KENYA COORDINATING MECHANISM MEETING

MINUTES OF KCM MEETING HELD VIRTUALLY ON 10TH AUGUST 2020

BETWEEN 9.11AM TO 3.01PM

Present

Present

1. Ms. Susan Mochache, CBS	KCM Chair/PS Health
2. Ms. Faith Ndung'u	Member/Vice Chair-NGO
3. Ms. Maurine Murenga	Member/PLWD-HIV-NSA
4. Dr. Berhard Oguttu	Member-KEMRI-Gov
5. Mr. John Kamigwi	Member/NACC-Gov
6. Ms. Jane Wamoko	Alternate/TNT-Gov
7. Mr. Stanley Bii	Member/DP-BL
8. Ms. Joyce Ouma	Member/AYP-NSA
9. Mr. Ischar Oluoch	Gov-Counties
10. Mr. Lattif Shaban	Member/FBO-NSA
11. Mr. Philip Nyakwana	Member/PLWD-TB-NSA
12. Ms. Rosemary Kasiba	Member/KP Rep.-NSA
13. Ms. Eva Muthuuri	Member/ Malaria-NSA
14. Mr. Peter Njane	Member/KP Rep-NSA
15. Mr. John Kihiu	Member/Private Sector Inf-NSA
16. Ms. Faith Muigai	Member/Private Sector F-NSA
17. Dr. Jonathan Kiliko	Member/FBO-NSA
18. Ms. Mebor Abuor	Member/COG-Gov
19. Mr. Meschack Ndolo	Alternate/COG-Gov
20. Mr. Samuel Muia	KCM Coordinator

In Attendance

1. Mr. John Ochero	Global Fund Secretariat-SGPM
2. Ms. Soukeyna Sylla	Global Fund Secretariat
3. Dr. Celestine Mugambi	NACC/FR Secretariat Chair
4. Mr. Nelson Otwoma	FR Secretariat-Co Chair
5. Mr. Olugbenga Mokuolu	FR writing team Consultant
6. Ms. Dorothy Agalla	FR Secretariat/ Core Team
7. Dr. Caroline Olwande	FR Secretariat/ Core Team
8. Dr. Pacifica Onyancha	MOH-Ag. Director MDSPPH
9. Dr. Nazila Ganatra	NSPHP MOH
10. Mr. John Muiruri	Alternate/PLWD-Malaria
11. Ms. Jecinta Mutegi	Alternate FBO/KCCB
12. Mr. Ahmed Said	Alternate member /KP Rep.
13. Ms. Lucy Wanjiku Njenga	Alternate Member/PLWD-HIV
14. Mr. Vincent Obwanda	Alternate to the KP consortium
15. Ms. Pamela Kibunja	Alternate/NGOs
16. Ms. Zilpha Samoei	Alternate FBO/CHAK
17. Ms. Gloria Kerubo	Alternate AYP
18. Ms. Patricia Kilonzo	Alternate/Private Sector Inf.
19. Ms. Patricia Kilonzo	Alternate/Private Sector Inf.
20. Dr. Pacifica Onyancha	MOH
21. Ms. Roseline Muchai	LFA
22. Mr. Joseph Kagiri	LFA
23. Dr. Githuka George	Division NMP
24. Dr. Elizabeth Onyango	Head/ National TB Programs
25. Ms. Carol Asin	GF Coordinator TB Program
26. Mr. Jonah Manjari	CEO KEMSA
27. Mr. David Muttu	KEMSA
28. Mr. Muiruiri Nyakinyi	FR Secretariat
29. Ms. Susan Njogo	FR Secretariat

30. Mr. Steven Macharia	FR Secretariat
31. Dr. Newton Omale	FR Secretariat
32. Ms. Consolata Opiyo	Alternate /TB cons.
33. Dr. Dan Koros	PEPFAR -FR Secretariat
34. Dr. Vallery Mackory	Office of the DMS/PPH
35. Ms. Josephine Mwaura	KCM Secretariat
36. Mr. Kevin Ogolla	KCM Secretariat
37. Ms. Margaret Mundia	KCM Secretariat

Apologies

1. Dr. Medhin Tsehiau	Member/DP-ML
2. Dr. Pierre Bello Yves	Member /BL
3. Ms. Shoko Isokawa	Alt Member/BL
4. Dr. Lucy Ghati	NSA Core Team

Agenda

1. Introduction/Apologies

2. Opening Remarks by the KCM Chair

3. Declaration of Conflict of interest.

4. Review of Funding Request Application Draft

- Presentation by Presentation by Dr Ananaba and Prof. Olugbenga -Funding Request Consultants

5. Review and approval of KCM eligibility performance assessment report/ Performance Improvement Plan

6. Review and confirmation of minutes of KCM meeting held on 16th June,2020, 9th July,2020 and 30th July,2020/ Matters arising

7. PR selection appeals / Appeals review process.

8. Closure

Min1/8/2020 Introduction/ Apologies

Meeting called to order at 9.11am with a word of prayer from Mr. John Kamigwi

Members Introduced themselves. Apologies registered as above.

Min 2/8/2020 Remarks by the Chair

The Chair, appreciated all members for finding time to attend the meeting, she acknowledged the unique role played by each player in the fight against TB, Malaria, HIV and building RSSH. The chair extended her sincere appreciation to the KCM and the Global Fund for their significant support towards the fight against HIV, TB and malaria in Kenya.

The Chair informed members that following the KCM meeting held on 30th July,2020, where the KCM endorsed the funding request application to support immediate needs for PPE and diagnostic tests in Kenya. The Global Fund had approved USD 8,306,205 of additional investments to support COVID-19 response in Kenya. The total amount approved by the Global Fund to support C19 response in Kenya amounts to USD 24,918,611.

She called on PRs to fast track the implementation of all approved interventions and activities to ensure that the country is properly positioned to fight the covid surge. In addition, she requested the KCM Oversight Committee and COVID-19 Funding Request Writing Team to work closely with the PR to ensure that all beneficiaries access this support in a timely manner.

The Chair requested all in-country stakeholders to prioritize on funding request application and submission in the next two weeks, she informed members that there was need to focus on high impact interventions and maximize on the benefits expected from the funding request application.

The Chair further stated that during the KCM meeting held on 9th July 2020, the PR selection report was approved and all bidders were notified of the outcome and granted a 14-days

appeal window. That KCM had received one letter of appeal, one letter of acceptance and six letters of concern and the KCM was to formally acknowledge receipt during the meeting. She reminded members to observe the provisions and guidelines as contained in the Global Fund Code of Ethical Conduct and KCM Conflict of interest policy while conducting KCM business.

In her conclusion the chair noted that the KCM has received official communication from NACC that Dr. Nduku Kilonzo had completed her term at NACC and on KCM. The alternate member, Mr. John Kamigwi would represent NACC until the next CEO takes office. She appreciated Dr Nduku Kilonzo for her great leadership at NACC and for the immense support she has continued to provide to the KCM and in the fight against HIV/AIDS/TB / Malaria in Kenya and Globally.

Min 3/8/2020 Declaration of Conflict of Interest

The KCM Coordinator informed members that KCM prepared and adopted declaration of conflict of interest to prevent and mitigate the effect of conflict of interest (COI). He elaborated that a COI occurs when a KCM member or his committees' use his or her position to advance personal ambition of interest, interest of the institution with which he or she is affiliated or those of a close associate in a way that disadvantages and excludes others.

Actual, perceived or potential COI may diminish public confidence in the KCM as an institution. In addressing conflict of interested he noted that members who declare COI may personally exempt themselves (recusal), have conditional participation, partial participation or total exclusion from the meeting. He reminded members that the Constitution guides that members shall recuse themselves from participating in KCM deliberations where selection of PR, SRs or other implementing entities in which members have an interest is being considered.

Failure to disclose COI , a member will be given an opportunity to respond; the KCM determines that a failure to properly disclose a COI has occurred; the chair would then initiate disciplinary action which may include delivery of a formal apology on part of the member, suspension of the member pending further deliberation on appropriate disciplinary action or removal of member from KCM.

He further asked that due to the nature of agenda items in discussion in the meeting, Members would be required to declare COI during each agenda item.

No Conflict of Interest was declared.

Min 4/8/2020 Review of Funding Request Application Draft

Presentation made by Dr Mugambi and Prof Olugbenga

The funding request Secretariat Chair informed the meeting of the wide stakeholder involvement in the ongoing funding request application process. She informed the meeting that during the KCM meeting held on 9th July,2020 the funding request Secretariat presented prioritized interventions and needs.

High impact interventions selected include: Under HIV (7). These are Prevention, PMTCT, HTS, Care and Treatment, Human Rights, RSSH-HMIS and TB/HIV. Under TB (5). These are: TB Care and Prevention, MDR TB, TB & HIV, Human Rights and RSSH-HMIS. Under RSSH (7) HMIS/M&E, HPM, Service Delivery, CSS, HRH, Labs and Governance and Learning.

Key considerations: Positioning the country's prioritized funding request within the country context, funding landscape and aim towards achieving national targets. It is required that: (i) Prioritization is evidence-based and built on analysis of the financial & programmatic gaps across the two programs and the funding Landscape; (ii) Prioritization of modules done within the realities of the country allocation (iii) Choices of the best interventions to achieve the highest impact with the investment (iv)Investments to address bottlenecks; (v)Value–for-

Money considerations; (vi) Consideration for expected impact and outcome from additional investments above the country allocation (PAAR).

