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# Consolidated Annual Report on Activities Implemented under the "Joint UN Programme of Support for HIV/AIDS in Kenya"

**Report of the Administrative Agent**
**for the period 1 January - 31 December 2011**

**Multi-Partner Trust Fund Office**
Bureau of Management
United Nations Development Programme
http://mptf.undp.org

31 May 2012

## PARTICIPATING UN ORGANIZATIONS

| | |
|---|---|
| | Food and Agriculture Organization (FAO) |
| | International Labour Organization (ILO) |
| | Joint United Nations Programme on HIV/AIDS (UNAIDS) |
| | United Nations Development Programme (UNDP) |
| | United Nations Educational, Scientific and Cultural Organization (UNESCO) |
| | United Nations Population Fund (UNFPA) |
| | United Nations High Commissioner for Refugees (UNHCR) |
| | United Nations Children's Fund (UNICEF) |
| | United Nations Office on Drugs and Crime (UNODC) |
| | United Nations Entity for Gender Equality and the Empowerment of Women (UNWOMEN) |
| | World Health Organization (WHO) |
| | World Food Programme (WFP) |

## PARTICIPATING NON-UN ORGANIZATIONS

| | |
|---|---|
| | International Organization for Migration (IOM) |

**CONTRIBUTING DONORS**

UK Department For International Development (DFID)

## Abbreviations and Acronyms

| | |
|---|---|
| ART | Antiretroviral Treatment |
| ARV | Antiretroviral |
| CCM | Country Coordination Mechanism |
| CT-OVC | Cash Transfer for Orphans and other Vulnerable Children |
| DFID | Department for International Development |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GoK | Government of Kenya |
| HIVDR | HIV Drug Resistance |
| HTC | HIV Testing and Counselling |
| IDU | Injecting Drug User |
| ILO | International Labour Organization |
| IOM | International Organisation on Migration |
| JAPR | Joint Annual Programme Review |
| UNJT | Joint UN Team on AIDS |
| JP | Joint Programme |
| KAIS | Kenya AIDS Indicator Survey |
| KDHS | Kenya Demographic Health Survey |
| K-MoHT | Kenya Modes of HIV Transmission Study |
| KNASA | Kenya National AIDS Spending Assessment |
| KNASP | Kenya National AIDS Strategic Plan |
| M&E | Monitoring and Evaluation |
| MARPs | Most-at-risk Populations |
| VMMC | Voluntary Medical Male Circumcision |
| NACC | National AIDS Control Council |
| NASCOP | National AIDS and STI Control Programme |
| NEPHAK | National Empowerment Network of People living with HIV and AIDS in Kenya |
| NGO | Non-Governmental Organization |
| OVC | Orphans and other Vulnerable Children |
| PLHIV | Persons Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PWP | Prevention with Positives |
| UCC | UNAIDS Country Coordinator |
| UNAIDS | Joint United Nations Programme on AIDS |
| UNCT | United Nations Country Team |
| UNGASS | United Nations General Assembly Special Session on HIV and AIDS |
| UNICEF | United Nations Children's Fund |
| UNJP | UN-Kenya Joint Programme of Support on HIV and AIDS |

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# Joint UN Programme of Support for HIV/AIDS in Kenya
# Part I: Annual Narrative Progress Report

| **Participating UN Organization:** | **Area/Theme:** |
|---|---|
| UNFPA, WHO, UNDP, UNICEF, UNHCR, ILO, IOM, UNAIDS, OCHA,FAO, UN Women, UNESCO, UNODC and WFP | HIV and AIDS |

| **Joint Programme Title:** | **Total JP Budget (in US$):** |
|---|---|
| Kenya Joint UN Programme of Support on AIDS<br><br>**ATLAS No:** 00067646 | US$ 93,300,000<br><br>Pass-through funding<br><br>Donor DFID US$ 13,988,760 |

**Implementing partners:**
National Counterparts: Mainly- National AIDS Control Council (NACC) & National AIDS/STI Control Programme (NASCOP). Others included civil society organizations, Networks of People Living with HIV, Key Populations such as MSM, IDUs, SW, women organizations, private formal and informal sector organizations.

**Joint Programme Duration**

State date: 2008 End date: 2012

## Introduction

This 2011 Consolidated Annual Progress Report under the Kenya Joint UN Programme of Support on AIDS covers the period from 1 January to 31 December 2011. This report is in fulfillment of the reporting requirements set out in the Standard Administrative Arrangement (SAA) concluded with the Donors. In line with the Memorandum of Understanding (MOU) signed by Participating UN Organisations, the Annual Progress Report is consolidated based on information, data and financial statements submitted by Participating Organizations. It is neither an evaluation of the Joint Programme nor an assessment of the performance of the Participating Organizations. The report provide the Joint Programme Steering Committee with a comprehensive overview of achievements and challenges associated with the Joint Programme, enabling it to make strategic decisions and take corrective measures, where applicable.

[Please provide a few paragraphs on the main achievement of this JP from Section "Results".]

2011 saw the development a new 10 year health policy framework which received substantial financial and technical support from the Joint UN Programme. The new health policy was developed to take on board the country's new constitution and guiding strategic document, the Kenya Vision 2030. The new constitution has redefined some mechanism for health services delivery through an expanded rights charter that includes right to emergency services, reproductive health and others. It has also decentralized the responsibility of health services provision to counties. Through vision 2030, Kenya aspires to have a health service delivery system of a middle-income country by 2030.

Existing guidelines were updated to facilitate the delivery of more comprehensive HIV prevention, treatment and care services. On the integration of standalone HIV services with other services, the UN Joint Programme was key in the review of the health sector service delivery system. For example cervical cancer screening using Visual Inspection with Acid (VIA) method was integrated into Comprehensive Care Centers (CCCs) which have the necessary capacity. Similarly, Maternal Child Health (MCH) received a new boost through a rapid results initiative thereby reaffirming the integrated service delivery approach with HIV interventions for the mother and child.

Furthermore progress was made towards mainstreaming, operationalizing and sustaining an equitable, human rights and gender-based multisectoral response to HIV and AIDS in planning and budgets. The UN Joint team led a process of analyzing the implication of the Constitution on HIV and AIDS sectoral policies, structures and Medium Term Expenditure Framework (MTEF) processes. The paper proposed recommendations that could be implemented in devolution with different public and private sectors, including distribution of HIV functions between national and devolved government:

Focus on the multi-sectoral response was maintained in 2011 through mainstreaming HIV in various sectors such as in the humanitarian interventions, public sector, formal and informal economies, civil. society organizations and interventions for young people.

High level advocacy was undertaken in helping the Government to establish a mechanism for sustainable domestic HIV financing. Progress was made towards addressing the technical justification and analysis of various options. Detailed macro-analysis of potential options available to the Government to increase domestic contributions was done through UN Joint Team (UNJT) support. Successful advocacy was undertaken that resulted in buy

in from all key stakeholders including Parliamentarians, political leadership civil society and private sector.

The Multi-Partner Trust Fund Office (MPTF Office) of the United Nations Development Programme (UNDP) serves as the Administrative Agent of the Joint Programme. The MPTF Office receives, administers and manages contributions from the Donors, and disburses these funds to the Participating UN Organizations in accordance with the decisions of the Joint Programme Steering Committee. The Administrative Agent receives and consolidates the Joint Programme annual reports and submits it to the Joint Programme Steering Committee.

This report is presented in two parts. Part I is the Annual Narrative Progress Report and Part II is the Annual Consolidated Financial Report. Part I is presented in four sections. Section I provides the purpose of the Joint Programme; Section II presents an overview of resources; Section III highlights implementation and monitoring arrangements and Section IV provides an overview of the achievement of the Joint Programme and the challenges. Part II of this report forms the Annual Consolidated Financial Report.

**This report covers achievements both for pass-through and other funding sources including internal sources.**

## I. Purpose

### 1.1 UN-Kenya Joint Programme of Support on AIDS (2010-2012)

The UN-Kenya Joint Programme of Support on AIDS (UNJP) is designed to increase effectiveness and harmonization of UN support to the national HIV and AIDS response. The Joint Programme is the front runner of UN reform 'Delivering as One' and is anchored in the UN Development Assistance Framework (UNDAF). The first UNJP was covered the period 2007-2012 and was fully aligned with the second generation of Kenya National HIV and AIDS Strategic Plan (KNASP II, 2005/06-2009/10). The programme was revised in 2009 to ensure alignment with the new national AIDS plan KNASP III (2009/10-2012/13) and again in 2011 to align with the national and global context.

The revised Joint UN Program on HIV has purposefully set out to make progress on overall health and development of Kenyan people through a strategy which is better integrated and demonstrates explicitly how investing in HIV can help achieve a wide range of MDGs and deliver on vision 2030.Its reform is around the pillar groups from the KNASP III as the functioning of the pillars was seen to be *the* critical barrier to the implementation and achievement of KNASP goals and targets. Through this reform it is also clearly demonstrates how it delivers on the HLM targets agreed to through the Political Declaration in New York in June 2011 as they are closely related to the national objectives.

To achieve these ambitious goals and targets the revised Joint UN Program on HIV is reformed around 4 clear outcomes

1. *Comprehensive and equitable health sector response to HIV*
2. *The Multi-Sectoral Response: Keeping Human Rights and Gender at the Forefront*
3. *Communities Empowered in the fight against HIV and AIDS*
4. *Leadership and Strategic Information and Accountability for a Sustained Response*

**How it relates to UNDAF**

UN support to Kenya is guided by the overall five-yearly UN Development Assistance Framework (UNDAF), which currently runs from 2009 to 2013 and has been negotiated with the Government of Kenya at the highest level. The UNDAF spells out agreed areas of cooperation in support of Government policies and priorities, as articulated in the Kenya Vision 2030 and first Medium Term Plan 2008 -2012 as well as the Millennium Development Goals (MDGs). The UNDAF represents not just the legal basis for UN work in-country, but also the starting point for preparation of country programmes by respective UN agencies. Responding to the HIV pandemic and protecting the rights of those affected is one of the key cornerstones and major outcome areas of the Kenya UNDAF. Embedded firmly in the framework is a focus on UN reform, harmonization and alignment of the UN system's work on HIV, particularly as it relates to increased alignment with the KNASP and promotion of the "Three Ones" principles. The HIV and AIDS component and interventions of the current UNDAF (2009-2013) that presently support the KNASP are: ***UNDAF Outcome 2.3:*** **Evidence-informed and harmonized national HIV response is delivering sustained reduction in new infections.**

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

The joint programme is implemented by the UN Joint Team on AIDS (UNJT), which operates under the UN Resident Coordinator system and consists of technical UN staff working on HIV. It comprises 17 agencies, namely: FAO,ILO,IOM,UNAIDS, UN Cares (UNON), UNDP,UNESCO,UNFPA,UNHCR,UNICEF, UN Women, UNODC,OCHA,WFP,WHO and Word Bank.

