

Kenya SID Narrative Cover Sheet

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years 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 89 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: The country has made progress in a majority of the domains and elements with only one notable area maintained at the same score and three others, witnessing a slight dips. Overall, despite the HRH strikes and an election year, the country's progress shows steadfast efforts in relation to investment in key sustainability areas. More significant, is the increase in the number of counties that are dedicating more resources towards HIV and AIDS as well as the country's renewed commitment to counterpart funding under the new Global Fund Grant signed in December 2018. Despite the progress and aforementioned investments, the national HIV/AIDS response in Kenya remains heavily donor dependent. As noted before, there is still greater need for investment for health (from both National and County governments and from private sector).

SID Process: The 2017 Sustainability Index and Dashboard (SID) process was implemented by PEPFAR in partnership with the National AIDS Control Council (NACC), NASCOP, UNAIDS and Council of Governors. However, it was noted that the approach to this year's SID was one of the major concerns especially in relation to the engagement of the GOK (both National and County levels). To ensure continuity, building on the SID 1.0 and 2.0 participants, 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, County leadership, UNAIDS, World Bank and other multilateral/bilateral donors, in-country experts/academia, and civil society, private sector as well as from within the PEPFAR team. The participants worked in four groups synonymous with the four domains; within groups, the participants validated the data sources associated and corresponding to the responses under each element; prioritized weak elements and proposed key activities; and then as a full group further refined the prioritized elements and activities. Prior to the meeting held on January 16th, 2018, the SID 3.0 was pre-populated with data from the SID 2.0. Together with government, civil society, UN agencies and other donor partners, the USG team represented by Interagency Technical Team (ITT) completed and validated the SID 3.0. While the results of the SID 3.0 has been shared with all stakeholders who participated, the outcome of meeting informed the COP 18 process. While the SID 2.0 process established a clear level of Government leadership on the SID process as part of the national sustainability agenda and while strides were made on the ownership/leadership towards both county and a national level Kenya SID, the momentum was lost at some point prior to the SID 3.0 process. It was agreed that going forward, the leadership and ownership of the SID process be led by GOK with NACC

and NASCOP as the leads in partnership and support by UNAIDS, COG and PEPFAR. It is noted that the Kenya SNU SID is pending completion.

Sustainability Strengths:

- **Policies and Governance (8.50, dark green):** NACC, NASCOP and in general, the Ministry of Health continues to lead 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. Notably, in the past two years, Test and Start, VMMC as well as eMTCT policies, guidelines for key population and self-testing were finalized and disseminated. In addition, all 47 counties finalized and disseminated costed County AIDS Strategic Plans under the funding and leadership of NACC. Coordination and implementation of these and other key policies remains a critical area for improvement needed to propel the country towards country ownership and epidemic control.
- **Quality Management (9.05, dark green):** Under SID 2.0, the country had just planned he country has witnessed an increase in the coordination and further capacity of the Ministry of Health including NACC and NASCOP to implement 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. While the country now has a functional national QM structure, it however, still relies fully on donors to cascade it down to the county/facility level.
- **Technical and Allocative Efficiencies (7.33, dark green):** Program Based Budgeting is a key approach to inform resource allocation; ROI Models, Human Life cycle; For Sustainable financing there is need to transition from external support from SILOS program to parallel mechanism for financial utilization within health systems (health system strengthening frameworks). The integration of County Health systems into the National Health systems remains critical. There is a need for development of aspects of alternative financing accompanied by explanations within the spheres of reducing donor funding with regards to: ROI on HIV among the Fiscal space; Investment cases on prevention and care; and How do we integrate the private sector on the development of the investment cases.
- **Financial/Expenditure Data (7.50, dark green):** NACC plans and implements HIV expenditure analysis but with support from development partners. This has been a huge undertaking in the last two years and improved the accessibility/discourse that informs fiscal planning and HIV expenditures. However, there remains a need to strengthen dissemination of expenditure data. Current data collected every alternate year and thus, there is need to develop a framework for annual data collection and dissemination.

NUANCES: The stakeholders note from SID 1.0 and 2.0 remain a concern. It is clear that while the responses to the domains provided the color-codes as highlighted in the dashboard, there are underlying issues that still need to be addressed to bring them to full scale sustainability capacity. There

is a need for follow up on the weighting of questions and scoring of the responses. Kenya has provided specific notes on the suggestions by domain in a separate communication to the S/GAC sustainability working group.

Sustainability Vulnerabilities:

- **Planning and Coordination (8.50, dark green):** Although the **Policies and Governance** element scored a dark green and is considered a strength, the stakeholders noted that the team needed to prioritize investment towards coordination. With the new constitution, the roles of NACC, NASCOP and Counties need to be review to allow for better alignment of resources and harness the benefits of the existing structures to move towards efficiency and resource management. Proposal included that the NACC and NASCOP, plan and hold consultations with County leadership (CoG) and other key stakeholders as well as establish a collaborative to improve coordination between private and public sectors especially on service delivery in relation to quality of care, data collection and reporting.
- **Service Delivery (6.44, Yellow):** Recommendations include:
 - Country has capacity to provide service salary investments for the local staff providing services
 - HRH support still critical for achievement of targets
 - Support counties for HIV service delivery given that health is devolved
 - Need to support TB services particularly roll out of IPT
 - Support KP programming to reduce over-reliance on external funding and TA
- **Commodity Security and Supply Chain (6.39, Yellow):** Recommendations include:
 - Strengthen commodity management in devolved units(county, sub-county, facility and community levels including infrastructure and CIS
 - Strengthen county leadership/oversight for supply chain functions at all levels
 - DRM for CS and Supply chain systems
- **Laboratory (6.67, Yellow):** The Lab element was noted as a priority given the critical role it plays in the testing, care and treatment continuum. While the strategic plan is under implementation, it is broad and covers all areas of lab including policy, quality assurance, technical guidance and HRH. A health economist will benefit implementation of the strategic plan to map out resource allocation and funding streams and monitor progress. Although much progress has been made with the listed documents developed and implemented within the last two years, there still exist a few gaps. Clear implementation frameworks and road maps will be developed to define timelines for achievement of full coverage for Lab EQA and QMS. The road maps will set targets with benchmarks for achievements with time. There is also a need to build the technical capacity of MoH staff to perform the more complex laboratory testing as well as implement quality monitoring systems fort these tests. Additionally, there is need to transition the more complex testing such as Viral load, EID and HIV DR from research settings to public health institutions. With new molecular diagnostic labs coming up, there is need to match technically competent HRH to run them.
- **Domestic Resource Mobilization (5.71, Yellow):** Recommendations include:

- Analytics and evidence generation to inform strategies for ensuring sustainable health financing including DRM (both public and private sectors)
 - Mainstream PEPFAR funding into existing health financing systems
 - Integration PEPFAR programs into the existing health systems for sustainability
 - PEPFAR should develop an exit strategy that will ensure national and county governments have a framework for financial sustainability
 - PEPFAR should support crosswalk between NHA and NASA for efficient financial tracking in health expenditure within the GDP and existing Fiscal space
- **Epidemiological and Health data (5.79, Yellow):** Recommendations include:
 - Surveillance activities are still significantly implemented with TA from SDPs and agencies. There is need to invest in building MoH capacity, improving coordination for KP surveillance as well as coming up with a single national agenda for KP surveillance and surveys.
 - Some counties have committed to some level of funding for surveys but still significant funding coming from development partners. Need to consider strengthening county capacity to plan local surveillance and work with a more coordinated funding approach
 - Need to have incidence surveillance in more SNU and work with existing structures
 - Incidence data is available for coarse age bands, but fine disaggregation is not available except for the same surveillance projects.

Additional Observations:

In addition, **Civil Society Engagement** also scored a light green and it was noted that we did not advance 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.

For the **National Health Systems**, it was noted that waste management, blood transfusion, infection prevention control need further to remain priorities and areas for investment. In addition, there is critical need for support to county governments to minimize strikes through planning ahead and support of mitigation plans.

Contact: For questions or further information about PEPFAR’s efforts to support sustainability of the HIV response in Kenya, please contact Maxwell Marx at MarxMO@state.gov.

Sustainability Analysis for Epidemic Control: Kenya

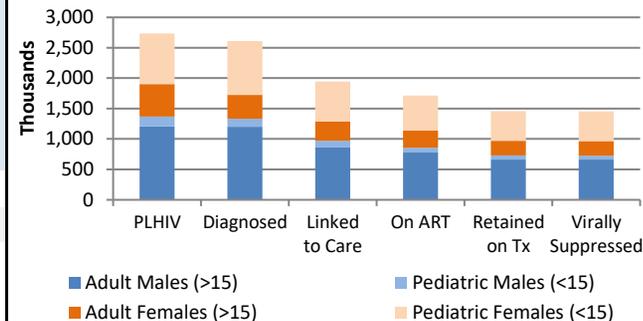
Epidemic Type: Generalized
 Income Level: Lower middle income
 PEPFAR Categorization: Long-term Strategy
 PEPFAR COP 17 Planning Level: \$557,340,446

