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 110 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 17 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.

Table 1: Sustainability Element Score Criteria
Dark Green Score (8.50-10.00 pts) **(sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 pts) **(approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 pts) **(emerging sustainability and needs some investment)**
Red Score (<3.50 pts) **(unsustainable and requires significant investment)**

Country Overview: The current health financing landscape indicates an improvement in government financing to the health sector. The proportion of total government budget allocation to health for both national and county levels has started showing improvement at 9.2 percent in FY 2018/19 after decreasing significantly from 7.8 percent before devolution in FY 2012/13. However, out-of-pocket spending still remains a large source of health financing (accounting for 32.8% of total health spending in 2015/16), placing vulnerable households at greater risk of incurring catastrophic or impoverishing health expenditures (estimated at 6.2% in 2013). Funding to the health sector remains limited. The large proportion of government revenue used to finance debts and wages, coupled with slow economic growth and demand from other competing sectors limit the expansion of health resources. The clamour for higher wages by public sector employees resulting in ongoing nationwide health worker strikes has contributed to the ballooning public wage bill (52% of government revenues in Kenya FY (KFY) 2017/18), leaving few resources to be used for health or other services. While public sector contributions to HIV/AIDS have increased from 18.8% in Kenya Fiscal Year (KFY) 2012/13 to 22.1% in KFY 2015/16, donors remain the predominant source of HIV financing, contributing 62.3% of HIV expenditures in KFY 2015/16. The remainder of shares are borne by households through out of pocket spending and employers at 9% and 6.5% respectively. Kenya's contribution as part of its Global Fund (GF) counterpart-financing requirement was $22 million in 2017/18 and 28/19 for procurement of ARVs and test kits, and is expected to increase by $25.4 million in KFY 2019/20 as shown by the budget estimates presented to the National Assembly. This is further expected to increase to $31 million by KFY 2020/21. Nevertheless, donors continue to finance the majority (86.4%) of all ARV needs in Kenya.

Given the above, significantly greater domestic financing for health and HIV is needed to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Increased government budget alone is inadequate to offset uncertainties in donor support. Despite the nominal changes to the scores, overall, the country has made progress in a majority of the domains and elements with only two notable drops. The GOK remains committed to ending AIDS by 2030, making for strategic health investments in health to maximize impact while increasing domestic resources to sustain the national HIV/AIDS response. Further, the GOK's plan for prioritization of affordable healthcare for all under the universal health care (UHC) agenda will advance progress to ensure equitable and affordable access to essential health services, particularly for the disadvantaged, vulnerable and poor in Kenya, including people living with or affected by HIV. 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).

2019 SID Process: The 2019 SID process was implemented by MOH under the leadership of the National AIDS Control Council (NACC), NASCOP, Ministries of Treasury & Planning, and the Council of Governors in partnership with, PEPFAR, UNAIDS and Global Fund.

For this SID as well as the Responsibility Matrix, in collaboration with UNAIDS and PEPFAR, the MOH held a separate orientation workshop for the key stakeholders leadership noted herein. For the main two-days of SID engagement, to ensure continuity, an orientation was held and participants were identified by NACC, NASCOP, PEPFAR and UNAIDS who were educated on the tool and were assigned responsibilities on managing the two day SID workshop. The participants we identified on the basis of being either a key technical expertise or advocate, academician, champion or beneficiary under the respective domain. Additional participants and invitees included the Ministry of Devolution, UNJT, World Bank and other multilateral/bilateral donors, in-country experts/academia, civil society, private sector as well as from within the PEPFAR Kenya team.

The participants worked in four groups synonymous with the four domains. For this SID process, the participants under each domain are the one who pre-populated and validated the data sources aligned to the responses under each element; discussed, prioritized elements and proposed key activities; and then as presented back to the whole SID meeting as part of a report out session. The final compiled notes and SID were shared with all stakeholders for any further feedback. The MOH and Treasury, held a joint follow up GOK meeting to review their inputs which were included in the final working SID as part of the ongoing process. The meetings dates held were: SID and RM Orientation (September 9) and SID and RM Completion:; September 10 and 11. –. The draft 2019 Kenya SID is attached.

Sustainability Strengths:

- **Quality Management (9.05, dark green):** SID stakeholders maintained the score on this element. However, notable items that emerged were that the host country has institutionalized QM systems, plans and work force capacities to ensure continuous

program and service delivery quality improvement. While the country now has a functional national QM structure, it however, still relies fully on donors on the lab and supplies as well as to cascade QI/QM down to the county/facility level.

- **Markey Openness: (8.76, dark green):** The market openness discussions revealed existing policies and legal framework that support doing business environment in the HIV space. Under market openness, the country has clear policies that enhance doing business environment for health care service delivery. The government policies in existence on doing business environment are set to provide health business space; however, compliance and regulatory processes should be aligned to the policies.

- **Performance Data (7.83, light green):** The Kenyan government has taken lead in ensuring availability of quality service delivery data for decision-making. There are systems such as EID, ACT Dashboard, and KHIS in place and standard HIV M&E tools. There is substantial technical capacity in terms of staffing within MoH to ensure quality at all levels.

- **Policies and Governance (7.64, light green):** The Government of Kenya through the Ministry of Health, NACC and NASCOP are quick to adopt and domesticate new policies that continue to guide HIV prevention and treatment. These policies include test and treat, differentiated care models (DCM), eMTCT policies, HIV selftesting, national implementation guidelines for HIV and STI programming among young key populations, national guideline on index case testing. Despite the policy adoption, there is need to fast track the implementation with fidelity.

- **Planning and Coordination (7.19, light green):** NACC and NASCOP have continued to provide overall leadership and coordination on the national HIV program through a multiyear strategy-KASF. Moving forward, the new KASF development needs to be fast tracked and linked to UHC. However, there is need to improve on the coordination between the devolved governments (counties), government entities and key stakeholders including non-state actors.

- **Domestic Resource Mobilization (7.18, light green):** The score has notably increased. The country is on a positive trend towards domestic resource mobilization. The country developed roadmap for domestic resource mobilization. In addition, both national and counties have increased their allocation towards HIV and AIDS.

Sustainability Vulnerabilities:

- **Civil Society (4.67, Yellow):** Mappings of HIV stakeholders and the coordinating points should be prioritized and Kenya National Bureau of Statistics engagement for information on sources of coordination. Mapping will help put into place measures for checking duplication and accountability by all stakeholders in HIV programming under the leadership and coordination of NACC. Private sector healthcare providers should be included in planning and monitoring activity tracking.

- **Commodity Security and Supply Chain (5.18, Yellow):** Minimal increase in the GoK allocation for procurement of HIV commodities over the last three years. Minimal MoH financing for supply chain functions and operations other than staff salaries at national and county levels. No comprehensive supply chain assessment to determine status and inform priorities and investments conducted over the last three years. Recommendation: (1) continued strengthening of supply chain functions and operations (Specifically provision of TA to improve planning and commodity management systems) and (2) support for a comprehensive supply chain assessment to improve the development of a country supply chain strategy.

- **Private Sector Engagement (5.71, Yellow):** NACC plans to develop a strategy to improve the coordination and integration on the private sector with the existing public health structures in order to improve overall quality of care and decongesting the public facilities. National Health Insurance Fund (NHIF) should include a comprehensive HIV package for private health facilities**.**

- **Epidemiological and Health Data (6.0, Yellow): A** system for uniquely identifying patients is weak. Integration of service data with other administrative data is not adequate. For integration of service delivery data and vital statistics, government is best suited to invest in this area, however substantial support from PEPFAR and GFATM is still required.

- **Laboratory (6.11 Yellow)**: Capacity of laboratory workforce – HIV rapid testing as well as complex lab testing – EID, VL and HIV DRT are majorly done by donor supported staff. VL infrastructure; although sufficient instruments are available, the supply chain and specimen transport system is majorly donor supported. HIV related lab testing (HIV rapid testing, CD4, VL, GXP, CrAg, HIVDRT) financing is donor dependent. The GOK supports other general tests e.g., chemistry and hematology which PLHIVs may benefit from for toxicity monitoring.

