MONITORING & EVALUATION FRAMEWORK

FOR THE SECOND KENYA AIDS STRATEGIC FRAMEWORK

2020/21-2024/25

What gets measured, gets done.

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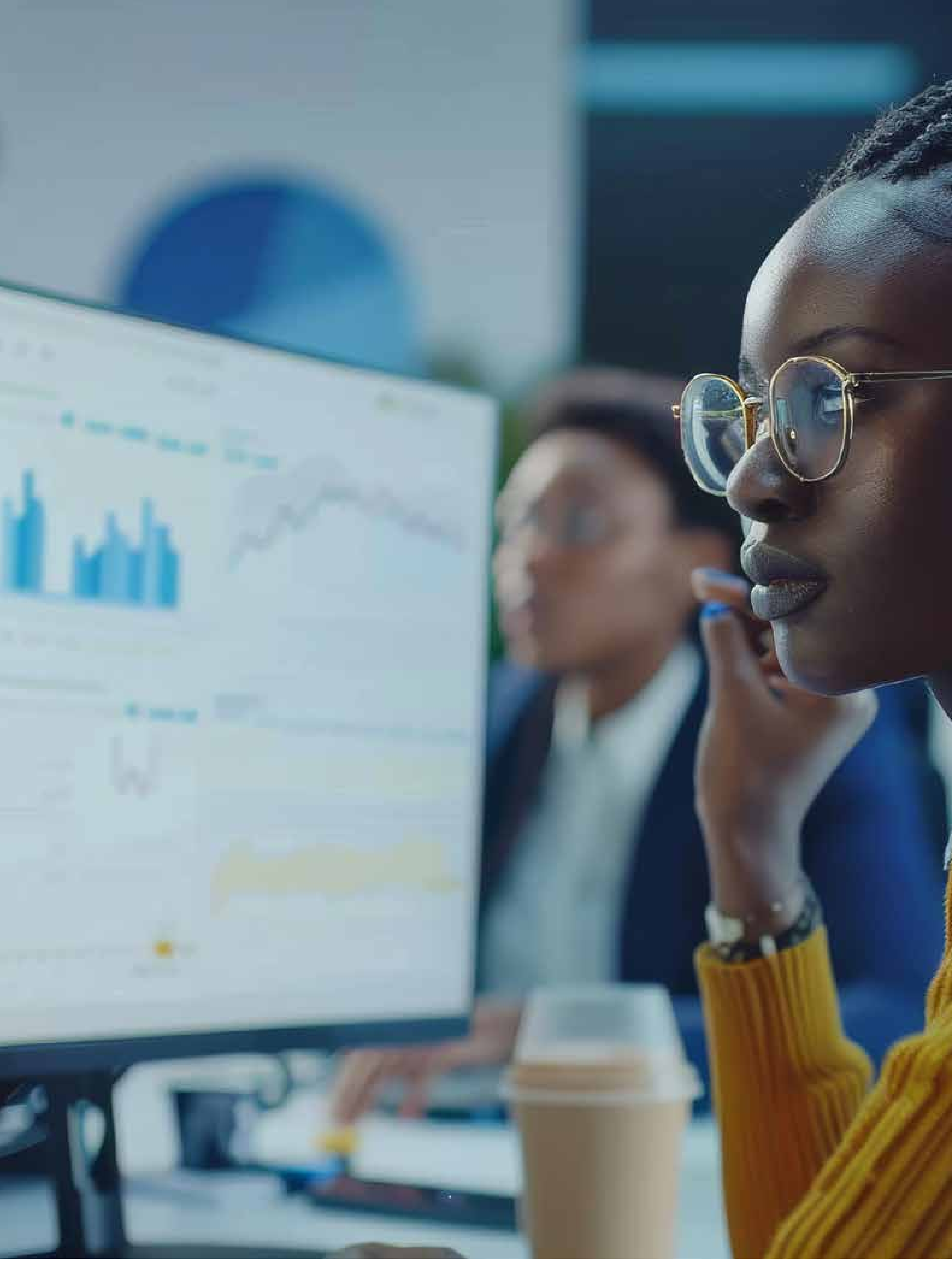


TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS iv

FOREWORD........ vii

ACKNOWLEDGEMENT viii

Section 1: **Introduction** 1

1.1 Background 1

1.2 Objectives of the M&E Framework 1

1.3 Guiding Principles of the M&E Framework 1

1.4 Process of Developing the Framework........ 2

Section 2: **Core KASF II Indicators**........ 4

2.1 KASF II Impact Level Results (ILR) and Indicators........ 5

2.2 Indicators for KASF II Thematic Areas 7

2.2.1 Thematic Area 1: Universal access to comprehensive, quality, and integrated HIV and Sexually transmitted infections prevention services........ 7

2.2.2 Thematic Area 2: Revitalise shared fast track commitment towards achieving of treatment targets 10

2.2.3 Thematic Area 3: Protect the rights of people to live a life free of violence, stigma and discrimination 12

2.2.4 Thematic Area 4: Invest in resilient systems for HIV and other health outcomes........ 14

2.2.5 Thematic Area 5: Leverage on communities led programmes for an effective HIV response. 15

2.2.6 Thematic Area 6: Integrate HIV in humanitarian and emergency responses 16

2.2.7 Thematic Area 7: Promote translation of strategic information, research, surveillance, innovations and implementation of science to inform HIV programming........ 17

2.2.8 Thematic Area 8: Invest in Long-term HIV financing models 19

2.2.9 Thematic Area 9: Promote Leadership, Communication and Advocacy........ 21

Section 3: **Routine Data Collection & Reporting** 24

3.1 KASF II Data Architecture........ 25

3.2 Kenya HIV and Health Situation Room 25

3.3 M&E Sub-systems 25

3.3.1 Monitoring and Reporting System for Health Sector Response 26

3.3.1.1 Overview of HMIS AND LMIS 26

3.3.2 Monitoring and Reporting System for Community-Based HIV Response 27

3.3.2.1 Overview of the Community-Based HIV Information System........ 27

3.3.2.2 The Community Based HIV Information System (CHIS) interface with the community and county health information systems........ 28

3.3.3 Monitoring and Reporting system for Public Sector HIV Response........ 28

3.3.3.1 Overview of Public Sector HIV Information System 27

3.3.4 Monitoring and Reporting System for Public Sector Hiv Response....30
3.3.4.1 Overview of Public Sector Hiv Information System....30
Section 4: **Surveys, Surveillance and Evaluations 34**
4.1 Surveys....35
4.1.1 Kenya Demographic and Health Survey (KDHS)....35
4.1.2 Kenya Population-based HIV Impact Assessment (KENPHIA)....35
4.1.3 Integrated Biological and Behavioural Survey (IBBS) 35
4.1.4 HIV-Related Stigma and Discrimination Survey....35
4.1.5 Key and Priority Populations Size Estimation....35
4.1.6 Kenya National AIDS Spending Assessment (KNASA)....35
4.1.7 Harmonized Health Facility Assessment 35
4.2 HIV Surveillance 36
4.2.1 ANC Sentinel Surveillance....36
4.2.2 Routine PMTCT Data for Surveillance....36
4.2.3 HIV Drug Resistance Surveillance....36
4.2.4 Demographic Surveillance Surveys....36
4.3 HIV Epidemic Modelling for Estimation....36
4.3.1 National HIV Estimates 36
4.3.2 Modes of Transmission Study 36
4.3.3 Evaluations....36
4.3.4 Programme Evaluation....36
4.3.5 Mid-Term Evaluation of KASF....37
4.3.6 End-Term Evaluation of the KASF....37
4.4 Timeframes for the Surveys, Evaluations and Surveillance....38
Section 5: **Monitoring and Evaluations Coordination 40**
5.1 KASF II Monitoring 41
5.2 KASF II Evaluations.... 41
5.3 Institutional Arrangements for M&E Coordination.... 41
TECHNICAL COORDINATION MECHANISMS....42
5.3.1 NATIONAL STRATEGIC INFORMATION RESEARCH AND INNOVATION TECHNICAL WORKING GROUPS (SIRI/SI TWG)....42
5.3.2 COUNTY MULTI-SECTOR COORDINATION CommitteeS (MCC)....42
5.3.3 ICCs at National and County Levels....43
Section 6: **Monitoring and Evaluations System Capacity and Performance Assessment Framework.... 46**
ANNEX 1: M&E PRODUCTS AND FEEDBACK MECHANISMS 52
ANNEX 2: KASF II M&E RESULTS FRAMEWORK....53
LIST OF CONTRIBUTORS....60
COUNTY REPRESENTATIVES....61

ABBREVIATIONS AND ACRONYMS

ACT	Accelerated Care and Treatment
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
aPNS	Assisted Partner Notification Services
ART	Antiretroviral Treatment/Therapy
AYP	Adolescent and Young People
BCC	Behaviour Change Communication
BSS	Behavioral Surveillance Survey
CAC	County AIDS Coordinator
CASCO	County AIDS and STI Coordinator
CAIP	County AIDS Implementation Plan
CAPR	Community Activities Programme Reporting
CBIS	Community-Based Information System
CBHIS	Community Based Health Information System
CBO	Community-Based Organization
CHA	Community Health Assistant
CHC	County HIV Committee
CHEW	Community Health Extension Worker
CHIS	County Health Information System
CHV	Community Health Volunteers
CHW	Community Health Worker
CIDP	County Integrated Development Plan
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
DATIM	Data for Accountability, Transparency and Impact Monitoring
DDIU	Data Demand and Information Use
DHIS	District Health Information System
EID	Early Infant Diagnosis
GAM	Global AIDS Monitoring Report
DQA	Data Quality Assurance
ECHO	Extended Community Health Outcomes
EMR	Electronic Medical Record
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith-Based organizations
FC	Faith Communities
GARPR	Global AIDS Response Progress Reporting
GBV	Gender Based Violence

HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System(s)
HPV	Human Papilloma Virus
HRH	Human Resource for Health
HTS	HIV testing and Services
IBBS	Integrated Biological and Behavioural Survey
ICC	Interagency Coordinating Committee
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
KAIS	Kenya AIDS Indicator Survey
KAM	Kenya Association of Manufacturers
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KENPHIA	Kenya Population-based HIV Impact Assessment
KEPI	Kenya Expanded Programme for Immunization
KEPSA	Kenya Private Sector Alliance
KHIS	Kenya Health Information System
KHSA	Kenya Health System Assessment Report
KMLTTB	Kenya Medical Laboratory Technicians and Technologists Board
KMTC	Kenya Medical Training College
KNASA	Kenya National AIDS Spending Assessment
KNBS	Kenya National Bureau of Statistics
KNHCR	Kenya National Commission for Human Rights
KP	Key Population
LISTEN	Local Innovations Scaled Through Enterprise Network
LMIS	Logistics Management Information System
M & E	Monitoring and Evaluation
MCDA	Multi-Criteria Decision Analysis
MDAs	Ministries, Departments, and Agencies
MOE	Ministry of Education
MoH	Ministry of Health
MSM	Men Who Have Sex With men
MTEF	Medium-Term Expenditure Framework
NSDCC	National Syndemic Diseases Control Council
NASA	National AIDS Spending Assessment
NASCOP	National AIDS and STI Control Programme
NCDs	Non-Communicable Diseases
NCPD	National Council for Population and Development

NCPI	National Composite Policy Instrument
NGO	Non-Government Organisation
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
PBS	Polling Booth Survey
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PETS	Public Expenditure Tracking System
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
POC	Point of Care
POCT	Point-of-Care Testing
PrEP	Pre-Exposure Prophylaxis
PSHIS	Private Sector HIV Information System
PWDs	Persons with Disabilities
PWIDS	People Who Inject Drugs
R&D	Research and Development
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SARAM	Service Availability and Readiness Assessment
SD	Strategic Direction
SDGA	State Department of Gender Affairs
SGBV	Sexual Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TWG	Technical Working Group
UHC	Universal Health Coverage
UHRIS	Unified HIV Response Information System
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USG	United States Government
VAC	Violence Against Children
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
TB	Tuberculosis
KMoT	Kenya Modes of Transmission
KHHSR	Kenya HIV and Health Situation Room
ILR	Impact Level Report

FOREWORD

This framework is aligned to the *'Three Ones Principle'* and is applicable to all stakeholders in the HIV field. It is standardized for adherence to reporting through the various M&E subsystems on core indicators monitoring the performance of KASFII. The framework is a coordination blueprint that provides data requirements, management protocols, feedback mechanisms in addition to defining roles and responsibilities of different stakeholders for effective tracking of KASFII implementation at national and county levels.

One of the main principles and goals of this framework is to promote transparency and mutual accountability among stakeholders. Coordination of the M&E framework's implementation will be done by the National Syndemic Diseases Control Council (NSDCC) through seven (7) KASFII coordination committees with a multisectoral composition, responsible for monitoring progress and evaluating outcomes of targeted results depicted with in the KASFII. Timely and accurate reporting on the status of KASFII implementation will show commitment towards ending the AIDS epidemic by 2030.

I call upon all sectors, stakeholders and partners to adopt this national HIV Monitoring and Evaluation framework from which all HIV expected results and strategies will be measure.

