Countries with overlapping high burden of tuberculosis (TB) and HIV must submit a single concept note that presents each specific program in addition to any integrated and joint programming for the two diseases.

In requiring that the funding requests be presented together in a single concept note, the Global Fund aims at maximizing the impact of its investments to make an even greater contribution towards the vision of a world free of the burden of TB and HIV. Enhanced joint HIV and TB programming will allow to better target resources, to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

All concept notes should articulate an ambitious, strategically focused and technically sound investment, informed by the national health strategy and the national disease strategic plans (NSPs).

The concept note for TB and HIV is divided into the following sections:

**Section 1:** The description of the country’s epidemiological and health systems context including barriers to access, the national response to date, country processes for reviewing and revising the response, and plans for further alignment of the NSPs, policies and interventions for both diseases.

**Section 2:** Information on the national funding landscape, additionality and sustainability

**Section 3:** The funding request to the Global Fund, including a programmatic gap analysis, rationale and description of the funding request, as presented in the modular template.

**Section 4:** Implementation arrangements and risk assessment.

**IMPORTANT NOTE:**

Applicants should refer to the TB and HIV Concept Note Instructions to complete this template.
### Applicant Information

<table>
<thead>
<tr>
<th>Country</th>
<th>KENYA</th>
</tr>
</thead>
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</tr>
<tr>
<td>Principal Recipient(s)</td>
<td>MOF, KRC and AMREF</td>
</tr>
</tbody>
</table>

*If the programs are to be managed as separate grants:*

| Funding Request Start Date for HIV | 01/07/2015     | Funding Request End Date for HIV | 31/12/2017 |
| Principal Recipient(s) for HIV    | MOF, KRC       |

| Funding Request Start Date for TB | 01/07/2015     | Funding Request End Date for TB | 31/12/2017 |
| Principal Recipient(s) for TB     | MOF, AMREF     |

### FUNDING REQUEST SUMMARY TABLE

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.
### 1.1 Country Disease, Health Systems and Community Systems Context

With reference to the latest available epidemiological information for TB and HIV, and in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the two diseases, including trends and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS.

b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint areas of both programs.

### A. CURRENT AND EVOLVING EPIDEMIOLOGY OF TB AND HIV IN KENYA

**INTRODUCTION:**

A new constitution was adopted in 2010, replacing a governance structure of eight provinces with 47 newly created counties.

In-line with the new Constitution, the devolution of government functions and resources to the 47 counties is swiftly changing the mode of operations for the health sector, including the management of HIV, TB, and leprosy and lung health. The health sector, previously characterized by central-level planning and supply-side financing, is shifting to devolved planning and demand-side financing modalities including national health insurance, conditional and performance-based grants, and equity-enhancing allocations of national resources. This background is provided as previous sub-national epidemiologic analysis of HIV and TB diseases were done on the basis of the erstwhile eight provinces and not the present 47 counties.

The country has gone through a process of revising its national disease strategies for HIV and TB to reflect the current operational structures and the prevailing disease epidemiology. The HIV program has developed a Kenya AIDS Strategic Framework (KASF) 2014/15 – 2017/2018 while the TB program has a National Strategic Plan for Tuberculosis, Leprosy and Lung Health (2015 -2018). This Concept Note is in alignment with these two national strategies.

Kenya has also taken bold steps towards generating county level analysis of the HIV and TB epidemiology. A specific effort at this is the development of estimates for HIV at both national and county level in 2014 – a project supported by UNAIDS¹. This provides necessary information for geographic prioritization along county lines and models retrospectively to generate but historical trends across counties.

Based on the 2009 population census, Kenya’s population is projected to be 41.2 million people. Kenya has a young population with 53 percent of the Kenyan population under 18 years, or 21.3 million children. Notably, adolescents 10-19 years constitute around 9.2 million or nearly a quarter of Kenya’s total population².

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¹ NASCOP, Kenya HIV Estimates, 2014
Kenya suffers from dual HIV and TB epidemics. Globally Kenya is ranked 4th in the HIV disease burden and 15th among the 22 high TB burden countries.

The epidemiological characteristics and clinical manifestations of both TB and HIV and confounding issues such as stigma related to the two diseases requires an integrated approach in the response. However, integration of the response to both HIV and TB in Kenya has previously experienced challenges including limited structural and human resources. National programs are overwhelmed by HIV treatment scale up and limited knowledge of treatment of TB/HIV co-infection in resource-limited settings. In addition, separate TB and HIV national programs have led to limited communication and interaction within national health systems resulting in limited function of joint committees. Optimal running of the committees will be a prerequisite for better program coordination and implementation.

The HIV epidemic in Kenya is both generalized among the general population and concentrated among specific Key Populations (KPs) and geographies. The HIV prevalence is estimated at 6.0% with an estimated 1.6 million persons living with HIV.

Mainstreaming HIV at various levels and sectors is a fundamental component of expanding the response to the HIV and AIDS epidemic. Kenya has achieved a comprehensive integration of HIV prevention, treatment and socio-economic protection interventions in all areas of the state and no state led sectors. This approach allows for better planning for HIV and AIDS services within sectors, programmes and decentralized institutions, taking into account issues of comparative advantage, possible context-specific interventions and their cost effectiveness as well as consequent appropriate resource allocations. This provides synergies and limits duplication of efforts among sectors and agencies.

Implicit in the ethos of prioritization is the effective use of the multi-sectoral approach to the delivery of the national AIDS response. This has become more pressing under the devolved system of governance in Kenya where accountability is diffused through national and county governments.

The epidemiological analysis is informed by data from national programme reviews and epidemiology and impact assessments carried out for both HIV and AIDS and TB prior to the development of this concept note amongst other available literature. The HIV analysis also has information sourced from KNASP III End Term Review, the Kenya AIDS Indicator Survey (2012), Kenya AIDS Response Progress Report 2014, the Kenya Demographic and Health Survey 2009, The Kenya HIV prevention revolution road map and National HMIS data.

The TB epidemiologic summary relies on TB routine program data, Epidemiological and Impact Analysis of TB (February 2014), Mid Term Review of the National TB Program, National Tuberculosis, Leprosy and Lung Disease Unit (NTLD) Report 2013 and WHO TB country profile for 2013.

The following narrative will provide further specific context around the HIV and TB epidemiology in Kenya.

**EPIDEMIOLOGY OF HIV IN KENYA**

**HIV Prevalence trends**

The 2014 National and County HIV and AIDS estimates were generated using the Estimation and Projection Package (EPP) and Spectrum software recommended by the UNAIDS Reference Group on Estimates, Modelling and Projections. The software used data collected from antenatal clinic surveillance, population based surveys including the new Kenya AID Indicator Survey II (KAIS 2012) and other program data to estimate the prevalence of HIV and its impact on the population. The report presents the trend of data generated since 2000 in the current EPP and Spectrum software which has been used for the development of this concept note. It is acknowledges that since data, methods and software changes influence each estimate process, the prevalence estimates are not directly comparable, only the estimates produced by a single curve or model can be meaningfully compared to assess changes as shown in Figure 1.

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3 NASCOP, Kenya HIV Estimates report, 2014
4 NASCOP, Kenya HIV Estimates report, 2014
The National HIV and AIDS Estimates Working group estimated HIV prevalence rate among people aged 15-49 to be 6.0% in 2013. Although the Spectrum results show a continued decline of HIV prevalence among adult population from late 1990s to 2008 the prevalence has since stabilized as depicted in the trend curve above. The sex disaggregated national prevalence in 2013 shows men with 5.6% and women 7.6% HIV prevalence. HIV prevalence among females is significantly higher than for males in every high burden county, as it is nationally.

The HIV estimates report also showed that HIV prevalence among young females aged 15-24 was higher than that of males in the same age group at 2.7% and 1.7% respectively. Notably young women in this age group account for 21% of all new HIV infections in Kenya, a clear incidence marker.

**HIV Incidence**

The HIV Estimates Report (2014) indicates that Kenya has seen a decline in HIV incidence rates among adults aged 15-49 from 0.62% in 2000 to 0.39% in 2013 possibly due to the scale up of various prevention and treatment programs.

In terms of absolute numbers, new HIV infections among persons above 15 years declined by 7% from 95,000 in 2007 to 88,620 in 2013. Notably, 29% of all new HIV infections are among adolescents and youth aged 10-24 years. There was a significant decline by 44% among children under 14 years from 44,000 in 2007 to 12,940 in 2013.

The HIV and AIDS epidemic in Kenya shows extreme geographic disparities with 9 of 47 counties accounting for 65% of new adult infections in 2013. The HIV Prevention Road map based on the country HIV estimates report classifies the 47 counties into three broad categories based on incidence- a) High incidence cluster comprising of 9 counties b) Medium incidence cluster comprising of 28 counties and c) Low incidence cluster comprising of 10 counties.

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Sources and Modes of transmission of new HIV infections

The MOT 2008 showed that heterosexual transmission remains the most prominent with 44% of all new HIV infections attributed to this mode of transmission in all areas of Kenya\(^7\). The report qualifies this conclusion by stating that “…..however, heterosexual transmission occurs in a variety of types of sexual encounters: between married couples or steady sexual partners, concurrent sexual partnerships (e.g. one person with both a steady, long term partner and a casual partner, or one person with more than one steady partner), casual sexual partners, and a range of transaction-based sexual practice”.

Additionally, the concentrated epidemic is driven by key populations. Studies conducted among key populations indicate a significantly higher prevalence among MSM, FSW and PWID estimated at 18.2%, 29.3% and 18.7% respectively\(^8\). A study conducted in Nairobi in 2010 by IOM and partners revealed a HIV prevalence of 23% among migrant sex workers, with limited access to HIV prevention and treatment services. Current evidence by UNHCR, though, estimates HIV prevalence in Dadaab refugee camp at 1.9% (2012 data) and 3% in Kakuma refugee camp. On the weight of available evidence it can be concluded that Key populations contribute a disproportionately high number of new HIV infections despite their small population size. According to the MOT 2008, although these populations represent less than 2% of the general population, they contribute a third of all new HIV infections.

Other forms of sexual practices also contribute to the epidemic and their contributions are depicted in figure 3 below.

Using the incidence model that considers data and contributions attributed to certain populations, 21% of the estimated 88,000 new HIV infections that occurred in 2013 in persons above 15 years occurred among young women aged 15-24 years contributed \(^4\). Other populations and modes of transmissions that contributed to the estimated 101,560 are depicted in the figure below.

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\(^7\) UNAIDS, Kenya HIV prevention response and modes of transmission analysis, 2009
\(^8\) NASCOP, Integrated Biological and Behavioural Survey among Key Populations in Nairobi and Kisumu, Kenya, 2010-2011
HIV in Children

KAIS 2012 showed that the HIV prevalence among children aged 18 months to 14 years was 0.9%. This corresponds to an estimated 101,000 children infected with HIV nationwide in 2012.

According to the Kenya HIV estimates 2014 report, there were an estimated 191,840 Children (0-14 years) living with HIV in 2013. An analysis of trends as reflected in the HIV estimates report showed that new HIV infections among children has declined from 44,000 in 2007 to 12,940 in 2013. This is still a significant number of new infections among children and is attributable to the high Mother-to-child transmission (MTCT) rates estimated at 14% in 2013 despite scale up of PMTCT services. The Kenya AIDS Indicator Survey, 2012 also indicated that unmet family planning (FP) need is high among HIV positive women.

The high MTCT rate is also compounded by the low testing rates for HIV exposed babies. At the end of December 2013, only 42.5% and 53% of infants received Early Infant Diagnosis (EID) and ARV prophylaxis respectively. Less than 50% of children less than 14 years in need of ART were on treatment in the same year.

Infrastructure limitations such as inefficient laboratory flow, inconsistent commodity supply for essential lab services, weak data collection systems, and poor provider knowledge have been sighted as some of the reasons for observed poor performance. Low stakeholder involvement including private sector, poor integration of services, and ineffective referrals are other important factors. Low PMTCT knowledge, poverty, stigma/ fear, and denial have also been known factors that prevent women from accessing or adhering to PMTCT interventions.

To address these challenges, the country has prioritized optimal implementation of the new treatment guidelines launched in June 2014 that recommends ART for HIV positive pregnant and lactating women regardless of the CD 4 or WHO stage; scale up of EID services and pediatric ART programs. The programme will also include scale up of interventions for children 15-18 years based on data that shows a growing cohort of adolescents living with HIV. In 2013, there were about 46,700 adolescents living with HIV in need of ART. Maternal and child health services have continued to improve over the past 2 year following increased political commitment through presidential initiative to launch free maternity services and championship of the agenda by the First lady through a campaign dubbed Beyond Zero. The country has also enhanced laboratory networking which has increased the rates of HIV exposed infants tested. These efforts have led to an increase in uptake of services including hospital deliveries and diagnosis that directly impact on the rates of mother to child transmission of HIV.

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9 UNAIDS, Global Progress Report, 2014
Geographical characteristics of HIV in Kenya

Kenya's HIV epidemic is geographically diverse, ranging from a prevalence of 25.7% in Homa Bay County in Nyanza region to approximately 0.2% in Wajir County. Three of the 47 counties (Homa Bay, Kisumu and Siaya) have more than 15 per cent HIV prevalence rates reaching hyper-endemic levels.

Figure 4: HIV Prevalence by counties 2013 (HIV Estimates Report, 2014)

Kenya has also classified counties based on their HIV burden. Ten counties have been identified as high HIV burden counties on the basis of absolute estimates of people living with HIV 15 years of age and above (Kenya HIV estimates report 2014).
Vulnerability and risk factor analysis for HIV transmission in Kenya

Several factors have been identified as contributing to vulnerabilities to HIV among various subpopulations in Kenya. This includes:

1. Sociocultural factors: High HIV stigma and discrimination, poor attitude to regular use of condoms, religious beliefs against condom use, gender inequalities including gender based violence and vulnerability of young girls, deepening poverty and food insecurity and widespread use of alcohol and substance abuse.
2. High risk sexual behaviour characterized by high incidences of concurrent sexual relations linked to mobility, intergenerational sex, transactional sex, denial and marginalization of key populations.
3. Biological factors including male circumcision and high prevalence of sexually transmitted infections.
4. Economic factors: Labour migration, increased cross-border travel, poverty and inequalities and vulnerability of adolescents, women and children.
5. Political factors including internal and external conflict, poor enforcement of anti-discrimination laws, weak social and legal protection of vulnerable populations such as irregular migrants, sexual minorities and inconsistent political support/will among others.

Kenya’s HIV epidemic disproportionately affects young women more than men of the same age group. Biological and gender related factors are attributed to their enhanced vulnerability and risk to HIV infection. The KDHS report (2008-09) established that almost half (45%) of women age 15-49 have experienced either physical or sexual violence. Specifically, 25% of women have experienced only physical violence, 7% have experienced only sexual violence, and 14% have experienced both physical and sexual violence. Studies have shown the link between HIV and gender based violence and this reinforces the prioritization of GBV interventions while addressing HIV to reduce risks and vulnerabilities.

Gender based norms, cultural practices and intergenerational sex are also known to increase the vulnerability of women HIV. Early sexual debut among young women is high; about 11% of young women had had sex at least once by age 15 and by the age of 18 years, 59% of young women had experienced at least one sexual encounter. Nearly all (95%) women had had sex by age 24.
sexual debut is associated with low condom use at sexual debut. The rate of condom use at sexual debut before 15 years was significantly low at 52.9% compared to condom use of 69.8% among women whose sexual debut was at the age of 15 to 24 years.

AIDS Related Mortality:
Since 2003 annual AIDS related deaths have declined from approximately 58,465 deaths in 2013 compared to 167,000 in 2003\textsuperscript{12}. The decline is directly attributable to the wider access to ART—made available with the roll out of free ART in 2003—and the ability of the National AIDS/STI Control Programme to cover treatment needs for HIV infected clients, TB/HIV co-infected patients and also provide care services.

To respond to the complex patterns of the HIV epidemic, the Kenya HIV Prevention Revolution Road Map has set the country on an ambitious path to end new HIV infections by 2030.

The Kenya HIV Prevention Revolution roadmap is a paradigm shift in HIV programming in Kenya. It promotes a combination prevention package with geographical prioritization that is population driven. It targets interventions at both geographical and population level. Based on this, counties have been clustered and granulation of the epidemic will be done at county and sub-county level and interventions targeted to that geographical areas and to the specific population to achieve maximum impact.

EPIDEMIOLOGY OF TB

TB prevalence
Data on TB prevalence and mortality are sparse. Kenya has not conducted a national TB prevalence survey in the recent past (the last TB prevalence survey was conducted in 1956), but the NLTD is planning to carry out a national prevalence survey from January 2015 which is expected to estimate the burden of TB in the country. Until the prevalence survey is completed, data from the national electronic case-based surveillance system (TIBU) and operational research studies will guide the program's priority setting. World Health Organization estimates of TB prevalence (all forms) to be 299 per 100 000 population\textsuperscript{13}. The trends indicate a relative stability from 2000 to 2012 as depicted in the figure below. In 2013 this figure stood at 283 per 100,000 population (WHO).

Figure 6: WHO Estimates of TB Prevalence in Kenya (2000-2012)

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{WHO_TB_Prevalence.png}
\caption{WHO Estimates of TB Prevalence in Kenya (2000-2012)}
\end{figure}

TB incidence

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{WHO_TB_Incidence.png}
\caption{WHO Estimates of TB Incidence in Kenya (2000-2012)}
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\caption{WHO Estimates of TB Incidence in Kenya (2000-2012)}
\end{figure}

11 Rachel Jewkes et al, Understanding rape perpetration in South Africa SA Crime Quarterly no 34 • December 2010
12 Kenya HIV Estimates report, 2014
Analysis of the trends in estimates of TB incidence as produced by WHO suggests a consistent decline in new TB cases over time. The decline in TB cases started in 2005 with an estimated incidence of 359/100,000 population to an estimated incidence of 268/100,000 population in 2013. A similar trend of decline is noted with incidence of TB/HIV co-infected cases which could be explained by the direct relationship between the twin epidemics of HIV and TB.

Figure 7: WHO estimates of TB incidence in Kenya (2000-2012)

**TB Case notifications**

Data from the national program reports indicate that the number of notified TB cases (all forms) increased from approximately 95,000 cases in 2003 to a peak of over 116,000 cases in 2007. After 2007, the number of notified TB cases steadily declined until 2013, when the number of notified TB cases was approximately 89,000 – the lowest it has been in over a decade. Approximately 10,000 fewer cases were reported in 2013 compared with 2012. However, due to changes in the reporting system i.e., the adoption of Treatment Information from Basic Unit (TIBU), low case numbers could be the result of under reporting. An inventory study is ongoing to investigate this dip in notification rates in 2013. The results are expected by March 2015. Over the last 5 years there has been a declining trend of TB in Kenya. This is attributable to intensive investments in funding for TB control and increased coverage for HIV treatment (Weyenga 2014). These numbers are expected to further decline with expansion in ART coverage and implementation of the new WHO guidelines that have been adopted by the HIV program which advocate for initiation of ARV at higher CD4 counts of 500 effectively reducing the risk of TB in this population. The country has put in place measures to increase case detection by implementing ICF among PLHIV and expanding this to other high risk populations including diabetes clinics, maternal and child health clinics, prisons, urban slums, contact tracing and introduction of new rapid and sensitive TB diagnostic technologies. The decline in incidence is expected to be at a higher rate through the above strategies.

However the trend observed from 2006 to 2012 which is of a more graduated pattern could be a result of the successes of the National TB program at decreasing TB incidence. The Epidemic Impact Assessment hinges on the three pillars of a) sustained government commitment with government’s financial contribution to TB increasing gradually over the past decade and now accounts for approximately 28% of all spending on TB control in the country b) Evidence based innovation as depicted by an early adoption of innovations in TB control, such as Public-Private Mix (PPM), community-based care, roll out of new diagnostic technologies and TB/HIV collaborative activities and c) strong partnerships where the NTLD benefits from long-standing collaboration with its donors and technical partners, especially USAID, Global Fund, WHO, CDC, KNCV, World Bank, GDF, and FIND through the Inter-agency Coordinating Committee (ICC).

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National TB case notification rates and geographic variation:

Analysis of national case notification rate for all TB cases (new and retreatment) shows three distinct trends. From 2000 to 2004, the TB case notification rate increased steadily; from 2004 to 2006, rates remained constant; and from 2006 to 2013, rates steadily declined, with rates in 2013 lower than those recorded in 2000. Based on Kenyan data, the case notification rates fell especially quickly between 2011 and 2013, decreasing approximately 8% and 12% each year, respectively. However this picture could change once 2013 data have been validated. Overall, decreasing case rates similar to the national level decrease were also seen in each region from 2006-2013. With the current devolution to counties, future analysis of trends will be provided based on the 47 counties as sub national geographical/reporting entities. The 2013 National Tuberculosis, Leprosy and Lung Disease 2013 annual report provides the first county level reporting for TB – a positive trend that will be sustained going forward. The report indicates that certain counties have higher notification rates compared to the national average. These include Mombasa county with a case notification rate of 469 per 100,000, Nairobi county with a case notification rate of 399 per 100,000, and Homa Bay county with case notification rate of 330 per 100,000. This could be driven by HIV epidemic, poverty and urban slums.

Figure 9: Trend of TB Case notification rate (all forms) Kenya 2000 -2013

![Number of Notified TB cases](image)

![TB Case notification rate (all forms) per 100,000 population](image)
Age and sex characteristics of TB case notification in Kenya

The Epidemiologic and Impact Analysis, 2014 showed that the largest number of TB cases occurred among young adults with the most cases reported for adults aged 25-34 years, followed by adults aged 35-44 and 15-24 years. This pattern is similar to the HIV prevalence by age groups indicating that HIV continues to be a major driver of the TB epidemic in Kenya. The average age of TB cases in 2012 and 2013 was 33.7 and 37.7 years, respectively; these are the only years for which case-based data are available. The fewest cases were reported in children aged 0-4 years. The NTLD Annual report 2013 indicates that a total of 6,717 new cases of children with TB cases were reported in 2013. This represented 9% of all new TB cases reported during the period. This proportion was below the expected range of 10% to 15% of all cases notified. This is partly attributed to the initial challenges of rolling out the new electronic system. The Kenya national TB strategy is cognizant of the problems encountered by vulnerable migrants such as poor living conditions in overcrowded, dark, and poorly ventilated spaces, which are conducive to the spread of TB. Moreover, lack of legal status in Kenya that results in fear of arrest and deportation, stigma, low health literacy, language and other socio-cultural barriers are some of the social factors which discourage migrants from seeking appropriate diagnosis and treatment for communicable diseases such as HIV and TB.

The Epi-analysis 2014 also shows that males had higher TB case notification rates than females among all age groups, except for children (0-15 years) and young adults (15-24 years). This is similar to findings in a study conducted in three provinces in Kenya\textsuperscript{15} that showed that there were more males (56%) than females affected by TB, but more females with dual infection. Females have a bimodal peak in age groups 15–24 and 25–34, while males have one peak age group at 15–24.

Among children and young adults Case Notification Rate (CNR), was equal between males and females. Adults aged 35 - 44 years had the highest CNR in both males and females; however, rates of TB among males in this age group were approximately 30% greater than rates of TB for females in the age group. This pattern will need to be further investigated to provide explanations that will possibly inform strategic shifts in program implementation.

Pediatric TB:

In 2012, 10,634 TB cases were reported among children under the age of 15, comprising 10.7% of all TB cases. Almost 28% of all child TB cases were in children under the age of one. Of the reported TB cases, 93% were tested for HIV and 30% were found to be HIV positive. Of those found positive, 90% were initiated on cART and 99% on cotrimoxazole. In 2012, 10 children were diagnosed with MDR TB and treatment started. Among the paediatric MDR TB cases, 20% were HIV positive.

There are significant variations across counties for Pediatric TB notifications. Some counties notified a very high number of children with Turkana and Samburu having >12% of their total cases being children while some have child TB cases being less than 5% of the total TB cases notified. It is also noteworthy that more children were diagnosed with TB in counties where there is food insecurity due to climatic characteristics.

The ratio of children <5 years to those 5-15 years diagnosed with TB also varies across counties. Over 70% of the counties have a ratio of less than 1:1.5 which is less than the WHO recommendation of 1.5:3.0 indicating that there is a possible under-diagnosis of children below the age of 5 years. There is therefore a need to evaluate the actual pediatric diagnostic practices among health care workers in the very high and very low case notification counties.

MDR-TB

http://www.hindawi.com/journals/eri/2013/417038/
Kenya notified 254 cases of MDR-TB in 2013, 28% of whom were refugees from neighboring Somalia. The number of MDR-TB cases detected in Kenya has risen steadily since 2010, when only 112 cases were detected. WHO estimates that there were 2,780 MDR-TB cases in Kenya in 2012. A drug-resistance survey is underway to determine a more precise DR-TB estimate. With Gene Xpert roll-out, it is expected that the number of MDR-TB cases detected will increase dramatically. In 2013, Kenyatta National Hospital, East Africa’s largest referral hospital, diagnosed and reported, for the first time, three cases of a new strain of Tuberculosis: Extensive drug-resistant tuberculosis (XDR-TB). Although two of the patients died a year later, one patient, a female, has lived under the care of Kenyatta National Hospital (KNH)\(^\text{16}\). This is a success story for KNH in partnership with the government, in its efforts to manage drug-resistant TB.

**TB Mortality**

Kenya does not have a national level vital registration system with standard ICD-10 coding in place and as such reliable TB mortality continues to be a challenge. However WHO estimates of mortality of TB cases (all forms, excluding HIV) per 100 000 population shows a relatively stable picture from 2000 to 2013. WHO estimates TB mortality for 2013 to be 20/100,000 Population. The country’s attempt to generate data through a mortality survey was terminated at pilot stage due to insensitivity of verbal autopsy methodology that was used. It was then suggested that there is need to strengthen the vital registration system.

*Figure 10: WHO estimates of TB mortality trends in Kenya (2000 -2012)*

**TB-HIV in Kenya:**

**HIV in TB patients:** The TB programme has continued to successfully test more TB cases for HIV over time. Although rates of HIV remain high among persons with TB who know their status, HIV prevalence among TB cases has been decreasing from 45% in 2008 to 38% in 2012\(^\text{17}\).

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\(^{17}\) NTLP, Program data
TB in HIV patients: The uptake of TB screening among people living with HIV (PLHIV) has improved, with 83% screened for TB at their last visit\(^\text{18}\). HIV testing among patients with TB was routinely conducted and monitored however, recording of TB screening among PLHIV while being done, was not consistently summarized and reported through standardized data capture systems. Limited access to diagnostics beyond smear microscopy is a major barrier to clinicians screening for TB among PLHIV.

In Kenya, the comparative incidences of tuberculosis among persons with and without HIV have not been described, and the differential impact of public health interventions on tuberculosis incidence in the two groups is unknown. However, a study on the comparison of trends in Tuberculosis Incidence among adults living with HIV and adults without HIV done in Kenya revealed interesting findings\(^\text{19}\). Tuberculosis incidence among both adults with HIV and adults without HIV increased during 1998–2004 then remained relatively stable until 2007. During 2007–2012, tuberculosis incidence declined by 28–44% among adults with HIV and by 11–26% among adults without HIV, concurrent with an increase in antiretroviral therapy uptake. In 2012, tuberculosis incidence among adults with HIV (1,839–1,936 cases/100,000 population) was still eight times as high as among adults without HIV (231–238 cases/100,000 population), and approximately one third of tuberculosis cases were attributable to HIV.

**Figure 11: Trends of HIV prevalence among TB patients (2008 -2012)**

![Trends of HIV prevalence among TB patients](image)

**Source:** NTLH program data

<table>
<thead>
<tr>
<th>Year</th>
<th>New tuberculosis patients</th>
<th>Proportion with HIV test result</th>
<th>Proportion with positive result among those tested</th>
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<td>2006</td>
<td>104,935</td>
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<tr>
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<td>99,807</td>
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<td>44.00%</td>
</tr>
<tr>
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<tr>
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<td>95,604</td>
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<tr>
<td>2011</td>
<td>93,964</td>
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</tr>
<tr>
<td>2012</td>
<td>89,143</td>
<td>93.90%</td>
<td>37.20%</td>
</tr>
</tbody>
</table>

(doc:10.1371/journal.pone.0099880.1001)
The study concludes that although tuberculosis incidence has declined among adults with and without HIV, the persistent high incidence of tuberculosis among those with HIV and the disparity between the two groups is a concern for the national program. It recommends that early diagnosis of HIV, early initiation on antiretroviral therapy, regular screening for tuberculosis, and isoniazid preventive therapy (IPT) among PLHIV, as well as tuberculosis control in the general population, are required to address these issues.

In 2013, over one-third (35%) of notified TB patients nationally were HIV infected, compared to 13% globally. Some regions reported up to 75% HIV infection among TB patients.

Despite the disease burden, Kenya has been recognized as a leader in implementing the recommended WHO TB/HIV collaborative activities. In 2013, out of every 20 patients with TB 19 (95%) had a documented HIV test result with 83% of those HIV-infected being put on cART and almost all on CPT. Intensified TB case finding has been strengthened and data collected during the 2014 mid-term review revealed that 83% of PLHIV in care and treatment were screened for TB during their clinical visit. It was however noted that only 2% of those screening negative for TB were initiated on isoniazid preventive therapy (IPT) more because the IPT program had not been fully established. With the current scale up of the program, this picture will be significantly reversed.

B. KEY POPULATIONS WITH DISPROPORTIONATELY LOW ACCESS TO SERVICES AND INCREASED VULNERABILITY TO HIV AND TUBERCULOSIS

Key populations in Kenya are defined as FSW, MSM and PWIDs for HIV. In regard to TB, prisoners, urban slum dwellers, diabetics, health care workers, uniformed service personnel (Military, Police, Prison wardens) nomadic, internally displaced persons and migrants, including irregular migrants20, refugees and asylum seekers, contacts of TB patients (derived from active case search and screening of families of smear positive TB patients and contributed 2287 notified cases in 2013), and people living with HIV are considered key populations due to their increased vulnerability. In HIV Key populations remain vulnerable

20 A migrant in an irregular situation is a person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in Kenya. Refugees in urban areas who cannot register are also considered to be in an irregular status under Kenyan law. The term “irregular” is preferable to “illegal” because the latter carries a criminal connotation and is seen as denying migrants’ humanity (see Glossary on Migration, IOM, 2011, and UN General Assembly resolution 3449, 2433rd plenary meeting, 9 December 1975).
to infection due to socio-cultural and legal barriers that limit access to HIV prevention, care and treatment services. Criminalization of sex work, homosexuality, and Injection Drug use remains a significant barrier to access to HIV services. Socio-cultural and religious factors have led to stigmatization of these populations among mainstream health service providers. This has further limited access to health services and propagates high risk practices that escalate the spread of HIV among key populations. In one of the studies, sexual and physical abuse was noted to be high among FSW at 17% and 24% of MSM as experienced 6 months preceding the survey. Majority of MSM have reported physical violence and arrests by law enforcers in the country21.

The incidence and prevalence of Tuberculosis is higher among groups identified as key population in regard to TB in Kenya. Immuno-suppressive conditions including HIV and diabetes increase the risk of TB. HIV/TB co-infection is high with 75% cases of TB cases reported among persons infected with HIV. Populations identified as key populations with high HIV risk such as MSMS, PWIDs among others are placed at higher risk of acquiring TB due to the burden of HIV and poor access to health care services occasioned by social and cultural circumstances. Besides the high TB risk, HIV infected TB patients have a case fatality rate that is four times that of TB patients without HIV. The risk of TB in diabetics is 2.5 times that for those without the condition. While local data on TB in diabetics is lacking, the International Diabetes Federation predicts the prevalence of diabetes in sub-Saharan Africa to rise by 98.1% between 2010 and 2030. This situation call for increased the focus of integrating TB services in chronic disease service points TB interventions and has been prioritized in the TB National strategic Plan (NSP).20.

Over-crowding and poor living conditions increase the risk of TB infection. This is a common risk factor for the slum dwellers, prisoners, displaced persons, irregular migrants and uniformed personnel who live in congregate settings. While the incidence of TB in slum areas throughout Kenya is not known, slums are considered a high-risk setting given the ease of transmission due to overcrowding and financial, geographical and social barriers to care. A pilot project launched under TB-REACH in 2010 to provide affordable and accessible services in Kibera, an urban slum near Nairobi, has increased case notifications by 10%. A study conducted in Kamiti Maximum Security Prison in Kenya reported the prevalence of active pulmonary TB as 2356 per 100 000 of population22.