SUSTAINABILITY DOMAINS and ELEMENTS

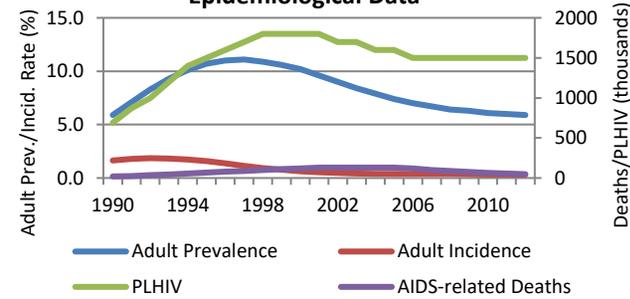
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.00	8.50		
2. Policies and Governance	7.02	8.50		
3. Civil Society Engagement	7.26	7.50		
4. Private Sector Engagement	8.06	7.33		
5. Public Access to Information	7.00	7.00		
National Health System and Service Delivery				
6. Service Delivery	4.21	6.44		
7. Human Resources for Health	6.58	6.55		
8. Commodity Security and Supply Chain	4.86	6.39		
9. Quality Management	8.48	9.05		
10. Laboratory	2.08	6.67		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.28	5.71		
12. Technical and Allocative Efficiencies	6.98	7.33		
Strategic Information				
13. Epidemiological and Health Data	5.36	5.79		
14. Financial/Expenditure Data	5.83	7.50		
15. Performance Data	7.80	7.67		

CONTEXTUAL DATA

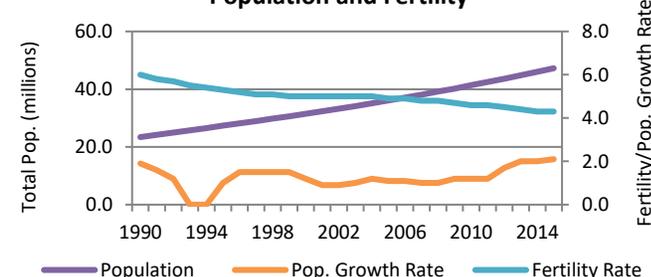
National Clinical Cascade



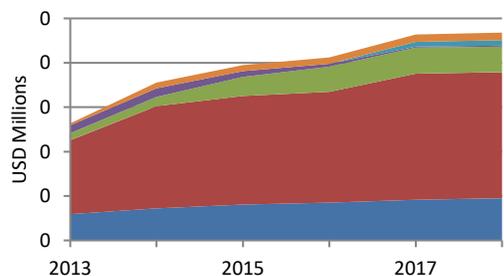
Epidemiological Data



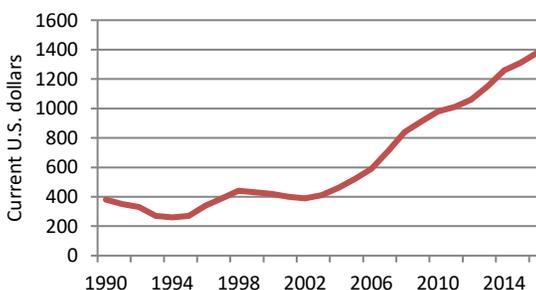
Population and Fertility



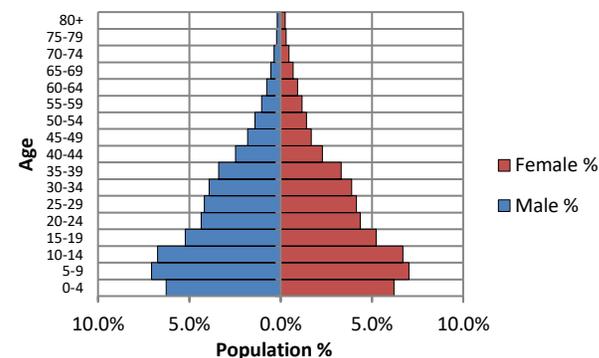
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2017)



CONTEXTUAL DATA

■ Partner Gov't ■ PEPFAR ■ Global Fund
■ Other Donors ■ Private Sector ■ Out of Pocket

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, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

		Data Source	Notes/Comments
<p>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.</p>			
<p>1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. There is a multiyear national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> It has measurable targets.</p> <p><input checked="" type="checkbox"/> It is updated at least every five years</p> <p>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)</p> <p><input checked="" type="checkbox"/> Strategy includes explicit plans and activities to address the needs of key populations.</p> <p><input checked="" type="checkbox"/> Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children</p> <p><input checked="" type="checkbox"/> Strategy (or separate document) includes considerations and activities related to sustainability</p>	<p>1.1 Score: 2.50</p>	<p>Kenya AIDS Strategic Framework (KASF); The Kenya HIV/AIDS Prevention Roadmap; Fast track 'Adolescents and young people' and the VMMC Strategic Plan; Draft MTR KASF review 2017</p> <p>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)</p>
<p>1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?</p>	<p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. The national strategy is developed with participation from the following stakeholders (check all that apply):</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p> <p><input checked="" type="checkbox"/> Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy</p> <p>Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR)</p> <p><input checked="" type="checkbox"/> External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy</p>	<p>1.2 Score: 2.50</p>	<p>Guidelines for TWG ,Minutes of TWG meetings for the national strategic plan,validation minutes and reports, participants lists for meetings; CASP development and launch meetings</p> <p>engagement with persons with disabilities to be improved (they agreed on the comment stated) Added: - Interrogate 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</p>

<p>1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc.</p> <p><input type="checkbox"/> The host country government routinely tracks and maps HIV/AIDS activities of:</p> <p><input type="checkbox"/> civil society organizations</p> <p><input type="checkbox"/> private sector (including health care providers and/or other private sector partners)</p> <p><input type="checkbox"/> donors</p> <p><input checked="" type="checkbox"/> 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.</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of implementing organizations.</p> <p><input type="checkbox"/> Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.</p>	<p>1.3 Score: 1.00</p>	<p>The National AIDS Expenditure Assessment (2015) draft, Reports of the National Accounts and Audits, HIPROS by NACC, M&E reports and tools, TWG, MOU for partnerships, minutes of road map meetings, private sector coordination, PEPFAR COP planning, PFIP, Joint planning with UNAIDS, Multilateral response coordinating between agencies</p>	<p>Mapping needs to be done, there is need to prioritize measures for checking duplication; 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? Tools exist for routine collection of data but not extensively used yet. Private Sector Healthcare providers should be included in planning and monitoring activity tracking</p>
<p>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 either checkbox under option B)</p>	<p><input type="radio"/> A. There is no formal link between the national plan and sub-national service delivery.</p> <p><input checked="" type="radio"/> B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.)</p> <p><input checked="" type="checkbox"/> Sub-national units have performance targets that contribute to aggregate national goals or targets.</p> <p><input type="checkbox"/> The central government is responsible for service delivery at the sub-national level.</p>	<p>1.4 Score: 2.50</p>	<p>CASP (County Aids strategic plans - 2015); Frequent RRI targets, County Data Review meetings and Reports: County Multi Sectoral HIV Plans.</p>	<p>All CASP Drafts Completed and Launched</p>
<p>Planning and Coordination Score:</p>		<p>8.50</p>		

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 WHO guidelines for initiation of ART, i.e. Test and START for all populations?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following: A. Adults (>19 years) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No B. Pregnant and Breastfeeding Mothers <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No C. Adolescents (10-19 years) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No D. Children (<10 years) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2.1 Score: 1.11	WHO Guidelines adapted in 2016

<p>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?</p> <p>Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> A national public health services act that includes the control of HIV</p> <p><input checked="" type="checkbox"/> A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART</p> <p><input checked="" type="checkbox"/> A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits</p> <p><input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months)</p> <p><input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months)</p> <p><input checked="" type="checkbox"/> Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready</p> <p><input checked="" type="checkbox"/> Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS</p> <p><input checked="" type="checkbox"/> Policies that permit HIV self-testing</p> <p><input checked="" type="checkbox"/> Policies that permit pre-exposure prophylaxis (PrEP)</p> <p><input checked="" type="checkbox"/> Policies that permit post-exposure prophylaxis (PEP)</p> <p><input type="checkbox"/> Policies that allow HIV testing without parental consent for adolescents, starting at age 15</p> <p><input type="checkbox"/> Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent</p>	<p>2.2 Score: 0.93</p>	<p>HIV prevention and control act (2006) (Social protection Act; National Road map for Child Protection; - National Public Health Service Act); Kenya has differentiated care; Kenya Test and Start, PrEP and PEP, self-testing guidelines available.</p>	<p>Need to review testing guidelines for under 18.</p>
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<p>2.3 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?</p>	<p>The country has policies in place that (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Govern the collection of patient-level data for public health purposes, including surveillance <input checked="" type="checkbox"/> Govern the collection and use of unique identifiers such as national ID for health records <input checked="" type="checkbox"/> Govern the privacy and confidentiality of health outcomes matched with personally identifiable information <input checked="" type="checkbox"/> Govern the use of patient-level data, including protection against its use in criminal cases 	<p>2.3 Score: 1.11</p>	<p>Use of National IDs for both private and public health insurance and services.</p>	<p>IDs not applicable for under 18. Unique identifier under consideration and review by the GOK for all ages and services.</p>
<p>2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?</p>	<p>Check all that apply:</p> <p>Transgender people (TG):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on gender diversity <input type="checkbox"/> Prohibitions of discrimination in employment based on gender diversity <input type="checkbox"/> A third gender is legally recognized <input type="checkbox"/> Other non-discrimination provisions specifying gender diversity (note in comments) <p>Men who have sex with men (MSM):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on sexual orientation <input type="checkbox"/> Hate crimes based on sexual orientation are considered an aggravating circumstance <input type="checkbox"/> Incitement to hatred based on sexual orientation prohibited <input type="checkbox"/> Prohibition of discrimination in employment based on sexual orientation <input type="checkbox"/> Other non-discrimination provisions specifying sexual orientation <p>Female sex workers (FSW):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on occupation <input type="checkbox"/> Sex work is recognized as work <input type="checkbox"/> Other non-discrimination protections specifying sex work (note in comments) 	<p>2.4 Score: 0.09</p>	<p>Harm reduction policy.</p>	

	<p>People who inject drugs (PWID):</p> <p><input type="checkbox"/> Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments)</p> <p><input checked="" type="checkbox"/> Explicit supportive reference to harm reduction in national policies</p> <p><input type="checkbox"/> Policies that address the specific needs of women who inject drugs</p>			
<p>2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?</p>	<p>The country has the following to protect key populations and people living with HIV (PLHIV) from violence:</p> <p><input checked="" type="checkbox"/> General criminal laws prohibiting violence</p> <p><input checked="" type="checkbox"/> Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population</p> <p><input checked="" type="checkbox"/> Programs to address intimate partner violence</p> <p><input checked="" type="checkbox"/> Programs to address workplace violence</p> <p><input checked="" type="checkbox"/> Interventions to address police abuse</p> <p><input checked="" type="checkbox"/> Interventions to address torture and ill treatment in prisons</p> <p><input checked="" type="checkbox"/> A national plan or strategy to address gender-based violence and violence against women that includes HIV</p> <p><input checked="" type="checkbox"/> Legislation on domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for violence against children</p>	<p>2.5 Score: 1.11</p>	<p>Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.</p> <p>HIV Tribunal and HIV ACT (2006); Kenya Constitution</p>	

2.6 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?