Mr. Geofrey Gitu
Chairperson
National Syndemic Diseases Control Council

ACKNOWLEDGEMENT

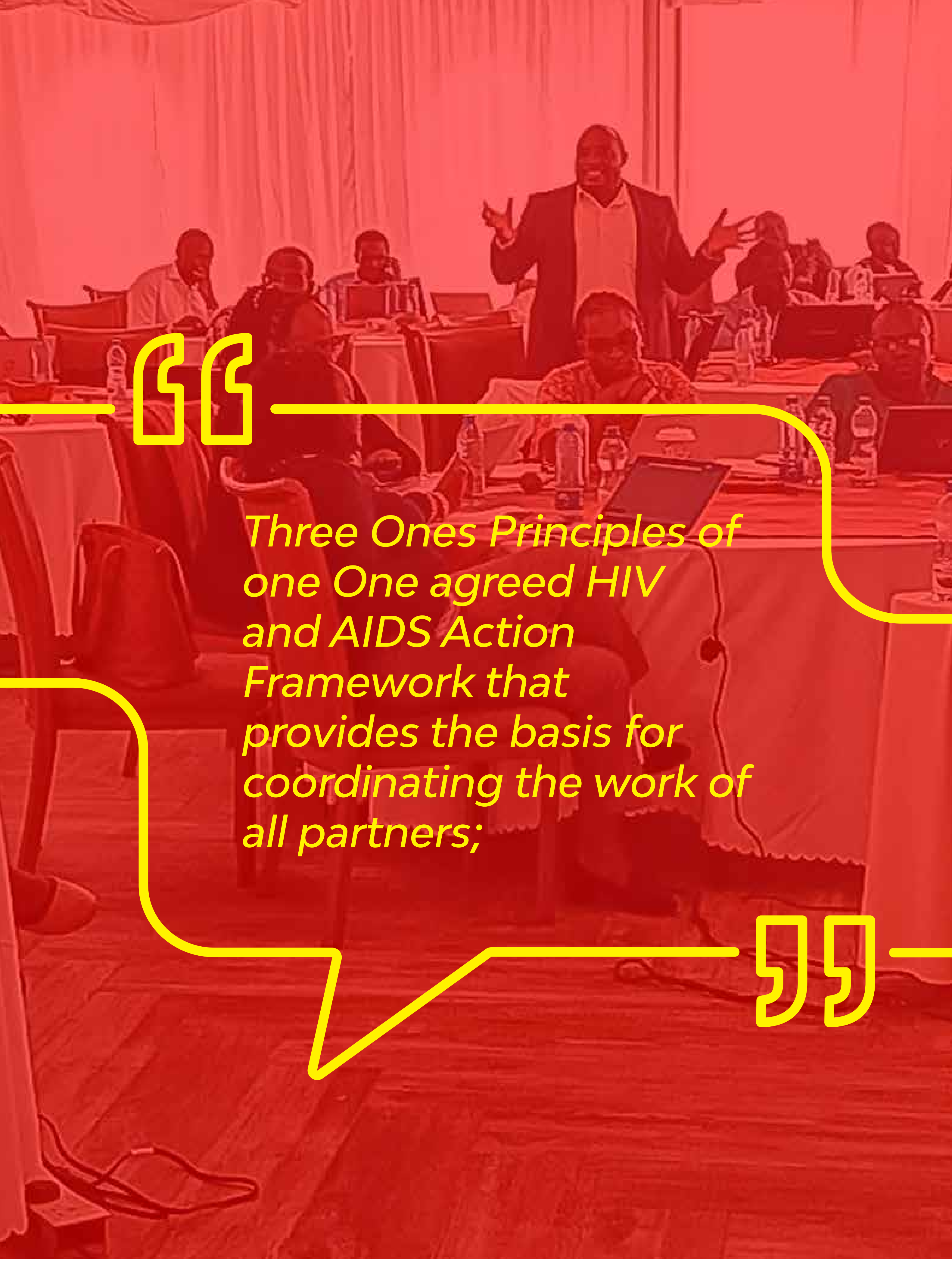
Development of this framework was undertaken through a wide participatory and consultative process. The National Syndemic Diseases Control Council would like to acknowledge the contribution of the National and County governments, development and implementing partners and all the communities for their invaluable technical support and financial resources in the development of this framework.

This endeavor would not have been possible without the KASF Strategic Information working group, comprising of experts from different institutions, who went out of their way to ensure this M&E framework was completed. Please see the complete list in the annex.

I acknowledge the contribution of Joshua Gitonga and Dr. Lily Muthoni, the Head of Strategic Information at the NSDCC and NASCOP respectively, for steering the process of development of this framework.

Finally, I would like to thank the editors, reviewers, designers, and printing firm that supported the delivery of this Monitoring and evaluation framework.

Dr. Ruth Laibon- Masha
Chief Executive Officer
National Syndemic Diseases Control Council


Three Ones Principles of one One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners;

Section 1:
Introduction

Monitoring and Evaluation (M&E) is an indispensable aspect of the Second Kenya AIDS Strategic Framework (KASF II) 2020/21-2024/25. It aims to ensure that priority HIV response actions outlined in the KASF II are implemented as planned against stated objectives and desired results towards a Kenya free of HIV infections, stigma and AIDS related deaths. The M&E framework will therefore guide the gathering and management of all the data for effective tracking of the KASF's key performance indicators. Implementation of the M&E framework will also guide decision making in the HIV response at all levels by providing the required strategic information on progress (or lack of it) made by both health and non-health sectors at national and county level.

1.1 Background

The One Country M&E Framework is aligned to the new governance structure in the country in line with the Constitution of Kenya 2010 and the devolved system of decision making and service delivery. National and County governments are key to the attainment of the M&E goals outlined herein. The framework thus provides mechanisms for communication and information sharing between the two levels of government. It should be emphasized that the indicators in this framework are core, and all stakeholders are encouraged to use this framework in defining the minimum set of indicators required for monitoring and evaluating the attainment of the objectives of the second Kenya AIDS Strategic Framework (KASF II) 2020/21-2024/25. All stakeholders are also urged to adopt and implement this M&E Framework, align their internal M&E systems to this framework, and be committed to reporting through the national systems outlined in the framework.

This framework, managed by the National Syndemic Diseases Control Council (NSDCC), draws from the different M&E sub-systems that report on various aspects of the HIV response. It further leverages on the use of technology to enhance timely reporting and improve data management. To this end, stakeholders will establish a common web-based database on core indicators for use. This tool will also enhance the production of M&E products and sharing of data and products to facilitate efficient and effective decision-making at all levels. In addition, the framework provides a robust approach for evaluation of KASF II. Critical surveys, evaluations and surveillance will be undertaken to measure outcomes and impact of the strategic framework.

1.2 Objectives of the M&E Framework

The purpose of this M&E framework is to facilitate the tracking of progress towards KASF II results and generation of strategic information to inform decision making by stakeholders at national and county levels. Specific objectives of the framework are:

1. To define the data requirements and assign responsibilities for effective tracking of KASF II implementation at all levels.

2. To define data management protocols and assign responsibilities for data collection, data flow, analysis and reporting by different stakeholders at national and county levels.

3. To define data feedback mechanisms and utilization for decision making at national and county levels and among stakeholders.

1.3 Guiding Principles of the M&E Framework

This M&E framework is anchored on the over arching internationally agreed "three ones" principle in addressing the HIV and AIDS epidemic, which emphasizes the need for having One Country M&E System for effective coordination. The implementation of the framework will be guided by the following principles:

1. **Harmonization and alignment:** All government agencies at national and county level as well as private, civil society and faith-based implementing organizations and partners will collaborate to attain KASF II results in a harmonized and coordinated manner. This M&E framework will

therefore provide guidance to enable implementing organizations and supporting partners to harmonize their data and M&E processes and work collaboratively to facilitate an efficient and coordinated process of tracking, monitoring, and evaluating KASF II results.

2. **Standardization of indicators and data collection:** KASF II indicators, data collection tools, and methods have been standardized to allow comparability of KASF outputs and outcomes across counties and between sectors.

3. **Strategic dialogue and partnerships:** Dialogue and partnerships will be strengthened through various stakeholder fora at national and county levels to review progress in the KASF II implementation and assess the effectiveness of HIV programmes.

4. **Data demand and use:** Data collected at all levels will be available to national and county governments for decision-making and programming of HIV interventions.

5. **Transparency, accountability and feedback:** Information dissemination mechanisms will be utilized to promote transparency and enhance accountability at national and county levels, taking advantage of information technology to enhance efficiency. Some of these mechanisms will therefore include online and media channels.

1.4 Process of Developing the Framework

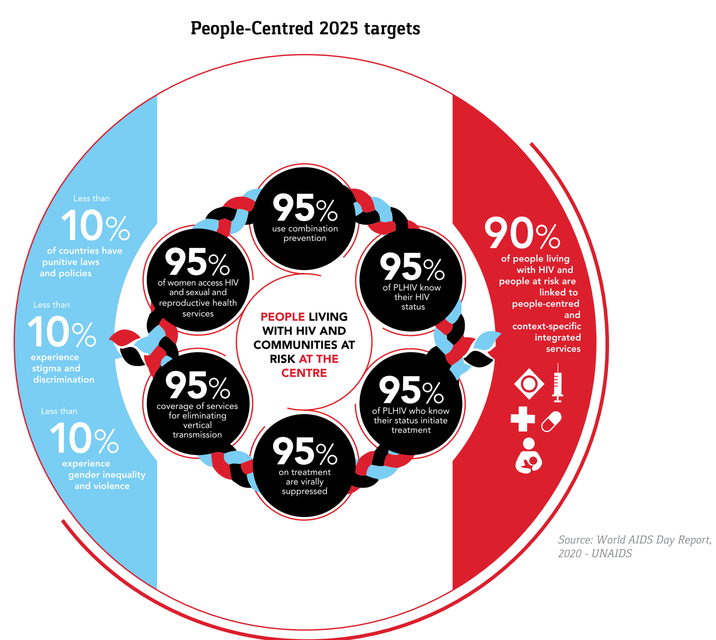
Development of this framework was undertaken through a wide participatory and consultative process, which is in line with the multi-sectoral nature of HIV and AIDS response.

To lead the process, a multi-sectoral M&E Technical Working Group was constituted, which included government agencies, development partners, professional bodies and institutions and implementers, spearheaded the development process.

The process was largely informed by a strategic review of the M&E system for HIV in Kenya. Various consultative fora were held with stakeholders to discuss the draft plan and select national indicators for tracking the HIV response.

The previous M&E Framework and International M&E indicators from sources such as the Global AIDS Response Progress Reporting (GARPR), the President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund and Universal Access targets largely informed the development of this M&E Framework. County representatives participated throughout the framework's development process.

People-Centred 2025 targets



Source: World AIDS Day Report, 2020 - UNAIDS

50%
95%

Section 2:

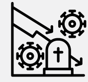
Core KASF II Indicators

The KASF II has identified priority interventions indicators for monitoring and evaluating the implementation of this strategic framework. This section outlines the core indicators to be used in monitoring, tracking, and evaluating the KASF II outputs, outcomes, and impact, and to inform decision making at national and county levels. The indicators measure the performance of KASF in line with the set goal and the targeted results for each of the Thematic/Investment areas. However, through development of specific plans to implement KASF II, counties and other implementing stakeholders will identify additional indicators to meet their information requirements.

2.1 KASF II Impact Level Results (ILR) and Indicators

The overall KASF II vision is to make Kenya free of HIV infections, stigma and AIDS related deaths while the goal is to contribute to attainment of Universal Health Coverage through comprehensive HIV prevention, treatment and care for all people in Kenya. The KASF II has defined the following targets to be achieved by 2025:

Reduce new HIV infections by 75%.



Reduce AIDS- related mortality by 50%.

Micro-eliminate viral hepatitis and reduce the incidence of sexually transmitted infections.

Reduce HIV related stigma and discrimination to less than 25%.

Increase domestic financing for the HIV response to 50%.

The impact indicators can be used for several purposes including tracking trends, identifying problem areas, and advocating for and allocating resources. Table 1 shows the indicators used to track the impact level results of KASF II, the data sources, and the purpose of each impact indicator.

Table 1: KASF II Impact Indicators

Impact Level Result	Indicator	*Disaggregation*	Data Source	Purpose/Use
Reduce new HIV infections by 75%	***ILR 1-1:*** HIV Incidence rate by age and gender	*Gender, age and Location.*	HIV estimate (Spectrum modeling)	Used to estimate annual number of new adult HIV infections by age and gender
	ILR 1- 3: Mother to Child Transmission (MTCT) rate	*Age and location*	Kenya HIV estimate	Used to estimate percentage of child infections from HIV-infected women delivering in the past 12 months and/or to estimate annual number of new child HIV infections
	ILR 1- 4: Number of new HIV infections	*Gender, age and Location.*	Kenya HIV estimate, Mode of Transmission (KMoT)	Used to estimate the number and mode of new HIV infections disaggregated by age and sex
	ILR 1- 5: HIV incidence among Key Population	*Gender, age, type and Location.*	Mode of Transmission (KMoT) Study, HIV Kenya Estimates	Used to estimate percentage of key population who are HIV infected disaggregated by sex and age
Reduce AIDS-related mortality by 50%	***ILR 2- 1:*** Number of HIV-related deaths	*Gender, age and Location.*	HIV estimate (Spectrum modeling)	Used to estimate annual number of HIV-related deaths
	HIV prevalence among young people aged 15–24	*Gender, age and Location.*	KENPHIA, KDHS, KHIS	Used to estimate national and county HIV incidence and prevalence as well as HIV viral load suppression
	HIV prevalence among Key Populations	*Gender, age, type and Location.*	IBBS, KENPHIA, KDHS, KHIS	Used to estimate national HIV prevalence for key populations
Micro-eliminate viral hepatitis and reduce the incidence of sexually transmitted infections	***ILR 3- 1:*** Prevalence of viral hepatitis (Hep C and Hep B)	*Gender, age, type and Location.*	KHIS, KENPHIA	Used to estimate national viral hepatitis (Hep B&C) prevalence
	ILR 3- 2: Prevalence of sexually transmitted infections	*Gender, age, type and Location.*	KENPHIA, KDHS, KHIS	Used to estimate national STIs prevalence
Reduce HIV stigma and discrimination to less than 25%	***ILR 4- 1:*** Percentage of women and men aged 15–49 who report discriminatory attitudes towards persons living with HIV and AIDS (PLHIV)	*Gender, age, type and Location.*	KENPHIA, KDHS	Used to estimate the percentage of women and men who report discriminatory attitudes towards persons living with HIV/AIDS (PLHIV)
	ILR 4- 2: Percentage of PLHIV who report having experienced discriminatory attitudes	*Gender, age, and Location.*	KDHS	Used to estimate the percentage of people living with HIV/AIDS (PLHIV) who report having experienced discriminatory attitudes
Increase domestic financing for the HIV response to 50%	***ILR 5- 1:*** Percentage of funding for the HIV response coming from the government [national and county governments]	*By source, and areas of expenditure*	KNASA, Annual multi-sector expenditure reports & County Financing Profiles	Used to measure domestic and international AIDS spending by categories and financing sources

2.2 INDICATORS FOR KASF II THEMATIC AREAS

To achieve the KASF II goal and the five (5) objectives/results of the framework, the following nine (9) thematic areas have been defined as the key delivery channels of the strategic outcomes and results:

Thematic Area 1: Universal access to comprehensive, quality, and integrated HIV and Sexually Transmitted Infections (STIs) prevention services.

Thematic Area 2: Revitalize shared fast track commitment towards achieving treatment targets.

Thematic Area 3: Protect the rights of people to live a life free of violence, stigma and discrimination.

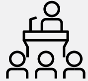
Thematic Area 4: Invest in resilient systems for HIV and other health outcomes.

Thematic Area 5: Leverage on communities led programmes for an effective response.

Thematic Area 6: Integrate HIV in humanitarian and emergency responses.

Thematic Area 7: Promote translation of strategic information, research, surveillance, innovations and implementation of science to inform HIV programming.

Thematic Area 8: Invest in long-term HIV financing models.



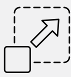
Thematic Area 9: Promote Leadership, Communication and Advocacy.

2.2.1 THEMATIC AREA 1: UNIVERSAL ACCESS TO COMPREHENSIVE, QUALITY, AND INTEGRATED HIV AND SEXUALLY TRANSMITTED INFECTIONS PREVENTION SERVICES

This thematic area addresses the complex patterns of the HIV epidemic characterized by high HIV prevalence and incidence among the key populations and high vulnerability of women, adolescents, and couples to HIV infection and geographical disparities of the epidemic. Under this thematic area, interventions will focus on four strategic focus areas:

Adapt and scale up comprehensive and high impact HIV prevention interventions.

