	126,625	126,625
Clinton Foundation	1,200	28,200	40,200	50,400	-	-
Médecins Sans Frontières	10,000	1,100	1,100	-	-	-
Private sector	5,000	4,500	4,500	5,000	5000	5000

Other	1,000	1,000	1,000	1,000	1000	1000
Total committed	**129,722**	**209,536**	**223,550**	**207,025**	**156,625**	**126,000**
Gap	**28,078**	**20,264**	**66,250**	**130,775**	**218,975**	**287,400**

Source: Report of the Inter-Agency Technical Assistance Mission on Monitoring and Sustainable Financing of Anti-Retroviral Treatment for HIV/AIDS in Kenya, March 2007.

Assumptions: Population of PLHA accessing services assumed to increase from 40% to 80% according to KNASP and universal access targets

Prevalence of HIV projected to decrease to 4.5% by year 2010 according to KNASP

Source: Kenya population projections for provinces and districts 2000 - 2020

Kenya National AIDS Strategic Plan 2005/06 - 2009/10 (KNASP)

Based on these figures, NASCOP anticipates a significant shortfall of first line ARVs, but anticipates that PEPFAR and the Clinton Foundation will cover most of the needs for paediatric and second line ARVs. Human resources and training are also covered. This proposal requests funding for CD4 tests, which are still inadequately funded.

The number of people in need of cotrimoxazole was arrived at using the following method:

	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Population 15-49	16,603,348	17,018,997	17,440,914	17,869,074	18,303,500	18,744,160	19,396,943	19,807,578
Prevalence	7.4%	5.9%	5.9%	5.5%	5.5%	4.5%	4.5%	4.5%
Population living with HIV	1,228,648	1,004,121	1,029,014	982,799	1,006,693	843,487	872,862	891,341
In care	491,459	401,648	411,606	491,400	604,016	590,441	698,290	713,073
Covered	0	186,250	226,500	226,500	0	0	0	0
Gap	491,459	215,398	185,106	264,900	604,016	590,441	698,290	713,073

Assumptions: Population of PLHA accessing services assumed to increase from 40% to 80% according to KNASP and universal access targets

Prevalence of HIV projected to decrease to 4.5% by year 2010 according to KNASP

The main assumption in estimating the antiretroviral treatment gap is that PEPFAR, whose current programme finishes in 2008 will continue to support the ART program in the country and will at least maintain the number of people they would have put on treatment by 2008 for the subsequent five years.

Source: Kenya population projections for provinces and districts 2000 - 2020

Kenya National AIDS Strategic Plan 2005/06 - 2009/10 (KNASP)

Nutrition: Lack of adequate nutrients has been identified as a major health concern for PLWHAs beginning ART in Kenya. The proposal initiates the provision of micronutrients and therapeutic feeding to ART patients in Suba District which has high HIV prevalence and high food insecurity. A total of 33,849 HIV patients will be put on nutritional supplements, and 3,009 children and 12,035 adults on therapeutic feeds. Therapeutic feeding is nutritional support to ARV patients who are hospitalized and severely malnourished.

The following table shows the gap calculation to reach 33,849 for patients needing nutritional supplements:

	Year1	Year 2	Year 3	Year 4	Year 5	TOTAL
No. of PWHA in Suba District eligible for ARVs	12,540	13,794	15,048	16,292	17,546	75,220
60% of population based on poverty	7,524	8,276	9,029	9,775	10,528	45,132

index[12]						
75% of those on ARV[13]	5,643	6,207	6,772	7,331	7,896	**33,849**

The next table shows the calculation to arrive at 15,044 patients on therapeutic feeding. It was assumed that 20% of these patients would be children, and the rest would be adults.

	Year1	Year 2	Year 3	Year 4	Year 5	TOTAL
No. of PWHA in Suba District eligible for ARVs	12,540	13,794	15,048	16,292	17,546	75,220
20% of total patients on ARV in need of therapeutic feeds	2,508	2,759	3,009	3,258	3,509	**15,044**

Partners proving nutrition/food support in the district and their commitments are as follows:

- GoK/USAID: are providing 5,000 patients in 52 GoK and church-based facilities with food/nutritional support. They intend to increase their support cover 80 sites by the end of 2007
- UNICEF – supporting health centres in nine health districts
- AMPATH (PEPFAR and WFP) – 30,000 people at 19 health facilities

Opportunistic Infection Prophylaxis and Treatment: It is estimated that there are 411,606 people in need of prophylaxis treatment in 2007. Of this number 330,000 are on treatment leaving about unmet need of 81,606. The Global Fund Round 2 program is the largest source of funding for cotrimoxazole, currently supporting 183,000 patients. It is estimated that the number of people in need will increase annually to reach 713,071 people in 2012. There are no commitments after 2008. This proposal will support 200,000 people annually beginning 2008; although this funding will not fill the gap, it will finance a large part of the gap.

In the area of OI prophylaxis, the other partner is PEPFAR which provides limited resources for cotrimoxazole. Most PEPFAR support in this area goes to basic health treatment for PLWHA and for TB/HIV care.

Laboratory Support: Laboratory services are supported by the Global Fund, GoK, PEPFAR and the Clinton Foundation. The GF R2 provides some support for CD4 testing. PEPFAR, through the APHIA II project, is setting up laboratory networks to transfer samples to existing CD4 machines. APHIA II also provides health system support including laboratory worker training, equipment. The Clinton Foundation provides laboratory supplies for paediatric lab testing, including PCR. The Round 7 proposal will be able to take advantage of the laboratory networks established by APHIA II. The only resources requested are for the procurement and distribution of CD4 reagents.

Orphans and Vulnerable Children: Support to OVCs is provided through PEPFAR and UNICEF. This area is not prioritized in this proposal.

Palliative Care: Palliative care is also provided by PEPFAR. At this time, the CCM does not predict a gap in funding in this area.

TB/HIV: TB/HIV programmes are covered by GF Rounds 5 and 6 TB grants, and by PEPFAR. A limited gap exists in this area and the CCM is not seeking funding in this area in this proposal.

Prevention

Counselling and Testing: The national target for people to be counselled and tested for HIV is 2,079,152 in 2007. Currently, resources are available counsel and test about 1,808,865 people in the year leaving a gap of 270,290 people for 2007. Fewer than 20% of Kenyans know their HIV status. The need for CT services will increase progressively over the proposal period to top 4,154,489 in 2012. Currently the supply of test kits is a major challenge. There are no commitments for supply of test kits after 2008. This proposal seeks support for procurement of test kits over the proposal term.

Calculation of people in need of CT is based on the 2007 commodity forecasting modelling done by NASCOP based on the 5.9% prevalence rate as a base factor. The calculation of test kits is based on 30% of the unmet need of people requiring CT.

Other partners in the area of counselling and testing are:

- Global Fund Round 2 is providing test kits
- PEPFAR has provided 750,000 tests in addition to PMTCT tests
- JICA is providing over 25,000 test kits

PMTCT: PEPFAR is providing funding for PMTCT, and has provided testing to 1,226,000 pregnant women since the beginning of the programme. Nearly 70,000 pregnant women have been placed on ART prophylaxis. Although the need for PMTCT programme exists, the CCM decided that this is not a priority area for Round 7 because PEPFAR is covering most of the need.

Communications: Strategic communications in this proposal will be used to provide ARV-related education (adherence, nutrition, increased demand, etc.) and to promote counselling and testing. Mass media campaigns will be used, as well as community outreach in focus areas. Messages will also be targeted to MARPs like youth, CSWs and their clients, IDUs, MSMs, prisoners and truck drivers. Other partners in the area of strategic communications are PEPFAR and DFID/WB through the TOWA programme.

Condom Distribution: The TOWA programme has a budget of $12m for the procurement of condoms. Therefore this area is not included in this proposal.

(b) **Complete table 4.4.1**

Table 4.4.1 is designed to assist Applicants to clearly illustrate overall programmatic needs in terms of people in need of key services.

In addition, please specify below relevant information concerning the groups targeted and any assumptions including target size.

The assumptions about target size are discussed in the section 4.4.1A

4 Component Section *HIV/AIDS*

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)									
Key Service 1	Antiretroviral treatment and monitoring (Projection based on 10% increase in number of people needing ARVs annually)	213,000	236,700	263,000	289,300	318,230	350,053	385,058	423,564
Key Service 2	Prophylaxis and treatment of opportunistic infections	491,459	401,648	411,606	491,400	604,016	590,441	698,290	713,073
Key Service 3	Counselling and testing (6% of total population over 15 years estimated to be HIV+. This percentage is projected to increase at a rate of 1% annually)	1,337,805	1,702,292	2,079,155	2,468,569	2,870,708	3,285,743	3,713,438	4,154,489
Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:									
Key Service 1	Antiretroviral treatment and monitoring (after 2009, based on estimates)	60,392	120,026	129,722	209,536	223,550	207,025	156,625	126,000
Key Service 2	Prophylaxis and treatment of opportunistic infections (No commitments from 2009 onwards)	0	186,254	226,500	226,500	0	0	0	0
Key Service 3	Counselling and testing (no commitments confirmed for the period beyond 2009)	997,078	1,398,719	1,808,865	2,832,000	0	0	0	0
Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal' ($A^1 - B^1 = C^1$, $A^2 - B^2 = C^2$ etc.)									
Key Service 1	Antiretroviral treatment and monitoring	152,608	116,674	133,278	79,764	94,680	143,028	228,433	297,564
Key Service 2	Prophylaxis and treatment of opportunistic infections	491,459	215,398	185,106	491,400	604,016	590,441	698,290	713,073

4 Component Section *HIV/AIDS*

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Key Service 3	Counselling and testing	340,727	303,573	270,290	271,543	2,870,708	3,285,743	3,713,438	4,154,489
Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL									
Key Service 1	Antiretroviral treatment and monitoring	*Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.*			20,254	41,254	62,764	62,764	62,764
Key Service 2	Prophylaxis and treatment of opportunistic infections				200,000	200,000	200,000	200,000	200,000
Key Service 3	Counselling and testing				378,845	783,703	916,722	1,058,320	1,208,956

4.4.2 Strategic actions to strengthen health systems

Table 4.4.2A – Summary of essential HSS Strategic Actions requested in Round 7

4.4.2A Summary of funding requested for HSS Strategic Actions in Round 7					
Total funds for essential HSS Strategic Actions requested over proposal term					
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
6,315,339.08	8,057,319.04	4,954,992.63	4,391,453	4,397,350	$ 28,116,453.75

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 1	**Health Worker Training** The first strategic action being taken in the context of this proposal to address weakness in the health system and service delivery is human resource development. Inadequacy of human resources for health has been identified as a major constraint to the health system in Kenya. There is a critical shortage in both numbers of health workers and in skills to adequately the deliver proposed services. Since human resource challenges are enormous and also affect other sectors, a wide range of efforts and enormous resources are required over a period of time. The first is through providing support for training of health and other related workers in the skills they need to provide services such as treatment, counselling, testing and nutrition. The training will contribute to improving the amount and quality of output from the existing workforce. It will be observed that the description of human resource issues in the component strategy section of this proposal has been incorporated in each of the intervention and capacity building areas and not under a specific service delivery area of human resources.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year.

Year 1	Year 2	Year 3	Year 4	Year 5
A total of 1210 health workers trained in nutrition and CT services				
Round 7 Funding Request Year 1				
624,096				

Describe below other current and planned support for this action over the proposal term

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	2006-2010	$4m	2,567 additional health

			workers recruited
Other Global Fund Grants (with HSS elements)	Until 2011	$3.6m for GF R2 Ph 2 and R6	596 counsellors trained on VCT (R2),155 staff for TB/HIV (R6)
Clinton Foundation/ DANIDA	2006 - 2007	$17m	An additional 1,000 workers recruited for the public sector

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 2	**Strengthening information systems** Monitoring and evaluation in the Kenyan health system is essentially based on reports from the routine Health Information Management Systems (HMIS), supervisory (field) visits and periodic reviews. The HMIS shows imperfections as timely and comprehensive data are not available at one place in the central MOH (the 'authoritative source' for all departments to consult). In addition, the information is not performance based or output oriented as it does not yet serve decision making. As a recent report, analyzing the current M&E and HMIS information system stated: "currently available information is not adequately used for managerial decision making, data quality and timeliness is not optimal and there are several gaps and a great deal of overlaps in data collection by the various programs.". In addition, a National M&E policy is not yet in place and the list of core indicators for use by the DHMT has not yet been formalized and endorsed nationally. Various health programs also have developed information systems to respond to other program needs beyond what is available through the HMIS. M&E for HIV and AIDS therefore involves both NACC and NASCOP information systems. NASCOP collects a broad range of HIV and AIDS data to enable it to track progress, manage the program and report to the Ministry of Health, NACC and donors. The unit is structured along intervention areas such as ART, VCT, STI, PMCT and Blood safety, each serving as sub units. NACC is responsible for compilation of HIV and AIDS data from all sectors and to track national HIV and AIDS response indicators as outlined in the KNASP. A number of partner agencies have M&E outfits that guide tracking of progress in their particular programs. PEPFAR has the Strategic Information Group (SIG) which is hosted by CDC. NASCOP are members of the group. MSF also have an M&E system for programs they support. Through the Private Sector Advisory Network (KPSAN) and with support from FHI (Family Health International), the private sector has established "the Gold Star Network" for service provision which also collects data. It appears as if the Gold Star data is not fully captured by NASCOP or NACC. Major weaknesses of HIV and AIDS M&E have to do with the factor that the different systems are not always harmonized and some data such as on ART cohorts has not been systematically collected. This HSS activity includes 5 workshops for CSO SRs on M&E, one vehicle for NACC, 104 motorcycles, 81 computers, printing of M&E materials, and the recruitment of 20 data clerks. This figure does not include overhead to the PRs for M&E.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, <u>as a total only</u>, the amount requested for each year.

Year 1	Year 2	Year 3	Year 4	Year 5
ART reporting tools rolled out to all districts through printing of	ART reporting tools rolled out to all districts through printing of	ART reporting tools rolled out to all districts through printing of	ART reporting tools rolled out to all districts through printing of	ART reporting tools rolled out to all districts through printing of

tools and M&E strengthened through recruitment and equipment	tools and M&E strengthened through recruitment	tools and M&E strengthened through recruitment	tools and M&E strengthened through recruitment	tools and M&E strengthened through recruitment
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
492,141	67,323	67,323	67,323	67,323

Describe below other current and planned support for this action over the proposal term

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term**	**Expected outcomes from existing and planned support**
Government	2006-2010	In kind support of staff salaries and administration	Support and funding to NASCOP and NACC
Other Global Fund Grants (with HSS elements)	2007-2008	$1.1m R2 Ph 2	Support to NASCOP and NACC for M&E

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 3	**Health Service Delivery** Delivery of services to populations that need them is often constrained by lack of or inadequate infrastructure and facilities close to the population served. In Kenya, many people in rural communities have huge problems accessing health services because health facilities are situated very far from where the people live. This proposal seeks to address issues relating to health service delivery to underserved communities and groups. This will be done by providing resources to deliver services (such as counseling and testing, behaviour change communication, treatment literacy and other preventive and care services) through outreach activities and mobile services. Working with the NACC and with CSOs, the proposal will provide CT, BCC, treatment sensitization, stigma reduction and other messages to hard to reach populations. This proposal will strengthen human resources for health through promoting involvement of community volunteers and part time workers. These include people living with HIV and AIDS who are often eager to be involved in service delivery and are often quite knowledgeable of HIV and AIDS issues. Other groups that will be engaged include community groups, peer groups and other knowledgeable individuals. These will be engaged to provide services such as counselling, treatment education, and community outreach. They will be encouraged to get involved by being hired as part time workers, by being awarded some stipends for services provided or by being provided other forms of incentives. This approach will contribute to effectively increasing overall the number of people delivering services in the face of recruitment caps set for the public sector at a macroeconomic level.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year.

Year 1	Year 2	Year 3	Year 4	Year 5
Mobile CT and	Mobile CT and	Mobile CT and	Mobile CT and	Mobile CT and

ART services being carried out in underserved districts, and communities are sensitized on prevention and treatment	ART services being carried out in underserved districts, and communities are sensitized on prevention and treatment	ART services being carried out in underserved districts, and communities are sensitized on prevention and treatment	ART services being carried out in underserved districts, and communities are sensitized on prevention and treatment	ART services being carried out in underserved districts, and communities are sensitized on prevention and treatment
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
4,983,574	7,723,169	4,472,653	3,907,602	3,913,532

Describe below other current and planned support for this action over the proposal term

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term**	**Expected outcomes from existing and planned support**
Government	2006-2010	Support for staff salaries and administration	GoK supports health centres and is scaling up services.
Other Global Fund Grants (with HSS elements)	2007-2008	$752,000 R2 Ph 2	Scale up VCT at hard to reach sites, prevention

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 4	**Procurement systems** Whereas supply of pharmaceutical and non-pharmaceutical products to the Faith Based Organizations has for a couple of decades been cost-effective and efficient, public sector provision has been largely supply-driven and unsatisfactory. In 1997, key stakeholders proposed measures to implement the policy imperative of the Kenya Health Policy Framework 1994-2010. The main thrust of the proposed mechanism was a shift from supply to demand-driven system. This required institutional, legal and policy related interventions. These efforts led to the creation of the Kenya Medical Supplies Agency (KEMSA) in 2001. It was equally proposed that most supplies shall be centrally procured to ensure quality and economies of scale. KEMSA recently took over the central procurement functions that are currently handled by the MOH headquarters and has been assisted in this function by the Procurement & Supply Chain Management Consortium (PSCMC). The medium-term procurement plan for health commodities (MTPP) will guide the central procurement requirements. The required reforms to procure and distribute supplies is expected to progress in tandem with the necessary capacity building for all public sector facilities and districts to plan, manage, use and monitor their requirements, based on a given resource envelope. Support for instituting these reforms is being provided by a number of development initiatives, including the Global Fund, PEPFAR and the Millennium Challenge Corporation. This proposal will contribute to strengthening national procurement by providing resources to provide training, equipment for logistics information and ongoing technical assistance to KEMSA and other related agencies.