For each question, select the most appropriate option:

Are transgender people criminalized and/or prosecuted in the country?

- Both criminalized and prosecuted
- Criminalized
- Prosecuted
- Neither criminalized nor prosecuted

Is cross-dressing criminalized in the country?

- Yes
- Yes, only in parts of the country
- Yes, only under certain circumstances
- No

Is sex work criminalized in your country?

- Selling and buying sexual services is criminalized
- Selling sexual services is criminalized
- Buying sexual services is criminalized
- Partial criminalization of sex work
- Other punitive regulation of sex work
- Sex work is not subject to punitive regulations or is not criminalized.
- Issue is determined/differs at subnational level

2.6 Score:

0.81

Kenya Penal Code; Sexual Offense Act and HIV ACT

Issues of descrimination still a challenge in Kenya.

Does the country have laws criminalizing same-sex sexual acts?

- Yes, death penalty
- Yes, imprisonment (14 years - life)
- Yes, imprisonment (up to 14 years)
- No penalty specified
- No specific legislation
- Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- Yes
- No, but prosecutions exist based on general criminal laws
- No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- Yes
- No

	<p>Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?</p> <p><input type="checkbox"/> Yes, promotion ("propaganda") laws</p> <p><input checked="" type="checkbox"/> Yes, morality laws or religious norms that limit LGBTI freedom of expression and association</p> <p><input type="checkbox"/> No</p>			
<p>2.7 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?</p>	<p>There are host country government efforts in place as follows (check all that apply):</p> <p><input checked="" type="checkbox"/> To educate PLHIV about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> To educate key populations about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> National law exists regarding health care privacy and confidentiality protections</p> <p><input checked="" type="checkbox"/> Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>2.7 Score: 1.11</p>	<p>The Government set up the HIV tribunal, The HIV AIDS tribunal has a strategic plan, KASF, HIV/AIDS act; Key Populations, CSW, IDU treatment guidelines</p>	<p>The tribunal does not have enough funding to carry out its mandate, there is need to harmonise Government policy documents NACC vs NACADA</p>
<p>2.8 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)?</p>	<p><input type="radio"/> A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry.</p> <p><input type="radio"/> B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more.</p> <p><input checked="" type="radio"/> C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.</p>	<p>2.8 Score: 1.11</p>	<p>Kenya National Audit Office (public finance management Act)</p>	<p>The Audit of programs is not regular, financial audit is not made public</p>
<p>2.9 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?</p>	<p><input type="radio"/> A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted.</p> <p><input type="radio"/> B. The host country government does respond to audit findings by implementing changes as a result of the audit.</p> <p><input checked="" type="radio"/> 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.</p>	<p>2.9 Score: 1.11</p>	<p>Reports for parliamentary accounts committee; Ministries Management reports</p>	<p>Not made public</p>
Policies and Governance Score:		8.50		

3. Civil Society Engagement			
<p>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.</p>		Data Source	Notes/Comments
<p>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?</p>	<p><input type="radio"/> A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response.</p> <p><input type="radio"/> 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.</p> <p><input checked="" type="radio"/> 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.</p>	<p>3.1 Score: 1.67</p>	<p>KASF, Strategic plans of CSOs, inclusion in the TWG, Inclusion of CSOs in the NACC, ICC board and KCM; Public Benefit Organization Act; TWG minutes</p>
<p>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)?</p>	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. There are no formal channels or opportunities.</p> <p><input type="radio"/> B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback.</p> <p><input checked="" type="radio"/> C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input checked="" type="checkbox"/> During strategic and annual planning</p> <p><input checked="" type="checkbox"/> In joint annual program reviews</p> <p><input checked="" type="checkbox"/> For policy development</p> <p><input checked="" type="checkbox"/> As members of technical working groups</p> <p><input checked="" type="checkbox"/> Involvement on government HIV/AIDS program evaluation teams</p> <p><input checked="" type="checkbox"/> Involvement in surveys/studies</p> <p><input checked="" type="checkbox"/> Collecting and reporting on client feedback</p> <p><input checked="" type="checkbox"/> Service delivery</p>	<p>3.2 Score: 1.67</p>	<p>Minutes of planning meeting, The HIV ICC and APR meeting, Minutes and attendance reports of TWGs, ICCs, CSOs do evaluation independently, the stigma index, the survey for implementation of methadone programs at the coast, Implementation reports from PLWHIV, NACC's stakeholders satisfaction Survey</p> <p>Reports need to be shared to stakeholders, suggestion boxes in health facilities should be operationalised</p>

<p>3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?</p>	<p>A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS.</p> <p><input type="radio"/></p> <p><input checked="" type="radio"/> B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply):</p> <p><input checked="" type="checkbox"/> In policy design</p> <p><input checked="" type="checkbox"/> In programmatic decision making</p> <p><input checked="" type="checkbox"/> In technical decision making</p> <p><input checked="" type="checkbox"/> In service delivery</p> <p><input checked="" type="checkbox"/> In HIV/AIDS basket or national health financing decisions</p>	<p>3.3 Score: 1.67</p>	<p>the formation of NACC was as a result of CSO Advocacy, In service delivery, availability of medicine, Advocacy, and resource mobilization.</p>	<p>CSO are limited by funding, they are limited in legal issues and policy matters, CSO need networks for mentorship - CSO not engaged in deciding how GoK portion is allocated/ Utilized</p>
<p>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)?</p> <p>(if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)</p>	<p><input type="radio"/> A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input checked="" type="radio"/> B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/> 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).</p> <p><input type="radio"/> 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).</p> <p><input type="radio"/> E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p>	<p>3.4 Score: 0.83</p>	<p>Annual Budget for CSO's involved</p>	<p>data source should be verified and CSO's were not involved.</p>
<p>3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)?</p> <p>Note: This sometimes referred to as "social contracting" or "social procurement."</p>	<p><input type="radio"/> A. There is no law, policy, or regulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs).</p> <p><input checked="" type="radio"/> B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply:</p> <p><input checked="" type="checkbox"/> Competition is open and transparent (notices of opportunities are made public)</p> <p><input checked="" type="checkbox"/> Opportunities for CSO funding are made on an annual basis</p> <p><input checked="" type="checkbox"/> Awards are made in a timely manner (within 6-12 months of announcements)</p> <p><input checked="" type="checkbox"/> Payments are made to CSOs on time for provision of services</p>	<p>3.5 Score: 1.67</p>	<p>The Kenya Constitution, The Public Benefits Organization Act, KRA policy documents, Public procurement Act. GOK funding allocation records for CSO</p>	
<p>Civil Society Engagement Score:</p>		<p>7.50</p>		

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
<p>4.1 Government Channels and Opportunities for Private Sector Engagement: Does the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p> <p>(If option B is true, check all subsequent boxes that apply.)</p>	<p><input type="radio"/> A. There are no formal channels or opportunities for private sector engagement.</p> <p><input checked="" type="radio"/> B. There are formal channels or opportunities for private sector engagement.</p> <p>i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply):</p> <p><input checked="" type="checkbox"/> Corporations</p> <p><input checked="" type="checkbox"/> Employers</p> <p><input checked="" type="checkbox"/> Private training institutions</p> <p><input checked="" type="checkbox"/> Private health service delivery providers</p> <p>ii. Stakeholders contribute in the following ways (check all that apply):</p> <p><input checked="" type="checkbox"/> The private sector contributes technical expertise into HIV program planning</p> <p><input checked="" type="checkbox"/> Data and strategic input into supply chain management for HIV commodities</p> <p><input type="checkbox"/> Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning</p> <p><input type="checkbox"/> Data on staffing in private health service delivery providers</p> <p><input type="checkbox"/> Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning</p> <p><input checked="" type="checkbox"/> For technical advisory on best practices and delivery solutions</p>	<p>4.1 Score: 1.25</p>	<p>PPP Act of 2013, Existence of the PPP node (unit) at the MOH . Within the KASF has the research Agenda for systems innovation. Private Sector engagement Desk at NACC part of the HIV Investment Department</p>	<p>Private sector data in terms of reporting and collection to inform the national response is still a gap; market analysis to inform private sector engagement should be explored to establish whether companies are willing to provide coverage</p>