Accelerate efforts towards elimination of mother to child transmission of HIV and syphilis.



Re-invigorate and scale up prevention, management, and control of Sexually Transmitted Infections (STIs) and Viral Hepatitis.

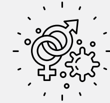
Enhance identification and linkages to HIV prevention, treatment, care, and support services.

The implementation will be augmented by other key national and county level strategic and operational documents which may contain more detailed indicators for tracking progress and results and provide additional information to the KASF II core indicators.

KAFS II outlines the four (4) expected results of HIV prevention with the indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results and targets in HIV prevention are as follows:

New HIV infections reduced by 75% among adults.

HIV transmission rates from mother-to-child reduced to less than 5%.



STIs incidences reduced, and micro-elimination of viral hepatitis achieved.

Community level viral suppression as a result of increased number of people living with HIV with knowledge of their status and treatment and care.

Table 2 outlines the indicators against each expected outcome, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 2: Indicators for Thematic Area 1: Universal access to comprehensive, quality, and integrated prevention of HIV and Sexually transmitted infections

Goal: To maximize the impact of the HIV and STI prevention interventions in Kenya				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
New HIV infections reduced by 75% among adults	Adapt and scale up comprehensive and high impact HIV prevention interventions	General population	***TA1-1:*** Percentage of women and men ages 15–49 years who had sexual intercourse with more than one partner in the last 12 months	KDHS/ KENPHIA
		Adolescent and Young people (AYP) programme	***TA1-2:*** Percentage of young women and men ages 15–24 who have had sexual intercourse before age 15	KDHS/ KENPHIA
			TA1-3: Percentage of adolescents ages 10-24 years having correct knowledge of how HIV is transmitted	KDHS
		Key and priority Populations	***TA1-4:*** Number and percentage of key populations reached with HIV prevention programmes	KHIS
		VMMC programme	***TA1-5:*** Number of males circumcised as part of the minimum package for male circumcision for HIV prevention services	Programme records
		Counseling and testing	***TA1-6:*** Number of People Counseled and Tested for HIV and who received their test results	Programme records
		Post-exposure prophylaxis (PEP)	***TA1-7:*** Number of sexual and gender-based violence (SGBV) survivors provided with PEP	KHIS
			TA1-8: Percentage of health facilities providing PEP Services	KHIS
		Pre-exposure prophylaxis (PrEP)	***TA1-9:*** Number of people (discordant couples, adolescent girls and young women (AGYW) and key population) provided with PrEP	KHIS
		Strengthening comprehensive condom programme	***TA1-10:*** Percentage of women and men ages 15–49 years who had sexual intercourse with more than one partner in the last 12 months and reported use of a condom during the last sexual encounters	KDHS/ KENPHIA
			TA1-11: Percentage of male and female sex workers reporting the use of a condom during penetration sex with their most recent client	KDHS/ KENPHIA
			TA1-12: Percentage of men reporting use of a condom last time they had anal sex with a male partner	IBBS
			TA1-13: Percentage of people who inject drugs who reported use of a condom the last time they had sexual intercourse	IBBS
		Elimination of mother-to-child transmission (eMTCT) programme	***TA1-14:*** Number and percentage of infants born to HIV-infected women who receive a virological test for HIV within 2 months of birth	KHIS / EID Website
			TA1-15: Number and percentage of pregnant women who know their HIV status	KHIS
			TA1-16: Percentage of women screened for syphilis at 1st ANC (Number of pregnant women tested for syphilis)	KHIS

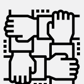
2.2.2 THEMATIC AREA 2: REVITALISE SHARED FAST TRACK COMMITMENT TOWARDS ACHIEVING OF TREATMENT TARGETS

This Thematic Area aims to reduce AIDS-related deaths and improve health outcomes as a result of optimized ARV treatment, improved access and innovative delivery models for HIV and STI care and treatment. The focus of this Thematic Area is to put the country on the path to achieving, the HIV treatment targets of 90% of all people living with HIV diagnosed, 90% of all people with diagnosed HIV infection put on anti-retroviral therapy, and 90% of all people receiving antiretroviral therapy having viral suppression. Under this thematic area, interventions will focus on the following five strategic focus areas:

Optimize ART treatment for all sub-populations to improve patient health outcomes.

Strengthen differentiated service delivery models to improve access.

Strengthen screening and management of TB, cervical cancers and other NCD's and comorbidities among PLHIV.



Strengthen multi-sectoral engagement including private sector in HIV service delivery to expand coverage and enhance effectiveness of interventions.

Prioritize mental health, substance, and alcohol control interventions in HIV programmes.

KASF II outlines three (3) results areas expected to guide monitoring of the achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Increased ART coverage towards universal access to Care and Treatment

Achieve population level sustained viral suppression.

Reduce comorbidity and mortality among People Living With HIV.

Table 3 outlines the indicators against each expected results, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 3: Indicators for Thematic Area 2: — Revitalize shared fast track commitment to achieve treatment targets.

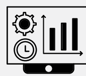
Goal: To reduce AIDS-related deaths and improve health outcomes				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Increased ART coverage towards universal access to Care and Treatment	Optimize ART treatment for all sub-populations to improve patient health outcomes	Improve access to treatment for all sub-populations (children, adolescents and young people, adult pregnant and breastfeeding women and key populations) to improve patient health outcomes	***TA2-1:*** Percentage of pregnant women newly initiated on highly active antiretroviral therapy in the last 12 months	KHIS
			TA2-2: Number of clients newly initiated on ART in the last 12 months	KHIS
			TA2-3: Percentage of adults and children currently receiving ART	KHIS
			TA2-4: Percentage of pregnant women currently on HAART	KHIS
		Improve treatment adherence, retention and support systems	***TA2-5*** Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (24 months, 36 months, 60 months)	KHIS/Cohort Analysis Reports
Achieve population level sustained viral suppression	Improve and sustain viral suppression amongst PLHIV on treatment	ART programme	***TA2-6:*** Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	KHIS/VL Website
	Strengthen differentiated service delivery models to improve access	Strengthen differentiated service delivery models for PLHIV	***TA2-7:*** Proportion of fast-track clients who have been categorized as stable	DWH
Reduce comorbidity and mortality among PLHIV	Strengthen screening and management of TB, cervical cancers, diabetes and other NCDs and comorbidities among PLHIV	HIV/TB co-morbidity	***TA2-8:*** Percentage of HIV patients screened for TB	KHIS/TIBU
			TA2-9: Percentage of TB/HIV co-infected clients who are receiving ART	KHIS/TIBU
		Cervical cancer screening for Women Living with HIV (15+)	***TA2-10:*** Number of annual Cervical cancer screening conducted for Women Living with HIV (15+)	KHIS/ Programme reports

2.2.3 THEMATIC AREA 3: PROTECT THE RIGHTS OF PEOPLE TO LIVE A LIFE FREE OF VIOLENCE, STIGMA AND DISCRIMINATION

This Thematic Area aims to protect human rights and eliminate all forms of violence and HIV related stigma and discrimination against people living with HIV, key and priority populations. The Thematic Area prioritizes the removal of barriers to access to HIV and sexual and reproductive health and rights (SRHR) services, improving policies and legal frameworks, reducing HIV-related stigma and discrimination, reducing gender-based violence, and improving access to legal and social justice Amongst people living with HIV, key and priority populations. The priority interventions will therefore focus on the following four strategic focus areas:

Promote accountability and responsiveness for enhanced human rights protection.

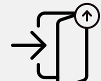
Promote access to justice through public awareness of legal frameworks and redress institutions.


cInstitutionalize progress monitoring of HIV related stigma and discrimination and other health and human rights violations.

Reduce all forms of violence among vulnerable priority groups.

KASF II has defined three expected results with indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Reduced HIV related stigma and discrimination index from 45% to less than 25%.


Increased access to justice among HIV vulnerable sub-populations, people living with HIV and people living with disabilities.

Reduced number of people living with HIV, key and priority populations who experience all forms of violence by 25%.

Table 4 outlines the indicators against each expected result, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 4: Indicators for Thematic Area 3: Protect the rights of people to live a life free of violence, stigma, and discrimination.

Goal: Protect human rights and eliminate all forms of violence and HIV related stigma and discrimination against people living with HIV, key and priority populations				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Reduced HIV related stigma and discrimination index from 45% to less than 25%.	Institutionalize progress monitoring of HIV related stigma and discrimination and other health and human rights violations	Stigma and Discrimination	***TA3-1:*** Number of people reached with anti-stigma messages	CAPR
Reduced number of people living with HIV, key and priority populations who experience all forms of violence by 25%.	Reduce all forms of violence among vulnerable priority groups	Gender Based Violence	***TA3-2:*** Proportion of ever-married or partnered women 15-49 years who experienced physical or sexual violence from a male intimate partner in the past 12 months	KDHS
	Strengthening integration of SRHR and HIV services	Integration of SRHR and HIV services	***TA3-3:*** Proportion of PLHIV who report experiences of HIV-related discrimination in health-care settings	HIV Stigma Index Survey
Increased access to justice among HIV vulnerable sub-populations, people living with HIV and people living with disabilities	Promote accountability and responsiveness for enhanced human rights protection	Improve legal and policy environment for human rights protection	**TA3-4:** Number of laws, regulations, and policies reviewed or enacted at national level that impact on the HIV response positively	National and County HIV reporting

2.2.4 THEMATIC AREA 4: INVEST IN RESILIENT SYSTEMS FOR HIV AND OTHER HEALTH OUTCOMES.

This Thematic Area aims to develop robust, resilient and sustainable systems for HIV and health (RSSH) service delivery at both national, county and community levels. Strengthening of health systems is critical for achievement of KASF II objectives, and realization of universal health care (UHC). Under this thematic area, interventions will focus on the following six strategic focus areas:

Integrated service delivery and quality improvement

Improve the management of human resources for health including community health workers.

Strengthen health management information systems and monitoring and evaluation.

Strengthen the health product management systems.

Harmonize and strengthen financial management system.

Enhanced infrastructure and equipment management systems and services.

KASF II outlines four expected results with indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Improved supply chain system, commodity security and pharmacovigilance.

Robust, reliable and expanded health infrastructure including laboratory systems and services.

Adequate and well-trained workforce for improved health service delivery.

Integrated quality improvement in HIV service delivery.

Table 5 outlines the indicators against each expected outcome, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 5: Indicators for Thematic Area 4: Invest in resilient systems for Health to improve HIV response and other health outcomes.

Goal: Develop resilient and sustainable health systems				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Integrated quality improvement in HIV service delivery	Integrated service delivery and quality improvement	Scale up QI interventions towards improving HIV Service Delivery	***TA4-1:*** Proportion of health facilities implementing DSD in HIV service provision	NDW/ VL Dashboard
			TA4-2: Proportion of care and treatment sites sending VL samples to the lab	NDW/ VL Dashboard
			TA4-3: Mean Turnaround Time for the Viral Load (VL) system.	NDW/ VL Dashboard
			TA4-4: Mean Turnaround time for Exposed Infants Diagnosis (EID) system	NDW/ VL Dashboard
Improved supply chain system, commodity security and pharmacovigilance	Strengthen the health product management systems	Pharmacovigilance	***TA4-5:*** A well-functioning pharmacovigilance system that caters for programme drugs and all other HIV commodities	VL Dashboard/ EID

2.2.5 THEMATIC AREA 5: LEVERAGE ON COMMUNITIES LED PROGRAMMES FOR AN EFFECTIVE HIV RESPONSE.

This Thematic Area aims to implement community-led innovations and differentiated approaches to improve access to HIV and other health services. Community engagement is key to the design, plans and implementation of HIV and other health programmes. Under this thematic area, interventions will focus on the following three strategic focus areas:

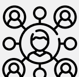
Design and implement people centered responses.

Reinforce the critical role of community-led interventions.

Strengthen community-led data monitoring and social accountability.

KASF II outlines three expected results with indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Increased number of trusted community access platforms.



Community led network sustained and strengthened.

Social accountability of HIV and health interventions enhanced.

Table 6 outlines the indicators against each expected results, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 6: Indicators for Thematic Area 5: Leverage on communities led programs for an effective HIV response.

Goal: Implement community-led innovations and differentiated approaches to improve access to HIV and other health services				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Community led network sustained and strengthened	Design and implement people centred responses	Community based HIV prevention program	***TA5-1:*** Number of CBOs, FBOs, faith communities and community-led organizations implementing HIV prevention programmes	CAPR
		Expand access to social health insurance for vulnerable and marginalized communities to meet UHC.	***TA5-2:*** No of households reached with information and referred for registration for social health insurance program (county social health insurance)	CAPR
		Expand partnerships with other key sectors to respond to community concerns that impact on HIV and health	***TA5-3:*** No of implementing partners supporting community interventions	HIPORs
Social accountability of the HIV and health interventions enhanced	Strengthen community-led data monitoring and social accountability	Strengthening community-based monitoring	***TA5-4:*** Number and percentage of community-based organizations that submit timely, complete, and accurate reports according to guidelines	CAPR

2.2.6 THEMATIC AREA 6: INTEGRATE HIV IN HUMANITARIAN AND EMERGENCY RESPONSES

This Thematic Area aims to ensure that people are protected from vulnerability to HIV and poor health outcomes in emergencies and humanitarian contexts. Under this thematic area, interventions will focus on the following three strategic focus areas:

Enhance multi-level and multi-sectoral capacity for risk preparedness, reduction and mitigation against impact of disasters.

Establish a framework to ensure continuity of HIV services.

Strengthen community centered emergency responses.

KASF II outlines two expected results with indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Functional, integrated emergency response system for HIV and other related comorbidities established.

Sustained HIV services during emergencies.

Table 7 outlines the indicators against each expected results, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 7: Indicators for Thematic Area 6: Integrate HIV in humanitarian and emergency responses.

Goal: Integrate HIV in Humanitarian and emergency response				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Sustained HIV services during emergencies.	Establish a framework to ensure continuity of HIV services	HIV services in humanitarian and emergency settings	***TA6-1:*** Percentage of contingency budget for HIV in Humanitarian and Emergency Responses	County Budgets/ CIDPs
	Strengthen community centered emergency responses	Engage with community leadership to design social protection measures and maintain HIV interventions	***TA6-2:*** Proportion of OVCs reached with Cash Transfer***s***	Children Department
	Establish a framework to ensure continuity of HIV services	HIV services in humanitarian and emergency settings	***TA6-3:*** Percentage of people offered PEP within 72 hours of possible exposure	SARAM/ Program records
	Strengthen community centered emergency responses	SGBV	***TA6-4:*** Number of HIV-related human rights violations reported and followed up on	SARAM/ Program records

2.2.7 THEMATIC AREA 7: PROMOTE TRANSLATION OF STRATEGIC INFORMATION, RESEARCH, SURVEILLANCE, INNOVATIONS AND IMPLEMENTATION OF SCIENCE TO INFORM HIV PROGRAMMING

This Thematic Area aims to Increase access to, and utilization of, location and population granulated strategic information for evidence informed HIV programming. Strategic information, research and innovation are key to enhancing evidence-based decision making and policy formulation for the HIV response and ensure timely production of county, country, regional and global reporting obligation for the HIV programme. KASF II therefore aims to strengthen the utilization of strategic information, research and innovation to address emerging challenges with interventions focusing on the following four strategic focus areas:

Strengthen routine programme reporting capacities for HIV, STIs and other comorbidities.

