KENYA
JOINT UN PROGRAMME OF SUPPORT ON AIDS
2007 - 2012

ACKNOWLEDGEMENTS

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ABBREVIATIONS AND ACRONYMS

AA	Administrative Agent
ABC	Abstinence, Being faithful, Condom use
ACU	AIDS Control Unit
AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
AMPATH	Academic Model for Prevention and Treatment of HIV in Kenya
AMREF	African Medical & Research Foundation
ANC	Antenatal Care
ARV	Antiretroviral drugs
ART	Antiretroviral Therapy
ASAP	AIDS Strategy & Action Plan
AWP	Annual Work Plan
BCC	Behavior Change Communication
CACC	Constituency AIDS Control Committee
CBO	Community Based Organization
CCC	Comprehensive Care Centre
CCF	Christian Childrens Fund
CDC	Centers for Disease Control and Prevention
CfBT	Centre for British Teachers
COBPAR	Community-based Programme Activity Report
CRS	Catholic Relief Services
CSO	Civil Society Organization
CSW	Commercial Sex Workers
CT	Counseling and Testing
DCH	Division of Child Health
DFID	Department for International Development (UK)
DHS	Demographic Health Survey
DRH	Division of Reproductive Health
ERS	Economic Recovery Strategy
EU	European Union
FAO	Food and Agricultural Organization (UN)
FHI	Family Health International
FBO	Faith Based Organization
FP	Family Planning
FSW	Female Sex Worker
GF/GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
GJLOs	Governance, Justice, Law and Order sector reform programme
GLIA	Great Lakes Initiative on AIDS
GoK	Government of Kenya
GTT	Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors
HACI	Hope for the African Child Initiative
GTZ	German Technical Cooperation
HAPAC	HIV/AIDS Prevention and Care Project
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
HPI	Health Policy Initiative
HR	Human Resources
ICRH	International Centre for Reproductive Health
IDP	Internally Displaced Person
IDU	Injecting Drug Use/user
IEC	Information, Education and Communication
IGP	Income-Generating Project
ILO	International Labour Organization (UN)
IOM	International Organization on Migration
IPM	International Partnership for Microbicides
IPPF	International Planned Parenthood Federation
JAPR	Joint HIV/AIDS Programme Review
JHPIEGO	Johns Hopkins University affiliate (not an acronym)
JICA	Japanese International Cooperation Agency
JSI	John Snow Incorporated
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supply Agency
KERS	Kenya Economic Recovery Strategy
KFW	KfW Entwicklungsbank (German Development Bank)
KNASP	Kenya National HIV/AIDS Strategic Plan (2005/06 – 2009/10)
KVOWRC	Kenya Voluntary Womens Rehabilitation Centre
LVCT	Liverpool VCT
MC	Male Circumcision
MCG	Monitoring and Coordination Group
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoE/MoEST	Ministry of Education, Science and Technology
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoU	Memorandum of Understanding
MSF	Medecins Sans Frontiers
MSM	Men who have Sex with Men
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NACADA	National Coordination Agency for AIDS and Drug Abuse
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for Development
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAF	Programme Acceleration Funds
PATH	Programme Appropriate Technologies for Health
PEP	Post Exposure Prophylaxis (PrEP post-rape PEP)
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provide-Initiated Testing and Counseling
PLHIV	People Living With HIV
PMPB	Pharmacy, Medicines and Poisons Board
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
QA	Quality Assurance
RH	Reproductive Health
SGBV	Sexual and Gender-Based Violence
SIDA	Swedish International Development Agency
SME	Small and Medium Enterprise
SMNH	Safe Maternal and Neonatal Health

SOP	Standard Operating Procedure
STI/D	Sexually Transmitted Infection/Disease
SW	Sex Work
SWAp	Sector Wide Approach programme
TB	Tuberculosis
TC	Testing and Counseling
ToR	Terms of Reference
TOWA	Total War Against AIDS
TS/TSF	Technical Support/Facility
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Science and Culture Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Women's Fund
UNODC	United Nations Office on Drugs and Crime
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UoN	University of Nairobi
UP	Universal Precautions
US/USG	United States Government
VCT	Voluntary Counseling and Testing
VetAID	Veterinary Aid Organization
WAD	World AIDS Day
WFP	World Food Programme (UN)
WHO	World Health Organization (UN)
WB	World Bank (UN)

EXECUTIVE SUMMARY

Kenya Joint UN Programme of Support on AIDS, 2007 - 2012

Following a year-long design process divided into various stages, the UN system in Kenya has in July 2007 finalized the *Joint UN Programme of Support on AIDS* aimed at increased effectiveness and harmonization of its support to the national HIV response. While anchored in the premises of UN reform towards 'Delivering as One' and the UN Development Assistance Framework, the Joint Programme is also fully aligned with the Kenya National HIV/AIDS Strategic Plan (KNASP).

The Joint UN Programme of Support on AIDS is based on a 3-tier analysis on i) the epidemic and sources of new HIV infections, ii) the HIV response stakeholders, interventions and gaps and, iii) comparative advantage of the UN system. Not being in a position to provide large-scale financial support to the national HIV response, it was important for the UN system to build the joint programme on its strategic role as a 'normative knowledge house' strengthening the country-level response through translation of international guidance and best practices into locally meaningful and standardized programmes.

Although the Joint UN Programme of Support on AIDS is designed to provide meaningful inputs to all the four KNASP priority intervention areas, it has a deliberate focus on Prevention/Reduction of new HIV infections as the one area that is critical for long-term control of the HIV epidemic and for which the UN system is well placed to make a significant contribution.

The first Kenya Joint UN Programme of Support on AIDS covers the period from July 2007 to December 2012 with total estimated budget of USD 93.3 million. Out of this amount, USD 38.6 million is projected to be covered through internal UN sources and USD 20 million from existing pledge from DFID. The remaining USD 34.7 million unfunded balance is expected to be covered through existing contributions and joint resource mobilization from external donors. The total budget incorporates procurement support through the World Bank, and a further USD 68 million credit contribution by the World Bank brings the total funding proposed through the UN system to USD 161.3 million.

The Joint UN Programme of Support on AIDS is implemented by the Joint UN Team on AIDS, which operates under the UN Resident Coordinator system and consists of technical UN staff working on HIV. The Kenya Joint UN Team on AIDS was established in June 2007 following final agreement on division of labour and official designation of members by the UN Resident Coordinator.

The goal and outcome areas of the Joint UN Programme of Support on AIDS are aligned with the Kenya National HIV/AIDS Strategic Plan 2005/06 – 2009/10 goal, priority intervention areas and objectives.

Goal: Reduced spread of HIV, improved quality of life of those infected and affected, and mitigated socioeconomic impact of the HIV epidemic in Kenya.

Primary purpose: To support the development of effective, evidence -informed and nationally -led multi-sectoral response to HIV in Kenya, through the increasingly effective UN contribution, improved donor harmonization and alignment in the support of KNASP and NACC.

- 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

These outcome areas are operationalized through a set of 20 outputs, for which the UN system holds itself accountable for. The outputs are translated into comprehensive set of tangible milestones and indicators, against which the Joint UN Programme will be measured.

FOREWORD

Following the recommendations of the Global Task Team (GTT) Report on Improving AIDS Coordination among Multilateral Institutions and International Donors at the country level, and subsequent instructions from the UN Secretary General to all UN Resident Coordinators, an urgent process was triggered in Kenya to further harmonize and consolidate the UN response to HIV. The highlights of this process included a plan of action for the establishment of the Joint UN Team on AIDS and development of this Joint Programme of Support on AIDS, accompanied by a Joint UN Technical Support Plan. By maximizing synergies within the whole UN system through UN reform in action, the Joint Programme aims at improved harmonization and effectiveness of UN approaches and interventions, and their full alignment with the national priorities and in support of efforts towards universal access to HIV prevention, treatment, care and support services.

We believe this Kenya Joint UN Programme of Support on AIDS to be innovative and relevant by:

- being based on thorough stock-taking of the current available epidemiological data and strongly evidence-informed and results-based design of content areas
- seeking to maximize synergies within the whole UN system and deriving from a comprehensive assessment of UN system comparative advantage, value-added and collective capabilities
- responding to the Paris Declaration call for greater harmonization and alignment of development assistance to increase efficiency and effectiveness facilitated by availability of core funding to catalyze common strategic action

Granted it will take time for UN agencies to fully change their current practice of largely working independently on the strengths of their respective mandates, it is clear that the process of visible reform has started in earnest, and that the Heads of Agencies in Kenya are fully committed to the process. As often reiterated by the UNAIDS Executive Director, Dr. Peter Piot, "the train on UN reform has left the station." Hence, the UN delivering as one on HIV is not optional.

We hope we will be able to demonstrate our commitment and strategic contribution to the Kenya national HIV response and the National HIV/AIDS Strategic Plan goals, through working together within the framework provided by this Joint Programme of Support on AIDS. We also hope this Joint Programme will provide and effective platform for open and productive engagement and collaboration with the Government of Kenya and our other partners.

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Signed on behalf of the Kenya UN Country Team:

Elizabeth Lwanga
UN Resident Coordinator

Nairobi, September 2007

BASIC FACT SHEET ON HIV IN KENYA

HIV IN KENYA AT A GLANCE

- First diagnosis in 1984
- Prevalence peaked in mid- to late 90's at around 10%
- Steady decline since, current national prevalence at 5,1% (2006)
- Current estimate for urban prevalence is 9.6% and for rural prevalence 4.6% (2005)
- Prevalence among men 4,0%, among women 7,7% -feminization of epidemic (2005)
- New adult infections estimated at 55,000 per year (2006)
- AIDS –related deaths 83,000 per year (2006)

The national epidemic has 'matured' and reached a plateau, characteristic with high number of deaths, which were in steady rise until 2004, but since then have decreased slightly due to scale up of ART.

People living with HIV (approx. 1,3 million):	1,024,000 (adults 15-49)[1]
	156,000 (children)
	96,000 (adults 50+)

OVC and paediatric epidemic: 2.4 million orphans with estimated 1.2 million due to AIDS. In 2006, estimated number of new infections among children was 19,000, occurring mainly through vertical transmission (MTCT).

Epidemiological characteristics: Kenya has a 'mixed' epidemic with elements of generalized epidemic with large portion of new infections occurring among mainstream population and of concentrated epidemic with clearly defined high-risk behaviours driving the epidemic. Geographical variations range from 10.percent in Nyanza to 2.0 percent in North Eastern province. Overall HIV prevalence among the 84 percent of Kenyan men who are circumcised is 3 percent, as opposed to 13 percent among non-circumcised Kenyan men (KDHS, 2003)

KENYA HIV RESPONSE HIGHLIGHTS

The multisectoral national HIV response in Kenya is coordinated by the National AIDS Control Council, guided by the current Kenya National HIV/AIDS Strategic Plan 2005/06 – 2009/10 and its M&E Framework.

Number of people on ART: 156,000. This represents over 50% of the estimated 263,000 in need of antiretroviral treatment. Even larger number of people have already been registered in pre-ART care programme. Mid-2007, 12,000 children receive ART, but this number is expected to grow rapidly.

HIV counselling and testing: Close to 750,000 Kenyans were tested for HIV in 2006. However, only 20% of adult Kenyans know their status at present. New HIV counselling and testing guidelines place significant emphasis on scale up through introduction of provider-initiated counselling and testing.

Prevention of mother-to-child transmission: Approximately 58 percent of HIV+ pregnant women are offered HIV testing and have access to services for prevention of mother-to-child transmission of HIV (2006).

Current positive trend in four key indicators:

- Number of sexual partners has declined
- Age of sexual debut for both young men and women has increased
- Condom use at perceived higher risk sex has increased
- Basic knowledge of HIV and AIDS has increased

1 The estimated number of HIV positive adults (15-49) has further declined to 934,000 based on 2006 estimates (see table 1, p. 12). At the time of printing of this document comprehensive data for 2006 was not yet available.

Organization of this document

This document describes the Kenya Joint UN Programme of Support on AIDS, 2007-2012. It contains 4 sections and a series of Annexes:

- **Section 1** is an introduction, which highlights the innovative premises and aspects of the Joint UN Programme.
- **Section 2** describes the analytical basis for the Joint Programme – understanding the Kenya epidemic and the national response to it.
- **Section 3** describes the conceptual framework for the Joint Programme in the context of what the UN itself is presently doing, and what the Joint Programme is - its aims, objectives and expected outputs.
- **Section 4** elaborates on the management arrangements of the programme, financial, accounting, programmatic and reporting, and how these will nurture joint accountability and results-based management
- The Annexes (4) provide summaries of critical issues and some practical details and arrangements.

1 INTRODUCTION

1.1 Kenya Joint UN Programme of Support on AIDS at a glance

Despite being cited by UNAIDS in 2006 as one of only three countries in Africa making appreciable progress in turning back the epidemic, Kenya is still contending with a serious HIV epidemic. Evidence suggests that progression of AIDS -related deaths, combined with saturation of infection among people most at risk and improved data quality, are the principle causes for the declining HIV prevalence. New infections are estimated to be around 55,000 annually. At the same time, positive behavior change has been noted with respect to increased knowledge of sero-status, sexual partner reduction, delayed sexual debut among young people and increased condom uptake. Kenya has also been particularly successful in scaling up access to HIV testing, PMTCT and treatment services.

In order to maximize its internal synergies in support of the Kenya national HIV response, the UN system in Kenya has in 2007 finalized a *Joint UN Programme of Support on AIDS* that is fully aligned with the Kenya National HIV/AIDS Strategic Plan (KNASP). The total budget for the Joint Programme is estimated at USD 93.3 million for the period 2007-2012.Out of this amount, USD 38.6 million is projected to be covered through internal UN sources and USD 20 million is requested from DFID. The remaining USD 34.7 million unfunded balance is expected to be covered by existing commitments/pledges and through joint resource mobilization from external donors. A further USD 68 million credit contribution by the World Bank brings the total funding proposed through the UN system to USD 161.3 million. The Joint UN Programme is supported by the Joint UN Team on AIDS under the UN Resident Coordinator system, and has one work plan and core budget contributions from the UN, DFID and other interested donors. At the country level, UN fundraising for HIV will be restricted to the contents of the joint programme.

1.1.1 Programme goal and outcomes and output areas

The ***overarching goal*** of the Joint UN Programme is, in line with the KNASP 2005/06 – 2009/10, to reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socioeconomic impact of the epidemic. The programme's ***primary purpose*** is to support the development of an effective, evidence-based and nationally-led multi-sectoral response to HIV in Kenya, through a more effective UN contribution and improved donor harmonization and alignment in the support of KNASP and NACC.

The Joint UN Programme outcomes are also in line with the KNASP 2005/06 – 2009/10:

- 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

This direct mirroring of the national priorities reflects the importance of harmonized and effective integration into the national HIV response. While strengthening the demonstration of the Programme's contribution towards the national priorities, it also means that the Joint UN Programme will need to have in-build flexibility to review its outcomes as part of formulation of the next KNASP.

The four Joint UN Programme outcome areas are further divided into twenty specific and well-defined output areas as the level of programme implementation and regular reporting. Many of these have corresponding priority outputs in the KNASP, while some are based on identified gaps and emerging areas requiring specific attention.

1.1.2 Programme work plans and joint technical support plans

The five– year (July 2007 – June 2012) framework of the Joint UN Programme of Support on AIDS is implemented through work plans, presented in accompanying operational document. The initial work plan covers the first 18 months (July 2007 – December 2008), thus bridging the gap between the current and new UNDAF cycles, up to the beginning of the new UNDAF.

Technical support forms major part of external contributions to the national HIV response, including that of the UN system's. The UN support to this critical area is two-fold: i) Joint UN Programme output 4.4 focuses on strengthening the management of technical support, while ii) the Joint Technical Support Plan July 2007 – December 2008, presented in accompanying operational document, compiles anticipated technical support provided through the UN system and complements the work plan for the same period.

1.1.3 Joint Programme management

The Joint UN Programme is implemented by the Joint UN Team on AIDS, further elaborated on in section 3.1.3 and in Annex 3. The Joint UN Team on AIDS comprises of technical staff directly working to support the national HIV response, lead by the UNAIDS Country Coordinator under the oversight of the UN Resident Coordinator and the UN Country Team.

1.2. Kenya Joint Programme of Support on AIDS analytical framework

The premise of the Joint UN Programme is a solid analytical framework based on three conceptual building blocks of understanding i) the epidemic and ii) the response (analysis of the external environment) and understanding iii) the role of the UN (internal readjustment and positioning).

1.2.1 Innovative HIV epidemic analysis

The primary basis for the programme of support is a careful situation analysis of available behavioural and epidemiological data to determine what the current dynamics of the epidemic seem to be in Kenya, and what the priority focus of efforts should be. A core element in this analysis is an attempt to develop a transmission-based understanding of the Kenyan response to the epidemic. It addresses the question—'where did the last 1000 infections in Kenya come from, and what level of attention is currently assigned to the identified sources of HIV transmission?' The analysis also responds to the considerable variations (by sex, geographical location, and by age) in prevalence; this aspect of the analysis suggests that, to complement general interventions, increased targeting of prevention, treatment and care, and impact mitigation strategies is required: going beyond overall national strategies to carefully-tailored, engendered, context –specific and cost-effective interventions with data collection systems robust enough to enable further disaggregated development of the evidence base and impact tracking. Finally, the analysis reflects on the increasing burden of care due to the epidemic, the large-scale roll-out of ART in response, and the key challenges this presents for the health system. These analyses are detailed further in Section 2.1 and Annex 1.

1.2.2 Understanding the national HIV response

The second building block of this Joint UN Programme derives from two distinct sets of analysis: i) an assessment of what the national response has been so far, and what partners (Government, development partners and civil society) are doing; ii) identified gaps in the national response not covered by other partners, confirmed by the JAPR process and direct consultation with the NACC. The comprehensive picture of the programmatic aspects (achievements and challenges) of the national HIV response, as well as corresponding funding situation (total amounts and gaps) were employed to further align the UN contribution and targets through the Joint Programme. These issues are covered in detail in Section 2.2 and Annex 2.

1.2.3 Comprehensive assessment of UN comparative advantage

This analytical component to define UN value-added was carried out through different analytical stages of mapping out the overall capacities available within the UN system, analysis of strategic components of the national response for which the UN system has successfully contributed, and/or can make a difference with the available resources. To begin with, the UN system in Kenya acknowledged that its approach to HIV has been fragmented, and that agency skill-sets do not always meet with expectations under the agreed division of labor and embarked on a process to readdress these gaps. The analysis also took into account the changing global environment for HIV response in which treatment prospects have now become a reality and more resources than ever have been made available, the UN family in 2005 developed its first policy position paper on *Intensifying HIV Prevention*. Within the context of this policy position paper and the universal access declaration, the UN in Kenya is well placed and committed to mobilizing a multi-stakeholder NACC-led movement to promote HIV prevention. This will be done under the banner "Uniting for HIV prevention". These issues are elaborated on in sub-section 2.2.3 and Annex 2.

1.2.4 Availability of core funding to catalyze common action

Traditionally, many of the UN organizations do not have a well established, systematic method of allocating and tracking HIV resources and expenditures annually. The reports on the efficiency and effectiveness of joint programming funding modality in Kenya (2005) and the joint programming retreat by the UN in 2006 confirm this. The proposed USD 20 million DFID support through the Joint Programme will afford the UN system an opportunity to increasingly define its collective support to accelerating the HIV prevention agenda, alongside treatment and care scale up. It is expected that the UN family will use the opportunity of common core funding from DFID to demonstrate increased working relationships with NACC (particularly through the JAPR process). It is also expected that further UN resources will be channeled through this programme in support of the Kenya National HIV/AIDS Strategic Plan (KNASP).

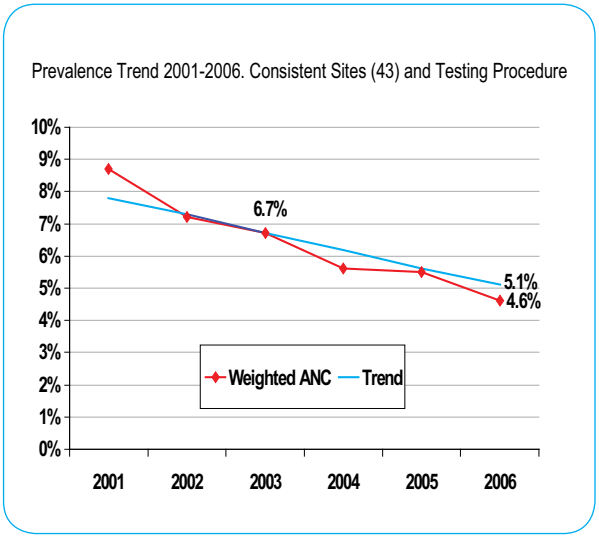
1.2.5 Harmonization and alignment

Responding to the Paris Declaration on aid effectiveness, the Joint UN Programme aims to move on from traditional project-based support, and work within a coherent partnership framework which will support a series of strategic priority interventions for HIV in the country within an effective, national strategy. The Joint UN Programme is further informed and sharpened by the developing processes and mechanisms for joint annual review and priority setting under the national programme (the JAPR process). This is particularly important in the present context, with substantial amounts of funding available for HIV in Kenya. USG funding through PEPFAR, for example, is increasing to staggering levels (USD 325 million in 2007 and over USD 500 million in 2008), and large sums have also been mobilized through the GFATM. However, as much of the funding will utilize new and complex channels through various branches of government, NACC's role as the coordinating agency becomes even more critical. The Joint UN Programme builds on and extends existing multi-partner, Government-led processes and activities, coordinated through NACC.

2 EVIDENCE –INFORMED HIV PROGRAMMING – UNDERSTANDING THE CONTEXT

2.1 HIV Epidemic in Kenya

In 2003, approximately 1.3 million Kenyans were living with HIV, including about 156,000 children. Despite rapidly expanded access to treatment in recent years, an estimated 140,000 adults still died due to AIDS-related illnesses in 2005. Out of an estimated 2.4 million orphans and vulnerable children (OVC) in need of care and support, about 1.2 million are believed to be due to rising AIDS mortality. 2005 estimates of incidence put the number of new HIV infections in the country between 236 and 397 per day.



It is therefore evident that Kenya is still contending with a serious HIV epidemic, despite being cited by UNAIDS in 2006 as one of only three countries in Africa making appreciable progress in turning back the epidemic. There has been clear evidence of declining HIV prevalence trend among pregnant women (see accompanying figure) in the country, with the extrapolated national adult HIV prevalence falling from over 10 percent in the late 1990s to about 6.7 percent in 2003 and 5.1 percent in 2006. The causes for this steep and consistent drop in infection levels are complicated, particularly when it is noted that new HIV infections peaked in the mid-to-late 1990s prior to major prevention efforts being mounted nationwide from 2000 onwards. That suggests that other factors contributed to the observed reduction in HIV prevalence and, in stead of HIV prevalence, incidence should be increasingly examined and highlighted as a 'proxy' for what lies behind the overall trends.

There seem to be various HIV epidemics occurring in Kenya, each with a slightly different set of main driving factors. At this point in the national epidemiological profile, however, it is clear that progression of AIDS–related deaths, combined with the saturation of infection among people most at risk and improved data quality (e.g. DHS in 2003 and better balance between urban and rural sentinel sites), are the principal explanations for the declining national HIV prevalence.

At the same time, available evidence also indicates some support in favor of genuine decline in adult HIV prevalence attributable in large part to changes in behavior regarding a number of variables. These include: a) increased knowledge of sero-status, b) sexual partner reduction, c) delayed sexual debut among young people, and d) increased condom uptake. Mass media and comprehensive sexual education have been specifically flagged to have been effective in changing behavior, especially among the youth. Conversely, evidence from the region provides limited support for several equally popular prevention interventions, such as treatment of bacterial STIs, peer education, women's empowerment, anti-stigma campaigns, establishment of youth clubs and general awareness-raising. More is required on the prevention efficacy of these interventions to warrant their scaled up continuation.

2.1.1 Spatial analysis of HIV prevalence and high risk behaviour distribution

Distribution of prevalence between the 8 provinces of Kenya is uneven. While estimated prevalence for most provinces is below the national average, the estimates for Nyanza and Nairobi are considerably higher. Almost all provinces have pockets of significantly higher prevalence and these are mostly linked to urban settings with high population density and movement, or proximity to main transport routes and trading sites.

While the map is based on the first population-based HIV prevalence survey in Kenya, table 1 presents data based on annual sentinel surveillance, extrapolated to the general population. Although different methods of arriving at HIV prevalence estimates cannot be directly correlated, the general trend has been consistent between the two types of information sources.

In general terms, between 2003 and 2006, prevalence estimates seem to have risen (over 1 % difference) in North Eastern, stabilized (less than 1% difference) in, Central, Coast and Nairobi provinces and reduced (over 1% difference) in Nyanza, Western, Rift Valley and Eastern provinces.

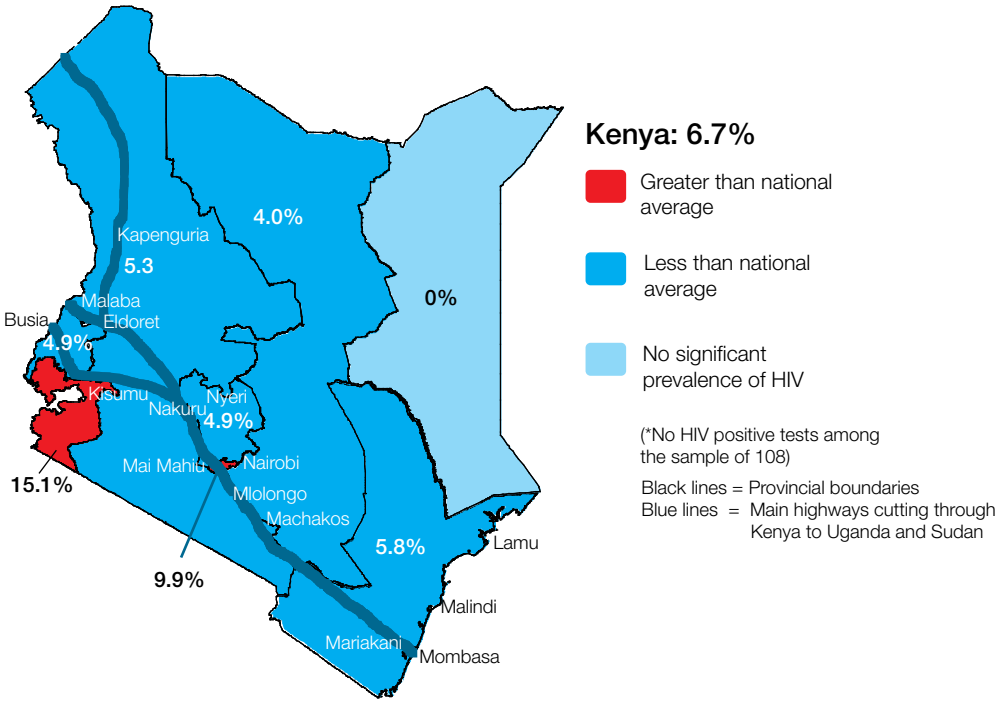


Table 1: Adult HIV prevalence by province in 2006 (based on annual sentinel surveillance)

Province	Number of PLHIV	Prevalence		
		Total (%)	Male (%)	Female (%)
Nyanza	209,000	8.7	6.8	10.7
Nairobi	188,000	10.0	7.9	12.0
Coast	87,000	5.4	4.6	6.3
Central	102,000	4.3	2.1	7.9
Western	79,000	3.6	2.9	4.4
Rift Valley (North and South)	188,000	4.1	2.8	5.3
Eastern	72,000	2.7	1.1	4.3
North Eastern	9,000	1.4	0.9	1.8
TOTAL	934,000	5.1	3.5	6.7

It is important to note that, in all provinces, prevalence among women is estimated to be higher than (often more than double) prevalence among men. Any effective response efforts need to carefully analyze this phenomena and consider the different needs of boys/men and girls/women. Kenya's male-female ratio of HIV prevalence is significantly higher than the regional average.

Geographical variations in prevalence are important for various reasons. First, prevalence (and incidence) may be high as a result of particular situations in particular geographical areas: for example, incidence and prevalence is very high in the districts of Nyanza bordering Lake Victoria, owing to the high vulnerabilities and risk associated with the 'fish-for-sex' transactional sex behaviours which occur there. The lack of circumcision among the Luo has also led to high prevalence in Nyanza. Prevalence is also much higher in Nakuru town than in the rest of the Rift Valley province, owing to its key location as a transport hub. Secondly, because of the considerable economic mobility, with people from rural areas migrating to towns for work, becoming infected there, but returning home when they start becoming ill, the provinces and districts with most need for access to treatment, care and support are not necessarily those with highest incidence. Finally, these provinces with the most need for access to treatment, care and support may well be those with weakest health care systems. In terms of planning for equitable services for those infected and affected, Nyanza (209,000), Nairobi (188,000) and Rift Valley (188,000) have highest numbers of people living with HIV. Thus in terms of urban-rural difference, urban areas have much higher prevalence rates but, as a large part of the population either permanently resides in rural areas and/or have tendency to return in times of grave illness, the burden of illness and the impact of infection is high in many rural areas. At the same time, availability of services is much lower in rural areas, awarding increased emphasis on support to community-care scale up and effective facility-community linkages and referral mechanisms.

While many stakeholders in the HIV response are present in Nyanza and Nairobi, which carry the highest burden of prevalence, and various interventions target the highway environs, these are largely uncoordinated, time-bound project-type activities, which are not adequately standardized, monitored and documented to inform decision-making for scale-up of effective interventions. Often weak are synergies among individual interventions or linkage between them and national policy and strategy, which would allow maximum benefit of all investment (information, infrastructure, financial and human resources) and development of holistic HIV prevention, treatment, care and support programmes.

Although UN support will largely be at national level providing normative guidance, technical support and funding to HIV response management and coordination, a key aspect of this work is to assist in determining appropriate geographical focus for strategies and interventions. Analysis of the factors contributing to HIV sero-conversion risk in different localities (Annex 1, Table 1) has identified key areas for focus for prevention interventions. These are primarily in Nyanza Province, along the coast and the main transport corridors, as well as in key urban hubs like Mombasa, Nairobi, Nakuru and Kisumu focusing on the groups with demonstrated high risk behaviours.

