OFFICE OF THE PRESIDENT

KENYA NATIONAL AIDS STRATEGIC PLAN

2009/10 – 2012/13

SUPPORTING DOCUMENTS FOR THE STRATEGIC PLAN

NATIONAL AIDS CONTROL COUNCIL

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Section 1: AN OVERVIEW OF KNASP III SUPPORTING DOCUMENTS

1. Introduction

The KNASP III supporting documents were developed to support the planning and implementation of the strategy. This documents has been compiled to enable stakeholders have easy access to all the documents and be able to cross reference to KNASP III easily. This document presents the major the supporting reports and plans for KNASP III.

The supporting documents compiled include:

- KNASP III Gap Analysis and costing
- KNASP III Commodity Quantification Report
- KNASP III Technical Support Plan
- National Plan of Operations

2. Purpose of each KNASP III Supporting Document

2.1 KNASP III Gap Analysis and Costing

The KNASP III gap analysis identifies the programmatic and financial gaps for the next four years. The programmatic gaps are presented as targets for KNASP III. These are the targets that the strategy plans to achieve in order to attain the planned change in the HIV epidemic. The targets identified are at output level and they are linked to the outcome level targets identified in the results framework. The link between the output targets and KNASP III outcomes has been maintained.

A gap analysis has been undertaken based on current and projected availability of funding to finance the activities that will lead to the achievement of the outputs targets. The gap represents the proportion of targets for which funding is not available. Resources mobilisation for KNASP III should focus on raising finding to achieve the gaps.

The KNASP III costing is guided by the KNASP III targets. It presents the cost of the inputs requires to achieve the targets. The financial gap analysis has been calculated based on the projected funding required and projected funding available in the next four years.

The KNASP gap analysis and costing data will support resources mobilisation for KNASP III, resources allocation and performance monitoring of the strategy.

Commodity quantification report

This report details the quantities of commodities to be procured in the next two years to meet the KNASP III service delivery targets. The objective of the commodities quantification is to develop detailed 2-year commodity quantifications aligned to the 2-year National Plan of Operations (NPO). Specifically, this exercise estimates the national needs for various HIV and AIDS commodities, determines the total country's commitments towards the needs above from all partners, and provides a provisional commodity procurement plan for the period July 2009 – June 2011 (FY 2009/10 -2010/11) which will facilitate timely procurement and delivery of these commodities to support the HIV & AIDS program.

The commodity quantification covers the major types of HIV and AIDS services: Treatment, Care, Prevention, and Laboratory services. Under these areas, the following commodity categories linked to HIV & AIDS are quantified.

1. **ARV Treatment** – drugs for Adult, Pediatric ART
2. **Care** – commodities for key OIs, HCBC and Palliative care, Nutrition
3. **Prevention** – commodities for PMTCT, VMAMC, Injection safety, Condoms (Male, Female), ECP (Emergency contraception pills) and PEP, MARPs commodities
4. **Laboratory** – commodities for Screening (HTC, EID and Blood Safety); Monitoring tests (CD4 and Viral load).

The methodology applied to quantify commodities involved forecasting future demand for services and commodity needs is based on the availability and quality of data on rate of consumption of drugs or commodities used, number and type of patients/ clients receiving services and program policies and expansion plans

The following types of data was used to guide the quantification:

- Demographic data based on characteristics of the target population (e.g. age, sex, geographic location)
- Morbidity data on prevalence or incidence of disease or infection in the target population
- Service provision data on the number of service delivery sites (SDPs), the volume of services

or number of patients per site, and the type of services received

- Data on consumption or use, losses from and adjustments to inventory, and the stock on hand at the various levels of the in-country supply chain.

This quantification report will guide programmes in estimating commodity need. Programmes providing HIV services that require these commodities can use the quantities and cost in this report for costing and developing procurement plans. The report will also support national level forecasting on commodity requirement to minimise stock outs.

Communication strategy for KNASP III

The communication strategy aims at supporting KNASP III to achieve its results through advocacy, information dissemination and social mobilisation. The strategy focuses on communicating KNASP III to stakeholders and providing guidelines for programmatic communication programmes. In this regard, the communication strategy targets a wide range of audiences including policy makers, development partners, implementing organisations, the media and key institutions coordinating the national response.

The key components of this strategy are as follows:

1. KNASP governance, financing and strategic information: This component lays out strategies for communicating KNASP III, the coordination structures and strategic information, leadership, roles and policies and the KNASP III resources mobilisation and allocation.

2. Advocacy, communication and social mobilisation for the National HIV and AIDS Programme component which provides guidelines for communication programmes for HIV prevention, treatment and care and social protection programmes.

3. This strategy provides guidelines for development of communication programmes and tools. The stakeholders should use it as a guide. It is mean to support programming of communication programmes and mainstreaming communication in service provision.

Health systems strengthening strategy

The Health Systems Strengthening (HSS) strategy seeks to address weaknesses in health systems that hinder the implementation of HIV and AIDS programmes. The strategy focuses on the governance, information systems, human resources, procurement and supply management and service delivery elements of the health system. The strategy proposes the key interventions required to strengthen service delivery. It also recognises the link between the health and community systems.

A detailed analysis of the health systems strengthening needs has been done and the key interventions that have high impact on health services delivery have been identified.

The HSS strategy should be used to guide investment into health systems strengthening. It is noted each programme invests in aspects of the health systems that are relevant to its delivery. This strategy will guide the coordination of such investments to contribute to a coherent health systems capacity development.

KNASP III Technical support plan

The purpose of the technical support plan is to harmonise the approach used by multiple partners in providing technical support in the country. The plan identifies the areas that partners should prioritise in providing technical support under KNASP III. The plan will also support the alignment of technical support to KNASP III to ensure that such support focuses on critical areas that impact on the effectiveness of the national response to HIV and AIDS.

The KNASP III technical support plan identifies the bottlenecks in the implementation of KNASPIII which should be addressed to scale up the national response to HIV and AIDS. The plan identifies the technical support needs for each KNASP III and the type of technical support required and the cost of the support.

The plan is divided into two sections: section 1 outlines the detailed technical support plan which includes a comprehensive listing of the key bottlenecks in KNASP implementation and the technical support required. Section II has prioritised the technical support required to address the major bottlenecks with an indication of the partners that will provide support.

KNAPS National Operational Plan

The operational plan for KNASP III prioritises the activities to be carried out in the firt two years of the strategy. The plan identifies activities to be implemented under each pillar to achieve specific targets. It also identifies the key partners responsible for implementation of the activities and timeframes for implementation.

The operational plan therefore serves the following purpose:

- It guides short term prioritisation in resources allocation
- It supports performance monitoring of the national response
- The plan forms a basis for annual KNAPS III reviews
- It provides a platform for coordination of all partners involves in the national response

The operational plan will be implemented through the programme plans which will be developed by partners. Development partners and implementing organisations should therefore align their short-term work plans to this operational plan.

SECTION 2: KNASP III GAP ANALYSIS AND COSTING

The gap analysis for KNASP III identifies the proportion of national output targets for which there is not projected funds available. This presents the gap for which additional resources should be mobilized to enable KNASP III to be implemented effectively. The gaps have been identified by estimating the targets for KNASP III over the next four years and the targets to be met using projected estimates of funds available in the next four years.

The targets at output level are linked to the outcome targets of the strategy. It is envisaged that this level of KNASP performance will lead to the achievement of expected outcomes. The outcomes have been established in the KNASP III results framework.

Some of the targets below are based on accurate and up to date baselines while others been determined based on estimates and projections. The planned strengthening of monitoring and evaluation of KNASP III will enable annual target setting in the life of KNASP II to be more accurate.

The targets outlined below also provide a basis for assessment of the KNASP II performance annually. The gap analysis will therefore be updated at the end of every year together with the operational plan. The projected gaps are expected to change form year to year based on the performance of KNASP III and availability of funding. Therefore, the gap analysis exercise should be carried out annually.

This gap analysis should be used by development partners and implementing organisations to align their programmes to the strategy. It is expected that programmes implemented by various partners under all the pillars will contribute to the achievement of the targets set out below.

KNASP III Gap Analysis

Thematic area	2009/10	2010/11	2011/12	2012/13
PREVENTION				
PMTCT: Number of women who receive PMTCT services	1,300,000	1,323,158	1,360,233	1,397,986
USG	1,300,000	1,300,000	1,300,000	1,300,000
GAP	0	23,158	60,233	97,986
HTC: Number of people receiving HIV testing and counselling in all settings	4,141,937	5,382,662	5,596,119	3,101,504
TOWA-NACC (WB CREDIT)	396,138	396,138	396,138	
USG	3,000,000	3,000,000	3,000,000	3,000,000
GAP	745,799	1,986,524	2,199,981	101,504
Number of males medically and voluntarily circumcised	200,000	200,000	200,000	200,000
USG	200,000	200,000	200,000	200,000
GAP	0	0	0	0
Hepatitis B (Hep B)	160,000	180,000	200,000	220,000
Hepatitis C (Hep C)	160,000	180,000	200,000	220,000

Thematic area	2009/10	2010/11	2011/12	2012/13
RPR (Syphilis)	2,000,000	2,200,000	2,420,000	2,642,000
Number of people receiving STI Detection & Management services[1]	25,200	51,761	82,269	103,988
(Nos of tests for people on care) (ABC) GAP	2,320,000	2,560,000	2,820,000	3,082,000
OI				
Adult Patients on Care (ABC)	639,842	747,834	851,846	865,755
Paed Patients on Care (ABC)	78,922	96,063	123,137	152,267
MoH-GFATM	200,000	200,000	200,000	200,000
USG	600,000	600,000	600,000	600,000
GAP	-81,236	43,897	174,983	218,022
Number of blood units screened	180,000	200,000	200,000	200,000
USG	180,000	200,000	200,000	200,000
GAP	0	0	0	0
Number of male condoms distributed 1	275,876,075	296,601,504	318,883,949	342,840,382
MoH	120,000,000	120,000,000	120,000,000	120,000,000
DFID	33,000,000	36,300,000	39,300,000	
GAP	122,876,075	140,301,504	159,583,949	222,840,382
Number of female condoms distributed 1	3,829,815	4,165,920	4,531,522	4,929,208
TOWA-NACC (WB CREDIT)	600,000	600,000	600,000	
(ABC) GAP	3,229,815	3,565,920	3,931,522	4,929,208
Number of people reached through community mobilisation HIV and AIDS prevention programs	3,085,000	5,804,000	9,236,000	11,267,000
TOWA-NACC (WB CREDIT)	2,378,994	2,378,994	2,378,994	
Unicef	70,000	120,000	150,000	180,000
GAP	636,006	3,305,006	6,707,006	11,087,000
Number of people reached through workplace programmes[1]	2.4 m	3	4.3m	5.3m
GAP				

Thematic area	2009/10	2010/11	2011/12	2012/13
Number of national Mass Media interventions/yr[1]	8	8	8	8
Min of Info & B and partners				
GAP	8	8	8	8
PEP	45,000	45,000	45,000	45,000
GAP	45,000	45,000	45,000	45,000
Retractable anti-re-use syringes with needles				
1. 2ml (ABC)	2,874,051	5,909,676		
2. 5ml (ABC)	4,311,076	8,864,514		
3. 10ml (ABC)	5,748,101	11,819,352		
4. 20ml (ABC)	1,437,025	2,954,838		
Total (ABC)	14,370,253	29,548,380		
(ABC) GAP	**14,370,253**	**29,548,380**		
Universal Precautions (# of hospital beds covered)				
ABC	10,477	21,543	40,602	60,697
MoH				
Other Partners				
(ABC) GAP	10,477	21,543	40,602	60,697
PREVENTION INTERVENTIONS AMONG SPECIFIC GROUPS [2] USG:[3]				
Number of female sex workers to be reached with HIV prevention services	64,000	64,000	104,418	155,982
TOWA-NACC (WB CREDIT)	41,570	41,570	41,570	
GAP	22,430	22,430	62,848	155,982
Number of male sex workers to be reached with HIV prevention services	1,500	3,081	5,801	8,666
TOWA-NACC (WB CREDIT)				
GAP	1,500	3,081	5,801	8,666
Number of truck drivers reached with HIV prevention services	18,000	36,972	69,612	103,988

Thematic area	2009/10	2010/11	2011/12	2012/13
TOWA-NACC (WB CREDIT)				
WFP	1,750	2,000	2,250	2,500
GAP	16,250	34,972	67,362	101,488
Number of prisoners receiving services	7,500	15,405	29,005	43,328
TOWA-NACC (WB CREDIT): Min of Home Affairs				
GAP	7,500	15,405	29,005	43,328
Number of fisher-folk receiving prevention services	8,250	16,946	31,906	47,661
TOWA-NACC (WB CREDIT)				
GAP	8,250	16,946	31,906	47,661
Targeted Number of injecting drug users receiving services				
ABC	4,000	4,500	6,961	10,399
TOWA-NACC (WB CREDIT)	2,320	2,320	2,320	
UNODC	1000	1100	1200	1400
GAP	680	1,080	3,441	8,999
Number of MSM receiving services	12,300	25,264	47,568	71,058
TOWA-NACC (WB CREDIT)				
GAP	12,300	25,264	47,568	71,058
Number of Military and Uniformed staff receiving services	18,000	36,972	69,612	103,988
TOWA-NACC (WB CREDIT): Min of Internal Security and Min of Defence				
GAP	18,000	36,972	69,612	103,988
Number of in-school youth receiving services				
# Primary Teachers to be Trained	16,194	33,253	62,627	93,642
# Secondary Teachers to be Trained	4,481	9,091	16,929	25,018
MoE (SWAP)	31,800	31,800		
Number of out-of-school youth receiving services	381,000	782,000	1,440,000	2,150,000

Thematic area	2009/10	2010/11	2011/12	2012/13
TOWA-NACC (WB CREDIT): MoE and Partners	387,022	387,022	387,022	
MoE-MOYAS-UNICEF	1,200	1,200	1,200	1,200
USG	1,200,000	1,200,000	1,200,000	1,200,000
GAP	-1,207,222	-806,222	-148,222	948,800
Number of internally-displaced people/ refugees receiving key services	209,543	323,144	442,931	606,966
TOWA-NACC (WB CREDIT)				
GAP	209,543	323,144	442,931	606,966
TREATMENT, CARE AND SUPPORT				
ART: Cumulative Number of adults on ART treatment	350,545	440,582	527,567	570,999
Number of adults on First line ART	343,059	423,929	500,068	530,906
USG (ARV only)	170,000	170,000	170,000	170,000
USG (with ART)	300,000	350,000	350,000	350,000
GAP (ARV)	173,059	253,929	330,068	360,906
GAP(ART)	43,059	73,929	150,068	180,906
ART paed: Number of children on ART treatment	38,453	49,253	60,053	68,453
USG (ARV only)	20,000	20,000	20,000	20,000
USG (with ART)	30,000	30,000	30,000	30,000
Unicef (ARV only)			9,000	15,000
Clinton Foundation	24,743	30,929		
GAP (ARV)	-6,290	-1,676	40,053	48,453
GAP(ART)	8,453	19,253	30,053	38,453
2nd Line ART : Number of adults on second-line ART	7,486	16,653	27,499	40,093
USG (ART and ARV)	5,000	10,000	15,000	25,000
Clinton Foundation	4,803			
(ABC) GAP	-2,317	6,653	12,499	15,093

Thematic area	2009/10	2010/11	2011/12	2012/13
Cumulative number of Patients on Care	718,764	843,897	974,983	1,018,022
Cumulative number of Adult Patients on Care (ABC)	639,842	747,834	851,846	865,755
Cumulative number of Paed Patients on Care ABC	78,922	96,063	123,137	152,267
USG[5]	670,000	750,000	750,000	750,000
GAP	48,764	93,897	224,983	268,022
Number of TB-HIV co-infected receiving treatment	Reflected in ART target			
Number receiving home and community based care services (incl nutrition support for adults)				
ABC (HBC + palliative care)	143,667	210,807	292,221	355,908
USG (basic home care package)	350,000	350,000	350,000	350,000
GAP	-206,333	-139,193	-57,779	5,908
Number of people on palliative care (not on plus those on/after ART)	62526	64183	54389	46033
	6621	5897	5219	4855
(ABC)GAP				
Number of children (under five) receiving nutritional support	33146	47070	68957	85270
Therapeutic	11,838	17,291	25,859	36,544
	5,924	6,728	7,572	8,283
MoH-GFATM (incl adults + children)	17,118			
WFP (*to review definition and target population)*	66,000	72,000	78,000	84,000
(ABC)GAP				
MITIGATION OF THE SOCIO-ECONOMIC IMPACT OF AIDS				

Thematic area	2009/10	2010/11	2011/12	2012/13
Orphans & vulnerable children supported (Nos of OVC supported for school fees for primary education)	394,996	477,394	578,591	654,359
GOK - MoG Children and Social Development				
UNICEF*	132,000	132,000	132,000	132,000
World Bank Credit to MoG Children and Social Development	65,393	104,993	144,593	184,193
GAP	98,603	141,401	202,998	239,166
SYSTEMS STRENGTHENING	**(Policy,**	**Admin,**	**Research,**	**M&E)**
Programme Management				
Research				
M & E				
Lab Equipment				
Inputs from Partners				
Lab infrastructure (USG)	19.5	19.5	19.5	19.5
Strategic information (USG)	18.7	18.7	18.7	18.7
HSS (USG)	12.5	12.5	12.5	12.5
TB/HIV (USG)	19.2	19.2	19.2	19.2
GAP	**69.9**	**69.9**	**69.9**	**69.9**

SECTION 3: KNASP III COSTING

The costing of KNASP III was done using the Activity Based Costing (ABC) model. This model defines all the key inputs required to achieve a specific target; based on the defined input data, a unit cost is calculated. The unit cost is applied to the target to establish the total cost. Unit costing for KNASP III was done using data from a variety of sources including historical and projected market rates for service provision and benchmarking some costs with the costing estimates used internationally especially for goods and services sourced outside the country. The detailed costing of KNASP III is provided in soft copy.

The costs in the table below are aligned to the targets. These costs can be used by partners to assess the percentage of KNASP II funded at any given time given that the level of funding is one of the key variables determining achievement of targets.

Cost estimates of KNASP III- 2009/10 to 2012/13[1]

Major activities and sub-activities	Yearly amounts (USD million)				Tot. US (M)	K Sh (M) ($1=Sh75)	% of total
	2009/10	2010/11	2011/12	2012/13			
Prevention							
- Priority populations							
Community mobilisation	5.0	9.0	14.0	17.0	45.0	3,351	1.3
Special populations	4.0	7.0	10.0	14.0	35.0	2,651	1.0
Youth in school	4.0	6.0	10.0	14.0	33.0	2,510	0.9
Youth out of school	3.0	6.0	11.0	16.0	36.0	2,728	1.0
Prevention for PLWH	1.0	2.0	3.0	3.0	9.0	712	0.3
Programs for CSW	3.0	3.0	6.0	11.0	23.0	1,745	0.7
Programs for MSM	1.0	1.0	2.0	3.0	7.0	550	0.2
Programs for IDUs			1.0	1.0	2.0	174	0.1
Workplace activities	3.0	4.0	5.0	6.0	18.0	1,378	0.5
- Service delivery							
VCT	30.0	43.0	45.0	17.0	136.0	10,209	3.8
PMTCT	20.0	23.0	26.0	27.0	97.0	7,255	2.7
Condom provision	15.0	17.0	18.0	20.0	69.0	5,170	1.9
Male circumcision	14.0	14.0	14.0	14.0	55.0	4,136	1.6
Mass media	5.0	5.0	5.0	5.0	20.0	1,500	0.6
- Health care							
Safe medical injections	14.0	15.0	17.0	18.0	63.0	4,750	1.8
Universal precautions	2.0	3.0	6.0	9.0	20.0	1,500	0.6
PEP	4.0	4.0	4.0	4.0	15.0	1,154	0.4
Blood safety	2.0	2.0	2.0	2.0	8.0	624	0.2
Sub-total prevention	**128.0**	**164.0**	**199.0**	**204.0**	**695.0**	**52,096**	**19.5**
Care and treatment							
ARV therapy	237.0	319.0	390.0	415.0	1,362.0	102,156	38.3

[1]Projections estimated using Activity Based Costing Model. Conversion rate K Sh to USD 75. No allowance made for inflation. Lines and columns may not cross add because of rounding.

Major activities and sub-activities	Yearly amounts (USD million)				Tot. US (M)	K Sh (M) ($1=Sh75)	% of total
	2009/10	2010/11	2011/12	2012/13			
Nutritional support	66.0	88.0	114.0	116.0	384.0	28,816	10.8
Treatment of OI	40.0	47.0	54.0	56.0	195.0	14,655	5.5
Home based care (inc. palliative care)	16.0	23.0	32.0	39.0	109.0	8,189	3.1
Psychological treatment & support	2.0	2.0	2.0	2.0	8.0	612	0.2
Sub Total Care and Treatment	**360.0**	**479.0**	**592.0**	**628.0**	**2,059**	**154,430**	**57.9**
Orphans and vulnerable children							
Education/family/ home support- OVC	56.0	68.0	83.0	93.0	300.0	22,504	8.4
Sub Total orphans and vulnerable children	**56.0**	**68.0**	**83.0**	**93.0**	**300.0**	**22,504**	**8.4**
AIDS program management							
Program management	33.0	37.0	40.0	43.0	153.0	11,477	4.3
Monitoring & evaluation	38.0	31.0	32.0	34.0	134.0	10,075	3.8
Surveillance	13.0	13.0	13.0	13.0	50.0	3,750	1.4
Information technology	19.0	19.0	19.0	19.0	75.0	5,610	2.1
Laboratory upgrades	20.0	20.0	20.0	20.0	78.0	5,850	2.2
Sub Total AIDS program management	**122.0**	**118.0**	**123.0**	**128.0**	**490.0**	**36,763**	**13.8**
Human resources							
Technical support	4.0	3.0	2.0		9.0	638	0.2
Sub Total Human resources	**4.0**	**3.0**	**2.0**		**9.0**	**638**	**0.2**
Enabling environment							
Community policies & guidelines	1.0	1.0	1.0	0.0	3.0	196	0.1
Human Rights	0.0	0.0	0.0	0.0	1.0	64	0.0
Women's policies & guidelines	0.0	0.0	0.0	0.0	0.0	18	0.0
Sub Total Enabling environment	**1.0**	**1.0**	**1.0**	**1.0**	**4.0**	**278**	**0.1**
Grand total	**671.0**	**833.0**	**998.0**	**1,054.0**	**3,556.0**	**266,708**	**100.0**

SECTION 4: KNASP III COMMODITY QUANTIFICATION 2009/10 – 2010/11

INTRODUCTION

The quantification of the commodity requirements to provide HIV and AIDS services to achieve the set targets for KNASP III was done to support the planning and costing of the strategy. A large proportion of the strategy will depend on effective procurement of required commodities. Target setting also requires an understanding of the required commodities for the level of services expected.

The quantification exercise covered all the major commodities required for HIV treatment, care and prevention services. The quantification was based on both demographic and service delivery data. Projections of the number of people targeted for various services under KNASP III was also used to make quantifications. The methodology used considered data on population, people in need of services, cost of commodities, national guidelines and treatment protocols as well as service delivery costs. The commodity quantification contributed to the development of the unit costs for overall costing of KNASP III.

This quantification will be used to:

- Form a basis for the development of procurement projections for KNASP III
- Support programming for services that require commodities
- Enable the country to minimise stock outs
- Support resources mobilisation effort

The quantification report covers two years – 2009/10 to 2010/11. This report will be updated annually to provide projections for subsequent two years. A standardised basis for quantification should be developed as the quality of data improves.

BACKGROUND

Background of the HIV & AIDS program in Kenya

Currently, an estimated 1.2 million to 1.5 million people are HIV-positive. HIV prevalence is about 7.1% for the population aged 15-64 and 7.4% for the population aged 15-49 (Kenya AIDS Indicator Survey (KAIS) 2007). It is estimated that about 14,000,000 people who are sexually active need to know their HIV status, over the baseline of 6 million (36%) who have already been tested (KAIS 2007).

About 390,000 HIV-positive patients are eligible to receive ART (using a cut-off of CD4 count <250), and about 460,000 are eligible to receive ART (using a cut-off of CD4 count <350). With a recommendation of using a cut-off of CD4 count <350, then only 51.4% of those needing ART were on treatment as at end December 2008, while if a cut-off of CD4 count <250 is used, then 90% were on treatment. About 622,000 patients were in HIV Care as at end Dec 2008 (about 555,600 adults and about 67,000 children).

About 226,000 patients were on antiretroviral treatment (ART) as at end December 2008, and by March 2009, this had scaled up to about 264,000 patients (240,000 adults and about 24,000 children). As at March 2009, the rate of scale-up for Adult ART was about 6,200, while for Paed ART, it was 720 monthly.

Kenya National AIDS Strategic Plan III

In 2008, the National AIDS Control Council (NACC) decided to develop a more responsive Kenya National HIV and AIDS Strategic Plan (KNASP) for the years 2009/10 -2012/13[2]. This was to be preceded by a comprehensive Strategic Review of the KNASP 2005/6-2009/10 (KNASP II) to be undertaken by a broad range of stakeholders[1]. The aim of this review was to determine the strengths, achievements, gaps and constraints both in planning and responding to HIV and AIDS in Kenya under KNASP II, and use these to develop a new KNASP III. This review was performed in several thematic areas including Prevention of New Infections, Improvement of quality of life, KNASP Support services, including Resources and Commodities among others.

Key findings of the review of KNASP II

Under KNASP II, there were many problems resulting in poor Commodity security, such as inadequate forecasting and quantification for ARVs and other commodities for treatment, care and support; condom procurement and distribution systems remain a major challenge. Health systems strengthening including health information systems and procurement and supply chain management were also not adequately covered.

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[2]KNASP 2005/6-2009/10 Strategic Review: Synthesized Report. February 2009

Goal and scope of the KNASP III HIV & AIDS Commodities Quantification

Objectives

The broad objective of the KNASP III HIV & AIDS Commodities Quantification is to develop detailed 2-year commodity quantifications aligned to the 2-year National Plan of Operations (NPO).

Specific objectives include:

- the estimation of the national needs for various HIV and AIDS commodities
- determination of the total country's commitments towards the needs above from all partners, and
- development of a commodity procurement plan for the period July 2009 – June 2011 (FY 2009/10 -2010/11) which will facilitate timely procurement and delivery of these commodities to support the HIV & AIDS program.

Scope of commodity quantification

The key commodity quantification covers the major types of HIV and AIDS services: Treatment, Care, Prevention, and Laboratory services. Under these areas, the following commodity categories linked to HIV & AIDS were quantified.

5. **ARV Treatment** – drugs for Adult, Pediatric ART
6. **Care** – commodities for key OIs, HCBC and Palliative care, Nutrition
7. **Prevention** – commodities for PMTCT, VMAMC, Injection safety, Condoms (Male, Female), ECP (Emergency contraception pills) and PEP, MARPs commodities
8. **Laboratory** – commodities for Screening (HTC, EID and Blood Safety); Monitoring tests (CD4 and Viral load).

The detailed 2-year commodity quantifications will covers the 2-year (GoK Financial year) period from July 2009 to June 2011 i.e. FY 2009/10 to FY 2010/11. The quantification exercise excludes equipment e.g. X-ray machines, vehicles, and infrastructure

METHODOLOGY

Forecasting and quantification methods

The methodology applied to forecast future demand for services and commodity needs is based on the availability and quality of data on:

- Rate of consumption of drugs or commodities used
- Number and type of patients/clients receiving services
- Program policies and expansion plans

The following types of data was used to guide the quantification:

- Demographic data based on characteristics of the target population (e.g. age, sex, geographic location)
- Morbidity data on prevalence or incidence of disease or infection in the target population
- Service provision data on the number of service delivery sites (SDPs), the volume of services or number of patients per site, and the type of services received
- Data on consumption or use, losses from and adjustments to inventory, and the stock on hand at the various levels of the in-country supply chain.

In this quantification exercise, the population-based method was used for the following reasons:

- The HIV & AIDS program continues to scale up rapidly hence consumption data would only provide for part of the commodity requirements but not cater for new clients.
- The current systems for collection of service statistics data and for consumption data are not yet in place for certain new programs, e.g. VMAMC, while for some of those where it is in place (e.g. condoms), the consumption data is not complete or is not of good quality.

General Assumptions

- The target populations and baselines (where available) and some assumptions for each commodity were obtained from various sources: Resource needs model output and Spectrum model
- Commodity market prices will remain constant for the period covered – there has been no adjustment for inflation.
- Exchange rate: KShs to the USD = 75
- Adjustments:
  - Buffer stocks: set at 6 months in general, but used 9 months especially for some chronic use products, 3 months for a few others.
  - Losses (e.g. wastage, expiries): Assume

2% of the quantity required of the commodity.

Cost adjustments:

- M&E: for Monitoring of commodities, including design and implementation of commodity logistics systems, operation of the LMIS (including courier services or other means for delivery of reports to the LMU) and printing of commodity data collection and reporting manual tools (e.g. CDRRs), set-up of electronic tools, monitoring and supportive supervision by commodity managers. Assume 5% of the cost of the commodity.
- Logistics costs: estimate to cover costs of procurement, warehousing, storage and distribution. Assume 10% of the cost of the quantified commodity.
- Commodities for Malaria and TB were assumed to be covered by the relevant programs (at DoMC, DLTLD) and were not included.

Notes

- The data on Quantity available for each commodity is taken from the physical count data provided by the central stores of the supply chains (mainly KEMSA, MEDS, RDC) as at end May 2009, where available.
- Data on Stocks pending with suppliers was provided by NASCOP, the supply chains (mainly KEMSA, PEPFAR through MEDS, SCMS), treatment implementing partners and donors, etc as at end May 2009. This means the confirmed orders which have already been placed with suppliers and for which stock delivery is expected from June 2009 onwards. In some cases, planned procurements have been mentioned, e.g. GF Round 7.
- Commodities required for each commodity category were provided mainly by NASCOP, but also by treatment partners and donors.
- Prices for commodities were taken from information provided by the supply chains, procurement agencies, treatment partners and donors.
- Information on Treatment Guidelines and Protocols, Testing algorithms, Policies and Standards, were provided by the guidelines and policies from NASCOP, the Ministries of Health (MoMS, MoPHS), and in some cases, information from treatment partners and donors.

DETERMINATION OF HIV and AIDS COMMODITY QUANTITIES

The table below presents a summary of the costs of the commodities for FY 2009/10 to FY 2010/11:

	Main Commodity category	Year 1 FY 2009/10 (USD)	Year 2 FY 2010/11 (USD)	**Total for the 2 years (USD)**
1	Commodities for Treatment (Adult and Paed ART)	56,700,843	127,940,581	**184,641,424**
2	Commodities for Care (including OI, Nutritional supplements, HCBC, etc)	242,948,422	263,800,923	**506,749,345**
3	Prevention commodities (including Condoms, PEP, PMTCT, etc)	34,261,046	42,274,335	**76,535,381**
4	Laboratory commodities (including test kits, CD4 reagents, etc)	43,948,697	49,996,413	**93,945,110**
	Sub-Total for commodities	377,859,008	489,608,361	**867,467,369**
5	M&E costs (5%)	18,892,950	24,480,418	**43,373,368**
6	Logistics costs (10%)	37,785,901	48,960,836	**86,746,737**
	Total	**434,537,859**	**563,049,615**	**997,587,474**

The details are provided in the following sections.

A. TREATMENT

1. Adult ARV medicines

i. Target population

The following are the year-end targets set for the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Cumulative number of **Adult** Patients on Care	639,842	747,834	851,846	865,755
Monthly scale-up of **Adult** Patients on Care	6,329	8,999	8,668	1,159
Adjusted Cumulative Number of **Adult** Patients on ART	350,545	440,582	527,567	570,999
Monthly scale-up of **Adult** Patients on ART	8,046	7,503	7,249	3,619

i) Key assumptions for arriving at the target population requiring ARVs and other commodities for Care for Adult HIV+ clients for the next 2 years:

- The number of Adults accessing care and treatment programs across the 4 years is influenced by the HIV prevalence rate and the scale-up of the national HIV testing program.
- The number of HIV +ve adult enrolling into Care will be about 50% across the years. An annual attrition rate of 10% has been used for clients lost to follow up.
- The number of adult patients on ARVs is cumulative and it assumes a 90% retention rate across all years (i.e. 10% of patients are lost to follow-up). 20 % of the patients already in Care join the population of new Adult patients for ART in Year 1, and 17% in Years 2-4. 30% of those newly enrolled into Care are eligible for ART (this % applies in all the years). In Year 1, there will be increased number of people on Care getting into ART due to change of national guidelines from a cut-off CD4 count of <250 to <350.

ii. Key assumptions for quantities of ARVs

The assumptions on distribution of adult patients across various 1st line and 2nd line ART regimens are as follows:

- Distribution of Adults on 1st Line or Substitution regimens: Year 1 - 97.7%, Year 2 – 96.9%.
  - Proportion of Adult patients on d4T:AZT:TDF
    - Current patients: Year 1:- 66%:22%:13%, Year 2:- 73:23:4
    - New patients: Year 1:- 66%:22%:13%, Year 2:- 54:20:26
  - Proportion of Adult patients on NVP:EFV
    - Current and New patients: Year 1:- 75%:25%, Year 2:- 75%:25%
    - The 25% on EFV will cater for all TB/HIV co-infections.
  - 3TC remains the backbone drug

- Distribution of Adults on 2nd line regimens: Year 1 – 2.3%, Year 2 – 3.1%.
  - ABC and LPV/r combined with TDF or ddI are the main regimens
  - Proportion of TDF:ddI:others = 35:28:37, across all years
  - Proportion of ddI 250mg: 400mg = 60%:40%.

- 3rd line (salvage) regimens: Quantification of commodities for 3rd line was not included, primarily because there are no official guidelines for the management of salvage patients. Should any treatment partner desire to procure, it may be assumed that 2% of patients on 2nd line require 3rd line in year 1 and 4% for the other years. The following regimens are provided by clinicians through NASCOP:

- Darunavir/ritonavir + Raltegravir + 3TC
  Dose: **Raltegravir 400 mg BD + Darunavir/ritonavir 600/100mg BD + 3TC 150mg BD**

- Atazanavir/ritonavir + Raltegravir + 3TC
  Dose: as above but Atazanavir/ritonavir (300/100 mg OD) as alternate to Darunavir/ritonavir

- Percentage switching from standard regimen to alternate / substitution drugs = 0%. All switches (single drug substitution) from d4T or AZT to TDF are covered under the 13% allocated for TDF.

	ART Regimen	Regimen Type	Year 1: 2009/10	Year 2: 2010/11	Year 3: 2011/12	Year 4: 2012/13
1	d4T/3TC/NVP	1st line	53.99%	47.46%	38.60%	36.2%
2	d4T/3TC/EFV	1st line	13.85%	13.00%	10.10%	9.5%
3	AZT/3TC/NVP	1st line	6.89%	14.26%	11.80%	11.4%
4	AZT/3TC/EFV	1st line	14.12%	12.42%	7.00%	6.8%
5	TDF/3TC/NVP	1st line	8.23%	7.73%	24.30%	27.1%
6	TDF/3TC/EFV	1st line	2.92%	5.13%	8.20%	9.0%
			100%	100%	100%	100%
7	ABC/ddI/LPV/r	2nd line	17.25%	16.70%	16.7%	16.7%
8	TDF/ABC/ LPV/r	2nd line	9.48%	12.50%	12.5%	12.5%
9	TDF/3TC/LPV/r	2nd line	22.84%	22.00%	22.0%	22.0%
10	AZT/ddI/LPV/r	2nd line	12.07%	11.70%	11.7%	11.7%
11	AZT/3TC/LPV/r	2nd line	24.14%	23.40%	23.4%	23.4%
12	d4T/3TC/LPV/r	2nd line	14.22%	13.70%	13.7%	13.7%
			100.0%	100.0%	100.0%	100.0%

- Adjustments:
  - Buffer stocks: 6 months (though recommended buffer for GoK procured should be 9 months, taking into consideration that ARVs are commodities that should be in full supply and that the public sector procurement process is often lengthy, taking 9-12 months)
  - Other stock adjustments: 2% for losses.

iii. Quantities of Commodities required

The quantities were calculated using the electronic quantification tools, Quantimed®.

FY 2009/10

ARV name	Pack Size	Price per pack (USD)	Total Qty Required (packs)	In Stock (Packs)	On Order (Packs)	Qty to Order (Packs)	Price (USD)
AZT/3TC 300/150mg FDC Tabs	60	9.54	514,271	164,368	188,027	161,876	1,544,297.03

ARV name	Pack Size	Price per pack (USD)	Total Qty Required (packs)	In Stock (Packs)	On Order (Packs)	Qty to Order (Packs)	Price (USD)
AZT/3TC/NVP 300/150/200mg FDC Tabs	60	14.00	808,102	43,400	21,000	743,702	10,411,828.00
d4T/3TC 30/150mg FDC Tabs	60	3.91	851,249	48,832	174,042	628,375	2,456,946.30
d4T/3TC/NVP 30/150/200mg FDC Tabs	60	7.40	3,122,376	364,500	792,673	1,965,203	14,542,502.39
ABC 300mg Tabs	60	25.75	38,847	17,110	13,055	8,682	223,561.50
AZT 300mg Tabs	60	8.75	15,566	40,746	225,585	-	0.00
ddI EC 250mg Tabs	30	18.34	22,670	4,529	-	18,141	332,705.94
ddI EC400mg Tabs	30	23.67	15,113	4,544	-	10,569	250,168.23
EFV 600mg Tabs	30	11.85	1,478,325	169,539	603,360	705,426	8,359,298.37
LPV/r 200/50mg Tabs	120	41.10	133,036	35,076	45,000	52,960	2,176,655.92
NVP 200mg Tabs	60	3.25	460,808	192,183	448,241	-	0.00
TDF 300mg Tabs	30	12.45	16,630	53,170	60,000	-	0.00
TDF/3TC 300/300mg Tabs	30	14.25	678,667	30,094	60,000	588,573	8,387,165.25
Total Cost (USD)							**48,685,128.94**

FY 2010/11

ARV name	Pack Size	Price per pack (USD)	Qty to Order (Packs)	Price (USD)
AZT/3TC 300/150mg FDC Tabs	60	9.54	620,296	5,917,623.82
AZT/3TC/NVP 300/150/200mg FDC Tabs	60	14	955,977	13,383,678.00
d4T/3TC 30/150mg FDC Tabs	60	3.91	928,910	3,632,038.18
d4T/3TC/NVP 30/150/200mg FDC Tabs	60	7.4	3,396,391	25,133,293.72
ABC 300mg Tabs	60	25.75	65,722	1,692,341.50
AZT 300mg Tabs	60	8.75	26,334	230,422.50
ddI EC 250mg Tabs	30	18.34	38,353	703,394.03

ARV name	Pack Size	Price per pack (USD)	Qty to Order (Packs)	Price (USD)
ddI EC400mg Tabs	30	23.67	25,569	605,218.23
EFV 600mg Tabs	30	11.85	1,888,484	22,378,536.12
LPV/r 200/50mg Tabs	120	41.1	225,074	9,250,541.06
NVP 200mg Tabs	60	3.25	1,246,691	4,051,745.75
TDF 300mg Tabs	30	12.45	28,135	350,280.74
TDF/3TC 300/300mg Tabs	30	14.25	1,735,799	24,735,135.75
Total Cost (USD)				**112,064,249.40**

iv. Suggested Procurement schedule

See combined Adult and **Pediatric** ARV schedule below

2. Pediatric ARV medicines

i. Target population

The following are the year-end targets set for the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Cumulative number of **Paed** Patients on Care	78,922	96,063	123,137	152,267
Monthly scale-up of **Paed** Patients on Care	962	1,428	2,256	2,428
Adjusted Cumulative Number of **Paed** Patients on ART	38,453	49,253	60.053	68,453
Monthly scale-up of **Paed** Patients on ART	800	900	900	700

The following were key assumptions made in arriving at the target population requiring ARVs and other commodities for Care for Paed HIV+ clients for the next 2 years:

- Number of children accessing care and treatment programs across the 4 years is based on projections from the Resource needs model.
- Consideration that by December 2008, there were an estimated 25,000 children on treatment (based on NASCOP data), and by June 2009, approximately 28,853 children are expected to be on treatment, after assuming an average scale-up rate of about 642 children per month.
- Average attrition rate of 25%, which is a compromise between the regional observations and the L-Stick survey for adults. No data available on attrition rate for children.
- Children lost to follow-up are replaced by an equal number of new patients
- The initial targets for **Pediatric** patients on ART were based on data from the Resource needs model on patients in need of ART. However these numbers were found to be low in comparison to actual scale-up rates which are currently at about 830 per month as at end April 2009. NASCOP has decided on scale-up at the rates shown in the table above.

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of ARVs needed to treat the estimated number of Pediatric ART clients for the next 2 years:

- NASCOP is implementing new treatment regimens for Children as shown in the table below

Regimen	1st Line	2nd Line
Preferred	**ABC + 3TC + NVP or EFV**	**AZT + 3TC + PI/r**
Alternative	**AZT + 3TC + NVP or EFV**	**ABC + ddI + PI/r**
NVP-exposed child	**ABC + 3TC + PI/r** or **AZT + 3TC + PI/r**	**Refer to Senior Clinician**

The assumptions on distribution of patients across various 1st line and 2nd line ART regimens were agreed as follows:

- Assume 3 average weights to cater for the differences among children: (i) syrup formulations to be taken by children of average 8kg, solid formulations to be taken by (ii) children of average weight 12 kg (iii) older children of average weight 20kg.
- For Current patients, weight proportions are 8kg:12kg:25kg = 15%:35%:50% (for d4T regimens, 8kg:12kg:25kg = 0%:35%:65%), while for new patients, weight proportions are 8kg:12kg:25kg = 30%:45%:25%.
- 1st Line regimens (including single substitution): Year 1 - 97%, Year 2 – 97%
    - Proportion of Paed patients on the various drugs:-
        - Current patients on AZT:d4T:ABC = Year 1:- 55.86%:34.28%:6.86% Year 2:- 58.20%:31.04%:7.76%
        - New patients on AZT:ABC: Year 1:- 70%:30%, Year 2:- 50%:50%.
    - Proportion of Current Paed patients on NVP: EFV:LPV/r is 64%:29%:7% for Years 1 and 2; while for New Paed patients, proportion on NVP: EFV:LPV/r is 60%:30%:10% for Year 1 and 40%:10%:50% for Year 2.
    - 3TC remains the backbone drug.
- 2nd line regimens: Year 1 – 3%, Year 2 – 3%
    - ABC/ddI/LPV/r is the main regimen
    - Weight band allocation - 50% of patients with average weight 15kg: 50% of patients with average weight 25kg across all years.
- 3rd line regimens: This was not taken into consideration as it was assumed that the clients are very few. The current guidelines do not contain 3rd line regimens.
- Percentage switch from standard regimens to alternate/substitution drugs = 4%. This rate remains constant over all the 4 years.
- ABC sensitivity: 0.5% of the patients will develop hypersensitivity.
- For TB/HIV co-infection patients:
    - 10% risk of TB in patients with HIV
    - Children more than 3yrs or 10kgs will be put on ABC/AZT + 3TC + EFV while those less than 3yrs or 10kgs will be put on AZT (or d4T) + 3TC + ABC.

– After completion of TB treatment, the majority of the children will be switched back to NVP-based regimens.

– Paed FDC regimens are now locally registered and may be procured for the public sector. This will significantly reduce the need for the more expensive and bulky Paed ARV single drug liquids.

– For Paed patients currently on treatment, the following assumptions were made for proportions per regimen:

	ART Regimen	**Type**	**Year 1: 2009/10**					**Year 2: 2010/11**				
			AZT : d4T : ABC	Regimen breakdown	Avg weight 8kg	Avg weight 12kg	Avg weight 20kg	AZT : d4T : ABC	Regimen breakdown	Avg weight 8kg	Avg weight 12kg	Avg weight 20kg
1	AZT/3TC/ NVP	1st	55.86%	35.75%	5.36%	12.51%	17.88%	58.20%	37.25%	5.59%	13.03%	18.63%
2	AZT/3TC/ EFV	1st		16.20%	0.00%	8.10%	8.10%		16.88%	0.00%	8.44%	8.44%
3	AZT/3TC/ LPV/r	1st		3.91%	0.59%	1.37%	1.95%		4.07%	0.61%	1.42%	2.04%
4	d4T/3TC/ NVP	1st	34.28%	21.94%	0.00%	7.68%	14.26%	31.04%	19.87%	0.00%	6.95%	12.92%
5	d4T/3TC/ EFV	1st		9.94%	0.00%	3.48%	6.46%		9.00%	0.00%	3.15%	5.85%
6	d4T/3TC/ LPV/r	1st		2.40%	0.00%	0.84%	1.56%		2.17%	0.00%	0.76%	1.41%
7	ABC/3TC/ NVP	1st	6.86%	4.39%	0.66%	1.54%	2.19%	7.76%	4.97%	0.74%	1.74%	2.49%
8	ABC/3TC/ EFV	1st		1.99%	0.00%	0.99%	0.99%		2.25%	0.00%	1.13%	1.13%
9	ABC/3TC/ LPV/r	1st		0.48%	0.07%	0.17%	0.24%		0.54%	0.08%	0.19%	0.27%
			97.00%	97.00%				97.00%	97.00%			
Patients on 2nd line					Avg weight 15kg	Avg weight 25kg					Avg weight 15kg	Avg weight 25kg
10	ABC/ddI/ LPV/r	2nd	3.00%		1.50%	1.50%			3.00%		1.50%	1.50%
			100.00%						100.00%			

– For new Paed patients starting treatment, the following assumptions were made for proportions per regimen:

	ART Regimen	**Type**	**Year 1: 2009/10**					**Year 2: 2010/11**				
			AZT: d4T	Breakdown per regimen	Avg weight 8kg	Avg weight 12kg	Avg weight 20kg	AZT: d4T	Breakdown per regimen	Avg weight 8kg	Avg weight 12kg	Avg weight 20kg
1	AZT/3TC/ NVP	1st	70.00%	42.00%	12.60%	18.90%	10.50%	50.00%	20.00%	6.00%	9.00%	5.00%
2	AZT/3TC/ EFV	1st		21.00%	0.00%	10.50%	10.50%		5.00%	0.00%	2.50%	2.50%
3	AZT/3TC/ LPV/r	1st		7.00%	2.10%	3.15%	1.75%		25.00%	7.50%	11.25%	6.25%

	ART Regimen	Type	Year 1: 2009/10					Year 2: 2010/11				
			AZT: d4T	Breakdown per regimen	Avg weight 8kg	Avg weight 12kg	Avg weight 20kg	AZT: d4T	Breakdown per regimen	Avg weight 8kg	Avg weight 12kg	Avg weight 20kg
4	ABC/3TC/ NVP	1st	30.00%	18.00%	5.40%	8.10%	4.50%	50.00%	20.00%	6.00%	9.00%	5.00%
5	ABC/3TC/ EFV	1st		9.00%	0.00%	4.50%	4.50%		5.00%	0.00%	2.50%	2.50%
6	ABC/3TC/ LPV/r	1st		3.00%	0.90%	1.35%	0.75%		25.00%	7.50%	11.25%	6.25%
			100%	100%				100%	100%			

- Adjustments:
  - Buffer stocks: 6 months (though recommended buffer for GoK procured should be 9 months, taking into consideration that ARVs are commodities that should be in full supply and that the public sector procurement process is often lengthy – about 9 months)
  - Other stock adjustments: 2% for losses

iii. Quantities of Commodities required

The quantities were calculated using the electronic quantification tools, e.g. Quantimed®.

FY 2009/10

Product	Pack Size	Price per pack (USD)	Total Qty Required (packs)	In Stock (Packs)	On Order (Packs)	Qty to Order (Packs)	Price (USD)
3TC 10mg/ ml liquid	240 ml	1.77	62,638	44,411	51,000	-	-
3TC 150mg Tab	60 tab	2.78	129,682	343,238	265,296	-	-
ABC 20mg/ ml liquid	240 ml	25.00	11,686	661	10,445	580	14,500.00
ABC 300mg Tabs	60 tab	25.75	12,085	0	0	12,085	311,188.75
ABC/3TC 60/30mg FDC Tabs	60 tab	7.90	154,657	5,000	27,000	122,657	968,990.31
AZT 100mg Caps	100 cap	5.02	126,116	14,971	85,120	26,025	130,645.50
AZT 10mg/ ml liquid	240 ml	2.40	114,643	77,964	40,000	-	-
AZT/3TC/ NVP 60/30/50mg FDC Tabs	60 tab	4.70	518,742	70,004	0	448,738	2,109,068.51
d4T 15mg Caps	60 cap	4.93	22,344	3,325	8,000	11,019	54,323.67
d4T 20mg Caps	60 cap	5.64	41,411	5,839	15,000	20,572	116,026.08

Product	Pack Size	Price per pack (USD)	Total Qty Required (packs)	In Stock (Packs)	On Order (Packs)	Qty to Order (Packs)	Price (USD)
d4T/3TC/ NVP 12/60/100mg FDC Tabs	60 tab	4.77	150,227	15,000	0	135,227	645,032.79
ddI 25mg Tabs	60 tab	7.57	12,085	7,931	0	4,154	31,445.78
ddI 50mg Tabs	60 tab	10.27	28,198	0	4,000	24,198	248,513.47
EFV 200mg Caps	90 cap	32.40	62,790	8,563	12,000	42,227	1,368,154.86
EFV 50mg Caps	30 cap	3.47	203,731	15,972	20,000	167,759	582,123.73
LPV/r 100/25mg Tabs	120 tab	24.50	21,833	0	1,000	20,833	510,408.50
LPV/r 200/50mg Tabs	120 tab	41.10	17,665	0	0	17,665	726,031.47
LPV/r 80/20mg/ml liquid	5 x 60 ml	45.34	2,197	52	1,000	1,145	51,914.30
NVP 10mg/ ml liquid	240 ml	2.70	110,632	82,636	0	27,996	75,589.20
NVP 200mg Tabs	60 tab	3.25	22,079	0	0	22,079	71,756.75
Total Cost (USD)							**8,015,713.68**

FY 2010/11

Product	Pack Size	Price per pack (USD)	Qty to Order (Packs)	Price (USD)
3TC 10mg/ml liquid	240 ml	1.77	88,017	155,790.09
3TC 150mg Tab	60 tab	2.78	163,317	454,021.26
ABC 20mg/ml liquid	240 ml	25.00	24,789	619,725.00
ABC 300mg Tabs	60 tab	25.75	16,106	414,729.50
ABC/3TC 60/30mg FDC Tabs	60 tab	7.90	248,456	1,962,802.42
AZT 100mg Caps	100 cap	5.02	158,587	796,106.74
AZT 10mg/ml liquid	240 ml	2.40	142,262	341,428.81
AZT/3TC/NVP 60/30/50mg FDC Tabs	60 tab	4.70	632,816	2,974,235.08
d4T 15mg Caps	60 cap	4.93	27,988	137,980.84
d4T 20mg Caps	60 cap	5.64	51,968	293,099.51
d4T/3TC/NVP 12/60/100mg FDC Tabs	60 tab	4.77	188,471	899,006.67
ddI 25mg Tabs	60 tab	7.57	16,106	121,922.42

Product	Pack Size	Price per pack (USD)	Qty to Order (Packs)	Price (USD)
ddI 50mg Tabs	60 tab	10.27	37,580	385,946.62
EFV 200mg Caps	90 cap	32.40	71,797	2,326,222.91
EFV 50mg Caps	30 cap	3.47	234,715	814,461.06
LPV/r 100/25mg Tabs	120 tab	24.50	47,074	1,153,313.00
LPV/r 200/50mg Tabs	120 tab	41.10	30,093	1,236,822.25
LPV/r 80/20mg/ml liquid	5 x 60 ml	45.34	7,765	352,065.10
NVP 10mg/ml liquid	240 ml	2.70	124,271	335,531.71
NVP 200mg Tabs	60 tab	3.25	31,114	101,120.50
Total Cost (USD)				**15,876,331.48**

iv. Suggested Procurement schedule for Adult and Paed ARVs

FY 2009/10

Product	Pack Size	Qty to Order (Packs)	Qtr 1 (Packs)	Qtr 2 (Packs)	Qtr 3 (Packs)	Qtr 4 (Packs)
3TC 10mg/ml liquid	240 ml	**-**	-	-	-	-
3TC 150mg Tabs	60 tab	**-**	-	-	-	-
AZT/3TC 300/150mg FDC Tabs	60	**161,876**	-	*48,563*	*113,313*	-
AZT/3TC/NVP 300/150/200mg FDC Tabs	60	**743,702**	*297,480*	*297,480*	*74,371*	*74,371*
d4T/3TC 30/150mg FDC Tabs	60	**628,375**	*188,512*	*188,512*	*125,676*	*125,675*
d4T/3TC/NVP 30/150/200mg FDC Tabs	60	**1,965,203**	*589,560*	*589,560*	*393,041*	*393,042*
ABC 20mg/ml liquid	240 ml	**580**	-	-	*580*	-
ABC 300mg Tabs	60	**20,767**	-	*12,460*	*8,307*	-
ABC/3TC 60/30mg FDC Tabs	60 tab	**122,657**	*36,797*	*36,797*	*24,533*	*24,530*
AZT 100mg Caps	100 cap	**26,025**	-	-	*26,025*	-
AZT 10mg/ml liquid	240 ml	**-**	-	-	-	-
AZT 300mg Tabs	60	**-**	-	-	-	-

Product	Pack Size	Qty to Order (Packs)	Qtr 1 (Packs)	Qtr 2 (Packs)	Qtr 3 (Packs)	Qtr 4 (Packs)
AZT/3TC/NVP 60/30/50mg FDC Tabs	60 tab	**448,738**	*89,748*	*89,748*	*269,242*	*269,242*
d4T 15mg Caps	60 cap	**11,019**	-	*6,000*	*5,019*	-
d4T 20mg Caps	60 cap	**20,572**	-	*12,342*	*8,230*	-
d4T/3TC/NVP 12/60/100mg FDC Tabs	60 tab	**135,227**	*27,045*	*40,568*	*40,568*	*27,046*
ddI 25mg Tabs	60 tab	**4,154**	-	-	*4,154*	-
ddI 50mg Tabs	60 tab	**24,198**	*7,260*	*7,260*	*4,839*	*4,839*
ddI EC 250mg Tabs	30	**18,141**	-	*6,047*	*6,047*	*6,047*
ddI EC 400mg Tabs	30	**10,569**	-	-	*5,569*	*5,000*
EFV 200mg Caps	90 cap	**42,227**	*12,668*	*10,560*	*10,560*	*8,439*
EFV 50mg Caps	30 cap	**167,759**	*50,320*	*41,940*	*41,940*	*33,559*
EFV 600mg Tabs	30	**705,426**	*141,085*	*211,628*	*211,628*	*141,085*
LPV/r 100/25mg Tabs	120 tab	**20,833**	*6,250*	*6,250*	*4,167*	*4,166*
LPV/r 200/50mg Tabs	120	**70,625**	-	*24,720*	*24,720*	*21,185*
LPV/r 80/20mg/ ml liquid	5 x 60 ml	**1,145**	-	*458*	*343*	*344*
NVP 10mg/ml liquid	240 ml	**27,996**	-	-	*13,983*	*13,983*
NVP 200mg Tabs	60 tab	**22,079**	-	-	*22,079*	-
TDF 300mg Tabs	30	**-**	-	-	-	-
TDF/3TC 300/300mg Tabs	30	**588,573**	*176,572*	*176,572*	*117,714*	*117,714*

vi. Summary table of costs for ARVs

Item	Year 1: 2009/10	Year 2: 2010/11
	Costs in USD	Costs in USD
ARVs for Adults	48,685,129	112,064,249
ARVs for Paeds	8,015,714	15,876,331
Total cost for ARVs	**56,700,843**	**127,940,580**

vii. Section References:

1. The DMS, Ministry of Medical Services (MoMS). Circular on *Change of Paediatric ART recommendations – Early initiation of ART in Infants*, dated 13 October 2008.
2. MoH/NASCOP. *Guidelines for Antiretroviral drug therapy in Kenya*. 3rd edition, December 2005. Nairobi: MoH.

B. CARE

1. Medicines for OI Prophylaxis (Cotrimoxazole)

i. Target population

All patients receiving Care are to get Cotrimoxazole (CTX) for prophylaxis of Opportunistic Infections.

The following are the estimated numbers of Patients in Care at year-end for the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Cumulative number of **Adult** Patients on Care	639,842	747,834	851,846	865,755
Cumulative number of **Paed** Patients on Care	78,922	96,063	123,137	152,267

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of CTX needed to treat the target patients for the next 2 years:

- Cotrimoxazole will be for prophylaxis and treatment of select OI conditions (PCP, Cerebral Toxoplasmosis, common bacterial infections).
- Dapsone is included as preventive therapy for patients allergic to Cotrimoxazole. An estimated 5% of patients require Dapsone compared to 95% on Cotrimoxazole (applies across all years).
- The proportion of children of weight <15 kg is 30% while that of children of weight >15kg to <=20kg is 70%. Assume average weight of 12kg for children <15kg.
- Estimated quantities also cover prophylaxis for PMTCT clients.
- Given that CTX is available as part of the Essential drugs (e.g. as part of the EMMS from KEMSA for GoK sites), the quantities procured below will be additional to what is procured for public sector sites.

Regimen	% on Regimen	Dosage	% Proportion
1. Cotrimoxazole			
- Adults and adolescents	95%	960mg OD	100%
- Children of weight >15 to <=20kg		480mg OD	70%
- Children of weight <15 kg (Average weight 12kg)		240mg (5ml) OD	30%
2. Dapsone			
- Adults and adolescents:	5%	100mg OD	70%
- Children (Average weight 12kg)		2mg/kg OD	30%

- Adjustments:
  - Buffer (safety) stocks: 6 months
  - Other stock adjustments: 2% for losses

iii. Quantities of commodities required

The table below shows the calculated Quantity to order based on assumptions and target population and after deducting available stocks and expected stocks (where available).

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. Cotrimoxazole tabs 960mg	1,000's	19.33	313,280	6,056,756	388,754	7,515,910
2. Cotrimoxazole tabs 480mg	1,000's	7.33	28,646	210,070	34,956	256,345
3. Cotrimoxazole susp 240mg/5ml	100ml bottles	0.28	600,899	168,252	749,061	209,737
4. Dapsone tabs 100mg	1,000's	11.40	8,143	92,826	9,517	108,493
5. Dapsone tabs 25mg	1,000's	2.85	430	1,227	524	1,493
Total				**6,529,130**		**8,091,979**

Note:

1. Note: Planned procurements for Cotrimoxazole 480mg tabs under GF Round 7 are 57,620 packs for FY 2009/10 and 57,620 packs for FY 2010/11.

2. For Dapsone 25mg, prices and pack size were not immediately available. Pack and price assumed to be about ¼ that of pack of 100mg tabs. The ART program through KEMSA currently does not stock Dapsone.

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Cotrimoxazole tabs 960mg	1000's	78,320	78,320	78,320	78,320
2. Cotrimoxazole tabs 480mg	1000's	7,161	7,161	7,162	7,162
3. Cotrimoxazole susp 240mg/5ml	100ml	150,134	150,225	150,225	150,225
4. Dapsone tabs 100mg	1000's	2,035	2,036	2,036	2,036
5. Dapsone tabs 25mg	1000's	106	108	108	108

2. Medicines for TB Prophylaxis (Isoniazid Preventive Therapy)

i. Target population

This applies only to Paed patients in care. Isoniazid is given for prophylaxis of TB (IPT).

The following are the estimated number of Paed clients in care requiring IPT at year-end over the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
% of **Paed** Patients on Care requiring IPT	10%	20%	35%	50%
Cumulative number of **Paed** Patients on Care	7,892	19,213	43,098	76,134

ii. Key assumptions

- Isoniazid Preventive Therapy (IPT) is for all HIV+ Paeds for whom TB has been excluded. The applicable TB guidelines have not been disseminated so uptake is likely to be low for the first two years.
- Dose of Isoniazid is 10mg/kg/day for 6 months (maximum dose 300mg OD).
- Assume average weight of 12kg for children.
- Adjustments:
  - Buffer stocks: 6 months
  - Other stock adjustments: 2% for losses

iii. Quantities of commodities required

The table below shows the calculated Quantity to order based on assumptions and target population.