Promote timely translation of research into policy and practice.

Strengthen surveillance and periodic surveys for HIV, STIs and other comorbidities.

Develop and disseminate timely strategic information products and capacities to improve data access, demand and use.

KASF II has defined three expected results with indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Increased access to, and utilization of, quality location and population granulated strategic information.

Programme reviews, surveillance, and periodic surveys for HIV, STIs and other co-morbidities conducted in a timely manner.

County, country, regional and global reporting obligation for the HIV programme honored.

Table 8 outlines the indicators against each expected results, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

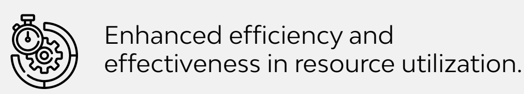
Table 8: Indicators for Thematic Area 7: Promote translation of strategic information, research, surveillance, innovations and implementation of science to inform HIV programming.

Goal: Increased access to, and utilization of, location and population granulated strategic information for evidence informed HIV programming				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Increased access to, and utilization of, quality location and population granulated strategic information.	Strengthen capacity for research and routine program reporting at all levels	Strengthen routine programme reporting	***TA7-1:*** Percentage of joint quarterly SIRI review meetings conducted	NSDCC Activity Reports
			TA7-2: Proportion of active community units reporting on CAPR	KHIS/CAPR
		Leveraging on technology for real time data, location and population granulated data	***TA7-3:*** Proportion of care and treatment facilities utilizing EMRs with Unique Patient Identifiers	National Data Warehouse
County, country, regional and global reporting obligation for the HIV programme honoured	Develop and disseminate timely strategic information products and capacities to improve data access, demand and use.	Develop and disseminate timely Strategic Information Products	***TA7-4:*** Annual preparation of HIV estimates at County and Sub County level	HIV Estimates
		Honor reporting obligations	***TA7-5:*** Annual reporting on GAM	GAM Reports
Programme reviews, surveillance and periodic surveys for HIV, STIs and other co-morbidities conducted in a timely manner.	Strengthen surveillance and periodic surveys for HIV, STIs and other comorbidities	Access to Strategic Information	**TA7-6:** Percentage of planned population-based surveys, HIV and STI surveillance, evaluations, and reviews conducted in line with set timelines	Bi-annual HIV reports

2.2.8 THEMATIC AREA 8: INVEST IN LONG-TERM HIV FINANCING MODELS

This Thematic Area aims to ensure HIV financing models for resourcing HIV and comorbidities response are sustained, expanded, and leveraged for the longer term. KASF II also aims to achieve an increased resource base for the HIV response to continue reducing HIV incidence in the country as well as improved efficiency to sustain and improve on gains already made within the UHC landscape. The priority interventions will therefore focus on the following three strategic focus areas:

Enhanced domestic resource mobilization and solutions for the HIV response.

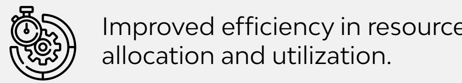


Enhanced efficiency and effectiveness in resource utilization.

Resource transition planning.

KASF II has defined four expected results with indicators for measuring achievement of the results and tracking progress in implementation of priority interventions. The expected results are as follows:

Increased domestic solutions for sustaining investment in HIV and priority NCDs' response.



Improved efficiency in resource allocation and utilization.

County governance and accountability of HIV resources enhanced.

Resource base transitions managed, and HIV interventions sustained.

Table 9 outlines the indicators against each expected results, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting.

Table 9: Indicators for Thematic Area 8: Invest in Long-term HIV financing models.

Goal: To ensure HIV financing models for resourcing HIV and comorbidities response are sustained, expanded, and leveraged for the longer term				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Increased domestic resource mobilization and investment in the HIV and priority NCDs' response	Enhance domestic resource mobilization to respond to HIV	Domestic funding/ investment and integration of HIV financing with the UHC model	***TA8-1:*** Percentage of government funding out of the total for the HIV response	National and County Budget (BROP, CBROP)
			TA8-2: Proportion of HIV funding coming from Social Impact Bonds, Infrastructure Resources, Lottery etc.	KNASA
Improved efficiency in resource allocation and utilization	Enhance efficiency and effectiveness in resource utilization	Efficiency and related modelling in service delivery (HIV and related comorbidities)	***TA8-3:*** Proportion of HIV implementing partners Reporting through HIPORs	HIPORS
County governance and accountability of HIV resources enhanced	Enhanced efficiency and effectiveness in resource utilization	Enhancing Governance and accountability of HIV resources	***TA8-4:*** Number of National and county financial data/ information products and policy advisory reports produced to inform decision making	National and county level HIV reporting
Resource base transitions managed, and HIV interventions sustained	Resource transition planning	Regularly updating plans to manage HIV resources transitions (resource transition planning)	***TA8-5:*** Number of Counties implementing integrated HIV financing within the UHC model	KNASA and Annual County Reports

2.2.9 THEMATIC AREA 9: PROMOTE LEADERSHIP, COMMUNICATION AND ADVOCACY

This thematic area seeks to ensure multi-sector HIV programme stewardship, ownership, optimal coordination, communication, and advocacy are strengthened at national and county level. The priority interventions will focus on the following strategic focus areas:

Promote transformational leadership among political and technical leaders for the national and county HIV/AIDS responses.

Enhance the use of data-led and results-based coordination mechanisms for the multi-sectoral HIV/AIDS response.

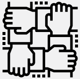
Ensure social accountability of the HIV programme is promoted at all levels.

Ensure sustained communication and advocacy.

KASF II has defined the following key expected results under this thematic/investment area:

Good governance practices and accountability mechanisms enhanced in the delivery of KASF II results.

Functional coordination and leadership structures established at all levels.



Results focused multi-sectoral engagement platforms established.

Visibility of the HIV agenda maintained throughout implementation period.

Table 10 outlines the indicators against the expected results, priority intervention areas, service delivery area, sources of data and institutions responsible for reporting

Table 10: Indicators for Thematic Area 9: Promote Leadership, Communication and Advocacy

Goal: Promote leadership, communication, and Advocacy				
Expected Results	**Strategic Focus Area**	**Service Delivery Area/ Intervention**	**Indicator**	**Data Source**
Good governance practices and accountability mechanisms enhanced in the delivery of KASF II results	Promote transformational leadership among political and technical leaders for the national and county HIV/AIDS responses	Governance for Multi-sectoral Response	***TA9-1:*** National composite policy instrument (NCPI) rating on political support for HIV and AIDS response	NCPI report
Functional coordination and leadership structures established at all levels		Multi-sectoral coordination and accountability mechanisms	***TA9-2:*** Number of Multi-sectoral committee meetings (CHC) meetiwngs held	County HIV Annual Reports
			TA9-3: Number of counties with county HIV coordination units	County HIV Annual Reports

Goal: Promote leadership, communication, and Advocacy				
Results focused multi-sectoral engagement platforms established	Enhance the use of data-led and results-based coordination mechanisms for the multi-sectoral HIV and AIDS responses	Enhance the use of data-led and results-based coordination mechanisms.	***TA9-4:*** Proportion of MDAs with approved HIV workplace work plans	MAISHA
Visibility of the HIV agenda maintained throughout implementation period.	Ensure sustained communication and advocacy.	Enhance access to, and uptake of information for increased uptake of services and better prevention, treatment and care and human rights outcomes	***TA9-5:*** Number of individuals reached on HIV and AIDS prevention information	CAPR

This section details the overall common data architecture to be put in place to manage the One Country M&E Framework for KASF II, the M&E sub-systems through which data will be collected, and the data flow channels within the context of the devolved government structure and a multi-sectoral HIV response.

MONTHLY
PRODUCTIVITY
REPORT
PRODUCTS

Section 3:

Routine Data Collection & Reporting

3.1 KASF II DATA ARCHITECTURE

The KASFII data structure is dependent on the M&E results matrix and is based on data source, frequency and tools of data collection. Different M&E sub-systems have been designed to capture data on the core indicators outlined in this framework, from routine programmatic data emanating from the health, community, private, and public sectors to non-routine data from evaluations, surveys, and surveillance.

Routine Programmatic Data

The programmatic data include:

a) Biomedical data (Health facilities)
- Kenya Health Information System (KHIS)
- Logistics Management Information System (LMIS)

b) Non biomedical data (Community, Public and Private sector)
- Community Activity Programs Report (CAPR)
- MAISHA Certification System

Non-Routine Data

The non-routine data include:

a) **HIV Epidemic Modelling and Estimation:** (National Estimates, Population size estimates, Modes of Transmission Study)

b) **Surveys:** These include Kenya Demographic Health Survey (KDHS), Kenya Population-based HIV Impact Assessment (KENPHIA), Integrated Biological and behavioral Survey (IBBS), Stigma Index Surveys, Kenya National AIDS Spending Assessment (KNASA)

c) **Surveillances:** These include Antenatal Clinic (ANC) sentinel surveillance, Routine PMTCT Surveillance, HIV Drug Resistance Surveillance, Demographic Surveillance Surveys.

d) **Evaluations:** Programme Evaluation, Midterm Evaluation of KASF, End term Evaluation of KASF

3.2 KENYA HIV AND HEALTH SITUATION ROOM

The Kenya HIV and Health Situation Room (KHHSR) is an interactive software platform that enables government and other authorities to effectively use their existing systems (e.g. epidemiological, service delivery, financial, logistic, public, private, community data and more) in *real-time* for decision-making. The KHHSR will receive data from several sub-systems that are responsible for reporting on selected KASF indicators as outlined in the KASF II *M&E Framework* for production of consolidate data to produce the required M&E products.

The platform will provide an intuitive collaboration mechanism that fosters national-to-county sharing, county- to-county sharing in addition to facility level collaboration. Given that it has administrative capabilities, the platform allows stakeholders to manage their own solution for sustainability and governance purposes.

3.3 M&E SUB-SYSTEMS

M&E systems and sub systems that will provide data to the KHHSR on various aspects of HIV interventions and keep track of implementation progress of the KASF II include but are not limited to: (a) Kenya Health Information System (KHIS) and Logistics Management Information System (LMIS), (b) County/District Heath Information System (C/DHIS) (c) MAISHA Reporting System, and (d) Community AIDS Programs Reporting (CAPR).

3.3.1 MONITORING AND REPORTING SYSTEM FOR HEALTH SECTOR RESPONSE

3.3.1.1 OVERVIEW OF HMIS AND LMIS

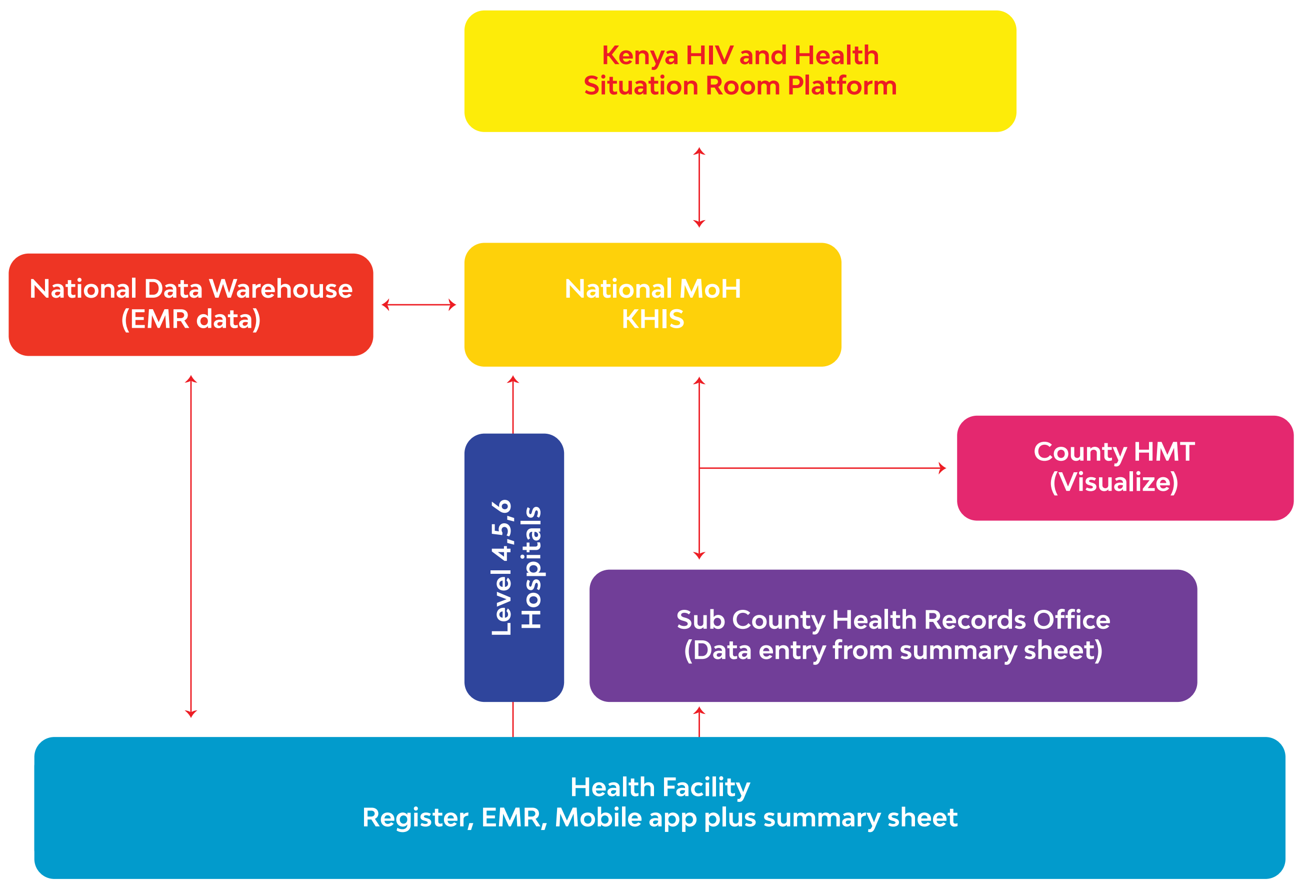
Kenya Health Information System (KHIS) is a central management information system for the health sector. All health facilities submit health data to the county health information system (formerly District Health Information System (DHIS). The sub-county health data is aggregated into a County Health Information System (CHIS) at the county level. This information in then reported to the national KHIS. The MoH plans to develop a unified health information system clouding platform, which will manage this database and facilitate interaction between sub-counties and central level. This system will be used to report on the KASF bio-medical indicators. Secondly, the Logistical Management Information System (LMIS) tracks the supply chain for pharmaceuticals and other health commodities to the health facilities. LMIS will provide data on HIV commodities stocks and supply to the health facilities.