	<p>iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply):</p> <p><input type="checkbox"/> The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response.</p> <p><input type="checkbox"/> A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan</p> <p><input type="checkbox"/> The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.</p>			
<p>4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time).</p> <p><input checked="" type="checkbox"/> The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management).</p> <p><input checked="" type="checkbox"/> The host country government has standards for reporting and sharing data across public and private sectors.</p> <p><input checked="" type="checkbox"/> Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies).</p> <p><input type="checkbox"/> There are strong linkage and referral networks between on-site workplace programs and public health care facilities.</p>	<p>4.2 Score: 1.50</p>	<p>PPP Act of 2013, Existence of the PPP node (unit) at the MOH . Within the KASF is the research Agenda for systems inovation. Minutes of multisectoral meetings, Private sector work place policy , PS initiative for financing in the KASF - Sustainable Financing Working Group minutes, Private Sector desk at NACC.</p>	<p>The concept of community systems strengthening came from the private sector; There is an opportunity for linkages and referral networks but its not as strong.</p>

<p>4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery?</p> <p>Note: Full score possible without checking all boxes.</p>	<p><input type="radio"/> A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services.</p> <p><input type="radio"/> B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years.</p> <p><input checked="" type="radio"/> C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply):</p> <p><input checked="" type="checkbox"/> Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications.</p> <p><input checked="" type="checkbox"/> Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting.</p> <p><input type="checkbox"/> Joint (i.e., public-private) supervision and quality oversight of private facilities.</p> <p><input type="checkbox"/> The government offers tax deductions for private facilities delivering HIV/AIDS services.</p> <p><input type="checkbox"/> The government offers tax deductions for private training institutions.</p> <p><input checked="" type="checkbox"/> The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores</p> <p><input type="checkbox"/> The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services.</p> <p><input checked="" type="checkbox"/> HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes</p> <p><input type="checkbox"/> There are open competitions for private health care providers to compete for government service contracts</p> <p><input checked="" type="checkbox"/> There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming</p> <p><input checked="" type="checkbox"/> The government effectively regulates the flow of subsidized commodities into the private sector.</p>	<p>4.3 Score: 2.08</p>	<p>PPOA Act, Documents for lease agreement of medical equipment; KRA Act</p>	
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<p>4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?</p>	<p><input type="radio"/> A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response.</p> <p><input type="radio"/> B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response.</p> <p><input checked="" type="radio"/> C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply):</p> <p><input checked="" type="checkbox"/> Market opportunities that align with and support the national HIV/AIDS response</p> <p><input checked="" type="checkbox"/> Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)</p>	<p>4.4 Score: 2.50</p>	<p>The Companies Act (2014) , PPP Act, HIV workplace policy, KASP, Multisectoral response to HIV/AIDS</p>	
<p>Private Sector Engagement Score:</p>		<p>7.33</p>		

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
<p>5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data and analyses are made available to stakeholders and general public in a timely and useful way?</p>	<p>A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection.</p> <p><input type="radio"/></p> <p>B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months.</p> <p><input checked="" type="radio"/></p> <p>C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.</p> <p><input type="radio"/></p>	<p>5.1 Score: 1.00</p>	<p>KAIS Kenya Aids Indicator Surveys; National HIV estimates and KDHS report, Stigma Survey and Index,</p>
<p>5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?</p>	<p>A. The host country government does not track HIV/AIDS expenditures.</p> <p><input type="radio"/></p> <p>B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures.</p> <p><input type="radio"/></p> <p>C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures.</p> <p><input checked="" type="radio"/></p> <p>D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.</p> <p><input type="radio"/></p>	<p>5.2 Score: 1.00</p>	<p>The National Health Accounts (NHA), County Health Accounts, Household Health Expenditure Survey, National HIV/AIDS Spending Assessments.</p>
<p>5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?</p>	<p>A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming.</p> <p><input type="radio"/></p> <p>B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming.</p> <p><input checked="" type="radio"/></p> <p>C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .</p> <p><input type="radio"/></p>	<p>5.3 Score: 1.00</p>	<p>The Joint Annual and Mid Program Reviews and Reports both at National and County level</p>

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

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.

			Data Source	Notes/Comments
<p>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.</p>				
<p>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.)</p>	<p>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)</p> <p><input checked="" type="checkbox"/> Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics)</p> <p><input checked="" type="checkbox"/> There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services</p>	<p>6.1 Score: 1.11</p>	<p>Guidelines for Differentiated Models of Care; Adolescent Package of Care; Key Populations Guidelines; DATIM as it disaggregates HTS by modality; PMTCT Communication Strategy; PrEP Guidelines. HIV prevention roadmap</p>	<p>Many facilities have extended hours for HTS, weekend and school holiday clinics for adolescents, VMMC mobile clinics, Demand generation done through national campaigns and posted materials at health facilities. KP programming DSD, VMMC</p>
<p>6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)</p>	<p>The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply):</p> <p><input checked="" type="checkbox"/> Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services</p> <p><input checked="" type="checkbox"/> National guidelines detailing how to operationalize HIV/AIDS services in communities</p> <p><input checked="" type="checkbox"/> Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities</p> <p><input checked="" type="checkbox"/> Providing financial support for community-based services</p> <p><input type="checkbox"/> Providing supply chain support for community-based services</p> <p><input checked="" type="checkbox"/> 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)</p>	<p>6.2 Score: 0.93</p>	<p>Community Health Strategy, SIMS reports on linkages, DHIS, SARAM report, facility referral directories, Kenya HIV Quality Improvement Framework specifically requiring community participation, Task Sharing Policy and Guidelines, DATIM HTS data disaggregated facility or community, eMTCT Framework, Differentiated Care Model Guidelines</p>	<p>Some counties pay for supervisors of community health services however they do not yet pay community health volunteers. Linkage not to full extent in all facilities, but process is standardized.</p>
<p>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 (i.e. excluding any external financial assistance from donors)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services</p> <p><input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services</p>	<p>6.3 Score: 0.83</p>	<p>National Health Accounts report, 2015/16</p>	<p>Total GoK spending was \$152M or 22% of HIV expenditures in 2015/16</p>

<p>6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?</p>	<p><input type="radio"/> A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance.</p> <p><input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.</p>	<p>6.4 Score: 0.74</p>	<p>PEPFAR COP 17, National Health Accounts 2015/16, National AIDS Spending Assessment 2013, County Health Budget Allocations</p>	<p>GF allocation funding note.</p>
<p>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 (i.e. without external financial assistance from donors)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input checked="" type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.</p>	<p>6.5 Score: 0.42</p>	<p>MSM strategy (NOPE), Global Fund Country application, 2018-2022</p>	<p>GoK allocations includes both direct and indirect program costs</p>
<p>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 without external technical assistance from donors?</p>	<p><input type="radio"/> A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.</p> <p><input checked="" type="radio"/> B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.</p> <p><input type="radio"/> C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.</p>	<p>6.6 Score: 0.37</p>	<p>MSM strategy (NOPE), KAIS, KP size estimate report, Global Funding request 2018-2022, Kenya AIDS Strategic Framework 2014-2019, NASCOP Key Populations Dashboard</p>	
<p>6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?</p>	<p>National health authorities (check all that apply):</p> <p><input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.</p> <p><input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.</p> <p><input checked="" type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.</p> <p><input type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations.</p> <p><input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services.</p> <p><input type="checkbox"/> 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.</p>	<p>6.7 Score: 0.93</p>	<p>KASF, county HIV/AIDS plan, guidelines, HIV country profiles and roadmaps, DHIS, National HRH strategy, SARAM report, KHQIF, Trainsmart, County staff appraisal plans.</p>	<p>KASF dissemination has been done. Update County HIV Strategic Plans. Counties develop their own budgets in devolved health.</p>

<p>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?</p>	<p>Sub-national health authorities (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. <input checked="" type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. <input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations. <input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services. <p>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.</p>	<p>6.8 Score:</p> <p>1.11</p>	<p>KASF, county HIV/AIDS plan, guidelines, HIV country profiles and roadmaps, DHIS, National HRH strategy, SARAM report, KHQIF, Trainsmart, County staff appraisal plans.</p>	<p>Counties are assessing staff needs for disease burden but not necessarily for the HIV sector.</p>
Service Delivery Score		6.44		

7. Human Resources for Health				
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.			Data Source	Notes/Comments
7.1 HRH Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers <input type="checkbox"/> The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden <input checked="" type="checkbox"/> The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas <input type="checkbox"/> 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:	0.28	KMTC graduation records, iHRIS, regulatory bodies HRH data from rHRIS, HRH strategy 2014-2019 The preservice training produce various cadres in different levels where some are adequate but a number are not adequate. The major concern is that health worker production is not matched by hiring and deployment by government, hence acute shortage of staff at facility is a reality. Retention strategies captured in the HRH strategy not implemented. information on social workers trained/ Gaps not available.
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). <input type="checkbox"/> Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. <input type="checkbox"/> The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services. 	7.2 Score:	0.37	1) Community health strategy, 2) Community health unit records, 3) county community health worker record 4) county bills passed There is a community health strategy that addresses various health interventions at community level including HIV/AIDS. The data for available community health workers is not consolidated. Government recognises the inputs of CHW delivering HIV/AIDS services however the cadres are not included in the official public service regulations. About 10 counties have budgeted for and will pay CHWs a stipend of \$20 per month beginning GoK financial year i.e., July 2018
7.3 HRH transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place.	<ul style="list-style-type: none"> <input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers <input type="radio"/> B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support <input checked="" type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented <input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan <input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated 	7.3 Score:	0.56	Donor supported health Workers guidelines. Global fund funding request 2017-2019. There is no formal centralised inventory for all donor supported health workers, however there exist GoK guidelines for transition of donor supported health workers. Some donors have developed specific transition plans as agreed by some counties. Such counties recognize the need to sustain the services provided by these donor supported contract workers.

