Kenya SID Narrative Cover Sheet

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed annually by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 90 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) **(sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 points) **(approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 points) **(emerging sustainability and needs some investment)**
Red Score (<3.50 points) **(unsustainable and requires significant investment)**

Country Overview: From National Health Accounts (2013) estimations, donors contributed 72.6% of total HIV expenditures, government contribution was at 18.2%, and household spending at 5.5%. Projections for 2015/16 show donor contributions declining to 69% , with a modest increase in GoK spending at 21%, and households at 6.0%. More recently, PEPFAR analysis of county budget allocations (in 12 counties) demonstrate increasing financial commitment towards the HIV program with a total of USD 2 million committed in FY2016/17 county budgets. Further, PEPFAR support contributed to the restoration of a commodities budget line under the National Treasury, with an initial allocation in 2015/16 of USD26.5 million to meet Global Fund Counterpart Financing requirements (of which $20m will be used to procure ARVs and test kits) and a similar amount proposed for the 2016/17 budget.

Notwithstanding the above, the national HIV/AIDS response in Kenya remains heavily donor dependent. Significantly greater investment for health (from both National and County governments and from private sector) is needed, alongside measures to address inefficiencies in the use of limited resources and health financing policies that target reduction of direct out of pocket payments and attract household resources (thru health insurance) that will provide an important source of domestic financing for HIV/AIDS.

SID Process: The 2016 Sustainability Index and Dashboard (SID) process was implemented in partnership and under the leadership of the National AIDS Control Council (NACC). During the launch of the COP 2016 attended by all the key stakeholders, the SID was presented as a critical component in the development and finalization of the Kenya COP. Together with government, civil society, and other partners, the USG team represented by Interagency Technical Team (ITT) completed the SID 2.0 over two stakeholder meetings: The initial meetings were held on Feb. 4 and 5 followed by a validation meeting on April 7. The outcome of the initial meeting was shared and informed discussions at the ITT Retreat, Data for Epidemic Control (D4EC) and DC Management Meeting. The outcome of the validation was shared with all stakeholders at the Report out Meeting on April 9. To ensure continuity, building on the SID 1.0, participants and through NACC's leadership on Sustainability and Domestic Resource Mobilizations, we identified key technical experts and champions for each domain from the Government of Kenya including the Ministry of Health, National Treasury, Ministry of Planning and Devolution and County Health Executives. Other key stakeholders included the UNAIDS, World Bank and other

multilateral/bilateral donors, in-country experts/academia, and civil society, private sector as well as from within the interagency PEPFAR team. The participants worked in four groups synonymous with the four domains. Within the groups, the participants prioritized weak elements and proposed key activities; and then as a full group further refined the prioritized elements and activities. During the validation meeting, the participants reviewed and affirmed the data sources associated and corresponding to the responses under each Domain. Notably, following the SID 1.0 and as part of the SID 2.0, NACC has taken the leadership on the SID process and is keen on owning the process with technical and other support from the USG team. To this regard, this year's participation included the strategic participation County leadership on Health who have a critical role to play on how the response of the epidemic will achieve success both at national and county level. The SID 2.0 process above included a specific session with participants representing the NACC, Civil Society, Private sector, PEPFAR, UNAIDS and County Health Executives (Mombasa, Tharaka Nithi, Kiambu, Bomet and Nairobi)on the SNU SID discussions. The outcome provided critical pointers on the way forward on both the design and potential expectations of the counties. NACC has submitted a request to the PEPFAR Kenya team to support its finalization and adaptation of the Kenya County SID as part of this COP. The draft Kenya SID Dashboard is attached to the SDS in the annex.

Sustainability Strengths:

- **Planning and Coordination (9.00, dark green):** The Government of Kenya remains a global leader in process of development and articulation of key institutional, programming and policy guidelines. The processes are very inclusive and are well structured in terms of shared responsibility and accountability, taking into account the diversity and comparative advantage of key stakeholders in the country across all levels of government and key stakeholders, civil society and the private sector. However, it is noted that there is still need to further invest in the implementation of the practice of same as articulated in the various roles and responsibilities for each key stakeholder.

- **Policies and Governance (7.02, light green):** NACC, NASCOP and in general, the Ministry of Health has led the country and counties in the development of key health and HIV policy and strategy documents that serve as the foundation that guides all key stakeholders on how and where to invest especially in response to HIV and AIDS. Implementation of key policies and coordination of key stakeholders remain critical areas of improvement needed to propel the country towards country ownership and epidemic control.

- **Civil Society Engagement (7.26, light green):** Local civil society organization remain an active partner in the HIV/AIDS response especially at service delivery levels, monitoring and evaluation, and in advocacy. CSOs, as part of the aforementioned processes , are also included in key consultations and strategic discourse that inform the national HIV/AIDS response. However, the investment towards organizational and capacity building for CSOs is needed as part of the country's systematic evolution under devolution.

- **Private Sector Engagement (8.06, light green):** The Private Sector (both private health care providers and private business) is a notable key player and an active partner in the HIV/AIDS response in Kenya. As key stakeholders, there are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs,

services and fiscal management of the national HIV/AIDS response. There is still a need for the Private Sector to complement government services further. This can be as a partner in training, research and innovation, workplace policies, service delivery and M&E, and disseminating information. The government on the other hand, needs to create incentives for businesses to engage in the clear structured but accountable way, in the response.