Gaps in HIV Response (High Level)

- Prevention - Rising HIV incidence in young populations and Concentrated epidemic in Key and Vulnerable Populations
- TB-HIV: TBHIV Co-morbidity
- Treatment: Gaps in the second "90"- PLHIV on ART; Gaps in the third "90" –PLHIV with Viral suppression
- HTS: Gaps in the first "90" and Significant number of estimated CLHIV undetected
- PMTCT: EID Coverage low; Low retention on ART for pregnant and breastfeeding YWLHIV and ART coverage for HIV exposed infants low
- Human Rights Stigma: Stigma and human rights barriers persist, and Critical enablers require reinforcement

HIV Investment Outlook. Main allocation in USD include: HIV Prevention: 14,400,000; PMTCT: 06,452,805; Differentiated HTS: 9,585,944; Treatment Care and Support: 178,004,678; Human Rights: 4,325,453*(Includes US$ 1,133,886 TB contribution); RSSH-HMIS and M&E: 6,234,212; Program Management: 13,096,564 with a total of USD 246,165,248. **Catalytic Funding:** HIV Prevention: 28,465,592; PMTCT: 0; Differentiated HTS: 9,585,944; Treatment Care and Support: 0; Human Rights: 3,800,000; RSSH-HMIS and M&E: 0; Program Management: 0 with a total of USD 18,200,000. **Module Totals:** HIV Prevention: 42,865,592 (16%); ; PMTCT 6,452,805 (2%); Differentiated HTS: 9,585,944 (4%); Treatment Care and Support: 178,004,678 (67%); Human Rights: 8,125,213 (3%); RSSH-HMIS and M&E: 6 6,234,212 (2%); Program Management: 13,096,564 (5%) with a total of USD 264,365,008 (100%).

Proposed Allocation was presented by module Intervention, Total funding per intervention and total PAAR was presented as: Prevention Module:

Condom and Lubricant Program – total funding $ 9,752,678; PAAR $ 2,951,454; Pre-exposure prophylaxis (PrEP) – total funding $268,674; total PAAR 0
Behavior change intervention – total funding $ 10,772,771; total PAAR $ 10,772,771; Community empowerment – total funding $ 2,285,195; total PAAR $ 768,794.84' Harm Reduction – total funding $ 44,934; total PAAR 0; Addressing stigma, discrimination & violence – total funding $ 906,751, total PAAR $324,300.11; Interventions for Young Key Populations – total funding $ 1,459,895, total PAAR $635,426; Prevention and Management of co infections and co morbidities total funding – total funding $ 1,459,895, total PAAR $1,856,117; Needle and syringe programs – total funding $ 1,770,199, total PAAR $29,052.03; OST & MAT- total funding $ 1,770,199, total PAAR $29,052.03; Overdose prevention and management total funding $ 60,492, total PAAR $0; Sexuality and Reproductive Health services including; Sexuality education total funding $ 14,880,855 total PAAR $680,277.48; Social protection interventions total funding $ 2,263,670, total PAAR $ 900,000; Gender based violence prevention and post violence care total funding $ 1,089,323; Integration into national multi sectoral responses of AGW Programs total funding $ 1,155,165; Voluntary Medical Male Circumcision total funding $ 1,355,967; Total cost (total funding $ 49,074,108 total PAAR $9,041,789).

Expected Outcomes for module HIV Prevention: Condoms- Increase use of condoms overall from the current 42% to 80% by 2023; VMMC - Increase use of condoms overall from the current 42% to 80% by 2023; PreP-KPs - PrEP coverage to 82% of MSMs, 70% of FSWs, 90% of PWID; for AGYW – 25% of the eligible populations; **Discordant Couples** - 90% of discordant couples know their status; **90% of discordant couples know their status** and Prevention programs for Key populations-defined packages of services will be availed to 100% of MSM, FSW, PWID and Transgender Population by 2023.

Module Differentiated HTS: Facility Based Testing - US$5,611,332; Community Based Testing - US$3,73,808 and Self Testing - US$600,804. Expected Outcome: MSM Test at 100% by 2023; PWID test at 100% by 2023 and FSW testing at 100% by 2023.

Module PMTCT:

Prong 1- Primary prevention of HIV infection- funding US$2,110,367 & PAAR US$2,828,419); Prong 2 - Preventing unintended pregnancies among WLHIV- funding US$1,007,680; Prong 3 - Preventing vertical HIV transmission- funding US$2,080,909); and Prong 4 - Treatment, care and support to mothers living with HIV, their children and families- funding US$1,253,847). **Expected Outcome**: Reduce unmet needs for FP in HIV positive women to 15%; HIV testing in Pregnant women increase from PMTCT Coverage increase from 94% to 98%; EID Coverage

Expected Outcome: Reduce unmet needs for FP in HIV positive women to 15%; HIV testing in Pregnant women increase from' PMTCT Coverage increase from 94% to 98% and EID Coverage

Prong 1 - Primary Prevention of HIV - Gap: Need to reduce HIV and syphilis incidence in the 15-49 yrs. women by 50%, and Low uptake 63% (2019), of syphilis testing among women attending ANC at any visit. **Priority Areas**: Use of PrEP for HIV-negative women in MNCH; routine repeat testing of pregnant and breastfeeding women; increased testing and retesting strategies; increased male partner involvement through couple counselling and tailored HIV prevention services for the pregnant AGYW. **Priority Population:** Adolescent Girls and Young Women aged (15-49years).

Prong 2 - Preventing unwanted pregnancies among WLHIV Gap: the unmet family planning need of female PLHIV with only 27% of needs met; and High rate of teenage pregnancies with 2,936 pregnancies among 10-19 in 2019. **Priority Activities:** linkages and referrals from SRH services to HIV/TB and broader PHC services, including HIV services at MNCH clinics; widespread and consistent access to family planning services and commodities for women living with HIV; and integrated family planning and HIV service delivery at AGYW clinics**. Priority Population** – HIV Positive women.

Prong 3 - Preventing vertical HIV transmission – Gaps reduce MTCT of HIV from 10.4% to 8%, Gaps in early infant diagnosis/identification of HIV positive infants with only 52% of HIV positive infants having had an early diagnosis; and 50% of new MTCT infection due to poor retention on ART for pregnant and breastfeeding HIV positive women**. Priority Activities**: provision of ARVs to newly diagnosed HIV positive pregnant and breastfeeding women; Scale up viral load testing for HIV positive pregnant and breastfeeding women; intensive adherence support for pregnant women on ART using both facility and community-based adherence models (e.g. "mentor mothers") and improved access to enhanced prophylaxis for new-borns. **Priority population**: Pregnant & breastfeeding WLHIV and their Children.

Prong 4 - Treatment, care and support to mothers living with HIV, their children and families

Gaps: Increase coverage from 94% to 98% of pregnant women in need of antiretroviral therapy and syphilis treatment for their own health with life-long antiretroviral therapy and optimal syphilis treatment. Priority activities: provision of HIV care, treatment (excludes ARV). **Priority activities:** support of women of reproductive age living with HIV and families; roll out of the PMTCT EMR module; designing, developing and implement strategies aimed to support retention of the mother baby pair in the PMTCT cascade, at all levels; early Diagnosis of HIV as early as 6 weeks of age; and integration with GBV response and information services (incl. PEP, PrEP and EC). **Priority population:** Mothers living with HIV, their children and families.

Module: **Treatment, Care and Support. Intervention Differentiated:** *ART service delivery and HIV care* **-** funding US$152,596,582; PAAR $82,682,87. *Treatment monitoring - Drug resistance* – funding US$2,184,030; PAAR US$336,325. *Treatment monitoring - Viral load* – Funding- US$220,167; PAAR- US$2,112,837. *Prevention and management of co-infections and co-Morbidities*-Funding- US$8,541,485; PAAR- US$4,200,183. *Counseling and psycho-social support*-funding- US$5,179,686; PAAR US$838,577.

Expected Outcome: PLHIV on treatment - Adults (76%) by 2023 from 74% (2019) as well as CLHIV on treatment - Children (86%) by 2023 from 63% (2019).