The Joint Programme is implemented through cluster approach based on the 4 outcomes. The membership of different agencies to each cluster is based on their areas of strength, mandate and Global Division of Labour (DoL). The clusters are then coordinated through a UNJT Management Group that brings together representatives from each participating agency.

## II. Resources.

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

**Human Resources:**

As of 2011 the UNJT had a staff membership of 38 appointed from the 17 UN agencies.

The team collectively and individually has the responsibility for two functions:

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

## III. Implementation and Monitoring Arrangements

Interventions implemented under the UN Joint Programme on AIDS are subject to standard agency procedures for monitoring and evaluation. Most of the interventions undertaken under this Joint Programme were implemented either through direct execution, technical support or the agency transferred funds to the implementing partner based on approved amounts. Leadership and membership of each of the UNJP's output areas is summarized below;

## IV: Results

### Outcome 1 – Comprehensive and equitable health sector response to HIV

2011 saw the development a new 10 year health policy framework. The new health policy was developed to take on board the new constitution and vision 2030. The new constitution has redefined some mechanism for health services delivery through an expanded rights charter that includes right to emergency services, reproductive health and others. It has also decentralized the responsibility of health services provision to counties. Through vision 2030, Kenya aspires to have a health service delivery system of a middle-income country by 2030.

2011 was also the mid-term review year for the KNASP III. A number of health sector HIV programmes, including PMTCT, male circumcision, HIV testing and counseling also underwent a review between 2010 and 2011. The KNASP III MTR therefore served to consolidate the findings of the various health sector programme reviews as well as cover those programme areas that did not specifically undergo a review. The overall findings of the KNASP III MTR indicate that the health sector HIV response was on track with scale up of HIV prevention, care and treatment having achieved set mid-term targets.

The KNASP III MTR however notes possible future challenges towards sustainable scale up of health sector response in order to achieve or maintain universal access. It singles out ongoing Global Economic Depression and access hampering health infrastructure, health workforce, socio-cultural, technological and other constraints

Outcome one is delivered by pillar 1, comprising of 9[1] member agencies and convened by WHO. Outcome one has 5 outputs structured in a manner that will systematically deliver the broader outcome: Government of Kenya has a comprehensive and equitable health sector response to prevention, treatment and care and an integrated health HIV service delivery system for sustainable response that contributes to a significant reduction in morbidity and mortality, particularly for mothers and children

During 2011 the health sector UN Joint Programme was instrumental in updating the existing guidelines to facilitate the delivery of more comprehensive HIV prevention, treatment and care services. On the integration of standalone HIV services with other services, the UN Joint Programme was key in the review of the health sector service delivery system. For example cervical cancer screening using Visual Inspection with Acid (VIA) method was integrated into Comprehensive Care Centers (CCCs) which have the necessary capacity. Similarly, Maternal Child Health (MCH) received a new boost through a rapid results initiative thereby reaffirming the integrated service delivery approach with HIV interventions for the mother and child.

[1] WHO, UNICEF, UNFPA, WFP, UNODC, WB, IOM, UNDP, UNAIDS

**Output 1.1 development of strategies and service delivery support systems that facilitate integrated delivery of HIV interventions with other health services at all levels including community.**

Substantial progress was made toward achievement of this output with respect to development and roll out of strategies for Maternal and Child Health (MCH), Reproductive Health/Family Planning (RH/FP) and TB.

The UN Joint Programmeprovided support to the Ministry of Health for the development of MCH/HIV integrated service delivery tools. The tools were finalized in 2011 and in the same year implemented during a Rapid Results Initiative (RRI). The RRI was focused on integrated delivery of HIV interventions: HIV exposure determination for infants and Polymerase Chain Reaction (PCR) early infant HIV diagnosis. The RRI was also extended and covered provision of ARV, TB and cotrimoxazole prophylaxis to exposed infants, initiation/continuation of ART treatment for PCR HIV positive infants. There results from this MCH/HIV integration RRI were analyzed and disseminated nationally. The performance was particularly encouraging that the Ministry of Public Health and Sanitation (MOPHS) embarked on a scaling up of systematic institutionalization of MCH HIV integration.

In 2011, the UN Joint Programme provided support to the RH/HIV integration strategy. Emphasis was directed in supporting service delivery aids for RH/HIV integration. Since 2009 five facilities have being piloting integrated RH/HIV interventions and the new service delivery aids were used to strengthen the delivery in these pilot sites.

Another area of focus in improving integrated service delivery was in the area of TB/HIV service delivery integration. In this area the UN Joint Programme supported the development of tools to facilitate Intensified Case Finding (ICF) and provision of Isomazid Prevention Therapy (IPT). The tools were finalized and rolled out through a nationwide orientation of service providers. Further the UN Joint Programme supported the revision of Infection Prevention Control (IPC) policy and guidelines. The guidelines were disseminated to reinforce existing approaches of preventing transmission of infectious diseases in healthcare settings with updates on TB infection control in HIV service settings and revised HIV PEP protocols incorporated.

**Output 1.2 advocacy and development of strategies that provide a coherent health sector framework for reducing sexual transmission of HIV through the adoption of innovative and evidence based approaches**

The major achievement under this output area was with regard to reducing sexual transmission was through scale up of evidence-based voluntary medical male circumcision and initiation of an overarching HIV prevention framework.

In order to institutionalize the HIV prevention revolution the UN Joint Programme was a key advocate for the establishment of theHIV prevention revolution task force at NASCOP. The Overall objective of the Technical Working Group (TWG) is to accelerate and revolutionize HIV prevention. UN Joint Programme supported the training of the members on GOALS modelling of cost-effectiveness of HIV prevention interventions. Through this training the members were equipped and will to be better prepared as they develop the HIV prevention strategy

In 2011 UN Joint Programme continued focus on male circumcision. They advocated for the expansion of services beyond Nyanza to geographical areas with male circumcision rates of below 80%. Turkana, Teso and Nairobi and various informal settlements were identified for further MC roll-out. . Safety acceptability studies were undertaken for three male circumcision devices (Alisklamp, Shang Ring and Prepex). The evidence from this

study will beutilized to inform further work in the male circumcision intervention. The UN Joint Programme also supported the development of the strategy on adverse events, partial circumcisions and harmful cultural practices in traditionally circumcising communities

In 2011, the 2-year HIV Testing and Counselling (HTC) roadmap came to an end and a report was prepared. The UN Joint Programme has been a strategic partner in the delivery of this road map. In particular in 2011, following the issuance of new retesting and referral policy, the health sector was supported to revise HIV testing and counselling guidelines. We also supported the national testing campaign in 2011, targeted at couples and key populations. .

In the recent past several studies in Pre-exposure Prophylaxis (Prep) have been conducted in Kenya. The studies include Kenya's FemPrEP, microbicides and Partners in PrEP study sites. In 2011 UN Joint Programme supported the release and dissemination of the results of the studies to inform policy and practice.

Finally, in 2011 ANC sentinel surveillance for HIV/syphilis report was included in the generation of EPP/SPECTRUM national HIV estimates. The results were used to enrich the universal access reports that would be used to inform programming for the national HIV response.

**Output 1.3 advocacy and development of operational frameworks that facilitate delivery of integrated Health/HIV services to IDUs, mobile populations and in special settings are advocated for and developed.**

During 2011 good progress was made towards generating up to date strategic information and size estimations, advocating for evidence based interventions, and strengthening service delivery capacity for MARPS programme.

Over the years the UN Joint Programme has been the lead in strategic information for policy and implementation. The comprehensive epidemiological and KAPB studies concluded in 2011 with support from UN Joint Programme, provided up to date strategic information on HIV for people who use drugs in prison settings. This evidence informed and intensified advocacy on effective IDU programming, the culmination of which was a national commitment towards introduction of more effective harm reduction interventions such as Needle/Syringe Programme (NSP) and Opioid Substitution Therapy (OST). As a follow on to this commitment and to ensure that implementation was well guided, UN Joint Programme supported the drafting of an NSP implementation roadmap.

Further, in 2011, UN Joint Programme supported a nationwide capacity assessment of NGOs delivering interventions for people who use drugs. Following this assessment capacity gaps were identified and capacity building strategy developed for more comprehensive IDU interventions

The UN Joint Programme was a key partner in the launch of the Salgaa Roadside Wellness Centres (RWC) service delivery site. This site will play an important role in increasing service provision to long distance truck drivers and communities around the RWCs. in order to increase knowledge to truckers and their managers, peer educators were trained to operationalize HIV workplace policies.

**Output 1.4 advocacy and development of service delivery strategies and support systems that facilitate equitable and sustainable access to quality HIV treatment and care services (including TB and malnutrition management).**

During 2011 significant efforts were made to determine the quality of the national

programme through monitoring of ART treatment outcomes through HIV drug resistance monitoring and updating of national ART guidelines based on new evidence. Support was also provided to ensure continued scale up of nutrition for PLHIV

Taking into consideration new guidance on TB/HIV, nutrition for PLHIV and provision of ART in emergency, UN Joint Programme supported the revision of National ART guidelines and expansion of provision of nutrition to ART clients. In particular nutrition and HIV tools/aids were disseminated to partners and UNICEF/WFP project service delivery sites. Nutrition support was provided to14,055 ART clients through CCCs under the Food by Prescription strategy. Food assistance was provided to 70,275 ART clients and their households members through household food assistance strategies.

In addition, UN Joint Programme supported the consolidation of the report on HIV drug resistance monitoring surveys into the 2010-11 national HIV drug resistance. The report summarizes results of Early Warning Indicators (EWI), adherence and ARV post-market assessments such as the Kisumu ground breaking HIV drug resistance survey on children conducted by CDC). The report was finalized and disseminated.