- **Public Access to Information (7.00, light green):** This means that the Ministry of Health including NACC and NASCOP, widely disseminates reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets related to HIV/AIDS. The stakeholders identified fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) as well as program and audit reports as areas that need improvement especially availability in the public domain.

- **Quality Management (8.48, light green):** This means the Ministry of Health including NACC and NASCOP, has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services. The investment in QA/QI remains an important contribution to the efficacy of service delivery and so this must remain a priority going forward.

- **Performance Data (7.00, light green):** This means that the Ministry of Health routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention. In all of these areas, government is quite engaged but the funding level from government is low in general.

NUANCES: While the elements noted herein are dark and light green, there are underlying issues that still need to be addressed to bring them to full scale sustainability capacity. For example, Kenya has very clear and concise policy and strategic documents but implementation and practice on the same remains limited or not happening at all. Across the board, there is a clear need for strategic investment towards realization and actualization of these policies and strategies. Notably, in essence, by virtue of the strategy and planning processes still being largely donor supported, true ownership by the country for effective implementation continues to be a challenge if that support is limited to planning.

Sustainability Vulnerabilities:

- **Laboratory (2.08, Red)**: The Lab element was noted as a priority given the critical role it plays in the testing, care and treatment continuum. The recommendation is for the PEPFAR to invest in the review, finalization, launch and dissemination of the Lab 2012 strategy. The strategy should include Human Resources and Workforce, VL infrastructure, QI/QA.

- **Service Delivery (4.21, Yellow):** Remains a priority given the new proposed service delivery models. Recommendations include:
    - Revisit and include use of Mobile clinics (as part of new service delivery model)
    - Define and review the locality and adapt mobile clinics to meet service and programmatic needs of the community
    - Explore option for a full package of testing and treatment services and appropriate for the particular county/context for high burden areas
    - Strengthen community/facility linkages for the complete referral loop
    - Invest in patient education to ensure they understand services and rights
    - Strengthen integration of KP services in health facilities

- **Domestic Resource Mobilization (5.28, Yellow):** The Element on DRM is a priority across the board. It builds on the ongoing investments to address tracking of domestic expenditures, insufficient costing and efficiency analysis of domestic HIV/AIDS investments, and limited analytics on domestic resource mobilization. The reform process of NHIF to include HIV care and treatment in benefit package (given other health priorities or hot topics, we need to ensure that HIV is part of NHIF for the long term beyond donor funding) remains high as one of the options to ensure coverage beyond donor and GOK resources. There is also a need to shift to output-based financing, the PEPFAR team was requested to look at HIV programs and consider which pieces can be optimized on performance-based financing. However, the issue on the role of CSO on advocacy – given Kenya will have elections next year, it is critical to continue advocating for additional resource allocation and funding for HIV. It is also the time to ensure this is put on agendas of next political leaders.

- **Technical and Allocative Efficiencies (6.98, Yellow):** This remains as priority especially the need to focus on Data for decision making, priority settings and the principles of value for money in service delivery to inform resource allocation for high burden areas as well as transition plans. There is need to invest in Data for decision making – for use as evidence to inform resource allocation for high burden counties as well as transition plans with low burden counties. In addition, invest in processes linked to the reform of NHIF to include HIV care and treatment in benefit package.

- **Human Resources for Health (6.50, Yellow):** In order to realize the scale-up and the pivot, we have to strategically invest in the corresponding and required HRH as well as those who can do mobile testing and further support the new service delivery models.

- **Commodities Security and Supply Chain (4.86, Yellow):** There remains deficiencies in both national-level procurement and distribution of commodities to the regional level and facility-level stock out rates in high-priority PEPFAR counties. More specifically, we need to strengthen the supply chain management and logistics of the commodities down to the county level – there is need to look at all components of the supply chain and logistics system.

Additional Observations: Although the **Policies and Governance** element scored in the dark green and is considered a strength, the stakeholders noted that the team needed to prioritize investment towards implementation of policies, strategies and plans esp. Test and Treat policies and County Strategic AIDS strategic plans. Proposal included that the NACC and NASCOP, plan and hold consultations with PLHIV

and Healthcare providers to conduct costing exercises to understand costs associated with priority policies and plan for and invest in periodic review and dialogue on regulatory changes for commodities as well as establish a collaborative to improve coordination between private and public sectors especially on commodities and supply chain management both at national and county levels. This should include reporting from the private sector on key indicators.

In addition, **Civil Society Engagement** also scored a light green but it was noted that in advancing the role of CSOs, the stakeholders recommended that PEPFAR consider investing in training and capacity building for CSO to ensure effective advocacy, accountability audits and engagement in PEPFAR and other HIV-related processes. In addition, set up and make accessible, a database for policy documents so that everyone can know where to go and get information on policies and be informed about what their rights are.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in Kenya, please contact Katherine Perry at PerryK@state.gov.

