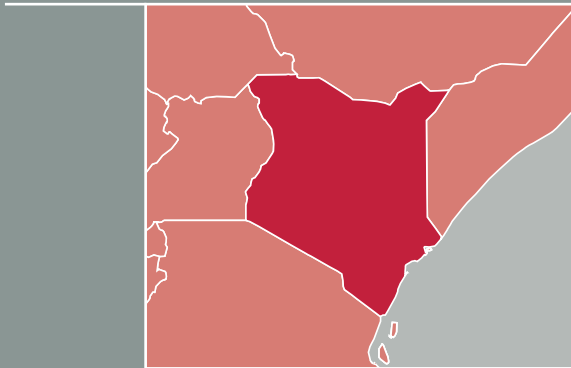


December 2012

RISK AND IMPACT ANALYSIS FOR KENYA OF CHANGES IN GLOBAL FUND FINANCING MODALITIES



*Phase 1 Report
Revised and Updated*

This publication was prepared by Arin Dutta and Nicole Perales of the Health Policy Project and Chris Alando of Deutsche Gesellschaft für Internationale Zusammenarbeit.

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The German BACKUP Initiative offers assistance to countries to submit viable project proposals and effectively employ the pledged funds. Since 2002, this global health programme has been helping applicant countries to utilise Global Fund monies. The programme was commissioned by BMZ and is currently funded until 30 September 2015. BACKUP works very closely with the Global Fund Secretariat in Geneva and also with governments and civil society and United Nations organisations around the world.

Risk and Impact Analysis for Kenya of Changes in Global Fund Financing Modalities

Revised and Updated Report

DECEMBER 2012

This publication was prepared by Arin Dutta,¹ Chris Alando,² and Nicole Perales.¹

¹ Futures Group, ² Consultant, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

The information provided in this document is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.

CONTENTS

Acknowledgments	v
1. Executive Summary	vi
2. Background.....	1
2.1 Global Fund Portfolio in Kenya	1
2.2 Rationale for This Study.....	3
2.3 Inception Report	4
2.4 Objectives and Scope of the Study	5
2.5 Organization of This Study	6
3. Situation Analysis of Recent Changes at the Global Fund	7
3.1 Developments at the Global Fund over 2009 to 2012	7
3.2 What is the Global Fund’s New Funding Model?.....	9
3.3 Implications of the New Funding Model for Kenya.....	15
4. Methodology.....	18
4.1 Methodology and Data for the Financial Gap Analysis	18
4.2 Methodology for the Policy Risk Analysis.....	20
4.2.1 Governance and Economic Environment Scan (GEES)	20
4.2.2 Methodology for the absorptive capacity analysis.....	21
5. Findings.....	23
5.1 Financial Gap Analysis for the Three Priority Diseases.....	23
5.1.1 HIV gap analysis.....	23
5.1.2 Tuberculosis gap analysis.....	24
5.1.3 Malaria gap analysis	25
5.1.4 Summary of gap analyses.....	27
5.2 Policy Risk: GEES and SWOT Analyses.....	28
5.2.1 Background: Kenya’s history with the Global Fund	28
5.2.2 Governance and Economic Environment Scan (GEES).....	29
5.2.3 Diagnosis of strengths, weaknesses, opportunities and threats (SWOT)	36
5.3 Policy Risk: Absorptive Capacity Related to Global Fund Grants.....	38
5.3.1 Recent grants and their budgets, disbursements, and expenditures	38
5.3.2 Three grants as case studies	40
5.3.3 Discussion.....	43
6. Summary of Recommendations	45
6.1 Policy Recommendations	45
6.2 Improved Financial Management	46
6.3 Improved Financial and Programmatic Oversight.....	46

6.4 For Further Analysis	46
Annex 1. Ministry of Finance (MOF) Flow-of-Funds Process.....	47
Annex 2. HIV/AIDS Detailed Gap Analysis	49
Annex 3. Tuberculosis Detailed Gap analysis	56
Annex 4. Malaria Gap Analysis	58
Annex 5. Detailed Gap analysis Summary	61
References	62

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1. EXECUTIVE SUMMARY

Introduction

Between 2009 and 2011, the Global Fund underwent a set of difficulties in replenishing its core funding. These difficulties resulted in the cancellation of Round 11 of the Call for Proposals in 2011.