Under KASF II, county HIV coordination units will collect health sector data for analysis and use from the sub-county information systems to support decision making at that level. Data entered into systems at the county level will be made available to NSDCC through KHHSR. Table 11 outlines roles and responsibilities of various institutions that will collect and report HIV data from the health sector.

Table 11: Roles and Responsibilities for data flow

Data flow functions	Responsible Organization	Frequency	Tools
Report health sector data	Service delivery points (Health facilities)	Monthly	MOH 711, MOH 731
Collate health sector HIV response data	County health records and information officer	Monthly	MOH 731 - to KHIS
Provide the health sector HIV response data for use at the county level	County HIV coordination unit and county AIDS and STI coordinating officer (CASCO)	Quarterly	KHIS
Review KHIS data and liaise with NSDCC to improve data quality	MoH (NASCOP)	Quarterly	KASF II data collation

Figure 1: Data and information flow under KHIS.



3.3.2 MONITORING AND REPORTING SYSTEM FOR COMMUNITY-BASED HIV RESPONSE

3.3.2.1 OVERVIEW OF THE COMMUNITY-BASED HIV INFORMATION SYSTEM

Monitoring and reporting on community-based HIV response uses the Community Activities Programme Reporting (CAPR) tool. Civil Society Organizations (CSOs) are required to complete the CAPR form and submit it to NSDCC on a monthly basis. The Community-Based Information System (CBIS) reports on behavioral and structural indicators and comprises the following key features:

- **Database of CSOs:** The common HIV database includes a civil society organization (CSO) module to capture all CSOs implementing HIV activities in each county. CSOs captured in the database are expected to report on their HIV interventions based on set guidelines.
- **Community Activities Programme reporting (CAPR) tool:** The CAPR tool allows CBOs to report against their planned activities, outputs and indicators. The Community Activity Programs Reporting (CAPR) tool aims to collect data on training of community resource persons; prevention; care and treatment; stigma and discrimination; home and community-based care and referral; school-based HIV prevention programs; Information, Communication and Education (HIV messages); gender-based violence; youth friendly and condom program. The reporting tool also incorporated prevention of TB, Malaria and Non communicable diseases in a bid to achieve universal access to care and treatment for all.

3.3.2.2 THE COMMUNITY BASED INFORMATION SYSTEM (CBIS) INTERFACE WITH THE COMMUNITY AND COUNTY HEALTH INFORMATION SYSTEMS

The Community Based Health Information System (CBHIS) will interface with the community health information system (CHIS) and County health information system to ensure synergy between community health strategy and the community-based HIV response. Mechanisms to link these two systems will be explored to minimize any duplication and enable Civil Society Organizations (CSOs) to report on interventions that support implementation of the Community Health Strategy. The following figure shows the data flow from CBOs to the one country M&E system as well as the proposed linkage with the community-based health information system (CBHIS).

Figure 2: Data and information flow for community-based HIV response.

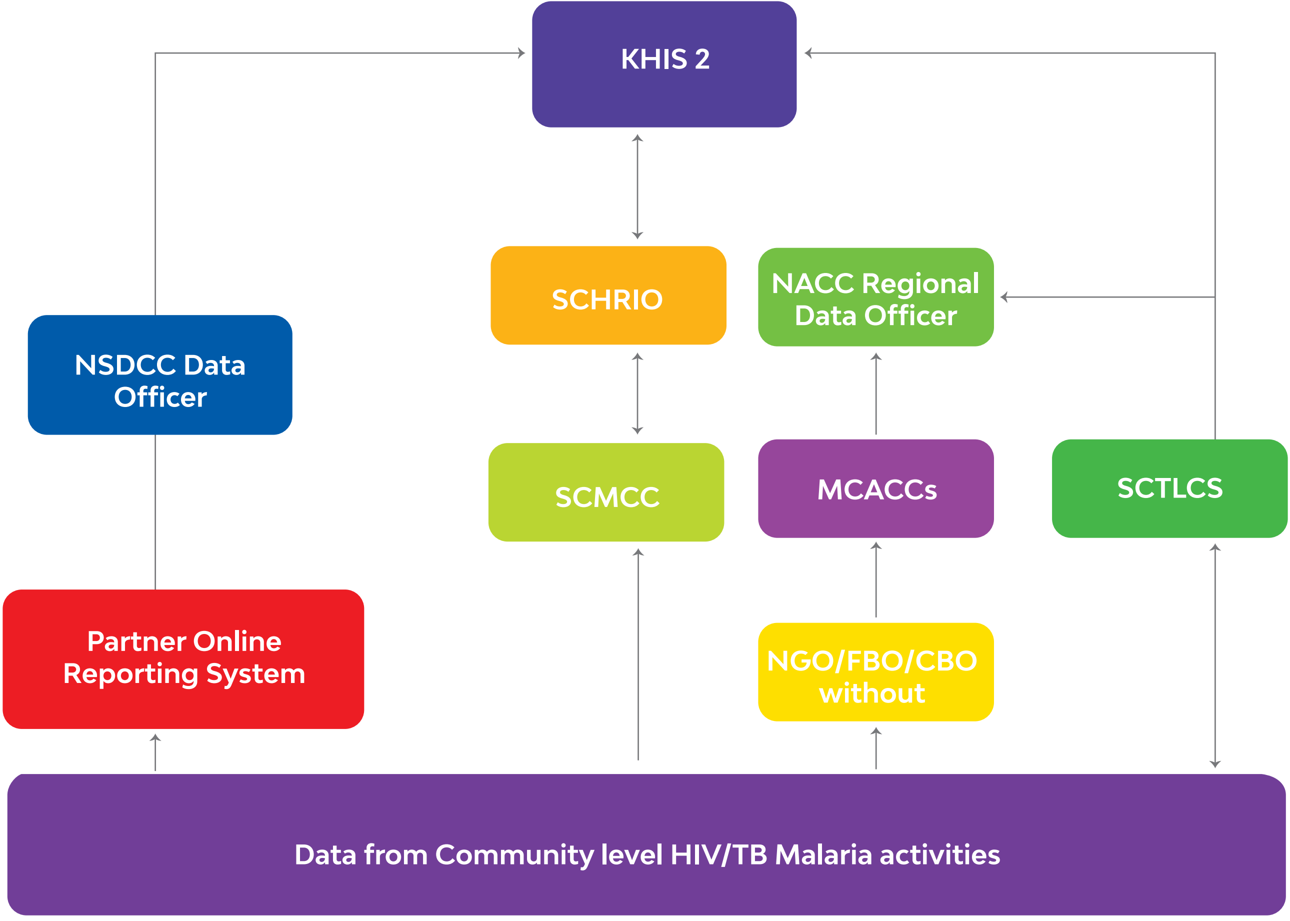


Table 12 outlines the roles and responsibilities of various institutions at the community level.

Table 12: Roles of Institutions at the community level

Institution	Role	Frequency	Reporting Tool
CBOs, FBOs, NGOs	Report through CAPR HIV activities implemented.	Quarterly	CAPR
Community health workforce (Community Health Volunteers (CHVs)/Community Health Assistants (CHAs)	Report HIV-related activities through CBHIS activities.	Monthly	CBHIS
County HIV Coordination Unit (and CASCO/DMS/HRIO)	Receive and input CAPR/CBHIS data into the County health information system	Quarterly	County HIV information hub
Malaria Coordinators	Report Malaria-related activities through CBHIS activities.	Monthly	CBHIS
TB Coordinators	Report TB-related activities through CBHIS activities.	Monthly	CBHIS
NCD Coordinators	Report NCD-related activities through CBHIS activities.	Monthly	CBHIS

3.3.3 MONITORING AND REPORTING FOR PRIVATE SECTOR HIV RESPONSE

3.3.3.1 OVERVIEW OF THE PRIVATE SECTOR HIV INFORMATION SYSTEM

The private sector HIV response is implemented by formal and informal private sector organizations. A standard reporting tool has been developed to capture data from both informal and formal private sector programmes. Private sector institutions will report on their HIV and AIDS activities using the MAISHA reporting tool (Private sector Platform). The data will be reported directly into the NSDCC M&E online system.

Figure 3: Data and information flow for private sector HIV response.

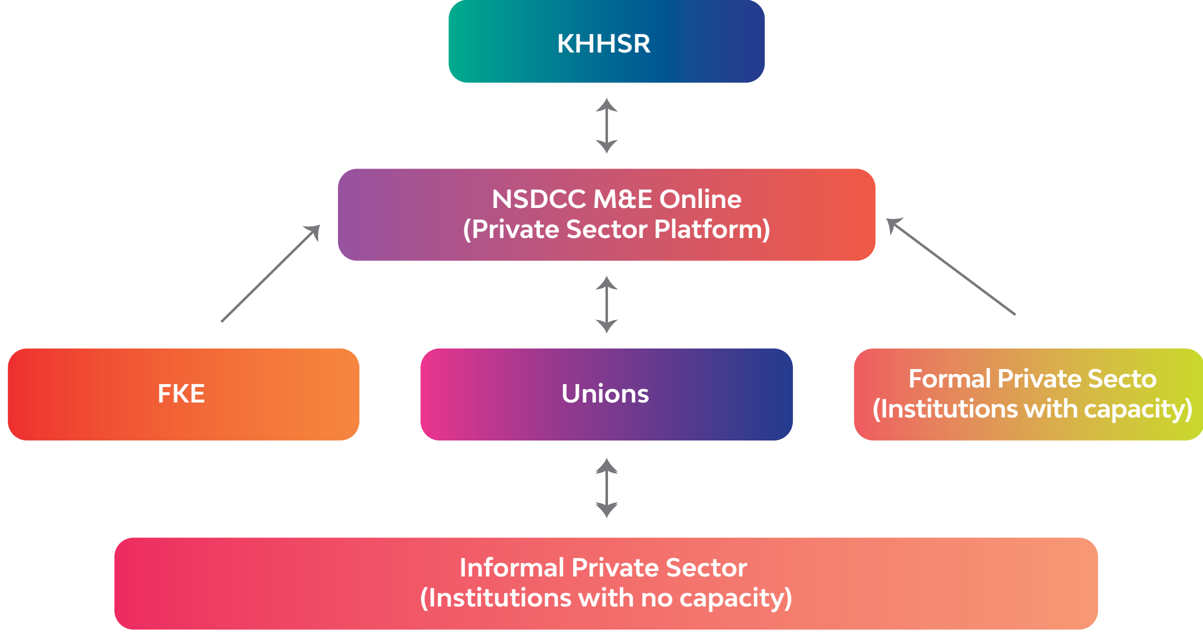


Table 13 outlines the roles and responsibilities of various institutions that will collect and report HIV data from the private sector.

Table 13: Roles and Responsibilities of the Private Sector

Institution	Role	Frequency	Reporting Tool
Private sector organizations, associations and CBOs	Implement HIV related activities in line with their mandates. Submit Report quarterly through private sector HIV response reporting tool.	Quarterly	MAISHA reporting tool
National Syndemic Diseases Control Council	Validate the data in the private sector database and link it to the KHHSR. Support supervision and DQA for the public sector.	Continuous	DQA plan Evaluation plan for private sector
County HIV coordination unit	Validate the county private sector data. Undertake DQA on quarterly basis and provide supportive supervision.	Quarterly	DQA plan/the NSDCC M&E online private sector reporting platform

3.3.4 MONITORING AND REPORTING SYSTEM FOR PUBLIC SECTOR HIV RESPONSE.

3.3.4.1 OVERVIEW OF PUBLIC SECTOR HIV INFORMATION SYSTEM

The public sector HIV response involves engagement of government ministries, departments, and agencies. Through the performance contracting process, these institutions are required to undertake and report on HIV prevention workplace interventions to NSDCC. Public sector institutions will report on their HIV activities to the county HIV coordination unit and to NSDCC using the MAISHA online reporting platform. The figure below shows the data and information flow for public sector HIV response.

Figure 4: Data and information flow for public sector HIV response.

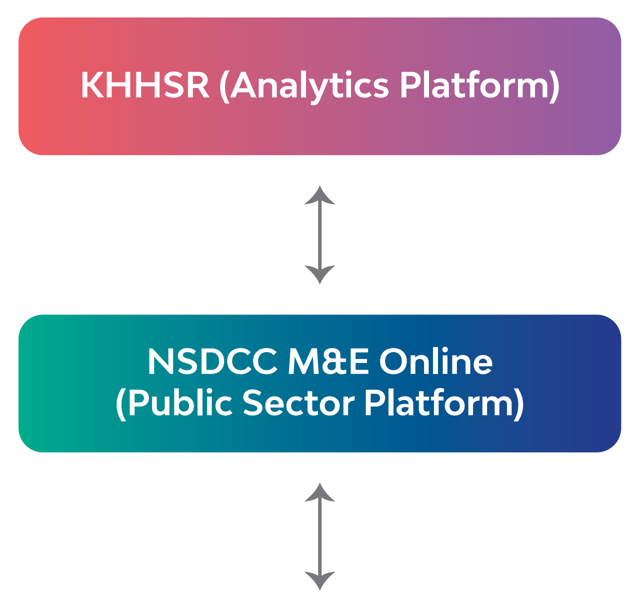


Table 14 defines the roles and responsibilities of various actors in the public sector in HIV reporting.

Table 14: Roles and Responsibilities of the Public Sector

Institution	Role	Frequency	Reporting Tool
Public sector institutions	• Develop HIV plans in accordance with the Performance Contracting Guidelines and submit to NSDCC. • Report quarterly through NSDCC M&E online system	Quarterly	MAISHA reporting tool
National Syndemic Diseases Control Council	• Validate the data in the MAISHA database and link it to the Kenya HIV and health Situation Room (KHHSR). • Undertake performance contract evaluation as the lead agency. • Support supervision and Data Quality Audits (DQAs) for the public sector.	Continuous	DQA plan Evaluation plan
County HIV coordination unit	• Validate the county public sector data. • Undertake DQA on quarterly basis and provide supportive supervision.	Quarterly	DQA plan/ The NSDCC M&E online public sector reporting platform

This section outlines the surveys, surveillance and evaluations that will provide data for KASF outcomes and impact indicators and the years when they will be undertaken.