Sustainability Analysis for Epidemic Control: Kenya

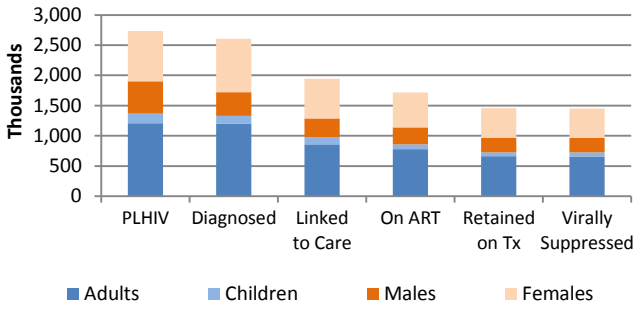
Epidemic Type: Generalized
Income Level: Lower-middle income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 16 Planning Level: 500,000,000

SUSTAINABILITY DOMAINS and ELEMENTS

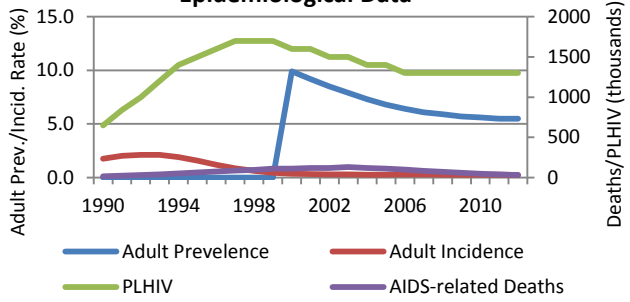
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.00			
2. Policies and Governance	7.02			
3. Civil Society Engagement	7.26			
4. Private Sector Engagement	8.06			
5. Public Access to Information	7.00			
National Health System and Service Delivery				
6. Service Delivery	4.21			
7. Human Resources for Health	6.58			
8. Commodity Security and Supply Chain	4.86			
9. Quality Management	8.48			
10. Laboratory	2.08			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.28			
12. Technical and Allocative Efficiencies	6.98			
Strategic Information				
13. Epidemiological and Health Data	5.36			
14. Financial/Expenditure Data	5.83			
15. Performance Data	7.80			

CONTEXTUAL DATA

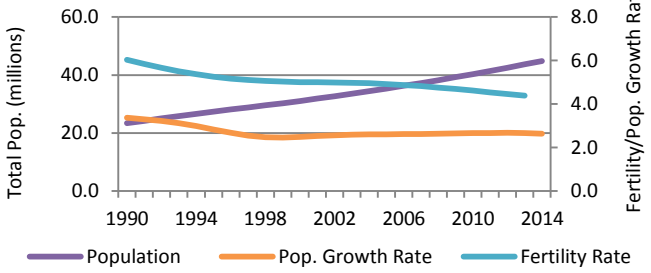
National Clinical Cascade



Epidemiological Data

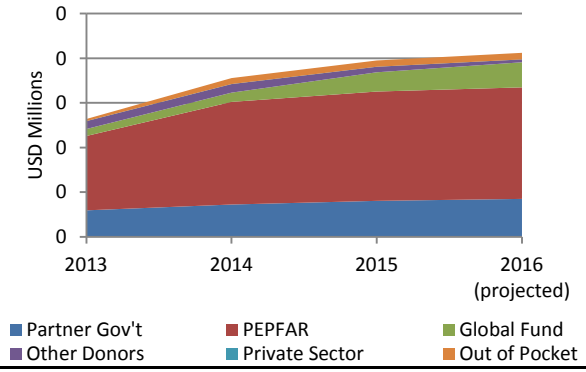


Population and Fertility

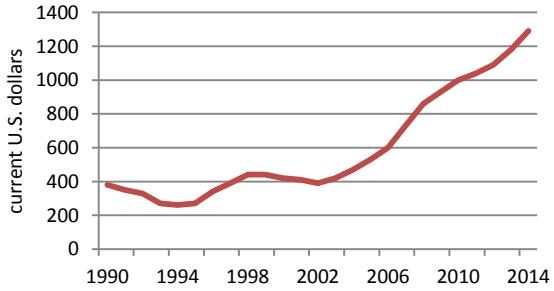


CONTEXTUAL DATA

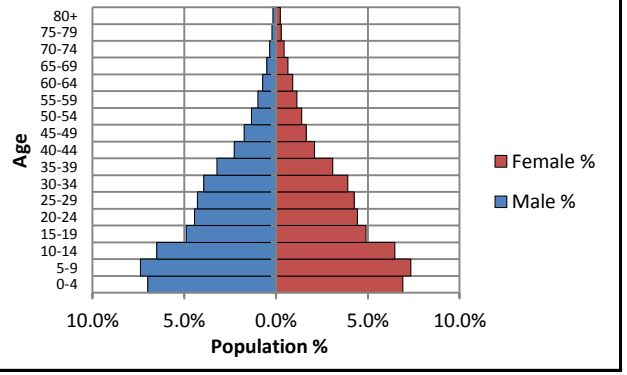
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2015)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It is updated at least every five years ☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☑ Strategy includes explicit plans and activities to address the needs of key populations. ☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children	1.1 Score: 2.50	Kenya AIDS Strategic Framework (KASF); The Kenya HIV/AIDS Prevetion Roadmap; Fast track 'Adolescents and young people' and the VMMC Strategic Plan	No detailed definition of PLWD in Kenya - Why separate (KP) and children as separate components. - Priority populations instead of key populations (at time of reviewing the KASF)
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☑ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☑ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.50	Gudelines for TWG ,Minutes of TWG meetings for the national strategic plan,validation minutes and reports, participants lists for meetings	engagement with persons with disabilities to be improved (thry agreed on the comment stated) Added: - Interogate engagement of private health sector providers(level of participation) - Include beneficiaries of services(adolescents, key populations, etc.) -May not necessarily be part of CSO's(number 2)