- **Service Delivery (6.33, Yellow):** Domestic provision of service delivery: delivering HIV services with substantial external support and domestic financing and service delivery for key populations (KP): Host Country providing minimal (1-9%) of financing for KP services with substantial external support for services. No structural continuous engagement with civil society to inform service delivery and programing. Minimal focus by both development and host government in support of a fully functional community based service delivery. KP program funding is heavily dependent on external support. The host country in collaboration with the donors should strengthen the community based service delivery system.

- **Human Resource for Health/Health Workforce (6.43, Yellow):** For the three SIDs the scores have remained relatively the same i.e., SID 15 Score 6.58, SID 17 score 6.55 and SID 19 score 6.43. 1) Donor funded workforce transition implementation, 2) HIV/AIDS specific community workforce recognition and funding by GoK, 3) management and monitoring of the health workforce and 4) use of HRIS data for budgeting, hiring and

rational distribution, domestic funding for health workforce. Recommendations: Domestic funding for health workforce intervention need an increase to cover for wage bill, other non-wage bill interventions at above facility, facility and community levels. Health workforce management and monitoring – need to improve performance quality, supervision and efficiencies to minimize e.g., absenteeism. Community workforce recognition and resourcing to reduce donor dependency ratio health workforce data systems completeness and use to inform resourcing, budgets and equitable distribution.

- **Technical and Allocative Efficiency (6.56, Yellow)**: Despite increase in resource allocation; optimal utilization remain a concern, thus areas of inefficiency need to be determined and mitigation measures put in place. Further, the country has no system for gathering cost information on routine and standardized basis but occasionally costing studies are conducted to inform decisions on resource mobilization and allocation. Data capture process to determine and reconciliation of allocations and expenditures are not routinely undertaken; hence a real-time data capture should be enhanced; this would include a crosswalk between NHA and KNASA. The World Bank has undertaken a study on allocative efficiency; though key questions regarding optimization; technical and allocative efficiency as well as disaggregated levels of service delivery at the county government has not been identified; hence the report may not address all key efficiency and allocative questions.

- **Financial/Expenditure Data (6.67, Yellow):** Limited financing in the government especially for conducting sustained surveys and surveillance activity. Development of multiyear strategy with partners is necessary that includes annual costed work plans with a clear road map leading to sustainability

Additional Observations:

NUANCE:

- **The team has included notes within the responses where there are notable drops. With this SID, the scoring and weighting changed so it's also important to note those technical changes as contributing to some of the changes attributed to both low and higher scores.**
- **Kenya is also in the midst of developing its next National and County AIDS Strategic Frameworks as well as preparing for the next Global Fund Application and just started its next fiscal budgeting process.**

- **Drastic drops in civil society and private sector engagement**. Recommendations include:

1. NACC to develop a strategy to improve the coordination and integration on the private sector with the existing public health structures in order to improve overall quality of care and decongesting the public health facilities. CSO coordination enhanced and communities at the center of the HIV response.

2. More effort by governments and development partners to support civil society in delivering health services including at the devolved levels. CSO also need to be meaningfully engaged in the accountability mechanism and not just at the ICC and KCM.

- **Domestic Resource Mobilization:** Government provisions inadequate given the need; however, there is need to finalize and implement the financing strategy. The payment levels for the current NHIF premiums should include HIV/AIDS in the benefit package; and streamline the reimbursement process. External resources are off-budget and not included in the HIV/AIDS planning process e.g. PEPFAR, CHAI, Gates Foundation, the Elton John AIDS Foundation; thus the resources should be incorporated in the national and county planning process. Building off the current government leadership both at national and county levels, thus there is need to further strengthen the coordination between the two levels of government and stakeholders as well as intra-county. Key areas of investment for DRM remain technical and financial support towards transition, as well as strengthening its leadership responsibilities.

- **HRH:** Community workforce resourcing, recognition and transition need more support in addition to what PEPFAR is investing in GoK at national and county need to increase funding to community workforce and reduce Donor decency ratio.

- **Technical and Allocative Efficiencies:** Recommendations: PEPFAR, GF and UNAIDS in collaboration with GOK have previously undertaken NHA and KNASA (in 2015/16FY); however, there is need for a cross–walk between NHA and KNASA resource tracking, efficiency determination and optimal allocation as well as (return on investment) ROI related to donor funding PEPFAR/USAID/GF/UNAIDS. This area remains a key aspect in the health system strengthening. Under the leadership of the GoK (MOH, Ministry of Treasury, COG and Ministry of Devolution), through the transition process, TE/AE should be included in the transition plans as well as entrenched in the regular timely data collection, dissemination, utility systems to be put in place (government takes lead, partners heavily support the process).

NOTE: The perspectives shared during these multi-stakeholder discussions are likely to be varied and therefore are not intended to be binding, but they should be a critical consideration as the PEPFAR, GoK MOH, UNAIDS and other development partners identify their respective sustainability priorities. For PEPFAR, this SID's findings will play an important role in the planning of COP investments, principally through improving approaches to 'sustainable' programs with the triangulation of SID 2019 with MER data, 2018 APR, FAST and Table 6 outcomes. For the GoK, the SID will inform its development of a Health Sector Transition Plan, 2019/2020 Health Budget, the KASF II and its Global Fund application in early 2020.

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.*

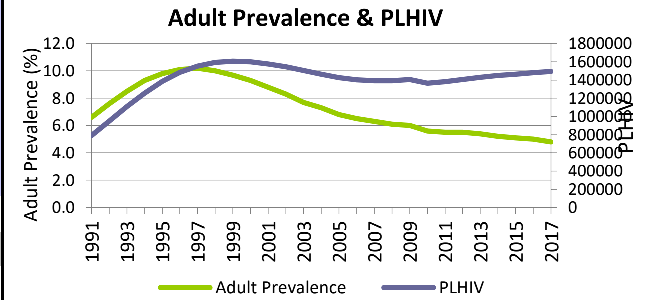
Sustainability Analysis for Epidemic Control: Kenya

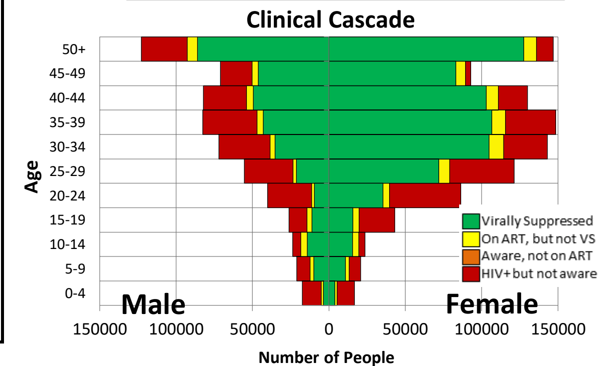
Epidemic Type: Generalized
Income Level: Lower middle income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 19 Planning Level: $ 374,931,001

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	7.64	
2. Policies and Governance	7.02	8.50	7.19	
3. Civil Society Engagement	7.26	7.50	5.50	
4. Private Sector Engagement	8.06	7.33	5.71	
5. Public Access to Information	7.00	7.00	7.00	
National Health System and Service Delivery				
6. Service Delivery	4.21	6.44	6.33	
7. Human Resources for Health	6.58	6.55	6.43	
8. Commodity Security and Supply Chain	4.86	6.39	5.18	
9. Quality Management	8.48	9.05	9.05	
10. Laboratory	2.08	6.67	6.11	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	5.28	5.71	7.18	
12. Technical and Allocative Efficiencies	6.98	7.33	6.56	
13. Market Openness	N/A	N/A	8.76	
Strategic Information				
14. Epidemiological and Health Data	5.36	5.79	6.01	
15. Financial/Expenditure Data	5.83	7.50	6.67	
16. Performance Data	7.80	7.67	7.83	
17. Data for Decision-Making Ecosystem	N/A	N/A	6.00	