As a response, the Health Sector Coordinating Committee in Kenya met in early 2012 and recommended a thorough risk assessment covering the policy level of funding for HIV/AIDS, tuberculosis, and malaria, and drafted Terms of Reference (TORs) for a study. These TORs requested a study to define the implications of the changes at the Global Fund on the three disease programs, including the financial risk of not receiving funds, the potential impact on the country's overall health objectives, and for recommendations to mitigate the emergent situation. Based on a request for support made at the Development Partners for Health in Kenya (DPHK) level, technical assistance was offered by GIZ and the USAID-supported Health Policy Project.

Since 2012, several events occurred which changed the complexion of the task. The Global Fund attracted new replenishment funding; Kenya's active grants received disbursements and funding commitments; and a new funding model at the Global Fund was announced. With the original Terms of Reference as a basis of discussion, an Inception Report was written, which considered these developments. Following stakeholder consultation, the team re-oriented the study to (a) focus on the Global Fund's new funding model, and (b) analyze current grants in the context of the entire disease program to look at gaps.

The Inception Report also concluded that the analysis should draw on validated projections of the financial gap, and the governance and economic environment that confront the use of Global Fund financing in Kenya. It should consider the long term and recommend appropriate mitigation measures. The first phase of analysis was conducted over November–December 2012 and is presented in this study. This analysis was updated in late 2013 to reflect changes in the HIV/AIDS, tuberculosis (TB), and malaria programs' targets and operational strategies, as well as new information available on the Global Fund's new funding model. These changes reflect comments received from in-country stakeholders during the review of the first draft. The scope of the current study includes three areas of inquiry:

1. A financial gap analysis based upon a scenario with no additional Global Fund support.
2. A review of Kenya's policy risk profile as it pertains to accessing new funding from the Global Fund. This includes the size of the financial gap, as well as barriers such as absorptive capacity.
3. Formulation and validation of related mitigation actions in the form of policy recommendations.

Findings

In late 2013, thirteen of the sixteen grants that Kenya has ever received from the Global Fund were considered active by the Global Fund, though only nine have recently received disbursements. Total disbursements to date equal US\$496.2 million, representing 3.7 percent of all funds ever disbursed in sub-Saharan Africa.

The New Funding Model and Kenya: At its 28th meeting in November 2012, the Board of the Global Fund approved its New Funding Model (NFM). The NFM, described in this report, will be a process in which applicants request funds based on a concept note that derives from their national strategy. The note expresses their total demand, of which the Global Fund may choose to finance only a portion. The highest amount a country may request is preset for each defined period, based on its being

placed in one of four country “bands.” The limit for a country then draws from the allocation to the band it belongs to, and a predefined range for the country itself, defined based on predetermined characteristics.

As of late 2013, the Global Fund has released more information on the NFM process, which will be implemented in full during 2014. Over the year 2013, several countries were involved in an ‘interim’ process of the NFM and received initial funding. Kenya was one of these countries, receiving \$13 million as top-up funds for existing TB grants, with additional value under negotiation for HIV (\$53 million) that would be included as part of the overall renewal funding of two existing grants. Separately from the NFM, Kenya has also recently been successful in getting a large renewal on its existing malaria grants, with total continued funding approved of nearly \$79.7 million.

As the NFM is fully launched in 2014, it is likely that Kenya will be able to access additional funds to meet key program gaps. The total amount of funding that will be available is not yet known, but will be an amount that reflects the status of current grants, the amount allocated under their renewal, and other considerations, including the quality of Kenya’s concept notes under the NFM process. With the four country bands decided by a composite measure of disease burden (need) and gross national income (GNI) per capita (ability to pay), Kenya will be placed in Band 1: “lower income, high burden” (i.e., low ability to pay and high need). There are 29 total countries in this band. According to preliminary simulations, Band 1 may be allocated nearly 50 percent of all funding under the NFM. Kenya has also been tentatively placed in an illustrative list of 27 underfunded countries. While this is good for Kenya’s chances of receiving additional funding, much is yet to be decided. Its ability to access funds under the full rollout of the NFM will depend on several factors, including the aspects of policy risk considered in this study.