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☐ The host country government routinely tracks and maps HIV/AIDS activities of: ☐ civil society organizations ☐ private sector ☐ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.50	The National AIDS Expenditure Assessment (2012), Reports of the National,The ,Accounts and Audits, M$E reports and tools,TWG, MOU for partnerships, minutes of road map meetings, private sector cordination, PEPFAR COP planning, PFIP,Joint planning with UNAIDS, Multilateral response cordinating between agencies	Mapping needs to be done, there is need to prioritize measures for checking duplication(Agreed on the above comment) -Added; - Need for clarity as to whether there is a national operational plan that is jointly implemented by partners. - Is there a mechanism of joint reviews of the operational plans?
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. Sub-national units have performance targets that contribute to aggregate national goals or targets. ○ C. The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	CASP(County Aids strategis plans (2015)	Currently 22 drafts are completed, 25 more to go
	Planning and Coordination Score: 9.00			

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?	For each category below, check no more than one box that reflects current national policy for ART initiation: A. Adults (>19 years) ☐ Test and START (current WHO Guideline) ☑ CD4 <500 B. Pregnant and Breastfeeding Mothers ☑ Test and START/Option B+ (current WHO Guideline) ☐ Option B C. Adolescents (10-19 years) ☐ Test and START (current WHO Guideline) ☑ CD4<500 D. Children (<10 years) ☑ Test and START (current WHO Guideline) ☐ CD4<500 or clinical eligibility	2.1 Score: 1.07		WHO guidelines adopted in 2015 - The situation may change. - Needs to be reviewed against current guidelines(new) - Section D - Children, it was ticked as it had not previously been ticked and commented that this was only for less than 5 years.

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?	Check all that apply: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☐ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☐ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☐ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS	2.2 Score: 0.41	HIV prevention and control act (2006) (Social protection Act; National Road map for Child Protection; - National Public Health Service Act	Added that: While there are no clear policies a number of these things are happening. - Task shifting etc. - Need for clarity on what HIV Prevention and Control Act being referred to? (2006 or 1999?)
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)	Check all that apply: Adults living with HIV (women): ☑ Law/policy exists ☑ Law/policy is fully implemented Adults living with HIV (men): ☑ Law/policy exists ☑ Law/policy is fully implemented Children living with HIV: ☑ Law/policy exists ☑ Law/policy is fully implemented Gay men and other men who have sex with men (MSM): ☐ Law/policy exists ☐ Law/policy is fully implemented	2.3 Score: 0.95	This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question. (the Case of HIV positive woman who was awarded damages by the court) UNHCR policies on migrants, the constitution, the bill of rights, the gender policy,	required: specific documentations and the years of implimentations of the laws on HIV. CSO shuld advocate for gay population non-discrimination, Policy Draft for PWID within NACC, should be adopted, specific laws should be harmonised for friendly program environment, Dissability Policy draft has not been passed for 10 years, The laws exist but are not fully implemented, More dialogue and advocacy for policies on sex workers

	Migrants: ☑ Law/policy exists ☑ Law/policy is fully implemented People who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is fully implemented People with disabilities: ☑ Law/policy exists ☐ Law/policy is fully implemented Prisoners: ☑ Law/policy exists ☑ Law/policy is fully implemented Sex workers: ☐ Law/policy exists ☐ Law/policy is fully implemented Transgender people: ☐ Law/policy exists ☐ Law/policy is fully implemented Women and girls: ☑ Law/policy exists ☐ Law/policy is fully implemented			

2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)	Check all that apply: Criminalization of sexual orientation and gender identity: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of cross-dressing: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of drug use: ☑ Law/policy exists ☑ Law/policy is enforced Criminalization of sex work: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs for people who inject drugs (PWID): ☑ Law/policy exists ☑ Law/policy is enforced Ban or limits on opioid substitution therapy for people who inject drugs (PWID): ☑ Law/policy exists ☑ Law/policy is enforced Ban or limits on needle and syringe programs in prison settings: ☑ Law/policy exists ☑ Law/policy is enforced Ban or limits on opioid substitution therapy in prison settings: ☑ Law/policy exists ☑ Law/policy is enforced	2.4 Score: 0.66	This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question. (the Case of HIV positive woman who was awarded damages by the court) UNHCR policies on migran, the kenya antinarcortics drugs laws of 1994 , The county council by-laws "in possession of drug use paraphenelia" (check section of the Kenya law-penal code)	Agreed. Added that: - Issues of descrimination still a challenge in Kenya.

