KENYA ANNUAL NARRATIVE REPORT FOR JOINT PROGRAMME ON HIV & AIDS
REPORTING PERIOD: 2008-DECEMBER 2009

Participating UN Organization: UNFPA, WHO, UNDP, UNICEF, UNHCR, ILO, IOM, UNAIDS, FAO, UN Cares (UNON), UNESCO, UNODC, OCHA, WFP, WHO, & World Bank	**Area/Theme:** HIV and AIDS
Joint Programme Title: Kenya Joint UN Programme of Support on AIDS **ATLAS No:** 00067646	**Total JP Budget (in US$):** US$ 93.3 Pass-through funding Donor DFID $ 5,435,490.99 Yes UN Agencies internal resources & other donors: USD 51,600,461.01

Implementing partners:
National Counterparts: Mainly NACC & NASCOP, Others included civil society organizations

Joint Programme Duration in Months:

I. Purpose

The first Kenya UN-JP was launched in 2007, covering the period 2007-2012. The total budget for the UN-JP was estimated at US$93.3 million for the period 2007-2012. The aim of the programme was to increase the effectiveness and harmonization of system-wide UN support to the national HIV response by, among others, supporting the National AIDS Control Council (NACC) in the development of effective, evidence-informed and nationally-led multi-sectoral response to HIV in Kenya, through improved and effective UN contribution, improved donor harmonization and alignment. While anchored in the premises of UN reform towards 'Delivering as One' and the UN Development Assistance Framework, the UN-JP was also fully aligned with the 2005/06-2009/10 Kenya National HIV and AIDS Strategic Plan (KNASP II). The UN-JP had the following key outcome areas:

- Outcome 1: Reduced number of new infections in both most-at-risk groups and general populations.
- Outcome 2: Improved treatment and care, protection of rights and access to effective services for infected and affected people.
- Outcome 3: Existing programmes adapted and innovative responses developed to reduce the impact of the epidemic.
- Outcome 4: 'Three Ones' effectively functioning as the basis for all programming and resource allocation in support of the national HIV response.

How it relates to UNDAF

UN support to Kenya is guided by the overall five-yearly UN Development Assistance Framework (UNDAF), which currently runs from 2009 to 2013 negotiated with the Government of Kenya at the highest level. The UNDAF spells out agreed areas of cooperation in support of Government policies and priorities, as articulated in the Kenya Economic Recovery Strategy (KERS) paper as well as the Millennium Development Goals (MDGs). The UNDAF represents not just the legal basis for UN work in-country, but also the starting point for preparation of country programmes by respective UN agencies. Responding to the HIV pandemic and protecting the rights of those affected is one of the key cornerstones and major outcome areas of the Kenya UNDAF. Embedded firmly in the framework is a focus on UN reform, harmonization and alignment of the UN system's work on HIV, particularly as it relates to increased alignment with the KNASP and promotion of the "Three Ones" principles. The HIV and AIDS components and interventions of the current UNDAF (2009-2013) that presently support the KNASP III (2009/10-2012/13) are: ***UNDAF Outcomes 2.3:*** **Evidence-informed and harmonized national HIV response is delivering sustained reduction in new infections.**

Main implementing partners/Participating Organizations, their roles and responsibilities and their interaction with each other.

The UN-JP was implemented by the UN-JT, which operated under the UN Resident Coordinator system and consisted of technical UN staff working on HIV. It comprised 16 agencies, namely: FAO, ILO, IOM.UNAIDS, UN Cares (UNON), UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, UNODC, OCHA, WFP, WHO, and Word Bank. As of 2009, the UN-JT had a membership of 38 from the above-listed agencies. The UN-JT was responsible for facilitating the UN-JP and supporting strategic response management and coordination of activities.

There are four major working groups of the Joint UN team on AIDS convened and chaired by agreed UN Lead Agencies: UNFPA leads the technical cluster on prevention while WHO is the lead on quality of life. UNDP on the other hand is the lead on mitigation supported by UNICEF and the Kenya National AIDS Strategic Plan support is spearheaded by the UNAIDS secretariat. UNDP further plays an additional role of Administrative Agent (AA) function of the Joint Programme. The coordination of the joint programme is majorly through the cluster leads who convene and chair wok planning meetings on the designated sub-working group. In addition, they organize quarterly and annual review meetings, including periodic joint monitoring activities and review of reports from Participating UN organizations. The conveners further report progress to the UNCT through the UNAIDS Coordinator as Chair of the Joint UN Team on AIDS

II. Resources.

The total budget for the UN-JP was estimated at US$93.3 million for the period 2007-2012. US$38.6 million was projected to be covered through internal UN sources. DFID committed to provide a total of US$20 million spread over four years and the remaining US$34.7 million was an unfunded balance expected to be covered by existing commitments and through joint resource mobilisation from external donors.

As at the close of 2009, a total of US$57, 035,952 had been spent on various programmatic areas. Discounting the expenditure on nutrition and AIDS related treatment services (which amount to US$10,828,123) and the cash-heavy cash transfer programme (amounting to US$15,317,778); the majority of the expenditure was on reduction of new HIV infections (US$15,198,226), thus underlying the UN's commitment to support the prevention agenda in the national response. Other areas in prevention that received reasonable funding include prevention among most-at-risk populations (US$6,842,648), HIV prevention acceleration (US$3,526,880), coherent interface between TB and HIV related services (US$4,430,720), quality and equity of AIDS related treatment services (US$3,198,984) and HIV mainstreaming and development financing (US$1,536,285). The UN financial support towards Kenyan National AIDS Strategic Plan (KNASP) support services totalled US$3,002,416 and the bulk of this support went towards strengthening of NACC and HIV response M&E system and strategic information generation.

There has been considerable improvement in the transfer and channelling of funds from the AA to the participating organizations. The teething challenges that were experienced with the transfer of the first tranche were almost all eliminated during the second tranche transfers.

Human Resources:

The Joint Programme is implemented by the Joint UN team on AIDS which has representation from all the Participating Organizations. The team collectively and individually has the responsibility for two functions:

- Provision of technical guidance and support on behalf of the UN system in the areas UN is best positioned to strengthen the Kenya national HIV response
- Developing, implementing and monitoring the UN-JP as the framework for UN system accountability on HIV to the Government of Kenya.

III. Implementation and Monitoring Arrangements

The Joint Programme is implemented by the UN-JT through cluster approach based on the four outcome areas of the UN-JP. The membership of different agencies to each cluster was based on their areas of strength, mandate and Global Division of Labour (DoL) The clusters are then coordinated through a UN-JT Management Group that brings together representatives from each participating agency. UNFPA convened the technical cluster on Prevention while WHO convened the cluster on Quality of Life. UNDP and UNICEF jointly convened the Mitigation Cluster while UNAIDS convened the Support Services Cluster.

Interventions implemented under the UN-JP were subject to standard agency procedures for monitoring and evaluation. Most of the interventions undertaken under this Joint Programme were implemented either through direct execution, through technical support or the National Execution where the agency transferred funds to the implementing partner based on approved amounts.

The first UN-JP review was conducted in August 2008 and it covered the period from 2007 to 2008. In summary, this review concluded that the UN-JP was going in the right direction, but majority felt that UN-JP had not reached a point where agencies got a sense that their results were better or more efficiently achieved through the UN-JP and UN-JT. The review also noted that UN-JP priority focus areas should include targeted prevention, harmonization of partners' programmes and operations, making the money work, accounting and reporting on contributions and development of a new and more evidence-informed national strategic plan.