The NFM can offer both opportunities and challenges to Kenya. The following are some of the more important **opportunities**. We discuss the background to these and other issues in Chapter 5.

1. Opportunity for constructive dialogue between the country and the Global Fund, especially to address factors that have hindered grant and program implementation (see next page).
2. Open a debate regarding the importance of financing and planning for the overall health sector versus for vertical disease programs, and where the two needs can converge.
3. Open a critical debate on “value for money,” inspired by the NFM’s emphasis on a Concept Note articulating the total financial need for “high impact interventions.” This may mean prioritization.
4. Inject a sense of urgency to strengthen and align financial accountability measures, and make necessary adjustments to the public sector’s financial systems and institutional/legal frameworks.

There may also be significant **challenges**. The proposed NFM resource mobilization process will require the attention of key stakeholders to focus on the actions needed to prepare a Concept Note. Addressing the policy risks we identify will also require high-level support in a period of major structural change in the health sector, including devolution and the organizational change in the Ministry of Health. The failure to mobilize additional funding from the NFM mechanism would have several implications:

- A prolongation of the financial gaps in Kenya described in this study.
- Lower confidence in the country’s strategies, processes, and capacities for the three diseases.
- Failure to fill **financial gaps** (Table ES.1) may lead to a lag in implementing strategic plans. Failure may also require scaling back or omitting some interventions based on prioritization.

Table ES.1. Summary of Financial Gap Analyses, 2012/13–2017/18, US\$ Millions

	HIV	Tuberculosis	Malaria
Total Resources Needed minus public sector salaries	\$2,649	\$327.9	\$710.1
Total Resources Available minus GOK salary budget*	\$2,406	\$69.5	\$297.7
Total Net Financial Gap**	\$242	\$258.4	\$412.4
Maximum Potential Outstanding Funding based on original value of current Global Fund grants	\$140.5	\$19.8	\$84.7

Source: See Ch. 4 (Methodology) and Ch.5 (detailed results). All resource needs are for program implementation as per national strategies, primarily through public and affiliated NGO/CBO facilities. Surpluses in initial years are assumed available to spend in subsequent years. * Includes any amounts donors spend on activities off-budget and in support of service provision in the private sector. ** Does not include the outstanding funding deriving from TRP-adjusted or original proposal amounts.

Inadequate health sector budget and dependencies: The health and community system is severely burdened by diseases and related human resources are strained. Kenya must take forward the already identified need into emergency-type funding for overall health systems strengthening.

However, successful application through the NFM could significantly plug the financial gaps. It could also come with conditions to strengthen reporting and the Financial Management System of principal recipients (PRs), and streamline procurement arrangements, among the other opportunities.

At about 11 percent of the total development partner contribution in FY 2012/13, the Global Fund is a major contributor to Kenya’s health sector, the second highest funder after the United States Government. It is an even more critical contributor to the HIV, malaria, and tuberculosis budgets from a programmatic perspective. Therefore, it is important that all stakeholders should invest in the effort to oversee grants and ensure they perform optimally. Given the size of the Global Fund portfolio, the critical dependencies for ART, etc., the health sector could face negative repercussions if Global Fund support is reduced.

Strengths, weaknesses, opportunities, and threats to seeking new funding: The performance and oversight of Global Fund’s grants to Kenya have improved since 2009 and many grants are well-rated. However, Kenyan grants have not always maintained this performance. An analysis of Kenya’s grants against the requirements of the Performance-Based Funding principle illustrates that certain grants in Kenya secure lower ratings due to avoidable issues. Some grants are implemented with a delay of six to 24 months. Financial management issues—including audit delays and accounting anomalies, conflicting policies across the Principal Recipients (PRs) and the Global Fund (e.g., audit and funds flow timelines), and problems in the procurement and supply management system—have led to delays.