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Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year.

Year 1	Year 2	Year 3	Year 4	Year 5
KEMSA procurement capacity building	KEMSA capacity in procurement and distribution enhanced	Timely procurement of quality drugs and health products by KEMSA	Timely procurement of quality drugs and health products by KEMSA	Timely procurement of quality drugs and health products by KEMSA
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
215,528.05	266,827.04	415,056.63	416,528.00	416,528.00

Describe below other current and planned support for this action over the proposal term

Name of supporting stakeholder ↓	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term**	**Expected outcomes from existing and planned support**
Government	2006-2010	Staff and administration support	GoK supports KEMSA and TA funds are part of procurements
Other Global Fund Grants (with HSS elements)	2007-2008	$2.4m R2 Ph 2	Procurement services (this includes TA and service delivery)
Other: *(identify)* Millennium Challenge Corp.	2004-2008 (may be extended)	$12.7m	Improving health care procurement and delivery, strengthening KEMSA, reforming the public procurement system

4.4.2 HSS Strategic Actions continued
Risks arising from support for the actions and cross-cutting issues

(b) Describe your consideration of the broader implications of the proposed strategic actions and their potential impact on the functioning and performance of the health system, key institutions and stakeholders and other health programs (through a SWOT or other similar exercise). Describe, especially, any risk mitigation strategies in response to potential threats to the health system, and proposed options for ensuring long-term sustainability of the strategies built into this proposal.

The strategic actions for health systems strengthening in this proposal represent only a part of wider efforts undertaken by various stakeholders and with varying levels of resource inputs. All these efforts taken together eventually will lead to a stronger health system in the country. For that to happen it is necessary to ensure that the actions taken produce more benefits to the system than they present challenges, although it is not always easy to determine that.

A number of **benefits** will accrue to the health system as a whole by the health system strengthening actions proposed in this component. Firstly, by facilitating further expansion of essential HIV and AIDS

services the measure are contributing to addressing one of the most formidable challenges facility the health system in Kenya. The negative impact of HIV and AIDS on health systems in sub-Saharan Africa has been well documented. Therefore, the fight against HIV and AIDS by itself is an effort in health systems strengthening.

Secondly, health system strengthening actions proposed represent a net contribution of resources into the health system. This means that some of the shared resources that were used in HIV and AIDS service delivery can now be freed up to be used for other disease control efforts. In a similar manner, involvement of more auxillary workers for HIV and AIDS eases the workload of the already overstretched health workers.

The health system strengthening support being included in this proposal can bring some direct benefits to all patients. For example, if procurement capacity in the country is improved and is able to make available quality commodities in a timely manner, the same system can be used to procure commodities for other disease control efforts.

The health system actions might also have some **negative effects** on the rest of the health system. There might be continued perception of HIV and AIDS programmes as being better funded than many other programmes. This could lead to some tensions among programmes. In addition, some actions proposed such as training health workers in delivery of services will sometimes take staff away from their jobs for periods. One way this proposal counters the negative effects is through channeling funds to CSOs, so that overwhelmed health services do not need to do all of the activities.

The **potential risk** in undertaking these health systems strengthening actions is that the support could be used for other purposes than originally intended.

Opportunities exist which can contribute to success in the venture of health systems strengthening. Important among these is the determination by the Government of Kenya to strengthen the health system. Health is a high priority in the country's Economic Recovery Strategy and the government has been progressively increasing funding for health.

Putting in place strong a accountability mechanism would be an important measure in ensuring that adverse effects of systems strengthening actions are kept in check. A good monitoring and eveluation system is important in this context.

(c)	Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7?	☐ Yes ➔ *complete (d) and (e), and then (f)* ☒ No ➔ *go to section 4.4.2(f)*
(f)	Are there any cross-cutting HSS Strategic Actions integrated within **another component** in your Round 7 proposal that will benefit this component?	☐ Yes, Tuberculosis ☐ Yes, Malaria ☒ No

(g) **CCM and RCM Capacity for Health Systems Strengthening Issue identification**.
The CCM has been drawing on technical advice of the Inter-Agency Coordinating Committees (ICCs) on HIV/AIDS, TB and malaria. The ICCs were established to coordinate technical efforts of all stakeholders including development partners in specific disease control areas. The ICC reports to the CCM on Global Fund issues.

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The CCM is now in the process of establishing similar links with the ICC on health systems. The CCM governance manual already stipulates that the Health Systems ICC will provide technical advice and guidance on health systems aspects of Global Fund grants. The Health Systems ICC is comprised of government ministries such planning and finance as well as representatives of developing partners. The ICC coordinates health systems strengthening efforts in the context of the SWAp. The ICC on health systems, as well as other ICCs meets regularly to consider issues and carry out annual reviews of performance of the specific areas. The CCM through the ICC on health systems will have adequate capacity to address broader health systems issues in Global Fund supported programmes and ensure harmonization with other programmes.

4.5 Financial Needs Summary

4.5.1 Overall Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, describe the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis).

Summarize the overall financial need in table 4.5.

The estimation of resource requirements for implementing the Kenya National HIV/AIDS Strategic Plan (KNASP) 2005-2010 was accomplished by use of Resource Needs Model. The Model estimates required resources for a given set of targets in line with the three broad categories of interventions, namely prevention, improving quality of life and mitigation of socio-economic impact. In addition, the resources required for support services are computed as a proportion of the total required for implementing the interventions.

It is estimated that a total of US$ 2,393 million will be required to achieve the objectives of the KNASP 2005/6-2009/10. Prevention of new infections will require US$ 575 (24%), improving quality of life US$ 693 (29%), mitigation of social impact US $ 717 (30%) and US $ 406 (17%) will go to provision of support services. It is anticipated that the resources will be from the government, development partners and the private sector organizations.

The costs were developed taking into account the population in need of the services, the targets that were set and the unit cost to deliver the service. The following steps were followed:

i. Key services necessary to achieve the results and targets specified in the KNASP were identified
ii. The unit cost of delivering the service was determined based on service provider experiences
iii. The population in need of the service based on demographic data was determined
iv. Appropriate level of coverage of the services for each year was determined.

The KNASP estimated the resource requirements to 2010. The requirement for 2011 and 2012 are estimated to increase by 15% over the previous year.

4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

The GoK is the major domestic source of funding for the KNASP activities. The GoK allocated US$ 3 million and US$ 4 million to control HIV and AIDS programmes in 2005/6 and 2006/7 respectively. In 2007/8 the GoK has set aside US $ 7.1 million for procurement of ART in addition to the regular recurrent and development budgeting increasing spending to US$ 11.5 million in 2007/8. It is planned that the GoK will increase its allocation over the proposal period to US $ 23.6 million in 2011/12 as shown in table 4.5.

Health sector broad objectives in the medium term are targeted to key priority areas to ensure access of basic health services. These include investing on interventions that will in particular benefit the poor,

the vulnerable and women, improve cross- sectoral cooperation for promotion and public health, increase the efficiency and effectiveness through close collaboration of GoK and its partners under the SWAp strategy and increasing total GoK spending on health in line with the Abuja Declaration.

(b) External Sources

Key external sources of funding for HIV and AIDS interventions in Kenya are the Global Fund, PEPFAR, the Clinton Foundation, DFID and the World Bank. Phase 2 of The Global Fund Round 2 has just been signed and US$70 million is expected in the next 2 years. Support from PEPFAR is estimated to be in the region of US$206 million annually while another US $10 million is expected from the Clinton Foundation annually. The $115m TOWA project funded by the World Bank, DFID and GoK is also factored into this proposal.

4.5.3 Overview of Financial Gap

In table 4.5, Line E, provide a calculation of the gap between the estimated overall need (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

There will be a substantial gap over the proposal period. In 2007 there is a projected gap of US $133 million. This will grow over the period to about US $562m in 2012.

4.5.4 Additionality

The funding requested from the Global Fund in this proposal is arrived at after establishing that the resources available from the domestic and external sources will not be adequate to cover the Kenyan people in need of key services to control the disease. Kenya is fortunate to have development partners who are supporting its HIV and AIDS response.

However, even with the support Kenya is getting now there is a substantial shortfall of resources to meet the needs. The gap analysis clearly establishes that even after factoring in the support from this proposal, Kenya will not satisfy all the needs. Therefore the resources requested for in this proposal do not in any way displace any existing efforts but are in addition. Instead, further efforts will have to be taken to mobilize additional resources to fully implement the national plan.

In arriving at the resources available, GoK resources have been increased over the proposal term. Current and potential development partners were involved during the proposal process and confirmed the support they will provide during the proposal period.

The CCM will monitor resource inflow to ensure that those who have promised support provide it and that the Global Funds resources will not substitute for other sources.

4.5.5 Strategy for achieving sustainability

The Government of Kenya has recently been actively considering various options for building in elements of sustainability in HIV and AIDS programmes. Currently a significant proportion of funding for HIV and AIDS services comes from external sources. This leaves the country in a difficult situation should those sources discontinue their support. The government also acknowledges that financial sustainability must be a long term goal as the country will not be able to meet most of its needs for some time.

In seeking to address issues of sustainability, the government of Kenya is already undertaking a number of initiatives. The Ministry of Health established the National Committee on Sustainable Financing which is comprised of government and donor agencies. The government also in March 2007 invited an inter-agency technical mission to advise approaches for working towards sustainable financing of HIV and AIDS services, with particular reference to ART services. The mission recommended a number of possible measures to be undertaken such as progressive increase in government expenditure on HIV/AIDS and integrating financing for HIV and AIDS activities into sector wide planning and financing mechanisms including the Medium Term Expenditure Framework (MTEF) process. HIV and AIDS must also be integrated in the health sector reform process in the arrangements for Sector Wide Approaches

(SWAp) and in developing broader health financing strategies and arrangements. Other measures identified include exploring the potential of the National Hospital Insurance Fund and national social health insurance, establishment of an HIV and AIDS Fund and expanding private sector financing.

The Ministry of Health and the National AIDS Control Council (NACC) took those recommendations seriously and are acting on them. The Ministry of Health included an amount of US$ 7.7 million in its 2007/2008 budget and is seeking additional special funding for the next 3 years from the Cabinet. The HIV and AIDS ICC and the sustainable financing committee of the Ministry of Health are looking into carrying forwards other measures to move towards sustainable HIV and AIDS financing in the medium and long term.

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Financial gap analysis								
	Actual		Planned		Estimated			
	2005	2006	2007	2008	2009	2010	2011	2012
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	-	338,000,000	428,000,000	448,000,000	533,000,000	605,000,000	695,750,000	800,112,500
Domestic source **B1**: Loans and debt relief (*provide donor name*)#	-	-	-	-	-	-	-	
Domestic source **B2**: National funding resources	3,366,047	6,321,428	11,328,571	11,747,142	15,350,428	20,771,185	23,614,018	23,614,018
Domestic source **B3:** Private Sector contributions (national)				2,557,142				
Total of Line B entries ➔ Total current & planned domestic resources	3,366,047	6,321,428	11,328,571	14,304,284	15,350,428	20,771,185	23,614,018	23,614,018
External source **C 1**: All current & planned Global Fund			34,012,202	57,091,974	31,882,723	28,352,985	28,146,620	28,624,266
External source **C** 2: World Band/DFID-TOWA	27,922,449	1,794,982	28,750,000	28,750,000	28,750,000			
External source **C3** ; PEPFAR	142,900,000	208,000,000	206,000,000	206,000,000	206,000,000	206,000,000	206,000,000	206,000,000
External source **C 4**;Clinton Foundation			80,00,000	13,171,429	10,000,000	10,000,000	10,000,000	10,000,000
External source **C 10** ;Others	270,450	237,648	5,890,500	7,467,913	884,114	884,114		
External source **C4**: Private Sector grants / contributions (International)								
Total of Line entries C ➔ Total current & planned external resources	**171,092,899**	**210,032,630**	**274,652,702**	**312,481,316**	**277,516,837**	**245,237,099**	**244,146,620**	**244,624,266**
Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)	**174,458,946**	**216,354,058**	**285,981,273**	**326,785,600**	**292,867,265**	**266,008,284**	**267,760,638**	**268,238,284**
Line E ➔ Total Unmet need (Line A – Line D) -	**(178,516,088)**	**121,645,942**	**142,018,727**	**121,214,400**	**255,483,163**	**338,991,716**	**427,989,362**	**531,874,216**

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4.6 HIV/AIDS component/implementation strategy

4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal

This is not a resubmission of any past proposal. However, the TRP comments on past proposals have been reviewed to ensure similar weaknesses are not repeated in this proposal.

Kenya has submitted two consecutive proposals in Rounds 5 and 6, respectively, both of which were not approved for funding. In preparing this proposal the TRP comments for Rounds 5 and 6 have been carefully reviewed to ensure that weaknesses of previous submissions are sufficiently addressed in this proposal.

The CCM also commissioned an analysis of the Kenya Global Fund proposal development process in March-April 2007. The report of that analysis provided several recommendations to the CCM to improve the proposal development process, including: beginning proposal development work earlier, reviewing comments by the TRP on previous proposals, reviewing comments on Grant Score Cards and Grant Performance Reports, etc.

The table below summarizes the comments from the TRP and shows how they were addressed in this proposal:

Weaknesses in R5 or R6 proposal	**Change in R7 proposal**
The gap analysis was not clear(R6)	Two important developments have happened since the last submissions which made it easier to have a clear gap analysis in this proposal. In the first place, the costing of the KNASP 2005-2010 was completed and the necessary costing data is now available and has been used in this proposal. Secondly, there is clearer information available on financial commitments of various partners. This was due to the fact that a number of studies and assessments were undertaken in the last one year which were aimed at addressing performance and financing weaknesses of various programs. The system of tracking resources is improving with common management and financing mechanisms introduced by GoK. All these measures have helped to have more reliable data and clearer analysis of resource gaps in this proposal.
Costs were too high (for the FMA, for NVP and ZDV prophylaxis) (R5, R6)	This problem has been remedied in this proposal by using prices that are comparable to those recommended by WHO and MSF in the 'Sources and Prices' publication. The appointment of the PR for Non-Government Organisations means that an FMA will not be required in this proposal.
Inconsistencies between the targets, activities and budget allocations, and lack of correlation between activities described and budget (R5, R6):	To address this problem, the drafters began writing much earlier so that there was time to carefully check all activities, indicators, and budget items. The first draft was made available to the ICC more than 6 weeks before the proposal was due. With more time, and more careful attention paid to this issue, we believe we have addressed inconsistencies. A detailed budget was developed based on the activities proposed. The consolidated budget is a summary of the detailed budget. The services delivery areas, activities and budgets are linked.
Overlap between GF Round 2 activities and proposed activities	A major focus of the gap analysis has created a clear picture on the activities GF R2 covers, and when those will end. We carefully mapped out when the procurement will

(R6):	take place, and how long the R2 ARVs will last. This was considered in setting the targets for year 1 and year 2 of the R7 proposal. After year 2, there will be no more R2 ARVs. We made similar calculations for the other aspects of the proposal, including OI drugs and test kits. We do not believe that there is any funding overlap in this proposal. Activities are designed to follow on to R2 seamlessly, so that patient services are not interrupted.
Work plan was inadequate and did not ascribe responsibility to specific partners (R5)	Kenya embarked on a very rigorous, independent selection process for SRs. An independent panel spent over a week reviewing SR applications without input from the drafters. The process was finished in early June, adequate time to input the selected SRs into the workplan and the activities. The workplan and budget of this proposal now clearly assigns planned activities to specific Principle Recipients and Sub Recipients.
Overlap between planned activities and PEPFAR activities (R5)	We worked closely with the PEPFAR office in Kenya and reviewed their Country Operational Plans. Through communication and review of their documents, many publicly available, we are confident that there is no overlap. In many cases, PEPFAR and the GF work side by side, but the activities will not be duplicative.
Technical weaknesses in the proposals (R5, R6)	To address concerns about the technical weaknesses in the proposals, the CCM and ICC named a group of drafters with technical knowledge in all areas of HIV/AIDS in Kenya. This group had a drafting retreat, and also met several times. The ICC and CCM also provided technical input. Many development partners, including the USG, WHO, UNAIDS and others provided technical advice on the proposal.
Concerns about how NGO activities would be carried out given previous challenges between the PR and civil society partners (R5)	This issue is addressed in this proposal by the CCM decision to select a non-governmental organization to be PR for civil society organizations.

4.6.2 Goals and objectives and service delivery areas

Goal: Improved quality of life for people living with HIV and AIDS in Kenya and reduced HIV infections

This proposal will contribute to national efforts to reverse the HIV and AIDS epidemic in Kenya. The focus of the proposal is to address priority area two of the Kenya National HIV/AIDS Strategic Plan: to improve the quality of life of people infected and affected by HIV and AIDS.

Although all areas of the national response to HIV and AIDS still require additional support, the area of treatment is one of the most challenging in terms of availability of resources to scale up and maintain the services. The needs assessment of this component has demonstrated that HIV and AIDS treatment represents a large gap in the national response. This proposal therefore seeks additional resources to complement existing efforts in treatment that are being undertaken by the GoK and various partners such as the Global Fund, PEPFAR, the Clinton Foundation, MSF and various CSOs and FBOs.

The proposal will contribute to improving the quality of life for people living with and affected by HIV and AIDS by expanding availability of treatment and related services. Provision of treatment services will particularly focus on extending these serves to communities that are not adequately covered at

present, especially rural communities. This will be done by decentralizing access to ARV treatment and treatment of opportunistic infections. These services need to go with related services such as increased access to HIV counselling and testing as well as information on HIV and AIDS treatment and prevention. Also included in this proposal are activities to strengthen the capacity of the health system and implementers, to ensure that the programmes included in the proposal are effectively implemented and monitored.