KPI INFOGRAPHIC

Section 4:

Surveys, Surveillance and Evaluations

4.1 SURVEYS

Surveys will be undertaken to assess the impact and outcome of the KASF and changes in the HIV epidemic. The surveys will inform realignment of KASF given the nature of the epidemic. All surveys will have sufficient sample to enable county level data analysis. The following surveys are planned for the period 2020/2021-2024/2025.

4.1.1 KENYA DEMOGRAPHIC AND HEALTH SURVEY (KDHS)

KDHS is a national representative household survey that provides data on a wide range of indicators in the areas of population, health, HIV and nutrition. This population-based survey is carried out every 5 years and includes an HIV module on knowledge, attitude and practices. Biomarker sample collection for HIV testing is a requirement for all subsequent KDHS. The last KDHS was conducted in 2022.

4.1.2 KENYA POPULATION-BASED HIV IMPACT ASSESSMENT (KENPHIA)

Kenya Population-based HIV Impact Assessment (KENPHIA) survey is a National household HIV survey. KENPHIA 2018 built upon the previous Kenya AIDS Indicator Surveys (KAIS 2007 and 2012). It adds some additional unique features that allow it to better assess the impact of HIV programs. KENPHIA provides key information for health policy makers and implementers on the size of the HIV epidemic, the impact that recent and ongoing HIV programming are having on the epidemic and a gap-assessment of key areas requiring further focus in the HIV response.[1]

4.1.3 INTEGRATED BIOLOGICAL AND BEHAVIOURAL SURVEY (IBBS)

IBBS is a survey conducted every year with the purpose of generating evidence on HIV prevalence and risk behaviors among key and priority populations by collecting data on prevalence, knowledge, behavior, stigma and discrimination relevant to the HIV epidemic.

4.1.4 HIV-RELATED STIGMA AND DISCRIMINATION SURVEY

This is a nationally sample survey conducted every 2 years that seeks to establish the knowledge of HIV-related stigma and discrimination and attitudes towards people infected and affected by HIV.

4.1.5 KEY AND PRIORITY POPULATIONS SIZE ESTIMATION

Key population size estimates are approximations developed every 2 years and used to measure and understand the impact and magnitude of HIV among key populations (sex workers, MSM, and people who inject drugs). These estimates will be updated every 2 years using primary and secondary data sources to support HIV service delivery to these groups.

4.1.6 KENYA NATIONAL AIDS SPENDING ASSESSMENT (KNASA)

This assessment will be conducted every 2 years to measure and determine resource allocation, main sources of funds, channels of flow of funds and areas of spending for HIV response at national and county levels. The results of the survey will be used to inform resource allocation to various HIV programmes against the KASF priorities.

4.1.7 HARMONIZED HEALTH FACILITY ASSESSMENT

The purpose of the Kenya HHFA survey is to provide external validation of service availability and readiness information gaps critical for delivery of Universal Health Coverage (UHC) agenda for health; and to provide necessary information for strategic planning, health sector priority investment areas and areas of acceleration to achieve 100% UHC.

4.2 HIV SURVEILLANCE

HIV surveillance will be undertaken to provide information on trends of the HIV epidemic and behaviour among the general population and key populations. The sentinel surveillance remains the most developed and extensive type of surveillance being undertaken in the country. Under the KASF, the scope of surveillance will be expanded to cover key populations, women and girls.

4.2.1 ANC SENTINEL SURVEILLANCE

Sentinel surveillance is conducted annually by the MoH and collects sero-prevalence data among women attending ANC clinics during pregnancy. This surveillance will be used to continually monitor the trends of the HIV epidemic among pregnant women as a proxy for HIV prevalence in the general population. With improvement of PMTCT data, this surveillance system will be reviewed continually to determine its relevance. The ANC will continue until the point where the PMTCT can be reliably utilized.

4.2.2 ROUTINE PMTCT DATA FOR SURVEILLANCE

Scale-up of Prevention of Mother To Child Transmission (PMTCT) services has led to improved uptake of HIV testing among pregnant women and increased availability of PMTCT data. The PMTCT data will be compared with the sentinel surveillance data in order for the country to decide whether to transition to the use of PMTCT surveillance.

4.2.3 HIV DRUG RESISTANCE SURVEILLANCE

The country will continually conduct surveillance for early warning indicators for HIV acquired and transmitted drug resistance from selected sentinel sites. This surveillance will be undertaken by the Ministry of Health with the support of relevant development partners.

4.2.4 DEMOGRAPHIC SURVEILLANCE SURVEYS

The country will collaborate with the existing surveillance sites to continually collect data relevant for KASF monitoring, including mortality surveillance. Kenya has three full-pledged Health and Demographic surveillance sites (HDSS) which include Kilifi, Nairobi and Kisumu HDSS sites.

4.3 HIV EPIDEMIC MODELLING FOR ESTIMATION

4.3.1 NATIONAL HIV ESTIMATES

The Estimation and Projection Package/ Spectrum software will be used to generate national and county HIV estimates annually. This information will inform the Global AIDS Monitoring Report (GAM), in addition to national and county level estimates to facilitate HIV programming and assessment of the impact on the population.

4.3.2 MODES OF TRANSMISSION STUDY

This is an incidence study conducted every 2 to 3 years based on availability of new population survey data. The study provides information on the contribution of each population group to the annual number of new adult infections. This information is key in determining the contribution of key and priority populations to the total number of new HIV infections.

4.3.3 EVALUATIONS

To assess the effectiveness, impact and sustainability of KASF, mid-term, end-term and programme evaluations will be conducted.

4.3.4 PROGRAMME EVALUATION

Programme evaluations will be used to establish the effectiveness and efficiency of HIV programmes. An evaluation agenda for KASF will be developed to come up with programme-specific assessments during the period of KASF implementation.

4.3.5 MID-TERM EVALUATION OF KASF

A mid-term evaluation to be undertaken by external independent experts will be scheduled for 2022/2023. This evaluation will assess the relevance, effectiveness, and efficiency of the strategic framework. A detailed evaluation protocol will be developed to ascertain the achievements against what was planned. Findings of this evaluation will inform the review of the strategic framework.

4.3.6 END-TERM EVALUATION OF THE KASF

This evaluation will be conducted by independent experts and will focus on the extent to which the KASF impact and outcome results have been achieved over the implementation period. This evaluation is scheduled for 2024/2025, and the findings will be expected to inform the development of the next strategic framework.

4.4 TIMEFRAMES FOR THE SURVEYS, EVALUATIONS AND SURVEILLANCE

Table 15 shows the timeframes for conducting the surveys, surveillance, and evaluations.

Table 15: Timeframes for Surveys, Surveillance, and Evaluations

		Timeframe					Lead Institution
		2021	2022	2023	2024	2025	
Surveys							
1	Kenya Demographic and Health Survey	X				X	KNBS/MOH
2	Kenya Population-based HIV Impact Assessment (KENPHIA)				X		NASCOP
3	Integrated Behavioral Surveillance Survey	X	X	X	X	X	NSDCC
4	IBBS targeting key populations	X	X	X	X	X	NASCOP
5	PLHIV stigma and discrimination survey		X			X	NSDCC
6	Key populations population size estimation	X			X		NASCOP
7	Kenya AIDS spending assessment	X			X	X	NSDCC
8	Kenya Harmonized Health Facility Assessment (HHFA)				X		MoH
Surveillance							
9	ANC surveillance	X	X	X	X	X	NASCOP
10	PMTCT data for surveillance	X	X	X	X	X	NASCOP
11	Surveillance for HIV drug resistance	X	X	X	X	X	NASCOP
HIV Epidemic Modeling for Estimation							
12	HIV estimation through Spectrum	X	X	X	X	X	NSDCC
13	Modes of transmission study	X			X		NSDCC
Evaluations							
14	Program evaluations	X	X	X	X	X	NASCOP/ NSDCC
15	Mid-term evaluation of KASF			X			NSDCC
16	End-term evaluation of KASF					X	NSDCC

This section details the key institutional arrangements and the technical structures for stakeholder coordination on M&E at the national and county levels. These structures are aligned to the overall KASF II coordination framework.

Subdivision 2
Best subdivision value
Value of all subdivisions
Main company
Subdivisions

Section 5:

Monitoring and Evaluations Coordination

5.0 KASF II MONITORING

The NSDCC M&E Division will be responsible for the implementation and coordination of the M&E activities of this KASF II. This will include providing the necessary technical support for joint assessments at the county level. The principle of joint assessment will be used at all levels of the health and non-health sectors during performance reviews. This will involve all stakeholders, both government and non-government actors, in review of performance. The purpose of the joint assessment is to review performance, determine priorities, action plans and spending for the subsequent period.

5.2 KASF II EVALUATIONS

A mid-term review and an end-term evaluation will be undertaken to determine the extent to which the objectives of this strategic framework are met across the different indicator domains - inputs/ processes, outputs, outcomes and impact. The mid-term review will coincide with the annual review of the strategic plan year three. The results will be used to adjust national strategies, priorities and objectives, if need be.

5.3 INSTITUTIONAL ARRANGEMENTS FOR M&E COORDINATION

The institutions that will play a key role in the coordination of the implementation of this M&E framework are outlined in Table 16.

Table 16: Key roles in the coordination and implementation of the KASF M&E framework

Institution	M&E Roles and Responsibilities
National Syndemic Diseases Control Council	• Ensure effective coordination of the overall KASF II M&E at the national and county levels. • Develop the overall operational guidelines for the KASFIIM&E framework. • Ensure effective rollout of KASF II M&E framework to counties and to all sectors. • Develop, in collaboration with counties and sectors, the community, private sector, and public sector reporting systems, including the tools and procedures. • Ensure effective data management, including review and management of the NSDCC M&E online system and automation of the community, public, and private sector response reporting systems. • Build the capacity of counties in M&E to enable them to operationalize the KASF II M&E framework. • Lead the national KASF monitoring committee and support counties to establish and operationalize the county KASF monitoring committee. • Coordinate KASF surveys, evaluations, and statistical modeling and facilitate dissemination of the findings to counties and other stakeholders. • Develop and disseminate national level M&E information products. • Ensure that all KASF M&E committees are established and operationalized at national and county levels by developing guidelines for these committees and supporting counties to operationalize the guidelines. • Advocate for the use of the Kenya HIV and Health Situation Room at national and county level
MoH/NASCOP	• Ensure effective rollout and overall management of the health sector response M&E system. • Provide technical support to counties in data collection, reporting, and analysis for health sector response M&E system. • Review data and provide feedback to counties. • Support counties to analyze and use data in planning for delivery of the health sector response. • Build the capacity of counties in DQA. • Conduct periodic data audits, develop data quality improvement plans, and monitor their implementation. • In collaboration with NSDCC, KNBS, and other stakeholders, provide technical expertise and/or lead the conduct of various evaluations and surveys, including KeNPHIA, KDHS, IBBS, and bio-behavioral surveillance survey (BSS). • Lead the M&E sub-committee(s) for the health sector response.
Performance contracting office	• Review performance contract indicators on HIV prevention to ensure that adequate weighting is achieved.

TECHNICAL COORDINATION MECHANISMS

The M&E technical coordination structures will include the Strategic Information Research and Innovation Technical Working Groups and ICCs at the national and county levels. The roles of these structures are outlined below.

5.3.1 NATIONAL STRATEGIC INFORMATION RESEARCH AND INNOVATION TECHNICAL WORKING GROUPS (SIRI/SI TWG)

The National KASF Monitoring Committee also known as SIRI/SI-TWG will play the following technical roles:

a) Advise on the rollout of the KASFII M&E framework.

b) Review M&E data to assess KASF implementation progress, identify bottlenecks, and make recommendations on possible solutions.

c) Review strategic information to be disseminated to the ICCs, counties, and other stakeholders.

d) Make recommendations on adjustments to KASF from time to time informed by evidence.

e) Establish linkage to the county-level KASF monitoring committee to:

(i) Build the M&E capacity at the county.

(ii) Support the operationalization of the M&E framework by guiding the development of county M&E plans.

(iii) Support the county sub-committees in data analysis.

Members of this committee will be M&E experts drawn from national institutions across all sectors and partners, including public, civil society, development partners, and private sector. Key priority populations and PLHIV will also be represented. The committee shall establish M&E sub-committees for each KASF strategic direction comprising between 6 and 15 members. The National Syndemic Diseases Control Council will coordinate and provide secretarial support to this committee.

5.3.2 COUNTY MULTI-SECTOR COORDINATIONCOMMITTEES (MCC)

The county multi-sector coordination committee will include M&E representatives who will largely play roles similar to those of the national level M&E committee, but at the county level. The roles include:

a) Review and analyze data received at the county level.

b) Advise the HIV coordination unit, ICC, and the county HIV Executive committee (CEC) on improvement of KASF implementation at the county level.

c) Facilitate the implementation of the decisions of the CEC and county HIV ICC related to HIV M&E.

d) Support the overall operationalization of the KASF M&E framework at the county level.

e) Maintain linkage with the SIRI TWG at the national level.

This committee will be convened by the county HIV coordination unit. Members of the committee will be people with M&E expertise drawn from across all sectors and partners, including public, private, civil society and key affected populations and PLHIV from the county.

5.3.3 ICCS AT NATIONAL AND COUNTY LEVELS

ICCs for HIV and AIDS existing at the national level will be maintained while the counties will establish ICCs at their level to provide a forum for stakeholders and

partners to periodically review the progress in implementation of KASF within a multi-sectoral context. These committees will be partnership forums whose roles will include:

a) Reviewing overall progress in implementation of KASF.

b) Identifying success and challenges in implementation of the HIV response.

c) Receiving and reviewing the monitoring reports for the counties (for county ICCs) and countrywide (for national ICCs).

d) Building consensus on emerging issues and adjustments that need to be made to the HIV plans based on evidence.

e) Promoting mutual accountability of all stakeholders.