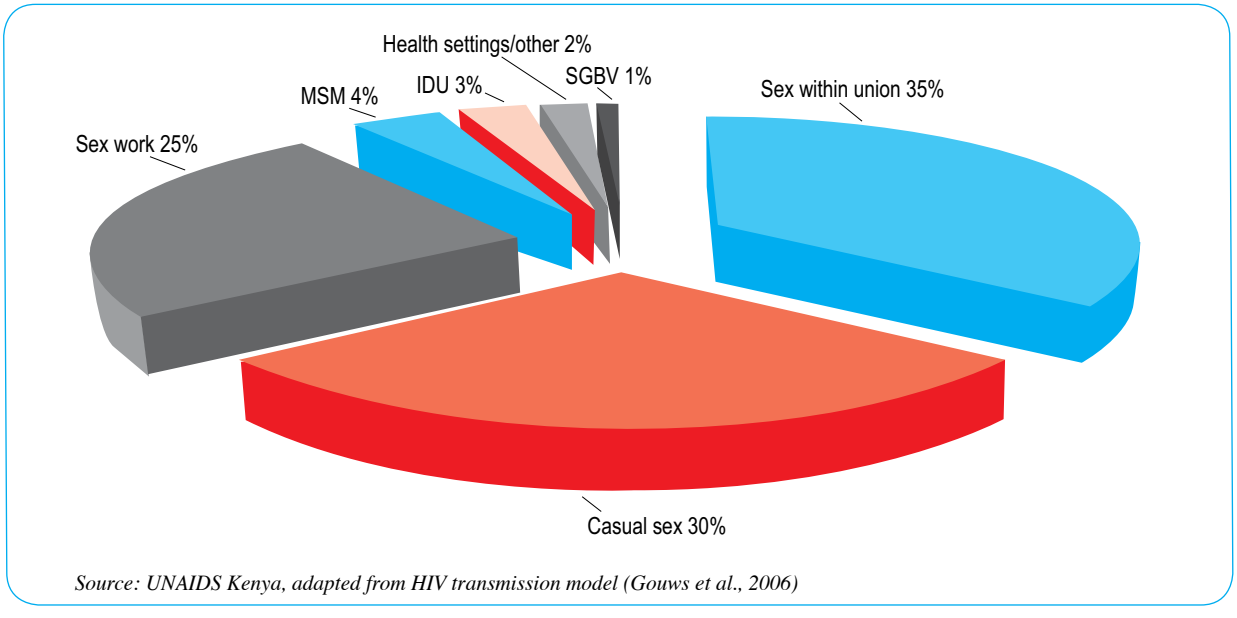
2.1.2 Analysis of the main modes of transmission

The dynamics of the HIV epidemic in Kenya are becoming better understood, but there is still not much clear evidence to suggest the most cost-effective interventions needed. It is expected that the results from the Kenya AIDS Indicator Survey, to be conducted in late-2007, will provide a clearer picture of the primary drivers of the epidemic. Sufficient evidence, however, exists in respect to certain key situations of significantly higher vulnerability and risk, and thus in need of priority attention.

Some of the latest data on key prevention indicators from a variety of sources (Annex 1, table 2) suggest a mixed trend with several key drivers of the epidemic, particularly those affecting young girls and women. Young women continue to face significantly higher levels of risk of HIV infection compared to young men of same age. Often underlying these immediate causal factors are issues of poverty, gender inequality, gender-based and sexual violence, and stigma.

To ensure that the available resources are used effectively, it is necessary for prevention efforts to be matched with the key sources of infection. Chart 1 (and Annex 1, Table 3) represents work in progress and attempts to develop a transmission-based understanding of the Kenyan response to the epidemic. It addresses the question—'where did the last 1000 infections in Kenya come from, and what level of attention is currently assigned to the identified sources of the epidemic?'

Chart 1: Sources of new infections

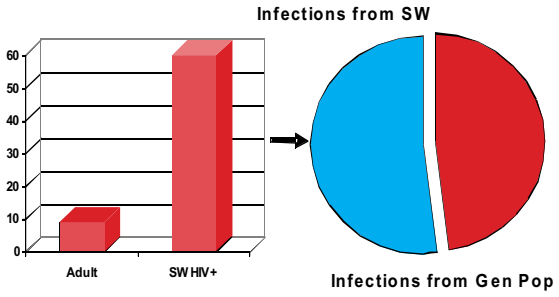


Source: UNAIDS Kenya, adapted from HIV transmission model (Gouws et al., 2006)

This analysis suggests that populations usually considered as "low risk", such as ***couples in union*** (married/cohabiting), or so-called regular/stable partnerships, would need to assume more center stage position in prevention efforts than before. Of all HIV –affected couples, estimated 50% are discordant i.e. one partner is HIV negative, while the other is HIV positive. Both knowledge of HIV status and use of condoms in regular relationships have remained alarmingly low, and half of Kenyan women marry early, before the age of 20 years.

Evidence indicates that a third of girls between the ages of 15-19 years do not perceive themselves as being personally at risk of HIV infection. Thus **casual sex**, often involving younger women and older men (in a non-marital situation)

HIV PREVALENCE AND TRANSMISSION SOURCES IN NAIROBI, KENYA



Source: Pisani et al, 2003

represents a particular risk situation in Kenya, along with other concurrent sexual partnerships. The analysis also shows that ***sex work***, both commercial and transactional in nature, should increasingly assume more significance in the Kenyan context (see accompanying figure on Nairobi, 1999).

A relatively new concern is the recent emergence of ***injecting drug use*** as a factor in Kenya's epidemic scene, combined with effects of other traditional types of substance abuse, alcohol in particular. The significance of ***MSM*** in Kenya is accentuated by the fact that an estimated 400,000 Kenyans pass through the correctional system annually, which increase the risk of 'contextual' MSM limited to situations of incarceration.

Equally concerning is recent research data (2006) indicating the nearly two-fold risk of ***infection transmission in health settings*** for women who receive one or more tetanus injection. However, closer analysis suggests these particular findings to be questionable and warranting further research.

The primary purpose of this analysis is to identify situations, *not individuals*, of highest vulnerability and risk, in which continuing incidence of HIV is primarily occurring. This helps to identify the main priorities for a prioritised strategic response. This does not mean that incidence and transmission does not occur outside these situations; nor that prevention efforts in other areas of lower vulnerability and risk should be completely discontinued. Given the relatively limited resources available for prevention, the weaknesses in many existing prevention efforts, and the urgent need to prioritize, it does, however, suggest the primary strategic focus for the core joint UN programme. This also provides the conceptual framework and impetus for greater integration and mainstreaming of longer-term, sustainable, general HIV prevention efforts within other socio-economic development programmes such as education and youth services.

2.1.3 Increasing burden of care

The number of people requiring ARV treatment in Kenya is currently estimated at 250,000 adults and 50,000 children. Kenya has made tremendous progress in scaling up antiretroviral therapy (ART). The numbers of people on ART have increased from 2,500 in Dec 2003 to 65,773 in Dec 2005. By December 2006, there were about 120,026 people receiving ART in Kenya. Implementation of the Rapid Results Initiative (RRI) in the second half of 2006 has led to a dramatic increase new people presenting for ART from around 1,800 patients per month to over 5,000 new patients per month.

TB-HIV linkages are also presenting a major problem. In 2005 in **Kenya** there were an estimated **219,582** new TB cases (incident cases). Of these, **155,751** were among adults with **28 percent** (43,626/155,751) of adult TB cases occurring in people living with HIV. Overall **108,401** tuberculosis patients were registered on treatment by the national tuberculosis programme.

Most of the programs providing care, support and treatment are, however, directed to adults. Provision of paediatric care has lagged behind that of adults in respect to procurement of drugs, training of health workers, advocacy and communication campaigns, provision of testing facilities and provision of appropriate counselling service. There are presently (mid-2007) 12,000 children on ART.

The PMTCT scale up on a national scale started in December 2001 with the largest funding provided through PEPFAR. By December 2006, 64 percent of facilities were providing services to 60-70 percent of all pregnant women. However, only 23 percent of the estimated HIV positive women are accessing any intervention and the majority of facilities provide Nevirapine only. It is expected that by December 2007 with funding from USG up to 1 million pregnant women will receive counseling and testing, and about 86,000 (75% of all in need) will be accessing ARV prophylaxis. However, the tradeoff for this progress is an excessive reliance of the government on the off-budget funding from mostly PEPFAR, as well as increased verticalization of the interventions and limited scope for a broader child- and mother-focused approach. A significant percentage of all new infections in Kenya are due to vertical transmission and, currently, only about 50 percent of the ART sites provide pediatric treatment, and only about 14 percent of the facilities offer comprehensive PMTCT.

There is growing evidence from many countries that the demands on health systems of the long-term, chronic care service delivery needed for OI/ART, are extensive; and Kenya is no exception. OI/ART services, both through the absolute numbers of people who will require them, and the particular life-time nature of their requirements, add very significantly to the

already exigent demands upon health services in Kenya. Areas of particular concern are in deploying and training adequate numbers of health care personnel; the establishment of sustainable procurement and logistics systems capable of securing uninterrupted supplies of ARV drugs (to reduce the development of wide-spread resistance); M&E and MIS systems based on accessible patient data management; changes to service delivery design, where facilities have to accommodate ever-increasing numbers of long-term, though ambulatory clients; and appropriate community links, as services expand, and various forms of home-based care, patient adherence follow-up, and management of side effects are needed.

2.2 National HIV Response – Accomplishments and challenges

The second Kenya National HIV/AIDS Strategic Plan covers the period 2005/6-2009/10, and aims to reduce the spread of HIV, improve the quality of life of those infected/affected and mitigate the socioeconomic impact of the epidemic. It is structured into four strategic pillars and objectives, costed at approximately $2.4 billion, as contained in table 5 below.

Table 2: KNASP pillars and strategic objectives

Response Pillars	Strategic Objectives	Total Budget (US$ mil.)
1. Prevention of new infections	*Reduce the number of new infections in both vulnerable groups and the general populations*	**575.0 (24%)**
2. Improving the quality of life of people infected and affected by HIV/AIDS	*Improve the treatment and care, protection of rights and access to effective services for infected and affected people*	**695.4 (29%)**
3. Mitigation of socio-economic impact of HIV and AIDS	*Adapt existing programmes and develop innovative responses to reduce the impact of the epidemic on communities, social services and economic productivity*	**718.7 (30%)**
4. Support services to the NACC and KNASP	*A NACC equipped with a wide range of support services necessary for effective delivery of a multi-sectoral response to the epidemic*	**403.6 (17%)**
Total		**2,400 (100%)**

2.2.1 Four strategic priority areas

Prevention of new infections

As indicated earlier, Kenya is considered a recent success story in the fight against HIV, in terms of decline in prevalence as well as progress in the national response implementation. Over the last few years, critical HIV campaigns and programmes have been scaled up beyond most people's expectations. As a result, *general* awareness and knowledge of HIV transmission are nearly universal; and behaviours are changing. However, only 34 % of the young women and 47% of young men in age group 15-24 have *comprehensive* knowledge of HIV and AIDS. The percentage of adult Kenyans who reported more than one sexual partner in the last 12 months declined from 4.2 percent among women and 24.1 percent among men in 1998 to 1.8 percent and 11.9 percent respectively, in 2003. An increased figure of 24 percent of the women and 47 percent of the men reported condom use in last higher-risk sex. In 2006, some 760,000 adult Kenyans underwent HIV testing, and between 55-70 percent of HIV positive pregnant women benefited from PMTCT services. But as demonstrated by the foregoing analyses, continuing new HIV infections mean that there is urgent need to do more and to respond more effectively to the epidemic.

Unlike many African countries, Kenya's epidemic is both generalized and concentrated. As understanding of the dynamics of the epidemic improves, programmatic responses on the ground need to be adjusted. For the last few years Kenya's national response has focused on 'generalized' prevention strategies, while emerging evidence suggests that a shift to include a more targeted approach would be more strategic, with a sharper focus on specific areas of transmission such as married couples, sex work, inter-generational and casual sex, and other most-at-risk groups such as MSM, IDU, truckers, etc. In addition, increased attention should be given to innovative approaches to counseling and testing, PMTCT and male circumcision etc.

Improvement in the quality of life for those infected by HIV

An estimated 140,000 (over 50%) of those in need of treatment in 2006 were reached through multiple treatment sites across the country, including about 6,000 children. This is a huge accomplishment, representing one of the best AIDS treatment

outcomes in Africa today. However, a recent inter-agency report on the sector highlighted a number of critical challenges warranting urgent attention. Chief among them is the need for an integrated and unified monitoring and evaluation system that is government-led and supported by all the partners involved in providing ART in the country, such as the USG, Global Fund, MSF, Clinton Foundation, private sector and others. Support with harmonization of ARV and diagnostics procurement and forecasting management systems would be essential to address the persistent threats of ARV stock-outs.

Another major problem area is the fact that nearly 100 percent of those currently on treatment are covered by external funding commitments. This poses a substantial risk for both the sustainability, and ownership of the national treatment programme. The number of children on treatment, while improving steadily, has not kept up with the recruitment of adult patients and needs to be given more emphasis. Also, despite a high level of co-infection between HIV and TB in Kenya (57.4%), only 14.3 percent of registered TB patients are reached with HIV testing and counseling. There is yet to be routine screening of PLHIV and AIDS patients for TB.

Lastly,an integrated model including nutritional care and support would enhance the quality of life, improve adherence and serve the populations requiring ARV treatment in Kenya, including an estimated 263,000 adults and 50,000 children.

Mitigation of the socioeconomic impact of HIV

The third KNASP priority area of *mitigation of the socio-economic impact of HIV and AIDS* has not received as much attention as other KNASP priority areas, although this scenario is slowly changing. Much of the effort has focused on addressing Orphan and Vulnerable Children (OVC) issues, less so on other vulnerable groups including women. Information on the socio-economic impact of HIV to other vulnerable groups, and the macro level impact is often anecdotal, and quantitative data is limited. Anecdotal data indicate that communities have had coping mechanisms, which are yet to be documented and quantified. Hence target setting for this priority area has been a challenge. The new TOWA Project will, however, be addressing many of these issues through its grant-making elements.

In addressing OVCs, a National OVC Policy exists, and a National Plan of Action for OVC is available; but this is yet to be costed. The Coordination of OVC efforts is ongoing with consistent and relatively strong leadership from the Ministry of Home Affairs, Children's Department. Institutional strengthening both at the central and decentralized levels is however required to coordinate the ever increasing number of stakeholders involved in OVC programmes. Significantly large projects with DFID, and World Bank funding, are about to start, however.

The NACC has just completed a socio-economic impact study. It was hoped that the study will form a basis for developing mitigation programmes. A review of the report however reveals a rather broad based approach and necessitates sector impact studies to inform programme. This has been a consistent recommendation of the previous JAPRs although the recommendation is yet to be carried out. The quantification of the impact of HIV will also support advocacy efforts with high level government structures, which should translate to allocation of resources earmarked for HIV in the MTEF processes and aid sustainable financing for HIV

Most private sector companies have workplace policies and ongoing HIV programmes but their application of the policies are yet assessed. Small to Medium Enterprises (SME) and informal sector remains a major challenge. This group has however had formal engagement in HIV related national processes but their engagement needs to be more strategic and the Private Sector Advisory Network needs to be strengthened.

The Department of Personnel Management has a public sector workplace policy but require support to implement the policy. AIDS Control Units have conducted awareness programmes but these have often been on ad hoc basis and not mainstreamed in ministries' work plans.

Support services to the NACC and KNASP

One of the emerging concerns for the national HIV response is sustainability of long-term interventions. Approximately 97 percent of currently available HIV funding is accounted for by international donors, with the US Government as the largest donor, and much of it is off-budget. An increasing amount of resources has started to be allocated to impact mitigation nationwide, especially through the MTEF processes.

Institutionally the NACC has been able to renew and establish itself as the one national coordinating authority on HIV in the country, with a substantially enhanced public image and credibility. NASCOP, however, continues to face serious challenges in its programme: weak commodity management (planning, procurement and distribution logistics) for key supplies; inadequate availability of trained human resources for service provision; ineffective monitoring and evaluation systems to inform the national response (frameworks exist, but still remains largely in-operational).

In order to address the above obstacles, the following activities to be facilitated as part of KNASP support services form part of Kenya Roadmap towards Universal Access:

- Harmonization and alignment of donor contributions and processes
- Increased Government of Kenya funding through direct engagement in the medium-term expenditure framework (MTEF) development process
- Development of one consolidated procurement and distribution system with an effective management structure
- Improved integration of HIV-specific human resource needs into the health sector wide approach (SWAp)
- Capacity development for data collection and analysis to strengthen information flows at all levels

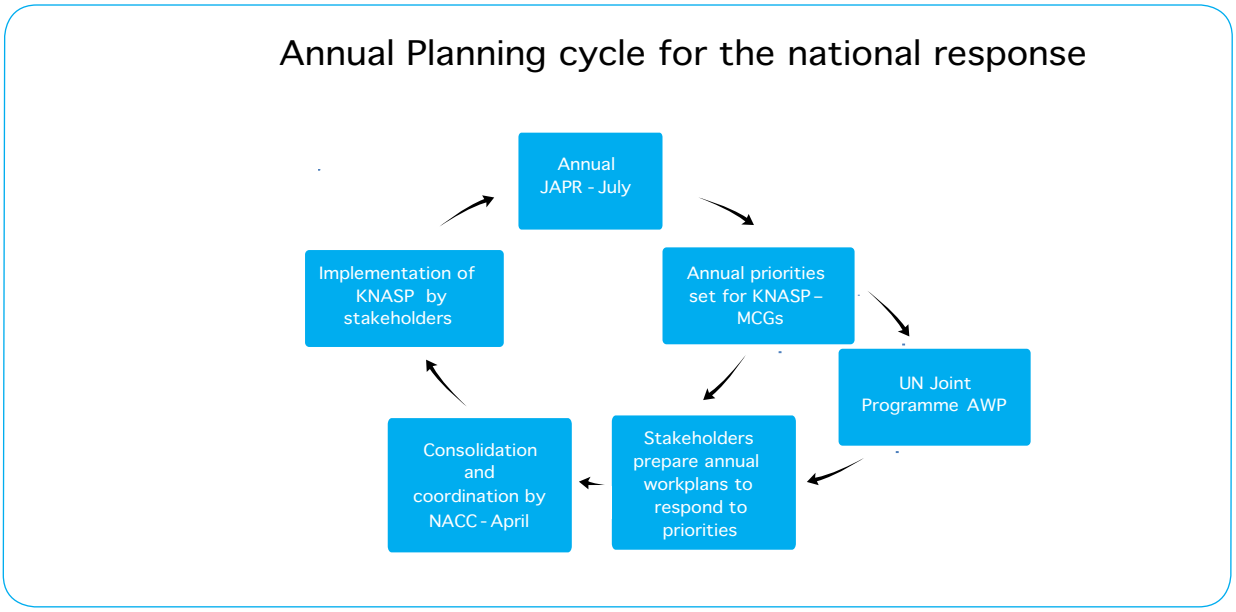
Specifically, multilateral institutions and international partners in Kenya must commit to working with the NACC, and to align their support to the national strategies, policies, systems, and the KNASP in line with the "Three Ones" principles. It is equally critical that the international development community is held accountable through an arrangement that involves both a peer review and review by national stakeholders.

Emphasis will also need to be placed on the continued need to fight stigma, which negatively affects health-seeking behaviours and hampers outreach to at-risk groups, thus potentially impeding Kenya from achieving its universal access targets by 2010.

2.2.2 National prioritization and planning process

Many of these issues have been addressed through the new process for annual prioritization being introduced through NACC. This is based upon the Joint AIDS Programme Review (JAPR), conducted annually, and involving all stakeholders. The JAPR process sets, reviews and monitors national progress against a set of priority targets drawn from the KNASP Results Framework. In 2006 this common monitoring process began at the district level and was consolidated through Provincial level discussions and concluded at the national level in the JAPR forum itself. Consultation also involved vulnerable groups extensively (CSW, MSM, IDU, refugees) to obtain their distinctive perspective.

A key mechanism within the JAPR process are the Monitoring and Coordination Groups (MCGs), established to monitor the four functional areas of KNASP (i.e. Prevention, Quality of Life, Social Impact Mitigation and Support Systems). The core task of the MCGs is commissioning and putting together the reports which form the major part of the JAPR, and identifying the priorities which arise from them. These priorities are then fed into an Outline Comprehensive National Plan.



The JAPR is scheduled to the GoK fiscal year, in order to link with the MTEF process, and with the district level planning processes, and aims to take place in July/August each year. The JAPR reports illustrate a steady improvement in stakeholder co-ordination with a widening a scope of participation and an increasing depth to the discussion. The establishment (JAPR 2006 recommendation) of a Steering Committee of the ICC to oversee the translation of priority JAPR recommendations into harmonized implementation plans, including Technical Assistance, is a further move in the direction of stakeholder coordination

The Joint UN Programme aims to link with the JAPR, even though formal UN planning is on the calendar year. This means that Joint Plans are prepared according to the JAPR cycle (see diagram above), drawing on the priorities set following the July JAPR, and being consolidated into the NACC Consolidated Work Plan by April.

2.2.3 Cross –cutting issues

A number of cross-cutting issues are of importance in both the understanding of the epidemic, and in the response. These are:

- Gender, and specifically the feminization of the epidemic
- Young people and specifically young, sexually active girls
- Mobile labour, and specifically those crossing borders regularly, such as long-distance truck-drivers
- The greater involvement of people living with HIV and AIDS (GIPA), and specifically in helping reduce stigma and discrimination.

Gender –aspects and feminization of the epidemic

Sixty-five percent of people living with HIV in Kenya are women, which is significantly higher than the regional average of about 50 percent. Average HIV prevalence in women 15-49 years of age is 8.7%, compared to 4.6% in men of the same age group. Infection rates for women dramatically worsen among young women 15-19 years of age, with infection rates that are six times higher than among young men of the same age group. Prevalence rates among young women peaks at 25-29 years of age, while those of the male peak at the 40-44 years age group. Married couples in so called *stable relationships* have significantly higher HIV prevalence at 8 % for women and 7 percent for men, compared to single (i.e. never married) with 5.6% for women and 1.6% for men. Discordance among HIV –affected couples is high with, contrary to popular believe that the husband is more likely to 'bring' HIV to the marital home, more discordant couples with the wife as the HIV + of the spouses.

Widows and divorced/separated women are shown to be particularly at high risk with prevalence of 31.8 % and 14.6%, respectively. Up to 16 % of women surveyed in 2003 reported having been sexually violated; and 30 % of young women 15-19 years of age reported having had experience a form of physical violence. Yet only 2 % of antenatal clinics in Kenya provide youth-friendly services. Addressing gender aspects of the epidemic, both in terms of causes and effects, is mainstreamed throughout the whole programme.

Young people, with focus on young, sexually active girls

The Ministry of Education, Science and Technology has a comprehensive programme to address HIV in the education sector to reach in school youth, with support from WB, DFID, EU etc. And efforts are underway to support the new Ministry of Youth to coordinate youth affairs, including HIV programmes. The USG through PEPFAR promotes Abstinence and Faithfulness with special emphasis of reaching 1 million youth to avoid HIV, with mobile teams to reach both in and out of school youth. Almost all international NGOs and most local NGOs who are implementing HIV programmes have a range of youth focused awareness interventions; many through RH/FP programmes. UNICEF provides strong HIV life skills education support to the Ministry of Education, and Kenya Institute of Education. There are plans to support national scale up to a national programme. UNFPA and UNICEF have long experience working in youth-related programmes, such as provision of youth friendly services, both at policy and at implementation level - in collaboration with the Ministry of Youth, MOH (DR), NCAPD, NASCOP and NACC as well as CSOs.

The key issue, however, is in identifying those groups of youth, or those situations of youth behavior, which are at significantly high risk for HIV transmission. In this regard, adolescent, already sexually active girls, are far and away those at greatest risk, and possibly those most difficult to reach.

Mobile labour with regular absences from home, such as long-distance truck-drivers

There are an estimated 8,000 female sex workers on the trans-Africa highway from Mombasa to Kampala, servicing primarily the trucker drivers and their crews who pass along it. Based on a detailed study of highway 'hot-spots', an estimated 3,200–4,148 new HIV infections occur on this portion of the trans-Africa highway every year. A large portion of HIV prevalence and high-risk behavior in the provinces are found along this major transport route, especially in close proximity to main truck stops like Mariakani, Mlolongo, Busia and Malaba and major urban hubs like Mombasa, Nairobi, Nakuru and Kisumu.

The USG/PEPFAR supports VCT in four of the five truck stops, NASCOP provides free condoms. No support for major truck driver stop (Mlolongo) where 450 – 500 trucks stop overnight, excludes those Truckers who do not need police escort. IOM provides technical support to the government-driven Great Lakes Initiative on AIDS. In 2006, IOM completed a regional assessment for GLIA/UNAIDS of trucker behaviours and service access and is working with NACC to mobilize resources for improved value-added coordination on prevention, treatment, care and support. WFP can replicate experience gained in pilot countries on Truck Driver programmes implemented through 9 wellness centers. With enhanced capacity and resources these experiences could support scale-up.

Greater involvement of people living with HIV and AIDS (GIPA), especially for stigma reduction

PLHIV groups state that access to social capital, to community networks and support, is challenged by enduring stigma and discrimination of people known or suspected to be HIV-positive. Stigma negatively affects health-seeking behaviours and hampers access to vulnerable groups. It is compounded by widespread gender perceptions and norms that continue to demand sexual probity of women and girls, while accepting permissive sexual behaviour by men; a woman or girl known or suspected to be infected is more likely to face exclusion, discrimination and even ostracism. There is growing perception among PLHIV groups that unless rights' and voice issues are addressed, the goal of meaningful involvement of people living with HIV/AIDS (MIPA) will in fact remain meaningless and tokenistic. Recognition of these needs is again mainstreamed across the Joint Programme: and much of the work in output 2.6 strengthening the framework for protection of human rights in the context of HIV involves collaboration with PLHIV and other advocacy groups on these issues.

2.3 Harmonization and alignment – Increased effectiveness of support to the national HIV response

2.3.1 Funding the Kenya National Strategic Plan (KNASP)

According to the official costing of the KNASP, the annual HIV requirement was estimated at USD 315 million in 2005/6 and USD 400 million in 2006/7, rising to USD 470 million in 2007/8, and to USD 525 million in 2008/9. Table 7 gives an indication of the match, or gap, between the KNASP financial needs and the pledged resources by the major donors. It only shows a marginal gap for 2005/6, but this gap has grown noticeably in 2006. By mid 2006, only about USD 250 million was being realized for the KNASP as compared to the USD 315 million budget for the financial year 2005/2006.

In terms of salient opportunities within the national response, there have been notable improvements in the political/governance environment and commitment by national political leadership in regards to HIV response. This has resulted in a boost in available resources by international partners in support of Kenya's efforts to curb the HIV epidemic. The recent signing of the Global Fund Round 2, Phase 2 grant, was a result of improved governance structures being put in place. Between 2006 and 2007, the U.S. Govt. increased its HIV allocation by 30 percent. In addition, the World Bank and DFID recently finalized negotiations for considerable additional support to the national response (USD 110 million), through the NACC. Issues of good governance and transparency must continue to remain paramount if this momentum is to be maintained.

Government funding, however, (recurrent + development) for HIV activities has declined sharply over the last three years, from $870 million in 2003/04 to $650 million in 2005/06. This seems to be almost in direct response to increases in HIV funding for the country by the development community. Apparent in the financial data is the fact that the national HIV response is almost exclusively financed by donors (97%), with the US Govt. contributing by far the largest amount (76%), followed by the UN system (8.6%) and Global Fund (7%). As pointed out several times already, this trend should be a matter of deep concern for both the Government of Kenya and development partners in terms of implications for national ownership and sustainability of the response. Both short- and longer-term measures and options would need to be pursued.

Table 3: Approximate resource allocations for HIV response in Kenya by international development partners and donors (at 2006 exchange rate of USD 1 = KSh72)

Development Partners	2005/2006	2006/2007
U.S. Govt. (PEPFAR, USAID, CDC)	$208,000,000	$323,000,000
United Nations System (incl. World Bank)*	$23,600,000	$33,800,000
Global Fund	$18,100,000	$30,000,000
DFID	$11,600,000	$4,200,000
Clinton Foundation	$7,300,000	$10,900,000
KFW	--	$4,200,000
Others	--	$8,600,000
*Govt. of Kenya***	*$5,400,000*	*$11,300,000*
Total	$274,000,000	$426,000,000

* There is an element of double-counting regarding the UN system contribution due to funds received in-country from DFID, USG and SIDA. In 2006, this amount is estimated at about USD 2.3 million.

**Approximately 80-90% of this allocation amount is for recurrent or fixed expenditures.

This analysis of the resource requirements for the KNASP for 2005/6-2009/10 requires further elaboration and analysis in the light of new donor commitments, in order to more precisely establish financial gaps and the adequacy of investment in the response continuum.

2.3.2 Distribution of resources

According to the official costing of the KNASP, impact mitigation should receive the largest share of funding at 30%, followed closely by treatment and care at 29%, prevention at 24% and the support services at 17%. A review of the major HIV funding mechanisms however reveals some imbalances in this allocation of resources. The Global Fund allocates 59% to the quality of life, and is slightly on target for prevention with 27%; no resources were allocated for impact mitigation and only some 14% to support services. The US Government (PEPFAR) programme for 2006 and approved budget for 2007 allocates 61 percent of the resources to the improvement in the quality of life for those infected by HIV (treatment and care) and 22% to prevention, 10% to mitigation, mainly on OVC-related interventions, and the remaining balance to support services, mainly training of health workers and monitoring and evaluation. The anticipated World Bank/DFID support to the KNASP has taken into consideration the above allocations, and has marked 47% across the prevention and impact mitigation pillars, and 53% to leadership, governance and other support services for the NACC.

In analyzing the above, it seems that resources allocated to the prevention priority are not very far from the targeted 24% of total resources. It is, however, important to assess if these resources are supporting appropriate interventions within this priority area. Improvement in the quality of life has received more than its fair share of resources from external sources. The impact mitigation priority area appears to receive the least attention and is least funded. This is partly due to limited data, evidence and understanding of interventions that are effective in mitigating impact. Most of the resources indicated in the various mechanisms for this priority area are targeted to interventions aimed to address the needs of OVC.

The above analysis is not robust, however, as allocations according to the KNASP priority areas need to be revised in light of the new developments, changing donor commitments, and the NACC's effort to ensure long term sustainable financing for HIV, through the mainstreaming efforts, including engagement in the MTEF process. From the analysis, it therefore makes sense for the UN System to allocate a considerable proportion of its resources (50%) to targeted prevention programmes, with substantial resources to improvement in the quality of life as second priority, to support the national policy, management and coordination role of government for this specific area, since the resources for this priority, as discussed above, are utilized mainly at the implementation level. Less than 20% percent of resources are targeted to mitigation of the socio-economic impact.

2.3.3 Stock-taking of current UN operations on HIV

At present, there are more than a dozen UN organizations that support HIV work in Kenya. The nature of the support provided includes direct financial contributions towards agreed activities implemented by programme partners, human resources for internal programme management, and technical support towards normative, coordination and implementation processes.