There are four objectives and seven service delivery areas under the goal of reversing the HIV and AIDS epidemic in Kenya through the scaling up of treatment programs and strategic prevention.They are as follows:

Goal	Objectives	Service Delivery Areas
Improved quality of life for people living with HIV and AIDS in Kenya and reduced HIV infections	Objective 1: To scale up and maintain PLWHAs on ART	SDA 1.1: Treatment: Antiretroviral treatment and monitoring
		SDA 1.2: Prophylaxis and opportunistic infections
	Objective 2: To increase access to HIV testing and counseling services	SDA 2.1: Counseling and Testing
	Objective 3: To increase uptake of HIV prevention and treatment services	SDA 3:1: Behaviour change communication – mass media
		SDA 3.2: Behaviour change communication – community outreach
	Objective 4: To strengthen institutional capacity to effectively implement and monitor HIV/AIDS services	SDA 4.1: Information system & operational research
		SDA 4.2: Strengthening of civil society and institutional capacity building
		Service delivery*
		Human resources*
		Procurement and Supply management*

**Activities in human resources, service delivery, and procurement and supply management are not listed as SDAs because they have been integrated in other parts of the proposal.*

4.6.3 Specific Interventions, Target Groups and Equity

(a) **Specific Interventions/Activities supported by this proposal**

Objective 1: To scale up and maintain PLWHAs on ART

The aim of this objective is to continue scaling up ART services to meet the growing need and demand. Currently, there are approximately 145,000 people on ART in Kenya. This represents about 40% of the total number of people estimated to be in need of ART in the country. Kenya is committed to moving towards the global goal of universal access to ART by 2010. In this regard the KNASP has set a target of reaching 75% of people who need ART by 2010. The current shortfall in ART services is still significant and will have to be filled by resources from various sources. This proposal will help to cover the treatment gap. It will serve as continuation for people on ART (42,500) currently supported by the Global Fund Round 2 grant once the grant comes to an end in 2008, and scale up to an additional 20,264 patients.

The proposal also provides for increasing access to prophylaxis and treatment of opportunistic infections and a nutritional improvement program for PLWHA in Suba District.

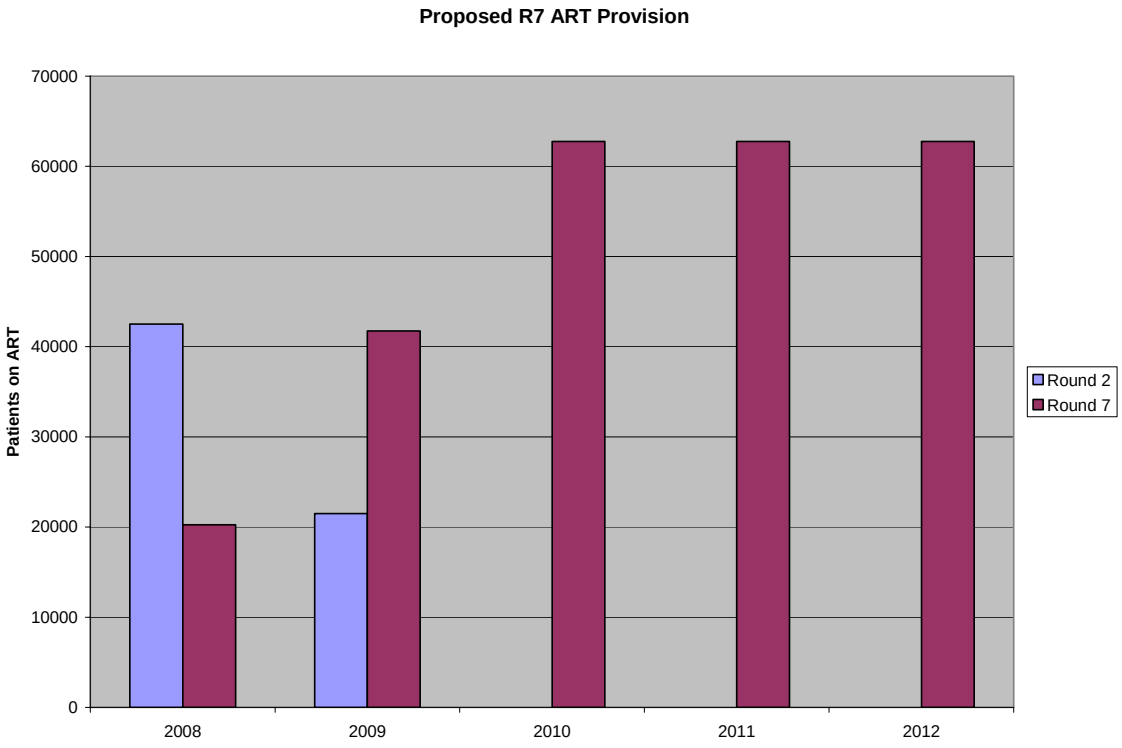
SDA 1.1: Anti-retroviral treatment and monitoring

Activities

1.1.1 Procurement and distribution of anti-retroviral drugs to ART clinics

Kenya has 144,545 people on ART and this number is projected to increased based on commitments from development partners and the GoK. About 73,764 PLWHAs eligible for ART will not have access to drugs and services in 2008. This number is projected to increase to 95,028 by 2010. The Global Fund Round 2 will also come to an end in 2008, leaving 42,500 patients without access to ART. This proposal seeks to put 20,654 new PLWHAs on ART in the first year (2008) and thereafter sustain the 42,500 patients from the GF Round 2 grant, for a total of 62,754 on ART. This effort will contribute to the achievement of the universal ART targets to which Kenya is a signatory. In Year 1 of the R7 program, only ARVs for the new patient will be necessary, or 20,264. In year 2, NASCOP will need to move 21,000 patients from R2 to R7 drugs, for a total of 41,254. In years 3-5, 62,764 patients will be supported by R7.

The National AIDS and STI Control Programme (NASCOP) will manage this component of the programme. Procurement will be managed by KEMSA and its technical partner. As mentioned above, second line drugs and paediatric formulations are covered by the Clinton Foundation and PEPFAR.



1.1.2 Procurement and distribution of CD4 reagents to regional laboratories

CD4 testing forms a strong basis for monitoring of patients on ART. New patients recruited into HIV/AIDS clinics require a minimum of 3 CD4 tests annually. Patients on ARVs require CD4 testing every 6 months. Nine regional laboratories are currently being strengthened to support ART monitoring with funding from APHIA II partners, supported by the PEPFAR programme.

Samples from districts will be tested at the regional laboratories to support ART monitoring. The demand for laboratory testing is expected to increase as more HIV clinics get access to the regional laboratories and patient monitoring in previously underserved clinics improves.

Based on the rate of increase of patients being recruited into care and ART programme, it is estimated that the number of CD4 tests required will rise from 679,202 in 2007/08 to 776,004 in 2008/09 and to 837,754 in 2009/10. PEPFAR will provide 500,000 CD4 tests over a period of 2 years covering 2007/08 and 2008/09. This proposal will provide CD4 reagents for 200,000 tests annually over the five year period. This activity will be carried out by NASCOP.

1.1.3 Procurement and distribution of nutrition supplements and therapeutic feeding to 14 ART sites in Suba district

This proposal seeks to provide nutrition supplements and therapeutic feeding in Suba district. This district has been selected because it has the highest prevalence rate (32.9% against a national average of 5.9%), highest poverty index (60% against a national average 46% poverty index) and high level of food insecurity. Given these factors, most PLWHAs on ART have high nutritional needs.

The proposal will provide nutritional supplements to 33,849 patients, therapeutic feed to 12,035 adults and 3,009 children. These commodities will be given in 14 ART clinics in Suba district. This initiative will enable the national ART programme to develop comprehensive delivery systems for nutrition and to plan for a scale up of the nutrition component of ART in the coming years. This activity will be carried out by NASCOP.

Specific activities to be carried out include:

- Procurement of nutritional micronutrient supplements for ART patients
- Procurement of therapeutic feeding for severely malnourished patients (adults and children) on ART. Nutrients to be provided will be F75, F100 and Plumpynut.

1.1.4 Procurement and provision of nutrition assessment equipment to ART clinics

This proposal will procure equipment for assessing nutritional status of ART patients. Equipment requested includes weighing scales, adult MUC tapes, children MUC tapes and heightometers. This will support prescription of nutrition supplements. The equipment will be supplied to 14 sites in Suba district. This activity will be carried out by NASCOP.

1.1.5 Training of service providers

Health workers in ART clinics where nutrition supplements will be provided under this proposal will be trained in nutrition using the current nutrition guidelines. 28 health workers will be trained, two in each of the 14 sites. This activity will be carried out by NASCOP.

1.1.6 Revision of nutrition guidelines

The national nutrition guidelines will be reviewed and revised in the first year of this proposal. Stakeholder workshops will be organized to review and update the nutrition guidelines. This activity will be carried out by NASCOP.

SDA 1.2 - Prophylaxis for opportunistic infections

The National HIV treatment guidelines for Kenya state that all patients recruited into the HIV and AIDS clinics should be on cotrimoxazole to prevent opportunistic infections. This has been practiced with significant success in all facilities providing HIV and AIDS care. With the decentralization of HIV and AIDS services to health centre level and with the inclusion of more facilities providing HIV/AIDS care, the number of clients accessing HIV and AIDS services and needing prophylaxis for opportunistic infections will increase significantly. It is projected that the number of people recruited into the HIV and AIDS clinics will increase from 411,606 at end of 2007 to 713,073 by the end of 2012. This projection assumes that the HIV prevalence will decline from the current 5.9% to 4.5% by 2010 as targeted in the KNASP.

Activities

1.2.1: Procurement and distribution of cotrimoxazole

The major activity to be implemented under this service delivery area is the procurement and distribution of cotrimoxazole to HIV and AIDS clinics. 756,000 packs of cotrimoxazole will be procured by end of the programme term. 200,000 patients will be covered by this service. NASCOP will manage this activity and KEMSA and its technical partner will be the procurement and supply agent.

Objective 2: To increase access to HIV testing and counselling services

Counselling and testing is an important entry-point to HIV and AIDS prevention, treatment and care. The more people seek to know their HIV status the more they are able to modify HIV-related behaviour and the more they are likely to seek treatment early. This results in reduced transmission and improved quality of life. Kenya has made significant progress in scaling up HIV counselling and testing. There are currently about 700 sites providing counselling and testing in the country and about 1.8 million people were tested for HIV in 2006.

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Kenya is moving towards increasing access to counselling and testing using multiple service provision models. Round 2 Global Fund grant is supporting the establishment of 273 VCT centres and supply of test kits. Kenya is also strengthening provision of counselling and testing services in health care setting by providing wider offer of testing in addition to ongoing diagnostic testing, in the context of Provider Initiated Testing and Counselling (PITC).

This proposal seeks to support counselling and testing efforts by making available additional HIV test kits to ensure that more people are able to access the service. Also included here will be efforts to extend counselling and testing services in underserved districts by introducing mobile services.

SDA 2.1– Counselling and Testing

Counselling and testing is a major strategy for prevention and treatment of HIV and AIDS. There are 881 VCT sites established in the country with an estimated uptake of 1.8 million people in 2007. Kenya is moving towards increasing access to counselling and testing using multiple service provision models. Fewer than 20% of Kenyans know their HIV status. Only about 20% of PLWHA know their status, which means many people continue to seek treatment at late stages of the disease.

This proposal seeks support for continued provision of test kits, training, and new mobile CT services. This service will be coordinated by NASCOP and implemented through VCTs and health facilities, with support from CSO implementers.

Activities

2.1.1: Procurement and distribution of HIV test kits

This proposal will provide 139,611 packs of test kits during the 5 year period. This includes 47,312 packs of Determine, 76,499 packs of Bioline, and 15,300 packs of UniGold. The procurement will be done by KEMSA and its procurement partner.

2.1.2: Conduct 4,245 mobile counselling and testing events in 81 districts

Mobile CT as a strategy for increasing access to CT is already being implemented. This proposal will support 405 mobile CT outreach activities by the end of programme term to accelerate the number of people accessing CT services especially in hard to reach areas. The mobile CT will be organized by the District Health Management Team. This activity will be implemented in hard to reach districts and where the concentration of VCTs is low. These areas include North Eastern, North Rift and Western Kenya.

This activity will be implemented as follows:

(i) Planning: The DHMTs will develop an implementation for the mobile CT identifying the locals for CT, personnel required, logistics and the awareness campaign.

(ii) Conduct community mobilisation: An awareness campaign will be carried out in the catchments around the location where mobile CT will be undertaken. This campaign will mobilize the community to attend the mobile CT services. The DHMT will work with local CBOs, NGOs and FBOs to provide information on CT.

(iii) Carry out mobile CT. After community mobilization, the actual mobile CT work will be done. Counsellors, nurses and laboratory technicians drawn from nearby health facilities will conduct this exercise. The DHMTs will provide transport and required commodities. Teams will spend one day in each location.

Civil society will partner with MoH/NASCOP to implement mobile counselling and testing. The civil society strength in this area is in reaching out to MARPs that MoH/NASCOP may not effectively reach. Two CSOs will implement this activity - Hope Worldwide Kenya will provide mobile CT services targeting Commercial Sex Workers and Long Distance Truckers at specific hotspots on the Mombasa-Busia Highway; targeting youth at Matatu (public transport bus stations) hotspots in Nairobi, Mombasa, Kisumu, Eldoret and Nakuru and lastly targeting Commercial Sex Workers and their clients at entertainment hotspots in Nairobi, Makindu, Kibwezi, Kitengela and Ikutha. Hope Worldwide Kenya will carry out a total of 3600 mobile CT events. The second organization, Nyarami VCT, will provide 240 mobile CT services in Migori, Rongo and Kuria districts and Nyanza province which have some of the highest HIV prevalence rates in the country. NOVOK will reach out to youth and run mobile clinics in Western Province and Vihinga.

2.1.3: Training of 1,182 health workers

NASCOP will train 756 health workers at health facility level on provider initiated testing and counselling, couples counselling and CT for the hearing impaired. The training will equip health workers with skills for counselling and testing for scale up of CT services. Currently, there are 63 CT supervisors, 88 couple counsellors, 6 CT counsellors trained in CT sign language and 1500 health workers trained in PICT. In order to achieve universal access to CT services, there is need to train additional health workers.

Further, the Organisation for Assisting the Hearing Impaired Persons (OAHIP) will train 426 health workers across the country on reaching out to and interacting with hearing impaired people so that they can access CT services.

Objective 3: To increase uptake of HIV/AIDS prevention and treatment services

This objective addresses information provision to target populations with the aim of increasing uptake and rational use of the treatment and care services offered. It also includes promoting HIV prevention. The inclusion of some prevention activities is due to the fact that information on treatment and care must go together with information on prevention. The two cannot be separated. In addition, it is in the area of communication and community outreach where civil society organizations often make the most contribution and become more involved in treatment and care programmes. The main services to be delivered under this objective relate to communication and community outreach on treatment literacy and HIV prevention.

SDA 3.1 – Behaviour change communication – mass media

This proposal aims at increasing the uptake of HIV/AIDS prevention and treatment services through strategic communication. HIV prevention programmes and messages will be developed and disseminated through radio, TV and outdoor communication tools. The proposal will provide messages on ART, CT and safe sexual behaviour focusing on condom use, abstinence and partner reduction. Targeted media programs will be developed on ART adherence, counselling and testing and sexual behaviour change. These programmes will specifically target PLWHAs, the youth, and MARPs. MARPs in this proposal are Commercial Sex Workers and their clients, Long Distance Truckers, Men Having Sex with Men, prisoners, and Injecting Drug Users. Strategic communication in this proposal will reinforce the delivery of services.

Activities

3.1.1: Development and airing of Radio and TV HIV/AIDS prevention and treatment programmes

HIV prevention programmes and messages will be developed using evidence based approach. Programmes and messages will target the PLWHAs, youth and MARPs.

Sub activities to be carried out include:

(i) Development and airing of programmes and advertisements:

A total of 3 radio and TV programmes will be developed annually. These programmes will be aired 370 times on radio and 130 times on TV over the five year programme term. 8 advertisements on the issues targeted in this proposal will be developed annually. These will be aired on national and regional radio 4,000 times (advertisement spots) annually.

The radio stations with high listenership among targeted populations will be used to air HIV prevention messages and programmes. The following radio stations will be used:

- Kenya Broadcasting Cooperation (KBC) – This is a national public radio station with countrywide coverage and will be used to target the all priority groups for this proposal.
- Citizen radio – A private radio station with national coverage and the second highest listenership. This will be used to target all the priority groups.
- Kiss FM – Private radio station with wide coverage, highly popular with youth.
- Ramogi, Baraka, and Coro radio stations – these are regional radio stations using local languages in areas with high infection rates.
- Iqra radio targeting Muslim community.

(ii) Development and distribution of 15 documentaries on HIV prevention and treatment to all partners

implementing this programme.

This activity will be implemented by the National AIDS Control Council, Ukweli Productions, Supreme Council of Muslims of Kenya and Women Development Response Agency.

SDA 3.2: Behaviour change communication – Community outreach

Community based participatory activities will be carried out to provide information and education on HIV prevention and treatment services. Community outreach activities will be carried to provide information and education on three areas:

(i) Anti-retroviral treatment targeting PLWHAs and their families
(ii) Counselling and testing targeting the youth and MARPs
(iii) Sexual behaviour change targeting the youth and MARPs

These activities will be carried out by NACC in partnership with civil society (CSOs) and faith based organizations (FBOs) and the private sector organizations. The CSOs implementing this activity include Health and Foundation and Zinduka Africa.

Activities

3.2.1: Sensitization of PLWHAs and families on ART

Information and education will be provided to PLWHAs and their families on ART services. The information and education will be in ART adherence with emphasis on adherence to drugs and nutrition. This activity will be implemented by CSOs, FBOs and Private Sector organizations using national guidelines and curriculum developed by NASCOP.

Sub activities:

(i) Community meetings targeting people living with HIV and AIDS and families: The information and education will be provided through 4,320 community meetings: Implementing organizations will organize community meetings targeting the families of PLWHAs. Associations of PLWHAs, chief's barazas and local CBOs will be used to reach out to PLWHAs and families.

(ii) Development and distribution of IEC materials on ART: 300,000 posters on ART will be developed and distributed in strategic places. The posters will provide messages on ARVs and nutrition as key components of ART.