Kenya hosts migrants including refugees from surrounding countries. WHO estimates that the countries from where most of the refugees originate have Tuberculosis prevalence similar to Kenya. Refugees currently account for 30% of all of the MDR-TB cases notified in the country. Other than poor living conditions, the risk of acquiring TB in the majority of these most at risk populations is compounded by poverty, poor nutritional status and poor access to health services.

Moreover Kenya shares a long, porous border with countries which have endured decades of strife such as Somalia and South Sudan. According to reports from IOM, over 80% of Somali MDR TB patients diagnosed in 2013 in Dadaab and Eastleigh had crossed the border into Kenya recently. Patients from Somalia were reportedly arriving in Dadaab and Eastleigh with a GeneXpert result of resistant TB in hand, indicating that they had MDR-TB and had heard that treatment was available and accessible in Kenya.

Health care workers in Kenya experience a high burden of TB. In a study conducted at Kenyatta national hospital in 2013, the TB case notification rate among hospital staff ranged between 413 and 901 per 100 000 staff members per year; 51% of all cases were extra-pulmonary TB; 74% of all cases were among medical, paramedical and support staff. The TB-HIV co-infection rate was 60%. Only 75% had a successful treatment outcome23.

Although the role of gender is poorly understood it seems to play an important role in Kenya’s TB epidemic. While women bear a higher burden of HIV, males have a higher TB burden across all age groups except in the 0-15 age group where rates are similar. However case fatality has been noted to be higher among women than men (WHO 2002)). It is unclear why males suffer a higher TB Burden.

C. HUMAN RIGHTS BARRIERS AND GENDER INEQUALITIES ANALYSIS

21 NASCOP PBS draft report 2014
22 Nyaturu O et al. University of Nairobi, Department of Clinical Medicine And Therapeutics, The prevalence of active pulmonary tuberculosis among prisoners at kamiti maximum security prison, 2011
There are significant human rights challenges noted in the response to HIV and TB. A number of criminal cases have been instituted in regard non-adherence behavior with regard to treatment and control of drug resistance to TB. These cases have involved people living with HIV and co-infected with TB presenting human rights violations. Additional challenges include the existence of law that criminalize HIV transmission, consensual adult sex, injecting drug use and forceful incarceration of TB non-adherent patients.

Kenya is however committed to address HIV related human rights violations as demonstrated on a number of national and international legal instruments. The Constitution of Kenya 2010, particularly chapter four, is the cornerstone and legal basis of incorporating human rights in the TB and HIV response. The legal frameworks for the protection of human rights is also based on laws such as the HIV and AIDS Prevention and Control Act 2006; and The Employment Act. International treaties ratified by the government form part of the Kenyan law as stipulated by e of Article 2(5) and (6) of the Constitution. Such ratified international laws in relation to HIV include; : the International Covenant on Economic Social and Cultural Rights; the Convention on the Rights of the Child; the Convention on the Elimination of all forms of Discrimination Against Women; the African Charter on Human and People’s Rights and the African Charter on the Rights and Welfare of the Child. In addition, although not legally binding, the Government continue to have regard for several international declarations and commitments it has signed up to, including the Paris Principles on Greater Involvement of Persons Living with HIV and AIDS (GIPA) 1994; the United Nations General Assembly (UNGASS) Declaration of Commitment on HIV and AIDS 2001; the Abuja Declaration on HIV, TB and other opportunistic infections 2001; The United Nations General Assembly (UNGASS) Declaration of Commitment on HIV and AIDS 2006 and the Political Declaration on HIV & AIDS 2011. Kenya is also a member of the International Labour Organisation (ILO), and is therefore bound by the ILO legal instruments that prohibit discrimination in the workplace on the basis of HIV status particularly the ILO HIV and AIDS recommendation No. 200 of 2010. This has been consistent in Kenya’s constitutional and statutory provisions.

Kenya has a constitutional obligation to review and reform laws to ensure that they create an enabling environment for those living with, affected and most vulnerable to HIV and TB infection. As evidenced by rights based approaches adopted and incorporated in the country’s HIV and TB strategic plans it is clear that Kenya is committed to ensuring human rights are central to effective national responses. Kenya’s national response adopts an approach that embraces human rights principles of inclusion and participation including particular focus on community sensitization to address stigma, access to legal services to facilitate access to justice for human rights violations, developing health systems that respond to patients’ needs while ensuring realization of the right to health and related rights of PLHIV. Examples of jurisprudence from the HIV Kenya equity tribunal and national courts in Kenya provide proof of compliance. More investment on education and information will deliver better outcomes in achieving public health objectives.

Access to justice remains a critical enabling to the success of basic HIV prevention and treatment programs in Kenya. This aspect is embedded in the constitution through the existence of the courts, national human rights institutes and in the HIV Prevention and Control Act 2006, through the establishment of the HIV & AIDS Equity Tribunal. The Kenya National Commission on Human Rights, The National Gender and Equality Commission, The Commission on Administration of Justice are key human rights institutes that can facilitate access to justice for those living with and affected by HIV when their human rights have been violated. The High Court of Kenya and the HIV tribunal have given positive decisions that reaffirm the rights of PLHIV and remain an important avenue to be utilized to facilitate access to justice. The office of the Director of Public Prosecutions is another key state department that can address the criminal complaints raised by person who are living with and affected by HIV. These institutions will be necessary for facilitation of access to justice in cases of HIV – related discrimination or other legal matters.

Gender factors influence epidemiological differences in exposure, risk of infection and progression from infection to disease. In Kenya, men between the ages of 24-40 years have higher TB, leprosy and lung diseases disease burden and are more likely to default from treatment. In 2013, among smear positive pulmonary TB, leprosy and lung disease patients, aged 15-54 years, men were twice as affected by TB, leprosy and lung diseases than females.24. Male gender norms in many contexts mean that men have delayed health-seeking behavior. Women are more susceptible to HIV and HIV is a risk factor for TB, leprosy and lung diseases. In addition to biological vulnerabilities that put women and girls at higher risk.

24 NTLP Annual program report, 2013
of contracting HIV, Gender inequalities still remain one of the monumental challenges to HIV response in our country, owing to the deep-rooted gender norms which make it difficult for women and young girls to protect themselves from HIV infection, and to negotiate safer sex as revealed in KAIS and other studies in this area. It is noted that women have higher TB, and HIV co-infection rates than men. We therefore expect there should be more women with TB, leprosy and lung diseases which is not the case. The lower numbers could be caused by structural barriers, limited access to resources, information and time which brings out questions about a possibility that women do not seek treatment or possibly other unidentified reasons are responsible. Focused efforts are needed to diagnose, treat and prevent HIV, TB, leprosy and lung diseases among women.

Societal structures contribute to why a majority of women do not enjoy the same right to health and health related rights as men, placing them at a greater risk and at a disadvantage with respect to treatment and care. Their access to information and finances in many contexts is determined or controlled by men as head of households who often have greater economic power. These differences will be taken into account when developing strategies for interventions in the HIV, tuberculosis, lung diseases and leprosy programs. The National Gender and Equality Commission is equally mandated to promote gender and equality in accordance with Article 27 of the Constitution providing an avenue to ensure gender issues are mainstreamed in the HIV and TB programmes being delivered under this grant.

Despite the various progressive pieces of legislations enacted in the recent past, the Kenyan society is still predominantly patriarchal, and women and girls are consistently marginalized and discriminated upon at family, community and societal levels. While the Constitution of Kenya Chapter Four on The Bill of Rights guarantees every person the right and fundamental freedoms that should safeguard women’s rights, in practice, social- cultural norms, weak laws and non-application of these laws continue to affect women and girls adversely and contribute to their vulnerability and poor health outcomes.

Women have suffered human rights violations due to this weak legal framework that does not adequately address the inequity and discriminations suffered in a male dominated society.

The weak legal framework has further allowed the application of harmful cultural practices such as female genital mutilation/cutting (FGM/C), early marriage, widow cleansing, forced evictions, widow inheritance and discriminatory property inheritance practices which prevent women from inheriting property, that in turn increases women’s vulnerability to abuse diseases Power dynamics in relationships’ that encourage multiple partnerships among men are putting women and girls at greater risk of HIV and may explain the high HIV prevalence in our general population.

The country will therefore continue to strengthen its rights and evidence based approaches to address these inequalities through a more gender responsive programming, advocacy and policy influence as well as infrastructural improvement that will improve access and services for women and girls including key populations. These approaches are included in the modules and include prevention programs (both TB/HIV care and prevention ) for key, vulnerable and general populations including community systems strengthening, training on rights, policy advocacy, Sexual and reproductive health and PMTCT targeting young women.

**D. HEALTH SYSTEMS ANALYSIS**

Kenya has a strong health component in its ‘Vision 2030’ policy, which aims to build a prosperous country with high quality of life. The goal of the health sector is to provide equitable, affordable and quality healthcare of the highest standard to all citizens. The Health Sector focuses on strengthening and scaling up of cost-effective, preventive and promotive healthcare system, with special attention to control of communicable and non-communicable diseases, reproductive and child-health services, environmental and rural health services. Other areas of focus are healthcare financing, ensuring quality of health commodities, improvement of infrastructure and provision of medical equipment. Within this policy the delivery of community based services are a flagship project.

There are significant changes in the health system in the country as a result of devolution of health service provision to the counties. Counties have the autonomy to plan and budget for health services. Other devolved functions include procurement of supplies which were previously centralized and managed by Kenya Medical Supplies Authority (KEMSA). To effectively conduct these functions, the need to strengthen capacity at the county level remains a key challenge.
The Kenya health system is analyzed through the WHO’s six building blocks.

**SERVICE DELIVERY**

The Kenya Essential Package for Health (KEPH) defines health services and interventions to be provided for each Policy Objective, by level of care and cohort (where applicable). The levels of care as defined in the Kenya Health Policy include:

1. **Community level:** The foundation of the service delivery system, with both demand creation (health promotion services), and specified supply services that are most effectively delivered at the community. In the essential package, all non-facility based health and related services are classified as community services – not only the interventions provided through the Community Health Strategy as defined in NHSSP II.

2. **Primary care level:** The first physical level of the health system, comprising all dispensaries, health centres, maternity / nursing homes in the country. This is the 1st level care level, where most clients health needs should be addressed.

3. **County level:** The first level hospitals, whose services complement the primary care level to allow for a more comprehensive package of close to client services.

4. **National level:** The tertiary level hospitals, whose services are highly specialized and complete the set of care available to persons in Kenya.

Kenya conducted a Service Availability and Readiness Assessment Mapping (SARAM) in 2013 which provided a comprehensive mapping of health services, capacity for service provision, sector investments and readiness to provide services by county. The mapping of health services was done against the Kenya Essential Package for Health, (KEPH) – which is the comprehensive service package for the Country. The number of facilities providing the KEPH services varies significantly, depending on the specific set of services. On average, 41% of KEPH services are available across the Country, with services addressing elimination of communicable conditions (including HIV and TB services) being the most available (54% of services), and essential health services the least available (27% of services). However, on average only 7% of facilities are providing all the KEPH services.  

A total of 7,995 health facilities were identified in Kenya, with Nairobi County having the highest number of facilities (868 facilities, representing 10.9% of the total facilities) and Isiolo County had the least number of health facilities (41 facilities, representing 0.5% of the total health facilities). 49.8% of all the health facilities in the Country are public, 16.6% are private not-for-profit and 31.7% are private for-profit. Of the total health facilities, 66% were from rural areas and urban health facilities constituted 34%. Hospitals constituted 7.6%, Health Centres 13%, dispensaries making the largest proportion, at 46% of all facilities, private clinics 31% while Maternity and nursing homes 4%.

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Relevant to the joint concept note is the readiness for provision of HIV and TB related services.

The SARAM report indicates that the general service readiness index for provision of HIV/AIDS services was 67% implying that only 67% of facilities are ready to provide the KEPH-defined HIV/AIDS services. Readiness is highest at the Primary Care facilities, and lowest for hospital services. Similarly, the public facilities are most ready to provide the HIV services, as compared to other facilities. On the other hand, the general service readiness index for provision of TB services is 60% - only 60% of facilities are ready to provide the KEPH-defined TB services. Readiness is highest at the Primary Care facilities, and lowest for hospital services. Similarly, the public facilities are most ready to provide TB services, as compared to other facilities.

**HEALTH WORKFORCE**

The SARAM 2013 report also provides an analysis of the health workforce in Kenya. It indicated that the different health workforce cadres are found across all the Counties. Of the total human Resources for Health (HRH) work force, 56% are females with the highest concentration in the nursing, clerks, medical social worker and supportive staff cadres with over 55%. The doctor population ratio was less than one.
(<1) to 10,000 population but the nurse population ratio was 3 per 10,000 and 1 registered clinical officer to 10,000 population. There is an acute shortage of health care workers with an inequitable geographic distribution and a mismatch between disease burden and the available HRH. According to the SARAM, there are 67,075 health workers distributed across several cadres and across the counties. The health workforce distribution by cadre, density and gender are represented below.

Figure 14: Health workforce distribution by cadre, gender and density (SARAM, 2013)

<table>
<thead>
<tr>
<th>Sno</th>
<th>Cadres</th>
<th>Total numbers</th>
<th>Cadres per 10,000 population</th>
<th>Male</th>
<th>Female</th>
<th>% male</th>
<th>% female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical officers</td>
<td>2239</td>
<td>0.54</td>
<td>1565</td>
<td>674</td>
<td>59.9%</td>
<td>30.1%</td>
</tr>
<tr>
<td>2</td>
<td>KCC</td>
<td>4723</td>
<td>1.13</td>
<td>3556</td>
<td>1667</td>
<td>44.7%</td>
<td>35.3%</td>
</tr>
<tr>
<td>3</td>
<td>BSC Nursing</td>
<td>772</td>
<td>0.19</td>
<td>268</td>
<td>504</td>
<td>34.7%</td>
<td>65.3%</td>
</tr>
<tr>
<td>4</td>
<td>KROHN</td>
<td>14214</td>
<td>3.41</td>
<td>3970</td>
<td>10244</td>
<td>27.9%</td>
<td>72.1%</td>
</tr>
<tr>
<td>5</td>
<td>KECHN</td>
<td>9201</td>
<td>2.21</td>
<td>2360</td>
<td>8821</td>
<td>25.9%</td>
<td>74.1%</td>
</tr>
<tr>
<td>6</td>
<td>Occupational Therapist</td>
<td>310</td>
<td>0.07</td>
<td>217</td>
<td>93</td>
<td>70.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>7</td>
<td>Dentist</td>
<td>186</td>
<td>0.04</td>
<td>116</td>
<td>70</td>
<td>62.4%</td>
<td>37.6%</td>
</tr>
<tr>
<td>8</td>
<td>Dental Technologist</td>
<td>180</td>
<td>0.04</td>
<td>108</td>
<td>72</td>
<td>60.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>9</td>
<td>Pharmacists</td>
<td>552</td>
<td>0.13</td>
<td>333</td>
<td>219</td>
<td>60.3%</td>
<td>39.7%</td>
</tr>
<tr>
<td>10</td>
<td>Pharmaceutical Technologist</td>
<td>1144</td>
<td>0.27</td>
<td>610</td>
<td>534</td>
<td>53.3%</td>
<td>46.7%</td>
</tr>
<tr>
<td>11</td>
<td>Physiotherapist</td>
<td>477</td>
<td>0.11</td>
<td>319</td>
<td>158</td>
<td>66.9%</td>
<td>33.1%</td>
</tr>
<tr>
<td>12</td>
<td>Orthopaedic technologist</td>
<td>144</td>
<td>0.03</td>
<td>97</td>
<td>47</td>
<td>67.4%</td>
<td>32.6%</td>
</tr>
<tr>
<td>13</td>
<td>Medical Social worker</td>
<td>291</td>
<td>0.07</td>
<td>99</td>
<td>192</td>
<td>43.0%</td>
<td>56.9%</td>
</tr>
<tr>
<td>14</td>
<td>Medical technologist</td>
<td>206</td>
<td>0.05</td>
<td>85</td>
<td>121</td>
<td>68.3%</td>
<td>31.7%</td>
</tr>
<tr>
<td>15</td>
<td>Laboratory Technologists</td>
<td>2060</td>
<td>0.36</td>
<td>1708</td>
<td>1201</td>
<td>50.7%</td>
<td>49.3%</td>
</tr>
<tr>
<td>16</td>
<td>Laboratory Technician</td>
<td>1515</td>
<td>0.36</td>
<td>715</td>
<td>800</td>
<td>47.2%</td>
<td>52.8%</td>
</tr>
<tr>
<td>17</td>
<td>Health Record &amp; Information Officers</td>
<td>497</td>
<td>0.12</td>
<td>267</td>
<td>230</td>
<td>53.7%</td>
<td>46.3%</td>
</tr>
<tr>
<td>18</td>
<td>Health Record &amp; Information Technicians</td>
<td>347</td>
<td>0.08</td>
<td>148</td>
<td>199</td>
<td>42.7%</td>
<td>57.3%</td>
</tr>
<tr>
<td>19</td>
<td>Nutritionists</td>
<td>496</td>
<td>0.12</td>
<td>136</td>
<td>380</td>
<td>27.4%</td>
<td>72.6%</td>
</tr>
<tr>
<td>20</td>
<td>Public health officer</td>
<td>1232</td>
<td>0.30</td>
<td>872</td>
<td>360</td>
<td>70.8%</td>
<td>29.2%</td>
</tr>
<tr>
<td>21</td>
<td>Public health technician</td>
<td>737</td>
<td>0.18</td>
<td>539</td>
<td>199</td>
<td>73.1%</td>
<td>26.9%</td>
</tr>
<tr>
<td>22</td>
<td>Health Administrative Officer</td>
<td>413</td>
<td>0.10</td>
<td>282</td>
<td>131</td>
<td>68.3%</td>
<td>31.7%</td>
</tr>
<tr>
<td>23</td>
<td>Medical Engineering</td>
<td>417</td>
<td>0.10</td>
<td>344</td>
<td>73</td>
<td>82.5%</td>
<td>17.5%</td>
</tr>
<tr>
<td>24</td>
<td>ICT Officer</td>
<td>207</td>
<td>0.05</td>
<td>119</td>
<td>88</td>
<td>57.5%</td>
<td>42.5%</td>
</tr>
<tr>
<td>25</td>
<td>Procurement Officer</td>
<td>239</td>
<td>0.06</td>
<td>138</td>
<td>101</td>
<td>57.7%</td>
<td>42.3%</td>
</tr>
<tr>
<td>26</td>
<td>Accountant</td>
<td>583</td>
<td>0.14</td>
<td>368</td>
<td>215</td>
<td>63.1%</td>
<td>36.9%</td>
</tr>
<tr>
<td>27</td>
<td>Drivers</td>
<td>645</td>
<td>0.20</td>
<td>796</td>
<td>49</td>
<td>94.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>28</td>
<td>Clerk &amp; Cashier</td>
<td>2452</td>
<td>0.60</td>
<td>917</td>
<td>1575</td>
<td>36.8%</td>
<td>63.2%</td>
</tr>
<tr>
<td>29</td>
<td>Cooks</td>
<td>452</td>
<td>0.11</td>
<td>168</td>
<td>284</td>
<td>37.2%</td>
<td>62.8%</td>
</tr>
<tr>
<td>30</td>
<td>Store Man</td>
<td>131</td>
<td>0.03</td>
<td>80</td>
<td>51</td>
<td>61.1%</td>
<td>38.9%</td>
</tr>
<tr>
<td>31</td>
<td>Support Staff (Casuals)</td>
<td>9692</td>
<td>2.32</td>
<td>4277</td>
<td>5405</td>
<td>44.2%</td>
<td>55.8%</td>
</tr>
<tr>
<td>32</td>
<td>Trained CHW</td>
<td>395</td>
<td>0.09</td>
<td>169</td>
<td>226</td>
<td>46.8%</td>
<td>53.2%</td>
</tr>
<tr>
<td>33</td>
<td>Radiographer</td>
<td>347</td>
<td>0.08</td>
<td>262</td>
<td>85</td>
<td>75.5%</td>
<td>24.5%</td>
</tr>
<tr>
<td>34</td>
<td>Community Oral HIV Officer</td>
<td>150</td>
<td>0.04</td>
<td>72</td>
<td>78</td>
<td>46.0%</td>
<td>54.0%</td>
</tr>
<tr>
<td>35</td>
<td>Biochemist</td>
<td>10</td>
<td>0.00</td>
<td>4</td>
<td>6</td>
<td>60.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>36</td>
<td>Economist</td>
<td>6</td>
<td>0.00</td>
<td>6</td>
<td></td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>37</td>
<td>Social Worker</td>
<td>26</td>
<td>0.01</td>
<td>9</td>
<td>19</td>
<td>32.1%</td>
<td>67.9%</td>
</tr>
<tr>
<td>38</td>
<td>Other</td>
<td>8306</td>
<td>1.99</td>
<td>4124</td>
<td>4182</td>
<td>49.7%</td>
<td>50.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>67075</td>
<td>16.08</td>
<td>26743</td>
<td>37332</td>
<td>44.3%</td>
<td>55.7%</td>
</tr>
</tbody>
</table>

County level distribution of the health workforce is also provided in the SARAM 2013 report attached.

- **HEALTH INFORMATION SYSTEMS**

The health information system provides programme specific data which to-date is not integrated and for the most part not linked to the national HMIS system (except for malaria information which is already included in the DHIS). Malaria, TB and HIV have all different systems with a differing degrees of electronic
sophistication and success in data collection. Integrating the various reporting systems and the LMIS (Logistics Management Information Systems) into the HMIS is a key focus of the HSS component of this application.

A comprehensive National HIV and AIDS Monitoring, Evaluation and Research Framework (M&E framework) was developed to coordinate stakeholders towards one agreed country-level monitoring and evaluation system. The goal of the M&E framework was to establish a well-coordinated, harmonized monitoring, evaluation and research system. The system is designed to provide timely and accurate strategic information to guide the planning of the national response to HIV and AIDS in order to achieve the objectives of fourth AIDS strategic framework. It has so far being implemented in accordance with the Organizing Framework for a National Monitoring and Evaluation System as recommended by the Global HIV Monitoring & Evaluation Reference Group (MERG). Similarly, the Division of Leprosy, Tuberculosis and Lung disease operates within the tenets of a National Monitoring and Evaluation Plan (2010 - 2015) and in conformity with the WHO recommendations has several reporting tools in respect to the various thematic areas.

Data collection for both disease programs and the larger health system are mainly through paper based methods and electronic means. TB/HIV data are generally polled from either the TB or HIV data systems with some level of variation. The planned integration of both systems will address this issue.

Kenya has a long history of maintaining a robust disease surveillance system, with a repository of data for the last 30 years. Since 2011, Kenya’s TB surveillance system has been in a state of transition, moving from a quarterly, paper-based recording and reporting system to a real-time, case-based, electronic system. The initial electronic data capture system which had been rolled out using PDA's provided useful experience to inform the development of a robust real time electronic data capture system. As of 2013, this system, called TIBU26, has been rolled out nationwide. TIBU is a multicomponent system that incorporates TB surveillance and programmatic management. In the TIBU system, Sub-County Tuberculosis and Leprosy Coordinators (SCTLCs) transcribe case-based data from TB treatment facilities into tablet computers from which the data are wirelessly uploaded to a national database. The case-based data from the national database are used for monitoring and evaluation (M&E) of tuberculosis trends throughout Kenya. However, an evaluation of TIBU in October 201327 found it to have strengths as well as some weaknesses. TIBU’s main strengths are its usefulness, simplicity, acceptability, and timeliness. However, the quality of data in the system was found to be mixed with some indicators not being properly captured. The majority of data items for cases were complete, though dates for HIV tests, and dates for treatment outcome, and treatment regimens had high proportions of missing values. In addition, a number of cases from the 2012 data in TIBU did not pass basic validation checks, and concordance between source documents and TIBU was limited. However, the facility registers have been revised to capture the new case definitions as recommended by W.H.O and the TIBU is undergoing an upgrade to reflect same. The country expects to report using the new case definitions by end of 2015. HIV has an electronic District Health Information System (DHIS2.0) which was launched and rolled out nationally to capture information in a way that facilitates its verification, sharing and use within the national HMIS system. At facility level, Routine health data are collected manually using registers and other paper based tools. Other data are collected through mobile technologies (m-Health) and Electronic health records (EHRs) and/or Electronic Medical Records (EMRs). The number of EMRs in the country is however still minimal and not well coordinated. Adequate data storage capacity has been established, to facilitate National and County data storage of HMIS information. There has been a revision of the HIV indicators and data collection tools in line with the new ART guidelines.

Vital registration Systems for the country remains weak and is a key priority in the revised strategic plans. In addition, human resources capacity for data management remains a challenge that requires ongoing support.

- ACCESS TO ESSENTIAL MEDICINES

Policy Framework:

The Kenya constitution (2010) is the base around which all actions in the health sector are defined. The Health Sector Strategic vision in Kenya is guided by the overall National Development Plan: ‘Vision 2030’. It focuses on attaining two critical obligations of the health sector: a rights based approach and ensuring

26 TIBU is a Swahili word meaning to treat. For its purpose, it is called' Treatment Information from Basic Unit'.

27 Evaluation of the Electronic Tuberculosis Surveillance System in Kenya’ (October 2013)
The four areas of guidance are: Policy (Kenya Health Policy KKHP 2012-2030), Strategy (Kenya Health Sector Strategic Plan KHSSP III 2013-2018), Investment (Joint Programme of Work and Funding) and Operational (Annual Work Plans AWP). The KHP and the KHSSP guide the implementation focusing on reducing disparities in health outcomes across regions and population groups. The KHSPP guides both the County and National Governments on the operational priorities related to health. The Kenya Essential Package for Health (KEPH) which is the comprehensive concept through which health care in Kenya is delivered at every level has been updated to reflect the KHSSP.

The Kenya pharmaceutical policy framework includes the Kenya National Pharmaceutical Policy (KNPP) of 2012 whose goal is “Universal access to quality pharmaceutical services, essential medicines and essential health technologies”. The policy replaced the Kenya National Drug Policy of 1994. The policy provides the legal and institutional reforms that are meant to improve the performance of the pharmaceutical sector in Kenya e.g. restructuring national institutions for the procurement, supply, regulation and quality control of health products, as well as developing adequate human resources. Essential medicines, effective partnerships and regulation are some of the guiding principles of the policy. The policy also seeks to address some critical pharmaceutical sector issues that include "weak legal framework and institutional structures for regulation, uncoordinated procurement and supply, inappropriate use of medicines by some health workers and consumers, inadequate investment and utilization of ICT in all aspects of pharmaceuticals, lack of integrated strategies for training, inadequate public financing for essential medicines". A National Pharmaceutical Strategy is under development as the official NMP implementation plan. Access to essential medicines/technologies as part of the fulfillment of the right to health, is recognized in both the constitution and the NMP. Implementation of the pharmaceutical policy is regularly monitored within the context of national joint health sector planning and monitoring and evaluation (M&E). The Department of Pharmacy, Division of Pharmaceutical Policies, is responsible for pharmaceutical policy monitoring.

Regulatory Framework:

In Kenya, there are legal provisions establishing the powers and responsibilities of the Medicines Regulatory Authority (MRA), which is the Pharmacy and Poisons Board (PPB). The PPB operates as a department of the Ministry of Health, but there are initiatives to establish it as a semi-autonomous agency under the MoH. As part of the KNPP 2012 reforms to strengthen the PPB performance, the PPB will be restructured to establish a Food and Drug Authority (FDA). The PPB’S mandate includes product registration, licensing of pharmaceutical premises and personnel and quality assurance of pharmaceuticals.

The National Quality Control Laboratory (NQCL) has the mandate to ascertain the quality of pharmaceuticals that are imported, distributed and used in Kenya. The laboratory is WHO pre-qualified which makes it recognizable as a qualified quality control (QC) laboratory by donors like Global Fund. The Faith Based Health Services WHO Prequalified QC laboratory and the KEMSA Mini QC laboratory provide additional quality control services. The KEMSA Mini-laboratory is mainly used for the preliminary QC and the confirmatory tests are done by the NQCL.

Public Sector Procurement:

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28 Kenya National Pharmaceutical Policy (KNPP) of 2012 (Sessional Paper No 4 of 2012),
29 Kenya Ministry of Medical services/WHO, Kenya Pharmaceutical Country Profile, 2010
Procurement in Kenya is guided by the Public Procurement Oversight Authority (PPOA) and the KEMSA strategic plan from which the procurement plan 2011 was developed. PPOA provides procurement oversight to ensure ethical practice in all public procurement processes. Public health sector procurement of medicines and other health commodities is both centralized and decentralized. Centralized procurement is the responsibility of KEMSA. Centralized procurement includes the procurement of products funded by partners such as the GFATM. Decentralized procurement is done by the respective health facilities.

Public Sector Distribution:

The government pharmaceutical supply system has a Central Medical Store at the National Level and 8 public warehouses in the secondary tier of the public sector distribution. Malaria medicines (ACT) procured under GF grants are distributed together with other essential medicines procured by the GoK while ARV and other HIV commodities including tuberculosis medicines are distributed separately. KEMSA, Kenya Pharma, the mission for essential drugs (MEDS) and other supply chain agencies such as Supply Chain Management Services (SCMS) and the Nutrition & HIV program (for HIV nutrition commodities), centrally manage the distribution of health products to the health facilities. KEMSA distributes to 6000 gazetted public health facilities. This includes monthly distribution of ARVs to 147 central ART sites who further distribute to about 1000 satellite sites. Kenya Pharma, a USAID funded project, distributes ARVs procured through USAID directly to 176 central ART sites who further distribute to about 1500 satellite ART sites. All other HIV commodities i.e. rapid test kits, CD4, EID, VL reagents, nutritional supplemental and therapeutic feeds and condoms are distributed by KEMSA. First line tuberculosis medicines are distributed quarterly and 2nd line (MDR medicines) monthly by KEMSA to the 180 TB distribution points from which 3,000 TB treatment sites (satellites of the 180) collect their medicines from. Despite HIV and TB distribution points are similar; HIV medicines are couriered while the TB medicines are distributed through the KEMSA system. The TB programme wants to set out a similar courier system for easy access to TB medicines by facilities - a potential area to be explored for joint alignment and efficiency. MEDS a registered Trust of the Kenya Episcopal Conference and Christian Association of Kenya distributes pharmaceuticals mainly to faith based health facilities, NGOs and some government health facilities.

Processes, systems and tools for procurement and supply management:

The Ministry of Health has developed measures/strategies to ensure data availability and accuracy for essential medicines. These include full implementation of the pull system governed by “no-report-no-supply rule”, strengthening central level data unit (LMU), strengthening support supervision (field visits), routine data verification, carrying out monthly logistics meetings at central level for analysis of national stock status and the training of service providers on tools and reporting systems. Implementation of these strategies is at different stages e.g. the pull system has not been fully implemented, the MOH Pharmacy Department has a functional LMU and monthly logistics meetings are held for programs and not essential medicines. The LMIS at central level is computerized and full automation is ongoing. The Ministry of Health developed tools that are included in the Pharmaceutical SOPs document of October 2010. The tools are for the ten priority SOPs and included storage and inventory management tools e.g. standard order forms, stock cards, medicines dispensing registers, temperature logs/charts, medicine expiry monitoring chart and poor quality medicinal product form. The developed tools were all paper based. However, the department is piloting a locally developed electronic inventory management tool, Health Commodity Management Platform (HCMP), in selected level 2 and 3 facilities. The tool is meant to

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30 Chidzaniria E et al, Assessment of warehousing, storage conditions and inventory management practices in public health facilities at regional and district levels in Kenya, 2012
strengthen the current manual stock control cards, prescription pads/books and standard order and report form.

Note is made that financial constraints has limited the consistent and planned implementation of support activities that focuses on commodity management, particularly essential medicines

HEALTH FINANCING

In 2010, the country passed a new constitution which changed the country’s political system from a centralized governance system to a devolved system of government. It was expected that this measure would address concerns of skewed economic development and rebalance growth by bringing services closer to the people and enabling counties to pursue diverse economic development strategies for an all-inclusive economic growth. The public financing architecture was changed and by extension health financing structures were also altered to transfer portions of health financing responsibilities to the counties.