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. Isoniazid 100mg tabs	1000's	5.80	2,159	12,524	5,257	30,489
Total cost (USD)				**12,524**		**30,489**

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Isoniazid 100mg tabs	1000's	539	539	540	541

vi. Section References, information sources

1. Ministry of Health/NASCOP. *National Manual for the Management of HIV-related Opportunistic Infections and Conditions: A Healthcare worker's manual*. 1st edition, 2008.

3. Medicines for other OIs and STI

No baseline data exists for management of HIV+ve patients with most OI conditions. There was no data available for STI conditions, but 2 conditions are covered: HSV-2 (as per data from KAIS) and Vaginal candidiasis.

As determined at the earlier Quantification assumptions meeting, the priority list of OI conditions considered in this Quantification exercise is as follows:

- Pneumocystic carinii pneumonia (PCP)
- Cryptococcal Meningitis (CM)
- Herpes Zoster
- Herpes simplex (HSV-2)
- Vaginal candidiasis
- Oral candidiasis (OC)
- Chronic diarrhea
- Peripheral neuropathy (PN)

Medicines for Cancers (Cancer of the cervix, Kaposi's sarcoma) were not covered. The number of Paed STI cases is negligible, and it was assumed that they can be covered by the EDP or through the quantities estimated for adult OI patients.

i. Target population

The number of patients targeted for each condition has generally been based on the number of patients receiving Care. The following are the estimated number of clients requiring treatment ay year-end for the years FY 2009/10 to FY 2012/13 for patients with various OI conditions:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of Clients receiving treatment for Cryptococcal Meningitis (CM)	63,984	74,783	85,185	86,575
Number of Clients receiving treatment for Herpes zoster	63,984	74,783	85,185	86,575
Number of Clients receiving treatment for Herpes Simplex (HSV-2)	204,749	239,307	272,591	277,042
Number of Clients receiving treatment for Vaginal Candidiasis	19,195	22,435	25,555	25,973
Number of Clients receiving treatment for Oral Candidiasis	31,992	37,392	42,592	43,288
Number of Clients receiving treatment for management of Chronic Diarrhea	31,992	37,392	42,592	43,288
Number of Clients receiving treatment for management of Peripheral neuropathy (PN)	14,917	15,882	17,147	17,459

ii. Key assumptions

- Cryptococcal Meningitis (CM): 10% of patients in care get CM. Assume 1 episode per client per year.
- Herpes zoster: 10% of those patients in Care get Herpes zoster. Assume 1 episode per client per year.
- Herpes simplex (HSV-2): According to KAIS 2007, there is about 80.7% prevalence among the HIV-infected. Assume only 40% of them are symptomatic and will be targeted for Treatment. Assume that 80% of those in care get HSV, of whom 40% get treatment. Assume 1 episode per client per year.
- Vaginal candidiasis: The majority of patients in Care are female. Assume 60% of people in care are female. Out of those 60%, 5% get vaginal candidiasis requiring treatment. Assume 2 episodes per client per year.
- Oral candidiasis (OC): 5% of those patients in Care get OC. Assume 2 episodes per client per year.
- Chronic diarrhea: 5% of those patients in Care get chronic diarrhea. Symptomatic management. Assume 1

episode per client per year. Chronic diarrhea in children is treated using ORS that is available in the public sector supply of Essential drugs.

- Peripheral Neuropathy (PN): 5% of those patients on ART (those on d4T or AZT-based regimens) get PN due to use of ARVs such as d4T.
- Quantities of medicines for STI are catered for under the overall quantities for OIs.
- It was assumed that the calculated quantities for Adults cover also the OIs experienced by pregnant women.
- The regimens used are as per the NASCOP Guidelines (*National manual for the management of HIV-related Opportunistic infections and conditions*, 1st edition, 2008).

Condition	Regimen for OI or STI condition	% Incidence	Number of episodes per year
Oral Candidiasis (OC)	Nystatin Mouth Paint 500,000 IU (5ml) QID for 14 days	5%	2
	Fluconazole 100mg OD for 7 days		
Herpes Zoster	Acyclovir 800mg 5 times per day for 7 days	10%	1
Cryptococcal Meningitis (CM)	Amphotericin B 1mg/kg/day for 2 weeks (assume 40kg pt)	10%	1
	Fluconazole 800mg per day for 12 weeks followed by maintenance dose: 200mg OD daily for 1 year		
Chronic Diarrhoea	Loperamide: 16mg per day for 10 days	5%	1
Peripheral Neuropathy	Pyridoxine 50mg OD for 1 year	5%	1
Herpes Simplex (HSV-2)	Acyclovir 400mg TDS for 10 days	80.70% Only 40% are symptomatic and require treatment	1
Vaginal candidiasis	Clotrimazole pessaries 1 intra-vaginally OD for 6 days	5% of females in care	2

- Adjustments:
  - Buffer stocks: 6 months
  - Other stock adjustments: 2% for losses

iii. Quantities of commodities required

The table below shows the calculated Quantity to order based on assumptions and target population, and after deducting available stocks and expected stocks (where available).

Commodity name	**Pack size**	**Unit prices (USD)**	**FY 2009/10**		**FY 2010/11**	
			Qty to order (packs)	**Estimated cost (USD)**	**Qty to order (packs)**	**Estimated Cost (USD)**
1. Nystatin oral susp 100,000 IU/ml	30ml	0.40	453,861	181,544	530,464	212,185
2. Fluconazole tabs 50mg	50's	1.91	13,616	25,961	15,914	30,342
3. Acyclovir tabs 400mg	25's	2.93	645,780	1,894,287	754,774	2,212,003
4. Amphotericin B IV inj, 50mg vial	1's	4.27	272,317	1,161,885	318,278	1,357,987
5. Fluconazole tabs 200mg	100's	14.27	541,521	7,725,704	632,919	9,029,642

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
6. Loperamide tabs 2mg	1000's	5.47	3,890	21,266	4,547	24,856
7. Pyridoxine (Vitamin B6) 50mg tabs	100's	0.72	175,061	126,044	204,607	147,317
8. Clotrimazole pessaries 100mg	6's with applicator	0.03	58,354	1,556	68,202	1,819
Total cost (USD)				**11,138,247**		**13,018,151**

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Nystatin oral susp 100,000 IU/ml	30ml	113,465	113,465	113,465	113,466
2. Fluconazole tabs 50mg	50's	3,404	3,404	3,404	3,404
3. Acyclovir tabs 400mg	25's	161,445	161,445	161,445	161,445
4. Amphotericin B IV inj, 50mg vial	1's	68,079	68,079	68,079	68,080
5. Fluconazole tabs 200mg	100's	135,380	135,380	135,380	135,381
6. Loperamide tabs 2mg	1000's	972	973	972	973
7. Pyridoxine (Vitamin B6) 50mg tabs	100's	43,765	43,765	43,765	43,766
8. Clotrimazole pessaries 100mg	6's with applicator	14,588	14,588	14,588	14,590

vi. Section references

1. Ministry of Health/NASCOP. *National Manual for the Management of HIV-related Opportunistic Infections and Conditions: A Healthcare worker's manual*. 1st edition, 2008.

4. Nutrition

This covers the commodities for the following:

Nutritional supplements

- Therapeutic food
- Micronutrients
- Infant feeding

There was inadequate baseline data available from NASCOP for number of clients on Nutritional support. The quantification of commodities for nutritional interventions for HIV and AIDS commodities focuses on the commodities needed by the moderately to severely malnourished patient that are not readily available under the essential package for care in health settings. It therefore includes provision of multiple micronutrient supplementation, provision of supplementary food, therapeutic supplements for stabilization of severely malnourished patients and provision of community based supplementary foods to support moderately malnourished patients. It does not include provision

of commodities required to address dehydration or electrolyte imbalance as these are provided through the essential medicines and medical supplies program.

i. Target population

For the Nutrition program, the key interventions identified are:

- Management of severely malnourished children (in-patient, transition phase and out-patient management)
- Nutritional supplementation for moderately malnourished adults and children
- Micronutrient supplementation for People living with HIV (both adults and children in care)
- Provision of breast milk substitutes for exclusive replacement feeding for infants where the acceptable, feasible, affordable, sustainable and safe (AFASS) criterion is met.

Nutritional care and support as an integrated component of the HIV and AIDS comprehensive care package is relatively new to Kenya. 512 comprehensive care clinics in the country, less than 50% provide nutritional interventions in the form of "*food by prescription*" or therapeutic supplementation. Commodities quantification therefore could not use historical consumption data in estimating future program requirements. In the absence of a country-wide assessment on the nutritional needs of those patients affected by HIV, both service statistics and morbidity data were not available for use in estimating program requirements. The quantification uses programmatic targets rather than consumption or service statistics data in quantifying the nutrition commodities. The targets are based on demographic projections on the course of the epidemic as provided by the Resource needs model.

The table below shows the targets for Nutrition interventions for FY 2009/10 to 2012/13:

Nutrition	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**
a) Nutritional Supplements				
Adult Patients receiving nutritional supplements	249,721	340,771	445,509	451,555
Pregnant and lactating women receiving nutritional supplements	19,013	25,668	31,525	33,268
Paed Patients receiving nutritional supplements	33,147	47,071	68,957	85,270
Total	**301,881**	**413,510**	**545,990**	**570,092**
b) Therapeutic feed				
Paed Patients requiring Therapeutic feeds	**11,838**	**17,291**	**25,859**	**36,544**
c) Micronutrients				
Adult Patients receiving Micronutrients	262,153	268,070	250,740	259,321
Pregnant and lactating women receiving Micronutrients	31,688	33,001	31,525	33,268
Paed Patients receiving Micronutrients	18,152	12,488	3,694	0
Total	**311,993**	**313,559**	**285,959**	**292,588**
d) Infant feeding (for Infants with mothers who are HIV+)				
Number of HIV-exposed Infants accessing Replacement feed (Infant formula)	**15,844**	**29,335**	**35,466**	**39,505**

The targets above were used to forecast the demand i.e. estimating the quantity of products (e.g. drugs to be dispensed) to meet customer demand for a future period of time. Once the demand was established it was necessary to calculate additional quantities of product needed to cover any expected product wastage, quality control, lead times, and buffer stocks to the forecasted demand. The requirements estimate is then adjusted by subtracting the quantity of each product already in the system (stock on hand) and any quantities already ordered but not yet received (quantity on order).

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of nutritional commodities for the next 2 years:

The KNASP III NPO targets that by 2013, 80% of health care facilities or care and treatment sites provide nutrition interventions including supplementary and therapeutic food for malnourished HIV-positive adults and children. At present, only between 38-45% of those in need of treatment are being reached so the coverage for nutrition interventions is much lower. In selecting the program targets, several assumptions were made to cover the paucity of data. With improved health systems strengthening and operational research into the nutrition interventions, it will be possible to improve the accuracy of future forecasts.

- **Specific Assumptions per Intervention**
  - **Therapeutic food:** Therapeutic feeding will be required by 24% of all pediatric patients on treatment to address severe malnourishment. (This is adjusted for scale-up as follows: year 1 (2009/2010) - 50% of patients that require therapeutic feed will receive it, year 2 - 60%, year 3 - 70%, year 4 - 80%).
    - Therapeutic interventions for the severely malnourished were targeted towards children at the in-patient and out-patient stages as per the *National guidelines for management of Acute malnutrition* (2008).
    - 25% of patients will require in-patient therapeutic care and therefore will need to access milk-based formulas (F 75 and F 100). The duration of treatment averages 10 days: 3 days on F75 and 7 days on F 100 respectively. These patients will be discharged with weekly rations of therapeutic food spread over a duration of 3 months.
    - 75% of patients will require out- patient therapeutic care based on their clinical assessment and will receive a weekly ration of therapeutic food spread for an average of 60 days.
    - It was assumed that 50% of the children in care are less than 10 kg while 50% are between 10-30 kg. The upper weight limit for the two weight categories was used to calculate the daily calorie requirements per patient.
  - **Nutritional supplementation:** Nutritional supplements will be required by 70% of the patients in care to address mild to moderate malnutrition. The *Nutrition and HIV and AIDS Strategy 2007-2010* provides that 70% of adults and children and 50% of breast-feeding and lactating women will require nutritional supplementation. (This is adjusted for scale-up as follows: Year 1 2009/2010 - 60% of patients that require nutritional supplementation will receive it, Year 2 - 70%, Year 3 - 80% Year 4 - 80%).
    - The *National Guidelines on Nutrition and HIV and AIDS* and the *National Guidelines for management of Acute Malnutrition* (2008) recommend the use of blended fortified flour (BFF) for the management of mild to moderate malnutrition.
    - The duration of treatment is 4 months, with a 2-month allowance for relapse in pregnant women while the duration for pregnant and lactating women is 6 months with an additional 2-month allowance for relapse.
    - A preparation from Insta Health products is available on the market at a price of 1,200 USD per metric tonne. The administration of blended flour for a period of 6 months is based on specifications provided by Insta Health products and contained in the *National guidelines for management of acute malnutrition*.
  - **Multiple Micronutrients:** The program proposes to adopt a policy of provision of multiple micronutrients to all patients in care less those patients receiving therapeutic feeding and nutritional supplementation. The preparation to be used will provide 1 Recommended Nutritional Intake (RNI) per serving as per UNICEF/WHO recommendations. Universal access or provision of these products to at least 80% of the target patients should be immediate to prevent patients from advancing to severe malnutrition.
  - **Exclusive Replacement feeding:** As per WHO recommendations on exclusive replacement feeding for infants, commercial infant formula will be provided where the acceptable, feasible, affordable, sustainable and safe

(AFASS) criterion is met. The estimate is that 50% of mothers will accept not to breast-feed. The public health program providing commercial infant formula aims to reach at least 50% of PMTCT mothers and infants in year 1 (2009/10), 80% by year 2, 90% in year 3 and 95% in year 4. The amounts to be purchased were based on the commercial infant formula available in the Kenyan market which is packed in 450mg tins. In addition, provision was made for a *safe water kit* that consists of a thermos flask (1 litre) and water filter per mother.

- Adjustments:

  Summary of supply chain parameters were used:
  - Buffer stocks: A buffer stock of 3 months
  - Product wastage (losses) assumed to be 2% of consumption requirement by patient

iii. Quantities of Commodities required

For Year 1, the value of nutritional commodities required is USD 223,564,610 and for Year 2, it is USD 240,297,632.

The tables below provide the detail of the commodities.

Table showing calculated Quantity required based on Assumptions and target population, and the final Quantity to order after deducting available stocks and expected stocks (where available)

FY 2009/2010 Requirements

Product Specification	Unit Pack Size	Unit Price (USD)	Qty Required	Buffer Stocks	Adjustment for Losses	Quantity on Order	Quantity to Purchase	Purchase Value (USD)
Therapeutic Milk F75 750 Kcal/410 gm bag	410 gm satchet	1.325	6,437	3,219	6,566	5,810	10,412	13,795
Therapeutic Milk F100 1000KCal/456 gm bag	456 gm satchet	1.963	19,684	9,842	20,078	9,176	40,428	79,360
Ready to Use Therapeutic Food (RUTF)	92 gm satchet	0.453	455,773	227,887	464,888	274,667	873,881	395,868
Fortified Blended Flour with nutrient mix for children	1 metric tonne	1,200	3,580	1,790	3,652	22	9,000	10,800,000
Fortified Blended Flour with nutrient mix for adults	1 metric tonne	1,200	40,455	20,228	41,264	1,458	100,489	120,586,800
Fortified Blended Flour with nutrient mix for pregnant women	1 metric tonne	1,200	4,107	2,054	4,189	0	10,350	12,420,000
Multiple micronutrient powder for children	Satchets	0.047	5,966,503	2,983,252	6,085,833	0	15,035,588	706,672
Multiple micronutrient tablet	Tabs/caps	355	72,379	36,190	73,827	0	182,396	64,750,580
Commercial Infant Feeding Formula (WHO specifications)	450 gm tin	4.8	1,109,080	554,540	1,131,262	0	2,794,882	13,415,433
Water kit (Filter + Thermos Flask)	1 kit	25	15,844	0	0	0	15,844	396,100
Total								**223,564,610**

2010/2011 Requirements

Product Specification	Unit Pack Size	Unit Price (USD)	Qty Required	Buffer Stocks	Adjustment for Losses	Quantity on Order	Quantity to Purchase
Therapeutic Milk F75 750 Kcal/410 gm bag	410 gm satchet	9,402	4,701	9,590	5,810	17,883	23,694
Therapeutic Milk F100 1000KCal/456 gm bag	456 gm satchet	28,741	14,371	29,316	9,176	63,252	124163
Ready to Use Therapeutic Food (RUTF)	92 gm satchet	665,704	332,853	679,018	274,667	1,402,908	635517
Fortified Blended Flour with nutrient mix for children	1 metric tonne	5,084	18,402	5,186	22	28,650	34,380,000
Fortified Blended Flour with nutrient mix for adults	1 metric tonne	36,803	18,402	37,539	1,458	91,286	109,543,200
Fortified Blended Flour with nutrient mix for pregnant women	1 metric tonne	8,316	2,772	8,482	0	19,570	23,484,000
Multiple micronutrient powder for children	satchets	5,966,503	2,983,252	6,085,833	0	15,035,588	706,672
Multiple micronutrient tablet	tabs/caps	70,781	0	72,197	0	142,978	50,757,190
Commercial Infant Feeding Formula (WHO specifications)	450 gm tin	2,053,408	0	2,094,476	0	4,147,884	19,909,843
Water kit (Filter + Thermos Flask)	I kit	29,334	0	0	0	29,334	733,350
Total							**240,297,632**

iv. Suggested Procurement schedule

Procurement Plan for FY 2009/10

Product Specification	Unit Pack Size	2009/2010			
		Q1	Q2	Q3	Q4
Therapeutic Milk F75 750 Kcal/410 gm bag	410 gm satchet	2,603	2,603	2,603	2,603
Therapeutic Milk F100 1000KCal/456 gm bag	456 gm satchet	10,107	10,107	10,107	10,107
Ready to Use Therapeutic Food (RUTF)	92 gm satchet	218,470	218,470	218,470	218,471
Fortified Blended Flour with nutrient mix for children	1 metric tonne	2,250	2,250	2,250	2,250
Fortified Blended Flour with nutrient mix for adults	1 metric tonne	25,122	25,122	25,122	25,123
Fortified Blended Flour with nutrient mix for pregnant women	1 metric tonne	2,588	2,588	2,588	2,586
Multiple micronutrient powder for children	satchets	3,758,897	3,758,897	3,758,897	3,758,897
Multiple micronutrient tablet	tabs/caps	45,599	45,599	45,599	45,599
Commercial Infant Feeding Formula (WHO specifications)	450 gm tin	698,721	698,721	698,721	698,719
Water kit (Filter + Thermos Flask)	1 kit	3,961	3,961	3,961	3,961

Procurement Plan for FY 2010/11

Product Specification	Unit Pack Size	FY 2010/2011			
		Q1	Q2	Q3	Q4
Therapeutic Milk F75 750 Kcal/410 gm bag	410 gm satchet	4,471	4,471	4,471	4,470
Therapeutic Milk F100 1000KCal/456 gm bag	456 gm satchet	15,813	15,813	15,813	15,813
Ready to Use Therapeutic Food (RUTF)	92 gm satchet	350,727	350,727	350,727	350,727
Fortified Blended Flour with nutrient mix for children	1 metric tonne	7,163	7,163	7,163	7,161
Fortified Blended Flour with nutrient mix for adults	1 metric tonne	22,822	22,822	22,822	22,820
Fortified Blended Flour with nutrient mix for pregnant women	1 metric tonne	4,893	4,893	4,893	4,891
Multiple micronutrient powder for children	satchets	3,758,897	3,758,897	3,758,897	3,758,897
Multiple micronutrient tablet	tabs/caps	35,745	35,745	35,745	35,743
Commercial Infant Feeding Formula (WHO specifications)	450 gm tin	1,036,971	1,036,971	1,036,971	1,036,971
Water kit (Filter + Thermos Flask)	1 kit	7,334	7,334	7,334	7,332

vi. Section references, information sources

1. Ministry of Health/NASCOP. *Kenya National Guidelines on Nutrition and HIV and AIDS*. Revised edition, January 2007. Nairobi:MoH.
2. Ministry of Medical Services/NASCOP. *Kenya Nutrition and HIV and AIDS Strategy 2007 to 2010*. August 2008. Nairobi:MoMS.
3. Pricing information for products taken from:
   UNICEF in collaboration with WHO. *Sources and Prices of selected medicines for children including therapeutic food, dietary vitamin and mineral supplementation.* January 2009. UNICEF/WHO.
4. *Sources and Prices of selected medicines for children including therapeutic food, dietary vitamin and mineral supplementation*, January 2009, UNICEF and WHO.

5. Home and Community-based Care (HCBC)

This includes commodities for Home and Community based care, as well as painkillers (Paracetamol) for Palliative care. The Standard Minimum HCBC (Home and Community based Care) kit already contains Paracetamol.

i. Target population

As of May 2008, the scaling-up of distribution of HCBC kits from Nyanza province to the national level had been estimated in the report *Costing the Nyanza Home and Community Based Care Model 2007/08 – 2011/2012*. The report assumed home-based care would be accessed by 50% of patients living with HIV which would range from 188,000 in 2007/8 to between 600,000 and 650,000 by 2012. Given the constraints at service delivery level, phasing-in targets were set for reaching these populations: 30% (2007/08), 40% (2008/09), 50% (2009/10), 60% (2010/11) and 80% (2011/12). However under the National Plan of Operations (NPO), the KNASP III aims to train 80% of Community health workers and community health extension workers in 80% of the districts by 2011. Commodities have to be available for community healthcare workers to carry out the mandate of provision of care to persons living with HIV.

The table below shows the targets for HCBC intervention for FY 2009/10 to 2012/13:

HCBC	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**
Cumulative number of Adult Patients on Care	639,842	747,834	851,846	865,755
Cumulative number of Paed Patients on Care	78,922	96,063	123,137	152,267
Total Number of Patients in need of HCBC and Palliative care (both Adults and Paeds)	359,382	421,948	487,492	509,011
% Scale-up of Patients requiring HCBC and PC from those in Care	40%	50%	60%	70%
Total number of patients requiring HCBC and PC	**143,753**	**210,974**	**292,495**	**356,308**

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of HCBC commodities for the next 2 years:

The *Implementation Framework for Home and Community based care in Kenya* (May 2008) states the contents of a standard minimum HCBC kit (revised content 2006):

Item	Unit	Description	Unit Cost (Kshs)	Quantity	Total Cost (KShs)	Total Cost (USD)
Antiseptic Lotion, 125mls	Bottle	Savlon	140	2	280.00	3.73
Bar Soap	Pieces		70	3	210.00	2.80
Chlorine Bleach, 250mls	Bottle	250 mls	70	2	140.00	1.87
Chorpheniramine	Tabs	4 mg	0.06	30	1.80	0.02
Cotton Bandages	Rolls		45	6	270.00	3.60
Cotton Wool 100grams	Rolls	100gms	65	2	130.00	1.73
Gauze	Pieces	Non-sterile	9.6	25	240.00	3.20
Gentian Violet	Bottle	Paint	35	1	35.00	0.47
Latex Gloves	Box	Examination	2.5	100	250.00	3.33
MoH/MI Printed Bags for Waste Disposal (size 14X9)	Set of 50 pcs	Printed bag	480	1	480.00	6.40
Multivitamins	Tabs		1	30	30.00	0.40
Nutrition kit (e.g. Insta powder)	Packet	2kg nutrition flour	160	1	160.00	2.13
Oral Rehydration Salts (ORS)	Sachets		4.25	20	85.00	1.13
Paracetamol	Tabs		0.2	60	12.00	0.16
Petroleum Gel, 50grams	Bottle	Vaseline	52	2	104.00	1.39
Scissors	Pair		200	1	200.00	2.67
Tissue (Toilet) Paper	Pieces		32	2	64.00	0.85
Zinc Oxide Plaster(1X2.5)	Rolls		90	1	90.00	1.20
Average cost for 1 HCBC kit					**2,781.80**	**37.09**

The cost of the above kit has been determined using pricing information from the MEDS Price guide of 2008. The average price for a HCBC kit (at an exchange rate of 1 USD = 75 KShs) amounts to 37.09 USD.

Given that 1 kit should serve an average of 12-16 clients per month, the median value of 15 clients per month was used to derive the unit cost to the client as USD 2.47 for a HCBC kit per month. There is a practice among some service providers to supply an initial kit that contains both the minimum package of content and a replenishment kit which has no scissors and waste disposal bag. The price difference of exclusion of these items amounts to USD 9.07 per kit, USD 0.6 per client per month and USD 7.25 per client per year. Provision of replenishment kits will reduce cost by about 20%. Therefore it has been assumed that there will be 2 types of kits provided: a standard kit and a replenishment kit.

iii. Quantities of Commodities required

A calculation was made of the number of home-based kits and replenishment kits required using the expected coverage targets and the coverage per kit. While the average patient will need chronic care for 3-4 months, a provision for 4 months supply of HCBC kit has been made. The extra 1-month supply will serve as buffer stock to cater for unexpected increased coverage.

The Requirements for FY 2009/2010 and FY 2010/11 are presented in the table below:

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. Standard HCBC kits	Kit (1 month supply)	37.09	14,063	521,606	19,500	723,268
2. Replenishment HCBC kits	Kit (3 month supply)	28.02	42,189	1,182,305	58,500	1,639,404
Total				**1,703,911**		**2,362,672**

Note: There are a number of non-governmental organizations (NGOs) providing home-based care such as Mildmay and the PEPFAR program through APHIA II partners. However, as supplies are not consistent, they have not been factored into the annual procurement plan.

iv. Suggested Procurement schedule

Procurement plan for FY 2009/10

Commodity name	Pack size	Call down schedule			
		Q1	Q2	Q3	Q4
1. Standard HCBC kits	Kit	3,516	3,516	3,516	3,515
2. Replenishment HCBC kits	Kit	10,547	10,547	10,547	10,548

Procurement plan for FY 2010/11

Commodity name	Pack size	Call down schedule			
		Q1	Q2	Q3	Q4
1. Standard HCBC kits	Kit	4,875	4,875	4,875	4,875
2. Replenishment HCBC kits	Kit	14,625	14,625	14,625	14,625

v. Notes and Recommendations

- Recommendations:
  - There is need for design and implementation of a *national* commodity logistics system for HCBC kit commodity data collection and analysis mechanism.

vi. Section References:

1. Ministry of Health/NASCOP. *Home Care Handbook - A reference manual for Home-based Care for people living with HIV and AIDS in Kenya*. 2nd edition, 2006.
2. MoH/NASCOP. *An Implementation framework for HCBC in Kenya*. May 2008. Nairobi: MoH/NASCOP.
3. MoH and Mildmay International. *Costing the Nyanza Home and Community Based Care Model 2007/08 – 2011/2012*. May 2008. Final report 8.9.08.

C. PREVENTION

Commodities for HTC and blood screening (blood safety) are covered under the Lab section, while those for treatment of STI have been covered under medicines for OIs above.

1. Prevention of Mother to Child transmission (PMTCT)

This section covers prevention of HIV in pregnant women and infants born to them.

i. Target population

The following are the estimated number of PMTCT clients at year-end over the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of pregnant women receiving PMTCT ARVs	63,376	73,336	78,812	83,169
Number of Exposed Infants receiving PMTCT ARVs	63,376	73,336	78,812	83,169

- The number of pregnant women per year across the 4 years has been taken from the Resource needs model projections (see appendix). To derive the number of women requiring PMTCT, it was assumed that the ANC coverage is at 92% (estimated from RH data), and that out of those coming to ANC, the % of women tested for HIV will move from 80% currently to 87% in FY 2009/10, 90% in FY 2010/11, 95% in years FY 2011/12 and 2012/13. The HIV prevalence in these women was taken from ANC Sentinel surveillance data from 2006 – 6.9% across all years.
- PMTCT clients are assumed to be women not yet on ART. ARVs for any women already on ART who become pregnant are assumed to have been covered under quantities for ART.
- It is assumed that each pregnant woman gives birth to only one live infant. 100% coverage of the exposed infants was assumed.
- Exposed infants will require ARVs and CTX for prophylaxis (from age 6 weeks), and access to replacement Infant feeds for several months after birth (see Nutrition section above - assumed that only 50% of women will accept replacement feeds, 50% will exclusively breast-feed). These requirements are covered under CTX above and the sections below.

ii. Key assumptions

The following were key assumptions for the ARVs for PMTCT clients for the next 2 years:

- The regimens for PMTCT were taken from *the Guidelines for PMTCT of HIV and AIDS in Kenya* (3rd edition, 2009).
- The regimens are shown in the tables below with the proportions of clients on each regimen per year:

	PMTCT Regimen for Women	Total Regimen duration during pregnancy and birth	2009	2010	2011	2012	2013
			%	%	%	%	%
1	Nevirapine (SD NVP) 200mg tab stat	Single dose	79.0%	50.0%	30.0%	10.0%	0%
2	Short course: AZT 300mg BD (from week 28-40); then NVP 200mg stat + AZT 600mg stat during labour; then 1 tab of AZT/3TC 300/150mg BD for one week post-partum	14 weeks	16.0%	40.0%	50.0%	60.0%	70.0%
3	PMTCT HAART 1: AZT 300mg + 3TC 150mg + NVP 200mg	30 weeks up to birth	4.75%	9.50%	19.0%	28.5%	28.5%
4	PMTCT HAART 2: AZT 300mg + 3TC 150mg + EFV 600mg	28 weeks	0.125%	0.25%	0.5%	0.75%	0.75%
5	PMTCT HAART 3: AZT 300mg + 3TC 150mg + LPV/r	28 weeks	0.125%	0.25%	0.5%	0.75%	0.75%

- Use of the regimen Single dose (SD) NVP will be phased out by 2013.
- All HIV+ pregnant women with CD4 count of ≤ 350 qualify for full HAART. A maximum of 30% of pregnant women will be put on HAART. This is because of health system challenges with roll-out of HAART for PMTCT. Duration of treatment differs depending on the settings where they are followed up.
- Proportion of women on each of the 3 HAART regimens:
  - AZT/3TC/NVP- 95%
  - AZT/3TC/LPV/r - 2.5% (especially for women with CD4 >250 who develop NVP hyper-sensitivity reactions)
  - AZT/3TC/EFV- 2.5%
- Women on HAART regimens will continue on the regimen for life. The above table considers only the duration of pregnancy and immediately after. Many women tend to come in from the 2nd trimester. Any women given the EFV-based regimen are assumed to start from 2nd trimester since EFV may be teratogenic if used in 1st trimester. The commodities for life-long HAART after pregnancy are part of the quantities for Adult ART.
- The short-course regimen is AZT-based and lasts 13 weeks from week 28 of pregnancy, followed by 1 week of AZT/3TC to cover the 3TC tail. For pregnant women with anaemia: Treat the anaemia and put them on short course regimen; for HAART, provide d4T instead of AZT-based regimens.

- The regimen proportions for infants are shown below:

	PMTCT Regimen for Infants	Total Regimen duration	2009	2010	2011	2012	2013
			%	%	%	%	%
1	Nevirapine (NVP) 2 mg/kg stat at birth	Single dose	30%	15%	10%	5%	0%
2	NVP 2 mg/kg stat + AZT 4mg/kg bd for 6 weeks	6 weeks	65%	55%	45%	35%	30%
3	NVP 2 mg/kg stat + AZT 4mg/kg bd for 6 weeks + 3TC 4mg/kg bd for 1 week	6 weeks	5%	30%	45%	60%	70%

- Use of the regimen Single dose (SD) NVP will be phased out by 2013.
- Some health facilities currently use the regimen of NVP with AZT alone presumably due to poor access to 3TC (the number of PMTCT sites at about 3,500 currently far exceeds the number of established ART sites at about 700), and poor dissemination of the previous guidelines (the new guidelines have not yet been widely disseminated). It is assumed that this will reduce to 30% by 2013.
- Adjustments:
  - Buffer stock: 6 months
  - Other stock adjustments: 2% for losses

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order based on assumptions and target population, and after deducting available stocks and expected stocks (where available).

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. Nevirapine 200mg tab	60's	3.25	1,525	4,957	1,672	5,434
2. AZT 300mg tab	60's	8.75	46,753	409,088	58,500	511,875
3. AZT/3TC 300/150mg FDC tabs	60's	9.47	1,573	14,900	3,641	34,484
4. AZT/3TC/NVP 300/150/200mg FDC tabs	60's	13.50	16,015	216,204	37,064	500,364
5. EFV 600mg tabs	30's	11.85	787	9,322	1,821	21,575
6. LPV/r 200/50mg tabs	120's	41.10	787	32,334	1,821	74,830
7. NVP liquid 10mg/ml	*60ml	*0.67	*1,606	1,084	*1,858	1,254
8. AZT liquid 10mg/ml	*150ml	*1.50	*53,946	80,918	*75,800	113,700
9. 3TC liquid 10mg/ml	*30ml	*0.22	*3,372	746	*23,409	5,179
Total cost (USD)				**769,553**		**1,268,695**

*Note: Please note the recommendations below.

1. As per those recommendations, the quantities of the syrups have been given in the preferred pack size that was considered suitable for this program, and not as per the currently available pack size in the market. The price shown has been adjusted accordingly.

2. When converted into the pack size currently available in the local market, the quantities are as follows: for FY 2009/10: NVP liquid 240ml (price USD 2.70) – 401 bottles, AZT liquid 240ml (price USD 2.40) – 33,716 bottles, 3TC liquid 240ml (price USD 1.77) – 421 bottles; for FY 2010/11: NVP liquid 240ml (price USD 2.70) – 464 bottles, AZT liquid 240ml (price USD 2.40) – 47,375 bottles, 3TC liquid 240ml (price USD 1.77) – 2,926 bottles. This assumes that facilities will be able to dispense the required quantities to clients by re-packing in smaller bottles, which raises safety issues.

3. Another more costly but safer alternative is to procure quantities of liquids in current market sizes matching the number of infant clients, taking into account buffer stock. This allows for full bottles to be provided to the clients and ignores the wastage of the liquid left after dispensing the required dose: for 2009/10, NVP liquid 240ml – 63,376 bottles, AZT liquid 240ml – 67,432 bottles, 3TC liquid 240ml – 4,817 bottles; for FY 2010/11: NVP liquid 240ml – 111,471 bottles, AZT liquid 240ml – 94,750 bottles, 3TC liquid 240ml – 33,441 bottles.

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Nevirapine 200mg tab	60's	381	381	381	382
2. AZT 300mg tab	60's	11,688	11,688	11,688	11,689
3. AZT/3TC 300/150mg FDC tabs	60's	393	393	393	394
4. AZT/3TC/NVP 300/150/200mg FDC tabs	60's	4,003	4,003	4,003	4,006
5. EFV 600mg tabs	30's	196	197	198	196
6. LPV/r 200/50mg tabs	120's	196	197	198	196
7. NVP liquid 10mg/ml	*60ml	401	401	402	402
8. AZT liquid 10mg/ml	*150ml	13,486	13,486	13,487	13,487
9. 3TC liquid 10mg/ml	*30ml	843	843	843	843

vi. Section references:

1. PATH. Handout on *A Pilot introduction of the Nevirapine Infant-dose pouch in Kenya in PMTCT programs*, dated 13 October 2008. PATH/USAID.
2. PATH. Handout on *Packaging solutions for Nevirapine*, dated May 2006.
3. MoH/NASCOP. *Guidelines for Prevention of Mother-to-Child transmission (PMTCT) of HIV and AIDS in Kenya*. 3rd edition 2009.
4. New Vision newspaper. Article on *Uganda: HIV Prevention - Nevirapine Repackaged for Home Births*. November 2, 2008. Kampala, Uganda. http://www.aegis.com/news/nv/2008/NV081103.html. Accessed 20 June 2009.

2. Post Exposure Prophylaxis (PEP), management of sexual assault and emergency contraception

This covers PEP, prophylaxis for STI, pain management and emergency contraception of clients experiencing sexual violence as per the package of care recommended in the *National Guidelines for management of Rape and Sexual violence*.

i. Target population

The following are the estimated number of Adult PEP clients at year-end over the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of Adult clients requiring ARVs for PEP: High risk exposure	27,000	27,000	27,000	27,000
Number of Adult clients requiring ARVs for PEP: Low risk exposure	18,000	18,000	18,000	18,000
Total cases of Adult PEP	45,000	45,000	45,000	45,000
Estimated Number of women requiring emergency contraception (ECP)	19,440	19,440	19,440	19,440

There was no data available on the number of sexual assault or PEP cases nationally per year. In the Commodities

Quantification assumptions meeting, the groups noted the inadequate Kenya Police data on the number of sexual assault cases. Data available from commodity consumption information reports from ART sites showed an average of about 2,450 cases over the period May 2008 to April 2009.

Therefore the number of PEP cases was estimated as follows:

- All health facilities (assume total of approximately 4,500) will have 1 low risk case (i.e. from occupational exposure) every 3 months (40% of cases)
- All health facilities (assume total of approximately 4,500) will have 1 high risk case (sexual assault) every 2 months (60% of cases).

The number of ECP clients was estimated as follows: Using the number of cases of High-risk PEP, assume 90% of the PEP high risk cases are women, and of those, 80% are women of reproductive age needing ECP.

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of commodities for PEP and sexual violence clients for the next 2 years:

- Adult PEP regimens:
  - Low risk: dual regimen of AZT/3TC or d4T/3TC.
  - Dose: AZT 300mg + 3TC 150mg BD for 28 days (30 days will be used instead for ease of similarity to the pack sizes for the drugs)
  - High risk: triple drug regimen of AZT/3TC or d4T/3TC with LPV/r.
- Pediatric PEP drugs:
  - Assumed that all children < 15 years are not likely to be cases of occupational exposure for PEP thus high-risk regimens to be provided for the Paed clients.
  - The dose is given according to weight and/or surface area. Drugs and dosages are available in the *National Guidelines for Medical Management of Rape and Sexual Violence* or in the *Guidelines for Antiretroviral drug therapy in Kenya*.
  - The ARVs needed for Paed PEP cases will be covered by the buffer stock of Paed ARVs for ART.
- Emergency Contraceptive Pills (ECP): dose is 2 tabs stat of Levonorgestrel 0.75mg tabs.
- Drugs for STI prophylaxis (offered to all Rape survivors) and for Pain management are as follows:

<table>
<tr><th>Type</th><th>Client type</th><th>Regimen</th><th>% on Regimen</th><th>No. of cases</th></tr>
<tr><td rowspan="6">STI prophylaxis</td><td rowspan="2">Non-pregnant adults</td><td>Norfloxacin 800mg stat</td><td rowspan="2">69%</td><td rowspan="7">Not quantified. The drugs for STI prophylaxis and for Pain management are commodities normally available as Essential drugs (e.g. in the EMMS provided by KEMSA to public health facilities). The quantities of these drugs are small and will be easily covered by the larger EMMS program.*</td></tr>
<tr><td>Doxycycline 100mg BD for 7 days</td></tr>
<tr><td rowspan="2">Pregnant adult females</td><td>Spectinomycin 2gm stat IM</td><td rowspan="2">1%</td></tr>
<tr><td>Erythromycin 500mg QID x 7 days</td></tr>
<tr><td rowspan="2">Children (average weight of 12kg per kid)</td><td>Amoxycillin 15mg/kg TDS for 7 days</td><td rowspan="2">30%</td></tr>
<tr><td>Erythromycin 10mg/kg QDS for 7 days</td></tr>
<tr><td>Pain management</td><td>Adults</td><td>Paracetamol 500mg 2 tabs TDS x 7 days</td><td>100%</td></tr>
</table>

**NASCOP should however monitor the KEMSA stock situation to ensure availability for clients at all times.*

- Adjustments:
  - Buffer stocks: 6 months for ARVs and the other drugs
  - Other stock adjustments: 2% for losses

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order based on assumptions and target population, and after deducting available stocks and expected stocks (where available).

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
Commodities for PEP:						
1. AZT/3TC FDC 300/150mg tabs	60	9.47	68,400	647,748	68,400	647,748
2. LPV/r 200/50mg tabs	120	41.10	41,040	1,686,744	41,040	1,686,744
Commodities for Emergency Contraception:						
3. Emergency Contraceptive Pill (Levonorgestrel 0.75mg)	Dose of 2 tabs	0.50	*Nil	0	*59,098	29,549
Total				**2,334,492**		**2,364,041**

**Note: No need for procurement of ECP in FY 2009/10. Instead NASCOP should work with DRH and KEMSA to provide 59,098 doses of ECP (the 2009/10 requirement) to the sites from the Pending orders with the DRH/FP program: UNFPA: 50,000 doses, GoK/KEMSA: 2,180,000 doses. As for 2010/11, the FP program planned to procure 10,345,806 doses in the Quantification of 24-25 June 2009. It is recommended that NASCOP follow up with DRH/FP for provision of the stock to the facilities.*

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. AZT/3TC FDC 300/150mg tabs	60	17,100	17,100	17,100	17,100
2. LPV/r 200/50mg tabs	120	10,260	10,260	10,260	10,260

b. Notes:

- Lab commodities used in post rape care e.g. HVS, pregnancy tests, liver tests, HIV test kits are assumed to be covered under the quantities for Lab commodities.
- Besides the commodities above, a list of consumables that is useful when offering post rape care at a facility is shown below. These commodities as well as equipment (e.g. speculum) were not quantified for, being assumed to be available through the normal public sector supply of non-pharmaceuticals.

Item	Qty per Rape kit	Cost per unit (USD)
1. Powder free latex gloves	1	3.1 per pack of 100
2. Six stick swabs	6	8 per pack of 400
3. Masking tape for use as labels	1	0.67 per reel
4. Brown envelopes for collecting specimens	20	0.13 per envelope

Item	Qty per Rape kit	Cost per unit (USD)
5. Tape measure	1	1.33 per unit
6. Needles	3	2 per pack of 100
7. Syringes	3	4 per pack of 100
8. Vacutainer tubes	1	11.33 per pack of 100

vi. Section references:

1. MoH/DRH. *National Guidelines for management of Rape and Sexual violence*. 1st edition, 2004. Nairobi:GoK/MoH.
2. MoH/NASCOP. *Guidelines for Antiretroviral drug therapy in Kenya*. 3rd edition, December 2005. Nairobi:MoH.

3. Condoms (Male, Female), Lubricants

This section covers the quantification for Male and Female condoms, lubricants for MSM, and condom dispensers for Male condoms.

i. Target population

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Estimated number of Actual Male condom consistent users	2,298,967	2,471,679	2,655,393	2,850,476
Estimated number of Actual Female condom consistent users	45,593	49,594	53,870	58,436
Number of MSM requiring Lubricants to use with male condoms	12,300	25,264	47,568	71,058

The targets were calculated as follows:

- For Male condoms: Of the estimated population of males aged 15-64, current users are estimated to be 50% (as per the *Kenya Modes of HIV Transmission Study* – see section references below), and it was assumed that the % will increase by 1% every year from 50% to 54%.
- For Male condoms: Assume 40.6% consistency of use for 2009 (ref: KAIS 2007, data on consistent condom use with partner of unknown or known discordant HIV status) and 1% increase in consistent users per year with focus on non-marital and co-habiting partners, thus the % will increase by 1% every year from 41% to 45%.
- For Female condoms, the population considered was for women of reproductive age (WRA) 15-49. Any sexually active women above this age are to be covered by the buffer stock. Based on KDHS 2003 data, assume that out of the women aged 15-49, 17% have never had sexual intercourse, while 11% had last sexual encounter more than 1 year before the survey of KDHS 2003, therefore the balance of 72% is the target.
- For female condoms, current users estimated to be 2.4% of target population (ref: *Report of the Situational Analysis on Condom Demand, Access, Appropriate Use and Disposal in Kenya*, 2008). It was assumed that with increased promotion, usage may increase by 0.05% from 2.4% in 2009 to 2.6% by 2013. Assume 25.5% consistency of use for 2009 and 0.5% increase in consistent Users per year with focus on non-marital and co-habiting partners (ref: KAIS 2007, data on consistent condom use with partner of unknown or known discordant HIV status).

- For MSM, target population is “all MSM reached” as provided by the Resource needs model. Assume 28% consistent actual users (estimate) as per the *Kenya Modes of HIV Transmission Study* (see section references below).

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of condoms and lubricants for the next 2 years:

- Male condoms:
  - Number of condoms required per male user per year is 120 (same as CYP).
  - The quantification for Male condoms and for lubricants covers the requirement for MSM.
  - MSM assumed to use the same latex condoms as the general male population.
  - The male condoms quantified also cover those for the HCBC kit and the needs for PWP.
  - At the FP commodities Quantification workshop of 24-25 June 2009, the participants looked at the proposed quantities of the male condoms calculated using the assumptions above. They also calculated using the proposed requirements for condoms using the following assumptions:
    - Population of 40.4M in FY 2009/10, 41.4M in FY 2010/11
    - 51% are females, of whom 48% are WRA, of whom 72% are sexually active
    - CPR of 46% (estimate increase from KDHS 2008 preliminary data) in 2009/10 and 47.4% in 2010/11, of which Male condoms comprise 2.65% per year, Female condoms 0.35% per year in the method mix. 120 CYP for both male and female condoms.
- Female condoms:
  - Number of condoms required per female user per year is 84 - assume a couple using female condoms consistently needs 7 pieces per month or 84 condoms per year (ref: *Report of the Situational Analysis on Condom Demand, Access, Appropriate Use and Disposal in Kenya*, page 22-23:- Estimated monthly usage of Male condoms among respondents was average of 7 per month. Assume same usage rate for the female condom.)
  - At the FP commodities Quantification workshop of 24-25 June 2009 mentioned above, after deducting closing stock for June and pending stocks, the meeting determined that the national quantity required for FP use in FY 2009/10 as about 5.65M and 5.8M in FY 2010/11, however the meeting noted that with the pending procurements (mainly through TOWA support for HIV prevention), there is no need for additional procurement of female condoms for FP program. This KNASP quantification will be used as the overall quantification for female condoms, which will be used both for HIV prevention and for Family planning.
- MSM:
  - Number of condoms required per MSM user per year is 80 (Number of sex acts per MSM per year as taken from Resource needs model and Spectrum data).
  - Assume all the MSMs targeted will use male condoms with lubricants.
- Condom dispensers for public sites:
  - According to the Condom program officer at NASCOP, 30,000 dispensers were issued in year 2006/7. Assume an increase of 10% per year over this figure (assuming that new outlets will be opened, roll-out of the Community Strategy).
  - 1 condom dispenser can hold about 600 pieces of condoms.
- Adjustments:
  - Buffer stocks: 6 months
  - Other stock adjustments: 2% for losses

iii. Quantities of Commodities required

a. Table showing calculated Quantity required based on assumptions and target population

FY 2009/10

Commodity name	Pack size	Calculated Qty required per year (Units)	Buffer stock (Units)	Adjustment for Losses (Units)	Qty to order (Units) per year
1. Male condoms	Piece	275,876,075	137,938,038	281,393,597	419,331,664
2. Female condoms	Piece	3,829,815	1,914,908	3,906,412	5,821,319
3. Lubricants	Satchet (5ml)	984,000	492,000	1,003,680	1,495,680

FY 2010/11

Commodity name	Pack size	Calculated Qty required per year (Units)	Buffer stock (Units)	Adjustment for Losses (Units)	Qty to order (Units) per year
1. Male condoms	Piece	296,601,504	148,300,752	302,533,534	450,834,285
2. Female condoms	Piece	4,165,920	2,082,960	4,249,238	6,332,198
3. Lubricants	Satchet (5ml)	2,021,136	1,010,568	2,061,559	3,072,127

b. Table showing Quantity to order after deducting available stocks and expected stocks (where available)

Commodity name	Pack size	Unit price (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated cost (USD)
1. Male condoms	Piece	0.02	* 181,201,087	3,624,022	* 338,125,714	6,762,514
2. Female condoms	Piece	0.61	5,621,319	3,451,490	6,332,198	3,887,969
3. Lubricants (Water-based)	Satchet (5ml)	0.62	1,495,680	920,418	3,072,127	1,890,540
4. Condom dispensers	Piece	56.67	39,930	2,262,700	43,923	2,488,970
Total cost (USD)			**10,258,630**		**15,029,993**	

Note:

1. For the Male condoms, advice from NASCOP was that the calculated quantity to order was too high, therefore it was reduced by 25%.

2. Information on total available stocks at central level as at end June 2009 (from KEMSA, PSI, FHOK, MSK): 114,930,185 male condoms, nil for other commodities

3. Information on total pending stocks with suppliers as at end June 2009 (from KEMSA, PSI, FHOK, MSK): 62,800,000 male condoms, 200,000 female condoms, nil for other commodities. Planned procurements include about 100 million male condoms through TOWA program.

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Male condoms	Piece	0	60,400,362	60,400,362	60,400,362
2. Female condoms	Piece	1,405,330	1,405,330	1,405,330	1,405,330
3. Lubricants (Water-based)	Satchet (5ml)	373,920	373,920	373,920	373,920
4. Condom dispensers	Piece	19,965	0	19,965	0

See recommendations below

vi. Section references:

1. NACC, Kenya. *Kenya: A Study on the Modes of HIV Transmission. Final synthesis report.* 2008. Nairobi, Kenya: NACC. Pages 39, 40.
2. MoH/NASCOP. *Report of the Situational Analysis on Condom Demand, Access, Appropriate Use and Disposal in Kenya, 2008.* Dec 2008.
3. MoPHS and NACC. *Draft National Condom Policy and Strategy 2009 – 2014.* Dec 2008.
4. Information on CYP with respect to Male condoms obtained from document on Couple Years Protection (CYP), from http://www.usaid.gov/our_work/global_health/pop/techareas/cyp.html
5. Geibel S. et al. *Improving HIV Programs for Men who Sell Sex to Men in Mombasa, Kenya*. Presentation for the 2007 HIV and AIDS Implementers' Meeting, Kigali, Rwanda, June 17, 2007.
6. Prices obtained: NASCOP, the FP program, the RH Interchange website (http://rhi.rhsupplies.org) for recent relevant FP commodity shipments to Kenya.

4. Infection prevention

This covers selected commodities in the areas of Injection safety and medical waste management.

i. Target population

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Estimated number of Hospital beds	69,848	71,810	73,822	75,871
Number of Hospital beds to be covered	10,477	21,543	40,602	60,697

The targets were taken from the Resource needs model.

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of commodities for the next 2 years:

- Retractable syringes with needles (Re-use prevention):
  - Auto-disable syringes i.e. prevent re-use / single use
  - Estimated public sector site syringe requirements: 3 syringes per bed per day

- 4 different sizes available: 2ml (Needle Gauge 23), 5ml (G21), 10ml (G21), 20ml (G21). Assume proportion of 20% for 2ml, 40% for 5ml, 30% for 10ml and 10% for 20ml out of total quantity required.

- Safety boxes (Puncture-proof, water-proof sharps containers):
  - Each safety box caters for an average of 80 sharps.
  - According to specifications availed, the boxes should be of yellow colour with a biohazard sign and easily combustible on ignition.
- Colour-coded Bins with fitting lids
  - 2 sizes: 40 lts for Hospitals, 20 lts for HCs and Dispensaries
  - According to specifications availed, they should be rigid, puncture-resistant, leak-resistant, tamper-proof bins with a biohazard sign, made of polyethylene (LLDP).
  - Qty required by a site per year:- (i) 54 for PGHs and Referral hospitals (ii) 30 for DHs, SDHs (iii) 12 for HCs and Dispensaries.
- Colour-coded Bin liners
  - For the 2 different bin sizes above. Should be of thickness at least 25 microns.
  - According to specifications availed, they should be made of polyethylene (PE).
  - Qty required per year:- (i) PGHs and Referral hospitals - 1 liner per bucket/day, assume average of 1.5 buckets at site which works out to 540 liners/year (ii) DHs, SDHs, HCs and Dispensaries - 1 liner per bucket/day, assume average of 1 bucket at site which works out to 360 liners/year for DH,SDH, HCs and Dispensaries.
- Other required equipment and items include:
  - Protective gear – including boots, goggles, overalls, face masks, heavy duty gloves, protective footwear, helmets, aprons, etc.
  - Laundry machines
  - Incinerators
  - All these items have not been quantified as it is assumed that their provision is already (or will be) supported by GoK or partners supporting infrastructure and equipment.

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order.

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (Units)	Estimated cost (USD)	Qty to order (Units)	Estimated Cost (USD)
1. Retractable anti-re-use syringes with needles, 2ml	pc	0.053	2,874,051	152,325	5,909,676	313,213
2. Retractable anti-re-use syringes with needles, 5ml	pc	0.058	4,311,076	250,042	8,864,514	514,142
3. Retractable anti-re-use syringes with needles, 10ml	pc	0.060	5,748,101	344,886	11,819,352	709,161
4. Retractable anti-re-use syringes with needles, 20ml	pc	0.060	1,437,025	86,222	2,954,838	177,290
5. Safety boxes	pc	1.00	179,628	179,628	369,355	369,355
6. Colour-coded Bins with fitting lids, 20lts	pc	26.67	108,000	2,880,000	108,000	2,880,000
7. Colour-coded Bins with fitting lids, 40lts	pc	26.67	5,220	139,200	5,220	139,200
8. Colour-coded Bin liners	pc	0.80	20,055,600	16,044,480	20,055,600	16,044,480
Total cost (USD)			**20,076,783**		**21,146,841**	

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Units)	Oct – Dec 2009 (Units)	Jan – Mar 2010 (Units)	Apr – June 2010 (Units)
1. Retractable anti-re-use syringes with needles, 2ml	pc	718,513	718,513	718,513	718,513
2. Retractable anti-re-use syringes with needles, 5ml	pc	1,077,769	1,077,769	1,077,769	1,077,769
3. Retractable anti-re-use syringes with needles, 10ml	pc	1,437,025	1,437,025	1,437,025	1,437,025
4. Retractable anti-re-use syringes with needles, 20ml	pc	359,256	359,256	359,256	359,256
5. Safety boxes	pc	44,907	44,907	44,907	44,907
6. Colour-coded Bins with fitting lids, 20lts	pc	27,000	27,000	27,000	27,000
7. Colour-coded Bins with fitting lids, 40lts	pc	1,305	1,305	1,305	1,305
8. Colour-coded Bin liners	pc	5,013,900	5,013,900	5,013,900	5,013,900

vi. Section references:

1. MoH. *National Standards and Guidelines on Injection safety and medical waste management*. February 2007. Nairobi:MoH.
2. MoH. *National Policy on Injection safety and medical waste management*. February 2007. Nairobi:MoH.
3. JSI/MMIS. Specifications for safety boxes, bins, bin liners, and PPE.

5. Injecting drug users (IDU)

This covers selected commodities used by injecting drug users, including commodities for opiate addiction treatment.

i. Target population

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of IDU actually reached	1,800	3,697	6,961	10,399

The figures are based on data from the Resource needs model.

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of commodities for the next 2 years:

- Test kits for HTC: quantities already covered under the HTC section above
- Condoms and condom dispensers: quantities already covered under the Condoms section above
- Retractable syringes with needles (Re-use prevention): Assume 2 syringes per IDU per day. Quantities already covered under the Infection prevention/injection safety section above. Provision of these syringes to IDUs may be held up by lack of a legal framework. If so, then the program staff at NASCOP requested provision of bleach (30ml per person/day or about 1 lt per month per person).
- Drugs for treatment of opiate addiction:

– Opiate substitution therapy e.g. Methadone: these drugs are not yet widely available locally. Expected dosage is 60mg per person/day.
– Detoxification drugs, e.g.
    - (i) Diazepam 10mg tds for 5 days
    - (ii) Ibuprofen 400mg tds for 5 days
    - (iii) Hyoscine butyl bromide
    - (iv) Carbamazepine

iii. Notes and Recommendations

Commodities for IDU have not been quantified. Commodities for detoxification are part of the commodities normally provided under EMMS.

a. Recommendations:

i. Policy and legal framework lacking for the support of IDU. There is a draft policy and legal framework which requires mainstreaming. Currently consultative meetings are ongoing.

ii. The exact number of IDU is unknown since use of the hard drugs is not legal. Community outreach education and mobilization programs are needed to identify drug users, and a referral network of service providers (linkages with sites with drug addiction programs) needs to be set up.

6. Voluntary medical adult male circumcision (VMAMC)

This covers only the expendable supplies (consumables) for VMAMC, namely the Male circumcision kit. The provision of the one-off equipment, protective clothing, related items and infrastructure for the MC program is assumed to be catered for by GoK and the various donors supporting the VMAMC program at the program's selected health facilities. The list of these items is available from the program staff at NASCOP.

i. Target population

The number of male clients to be reached per year over the years FY 2009/10 to FY 2012/13 was provided by the program manager at NASCOP as follows:

Description	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of Clients to be reached per year	50,000	150,000	150,000	150,000

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of Male circumcision kits for the next 2 years:

- The list of consumable items in a kit for the circumcision of 50 males is as follows:

MC kit with consumable items for 50 MCs

	Item description	Quantity per kit	Details	Cost (USD)
1	Sterile surgical gloves size 7.5"	6 x 50 pairs	300 pairs	60.00
2	Sterile surgical gloves size 8"	3 x 50 pairs	150 pairs	30.00
3	Utility (heavy duty) gloves	2 pairs	2 pairs	10.67
4	Clean examination gloves	3 x 100	300 pairs	60.00

	Item description	Quantity per kit	Details	Cost (USD)
5	Gauze (non-sterile)	4 x 4 (2 boxes x 20 x 50)	2,000 pieces	56.67
6	Vaseline gauze	10 packets	10 packets	46.67
7	Sutures (chromic catgut 3/0 with 75mm suture, 30mm roundbody needle)	10 x 12 packets	120 sutures	49.33
8	Surgical blades size 10"	2 box (200)	200 blades	9.33
9	Strapping	8 Rolls	8 rolls	3.20
10	Face masks (3-ply)	300	300 masks	16.00
11	Normal Saline	50 bottles	50 bottles	22.67
12	Antiseptic soap e.g. Dettol	10 pcs	10 pieces	18.67
13	Precepts tablets for sterilization/disinfection	2 tins (1 tin = 100 tabs)	200 tabs	42.67
14	Betadine 500 mls (30mls/procedure)	5 bottles	5 bottles	45.00
15	Jik (Chlorohexidine)	2 x 5 litre packs	2 x 5 litre packs	12.00
16	Lignocaine 2% without epinephrine, 30ml vials (15mls/ client)	40 vials	40 vials	7.47
17	Syringes 20cc	100 syringes	100 syringes	9.33
18	Needles G 21	70	70 needles	1.20
19	Needles G 23	70	70 needles	1.20
20	Paracetamol tablets (30 tabs prescribed as 6 tabs/day for 5 days)	2,000	2 tins, each of 1,000 tabs	12.00
21	Dispensing envelopes	1,000	1,000 envelopes	2.67
22	Disposable plastic bags (black and red)	1 roll of each	2 rolls	53.33
23	Client folders	50	50 folders	6.67
24	Paper towels/serviettes (for drying hands as disposable hand towels)	4 packets	4 packets	3.25
25	Surgical spirit	5 litres	5 litres	8.67
26	Amoxicillin/cloxacillin 500 mg capsules	200 caps	200 caps	13.33
27	Powder soap (5kg packets)	1 large packet	1 large packet	2.27
28	Toothbrushes	12	12	16.00
29	Fliers as IEC materials for passing information about MC to clients	200 pieces	200 pieces	26.67
Total				**646.92**

- Adjustments:
  - Buffer stocks: 3 months
  - Other stock adjustments: 2% for losses

The table below shows the calculated Quantity to order based on assumptions and target population, and after deducting available stocks and expected stocks (where available).

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. Male circumcision kits	Kit	646.92	1,270	821,588	3,810	2,464,765
Total cost (USD)			**821,588**		**2,464,765**	

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Male circumcision kits	Kit	0	635	0	635

vi. Section references:

1. MoH/NASCOP. *Policy on Male circumcision in Kenya*. 2008. Nairobi:MoH.
2. MoPHS/NASCOP. *Clinical manual for Male circumcision under Local Anaesthesia.* 2008. Nairobi:MoPHS.

D. LABORATORY COMMODITIES

The lab tests considered in this section are as per the *Guidelines for ART in Kenya* (Table 5.5: Follow-up, Laboratory and clinical monitoring schedule for patients on ART), as well as other guidelines for screening for HIV, prevention of HIV, and the care and treatment of HIV patients.