As a system, the UN comprises of unique and diverse mandates to provide technical support and support to the Government of Kenya (GoK) to implement the national response on HIV. Many of the UN organizations already have well established and close working relationships with the NACC, Ministry of Health (MoH), Ministry of Education (MoE) and Ministry of Home Affairs (MoHA). They also have equally well established close collaborations with other key sectors and partners, including civil society and community-based groups.

Table 4: UN HIV expenditure by organization

UN Agency/ Organization	2004 (US$)	2005 (US$)	2006 (US$)
FAO	42,600	27,700	258,096
UNDP	967,197	782,023	409,219
UNFPA	1,930,543.59	2,206,102.70	1,389,438
UNHCR	338,878	294,414	165,500
UNICEF	1,098,861	3,453,626.70	5,040,097
UNODC	63,700	650,000	452,700
World Bank[1]	10,000,000	10,000,000	0
WFP	1,297,000	1,099,500	1,300,000
WHO	500,000	500,000	585,088
Others[2]	380,000	450,000	520,000
Total	**16,238,779.59**	**19,463,366.4**	**10,120,138**[1]

[1] The World Bank TOWA programme was suspended throughout 2006.

[2] Category consists of combined annual expenditure estimations for the UN regional entities—UNESCO, ILO—as well as UNIFEM, UNAIDS Secretariat and IOM.

Based on agency-reported figures (table 4), the UN system in Kenya in 2006 spent a total of USD 9.4 million to support HIV activities. Out of this nominal contribution, almost 50% was targeted at prevention activities, including condom procurement (11%), general behavior change communication (10%), PMTCT (5.5%), youth-focused interventions (5.8%), IDUs and prisoners (4.5%) and sex workers (4.5%). Injection safety, STI and PEP together accounted for about 0.5%. Approximately 20 percent was spent on treatment, care and support issues, particularly training and monitoring for the ART programme (5.2%) and nutrition support for ART patients and directly affected households (10.5%). About 30 percent was spent on impact mitigation with the bulk of the support going towards cash transfer programme for OVC (20%). Policy and coordination support for the NACC accounted for 4 percent of the expenditure. With the anticipated resumption of the World Bank TOWA programme during the financial year 2007/8, an increased budget of USD 15,49 million is projected to be committed to HIV by the UN family at a minimum. Including contributions to be raised from donors in-country by the agencies, this nominal amount can be expected to increase up to USD 17-20 million.

According to UNDP, HIV accounted for 1% of total external development assistance for Kenya in 2005. At that time, some 12% of this was provided by the UN system. This has now fallen, with the great increase in PEPFAR funding, to 2.5% (excluding WB). Thus whatever role the UN is to play must be based upon the UN's unique comparative advantage as primarily a normative knowledge house and technical support institution, rather than as a donor or implementer.

The identification of the UN role under this joint programme design is based on three pieces of analysis:

- A critical self-evaluation of current UN role vis-à-vis the KNASP strategic components and other actors in the areas
- An assessment of UN system work and human resources on HIV, and recommendations for internal capacity improvements with regard to the division of labor
- An analysis of UN comparative advantage for HIV programming .

The details of the three analytical components are presented in table format in Annex 2:

Table 1 examines what other partners and stakeholders are doing, and what the UN system has been doing, with respect to each of the main areas of the KNASP. This analysis helped to identify the key areas where UN system programming should continue or be added.

Table 2 of this Annex frankly assesses current areas of work and key features of Agency activities for HIV, and currently available human resources. Presently, there are only about 14 full-time operational UN personnel working on the ground in HIV.

Based on agreed *Division of Labour* (Annex 3*)* and following a capacity mapping exercise involving the UN agencies operating in Kenya, strengthening and aligning human resources and skill-sets with the requirements of the Joint Programme will be an important and continuous task for UN organizations over the coming years.

Table 3 presents the final analytical component made of the overall UN comparative advantage in HIV programming. In summary, the UN comparative advantage lies in four areas:

- **Up-stream work:** policy, international reference, international credibility, best practice, the normative knowledge base;
- **Consistency:** here for the long haul; a consistent, sustained presence providing a coherent framework and support;
- The **'honest broker':** no political, social, financial, or nationalistic bias; bridging, communicating, facilitating, advocating;
- **Technical Assistance:** providing from within its specialized agencies, or procuring from outside, specific technical assistance.

The Joint UN Programme of Support is thus based primarily upon the operationalization of these comparative advantages.

3 JOINT UN JOINT PROGRAMME OF SUPPORT ON AIDS – ACTING ON KNOLWLEDGE AND DELIVERING AS ONE

3.1 The current situation and UN Reform in Kenya

3.1.1 Need for Joint Programming on HIV

As the previous analyses show, the UN acknowledges that its present approach to HIV is fragmented to a large extent, and that agency skill-sets do not yet meet with expectations under the agreed division of labor. Neither do agencies have a well established, systematic method of allocating and tracking HIV resources and expenditures annually. The reports on the efficiency and effectiveness of joint programming funding modality in Kenya (2005) and the joint programming retreat by the UN in (2006) confirm this. They further confirm that much work still needs to be done to enable each agency to assess its comparative advantage realistically (vis-à-vis its own resource envelop), and to focus on agreed key strategic areas of support and gaps in the national response.

Following the recommendations of the Global Task Team (GTT) Report on Improving AIDS Coordination among Multilateral Institutions and International Donors at the country level, and subsequent instructions from the UN Secretary General to all UN Resident Coordinators, an urgent process was triggered in Kenya to further harmonize and consolidate the UN's response to HIV. The highlights of this process included a plan of action for the establishment of the Joint UN Team on AIDS and development of a Joint Programme of Support on AIDS, together with an accompanying UN Technical Support Plan. The primary aim of the joint programme of support is to better harmonize UN approaches and interventions (including technical support arrangement), and to align them fully behind the national priorities and towards universal access to HIV services.

A difficult and thorny aspect of developing such coherence of support has always been the lack of a common core budget with which to support the joint programme of work of the one UN team on AIDS. Without financial resources made available in common, UN activities in HIV tend to continue to reflect mainly the concerns of individual agencies rather than a strategic joint direction of the system. But this situation has now changed: the new DFID support to the Joint UN Programme provides USD 20 million over 5 years for exactly the kind of core, common funding required. This joint programme proposal, using the DFID funding, to mainly accelerate access to HIV prevention and support services for the NACC has been specifically developed to address the cyclical problem of having to make whatever the UN agencies are working on at the time as the primary departure point for any joint programming effort. Around this core the full Joint Programme is then being designed.

Once operational, it is envisioned that the joint UN programme of support will greatly save staff time and minimize transaction costs and duplications for the national authorities, while maximizing synergies and complementarities among the different UN agencies and national counterparts. This will be achieved through progressively increasing harmonization and alignment of UN programming on AIDS, clear division of roles and areas of responsibility of the different UN entities in relation to partners in the national response, and setting up joint implementation and monitoring mechanisms involving the NACC. There will be agreements on reduced overhead charges for joint programming as further specified in other parts of this proposal. It is expected that all this will translate into improved effectiveness and impact on Kenyan lives in terms of expanded HIV prevention, treatment, care and support, and reduction in new infection levels.

3.1.2 Positioning of Joint UN Programme in UN and national planning frameworks

General principles

The UN family in Kenya remains fully committed to the reduction of poverty and achieving the Millennium Development Goals (MGDs), and fully understands the significance of, and interrelationships among HIV, ill health and poverty. It also remains equally committed to promoting a number of other critical global instruments and frameworks in the HIV sector, including the (2001) UN General Assembly Declaration on HIV/AIDS, the GIPA principle, the (2004) 'Three-Ones' principles, the (2004) 3 by 5 initiatives to roll out treatment in resource poor countries, and the (2005) Universal Access consultation and target setting (see below).

The UNDAF

UN support to Kenya is guided by the overall five-yearly UN Development Assistance Framework (UNDAF), which currently runs from 2004 to 2008. 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.

UNDAF Outcomes 3 and 4: To contribute to the reduction of the incidence and mitigation of the psycho-social and economic impact of HIV/AIDS [malaria and TB]

The HIV components and interventions of the current UNDAF that presently support the KNASP are:

- prevention programmes
- advocacy, communication and resource mobilization;
- improvement of the nutrition and care for people affected by and infected with HIV, TB
- gender mainstreaming in programming, and strengthening of integrated youth friendly sexual and reproductive health services, including procurement of both male and female condoms;
- targeting of HIV/STI/drug abuse prevention activities to the refugees and other special populations (internally displaced persons, uniformed forces, sex workers, truckers, OVC);
- development and implementation of a comprehensive package on VCT;
- accelerated access to AIDS treatment and care, including procurement of ARVs and nutritional support to AIDS patients; and
- support to NACC for national HIV surveillance and operational research, and implementation of the national M&E plan.

The UNDAF is currently undergoing an evaluation, to be completed by December 2007, along with development of a new UNDAF for the period 2008-2012. Some adjustments and further articulation of the present Joint Programme components might be necessary to ensure the indicated short-term and long-term outputs and outcomes are reflected in the new UNDAF.

The Roadmap towards Universal Access

National scaling up toward Universal Access in Kenya is based on the existing national AIDS planning and review processes. Kenya's Roadmap towards Universal Access is guided by the *Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/06-2009/10* (NACC, 2005), which was produced through a comprehensive consultative process. The KNASP is accompanied by a rolling results framework, which is reviewed and modified annually at the Joint AIDS Programme Review (JAPR). The framework identifies the results or milestones to be achieved within each year of KNASP; the milestones serve as performance benchmarks for the national response. The country also has a consolidated national M&E Framework, which sets out core indicators for performance monitoring and evaluation. A detailed M&E Operational Plan outlines mechanisms to be established for continuous and regular tracking and reporting on the performance of the national HIV response. These key national documents and tools form a strong foundation for scaling up interventions and building consensus on the Roadmap towards Universal Access to Prevention, Treatment, Care and Support by 2010.

Through an inclusive consultation in 2006, national stakeholders built a consensus on efforts to scaling up towards Universal Access. The process aimed at identifying critical **obstacles** blocking progress and identifying corresponding solutions to be developed into concrete actions at national, regional and global levels. Accompanied by interim **milestones**, these were formulated into a national plan or **"Roadmap"** for achieving targets, as identified in the KNASP towards Universal Access to Prevention, Treatment, Care and Support services by 2010. The Joint Programme responds directly the roadmap.

3.1.3 Joint UN Team on AIDS

The first step in developing this Joint Programme was the formation of the Joint UN Team on AIDS. The Team is made up of all UN staff working part- or full-time on HIV. This Team, collectively and individually, has the responsibility for developing and implementing the Joint Programme. Team members are nominated by their Agency, and confirmed as team members, with specific responsibilities, by the Resident Coordinator. Responsibilities are derived from the confirmation of the locally-agreed *Division of Labour* for Kenya, by the UN Country Team (see Annex 3).

The Team is divided into four **Technical Clusters**, responding to the four components of the KNASP, each convened and chaired by a **Lead Organization**. The four technical clusters of the Joint UN Team on AIDS are:

- **Prevention**: Lead organization UNFPA
- **Quality of Life**: Lead organization WHO
- **Impact Mitigation**: Lead organization UNDP (mainstreaming), supported by UNICEF (OVC)
- **KNASP Support**: Lead organization UNAIDS Secretariat

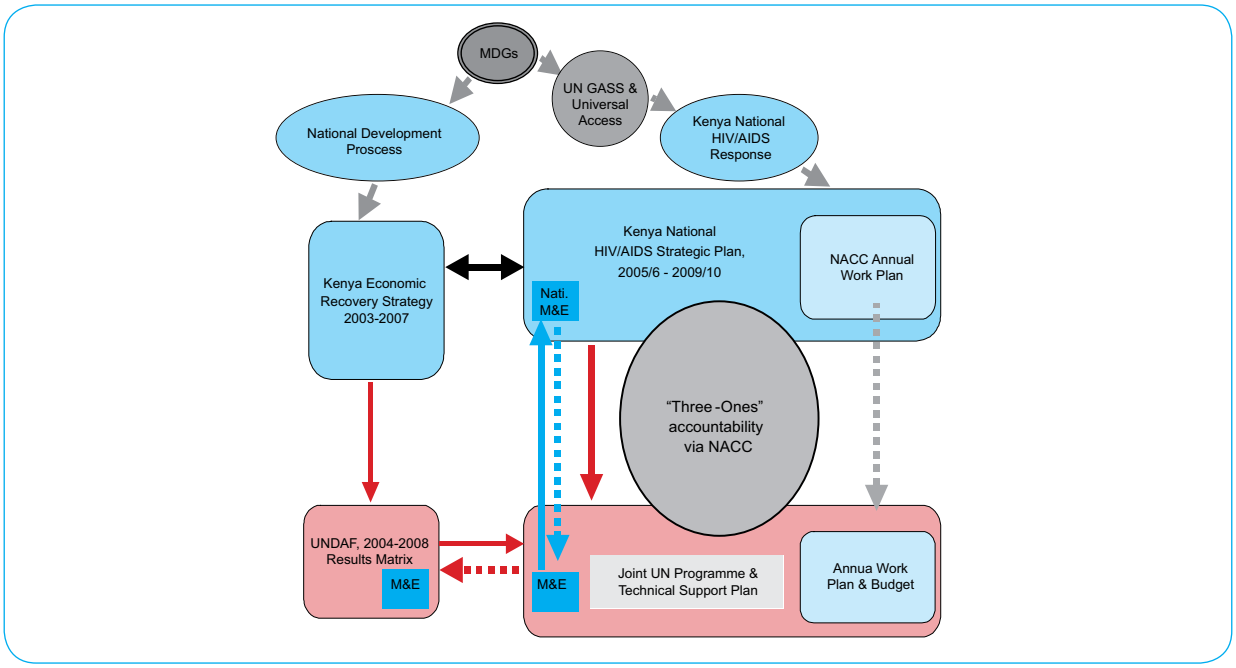
The clusters report progress to the UNCT, through the UNAIDS Country Coordinator, as Chair of the Joint UN Team on AIDS. More details and ToRs for the key actors and groups are in Section 4.1.

3.2 Joint UN Programme of Support on AIDS content and financing framework

3.2.1 Context, partnerships and components

Context:

The accompanying figure illustrates both the context and relationships among the joint UN programme of support, the national development instruments (i.e. Kenya ERS and NASP) and the relevant global instruments.



The Joint Programme also responds directly to the KNASP. Table 5 shows the links between the objectives and components of the KNASP and the Outcomes and Outputs of the Joint Programme.

Partners

The primary partners of the Joint Programme, and the Joint Team, are the government ministries and institutions who work on the national response. A wide range of other stakeholders, however, are also taken into account in the formulation of the Joint Programme and the work of the Joint Team. Not all these are noted in the description of the Joint Programme here; where partners or other programmes are particularly crucial to the work of the joint programme, or are particularly linked with the Team in certain aspects of their work, these are noted. In addition, partnerships where the UN has a key role to play in helping bring about harmonization and alignment are noted.

Components - focus on performance and results

The Joint Programme uses the four objectives of the KNASP as its framework to achieve its goal.

- 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

The following pages describes the Outcomes and Outputs of the Joint Programme (table 5), whereas the rationale for each, objectives set by the thematic teams, the role of the UN, using its comparative advantage, and the milestones to be achieved up to 2012 as further elaborated in Annex 4. These are translated into concrete indicators presented in the Joint Programme Results Matrix (Annex 4). The accompanying operational document further reflects the Results-Based Management framework adopted by the UN system and details Key Results and Main Activities 2007-08, which together with Joint Technical Support Plan for the same period, form the first Rolling Work Plan of the Joint Programme

Table 5: Link between the KNASP and the Joint UN Programme of Support

Priority Areas of the KNASP

KNASP Goals

- **Prevent new HIV infections**
- **Improve quality of life of infected and affected people**
- **Mitigate the socioeconomic impact of HIV**

Joint UN Programme Result Areas

1. Prevention of New Infections

Outcome 1: Reduced number of new infections in both vulnerable groups and general populations:

1.1 HIV prevention becomes evidence -informed and accelerated
1.2 National structures and capacity to manage and coordinate effective BCC programmes in place
1.3 Comprehensive national programme for prevention of mother-to-child transmission (PMTCT) in place and supported by all stakeholders
1.4 Prevention among most-at-risk groups (vulnerable youth, IDUs, sex workers, truckers, prisoners, MSM) and populations of humanitarian concern advocated and scaled up as part of the national response
1.5 National condom programme strengthened and supported with procurement and distribution of male and female condoms

2. Improvement of Quality of Life for Infected and Affected People

Outcome 2: Improved treatment and care, protection of rights and access to effective services for infected and affected people:

2.1 Quality and equity of national AIDS -related treatment services (including commodities forecasting and distribution) effectively strengthened
2.2 Coherent interface between TB and HIV -related services is established and maintained
2.3 Comprehensive national service delivery framework for the continuum of treatment and care for HIV -exposed children established
2.4 Approach for HIV care in community setting standardized
2.5 Nutritional clinical care and support integrated into AIDS -related treatment services
2.6 Strengthened framework in place for protection of human rights in the context of HIV

3. Mitigation of the Socio-economic Impact of HIV

Outcome 3: Existing programmes adapted and innovative responses developed to reduce the impact of the epidemic on communities, social services and economic productivity:

3.1 HIV mainstreamed in development budgets as articulated in MTEF and district development plans
3.2 National OVC Plan of Action is operationalized and conditional cash transfer pilot and other sustainable livelihood interventions targeting orphans scaled up
3.3 HIV and AIDS integration strategy in private and informal sector developed and implemented
3.4 HIV mainstreamed in six priority sector plans (education, health, agriculture, transport, security, law and order)

4. NACC/KNASP Support Services

Outcome 4: 'Three Ones' effectively functioning as the basis for all programming and resource allocation in support of the national HIV response:

4.1 NACC equipped with coordination capacity and support services necessary for effective delivery of a multi-sectoral response to HIV
4.2 Evidence –informed and harmonized processes for KNASP planning and implementation in place
4.3 Synchronized national HIV response M&E system and robust strategic information utilization mechanism in place
4.4 Consolidated technical support management system in line with the KNASP designed and implemented
4.5 Increased and coordinated contribution of the UN system to the national HIV response

3.2.2 Joint Technical Support Plan: Towards effective technical support delivery and management

The technical support component of the Joint UN Programme of Support on AIDS

The technical support (TS) component of the Joint UN Programme of Support on AIDS forms part of the National Technical Support Plan and complements other mechanisms for technical support provision, such as technical support financed by DFID through AMREF to strengthen civil society partners' contribution to the KNASP and selected technical assistance to be implemented by NACC through a specific component of the TOWA project.

Technical support to be provided as part of the Joint UN Programme of Support on AIDS can be divided into three categories with the first two being directly linked to NACC based on its annual consolidated technical support plans, and the third linked to the Joint UN Programme itself and technical support requirements within its implementation.

1) Programmatic technical support for NACC – technical support towards components of the NACC/national Technical Support Plan pertaining to core technical implementation of the KNASP priority areas 1, 2 and 3 (Prevention, Improvement of Quality of Life for Infected and Affected, Mitigation of Socio-Economic Impact)

2) Institutional technical support for NACC –technical support towards components of the NACC/national Technical Support Plan for capacity development, coordination and management of the national HIV response based on KNASP priority
area 4

3) Internal Joint Programme Technical Support – TS in support of implementation of the components of the Joint UN Programme of Support on AIDS, both its technical and coordination/management aspects

All the types of technical support provided under the Joint UN Programme will be captured in the UN Technical Support Plan, which will be used as a basis for monitoring and evaluation (Accompanying operational document contains the Joint UN Technical Support Plan for July 2007- December 2008).

Building capacity for sustainable management of Technical Support

To avoid duplication and inefficiency in the provision and management of technical support, a NACC Annual Technical Support Plan will be developed with contributions sought from a wider range of development partners. While the core work will be carried out with support through the Joint UN Programme, this will be complemented by resources from other development partners, as well as the UN system through other resources for specific components of the plan.

Similarly, levels of required funding will be managed in the planning and implementation of technical support through strategic prioritization and maximization of local technical support and development of relevant skill sets among stakeholders already present in the local context. Support for this capacity building is reflected in Output 4.4 of the Joint UN Programme.

Maintaining a level of flexibility in technical support provision will be necessary. In addition to the planned TS components, the Joint UN Programme contains a small 'flexi fund', which can be used to cover urgent TS needs emerging in the course of annual implementation of the KNASP, based on request by NACC.

3.2.3 Budget of the Joint UN Programme of Support on AIDS, 2007-2012

The UN system in Kenya is in the process of finalizing a Joint UN Programme of Support on AIDS that is fully aligned with the Kenya National HIV/AIDS Strategic Plan, 2005/6 – 2009/10. Total budget for the Joint Programme is estimated at USD 93.3 million for the period 2007-2012 (table 13). Out of this amount, USD 38.6 million is projected to be covered through internal UN sources and 20 million is requested from DFID. The remaining USD 34.7 million unfunded balance is expected to be covered by existing commitments/pledges and through joint resource mobilization from external donors.

The joint programme will be supported by one UN team on AIDS and will have one work plan and core budget contributions from the UN, DFID and other interested donors. At country level, UN fundraising for HIV will be restricted to the contents of the joint programme. There will be strong advocacy with the donors to that effect.

Budget: Joint UN Programme of Support on AIDS, 2007-2012

KNASP Priority Area 1: Prevention of new infections	Total budget 2007-2012	UN resources[2] 2007-2012		Unfunded[3]
		Per annum (average)	Total 2007-2012	
1.1 HIV prevention acceleration	10,000,000	240,000	1,200,000	8,800,000
1.2 National BCC structures and programmes	15,000,000	1,000,000	5,000,000	10,000,000
1.3 PMTCT	2,000,000	100,000	500,000	1,500,000
1.4 Prevention among most-at-risk groups	10,000,000	800,000	4,000,000	6,000,000
1.5 National condom programme and procurement [4]	15, 000,000	2, 440,000	12,200,000	2,800,000
Sub-total	**52,000,000**	**4,580,000**	**22,900,000**	**29,100,000**

KNASP Priority Area 2: Improvement of Quality of Life	Total budget 2007-2012	UN resources 2007-2012		Unfunded
		Per annum (average)	Total 2007-2012	
2.1 Quality and equity of AIDS –related treatment services	3,000,000	250,000	1,250,000	1, 750,000
2.2 Coherent interface between TB and HIV related service	1,000,000	100,000	500,000	500,000
2.3 Service delivery framework for HIV exposed children	1,400,000	50,000	250,000	1,150,000
2.4 AIDS-related care in community setting	4,000,000	150,000	750,000	3,250,000
2.5 Nutrition and AIDS-related treatment services	8,000,000	1,000,000	5,000,000	3,000,000
2.6 Protection of human rights of HIV infected and affected	2,000,000	250,000	1,250,000	750,000
Sub-total	**19,400,000**	**1,800,000**	**9,000,000**	**10,400,000**

KNASP Priority Area 3: Mitigation of socio-economic impact	Total budget 2007-2012	UN resources 2007-2012		Unfunded
		Per annum (average)	Total 2007-2012	
3.1 HIV mainstreaming in development and financing	1,500,000	250,000	1,250,000	250,000
3.2 National OVC Plan of Action and conditional cash transfer	10,000,000	500,000	2,500,000	7,500,000
3.3 HIV integration strategy in private and informal sector	200,000	40,000	200,000	0
3.4 HIV mainstreaming in six priority sectoral plans	1,800,000	110,000	550,000	1,250,000
Sub-total	**13,500,000**	**900,000**	**4,500,000**	**9,000,000**

KNASP Priority Area 4: Support services	Total budget 2007-2012	UN resources 2007-2012		Unfunded
		Per annum (average)	Total 2007-2012	
4.1 Strengthening of the National AIDS Control Council	500,000	20,000	100,000	400,000
4.2 Improved KNASP planning and implementation	500,000	20,000	100,000	400,000
4.3 HIV response M&E system and strategic information	800,000	40,000	200,000	600,000
4.4 Consolidated technical support management system	4,250,000	100,000	500,000	3,750,000
4.5 Effective UN contribution to the national HIV response	1,700,000	260,000	1,300,000	400,000
Sub-total	**7,750,000**	**440,000**	**2,200,000**	**5,550,000**

Unallocated	650,000	0	0	650,000
Total UN budget (excl. World Bank)	**93,300,000**	**7,720,000**	**38,600,000**	**54,700,000**
7. Financing of KNASP/ NACC (World Bank)[5]	68,000,000	13,600,000	68,000,000	0
UN Total , incl. World Bank	**161,300,000**	**21,240,000**	**106,600,000**	**54,700,000**
8% administrative cost (AA fee 1%, organization overheads 7%) applies across the Joint Programme budget, unless alternative arrangements are explicitly agreed on for specific items				

2 Estimates based on 2003-2006 trend analysis on utilization of funds mobilized at global and regional levels, including organizational core resource allocations, but excluding the World Bank financial resources. Also excluded are current funds received at country level (DFID –supported conditional cash transfer programme, PEPFAR contribution to PMTCT, SIDA and Italian Government contributions).

3 Includes existing commitments from external donors and remaining balance to be raised

4 Includes USD 12 million from World Bank for condom procurement through UNFPA.

5. See footnote #3 earlier. The total amount of loan to be provided by the World Bank is USD 80 million.

4 IMPLEMENTATION AND MANAGEMENT ARRANGEMENTS OF THE JOINT PROGRAMME — NURTURING JOINT ACCOUNTABILITY AND RESULTS-BASED MANAGEMENT

4.1 Management Arrangements

Management of the joint programme will be linked to the overall co-ordination structure of the UNDAF and the Joint UN Team on AIDS, as described below. The UNCT will have primary responsibility for the implementation of the joint programme. Each participating UN organization – working through the Joint UN Team on AIDS, UNAIDS Secretariat and the Administrative Agent (AA) – will contribute to prepare an integrated annual work plan (AWP) and budget, covering the mutually agreed parts of the proposal. The UNAIDS Secretariat and Joint Team will ensure that the AWP is prepared in close consultation with the NACC, NASCOP and others. Each of the programmatic areas of the AWP will be developed taking into account comparative advantages and different expertise the collaborators bring to the table. Emerging issues, challenges and gaps identified through the JAPR and NACC MCGs will be integrated. Synergies within and between the expected outcomes will be built into the programme design through a joint planning process.

With facilitation from the UNAIDS Secretariat, the AA formally submits the consolidated AWP to the UNCT for approval. Based on the approved AWP, funds are then channeled to the participating organizations on a quarterly basis. Implementation of the approved activities is then undertaken through the combined effort of the lead and contributing UN organizations and their national implementing partners (including CSOs). Apart from implementation interventions, the UN will engage in sustained provision of technical expertise to the national HIV response in the areas identified. On behalf of the country HoAs, individual members of the Joint UN Team on AIDS will be responsible for facilitating aspects of the joint programme and can be called upon, and be expected, to participate in supporting strategic response management and coordination activities.

4.1.1 Roles and responsibilities of Joint AIDS Team groups and actors

(for specific separation of roles and responsibilities, please refer to UNDGO 2006 Guidance Paper on Working Mechanisms for the Joint UN Team on AIDS at Country Level)

1. Lead UN organization for each strategic outcome or cluster

There are four major working groups of the Joint UN Team on AIDS convened and chaired by agreed UN Lead Agencies as follows: UNFPA for Prevention, WHO for Quality of Life, UNDP for Impact Mitigation (mainstreaming) with support from UNICEF (OVC) within the same cluster, and UNAIDS Secretariat for NACC/KNASP support. The ***cluster conveners*** report progress to the UNCT through the UNAIDS Country Coordinator, as Chair of the Joint UN Team on AIDS. Below are their ToRs:

- Convenes and chairs work planning meetings on the designated sub-working group
- Organizes quarterly and annual review meetings, including periodic joint monitoring activities and review of financial reports from participating UN organizations
- Communicates with participating UN agencies and other partners to monitor and follow-up on the implementation of activities as agreed upon in the AWP
- Acts as an entry point of contact or liaison for external partners (government, donors, NGOs, etc.) for the designated outcome area, and ensures that the concerned UN organizations and development partners are kept abreast of the latest programme and field implementation issues
- Brokers related technical support requests for national authorities and other partners
- Consolidates quarterly, six-monthly and annual programme progress reports to be submitted to the UNCT, through the Joint Team

2. Each participating UN agency or their Joint UN Team on AIDS member

- Contributes to the development of the AWP and budget
- Ensures timely implementation of designated activities under the AWP
- Ensures financial and programme accountability for resources entrusted to the individual participating organization
- Monitors outcomes, indicators, and programme targets as indicated in the AWP, including field visits to ensure effective overall management of the programme implementation
- Regularly participates in sub-group meetings, reviews and related activities
- Contributes to prepare progress reports to be submitted to the Lead UN organization for consolidation and onward transmission to the UNCT

3. Technical Leader for Thematic Areas, Working Groups, Taskforces, Committees and Forums

In terms of process, the Technical Leaders are identified for each of the known or existing thematic or task groups under the national response coordination arrangement, in line with the agreed division of labor among UNAIDS cosponsors at the country level. The UNAIDS Secretariat, in consultation with the Joint Team, periodically reviews and assesses the workings of the focal point system with a view to suggesting necessary changes and updates to the list of thematic areas, task groups, etc. and their assigned Technical Leaders. As with all key assignments of the Joint Team member, the Technical Leaders' responsibilities are included in the designated staff members' terms of reference, performance appraisal and work plan. The UNAIDS Secretariat ensures that the Technical Leaders are copied on relevant documents that will enhance their knowledge and ability to perform the assigned responsibility (e.g. meetings and workshops invitations, and trip/meeting reports). Below are ToRs for the Technical Leaders:

- Attend or arrange the attendance of relevant meetings, events and activities associated with the assigned thematic areas or groups.
- Serve both as a single entry and reference point for the latest information on the thematic area of concern, and provide technical support to the group or thematic area as necessary.
- Speak on behalf of the UN system and respond to queries and requests for information on the thematic area, in collaboration with the relevant Joint Team members and UNAIDS Secretariat, if and when necessary.
- Consult with other Joint Team members and UNAIDS Secretariat when contemplating a UN system-wide viewpoint or interests related to the thematic area or work group.
- Ensure that relevant key information on the thematic area is shared with concerned Joint Team members, UNAIDS Secretariat and Cosponsors level to enhance country support. The Technical Leader will have the responsibility to determine the type of information to be shared.