Sources of financing to the health sector include the government (representing the public sector budget allocation), households, private sector, donors, local foundations and others. Resource allocation to the Health sector by the government has been on an increasing trend apart from 2013/14 when the allocation declined from Ksh. 86.97 billion in 2012/13 to Ksh 37.5 billion in 2013/14 due to devolution of health services to the counties\(^{31}\). However, the per capita allocation on health services over the years has been below $34 recommended by WHO to provide a minimum health package.

According to the 2009/10 National Health Accounts, the Total Health Expenditure (THE) in absolute value increased from Ksh 82.2 billion (US$1,046 million) in 2001/02 to Ksh 122.9 billion (US$1,620 million) in 2009/10, an increase of 49%. THE per capita also increased, from Ksh 2,636 ($34) in 2001/02 to Ksh 3,203 ($42) in 2009/10. THE as a %age of the Gross Domestic Product (GDP) remained nearly constant between 2001/02 and 2009/2010, at 5%. Government health expenditures as a %age of total government expenditures declined from 8% in 2001/02 to 4% in 2009/10.

The health sector continues to be predominantly financed by private sector sources (mainly by households’ out-of-pocket (OOP) spending), although the private sector share of THE decreased from a high of 54% in 2001/02 to 37% in 2009/10.

Public sector financing remained constant over the last decade, at about 29% of THE, while the contribution of donors to THE more than doubled, from 16% in 2001/02 to 35% in 2009/10.

The role of the private sector as a financing agent or manager of THE decreased - In 2009/10, the private sector controlled almost a third of total health spending, compared to nearly 50% in 2001/02. NGOs and donors controlled 30% of THE in 2009/10 — four times more than in 2001/02. Public sector entities that managed 43% of THE in 2001/02 controlled just 37% in 2009/10.

In recognition of the existing funding gap for health in general and the triad of HIV, Tuberculosis and Malaria, the country has identified innovative domestic financing initiatives to be explored. These include the establishment of the HIV Trust Fund; financing parts of the HIV/AIDS services through the National Hospital Insurance; improving efficient use of existing resources; sustained advocacy to Government and counties for greater funding allocation to health in statutory annual budgets and push for greater private sector resourcing for health.

LEADERSHIP / GOVERNANCE

The Health sector in Kenya is defined by the Government and the Coordination of Service Delivery as defined through a Sector wide approach, the Kenya Health SWAp (KHSWAp) which brings together all Health Stakeholders and managed through a partnership instrument-the Code of Conduct. The Code works through coordination mechanisms at all of the management levels of the system that bring together all recognized health stakeholders to discuss and agree on sector focus. The national level has the Joint Interagency Coordinating Committee (JICC), Health Sector Coordinating Committee (HSCC), and Interagency Coordinating Committee’s (ICC’s). Counties and District levels have respective stakeholders’ forums that are proposed in the Kenya Health Sector Strategic Plan (KHSSP) III 2012-2017.

County planning, prioritization, implementation, monitoring, resource allocation and budgeting of programmes and interventions in counties are functions under the devolved government. Thus, counties are responsible for implementation of HIV services and programmes across different sectors. In this regard, the County Government Act, 2012, requires the County Executive Committee to design a performance management plan to evaluate implementation of county policies by the county public service. It further requires that the County Governor submits the county plans and policies to the county assembly for approval together with an annual report on the implementation status. To facilitate working relations between National State Organs and County Governments, a framework for management of intergovernmental relations is provided in Article 189. The operability of the framework is dependent on entrenching good governance practices that build leadership capacity for health while establishing effective stakeholder, intergovernmental and multi-sectoral co-ordination mechanisms.

Governance structures and systems are evident through boards / Health facility committees at the respective service delivery levels (Dispensaries, health centres, hospitals, and districts). A common framework for planning and implementation is in place, with decentralized sector wide annual work plans, and monitoring processes. However, capacity gaps still exist in leadership and governance.

Leadership and Management skills mix is limited, particularly at sub national levels.

Incomplete adoption of partnership processes at some levels of the sector implies some key partners are not appropriately engaged when required. Additionally, key health related sectors are not fully engaged by the Health Ministry, to allow for addressing comprehensively the Kenya health agenda.

E. COMMUNITY SYSTEMS ANALYSIS

Community Health Strategy: In 2006, the Ministry of Health through its National Health Sector Strategic Plan II 2005-2010 came up with Community Health Strategy (CHS) to re-vitalize the PHC concept. This is implemented by both state and Non state actors. Since the rolling out of the community health strategy in 2007, 2943 CUs with about 73,575 CHVs, serving about 3,626,259 households (www.ehealth.or.ke/mcul/) with 1,587 of them being fully functional. The department of Community Health Services estimates the gap of CUs in the country to be about 5000 (KHSSP 2014-2019). This ultimately translates to weakened community mobilization, poor referral/linkage networks and weak specific disease follow up and supportive initiatives such as provision of psychosocial support, defaulter tracing, case finding and other community health interventions. While this gap is skewed country wide, there is need to prioritize establishment and supporting functionality of CUs in the high burden counties.

State Actors: Kenya revised its Community Strategy in 2007 as the vehicle for community interventions in collaboration with both state and non-state actors. The state actors are coordinated by the Ministry of Health through the division of Community Health Services, whereas the non-state actors bring together individuals, family members, community members, women groups, traditional healers, Community Based Organizations, Faith Based Organizations, Key Populations, PLHIV, TB patient groups, and the private sector. All these partners contribute to the community outcomes related to health in collaboration with the
broader Ministry. Strengthening of the community systems is necessary towards ensuring a well functional health system.

Non–State Actors: The non-state actors include community, national, regional and international NGOs/CBOs, faith based organization and Self-help groups. There are over 20,000 partners from the non-state actors spread across the 47 counties. These groups have a critical role to play in Malaria, Tuberculosis and HIV prevention, care, treatment and support. Their roles include referrals and linkages to care and treatment services, treatment literacy, community mobilization, home and community based care (HCBC), advocacy for gender and human rights amongst others. With the new integrated approach to both HIV and TB service delivery, there is need to build the capacity of all the CBOs/NGOs and other civil societies to play these roles including gender and human rights mainstreaming.

Community Units: The Community Units have assisted in creating demand for health services, good health seeking behaviors as well as prevention of common illnesses. This is mainly through the coordination between CHEW and the CHVs who participate in identifying cases of illnesses at the community level and referring them to the health facilities. This has led to the communities increasingly becoming aware of their right to quality health care. The Community units work in close collaboration with NASCOP, Malaria Control Unit (MCU) and the NTLD in the implementation of the Community Strategy. Though there are historical examples of collaboration and the move towards an integrated, service delivery approach needs to be strengthened using community structures including strengthening community accountability.

Coordination of community actors: The coordination mechanism for community actors is not well developed. The country recognizes the need to strengthen this component of service delivery to improve community networking and linkages and to also ensure that community programmes demonstrate efficiencies and effectiveness. The country has prioritized the need to conduct a mapping exercise for all the actors within the community including CUs to support improved community supervision, monitoring, reporting and resource allocation.

Community data management: In line with full integration, community generated data alongside facility data should flow from the community to the national health management information system (DHIS) with the CHVs being the source of the information. Government of Kenya has developed tools to support this process. Despite this, very minimal data from the community has been fed in the DHIS. This could be as a result of work overload for the data clerks and/or reporting officers. This has led to under representation of the community generated data in national datasets. This is a gap in the national information managements system that will need to be addressed. Simple innovative methodologies of supporting this process such as monthly data review forums between the community, health focal persons and health records officers will be critical.

1.2 National Disease Strategic Plans

With clear references to the current TB and HIV national disease strategic plan(s) and supporting documentation (including the name of the annexed documents and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.

b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed.

d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.

e. Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.
A. OVERVIEW OF THE NATIONAL STRATEGIC PLANS FOR HIV AND TB


Background
The KASF (2014/15 -2018/19) succeeds the KNASP III that came to an end in June 2014. KASF builds on past KNASP successes, partnerships, leadership and legislations. The framework provides strategic policy, planning and implementation guidance and leadership for a coordinated multi-sectoral response to HIV and AIDS in Kenya. The strategy is premised on Kenya’s Vision 2030 description of HIV and AIDS as ‘one of the greatest threats to socio-economic development in Kenya’. KASF marks a paradigm shift for the national response from doing ‘business as usual’ to evidence and results based multi-sectoral and decentralized planning.

Regarding decentralized planning, the KASF is developed in the context of a significant change to the political/administrative structure in Kenya following the constitutional review of 2010. Specifically, the devolution from a regional structure to the county structure with 47 autonomous counties created demands a paradigm shift in the way health is managed in the country. Responsibilities across the tiers of service delivery have been changed and all health service delivery activities are required to align to these changes.

The new plan also takes into cognizance lessons learned from the implementation of the KNASP III. The findings from the end term review of the KNASP III are also incorporated into the development of the KASF to ensure its responsiveness to the current context and an overall improvement to health outcomes for the national HIV response.

The framework is aligned to the Three Ones Principle and investment case approach with its emphasis on prioritization, feasibility and sustainability for impact.

Note is made that the KASF is aligned with international and regional obligations, commitments and targets related to HIV/AIDS, TB and the broader health indices for the country particularly around reduction in mortality and morbidity from communicable diseases and ensuring equitable access to health services.

Goals:
Contribute to achieving Vision 2030 through universal access to comprehensive HIV prevention, treatment and care for all.

Objectives: By 2019,
1. Reduce new HIV infections by 75%
2. Reduce AIDS related mortality by 25%
3. Reduce tolerance to HIV related stigma and discrimination by 50%
4. Increase the domestic financing of the HIV response by 50%

Key Strategic Directions:
1. Reduction of new HIV infections through the following sub activities:
   a. Intensifying HIV prevention efforts to priority geographies and population
   b. Adaptation and scale up of effective evidence based combination prevention interventions
   c. Maximizing efficiency in service delivery through integration
   d. Leveraging opportunities through creation of synergies with other sectors
2. Improving health outcomes and wellness of people living with HIV through the following sub activities:
   a. Improve timely linkage to care for persons diagnosed with HIV infection
   b. Increase coverage to care and treatment services
   c. Scale up interventions to improve quality of care and improve health outcomes
3. Health & Community Systems Strengthening along the six health system building blocks and strengthening of existing community systems
4. Using a human rights based approach to facilitate access to services through:
   a. Reducing stigma and discrimination
   b. Reducing incidences of sexual and gender-based violence (SGBV)
   c. Advocacy for the formulation and implementation of rights based laws and polices
   d. Reducing social exclusion

5. Promoting Innovative and Domestic Financing through:
   a. Maximizing efficiency of existing funds by refocusing existing efforts and deliver better results to the Kenyan people
   b. Establishment of a private-public trust fund for HIV and AIDS to raise and, pool domestic resources.
   c. Take deliberate steps to align HIV investments to KASF priorities

6. Strategic Information and Information Management
   a. Strengthen M&E capacity to effectively track the KASF performance and HIV epidemic dynamics at all levels
   b. Ensure harmonized, timely and comprehensive routine and non-routine monitoring systems to provide quality HIV data
   c. Establish multi-sectoral and integrated real time HIV platform to provide updates on HIV epidemic response accountability at county and national level

7. Strengthen Research, Innovation and Information Management to meet KASF goals

8. Strengthen Leadership, Governance and Coordination of the response through:
   a. Entrenching good governance practices and build accountable leadership capacity for the multi-sectoral HIV/AIDS response at all levels
   b. Establish effective stakeholder, intergovernmental and sectoral coordination mechanisms for the multi-sectoral response
   c. Establish and assure enabling policy, legal and regulatory environment for the multi-sectoral response.

IMPLEMENTATION TO DATE – MAIN OUTCOMES AND IMPACT ACHIEVED
A review of implementation to date will represent implementation of the ended KNASP III.

HIV Prevention in General Population:

**HTC achievements:** Percentage of women and men aged 15–49 years who received an HIV test in the past 12 months and who know their results increased from a 2009 baseline value of males (22.8%)/females (29.3%)\(^{32}\) to males (35.8%)/females (47.3%) in 2012\(^{33}\). In absolute numbers, the number of people tested for HIV annually has increased from about 860,000 in 2008 to 6.4 million in 2013\(^{34}\).

**Condom Programming:**

The Kenya Prevention revolution road map depicts key statistics around condom use sourced from the 2012 KAIS. 43% consistent condom use among men 15-24 years with partner of discordant or unknown HIV serostatus in the past 12 months with 14% consistent condom use among men 25-64 years with partner of discordant or unknown HIV serostatus in the past 12 months. For females, there is 11% consistent condom use among women 15-24 years with partner of discordant or unknown HIV serostatus in the past 12 months and 5% consistent condom use among women 25-64 years with partner of discordant or unknown HIV serostatus in the past 12 months. There is also low condom use among women 15-49 with multiple partners (32%). Condom programming has been prioritized as a component

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\(^{32}\) Kenya Demographic Health Survey, 2008/2009
\(^{33}\) KAIS, 2012
\(^{34}\) Kenya AIDS Response Progress Report, 2014
of the national combination prevention package with commodity gaps and supply chain challenges being addressed through funding from the current Phase II grant.

**VMMC**: Kenya initiated Voluntary Medical Male Circumcision VMMC in 2008. Since then, the programme has been scaled up from about 8,000 VMMCs performed annually in 2008 to 190,000 in 2013. Over the five year period, about 670,000 VMMCs were performed against a target of 860,000 representing 77% achievement of the target. About 50% of the males circumcised were aged 15-19 years and about 80% of the VMMCs were conducted in Nyanza region. The overall coverage of circumcision among men aged 15-49 in the country is estimated at 91% (Kenya AIDS Response -Progress report, 2014).

**HIV Prevention in Key Populations:**

**FSW**: The %age of FSW reporting the use of a condom with their most recent client stands at 86.2% in 2011\(^35\) while the %age of FSW who have received an HIV test in the past 12 months and know their results is reported at 68%\(^36\)

**MSM**: The %age of MSMS counselled and tested for HIV annually increased from a low of 35% in 2011 to 74% in 2013\(^32\). However, condom use remains low although there has been an increase from 54.9% in 2011 to 68.8% in 2013\(^31\)

**Prevention of Mother to Child Transmission and Early infant diagnosis**

A review of data on women in need and those accessing PMTCT services shows an average of 76% coverage of this service. The PMTCT coverage declined from 86% in 2010 to 70% in 2013 largely due to the recent commencement of implementation of the new (option B\(^3\)) guidelines\(^37\). Over the last three years, Kenya scaled up early infant diagnosis to reach 45% of infants annually by 2013. However, the early infant diagnosis still remains low and there is need for scale up strategies to be put in place. At impact level there has been a significant decline by 44% of new infections among children under 14 years from 44,000 in 2007 to 12,940 in 2013. However, with MTCT rate of 14% in 2013 and approximately 13,000 children under-14 years newly infected annually (HIV estimates), a lot of work is still required in this intervention mix if the country is to achieve elimination of MTCT in the near term.

**HIV Care and Treatment**

Kenya has tremendously scaled up HIV treatment and care the last 10 years to reach about 80% of those in need. From a 2008 baseline (Adults 63.8%/Children 16%) to a 2013 figure of Adults 78.5% and Children 43.3%. Clearly the Paediatric ART program will need to be scaled up to bridge the gap. Note is made that the reported coverage is calculated based on the 2009 W.H.O. guidelines and the denominator is the total number of PLHIV in need of ART. With adoption of the WHO eligibility criteria of CD4 <500 coverage among adults goes down to 51% and among children to 36%. This is largely due to the larger denominator used for calculation using the new guidelines.

A measure of impact, over the last five years, annual AIDS related deaths have been on a declining trend, from about 85,000 in 2009 to 58,000 in 2013\(^38\) and this is directly attributable to the success of the treatment and care programme.

**Collaborative TB-HIV services**

Testing for HIV in TB patients was 94% in 2012 up from 93% in 2011 while co-infection rate declined by one point from 39% to 38% over the same period.

The percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV increased from 56.4 in 2011 to 82.8%. ART and CPT uptake stood at 83% and 99% respectively in 2013\(^39\). However, the coverage of IPT in HIV positive patients has remained low with only 2% of those eligible initiated on IPT. This is related to the fact that the County had not scaled up its IPT program owing to lack of funding and lack of appropriate tools and guidelines. This is however being reversed with the new implementation approach proposed in the revised TB NSP.

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\(^{35}\) Data source: Polling booth survey conducted in Nairobi and Mombasa sites, 2011

\(^{36}\) Data source: Integrated Bio-Behavioural Survey conducted in Nairobi and Mombasa, 2011

\(^{37}\) Kenya AIDS Response Progress Report, 2014 pg. 20

\(^{38}\) Kenya AIDS Response Progress Report, 2014

\(^{39}\) Kenya TB Annual report_2013
NATIONAL STRATEGIC PLAN ON TUBERCULOSIS, LEPROSY AND LUNG DISEASES
(2015 – 2018)

Background:
The National TB, Leprosy and Lung Disease Unit (NTLD) has been implementing activities within the framework of a five-year (2011-2015) national strategy. While considerable progress has been made, TB remains the 4th leading cause of death in Kenya with nearly 90,000 cases notified in 2013. To align with the national planning cycles, and the Kenya Health Sector Strategic and Investment Plan, this plan has been designed to cover only four years (2015 – mid 2018).

The National Strategic Plan (NSP) for TB, leprosy and lung health represents a transition to: a) programme implementation through the newly established 47 counties; and b) intentional acceleration of declining incidence. The NSP is based on robust evidence generated by the national case-based electronic data system (Tuberculosis Information from Basic Units (TIBU)) as well as results of small scale pilot projects, and Epidemic and Impact Analysis and operational research. The NSP intentionally capitalizes on well-performing counties as mentors and training hubs for other counties, while also scaling up high impact pilot projects. It describes a county-tailored approach to the prioritization of technical assistance and programmatic enhancements addressing particular challenges of each county and sub-population.

Devolution to the 47 counties presents opportunities for local prioritization and adaptation of TB and leprosy control activities that are targeted and patient-centered. Translating the cascade model of technical excellence and assistance into the new structure is ongoing and will require additional human resources and new skill sets, given the expanded number of administrative units and new requirements for planning capacity at county level. The NSP describes how the gains of the past 5 years will be sustained under this new system of governance.

Goals:

To accelerate the reduction of TB, leprosy and lung disease burden through provision of people-centered, universally accessible, acceptable and affordable quality services in Kenya

Objectives:

1. Sustain the gains made over the past decade, in the context of a newly devolved health system
2. Intensify efforts to find the “missing” cases of TB and leprosy
3. Reduce transmission of TB and leprosy
4. Prevent active disease and morbidity
5. Enhance the quality of care for chronic lung diseases

Key Strategic Directions:

a) Devolve implementation of activities and budgets
   i. Establish Inter-Governmental Agreements between the central NTLD and NTRL and each county
   ii. Bolster county-level capacity for planning for TB, leprosy and lung health
   iii. Establish County-based centers of excellence, based on strong performance
   iv. Develop and implement a technical assistance and quality assurance plan through a cascade from central to community levels.

b) Ensure a stable and quality supply of medicines, diagnostics and other commodities
   i. Build political commitment at central and in all 47 counties for funding of TB medicines and diagnostics.
ii. Strengthen the capacity of counties to appropriately plan for, procure, store, distribute and manage inventories of commodities utilizing their county budgets.

iii. Improve the distribution system, including the integration of laboratory diagnostics.

iv. Strengthen and link the existing DHIS, TIBU and LMIS systems for better management of supplies.

v. Ensure quality of TB medicines and diagnostics in the country and each county.

vi. Establish commodity security committees at county level.

c) Core DOTS

i. Ensure treatment success rate of at least 90% nationally among all drug – susceptible (DS) forms of TB.

ii. Reach marginalized, high-risk and under-served populations, closing the case detection gap.

iii. Incorporate TB into existing and emerging social protection schemes, including nutritional support platforms.

d) Paediatric TB

i. active paediatric TB case finding

ii. management, prevention, advocacy and integration of child TB services in other departments.

iii. scale up and sustain gains made in child TB surveillance.

iv. strengthen TB/HIV care for children; and

v. Capacity building activities for HCWs.

e) Programmatic Management of Drug Resistant TB

i. Strengthening systems that support PMDT.

ii. Systematic surveillance of DR-TB, including children.

iii. Reducing time to diagnosis of DRTB.

iv. Ensuring timely initiation of treatment (within 1-2 weeks of diagnosis).

v. Improve monitoring and evaluation of presumptive and confirmed DRTB cases.

vi. Improve treatment outcomes for DRTB patients, including children.

f) Engage all care providers- Public Private Mix (PPM)

i. Sustain the gain in areas where PPM is currently being implemented.

ii. Scale-up the number and diversity of private providers contributing to NTLD aims, in all counties.

iii. Strengthen coordination mechanisms for PPM at the national and county levels.


g) Promote and strengthen community engagement and build national commitment to TB, leprosy and lung disease.

i. Build the foundation for systematic community and partner engagement.

ii. Operationalize patient-centered care through community structures, scaling up proven community-based models.

iii. Improve monitoring and evaluation of community-based TB, leprosy and lung disease interventions to increase accountability to all stakeholders.

h) Enhance multi-sectoral response to TB/HIV

i. Formation of TB/HIV coordinating bodies.

ii. IPT for all eligible PLHIV:

iii. Scale up of TB IPC in healthcare and congregate settings.

iv. Integration of TB and HIV services.

v. TB intensified case finding.

vi. Immediate cART and CPT uptake.

vii. Conduct operations research on 5I’s implementation.

i) Accelerate appropriate TB diagnosis

i. Accelerate time to diagnosis, especially among rural populations.

ii. Roll out and scale up Xpert MTB/RIF.

iii. Networking of Xpert MTB/RIF machines.
iv. Operational research

j) Enhance evidence-based programme monitoring and implementation
   i. Continuously improve monitoring and evaluation tools and capacities at all levels
   ii. Strengthen TIBU and its integration with other surveillance platforms
   iii. Improve TB financial reporting and quantification
   iv. Improve mortality statistics
   v. Improve the quality and systematic use of strategic information
   vi. Ensure availability of a supporting infrastructure
   vii. Promote impact assessment and prioritize research, including operational research, which will address programme challenges

k) Enabling Environment and Policy
   i. Actively participate in national policy and planning process in the move towards universal health coverage, ensuring that TB and leprosy control are appropriately positioned
   ii. NTLD to actively seek to expand its partner base; to facilitate the mainstreaming of programme priorities into the devolution and Universal Health Care (UHC) processes.
   iii. Address the social determinants of TB through policy change and social protection schemes
   iv. Update national policies

l) Advocacy and communications

m) Human Rights and Gender Mainstreaming
   i. Monitoring and reforming laws, regulations and policies relating to TB, leprosy lung diseases
   ii. Removal of the legal, human rights and gender barriers to access of TB, leprosy and lung diseases services
   iii. Training of law makers, law enforcement agents and healthcare workers
   iv. Formation of inter-sectoral partnerships between the Ministry of Health (NTLD) and other parts of government to embed TB, leprosy and lung diseases concerns
   v. Research, knowledge management and M & E

n) Prevent transmission and disease: infection prevention and control, contact tracing and isoniazid preventive therapy
   i. Mainstream IPT, IPC and CT into the core functions, guidelines and tools of the NTLD
   ii. Scale up successful models of IPT for PLHIV and for children in contact with active TB cases
   iii. Scale-up successful models of contact investigation and management.
   iv. Operationalize the Infection Prevention and Control plans existing and national and sub-national levels, and expand to other settings

IMPLEMENTATION TO DATE – MAIN OUTCOMES AND IMPACT ACHIEVED
A review of implementation to date will reflect implementation of the TB NSP 2011-2015.

Case notifications
At the national level, the number of notified TB cases (all forms) increased from approximately 95,000 cases in 2003 to a peak of over 116,000 cases in 2007. Within the implementation period of the NSP, the number of cases notified declined from 106,083 in 2010 to 89,760 in 2013. Analysis of national case notification rate for all TB cases (new and retreatment) shows that the case notification rates fell from 264/100,000 population in 2010 to 203/100,000 population in 2013. There are concerns of data quality issues but however the trends are similar to those using WHO estimates.

A total of 6,717 new cases of children with TB cases were reported in 2013. This represented 9% of all new TB cases reported during the period. This proportion was below the expected range of 10% to 15% of all cases notified. This is attributed to the initial challenges of rolling out the new electronic system and possible underreporting and/or underdiagnoses of TB in children in Kenya.

Case diagnosis
The percentage of new cases that are bacteriologically confirmed has remained stable from a figure of 37.6% in 2009, 39.5% in 2011 and 41.2% in 2012. There are 1818 Tb diagnostic sites with 1804 of them doing EQA. There are a total of 3052 TB treatment sites in the country as at 2013 with a ratio of 7 treatment sites per 100,000 population.

**TB treatment success rate**

TB cases case holding per patient type as observed in 2012 cohort, 81.82% patients got cured with the country observing 87.82% treatment success rate

Treatment success rate for new smear positive TB cases has increased from 84% in 2009 to 86% in 2012\(^40\) and 88% in 2013\(^41\). Treatment success rate for smear positive TB cases co-infected with HIV were lower at 82% in 2009 and 83% in 2012\(^34\).

**TB/HIV Services**

The program has maintained commendable results in the area of TB/HIV control. ART uptake has gone up from 30% in 2008 to 83% in 2013\(^35\) and with closer collaboration with other implementing partners this indicator is expected to reach the intended target of universal coverage.

Testing for HIV in TB patients has remained at a steady rate of 93% while the co-infection rate was at 37% a slight decline from 39.3% the previous year\(^35\).

**Case detection of Drug Resistant TB (MDR-TB):**

In Kenya, rifampicin susceptibility testing is routinely carried out on high risk groups for MDR TB, defined as treatment failures, relapse, retreatment, cases who are contacts of an MDR-TB case and health care workers. However, programmatically, to date, there is virtually no systematic process in place to successfully capture, monitor and track all MDR TB suspects nationally. Data on MDR-TB cases and treatment are captured in TIBU, the electronic surveillance system. Of the 1,344 cases tested for MDR TB in 2012, the number of lab confirmed MDR-TB cases detected nationally was 225 (9 new and 205 retreatment)\(^42\). The 2013 TB annual report indicates that there were a total of 291 DRTB cases notified, of which 254 were MDR. The TB/HIV co-infection rate was 25% among the MDR patients.

**MDR-TB case management**

The uptake of treatment among diagnosed MDR patients has gradually increased over the years. In 2013 there was a slight decrease from 96% (2012) to 90% (2013). During 2013, there was an influx of refugees into the country and among the diagnosed MDR-TB cases, 28% were from the refugee camp. This was a sharp increment compared to year 2012 and this led to MDR-TB treatment commodity stock out in the year which may have resulted in some diagnosed patients not receiving treatment.

**MDR-TB treatment success rate**

Treatment success rate for MDR-TB cases was 68% in 2011\(^43\)

**B. LIMITATIONS TO IMPLEMENTATION OF TB & HIV NSP AND LESSONS LEARNED**

The TB epidemic and impact assessment report details identified limitations to implementation of the TB NSP. These include:

- Uncertainty around the estimates of TB incidence, prevalence and mortality. The WHO estimate of incidence is more likely to approximate the true TB incidence in Kenya than the notification data, as it takes into account the coverage of the TB surveillance system, and adjusts for underreporting (case notifications/1-underreporting).
- Potential under-reporting of TB cases in the national data that will need to be investigated through an inventory study.

\(^40\) WHO Global Health Observatory (http://apps.who.int/gho/data/view.main)

\(^41\) Kenya TB Annual report, 2013

\(^42\) WHO TB database (http://www.who.int/tb/country/data/download/en/index.html)

\(^43\) WHO Global Health Observatory (http://apps.who.int/gho/data/view.main)
• The need to strengthen the TB surveillance system which is characterized by a) lack of internal consistency within TB surveillance data, b) Inconsistent completeness in data, c) lack of sufficient data to directly measure levels of drug resistance, d) limited reliability of surveillance data for children, and e) a sub-optimal vital registration system.

• Long delays in diagnosis and suboptimal coverage and treatment outcomes for MDR TB which may factor into the slower rate of decline in prevalent TB cases.

• A need to sustain and possibly improve the current level of financing of the TB program

• Need to calibrate the TB response to respond to the current epidemiology. Specifically, there is a need to focus on certain subpopulations and geographic areas. The low numbers of TB cases reported among children aged 0-4 years suggest a need to focus on diagnosis and reporting of childhood TB. The burden of TB among the oldest population (≥65 years) suggests a need to target this population with TB interventions (e.g. Practical Approach to Lung Health). TB in the key population of refugees with increasing case notifications need to be investigated. Also, geographically, highly populated areas with a steady decline in TB, such as Nairobi, suggest a need for active case finding to ensure all cases are being diagnosed.

• Sustaining access to HIV testing and ART access for TB patients with HIV infection in Rift Valley South and the most populated areas, like Nairobi, is of utmost importance to achieve continued success in the TB programme.

The Kenya AIDS Strategic Framework (KASF) 2014 was recently completed and is yet to be implemented. However, the KNASP III End Term review report provides a picture on the challenges faced during implementations of the HIV strategic plan. These include:

• HIV prevention remains a key challenge in the national response as the key impact result of reducing new infections by 50% has not been met. Challenges have been mapped to the specific intervention areas with suggestions around a) the need to target Key populations with significantly higher than national prevalence rates (MSM, FSW, PWIDS) including addressing noted barriers to access b) the limited service coverage for PMTCT and pediatric ART c) the need to scale up behavior change strategies to increase testing, encourage disclosure, correct condom use in (discordant) couples, and to reduce (concurrent) multiple partnerships. The KNASP End Term review report (pg. 11 -13) provides further details on the contributing factors to these noted gaps.

• The decreasing funding envelope for HIV in Kenya with the ending of several funding streams and gradual decline in PEPFAR resources. This amplifies the need for sustainable financing mechanisms

• The need to address health system challenges that are occasioned by the need to achieve equity of access more so in a devolved system. These include a) the lack of qualified Human Resources for Health; b) need to strengthen laboratory services and procurement systems;

• The need to strengthen Community systems to achieve linkages between communities and service delivery facilities

• Multiple /parallel M&E systems which is affecting the ability of in-country implementers to focus on the programmatic enablers needed to increase the overall efficacy of their programs. A one “M&E” system is recommended with a robust oversight mechanism.

• Modest dissemination, uptake and implementation of the policy guidelines developed for mainstreaming of human rights, gender, youth, children, PLHIV, People with Disabilities (PwDs), KPs and vulnerable groups in HIV and AIDS programming across sectors.

• Weak implementation of the communication strategy of KNASP III.

• Poor enforcement of policy and legislative frameworks and generally national governance of prevention programmes

• Lack of specific policy and legal enforcement tools to address explicit needs of KPs and People with Disabilities (PwDs).

C. **LINKAGES WITH THE NATIONAL HEALTH STRATEGY**

The two strategic plans are aptly aligned to the plan, National Health Sector Strategic Plan II (NHSSSP II, 2005-2010). The two plans are developed within the same policy framework (the Kenya Health Policy) that prioritizes the elimination of communicable diseases AND the national development strategy Vision
2030, which underscores the importance of health as a key building block in transforming Kenya into a successful middle-income country.

Both plans contain strategies that align with key policy objectives of the NHSSP III and include:

1) Elimination of communicable diseases:
2) Provision of essential health care.
3) Minimize exposure to health risk factors.
4) Strengthen collaboration with other sectors.

The plans also reflect the tenets of the devolution system which is to ensure equity and access to development in all counties in the nation. Service delivery strategies in the two strategic plans have responded to this changing landscape.

D. COUNTRY PROCESSES FOR REVIEWING AND REVISING THE NATIONAL DISEASE STRATEGIC PLAN(S).

The plans were developed through in-depth analysis of available data and a highly participatory process involving a wide range of stakeholders (including TB, HIV, Malaria and broader health actors) drawn from government; civil society including non-governmental organisations, faith based organisations, networks of people living with HIV and key affected populations; private sector and development partners. Key aspects of the development process include:

- Programme reviews: The two programmes had broad external programme reviews to pace the achievements, challenges and lessons learned from previous implementation that would inform the design of the new strategy. The HIV program had an End term review of KASP 2009-2014 while the TB program had an Epidemiological and Impact assessment review conducted as a prelude to the development of the new plans.

- Establishment of an oversight committee: Cross-cutting oversight committees were created to guide the development process. These committees had representation from the key constituencies.