General note:

- This section covers only the commodities (reagents, consumables, etc) for the Lab. It has excluded equipment which is assumed to be already in place or to be provided by GoK with support from HIV & AIDS stakeholders.
- Adjustment of quantities to procure:
  - Buffer stocks: Not included for these Lab commodities, however with the information given below, the quantities can be rapidly adjusted for inclusion of 6 months of buffer stock.

1. HIV Testing and Counselling

i. Target population

This covers testing for PITC, VCT, PMTCT, home-based testing, Sentinel surveillance and any testing campaigns. The following are the estimated number of clients aged 15-64 targeted for counseling and testing over the years FY 2009/10 to FY 2012/13:

Description	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
No. of people targeted for C&T (age 15-64) (Includes 30% Repeat testers)	**4,141,937**	**5,382,662**	**5,596,119**	**3,101,504**
Comprising:-				
Routine testing (assumed = 20%, including PITC and VCT)	828,387	1,076,532	1,119,224	620,301
Door-to-door testing	326,548	482,972	516,662	183,217
HIV Testing Campaigns	1,700,000	2,500,000	2,600,000	900,000
PMTCT	1,287,002	1,323,158	1,360,233	1,397,986
Cumulative numbers tested (Includes 30% Repeat testers)	10,141,937	15,524,600	21,120,719	24,222,223

The number of clients targeted for CT was obtained by scaling up from the KAIS 2007 baseline of about 6 million ever tested by 24% in year 1, 30%, 30% and 16% in years 2-4.

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of HTC commodities for the next 2 years:

- Serial testing algorithm: screening test (100%, e.g. Determine), confirmatory test (10%, e.g. Bioline), tie-breaker (2%, e.g. Unigold).
- QA reduces from 10 % to 5% from 2010 due to Proficiency testing (PT) using panels and will remain constant to 2013.
- Adjustments: 5% for invalid tests and losses
- The table below provides a summary of the assumptions:

Type of Service	**Testing Algorithm**	**% for test used for service type**			**% used for QA (2009)**	**% used for QA (2010-2013)**	**% losses (all years)**
		Test 1 (screening)	**Test 2 (Confirmatory)**	**Test 3 (Tie-breaker)**			
PITC and other CT types	Serial	100%	10%	2%	10% (ELISA or Rapid test)	5%	5%

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order based on assumptions and target population

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. Test 1 (e.g. Determine)	100	80.00	43,490	3,479,227	56,518	4,521,436
2. Test 2 (e.g. Bioline)	30	23.70	15,222	360,752	19,781	468,816
3. Test 3 (e.g. Unigold)	20	32.00	479	15,343	623	19,940
Total cost (USD)				**3,855,323**		**5,010,192**

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. Test 1 (e.g. Determine)	100	10,872	10,873	10,872	10,873
2. Test 2 (e.g. Bioline)	30	3,805	3,806	3,805	3,806
3. Test 3 (e.g. Unigold)	20	120	120	120	119

2. Blood safety

i. Targets

The following are the targets for number of blood units tested over the years FY 2009/10 to FY 2012/13:

Description	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of Blood Units required	160,000	180,000	200,000	220,000

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of Blood safety commodities for the next 2 years:

- Serial testing algorithm: screening test (100%), confirmatory test (20%), tie breaker (1%).
- The quantities for RPR will cover tests conducted for PMTCT (ANC clients), sporadic testing, STI and Blood safety services.
- The table below provides a summary of the assumptions:

Test	Testing Algorithm	% for test used for service type			% used for QA (2009)	% used for QA (2010-2013)	% losses (all years)
		Test 1 (screening)	Test 2 (Confirmatory)	Test 3 (Tie-breaker)			
Blood safety	Serial	100%	10%	1%	10%	5%	5%
Surveillance	Serial	100%	20%	1%	10%	5%	5%

Estimated Total requirement for Test	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Hepatitis B (Hep B)	160,000	180,000	200,000	220,000
Hepatitis C (Hep C)	160,000	180,000	200,000	220,000
RPR (Syphilis)	2,000,000	2,200,000	2,420,000	2,642,000

iii. Quantities of Commodities required

Commodity name	Pack size	Unit prices (USD)	FY 2009/10		FY 2010/11	
			Qty to order (packs)	Estimated cost (USD)	Qty to order (packs)	Estimated Cost (USD)
1. HIV Long ELISA test 1 (e.g. Vironostika)	576	639.00	292	186,375	328	209,672
2. HIV Long ELISA test 2 (e.g. Murex HIV)	480	652.00	70	45,640	79	51,345
3. Hepatitis B (Hep B)	480	544.79	350	190,675	394	214,509
4. Hepatitis C (Hep C)	480	1,227.73	350	429,532	394	483,223
5. RPR (Syphilis)	100	7.66	22,000	168,520	24,200	185,372
Total cost (USD)			**1,020,741**		**1,144,121**	

iv. Suggested Procurement schedule

Commodity name	Pack size	Call down schedule			
		July – Sept 2009 (Packs)	Oct – Dec 2009 (Packs)	Jan – Mar 2010 (Packs)	Apr – June 2010 (Packs)
1. HIV Long ELISA test 1 (e.g. Vironostika)	576	73	73	73	73
2. HIV Long ELISA test 2 (e.g. Murex HIV)	480	10	15	20	25
3. Hepatitis B (Hep B)	480	50	50	100	150
4. Hepatitis C (Hep C)	480	90	90	90	80
5. RPR (Syphilis)	100	5,500	5,500	5,500	5,500

3. CD4 testing

i. Target population

All patients in Care (including those on ART) are to get CD4 tests for monitoring treatment.

The following are the estimated numbers of Patients in Care for the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Cumulative number of **Adult** Patients on Care	639,842	747,834	851,846	865,755
Number requiring CD4 test (Adults starting ART)	121,281	127,040	133,300	95,813
Number requiring CD4 test (Pregnant HIV+ women)	63,376	73,336	78,812	83,169
Estimated number with Treatment failure (Adults)	7,011	17,623	21,103	22,840
Total for Adults	831,510	965,833	1,085,062	1,067,577
Cumulative number of **Paed** Patients on Care	78,922	96,063	123,137	152,267
Number requiring CD4 test (Paeds starting ART)	6,717	6,005	5,976	5,715
Estimated number with Treatment failure (Paeds)	711	1,663	1,902	2,131
Total for Paeds	86,351	103,731	131,015	160,113
Total (Adults and Paeds)	**917,860**	**1,069,564**	**1,216,076**	**1,227,689**

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of CD4 tests needed to for the next 2 years:

- Minimum CD4 count for initiation of treatment is 350.
- Every patient on Care requires 2 tests per year (including Patients on ART).
- For pregnant women, there will be 2 tests annually (every 6 months). The quantities required for pregnant women who need a CD4 test (to determine whether they need to start HAART) are assumed to be included in the quantities for adult patients in care.
- Infant testing will be via FACS Calibur (to get CD4%). Infants will get 2 tests for the infants.
- Patients with treatment failure and Patients starting on ART will require 3 tests for the 1st year. Treatment failure: 2% failing treatment in year 1, 4% failing treatment in years 2-4, of all 1st line, 2nd line and salvage patients on ART.
- Assumed platforms: FACS Count 60%, FACS Calibur 15%, Partec 25%
- Repeats due to clinician request: FACS Count 5%, FACS Calibur 5%.
- Control reagents will be purchased.
- FACS Count: 5% wastage, 10% symptom-directed tests; FACS Calibur: 5% wastage, 2% symptom-directed tests.

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order based on assumptions and target population.

CD4 TESTING				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
1. Becton Dickinson (BD) FACSCount							
Reagents							
BD FACS Count-CD3/4 Reagent Kit	50	test	295.00	18,888	5,572,092.55	22,345	6,591,712.12
BD FACS Count-FacsClean	5	litre	32.00	236	7,555.38	279	8,937.91
BD FACS Count-FacsRinse	5	litre	32.00	236	7,555.38	279	8,937.91
BD FACS Count-FacsFlow	20	litre	32.00	284	9,075.54	336	10,736.24
BD FACS Count-Control Kit	25	test	175.00	1,116	7,812.00	1,116	7,812.00
BD FACS Count-Thermal Paper	1	roll	15.00	6,651	99,763.59	7,868	118,019.02
2. Becton Dickinson (BD) FACSCalibur							
Reagents							
BD FACS Calibur - TriTEST CD3/CD4/CD45 with TruCOUNT Tubes	50	test	184.65	4,407	813,808.84	3,707	684,565.87
BD FACS Calibur CD 3/4/45- Calibrite 3 CE 25T	25	test	100.00	59	5,905.79	50	4,967.88
BD FACS Calibur CD 3/4/45- FacsClean	5	litre	32.50	55	1,790.47	46	1,506.12
BD FACS Calibur CD 3/4/45- FacsRinse	5	litre	32.50	55	1,790.47	46	1,506.12
BD FACS Calibur CD 3/4/45- FacsFlow	20	litre	37.50	551	20,659.24	463	17,378.30
BD FACS Multicheck control	2.5	test	380.00	276	41,952.00	276	41,952.00
BD FACS Calibur CD 3/4/45- FacsLysing Solution	100	ml	220.00	110	24,240.18	93	20,390.53
3. Partec equipments							
Reagents							
Partec Easy Count Kit	100	tests	350.47	3,410	1,195,247.96	4,034	1,413,962.59
Countercheck Beads Greab	50	tests	51.87	492	510.40	492	510.40
Consumables							
Sample tubes 3.5ml	500	pieces	13.88	853	11,834.14	1,009	13,999.63
Decontamination Liquid	250	ml	35.05	221	7,760.07	221	7,760.07
Cleaning Solution	250	ml	11.22	221	2,484.11	221	2,484.11
Inline Filter for Sheath container	10	pieces	36.45	41	149.45	41	149.45
Flow Cuvette tubing replacement	2	pieces	29.44	82	1,207.04	82	1,207.04

CD4 TESTING				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
Sheath/ wastes container tube replace net	2	pieces	29.44	82	1,207.04	82	1,207.04
Hypochlorite solution	250	ml	23.83	89	2,110.38	89	2,110.38
Thermo paper	5	pieces	12.62	3,410	43,039.43	4,034	50,915.08
Sheath water	5	ml	21.03	3,410	71,721.02	4,034	84,845.02
Other Consumables for CD4 Testing							
Vacutainer EDTA 4 ML	1000	1 piece	89.80	1,312	117,790.47	1,552	139,344.57
Vacutainer needle 21G	480	1 piece	62.98	2,733	172,105.69	3,233	203,598.77
Vacutainer holder: single use	1000	1 piece	28.80	1,312	37,776.90	1,552	44,689.57
Alcohol swabs	50	Pieces	6.00	26,234	157,403.74	31,034	186,206.56
Microtainer EDTA tubes	200	Pieces	33.08	1,312	43,390.97	1,552	51,330.94
Microtainer Lancets	2000	Pieces	352.40	131	46,224.23	155	54,682.66
Lancet Quickheel blade	200	Pieces	147.42	1,312	193,370.50	1,552	228,754.76
Sub-Total CD4 testing				***8,719,334.95***		***10,006,180.66***	

iv. Suggested Procurement schedule

The commodities for Year 2009/10 should be delivered in one consignment.

4. Viral load testing

i. Target population

All new patients (those starting on treatment) and patients failing treatment are to get Viral load (VL) tests for monitoring treatment.

The following are the estimated numbers of patients needing VL for the years FY 2009/10 to FY 2012/13:

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
New Adult patients on ART	121,281	127,040	133,300	95,813
New Paeds on ART	6,717	6,005	5,976	5,715
Estimated number with Treatment failure (Adults and Paeds)	7,722	19,286	23,005	24,971
Total (Adults and Paeds)	**135,720**	**152,331**	**162,281**	**126,499**

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of VL tests needed to for the next 2 years:

- VL for Adults: For all *new* patients starting ART: 1st test at 6 months, 2nd test at 18 months
- VL for Paeds: For all *new* kids initiating ART: at baseline, at 6 months and at 18 months. After that, a VL is only needed if treatment failure is suspected.

- 1 VL for patients suspected to be failing treatment (2% failing treatment in year 1, 4% failing treatment in years 2-4, of all 1st line, 2nd line and salvage patients on ART).
- 20% of tests are symptom-directed, 5% repeats on clinician requests
- Equipment for VL currently mainly in research labs e.g. KEMRI. Assumed that procurement by GoK and donors will be for type of equipment at those labs (e.g. Roche).

iii. Quantities of Commodities required

VIRAL LOAD				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
1. Roche Cobas TaqMan							
Reagents							
Cobas TaqMan (CTM48) - Ampliprep Wash Buffer 5L	5	litre	54.71	1,255	68,667.79	1,333	72,922.83
Cobas TaqMan (CTM48) - SPU 24x12	288	units	476.85	872	415,628.81	926	441,383.50
Cobas TaqMan (CTM48) - K Tips (432)	432	units	246.86	581	143,444.31	617	152,332.92
Cobas TaqMan (CTM48) - K Tubes (1152)	1152	units	757.00	218	164,952.82	231	175,174.22
Cobas TaqMan (CTM48) - 1ml Tips - Filtered (100)	1000	tips	57.00	251	14,308.40	267	15,195.03
Cobas Ampliprep - Reagent Cassettes (48)	48	units	737.42	5,230	3,856,470.51	5,554	4,095,439.03
Cobas Ampliprep - Ampliprep Wash Buffer 2L	2	litre	54.71	3,138	171,669.47	3,332	182,307.07
Cobas Ampliprep - Amplicor Wash Buffer 2L	2	litre	86.07	3,138	270,071.13	3,332	286,806.25
Cobas Ampliprep - D-Cups 840	840	cups	253.03	299	75,615.19	317	80,300.73
Cobas Ampliprep - A-Rings 24	24	rings	81.87	10,459	856,307.78	11,107	909,369.41
Cobas Ampliprep - SPU 288	288	units	476.85	872	415,628.81	926	441,383.50
Cobas Ampliprep - K-Tips 432	432	tips	246.86	2,324	573,777.23	2,468	609,331.68
Cobas Ampliprep - S Output Tubes 360	360	tubes	253.03	697	176,435.45	740	187,368.38
Cobas Ampliprep - S Input Tubes 288	288	tubes	278.00	872	242,308.50	926	257,323.29
Cobas Ampliprep - 5ml Pipette Tips	1000	tips	152.38	1,255	191,255.67	1,333	203,106.94
Cobas Ampliprep - 200ul Tips Filtered 960	960	tips	57.00	523	29,809.18	555	31,656.32
Cobas Ampliprep - 1000ul Tips - Filtered 1000	1000	tips	57.00	502	28,616.81	533	30,390.07
2. Nuclisens (Easy MAG/Q)							
Nuclisens (Easy MAG/Q) - 1000ul Tips Filtered	1000	tips	57.00	502	28,616.81	533	30,390.07
Nuclisens (Easy MAG/Q) - 200ul Tips Filtered	960	tips	57.00	523	29,809.18	555	31,656.32

VIRAL LOAD				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
Nuclisens (Easy MAG/Q) - Biohit 1200 Tips 1000	1000	tips	167.62	1,255	210,383.74	1,333	223,420.30
Nuclisens (Easy MAG/Q) - 20ul Tips	960	tips	152.38	1,307	199,224.65	1,388	211,569.73
Nuclisens (Easy MAG/Q) - Microwells 1x96 (100)	100	microwells	452.54	2,510	1,135,986.87	2,666	1,206,378.98
Nuclisens (Easy MAG/Q) - PCR Strips (100)	100	strips	214.59	2,510	538,673.76	2,666	572,053.00
Nuclisens (Easy MAG/Q) - PCR Lids (100)	100	lids	39.33	2,510	98,727.99	2,666	104,845.73
Nuclisens (Easy MAG/Q) - Magnetic Silica 48 x 3ml	144	vials	870.46	1,743	1,517,409.04	1,851	1,611,436.21
Nuclisens (Easy MAG/Q) - Extraction Buffer 1 4L	4	litre	436.30	1,569	684,512.79	1,666	726,929.04
Nuclisens (Easy MAG/Q) - Extraction Buffer 2 4L	4	litre	182.38	1,569	286,136.70	1,666	303,867.34
Nuclisens (Easy MAG/Q) - Extraction Buffer 3 4L	4	litre	217.43	1,569	341,126.79	1,666	362,264.91
Nuclisens (Easy MAG/Q) - Lysis Buffer 3 4L	4	Litre	507.81	1,569	796,705.12	1,666	846,073.43
Nuclisens (Easy MAG/Q) - Easy MAG Disposable	384	units	894.79	654	584,933.15	694	621,178.89
Nuclisens (Easy MAG/Q) - Nuclisens Easy Q HIV Kit	48	tests	942.21	5,230	4,927,456.65	5,554	5,232,789.47
Nuclisens (Easy MAG/Q) - EasyQ Cal/ C Diluent	384	tests	937.50	654	612,853.11	694	650,828.92
Sub-Total Viral Load Testing				***19,687,524.19***		***20,907,473.50***	

iv. Suggested Procurement schedule

The commodities for Year 2009/10 should be only be procured and delivered *after* it has been confirmed that the required machines are available and in place at the relevant sites.

5. Early Infant Diagnosis

i. Target population

The following are the estimated number of infants requiring EID over the years FY 2009/10 to FY 2012/13.

Item	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Number of Exposed Infants	63,376	73,336	78,812	83,169
% kids covered for EID testing	55%	65%	75%	80%
Number of Infants actually accessing DNA PCR testing (EID) - Age 0 - 2 (18 mths)	36,356	47,669	59,109	66,535
Number of Infants who require PCR re-test after age 9 months	7,271	9,534	11,822	13,307

– The exposed children will require a HIV test. The % for coverage of these children for EID testing was

assumed to be 55% in 2010, 65% in 2011, 75% in 2012 and 80% in 2013. The estimated baseline for kids tested was 30,657 children in 2009.

- It was assumed that 20% of these babies will require re-testing by PCR at age 9 months following a positive antibody test (as per latest EID algorithm).

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of EID commodities for the next 2 years:

- Reagents and Consumables for EID based on Roche equipment (Roche AMPLICOR).

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order based on assumptions and target population, and after deducting available stocks and expected stocks (where available).

PCR - Paediatric				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
Reagents							
Roche AMPLICOR	96	kit	840.00	454	381,736.16	596	500,521.61
Consumables							
DBS Bundles	50	test	141.00	873	123,028.11	1,144	161,310.97
DNA PCR Consumables Kits	960	test	2,728.00	45	123,973.36	60	162,550.35
Whole Blood Collection Kits	50	test	141.00	873	123,028.11	1,144	161,310.97
Plate Sealers	100	piece	4.00	13,961	55,842.55	18,305	73,219.16
Sub-Total EID				***807,608.30***		***1,058,913.06***	

iv. Suggested Procurement schedule

The commodities for Year 2009/10 should be only be procured and delivered *after* it has been confirmed that the required machines are available and in place at the relevant sites.

6. Other Lab tests

i. Target population

Patients in care and on ART over the years FY 2009/10 to FY 2012/13 require other tests:

- Pregnancy test
- Clinical chemistry
- Haematology.

ii. Key assumptions

The following were key assumptions made in arriving at the quantities of the above tests for the next 2 years:

- Clinical chemistry:

  - New patients on ART need 3 tests, patients on care need 2 tests
  - Platforms: (i) Automated 28% (ii) Semi-automated 72%. Reagents provided as per list of equipment available in the field.
  - 20% wastage
- Haematology:
  - Assume closed system machines.
  - Reagents provided as per list of equipment available in the field.

iii. Quantities of Commodities required

The table below shows the calculated Quantity to order for years 2009/10 to 2010/11.

				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
A. PREGNANCY TEST							
Reagents							
Pregnancy test kit	50	1 kit	14.57	23,681	345,029.79	24,346	354,722.78
Consumables							
Universal container	1000	1 piece	60.00	1,184	71,042.51	1,217	73,038.32
Sub-Total Pregnancy Test				**416,072.30**		**427,761.10**	
B. CLINICAL CHEMISTRY TESTING							
1. Clinical Chemistry: SEMI-AUTOMATED							
a) HUMALYZER 2000/3000 (70)/BTS 330 (130)							
ALT(GPT) Liquicolor UV 10 X 10ml	100	ml	103.63	13,315	1,379,898.42	15,758	1,633,096.44
AST(GOT) Liquicolor UV 10 X 10ml	100	ml	103.63	13,315	1,379,898.42	15,758	1,633,096.44
Creatinine liquicolor, 200ml	200	ml	21.90	6,658	145,825.23	7,879	172,582.75
Cholesterol	750	ml	105.76	370	39,116.47	438	46,293.96
HDL Cholesterol Liquicolor (Direct)	80	ml	84.35	3,467	292,466.64	4,104	346,131.44
Glucose liquicolor, 1L	400	ml	34.82	693	24,145.50	821	28,575.97
Urea liquicolor, 2x100ml	2000	ml	51.00	139	7,073.64	164	8,371.58
Bilirubin Direct & Total	200	ml	18.96	1,387	26,299.33	1,641	31,125.00
Triglycerides	400	ml	42.83	693	29,700.10	821	35,149.78
Control Normal (N19) , 6x5ml	30	ml	26.15	1,632	42,682.94	1,632	42,682.94
Control Pathological (P17), 6x5ml	30	ml	26.15	1,632	42,676.80	1,632	42,676.80

				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
2. Clinical Chemistry: AUTOMATED							
a) HUMASTAR 180 / EUROLYSERS (30)							
Reagents							
ALT	200	ml	103.63	148	15,332.20	175	18,145.52
AST	100	ml	103.63	148	15,332.20	175	18,145.52
Creatinine	200	ml	21.90	178	3,888.67	210	4,602.21
Urea	100	ml	105.76	22	2,346.99	26	2,777.64
Cholesterol	90	ml	84.35	22	1,871.79	26	2,215.24
Cholesterol HDL	204	ml	34.82	39	1,363.51	46	1,613.70
Bilirubin Direct	100	ml	51.00	17	870.60	20	1,030.35
Bilirubin Total	100	ml	18.96	17	323.68	20	383.08
Triglycerides	200	ml	42.83	22	950.40	26	1,124.79
Glucose	100	ml	42.83	22	950.40	26	1,124.79
System Calibrator	1	pack	156.80	360	56,448.00	360	56,448.00
Control serum	1	pack	242.30	360	87,228.00	360	87,228.00
Control serum	1	pack	252.50	360	90,900.00	360	90,900.00
b) CLINICAL CHEMISTRY METROLAB (23)							
ALT/GPT	125	ml	28.78	444	12,773.60	525	15,117.43
AST/GOT	125	ml	28.78	444	12,773.60	525	15,117.43
Creatinine	255	ml	21.98	1,088	23,910.57	1,287	28,297.93
Cholesterol	600	ml	69.12	100	6,902.54	854	58,998.95
HDL Cholesterol	30	ml	48.18	111	5,346.00	2,189	105,449.06
Glucose	1000	ml	41.34	100	4,128.34	827	34,200.95
Urea Liquicolor	250	ml	46.60	133	6,204.83	1,208	56,299.03

				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
Bilirubin Total & Direct	250	ml	31.93	67	2,125.75	683	21,803.66
Triglycerides	300	ml	122.93	200	24,552.34	1,707	209,859.39
Elitrol 1 Normal	500	ml	303.11	276	83,658.36	276	83,658.36
Elitrol II Normal	500	ml	310.95	276	85,822.20	276	85,822.20
3. Other Consumables for Clinical Chemistry Testing							
Plain vacutainer tubes 4ml (red top with silica/plain)	1000	1 piece	104.30	1,849	192,883.70	2,189	228,275.99
Eclipse blood collection needles 21g	480	1 piece	62.98	3,853	242,645.72	4,560	287,168.86
Needle holders	1000	1 piece	28.80	1,849	53,260.31	2,189	63,033.06
Butterfly needles 21G	50	1piece	37.30	36,986	1,379,590.01	43,773	1,632,731.43
Pipette tips - yellow 200uL	1000	1 piece	12.00	1,849	22,191.80	2,189	26,263.78
Pipette tips - blue 1000uL	1000	1 piece	17.10	1,849	31,623.31	2,189	37,425.88
Thermal Paper	5	1 roll	6.00	18,493	110,958.98	21,886	131,318.88
Cuvette pack	500	1 piece	67.00	3,699	247,808.39	4,377	293,278.84
Alcohol swabs	50	Pieces	6.00	36,986	221,917.96	43,773	262,637.76
Sub-Total CLINICAL CHEMISTRY				***6,458,668.25***		***7,982,280.79***	
C. HAEMATOLOGY TESTING							
1. CELTAC 6400 Analyzer (122)							
Diluent, Isotonac.3, MEK-640	20	l	82.50	2,954	243,728.34	3,496	288,450.13
Detergent, Cleanac, MEK-520 (For Daily Use)	5	l	75.00	1,477	110,785.61	1,748	131,113.70
Detergent,Cleanac 3, MEK-620	1	l	52.50	1,182	62,039.94	1,399	73,423.67
Haemolysing Reagent, Hemolynac 3N, MEK-680	1	l	112.00	1,182	132,351.87	1,399	156,637.16
Haematology Control 2ml	12	ml	175.00	1,464	256,200.00	1,464	256,200.00
Computer Printer Paper	2000	pieces	32.00	591	18,907.41	699	22,376.74
2. CELTAC 8222 Analyzer (24)							
Diluent, Isotonac.3, MEK-640	20	l	82.50	583	48,059.11	689	56,877.49

				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
Detergent, Cleanac, MEK-520 (For Daily Use)	5	l	75.00	291	21,845.05	345	25,853.40
Detergent, Cleanac 3, MEK-620	1	l	52.50	233	12,233.23	276	14,477.91
Haemolysing Reagent, Hemolynac 3N, MEK-680	1	l	112.00	233	26,097.55	276	30,886.20
Haemolysing Reagent, Hemolynac 5	1	l	112.00	233	26,097.55	276	30,886.20
Haematology Control, 2 Vials Each of 3ml	3	ml	220.00	276	60,720.00	276	60,720.00
Continuous Computer Printer Paper	2000	pieces	32.00	117	3,728.22	138	4,412.31
3. BECKMAN COULTER Ac*T 5Diff CP (5)							
Act 5 diff Rinse	1000	ml	50.00	60	2,995.89	71	3,545.61
Act 5 diff Hgb Lyse	400	ml	120.00	60	7,190.14	71	8,509.46
Act 5 diff diluent	2000	ml	108.00	342	36,885.43	404	43,653.55
Act 5 diff WBC Lyse	1000	ml	150.00	1,434	215,165.00	1,698	254,645.70
Act 5 diff Fix	1000	ml	150.00	1,434	215,165.00	1,698	254,645.70
Act5 Diff Control plus 6 x 2.3ml	13.8	ml	312.00	120	37,440.00	120	37,440.00
4. BECKMAN COULTER Act Diff II (18)							
Diff Act Pak	15000	ml	325.00	330	107,103.16	390	126,755.55
Act Rinse	500	ml	40.00	8,239	329,548.18	9,750	390,017.08
4CES Tri Pak 3 x 3.3ml	9.9	ml	160.00	216	34,560.00	216	34,560.00
5. Consumables for Hematology testing							
Vacutainer EDTA 4 ML	1000	1 piece	89.80	1,664	149,461.75	1,970	176,886.53
Vacutainer needle 21G	480	1piece	62.98	3,467	218,381.15	4,104	258,451.97
Vacutainer holder: single use	1000	1 piece	28.80	1,664	47,934.28	1,970	56,729.76
Alcohol swabs	50	Pieces	6.00	33,288	199,726.17	39,396	236,373.99
Microtainer EDTA tubes	200	Pieces	33.08	1,664	55,057.85	1,970	65,160.43

				FY 2009/10		FY 2010/11	
				Packs	Cost (USD)	Packs	Cost (USD)
Microtainer Lancets	2000	Pieces	352.40	166	58,652.92	197	69,415.16
Lancet Quickheel blade	200	Pieces	147.42	1,664	245,363.60	1,970	290,385.44
Sub-Total HAEMATOLOGY TESTING				***2,983,424.40***		***3,459,490.84***	
Overall Sub-Total (Pregnancy, Clinical Chemistry, Haematology)				***9,906,224.05***		***16,006,077.52***	

vi. Section references:

1. Ministry of Health/NASCOP. *National Guidelines for HIV testing and counseling in Kenya*. 2008
2. Ministry of Health/NASCOP. *Guidelines for HIV Counseling and Testing in Clinical settings: An orientation package for health care providers.* 2008
3. Information sources: NPHLS, SCMS, GF PSCMC

Limitations and Challenges

1. Fluctuation of the USD vs the local currency (Kenyan shilling) over the 2 years of the Quantification may change the Commodity costs significantly.
2. There was inadequate data on target populations requiring specific interventions: baselines as at end 2008 or beginning of 2009/10, projections of patients/clients requiring the various commodities every year for the next 4 financial years. This led to development of assumptions to estimate the populations for the various interventions.
3. Baseline data on previous procurement and supply chain management gaps under the previous KNASP was minimally available (the KNASP III Phase 1 reports were lacking in details on specific gaps in commodity procurement and supply).
4. To identify key issues affecting health systems strengthening for commodities, the Core commodity team had reviewed the Phase 1 reports (e.g. the final Resource and Commodities report). Since these were lacking in detail, the team requested for a situational analysis to be carried out. Unfortunately support for a situational analysis of the health systems issues affecting commodities was not available at time of preparing this Commodity plan, hence a complete analytical report on the HSS issues could not be provided.

Recommendations

1. NACC and NASCOP should conduct a Situational analysis to determine the issues affecting Commodity Health systems strengthening (HSS) issues noted under KNASP II review.
   For KEMSA, several assessments have been done by various organisations in the recent past and will be useful for reference, e.g. the KEMSA Taskforce report, 2008. *See the List of References for a list of some of the assessment documents.*

2. Support for Logistics costs has not been frequently provided by donors who provide a large part of the commodities for HIV & AIDS. This often hinders effective commodity distribution and use. NASCOP, KEMSA and stakeholders need to negotiate on an appropriate method of determining these costs and providing the required funds for use. Some recent progress has been made in developing a Billing Structure by KEMSA.
3. KEMSA and NASCOP will need to collaborate closely for effective commodity distribution. Greater participation by KEMSA staff in the HIV & AIDS Commodities committee will be useful.

Appendix 1: List of References

1. NACC. *KNASP 2005/6-2009/10 Strategic Review: Synthesized Report*. February 2009. Nairobi: NACC, Kenya.
2. NACC. *Concept Note for the development of Kenya National HIV and AIDS Strategic Plan (KNASP III) 2009/10-2012/13: Phases II and III.* January 2009. Nairobi: NACC, Kenya.
3. MoH/NASCOP. *Kenya AIDS Indicator Survey (KAIS) 2007. Preliminary report.* July 2008. Nairobi:MoH.
4. Mureithi, Dr P., NACC. *2007 KAIS Kenya AIDS Indicator Survey*. PowerPoint Presentation. 26th January 2009. KAIS Working group, NACC.
5. Mohammed, I. et al. *HIV Prevalence and Unmet need for HIV Testing, Care and Treatment in Kenya: Results of a Nationally Representative Survey*. PowerPoint Presentation. 11th February 2009, 16th CROI. Nairobi:MoH/NASCOP.
6. MoMS & MoPHS/NASCOP. *National Quantification report for HIV & AIDS Commodities for the years 2008/9, 2009/10 & 2010/11*. September 2008
7. DRH & MSH. *Report on Forecasting and Quantification of Reproductive Health Commodities Workshop*. September 2008
8. MoH/NASCOP. *Guidelines for Antiretroviral drug therapy in Kenya*. 3rd edition, December 2005. Nairobi : MoH.
9. MoH/NASCOP. *Kenya Continuity of Services Application to Global Fund - December 2008 – November 2010*. December 2008. Nairobi : MoH.
10. The Kenya Country Coordination Mechanism (CCM). *Procurement and Supply management plan for the period from year 2008 to year 2010*. HIV and AIDS Round 7 phase 1, part of the Kenya Round 7 Proposal to the GFATM. December 2008. Nairobi : CCM.
11. MoH/NASCOP. *An Implementation framework for HCBC in Kenya*. May 2008. Nairobi: MoH/ NASCOP.
12. MoH/NASCOP. *Policy on Male circumcision in Kenya*. 2008. Nairobi:MoH.
13. Ministry of Health/NASCOP. *National Manual for the Management of HIV-related Opportunistic*

Infections and Conditions: A Healthcare worker's manual. 1st edition, 2008.
14. NACC. *A Study on the Modes of HIV Transmission*. 2008. Nairobi: NACC, Kenya.
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18. Ministry of Health/NASCOP. *An Implementation Framework for Home and Community Based Care in Kenya*. 2008.
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20. Ministry of Medical Services/NASCOP. *Kenya Nutrition and HIV and AIDS Strategy 2007 to 2010*. August 2008. Nairobi:MoMS.
21. MoH and Mildmay International. *Costing the Nyanza Home and Community Based Care Model 2007/08 – 2011/2012*. May 2008. Final report 8.9.08.

Documents on assessment of KEMSA and related issues:-

22. Bunde, E., Ronnow E. and Kimondo, G. *Kenya: Stock status and Logistics System Assessment 2006*. 2007. Arlington, Va.: DELIVER for USAID.
23. DELIVER. *Kenya: Final Country Report*. 2007. Arlington, Va.: DELIVER for USAID.
24. Johnson, M., Hazemba, O., Kimeu, J. and Thuo, M. *Assessment of KEMSA at operational sites in the Nairobi province and the Nyeri Depot in the Central province*. April 2008. MSH/SPS Regional Office, Nairobi.
25. MoMS/Task Force on KEMSA. *KEMSA Task Force Report*. October 2008. Nairobi:MoMS.
26. Ministry of Health/UNES. *Review of Softwares in the Health Sector*. Final report, 23rd March 2009. Nairobi:MoH (Health Sector Programme Support – Phase 2. Ref: 346/40455/01).

Sources of prices and commodity information:

1. MSH. *International Drug Price Indicator Guide, 2008 edition*. 2009. Arlington, Va: MSH
2. KEMSA's Inventory Control system (ICS)
3. DRH/FP program.
4. MEDS Price list 2008
5. SCMS database
6. UNICEF in collaboration with WHO. *Sources and Prices of selected medicines for children including therapeutic food, dietary vitamin and mineral supplementation.* January 2009. UNICEF/WHO.
7. The RH Interchange website (http://rhi.rhsupplies.org) for recent relevant FP commodity shipments to Kenya.

SECTION 5: COMMUNICATION STRATEGY FOR KNASP III

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1.0 Introduction

The Kenya National AIDS Strategic Plan (KNASP) is the one agreed national framework that provides the basis for coordinating the work of all partners responding to HIV and AIDS in Kenya. Through this coordination, it aims at achieving the most effective and efficient use of resources and ensuring that stakeholders are managed based on the results they are expected to achieve.

A major objective of KNASP III (2009/10-2012/13) is to have all stakeholders in the HIV and AIDS response determining their programme objectives, targets and resource allocation within the KNASP results framework.

Expected KNASP Results

The vision of KNASP III is "An AIDS Free Society in Kenya." The strategy is expected to achieve the following impact by 2013[3]: To halve HIV incidence and reduce mortality by at least 25%. The strategy further aims to significantly increase access to social protection for persons infected and affected by HIV.

Outcome Results of KNASP III:

1. By end 2013, Universal Access targets to prevention, treatment, care and support services in Kenya are delivered.
2. By end 2013, Community capacity towards achieving Universal Access and social transformation for an AIDS-competent society is strengthened.
3. By end 2012, HIV mainstreamed in public and private sectors to address both the root causes and effects of the epidemic.
4. By end 2013, informed leadership, oversight, coordination and accountability is strengthened for the national HIV and AIDS response at all levels.

1.1 Objective of this communication strategy:

The objective of this communication strategy is to support programmes to achieve KNASP III results through advocacy, communication and social mobilization. The strategy is intended to facilitate information sharing among stakeholders. It will also outline key principles to be employed in the delivery of communication programmes through the pillars. The strategy will guide stakeholders in creating the right key message, tailoring it to the right audience, using the right tools, channels and partnerships.

[3] *These are also referred to as Goals*

2.0 Framework of the Communication Strategy

This communication strategy intervenes through three main domains:

- Advocacy to raise and sustain governance (leadership, accountability, policy, coordination), financial commitment, generate and use strategic information under the result areas of KNASP III.
- Social mobilization to build commitment of stakeholders at all levels and sustain a multi-sectoral response at national and decentralized levels.
- Strategic behaviour change communication to stimulate dialogue on sexual and cultural change[4].

To achieve the ambitious set of KNASP III results, a mix of all three domains will be relied upon during different stages of KNASP III implementation. For instance, while advocacy was employed during the drafting of KNASP III to obtain stakeholder's validation, social mobilization will aim to build sectors' commitment to reporting under KNASP III framework, while strategic behavior change communication will seek to change individual behavior and cultural norms.

To maintain the link with the Strategic Plan, its Higher Level Outputs (HLOP) that are relevant to communication and advocacy have been transformed into key thematic messages. Communication outputs whose implementation would logically lead to the achievement of key results have consequently been developed and supported by a broad strategy that includes the audiences, channels of communication and timeframes.

Audience

The principle audience for this strategy is the general public. It is to this primary audience that all interventions carried out by the following outlined secondary audiences will focus to ensure they

[4] *Advocacy: Advocacy for HIV and AIDS is to be understood as a broad set of coordinated interventions, designed to place HIV and AIDS high on the political and development agenda, foster political will, increase and sustain financial and other resources. Communication: Within countries, and in the context of HIV responses, communication primarily seeks to create and improve knowledge among the general public about AIDS interventions, coordination, implementation and review processes. Social Mobilization: In the national and sub-national contexts, social mobilization is a process of generating public will by actively securing broad consensus and social commitment from communities, sectors, and national decision-makers towards eliminating the HIV pandemic. Social mobilization seeks to convert knowledge into demonstrable action.*

develop interventions that will make a difference in the country.

The secondary audiences are:

- Policy makers and planners,
- Development partners
- Implementing Agencies in the public and private sectors, NGOs, Faith based Organizations and Civil Society.
- Media
- Pillar coordination teams
- Direct beneficiaries

Each of the audiences will play a variety of roles that sometimes intertwine. These roles range from financing, advocating, overseeing, guiding, and broadcasting to coordination and changing behaviour.

Tools / Mechanisms

A number of communication tools, mechanisms or resources to be used in reaching the above audiences. These include:

- Conventional mass media to reach large audiences
- Social marketing to segmented audiences
- Building social networks to change behaviour through the AIDS Competence process.
- Enhancing community empowerment to increase access to prevention, treatment and mitigation services and enhance appropriate health-seeking behaviour.
- Mainstreaming HIV in the media to enhance the role of the media in national response to HIV
- Popular/folk media to generate dialogue and activate informational networks
- Advocacy through interpersonal communication to improve planning and service delivery

3.0 Situation Analysis

The situational analysis for KNASP III identified the following key issues:

- The high level of awareness of HIV and AIDS in Kenya (98%) has not been matched by comparable behaviour change mainly due to diverse socio-cultural and personal factors which are inherent in society.

- HIV financing is not prioritised with some areas heavily funded while others in the national response receive minimal or no resources. Before KNASP III, there was little basis for funding the HIV programme in a sustainable, pooled and strategic manner.

- The HIV and AIDS response is currently lacking some policies and guidelines. For example, the HIV and AIDS Prevention and Control Act, the Public Health Act and laws protecting MARPS are inadequate, non-existent or not enforced.

- Much research and data generated in the country does not strategically inform policymaking and programme implementation within Kenya.

- Regarding programme implementation, more than one-third of all new infections occur among the MARPS II (KAIS, 2008). Forty five percent of married HIV positive people have partners who are not currently infected, therefore making the issue of discordance in marriage a great risk. According to the KAIS 2008 report, 70 percent of HIV positive adults are currently living in the rural areas while most HIV campaigns are concentrated in urban areas.

- Gender disparities in Kenya are high: prevalence among adolescent girls aged 15-19 is six times that of men (3% of all young women in that age group, as compared to less than 0.5% of young men). Interventions targeting girls are inadequate. Although condom use at last higher- risk sex shows substantial progress for both women (23.9 percent in 2004 KDHS- 35.0 percent in 2008 KAIS) and men (46.5 percent – 51.8 percent), this level of uptake is too low to lower transmission of HIV.

- Further programmatic and financial gaps exist in prevention (HTC, PMTCT, BCC, VMAMC, etc.), treatment (ART, TB/HIV, OI, Nutrition, etc.) and Mitigation (OVCs, Social Protection Policy). These include commodity and coverage gaps, weaknesses in the strategic design of the programmes, poor linkages between communication programmes and service delivery, failure to segment message receivers and account for audience diversity – including linguistic, spiritual, cultural, socio-economic and geographic contexts; inadequate beneficiary participation in design of communication programmes; and limited of communication research.

- Systems for the delivery of health services in Kenya have remained a major constraint with inadequate efforts made to strengthen them. These include governance (coordination, policy, leadership and

accountability) financial systems, procurement management, information systems, service delivery systems and human resource.

- Prioritization of interventions, the use of rights and evidence-based approaches have been inadequate. As a result, disaggregation and work with MARPs has been inadequate.

- The community, where the outcome of the entire response pivots, was previously not considered as an equal partner in planning the response and for service delivery.

- Sectoral HIV and AIDS mainstreaming has previously been ad-hoc, hindered by lack of policy and concrete strategies. Previous Strategies, while financially aligned to other sectors, where not programmatically aligned.

Implications of the issues for communication

Communication programmes should reinforce preventive behaviours towards the spread of HIV infection through institutional and individual behaviour and social change approaches. This strategy identifies a range of communication approaches that operate at national and institutional levels.

- **Governance and strategic information:** There is a need for a communication strategy that will inform all partners in the country on the outcomes of KNASP III and the need to have a reservoir for all data in the country.

- **Financing:** This strategy supports KNASP III resources mobilization strategy by providing information and advocating to policy makers in government to be adequately informed on areas where funding by Government and all development partners will be utilized in the national response.

- **Policy:** Gaps in this area imply that much of the communication agenda for KNASP III will be to advocate towards creating of an enabling policy and legal environment for improved coordination, programme planning, implementation and systems strengthening. This strategy aims to communicate the work of Pillar 4 of KNASP III, which seeks to improve the policy and legal environment.

- **Commodity security:** The strategy proposes a broad communication approach that will publicize the HIV Commodity Plan, which seeks to improve the information system for supply and delivery of all HIV and AIDS related commodities to avoid stock-outs and procure in a timely manner and store well.

- **Communication for Behaviour change:** A large section of KNASP III and subsequently this communication strategy is dedicated to specific cultural practices that promote positive behaviour change and discourage negative practices. Focus here is placed on promoting social-cultural norms, values, beliefs and enacted laws.

- **Equity:** Communication for behavior change will therefore need to focus on the modes of transmission, and be disaggregated by gender and geographical coverage.

- **Mainstreaming:** The communications strategy seeks to advocate for HIV mainstreaming and promote mechanisms to utilize existing opportunities derived from the harmonization of KNASP III and the Vision 2030 Medium Term 2008/9-2012/13.

- **Most at Risk Populations and Vulnerable Groups:** These include Men who have sex with Men, Male and female sex workers, Injecting Drug Users. Prisoners, Truck Drivers and Fishing communities constitute highly vulnerable groups whose behavior also places them at higher risk of infection. Women, girls, youth, PwD, the elderly, widows, children, the very poor and others also face varying risks of vulnerability because they live in environments that allow them very little control of their sexual behavior. This Strategy communicates initiatives to:

    - Develop policies and guidelines to protect the public from exposure to HIV infection
    - Protect the public from unethical promotion of doubtful cures and treatment of HIV and AIDS
    - Develop policies, which protect vulnerable and most at risk groups from marginalization
    - Improve infrastructure of health facilities and capacity of health care workers to respond to the unique requirements of MARPs

Innovative communication approaches will be utilized to reach these populations. For instance:

MSM and **prisoners**' greatest risk revolves around having unprotected anal sex. Communication strategies targeting these groups will aim at educating the MSMs about the risk associated with anal sex, and the need

to use protective devices during sexual intercourse with all partners. In addition, **the prison** department will ensure access to prevention as well as treatment and care services by prisoners.

Sex workers: Communication strategies for sex workers will emphasize the need for one hundred percent consistent and correct condom use and appropriate treatment of other sexually transmitted infections to avoid transmission of HIV.

Truck drivers need to access information and education on safer sexual behavior such as partner reduction, abstinence (engagement in other recreational activities along transport corridors), and treatment of STIs.

Fishing communities: Among fishing communities, especially those residing in Nyanza province, vulnerability is associated with a low circumcision rate, cultural practices and high HIV prevalence of up to 40% in some regions. Communication strategies will advocate for Male medical circumcision, HIV counseling and Testing, Condom use among regular partners, Partner reduction campaigns, Prevention with positive strategies and Treatment of those infected with HIV will be delivered as a package to the community.

Injecting Drug Users (IDU): IDU engage in highly risky behavior such as the use of contaminated needles and syringes to inject drugs intravenously. This group will be addressed in partnership with the National Agency for the Control of Drug Abuse (NACADA) and civil society organizations managing Drug rehabilitation centers to promote harm reduction and HIV prevention packages to IDUs.

Alcohol abuse: Of greater interest however, are alcohol abusers whose population is as high as 34% in the country, according to NACADA. Alcohol abuse has been associated with reduction in the perception of risk of the victims. In addition, it enhances disease progression among those infected with HIV. Alcohol further reduces the efficacy of ARTs while lowering the chances of adherence among alcohol abusers. This strategy encourages communication that promotes responsible alcohol consumption as a way of preventing HIV infection and promoting adherence to ART.

4.0 Communicating KNASP III Governance, Financing and Strategic Information

This section addresses the advocacy and communication of KNASP III as the framework guiding national responses to HIV under the Three Ones principles. It also outlines a communication strategy for presenting NACC as the custodian of the Three Ones principles. The immediate expected outcome of this section of the strategy is that by mid 2010, HIV and AIDS is high on the political and development agenda at national and district and community levels across all sectors; and KNASP III fosters political will, increases and sustains financial and other resources.

This section presents the approach to be adopted in communicating the KNASP III. The key elements of this approach include:

i. Thematic messages: The key thematic messages that will to accompany the planning and implementation stages of KNASP III. It is expected that by the end of this exercise partners will clearly differentiate key issues for KNASP III and that the vast majority of implementing partners will sign an MoU having been positively made aware of its purpose.

ii. Communication strategy and plan for communicating the governance framework for KNASP III: This strategy supports the institutional framework to support a multidimensional, multilevel, coordinated response. It is mainly expected that partners will then adhere to the coordination framework of KNASP III as part of the Three Ones principles. This section does not address programme support issues around governance as these are elaborated further under the Pillar 4: Advocacy, communications, and social mobilization for the National HIV and AIDS Programme in section 5.

iii. Tools and channels for communicating strategic information: The section outlines a plan for conveying and supporting the adherence to one reporting framework and hierarchy for HIV and AIDS results at national and decentralized levels. The communication strategy will provide a dissemination approach that will inform all partners in the country on the benefits of KNASP III and the need to have a reservoir for all data in the county.

iv. Communicating the resource mobilization, allocation and prioritization plans for KNASP III: It is hoped that the communications strategy will drive the quest to achieve a fully resourcing of the KNASP III by 2011.

i. Communicating the KNASP III

Result: By end 2009, 80% of implementers internalize KNASP III and its coordination framework						
Key Message	**Audience**	**Stakeholders/ partners**	**Tools/ media**	**Conveyors**	**Evaluator/ timeframe**	**Total Cost USD 410,000**
Changes in coordination framework from MCGs to Pillars 1, 2, 3, 4 & 5;	Implementors; development partners; Kenyan public; parliament	development partners; co-convening ministries	Meetings (before and after KNASP launch);	Conveners & facilitators	Week 1, July- Week 4 September	
			Newspapers (2 newspaper ads in the largest dailies)	NACC KNASP & Newspapers	Week 4 September - week 1 October 09	
			20,000 copies of KNASP document; pamphlets; abridged KNASP III version; JAPR meeting	President & UNAIDS GVA	Week 4 August 09	USD 410,000 as dissemination costs (see dissemination budget)
			Radio & TV during launchweek;	NACC KNASP & Radio	Week 1-2 October 09	
			Segment on TV (e.g. mending the ribbon; current affairs programme; prime time coverage) NACC website	NACC Comm & TV Station	Week 1, October 09	
Inclusion of national stakeholders external to NACC in convening and co-convening pillars	Implementors; development partners; Kenyan public; parliament		Meetings; Newspapers; Radio	Conveners & facilitators	Week 1 July – Week 4 November 09	Covered above

New convening structures and teams / task forces	Implementers; M&E officers; development partners; NACC technical & programme partners e.g. NASCOP		Meetings; KNASP document	Conveners; NACC M & E, NACC strategy; New NACC decentralized structures;	October 09 – June 10	Covered by the above costs
KNASP III decentralized structures	Implementers; M&E officers		Meetings; maisha newsletter; pamphlets; campaigns, popular version	M & E officers, Conveners & Co- Conveners, NASCOP	October 09 – June 10	Covered by the above costs
Highlight of key new features / concepts of KNASP III; cost of new KNASP	Kenyan public; Implementers; Donors; Parliament		Newspapers; Maisha newsletter; radio; international newsletters	Conveners; NACC M& E; NACC Communication; NACC strategy	October 09- June 10	

ii. Communicating coordination structures & strategic information

Expected Results: By end 2010, 80% of all implementers have signed a MoU with NACC
By end 2010, all development partners have aligned their workplans with NPO
By end 2010 all implementers who have signed MoU with NACC are reporting required results to the correct structure in a timely manner

Key Message	Audience	Stakeholders/ partners	Tools/ media	Conveyors	Evaluator/ timeframe	Cost USD 560,000
Existence, contents, significance and implications of NACC MoU with implemeters of HIV and AIDS programmes	16000 implementers of HIV and AIDS programmes countrywide; development partners; decentralized ministry offices (planning, gender, health, finance)	Development partners; Ministries resp. for health; Ministry of Gender…, Ministry of Planning; Major CSOs	Meetings; newspaper	NACC decentralized structures; conveners & co-conveners; Development partners; Ministry of Health; Ministry of Gender…, Ministry of Planning; Major CSOs; Newspapers	NACC M&E; June 2010	$ 260,000 **Cost Assumptions:** Information brochures 20000 @$3 each 20 regional Dissemination meetings @ 10,000 each
Existence of prioritized and costed National Plan of Operations with coded activities from which implementers can choose	16000 implementers of HIV and AIDS programmes countrywide; development partners; decentralized ministry offices (planning, gender, health, finance)	Development partners; Ministries resp. for health; Ministry of Gender…, Ministry of Planning; Major CSOs	Meetings; newspaper	Same as above	August-September 2009; NACC and Conveners	**$300,000** NPO printing costs
Reporting hierarchies, timelines for KNASP III and results framework; what results to report by each stakeholder	16000 implementers of HIV and AIDS programmes countrywide; development partners; decentralized ministry offices (planning, gender, health, finance)	Development partners; Ministries resp. for health; Ministry of Gender…, Ministry of Planning; Major CSOs	Meetings; newspaper	same as above	August – September 2009	

*** Refer to Annex A for Dissemination Plan for M&E and Research Products 2009/10-2012/13.**

iii. Communicating leadership, roles and policy

Expected Result : By 2011, all policies in place to ensure seamless implementation of KNASP III ; By end 2010 policies operationalized to ensure seamless coordination of KNASP III by NACC						
Key Message	**Audience**	**Stakeholders/ partners**	**Tools/ mechanisms**	**Conveyors**	**Evaluator/ timeframe**	**Cost $110,000**
Various policies needed to ensure that NACC and partners function seamlessly	NACC council, parliament; cabinet	development partners	Meetings	NACC, NASCOP;	NACC; ministry of special programmes June 10	**Cost assumptions**: 2 workshops meetings @ 5000 each
The need for all stakeholders to adhere to the Three Ones principles - particularly coordination of all National AIDS programmes under one authority	Development partners and implementers	Development partners; ministries	meetings; newsletters; newspaper and radio	NACC; Ministries; decentralized structures; development partners	NACC; ministry of special programmes June 10	10 regional meetings @ $10000 each

iv. Communicating for resource mobilization and allocation in KNASP III

Expected Result: By 2011, KNASP III is fully financed						
Key Message	**Audience**	**Stakeholders/ partners**	**Tools/ media**	**Conveyors**	**Evaluator/ timeframe**	**Cost $140,000**
Resources needed to finance the implementation of KNASP III	NACC council, parliament; cabinet; development partners (locally present and internationally)	development partners	Local and international meetings (G8, US Senate; Western Parliaments; Global Fund R9) R10 NSA application, PEPFAR & UN ; GoK MTEF process; Kenya Revenue Authority; NHIF; local and international media (Washington Post, International Herald Tribune; The Economist); international newsletters; development partner newsletters; Global Business Coalition	NACC, NASCOP;	NACC; GoK; development partners- September 2009 – June 2013	Cost Assumptions: 8 meetings @5000 each; 10 international meetings –travel@10,000 each
Financial Gaps and priority interventions of KNASP III	Development partners and implementers	Development partners; ministries	meetings; newsletters; newspaper and radio; Report on KNASP III Gap Analysis	NACC; Ministries; decentralized structures; development partners	NACC; ministry of special programmes	

5.0 Advocacy, Communication, and Social Mobilization

This section outlines the communication, advocacy and social mobilization needs of the health sector response (Pillar 1 of KNASP III), the communication needs for HIV mainstreaming in all sectors (Pillar 2); the communication support needs for community interventions and systems (Pillar 3- in line with the socio-ecological model and AIDS competence process outlined in the introductory sections of this document); and the coordination, policy and leadership, and strategic information communication needs (Pillar 4).

Pillar 1: Health Sector Response

The health sector response will implement both prevention and treatment communication programmes to enhance behavior change and promote service uptake e.g. condoms, HTC, PMTCT, Male Medical circumcision, TB and HIV co-infection, treatment of Sexually Transmitted Infections, management of sexual and gender based violence and universal precautions of medical transmission. The strategy will also address treatment literacy, ART adherence, nutrition, and healthy seeking behavior for people infected with HIV and AIDS.

a) Communication for HIV prevention

This communication strategy will support the following KNASP III programmes

1. Supporting HIV Testing and Counselling

This communication strategy will contribute to the achievement of the following KNASP III High-Level Outputs (HLOP)

- Knowledge of HIV prevention among men and women aged 15-64 enhanced
- Proportion of men and women aged 15-64 who know their HIV status increased

The Strategic Plan emphasizes universal knowledge of HIV sero-status as the basis for expanding and implementing prevention, treatment and care. KNASP III identifies strategies to increase knowledge of HIV status include HCT, VMAMC, TB/HIV, STI, PMTCT, and Condom promotion.

Majority of Kenyans are aware of HIV and AIDS as a disaster that affects our society. However, about 61% of Kenyans do not perceive themselves as being at risk of getting infected (KAIS 2007). To raise the perception of risk, more national campaigns will be implemented to address the risk factors for HIV transmission and attitudes towards testing. Health promotion campaigns on the importance of various prevention services such as HTC, Condom use, MC, TB/HIV co-infection, treatment of STIs will be sustained to help the public make informed decisions. Special focus will be provided to reach the Most at Risk Populations with a comprehensive prevention package of HIV services.

The HTC communication programme will develop revitalized and balanced A, B, C and D programmes to promote the following:

A. Abstinence: Delayed sexual debut by young people; or secondary abstinence (abstaining from sex for periods of time after sexual debut) by sexually experienced youth and persons living away from their partners.

B. Being faithful: Partner reduction emphasizing mutual monogamy and knowing their HIV status

C. Condom use: This should be promoted to sexually active youth and adults, especially sex workers emphasizing that non-compliance with A and B constitute a risk and risk reduction requires that condoms be used consistently and correctly. The public will also be educated on disposal of condoms to reduce the environmental pollution occasioned by increased condom consumption.

D. Don’t take risks: The risk associated with gender-based sexual violence, alcohol and drug abuse, discordant couples and mother to child transmission of HIV has been identified. Communication programmes stressing harm-reduction approaches such as prevention with positives, PMTCT, STI screening and treatment, and disclosure of status between couples and family for sexually active youth and adults are recommended as an integral part of HCT campaigns.

HCT campaigns will also emphasize the use of opportunities to reach the public with CT services. Such opportunities include integration of CT within other health facility services especially Sexual and reproductive health services, use of community forums e.g. chiefs’ barazas, school events, sports, (Bull fighting, soccer, athletics, rugby, etc), faith based events, Farming related events, market days, and other public events.

A sustained communication campaign that promotes uptake of HTC services will be employed to meet the targets set in the KNASP III. Proper training in interpersonal communication approaches is critical

to the success of CT programmes. With the client's consent, counseling will be extended to sex partners to provide a dialogue- oriented communication approach to facilitate behaviour change. Formal entry points for communication initiatives with the community are described under Pillar 3, Chapter 4 of KNASP III.

2. Supporting Prevention of Mother to Child Transmission

This strategy will contribution to the achievement of the following PMTCT output:

- ***Prevention of mother-to-child transmission of HIV (PMTCT):* HLOP: Proportion of pregnant women accessing PMTCT services increased**

At least 80% or 4.3 million pregnant women will benefit from interventions preventing vertical transmission of HIV under KNASP III. PMTCT Communication programmes will target young women to ensure that potential mothers are protected from infection through targeted interventions mentioned in this strategy. With only 42% of pregnant mothers delivering under skilled attendants in Kenya, more emphasis will be placed on promotion of health facility based delivery to pregnant mothers in rural areas to achieve the set target of 80% accessing skilled delivery by 2013.

3. Supporting Prevention through people living positively with HIV and AIDS (PwP)

Under this pillar, People living with HIV and AIDS will be trained and facilitated as advocates and stewards for ART adherence, prevention and treatment of HIV, STIs and OIs, PMTCT, adequate nutrition, consistent counseling, correct and consistent condom use and monitoring. For instance, it is estimated that 45% of all those who are HIV positive are in a discordant relationship, amounting to about 630,000 discordant couples in Kenya (KAIS 207). The negative partner in a discordant couple represents the highest risk group because condom use is low among married/ regular partners, as is mutual knowledge of sero - status. Targeted communication programmes will be developed to provide new information and behavior change to the affected populations.

4. Communication to support voluntary medically assisted male circumcision (VMAMC)

The current programmes on Medical Male Circumcision are focused on communities that do not circumcise in Kenya. A closer look at those that circumcise reveal other cultural factors, some of which are associated with circumcision, that still predispose the community to high risk behavior. In addition, the Medical Male Circumcision package provides for more preventions interventions such as counseling and testing that need to be provided to all males in the country. A national rollout of the medical male circumcision programme will be performed to reduce misconceptions of MC in HIV transmission.

5. *BCC: Male and Female condom provision*

KNASP outputs

- **Increased demand and use of male condoms,**
- **Increased demand and use of female condoms**

Over 1.817 billion male condoms (Scaled up from between 200 and 800 million annually) and 5.65 million female condoms (scaled up from 250,000 and 3 million annually) will be distributed by 2013. Community based communication programmes emphasizing 100% condom use targeting populations that engage in transactional sex will be carried out improve condom utilisation. Condoms will also be promoted among couples for their dual role of Family Planning and prevention of infections.

7. Communication to support STI

Prevention, screening and treatment of sexually transmitted infections through post rape care and other post exposure prophylaxis services will reach at least 250,000 males and females or 80% of the population in need, by end 2013. Promotion of effective communication programmes that emphasize prevention of STI, early detection and effective treatment of STIs including partner tracing is recommended.

8. Blood transfusion

KNASP III HLOP: By 2013, National blood transfusion need is met through centrally collected blood that is 100% screened for transfusion transmissible infections

According to the National Blood Transfusion services Kenya requires 200,000 units of safe blood for transfusion each year. The centre has been collecting only 130,000 units with a declining trend each year. The decline in the number of blood donors is occasioned by fear of people knowing their HIV status among other issues. To achieve the set target of 200,000 blood units annually, targeted National blood donation campaigns will be enhanced. In addition, information and communication programmes aimed at reducing demand for blood transfusion, such as nutrition education among vulnerable population, road accident

reduction will be promoted.