UN Joint Programme supported the revision of 2-year rolling plan for HIV commodities forecasting and quantification (F&Q. finalization and nationwide dissemination of the harmonisedARV logistics tool for ART, PMTCT and PEP was done to enable ARV drugs F&Q across the three programmes. Two post market ARV surveys were conducted with support from UN Joint Programme

**Output 1.5 advocacy for documentation of universal access to HIV prevention focusing on elimination of vertical transmission and HIV transmission in health care settings, testing of innovations, and national rolling out.**

In 2011 there was substantial progress as evidenced by the development and piloting of a national framework and communication strategy for virtual elimination of mother to child transmission:

UN Joint Programme was critical in leading advocacy to secure high national level political and technical commitment towards elimination of mother to child transmission of HIV by 2015. In this process strategic partnerships were forged between Ministries of Health, USG, UN Joint Programme and ICAAP for PMTCT scale up and quality improvement. Through these partnerships resources were mobilized from United States Government, Global Fund, and World Bank to deliver elimination of mother to child transmission

The National knowledge attitudes, practices and Behavioural (KAPB) survey on PMTCT was conducted in 2011 and the results of the KAPB survey and the earlier PMTCT programme review were used to draft a national elimination of mother to child transmission of HIV and keeping mothers alive (eMTCT) Framework/Strategy. The national eMTCT strategy will contribute to the efforts towards elimination of paediatric HIV and keep mother alive. As a result piloting of eMTCT is ongoing in 5 districts with continuous data analysis and progress review.

Advocacy and communication is a critical part of the eMTCT strategy, as a result UN Joint Programme supported the development and implementation of the national eMTCT Advocacy and Communication campaign named *Kata Shauri*.

**A cross-cutting output under outcome1 was the strengthening of the health sector to convene, coordinate and monitor the health sector HIV response through KNASP Pillar 1 and health sector coordination mechanisms.**

In 2011 UN Joint Programme supported the health sector to address the Technical Review Panel (TRP) conditional requirements for Global Fund round 10 grant. The support

provided by the UN Joint Programme was critical in ensuring the country was well prepared to negotiate and sign the largest HIV award.The support offered included defining clear targets for MARPS interventions, strengthening the skilled deliveries component of the proposal to address sustainability issues and addressing Global Fund audit queries for rounds 2 and 7.

In 2011 the country embarked on a Mid-Term Review (MTR) of the National Strategic Plan (KNASP III). The UN Joint Programme supported this process by providing technical support to the NACC Health Sector Pillar. The draft report of the KNASP mid-term review was successfully prepared indicating that the Health Sector had achieved most of its mid-term review targets.

**Outcome 2 - The *Multi-Sectoral Response: Keeping Human Rights and Gender at the Forefront***

In 2011 much progress was made towards mainstreaming, operationalizing and sustaining an equitable, human rights and gender-based multisectoral response to HIV and AIDS in planning and budgets

2011 was a particularly important year in the area of Human Rights. The leading force in this direction is the Constitution of Kenya (2010) which provides unprecedented opportunities to maximize rights. The UN Joint team led a process of analyzing the implication of the Constitution on HIV and AIDS sectoral policies, structures and MTEF processes. The paper proposed recommendations that could be implemented in devolution with different public and private sectors, including distribution of HIV functions between national and devolved government:

Further, The members of world's first ever HIV-specific Tribunal were sworn-in in 2011. The Tribunal's objective is mainly to address discrimination and human rights violations against people living with HIV thereby advancing the vision of Zero discrimination.

Focus on the multi-sectoral response was maintained in 2011 through mainstreaming HIV in various sectors such as in the humanitarian interventions, public sector, formal and informal economies civil society organizations and interventions for young people.

**Output 2.1. Support to Ministry of Planning and Development and NACC to ensure all sectors have positioned, prioritized and financed HIV within the context of the devolved policies, structures and MTEF processes**.

During the reporting period Outcome 2 made much progress towards achievement of the output 2.1. In terms of strategic information, a position paper on HIV and the constitution was developed to form the basis for advocacy on HIV within the devolution structures. The position paper will be used to inform important programming decisions with regard to implication of HIV in the new constitution and the devolved structures. Its recommendations will be implemented within the devolution context with different public and private sectors, including distribution of HIV functions between national and devolved government.

In order to enhance leadership and governance of the public service for the HIV and AIDS response through the development of policies and a legal framework, UN Joint Programme provided support to Kenyan members of parliament to develop a toolkit for sensitization of stakeholders on the Constitution. Additional support for governance and leadership on HIV/AIDS policies for local authorities was provided through regional workshops in nine regions that reached 175 local authorities.

To ensure HIV budget allocation during the budgetary planning cycles, technical support was provided to District Development Officers (DDOs) and planning officers in a workshop which covered resource mobilization and budgeting for donor and government funds especially for the HIV response in the country.

One of the key strategic activities that was supported by the UNJT was the drafting of the NACC Bill. The Government was supported to undertake wide stakeholder consultations on the NACC Bill. If adopted, the new bill gives KNAC a stronger mandate which will in turn enable the institution to effectively provide better guidance and support toward the national response. It also effectively tackles issues of gender mainstreaming and addresses some of the issues affecting vulnerable women and girls. In addition, the Bill clearly outlines the functions of the proposed Council both at national and county level as well as the qualifications and appointment criteria for all members of the Council.

**Output 2.2: GOK supported to develop and implement a multi-sectoral framework for HIV preparedness and response in emergencies.**

The major achievement under this output was mainstreaming of HIV in existing humanitarian interventions and planning by having HIV included in the 2011/12 Emergency Humanitarian Response Plans. A multi-sectoral National Steering Committee on HIV in emergencies (NSC) was formed comprising of government ministries, civil society and Joint UN Team on HIV and AIDS to steer the humanitarian response. In 2011 NSC conducted rapid assessments to identify gaps in HIV preparedness and response in six disaster prone regions (drought and flood prone areas) of Mandera, Isiolo, Budalangi, Nyando, Kinango, Kwale, Tana River, and Turkana. Some of the key findings included: HIV is excluded in plans and responses; PLHIV are not prioritized; increase in HIV infection risk during emergencies as a result of transactional sex, Sexual Gender Based Violence (SGBV), drug abuse; disruption of prevention, care and treatment services; increased stigma and weak coordination among humanitarian actors and government. As a result of this assessment an advocacy tool was developed and an action plan for implementation of activities was outlined.

The UN Joint Programme also supported various capacity building initiatives to strengthen the humanitarian response. The capacity of Trainer of Trainers was enhanced in the area of HIV in emergencies for the roll out of IASC guidelines at regional level. Staff from the Ministries of Agriculture and Livestock and allied implementing partners trained on gender and HIV integration in food security assessments, to guide food security partners by introducing specific measures that protect and adapt the livelihoods of HIV affected households and support their food production. Six NGOs were also supported to promote life skills among vulnerable women and men through the Farmers Field and Life Schools in the post election violence affected areas of Wareng and Eldoret East, the eastern Kenya drought affected districts of Mwingi and Kakuma refugees and their host community in Turkana.

**Output 2.3 Gender mainstreamed and audited in the national HIV response.**

The major achievement under this output was intensified advocacy for gender and GIPA mainstreaming to ensure that the response was taking into account these important elements. The UN joint Programme supported several advocacy forums for senior decision makers (Permanent secretaries and planners) from targeted ministries/institutions on gender and human rights mainstreaming in the national response. Moreover**,** to provide guidance to stakeholders on how to mainstream gender in processes and structures, several supporting documents were developed and produced including policy briefs on ‘Women and HIV’; Gender and HIV Data Sheets; 2008 Gender Audit report; Gender Guidelines and

discussion paper on Gender to strengthen the case and advocacy for the repeal of Section 24 of HAPCA on the criminalization of deliberate HIV transmission was also developed.

The UN Joint Programme supported the dissemination of GIPA guidelines to enable mainstreaming across nine regions in the country. This also included strengthening of networks of Women Living with HIV (WLHIV) and Men Living with HIV (MLHIV) thereby enhancing the performance of the networks in carrying out the advocacy and policy influencing mandate on behalf of PLHIV. Rights awareness among HIV infected and affected persons was supported through sensitization on HIV and AIDS to actors across five regions as well as group therapy sensitization workshops. The UNJT continued to provide support to NEPHAK secretariat. Mapping of the networks of Women Living with HIV (WLHIV) resulted in a stakeholder directory of the WLHIV and the First National Leadership forum for WLHIV held. The National Leadership Forum brought together over 200 WLHIV leaders. During the meeting, champions for WLHIV were identified and awarded national recognition.

**Output 2.4**: **Public, Civil society organizations and private sector supported to develop and implement evidence-based sectoral/workplace HIV and AIDS non-discriminating policies**

The UN Joint Programme in 2011 focused its efforts in providing strategic information to ensure that the various sectors have evidence-based sectoral/workplace HIV and AIDS non-discriminating policies. Rapid assessment studies on the socio economic impact of HIV& AIDS in the following key sectors: education, health, transport, informal sector and among PLWHA were completed. Response analysis studies were also supported in the universities, analysis of the implementation of workplace programme and policy in the formal sectors well as situational analysis report for sex workers and clients were completed. The studies assisted in the identification of gaps at policy and programmatic levels as well as gaps in the implementation process and also provided clear recommendations for a sustained HIV response in the workplace.

In 2011 various sectors benefited from the development and dissemination of several policies and guideline to support mainstreaming in various sectors including the Roads Sector policy on HIV and AIDS, HIV mainstreaming guide for AIDS Control Units, disseminated the recommendations concerning HIV and AIDS and the world of work, No. 200 and National Code of Practice on HIV and AIDS at the workplace.

In order to scale up mainstreaming of HIV and AIDS and mitigation strategies in the public sector, formal, informal sectors, and civil society organizations the UNJT provided technical support in order to enhance compliance to ILO recommendations. The UNJT support was towards development of HIV and AIDS workplace programmes and non-discriminatory policies, integration of Tuberculosis into existing workplace programmes and policies as well as equipping women leaders with business management skills.

**Output 2.5: Mainstreaming HIV interventions for young people**

One major achievement under this output was advocacy by the UN Joint Programme around a comprehensive response to HIV and AIDS in learning institutions and contributing to the domestication of the International Technical Guidance on Sexuality Education and strengthened Youth Networks as forums for sharing HIV and related information in Kilifi, Migori, Naivasha and Nairobi West with additional support for dissemination of the Kenya National Communication Strategy for the Youth 2008 in North Rift and North Eastern. Close to one million young people in and out of school were reached BCC campaigns, HIV Testing and Counselling(HTC), life skills aimed at

improving HIV prevention among young people

**Internal Mainstreaming: HIV workplace program in the UN system in Kenya**
Throughout 2011, UN Cares Kenya was actively engaged in several activities targeting staff from all the UN agencies operating in Kenya. The key result areas include :Accelerated prevention activities- orientation and training sessions for staff, HTC campaigns for staff to know their HIV status: Anti-stigma campaign was successfully mounted and materials for UN Cares Kenya website produced. Psychosocial support and access to treatment and care services for staff and their families

**Outcome – *3. Communities Empowered in the fight against HIV and AIDS***
By 2013, Ministry of Gender and NACC ensure community pillar of the Kenya National AIDS Strategic Plan has established/strengthened strategic information systems and coordinating structures and are empowering communities to ensure equitable access to HIV services.
Given below are output related achievements.