This activity will be implemented by the following organizations by NASCOP, Young Professionals for Development, Women Fighting AIDS in Kenya, Women Development Response Agency and Marie Stopes.

3.2.2: Sensitization of the youth and MARPs on counselling and testing

This proposal will provide information and education to the youth and the prioritized MARPs to enable them to seek counselling and testing services. The following strategies will be used to reach these groups:

(i) 12,600 community outreach events for the youth: The youth will be sensitized on the importance and availability of HIV counselling and testing services. This activity will be carried out CSOs and FBOs in collaboration with local VCT and health workers. Organisations to implement this activity include Kenya AIDS Consortium, Zinduka Africa, Mpala Community Trust, Friends of AIDS Victims Organisation, Peace and Development Trust, Women Fighting AIDS in Kenya (WOFAK), Wajir South Development Association, Family Support Institute, Goal, Self Help Development International Kenya, Health and Water Foundation.

(ii) 1,150 outreach events targeting CSWs and clients, MSMs and IDUs: These groups will be targeted at the hotspots where they socialize. The activity will be implemented by KANCO through its member organizations who are currently reaching these groups. The Catholic Diocese of Homa Bay will target IDUs specifically using networks and linkages established under an ongoing programme funded by UNODC. Under this proposal, the program will be expanded to reach more IDUs.

(iii) Outreach activities for people with disabilities: According to the United Nations Statistics Division, 0.7% of Kenyans are disabled. Kenya has played a leadership role in providing services to the blind, the deaf and the disabled in Africa. Under this proposal, 585 community outreach events will be carried out targeting the Blind and the Mentally Handicapped using the relevant

associations. Kenya Union of the Blind and Kenya Society for the Mentally Handicapped will implement this activity.

3.2.3: Sensitization of the youth and MARPs on sexual behaviour change

The youth and MARPs prioritized for this proposal will be provided with information and education to promote safe sexual behaviour. Focus will be on abstinence, condom use and partner reduction. This communication strategy will also be linked to the information on HIV counselling and testing.

The specific strategies for delivering this activity include:

(i) Peer education: 15,000 peer educators will be trained over the proposal term to provide sensitize to the youth. This strategy will be implemented by Kenya AIDS Consortium, Merlin, Supreme Council of Muslims, the Organisation for Assisting Hearing Impaired Persons, Neighbours in Action and the National Organisation of Peer Educators.

(ii) Establishment of 57 school health clubs: These clubs will sensitize the youth in school on safe sexual behaviour. The organizations to implement this strategy will be building on the work that they are already doing. Implementers include Self Help Development International, Goal, National Organisation of Volunteers and Charity Workers in Kenya, Beacon of Hope.

(iii) Participatory education theatre: Information and education on safe sexual behaviour will also be provided to the youth and MARPs through theatre. 1240 theatre events will be implemented over the period of this proposal. Implementers include National Council of Churches of Kenya, Merlin, Beacon of Hope, Maji na Ufanisi and the Organisation for Assisting Hearing Impaired Persons.

(iv) Youth to Youth activities: These activities will target youth out of school. The activities to be carried out include 225 sports events, 950 activities targeting youth groups, establishment of 62 youth resource centres and distribution of 2000 IEC materials in first, third and fifth year of the programme. Implementers of this activity are Kenya AIDS Consortium, Supreme Council of Muslims of Kenya, Beacon of Hope, Sanaa Arts Promotions, Maji na Ufanisi, Kwetu Training Centre, Food for the Hungry Kenya and Family Support Institute.

3.2.4: Providing of HIV/AIDS prevention and treatment information and education in private enterprises

This activity will target employees in private enterprises of all sizes to enable them seek HIV/AIDS services. Key messages will be on ART, CT and safe sexual behaviour. Specific strategies for delivering this activity include:

(i) Printing of 6,000 IEC materials and distribution to private enterprises

(ii) Training of 600 peer educators drawn from private enterprises

(iii) Implementing 250 work place sexual behaviour change events

This activity will be implemented by the Federation of Kenya Employers using its countrywide organizational structures.

3.2.5 Training of CSOs, FBOs and Private sector on HIV/AIDS prevention and treatment information and education

NACC and NASCOP will develop a standard curriculum to be used by CSOs, FBOs and Private Sector to provide information and education on HIV and AIDS prevention and treatment. This will ensure that information provided in standard and fits national guidelines. The key sub activities to be carried are as follows:

(i) Development of the training manual: This manual will be based on the national guidelines for ART, CT and communication strategy for sexual behaviour change. 5,000 IEC materials will be produced and distributed.

(ii) Training of the trainers drawn from CSOs, FBOs and Private Sector organizations: The trainers will be trained on content (curriculum) and delivery strategies. The trainers will be used to train 100 peer educators who will be delivering community outreach activities.

Objective 4: Strengthening institutional capacity

There are a number of capacity constraints in various institutions providing HIV/AIDS services that often impede effective delivery of HIV and AIDS services. Most of these have already been highlighted in the

description of the national health system in section 4.3.4 of this component. Experience in implementing programmes supported through the Round 2 grant indicate that it is important to take full consideration of measures aimed at strengthening institutional capacity, for effective implementation and accountability. Under this objective the need to strengthen institutional capacity of implementing and coordinating institutions is taken into account. Capacity building under this objectives addresses a range of issues such as human resources, service delivery, monitoring systems as well as procurement and supply management. Support to strengthen institutions will be provided to NGOs, private sector as well as government institutions.

This objective includes monitoring and evaluation for HIV/AIDS programmes generally and for ongoing Global Fund grants. M&E has been a weakness, with Kenya being unable to report effectively on the Round 2 phase 1 grant. Several assessments have been carried out to establish the bottlenecks in the M&E function. Recommendations from these assessments have pointed more specifically what needs to be done to improve M&E. Some of these recommendations are already being implemented. In this proposal, Kenya seeks assistance to reinforce the on-going M&E improvement.

There are several Service Delivery Areas for strengthening institutional capacity that have been integrated into other parts of the proposal. These are: human resources, service delivery, and procurement and supply management.

- **Human resources:** Human resource development is a major issue in Kenya, and has been integrated into the proposal in activities 1.1.5 Training of service providers, 2.1.3 Training Health Workers, 3.2.3 peer educator training, 4.11 technical and management assistance, etc.
- **Service delivery:** Service Delivery is integrated into sections of the proposal on Delivery of ARVs, OI prophylaxis, CD4 testing reagents, counselling and testing, mobile counselling and testing, and prevention activities.
- **Procurement and supply management:** A large portion of this proposal will go towards procurement of drugs and reagents, and a strong procurement and supply management system is essential towards meeting the program's goals. As described in section 4.10, KEMSA will work with a technical partner on procurement and distribution, and the proposal includes technical assistance and monitoring to ensure that capacity is built for KEMSA.

SDA 4.1: Information System & Operational Research (these activities need to be harmonized with the budget)

This proposal will strengthen M&E systems for health sector HIV/AIDS response and Civil Society, FBOs and Private Sector activities. CDC and JICA are supporting NASCOP to roll out the M&E to the health facilities. The M&E collects data on all HIV/AIDS services including ART, VCT, PMTCT, DTC, Nutrition and HBC at health facility. The systems have been pre-tested in Western and Coast provinces and the programme is now prepared to roll out the system countrywide. Global Fund Round 7 will support NASCOP in data collection and reporting from health facility to district level.

National AIDS Control Council will also be supported under this programme to strengthen the implementation of COBPAR at the constituency level. This tool will enable civil society, faith based organizations and private sector organizations to report on activities and funds expenditure to NACC. This proposal will strengthen this M&E system.

Activities

4.1.1 Capacity Building of Global Fund Implementers

This activity will fund the CARE to hold one workshop per year for the Non-Government SRs. Capacity building activities will include monitoring and evaluation, program management, Global Fund rules and requirements.

4.1.2 Field assessment supervisory visits and data verification

This support will enable NACC M&E to conduct 38 quarterly supervision and data verification missions to strengthen the performance of Kenya's HIV and AIDS GF grants.

4.1.3 Evaluation of the programme

This proposal will support mid term and end of term evaluation of this proposal. This will take place at the second and fifth year of the programme. The evaluation will be commissioned by the PRs in collaboration with the CCM.

4.1.4 Procure one motor vehicle to support Coordination, supervision and monitoring of the programme

This activity will allow NACC to procure one motor vehicle for coordination, supervision and programme monitoring. There is also a budget for fuel and maintenance of the vehicle. This will strengthen NACC's ability to coordinate the National Response.

4.1.5 Procurement of 104 motorbikes for M&E

NASCOP will purchase 54 motorbikes to be used by district health data clerks to collect data on HIV and AIDS services provided at health facilities. NACC will also procure 50 motorbikes to be used by the constituency coordinators to monitor the national response to HIV and AIDS. The proposal also budgets fuel and maintenance over the five year span of the program.

4.1.6: Procurement of 81 computers

This will be support to the strengthening of the National HIV and AIDS M&E system to improve quality of data. NACC will procure 81 computers to be installed in constituencies to facilitate reporting by constituencies on HIV and AIDS activities. The computers will be used by Constituency AIDS Control Coordinators.

4.1.7: Printing of ART data collection tools

This proposal will support NASCOP to print data collection tools to be distributed to districts and health facilities for use. The data tools will strengthen reporting of clinical data.

4.1.8: Recruitment of 20 district data clerks

The data clerks will be deployed to districts to facilitate implementation of the HIV and AIDS M&E system. This will be additional to 100 clerks deployed with support from CDC. This will be implemented by NASCOP.

SDA 4.2: Strengthening of civil society and institutional capacity building

This is the first proposal where Kenya is proposing a civil society organization as a PR. 34 CSOs will be SRs. This SDA is developed in order to build the capacity of these CSOs to be effective implementers of GF programs. They will need technical assistance in the area of program management, financial management and reporting.

Activities

4.2.1 Support to CSO, FBOs and Private Sector organisations SRs

The proposal will support the selected CSOs, FBOs and Private Sector organisations to implement the activities in this proposal. This support covers management, administration, and M&E for the 34 sub recipients.

4.2.2 Monitoring and Supervision by the PRs

This covers the cost of administration, program management, M&E and capacity support to be provided by the Principle Recipients. The budgets for Care are larger than the budget for the MoF because Care will need to manage and supervise 34 SRs, which will be a significant amount of work.

4.2.3 Technical Assistance

This activity covers all of the TMA requested in section 4.11 of this proposal.

(b) **Target groups**

Provide a description of the target groups (and, where relevant, the rationale for inclusion or exclusion of certain groups). In addition, describe how the target groups were involved during planning, implementation and evaluation of the proposal prior to submission to the Global Fund. Describe the impact that the program will have on these group(s).

This project primarily targets PLWHAs, youth, and MARPs.

1. PLWHAs

The ART services proposed will target PLWHAs, who will have access to comprehensive ART services.

The project will contribute to the attainment of universal ART targets for Kenya. PLWHAs will have access to ART services which will include ARVs, patient monitoring and nutrition. The project will contribute to overall improvement of the quality of life of PLWHAs and reduction of the overall impact of HIV and AIDS.

Within PLWHA groups, ARVs will be provided to pregnant women, people with TB, and other MARPs.

Members of PLWHA groups are involved in the CCM and the ICC, which was responsible for drafting the proposal. Feedback was sought by PLWHA during the writing of the proposal.

2. Youth (15-24 years)

HIV prevention interventions proposed in this project will target the youth as a key priority group. Youth are essential to the reduction of new HIV infections and the reduction of HIV prevalence in the long run. Prevalence rates among the youth are an indication of the future trend in HIV pandemic.

The impact of the prevention interventions proposed will contribute to the reduction of new infections to achieve national targets among the youth of 0.8% for boys and 4.5% for girls through promotion of safe sexual behaviour and raising the age for sexual debut.

3. Most-at-risk-populations (MARPS)

Prevention interventions will also target MARPs – commercial sex workers and their clients, long distance transporters, prisoners, migratory workers, MSMs and IDUs. These groups have been identified given their role in driving HIV infections.

(c) **Equitable access to services**

Kenya presently has over 144,000 people on ARVs, and is scaling up rapidly. A key strategy in this is the decentralization of services to the health centre level. Currently 190 sites receive drugs from PEPFAR and 124 from the Global Fund, with an additional 50 sites providing ARVs from both programs. Other sites include MSF (10) and other donors. These sites are equitably distributed countrywide.

ARVs are free in Kenya, so there patients do not have to pay for them at public health centres. Health centres charge a small consultation fee, but there is a waiver system for the poor.

This proposal also includes work from 34 civil society organizations, many who do not currently provide GF programming. This will also allow for outreach beyond locations where the Global Fund has worked in the past. In the selection of SRs, the Independent Review Panel considered the geographic region(s) where the CSO proposed to work, and looked in particular for groups capable of working in underserved regions in the North of Kenya. The CSOs selected also include a range of different types of groups, including CSOs, FBOs and the private sector, and this should increase access among the population.

The nutrition program proposed is in only one district. The need for nutrition programs is overwhelming, but Suba District is particularly in need and was selected because of the dearth of other programs operating there. To increase equity, nutrition supplements will be provided for both adults and children. In the future, the CCM would consider applying for additional resources for nutrition to increase equity.

(d) **Social inequalities targeted in this proposal**

Currently, 55% of those in need of ARVs have access to them, and the Kenya's goal is to reach 75% of people in need of ARVs by 2010. Because of this, the MOH is actively reaching out to all groups for counselling and testing, so that they will have access to services. NASCOP has not identified any gender barrier to ARV access, and slightly more women receive ARVs than men. Therefore, there are no major social inequality challenges in this proposal.

(e) **Stigma and discrimination**

This proposal will provide information and education on HIV prevention and treatment targeting PLWHAs and vulnerable groups. Associations of PLWHAs will be targeted and also used to reach out to the communities. This participation of PLWHAs will impact positively on stigma associated with HIV and AIDS. The strategies adopted in this proposal ensure that PLWHAs will not be discriminated. On the contrary, a large percentage of this proposal will provide services to PLWHAs.

4 Component Section *HIV/AIDS*

Linkages to other programs

4.6.4 Performance of and linkages to current Global Fund grant(s)

(a) If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why.

Five of the SDAs that are supported in Round 2 grants are included in this proposal namely: Counselling and testing; Behaviour change and communication- mass media; Antiretroviral and monitoring; Prophylaxis and treatment for opportunistic infections; and Institutional building.

The ART support being sought in this proposal is to expand the services to reach more peoples in need, and to cover patients after R2 ends. The number of people needing ART has increased over time and is projected to increase at the rate of 5,000 new clients monthly during the proposal period. As can be readily seen from table 4.5.2 there is a gap in ART services that calls for scaling up to over 423,564 people by 2012. Another 713,073 need OI drugs. At the same time ART is being expanded to include supplements and therapeutic feeding. The proposal therefore seeks support for procurement of ART and OI drugs.

The BCC support being sought in this proposal is for scaling up CT services to generate demand among the general population and target the higher risk populations. The CT uptake in Kenya is still low to effectively contribute to prevention of new infections.

The Counselling and testing component in Round 2 was to increase access to counselling and testing services primary by supporting the expansion of VCT sites, recruitment and training of more counsellors. The focus of this proposal remains increasing access to counselling and testing service through different strategies, supporting the procurement of testing kits and use of mobile outreach services.

Institutional support to strengthen M&E and build organizational and institutional capacity is also sought in this proposal. M&E remains a major bottleneck in programme management and needs urgent attention.

The following table compares targets of key services between R2 and R7:

Interventions	Round	Targets					
		2007	2008	2009	2010	2011	2012
People on ART	2	42,500	42,500				
	7		20,254	41,254	62,764	62,764	62,764
People receiving counselling and testing	2	not an indicator					
	7		378,845	783,703	916,722	1,058,320	1,208,956
OI prophylaxis	2	120,000	156,000				
	7		200,000	200,000	200,000	200,000	200,000

(b) Where there are any linkages in this proposal to planned interventions already supported by Global Fund grants, **describe, by reference to information generated in regard to those existing grants**,** how implementation bottlenecks and lessons learned have been incorporated into the implementation strategy for this proposal to better ensure the overall feasibility of the planned interventions

Performance of in Phase 1 of the Round 2 grant was not satisfactory for a number of reasons. They include the following:

- The necessary financial management and procurement systems in the Principal Recipient (PR) and Sub-Recipients (SR) had not yet been well established.
- There was delayed and poor quality of reporting which did not clearly link expenditure to activity results. Delayed reports resulted in delayed disbursement requests, as the two go together.
- There was lack of clarity in the roles of various entities involved in managing Global Fund supported

programmes. The involved entities include the PR, the CCM Secretariat, the CCM, NASCOP, NACC and the Local Fund Agent (LFA). This often resulted in poor communications and delayed and inadequate reporting.

In view of the poor performance the CCM commissioned a number of studies to identify the implementation and reporting bottlenecks. Following these studies, the CCM formed a Transition Team to translate the findings of these studies into required action. The following actions were undertaken under the guidance of the Transition Team:

- Capacity of the PR was reinforced with additional staff and skills to increase management capacity.
- The CCM governance manual and conflict of interest statement were drafted through a participatory. The governance manual aims to improve participation, transparency and accountability in the business of the CCM.
- There were internal changes in the management of the CCM secretariat.
- The Procurement & Supply Chain Management Consortium (PSCMC) was created and started functioning.

Further measures are being taken to ensure improved implementation of programmes contained this proposal. They include:

- Proposing two Principal Recipients, some of whom are closely associated with the services to be provided. This will help to ensure that one PR does not become overwhelmed with the demands for supervision and reporting.

- There has been particular effort in clearly identifying the implementers beforehand. This will enable the implementers to begin to prepare themselves early for implementation of the programme.

Strengthening the existing PR

The MOF which is the PR for other GF grants has been strengthened with a view to improving its performance in Global Fund grant management. The GF Unit is better staffed with the appointment of the GF national coordinator, a technical advisor, and a procurement and finance expert. The Grant Score Card (GSC) for R2 noted serious concerns about the PR, including inadequate program monitoring and problems with reporting. This proposal seeks to strengthen the PR, and proposes a second PR for civil society sub-recipients.