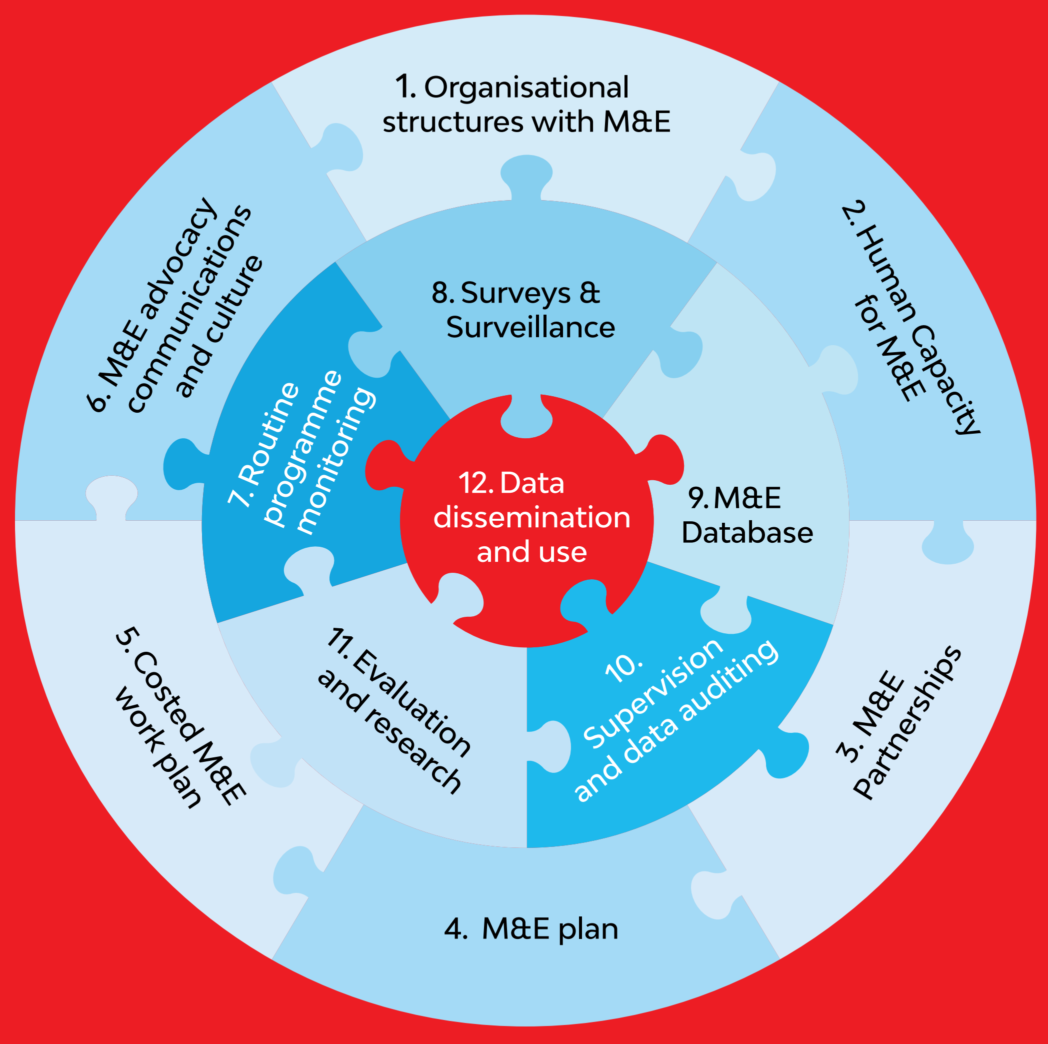
Section 6:

Monitoring and Evaluations System Capacity and Performance Assessment Framework

Monitoring and Evaluation (M&E) is an indispensable function for guaranteeing that priority HIV response actions outlined in KASF II are implemented as planned against stated objectives and expected outcomes. This section provides a framework for the capacity assessment and performance review of the national HIV M&E system by the National Syndemic Diseases Control Council, implementing partners and other organizations participating in the assessment. The aim is to identify strengths and weaknesses in the KASF II M&E system and recommend actions to enhance the system performance based on the 12 Components of the M&E System . The results of the assessment would also be used to develop capacity building plans to strengthen the capacity of the system to perform the M&E functions of the national response.

12 Components Monitoring & Evaluation Systems Assessments

Organizing Framework for a Functional National HIV M&E Systems 12 Components



Monitoring and Evaluation System Assessment Framework

	REQUIRED	STATUS	RECOMMENDED
Organizational Structure with HIV M&E	• Effective leadership for M&E in key organizations • Adequate number of skilled M&E staff • Commitment to ensure M&E system performance. • Well-defined organizational structure • Well-defined M&E roles and responsibilities Mechanisms for M&E planning, management, and coordination	• The organizational structure for HIV M&E functions is well established but over relies on external support. • The organizational capacity of the M&E system thus requires strengthening to effectively fulfil routine M&E tasks including regular M&E units and stakeholders' meetings at different levels to assess progress, plan and coordinate M&E activities.	• Advocate for increased technical assistance and Government financial support for the M&E units at different levels to effectively perform the HIV M&E functions.
Human capacity for HIV M&E	• Defined skill set for individuals and organizations at national, sub-national, and service-delivery levels. • Workforce development plan, including career paths for M&E • Costed human capacity building plan. • Standard curricula for organizational and technical capacity building • Local and/or regional training capacity, including links to training institutions. • Supervision, in-service training and mentoring	• M&E staff, training and capacity building largely relies on external financial and technical support with minimal GoK support.	• Absorption of personnel into County systems • Identify resources to support absorption process. • Advocate for increased Government financial support for M&E human resource capacity development and training at national and county levels.
Partnerships & Governance	• M&E performance strategy or policy • Standard operating procedures • Stakeholders' commitment to support M&E activities and performance improvement. • An updated/inventory of stakeholders for the division M&E • Clear mechanisms to communicate M&E activities and decisions. • M&E units to support other program areas.	• Inadequate external and government financial and technical support • Effective stakeholder communication system and mechanisms	• Advocate for increased Government and partners financial and technical support to strengthen the M&E Partnerships and Governance system.

Monitoring and Evaluation System Assessment Framework

	REQUIRED	STATUS	RECOMMENDED
National M&E Workplan	• Broad-based participation in developing the national M&E plan. • M&E plan explicitly linked to the National HIV and AIDS Strategic Framework • The M&E framework adheres to international and national technical standards. • M&E system assessment conducted and recommendations for system strengthening made.	• The development of the National M&E Framework and assessment of the M&E system lack adequate external technical assistance and financial support from GoK.	• Advocate for increased Government financial support for the assessment/review of the M&E system.
Annual Costed M&E Workplan	• National M&E work plan endorsed by all relevant stakeholders. • The M&E work plan explicitly linked to the government Medium Term Plan and Medium-Term Expenditure Framework (MTEF) budgets. • Resources (human, physical, financial) are committed to implementing the M&E work plan. • The M&E results matrix is updated annually based on performance monitoring.	• Inadequate resources committed by GOK to implement the M&E work plan.	• Identify resources to support implementation of M&E framework at all levels. • Advocate for increased Government financial support for the implementation of the M&E work plan.
Advocacy, Communication & Cultural Behaviour	• A communication strategy that includes a specific M&E communication and advocacy plan. • M&E explicitly referenced in national policies. • M&E champions that are actively endorsing M&E actions. • M&E materials that target different audiences and support data sharing and use.	• HIV response communication strategy does not address all program activities including M&E communication and advocacy activities. There is also inadequate financial support from the government at national and county levels to implement program communication strategies.	• Strengthen M&E communication and advocacy within the HIV response communication strategy. • Advocate for increased Government financial support for M&E communication and advocacy.

Monitoring and Evaluation System Assessment Framework

	REQUIRED	STATUS	RECOMMENDED
Routine Monitoring	• Data collection strategy is explicitly linked to data use. • Clearly defined data collection, transfer, and reporting mechanisms, including collaboration and coordination among the different stakeholders. • Essential tools and equipment for data management (e.g., collection, transfer, storage, analysis) are in place. • Routine procedures for data transfer from sub-national to national levels	• Inadequate financial resources and external technical assistance to develop and update essential tools and guidelines for routine monitoring.	• Identify resources to support the development and update of routine monitoring tools and guidelines. • Strengthen data collection, transfer, and reporting mechanisms, including collaboration and coordination among the different stakeholders.
Surveys and Surveillance	• Protocols for all surveys and surveillance based on international standards. • Specified schedule for data collection linked to stakeholders' needs, including identification of resources for implementation. • Inventory of surveys conducted Well-functioning surveillance system (program dependent)	• Inadequate government funding and external technical assistance to support the strengthening of the surveillance system, surveys, and surveillance activities.	• Identify resources to strengthen the surveillance system and support surveys and surveillance activities.
National and Sub-National Databases	• Database(s) designed to respond to the decision-making and reporting needs of different stakeholders. • Interoperability between different relevant databases • A national database to capture, verify, analyze, and present data at all levels.	• Weak structures, mechanisms, and procedures for transmitting, entering, extracting, merging and transferring data between databases that support the national M&E. Inadequate resources to design and develop and maintain national and county-level databases.	• Identify resources to strengthen structures, mechanisms and procedures for transmitting, entering, extracting, merging and transferring data between databases that support the national M&E function.

Monitoring and Evaluation System Assessment Framework

	REQUIRED	STATUS	RECOMMENDED
AUDIT **Supervision and Auditing**	• Guidelines for supervising routine data collection at facility and community level • Routine supervision visits, including data assessments and feedback to local staff. • Periodic data quality audits Supervision reports and audit reports	• Inadequate sharing of findings from the data quality audits; technical assistance and financial support for the development and implementation of supportive supervision guidelines and tools; dissemination of results of data quality audits	• Strengthen supervision and data quality audit systems.
Evaluation and Research	• Inventory of completed, ongoing evaluations, research studies and research capacity. • National evaluation and research agenda • Evaluation and research protocols • National conferences/forum for dissemination and discussion of research and evaluation findings	• Inadequate government financial support to develop an inventory/register/ database of research and evaluation and hold national conferences or forums for dissemination evaluation and research findings.	• Advocate for increased Government financial support for evaluation and research.
Data Demand and Use	• Data use plan included in the national HIV and AIDS Strategic Framework and M&E plan. • Mapping of program data needs and data users • Data use calendar to guide for major data collection efforts and reporting. • requirements. • Evidence of information use (e.g., data referenced in funding proposals and planning documents)	• Inadequate resources to develop data use plan, disseminate information products to stakeholders/data users and carry out M&E system assessment for system strengthening. • The data use plans are not explicit linked to the National HIV and AIDS Strategic Plan	• Identify resources to strengthen data use planning and dissemination of information products.

ANNEX 1: M&E PRODUCTS AND FEEDBACK MECHANISMS

Mechanisms for dissemination of M&E products and providing feedback to various audiences are outlined in the following table.

Report	Purpose	Description of the M&E Product	Frequency	Dissemination/ Feedback	Target Audience	Responsible Institution
Consolidated biannual M&E report	To provide data against outcome and output indicators of the KASF disaggregated by county and sector	A consolidated report will be produced using the data submitted to the National HIV Database, evaluation, surveys, and surveillance data.	Biannual	Biannual meetings National database County and national MoH websites	County and National governments	NSDCC/ NASCOP
Annual HIV consolidated report	To provide the KASF implementation progress against core indicators and identify challenges and priorities for the following year	A consolidated report will be produced using the data submitted to the National HIV Database, evaluation, surveys, and surveillance data as well as Spectrum modelling data.	Annual	MoH website (NSDCC/NASCOP) Stakeholders' fora County and national HIV fora	County and National government County and national health stakeholders	NSDCC/ NASCOP
County HIV profiles	To inform HIV planning and programming at the county level	County profiles provide a snapshot of the county HIV epidemic. The profiles will be developed based on routine programme data and survey findings.	2 years	MoH website (NSDCC/NASCOP) Public notice boards	Implementing partners County and national governments	MoH (NSDCC/ NASCOP) County HIV coordinating units
Global AIDS response progress report	To contribute to the development of the Global AIDS report To communicate the country progress in HIV prevention and control	This report will be produced using the data collected through the HIV M&E database and consolidated reports. The GARPR report will be produced and submitted according to the global reporting guidelines.	Annually	Situation room UNAIDs website	UNAIDS County and national governments	MoH (NSDCC/ NASCOP)
Evaluation and survey reports	To assess the key outcomes of KASF for planning and decision making	` These are reports of all evaluations, surveys, and surveillance outlined in this M&E framework that will be produced and disseminated. These include the mid-term and end-term evaluation of the KASF, the population-based surveys, and the special evaluations and surveys such as AIDS spending, Spectrum modelling and service provision assessments.	5 years	Conferences Review meetings. Stakeholders' forums	County and national governments Health stakeholders	MoH (NSDCC/ NASCOP/ KNBS) Partners

ANNEX 2: KASF II M&E RESULTS FRAMEWORK

M&E RESULTS FRAMEWORK												
Indicators	**Disaggregation by Age/Sex/ Population**	**Baseline Numerator**	**Denominator**	**% at Baseline**	**Baseline Baseline Year**	**Source**	**Target 2021**	**2022**	**2023 (Mid Term)**	**2024**	**2025 (End Term)**
							0.85	0.7	0.55	0.4	0.25
Annual new HIV infections	Total 15+ (Male/female	34,652	41,456	83.6%	2020	HIV Estimates	29,454.20	24,256.40	19,058.60	13,860	8,663.00
	Adult Males (15+)	13,116	34,652	37.9%	2020	HIV Estimates	11,148.60	9,181.20	7,213.80	5,246.40	3,279.00
	Adult Females (15+)	21,536	34,652	62.1%	2020	HIV Estimates	18,305.60	15,075.20	11,844.80	8,614.40	5,384.00
	Total 15-24 (Male/female)	14,315	41,456	34.5%	2020	HIV Estimates	12,167.75	10,020.50	7,873.25	5,726.00	
	Young women (15-24)	10,340	14,315	72.2%	2020	HIV Estimates	8,789.00	7,238.00	5,687.00	4,136.00	2,585.00
	Young men (15-24)	3,975	14,315	27.8%	2020	HIV Estimates	3,378.75	2,782.50	2,186.25	1,590.00	993.75
	Children (0-14yrs)	6,805	41,456	16.4%	2020	HIV Estimates	5,784.25	4,763.50	3,742.75	2,722.00	1,701.25
MTCT Transmission Rate	MTCT Rate	10.8%		10.8%	2020	HIV Estimates	<5%	<5%	<5%	<5%	<5%
Annual new HIV infections among key populations	FWID	302	5,893	5.1%	2020	MOT	256.70	211.40	166.10	120.80	75.50
	PWID	74	5,893	1.3%	2020	MOT	62.90	51.80	40.70	29.60	18.50
	MSM	556	5,893	9.4%	2020	MOT	472.60	389.20	305.80	222.40	139.00
	FSW	4,961	5,893	84.2%	2020	MOT	4,216.85	3,472.70	2,728.55	1,984.40	1,240.25
							0.9	0.8	0.7	0.6	0.5
Annual number AIDS deaths	Adults 15+ (Male/Female)	16,572	21,068	78.7%	2020	HIV Estimates	14,914.80	13,257.60	11,600.40	9,943.20	8,286.00
	Adult Males (15+)	9,317	16,572	56.2%	2020	HIV Estimates	8,385.30	7,453.60	6,521.90	5,590.20	4,658.50
	Adult Females (15+)	7,255	16,572	43.8%	2020	HIV Estimates	6,529.50	5,804.00	5,078.50	4,353.00	3,627.50
	Young People 15-24yrs (Male/Female)	2,604	21,068	12.4%	2020	HIV Estimates	2,343.60	2,083.20	1,822.80	1,562.40	1,302.00
	Young men (15-24yrs)	1,266	2,604	48.6%	2020	HIV Estimates	1,139.40	1,012.80	886.20	759.60	633.00
	Young women(15-24yrs)	1,339	2,604	51.4%	2020	HIV Estimates	1,205.10	1,071.20	937.30	803.40	669.50
	Children (0-14yrs)	4,495	21,068	21.3%	2020	HIV Estimates	4,045.50	3,596.00	3,146.50	2,697.00	2,247.50
							0.85	0.7	0.55	0.4	0.25
Annual reported cases of Sexually Transmitted Infections (STI)	General Population >5yrs	322,644	1,321,078	24.4%	2020	KHIS	316,836.41	312,319.39	309,092	307,157.09	306,511
	ANC	16,455	1,321,078	1.2%	2020	KHIS	16,158.81	15,928.44	15,763.89	15,665.16	15,632.25
	Key populations	17,545	177,228	9.9%	2020	KHIS	17,229.19	16,983.56	16,808.11	16,702.84	16,667.75
Incidence of Viral Hepatitis	General Population >5yrs	10,785	242,687	4.44%	2020	KHIS	10,590.87	10,439.88	10,332.03	10,267.32	10,245.75
	Key populations	753	28,364	2.7%	2020	KHIS	739.45	728.90	721.37	716.86	715.35
Percentage of women aged 15–49 expressing accepting attitudes towards PLHIV	Women	26%			2014	KDHS	26%	26%	26%	26%	26%