During 2011 the UNJT made tremendous progress towards achieving outcome 3 results. Joint technical and financial support, and continuous advocacy by the Joint UN Outcome 3 team resulted in jumpstarting the dormant Pillar III coordination mechanism at national and sub-national levels resulting in implementation of critical Pillar III activities, such as, development and operationalization of TOR for the Pillar III coordination structures at national and sub-national levels, rolling out of Code of Conduct and initiation of processes for the development of the Kenya specific AIDS competency framework, availability and use of data on community HIV related interventions

**Output 3.1: Pillar III Convenors operationalised HIV coordination and accountability structures at national level.**
During the reporting period the UNJT supported the strengthening and functioning of Pillar III Convenor at National level. This was in response to findings from the 2010 JAPR which had found that Pillar III Convenor was not operational. Ministry of Gender Children and Social Development (MoGCSD) and NACC were empowered to lead as pillar conveners through technical assistance including placement of an UNV at NACC to support the logistics and administrative components of Pillar III. A National Pillar III think tank was established with participation from key civil society members, partners (bilateral and multilateral) and government representatives. The process of Pillar coordination was introduced at sub-national level through meetings that piggybacked on the MTR process.

**Output 3.2: Community HIV related data harmonized and available for analysis & use at the national level**
During this reporting period the UNJT team made much progress towards addressing the lack of community HIV related data. During the 2010 JAPR Pillar III had failed to present progress report against agreed targets on community interventions. This serious gap in data led UNJT to prioritize the development of county HIV profiles. By the end of 2010 a concept on county HIV profiles had been developed and consensus secured. Steps were also supported towards addressing the problem of lack of harmonized data at community level through dissemination of code of conduct that require all partners to collaborate and share data at community level. UNJT supported review, harmonization and roll out of community-based reporting tool (COBPAR) and data migration from old data base to new automated COBPAR was advocated for and supported. Availability of sub-national HIV status was enhanced through support to generation of sub-national HIV estimates.

**Output 3.3: Strategic information on HIV social protection programs generated and integrated into the Kenya National Social protection framework and gaps arising addressed at national and sub-national levels**

Social protection is an area where the UNJT made a very visible mark during the reporting period. Besides supporting scale up of social protection interventions, the UNJT also supported generation of strategic information on social protection. Outcome 3 took advantage of and collaborated on a World Bank Social Protection Sector Review which generated strategic information on social protection. The review was conducted with an aim of identifying and analysing the interactions, links, and coordination among the country's various social protection programmes. The influence of HIV can be noted by the fact that 48% of the programmes reviewed used HIV/AIDS/TB status as an individual or household targeting criteria. The UNJT continued to address social protection gaps by scaling up agricultural knowledge and life skills for livelihood support and food security of orphaned and vulnerable boys and girls through provision of training, cash grants and learning material support to Junior Farmers Field and Life Schools (JFFLS). The UNJT supported farmers field program benefited PLHIV and HIV affected households especially those in areas affected by the 2007 election violence. Interventions included provision of farm inputs, such as fertilizer, seeds, farm tools, food assets including poultry, small stocks, cash grants and food through voucher for work.

Through strong advocacy and support, the number of households benefiting from the cash transfer OVC program was increased by 66% from 85,891 in 2010 to 129,526 in 2011. UNJT supported interventions to mitigate the impact of HIV/AIDS included food support to 30,000 OVC, and their beneficiaries in 6,000 households in Western Kenya. The Government of Kenya budget allocation for the CT-OVC programme increased from 48 millionKsh2005 to Ksh 833 million in 2010 and was at Ksh 1. 26 billion in 2011 basically 40% of the CT-OVC programme's annual budget, thus strengthening Government of Kenya ownership and the programme.

Analysis of strategic information on social protection showed that levels of spending on social protection increased between 2005 and 2010, although this general trend masks significant variations among the sub-sectors. In 2005, social protection expenditure amounted to KSh 33.4 billion. By the end of the decade, this had increased to KSh 57.1 billion. However, sustainability of safety nets programs (in terms of financing) for this sector is still a concern with the largest source of financing to safety nets in 2010 coming from external bilateral sources (65%), 23% came from multilateral agencies and 11% from the government. Government spending, however, has been increasing over the past five years, as is clear from its increased spending on the OPCT (Older Persons Cash Transfer) and the CT-OVC (Cash Transfer for Orphans and Venerable Children).

**Output 3.4: An HIV framework that outlines support to communities to demand accountability across sectors, mobilize resources at decentralized levels and ensures PLHIV involvement within community and decentralised coordinating structures is developed and implemented in a number of settings.**

The 2010 JAPR brought out the lack of functional accountability framework across the sectors given that the Pillar coordination mechanism had not functioned at both National and sub-national levels. Addressing this gap became a UNJT priority for 2011. Development of a community AIDS competence framework was prioritized and progress was made. Technical assistance to facilitate the development of the AIDS Competency implementation framework was commissioned in October 2011. The team completed

literature review and also visited various organisations implementing Community AIDS Competency programs including study visits to Ethiopia to learn from their experience in implementing and coordination of community programs. The AIDS Competency framework is expected to provide guidance to organisations implementing community programs. A paper on devolution and HIV was developed to inform to inform HIV coordination framework within the context of devolution.

**Outcome 4 By 2013 Government of Kenya has demonstrated leadership through increased domestic finance for HIV and strengthened governance and accountability structures for the HIV response.**

2011 was an MTR year and this took place against the background of a new constitutional dispensation. The new constitution has redefined the mechanism for service delivery putting Counties at the centre stage. In terms of resources, HIV financing continued to be at risk as Kenya witnessed continued flat lining by some donors coupled by a shift towards health sector financing in the context of Health/HIV integration.

**Output 4.1: Strategy (vision) and capacity for improved governance and pillar coordination to review and report on KNASP III implementation progress developed**.

GOK priority for 2011 shifted towards implementation of new constitution making it very challenging to push other agendas. High level advocacy was undertaken to ensure that HIV remained on top of the GOK priorities and this resulted in efforts towards integrating HIV into the constitution implementation process. Pillar coordination mechanism was operationalized with Pillar III becoming functional including conducting of regional pillar coordination meetings and regional monitoring visits. Through UN Joint Team support the MTR process was launched and given priority. The MTR process came up with several key recommendations towards strengthening the national response.

The reform of the institutional and programme framework of the UN-Kenya Joint Team on AIDS was a major achievement during the reporting period. This reform put the UNJT in a better position to provide strategic support to the Government for im[proved coordination of the National response. This marked the complete review of the UN-Kenya Joint Programme of Support for AIDS Results Matrix and the joint programme work plan. This reform also saw the development of enhanced structures for the UN-Kenya Joint Team on AIDS so as to be able and manage the joint programme and the spirit of 'Delivering as One'. The revised Results Matrix now has 4 joint programme Outcome Areas and 20 Output Areas. The review also took the UN-Kenya Joint Programme of Support for AIDS away from the 12 Output Areas that were developed in 2010 as part of a response to realign with new KNASP III, and reorganised the UN-Kenya Joint Programme of Support for AIDS structure around the four KNASP III Pillars. Each of the four Outcome Areas has a Convenor and Alternate Convenor as well as participating agencies. The total number of UN-Kenya Joint Team on AIDS participating agencies still stands at 16 and the accountability framework also remains the same with the UN-RC being the overall responsible and the UNAIDS UCC being the Convenor of the UN-Kenya Joint Team on AIDS and UN-Kenya Joint Team on AIDS Management Group. The day-today coordination of the UN-Kenya Joint Programme of Support for AIDS in 2011 also remained the same and was provided by the UNAIDS Senior Institutional Development Adviser.

The other key accomplishment was the domestication of the UNAIDS Global Division of Labour (see annex). Kenya has reduced the Global DoL Areas from 15 to 11 and has merged two into one. The uniqueness of the domesticated Kenya DoL is that is has apportioned roles and responsibilities to non-Cosponsor agencies who are participating in

the UN-Kenya Joint Team on AIDS. This approach has been considered good practice by the UN-Kenya Joint Team on AIDS as the same was applied on the previous Global DoL.

**Output 4.2: The multisectoral response maintained in the devolved system with (i) implementation of Institutional review recommendations and (ii) monitoring & evaluation and accountability improved through performance reviews including JAPR**.

During the reporting period the UNJT supported the Government to carry out MTR with deliberate emphasis on understanding the key achievements and obstacles in the coordination of the multisectoral HIV response. A key finding from the MTR and the JAPR 2010/11 was that with the exception of Pillar 1, the Pillar coordination mechanism was deemed ineffective due to their lack of functioning. Specifically Pillar III coordination was dormant since the inception of KNASP III, with Pillar convenors not organising any national or sub national level Pillar III meetings. These findings on dysfunctional Pillar mechanisms contributed to the re-organization of the UN-Kenya Joint Programme Outcome groups and key results with emphasis on Pillar coordination and accountability. The UN-Kenya Joint Team on AIDS support to the MTR process was used to prioritise the operationalisation of all Pillars and sub-groupings.

Progress was also made towards GOK approving implementation of the NACC institutional review recommendations. A ground breaking paper on positioning HIV within the constitution and devolved structure produced resulting in key recommendations on how best to integrate HIV in the on-going constitutional implementation process. Methodology and tools for improving monitoring and accountability were developed including JAPR tools and KNASP III tracking tools.

**Output 4.3: Improved evidence into policy and practice and to guide KNASP III and development of KNASP IV made available**.

During 2011 good progress was made towards generating and making available strategic information. All major national reporting requirements were met in time and these included ANC Surveillance, Universal Access, National HIV profile and UNGASS (2011) reports. The first ever National HIV and AIDS Conference was successfully hosted and provided an opportunity for disseminating research and evaluation findings to key stakeholders. Another milestone was the development of a National HIV research and evaluation inventory with 937 abstracts making it one of the most comprehensive HIV inventory to date. A research and evaluation gap analysis was also carried out leading to the development of a National research and evaluation priority agenda. The UNJT supported Government efforts to coordinate research and evaluation by producing a National HIV Surveillance Strategy. As part of implementing the National Surveillance strategy, several population estimates for selected key population groups were initiated and these include sex workers, IDUs and MSM. During the same reporting major initiatives were launched aimed at generating strategic information such as National HIV Program Efficiency evaluation supported by World Bank, Evaluation of Social Interventions, Kenya AIDS Indicator Survey, National and County HIV estimates and projections etc.