4. UNAIDS Country Coordinator as head of the Secretariat and leader of the Joint UN Team on AIDS

- Works with the concerned Technical Leaders and UN Lead Organizations/Conveners for strategic clusters to ensure effective functioning of the sub-working groups or thematic areas, and facilitates work relationship across participating organizations and sub-groups to follow up on implementation of the programme
- Ensures periodic review and update of the joint programme and identifies obstacles and solutions to agreed outcomes and outputs; and where necessary, conducts joint monitoring and evaluation on the supported interventions
- Regularly reports the programme implementation progress to the UNCT
- Provides technical advice to the UNCT and recommends allocation and re-allocation of resources
- Operationalizes problem solving interventions, in line with decisions of the UNCT
- Harmonizes and aligns the joint programme activities with the broader joint UN programme of support on AIDS
- Serve as an overarching common entry point for DFID, NACC, other donors and partners in the programme, and provides links to external problem-solving mechanisms and technical support facilities

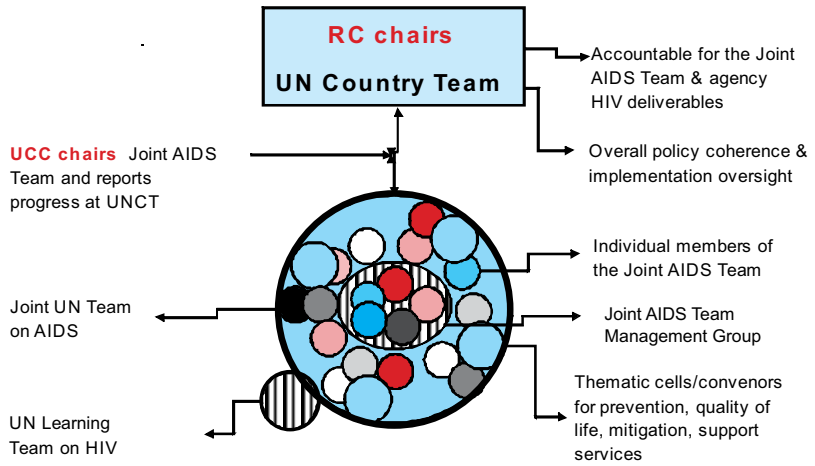
4.1.2 Accountability mechanism for the Joint UN Team on AIDS

The Joint UN Team on AIDS will work under the day-to-day facilitation and leadership of the UNAIDS Country Coordinator, guided and supported by the UN Resident Coordinator and Country Team members. Individual members will be held accountable for fulfilling their assigned roles and responsibilities within the Joint UN Team on AIDS. Individual performance assessment will take into account time and technical contribution to the Joint UN Team on AIDS. The UN Resident Coordinator and respective Heads of Agency (HoA) will use existing accountability frameworks and individual organization processes. Specifically:

- Through the HoA, Joint UN Team on AIDS members' agreed annual key deliverables under the joint AWP will be reflected in their respective agency performance appraisal system.
- The Resident Coordinator, together with the UCC, contributes to the performance assessment review of the Joint UN Team on AIDS members' *vis-à-vis* the AWP.
- The Resident Coordinator and UCC's assessment of the Joint UN Team on AIDS members' performance will be part of their annual institutional performance appraisal system
- The Joint UN Team on AIDS's performance and outputs (including performance on the DFID support) will be reviewed annually with the national authorities and other partners, supplemented with an internal UN mid-year review of the Joint Team as a whole

In line with directives from the UN Secretary-General (December 2005), the UN Resident Coordinator has responsibility and overall accountability over the operations of the Joint UN Team on AIDS, as indicated in the diagram below. Previous to the decisions taken at the April 2007 UNCT retreat to further enhance system-wide coherence on HIV actions, direct accountability over the affairs of the Joint Team rested with the Theme Group on HIV (or an agreed Head of Agency) with delegated leadership from the Resident Coordinator.

Kenya: UN Leadership Structure on HIV



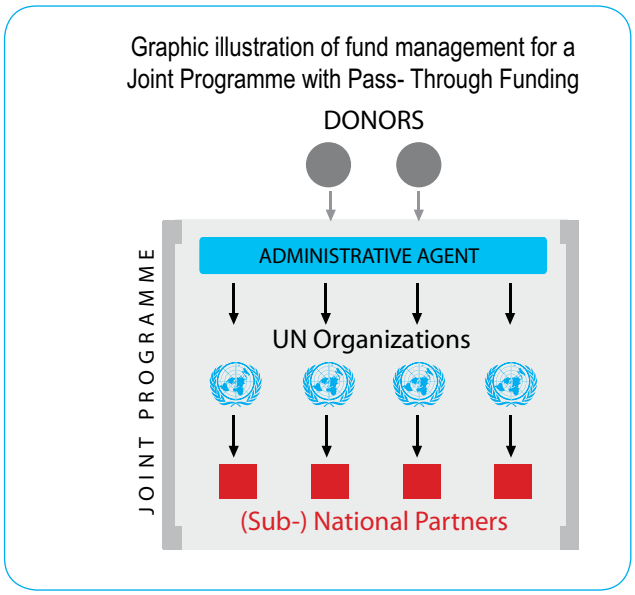
4.1.3 Fund management and resource flow

UN organizations participating in joint programmes are required to select from among themselves an AA, taking into consideration the following elements: i) country presence; ii) financial and administrative capacity to interface between the donor and participating UN organizations, iii) thematic and functional expertise in HIV, iv) on-the-ground experience with AA functions, and v) competitive AA fees. Using this criteria and process, the UNCT in November 2006 unanimously selected UNDP to serve as the AA for the joint programme. This means that funds from donors will be channeled to UNDP as AA, and then UNDP in turn would channel the resources to the other participating UN agencies (including to itself), based on a common AWP and budget to be approved by the UNCT. This is known as the Pass-Through Fund Management mechanism (see illustration below), which typically pertains to situations where several UN organizations develop a joint proposal, identify funding gaps and submit a joint programme document to a donor.

4.1.4 Financial accountability, audit and administrative costs

As indicated, the UNCT will be accountable to donors for the funds, through the AA. Authorized by the UNCT, UNDP as AA will negotiate and sign a Letter of Agreement with donor in respect of the joint programme (in operational document). UNDP as AA will also sign a Memorandum of Understanding with the participating UN organization (in operational document), under which each organization will have the responsibility to programme and manage the allocated funds in line with its established regulations and rules. In other words, both programmatic and financial accountability will rest with the participating UN organizations. This is elaborated further in the accompanying operational document.

Funds received from donors will be recorded by UNDP as AA in a joint programme account. UNDP as AA will not record funds channeled to other participating UN organizations as income. UNDP as AA will only record as income those funds for which it is programmatically and financially accountable (i.e. for its part of the joint programme as a participating organization).



Consistent with accounting for the funds distributed by the AA in respect of its own component(s) of the programme, each UN organization will also be responsible for auditing its own contribution to the programme in accordance with its existing regulations and rules. Audit opinions of the individual UN organizations should be accepted by the other UN organizations and by donor.

Given the nature of the AA functions envisaged, the UNDP as AA will be authorized by the UNCT to allocate 1 percent of the amount contributed by the donor (with no ceiling), for its costs of performing the AA's functions. The anticipated work load of the AA will entail passing funds at least twice a year to seven executing UN organizations (i.e., excluding the UNAIDS Secretariat and possibly other smaller UN organizations, which currently operates a multiple transaction-based cost recovery arrangement with UNDP).

Additional to this AA fee, each participating UN organization will be expected to recover its own indirect costs in accordance with its financial regulations and rules, and as documented in the Memorandum of Understanding signed with the AA. In the past, because of the differing nature of mandates and expertise required, the rate of cost recovery varied between UN organizations. However, the UN Development Group Management Group (representing UNDP, UNICEF, WFP and UNFPA) recently agreed to levy their administrative fee for such joint activities at 7 percent across the board. Subsequently, the WHO office in-country has officially agreed to this 7 percent levy, with less formal concurrence UNHCR, UNODC and UNAIDS Secretariat – would also follow suit.

Hence, in total and including the administrative costs of the AA, a UN system administrative cost of 8 percent can be expected to apply to the donor contribution. This is a highly competitive overhead cost by any standards, and translates to a potential net savings for programme activities, as compared to the use of a traditional parallel funding mechanism to reach the participating organizations. What is more, it may actually cost donors significantly more to go through government or civil society organizations to execute the contributions.

4.2 Monitoring, evaluation and reporting

4.2.1 M&E of the Joint UN Programme of Support on AIDS

The UNAIDS Secretariat, working through the Joint UN Team on AIDS, will be responsible for undertaking the programme monitoring, evaluation and reporting to the UNCT to feed into the NACC-led JAPR process. Therefore, working closely with the NACC and other key government and CSO partners, the Joint UN Team on AIDS will use the following four elements to monitor performance of the donor support, and ensure it is fed into the NACC M&E system and process:

1. Rolling Annual Work Plan and Budget
2. Six-monthly Financial and Programme Implementation Progress Report
3. Full Annual Progress Report – linked to NACC JAPR process
4. Mid-Term Review (MTR) to be conducted after three years of funding

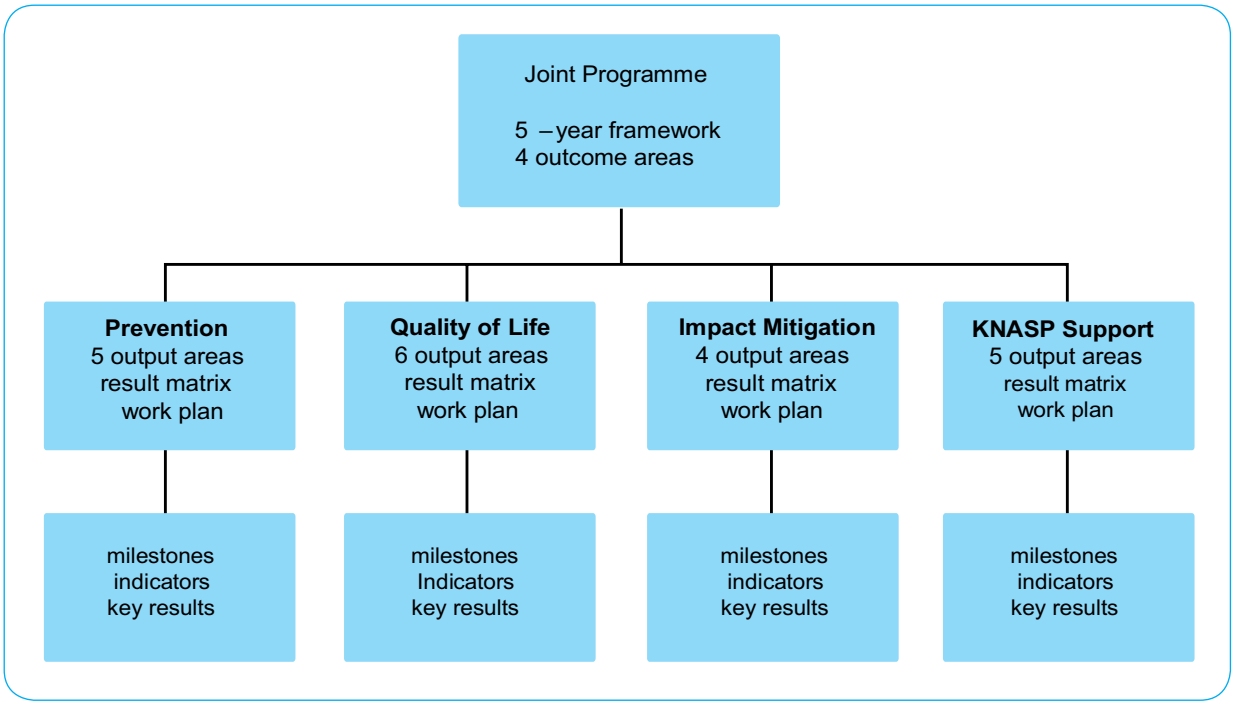
In terms of division of labor, each participating UN organization will prepare both financial implementation and progress reports in accordance with its financial regulations and rules. In addition to the financial reports prepared by the participating UN organizations, UNDP as AA will also prepare consolidated financial reports consisting of its disbursements to the participating organizations over the reporting period. These different reports and inputs will then be consolidated by the UNAIDS Secretariat and the Joint Team to highlight key issues, achievements, lessons learned and recommendations for future action. Subsequently, and following a technical review by the Joint UN Team on AIDS, the UNAIDS Country Coordinator will present the final report to the UNCT for final review and approval, and onward transmission to NACC and the donor by the UNDP as AA, on the behalf of the UNCT. NACC and donors may be invited to internal UN reviews to appraise programme progress. At the request of NACC or the donor, the final consolidated report may annex individual reports from all agencies.

To compliment the standard MoU and Letter of Agreement documents as guiding principles to the management of the Joint Programme, a detailed elaboration on the step-by-step application of the cash flow and financial management arrangements is provided in Annex 6, using the donor –funded elements of the Joint Programme as an example.

4.2.2 Linking with UNDAF and the KNASP/NACC results matrix and JAPR process

The Outputs, Milestones and time-bound Key Results from the Work Plan are used to produce progress reports every six months (internal) and annually (external). Through a comprehensive Results matrix, these will be linked with indicators from the KNASP M&E Framework to show the contribution of the UN. The Joint UN Programme Result Matrix is presented in Annex 5.

The below graph demonstrates the range of components and tools at the different levels of the Joint Programme design, against which systematic monitoring and evaluation will be carried out.



4.2.3 Risk analysis

Table 7 articulates and elaborates on the likely internal/external risks to be associated with the Joint Programme, and the ways in which these could be mitigated accordingly.

Table 7: Analysis of internal and external risks factors to the Joint UN Programme and mitigation measures

Potential internal risks	**Risk mitigation**
Inadequate commitment of the UN agency heads, and especially the UN Resident Coordinator to joint programming *(low probability, high impact)*	Commitment of all HoA officially sought prior to signature of MoU and HoA/agency-specific accountabilities built into the programme Commitment and full support of the UN Resident Coordinator established prior to programme development process
Choice of an AA and the percentage of individual UN organization administrative fee are potential sources of misunderstanding and conflict in joint programme activities *(low probability, medium impact)*	Standardized rates and ceilings have been negotiated with all participating agencies beforehand Explicit instructions from UN Development Group to ExCom agencies (UNICEF, UNFPA, UNDP and WFP) to apply agreed ceilings for joint programming are expected at country level prior to implementation of the joint programme in Kenya
Inability of the UN system participating organizations to agree on joint content/agenda, division of labour and resources *(low probability, medium impact)*	Division of Labor based on global guidance with local adaptation already agreed on based on local UN system capacity analysis Strengthened coordination mandate of the UNAIDS Secretariat has been communicated to, and endorsed by all participating organizations
Inability of the UN system participating organizations to work together, communicate effectively and deliver in a timely manner against the joint programme *(high probability, high impact)*	M&E, accountability and systematic consultation mechanisms to be put in place for early 'diagnosis' of any problems Involvement of the Regional Directors Team (RDT) in accelerating translation of the agency commitments to joint programming into action at country level Global Implementation Support Team (GIST) in place and on stand-by to support problem solving at country level
Lack of critical human resource mass, especially within the UNAIDS Secretariat and certain UN organizations, to drive the joint programming agenda across agencies, and to programmatically follow-up and report on this substantial infusion of funds. (See Annex 1 on analysis of current HIV capacity within the UN) *(low probability, high impact)*	Capacity analysis conducted on the ability of the participating agencies to perform at required level includes recommendations and conditions to be met by the agencies in terms of staff retention/ recruitment prior to signing of MoU. This has been presented to, and committed to by the HoA. Continuous performance monitoring system and programmatic M&E in place
Resistance by agencies due to the restrictiveness of their current programmes as well as modus operandi • Appropriate synergies may not be built between the elements of the joint programme • Joint team agency members managing HIV within the agencies would be spread thin, caught between managing two or more parallel programmes and wearing multiple hats *(medium probability, high impact)*	Continuous focus on progressive harmonization and increased pooling of resources within the UN system. Incentives for joint programming need to be visible for individual agencies Continuous involvement and peer review of Heads of Agencies (HoA) through the Theme Group and technical staff through the Joint UN Team on AIDS

Potential external risks	**Risk mitigation**
Overall poor credibility and image of NACC with the public and donors *(low probability, high impact)*	NACC has effectively 'renewed' itself through a series of actions resulting in a more transparent structure and improved modalities for stakeholder participation and representation
Future financing of NACC, and the uncertainty surrounding the approval of the World Bank funded TOWA programme • Shared risk with DFID through its planned contribution to TOWA *(medium probability, high impact)*	Mainstreaming HIV into the MTEF, ERS and other relevant financing and development instruments to increase GoK financial input into HIV response Improved NACC grant eligibility through institutional strengthening measures
Delays in DFID programme start-up • Likely gap in time between the end of DFID's HAPAC III and the commencement of a successor programme *(high probability, medium impact)*	Need to clarify expected date of commencement and develop an intermediate plan to meet urgent requirements regarding the proposed programme areas
Possible dilution of DFID's active and visible role in the local HIV scene • Absence of major donors is especially problematic for advocacy and practical work towards increased harmonization and alignment *(high probability, medium impact)*	Issue has been discussed with DFID, who are looking to address the need for physical presence at key junctures to compliment their financial support
Any abrupt suspension or discontinuation of support by DFID will constitute a major risk factor for the UN *(low probability, high impact)*	Issue has to be discussed explicitly and a good understanding achieved between DFID and the UN prior to the signing of MoU
Failure to effectively and meaningfully mainstream HIV into Health Sector planning and implementation (70% of response carried out by health sector) would be detrimental to expected outcomes *(low probability, medium impact)*	Urgent and aggressive engagement by NACC in the Health SWAp and public sector (health) planning processes supported by UN partners
Change in the funding environment if U.S. policy changes results in decreased funds currently made available *(low probability, high impact)*	Immediate TS to NACC to explore alternative financing mechanisms and expansion/diversification of external funding sources
Financing of male condoms, one of the core interventions, not addressed/agreed to be covered through any specific source of funding *(high probability, medium impact)*	Need to clarify funding status with key stakeholders and come up with emergency and medium-term plans
Decrease in the level of funding available for critical technical assistance to the national response *(high probability, medium impact)*	Compensatory measures built in the UN TS facilitation mechanism (maximization of local TS and skills transfer) Diversification of TS partnerships through development and wide dissemination of NACC annual TS plan

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ANNEX 1- 2

SUPPORTING ANALYSIS INFORMATION

ANNEX 1: UNDERSTANDING HIV TRANSMISSION IN KENYA

This annex contains three analytical components leading to better understanding of transmission dynamics in Kenya. These are:

- An analysis of the factors contributing to transmission in various localities, to give a sense of the geographical diversity of the epidemic (table 1);
- A table showing key indicators and data for prevention of new infections (table 2);
- Analysis of perceived sources of new adult HIV infection in Kenya (Table 3).

Table 1: Factors contributing to HIV sero-conversion risk in different localities

LOCATION	BROAD HIV RISK ANALYSIS
Main urban hubs	Mombasa, Nairobi and Nakuru witness combinations of all the high risk behaviours. They also have large vulnerable populations, such as the children living on the street, slum dwellers and internally displaced persons (IDP).
Mombasa-Kampala highway	There are an estimated 8000 female sex workers on the trans-Africa highway from Mombasa to Kampala. Based on annual numbers of different sexual partners per female sex workers at 129, annual numbers of sexual acts per FSW at 634, percentage of sexual acts protected by condom use at 77.7 percent, estimated 3200–4148 new HIV infections occur on this portion of the trans-Africa highway in 1 year. Large portion of HIV prevalence and high-risk behaviours in the provinces are found along this major transport route, especially in close proximity to main truck stops like Mariakani, Mlolongo, Busia and Malaba and major urban hubs like Mombasa, Nairobi, Nakuru and Kisumu.
Nyanza Province	HIV prevalence in Nyanza province is significantly higher than elsewhere in the country, apart from Nairobi. Its proximity to, and interaction with the HIV epicenter across the border in Uganda, traditional practices (such as non-circumcision of men), transactional sex linked to the fishing industry on the shores of Lake Victoria have all been presented as contributing factors to this state of affairs. HIV prevalence is not uniform within the province but pockets of higher prevalence exist.
Nairobi Province	The province consisting of the bustling capital city and its environs has much higher HIV prevalence than the provinces surrounding it. Although availability of preventive commodities and services is high, large part of the population live below poverty line in informal settlements such as Kibera, with limited access to essential information and services.
Coast Province	Some of the contributing factors for HIV prevalence in the province covering much of Kenya's coastline are relatively high levels of injecting drug use and sex work linked to the transport/trade industry and tourism. Intravenous drug users have probably highest concentration of HIV, after commercial sex workers and the two are also often linked. Engagement in sex work or transactional sex starts at young age increasing the risk to youth, especially girls.
Rift Valley Provinces (North and South)	Risk behaviours linked with proximity to the main highway between Kenya and Sudan, which is also used by supply trucks to Lokichoggio refugee camp, are likely to contribute significantly new infections, especially in truck stop locations like Kapenguria. Athough overall prevalence in the province is lower than national average, the main urban hub in the province, Nakuru, witnesses somewhat higher rates likely due to high risk behaviours (IDU, CSW).
Western Province	The province provides a gateway between Kenya and Uganda and, while the border posts themselves might not be major hubs for high-risk activities, the general economic mobility contributes to HIV prevalence in the province.
Central province	Lower than national average prevalence, but somewhat higher in main hubs like Nyeri. High level of male circumcision is likely to provide significant protective factor regarding HIV transmission.
Eastern Province	Lower than national average HIV prevalence, but somewhat higher in main hubs like Embu, Meru and Isiolo.
North-Eastern Province	Relative isolation and being populated mainly by muslims who also practice male circumcision are likely contributors to the very low HIV prevalence in this region. Recent drought and flooding have increased general vulnerability among its population and likely contribute to increased migration into other parts of the country.

Table 2: Key indicators and data for prevention of new infections[1]

1. Knowledge of HIV prevention	• 58 % of women and 70 % of men reported knowing that the risk of HIV infection can be reduced by using condoms and limiting the number of sexual partners. However, only 26.5 % of women and 39.5 % of men had 'accepting attitudes to PLHIV' • Generally, messages targeted at young people aged 14-24 are poorly adapted to their lifestyles and info needs
2. Age at first sex	• Median age at sexual debut rose from 16.7 in 1998 to 17.8 in 2003 for women
3. Knowledge of HIV status	• Number of VCT sites has increased from 650 to 840, and the number of people benefiting has also gone up dramatically from about 440,000 to 760,000 in 2006 • Up to 15 % of women and 16 % of men in the age group 18-49 had been tested and counseled for HIV, with majority having received their results • Between 400,000 – 500,000 couples in Kenya are discordant
4. Feminization of the epidemic and vulnerability of young women	• 65 % of people living with HIV in Kenya are women, which significantly higher than the regional average of about 50 % • HIV prevalence in women 15-49 years of age is 8.7 %, compared to 4.6 % in men of the same age group • Infection rates for women dramatically worsens among young women 15-19 years of age, with infection rates that are six times higher than among young men of the same age group • Prevalence rate among women peaks at 25-29 years, while for men peak occurs at 40-44 years • Married couples have significantly higher HIV prevalence (8% for women, 7 % for men), compared to single (i.e. never married) women (5. 6%) and men (1.6%). In a mature (and generalized) epidemic, regular partner is often 'higher-risk' partner • HIV prevalence is high among widows (31.8 %) and divorced/separated women (14.6 %) • Up to 16 % of women surveyed in 2003 reported having been sexually violated. However, HIV prevalence among them was generally not higher than among those who did not report sexual violence • 30 % of young women (15-19 years) reported having had experience a form of physical violence. Connection to HIV prevalence or (direction of) causal relationship has not been established • Only 2 % of antenatal clinics in Kenya provide youth-friendly services
5. Condom use	• Percentage of adult Kenyans who reported more than one sexual partner in the last 12 months declined from 4.2 % among women and 24.1 % among men in 1998 to 1.8 % and 11.9 % respectively, in 2003 • 18 % of women and 40 % of men reported engaging in higher-risk sex (i.e. with non-marital, non-cohabitating partner) in the previous 12 months. While HIV prevalence among women who reported higher-risk sex was 17.2 % vs. 8.3 % among those who did not, surprisingly among men those who reported higher-risk sex prevalence was 4.7 % vs. 6.7 % among those who did not • Among the young women and men (15-24 years), 30 % of women and 84 % of men reported engaging in higher-risk sex • 24 % of the women and 47 % of the men reported condom use in last higher-risk sex • It is estimated that increasing condom use from 77.7 % to 90 % could prevent almost two-thirds of new infections among sex workers and clients along the Mombasa-Kampala highway
6. Prevention of mother to child transmission (PMTCT)	• About 1.0 million pregnant Kenyan women in total need to be reached annually with routine offer of HIV testing and counseling in connection with PMTCT. Approximately 86,000 of this total would further need to be reached with prophylaxis/interventions to prevent mother-to-child transmission • In 2004, 40 percent of all women visiting the ANC were reached with PMTCT services • Between April 2005 and March 2006, at least 440,000 pregnant women benefited from HIV testing and counseling within the context of the US Government -assisted PMTCT programme
7. Most-at-risk groups *(note: Important to recognize that belonging to any group does not in itself increase risk, which is always linked to individual behaviour)*	• 6 % of women aged 15-49 reported having received money, favors or gifts in return for sex in the past 12 months; among girls 15-19 years of age, the figure rises to 16 % • 3.5 % of young men aged 15-24 reported having paid for sex in the past 12 months, while for men aged 15-49 the total figure is 2.9 % with 65 % reporting condom use • Kenya has estimated 80,000 female sex workers, with infection levels up to 60 % (Nairobi). However, while HIV prevalence was 4.3 % among men who reported having paid for sex in the past 12 months, it was 4.9 among those who reported not having paid for sex • Estimated 600 male sex workers work in Nairobi alone, servicing both male and female clients, in a context with little prevention information and commodities specific to anal sex • Estimated 3,200 – 4,148 annual new HIV infections on the Mombasa-Kampala part of the trans-Africa highway • Ten years ago transport workers attending road side clinics in Athi River and Mariakani had HIV prevalence of 27 percent and 26 percent, respectively – updated figures urgently required • Estimated 46 % of adolescent girls at Kenyan truck stops have engaged in sex with transport workers, 78 % of females had traded sex for gifts or money and 52 % had experienced an STI • There are an estimated 20,000 injecting drug users in Kenya, and more than 50 percent of injecting drug users in Mombasa and Nairobi are estimated to be HIV positive • Studies from the lake communities in Western Kenya, as well as those carried out along the main transport routes, indicate high prevalence of routine risk practices
8. HIV infection in health care settings	• According to a study published in late-2006, receiving one or more tetanus injections seemed to significantly increase HIV sero-conversion risk among Kenyan women (1.89 times). On closer scrutiny the analysis producing these results has been shown to be questionable, awarding only a guarded acceptance that more research needs to be undertaken in this area
9. Emerging issues	• HIV prevalence among the 84% of Kenyan men who are circumcised is 3 % as compared to 13 % HIV prevalence among non-circumcised men • Recently announced results from the Kisumu randomized control trial confirmed a 53-65 % protective effect (to the man) of male circumcision on HIV infection

1 Generally, data from credible sources between 2003 (KDHS) and 2006, unless otherwise stated

Table 3: Perceived sources of new adult HIV infection in Kenya

Source of infection	Remarks	Supporting data [or details from selected studies refer to Table 1; also see Gouws, E. et al. (2006)]	Gestimate distribution of new HIV infections	Possible change factors and target populations
Sex within marriage/stable partnership(i.e. so called low risk sex)	• Includes inter –generational relationships and early marriage • High levels of discordance • Transmission rate might be relatively low, but involves large part of the population	HIV prevalence higher for married women compared to unmarried ones High level of discordance in HIV affec§ples (estimated 50% of married, HIV –positive adults in Kenya have HIV negative partner; in Uganda, 65 percent of new infections occurred among married people, and with that an estimated 50 percent of the infections occurred among people with an HIV-infected spouse	35% Nat. Progr. Effort Index Low	Knowledge of HIV status HIV awareness Faithfulness Condom use (especially discordant couples) Prevention of early marriages Male circumcision Married men Married women
Casual sex	• Sex with non-regular concurrent and/or serial partners (serial monogamy) • Inconsistent condom use contributes to risk in this category • Substance abuse/intoxication has a significant contribution to higher risk sex with casual partners	Increase in prevalence correlates positively with number of sexual partners High level of infection and reported engagement in sex with significantly older partner among young girls compared to young boys	30% Nat. Progr. Effort Index Medium	Knowledge of HIV status HIV awareness Partner reduction Abstinence IGP/Vocational training YF services for HIV and RH Life skills/sexual assertiveness skills Condom use Male circumcision Young girls and their parents Boys/ (older) men, girls/women
Sex work	• Includes commercial sex work (12%) and all forms of transactional sex (13%). • The former seems to be more prevalent in urban centres and the latter in rural settings and along main transport routes • Includes high level of inter-generational sex involving a partner under the age of 20 and at least 10 year age gap	Prevalence very high among CSW and high among those engaged in transactional sex compared to general population	25% Nat. Progr. Effort index Low	Knowledge of HIV status HIV awareness Treatment of STIs Condom usage Male circumcision Protection Sex workers Clients
Men who have sex with men (MSM)	• Includes MSM, especially with multiple partners, those also in heterosexual relationships (bisexual men), 'contextual MSM' e.g. among prison populations	Higher prevalence among MSM and prison populations compared to general population	4% Nat. Progr. Effort index Low	Knowledge of HIV status HIV awareness Condom usage Treatment of STIs MSM, prison populations
Intravenous drug use (IDU)	• Includes direct infection from IDU. • IDU linked through causal relationship to sex work and other forms of substance abuse as secondary risk factors	Very high prevalence and infection rate among IDU compared to gen. Pop.	3% Nat. Progr. Effort index Medium	Knowledge of HIV status HIV awareness Harm reduction Rehabilitation Intravenous drug users

Transmission in Health Settings/ Others	• Includes infection through informal/unsafe blood transfusion, direct blood contact and infection through injections/ needle-prick injury in health care settings (health workers/clients)	Currently available studies have methodological or analytical flaws and have not been able to demonstrate significance of HIV transmission in health settings i.e. inconclusive evidence, but likely that small number of infection takes place in especially informal health settings An unspecified small number of infections are likely to be due to transmission other than mentioned in this table	2% Nat. Progr. Effort index High	Knowledge of HIV status HIV awareness Adequate Universal Precautions Availability of PEP Enforcement of legislation Policy on injection safety Health care workers Patients/clients General population
Sexual and gender-based violence (SGBV), sexual exploitation, abuse of power and forms of harmful traditional practices	• Includes infection resulting from coercive sex, as well as sexual contact that can be classified as sexual exploitation by person of authority	Due to nature of sexual contact, infection risk is increased. However, HIV infection rates among young women reporting having experienced sexual violence was lower than among those not reporting it (KDHS)	1% Nat. Progr Effort Index High	Knowledge of HIV status HIV awareness Protection/legal aid Awareness/availability of PEP Survivors of SGBV School pupils/student, work staff Police, HC providers, judiciary

Source: UNAIDS Kenya – Internal Focus Group Discussion (FGD), January 2007. Updated June 2, 2007

ANNEX 2: IDENTIFICATION OF THE UN'S ROLE UNDER THE JOINT PROGRAMME DESIGN

The identification of the UN role under this joint programme design is based on three pieces of analysis. This annex contains the detailed analyses in three tables.