Beyond the financing gaps summarized earlier, some potential problems may occur in implementation:

1. Weak or underfunded sub-recipient (SR) structures at the decentralized/sub-county level.
2. Confusion about the status of future sub-county governance and financing structures, brought about by the lengthy implementation of the country’s new constitution in the health sector.
3. Global Fund grants and reporting structures are frequently in competition for time and expertise with those of other development partner programs. The M&E framework of the health sector is yet to fully consolidate and leverage efforts at data collection, etc.

Specific problems with absorptive capacity: The Ministry of Finance (MOF), a major Global Fund PR, estimates that its procurement lag averages two years. Other health sector partners implement with an average of a one year lag. This may be caused by poor forecasting or procurement planning, coordination problems, or *force majeure*. Given procurement delays, a PR may have high expenditure levels (a large percentage of funds disbursed to SRs) but still fail to achieve outcome indicators.

A stage of the process of funds flow in need of careful consideration is the audit of MOF grants. Kenya's rules and regulations require MOF grants to be audited by the Kenya National Audit Office (KENAO) rather than independent auditors. External auditors need to be approved by KENAO. However, KENAO completes its audit at least 180 days after the calendar year, whereas the Global Fund requires an audit within 90 days. Problems in the absorptive capacity of PRs pose a serious risk to the success of current grants. If these problems continue, they also imperil Kenya's ability to secure funds with the NFM.

Recommendations

Policy: Kenya has two choices in this context. The first option is to prioritize interventions and rationalize coverage and programmatic activities, such that more can be achieved while remaining within the resources available. The second option is to aim to pursue a resource mobilization strategy that will increase funds for the three priority diseases from various sources, including increasing government co-funding. Towards the latter option, we have specific recommendations:

1. *Mobilizing increased government co-funding:* Kenya should accelerate approaches towards innovative and local financing. In anticipation of oil revenues, for example, a plan could be developed to ring-fence an allocation for health. Additionally, the Ministry of Health and the National Aids Control Council (NACC) (for HIV) should advocate for increasing the level of Government of Kenya co-funding of expenditures for the three priority diseases. There is growing reliance on the Global Fund for key interventions, such as antiretroviral therapy (ART). This reliance may not be sustainable in the long run. New and existing government co-funding should target key commodities and priority interventions, such as ART, to mitigate the risk and maintain current service delivery levels.
2. *Mobilizing additional Global Fund resources:* Even so, it is likely that Kenya may need to seek additional Global Fund resources. In this context, recommendations below regarding financial management and oversight are relevant. The disease programs should begin to look critically at existing strategies and identify critical gaps that could be prioritized for NFM application. Kenya should address key issues that are important among the criteria for the NFM, such as absorptive capacity, co-funding, and reduction in other forms of operational and programmatic risk.

Improved Financial Management: (a) The MOF and other PRs should diagnose their SR's financial management systems using the Global Fund guidelines and prepare a timed capacity building plan to strengthen these. (b) The PRs should hold trainings to strengthen Performance Based Funding. (c) The MOF, SRs, and sub-county level funds flow systems should be reviewed to harmonize them with the Global Fund's performance and timeliness requirements. (d) The PRs, in collaboration with the Global Fund, should perform an operational risk assessment and develop a Global Fund risk mitigation plan that covers all the areas of risk identified by the Global Fund local fund agent (LFA) guidelines.

Improved Financial and Programmatic Oversight: The following are specific recommendations:

1. *Governance and stewardship:* The central Ministry of Health and the 47 county governments should engage in discussions driven by the draft assignment of health functions to define the division of labor. This should be done as part of a program-level approach (i.e., looking at key actions under the disease programs), which will also be relevant in the future for NFM-related

Concept Notes. Specifically, this will clarify roles and responsibilities, in addition to meeting the Global Fund's request for clear demarcation of responsibility related to the NFM.

2. *Audits:* The MOF should consider requesting a waiver of government policy to allow the Kenya National Audit Office to outsource the audit of Global Fund grants in order to speed up the process. KENAO would still retain its national obligations under this arrangement.
3. *Oversight:* The Kenya Coordinating Mechanism (KCM) should improve oversight and pre-audits of all grants, with a special emphasis on those previously judged problematic. All development partners should invest in the effort to oversee grants, especially for the NFM in the future. The DPHK should continue to invest in oversight capacity strengthening processes, including by providing technical and financial support to the KCM oversight process and following up on the implementation of grant and PR oversight report recommendations.