**Output 4.4: Leadership and advocacy for prevention strengthened, including efforts to ensure non criminalization of HIV and no adoption of punitive laws**.

This output remains the most challenging output and yet very critical towards accelerating progress towards ZERO. Notable progress was made in 2011 in terms of strengthening leadership for prevention. NASCOP established a functional TWG for prevention, GOK established an HIV and AIDS tribunal and launched it during the reporting period. The gazetment of the HIV prevention Act was another milestone including the hosting of

prevention conferences/workshops for key populations. During the reporting period major milestones were achieved in improving access to HIV services by key populations such as IDUs, MSM and sex workers.

**Output 4.5: National sustainable HIV financing strategy to coordinate HIV resources endorsed by cabinet and HIV Trust Fund established resulting in increased domestic resources.**

During 2011 a lot of effort was put towards helping the Government to establish a mechanism for sustainable HIV financing. A lot of progress was made towards addressing the technical justification and analysis of various options. Detailed macro-analysis of potential options available to the Government to increase domestic contributions was done through UNJT support. Successful advocacy was undertaken that resulted in buy in from all key stakeholders including Parliamentarians, political leadership civil society and private sector.

Other notable achievements during the reporting period include signing of the GFATM grant for round 10. Support was also provided towards strengthening the CCM and the GFATM secretariat. During the same reporting period Kenya witnessed improvements in performance of TOWA and GFATM. Lack of clarity on Health/HIV integration continues to be an obstacle as donors shift towards broad health financing. This output is yet to be realized but however the following have been achieved: Technical work on HIV resource efficiency and effectiveness commissioned.

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

Key challenges faced during implementation included:

- **Limited funding and staffing:** most of the UN agencies responsible for providing ongoing UN support towards implementation of pillar 1 KNASP III activities have limited available funding for staffing their HIV/AIDS portfolios and for support activities. Hence currently provided UN support is not commensurate with KNASP III response implemented through pillar 1 (estimated at 60-70%)
- **Limited provision of support for UN non-joint focus areas:** the UN joint support mechanism focuses its support primarily on programme areas where the UN support mandate is shared across more than one agency. As such, KNASP pillar 1 activities around treatment, health systems strengthening, blood safety, infection prevention and control, etc. are minimally unsupported because they are the mandate of one agency.
- Financial constrains included: Delay in disbursement of funds and the slow process of creating budget codes by agency Headquarters for DFID funds has frustrated efforts at implementation level. Limited funding to support activities especially in the areas of emergencies and in humanitarian settings. Inadequate resources to mobilize the social partners to give effect to the Recommendations Concerning HIV and AIDS and the world of work, 2010, No. 200 pose a key challenge. Implementation of policies on HIV and AIDS at enterprise level pose a key challenge due to inadequate resources, capacity and lack of compliance enforcement mechanisms
- Institutional constrains included: Lack of effective coordination within inter-ministerial platforms due to multiple stakeholders such as National AIDS Control Council, NASCOP and the Ministry of Youth Affairs and Sports. Competing demands among humanitarian actors and low commitment among members of the UN Joint team causing challenges in mainstreaming. Absence of consistent focal point at NACC in the area of HIV in emergencies and in humanitarian settings. Weak sectoral policy, inadequate knowledge and skills in HIV and Gender mainstreaming and rights-based approaches, inadequate

nutritional interventions in existing food and nutritional security programmes and inadequate funding to support HIV in emergency were observed as key challenges Capacity to address HIV and AIDS issues within the Informal sector and the small and medium enterprises is inadequate and needs to be enhanced through their existing structures and associations. Challenges on informal sector coordination need to be addressed. Limited capacity and advocacy tools for sectoral Mainstreaming of HIV and AIDS at both public and private levels

- Strategic information constrains included: Absence of strategic data to guide implementation of youth programmes.
- Socioeconomic constrains include: Complacency to HIV and AIDS response within the workplace especially within the formal sector and expansion into overall health and wellness may lead to scale down in HIV interventions in the workplace. Stigma at the workplace, limited access to health insurance cover across in the various UN agencies.
- Limited resources and capacities of the National convener MoGCSD and lack of leadership and commitment at NACC impacted achievement of key Pillar III deliverables. Capacity remains a challenge, particularly among Civil Society Organizations (CSOs) including NGOs and CBOs that need continuous training. While one M&E system is in place, it is not fully operationalized and parallel systems, also related to donor programs, are still in place.
- Lack of clarity in the role of Pillar Convenors and absence of a functional accountability mechanism for tracking Pillar progress/leadership by Pillar Convenors continues to negatively impact the achievement of Pillar Outputs/Outcomes. In order to overcome this challenge and ensure achievement of KNASP III targets, it is imperative that NACC operationalize the Pillar accountability mechanism, clarify the Terms of Reference for Pillar Convenors and advocate at the highest level to ensure buy-in from the respective Pillar convening ministries.
- While substantive progress was made towards a national information management mechanism, the link to other Ministries' information systems and to partner information systems will be critical to its effectiveness.
- With the onset of drought in northern Kenya, the already vulnerable situation of many pastoralist and impoverished children was exacerbated. Lack of coordination and absence of HIV within the emergency response resulted in a limited/ineffective community based response to address HIV in the drought affected areas of Northern Kenya.
- With only about one in five households caring for vulnerable children currently receiving any form of free support, increased advocacy for a coordinated social protection response is critical or else the climb to achieve national goals to mitigate the epidemic's impact on children will be steep.

## V. Future Work Plan

In November 2010, the Joint UN Program on HIV and AIDS started an ambitious mid term review of outcomes and results in order to better position itself to the changing national and global context. Nationally with the promulgation of the new constitution and the expected devolution of governance and planning there were opportunities for scaling up the response to HIV. Furthermore the national Joint AIDS Program Review and the subsequent Mid Term Review of the Kenya National AIDS Strategic Plan III alerted partners to the considerable progress that had already been made (some goals were surpassed) and to the considerable challenges in implementing the KNASP.

Internationally in December 2010 the United Nations and Multilateral System launched its first global HIV strategy with 10 clear goals and results and a new division of labour. In

June 2011 a new Political Declaration for HIV and AIDS and global goals and targets were set.

These important milestones demanded that the Kenya UN Joint Program on HIV revise its program and reposition itself to deliver and report on these goals and results nationally and internationally.

***Maximizing new National Opportunities***

Kenya has achieved remarkable social and economic progress over the last decade. Life expectancy is increasing and child mortality and the numbers living in poverty are dropping. These achievements are the result of the effective growth, the poverty reduction policy compact.

However, to achieve Kenya's Vision 2030 goals and make progress on a number of Millennium Development goals, many challenges have to be overcome, one of which is HIV/AIDS. The "Assessment of the socio-economic impact of HIV and AIDS on key sectors in Kenya" carried out in 2006 confirmed widespread evidence of the detrimental effects of HIV on the economy. Per capita output is estimated to be 4.1% lower because of HIV and this across the entire economy. The Joint UN Program on HIV has purposefully set out to make progress on overall health and development of Kenyan people through a strategy which is better integrated and demonstrates explicitly how investing in HIV can help achieve a wide range of MDGs and deliver on vision 2030.

With an HIV prevalence rate of 6.2%, 1.6 million Kenyans living with HIV, and 111,000 new adult and child infections every year, Kenya is hard-struck by the epidemic[2].This context has a serious impact on achieving the MDGs. While mortality rates for children under 5 have dropped, the trend is not yet steep enough to reach the MDG. Maternal mortality rates also remain persistently high with no significant change. HIV accounts for 15% of under-5 mortality and 20% of maternal mortality in Kenya[3]. In addition AIDS is by far the largest cause of adult mortality in Kenya, accounting for 29.3% of deaths. To mitigate the negative impact of AIDS, the Government has set up a robust and multi-sectoral response and major progress has been achieved. For instance, the coverage of people receiving ART was 72% in 2011[4].

The Government of Kenya (GoK) with the assistance from the UNJT and partners conducted a Mid-term Review (MTR) of the KNASP III in the second half of the year. Several key recommendations were made aimed at strengthening the coordination mechanisms and refocusing the response to align with the new constitutional dispensation. In addition the MTR made key recommendations to improve programming, coordination and increasing domestic financing.

***Results on* Revised Joint UN Program on HIV in Kenya 2011-2013**

The revised Joint UN Program on HIV has purposefully set out to make progress on overall health and development of Kenyan people through a strategy which is better integrated and demonstrates explicitly how investing in HIV can help achieve a wide range of MDGs and deliver on vision 2030.It's reform is around the pillar groups from the KNASP III as the functioning of the pillars was seen to be *the* critical barrier to the implementation and achievement of KNASP goals and targets. Through this reform it is also clearly demonstrates how it delivers on the HLM targets agreed to through the

[2] 2011 Kenya Estimates and Projections
[3] CAPRISA study and NHSSPII respectively
[4] NACC (2011) Policy Brief on Sustainable financing of HIV/AIDS in Kenya

Political Declaration in New York in June 2011 as they are closely related to the national objectives.

The achieve these ambitious goals and targets the revised Joint UN Program on HIV is reformed around 4 clear outcomes

2. *Comprehensive and equitable health sector response to HIV*
2. *The Multi-Sectoral Response: Keeping Human Rights and Gender at the Forefront*
3. *Communities Empowered in the fight against HIV and AIDS*
4. *Leadership and Strategic Information and Accountability for a Sustained Response*

## VI. INDICATOR BASED PERFORMANCE ASSESSMENT

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| **Outcome 1[5] Comprehensive and equitable health sector response to HIV** | | | | | | | |
| **Output 1.1** Development of strategies and service delivery support systems that facilitate integrated delivery of HIV interventions with other health services at all levels including community. | **Indicator 1.1.1**<br>• Level of integration within Annual Operations Planning (AOP) process at National and County levels | Need for integration identified at national level (2010) | High level of integration | Partial at national level (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.1.2**<br>• Existence of an agreed Health and HIV integration package supported by a Ministerial circular | Need for integration agreed (2010) | Integration tools and strategies rolled out | Integration tools and strategies rolled out (2011) | None | Agency and Partner reports | N/A |

[5] For PBF: Either country relevant or PMP specific.