CONTEXTUAL DATA





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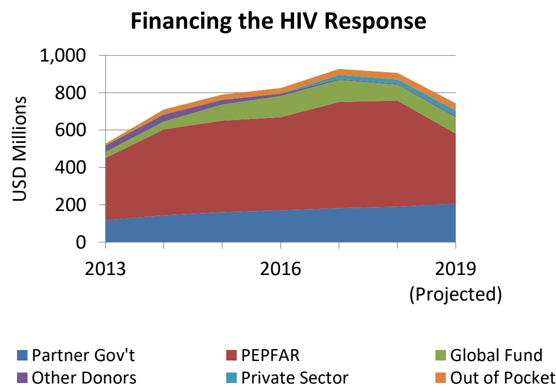

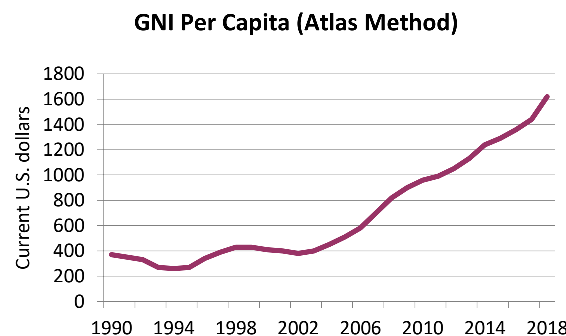

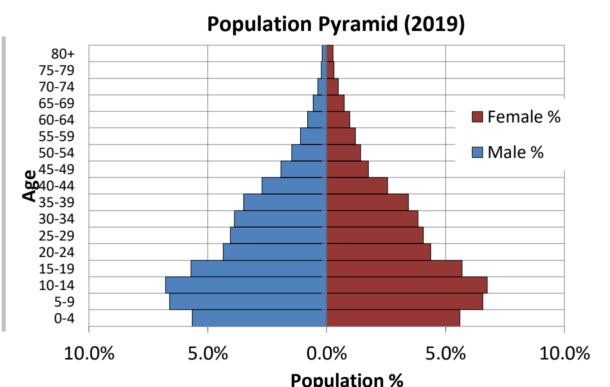

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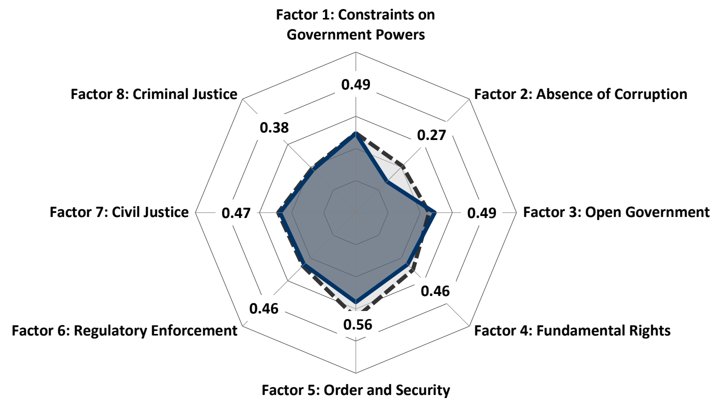
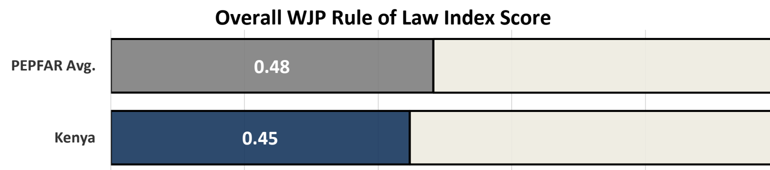
Sustainability Analysis for Epidemic Control: Kenya

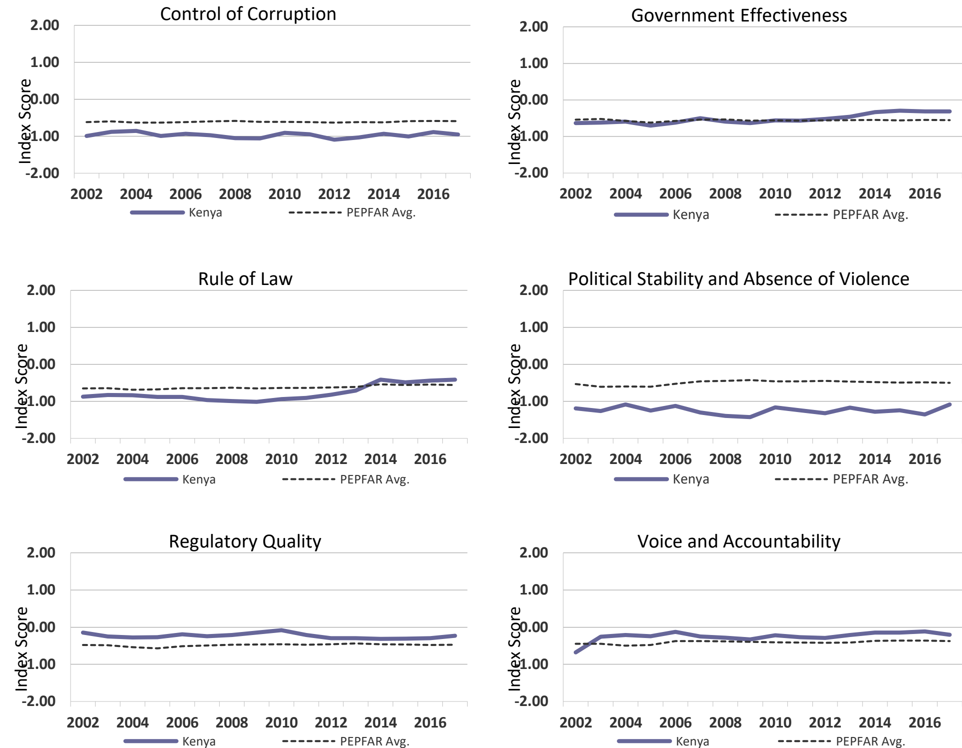
Contextual Governance Indicators

Rule of Law Index (World Justice Project)





Worldwide Governance Indicators (World Bank)



WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

1. Constraints on Government Powers: Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.

2. Absence of Corruption: Government officials in all branches of government do not use public office for private gain.

3. Open Government: Citizens have open access to government information and data, complaint mechanisms, and civic participation.

4. Fundamental Rights: There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.

5. Order and Security: Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.

6. Regulatory Enforcement: Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.

7. Civil Justice: Civil justice is accessible and free of discrimination, corruption and improper government influence.

8. Criminal Justice: Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019

The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

1. Control of Corruption: captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.

2. Government Effectiveness: measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.

3. Rule of Law: captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.

4. Political Stability and Absence of Violence: measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.

5. Regulatory Quality: Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.

6. Voice and Accountability: captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: https://info.worldbank.org/governance/wgi/

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.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ● B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It has measurable targets. ☑ It is updated at least every five years ☐ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☐ Strategy includes explicit plans and activities to address the needs of key populations. ☐ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children ☐ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 1.64	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 KENPHIA MTR KASF review 2017 National TB and Malaria strategies UHC data source? There are some lessons learnt Health Act 2017? Is government specific on doing any policy documents on UHC).	Need to be specific on population moving forward. Kenya is currently between two strategic plans bridged by an addendum that covers the period of Jan 2019 to Jan 2020. This limits the response to this question to what the stakeholders agreed on pending the new KASF which is due out in early to late December. New KASF has to be linked to UHC agenda in the country 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)