- Proposal development task force: A proposal development task force was created to provide technical leadership and guidance for the writing teams with a focus on the quality of the products developed by the technical teams. The task force provided technical feedback to the technical teams, and provided advice and sought strategic ad policy direction from the oversight committee.

- Technical teams: These teams reviewed available data and defined the results and strategic interventions for each thematic area of both strategic plans. Teams were constituted around the various thematic areas in the strategic plans. Membership of the technical teams was open to provide a platform for wide stakeholder participation.

- Regional consultations: Stakeholder consultations fora were held in all regions of the country to collect information on the disease programs, needs and challenges in accessing services across the country including health and community systems perspectives. Consultations with key populations were also conducted to determine what their expressed needs were and how best to tailor this to the national strategic focus.

- Consultations with county governments provided an opportunity to engage the political leadership within the devolved system. This helped provide insight into what feasible service delivery/coordination/health financing mechanisms could be adopted in the strategic plans.

- Peer review of the strategic framework: This allowed for an enrichment of the process through the incorporation of global best practices and cross fertilization of ideas from other climes.

1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions

In order to understand the future plans for joint TB and HIV planning and programming, briefly describe:
a. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of cross-cutting activities, and iii) expected efficiencies that will result from this joint implementation.

b. The barriers that need to be addressed in this alignment process.

A. PLANS FOR FURTHER ALIGNMENT OF THE TB AND HIV STRATEGIES, POLICIES AND INTERVENTIONS

(i) Steps for the improvement of coverage and quality of services

Complete integration of TB and HIV services at National level has not been achieved even though substantial collaborative activities have been occurring in the past. The picture at facility level has been much better owing to the fact that same health workers are responsible for service provision at that level.

At national level, the recent increase in global attention to tuberculosis has equally increased interest of many partners, both local and international, to support TB control activities in the country. This welcome development has created challenges of coordination of response in the field to ensure that individual partner activities are in line with the national strategy and other national policies. This has been a similar situation with HIV in the past years. The TB Inter Agency Coordination Committee (TB-ICC) and the HIV Inter-Agency Committees (HIV–ICC) initially created to meet the requirements of Global Fund to Fight AIDS, TB and Malaria has shaped the role of all major players in TB and HIV control as membership is all inclusive. These committees had Technical Working Groups (TWG) that responded to matters of policy whenever they appear and meets at least quarterly to deliberate on all issues pertaining to TB and HIV control in Kenya. Recently, the TBICC and HIVICC have been collapsed to create Joint TBICC and HIVICC so as to mobilize resources from GFATM in a single concept note that espouses joint response to the dual epidemic. The Technical Working Groups of the joint HIVICC and TBICC include National TB/HIV steering Committee, Laboratory, M&E, MDR TB, Commodity, ACSM, community and gender, special groups, PPM and Lung Health amongst others. These technical working groups draw membership from both technical and financial partners including affected communities. Some of these working groups have been cascaded to lower levels and hold meetings in stakeholders’ forums where critical issues of implementation and challenges are discussed and addressed.

However, with the devolution process in Kenya the challenge of ensuring similar coordination structures are established at county level and activities sustained at similar pace becomes a challenge. This has been identified as critical and has similarly been prioritized across the two newly developed national strategic plans. The plans aim to review, strengthen and establish effective and well-functioning stakeholder, intergovernmental and multi-sectoral coordination and accountability mechanisms for the joint national response aligned with the devolved governance system by 2017. Specifically, the plans will focus on effective coordination mechanisms at the decentralized and community levels to involve Sub-county AIDS Control Committees (SCACCs)/Constituency AIDS Control Committees (CACCs), Ward AIDS Control Committees (WACCs) and Community Health Units (CHUs) through technical assistance, capacity and capability assistance and expand roles to include an integrated oversight role for TB and HIV activities. Formation of joint team, involvement in TB and HIV strategic plan development,

Community interventions-pilot joint TB HIV Malaria, Joint supervision, Joint PMS, HSS lab strengthening, At grant making will develop a joint work plan for areas of joint implementation. Joint distribution for commodities. Optimize use of gene experts in areas where CD4 are being done to ensure a one stop shop. Joint networking for laboratory. Joint planning for placement of gene experts where the CD4 machines. This will also guide expansion and human resource placement. Joint TB HIV Malaria training for lab staff. Development of integrated reporting tools. Coordination- revamping the joint technical working groups for TB HIV, joint ICC beyond concept note, Grant management processes- PUDR reporting, OSDVs, DQA/SQA, Joint secretariat team that will periodically report on progress. Joint county planning post grant making will also be embarked upon.

(ii) Opportunities for joint implementation of cross cutting activities
Integration of TB and HIV services will potentially provide opportunities for the joint implementation of crosscutting activities. Such activities may include joint capacity building; one stop TB and HIV diagnostic services; joint resource mobilization; joint procurement and supply of medicines and commodities; and harmonized health information systems. The following are identified opportunities for joint implementation:

a) **Joint planning**

Involvement of the programs in each the different disease strategic planning provided an opportunity for joint planning. Formation of a joint TB HIV Malaria ICC with a joint TB HIV malaria ICC secretariat who were responsible for concept note writing as well as grant making and reviewing progress of program implementation will ensure continuity of the vision of the concept note. The joint TB/HIV ICC has and will continue to provide an opportunity for joint coordination and programme management as well as accountability mechanisms for the 3 diseases. At grant making, the 3 programs will jointly plan the implementation of the grant with the counties. A joint work plan will hence be developed to guide count

A Technical working group for TB HIV exists and this will be strengthened by expanding their mandate beyond the current 12 collaborative activities to include areas of joint implementation and alignment including health and community system strengthening activities.

b) **Aligned Information systems**

Both TB ad HIV programs have committed to contribute to the strengthening of DHIS which is the common platform for TB and HIV reporting. Currently there are ongoing efforts to strengthen data sharing between TB and HIV data systems as well as DHIS.

c) **Joint Procurement and supply chain management**

Procurement of both HIV and TB medicines and commodities are managed by KEMSA. This creates a room for further collaboration in HIV and TB services at the level of quantification of these supplies. PSCM alignment will be achieved through joint procurement planning and distributions, joint TB HIV and Malaria post market surveillance, Joint capacity building on commodity management and logistics management information systems (LMIS).

d) **Integrated Laboratory systems and service delivery**

The alignment of diagnostic services for TB (1818) and HIV (1829 ART sites) will enable laboratories especially in lower level health facilities that are housed in the same buildings and are managed by the same person, to effectively offer services in a timely manner, hence reduce clients’ burden of accessing these services from different points or different time.

Aligning Laboratory systems and service delivery through optimizing use of gene experts in already established laboratories conducting CD4 tests to ensure a one stop shop for TB and HIV patients. Joint laboratory networking that will ease sample transportation and relay of results. In addition, renovation of laboratories will benefit all the 3 diseases as well as the quality assurance plan will lead to upgrading and accreditation of these labs. Joint planning for placement of gene experts where the CD4 machines. This will also guide expansion and human resource placement. The human resource placed in these labs will work to support all the 3 diseases and we will roll out a joint TB HIV and Malaria training for the laboratory staff.

e) **Integrated Community interventions**

An integrated community intervention to respond to the 3 diseases will be piloted in 3 counties to assess feasibility for countrywide scale up. This will include ensuring community units are fully functional in these 3 counties. This will include an integrated technical training of TB HIV and Malaria to the Community health volunteers and Community health extension workers. The CHVs will then be facilitated to report HIV, TB and Malaria cases and refer them to health facilities. An integrated reporting tool that can capture indicators of all the three diseases will be used for this pilot which will be reported in the DHIS. Annex-Implementation framework for community interventions Joint community mobilization for demand creation and action, including those addressing human rights and gender equality challenges. This support for community will not only result in integration between the 3 diseases but health as a whole.

f) **Joint program reviews and evaluations**
During implementation the programs will carry out joint data quality assessments, supervisions and data verification exercises. There will be joint evaluations in mortality data. This will strengthen the joint review meetings and TB/HIV committees. Since there has been joint concept note development, the implementation will be in collaboration TB and HIV program and to some extent the Malaria program. This will reduce the time that health facility staffs spend to two programs separately that would be used for attending hospital services.

9) Human Resources

Human resource: In facilities where both TB (3326 sites) and HIV (4588 sites using PMTCT as a proxy) services are offered, the same health personnel will be able to provide both services, hence optimizing services delivery. Provision of joint TB and HIV services under one roof enhance programs performance and minimize the gap in human resource for HIV and TB

iii) Expected efficiencies that will result from this joint implementation.

It is implicit that joint implementation (joint programme reviews, supervision, procurement and planning) between the 3 disease programs is likely to improve efficiencies in the management of scarce health resources. Specifically, there will be minimization on transactional and human resource costs for the targeted outputs. Joint planning will lead to better coordination and avoid duplication of activities saving both time and money. Savings made will be used to fill other service provision gaps. From the community and patients’ perspective joint provision of health services, for example ART in TB clinics under one roof reduces the unnecessary clinic visits and transportation costs potentially contributing to low default rates, reducing clients’ burden of accessing these services from different points or different time. An integrated community approach will lead to a better coverage of community interventions and provide an avenue for providing education on both TB and HIV especially for co-infected clients.

B. BARRIERS TO BE ADDRESSED IN THE ALIGNMENT PROCESS

i. Historical parallel programming: Implementation of HIV and TB programs has been relatively unrelated and this dates back to the establishment of the respective programs. Reservations for potential structural re-organization could be inevitable. Alignment of interventions will therefore require significant efforts from programmes, time and sustained political will from the senior management. This is clearly evidenced across several countries (e.g. South Africa) where integration has been attempted.

ii. Resistance to change: Alignment processes will imply new ways of programme management and the implementation and is likely to be associated with uncertainties around potential dilution of core successes from each programme. Thorough and elaborate plans for staff orientation need to be put in place in order to address staff concerns, misperceptions and resistance to change.

iii. Different levels and coverage of services: Levels of service provision for TB and HIV services are not necessarily the same. TB services are more decentralized than HIV service delivery points. There is however a need for attention to be paid to the most effective areas for integration.

iv. Funding: Alignment process will involve investments in integrated guidelines, training manuals and M&E tools and systems. Furthermore, investments will target capacity building for health workers in health facilities and at community level. Funding for such investments will be required to ensure that smooth alignment of the two programs and services.
To achieve lasting impact against the diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are insufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the TB and HIV national programs and how this funding request fits within these, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

A. Funding availability for the disease programs

Funding Landscape for National TB Program

Table 1: Funding landscape for National TB program (2015/16 – 2016/17)

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount (US$)</th>
<th>% of NSP cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total NSP Budget for NFM period</td>
<td>*172,016,708</td>
<td>100%</td>
</tr>
<tr>
<td>Available Funds by Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government of Kenya</td>
<td>*28,377,383</td>
<td>16%</td>
</tr>
<tr>
<td>US Government</td>
<td>30,450,000</td>
<td>18%</td>
</tr>
<tr>
<td>Global Fund NFM Allocation</td>
<td>30,182,342</td>
<td>18%</td>
</tr>
<tr>
<td>Total Funds Available</td>
<td>89,009,725</td>
<td>52%</td>
</tr>
<tr>
<td>Financial Gap</td>
<td>83,006,983</td>
<td>48%</td>
</tr>
</tbody>
</table>

*NSP 2015-2018 (pg. 159, table 17 and 18)

Financing of the TB program in Kenya is sourced from contributions from the Government of Kenya and the donor community. Major donors include the Global Fund and the US Government, which together will contribute 36% of the funding need of the TB NSP for 2015/16 – 2016/17 implementation period. By this analysis, the NSP is resourced up to 52% of needs with a gap of $83 million representing 48% of NSP costs.

This is a substantial financial gap for the national TB program and will need to be bridged if the commendable gains made so far in the program are to be sustained and rightfully scaled up. The GoK will at a minimum increase its annual contribution by an average of 10% annually as has been the case in the past. Other planned approaches towards addressing the financial challenges as articulated in the NSP include:

a) Increasing direct budgetary allocations at both national and county levels to secure additional resources from the national government’s share of revenue

b) Development of a national and county specific financing strategy to take full advantage of the new public financing opportunities

c) Filling the financing gap through supply and demand-side financing through scale up of health financing innovations and reducing household out-of-pocket expenditures by expanding the Social Health Insurance scheme to include more basic and essential services

d) The TB program working with MOH and Treasury to develop a framework for disbursing conditional grants for implementation activities
e) Improving efficiencies of available funding through an annual budget review of NSP to address emerging issues and allow flexibility within budgets for re-allocation

f) Improving partnerships with the private sector both for service delivery and financial support

Funding Landscape for National HIV Program

Table 2: Funding Landscape for National HIV program (2015/16 - 2016/17)

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Amount (US$)</th>
<th>% of KASF cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total KASF budget for NFM period</td>
<td>2,201,834,718</td>
<td>100%</td>
</tr>
<tr>
<td>Available Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government of Kenya</td>
<td>348,772,498</td>
<td>16%</td>
</tr>
<tr>
<td>US Government</td>
<td>823,386,000</td>
<td>37%</td>
</tr>
<tr>
<td>DFID</td>
<td>1,041,043</td>
<td>0.05%</td>
</tr>
<tr>
<td>Clinton Foundation</td>
<td>9,894,132</td>
<td>0.4%</td>
</tr>
<tr>
<td>UN agencies</td>
<td>19,200,000</td>
<td>1%</td>
</tr>
<tr>
<td>Global Fund NFM Allocation</td>
<td>182,678,663</td>
<td>8%</td>
</tr>
<tr>
<td>Total Funds Available</td>
<td>1,384,972,336</td>
<td>63%</td>
</tr>
<tr>
<td>Financial Gap</td>
<td>816,862,382</td>
<td>37%</td>
</tr>
</tbody>
</table>

Source: NACC and USAID Health Policy Project (2014)

The National HIV program has been heavily dependent on donor financing. The major donors include US Government, the Global Fund, UN agencies and DFID which together contribute to 47% of overall funding need for the HIV program in Kenya for the period 2015/16 – 2016/17 while the GoK contributes 16% of the KASF budget. From available commitments to date from GoK and donors, the national HIV strategic plan is resourced at 63% of needs. A gap of 37% equivalent to approximately $816 million does exist for implementation activities for the 2015/16 – 2016/17 plan period. This is a very significant financial gap that will require innovative approaches at resource mobilization by all stakeholders in Kenya particularly domestic efforts at financing this gap.

The size of this funding gap calls for strategic shifts in implementation activities. Due to the current funding landscape, it is planned in this application to attain HIV treatment targets set in the Global Fund Phase II grant by June 2015 and at a minimum maintain these numbers on ART until the end of 2017 using the incremental amount. Funding beyond December 2017 can only be assumed to be from the GoK which has historically never sufficed to fund the national HIV program budget. This scenario is a source of concern to the national HIV program. It is anticipated however that efficiencies gained from implementation will allow for some level of scale up but to achieve the desired national targets, extra financing will need to be sourced by mid-2016 in consideration of lead times for procurement of commodities.

The conversation around increasing domestic funding for the national HIV program has begun in earnest both at national and county levels. As an interim measure, the country has in this application included a request above allocation to bridge the funding gap but will intensify measures to further reduce the gap from domestic means.

Currently, the country has articulated several financing options in the KASF 2014/15 -2018/19 including:

a) Sustained advocacy for an increase in funding allocation from the GoK (specific amounts will be made known in the 2015/2016 budget estimates). The KASF indicates that Government allocation (at National and County levels) is proposed to be increased to 2% of GoK ordinary revenue to HIV, hedging potential reductions in current investment of 1%. This is estimated to raise $423 million in 2018/19 and when combined with domestic private sector funds can finance up to 55% ($566 million) of the KASF net resource needs.

b) Improving efficiencies of current funding through promotion of cost saving models of HIV/AIDS service delivery

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44 KASF 2014/15 -2018/19
c) Financing parts of the HIV/AIDS services through the National Hospital Insurance Fund. It is planned to include ART in the package offered by the NHIF and this would require an estimated $345 million in 2014 alone (excluding overhead costs). The total revenue of the NHIF is projected to be at $470 million in 2014/15.

d) Establishment of the HIV Trust/Investment Fund. The HIV Trust Fund shall adapt a leverage model to raise and leverage National and County resources. It shall aim to contribute to and catalyze the investment for a broader health fund that will subsidize Government liability in HIV investment and Prevention costs. It will ultimately facilitate Kenya’s drive towards Universal Health Coverage. It will have a Governance framework, leveraging best-in-class fund administration and governance frameworks. To capitalize the HIV Trust fund, diverse funding sources shall be used to leverage Government financing and these include i) Debt swap options ii) AIDS lottery iii) Corporate Social Investments (CSI) iv) Infrastructure HIV resources v) Health bonds vi) Portion of interest from dormant funds and vii) Organized informal sector contributions.

FUNDING SPLIT AND SELECTION OF PRIORITY MODULES

Process for selection of priority modules and the funding split

With background information on the funding allocation from Global Fund, the joint TB/HIV ICC conducted several stakeholders’ dialogue process to develop a list of priority areas to be considered for funding in this application. The TB/HIV ICC mandated the proposal development secretariat to carry out an analysis of the programmatic and financial requirements as well as gaps for all intervention areas. Follow-up dialogues were held (and documented) to split funds across these identified priorities based on the analysis. The final disease funds split were presented to the joint TB/HIC ICC for ratification and thereafter to the KCM for endorsement. At a macro level, the two disease programs were found to be underfunded and at intervention level there were variations as to the levels of funding with some having relatively sufficient funding while others where significantly underfunded. Some key considerations agreed upon included:

a) Exploring the existing grants for savings and reprogramming opportunities and plowing these back into the allocation pool for distribution to priority areas
b) Maintaining current fund distributions in the approved Phase II HIV grant

Under the HIV phase 2 grant signed in July 2014, the country prioritizes Adult and Pediatric care and treatment, elimination of new HIV infections among children, voluntary medical male circumcision and interventions focused among key populations. It also included a component to support skilled delivery and surveillance. In addition, the grant included the Kenya Combo Prevention-Targeted Interventions initiative which is a component to implement high impact combination interventions targeted in geographical locations experiencing both generalized and mixed interventions to demonstrate impact. Two counties Mombasa and Homa bay have been selected for this particular focus.

Priority Modules:

In view of the aforementioned processes of determining financial and programmatic gaps; consideration of high impact interventions and including identifying efficiency gains from existing grants, fourteen priority modules were selected through the country dialogue process. These modules are:

1. Prevention for general population
2. Prevention programs for MSMs
3. Prevention programs for FSWs
4. Prevention programs for PWIDs
5. PMTCT
6. Treatment, care and support
7. TB care and prevention
8. MDR-TB
9. TB/HIV
10. Procurement supply chain management
11. Health information systems and M&E
12. Service delivery
13. Community systems strengthening
14. Program management
Funding Landscape across intervention areas

The table below details the funding landscape across key intervention areas. This was considered in the determination of resource allocations to the selected modules. Key consideration was also made of the prevailing HIV epidemiology resulting in the prioritization of prevention efforts in the general population (targeting youth, young girls and women 15 - 45 years) and a targeted approach to prevention among Key populations (MSM, FSW and PWUDs). Other Key interventions like VMMC, blood safety; condom procurement and care for the chronically ill are significantly resourced through the Phase II grant and funding from PEPFAR and were thus not allocated funds from the incremental amount. The treatment gap (including transition to Option B+ for PMTCT) and the ethical requirement to maintain currently enrolled patients on treatment with minimal scale up were also considered.

**Table 3: Funding across interventions (2015/16 – 2016/17)**

<table>
<thead>
<tr>
<th>Intervention Area</th>
<th>NSP</th>
<th>GoK</th>
<th>USG</th>
<th>Other Donors excl GF</th>
<th>Total Fund Available Less GF Allocation</th>
<th>Gap</th>
<th>GF Allocation</th>
<th>Residual Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC</td>
<td>74.72</td>
<td>-</td>
<td>44.10</td>
<td>-</td>
<td>44.10</td>
<td>30.62</td>
<td>2.10</td>
<td>28.51</td>
</tr>
<tr>
<td>Condom</td>
<td>39.49</td>
<td>-</td>
<td>3.00</td>
<td>1.08</td>
<td>4.08</td>
<td>35.41</td>
<td>6.83</td>
<td>28.58</td>
</tr>
<tr>
<td>HTC</td>
<td>168.64</td>
<td>61.09</td>
<td>50.40</td>
<td>0.06</td>
<td>111.55</td>
<td>57.09</td>
<td>4.99</td>
<td>52.10</td>
</tr>
<tr>
<td>VMMC</td>
<td>38.35</td>
<td>-</td>
<td>27.30</td>
<td>0.06</td>
<td>27.36</td>
<td>10.99</td>
<td>2.15</td>
<td>8.84</td>
</tr>
<tr>
<td>FSW</td>
<td>27.72</td>
<td>-</td>
<td>3.98</td>
<td>-</td>
<td>3.98</td>
<td>23.74</td>
<td>5.22</td>
<td>18.52</td>
</tr>
<tr>
<td>MSM</td>
<td>8.81</td>
<td>-</td>
<td>1.33</td>
<td>-</td>
<td>1.33</td>
<td>7.48</td>
<td>5.36</td>
<td>2.12</td>
</tr>
<tr>
<td>PWD</td>
<td>9.72</td>
<td>-</td>
<td>1.33</td>
<td>-</td>
<td>1.33</td>
<td>8.39</td>
<td>5.70</td>
<td>2.69</td>
</tr>
<tr>
<td>PMTCT</td>
<td>102.97</td>
<td>42.63</td>
<td>28.70</td>
<td>22.78</td>
<td>94.32</td>
<td>8.65</td>
<td>10.34</td>
<td>1.69</td>
</tr>
<tr>
<td>ART</td>
<td>734.24</td>
<td>183.54</td>
<td>270.60</td>
<td>23.98</td>
<td>478.12</td>
<td>256.12</td>
<td>113.45</td>
<td>142.67</td>
</tr>
<tr>
<td>TB Prevention &amp; Care</td>
<td>137.60</td>
<td>26.18</td>
<td>30.45</td>
<td>-</td>
<td>56.63</td>
<td>80.97</td>
<td>17.08</td>
<td>63.89</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>34.40</td>
<td>17.46</td>
<td>-</td>
<td>-</td>
<td>17.46</td>
<td>16.94</td>
<td>5.09</td>
<td>11.86</td>
</tr>
</tbody>
</table>

Source: Donor mapping survey supported by USAID Health Policy project

(b) How the proposed Global Fund investment has leveraged other donor resources.

In Kenya, the main sources of funding for the HIV and TB response are USG, GFATM and Government of Kenya. The requested fund from Global Fund will leverage the resources from these main sources as depicted in the table above. These sums have been factored into the gap analysis tables developed for the concept note.

In terms of health systems, the government provides a lot of resources both financial and non-financial. Government also provides resources for training health personnel both pre-service and in-service. Additionally, government continues to provide resources for laboratory infrastructure as well laboratory reagents. The funding request from Global Fund will provide synergy to these government efforts as well as PEPFAR and World Bank support for laboratory infrastructure development. The government has also put in place a community strategy, and the request for funding from Global Fund for the CSS module will also support realization of the strategy.

(c) For program areas that have significant funding gaps, planned actions to address these gaps

The KCM notes the analysis of gaps and the challenges related to these. It is planned that all gaps noted with implementation of the disease strategic plans will be funded through the sustainable financing strategies highlighted in earlier sections.
2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. For TB and HIV, indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

<table>
<thead>
<tr>
<th>Counterpart Requirements</th>
<th>Financing Requirements</th>
<th>Compliant?</th>
<th>If not, provide a brief justification and planned actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Availability of reliable data to assess compliance</td>
<td>☒ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)</td>
<td>☒ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Increasing government contribution to disease program</td>
<td>☒ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

National TB program

Within the duration of the implementation period for this application, the government of Kenya is projected to contribute $13,842,626 (2015/16) and $14,534,757 (2016/17) respectively to the National TB program. These investments are expected to count towards the willingness to pay allocation from the Global Fund. These funds are pooled resources from the Government’s own sources and expected to be utilized amongst others for the purposes of first line drug procurement, human resources for health, health systems maintenance and supporting laboratories including consumables/reagents.

National HIV Program

Within the duration of the implementation period for this application, the GoK is projected to contribute $169,718,977 (2015/16) and $179,053,521 (2016/17) respectively to the National HIV program. These estimates are derived from the Kenya National AIDS Spending Assessment report, 2014 for the fiscal years 2009/10 - 2011/12 and applying a projected GDP growth rate of 5.5%. These investments are expected to count towards the willingness to pay allocation from the Global Fund. These funds are earmarked for staff salaries, purchase of HIV test kits, ARV drugs, prevention interventions and commodities; other systems strengthening investments like renovation of facilities; printing of HMIS

tools, trainings, and program coordination amongst others. These contributions are complemented by funding from other sources and have been factored into the gap analysis tables for priority modules attached to this concept note.

**Assessment of the completeness and reliability of financial data**

The financial data are sourced from public expenditure reviews and budget estimates from official documents of the parliament of Kenya. Operative assumptions are annual increases in the national health budget estimated to correlate with projected annual GDP growth of 5.5% annually\(^\text{43}\).

**SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND**

This section details the request for funding and outlines how the investment is strategically targeted to achieve greater impact on the diseases and health systems. While the investments for both the HIV and TB programs should be described, the applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant.

### 3.1 Programmatic Gap Analysis

A programmatic gap analysis should be conducted for the six to twelve priority modules within the applicant’s funding request. These modules should appropriately reflect the two separate disease programs in addition to cross-cutting modules for both programs such as Health System and Community Systems Strengthening.

Complete a programmatic gap table (Table 2) for the quantifiable priority modules within the applicant’s funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps in the narrative section below.

**Community Systems Strengthening**

Community Systems are proven catalysts in driving the health agenda in the country. It provides for the missing link between the community and the health service delivery platforms and complements efforts towards increasing and sustaining access to health services.

Within the community system in Kenya, there are identified critical gaps which could be mapped to specific CSS intervention areas in the GF modular template and are summarized thus:

**Thematic Area:** Social mobilization, building community linkages, collaboration and coordination

**Gaps**

- Few functional Community Units (CUs). The department of community health services estimates that the country has only 2943 CUs serving about a third of Kenyan population (computed from population coverage per CU of 5000 persons per CU).
- Weak coordination mechanism between different community actors and other community structures such as community units.
- Weak linkages between different community players consequently affecting referral and overall service provision.
- Weakened community mobilization processes, which limits demand creation efforts/utilization of key HIV/TB and malaria prevention interventions.
- Gaps in the use of community structures to address gender equality and social transformation to reduce SGBV, stigma, discrimination and harmful cultural practices.
**Thematic Area**: Institutional capacity building, planning and leadership development in the community sector

**Gaps**
- Limited involvement of the project beneficiaries such as key populations, people affected by the diseases, women and girls among others in the design, implementation and monitoring of community-based interventions.
- Limited capacity for leadership and governance within community groups and organizations.
- Need for sustaining transparency and accountability in the activities of the community groups and organizations.
- Non-inclusive community level program design and management that limits human rights and gender mainstreaming in community-based services.

**Thematic Area**: Community-based monitoring for accountability

**Gaps**
- Limited capacity for coordinated reporting and documentation of evidence based monitoring framework.
- Weak systems to streamline community based health information into the national health system.
- Community based monitoring lack measures and standards for quality assurance for comprehensive health care service that is expected to support HIV, TB & Malaria documentation for planning and decision-making.
- The framework for monitoring priority target population and gender & human rights is weak and lacks policy support.

**Service delivery**

Investing resources in improving coverage, uptake and quality of laboratory services is key to supporting delivery of programmatic goals in the Malaria, TB and HIV programmes.

The Laboratory Strategic Draft Plan 2014 prioritizes several interventions for improving laboratory services in the country. The plan proposes to strengthen the Laboratory Information System (LIS) which in this case will automate results notification to clinicians and patients. Other priorities include quality management systems and human resource capacity to support efficient disease prevention, care and treatment initiatives.

The physical infrastructure for diagnostics in Kenya depicts a picture of inadequate infrastructure, low investment in systems and workforce capable of providing services to satisfy the increasing demand and specialized testing services. SARAM report 2013 (Table 17; page 25) highlighted Laboratory as the weakest link in supporting primary healthcare service delivery in the counties.

There has been a deliberate effort to redress this imbalance by improving the infrastructure through upgrading and renovation of Laboratories under the World Bank project where five (5) Laboratories have been constructed and equipped to provide specialized services at the county level. Early infant diagnosis of HIV and HIV Viral load testing are provided in seven (7) laboratories in Kenya that have capacity and infrastructure for molecular testing.

For the concept note, priority areas identified by the joint TBHIV ICC for strengthening (Laboratory ICC Report 2014) includes
- Infrastructure upgrading
- Improving laboratory systems to provide specialized laboratory services in a phased approach.

**Thematic Area: Laboratory infrastructure upgrade**

Vertical programming in sample referral networking is already in existence for Early Infant Diagnosis, HIV viral load testing, CD4 testing, TB GeneXpert and culture testing. This has created a need for integration across the three disease programs in order to maximize resources and standardization of practices and commodities used to collect, package and transport biological samples and bio-safety requirements in
compliance with WHO/IATA guidelines. Work is due to start 2015. With resources from the HIV R10 Phase II Global Fund grant, 11 laboratories were identified to be upgraded. The cost allocated to upgrade each of these laboratories to provide diagnostic services which include Viral Load, CD4, Early Infant Diagnosis (EID) and GeneXpert is USD $48,864 USD per laboratory. In addition, the grant supports specimen referral from PMTCT/ART sites through a courier system to the reference laboratory.

Gaps

- Only Limited availability of lab POC at the community level
- Specimen referral challenges
- Challenges in referral of results
- Meeting the requirement of molecular testing (Viral load, EID, and GeneXpert testing)
- Low Ministry of health (MOH) Laboratory staffing levels in testing Laboratories,
- Weak infrastructure (buildings, electricity, equipment, water, ICT architecture and hardware)
- Vertical Program Networking for TB, EID, Viral load testing is currently in place with the latter two restricted on small scale implementation due to weak sample referral, testing and human resource infrastructure.

Thematic Area: Laboratory Quality Systems

Gaps

- Weak Capacity to perform molecular testing due to low investment over the years
- Low utilization of LIMS to Manage Samples in Network testing to manage efficiencies in turnaround times for testing,
- Weak Quality Management Systems to deliver timely quality results (EQA, Supervision and Monitoring QMS and reporting) within Laboratory strategic plan and health sector investment plan.

Procurement and supply chain management

Resources are available to upgrade the 47 county stores through the HIV R10 Phase II Global Fund grant for USD$ 2.186 million. Upgrades to the peripheral storage structures are necessary to ensure quality assurance and commodity security of programme medicines. The Warehousing Assessment Report (2012) showed that only 20% of health facilities visited had adequate storage capacity to store medicines (p. 25). Ability to forecast and quantify at the county and sub county levels and maintain accurate records of commodity movements are challenges accentuated by devolution. The existing grant also supports trainings on commodity and inventory management.

Thematic Area: Improvement of procurement and supply management infrastructure and development of tools.

Gaps:

- Multiple central warehousing and distribution points and parallel distribution cycles for HIV, TB and Malaria commodities
- Inadequate storage facilities and conditions at county and health facility levels
- Weak or non-existent county distribution structures to health facilities, multiple distribution processes, transportation challenges
- Inadequate infrastructural support for PSCM i.e. ICT, diagnostic and computer equipment, physical structures, electricity, water, internet

Thematic Area: Operationalization of procurement and supply chain management systems for RMNCH, TB, Malaria and HIV services

Gaps:

- Inadequate capacity for timely and accurate forecasting and quantification at county and health facility level
- Long procurement lead times
- Inappropriate use of medicines and other supplies
- Measures to ensure quality assurance along the supply chain; during procurement, distribution and storage are weak or non-existent
- Infrequent and parallel Post Market Surveillance (PMS) with long turnaround time for laboratory quality testing and lack of adequate resources to carry out screening tests for quality at county levels.
- Existence of parallel, mainly manual, logistics management information systems for the three disease areas leading to parallel ordering cycles; poor data quality and low reporting rates.
- There are weak or non-existent mechanisms for routine monitoring and evaluation of supply chains for efficiencies and commodity security at national, county and health facility levels.