Differentiated ART service delivery and HIV care

Gaps: Low uptake of ART - children 63%, adults 75%; poor viral suppression among PLHIV – Children 51%, Adults 69%; Gaps in retention on ART and treatment fatigue among adolescents. **Priority Activities:** Enhancing HIV case identification for paediatrics and adolescents through the meaningful involvement of people with HIV/AIDS (MIPA), scale up of decentralized drug dispensing of ARV through registered private community pharmacies, implementation of differentiated Care Models (DCM) including Community ART Groups (CARG), Using peer educators to conduct treatment literacy training and Commodity security will be ensured through availability of ARVs and other HIV commodities at national and facility level. **Priority population:** all PLHIV

Treatment monitoring - Drug resistance

Gaps: Need to sustain Surveillance for drug resistance. **Priority Activities:** Resistance (HIVDR) Early Warning Indicators (EWI) reporting system. Biannual generation of report on toxicity analysis causing regimen cessation or substitution, survey of HIV Acquired drug resistance (ADR) in populations receiving ART and pre-treatment drug resistance (PDR) surveillance in people initiating or re-initiating treatment. **Priority population:** all PLHIV

Treatment monitoring – Viral Load

Gaps: Need to sustain viral load monitoring as a measure of treatment success and tracking the third "90" **Priority Activities:** set up 32 additional VL and EID sites near Point of Care (POC) sites to improve access to Viral Load testing, testing and data quality improvement and capacity building of the POC facilities and provision of technical support to monitor performance of quality at all EID and VL testing facilities.**Priority population**: all PLHIV

Prevention and management of co-infections and co-morbidities

Gaps: Need to sustain quality of care components that improves treatment outcomes for PLHIV in care, sustain nutritional support to PLHIV in care, rising prevalence of NCDs amongst PLHIV and Gaps in access to cervical cancer screening for female PLHIV. **Priority Activities:** development of an integrated operational manual/pocket guide for HCW for managing undernutrition and over nutrition, procurement and distribution of nutrition assessment equipment (digital height weight scales with automatic BMI reader, waist circumference tapes, Bioelectric impeders (BIAS) machines and institutionalize cervical cancer screening of 90% of Women living with HIV in comprehensive care centre (CCC) clinics. **Priority population:** all PLHIV

Counseling and psycho-social support

Gaps: Gaps in retention in care owing to limitations in counselling and psychosocial support**. Priority Activities** engagement of PLHIV network to enhance disclosure, psychosocial support, adherence and defaulter tracing in the community, support for facility-community linkages for continuum of care for PLHIV, support for support groups for PLHIV not in CAGs, development and dissemination of patient literacy materials for adherence, management of treatment fatigue, cervical cancer, STIs, VH and dissemination of caregiver literacy package to support age appropriate messaging for Children, Adolescents and Young People Living with HIV (CALYPHIV). **Priority population:** all PLHIV

Module – human Rights, stigma and Gender barriers

Stigma and discrimination reduction- funding of US$ 3,164,569; *Training for health care workers on human rights and medical ethics (HIV and TB)*- US$ 682,034 ; *Legal literacy / "Know Your Rights" programs*-US$ 1,707,298 ; *HIV and TB-related legal services*- US$ 750,864; *Sensitization of law-makers and law enforcement agents*- US$ 162,227; *Monitoring and reforming laws, regulations and policies relating to HIV and TB*- US$ 1,095,381 ; *Reducing discrimination against women in the context of HIV and addressing gender barriers to access to HIV and TB services*- US$ 562,840 **Expected Outcome:**Reduction in barriers to access

Module – Disease specific RSSH- HMIS AND M&E

Routine reporting, Program and data quality, Analysis, Evaluation, reviews and transparency and surveys would receive fund allocation on further consultation. **Expected Outcome:** Functional HMIS and M&E and Good data quality for HIV

Module- Program Management

Program management costs for PR1 (National Treasury)- US$2,438,896; Program management costs for PR2 (TBD)- US$6,252,172; Program management costs for NASCOP-US$2,843,916; Program management costs for NACC-US$1,561,580

Expected Outcome: Functional HMIS and M&E and Good data quality for HIV

Gaps in the TB response (*High Level)*

TB Care & Prevention: Missing TB cases and TB case detection rate of 55% (2018) is below the desired rate of 90%, **TB/HIV**: HIV Co-morbidity with low TB case detection in PLHIV and High Cost of new TPT regime, **System capacity**: Gaps in Laboratory capacity and Sample referral gaps, **Barriers to Access**: Stigma and Geographical barriers and **MDR-TB**: Low Case detection and Sub-optimal access to second line DST among RR/MDR patients

There are Significant resource gaps for the TB Program.

Investment outlook –TB

TB Care and prevention module; main allocation US$ 20,111,172; Catalytic Fund US$ 8,000,000; Total US$ 28,111,172; that is 41%, MDR TB main/ Total allocation US$ 12,223,380-18%; TB/HIV main/ Total allocation US$ 16.378,184- 24%; Program Management main/ Total allocation US$ 8,504,145-12%; Disease Specific RSSH main/ Total allocation US$ 3,644,051-5% making a total and main allocation of USD 60,860,932, total catalytic fund US$ 8,000,000-100%.

* Includes HIV contribution (USD 7,874,040)

Module TB Care and prevention

Case detection; Funding US$ 2,156,623, PAAR US$ 1,461,805, Lab. Diagnosis Funding US$4,894,794, PAAR US$ 3,955,267; Treatment funding US$5,188,024, PAAR US$ 1,634,357; Nutrition funding US$2,311,766; PAAR US$ 156,598, Engage all care providers funding US$ 1,188,040; PAAR US$ 2,345,840 and Community TB Care delivery/ACSM Funding US$ 2,341,188; PAAR US$ 72,644, Key Populations- Children funding US$ 861,646; PAAR US$ 213,340; Key populations-Prisoners and others US$ 472,466 and TB and other comorbidities US$ 696,625; PAAR 280,836

Expected Outcome:

Implementation of this module is expected to notify 301,123 cases of all forms of TB (bacteriologically confirmed + clinically diagnosed), includes new and relapse cases and successfully treat 90% of the cases

Care and prevention- Case detection and diagnosis – Case Finding

Gaps TB case detection rate of 55% (2018) is below the desired rate of 90%, Poor care seeking (65%), Poor TB awareness and risk perception in the community (75%), High stigma, Cost barriers, Inadequate psychosocial support, Suboptimal utilization of level 1 facilities, suboptimal contact tracing referrals, Poor case finding approaches, Low index of suspicion of TB among Health Care Workers, lack of policy document to guide the contact management of TB patients, Poor access to chest x-ray due to costs, Inadequate documentation and notification from private health facilities, suboptimal utilization of data to inform decision making

Priority activities Implement innovative and patient-centered communication methods to improve care seeking in the community, Community Based Systematic, Screening of Key Populations (targeted TB outreaches in areas of focalized transmission like urban slums, matatu industry, congregate settings (schools, workplaces, prisons), Systematic screening for TB for all household contacts (and workplaces contacts) of people with TB, Innovative approaches to increase TB awareness and risk perception in the community, screen and refer for diagnosis, Strengthen and expand quality improvement to find missing people with TB in all health facilities (public and private), Strengthen contact invitation by the health care workers including contacts above 5 years and Use of a broader/more sensitive TB screening

approach that combines broader symptom screening criterion and additional use of chest radiograph for triage. **Priority population:** TB patients, household, general population

Care and prevention- Case detection and diagnosis – Diagnosis

GAPS: Only 47% of notified TB cases have access to GeneXpert testing at the time of diagnosis; Sample referral systems, Equipment downtown (power, service), frequent cartridge and supplies stock out, suboptimal engagement of private labs, limited coverage of point of care tests like TB LAM and Xpert Omni; Quality assurance, Lack of standard guidelines for Xpert MTB/RIF quality assurance procedures, Lack of sufficient and sustainable PT production and management for GeneXpert, Lack of minimum standard for Xpert testing focusing on QMS and CQI, Unavailability of a clear Xpert MTB/RIF EQA leadership and governance, Lack of minimum standards for Xpert MTB/RIF testing services and weak biosafety and biosecurity measures, Insufficient

Priority Activities: Expand use GeneXpert MTB/RIF as initial TB diagnostic test for all adults and children being investigated for TB –placement public and private labs, sample networking interventions with electronic results dissemination, Power inverters; Strengthen integrated sample referral system to improve the efficiency GeneXpert network structure by increasing the number of counties that have an established TB sample referral system to 80 percent - integrated Sample Referral System; Strengthen quality of laboratory services through expansion of quality assurance system for all diagnostic tests in public and private laboratories – Genexpert (PT), Microscopy (EQA) and TB LAM.

Priority population: TB patients, household, general population

Care and prevention- Treatment

Gaps Treatment success rate (TSR) of 83% (2017 cohort) is below the desired target of 90%.; Only 43% (28% of moderate acute and 15% of severe acute malnutrition); Initial loss to follow up of 21% among BC patients due to poor linkages between the lab and clinician in health facilities; 5% LTFU among all patients in 2016 - high pill burden, adverse drug reaction, stigma, inadequate patient education, health systems not sensitive to patients needs, out of pocket expenditure (26% DS TB); Mortality rate above 5% - delay diagnosis,

malnutrition (13%), co-morbidity, sub-optimal patient monitoring and follow up; Lack of integration of services for TB with comorbidities (HIV, HTN, Diabetes) and Gap in documentation of treatment outcomes

Priority Activities Strengthen linkage of all diagnosed patients to care through physical linkage of patient, integration of LMIS to TIBU, and strengthening recording of lab request forms and lab register; Provide TB services that are centered around patients' needs to strengthen adherence to TB treatment (differentiated care) – patients kits, flexible hours, differentiated care, decentralization of TB treatment, digital solutions, patients support systems, documentation, community systems; Strengthened engagement of county and facility leadership in providing integrated patient-centered and high quality of care and interventions – county engagement, CoE, meetings (Multidisciplinary team); Strengthen systematic universal nutritional assessment for all TB Patients at treatment initiation and during follow up of patients and enroll those eligible in the nutritional program – nutrition commodities, anthropometric equipment and Improve on integration of community health nutrition programs into TB nutritional care to enhance linkage of TB patients – mapping, linkage (IGA, community nutrition and social programs), NHIF. **Priority population:** TB patients, household, general population