<p>7.4 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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no (0%) health worker salaries</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) health worker salaries</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) health worker salaries</p> <p><input checked="" type="radio"/> D. Host country institutions provide most (approx. 50-89%) health worker salaries</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries</p>	<p>7.4 Score: 2.50</p>	<p>HRH strategy (2014-19), National and County Budget Analysis (2016/17), Budget Policy Statement (2017), iHRIS</p>	<p>Except contract staff (about 8,000) the rest of the health workers are paid by Government and private sector (close to 90%)</p>
<p>7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p> <p>Note: List applicable cadres in the comments column.</p>	<p><input type="radio"/> 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)</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input checked="" type="checkbox"/> Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input checked="" type="checkbox"/> Institutions maintain process for continuously updating content, including HIV/AIDS content</p> <p><input checked="" type="checkbox"/> Updated curricula contain training related to stigma & discrimination of PLHIV</p> <p><input type="checkbox"/> Institutions track student employment after graduation to inform planning</p>	<p>7.5 Score: 0.97</p>	<p>Regulatory boards core curriculum</p>	<p>Some of the new HIV/AIDS services approaches have been incorporated into the curriculum for some cadres. Some of the curriculum contain content on Stigma and discrimination. The training institutions have not been tracking the students after graduation, the regulatory bodies are better placed to do that.</p>
<p>7.6 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?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p>Check all that apply among A, B, C, D:</p> <p><input checked="" type="checkbox"/> A. The host country government provides the following support for in-service training in the country (check ONE):</p> <p><input type="checkbox"/> Host country government implements no (0%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements some (approx. 10-49%) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> Host country government implements most (approx. 50-89%) HIV/AIDS in-service training</p> <p><input type="checkbox"/> Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> 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</p> <p><input checked="" type="checkbox"/> C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians</p> <p><input checked="" type="checkbox"/> 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)</p>	<p>7.6 Score: 1.04</p>	<p>HRIS train, county specific personnel training records, regulatory HRIS, NASCOP's TrainSmart</p>	<p>Host government collaborates with donors and IPs to implement in-service training (i.e. trainers, venues and facilities). However the donors provide much of the financial resources. There is a database to track trainings however data entry by some of the donors and IPs is low.</p>

<p>7.7 HR Data Collection and Use: Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?</p>	<p><input type="radio"/> A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management</p> <p><input type="radio"/> B. There is no HRIS in country, but some data is collected for planning and management</p> <p><input type="checkbox"/> Registration and re-licensure data for key professionals is collected and used for planning and management</p> <p><input type="checkbox"/> MOH health worker employee data (number, cadre, and location of employment) is collected and used</p> <p><input type="checkbox"/> Routine assessments are conducted regarding health worker staffing at health facility and/or community sites</p> <p><input checked="" type="radio"/> C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country:</p> <p><input type="checkbox"/> The HRIS is primarily financed and managed by host country institutions</p> <p><input type="checkbox"/> There is a national strategy or approach to interoperability for HRIS</p> <p><input checked="" type="checkbox"/> The government produces HR data from the system at least annually</p> <p><input checked="" type="checkbox"/> Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)</p>	<p>7.7 Score: 0.83</p>	<p>HRIS data system</p>	<p>There is an HRIS data system mainly funded by donors but hosted in government premises. Routine data from the system is used for planning, budgeting and other HRH decision making. Routinely, data from the system is used for planning, budgeting and other HRH decision making such as identification of gaps for recruitment.</p>
<p>Human Resources for Health Score</p>		<p>6.55</p>		

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
<p>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)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<input type="radio"/> A. This information is not known. <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50 – 89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.21	Global fund reports.	Government increasing allocations for ARVs in the MTEF	
<p>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)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<input type="radio"/> A. This information is not known <input type="radio"/> B. No (0%) funding from domestic sources <input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input checked="" type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.42	GoK contribution for FY 2017 is around 14% (KEMSA reports, counter part financing). MoH 15/16 forecasting and quantification reports, KEMSA reports, GF application (2017)	Government increasing allocations for test kits in the MTEF	
<p>8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? <i>Note:</i> The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<input type="radio"/> A. This information is not known <input checked="" type="radio"/> B. No (0%) funding from domestic sources <input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.00	MoH year 15/16 HIV commodities F&Q report, MoH printed estimates		

<p>8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?</p>	<p><input type="radio"/> A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).</p> <p><input checked="" type="radio"/> B. There is a plan/SOP that includes the following components (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Human resources <input checked="" type="checkbox"/> Training <input checked="" type="checkbox"/> Warehousing <input checked="" type="checkbox"/> Distribution <input checked="" type="checkbox"/> Reverse Logistics <input checked="" type="checkbox"/> Waste management <input checked="" type="checkbox"/> Information system <input checked="" type="checkbox"/> Procurement <input checked="" type="checkbox"/> Forecasting <input checked="" type="checkbox"/> Supply planning and supervision <input checked="" type="checkbox"/> Site supervision 	<p>8.4 Score: 2.22</p>	<p>KEMSA has SOPs on all areas checked.</p>	<p>SOPs not collated into one document.</p>
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not available.</p> <p><input type="radio"/> B. No (0%) funding from domestic sources.</p> <p><input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources.</p> <p><input type="radio"/> D. Some (approx. 10-49%) funding from domestic sources.</p> <p><input type="radio"/> E. Most (approx. 50-89%) funding from domestic sources.</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funding from domestic sources.</p>	<p>8.5 Score: 0.21</p>	<p>MoH printed estimates, KEMSA audited accounts</p>	

<p>8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities <input checked="" type="checkbox"/> Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time <input checked="" type="checkbox"/> MOH or other host government personnel make re-supply decisions with minimal external assistance: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Decision makers are not seconded or implementing partner staff <input checked="" type="checkbox"/> Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects <input checked="" type="checkbox"/> Team that conducts analysis of facility data is at least 50% host government 	<p>8.6 Score: 2.22</p>	<p>Procurement plan. Commodity security meeting minutes, F&Q reports. Monthly ART stock status report.</p>	
<p>8.7 Assessment: Was an overall score of above 80% achieved on the 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)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. A comprehensive assessment has not been done within the last three years. <input checked="" type="radio"/> B. A comprehensive assessment has been done within the last three years but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments <input type="radio"/> C. A comprehensive assessment has been done within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment 	<p>8.7 Score: 1.11</p>	<p>KEMSA Assessment</p>	<p>Assessment done, but with the global tool; hence not scored.</p>
<p>Commodity Security and Supply Chain Score:</p>		<p>6.39</p>		

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
<p>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?</p>	<p><input type="radio"/> A. The host country government does not have structures or resources to support site-level continuous quality improvement</p> <p><input checked="" type="radio"/> B. The host country government:</p> <p>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</p> <p><input checked="" type="checkbox"/> Has a budget line item for the QM program</p> <p>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</p>	<p>9.1 Score: 2.00</p>	<p>KHQIF, Minimum service standards for OVC, MoH Norms and Standards for Health Service Delivery</p>	<p>We have a national QM structure. However, it relies fully on Donors to cascade it down to the county/facility level. In some counties/subcounties we have no focal person.</p>
<p>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.)</p>	<p><input type="radio"/> A. There is no HIV/AIDS-related QM/QI strategy</p> <p><input type="radio"/> B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized</p> <p><input checked="" type="radio"/> C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized.</p> <p><input type="radio"/> D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.</p>	<p>9.2 Score: 1.33</p>	<p>KHQIF, KQMH</p>	
<p>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?</p>	<p><input type="radio"/> 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.</p> <p><input checked="" type="radio"/> 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):</p> <p><input checked="" type="checkbox"/> 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</p> <p><input checked="" type="checkbox"/> 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</p> <p><input checked="" type="checkbox"/> There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels</p>	<p>9.3 Score: 2.00</p>	<p>eMTCT Stock Taking, NASCOP National Best Practices Meeting, County Health Management Team meetings, National HIV Acceleration Plan 2015-19, National HIV Situation Room</p>	

<p>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?</p>	<p><input type="radio"/> A. There is no training or recognition offered to build health workforce competency in QI.</p> <p><input checked="" type="radio"/> B. There is health workforce competency-building in QI, including:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Pre-service institutions incorporate modern quality improvement methods in curricula <input checked="" type="checkbox"/> 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 	<p>9.4 Score: 2.00</p>	<p>QI Pre-service Training Curriculum, Comprehensive HIV Training Curriculum covers in-service</p>	
<p>9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?</p>	<p>The national-level QM structure:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services <input type="checkbox"/> Regularly convenes meetings that include health services consumers <input checked="" type="checkbox"/> Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement <p>Sub-national QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services <input checked="" type="checkbox"/> Regularly convene meetings that includes health services consumers <input checked="" type="checkbox"/> Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement <p>Site-level QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement 	<p>9.5 Score: 1.71</p>	<p>National HIV Consultative Forum, National QI Plan. National and sub national TWG meeting minutes</p>	<p>NASCOP QI Team, National Viral Load Website data, DHIS data, County and Facility level QI activities are largely donor led, few counties have hired health QI specialists (not HIV specific)</p>
<p>Quality Management Score:</p>		<p>9.05</p>		