9. Communication targeting MARPs

The health sector will promote human rights standards in programs, especially for the most at risk populations and vulnerable groups. Training will be offered to health professionals to make them better provide services to MARPs and vulnerable groups. Specific intervention packages will be designed to reach most at risk populations such as sex workers and their clients, men who have sex with men, intravenous drug users and prisoners.

10. Communication support post exposure prophylaxis services

KNASP HLOP: By 2013, Populations in need including survivors of sexual and gender-based violence accessing PEP services

Sexual and gender based violence has silently escalated in Kenya in recent years. Many survivors were recorded during the post election violence in 2007. Some major gaps witnessed in the management of SGBV survivors is the lack of knowledge of existence of post exposure prophylaxis services in all health facilities in the country and shortage of disaster-prepared staff. Most SGBV victims report the violence late due to stigma associated with rape and other GBV. A clear communication strategy will be developed to inform the public about the correct means of dealing with SGBV.

b) Communicating treatment, Care, Support and Monitoring:

Communication programmes under the treatment, care, support and monitoring component of the KNASP III will contribute to the achievement of the following outputs:

- HLOP 1.2.0- By 2013: No of eligible PLHIV enrolled on ART increased
- HLOP 1.2.0- By 2013: PLHIV in need enrolled on home and community based care (HCBC)
- HLOP 1.2.0- By 2013: Proportion of TB patients who are HIV infected on ART increased
- HLOP 1.2.0- By 2013: Increase PLHIV receiving nutritional support
- HLOP 1.2.0- By 2013: Increase PLHIV receiving therapeutic nutrition

Communication programmes will be developed to support the delivery of the following services

1. ART Provision

The ART programme will provide medication and care to at least 80% of HIV positive men, women and children in need of treatment. By 2013, over 570,000 male and female adults and 68,000 male and female children in need of ARVs will be on treatment. Efforts would be made to ensure gender equity and that human rights are upheld in reaching these targets.

The communication programmes focusing on treatment literacy and drug adherence will be designed and channeled through appropriate cost effective media to avoid development of HIV Multi-drug resistance. In addition, stigma associated with HIV treatment as well as HTC services will be promoted to achieve the universal access targets of eligible clients in the country.

2. Home and Community Based Care

Care programmes will provide access to a basic service package at the community, home and health facilities to 80% of those in need. Meaningful support will be offered to people living with HIV who will be offered a prevention and care package using the NASCOP HCBC care package. The communication programme will promote access to HCBC services.

3. Therapeutic nutrition

Communication programmes will be designed to promote nutrition as a ker component of treatment and care. Therapeutic nutrition will be offered to at least 30% of those on ART by 2013, from the current 15%. Through mainstreaming HIV and AIDS in all sectors, including agriculture (Pillar 2) and offering social protection at the community level the more needy households will obtain nutritional support, while about 600,000 people will be accessing a nutrition sub-package through the Home and Community-Based Care intervention.

4. TB/HIV Co-infection

By 2013, at least 80% of TB/HIV patients will be receiving ART. The country's TB burden and rates have increased a tenfold increase from 10,000 in 1987 to 116,723 in 2007. The risk of developing active TB disease is 10 times greater for an individual living with HIV compared to a person who is HIV-negative. In addition, the two diseases share high levels of stigma associated with screening, testing and treatment adherence.

In view of this, social mobilization programmes promoting screening of HIV positive clients for TB and vice versa is recommended and facilities that provide counselling and testing need to integrate TB screening to improve early detection and treatment. Communication programmes will also aim at reducing stigma associated with TB and HIV and screening. To increase collaboration between TB and HIV programmes, regular meetings between the two programmes will be enforced at National as well as regional and district level.

c) Communication to improve systems

KNASP III HLOP: By 2013, Health Ministries have improved systems for optimized utilization and integration of HIV resources in the health sector

HIV and AIDS services delivery have been faced with a number of challenges including: i) Low number of Health care workers in relation to number of clients, ii) Inadequate infrastructure to provide personalized care, and 3) Parallel HIV and AIDS programmes require parallel systems including parallel reporting tools

To overcome these challenges, the following measures will be undertaken:

- HIV services will be integrated within other health services including sexual and reproductive health services to increase service delivery points and reduction in the overburdening of some health care workers. Health care workers will be trained on the job to increase the number of health care personnel who can manage different HIV programmes through different clinics. Health services that will require immediate integration are: STI, VCT, ANC, PMTCT, CCC, FP, MCH, TB and OP. Other clinics can follow to cover the whole health facility services.

- Mobile phone technology will be used to track and make follow up with patients on treatment through provision of toll free lines and Short Message Service.

- ICT and telecommunication technology will be established to address commodity management, procurement and supply system strengthening.

d) Communication to improve leadership in the health sector

KNASP III HLOP: By 2013, Health Ministries provide consolidated, streamlined and responsive leadership and governance for HIV services in the health sector

The role of the health ministries and other Ministries will be clarified to avoid duplication of responsibilities and gaps in programme implementation at all levels.

- The heath sector will provide leadership in advocating for improvement of the policy and legislative environment for implementation of the HIV and AIDS programmes.

- Areas of programming affected by the HIV and AIDS prevention and control Act and the Public health Act will be identified for revision.

- Advocacy programmes for importation of generic HIV drugs and commodities under the emergency setting of the National HIV response will be carried out to reduce the cost of HIV management in Kenya and increase access.

- Advocacy programmes will be designed by MOH with the support of NACC to increase government allocation to the HIV and AIDS programme. They will highlight areas experiencing funding gaps for prioritization by development partner support.

PILLAR 1: Health Sector Response

Output Result (& timeframe)

- **Outcome 1: Reduced risk behaviour among the general, infected, most-at-risk and vulnerable populations.**
- **Outcome 2: Proportion of eligible PLHIV on care and treatment increased and sustained**
- **Outcome 3 : Health systems deliver a package of HIV services according to KNASP strategy**

Key Message	Audience	Stakeholders/ partners	Tools/ media	Conveyors	Evaluator/ timeframe	Cost
HLOP 1.1.0 (BCC- National Campaigns) Need to provide knowledge on prevention services i.e. HTC,male circumcision, condom use, medical transmission, PMTCT and comprehensive services for MARPs	Members of the community, PLWHA, young women, pregnant women, Caretakers, health workers, MARP's,	UN, PEPFAR, CSO's, FBO's, local and International NGO's, PMTC partners,KEMSA, LVCT	Advocacy, capacity building, Counselling sessions, media publicity (TV, Radio, print), posters, Outreaches, folklores,	NACC communication , NASCOP, MOH and partners conveners, co-conveners	NACC and NASCOP June of each year – 10,11,12,13	National: HTC, PMTCT, Condom promotion, alcohol (co-funded by NACADA and Pvt sector), VMAMC, sex work, discordance. @1million a year = $4M Regional campaigns: (sustained Vernacular station & community materials – publications- leaflets, posters, merchandise (stickers/ T-shirts @ $5 each) , meetings, peer education for MSM, VMAMC, Orphans, stigma, etc.; 208 radio spots per year; 200,000 T-shirts, BCC IEC materials = 11.2+0.8 M= $12 M
HLOP 1.2.0 Need to provide knowledge on treatment services, care and support	PLWHA networks, OVC's, health care workers, community caregivers and other members	PEPFAR, UNICEF, AED, CSO's, FBO's, GoK, local and international NGO's, KEMRI	Advocacy, capacity building, Counselling sessions, media publicity (TV, Radio, print), posters, Outreaches, folklores	NACC, NACC communication , NASCOP, NLTP, conveners, co-conveners,	MoPH/MoMS Ministry of Special Programmes June 10, 11, 12, 13	IEC materials, refresher training, nutrition issues, referral toolkits @ $1.5-8% HIV positive out of 18 million tested =$2.16M

HLOP 1.3.0 Improve structures for health facilities to support universal access. (Conduct advocacy for resource mobilization.)	Development partners , government MoF and ACUs and CPPMUs, Health care managers, communities, Private sector and CSOs, PLWHA.	KEMSA, CDC/ NIH, AMREF, MOH training team, universities, referral hospitals i.e. Mbagathi, WHO, Pop Council, JHPIEGO, MSF Belgium	Training, Advocacy, capacity building, media publicity (TV, Radio, print),	NACC communication , NASCOP, MOH and partners conveners, co-conveners, pharmacy and poisons board	NACC, MOH Dec 09, June 10, Dec 10, June 11, Dec 11, June 12, Dec 12, June 13	$5,000 per meeting *2 advocacy meetings every planning quarter = $40,000
HLOP 1.4.0 Institutionalizing appropriate legislation/policies to support the health sector under one programme and funding of the same (Advocacy and social transformation)	Cabinet committee, Parliament, NACC Board, Health Managers, Min of Finance , MoPND and Programme managers & planners, NACC Resource Mobilization team, development partners PLHIV networks, human rights groups.	Private sector, CSO's, FBO's, GoK, local and international NGO's, Development partners	Advocacy, capacity building, lobbying, meetings, technical groups, media publicity (TV, Radio, print), posters,	NACC, NASCOP, conveners, co-conveners, MoH	NACC/ MoSP June 2012	4 advocacy meetings@5000 each and 10 regional dissemination meetings@10,000 each =$120,000

Pillar 2: HIV mainstreaming in all sectors

KNASP III outputs

- **All sectors develop and implement HIV and AIDS programmes**
- **Increase the public and private institutions with work place HIV and AIDS programmes**
- **Increase the households with an OVC receiving cash transfer**
- **Increase the households with an OVC receiving cash transfer**

A critical component of the successful implementation of KNASP III is coordination through a multi-sectoral response to HIV and AIDS. This takes into account the role of various institutions the implementation of KNASP III. To facilitate meaningful contributions from all sectors, NACC will develop and implement a mainstreaming policy to facilitate incorporation of HIV and AIDS programmes in the core functions of each sector.

1. Building multi-sectoral partnerships in communication

The communication strategy will drive the HIV mainstreaming process. Each of the 11 mandated sectors will be expected to generate HIV strategic information to guide planning and implementation of the Programme. A multi-sectoral advocacy programme will be developed to highlight achievements in various sectors to the public. An 'HIV and AIDS Awards', recognition programme will be instituted to motivate and encourage organizations tto achieve KNASP III results. It will in addition highlight important contributions in the fight against AIDS from outstanding sector.

NACC will build partnerships with institutions such as the Communication Commission of Kenya and other bodies responsible for regulation of media content to ensure that media content is censored and moderated to avoid the media driving new infections among young people.

2. Partnerships with the private sector

The private sector utilizes the mass media for the promotion of their products. They are, therefore, very influential in creating lasting impressions in the minds of their consumers. Building partnerships with the private sector provides a forum to ensure that messages developed are responsible and that they do not fuel risky behaviour.

Additionally, building partnerships with the private sector is necessary for increasing resources available for HIV and AIDS communication programmes. The private sector employs about 9 million people in the productive age group. Partnership with the media will facilitate delivery of results aimed at reaching the workers in a cost effective manner. The strategy recommends that private sector organizations should contribute their resources to the fight against HIV and AIDS through their marketing channels.

3. Partnerships in communication with the media

Institutional strengthening of media houses to build a greater understanding of behaviour and social change communication through tailor-made training programmes to mainstream HIV and AIDS will be done. Initiatives such as the Coalition of Media and Health Professionals, and Network on Women Journalists on HIV and AIDS in Kenya and the Media Red ribbon Award will be strengthened to encourage competition in the coverage of HIV messages through the media.

4. Partnerships in communication with faith-based sector

The faith-based organisations have extensive networks in urban and rural communities where respected religious leaders exert influence on many aspects of life. More than 24 million Kenyans attend churches, mosques and temples every week. This presents a considerable opportunity for reinforcement of the key communication messages of abstinence, fidelity in marriage and compassion and care of the infected and affected. Faith based institutions are also viable centres for advocacy and delivery of services such as voluntarily counselling and testing (VCT), Medical male circumcision, support and care for orphans and people living with HIV and AIDS, and dissemination of a range of communication materials.

PILLAR 2 – SECTORAL MAINSTREAMING OF HIV and AIDS

Result (& timeframe)						
• Outcome 4: HIV mainstreamed in sector-specific policies and sector strategies.						
Key Message	**Audience**	**Stakeholders/ partners**	**Tools/ media**	**Conveyors**	**Evaluator/ timeframe**	**Cost**
HLOP 2.1.1 Need for policy support in mainstreaming HIV in all sectors. i.e., religious, education, health, workplace, All line ministries, local authorities.	Civil servants, Private employees, policy makers, parliament, human rights, PLWHA networks and groups.	NCCK, SUPKEM, CBO's, NGO's, KNHCR, NHIF, NSSF, FKE, business coalitions, development partners, COTU	Lobbying, reviews, meetings, working groups and technical committees, workshops, media publicity i.e. breakfast shows, radio and TV interviews	Line ministries, NACC, conveners, development partners	NACC, Pillar 2 conveners June 2010	Award programme for advocacy & social transformation $20,000 annually- $5000 award and $15000 publicity and ceremony = $80,000
HLOP 2.2.1 Findings from HIV surveillance and research on all sectors to be documented including impact on human resource, workplace risks and vulnerabilities to HIV	Public sector, Private sector, policy makers, PLWHA networks, parliament, human rights activists, health care workers	NGO's CBO's, FBO's, KNHCR, FKE, Business coalitions, development partners,	Lobbying, advocacy, workshops, meetings, mainstream media for publicity	NACC, sector line ministries and HRD, development partners,	NACC, June 10, 11, 12, 13.	Dissemination costed under M&E plan
HLOP 2.3.1 Strengthening HIV programmes in public and private sector including OVC's support, MARP's and care givers	Health care workers, OVC's, MARPS, civil servants, private employees, communities	Law Reform Commission, NGO's, CBO's, development partners, FKE, COTU,	Workshops, meetings, trainings, Networking, TWG, Media publicity	Conveners, co-conveners, NACC, line ministries, KNBS, members of children committee	NACC, Pillar conveners June 10, 11, 12, 13	Social transformation and advocacy 11 sectors * 2 meetings@ 10000 = $220,000
HLOP 2.4.1 Creating an integrated system to access and utilize HIV strategic information to guide policy, planning and monitoring in all sectors	Public sector, Private sector, policy makers, PLWHA networks, parliament, human rights activists, health care workers	M&E experts, strategic experts, development partners, NGO's, CBU's,	Meetings, workshops, networking, lobbying, media publicity	NACC, NACC communication, conveners, line ministries, M&E directorate	Dec 10	Costed under M&E plan

Pillar 3: Community interventions & Systems

KNASP III Outputs

- By 2013: Increase the CSOs supported to deliver HIV services at community level responsive to local context
- By 2012: Increase and sustain community outreach programmes targeting MARPs and vulnerable groups
- Linkages between community own structures and health systems strengthened

For the first time in the Kenyan response to AIDS, communities have been placed at the centre of the response, with their own financing and convening structures. Without a solid communication strategy, the many disjointed responses witnessed at the decentralized level in the past may once again disintegrate into haphazard implementation and reporting. To this end, KNASP III prescribes a communication strategy for this pillar.

Steps towards programme implementation in Pillar 3 will include:

- Community mapping of 80% of all Kenyan communities (i.e. 6400 community units); use of the socio-ecological model to map out their specific risks and vulnerabilities; conducting a feasibility study with members of the village technical committee and health sector management team.
- Community mobilization; which includes "Health Talk" or advocacy, door-to-door campaigns, village meetings ("Barazas") and AIDS Competence self-assessment gatherings.
- Outreach for specific high-risk and vulnerable groups.
- Cross-referral with health facilities (Pillar 1) and other sectors/ line ministries (Pillar 2) for sector-specific services.
- Monitoring and reporting on the outcomes of interventions, quality control and feedback from other sectors, and exchanging knowledge and skills on AIDS competence with other communities.

Some major expected results from this pillar are that by 2013 80% of communities in Kenya, particularly the vulnerable and marginalized, demand comprehensive universal HIV prevention, treatment, care and support services and realize implementation of their rights; 80% PLHIV networks and associations will be engaged in policy and program development and make decisions regarding their HIV treatment outcomes by 2012; and that by 2012, community prevention programs are rights-based and incorporate prevention with positives (PWP). The Community Pillar will remove community-level obstacles to disclosure, improve rights of PLHIV and meaningfully involve PLHIV in prevention programs.

Prevention

The community will utilize comprehensive HIV prevention, treatment and care services by participating in the development of prevention communication programmes. The community will be used to identify risk factors that are cultural and religious and the most appropriate means of overcoming such impediments in each community. The community will be used as part of the solution and not just the beneficiary in the achievement of the KNASP III outcome results.

Prevention targets will be prioritized towards:

MARPs: Those who are most at risk of being infected in terms of numerical sizes infected annually; be they bridge populations (such as clients of infected sex workers), or populations at risk (such as young women 15-18, uncircumcised men), etc; Those who are most at risk of infecting others in terms of the numerical population sizes that they could infect within a year; Those for whom it is crucial to keep out of risk due to the quick spread of infection among them in terms of numerical sizes that the group could infect within a year. A rights based approach will be promoted to increase demand and access to services.

Sex workers: Between 27,000 and 155,000 female sex workers (street, club, contextual…) will be reached with HIV prevention services through community outreach followed by specific interventions, between 2009 and 2013. Their male counterparts reached will number between 1,500 and 8,600. Community outreach will mainly involve peer education for BCC and distribution of prevention materials.

MSM: Between 12,000 and 71,000 MSM will be reached with prevention services between 2009 and 2013. Services offered will include BCC through peer education, condom distribution and behavior change transformation.

IDU: At least 80% of intravenous drug users will be reached through community outreach and receive a comprehensive package.

Vulnerable groups:

Prevention with PLHIV and AIDS: New prevention with

positives (PWP) programmes that aim to support HIV infected persons and limit HIV transmission will be implemented. Sexual transmission of HIV will be dramatically reduced through education and the increased involvement of those most likely to transmit it.

Truck drivers: Between 18,000 and 104,000 truck drivers will be reached with prevention services annually.

Widows: About 80% of widows (about 340,000) will be reached through also receive prevention service packages.

Discordant couples: About 80% of discordant couples will be reached with prevention a prevention package at various entry points, including PMTCT, HCBC, HTC and others.

Culturally appropriate BCC strategies will be implemented for specific groups including fishing communities, non-circumcised men, out of school young-people, PLHIV and AIDS and others. These groups are addressed more comprehensively in the Communication Strategy that accompanies this document.

Treatment, Care and Support

Treatment, care and support strategies will include adherence support for community members on ART, treatment literacy, psychosocial support, and home and community based care. Treatment literacy will be offered as a strategy to increase knowledge of PLWHIV and AIDS on HIV treatment and make decisions regarding treatment outcomes; Improve PLHIV ownership of care options and improve adherence to treatment.

Home and Community based care will be offered to 80% of all in need (600,000 people) by 2013.

Social Protection

OVC: Social protection in affected communities will include OVC care and livelihood support, Similar support will also be accorded specific widows and other special populations made vulnerable to HIV through marginalization. At least one third of OVC (Over 400,000) will receive in-school and out of school support. This will include school fees and uniform (through pillar 2) and nutrition, psychosocial counseling through pillar 3.

PLHIV and AIDS: Social protection services will mainstream PLHIV and AIDS in order to prioritize them when providing products and services to populations in need.

In order to address the outlined KNASP III Results, the following strategic approaches will be used at community level to mobilize the community towards social change:

a) Community based programmes – drama, song, puppetry, folk media, door to door, lobbying, discussions
b) Mass media communications – national and vernacular stations
c) Programmes in and out of school – curricula and co-curricular activities, life skills, games, spots,
d) Building partnerships with faith based institutions
e) Advocacy through community leaders
f) Publication materials- leaflets, posters, flip charts,
g) Sponsorships
h) Merchandising
i) New mass media (mobile Phone, websites, etc)

Both prevention and treatment and care communication campaigns designed at community and national levels will engage the network of people living with HIV and AIDS in the design and implementation of the programme. This will enhance penetration of messages to the families affected with HIV and reduce misconceptions and stigma associated with HIV programmes. Community level advocacy to improve reporting on HIV programmes taking place at this level will be enhanced. The COBPAR tools will be disseminated to all community level structures and implementers to enhance utilization of the tool in reporting.

PILLAR 3- COMMUNITY INTERVENTIONS AND COMMUNITY SYSTEMS STRENGTHENING

Result (& timeframe) • **Outcome 5: AIDS Competent Communities respond to HIV within their local context**						
Key Message	**Audience**	**Stakeholders/ partners**	**Tools/ media**	**Conveyors**	**Evaluator/ timeframe**	**Cost**
HLOP 3.1.1 Need to uptake HIV prevention services i.e. Counselling and Testing, condom use, treatment, care and support services	Members of the community, PLWHA, OVC's, Caretakers, health workers, mobile populations, VCT counsellors,	CSO's, FBO's, local and International NGO's, NCBDA, Local authorities	Counselling sessions, media publicity (TV, Radio, print), posters, Outreaches, folk media, community forums, games, sports, door to door	NACC communication, NASCOP, conveners, co-conveners, local authorities	NACC June 10, 11, 12, 13	Costed in pillar 1 and 3
HLOP 3.2.1 PLHIV networks to make decisions regarding uptake of ART's and policy development	PLWHA networks, policy makers, parliament, human rights activists, health care workers	CSO's, FBO's, local and international NGO's	Lobbying, advocacy, workshops, meetings, door to door, group therapy discussions, mainstream media	NACC decentralized structures, NACC communication , NASCOP, conveners, co-conveners, line ministries	June 10, 11, 12, 13	3 advocacy meetings @5000 , 8 social transformation meetings @10000 = $105,000
HLOP 3.3.1 Enhancing institutional capacity of CBO's to improve financing mechanisms and mainstreaming HIV and AIDS based on local evidence	PLWHA networks, members of the communities and other implementers	CSO's, development partners, local and international NGO's	Workshops, meetings, trainings, Networking	Conveners, co-conveners, NACC, development partners	June 11, 12, 13	
HLOP 3.4.1 Need to operationalize M&E programme and research system at community level	Implementers, community members, CSO's, PLHA groups and networks, HIV scientists/experts,	CSO's, M&E experts, development partners, Research institutions,	Stakeholder meetings, trainings, conferences Mainstream media publicity	NACC, KARSCOM, other conveners, development partners, research institutions government and private	June 2011	

Pillar 4: Governance (Policy and leadership, Coordination, Accountability) and Strategic Information

KNASP III Outputs

- HLOP 4.1.2 by mid 2013 use of evidence and validation of data ensured through strengthening of co-ordination mechanisms.
- HLOP 4.2.1 By mid 2013 all stakeholders/partners use KNASP III Results to determine their programme objectives, targets and resource allocation
- HLOP 4.3.1 By mid-2013 mandated institutions are held accountable and achieving intended results within the existing institutional and coordination frameworks**.**

Coordination structures for communication such as the National and regional Behaviour change communication consortia will be strengthened to address all aspects of strategic communication for KNASP III governance. Other coordination and leadership structures such as the cabinet committee on HIV and AIDS will be strengthened and their targets appropriately communicated through cabinet office to ensure timely reporting on their deliverables related to improvement of leadership and policy environment for the national response. Strategic information from Research findings and M&E data will be summarized and submitted to the Cabinet committee on HIV and AIDS on a quarterly basis. Permanent Secretaries will hold a bi- annual meeting with NACC management to review progress, strategic information and its implication to each sector.

New and revised policies and guidelines, including KNASP III, will be disseminated through meetings and distribution of copies to relevant stakeholders. The policies will also be posted on the NACC website as well as to partners' websites to facilitate ease of retrieval by any interested parties.

Shorter/popular versions and job aids of the legislation, policies and guidelines will be developed to facilitate ease of reference.

Members of Parliament will expected to report on HIV and AIDS projects and advocacy initiatives undertaken in their constituency on a bi-annual basis.

The National AIDS Control Council will develop a monthly magazine programme to highlight important milestones achieved by various sectors. This will be channeled through electronic mass media and newsletters to the public. The magazine programme will clarify roles and responsibilities of each sector and achievements made on a monthly basis.

Coordination of communication Strategies

KNASP III has changed the coordination framework from the MCGs to Pillars 1, 2, 3 and 4 under which there still exists relevant Monitoring and Coordination Groups. This will be communicated effectively to stakeholders at National, regional levels and community levels through various channels to reach all stakeholders in a timely manner, to allow stakeholders to align themselves appropriately with the right Pillar within KNASP III.

Conveners of various pillars will hold quarterly meetings with relevant stakeholders at national and regional level to review NACC MOU with a view to building consensus and signing. The MOU will provide an opportunity for implementing agencies to capture the Result area in KNASP III, through which they will commit themselves to implement. Challenges experienced in the implementation process will be channeled to relevant institutions for immediate action. Recommendations will be channeled through various tool and media to all stakeholders.

The National AIDS Control Council will convene relevant stakeholders to including cabinet and parliament to review and revise current policies and guidelines to facilitate smooth implementation of the national response. The review of policies will be carried out concurrently to avoid timely delivery on this result in KNASP III.

Strategic information tools will be developed to inform National and international stakeholders on the resource envelop currently available for implementation of KNASP III, and the existing gaps. An advocacy strategy to mobilize more resources will be employed to increase allocation to meet existing gaps through the GOK MTEF process, the Global fund NSA process, and other international sources of funding. In addition, strategic information from evidence based cost analysis studies will be generated to ensure that available resources are allocated to the most cost effective interventions. This may include integration of services and clear targeting of programmes.

To coordinate communication programmes implemented at various levels in the country, the following coordination structures will be strengthened to provide technical support, guidance and clearance for communication programmes at regional and district/constituency level:

1. National, Regional, and district level Behaviour

change communication consortia

2. The Joint AIDS Programme review for National, district and provincial stakeholders
3. The ICC for HIV and AIDS
4. Pillar Task Teams
5. Technical working groups at National and Regional levels.

PILLAR 4: GOVERNANCE & STRATEGIC INFORMATION

Result (& timeframe) – PILLAR 4 • **Outcome 6: KNASP is effectively operationalised**						
Key Message	**Audience**	**Stakeholders/ partners**	**Tools/ media**	**Conveyors**	**Evaluator/ timeframe**	**Cost**
HLOP 4.1.2: New HIV research and programme evaluations.	Researchers, Implementers, ministries, development partners, Kenyan public, PLWHA, KARSCOM	KARSCOM, Researchers Implementers, convening ministries, development partners,	Workshops, meetings, newspapers, NACC website, segments on TV, Maisha Newsletter, Mass Media, NACC website	M &E officers, KARSCOM, line ministries, NACC decentralized structures, NACC communication team	KARSCOM, Researchers, Ethics committee June 2010, 11, 12, 13	Costed under M&E plan
HLOP 4.2.1: Transition plan and guidelines communicated to all stakeholders for programming purposes under KNASP III	Implementers, development partners, NACC, Pillars, Conveners	Line ministries, development partners, implementers, Conveners	Workshops, meetings, newspapers, Transition plan document, NACC website	UNAIDS, NACC, Conveners, NACC decentralized structures, NASCOP	NACC, JAPR June 10	Costed under pillar 4
HLOP 4.3.1: Stakeholders should use strategic communication planning frameworks.	Implementers, development partners,	Implementers, line ministries, development partners	Meetings, workshops, newspapers, NACC website, segments on TV	NACC, M & E officers, newspaper, NACC decentralized structures, NACC communication team	NACC, M & E team, NACC Communication, June 2010	16 regional communication & advocacy meetings @10,000 each & 2 advocacy meetings @ 5000 = $170,000

6. Work plan for development and dissemination of information products

	Information Products	2009/2010				2010/2011				2011/2012				2012/2013			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A	**INTEGRATED PROGRAMME REPORTS**																
	Quarterly Service Statistics Summary (COBPAR, HMIS, NBTS, NLTP, FMS, PSM)																
	Quarterly Programme Coverage Reports																
	National HIV and AIDS M&E Programme Report																
B	**PLANNING AND REVIEW REPORTS**																
	Quarterly Programme Review Report																
	Technical Coordination Group Review Reports																
	Semi-Annual Programme Review Report																
	Joint Annual Programme Review Report																
	Joint Annual Management Review Report																
	Mid-Term Review Report																
	End of Term Review Report																
C	**STAND ALONE SUBSYSTEM REPORTS**																
	Sentinel Surveillance Report																
	Behavioural Surveillance Report																
	KESPA Report																

	Information Products	2009/2010				2010/2011				2011/2012				2012/2013			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Demographic Surveillance Survey Report																
	Incidence Survey Report (MOT), Stigma Index																
	KDHS+ Report																
	KAIS Report																
	Mid-Programme Evaluation Report																
	End of Programme Evaluation Report																
	Targeted Evaluation Reports																
	Research Reports, GIPA Score Card																
	KNASA Reports																
	UNGASS Report																

SECTION 6: HEALTH SYSTEMS STRENGTHENING STRATEGY

An equitable, quality, responsive national health system is an essential component of a successful national HIV response. For example, poor access to health services, combined with poor health seeking behaviour among pregnant women, results in less than 40% ultimately giving birth in health facilities. The low proportion of pregnant women accessing antenatal services undermines the effectiveness of PMTCT interventions[5]. The importance of the health system is emphasized in the KNASP III Strategic Plan where one of four strategic Pillars is the Health Sector HIV Service Delivery.

Key strategic documents and reviews, including Kenya's long-term, national development strategy, Vision 2030, have identified weak health systems as one of the factor constraining implementation of HIV, tuberculosis, malaria and other disease interventions in the country[6]. An analysis of the health system based on WHO health system building blocks found that the health system is weak and inadequate to effectively address the burden exerted by tuberculosis, malaria and HIV. While the review concluded that much has been achieved, weak health systems continue to constrain implementation at all levels (1 to 6) of the national health sector[7].

At the national level these constraints were observed in: (1) human resources, including staffing, skills mix and management; (2) service delivery - inadequate infrastructure, status of outreach services; (3) systems financing; (4) information systems; (5) medicines, vaccines and technologies -- including procurement and supply management; and, (6) governance -- including policies, guidelines, management structures, leadership and coordination. At decentralized levels, including communities, system constraints were observed in three broad areas: (i) leadership and governance; (ii) capacity building; and, (iii) sustainable financing[8]. The KNASP II Strategic Review, pointed out that poor programmatic performance is almost always symptomatic of a health system constraint. Programme goals and targets cannot not be achieved without an effective health system.

To address these challenges the government, civil society and development partners carried out collaborative, rigorous, evidence-based strategic planning processes aimed at ensuring better implementation of disease programmes, grounded in a strong and dynamic national health system. The key output of this work is a Health System Strengthening (HSS) Strategy, which includes the following priority areas:

1. Service Delivery

To promote the utilization of services at the community level the government will set up comprehensive community health services in areas with limited access to, and/or use of, health services. The Community Health Division of the Ministry of Medical Services, working with civil society, will establish Community Health Units in a number of districts. Furthermore, it plans to build the capacity of 45,000 additional Community Health Workers (CHW), Community Health Extension Workers (CHEWs), and Community Health Committees. In addition, the Ministry will undertake the following interventions to increase access to health services: sensitize and mobilize communities to demand general health services; provide technical support; procure health equipment and kits; improve linkages between the community and service providers; build the capacity of implementing partners, including civil society organizations; and supervise, monitor and evaluate the community programme. These initiatives will complement Pillar 3 of KNASP III, called Community-based HIV Programmes.

Most at Risk Populations and vulnerable groups will also benefit from health systems strengthening since Community Health Units will identify and connect them faster to the national health referral system allowing

[5] *Ministry of Medical Services Health System Facts and Figures 2008.*

[6] *See Vision 2030, KNASP II Synthesized Strategic Review Report 2009, KEMSA Task Force Report 2008, NHSSP, Ministry of Medical Services and Ministry of Public Health and Sanitation Strategic Plans, HMIS Report, HSS Task Force Gap Analysis 2009, Health Sector Reforms and Primary Care Concept, among others.*

[7] *There are more than 5000 health facilities run by government, civil society and the private sector in Kenya. These are divided into 6 levels. Level 1 -- including community, family and households -- is concerned with promoting health-seeking behaviour, HIV prevention and ART adherence support. Level 2 includes dispensaries and clinics. Level 3 includes health centres, maternities, and nursing homes. Levels 2 and 3 address health seeking behaviour, prevention, treatment and care. Level 4 includes primary hospitals. Levels 5 and 6 include secondary and tertiary hospitals. The last three levels address curative and rehabilitative care with limited preventive care.*

[8] *KNASP II Synthesized Strategic Review Report, February 2009.*

them quicker access to preventive, treatment and social protection services.

An effective health system is crucial to address HIV infections among infants. Each cluster of 4 million people that the Ministry covers (10% of the country) will lead to approximately 40,000 more pregnant women accessing health services and approximately 4,000 more HIV positive pregnant women receiving PMTCT services and receiving ART under the antenatal care programme. Each 10% additional investment in community health systems would lead to an estimated 2,000 reduced infant infections representing at least over 5% reduced HIV infections among infants.

To improve the management and quality of treatment across different health system levels, the HSS Strategy will support improved functioning of horizontal and vertical referral and feedback mechanisms at both public and non public service provider levels (i.e. civil society and private sector). The health sector will revise and disseminate referral tools together with clinical guidelines. It will also ensure that transport (including ambulances) and equipment are available and functional around the country. The roll out of an integrated quality assurance and management system in public and non-public facilities is planned under the Ministry of Medical Services Strategic Plan for Medicines, Vaccines and Technologies.

To address procurement challenges that have occurred over the last decade concerning HIV commodities Kenya will use the Voluntary Pooled Procurement (VPP) mechanism. Guiding the proposed VPP initiative is a detailed Commodity Plan (2009) that covers the four-year, KNASP III Strategic Plan period.

To complement the VPP initiative, the HSS Strategy will decentralize LMIS, warehousing and distribution to at least three regional depots - Kisumu (the proximal city to Nyanza Province, which has the highest HIV and malaria prevalence), Mombasa, Coast Province, and Eldoret in the North Rift Province[9]. In addition, the sector will implement ERP, which is an effective commodity management information system, across the entire supply chain, and ultimately integrate information on all diseases under the health management information system (HMIS). In addition, the sector will build the capacity of human resources (pharmacists, pharmacy technologists, some nurses and community health workers, etc.) at all healthcare levels, including FBO facilities, in supportive supervision, pharmacovigilance and appropriate medicines use, especially ARTs. Finally, the sector will standardize commodity supply management and appropriate drug use by developing a supply management strategy and disseminating guidelines to all facilities.

[9] *There are two major supply chains in Kenya: KEMSA, which is a government parastatal, and MEDS, which is a faith-based procurement and distribution system supported mainly by PEPFAR.*

2. Information Systems

It is critical to develop a coordinated approach to information systems that improves capacity for collection, analysis and use of health information at public and non-public facilities. There have been much progress in HMIS including the revamping of the system to support a File Transfer Protocol (FTP), the national roll-out of a web based reporting system, and revision and harmonisation of M&E tools for data capture and reporting. However, in the long-term, an integrated single HMIS database that captures all health management information needs for all diseases from levels 1-6 must be developed, and provide access to other key partners such as NACC, the Kenya National Bureau of Statistics and Civil Society.

In the medium term, the HMIS Unit will implement an integrated electronic health facility information system (EHR) at health facilities. It will build the capacity of sub-systems (data sources) on data warehousing, analysis, dissemination and use of information. Finally, the sector will build the capacity of health information system institutional, coordination and partnership structures.

3. Human Resources

With 17 doctors for every 100,000 people living in Kenya[10], and the number of nurses approximately five times this number, Human resources in Kenya's health system are severely constrained. HR issues are not primarily related to staff shortages, but issues of inequitable staff deployment and staff rationalisation. In response to the current health sector shortages in HR, the government has been systematically increasing the

[10] *Ministry of Medical Services Health System Facts and Figures 2008*.

allocation of funds towards HR. The latest increases in funding are listed in Table 9 below.

Table: Recently announced, increased GOK funding to health sector for HR

	No.	Unit Cost P.A.	Total Cost (KShs.)	Total Cost (US$= KShs. 75)
Ministry of Medical Services				
Absorption of contract staff	1974	300,000	592,200,000	7,896,000
Common cadre expansion (various cadres)	1	1,770,000,000	1,770,000,000	23,600,000
Recruitment of new staff -- various JG, G-H	1500	300,000	450,000,000	6,000,000
Recruitment of new staff – Interns (medical officers)	650	63,500	41,275,000	550,333
			2,853,475,000	**38,046,333**
Ministry of Public Health and Sanitation				
Recruitment of 20 nurses per constituency	4200	300,000	1,260,000,000	16,800,000
			1,260,000,000	**16,800,000**
Net Total			**4,113,475,000**	**54,846,333**

The government, with support from development partners, has committed to support the implementation of the Health Sector Human Resources Strategy, which will form the basis for the establishment of the overall HR need by level and cadre in the public health sector. The Strategy will also provide strategic direction on issues such as staff retention, development, planning and deployment.

4. Governance

To support successful implementation of HSS reforms, greater emphasis will be placed on coordination and leadership. The existing Health Systems Coordinating Committee (HSCC) will establish a Programme Management Unit to oversee partner coordination. Plans are underway to form a sub-committee under the ICC to address health-related systems issues. The development of health systems directly related to HIV outcomes will be overseen by the HSS Committee under Pillar 4, consisting of conveners of the various health systems building blocks and chaired by NACC.

Annex 1: HSS Gap analysis for and prioritization

The tables below show a detailed gap analysis of the health deliver systems and identifies the prioritized areas for systems strengthening which have the potential of creating high impact on the three diseases – HIV and AIDS, Malaria and TB. The prioritization is meant to guide investment into health systems strengthening by programmes.

Annex 1: Health System Strengthening: Prioritization based on Health Sector Strategic Plans

1.1. Measures used for weighting Health Systems Interventions

Measure	Weight	
	Lowest score (+)	Highest score (+++++)
1. Absence of support from other sources for the priority	*Other support relatively available*	*Other support relatively limited*
2. Presence of a tangible deliverable, which can be readily and repeatedly quantified and measured	*Diffuse deliverables*	*Clear and tangible deliverables*
3. Intervention has relatively good impact on all programs	*Impact of intervention felt on few / one program*	*Significant impact of intervention felt across all programs*
4. Intervention has significant impact on program objectives if supported	*Relatively limited impact*	*Significant impact*

1.2. Health System Strengthening priority issues ro address and ranking

	Health Sector Objective	Priorities in Health System Strengthening that would address highlighted challenges	Weighting				Total
			Lack of existing support	Tangible deliverable	Supports issues for all disease programs	Relative program impact	
1	**Increase equitable access to health services**	• Scale up outreach services in areas with poor access to services	++++	+++	+++++	+++	15
		• Set up comprehensive community health services in areas with limited access and/or use of services	+++	++++	+++++	+++++	17
		• Increase construction of new infrastructure in areas with poor access to services	++	+++++	++++	+++	14
		• Increase availability of defined Human Resource Cadres for public and non public facilities in areas with inadequate numbers	+++	+++++	++++	+++	15

2	**Improve quality and the responsiveness of services in the sector**	• Training for improving skills in management of services	+++	++	++	++++	11
		• Design, and roll out system of rationalization of service delivery within the health facilities	++++	++	++++	+++	13
		• Provide specified equipment and supplies	++	+++++	++++	+++++	16
		• Roll out integrated quality assurance & management system in public and non public facilities	+++++	++++	+++++	+++++	19
		• Support improved functioning of the horizontal and vertical referral and referral feedback mechanisms, through both public and non public service providers	+++++	++++	+++++	++++	18
3	**Foster partnerships in improving health and delivering services**	• Elaboration of Public Private Partnership Policy and Strategy	++	++++	++++	+++	13
4	**Improve the efficiency and effectiveness of service delivery**	• Strengthen the commodity and supply chain distribution and management from national to implementation levels	++++	+++++	+++++	+++++	19
		• Improve capacity for collation, analysis and use of Health Information at public and non public facilities	++++	++++	+++++	++++	17
		• Improve capacity for comprehensive and coordinated planning and supervision follow up of health services provided by public and non public providers at district level	++++	+++	+++++	++++	16
		• Strengthen of deployment retention and motivation of health workers in underserved areas	+++	++++	+++++	++++	16
		• Strengthen logistics for storage and distribution of centrally collected blood and blood products	++++	++++	+++	+++	14
5	**Improve financing of the health sector**	• Develop strategies for resource mobilization	+++	++	++++	+++++	14

2. Resultant priorities for Health System Strengthening through Global Fund NSA

No	Health System Strengthening intervention	Score	Lack of existing support weight
1	Roll out integrated quality assurance & management system in public and non public facilities	19	+++++
2	Strengthen the commodity and supply chain distribution and management from national to implementation levels	19	++++
3	Support improved functioning of the horizontal and vertical referral and referral feedback mechanisms, through both public and non public service providers	18	+++
4	Improve capacity for collation, analysis and use of Health Information at public and non public facilities	17	++++
5	Set up comprehensive community health services in areas with limited access and/or use of services	17	+++
6	Improve capacity for comprehensive and coordinated planning and supervision follow up of health services provided by public and non public providers at district level	16	++++
7	Strengthen of deployment retention and motivation of health workers in underserved areas	16	+++
8	Provide specified equipment and supplies	16	++
9	Scale up outreach services in areas with poor access to services	15	++++
10	Increase availability of defined Human Resource Cadres for public and non public facilities in areas with inadequate numbers	15	+++
11	Strengthen logistics for storage and distribution of centrally collected blood and blood products	14	++++
12	Develop strategies for resource mobilization	14	+++
13	Increase construction of new infrastructure in areas with poor access to services	14	++
14	Design, and roll out system of rationalization of service delivery within the health facilities	13	++++
15	Elaboration of Public Private Partnership Policy and Strategy	13	++
16	Training for improving skills in management of services	11	

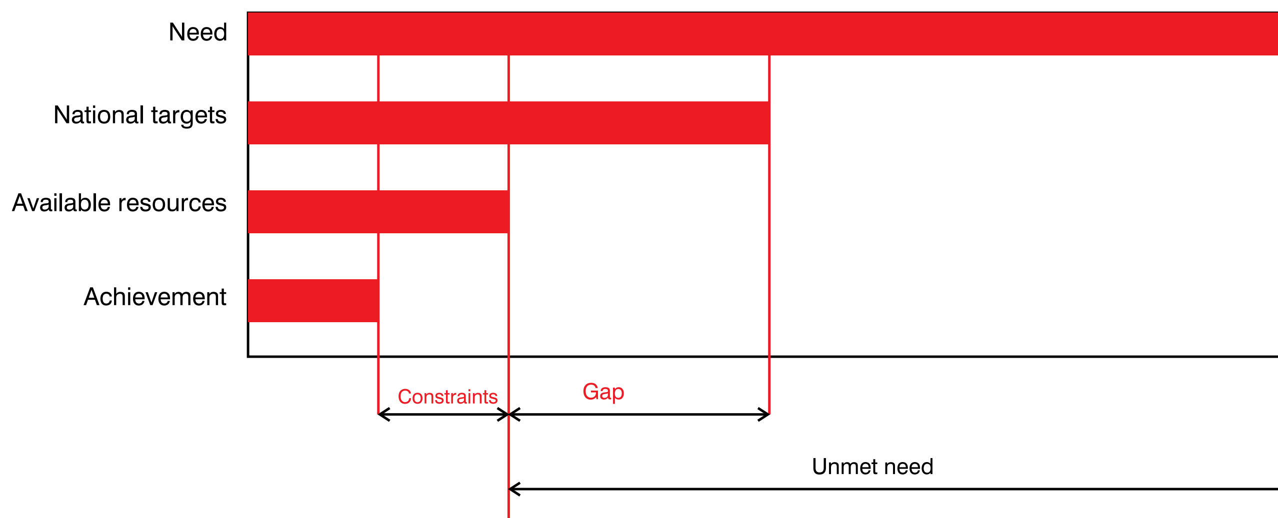
* Cut off mark = 17/ 20

3. Gap analysis for prioritized National Strategy Application (NSA) interventions:

1. Roll out integrated quality assurance & management system in public and non public facilities.*
2. Strengthen the commodity and supply chain distribution and management from national to implementation levels.
3. Support improved functioning of the horizontal and vertical referral and referral feedback mechanisms, through both public and non public service providers.
4. Improve capacity for collation, analysis and use of Health Information at public and non public facilities.
5. Set up comprehensive community health services in areas with limited access and/or use of services.

	Programme target definition	**% Funded**	**Programmatic Gap (Financing gaps estimated in health sector strategic plans; Annexes 4 & 5)**	**HSS Reference Document for activity and financial gaps**
Intervention 1	% of health facilities meeting QA/AC standards	-		Annexes 4, 5 & 3a
Intervention 2	Number of functional strategic distribution units (Related indicator: facilities reporting no stock outs) target= 100%	25%	75%	Annex 15, 3a
	% facilities with electronic tracking tools for health commodities (622 baseline)	8.2%	91.8%	Annexes 8, 4, 5, 15, Commodity Plan (NSA HIV proposal attachment)
Intervention 3	Districts / health zones with fully functioning referral systems for management of physical client movement (75% target)	Less than 30%	Over 45%	Annex 14, Annex 3a
Intervention 4	Reduced HMIS staffing/capacity gap from 89% to 53% (i.e. reduced HR gap by 40%) or 4774 HMIS staff recruited and trained	13% (622 staff trained)	87%	Annexes 11, 13, 3a, 4 & 5
Intervention 5	16 million people covered with functional community units / level 1 services	14%	86%	Annex 9 (Community strategy), Annex 31

Gap = Budgetary or programmatic targets as % of total country needs – available resources or the equivalent population that these resources could cover. The diagram below explains the gap analysis approach taken.



Constraints = Available resources – achievements.

4. Identified gaps within prioritized HSS interventions

Intervention 2: Procurement and Supply Chain Management Gaps

HSS Component	Gap Areas
HSS: Procurement and supply management for medicines, vaccines and technologies	
Policy/ Legal/ Governance	• Development, Dissemination & supervision of policy and guideline implementation (decentralization/ HR, lab commodity management, referral strategy, MOMs…) • Integration of commodity management systems, training, • Decentralization of supply chain? • Distribution policy
Procurement	• Quantification of National needs (data capture of consumption, training on, equipment, inclusive process) • Funding allocation (gap analysis needs vs. allocation) • Development of procurement master plan (donor funded)/ procurement planning
Warehousing	• Inadequate Storage & service point facilities (minimal renovations • Financing • Equipment • Decentralization of warehousing & distribution (phase I: 3 regional depots)
Distribution	• Mixed distribution systems (Pull System) • Integration of distribution mechanisms (Cost analysis; financing) • Cold chain infrastructure (procurement, return system)
Use (Facility level)	• Development & Printing of IEC materials • MTCs • PV

Management Support	• Quality assurance
	• HR- No's, Skill mix, deployment (Training (in & pre) on commodity management, supervision, computer,PV,AMU,)
	• LMIS- (Integration of MIS; data capture
	  ○ Infrastructure (hardware & software-antivirus)
	  ○ Harmonization of systems
	  ○ Tools: quantity?/ manual & electronic (EDT/ ITT- include % of facilities to be covered)
	  ○ Training on tools & data for decision making
	• Information system
	  ○ Commodity availability; communication - feedback);
	  ○ ERP for KEMSA,MOMS,MoPHS (e-ordering system)
	  ○ HMIS data capture & reporting (to assist in quantification)
	  ○ Link LMU & KEMSA
	Supportive supervision :link to oversight, PP, District HMTs

<u>Intervention 3 Gap Analysis: H</u>orizontal and vertical referral and referral feedback mechanisms for public and non-public health service providers

Policies:	***Transport policy for the health sector*** No national transport policy that defines; the type and numbers of vehicles required for an effective and efficient transport system at the different levels of health service delivery, maintenance programme, safe and economical use of vehicles including ambulances and guidelines for vehicle replacement. No by-pass policy that regulates clients to report at levels appropriate for their condition resulting into inappropriate self referral to higher levels of care
Coordination	There is no coordination structure at the national and provincial levels that is responsible for the oversight of the implementation of the referral strategy
Quality assurance:	Lack of quality standards and performance monitoring tools for referral services affects the auditing of the referral system and development of continuing education for the referral service providers.
Finance	They are no policy guidelines on who is responsible for financing of the referral service and care received at the receiving facility
Implementation gaps	***Ineffective networking of the different levels*** Currently all health facilities in the sector are not working as a coordinated network. The linkages between different levels of the health system and between different providers of health services are not clear to the providers and the general public. ***Inadequate communication and transport systems*** Transfer of case or specimen is in most cases delayed. This is often due to lack of communication and transport facilities at the referral centre. Most facilities in the rural areas do not have means of communication to call for an ambulance or discuss a case or specimen with the higher level facility. Most health zones are short of ambulances. Most health facilities lack new technology for telehealth (telemedicine, e-health, e-mail). ***Ineffective referral and feedback information system*** A system of maintaining records and information is therefore mandatory. Unfortunately, there are no standardized tools that capture this type of data. These tools would include referral forms, referral registers, data collection and update forms, patient tracking forms, feedback forms and directory of services among others. ***Issues of financing*** Inadequate financing for operations and maintenance related to referral services. ***Centralised patient data base*** The lack of automated transmission of patient medical information from referring facility to the next level affects proper planning and execution of referral services however confidentiality of patient records is a big challenge which has to be addressed.

Intervention 4 Gap Analysis: Capacity for collation, analysis and use of Health Information at public and non-public facilities

HSS Component	Gap areas
Policy	Lack of HIS policy and legal Framework
Human resources	Inadequate personnel in absolute numbers and in skills The staffing level required for the implementation of the plan is 4310 HRIOs, 227 ICT officers, 221 statisticians and 16 health professionals. Only 11% of the total human resource requirements are employed. The most notable staffing gaps are in the cadre of Health Records & Information Officers (88.3% gap), ICT officers (96.6% gap) and statisticians (100% gap) Lack of focused training for the majority of HIS staff. Low staff morale
Data Systems, Infrastructure & Equipment	Weak linkages and feedback Lack of integration of data at all levels Inadequate working and storage space Inadequate hardware infrastructure
Data Quality Assurance	Inadequate supportive supervision
Finance	Inadequate Finances to support HIS activities Estimated cost of entire HIS Strategic Plan, (minus staffing) is over USD 25.3 million; only about 50% is available.
Coordination	Presence of many data collection systems with poor coordination Parallel information systems at disease, programme and health facility levels, from community to tertiary levels.

Intervention 5 Gap Analysis: Set up comprehensive community health services in areas with limited access and/or use of services

HSS Component	Gap areas
Staffing & Capacity	Besides professional health worker shortage; less than 10% of community health workers or community owned resource persons available. (22,500 / 255,000)
Financing	Less than 30% of needed funding for rollout of community strategy is available. Less than 10% community units connected to national or district financing system.

Implementation	Transport and communication Need for transport and communication equipment including bicycles, motorcycles for community workers to cover long distances especially in hard-to-reach areas. Operations management Need for management funds both at community and ministry (division of community health services) level Capacity building Less than 10% workers and communities trained and sensitized on community strategy.
Coverage	Only 2.25 million out of a targeted 16 million people are covered; only 450 out of targeted 3200 community units are functional.

SECTION 7: KNASP III TECHNICAL SUPPORT PLAN

The provision of technical support has been done with limited coordination. Partners tend to access or provide technical support based on immediate need. There has been no plan to guide technical support especially at a strategic level.

The Technical Support Plan for KNASP III was developed partly to address this issue of uncoordinated support as well as target technical support to unblock bottlenecks to implementation of the national response. The plan has identified the challenges that KNASP III is likely to face and the weaknesses in the service delivery systems and identified the technical support needs.

The technical support needs have been identified for each pillar. By addressing these needs, the performance in implementation of KNASP III will be improved.

This plan should be used by all partners to strategically position technical support to achieve specific outputs and contribute to specific outcomes under KNASP III. It should guide the allocation of resources, coordination, and harmonisation and alignment of technical support.