Care and prevention- Key population –Childhood TB

Gaps: Proportion of children with TB who are detected is 35% below the desired target of 70%. Proportion of children <5 years initiated on TPT 13% much below the target of 90%.
Sub-optimal child contact investigation and preventive therapy; 2. Knowledge gap among health care workers in childhood TB prevention, diagnosis and care, including sample collection, and 3, Sub optimal engagement of private sectors, Weak linkages and limited integration with maternal, child health and nutrition departments.
Priority Activities: Build capacity of HCWs and CHVs in detection and management of pediatrics TB; Scale up pediatrics ACF; Increase access to high quality diagnostics for children at no cost and Scale up active contact screening and preventive therapy. **Priority population:** TB patients, household, general population

Care and prevention- Community TB care delivery

Gaps Sub-optimal linkages between community systems and health facilities, with CHWs contributing only 10% of notified cases

Poor screening of TB among HCWs, CHWs; No status report on Implementation of IPC at community; Limited Training, coaching and mentorship of CHVs on current information and practice on TB prevention; High attrition rate of CHWs trained to provide community TB services affecting quality of services; Lack of Community stakeholder analysis and multi sectoral engagement framework; Limiting M&E and reporting systems at community to enhance social accountability; Inadequate documentation of contribution of CHWs to TB case notification at health facilities with a proportion of patients referred from the community indicated as self-referrals; Inadequate establishment of innovations that enhance social support groups at community and Suboptimal utilization of level 1 for TB activities (due to inadequate incentives and supervision)

Priority Activities: Build political support for TB prevention, awareness, screening, treatment & care at all levels; Strengthen routine screening at community level and referral linkages; Implement IPC at community through mapping out the priority households; Training and mentorship of CHVs on current information on TB prevention and Embracing digital technologies to enhance M&E and reporting systems at community. **Priority population:** TB patients, household, general population

Care and prevention- Key population –Prisons & Others vulnerable populations

Gaps: Case notification rate of TB among prisoners is high at 1,142 cases per 100,000 populations where there is Sub-optimal screening of inmates (use of PF10) during admission; There are no mechanisms for contact tracing among prisoners and Delivery of TB screening, testing and treatment is hampered by frequent movement of inmates across various prisons and the poor linkages between different prisons, remand centers, and communities

Priority Activities: Enhance TB infection control measures and systematic screening for TB and continuum of care in prison; Carry out periodic community-based screeningand TB services for refugees and Internally Displaced Persons. **Priority population:** Prisoners, prison warden and their families/contacts, refugees, IDPs, Work places, slums dwellers etc.

Care and prevention- Nutrition

Gaps: Sub optimal nutrition assessment for TB patients; Challenges in logistics management of nutritional commodities mainly due to poor reporting practices causing delays in distribution of nutritional commodities; Patients incurring non-medical catastrophic costs mainly nutrition related costs and inadequate availability of anthropometric equipment

Priority Activities: Strengthen systematic universal nutritional assessment for all TB Patients at treatment initiation and during follow up of patients and enrol those eligible in the nutritional program. These include; Provision of anthropometric equipment for all health facilities; Build HCWs capacity to Improve documentation, reporting and requisition and nutrition management and Provision of adequate nutrition commodities (RUTF and FBF)

Priority Population: TB Patients

Care and prevention- PPM

Gaps: Low case notification/ case finding from the private sector, Weak engagement of corporate organizations with limited data on engagement of corporates, Inadequate capacity to diagnose and manage TB patients in private sector and Under reporting from the private sector (20% of patients diagnosed and treated from private sectors not notified)

Priority Activities: Expand multi-sectoral engagement to secure high level of political willingness and commitment; TB services in unengaged private for profit; Sustain TB services in engaged and unengaged FBO in selected counties; To engage corporate sector in TB care and control; Scale up of informal private providers in TB care and prevention; Awareness raising and advocacy and Improve notification & quality of diagnosis and management of TB in private sector

Module –Multi drug resistant TB

Case detection has a funding allocation of US$ 2,809,471; PAAR US$ 329,325; DR TB Care and treatment – US$ 6,099,899; PAAR US$ 695,967, Social protection and National Health Insurance (NHIF) cover- US$ 3,176,606; PAAR US$ 2,225,980, Infection prevention and control- US$ 53,981; PAAR US$ 572,504, Community MDR-TB Delivery- US$ 83,422; PAAR US$ 39,990 and Key population PAAR US$ 75,122.33

Expected Outcome: It is expected that during the funding period a total of 3,055 RR/MDR TB patients will be notified.

Intervention 1: DR-TB- Case detection and diagnosis

Gaps: Low case detection - 75% of incident DR TB cases were not detected thus not put on treatment in 2018 (Global TB report 2019; TIBU) and Sub-optimal access to second line DST among RR/MDR patients - Reagent stock outs, equipment downtime etc.

Priority Activities: Scale up access to quality and timely genotypic and phenotypic DST testing for second line drugs including new molecules for all patients diagnosed with Rifampicin Resistant TB; Procure adequate reagents, consumables and supplies for TB culture and DST; Obtain annual recertification on biosafety level 3 (BSL 3) status for NTRL (in conformity with international recommendations); Training 30 TB culture laboratory personnel on supply chain management and inventory control; Continue to support 11 NTRL GF staff to strengthen national surveillance and the additional role of supporting regional laboratories; Training on gene sequencer to support further analysis of current culture samples at NTRL; Drug resistance survey (DRS); Support for equipment maintenance at NTRL to provide seamless services; Support shipping of TB isolates to the supranational laboratory in Uganda for validation purposes; Procurement of American Type culture collection (ATCC) TB reference strains for NTRL internal controls and Support mentorship of new decentralized laboratories. **Priority Population:** TB Patients, High risk contacts of DR TB, Children

Intervention 2: DR-TB – Care and Treatment

Gaps Introduction of IFR; Sub-optimal quality of care of DR TB patients as indicated by treatment outcomes of 2017 cohort with a TSR of 66%, LTFU 4% and death rate 11% - non-adherence; Sub-optimal adverse drug reactions management i.e. Limited availability to ECGs at SDPs; Lack of palliative care services and inadequate post-treatment care for DR TB patient and Lack of paediatric friendly formulations for treatment of DR TB.

Priority Activities Procurement & supply chain management of second line medicines (including pediatric friendly formulations); Decentralize & strengthen the delivery of patient-

centered care for DR TB patients; Pharmacovigilance and patient monitoring; Capacity building of HCWs and Strengthening post treatment, palliative and end of life care for DR TB patients. **Priority Population:** DR-TB Patients

Intervention 3: DR-TB – Social

Gaps Catastrophic costs incurred by DRTB patients. **Priority Activities:** NHIF package for TB care; Cash transfer for DR TB patients' Support DR TB patients post treatment follow up & contacts' management; Clinical, nutritional & social assessment and support visit to DR TB patients at the community. **Priority Population:** DR-TB Patients

Intervention 4: Community DR-TB care delivery

Gaps: Sub-optimal engagement of the community on DR TB control has contributed to limited knowledge and awareness of DR TB prevention and control in the community.

Priority Activities Build political support for TB prevention, awareness, screening, treatment & care at all levels' Strengthen routine screening at community level and referral linkages; Implement IPC at community through mapping out the priority households, Training and mentorship of CHVs on current information on TB prevention and Embracing digital technologies to enhance M&E and reporting systems at community. **Priority Population:** TB Patients, General population

Intervention 5: DR-TB – Prevention

Gaps: Limited access to isolation facilities that would provide specialized and inpatient care for DR TB patients; Inadequate capacity of majority of health facilities to implement IPC measures; Lack of guidance on the TPT regimens for DR TB contacts including children and Sub-optimal engagement of the community on DR TB control has contributed to limited knowledge and awareness of DR TB prevention and control in the community

Priority Activities: Procurement of N95 and surgical masks. **Priority Population:** TB Patients, General population

Module-TB-HIV Collaboration

Screening, testing and diagnosis of TB/HIV funding- US$ 7,886,947; PAAR US$ 1,378,315 ; Treatment (TB/HIV) Funding US$1,388,830; PAAR US$ 210,917, Prevention (TB/HIV) Funding US$ 7,102,406 PAAR US$ 5,053,209.

Expected Outcome:

To maintain HIV testing of TB patients and ART coverage among HIV co-infected patients to above 95%; improve treatment success among the TBHIV to 85% and increase TPT coverage among the PLHIV to the national target of 90%.