Strengthening CCM oversight capacity

The oversight capacity of the CCM has been strengthened with the development of the Governance manual that clearly spells out the functions of the CCM. Additional strengthening is needed for oversight, and this will be done with the support of development partners. The CCM is implementing the Hatib report, and has approved its Governance manual and held constituency elections so that it is now in compliance with CCM requirements, as requested in the GSC.

M&E Support

NACC is implementing the Community Based M& E system (COBPAR). This system is expected to improve data collection for programme reporting. NASCOP is also rolling out the M&E system that is expected to improve data collection, analysis and reporting. The GSC notes that the quality, reliability and timeliness of data collection has been poor, but that partners are supporting improvements Recent funding from the French Cooperation will strengthen M&E at the MoF PR, and a civil society PR has been selected. As noted elsewhere, NACC has been strengthened recently and is now operating very well, which will contributed to strengthened M&E.

Funds flow

Funds to the NASCOP programme will be shortened by sending funds direct from treasury to the programme instead of to MoH headquarters. The decision to select a civil society PR will hasten the flow of funds to civil society.

4.6.5 Performance of and Linkages to other donor funding for the same disease

The proposed programme is linked to programmes funded by other donors. All major programmes have been taken into account in deciding on the service delivery areas for this proposal. Donor commitments in Kenya do not extend to 2012. Linkages between this proposal and on-going programmes are in the following areas:

- ART: This proposal only covers first line drugs because PEPFAR and the Clinton Foundation cover second line, as well as paediatric ARVs. The proposal considers PEPFAR contributions to first line drugs as well. The PEPFAR goal is to reach 169,260 on ART in FY 2008, while the Clinton Foundation goal is to put 20,000 children on ART.
- Test kits will complement those provided by PEPFAR and JICA. This linkage will scale up access to CT services. PEPFAR has committed 750,000 test kits, and JICA has committed 25,000.
- The CD4 reagents will complement efforts by other donors in providing CD4 count machines, reagents and support, including the Clinton Foundation and PEPFAR.
- The CT services will identify HIV+ cases and refer them to the ART programmes which are funded by other donors well as GF.
- Strategic communication will increase demand for services for HIV/AIDS services provided by all donors and GoK.
- Condom promotion – under this proposal, no condoms will be procured, but the strategic communications messages will support the TOWA program, which procures condoms. PEPFAR also works on strategic communication for condom promotion, rather than procurement.
- M&E – Several other partners are involved in strengthening M&E, including PEPFAR, TOWA and JICA.

The most significant bottleneck that all partners face is the absorptive capacity of the Kenyan health system. This refers to human and infrastructure resources. The partners are actively engaged with the GoK in addressing these challenges. Several partners are training health workers or recruiting new ones into the health care system. Other partners, notably PEPFAR, are strengthening lab networks and health centres. The decentralization of ART is also expected to ameliorate the problem, as more facilities will be treating PLWHA.

Private Sector Contributions

4.6.6 Private Sector contributions

(a) If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs.

The private sector has been under-involved in the fight against HIV/AIDS in Kenya, but this is improving. The Private sector is represented on the CCM by the Private Sector Network on HIV/AIDS and the Kenya Medical Association.

Unfortunately, no private sector organizations were selected as SRs by the Independent Review Panel, and very few applied. In order to reach the public sector, and increase their participation in the fight against HIV/AIDS, two activities will be targeted at the private sector:

1. Activity 3.2.4, which will be implemented by the Federation of Kenya Employers, targets employees in private enterprise to receive key messages on ART, counselling and testing, and safe sexual behaviour. Peer educators will also be selected and trained.
2. Activity 3.2.5, to be implemented by NACC and NASCOP, will develop the curriculum and manuals for CSOs, FBOs and the private sector. TOTs will be held in all three sectors.

FHI has a private sector development program funded by PEPFAR, aimed at harmonizing private sector activities with public sector activities. It is hoped that this program will bring the private sector closer to the Global Fund in Kenya, and there will be more collaboration with the private sector in the future.

(b)	Referring to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution.)	
	Size of population group that is the focus of the Private Sector contribution ➔	N/A

4 Component Section *HIV/AIDS*

4.7 Principal Recipient information

Table 4.7: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through one or several Principal Recipients.	☐ One
	☒ Several

Responsibility for implementation			
Name of Nominated Principal Recipient(s)	**Sector Represented**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**
Ministry of Finance	Government Institutions (Public sector)	Joseph K. Kinyua	Ministry of Finance/Treasury P.O. Box 30007 NAIROBI, KENYA Fax: 219365 e-mail: psfinance@treasury.go.ke Tel: 240051
Care International in Kenya	Non Government Organisations (Civil Society, Faith Based Organisations and Private Sector)	Bud Crandall Country Director	P.O Box 43864-00100 Nairobi Mucai Road, off Mucai Drive, off Ngong Road Tel: *27100674/2712374/2711766* Email : bud@care.or.ke

4.8 Program and financial management

4.8.1 Management approach

1. Overall management

The CCM will oversee the implementation of the programme, the PRs will manage the programme and ensure efficient funds disbursement, M&E and reporting and sub recipients will be tasked with the implementation role. All players work towards achieving of targets agreed on with the GF. All the players will be guided by clear plans that are linked and that reflect their respective roles.

The CCM will take a more proactive approach to the management of the Round 7 programme to effective oversee the two PRs and to ensure that actions being taken to improve Kenya's performance in GF grants are maintained. The CCM will develop an annual work plan with clear benchmarks and targets to effectively operationalise its oversight role. The committee will require the two PRs to submit work plans for review and approval before being sent to Global Fund. The PRs will also submit periodic progress reports and performance reports to the CCM before being sent to Global Fund. The CCM is strengthening its secretariat through effective staffing to provide support in the overall oversight of the programme.

2. CARE International in Kenya: PR for Non-Government Organisations

management approach

CARE International in Kenya (CARE Kenya) will manage the non-government component of this proposal within the framework of the Global Fund governance structures and National Response to HIV and AIDS coordinating systems. The CCM will oversee the management and implementation of this proposal. CARE will provide programme plans and reports to the CCM for review and approval as well

as ensure efficient communication to the CCM during programme implementation.

CARE Kenya will develop strong working relations with the National AIDS Control Council to ensure that the GF R7 programme is integrated within the national response and harmonized with other on-going and planned interventions. This will enhance the three ones principle. In this respect, CARE Kenya will collaborate with NACC at all phases of the programme. During planning, CARE will collaborate with NACC to ensure that plans developed by non-government organisations fit within the overall national response framework and can deliver the targets set out in this proposal. CARE will also link the programme to the National M&E systems to ensure that data collected under this programmes is captured by the national M&E system.

CARE will also seek membership at the ICC (civil society representation) for HIV and Malaria to enhance continued synergistic efforts and information sharing from GF as a PR as well as get a benefit of other funding streams that could impact on the delivery of GF program by the CSO, FBOs and Private Sector organizations.

Roles Clarification
CARE will enhance cohesiveness and understanding of the PR's roles and responsibilities in relation to the roles and responsibilities of the CCM, sub- recipients and national coordination mechanisms such as the National Aids Control Council (in her coordination roles such as monitoring and evaluation, monitoring prevalence rates and policy development and oversight). It's in the best interest of the country to enhance synergies through roles clarification and continued communication of progress made during the implementation.

CARE in Kenya engages in development interface with communities and GOK and as such undertakes projects as a grants recipient and implementer, managing HIV and AIDS projects as well as other development projects. Effective communication will reduce risks of misinterpretation of CARE's roles and responsibilities in relation with CSOs, FBOs and Private Sector players interacting with CARE in the PR role and in strategic and implementation roles in other development and humanitarian projects in the country. CARE, therefore, will continue with her strategic engagement with national mechanisms while communicating her roles and responsibilities as appropriate.

Global Fund Programme Management Team
CARE Kenya will set up a program management team to enhance efficient management of the program. Under the leadership of the Assistant Country Director-Programs and managed under the HIV&AIDS and CSO Strengthening Sector head (as Program Advisor) the team will comprise of a full time Program Manager, Monitoring and Evaluation Manager, (GF), Contracts and Grants Accountants (3), and Program Officers(4), Program Assistant (1) and drivers (2). The team will be hosted at CARE Kenya's headquarters in Nairobi and will be hooked into the existing field offices structure to ensure an effective and efficient implementation and monitoring of the programme. Where necessary, particularly in regions where CARE has no physical presence, appropriate arrangements will be put in place to ensure that this does not affect implementation or compromise programme quality.

Proposal reviews, Capacity Review and Contracting
Upon contracting by GF, CARE Kenya will follow up on the recommendations of the Independent Review Panel and Proposal Development Team to plan for the implementation of the programme. The IRP report will form a basis for formal interaction with the partners, guide proposal reviews in line with approved targets, review work plans and budgets, upon which contracting and disbursements shall be done.

The team will also undertake capacity assessment of the CSOs to identify their strengths and weaknesses, as this may impact on GF program implementation with a view of recommending areas of improvement and agree on timelines for bridging these gaps, for purposes of enhancing programme delivery. This will ensure that targets are realistic, feasible and that approaches are facilitative to allow the achievement of targets. This will facilitate efficient and accountable utilization of funds in line with priorities set. CARE shall enhance timely communication and feedback to the partners. Contracts shall be prepared in line with performance based targets as set out in the round 7 proposal.

Programme monitoring
CARE shall seek to strengthen reporting by CSOs, FBOs and Private sector to the national monitoring

and evaluation system in support of the three-one principle. However, given the contractual responsibility to report results of the programme to the GF, CARE shall develop a sub-system with relevant tools that respond to the targets agreed with GF, in collaboration with the National M&E system at the National Aids Control Council. It is expected therefore that CARE shall bear the responsibility of reporting these results to the National M&E system at the time of reporting to GF. This will avoid any areas of double or multiple reporting of the same information and distortion of the country's position with respect to HIV and AIDS response.

Programme review meetings

To enhance cross learning and technical capacity strengthening of the sub recipients, CARE shall organize semi-annual thematic and disease based partner review meetings, at regional levels (4 regions). These shall also act as stakeholders sharing forums on critical aspects of GF performance targets. It is expected that, an initial programme start up partners meeting shall be organized, to identify actors implementing in the same region, seek to identify areas of synergy and learning. Subsequent forums shall be based on experiences gathered through implementation monitoring and reporting, phase 2 application requirements, accounting and audit related concerns, as well as assets management and exit strategy at the end of the 5 year program.

CARE will hold annual programme review meetings with CSOs, FBOs and Private Sector organisations implementing this proposal. The meetings will provide a forum for a participatory review of programme performance, addressing emerging challenges, consolidating lessons learnt and developing annual work plans.

Technical Assistance

CARE shall strengthen her ability as a PR and support to the sub-sub recipients through continued identification of gaps and seeking to respond to these through technical assistance. Some of the areas that CARE proposes as necessary include a review of cost-effectiveness of delivery approaches, building of sub recipient's capacity in M&E, technical appraisal of the program, support to consolidating end of phase one performance and support to phase two roll out.

2. Ministry of Finance: PR for Government Institutions

Management approach

The Ministry of Finance (MoF) will obtain the Global Fund approved work plan for the purpose of monitoring financial and programmatic results of the programme and the overall implementation of the programme. The PR will work closely with the programme sub recipients to ensure that they work within the time lines in the work plans while at the same time resolving issue that will emerge in implementation process. Sub recipients will be required to develop work plans against which disbursements will be done. The work plans will be linked to the GF targets. Sub recipients will implement the programme using the existing health service delivery systems and infrastructure.

The PR will also require monthly financial reports, quarterly programmatic/financial reports. Funds shall be disbursed on basis of satisfactory quarterly reports. This will make it easier for the PR to compile data and report to Global Fund while at the same time keeping track of implementation process.

At the beginning of the grant, the PR will assess the human resource capacity available at the SR levels. The assessment is necessary in order to address the issues of slow absorption of funds. This will ensure that challenges faced by previous GF grants are identified at the beginning and addressed.

The MoF will also assess the data collection system to link them effectively with the M&E system that will be developed at the PR unit. At sub-recipient level, M&E will utilise the existing sub systems. MoF will put in place programmatic M&E to ensure efficient reporting to GF.

MoF will submit financial and programmatic reports to the CCM for review and approval before being sent to the Global Fund. This process will enhance mutual trust and build partnerships within the country.

4.8.2 Principal Recipient capacities

*Please note that if there are multiple Principal Recipients, section 4.8.2 below **must be completed separately for each one**.*

(a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient ('PR'). Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

CARE International in Kenya

Management capacity

CARE has been operating in Kenya since 1968. CARE's capacity to manage development and humanitarian programs is supported by good governance mechanisms, which is reflected in the professional and role based division of the Senior Management Team at country level. CARE Kenya's are guided by the Country Director who is supervised by the Regional Director for East and Southern Africa, based in Canada. A Board of Directors elected annually by members, appoints the Executive team which provides management and technical oversight to both headquarters and Country Office operations. This management strength supports strong programming based on core programming principles that seek to promote empowerment, support working with partners, ensures accountability and promote responsibility, address discrimination, promote non violent resolution of conflicts and seek sustainable results.

Under the leadership of the Assistant Country Director–Programs, CARE exhibits strong programming and has identified HIV and AIDS and Civil Society Strengthening as a thematic area. The team is supported by strong support units under the leadership of the Assistant Country Director–Support (overseeing financial, procurement and administration) functions. This multi-disciplinary team supports efficient program management, financial accounting and reporting. Quality assurance is ensured by the technical program team and supported through program monitoring. A review of the current M&E systems will be necessary to ensure that they in tandem with the GF requirements.

Technical capacity in HIV and AIDS

CARE's experience in HIV and AIDS programming combines experiences in Grants management, Institutional Capacity building of CSO actors in effective delivery of HIV prevention, treatment and care projects, direct implementation roles in all components of the response (prevention of new infections, quality of life for infected and affected as well as programs targeted at mitigation of socio-economic impact). These experiences in Kenya have been augmented by CARE's global expertise in HIV and AIDS programs with annual funding of $ 60 million and where cross country learning and sharing, as well as technical support is enhanced. HIV and AIDS initiatives are also mainstreamed into projects in livelihoods, humanitarian assistance, and entrepreneurship.

CARE has a thematic sector in HIV and AIDS as part of the CO priority in responding to the HIV and AIDS response in the country, in view of the contribution that the disease plays in eroding people's capacities and investments which result to increased poverty levels. The sector drives CARE's mainstreaming in HIV in other thematic sectors including livelihood projects and humanitarian response. This sector has a team of professionals and has managed large programs in HIV and AIDS with significant success. The experts are in the areas of program cycle management, technical skills in clinical aspects to HIV programming as well as behaviour and social aspects to HIV programming including behaviour change communication, strategic communication for risk reduction targeted at high risk and vulnerable groups, stigma and discrimination reduction programming, economic empowerment for OVC care givers and heads of affected households, policy engagement as well as institutional capacity building for organizations. The team has a good understanding of national HIV and AIDS policy and strategy and continues to play a key role in national policy and implementation for HIV and AIDS programming. This team has managed HIV&AIDS grants from USAID/PEPFAR, CDC/PEPFAR, CIDA, NORAD, HAKI, REDSOL and DFID in accordance to donor regulations These programs have been implemented

in 4 of Kenya's 8 provinces working in partnership with local civil society organizations including Faith Based organizations. CARE invests in partnerships with clearly defined roles and responsibilities, while allowing innovativeness and adaptability to local situations and contexts. This has maximized program goals while remained focused on results. CARE invests adequately in capacity assessment, capacity building resources (human and financial) before granting and during implementation as part of strengthening local organizations capacity in technical skills in HIV and AIDS programming which are key to supporting effective delivery of program targets. Continued staff development in emerging areas of the HIV and AIDS response is Key.

Given that the PR responsibility will require additional staffing for this added responsibility, the Sector Manager, supported by the Programs director, will hire qualified staff and orient them into their roles effectively. The staff includes the GF programme manager, Monitoring and Evaluation manager, programme officers (4), grants officers (2), programme assistant and driver (2). The Sector manager will be a part time program advisor to this programme. The finance technical team will support processing of grants, review capacities and offer technical expertise to the GF CSO partners, manage grants performance in collaboration with program team as well as manage reporting, timely to GF.

The finance department has a team of experienced professionals headed by the Assistant Country Director – support (Finance and procurement) with over 17 years of experience internationally. The finance department is fully functional headed by a finance manager and supported by Grants Manager, accountants, and grants officers. CARE has an internal auditor. CARE has a strong financial management system and absorptive capacity including elaborate systems for disbursements of funds to sub-grants, grants monitoring systems, good accounting practices and reporting systems. The team supports the projects on a cost share basis and this allows the country office to maintain professional staff as well as streamline operations.

CARE management systems (Operational, finance and human) are facilitative of programming. However, a review of the requirements of the GF Principle Recipient role vis-à-vis the existing systems are crucial to ensure that the program starts without any systemic challenges.

(b)	Has the nominated PR previously managed a Global Fund grant?	☐ Yes
		☒ No

If yes to (b), explain the rationale for nominating the same PR(s) to manage the activities in this proposal.

The CCM selected a second PR for the GF grants to increase the country's absorptive capacity and improve the performance of the grants. The second PR will easy the work load of the MoF in managing the Non – Government component of the grant. This decision also means that Kenya will not require services of an FMA. CARE will manage both the financial and programmatic aspects of the grant thereby linking the two aspects which have hitherto been separated.

The choice of CARE as the PR was based in the competitive bidding process instituted by the CCM. CARE scored highest among the 6 applicants.

(c)	Is the nominated PR currently managing a large program funded by another donor?	☒ Yes
		☐ No

(d) Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

USD15 Million

(e) Describe the performance history of the nominated PR in managing these programs/grants.