The plan is presented in two sub sections:

- Sub section I outlines all the bottlenecks identified under KNASP III and the technical support requirements
- Sub section II prioritises the technical support requirements to guide effective resources allocation

SUB SECTION I: KNASP III DETAILED TECHNICAL SUPPORT PLAN 2009-2013

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
Service Delivery Area Pillar 1 – Health Sector HIV Service Delivery										
1	Low perception of risk	Preparation of a BCC and character formation campaign that focuses on risk and general HIV knowledge by the population	1 a. Technical assistance on BCC and character formation strategies at NACC to help design and implement a national BCC and character formation campaigns focusing on risk and general knowledge of HIV	1A) Recruit Technical Assistance for 1 year to help a) review existing BCC and character formation activities b) Operationalize the BCC consortium c) define strategies pertaining to at-risk groups and individual risk perception d) assist in disseminating the BCC and character formation curriculum	BCC and character formation plan implemented	$300,000.00	$300,000.00			

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
2	CT sites are not MARP friendly	A) MSM: Elaborate strategy on delivering HIV services for MSMs B) SWs: Elaborate strategy on delivering HIV services to SWs C) Mapping fishing communities and CT centres at these villages see 14 and 16	2A) Consultant to elaborate strategy on delivering services to MSM 2B) Consultant to elaborate strategy on delivering services to SWs and protecting their children 2C) Identify and visit best practice programs 2D) Consultant to map fishermen's villages and develop action plan to set up CT centres at these villages	2A) 1) Recruit consultant for one month to help 2) define a global BCC strategy focusing on MSM services 3) develop an action plan 4) train focal persons in Action Plan implementation 2B)1) Recruit consultant for one month to help 2) define a global BCC strategy focusing on SW services 3) develop an action plan 4) train focal persons in Action Plan implementation 2C 1) contact DRH authorities at MOH 2) select members of delegation 3) organize logistics 2D) recruit consultant for two months to map sites, visit them and propose network of VCT centres at fishermen's villages	A) youth friendly CT activities intensify B) Strategy to organize services for MSMs defined C) peer-to-peer CSW program implemented D) CT sites operational at fishermen's villages	$72,000.00	$72,000.00			
3	Older persons (50+) not reached by testing services	Dissemination and implementation of national guidelines for HTC	3) Expand training of health personnel to increase manpower for testing at various levels	Support for training of trainers at regional level	Increased access to CT services for older Kenyans	$40,000.00	$40,000.00			
4	Pre and post counseling services need improvement in quality (need for accreditation)	survey to assess the quality of pre and post test counseling	Part of health facility survey	See "Health Facility Survey" HFS (see 30)	Improved quality of testing services	see HFS				

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
5	Insufficient integration of CT services at health providing units such as RH services, STI sites, MCH/IMCI clinics	Support to integrate CT services at health provider units	See "Health Facility Survey"	See "Health Facility Survey"(see 30)	CT services integrated at provider service delivery units	see HFS				
6	Stand alone testing centers insufficient	Deployment of CT sites to be analyzed as part of comprehensive health facility survey (see below)	see "Health Facility Survey"	see "Health Facility Survey"(see 30)	1) Map for new CT centers ready 2) Number of CT centers expanded	see HFS				
Service Delivery Area: Condom promotion and distribution										
7	Low uptake of female condoms	Survey on condom use, demand and distribution mechanisms	Review overall condom strategy and in particular segmentation to various subgroups	Recruit consultant to review the entire condom strategy and revise it	National condom strategy revised to focus on distribution mechanisms to reach all priority target groups	$20,000.00	$20,000.00			
8	Inadequate advocacy and promotion of condoms at the local level	see 7	see 7							
9	MARPs not effectively addressed	see 7	see 7							
10	Sexually active youth not effectively addressed	see 7	see 7							
Service Delivery Area: Prevention with positives										
11	Disclosure issues amongst discordant partners	Support for the promotion of couples testing as part of CT promotion campaign	see 1	see 1	increased number of people tested as couples					
Service delivery area: Youth services										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
12	HIV services are not youth-friendly	Capacity building at NASCOP to address youth issues and improve the provision of services to youth	Develop strategy to create youth-friendly corners embedded in MOH health facilities that offer counseling, testing, condom distribution, develop strategy to incorporate testing at existing youth centers; develop strategy to do CT at youth events (concerts, festivals , edutainment events)	12A) create youth services office at NASCOP; 12 B) Organize trips to other countries that have successful youth programs; 12C) develop operational plan for comprehensive youth services	HIV services for youth more youth-friendly	$150,000.00	$75,000.00	$75,000.00		
Service Delivery Area: Communication										
13	See 64	Strengthen NASCOP communications office as part of overall NASCOP reorganization	Broad review of NASCOP current operational structure and development of a NASCOP organizational development plan	Consultant to provide organizational development technical to NASCOP a) review of current structure b) consultations with NASCOP staff on administrative and technical bottlenecks hampering the operations of NASCOP c) annual retreat to use the MOST tool for NASCOP self-assessment d) develop an action plan for strengthening different level of operations of NASCOP e) follow-up on implementation of the plan	NASCOP reorganized and strengthened	$150,000.00	$75,000.00	$75,000.00		
Service Delivery Area: MARPS										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
14	HIV prevention clinical services for MARPS inadequate	14A) NASCOP needs comprehensive MARP service strategy to be developed in tandem with pillars 2 and 4 14B) mapping of SW areas. See 2 and 16	14A) Support for a "watchdog team" in Pillar 4 to monitor interventions on MARPs and other cross-cutting issues and a desk at NASCOP 14B) Consultant to assist in mapping protocol and the development of a comprehensive service strategy for MARPS 14 C) Mapping exercise to identify areas of SW concentration and their estimated number	14 A) MOH involves the "watchdog" team in setting up desk 14B) TOR for the desk developed 14C) desk established 14D) Mapping protocol developed 14E) survey staff for mapping trained 14F) Comprehensive cross-pillar MARP service delivery plan developed	Strategies to provide MARPS with accessible HIV services defined and implemented	$150,000.00	$75,000.00	$75,000.00		
Service Delivery Area: STI										
15	STI/CT services not integrated	Develop new STI training curriculum that integrates HSV2 in syndrome protocol as well as MARP health and newer treatment regimens; ;	1) Consultant to adjust STI curriculum , including drugs to be used 2) Support for training of trainers at pre service and in service context	1) Recruit consultant to revise curriculum, have it validated, and train trainers	1) Health personnel competent in the treatment of STIs 2) Appropriate drugs available for STI treatment	$50,000.00	$50,000.00			
16	Staff not trained on specific needs of various MARPS	Training of health personnel to a) encourage all STI patients to be tested for HIV b) to be sensitive to special MARP needs for STI treatment see 2 and 14								
17	Syndromic protocol does not include HSV2	see 15								

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
18	Limited STI care sites for truck drivers, migrants and refugees	18) develop STI treatment sites for underserved populations as part of HSS	see "Health Facility Survey"(see 30)	see "Health Facility Survey"	Increased access to STI treatment services by the population					
Service Delivery Area: STI Surveillance										
19	STI surveillance inadequate	Development of a comprehensive surveillance system including STIs	Consultant to develop protocol on health surveillance that includes STI surveillance, integrate reporting tools into routine HMIS and train personnel in the use of these tools	1) Recruit consultant 2) design of surveillance protocol 3) incorporate reporting tools into HMIS 4) training of trainers at the provincial level	STI surveillance system operational	$150,000.00	$50,000.00	$50,000.00	$50,000.00	
Service Delivery Area: Male circumcision										
20	Not in KNASP2	incorporate VMCC into KNASP 3	Dissemination of circumcision guidelines	"Health Facility Survey"(see 30); disseminate circumcision guidelines	Circumcision guidelines disseminated at health facilities	$25,000.00		$25,000.00		
Service Delivery Area: PEP										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
21	Information on PEP is poor	Support to strengthen entire PEP program by: 1) IEC on PEP 2) improved logistics of PEP drugs 3) training of health personnel and law enforcement officers	21A) Develop posters on PEP measures to be placed at all health facilities 21B) Train personnel on PEP, particularly management of rape victims 21C) Train law enforcement officers on management of rape victims	21A) Recruit marketing firm to design and pre-test a PEP poster and PEP brochures 21B) training of trainers on PEP and management of rape cases (health and law enforcement)	More appropriate case management of Post exposure cases , including rape through adequate PEP measures	$140,000.00	$70,000.00	$70,000.00		
22	Reporting on exposure is poor									
23	Inappropriate attitude toward rape and sexual violence									
24	Availability of PEP drugs at the facility level is erratic									
25	Limited training of health personnel on PEP									
Service Delivery Area: Injection safety										
26	Too many inappropriate injections	IEC campaign directed at general public (client demand), prescribers to reduce demand for injections	Finance IEC campaign	Recruit marketing firm to design target specific campaign to discourage inappropriate injections	Decrease in unneeded injections	$120,000.00	$60,000.00	$60,000.00		
27	Insufficient injection equipment leads to re-utilization of syringes and needles	Review national treatment and procurement policies for injections	On-going support to a national commission on injection safety, PEP and waste management (see below)	Support to national commission on injection safety to review treatment protocols	The number of needle stick injuries is reduced	$600,000.00	$300,000.00	$300,000.00		

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
28	Limited number of blood donors	Development of a marketing strategy to recruit blood donors B) extend mobile blood collection	Recruit marketing firm to design campaign for blood drives	28A) survey of current blood donors to develop profile 28B) identify most likely targets for campaign 28C) develop blood donor messages 28D) pre test messages 28E) Launch campaign 28) monitor its effectiveness	The number of volunteer blood donors has increased	$250,000.00	$250,000.00			
Service Delivery Area: Waste management										
29	Not present in KNASP 2	Assistance to implement phlebotomy safety, Injection Safety and medical waste Mgt	Comprehensive injection safety and waste mgt plan assessed periodically	Annual facility-based progress review on injection safety and waste mgt.	Coherent medical waste management plan implemented	$50,000.00	$25,000.00	$25,000.00		
Service Delivery Area: PMTCT										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
30	Lack of adequate staffing of PMTCT facilities	Detailed PMTCT assessment as part of health facility assessment	National Health Facility Survey	Hire firm to conduct comprehensive Health Facility Survey 30A) Create PMTCT cluster involving all stakeholders to insert PMTCT assessment into overall health facility assessment 30B) conduct health facility survey that includes PMTCT module 30C) develop updated PMTCT strategy based on results of the assessment	Comprehensive data on capacities of each health facility in the country including capacity to provide PMTCT services	$750,000.00	$250,000.00	$250,000.00	$250,000.00	
31	Distribution of PMTCT sites inadequate	Detailed PMTCT assessment (supply and demand for PMTCT services) as part of Health Facility Survey (above) including the strengthening of community-based services								
32	PMTCT services not sufficiently integrated at sites that offer ANC services									
33	Pregnant women who do not access health facilities are being missed									
34	Low community understanding of PMTCT									
35	Inadequate male perception of PMTCT services									
36	Referrals of HIV positive pregnant women and children remains a challenge									
37	Scale up of more efficacious regimens remains a challenge									
Service Delivery Area: ART										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
38	Shortage of skilled health care workers and inadequate care by existing HCW	Operationalization of HR plan	Identification of resources for new staff, retraining at pre service and in service, deployment requirements	Create HR Team in Pillar 4 and have a HR focal point at NACC	HR plan operationalized	$30,000.00		$30,000.00		
39	High staff turnover	Operationalization of HR plan	see 38							
40	New districts not targeted	see Comprehensive Health Facility Survey (30)	See "Health Facility Survey"(see 30)	See "Health Facility Survey"(see 30)	New districts provided with ARV sites	see HFS				
41	Difficulty in dealing with discordant couples	see 11	see 11	see 11	see 11	see 11				
42	Weakness in monitoring treatment outcomes adherence plans inadequate	Development of comprehensive strategy for patient follow-up including adherence plan, biologic follow-up, resistance monitoring and electronic medical records and routine medical care	Identify organization capable of providing support in all areas of ART patient follow-up	42A)develop TORs for organization 42B) analyze bids 42C) select organization 42D) assess current follow-up system components 42E) develop action plan for comprehensive follow-up 42 F) purchase equipment and software 42 G) train personnel	Follow-up of patients on ARV improved ARV resistance detected Cohort-based data on drop outs and survival available	$850,000.00	$283,333.33	$283,333.33	$283,333.33	
43	Use of different data tools by different partners	see 42	see 42	see 42						
44	Lack of adequate infrastructure in many districts	see ``Health Facility Survey" (see 30)	see 30	see 30	see 30	see 30				
45	Double registration of patients	see 42	see 42	see 42						

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
46	Poor peadiatric targeting	see 30	see 30	see 30						
47	Quality of care not uniform at all ARV sites	see 30	see 30	see 30						
48	Limited access to infant HIV diagnosis by PCR	Strengthen the capacity to diagnose infant HIV	see 30	see 30	Improved access to infant HIV testing	see 30				
49	Limited access to CD4 testing, and other routine follow-up tests (blood chemistry, hematology etc.)	Plan to systematically strengthen laboratories at ARV centers	see 42	see 42	see 42	see 42				
50	50) Inadequate supervision of laboratories to ensure quality	Development and implementation of a QA/QC plan for laboratories involved in the biological follow-up of HIV patients	Develop plan to set up laboratory networks and national and regional supervisory plans	Resident advisor (4 years) to assess capacity of National Reference laboratory to supervise peripheral labs and provide on-going support	Improved supervision of laboratory network	$400,000.00	$100,000.00	$100,000.00	$100,000.00	$100,000.00
Service Delivery Area: Surveillance of resistance										
51	Limited capacity to detect emergence of resistance	Implementation of a resistance surveillance system	Technical as to set up a resistance surveillance system and regional integration into an international surveillance network, as part of improved follow-up system for patients on ART (see 42)	Recruit national expert responsible for all surveillance issues	increased capacity by NASCOP to detect resistance to ARVs	see 42				
Service Delivery Area: Opportunistic infections										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
52	Inadequate M&E system for OIs	Incorporate OI tools in the revised M&E system	see 62	see 62	OI tools and indicators incorporated into M&E system	see 62				
Service Delivery Area: HIV/TB										
53	HIV ART care not adequately integrated in TB clinics 53B) Screening HIV patients for TB not adequate	Development of a comprehensive HIV-TB co-infection management protocol and train HV and TB staff in protocols and procedures	Consultant to design protocol for case mgt of TB patients seen at TB clinics to detect co-infection and HIV patents seen at health care settings to detect TB; 2) train HIV and TB staff in protocols, procedures, prophylaxis and treatment regimen in cases of co-infection	53 A) Review by consultant of existing practices (QA/QC) 53 B) Consultant develops adapted protocols and procedures for TB clinics and HIV sites 53C) consultants trains trainers in co-infection mgt.	All TB patients seen at TB clinics tested for HIV and receive appropriate prophylaxis and/ or treatment All HIV patients screened for TB co-infection	$75,000.00	$75,000.00			
Care and support										
Service Delivery Area: PLHIV support										
54	Inadequate HR capacity to meet nutritional needs of PLWHA Nutrition and HIV guidelines needed	Capacity building in nutrition support for PLHIV	54A) dissemination and implementation of nutrition and HIV guidelines for community and training curriculum 54B) training of health personnel in pre service and in service settings	Recruit consultant to design plans to disseminate nutrition guidelines and train nutritionists in HIV support	Nutrition and HIV guidelines disseminated HCW trained in nutrition support for PLHA patients	$50,000.00	$50,000.00			
55	Insufficient service delivery points to provide nutrition services	see 54	see 54							

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
56	Inadequate access to basic preventive services for PLWHA (malaria, sanitation, access to clean water)	see 42	see 42	see 42	Improved access by PLHIV to basic preventive services					
Health systems strengthening										
Service Delivery Area: Health care facility strengthening										
57	Insufficient equipment and supplies	Health facility survey	Comprehensive health facility survey to identify needs in infrastructure, equipment, HR (see 42)	Hire firm to conduct comprehensive health facility survey	Detailed procurement plan developed for equipment and supplies of health facilities	see HFS				
Service Delivery Area: Quality assurance and quality improvement										
58	Inadequate support of satellite sites	Implementation of IMAAI strategy	Resident advisor to assist in the implementation of IMAAI	Analysis of results of Health Facility survey; designation of centers of excellence to provide QA QC and supervision for satellite centers	Improved supervision of satellite sites leads to improved quality of services	$400,000.00	$133,333.33	$133,333.33	$133,333.33	
Service Delivery Area: Decentralisation										
59	Inadequate support of satellite sites	Implementation of IMAAI strategy								
60	Human resources insufficient and inadequately deployed	Operationalize human resource plan	Development of specific sub-proposal addressing issues of manpower requirements at HIV service delivery facility and at the community-level	Consultant to review current human resource plan and develop proposal to Operationalize the plan	Detailed costed plan to fully staff the HIV program is available	$120,000.00	$120,000.00			
Service Delivery Area: Infrastructure										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
61	Inadequate infrastructure	see Health Facility Survey (30)	see HFS	see HFS	Construction and renovation plan for health facilities developed	see HFS				
Service Delivery Area: M&E										
62	M&E system harmonization of tools; capacity for data analysis; data transfer; new technology, modeling for service needs	Support to develop unified M&E system	Capacity building of entire data collection system: development of harmonized data collection instruments, data transfer electronic technology (internet), data quality check, data analysis, modeling and feedback to periphery	On-going organizational development assistance to NACC & NASCOP to coordinate activities designed to harmonize M&E tools, disaggregate data by age and sex and by groups, to improve data transfer, to increase the capacity of NACC & NASCOP for data analysis, to introduce new technologies into the system and to facilitate modeling for service needs	Unified M&E system provides comprehensive information on HIV service delivery accessible to all stakeholders and is used for decision-making	$250,000.00	$83,333.33	$83,333.33	$83,333.33	
Service Delivery Area: HIV/STI surveillance										
63	Surveillance not institutionalized	see 19	see 19	see 19	Improved surveillance of HIV	see 19				
Service Delivery Area: Management and coordination										
64	Strengthening the technical competence of NASCOP to coordinate the health sector response to HIV	Review of NASCOP structure, staffing and functions OD for planning, policy development and implementation	see 13							
Pillar 2 – Sectoral HIV mainstreaming										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
65	ACUs inadequately staffed and trained	Assessment of ACUs across various Ministries	Develop standardized guidelines for ACU staffing, TORs	Consultant to review ACUs and develop standardized guidelines Consultants assigned to various ministries to help each ACU develop an action plan	ACU TORS better defined	$50,000.00	$50,000.00			
66	Inadequate skills in dealing with HIV and AIDS in general and PLHIV and in particular	Sensitization of ACU staff to HIV issues	Training curriculum and provision of training to ACU staff on HIV	Recruit training institution to develop curriculum and train ACU staff	ACU staff attitude toward HIV and PLHIV improved	$50,000.00	$50,000.00			
67	ACU staff not adequately positioned to coordinate HIV work within their ministries	see 65	see 65	see 65	see 65	see 65				
Service Delivery Area: Mobilisation										
68	Limited buy-in and ownership by non-state actors	Expand notion of workplace to include all formal sector activities (unions, churches, professional associations, cooperatives, women's organizations etc.)	census of all organizations with potential to be involved in mainstreaming: secondary schools, universities, churches, workers unions, farmers associations, fishermen's associations, women's organizations etc. Design plan to build the capacity of these organizations in HIV work	A) Task a NACC staff to develop listing of organizations B) Recruit consultant to develop capacity building plan for various sectoral entities C) TOT in capacity building	various sectoral entities buy into the KNASP and have an increased capacity to implement HIV programs	$120,000.00	$120,000.00			
Service Delivery Area: Workplace policy										
69	Number of firms that need to implement workplace policy is unknown	contact chambers of commerce and employer organizations to determine number of firms in the country	none							

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
70	HIV workplace policies not widely implemented	develop "catalyst" project to encourage firms to implement HIV workplace policies.	identify international firm with expertise in HIV workplace policy to provide support and services to private firms	firm identified and contracted workshop for employers organization of service delivery activities (testing) capacity building of firms	HIV workplace policies widely implemented	$850,000.00	$212,500.00	$212,500.00	$212,500.00	$212,500.00
Service Delivery Area: Community outreach and schools										
71	Low risk perception	refer to bottleneck 1.	see 1	see 1	see 1					
72	Inadequate support for the development and/or strengthening of grassroots community organizations	Strengthening of grassroots community organizations	Disseminate best practices in community mobilization	Survey to document and assess best practices in various community mobilization strategies used in Kenya; organize national conference on community mobilization TOT to disseminate best practices	Best practices in community mobilization adopted by NGOs and CSOs	$250,000.00		$250,000.00		
73	BCC and character formation activities not well coordinated	Survey to identify who does what in terms of BCC and charcater formation at the National and sub national level	Hire firm to conduct BCC and character formation audit of activities of NGOs, CSOs etc.	Recruit firm Develop protocol Do BCC and character formation activities census Assess effectiveness and impact of BCC and character formation activities (Use rapid epidemiologic assessment tool such as LQAS to measure key BCC and character formations indicators such as knowledge of HIV (5 UNAIDS knowledge points)	Appropriate BCC and character formation messages segmented to different target audiences	$150,000.00	$150,000.00			

74	Lack of trained personnel on BCC at the community level	Assessment of role of various community members in transmitting HIV-relevant messages and their needs for training (pastors, priests, school teachers, radio station disc jockeys, artists, music bands, athletes etc.)	see 73	see 73						
75	BCC and character formation messaging inadequate	Strategy to be developed to utilize various sectors more effectively to pass HIV messages to their constituencies (farmers, school teachers and students, athletes etc.), and to better tailor BCC and character formation messages to their target	see 73	see 73						
76	Insufficient use of peer to peer mechanisms to reach various target audiences	see 73	see 73	see 73						
77	Current BCC programs not evaluated for effectiveness	Evaluation of various BCC approaches used by CSOs and NGOS to ascertain content and impact	see 74							
Service Delivery Area: Care and support of the chronically ill										
78	Inadequate capacity at the community level in HCBC and palliative care	Document HCBC activities, including OVC support and community mobilization activities	National conference on community care to review various survey results and develop action plan	Consultant to do document review, synthesis and presentation at national conference; design action plan on community care	Plan for standardized community services package in home base care and palliative care	$50,000.00	$25,000.00	$25,000.00		

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
79	Current M&E system does not link community based care networks and health facilities	see 62	see 62	see 62	Integrated M&E system provides data from all levels of service delivery	see 62				
80	Insufficient capacity of NASCOP to supervise HCBC, OVC centrally and peripherally	Review of current NASCOP structures and need for expansion see 64	Organizational development assistance to NASCOP centrally and peripherally (see 13)	see 13	see 13					
81	PLHIV organizations weak	Strengthening of PLHIV organizations	Organizational development support to PLHA organizations in terms of capacity building, organization, action	contract to entity to provide support to PLHA organizations in organizational development and expansion	PLHIV organizations strengthened and have increased capacity for participation in planning, implementing and evaluating services for PLHIV	$250,000.00		$125,000.00	$125,000.00	
Service Delivery Area: OVC										
82	Inadequate reporting of activities in support of OVCs to NACC	see 78	see 78	see 78	see 78	see 78				
83	OVC activities inadequately supervised	Creation of joint OVC cross-pillar task force; strengthen OVC office at Ministry of Gender, Children and Social Development	OD support to Ministry of Gender, Children and Social Development	Resident Advisor to provide OD support to Ministry of Gender, Children and Social Development		$50,000.00	$25,000.00	$25,000.00		

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
84	Norms and standards for OVC programs inadequate	Development of comprehensive package of services that includes health care services, protection services, educational services, psychosocial support, economic support to caretakers and train requisite personnel	Support to OVC "cluster" across pillars	see 79	OVC care norms and standards disseminated	$150,000.00	$75,000.00	$75,000.00		
85	M&E system does not capture all OVC activities	Incorporate OVC indicators in M&E system (62)	see M&E systems strengthening (62)	see 62	see 62	see 62				
86	Inadequate capacity at community level to provide OVC services	see 78	see 78	see 78	see 78	see 78				
Service Delivery Area: Stigma reduction										
87	Stigma reduction messages inadequate	see 73	see 73	see 73	see 73	see 73				
Service Delivery Area: Empowerment										
88	Weak community organizations	Document and assess various community mobilization strategies: organize national conference on community mobilization	see 72	see 72	see 72	see 72				
Pillar 4 – Governance and Strategic Information										
Service Delivery Area: National coordination of HIV programmes										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
89	Insufficient capacity for coordination of the national HIV program at the central level	Strengthen the capacity of NACC to coordinate the national HIV program at the central level	NACC capacity building	A. Development of an operational coordination strategy that will allow NACC to: 1. Assess the content of defined HIV service packages at the sectoral level as implemented by independent provider organizations (IPOs: Ministries, civil society organizations); NACC to: 2.Define and transmit to these IPOs indicators required by the Strategic information system to guide policy and program orientation that each IPO will be reporting on and be held accountable for; 3.Set up a strategic information data collection, transfer and analysis system 4.Stengthen its capacity for data analysis B. Assist in setting–up an appropriate structure to implement this coordination strategy (manpower, logistics, MIS)	NACC capacity for coordination at the central level strengthened	$175,000.00	$58,333.33	$58,333.33	$58,333.33	
Service Delivery Area: Local level coordination										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
90	Reduced effectiveness of decentralized community-based coordination structures	Improve the effectiveness of decentralized community-based coordination structures	Analyze the operation of CACCs, DTCs, FOs	Review current tasks of various NACC decentralized structures (CACCs, DTCs, FO) and develop strategy to streamline their activities and mandates (see pillar 2)	NACC capacity for coordination at the local level strengthened	$75,000.00		$75,000.00		
Service Delivery Area: Coordination of gender programmes										
91	Inadequate capacity by NACC to develop, implement, evaluate and coordinate gender-sensitive HIV and AIDS programs	Strengthen the capacity of NACC to develop, implement, evaluate and coordinate gender-sensitive HIV and AIDS programs see 99	Capacity building of staff at NACC and key gender program officers at Ministries and civil society organizations	1) 6-12 month training sessions for key (7) gender program officers supporting ACUs 2) training of national gender units in 8 implementing agencies that have national coverage structures	The capacity of NACC to develop, implement, evaluate and coordinate gender-sensitive HIV and AIDS programs is strengthened					
Service Delivery Area: Research										
92	Limited surveys and research on various communities as well as on mapping the trends of the HIV epidemic,	Development of a research agenda	Support to develop a research agenda focusing on conducting situational analyses of the populations identified at risk in the MOT study (consensus workshops, consultant time, follow-up)	Recruit consultant Review of existing and planned research activities Consensus workshops with stakeholders Development and follow-up of a research agenda	Developed research agenda guides investments in research activities	$120,000.00	$120,000.00			
93	PWD not included specifically in HIV programming and service delivery	Facility assessment for disability accessibility	see Health Facility Survey (30)	see 30	see 30	see 30				

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
94	Mitigation guidelines that address PWD not developed	Development of mitigation guidelines	Consensus workshop to develop guidelines; dissemination of guidelines	Recruit consultant to define guideline, convene workshop, finalize guideline, develop dissemination plan and assist in dissemination	Mitigation guidelines for PWD developed and disseminated	$90,000.00		$45,000.00	$45,000.00	
Service Delivery Area: Human rights										
95	Protection mechanisms for female OVC to prevent abuse lacking	strengthen traditional community mechanism to protect OVCs and widows	Review laws; strengthen community capacity to support OVC and widows	Recruit consultant to review existing laws; design program to disseminate information on OVC and widow rights and devise method of implementation of program	Community-based protection mechanisms for OVC and widows strengthened	$150,000.00			$150,000.00	
96	Protection mechanisms for property rights of widows inadequate									
97	Accepting attitudes towards PLWHA low among general population and care providers	see 75	see 75	see 75	see 75	see 75				
Service Delivery Area: Gender										
98	Legal and policy framework creating an enabling environment6 for gender mainstreaming inadequate	Strengthen legal office at NACC	Strengthen NACC legal and gender offices; additional training on gender; support to women's groups, including HIV+ women`s organizations;	1) strengthen gender unit at NACC 2) organize sensitizing sessions for, and high level dialogue with, decision makers 3) train ACU staff on gender issues 4)Convene HIV+ women's groups and women advocates working on gender equality and HIV and AIDS to prioritize issues and develop their vision and agenda.5) Conduct advocacy training and skills building sessions,	Senior decision makers more aware of gender issues; Gender unit at NACC has increased capacity to monitor integration of gender themes in HIV	$195,000.00	$97,500.00	$97,500.00		
99	Inadequate capacity by NACC to develop, implement, evaluate and coordinate gender-sensitive HIV and AIDS programs	1) organization of sensitizing sessions on gender for high level policy makers and decision makers 2) organization of training sessions for ACU members and service delivery providers on gender issues								

100	Inadequate technical capacity to coordinate and implement gender mainstreaming	support for strengthening of gender unit at NACC		for HIV+ women's groups 5) organize short-term training sessions for key (7) gender program officers supporting ACUs and for training of national gender units in 8 implementing agencies that have national coverage structures 7) develop support program to strengthen women's organizations as channels for transmitting information and referrals to young girls and women	programming across sectors; Communities develop effective programs to reduce gender violence					
101	Inadequate access by young girls and women to appropriate information on HIV and AIDS	support to strengthen women's organizations as channels for transmitting information and referrals	see 72							
102	Inadequate tools to assess whether gender issues have been incorporated in programs and funding mechanism	none								
103	Inadequate national programming on gender violence in relation to HIV	Development of national action plan to deal with gender violence in relation to HIV and AIDS	Strategy and activities to sensitize community leaders on gender violence Development of local community mechanisms to reduce gender violence	Capacity building of traditional leaders civil society and provincial administration to initiate dialogue within their communities on gender violence National baseline survey on SGBV National survey related to stigma						
Service Delivery Area: MARPS										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
104	MARPS insufficiently involved in the design, development and implementation of HIV services	Capacity building of focal persons	see 2	see 2	see 2	see 2				
Service Delivery Area: Systems strengthening										
105	Services not completely accessible to the population	see 30	see 30	see 30	see 30	see 30				
106	Human resources insufficient and inadequately deployed	see 60	see 60	see 60	see 60	see 60				
107	Commodity mgt inadequate to prevent stock-outs	Capacity-building of the MOH to procure, stock and distribute commodities and do forecasting	Analysis of competing CSM systems; review their efficiency and ways to unify the system and introduce electronic CSM at the central and facility level	Recruit consultant to: 1) Carry out management situational analysis 2) Develop comprehensive strategy 3) Develop medium to long term procurement plan 4) review options for an electronic commodity mgt system at the central and peripheral levels and make recommendations on what system to adopt	Efficient CSM avoids stock-out at the service delivery level	$50,000.00	$50,000.00			
108	M&E system does not capture all HIV activities	see 62	see 62	see 62						
109	Available funds not disbursed	develop mechanism to facilitate fund disbursement	1) identification of disbursement bottlenecks 2) design procedures to facilitate fund disbursement	Hire financial firm to do a comprehensive review of mechanism for fund disbursement and to develop procedures to streamline fund disbursements	Disbursement mechanisms streamlined	$75,000.00	$75,000.00			
Service Delivery Area: Comprehensive review of KNASP III										

No.	Bottlenecks	Technical support needed	Priority TS interventions	Actions/activities	Anticipated result	Estimated cost US dollars	Year 1	Year 2	Year 3	Year 4
		TA for JAPR, MTR				$250,000.00	$62,500.00	$62,500.00	$62,500.00	$62,500.00
Service Delivery Area: TSF follow up										
		Technical Assistance at NACC to follow-up on TSP implementation	Follow-up and evaluation of TSP activities	Collect and analyze activity reports and deliverables		$160,000.00	$40,000.00	$40,000.00	$40,000.00	$40,000.00
				Recruit special focal point at NACC to follow-up TSP activities						
	Total cost					**$8,502,000.00**	**$3,767,833**	**2,725,833**	**1,593,333**	**$415,000**

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Pillar 1 – Health Sector HIV Service Delivery										
Health sector Service delivery (HLO 2.2, 2.3, 2.4, 3.3, 4.1)	3, 4, 5, 6, 15, 16, 17, 18, 30, 31, 32, 33, 34, 35, 36, 37, 40, 41, 42, 44, 46, 47, 48, 53, 57, 58, 59, 61, 93, 105	Insufficient access by the population to facility-based clinical HIV prevention and treatment services	Health facility assessment and operational plan to correct deficiencies	1) collect and analyze data from each health facility; 2) disseminate results; 3) develop corrective action plan	PEPFAR (SA), NASCOP (CL)	Comprehensive data on capacities of each health facility in the country including capacity to provide PMTCT services	650000			
Specific services: ART (HLO 3.1, 7.2)	42,47, 48, 49, 50, 51	Follow-up of patients on ART is inadequate: adherence, biological follow-up (lab) , resistance surveillance decentralized care (IMAAI strategy)	Development and implementation of a comprehensive strategy for patient follow-up	1) recruit firm or NGO to coordinate all individual elements of technical support for patient follow-up; 2) carry out an assessment of factors influencing adherence among adults, adolescents and children; assess paediatric ART issues; 3) develop curriculum for second line ARVs 4) develop specific action plan for each area of follow-up 5) train health personnel on the use of second line ARVS	PEPFAR (SA), NASCOP (CL)	Optimum follow-up of patients on ART reduces drop-out rate and increase the survival of AIDS patients	283333.3333	283333.3333	283333.3333	

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Specific services: youth (HLO 2.1)	12	HIV-services are not youth-friendly	Develop strategy to create youth-friendly corners embedded in MOH health facilities that offer counseling, testing, condom distribution, develop strategy to incorporate testing at existing youth centers; develop strategy to do CT at youth events (concerts, festivals , edutainment events)	12A) Create youth services desk at NASCOP; 12 B) Identify and visit best practice/ model youth programs; 12C) develop operational plan for comprehensive youth services	UNFPA (SA), NASCOP (CL)	HIV services for youth more youth-friendly	75000	75000		
Specific services: MARPS (HLO 2.2, 6.2)	2, 12, 14, 104	Services offered at facilities are not MARP-friendly	Observational trips (youth, MSM, SW programs); segmented consultations to develop approaches to service delivery for each MARP group	Identify and visit best practice/model programs; recruit consultants for segmented strategy development specific to each MARP group	Global Fund (SA), NASCOP (CL)	MARP friendly services at all HIV service delivery facilities; MARP run service centers at selected locations	75000	75000		

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
HSS Human Resources (HLO 3.1, 4.3 outcome 4.0)	38, 39,60, 106	Human resources insufficient and inadequately deployed	Development of specific sub-proposal addressing issues of manpower requirements at HIV service delivery facility and at the community-level	Consultant to review current human resource plan and develop proposal to Operationalize the plan	World bank (SA) NACC (CL)	Detailed plan to fully staff the HIV program is available	120000			
Monitoring and evaluation (HLO 7.2)	19, 43, 45, 52, 62, 63, 79, 85, 108	Multiple M&E systems do not capture adequately all HIV service delivery activities	Strengthen the capacity of NASCOP to collect and analyze data and to make evidence-based decisions	On-going organizational development assistance to NASCOP to coordinate activities designed to harmonize M&E tools, disaggregate data by age and sex and by groups, to improve data transfer, to increase the capacity of NASCOP for data analysis, to introduce new technologies into the system and to facilitate modeling for service needs	PEPFAR	Unified M&E system provides comprehensive information on HIV service delivery accessible to all stakeholders and is used for decision-making	83333.33333	83333.33333	83333.33333	

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Commodity Supply Management (CSM) (HLO 4.2)	107	Inefficient Commodity Supply and Management System; multiple distribution systems	Analysis of competing CSM systems; review their efficiency and ways to unify the system and introduce electronic CSM at the central and facility level	Recruit consultant to: 1) Carry out management situational analysis 2) Develop comprehensive strategy 3) Develop medium to long term procurement plan 4) review options for an electronic commodity mgt system at the central and peripheral levels and make recommendations on what system to adopt	PEPFAR (SA), NASCOP (CL)	Efficient CSM avoids stock-out at the service delivery level	50000			

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Coordination of health services (outcome 4.0)	13, 64, 80	Insufficient capacity of NASCOP for HIV service oversight at the national and local level	Broad review of NASCOP current operational structure and development of a NASCOP organizational development plan	Consultant to provide organizational development technical to NASCOP a) review of current structure b) consultations with NASCOP staff on administrative and technical bottlenecks hampering the operations of NASCOP c) annual retreat to use the MOST tool for NASCOP self-assessment d) develop an action plan for strengthening different level of operations of NASCOP f) follow-up on implementation of the plan	PEPFAR (SA), NASCOP (CL)	The oversight of NASCOP on HIV services delivered by the health sector is strengthened	150000	150000		
Pillar 2 – Sectoral HIV mainstreaming										
ACUs (outcome 5.0)	65, 66, 67	ACU staff not adequately positioned to coordinate HIV work within their ministries	Assess current ACU operations, develop and implement restructuring plan	Develop standardized guidelines for ACU staffing, TORs, and assist each Ministry to strengthen its ACU and develop a sectoral action plan	Global Fund (SA), NACC (CL)	Improved coordination of mainstreaming activities in the public sector by ACUs		120000		

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Mainstreaming (outcome 5.0)	69, 70	Insufficient implementation of mainstreaming HIV activities by civil society organizations	Identification of key national and regional organizations; assess current activities and capacity in HIV and AIDS; design operational plan to increase these capacities	Census/mapping of all organizations with potential to be involved in mainstreaming: secondary schools, universities, churches, labour unions, farmers associations, fishermen's associations, women's organizations etc. and design plan to build the capacity of these organizations in HIV work. Design plan for improving access to services by the constituencies of these organizations	UNAIDS (SA), NACC (CL)	Civil society organizations formally engaged in the fight against HIV and AIDS		95000		
Pillar 3 – Community-Based HIV Service and Interventions										
Community mobilization (HLO 6.1)	72,81, 88, 68	Inadequate support for the development and/or strengthening of grassroots community organizations to facilitate community mobilization	Strengthening of community-based organizations for advocacy, and implication in HIV program development, implementation and evaluation	1)Survey to document and assess best practices in various community mobilization strategies used in Kenya; 2)organize national conference on community mobilization 3) training in advocacy 4) organizational development support	Global Fund (SA)	Community organizations have an organized structure (bylaws, officers), management systems and capacity for advocacy and for managing projects on an accountable basis,		425000		

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Community HIV competence, knowledge (HLO 2.1)	71, 73, 75, 76, 77	Low perception of risk of being infected with HIV in the general population	Identify various channels for BCC and character formation (mass media, face to face communication, edutainment events etc.) and develop segmented communication strategies for various sub-groups of the population (couples, MARPS, youth etc.).	Preparation of a BCC and character formation campaign that focuses on risk and general HIV knowledge by the population and development and pre-test of segmented messages. Design and implement awareness programmers with basic information on ART services, available options, drug resistance, side effects etc. to enable them make informed choices)	Global Fund (SA), NACC (CL)	Specific channels for BCC are mobilized and BCC campaign is implemented Community becomes more ART literate		150000		

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Community-based services (HCBC, OVC, widows, widowers) (HLO 6.2)	54, 55, 74, 78, 84, 86, 94	Inadequate capacity at the community level in HCBC, palliative care and support to OVCs, widows and widowers	Capacity-building of communities in HCBC, OVC and care of people affected by HIV and AIDS	Document HCBC activities, including OVC support and community mobilization activities, including existing community coping strategies; Baseline survey on older OVCs and child headed households; National conference on community care to review various survey results and develop action plan to strengthen community capacity to provide care and support services	DIFID (SA), NACC (CL)	Community structures have increased capacity to provide palliative care and support services		250000		

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Pillar 4 – Governance and Strategic Information										
National coordination (outcome 7.0)	81, 99, 100, 89	Insufficient capacity for coordination of the national HIV program at the central level	NACC capacity building	A. Development of an operational coordination strategy that will allow NACC to: 1.Assess the content of defined HIV service packages at the sectoral level as implemented by independent provider organizations (IPOs: Ministries, civil society organizations); 2) Define and transmit to these IPOs indicators required by the Strategic information system to guide policy and program orientation that each IPO will be reporting on and be held accountable for. 3.Set up a strategic information data collection, transfer and analysis system B. Assist in setting–up an appropriate structure to implement this coordination strategy (manpower, logistics, MIS)	NASTAD (SA) NACC (CL)	NACC capacity for coordination at the central level strengthened	58333	58333	58333	

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Local coordination (outcome 6.0)	90	Reduced effectiveness of decentralized community-based coordination structures	Capacity building of entities responsible for local coordination	Review current tasks of various NACC decentralized structures (CACCs, DTCs, FO) and develop strategy to streamline their activities and mandates	Global Fund (SA) NACC (CL)	NACC capacity for coordination at the local level strengthened		75000		
BCC (HLO 2.1)	73	BCC and character formation activities not well coordinated	Hire firm to conduct BCC and character formation audit of activities of NGOs, CSOs etc.	Recruit firm Develop protocol Do BCC and character formation activities census Assess effectiveness and impact of BCC and character formation activities (Use rapid epidemiologic assessment tool such as LQAS to measure key BCC indicators such as knowledge of HIV (5 UNAIDS knowledge points)	DFID (SA) NACC (CL)	Appropriate BCC and character formation messages segmented to different target audiences	150000			

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Research (HLO 7.2)	92	Limited surveys and research on various communities as well as on mapping the trends of the HIV epidemic	Support to develop a research agenda focusing on conducting situational analyses of the populations identified at risk in the MOT study (consensus workshops, consultant time, follow-up)	Recruit consultant Review of existing and planned research activities Consensus workshops with stakeholders Development and follow-up of a research agenda	PEPFAR (SA) NACC (CL)	Developed research agenda guides investments in research activities			120000	

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Human rights (HLO 5.3)	95, 96, 101	Human rights insufficiently mainstreamed in HIV programs	Capacity building on human rightist issues at the central, local, institutional and organizational levels	a) Review the curriculum for HCWs to ensure inclusion of legal, treatment and reproductive rights issues. b) Finalize development of HIV and AIDS Human Rights Guidelines. c) Carry out a consultative workshop of all major stakeholders in the Human Rights Sector on this and other indicators. d) Implementation of the recommendations of the Consultative workshop. e) Finalize development of HIV and AIDS Human Rights Guidelines f) Develop IEC materials. g) Disseminate the Guidelines	World Bank (SA), NACC (CL)	Human rights mainstreamed into HIV programs		150000		

Service delivery area	Bottleneck number	Bottlenecks	Priority TS interventions	Actions/activities	Supporting agency and Client	Anticipated result	Year 1	Year 2	Year 3	Year 4
Gender (HLO 5.3)	98, 99, 101	Gender issues insufficiently mainstreamed in HIV programs	Capacity building on gender issues at the central, local, institutional and organizational levels	1) Strengthen gender unit at NACC 2) Organize sensitizing sessions for, and high level dialogue with, decision makers 3) Train ACU staff on gender issues 4) Convene HIV+ women's groups and women advocates working on gender equality and HIV and AIDS to prioritize issues and develop their vision and agenda. 5) Conduct advocacy training and skills building sessions, for HIV+ women's groups 6) organize short-term training sessions for key 7) gender program officers supporting ACUs and for training of national gender units in 8 implementing agencies that have national coverage structures 8) develop support program to strengthen women's organizations as channels for transmitting information and referrals to young girls and women	UNIFEM (SA) NACC (CL)	Gender issues mainstreamed into HIV programs	97500	97500		

GIPA (outcome 6.0)	97	Insufficient involvement of PLHIV in the planning, implementation and evaluation of HIV programs	Identification of key national and regional PLHIV organizations; assess current activities and capacity in HIV and AIDS; design and implement operational plan to increase these capacities	Firm to be hired to strengthen the capacity of PLHIV organizations in terms of policies and procedures, administration and financial mgt, advocacy and coordination of service delivery activities	UNFPA (SA) NACC (CL)	PLHIV organizations strengthened in their capacity for advocacy and self management		250000		
Financing (HLO 7.3)	109	Available funds not disbursed	1) Identification of disbursement bottlenecks 2) Design procedures to facilitate fund disbursement	Hire financial firm to do a comprehensive review of mechanism for fund disbursement and to develop procedures to streamline fund disbursements	World Bank (SA) NACC (CL)	Disbursement mechanisms streamlined	75000			
Comprehensive program review										
JAPR/MTR (HLO 7.2)		TA for JAPR and MTR			Global Fund (SA) NACC (CL)		62500	62500	62500	62500
TSP follow-up and evaluation					UNAIDS (SA) NACC (CL)		40000	40000	40000	40000
TOTAL							1970000	2,440,000	647500	102500
Total request from Global Fund							137500	907500	62500	62500

SECTION 8: KNASP III NATIONAL PLAN OF OPERATIONS 2009/10 – 2010/11

Introduction

This National Plan of Operations (NPO) highlights the key activities that will be implemented during the years 2009/10 -2010/11, under the Kenya National HIV and AIDS Strategic Plan 2009/10-2012/13. All the activities and output results in this NPO are logically linked to the KNASP III results framework, which details the higher level output results, outcomes and expected impact. KNASP III also describes how this plan will be coordinated.

The NPO is divided into the implementing pillars: 1) Health Sector, (2) HIV Mainstreaming in all other sectors and line ministries (3) Community and (4) The Governance and Strategic Information Pillar, which includes cross-cutting issues and spells out the oversight roles of NACC.

Structure of the NPO

The activities are presented on a table that: Clearly links activities to measurable results; Specifies roles and responsibilities of key actors; Provides clear outputs and expected outcomes; Indicates the accountabilities and responsibilities and indicates the inputs and tasks for costing each activity.

The first row of the NPO table details the expected long-term outcome result of KNASP III. The second row details the higher–level output, which is an expected mid-term result of the KNASP III that if well implemented, will logically lead to the achievement of that outcome. Outcomes are behavioural and institutional changes resulting from the implementation of this NPO. Outcomes and Higher-level Outputs (HLOP) are derived directly from the Results Framework of KNASP III. The third row details the output, a set of short-to-medium term operational changes that take between a month and two years to achieve. These outputs have been analyzed and found to be logical and adequate to achieve the set of outcomes.

In turn, the outputs logically result from implementing the activities proposed under them. These activities, detailed on the first column, are performed by implementers based on their strategic and operational programmes, and are considered necessary and sufficient to achieve the desired outputs. They have been arrived at after a rigorous analysis of evidence and lessons learned during implementation of the previous strategic plan. The second column names the responsible or lead organization that will manage and account for overall results during the implementation of that activity.

Each activity is to be accompanied by an objectively verifiable process or input indicator (preferably placed by the entity adopting this NPO) which states clearly the targeted operational change that the entity hopes to achieve, can be measured, and the timelines within which it should be achieved. For example, the operational change can be “35 students trained in life-skills”. The selected indicator should be related somewhat to the output indicator. The next column states the estimated cost of implementing the activity, and the assumptions used to arrive at this cost, that is, the specific tasks that will be performed. Next to this column is another detailing a few of the stakeholder groups who will participate in implementing each activity. The last column shows four quarters (sets of three months) within the two years, during which time the activities are most likely to be implemented.

1.3. How to use this plan:

Implementers: This plan is primarily developed to inform implementers on the specific ways through which they can contribute to results. It is important for the implementers to understand that they will need to report on the results achieved during their implementation of this plan. Implementers should therefore use this Plan in the following way:

1. Identify the results to which they to contribute;
2. Work with the convener(s) / responsible partners of the pillar(s)
3. As far as possible, use the plan, its indicators and the project process indicators to design the organisation’s own specific implementation plans, including budgets.
4. Interact, cooperate, collaborate, and coordinate with other stakeholders and partners through the various teams convening and coordinating the pillars. When in doubt, implementers should contact the National AIDS Control Council (NACC) for further details.

5. Report results as frequently requested by your convener.

Government of Kenya Line Ministries and Sectoral Institutions (including public sector, the formal and informal corporate/ private sector): The plan identifies and defines in great detail, the activities and tasks through which they can achieve such complicated expectations as "Mainstreaming" and the results they must achieve through partnership with private institutions and civil society.

Civil Society: This plan identifies areas of implementation where civil society can make the most effective contribution. In addition, the plan describes how implementation can be coordinated and managed, so that civil society organizations know exactly with whom and where to work, how and when to monitor and report their results, and how to provide oversight in the overall implementation of the plan.

Development Partners and donors: the plan provides an evidence-informed set of results in which they could invest and meet both the country's and their objectives. Investing in this plan ensures that support is coordinated and harmonized hence achieving additional and non-duplicative results.

NACC: The plan provides a framework and mapping of all activities through which NACC, as mandated, can hold implementers accountable on an on-going basis. The plan offers an annual flexibility that will henceforth make it simpler to change course as quickly as the epidemic changes. The quarterly and annual results-based planning represented by this plan makes it more likely that impact will be achieved, since it is now possible to recognize potential gaps and delays even as the country begins to implement.

Bi-Annium Work Plan – Pillar 1: Health Sector HIV Services

Outcome Result: **Reduced risk behaviour among the general, infected, most at risk and vulnerable populations.** **(Indicators):** **Median age of girls' and boys' sexual debut; # of men and women who have had sex with more than one partner in the last 12 months; % discordant couples using condoms; % IDUs reporting sharing equipment; % male and female sex workers using condoms.**

HLOP : Knowledge of HIV prevention among men and women aged 15 – 64 enhanced

(Indicator): 1) % of population with comprehensive correct knowledge of HIV and AIDS (disaggregated by target audience, type of HIV message and location); 2) % of Most at risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age, sex)

Output Result 1.1.: By 2013 80% of the population has comprehensive information on HIV prevention BCC

(Indicator): % of individuals reached with at least one HIV IEC or BCC (disaggregated by target audience, location and mechanism and information type)

Milestone for 2009/10: 3 campaigns per region conducted

Milestone for 2010/11: 4 campaigns per region conducted

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.1.1 Communicate for social transformation and behaviour change	NASCOP	Activity 1.111 Develop, produce and disseminate behaviour change communication messages on HIV prevention through different campaigns and media according to the KNASP III communication strategy. Activity 1.112: Train 420 PLWHAs, CHWs, CHEWS, HCW as ToTs for prevention through HTC, Condoms (male and female), TB /HIV, STIs, Male circumcision, Medical transmission, PMTCT, BCC; Train and sensitize 7,035 HCW on human rights, gender and issues of MARPs, youth and vulnerable groups	CDC LVCT JICA			x	x	x		x	x

HLOP : Proportion of men and women aged 15 – 64 , (and children) who know their status increased

(Indicator): % of men and women aged 15 – 64, and children who received their HIV test results (disaggregated by sex, by partner status; No. of people tested and counselled for HIV annually (disaggregated by age and sex, No. of MSM who received their HIV test result, No. of FSW who received their HIV test results

Output Result 1.2.: By 2013 HIV testing and counselling scaled up reaches more than 4 million persons annually

(Indicator): Number of individuals reached through facility-based and community HIV testing campaigns (disaggregated by type of testing, target audience, age, gender, location)

Baseline 2008/2009: 2 million annually

Milestone 2009/2010: 4,137,097 to be tested annually

Milestone 2010/2011: 5,376,670 to be tested annually

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.2.1 Scale up HIV Testing and Counseling	NASCOP and Partners	Activity 1.211.: Provide capacity building in HTC facilities to enable staff to provide updated evidence based HTC services that are also rights respecting; gender sensitive, child specific; MARP-and-vulnerable-group-friendly. Activity 1.212: Revise HTC M& E data collection tools to reflect desegregation across different target populations. Activity 1.213: Revise referral and supervision tools to strengthen referral mechanisms for care, treatment and support service provision across target populations. Activity 1.214: Procure and distribute HTC equipments and supplies Activity 1.215: Improving and strengthening the existing HTC facilities infrastructure. Activity 1.216: Conduct facility based, workplace and community based HIV testing and counselling	HTC Partners PEPFAR APHIAs	x	x	x	x	x	x	x	x
Sub Total Result 1.2.1											

Output Result 1.3: By 2013 80% of HIV positive persons are accessing services to support prevention of HIV transmission and acquisition (PwP interventions).

(Indicator): 1) % of HIV positive persons reached by appropriate prevention and treatment (PwP) services (disaggregated by age, gender, location) 2) % health facilities providing integrated PWP services (disaggregated by facility level, location)

Baseline: 400,000 PLHIV in care and PWP interventions

Milestone 2009/10: 600,000PLHIV who know their status and are accessing PwP interventions

Milestone 2010: 800,000 PLHIV who know their status and are accessing in PwP interventions

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.3.1 Implement prevention of HIV transmission aimed at people living with HIV (PwP)	NASCOP and partners	Activity 1.311 Capacity building on HIV prevention with positives (PwP) for general population including MARPs and vulnerable groups living with HIV Activity 1.312: Conduct BCC activities for PwP Activity 1.313. Production and dissemination of the PWP guidelines reviewed			X	X	X	X	X	X	X
Sub Total 1.3.1.											

Output Result 1.4 : By 2013 health care workers have the appropriate knowledge, skills and attitudes to provide services friendly to MARPs and vulnerable groups.

(Indicator): Number of persons seeking HIV services per 10 000 population (disaggregated by target group for MARPs and other vulnerable groups, type of HIV service)

% of health care workers (including volunteers) who successfully completed a training program for user friendly services (disaggregated by type of training and cadre)

Activity description	Responsible/lead organisation/agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1..4.1 Provide prevention services for most at risk populations and vulnerable groups	NASCOP	Activity 1.411 Review and develop policies and guidelines for moat at risk groups (MARPs) and vulnerable groups Activity 1.412 Make available MARP friendly service delivery points Activity 1.413 Develop and implement comprehensive prevention programme for IDUs including needle syringe exchange programme and OST Activity 1.414: Capacity building Activity 1.415: Design behaviour change communication strategies targeting MARPs and vulnerable groups									
Subtotal Result 1.4.1:											
HLOP : Proportion of pregnant women accessing PMTCT services increased (Indicator): % of pregnant mothers counselled, tested and received their HIV test at ANC, % of HIV positive mothers provided with complete course of ARV prophylaxis to reduce MTCT risk, % of infants born to HIV infected mothers who are infected.											

Output Result 1.5 : By 2013, 95% of HIV positive pregnant women have access to comprehensive HIV care services.

(Indicator): % of HIV+ve pregnant women who have access to comprehensive care services.

Milestone: 2009/10: 80% HIV positive pregnant women have access to comprehensive care services

Milestone 2010/11: 90% HIV positive pregnant women have access to comprehensive care services

Activity description	Responsible/lead organisation/agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.5.1 Scale up prevention of mother to child transmission of HIV	Ministry of Health Reproductive Health NASCOP	Activity 1.511 Promotion of Focussed Antenatal Care (FANC) services. Activity 1.512: Provide HIV counselling and testing opt using the “opt – in / out” strategy to all pregnant women and include counselling on infant feeding options, need for hospital delivery, disclosure, adherence and long term HIV related care Activity 1.513: Perform WHO staging and CD4 count to all HIV+ve pregnant women Activity 1.514: Provide ARV prophylaxis or HAART based on CD4 count and WHO staging to all HIV+ve pregnant women according to National guidelines Activity 1.515: Offer CTX prophylaxis to HIV+ve pregnant women Activity 1.516: Supply LLITN to all pregnant women Activity 1.517 Review PMTCT programme and strengthen integration of nutritional support and treatment in the context of PMTCT through supportive supervision and monitoring Activity 1.518 Provide psychosocial support to all HIV positive mothers opting out from breastfeeding and provide free infant formula for 6 months for their infants	PMTCT partners	X	X	X	X	X	X	X	X
Sub Total 1.5.1											

Output Result 1.6: By 2011, Greater than 95% of HIV positive pregnant women have access to skilled delivery (in health facilities)

(Indicator): % of HIV positive mothers delivering in health facilities

Milestones:2009/10: 70% of HIV positive pregnant women have access to skilled delivery

Milestones 2010/11: 80% of HIV positive pregnant women have access to skilled delivery

Activity description	Responsible/lead organisation/agency or division/unit	Resource needs and baseline	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.6.1 Scale up promotion of safe delivery services	Ministry of Health/ Reproductive Health / NASCOP	Activity 1.611 Promote facility delivery for HIV +pregnant women Activity 1.612: All HIV+ve pregnant women supported to have skilled deliver in a health facility (free deliveries for all HIV+ve pregnant women) unable to pay for hospital charges) Activity 1.613: Intrapartum HTC offered to all pregnant women with unknown HIV status Activity 1.614: All HIV+ve pregnant women on HAART continue during labour, mothers on AZT to receive SD-NVP and tail protection. (According to national guidelines) Activity 1.615: Counsel all HIV+ve pregnant women on infant feeding options, disclosure, adherence and long term HIV related care Activity 1.616: Provide counselling and psych socio support to HIV positive mothers who elect not to breast feed Activity 1.617: Undertake comprehensive studies on modes of transmission for infants and concerns relating to breastfeeding by mothers on ARVs. Activity 1.618: Provide all pregnant mothers comprehensive education on modes of transmission to infants to facilitate informed choices Activity 1.619: Design advocacy strategy targeting all child bearing women with education and information on the importance of knowing their status, preventing HIV transmission, attending ANC clinics when pregnant, understanding MTCT and making informed choices for child and delivering in health care facilities. Activity 1.610: Develop an integrated model of PMTCT and ART services including mechanisms for case-finding in order to expand PMTCT services to home deliveries of both pre-natal attendants and non attendants by strengthening linkages with TBA/ CHWs.	PMTCT partners	X	X	X	X	X	X	X	X
Sub Total 1.6.1											

Output Result 1.7: By 2013 Greater than 95% of the HIV exposed infants and their mothers have access to comprehensive care services

(Indicator): % of HIV exposed infants and mothers receiving comprehensive postnatal care services (1 year)

Milestone: 2009/10: Greater than 70% of HIV exposed infants and their mothers access to comprehensive care services

Milestone: 2010/11: Greater than 80% of HIV exposed infants and their mothers access to comprehensive care services

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.7.1 Scale up access to care for HIV exposed infants and their mothers	Ministry of Health/NASCOP	Activity 1.711 All HIV exposed infants receive ARV post-exposure prophylaxis Activity 1.712: All HIV exposed infants are fully immunised and followed in MCH clinic (as per national guidelines). Activity 1.713: Counsel all HIV+ve mothers on infant feeding options, disclosure, adherence and long term HIV related care Activity 1.714: HIV+ve mothers opting to breastfeed counseled on safe breastfeeding practises and encouraged to do exclusive breastfeeding Activity 1.715 Provide counselling and psych socio support to HIV positive mothers who elect not to breast feed. Activity 1.716: HIV+ve mothers opting not to breast feed their infants are provided with infant formula and safe water kits according to national policy and guidelines Activity 1.717 Support HIV+ve mothers to avoid mixed feeding during complementary feeding period Activity 1.718: All HIV exposed infants follow national early infant diagnosis (EID) algorithm (disaggregated by type, timing and result) Activity 1.7119: Infants with HIV+ve results referred for comprehensive care service (HAART, nutrition, OI management.) Activity 1.7120: All HIV+ve mothers continue to be assessed with CD4 count, WHO staging, appropriate ARV , TB and OI screening, medications and care Activity 1.7121: Nutrition assessment done for HIV+ve mothers and their infants and support based on national guidelines Activity 1.7122: All HIV+ve mothers offered family planning services and STI screening and treatment Activity 1.7123: All HIV+ve mothers offered psychosocial support services (linked with HBC) Activity 1.7124: Encourage partner involvement	PMTCT partners* Reproductive health partners	X	X	X	X	X	X	X	X

Sub Total 1.7.1											

HLOP : Men in non-circumcising communities accessing voluntary medically assisted circumcision services increased

(Indicator): Number of male circumcised in non circumcising communities under VMAMC

Output Result 1.8: By 2013 80% of males are circumcised across all regions:

(Indicator): Number of males circumcised in accordance with national guidance within the last 12 months in non-circumcising societies (disaggregated by age groups, region, medical/traditional provider, & circumcision prevalence)

Baseline: 08/09: 20,000 males had undergone voluntary medical male circumcision

Milestone 2009/10: 150,000, males undergo voluntary medical male circumcised (VMMC)

Milestone 2010/11: 200,000 males undergo voluntary medical male circumcised (VMMC)

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.8.1 Scale up voluntary medically-assisted male circumcision	NASCOP and partners	Activity 1.811: Capacity building of health providers in male circumcision service provision Activity 1.812: Advocacy, community mobilisation and sensitisation on male circumcision Activity 1.813: Provision of male circumcision services									
Sub Total 1.8.1											

HLOP : By 2013, Increase demand and use of male condoms

(Indicator): 1) Number of male condoms procured and left facilities

Output Result 1.9: By 2013 national universal access target for male condom use achieved

(Indicator): 1) % of annual target number of condoms available for distribution nationwide during the last 12 months (disaggregated by; distributed for free or purchase; via public or private condom outlets) 2) Number of condom outlets (disaggregated by health or non-health facility, public or private) 3) % of persons reporting condom use at last higher risk sex (disaggregated by age, sex, population group)

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.9.1 Scale up male condom provision	NASCOP and partners KEMSA	Activity 1.911: Provision and distribution of condoms dispensers, male and female condoms and lubricants Activity 1.912 Design and implement appropriate national advocacy strategy for increased uptake of the male condom targeted at different populations Activity 1.913: Conduct assessments of male condom and lubricant use amongst MARPs, youth and vulnerable groups.	HTC partners Social places NASCOP ,LVCT; GALCK	x	x	X	X	X	X	X	x
Sub Total 1.9.1											
HLOP : By 2013, Increased demand and use for female condoms											
(Indicator): 1) Number of female condoms procured and left facilities											

Output Result 1.10: By 2013 national universal access target for female condom use achieved

(Indicator): 1) % of annual target number of condoms available for distribution nationwide during the last 12 months (disaggregated by distributed for free or purchase; via public or private condom outlets) 2) Number of condom outlets (disaggregated by health or non-health facility, public or private) 3) % of persons reporting condom use at last higher risk sex (disaggregated by age, sex, population group)

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.10.1 Scale up female condom provision	NASCOP and partners KEMSA	Activity 1.1011: Provision and distribution of condoms dispensers, female condoms and lubricants Activity 1.1012 Design and implement appropriate national advocacy strategy for increased uptake of the female condom targeted at different populations Activity 1.1013: Conduct assessments of female condom and lubricant use amongst MARPs, youth and vulnerable groups b) Establish regional pilot projects in both rural and urban to assess the level of use of the female condom.	HTC partners Social places NASCOP ,LVCT; GALCK	x	x	X	X	X	X	X	x
Sub Total 1.10.1											

HLOP : By 2013, Populations in need including survivors of sexual and gender based violence accessing PEP services

(Indicator): 1) Number of PEP kits produced and distributed

Output Result 1.11: By 2013 80% of persons reporting sexual violence receive comprehensive HIV prevention services.

(Indicator): % of rape cases referred to a H/facility and receive post-rape care services (including PEP) in the last 12 months-% hospitals and health centres with operational post rape care (PRC) services.