Intervention 1: TB/HIV- Screening, testing and diagnosis

Gaps: TB cases notified among PLHIV is 51%, this is below the desired target of 90%. low TB case detection rates among PLHIV at both the community level and within the health system; missed opportunity of TB screening of all people undergoing HIV testing; suboptimal quality of TB screening among PLHIV and suboptimal access to Rapid TB Diagnostics

Sustain 98% HIV screening among notified TB patients

Priority Activities: Establish/ strengthen TB/HIV service linkages at community level and/with health systems and Increase access to rapid TB screening and diagnostics including GeneXpert MTB/RIF or Ultra, POC tests like LF- LAM. **Priority Population:** TB and HIV Patients

Intervention 2: TB/HIV – Treatment

Gaps: Treatment success rate amongst HIV co-infected TB patients is lower than that of the HIV negative TB patients (78% vs 87%), and in addition lower than the target of 85%; Higher death rate among the HIV co-infected TB patients (12.4%) compared to the HIV negative TB patients (4.3%); late presentation of HIV/AIDS patients at the facility; HCW knowledge gaps in identification and management of comorbid conditions and HIV treatment failure

Priority Activities: Integration of TB and HIV retention strategies at community and facility levels and Establish TBHIV Quality Improvement process and guidelines with routine assessments. **Priority Population:** TB and HIV Co- infected Patients

Intervention 2: TB/HIV –

Gaps: Newly identified PLHIV initiated on TPT is 83% below the desired target of 90%. Suboptimal TPT uptake; poor documentation, reporting of outcomes and adverse events and no in country policy on adoption of newer, safer, shorter regimens of TPT. **Priority Activities:** Sustain proportion of PLHIV and other at-risk populations initiated on TPT through high service coverage for TPT, develop a comprehensive framework for LTBI management that includes use of WHO-recommended shorter TPT regimens and Create demand and Develop digital support mechanisms for adherence, patient education and support. **Priority Population:** TB and HIV Patients, general population

Module-HMIS AND M&E

Routine reporting Funding -US$1,185,205; Program and data quality Funding- US$248,501; Analysis, evaluations, reviews and transparency Funding - US$ 1,882,743; Surveys Funding- US$222,060; PAAR US$99,361.76; Vital registration funding- US$ 105,541

Expected Outcome: Ensure continued availability of quality data for decision making in TB control in the country; Improve data quality for decision making at all levels; Improve capacity of the program on data analysis modelling and dissemination that will promote data use for policy and decision; Provide estimate of TB burden among health care workers and improved capacity to implement OR activities at all levels and Provide more accurate in country mortality statistics.

Module – PROGRAM MANAGEMENT

Program management cost for State PR - including NTLDP

Funding- US$2,983,525 and Program management cost for Non-State PR funding- US$4,193,101

Expected Outcome: Implementation of this module is expected to ensure continued support in program activities for implementation of the grant and TB service delivery.

GAPS IN THE RSSH (HIGH LEVEL)

HRH: HCW retention and HCW capacity; **Lab:** Lab capacity and ISO Certification; **HMIS**: Data quality issues, Multiple platforms needing integration and Tailored surveys for evidence.

HPM: KEMSA storage and distribution capacity, improve procurement processes and Quality Assurance; **CSS**: Limited capacity of CBOs and Need for greater involvement of community structures; **Governance**: Domestic resource mobilization and **Service delivery**; Quality of care gaps and Service integration for efficiencies.

There are Significant resource gaps for the health System

Investment Outlook- RSSH

Health Products Management Module: Main allocation of USD$ 4,198,849- 15%; HMIS and M&E Main allocation of USD$5,040,000-18%; Integrated Service delivery Main allocation of USD$2,934,885- 10%; Laboratory Systems Main allocation of USD$-2,922,137- 10% Human Resources for Health Main allocation of USD$ 3,788,271- 13% ; Financial Management Systems Main allocation of USD$ 1,614,977- 6%; Community Systems Strengthening Main allocation of USD$5,996,882- 21%; Health Governance and Planning Main allocation of USD$ 2,160,401- 8%. **Total US$ 28,656,402-100%**

Module- HEALTH PRODUCTS MANAGEMENT

Policy, strategy, governance funding- US$1,407,286 PAAR -US$368,806; Storage and distribution capacity funding- US$378,294, PAAR US$184,506; Procurement capacity PAAR US$167,600; Regulatory/quality assurance support funding- US$2,413,268 PAAR US$1,062,211; Avoidance, reduction and management of health care waste PAAR US$501,180.

Expected Outcome: Improved functionality of KEMSA with two fully functional regional distribution centres in Mombasa and Kisumu; National capacity for Post market Surveillance and Pharmacovigilance will be strengthened and Improved efficiencies and HPM capacity at county and facility levels through Integrated supervisory visits and on-the-job trainings

Module-HMIS and M&E

Surveys funding of US$1,208,067; Analysis, evaluations, reviews and transparency funding of US$763,5436; Routine Reporting - US$1,013,314; Program and Data Quality- US$1,376,528 and Civil Registration and Vital statistics- US$695,505.

Expected Outcome:A robust National HMIS & ME with bottlenecks resolved and generating evidence for decision making.

Module- Human Resource for Health, Including Community Health Workers

HRH policy and governance Funding- US$ 298,296; Remuneration & deployment of existing/new staff (excluding community health workers) Funding- US$3,192718; In-service training (excluding community health workers) Funding- US$297,256

Expected Outcome:A strengthened workforce to improve service delivery for HIV, TB and Malaria and One year cover for TB Lab staff and transitioning in year 2

Module- Integrated Service Delivery and Quality Improvement

Quality of care Funding- US$2,152,028; Service delivery infrastructure Funding- US$783,424

Expected Outcome: Improved quality of neonatal and Child Health care at all levels with reduction of preventable neonatal, infant and under 5 deaths; Strengthened coordination between the National and county levels and Improved quality of community health services in ten counties with the highest coverage of community health units.

Module-Financial Management Systems

Routine grant financial management Funding-

US418,428, PAAR US$395,596; Public Financial management Funding- US$1,061,350 PAAR US$165,892

Expected Outcome:A robust National HMIS & ME with bottlenecks resolved and generating evidence for decision making.

Module- Health Sector Governance and Planning

National health sector strategies and financing funding- US$ 1,758,533; Policy and planning for national disease control programs funding- US$ 401,868.

Expected Outcome:A better coordinated health sector with governance structures strengthened to play their respective roles in improving the effectiveness of the HIV, TB and Malaria programs.

Module- Community Systems Strengthening

Social mobilization, building community linkages and coordination; Institutional capacity building, planning and leadership development; Community-Based Monitoring and Community-led advocacy and research.

Expected Outcome: Communities and affected populations engage effectively in activities to improve their own health outcomes; Community groups, organizations and networks have appropriate capacity to perform roles in service delivery, advocacy, leadership and community sector organizing and CBOs and other community groups (CGs) monitor, document and analyse relevant issues as a basis for accountability, advocacy and policy activities.

Module- Laboratory Systems

National laboratory governance and management structures Funding-US$79,301, PAAR US$96,893; Infrastructure and equipment management systems Funding-US$690,711; Quality management systems and accreditation Funding-US$1,535,046, PAAR US$178,709; Information systems and integrated specimen transport networks Funding-US$637,688 PAAR US$314,854; Laboratory supply chain systems PAAR US$87,650.

Expected Outcome:ISO 15189 accredited National Malaria Reference Laboratory**;** Expanded NPHL capacity to provide EQA services that cover all testing scopes in HIV, malaria and TB;

Sustainable implementation of SLMTA in the country and Overall improvement of the quality of HIV, malaria and TB testing services in the country

Key Outputs Expected

1. Funding Landscape & Programmatic gap tables by (July 27)
2. Performance Framework & Essential Data tables (Aug 14)
3. Detailed Budget (Aug 14)
4. HPM (Aug 14)
5. PAAR (Aug 14).
1. Funding Request Narrative Draft 1 – July 20; Draft 2 –KCM, external peer review and GF Country Team Review, Final draft – Aug 20
6. CCM Eligibility Requirements Aug -11
7. CCM Endorsement of Concept Note- Aug -25

Malaria Application

Presentation by Mr. Olugbenga -Consultant

The FR Consultant took members through the Application model based on the NSP template
Through the allocation letter from the GF, Kenya was invited to present a malaria funding request through the NSP Tailored approach. The form has 4 key sections
Section 1: context related to the funding request
Section 2: Funding request and Prioritization
Section 3: Operationalization and implementation arrangements
Section 4: Co-Financing, sustainability and transition

Section 1: context related to the funding request

The first part of the section was largely completed; second part is work in progress which have to be complete when most of the other sections have been complete to provide a proper

overview on defining strategies for key population and through needs already provided for to a large extent. Over all orientation is maintaining high coverage of high impact interventions, reaching all vulnerable populations in the drive towards malaria elimination.

Section 2: Funding request and Prioritization on the Funding Request and prioritization**;** Structured to address the following 1). The need and what is financed so as to generate a gap; 2). The funding request largely to meet the gap; 3). The Justification for the request. Prioritization process- stratification, disease burden, consultation processes, data use, Key Populations and value for money.

The grant summary has an allocation amount of New Grant amount US$ 86,966,676 whereas the current grant amount US$ 83,087,221; RSSH Cross-cutting New Grant amount US$ 6,000,701 current grant amount US$ 3,128,397; Disease Specific Interventions New Grant amount 80,965,975 US$ current grant amount US$ 79,958,824.