Question	Response	Score	Evidence	Comments
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☑ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☑ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.50	Gudelines for TWG ,Minutes of TWG meetings for the national strategic plan,validation minutes and reports, participants lists for meetings; CASP development and launch meetings County AIDS Strategic Plans (CASP), Meeting reports of the county consultations of CASPs, KCM Report, HIV ICC reports, Country Operation Plan	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 Deliberate effort to engage with persons with disabilities to be improved in developing of KASF. Kenya Health Federation, the Kenya Association of Private Healthcare Providers in discussion of provision of health care as a responsibility not just as private In the context of devolution and due to diverse constituencies,
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?	Check all that apply: ☐ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☐ The host country government routinely tracks and maps HIV/AIDS activities of: ☐ civil society organizations ☐ private sector (including health care providers and/or other private sector partners) ☐ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.00	The National AIDS Expenditure Assessment (2015) , 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 Minutes of ICC-HIV , Minutes of KCM, County HIV reports by NACC (Multisectoral coordination), Joint Annual Programme Reviews,	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 Mappings of HIV stakeholders and the coordinating points, Kenya National Bureau of Statistics for information of sources of coordination

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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)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☑ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☐ The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	CASP (County Aids strategic plans - 2015); Frequent RRI targets, County Data Review meetings and Reports: County Multi Sectoral HIV Plans	All CASP Drafts Completed and Launched
		Planning and Coordination Score: 7.64		

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., optimal ART regimens for all populations (including TLD as recommended)?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 0.91	WHO Guidelines adapted in 2016	ART Treatment Guidelines updates FY August 2019 to support the use of DTG for women of child bearing age

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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? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	Check all that apply: ☑ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☑ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☑ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☑ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☑ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS ☑ Policies that permit HIV self-testing ☑ Policies that permit pre-exposure prophylaxis (PrEP) ☑ Policies that permit post-exposure prophylaxis (PEP) ☐ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☐ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.76		As part of the UHC benefit package there is an opportunity for expansion. Consolidation of policies to look at the consent for age. Is there change policy change to lower consent age? Public health facilities are providing services for KPs.

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2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any HIV services in the public sector: clinical, laboratory, testing, prevention and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☑ No, neither formal nor informal user fees exist. ☐ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.3 Score: 0.91		Need to standardize the practices on labs and other hidden costs on ART
2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☐ No, neither formal nor informal user fees exist. ☐ Yes, formal user fees exist. ☑ Yes, informal user fees exist.	2.4 Score: 0.45	NHIF and Linda Mama Program, UHC proposed coverage plans, Level 1 to 5 informal and administrative fees.	There is payment of user fees - which is not standardised
2.5 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?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☐ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information ☑ Govern the use of patient-level data, including protection against its use in crimincal cases	2.5 Score: 0.68	Use of National IDs for both private and public health insurance and services	Processes ongoing. Do vital registration of NHIF Recommendation for SMARTCARE Huduma Number and the link to the health system IDs not applicable for under 18. Unique identifier under consideration and review by the GOK for all ages and services. The previous 3.0 version, stakeholders checked second bullet but with current deelopments, a clear

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2.6 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☐ Constitutional prohibition of discrimination based on gender diversity ☐ Prohibitions of discrimination in employment based on gender diversity ☑ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☐ Constitutional prohibition of discrimination based on sexual orientation ☐ Hate crimes based on sexual orientation are considered an aggravating circumstance ☐ Incitement to hatred based on sexual orientation prohibited ☐ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☐ Constitutional prohibition of discrimination based on occupation ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.6 Score: 0.15	Harm Reduction Policy; Policy for the prevention of HIV infections among Key Population in Kenya ; Constitution of Kenya 2010 Kenya UNAIDS NCPI (2016 - 2018). https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf.	Does not specify or prohibit. Kenya National Population Census has recognized the 3rd gender. ACTS there is no explicit language

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	People who inject drugs (PWID): ☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☑ Explicit supportive reference to harm reduction in national policies ☐ Policies that address the specific needs of women who inject drugs			
2.7 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☐ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☐ Programs to address intimate partner violence ☑ Programs to address workplace violence ☑ Interventions to address police abuse ☑ Interventions to address torture and ill treatment in prisons ☑ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☐ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.7 Score: 0.64	National GBV Policy HIV Tribunal and HIV ACT (2006); Kenya Constitution Kenya UNAIDS NCPI (2016 - 2018). https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf.	National Gender and Equalisation Commission. There are current efforts by the GOK to address the gender and sexual violence policy and program space. The stakeholders noted that the gaps that have emerged or lack of data or clear guidelines to support the options not checked but previously checked in 2017. Weighting also changed on this section as well as the score.

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Question	Options	Score	Source	Notes
2.8 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	2.8 Score: 0.64	The Penal Code (Cap. 63). Kenya UNAIDS NCPI (2016 - 2018). https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf. various laws under The Kenya Narcotic Drugs and Psychotropic Substances (control) Act no 4 of 1994 section 3 and 4 criminalize drug use within its jurisdiction. The rationale for the criminalization of drugs is deterrence. Kenya has adopted a 'war on drugs' policy that involves punitive laws and practices including incarceration and fines. The Kenya Narcotic Drugs and Psychotropic Substances (control) Act no 4 of 1994 section 3 and 4 criminalizes possession and trafficking of drugs as follows: Article 3 (1) criminalizes possession any narcotic or psychotropic substance Article 3 (1) states that any person who has in his possession any narcotic or psychotropic substance shall be guilty of an offence. Article 3 (2) section (1) a and b criminalizes drug use attracting fines and/or imprisonment Section 5 of the same Act list penalties for narcotic drugs. Section 5 (1) penalizes *drug use *being in areas where	The legalization of sex work is vague; Noted that this question is not the same as positioned and structured in the last SID 3.0. It's weighting is not also the same given the breakdown and content. So not comparable between the 2017 and 2019 versions. Overall, the country has a penal code that still prohibits same sex relations. However, the country has health strategies, prevention and treatment guidleines guaranteeing access to health for all key populations. Important steps have been taken to provide more space for harm reduction programmes. This allows for a public health and human rights---based approach towards drugs. However, Kenya is still very much in transition.

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

drugs are smoked, inhaled or sniffed
*ownership or occupying any premises used for the purpose of preparation, smoking or sale, or the smoking, inhaling, sniffing or otherwise using any narcotic drug or psychotropic substance
*Possession any pipe or other utensil for use in connection drug use
These offenses attract a fine of Ksh 200 thousand or imprisonment to a term not exceeding 10 years or both. The National Drug Control Bill of 2011 that mandates the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) put excessive focus on prevention and incarceration.

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☑ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☐ No			
2.9 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, adolescents, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☑ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☐ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.9 Score: 0.68	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	The tribunal does not have enough funding to carry out its mandate, there is need to harmonise Government policy documents NACC vs NACADA AG Chambers and ombudsman provides free legal services, HIV tribunal. GOK does not cover funding for legal redress justice and prosecution expect for the HIV tribunal. This limitation changed the last option. Noted that the scoring and weighting also changed for this question.
2.10 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.10 Score: 0.91	MTR process; In addition to the Auditor General's office and reviews, there are designated seconded auditors assigned to each GOK ministry for quarterly and internal accounting controls.	In built audit system, Auditor General Reports as well as Annual Controller of Budget Reports. Weighting for scores and responses changed.
2.11 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ◉ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ○ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.11 Score: 0.45	Reports for parliamentary accounts committee; Ministries Management reports	Not made public. Weighting for scores and responses changed.
	Policies and Governance Score:	**7.19**		

3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			Data Source	Notes/Comments
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ◉ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ○ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 0.83	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	
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☑ Involvement on government HIV/AIDS program evaluation teams ☑ Involvement in surveys/studies ☑ Collecting and reporting on client feedback ☑ Service delivery	3.2 Score: 1.67	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, Implemetation reports from PLWHIV, NACC's stakeholders satifaction Survey.	Reports need to be shared to stakeholders, suggestion boxes in health facilities should be operationalised. Team noted that unlike before with other donor support during the 2017 period, CSOs currently do not collect or report on client feedback in structured way.