The second Joint Programme and UN-JT review was conducted from October-December 2009 and it covered the period from 2008 to 2009. Being a second review it built on findings from the previous review and took into consideration the requirements for the review of DfiD support to the UN-JP.

IV. Results

1. Programmatic Achievements

A. Priority Area One: Prevention of New Infections

The key result areas under this priority area included HIV prevention acceleration, national BCC structures and programmes, Prevention of Mother to Child Transmission (PMTCT), prevention among MARPs and national condom programme and procurement. However, during the reporting period, work planned interventions under this area included revision of STI guidelines, related tools and development of a national system for quality assurance of HIV test kits and testing in order to facilitate on-going scale up and equitable access to quality HTC services.

Between 2007 and 2009, UN provided technical and financial support towards prevention of new infections in the national response. In providing such support, the UN contributed to the following key accomplishments related to HIV prevention in the national response.

a. There has been significant improved national awareness and focus on the prevention agenda in the national response.

- *Know Your Epidemic, Know Your Response Analysis:* The Know Your Epidemic and Your Response Analysis largely involved generation and utilization of strategic information to inform the national response. The UN provided technical and financial support for 2008 Kenya Modes of HIV Transmission Study (K-MoHT), 2007 Kenya AIDS Indicator Survey (KAIS), 2008 Kenya Demographic Health Survey Plus (KDHS+[1]), 2008 ANC Surveillance and 2007 HIV model estimates. The strategic information generated has significantly influenced the thinking and practice of partners in the national response. For example, strategic information related to sources of new infections has influenced resource allocation in the national HIV and AIDS planning process. Strategic information generated was disseminated at various national and sub-national forums. Besides using the strategic information for national planning, the information has also been used to inform the Kenya public so that it is better informed on HIV and AIDS.
- *High Level Prevention Summit in 2007 and 2008*: High level Prevention Summits were conducted in 2007 and 2008. A total of 438 stakeholders including the Prime Minister, Ministers, Senior Government Officials, Academicians, Donors, the United Nations, International and Local Non-Governmental Organizations participated in the Summits. During the two prevention summits, critical resolutions were made. Notably, arising from the 2007 Prevention Summit was the establishment and decision to strengthen the NACC-led National HIV Prevention Taskforce (NHPTF) to serve as a high-level vocal constituency for monitoring utilization of new evidence, defining new measures to be included in the national response, setting of ambitious prevention targets and mobilizing resources accordingly. Other critical resolutions from the 2008 Prevention Summit[2] included (a) the need to ensuring that the development of the new KNASP is principally informed by KAIS, KDHS+ and K-MoHT study, and rigorous assessments of existing programmes and services (b) urgent re-focusing of the national prevention priorities and calls for proposal for 2009 by NACC to include interventions for couples/partners, Prevention with Positives (PwP), MSM, prisoners, uncircumcised men, IDUs, fishing communities, sex workers and their clients, sexually active youth, and other most-at-risk groups (c) Continued prioritization towards accelerating HIV testing including an annual national HIV Testing Week, with couple/partner testing as proposed theme for 2008 and (d) Continued advocacy for male circumcision as an HIV prevention strategy, ensuring that any cultural and/or political barriers are appropriately addressed, among others. To-date, almost all resolutions agreed during the 2007 and 2008 Prevention Summits have been fulfilled.
- *Human rights approach to MARPs in general and MARPs in conflict with the law in particular:* HIV prevalence in Kenya is 14% among most-at-risk populations (MARPs) compared with 7.1% for the general Population (K-MoHT, 2009). Due to the nature of their sexual activities, Injecting Drug Users (IDUs) and Men who have Sex with Men (MSM) are not able to access HIV and AIDS services because they face stigma and discrimination and can be prosecuted and/or imprisoned if found. Through national level advocacy, the UN has contributed on advocating the human rights approach to MARPs in conflict with the law. With evidence showing high contribution of this group to HIV

[1] KDHS+ because HIV and AIDS Module was added to the regular KDHS module
[2] 2nd Kenya National HIV Prevention Summit, 16-17 September 2008

incidence, significant progress on programming for MARPs has been made including inclusion of MARPs in the KNASP III and budget allocation of KSH550 million for MARPs in the 2009/2010 national budget, establishment of health sector taskforce and Technical Working Group (TWG) for MARPs and development and utilization of national framework for HIV prevention among different categories of MARPs. Other accomplishments in the work on MARPs include the initiating sex work and Injecting Drug Use (IDU) mapping and national plan for population estimates for all MARPs in Kenya.

- Overall, service delivery interventions for HIV prevention among IDUs have been strengthened. A strong network of Ministry of Public Health, four (4) NGOs, four (4) drop-in centres and a number of partnering Voluntary Testing and Counselling (VCT) Centres, including mobile VCT contributed to scaling up of HIV prevention services among IDUs. Support was provided to 4 CSOs to carry out community outreach for HIV prevention including referral for drug dependence treatment reaching 12,811 drug users (1,948 were IDUs between January 2008 and October 2009

As part of developing a national strategy policy framework for MARPs, a study tour was conducted to Mauritius for 8 officials from the Ministry of Medical Services, the Judiciary, and the Attorney General's Office, Police Anti Narcotics Unit, NACC, Prisons Service and the National Camping against Drug Abuse Authority (NACADAA).

b. Increased national knowledge of HIV status and improved access to HTC services through national programming support. Only 36% of Kenyans know their HIV sero-status and 80% of HIV infected people do not know their status (KAIS, 2007). In order to increase national knowledge of HIV status and improve access to HTC services, the UN supported national programmes in this area, specifically through the following interventions:

- *HIV testing and counselling (HTC):* Over the past years, there has been significant increase in the number of people who have gone for counselling and testing. The cumulative number of voluntary counselling and testing and PMTCT clients, has grown from 1.7 million in 2005 to more than 4.6 million at end of 2007. The number of HTC sites (excluding PMTCT) has also increased from 3 in 2000 to 960 countrywide in 2007[3] . The National HTC Week, one of the initiatives supported by the UN has played a critical role in scaling up HTC since 2007. Since its inception in 2007, the number of people tested during the Week has increased from 101,925 (8% positive) in 2007 to 689,319 (5.2% positive) in 2008 to over 1.0 million in 2009.

  Notably, the National HTC Week has "graduated" from being seen as a once-off activity to being a strategic approach to increasing access to HTC in Kenya, now fully mainstreamed and adopted by the National AIDS Control Council (NACC).
- *Behaviour Change Communication (BCC) Consortiums:* BCC Consortiums play critical role in BCC in the national response. In collaboration with national partners, the UN-JP supported establishment of Regional BCC Consortiums, which are intended to strengthen capacity to provide guidance for effective BCC programmes at regional level.

c. Scale up, improved access to quality PMTCT services and data quality for Prevention of Mother to Child Transmission (PMTCT): the rationale for strengthening quality of data is that only 60% of health facilities report into the national M&E for PMTCT, of which