	Ban or limits on the distribution of condoms in prison settings: ☑ Law/policy exists ☑ Law/policy is enforced Ban or limits on accessing HIV and SRH services for adolescents and young people: ☑ Law/policy exists ☑ Law/policy is enforced Criminalization of HIV non-disclosure, exposure or transmission: ☐ Law/policy exists ☐ Law/policy is enforced Travel and/or residence restrictions: ☐ Law/policy exists ☐ Law/policy is enforced Restrictions on employment for people living with HIV: ☐ Law/policy exists ☐ Law/policy is enforced		

2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☑ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☐ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.5 Score: 1.07	The Government set up the HIV tribunal, The HIV AIDS tribunal has astrategic plan, KASF,HIV/AIDS act	The tribnal does not have enough funding to carry out its mandate, there is need to harmonise Government policy documents NACC vs NACADA
2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.6 Score: 1.43	Kenya National Audit Office (public finance management Act)	The Audit of programs is nor regular, financial audit is not made public
2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ◉ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.7 Score: 1.43	Reports form parliamentary accounts committee; Ministries Management reports	Not made public
	Policies and Governance Score:	**7.02**		

3. Civil Society Engagement: Local civil Society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ○ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ◉ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 1.67	KASF,Strategis plans of CSOs, inclusion in tehe TWG, Inclusion of CSOs in the NACC board	
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☐ Involvement on government HIV/AIDS program evaluation teams ☑ Involvement in surveys/studies ☑ Collecting and reporting on client feedback	3.2 Score: 1.43	Minutes of planning meeting, The JAPR meeting, Minutes and attendance reports of TWGs, CSOs do evaluation independently, the stigma index,the survey for implimentation of methadone programs at the coast, Implemetation reports from PLWHIV, NACC's stakeholders satifaction Survey	Reports need to be shared to stakeholders, suggestion boxes in health facilities should be operationalised

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply): ☑ In advocacy ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☑ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.67	the formation of NACC was as a result of CSO Advocacy, In service delivery, availability of medicine, Advocacy, and resource mobilization.	CSO are limited by funding, they are limited in leagl issues and policy matters, CSO need networks for mentoship - CSO not engaged in deciding how GoK portion is allocated/ Utilized
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ◉ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).	3.4 Score: 0.83	Annual Budget for CSO's involved	data source should be verified and CSO's were not involved.
3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?	○ A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy ◉ B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (check all that apply): ☑ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☑ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change ☑ There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.	3.5 Score: 1.67	The Kenya Constitution, The NGO Board Regulations Act, KRA policy documents, Publuc procurement Act.	
		Civil Society Engagement Score: 7.26		

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. There are no formal channels or opportunities ○ B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback ◉ C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply: ☑ Corporate contributions, private philanthropy and giving ☑ Joint (i.e. public-private) supervision and quality oversight of private facilities ☐ Collection of service delivery and client satisfaction data from private providers ☑ Tracking of private training institution HRH graduates and placements ☑ Contributing to develop innovative solutions, both technology and systems innovation ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 1.39	PPP Act of 2013, Existence of the PPP node (unit) at the MOH . With in the KASF has the research Agenda for systems inovation. Private Sector engagement Desk at NACC	

4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?	○ A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS. ◉ B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply): ☑ In patient advocacy and human rights ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery for both public and private providers ☑ In HIV/AIDS basket or national health financing decisions ☑ In advancing innovative sustainable financing models ☑ In HRH development, placement, and retention strategies ☑ In building capacity of private training institutions ☑ In supply chain management of essential supplies and drugs	4.2 Score: 1.67	PPP Act of 2013, Existence of the PPP node (unit) at the MOH . With in the KASF is the research Agenda for systems inovation. Minutes of multisectoral meetings, Private sector work place policy , PS innitiative for financing in the KASF - Private Sector working group minutes, Private Sector desk at NACC.	The concept of community systems strengthening came from the private sector

4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☑ Systems are in place for service provision and/or research reporting by private sector facilities to the government. ☑ Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. ☑ Tax deductions for private health providers. ☑ Tax deductions for private training institutions training health workers. ☑ Open competition for private health providers to compete for government services. ☑ General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. ☑ Freedom of private providers to advocate for policy, legal, and regulatory frameworks. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.	4.3 Score: 1.67	PPOA Act, Documents for lease agreement of medical equipment; KRA Act	The Ethics committee exists but the private providers do not follow up, waivers given where necessary - Recommended checking of all the boxes.
4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☑ Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). ☑ Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. ☑ Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. ☑ Workplace policies support HIV-related services and/or benefits for employees. ☑ Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.	4.4 Score: 1.67	The Companies Act(2014) , PPP Act,HIV workplace policy, Multisectoral response to HIV/AIDS	

4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?	○ A. There are no enablers for private health service provision for lower and middle-income HIV patients. ◉ B. The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply): ☑ Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs. ☑ The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.	4.5 Score: 1.67	Comprehensive NHIF Insurance package	More awareness to be done to the public
4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?	◉ A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector. ○ B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply): ☐ HIV-related services/products are covered by national health insurance. ☐ HIV-related services/products are covered by private or other health insurance. ☐ Adequate risk pooling exists for HIV services. ☐ Models currently exist for cost-recovery for ART. ☐ HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.	4.6 Score: 0.00		
		Private Sector Engagement Score: 8.06		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?	○ A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years. ○ C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.	5.1 Score: 1.00	KAIS Kenya Aids Indicator Surveys; National HIV estimates and KSHD report	
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures. ◉ B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.	5.2 Score: 1.00	The National Health Accounts (NHA) Kenya National HIV/ AIDS Spending Assessments.	
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming. ◉ B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .	5.3 Score: 1.00	The Joint Annual and Mid Program Reviews and Reports	