**Health Management Information Systems/ Monitoring and Evaluation**

Kenya’s response to the evolving HIV epidemic is largely influenced by strong commitment to availing quality data in a timely manner for effective evidence-based decision making. In order to maximize effective use of all available information and implement evidence based planning, a robust Strategic Information Management System (SIMS) that focuses on programme monitoring, evaluation, surveillance and knowledge management is key.

The HIV, Malaria and Tuberculosis disease programmes have different levels of data collection, validation, aggregation, reporting rates and utilization. Thus far, each of the programmes have various degrees of success with their information systems so while there are system wide constraints, others are disease programme specific. Largely interventions for HIV consist in capturing and using data from key populations whereas TB requirements are more substantial.

Investments in strategic information have been supported by PEPFAR and UNAIDS. The Global Fund Round 10 HIV grant supports HSS activities that implement data quality and verification, data analysis trainings for data management assistants and county health staff involved in HIV programming, printing of routine HIV M&E tools, cohort analysis, and national and county data review meetings. Kenya has carried out operations research and relevant programme activities and surveys mostly supported by the Global Fund through the current TB grant, these include: TB KAP survey (completed), TB prevalence survey to start in January 2015. The TB diagnosis data survey is currently in the data collection phase. Resources were also allocated to the TB inventory study (expected completion end of 2014), a national evaluation (2015) and the TB Mortality Survey which the programme proposes to contribute to the strengthening of vital registration mainly on capacity building on ICD 10. The CDC supported Paediatric TB survey and a surveillance system evaluation.

**Thematic Area: Supporting the capacity for routine recording and reporting.**

**Gaps:**
- Sub-optimal utilization of the electronic TB reporting system associated with limited capacity of health care workers compounded by change of personnel at county levels. This requires that new health care workers be trained on the system.
- Data quality issues that are largely associated with data capture and errors of transcription from the manual facility register to the system. Such issues include incompleteness, inaccuracy and internal inconsistencies.
- National data capture information on Kenyan nationals and does not reflect TB and HIV status of all persons living in Kenya. This has an impact on national public health programming.
- There are also gaps in the provision of the electronic tools such as tablets in case of loss or defect of the device.

**Thematic Area: Improve data quality and use of information for strategic decision-making**

**Gaps:**
- Lack of utilization of locally generated data for decision making.
- Poor linkages for TB reporting with DHIS in largely parallel systems.
- Sub-optimal reporting and quality of data as reported in DHIS2 (inaccuracies and incompleteness of data noted for various HIV data elements).
- Childhood TB data in TIBU are inaccurate.
- Limited capacity and knowledge of health workers in manual and electronic reporting.
- Limited M&E tools at all levels.
- Infrequent data quality assessments.
Thematic Area: Conduct impact evaluations and operations research.

Gaps:
- Barriers to TB treatment adherence in counties whose TB treatment success rate is less than 80% is poorly understood
- Low scale up of Electronic Medical Records (EMR) roll out and use of other technologies such as mobile technology.
- Multiple information demands at facility level.

Thematic Area: Key population reporting tools development and roll out including integration to DHIS

Gaps:
- Lack of data from Key Population programmes being reported in routine data systems including collation into DHIS2.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant’s funding request for TB and HIV, including both the proposed investment of the allocation amount and the request above this amount.

Include the specific elements related to joint programming such as health systems and community systems strengthening.

Describe how the request addresses the gaps and constraints described in sections 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

A strategic overview of the request for TB and HIV is presented in the table below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Allocation</th>
<th>Above Allocation</th>
<th>Total Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention General Population</td>
<td>13,145,120</td>
<td>7,001,560</td>
<td>20,146,680</td>
</tr>
<tr>
<td>Prevention for FSW</td>
<td>5,064,107</td>
<td>494,634</td>
<td>5,558,741</td>
</tr>
<tr>
<td>Prevention for MSM</td>
<td>5,205,077</td>
<td>329,514</td>
<td>5,534,592</td>
</tr>
<tr>
<td>Prevention for PWID</td>
<td>5,540,044</td>
<td>-</td>
<td>5,540,044</td>
</tr>
<tr>
<td>PMTCT</td>
<td>10,434,126</td>
<td>-</td>
<td>10,434,126</td>
</tr>
<tr>
<td>Treatment Care and Support</td>
<td>112,712,236</td>
<td>95,815,950</td>
<td>208,528,186</td>
</tr>
<tr>
<td>TB Care and Prevention</td>
<td>17,062,926</td>
<td>2,261,766</td>
<td>19,324,691</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>5,088,917</td>
<td>16,404,407</td>
<td>21,493,324</td>
</tr>
<tr>
<td>TB/HIV</td>
<td>5,144,210</td>
<td>1,177,142</td>
<td>6,321,352</td>
</tr>
<tr>
<td>HMIS/M&amp;E</td>
<td>10,891,491</td>
<td>-</td>
<td>10,891,491</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>2,741,293</td>
<td>3,282,715</td>
<td>6,024,008</td>
</tr>
<tr>
<td>PSCM</td>
<td>2,998,283</td>
<td>10,543,679</td>
<td>13,541,962</td>
</tr>
<tr>
<td>CSS</td>
<td>4,848,140</td>
<td>265,769</td>
<td>5,113,909</td>
</tr>
<tr>
<td>Program Management</td>
<td>14,485,034</td>
<td>-</td>
<td>14,485,034</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$215,361,004</strong></td>
<td><strong>$ 137577136</strong></td>
<td><strong>$ 352,938,140</strong></td>
</tr>
</tbody>
</table>
Kenya has recently signed Phase 2 grants for HIV and TB and hence the majority of funds is from existing funds. The table below summarizes the distribution of existing funds and new funds under each module.
To depict how the application addresses gaps and constraints, and adapts to maximize impact, a module by module narrative is provided for clarity.

**Module 1: Prevention for General Population**

**Noted Gaps & Constraints**

In line with the HIV Epidemiology described in section 1 and the analysis of implementation to date of the KNASF III, the following are noted gaps under the prevention for general population module and are articulated in further detail in the Kenya Prevention Revolution Road map attached.

- Slow progress in changes to sexual behavior such as reduction of multiple concurrency and low condom particularly among women and girls aged 15-24
- High levels of HIV related stigma and discrimination that leads to low uptake of HIV testing and counseling[^46]. These are related to structural (gender Inequality related) and cultural issues that impede access to prevention knowledge and limit access to services.
- Significantly high levels of new HIV infections among young girls and women of reproductive age who account for 21% per cent of all new HIV infections.
- Implementation of uniform and highly biomedical prevention intervention despite diverse risk among populations and geographical locations
- Inconsistencies in scaling up educational messages

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[^46]: Additional reference or note could be included here for more detailed information on this point.
Low utilization of opportunities in other sectors to increase efficiencies, address vulnerabilities and create synergies

Low use of condoms during high risk sex among sexually active individuals. Among unmarried youth aged 15-24, condom use during last sexual intercourse is significantly low at 11%. This is compounded by a) distribution challenges with free government procured condoms only distributed to the public through health facilities, drop-in centers, community based organizations and other outlets b) Youths and KPs may face limitations to accessing condom programming services due to a dearth of “friendly” service delivery points specifically designed for them c) Weak distribution channels for female condoms and frequent stock-outs of female condom.

Overall health system barriers including limited geographical access to and unequal distribution of services, human resource inadequacies, poor referral and tracking mechanisms, lack of unique identification, and limited infrastructure for information management systems are also noted

Application response to the gaps

The Kenya Prevention Revolution Road Map 2014 provides the overarching framework for HIV prevention in Kenya and this application is in alignment with this national strategy. The Roadmap recommends the need to implement high impact combination prevention focused on populations and geographical locations.

The Kenya fourth HIV strategic plan has identified young girls and women, people in prisons and other closed settings, fishing communities, long distance truck drivers and other migrant populations especially those in humanitarian crisis and people living with HIV as priority populations for interventions targeting the general populations. In order to demonstrate impact, efforts will be intensified in Homa bay county with the highest burden and HIV incidence in the country while experiencing a generalized epidemic. The outcomes from Homa bay County will be used to advise other counties with similar epidemics. In addition, Mombasa County with a mixed epidemic, concentrated among key populations and generalized across the County will be a case for demonstration of impact among key populations.

The current application has prioritized key interventions within this module to address the noted challenges taking into cognizance, investments by other partners. Specifically, this application has prioritized the following interventions:

a) HIV testing and counselling as a critical point of entry for HIV prevention care and treatment. Early knowledge of HIV status can stimulate positive behavioral change especially amongst those tested HIV positive. A concomitant effort at strengthening HIV diagnostic infrastructure and systems will also be implemented including strengthening linkages to care and ensuring retention in the treatment cascade. In response to the current epidemiology with higher vulnerability amongst women and young girls, women aged 15-64 years will be targeted for HTC services through reproductive health clinics, Antenatal clinics and PITC in health facilities. Young women aged 20-24 years will also be targeted through existing youth programmes supported by PEPFAR. Community based structures will also be utilized to target this vulnerable population particularly around increasing awareness and linkages to facilities where HCTC services could be accessed.

b) Development and dissemination of tailored behavioural change messages on risk reduction and skill building among vulnerable populations.

c) Implementation of an integrated HIV prevention (structural and biomedical), sexual and reproductive health education and TB prevention programs. Services will be delivered in both facility and community settings.

d) Gender-based violence (GBV) prevention programs. Funds have been earmarked to ensure geographic concentration of GBV at individual, community, institutional and policy level. For policy advocacy and human rights which comprehensively addresses issues of barriers to access, gender based violence and violence against key populations including interventions addressing gender inequality, in particular socio-cultural norms and practices affecting girls and young women. Also included are interventions addressing violation of sexual and reproductive rights of women living with HIV and those of key populations. Rights education sessions will be conducted including literacy sessions for law enforcement officers and legal practitioners on these issues. Rights and policy advocacy will also be conducted to members of parliament to keep women and gender biases at the top burner of the political discuss at that level.

46 NACC, The National HIV and AIDS Stigma and Discrimination Index Study, July 2014

Kenya TB and HIV Concept Note Template 29 January 2015 | 53
e) Promote male and female condom use and distribution among priority populations (to include women and men 15-24 yrs.).

f) Blood Safety related activities that include strengthening donor notification of HIV results, training health care workers on infection prevention, supporting recruitment of voluntary non remunerated blood donors and Blood safety reagents

Adaptation measures to maximize Impact

The current Round 10 Phase II HIV grant supports targeted HIV testing campaigns, capacity building of health providers, voluntary medical male circumcision for selected counties, behavior change communication, blood safety reagents and procurement of test kits to support the campaigns. This will be leveraged to ensure both funding streams complement each other.

In recognition of the disparities and pattern of the AIDS epidemic, the Ministry of Health developed a revolutionary roadmap to improve the effectiveness of HIV prevention interventions. The roadmap recommended shifts in prevention programmes from national to county clusters; from focus of interventions to populations; from heavily biomedical to combination interventions; and from a narrow focus in the health sector to leverage on opportunities to address structural issues in other sectors. To determine the efficiency gains that could be obtained by combination prevention and geographic, prioritization of interventions, mathematical models were developed and demonstrated that this shift would avert 1,149,000 new HIV infections, 761,000 adults and 11,000 AIDS-related deaths by 2030 at no extra cost (Kenya HIV Prevention Roadmap 2014 pg. 12). The significant impact and efficiency gains have been adopted on the Kenya AIDS Strategic Framework 2014/2015-2018/2019 which recommends of county specific tailored AIDS responses.

Module 2: Prevention for Key Population (FSW)

Noted Gaps & Constraints

Section 1 details the HIV epidemiology among Key Populations including FSWs and is characterized by an above national average prevalence rate of 45% and issues of increased vulnerability. Particular challenges to the FSW program in Kenya include:

- The need to expand interventions to unreached locations and improve the existing programs to meet unmet needs and ensure that all members of key populations are able to access a full range of combination prevention services in their area.
- Funding limitations to scale up of the FSW HIV prevention program
- The existing programmes have been largely focused on biomedical interventions with limited behavioural and structural components. This is a gap that will be addressed in this application by incorporating a strong component of behavioural and structural interventions to the FSW module.
- Physical and sexual violence against FSWs is high and high number of them also experience arrests by law enforcements and “askaris”. 22% of FSW reported being beaten or physically abused in the last 6 months. 44% of FSWs also reported being arrested in the last 6 months47. Interventions to address violence prevention and response will need to be sustained in this application.

Application response to the gaps

This proposal seeks to address the gaps in coverage by expanding interventions to increase coverage of FSW by 25,800 FSWs in year 1 to 34,550 FSWs in year 3. This will ensure that 80% of the estimated FSWs are covered through interventions in the country by 2017. It is intended in this application that the gaps be addressed by expanding to priority geographical areas with a combination prevention approach.

The priority geographies for FSW interventions are:

1. Counties which have high HIV prevalence, High estimates of FSWs and / or High FSWs per 1000 adult men BUT have no interventions. These counties are –

47 Polling Booth Survey Report (draft), NASCOP 2013
## Counties with High HIV Prevalence, High Estimates of FSWs and/or High FSWs per 1000 Adult Men

<table>
<thead>
<tr>
<th>S/N</th>
<th>County Name</th>
<th>Total Population as per 2009 census (&gt;5000)</th>
<th>FSW</th>
<th>FSWs per 1000 adult men</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Murang’a</td>
<td>99156</td>
<td>442</td>
<td>61</td>
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<tr>
<td>2</td>
<td>Taita Taveta</td>
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<td>6.1</td>
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<tr>
<td>3</td>
<td>Nyamira</td>
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<tr>
<td>4</td>
<td>Trans Nzoia</td>
<td>117846</td>
<td>815</td>
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<td>5.1</td>
</tr>
<tr>
<td>5</td>
<td>Kakamega</td>
<td>215115</td>
<td>3405</td>
<td>71</td>
<td>5.9</td>
</tr>
</tbody>
</table>

## Counties with High HIV Prevalence, High Estimates of FSWs and/or High FSWs per 1000 Adult Men BUT have Interventions Covering Lower than 50% of the Estimates

<table>
<thead>
<tr>
<th>S/N</th>
<th>County Name</th>
<th>Total Population as per 2009 census (&gt;5000)</th>
<th>FSW</th>
<th>FSWs per 1000 adult men</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Makueni</td>
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<td>503</td>
<td>5.6</td>
</tr>
<tr>
<td>7</td>
<td>Kwale</td>
<td>102352</td>
<td>1112</td>
<td>71</td>
<td>5.7</td>
</tr>
<tr>
<td>8</td>
<td>Kilifi</td>
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<td>4676</td>
<td>78</td>
<td>4.4</td>
</tr>
<tr>
<td>9</td>
<td>Meru</td>
<td>158622</td>
<td>3391</td>
<td>119</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
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<tr>
<td>11</td>
<td>Kisumu</td>
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<tr>
<td>12</td>
<td>Mombasa</td>
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<td>40</td>
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<tr>
<td>13</td>
<td>Nakuru</td>
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<td>5.3</td>
</tr>
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<td>14</td>
<td>Uasin Gishu</td>
<td>314007</td>
<td>2442</td>
<td>34</td>
<td>4.3</td>
</tr>
<tr>
<td>15</td>
<td>Vihiga</td>
<td>168042</td>
<td>2749</td>
<td>93</td>
<td>3.8</td>
</tr>
</tbody>
</table>

The combination prevention package planned will include biomedical, structural and behavioural interventions.

A second priority intervention in this module is scaling up of comprehensive interventions for violence prevention and response and policy advocacy on legal rights. This is derived from consideration of an expressed need by FSWs (following consultations with a sample in the country)\(^{48}\) and is applicable to other key population groups. This intervention area will be applicable to all Key Population modules and is replicated in those modules for emphasis.

**Adaptation measures to maximize impact**

The current application takes into consideration the existing committed funding in the Round 10 phase II grant for KPs. Specifically, it will leverage the planned procurements of condoms and test kits in the phase II grant to complement the package of services on offer. In addition, training of service providers to support wellness centers for KPs under Phase-I of this grant will be leveraged. Also the ongoing engagement of political and religious leaders in constructive dialogue towards the drafting of a policy will also be leveraged. The planned comprehensive package of SRH services with integration of services which are less stigmatizing/discriminative such as TB screening, ART provision etc. Peer education, training of peer educators, setting up and supporting the wellness clinics to reach out to larger population, service delivery points are some other activities that will continue in the Phase-II SSF grant implementation and leveraged by this application.

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\(^{48}\) Polling Booth Survey Report (draft), NASCOP 2013
Module 3: Prevention for Key Population (MSM)

Noted Gaps & Constraints

For the purpose of this proposal the higher range of estimates of the MSM population (26,715) has been considered and includes male sex workers. NASCOP key population programme coverage report for 2nd quarter of 2014 show that there is coverage of 21,622 MSMs. The Kenya National Strategic Framework 2014 aims to scale up intervention with MSM to reach 90% of the estimated MSM (24,000 MSM) with good quality programmes by 2019. Currently PEPFAR has committed to fund coverage of 16,600 MSM over the next three years. This funding supports coverage of 62% of the estimated MSM population.

Besides funding gaps, the existing programmes have been largely focused on biomedical interventions ignoring behavioural and structural needs. Structural factors including conflicting legal provisions coupled with the rampant negative attitudes and perceptions perpetuated by the conservative cultural and religious beliefs have contributed to numerous barriers to access HIV and health services by MSMs.

The KASF recommends a combination prevention approach to interventions for key populations as an approach towards ensuring the quality of the prevention package for Key populations. This is a gap that will need to be addressed in this application by incorporating a strong component of behavioural and structural interventions to the MSM module.

Application response to the gaps

This proposal seeks to address the gaps in coverage by expanding interventions to increase coverage of MSM by 7,033 MSM in year 1 to 8,483 MSM in year 3. This will ensure that 95% of the estimated MSM are covered through interventions in the country by 2017.

We propose that the gaps would be addressed by expanding to priority geographies with a combination prevention approach.

The priority geographies for MSM interventions are:

A) Counties which have high HIV prevalence, high estimates of MSM BUT have no interventions. These counties are -

<table>
<thead>
<tr>
<th>S/N</th>
<th>County Name</th>
<th>Total Population</th>
<th>MSM</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bungoma</td>
<td>222579</td>
<td>211</td>
<td>3.2</td>
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<tr>
<td>2</td>
<td>Kakamega</td>
<td>215115</td>
<td>314</td>
<td>5.9</td>
</tr>
<tr>
<td>3</td>
<td>Nyamira</td>
<td>47305</td>
<td>118</td>
<td>6.4</td>
</tr>
<tr>
<td>4</td>
<td>Murang’a</td>
<td>99156</td>
<td>184</td>
<td>5.2</td>
</tr>
</tbody>
</table>

B) Counties which have high HIV prevalence, High estimates of MSM BUT have interventions covering lower than 50% of the estimates. These counties are –

<table>
<thead>
<tr>
<th>S/N</th>
<th>County Name</th>
<th>Total Population</th>
<th>MSM</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Vihiga</td>
<td>168042</td>
<td>151</td>
<td>3.8</td>
</tr>
<tr>
<td>6</td>
<td>Migori</td>
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<td>673</td>
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<tr>
<td>7</td>
<td>Siaya</td>
<td>84993</td>
<td>618</td>
<td>23.7</td>
</tr>
</tbody>
</table>

49 KNASP III ETR report, 2014
A second priority intervention in this module is scaling up of comprehensive interventions for violence prevention and response and policy advocacy for legal rights. This is derived from consideration of an expressed need by MSMs (following consultations with a sample in the country during the polling booth survey).50

**Adaptation measures to maximize Impact**

The current application takes into consideration the existing committed funding in the Round 10 phase II grant for KPs. Specifically, it will leverage the planned procurements of condoms, lubricants and test kits in the phase II grant to complement the package of services on offer. In addition, training of service providers to support wellness centers for KPs under Phase-I of this grant will be leveraged. Also the ongoing engagement of political and religious leaders in constructive dialogue towards the drafting of a policy will also be leveraged. The planned comprehensive package of SRH services with integration of services which are less stigmatizing/ discriminative such as TB screening, ART provision etc. Peer education, training of peer educators, setting up and supporting the wellness clinics to reach out to larger population, service delivery points are some other activities that will continue in the Phase-II SSF grant implementation and leveraged by this application.

**Module 4: Prevention for Key Population (PWID)**

**Noted Gaps & Constraints**

- Higher than national HIV prevalence rates among PWIDs (18.2%)
- Limited scope and scale of the HIV prevention program for PWIDs in Kenya
- Increased vulnerability as a result of structural barriers including conflicting legal provisions coupled with the rampant negative attitudes and perceptions perpetuated by conservative cultural and religious beliefs
- Physical violence and unlawful arrests by law enforcement agents that have remained uncontrolled.

For the purpose of this proposal the size estimate of PWID is considered at 18,327. NASCOP key population programme coverage report for 2nd quarter of 2014 show that there is current coverage of 7,930 PWIDs. The Kenya National Strategic Framework 2014 aims to scale up intervention with PWID to reach 90% of the estimated PWID (16,500 PWID) with good quality programmes by 2019. Currently PEPFAR has committed to fund coverage of 8000 PWID over the next three years. This funding supports coverage of 44% of the estimated PWID. It needs to be noted that PEPFAR funding does not allow provision of NSP to PWID.

**Application response to the gaps**

This proposal seeks to address the gaps in coverage by expanding interventions to increase coverage of PWID by 4,990 PWID in year 1 to 9,000 PWID in year 3. This will ensure that 93% of the estimated PWID are covered through interventions in the country by 2017.

We propose that the gaps would be addressed by expanding to priority counties with a combination prevention approach.

The priority counties for PWID interventions are:

1) Counties which have high HIV prevalence, High estimates of PWID BUT have no interventions. These counties are:

<table>
<thead>
<tr>
<th>S/N</th>
<th>County Name</th>
<th>Total Population</th>
<th>PWID</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bungoma</td>
<td>222579</td>
<td>211</td>
<td>3.2</td>
</tr>
</tbody>
</table>

50 Polling Booth Survey Report (draft), NASCOP 2013
2) Counties which have high HIV prevalence, High estimates of PWID BUT have interventions covering lower than 50% of the estimates. These counties are –

<table>
<thead>
<tr>
<th>S/N</th>
<th>County Name</th>
<th>Total Population</th>
<th>IDU</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Kakamega</td>
<td>215115</td>
<td>314</td>
<td>5.9</td>
</tr>
<tr>
<td>3</td>
<td>Nyamira</td>
<td>47305</td>
<td>118</td>
<td>6.4</td>
</tr>
<tr>
<td>4</td>
<td>Murang’a</td>
<td>99156</td>
<td>184</td>
<td>5.2</td>
</tr>
<tr>
<td>5</td>
<td>Meru</td>
<td>158622</td>
<td>545</td>
<td>3</td>
</tr>
</tbody>
</table>

The combination prevention package includes biomedical, structural and behavioural interventions. Interventions targeting law change, violence prevention and response are also planned.

A second priority intervention in this module is scaling up of comprehensive interventions for violence prevention and response and policy advocacy for legal rights as described above for other KP populations.

**Adaptation measures to maximize Impact**

The existing KPs program as supported by the GF and the USG will be leveraged. The phase II programming focuses on behavioral and biomedical interventions using 3 models of implementation. The program established innovative KP centres that provide comprehensive clinical services with essential supplies from KEMSA. This is complemented with comprehensive outreach services at various hotspots targeting hard to reach KPs. In addition, peer educators are trained and supported to provide prevention commodities, risk reduction counseling and individual peer support.

**Module 5: Prevention of Mother to Child Transmission (PMTCT)**

**Noted Gaps & Constraints**

The analysis of PMTCT performance is as depicted in section 1. For emphasis, the noted gaps are summarized as follows:

- Limited coverage of PMTCT based on the new guidelines (70.6%)
- Low EID coverage (45.2%)
- Low ARV prophylaxis for HIV exposed babies (43.3%)
- Low ART coverage for HIV positive children (less than 50%)
- High unmet FP need among HIV positive women related to barriers to access which include the fear of side effects and other health concerns. Also, religious prohibitions, opposition to use, menopause, infertility, desire for many children, and infrequent sex contribute to lower use of FP methods.
- Limited integration of FP, PMTCT, reproductive health care, and maternal and child health services

**Application response to the gaps**

The obvious programmatic gaps in the PMTCT program require a holistic but targeted approach to scale up of the program. This application plans to invest in interventions across the four prongs of PMTCT programming. The strategies to be employed will include prevention of unintended pregnancies through improved access to FP services and will involve integration of FP, PMTCT, reproductive health care, TB screening and maternal and child health services in all health facilities. To further address the gaps of FP unmet needs, and by extension PMTCT, this application will invest in capacity building of health care workers.

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51 Kenya AIDS Indicator Survey 2012 (KAIS) showed that 62% of women who self-reported HIV infection and did not want a child within the next two years or in future, were using modern contraception. The missed opportunities for counseling HIV infected women regarding FP were well illustrated in the Kenya PMTCT operations research studies where more than one fifth of women reported that they engaged in a discussion about FP during their antenatal visit, but fewer than 4% reported receiving any postpartum counseling on this topic.

52 Kenya Demographic and Health Survey, (KDHS) 2009
and clients on FP use and safety within the HIV context. Sensitization trainings for health workers and appropriate counseling for women of reproductive age will also be provided. Other PMTCT prongs will also be addressed as detailed in the modular template section.

**Adaptation measures to maximize Impact**

The maintenance of the program interventions in all active sites and targeting high yield facilities (for retention initiatives) is the notable adaptation to requested Global Fund support. Also key is the linkages with the National TB program where all pregnant women will be offered TB screening alongside HIV testing in all facilities.

**Module 6: Treatment Care and Prevention**

**Noted Gaps & Constraints**

**Background**

Antiretroviral therapy remains a cornerstone in the control of HIV. The Kenya AIDs strategic framework (KASF) 2014/15 -2018/19 identifies provision of HIV Care and ART for people living with HIV as one of the major strategic areas in the HIV response. Great progress has been made in increasing access to HIV care, treatment and support services that have led to declining morbidity and mortality among persons living with HIV. As at June 2014, over 680,000 persons were receiving ART. In Kenya, since 2009 over 390,000 deaths have been averted by the use of ART (HIV Estimates Report 2013). In 2013, 58,465 deaths occurred among PLHIV a quarter of which occurred in children and adolescents living with HIV, a reflection of the disproportionately lower coverage of ART in children compared to adults. Overall gaps exist along the cascade of care from linkage, accessing ART to retention and other treatment outcomes including viral suppression and quality of care. The knowledge of HIV status remains the entry into HIV Care. Suboptimal linkages following HIV diagnosis compounded by poor referral systems and tracking mechanisms for linkage to care, lack of unique identification mechanisms remain a gap. There is disproportionately lower coverage of ART in children and adolescents; suboptimal prophylaxis and management of co-infections and other priority co-morbidities, high attrition of persons enrolled in care and treatment, inequitable access to care and treatment services by subpopulations and geographic regions. In addition adolescents living with HIV experience disclosure, adherence and other challenges, so do key populations living with HIV. National data shows gaps in quality of care and outcomes of persons on ART that include children, adolescents, and adults. Viral load systems, including infrastructure and capacity to use these technologies remain suboptimal. Health outcomes for PLHIV also rely on greater acceptance, improved social protection and reducing barriers for orphans and vulnerable children, adolescents and key populations who are HIV positive to enroll and be retained in care and treatment. Poor treatment outcomes have also been attributed to the limited coordination and support by other sectors such as learning institutions, nutrition, legal and social services. Strengthening private sector service provision is also identified as an area that needs attention in the KASF.

**Gaps in treatment**

In June 2014 Kenya adopted and launched new guidelines on ART in line with WHO 2013 guidelines which recommend earlier initiation of ART for all including ART for all children aged 10 years and below, pregnant women , and TB patients among other priority populations. The KASF 2014/15 -2018/19 has aligned with the UNAIDs global treatment targets of 90-9-90 and plans to achieve 90% treatment coverage and 90% viral suppression for those on treatment. The new guidelines significantly increase the need for ART for all populations. Based on these guidelines over 80% of PLHIV are in need of ART. In order to move towards achieving the targets set by KASF to achieve 90% treatment coverage by 2019 which require the number of persons on ART to be doubled within 5 years, the country has set ambitious targets for persons on ART per year. Available resources from PEPFAR and GOK to cover treatment costs particularly for procurement of ARVs will only cover 31% of the treatment need. The total allocation of Global Fund resources for treatment (Single stream funding and new funding model) will cover an additional 24% and 25% of the need in the 1st and 2nd year respectively. The targets for the phase 2 will be maintained till December 2017.

**Application response to the gaps**
This application focuses on key interventions in response to the gaps identified in the KASF for improving wellness and health outcomes of PLHIV taking into account the contribution by other stakeholders. Most interventions in this application will target achieving national coverage.

Specifically this application focuses on the following priority areas:

- Improving linkages to care and treatment through proper documentation and patient support systems to link clients to care
- Improving access to ART through ensuring commodity security, capacity building of health care providers and supporting provision of treatment services for key populations including children
- Interventions to improve treatment adherence and retention on ART specifically targeting adolescents and enhancing treatment literacy and patient support mechanisms.
- Engagement with the private sector as a critical component of expanding access to HIV treatment services. Understanding the nature and quality of treatment in the private sector has been prioritized to ensure that the 50% of care seekers who utilize services through this sector receive quality services.

Adaptation measures to maximize Impact

This application will leverage on existing GF resources and other donor and domestic resources to cover the need for treatment. Some of the activities under the existing grant include; provision of ART for adults and children, training of health providers, improvement of care through telemedicine, monitoring of emerging drug resistance in patients who are newly initiated or switching treatment, monitoring of drug resistance among others. The application also focuses on supporting interventions above that will provide long term benefits and provide benefit across the various steps in the cascade of care.

Module 7: TB Care and Prevention

Noted Gaps & Constraints

Despite Kenya being the first country in the African region to achieve WHO targets of case detection rate and treatment success rates of new smear positive pulmonary TB cases, sub national analysis of the program reveals challenges that will need to be addressed through this application leveraging on other investments within the country for TB.

- **Case Notification:** It is estimated that approximately 75% of new TB cases were notified in 2013 leaving about 20% missed. There is however inter-county variations in case notification for Tuberculosis. It is not known if the variance reflects true epidemiological differences, but certainly it can be assumed that cases are missed in all counties to varying degrees. There is therefore a need to implement aggressive interventions to reach the unreached 20% of the new TB patients. Considering the well-documented relationship between poverty and TB, areas of lower case notification and high poverty density may provide hints as to the location of some of the 20% of cases who are undetected.

- **Limited Integration of TB services with other health services:** The operationalization of national norms occurs through service delivery that is fully integrated into the public health network. Dedicated TB and leprosy coordinators assigned at devolved levels provide supportive supervision to sub-counties and health facilities. However the scope of this integration in a devolved system will need to be increased to be able to replicate the gains noted with the national TB program.

- **Limited infrastructure for prevention, diagnosis and treatment:** Currently, one TB treatment or follow-up center serves fewer than 15,000 populations. However, despite efforts to build capacity for TB prevention, detection and care at all levels of the health system, it is estimated that fewer than 40% of dispensaries are able to provide TB diagnosis and treatment. There are also noted challenges with the existing diagnostic infrastructure to include 1) Lack of an integrated sputum transport mechanism, 2) Underutilization of Gene Xpert, 3) Delayed transmission of laboratory results from the laboratories to clinicians, 4) poor access to 2nd line DST for TB, 5) limited external quality assurance for TB diagnostics which currently stands at 88% for AFB microscopy, 6) weak biosafety and infection
prevention measures, 7) Limited geographical access to diagnosis in remote areas. These are important gaps that will need to be addressed to sustain the current performance.

- **TB in key populations:** Based on existing evidence from within Kenya and other neighboring countries, the following high risk groups are recognized as hosting disproportionately high rates of TB and/or being underserved by health services a) Urban Slum dwellers b) Health care workers c) migrant populations including refugees and asylum seekers e) Prisoners f) Uniformed service personnel g) PLHIV h) contacts of TB patients and i) Diabetics. Interventions will need to be designed to reach these populations with above average TB incidence.

- **Limited scope of Public Private Mix (PPM):** Kenya has been implementing a PPM initiative involving the private self-financing sector for over 15 years with very good results. The total number of cases notified from this sector rose from 7,160 in 2010 to 11,000 in 2012, representing 19% of total cases notified by the NTLD. Though it is implemented in almost all counties in the country, the initiative is currently most vibrant in 15 urban centers in Kenya. About 255 private health facilities are included along with 185 private laboratories that are linked to the national public sector-led external quality assurance system for TB bacteriology. Currently, out of the 245 laboratories involved in PPM, only 75% are linked to the national EQA system. Therefore the engagement of private health care providers and especially solo private providers remains a challenge.