Baseline 2008/2009: 100 Health facilities offering post rape care services

Milestone 2009/2010: 300 health facilities offer comprehensive post rape care services

Milestone 2010/2011: 1000 Health facilities offer comprehensive post rape care services

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.11.1 Scale up post rape care services	DRH/NASCOP/ KEMSA	Activity 1.1111: Review, produce and disseminate national guidelines on post rape care. Activity 1.1112: Build staff capacity on post rape care that includes clinical and forensic management plus trauma counselling. Activity 1.1113: Procure and distribute post rape care commodities Activity 1.1114: Conduct behaviour change communication campaign and activities on post rape care and prevention of rape and risk reduction Activity 1.1115: Establish linkages between clinical post rape care services and the legal/justice systems through training and capacity building activities.	DRH/NASCOP and other partners (LVCT, GTZ)								
Subtotal Result 1.11.1:											

HLOP : By 2013, Universal prevention of medical transmission of HIV is achieved

(Indicator): % of reported cases of occupational exposure (disaggregated by sex, HIV status, facility level); Proportion of incidence attributed to medical transmission MTP (MoT)….medical injections 1.93% nationally / blood transfusion 0.27%; Alternative indicator 3: % of donated blood units screened and quality-assured for transfusion transmissible infections (TTIs) in a quality assured manner per 1000 population per year (HIV, Hepatitis and key STIs)

Output Result 1.12: By 2013 90% of national blood transfusion need is met through centrally collected blood that is 100% screened for transfusion transmissible infections (TTIs)

(Indicator): 1) Percentage of blood units collected and screened by the National Blood Transfusion Services network which are identified as reactive for TTIs by an NBTS network laboratory (disaggregated by type of TTIs)

2) % of donated blood units screened for Transfusion Transmittable Infections (TTIs) in a quality assured manner (disaggregated by type of TTI, location)

3) Number of units of properly screened blood available annually

Baseline:100% of NBTS blood collected is screened

Milestone 2009/10: 100% of all blood collected is screened

Milestone 2010/11: 100% of blood is collected is screened

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.12.1 Blood safety	NBTS , NASCOP	Activity 1.1211 Review / develop/produce /disseminate existing blood safety policy documents and guidelines Activity 1.1.4.1.2: Mobilize the public to donate blood. Activity 1.1212: Collect , screen, process and store blood and blood products at regional centres Activity 1.1213: Develop capacity of staff at NBTS and hospital Activity 1.1.4.1.5: Develop blood safety infrastructure capacity of health facilities	NBTS, NASCOP, NACC, MOH, private sector among other partners	x							
Sub Total 1.12.1											

Output Result 1.13: By 2013 80% of heath facilities fully meet with universal infection prevention and control standards (including injection safety and waste management)

(Indicator): % health facilities with no stock outs of new sterile syringes, safety boxes or final disposal method in the prior 6 months (disaggregate by facility level, location)

Milestone 2009/10: National Infection Prevention and Control Policy developed

Milestone 2010/11: 1,000 health facilities reached through sensitization on Infection Prevention and Control Policy document

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.13.1 Universal infection prevention and control	NASCOP/ KEMSA /and Other partners	Activity 1.1311 Advocate, review develop, produce and disseminate IPC policy guidelines document Activity 1.1312: Build staff capacity on infection prevention and control Activity 1.1313: Procure and distribute adequate injection safety and medical waste equipments and protective gear Activity 1.1314: Construct, renovate and secure waste disposal sites Activity 1.1315: Conduct BCC activities for IPC: injection safety, biomedical waste management.	NASCOP, NBTS, NACC, MOHs, KEMSA, private sector among other partners								
Sub Total 1.13.1											

Output Result 1.14: By 2013 100% of district hospitals and health centres are providing appropriate occupational and non occupational post exposure prophylaxis (PEP)

(Indicator): % of Health facilities with post-exposure prophylaxis available (disaggregated by facility level and exposure type)

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.14.1 Post exposure prophylaxis (PEP)	NASCOP KEMSA	Activity 1.1411: Review, develop and disseminate updated guidelines on occupational and non occupational post exposure prophylaxis. Activity 1.1412: Build staff capacity on PEP Activity 1.1413: Procure and distribute PEP commodities Activity 1.1414: Conduct BCC activities to create awareness on PEP services	NASCOP and other partners								
		Subtotal Result 1.14.1									

Outcome Result : Proportion of eligible PLHIV on care and treatment increased and sustained
(Indicator): % of adults and children with HIV known to be receiving treatment two years after the start of ART; No. of PLHIV receiving care by age and sex

HLOP : No. of eligible PLHIV enrolled on ART increased

(Indicator): No. of people on ART by age and sex

Output Result 1.15: By 2013 50% of health care facilities provide comprehensive HIV care and 35% provide ART services

Indicator): % of health care facilities that have the capacity to provide I HIV and AIDS care and support services, including provision of ART (disaggregated by facility level, public/private)

Baseline: 730 ART sites in 5,250 facilities

Milestone 2009/2010: By 2010 have additional 350 sites providing care and treatment

Milestone 2010/2011: By 2011 additional 400 sites providing care and treatment (in 2 years total cumulative number of sites =1500 sites)

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.15.1 Provide comprehensive HIV care and treatment services	MOH NASCOP/ DLTLD/ HMIS CSOs AMREF LVCT KEHPCA, CMMB (M2M)	Activity 1.1511Training of all cadres of HCWS to provide care and treatment services TOT and Service providers training. Activity 1.1512: Training of PLHIV on treatment literacy, group facilitation, stigma reduction , peer educators, support group governance. Activity 1.1513: Train CHWs/CHEWS on basic HIV care related services (psychosocial support for PLHIV, treatment literacy, stigma reduction, governance, TB/HIV, HCBC, Palliative care , nutrition and OI and HIV related conditions, etc) Activity 1.1514: Mentorship of health care workers on HIV care and treatment services including clinical care for children and adults, laboratory, M& E , nutrition , counselling , pharmacy Activity 1.1515: Integration/ merging and updating of all existing care and treatment curricula in one curriculum in modular form to include all care and treatment materials (ART, nutrition, RH, TB , OI, commodity management) Activity 1.1516: Develop additional modules to address the needs of different groups (stigma reduction, discrimination, special group needs and co-morbidities) for HCWs and community providers and other relevant upcoming issues (psychosocial support for adults , co-morbidities) Activity 1.1517: Develop and disseminate comprehensive HIV care curriculum for the CHEWs (1 month) : Trainers Manual – 3,000, Participants manual-3,000 Activity 1.1158: Develop community provider (CHW) versions of all existing relevant trainings (OI, treatment , adherence, PWP) Activity 1.1519: Develop comprehensive curriculum for PLHIV Activity 1.15120: Equip 80 % of health facilities to provide basic HIV and laboratories services:	Non-PEPFAR NASCOP PEPFAR USAID CDC UNICEF, USAID, AED, NACC Provinces/ Districts, partners and other stakeholders								
Subtotal for Result 1.15.1:											

Output Result 1.16: By 2013 the proportion of adults and children with HIV infection who are eligible and are receiving ART is increased to 75% in children and 80% in adults

Indicator): % adults and children with HIV infection who are eligible receiving ART (disaggregated by HIV disease status, sex, age)

Milestone 2009/2010:No.of adults and children with HIV infection who are eligible and are receiving ART is increased

Milestone 2010/2011: No. of adults and children with HIV infection who are eligible and are receiving ART is increased

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.16.1 Provision of Antiretroviral Therapy	NASCOP	Activity 1.1611: Formation of patient support groups for adults, children and caregivers Activity 1.1612: Provision of AR T to PLHIV Activity 1.1613: Establish bidirectional functional referral system (i.e. for second line, salvage patients, complicated patients, stable patients to lower level facilities) -Work with post-test clubs to allay patient anxiety -Quarterly meetings amongst facilities in referral catchment area -Guidelines on referral (bidirectional),referral tools – requires meeting of experts and consultant	Non-PEPFAR NASCOP PEPFAR USAID CDC								
Subtotal for Result 1.16.1											

Output Result 1.17: By 2013 annually 80% of children and adult ART clients are adhering to treatment

(Indicator): % of Adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (disaggregated by age, sex)

Milestone 2009/2010: No. of Health facility trained on use of cohort registers

Milestone 2010/2011: No. of facilities reporting using cohort registers

Activity description	Responsible/ lead organisation/ agency or division/unit	Assumptions and resource needs	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.17.1 Improving defaulter tracing and strengthening cohort monitoring systems	NASCOP	Activity 1.1711: Establish defaulter tracing mechanism (uniform/ national defaulter tracking form and electronic medical records to support this) Activity 1.1712: Strengthen the use of cohort monitoring registers in the facilities Activity 1.1713: Strengthening cohort data collection Activity 1.1714: Printing, and distribution of revised materials and M&E tools									

Output Result 1.18: By 2013 an improved system for clinical monitoring of ART clients that includes longitudinal patient tracking will be in place (cross ref with HMIS)

(Indicator): 1) % of Health facilities with an adherence register or other patient tracking system available and reporting on clinical outcomes for ART clients (disaggregated by facility level) 2) Number and percentage of people starting antiretroviral therapy who picked up all prescribed antiretroviral drugs on time (disaggregated by age, sex)

Milestone 2009/2010: Process for development of ART adherence registers/tools initiated

Milestone 2010/2011: Draft ART adherence tools available and piloted in facilities

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.18.1 Longitudinal HIV related clinical patient monitoring	NASCOP /HMIS/ DLTLD	Activity 1.1811: Establish defaulter tracing mechanism (uniform/national defaulter tracking form and electronic medical records to support this) Activity 1.1812: Support the use of cohort monitoring registers in the facilities Activity 1.1813 Revise care and treatment tools to include indicators for TB, adherence RH, OI, co-morbidities and nutrition Activity 1.1814: Revise patient data capture and reporting tool (cards, registers) to cater for infants and children Activity 1.1815: Develop program reporting tool for facilities, districts provinces and national level (Health systems component Activity 1.1816: Print and distribute care and treatment tools	Non-PEPFAR PEPFAR USAID CDC								
HLOP : PLHIV in need enrolled on care increased **(Indicator):** No. of people receiving home and community based care package; no. of HCBC kits procured and distributed											

Output Result 1.19: By 2013 80% of HIV positive adults and children are receiving care for the management of opportunistic illnesses (80% of those who know their status-)

(Indicator):1)% of Infants born to HIV-infected women starting on cotrimoxazole prophylaxis within 2 months of birth 2) % HIV positive persons receiving cotrimoxazole prophylaxis

Milestone 2009/2010: OI guidelines revised and distributed

Milestone 2010/2011: No of facilities providing basic OI services to PLHIV

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.19.1 Prevention and treatment of opportunistic infections	NASCOP / Health facility/ NPHL	Activity 1.1911: Provide care kit to patients of on care Activity 1.1912: Revise and update OI guidelines to include HIV related conditions and co-morbidities and develop related tools Activity 1.1913: Support additional health facilities to provide basic NON-ART care and treatment services: OI drugs (to provide CTX prophylaxis); Diagnostic equipment (BP machine, weighing scale, stethoscopes ,thermometers, Glucometer/ Glucosticks, biochemistry machines) and related tools Activity 1.1914: Routine clinical and laboratory assessment of patients on ART: (BP- initially and at every visit; Diabetes; FBS as indicated; cholesterol profile- baseline if indicated and then annually for all on ART) Activity 1.1915: Provide secondary prophylaxis and treatment for HIV related morbidities Activity 1.1916: Provide co-trimoxazole for patients on care Activity 1.1917: Provide INH prophylaxis for children (as per DLTLD guidelines) Activity 1.1918: Provide INH for confined populations e.g. prisoners (as per DLTLD guidelines) Activity 1.1919: Develop guidelines that define services to be provided at different levels of health care facilities and develop comprehensive national service delivery framework for the continuum of care for HIV exposed children Activity 1.19110: Training service providers on visual inspection for CA cervix Activity 1.19111: Perform visual inspection of cervix annually for women in care Activity 1.19112: Support substitution, second line and salvage therapy treatment for all who need	Non-PEPFAR PEPFAR USAID CDC								
Subtotal for 1.19.1											

Output Result 1.20: By 2013 all HIV positive adults and children will be assessed and managed appropriately for co-morbidities in all CCCs (hypertension, Diabetes and cardiovascular disease,)

(Indicator): % of CCC providing appropriate co-morbidities services in CCCs.(screened and referred for co-morbidities (disaggregated by type of co-morbidity

Milestone 2009/2010: % of facilities equipped with BP machine, Glucometer and commodities

Milestone 2010/2011:% of facilities reporting on comorbidity management for PLHIV

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.20.1 Management of co-morbidities	MOMS/MOPHS/ NASCOP/ Health facilities	Activity 1.2011: Routine clinical and Laboratory Assessment of patients on ART: BP- initially and every visit; Diabetes-RBS-initially then 6 monthly lipid profile-initially then 6 monthly Activity 1.2012: Routine clinical and Laboratory Assessment of patients on Care- BP- initially and every visit, diabetes-RBS-initially then 6 monthly, lipid profile-initially then 6 monthly Activity1.2013:Provision of equipment, BP machine, weighing scale, Glucometer/ Glucosticks; Biochemistry machine in all CCCs Activity 1.2014: Develop/revise referral forms and disseminate to all CCCs	Non-PEPFAR PEPFAR USAID CDC								
Sub Total 1.20.1		(Co-morbidity activities are common with OI management and should be costed there)									

Output Result 1.21: By 2013 80% of those in need have access to appropriate STI information, prevention, screening, treatment and referral

(Indicator): 1) % health facilities providing comprehensive STI services (disaggregated by facility level, location, rural/urban, public/private)

2) % of patients with sexually transmitted infections at health care facilities (disaggregated by type of STI, age, sex, rural/urban, location)
3) % of patients with STIs at health care facilities who are appropriately diagnosed, treated, and counselled (disaggregated by age, sex, facility level, rural/urban, public/private)

4) Syphilis prevalence among pregnant women

Baseline: 32% (HSV2) of adult population of 20million

Milestone 2009/10: 1 million STI clients accessing STI services

Milestone 2010/11: 1.5 million STI clients accessing STI services

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.21.1 Prevention, diagnosis and treatment of sexually transmitted infections (STIs)	NASCOP and partners	Activity 1.2111 Capacity building on STI management. Activity 1.2112: Provision of STIs services and treatment Activity 1.2113: Create awareness of STI services amongst MARPs, youth and vulnerable groups									
Sub Total 1.21.1											

Output Result 1.22: By 2013 80% of HIV positive clients have received patient education on care and treatment

(Indicator): Number and % of PLHIV reached with individual and/or small group level health education interventions that are based on evidence and/or meet the minimum standards (disaggregated by sex)

Milestone 2009/2010: # of HIV positive clients receiving patient education on treatment and care

Milestone 2010/2011: # of HIV positive clients receiving patient education on treatment and care

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.22.1 Patient education on ART	NASCOP	Activity 1.2211: Print and distribute patient education materials on treatment and care.	NACC, Non-PEPFAR PEPFAR: USAID, CDC			X	X	X	X	X	X
Sub total for Result 1.22.1:											
HLOP: Proportion of TB patients who are HIV infected on ART increased **(Indicator):** No. of TB/HIV co-infected receiving ARTs											

Output Result 1.23: By 2013 80% of TB/HIV patients receive ART

(Indicator): % of all HIV/TB patients that received treatment for TB and ART (disaggregated by sex, age and location)

Milestone 2009/2010: M and E tools are revised to capture TB/HIV patients receiving ART

Milestone 2010/2011: % of facilities using revised tools that capture TB/HIV patients receiving ART

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partner for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.23.1 TB / HIV co-management	NASCOP/DLTLD	Activity 1.2311: Revision of ART tools to capture PHHIV screened for TB and TB patients on ART, through a committee or meeting to revise the tool Activity 1.2312: Sensitization (CMEs at facility level) of health care workers on TB HIV tools and disseminate them Activity 1.2313: Monitoring and evaluation Activity 1.2314: Integration of TB & ART services; -Joint planning meetings between P/DASCO and P/DTLC; -Provision of ART in TB clinics, -Provision of TB treatment in CCC, -Provisions of TB screening in CCC Activity 1.2315: Training on TB and HIV integration	Non-PEPFAR PEPFAR USAID CDC								
Subtotal for Result 1.23.1:											

Output Result 1.24: By 2013 80% of adults and children enrolled in HIV care will have had their TB status assessed and recorded during their last visit

(Indicator): % of HIV-positive patients who were screened for TB in HIV care or treatment settings (disaggregated by age, sex)

Milestone 2009/2010: % of facilities with appropriate tools

Milestone 2010/2011: % of facilities reporting on TB screening in PLHIV

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.24.1 TB screening of all HIV patients in care and treatment	NASCOP/ HMIS/ DLTLD	Activity 1.2411: Update , print and provide TB screening job aids in 80% of HIV care and treatment settings: screening flow charts, paediatric scoring chart, TB screening tool. Activity 1.2412: Support integration of TB & ART services through joint planning meetings between P/DASCO and P/DTLC; provision of ART in TB clinics; provision of TB treatment in CCC; and provision of TB screening in CCC Activity 1.2413: Provide TB screening for all HIV clients in care	Non-PEPFAR PEPFAR USAID CDC	X	X	X	X	X	X	X	X
Subtotal for Result 1.24.1											

HLOP : Increase in PLHIV receiving nutritional care and support

(Indicator): % of PLHIV receiving nutritional support; No. of households receiving food support, No. of households receiving therapeutic nutrition

Output Result 1.25: By 2013 80% of health care facilities/care and treatment sites provide nutrition interventions including supplementary and therapeutic food for malnourished HIV positive adults and children.

(Indicator): Number of HIV-positive malnourished clients who received supplementary or (blended fortified flour is removed) therapeutic food (Ready to Use Therapeutic Food) (disaggregated by age groups, sex)

Activity description	Responsible/lead organisation/agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.25.1 Nutritional support associated with antiretroviral therapy	NASCOP KEMRI NACC	Activity 1.2511: Provide therapeutic foods (RUTF) to severely malnourished clients Activity 1.2512: Provide supplementary foods to moderately malnourished clients Activity 1.2513: Support nutrition counselling and education of PLWH Development, printing and dissemination of counselling and education materials Activity 1.2514: Strengthen the M&E system at district and central levels Print and disseminate nutrition registers to all health facilities providing HIV care and treatment services. Provide hardware, software, accessories plus technical support Activity 1.2515: Support implementation of nutrition operational research to strengthen scale-up Activity 1.2516: Support nutrition advocacy and communication Activity 1.2517: Procure and distribute basic equipment for nutrition assessment of PLWHA in unequipped facilities Activity 1.2518: Review national nutrition & HIV guidelines, training and educational materials, print and disseminate nationally Development of nutrition and HIV IEC material Activity 1.2519: Develop, print and disseminate standard operating procedures for nutrition care and support at health facilities and other care & treatment sites	MOH (D/ Nut), UNICEF, WFP, USAID/ NHP NACC, , AED, WFP, UNICEF Tertiary institutions, (UON, KU), PLWHA network bodies Private companies AMPATH NPHLS								

Sub Total 1.25.1											

Outcome Result : Health systems deliver a package of HIV services according to KNASP strategy
(Indicator): Extent to which health sector related outcomes of KBNASPIII are achieved

HLOP 3.1.0.0: Proportion of health facilities with QA/AC standards to support achievement of universal access to quality care achieved

(Indicator): % of health facilities meeting QA/AC standards

Output Result 1.26: By 2013 at least 1 HIV service delivery point per administrative district with adequate lab infrastructure and equipment to perform HIV testing, TB diagnostics and other common OIs, syphilis testing, malaria and HIV disease monitoring as per updated national standards (approximately 250 sites nationally):

(Indicator): Number of laboratories with infrastructural capacity to perform clinical laboratory tests as per national standards (disaggregated by facility level, type of test)

Milestone 2009/2010: Develop and disseminate inventory of laboratory capacity

Milestone 2010/2011: Capacity build 250 health facilities with required skills

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.26.1 Upgrade laboratory infrastructure	NASCOP MOPH MOMS NPHLS	Activity 1.2611:,Develop and launch an inventory of laboratory equipment of all public sector HCFs to establish baselines and monitor progress towards meeting national guidelines. Activity 1.2612 Conduct biannual update and dissemination inventory and national standards for lab equipment per HCF. Activity1.2613: equip HIV service delivery Points with laboratory equipment and reagents to support HIV services : Lease/purchase, distribute and maintain updated package of equipment and reagents for at least 80% of each health facility level by 2012 as per national guidelines Activity 1.2614: Recruit and retain appropriately trained laboratory staff to provide HIV diagnostic and monitoring tests. Activity 1.2615 Equip provincial level hospitals with HIV Eliza testing machines ad washers to conduct QA for testing	MOH MOPH MOMS, HMIS, medical universities SCMS CDC/NIH, medical universities, professional associations, KEMSA, SCMS/ PEPFAR	X	X	X	X				
Subtotal - 1.26.1.											

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation								
1.27.1 Develop guidelines on QA/QC/ QI	NASCOP+MOH HMIS	Activity 1.2711: By 2010, develop policy , guidelines , standards of care and service package for HIV services; By 2010, Disseminate and orient HCWs and administrators standards on care and indicators for quality service delivery Activity 1.2712: Conduct Annual accreditation of HIV servicers at district and provincial hospitals	MOH MSH Univ. of Pennsylvania +Mbagathi Hospital Univ of Washington MSF-Belgium MOMS								

Output Result 1.28: By 2013 80% of service delivery points are offering high quality HIV services according to guidelines and standards

(Indicator): 1) % of Health facilities that meet quality HIV services standards (disaggregated by facility level and type of HIV services) 2) Number and % of health care facilities that received supervision in the past six months (disaggregated by facility level, location)

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.28.1 Monitoring of HIV service delivery standards	NASCOP, MOH. NPHLS, HMIS	Activity 1.2811: Conduct regular monitoring of implementation of standards of care at sites . Activity 1.2812: by 2010, conduct continuing medical education for HCWs on HIV services .	MOMS, MOPH, KEMRI NPHLS, Institutes of Higher Learning and CDC, USAID								
Sub – Total 1.28.1											

Output Result 1.29: By 2012, 50% of health care facilities establish new linkages for integration of HIV services

(Indicator): Number and % of health facilities reporting new partnerships for delivery of integrated HIV services (disaggregated by facility level, location)

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.29.1 Integration of HIV services	HMIS NASCOP	Activity 1.2911: A stakeholders meeting to review and harmonize the existing systems and reporting tools for integrated services, health programs and sectors Activity 1.2912: Stakeholders dissemination and consensus meeting to adopt the reviewed tools and systems. Activity 1.2913: Training of TOT's on the reviewed reporting tools and systems Activity 1.2914: Training of District teams on the reviewed reporting tools Activity 1.2915: Training of Health workers on the reviewed reporting tools	CDC APHIA II WHO								
Sub Total 1.29.1											

Output Result 1.30: By 2012, 50% of health facilities establish new linkages for integration with other health programs

(Indicator): Number and % of health facilities reporting new partnership for HIV integration into other health programs (disaggregated by facility level, location)

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
Activity 1.30.1 Support improved linkages & functioning of the horizontal and vertical referral and feedback mechanisms, through public and non public service providers.	HMIS NASCOP RH MoMS	Activity 1.3011: Stakeholders meeting to review HIV integrated tools and guidelines. Activity 1.3012: Dissemination/Consensus meeting on the reviewed tools and guidelines. Activity 1.3013: Printing of the reviewed HIV integrated tools and guidelines Activity 1.3014: Sensitization meeting on HIV Integrated tools and guidelines Activity 1.3015: Distribution of tools and guidelines to facilities Activity 1.3016 Strengthen the capacity of referral zones to provide specialized services at level 4 facilities and to develop skills of staff at level 4 to handle complicated cases at that level Activity 1.3017 Provide logistical and communication support in prioritized referral zones, including utility vehicles. Activity 1.3018 Provide communication equipment, ambulances for levels 1-4 facilities. Activity 1.3019 Strengthen infrastructure capacity at level 4 to provide secondary services to cases referred from level 2 and 3 facilities.	CDC/APHIA II/ WHO/ GoK		X	X	x	x	x	x	x
Sub Total 1.30.1											

Output Result 1.31: By 2012 50% of HIV health services at the district level establish linkages with other sectors

(Indicator): Number and % of health facilities reporting new partnerships with other sectors for delivery of integrated HIV services (disaggregated by facility level, location)

Milestone 2009/2010: Establish linkages with other partners and sectors

Milestone 2010/2011: Monitor linkages with other sectors

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.30.1 Linkages with other sectors	NASCOP DRH KMTC UON OTHERS	Activity 1.3011: Review of training curricula on networking and linkages with other sectors. Activity 1.3012: Sensitisation of managers on curricula and approaches to developing linkages with other sectors. Activity 1.3013: Provide support for planning and establishment of linkages with other sectors. Activity 1.3014: Monitor and evaluate implementation using the tracking system.	CDC APHIA II WHO								
Subtotal Result 1.30.1											

Output Result 1.32: By 2013 80% of health care facilities provide integrated RH/HIV services including STI services

(Indicator): % of Health facilities that meet basic service capacity standards for integrated RH/HIV services (disaggregated by facility level)

Milestone 2009/2010: implementation framework to facilitate integration of RH and HIV Services available

Milestone 2010/2011:% of facilities providing integrated services in CCC:

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.32.1 Provision of integrated RH / HIV and STI services	NASCOP/DRH	Activity 1.3211: Conduct RH / HIV Taskforce Meetings. Activity 1.3212: Develop an implementation framework to facilitate integration of RH and HIV Services Activity 1.3213: Identify and assess existing RH and HIV materials (guidelines, curriculum, training packages) Activity 1.3214: Identify and assess existing RH and HIV M & E tools for integration of RH and HIV Activity 1.3215: Systems strengthening to enable provision of integrated services at all levels Activity 1.3216: Advocacy and dissemination of the RH/HIV strategy, materials and tools Activity 1.3217: Monitor RH HIV services through targeted support supervisions	WHO,CDC,USAIDAPHIA II, FHI, JHPIEGO, POP Council, HPI, MSH, EH, and other NGOs Training institutions, regulatory bodies ‘ Provinces/District partners and other stakeholders								
Subtotal for Result 1.32.1:											
HLOP : By 2013 health sector supply chain management system has uninterrupted supply of quality commodities to health facilities **(Indicator):** % of public facilities reporting no stock outs of tracer commodities all year round; % of HIV commodities meeting established quality standards											

Output Result 1.33: By 2013 all HIV related commodities are quality assured

(Indicator): % of Product batches of pharmaceuticals and lab commodities that have undergone a quality control process at the initial receipt according to standard procedures

(disaggregated by type of product)

Milestone 2009/2010: Develop standards for QA for HIV pharmaceuticals

Milestone 2010/2011: Implement QA strategy for HIV commodities

Activity description	Responsible/ lead organisation / agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.33.1 Quality assurance of HIV commodities performed	Pharmacy and Poisons Board, KEMSA NASCOP (Commodity Logistics Team) HMIS, NPHLS National Quality Control Labs. PPB	Activity 1.3311 By 2010, develop a product tracking and recall system for all commodities integrated w HMIS Activity 1.3312 Develop Standards for procurement of laboratory commodities and handling of donations. Activity 1.3313 Development of standards for warehousing of commodities and disposal and recall of expired products. Activity 1.3314: by 2010, conduct increased batch sampling and evaluation (both for new and routine) Activity 1.3315: Conduct routine post market surveillance of pharmaceutical products in the market Activity 1.3316: by 2010, Create, deploy and maintain a system for patients and health workers at the front lines to publically document products found with defects (and stock outs).	KEMSA, MSH (?)Ministries of Health, KEMSA, USG, JSI, MEDS, HAI-AFRICA, SCMS ; WHO-drug prequalification program GROOTS-Kenya, KEMSA, CBOs-networks of post test clubs								
Sub Total 1.33.1											

Output Result 1.34: By 2011 all laboratory tests performed in a quality assured manner

(Indicator): % of Laboratories performing regular external quality assurance for specific tests (disaggregated by type of test, facility level)

Milestone 2009/2010: Develop policy and guidelines for QA for laboratories

Milestone 2010/2011: Roll out Laboratory QA system

Activity description	Responsible/ lead organisation/ agency or division/unit		Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.34.1 Strengthen quality assurance for laboratories	NPHLS/ NASCOP HMIS	Activity 1.3411 :By 2010 and annually thereafter, development of updated lab policy guidelines and QA systems and standards Activity 1.3412 :Establishment of a quality assurance program and enrolment of laboratories into an external quality assurance scheme Activity 1.3413: Training and mentorship of medical laboratory technologists on QA and networking	JICA, MSH, CDC, WHO, GOK, DSW								
Sub Total 1.34.1											

Output Result 1.35: By 2013 policy, guidelines and framework established and updated to support universal access to commodities

(Indicator): 1) National policy, guidelines and framework for universal access to HIV related commodities developed, implemented and reviewed s) % patients with medicines prescribed based on national treatment guidelines (disaggregated by regimen)

Milestone 2009/2010 Develop policy, guidelines and commodity logistics framework

Milestone 2010/2011: Automate inventory an supply chain management system for commodities

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.35.1 Strengthen commodity management, supply and distribution.	NASCOP & KEMSA (Commodity Logistics Team) HIMS NASCOP, NPHLS, DRH & KEMSA (Commodity Logistics Team) HMIS	Activity 1.3511: By 2010, develop policy guidelines and commodity logistics framework for automated electronic commodity inventory supply and control for *care* (HCBC and palliative care, nutrition) and *prevention* (VMAMC, injection safety, IDU, MSM & WSW) as well as routine medical supplies (gloves, etc.) integrated w HMIS. Activity 1.3512: By 2010, review and strengthen guidelines and commodity logistics framework for automated electronic commodity inventory supply and control for ARVs and treatment and prevention of OIs + STDs (ART, PMTCT, PEP, plus HTC, laboratory reagents and supplies, condoms, emergency contraception pill, OIs & STIs) integrated w HMIS. Activity 1.1353: By 2010, create national automated inventory supply chain control and management system, integrated with HMIS (scaling up and automating already existing pilots): Training of HCF staff where system is installed. Maintain and update system, including remote tech support online and by phone, plus travelling onsite tech support and training offices located one per each province. Activity 1.1354: Create and deploy a system for patients and health workers at the front lines to publically report and document stock outs (and products found with defects) Activity 1.1355: Decentralize KEMSA warehousing and distribution functions to regional depots /Strategic distribution units Activity 1.1356: Facilitate the automation of supply chain management by linking KEMSA Enterprise Resource Planning and the facilities. Activity 1.1356: Implement effective information management systems that will strengthen commodity management across the supply chain. Activity 1.1357: Avail commodity tracking tools in gazetted health facilities in the selected implementation regions; sub-activities: Avail electronic tracking tools (Electronic dispensing tool, Inventory tracking tool) at all level 4&5 facilities and large mission hospitals; purchase and install commodity management software in all dedicated or shared computers for commodity management in selected facilities. Activity 1.1358: Train all health care staff with particular emphasis on pharmacists, pharmaceutical technologists, procurement officers, and lab technicians on hardware and software use;	Ministries of Health, KEMSA, USG, JSI, MEDS, MSH, SCMS AFRICA, APHIAs, GTZ, PEPFAR-SCMS consortium, GROOTS-Kenya, CBOs-networks of post-test clubs		X	X	X	X	X		

		Activity 1.1359: Ensure effective commodity management through supportive supervision using existing national supervisory tools) Activity 1.135.10: Build the capacity of HR at all healthcare levels in the regions including FBO facilities in various supply chain management areas. (Commodity management, including the pull system; Activity 1.135.11: Train District Health Management Team members on supportive supervision; Activity 1.135.12: Train health facility staff on basic IT skills; Activity 1.135.13: Disseminate more training tools and guidelines on Pharmacovigilance. Activity 1.135.14: Develop and disseminate training tools, and guidelines on Appropriate Medicines Use (AMU.)									
Sub Total 1.35.1											

Output Result 1.36: By 2013 commodity management is effectively coordinated

(Indicator): Existence of a nationally coordinated multi-year HIV commodity plan with a schedule for procurement prepared and being implemented

Milestone 2009/2010 Develop and Review multi-year commodity plan and procurement schedule

Milestone 2010/2011: Harmonize procurement operations among partners

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.36.1 Management of commodity plan	NASCOP (Commodity Logistics Team)	Activity 1.3611 By 2010, develop a multi-year commodity plan and procurement schedule (HCBC, palliative care, nutrition, PMTCT, VMAMC, injection safety, STDs), reviewed annually to account for updates in standards of care and practice. Activity 1.3612: By 2010, review the multi-year commodity plan and procurement schedule (ART, TB, malaria, HTC, OI treatment and prevention, laboratory, condoms, emergency contraception program and PEP) reviewed annually to account for updates in standards of care and practice. Activity 1.3613: by 2011, harmonise procurement operations for all implementing partners (e.g. PEPFAR)	NPHLS, KEMSA, PEPFAR, Clinton Foundation, MEDS, JSI, Procurement Agents NACC								
Sub Total 1.36.1											

Output Result 1.37: By 2013 harmonized, HIV commodity needs identified for incorporation into Mid Term and Annual Procurement Plans

(Indicator): % partners following standard ARV procurement mechanisms according to national guidelines (disaggregated by type of partner, location)

Milestone 2009/2010: Conduct annual forecasting for HIV commodities and incorporate in AOP 2010

Milestone 2010/2011: Conduct annual forecasting for HIV commodities and incorporate in AOP 2011

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.37.1 Harmonization of HIV commodity needs	NASCOP (Commodity Logistics Team) NPHLS, DRH	Activity 1.3711 Undertake forecasting for all HIV, TB and malaria commodities, revised annually to incorporate updates in standards of care. Activity 1.3712: Incorporate the HIV commodity needs into AOPs and MTEF process	DRH, NPHLS, KEMSA, PEPFAR, Clinton Foundation, MEDS, JSI, Procurement Agents, users, etc DRH, DOP,NUTRITIONISTS,	X				X			
Sub Total 1.37.1											

HLOP : By 2013, new and existing health workers are deployed equitably to meet staffing needs of HIV services

(Indicator): Number of health workers per 100, 000 population (disaggregated by sex, cadre, newly recruited/existing, region, service delivery point)

Output Result 1.38: Adequate staffing for HIV services appropriate for each level and informed by disease burden and package of services

(Indicator): % of Health facilities that meet basic HIV staffing capacity as per national norms and standards (disaggregated by facility level, cadre)

Milestone 2009/2010: developing staffing inventory

Milestone 2010/2011: optimize utilization and deployment of existing medical professionals

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.38.1 Strengthen Human resources for health	MOH/MOMS KMTC MOH + MO Higher Education	Activity 1.3811: Conduct staffing (and equipment) inventory of all public sector HCFs, graduation rates from all medical and nursing educational institutions in Kenya, and measurements of unemployed and underemployed health professionals of working age to establish baselines and goals for production and retention, and to monitor progress Activity 1.3812 By 2010, establish and continue increased scholarship programs to pay tuition and increase enrolment.; By 2010 through 2013, new medical and nursing educators are recruited at relevant educational institutions to increase enrolment.; By 2010, new construction and/or renovation of new or existing education facilities and student housing is launched, and completed by 2011 Activity1. 3813: establish and achieve an improved standard for student/lecturer ratios at medical and nursing education institutions Activity 1.3814: by 2010, review medical and nursing education standards to develop and implement areas for improvement, including partnering/twinning with other external institutions and exchange programs, QA/QC standards, and accreditation. Update every two years.; Begin rollout of implementation in 2010, complete by 2012 Activity 1.3815 By 2010, contact unemployed or retired HC professionals of working age to recruit back in to service Activity 1.3816 in 2009-2010, review and revise as needed (possible advocacy campaign) HCW employment policies that contribute to underemployment, mal-distribution and unemployment of existing HCWs Activity 1.3817 beginning in 2010, optimize utilization and deployment of existing unemployed and underemployed medical professionals Activity 1.3818: by 2013, enough new and existing HCWs are deployed or in the education pipeline to achieve national staff standards at all [OR: 80% of hardest hit] health facilities			X	X					

Output Result 1.39: Disparities in distribution of health professionals reduced and retention increased:

(Indicator): Distribution and annual rate of retention of trained HIV service providers at public health facilities (disaggregated by cadre, region, and sex)

Milestone: 2009/10: Development of health worker retention strategy

Milestone 2010/11: Implementation of health worker retention strategy

Activity description	Responsible/ lead organisation/ agency or division/unit	Resource needs and baseline	Participating partners for implementation	Scheduled Time frame							
				2009/10	2010/11						
				1	2	3	4	1	2	3	4
1.39.1 Attraction and retention of health workers	NASCOP MOMS, MPH MoF	Activity 1.3911Advocate for harmonisation of wages between disease initiatives and public sector Activity 1.3912: Develop/update (2009) and implement (2010-2013) comprehensive urban and rural retention strategies sufficient to double estimated retention rates retain health workers in numbers that meet national health worker staffing guidelines. Activity 1.3913: Coordinate in-service training programs sponsored by state and non-state actors and integrate with national CPD systems Activity 1.3914: Advocate to prioritise rural health workers' career advancement, giving promotion preference for those who have performed extended rural service Activity 1.3915: Recruit and deploy existing and additional health workers to meet national distribution /staffing norms in rural settings	Global health initiatives MOH + other relevant ministries, AMREF and health professional associations devise strategies HCFs implement, with others PEPFAR, USAID/Capacity Project, GFATM, GOK DfID								
Sub Total 1.39.1											

Output Result 1.40: Enhanced management of human resources to improve performance

(Indicator): Health sector human resource management plan developed, agreed, implemented and reviewed annually (GFATM)

Milestone 2009/2010: Review of Health sector human resource strategies

Milestone 2010/2011: Capacity building of regional management teams

Activity description	Responsible/ lead organisation/ agency or division/unit	Resource needs and baseline	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.40.1 Capacity building and review of HRH polices, strategies and guidelines	MOH	Activity 1.4011: advocate for review and update as needed existing NHSSP III health sector human resource management policies Activity 1.4012: Promoting and supporting innovative in-service learning approaches for HCWs that are cost effective, including distance learning with accredited online courses, service rotations at diverse rural and urban locations in-country Activity 1.4013: Conduct management development training for provincial/ district management teams in at least 24 districts in two provinces.	MOH, MOMS, Mo Higher Education, Global disease initiatives Medical/nursing universities SAFCOM, ZAIN, TELKOM etc AMREF								
Sub Total 1.40.1											

Output Result 1.41: By 2013 HIV services are implementing MOH Community Health Strategy's components of task shifting to improved accessibility to services at facility and community level

(Indicator): % of service providers with minimum capacity performing HIV tasks formerly routinely implemented by higher cadres as per national guidelines

(disaggregated by specific prevention, treatment or care services, cadre)

Milestone 2009/2010: Policy Review of task shifting

Milestone 2010/2011: Implement task shifting policy

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.41.1 Implement community health strategy and task shifting	MoH	Activity 1.4111 by 2011, Train CHWs and Community Health Extension Workers (CHEWs) in numbers sufficient to fully implement the MoH Community Health Strategy for Level 1 Facilities in 80% of districts (hardest hit by AIDS-TB-malaria), including distance learning; Renew/update training annually/biannually based on community needs assessments. Activity 1.1422 Starting in 2009 (activity *is already* underway) and completing by 2011, Equip, deploy and compensate CHWs and Community Health Extension Workers in numbers sufficient to implement the MoH Community Health Strategy for Level 1 Facilities in 80% of districts Activity 1.4113: By 2009, conduct policy review of the tasks to be shifted Activity 1.4114: Promotion of policies to facilitate task shifting. Review of those inhibiting the same. Activity 1.4115 Sensitization and mobilization of communities Activity 1.4116 Technical support, Supervision, monitoring and evaluation Activity 1.4117 Procure equipment and health kits Activity 1.4118 Improve linkages between the community and service Providers Activity 1.4119 Strengthen Community Systems.	ALL public sector HCFs, FBO HCFs and partner supported private health facilities AMREF Partners in Health APHIAs- CBOs, Home Based Care Alliance/ GROOTS Kenya Division of Community					X	X	X	X
HLOP : By 2013, Health Management Information System provides strategic HIV information and evidence to guide policy and planning											
(Indicator): % of districts submitting timely, complete and accurate reports to the national level (number and percentage))											

Output Result 1.42: By 2011 routine patient monitoring systems for HIV harmonized and generating quality data for timely decision making at patient and programmatic level

(Indicator): Universal implementation of the integrated health sector HIV reporting system/ % of health facilities utilizing harmonized HIV reporting systems

Milestone 2009/2010: Analysis for health sector indicator baselines

Milestone 2010/2011: Harmonization and roll out national HIV M and E system

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame
1.42.1 Strengthen the information system to provide quality, timely strategic HIV information from all districts and sectors.	**HMIS/NASCOP**	Activity 1.4211: Provide Technical, administrative and logistical support for rapid situational analysis to gather baseline information for critical health sector indicators for KNASP III (1 month consultancy) Activity 1.4212: Consultative stakeholder meetings to develop consensus protocols for coordinated standardized data collection, transfer, reporting and use of routine HIV programme monitoring held Activity 1.4213: Develop/adapt protocols, tools and reporting systems for routine HIV programme monitoring Activity 1.4214: Consultative stakeholder meeting to endorse revised protocols, tools, reporting systems Activity 1.4215: Training/orientation conducted for different levels on standardized routine HIV programme monitoring protocols integrated in to HMIS Activity 1.4216: Provide appropriate equipment and tools for routine HIV programme monitoring included as part of HMIS to all provinces/districts /partners. Activity 1.4217: Administrative and logistical support for mobile provincial and district mentorship team visits to support facility levels Activity 1.4218: Hold quarterly provincial/central level meetings for review & triangulation of HIV programme monitoring data. Activity 1.4219: Implement an elaborate integrated and interoperable Electronic Health Facility Information System (EHR) at Level 4 hospitals. (Sub-activities: Assess EHR system readiness in the hospital, procure computer hardware and accessories; Acquire software, review and rollout in hospitals.) Activity 1.421.10: Conduct capacity building on data warehousing, analysis, dissemination and use of information for all sub systems/ data sources. (Sub-activities: Build capacity on data warehousing, analysis, dissemination and use of information in all sub systems) Activity 1.421.11: Strengthen HIS institutional, coordination and partnership structures. (Sub-activities: Establish structures for a functional and well coordinated National Health information system with sustained partnerships, Strengthen supportive supervision for HMIS)	Gates Fdn HMIS Unit, Priority Programmes, TA, PHMTs, DHMTs, Civil Society, Private Sector, disease programmes and other stakeholders.	
Sub Total 1.42.1				

HLOP : Improved absorption capacity of HIV funding to the health sector

(Indicator): % of funds received by health sector

Output Result 1.43: By 2012 financial systems are harmonized and optimized to improve efficiency and support timely disbursements, reduced costs, integration and enhanced accountability from national to service delivery level

(Indicator): % of health sector units meeting established HIV financial management criteria (disaggregated by admin level, location)

Milestone 2009/2010: Develop financial reporting system for HIV interventions

Milestone 2010/2011: Roll out and monitor financial reporting system

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.43.1 Harmonization of financial systems / financial tracking	NASCOP	Activity 1.4311 Hold half yearly national meeting on financial resource allocation and utilization under the NPO Activity 1.4312 Disseminate the resource allocation and utilization report (across funding sources) to the regions. Activity 1.4313 Employ district accountants to all districts in the country Activity 1.4314: Develop reporting software for all programmatic and financial reports. Activity 1.4315: Train 300 accountants and managers on utilization of resource tracking and reporting software. Activity 1.4316: Develop online funds flow tracking system (web page showing amounts available movement and amounts spent) Activity 1.4317 Hire IT expert to collect data for the funds flow tracking system. Activity 1.1438 Communication costs to collect information for the national funds flow tracking system Activity 1.4319 Hire external auditor to expedite preparation of audit reports Activity 1.43110: Disseminate funds based on NPO workplan. Activity 1.43111 Prepare report for senior level consumption on bottlenecks on financial disbursement, utilization and reporting			X		X				

Output Result 1.44: By 2012 an adequate national feedback mechanism is in place that feedbacks summaries of program and finance reports to all district managers at all levels

(Indicator): % districts that received timely, updated and objective feedback for reports submitted in past 12 month (disaggregated by location, type of report, and source of feedback)

Milestone 2009/2010: Conduct regional M and E financial tracking interventions

Milestone 2010/2011: Develop and maintain database of regional reports

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.44.1 Feedback of M & E findings	NASCOP DMS, DPHS PDPHS, DASCO, DMOH, DHMT Team and Partners	Activity 1.4411 Meetings at District Level on feedback quarterly yearly. Activity 1.4412: Meetings at Regional Level on feedback half yearly. Activity 1.4413: Meetings at National Level on feedback half yearly. Activity 1.4414 Maintenance of database of programmatic and financial reports	APHIA 2 and other Partners	x	x	x	x	x	x	x	x
Sub Total 1.44.1											

Output Result 1.45: By 2012 financial planning, budgeting, allocation of funds and forecasting by the health ministries facilitating timely disbursements

(Indicator): % of health service delivery units receiving an allocation for HIV and AIDS work plans one month within due date (disaggregated by admin level, location)

Milestone 2009/2010: Develop a financial disbursement tracking system

Milestone 2010/2011: Manage funding and budgeting cycle

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.45.1 Financial management	NASCOP Service delivery units in charge HMIS	Activity 1.4511: Utilize the NPO to submit a detailed budget by March of every year to NASCOP Activity 1.4512: Develop a tracking system to identify bottlenecks in approval process Activity 1.4513: Recruit an expert to manage budgeting and funding cycle and generate reports for senior management	APHIA 2, and others								
Sub Total 1.45.1											

Output Result 1.46: By 2012 additional approaches are utilized to ensure predictable financing and sustainability for the health sector HIV response

(Indicator): % of health sector HIV response sustained by other resources (disaggregated by source)

Milestone 2009/2010: Advocate for additional funding for HIV services in health sector

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.46.1 Monitoring of financial resources	NASCOP	Activity 1.4611. Develop funding dashboard detailing all funds incoming utilized and bottlenecks Activity 1.4612: Develop a quarterly bottleneck report for senior management Activity 1.4613: Develop rolling report on the cost of the HIV commodities for consumption by senior level ministry of health management to advice on sustainability planning. Activity 1.4614: Meet with manufacturers of drugs and commodities in Kenya to develop strategic drug manufacturing capability in country	APHIA 2 and other partners								

Outcome Result: By 2013, KNASP III is effectively operationalized

(Indicator): KNASP III coordination and implementation structures in place

HLOP : By 2013, Mechanism for coordination of KNASP III in place and operational

(Indicator): No. of partnership fora functioning at all levels and sectors

Output Result 1.47: Advocacy conducted by health ministries for appropriate policies, frameworks and guidelines

(Indicator): Health sector advocacy agenda, strategy and implementation plan developed, agreed, implemented and renewed annually

Milestone 2009/2010: HIV health sector advocacy agenda developed

Milestone 2010/2011: HIV health sector advocacy agenda reviewed

Activity description	Responsible/lead organisation/agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
1.47.1 Advocacy	Ministries of Health NASCOP	Activity 1.4711: Develop and agree with stakeholders on national advocacy agenda. Strategy and implementation plan. Activity 1.4712: Implement national advocacy activities specified under strategy and implementation plan Activity 1.4713: Monitoring and evaluation of health sector HIV advocacy implementation plan	CSO NGOs		x	X	x	x	x	x	x

Output Result 1.48: By 2013 appropriate policies and guidelines are reviewed, developed and implemented

(Indicator): Number of polices and guidelines reviewed, developed and implemented

Activity description	Responsible/lead organisation/agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.48.1 HIV Policy development	NACC / Ministries of Health	Activity 1.4811 Advocate, review and update HIV policies, standard operating procedures (SOPs), guidelines and roll out implementation/operational plans on HIV prevention programmes: HTC, Condoms, TB /HIV infection control, STIs, Male circumcision, Medical transmission PMTCT									

Output Result 1.49: By 2013 an all inclusive HIV health sector plan developed and implemented and reviewed annually

(Indicator): A nationally coordinated multi-year HIV health sector plan of operation has been prepared and is implemented

Milestone 2009/2010: Health sector HIV business plan in place

Milestone 2010/2011: Health sector HIV business plan updated

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.49.1 Development of annual operational plans	Health Ministries / NASCOP	Activity 1.4911: Conduct annual national and regional level coordination workshops to develop 3-year operational plan rolling over annually with accompanying procurement plans. Activity 1.4912: Hold regular bi-annual planning and review meetings with stakeholders at regional and national level. Activity 1.4913: Conduct regular monitoring meetings and supportive supervision visits of programme activities.	NASCOP and all HIV implementing partners in the health sector				X				X

Output Result 1.50: By 2013 roles and functions of different levels of NACC and NASCOP clearly defined and operationalized

(Indicator): Harmonization and alignment of roles and functions for NACC and NASCOP developed and agreed upon for all levels

Milestone 2009/2010: Assessment of roles and functions of different levels of NASCOP and NACC conducted

Milestone 2010/2011: Roles and functions between NACC and NASOP harmonized

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.50.1 Institutional strengthening	NACC/NASCOP ministries of health	Activity 1.5011 Undertake assessment of roles and functions of different levels of NACC and NASCOP under KNASP III Activity 1.5012: Harmonize and align roles and functions of different levels of NACC and NASCOP under KNASP III Activity 1.5013: Support organisational structures of NASCOP to enable it to undertake its mandate of coordination of all actors in the health sector responding to HIV at all levels Activity 1.5014: Conduct regular annual Health Sector reviews of progress of KNASP III.			X						

Output Result 1.51: By 2013 a code of conduct for Health Sector and its partners in public, private, NGO and FBO sectors that ensures the involvement and accountability of all key stakeholders in the HIV response is developed and operational

(Indicator): % partners working in HIV having signed a Code of Conduct with ministries of health (disaggregated by type of partner, level)

Milestone 2009/2010: number of partners working in HIV have signed Code of Conduct with ministries of health

Milestone 2010/2011: number of partners working in HIV have signed Code of Conduct with ministries of health

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
1.51.1 Codes of conduct	NASCOP	Activity 1.5111: Review existing code of conduct and hold sensitization meetings with stakeholders Activity 1.5112: Organise consultative meetings for partners to sign Code of Conduct with ministries of health Activity 1.15113: Hold annual meetings to review implementation of code of conduct.	CSOs, FBOs, NGOs, private sector								

Output Result 1.52: By 2013 coordinated structures and processes at national, provincial and district levels that are inclusive and ensure the input and participation of all health sector key stakeholders in the public, private, NGO and FBO sector, civil society and PLHIV

(Indicator): % of partners programming and reporting within KNASP priorities for health sector (disaggregated by type of partner, level)

Milestone 2009/2010: 50% of National provincial and district HIV and AIDS health sector coordinating forums in place

Milestone 2010/2011: 100% of National provincial and district HIV and AIDS health sector coordinating forums in place

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.52.1 Coordination of programme activities	NASCOP	Activity 1.5211 Constitute national, provincial and district HIV and AIDS health sector coordinating forums Activity 1.5212: Constitute Health Sector HIV and AIDS Technical working groups Activity 1.5213: Hold regular Health Sector HIV and AIDS Technical working group meetings.		x	x	x	x	x	x	x	x

Output Result 1.53: By 2013 NASCOP institutional capacity assessed and organizational structure developed and operational that ensures participation in planning, monitoring and coordination of HIV activities in the health sector (reinforcing of existing organizational plan)

(Indicator): NASCOP institutional capacity assessed, and organizational structure developed and operationalized for planning, monitoring and coordination of health sector HIV response

Milestone 2009/2010: NASCOP institutional assessment and revised organisational structure

Milestone 2010/2011: Report of annual performance review

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.53.1 Strengthen organisational structures of NASCOP	NACC, ministries of health, NASCOP	Activity 1.5311 Conduct institutional capacity assessment of NASCOP organisational structure. Activity 1.5312: Support organisational structures of NASCOP to enable it to undertake its mandate of coordination of all actors in the health sector responding to HIV at all levels Activity 1.5313: Implement recommendations of assessment and institute capacity building measures Activity 1.5314: Conduct annual reviews of NASCOP performance and prepare annual report and plan for coming year .			X	x	x	x	x	x	x

HLOP : National M & E system for KNASP III in place and operational

(Indicator): % of complete and accurate reports received from pillars

Output Result 1.54: By 2012 health sector clinical and operational research agenda for HIV developed and innovative approaches and best practices confirmed through quality research

(Indicator): 1) Health sector HIV research agenda and costed work plan developed, agreed, implemented and reviewed annually 2) Number of health sector HIV studies conducted, disseminated and

operationalised (disaggregated by type & focus of study)

Milestone 2009/2010: Develop health sector HIV research agenda

Milestone 2010/2011: Implement health sector HIV research agenda

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.54.1 Development of HIV research agenda	NASCOP/ KARSCOM	Activity 1.5411: Technical, logistical plus administrative support for situational analysis for inventory of past in-country HIV evaluation and identify research gaps (1 month consultancy) Activity 1.5412: National consultative stakeholder meetings to develop draft health sector research agenda and costed work plan (with TA). Activity 1.5413: Technical support for review and update guidelines on approach and standards for health sector HIV research (1 month consultancy) Activity 1.5414: Technical working group meetings to develop protocols for selected HIV research studies. Activity 1.5415: Seek ethical approval for health sector HIV research protocols Activity 1.5416: Train focal persons on Good Clinical Practices/ Good Clinical and Laboratory Practices (3 days course) Activity 1.5417: Equip selected sites with study tools and equipment Activity 1.5418: Recruit and train study teams for selected research Activity 1.5419: Administrative and logistical support for implementation of selected field research Activity 1.54110: Technical support for internal and external study monitoring and supervision on participant recruitment, study procedures, data management. Activity 1.54111: Technical support for data analysis and report writing (1 month per study) Activity 1.154112: Disseminate research findings locally, regionally and elsewhere via meetings and conferences				X	X				

Output Result 1.55: By 2012 regular program evaluations of needs, trends and projections influencing health sector planning, costing and implementation of HIV prevention, treatment, care and support programmes

(Indicator): Number of health sector HIV programme evaluations conducted, disseminated and operationalised (disaggregated by type of programme and type of evaluation)

Milestone 2009/2010: HIV programme evaluations needs defined

Milestone 2010/2011: Selected HIV programme evaluations conducted

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame				
				2009/10				2010/11
				1	2	3	4	1
1.55.1 Programme Evaluations	NASCOP/NACC	Activity 1.5511: National consultative stakeholder meetings to draft health sector HIV programme evaluation agenda and costed work plan (with TA) Activity 1.5512: Technical support for review and update guidelines on approach and standards for health sector HIV evaluations. Activity 1.5513: Train focal persons on national guidelines and standards for HIV program evaluations Activity 1.5514: Technical working group meetings to develop protocols for selected HIV program evaluations. Activity 1.5515: Seek approval for evaluation protocols. Activity 1.5516: Recruit and train evaluation teams for specific program evaluations Activity 1.5517: Administrative and logistical support for implementation of selected baseline, mid-term and end-of-program evaluations Activity 1.5518: Technical support for internal and external monitoring and supervision on participant recruitment, procedures, data management for program evaluations Activity 1.5519: Technical support for data analysis and report writing on program evaluation(s) Activity 1.55110: Disseminate evaluation findings locally, regionally and elsewhere via meetings and conferences		X	X			

Output Result 1.56: By 2012 a harmonized, standardized, and customized database for health sector M& E information system is functioning and widely accessible

(Indicator): Health sector integrated database for health sector information system developed, approved, implemented and reviewed annually

Milestone 2009/2010: Develop and electronic health sector HIV information system integrated with HMIS

Milestone 2010/2011:Roll out system for use in health facilities

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame				
				2009/10				2010/11
				1	2	3	4	Y2
1.56.1 HIV information database	NASCOP/HMIS/ NACC	Activity 1.5611: Conduct consultative stakeholder meeting to reach consensus on design and function of an integrated national health sector HIV and AIDS information system with linkages to HMIS [including supply chain management]. Activity 1.5612: TWG meetings to define SOW for software developer for integrated database and potential consumers . Activity 1.5613: Technical support for development of health sector national HIV information database software and user guidelines (1 month consultancy) Activity 1.5614: Logistical and administrative support to pilot integrated database software and user guidelines at central and provincial level Activity 1.5615: Procure and install required hardware and accessories for integrated HMIS national HIV database Activity 1.5616: Improve internet connectivity and computer literacy for national and sub-national level consumers in public sector, medical suppliers, FBO and donors sponsored HCFs Activity 1.5617: Recruit, train and mentor focal persons responsible for updating of national health sector HIV database in HMIS Activity 1.5618: Administrative and logistical support for regular collection, posting of HIV M&E and research reports on integrated health sector HIV database Activity 1.5619: Disseminate updates on national HIV database at all levels via website Activity 1.56110: Annual meetings to review national health sector HIV database performance	Gates Fnd MOH PEPFAR MSH GFATM PEPFAR Clinton Foundation? GoK, partners, universities	X	X			

Output Result 1.57: By 2012 epidemiological surveillance system is expanded to include longitudinal ART client monitoring and HIV drug resistance monitoring

(Indicator): Health sector HIV surveillance and ART monitoring agenda and costed work plan developed, agreed, implemented and reviewed annually

Milestone 2009/2010: Develop HIV epidemiologic surveillance plans and protocols

Milestone 2010/2011: Implement HIV surveillance protocols

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.57.1 HIV surveillance	NASCOP/NACC	Activity 1.5711: Consultative meetings to review priority areas, protocols and develop work plan for HIV biological and behavioural surveillance at individual patient, cohort, and population levels. Activity 1.5712: Technical support to develop/adapt protocols for new surveillance (HIVDR or ART client monitoring, etc.) Activity 1.5713: Train focal persons on specific HIV surveillance protocols Activity 1.5714: Provinces/districts/sites equipped with resources, and appropriate tools and equipment for HIV surveillance Activity 1.5715: Administrative, logistical and technical support for implementation of selected surveillance Activity 1.5716: Technical support for data analysis and reporting on selected surveillance Activity 1.5717: Disseminate surveillance findings locally, regionally and elsewhere via meetings and conferences.	MOH PEPFAR GF WHO								

Output Result 1.58: By 2012 findings from all HIV surveillance, surveys and research are widely disseminated

(Indicator): Number of stakeholders who received updated and objective strategic information obtained through HIV surveillance, surveys and research

(disaggregated by type of stakeholder, information product, location and admin level)

Milestone 2009/2010: Develop an HIV information dissemination framework

Milestone 2010/2011: Implement HIV information dissemination framework

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.58.1 Dissemination of M & E and research findings	NASCOP/NACC	Activity 1.5811: TWG meetings to define priority information needs, audiences and schedule and costed work plan for dissemination of health sector HIV M&E and research activities Activity 1.5812: Technical support to develop scientific writing skills for focal persons in health sector. Activity 1.5813: Technical support for development of information products targeting various audiences Activity 1.5814: Orientation of policy makers and media on interpretation and communication of health sector HIV strategic information and research evidence Activity 1.5815: Administrative and logistical support for dissemination (press conference, print, brochures, reports, broadcast, etc.) Activity 1.5816: Annual consultative meetings with policy makers and programmers to review and apply health sector strategic information and evidence to policy and work plans. Activity 1.5817: Annual monitoring and reporting on dissemination activities for health sector HIV M&E and research									

Output Result 1.59: By 2012 at least 7% of financial resources for the health sector HIV response are allocated to M&E activities

(Indicator): % of funds received by health sector for HIV and AIDS utilized for HIV M&E (disaggregated by source, type of activity)

Milestone 2009/2010: Define costing for all M and E interventions

Milestone 2010/2011: Advocate for more funding for M and E

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
	NASCOP/HMIS	Activity 1.5911: Train epidemiologists, surveillance Activity 1.5912:Employ epidemiologists, surveillance experts statisticians and data clerks for all levels experts and statisticians Activity 1.5913: Cost for all surveys to be conducted under KNASP III (KAIS, Behavioural survey, KDHS, treatment outcome surveys, HIV DR surveys) Activity 1.5914: Develop a singular information system integrating HMIS, LMIS, and all other information systems. Activity 1.5915: Develop a laboratory information system and integrate it to the integrated information system Activity 1.5916: Develop a national web based information feedback mechanism Activity 1.5917: Provide IT equipment with internet connection to all districts in the country. Activity 1.5918: Employ IT expert to maintain the web based system Activity 1.5919: Contract an IT firm to carry out maintenance of the web based information system									
HLOP : By 2013, financing of KNASP III is harmonised and aligned **(Indicator):** % KNASP funding need met; % financing of KNASP by source; % of KNASP funding utilized											

Output Result 1.60: By 2010 justification for financing of health sector response under MTEF process to cover funding gaps and ensure sustainability submitted to treasury

(Indicator): % resources mobilized by Treasury for the health sector HIV response under the MTEF

Milestone 2009/2010: Justification for funding under MTEF submitted to ministry of finance and planning

Milestone 2010/2011: Report on level of funding for Health sector HIV response mobilized under MTEF

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
1.60.1 Advocacy for MTEF funding / Resource mobilisation	NASCOP NACC	Activity 1.6011: Prepare and submit annual justification for request of financing under MTEF Activity 1.6012: Advocate for mobilization of resources from ministry of finance and planning Activity 1.6013: Monitor progress of mobilization of resources under MTEF			X				X		

Output Result 1.61: By 2010 health facility funds are utilized for specific HIV activities

(Indicator): % contribution of health facility fund for HIV activities (disaggregated by type of HIV programme and facility type and region)

Milestone 2009/2010: Number of facilities utilizing health facility funds for HIV activities

Milestone 2010/2011: Number of facilities utilizing health facility funds for HIV activities

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
1.61.1 Resource mobilisation through health facility funding	NASCOP / NACC	Activity 1.6111 Hold planning meetings to determine specific HIV activities to be supported through health facility funds Activity 1.6112 Hold high level meetings with policy makers to advocate for utilization of health facility funds for specific HIV activities. Activity 1.6113: Carry out annual review to determine progress.									

Output Result 1.62: By 2011 private sector participation in the health sector response to HIV in place through public private partnerships

(Indicator): Number and % of private sectors that work in partnership with public health sector in delivering HIV services (disaggregated by type of response and private sector)

Milestone 2009/2010: Number of public private collaborative agreements in place with

Activity description	Responsible/ lead organisation/ agency or division/ unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
1.62.1 Public private partnerships	Ministries of health and private sector	Activity 1.6211: Hold consultative meetings to explore development of mechanisms for public private partnerships in the health sector response to HIV Activity 1.6212: Facilitate private sector response to HIV through collaboration agreements for support for provision of drugs, testing kits, assistance for data collection and supportive supervision Activity 1.6213: Ongoing monitoring and reporting on progress	Private Sector Organisations								
Sub Total											

Bi-Annium Work Plan – Pillar 2: Sectoral Mainstreaming of HIV and AIDS

Outcome Result: By end 2013, HIV mainstreamed in all sector-specific policies and sector strategies.

INDICATOR: Number of sectors mainstreaming HIV

HLOP: By end 2013, all sectors develop and implement HIV and AIDS programmes.

Indicator: No. of sectors with HIV and AIDS programmes.

Output Result 2.1: By end 2011 National Social Protection Policy contextualized to HIV & AIDS and operationalised

Indicator: National Social Protection Policy reviewed with provisions for HIV and AIDS mitigation in line with the HIV Act

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame 2009/10 2010/11							
				1	2	3	4	1	2	3	4
2.1.1: Mainstream HIV and AIDS in the National Social Protection Policy and sectoral policies for programme planning.	Min Gender Children & Social Development.	-Activity 2.111: Identify and provide technical support for the contextualization of HIV & AIDS in the National Social Protection Policy; TA 140 man-days; production 100 000 copies, distribution, implementation, training & orientation.. -Activity 2.112: Provide technical support for developing the operational guidelines for Social Protection Policy, 100 000 copies, dissemination & training; 140 man-days. **(NASA Function- Policy: ASC. 7.01)**	National OVC Steering committee. Min. Education, KCS, NCCK, SUPKEM, Red Cross	x	x	x	x	x	x	x	x
Sub- total for Result 2.1.1											

Output Result 2.2: By end 2011 National Children Policies and frameworks reviewed and contextualized to HIV & AIDS and incorporate relevant HIV Act provisions.

Indicator: Percentage of National Children Policies and frameworks reviewed with relevant provisions for HIV and AIDS in line with the HIV Act.