[3] *AIDS in Kenya, Trends, Interventions and Impact*, 7th Edition 2005, Ministry of Health, GOK

significant proportion is inaccurate data and less than 20% of the facilities use the data in planning and addressing bottlenecks in the PMTCT programme. Statistics show that there were 125,629 HIV pregnant women in 2008 and 128,887 in 2009 (Kenya National HIV Estimates 2007). Through the UN support, NASCOP was enabled to initiate an extensive review of current reporting systems and reporting was analyzed from all provinces and 150 health facilities were reviewed. In terms of PMTCT services scale-up, there were 1000 PMTCT antenatal sites offering PMTCT services by end of 2009. The UN providedUS$1,606,015 in financial support towards PMTCT from 2007 to 2009 and supported quality PMTCT services in the country, including expansion of comprehensive PMTCT services to eight new districts and technical support towards collection and maintenance of quality PMTCT data. During the reporting period, infant feeding activities were scaled up and a scale up of capacity building for infant feeding counselling at facility and community levels in 5 provinces were completed (Nyanza, Western, Rift Valley, Nairobi and North Eastern Province) targeting 67% of the 1.5 million receiving antennal and postnatal care and exclusive breastfeeding rates increased from 12.7 % in 2003 to 31.9 % in 2008. Other PMTCT related interventions supported by the UN include revision of paediatric ART and PMTCT guidelines in order to improve efficacy of drug treatments for pregnant/lactating women with HIV and infants exposed to the disease.

d. **Introduction and roll-out of Voluntary Medically-Assisted Male circumcision (VMMC):** Following the release of the Kisumu and Rakari MC Trial results, the Kenya Ministry of Health made an indicative statement in 2007 of its intent to increase the availability of safe male circumcision services alongside other HIV prevention services in the formal health system. Given the emerging evidence that male circumcision (MC) reduces the risk of HIV acquisition by as much as 60% (National Guidance for Voluntary Male Circumcision in Kenya, 2008) and government's decision to increase the availability of safe MC services, the Joint Programme supported government in the realization of its objective to roll-out VMMC. The programme supported government's MC scale up plans through production of critical documents such MC Policy, Clinical Manual under LA, MC 5 year strategy in line with KNASP III, MC Communication Strategy and M&E tools and provision of the service to those voluntarily seek it. Notably, during an MC Rapid Results Initiative (RRI) from November 9 to December 20, 2009, a total cumulative 20, 282 VMMC were done (NASCOP, 2009).

B. Priority Area Two: Improve the quality of life of people infected and affected by HIV and AIDS

In line with KNASP II, the key result area for this priority area were as follows: quality and equity of AIDS related treatment services, coherent interface between TB and HIV related services, service delivery framework for HIV exposed children, AIDS-related care in community setting and protection of human rights of HIV infected and affected. During the reporting period, the UN-JT through relevant cluster, planned the following interventions: national HIV treatment programme and development of HIV and AIDS treatment guideline materials and tools for both adult and paediatric AIDS management; strengthening of the ART monitoring system and supporting roll-out of the treatment outcome monitoring system and establish a quality assurance system focusing on HIV drug resistance monitoring, pharmacovigilance and ARV post-market surveillance. Other planned areas of UN joint support included strengthening of the national HIV treatment commodities management system including supply forecasting and stock monitoring; development and implementation of a framework to facilitate decentralization of

ART service delivery; developing service frameworks and tools to facilitate intensified TB diagnosis in HIV and AIDS service settings, cotrimoxazole prophylaxis and monitoring of TB in HIV service settings; documentation of HIV treatment service provided by private for profit service providers and facilitate establishment of a periodic treatment monitoring system for the private sector; development of service frameworks and tools to facilitate children's entry into care and treatment through the multiple entry points; and supporting continuity of diagnosis, treatment and care for HIV exposed infants.

a. **Improved forecasting of national ARV requirements:** The UN-JT, through WHO is a member of the ART Commodities Taskforce. With committed government leadership, the taskforce is made up of multi-sectoral and multidisciplinary stakeholders in ART and meets regularly to deliberate on programmatic and technical issues pertaining to ART, including ART commodity surveillance. Through the taskforce, continuous forecasting of national requirements of ARVs and other treatment commodities was done, including monitoring and updating of ARV stocks across all the supply chains in the country. Specifically, the UN also supported printing of 80,000 mother-baby cards and conducting a cotrimoxazole utilization study.
b. **Improved management of ART stock-outs or stock-out threats:** In the last three years, there have been occasions of stock-out threats. The UN has been instrumental in working with other national development partners to better manage such stock-out threats. For example, during the last quarter of 2009, there was a looming ARV stock-out due to a Court Injunction over alleged procurement irregularities which stopped government from proceeding with procurement of ARVs until matters in courts were sorted out. The UN brokered with PEPFAR to provide short-term support while other options were being assessed.
c. **Treatment scale-up and quality:** Kenya has registered a significant scale up of treatment and care in the last years. It is estimated that 38-45% of those in need of treatment are being reached and 30,000 of those on treatment are receiving nutritional support. About 250, 000 Kenyans are aware of their positive sero-status (KNASP III, 2009/10-2012/13). As of March 2009, a total of 258, 925 were on first and second line ART. Out of 258,925 on ART regimen, 23,221 were children as detailed in Table 4.

   A total of 55, 100[4] deaths were averted through scale-up of ART by close of 2008.

   - *Treatment guideline revision and scenarios development for Kenya:* Globally, there have been discussions and recommendations to revise treatment guidelines including upward revision of CD4 at initial point of recruitment. The UN through WHO has been involved in assessing scenarios and implications of the changes in the Kenya national response, specifically in view of anticipated changes on initiating treatment from CD4 at 250 to CD4 at 350. It is expected that changing from CD4 count at initial treatment has funding implications and the scenarios development has been intended to help government and partners be thoroughly prepared for such a change.
   - *Treatment monitoring and revision of ART protocols, tools and guidelines:* Adequate supplies of the national ART monitoring tools ('blue card', pre-ART register, ART register, clinic appointment registers and quarterly reporting tools) were printed and distributed to all sites in 2007/08. A five year national HIV Drug Resistance (HIVDR)

[4] This projection is based on draft targets for adult treatment and PMTCT included in the KNASP III 2009/10 – 2012/13

plan was developed together with three protocols for threshold survey, periodic surveys of ART treatment sites to collect HIVDR early warning indicators (EWI) and ongoing HIVDR monitoring of patients in selected sentinel sites. Following ethical clearance by Kenya Medical Research Institute (KEMRI), second threshold survey was conducted in Nairobi and Kisumu. A pilot early warning indicators survey was conducted in Nairobi province and sentinel sites preparations for HIVDR monitoring of patients on ART were initiated. Besides, holding an HIV treatment summit in 2008 to review the HIV treatment and care programme as part of the KNASP II review process resulted in revisions to national ART treatment protocols including the phasing out of d4T 40mg formulation and to diversify away from d4T by encouraging increased use of AZT based first line regiment and tenofovir for alternative first line regimen.

- *Decentralization of ART in order to ease clients' access to treatment:* Efforts have been made to improve access to ART. Specifically, an ART decentralization policy was prepared and launched together with healthcare providers' mentorship guidelines to support decentralization of ART and other HIV and AIDS services so that clients can easily access the services. The decentralisation policy gave rise to districts and ART service sites taking charge of establishing increased number of satellite ART sites. Following issuance of revised WHO global guidance on paediatric ART treatment recommendations, Kenya's paediatric ART treatment policy and protocols were revised and a circular was issued by the Director of Medical Services informing all of this policy change. Implementation of the new policy was further supported with the development of HIV testing for infants using Polymerase Chain Reaction (PCR), revision of ARV dosing aids for children and the mother-baby booklet.

d. **Support towards nutrition and care services:** In terms of nutrition services, 1177 health and nutrition staff were trained on integrated management of malnutrition including nutritional care for Paediatric HIV and AIDS. Service strengthening, commodity provision and monitoring in 50% of hospitals were also supported. A national register for nutrition in HIV service points were reviewed and piloted in 2 provinces.