2. BACKGROUND

2.1 Current Global Fund Portfolio in Kenya

Since 2002, sixteen grants have been implemented in Kenya spanning the three priority diseases. In late 2013, nine of those sixteen grants had received any disbursement since 2010 and could be considered actively funded. These represented about US\$480.5 million in grant agreement amounts over their current implementation phases. These grants are summarized in Table 1 in terms of the commitments, a firm indication of the funding available to be transferred. It is important to distinguish the signed amount, which represents a financial bond between the Global Fund and the principal recipient (PR), from the overall amount committed. These distinctions become clearer as we discuss Round 10 in detail.

Box 1: Staggered Commitments

For Round 10, under the “*staggered funding commitment policy*,” funds were set aside using the “1+1+1” rule: a first commitment at the time of signing the Grant Agreement, for the first year. A second commitment is for the second year of the grant, committed no earlier than nine months from the first implementation period end date. The third commitment, for the third year, is made no earlier than 18 months from the first period end date.

Source: (GFATM 2012e)

Table 1. Kenya: summary of active Global Fund grants as of January 2014

Disease	Principal Recipient	Round	Signed Grant Period (month - year)	Total Signed Amount ¹ (US\$ millions)	Total Committed Amount ² (US\$ millions)
HIV/AIDS	Kenya Red Cross	Single Stream (Round 10)	Dec-11 to Jun-14	\$18.11	\$18.11
HIV/AIDS	MOF	Single Stream (Round 10)	Sep-11 to Jun-14	\$170.94	\$104
HIV/AIDS	CARE Intl.	Round 7	Apr-09 to Mar-14	\$28.34	\$27.58
TB	AMREF	Single Stream (Round 9)	Jan-11 to Dec-15	\$18.99	\$13.22
TB	MOF	Single Stream (Round 9)	Jan-11 to Dec-15	\$37.71	\$26.29
Malaria	AMREF	Round 10*	Feb-12 to Jan-14	\$5.81	\$5.81
Malaria	MOF	Round 10*	Jan-12 to Dec-13	\$38.44	\$38.44
Malaria	MOF	Round 4 (extension)	Feb-06 to Dec-13	\$162.17	\$162.17
			TOTAL	\$480.51	\$395.61

Source: Global Fund, data as of Jan. 10, 2014. Values have been rounded up to two decimal points.

* Recently approved Phase 2 renewal amounts are not shown here. The grant period is likely to change.

¹ Also known as the grant amount, this refers to the amount of funds available for commitment under the terms of the grant agreement and within the applicable implementation period.

² The confirmed committed amount is the amount which is legally available from the grant amount to be transferred in cash to the principal recipient (or other third party) under the terms of the grant agreement and within the applicable implementation period.

The PRs in Kenya have ranged from ministries to local and international nongovernmental organizations (NGOs). Past PRs included Sanaa Art Promotions and the Kenya Network of Women with AIDS. The Ministry of Finance (MOF) has been the most prominent PR of Global Fund grants and the only PR with fund management experience in all three diseases. The total historical amount of Global Fund agreed (signed) funding to Kenya is \$597.61 million, inclusive of closed grants from Rounds 1 and 2, as well as the Round 5 tuberculosis grant that was stopped after its Phase 1 (AIDSPAN 2014; GFATM 2014b). Although the number of grants being implemented within each disease is similar, the amount of \$597.61 million representing agreed funding is distributed with a strong bias towards HIV/AIDS with \$217.4 million (45 percent), followed by malaria at \$206.4 million (43 percent), and tuberculosis at \$56.7 million (12 percent) (AIDSPAN 2014). These amounts do not account for the additional funds that are in process from renewal funding (Phase 2) for the two malaria grants from Round 10, or under the ‘interim’ process of the Global Fund’s new funding model for the single-stream HIV grants (Table 2). Additional funding for the single-stream HIV grants under their Phase 2 renewal had not been firmly decided at the time of writing this report, though an indicative amount is shown in Table 2.