- **Limited Operations research opportunities:** Funding limitations has continually challenged the scope of operations research for TB.

- **Lack of integration of LMIS with the TIBU:** The national information management system for TB (TIBU) needs to be integrated with the existing LMIS for ease of relating product data with program output and outcome data.

**Application response to the gaps**

In order to maintain the quality of TB services while at the same time improve service delivery to improve quality of services and reach the 20% "missing" cases, the country has prioritized the following interventions:

- Provision of TB case detection and diagnostic services
- Provision of care and treatment for all diagnosed TB patients
- Engaging all care providers
- Targeting key affected populations with intensified TB case finding and prevention interventions
- Collaborative activities with other programs and sectors like maternal and child health services
- Retaining human resources – lab technologists, clinical officers, statisticians, epidemiologist, M&E officers, ICT officers and finance officers for the NTLD

**Adaptation measures to maximize Impact**

This application will leverage substantially from existing Global Fund grants and other domestic resources in the country. A conscious effort has been made to ensure there is no duplication of already funded activities.

**Module 8: MDR-TB**

**Noted Gaps & Constraints**

- **Limited MDR-TB Case Notification:** W.H.O. estimates that there were 2,780 MDR-TB cases in Kenya in 2012. Kenya however notified only 254 cases of MDR-TB in 2013, 28% of whom were refugees from neighboring Somalia. The number of MDR-TB cases detected in Kenya has risen steadily since 2010, when only 112 cases were detected. This depicts limitations with case notifications of MDR-TB cases in the country. It is expected that with GeneXpert roll-out, the number of MDR-TB cases detected will increase dramatically. Currently, there are 257 sites providing MDR treatment in Kenya.\(^{53}\)

- **Other areas needing support include:**

  a) Strengthening systems that support programmatic management of drug resistant TB (PMDT).
  b) Systematic surveillance of DR-TB, including children.
  c) Reducing time to diagnosis of DRTB.

\(^{53}\) TB National Program data, 2014
d) Ensuring timely initiation of treatment (within 1-2 weeks of diagnosis).
e) Improving monitoring and evaluation of presumptive and confirmed DRTB cases.

**Application response to the gaps**

In order to address most of the gaps outlined above, the country has prioritized the following interventions;

a) DRTB case detection and diagnosis through a widening of the inclusion criteria to include children, retreatment cases, smear negative cases, smear positive at 2 months and key populations (refugees and urban slum dwellers)
b) Treatment and nutritional support for identified DRTB patients
c) DRTB Prevention (IPC)
d) Collaborative activities with other programs and sectors

**Adaptation measures to maximize Impact**

This application will leverage substantially from existing Global Fund grants and other domestic resources in the country.

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**Module 9: TB and HIV Collaborative activities**

**Noted Gaps & Constraints**

The TB/HIV epidemiology and the progress with implementation of the KNASF detailed in section 1 provide a background on the gaps with the TB/HIV program in Kenya. For emphasis, the following are some of the key challenges/constraints:

- Need to increase and sustain HIV testing in TB settings
- Need to attain universal access to ART for all eligible TB patients
- Low IPT coverage despite high TB screening (83%) in HIV settings.
- Collaborative TB HIV activities have been implemented widely in mainstream TB and HIV clinics but key populations including prisoners, migrant populations, urban slum dwellers, MSMs and FSW remain largely unreached.

**Application response to the gaps**

This grant will focus on strengthening TBHIV coordination in the devolved structures, closing gaps in HTC for TB patients, supporting universal access to ART, improving TB IPC, supporting national scale-up of IPT for PLHIV, prisoners and children, increasing access to xpert MTB/rif as the initial test for PLHIV with presumptive TB and integration of TBHIV services in MNCH, special clinics, in and outpatient departments. Also the application seeks to strengthen the TB/HIV M&E systems.

**Adaptation measures to maximize Impact**

An active process of engagement and collaboration between the TB and HIV national programs is a key adaptation that must be made for impact. The existing Global Fund grants will be required to explore for opportunities for collaboration including improving efficiencies. Joint trainings and supervisory visits on TBHIV activities will be instituted to leverage costs and the national coordination efforts will be sustained at national level and replicated at county levels.

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**Module 10: HMIS/M&E**

**Noted Gaps & Constraints**

Kenya’s response to the evolving HIV and TB epidemic is largely influenced by strong commitment to availing quality data in a timely manner for effective evidence-based decision making. In order to maximize effective use of all available information and implement evidence based planning, a robust Strategic Information Management System (SIMS) that focuses on programme monitoring, evaluation, surveillance and knowledge management is key. Thus far, each of the programmes have various degrees of success with their information
while there are system wide constraints, others are disease programme specific. Largely gaps for HIV are related to capturing and using data from key populations whereas TB requirements are more substantial. The noted gaps and constraints with this module are detailed in the programmatic gap narrative in Section 3.1

**Application response to the gaps**

This application plans to invest across the areas of a) strengthening routine reporting systems for Malaria, TB and HIV b) Providing support for Analysis and transparency of generated data to inform decision making c) Providing support for Surveys necessary to generate impact and outcome level data for the three disease programs and d) support towards strengthening the vital registration systems in the country to help with the recording and reporting of morbidity and mortality data for the three focus diseases and the larger health sector.

Specifically also, in view of the limited funding available in the country allocation and also taking cognizance of the ongoing strategic information management investments from other partners, this application has prioritized to develop national M&E systems for key populations. This will be done through the following:

- Conduct stakeholder meetings for consensus on indicators for routine key population data – for both paper and electronic based reporting systems
- Development of tools and indicator manual for use at facility to sub-county level for data collection and collation. For this to be done hire of a consultant will be required
- Development of DHIS2 module for key population data so that collated data from sub-county level is uploaded into the system
- Roll out of the tools: this will include pilot of tools, healthcare worker sensitization/training on the tools
- TB data collection tools currently have HIV data elements (HCT, ART, CPT, and IPT) and will continue to be rolled out to all sites. HIV data collection tools also capture TB data elements (TB screening, CPT, ART for TB cases).

**Adaptation measures to maximize Impact**

Note is made that consideration has been made of the available resources from the existing Global Fund Round 10 phase II grant and other domestic resources towards strengthening the HMIS/M&E systems in the country. This investment will initially target all service delivery points that manage key populations. It is envisioned that in subsequent years as management of key populations gets integrated into health facilities that scale up of this strategy will be done. However, this application has given significant attention to the TB program which will have no funding resource available at the start date of this application.

**Module 11: Service Delivery**

**Noted Gaps & Constraints**

The noted gaps and constraints for this module are reflected in the programmatic gap narrative in Section 3.1.

**Application response to the gaps**

This application has prioritized two areas of intervention for this module and these include:

a) Improving Laboratory quality systems through
   - Capacity development of technical personnel on sample handling, transportation and testing
   - EQA enrolment of testing Laboratories
   - QA intervention for testing Network Laboratories
   - LIMS implementation in Network testing Laboratories
   - Infrastructure in Network testing Laboratories
   - Engagement of the NRL on TB Quality Laboratory Management Systems with intention-to-accreditation to ISO standard 15189, and other relevant lab standards

b) Upgrade of laboratory infrastructure through
   - Renovation of 17 Laboratories in a phased approach
Lay out ICT infrastructure to support LIMS implementation within renovation plans
Hire 17 specialized personnel to boost network testing volumes
Procure and install LIMS Package (with vendor application training and support)

Adaptation measures to maximize impact

This investment will be targeting a select number of strategic network laboratories based on workload, country epidemiology and catchment population served.

Module 12: Products and Supply Chain Management (PSCM)

Noted Gaps & Constraints

The products and supply chain management system has been described in earlier sections. Gaps have been through routine reviews and specific assessments also cited in previous section. Below are a summary of these gaps from a broad perspective:

- Inadequate capacity for timely and accurate forecasting and quantification at county and health facility level
- Long procurement lead times
- Multiple central warehousing and distribution points and parallel distribution cycles for HIV, TB and Malaria commodities
- Inadequate storage facilities and conditions at county and health facility levels
- Weak or non-existent county distribution structures to health facilities, multiple distribution processes, transportation challenges
- Inappropriate use of medicines and other supplies
- Measures to ensure quality assurance along the supply chain; during procurement, distribution and storage are weak or non-existent
- Infrequent and parallel Post Market Surveillance (PMS) with long turnaround time for laboratory quality testing and lack of adequate resources to carry out screening tests for quality at county levels
- Existence of parallel, mainly manual logistics management information systems (LMIS) for the three disease areas leading to parallel ordering cycles; poor data quality and low reporting rates
- There are weak or non-existent mechanisms for routine monitoring and evaluation of supply chains for efficiencies and commodity security at national, county and health facility level
- Inadequate infrastructural support for PSCM i.e. ICT, diagnostic and computer equipment, physical structures, electricity, water, internet

Application response to the gaps

In view of the limited funding available in the country allocation and also taking account of the ongoing health systems investments from other partners, this application has prioritized a number of gaps to be addressed. Specifically the application seeks to:

1. Strengthen the logistics management and information system for RMNCH lifesaving commodities, TB, malaria and HIV through:
   - Harmonization/integration of LMIS systems (RMNCH; TB, HIV and Malaria)
   - Incorporation of LMIS commodity data into DHIS service delivery data
   - Provision of stock management tools at the lowest levels

2. Increase the capacity of warehousing, storage and distribution of RMNCH lifesaving commodities, TB, malaria and HIV commodities through:
   - Support the improvement/renovation of county and sub-county storage areas so that they meet the minimum standards prescribed
   - Joint curriculum for integrated inventory management trainings up to sub-county level and supporting the lowest level in meeting their training needs
3. Enhance county capacity to accurately quantify, forecast and manage the supply chain of RMNCH lifesaving commodities, TB, HIV and malaria medicines, diagnostic supplies and equipment
   - Mentoring of counties and sub counties on LMIS and data use for decision-making
   - Scale up use of electronic LMIS tools at facility for data capture and transmission
   - Support joint forecasting and quantification workshops at the 47 counties coordinated by the national level.
   - Centralized procurement of all program commodities to achieve economies of scale related to lowest pricing and quality assured commodities

4. Support regular joint post-market surveillance for malaria, TB, HIV and RMCNH lifesaving commodities
   - Support a countrywide joint PMS survey by the programs
   - Support sample collection, transportation and analysis during PMS survey
   - Support regulatory actions taken by the drug regulatory authority following recommendations of the PMS report
   - Support dissemination and implementation of the recommendations from PMS report

Adaptation measures to maximize Impact
The noted adaptation here is the leveraging of other existing sources of funding for this systems strengthening intervention.

Module 13: Community Systems Strengthening

Noted Gaps & Constraints
The Community systems analysis of gaps in section 3.1 details the attendant gaps to the community structures in Kenya.

Application response to the gaps
This application seeks to bridge these gaps through a mix of interventions with prioritized sub activities that fit into the funding available for CSS in this allocation. These interventions include:

a) Social mobilization, building community linkages, collaboration and coordination through capacitating community units across the counties to increase demand for quality health services
b) Institutional capacity building, planning and leadership development in the community sector through empowerment of community groups and civil society organizations to be able play their role as advocates for an integrated TB-HIV-Malaria service delivery system at community level
c) Community- based monitoring for accountability
d) Interventions addressing barriers related to human rights violation and gender inequality, including harmful socio-cultural practices, stigma and discrimination and violation of sexual and reproductive rights of women living with HIV and those from key populations

Adaptation measures to maximize Impact
There have been noted investments in the area of community systems through the round 10 HIV grant and from various other sources. This application has been structured to leverage these investments and limit scope to only geographical areas and specific interventions to yield results in the near term.

Module 14: Program management

Noted gaps and constraints
The existing HIV SSF Global fund grant run up to June 2017 while the existing TB SSF GF grant run up to December 2016. The priority under this module therefore is to continue with the coordination of this grant up to December 2017. In view of the above, noted gaps and constraints under program management fall under two categories;
Policy, planning, coordination and management

Grant management

Application response

Policy, planning, coordination and management - This application will support; revision of National TB and HIV guidelines according to the current National and international recommendations; Coordination of key stakeholders in implementing HIV and TB response through existing mechanisms such as thematic Technical Working Groups; provide technical and financial support to effectively coordinate National and county level Multi Sectoral AIDS Committees; support National and County joint TB/HIV review meetings and supervision to provide oversight to the regions and councils; support coordination of partnerships and networks for HIV and TB response at County and National levels; and dissemination of KASF to key stakeholders at the county and National levels.

Grant management: With responsibility for grant implementation, technical coordination, financial management, monitoring, evaluation and reporting, managing procurements and coordinating multi-stakeholder efforts for programme results and financial accountability, all the principal recipients (National Treasury, Kenya Red Cross Society and AMREF), SRs and SSRs will require support for grant management activities. These activities include remuneration of staff under the grant (salaries and salary top up), capacity building for the staff, overhead running cost, review meetings, stakeholder forums and other oversight activities undertaken by the PRs. This is to enable them coordinate Global Fund activities efficiently and effectively up to December 2017.

Adaptation measures

This application will leverage on existing Global Fund HIV SSF grant and domestic resources to cover the need for grant management.
3.3 Modular Template

Complete the **modular template (Table 3)**. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are cross-cutting for both diseases.

To accompany the modular template, for both the allocation amount and the request above this amount, explain:

a. The rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases.

b. The expected impact and outcomes of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.
See the Modular Template, attached.

**Country dialogue and prioritization process of the modules:**

In order to prioritize the modules for this application, a country dialogue process was embarked on with stakeholders in health, HIV and TB technical experts, the donor community, and civil society groups representing the populations affected by the two diseases. Documentation of the related processes is attached to this application.

The stakeholders considered the following general and specific factors for prioritization:

**General Considerations:**

1. Alignment with the revised national strategic plans to ensure a unified vision
2. Consideration of the implications of a devolved health system with its incipient challenges….attempting to balance the psychology of equity versus allowing independent entities to develop and operate at their own pace.
3. Consideration for the ethical requirement of ensuring that already enrolled persons on treatment are maintained on treatment
4. Understanding that the resources are limited and as such a minimal scale up will be entertained and geographical scope to be determined by the country epidemiology
5. Adopting a leverage approach that required due consideration for existing domestic resources for programmes and avoiding duplication of activities to improve efficient use of available resources

**Specific Considerations:**

1. Analysis of the epidemiology of HIV and TB in Kenya to identify geographical areas with the highest burden for TB and HIV.
2. For improved access to services and institutionalization of the community-based approach, the community systems strengthening module was prioritized. This approach will strengthen community systems to collectively address the issues of service integration and demand creation
3. The barriers to access for both HIV and TB have been identified as limitations to the national programme and measured steps will be required to be taken to address them. The interventions around violence prevention and policy advocacy for legal rights has been selected to address issues of stigma and discrimination derived from local practices and beliefs, legal barriers to access and advocacy for a rights-based approach to service delivery for the two diseases. This will be implemented as a cross cutting consolidated intervention covering all the KP groups and is represented in all the related modules for emphasis. It will also uniquely take into account the devolved structures in the country to include senators, members of county assemblies and county council security operatives -“Askaris”.

**OVERVIEW OF PRIORITIZED MODULES**

**Module 1 : HIV Prevention Programs for the General Population:**

**Application summary for module:**

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**Rationale for the selection:**
The HIV epidemic in Kenya is both generalized and concentrated among specific populations and geographic areas. To respond to the complex pattern of the HIV epidemic, Kenya developed its HIV prevention Revolution Road Map to set the country on an ambitious path to end new HIV infections by the year 2030. This plan responds to the road map priority of a need for Kenya to shift focus to reduce HIV incidence through intensified HIV prevention efforts to priority geographies and population.

Prioritised Interventions:

a) **HTC as part of programs for general population**  
Allocation amount: $ 6,717,162

**Target Population & Geographic Scope:**
High yield HTC approaches focusing on patients visiting health facilities to utilize various services (both inpatient and outpatient departments), sexual partners and family members of PLHIVs, populations living within high incidence clusters, as well as other vulnerable and high risk groups within the 9 high incidence counties including Homabay, Siaya, Kisumu, Migori, Kisii, Nyamira, Turkana, Bomet, Nakuru that contribute to 65% of new HIV infections in Kenya.

The adolescents and youth including young women and girls have been targeted in HIV prevention and HIV care and treatment services. At national level, the annual HIV test and link campaign will target HIV testing and linkage among adolescents including young women and girls. Under behaviour change campaigns, a national advocacy campaign will be held dubbed "Keeping girls in school". HIV prevention education and treatment in schools will also be enhanced. Under the Kenya Combo prevention targeted interventions in Homabay and Mombasa counties, a comprehensive package for youth will be implemented.

**Implementation Approach:**

a) Targeted HTC will be delivered in both facility and community settings, and maximize opportunity for reaching targeted populations with combination prevention. This approach will leverage investments in other prevention approaches including VMMC, Condom programming for general and Key populations, family planning services and existing BCC interventions.

b) Scale up Provider Initiated Testing and Counselling (PITC) in both outpatient and inpatient departments,

c) Scale up of HIV testing of PLHIVs sexual partners and family members through facility and community testing and the Rapid Results Initiatives (RRI) for targeted high incidence areas and groups

d) Door to door testing and community based testing targeting vulnerable groups and high prevalence clusters.

e) Development and implementation of a communication strategy for demand creation through advocacy and campaigns

f) Funds from the existing HIV phase II grant will be utilized as in the approved grant documents attached to this application for the purposes i) procurement and supply of HIV rapid test kits ii) annual mass-media campaigns focusing on specific sub-populations iii) community and home based testing as a means to enrol patients in HIV care and provide ART iv) Promotion of family testing through index client, provider initiated counselling and testing and facilitating rapid result initiative for identification, testing and linking HIV infected children into care and treatment v) Refresher training for service providers on new HTC and vi) printing and dissemination of 15,000 HTC guidelines to support testing and counselling activities.

**Above allocation: $7,001,560**

**Target Population & Geographic Scope:**
National

**Implementation Approach:**

The above allocation amount will bridge the HIV test kit commodity gaps as well as increasing the scope of planned testing activities towards achieving national testing targets.

b) **Behavioural change as part of programs for general population**

**Allocation Amount: $ 2,292,099**
Target Population & Geographic Scope:
National

Implementation Approach
This will be implemented as in the approved HIV Phase II grant. No new allocation funds are earmarked for this intervention area. Key activities will be in alignment with the prevention revolution road map (attached) and will include:

- Annual mass media campaigns through electronic and print media targeting HIV testing and linking PLWHIV on treatment and targeting adolescents and youth.
- Local Radio Programmes
- Distribution of documentary for adult ART
- Develop and distribute IEC materials to support Prevention and ART services
- Promoting condom use particularly for the 15-24 yrs. age group (men and women) by providing consistent and correct messages
- Addressing issues around GBV and multiple concurrent partnerships.

c) Voluntary Male Medical Circumcision
Allocation Amount: $2,145,708
Implementation Approach:
This funding for this intervention is sourced from the existing HIV phase II grant. Implementation will be in line with approved activities in that grant. VMMC activities will be implemented in Turkana, Nairobi, Marsabit, and Mombasa counties. Related implementation activities will include:

- An intensive mass media campaign to mobilise 50,000 men for VMMC in each of the four target counties and organise at least two community dialogue meetings every year in Counties.
- Provision of food vouchers to support families of married men during the three days recuperation post VMMC
- Training of Health Care Workers on VMMC intervention in target counties and convening of consultation meetings with traditional circumcisers
- Procurement and distribution of MC equipment and consumables (MC Kits) and renovation of 20 minor theatres in the target areas to undertake MC services
- Documentation of practices surrounding MC services and review and update VMMC training curriculum and tools
- Printing and dissemination of M&E tools related to MC
- Conducting 4 EQA and regular supervision of VMMC services

No new allocation funds are earmarked for this intervention.

d) Blood Safety
Allocation Amount: $ 1,694,183
Target Population & Geographic Scope:
National
Implementation Approach
This is as contained in the approved Phase II grant and relates to the procurement of blood safety reagents and supplies (blood typing reagents, vacutainers, assorted blood bags) to support complete screening for TTIs markers and equipment (plasma freezers and blood typing bank refrigerators). Other activities will include a) training of 375 blood safety community mobilisers b) facilitating the formation of blood donor clubs with 30 members each and facilitate their quarterly review meetings c) facilitating the recruitment of blood donors at community and work place levels via 1 day training of 6000 regular donor mobilisers d) providing support for
blood donor notification and e) support for the creation of a blood donor data base to support mobilization, notification and distribution of screened blood products.

e) Other Interventions for general population: Post Exposure Prophylaxis for rape victims
Allocation Amount: $ 295,968

Target Population & Geographic Scope:
Rape survivors in the country.

Implementation Approach:
Implementation will be as in the approved HIV phase II grant and according to national guidelines. Post Rape Kits will be procured through this allocated fund. These funds will also be used to sensitize the police on Post Rape Care (PRC) and PEP; train service providers on Post Rape Care and will also pilot Pre-exposure prophylaxis for FSW and MSM.

f) Condom Programming

Allocation amount: Covered under KP budget in current phase II grant ($6,828,441)

Implementation Approach:
Condom programming will include commodity procurements (condoms and lubricants) which are housed in the KP budget. Other related components including social marketing and distribution are components of the combination prevention approach detailed in the prevention revolution road map.

Module 2: HIV prevention programs for Female sex workers (FSW) and their clients:

Application summary for module:

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<td>$ 5,064,107</td>
<td>$ 494,634</td>
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Rationale for the selection:
The country epidemiology indicates that HIV prevalence rates amongst FSW are significantly higher than national average. The MOT study also suggests that FSW and clients of FSWs are principal sources of new HIV infections in Kenya. Although progress has been made to reduce the incidence and prevalence of HIV in the general population, evidence shows that these gains may be reversed if a concerted effort is not made to reduce HIV transmission among the key populations at greater risk of HIV. Interventions for key population groups have already been initiated in many counties with funding support from PEPFAR and Global Fund since the prioritization of key populations in Kenya National AIDS Strategic Plan III. NACC and NASCOP have developed few guidelines and strategy documents to clearly define the country’s position and plan to work with the key populations. 62 FSW interventions spread over 30 counties report to NASCOP on a regular basis. However the need is to expand interventions to unreached locations and improve the existing programs to meet unmet needs and ensure that all members of key populations are able to access a full range of services in their area. This module is selected in response to the HIV epidemiology and the existing opportunity to maximize impact through leveraging of resources.

Prioritized interventions

1. Other interventions as part of programs for FSWs and their clients
   (Combination Prevention package: Biomedical, Structural and behavioural)

Allocation Amount: $ 4,968,186

Implementation approach:
a) The intervention approach includes investment on a robust outreach strategy involving FSW as peers and outreach workers. NASCOP-MOH key population HIV prevention guidelines recommend 1 peer educator for 60 FSW and 1 outreach workers to support and supervise 5 peer educators. That is the ratio proposed in this proposal. These outreach teams will be trained in peer education curriculum developed by NASCOP including micro planning tools and techniques. Inter Personal Communication (IPC) is a big part of behavioural interventions and NASCOP approved IPC materials will be printed and peers will be trained in IPC skills to use the materials for behaviour change.

b) Based on the client volume and sex acts of the FSW, condom and lube requirement will be worked out and condoms and lubes will be demonstrated and distributed during outreach. During discussions FSW have also expressed their need for female condoms for use especially during sex with regular partners. These will be also distributed when needed.

c) Setting up safe spaces for FSW is essential. Drop in Centres will be set up in all intervention sites to provide safe space for the FSW. These DICs will also provide clinical services (STI screening and treatment, TB screening, SRH services, HIV test, Care and treatment where applicable) and will have a qualified clinician and nurse. Outreach clinical services to the hot spots will be also provided to increase access to services for FSWs.

2. Other interventions as part of programs for FSWs and their clients
   (Policy advocacy on legal rights)

Allocation Amount: $ 95,921

Implementation approach:

The intervention approach is to set a system to prevent and respond to violence immediately. Prevention activities include sensitising the police and law enforcement including judiciary, sensitising the stakeholders, advocacy with media etc. The response related activities include rights education for sex workers, setting up a crisis management system so that help is available to the sex workers immediately, legal and clinical support. Advocacy with parliamentary health committee and parliamentary justice committee will continue to influence them to change laws which are archaic and negatively impact HIV prevention among sex workers. In consideration of the devolved structures in the country, the advocacy will expand to include senators, members of county assemblies and county council security operatives -“Askaris”. Note is made that this will be implemented as a cross cutting consolidated intervention covering all the KP groups and is represented in all the related modules for emphasis.

Above Allocation Amount: $ 494,634

Target population & Geographical scope
National

Implementation approach:
The above allocation is being requested to expand the scope of activities related to addressing legal rights
and violence against female sex workers. It will also support the operationalization of the actions towards
elimination of human rights violation among FSW. The interventions focus on crisis support and active
campaigns against violence. Specific activities proposed will include:

- Training of peer educators on human rights and violence
- Campaign on violence against women and FSW
- Providing crisis support through Paralegals

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Module 3: HIV Prevention Programs for MSM

Application summary for module:

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Rationale for the selection:

Epidemiological and research data abound to show that the HIV prevalence amongst MSMs is higher than the
general population. According to the Kenya HIV Prevention roadmap (2014) and Kenya Modes of
Transmission Study (2008), 15.2% of new infections were attributed to men who have sex with men and prison
populations. A meta-analysis of HIV prevalence among MSM and adults of reproductive age, Baral and his
team found that HIV prevalence among MSM in Kenya is higher (11%) compared to adults of reproductive
age in the country (7%). Selection of this module is in clear response to the epidemiology and an opportunity
to achieve impact by leveraging existing resources.

Prioritized Interventions

I. Other interventions as part of programs for MSM (Combination Prevention)

Allocation Amount: $ 4,796,186

Target population & Geographical scope:

MSM in prioritized regions (Bungoma, Kakamega. Nyamira, Murang’a. Vihiga, Migori, Siaya, Kisii, Machakos
and Meru)

Implementation approach:

Peer mediated behavioural interventions will be a core component of the of the MSM groups. This will entail:

a) Training of a resource pool of an appropriate number of peer educators to match the numbers of MSM
population at the approved ratio of 1:40. Recruitment and training of outreach workers at the ration of 1:5
peer educators

b) The Peer educators will undertake periodical micro planning and regular outreaches to the assigned
populations

c) The behavioural interventions will entail setting up and maintaining the existing drop in centers through
which risk reduction counselling, STI screening, HTC and other appropriate social support services are
offered.

d) Condom and lube requirement will be worked out and condoms and lubes will be demonstrated and
distributed during outreach.

e) Setting up safe spaces for MSM is essential. Drop in Centres will be set up in all intervention sites to
provide safe space for MSM. These DICs will also provide clinical services (STI screening and treatment,
Tb screening, SRH services, HIV test, Care and treatment where applicable) and will have a qualified clinician and nurse.

2. **Other Intervention as part of programs for MSM**  
**Policy advocacy on legal rights**

**Allocation amount:** $408,891  
**Target population & Geographical scope:** National

**Implementation approach:**

a) Develop policy briefs on the need to align the existing laws touching on MSM/SWs & the HIV act, to the constitutional right to health. The briefs will focus on highlighting current areas of conflict and legal impediments that create barrier to access to HIV services by Key Populations.

b) Hold advocacy meetings with legislators – MPs (Justice and legal affairs parliamentary committee and Parliamentary health committee) to create awareness of the legal barriers to access to HIV services and why legal review is necessary. The aim of these advocacy meetings is to ensure there is buy in for aligning the current laws touching on MSM, SWs and intentional transmission of HIV so that they can be the advocates and champions for these reforms in parliament.

c) Hold advocacy meetings with senior judicial officers so that we can have buy-in with a view to creating judicial precedence that affirms right to health

d) Senior ministry of health officials so that we can have buy-in for policy review and implementation including performance contracting.

e) Set a system to prevent and respond to violence immediately. Prevention activities include sensitizing the police and law enforcement including judiciary, sensitizing the stakeholders, advocacy with media etc. The response related activities include rights education for MSM, setting up a crisis management system so that help is available to the MSM immediately, legal and clinical support and so on.

f) Strengthen capacity, planning and leadership development in Key Population serving organizations through the regional (county/inter-county) networks/alliances that they are affiliated with.

g) Specific activities will include institutional systems assessment of these organizations to identify the strengths and gaps to inform a contextualized capacity building plan to address the noted deficiencies at the network and individual organizational level.

h) Additionally, capacity building to strengthen the social mobilizations skills and constituency building amongst the Key Population community members and allies.

In consideration of the devolved structures in the country, the advocacy components will also include senators, members of county assemblies and county council security operatives - “Askaris”. Note is made that this will be implemented as a cross cutting consolidated intervention covering all the KP groups and is represented in all the related modules for emphasis.

**Above Allocation:** $453,000

**Target population & Geographical scope:** National

**Implementation approach:**

The above allocation is being requested to expand the scope of interventions targeting issues around legal rights, barriers to access and violence against MSM. The above allocation funding request is intended to support the operationalizing and expanding legal support to MSM. The interventions focus on provision of pro-bono legal representation, crisis support and active involvement of MSM CSOs and networks in addressing barriers to full attainment of rights of MSM. Specifically, the following activities have been identified:

- Build capacity of clinical teams to address violence
- Retain lawyers for legal support
- Training for lawyers providing legal services to MSM

- Capacity building of regional networks for continued advocacy around removing barriers to access for MSMs
- Support to community based organisations for implementation
- Advocacy meetings with parliamentary health committee
- Advocacy meetings with parliamentary justice and legal affairs committee

Module 4: HIV prevention programs for PWID:

Application summary for module:

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Rationale for the selection:

The country epidemiology indicates that HIV prevalence rates amongst PWID are significantly higher than national average. The MOT study also suggests that PWIDS are one of the principal sources of new HIV infections in Kenya. Although progress has been made to reduce the incidence and prevalence of HIV in the general population, evidence shows that these gains may be reversed if a concerted effort is not made to reduce HIV transmission among the key populations at greater risk of HIV. Interventions for key population groups have already been initiated in many counties with funding support from PEPFAR and Global Fund since the prioritization of key populations in Kenya National AIDS Strategic Plan III. NACC and NASCOP have developed few guidelines and strategy documents to clearly define the country’s position and plan to work with the key populations. This module is selected in response to the HIV epidemiology and the existing opportunity to maximize impact through leveraging of resources.

Prioritized interventions

1. Other interventions as part of programs for PWID (Combination Prevention package)

Allocation Amount: $ 4,767,637

Target population & Geographic scope:

PWID, nationwide

Implementation approach:

a) A mix of site based, peer led and mobile outreach model for reaching PWIDs with both behavioural and behaviour-linked biomedical interventions like IEC, risk reduction counselling, condom and lubricant information and distribution, HTC, STI screening, abscess treatment and needle and syringe programme (NSP) among others. The intervention combination is based on the recognition of harm reduction as part of a comprehensive approach combining structural, biomedical, and behavioural interventions to have effective impact on behaviour change.

b) Peer mediated behavioural interventions will be a core component of the intervention. This will entail:
   - Training of a resource pool of an appropriate number of peer educators and outreach workers to match the numbers of PWID population at the approved ratio of 1:40, and outreach worker to peer educators approved ratio of 1:5.
   - The Peer educators and outreach workers will undertake periodical micro planning and regular outreaches to the assigned populations.
   - The Peer educators and outreach workers will conduct social mobilization through peer support groups and networks, provide HIV information and commodities, and link the PWIDs with health services based on need.

c) The interventions will also entail setting up and maintaining the existing drop-in centers through which risk reduction counselling, STI screening, HTC and other appropriate social support services are offered.
d) Using the hotspot approach, facilitate the identification, planning and implementation of community based clinical outreach through moonlight/ outreach clinics at hot spots

2. **OST and other drug dependence treatment (PWIDs and their partners)**
   
   **Allocation Amount:** $ 322,891

   **Target population & Geographic scope:**
   
   PWID, nationwide

   **Implementation approach:**
   
   Kenya is currently receiving support from CDC to pilot a MAT programme targeting four referral health facilities in Nairobi, Kilifi and Mombasa. The four health facilities are Malindi hospital, Mathari Hospital, Coast general hospital and Kilifi hospital. The resources for this intervention will support outreach programs that will be instrumental in assessing the level of preparedness of the PWID, selection, referral to the MAT facilities and follow up of the clients among other roles.