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Element	Response options		Score	Data sources	Comments
3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☑ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions		3.3 Score: 1.33	The formation of NACC was as a result of CSO Advocacy, In service delivery, availability of medicine, Advocacy, and resource mobilization.	CSO are limited by funding, they are limited in legal issues and policy matters, CSO need networks for mentorship - CSO not engaged in deciding how GoK portion is allocated/ Utilized
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ◉ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).		3.4 Score: 0.83	Annual Budget for CSO's involved	data source should be verified and CSO's were not involved
3.5 Civil Society Enabling Environment: 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)? Note: This sometimes referred to as "social contracting" or "social procurement."	◉ 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). ○ 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: ☐ Competition is open and transparent (notices of opportunities are made public) ☐ Opportunities for CSO funding are made on an annual basis ☐ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services		3.5 Score: 0.83	The Kenya Constitution, The Public Benefits Organization Act, KRA policy documents, Public procurement Act. Previous GOK funding allocation records for CSO through World Bank. Some of these have since changed due to the new Constitution dispensation.	Public Benefit Organisation ACT has not been signed into law. The GOK Budget does not currently have provisions to fund CSOs other than through the Global Fund NonState Actors Funding through Red Cross and AMREF. The stakeholders left this response blank as the law that would enable this funding is not yet finalized and assented to by the Presidency. We also note that the team unchecked the previous selections made in 2017 as the subsets selected were done without noting limitation in law but also did not check option B. Hence the drop for this element.
			Civil Society Engagement Score: 5.50		

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does 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? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. 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): ☑ Corporations ☑ Employers ☐ Private training institutions ☑ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☐ Data and strategic input into supply chain management for HIV commodities ☐ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☐ Data on staffing in private health service delivery providers ☐ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 0.90		The private sector attends bid meetings. Private sector engagement is sporadic and agenda driven. In addition, though structured and available is not fully explored to the extent possible. With Notably, with Private Sector input for this process, changes were noted from the previous 2017 responses.

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	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☐ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☐ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ 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.			
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?	Check all that apply: ☑ 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). ☐ 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). ☐ The host country government has standards for reporting and sharing data across public and private sectors. ☐ 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). ☐ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 0.50	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.	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

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? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ 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. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☐ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☐ The government offers tax deductions for private training institutions. ☐ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☐ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☐ There are open competitions for private health care providers to compete for government service contracts ☑ 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 ☑ The government effectively regulates the flow of subsidized commodities into the private sector. ☐ Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.	4.3 Score: 1.81	PPOA Act, Documents for lease agreement of medical equipment; KRA Act	While the GOK has laws, policies and regulations in place for Private Sector service provision, there is a disconnect between those provisions and the is a gap.

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?	○ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ◉ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☑ Market opportunities that align with and support the national HIV/AIDS response ☑ 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)	4.4 Score: 2.50		conflict of interest
		Private Sector Engagement Score: 5.71		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance data and analyses are made available to stakeholders and general public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS surveillance data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within 6-12 months. ○ C. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within six months.	5.1 Score: 1.00	KAIS Kenya Aids Indicator Surveys; National HIV estimates and KDHS report, Stigma Survey and Index KENPHIA???	
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?	○ A. The host country government does not track HIV/AIDS expenditures. ○ 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. ◉ 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. ○ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score: 1.00	The National Health Accounts (NHA), County Health Accounts, Household Health Expenditure Survey, National HIV/AIDS Spending Assessments.	

5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?	○ 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. ○ 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. ◉ 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 . At what level of detail is this performance data reported? [CHECK ALL THAT APPLY] ☑ National ☑ District ☑ Site-Level	5.3 Score: 2.00	DQAS, Mid Term Review Meetings, CIDP, Annual Work Plan meetings The National Health Accounts (NHA), County Health Accounts, Household Health Expenditure Survey, National HIV/ AIDS Spending Assessments. Annual Global AIDS Monitoring Report	Weighting and scoring options changed. As well as the depth and coverge by the question.
5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. The host country government does not make any HIV/AIDS procurements. ○ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ◉ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ○ D. The host country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 1.00	Public Procurement Act, Newspapers, adverts and online (for tenders)	

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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?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	NASCOP/NACC	
	Public Access to Information Score:	**7.00**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

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Domain B. National Health System and Service Delivery

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

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.95	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	Some health 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 progamming DSD, VMMC. Same responses but scoring and weighting
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.)	The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV/AIDS services in communities ☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ Providing financial support for community-based services ☐ Providing supply chain support for community-based services ☑ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.79	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	Some counties pay for supervisors and community health volunteers. Linkage not to full extent in all facilities, but process is standardized.Same responses but scoring and weighting changed for this SID.
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 0.83	National Health Accounts report, 2015/16	Total GoK spending was $152M or 22% of HIV expenditures in 2015/16

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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?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.63	PEPFAR COP 18, National Health Accounts 2015/16, National AIDS Spending Assessment 2013, County Health Budget Allocations	GF allocation funding note. Same responses but scoring and weighting changed for this SID.
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations, or information is not available. ◉ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.42	Global Fund Country application, 2018-2022	GoK allocations includes both direct and indirect program cost. Same responses but scoring and weighting changed for this SID.
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?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.32	KAIS, KP size estimate report 2018, Global Funding request 2018-2022, Kenya AIDS Strategic Framework 2014-2019, NASCOP Key Populations Dashboard, COP 2018 & COP 2019 funding allocation	***Same responses but scoring and weighting changed for this SID.***
6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery activities including practice standards, quality, health outcomes, and information monitoring across all sectors. Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	6.7 Score: 0.63	KASF, county HIV/AIDS plan, guidelines, HIV country profiles and roadmaps,	KASF dissemination has been done. Update County HIV Strategic Plans.

6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	National health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or	6.8 Score: 0.95	KASF, county HIV/AIDS plan, guidelines, HIV country profiles and roadmaps, DHIS, National HRH strategy, SARAM report, KHQIF, Trainsmart, National and County staff appraisal plans.	National and County Governments are assessing staff needs for disease burden but not necessarily for the HIV sector. National level budget allocation is based on poverty index, population size and marginalization index. County budget allocations are based on needs at the county level. However, allocation varies from county to another with funding being inadequate as per the needs and there are absorbtion inefficiencies. The level and extent of engagement can improve. All ministries sign Annual Peformance Contracts with the Presidency, out of which Staff Appraisal and Training Plans are drawn at NAtional and County Levels. However
6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.9 Score: 0.79	KASF, county HIV/AIDS plan, guidelines, HIV country profiles and roadmaps, DHIS, National HRH strategy, SARAM report, KHQIF, Trainsmart, County staff appraisal plans	County Governments are assessing staff needs for disease burden but not necessarily for the HIV sector. There is sub optimal rationalization of staff, especially at the lower level facilities, which impacts on HIV Service delivery. County budget allocations are based on needs at the county level. However, allocation varies from county to another with funding being inadequate as per the needs and there are absorbtion inefficiencies. There is no effective and meaningful engangment of CSOs at the county level. All County ministries sign Annual Peformance Contracts with the Governors, out of which Staff Appraisal and Training Plans are drawn. However,
	Service Delivery Score	**6.33**		

7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce 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 Health Workforce 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: ☑ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas ☑ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.48	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: ☑ 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). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☐ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.32	1) Community Health Strategy, 2) Community Health Unit Records, 3) County Community Health Worker Record 4)County bills passed, 5) KHIS - 2	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 CHWs delivering HIV/AIDS services however CHEWs have a scheme of service while CHVs do not. There are non formal cadres (peer educators, mentor mothers) delivering
7.3 Health Workforce 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 and timeline for transition.	○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ◉ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.3 Score: 0.48	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. The donors include USAID - Letters of Agreement. The

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7.4 Domestic Funding for Health Workforce: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ◉ D. Host country institutions provide most (approx. 50-89%) health worker salaries ○ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.4 Score: 2.50	HRH strategy (2014-19), National and County Budget Analysis (2018/19), iHRIS. National Workforce Accounts, HRS Strategy 2019 - 2023, National Health Sector Strategic Plan iii	Except contract staff (about 8,000) the rest of the health workers are paid by Government and private sector (close to 90%)
7.5 Pre-service Training: 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? Note: List applicable cadres in the comments column.	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☑ Updated curricula contain training related to stigma & discrimination of PLHIV ☐ Institutions track student employment after graduation to inform planning	7.5 Score: 0.83	Regulatory Boards Core Curriculum	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. Same responses but scoring and weighting changed for this SID.
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? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☑ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☑ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☐ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.6 Score: 0.36	HRIS train, county specific personnel training records, regulatory HRIS, NASCOP's TrainSmart	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 incomplete.