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. Host country government does not make any HIV/AIDS procurements. ○ B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 2.00	Public Procurement Act, Newspaprs,, adverts(for tenders)	
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	NACC/NASCOP	
		Public Access to Information Score: 7.00		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☐ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☐ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☐ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.00	SARAM report 2013	Services not tailored like working hours and working days. Customizing services not done especially in the rural areas esp where issues of culture are concerned, its time we thought of innovative ways of engaging grps such as adolescents and/or people accessing services out of the usual clinic days. Private providers need to be brought on board. Public services are still challenged as they are largely donor driven and govt needs to be have ownership of this for sustainability . Mostly donor driven
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?	The host country has standardized the following design and implementation components of community-based HIV services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV services in communities ☐ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☐ Providing financial support for community-based services ☐ Providing supply chain support for community-based services ☑ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.56	Community strategy available, tools and referral documentations available, SIMS report on linkages, DHIS, SARAM report	There is the community strategy although it is not being actualized in all the counties, no fomal qualifications, no support for supply chain, in some counties support for linkages is going on, tools are already available/in place however the institutionalization of these has not cascaded to all. No formal recognition in all counties but a few eg Busia do provide stipend and linkages.
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas	6.3 Score: 0.83	National Health Accounts report, national AIDS spending Assessment (NASA) 2013, County health budget allocation , National Health Accounts report, national AIDS spending Assessment (NASA) 2013, County health budget allocation	Total spending was 574M, GOK contributed 21%

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.	6.4 Score: 0.37	National Health Accounts report, national AIDS spending Assessment (NASA) 2013, County health budget allocation	
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ◉ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.	6.5 Score: 0.42	MSM strategy (NOPE), KAIS, KP size estmate report, Global Fund Concept Note Application 2015-2017	Not looking at it entirely from a financial perspective but also interms of paying for staffing offering the service, support for policy development and documents guiding provision of the service
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	MSM strategy (NOPE), KAIS, KP size estmate report, GF Concept note application 2015-2017, KSF	
6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?	The national MOH (check all that apply): ☑ Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assesses current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☐ Develops sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engages with civil society in program planning and evaluation of services . ☑ Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.7 Score: 0.93	KASF, sub county HIV/AIDS plan, guidelines, HIV county profiles and roadmaps, DHIS, TWG participation, National HRH strategy, SARAM report	✓ KASF dessimnation has been done although counties are yet to submit their plans (only 20 have so far handed in drafts. ✓ Although engagement is not effective it is on-going, menaingful engagemen civil society needs to done

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score: 0.74	Ditto above	Counties are assessing staff needs for disease burden but not necessarily for the HIV sector
		Service Delivery Score **4.21**		
7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**HRH strategy, HRH databases for county, pub**	**Notes/Comments**
7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers ☐ The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas ☐ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.00	HRH straregy, HRH database for counties, health systems assessment (2010)	Although various cadres of HCWs are produced, they still have to undergo HIV relatedd training to be able to provide HIV services.
7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ◉ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.2 Score: 1.00	HRH strategy	Inventory is available but transition is adhoc or not being implemented uniformly across the various counties.

7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ◉ D. Host country institutions provide most (approx. 50-89%) health worker salaries ○ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.3 Score: 2.50	HRH startegy (2014-19)	The CHWs are not supported by the govt and save for some counties, most are paid by partners. counties are at different stages
7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☑ Updated curricula contain training related to stigma & discrimination of PLWHA ☐ Institutions track student employment after graduation to inform planning	7.4 Score: 1.17	PACE program reports, updated intergrated training curricula, updated co curricula	
7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☑ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☐ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☑ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☑ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.5 Score: 0.75	HRH ICC Capacity HRIS boards CPD cor licensure, Trainsmart database housed by NASCOP, National Intergrated HIV AIDS Curriculum	Intergrated HIV curriculum adopted by MoH now ongoing adoption at county level. Some counties especially in Nyanza have been initiated with TOTs and Mentors trained.

7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☐ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☑ The government produces HR data from the system at least annually ☑ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.6 Score: 1.17	**National HRIS System**	
		Human Resources for Health Score	**6.58**	
8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ○ B. No (0%) funding from domestic sources ◉ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.21	National health accounts, GF reports, forecasting and quantification reports	
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ◉ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.21	MOH 15/16 Forecasting and quantification reports, KEMSA reports	

8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ◉B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ○F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.00	MOH year 15/16 HIV commodities forecasting and quantification report	All condoms are donor funded (GF & UNFPA)
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉B. There is a plan/SOP that includes the following components (check all that apply): ☑Human resources ☑Training ☑Warehousing ☑Distribution ☑Reverse Logistics ☑Waste management ☑Information system ☑Procurement ☑Forecasting ☑Supply planning and supervision ☑Site supervision	8.4 Score: 2.22	KEMSA reports, national F&Q reports (15/16)	
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	◉A. This information is not available. ○B. No (0%) funding from domestic sources. ○C. Minimal (approx. 1-9%) funding from domestic sources. ○D. Some (approx. 10-49%) funding from domestic sources. ○E. Most (approx. 50-89%) funding from domestic sources. ○F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.00		