   With UN support and participation, a new home based care (HBC) service delivery framework was developed. The new framework is now referred to as community and home based care (CHBC) since it incorporates interventions that go beyond those geared towards caring for the sick at home. It includes prevention interventions such as HIV testing at home, adherence support interventions and provision of ART within the community and home setting.

e. **Improved HIV service provision to mobile populations through establishment of Roadside Wellness Centres (RSWC) for truck drivers, sex workers and the community:** Working with main partners (North Star Alliance Kenya, Hope Worldwide Kenya, Ministry of Medical Services, Ministry of Public Health and Sanitation, NASCOP, NACC and others), the UN through leadership of WFP implemented Roadside Wellness Centres (RSWC). The programme entailed an integrated network of drop-in clinics giving mobile transport workers (long distance truck drivers) access to treatment and prevention services. One Wellness Centre was established at Gate 18 at Port Mombasa and a second centre opened at Mlolongo centre. Over the ten month period that the Mombasa Wellness Centre has been operational, a total of 4,069 people have visited the centre for various services. The VCT unit saw 1,524 clients out of which 32 visited the centre for STI services and 101 for treatment of minor ailments. The knowledge room received the highest number of visitors of 2,412.

C. Priority Area Three: Mitigation of Socio-economic Impact

There were four results areas under this priority area. These included HIV mainstreaming in development and financing, national OVC plan of Action and conditional cash transfer, HIV integration strategy in private and informal sector and HIV mainstreaming in six priority sectoral plans. However, the following interventions were planned during the reporting period (a) Provision of technical and financial support to NACC to conduct impact studies in education, health, agriculture, transport, security, law and order sectors (b) Technical support to build capacity for decentralized implementation plans and budgets (c) Support to MoPNDV2030 in conducting training workshops for mainstreaming HIV and AIDS in development plans and budgets (d) Provision of technical support for policy dialogue and advocacy around findings of 'impact studies' and review of integration of HIV and AIDS in the vision 2030 (e) Completion of National OVC Plan of Action and shared with key stakeholders in civil society, private sector; District-level discussions on plan; roll out of implementation in all districts (f) Support expansion of cash transfer to 47 districts (g) Evaluation of impact of OVC cash transfer and other OVC interventions (h) Technical support for stakeholder consultations and advocacy for development of a draft workplace policy for informal sector (i) Technical and financial support to NACC for development of draft workplace policy for informal sector (j) Technical support for organizing stakeholder meetings for advocacy, policy dialogue and consensus-building for policy adoption (k)Technical assistance for developing agenda on operational studies in the education sector.

Through this financial commitment and other technical support, the Joint Programme contributed towards the accomplishment of the following achievements in the national response:

a. Enhanced integration of HIV and AIDS in national development planning, policy making, priority setting and budgetary processes: Mainstreaming is seen as an effective way to scale up, deepen and sustain the HIV response by mobilizing key actors and sectors to contribute to an effective and sustained national response

- *Support towards HIV mainstreaming in the public sector:* The UN provided technical support to NACC towards conceptualization of impact studies in education, health, agriculture, transport, governance, justice, law and order and security (GJLOS) sectors. GJLOS impact study was conducted and a final report was submitted to the Ministry of Justice's Programme Coordination Office. Plans are under way for the participating ministries to take up recommendations of the impact study. In addition, the UN provided technical support to build capacity for decentralized implementation plans and budgets through training of key public sector officials in mainstreaming HIV and AIDS in development plans and budgets.
- *Support towards HIV mainstreaming in the work place:* The National Code of Conduct on HIV and AIDS at the Workplace was successfully developed, largely as a result of the effective collaboration between Ministry of Labour (MoL), Federation of Kenya Employers (FKE), Congress of Trade Unions (COTU), ILO, NACC and other private and public sector partners. Since the launching of the code, dissemination across the country has begun.

  In collaboration with Kenya HIV and AIDS Private Sector, the Business Council and AIDS Law Project, the UN-JP embarked on summarizing into a booklet "the Legal aspects of HIV and AIDS at the Workplace". A second booklet titled "Handbook on HIV

and the law at the workplace' was produced to provide employees with information on their rights and case studies pertaining to HIV and AIDS issues at the workplace. Brochures on frequently asked questions were also produced.

Through the initiative of the Ministry of Labour, Labour Inspectors were provided with HIV and AIDS training. This training has enabled Labour Inspectors to apply HIV and AIDS relevant regulations during their regulatory functions and advisory services. Capacity was strengthened for COTU affiliates on integrating HIV and AIDS workplace issues into Collective Bargaining Agreements (CBAs).

- *Documentation of Best Practices of HIV and AIDS mainstreaming in public sector institutions:* With the support of UN, NACC documented best practises in HIV and AIDS mainstreaming in the public sector institutions. The document also captured some of the lessons learnt as well as challenges these organizations face as they carry out HIV activities. The document is intended to serve as a key baseline to inform future mainstreaming agenda in the country.

b. Enhanced mitigation of the socioeconomic impact of HIV and AIDS on orphans and vulnerable children (OVC)

- *Support towards development of framework, plan and minimum OVC package:* Revision of the National OVC Plan of Action (NPA) completed and shared with partners and key government partners. The NPA was revised reaching consensus on definition of OVC, costing of the minimum package for OVC and defining an M&E framework.
- *Support towards Cash Transfer Programme for OVC (CT-OVC):* Kenya has about 2.4 million orphans and vulnerable children. About half (48%) of the orphans are due to the HIV and AIDS pandemic. The UN supported the GoK in implementing a cash transfer programme for orphans and vulnerable children. The CT-OVC programme expanded from 37 districts in 2007 to 47 districts in 2008, and commensurate increase in Government of Kenya (GoK) contributions from US$2,400,000 to US$8,200,000 in 2008/09. The number of households covered by the CT-OVC programme increased from 12,500 to 60,000. Steps taken to improve programme implementation and efficiency included improvements to the Operational Manual, Management Information System (MIS), a 5-year M&E plan and expanded programmes for community participation and caregivers. In order to mitigate the targeting related challenges of cash transfer programmes, a geographic and household targeting system has been finalized. The adjusted targeting process combines a community based mechanism with an independent proxy-means test that is validated by the community. A consolidated payment mechanism has been operationalised such that more than 98% of the beneficiaries have collected the cash subsidies. In terms of funding commitments, a national budget allocation to CT-OVC has increased from US$800,000 to more than US$10 million in four years. External funding has also increased, with commitments of more than US$150 million over the next 10 years, essentially from the UN (UNICEF and World Bank), DfiD and SIDA.
- *OVC support through Junior Farmer Field and Life Schools (JFFLS):* Junior Farmer Field and Life Schools was component which targeted primary school going OVC between ages 12-17 years. The children were trained in both agricultural and life skills through the JFFLS approach where they are sensitized on issues of HIV and AIDS

prevention and good nutritional practices, among others. Through this approach, a total of 9000 OVC (1,500 direct beneficiaries and 7,500 indirect beneficiaries) and 5400 farmers (900 directly and 4,500 indirectly) benefited from the JFFLS approach.

c. Strategic support to Civil Society Organizations (CSOs) to enhance their strategic engagement in the national response: The Joint Programme has provided support towards enhanced engagement of CSOs in the national response. For the first time ever, CSO participation in national development process has been outstanding. Cases in point include the participation of CSO in the development of KNASP III, including further participation in national response through the community pillar and in the development of National Strategic Application (NSA) to the Global Fund to Fight AIDS TB and Malaria.