7.7 Health Workforce 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?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☐ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☑ The government produces HR data from the system at least annually ☑ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.7 Score:	0.83	**HRIS data system**	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 such as identification of gaps for recruitment, rationalization and resizing.
7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	7.8 Score:	0.63	**HRIS data system, Public Service Commission at National and County Levels**	
		Health Workforce Score:	**6.43**		

8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ◉ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.42	Global Fund, Budget and Procurement Data from KEMSA, PEPFAR and GF	Government increasing allocations for ARVs in the MTEF
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ◉ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.42	GoK contribution for FY 2017 is around 14% (KEMSA reports, counter part financing). MoH 15/16 forecasting and quanitifcation reports, KEMSA reports, GF application (2017)	Government increasing allocations for test kits in the MTEF
8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	◉ A. This information is not known ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.00	MoH year 15/16 HIV commodities F&Q report, MoH printed estimates	

8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☐ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☐ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 1.36	MoH/NASCOP have annual plans developed in collaboration with other stakehlders and funders	Some elements are missing from the procurement plan including waste management, human resources. Same responses but scoring and weighting changed for this SID.
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ◉ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ○ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.21	MoH printed estimates, KEMSA audited accounts	

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 1.67	Procument plan. Commodity security meeting minutes, F&Q reports. Monthly ART stock status report.	
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)	◉ A. A comprehensive assessment has not been done within the last three years. ○ 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 ○ 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	8.7 Score: 0.00	Independent KEMSA Assessment	Assessment done, but with the global tool; hence not scored. KEMSA should give their input on public and non public assessments.
8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	8.8 Score: 1.11	NASCOP and KEMSA	
	Commodity Security and Supply Chain Score:	**5.18**		

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9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			Data Source	Notes/Comments
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☑ Has a budget line item for the QM program ☑ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 2.00	KHQIF, Minimum service standards for OVC, MoH Norms and Standards for Health Service Delivery	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.
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	KHQIF, KQMH	
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☑ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☑ There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels	9.3 Score: 2.00	eMTCT Stock Taking, NASCOP National Best Practices Meeting, County Health Management Team meetings, National HIV Acceleration Plan 2015-19, National HIV Situation Room	

9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☑ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 2.00	QI Pre-service Training Curriculum, Comprehensive HIV Training Curriculum covers in-service	
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that include health services consumers ☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☑ Regularly convene meetings that includes health services consumers ☑ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 1.71	National HIV Consultative Forum, National QI Plan. National and sub national TWG meeting minutes	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)
	Quality Management Score:	9.05		

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10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			Data Source	Notes/Comments
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed ◉ F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 1.33	National Pulbilc Health Laboratory Strategic Plan 2016 - 2020.	The strategic plan is under implemetation. It is broad enough and covers all areas of lab including policy, quality assurance, technical guidance and HRH. It is anchored on the MOH strategic plan.
10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	○ A. No, there is no entity. ◉ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	10.2 Score: 0.44	National Pulbilc Health Laboratory Strategic Plan 2016 - 2020.	At the national level the NPHLS is adequately staffed across the different departments. However, sufficient funding to support its core functions remain suboptimal.e.g. insufficient funds to conduct routine monitoring visits.Same responses but scoring and weighting changed for this SID.
10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ◉ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.3 Score: 1.00	• Kenya Medical Laboratory Technicians and Technologists Board ACT • 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 Guidelne-2016 • Quality HIV testing in Kenya: TOT and lab supervisors curriculum-2016 • Utilization of multi-disease testing platforms for optimization of EID in Kenya • The National HIV VL testing scale-up implementation guidelines 2016-2019 • National POC testing implementation roadmap	Although much progress has been made with the listed documents developed and implemented within the last wto 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. Same responses but scoring and weighting changed for this SID.
10.4 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	○ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ◉ B. There are adequate qualified laboratory personnel to perform the following key functions: ☑ HIV diagnosis by rapid testing and point-of-care testing ☑ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☐ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☑ TB diagnosis	10.4 Score: 1.00	1. National HRH Strategy 2014-19. 2. National HRH Strategy 2019-2024 3. Human Resource Information Systems (HRIS) dashboards 4. National Workforce Accounts (under development)	Same responses but scoring and weighting changed for this SID. Most public health facilities have staff to suppprt HIV diagnosis and routine laboratory testing. A majority of thse staff are HTS counsellors that are partner supported. 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 fort these tests. Additonally, there is need to transition the more complex testing such as Viral load, EID and HIV DR from research settings to public

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Question	Response	Score	Sources	Comments
10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	○ A. There is not sufficient infrastructure to test for viral load. ◉ B. There is sufficient infrastructure to test for viral load, including: ☑ Sufficient HIV viral load instruments ☑ All HIV viral load laboratories have an instrument maintenance program ☐ Sufficient supply chain system is in place to prevent stock out ☐ Adequate specimen transport system and timely return of results	10.5 Score: 0.67	• The National HIV Viral Load Testing Scale-up Implementation Guidelines: 2016-2019 • National HIV Acceleration Plan 2015-19. • The National Viral Load/EID Website	Same responses but scoring and weighting changed for this SID. Most viral load testing is done in research laboratotries. There are plans to move the testing to public health facilties. Based on laboratory instrument optimization and mapping 2018, Kenya has adequate VL/EID instruments to meet the testing demand. These instruments are on lease agreement and allow flexibility to match the demand i.e. more instruments can be placed if need increases. Kenya has a robust and
10.6 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ○ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ◉ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ○ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.6 Score: 1.67	Annual forecasting and quantification (F&Q) Report-2019/2021	The NatioanalTreasury has a vote head for public health laboratories. The government supports procurement of generalt lab reagents, HR and infastructure. However for HIV-related tests (HIV rapid testing, EID, CD4,CRAG, VL, HIVDR, TB microscopy & Gene Xpert) are mainly donor funded by PAPFRA, Global fund and TB ARC. The government is also working on increasing domestic funding for laboratories under Universal Health
	Laboratory Score:	6.11		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

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. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	7%		NHA, 2016	The data available is too old; There is need to undertake both NHA and NASA to help verify the figures
2. What is the per capita health expenditure all sources?	$78.60		NHA, 2016	The data available is too old; There is need to undertake both NHA and NASA to help verify the figures
3. What is the total health care expenditure all sources as a percent of GDP?	5.20%		NHA, 2016	The data available is too old; There is need to undertake both NHA and NASA to help verify the figures
4. What percent of total health expenditures is financed by external resources?	23.40%		NHA, 2016	The data available is too old; There is need to undertake both NHA and NASA to help verify the figures
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%		NHA, 2016	The OOP includes premiums and other pre-paid schemes; the NHA/NASA should disaggregate the payment options;

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11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.		Data Source	Notes/Comments
11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☑ 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): 11.1 Score: 0.67 ☑ ARVs are covered ☑ Non-ARV care and treatment is covered ☑ Prevention services are covered ☑ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☑ It covers 25% or less of the population. ☐ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☐ It covers more than 75% of the population. ☑ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☐ ARVs are covered. ☑ Non-ARV care and treatment services are covered. ☐ Prevention services are covered (specify in comments). ☑ It includes public subsidies for the affordability of care.	National and County Budgets/Annual Workplans	Government provisions inadequate given the need; The payment levels for the current NHIF premiums are low;hence need for a business model to ensure higher coverage