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.2.1: Mainstream HIV and AIDS into National Children's Policies.	Min Gender Children & Social Development,	- Activity 2.211: Identify sources for and provide technical support for the finalization of the development & implementation of the National Childrens Policy / Framework ensuring inclusion of OVC minimum care & support packages childrens rights and relevant provisions of the HIV Act. 2 TA 40 man-days. -Activity 2.212: Develop and disseminate standardized operational guidelines, procedures, & tools to assess eligibility criteria and continuous ongoing support for foster parents. 20 000 copies. TA to develop operational procedures.20days, production, distribution of 20 000 copies.	NGO,CBO,FBO, Local authorities								
		- Activity 2.1.1.2.3: Develop documentation and reporting procedures to monitor social protection service delivery. Client Satisfaction Survey; TA, bi - annual; 120 man-days.	Line Ministries,Local Authorities, NGO, CBO, FBO								
Sub- total for Result 2.1.2											
Output Result 2.3: By end 2011 National Food Security policy reviewed and contextualized to HIV to mitigate the impact of HIV and AIDS on the infected and affected.											
Indicator: National Food Security Policy reviewed with relevant provisions for HIV and AIDS mitigation in line with the HIV Act											

Activity Description	Reponsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.3.1: Mainstream HIV and AIDS into National Food Security Policy	Min of Agric. Min. of Coop Dev.	-Activity 2.311: Review the National Food Security Policy to contextualize it to HIV & AIDS [Identify sources and provide technical support in development and dissemination of National Food Security Policy; TA 20 days, development, production 20 000 copies, dissemination 9 Provinces, 200 districts] -Activity 2.312 Provide nutritional support to destitute people living with HIV sectors.	Min Spec. Progr, NGO,CBO,FBO, Dev. Partner								
Output Result 2.4: By 2011 the education sector policies have mainstreamed HIV and AIDS and the relevant sections of the HIV and AIDS Prevention and Control Act.											
Indicator: Percentage of education sector policies with relevant provisions for HIV and AIDS in line with the HIV Act											

Activity Description	Reponsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.4.1: Mainstream HIV and AIDS into Education Policy	Min of Ed; NACC	-Activity 2.411: Review the Education Policy to mainstream HIV and the relevant sections of the HIV Act. -Activity 2.412: Provide technical support in development and dissemination of operational guidelines on HIV relevant education Policies including protection from HIV related discrimination in educational institutions; (TA 20 days, development, production 20 000 copies, dissemination 9 Provinces, 200 districts] -Activity 2.413 –Provide life-skills education towards behaviour change to in and out of school youth and children. (Cost estimated under Results Matrix costing; includes costing for life skills to under14.)									
Output result 2.5: Relevant laws and policies reviewed to protect against HIV related stigma, discrimination, human rights violations including the right to property and access to justice by the vulnerable											
Indicator: Percentage of relevant policies and laws reviewed with provisions against HIV related issues (stigma, discrimination, human rights violations and property rights) in line with the HIV Act											

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.5.1: Mainstream HIV and AIDS into GJLoS policies and review laws to protect against Rights Violations	NACC, MOJCA, KNCHR, PSC MOJCA,FKE, COTU, TSC, KNUT, Ministry of Justice, AG, Law reform Commission, Ministry of Lands, Judiciary	-Activity 2.511: TA mainstream HIV in the national Human rights policy and Develop national Guidelines on HIV related Human rights, and gender concerns and disseminate in all public and private Sectors and institutions, businesses, enterprises, organizations. TA 90 man-days -Activity 2.512: Review the Succession and Land Laws and Policies to protect inheritance and property rights of vulnerable populations. -Activity 2.513: Review the policy on alternative dispute resolution to facilitate alternative structures to enable access to justice by rural and community based populations to justice.	Kenya National Human Rights Commission, NGO,CBO,FBO, Dev.Partner, Local Authorities								

Output 2.6: Relevant local government policies reviewed to mainstreaming HIV concerns for informal settlements

Indicator: Percentage of relevant government policies reviewed that address HIV concerns among informal settlements in line with the HIV Act

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.6.1: Mainstream HIV and AIDS into local government policies.	Ministry of Local Government/ NACC	-Activity 2.611: Review the local government policies to mainstream HIV concerns for informal settlements.									

Output Result 2.7: By end of 2011 National Health Insurance Fund (NHIF) policy reviewed to facilitate greater access to health services and facilitate mainstreaming of the HIV Act and HIV-related benefits.

Output 2.8: Relevant Insurance policies reviewed to incorporate relevant provisions of the HIV Act.

Indicator: Percentage of relevant insurance policies reviewed with provisions for HIV and AIDS in line with the HIV Act

Indicator: NHIF contribution as % of total payment for HIV AIDS Services.

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
2.8.1: Mainstream HIV and AIDS into National Health Insurance Fund and other public and private insurance policies.	Ministry of Medical Services, NACC, Private Sector	-Activity 2.811: Review current NHIF coverage and possibilities for expansions. TWG meetings per day for extended period of time; 2x/month; 56 days. -Activity 2.812: Reform the NHIF to increase the number of population receiving HIV related NHIF payout /reimbursement. TA 60 man-days; - Activity 2.813: TA to modify Health sector charging mechanisms (electronic cards) for NHIF to cover for treatment of PLHIV. TA 40 man-days, -Activity 2.1.1.8.1: Review the Insurance policies to mainstream HIV concerns and the provisions of the HIV Act.	NHIF NHIF, MoF, MoPND & V2030 NHIF, MoF, MoPND & V2030	x	x	x	x	x	x	x	x
Output 2.9: Sessional Paper Number 4 of 1997 on AIDS reviewed in line with current trends of HIV. Indicator: Sessional Paper Number 4 of 1997 on AIDS reviewed to address current HIV trends.											
2.9.1: Update Sessional Paper No. 4 of 1997.	NACC, Sector Ministries, Line Ministries	-Activity 2.911: Review of Sessional Paper #4 in line with current HIV trends and emerging issues that require national guidance. -Activity 2.912: Present Revised Sessional Paper on AIDs to parliament for adoption.	OPM, OP, State Law Office, Parliament								
Output 2.10: By end 2011 HIV and AIDS Prevention and Control Act (2006) amended to entrench national HIV and AIDs institutional and coordination (NACC) framework and other key policy issues concerned. Indicator: National Composite Policy Index.											

Activity Description	Reponsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.10.1: Amend and update the National HIV and AIDS Prevention and Control Act.	State Law Office, NACC, M for Special Prog, Sector Ministries, Line Ministries	-Activity 2.101: Review the HIV Prevention Act to entrench institutional and legal framework for coordination by NACC and decentralised entities into legislation and include other identified sectoral concerns. -(sub activity) 2.102: Identification and documentation of outstanding issues. Meetings -(sub activity) 2.103: Building consensus around outstanding issues - (sub activity)2.104: Dissemination & advocacy on the Act. -(sub activity) Activity 2.105: Development of the operational rules & regulations for the Act . **-**(sub activity) Activity 2.106: National advocacy workshops to high level policy makers in every sector; 2 national workshops per sector, 1 regional workshop for KNASP III.	NGO,CBO,FBO, Dev.Partner, Private Sector (Informal and formal)	X	X	X	X	X	X	X	X
Output Result 2.11: By end 2011 National Gender Policy and their implementation frameworks reviewed and contextualized to HIV & AIDS. Indicator: Percentage of National and sectoral gender operational frameworks incorporating HIV specific contexts .											

2.11.1: Mainstream HIV and AIDS into National gender Policy	Min Gender Children & Social Development,	- Activity 2.11.1: Identify resource and provide technical support for the review of the national gender and development policy ,HIV and workplace guidelines, and ensure that the sexual offenses act and the HIV Act have mainstreamed gender aspects of HIV. -Activity 2.11.2: Develop and disseminate standardized operational guidelines, procedures ,& tools of the national gender policy which take into account the HIV context. TA to develop operational procedures.20days, production, distribution of 20 000 copies. Activity 2.11.3 Develope a guide on the HIV gender perspectives in Kenya to guide HIv mainstreaming in gender policies . TA for research for consolidation of HIV gender concerns. Consultative meetings with relevant technical committee. - Activity 2.11.4: Develop documentation and reporting procedures to monitor HIV context in gender mainstreaming programmes and activities.. - Activity 2.11. 5: Conduct sectoral studies to determine the most vulnerable populations plus the respective socio-economic cultural and political risk factors. - Activity 2.11. 6: Develop sector-specific gender-sensitive indicators in HIV and AIDS programmes to monitor progress in respective initiatives - Activity 2.11.7: Conduct organizational assessment for the organization/department to assess capacity to mainstream gender in HIV programmes and implement proposals - Activity 2.11.8: Evaluation of sectoral HIV related plans, polices and laws in terms of their effectiveness in addressing the rights and needs of different age groups of both sexes in the sector and use the results/recommendations to lobby for the roll out, review, enactment or reinforcement of protection from practices that promote HIV infection and impacts for women and girls. - Activity 2.11.9: Establish and equip a gender desk within the ACUs or establish operational linkages between ACU and the existing gender focal point in the organization to advice and provide enhanced advocacy on gender in research agenda-setting, funding, planning, program design and implementation, monitoring and evaluation.	NGO,CBO,FBO, Private Sector, Local authorities Line Ministries, Local National Gender Commission								
Output Result 2.12: By end 2012 National Youth Policy and Strategic Plan reviewed and contextualized to HIV & AIDS .											
Indicator: Percentage of National Youth Policy operational frameworks reviewed and contextualised to HIV and AIDS .											

2.12.1: Mainstream HIV and AIDS into National youth Policy and strategy	Min Youth and Sports	- Activity 2.12.1: Identify resource and provide technical support for the review of the youth and development policy , Strategic Plan, HIV and workplace guidelines, to mainstream youth aspects of HIV. -Activity 2.12.2: Develop and disseminate standardized operational guidelines, procedures ,& tools of the national youth policy which take into account the HIV context. Activity 2.12.3 Develop a guide on the HIV youth perspectives in Kenya to guide HIV mainstreaming in youth policies . (TA for research for consolidation of HIV youth concerns. Consultative meetings with relevant technical committee.) - Activity 2.11.4: Develop documentation and reporting procedures to monitor HIV context in youth mainstreaming programmes and activities.. - Activity 2.11. 5: Conduct sectoral studies to determine the most vulnerable populations plus the respective socio-economic cultural and political risk factors. - Activity 2.11. 6: Develop sector-specific youth-sensitive indicators in HIV and AIDS programmes to monitor progress in respective initiatives - Activity 2.11.7: Conduct organizational assessment for the organization/department to assess capacity to mainstream youth in HIV programmes and implement proposals.	NGO,CBO,FBO, Informal and formal private sector, Local authorities Line Ministries,								
Sub- Total for Result											
Total HLOP											
HLOP: Increase the public and private institutions with work place HIV and AIDS programmes **(NASA Cost Function : ASC: 7.01 Policy)** **Indicator 1: No of institutions with work place HIV and AIDS programmes;** **Alternative Indicator: Number and % of sector workplace policies reviewed with provisions for human rights, gender and GIPA concerns according to the HIV Act**											
Output Result 2.11: By end 2011 50% of public and private sector workplaces are covered by appropriate HIV workplace policies. Indicator: % of public and private sector covered by workplace policies											

Activity Description	Reponsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.11.1: Mainstream HIV and AIDS (including human rights, GIPA and gender concerns) into all Workplace Policies. **2.11.2: Review and update workplace HIV policies with provisions of the HIV Act.**	PSC, Ministry of labour, FKE, COTU, TSC, KNUT,NACC, Ministry of Public Service, Umbrella Trade Unions, IRCK Min Public services, Min Labour, NACC, FKE, and COTU. Min of Labour & HRD, MoSPND & V2030, NACC NACC	-Activity 2.111: Review current labour laws and workplace policies to mainstream HIV and the relevant provisions of the HIV Act and other human rights, gender and GIPA principles. -sub activity) Activity: 2.112 Commission a survey on the status of HIV AIDs workplace policies. TA 30days -Activity 2.113: Integrate survey findings on the impact of HIV on human resource into key sector strategy papers for economic planning & budgeting. TA 30 days, -(sub activity) Activity: 2.114 Build National consensus on harmonized workplace policy HIV & AIDS mainstreaming. 3 day national level meeting; 100 participants. -Activity 2.115: Develop guidelines for the implementation of reviewed workplace policy in the various sectors. -(sub activity) Activity 2.116: Produce & distribute 100 000 Copies of harmonized guidelines for HIV & AIDS mainstreaming. Document Development , TA 20 days, Production, distribution in 9 Provinces, 200 Districts; Fuel & Transport -(sub activity) Activity 2.117: Disseminate 9 Sector specific implementation guidelines in line with KNASP III addressing vulnerable populations/MARPS, Human Rights,Gender, Stigma & Discrimination, violence, sexual harassment. Document Development; TA 20days/ sector, 180 man-days, Production of 10 000 copies of each sector, distribution to 200 Districts fuel & transport.	Kenya Nat. Bureau of Statistics, Min. Planning,Min.Public Service. Relevant Line Ministries, FKE. Line Ministries,FKE,Local Authorities. TSC, Local Authorities, Private Sector entities, NGO Council, Nat.NGO Coordination Bureau Dev.Partners. Min. Gender Children & Social Dev. Public Sector Private Sector entities, NGOs, CBOsFBOs, Dev.Partners								

Output Result 2.12: By end 2011, 75 % of the HIV and AIDS programmes (ACUs) in Line Ministries & organizations have their roles and responsibilities redefined & fine tuned to sector and institutional objectives at each level.

Indicator: % of HIV Units (ACUs) receiving organizational and systems development support (disaggregated by sector, admin level)

Indicator 2: % of HIV Units (ACUs) with roles & responsibilities aligned to sector and institutional objectives.

				Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.12.1: Strengthen AIDS Control Units in all sectors.	NACC, Line Ministries, Min. Public Services, Private Sector,	-Activity 2.121: Develop sector specific human resource plan for effective ACU staffing at each administrative level including expertise on key aspects of human rights, gender, MARPS, GIPA etc. At four admin levels. Human Resource Capacity Needs assessment/HR mapping; TA 20days -Activity 2.122: Develop sector specific HIV & AIDS Mainstreaming Guidelines for planning & budgeting purpose. Developing & dissemination training and use. TA 20 days; training & orientation; each Ministry 3 days(120) at 200 districts (630); Facilitator 780 days. - Activity 2.123: Strengthen competence and capacity of ACUs in planning, budgeting, programme implementation, data management in line with KNASPIII monitoring tools. TA 5days orientation each Ministry-200 man days. - 2.124: Develop standard reporting format & reporting protocol in line with activity indicators based on the UNGASS workplace data collection sheet. - Activity 2.125: Conduct orientation sessions for the use of the reporting format and the protocol at each sector, national, Province, district, constituency, local authority including NGO,CBO,FBO, 3 day documentation workshop. -Activity 2.3.1.1.3: Develop & implement award scheme for private sector high performing companies. High Level function once /year	Dev. Partners, NGO, CBO, FBO, Local Authorities, Business Coalitions								
Activity Description	**Responsible/ Lead organization/ agency/ division/unit**	**Detailed Activities**	**Participating Partners for Implementation**	**Scheduled time Frame**							
				2009/10				**2010/11**			
				1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Review human resource policies and service charters to prohibit discrimination at the workplace		Activity 2.1.2.3.1: Review human resource policies in sectoral and institutional settings to prohibit HIV related discrimination in the recruitment, promotion and retention practices in workplaces. Activity: 2.1.2.3.2: Develop Service charters prohibiting HIV related discrimination in work places.									
Output Result 2.13. By end 2011 Workplace risks and vulnerabilities to HIV are identified and documented. **Indicator: % of Sectors providing HIV and AIDS Support & care for service providers and clients (disaggregated by sector)**											

Activity Description	Responsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.13.1: Develop guidelines to address workplace risks and vulnerabilities.	Mini. Of Medical Services, Min. of Labour & HRD NACC, Public Sector	Activity 2.131: Carry out situation analysis on workplace risks and vulnerability to HIV and Aids. Activity 2.132 : Develop guidelines and recommendations on workplace occupational risks and vulnerabilities to HIV and AIDS.	NGO,CBO,FBO, Dev.Partner, Local Authorities	X	X	X	X				

HLOP: By end 2013, 35% of Orphans, and other vulnerable populations receiving social protection

Output Result 2.14: By end 2013 Reduced differential of transition and completion rate from primary to secondary school between orphans and non orphans for boys and girls.

Indicator 1: % of orphans in school compared to non-orphans (disaggregated by age groups <10, 10-14, >14; sex, location)

Indicator 2: % of orphans compared to non orphans completing secondary school (disaggregated by sex, age group, location)

Activity Description	Responsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.14.1: Mainstream social protection of orphans in all sectors. **OVC: 3.0.1**	MoG, Children and SD, FKE, Sector Associations	-Activity 2.141: Carry out feasibility study on scholarship/ mentorship schemes in Kenya. 3 consultants 2 months; 120 man-days. -Activity 2.142 : Advocacy for private sector support for scholarship/ mentorship schemes. Info material, leaflets, venue, seminars, media, newspaper adverts. -Activity 2.143: Campaign for Community Private Partnership to involve Grassroots into operation of scholarship/ mentoring schemes in all Districts; 1 month awareness & orientation campaign.	Min. of Labour & HRD, NGO,CBO,FBO, Dev. Partner								

Provide social protection to Orphans and Vulnerable Children **OVC: 3.99**	Ministry of Education, Teachers Service Commission	-Activity 2.144: Develop National Affirmative Plan of Action for promoting orphans enrolment, retention and transition. TA 20 days. -Activity 2.145: National launch of the Action Plan; IEC development, Banner, Venue, Media, Guests Speakers. -Activity 2.146: Orientation for managers administrator and education providers at all levels. Seminars, advocacy; 210 districts; 3 days facilitator 620 man-days. -Activity 2.147: Provide TA for increase OVC focus for targeting socio-economic mitigation strategies at each levels. Progress review; consultant bi-annually; 20 days; 40 man days. -Activity 2.148: Train admin staff/teacher in 18 569 primary schools & 5019 secondary schools in reporting & data management in all districts.	MoG, Children and SD, NGO,CBO,FBO, Dev.Partner								
Output Result 2.15: By 2011 Vulnerable Groups (including MARPS) profiled in every sector and interventions developed and implemented. **Indicator: % of sectors with plans for HIV interventions targeting vulnerable groups including MARPS developed and implemented (disaggregated by sector, location, intervention)**											

2.15.1: Provide social protection to Most-at-Risk populations (Sex workers, IDU, MSM, and Prisoners), People Living with HIV and AIDS (PLHIV) and vulnerable groups across all sectors.	MoG, Children and SD, Min. of Justice and Const. Affairs. NACC, Public Sector Private Sector; Line Ministries.	-Activity 2.151: Develop intervention strategies (including human rights, gender & GIPA) & operational formation of networks of PLHIV for most vulnerable populations by sex, occupational risk, and marital status. Consultant 20 days for each sector; 180 man-days. First four quarters. -Activity 2.152: Operational formation of sector specific networks of PLHIV. TA to review/restructure existing networks & establish functional groups; 20days/sector, 180 man days; TA to supervise & guide/ mentor operations; quarterly 10 days; 40 man-days/year. All 8 quarters. -Activity 2.153: TA to introduce communication strategy within Public Sector institutions to demonstrate productivity attributable to reduction of stigma & discrimination highlighting the MARPS & most vulnerable populations. TA 20 days x 9; 180 man days. -Activity 2.3.1.3.4: TA to develop guidelines on human rights approaches and customer service charters defining reduction of stigma and discrimination as core values in each institution and organization/ private sector. TA 40 days/sector; 360 man-days. -Activity 2.3.1.3.5. Advise private sector media houses and outlets (FM radios, TVS) in HIV & AIDS mainstreaming with reviewed & revised programming and appropriate language that contributes to reduction of stigma and discrimination on the internal & external work environment. TA to develop sensitive messages; 20 days; Integrate Communication Strategy into media; TA 20 days - Activity 2.3.1.3.6. Establish Sector taskforces to develop capacity of sectoral implementers & integrate innovative approaches to reduce stigma & discrimination; Meetings , orientation and discussions with PLHIV networks, relevant organizations with focus on MARPS.	Law reform Commission, NGO,CBO,FBO, Dev.Partner, Local Authorities		X	X	X	X	X	X	X

Output Result 2.16 By end 2011 Programmes in place to support 80% care givers and service providers.

Indicator: % of Sectors that have HIV and AIDS Support & care for service providers and clients (disaggregated by sector).

Activity Description	Responsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation								
2.16.1: Social mitigation **2.16.2: Provide social protection (mitigation) services to caregivers.**	Mini. Of Medical Services, Min. of Labour & HRD NACC, Public Sector Private Sector Enterprises	Activity 2.161 : TA to develop workplace/ occupational health safety and care giver / counsellor support programme in all Sectors and Institutions. TA 180 man-days for all sectors & institutions. Activity 2.162: Conduct orientation seminars on workplace/occupational HIV related Risk situations, safety & counsellor support in all sectors & institutions at national, provincial, district levels including local authorities, private sector, NGO,CBO,FB. Conduct education for policy makers and human resource personnel on workplace risks and vulnerabilities to HIV and AIDs. Activity 2.163: Develop a pool of sectoral trainers on HIV related human rights, gender, GIPA, and specific concerns for MARPs and other vulnerable groups for all public and private sectors, private enterprises , organizations, institutions at national, provincial, district , constituency level including local authorities, NGO,CBO, FBO.(3 TOT workshops of 30 pacts each for 5 days each , residential Activity 2.164: conduct sectoral trainings on HIV related human rights, gender and GIPA and concerns of Vulnerable groups and MARPs and on reduction of stigma and discrimination.	NGO,CBO,FBO, Dev.Partner, Local Authorities								

HLOP: By end 2013, Health Management Information System provides strategic HIV information and evidence to guide policy and planning

Indicator 1: % Districts submitting timely, complete and accurate reports to the national level (number and percentage)

Indicator 2% of sectoral policies that make reference to updated and objective information obtained through M&E or research for national HIV response. (disaggregated by sector, source of information)

Output Result 2.17: By end 2011 routine sectoral monitoring systems for HIV and AIDS harmonized and generating quality data for timely decision making at sectoral level (includes tracking for HIV related OVC services)

(Indicator): Universal implementation of integrated multi-sectoral HIV monitoring system (disaggregated by sector,); % of sectors that conducted supervision and data audit for HIV monitoring systems in the past 6 months (disaggregated by sector, level)

Activity Description	Responsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.17.1: Strengthen and align sectoral HIV and AIDS M&E systems **2.17.2: ASC: 4.03 Programme Support: Monitoring and Evaluation**	CPPMUs of Line Ministries, NACC Ministry of State for Sp. Progr. NACC CPPMUs of Line Ministries, KNBS, NACC CPPMUs of Line Ministries, KNBS, NACC “ “	Activity 2.171: Technical support to gather missing baseline data for Pillar 2 indicators from various sectors and stakeholders. Activity 2.172: Consultative stakeholder meetings to develop consensus & protocols for coordinated standardized multisectoral data collection, transfer, reporting and use of routine HIV programme monitoring held. Activity 2.173: Technical Support plus Working Group meetings to develop/adapt multisectoral protocols, tools and reporting systems for routine HIV programme monitoring. Activity 2.174: Consultative multisectoral stakeholder meetings to endorse revised protocols, tools, reporting systems. Activity 2.175: Training/orientation sessions on standardized multisectoral routine HIV programme monitoring protocols for different sectors at various admin levels. Activity 2.176: Provision of appropriate equipment and tools for routine HIV programme monitoring to all sectors at national and sub national levels plus partners. Activity 2.177: Administrative and logistical support for quarterly mentorship and supervision visits by focal persons to sectoral implementation level. Activity 2.178: Administrative and logistical support for multisectoral data collection, transfer and reporting for routine HIV programs. Activity 2.179: Annual consultative meetings to review performance of multisectoral routine HIV monitoring system.	NGO,CBO,FBO, Dev.Partner, Local Authorities	x	x	x	x	x	x	x	x

Output Result 2.18: By 2012 sector-specific operational research agenda for HIV developed and innovative approaches and best practices confirmed through quality research.

(Indicator): % government ministries receiving an allocation for HIV research plans; # of sector specific studies conducted, disseminated and operationalised.

Milestones 2009/10: 1) Pillar-specific HIV research agendas and work plans developed and implemented in a coordinated manner;

2) Pillar-specific approved HIV research fully funded and implemented as per national HIV research guidelines

.Milestones 2010/11: 1) Pillar-specific approved 2009/2010 HIV research studies completed and findings disseminated

2.18.1: Develop and implement a multi-sectoral Operations Research Agenda. 2.18.2: ASC. 4.04 : Programme Support/ Operations Research.	KARSCOM/ NACC/Min of Planning	-Activity 2.181: Technical support for situational analysis to produce inventory of past in-country sectoral HIV studies and identify key sectoral HIV research , (TA 1 month, 2 meetings, 2 day res, 60 persons SEE Reference 4.1.1.2.1 - (TA 1 month, *2 meetings, 2 day res, 60 persons.* Activity 2.182: National consultative stakeholder meetings to develop draft multisectoral HIV research agenda(s) and costed work plan(s) (TA 15 days; 1 meeting per year, 2 day res, 60 persons) Activity 2.183: Technical support for reviewing and update of guidelines on multi-sectoral HIV research approach and standards, (TA 15 days; 1 meeting 2 day res, 60 persons) Activity 2.184: Annual technical working group meetings to develop and circulate call for proposals, review and select winning protocols for priority (multi) sectoral HIV research studies, (TA 15 days; 2 meetings x 3 day res, 40 persons, advertisements in local newspapers and website) Activity 2.185 Issue sectoral HIV research grants to winning group/institution. Activity 2.186: Ongoing external study monitoring and supervision on participant recruitment, study procedures, data management for (multi)sectoral studies , TA per Study site: monthly 2 day visits by 5 persons.	academic and research institutions, UNAIDS, USG CDC, TOWA								

Output Result 2.19: By end 2012 a single national HIV information system database capturing up to date sectoral HIV M&E information is created and agreed upon.

(Indicator): % of sectors with updated and objective information obtained through the national multi-sectoral HIV database; % HIV M&E and research information products for last 12 months covered by national HIV information system; % of sectors submitting timely and accurate reports on HIV-related public health and management indicators as per guidelines.

2.19.1: Develop an integrated HIV and AIDS information system for all sectors. (ASC: 4.03 Programme Support: Monitoring and Evaluation	MoSPND & V2030-M&E Directorate, NACC, CPPMUs of Line Ministries. NACC NACC CPPMUs of Line Ministries, NACC “	- Activity 2.191: Consultative stakeholder meeting to reach consensus on design and function of an integrated national multisectoral HIV and AIDS information system with linkages. - Activity 2.192: TWG meetings to define SOW for software developer for integrated database and potential consumers. Activity 2.193: Technical support for development of national multisectoral HIV information database software and user guidelines (1 month consultancy) Activity 2.194: Logistical and administrative support to pilot integrated database software and user guidelines in a few sectors at central and provincial level. Activity 2.195: Procure and install required hardware and accessories for integrated national multisectoral HIV database at selected focal offices. Activity 2.196: Improve internet connectivity and computer literacy for national and sub-national level consumers in various sectors at national and sub national levels. Activity 2.197: Recruit, train and mentor sectoral focal persons responsible for updating of national multisectoral HIV database. Activity 2.198: Administrative and logistical support for regular collection, posting of HIV M&E and research reports on integrated multisectoral HIV database. Activity 2.199: Disseminate updates on national multisectoral HIV database at all levels via website.	NGO,CBO,FBO, Dev.Partner, Local Authorities	X	X	X	X	X	X	X	X

Output Result 2.20: By end 2012 sectoral surveillance systems for HIV expanded to meet KNASP III information needs. **(Indicator): % sectors with HIV M&E operational plans for sector-specific survey & surveillance implementation and data analysis prepared and is being implemented.**											
2.20.1: Expand sectoral HIV surveillance systems to inform KNASP III annual planning. **(ASC: 4.03 Programme Support: Monitoring and Evaluation)**	CPPMUs of Line Ministries, NACC	Activity 2.201: Consultative meetings to review priority areas, protocols and develop work plan for multi-sectoral HIV surveillance. Activity 2.202: Technical support to develop/adapt protocols for new (multi-)sectoral surveillance (e.g. HIV-related disability, morbidity, mortality trends in the sector, etc.) Activity 2.203: Ethical approval for sector-specific HIV surveillance protocols Activity 2.204: Train sectoral focal persons on specific HIV surveillance protocols; Activity 2.205: Selected sector surveillance sites provided with appropriate tools and equipment and other resources; Activity 2.206.: Administrative, logistical and technical support for implementation of sector-specific surveillance ; Activity 2.207: Technical support for data analysis and reporting on sector-specific surveillance; Activity 2.208: Disseminate surveillance findings locally, regionally and elsewhere via meetings and conferences.	NGO,CBO,FBO, Dev.Partner, Local Authorities	x	x	x	x	x	x	x	x
HLOP: All sectors develop and implement HIV and AIDS programmes											
Output Result 2.21: Impact assessments and evaluation of HIV and AIDS response conducted in all Sectors (includes evaluation for National Food Security) **(Indicator): # of sector-specific vulnerability and impact studies conducted, disseminated and operationalised; % of HIV-related loss of man hours and human capital captured by sectoral impact assessments and evaluations (disaggregated by sector)**											

2.21.1: Perform HIV and AIDS impact assessment and evaluate response across all sectors. **2.21.2: ASC: 4.03 Programme Support: Monitoring and Evaluation**	CPPMUs of Line Ministries, NACC	-Activity 2.211: National consultative stakeholder meetings to draft multisectoral agenda and costed work plans for HIV impact assessments and programme evaluation (with TA) -Activity 2.212: National consultative stakeholder meetings to draft agenda and work plan for multisectoral HIV impact assessments and evaluations on sectoral response (with TA) -Activity 2.213: Technical support for development of protocols for multisectoral HIV impact assessment(s) and sector-specific program evaluations. -Activity 2.214: Seek ethical approval for protocols for HIV impact assessment and sector-specific program evaluation(s). -Activity 2.215: Recruit and train assessment teams for multisectoral HIV impact assessment(s) and sector-specific program evaluations. - Activity 2.216: Administrative and logistical support for implementation of HRD impact assessment(s) and sector-specific program evaluations at national at sub national levels. -Activity 2.217: Technical support for internal and external monitoring and supervision on impact assessment(s) and sector-specific program evaluations (participant recruitment, procedures, data management) -Activity 2.218: Technical support for data analysis and report writing on multisectoral HIV impact assessment(s) and sector-specific program evaluations. -Activity 2.219: Technical support for data analysis and report writing on multisectoral HIV impact assessment(s) and sector-specific program evaluations. -Activity 2.2110: Technical support for the assessment and integration of HIV & AIDS into implementation framework of the Nat Food Security Policy at all levels annually. 30 days; 2 consultants; evaluation survey; 60 man days. -Activity 2.2111: Develop national framework for tracking HIV related OVC services at all levels and locations. (e.g.: nature of support, source of support, access to benefit of deceased, orphans enrolled, returned, complete PE, secondary school). TA to develop monitoring framework; 20 days, production, distribution 100 000 copies.	NGO,CBO,FBO, Dev.Partner, Local Authorities	X	X	X	X	X	X	X	X

Output Result 2.22: Impact of HIV & AIDS on Human Resource Development in key sectors of the economy used for evidence-based planning.

(Indicator): HIV & AIDS module included with HRD Survey

Milestones for 2009/2010: 1) Sector-specific HRD guidelines developed based on information generated by HIV impact assessment.

Milestones for 2010/2011: 1) Sector-specific HRD guidelines disseminated and implemented

2.22.1: Build sectoral capacity to integrate sectoral impact assessment recommendations into sectoral plans and MTP 2013-2017. **ASC: 4.01 Programme management**	CPPMUs of Line Ministries, Ministry of Information and Communication, Communication Units in Line Ministries, NACC	-Activity 2.221: National consultative stakeholder meetings to review report(s) on multisectoral HIV impact assessments and develop sectoral HRD plan(s) (with TA) *: 1 national meeting 2 days/80 persons non-res* , -Activity 2.222: Technical support for drafting sector-specific HRD guidelines based on HIV impact assessment(s) ; (TA 30 days, 2 x 3 day meetings res 40 persons, printing 50 pg x 40) -Activity 2.223: Senior level consultation for review and approval of new HRD guideline(s) -Activity 2.224: Disseminate new multisectoral HRD guidelines *(1 National workshop - 3 days Res., 100 person; 9 regional meetings – 1 day non- res, 80 person; printing 1000 copies x 50 pgs*									
		-Activity 2.225: TWG meetings to define multisectoral HIV M&E and research information needs, audiences and schedule and costed work plan for dissemination . -Activity 2.226: Technical support to develop scientific writing skills for focal persons in different sectors. -Activity 2.227: Technical support for development of multisectoral HIV information products targeting various audiences (press releases, newsletters, brochures, broadcasts, scientific publications). -Activity 2.228: Orientation of policy makers and media on interpretation and communication of multi-sectoral HIV strategic information and research evidence. -Activity 2.229: Administrative and logistical support for dissemination of multi-sectoral HIV M&E and research information (press conference, print, brochures, reports, broadcast, etc.). -Activity 2.2210: Annual consultative meetings with policy makers and programmers to review and apply multi-sectoral HIV strategic information and evidence to sector specific policy and work plans. -Activity 2.2211: Annual monitoring and reporting on dissemination activities for multisectoral HIV M&E and research.	NGO,CBO,FBO, Dev.Partner, Local Authorities	x	x	x	x	x	x	x	x
Output Result 2.23: By end 2011 all sectors identified and document factors contributing to HIV and AIDS vulnerability, access to services and allocate resources accordingly. **(Indicator): # of sector-specific vulnerability studies conducted, disseminated and operationalised.**											

Activity Description	Responsible/ Lead organization/ agency/ division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.23.1: Assess risk and vulnerability factors promoting HIV transmission across all sectors & build the capacity of sectors to assess and address these.	NACC, KIPPRA. Sector Line Ministries, CPPMUs in Sector Line Ministries. NACC, CPPMUs in Sector Line Ministries	-Activity 2.231: Conduct sector specific special surveys to assess risk & vulnerability. TA 20 days each sector: 180 man-days. -sub activity 2.232: National consultative stakeholder meetings to draft multisectoral agenda and costed work plans for HIV vulnerability assessment (with TA) -sub activity 2.233: Technical support for development of protocols for sector-specific HIV vulnerability assessment(s) Protocols on HIV in Prisons, Police, Fishing industry, transport industry, internal security, displaced persons, refugees, labour sector. -sub activity 2.234: Obtain ethical approval for protocols for sector-specific HIV vulnerability assessment(s) -sub activity 2.235: Recruit and train assessment teams for sector-specific HIV vulnerability assessment(s) -sub activity 2.236: Administrative and logistical support for implementation of sector-specific vulnerability assessment(s) at national at sub national levels -sub activity 2.237: Technical support for internal and external monitoring and supervision on sector-specific vulnerability assessment(s) at various levels (participant recruitment, procedures, data management -Sub activity 2.238: Technical support for data analysis and report writing on multisectoral HIV vulnerability and impact assessment(s) and sector-specific program evaluations. - sub activity 2.239: Disseminate findings from vulnerability assessment locally, regionally and elsewhere via meetings and conferences -sub activity 2.2310: National consultative stakeholder meetings to review report(s) on multisectoral HIV vulnerability assessments and develop guidelines for HIV sectoral budget allocations (s) (with TA) -sub activity 2.2311: Print and disseminate new guidelines for sector-specific HIV funding to all sectors and funding sources. -Sub Activity 2.2312: Distribute Result -Sub Activity 2.2313: Build the capacity of the national response to address HIV in emergency situations	NGO,CBO,FBO, Dev. Partner MoGender, C & Social Dev. NGO,CBO,FBO, Dev. Partner NGO,CBO,FBO, Dev. Partner	X	X	X	X	x	x	x	x

Indicator:# of sector specific reports on HIV and AIDS impact on Human Resource documented, disseminated. and operationalised											
2.24 .1 Include HIV & AIDS module for the National Human Resource Development survey; and develop new HRD guidelines.	Min of Labour & HRD, MoSPND & V2030, NACC, FKE	- Activity 2.241: Develop HIV & AIDS module for the National Human Resource Development survey. TA 30 days. -Activity 2.242: National consultative stakeholder meetings to review report(s) on multisectoral HIV impact assessments and develop sectoral HRD plan(s) (with TA) -Activity 2.243: Technical support for drafting sector-specific HRD guidelines based on HIV impact assessment(s) -Activity 2.244: Senior level consultation for review and approval of new HRD guideline(s) -Activity 2. 245: Disseminate findings new multi-sectoral HRD guidelines locally, regionally and elsewhere via meetings and conferences	Relevant Line Ministries. NGO,CBO,FBO, Dev.Partner, Local Authorities								
2.25.1 Support programme communication by linking all sector HIV and AIDS offices. (ASC 4.08)	Ministry of Planning, National Development & Vision 2030	Activity 2.25.1: Link all sector AIDS offices through wide and local area fibre –optic network. (Costed under vision 2030 MTP 2008-2012)	Government – Ministry of Information & Communications.								

Bi- Annium Work Plan-Pillar 3 : Community/ Area-Based HIV Programmes
Outcome: By end 2013, 50% of AIDS Competent Communities (and PLHIV networks) respond to HIV within their local context **Indicators: No. of CSOs supported; % of AIDS Competent Communities;**
HLOP: By 2013, 50% increase in the number of CSOs supported to deliver HIV services at community level that are responsive to their local contexts. **Indicators: No. of CSOs supported; % of funded CSOs whose capacity is built; Community leadership structures whose capacity is built to address HIV based on local evidence.**
Output Result 3.1: By 2013, 60% of communities mobilized to embrace and demand for comprehensive services for HIV prevention, investigate and address root causes of risks & vulnerabilities locally, including Most-at-risk and vulnerable populations. **(Indicator):** Number and % of intended target population seeking comprehensive HIV prevention services at the community level (disaggregated by type of service, population, age, sex, location) **;** Number of community based vulnerability and impact studies conducted, disseminated and operationalized; of communities that received organizational support confronting HIV vulnerability and risks at community level (disaggregated by population, location, specific intervention (target: 50%) **Milestones: End of year 1: 50% of mobilization and capacity building activities completed; mapped out, planning process completed, action plans ready, requests for funding of action plans done. End of year 2:Community action plans fully implemented; End of year 1: Planning process completed, action plans developed, requests for funding of action plans done. End of year 2:Community action plans fully implemented; 100% of mobilization and capacity building activities completed.**

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
ASC 1.02 Community Mobilization and outreach 3.1.1: Activity : Mobilize & sensitize communities on comprehensive prevention among general population, MARPs and vulnerable groups through community owned communication channels (folk media, community forums, games, sports etc)	NACC, NCBDA	-3.111: Identify and build capacity of community level mobilizes- train 1600 community mobilizers on comprehensive prevention -Undertake outreach activities to 80% of most at risk populations. -Support 50% communities to interrogate and address root causes of HIV infection (harmful traditional practices, SGBV, leadership structures, policies, etc) through participatory planning approaches, socio-ecologolical model and AIDS Competence approach -3.112: Monitor demand for HIV prevention services at the community level (One survey per year, for each survey -Activity 3.113: Conduct nationwide survey to identify, contextualize and prioritize communities with localised risks and vulnerabilities for informed intervention (*consultancy, workshops)* -Activity 3.114: Conduct participatory planning process with identified communities to develop community actions plans addressing risks and vulnerabilities within their local contexts*(20 workshops)* -Activity 3.115: Provide grants to community groups to support implementation of action plans (action plans should include development of AIDS competence in selected communities) -Activity 3.116: Support 3900 community units to interrogate root causes HIV through participatory planning approaches *(twenty workshops, residential, 3 days, 40 participants)* -Activity 3.117: Provide grants to communities to 3900 communities to carry out community advocacy, awareness raising, and other relevant interventions around root causes of vulnerability (harmful traditional practices, SGBV, leadership structures, policies etc)	CSOs, KNBS	X	X	X	X	X	X	X	X

Output Result / Indicators											
Output Result 3.2: By 2010 50% of communities supported to map and identify support needs **(Indicator1):** % of communities with social mapping of priority HIV needs conducted, disseminated and operationalized (disaggregated by location) **(Indicator2:** # of communities receiving support for conducting HIV situational analysis **Milestones: End of year 1: CBOs mapped out, capacity built, assisted to develop action plans** **End of year 2:40 grants given out, action plans implemented**											
3.2.1: Build 3900 community units' competence to respond to HIV and AIDS within their local contexts	NACC	Activity 3.211: Map out and conduct capacity assessments of CBOs in 50% of communities in regard to their capability to provide HIV and AIDS services and supporting them to develop plans for capacity building *(Consultancy)* Activity 3.212: Building the capacity of community based organizations in 50% of communities to collect and use local data to design and implement HIV & AIDS programs and provide technical support to help them develop action plans on HIV interventions *(40 workshops, 40 participants, 3 days, res)* Activity 3.213 Train 50% of CBOs in Resource mobilization; governance, and grant management *(40 workshops, 40 participants, 3 days, res)* Activity 3.214 Provide 40 grants to support CBO action plans	CSOs		X	X	X	X			
HLOP: By 2013, 50% of community owned structures have linkages to the health system. **Indicators: % of community structures with formal linkage with health system.**											
Output Result 3.3 By 2011 80% of FBOs and CBOs align HIV and health programs with KNASP III ; community leadership structures identified and sensitized to mainstream HIV in their agenda in 80% of the regions **(Indicators):** % of FBOs/CBOs with plans for harmonization and alignment of HIV programs with KNASP developed, agreed, implemented and reviewed annually (disaggregated by location); % Community level health care programs that work in partnership with other providers in delivering HIV services; % of registered community leadership structures supported advocating for HIV interventions (disaggregated by location) **Milestones: End of year 1: All target FBOs and CBOs align their programs with KNASP; 40% of level 1 programmes integrate HIV; End of year 2: 80% of level 1 programmes integrate HIV; End of year 1: 80 workshops held; End of year 2: 40 action plans implemented.** **(Indicator1) Milestones: End of year 1: 80 workshops held; End of year 2: 40 action plans implemented.**											

3.3.1: Align community programmes with KNASP III and Strengthen partnerships between community and other sectors in 8 regions	NACC, CSOs	Activity 3.311: Conduct regional Dissemination workshops of KNASP III objectives and activities to implementing FBOs and CBOs *(8 workshops, 2 days, 40 participants, res)* Activity 3.312: Conduct assessment of HIV programs implemented by CBOs/FBOs to identify areas of capacity building as per KNASP III objectives*(100 days consultancy, car hire 80 days, travel costs to all provinces, per diem and accommodation for 80 days for one person, 40 one day meetings, 40 participants, non-res)* Activity 3.313: Incorporate integration of HIV and AIDS services in participatory planning process for community based groups in 50% of communities (*40 workshops 2 days, 40 participants, res)* Activity 3.314: Provide grants to support at least one CBO per community (3900 CBOs) to integrate and sustain delivery of HIV services at the community level in partnership with level I health facility *(40 grants, KShs USD8000 each)* Activity 3.315: Monitor implementation of HIV and AIDS interventions funded by community financing mechanisms*(80 one day meetings, 40 participants, non-res)* Activity 3.316: Hold at least one training per community per year for divisional and local authority level community leaders on HIV mainstreaming (80% of communities) *(80 workshops, 40 participants, 3 days, res every year)* Activity 3.317: Conduct one training annually for 50% of lower level community leadership structures(Village elders, chiefs, women leaders;)on HIV and AIDS mainstreaming and support them to develop action plans for mainstreaming *(40 workshops, 40 participants, 3 days, res)* Activity 3.318: Organize participatory planning and consultation forums with religious leaders, teachers and leaders of CSOs on community based HIV programming *(40 workshops, 40 participants, 3 days, res)* Activity 3.319: Provide 40 grants to support lower level community action plans. Activity 3.31.10 Undertake capacity building for CHWs, CHEWs, CHCs and NGO, FBO, CBO, Private formal and informal organizations Activity 3.31.11 Provide community equipment and kits Activity 3.31.12 Improve linkages between the community and public and CSO, FBO and private service providers Activity 3.31.13 Strengthen leadership and governance, technical capacity and sustainable financing mechanisms of community units.	CSOs Division of Community Health (DCHS) Office of the President/ CSOs	X	X	X	X	X	X	X	X

Output Result 3.4 By 2010 80% of community financing mechanisms (CAF, LATF, CDF, Women, youth other decentralized funds and SACCO schemes Fund) mainstream HIV ; community capacity substantially developed to identify own resource needs to address HIV **(Indicator1)) % of resources from community financing mechanisms mobilized for HIV (disaggregated by source, location; % communities receiving support for HIV programming and budgeting successfully costing local resource needs (disaggregated by location) ; % communities receiving funding for HIV and AIDS plans from external resources (disaggregated by sources and funding mechanisms.)**											
3.4.1: Strengthen community financing systems and make them more sustainable in 50% (3900) community units	NACC	Activity 3.411: Provide technical support to Community financing mechanisms on health and mainstreaming HIV and AIDS *(80 workshops, 2 days, 40 participants, res)* Activity 3.412: Assist 50% of communities to identify and use locally available resources in addressing HIV and AIDS interventions through participatory planning processes *(40 workshops, 40 participants, 2 days, res)* Activity 3.413: Train community organizations in resource mobilization and accountability including proposal development *(40 workshops, 40 participants, 3 days, res)* Activity 3.414: Train women groups on Resource mobilization (1 Per region) *(8 workshops, 40 participants, 3 days, res)* Activity 3.415: Hold biannual community consultative meetings (2 per district) on funding opportunities, utilization and accountability at the district level *(300 one day meetings, 40 participants, non res)* Activity 3.416.: Establish one strategic information point per community unit (total 3900 units) to create awareness on HIV and AIDS funding opportunities *(use biannual meetings above)*	CSOs	X	X	X	X	X	X	X	X
Outcome: By 2013, reduced risk behaviour among the general, infected, most-at-risk and vulnerable populations. **Indicators: Median age of girls' and boys' sexual debut; No of men and women who have had sex with more than one partner in the last 12 months; No. of men and women using condoms with non regular partners in the last 6-12 months; % discordant couples using condoms; % IDUs reporting sharing equipment; % male and female sex workers using condoms.**											
HLOP: By end 2013, 80% of men and 80% of women aged 15-64 know their HIV status. **Indicators: % of men and women aged 15-64 who received their HIV test results (disaggregated by sex, by partner status); Number of people tested and counselled for HIV annually (disaggregated by age and sex); No. of MSMs who received their HIV test results; No. of FSWs who received their HIV test results; No. of prisoners who received their HIV test results.**											

Output Result 3.5 : By 2013, 80% of the population demand and receive HIV counselling and testing to know their status

(Indicator): Number and % of intended target population seeking HIV counselling and testing services at the community level (disaggregated by population, age, sex, location, and type of HCT)

Milestones: End of year 1: 50% of campaign and testing activities completed.

End of year 2:100% of campaign and testing activities completed.

Output Result 3.6: By 2012, 60% of communities have established community based CT services for the marginalized and vulnerable

(Indicator): % communities providing HCT services at the community level as per national guidelines (disaggregated by population, location)

Milestones: End of year 1: assessment done, training conducted, 30% of outreaches done.

End of year 2: all outreach activities done, monitoring up to date.

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.6.1: ASC: 1.03 Undertake 50% of HTC testing through community outreach	NACC/ CSOs, NCBDA	Assumptions: Task 3.611 Mobilize communities (including hard to reach populations such as IDUs, mobile populations) for HIV testing using door to door hot spots outreach, camel back, market place and other community level HIV testing strategies *(two outreach activities per week for two years, for each outreach – two VCT counsellors, 50 VCT kits, half day minibus vehicle hire)* - Use appropriate mass media for each targeted group to reach 80% of MARPS and Vulnerable groups with HTC promotion messages according to KNASP III communication strategy. -Do 50% of all tests through community outreaches using door-to-door, hot spots outreach, camel back market place and other community level testing strategies. -Train 1600 level 1 health workers on non-static HTC approaches (40 workshops residential, 3 days 40 participants -Activity 3.612 Conduct a national assessment to identify and prioritize CT needs including defining existing partnerships and referral networks for CT for MARPS in 4900 community units) *(consultancy 100 days, travel to 3 districts per province x 8 provinces, meals and incidentals 60 days, accommodation 60 nights, stationery all x 1 person)* - Activity 3.613: Provide technical and financial support to at least one group in 4680 communities to conduct monthly appropriate outreach CT service to each target populations.	Media houses	X	X	X	X	X	X	X	X

HLOP: By 2013, 80% of pregnant women accessing PMTCT services Indicator: % of pregnant mothers counselled, tested and received their HIV test at ANC; % of HIV positive mothers provided with complete course of ARV prophylaxis to reduce MTCT risk; % of infants born to HIV infected mothers who are infected.											
Output Result 3.7 (ASC: 1.17 Prevention of mother to child transmission): By 2012, 60% of communities access quality PMTCT services at the community level. **(Indicator1)**% of communities with access to PMTCT services at the community level (disaggregated by population, location) **(Indicator2)** % of women delivering at the community reached by PMTCT service providers (disaggregated by type of service, location) **Milestones: End of year 1: community level actors identified and trained, 30% of IEC distribution and grants given.** **End of year 2:Remaining IEC materials and grants given**											
Activity description	**Responsible/ lead organisation/ agency or division/unit**	**Detailed Activities**	**Participating partners for implementation**	**Scheduled Time frame**							
				2009/10				**2009/10**			
				1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
3.7.1; ASC: 1.17- Prevention of mother-to-child transmission: Provide community-level PMTCT services and messages to 60% of pregnant women.	NACC/ NCBDA	3.711: ASC: 1.17- Prevention of mother-to-child transmission: disaggregated pillar cost needed. 3.712: Reach 80% of women of child-bearing age with PMTCT messages using local networks- women's' groups, church groups, clubs, etc. 3.713: Train 1000 community level PMTCT actors (CHW, TBA) on nutritional support to pregnant mothers and other aspects of care (25 residential workshops , 40 participants) 3.714: Activity 3.1.2.2.4 Support 1000 community-level PMTCT actors to counsel, refer and support pregnant women on a continuous basis -Activity 3.715: Provide technical and financial support to at least one CSOs per community to develop culturally appropriate IEC materials on PMTCT. -Activity 3.716: Provide support to 4680 CSOs to disseminate the IEC materials to target population. - Activity 3.718: Provide grants to CBOs to hold community forums on PMTCT to raise awareness and increase support for mothers at community level *(50 grants, each USD 8,000)*	CSOs			X	X	X	X	X	X
HLOP: By 2013 men in non-circumcising communities accessing voluntary medically assisted circumcision services. **Indicator: Number of males circumcised in non-circumcising communities under VMAMC**											

Output: 3.8... Reach 80% of uncircumcised males annually with voluntary medically-assisted male circumcision (VMAMC) messages and peer support annually.

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.8.1: ASC: 1.21 Provide community-level VMAMC	NACC	3.811: Tasks: Develop and disseminate locally relevant male-circumcision messages according to the KNASP III communication strategy 3.812: Reach 80% of uncircumcised male populations with messages, peer support and referral services for male circumcision	NACC/ CSOs / MoH								

HLOP: By 2013, 85% men and 85% women aged 15-64 have enhanced knowledge of HIV prevention.

Indicator: % of men and women aged 15-64 who received their HIV test results (disaggregated by sex, by partner status); Number of people tested and counselled for HIV annually (disaggregated by age and sex); No. of MSMs who received their HIV test results; No. of FSWs who received their HIV test results; No. of prisoners who received their HIV test results.

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.9.1 Carry out mass media campaigns targeting 80% of general and 80% most at risk population.	NACC	3.9.11 Design and disseminate HIV and AIDS messages prepared according to the KNASP III communication strategy to reach 80% of most–at-risk (female and male sex workers, MSM, prisoners,) and vulnerable groups.									

Output Result 3.10 By 2011, 80% of community structures introduce social transformation programs based on evidence generated on risks and vulnerabilities

(Indicator1) % of community structures piloting individual/small group HIV-related social transformation interventions that are based on evidence

Milestones: End of year 1: 20% of structures introduce; End of year 2:Remaining 60% introduce.

Alternate Output Result : By 2010, 80% of community change agents and opinion leaders align their messages to the national HIV strategic direction.

(Indicator1) % Community change agents and opinion leaders receiving support for BCC delivering HIV messages within KNASP framework

Milestones: End of year 1: All change agents and opinion leaders align community plans to KNASP.

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities Budget required	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.10.1: Implement BCC programmes at community level to promote social transformation and institutional behaviour change.	NACC	-Activity 3.10.1: Carry out at least 1 dissemination workshop and ToT for opinion leaders per region on KNASP III *(8 workshops, 40 participants, 2 days, res)* - Activity 3.10.2: Provide grants and technical assistance to 3900 community groups (1 per Community) to develop and disseminate messages that deconstruct myths, misconceptions and harmful practices on HIV related GBV, stigma and discrimination. *(40 grants, each USD 8,000)*	CSOs	X	X						

Outcome: By 2013, 80% of eligible men, women, boys and girls living with HIV receiving sustained care and treatment.

Indicators: % of adults and children with HIV Known to be receiving treatment two years after the start of ART; No. of PLHIV receiving care by age and sex

HLOP: By 2013, 80% of eligible adults and children enrolled on ART

Indicator: No. of people on ART by age and sex

Output Result 3.11: By 2009, GIPA guidelines rolled out and implemented

(Indicator1): % community based organizations providing HIV and AIDS prevention, treatment, care and support services at the community level according to GIPA guidelines (disaggregated by location)

Milestones:

End of year 1: 1300 communities benefit from grants.

End of year 2:2600 communities benefit from grants.

Output Result 3.12: By 2011, 80% of community based organizations implementing PWP at community level

(Indicator): % community based organizations providing prevention with positive services at the community level (disaggregated by location)

Milestones: End of year 1: 10 grants given out; End of year 2:30 grants given out

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.12.1: ASC: 1.07 Implement PwP and promote greater involvement of people living with HIV and AIDS in 6000 community units	NACC/NEPHAK	**Activity 3.121: Map out PLHIV networks and associations in 7800 communities*(consultancy 50 days, travel to province x 8 provinces, meals and incidentals 30 days, accommodation 30 nights, stationery all x 1 person)*** **Activity 3.122: Mobilize PLHIV networks and associations through regional workshops for dissemination of 2009 GIPA guidelines & development of action plans. *(8 two day workshops, residential, 40 participants)*** **Activity 3.123: Provide grants and technical support to at least 1 network per community unit (3900 units) for the implementation of action plans of 2009 GIPA guidelines through the networks (The action plans should include advocacy for integration of GIPA into decentralized level, local authority structures, and community leadership structures) *(40 grants, each 8,000)*** **Activity 3.124: -Document best practices and lessons learnt on GIPA mainstreaming *(consultancy 20 days, travel to province x 8 provinces, meals and incidentals 2 days, accommodation 2 nights, stationery all x 1 person)*** **Activity 3.125 Disseminate national PWP community level strategy and guidelines to community based HIV programs *(8 workshops, 2 days, residential)*** **Activity 3.126 Train 80% of all PLHIV networks on PWP community level guidelines *(60 workshops, 3 days, residential)*** **3.127 Translate PWP IEC materials to Kiswahili and at least 5 local languages for rollout at community level *(50 consultancy days, printing 2000 copies of translated copies)*** **3.128 Train CHWs at the community level on PWP guidelines for effective roll-out and linkage to clinical level PWP activities *(60 workshops 2 days, 40 participants non-res)*** **Activity 3.129: Work with at least one implementing organization per community (3900 in total) to implement community level PWP guidelines *(40 grants, each $8000)***	Ministries of Health -Gender and social services								

2. Treatment, Care and Support

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
Output Result 3.13: By 2011, treatment literacy integrated in 50% of community based HIV support programs **(Indicator1): % of community based HIV programs that meet basic service capacity standards for integrated treatment literacy and support services (disaggregated by location)** **Milestones: End of year 1: 10 grants given out;** End of year 2:30 grants given out Output Result 3.2.3.2: By 2012, 80% of PLHIV networks supported to promote treatment adherence (Indicator): % of PLHIV networks receiving support to promote treatment adherence (disaggregated by population, location, type of mitigation) Milestones: End of year 1: 5 grants given out; End of year 2:15 grants given out.											
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.13.1: Promote treatment literacy and adherence support	NASCOP (This activity shared with Pillar 1)	**Activity 3.131: Develop and print standardized community level treatment literacy materials** **Activity 3.132: Identify community level actors in 3900 units and define their geographical areas of action on treatment literacy *(40 days consultancy, car hire 20 days, travel costs to all provincial HQ, per diem and accommodation for 20 days for one person)*** **.2.133 Pprovide grants to community groups for treatment literacy (community activities to include community forums on treatment literacy and dissemination of IEC materials) *(40 grants, USD 8,000 each)*** **Activity 3.134:** Establish PLHIV treatment support circles for different age cohorts linked to 50% of primary health centres. **Activity 3.135 Train 50% of PLHIV networks on treatment adherence and support them technically to develop action plans on treatment adherence *(40 workshops, 3 days each, residential)*** **Activity 3.136: Provide PLHIV networks with grants to implement treatment adherence action plans (action plans should incorporate support to PLHIV networks to provide on-going adherence counselling) *(20 grants, $ 8,000 each)*** **Activity 3.137 Link peer educators on adherence support to at least 50% of comprehensive care centres *(budgeted for in the grants above)***	NACC, CSOs	X	X	X					
ASC: Treatment of opportunistic infections TB/HIV co-infections											

HLOP : 80 % of TB patients who are HIV co-infected provided ART increased

Indicator: No of TB /HIV co-infected who need receiving ARTs.

Output Result 3.14: By 2010, communities act to create awareness on TB prevention, care and support

(Indicator1): % of population with correct knowledge on TB (mode of transmission, symptoms, treatment and curability) (disaggregated by cadre, age, sex)

Indicator 2: Percentage of patients adhering to TB treatment

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				1	2	3	4	1	2	3	4
3.14.1: Train 50% of community health workers on TB detection and support community groups to disseminate information and respond to TB	NASCOP	**-Activity 3.141 Train level 1 health workers and PLHIV networks on TB detection, treatment and referral systems through regional workshops in 50% of communities *(40 workshops, 40 participants, 3 days, residential)*** **-Activity 3.142: Provide grants to at least one group per community in 50% of communities to disseminate information on HIV and TB and refer the affected for treatment** **-Activity 3.143: Provide grants to train and support TB ambassador programs in 50% of communities *(utilize budget in grants above)***	NACC, CSOs	X	X						

HLOP: 80% of PLHIV in need enrolled on home and community based care (HCBC)

Indicator: Number of people receiving Home and Community based care package

Indicator: Number of HCBC kits procured and distributed

ASC 2.09 Home and Community Based Care

Output Result 3.15 : By 2013 80% of communities mobilized and act to mitigate the impact of HIV on the coping capabilities of affected families

(Indicator1) % communities providing social support to mitigate the HIV impact on affected families as per national guidelines (disaggregated by population, location, target clients)

Milestones: End of year 1: Grants given to 30% of communities; End of year 2:Remaining communities receive grants

Activity description	Responsible/lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.15.1: Provide home and community based care to affected families in 80% of communities	NACC	**Activity 3.151 Develop guidelines for mainstreaming HIV in community financing mechanisms, *(Consultant 20 days, 2 one day meetings for 20 people, non-residential. Design and printing of 1000 copies)***									
	Cooperative Development / CSOs	***Activity* 3.152 Conduct regional workshops with community financing mechanisms to introduce guidelines and develop plans for HIV mainstreaming according to new guidelines *(8 workshops, residential, 3 days)***									
		- Activity 3.153: Train microcredit organizations on HIV and link them up with CBOs working on HIV (train at least one per community) *(50 three day workshops, residential, 40 participants)*									
		-Activity 3.154: Support at least one CBO per community (6400 communities) with a grant to train and support affected families with micro credit activities. *(50 grants, each $8000)*			X	X					
		Activity 3.155: Conduct a participatory process to help communities identify and design responses to the impact of HIV including responses to the needs of the elderly and child headed households. (30 three day workshops, residential, 40 participants)					X	X			
		Activity 3.156: Provide technical and financial support to at least one CSO per community(3120 community units) to implement impact mitigation action plans *(30 grants each $8,000)*							X	X	X
		Activity 3.157: Train at least one support group per community on care for care givers. *(40 two day residential workshops for 40 participants)*									
	Ministry of Special programmes	***Provide home and community-based care to 600,000 people in need according to national guidelines.***									
Outcome: By 2013, HIV mainstreamed in sector-specific policies and sector strategies.											
Indicator: Number of sectors mainstreaming HIV.											