Globally CARE has had extensive involvement in the Global Fund's implementation process,

representing Civil Society as a CCM member, as a Principle Recipient, and as a sub-recipient of a grant from the PR. Since the Fund's inception in 2002, CARE has served as a Principle Recipient for ten grants in Cameroon, Cote d'Ivore, Ecuador, Peru and Thailand; seven of these funds have supported HIV and AIDS programs and the rest have supported Malaria and TB. CARE has generated valuable lessons from these experiences, including important lessons in securing funding, building technical capacity, developing effective partnerships, and understanding how to make the most of the Global Fund's grants. The performance of these grants has been satisfactory.

(f) Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**.

CARE International in Kenya was selected as PR after meeting the criteria set out by the CCM. The key criteria points include experience in coordinating and managing HIV and AIDS and malaria programmes, track record in grants management, adequate human resources and physical infrastructure, effective M&E and reporting systems, strong governance and internal controls and strong financial and accounting systems. CARE also demonstrated experience of acting as PR in other countries – Peru and Cameroon. In Kenya, CARE has an elaborate infrastructure across the country to manage the large programmes.

4.8.2 Principal Recipient capacities

*Please note that if there are multiple Principal Recipients, section 4.8.2 below **must be completed separately for each one**.*

(a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient ('PR'). Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

Ministry of Finance – PR for Government Institutions

Management and financial capacities

The MoF has in place a capacity building plan to improve its management of the GF grants. The plan was developed following a series of assessment of its capacity. The MoF has built several capacities in the last one year and continues to build its capacity to deliver on its responsibilities as PR.

The following are the key capacities within the MoF:

a) Managerial capacity: MoF has demonstrated support at the highest level of policy makers for its role as PR for the GF grants. The Ministry has allocated adequate senior staff to the PR Unit and supports the units with administrative services. The PR unit has a National Global Fund Coordinator and an assistant, a Financial accountant, Management Accountant, Procurement Specialist, Auditor, Partnership Coordination Officer and Information Technology Officer

b) Financial management and accounting capacity: The Principal Recipient is also the Ministry of Finance/The Treasury. The Ministry of Finace oversees the financial audit and accounting function of the Government. The Principal Recipient has designed financial system in all Government departments which include the SRs (Ministry of Health and National Aids Control Council). It ensures financial accounting and reporting on all public funds.

c) Monitoring and evaluation and reporting: The PR unit is building its capacity in M&E to ensure effective implementation of the GF programme. The PR is recruiting a technical expert in M&E with support from the French Government to build internal capacity in this area. There is also on-going short term TA to support the development of a robust M&E system.

The key shortcoming for the MoF as PR has been its understanding of its roles. It had also not put

in place M&E systems to facilitate reporting to the Global Fund. The linkages with the SRs, especially on technical issues, were also relatively weak. These areas will be addressed in this proposal through provision of targeted technical assistance in the first two years of the programme. The PR will also continue implementing the action plan agreed with the CCM.

(b)	Has the nominated PR previously managed a Global Fund grant?	☒ Yes
		☐ No

If yes to (b), explain the rationale for nominating the same PR(s) to manage the activities in this proposal.

MoF has learnt several lessons from the management of the previous grants. A detailed assessment of the MoF's role as PR was carried out in 2006. The assessment recommended specific areas of improvement for the PR to play its role effectively. Part of the challenge was that the MoF did not have adequate understanding of the requirements of the PR role.

The PR, collaboration with the CCM, has been implementing the recommendations of the assessment. Over the last one year, a well staffed and equipped PR unit has been put in place dedicated to the GF programme. The PR has also demonstrated proactiveness in dealing with the challenges that faced grants implementation.

Currently, the PR is in the process of developing an M&E system to support reporting to the Global Fund. Other efforts in building its capacity include the assistance from AFD in supporting technical assistance in M&E. With this investment, it is prudent to provide an opportunity to MoF to continue as PR than to start all over with investing in a new PR. The CCM has appointed a second PR to easy the work load on MoF and to strategically start building capacity for PR in another institution in order to increase the country's absorptive capacity in the long run. The second PR, being for non-government organisations – enhances the participation of the CSOs, FBOs and Private Sector in the GF programme.

(c)	Is the nominated PR currently managing a large program funded by another donor?	☒ Yes
		☐ No

(d) Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

The Ministry of Finance – USD 239,999,986

(e) Describe the performance history of the nominated PR in managing these programs/grants.

The Ministry of Finance manages the consolidated fund for the Kenya which includes domestic and external financial resources. The PR unit will however manages the GF funding. At the time the Country started receiving Global Fund funds to address HIV/AIDS, Tuberculosis and Malaria, there were no sufficient consultations and as a result no structures were put in place to deal with the Funds on the part of the PR. The PR was not aware of its fiduciary role and left the entire process to the SRs. The implementation was also not clear of Global Fund grants performance based approach. This gave the Global Fund a poor start in the country.

The Principal Recipient has now understood its obligations under Global Fund arrangements. As a result, it has created a unit exclusively for managing PR responsibilities. The unit structure is based on recommendations of consultancies mandated by the CCM for assessment of PR weaknesses. The unit is composed of the following officers:- National Global Fund Coordinator, Assistant Coordinator, Procurement specialist, two accountants, auditor, information technology officer, two secretaries, two drivers and one office messenger. The unit will be supported by and M & E expert provided through the French Government.

The Unit is fully functional currently. The PR will endeavour to track down project implementation

by visiting the implementers at all level and satisfying itself that the system within SR are functional and are applied in data collection including ensuring data quality. The Unit will also track down the implementation activities to ensure timeliness in reporting.	
(f)	Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**.
The Principal Recipient has started a close engagement with Sub-recipients for the purposes of closely tracking down the implementation progress in SRs. There is an improvement in absorption of funds and reporting under TB Round 5 and Malaria round 4 and PR will build on these developments to improve the overall performance of the programme. Most assessment carried out since 2005 advise that Kenya need to build on the investment made in capacity building of the current GF governance and management architecture to accelerate grants implementation than starting all over with new structures. There is commitment from the CCM, the PR and SRs to make the current framework succeed. The appointment of the MoF as PR is also in line with the Paris Declaration on AIDS effectiveness which Kenya subscribes to. This nomination will enhance the harmonisation of donor aid to Kenya and ensure that GF works with the national funding framework.	

4.8.3	**Sub-Recipient information**	
(a)	Are sub-recipients expected to play a role during the term of the proposal? *(Only in the very rarest of cases would the Global Fund expect there to be no sub-recipients.)*	☒ **Yes** ➔ ***complete the rest of 4.8.3***
		☐ No ➔ *go to 4.9*
(b)	How many sub-recipients will or are expected to be involved in the implementation?	☐ 1 – 5
		☐ 6 – 20
		☒ 21 – 50
		☐ more than 50
(c)	Have the sub-recipients already been identified?	☒ Yes ➔ *complete 4.8.3. (d) –(e) and (f) and then go to 4.9*
		☐ No ➔ *go to 4.8.3. (g) – (h)*

(d) Describe:

(i) The **transparent** process by which sub-recipients were identified, the rationale for the number of sub-recipients **and the criteria** that were applied in the identification process.

(ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will **either** receive a significant proportion of the funding from this proposal **or** who will be involved in on-granting of funding to sub-sub-recipients

The Kenya CCM conducted a study on the challenges it has faced in the past in developing GF proposals, prior to commencing the development of the Round 7 proposal. The study identified the process for selection of sub-recipients as one of the key weaknesses in the proposal development process. In the past, sub-recipients were required to submit proposals in the Global Fund format which most organizations found very difficult to use. The criteria for selection for sub-recipients were not shared with applicants and the selection was not well established. Most civil society, faith based and private sector organizations perceive the process adopted by Kenya not to be transparent and somewhat subjective.

The Kenya CCM developed the process for selection of sub-recipients for the Round 7 proposal based on the findings and recommendations of this study. The process involved identification of priority areas in which organizations should focus their applications, establishment of a clear criteria that is publicly shared with all applicants priory to applying, and an independent selection process applying the established criteria.

Details of this process are outlined below:

1. Establishment of application guidelines and criteria

The CCM developed and agreed on the criteria and process for selection of the sub-recipients. The process adopted involved submission of an organizational capacity profile and project proposal by all applicants. The criteria specified specific aspects of organizational capacity and project proposals that were to be assessed.

In-country guidelines and formats were developed to make it easy for applicants to apply. Simplified guidelines indicating the priority areas and providing instructions for application were developed. Application documents included an organizational capacity assessment questionnaire, project proposal, work plan and budget formats.

2. Advertisement of expression of interest

An Expression of Interest (EoI) inviting organizations to submit organizational capacity profile and project proposals was advertised in the print media, CCM website and CSOs networks. Organizations were provided with guidelines for application, the criteria for assessment, a capacity assessment questionnaire and simplified project proposal, work plan and budget formats. 412 organizations submitted expressions of interest by close of deadline on 24 May 2007.

2. Constitution of independent review panel

The CCM established an Independent Review Panel (IRP) to assess the EoIs and select sub recipients. The purpose of constituting an independent review panel was to ensure objectivity in the selection process. The panel was selected based on criteria agreed on by CCM. The selection was carried out with the assistance of the USG and UN agencies to ensure members selected did not have conflict of interest in the process. The panel comprised 8 members.

3. Review of EoIs

The IRP reviewed the 412 expressions of interest based on the criteria established by CCM. The review was done in three stages:

Stage 1: Assessment of admissibility of the documents: The panel assessed whether applicants had completed all the documents required and submitted complete applications using recommended formats. This was to ensure all applicants had complied with the instructions

provided in the guidelines for application. Only those applicants that met this criterion were assessed in stage 2.

Stage 2: Organizational capacity assessment: The capacity of organizations to implement HIV and AIDS projects was reviewed based on the criteria established by CCM. Elements of organizational capacity reviewed included experience in implementing HIV and AIDS projects, governance and management, human resources capacity, financial management and accounting capacity and technical skills in planning, M&E and reporting. Applicants that demonstrated minimum capacity requirements were assessed in stage 3.

Stage 3: Project proposal, work plan and budget evaluation: The panel evaluated the project proposals, work plans and budgets for clarity, relevance, effectiveness, coherence and cost effectiveness. The panel also considered the comparative advantage of some of the organizations in addressing specific issues or reaching out to specific vulnerable groups. Organizations with effective proposals were selected to be included in the country proposal as sub-recipients.

4. Results of the EoI review

A total of 34 sub-recipients were selected to be included in the Round 7 proposals. The table below shows the details of the assessment of the 412 expressions of interest received:

Summary of EoI review results

Total No. of Expression of Interest	No. Disqualified at Stage 1 – Administration Compliance	No. Disqualified at Stage 2 – Capacity Assessment	No. Disqualified at Stage 3 – Project Proposal, Work Plan and Budget	No. Disqualified at Stage 4 – Comparative Advantages	No. Pre-qualified for GF Round 7
412	298	29	39	12	34

The organizations selected are variedly distributed across local, national and international partners and bring into the proposal a mix of strengths in carrying out different types of activities and in working at different levels. The table below shows the type of organizations selected.

Distribution of selected organizations by type of registration

Type of organization	**Number**
Community Based Organizations	3
Local Non Governmental Organizations	24
International Non-Governmental Organizations	1
Faith Based Organizations	4
Trust	1
Trade Union (Private Sector)	1
Total	**34**

The organizations selected will implement activities in all provinces in the country. Most of the organizations will work with other local CBOs and NGOs in the districts.

Distribution of selected organizations by geographical distribution

Province	**Number of Organizations**
Nairobi	1
Nyanza	4
Eastern	1
North Eastern	3
Rift Valley	3
Central	0
Western	3
Coast	1
Multiple province coverage	18

Total	**34**

Past implementation experience of sub recipients

All the sub recipients were selected based on their past experience in implementing HIV and AIDS projects. This was a major criterion in the assessment of the expressions of interest. The assessment also considered the size of past projects implemented by the organizations to decide on the proportion of activities and geographical coverage for each sub recipient.

Government sub recipients institutions

The Ministry of Health and National AIDS Control Council will be the government sub recipient institutions in this proposal. These institutions were appointed to be sub recipients given their central role in coordination and management of HIV and AIDS programmes. NACC will coordinate this programme to ensure it fits within the national framework. MoH will implement activities in this proposal through the NASCOP.

(e) **Attach a list of sub-recipients** that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal.

Below please **comment on the relative proportion of interventions** that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work.

Non Government sub recipients will undertaken about 19.8% of the planned interventions. About 25% will participate in this proposal through service provision based on an estimated proportion of FBO and private health facilities and CSOs run VCT sites that will provided with commodities under this proposal.

Sub recipients will be directly funded to undertake activities in objective 2, 3 and 4 of this proposal. These are the interventions that the organisations proposed to carry out under this proposal.

Sub recipient activities include:

(i) Counselling and testing: the sub-recipients will provide mobile CT services targeting most-at-risk groups and the youth.

(ii) Behaviour change communication using mass media: Some of the sub-recipients will develop and air radio programmes on HIV prevention and treatment tailored to the local audiences.

(iii) Behaviour change communication using community outreach approaches: the strength of most sub recipients is in social mobilisation. These organisations will provide information and education to youths, PLWHAs and most-at-risk groups using community mobilisation strategies described in section 4.6.3.

(iv) HIV and AIDS prevention and treatment information and education targeting private enterprises: Sub recipients will target workers in private enterprises structures of private sector associations and trade unions.

Non Government Organisations will also participate in this proposal through partnerships in areas where government will be the lead agency. Specific areas of partnership include:

(i) Provision of ARVs and cotrimoxazole: These drugs will be procured by government but will be distributed to both government and non-government health facilities, especial those run by faith based organisations, providing HIV and AIDS treatment services.

(ii) HIV test kits will also be procured by government and distributed to VCTs run by CSOs and FBOs across the country.

(iii) Patient monitoring: The FBO health facilities will utilize the services of the Government laboratories for ART patient monitoring.

The partnership between government and non-government institutions in implementing this proposal therefore goes beyond the direct funding of activities. Service delivery is interlinked and

both institutions benefit.

4.9 Monitoring and evaluation framework

4.9.1 Monitoring and evaluation plan

Monitoring and Evaluation and reporting for this proposal will be carried out at three levels: CCM, PR, and Sub Recipients. The M&E tasks these stakeholders will carry out are outlined below:

1. Country Coordinating Mechanism – Oversight function

The CCM will have an oversight function for the Global Fund Round 7 Proposal. The committee will receive work plans from the two PRs for review and approval, to ensure they are consistent with the proposal and are geared towards achieving the set targets. The committee will also review progress reports from the Principal Recipient before these reports are submitted to the Global Fund. The CCM will also commission periodic data quality assurance missions to verify the reports submitted by the Principal Recipients and to assess programme performance. The data quality assurance will be carried out every six months on a sample basis.

2. CARE Kenya: M&E for non-government component

CARE will work with NACC and other appropriate agencies to develop, in a participatory way, an appropriate result based monitoring and evaluation (M&E) system to ensure that collected data and information feed into the national HIV and AIDS M&E system. To monitor progress towards achievement of the targets set out in attachment A, CARE Kenya will first develop a data management system including reporting formats together with data capture tools to be used by all implementing partners. This will be discussed with selected sub-recipients for their understanding and adapting into their respective systems. Each partner will be required to report on the targets on a quarterly basis. Data flow mechanism will be sensitive to existing structures – from frontline to project managers to HQ and onward submission to GF and NACC. The quarterly reports from the various sub recipients will be consolidated into one financial and programmatic report and submitted to both Global fund, NACC and other stakeholders.

To enhance program quality and self-monitoring, data will be analysed quarterly and feedback provided to the implementers. An M&E Advisor at the national level will be responsible for coordination of data management, maintenance of database and data quality assurance. Program officers in sub recipient organisations with reporting responsibilities will be trained on M&E. A provision for appropriate adequate budgetary allocation for M&E – training, progress review meetings, dissemination, tools, database development and maintenance including relevant software is included in the budget.

At the beginning of the 3rd year a mid term review (MTR) for this component will be undertaken. The review will provide information on the progress towards achievement of the program objectives. Specifically the review will focus on the effectiveness and efficiency in programme implementation thereby providing information for management decision making on which way the impact of the programme is likely to take. Based on the results received the management will make informed judgment on actions to take to ensure the programme achieves its intended objectives and quality.

A final programme evaluation will also be undertaken at the end of the five year period. This will help in highlighting the impact of the program on the beneficiary communities and documenting the lessons learned during the implementation of the programme.

3. Ministry of Finance: M&E for Government Institutions Component

MoF, in its role as PR, will be responsible for reporting on the targets for the component of this proposal implemented by Government Institutions. It will develop an M&E plan based on the indicators and targets in attachment A which government institutions are responsible for. MoF will set up an M&E system including required data collection protocols and tools to operationalise the M&E plan. MoF will also conduct briefing sessions with the sub recipients to induct them in the

M&E system and reporting tools they will be expected to use. Sub recipients – MoH/NASCOP - will use the existing M&E system to report to the MoF. This implies that the M&E system to be developed by the PR will not duplicate the existing national HIV and AIDS M&E system and its decentralised sub-system but will rely on these systems to report to the CCM and the Global Fund.

MoF will carry out field monitoring visits to verify the data submitted by the sub recipients and assess the overall performance of the programme. A field monitoring tool will be developed to guide this process and a feedback system to inform the sub recipients of the outcome of these visits will be put in place. Field monitoring will be carried out quarterly. It will use the field visits to identify emerging issues and increase understanding of the GF performance based funding processes among sub recipients and implementers.