The impact of UN support on the CSOs has been far-reaching; including their capacity building to deliver services. For example, CSO have been involved in pro bono human rights and legal clinics. Specifically, KANCO conducted three legal aid clinics in three slum areas surrounding Nairobi namely Huruma, Mlolongo and Rongai. The broad objective of the clinics was to increase access to justice and legal education for people living with HIV in limited resource settings. Seventy-nine (79) clients attended the clinics of which 57 were female and 22 were males. The clients were manned by 6 lawyers on one-on-one basis. Further referrals were given to clients needing further attention. During the sessions the lawyers also created awareness on HIV and AIDS prevention and Control Act, Sexual Offences Act, Children Custody and maintenance and property and succession rights. The UN has provided the strategic support to the CSOs through the following interventions:

- *Support towards institutional support of NEPHAK and conducting national delegates' conference of people living with HIV:* With support of the UN, institutional assessment of NEPHAK leading to development of a strategic plan has been done. The NEPHAK Board was also trained in issues of governance. A National Coordinator is recruited and their salary paid. The Coordinator was very instrumental in organizing the National Delegates Conference as well as articulating issues that affect network members through the media and other HIV and AIDS forums. The UN-JP also supported the NEPHAK national delegates' conference. The high level conference brought together 200 regional representatives and members of people living with HIV and AIDS support groups drawn from the 8 regions of Kenya. The conference also attracted high level policy makers who took the opportunity to advocate for a stigma free society and the need to meaningfully engage PLHIV as well as the need for the country to put more national resources in the fight against HIV and AIDS other than heavily relying on external resources.
- *Support towards Regional CSO Workshop on capacity building in human rights based approaches and gender in HIV and AIDS:* The UN supported Kenya AIDS NGO Consortium (KANCO) to organize and facilitate regional workshops in Rift Valley, Nyanza, Western and coast. The workshop managed to reach out to over 100 CSOs. The aims of the workshops were to build the capacities of CSOs on human rights based approaches to programming and gender issues as they relate to HIV. The workshops also provided opportunities to disseminate various relevant laws that have been recently passed that affect the HIV and AIDS response such as HIV and AIDS Prevention and Control Act and the Sexual Offences Act. Other policy documents that were disseminated at these workshops include Greater Involvement of People Living with HIV and AIDS (GIPA) guidelines. The guidelines provide specific procedures on how to involve and

work with PLHIV to achieve maximum benefit. At the end of the workshops participants developed work plans on how to work with various legal, administrative and other community structures to protect the rights of those infected and affected.

- *Support towards development of national HIV and AIDS Code of Practice:* UNDP supported FKE to develop a national HIV and AIDS code of practice. The code of practice's potential impact is the harmonization of all workplace policies in Kenya and improved implementation of HIV and AIDS work at the workplace. This is bound to reduce the impact of HIV and AIDS at the workplace.
- *Support towards institutionalization of Kenya Private Sector AIDS Network (KPSAN):* The UN provided support towards institutionalization of Kenya Private Sector AIDS Network (KPSAN). Specific support to KPSAN institutionalization included support to establishment of the institution, development of strategic plan and mapping of services.

D. Priority Area 4: KNASP Support Services

The result areas for KNASP Support Services included strengthening of NACC, improved KNASP planning and implementation, HIV response M&E system and strategic information, consolidated technical support management system and effective UN contribution to the national HIV response. However, planned outputs under this priority area included (a) Operationalisation of NACC Partnership Forum (b) High-level committee on national HIV response oversight is meeting on regular basis (at least bi-annually) and providing feedback reports (c) High-level Public Sector Committee on HIV is established as part of government accountability structure for HIV mainstreaming (d) Consolidate resource mobilization plan for the national HIV response (e) KNASP II mid-term review and re-costing exercise (f) National AIDS Spending Assessment for Kenya (g) Development and endorsement of consolidated national HIV response work plan for 2008/09 the KNASP III and (h) Routine collection, compilation, analysis and periodic publication of facility and community-based data. Other planned outputs over the reporting period included support to (i) Policy decisions, selection of priorities, programming and calls for proposals are based on information compilation through the JAPR (j) Development and publishing of annual consolidated and comprehensive HIV response document (k) Development and dissemination of national annual 2007 STI/HIV surveillance report (l) Conduct national annual STI/HIV surveillance exercise for 2008 (m) Comprehensive national technical support plan is in place and fully funded as integral part of consolidated annual work plan (n) Implementation of first Joint UN Technical Support Plan and (o) Effective partnerships are formed an d structures are put in place to strengthen management of large grants.

In supporting KNASP services, the Joint Programme spent a total of US$3, 002,416 from 2007 to 2009 specifically towards strengthening of NACC (US$1,234,892), improved KNASP planning and implementation (US$580,155), HIV response M&E system and strategic information (US$1,157,369) and effective UN contribution to the national HIV response (US$30,000). The following key achievements were recorded under this priority area:

a. **Strategic review of KNASP**: The KNASP strategic review was undertaken between August 2008 and October 2009 and it included review of KNASP II and its coordination framework, development of KNASP III, development of National Strategy Application (NSA) through consultation and peer review processes. The Joint Programme provided technical and financial support to the process. The UNAIDS Secretariat and agencies were members of Strategic Review Advisory Group (SRAG) and KNASP Working Team and various

technical working groups which provided guidance and technical support to the KNASP review process.

b. **Improved harmonization and alignment of donors' and partners' support to the national response:** The UN-JP supported operationalisation of NACC Partnership Forum and supported regular Inter-Agency Consultative Committee (ICC) meetings and Advisory Committee of the ICC. As part of support to the partnership forum, an assessment using Country Harmonization and Alignment Tool (CHAT) was done and its findings were widely disseminated and the findings used in the KNASP II strategic and NACC institutional review exercises. In order to support NACC efforts to ensure that all major stakeholders in the national HIV response base their contribution on formal agreement with the Council, the UN supported the alignment of the USG support under the Partnership Framework, the development and finalization of a code of conduct that was signed by stakeholders.

c. **Resource mobilization for the national response:** As part of resource mobilization for the implementation of KNASP III, technical support was provided towards proposal writing for Round 7 and 8 as well as the National Strategy Application (NSA) to the Global Fund. CSO Principal Recipient (PR) was also supported for assessment and support to 58 CSOs under Round 7. The implementation of the 2009 Kenya National AIDS Spending Assessment (KNASA) provided opportunities for national partners to assess financing and spending to the national response. The UN supported the completion of KNASA Part I, which provided valuable information to the development of KNASP III and also was used as a platform to discuss and agree on means of institutionalizing the assessment among key stakeholders as well as costing of the National Plan of Operations (NPOs).

d. **Establishment and operationalisation of national M&E systems and subsystems:** Along with the review of KNASP, the programme supported the development of HIV and AIDS national M&E system and subsystems, including establishment of the National Monitoring and Evaluation Committee. Support was also provided towards routine collection, compilation, publication of facility and community-based data. Specific support provided included support to work plan development and the development of the Community Programme Based Activity Reporting (COPBAR) forms, data use manual and training programmes. COBPAR development was successfully completed and 711-form was developed and rolled out for facility based data collection.

e. **HIV prevention programming support towards mitigation of HIV related effects of the post-election violence:** The UN provided critical support addressing gender-based violence including dissemination of post exposure prophylaxis (PEP) kits and communication materials to address HIV prevention in emergency settings.

f. **Support to national events such as the World AIDS Day (WAD)**: The UN fully supported the 2008 and 2009 World AIDS Day (WAD) which were highly successful. Most notable was the shift of focus from the capital to one of the most remote and hard-to-reach regions of the country, North Eastern Province, where the UN system, through the leadership of the UNCT and the UCC celebrated the WAD in Garissa, the provincial town. While this area is considered to have the lowest HIV prevalence rate in the country there are already very strong signs of an increasing trend in new infections, especially among women and young people.

g. **Effective management and functioning of the Joint Programme:** The UN-JT Management Group met regularly to provide leadership while the Cluster Conveners met frequently to plan and review the joint programme and provide day-to-day collective leadership. Regular meetings for the UN-JT were conducted in order to follow progress. An annual review meeting of the UN-JP and UN-JT was conducted in 2008 and one in 2009. There has also been increased and coordinated contribution of the UN system to the national

HIV response. The Secretariat provided financial management support to both the UN-JT and the UN-JP.