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
<p>10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?</p>	<p> <input type="radio"/> A. There is no national laboratory strategic plan <input type="radio"/> B. National laboratory strategic plan is under development <input type="radio"/> C. National laboratory strategic plan has been developed, but not approved <input type="radio"/> D. National laboratory strategic plan has been developed and approved <input type="radio"/> E. National laboratory plan has been developed, approved, and costed <input checked="" type="radio"/> F. National laboratory strategic plan has been developed, approved, costed, and implemented </p>	<p>10.1 Score: 1.67</p>	<p>National Public Health Laboratory Strategic Plan 2016 - 2020.</p> <p>The strategic plan is under implementation. It is broad and covers all areas of lab including policy, quality assurance, technical guidance and HRH. It is anchored on the MOH strategic plan. A health economist will benefit implementation of the strategic plan to map out resource allocation and funding streams and monitor progress</p>
<p>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?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p> <input type="radio"/> A. Regulations do not exist to monitor minimum quality of laboratories in the country. <input type="radio"/> B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). <input type="radio"/> C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated). <input type="radio"/> D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). <input checked="" type="radio"/> E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). <input type="radio"/> F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated). </p>	<p>10.2 Score: 1.25</p>	<ul style="list-style-type: none"> • Kenya Medical Laboratory Technicians and Technologists Board ACT • Laboratory technical support and mentorship Guideline-2016 • Laboratory technical support and mentorship Guideline-2016 • National Integrated EQA strategy for Medical Lab services-2016 • Operational Manual for the Implementation of quality assurance in rapid HIV testing in Kenya-2016 • Point-of-care Testing Policy Guideline-2016 • Quality HIV testing in Kenya: TOT and lab supervisors curriculum-2016 • Laboratory technical support and mentorship Guideline-2016 <p>Although much progress has been made with the listed documents developed and implemented within the last two years, there still exist a few gaps. Clear implementation frameworks and road maps will be developed to define timelines for achievement of full coverage for Lab EQA and QMS. The road maps will set targets with benchmarks for achievements with time.</p>
<p>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?</p>	<p> <input type="radio"/> A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control <input checked="" type="radio"/> B. There are adequate qualified laboratory personnel to perform the following key functions: </p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV diagnosis by rapid testing and point-of-care testing <input checked="" type="checkbox"/> Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria <input type="checkbox"/> Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays <input checked="" type="checkbox"/> TB diagnosis 	<p>10.3 Score: 1.25</p>	<p>National HRH Strategy 2014-19.</p> <p>Most public health facilities have staff to support HIV diagnosis and routine laboratory testing. However, there is a need to build the technical capacity of MoH staff to perform the more complex laboratory testing as well as implement quality monitoring systems for these tests. Additionally, there is need to transition the more complex testing such as Viral load, EID and HIV DR from research settings to public health institutions. With new molecular diagnostic labs coming up, there is need to match technically competent HRH to run them.</p>

<p>10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?</p>	<p><input type="radio"/> A. There is not sufficient infrastructure to test for viral load.</p> <p><input checked="" type="radio"/> B. There is sufficient infrastructure to test for viral load, including:</p> <p><input type="checkbox"/> Sufficient HIV viral load instruments</p> <p><input checked="" type="checkbox"/> All HIV viral load laboratories have an instrument maintenance program</p> <p><input checked="" type="checkbox"/> Sufficient supply chain system is in place to prevent stock outs</p> <p><input type="checkbox"/> Adequate specimen transport system and timely return of results</p>	<p>10.4 Score: 0.83</p>	<ul style="list-style-type: none"> • The National HIV Viral Load Testing Scale-up Implementation Guidelines: 2016-2019 • National HIV Acceleration Plan 2015-19. • The National Viral Load/EID Website 	<p>Most viral load testing is done in research laboratories. There are plans to move the testing to public health facilities. Currently 17 have been or are in the process of being constructed with support from World bank and Global Fund. These will need to be equipped and the specimen transport system strengthened. Additional investment will be made to ensure optimum turnaround time</p>
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No (0%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources.</p> <p><input checked="" type="radio"/> C. Some (approx. 10-49%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> D. Most (approx. 50-89%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.</p>	<p>10.5 Score: 1.67</p>	<p>National budget allocation</p>	<p>The National Treasury has a vote head for public health laboratories. The government supports procurement of most lab reagents, HR and infrastructure. The government is also working on increasing domestic funding for laboratories under Universal Health Coverage (UHC) scheme and National Health Insurance Fund (NHIF). Additionally most counties are allocating funds to improve lab infrastructure, add additional equipment, staffing as well as support lab quality assurance.</p>
<p>Laboratory Score:</p>		<p>6.67</p>		

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.

Fiscal Context for Health and HIV/AIDS			Data Source	Notes/Comments
This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.				
1. What percentage of general government expenditures goes to health?	8.2%		Draft National and County budget analysis (2017/18) - validate with Controller of Budget and CRA	Counties investing heavily in health; other non-health sectors investing in health very small (educ,); add % changes 27.2% ave county allocation to health; - The expenditure analysis from NHA(2016), need to be undertaken. Expenditure Analysis&Tracking and Efficiency need to be undertaken
2. What is the per capita health expenditure all sources?	\$78.60		National Health Accounts (2015/16)	Trend analysis needed to show progress; approaching 84\$ WHO recommendation for WHO benefit package
3. What is the total health care expenditure all sources as a percent of GDP?	5.20%		National Health Accounts (2015/16)	Low as compared to the Abuja Declaration for the 15%, Whats are the benchmarks: Resource Tracking and Efficiency key to identify Government resource utilization
4. What percent of total health expenditures is financed by external resources?	22.20%		National Health Accounts (2015/16)	
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	32.80%		National Health Accounts (2015/16)	

<p>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.</p>	<p>Data Source</p>	<p>Notes/Comments</p>
<p>11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?</p> <p>Check all that apply:</p> <p><input type="checkbox"/> A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply):</p> <p style="text-align: right;">11.1 Score: 0.36</p> <p><input type="checkbox"/> ARVs are covered</p> <p><input type="checkbox"/> Non-ARV care and treatment is covered</p> <p><input type="checkbox"/> Prevention services are covered</p> <p><input checked="" type="checkbox"/> B. Yes, there is an affordable health insurance scheme available (check one of the following).</p> <p><input checked="" type="checkbox"/> It covers 25% or less of the population.</p> <p><input type="checkbox"/> It covers 26 to 50% of the population.</p> <p><input type="checkbox"/> It covers 51 to 75% of the population.</p> <p><input type="checkbox"/> It covers more than 75% of the population.</p> <p><input checked="" type="checkbox"/> C. The affordable health insurance scheme in (B.) includes the following (check all that apply):</p> <p><input type="checkbox"/> ARVs are covered.</p> <p><input checked="" type="checkbox"/> Non-ARV care and treatment services are covered.</p> <p><input type="checkbox"/> Prevention services are covered.</p> <p><input checked="" type="checkbox"/> It includes public subsidies for the affordability of care.</p>	<p>Government Printed Estimates (Various yrs), NHIF benefit package, Kenya Health Policy (2014-30) KHHEUS 2013;</p>	<p>Government share is small so 'YES' is relative; need to disaggregate components ; County level needs to also contribute to counterpart financing; need question on public subsidies and SHI on its own; mixed response; no weighting on responses i.e. ARVs; NHIF no exclusions but no reimbursement for HIV; donor subsidies crowding out; "Affordabe' insurance; - The Universal, Comprehensive financing scheme which is LONG TERM does not exist(An area if Investment) also the QUESTION OF LONG TERM is not defined. - For Question A is NO:-For Question C, - This constitutes part of the 17% covered under the NHIF</p>

<p>11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?</p>	<p><input type="radio"/> A. There is no explicit funding for HIV/AIDS in the national budget.</p> <p><input checked="" type="radio"/> B. There is explicit HIV/AIDS funding within the national budget.</p> <p><input checked="" type="checkbox"/> The HIV/AIDS budget is program-based across ministries</p> <p><input checked="" type="checkbox"/> The budget includes or references indicators of progress toward national HIV/AIDS strategy goals</p> <p><input checked="" type="checkbox"/> The budget includes specific HIV/AIDS service delivery targets</p> <p><input type="checkbox"/> National budget reflects all sources of funding for HIV, including from external donors</p>	<p>11.2 Score: 0.83</p>	<p>Printed estimates for GoK; MTEF forecasts</p>	<p>Provision of GF counterpart financing is growing; other significant indirect investment from MoH i.e. HRH, service delivery etc.; yet 93% of ARVs covered by GF and PEPFAR; "national" budget alone? Counties are contributing additional resources for HIV; - The budget does NOT reflect on ALL other sources of funding - However, even the explicit, the aspect on areas of utilization needs to be disaggregated</p>
<p>11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?</p>	<p><input type="radio"/> A. There are no HIV/AIDS goals/targets articulated in the national budget</p> <p><input checked="" type="radio"/> B. There are HIV/AIDS goals/targets articulated in the national budget.</p> <p><input checked="" type="checkbox"/> The goals/targets are measurable.</p> <p><input checked="" type="checkbox"/> Budget items/programs are linked to goals/targets.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during budget execution.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during the development of the budget.</p>	<p>11.3 Score: 0.95</p>	<p>Kenya AIDS Strategic Framework, Kenya Health Sector Strategic Plan, Annual Program Reviews/Mid Term Reviews of AIDS plans</p>	
<p>11.4 HIV/AIDS 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?</p> <p>(If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)</p>	<p><input type="radio"/> A. There is no HIV/AIDS budget, or information is not available.</p> <p><input type="radio"/> B. 0-49% of budget executed</p> <p><input checked="" type="radio"/> C. 50-69% of budget executed</p> <p><input type="radio"/> D. 70-89% of budget executed</p> <p><input type="radio"/> E. 90% or greater of budget executed</p>	<p>11.4 Score: 0.32</p>	<p>Government Appropriation Accounts; GFATM Review reports; Public Expenditure Reviews</p>	<p>Counties 70% of health budget execution; Counterpart financing for HIV is 62%; Mobilizing more money if spending is 62%?</p>