   Also, peer mediated behavioral change activities will be a core component of the intervention. Planned sub-activities will include:
   
   - Training of a resource pool of peer educators and outreach workers on MAT for support, information provision and linkage to the PWID
   - The peer educators and outreach workers will undertake periodical micro planning and regular outreaches to the assigned populations.
   - The peer educators and outreach workers will assess readiness, select participants, refer and follow up for adherence support as well as with the PWID with other health services based on need.
   - Provide outreach support to reach, appraise, link to treatment, and retain in OST treatment
   - Conduct training of HCW and DIC staff to increase their capacity for delivering high-quality health care services for PWID, including training in drug dependence treatment modalities

3. **Other Interventions as part of programs for PWID and their partners**
   
   **(Policy advocacy on legal rights and violence against PWID)**

   **Allocation Amount:** $ 449,516

   **Target population & Geographic scope:**
   
   PWID, nationwide

   **Implementation approach:**
   
   This intervention will involve a mix of sub activities to include:
   
   - Development of policy briefs on the need to align the existing laws touching on Key Populations & the HIV act, to the constitutional right to health. The briefs will focus on highlighting current areas of conflict and legal impediments that create barrier to access to HIV services by Key Populations.
   - Holding advocacy meetings with legislators – MPs (Justice and legal affairs parliamentary committee and Parliamentary health committee) to create awareness of the legal barriers to access to HIV services and why legal review is necessary. The aim of these advocacy meetings is to ensure there is buy-in for aligning the current laws touching on KPs and intentional transmission of HIV so that they can be the advocates and champions for these reforms in parliament.
   - Holding advocacy meetings with senior judicial officers so that we can have buy-in with a view to creating judicial precedence that affirms right to health
   - Advocacy sessions with senior ministry of health officials to achieve buy-in for policy review and implementation including performance contracting.
   - Capacity building and sensitization of a core group of resource persons from Police, county guards (law enforcement), prison officers, relevant senior civil servants and religious leaders on violence prevention, mitigation and redress. The training is aimed at transforming the perception and practices
of the targeted officers and the religious leaders who are then expected to act as change agents in cascading the same information to their colleagues and support the institutional transformation.

- Further, activities focusing on enhancing access to legal services will be undertaken. This will include undertaking literacy enhancement legal literacy sessions through paralegal training and outreaches. Additionally, sensitization of lawyers will be undertaken so that the same lawyers can be engaged in periodic legal aid clinics
- Conduct law enforcement sensitization with regular advocacy events with law enforcement officers
- Training of senior judicial officers.
- Also, a regional (county) and national (legal, psychosocial, medical) referral system will be developed to aid access to justice and health services survivors of violence including sexual violence

In consideration of the devolved structures in the country, the advocacy components will also include senators, members of county assemblies and county council security operatives - “Askaris”. Note is made that this will be implemented as a cross cutting consolidated intervention covering all the KP groups and is represented in all the related modules for emphasis.

Plans for long term sustainability of Key Population Programming (module 2, 3 & 4):

Sustainability plans for Key population programming in Kenya is hinged on several pillars.

a) Policy and service standardization: The ministry of health has developed and implemented several national guidelines for key population programming. This ensures services are of similar standards across all implementing entities.

b) Improved Coordination: The ministry has a coordinating unit focusing on ensuring key population programming remains a priority in the national HIV response. Coordination of donor efforts/support for the Key population programs has been established and will be sustained.

c) Integration of Service provision by both State and Non State implementers: The National program has prioritized and is following through with the integration/linkage of drop-in and wellness centres currently run by civil society organization with the government run health facilities. This is being implemented as a pilot model to ensure the country starts to transition towards a more sustainable integrated approach to programming. Some centres are operated within the GoK health facilities with some staff seconded from government. The Civil Society run key population centres are being given the master facility code (MFL codes) to enable them become part of the government of Kenya health system for the purpose of accessing government approved essential medical supplies

d) Capacity building: The country is focusing on capacity building of health facilities both in infrastructure and human resource to ensure enough capacity exist to cover additional demand that may be placed on the system by Key Population services. Health care workers support the facilitation, training and supervision of key population centre activities both at community and facility levels.

There however remains a key role that the CSOs will continue to play in Key Population programing as the KPs feel these centres are their safe space and have expressed the need to have them separate from government health facilities. Sustainable KP programming will therefore continue to be a collaborative effort between government and CSO implementers.
Module 5: Prevention of Mother to Child Transmission (PMTCT)

Application summary for module:

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Rationale for the selection:
eMTCT is a global commitment to which the GoK is a signatory. This high impact intervention is proven to significantly reduce the rate of new infections and guarantee an AIDS free generation. Kenya has made significant progress with this and is set to achieve its 2015 targets through ensuring that the unmet contraceptive need is eliminated, 90% HIV testing is conducted and that efficacious ARV prophylaxis for PMTCT is above 90% for both women and children and families are supported to take up package of interventions. Note is made that the Prongs 2 and 4 have been selected for this module. Prong 1 is covered by the existing and planned prevention initiatives for the general population. Prong 3 is covered under the treatment module in view of the change in guidelines to Option B+. The required additional funding for PMTCT has been captured under the ART module in view of the change in guidelines.

Prioritized Interventions:

1. **Prong 2: Prevention of unintended pregnancies**
   - **Allocation:** $ 492,000
   - **Target population and geographic scope:**
     Women 15-49 years of reproductive age will be the target for this intervention. Geographic scope will be national. The young women will be targeted in PMTCT through the prevention of unintended pregnancies by education on Family planning use and safety.
   - **Implementation approach**
     There will be a move to integrate FP services, PMTCT, reproductive health care, TB screening and maternal and child health services in all health facilities. Other key activities will include:
     - Capacity building of health care workers and clients on FP use and safety within the HIV context.
     - Developing and printing of reproductive health basic screening tool, IEC materials and job aids targeting FP.
     - Sensitization of health care workers on FP including contraceptive /ARV Pharmacovigillance.
     - Commodity procurements of FP materials will be leveraged from existing FP investments in the country.

2. **Prong 3: Preventing vertical HIV transmission**
   - **Allocation:** $ 8,737,200
   - **Target population and geographic scope:**
     Target population will be HIV positive pregnant and lactating women, HIV exposed infants.
   - **Implementation approach**
     Implementation will be as in the national eMTCT guidelines with the adoption of the Option B+ approach. These funds were earmarked under the HIV Phase II grant for the procurement of commodities and trainings for health care workers on skilled delivery of HIV positive pregnant women. Other support activities are covered under the ART budget.

3. **Prong 4: Treatment, care & support to mothers living with HIV & their children**
   - **Allocation:** $ 1,204,926
   - **Target population and geographic scope:**
     Target population will be pregnant and lactating women, HIV exposed infants, HIV infected infants <2 years. Geographical scope will be National.
Implementation approach

Implementation will involve innovative approaches to ensure retention of mother-baby pairs throughout the postnatal period until discharge from the PMTCT program. Use of technology, training of health care workers across private and public sector, scale up of Kenya mentor mother program, engagement of PLHIV and communities are some of the other key interventions to accelerate progress. Other specific activities will include:

- Meaningful involvement of PLWHA and communities in supporting PMTCT outcomes through training of community health volunteers, peer educators and lay counsellors and support stipends and transport for community health volunteers, peer educators, mentor mothers and lay counsellors.
- Leverage commodity procurements for EID including DBS bundles, and lab reagents in the Round 10 Phase II grant
- Support Mother–baby pair retention in care through scale up of Electronic Medical Registry (EMR) and m-health for eMTCT to support client, lab, facility and DHIS communication
- Support DBS transportation and results delivery
- Revision, printing and dissemination of immunization permanent register to capture EID data
- Enhance psychosocial, nutritional support & safe infant feeding practices through recruitment and facilitation of mentor mothers for 100% FTE

Module 6: Treatment, care and support (HIV)

Application summary for module:

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Rationale for the selection:

Antiretroviral therapy remains a cornerstone in the control of HIV. The Kenya AIDS strategic framework (KASF) 2014/15 -2018/19 identifies provision of HIV Care and treatment for people living with HIV as one of the major strategic areas in the HIV response. This module is selected to contribute towards bridging the huge treatment gaps occasioned by the change in treatment guidelines in the country and particularly the gaps in treatment for children. The module also seeks to maximize the potential of the private sector as a partner in the provision of quality treatment services in Kenya.

Prioritized Interventions:

1. Pre-ART care
   Allocation Amount: $310,345

Target Population:

This intervention targets persons living with HIV including children, adolescents and adults. It will be limited to selected high burden health facilities. To improve treatment adherence among children and adolescents, support groups will be targeted for treatment literacy trainings for high defaulters and capacity building of caregivers including parents and teachers in selected areas.

Implementation Approach:

Peer support mechanisms are effective in supporting linkage to HIV care services, adherence and retention in HIV care services. In Kenya various peer support approaches have been successfully and effectively employed. The key activity in this intervention will be:

a) Recruitment of peer educators in selected high burden facilities to improve linkage to care and treatment services. These will be based at health facilities and will work at facility level to identify clients for linkage to care and will also provide follow up at both facility and community level. The peer supporters will also serve to provide adherence support to patients and track patients who default or get lost from care.
2. **Antiretroviral Therapy (ART)**

**Allocation amount:** $ 104,615,410

**Target Population and Geographic Scope:**

The target population is people living with HIV in need of ARVs as determined by national eligibility criteria. This includes all children less than 10 years, pregnant women, TB HIV co-infected patients, HIV/HBV co-infected patients and positive partners in serodiscordant relationships regardless of CD4 count and for all aged above 10 years with CD4 count of 500 cells. This includes key populations and adolescents.

Geographic scope: The procurement and distribution of ARVs for treatment will cover all clinics providing ART services for walk-in cases nationwide. Capacity building of services providers will also be provided nationwide as a complement to capacity building activities earmarked in the Round 10 phase II grant. However, the component of treatment support for key populations will focus on 3 counties with high burden of key populations namely Nairobi, Kisumu and Mombasa.

**Implementation approach:**

*Adolescents and Adult ART:*

This intervention will include support to ensure commodity security for persons on ART and capacity building of service providers to scale up care and treatment and provide quality treatment services. The key activities in this intervention will include:

a) New funding will support procurement of ARVs for children, adolescents and adults including pregnant women on Option B+ - 393,051 in 2015/2016, 393,051 in 2016/2017 and 282, 532 in July-December 2017

b) Training of regional mentorship teams on the advanced HIV Clinical Course (AHCC)

c) Training of service providers on dealing with key populations in selected existing public treatment centers in 3 counties (Nairobi, Kisumu and Mombasa)

d) Support recruitment of peer counsellors for KPs in high volume ART public government facilities in 3 counties (Nairobi, Mombasa, Kisumu)

e) Existing funds in the approved Phase II grant will be utilized as approved in the attached grant documents.

*Pediatric ART*

f) Scale-up of ART provision for pediatric patients through 1) building capacity for paediatric ART treatment as part of the AHCC program 2) Reach more children through child health clinics (immunization & RMNCH) that also provide Option B+ 3) All HIV-exposed infants will be offered routine DNA PCR testing at the 6-week immunization visit, or at the earliest opportunity for infants seen after 6 weeks of age 4) PITC for children who present sick and/or malnourished at health clinics.

g) The pediatric ART program will leverage on the rollout of Option B+ in RMNCH/ PMTCT clinics with high yield. Capacity will be built to upgrade these high yield facilities to provide integrated RMNCH, PMTCT and pediatric ART services.

h) Furthermore, ART eligibility for children has been adjusted to include all children with HIV 10 years and below irrespective of CD4 count. This eligibility criteria will markedly increase pediatric ART coverage as those who are already on pre-ART care will be absorbed into ART care, while all newly identified children with HIV will immediately be initiated on ART.

**Above Allocation: $ 95,815,950**

**Target Population & Geographical scope**

Geographical scope for the above allocation amount will be nationwide coverage.

**Implementation Approach:**

This will be similar to the allocation amount but the scope will be geared towards achieving national targets. This is a full expression of need for the Kenya ART program.

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3. **Treatment Adherence**
Target Population and Geographic Scope:
This intervention targets children, adolescents and adults in care and Treatment. Some activities will be implemented nationally while others will target selected high burden counties and facilities.

Implementation Approach:
Enhancing Treatment literacy for patients is expected to empower patients and enhance adherence and retention on ART. This will target both patients and care givers of children living with HIV. The capacity building of service providers to manage and provide care to adolescents living with HIV will improve provision of adolescent friendly services. The support towards these activities will be complemented by funding from other sources including PEPFAR and the UN agencies to achieve a national coverage. The specific activities include:

a) Support treatment support group meetings for 10 support groups of PLHIV identified have high failure and defaulting rates. This activity will be driven by networks of PLHIV
b) Promote patient literacy, psychosocial support and legal and human rights literacy and advocacy for care and treatment services through development of literacy materials
c) Capacity building of care givers to support treatment adherence and retention for children
d) Adolescent package of care training for HCWs in 9 high burden counties (Nairobi Homa bay, Kisumu, Siaya, Migori, Kisii, Nakuru, Kakamega, Mombasa, Kiambu). The MOH developed a national package of care for adolescents. This will be used to train service providers in selected counties.

4. Treatment Monitoring
Allocation Amount: $ 38,259

Target Population:
This targets children, adolescents and adults living with HIV and in care and on antiretroviral therapy receiving care in the private sector.

Implementation Approach:
Treatment monitoring including HIV Drug resistance monitoring and adverse drug reaction monitoring are currently covered in the existing HIV SSF grant according to national guidelines. In addition PEPFAR is currently providing support for viral load monitoring (all HIV-infected children, adolescents and adults initiating ART (1st, 2nd or 3rd line ART regimens) receive a viral load test 6 months following ART initiation, at 12 months and thereafter one viral load test per year) that includes procurement and distribution of reagents. This application is innovative as it focuses on support for the private sector service providers. The private sector contributes to almost 50% of overall health care delivery. There is lack of clarity on the needs, services provision and quality of care provided in the private health facilities. The specific activity here will involve an assessment of treatment services in the private sector as a precursor to the design and implementation of a quality improvement program for the private sector.

5. Other interventions for treatment – Care & support for PLHIV
Allocation Amount: $ 7,489,785

Target Population:
PLHIV within the continuum of care in 50 high prevalence districts

Implementation Approach:
The funds earmarked in the signed HIV phase II grant are for provision of SRH and MCH services to PLHIV in 50 high prevalence districts and provision of nutrition support to PLHIV in 50 target districts.

Module 7: TB Care and Prevention

Application summary for module:
Kenya Ministry of health: Guidelines on use of antiretroviral drugs for treating and preventing HIV infection, June 2014
Rationale for the selection:
Kenya was the first country in the African region to achieve WHO targets of case detection rate and treatment success rates of new smear positive pulmonary TB cases. Treatment success continues to be a hallmark of the program, with rates among new smear positive cases averaging over 88% among HIV negative patients, 82% among PLHIV, and about 68% among those treated for MDRTB.

Within the context of a newly devolved health system, the goal of the 2015-2018 NSP is to accelerate the reduction of TB, leprosy and lung disease burden through provision of people-centered, universally accessible, acceptable and affordable quality services in Kenya. This module is selected to continue investments at sustaining the gains made in TB care and prevention and to increase the scope of achievements over the application period.

Prioritized Interventions:
1. Case detection and diagnosis
Allocation amount requested: $8,783,955

Target population & geographic scope:
Population:
All estimated adults and children suspected of TB infection. Target population will also include key affected populations – prisoners, urban slum dwellers; health care workers, diabetics, uniformed service personnel, migrant populations, contacts of TB patients and people living with HIV.

Geographical scope: This intervention will be implemented across the country in all TB diagnostic and treatment health facilities.

Implementation approach:
   a) Procure and distribute Consumables for AAFB & LED microscopy
   b) Capacity building for HCWs on childhood TB; laboratory diagnosis of TB; EQA of TB diagnosis & management of TB
   c) HIV testing for TB suspect cases and linkage to HIV Care and treatment services
   d) TB screening in MNCH settings as part of an integrated service
   e) TB screening in diabetic clinics
   f) Symptom-based screening for TB in children and linkage to care and treatment
   g) Contact screening

Expected Impact:
More people will know their TB status leading to early initiation of treatment, cure, and reduction in transmission and eventual decline in overall TB incidence, prevalence and mortality.

Above allocation: $973,836
The above allocation being requested will expand scope of the case detection intervention and help the program attain national targets of 83% and 85% in 2016 and 2017 respectively.

Kenya is estimated to have 20% of the estimated case being undetected. Efforts are being made to increase detection among these missed cases hence the increased case detection rate in the NSP. The above allocation will help to intensify efforts towards detecting the missed cases.

2. Treatment for susceptible TB
Allocation amount requested: $6,083,156

Target population & geographic scope:
This intervention targets the entire estimated population in need for TB treatment, country wide.

**Implementation Approach**

a) Provision of uninterrupted quality assured first line adult and pediatric TB drugs.

b) Provision of therapeutic feeds for malnourished TB patients including paediatrics

**Expected Impact**

This will reduce the incidence and mortality of TB in the population.

**Above Allocation: $1,287,930**

The above allocation amount will enable us achieve our NSP targets in years 2 and 3 where there is a gap.

3. **Engaging all care providers**

Allocation amount requested: $ 67,886

**Target population and geographic scope**

Urban centres in all the counties with thriving private health facilities

**Implementation approach**

This intervention will be implemented through the Public-Private –Mix approach in all the counties’ urban areas where the private sector is significantly present. The activities under this intervention will include:

a) Supporting the national PPM TWG to hold annual PPM meetings

b) Support annual county PPM stakeholders meetings across the 47 counties

c) Print recognition certificates and plaques for best performing private health facilities in all the counties

d) Hold annual national PPM workshop to disseminate PPM norms and standards, practices reporting systems and review progress

e) Development of peer review tools

f) Emphasis TB – HIV integrated service delivery through the public private partnerships.

**Expected impact**

Achieving a 25% increase in number of TB cases notified by the private sector from 19,134 cases in 2013.

4. **Community TB care delivery**

Allocation amount requested: $ 1,230,502

**Target and geographical scope**

Target population will be TB suspect cases in community settings in priority counties defined by the epidemiologic cluster.

**Implementation approach**

Through this funding, community interventions will be scaled up in priority counties based on epidemiologic clusters and especially rural areas by using the new WHO ENGAGE TB approach. Implementation will vary according to epidemiologic clusters viz:

a) Defaulter tracing – This will be actively conducted in 23 counties where treatment success rates in 2012 were below the national target of 88%.

b) Active case finding, with county-based tailoring of the modalities and target groups in 16 counties with CNR < 175/100,000

c) Systematic Contact investigation for 1) all child contacts of patients with TB 2) all household contacts of all bacteriologically confirmed Tuberculosis and, 3) household contacts of MDR TB patients

d) To address barriers to access, the NLTP will engage community structures to provide awareness on TB and HIV diseases. Also, ACSM approaches will be utilised to mitigate stigma and discrimination through targeted TB advocacy and health promotion activities.
e) The NLTP will implement innovative approaches aiming at increasing access to services for key populations such as slum dwellers, prisoners and children of TB patients and contacts. These approaches include targeted ACSM messages for each key population that will raise awareness on TB and HIV diseases.

**Expected Impact:**

Reaching the unreached TB cases, stigma reduction leading to patients coming forward for investigation and care. Supporting treatment to improve treatment outcomes.

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5. **Key affected Populations**

**Allocation amount requested:** $897,427

**Target Population and Geographic Scope:**

The country plans to reach marginalized, high-risk and under-served populations, closing the case detection gap by special initiatives with adapted diagnosis and treatment models. The target populations are healthcare workers, prisoners, uniformed service personnel, migrants, cross border communities and urban slum dwellers.

**Implementation Approach:**

Key population specific interventions will be implemented within their specific geographical areas. These include:

a) Interventions for prisoners and people in other congregate settings include
   - Train 480 prison wardens on a comprehensive service package (TB screening upon entry to prisons and health education)
   - Print TB screening tools for prisons
   - Ensure DOT for all inmates diagnosed to have Tuberculosis
   - Conduct 15 TB IPC training targeting prison staff
   - Conduct TB infection risk assessment in 15 prisons

b) Interventions targeting the uniformed service
   - Introduce annual TB screening as part of routine/periodic wellness

c) Interventions targeting migrants and refugees
   - Introduce annual TB screening as part of routine/periodic health checks in refugee camps and known migrant location
   - Provide linkage to care and prevention services

**Expected Impacts**

To improve case notification among the high risk groups.

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**Module 8: Multi-Drug Resistant TB (Diagnosis and treatment)**

**Application summary for module:**

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### Rationale for the selection:

The midterm review conducted by the TB program identified low case notification for MDRTB as the main gap. According to the NSP 2014-2018, the country target is to increase MDRTB case notification from the current 16% (based on the current estimated prevalence of 2,780) to 75% by 2018. This module is selected to address this gap.

### Prioritised Interventions:

The following interventions were selected in priority order

1. **Case detection and diagnosis (MDR-TB)**
   - **Allocation amount:** $290,567

   **Target population:**
   All presumptive MDR-TB cases across the nation according to national guidelines

   **Implementation approach:**
   - a) Case detection will be increased through strengthening the surveillance system and maintenance of the culture and DST services in the country.
   - b) In collaboration with the development and implementing partners such as PEPFAR/USAID Xpert MTB/Rif technology will be rolled out in all counties with high workload and high HIV burden. Training, supervision and mentorship of health care workers on the use of new diagnostic technologies. This will leverage on the planned procurement of consumables and supplies in the TB/HIV module.
   - c) Widening the inclusion criteria to enhance case detection (to include children, all retreatment cases, all smear negative cases and all smear positives at month 2)
   - d) Reducing time to diagnosis of DRTB through building the capacity of HCWs on diagnosis and management of DR-TB

   **Above Allocation Amount:** $1,161,287
   This is requested as a full expression of need required for achieving WHO and NSP targets of a cumulative 700 in year 1, 1373 in year 2 and 2018 in year 3 case detection targets for MDR-TB.

   **Expected Impact**
   Intensified case detection leads to early detection of MDRTB hence reducing transmission and mortality.

2. **MDR-TB Treatment**
   - **Allocation amount requested:** $3,453,213

   **Target population:**
   According to the NSP 2014-2018, the country targets to attain a treatment success rate of 80% among all DRTB patients from the current 67% by 2018. Geographic scope is national.

   **Implementation Approach**
   This activity will be implemented nationally and the activities will include:
   - a) Provide second Line Drugs for all the DRTB patients including children
   - b) Support quality Programmatic Management of DR-TB (PMDT) through;
     - Monitoring of side effects of drugs and availing eligible patients auxiliary drugs
     - Baseline and follow-up investigations
     - Audiometry
     - Patient psychosocial support

   **Above Allocation Amount:** $4,466,156
   This is requested as a full expression of need required for achieving national treatment targets for MDR-TB.
**Expected Impact**
To reduce transmission, reducing further TB resistance mortality and incidence

3. **Prevention of MDR-TB**  
**Allocation amount requested:** $1,345,137

**Target population:** All Health facilities offering TB services

**Implementation Approach:**
Implementation of infection prevention control at all levels through:
- Capacity building of HCW
- Provision of protective gear and other IPC commodities
- Review of hospital preparedness for infection prevention and control
- Maintenance of the MDR TB isolation facility
Expected Impact
Reduction in incidence and morbidity from MDR TB in the community.

Module 9: TB & HIV joint programming
Application summary for module:

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Rationale for the selection:
For improved efficiencies and better public health impact, improving joint TB and HIV programming has become very necessary. This module is aimed at scaling up joint programming activities and effectively addressing morbidity and mortality related to co-infection with the two diseases.

Prioritised Interventions:

1. **TB/HIV Collaborative interventions**
   Allocation amount: $229,598

   Target population & Geographical scope:
   TB/HIV stakeholders at National and across all 47 counties

   Implementation approach
   Recently Kenya adopted a devolved government system that mandated the 47 county governments to deliver health services. The reorganization of government structures calls for strengthening of coordination between and within the county and national governments. The 47 newly developed county TB/HIV coordination committees that bring together TB/HIV stakeholders within the counties will be supported to meet on quarterly basis as per the national TB HIV guidelines. In addition biannual national TB HIV stakeholders meeting will be supported by partners to bring together players from the county and national level to discuss the progress in each of the counties and advocate for resource allocation for TBHIV activities.

   Expected Impact
   Coordinated mobilization of resources and in integrated implementation of the planned activities leading to efficient utilization of resources

2. **Collaborative activities with other programs and sectors**
   Allocation: $4,914,612

   Target population and geographic scope
   This intervention will target all TB and HIV susceptible adults and children in a phased geographic approach

   Implementation approach
   a) **Scale up of Isoniazid Prevention Therapy (IPT):** Kenya will roll out isoniazid preventive therapy for PLHIVs (including prisoners and other key populations) and children aged below 5 year exposed to smear positive TB on a national scale. The 21 high burdened counties will be prioritized in the first year followed by 19 medium burdened counties. The support will be directed towards procurement and distribution of isoniazid and pyridoxine. Training of health care providers will be supported by other implementing partners

   b) **Increasing TB case detection:** Funds from this grant will be used to support TB case detection through intensified TB case finding among people living with HIV, screening for TB in specialized clinics including diabetes clinics in MNCH in and out patient departments as well as drop in clinics for Key...
populations. In addition, access to new diagnostic tools (GeneXpert test) will be expanded through procurement of additional GeneXpert machines and related consumables. These machines will be situated in high burden counties with notable high laboratory workload. Due consideration will be given to the need to maximize efficiencies by monitoring the through-put of machines and maintenance capacity of the proposed sites before deployment.

c) **Scale up Infection prevention and Control (IPC):** This grant will support IPC in congregate and health care setting. A multi-sectoral stakeholder meeting involving non-medical stakeholders including the ministry of housing, prisons authority, ministry of education among others to lobby for support for IPC activities as well as advocate for infrastructural improvement and standards to meet TB IPC.

d) **Increasing ART uptake and integration:** Gaps in ART uptake will be identified through available surveillance data and health care workers in counties with low ART uptake trained on TBHIV integration and provision of ART. Support will be provided to facilitate provision of ART to TB patients in all sites that provide ART for children, adults and pregnant women. Consultative meeting will be held with other units including MNCH, non-communicable diseases, and those dealing with Key populations to revise tools and ensure that TBHIV indicators are captures.

e) **HIV testing to all TB patients** and provision of CPT and ART for those co-infected patients in all clinic settings.

f) **Address noted barriers to access** to these services the program will amongst others ensure the following:
- Integration with other health services: TB prevention, care and treatment will be integrated with other health services through a co-location initiative –the "one stop shop approach".
- The limited access to HIV and TB services by children has been linked to inadequate skilled personnel for treatment and also limited diagnostic capacity to identify children with HIV and TB infection. To address this barrier to access, the program will actively build capacity of health workers on pediatric diagnosis for HIV and TB. It will also build infrastructure capacity of health facilities including investments to strengthen the EID network and the use of GeneXpert technology.
- Strengthen the TB/HIV M&E system to track the progress with the collaborative activities.

**Above Allocation: $1,177,142**
The above allocation amount will be required for the following activities:
- Print contact tracing registers
- Print ICF/IPT cards
- Print IPT patient appointment cards
- Print IPT register
- Support Multi-sectoral stakeholder’s forum including other non-medical stakeholders (such as Ministry of Housing, prison authority and ministry of education).
- Sensitize healthcare workers from 2 facilities per county in 16 counties to initiate screening for TB (DM clinics, RMNCH, in-patient and outpatient)
- Procurement of some GeneXpert machine consumables

**Expected Impact:**
Early case detection, treatment reducing TB incidence, morbidity and mortality. Enhanced integration, ownership of TB services.
Module 10: Health information systems and M&E

Application summary for module:

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Above Allocation</th>
<th>Full Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,891,491</td>
<td>$0.00</td>
<td>$10,891,491</td>
</tr>
</tbody>
</table>

Rationale for the selection:
The HIV and TB programs require quality data to guide program implementation and decision making. This module is selected to address the gaps noted in the analysis of the national health information systems and to provide the necessary data support to the management of the Malaria, HIV and TB programs.

Prioritised Interventions:

1. **Routine reporting**
   - **Allocation:** $3,738,462
   - **Target Population & Geographical scope:** National, County and sub-county levels
   - **Implementation Approach:**
     - **HIV:** This investment takes into cognizance the available funding under the Round 10 phase II grant for routine reporting purposes and will be complementary for the purposes of patient adherence & survival (tracking loss-to-follow-up); Data collection and reporting from other service providers (communities and civil society); Reporting on distribution of commodities such as condoms, routine reporting of TB/HIV collaborative activities and infection control measures and routine data quality audits once every year.
     - **TB:** The implementation involves provision of reporting tools at all levels including Tablets for implementation of TIBU for the TB program, and integration of reporting tools into DHIS to capture key indicators for the two diseases. Other activities to be supported will be routine R & R/ e-TB register; Data collection and reporting from other care providers (PPM, communities and civil society); Routine reporting of TB/HIV collaborative activities and infection control measures; Surveillance systems standards & benchmarks checklist applied; case and death notification and vital registration systems. Also there will be joint technical assistance to counties and sub county levels on recording and reporting for the three diseases. There will also be capacity building for health care workers on recording, reporting, data cleaning and annual routine data quality audits.
     - **Malaria:** This investment will complement existing resources under the malaria grant for routine systems for reporting on microscopy and RDT tests and anti-malaria treatment; reporting on stock-outs; data collection and reporting from other care providers (private, communities and civil society); reporting on ITN/LLIN distribution and IRS.

2. **Analysis, review and transparency**
   - **Allocation Amount:** $5,714,974
   - **Target Population & Geographical scope:** National and county level
   - **Implementation Approach:**
     - The implementation will involve holding stakeholder meetings at the national and county level for quarterly data review that will include Malaria, TB, HIV and HMIS focal persons together with M&E national officers.
     - The investment will also support mid-term review reviews of the TB and HIV national health strategies.
• A ring fenced sum will be provided to support operations research within the HIV, TB, and Malaria control programs. The research agenda will be developed within the joint Malaria & TBHIV Interagency Coordinating committees (ICC).
• National estimates for HIV will also be supported to develop impact and outcome data for the HIV program
• Capacity building of stakeholders on the use of data for management and decision making will also be supported.
• Data management manuals will be developed and disseminated at all levels of implementation.

3. Surveys
Allocation Amount: $700,654
Target Population & Geographical scope:
National
Implementation Approach:
This allocation is to fund the generation of evidence for the improvement of the national disease programs. The following are proposed:
TB:
• Carry out an assessment of the impact of Xpert MTB on diagnosis of TB (as per the national protocol)
HIV: Assess barriers to treatment adherence in some selected counties; support for polling booth Survey (PBS) for Key Populations; Support for IBBS survey
All: Capacity building and mentorship programs for health care workers to promote the culture of research among health care workers.

4. Vital registration system
Allocation amount: $737,401
Target Population & Geographical scope:
National.
Implementation Approach:
This is a national intervention that aims to improve the vital registration for key events in order to reliably estimate mortality for Malaria, TB and HIV among other health conditions. Planned activities include:
• Build capacity of health care workers on ICD 10.
• Hold two mortality data analysis workshops annually.

Module 11: Service Delivery
Application summary for module:

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Above Allocation</th>
<th>Full Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,741,293</td>
<td>$3,282,715</td>
<td>$6,024,008</td>
</tr>
</tbody>
</table>

Rationale for the selection:
The service delivery module is an important component of Health Systems Strengthening. This particular investment seeks to address noted challenges with the laboratory infrastructure for the support to delivery of HIV, TB, and Malaria and RMNCH services in Kenya. These laboratories will act as reference laboratories for HIV, TB and Malaria and lead in quality assurance.
Under the existing HIV grant, there will be a baseline assessment to inform renovation actual bill of quantities for pre-selected facilities earmarked under this grant, current state of infrastructure, capacity in terms of personnel number and levels of training, status on WHO Stepwise accreditation and status of equipment are consideration among others. MOH in collaboration with NASCOP carried out integrated GIS -ART service mapping that had Clinical, Laboratory and Pharmacy component the service report is in the final stage and this shall be used to inform selection of the priority Laboratories targeted for renovation. Selection of 17 was informed by HIV/TB and Malaria needs and considered support from the World Bank and CDC. The labs will be selected based on reference population of ART Viral load need at 1.2 million population, numbers for TB diagnosis and malaria tests will add to this. It’s expected that all specialized test shall be done in this Laboratories through a standardized referral system for specimens through courier service to cover the whole country. Unavailability of Laboratory should be not be misconstrued to mean lack of services; Laboratory services shall be accessed through a network.