Indicative Splits are a work in progress where module 1 Vector Control split 64% amount millions US$ 51.8; Module 2: case man split 15.8% amount million US$ 15.5; module 3a: MIP, split 1.0% ,amount US$ 0.8; Module 3b: Social Behavior Change split 3.5%, amount US$ 2.8; module 3c Malaria Elimination split 0.3%, amount US$ 0.26; module 4 RSSH(M&E) split 7.2%, amount US$ 5.8; Module 5, Program Management split 4.6% amount US$ 3.7; PR-2 Admin costs including SR admin split 3.7% amount US$ 3.5 with a **total amount (current /estimated budget) -80.93M.** *budgets are tentative are defining process is ongoing.*

Summary for the Malaria Grant

Commodities: Medicine (uncomplicated Malaria)- budget Amount US$ 6,457,753, Medicines (Severe Malaria)- US$ 2,476,800, Rapid test kits US$ 3,450,000, Insecticide treated nets US$ 48,764,041 and Entomological Equipment US$ 404,000 **total US$ 61,147,577(75.5%).** Capacity building; Insecticide resistance management US$ 380,030, Health care workers (diagnosis and treatment) US$ 1,601,250, Orientation on CHVs on MIP US$ 613,240, Malaria Surveillance and EPR US$ 1,857,223, Malaria Elimination training US$276,019, capacity for Advocacy (SBC) US$ 346,471, Overall Malaria programming (county Coordinators) and commodity Mgmt. US$ 741,435 **total US$ 5,815,668 (7.1%).** Other

activities include vector control, Entomological surveillance and insecticide resistance monitoring and net durability studies; budget Amount 733,767.93, Case mgmt.: QA activities; Oversight and mentorship budget Amount 1,853,941.32, malaria in pregnancy, Messaging for CHVs to refer pregnant women, implementer engagement at county/sub-county level budget Amount 148,768.89, SMEOR: Community and facility surveys; data quality; Malaria surveillance, EPR budget Amount 4,702,247.50, Elimination: establishing systems and structures on elimination budget Amount 74,567.11, social behavior change budget Amount 2,024,790.05, Prog. Mgmt. and Grant Mgmt budget Amount 2,032,901.41, PR2 Admin budget Amount 3,500,000.00 total (16.6%) 13,510,587.00

Module on Malaria Vector Control

Long lasting Nets mass campaign LLIN-PBO, targeting all populations residing in malaria endemic, highland epidemic prone and hot spots in selected counties (27) aligned to NSP and lessons learnt from previous implementation with a total allocation of US$ 48.76M.

In door residual Spraying of select institutions within areas of mass net distribution in select counties aligned to NSP and lessons learnt from previous implementation with a total allocation of US$5.41M PAAR

Surveys to assess entomological parameters, insecticide resistance and durability of LLINs for communities in all counties/nationally with a delivery approach aligned to NSP, Capacity development, equipment surveillance across the country and lab. Work with a total allocation of US$ 2.03 M.

Module: case management

Provision of anti-malarial to malaria all cases across the country aligned to NSP with a current allocation of US$ 8.9M, provision of MRDTs, malaria cases across the country aligned to NSP with a current allocation of US$ 3.4 M, enhancing adherence to guidelines on health workers capacity across the country aligned to NSP with a current allocation of US$2.73M, Quality assurance for diagnosis for health facilities, lab. Staff and QA lab. officers across the country aligned to NSP and lessons learnt with a current allocation of US$0.59M, Community case Management of populations in malaria lake endemic areas, current scope of implementation in 10 counties all aligned to NSP, Scale up of service to larger scale within

implementation area and lessons learnt with a resource allocation of US4 16M (to be adjusted to scope and scale)

Module: specific Prevention interventions (MIP and SBC)

IPT-p for MIP prioritized to pregnant women in 14 malaria endemic counties in the 8 lake regions, 6 coast counties to scale up services, aligned to NSP and lessons learnt from implementation; also prioritize health workers and CHVs in 14 malaria endemic counties as above in order to scale up services aligned to NSP total US$ 0.85M.

SBC Advocacy on capacity building (counties and National level) aligned to NSP, scale up of services with total resource allocation of US$ 0.38.

SBC- Community engagement on community units in Malaria endemic counties in select counties aligned to NSP, scale up of services with total resource allocation of US$0.8M

SBC-Mass Media for all populations as aligned in the NMP with total resource allocation of US$4.3M

Module: Malaria Elimination

Main intervention is to establish systems and structures for malaria elimination to county leadership and health teams in 2-4 counties as aligned in NSP, capacity development and establishing of structures at national and county levels with a resource allocation of US$ 0.26M.

Module: Malaria M&E

Interventions on malaria surveillance for county and facility level health workers nationally as aligned to NSP with a resource allocation of US$ 1.8M; Malaria DQA for county and facility level health workers nationally as aligned to NSP with a resource allocation of US$2.2M; Supervision and Mentorship for community units, health facilities, sub counties and counties nationally as aligned to NSP with a resource allocation of US$0.84m; Malaria epidemic preparedness and response for populations in epidemic prone areas (23 counties and 126 sub counties across the country in select counties and sub counties for county and facility level health workers as aligned to NSP with a resource allocation of US$ 2.75M; Facility and community surveys for community, facilities KMIS to PAAR nationally as aligned to NSP and lessons learnt with a resource allocation of US$4.2M; Operational research on HRP-II

deletion , durability monitoring, Ops research annual review nationally as aligned to NSP with a resource allocation of US$ 0.75M

Module program management

Interventions in partnership and coordination and increase in Domestic resources in malaria stakeholders (National and County level) nationally as aligned to NMP with resource allocation of US$ 1.8M; in enhancing programme implementation capacity in national and county health teams nationally for scale up of services and capacity with resource allocation of US$0.38M; grant management for DNMP and the TNT as aligned to NSP , previous implementation with resource allocation of US$ 1.3M; PMS Coordination for targeted counties and national level nationally aligned to NSP with resource allocation of US$1.8M; PR-2 Administration targeting PR-2 and SRs nationally aligned to NSP with resource allocation of US$ 3.5M

Section 3: Operationalization and implementation arrangement

Implementation arrangements include PR1, PR2, Line Ministries, County Government and CSOs.

The role of CSOs includes LLINS, case management, SBC, SMEOR Program Management and MIP.

Section 4: Financing, sustainability and Transition

Most of this is completed; Risk assessment done, number of other relevant documents being finalized as attachments include GAP Tables, Essential data table, performance Framework and budget.

Conversations were ongoing on the funding land scape

The current costing (work in progress) has case management sum allocation of 15,642,020; community case management allocation of 16,700,900; Malaria elimination allocation of 385,307, Malaria in Pregnancy allocation of 847,378; Operational research allocation of 751,156; program Management allocation of8,648,276; SBC allocation of 5,522,149, SMEOR allocation of 9,647,360 sum of PAAR 2,346,349; vector control allocation of 51,704,195 sum of PAAR 5,414,747 **grant total sum allocated 109,848,741/ PAAR 7,761,096.** Working with a **grant ceiling of 80,965,975.**

Discussion

The chair thanked the Funding request Secretariat for the detailed presentation, the Chair informed members that she had been called upon to attend an urgent meeting and therefore she was to make her contribution /inputs to the funding request draft and hand over the meeting to the Vice Chair to continue Chairing.

The Chair informed the meeting that salaries proposed in the funding request application for human resource were high and should be aligned to the Government /MOH salary scales for the respective cadres. She informed the funding request secretariat to focus on reducing programme management cost and direct resources to high impact intervention e.g. treatment and care as this were important for sustainability and transition.

On the NHIF cover; the Chair sought clarification on the modalities to be used in enrollment of the patients in terms of the targeted number and intended duration of cover. She added that clarity is required to ensure such programs are sustainable under universal health Care.

The KCM Vice chair then opened the floor for further discussions and deliberation.

Dr Kiliko Member FBO Constituency appreciated the FR team for an elaborate presentation, he however observed that, timelines were a challenge and added that everyone needed to put their eyes on the ball. He informed the meeting that there was need to review a more advanced draft with proposed diseases splits as well as PR1 and PR2 splits. He cautioned that whereas the presentation looked balanced; issues raised by constituencies should be incorporated in the funding request application. In addition, he also noted some omissions/concerns in some programs/interventions e.g. introduction of contraceptives on AGYW was a great concern by the FBO and that there was need to listen to the voices of the FBO.

Rosemary Kasiba, KP representative, noted that KP constituency has had two meetings with NASCOP and consultants, however some items were added and dropped. She requested NASCOP and Funding request consultants to ensure that the proposal by the Key population was considered.

Member/PLWD-TB noted that based on discussions the current FR update, gaps tables and interventions should have been undertaken at the ICC, that the team needed to bring ready document that can be endorsed. In addition, KCM would receive specific asks for review and endorsement. During the meeting it was clarified that the KCM had a role also to review the funding request application draft and provide inputs before the final version was presented for endorsement.

The Member Malaria constituency cautioned that the FR secretariat needed to explain further or moderate some of the terminologies and abbreviations.

Mr. Kihiu requested the FR team to factor in support for the informal private sector capacity building programmes

Mr. Kamigwi KCM Member NACC / Co Chair Joint ICC, clarified that the Funding request presentation was a welcome move. This provided a unique opportunity to update members on the FR development process and also for the KCM to review draft FR documents and share inputs for in cooperation.

The Chair funding request secretariat, noted that all comments are welcomed. She took note the salary payment concern and added that the core team would rationalize all program salaries remunerations with those of the Government.

She noted that that she was informed that the KP had a weekend meeting and had received an email to that effect. She reassured the KP Constituency that a follow up meeting will be held with NASCOP and FR Consultant to look into the issues raised.

Dr. Newton Omale FR Secretariat member noted that they had a successful meeting with the HIV Community on issues of HIV Prevention and PMTC. The AYP issues were addressed by the consultants and incorporated into the document.