Implementation constraints, lessons learned from addressing these and knowledge gained in the course of the reporting period

Since its inception in 2007, the Joint Programme on AIDS in Kenya has realized various accomplishments in relation to the national response. Notwithstanding the accomplishments, implementation of the programme in general was constrained by the following challenges:

Externally;

- The 2007 post election crisis diverted the attention and resources of the Joint Programme. As an aftermath, the split of NASCOP along two ministries of health established as part of the Grand Coalition Government brought with it added challenges of coordination and national leadership between the two ministries. Further, the split has presented coordination and reporting challenges to NASCOP, a programme with a huge HIV and AIDS mandate in the health sector.
- The development of the third generation KNASP and accompanying National Strategy Application (NSA) took more time of the UN-JT and NACC than was earlier envisaged.

Internally;

- Some human resource capacity constraints, specifically inadequate staff against a back-drop of competing priorities were experienced in some UN agencies and these .affected the coordination and implementation of the joint programme.
- Delays in receiving funding for 2007/08 activities from DfiD and initial teething problems on the UN modalities of engagement of fund transfers from the AA to the UN agencies and from the agencies themselves to the national partners subsequently delayed implementation of the planned joint programme interventions.

V. Future Work Plan : UN Kenya and UN JP Priority Areas for 2010-2013

After undergoing a consultative process with key government counterparts and development partners, the UN-JT proposed a set of UN-JP priority areas. These priority areas for the joint programme were approved by the UN Kenya Country Team (UNCT) after a through discussion. Following are the priority areas for the UN-JP for 2010-2013 and these areas are in alignment with the following key and contemporary planning and strategy documents:

- Kenya National AIDS Strategic Plan, 2009/10 – 2012/13
- Updated and Re-launched UN Development Assistance Framework, 2000 – 2013
- Joint Action for Results – UNAIDS Outcome Framework, 2009 – 2011

However, in order to ensure direct linkage to KNASP III, the prioritized areas are grouped under the six KNASP III outcomes:

Outcome 1: Reduction of risky behaviour among the general, infected, most-at-risk and vulnerable populations focusing on:

a. *Advocacy for PwP programs and new HIV prevention strategies will be led by World Health Organization (WHO) and includes UNFPA, UNICEF as members.*
   - Advocacy for the expansion of male circumcision to traditional circumcising communities and among neonatal infants
   - Advocacy and programming for female condom
   - Prevention with positives (PLHIV) and among widows
   - Advocacy for PEP scale up, microbicides and vaccine

b. *Prevention diplomacy in support of MARPs, especially those in Conflict with the Law. Under the leadership of UNODC, other members include UNFPA, IOM, WFP and UNAIDS. Prevention diplomacy will focus on the following areas:*
   - Advocacy and programme strengthening for: MSM, Prisoners, SW, IDU, and trafficked children/women
   - Strategic information and advocacy in support of most-at-risk young people
   - Population of humanitarian concerns

c. *Universal knowledge of HIV status among the general population and MARPs will be led by WHO and other agencies including UNFPA, IOM, UNODC, WFP and UNHCR. Universal knowledge will focus on the following areas:*
   - Campaign based and non-traditional modes to scale up HIV testing and counselling
   - Couple-based HIV testing and counselling and disclosure to address infections in marriages and discordance
   - HIV testing and counselling among young people and MARPs
   - Facility-based and provider-initiated testing and counselling

d. *Virtual elimination of PMTCT babies becoming infected with HIV, will focus on the following areas and UNICEF will provide the leadership but other members will include WHO, UNAIDS and UNFPA:*
   - National leadership and quality assurance of PMTCT
   - Advocacy for high-level national commitment and champions for PMTCT
   - Advocacy and programming in support of all four prongs of PMTCT
   - Support for national ownership, coordination and monitoring of the PMTCT programme
   - Support for quality assurance and service integration (RH and child health), including adoption of new global guidelines

Outcome 2: Proportion of eligible PLHIV on care and treatment increased and sustained.

Treatment and Care cluster will be led by WHO with members including WFP, UNICEF, FAO and UNDP. This area will specifically focus on the following:
- Advocacy for scale up and equity for quality of treatment and care
- Advocacy for integrated delivery of TB and HIV services, including for intensified case finding of TB in HIV services
- Advocacy and technical guidance for infant and young child feeding
- Evaluation of quality of life for PLHIV on treatment.

Outcome 3: Health systems deliver comprehensive HIV services

Health Systems Strengthening, with leadership from WHO and membership of UNICEF, World Bank, UNFPA, UNAIDS and UNDP, this area will focus on the following:

- Commodity surveillance/intelligence (primarily ARVs and test kits) and advocacy to ensure ARV security
- Advocacy and support for taking HIV out of isolation and mainstreaming interventions in broader health sector agenda

Outcome 4: HIV mainstreamed in sector-specific policies and sector strategies.

a. HIV and AIDS mainstreaming in public and private sectors (UNDP as lead and members will include ILO, IOM, UNESCO, World Bank, WHO and UNODC)

- Strategic information and support for an institutional framework for sectoral mainstreaming of HIV, and repositioning of the ACUs.
- Strengthening of PLHIV networks accountability for GIPA (GIPA score card and stigma index) and support to NEPHAK

Outcome 5: Communities respond to HIV within their local context.

Community Interventions Programming & Strategic Information, with UNICEF as the lead (members include UNDP UNIFEM, UNFPA, UNESCO, UNODC, WFP and FAO), interventions in this area will focus on the following:

- Support strategic monitoring and review of the National OVC Plan of Action
- Advocacy and strengthening of systems for scale up and broadening of the Cash Transfer Programme
- Support piloting and roll of AIDS competency in communities.