HLOP: 35% of vulnerable people receiving social protection

Indicator: No. of households receiving cash transfer

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
Activity 3.1.2.5.1: Conduct at least two community outreaches per year per community in 6240 communities to sensitize guardians on the rights of the OVC and work with CBOs to develop locally appropriate OVC care programs.	Children's department/ CSOs	**-Activity 3.1.2.5.1: (ASC 3.04) sensitize at least 6240 communities through two outreaches per year per community to sensitize guardians on the rights of the OVC and work with CBOs to develop locally appropriate OVC care programs.** **-Activity 3.1.2.5.2 (ASC 3.03) Increase the budget for the OVC cash transfer and implement the cash transfer in 80% of the districts *(Averagely KShs 1,000,000 per district per year for 58 districts)*** **-Activity 3.1.2.5.3 Support community capacities to care for orphans through implementation of appropriate community endorsed social protection programmes *(50 grants, each $8,000)*** **--Activity 3.1.2.5.4 Support programmes that reach the elderly and child headed households (including using community support mechanisms)*(40 grants)*** **--Activity 3.1.2.5.5 *Provide primary and secondary education to80% of OVC in need*** **-Activity 3.1.2.5.6 *Provide healthcare to OVC in need*** **-Activity 3.1.2.5.7 *Support 80% of needy families caring for OVC through cash transfer*** **-Activity 3.1.2.5.8 *Reach 80% of the community with information on the rights of OVC*** **-Activity 3.1.2.5.9 *Support the costs of 80% of OVC in institutions of care***	CSOs		X	X	X	X	X	X	X

6.03 Social services

Output Result 3.16 By 2013, affected and infected individuals in Kenya have increased access to community Para-legal and legal services

(Indicator1) % HIV affected and infected persons with access to legal aid and paralegal services at the community level (disaggregated by age, sex, location)

Milestones: End of year 1: 30% of community action plans implemented; End of year 2:Remaining 60% of action plans implemented

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.16.2: Provide social & Para-legal social services to 3900 community units. ***(NASA category ASC. 6.03)***	Ministry of Justice/ CSOs / NACC	**Activity 3.161: Train and support at least one community group per community to map out available Para-legal and legal services and develop action plans for providing the infected and affected with the services.** ***(40 workshops, 2 days, 40 participants)*** **Activity 3.162: Provide grants and technical support to trained community groups to implement action plans on legal and Para-legal services (action plans should establish and implement community paralegalism)** ***(40 grants)***	CSOs			X	X				

Output Result 3.17: By 2013, 30% of affected communities, protect women's and orphans' rights to land and property in the context of HIV and assure their right to inheritance; 2012, 80% of the population has correct information on HIV that respects, promotes and protects the rights of those affected by and infected with HIV; By 2012, 80% of the population has correct information on HIV that respects, promotes and protects the rights of those affected by and infected with HIV

(Indicator): % of registered communities with minimum capacity to provide land protection and legal aid services for vulnerable women and children); of population that expresses the need to respect, promote and protect the rights of those affected and infected with HIV (disaggregate by age, sex, location, target group); National stigma index

Milestones: End of year 1: preparatory activities completed and communities have developed action plans, requests for funding of action plans done. End of year 2:Community action plans fully implemented; 30% of target communities implement activities; Remaining 60% of communities implement activities ; Stigma index reduced by 25%.; End of year 2: Stigma index reduced by 50%

(NASA Functions: ASC: 7.0 Enhanced Environment; ASC: 7.02 Human Rights (and gender)

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.17.1: ASC 7.02: Human Rights & Gender **Implement land and property rights interventions in 30% of communities.**	NACC/Ministry of Gender	**- Activity 3.1711 Conduct national assessment to identify communities in which widows and orphans mostly suffer violation of their human rights including the right to property and inheritance by widows and orphans. *(consultancy 100 days, travel to 3 districts per province x 8 provinces, meals and incidentals 60 days, accommodation 60 nights, stationery all x 1 person* -Activity 3.1712 Conduct annual national TOT on rights based approach in HIV prevention, care, support and mitigation *(One TOT per year, for each 40 participants, residential, five day)* -Activity 3.1713: Design appropriate community based interventions for access to justice by widows and orphans in target communities through participatory planning processes. *(ten workshops, residential, 3 days, 40 participants)* -Activity 3.1714: Design appropriate community based interventions for access to justice by widows and orphans in target communities through participatory planning processes. *(ten workshops, residential, 3 days, 40 participants)* -Activity 3.1715: Provide grants to community groups to implement action plans aimed at providing social and legal support to disinherited widows and orphans -Activity 3.1716 Working with community change agents, provide technical support for communities to develop action plans for building community awareness on health and HIV related gender and human rights -Activity 3.1717: Create awareness through at least one outreach activity per community per year on the importance of succession plans -Activity 3.1718: Support at least one CBO per community technically and financially to assist the affected and infected to develop succession plans Activity 3.1719: Create awareness through at least one outreach activity per community per year on the importance of succession plans.**	Ministry of education, KNBS, CSOs Min of lands, KNHCR, CSOs	X							

3.17.2: Address stigma and discrimination against people living with HIV in communities	NACC/ Ministry of Gender	**Activity 3.1721 Conduct a participatory planning process with 3900 communities to identify and develop action plans to address community level stigma and discrimination** ***(40 workshops, 3 days, 40 participants)*** **Activity 3.1722: Train and work with at least one CSOs/network per community (including MARPS networks and vulnerable populations) to develop action plans on promoting community solidarity and fighting social prejudice for PLWAs relevant to the local context.** ***(40 workshops, 3 days, residential)*** ***Activity*** **3.1723: Provide technical and financial support to CSOs to implement action plans on reducing stigma and discrimination. (Action plans should have awareness raising activities on the harmful effects of stigma and discrimination and strengthen 3900 community systems to deal with the two problems)** ***(40 grants)*** **3.17110 Provide grants to 6240 communities to develop and disseminate relevant information that protects the rights of infected and affected persons.**	CSOs								
3.173 Address sexual and gender based violence in communities	NACC/ Ministry of Gender	**3.1731 Provide grants and technical support to at least one CBO per community to identify and support cases of SGBV ;** **3.1732 Engage community structures to act and educate communities on sexual offences act and implications to perpetrators of SGBV as well as publicize community and court rulings on HIV related SGBV cases** ***(30 grants, each $8000)***	CSOs								

OUTCOME: By 2013, health systems deliver a package of HIV services according to KNASP strategy.

Indicator: Extent to which health sector related outcomes of KNASP III are achieved

HLOP: Health Management Information System provides strategic HIV information and evidence to guide policy and planning;

Indicator: % Districts submitting timely, complete and accurate reports to the national level (number and percentage)

ASC. 4.03 Monitoring and evaluation; ASC8.04 Social science research

Output Result 3.18: By 2011 programme monitoring systems for community level HIV interventions harmonized and generating quality data for timely decision making

(Indicator 1): % of programme work plans with updated and objective information obtained through routine programme monitoring (disaggregated by programme, level, location)

(Indicator 2): % of community based programmes with implementation plan revised due to evidence obtained through routine programme monitoring (disaggregated by programme, level, location)

Milestones: End of year 1: All preliminary activities for setting up coordinated M&E conducted

End of year 2: Required data collection happens

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
Develop and roll out a standard community HIV program monitoring system.	NACC Min. Of Youth	**Activity 3.181:** Consultative stakeholder meetings to develop consensus for coordinated standardized community level data collection, transfer, reporting and use of routine HIV programme monitoring held *(incorporate this in all community meetings above)* **Activity 3.182.: Provide t**echnical Support and hold Working Group meetings and stakeholder meetings to develop/adapt community HIV protocols, tools and reporting systems for routine HIV programme monitoring*(one meeting, 40 participants, 2 days, res)* **Activity 3.183.:** Training/orientation sessions on standardized community-level routine HIV programme monitoring protocols for different community focal persons from various community groups *(40 workshops, 2 days, 40 participants, res)* **Activity 3.184.:** Administrative and logistical support for quarterly mentorship and supervision visits by focal persons to community level *(for each district: vehicle for 5 days every 3 months, per diem)* **Activity 3.185:** Annual consultative meetings to review performance of community level routine HIV monitoring system *(2 workshops, 2 days, 40 participants, res)* **Activity 3.186** Establish and create linkages with digital villages to integrate HIV and AIDS information in each community *(three 2 day training workshop, 40 participants, res)* **Activity 3.187: Train trainers identified by the community on community level monitoring and evaluation systems *(8 workshops, 40 participants, 3 days, res)***	CSOs								

Output Result 3.19: By 2012 community based operational research agenda for HIV developed and innovative approaches and best practices validated through quality research

(Indicator 1): Community based HIV research agenda developed, agreed, implemented and reviewed annually

(Indicator 2): Number of community based HIV studies conducted, disseminated and operationalised as per research protocol (disaggregated by study type and priority area)

Milestones: End of year 1: 50% of activities implemented; End of year 2: 100% of activities implemented

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.19.1; Develop community HIV Research Inventory and gap analysis and inform on best practices nationally	KARSCOM/ NACC	**Activity 3.191:** Technical support for situational analysis to produce inventory of past in-country community HIV studies and identify key community HIV research gaps *(make this part of community capacity assessment)* **Activity 3.192.:** National consultative stakeholder meetings to develop draft community HIV research agenda(s) and costed work plan(s) (with TA)*(3 day workshop, 40 participants, res)* **Activity 3.193.:** Technical support for reviewing and update of guidelines on community HIV research approach and standards *(consultancy 50 days)* **Activity 3.194.:** Technical working group meetings to develop protocols for priority community HIV research studies *(ten meetings, one day each, non-res, 20 participants)* **Activity 3.195.:** Ethical approval for community HIV research protocols *(100 consultancy days for technical ethical review)* **Activity 3.196: Provide grants to support one study per region per year (8 research grants annually, each USD 16,000)** **Activity 3.197.:** Consultative meetings with policy makers and programmers to review and apply community HIV research evidence to policy and work plans *(8 meetings, 2 days, 40 participants, res)*	CSOs								

Output Result 3.20: By 2012 program evaluations influencing community based planning, costing and implementation of HIV prevention, treatment, care and support programmes at community level

(Indicator 1): % of community based HIV programmes whose plan, costing and implementation approach was based on updated and objective program evaluation information (disaggregated by programme, level, location)

(Indicator 2): Number of community based HIV program evaluations conducted, disseminated and operationalised as per protocol (disaggregated by study type and priority area)

Milestones: End of year 1: 50% of activities done; End of year 2:50% of activities done

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.20.1: Evaluate community programmes to strategically inform subsequent national planning processes.	NACC	**Activity 3.201:** National consultative stakeholder meetings to draft agenda and costed work plans for community HIV programme evaluations (with TA) *(one workshop, 40 participants, 3 days, res)* **Activity 3.202.:** Technical support for development of protocols for community HIV program evaluations *(Consultancy 100 days)* **Activity 3.203:** Recruit and train assessment teams for community HIV program evaluations *(8 workshops, each workshop 40 people, 3 days, res)* **Activity 3.204.:** Technical support for internal and external monitoring and supervision on community HIV program evaluations (participant recruitment, procedures, data management) *(consultancy 100 days)* **Activity 3.205.:** Technical support for data analysis and report writing on community HIV program evaluations *(consultancy 200 days)* **Activity 3.206.:** Disseminate findings from community HIV program evaluations locally, regionally and elsewhere via meetings and conferences (2 national conferences, 1000 participants, 3 days)	CSOs								

Strengthen the national community information system

Output Result 3.21: By 2012 a national HIV information system database capturing up to date HIV M& E information from community based HIV programmes

(Indicator 1): Integrated database for community based HIV information system developed, approved, implemented and reviewed annually

(Indicator 2): % of community-level programme partners submitting timely and accurate reports on HIV-related public health and management indicators as per guidelines (disaggregated by location, type of programme)

Milestones: End of year 1: 50% of activities done; End of year 2:50% of activities implemented

Activity description n	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.21: Strengthen the Community Information System (CIS) - health management information system (HMIS) at community level.	NACC	**Activity 3.211:** Consultative stakeholder meeting to reach consensus on design and function of an integrated national community HIV information system with linkages *(two meetings, 40 participants, two days each, non-res)* **Activity 3.212.:** TWG meetings to define SOW for software developer for integrated community HIV database and potential consumers (*3 one day meetings, 20 people, non-res)* **Activity 3.213.:** Technical support for development of national community HIV information database software and user guidelines *(1 month consultancy)* **Activity 3.214.:** Logistical and administrative support to pilot integrated community HIV database software and user guidelines in a partners at central and sub national levels **Activity 3.215.:** Procure and install required hardware and accessories for integrated national community HIV database at selected focal offices *(150 computers, appropriate software.)* **Activity 3.216.:** Improve internet connectivity and computer literacy for national and sub-national level consumers in various community structures at national and sub national levels *(budgeted under communication budget)* **Activity 3.217.:** Recruit, train and mentor community HIV focal persons responsible for updating of national community HIV database *(8 workshops, 40 participants, 3 days, res)* **Activity 3.218.:** Administrative and logistical support for regular collection, posting of HIV M&E and research reports on integrated community HIV database *(district data entry clerks* **Activity 3.219.:** Disseminate updates on national community HIV database at all levels via website *(website maintenance costs)*	CSOs								

Output Result 3.22: By 2012 community HIV surveillance structures and systems linked to care and support

(Indicator 1): Number of community based HIV surveillance studies conducted, disseminated and operationalised as per surveillance protocol (disaggregated by study type and priority area)

(Indicator 2): Number of community structures supported for community based HIV surveillance (disaggregated by type of surveillance and location)

Milestones: End of year 1: 50% of activities done; End of year 2:50% of activities done

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.22.1: Prepare and implement community surveillance work plans and link community systems to care and support	NACC	**Activity 3.221:** Consultative meetings to review priority areas, protocols and develop work plan for community HIV surveillance *(40 meetings, 40 participants per meeting, 2 days, residential)* **Activity 3.222.:** Technical support to develop/adapt protocols for new community surveillance (e.g. HIV-related disability, mortality, etc.) *(consultancy 30 days* **Activity 3.223.:** Ethical approval for community HIV surveillance protocols *(consultancy 5 days)* **Activity 3.224.:** Train community focal persons on specific HIV surveillance protocols *(40 workshops, 40 participants per workshop, 2 days, res)* **Activity 3.225.:** Administrative, logistical and technical support for implementation of community HIV surveillance *(consultancy 100 days)* **Activity 3.226:** Technical support for data analysis and reporting on community HIV surveillance *(consultancy 100 days per year)* **Activity 3.227.:** Disseminate community HIV surveillance findings locally, regionally and elsewhere via meetings and conferences *(national conference, 50000 participants 3 days)*	CSOs								

Output Result 3.23: By 2012 findings from all HIV M&E, surveillance, surveys and research are widely disseminated

(Indicator 1): % of KNASP partners reached with updated and objective information obtained via community-based HIV M&E and research (disaggregated by programme, level, location)

(Indicator 2): % HIV M&E research information products for last 12 months covered by national HIV information system

End of year 1: 50% of activities done; End of year 2:50% of activities done

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
2.23.1: Develop and implement community HIV M&E and research dissemination plan	NACC	**Activity 3.231:** TWG meetings to define priority information needs, audiences and schedule and costed work plan for dissemination of community HIV M&E and research activities (*5 one day meetings, non-res. 40 participants)* **Activity 3.232:** Technical support to develop publication writing skills for focal persons at community level *(consultant 30 days)* **Activity 3.233.:** Orientation sessions for community focal persons on community HIV data interpretation and dissemination *(do this in community planning forums budgeted for already)* **Activity 3.234.:** Annual consultative meetings with policy makers and programmers to review and apply community HIV strategic information and evidence to policy and work plans *(do this during community planning sessions already budgeted for.*)	CSOs								

Output Result 3.24 By 2012 community HIV surveillance structures and systems linked to care and support

(Indicator1): Number of community based HIV surveillance studies conducted, disseminated and operationalised as per surveillance protocol (disaggregated by study type and priority area)

Indicator2): Number of community structures supported for community based HIV surveillance (disaggregated by type of surveillance and location

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.24.1: Link community HIV surveillance structures and systems to care and support services	NACC	Activity 3.241 : Develop a checklist for HIV surveillance (consultancy 20 days) Activity 3.242.: Develop a strategy for linking surveillance structures to care and support (consultancy 30 days, TWG meetings – 3 meetings, 20 people, one day each, non-res) Activity 3.243.: Train surveillance site teams in comprehensive care and support (8 workshops, each 3 days, 40 participants, res) Activity 3.244: Provide technical and financial support to surveillance teams to link surveillance to care and support (consultancy 200 days, 8 grants each 500,000)	CSOs								

Output Result 3.25. By 2012, 80% of community structures share best practices and lessons learned with other community based HIV programs

(Indicator1) % community structures documenting and sharing best practices and lessons learnt in past 12 months as per the national guidelines

End of year 1: 50% of activities done ; End of year 2:50% of activities done

Activity description	Responsible/ lead organisation/ agency or division/unit	Detailed Activities	Participating partners for implementation	Scheduled Time frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
3.25.1: Develop an information sharing and knowledge management workspace for all community groups and train communities on documentation and dissemination	NACC	**Activity 3.251:** Develop training package for documentation of community HIV programs *(consultancy 30 days* **Activity 3.25.12.:** Train focal community persons on documentation of best practices and lessons learnt (*8 workshops, each 40 participants, 3 days, res)* **Activity 3.253.: Support community groups to conduct exchange visits and share lessons *(40 grants, each KShs 500,000)*** **Activity 3.254: Hold quarterly district dissemination meetings for community implementers and partners *(4 one day meetings per district per year, non-res, 40 people)*** **Activity 3.255.: Set up a central depository unit / workspace to store all community based information. *(monthly rent, furniture, fixtures, communication costs, staff)***	CSOs								

Bi-Annium Work Plan-Pillar 4 : Governance and Strategic Information
OUTCOME: By 2013, KNASP is effectively operationalized **Indicator: KNASP III coordination and implementation structures in place**
HLOP: By 2013, National M&E system for KNASP III in place and operational **% of complete and accurate reports received from pillars**
Output Result 4.1: By mid-2013 Implementation of integrated M&E and Research frameworks and related annual costed work plans continuously generate evidence and disaggregated information to guide the national HIV & AIDS response **Indicator:** 1. A nationally coordinated multi-year HIV M&E plan with a schedule for survey implementation and data analysis has been prepared and is being implemented 2. Annual costed work plans for national M&E developed, agreed, implemented and reviewed annually **Milestones:** Year 1: Database management system in place; Year 2: Annual Costed Work plans at national and sub-national level in place

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.1.1:Develop and disseminate a single, integrated M&E coordination framework and database for use by all stakeholders NASA function: ASC. 8.04 (Programme Support: National M&E and research framework)	NACC, M&E Committee ACC, M&E Committee, Line Ministries NACC, M&E Committee, Line Ministries, Mandated Institutions Heads of sub-systems and line ministries NACC, Line Min. KARSCOM	- Activity 4.111: Establish KNASP III single-platform database management system and structure for M&E and Research, (Institutional TA for 2 years, office equipment and running costs, communication costs, software) - Activity 4.112: Develop and disseminate policy, guideline and tools for strengthening M&E coordination: (1 W/Shop - 3 days Res., 40 person; 1 W/ Shop – 1 day non- res, 100 person; printing 1000 copies x 50 pgs) - Activity 4.113: Define organizational roles and functions in relation to national HIV M&E system (develop and disseminate document with TORs for M&E) (1 National W/shop, 2 day res, 40 persons) - Activity 4.114: Establish M&E desks (with at least two key persons) and provide capacity building in all sectors (in each sub-system and line ministry) (2 x 3-day training res. W/Shop for 100 persons) - Activity 4.115: Procure, install and maintain software (incl. SPSS) and hardware (2 computers, 1 printer, furniture) for all M&E Units (each sub-system and line ministry) (25 Priority Units/Sub-Systems) - Activity 4.116: Develop consensus on organisational and sectoral roles and functions for HIV M&E and research (1 national meeting 2 days/80 pax non-res.) - Activity 4.117: Conduct annual/quarterly multi-sectoral review, work planning and costing of HIV M&E and research activities at national and sub-national levels. (10 meetings, 2 days per year to cover each region (res.) 80 persons & national level (non-res) 100 pax - Activity 4.118: Progress review of M&E annual work plan implementation at national and sub-national levels (Constituency meetings of 2 days non res for 40 pers, Regional (2 day Res) 60 pers & National level (2 day non res) 100 pers) - Activity 4.119: Review of the national HIV M&E and research framework (indicators, data sources, tools, information products, and plans for dissemination and use of data) - 1 National meeting every two years, 3 -day meeting non-res 100 pax	UNAIDS All sectors All sectors Heads of Sub-System and Line Ministry. M&E sub-System, All Sectors M&E sub-syt. Sectors. Pillar conveners Pillar Conveners Pillar conveners								
Sub- total for Result											

Output Result 4.2: By mid 2013 mandated institutions, partnerships and implementers apply common tools within the M&E System.

Indicator: 1. Number & % M&E units that work in partnership with public/private HIV stakeholders on M&E and research activities (disaggregated by level, type of partner, location)

2. % of registered stakeholders reporting HIV M&E data according to national guidelines in past 12 months (disaggregated by level, type of partner, location)

Milestones: Year 1: Inventory of stakeholders and national & sub-national level in place; **Year 2:** Quarterly and annual multi-sectoral M&E reports in place

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.2.1: Standardize and harmonize M&E tools across all sectors. (NASA function 8.03: Partnerships for M&E)	NACC	Activity 4.211 Develop & update inventory and produce reports on existing stakeholders with activities that need to be captured under M&E at national and sub-national levels. Database and reporting – quarterly and annual – printing 1000 copies x 50 pages)									
		Activity 4.212: Sensitization workshop(s) for establishing national and sub-national multi-sectoral technical working groups for HIV M&E (Once in year 1 at Natl half-day meeting, non resid 40 pers & regional Level half-day, non-res,30 pax)									
		Activity 4.213: Quarterly planning and review meetings for national and sub-national multi-sectoral TWGs for HIV M&E (10 meetings, 2 days 80 persons/year to cover each region (res.) & national level (non res) 80 pax)									
		Activity 4.214: Carry out continuous monitoring with reports on status of HIV M&E TWGs & partnerships by M&E Desks at national and sub-national levels (Quarterly and annual reports) – Travel: 9 region x 200 km x 20 districts per quarter; per diems for 2 persons for 14 days per quarter									
Sub- total for Result											

Output Result 4.3: By 2013 Bi-annual National Action Plans are utilizing quality-assured evidence from M&E system to revise targets and maintain relevance of interventions and resource allocation. (ref 2.1, 2.2, 2.3, 3.4)

Indicator: 1. Number of National Plans of Action developed with updated and objective strategic information obtained through HIV M&E and research

2. NPO interventions reviewed based on updated and objective strategic information obtained through HIV M&E and research
3. of M&E sub-systems that were audited in the past 12 months

Milestones: Year 1: M&E and Research information needs and products defined; Year 2: Information generated to address needs and further used to revise NPO targets

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.3.1: Enhance consistent production and use of strategic information in planning. (NASA function: ASC 8.12 Dissemination and use/ ASC 8.06 Advocacy, communications and culture for M&E and Research)	NACC, M&E Committee, KARSCOM	Activity 4.311: Define key HIV M&E and research information needs, products and schedule for HIV programming and policy making (1 national meeting per year, 2 days non res, 80 persons)	UNAIDS								
	Pillars, Mandated Institutions	Activity 4.312: Review new HIV M&E and Research evidence relevant for KNASP III. 1 meeting of Technical Working Group per year, 2 day res, 60 persons)	UNAIDS								
	Prevention Task Force, Pillars	Activity 4.313: Revise NPO targets using available evidence (data referenced in funding proposals, policy and programme documents) -TA for 15 days, Printing 1000 x 50 pgs)	UNAIDS								
		Activity 4.314: Develop and implement audit plans for the M&E Sub-systems (including gender and human rights audit) TA 10 days)	UNAIDS								
		Activity 4.315: Organize annual HIV Prevention Summits to review and update evidence to guide policy and programming - 2 day meeting per year, 300 persons, non-residential	NASCOP USG								
		Activity 4.316: Facilitate work of HIV Prevention Task Force as advisory body on prevention initiatives. TA for 2 years (Senior HIV Prevention Adviser), 2 x travel to international conference/meeting of five days	NASCOP USG								
Sub- total for Result											

Output Result 4.4: By 2013 a comprehensive national HIV research/evaluation agenda is implemented in a coordinated manner based on priority information needs and generates evidence that ensures an effective national HIV and AIDS response

Indicator: 1. National HIV research and evaluation agenda and related costed work plans developed, agreed, implemented and reviewed periodically

2. Number of prioritised HIV research and programme evaluations conducted, disseminated and operationalized in past 12 months

(disaggregated by type of research or evaluation - including key targeted populations such as youth, children, PWD, vulnerable groups and MARPs etc

3. % of KNASP III funding allocated for research (disaggregated by type of research and funding source) including that targeting youth, children, PWD, vulnerable groups and MARPs

Milestones	2009/10	Priority Research agenda (including situational assessment targeting youth, vulnerable groups and MARPS) in place										
Milestones	2010/11	Priority Research agenda (including situational assessment targeting youth, children, PWD, vulnerable groups and MARPS) financed, implemented and information disseminated										
Activity Description	**Responsible/ Lead organization/ agency/division/ unit**	**Detailed Activities**	**Participating Partners for Implementation**	**Scheduled time Frame**								
				2009/10				**2010/11**				
				1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	
4.4.1: Develop, implement and coordinate a prioritized research and evaluation agenda.	NACC, Line Ministries, KARSCOM, M&E Comm, Pillars	Activity 4.411: KARSCOM & National M&E Committees strengthened through additional two professional staff	KARSCOM, M&E Committee									
		Activity 4.412: Define prioritized research and evaluation agenda and allocate resources annually, including situational assessment targeting youth, vulnerable groups and MARPS (1 workshop per year, 2 days, res 40 persons.)	KARSCOM, M&E Committee									
(ASC. 8.04 National M&E and Research Framework)		Activity 4.413: Coordinate the financing, implementation and monitoring of priority research and evaluation agenda including the specific targeting of youth, vulnerable groups and MARPs (Quarterly KARSCOM and M&E Meetings 1 day semi-resid, 80 pers...Financing of Priority Research & Evaluation: Est. 4% of NPO.)										
Sub- total for Result												

Output Result 4.5: By 2011 Research evidence and updates on national policy and strategic programming is captured in national integrated HIV information system, widely disseminated and reported

Indicator: 1. National integrated database for HIV M&E and Research information system developed, implemented and reviewed annually

2. % of partners with updated and objective information obtained through national HIV information system (disaggregated by partner, level)

3 . % HIV M&E and research information products captured by national HIV database system (disaggregated by source and type of product)

Milestones: **Year 1:** Annual National Research Conference Held**; Year 2:** Web-based research/evaluation database in place and updated regularly

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.5.1: Ensure wide and regular availability of research and evaluation findings (ASC. 8.12 Dissemination and use.)	NACC, M&E Committee, KARSCOM	Activity 4.511: Carry out stakeholder consultation on development and update of web-based research/evaluation database. (1 meeting, 2 day non-res, 40 persons)	KARSCOM, M&E Committee								
		Activity 4.512: Establish and maintain web-based database for NACC/KNASP M&E and information management.	KARSCOM, M&E Committee								
		Activity 4.513: Carry out regular update of web-based database on quarterly basis. (TA 2 persons x 15 day/quarter)	KARSCOM, M&E Committee								
		Activity 4.514: Disseminate research & evaluation findings annually through. 1 conference per year, 3 days, non-res 400 persons).TA 25 days…Printing Reports 200 pgs x 3000	KARSCOM, M&E Committee								
		Activity 4.515: Annual Report on Research and Evaluation (TA 14 days; 3000 copies x 100 pages)									
Sub- total for Result											

HLOP: By 2013, mechanism for coordination of KNASP III in place and functional

Indicator: No. of partnerships fora functioning at all levels and sectors; % of stakeholders with work plans aligned to KNASP.

Output Result 4.6: By end 2009 transition plan in place and communicated to all stakeholders for usage of KNASP III as programme framework

Indicator) 1. % of stakeholders receiving updated and objective information on KNASP III programme framework (disaggregate by stakeholder, programme area, level, location)

Milestones: **Year 1**; Transition plan and guidelines in place and shared with stakeholders; **Year 2;** Pillar Conveners facilitated to carry out their roles.

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.6.1: Support timely and coordinated implementation of KNASP III by all stakeholders. (NASA function: Programme Management (& Support))	NACC, Pillars, Line Ministries and mandated institutions	Activity 4.611: Compile comprehensive inventory and produce national HIV implementation map & stakeholder directory. (TA 21 days senior level (compilation), TA 21 days support level (directory production, including electronic database), communication (information gathering, verification), printing/publication 100 pgs x 1000 copies)	UNAIDS								
		Activity 4.612: Develop transition plan and guidelines for stakeholder programming under KNASP III (Institutional TA for 20 days)	UNAIDS								
		Activity 4.613: Sensitization workshops at national and sub-national levels on KNASP III (1 national 1 days (non res), 200 person and 9 regional (res) workshops x 80 persons each incl. transport)	UNAIDS								
		Activity 4.614: Provide technical support to pillar conveners to facilitate execution of convening function . 1 Institutional TA, Pillar Coordination - office equipment and running costs per pillar (total 5) for 2 years (NACC, MoH/NASCOP, MPND), travel costs - ref. 4.1.1.2.4	UNAIDS, DFID								
		Activity 4.615: Establish Technical Working Groups and Committees at national and sub-national level to monitor KNASP III implementation and provide regular capacity building. 1 national 1 days (non res), 200 pers each year; and 9 regional (res) workshops x 80 persons each year									
Sub- total for Result											
Output Result 4.7: By mid 2013, contribution of all stakeholders at national level are being attributed under KNASP outcome pillars **Indicator:** 1. Number and/or % of stakeholders indicated as KNASP 'participating partners for implementation' (disaggregated by pillar and level) 2. Number and/or % of stakeholders regularly participating and reporting under pillar coordination mechanisms (disaggregated by pillar and level)											
Milestones	2009/10	Annual Stakeholder Reports on Alignment covering regional and national level									
Milestones	2010/11	Annual Stakeholder Reports on Alignment level of funding to KNASP III covering regional and national level									

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.7.1: Monitor and report on stakeholder uptake of KNASP III (NASA Function: Programme Management)	NACC, M&E Committee, Pillars	Activity 4.711: Monitor and report on stakeholder uptake of KNASP III results in their programming Travel 2 person per region (9) x 200 km x 20 districts per quarter)									
		Activity 4.712: Monitor and report on level of allocation of available funding against KNASP outcome pillars.									
Sub- total for Result											
Output Result 4.8: By mid- 2013 two National Plans of Operations (NPO) cycles of two years each are being completed **(Indicator):** 1. Number of National Plans of Operation developed, agreed, implemented and reviewed **Milestones: Year 1**: M&E Desks Established in Sectors and Mandated Institutions; **Year 2:** NPO II Developed											
Activity Description	**Responsible/ Lead organization/ agency/division/ unit**	**Detailed Activities**	**Participating Partners for Implementation**	**Scheduled time Frame**							
				2009/10				**2010/11**			
				1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
4.8.1: Support and implement timely and coordinated implementation of NPO by all stakeholders. (NASA Function: programme management)	NACC, Pillars, Line Ministries and Mandated Institutions	Activity 4.811: Develop and disseminate guidelines for NPO implementation and reporting at national and sub-national level (1 national 1 day (non res), 200 and 9 regional (res) workshops x 80 persons each incl. transport)	UNAIDS								
		Activity 4.812: Established M&E desks, monitor and report on progress of NPO implementation.	UNAIDS								
		Activity 4.813: Develop and disseminate NPO II (TA – 2 x 4 pillars & 2 for cross-cutting issues, 2 for costing .) 30 days, W/Shops 4 Non Resid of 30 persons, 1 national 1 day semi-res of 300 person, printing 3000 copies of 100 pgs)	UNAIDS, Pillar conveners								
Sub- total for Result											

Output Result 4.9: By mid 2013 Costed bi-annual regional Plans of Operation are reviewed and institutionalized

(Indicator): 1. Number of sub-national operational plans developed and implemented (disaggregated by location and level)

2. Number of sub-national operational plans reviewed, disseminated and operationalized (disaggregated by location and level)

Milestones: Year 1: Regional Plan of Operations that take into account regional specific situation incl. youth, vulnerable groups and MARPS are in place; Year 2: Review of Plan of Operations and development of NPO II

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.9.1: Develop, review and institutionalize costed regional plans of operation. (NASA Function: programme management)	NACC, Pillars, Decentralized Structures of NACC and Sectors	Activity 4.911: Develop region-specific HIV situation analyses (9) including analysis that focuses on youth, children, PwD, vulnerable groups and MARPS.	UNAIDS								
		Activity 4912: Convene multi-sectoral consultative meetings for 'domestication' of NPO into evidence-informed regional Plan of Operations (9) ; 9 meetings x 3 days, residential, 80 pax each, bi-annual printing (2000 x 60 pages x 9) and distribution of regional Pos	UNAIDS								
		Activity 4.913: Establish desks for monitoring and reporting on progress of PO implementation by regions.									
		Activity 4.914: Conduct resource mobilization and allocation using the regional plans targeting different sources of funds (TOWA, GF, PEPFAR, etc) Institutional function, no additional cost implications,	UNAIDS								
Sub- total for Result											

Output Result 4.10: By end mid 2013 JAPR cycle is evidence informed and is monitoring and attributing annual Results to institutions and partners

(Indicator): 1. % of KNASP partners that receive credit for annual results through JAPRs according to the national M&E results framework (disaggregated by partner and result)

2. % of JAPR reports with updated and objective information on annual results by implementing partners (disaggregate by level, location)

Milestones: year 1: JAPR Report that fully reports on NPO at all levels; JAPR report disseminated at all levels

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.10.1: Develop and review JAPR monitoring and reporting guidelines and tools in line with KNASP III reporting needs. (NASA Function: programme management: M&E)	NACC, M&E Committee, JAPR Task Force, Pillars, Decentralised Structures	Activity 4.101: Develop and review JAPR monitoring and reporting guidelines and tools in line with NPO reporting needs, Institutional function of NACC M&E, no cost implication	Pillar conveners								
		Activity 4.102: Orientation for JAPR desks at national and sub-national levels, (1 national meeting 1 day non-res, 40 pers; 1 day, 40 pers x 9 regions residential)	Pillar conveners								
		Activity 4.103: Technical and logistical support to M&E desks to gather, consolidate and analyse reports on results by concerned institutions/partners	Pillar conveners								
		Activity 4.104: Validate results and rank annual performance for all stakeholders at regional level using set criteria (5 meetings per pillar x 10 pax (1 day non-residential, peer reviewer honoraria)	Pillar conveners								
		Activity 4.105: Develop and disseminate JAPR reports for different levels. (TA 2 x 20 days, printing 3000 x 100 pgs)	UNAIDS								
		Activity 4.106: Formally acknowledge contribution of all stakeholders to KNASP results via press, reports, certification, awards and other mechanisms,(full page x 2 newspaper, electronic communication)	Pillar conveners								
Sub- total for Result											

Output Result 4.11: By mid 2011 KNASP II Mid-Term Review (MTR) is carried out

((Indicator): 1. KNASP Mid-programme review conducted, disseminated and operationalized (disaggregated by type of programme and type of evaluation)

Milestones: Year 2: MTR conducted and report generated

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.11.1: Perform a mid-term review of KNASP III (NASA Function: programme management)	NACC, MTR Working Team, Pillars	Activity 4.111: Consultative meeting(s) to develop Terms of Reference for mid-term review, Institutional function, no cost implication	Pillar conveners								
		Activity 4.112: Recruit MTR consultants via competitive bidding process, (Half- page newspaper add x 2 TA 20 days, TA – 2 x 4 pillars & 2 for cross-cutting issues, 45 days, W/Shops 4 Non Resid of 30 persons, 1 national 1 day semi-res of 300 person, printing 3000 copies of 100 pgs) [this is linked to 4.2.2.1.3]	Pillar conveners								
		Activity 4.113: Conduct MTR at national and sub-national level, (W/Shops 4 Non Resid of 50 persons, 1 day Regional workshops (9) for 100 persons , 2 national 1 day semi-res of 300 person, 7 consultants x 21 days, printing 3000 copies of 100 pgs)	Pillar conveners								
		Activity 4.114: Produce and disseminate final MTR report at national and sub-national level; Printing 3000 copies of 100 pgs	Pillar conveners								
		Activity 4.115: Develop consensus on incorporating MTR recommendations into next NPO at national and regional levels, Institutional function, no cost implication	Pillar conveners								
Sub- total for Result											

Output Result 4.12: By mid-2013 stakeholders fully adhere to Code of Conduct (CoC)

(Indicator): 1. Code of Conduct for KNASP III endorsed, implemented and reviewed annually

2. % stakeholders having signed and adhering to Code of Conduct (disaggregated by partner, level, location)

Milestones: Year 1: Code of Conduct Launched; Year 2: Annual Report on Compliance

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.12.1: Promote, monitor and report on adherence to the Code of Conduct. (NASA Function: programme management)	NACC, Pillars	Activity 4.121: Print and launch final Code of Conduct (CoC) document at national and sub-national levels (Printing: 3000 x 20 pgs, half page newspaper advert x 2, half-day national launch 300 pers semi-residential)	UNAIDS								
		Activity 4.122: Conduct advocacy for stakeholder CoC buy-in and signing, Institutional function, no cost implication	Pillar Conveners UNAIDS								
		Activity 4.123: M&E Desks monitor and report on stakeholder compliance to Code of Conduct on an annual basis, Ref: 4.1.1.2.4	Pillar conveners								
Sub- total for Result											

Output Result 4.13: By 2010 KNASP III mandated institutions are effectively managed at all levels

(Indicator): 1. % of annual KNASP III targets (incl. those on youth, children, PwD and MARPs) achieved (disaggregated by pillar, mandated institution, implementing partner)

2. % mandated institutions programming and reporting on KNASP III implementation as per national guidelines (disaggregated by level, location)

3. % stakeholders expressing satisfaction with the management of KNASP III (disaggregated by pillar, mandated institution, stakeholder, programme area, level,

Milestones: Year 1 Orientation on KNASP III Management Conducted among desk officers; Year 2: Annual client/customer satisfaction survey Report

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.13.1: Develop and review KNASP III management guidelines and structures. (NASA Function: Creating and enabling environment)	NACC, Pillars, Line Ministries, Conveners and key Mandated Institutions	Activity 4.131: Develop KNASP III management guidelines, 819,000 (TA for 20 months)									
		Activity 4.132: Provide orientation on KNASP III management guidelines for concerned desk officers of all mandated institutions (public sector, private sector, FBOs, CSOs, Developments) at national and sub-national levels (5 national meetings, 1 day non-resident of 60 pers per meeting; and regional (9) combined meetings 1 days, resident 100 pers)									
		Activity 4.133: Technical Working Groups are formed and Monitor KNASP III implementation and gather feedback from stakeholders on KNASP management at all levels every six months (meetings, interviews) , (TA for 20 days every six months, 5 TWG of 60 person at national level meeting 2 days non-residential twice per year; 1 day non-res meeting of 80 pers in 9 regions, twice per year, reports 2000 x 50 pages)									
		Activity 4.134: Consolidate feedback and review management guidelines(TA for 10 days; In-house Technical Working Group meetings, [Linked to 4.3.1.1.1 and 4.2.2.5.3]									
		Activity 4.135: Carry out annual client/customer satisfaction surveys focusing on each of the mandated institutions including NACC and All Conveners and disseminate findings (TA: 3 for 60 man-days); data collection in all regions with average travel of 1,200 km per team; Printing: 3000 copies x 100 pgs; Dissemination Meetings –1 day non-res, 300 persons) per year									
Sub- total for Result											

Output Result 4.14: By 2010 all KNASP III partners sign an MOU identifying their mandates, roles and expected accountability

(Indicator): 1. % of development partners having signed a joint MoU with NACC for reporting (disaggregated by partner, HIV programme, location)

Milestone: Year 1: MOU signed by Mandated Institutions

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.14.1: Consensually develop and promote partners' signing and adherence to a Memorandum of Understanding. (ASC: Creating an enabling environment)	NACC, Mandated Institutions, development partners	Activity 4.141: Drafting MOUs through Technical Working Group, 1,306,968, TA for 14 days; W/ Shop for 3 days resid, 15 pers,									
		Activity 4.142: Develop consensus on draft MOU with relevant coordinating bodies; National meetings 1 day non-res for 100 person									
		Activity 4.143: Conduct advocacy for mandated institutions signing, Institutional function, no cost implication									
Sub- total for Result											

Output Result 4.15: By 2010 Implementing partners incl. Public Sector, CSO and Private Sector coordination and support mechanisms are delivering on KNASP III results

(Indicator): 1. % of registered CSO and registered sector partners achieving intended results according to the national M&E framework in past 12 month (disaggregated by type of partner result)

Milestones: Year 1: Coordination and accountability mechanisms developed; Year 2: Capacity building for established coordination and accountability mechanisms conducted

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.15.1: Develop guidelines and structures for public sector, CSO and private sector coordination, accountability and support under KNASP III.	NACC, Pillars, Mandated Institutions	Activity 4.151: Develop and update guidelines for public sector, CSO and private sector coordination and support for KNASP III (TA for 20 day)									
		Activity 4.152: Establish relevant Public Sector, CSO, private sector & FBO coordination and accountability mechanisms (network, council, consortium, alliance) for KNASP III results; National W/Shops: 4 (Public Sector, CSO, private sector & FBO) x 2 meetings x 2 days, non-resid	PSAN, KHBC, ACU network etc								
		Activity 4.153: Conduct capacity building for established CSO and private sector coordination and accountability mechanisms; (Trainings workshops for Public Sector, CSO, private sector & FBO for 3 days/ 100 pers, semi-resid, 2 times per year)									
(NASA Function: ASC 8.03/4 programme management: M&E : Partnerships/ M&E and Research Framework)		Activity 4.154: Carry out bi-annual audit of the established mechanisms targeting Public Sector, CSO and private sector coordination mechanism and disseminate report;(TA for 30 days every two years; W/shop of 2 days, semi-resid, 250 pers, every two years)									
Sub- total for Result											

Output Result 4.16: By mid 2013 sustained high level leadership is provided in line with defined institutional mandates for effective resource mobilization, advocacy, legislation and overcomes systems constraints.

(Indicator): 1. % of national HIV response funded by the GoK budget

2. Frequency of high level (ministerial and above) advocacy and resource mobilization interventions for national HIV response.

Milestones: Year 1: Regular Financial Reports and Memoranda made to the Meetings of PSs and Cabinet Sub-Committee on HIV and AIDS; Year 2: Regular Meetings of Members of Parliament on HIV and AIDS

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.16.1: Strengthen leadership and governance systems capacity for effective resource mobilization, advocacy and legislative support of KNASP III. (Health Systems Strengthening: Governance and Leadership)	Line Ministries, Pillars NACC, MSSP, Cabinet office and National Assembly	Activity 4.161 Develop and review sectoral policy papers on HIV and AIDS and support sectors in resource mobilization; One national meeting 2 days/100 semi-res; 11 MTEF sectors Annual W/ Shops, 2 day for 60 pers semi- res, TA 35 days									
		Activity 4.162: Develop programmatic and financial reports/memoranda for presentation to the Cabinet Committee on HIV and AIDS and meetings of PSs on quarterly basis (Printing 1000 copies of 10 pages), Ref. 4.3.1.4.1									
		Activity 4.163: Mobilise political and policy level support targeting Members of Parliament, PSs, CEOs in private sector etc; 1 annual meeting of PSs 50 person, 2 day non-resid; 1 annual meeting with MPs 220 pers, reside, 1 annual meeting of CEOs 50 person, 1 day non-resid; 1 annual meeting with National Assembly Health Committee, 20 pers, 2 day, resid), printing 3000 copies x 150 pages per year.									
Sub- total for Result											

Output Result 4.17: By mid 2013 Stakeholders use strategic communication coordination frameworks to design, implement and evaluate advocacy and programmatic communication in key thematic programme areas

(Indicator): 1. # of stakeholders designing, implementing and evaluating advocacy and programmatic communication in line with the communication

Coordination framework and set guidelines (disaggregated by type of stakeholder, location.

Milestones: Year 1: Guidelines on strategic Communication launched; Year 2: Regular reporting on implementation of guidelines

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.17.1: Promote use and adherence to the KNASP III communication strategy and monitor its use. (NASA Function: programme management: Advocacy & Communication)	NACC, Pillar 4, Strategic Communication Sub-Group	Activity 4.171 Develop KNASP III Strategic Communication Guidelines on advocacy, BCC and character formation, (TA 45 days; W/Shops: 1 national 2 day semi-res, 100 pers, Regional (9) 2 day res meeting, 80 pers)									
		Activity 4.172: Launch Strategic Communication Guidelines (1 national ½ day meeting, semi-res 300 per)									
		Activity 4.173: Build capacity of National and sub-national BCC/Character formation consortia to provide necessary support to stakeholders, 30,549,376 (1 workshop at national level 2 days/ 80 per and 9 workshops 2 days resid for 80 per)									
		Activity 4.174: Monitor implementation of guidelines on advocacy, BCC and character formation and report on stakeholder compliance Ref 4.1.1.2.4									
Sub- total for Result											
Output Result 4.18: By mid 2013, guidelines for capacity building and technical assistance developed, agreed, implemented and reviewed annually.											
(Indicator): 1. National capacity building and technical assistance guidelines for KNASP III developed, agreed, implemented and reviewed annually (Disaggregated by technical area)											
Milestones: Year 1: Capacity Building Plan Updated; Year 2: Regular Reports by Mandated Institutions											

<table>
<tr><th rowspan="3">Activity Description</th><th rowspan="3">Responsible/ Lead organization/ agency/division/ unit</th><th rowspan="3">Detailed Activities</th><th rowspan="3">Participating Partners for Implementation</th><th colspan="8">Scheduled time Frame</th></tr>
<tr><th colspan="4">2009/10</th><th colspan="4">2010/11</th></tr>
<tr><th>1</th><th>2</th><th>3</th><th>4</th><th>1</th><th>2</th><th>3</th><th>4</th></tr>
<tr><td rowspan="4">4.18.1: Consensually develop, implement and review capacity building and technical assistance guidelines.

(NASA Function: programme management: ASC 4.03 Inst. devt)</td><td>NACC, Line Ministries, Mandated Institutions</td><td>Activity 4.181 Carry out a capacity needs assessment for mandated institutions, (TA for 1 30 days, printing of reports 1000 copies of 100 pgs)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Activity 4.3.182 Update the Technical Assistance/Capacity Building Plan (TA 10 days; 1 National Meeting of 2 days, semi-resi, for 100 pers)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Activity 4.183: Build capacity of National and sub- national priority implementing organisation, 5% of total cost of NPO</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Activity 4.184: Mandated institutions provide quarterly reports to NACC, Institutional Cost</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="12">Sub- total for Result</td></tr>
<tr><td colspan="12">Output Result 4.19: By mid 2013 capacity building and technical assistance plan is efficiently coordinated, implemented and reviewed

(Indicator): 1. % of planned capacity building and technical support activities implemented (disaggregated by type, target group, level, location)

2. % of planned capacity building and technical support interventions reviewed and implemented (disaggregated by type, target group, level, location)</td></tr>
<tr><td colspan="12">HLOP 4.3.3: By mid 2013 Implementation of KNASP III is fully supported by an enabling legislative and policy environment

(Indicator): 1. National Composite Policy Index</td></tr>
<tr><td colspan="12">Output Result 4.20: By 2011 the necessary legal and policy framework for effective management and coordination (clearly defining mandates of relevant institutions) of all HIV & AIDS programmes is in place and operational

(Indicator): 1. National HIV legal and policy framework for KNASP III coordination and management developed, reviewed, agreed, and operationalized.

Milestones: Year 1: Sessional Paper No. 4 on AIDS in Kenya of 1997 Revised; Year 2: HIV and AIDS Prevention and Control Act 2006 Reviewed and Legislative framework to support NACC enacted</td></tr>
</table>

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.20.1: Create an enabling legislative and policy environment for effective implementation, management and coordination of KNASP III.	NACC and Ministry of Special Programmes, AG, Parliament, NACC & Task Force, Line Ministries	Activity 4.201 Review the HIV and AIDS Prevention and Control Act 2006/ draft legislative framework to support NACC/amending Public Health Act (10 Task force meetings of 2 days/ 30 pax, 1 TA for 2 months)									
		Activity 4.202: Review and revise the Sessional Paper No. 4 on AIDS in Kenya of 1997 (10 Task force meetings 2 days/ 30 pax, (1 TA for 2 months)									
		Activity 4.203: Engage Parliamentary Committee on Health on review and amendment to legislative framework on HIV and AIDS and revision to Sessional paper #4 , Cost: Ref to 4.3.1.4.3									
		Activity 4.204: Printing, distributing Guidelines and holding meetings with desk officers at National & Regional Level (Printing 2000 copies of 60 pages and courier charges)									
		Activity 4.205: Monitor the operationalisation of legislative and policy on HIV and AIDS through sectoral policies. Quarterly 1 day meetings, non-resid, 100 persons									
Sub- total for Result											

Output Result 4.21: By mid-2013 appropriate policy framework in place and operationalised to guide mainstreaming issues on human rights, gender, GIPA, youth, children and PwD in HIV and AIDS programming in all sectors

(Indicator): 1. National Composite Policy Index

2. % of sectors that have human rights, gender, GIPA, youth, children and PwD compliant HIV&AIDS policies and programmes

Milestones: Year 1: Guidelines on mainstreaming of Human Rights, Gender, GIPA developed/updated; Year 2: Regular monitoring reports on mainstreaming of Human Rights, Gender, GIPA

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.21.1: Develop and operationalize appropriate policy frameworks to guide mainstreaming issues on human rights, gender, GIPA, youth, children and PwD in HIV and AIDS programming in all sectors. (Be careful to dissagregate these groups.) (NASA Function: Creating and enabling environment)	NACC, Ministry of Gender, other Line Ministries, Human Rights Commission, Networks of PLWHA	Activity 4.211 Develop and update specific guidelines/modules on programming for mainstreaming: Human Rights, Gender, GIPA, (TA 30 days; 2 Meetings of 2 days, non-res, 60 pers									
		Activity 4.212: Print, distribute the guidelines & specific modules for mainstreaming: Human Rights, Gender, GIPA) (15,000 X 3 copies for 60 pages)									
		Activity 4.213: Develop capacity in addressing human rights, gender, GIPA, at national and regional level, (TA of 30 days X various disciplines) per year; 1 national, 3 day non-resid, 100 pers per year; Regional (9) 3 day res, 80 pers per year)									
		Activity 4.214: Carry out quarterly and annual monitoring on mainstreaming: Human Rights, Gender, GIPA and produce reports. (10 meetings for 2 day/ 30 pers X …, semi-resid; reports 1000 copies x 40 pages)									
Sub- total for Result											

Output Result 4.22: By mid-2013 a national HIV and AIDS Policy Framework to facilitate effective service delivery to vulnerable groups and MARPs developed and operational

(Indicator): 1. HIV&AIDS Policy Framework for targeting MARPS and Vulnerable groups developed and agreed upon by all partners

2. HIV programmes for MARPs and vulnerable groups developed and implemented (disaggregated by location, intervention, target group)

3. Number of MARPs and vulnerable people reached (disaggregated by target group, sex, intervention, location)

Milestones: Year 1: Guidelines/modules on programming targeting Youth, children, Vulnerable Groups & MARPS developed; Year 2: Regular monitor reports on implementation of guidelines on programming targeting Vulnerable Groups & MARPS

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.22.1: Develop and operationalize appropriate policy frameworks to guide mainstreaming issues MARPS and vulnerable groups in HIV and AIDS programming in all sectors. (Be careful to disaggregate these groups.) (NASA Function: creating and enabling environment)	NACC, Ministry of Youth, Children Dept, other Line Ministries	Activity 4.221 Develop and update specific guidelines/modules on programming targeting Youth, children, Vulnerable Groups & MARPs (TA for 30 days, 2 national meetings of 2 days, semi-res, 50 /p)									
		Activity 4.222: Print, distribute the guidelines & specific modules on programming targeting Youth, children, Vulnerable Groups & MARPs, (2000 copies of 50 pages)									
		Activity 4.223: Develop capacity in addressing needs of children, youth, other vulnerable groups and MARPS at national and regional level (TA of 30 days (various disciplines); [Refer also to 4.3.3.2.3)									
		Activity 4.224: Monitor implementation of guidelines on programming targeting Youth, Children, Vulnerable Groups & MARPs on Quarterly and annual basis (10 meetings for 2 day/ 30 pers, semi-resid; reports 1000 copies x 40 pages)									
Sub- total for Result											

HLOP : By 2013, Financing of KNASP III is harmonized and aligned

Indicators: % of KNASP funding need met

% financing of KNASP by source

% of KNASP funding utilized.

Output Result 4.23: By mid-2013 mainstreaming of HIV and AIDS Interventions in the Public Sector Planning and Budgeting and in Decentralised Funding Mechanisms Strengthened

(Indicator): 1. % increase in allocations from all sources by sector and Line Ministry (disaggregated by Recurrent, Development)

2. % increase in GoK Allocations by Sector and Line Ministry (disaggregated by Recurrent, Development)
3. % Health Sector Budget mobilized from GoK through the MTEF (disaggregated by Recurrent and Development)
4. % resources required by the Social Protection/Conditional Cash Transfer Budget mobilized from GoK through the MTEF (disaggregated by funding source)

Milestones: Year 1: All Lines Ministries have Prioritised and Decentralised HIV and AIDS Programmes; Year 2: JAPR and KNASA carried out annually

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.23.1: Strengthen the capacity of Public Sector Planning and Budgeting mechanisms; Decentralized Funding Mechanisms to mainstream HIV and AIDS Interventions. (Systems strengthening: Systems Financing)	NACC, MOF, Line Ministries, Dev Partners, MOSSP	Activity 4.231: Carry out annual expenditure review KNASA (Data collection 5 teams of 3 persons travelling 1,500km for x 20 days; 1 lead consultant for 45 days, 15 support consultant x 35 days; 3 workshops of 1 day semi res for 100 pers; reports 2000 x 120 pages)									
		Activity 4.232: Carry out annual JAPR and Strengthen Linkage with MTEF (TA of 30 days to Support Sectoral Review, JAPR: National level of 2 days meetings per year semi-res, 400 pers; Regional level (9) meetings of 2 days per year semi-res, 100 pers; District level (254) meetings of 2 days per year semi-res, 60 pers; 1 TA x 30 days; Reports 3000 x 120 pages)									
		Activity 4.233: Sectors Review and prioritise HIV and AIDS programme needs annually and mobilise resources through MTEF (TA for 30 days per year; 3 day residential meeting, 100 persons per year)									
		Activity 4.234: Advocate for increased GOK resources (targeting Commodities, Social Protection etc) and creation of specific Recurrent Budget Lines. (2 day non-residential meeting, 100 persons per year)									
		Activity 4.235: Develop and review specific finance agreements in different sectors with different partners and advocate for aligning to KNASP III (TA – 20 days, Consultative Meetings)									
		Activity 4.236: Carry out advocacy for policy review targeting decentralized funding to support HIV and AIDS activities.									
		Activity 4.237: Carry out annual expenditure review to determine allocations to priority results and to interventions targeting gender, vulnerable groups and MARPS (Further Analysis of KNASA and other reports. (TA 15 man-days)									
Sub- total for Result											

Output Result 4.24: By mid-2013 , mobilization of resources from development partners and the private sector strengthened

(Indicator): 1. % allocations from all sources including development partners and private sector (formal and informal) – disaggregated by result area and location

Milestones: Year 1 : High level Advocacy for Resource Mobilisation Targeting Development Partners, Private Sector; Year 2: New Sources of Resources Secured

Activity Description	Responsible/ Lead organization/ agency/division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.24.1: Strengthen the HIV and AIDS financing system to improve resource mobilization outcomes with the public and private sector. (Systems strengthening: Systems Financing)	NACC, MOF, MOSSP, Line Ministries, Dev Partners, Networks, MOSSP	Activity 4.241: Carry out high level advocacy targeting potential funding partners at local, regional and international level (2 National one day meetings of 40 pers, non-reside; 4 foreign trips of 5 days by teams of four persons)									
		Activity 4.242: Develop and review specific finance agreements in different sectors with different partners and advocate for aligning to KNASP III *(TA – 20 days, Consultative Meetings)*									
		Activity 4.243: Coordinate resource mobilisation in the formal and informal private sectors. (Semi Annual Review Meetings National Level of 80 pers, 1 day non-res; 9 regional meetings 1 day residential.)									
		Activity 4.244: Coordinate resource mobilisation by FBO and Civil Society (Semi Annual Review Meetings National Level of 80 pers, 1 day non-res; 9 regional meetings 1 day residential.)									
Sub- total for Result											

Output Result 4.25: Innovative and long-term financing mechanisms put in place

(Indicator): 1. % (and amounts) of allocations derived from long-term agreements, programmes and AIDS Fund with life span of at least 5 years (disaggregated by source and result area)

2. % (and amounts) of allocations derived from non-traditional sources including AIDS Fund (disaggregated by source and result area)

Milestones: year 1: Advocacy for Creation of AIDS Fund carried out; Year 2: Act in place and operationalised

Activity Description	Responsible/ Lead organization/ agency/division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.25.1: Institute mechanism for innovative financing of HIV and AIDS, from traditional and non-traditional sources. (Systems strengthening: Systems Financing)	NACC, MOSSP, AG, MOF, V2030	Activity 4.251: Develop, advocate and amend HIV Prevention and Control Act to incl. Section creating HIV and AIDS Fund **(**TA for Drafting 30 days, meetings with stakeholders – 3 meetings of 1 day non res, 100 persons; 2 meetings with Parliamentary Committee on Health, 1 day res, 20 pers**)**									
		Activity 4.252: Task force develops guidelines on operationalization of the Act and Policy with regard to financing (TA for 14 days, 3 meetings non resid of 30 persons)									
		Activity 4.253: Printing, distributing Guidelines and holding meetings with key institutions & sectors: Ministry of Finance & other Ministries, Development Partners, Private Sector, (1000 copies x 50 pages)									
		Activity 4.254: Establish the Fund (Staff – 12 professional staff & 12 support staff, 18 computers & software, 8 lap-top, 3 LCD Proj , Offices Furniture for 20, 3 vehicles; install financial management system, pay rents)									
		Activity 4.255: Carry out regular fund-raising targeting GOK, Development Partners, Private Sector etc as part of JAPR/MTEF Process (hold high level meetings 2 per year targeting 150 participants)									
Sub- total for Result											

Output Result 4.26: By mid-2013 financial resource absorption capacity increased

(Indicator): 1. % of allocations actually spent (disaggregated by source and result area)

Milestones: Year 1: Regular Procurement and Logistic Coordination Meetings Held; Regular Meeting to review programmatic reporting

Activity Description	Responsible/ Lead organization/ agency/division/unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.26.1 : Strengthen financial, procurement and supply management system for faster and more efficient implementation. (Systems strengthening)		Activity 4.261: Coordinate strengthening of Procurement and Logistic Management System. Quarterly Meetings at National Level of 80 pers, 1 day non-res									
		Activity 4.262: Coordinate Strengthening Programmatic Reporting (Semi-annual TA of 30 days to assess absorption and reporting gaps and bottleneck; Semi-Annual Review Meetings at National Level of 80 pers, 1 day non-res; 9 regional meetings of 100 pers, 1 day res.)									
Sub- total for Result											

HLOP 4.4.2: By mid 2013 efficiency in management of financial resources enhanced

(Indicator): 1. % of funding channelled through the GoK budget

2. % of funding managed through pooling of funds and other joint funding mechanisms

Output Result 4.27: By mid-2013 the Financial and Funding Mechanisms Improved at all levels

Indicator: 1. Number of partners who have agreed on pooling of funds and other joint funding mechanisms

2. Number of partners who finance KNASDP III through MTEF

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.27.1: Enhance efficiency of financial management system. (Systems strengthening:)		Activity 4.271: Advocacy carried among development partners towards pooling of funding. Semi-Annual High level meetings at national level of 60 pers, 1 day non-res									
		Activity 4.272: Coordinate capacity building in Financial Management of implementers and key institutions. (2% of NPO Cost)									
Sub- total for Result											

Output Result 4.28: By mid-2013 efficiency in resource allocation and use enhanced

(Indicator): 1. % (and amounts) of allocations derived from long-term agreements and programmes and AIDS Fund with life span of at least 5 years (disaggregated by source and result area)

Activity Description	Responsible/ Lead organization/ agency/division/ unit	Detailed Activities	Participating Partners for Implementation	Scheduled time Frame							
				2009/10				2010/11			
				1	2	3	4	1	2	3	4
4.28.1: Build stakeholder capacity for efficient resource allocation and use. (NASA Function: …)		Activity 4.281: Coordinate capacity building on evidence informed resource allocation targeting mandated institutions. (TA of 20 days per year; Annual Capacity Building Workshop for 120 pers, 3 days, resid per year.)			x	x	x				x
		Activity 4.282: Carry out programme implementation efficiency studies annually and disseminate findings. (100 man days; data collection in 9 regions by teams of 3 persons each for 15 days, each travelling 1,500 km , workshop at National Level of 80 pers, 1 day non-res; 9 regional meetings of 100 pers, 1 day residential)									
Sub- total for Result											

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