Prioritised Interventions

1. **Improving Laboratory Systems**
   
   **Allocation Amount:** $1,912,301
   
   **Target Population & Geographical scope:**
   
   24 network laboratories nationwide.

   **Implementation Approach**
   
   - Procurement, installation, training, commissioning and maintenance of LIMS

2. **Improving Laboratory service delivery infrastructure**
   
   **Allocation Amount:** $828,991
   
   **Target Population & Geographical scope:**
   
   24 network laboratories nationwide in level 4 and 5 health facilities

   **Implementation Approach**
   
   a) Strengthen lab networking to support integrated specimen referral system (training on integrated sample referral; procurement of temperature monitoring equipment for 20 labs and remote sensors for 40 facilities supported by each of the labs)
   b) Renovation of 5 laboratories

   **Above Allocation amount:** $3,282,715
   
   **Target Population & Geographical scope:**
   
   24 network laboratories nationwide in level 4 and 5 health facilities

   **Implementation approach:**
   
   a) Strengthening environmental and biosafety controls in network testing labs (installation of CCTV; procurement of biometric card system, class 2 biosafety cabinets; safety centrifuge, fire safety system and emergency shower and eye wash station) – 973,000
   b) Procurement of EQA panels for 35 labs
   c) Quarterly QA meetings
   d) Renovation of 19 laboratories

Module 12: Procurement supply chain management (PSCM)

**Application summary for module:**

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Above Allocation</th>
<th>Full Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount</td>
<td>2,947,911</td>
<td>10,543,678</td>
</tr>
<tr>
<td>----------</td>
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</tr>
</tbody>
</table>

Rationale for the selection:
Over 80% of the GF investments in the country are spent on procurement of health products for TB, HIV and Malaria programs hence the need to strengthen their procurement and supply chain management systems. The prioritized interventions and implementation approach are provided below. A detailed activity plan is attached to this application.

Prioritised Interventions:

1. **PSM infrastructure and development of tools**
   **Allocation amount:** $721,593

   **Target population:**
   National supply chain management systems in Kenya including counties, sub counties and health facilities

   **Implementation approach:**
   a) Harmonization of LMIS systems for RMNCH; TB, HIV and Malaria programs and integration into DHIS
   b) Printing of RMNCH,TB, HIV and Malaria program LMIS tools
   c) Support upgrading/improving of storage facilities at sub-county level

   **Above Allocation amount:** $9,540,230

   **Implementation approach:**
   Support upgrading of national storage/warehousing capacity at KEMSA. Establishment of the new KEMSA warehouse works towards strengthening the performance of priority health systems components that are relevant for effective delivery of HIV/AIDS, TB and malaria programs, including the collaborative TB/HIV activities and other essential medicines. The new warehouse will ensure that program supplies are handled effectively and efficiently whilst noting that most of the program supplies require emergency response which will be realized in a central warehouse. Establishing the warehouse offers numerous advantages as stated in the annex, however the warehouse is a resource intensive project yet we have minimal available resources for HSS.

2. **Operationalization of procurement and supply chain management system**
   **Allocation:** $2,276,690

   **Target population & Geographic Scope**
   National supply chain management systems in Kenya including counties, sub counties and health facilities

   **Implementation Approach:**
   a) Training of county MOH on commodity management
   b) Support periodic redistribution of TB, HIV, Malaria and RMNCH commodities at the county level
   c) Support integrated national and county level PSM support supervision
   d) Develop and disseminate guidelines and M&E framework for PSM for TB, HIV, Malaria and RMNCH commodities
   e) Conduct joint Post Market Survey (PMS) for TB, HIV, Malaria and RMNCH medicines every 3 years
   f) Conduct joint annual sampling and quality testing for TB, HIV, Malaria and RMNCH commodities
   g) Training of sub county staff on pharmacovigilance

   **Above Allocation amount:** $1,003,448

   **Target population & Geographic Scope**
   National supply chain management systems in Kenya including counties, sub counties and health facilities

   **Implementation Approach:**
a) Support monthly commodity security meetings at each county
b) Equip the PPB PMS lab with Four HPLC machines

Module 13: Community Systems Strengthening

Application summary for module:

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Above Allocation</th>
<th>Full Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 4,848,138</td>
<td>$ 265,769</td>
<td>$ 5,113,907</td>
</tr>
</tbody>
</table>

Rationale for the selection:

Communities are at the foundation of affordable, equitable and effective health care. In order to reach the unreviewed and to find TB and HIV patients early in the course of their illness, a wider range of stakeholders already involved in community-based activities needs to be engaged. These include the nongovernmental organizations (NGOs), community based organisations, women groups and other civil society organizations (CSOs) that are active in community-based development, particularly in primary health care, and maternal and child health, but have not yet optimally included TB and HIV in their priorities and activities.

This is in line with the overall goal of Kenya’s Community Health Strategy, which is to enhance community access to health care in order to improve individual productivity and thus reduce poverty, hunger, child and maternal deaths, as well as improve education performance. In addition, within Kenya Vision 2030 policy, delivery of community based services is a flagship project. As such it will be easier to leverage and effectively use government support for healthier communities.

Still, strong linkages between facilities and the community are essential to ensure uptake, retention and continuum of care. This should be built on a strong foundation of documentation of community based activities and ensuring it is reported in the national health information system. Communities can be engaged through civil society organizations, community health volunteers and peer leaders of PLHIV, key populations, people with disabilities and other priority populations as key stakeholders of TB and HIV prevention. Investment in Community Health Systems outside being a social enabler for uptake of HIV and TB services will also ensure the following:

a) Build the capacity of community groups, organizations, networks and other actors
b) Help establish functional and sustainable institutions
c) Ensure greater community involvement in delivering services at community level
d) Improve coordination among community actors at the local and national levels
e) Improve service quality by institutionalizing consumer involvement in monitoring the performance of services
f) Greater community participation in relevant policy and advocacy forums around health, gender, equality and human rights.

A cross cutting implementation approach for all prioritized interventions will entail that each prioritized sub county will be covered and supported by one community actor (NGO/FBO/CBO including KP organizations) in collaboration with related county/sub-county health team. A narrative on the proposed implementation approach by the two non-state PRs is attached to this application.56

Geographic scope of all interventions:

The Tuberculosis National Strategic Plan 2015-18, Kenya AIDS Strategic Framework (2014-19) and Kenya HIV Prevention Revolution Road Map proposes shifts in TB and HIV prevention paradigms from national approach to geographical (cluster) approach. This particular evidence driven approach will be employed under this module to cater for all the three diseases. 3 counties (Homa Bay, Siaya and Kisumu) have been prioritized for this module on the basis of their relatively high burdens for HIV, TB and malaria. These counties have HIV prevalence and have been classified as hyper endemic counties with over 15% prevalence rates (The Kenya Revolution Road Map, 2013, page 17) and also have some of the highest HIV/TB confection rates. These counties are also along the lake with fishing being one of the main economic activities. The HIV Sero-
KRCS, AMREF: A narrative on the implementation arrangement for Community Systems Strengthening module.
Behavioural study among fishing communities in Lake Victoria in Kenya 2010, showed that the prevalence of HIV among fisher folks was 26.2% (about 5 times more than the national prevalence).

<table>
<thead>
<tr>
<th>County</th>
<th>Total Population</th>
<th>HIV prevalence</th>
<th>No of PLHIVs</th>
<th>TB/HIV co- infection rate (National average is 37%)</th>
<th>Malaria Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homa Bay</td>
<td>1,053,465</td>
<td>25.7%</td>
<td>159,970</td>
<td>73%</td>
<td>Endemic</td>
</tr>
<tr>
<td>Siaya</td>
<td>920,671</td>
<td>23.7%</td>
<td>128,568</td>
<td>68%</td>
<td>Endemic</td>
</tr>
<tr>
<td>Kisumu</td>
<td>1,059,053</td>
<td>16.3%</td>
<td>134,826</td>
<td>67%</td>
<td>Endemic</td>
</tr>
</tbody>
</table>


**Prioritised Interventions:**

1. **Social mobilization, building community linkages, collaboration and coordination:**

   **Allocation amount:** $1,649,931

   **Target population & geographic scope**

   Target population will be the Community Units. Geographical scope is as described above.

   **Implementation approach**

   a) Support the functionality of the already established but non-functional community units to include support for community dialogues, community health action days, CHV feedback/review meetings, community health committees (CHC) meetings among others.

   b) Community Units will be supported to embark on demand creation for quality HIV, TB and Malaria health services

   c) Improving community referral and linkages backed by proper documentation and reporting. The CU and its members will be trained on specific disease modules which will equip them with knowledge on the different disease to support the referral and linkage component

   d) To further strengthen referral/linkage and coordination, a community mapping exercise will be conducted. It will encompass using a GIS method to map out key health referral sites including GBV sites, KP organizations/NGOs/CBOs/FBOs, community units and households

   e) CU members (community health volunteers) will be trained of communication skills, specific disease modules, HCBC, gender and human rights modules, stigma reduction among others

   f) The Community Health Committees (CHCs) which are the governing and management bodies of the CUs will be trained and mentored on programme management, volunteer management and mainstreaming of human rights and gender issues.

2. **Institutional capacity building, planning and leadership development in the community sector**

   **Allocation:** $2,918,376

   **Target population & geographic scope**

   Our target will be Community structures, groups and organizations providing integrated services for AIDS, Tuberculosis, Malaria and other health issues in the prioritized counties.

   **Implementation approach**

   a) 309 community groups and actors will be identified and sensitized on law enforcement and community leadership. The groups will be based on the number of CUs supported by the programme. This will be with the aim of strengthening their capacity on existing laws, accessibility to services and most importantly better leadership and governance.
b) The community actors (CBOs/NGOs) within the targeted counties will be trained on programme management, leadership, governance, Gender and human rights and M&E to enable them to support the programme and coordinating programme community activities including strengthening referral and linkage component which will ultimately lead to increased utilization of services at the facility level.

**Above Allocation: $46,790**

The above allocation amount if approved will support training of CSOs on programme management, leadership, governance and gender and human rights (This will enable them to support HIV, TB and Malaria interventions such as community mobilization, defaulter tracing, case detection etc. which will support high level interventions such as ART provision among others)

### 3. Community-based monitoring for accountability

**Allocation:** $279,832

**Target population & geographic scope**

Community structures, groups and organizations providing integrated services for AIDS, Tuberculosis, Malaria and other health issues in the three prioritized counties for this module.

**Implementation approach**

This intervention will involve the establishment of community based monitoring forum that takes the lead in the coordination of data and linkage to the DHIS systems of the Ministry of Health. This will involve facilitating monthly meetings that bring together the County Health Strategy Focal Person, the Head of CHVs and other community actors to be able to collate the data from the community groups based on the target’s and indicators as they relate to AIDS, TB and Malaria. These groups will have tools and instruments that will enable data collection and inclusion into DHIS data platform.

**Above Allocation: $218,979**

The above allocation amount if approved will support Community data management forums - CDMF (forums between the sub-county health officials-community strategy focal persons, HIV, TB and Malaria focal persons and the Community Health Extension Workers-CHEWs) to target 14 districts within the 3 counties which have functional CUs. These forums will complement the Community based monitoring forums and will provide a platform for the key sub county health officials to discuss the collated community data and support initiative of having the same community data streaming into the DHIS. In addition, the forums will provide these key officials with an opportunity to access community data in one sitting which will subsequently give them an opportunity to interrogate the data further as well as using it in decision making.

### Module14: Program Management

**Application summary for module:**

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Above Allocation</th>
<th>Full Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>$14,485,034</td>
<td>$0.00</td>
<td>$14,485,034</td>
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</tbody>
</table>

**Rationale for the selection:**

This module is a necessary module to address challenges with national and county level coordination, policy development and monitoring of policy implementation for the two diseases. The grant management component serves to ensure the grants will be adequately managed according to recommended Global Fund best practices.

**Prioritised Interventions:**

1. **Policy, planning, coordination and management**

   **Allocation amount:** $1,200,000
**Target population:**
National Level coordination structures (National, County and district level health structures)

**Implementation approach:**
This intervention will be implemented through the following approaches:

a) Ensure national TB and HIV policies and guidelines are revised according to current national response and international recommendations.

b) Ensure effective coordination among key stakeholders in implementing HIV and TB response through existing mechanisms such as thematic TWG.

c) Technical and financial support to effectively coordinate National and county level Multi Sectoral AIDS Committees

d) Ensure joint TB/HIV review meetings and supporting supervision to provide oversight to the regions and councils.

e) Advocacy to high level decision and policy makers to sustain the programs through media and consultative meeting.

f) Coordination of partnerships and networks for HIV and TB response at County and National levels

g) Joint TB and HIV Programme review meetings at the National and county levels

h) Dissemination of KASF and TB NSP to key stakeholders at the county and National levels

2. **Grant management**

**Allocation amount:** $13,285,034

**Target Population:**
PRs, SRs and sub-sub recipients (SSR) at National and sub-national levels.

**Implementation Approach**

a) Strengthening capacity of PR, SR and SSR on grant implementation. This investment will seek to bridge noted implementation and grant management capacity gaps of both the PR and SRs. It will also be used to cover other running costs for the PRs and SRs. This includes remuneration of staff under the grant (salaries and salary top up), capacity building for the staff, overhead running cost, review meetings, stakeholder forums and other oversight activities undertaken by the PRs. This is to enable them coordinate Global Fund activities efficiently and effectively up to December 2017.

b) Strengthening PMU capacity in terms of human resources, joint review, and planning of the disease programs.

3.4 **Focus on Key Populations and/or Highest Impact Interventions**

This question is **not applicable** for Low Income Countries.

For TB and HIV, describe whether the focus of the funding request meets the Global Fund’s Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle income country, describe how the funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

b. If the applicant is an upper-middle income country, describe how the funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

Kenya is classified as a low income country and this section is not applicable.
SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

This section requests information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers is essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the Country Coordinating Mechanism (CCM) can nominate one or more PRs, as appropriate given the country context.

### 4.1 Overview of Implementation Arrangements

For TB and HIV (including HSS if relevant), provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

- If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).
- If more than one PR is nominated, how co-ordination will occur between PR(s) for the same disease and across the two diseases and cross-cutting HSS as relevant.
- The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.
- How coordination will occur between each nominated PR and its respective sub-recipient(s).
- How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

---

| a) | The KCM endorsed three PRs namely the state PR (the National Treasury) and two non-state PRs (AMREF and Kenya Red Cross Society). This is aligned to the dual-tracking financing arrangement of the Global Fund.
| b) | Coordination is done both at the National level and county level. The KCM will coordinate the three PRs. The KCM retains the overall role of grant oversight through the technical committees. Kenya Coordinating Mechanism (KCM) is composed of different constituencies key among them the private sector, government, civil societies and communities. It is composed of technical committees with expertise in finance, programming and each disease component. These committees are then supported by ICCs of respective disease. Each of the disease program have an ICC which deliberate on the technical issues then consensus build at the joint ICC (Joint Malaria, HIV and TB ICC) for final approval by the KCM which is the overall oversight body. Three PRs will report to the KCM through ICCs at every quarter. The expected reports from the PR cover the program implementation in regards to financial management, realization of objectives and targets and adherence to grant conditions.
| c) | A gap analysis will be done to access the need of additional SRs to cover new targets and new interventions and an open competitive bidding process to follow to select the implementing partners. Considerations will be given to the existing SRs based on performance. The PR will enter into a legal bidding contract with the SRs. The contracts drawn will consider the Kenyan Laws especially on issues with respect to human rights and gender.
| d) | Each of the PR will have programme management unit (PMU) comprising of technical staff including M&E, Finance, programme management and logistics. This is to support the SR to gain quality project management, joint planning and risk planning and management. Each of the SRs is expected to report on a monthly basis to the PR and the PR organises for quarterly review meetings for the SRs and other stakeholders including participation by the Ministry Of Health.
| e) | Women organizations and people living with disease are encouraged to apply as SRs and each of the selected SR will be required to include this group during the implementation of the grant. These groups
have also been involved in designing minimum service package. They are also involved in decision making processes at KCM level and also in technical working groups. The Key populations are going to be trained and continue engagement as peer educators and Community Health Volunteers.

### 4.2 Ensuring Implementation Efficiencies

<table>
<thead>
<tr>
<th>Complete this question only if the CCM is overseeing other Global Fund grants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>From a program management perspective, describe how the funding requested links to any existing Global Fund grants, or other funding requests being submitted by the CCM at a different time. In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.</td>
</tr>
</tbody>
</table>

The current application has linkages to the existing grants for HIV and TB in Kenya. Specifically, the recently approved Round 10 Phase 2 grant for HIV has been taken into consideration to ensure that this current application provides complementary support towards bridging funding gaps in the National HIV response. A clear attempt has been made to ensure that duplication of costs is avoided.

Successes from the implementation of previous Global Fund grants will also be sustained.

An active process of leveraging resources from all Global Fund investments has been adopted in this application. Specific leverage opportunities identified include:

- **a) Human resources**: The existing workforce for implementation and management of previous Global Fund grants will be retained under same conditions to avoid the need to hire new hands and the potential loss of institutional memory for the programs.

- **b) Training**: Previous Global fund grants have invested significantly in the training of human resources for both the management and implementation of service delivery activities for both HIV and TB program in Kenya. It is critical assumption in this application that this human resource pool with capacities built have also been retained within the health workforce and will be utilized for implementation of planned activities in this application. Provision has only been made for refresher training. Training documents and job aids developed from the previous grant will be used to conduct such training activities as well as improve implementation capacities at the service delivery points.

- **c) Monitoring and Evaluation**: Investments towards strengthening the monitoring and evaluation systems for both disease program will be leveraged in this application. The existing HMIS including electronic platforms and tools will be used for this application. An active effort has been made to streamline activities in this application to ensure that there are no duplications.

- **d) Lessons learned from the implementation of the current grants and key findings and recommendations of programme reviews carried out will be used to inform implementation strategies for this grant.**

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### 4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

<table>
<thead>
<tr>
<th>For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.</th>
</tr>
</thead>
</table>

#### PR 1 Name
Ministry of Finance - National Treasury

- **Sector**

- **Public**

<table>
<thead>
<tr>
<th>Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

#### Minimum Standards

<table>
<thead>
<tr>
<th>CCM assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. National Treasury is the state PR. It has a PMU headed by the National Global Fund Coordinator.</td>
</tr>
</tbody>
</table>

**1. The Principal Recipient demonstrates effective management structures and planning**
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Answer</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)</td>
<td>Yes.</td>
<td>The National Treasury has the capacity and systems in place to conduct oversight of sub recipient. It has successfully provided oversight to SRs in previous grants.</td>
</tr>
<tr>
<td>3.</td>
<td>The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud</td>
<td>Yes.</td>
<td>The PR has effective internal control systems that have been in use with previous grants and have been regularly reviewed by the LFA. Internal and External audits are conducted on an annual basis. External audits are usually done by The Kenya National Audit Office (KENAO) and the reports are submitted to the PR for action.</td>
</tr>
<tr>
<td>4.</td>
<td>The financial management system of the Principal Recipient is effective and accurate</td>
<td>Yes.</td>
<td>The National Treasury rolled out the Integrated Financial Management Information System (IFMIS) for better public finance management, including Health and HIV related entities (e.g., Ministries of Health, NACC, NASCOP, TB unit). This feeds into the execution and monitoring process for effective oversight and coordination. In addition, the PR developed a financial management and reporting tool. The tool is populated monthly by the finance officers both at the disease programs and the principal recipient in order to capture expenditure and monitor the budget to facilitate reporting.</td>
</tr>
<tr>
<td>5.</td>
<td>Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</td>
<td>Yes.</td>
<td>The procurement agent (KEMSA) has adequate storage capacity at the central warehouses and also at regional warehouses.</td>
</tr>
<tr>
<td>6.</td>
<td>The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions</td>
<td>Yes.</td>
<td>The procurement agent does the distribution of commodities to the service delivery points based on the needs of those sites.</td>
</tr>
<tr>
<td>7.</td>
<td>Data-collection capacity and tools are in place to monitor program performance</td>
<td>Yes.</td>
<td>The PR utilizes National tools through the Ministry of Health (Sub recipient) to collect data from the facilities. The tools have well defined indicators that allow data collection and monitoring of routine activities.</td>
</tr>
</tbody>
</table>
These tools are available and periodically reviewed based on emerging data issues that affect the three diseases (TB, HIV and Malaria).

8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately.

Yes. The PR uses two functional systems i.e. DHIS and TIBU for routine reporting of program data. The systems cover the whole country and are available in all the 47 Counties. These systems are in tandem with the reporting tools which have clearly defined indicators for the three diseases.

9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain.

Yes. The PR through the disease programs and KEMSA have the capacity to comply with and monitor products quality in the supply chain. This is done by qualified personnel as the commodities are received at the warehouse from the supplier and at the facility level through sampling after distribution of the commodities.

### 4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

<table>
<thead>
<tr>
<th>PR 2 Name</th>
<th>Sector</th>
<th>NGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenyan Red Cross</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?

Yes

#### Minimum Standards

<table>
<thead>
<tr>
<th>CCM assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. The PR has successfully managed previous and current Global Fund grants. A robust tiered governance structure exists for planning and management of GF and other grants.</td>
</tr>
</tbody>
</table>

2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)

Yes. The PR has an effective structure that has successfully provided oversight to sub-recipients in previous and current GF grants. Specifically, a Program Management Unit (PMU), headed by a Deputy Secretary General for the Global Fund Grant is in existence. The PMU supported by 6 regional offices provide sufficient management and oversight to SRs and will apply same to this grant.

3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud

Yes. There are internal control mechanisms in place to ensure sound fiduciary practices. The Society undergoes internal audit reviews on a
quarterly basis which is conducted by the organization’s internal audit department according to the Internal Audit Plan of the Audit and Risk committee. In addition, annual external audits are conducted by independent external auditors for all the Society’s activities on yearly basis. This system has sufficed for the prevention of fraud and misuse of funds.

4. The financial management system of the Principal Recipient is effective and accurate

Yes. KRCS has detailed policies and procedures guiding its financial management and transactions including those for SRs. KRCS utilizes Microsoft Dynamics Enterprise Resource Planning (ERP) System to record, track and report all financial activities. With in-built capabilities the system facilitates easy ‘uploading’ of budgets and expenditures from the implementing partners and has facilitated timely reporting of expenditure as well as variance analysis which ensures corrective action is taken at the earliest opportunity. The system is easy to customize and has enabled the KRCS to submit timely and accurate reports to the donors as well as present information needed by different stakeholders.

5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products

Yes. KRCS has an extensive network of logistics centers. KRCS has a central warehouse in Nairobi as well as 8 regional warehouses to enable quick movement and pre-positioning of bulk supplies.

6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions

Yes. The KRC has a fleet of 5 heavy commercial vehicles and 120 light vehicles with 4 X 4 capabilities that ensure effective distribution of commodities to all parts of the country. The logistics unit of KRCS has a logistics manager at Headquarters and 8 regional logistics that plan coordinate and report on the distribution of commodities.

7. Data-collection capacity and tools are in place to monitor program performance

Yes. KRCS has a robust M&E unit with sufficient human and material capacity to effectively monitor program performance. These have been put to use in previous and existing Global Fund grants.

8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately

Yes. The PR has a functional routine reporting system with sufficient coverage for this grant. Reports from SRs are collated at regional level and
uploaded to the central KRCS Microsoft Nav. System. Necessary reviews and feedbacks are routinely provided to reporting units in a timely manner. Reporting tools are standardized and aligned to national reporting requirements.

9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain

Yes. The PR has a reliable process of Quality Assurance of commodities and has been involved in procurement, storage and distribution of health commodities for previous GF grants.

### 4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

<table>
<thead>
<tr>
<th>PR 3 Name</th>
<th>AMREF</th>
<th>Sector</th>
<th>NGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimum Standards</th>
<th>CCM assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. The Principal Recipient demonstrates effective management structures and planning</strong></td>
<td></td>
</tr>
<tr>
<td>Yes. AMREF has effective management structures that include: Governance and Oversight, Financial management, Grants Management and Procurement &amp; supply. There is a dedicated PMU for the Global Fund grant. AMREF’s Programme Technical Committee (PTC) supports projects to perform based on set targets. AMREF also develops a Results based annual work plan and budget. The quarterly plans are extracted from this and loaded to Enterprise Resource Planning (ERP). ERP system provides a paperless integrated real-time planning and resource management. Projects performance review and planning are undertaken on monthly, quarterly and annual basis to ensure that any corrective measures.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)</strong> |
| Yes. AMREF is experienced in managing large and complex grants implemented through sub recipients (SRs). Currently it manages 34 Sub recipients and 25 Sub recipients in Global fund supported projects. Her governance and oversight role over the implementing partners is executed at various levels under the overall leadership and oversight of the AMREF International Board and the |</p>
<table>
<thead>
<tr>
<th>3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud</th>
<th>Yes. AMREF has a risk-based internal audit function. All country programmes and grant making projects are assessed by the internal audit at least once per year in addition to regular monitoring and mentorship visits. External audits are also conducted annually by reputable accounting firms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. The financial management system of the Principal Recipient is effective and accurate</td>
<td>Yes. AMREF has a robust financial management system that links financial expenditure and procurement to programmatic performance. International standards on financial and grant management are followed. The organization uses Sun Systems, accounting package to monitor expenditures and progress on projects as well as a Grants Management Information Systems (GMIS) that is used to record, track and monitor all grantees’ financial performance. It is able to generate real time reports and financial status of all SRs.</td>
</tr>
<tr>
<td>5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</td>
<td>Yes. AMREF uphold highest standards in the warehousing and storage of health commodities. It has demonstrated this in its management of previous GF grants.</td>
</tr>
<tr>
<td>6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions</td>
<td>Yes. AMREF has a total of 86 operational motor vehicles and 23 motorcycles spread all over AMREF operational areas. AMREF also has 4 ground vehicular Ambulances and 6 light aircrafts to support its programmes distribution and transport arrangements. When required, private transporters are engaged to transport large quantities to regional distribution centres to ensure efficiency and cost effectiveness.</td>
</tr>
</tbody>
</table>
### 7. Data-collection capacity and tools are in place to monitor program performance

Yes. AMREF has aligned her reporting to the National health systems by ensuring use of the approved government of Kenya reporting tools including the TIBU system. Data is collected on a monthly basis and entered to the Grants Management and Information System (GMIS) that is used to track performance. Internal tools to monitor performance of donor projects and compliance among others are also in use.

### 8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately

Yes. AMREF has an existing Monitoring and Evaluation framework that applies an integrated results-based approach to guide the delivery of project interventions. Monitoring and Evaluation plans are developed to guide the process of monitoring achievements and documentation of desired results.

AMREF has an innovative Information Management System (AIMS) used across all AMREF offices globally to capture specific project achievements on quarterly basis.

### 9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain

Yes. AMREF Kenya uses Continuous Quality Improvement (CQI) framework based on ‘Plan-Do-Study-Act’ (PDSA) model which aids in enhancing and monitoring quality of service so as to improve patient outcomes using global and national standards.

### 4.4 Current or Anticipated Risks to Program Delivery and PR(s) Performance

#### a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers’ capacity, past and current performance issues.

#### b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

#### Proposed Risks and mitigation measures

**Issue 1:**
Disaggregation of data indicates that children (paediatric) coverage with ART remains low. The programme needs a clear strategy for increasing coverage of ART among children.

**Mitigation Strategy:**
This has been noted and the current funding allocation prioritizes paediatric ART. With integration of HIV treatment services with MNCH offering facilities and the scale up of EID services more children will be availed testing services and linked to treatment services. Offering PITC for all children in MNCH and paediatric clinic settings is also being planned. Based on the 2014 revised national guideline (ART to be initiated in all HIV-infected children aged 10 years and below, regardless of WHO stage or CD4 count/%) the threshold has shifted and more children will be reached.
**Issue 2:**
Monitoring progress on the KP indicators has been difficult to assess and it is recommended that targets be set so that results can be measured against intended targets.

**Mitigation Strategy:**
Indicators disaggregated by each KP population/intervention has been set with baselines derived from the 2014 polling booth survey report.

**Issue 3:**
There is a need to ensure that revised tools integrating HIV data into HMIS are rolled out to all ART sites and capacity of staff built on their use to facilitate the use of DHIS to report on results together with LMIS.

**Mitigation strategy:**
This is noted and implementation is ongoing and also planned for in this application.

**Issue 4:**
Following the M&E system assessment the country is advised to prioritize the following components of the HMIS/M&E system found to have weaknesses: a) support to DHIS/LMIS to ensure quality, complete and timely reporting through the DHIS/LMIS b) Strengthen analytical capacity c) strengthen the country’s program review capacities d) supporting any gaps in critical surveys.

**Mitigation strategy**
This is noted and specific interventions and funding allocations have been made to address each of the raised issues. Details are provided in the modular template section above.

**Issue 5:**
A warehouse assessment was conducted and the main gaps identified were mostly concerning the warehouse conditions at the decentralized level.

**Mitigation Strategy:**
The CCM acknowledges these gaps at county level warehouses and has earmarked funds for upgrade of county level warehouses in this application. This will leverage existing funds earmarked for central warehouse renovations in the existing phase II grant.

**Issue 6:**
The cumulative absorption rate has been low with noted significant delays in disbursing funds for program activities from the PR account to the Ministry of Public health and sanitation and then to the HIV program.

**Mitigation Strategy:**
Noted. The bottlenecks to speedy disbursements have been identified and the processes streamlined to improve disbursement turnaround times.

**Issue 7:**
Procurement delays leading to low absorption rates. The KCM should provide updates on the status of the Memorandum of understanding and ensure that previous gaps in the MOU that contributed to delays in procurement and payment of suppliers have been addressed adequately in the new version.

**Mitigation Strategy:**
This is acknowledged and a committee has been set up to identify the related bottlenecks for procurement and to make recommendations for streamlining the processes to reduce procurement lead times. An update on the MOU has been submitted to the Global Fund.

**Issue 8:**
Nutritional component: There is no clear reporting system for the nutritional supplements for HIV and TB patients. This could lead to inefficiencies in management of the support for eligible beneficiaries. The joint
HIV/TB concept note should be used as an opportunity to align the systems in search for possible savings/efficiencies.

Mitigation Strategy:
This is noted and the concept note proposes to align the systems for improved efficiency.

Issue 9:
Community component: Over the last year, the increase in the TB default rate was noted. AMREF reported a result of 5.5% compared to target of 4.5% (82% achievement). This is a decline from the 4% default rate achieved in June 2013. The increase in the default rate during the last year should be investigated and a mitigation plan put in place.

Mitigation Strategy:
This is noted and is currently being investigated. The need to improve on performance on defaulter rates has been prioritized in this concept note with significant investments planned to strengthen community structures and the use of technology for follow up of patients.

Issue 10:
TB Treatment: Devolution and its impact on treatment disruption: Funding for TB commodity needs was devolved to the counties in 2013. As of June 2014 no county has tendered for TB medicines or ordered through KEMSA and a 3-month stock of several TB medicines needed for retreatment cases was all that was remaining at the Kenya Medical Supplies Agency (KEMSA). A normal procurement cycle can take 6-9 months. KEMSA remains responsible for procurement, storage and distribution to counties.

Mitigation Strategy:
This is acknowledged. The PR/ TB program through the TB commodity committee is closely monitoring the consumption pattern and stock levels and will ensure that call downs are made early enough to avoid the risk of stock out. The KCM through the TB ICC has set up a committee to monitor the stock status at central and peripheral levels and to routinely track and ensure timely stock requests are made by service delivery points. As advised the KCM will ensure that the PR/TB program will observe the first-expiry-first out (FEFO) dispensing method at the central level and all the health facilities.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- Table 1: Financial Gap Analysis and Counterpart Financing Table
- Table 2: Programmatic Gap Table(s)
- Table 3: Modular Template
- Table 4: List of Abbreviations and Attachments
☐ CCM Eligibility Requirements
☐ CCM Endorsement of Concept Note