11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☑ The HIV/AIDS budget is program-based across ministries ☑ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☑ The budget includes specific HIV/AIDS service delivery targets ☐ National budget reflects all sources of funding for HIV, including from external donors	11.2 Score: 0.83	National and County Budgets/Annual Workplans	Off-budget are not included in the HIV/AIDS budgets e.g: PEPFAR, CHAI, Gates Foundation; Elton Johns Foundation
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ◉ B. There are HIV/AIDS goals/targets articulated in the national budget. ☑ The goals/targets are measurable. ☑ Budget items/programs are linked to goals/targets. ☐ The goals/targets are routinely monitored during budget execution. ☑ The goals/targets are routinely monitored during the development of the budget.	11.3 Score: 0.83	National and County Budgets/Annual Workplans	The budgets are intergrated in the Annual budget development process; as well as the CIDPs
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? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	○ A. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ◉ D. 70-89% of budget executed ○ E. 90% or greater of budget executed	11.4 Score: 0.63	Budget review and Maisha certification reports	This programme management and community HIV prevention services (NASCOP, NACC and MCDAs budgets for HIV/AIDS)

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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?	○ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ◉ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.95	NHA and KNASA	Most of donor support is off budget and currently there is no system for gathering expenditure infomration on annual basis except for government funded activities. However, NHA tool is used to gether information from all sources evry 5 years and therefor the need to institutionalize the data collected from DPHK annually
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very liitle (approx. 1-9%) is financed with domestic funding. ◉ C. Some (approx. 10-49%) is financed with domestic funding. ○ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 1.67	KNASA; Annual Budget reviews	The national and county governments budgets including private sector is estimated at 32%
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	○ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ○ C. 50-69% of budget executed. ◉ D. 70-89% of budget executed. ○ E. 90% or greater of budget executed.	11.7 Score: 0.63	Budget and Expenditure Analysis	The estimated budget execution for health is estimated at 74% as per 2017/18 FY
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?	○ A. There is no system for funding cycle reprogramming. ○ B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used. ○ C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data. ◉ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, and is based on data.	11.8 Score: 0.95	Annual workplans	Transitions are based on data; that is provided in the supplementary budgets
	Domestic Resource Mobilization Score:	**7.18**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? 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) (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☑ Modes of Transmission (MOT) Model ☑ Other recognized process or model (specify in notes column)	12.1 Score: 2.00	KNASA/NHA, DHIS	KNASA , DHIS and NHA is used in determining expenditure in programming. Scoring and weighting changed for this SID.
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)? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ◉ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.2 Score: 1.00	Annual Budget analysis	The government has devolved health to the county governments which is provides budget allocation as per their priorities

12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	(●) A. The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services. ( ) B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning. ( ) C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for bugeting or planning purposes for the following services (check all that apply): ☐ HIV Testing ☐ Laboratory services ☐ ART ☐ PMTCT ☐ VMMC ☐ OVC Service Package ☐ Key population Interventions ☐ PrEP	12.3 Score: 0.00	n/a	The country has no system for gatheringcost information on aroutine basis but accassionally costing studies are conducted to inform decisions on resource mobilization and allocation. This is a huge impact on the sustainability plans as we need accurate and consistent multi-year costing modeling in place
12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☑ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☑ Improved procurement competition ☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years)	12.4 Score: 1.56	National Policies and guidelines	Decentralized care model for drug picks ups, self testing; targeted testing;

	☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☑ Developed and implemented other new and more efficient models of HIV service delivery (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)			
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? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ◉ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.5 Score: 2.00	KEMSA and Procurement Act	
	Technical and Allocative Efficiencies Score:	**6.56**		

13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.			Data Source	Notes/Comments
13.1 Granting exclusive rights for services or training: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies grant exclusive rights for the government or another local provider to provide HIV services?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) polices: A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)? ☐ Yes ☑ No B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services? ☐ Yes ☑ No C. Grant exclusive rights to government institutions for providing health service training? ☐ Yes ☑ No	13.1 Score: 0.36	**National policies and guidelines**	**The Donor (PEPFAR/GFTAM) dostort the marekt given that health care provisions are free in the all public facilities . The government provides the guidelines for use in training institutions both private and public**
13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?	A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities. B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.	13.2 Score: 0.36	**National policies and guidelines**	The government has set out the Kenya Essential Package for Health; as well as regulatory bodies that will allow and limit health care provision depending on the levels of the facility/health care provider

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13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?	National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services: ☐ Prevention ☐ Testing and Counseling ☐ Treatment	13.3 Score: 0.36	National policies and guidelines	The policies do not restrict however, the services provided are subject to infracture requirements
13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?	A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services? ☐ Yes ☑ No B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)? ☐ Yes ☑ No C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]: ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)? ☐ Yes ☑ No	13.4 Score: 0.36	National policies and guidelines	The policies do not restrict however, the services provided are subject to infracture requirements

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13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?	A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards? ○ Yes ◉ No B. [IF YES] For which of the following is local manufacturing restricted? ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other	13.5 Score: 0.36	National policies and guidelines	The government has not provided policies that restrict commodity production; however; the business environment is very punitive, e.g: the tax regimes is a dis-incentive for local manufacturing
13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?	Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)? ☑ Yes ☐ No	13.6 Score: 0.00	National policies and guidelines	The competitive advantage by the govenrment and the donor are higher compared to local health facilities especially privately owned/FBO
13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?	A. Are certain geographical areas restricted to only government or donor-supported HIV service providers? ○ Yes ◉ No B. [IF YES] Which of the following are geographically restricted? ☐ Supplying HIV supplies and commodities ☐ Supplying HIV services or health workforce labor ☐ Investing capital (e.g., constructing or renovating facilities)	13.7 Score: 0.36	National policies and guidelines	The policies allows for free market market operation; however, there are no incentives that enhancing coverage to remove and ASALs which is a challenge to private investors
13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services? [Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces? ☐ Yes ☑ No	13.8 Score: 0.63		

13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY] ☑ Yes ☐ No, government service providers are held to higher standards than nongovernment service providers ☐ No, FBOs/CSOs are held to higher standards than government service providers ☐ No, private sector providers are held to higher standards than government service providers	13.9 Score: 0.63		
13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?	Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES] ☐ Yes ☑ No	13.10 Score: 0.63		
13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?	A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers? ☑ Yes ☐ No B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others? ☑ Yes ☐ No C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions? ☑ Yes ☐ No D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others? ☐ Yes ☑ No	13.11 Score: 0.16		
13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services?	13.12 Score: 1.25		

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regulatory regime?	☐ Yes ☑ No			
13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies require or encourage information on local providers' outputs, prices, sales or costs to be published?	A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]: ☐ HIV service caseload ☐ Procurement of HIV supplies/commodities ☐ Expenses B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]: ☑ Distribution ☑ Sales/Revenue ☐ Production costs	13.13 Score: 0.83		This is applicable for KEMSA which is a government entity.
13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose: A. Which HIV service providers they use? ☐ Yes ☑ No B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)? ☐ Yes ☑ No	13.14 Score: 1.25		The variety of choices is limited;
13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient's ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider? ☐ Yes ☑ No	13.15 Score: 1.25		The market environent is distorted and the market for free goods may create the restrictions; that may be inhibited by cost of waiting time; probability of stigma etc
	Market Openness Score:	**8.76**		

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.