- A critical self-evaluation of current UN role vis-à-vis the KNASP strategic components and other actors in the areas (table 1)
- An assessment of UN system work and human resources on HIV, and recommendations for internal capacity improvements with regard to the division of labor (table 2)
- An analysis of UN comparative advantage for HIV programming (table 3)

Table 1: Critical self-evaluation of current UN role vis-à-vis the KNASP strategic components and other actors in the areas

KNASP Area1: Prevention of New Infections **Reduce the number of new infections in both vulnerable groups and the general populations**		
KNASP categories	Key contributions by other stakeholders	UN focus and competence (i.e. low, medium, high)
1 Youth focused interventions	• MOEST has a comprehensive programme to address HIV in the education sector to reach in school youth (Support from WB, DFID, EU etc), • Efforts are underway to support Ministry of Youth to coordinate youth affairs including HIV programme • USG through PEPFAR promotes Abstinence and Faithfulness with special emphasis of reaching 1 million youth to avoid HIV through FHI, PATH, EngenderHealth, mobile team to reach both in and out of school youth • DFID through CfBT has a lifeskills programme in schools • IPPF, other small grants and foundations to reach youth thro RH/FP programmes • Almost all international NGOs and most local NGOs are implementing HIV programmes have a range of youth focused awareness interventions	Medium with high potential through UNICEF and UNFPA • UNICEF has strong HIV life skills education with the Ministry of Education and Kenya Institute of Education. There are plans to support national scale up to a national programme • UNFPA and UNICEF have strong experience working in youth related programmes, such as provision of youth friendly services both at policy and at implementation level – in collaboration with the Ministry of Youth, MOH (DR), NCAPD, NASCOP and NACC as well as CSOs
2. Sex workers and their clients	• University of Nairobi STI/STD project (ended June 2006) provides solid lessons learned on engaging sex workers. The Center for HIV prevention and Research (within the University) and KVOWR an NGO that rehabilitates former SW are an offshoot of the project. • DFID through HAPAC supports Merlin to implement prevention activities among beach communities in Kisumu • USG/PEPFAR through FHI support VCT in four of the five truck stops, NASCOP provides free condoms, No support for major truck driver stop (Mlolongo) where 450 – 500 trucks stop overnight, excludes those Truckers who do not need police escort. • Previously FHI supported ICRH Peer Education Programme at the coast to work with CSW 127 trained Peer Educators reach an estimated peer population of 1500 sex workers • International Rescue Committee (IRC) works with sex workers and their truck driver clients	Low through UNODC, WFP, UNFPA, IOM and ILO • Despite being a high source of new infection (e.g. 60 percent of sex worker in Nairobi are HIV positive) however there is no national programme addressing this group and limited national capacity to address thus area • IOM provides technical support to the government-driven Great Lakes Initiative on AIDS. In 2006, IOM completed a regional assessment for GLIA/UNAIDS of trucker behaviours and service access and is working with NACC to mobilize resources for improved value-added coordination on prevention, treatment, care and support. • WFP can replicate experience gained in pilot countries on Truck Driver programmes implemented through 9 wellness centers) and UNODC through their work with IDU in collaboration with CSOs • If capacity and resources are enhanced these experiences could support scale-up • UNFPA has been agreed as technical lead for work with SW and will consolidate existing work and provide strategic guidance to all participating organizations • Overall, the UN is well placed to address the sensitivity of the area with due regards to human rights and the principles of non-discrimination

3. Work place policy and programmes	• Most international business organizations have workplace programmes, • Federation of Kenya Employers support to workplace policy in the private sector, • GTZ Private Public Partnership programme to support workplace programmes • USG through FHI supports some workplace programmes • Reaching SME and informal sector major challenge although umbrella organization representatives are engaging in national consultations with the NACC	High through ILO and UNDP
4. Harm reduction programmes	• PEPFAR through AED will support prevention of HIV in IDU by promoting testing and referral to access other services – this is to be implemented in 2007	Low with high potential through UNODC and WHO • UNODC has had prevention programmes for IDU (VCT and treatment) but it has only been at small scale, mainly due to lack of resources for programming and technical staffing. It is also due to the sensitivity of area as IDU is illegal in Kenya • UN is well positioned to address the sensitivity associated with IDU and drug abuse
5. Uniformed services	• USG/CDC support comprehensive HIV programme with Uniformed Services, • International Rescue Committee implements prevention programmes for Uniformed services	Low through UNDP and UNAIDS Secretariat
6. Other vulnerable populations [e.g. MSM, prisoners, displaced persons, OVC, widows, girls, etc.	• CDC supports training of prison wardens and provision of VCT services • DFID support the Kenyan Prison Service strengthen service provision for those with HIV and TB • Few new local NGOs engaging with prevention work for MSM (ISHTAR)	Medium with high potential through UNICEF, UNODC, UNAIDS Secretariat, UNIFEM, UNHCR, WFP, IOM, UNDP and FAO • UNODC has a prevention programme for prison inmates and although it is small scale, it provides useful lessons and basis for scale up • Gender and women rights issues are a cross cutting priority for the UN in general. The UN has spearheaded advocacy and women programming • FAO has a Junior Farmers Field and Life School programme targeting OVCs and other vulnerable populations
7. Prevention among populations of humanitarian concern	• USG and EU through IRC support programmes to educate conflict-affected communities about safer sexual practices and providing them with counseling and testing; • SIDA, NORAD through Kenya Red Cross provide HIV prevention services • Care international also has programme in this area	Medium with high potential through UNHCR, UNFPA, UNICEF, WFP and IOM
8. Condom provision [both male and female condoms]	• MOH distributes condoms through their facilities, • PEPFAR through(PSI) social marketing, • GTZ social marketing of public condoms, • Private sector outlets for condoms	High through UNFPA and World Bank • The World Bvank, through UNFPA, has supported the procurement and distribution of the male and female condoms in Kenya • UNFPA has extensive institutional experience in condom programming both as a reproductive issue and as HIV prevention

9. Counseling and testing [incl. positive prevention, campaign mode to testing]	• NASCOP with support from USG have steadily scaled up VCT services in the country • LVCT is looking to campaign mode for VCT but nothing implemented yet • No national efforts relating to positive prevention	Low with high potential through WHO, UNAIDS Secretariat, UNFPA, UNICEF • UN involvement in VCT has been low because the MOH (NASCOP) with support from CDC has been successful in the scale up the national programme. However, only about 20 percent of Kenyans know their status; there is need to move towards a more expanded context for HIV testing and counseling (including campaign-mode testing) as being advocated by the UN and CDC • At the November 2006 UNAIDS Executive Board Meeting, a global HIV Testing Week/Day initiative was approved to signal a move away from restricted contexts for HIV testing and counseling
10. Sexually transmitted infection management	• Comprehensive national programme institutionalized within the MOH	Low through WHO, UNFPA and UNICEF
11. Prevention of mother to child transmission	• USG/PEPFAR main support to MOH GTZ also provides some support	Medium through UNICEF and WHO • UNICEF has been supporting some aspects of PMTCT implementation, while WHO has been assisting with aspects of policy guidelines development • Since there is no national programme in place, and QA and monitoring are still a challenge (PEPFAR will be scaling up service provision) UNICEF and WHO will continue to support upstream (policy related work)
12. Behavior change communication	• PEPFAR through PSI, EngenderHealth, FHI, PATH, PSI campaigns geared to general populations	Medium through UNICEF and UNFPA • UNICEF and UNFPA have experience implementing various BCC interventions and now currently supporting the NACC develop a national BCC strategy for the youth and are members of the BCC working group • UNICEF in particular has adequate staffing for BCC work
13. Blood safety	• USG/CDC supports MOH in improved blood collection and testing services in Kenya.	Low through WHO
14. [Injection safety and] post-exposure prophylaxis	• USG/CDC improved blood collection and testing services in Kenya, • PEP available in all ART sites supported mainly through USG/PEPFAR	Low through WHO, UNFPA, UNIFEM • UNFPA has been training law enforcement officers in PEP • WHO continuously supports policy level work on PEP as well as in Injection Safety

KNASP Area 2: Improve the quality of life of people infected and affected by HIV and AIDS Improve the treatment and care, protection of rights and access to effective services for infected and affected people		
KNASP categories	**Key contributions by other stakeholders**	**UN Competence/comparative advantage**
15. Home based care	• DFID through HAPAC programme supports Mildmay Nyanza Model of Home-Based Care; • PEPFAR through Pathfinder International working in central, eastern province • Academic Model for the prevention and treatment of HIV/AIDS (AMPATH) supported by CDC, USAID, PEPFAR, Rockefeller Foundation, working in western Kenya support for hospice care has been established. Plans to expand in future years to cover more providers and promote wider availability of quality end-of-life care for Kenyans. • MSF provides HBC as part of their comprehensive care programme	Low through UNICEF, WFP, UNIFEM, WHO
16. Palliative care		None There is no distinct UN intervention in the area of palliative care beyond support for standard HBC initiative.
17. Diagnostic testing [and provider-initiated testing and counseling]	• National roll out available to all district health facilities but Standardization, QA in scale-up remain a major gap; • USG/PEPFAR through CDC and JHPIEGO support NASCOP with PITC • LVCT and MSF Belgium have documented lessons learned to date including gap areas (from their operational work) to be disseminated end March. • AMPATH - western Kenya also provide useful lessons learned	Medium with high potential through WHO and UNAIDS Secretariat • WHO has been supporting the training of health workers in diagnostic HIV testing and counseling • WHO/UNAIDS Geneva recently released a new global on Provider-Initiated Testing and Counseling (PITC) which country offices are being requested to facilitate its domestication at the country level and ensure that human rights are protected with the shift in approach
18. Treatment of opportunistic infections	• USG/PEPFAR providing hospice, home-based and other basic health care services	Low through WHO
19. Opportunistic infection prophylaxis		Low with high potential through WHO and UNICEF
20. Laboratory support for HAART	• PEPFAR, CDC • JICA	Low with potential through WHO and UNICEF
21. Antiretroviral therapy [incl. monitoring and systems development]	1. USG/PEPFAR 2. Global Fund 3. MSF Belgium 4. private sector 5. Clinton foundation 6. monitoring and QA remain a major challenge	Medium with high potential through WHO and UNAIDS Secretariat • WHO, with the experience of rolling out the 3 by 5 initiative, is well positioned to continue to provide technical and monitoring support for treatment scale up in the country • UNICEF is beginning to address issues of lack of unified monitoring and evaluation system for ARV supply and diagnostics, and pediatric care of children with HIV • UNAIDS Secretariat is facilitating Technical Assistance in Monitoring and Financing Antiretroviral Treatment consultations •
22. Training of healthcare workers	• USG – through Capacity Project; Health Policy Initiative (HPI);	High through WHO, UNICEF and UNFPA

23. Nutritional support	• AMPATH, Kenya Red Cross • (see mitigation programmes)	Medium with high potential through WFP, UNICEF and FAO • UNICEF with strong technical support to government establishing national policy, strategy, guidelines and curriculum development on nutritional care and support for HIV and AIDS
24. Protection of human rights	• New area for HIV related work – Action AID support advocacy, USG through HPI	Medium with high potential through UNDP, UNIFEM, UNFPA, UNICEF and UNAIDS Secretariat • UNDP and UNIFEM have extensive experience addressing Human rights related issues and have actively supported the process of the development of the HIV and AIDS Bill and the strengthening of the Networks of PLWHA • UNICEF is the leading global advocate for women and children's rights, while UNAIDS Secretariat is the leading global advocate for GIPA

KNASP Area 3: Mitigation of socio-economic impact of HIV and AIDS **Adapt existing programmes and develop innovative responses to reduce the impact of the epidemic on communities, social services and economic productivity**		
KNASP categories	**Key contributions by other stakeholders**	**UN Competence/comparative advantage**
25. Mitigation policy		Medium through UNDP, UNICEF and UNAIDS Secretariat • WB,UNAIDS Secretariat and UNDP have been supporting the NACC to define the direction for mitigating social economic impact of AIDS
26. Mitigation advocacy		High through UNICEF, UNDP and UNAIDS Secretariat (See below)
27. Livelihood and social security	• PEPFAR through Catholic Relief Services (CRS), • OXFAM, VETAID food security programmes, Machakos	Low through WFP, UNICEF and FAO (See below)
28. Targeted sectoral mitigation programmes for vulnerable group, e.g. OVC, care-givers, widows, girls, etc.	• PEPFAR adds support to CCF, Plan international, Care International HACI, Word vision, Care international, AED for OVC programming) • TS Through Health Policy Initiative • Capacity strengthening through GTZ, JICA • DFID through Constella Futures • SIDA through AMREF • Stephen Lewis foundation, • Actionaid international, AMREF • Help age Kenya	High through UNICEF and UNIFEM • UNICEF is supporting Kenya Govt. to pilot the conditional cash Transfer Programme to advice national scale up; • WFP has provided food to OVC and vulnerable households • UNIFEM supports grandmothers as care takers of OVC • FAO supports Junior Farmers Field and Life Schools targeting OVCs and population of humanitarian concern
29. Community empowerment – (Capacity building)	• Actionaid, SNV, DFID through HAPAC, SIDA thru AMREF both in Nyanza and Western Kenya, Center For African Studies(CAFS) all have capacity building programmes for CSOs	Medium through UNICEF and UNDP • UNICEF supports community to care for orphans • UNDP has been strengthening capacity strengthening of local organizations
30. Human resource planning	• USAID- Capacity Project	Medium through WHO and ILO

KNASP Area 4: Support services to the NACC		
KNASP categories	**Key contributions by other stakeholders**	**UN Competence/comparative advantage**
31. Monitoring and evaluation	• Technical support from MEASURE through PEPFAR; • Technical and programme support from Constella Futures through HAPAC, • Support through AMREF for COPBAR (SIDA), • Global Funds supports M& E Field Officers	High through World Bank, WHO and UNAIDS Secretariat • World Bank has been strengthening the NACC institutionally to address issues of M & E. • UNAIDS has supported the NACC develop the M&E framework and will in 2007 have a fulltime M&E Adviser to support NACC
32. Research	IAVI for Vaccine trials, CDC through KEMRI Center for HIV prevention and Research(UON) International Partnership for Microbicides (IPM),	Low with high potential through all UN system organizations • Commonly identified UN HIV research agenda to b be supported through the TS component of the assistance requested from DFID • UN agency resources will continue to be used to support research agenda touching on gender, human rights, vulnerability assessment and humanitarian assistance
33. Financing and procurement	• Procurement: Mission for Essential Drugs and Supplies (MEDS), as the purchaser and distributor of the vast majority of USG-procured ARVs founded by the Christian Health Association of Kenya and the Kenya Episcopal Conference • JSI (up until 2006) • MOH through KEMSA	Medium to high potential through World Bank • UNAIDS secretariat, UNDP and the WB have been supporting the NACC and some sectors to engage in mainstreaming efforts. For sustainability and institutionalization of this process the UN support in terms of TS and resources is required
34. Institutional capacity building [incl. technical assistance]	• DFID, through HAPAC for Joint Institutional strengthening • USG, through Health Policy Initiative and the Capacity Project	High through World Bank UNAIDS Secretariat and UNDP • UNAIDS currently operates a Technical Support Facility (AMREF) for strategic areas of work in HIV and has some catalytic funding to demonstrate the initiative • In addition to the above experience, UNAIDS is uniquely positioned to carry forward the work formerly done by Constella Futures
35.Communication, coordination and networking	• DFID through HAPAC, SIDA through AMREF, USG and USG supported international NGOs	High through UNAIDS, World Bank and UNDP • UNAIDS Secretariat is globally charged with the responsibility for facilitating, monitoring and reporting on the implementing the GTT recommendations to strengthen national leadership, coordination and harmonization within the UN and external to UN • At present, UNAIDS plays a leading role in the harmonization task force with NACC

Table 2: Summary of UN system work and human resources on HIV, and recommendations for internal capacity improvements with regard to the division of labor

Agencies/ Organizations	Current areas of work and key features	Capability statements and remarks on compliance with the UN Division of Labor
1. UNAIDS Secretariat	- Coordinates UN system policy, programmes and contributions in support of the national HIV response - Provides considerable support to the NACC, particularly on the Three-Ones, GTT recommendations and Universal Access	- 4 full time professional positions, including 1 international post supported by DFID. - *Continued DFID staffing support will be needed in order to meet up with the priority focus on harmonization and operationalizing the joint team and joint programme of support; an additional position may be needed to oversee management and quality assurance of TS under the KNASP*
2. World Bank	- One of the original six co-sponsors of UNAIDS, and the earliest and biggest financier of NACs globally, including NACC Kenya - Supports institutional development within NACC and finances the overall national response - Engages in policy dialogue and advisory for the national response	- No full time officer - 3 professional officers, all working 10-25 percent on HIV - Responsible Officer based outside of the country and working the human development and health field - *For the nature of work done, there is adequate capacity and seniority in staffing* - *However, there is need to strengthen and regularize the Bank's participation in the Theme Group on HIV and Joint Team on AIDS*
3. WHO	- A key co-sponsor of UNAIDS and home of the Global AIDS Programme (GAP), which gave way to the formation of UNAIDS - Provides technical support primarily to Ministry of Health and other health related institutions on health sector HIV interventions and all associated diseases, including tuberculosis, malaria and other opportunistic infections	- 2 full time professional officer positions but 1 national officer post has remained vacant for a long time - Contract of the senior HIV and AIDS Officer expires in May 2007 with no confirmed sources of funding for continuation - Work of several WHO officers touches on HIV (in areas of TB, essential drugs, child health, reproductive health, health systems and health promotion) - Expectation is that 2 new WHO staff will be recruited by CDC through a WHO/CDC collaborative agreement to be entered into soon with a focus on HIV prevention and monitoring - *To meet up with expectations under the joint programme, this staffing situation in WHO needs to be addressed as a matter of priority. If recruitment plans materialize, proposed capacity is considered adequate for expectations under the joint programme* - *Skill sets for the vacant national officer position should address specifically UN's technical leadership needs in HIV surveillance and epidemiology*
4. UNFPA	- Provides support to prevention and reproductive health activities among adolescents - A strong partner of the government in the area of condom procurement	- 1 full time professional officer newly recruited - 3 part-time professionals working on BCC advocacy, reproductive health and condoms - *Current capacity is considered adequate for expectations under the joint programme although increased capacity for BCC and youth-friendly initiatives may be a consideration for the agency*
5. UNICEF	- Supports PMTCT, HIV prevention in youth, paediatric AIDS treatment - Works closely with Ministry of Home Affairs to pilot cash transfers to OVC and develop the national strategic plan on OVC	- 4 full time professional officers - 1 part time professional in OVC, plus several other officers whose regular work touch on HIV Head of Health Section now coordinates the HIV response within the office, through regular thematic meetings. UNICEF may want review the effectiveness of this arrangement after a trial period of six months to one year - *There is adequate technical support in UNICEF for strengthening national systems on nutritional care and HIV, OVC, PMTCT and pediatric HIV. However, there is need for UNICEF to support increasingly upstream intervention in these areas* - *What remains outstanding for UNICEF are the skill sets for addressing UN expertise on ARV/diagnostics procurement and supply management*
6. UNESCO	- Works closely with the MOE on HIV education sector policy, and how to mainstream HIV through capacity building of senior education administration officials	- No full time staff for Kenya; office is a regional entity - 1 professional officer who works only 20 percent on HIV across 8 countries - *Virtually no capacity for in-country HIV work; hence, mandate for HIV prevention for young people in educational institutions to be reassigned to UNICEF and UNFPA by the UN Theme Group*

7. ILO	- Collaborates with the Ministry of Labor on work place policy issues, including HIV - Supports child labor initiatives, with funds and packages for school reintegration, and funds for OVC families/guardians OVC to start income generation activities	- No full time staff on HIV; office is a regional entity - 1 senior technical officer who works 25 percent on HIV - *Without additional capacity, ILO can only play an advisory role* - *Much of the agency's work on mainstreaming HIV in the work place would have to rely on close collaboration with UNDP and UNAIDS Secretariat*
8. UNDP	- Provides human resources support to NACC and strengthens capacity of CSO to address HIV - Works with Ministry of Local Government to integrate HIV into decentralized community development initiatives - Supports mainstreaming in the public sector (incl. MTEF, ERS), and works with the Federation of Kenya Employers to develop HIV work place policy and programmes	- 1 national UN volunteer working full time on HIV - *1 senior officer working 50 percent on HIV* - *As work on mainstreaming in priority public sector is rapidly scaled up over the next few years, increased UNDP leadership will be required* - *At current level of staffing, it is unlikely that expectations would be met by the agency for increased resource infusion under the joint programme* - *For the Administrative Agent functions, existing capacity may need to be further strengthened*
9. UNON/UN Medical Services	- Provides leadership advocacy and coordination for UN Learning Strategy on HIV, including work place programme for the UN system	- 1 full time HIV work place programme coordinator - Not a co-sponsor of UNAIDS and thus not bound by the agreed division of labor - *Occasional capacity support needs for UN Learning Strategy can be met through provision of flexible TS*
10. WFP	- Pilots an academic model of nutritional intervention for vulnerable AIDS patients on ART, as well as works with community–based care-givers to improve the nutritional wellbeing of orphans and their families - Works with transporters servicing the organization to put in place HIV work place policy and programmes	- 1 full time officer on HIV and nutrition - Current capacity is marginally adequate for the level of responsibility, as the responsible officer is often away on field assignments - *There is need for a more strategic engagement of government partners in support of scaled national programmes with regards to nutrition needs of orphans and vulnerable AIDS patients on ARV*
11. UNHCR	Collaborates with NGOs working in camp-settings to address the HIV needs of refugees and internally displaced persons	- No full time HIV officer - 1 part time officer working 30 percent on HIV, plus other officers whose regular work touch on HIV - *Current capacity is adequate for addressing HIV prevention issues among refugees in camp setting.*
12. UNODC	- Collaborates with government and NGOs to pilot support for prevention activities and care service for most-at-risk groups, such as injecting drug user, prisoners and sex workers	- 1 full time HIV officer to oversee PEPFAR-funded initiatives; office is a regional entity - Contract of the full time officer expires in April 2007 with no possibility of extension - *In view of government and donors' priority to highlight and address the needs of most-at-risk groups, it will be necessary to strengthen UNODC's capacity with 1 fulltime national officer position*
13. IOM	- Partners with government and NGOs at all levels to develop health and social systems that respond to the unique needs of trafficked persons, mobile populations, migrants and refugees	- 1 full time HIV officer with a regional mandate - 1 Senior Health and HIV assistant working 30 percent on HIV - Although not a UN agency, IOM is highly committed to supporting Governments via the UN Joint Response - *IOM is capable of being the UN technical Focal Point for a number of aspects related to population mobility*
14. UNIFEM	- Works with the Ministry of Gender on policy advocacy and governance	- No full time HIV staff; office is a regional entity - Not a co-sponsor of UNAIDS and thus not bound by the agreed division of labor - *No additional capacity is necessary for it to continue to play an advisory role on gender aspects of the joint programme*
15. FAO	- Collaborates with the Ministry of Agriculture to develop models for national food security, and for assessing the socioeconomic impact of HIV at the household level	- No full time HIV staff - Not a co-sponsor of UNAIDS and thus not bound by the agreed division of labor. However, FAO is committed to collaborate with the UN system, particularly with WFP, UNDP, UNHCR and UNAIDS secretariat. - *No additional capacity required*

Table 3: Outline of UN comparative advantage for HIV programming

HIV response needs	UN's comparative advantage compared to other development partners
1. The global HIV epidemic is dynamic and, correspondingly, responses to it should be based on latest available information and apply best practices based on international frameworks and standards.	UN is central in developing this international body of knowledge and normative guidance. This can most effectively be communicated at country-level and translated into enabling national legislation and policies through the UN system Due to the engagement of the UN system in HIV responses at all levels (global, regional and national), the UN system represents a normative knowledge house which can draw on internal expertise to support strategic country-level processes.
2. The nature of the epidemic is such that multisectoral approaches are needed to address the myriad of causalities and issues involved.	The UNAIDS family in Kenya is made of more than one dozen UN agencies and organizations with expertise and specialization ranging from HIV, health, nutrition, education, population, the environment, financing, gender, children, etc. No other group of development partners possesses such a diverse range of sectoral expertise and on-the-ground involvements and partnerships. In the context of the KNASP, the UN provides direct support to all its four strategic pillars. The UN system is in a position to provide effective support to multisectoral HIV responses through the established working relationships between UN organizations and counterpart ministries/ implementing partners. This allows it to directly contribute to effective response to HIV within different sectors, as well as, through the UNAIDS Secretariat, support NACC to spearhead harmonization and alignment agenda across interventions and partners in the HIV response.
3. The principles of human rights, gender equality, non-discrimination and inclusiveness (of the voiceless and marginalized) underlie both the structural causes/drivers of the epidemic as well as the responses to it.	The UN the world over is a standard bearer for these issues, never more so than in HIV. These principles constitute the basic building blocks for the common country assessment leading to the development of the UNDAF which governs the UN's involvement at the country level. The UN generally aims at advancing enabling policy and legislative frameworks with these principles in mind.
4. Owing to the growth and multiplicity of players in the HIV arena (including the presence of major and overwhelming donors), there is need for an 'honest broker' to support the coordination process in achieving a level playing field and enhancing national ownership and leadership.	The UN system is widely perceived as an 'objective broker' in that it does not serve interests of any particular constituency or take instructions from any governments of member states, while giving uttermost respect for the priorities and wishes expressed by the Kenyan Government and people. Additionally, through a number of global HIV process (the "Three Ones" and the GTT) the UN system has been mandated by the international community to support coordination efforts at the country-level to harmonize and align HIV programming and investments. Specifically through the Joint UN Programme of Support, the UN will also aim at strengthening synergies between different components of DFID support to the national HIV response, namely the 'TOWA' programme supported jointly with the World Bank and delivered through NACC, and the 'Maanisha' programme jointly supported with SIDA and delivered through AMREF.
5. For the foreseeable future, the biggest challenge in HIV will be making the vast sums of money committed to-date work for the people, through accurate and timely assessment of implementation bottlenecks and rapid brokering of both short-term and long-term technical support to address the shortcomings.	As a result of consistent and strategic positioning in the various HIV coordinating structures (ICCs, ICC Steering Committee, CCM, Harmonization Taskforce, MCGs, donor/development partners groups, UN Joint Team, etc.), the UN is uniquely placed to know and appreciate both the policy and operational challenges of the national response. Also, being a technical knowledge warehouse with regional and global level technical networks and databases (e.g. TSFs), the UN is well positioned to assist with the technical support that Kenya may need. The UN' s programme of support to the KNASP will be mainly carried out through the following steps: 1) technical and financial assistance to and through NACC to develop effective policies, strategies; 2) technical and financial assistance to develop guidance on standardization of programmatic approaches and their operationalization through translation into action at different levels and within different sectors; 3) mapping and identification of strategic implementing partners to deliver targeted interventions; 4) technical assistance for systems and institutional strengthening to partners to access capacity development and/or grants through Maanisha and/or TOWA; 4) support linkages, strategic exchange, continuous monitoring, documentation and dissemination of best practice during programme implementation and facilitate feedback loop to policy and programmatic decision-making.