M&E RESULTS FRAMEWORK											
Percentage of women aged 15–49 expressing accepting attitudes towards PLHIV	Men	44%			2014	KDHS	44%	44%	44%	44%	44%
							6.60%	6.60%	6.60%	6.60%	6.60%
Percentage of government funding for the HIV response	National	17%		17%	2014	KNASA	23.60%	30.20%	36.80%	43.40%	50.00%
THEMATIC AREA 1: Universal access to comprehensive, quality and integrated HIV and sexually transmitted infections prevention services											
Number of individuals who received HIV Testing Services (HTS) and received their test results	All	5,088,610			2020	KHIS	4,188,976	4,608,020	4,682,289	49542199	5241931
Number of people Counseled, Tested and given a positive result (positivity)	1-14yrs	4,910	304,939	1.6%	2020	KHIS	6600	6600	6600	6600	6600
	15-24yrs	19,192	1,691,739	1.1%	2020	KHIS	8700	8700	8700	8700	8700
	25+	110,531	3,194,914	3.5%	2020	KHIS	27,500	27,500	27,500	27,500	27,500
Number of key populations Counseled and Tested	FSW	82,059	172,946	47.4%	2020	KHIS	58.0%	68.5%	79.0%	89.5%	100.0%
	MSM	28,447	56,453	50.4%	2020	KHIS	60.3%	70.2%	80.2%	90.1%	100.0%
	PWID	15,459	25,234	61.3%	2020	KHIS	69.0%	76.8%	84.5%	92.3%	100.0%
Proportion of Key Population Counseled, Tested and given a positive result (positivity)	FSW	5,055	82,059	6.2%	2020	KHIS	1.2%	0.9%	0.6%	0.3%	0.1%
	MSM	2,273	28,447	8.0%	2020	KHIS	1.7%	1.4%	1.1%	0.8%	0.5%
	PWID	250	15,459	1.6%	2020	KHIS	0.3%	0.2%	0.1%	0.1%	0.1%
Number of individual HIV self-test kits distributed	None	642,828		642,828	2020	KEMSA-LMIS	3,941,170	3,893,218	3,945,053	3,945,053	3,945,053
Percentage of young women and men ages 15–24 who have had sexual intercourse before age 15	15-24yrs	12%		12%	2014	KDHS	12%	12%	12%	12%	12%
Percentage of adolescents ages 10-24 years having correct knowledge of how HIV is transmitted	10-24 yrs	57%		57%	2014	KDHS	57%	57%	57%	57%	57%
Proportion of sexual and gender-based violence (SGBV) survivors provided with PEP	All ages	12,278	19,762	62.1%	2020	KHIS	67.7%	73.3%	78.9%	84.4%	90.0%
Percentage of health facilities providing PEP Services	All PEP sites/facilities	3,522	7,308	48.2%	2020	KHIS	52.6%	56.9%	61.3%	65.6%	70.0%
Proportion of occupational exposures among HCWs	All HCWs	3,663	62,544	5.9%	2020	KHIS	4%	3%	2%	1%	1%
Percentage of new infections resulting from survivors	None	189	19,762	1.0%	2020	KHIS	0.8%	0.6%	0.4%	0.2%	0.1%
Proportion of eligible clients initiated on PrEP	Discordant couples	11,958	25,544	46.8%	2020	KHIS	55.5%	64.1%	72.7%	81.4%	90.0%
	General population	11,819	41,403	28.5%	2020	KHIS	40.8%	53.1%	65.4%	77.7%	90.0%
	Key population (FSW)	8,699	105,398	8.3%	2020	KHIS	24.6%	41.0%	57.3%	73.7%	90.0%
	Key population (MSM)	2,593	27,651	9.4%	2020	KHIS	25.5%	41.6%	57.8%	73.9%	90.0%
	key population (PWID)	265	6,835	3.9%	2020	KHIS	21.1%	38.3%	55.6%	72.8%	90.0%

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Proportion of infants born to HIV-infected women who receive a virological test for HIV within 2 months of birth	HEI <2months	40,939	57,686	71.0%	2020	EID Website	74.8%	78.6%	82.4%	86.2%	90.0%
Proportion of infants born to HIV-infected women starting on cotrimoxazole prophylaxis within 2 months of birth	HEI <2months	23,551	56,837	41.4%	2020	KHIS	51.1%	60.9%	70.6%	80.3%	90.0%
Proportion of pregnant women who know their HIV status	Pregnant& lactating women	1,339,322	1,571,208	85.2%	2020	KHIS	88.2%	91.1%	94.1%	97.0%	100.0%
Proportion of pregnant women tested for syphilis	Pregnant women	1,126,956	1,322,715	85.2%	2020	KHIS	86.2%	87.1%	88.1%	89.0%	90.0%
Percentage of HIV positive pregnant women who received anti-retroviral medication to reduce the risk of mother-to-child transmission (PMTCT)	Pregnant and lactating women	56,837	60,400	94.1%	2020	KHIS	95.3%	96.5%	97.6%	98.8%	100.0%
Percentage of women and men ages 15-49 years who had sexual intercourse with more than one partner in the last 12 months and reported use of a condom during the last sexual encounters	All population	42%		42%	2014	KDHS	53.6%	65.2%	76.8%	88.4%	100.0%
Percentage of male and female sex workers reporting the use of a condom during penetration sex with their most recent client	Key Population (FSW)	92%		92%	2017	PBS	92%	92%	92%	92%	92%
Percentage of men reporting use of a condom last time they had anal sex with a male partner (MSM)	Key Population (MSM)	79%		79%	2017	PBS	79%	79%	79%	79%	79%
Percentage of people who inject drugs who reported use of a condom the last time they had sexual intercourse non-regular partner	Key Population (PWID)	76%		76%	2017	PBS	76%	76%	76%	76%	76%
Percentage of people who inject drugs who reported use of a condom the last time they had sexual intercourse a regular partner	Key Population (PWID)	45%		45%	2017	PBS	45%	45%	45%	45%	45%
Number of condoms per man per year	Men (15-49yrs)	170275720	11842064	14	2020	KEMSA-LMIS	20	25	35	40	24condoms/ man/yr.
Prevalence of male circumcision in Kenya	male (15-64yrs)	54.5%		54.5%	2018	KENPHIA	61.6%	68.7%	75.8%	82.9%	90.0%

M&E RESULTS FRAMEWORK											
proportion of males circumcised as part of the minimum package for male circumcision for HIV prevention services	Age 0-14	13610	6453924	0.2%	2020	KHIS	18.2%	36.1%	54.1%	72.0%	90.0%
	Age 15-24	59095	6453924	0.9%	2020	KHIS	18.7%	36.5%	54.4%	72.2%	90.0%
	Age 25+	6100	6453924	0.1%	2020	KHIS	18.1%	36.1%	54.0%	72.0%	90.0%
Number and percentage of estimated PLHIVs enrolled in HIV care and currently receiving cotrimoxazole prophylaxis	All ages	1220293	1508405	80.9%	2020	KHIS	82.7%	84.5%	86.4%	88.2%	90.0%
Percentage of FSW living with HIV currently receiving ART among all FSW LHIV.	All ages FSW	24150	42547	57%	2020	KHIS	63.4%	70.1%	76.7%	83.4%	90.0%
Percentage of MSM living with HIV currently receiving ART among all MSM LHIV.	All ages MSM	5197	6650	78%		KHIS	80.5%	82.9%	85.3%	87.6%	90.0%
Percentage of PWID living with HIV currently receiving ART among all PWID LHIV.	All ages PWID	1439	3185	45%	2020	KHIS	54.1%	63.1%	72.1%	81.0%	90.0%
THEMATIC AREA 2: Revitalize shared fast track commitment towards achieving of treatment targets											
Percentage of newly identified HIV positive pregnant and breastfeeding women initiated on highly active antiretroviral therapy.	Pregnant women	16536	19021	87%	2020	KHIS	87.5%	88.2%	88.8%	89.4%	90.0%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	All ages	8132	9948	81.7%	2020	KHIS	83.4%	85.0%	86.7%	88.3%	90.0%
Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	All ages	801,475	1292749	62.0%	2020	KHIS	68.6%	75.2%	81.8%	88.4%	95.0%
% of active malnourished PLHIVs after a nutrition assessment was done	PLHIV on ART	19,193	611,167	3.1%	2020	KHIS	2.8%	2.4%	2.0%	1.6%	1.2%
Proportion of children and adolescents on ART	Children and adolescents on ART (0-24yrs)	163,371	252,278	64.8%	2020	KHIS	69.8%	74.9%	79.9%	85.0%	90.0%
Percentage of HIV patients screened for TB	0 -14	64195	69401	92.5%	2020	KHIS	94.0%	95.5%	97.0%	98.5%	100.0%
	15+	1055624	1163495	90.7%	2020	KHIS	92.6%	94.4%	96.3%	98.1%	100.0%
Proportion of fast-track clients who have been categorized as stable	All ages	165067	885811	19%	2020	DWH	28.9%	39.2%	49.5%	59.7%	70.0%
Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both HIV and TB	All ages	978		2020	TIBU						0.5

M&E RESULTS FRAMEWORK											
Percentage of people living with HIV enrolled into care and started on Isoniazid Preventive Therapy	All ages	96,432	125,341	76.9%	2020	TIBU	-	-	-	-	-
Percentage of women of reproductive age screened for cervical cancer	Female (15-49)	343855	1,571,208	21.9%	2020	KHIS	35.5%	49.1%	62.8%	76.4%	90.0%
Percentage of WLHIV screened for cervical cancer	WLHIV (15+)	6,727	781674	0.9%	2020	KHIS	18.7%	36.5%	54.3%	72.2%	90.0%
THEMATIC AREA 3: Protect the rights of people to live a life free of violence, stigma and discrimination											
Proportion of ever-married or partnered women 15–49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months	women 15-49 years	39%	-	37%	2014	KDHS	35.20%	31.40%	27.60%	23.8%	20%
Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings						HIV Stigma Index Survey	-				
Number of people reached with anti-stigma messages	All populations	428,718			2020	CAPR/KHIS	642974.4	857,231	1,071,487	1,285,744	1,500,000
Percentage of women and men experiencing physical violence since age 15	GBV cases	45%		45%	2014	KDHS	38%	31%	24%	17%	10%
THEMATIC AREA 4: Invest in resilient systems for HIV and other health outcomes											
Proportion of health facilities implementing DSD in HIV service provision	None	70	3,800	1.84%	2020		19.5%	37.1%	54.7%	72.4%	90.0%
Proportion of care and treatment sites sending VL samples to the lab	Care and treatment sites	2,536	3,800	66.7%	2020	NPHL, VL	73.4%	80.0%	86.7%	93.3%	100.0%
Mean turnaround time for the Viral Load (VL) System	All populations	12 days		2020	NPHL, VL	10 days	56 days	5 days	5 days	5 days	5 days
Mean turnaround time for Exposed Infants Diagnosis (EID) System	None	10 days	5 days	2 times more than the expected TAT (200%)	2020	EID-Database	5 days	5 days	5 days	5 days	5 days
Proportion of health facilities with incinerator	None	54%	54%	2016	Health care waste management plan 2016-2021	63.2%	54%	90.8%	100.0%	100.0%	100.0%
THEMATIC AREA5: Leverage on community led data programmes for an effective response											

M&E RESULTS FRAMEWORK											
No of implementing partners supporting community interventions	County			2020	HIPORs			210	220	230	240
THEMATIC AREA6: Integrate HIV in humanitarian and emergency responses											
% of contingency budget for HIV in Humanitarian and emergency responses	None			2020	KNASA	1% of HIV program budget		1% of HIV program budget	1% of HIV program budget	1% of HIV program budget	1% of HIV program budget
Proportion of OVCs reached with cash transfers	All ages	10,401	656,318	1.58%	2020	Children department	15.3%	29.0%	42.6%	56.3%	70.0%
THEMATIC AREA7: Promote translation of strategic information, research, surveillance, innovations and implementation of science to inform HIV programming											
Community reporting rate (CAPR)	County	1476	2642	55.9%	2020	KHIS	64.7%	73.5%	82.3%	91.2%	100.0%
Percentage of joint quarterly SIRI review meetings conducted	None	2	4	**50%**	2020	Reports	100%	100%	100%	100%	100%
Proportion of care and treatment facilities utilizing EMRs	None	1274	3,800	33.5%		NDWH/KHIS	40.8%	48.1%	55.4%	62.7%	70.0%
THEMATIC AREA8: Invest in long term HIV financing models											
Percentage of government funding towards HIV response		17 billion			2020	KNASA	18.6 billion	20.2 billion	21.8 billion	23.4 billion	25 billion
Proportion of HIV funding from Infrastructure Resources	County/Subcounty	1.8Billion			2020	KNASA	1.9 billion	2 billion	2.1 billion	2.2 billion	2.3 billion
Proportion of HIV Implementing partners reporting through HIPORS	Implementing Partners	30	411	7.3%	2020	HIPORS	23.8%	10%	11%	12%	13 %
THEMATIC AREA9: Promote leadership, communication and advocacy											
Proportion of MDAs with approved HIV workplace workplans	Approved Workplans	330	389	85%	2020	MAISHA	88%	90.9%	93.9%	97.0%	100.0%
Proportion of people with comprehensive knowledge on HIV amongst women	Kenya Demographic Health Survey	56%			2014	KDHS	62.8%	69.6%	76.4%	83.2%	90.0%
Proportion of people with comprehensive knowledge on HIV amongst men	Kenya Demographic Health Survey	66%			2014	KDHS	70.8%	75.6%	80.4%	85.2%	90.0%

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