Outcome 6: KNASP III stakeholders aligned and held accountable for results, UNAIDS will provided leadership of this cluster and the Joint Programme will focus on the following areas:

a. Strengthened National Leadership and accountability for HIV prevention (Led by UNFPA, other members include UNAIDS, UNICEF, IOM and UNODC)

- Support for the national HIV prevention task force, the annual HIV prevention summit, and symposium on MARPs
- Use of evidence for national strategic plan development and to set ambitious targets
- Gender audit and monitoring of KNASP III

b. Know Your Epidemic and Know Your Response (Led by UNAIDS, other members include UNICEF, UNFPA, IOM, UNODC and UNODC

- Strategic information generation and coordination (Sentinel Surveillance, KAIS, DHS, MOT, BSS)
- Targeted strategic information for programming on MARPs and vulnerable populations
- Analysis of barriers to HIV prevention services, including inequity, gender and human rights
- Support for evidence informed annual, midterm and summative review of programmes, including M&E-centric JAPR
- Strengthened M&E sub-systems, Best Practices, and improved data utilization to consolidate the HIV M&E System

- Production of statutory and periodic monitoring reports (UNGASS, UA report, Flagship publication, etc.)

c. Governance and Policy Coordination (Led by UNAIDS, other members include World Bank, Office of the Coordination of Humanitarian Affairs (OCHA)

- Support for implementation of the NACC Institutional Review recommendations
- Enhanced authority and accountability for NACC including (a) KNASP III coordination (TWGs, pillar coordination, etc.), and (b) national oversight mechanisms (cabinet committee, Act of Parliament)
- Sustainable HIV financing (GoK budget, public insurance, private sector contributions) and resource tracking
- Harmonization and alignment of donor practices and funding mechanisms
- Development and institutionalize a national TS Planning process

The UN-JT plans to embark on a developing the next UN-JP (2010-2013) on the basis of these agreed prioritises. It is expected that new UN-JP programme document will be in place by March 2010.

VI. Abbreviations and Acronyms

ANC	Antenatal Care
ART	Antiretroviral Treatment
ARV	Antiretroviral Drug
BCC	Behaviour Change Communication
CBAs	Collective Bargaining Agreements
CCM	Country Coordination Mechanism
CDC	Centres for Disease Control
CHAT	Country Harmonisation and Alignment Tool
CHBC	Community Home Based Care
COPBAR	Community Programme Based Activity Report
COTU	Confederation of Trade Unions
CSO	Civil Society Organization
CT	Cash Transfer
CT-OVC	Cash Transfer for Orphans and other Vulnerable Children
DFID	Department for International Development (UK)
FSW	Female Sex Workers
GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV and AIDS
GoK	Government of Kenya
HBC	Home Based Care
HHR	Health Human Resources
HIMS	Health Management Information Systems
HIVDR	HIV Drug Resistance
HTC	HIV Testing and Counselling
ICC	Inter-Agency Coordinating Committee
IDU	Injecting Drug User
ILO	International Labour Organization
IOM	International Organisation on Migration
JAPR	Joint Annual Programme Review
UN-JT	Joint UN Team on AIDS
JP	Joint Programme
KAIS	Kenya AIDS Indicator Survey
KARSCOM	Kenya AIDS Research and Study Committee
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supply Agency
KJAS	Kenya Joint Assistance Strategy
K-MoHT	Kenya Modes of HIV Transmission Study
KNASA	Kenya National AIDS Spending Assessment
KNASP	Kenya National AIDS Strategic Plan
KPSAN	Kenya Private Sector Advisory Network
M&E	Monitoring and Evaluation
MARPs	Most-at-risk Populations
MC	Male Circumcision
MCH	Maternal Child Health

MDG	Millennium Development Goals
MoPNDV2030	Ministry of State for Planning, National Development and Vision 2030
MSM	Men who have Sex with Men
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NEPHAK	National Empowerment Network of People living with HIV and AIDS in Kenya
NHPTF	National HIV Prevention Taskforce
NGO	Non-Governmental Organization
NPA	National Plan of Action
NSA	National Strategy Application
OVC	Orphans and other Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWP	Prevention with Positives
RH	Reproductive Health
STI	Sexually Transmitted Infection
TOWA	Total War Against AIDS
TSF	Technical Support Facility
TWG	Technical Working Group
UA	Universal Access
UCC	UNAIDS Country Coordinator
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nationals Development Programme
UNESCO	United Nations Education, Science and Culture Organizations
UNFPA	United Nations Population Fund
UNHCR	United Nations Commissioner for Refugees
UNIFEM	United Nations Women's Fund
UNODC	United Nations Office on Drugs and Crime
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UN-JP	UN-Kenya Joint Programme of Support on HIV and AIDS
UNV	United Nations Volunteer
USG	United States Government

Annexe 1.

VII. 2010 Work Plan

Programme Activities	**DFID Contribution in USF/GBP (Exchange rate x)**	**Time Frame for utilization of DFID funds/remarks**
Universal knowledge of HIV status among the general population and MARPS	USD 150,000	Technical Assistance to support the implementation, coordination and monitoring of overall IDU related JP outputs and support the coordination of the JO output 1.3 (universal knowledge of HIV status among the general population and MARPS) Salary component for IDU Programme Officer (May 2010-april 2011) Key intervention areas; 1. Mapping and studies of IDUs. 2.Coordination support of the JP output 1.3 3.Monitoring and evaluation of the JP output area
Strengthened national leadership and accountability for HIV prevention Know Your Epidemic and Know Your Response Governance and Policy Coordination	USD 280,000 USD 170,000	Technical Assistance to support the UN Joint Team and Joint Programme Coordination and development of a technical support plan, support to the harmonization and alignment mechanism of the national response and the institution development of NACC through the JP Output areas of 61., 6.2 and 6.3. Salary component for Senior Institutional Development Adviser and Technical Support Officer (July 2010-June 2011) Key intervention areas 1. Coordination support to the UN Joint Team 2. 2.Development of technical support plan 3. 3.TA support to the harmonization and alignment mechanism of the national response 4. 4. Monitoring and evaluation of the JP and periodic review and re[porting .

Programme Activities	**DFID Contribution in USF/GBP (Exchange rate x)**	**Time Frame for utilization of DFID funds/remarks**
		5. 5. GF Round 10
Programme Total	USD 594000	
Administrative Overhead (1 %)	USD 6000	
TOTAL Requested Amount ***For third tranche***	**USD 600,000 (100) %**	
1.1 Advocacy for PWP programs and new HIV prevention strategies 1.2 Prevention diplomacy in support of MARPS especially those in conflict with the law 1.3 Universal knowledge of HIV status among the general population and MARPS 1.4 Virtual elimination of PMTCT babies becoming infected with HIV 1.5 Prevention among population of humanitarian concern 1.1 Treatment and care 3.1 Health Systems Strengthening (HSS) Sub -total	USD 600,000 USD 200,000 USD 450,000 USD 550,000 USD 200,000 USD 2,000,000 (50%)	Activities to support development of evidence informed prevention content and operationalize new national strategic plan for HIV (May-Dec 2010). Key interventional areas 1.Mapping and studies 2.MC roll out 3.PwP and MARPSs strategy and communication development 4. Strengthening national ownership and leadership of PMTCT 5. support to development of national HIV prevention and care programme for populations of humanitarian concern 4. Updated/harmonized treatment policy and programmes 7. Support to HSS

Programme Activities	**DFID Contribution in USF/GBP (Exchange rate x)**	**Time Frame for utilization of DFID funds/remarks**
.1 HIV and AIDS mainstreaming in public and private sectors 5.1 Community interventions Programming & Strategic information Sub Total	USD 500,000 USD 300,000 USD 100,000 USD 900,000 (22.5%)	Activities to support enhanced mainstreaming of HIV in public, private and CSO sectors Activities to support the articulation of HIV competent communities, strengthening PLWHA networks and scale up of social protection and mitigation (ma –Dec 2010) Key intervention area are 1.Baseline assessment on mainstreaming 2.ACUcapacity development 3. Vulnerability assessment in the informal sector 4.GIPA 5.Grants for PLWHA networks in provinces
6.1 Strengthened National Leadership and accountability for HIV prevention 6.2 Know Your epidemic and Know Your Response Governance and Policy Coordination Sub-total	USD 400,000 USD 300,000 USD 400,000 USD 1,100,000 (27.5%)	Activities to support national leadership and accountability or HIV as well as operationalize new national strategic plan for HIV (May-Dec 2010). Key interventional areas 1.Population estimates 2.Prevention summit 3. Strengthen PLWHA and PMTCT links 4. Research and analysis 5.NACC Co-ordination & harmonization support 6.Domestic & sustainable financing 7.Flexi pot for TA
Programme Total	USD 3,960,000	
Administrative Overhead (1%)	USD 40,000	
Total Requested Amount ***for Fourth tranche***	**USD 4,000,000 (100%)**	
TOTAL REQUEST FOR 2010	**USD, 4,600,000**	