14.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**
14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. Select only ONE answer.	○ No, there is no entity. ○ Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ Yes, there is an entity with authority and sufficient staff and budget.	14.1 Score: 0.56	Kenya Act of Paliarment, 2018 Statistical Act 2019 Kenya AIDS Strategic Framework Kenya HIV Surveillance strategy	MOH (NACC/NASCOP) is the entity with authority
14.2 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 surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	14.2 Score: 0.42	KENPHIA 2017 Protocol, KDHS Report 2014, National Census Data, Kenya HIV Surveillance strategy, Case based surveillance technical guidelines	Technical expertise is required in govt; External agencies need to work with host govt on adequate funding modalities for sustained HIV response. Same responses but scoring and weighting changed for this SID.
14.3 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	14.3 Score: 0.42	Mapping and Size Estimation of KP in the country, 2018	Same responses but scoring and weighting changed for this SID.

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14.4 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	14.4 Score: 0.42	KDHS Report, 2014 National Census Data Specific surveillance reports Case based surveillance technical guidelines	External agencies need to work with host govt and county govt on adequate funding modalities for sustained HIV response. Same responses but scoring and weighting changed for this SID.
14.5 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	14.5 Score: 0.42	Mapping and Size Estimation of KP in the country, 2018	Same responses but scoring and weighting changed for this SID.

14.6 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?	Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units	14.6 Score: 0.67	KHIS Kenya HIV Estimates KENPHIA report (Pending completion)	The Recency surveillance data will contribute to this evidence in future -The score for checking the finer age disaggregates should be inclusive of the coarse disaggregates -The host country collects KP data, however this does not necessarily contribute to incidence data

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14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage is known, please note in Comments column)	○ A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load coverage data (answer both subsections below): Government collects/report viral load coverage data according to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV does the government collect/report viral load coverage data (select one of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☑ More than 75%	14.7 Score: 0.63	NASCOP National Data warehouse http://www.nascop.org/eid/overall.php National ACT Dashboard _NASCOPNHRL	The National ACT Dashboard is currently being revived
14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS <u>or</u> integrated into other routine surveillance such as HSS+) and size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.) Please note most recent survey dates in comments section.	○ 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.). ◉ B. The host country government conducts (answer both subsections below): IBBS (or other integrated behavioral surveillance) for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☑ Transgender (TG) ☑ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☑ Transgender (TG) ☑ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	14.8 Score: 0.83	Mapping and Size Estimation of KP in the country, 2018	No size estimation done yet for Priority Populations listed (

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14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ◉ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	14.9 Score: 0.83	KASF Kenya HIV Surveillance strategy Case based surveillance technical guidelines	Are there Mid term and End term KASF reports (MTR)??
14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☑ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews all protocols.	14.10 Score: 0.83	KENPHIA protocol KASF Kenya HIV Surveillance strategy Case based surveillance technical guidelines	Giving timely feedback to data collection staff needs to be strengthened at all levels; this is stipulates in case based surveillance technical guidelines
	Epidemiological and Health Data Score:	**6.01**		

15. 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**
15.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ◉ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	15.1 Score: 1.67	National Health Accounts (NHA) Kenya National AIDS Spending Assessment (KNASA) County Health Accounts (CHA) HIPPORS Report	Same responses but scoring and weighting changed for this SID.
15.2 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?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☑ Sub-nationally	15.2 Score: 3.33	National Health Accounts (NHA) Kenya National AIDS Spending Assessment (KNASA) County Health Accounts (CHA) HIPPORS Report	Same responses but scoring and weighting changed for this SID.
15.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ A. No HIV/AIDS expenditure data are collected ○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ◉ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ○ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	15.3 Score: 1.67	National Health Accounts (NHA) Kenya National AIDS Spending Assessment (KNASA) County Health Accounts (CHA) HIPPORS Report	Three year time period is too long; propose to be bi-annual with govt to take charge External agencies need to work with host govt on adequate funding modalities. Same responses but scoring and weighting changed for this SID.
	Financial/Expenditure Data Score:	**6.67**		

16. Performance data: Government routinely collects, reports, 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, and viral load testing coverage and suppression.			Data Source	Notes/Comments
16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?	○ A. No system exists for routine collection of HIV/AIDS service delivery data ○ B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ◉ D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○ E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	16.1 Score: 1.00	National Data Warehouse EID Website KHIS	Same responses but scoring and weighting changed for this SID.
16.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No routine collection of HIV/AIDS service delivery data exists ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ◉ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	16.2 Score: 1.67	Expenditure reviews and reports Annual work plans	Same responses but scoring and weighting changed for this SID.

16.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☑ Voluntary Medical Male Circumcision ☑ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☑ By key population (FSW, PWID, MSM, TG, prisoners) ☑ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☑ From all community sites (public, private, faith-based, etc.)	16.3 Score: 1.33	KHIS National Data Warehouse	The Priority Populations reported is the AGYW and Fisher folk data. Same responses but scoring and weighting changed for this SID.
16.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	16.4 Score: 1.33	KHIS	Data is collected and reported on monthly basis. Same responses but scoring and weighting changed for this SID.

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16.5 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, viral suppression, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☑ Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☑ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☑ Results against targets ☑ Coverage or recent achievements of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☐ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☑ Creation of maps to facilitate geographic analysis	16.5 Score: 1.17	KHIS Annual Performance reports Quarterly performance reviews	Same responses but scoring and weighting changed for this SID.
16.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☑ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☑ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☑ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	16.6 Score: 1.33	NASCOP DQA strategy MoH DQA Protocol KASF	Need to strengthen dissemination of reports and findings. Same responses but scoring and weighting changed for this SID.
	Performance Data Score:	**7.83**		

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17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society.			**Data Source**	**Notes/Comments**
17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publically available in a timely manner?	○ A. No, there is not a CRVS system. ◉ B. Yes, there is a CRVS system that... (check all that apply): ☑ records births ☑ records deaths ☑ is fully operational across the country [IF YES] How often is CRVS data updated and made publically available (select only one)? ☐ A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection. ☐ B. The host country government makes CRVS data available to the general public within 6-12 months. ☑ C. The host country government makes CRVS data available to the general public within 6 months.	17.1 Score: 2.00	Vital Statistics reports by National Directorate of Civil Registration	The completeness and accuracy of the births and deaths data needs to be improved at all levels
17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information?	Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? ◉ A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services. ○ B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services. ○ C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services. [IF YES to B or C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information? ☐ Yes ☐ No	17.2 Score: 0.00		There are on going discussions in government to introduce unique identifier named Huduma Number that will be used to access all government/public services including health.

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Question	Response	Score	Source	Notes
17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?	(selected) A. No, there is no central integration of HIV/AIDS data with other relevant administrative data. ( ) B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following: ☐ a. TB ☐ b. Maternal and Child Health ☐ c. Other Health Data (e.g., other communicable and non-communicable diseases) ☐ d. Education ☐ e. Health Systems Information (e.g., health workforce data) ☐ f. Poverty and Employment ☐ g. Other (specify in notes)	17.3 Score: 0.00	EMR Standards Interoperability Framework (Draft)	Administrative data in this case would relate to other services beyond service provision such as commodity, HRH, financial, equipments, etc
17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?	( ) A. No, the host country government does not collect census data at least every 10 years ( ) B. Yes, the host country government regularly collects census data, but does not make it available to the general public. (selected) C. Yes, the host country government regularly collects census data and makes it available to the general public. [IF YES to C only] Data that are made available to the public are disaggregated by: ☑ a. Age ☑ b. Sex ☑ c. District	17.4 Score: 2.00	National Population and Housing Census Report	District is now changed to County for Kenya
17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?	( ) A. No, the country's subnational administrative boundaries are not made public. ( ) B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes. (selected) C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.	17.5 Score: 2.00	IEBC - DELIMITATION OF BOUNDARIES OF CONSTITUENCIES AND WARDS REPORT, 2012. Site level geo-codes are available through the Master Facility List (MFL) which can be accessed by anyone following the laid down proceduer for	Kenya, through the Independent Electoral and boundaries commission, sets and publishes all sub-national boundaries that include county, sub county, constituencies and wards. Site level geo-codes are available through the Master Facility List (MFL) which can
	Data for Decision-Making Ecosystem Score:	**6.00**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D