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | **Indicator 1.1.3**<br>• Number of MOH units that have integrated HIV in their strategies and tools | None (2010) | 100% integration | Integration done in MCH, PH/FP, TB, (2011) | None | Agency and Partner reports | N/A |
| **Output 1.2**<br><br>Advocacy and development of strategies that provide a coherent health sector framework for reducing sexual transmission of HIV through the adoption of innovative and evidence based approaches | **Indicator 1.2.1**<br>• Existence of health sector policy that articulates innovative approaches to reduce sexual transmission | Revision underway (2010) | MOH health sector policy integrating HIV | Draft sector policy produced (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.2.2**<br><br>• Existence of a functional National HIV prevention revolution task force | Concept and TOR developed (2010) | Functional prevention task force | Functional Prevention Task force in place (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.2.3**<br>• Number of women and men aged 15 | 6,053, 532 (2010) | Not set | 5,917,781 (2011) | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | and older who received HIV testing and counseling in the past 12 months and know their results | | | | | | |
| | **Indicator 1.2.4**<br>• Number of male circumcisions | • 287,000 (2010) | Not set | 392,000 (2011) | None | Agency and Partner reports | N/A |
| **Output 1.3**<br>Advocacy and development of operational frameworks that facilitate delivery of integrated Health/HIV services to IDUs, mobile populations and in | **Indicator 1.3.1**<br>• Number of Universal access IDU indicators populated | • Zero out of six indicators (2010) | Not set | 4 out of 6 indicators (2011) | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| special settings are advocated for and developed. | | | | | | | |
| | **Indicator 1.3.2**<br>• Existence of strategies (implementation roadmap) for increasing HIV services to IDUs, mobile populations and in special settings | • None for IDUs (2010) | Not set | Roadmap for IDU developed (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.3.3**<br>• Number of initiatives supported to generate strategic information on IDUs, mobile populations and in special settings | • Started SI initiative on IDU (2010) | Not set | Completed SI initiative on IDU (2011 | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | **Indicator 1.3.4**<br>• Number of organizations supported to increase capacity to provide HIV services to IDUs, mobile populations and in special settings. | No data | Not set | 19 organizations to provide IDU related services (2011) | None | Agency and Partner reports | N/A |
| **Output 1.4**<br>Advocacy and development of service delivery strategies and support systems that facilitate equitable and sustainable access to quality HIV treatment and care services (including TB and malnutrition | **Indicator 1.4.1**<br>• Existence of up-to-date National ART guidelines based on evidence | Existence of up-to-date National ART guidelines based on evidence | Pilot completed | Pilot completed | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| management) | | | | | | | |
| | **Indicator 1.4.2**<br>• Existence of ART drug resistance monitoring report as part of the pharmaco-vigilance monitoring framework | • Under development (2010) | Phamaco-vigilence monitoring framework | Report finalized (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.4.3**<br>• Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission | • 61% (2010) | 0% | 65% (2011) | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | in the first 6 months | | | | | | |
| | **Indicator 1.4.4**<br>• Percentage of eligible adults and children currently receiving antiretroviral therapy | • 61% or 432621 ART patients (2010) | 80% | 72.25 % or 538,983 ART patients (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.4.5**<br>• Percentage of health facilities that provide virological testing services for diagnosis of HIV in infants on site or from dried blood spots | • 50% (2010) | 80% | 65% (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.4.6**<br>Number of ART clients receiving Nutritional support during the last 12 months. | • Not available (2010) | 80% | • 84, 330 (2011) | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| **Output 1.5** Advocacy for documentation of universal access to HIV prevention focusing on elimination of vertical transmission and HIV transmission in health care settings, testing of innovations, and national rolling out. | **Indicator 1.5.1**<br>• Percentage of HIV infected pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission | • 76% (2010) | To be determined | 69.17% (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.5.2**<br>• Existence of National eMTCT strategy | • Strategy limited to 5 pilot districts(2010) | To be determined | Development of national eMTCT strategy initiated (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 1.5.3**<br>• Number of Strategic | • PMTCT programme review done | To be determined | National KABP survey on eMTCT done (2011) | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | Information initiatives on eMTCT conducted | (2010) | | | | | |
| | **Indicator 1.5.4**<br>• Existence of annual report on eMTCT program in 5 pilot | • report done (2010) | To be determined | Report produced (2011) | None | Agency and Partner reports | N/A |
| **Outcome 2: The Multi-Sectoral Response: Keeping Human Rights and Gender at the Forefront** | | | | | | | |
| **Output 2.1**<br>Support to Ministry of Planning and Development and NACC to ensure all sectors have positioned, prioritized and financed HIV within the context of the devolved policies, structures | **Indicator 2.1.1**<br>• Percentage of Ministries that have budgeted HIV as part of the MTEF process | 95% (2009) | 100% | 100% (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 2.1.2**<br>• Number of local authorities supported to strengthen Governance and | Not available | 100% of counties and urban councils | 175 local authorities | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| and MTEF processes | Leadership on HIV and AIDS | | | | | | |
| | **Indicator 2.1.3**<br>• Existence of NACC Bill that empowers it to effectively coordinate multi-sectoral HIV response | Consultations conducted | KNAC Bill adopted | Draft bill and Cabinet paper developed and submitted to Parliament (2011) | None | Agency and Partner reports | N/A |
| | **Indicator 2.1.4**<br>• Strategic information generation initiatives undertaken to guide integration of HIV into county governance and service delivery structures | None | Position paper on HIV and the new constitution produced | Position paper on HIV and the new constitution produced | None | Agency and Partner reports | N/A |
| **Output 2.2** GOK supported to | **Indicator 2.2.1**<br>• Existence of an up-to-date | Draft | Up-to-date EHRP | Final plan disseminated (2011) | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| develop and implement a multi-sectoral framework for HIV preparedness and response in emergencies | emergency humanitarian and response plan (EHRP) | | | | | | |
| | **Indicator 2.2.2**<br>• Existence of a functional National Steering Committee on HIV in emergencies (NSC) | Consultation phase | Functional NSC | Functional committee in place | None | Agency and Partner reports | N/A |
| | **Indicator 2.2.3**<br>• Number of Strategic Information initiatives on HIV preparedness and response in emergency settings | Lack of data | Up-to-date data base | Rapid assessments completed | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| **Output 2.3** Gender mainstreamed and audited in the national HIV response. | **Indicator 2.3.1**<br>• Existence of functioning National Gender Technical Committee on HIV response | Partially functional | Fully functional TWG | Fully functional | None | Agency and Partner reports | N/A |
| | **Indicator 2.3.2**<br>• Existence of up-to-date Gender implementation strategy for mainstreaming HIV and AIDS | Developed (2010) | Up to date | Finalized and disseminated | None | Agency and Partner reports | N/A |
| | **Indicator 2.3.3**<br>• Number of strategic information initiatives to inform gender mainstreaming in HIV response | Not available (2010) | Not set | 3 policy briefs | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | **Indicator 2.3.4**<br>• Existence of fully functional networks for PHLIV | NEPHAK'w weak institutional structures | 100 % GIPA | NEPHAK effectively functional | None | Agency and Partner reports | N/A |
| **Output 2.4** Public, Civil society organizations and private sector supported to develop and implement evidence-based sectoral/workplace HIV and AIDS non-discriminating policies | **Indicator 2.4.1**<br>• Stigma and discrimination index | None (2010) | Not set | TOR for consultant developed | None | Agency and Partner reports | N/A |
| | **Indicator 2.4.2**<br>• Number of strategic information initiatives undertaken to inform sectoral HIV and AIDS mainstreaming | Not available | Not set | 8 research/ evaluations completed | None | Agency and Partner reports | N/A |
| | **Indicator 2.4.3**<br>• Number of organizations adopting HIV and AIDS | Not available | Not set | Not yet achieved | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | policies and guidelines in compliance to ILO recommendations no. 200 | | | | | | |
| | **Indicator 2.4.4**<br>• Number of organizations whose capacity was strengthened towards operationalizing ILO recommendations no.200 | Not available | Not set | 14 organizations) | None | Agency and Partner reports | N/A |
| **Output 2.5** Mainstreaming HIV interventions for young people | **Indicator 2.5.1**<br>• Number of youth organizations that benefited from UN-supported HIV mainstreaming | Not available (2010) | Not set | Not available | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | interventions | | | | | | |
| | **Indicator 2.5.2**<br>• Number of young people reached through the NYTA program | Not available (2010) | Not set | Not available | None | Agency and Partner reports | N/A |
| **Outcome 3:** | | | | | | | |
| **Output 3.1** Pillar III Conveners operationalised HIV coordination and accountability structures at national level. | **Indicator 3.1.1**<br>Monthly Pillar III meetings conducted at National level | Zero2010 | Quarterly meetings | 22 Pillar III coordination meetings | None | Agency and Partner reports | N/A |
| | **Indicator 3.1.2** Annual M&E-centric JAPR conducted | (Not M&E-centric 2010) | 100% M&E centric | M&E-centric JAPR conducted | None | Agency and Partner reports | N/A |
| **Output 3.2** Community HIV related data harmonized and available for analysis & use at the national level | **Indicator 3.2.1** Existence of annual County HIV profiles | zero 2010) | County profiles | Draft concept developed | None | Agency and Partner reports | N/A |
| | **Indicator 3.2.2** Percentage of counties enforcing the HIV code of conduct among | zero 2010) | Full enforcement | Code of conduct disseminated | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | CSOs | | | | | | |
| | **Indicator 3.2.3** Percentage of counties using KNASP Tracking tools for reporting | zero 2010) | Online reporting system | Computerization of COBPAR completed | None | Agency and Partner reports | N/A |
| **Output 3.3** Strategic information on HIV social protection programs generated and integrated into the Kenya National Social protection framework and gaps arising addressed at national and sub-national levels | **Indicator 3.3.1** Percentage of households with OVC aged 0-17 who received external support in the last 12 months preceding the survey | (21.4% 2007) | Not set | Indicator included in KAIS III protocol | None | Agency and Partner reports | N/A |
| | **Indicator 3.3.2** Number of households benefiting from cash transfer for OVC programs | (85,891 in 2010) | Not set | 129,526 in 2011 | None | Agency and Partner reports | N/A |
| | **Indicator 3.3.3** GOK budget allocation to cash transfer for OVC programs | (833Ksh million 2010) | Not set | 1.26 Ksh billion in 2011 | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| | **Indicator 3.3.4** Number of NGOs supported to promote life skills among vulnerable women and men in communities affected by post election violence | Zero 2010 | Not set | 6 NGOs through farmers Field program | None | Agency and Partner reports | N/A |
| **Output 3.4** An HIV framework that outlines support to communities to demand accountability across sectors, mobilize resources at decentralized levels and ensures PLHIV involvement within community and decentralized coordinating | **Indicator 3.4.1** Existence of County planning and budgeting guidelines that have integrated HIV | Zero 2010 | 100% of counties | Paper on devolution to understand county structures developed | None | Agency and Partner reports | N/A |
| | **Indicator 3.4.2** Percentage of counties enforcing the HIV code of conduct among CSOs | Zero 2010 | Full enforcement | Code of conduct disseminated | None | Agency and Partner reports | N/A |
| | **Indicator 3.4.3** Existence of Community AIDS Competence framework | Zero 2010 | Community AIDS Competence framework | TORs developed and consensus brokered | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| structures is developed and implemented in a number of settings. | | | | | | | |
| **Outcome 4:** By 2013 Government of Kenya has demonstrated leadership through increased domestic finance for HIV and strengthened governance and accountability structures for the HIV response | | | | | | | |
| **Output 4.1:** Strategy (vision) and capacity for improved governance and pillar coordination to review and report on KNASP III implementation progress developed. | **Indicator 4.1.1** Percentage of constituencies with functional AIDS coordinating committees | Zero 2010 | 100% | Code of conduct disseminated | None | Agency and Partner reports | N/A |
| | **Indicator 4.1.2** Annual meeting of permanent secretaries to deliberate on HIV and AIDS and make recommendations to Cabinet Committee. | Zero 2010 | Annual meetings held | 1 annual meeting held | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| **Output 4.2:** The multisectoral response maintained in the devolved system with (i) implementation of Institutional review recommendations and (ii) monitoring & evaluation and accountability improved through performance reviews including JAPR. | **Indicator 4.2.1** Stakeholder satisfaction with NACC as shown in the annual stakeholder satisfaction survey | 58% (2009) | 100% | 65% (2010) | None | Agency and Partner reports | N/A |
| | **Indicator 4.2.2** Percentage of constituencies with functional AIDS committees | 100% in constituencies (2010) | 100% | 100% in constituencies | None | Agency and Partner reports | N/A |
| **Output 4.3:** Improved evidence into policy and practice and to guide KNASP III | **Indicator 4.3.1** Number of Public sectors presenting sector HIV reports during JAPR | One-Health sector (2010) | 100% | One-Health sector | None | Agency and Partner reports | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| and development of KNASP IV made available. | **Indicator 4.3.2** Existence of county HIV fact sheets to inform planning and resource allocation | (zero 2010) | County profiles in existence | County estimates produced | None | Agency and Partner reports | N/A |
| **Output 4.4:** Leadership and advocacy for prevention strengthened, including efforts to ensure non criminalization of HIV and no adoption of punitive laws | **Indicator 4.4.1** Existence of functional HIV tribunal | Establishment of tribunal not complete (2010) | Functional tribunal established | Functional HIV tribunal launched | None | Agency and Partner reports | N/A |
| | **Indicator 4.4.2** Existence of functional HIV prevention revolution task force | Weak HIV prevention TWG (2010) | Fully functional HIV prevention TWG | Fully functional HIV prevention TWG | None | Agency and Partner reports | N/A |
| **Output 4.5:** National sustainable HIV financing strategy to coordinate HIV resources endorsed by cabinet and HIV Trust Fund established | **Indicator 4.5.1:** Kenya domestic and international contribution to AIDS spending by categories and financing sources | 14% domestic contribution (2009) | To be determined | 17% domestic contribution) | None | Agency and Partner reports | N/A |
| | **Indicator 4.5.2:** Percentage of budget | Less than 10% (2009) | To be determined | Less than 10% | None | Agency and Partner | N/A |