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 2.22	KEMSA LMIS, commodity securty committees in the county, commodities TWG @ NASCOP	
8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	◉ A. A comprehensive assessment has not been done ○ B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ○ C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 0.00		
	Commodity Security and Supply Chain Score:	**4.86**		
9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☑ Has a budget line item for the QM program ☑ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 2.00	KHQIF, Minimum service standards for OVC	We have a national QM structure; however relies fully on the Donors to cascade it down to the county/ facility level.In some counties/ sub counties we have no focal person at county level

9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) ○ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements ◉ D. There is a current HIV/AIDS program specific QM/QI strategy	9.2 Score: 2.00	KHQIF	
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☐ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☑ There is documentation of results of QI activities and demonstration of national HIV program improvement	9.3 Score: 1.33	DHIS2, NASCOP quarterly reports, national HIV consultative forums, KAIS	E.g. multiudisciplnary teams formed at site level, viral load access improvement etc
9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☑ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 2.00	QI inservice training curricula	Pre-service just starting

9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that includes health services consumers ☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 1.14	WIP reports, facility reports, DHIS, SIMS reports	Not routinely but its happening
		Quality Management Score: **8.48**		
10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ◉ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed	10.1 Score: 0.83	Draft national strategic plan 2012-2016	2012 version finalized but not yet approved as a follow-on to version 2008-2012
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ◉ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ○ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.2 Score: 0.42	national public health laboratories, NHRL, KMLTB	less than 10%, PT for HIV testing is being done although not optimally, none for POC sites

10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	◉ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ○ B. There are adequate qualified laboratory personnel to perform the following key functions: ☐ HIV diagnosis in laboratories and point-of-care settings ☐ TB diagnosis in laboratories and point-of-care settings ☐ CD4 testing in laboratories and point-of-care settings ☐ Viral load testing in laboratories and point-of-care settings ☐ Early Infant Diagnosis in laboratories ☐ Malaria infections in laboratories and point-of-care settings ☐ Microbiology in laboratories and point-of-care settings ☐ Blood banking in laboratories and point-of-care settings ☐ Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings	10.3 Score: 0.00	HRH 2014-2019	not sustained as most lab staff are currently supported by donors. Viral load testing staff not available
10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	◉ A. There is not sufficient infrastructure to test for viral load. ○ B. There is sufficient infrastructure to test for viral load, including: ☐ Sufficient viral load instruments and reagents ☐ Appropriate maintenance agreements for instruments ☐ Adequate specimen transport system and timely return of results	10.4 Score: 0.00	national viral load strategy, ACT plan	currently there are 7 testing labs but not sufficient to support the VL scale up towards the last mile. Breakdown of machines is a cause for delayed TAT
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ◉ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ○ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ○ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.5 Score: 0.83	KEMSA, NASCOP national website (HEI/VL), NHRL	
	Laboratory Score:	**2.08**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☑ The HIV/AIDS budget is program-based across ministries ☑ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☑ The budget includes specific HIV/AIDS service delivery targets ☐ National budget reflects all sources of funding for HIV, including from external donors	11.1 Score: 1.94	GOK budget estimates books	(i).budget for which years- current budget- but was GOK contribution to global fund? - line item at national level but not at county levels. However, at national level the line item is for the GOK counter fund-ritual. (ii) need to consider other sources of domestic funding e.g. private sector contribution (insurance, households) (III) other non targetted GOK expenditures e.g. to TB need also to be considered including allocations to other ministries, CDF funds. Regarding HIV budget accross ministries -Only some selected ministries e. g. MOH, MOE. It is important to note that although there is an explicit budget for HIV at national level, The budget does not address issues of adequacy (budget deficits) . The national budget does not reflect off budget funds
11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. ○ C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. ○ D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. ◉ E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. ○ F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.	11.2 Score: 1.67	perfomance contract, Gok audited accounts. The targets are program targets including all donor funding	the questions do not respond to the responses. The national budget for HIV includes funding from other sources(e.g. global fund). The targets in the national plan are set jointly by all stakeholders not just GOK.

11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	◉ A. Information is not available ◯ B. There is no national HIV/AIDS budget, or the execution rate was 0%. ◯ C. 1-9% ◯ D. 10-49% ◯ E. 50-89% ◯ F. 90% or greater	11.3 Score: 0.00		Very important, NACC should be responsible for this kind of information- Need to separate the Qs. One for national and another one for national because of devolution
11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)				
11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)? (if exact or approximate percentage known, please note in Comments column)	◯ A. None (0%) is financed with domestic funding. ◯ B. Very little (approx. 1-9%) is financed with domestic funding. ◉ C. Some (approx. 10-49%) is financed with domestic funding. ◯ D. Most (approx. 50-89%) is financed with domestic funding. ◯ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 1.67	NHA 2013	
Domestic Resource Mobilization Score:		**5.28**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☐ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 1.43	One Health MOH report	One health - spectrum is a component
12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available ○ B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.	12.2 Score: 0.00		

12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ○ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.3 Score: 0.00		PBB will provide this information in future
12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming ○ B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used. ○ C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ◉ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 1.43	Revised?/supplementary budgets	
12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Care and Support ☑ ART ☑ PMTCT ☑ VMMC ☑ OVC Service Package ☑ Key population Interventions	12.5 Score: 1.43	Spectrum, One Health, WHO/CDC reports, Facility returns, F&Q reports	Use of data for quantification, projection and gap analysis