ANNEX 3
JOINT TEAM COMPOSITION

ANNEX 3: LOCALLY AGREED DIVISION OF LABOUR

Kenya Joint UN Team on AIDS
(Total membership: 56; Designated members: 35; Technical leaders: 26; Management group: 14)

OVERALL GOVERNANCE AND LEADERSHIP			
Overall UN system leadership and accountability on AIDS, and representation to the Head of State	Elizabeth Lwanga	UN Count Team (UNCT) Kenya Coordination Group (KCG) Donor Coordination Group (DCG) Harmonization, Alignment and Coordination Group (HAC)	Office phone: 020-7624462 Cell phone: 0722-516988 E-mail: elizabeth.lwanga@undp.org
Joint AIDS Team operations and overall national policy, strategic planning, coordination and resource mobilization	**Erasmus Morah**	UN Count Team (UNCT) Inter-Agency Coordinating Committee (ICC) Steering Committee Country Coordinating Mechanism for Global Fund (CCM) Harmonization Task Force	Office phone: 020-7624391 Cell phone: 0722-754764 E-mail: morahe@unaids.org

UN thematic and technical areas	**Technical Leader**	**Corresponding coordination and working groups, task forces, committees, forums**	**Contact details**
PREVENTION			
1. IEC and behavior change communication	Florence Gachanja *(Susan Roe – programme communication and campaigns)*	Condom Programming and BCC Task Force BCC Consortium	Office phone: 020-7624426 Cell phone: 0733-768152 E-mail: gachanja@unfpa.og Office phone: 020-7622815 Cell phone: 0725-285501 E-mail: sroe@unicef.org
2. Condom programming and procurement	Stephen Wanyee	Condom Programming and BCC Task Force Forecasting and Commodities Task Force (NASCOP)	Office phone: 020-7624407 Cell phone: 0722-806040 E-mail: wanyee@unfpa.org
3. Mother–to–child transmission (MTCT)	**Christopher Ouma**	STI and PMTCT Task Force Paediatric AIDS Technical Working Group	Office phone: 020-7622732 Cell phone: 0721-644642 E-mail: chouma@unicef.org
4. Transmission in health care settings, blood and injection safety, universal precautions, testing and counseling, STI diagnosis and treatment, PEP	Rex Mpazanje	Monitoring and Coordinating Group for Prevention (MCG-1) Counseling and Testing Task Force Blood/Injection Safety and PEP Task Force	Office phone: 020-2717902 Cell phone: 0736/0724-416660 E-mail: mpazanjer@ke.afro.who.int
5. New prevention technologies and strategies (microbicides, vaccines, male circumcision, pre-exposure prophylaxis)	Rex Mpazanje	Male Circumcision Task Force Kenya AIDS Research Committee (KARSCOM)	Office phone: 020-2717902 Cell phone: 0736/0724-416660 E-mail: mpazanjer@ke.afro.who.int
6. Young people in education institutions	Roselyn Mutemi-Wangahu *(**Alice Ochanda** – Tertiary and vocational education settings, mainstreaming)*	BCC Consortium KIE HIV Committee	Office phone: 020-7622157 Cell phone: 0721-209475 E-mail: rmutemi@unicef.org Office phone: 020-7622086 Cell phone: 0733-925009 E-mail:alice.ochanda@unesco.unon.org

7. Young people and vulnerable groups outside schools (incl. sex workers and their clients)	**Geoffrey Okumu**[2] *(Judith Kunyiha-Karogo – young people, liaison to MoYA)*	Monitoring & Coordination Group for Prevention (MCG-1) NACC Youth Working Group	Office phone: 020-7625556 Cell phone: 0722-903-909 E-mail: okumu@unfpa.org Office phone: 020-7625557 Cell phone: 0734-600888 E-mail: karago@unfpa.org
8. Injecting drug users and prisoners, including contextual MSM	**NOC, UNODC, under recruitment** *(Reychad Abdool – **regional** oversight and policy coordination)*	IDU Advisory Network Drugs and HIV Working Group BCC Consortium	Office phone: Cell phone: E-mail: Office phone: 020-7623663/37 Cell phone: 0722-203825 E-mail: reychad.abdool@unodc.org
9. Refugees, internally displaced persons (IDPs) and mobile populations (incl. cross-border migrants)	**Babu Swai** *(refugees)* **Gregory Irving** *(IDPs and mobile populations*	Great Lakes Initiative on AIDS (GLIA) IGAD and EAC regional fora on HIV UN Humanitarian Working Group Disaster Management Task Force	Office phone: 020-4232310 Cell phone: 0733-880881 E-mail: swaib@unhcr.org Office phone: 020-4444174 Cell phone: 0725-456375 E-mail: girving@iom.int
10. Uniformed services, crisis situation and humanitarian response	Sari Sepanen-Verrall	Great Lakes Initiative on AIDS (GLIA) Disaster Management Task Force	Office phone: 7624391 Cell phone: E-mail:
11. AIDS work policy and programmes, and private sector mobilization	**Wangui Irimu**	Private Sector Advisory Network (PSAN) NACC Private Sector Working Group	Office phone: 020-2731980/2019 Cell phone: 0721-375232/0733-627570 E-mail: wirimu@iloipec.or.ke
12. UN Learning Strategy (incl. UN work place policy and programmes)	George Wainaina	Capacity Building/Institutional Capacity Task Force	Office phone: 020-7621277 Cell phone: 0722-706661 E-mail: george.wainaina@unon.org

TREATMENT, CARE, SUPPORT AND IMPACT MITIGATION			
13. AIDS treatment and monitoring (adults and children), including ARV forecasting and treatment of AIDS –related conditions (OIs, mental and malnutrition)	**Rex Mpazanje**[3]	Monitoring & Coordination Group for Quality of Life (MCG-2) ARV Task Force (NASCOP) Forecasting and Commodities TF (NASCOP)	Office phone: 020-2717902 Cell phone: 0736/0724-416660 E-mail: mpazanjer@ke.afro.who.int
14. Tuberculosis and HIV (TB/HIV collaboration)	Joel Kangangi	NLTP (MoH) TB/HIV fora	Office phone: 020-2717902 Cell phone: 0733-428136 E-mail: kangangij@ke.afro.who.int
15. Economic impact alleviation, poverty reduction, sectoral work and financing	**Wacuka Ikua**	Monitoring & Coordination Group for Support Services (MCG-4) Financing and Procurement Task Force Capacity Building Task Force Joint AIDS Programme Review (JAPR) Task Force	Office phone: 020-3226417 Cell phone: 0722-520110 E-mail: wikua@worldbank.org
16. Orphans and vulnerable children, and affected households	Catherine Kimotho[4]	Monitoring & Coordination Group for Impact Mitigation (MCG-3) Mitigation Policy and Programme Task Force National OVC Steering Committee	Office phone: 020-7622174 Cell phone: 0723-676526 E-mail: ckimotho@unicef.org

2 Cluster Convener for 'Prevention'

3 Cluster Convener for 'Quality of Life'

17. Dietary and nutrition support for AIDS patients and affected households	**Margaret Lukoye** *(Linda Beyer – policy / guideline development and clinical nutritional care)*	Monitoring & Coordination Group for Quality of Life (MCG-2) Care Task Force Nutrition and HIV/AIDS Steering Committee (NASCOP) Paediatric AIDS Technical Working Group	Office phone: 020-7622777 Cell phone: 0733-632332 E-mail: margaret.lukoye@wfp.org Office phone: 020-7621356 Cell phone:0723-431244 E-mail: lbeyer@unicef.org
18. Food security and agricultural inputs for affected households	**Augusta Abate**	Livelihood and Social Security Task Force	Office phone: 020-2725369 Cell phone: 0721-839886 E-mail: augusta.abate@fao.org
19. Human rights and gender, ethics and law, stigma, discrimination and social exclusion	**Elly Oduol**[5] *(***Funmi Balogun** *– gender analysis, mainstreaming and advocacy)*	Human Rights Task Force HIV Act Task Force	Office phone: 020-7624445/4381 Cell phone: 0722-744615 E-mail: elly.oduol@undp.org Office phone: 020-7624318 Cell phone: 0726-564479 E-mail: funmi.balogun@unifem.org
CROSS-CUTTING SUPPORT SERVICES			
20. Strategic information, knowledge sharing and M&E, including research and prevalence estimation, demographic impact projection	**Girmay Haile**[6]	Monitoring & Coordination Group for Support Services (MCG-4) Monitoring & Evaluation Task Force (NACC) M & E Technical Steering Committee (NASCOP) Joint Annual Programme Review (JAPR) Task Force Kenya AIDS Research Committee (KARSCOM) Kenya AIDS Indicator Survey Steering Committee	Office phone: 020-7624379 Cell phone: 0725-843594 E-mail: girmay.haile@undp.org
21. Epidemiology and surveillance (biological and behavioral)	WHO, under recruitment (Rex Mpanzanje)	Task Force on HIV Surveillance Demographic and Health Survey Task Force	Officephone: 020 2717902 Cell phone: 0736/0724 416660 E-mail: mpazanjer@ke.afro.who.int
22. AIDS financing, governance, institutional development (costed national plans, financial management, human resources, capacity and infra-structure development)	Adam Lagerstedt	UN Count Team (UNCT) Inter-Agency Coordinating Committee (ICC) Steering Committee Harmonization Task Force (ICC) Health Donor Working Group Monitoring & Coordinating Group for Support Services (MCG-4)	Office phone: 020-3226773 Cell phone: 0724-975794 E-mail: alagerstedt@worldbank.org
23. Institutional development, harmonization and UN reform (incl. joint team and joint programme)	Mira Ihalainen	Monitoring & Coordination Group for Prevention (MCG-1) Harmonization Task Force Health/HIV Donor Working Group Theme Group/Joint Team Coordination and Review Meetings	Office phone: 020-7625123 Cell phone: 0733-651746 E-mail: ihalainenm@unaids.org
24. Technical Support Plan and Technical Support Facility	UNAIDS, under recruitment *(Mira Ihalainen – linkage to national TS planning)*	Technical Assistance Oversight Committee Capacity Building/Institutional Capacity Task Force	Office phone: Cell phone: E-mail: Office phone: 020-7625123 Cell phone: 0733-651746 E-mail : ihalainenm@unaids.org

4 Convener for OVC/social protection within 'Impact Mitigation' cluster

5 Cluster Convener for 'Impact Mitigation' (mainstreaming)

6 Cluster Convener for 'KNASP Support'

25. Advocacy, partnership building, social mobilization and communication (incl. GIPA)	Jacqueline Makokha	Monitoring & Coordination Group for Impact Mitigation (MCG-3) Communication and Networking/ CSO/GIPA Task Forces World AIDS Day Organizing Committee	Office phone: 020-7624379 Cell phone: 0733-775298 E-mail: makokhaj@unaids.org
26. Mainstreaming in Development, (MDGs, ERS, MTEF, decentralization) and enabling legislation	Elly Oduol *(Wacuka Ikua – HIV mainstreaming in financial instruments)*	Monitoring & Coordination Group for Impact Mitigation (MCG-3) Mainstreaming, Financing, Procurement Task Force Vision 2030 Steering Committee ERS (PRSP) Working Group	Office phone: 020-7624445/4381 Cell phone: 0722-744615 E-mail: elly.oduol@undp.org Office phone: 020-3226417 Cell phone: 0722-520110 E-mail: wikua@worldbank.org
27. Procurement and supply chain management, including training	Moges Alemu	Mainstreaming, Financing, Procurement Task Force Forecasting and Commodities Task Force	Office phone: 020-7622206 Cell phone: 0725-983453 E-mail: malemu@unicef.org
28. Financial management of pass-through and pooled funding and administrative modalities for the Joint UN Programme on AIDS	Innocent Kayihura *(Betty Murimi – Joint Team operational support)*	Joint Team Reviews with DFID, NACC and others	Office phone: 020-7624440 Cell phone: 0727-532266 E-mail: innocent.kayihura@undp.org Office phone: 020-7625115 Cell phone: 0722-821116 E-mail: murimib@unaids.org
Some technical leaders have multiple technical leadership areas and correspondingly appear more than once in the above table. Cluster Conveners are indicated by footnotes. **Bolded** names represent membership in the **Joint Team Management Group** comprising one Focal Point for each participating organization and chaired by the UNAIDS Country Coordinator. The Management Group is supported by officials of the UNAIDS Secretariat and the UN Learning Strategy Coordinator. The Management Group may also decide to permanently or temporarily co-opt additional members from among the Technical Leaders and other Joint Team members as deemed relevant.			

Undesignated UN staff supporting and working closely with the Joint Team and who may in specific identified circumstances be co-opted or act as alternates to relevant Joint Team members

1. Grace Banya, HIV in the Workplace (ILO, gbanya@iloipec.or.ke), representing UN in MoL HIV Workplace Policy Advisory Board
2. Jeanine Cooper, Humanitarian response and HIV (OCHA, jeanine.cooper@undp.org)
3. Marilyn McDonagh, Health Sector Coordination (UNICEF, mmcdonagh@unicef.org)
4. Roger Pearson, Programme Coordination (UNICEF, rpearson@unicef.org)
5. Inderpal Dhiman, coordinator (RCO, dhiman.inderpal@undp.org)
6. Susan Nkinyangi, HIV in Education (UNESCO, susan.nkinyangi@unesco.unon.org)
7. Sara Cameron, Head of Communication Section (UNICEF, scameron@unicef.org)
8. Nasser Ega-Musa, Deputy Director, (UNIC, nasser.ega-musa@unon.org)
9. Assumpta Muriithi, Child health and nutrition (WHO, muriithia@ke.afro.who.int)
10. Joyce Lavussa, Reproductive health and PMTCT (WHO, lavussaj@ke.afro.who.int)
11. Regina Mbindyo, Essential Drugs and Medicines (WHO, mbindyo@ke.afro.who.int)
12. Euralia Namai, Health Promotion (WHO, namaie@ke.afro.who.int)
13. Humphrey Karamagi, Health Systems (WHO, karamagih@ke.afro.who.int)
14. Zipporah Gathiti, Monitoring and Evaluation (UNFPA, gathitiz@unfpa.org)
15. Jennifer Miquel, RH/HIV/AIDS/GBV in Emergencies (UNFPA, miquel@unfpa.org)
16. Hamai Mitsugu, Junior Programme Officer (WFP, hamai.mitsugu@wfp.org)
17. Wacheke Bobotti, General Staff Support (WFP, wacheke.bobotti@wfp.org)
18. John Mbugua, Clinical Officer (UNHCR, mbuguaj@unhcr.org)
19. Bernard Kiura, Programme Officer (ILO, bkiura@iloipec.or.ke)
20. Masai Masai, Food Security and HIV/AIDS (FAO, masai.masai@fao.org)
21. Dahabo Shale, Programme Officer (UNDP, dahabo.shale@undp.org)

ANNEX 4 - 5

DETAILS OF THE JOINT PROGRAMME COMPONENTS

ANNEX 4: CONTENT OF THE JOINT UN PROGRAMME OF SUPPORT ON AIDS

Outcome 1: *Reduced number of new infections in both most-at-risk groups and general populations*
Convenre/lead organization: UNFPA

Output 1.1 HIV prevention becomes evidence- informed and accelerated

Coordinating organization: WHO

Rationale:

Though Kenya has witnessed a steady decline in HIV prevalence from a peak of 10% in 2000 to 5.1% in 2006, there is a threat that this decline may not continue if the estimated incidence of between 55,000 and 100,000 is not significantly further reduced while mortality continues to come down with the continued scale-up of ART now at 50% of those in need. Hence, there is a clear imperative for accelerating the scale-up of HIV prevention and side the continued ART rollout focusing at those practical interventions that are informed by evidence including new interventions.

This sub-component focuses on the health sector-led critical HIV prevention interventions including; injection safety, blood safety, male circumcision, STI management, microbicides/HIV vaccine development, HIV prevention with the positives and HIV testing/counselling (voluntary, provider-initiated and infant HIV diagnosis). Successive JAPRs have flagged the disjointed nature of current prevention efforts and the need to find a clearer leadership and direction. At present, NASCOP is indicated under the KNASP II as leading in about 80 percent of the prevention interventions, while NACC leads in the area of BCC and prevention among most-at-risk and vulnerable groups.

Objectives:

1. To support the strengthening of national accountability and the leadership framework for HIV prevention
2. To facilitate standardization and accelerated scale-up of HIV prevention interventions in the health sector.

Role of the UN and partnerships:

The UN will provide technical and financial support to NACC, NASCOP, other MoH divisions and health parastatals:

- to review and recommend national accountability and leadership framework within the context of the MCGs for HIV prevention coordination, division of labour/responsibilities and mechanisms for setting of prevention targets, allocating resources and monitoring of progress,
- to develop national prevention strategy with clear, measurable targets and review mechanisms
- for development of the country's HIV prevention research agenda within the context of overall HIV research agenda
- in revising and consolidating existing HIV testing guidelines, service provision tools/aids, advocacy and M&E materials to incorporate recent international and local policy shifts
- for development of an HIV testing scale-up plan including a plan for HIV testing campaigns
- in rolling out PCR/p24 antigen laboratory networks for early infant HIV diagnosis, supervision, site accreditation and testing QA systems
- in defining interventions frameworks for HIV prevention with positives (PwP); developing support tools and training PwP service providers; and supporting development of funding proposals for PwP interventions.
- in putting in place a national framework for injection safety, blood safety and HIV lab QA including development of policies, guidelines, equipment and supplies standards, training materials and health worker aids/SOPs
- for development of male circumcision advocacy strategy and materials/community mobilization activities, including putting in place a policy, service delivery guidelines, equipment and supplies standards, certification and accreditation standards, training materials, health worker aids, supervisory and M&E tools, health facility implementation capacity assessment tools, scale-up plan, proposals for male circumcision funding
- reviewing STI programme including efficacy testing of current syndromic management drugs; revision of STI guidelines, training materials and other support tools; and training of health workers on the revised programme standards & tools.
- and development of country readiness plans, regulatory procedures and standards for HIV vaccine, microbicides and other health sector HIV prevention technologies that will become relevant during the period of implementation of this supported programme.

UN support will primarily be through NACC, NASCOP, NPHLS and PMPB. The UN will closely work with all partners supporting the health sector in this programme area including USG (CDC, USAID), GFATM, FHI, Liverpool VCT, World Bank TOWA, JHPIEGO, JSI-MMIS project, KAPC (Kenya Association of Professional Counselors), NEPHAK, AMREF and other programme division of the ministry of health e.g. EPI.

Milestones to 2012:

1. By end-2007, plan for HIV testing campaign is developed
2. By end-2007, national HIV prevention task force is established
3. By end-2008, national prevention strategy is developed
4. By end-2008, harmonized HIV testing and counselling guidelines, service documentation tools and training materials are developed/revised
5. By end-2008, an assessment on the need for blood, and standards for equipment and QA is established
6. By end-2008, the main sources of HIV infections in Kenya are documented, including drivers of the epidemic and the efficacy of ongoing interventions
7. By end-2008, national HIV prevention summit instituted as an annual event
8. By end-2009, STI guidelines, related tools and materials are revised
9. By end-2009, a national system for QA of HIV test kits and testing is developed in order to facilitate the on going scale-up, and ensure equitable access to quality VCT services
10. By end-2010, a national policy, scale-up plan, guidelines, tools, communication materials, QA framework and equipment standards for MC are developed
11. By end-2010, HIV research agenda is developed and annual national research dissemination conference is instituted
12. By end-2010, STI training curricula is revised and service providers re-oriented on the updated service standards and tools
13. By end-2010, decisions on national HIV prevention agenda is guided by “Know Your Epidemic” analytical synthesis and regular response reviews
14. By end-2011, HIV testing and counselling programme is reviewed, lessons learned are documented and disseminated
15. By end-2011, STI and HIV testing and counselling training is integrated into pre-service curricula of relevant service provider cadres
16. By end-2012, HIV testing and counselling guidelines and supporting tools are revised and service providers re-oriented on the updated service standards and tools
17. By end-2012, MC guidelines and supporting tools are revised and service providers are re-oriented on the updated service standards and tools
18. By end-2012, country readiness plans, regulatory procedures and standards for HIV vaccine and microbicides trials and intervention implementation are in place

Output 1.2 National structures and capacity to manage and coordinate effective BCC programmes in place

Coordinating organization: UNFPA

Rationale:

Although different misconceptions about HIV transmission and prevention remain relatively commonplace, almost all Kenyan adults have heard of HIV and AIDS. A large majority of the adult population know how to protect themselves from infection. The emerging consensus is that the lack of HIV general prevention awareness is no longer a primary driver of new infections in Kenya. Rather, it is said that "Kenyans know but they do not change"; so more effective targeting of behavior change are needed.

Many prevention efforts in Kenya have been primarily about developing communication programmes and interventions targeted to changing behaviors; some have even targeted those behaviors that increase risk of being infected with HIV. However due lack of consensus and understanding of what Behaviour Change Communication really is, these efforts have been of varied quality, many have not been evidence-based, and many have not been assessed for effectiveness. They have also failed to address barriers that prevent people from accessing services. The need to improve management and coordination for BCC is long over due. In addition most of the communication efforts to date have been targeted at the general population, with limited if any targeted at the most at risk groups.

Objectives:

1. To strengthen national mechanisms for management and coordination of BCC
2. To develop capacity to identify and design BCC interventions that significantly contribute to reduction in HIV transmission rates

Role of the UN and partnerships:

The UN HIV Communication group will, on behalf of the UN, support the NACC primarily through the BCC Consortium, and will provide technical and capacity building support to:

- review and refine the BCC Consortium Terms of Reference to ensure they reflect current needs and priorities.
- map country expertise in BCC and identify gaps
- strengthen the BCC Consortium capacities to provide guidance - through creation and use of a Core Team within the agency - to ensure BCC approaches are standardized and tools harmonized
- provide additional resources and skill development through development and use of a BCC Tool Kit for use by the BCC Consortium and partners
- ensure capacities developed within implementing partners to deliver effective stand-alone and/or integrated BCC programmes to reach specific target groups developed and rolled out, including those addressing issues of stigma and discrimination. (mainly through sourcing appropriate TA)
- play Quality Assurance (QA) role for HIV communication programming
- Consolidate evidence for effective communication programming.

The UN group will also facilitate and encourage the full participation of all BCC Consortium members (such as PSI, University of Nairobi, Merlin, etc). The UN group will also work to bridge the gap between national level stakeholders and the decentralized structures and CSOs at district and community level working on BCC.

Milestones to 2012:

1. By mid-2008, National and Regional BCC consortiums are in place
2. By mid-2008, Behavior Change Communication Consortium capacity to provide guidance is strengthened and supported by standardized guidelines and harmonized tools
3. By end-2008, NACC capacity to coordinate and monitor mechanism for BCC is strengthened and institutionalized, including systems for quality assurance
4. By end-2008 Communication Strategy is reviewed and disseminated, and HIV education/life skills policy is implemented
5. By mid-2009, BCC Strategy concerning MARPs is developed and capacity of implementing partners to conduct BCC activities is strengthened
6. By end-2011, a comprehensive BCC campaign is fully implemented and evaluated

Output 1.3 Comprehensive national programme for prevention of mother-to-child transmission (PMTCT) in place and supported by all stakeholders

Coordinating organization: UNICEF

Rationale:

Very few HIV infected children survive beyond their fifth birthday; approximately 50 percent die before turning age two. Yet a significant percentage of all new infections in Kenya are still due to vertical transmission. With a huge support from the US Govt., Kenya is making good progress in addressing this principal driver of the epidemic. Approximately 53 percent of all pregnant women attending antenatal clinics were offered PMTCT services in 2006. By the end of 2007, up to 1 million pregnant women will receive counseling and testing, and about 86,000 (75% of all in need) will be administered with ARV prophylaxis. However, the tradeoff for this spectacular progress includes an excessive reliance of the government on the off-budget funding from mostly PEPFAR, as well as increased verticalization of the interventions and limited scope for a broader child- and mother-focused approach. Currently, only about 50 percent of the ART sites provide pediatric treatment, and only about 14 percent of the facilities offer PMTCT+ (counseling and testing, ARV prophylaxis, infant feeding counseling, family planning *and* HAART where indicated). There is need for strong government involvement to pull together the sector interventions. Due to ongoing support to the districts with the poorest PMTCT coverage UNICEF with support from USAID will specifically target eight district in the Northern Areas.

Objective:

1. To support the development of a comprehensive national PMTCT program led by the government and supported by all stakeholders.

Role of the UN and partnerships:

The UN will provide technical cooperation and support to the MoH through the Division of Reproductive Health (RHD), Division of Child Health (CHD) and NASCOP to:

- develop policy to move forward integration and the scale up of services for women and children and help achieve the health-related MDGs.
- support an improved policy frame work for SMNH and the scaling up of SMNH activities in the Northern Areas
- scale up IMCI with improved Pediatric HIV prevention, treatment and care component nationally through technical input and support, support to training programs and facilitating supervision.
- link and integrate PMTCT with Reproductive Health and Safe motherhood/ Neonatal health services through standardizing Focused Antenatal Care (FANC) and supporting the introduction of the mother / baby card.
- to improve on the provision of safe motherhood services through rolling out FANC and comprehensive PMTCT as a service package, increase the proportion of women who have a skilled attendant during birth through communication support to MoH and social mobilization, support for voucher schemes for pregnant women and support pediatric ART roll out through the training of health workers and support in the purchase of laboratory equipment.
- support the printing and distribution of integrated monitoring tools and ensure every health facility is able to access them.
- support the design of Kenyan M&E tools for effective PMTCT reporting.

The UN group will also facilitate and encourage the full participation of all PMTCT Technical Working Group members and members of the MCG 1(such as Division of Reproductive Health, Division of Child Health, CDC, USAID, APHIA Partners etc)

Milestones to 2012:

1. By end-2008, national assessment on the impact of the national PMTCT programme is conducted
2. By end-2008, the national PMTCT communication strategy is launched and disseminated
3. By end-2010, 100% of PMTCT beneficiaries in 8 target districts receive infant feeding and counseling according to WHO standards
4. By end-2010, effectiveness of PMTCT interventions is reviewed and lessons learned documented
5. By end-2012, the proportion of facilities providing Comprehensive PMTCT services is 50 %
6. By end-2012, the proportion of pregnant women accessing PMTCT care and treatment services is 80 %
7. By end 2012, the proportion of infected mothers receiving ART is 75%
8. By end-2012, the number of new born babies benefiting from effective ART regimen is 80%

Output 1.4 Prevention among most-at-risk groups and populations of humanitarian concern advocated and scaled up as part of the national response

Coordinating organization: UNODC

Rationale:

In generalized epidemic environments, the unfortunate tendency has been not to combine targeted prevention efforts. Kenya is no exception in that regard. The current epidemiology of Kenya requires that increased attention be given to the traditionally neglected high risk groups, such as injecting drug users, sex workers, truck drivers, prisoners, men who have sex with men, girls and vulnerable young women, and discordant couples. Although consistent condom use among the most-at-risk groups is shown to be generally higher than in the mainstream population, the combined effect of unprotected sexual activities among such groups with generally above average HIV prevalence is likely to still constitute an important epidemic driver in Kenya.

Anecdotal information suggests that commercial or transactional sex, in its diverse contexts, is a key contributor to new incidence, especially in the most affected geographical areas. Expanded and evidence-informed programmes are required that respond to the specific needs of sex workers and their clients.

Injection drug use and sex among prisoners or homosexuality are illegal in Kenya; hence, it has been difficult to reliably assess the extent of these practices and their contribution to driving the epidemic. Further anecdotal information also suggests that extending effective prevention programmes to prisons, or to especially bisexual men in long-term heterosexual relationships, would be an important prevention milestone. The Kenyan public is not yet ready to confront aspects of the most-at-risk groups, especially MSM and IDUs.

Objectives:

1. To advocate and highlight the rights and needs of most-at-risk populations, and integrate their concerns into the national strategies and programmes
2. To strengthen the capacity of government, private sector, network organizations and CSO working with most-at-risk groups

Role of the UN and partnerships:

UN will provide technical and financial support to strengthen the capacity of NACC to coordinate scale-up and harmonization of programmes targeting MARPS, and specifically to:

- accumulate information and coordinate HIV response among those most-at-risk,
- sensitize decision-makers and support the development of enabling legislation
- support the development of a multi-sectoral policy framework with focus on vulnerability reduction
- assess the needs and map the presence of MARPs
- focus grant-making and other aspects of TOWA more effectively on MARPs
- support the different Government ministries and Departments, and CSO, to build their capacity to address the prevention of HIV among MARPs, review and update legislations, developing national strategies, and to scale up services to increase geographical and service coverage for the MARPs
- build capacity of a selected set of partners to deliver evidence-based and comprehensive programmes catering for specific most-at-risk groups.
- establish in collaboration with the Ministry of Transport an integrated HIV prevention services (wellness Centers), linked to treatment, care and support, at major truck stops and border crossings piloted, with coordination, technical support, and harmonized M&E under NACC/NASCOP.

The UN group will also facilitate and encourage the full participation of all line ministries, government agencies and members of MCG 1 implementing programs for the MARPs (such Ministry of Transport, University of Nairobi, FHOK, Prisons, NACADA, FHI etc). The UN group will also work to.

Milestones by 2012:

1. By mid-2008, advocacy campaigns for different MARPs groups are developed and conducted
2. By mid-2008 capacity of the UN and NACC to support sex work programmes is enhanced
3. By mid-2008, national assessments and mapping of the HIV situation among MARPs are conducted
4. By end-2008, national framework for HIV prevention among MARPs is developed
5. By end-2008, national strategies for prevention of HIV among MARPs are developed and disseminated
6. By end-2010, comprehensive and harmonized integrated prevention programme along transport corridors is developed and rolled out
7. By end-2012, interventions for the prevention of HIV among MARPS are scaled-up and maintained

Output 1.5 National condom programme strengthened and supported with procurement and distribution of male and female condoms

Coordinating organization: UNFPA

Rationale:

Condom-use in perceived high-risk sex and age at first sex by women have both gone up significantly in Kenya, thus suggesting that behavior change is occurring. But uptake of condom in general has remained a challenge, more so with female condoms. Repeated comments at the October 2006 JAPR focused on the high costs and unavailability of female condoms at the end-users points. Only between 12-14 percent of young women and men used condom during their first sex. At the same, there is new disturbing data that marital status is related to HIV prevalence. Both men and women in marital unions, or so-called stable relationships, are shown to have higher levels of infection than those not in marital unions. Widows and separated women run the highest risk. There is an urgent and overdue need for the development of a national condom programming that takes the view of condom as being much more than a supply operation or a social-marketing exercise. At the same, there is also need to ensure a sound pipeline for regular and uninterrupted supply of both female and male condoms, all the way down to the end-user point in the communities.

Objective:

1. To strengthen the national condom programme, and ensure uninterrupted supply of free male/female condoms and availability at end-user points

Role of the UN and partnerships:

Linking with the TOWA programme, the UN support will mainly provide technical assistance to NACC, NASCOP, DRH and civil society partners to:

- conduct a needs assessment and build the capacity of national institutions to conduct follow up surveys on user profile, access, gender dynamics, perceptions of condoms and the setup of condom programming, including logistics, distribution channels, health provider knowledge and attitudes
- develop a participatory process for the review and dissemination of a condom strategy and policy
- integrate female condoms into their prevention efforts along with male condom initiatives
- scale up the procurement of female and male condoms based on the NASCOP projection and enhance the technical capacity of KEMSA to implement a national condom procurement plan
- develop a sustainable condom distribution system from the district to the end-user
- work with health providers and policy makers to help de-stigmatize the female condom and help its integration into clinical practice and programming planning
- conduct an assessment of user and community attitudes so that programming can address any potential attitudinal barriers to access and use.
- develop tools to determine the relative cost effectiveness of introducing the female condom.
- support NASCOP and DRH to develop environmentally friendly condom disposal messages.

The UN group will also facilitate and encourage the full participation of all members of the condom working group under the leadership of NASCOP and NACC (such as PSI, KEMSA, MSH, GTZ, Futures group, etc). The UN group will also strengthen the capacity of KEMSA to enable them forecast, monitor and evaluate the distribution of both male and female condoms and also strengthen the distribution system beyond the district hospitals to the community.

Milestones to 2012:

1. By end-2008, report on male and female condom acceptability, utilization and cost-effectiveness is finalized
2. By mid-2008, a condom procurement plan is developed and implemented
3. By mid-2009, capacity of KEMSA is built to manage the logistic management information system
4. By mid-2009, capacity of KEMSA, NACC, NASCOP and DRH is strengthened to improve the national condom procurement plan
5. By end-2009, the national condom strategy and policy are revised and disseminated
6. By end-2010 condoms are procured and distributed without stock-outs at any level
7. By end-2012, evaluation study on effectiveness of condom strategy and its implementation is conducted

Outcome 2: *Improved treatment and care, protection of rights and access to effective services for infected and affected people*

Convener/lead organization: WHO

Output 2.1 Quality and equity of national AIDS-related treatment services (including commodities forecasting and distribution) effectively strengthened

Coordinating organization: WHO

Rationale:

The scale-up momentum for ART has gathered pace such that by end of 2006 120,026 patients were on ARVs, surpassing the country's own set ART enrolment target of 110,000 PLHIV. Despite good performance, the country continues to face challenges with regard to its ART monitoring system owing to the multiple partners supporting the programme and the different M&E initiatives the partners are supporting for their different reporting requirements. Currently, the country is only able to monitor its ART enrolment numbers from drug consumption figures, such that it is currently not possible to tell the break down enrolment numbers by gender, age and other social characteristics; or monitor treatment outcomes and adherence.

The patient tracking system has not yet become functional although NASCOP has made commendable strides with support from WHO, CDC, FHI and PHR+ in adapting WHO generic tools and developing national ART M&E tools, piloting them in one province, revising and finalizing them and preparing for national roll-out along with other health facility level HIV intervention tools. NASCOP has also, with support from WHO and CDC, implemented HIV drug resistance threshold surveillance survey whose results have shown it to be below the threshold; and with support from DFID (Futures) NASCOP has quantified anti-retroviral drugs requirements for the 3 years which need ongoing updating.