Dr. Elizabeth TB Program Lead stated that MDR TB follow-up had been factored in the FR Application, the proposal was for MDR patients to receive a Ksh. 6000 steeped per month which was not adequate. A catastrophic survey done advocated that for there to be a reduction of the catastrophe of ill health as pertaining MDR TB, it was imperative to offer medical

insurance. The NHIF super cover is meant for hospitalization and other associated medical costs not covered by the program as the current cover did not adequately address these immediate medical needs. The TB Program had an annual target of 1000 people on MDR TB treatment per year.

Dr. Mugambi Chair FR secretariat, clarified that the funding request development was a multi stakeholder engagement process and the writing team needed inputs from the secretariat, KCM Members and ICC. All comments given here are very important and hoped that all areas of contention would be flagged out through this engagement. She however clarified that the modular splits were available in the presentation given.

Action Points

Members agreed that the Funding request secretariat would;

- Modular splits to be presented to the KCM on 17th August,2020 for endorsement
- Incorporate comments and inputs from the KCM and ICCs in the revised version to be presented on 17th August,2020 to the KCM. Members requested to share any additional review comments by 12th Augsut,2020.
- Funding request Secretariat to Share documents with the KCM for review at least 3days before scheduled KCM Meeting.

Remarks by Mr. John Ochero, Senior Fund Portfolio Manager

The GF Portfolio Manager in his remarks appreciated the invitation to the KCM meeting. He appreciated all stakeholders for their continued support to the FR deliberations; constructive disagreements were welcomed. He noted that only 3 weeks were remaining before the submission date and these discussions are welcomed to help incorporate all updates and corrections made to make a good and timely FR.

He noted that the GF country team had been involved in the process and would give detailed remarks and updates by Close of business. He emphasized the need to focus on implementation of the current grant and ensure continued improved grant performance. He assured members that the GF country team would be available for further consultations and guidance.

Min 4/8/2020 Review and approval of KCM eligibility performance assessment report/ Performance Improvement Plan

The KCM Coordinator took members through the eligibility performance self-assessment report.

Requirement 3 on ensuring success of program implementation;

***Fully Compliant activities include*:** The Oversight plan and CCM Funding agreement, meeting minutes, email communications, consultation reports, oversight visit reports and CCM Website, OB meeting minutes/reports, oversight tool; action plan to correct gaps and CCM website, Oversight tool; action plan to correct gaps; OB Meetings minutes and Oversight reports; email communications; CCM Website.

Indeterminate Compliant includes: Oversight Committee Membership has not been fully constituted since expiry of Oversight committee terms of office on 30th June 2020. TB-ICC has however renewed their membership, and the new members are Dr. Eunice Omesa (DP/WHO) and Evelyn Kibuchi (CSO/Stop TB Kenya). PLWD – HIV ICC yet to submit the new names. The names were to be submitted by 14th august,2020.

On requirement 4 and 5 on ensuring an inclusive and meaningful representation in the CMM composition

Fully Compliant in the area of CCM Membership list and CCM meeting minutes

With Key population represented by 2 members/2 alternates in the KCM, PLWDs are well represented in the KCM and CCM Female representation over 30% of membership i.e. 35%

substantive /65% alternate CCM members as listed in the membership list, Civil Society sector representatives in CCM Kenya's is 48%, above the 40% required by the GF, KCM Chair selected from Government Constituency and Vice Chair from Non State Actors. KCM Chair appointed on 6th March,2019 and Vice Chair on 6th December,2018. As per the appointment letter, KCM minutes and KCM Constitution.

Indeterminate Compliant includes: Civil society sector meeting minutes, member endorsement letters from civil society constituencies evident by renewal of membership for FBO Constituency currently ongoing as well as Work plans for civil society sector representatives; meeting minutes of civil society constituencies hence Evidence of regular exchange of information.
Constituency reports/Work plan for 2018/2019 up to date. Constituency reports for 2019/2020 three Constituencies have filled reports.

On requirement 6, on ensuring appropriate management of conflict of interest ***Fully Compliant***
In CCM Conflict of interest policy evident by a copy of CCM Kenya conflict of interest policy and KCM minutes demonstrating Compliance, During the KCM meeting held on 5th May,2020 the KCM established an ethics committee.

The coordinator took members through the outlook of membership on the Oversight Committee membership 1st July 2020 to 30th June 2022

Discussions
The KP Representative enquired on what guides the selection of the alternate members on Oversight committee. Whereas Ms. Jacinta Mutegi sought a clarification on representation of ICCs on the KCM Oversight Committee.
Response
The KCM Coordinator clarified that the KCM Oversight Plan and Terms of reference guides that;

The Oversight Committee shall be comprised of 10 members. 7 members will be from KCM (representing National Government, County Governments Multilateral/ Bilateral Partners, Adolescents and Young People, Private Sector, PLWDs and KAPs), and 3 ICC representatives (HIV, TB and Malaria respectively).

Each KCM constituency will appoint or elect 1 representative and an alternate. The alternates representing each constituency on the KCM are not automatically the alternates for the Oversight Committee. The appointment and/or election process must be transparent and documented.

In order to mitigate against conflict of interest, Oversight Committee members shall not be Principal Recipients, Sub Recipients or Sub-Sub Recipients.

The Member FBO Constituency, highlighted that it was important to have a discussion on the strategic plan and that a high-level presentation is made during the next KCM meeting for members to review and approval.

The FBO constituency committed to endure that renewal of membership is completed by 20th August.2020.
Reconstituted oversight committee membership for the period July 2020 to June 2022 was approved. See full list as contained in annex 1.

The Request for approval and endorsement of the EP self-assessment report for onward submission to the Global Fund

Proposed Mr. Phillip Nyakwana
Seconded Mr. John Kihiu

Min 5/8/8/2020 Review and confirmation of minutes of KCM meeting held on 16th June,2020, 9th July,2020 and 30th July,2020/ Matters arising

The chair appreciated FR writing team dedication to the FR process. They were then asked to exit the meeting to enable the KCM deliberate on inhouse business.

The KCM Coordinator took members through the minutes meeting held on the 16th June, 9th July and 30th July 2020 and Matters Arising.

Minutes of meeting held on 16th June 2020

The Minutes were endorsed as a true record of the days meeting

Propose: Mr. Bernhards Ogutu

Seconded: Patricia Kilonzo

Minutes of meeting held on 9th July 2020

Matters Arising:

Ms. Rosemary Kasiba noted that some issues raised in the meeting had not been captured in the minutes. Example Mr. Kihiu had requested for members to vote; There was also a concern that , the PR Evaluation Report approved was a power point presentation but not a report; The request from Mr. Peter Njane for a day or two to deliberate on PR report was not captured and That the RFP document needed to be discussed in the ICCs. The KP constituency stated that the meeting ended without a conclusion.

Member PLWD-TB constituency stated that amendments may be done to the minutes. He added that the secretariat had done exceptionally well in discharging their duties and the minutes would be adopted with the recommended changes.

The KCM Chair highlighted that she does not recall a call for a vote on the selection of non-state PR and requested members for their views.

Mr. John Kihiu noted that he remembered an argument amongst members and when they did not agree, he suggested that a vote would be taken.

Mr. John Kamigwi, remembered the main issue was based on the fact that the tendering process was a procurement issue and would be dealt in line with procurement guidelines and procedures. The Evaluation Committee report presented was comprehensive. Any issues that may arise need to be presented at the appeals stage. He stated that he does not recall any time a vote was in discussion.

Mr. Ahmed Said, KP Constituency asked the secretariat to revisit archived recording of the same meeting and share the minutes together with the recording. He asked that all matters discussed need to be captured.

Ms. Jacinta Mutegi sought clarification on whether the IRP report was sent to members

The KCM coordinator stated that the requested by the KPs was well taken. He added that he shared the draft minutes with all members 4 days after the meeting for review, he further requested the KP representatives to review/inputs and track changes on the version shared by the secretariat. All changes tracked by members had already been incorporated. On the IRP Report he confirmed that the detailed presentation made by the IRP to the KCM on 9th September,2020 is part of the report shared with all KCM members on 15th July ,2020 after IRP members had finalized signing the report.

Actions Points

Most of the members present during the meeting confirmed that they received the IRP Report but asked the secretariat to re share the IRP Report again.

The minutes were endorsed with above noted amendments

Propose: Mr. Kihiu John

Seconded: Mr. Peter Kamigwi

Minutes of meeting held on 30th July 2020

The Minutes were endorsed as a true record of the days meeting

Propose Mr. Phillip Nyakwana

Seconder: Mr. John Kamigwi

Member TB program, stated that the Dual track procurement channel should be discussed in details. The KCM Coordinator proposed that the Management Committee explore and put up a concept note and thereafter present to the KCM deliberation.

The chair then recommended that the Management Committee members should evaluate the feasibility of the dual track procurement process.

Propose Mr. Phillip Nyakwana

Second Mr. John Kamigwi

Min 6/8/2020 PR selection appeals / Appeals review process.