12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☑ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☑ Improved procurement competition ☑ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☑ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.6 Score: 1.27	MOH strategies, Efficiency studies (World bank, HPP, WHO),TWGs	The new models include intergration of ART into MCH, Self testing (launched but not yet implemented) . Improved efficiency through e-procurement, pooled procurement for economies of scale. HIV integration into primary care services source of information NASCOP TWG. HIV is covered
12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ◉ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.7 Score: 1.43		
Technical and Allocative Efficiencies Score:		**6.98**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.48	Surveillance Protocol (KAIS 2012 and KDHS 2014 protocol) Surveillance Concept note (TB AND HIV CONCEPT NOTE 2015-2017) Publications from specific Surveillance Surveillance reports	
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.48	Surveillance Protocol (KAIS 2012 and KDHS 2014 protocol) Surveillance Concept note (TB AND HIV CONCEPT NOTE 2015-2017) Publications from specific Surveillance Surveillance reports	
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 0.42	Surveillance Protocol (KAIS 2012 and KDHS 2014 protocol) -for Technical Assistance roles Annual GOK allocation budgets Annual Donor Allocation budgets Surveillance Survey reports	factored in technicalexpertise and funds

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ◉ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.42	Surveillance Protocol (KAIS 2012 and KDHS 2014 protocol) -for Technical Assistance roles Annual GOK allocation budgets Annual Donor Allocation budgets Surveillance Survey reports	
13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☑ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☐ Sub-national units	13.5 Score: 0.71	National Surveillance reports (KAIS 2012 and KDHS 2014 protocol) DHIS 2 -Kenya Surveillance presentation on specific surveys conducted Publications from specific surveys Kenya HIV County Profiles (2014)	

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☑ 25-50% ☐ 50-75% ☐ More than 75%	13.6 Score: 0.48	http://www.nascop.org/eid/overall.php National ACT Dashboard _NASCOP NHRL	Changed from 50-75% from 25-50% Add data element for Key Populations and Priority populations on the Viral load databases
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.)	13.7 Score: 0.95	Preventio road map report KAIS Report DHS Report Kenya Fast Tack Plan to End Adolescents AIDS and Young People KENYA AIDS STRATEGIC FRAMEWORK	
13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ◉ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.95	Kenya HIV Prevention Revolution Road Map KAIS Report DHS Report Kenya Fast Tack Plan to End Adolescents AIDS and Young People KENYA AIDS STRATEGIC FRAMEWORK	

13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☐ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews reviews all protocols.	13.9 Score: 0.48	KENYA AIDS STRATEGIC FRAMEWORK (2014/2015-2018/2019) survillance protocol (KAIS 2012 and KDHS 2014 protocol)	
		Epidemiological and Health Data Score:	**5.36**	
14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ◉ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 0.83	SDS Global fund country operation plan	
14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	14.2 Score: 0.83	County government financial plan	

14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☐ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☐ Sub-nationally	14.3 Score: 0.83	http://www.nacc.or.ke/index.php/strategic-framework/funding KENYA AIDS STRATEGIC FRAMEWORK, KNASA	
14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○A. No HIV/AIDS expenditure data are collected ○B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ○C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ◉E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.4 Score: 1.67	http://www.nacc.or.ke/index.php/strategic-framework/funding KENYA AIDS STRATEGIC FRAMEWORK, KNASA	
14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?	○A. The host country government does not conduct health economic studies or analyses for HIV/AIDS ◉B. The host country government conducts (check all that apply): ☑ Costing ☑ Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis) ☑ Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation) ☑ Market demand analysis	14.5 Score: 1.67	Added: - Impact Evaluation, Program Efficiency, Acturial Evaluation, KNASA, LMIC Study and Implication for HIV	
	Financial/Expenditure Data Score:	**5.83**		
15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○A. No system exists for routine collection of HIV/AIDS service delivery data ○B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ◉D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 1.00	DHIS 2 National ACT dashboard NASCOP Situation room -NACC DHIS 2 Situation room -NACC National ACT Dashboard _NASCOP	

15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○A. No routine collection of HIV/AIDS service delivery data exists ○B. No financing (0%) is provided by the host country government ○C. Minimal financing (approx. 1-9%) is provided by the host country government ○D. Some financing (approx. 10-49%) is provided by the host country government ◉E. Most financing (approx. 50-89%) is provided by the host country government ○F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 2.50		response from a health economist will be of essence to us
15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☑ Voluntary Medical Male Circumcision ☑ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☑ By key population (FSW, PWID, MSM/transgender) ☑ By priority population (e.g., military, prisoners, young women & girls, etc.) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☑ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.33	Facility Registers Summary tools/reporting tools *Service availability and readness assessment mapping/Service provision Assessment survey* *Kenya, County HIV Service Delivery Profiles -NASCOP*	
15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○B. The host country government collects & reports service delivery data annually ○C. The host country government collects & reports service delivery data semi-annually ◉D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 1.33	Service availability and readness assessment mapping/Service provision Assessment survey Kenya, County HIV Service Delivery Profiles -NASCOP	

15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☑ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☐ Creation of maps to facilitate geographic analysis	15.5 Score: 0.83	Registers Reporting tools National ACT Dashboard-NASCOP	
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☑ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☐ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.80	KENYA AIDS STRATEGIC FRAMEWORK Kenya, County HIV Service Delivery Profiles -NASCOP	ask the team for assistance
	Performance Data Score:	**7.80**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D