Further to the M&E gap, the ART programme has also come of age to require a review or evaluation as well as a broadening of focus beyond scale-up numbers to service quality in form of treatment outcomes; service quality (through site accreditation); ARV drugs resistance profiles of naïve and treated population; pharmacovigilance and post-market surveillance of ARVs. Also of critical importance in the ongoing ART scale-up is the decentralization of ART services to lower level facilities and cadres in order to bring the services nearer to where people live, task-shift some of the ART tasks to lower cadres and facilitate better integration of ART services with other healthcare services including TB, MCH, general adult/paediatric out-patient and in-patient care.

Another gap that Kenya will focus on is that of exploring ways of standardising ART services along the major transport routes in cognisant with standards used in neighbouring countries. This will be aimed at ensuring continuum of ART treatment and related services for mobile populations of the East African region. The proposed standardisation will draw most of its inputs from the work of the East African inter-governmental bodies e.g. GLIA along with some of the local development partners e.g. FHI and DFID who are supporting projects in this area.

Objectives:

1. To strengthen HIV/AIDS treatment services decentralization, site networking and quality assurance of ART services, supportive laboratory tests and ARV drugs
2. To facilitate standardization of HIV/AIDS treatment, care and support services to mobile populations along major regional transport routes
3. To strengthen comprehensive monitoring of the national ART programme and health sector HIV services delivery, in line with the Three-Ones principles

Role of the UN and partnerships:

The UN will provide technical support to NASCOP and other relevant partners in:

- conducting a review of the ART programme
- development of revised ART plan and tools/materials for ART serviced decentralization, networking, M&E and communications
- development of national policy, standards, strategies, service mapping and monitoring frameworks for ensuring continuum of ART treatment for mobile populations along regional transport routes
- rolling out tracking systems for ART patients (HMIS), treatment commodities and treatment outcomes nation-wide
- reviewing, documenting and consolidating existing ART electronic medical records (EMR) systems
- developing a pharmacovigilance system for ARVs (i.e. a surveillance system for drug related adverse effects), a post-market surveillance system and a drug resistance surveillance system
- development of a monitoring system for opportunistic infections (OIs) management and related services, documentation on access to ART by gender, geographical area and monitoring ARV drug utilization (actual and projected)
- strengthening QA/QC system for ART related laboratory tests including CD4 and viral load test.

Further financial support will be provided towards:

- stakeholders consultation meetings at all levels
- training of health workers and records personnel,
- printing and distribution of plans, protocols, M&E tools, reports and communications materials
- field visits as part of programme review, supervisory/mentorship/accreditation visits,
- logistical support for transportation of lab QA/QC samples, submission of M&E data and follow-up
- initial equipment/supplies for reference laboratory, M&E database

UN support will primarily be through NASCOP, National HIV Reference Laboratory, KEMSA and PMPB. The UN will work closely with the other major players in ART as a way of ensuring coordination, consensus and harmonization of all ART programme activities into one national programme. Such partners include MSFs, GFATM, USG (CDC, USAID, DOD) and their sub-contracted organisations such as APHIA II partners, MSH, policy project etc.

Milestones to 2012:

1. By end-2008, the national standards and service delivery frameworks for HIV treatment services are coherent with international standards
2. By end-2008, the national system for HIV treatment commodities management includes forecasting, quantification and standardized delivery mechanism
3. By end-2009, national ART monitoring and patient tracking systems are rolled out to all ART services delivery sites
4. By end-2009, national communication and advocacy strategy is established and addresses sensitization, treatment literacy and equity for improved access to HIV service delivery
5. By end-2009, national quality assurance framework is established for HIV treatment services
6. By end-2010, evaluation on level of HIV treatment service alignment with national standards and service delivery frameworks is completed
7. By end-2010, an independent review for evaluation of national HIV treatment service delivery is undertaken
8. By end-2011, a QA system for HIV treatment services and ARV drugs that includes pharmacovigilance, post-market surveillance and drug resistance surveillance/monitoring is functional
9. By end-2012, ART guidelines, provider handbooks, related monitoring tools and training materials are revised and health providers are re-oriented on the updated standards
10. By end-2012, national, provincial and high ART patient volume district hospitals have migrated to electronic medical records systems for ART that meet national EMR standards
11. By end-2012, national strategy, guidelines and tools for treatment preparedness and literacy are developed and disseminated

Output 2.2 Coherent interface between TB and HIV -related services established and maintained

Coordinating organization: WHO

Rationale:

HIV co-infection in TB patients is estimated at 50 to 60% in Kenya. TB/HIV collaboratory activities encompassing HIV diagnosis for TB patients have now been scaled up almost country wide with a coverage of 70% of all TB patients receiving an HIV test.

Main challenge has been to similarly integrate and scale-up diagnosis of TB in HIV service settings. Only few VCT sites and comprehensive care clinics systematically provide services to diagnose TB. Further challenges have been with regard to referral of HIV positive TB patients for HIV care and ART treatment due to the fact that TB services are more decentralized than are HIV treatment services

Objective:

1. To strengthen integration of TB interventions into HIV/AIDS services including their scale-up and monitoring

Role of the UN and partnerships:

The UN will provide technical support to NASCOP and NTLP in:

- review of the ART programme including the level of integration of TB suspects identification
- development of national framework, tools and materials for integration of TB identification in HIV service settings
- development of ART decentralization and networking framework, tools and materials
- health centre identification, capacity building and follow-up for decentralization of ART services
- review of HIV and TB monitoring tools for integration of TB/HIV indicators

UN support will primarily be through NASCOP and NLTP. The UN will work closely with the other major players in TB and HIV/AIDS through the TB/HIV working group and the ART Task Force include MSFs, USG (CDC, USAID) and their sub-contracted organisations such as APHIA II partners, MSH, policy project etc.

Milestones to 2012:

1. By end-2008, current HIV service frameworks used for integration of TB into HIV services are documented and optimal framework is proposed
2. By end-2009, the national monitoring systems for TB and HIV treatment include data on HIV and TB service integration
3. By end-2009, the national standards for HIV treatment services incorporate identification of TB and access to TB treatment
4. By end-2009, the national service delivery framework for TB facilitates access for 80 % of TB patients to HIV treatment
5. By end-2010, facility service mapping of those facilities providing HIV and TB services is carried out and a plan to expand HIV services to facilities providing TB services but not HIV services is developed
6. By end-2012, all TB providing facilities provide the minimum HIV prevention, treatment, care and support interventions recommended for the facility level

Output 2.3 Comprehensive national service delivery framework for the continuum of treatment and care for HIV-exposed children established

Coordinating organization: WHO

Scale-up of ART for children continues to lag behind that of adults in Kenya. The realisation of this made the National ART programme to form a Paediatric HIV Treatment and Care Group to Champion acceleration of development and scale up of HIV services targeted at children.

Through this group a scale-up strategy, early infant diagnosis algorithm, paediatric ART communications package, paediatric ART training and orientation material, etc have been developed and a paediatric ART RRI is currently in operation.

What remains a challenge is finalisation of the paediatric HIV treatment and care framework that ensures continuum of HIV prevention, treatment and care from PMTCT to MCH and beyond. Currently an integrated child mother card is being developed along with new recommendation for early infant diagnosis for children unaware of their HIV exposure status during immunization as well as starting all HIV exposed infants on cotrimoxazole prophlaxis. Also to be strengthened are issues concerning infant feeding especially within the context of PMTCT

Objective:

1. To strengthen national service delivery framework in order to ensure access and continuum of HIV/AIDS treatment and care for HIV exposed children

Role of the UN and partnerships:

The UN will provide technical support to NASCOP and division of child health in:

- finalization, printing and dissemination of the paediatric HIV and AIDS strategy, guidelines, related tools and materials
- finalization of various paediatric HIV/AIDS service provision protocols including EID and their implementation framework
- finalization and printing of integrated child health card and paediatric HIV/AIDS services monitoring tools
- documentation and dissemination of paediatric HIV approaches and interventions

WHO will work with UNICEF to provide UN support primarily through NASCOP and division of child health. The UN will work closely with the other major players in paediatric HIV and child health including Clinton Foundation, USG (CDC, USAID) and their sub-contracted organisations such as APHIA II partners, MSH, policy project etc.

Milestones to 2012:

1. By end-2008, the national monitoring and evaluation system includes a framework for monitoring the continuum of care for HIV -exposed children
2. By end-2009, the national paediatric HIV and AIDS strategy and related protocols strengthen the continuum of care for HIV -exposed infants
3. By end-2010, national clinical pathways for treatment and care of HIV exposed children are established to enhance access to comprehensive services
4. By end-2011, WHO IMCI/IMAI HIV service delivery framework is adapted for Kenya and integrated in the country's IMCI service framework
5. By end-2012, IMCI related tools are revised and service providers are updated on the revised service delivery standards

Output 2.4 Approach for HIV care in community setting standardized

Coordinating organizations: WHO and UNICEF

Rationale:

The National Health Sector Strategic Plan 2005 (NHSSPII) proposed establishment of a package of life cycle focused health interventions at community level as level 1 in the Kenya Essential Package for Health (KEPH). Since then, the Ministry of Health has developed the Community Strategy in order to initiate the implementation of health actions at level 1. Along side the strategy, the Ministry has also developed its implementation guide, key messages and training materials for community heath workers.

The implementation of this strategy will result in bringing under one framework all vertically implemented interventions in Kenya, including HIV Home Based Care. A number of home based care programmes are currently active each with own unique characteristics. Main partners in Community Home-Based Care include Mild May International, AMREF and MSF. Although the overall policy framework on community health interventions has now moved on with the operationalization of the community strategy, there is a need to carefully migrate home based care in order not to lose the success accrued to date.

The review and integration of home based care into the level 1 service package will be used as an opportunity for address the funding gaps, integration of nutritional care and support and palliative care into service delivery, development of tools to support operational guidelines, and the need to evaluate the impact of service delivery. It is anticipated that TOWA funds will provide significant support for the scale up of community services and home based support.

Objectives:

1. To standardize HIV and AIDS interventions in the community within the framework of the level 1 KEPH package
2. To facilitate equitable scale-up of standardized community HIV and AIDS interventions

Role of UN and partnerships:

The UN will provide technical support to NASCOP, health sector reforms unit, health promotion unit and clinical department in:

- reviewing the community home based care programme, documenting current approaches, interventions and coverage
- development of the minimum community level HIV/AIDS interventions package (covering prevention, treatment, care and support) to be implemented through KEHP level 1 services
- reviewing systems & indicators in existence for monitoring community based HIV and AIDS services
- contributing to the development of the KEPH level 1 services delivery framework and related tools for the integration of the HIV and AIDS service package
- contributing to the roll-out of comprehensive KEPH level 1 services, training of providers, and ongoing monitoring system

UN support will be provided by UNICEF, WHO and WFP primarily through NASCOP and the health reforms unit. The UN will work closely with the other major players in community care including MSF, Mildmay, AMREF and the USG group (CDC, USAID) and their sub-contracted organisations such as APHIA II partners, MSH, policy project etc.

Milestones to 2012:

1. By end-2008, the national monitoring and evaluation framework for community HIV service delivery (e.g. COPBAR) is strengthened
2. By mid-2009, a national service delivery framework is established and operational guidelines are developed for community based care for PLHIV within the context of level 1 services
3. By mid-2010, a national framework is established to address equitable scale up of community based HIV services
4. By end-2012, HIV community level minimum interventions are fully integrated into the KEPH level 1 service package implementation

Output 2.5 Nutritional clinical care and support integrated into AIDS -related treatment services

Coordinating organizations: UNICEF and WFP

Rationale:

HIV and malnutrition are interlinked, both epidemiologically and physiologically. On one hand, HIV/AIDS causes or worsens malnutrition due to decreased food intake, increased energy requirements, poor nutrient absorption and opportunistic infections. On the other hand, malnutrition further weakens the immune system, increasing susceptibility to infections and worsening the disease's impact.

Following evidence presented at the Nutrition and HIV meeting in Durban 2005 and Kenya 2007, WHO now recommends integration of nutrition in treatment and care for people living with HIV (PLHIV) in order to facilitate maintenance and/or improvement (or slow deterioration of) nutritional status, boost immune response, manage the frequency and severity of symptoms, and improve response to ART and other medical treatment.

Kenya has currently developed nutrition guidelines and is currently is in the process of finalizing a strategy document. A number of tools and supporting materials for the guidelines and strategy are yet to be developed and used for building provider capacity. Facilitation of implementation of the standardized interventions will be critical since the country does not currently have standardized nutrition interventions on the ground.

Objectives:

1. To support standardization of nutrition interventions in the context of HIV
2. To facilitate integration of nutrition interventions into AIDS -related comprehensive treatment and care services
3. To facilitate equitable scale-up of nutrition interventions in the context of HIV

Role of UN and partnerships:

The UN will provide technical support to NASCOP in:

- strengthening national services and meeting universal targets for nutritional care and support of PLHIV
- establishing and scaling up national services and ensure that nutrition is integrated into strategic points of service delivery
- developing national guidelines, curriculum and counselling materials on nutrition, HIV and AIDS
- establishing nutritional support through facility and community based services
- advocacy and resource mobilization at a national level and to implement areas of the national strategy on nutrition and HIV/AIDS.

UN support will be provided by UNICEF with support from WHO and WFP through NASCOP and the nutrition unit. The UN will work closely with the other major players in nutrition and HIV/AIDS care including MSF, Mildmay, AMREF and the USG group (CDC, USAID) and their sub-contracted organisations such as APHIA II partners, MSH, policy project etc.

Milestones to 2012:

1. By end-2008, national strategy on nutrition, HIV and AIDS is finalized and adopted
2. By end-2008, the national monitoring framework for HIV treatment services integrates nutritional care and support
3. By end-2009, the national essential drug list includes key nutritional commodities for PLHIV
4. By end-2009, 50 % of national HIV treatment sites integrate national standards for nutritional care
5. By end-2012, all national HIV treatment sites provide services in line with national standards for nutritional care

Output 2.6 Strengthened framework in place for protection of human rights in the context of HIV

Coordinating organization: UNICEF

Rationale:

The human rights dimension of the HIV epidemic span the full range of civil, political, economic, social and cultural rights and include:

- Direct discrimination against PLHIV and denial of basic human rights of HIV infected and/or affected people
- Increased vulnerability to HIV, whether due to inequalities based on poverty, gender –based discrimination and violence or other determining factors resulting in diminished possibilities to prevent HIV infection
- Factors limiting effective response to HIV epidemic, such as societal norms or cultural practices that hinder addressing specific HIV vulnerabilities

Based on the above, promotion and protection of human rights within the HIV context are imperative for effective prevention and control of the epidemic. Within this context human rights frameworks must be able to i) empower communities to respond to the epidemic, ii) reduce vulnerability of un-infected individuals and iii) improve quality of life and minimize the impact of the epidemic on those who are infected and, iv) advocate for reduction of discrimination and stigmatization of PLHIV in all settings.

Objective:

1. To ensure that the rights of HIV –infected and affected Kenyans are protected and that they increasingly have access to quality legal and health services.

Role of the UN and partnerships:

Under coordination of NACC, the UN will support work with various partners to support key sectors in strengthening human rights protection frameworks and will specifically:

- Facilitate the development of the HIV Act regulations and set up of oversight committee
- Facilitate the development of guidelines and protocols for implementation of human rights components of the HIV Act, including those related to women's inheritance rights in the context of AIDS
- Support and build capacity of civil society organizations to mainstream human rights and gender approaches in programming and policy dialogue
- Promote access to information on HIV prevention, care and support for all Kenyans
- Support the civil society networks for advocacy activities towards universal access to care
- Support processes to develop the capacity of comprehensive care centers to provide information to PLHIV on their reproductive and legal rights
- Support the Ministry of Home Affairs to provide and monitor AIDS -related care services within prison settings (for both inmates and guards) with a referral network for those leaving prison
- Advocate for the extension of pro-bono legal services to aggrieved HIV positive Kenyans through the legal unit
- To ensure that gender, as a human rights issue, is mainstreamed into all national HIV prevention and control structures and frameworks

Milestones to 2012:

1. By end-2008, HIV Act regulations are developed and disseminated
2. By end-2008, all CCCs are providing information to PLHIV related to their reproductive health and legal rights
3. By end-2008, NACC Secretariat gender desk is strengthened to provide coordination services on gender issues
4. By end-2008, NACC committee on gender is re-activated and strengthened to provide advise to the Secretariat, ICC and to strengthen linkages with sexual and gender-based violence working group(s)
5. By end-2009, mechanism for clear target setting and monitoring of realization of rights of HIV –infected and affected is established and incorporated into the KNASP
6. By end-2009, media owners association commits to addressing HIV, AIDS and human rights , particularly with regard to reduction of stigmatization and discrimination
7. By end-2009, oversight committee on human rights is established under the NACC legal unit and provides reports to the NACC for national coordination purposes
8. By end-2010, national pro-bono service available and handling PLHIV legal complaints
9. By end-2010, Ministry of Home Affairs is strengthened to provide care and support services within prison settings and existing operational networks for referral services to those departing prison
10. By end-2010, PLHIV associations are supported to establish and operationalize at least 10 HIV anti-stigmatization advocacy groups in each district
11. By end-2011, community- and religious leaders are actively engaged in anti-stigmatization/discrimination campaign under the umbrella PLHIV network
12. By end-2012, evaluation on the rights –based framework for HIV –infected and affected is carried out

Outcome 3: ***Existing programmes adapted and innovative responses developed to reduce the impact of the epidemic***

Convener/lead organization: UNDP (UNICEF for OVC)

Output 3.1 HIV mainstreamed in development budgets as articulated in MTEF and district development plans

Coordinating organization: UNDP

Rationale:

Sustainable financing of HIV in Kenya is without a doubt the single biggest threat facing the long-term future of the sector. While much of the focus to-date has been on accelerating universal access to treatment and preventions services, the sources of funding for doing so cannot continue to be a secondary matter. As already mentioned several times in this document, HIV response in Kenya is 97 percent foreign financed, with the current Government of Kenya expenditure accounting only for a small amount (less than 3% of total HIV activities or just over 5 of on-budget HIV activities). Despite an overall increase in GoK funding to the MoH, the allocation to HIV has declining in real terms over the past three years.

Mainstreaming should be seen as an effective way to help scale up, deepen and sustain the HIV response, by mobilizing key actor and sectors to contribute to an effective and sustained national response. This includes fuller integration of HIV and AIDS responses into national development planning, policy making, priority setting and budgeting and ensuring that macroeconomic and public expenditure frameworks support and appropriately prioritize the implementation of national AIDS action frameworks and annual priority AIDS action plans.

The NACC, in collaboration with the Ministry of Finance and Ministry of planning and National Development, has set up structures to look develop means to ensure that HIV programme costs are increasingly built into the national development planning and budgetary processes.

Objective:

1. To facilitate the process for mainstreaming HIV and AIDS in national and district level plans and budgets

Role of the UN and partnerships:

The Un will be engaged in provision of technical and/or financial support to NACC and MPND for:

- the mainstreaming and integration of HIV and AIDS in the Kenya Vision 2030 by ensuring participation of actors in the HIV/AIDS landscape in the entire process
- conducting stakeholder consultations to develop a Concept Note that will facilitate engagement in the Vision 2030 process.
- Development of medium term implementation strategies for integration of HIV/AIDS integration in sector responses to meet development of objectives and targets
- strategic collaboration with the Public Sector Reform and Development Secretariat (PSRDS) in the Office of the President, Cabinet Office and the Kenya Institute of Administration
- development of a module on HIV and AIDS in relation to economic development planning and broad policy level training, to be anchored at the KIA.

Milestones to 2012:

1. By end-2007, key public sector officials, including those running the AIDS Control Units (ACUs) are trained on HIV and AIDS integration in Poverty Reduction Strategies and Medium Term Expenditure Framework (MTEF)
2. By end-2007, the draft PRS document contains HIV activities and indicators
3. By end-2008, HIV integrated in Kenya Vision 2030
4. By end-2009, HIV budgets are fully incorporated in MTEF
5. By end-2009, a mechanism is established to facilitate effective participation of non-state actors in the planning and implementation of the HIV aspects in the PRS
6. By end-2010, HIV programming is institutionalized in district development plans and budgets
7. By end-2012, review on level of HIV mainstreaming and implementation across sectors and decentralized levels is carried out and report is disseminated

3.2 National OVC Plan of Action is operationalized and conditional cash transfer pilot and other sustainable livelihood interventions targetting orphans scaled up

Coordinating organization: UNICEF

Rationale:

Out of the over 2.4 million orphans in the country 1.2 million are estimated to be due to AIDS (NACC 2005). This does not represent total numbers of children affected by AIDS as many more are taking care of ailing parents and adults. Most of these children have limited or no access at all to protection and basic social services.

The National Plan of Action being developed by the Department of Children Services with support from development partners and national stakeholders seeks to spells out the necessary measures needed to protect these children from exploitation, discrimination, stigma and abuse and to access them to basic services just like other children in the country. The NPA defines minimum package needed to reach each OVC, the cost of this package and provides a budget for the roll out of the NPA over a period of 5 years. Important to note is that the actualization of NPA is multi-sectoral and calls for enhanced coordination and monitoring

It is agreed that children are best taken care of within family environment. The NPA spells out support to families as first key priority area. The government of Kenya, with support from UNICEF, DFID and SIDA is currently piloting a Cash transfer programme to extremely poor households fostering OVC. The objectives of the cash transfer programme includes ensuring OVC are retained within fostering families, and that their general welfare is improved including access to improved nutrition, education, health care and birth registration. The current pilot transfers Kshs. 1,500 to beneficiary household per month covering 8,000 households within 19 districts. The pilot is accompanied by impact evaluation process seeking to generate lessons on identification, delivery mechanism and cost effectiveness of the programme, and to evaluate the impact on general welfare of beneficiary children and households.

The current situation for Kenya is that funding is assured for a programme that will scale-up to somewhere between 30,000 and 50,000 households in 40 districts by the end of 2009, depending on the size of the transfer, through a combination of funding from Kenyan taxpayers, DFID, SIDA, UNICEF and the World Bank. An envisioned full scale national programme would involve 100,000 beneficiary households (or 300,000 OVC) in 74 districts and would cost an estimated USD 37 to USD 43 depending on the value of the transfer.

Objectives:

1. To scale up interventions for implementation of the National Plan of Action for OVC
2. To strengthen institutional capacity both at the central and decentralized levels to improve a coordinated network of stakeholders involved in OVC programmes
3. To assess the impact of cash transfer programmes in improving the welfare of beneficiary OVC

Role of the UN and partnerships:

The UN will provide technical support to the Department of Children Services in the office of Vice President, Ministry of Home Affairs, other relevant ministries and non-state actors:

- for completion of OVC NPA, and integration of key components of child survival, development and participation
- to facilitate sharing of OVC NPA with key stakeholders (GoK, CSO, private sector and communities)
- for strengthening of organizational/administrative structures for implementation of the NAP on OVC
- for sharing best practices in utilization of community/district structures in identification of, and intervention on OVC
- for ensuring effective and efficient implementation of the cash transfer program
- for evaluation of the impact of OVC cash transfer programme and other OVC interventions
- for facilitating documentation and dissemination of good practices on cash transfer programmes
- for development of national guidelines on provision of psychosocial support for OVC
- for support of situational analysis for OVC exercise
- for development of national regulations and/or guidelines on alternative family care for OVC
- for development of national social work standards

Milestones to 2012:

1. By end-2007, National Plan of Action on OVC is finalized and officially launched
2. By end-2008, roll-out and implementation of NPA for OVC is functional
3. By end-2009, national guidelines on psychosocial support for OVC are in place and disseminated
4. By end-2009, national regulations and/or guidelines for alternative family care are developed and disseminated
5. By end-2009 , national standards for social work are developed and disseminated
6. By end-2011, communities demonstrate ownership for management of OVC interventions
7. By end-2012, cash transfer programme is reaching 100,000 households

3.3 HIV intergration strategy in private and informal sector developed and implemented

Coordinating organization: UNDP

Rationale:

As a provider of a significant portion of HIV –related services, as well as a large employer in itself affected by HIV, private sector has been acknowledged as a key constituency in the national HIV response. So far, it has been challenging to find a sustainable mechanism to facilitate and foster systematic private sector engagement of the formal private sector. The same challenges apply to the informal sector engagement.

The majority of the people living with HIV globally are workers. In Kenya, the prevalence rate is highest amongst the 15 – 49 yr age group, which is the most economically active segment of society. The role of the workplace in providing prevention and care, as well as the protection of rights was recognized by the UN general assembly in 2001 (UNGASS) which committed to strengthen the response to HIV and AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work.

The cost of AIDS in the private sector is crystal clear. The core problem for employers is the loss of skilled workers with job-specific competence and organizational experience. Studies have shown absenteeism in the private sector in Kenya to account for 25 – 45% of all costs (ILO, 2004). Another study found costs already ranging from 1% to 9% of profits, largely due to increased absenteeism. Workplace programmes responding to HIV and AIDS are the conduit for mitigating the impact of the epidemic. There remain a large number of enterprises that do not have any programme that addresses HIV, and there is a need to mainstream them into their daily operations.

The informal sector comprises of about 80% of the total labour force, and yet very few HIV –related workplace interventions have been implemented therein. It has been a dynamic source of employment and income growth for several decades. It is characterized by enterprises that are unincorporated and comprise economic production units owned by households, often tantamount to self-employment. Given the size and complexity of the informal sector, HIV and AIDS can have far reaching consequences on those working therein. Yet, very few interventions have targeted workers in the informal sector hence excluding the majority of Kenya's working population.

In 2006, NACC established Private Sector Advisory Network (PSAN) to help address the above gap in the national HIV response, but the structure needs considerable support to fulfill its mandate and to build strategic working relationships, to establish viable dialogue and inclusion of the formal private sector and informal sector at level commensurate with their potential as strategic partners in the national HIV response.

Objectives:

1. To build capacity for integration of HIV and AIDS into private and informal sectors with clearly defined policies and implementation guidelines and protocols.
2. To facilitate implementation and monitoring of workplace policies that combat HIV/AIDS as a means for mitigating the impact of the disease.

Role of the UN and partnerships:

The UN will provide technical and/or financial support to NACC, MPND, Ministry of Labour, HIV Business Council, Federation of Kenyan Employers and other key member organizations/associations in the private/informal sector:

- for stakeholder consultations, advocacy, draft workplace policy for informal sector and consensus-building
- to facilitate assessment of status and progress in alleviation of on HIV/AIDS-related workplace discrimination in informal and private sectors.
- for policy dialogue and adoption
- for development of work place policy guidelines and protocols for informal sector
- for advocacy and policy dialogue on policy adoption
- for development of management structure and strategic plan

Milestones to 2012:

1. By mid-2008, PSAN is revived and functioning effectively on the basis of its ToR
2. By end-2008, private and informal sector HIV response engagement framework is developed
3. By end-2008, a draft workplace policy for public, private and informal sector is in place
4. By end-2008, guidelines and protocols for management structures and implementation strategies for informal sector work place policy are developed
5. By end-2010, private sector workplace policies and plans conform to the HIV Act
6. By end-2012, a clearly defined workplace policy for informal sector being implemented
7. By end-2012, comprehensive review on quality and coverage of private sector work place policy and programme implementation is carried out

Output 3.4 HIV mainstreamed in six priority sector plans (education, health, agriculture, transport, security, law and order)

Coordinating organization: UNDP

Rationale:

One of the priorities for NACC is to explore means to better influence mainstreaming of HIV inside the government bureaucracy. Linked to increased mainstreaming of HIV in national development frameworks and financial instruments, high-quality implementation of HIV mainstreaming agenda in public sector requires development of tools and capacities. In this regard, it has been noted that the ACUs within the ministries have made some progress regarding internal mainstreaming work. However, due to a disconnect between the ACUs and the Central Planning and Monitoring Units (CPMUs), HIV does not feature adequately in the planning and development prioritization across ministries. There are currently no guidelines to help ministries mainstream HIV in their planning and budgeting or for effective working modalities with civil society and other relevant stakeholders to enhance external mainstreaming. At the same time, advocacy work for high level commitment and accountabilities for public sector HIV mainstreaming is required.

Objectives:

1. To strengthen capacity for coordination and management for mainstreaming HIV/AIDS in key sectors and civil society.
2. To build capacity for mainstreaming of HIV in the six key sectors of education, agriculture, health, transport, governance, justice, law and order (GJLOs) and OP (security)

Role of the UN and partnerships:

Linking with the TOWA programme, the UN support will provide technical assistance and financial support to NACC, MPND, other line ministries and civil society within a guiding framework of key 'entry points' for effective mainstreaming: i) Rapid Assessment, Analysis and Action Process to produce situation analysis and support to development of evidence –informed policies and plans, ii) capacity development and resource mobilization to help operationalize mainstreaming agenda, iii) strategic evaluations of HIV mainstreaming processes and results. Specific support will be provided:

- to carry out impact studies in education, agriculture, health, transport, security, law and order sectors
- for advocacy and policy dialogue on findings of 'impact studies' to enhance development of new policies and strategies for implementation
- for the development of frameworks and management structures for mainstreaming HIV in health, education, agriculture, transport, security, law and order sectors,
- to facilitate regular consultative processes involving line ministries, civil society and development partners for comprehensive and integrated planning and implementation of mainstreamed components
- for capacity building on planning around impact of HIV on the six priority sectors
- to strengthen linkages with and between sectors for mainstreaming HIV
- to facilitate bi-annual stakeholder meetings/fora for monitoring the progress in mainstreaming HIV and AIDS in the various sectors
- for developing M&E framework - indicators for monitoring and evaluation of mainstreaming initiatives
- for development of software for tracking and monitoring progress/performance in mainstreaming HIV and AIDS in education, health, agriculture, security, transport sectors
- to work with indigenous CBOs and NGOs to build their capacity for mainstreaming HIV and AIDS in their development plans, activities including proposals

Milestones to 2012:

1. By end-2008, impact studies in the six priority sectors are conducted
2. By end-2008, sector policies that mainstream HIV in the six key sectors are reviewed/developed
3. By end-2008, management, coordination and operations structures are established within priority ministries, to direct, guide and monitor sector-wide response mainstreaming
4. By mid-2009, budgeted HIV action plans integrated into overall operations of the six priority sectors
5. By end-2009, all six priority sectors accessing funds through TOWA for programme implementation
6. By end-2012 key sectoral plans are being implemented to mitigate causes and impact of HIV

Outcome 4: *'Three Ones' effectively functioning as the basis for all programming and resource allocation in support of the national HIV response*

Convener/lead organization: UNAIDS Secretariat

Output 4.1 NACC equipped with coordination capacity and support services necessary for effective delivery of a multi-sectoral response to HIV

Coordinating organization: UNAIDS Secretariat

Rationale:

Under the 'Three Ones' principle, one of the key success elements for multisectoral national HIV response is the effectiveness of leadership and coordination provided by the National AIDS Control Council towards development of effective systems and partnerships at country level. Guided by the global recommendations on improved aid effectiveness and harmonization of support to national HIV responses, the UN system is well placed to act as an 'honest broker' in facilitating development of structures and modalities to drive increased effectives of programme delivery, utilization of resources, monitoring and evaluation mechanisms in support of the national HIV response in Kenya.