4. National AIDS and STI Control Programme (NASCOP) M&E sub-system

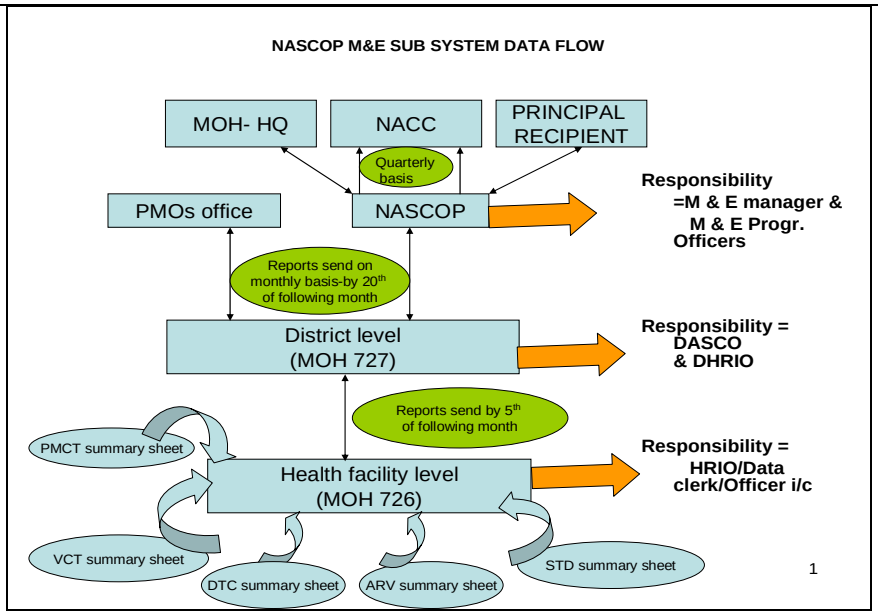
The NASCOP M&E sub-systems will be used to report on most of the indicators and targets for the Government Institutions activities in this proposal. This sub-system will used to collect data and report on the indicators and targets for ART, CT, OI prophylaxis and nutrition. NASCOP sub-system structure follows the structure for health care service delivery. NASCOP reports to the MoH Health Information Management Systems department and National HIV and AIDS M&E managed by the National AIDS Control Council. At the district level, the District Health Records and Information Officer are responsible for data collection and reporting to the national level. This officer receives data from the health facilities in the district.

NASCOP will use these existing structures to collect data and report on the activities of this proposal using the following procedures:

(i) The health facility information will be generated from the client forms and the Daily Activity registers from the different Service delivery points (ART, CT, DTC and PMTCT). These registers will then be used to populate the Service Monthly Summary forms. All summaries will then be collected at one central point where information will be fed into the Integrated tool (MOH 726) which is an integrated Facility based monthly summary. It will be filled in duplicate to allow one copy to be send to the next level (district) while the other to remain at the facility for their use. This report should be submitted to the district health office by the 5th day of the next month.

(ii) The District Health Records & Information Officer (DHIRO) will receive the filled MoH 726 data tool and use it to compile a monthly district report using form MOH 727 (a district based integrated tool). The DHRIO submit the completed 727 data tool to NASCOP and the Provincial Medical Officer (PMO and also remain with one copy for use by the District Health Management Team. This report should be submitted to NASCOP by 20th of the month.

(iii) The M & E manager at NASCOP will finally take responsibility of ensuring that all reports from all districts are received and aggregated to produce a national report by consolidating data received from all districts. The national report will be submitted to NACC, HMIS, Principal Recipient and other partners. The same channels will be used for feedback. The NASCOP M&E officers will also undertake field visits to very data reported from the districts and also address emerging issues.



Measurement of outcome and impact indicators

Various methods will be used to measure progress towards meeting the outcome and impact indicators:

Treatment and care

Health services statistic, population based surveys and operational research will be used to measure improvement in quality of life of people living with HIV and AIDS. The proxy indicator for improved quality of life being the percentage of people still alive 12 months after initiation of antiretroviral therapy.

Health services (program) statistics will be used to generate data on all the other treatment, care and support indicators. Population based surveys will supplement service statistics in generating data on (i) number of adults (over 15 years) who have been chronically ill for 3 months or more in the past 12 months due to HIV and AIDS and receiving nutrition support.

Prevention

The impact of prevention activities, "percentage of adults aged 15-24 who are HIV infected," will be measured primarily through the national HIV and STI sentinel surveillance system. National sentinel surveillance surveys of antenatal clinic (ANC) attendees have been conducted in Kenya for some years now. There are currently 20 Antenatal Sentinel Surveillance Sites, 12 of them in urban centres and 8 in rural areas, spread throughout the country. Data from sentinel sites collected, analyzed and a report produced every two years. The other major source of data is the Kenya Demographic and Health Survey (KDHS) which is conducted every 5 years. The last KDHS was conducted in 2003 and the next one will be in 2008. Using data from the sentinel surveillance system and population based surveys, the EPP/Spectrum methodology is used to arrive at estimates of adult HIV prevalence, number of people living with HIV and AIDS, and the number of AIDS-related deaths.

Population based surveys and other qualitative methods will be used to generate data on other prevention indicators such as; (i) percentage of young people reporting the use of condoms the last time they had sex with a non-regular sexual partner and (ii) number of people in rural communities reached by BCC prevention outreach and peer education.

Health services statistics and health facility surveys will be used to generate data for indicators of prevention activities such as: (i) number of service outlets providing counselling and testing according to national standards; (ii) number of people trained as HIV/AIDS counsellors; (iii) number

of people who receive testing and counselling; and (iv) number of civil society organizations that received support to build their institutional capacity.

Planned programme evaluations/surveys

A midterm review of the proposed programme will be carried out to assess its performance. The PRs will use the mid-term review results to propose to the Global Fund any required reprogramming and to strengthen programme implementation. The midterm evaluation will be carried out at the end of phase 1 of this proposal.

An end of programme evaluation after five years will also be carried out to identify strengths and weaknesses, key lessons and achievements of the proposed programme. The findings of the end term evaluation will be built into other programmes.

4.9.2 M&E Systems Capacity Assessment.

Kenya has a National Monitoring and Evaluation Framework (attached), which was approved in July 2005.

M& E activities in NASCOP have been hampered by a weak system under significant pressure to report to the government and many donors. Though a system has been designed, its roll out has been slow owing to inadequate funding. Health staff in facilities have not been trained to administer the data collection tools, although training is now being done with support from PEPFAR and JICA. The tools have not been availed to the facilities because funds for printing are inadequate. This proposal requests funds to hire 20 data clerks for NASCOP, which will improve the timeliness and quality of the data, 51 motorbikes to assist in the collection of data, and support to print data registers.

M&E at NACC has worked better, and there has been significant support from the GF R2. This proposal requests 81 computers for use by the CACCs, as well as 51 motorbikes to be used by CACCs who cover large terrain. This support will greatly improve the ability of the NACC to gather and report more effectively.

4 Component Section *HIV/AIDS*

4.10 Procurement and supply management of health products

4.10.1 Roles and responsibilities for procurement and supply management of health products

(a) In the table below, describe the planned roles and responsibilities for procurement and supply management.

Activity	Which organizations and/or departments are responsible for this function?	In this proposal what is the role of the organization responsible for this function?	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	MOF, KEMSA	PR, Procurement Agent	☒ Yes ☐ No
Quality assurance and quality control of pharmaceuticals	MOH, KEMSA, technical partner	SR, Procurement Agent	☒ Yes ☐ No
International and national laws (patents)	Ministry of Trade and Industry	Oversight	☐ Yes ☒ No
Coordination	MOH, MOF, KEMSA, CARE Kenya	Procurement Agent	☒ Yes ☐ No
Management Information Systems (MIS)	MOH, KEMSA, technical partner, CARE Kenya	PR, SR, Procurement Agent	☒ Yes ☐ No
Product selection	MOH, KEMSA, CARE Kenya	PR, SR, Procurement Agent	☐ Yes ☒ No
Forecasting	MOH, KEMSA, technical partner, CARE Kenya	PR, SR, Procurement Agent	☒ Yes ☐ No
Procurement and planning	MOH, KEMSA, technical partner, CARE Kenya	PR, SR, Procurement Agent	☒ Yes ☐ No
Storage and Inventory management	KEMSA, technical partner, CARE Kenya	PR, Procurement Agent	☒ Yes ☐ No
Distribution to other stores and end-users	KEMSA, technical partner, CARE Kenya	PR, Procurement Agent	☒ Yes ☐ No
Ensuring rational use	MOH, CARE Kenya	SR, PR	☒ Yes ☐ No

(b) Briefly describe the organizational structure of the unit with overall responsibility under this proposal for procurement and supply management of health products, including medicines. Indicate how it coordinates its activities with other entities such as the National Drug Regulatory Authority, Ministry of Finance (for budgeting and planning), Ministry of Health, drug storage facilities, distributors, etc.

For Round 7, the CCM established a working group to review procurement and supply chain management (PSM) under existing Global Fund grants and to propose how PSM should be managed for Round 7. Based on the working group recommendations, the CCM decided the following:

- KEMSA has significantly improved its capacity to handle procurement and serves as the lead partner of the Procurement and Supply Chain Management Consortium (PSCMC);
- The PSCMC had a slow start-up and there have been challenges, but generally it is managing the procurement process well;
- KEMSA does not yet have the capacity to manage some parts of the procurement process without technical support; therefore,
- KEMSA will be the lead procurement agent with support from another partner to be selected in a competitive process.
- UN Agencies will continue assisting KEMSA in procurement under this proposal

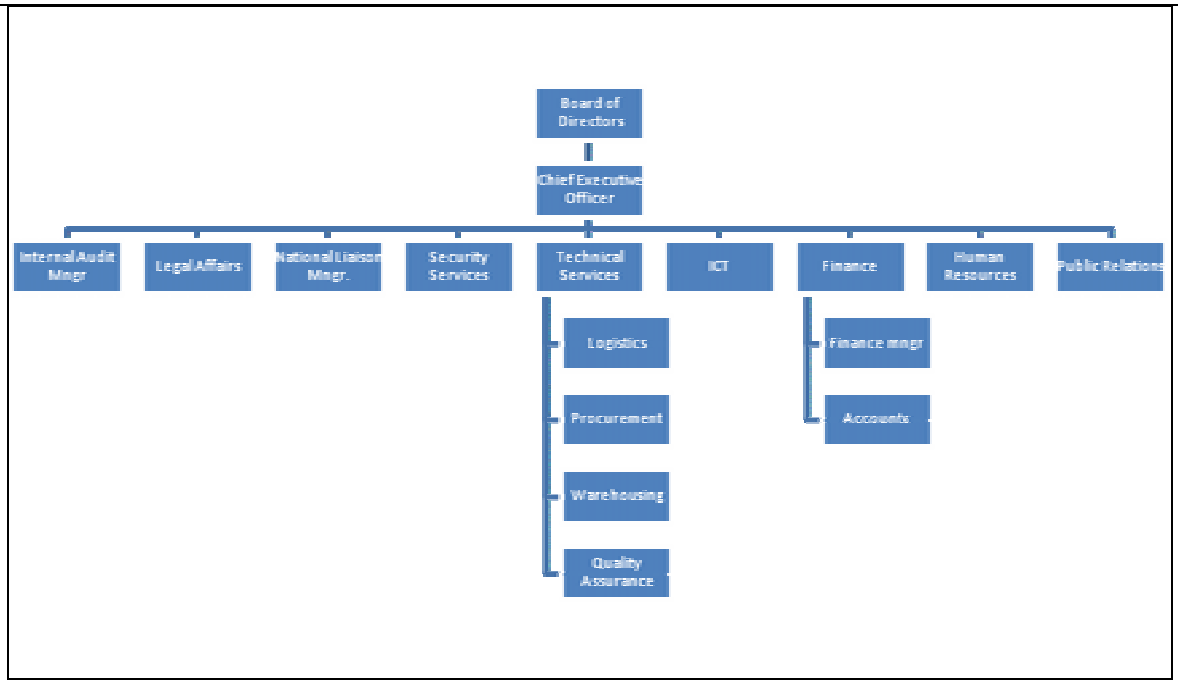
The CCM decided that KEMSA would work with another partner. The PSCMC Consortium currently holds the contract to do this work, through June 6, 2008. The CCM will select the partner to work with KEMSA through competitive tendering after the current contract with the PSCMC expires. The partner will work alongside KEMSA and will contribute technical assistance and capacity building to KEMSA.

Structure of KEMSA

KEMSA has the structures, policies and procedures in place to undertake procurement of commodities financed by the Global Fund and to warehouse and distribute them to health facilities countrywide. KEMSA has built its capacities working with the PSCMC and receives additional support from PEPFAR. Support through a Threshold Program Agreement[14] from the Millennium Challenge Account of the United States is also ongoing.

1. KEMSA has a competent Board that provides policy guidance through the Chief Executive to the management.
2. KEMSA has qualified and experienced staff that blend private and public sector experience. This increases efficiency as it integrates private sector solutions within a public sector environment, especially with the enactment of the Procurement Act and regulations.
3. KEMSA is a supply chain organization that provides an integrated solution encompassing procurement, warehousing, and distribution.
4. KEMSA has excellent knowledge of the Kenya public medical supply system. All medical commodities procured have to be registered with the National Drug Regulatory Body. Routine testing of commodities is done in collaboration with the National Quality Control Laboratory and the Kenya Bureau of Standards.
5. KEMSA works closely with the Ministry of Health to ensure that supply chain management issues are addressed. Tender evaluations are done in collaboration with the MOH.
6. All commodities procured under Global Fund Round 2 are being stored and distributed by KEMSA.

Figure 1: Key Management Structures at KEMSA



Responsibilities

1. Procurement Policies, Systems and Capacity

Procurement Regulations and Manuals
KEMSA will work with its technical partner on procurement regulations. KEMSA conducts procurement transparently and competitively according to the Government Procurement Regulations as laid down in the Public Procurement and Disposal Act of 2005.

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 does not offer effective competition. All International Competitive Bidding will be done as a partnership between KEMSA and its technical partner.

In addition to the exchequer regulations, KEMSA has developed its own in-house supplementary procurement manual. KEMSA will undertake procurement processes in line with Global Fund policies in procurement and supply chain management and interagency guidelines on operational principles for good pharmaceutical procurement.

ICT Infrastructure
KEMSA has a well structured ICT network with modern supply chain system based on Microsoft Business Dynamics Navision. Navision is an Enterprise Resource Planning System that is widely used for Supply Chain Management in a number of medical commodity management organizations worldwide. KEMSA has been using Navision for the last three years for inventory management and order processing. KEMSA is also now using Navision for financial, warehouse, sales order processing and procurement management. This will allow KEMSA to integrate its processes and achieve visibility in the entire supply chain management process.

National Drug Regulatory Authority
The Kenya Pharmacy and Poisons Board is a regulatory body established under the Pharmacy and Poisons Act with the responsibility of carrying out registration of drugs and GMP inspections of pharmaceutical companies and manufacturing plants. This capacity in continuously being strengthened through the government and other global initiatives.

Quality Assurance

KEMSA will work with its technical partner on quality assurance. Quality Assurance at KEMSA is achieved through:

1. Prequalification 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. KEMSA's goal is to have zero failures in the quality of its products and services. To achieve this objective, KEMSA has updated the Tender document to include concise technical specifications detailing requirements to be met by manufacturers, suppliers and products. All pharmaceutical products must be registered with the Pharmacy and Poisons Board; special authority is sought for the procurement of critical items that are not registered. The technical specification of the tender document have very clear requirements for registration, packaging and labelling. Further, products are required to have a minimum remaining shelf life of at least five sixths (5/6ths) of the total stipulated shelf life for goods with a shelf life of more than two years and three fourths (3/4th) of the total stipulated shelf life for goods with a shelf life of two years or less.
3. KEMSA conducts its procurement of medical commodities by sample. Tender bids are submitted with samples and literature for evaluation by KEMSA's technical specialists with representatives from the MOH. The technical evaluation is very stringent and ensures that manufacturers have Good Manufacturing Practices that the supplier is authorized by relevant NDRA, and products conform to national specifications and standards.
4. KEMSA has strict receipt procedures that ensure that the products supplied by the supplier match the tender sample and meet the required quality specifications.
5. KEMSA annually signs a performance contract with the Ministry of Health. In addition, KEMSA annually conducts a customer satisfaction survey to track performance against customer expectations and to continuously improve and meet expectations. KEMSA has been audited and accepted for ISO 9001 (2000) certification and is awaiting certification.
6. KEMSA works closely with its suppliers and service delivery points to ensure the provision of quality products and services. Various conferences have been held with potential suppliers to share KEMSA's quality vision.
7. KEMSA's quality assurance team will make regular inspection visits to successful and potential suppliers as part of ensuring that any quality issues are picked up early in the supply chain process.
8. With the support of the service liaison team, KEMSA has established a structured reporting system with its clients to detect poor quality products at service delivery points. This information is fed to the MOH and the Pharmacy and Poisons Board.

Laboratory Facilities

KEMSA works very closely with the Pharmacy and Poisons Board and the National Quality Control Laboratory and Kenya Bureau of Standards. KEMSA has developed a quality manual documenting all its business processes including product evaluation, supplier evaluation, receipt and storage, dispatch and product recall procedures. KEMSA is in the final stages of installing a mini-lab to carry out quick-identification tests. A Testing Services contract as been negotiated with the National Quality Control Laboratory and the Kenya Bureau of Standards. KEMSA has also established a working relationship with the Centre for Quality Assurance of Medicines, a WHO pre-qualified laboratory in South Africa.

2. Inventory Management

KEMSA's head offices are based on Commercial Street, Industrial Area, which also houses its main warehouse comprising 42,000 square feet. In addition to its Commercial Street warehouse, KEMSA has a network of 8 warehouses with 44,810 sq. ft. of space strategically located across the country as follows:

Warehouse	Area (sq.ft)
Eldoret	7,920
Garissa	2,000
Kakamega	2,000
Kisumu	8,400
Meru	2,000
Mombassa	6,160
Nakuru	7,210

Nyeri	9,120
Total	**44,810**

KEMSA is in the process of modernizing its warehouse infrastructure and operations. Additional warehouse space equivalent to 150,000 square feet has been hired. A modern warehouse is earmarked for construction on a five acre piece of land with KEMSA has acquired. Funds mobilization towards this is in process.