<p>11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?</p>	<p>A. Neither the Ministry of Health nor the Ministry of Finance routinely <input checked="" type="radio"/> collects all donor spending in the health sector or for HIV/AIDS-specific services.</p> <p><input type="radio"/> B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.</p> <p><input type="radio"/> C. The Ministry of Health or Ministry of Finance routinely collects <input type="radio"/> all donor spending all the entire health sector, including HIV/AIDS-specific services.</p>	<p>11.5 Score: 0.00</p>	<p>Medium Term Expenditure Reviews, Annual Operations Plans, National Health Accounts, HIPPORS</p>	<p>Fragmentation of the donor financing - We need to streamline the financing from donor financing - HIPPORS should be strengthened (people are not aware, accountability aspects by donors) while intergrating with other indicators like efficiency. System intergration for data collection should be developed</p>
<p>11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. None (0%) is financed with domestic funding.</p> <p><input type="radio"/> B. Very little (approx. 1-9%) is financed with domestic funding.</p> <p><input checked="" type="radio"/> C. Some (approx. 10-49%) is financed with domestic funding.</p> <p><input type="radio"/> D. Most (approx. 50-89%) is financed with domestic funding.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) is financed with domestic funding.</p>	<p>11.6 Score: 1.67</p>		<p>The range is too wide hence needs mechanisms of achieving higher accurancies on the estimates</p>
<p>11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?</p>	<p><input type="radio"/> A. There is no budget for health or no money was allocated.</p> <p><input type="radio"/> B. 0-49% of budget executed.</p> <p><input type="radio"/> C. 50-69% of budget executed.</p> <p><input checked="" type="radio"/> D. 70-89% of budget executed.</p> <p><input type="radio"/> E. 90% or greater of budget executed.</p>	<p>11.7 Score: 0.63</p>	<p>Public Expenditure Reviews, Appropriation Accounts</p>	
<p>11.8 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?</p>	<p><input type="radio"/> A. There is no system for funding cycle reprogramming.</p> <p><input type="radio"/> B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used.</p> <p><input type="radio"/> C. There is a policy/system that allows for funding cycle <input type="radio"/> reprogramming and reprogramming is done as per the policy, but not based on data.</p> <p><input checked="" type="radio"/> D. There is a policy/system that allows for funding cycle <input checked="" type="radio"/> reprogramming and reprogramming is done as per the policy, and is based on data.</p>	<p>11.8 Score: 0.95</p>	<p>Annual supplementary estimates</p>	<p>Procurements difficult due to timing; County CHMTs need capacity</p>
<p>Domestic Resource Mobilization Score:</p>		<p>5.71</p>		

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
<p>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?</p> <p>If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development)</p> <p>(note: full score achieved by selecting one checkbox)</p>	<p><input type="radio"/> A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources.</p> <p><input checked="" type="radio"/> B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply):</p> <p><input type="checkbox"/> Optima</p> <p><input checked="" type="checkbox"/> Spectrum (including EPP and Goals)</p> <p><input checked="" type="checkbox"/> AIDS Epidemic Model (AEM)</p> <p><input checked="" type="checkbox"/> Modes of Transmission (MOT) Model</p> <p><input checked="" type="checkbox"/> Other recognized process or model (specify in notes column)</p>	<p>12.1 Score: 2.00</p>	<p>Kenya AIDS Strategic Framework, OneHealth Model used for costing and results used for resource allocations</p> <p>Program Based Budgeting is key approach to inform resource allocation; ROI Models, Human Life cycle; For Sustainable financing there is need to transition from External support from SILOS program to Parallel mechanism for Financial utilization within health systems (health system strengthening frameworks) - Integration of County Health systems into the National Health systems - Aspects of alternative financing needs to be developed and explained within the spheres of reducing donor funding with regards to ROI on HIV among the Fiscal space, Investment cases on prevention and care, How do we integrate the private sector on the development of the investment cases</p>
<p>12.2 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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input checked="" type="radio"/> A. Information not available.</p> <p><input type="radio"/> B. No resources (0%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.</p>	<p>12.2 Score: 0.00</p>	<p>Counties budget for service delivery; Donor commodities targeted to high burden counties; crowds out domestic financing?</p>

<p>12.3 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?</p> <p>(note: full score can be achieved without checking all disaggregate boxes).</p>	<p><input type="radio"/> A. The host country government does not have/use recent expenditure data or cost analysis to estimate unit costs</p> <p><input checked="" type="radio"/> B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV Testing <input checked="" type="checkbox"/> Laboratory services <input checked="" type="checkbox"/> ART <input checked="" type="checkbox"/> PMTCT <input checked="" type="checkbox"/> VMMC <input checked="" type="checkbox"/> OVC Service Package <input checked="" type="checkbox"/> Key population Interventions 	<p>12.3 Score: 2.00</p>	<p>KASF costing, GF application analyses</p>	
<p>12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies <input type="checkbox"/> Reduced overhead costs by streamlining management <input checked="" type="checkbox"/> Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. <input checked="" type="checkbox"/> Improved procurement competition <input type="checkbox"/> Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) <input checked="" type="checkbox"/> Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) <input checked="" type="checkbox"/> 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) <input checked="" type="checkbox"/> 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) <input checked="" type="checkbox"/> Developed and implemented other new and more efficient models of HIV service delivery (specify in comments) 	<p>12.4 Score: 1.33</p>	<p>KEMSA systems improvements/efficiencies</p>	<p>internal efficiency improvements to operations, not studies per se (Treasury); ongoing studies not yet utilized ; 'integration in insurance' because no exclusions; many stand alone remain donor funded; Combo/differentiated care models introduced; mother-child pairing (However, for full intergration of TB and HIV, the Question of WHO should own particular aspects of service delivery should be identified); -The evidence of some levels of integration should be established</p>

<p>12.5 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?</p> <p>(Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)</p>	<p><input type="radio"/> A. Partner government did not pay for any ARVs using domestic resources in the previous year.</p> <p><input type="radio"/> 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.</p> <p><input type="radio"/> 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.</p> <p><input type="radio"/> 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.</p> <p><input checked="" type="radio"/> 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.</p>	<p>12.5 Score: 2.00</p>	<p>KEMSA Tenders</p>	<p>US \$10</p>
<p>Technical and Allocative Efficiencies Score:</p>		<p>7.33</p>		

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
<p>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.)?</p>	<p><input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</p> <p><input type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</p> <p><input checked="" type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</p> <p><input type="radio"/> 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</p>	<p>13.1 Score: 0.71</p>	<p>Publications from specific Surveillance reports and KENPHIA 2017 Protocol</p>	<p>Kenya is the first country to pilot CBS and currently finalizing a surveillance strategy including mortuary surveillance.</p>
<p>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.)?</p>	<p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</p> <p><input checked="" type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</p> <p><input type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</p> <p><input type="radio"/> 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</p>	<p>13.2 Score: 0.48</p>	<p>Publications from specific Surveillance reports and KENPHIA 2017 Protocol</p>	<p>Surveillance activities are still significantly implemented with TA from SDPs and agencies. There is need to invest in building MoH capacity, improving coordination for KP surveillance. Coming up with a single national agenda for KP surveillance and surveys (Guidance document)</p>
<p>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.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90%+) is provided by the host country government</p>	<p>13.3 Score: 0.42</p>	<p>Surveillance Protocol (KENPHIA protocol) -for Technical Assistance roles Annual GOK allocation budgets Annual Donor Allocation budgets Surveillance Survey reports</p>	<p>Some counties have committed to some level of funding for surveys but still significant funding coming from development partners. Need to consider strengthening county capacity to plan local surveillance and work with a more coordinated funding approach</p>

<p>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.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (approx. 90% +) is provided by the host country government</p>	<p>13.4 Score: 0.42</p>	<p>Surveillance Protocol (KENPHIA protocol) -for Technical Assistance roles Annual GOK allocation budgets Annual Donor Allocation budgets Surveillance Survey reports</p>	<p>Owing to the lack of common approach for KP surveillance, very minimal investment from GoK and counties. This can be guided by investing more on a clear KP surveillance agenda.</p>
<p>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?</p> <p>(Note: Full score possible without selecting all disaggregates.)</p>	<p>Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data:</p> <p><input checked="" type="checkbox"/> A. The host country government collects at least every 5 years HIV prevalence data disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age (at coarse disaggregates) <input checked="" type="checkbox"/> Age (at fine disaggregates) <input checked="" type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> Sub-national units <p><input checked="" type="checkbox"/> B. The host country government collects at least every 5 years HIV incidence disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age (at coarse disaggregates) <input checked="" type="checkbox"/> Age (at fine disaggregates) <input checked="" type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input type="checkbox"/> Sub-national units 	<p>13.5 Score: 0.67</p>	<p>National Surveillance reports (KENPHIA 2017-18 protocol) DHIS 2 -Kenya Surveillance presentation on specific surveys conducted. Publications from specific surveys Kenya HIV County Profiles</p>	<p>No clear data for KP and priority populations and with finer disaggregation. Some longitudinal data from nested projects exist from KEMRI projects in Siaya County. Need to have incidence surveillance in more SNUs and work with existing structures Incidence data is available for coarse age bands, but fine disaggregation is not available except for the same surveillance projects.</p>