The KCM coordinator informed members that the KCM had received 8 correspondences regarding the PR Selection process. The letters were highlighted as summarized below;

S. No	Organization	Date	Appeal/Concern
1.	Kenya CSO`s	18th July,2020	Concern: Selection of Non-State Principal Recipients for GFATM 2021-2024
2.	KP Consortium of Kenya	19th July,2020	Concern: Selection of Non-State Principal Recipient
3.	AMREF HA	21st July,2020	Acceptance letter
4.	NEPHAK	22nd July,2020	Concern: Selection of Non-State Principal Recipients for GFATM 2021-2025
5.	KRCS	28th July,2020	KRCS Appeal: Evaluation of Tender No RFP/KCM/001/2019-2020
6.	AYP	2nd August,2020	Concern: Selection of Non-State Principal Recipients for GFATM 2021-2025
7.	KCM Non-State Actors	8th August,2020	Resolutions: KCM Non - State Actors Resolutions on Kenya's Global Fund 2020 Application.
8.	TB Action Group	3rd August,2020	Concern: The Untold Story of the Non-State Principle Recipient and Funding Request 2020

In compliance with the KCM conflict of interest policy, members were requested to declare conflict if any, it was noted that some of the organization listed in the letters to be reviewed by the KCM Appeals Committee were also represented on the KCM membership.

Members who declared conflict included;

1. Maurine Murenga
2. Rosemary kasiba
3. Peter Njane
4. Ahmed said
5. Vincent Obwanda

Members were requested to recuse themselves from the meeting as the KCM deliberated on agenda **6 on PR selection appeals / Appeals review process.** Members were to be alerted and join back during agenda 7. The KCM formally acknowledged all letters received for review by the KCM Appeals Committee.

The KCM Coordinator informed members that the KCM reconstituted an appeals committee during the KCM meeting held on 13th June,2019, committee members include;

1. Dr. Jonathan Kiliko- KCM Member/ MEDS/Procurement expert
2. Mr. John Kihiu- KCM Member/Private Informal sector
3. Mr. Jackson Mwangi-KCM Member/ Ministry of Devolution/ Legal expert
4. Mr. Kennedy Moseti-Legal Expert/NACC
5. Dr. Dan Koros - PEPFAR

Discussion

Members noted that Mr. John Kihiu was a member of the adhoc committee that participated in the formulation of the PR selection request for proposal guidelines and there was need to replace him with another member.

During the Meeting Ms. Faith Muigai member Formal Private Sectors was selected to replace Mr. John Kihiu on the appeals committee.

Next steps

- All letters of concern and appeal to be acknowledged
- Appeals committee approved with changes as highlighted above.
- Appeals committee to review all letters and present report to the KCM

Proposed: Mr. Bernhards Oguttu

Second: Ms. Faith Mwende

Members agreed that the appeals committee did not have much time and would make their reviews within a week and present report to the KCM on the 17th August 2020.

Proposed: Mr. Latiff Shaban

Seconded: Ms. Faith Ndungu

Mr. John Ochero thanked members for their commitment to the process. He retaliated that members needed to familiarize themselves with the eligibility requirement as PR selection fell under ER 2 and the process needed to be open and transparent. In addition, the process needed to be documented in detail and objectively stating how COI was managed. These minutes would form part of the submission documents and all requirements under these criteria would need to be met so that the funding request sails through seamlessly.

Min 7/8/8/2020 Closure/AOB

The KCM Secretariat reached out to members who had recused themselves to join the meeting.

There being no other business, the chair thanked members as well as the country team for their important inputs. He asked the appeals committee to uphold the principles of integrity, confidentiality and transparency during the appeals review process.

Meeting ended at 3.01PM

Sign: ..... **Date: 14/08/2020**

Mr. Samuel Muia
KCM Coordinator

Sign……. **Date: .....**

Ms. Susan Mochache, CBS
KCM Chair

Minutes to be confirmed during the next KCM meeting

Annex 1.

OVERSIGHT COMMITTEE MEMBERSHIP 1st JULY,2020 T0 30TH JUNE 2022
ENDORSED DURING THE KCM MEETING ON 10TH AUGUST,2020

S No	Name	Designation	Constituency
1.	Dr Bernhards Oguttu	Chair	Gov
2.	Dr Medhin Tsehaiu	Member	ML DPs
3.	Mr. John Kihiu	Member	Informal Private Sector
4.	Dr Ischar Oluoch	Member	Gov-Counties
5.	Ms. Rose Mary Kasiba	Member	KP
6.	Ms. Joyce Auma	Member	AYP
7.	Mr. Philip Nyakwana	Member	PLWD
8.	Dr Victor Sumbi	Member	Malaria ICC
9.	Ms. Rose Kaberia	Member	HIV ICC
10.	Dr Eunice Omesa	Member	TB ICC
1.	Ms. Evelyne kibuchi	Alternate-Incoming	TB ICC
2.	Ms. Hellen Gatakaa	Alternate	Malaria ICC
3.	TBC	Alternate	HIV ICC
4.	Dr Dan Koros	Coopted	GF/PEPFAR LIAISON
5.	Dr Caroline Olwande	Coopted	UNAIDS
6.	Mr. Samuel Muia	KCM Coordinator	KCM Secretariat
7.	Ms. Jopshine Mwaura	Oversight Officer	KCM Secretariat

Annex 2. Updates on Previous KCM Recommendations

KENYA COORDINATING MECHANISM UPDATES ON KCM RECOMMENDATIONS MADE ON 16TH JUNE,2020, 9TH JULY & 30TH JULY,2020		
RECOMMENDATIONS	**UPDATES**	**STATUS**
Update on Funding Request Development Process / Review and Endorsement of Funding Request Priorities.	• KCM reviewed and shared inputs on the Funding request priorities and interventions	Ongoing
Min4/6/1/2020 Joint Management /Oversight Committee Report The KCM requested the Ad Hoc committee defining implementation arrangements for Global Fund grants in Counties to reconvene and recommend options to the KCM before end of June,2020	• Adhoc committee convened and analyzed options of devolving GF Grants to Counties and recommended the best option. • The KCM Chair formally requested COG to review the KCM Report and share final inputs by 30th July,2020 before adoption. • Follow made on 6th August,2020 and COG Committed to share final inputs by 14th August,2020	Ongoing
Review and endorsement of KCM eligibility self-assessment report/Improvement plan; and KCM Performance report for 2019/2020. KCM Work plan and Budget for 2020/2021 KCM eligibility assessment report / PIP substantive agenda Constituencies requested to submit Constituency Dialogue Reports. So far, only 3 out 9 Constituencies had been submitted. The reports are part of the annexes for ER 1 needed during submission of the Funding Request Application to the Global Fund.	self-assessment report highlighting the KCM /KCM Secretariat performance during the period 1st July 2019 to June,2020 approved during the KCM meeting held on 16th June,2020 and shared with GF. KCM Secretariat evaluation outcome: - Members agreed that the Secretariat had done exceptionally well. KCM approved proposed budget and work plan. Secretariat submitted reports to the CCM Hub on 31st July,2020. KCM eligibility assessment report / PIP substantive agenda	Done Ongoing
Progress report on the KCM Strategic Plan Development Process	Reviewed by management committee on 5/8/2020 and	On-Going

KENYA COORDINATING MECHANISM UPDATES ON KCM RECOMMENDATIONS MADE ON 16TH JUNE,2020, 9TH JULY & 30TH JULY,2020		
RECOMMENDATIONS	**UPDATES**	**STATUS**
	shared with KCM on 6th August,2020 for review and approval	
Transition of HR in the current grant	The Ministry of Health established a Technical Team to examine all requests regarding transition arrangements for GF staff. The task force report was being reviewed by the Human Resource Department at the Ministry of Health for the next steps.	On-Going
Submission of Constituency Dialogue Reports. So far, only 3 out 9 Constituencies had been submitted.	Constituency Dialogue Reports are still pending. The reports are part of the annexes for ER 1 needed during submission of the Funding Request Application to the Global Fund.	On-Going
SPECIAL KCM MEETING HELD ON 9TH JULY,2020: recommendations	Update	Status
Review and Approval of Report on Selection of Principal Recipients.	• Evaluation Committee report approved. • Official notification on the outcome of the evaluation done to all bidders. 14days appeals window granted up to 3rd August,2020. • One appeal, 6 letters of concern, one letter of recommendation and one acceptance letter received. • Appeals review substantive agenda.	Done On-Going
Adhoc committee to reconvene and recommend best option to channel GF Funds to the Counties	• Adhoc committee convened and analyzed options of devolving GF Grants to Counties and recommended the best option. • The KCM Chair formally requested COG to review the KCM Report and share final inputs by 30th July,2020 before adoption. • Follow made on 6th August,2020 and COG Committed to share final inputs by 14th August,2020	Done Ongoing
SPECIAL KCM MEETING HELD ON 30TH JULY,2020		
Endorsement of C19 RM Additional Funding Request Application for PPE and Diagnostic Tests	Funding request endorsed on 30th July,2020 and submitted to the Global Fund same day at 11.115pm The Global Fund has approved USD 8,306,205 of additional investments to support COVID-19 response in Kenya, this bring the total amount approved by the Global Fund to support COVID Response in Kenya to	Done

KENYA COORDINATING MECHANISM UPDATES ON KCM RECOMMENDATIONS MADE ON 16TH JUNE,2020, 9TH JULY & 30TH JULY,2020		
RECOMMENDATIONS	**UPDATES**	**STATUS**
	USD 24,918,611.	
Request to replace all the brand names used in the application for Laboratory diagnostic with generic names where possible.	Brand names replaced with generic names	Done
Need to explore on additional procurement streams.	Oversight and Management committee to deliberate and share report to the KCM	Ongoing