KEMSA has implemented an inventory management system that will ensure that various stocks are issued on a First Expiry First Out (FEFO) system. This system has the capacity to give various reports including the total number of commodities issued to individual treatment sites. Thus the system will help minimize wastage through expiration and pilferage at KEMSA. A Logistics Management Information System (LMIS) is already in place for HIV/AIDS and NLTP commodities. Plans are in place to integrate all the other essential medical commodities and supplied into this LMIS.

KEMSA's service liaison team will play an important role in ensuring this information is available to KEMSA. This team provides basic training to healthcare workers on commodity management.

3. Distribution to other stores and end users

KEMSA offers delivery service 365 days a year. The National Distribution Centre is based on Commercial Street in Nairobi which houses the headquarters of KEMSA. A second warehouse in Nairobi for storage of bulk slow moving commodities is located on Likoni Road. KEMSA distributes to all public health facilities.

Currently KEMSA uses a combination of internal as well as outsourced transport. Distribution is centralized and deliveries are made to the specific user points. Secure courier services are used for low bulk high value items like ARVs or test kits. Rural health facilities (health centres and dispensaries) are supplied with kits once every quarter, while deliveries to hospitals are made against their orders on a bimonthly basis.

Distribution will be managed by KEMSA and its technical partner.

4.10.2 Procurement capacity		
(a)	Will procurement and supply management of medicines and other health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also conduct procurement and supply management of these products?	☒ Principal Recipient only
		☐ Sub-recipients only
		☐ Both
(b)	For each organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below.	

Organization Name	**Total value of medicines and other health products procured during last financial year** *(In same currency as this proposal)*
Kenya Medical Supplies Agency (KEMSA)	USD $28.5m

4.10.3 Coordination	
(a)	For the organizations described in section 4.10.2.(b) above, indicate **in percentage terms, relative to total value**, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.
KEMSA - National Programs 12.5%, Donors 5.5%, GOK-funded Essential Commodities 82%	
(b)	Specify participation in any donation programs through which medicines or other health products are currently being supplied (or have been applied for), including: the Global Drug Facility for anti-tuberculosis drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.
KEMSA has been involved in warehousing and distribution of drugs donated by other governments, multilateral agencies, and NGOs, including the Government of China, UNICEF, and the Government of Egypt.	

4.10.4 Supply management (storage and distribution)		
(a)	Has an organization already been nominated to provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?	☒ Yes ➔ *continue to (b)* ☐ No ➔ *go to 4.10.5*
(b)	**If yes to (a) above**, indicate, which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	☒ National medical stores or equivalent ☒ Sub-contracted national organization(s) *(specify which one(s))* KEMSA ☒ Sub-contracted international organization(s) *(specify which one(s))* Technical partner to be selected through competitive bidding ☐ Other *(specify)*
(c)	Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how the increased requirements under this proposal will be transparently and effectively managed.	
KEMSA has warehouse space of up to 230,000 sq. feet, and the ability to lease additional warehouse space as the need arises.		
(d)	Describe each organization's **current distribution capacity** for medicines and other related health products and indicate how the increased coverage will be managed, and potential challenges addressed if any. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal, and the extent of incremental increase that is on existing distribution arrangements.	
KEMSA is currently handling distribution to all public health facilities for all commodities procured by stakeholders including the Global Fund. All reporting and tracking requirements are being fulfilled. PSCMC provides technical support for logistics through JSI. Under the Round 7 proposal,		

KEMSA would be supported through its technical partner.

4.10.5 Pharmaceutical products selection

Kenya's national treatment guidelines are in line with WHO's Standard Treatment Guidelines and NASCOP/MOH works closely with WHO to adapt and revise the guidelines as new guidance is developed. Kenya's guidelines are titled, "Guidelines for Antiretroviral Drug Therapy in Kenya", 3rd Edition, Ministry of Health, December 2005.

4.10.6 Multi-drug-resistant tuberculosis

Does the proposal request funding for the treatment of multi-drug-resistant tuberculosis?	☐	Yes
	☒	No

4.11 Technical and Management Assistance and Capacity-Building

4.11.1 Capacity building and training

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further strengthen national capacity, capacity of Principal Recipients and sub-recipients, as well as any target group. Ensure that these activities are included in the detailed budget in section 5.

Implementation of strategies contained in this proposal will require continued building of capacity of implementers, recipients and some target populations. Areas in which capacity building will be required include the following:

PR and SR Capacity: The PR has received several audits of its abilities, and there are some management shortcomings that are being addressed. There is funding from the Global Fund as well as the French Cooperation for PR capacity building. This proposal requests funds for M&E TA for the PR. There are 34 proposed SRs, many of whom are new to the Global Fund. These SRs will need significant capacity building in order to learn GF processes and reporting requirements, and to increase their capacity to implement and manage programs. Funds for this are budgeted under the TMA section.

Human Resource capacity issues: As has been described in other sections of this proposal, human resources are constrained in Kenya, particularly in rural areas. Scaling up ART creates an increased burden on health care workers. NASCOP believes this can be handled by decentralizing the distribution of ART to more sites, thus spreading the work over more staff and more facilities. This proposal includes funding for training of the health workers in these sites, as well as resources for increased monitoring and evaluation. The Clinton Foundation/DANIDA health worker initiative has hired many additional nurses and clinical officers, which will support this proposal. Overall, while the proposal will place increased burdens on human resources, we are confident that the capacity is present and will not impede implementation of the program.

Skills: Implementing the interventions contained in this proposal will require upgrading the skills of many programme implementers, health workers, people living with HIV/AIDS and community supporters. The skills required include those for providing services such as treatment, counselling, testing, communications and behaviour change. Skills will also be required for reaching specific populations such as the youth and marginalized groups. The required skills will be developed through a number of training activities. Training will be provided for various groups including professional and non professional personnel.

Procurement: A large portion of the budget for this proposal is for the procurement of ARVs and test kits, so efficient and timely procurement is essential to the success of the proposed program. In the past, Kenya has been faced with procurement and supply chain management challenges, although much effort has been put into this area and there have been improvements. KEMSA will need TMA to fully automate its procurement process, which will require capacity building on the new systems. To address these concerns, the proposal budgets TA for KEMSA. Procurement will be closely monitored by the CCM and the PR.

M&E: M&E has been a weakness in previous GF grants. One of the main reasons for this is that there was such a large increase in funding for HIV/AIDS programs that occurred in a short period of time, and NASCOP and NACC needed time to scale up their efforts. This proposal would place increased pressure on both NASCOP and NACC, as well as the PR, to adequately monitor and evaluate. The proposal includes funding for equipment (computers, motorbikes, etc.) for NASCOP and NACC, as well as the recruitment of 20 data clerks for NASCOP.

4.11.2 Technical and management assistance

(a) **Needs Assessment**

CCM: The CCM needs TA in the area of program oversight and reporting, to ensure that reports collected are accurate before they are sent to the Global Fund headquarters in Geneva. Given the limited resources that are available through the Global Fund for CCM support, we propose to procure this TA through development partners.

PR: The PR already has significant TA available to it through existing GF grants and the French Cooperation. However, the PR still needs TA in the area of M&E, which we propose to provide through this proposal. Short term TA will be provided to strengthen M&E systems and build internal capacity during the first two years.

SRs: Many of the civil society and FBO SRs will set up systems to manage the Global Fund projects. They will need TMA to set up financial management, program management and reporting systems. These needs can be met by short term TA over the first two years of the program.

Procurement: Technical assistance will be required for the first two years to assist in capacity building. TA will be required for quality assurance, product selection and forecasting, planning, and storage and inventory management. TA will also be required in logistics management and in the implementation of a fully integrated Logistics Management Information System (LMIS).

M&E: NASCOP has more significant needs because it is rolling out new reporting tools throughout the public health system. NASCOP has TA for the training of health workers, but no additional TA. This proposal budgets for a short term TA to support the new M&E.

(b) **Planned sources and mechanisms for procurement of services**

The UNAIDS Technical Support Facility (TSF) for East Africa is located in Nairobi, and has many consultants who have received training from the Global Fund. Kenya will make use of these consultants when they are available and have the needed skills. These would be national consultants. Because many TSF consultants are based in Kenya and are already experienced with the Global Fund in Kenya, we will be able to use them as short term consultants or as part-time long term consultants.

The CCM will also be able to request TMA from international sources. In the past, TMA has been provided through PEPFAR, WHO, UNAIDS, DFID and other international partners.

5 Component Budget *HIV/AIDS*

5. HIV/AIDS Component Budget - Overview and general guidance

5.2 Summary by objective and service delivery area

Table 5.2: Budget breakdown by service delivery area and objective.

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
1	**SDA 1.1: Anti-retroviral treatment and monitoring**	10,045,269	12,025,361	17,738,508	17,826,856	17,858,399	**75,494,394**
	SDA 1.2 - Prophylaxis and opportunistic infections	1,220,638	1,220,638	1,220,638	1,220,638	1,220,638	**6,103,188**
2	**SDA 2.1– Counselling and Testing**	1,195,214	2,010,958	2,076,012	2,249,675	2,501,688	**10,033,548**
3	**SDA 3.1 – Behaviour Change Communication – mass media**	867,178	865,044	855,244	838,510	850,244	**4,276,220**
	SDA 3.2- Behaviour change Communication – Community outreach	4,711,045	7,314,215	4,200,445	3,703,125	3,709,125	**23,637,955**
4	**SDA 4.1: Information system and operational research**	758,141	417,373	347,373	347,373	417,373	**2,287,634**
	SDA 4.2: Strengthening of civil society and institutional capacity building	2,244,624	2,250,214	1,914,764	1,960,443	2,066,799	**10,436,844**
	TOTAL	**21,042,109**	**26,103,803**	**28,352,985**	**28,146,620**	**28,624,266**	**132,269,783**

5 Component Budget *HIV/AIDS*

5.3 Summary by cost category

Table 5.3 – Budget breakdown by cost category

Use the "HIVTable53Line" button in the standard toolbar to insert row at the end of table

	Breakdown by cost category *(same currency as in section 1.1 of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	975,199	516,750	346,500	318,375	318,375	2,475,199
Technical Assistance	320,500	372,550	0	0	0	$693,050
Training	3,465,845	6,086,265	3,455,145	3,089,150	3,089,150	$19,185,555
Health products and Health Equipment	711,752	1,463,138	1,711,373	1,975,765	2,227,778	$8,089,806
Medicines and pharmaceutical products	9,505,692	11,215,659	16,156,645	16,205,691	16,205,691	$69,289,377
Procurement and supply management costs	1,425,854	1,682,349	2,423,497	2,430,854	2,430,854	$10,393,407
Infrastructure and other equipment	616,141	201,373	201,373	201,373	201,373	$1,421,634
Communication Materials	1,393,478	1,696,244	1,374,044	1,254,110	1,271,844	$6,989,720
Monitoring & Evaluation	255,068	329,070	199,070	199,070	269,070	$1,251,348
Living Support to Clients/Target Populations	681,524	895,812	743,644	684,860	716,402	$3,722,241
Planning and administration	1,431,452	1,384,990	1,482,090	1,527,769	1,634,125	$7,460,426
Overheads	259,604	259,604	259,604	259,604	259,604	$1,298,020
Total funds requested from Global Fund	**$21,042,109**	**$26,103,803**	**$28,352,985**	**$28,146,620**	**$28,624,266**	**$132,269,783**

Please note that the "Others" is specifically Overheads as in the table above.

5.4 Key budget assumptions

The detailed component budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for year 1 and year 2 in relation to three key areas.

5.4.1 Pharmaceuticals and other health products and equipment

Assumptions for drugs are included in the detailed budget

5.4.2 Human resources costs

Human resources are not a large part of this budget. In year one, there is funding for 28 health workers to be trained in nutrition in Suba District, and for training of 1,182 health workers in counselling and testing. The budget also provides for 20 data clerks to be hired for the five years of the proposal to work on data collection for NASCOP. Finally, there are funds for training of trainers for communities on prevention issues, but these people are not employees of the health system.

5.4.3 Other key expenditure items

Explain the rationale for how other expenditure categories which form an important share of the budget (e.g., infrastructure and other equipment; communication materials; or planning and administration), have been budgeted for the first two years.

The budget lines for management and administration will provide support to the two PRs and SRs to implement this programme. The costs are task based.

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 4: Component Strategy – HIV/AIDS		**Annex Number to your proposal**
4.3.1	Documentation relevant to the national disease program context.	Annex 17: National Health Sector Strategic Plan II Annex 18: Kenya National HIV/AIDS Strategic Plan Annex 19: Kenya ART Strategy Annex 21: National Nutrition Guidelines Annex 22: Kenya National HIV/AIDS Data Book
4.3.5(c) *(**only** if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	N/A
4.3.5(d) *(**only** if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism.	N/A
4.6	**A completed 'Targets and Indicators Table'** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A – HIV/AIDS**
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	Annex 23: Detailed work plan
4.6	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals.	Annex 24: TRP Review Form for Round 5 and 6
4.8.3 (c)	List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**)	Annex 25: List of sub-recipients
4.9.1	National Monitoring and Evaluation Plan/Strategy (if one exists)	Annex 26:National HIV/AIDS M&E Framework
Section 5: Component Budget – HIV/AIDS		**Annex Number to your proposal**
5.1	**Detailed component Budget**	Annex 27: Detailed budget

5.1 *(if HSS strategic actions are included – see section 4.4.2)*	Details of cross-cutting HSS amount (if not clearly identifiable from the detailed component budget).	N/A
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3)	**Attachment B – HIV/AIDS**
5.4.2	Human resources costs.	N/A
5.4.3	Other key expenditure items.	N/A
5.1 - 5.3 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	N/A
Other documents relevant to sections 4-5 attached by Applicant:		**Annex Number to your proposal**
4.3.1	Documentation relevant to the gap analysis	Annex 28: Report of the Inter Agency Technical Assistance Mission on Monitoring and Sustainable Financing of ART of HIV and AIDS
4.3.1	Documentation relevant to the gap analysis	Annex 29: HIV and AIDS Commodity Forecasting 2007/08 to 2009/10

HIV/AIDS Attachment A to the Proposal Form

Program Details

Country:	KENYA
Disease:	HIV/AIDS
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	Improved quality of life of people living with HIV and AIDS and reduced new HIV infections /AIDS
2	

Impact and outcome Indicators	Indicator formulation	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	% of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures)	Not applicable	2003	Patient records						With the roll out of patient registers cohort analysis of patient on ART will be done annually
impact	% of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures)	5.8% Women and 1.2% for men	n/a	DHS/DHS+ (Demographic and Health Survey)			4.5% women and 1% for men			This is the target set by 2010 in the national HIV and AIDS strategic plan
outcome	% of young people aged 15-24 who had sex with more than one partner in the last year	1.6% women and 11.3% men	2003	DHS/DHS+ (Demographic and Health Survey)						
outcome	% of young people aged 15-24 reporting the consistent use of a condom with non-regular sexual partners in the last year	25.4%women and 46.8% men	2003	DHS/DHS+ (Demographic and Health Survey)			40% women and 65%men			This is the target set by 2010 in the national HIV and AIDS strategic plan
outcome	% of adults and children who are still on treatment after 6 months, 1, 2, 3, 5 years from the initiation of treatment			Patient records						With the roll out of patient registers cohort analysis of patient on ART will be done annually

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	To scale up and sustain PLWAs on ART	
2	To increase access to HIV counseling and testing	
3	To increase uptake of HIV and AIDS prevention and treatment	
4	To strengthen institutionls capacity	

HIV/AIDS Attachment A to the Proposal Form

Program Details

Country:	KENYA
Disease:	HIV/AIDS
Proposal ID:	

Objective / Indicator Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5				
1.1	Treatment: Antiretroviral treatment (ARV) and monitoring	Number of adult patients on first line ARVs	129'722	juin.05	Patient records	20'264	20'264	41264	41264	62'754	62'754	62'754	Y	N	Y - over program term	
1.2	Treatment: Antiretroviral treatment (ARV) and monitoring	Number of people on nutrition supplements			Patient records	1881	5'643	8'746	11'850	18'522	25'853	33'749				
1.3	Treatment: Antiretroviral treatment (ARV) and monitoring	Number of children on therapeutic feeds			Patient records	167	502	778	1054	1655	2307	3009				
1.4	Treatment: Antiretroviral treatment (ARV) and monitoring	Number of children on therapeutic feeds			Patient records	669	2007	3110	4214	6622	9228	12034				
1.5	Treatment: Prophylaxis and treatment for opportunistic infections	Number of patients on care being offered cotrimoxazole	226'500	juin.05	Health services statistics	200'000	200'000	200'000	200'000	200'000	200'000	200'000	Y	N	Y - over program term	
2.1	Prevention: Testing and Counseling	Number of people counseled and tested for HIV	1'808'865	2007	Health services statistics		378'845		1'162'548	2'079'270	3'137'600	4'346'558	Y	N	Y - cumulative annually	The data will be collected monthly using Health facility data collection tools
3.1	Prevention: BCC - Mass media	Number of media campaigns(TV, Radio and outdoor)			please select…	2'500	4'000	6'000	8'000	12'000	16'000	20'000	Y	N	Y - over program term	
3.2	Prevention: BCC - community outreach	Number of organisation funded to give BCC community outreach			Reports (Global fund FMA)	34	34	34	34	34	34	34	Y	N	Y - over program term	
3.3	Prevention: BCC - community outreach	Number of youth outreach events			Reports (Commnity Based Programme Activity reports)	506	2'520	4'410	6300	8820	10'720	12600	Y	N	Y - over program term	
3.4	Prevention: BCC - community outreach	Number of community outreach events			Reports (Commnity Based Programme Activity reports)	172	864	1512	2160	3024	3672	4320				
3.5	Prevention: BCC - community outreach	Number of youth groups supported			Reports (Commnity Based Programme Activity reports)	190	950	950	950	950	950	950				
3.6	Prevention: BCC - community outreach	Number of youth resource centers established			Reports (Commnity Based Programme Activity reports)	12	62	62	62	62	62	62				
4.1	Information systems and operational research	Number of implementers reporting regularly			Reports (specify)	36	36	36	36	36	36	36	Y	N	Y - over program term	