<p>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?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. The host country government does not collect/report viral load data or does not conduct viral load monitoring</p> <p><input checked="" type="radio"/> B. The host country government collects/reports viral load data (answer both subsections below):</p> <p>According to the following disaggregates (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Age</p> <p><input checked="" type="checkbox"/> Sex</p> <p><input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners)</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>For what proportion of PLHIV (select ONE of the following):</p> <p><input type="checkbox"/> Less than 25%</p> <p><input type="checkbox"/> 25-50%</p> <p><input type="checkbox"/> 50-75%</p> <p><input checked="" type="checkbox"/> More than 75%</p>	<p>13.6 Score: 0.71</p>	<p>http://www.nascop.org/eid/overall.php National ACT Dashboard _NASCOPNHRL</p>	<p>Streamlining data management for VL and the entire information management process.</p> <p>Streamline data management for VL for KP. Investing in reengineering the EID/VL data system to cope with the current VL need and address common vision for the country. Assumption that we are using PLHIV on care/treatment as Denominator.</p>
<p>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.)</p> <p>Please note most recent survey dates in comments section.</p>	<p><input type="radio"/> A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.).</p> <p><input checked="" type="radio"/> B. The host country government conducts (answer both subsections below):</p> <p>IBBS for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input checked="" type="checkbox"/> Men who have sex with men (MSM)</p> <p><input type="checkbox"/> Transgender (TG)</p> <p><input checked="" type="checkbox"/> People who inject drugs (PWID)</p> <p><input type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>Size estimation studies for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input checked="" type="checkbox"/> Men who have sex with men (MSM)</p> <p><input type="checkbox"/> Transgender (TG)</p> <p><input checked="" type="checkbox"/> People who inject drugs (PWID)</p> <p><input type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p>	<p>13.7 Score: 0.71</p>	<p>Prevention road map report, DHS Report Kenya Fast Tack Plan to End Adolescents AIDS and Young People KENYA AIDS STRATEGIC FRAMEWORK</p>	<p>Only Fisher Folk IBBS but need to cover other priority populations. Intention for all the groups but limited funding for all the groups.</p>

<p>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)?</p>	<p><input type="radio"/> 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</p> <p><input type="radio"/> 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</p> <p><input checked="" type="radio"/> 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</p>	<p>13.8 Score: 0.95</p>	<p>Prevention road map report, DHS Report Kenya Fast Track Plan to End Adolescents AIDS and Young People KENYA AIDS STRATEGIC FRAMEWORK</p>	<p>No change Moving towards sustainability</p>
<p>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?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):</p> <p><input checked="" type="checkbox"/> A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data</p> <p><input checked="" type="checkbox"/> A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance</p> <p><input type="checkbox"/> Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection</p> <p><input checked="" type="checkbox"/> An in-country internal review board (IRB) exists and reviews all protocols.</p>	<p>13.9 Score: 0.71</p>	<p>KENYA AIDS STRATEGIC FRAMEWORK (2014/2015-2018/2019) surveillance protocol (KENPHIA 2017)</p>	<p>Standard National Surveillance procedures need to be documented and institutionalized especially through a surveillance working group led by MoH</p>
<p>Epidemiological and Health Data Score:</p>		<p>5.79</p>		

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?	<input type="radio"/> A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years <input type="radio"/> 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 <input type="radio"/> 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 <input checked="" type="radio"/> 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 <input type="radio"/> 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: 2.50	Global fund country operation plan, NACC Expenditure plan documents	NACC plans and implements HIV expenditure analysis but with support from development partners
14.2 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?	<input type="radio"/> A. No HIV/AIDS expenditure tracking has occurred within the past 5 years <input checked="" type="radio"/> B. HIV/AIDS expenditure data are collected (check all that apply): <input checked="" type="checkbox"/> By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> By expenditures per program area, such as prevention, care, treatment, health systems strengthening <input checked="" type="checkbox"/> By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel <input checked="" type="checkbox"/> Sub-nationally	14.2 Score: 3.33	NACC Expenditure reports and County government financial plan	Need to strengthen dissemination of Expenditure data
14.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	<input type="radio"/> A. No HIV/AIDS expenditure data are collected <input type="radio"/> B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago <input checked="" type="radio"/> C. HIV/AIDS expenditure data were collected at least once in the past 3 years <input type="radio"/> D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures <input type="radio"/> E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.3 Score: 1.67	NACC Expenditure reports and County government financial plan	Current data collected every alternate year and there is need to develop a framework for annual data collection and dissemination.
Financial/Expenditure Data Score:		7.50		

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
<p>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?</p>	<p><input type="radio"/> A. No system exists for routine collection of HIV/AIDS service delivery data</p> <p><input type="radio"/> 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</p> <p><input type="radio"/> C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution</p> <p><input checked="" type="radio"/> 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</p> <p><input type="radio"/> E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government</p>	<p>15.1 Score: 1.00</p> <p>DHIS 2 National ACT dashboard NASCOP Situation room -NACC DHIS 2 Situation room -NACC National ACT Dashboard _NASCOP</p>	<p>DATIM data is not fully aligned and harmonized with National MoH data system and significant partner involvement in data collection and transmission. Data alignment needs to address the harmonization of reporting. A number of these are affected by freeze. Significant investments in the data collection systems that align to National Data requirements. HR contributions from Counties required including HRH review.</p>
<p>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)</p>	<p><input type="radio"/> A. No routine collection of HIV/AIDS service delivery data exists</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input checked="" type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90% +) is provided by the host country government</p>	<p>15.2 Score: 1.67</p> <p>NACC HIV expenditure analysis reports, County Financial plans</p>	<p>Significant partner contribution towards Information Systems, M&E staff, data collection tools, aggregate systems. Host country provides staff for facilities. Data quality initiatives are not led by government. SID 2.0 was not accurately represented. Partners supporting data management will need to move towards strengthening county ownership.</p>

<p>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.)</p>	<p>Check ALL boxes that apply below:</p> <p><input checked="" type="checkbox"/> A. The host country government routinely collects & reports service delivery data for:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV Testing <input checked="" type="checkbox"/> PMTCT <input checked="" type="checkbox"/> Adult Care and Support <input checked="" type="checkbox"/> Adult Treatment <input checked="" type="checkbox"/> Pediatric Care and Support <input checked="" type="checkbox"/> Orphans and Vulnerable Children <input checked="" type="checkbox"/> Voluntary Medical Male Circumcision <input checked="" type="checkbox"/> HIV Prevention <input checked="" type="checkbox"/> AIDS-related mortality <p><input checked="" type="checkbox"/> B. Service delivery data are being collected:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> By key population (FSW, PWID, MSM, TG, prisoners) <input checked="" type="checkbox"/> By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> By age & sex <input checked="" type="checkbox"/> From all facility sites (public, private, faith-based, etc.) <input checked="" type="checkbox"/> From all community sites (public, private, faith-based, etc.) 	<p>15.3 Score: 1.33</p>	<p>Facility Registers Summary tools/reporting tools Service availability and readiness assessment mapping/Service provision Assessment surveyKenya, County HIV Service Delivery Profiles -NASCOP</p>	<p>Data routinely collected with need to strengthen data quality especially for HIV -related mortality</p>
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<p>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?</p>	<p><input type="radio"/> A. The host country government does not routinely collect/report HIV/AIDS service delivery data</p> <p><input type="radio"/> B. The host country government collects & reports service delivery data annually</p> <p><input type="radio"/> C. The host country government collects & reports service delivery data semi-annually</p> <p><input checked="" type="radio"/> D. The host country government collects & reports service delivery data at least quarterly</p>	<p>15.4 Score: 1.33</p>	<p>Service availability and readiness assessment mapping/Service provision Assessment surveyKenya, County HIV Service Delivery Profiles -NAS COP</p>	
<p>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)?</p>	<p><input type="radio"/> A. The host country government does not routinely analyze service delivery data to measure program performance</p> <p><input checked="" type="radio"/> B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention <input checked="" type="checkbox"/> Continuum of care cascade for each relevant key population (FSW, PWID, MSM, ITG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention <input checked="" type="checkbox"/> Results against targets <input checked="" type="checkbox"/> Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) <input checked="" type="checkbox"/> Site-specific yield for HIV testing (HTC and PMTCT) <input type="checkbox"/> AIDS-related mortality rates <input checked="" type="checkbox"/> Variations in performance by sub-national unit <input checked="" type="checkbox"/> Creation of maps to facilitate geographic analysis 	<p>15.5 Score: 1.00</p>	<p>Registers Reporting tools National ACT Dashboard-NAS COP, Annual HIV report</p>	<p>Strengthen capacity for geospatial analysis. Mortality rates are not uniformly collected, and the data is not analyzed. Need to use the foundation to strengthen routine reporting for HIV related mortality.</p>
<p>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?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Standard national procedures & protocols exist for routine data quality checks at the point of data entry <input checked="" type="checkbox"/> Data quality reports are published and shared with relevant ministries/government entities & partner organizations <input checked="" type="checkbox"/> 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 	<p>15.6 Score: 1.33</p>	<p>KENYA AIDS STRATEGIC FRAMEWORK Kenya, County HIV Service Delivery Profiles -NAS COP</p>	
<p>Performance Data Score:</p>		<p>7.67</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D