Objectives:

1. To strengthen the capacity of NACC to provide leadership and coordination for an inclusive and aligned multi-sectoral national HIV response, across wide range of stakeholders and intervention areas at national and decentralized levels
2. To advocate for, and facilitate design of structures and mechanisms for wider development partner harmonization and alignment within the context of GTT recommendations

Role of the UN and partnerships:

Building upon the UNAIDS role in provision of normative guidance, the interventions of the UN system aim at translating international guidelines, good practices and lessons learned for improved effectiveness of country level HIV programming in Kenya. Through continuous technical and process support by the UNAIDS Secretariat and other relevant organizational and financial inputs, the UN system will:

- Advocate for, and provide technical support to establishment and operationalization of clear leadership, accountability structures and management performance monitoring for the national HIV response
- Review existing partnership arrangements within the national HIV response and facilitate coordinated processes for identification of opportunities for enhanced public-private partnerships and civil society participation
- Continue technical inputs and facilitation support to the NACC in coordinating the implementation of the Harmonization Agenda, specifically promoting active engagement by key development partners, and move towards a common integrated work plan for the HIV response under the auspices of NACC
- Actively engage in NACC structures and forums facilitating establishment of sustainable mechanisms, and increasing harmonization and predictability for national HIV response financing

Milestones to 2012:

1. By mid-2008, clear framework for civil society and private sector engagement in the national HIV response and collaboration with NACC is in place
2. By end-2008, high-level, multisectoral public sector HIV accountability structure is established and functioning
3. By end-2009, all funding partners to the national HIV response have undergone a minimum of one peer review
4. By end-2009, all major stakeholders in the national HIV response base their contribution on formal agreement with NACC (MoU/Code of Conduct)
5. By end-2010, information on all resource allocation, programming and monitoring data is channelled through/available to NACC
6. By end-2010, an effective mechanism is in place for sustainable long-term funding of the national HIV response
7. By end-2012, harmonized coordination framework is evaluated and report is disseminated

Output 4.2 Evidence-informed and harmonized processes for KNASP planning and implementation in place

Coordinating organization: UNAIDS Secretariat

Rationale:

Kenya is in a fortunate position to have a substantial body of knowledge developed through a robust set of research activities. In order for the available information to be utilized effectively to inform national strategy and to allow identification of still existing knowledge gaps, a structured and systematic 'Know Your Epidemic' analyses have to be instituted. Based on a high-quality analytical framework and build on participatory process principles, Kenya is likely to benefit from a relevant and achievable strategic plan, which brings sustainable gains. Furthermore, the strategy needs to be effectively translated into ambitious consolidated work plans in order to facilitate the kind of progress required to contain the HIV epidemic and to improve lives of those affected by it.

Objectives:

1. To provide technical support to timely KNASP review and development processes with a view of ensuring a high quality, evidence – based strategic framework for the Kenya national HIV response with wide ownership through participatory processes and effective dissemination
2. To support the MCGs on coordination and development of tools for annual national prioritization and consolidated work planning exercise

Role of the UN and partnerships:

Facilitated by the UNAIDS Secretariat, the UN will engage in strengthening and consolidating the national strategic planning and review processes (KNASP and related plan development and reviews, JAPR) and will:

- Facilitate generation of analytical synthesis reports on the national HIV epidemic and response
- Provide strategic, high-quality technical inputs and active participation
- Facilitate additional technical assistance as required
- Engage with other partners and stakeholders to provide coherent, consistent and objective support for the institutionalization of the process
- Solicit support from development partners and stakeholders
- Provide financial support as appropriate.

Milestones to 2012:

1. By mid-2008, KNASP II mid-term review is carried out and re-costing is finalized
2. By end-2008, NASA is carried out and HIV and AIDS Public Expenditure Review is introduced as an annual exercise
3. By end-2009, the KNASP III is developed and endorsed
4. By end-2010, all major development partners coordinate their inputs to the national HIV response through the national consolidated work plan
5. By end-2012, evaluation of consolidated planning and implementation process is carried out and documented

Output 4.3 Synchronized national HIV response M&E system and robust strategic information utilization mechanism in place

Coordinating organization: UNAIDS Secretariat

Rationale:

Kenya has a mature HIV epidemic with correspondingly developed and complex response to it. In such context functioning and robust M&E system providing timely and relevant information through a consolidated mechanism becomes a necessity. In order to construct an accurate picture of the HIV epidemic and response at any given time, the systems that generate data need to be harmonized and connected to form one comprehensive body of knowledge to allow informed analysis and decision making. In order to avoid duplication of efforts and to harmonize resources in support of the national HIV response, joint review and assessment mechanisms and processes are urgently required to be institutionalized. On the other hand, harmonization has to bring added value and, as such, development partners and other stakeholders can only be requested to substitute individual reviews and assessments for a joint process, which is well organized with high-quality data inputs and analytical strengths.

Objectives:

1. To support strengthening of data quality and consolidation into one system, with strong quality assurance elements and effective information utilization plans
2. To ensure that the JAPR process is conducted in an effective, transparent and accountable way and its quality and depth annually improved.
3. To strengthen NACC's capacity to manage and produce high quality documentation of the JAPR process
4. To support improved availability and accessibility of core information for effective monitoring of the national HIV response and achievement of Universal Access targets

Role of the UN and partnerships:

Through the UNAIDS Secretariat, the UN will engage in support to the mechanisms for M&E collection and consolidation, joint review processes strengthening, and will:

- Provide technical support to assess and improve the current facility- and community –based data flows
- Provide technical and financial support towards effective utilization of information, including meaningful and relevant feedback to facility- and community – level
- Advocate for, and technically support development of consolidated periodic 'flagship' publications on the status of the HIV epidemic and response in Kenya
- Facilitate enhancement of the JAPR concept and process implementation based on 'user' need assessment
- Facilitate progress reviews against Universal Access targets
- Provide technical support towards evaluation of the national HIV/STI annual surveillance system and revise national HIV/STI surveillance guidelines and tools
- Facilitate annual HIV/STI national surveillance field activities, publication and dissemination of annual surveillance report
- Provide technical assistance towards HIV service coverage and effectiveness survey in the health sector and publication of the survey report

Milestones to 2012:

1. By end-2008, facility-based data is routinely collected, compiled, analyzed and published periodically
2. By end-2008, policy decisions, selection of priorities, programming and calls for proposals are based on information from, and compiled through the JAPR
3. By end-2008, mid-term review of the roadmap to achieve Universal Access targets by 2010 is available
4. By end-2008, first annual consolidated and comprehensive HIV response document is published
5. By mid-2009, all development partners contribute to consolidated plan for programmatic assessments based on jointly identified needs
6. By end-2009, national HIV/STI annual surveillance system is reviewed and report is disseminated
7. By end-2010, the comprehensive analysis of Universal Access achievement is published
8. By end-2010, national HIV/STI surveillance guidelines and tools are reviewed, revised and disseminated
9. By end-2012, national HIV/STI annual surveillance report is developed and disseminated each year
10. By end-2012, health sector HIV and AIDS services coverage and effectiveness survey is conducted, survey report is published and disseminated

Output 4.4 Consolidated technical support management system in line with the KNASP designed and implemented

Coordinating organization: UNAIDS Secretariat

Rationale:

Technical support is one of the largest cost items in any national HIV response in terms of financial implications and time allocation. Effective and coordinated technical support management is one of the key success elements for the timely and high quality achievement of set national targets. The UN system is committed to make sustained investments in improving mechanisms for delivery of technical support at country level with focus on building local capacities for technical support provision and management.

Objectives:

1. To provide high quality technical support to NACC, NASCOP and other partners in selected areas to 'Make the Existing Money Work' and start to deliver on the national commitments on Universal Access
2. To strengthen NACC capacity to develop consolidated tools and mechanisms, and to directly facilitate and manage majority of technical support needs towards the national HIV response
3. To facilitate problem solving for improved country performance vis-à-vis grant management and programme results

Role of the UN and partnerships:

Through the UNAIDS Secretariat, the UN will support the national HIV response to obtain strategic, high-quality technical support through:

- engagement in development of consolidated annual technical support plans for NACC
- consolidation of the UN Joint Technical Support Plan into the national technical support plan
- facilitation of wide support among development partners
- ensuring timely delivery of UN-facilitated technical support
- facilitation of flexible 'emergency' technical support based on jointly identified emerging and unplanned priorities

In addition to facilitating technical support towards the annual Technical Support Plan, the UN system will help build capacity in NACC to manage all its technical support, including that planned under TOWA.

Milestones to 2012:

1. By mid-2008, the comprehensive HIV national technical support plan is in place as an integral part of the national consolidated annual work plan
2. By end-2008, the first Joint UN Technical Support Plan is fully implemented
3. By end-2008, effective partnerships are formed and structures are put in place to strengthen management of large grants
4. By end-2010, identified country-level systemic challenges to implementation of large grants (GF, PEPFAR, TOWA) and Universal Access plans are resolved
5. By end-2010, all technical support for the national HIV response is coordinated with/through NACC
6. By end-2012, HIV response technical support effectiveness is reviewed and findings are disseminated

Output 4.5 Increased and coordinated contribution of the UN system to the national HIV response

Coordinating organization: UNAIDS Secretariat

Rationale:

The establishment of the Kenya Joint UN Team on AIDS, under the overall leadership of the UN Resident Coordinator, development and operationalization of the Joint UN Programme of Support on AIDS are crucial steps in maximizing the effectives of collective UN resources and support to the Kenya national HIV response. Ensuring the transition into delivery 'as one' by the UN system and clarification of technical advisory roles among staff is performed in a way resulting into significant improvements in the support provided to the national HIV response is a priority for the UN system.

Objectives:

1. To achieve set targets of the Joint Programme, supported by one UN Team on AIDS and a common core budget, guided by the UNCT and the UN Resident Coordinator within the context of UN reform
2. To ensure that individual members of the Joint Team are held accountable for fulfilling their assigned roles and responsibilities within the Joint Programme
3. To provide consistent, coherent, consolidate and coordinated support to the national response

Role of the UN and partnerships:

The Joint UN Team on AIDS, supported by the UNAIDS Secretariat, and in close collaboration with the National AIDS Control Council:

- Works with the concerned UN Lead Organizations to ensure effective functioning of the working groups, and facilitates working relationships across participating organizations and sub-groups to plan and follow up on implementation of the Joint Programme of Support on AIDS
- Ensures periodic reviews and updates of the Joint Programme of Support on AIDS work plan, and joint technical support plan
- Identifies and resolves obstacles to agreed outcomes and outputs, inline with decisions of the UN Country Team; and where necessary, conducts joint monitoring and evaluation activities on the supported interventions
- Regularly reports the programme implementation progress to the UN Country Team (UNCT)
- Provides technical advice to the UNCT and recommendations on allocation and re-allocation of resources
- Harmonizes and aligns the joint UN Programme of Support on AIDS in Kenya content and work plans with the National Strategic Plan (KNASP) and consolidated national HIV work plans and technical support plans
- Serves as an overarching common entry point for NACC, donors and partners in the programme, and provides links to external problem-solving mechanisms and technical support facilities

Milestones to 2012:

1. By mid-2008, identified human resource and capacity development needs of the Joint UN Team on AIDS are met to maximize provision of effective technical support to implementation of 'Three Ones', GTT recommendations and Universal Access targets in Kenya
2. By mid-2008, Joint UN Programme of Support on AIDS is fully incorporated into the consolidated national work plan
3. By mid-2008 reviews of Joint UN Programme are linked to JAPR
4. By mid-2008, Joint UN Team on AIDS and the Programme of Support on AIDS are harmonized with UN Learning Strategy on HIV and AIDS
5. By mid-2008, joint matrix of annual UN budget allocations and expenditures on HIV is available
6. By end-2009, majority of UN funds for HIV are channelled through the Joint Programme common financial management system
7. By end-2010, UN planning framework is completely aligned with the national planning framework
8. By end-2010, the Joint UN Programme of Support on AIDS is fully funded
9. By end-2012, Joint Programme of Support on AIDS, 2007-2012 evaluation report is available
10. By end-2012, a new framework for UN programming on HIV (Joint Programme II) is developed

ANNEX 5: JOINT UN PROGRAMME OF SUPPORT ON AIDS 2007-2012: PROGRAMME LOGFRAME

MDG Goal:	Goal 6: Combat HIV/AIDS, malaria and other diseases - Target 7: Have halted by 2015, and begun to reverse the spread of HIV/AIDS
KNASP Goal:	Reduce the spread of HIV, improve the quality of life of those infected and affected and mitigate the socio-economic impact of the epidemic
UNDAF Outcome:	Reduce the incidence and socio-economic impact of HIV/AIDS, malaria and TB
TOTAL Budget:	USD 93,300,000

GOAL	**CORE INDICATORS** **(KN) = KNASP/result framework/ M&E framework** **(UA) = Universal Access Indicator**	**MEANS OF VERIFICATION**	**ASSUMPTIONS**
Contribute to the reduction in the spread of HIV, improvement in the quality of life of those infected and affected, and mitigation of the socioeconomic impact of the epidemic	Decrease in HIV prevalence among general population (KN) Target: *5.0%* • Decrease in HIV prevalence among young women aged 15-24 (KN) Target: *4.0%* • Decrease in HIV prevalence among young men aged 15-24 (KN) Target: *0.5%*	KDHS/AIS	Adequate resources are allocated to the national HIV response Political situation remains stable/calm
	Increase in % of those appropriate for treatment receiving ART (KN) Target: *75%*	NASCOP, National HIV M&E	Planned increase in ART availability/ uptake materializes (GoK, PEPFAR)

PURPOSE	CORE INDICATORS (KN) = KNASP/result framework/M&E framework (UA) = Universal Access indicator	MEANS OF VERIFICATION	ASSUMPTIONS
To support effective, nationally-led, evidence-based, multi-sectoral programming that responds to priority needs in the four KNASP component areas • Reduced number of new infections in both vulnerable groups and the general populations • Improved treatment and care, protection of rights and access to effective services for infected and affected people • Existing programmes adapted and innovative responses developed to reduce the impact of the epidemic on communities, social services and economic productivity • 'Three Ones' effectively functioning s the basis for all programming and resource allocation in support of the national HIV response	Increase in number of individuals who access (voluntary) counseling and testing annually (KN) Target: 2 million (tested and received results)	NASCOP, National M&E system	Adequate resources to procure testing commodities/kits and effective distribution chain
	Increase in % of people in age range 15-49 who have ever been tested and received result (KN) Target: 25%	NASCOP, National M&E system	Adequate resources to procure testing commodities/kits and effective distribution chain
	Decrease in % of girls and boys who have sex before age 15 (KN)		Adequate resources and development of effective evidence-based interventions for BCC targeting young people
	Decrease in % of infants born to HIV+ mothers who will be HIV+ (KN) Target: Below 23%	NASCOP, National HIV M&E	Planned increase in PMTCT service provision takes place (GoK, PEPFAR)
	Increase in number of male and female condoms procured and distributed annually (KN, UA) Target: 240 million (male), 1 million (female)	MoH, National M&E system	Adequate resources to procure at accelerated levels and effective nation-wide distribution chain
	Increase in condom use at most recent high-risk sex in 15-24 age group (KN)	KDHS/AIS	Availability and accessibility of condoms to young sexually active people
	Increase in % of adults and children on ART who are still alive 12 months after initiation of antiretroviral therapy (KN, UA) Target: 90%	NASCOP, National HIV M&E	Planned mechanism/tools for systematic treatment outcome monitoring developed
	Number of OVC receiving care and support in past 12 months Target: 300,000	KDHS/Special survey	Adequate resources to address social protection and scale-up conditional cash transfer and other forms of support
	Increase in portion of the national HIV response funded by GoK (N) Target: 10%	GoK expenditure review	Accurate data on national HIV response funding levels/sources available
	Increase in number of development partners having signed a joint MoU with NACC for programming and reporting within KNASP priorities (N) Target: 90%	NACC (peer review process) JAPR	Willingness of development partners to increase harmonization and alignment
	Increase in UN resources on HIV allocated to, and implemented through the Joint Programme Target: 50%	Annual report on UN system performance in support of the national HIV response	Continued prioritization of, and commitment to UN reform at all levels

OUTPUTS	LEAD/ PARTICIPATING ORGANIZATIONS	INDICATORS[7]	MEANS OF VERIFICATION	ASSUMPTIONS
1.1 HIV prevention becomes evidence –informed and accelerated	WHO UNAIDS Secretariat, UNDP UNODC, UNFPA, UNICEF	• No. and % of VCT centres offering quality services in accordance • % of VCT service points meeting their reporting requirements • % of blood transfusion centres that have quality assurance programme (KN) • No. of HIV testing campaigns carried out • No. of individuals tested for HIV through campaign mode • Performance rate against national accountability table for HIV prevention • Status of national HIV prevention strategy development and implementation • Level of financing towards prevention research agenda • Standardization and harmonization of HIV testing approaches • with national VCT guidelines (accreditation) (KN) • Performance of National HIV Prevention Task Force • Status of MC, vaccines and microbicides guidance document development • Status of HIV testing and STI guidelines revision	JAPR KDHS/AIS National M&E system MoH/NASCOP	NACC, MoH/ NASCOP and DRH able to agree on accountabilities Budget, reliable procurement and distribution system in place for adequate number of HIV test kits Monitoring data available from facility-level
1.2 National structures and capacity to manage and coordinate effective BCC programmes in place	UNFPA, UNICEF UN system	• % of women and men aged 15-24 correctly identifying ways of preventing sexual transmission of HIV/AIDS • % of women and men aged 15-24 with comprehensive knowledge of HIV and AIDS (UNGASS) • No. of BCC campaigns implemented • Status of national BCC strategy for priority population groups development (KN) • Performance of national coordination for BCC (Consortium)	JAPR KDHS/AIDS Indicator Survey (AIS)[8]	NACC demonstrates leadership in coordination and harmonization of BCC interventions

7 (KN) = KNASP/result framework/M&E framework. (UA) = Universal Access indicator, (UNGASS) = UNGASS indicator

8 It is envisioned that the specialized AIS, to be carried out in 2007 and 2010, will incorporate most of the HIV components of the KDHS+

1.3 Comprehensive national programme for prevention of mother-to-child transmission (PMTCT) in place and supported by all stakeholders	UNICEF WHO, UNFPA	• % of facilities providing Comprehensive PMTCT services • % of pregnant women accessing care and treatment services from PMTCT clinics • % of HIV positive pregnant women provided with a complete standard short course of ARV to prevent MTCT (KN) • % of new born babies benefiting from effective ART regimen • % of PMTCT beneficiaries in eight target districts receiving infant feeding and counselling • No. of health workers trained on standard curricula for expanded PMTCT (PMTCT+) • Status of national PMTCT communication strategy dissemination • National PMTCT programme adoption and endorsement rate among development partners • Effectiveness of national PMTCT interventions and programme impact	National PMTCT programme JAPR MoH/NASCOP National M&E system PMTCT programme impact assessment	Well functioning national M&E system able to capture PMTCT data Planned increase in PMTCT service provision takes place (GoK, PEPFAR)
1.4 Prevention among most-at-risk groups and populations of humanitarian concern advocated and scaled up as part of the national response	UNODC WFP, UNFPA, UNAIDS, UNIFEM, WHO,IOM, UNHCR, ILO	• % of condom use among sex workers to with casual and regular clients • % of injecting drug users who have adopted behaviours that reduce transmission of HIV (KN, UA) • % of most-at-risk groups tested and received results (inmates, sex workers and clients (KN), intravenous drug users) • No. of targeted advocacy campaigns carried out • No. of policies on most-at-risk groups and level of resources • No. of guideline revisions on harm reduction, sex workers, prison inmates, MSM, transport workers and others • Status of condom procurement plan implementation	JAPR BSS/Special surveys	Enabling legislation changes in support of outreach/data collection among at-risk groups approved Adequate resources to procure condoms and testing commodities at accelerated levels and effective nation-wide distribution chain
1.5 National condom programme strengthened and supported with procurement and distribution of male and female condoms	UNFPA WB, WHO, UNICEF, UNAIDS	• No. of female condoms procured annually (N, UA) • No. and total duration of male condom stock-outs reported at district level in past 12 months • Condom demand among different target groups	KDHS/AIS Special surveys/BSS NASCOP, DRH JAPR National M&E system	Budget, reliable procurement and distribution system in place for adequate number of condoms Enabling legislation to support outreach/ data collection among at-risk groups Monitoring data available from facility-level

OUTPUTS	EXECUTING/ COLLABORATING ORGANIZATIONS	INDICATORS[1]	MEANS OF VERIFICATION	ASSUMPTIONS
2.1 Quality and equity of national AIDS –related treatment services (including commodities forecasting and distribution) effectively strengthened	WHO UNAIDS, UNICEF, UNFPA	• % of those initiating ART that are at stage 4 (KN) • % of data sources due in the past 12 months that have been delivered to the NACC on time (KN) • % of ART service delivery sites covered by national ART monitoring and patient tracking system • Facility-based integrated tool (MoH 726/727) roll-out rate and data quality • Quality of national standards and service delivery frameworks • HIV treatment service alignment level with national standards and service delivery frameworks • Quality of national HIV treatment commodity management • Status of communication and advocacy strategy on AIDS –related services development • Status of HIV treatment service quality assurance framework	MoH/NASCOP National M&E system HMIS	Adequate funds and technical support for roll-out of facility- and community-based reporting systems, including data entry and dissemination
2.2 Coherent interface between TB and HIV – related services established and maintained	WHO UNICEF, UNFPA	• % of TB patients offered HIV testing (KN) • % of people with TB and HIV who receive ART before the end of TB treatment (KN) • % of TB service facilities providing appropriate level HIV intervention • Quality and scope of HIV and TB service integration monitoring • Level of TB identification and treatment access incorporation into national standards for HIV treatment services	MoH/NASCOP National M&E system	Diagnostic services available at all TB sites
2.3 Comprehensive national service delivery framework for the continuum of treatment and care for HIV – exposed children established	WHO UNICEF	• % of tested HIV+ children with access to Cotrimoxazole (N, UA) • No. of children with HIV/AIDS receiving ART (KN) • Status of monitoring framework for HIV –exposed children care continuum • Status of paediatric HIV and AIDS strategy and clinical pathways • Level of WHO IMCI/IMAI HIV service delivery framework integration into national IMCI service framework • Status of IMCI –related tool revision	MoH/NASCOP National M&E system	Availability of Cotrimoxazole (as essential drug)

2.4 Approach for HIV care in community setting standardized	WHO, UNICEF WFP	• % of eligible PLWHA provided with standard package of care at community/home levels (KN) • No. of community health workers/ volunteers/care givers trained to provide support to HIV infected people receiving ART (KN) • Status of standardized community-care package adoption • Performance of community HIV service monitoring (COBPAR) • Status of PLHIV community care guideline operationalization • Status of national framework for community-based HIV service development • Level of HIV community-level intervention integration into KEPH level 1 service package implementation	MoH/NASCOP National M&E system	Effective interface between facility and community-based reporting
2.5 Nutritional clinical care and support integrated into AIDS –related treatment services	UNICEF, WFP WHO	• % of PLHIV receiving nutritional education and counseling at health facilities and community levels • % of PLHIV requiring supplementary nutritional support receiving nutritional care package at health facilities and/or communities • % of national HIV treatment sites integrating national standards for nutritional care • Status of nutrition, HIV and AIDS national strategy development • Status of nutritional care and support integration into national monitoring framework for HIV treatment services • Status of key PLHIV nutritional commodities inclusion in national essential drug list	MoH/NASCOP National M&E system	Effective identification mechanism or PLWHA in need of nutritional support Adequate nutritional supplements available for intervention scale-up
2.6 Strengthened framework in place for protection of human rights in the context of HIV	UNICEF UNAIDS Secretariat, UNIFEM, UN system	• % of CCCs providing information to PLHIV on RH and legal rights • % of districts with HIV anti-stigmatization advocacy groups • Level of HIV Act regulation enactment • Performance of NACC Secretariat gender desk and NACC gender committee • Depth of HIV –related human rights monitoring within KNASP • Commitment of media owners association to address HIV, AIDS and human rights/HIV –related stigma and discrimination • Performance of human rights oversight committee under NACC legal unit • Coverage of national pro-bono legal service for PLHIV • Performance of MoHA in addressing HIV –related services within, and referral from prisons • Level of community- and religious leader engagement in anti-stigmatization/discrimination campaign • Effectiveness of HIV and human rights –based framework	JAPR COBPAR HIV and human rights framework performance evaluation	Political commitment and adequate resource allocation for enactment of the HIV Act components

OUTPUTS	EXECUTING/ COLLABORATING ORGANIZATIONS	INDICATORS[1]	MEANS OF VERIFICATION	ASSUMPTIONS
3.1 HIV mainstreamed in development budgets as articulated in MTEF and district development plans	UNDP UNAIDS Secretariat	• % of district development plans and budgets with institutionalized HIV programming • No. of public sectors with key officials trained on HIV integration in PRSP and MTEF • Level and quality of HIV activities and indicators in PRSP (ERS) • HIV integration in Kenya Vision 2030 • HIV budget incorporation in MTEF • Scope and quality of non-state actor participation in PRSP HIV aspects • Level of HIV mainstreaming and implementation across sectors and decentralized levels	JAPR GoK annual budget NASA HIV mainstreaming review	GoK prioritizing HIV funding/political will to increase GoK funding contribution
3.2 National OVC Plan of Action is operationalized and conditional cash transfer pilot and other sustainable livelihood interventions targeting orphans scaled up	UNICEF UN system	• % of resources required by the NPA mobilized from GoK through the MTEF (N) • % of orphans in school to be at least 90% of percentage of non-orphans in school in age range 10-14 (KN) • No. of OVC enrolled in care and support programmes supported through free standard external package of support (KN) • No. of qualified households covered by cash transfer programme • Levels of funding and implementation against OVC NPA • Status of OVC psychosocial support and alternative family care national guidelines development • Community ownership level of OVC intervention management	MTEF sectoral allocations MoHA (Children's Department) KDHS	Costing of the NPA finalized in 2007
3.3 HIV integration strategy in private and informal sector developed and implemented	UNDP ILO, UNAIDS Secretariat	• Performance of PSAN • Status of private and informal sector HIV response engagement framework and workplace policy development • Level of conformity to HIV Act of private sector workplace policies • Implementation of informal sector workplace policy • Quality and coverage of private sector workplace policy and programme implementation	JAPR National HIV workplace policy and programme assessment	PSAN revived or other effective platform for dialogue with private/informal sector established
3.4 HIV mainstreamed in six priority sector plans (education, health, agriculture, transport, security, law and order)	UNDP UNESCO, UNICEF, UNODC, WFP, IOM, UNFPA, WHO, FAO	• No. of priority sector –specific HIV impact studies and policies with HIV mainstreamed • No. of priority sectors with budgeted HIV action plans integrated into overall operations and coordination structures for direction and monitoring • No. of priority sectors accessing programme funding through TOWA • No. of sector plans to mitigate causes and impact of HIV	JAPR Sector budgets	In-depth analysis of all sectors in the HIV response included in the JAPR and translated into action in KNASP results framework

OUTPUTS	EXECUTING/ COLLABORATING ORGANIZATIONS	INDICATORS[1]	MEANS OF VERIFICATION	ASSUMPTIONS
4.1 NACC equipped with coordination capacity and support services necessary for effective delivery of a multi-sectoral response to HIV	UNAIDS Secretariat UNDP, WHO	• No. of funding partners in the national HIV response who have undergone minimum one peer review • No. of major stakeholders in the national HIV response basing their contributions on formal agreement with NACC (MoU/Code of Conduct) • Performance of high-level, multisectoral public sector HIV accountability structure • Effectiveness of civil society (and private sector) engagement framework • Scope and depth of resource allocation, programming and monitoring data channelled through or available to NACC • Effectiveness of mechanism for sustainable long-term funding of the national HIV response • Performance of harmonization and alignment framework	NACC Harmonization and alignment review JAPR	NACC demonstrates leadership and technical capacity in national HIV response coordination
4.2 Evidence –informed and harmonized processes for KNASP planning and implementation in place	UNAIDS Secretariat UN system	• % of development partners carrying out major individual assessments and reviews • Status of KNASP II MTR, re-costing and KNASP III development • Status of NASA and HIV Public Expenditure Review • No. of major development partners coordinating their inputs to HIV through the national consolidated work plan • Effectiveness of consolidated planning and implementation process	JAPR UNGASS report HIV response publication	Adequate resources for strategic planning and implementation
4.3 Synchronized national HIV response M&E system and robust strategic information utilization mechanism in place	UNAIDS Secretariat UN system	• Effectiveness of facility-based data collection and utilization • Level of policy decisions, priority selection, programming and calls for proposals conformity with JAPR • Status of national Universal Access MTR and final evaluation • Status of consolidated HIV response document development • No. of development partners contributing to consolidated programmatic assessment plan • Performance of national HIV/STI annual surveillance and guideline revision • Coverage and effectiveness of health sector HIV and AIDS services	National M&E system JAPR NACC annual reports Health sector HIV service assessment	Quality of KNASP and JAPR process adequate for increased adoption by development partners

4.4 Consolidated technical support management system in line with KNASP designed and implemented	UNAIDS Secretariat UN system	• % of all technical support to national HIV response coordinated with/ through NACC • % of completed agreed activities in consolidated HIV national technical support plan and Joint UN Technical Support Plan • % of the HIV commodity requirements procured as planned • % disbursement of total TOWA budget • Effectiveness of large grant management structures • Performance of large grant implementation	JAPR HIV response TS review	Adequate financial resources available and buy-in from development partners for effective annual TA plan implementation
4.5 Increased and coordinated contribution of the UN system to the national HIV response	UNAIDS Secretariat UN system	• % of Joint UN Team on AIDS capacity development plan activities implemented • % of participating organizations with minimum one full-time staff member on HIV • % of Joint UN Programme activities incorporated into consolidated national work plan • % of UN funds for HIV channelled through the Joint Programme common financial management system • % of funding against Joint UN Programme budget • % of all UN programming on HIV in line with KNASP • % of Joint Programme annual work plan implemented on time • No. of available joint annual UN budget allocation/expenditure matrices and programme review documents • Linkage between Joint UN Programme reviews and JAPR • Harmonization between Joint UN Programme/Team and UN Learning Strategy • Performance of Joint UN Programme and status of new programme development	Joint Team/ Programme annual reports Joint Programme review	All Heads of Agencies at country level support the Joint Team and Joint Programme

UNAIDS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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