Annex 2. *Kenya Joint UN Team on AIDS and Partners (Government and CSO) at the 2009 Joint Programme Review*

JOINT UN PROGRAMME OF SUPPORT FOR HIV/AIDS IN KENYA
FINANCIAL REPORT FOR THE PERIOD
1 JANUARY TO 31 DECEMBER 2009

1. Source and Use of Fund

Table 1. Sources, Uses, and Balance of Fund, as of 31 December 2009, in US$ Thousands

In the period 2008-9, a total of US$5, 581,304.03 was disbursed by DFID in two tranches, the first in 2008 amounting to US$1, 408,666.03 and the second in 2009 amounting to US$4, 172,638.00

	Prior Years	2009	Total as of 31 December 2009
Source of Funds			
Gross Contributions	1,409	4,173	5,581
Fund Earned Interest Income	11	1	13
Participating Organization Earned Interest Income	0	0	0
Total - Source of Funds	**1,420**	**4,174**	**5,594**
Use of Funds			
Transfers to Participating Organizations	**1,395**	**4,041**	**5,435**
From Donor Contributions	1,395	4,041	5,435
From Earned Interest	0	0	0
Refund of Unutilized Balances on Closed Projects by Participating Organizations	0	0	0
Administrative Agent Fees	0	56	56
Direct Costs: (Steering Committee, Secretariat … etc.)	0	0	0
Other Expenditures from Earned Interest	0	0	0
Bank Charges	0	0	0
Total - Use of Funds	**1,395**	**4,097**	**5,491**
Balance of Funds Available	**26**	**77**	**103**

2. Donor Deposits

Table 2. Total Donor Deposits, cumulative as of December 2009, in US$ Thousands

Donor Name	Gross Donor Deposits		
	2008	2009	Grand Total
DEPARTMENT FOR INT'L DEVELOPMENT (DFID)	1,409	4,173	5,581
Grand Total	**1,409**	**4,173**	**5,581**

3. Transfer of Funds

Table 3. Transfer of Funds by Participating Organization, as of 31 December 2009, in US$ Thousands

Participating Organization	Funds Transferred		
	Prior Years	2009	Cumulative as of 31 Dec 2009
FAO	0	505	505
UNDP	64	0	64
UNFPA	485	660	1,145
UNICEF	147	700	847
WFP	96	128	224
WHO	0	635	635
IOM	64	107	171
UNAIDS	356	955	1,311
UNODC	182	352	534
Total	**1,395**	**4,041**	**5,435**

4. Delivery

Table 4. Financial Delivery Rates, for 2009 and cumulative as of 31 December 2009, in US$ Thousands

	Cumulative			2009	
	Total Transfers	Expenditures	Delivery in %	Transfer	Expenditures
JP – Kenya HIV and AIDS	5,435	3,927	72.26	4,041	3,658

5. Expenditure

Table 5.1. Total Expenditure by Category and Reporting Period, in US$ Thousands

Category	Total Expenditures		% of Total Programme Costs
	2008	2009	
Supplies, equipment	9	554	15.23
Personnel	64	1,110	31.77
Training of counterpart	0	52	1.42
Contracts	55	1,704	47.60
Other direct costs	120	27	3.99
Programme Costs Total	**248**	**3,448**	**100.00**
Indirect costs	22	211	6.29
Total Expenditure	**269**	**3,658**	

Table 5.2. Expenditures reported by Participating organizations, cumulative as of 31 December 2009, in US$ Thousands

Participating Organization	Transfers		Expenditures		
	Budget Amount	**Funds Transferred**	**2008**	**2009**	**Cumulative**
FAO	505	505	0	29	29
IOM	171	171	58	-55	4
UNAIDS	1,311	1,311	30	540	570
UNDP	64	64	0	76	76
UNFPA	1,145	1,145	121	715	836
UNICEF	847	847	54	650	704
UNODC	534	534	0	396	396
WFP	224	224	6	90	96
WHO	635	635	0	1,215	1,215
Total	**5,525**	**5,435**	**269**	**3,658**	**3,927**

Notes:

The negative expenditures of IOM in the year 2009 is because of a correcting entry to record correction of expenses recorded in JP-Kenya in the year 2008 in error.

Table 5.3. Total Expenditure by Participating UN Organization with breakdown by category, cumulative as of December 2009, in US$ Thousands

Participating Organization	Funds Transferred	Total Expenditure	Expenditure by Category					Total	
			Supplies, equipment	Personnel	Training	Contracts	Other direct	Programme Cost	Indirect costs
FAO	505	29	0	22	5	0	0	28	2
IOM	171	4	0	4	0	0	0	4	0
UNAIDS	1,311	570	0	324	5	241	0	570	0
UNDP	64	76	0	80	0	0	-3	77	0
UNFPA	1,145	836	506	138	0	14	124	782	55
UNICEF	847	704	29	80	0	549	0	658	46
UNODC	534	396	9	122	34	186	20	371	26
WFP	224	96	18	42	3	20	6	90	6
WHO	635	1,215	1	363	5	748	0	1,117	98
Grand Total	**5,435**	**3,927**	**563**	**1,174**	**52**	**1,759**	**147**	**3,695**	**232**

Notes:

1. UNDP's expenditure is higher than the amount received during the period because at the time of capturing the expenditure, a wrong account was picked (the JP account). However, this has subsequently been rectified.
2. WHO Country Office has noted a lower than reported expenditure (USD 590,539 actually spent versus USD 1,214,745 reported via UNEX).
3. The negative figure for UNDP's other direct costs is a correction entry in the system to record a mis-posting

Table 5.4. Total Expenditure by Participating UN Organization with breakdown by Category, 1 January - 31 December 2009, in US$ Thousands

Participating Organization	Funds Transferred	Total Expenditure	Expenditure by Category					Total	
			Supplies, equipment	Personnel	Training	Contracts	Other direct costs	Programme Cost	Indirect costs
FAO	505	29	0	22	5	0	0	28	2
IOM	107	-55	-9	-22	0	-5	-16	-51	-4
UNAIDS	955	540	0	294	5	241	0	540	0
UNDP	0	76	0	80	0	0	-3	77	0
UNFPA	660	715	506	129	0	14	20	668	47
UNICEF	700	650	29	80	0	499	0	608	43
UNODC	352	396	9	122	34	186	20	371	26
WFP	128	90	18	42	3	20	6	90	0
WHO	635	1,215	1	363	5	748	0	1,117	98
Grand Total	**4,041**	**3,658**	**554**	**1,110**	**52**	**1,704**	**27**	**3,448**	**211**

Notes:

1. The negative expenditures both for IOM and UNDP's are correction entries

2. The over-expenditure on UNDP is as a result of mis-posting which was later rectified after it was noted. The over-expenditure for UNFPA and UNODC are explained by the fact that the two agencies still had carry over funds that they continued to use in the year 2009.