| | Performance Indicators | Indicator Baselines | Planned Indicator Targets | Achieved Indicator Targets | Reasons for Variance (if any) | Source of Verification | Comments (if any) |
|---|---|---|---|---|---|---|---|
| resulting in increased domestic resources. | allocated to health | | | | | reports | |
| | **Indicator 4.5.3:** Percentage of ministries with HIV budget | 95% (2010) | 100% | 100% | None | Agency and Partner reports | N/A |
| | **Indicator 4.5.4:** GFATM ranking of grant performance | B2 (2010) | To be determined | A1 | None | Agency and Partner reports | N/A |
| | | | | | | | |

# VI. Joint UN Programme of Support for HIV/AIDS in Kenya
# Part II: Annual Consolidated Financial Report

## 1. Source and Use of Funds

Table 1 provides an overview of the overall sources, uses, and balance of the HIV/AIDS Joint Programme in Kenya as of 31 December 2011. By the end of 2011, total contributions of US$ 13.99 million have been received from the United Kingdom Department for International Development (DFID). Additionally, US$ 63,936 has been earned in interest, bringing the cumulative amount of programmable resources to US$ 14.05 million. Out of US$ 14.05 million available for programming, US$ 11.65 million has been transferred to the Participating Organizations.

***Table 1: Financial Overview for the period ending 31 December 2011 (in US Dollars)***

| | Prior Years as of 31 Dec 2010 | Current Year Jan-Dec 2011 | TOTAL |
|---|---|---|---|
| **Sources of Funds** | | | |
| Gross Donor Contributions | 9, 936,172 | 4, 052,587 | 13, 988,760 |
| Fund Earned Interest Income | 27,680 | 12,214 | 39,894 |
| Interest Income received from Participating Organizations | 19,762 | 4,280 | 24,042 |
| Refunds by Administrative Agent (Interest/Others) | - | - | - |
| Other Revenues | - | - | - |
| **Total: Sources of Funds** | 9, 983,615 | 4, 069, 081 | 14, 052,696 |
| **Use of Funds** | | | |
| Transfer to Participating Organizations | 9, 836,809 | 1, 813,640 | 11, 650,449 |
| Refunds received from Participating Organizations | - | - | - |
| **Net Funded Amount to Parti Organizations** | 9, 836,809 | 1, 813,640 | 11, 650,449 |
| Administrative Agent Fees | 99,362 | 40,526 | 139,888 |
| Direct Costs | - | - | - |
| Bank Charges | - | 83 | 83 |
| Other Expenditures | - | - | - |
| **Total: Uses of Funds** | 9, 936,171 | 1, 854,249 | 11, 790,420 |
| **Balance of Funds Available with Administrative Agent** | **47, 444** | **2, 214,832** | **2, 262,276** |
| Net Funded Amount to Participating Organizations | 9, 836,809 | 1, 813,640 | 11, 650,449 |
| Participating Organizations' Expenditure | 6, 590,437 | 1, 955,421 | 8, 545,857 |
| **Balance of Funds with Participating Organizations** | **3, 246,372** | **(141,781)** | **3, 104,592** |

Apart from donor contributions, the Joint Programme also receives funds from interest income earned on the balance of funds. 'Fund earned interest' comprises two sources of interest income: (1) interest earned on the balance of funds held by the Administrative Agent; and (2) interest earned on the balance of funds held by Participating Organizations where the Financial Regulations and Rules of the Participating Organization permit remittance of interest.

As shown in Table 1, by the end of 2011, the Joint Programme earned interest amounted to US$ 39,894 and interest income from Participating Organizations was US$ 24,042 for a

cumulative total interest of US$ 63,936.

The Administrative Agent fee is charged at the standard rate of 1 percent of donor contributions received. As of 31 December 2011, the cumulative AA fees charged to the Joint Programme total US$ 139,888.

## 2. Donor contributions

Table 2 shows that the Joint Programme is currently being financed by one donor that signed the SAA, namely DFID. In 2011 US$ 4.05 million have been received in donor contributions, bringing the total fund contribution of DFID to US$ 13.99 million.

***Table 2: Donor Deposits (in US Dollars)***

| | **Prior Years as of 31 Dec 2010** | **Current Year Jan-Dec 2011** | **TOTAL** |
|---|---|---|---|
| DEPARTMENT FOR INT'L DEVELOPMENT (DFID) | 9, 936,172 | 4, 052,587 | 13, 988,760 |
| **Total** | **9, 936,172** | **4, 052,587** | **13, 988,760** |

## 3. Transfer of Funds

Donor contributions are the main source of funding of the Joint Programme. In 2011, a total of US$ 1.81 million has been transferred to Participating Organizations, as shown in Table 1.

The distribution of approved funding, consolidated by Participating Organization is summarized in Table 3. The term "Net funded amount" refers to amounts transferred to a Participating Organization minus refunds of unspent balances from the Participating Organization.

Since 2008 thirteen Participating Organizations received funding. In 2011 the Net Funded Amount was US$ 1.81 million, bringing the cumulative net funded amount to US$ 11.65 million. The distribution of net funding consolidated by Participating Organization is summarized in Table 3.

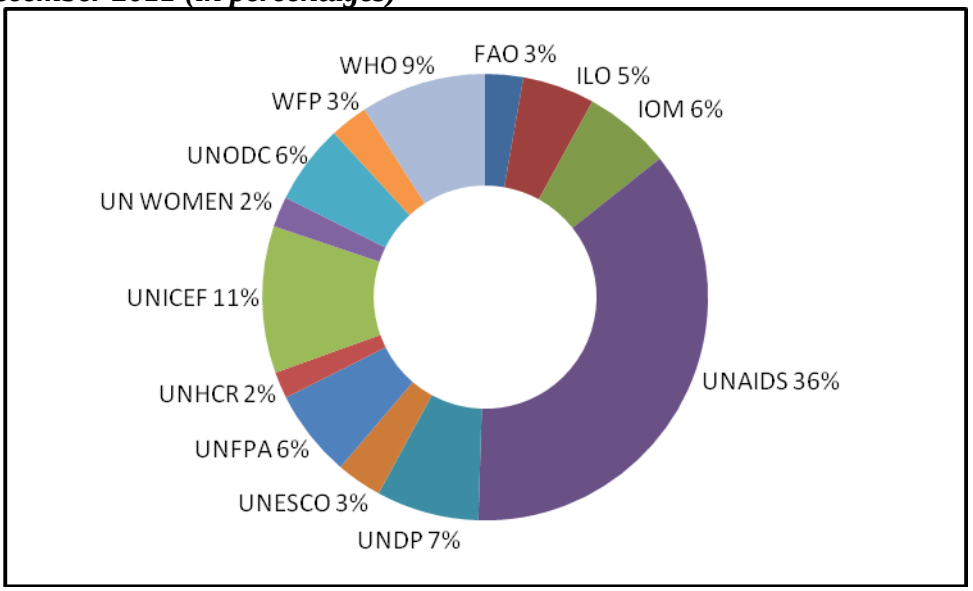
***Table 3: Transfers/ Net Funded Amount by Participating Organization (in US Dollars)***

| Participating Organization | Prior Years as of 31 Dec 2010 | | Current Year Jan-Dec 2011 | | TOTAL | |
|---|---|---|---|---|---|---|
| | Approved Amount | Net Funded Amount | Approved Amount | Net Funded Amount | Approved Amount | Net Funded Amount |
| FAO | 675,000 | 675,000 | 50,000 | 50,000 | 725,000 | 725,000 |
| ILO | 100,000 | 100,000 | 95,000 | 95,000 | 195,000 | 195,000 |
| IOM | 291,200 | 291,200 | 115,000 | 115,000 | 406,200 | 406,200 |
| UNAIDS | 2,407,109 | 2,407,109 | 655,640 | 655,640 | 3,062,749 | 3,062,749 |
| UNDP | 404,200 | 404,200 | 135,000 | 135,000 | 539,200 | 539,200 |
| UNESCO | 100,000 | 100,000 | 60,000 | 60,000 | 160,000 | 160,000 |
| UNFPA | 1,554,820 | 1,554,820 | 115,000 | 115,000 | 1,669,820 | 1,669,820 |
| UNHCR | - | - | 35,000 | 35,000 | 35,000 | 35,000 |
| UNICEF | 1,637,180 | 1,637,180 | 193,000 | 193,000 | 1,830,180 | 1,830,180 |
| UNODC | 973,500 | 973,500 | 105,000 | 105,000 | 1,078,500 | 1,078,500 |
| UN WOMEN | 70,000 | 70,000 | 40,000 | 40,000 | 110,000 | 110,000 |
| WFP | 323,800 | 323,800 | 50,000 | 50,000 | 373,800 | 373,800 |
| WHO | 1,300,000 | 1,300,000 | 165,000 | 165,000 | 1,465,000 | 1,465,000 |
| **Total** | **9,836,809** | **9,836,809** | **1,813,640** | **1,813,640** | **11,650,449** | **11,650,449** |

On a cumulative basis for 2008-2011, UNAIDS received the largest share of funding (US$ 3.06 million or 26 percent of the total) followed by UNICEF, UNFPA and WHO receiving US$ 1.83 million (15 percent), US$ 1.67 million (14 percent) and US$ 1.47 million (13 percent) respectively.

As shown in Table 3 and Figure 1 below, in 2011 UNAIDS received the largest share of funding (US$ 655,640 or 36 percent), followed by UNICEF (US$ 193,000 or 11 percent), and WHO (US$ 165,000 or 9 percent).

***Figure 1: Net funded amount by Participating Organization for the period of 1 January to 31 December 2011 (in percentages)***



## 4. Expenditure Reported by Participating Organizations

Project expenditures are incurred and monitored by each Participating Organization and are reported as per the six categories for inter-agency harmonized reporting of expenditure approved by the UN Development Group (UNDG) organizations. The reported expenditures were submitted to the MPTF Office by the Participating Organizations via the UNEX - the MPTF Office's expenditure reporting tool. The 2011 expenditure data has been posted on the MPTF Office GATEWAY and can be found in this report in Tables 4.1, 4.2, 4.3 and 4.4.

### 4.1. Financial Delivery Rate

Table 4.1 below reflects the percentage delivery (cumulative) measured against total funds received by the Participating UN Organizations for the period up to 31 December 2011. The cumulative delivery rate was 73 percent, which is 6 percent higher than last year's cumulative delivery rate.

***Table 4.1 Financial Delivery Rate (in US Dollars)***

| Net Funded Amount | Expenditure | | | Delivery Rate ( % ) |
|---|---|---|---|---|
| | Prior Years as of 31 Dec 2010 | Current Year Jan-Dec 2011 | Total | |
| **11, 650,449** | 6, 590,437 | 1, 955,421 | 8, 545,857 | 73.35 |
| **11, 650,449** | **6, 590,437** | **1, 955,421** | **8, 545,857** | **73.35** |

### 4.2. Total Expenditure Reported by Category

Table 4.2 shows the Joint Programme expenditure in six categories agreed to by the UNDG organizations. The highest amounts of cumulative (combined prior years and 2011) expenditure were: Contracts (50 percent) and Personnel (29 percent), followed by Supplies, Commodities, Equipment and Transport (10 percent), Training of Counterparts (8 percent) and Other Direct Costs (3 percent).

***Table 4.2 Total Expenditure by Category (in US Dollars)***

| Category | Expenditure | | | % of Total Programme Costs |
|---|---|---|---|---|
| | Prior Years as of 31 Dec 2010 | Current Year Jan-Dec 2011 | Total | |
| Supplies, Commodities, Equipment and Transport | 690,694 | 111,249 | 801,943 | 10 |
| Personnel | 1, 751,957 | 605,153 | 2, 357,110 | 29 |
| Training of Counterparts | 443,623 | 203,874 | 647,497 | 8 |
| Contracts | 3, 027,240 | 980,283 | 4, 007,523 | 50 |
| Other Direct Costs | 226,129 | 10,017 | 236,147 | 3 |
| **Programme Costs Total** | **6, 139,644** | **1, 910,576** | **8, 050,220** | **100** |
| Indirect Support Costs | 450,793 | 44,845 | 495,637 | 6 |
| **Total** | **6,590,437** | **1, 955,421** | **8, 545,857** | |

### 4.3. Financial Delivery Rate by Participating Organization

As reflected in table 4.3, UNHCR reported the highest delivery rate (100 percent) followed by WFP (91percent) and FAO (86 percent).

***Table 4.3. Financial Delivery Rate by Participating Organization (in US Dollars)***

| Participating Organization | Total Approved Amount | Net Funded Amount | Total Expenditure | Delivery Rate (%) |
|---|---|---|---|---|
| FAO | 790,000 | 725,000 | 621,216 | 86 |
| ILO | 235,000 | 195,000 | 62,140 | 32 |
| IOM | 455,200 | 406,200 | 250,934 | 62 |
| UNAIDS | 4, 082,944 | 3, 062,749 | 2, 231,467 | 73 |
| UNODC | 1, 288,500 | 1, 078,500 | 904,679 | 84 |
| UNESCO | 190,000 | 160,000 | 83,115 | 52 |
| UNFPA | 1, 889,820 | 1, 669,820 | 1, 248,728 | 75 |
| UNHCR | 35,000 | 35,000 | 35,000 | 100 |
| UNICEF | 2, 040,180 | 1, 830,180 | 1, 302,507 | 71 |
| UN WOMEN | 155,000 | 110,000 | 17,233 | 16 |
| WFP | 441,800 | 373,800 | 341,632 | 91 |
| WHO | 1, 610,764 | 1, 465,000 | 1, 194,436 | 82 |
| UNDP | 602,200 | 539,200 | 252,771 | 47 |
| | **13, 816,408** | **11, 650,449** | **8, 545,857** | **73** |

### 4.4. Cumulative Expenditure of Participating Organizations, with breakdown by Category

Cumulative expenditure reported by Participating Organizations are shown in six categories in Table 4.4

***Table 4.4. Total Expenditure by Participating Organization, with breakdown by Category, as of 31 December 2011 (in US Dollars)***

| Participating Organization | Net Funded Amount | Total Expen-diture | Expenditure by Category | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Supplies, Commodities, Equip & Transport | Personnel | Training of Counter-parts | Contracts | Other Direct Costs | Total Programme Costs | Indirect Support Costs | % of Programme Costs |
| FAO | 725,000 | 621,216 | 65,406 | 122,505 | 245,519 | 133,431 | 13,714 | 580,576 | 40,640 | 7.00 |
| ILO | 195,000 | 62,140 | - | - | - | 58,075 | - | 58,075 | 4,065 | 7.00 |
| IOM | 406,200 | 250,934 | 5,504 | 99,310 | - | 129,704 | (1) | 234,517 | 16,417 | 7.00 |
| UNAIDS | 3, 062,749 | 2, 231,467 | - | 928,851 | 23,747 | 1,214,966 | - | 2,167,564 | 63,903 | 2.95 |
| UNDP | 539,200 | 252,771 | - | 149,694 | 13,999 | 10,832 | 67,938 | 242,464 | 10,307 | 4.25 |
| UNESCO | 160,000 | 83,115 | 3,587 | 49,089 | 18,300 | 6,702 | - | 77,678 | 5,437 | 7.00 |
| UNFPA | 1, 669,820 | 1, 248,728 | 505,662 | 241,032 | 201,272 | 68,100 | 150,378 | 1,166,444 | 82,284 | 7.05 |
| UNHCR | 35,000 | 35,000 | 7,520 | 10,798 | 7,848 | 2,545 | 3,999 | 32,710 | 2,290 | 7.00 |
| UNICEF | 1, 830,180 | 1, 302,507 | 45,475 | 243,091 | 3,348 | 923,698 | 1,685 | 1,217,296 | 85,211 | 7.00 |
| UNODC | 1, 078,500 | 904,679 | 28,133 | 212,221 | 125,653 | 449,138 | 30,772 | 845,917 | 58,762 | 6.95 |
| UN WOMEN | 110,000 | 17,233 | - | 10,037 | - | - | - | 10,037 | 7,196 | 71.70 |
| WFP | 373,800 | 341,632 | 139,799 | 90,313 | 7,809 | 43,251 | 36,006 | 317,177 | 24,454 | 7.71 |
| WHO | 1, 465,000 | 1, 194,436 | 858 | 200,170 | - | 967,082 | (68,345) | 1,099,765 | 94,671 | 8.61 |
| **Total** | **11,650,449** | **8, 545,857** | **801,943** | **2,357,110** | **647, 497** | **4,007,523** | **236,147** | **8,050,220** | **495,637** | **6.16** |

As shown in Table 4.4, UNAIDS reported the highest amount of expenditure in the Joint Programme, amounting to 26 percent of the total reported expenditure, followed by UNICEF (15 percent), UNFPA (15 percent) and WHO (14 percent).

## 5. Accountability and transparency

The MPTF Office GATEWAY (http://mptf.undp.org) has been further enhanced and continues to serve as a knowledge platform providing real-time data, with a maximum two-hour delay, on financial information from the MPTF Office accounting system on donor contributions, programme budgets and transfers to Participating UN Organizations. All narrative reports are published on the MPTF Office GATEWAY, which provides easy access to over 8,000 relevant reports and documents, with tools and tables displaying financial and programme data. By providing easy access to the growing number of progress reports and related documents uploaded by users in the field, the site facilitates knowledge sharing and management among UN Organizations. It is designed to provide transparent, accountable fund-management services to the UN system to enhance its coherence, effectiveness and efficiency. The MPTF Office GATEWAY has been recognized as a 'standard setter' by peers and partners**.**

Information on the operations of the HIV/AIDS Joint Programme in Kenya are available at the HIV/AIDS JP Kenya website on the MPTF Office GATEWAY at http://mptf.undp.org/factsheet/fund/JKE00.