Table 2. Expected funding under certain active grants in Kenya, US\$ millions

Disease	Principal Recipients	Round	Additional funds expected	Period covered by new funds
HIV/AIDS	Kenya Red Cross	Single Stream (Round 10)	\$300.04 ¹	Oct. 2014 – Jun. 2017
	MOF			
Malaria	AMREF	Round 10	\$69.6 ²	Jan. 2014 – Dec. 2016
	MOF	Round 10	\$10.1 ²	Feb. 2014 – Jan. 2017
TB	AMREF	Single Stream (Round 9)	\$16.28 ³	Jan. 2014 – Dec. 2015
	MOF			

¹ Based on anticipated Phase 2 renewal plus NFM interim funding. Amount may change before signing.

² Anticipated Phase 2 renewals. ³ Expected funding under the current grants, based on TB program estimates. Sources: (AIDSPAN 2014; GFATM 2014b; GFATM 2014a).

Some of the grants currently in implementation operate under a mechanism known as a single stream of funding (SSF) which allows multiple previous grants managed by the same PR to be consolidated into one funding agreement per disease. Under the current grant architecture, SSFs would undergo a periodic review at the end of the implementation period which would determine additional funding to be added to the single stream. In December 2013, the first phase of the Round 10 malaria grants is scheduled to end, which makes the renewal funding of \$79.7 million acutely needed, as shown in Table 2. In addition, Phase 2 renewal and interim NFM funding for the HIV grants from Round 10 is imminent, which will fund services from October 2014 onwards. In this report, we consider some of the forecasted needs for the three programs, and after taking into account currently known grant renewal amounts, we anticipate what needs may still remain to be covered. Some of these needs may be relevant for new requests to the Global Fund under the NFM (discussed in depth in Chapter 3).

2.2 Rationale for This Study

The rationale for this study may be best understood when we consider *policy risks* as being separate from the risk in general implementation—i.e., operational risk at the level of an individual PR (Box 2). The latter type of risk is usually the main focus of a Global Fund-appointed Local Fund Agent’s (LFA) risk assessment. Policy risk analyses focus on the risks inherent to the country (specifically, the health sector) and on their impact and implications. Some of this risk, as we will examine in this study, is as a result of changes in Global Fund financing levels and modalities. On the other hand, the LFA’s risk assessment and subsequent PR-oriented risk management plan focuses on programmatic factors and those related to the surrounding implementation environment.

Box 2: Policy Risks in the Health Sector

We define policy risk as an issue(s) at the level of the *entire disease program*, or the health sector in a country, which threatens the achievement of overall health outcomes. A policy risk can be a barrier to receiving new funding, or a barrier to spending funds that is common across different implementers.

Between 2009 and 2011, the Global Fund underwent a set of difficulties in replenishing its core funding through both its traditional and nontraditional donors, due in part to the global recession and in part to donor concerns about the Global Fund’s governance structure. These difficulties resulted in the cancellation of Round 11 of the Call for Proposals in 2011, and adoption of a more restrictive Transitional Funding Mechanism covering 2011–2012. These events signaled to policymakers in Kenya that continued Global Fund support could be at risk (i.e., funding would not always be assured or predictable).

As a response to this understanding, the Health Sector Coordinating Committee (HSCC) in Kenya met in early 2012 and recommended that:

- The country reviews and restructures the mode of service delivery using external funding in order to sustain the gains made in the fight against malaria, tuberculosis, and HIV/AIDS;
- The country mobilizes additional resources to bridge an anticipated widening financing gap;
- Kenya sees the situation as a call to strengthen the health sector’s financial sustainability and to accelerate approaches to innovative financing. The search for innovative financing in early 2012 was ongoing, but was yet to gain traction and obtain full support at cabinet and policy level.

In addition, to inform efforts towards implementing the above recommendations, the committee strongly recommended a thorough risk assessment covering the policy level. The HSCC formed a team drawn from technical partners to draft the Terms of Reference for the risk assessment study.

However, while the three recommendations above remain valid, the reasons for commissioning the task have significantly shifted. This is because the policy risks as pre-supposed have altered. The 2012 HSCC meeting had closely followed the Global Fund’s Board and replenishment meetings held in 2011, which had resolved to cancel Round 11; stay any new financing pending further review of the replenishment, including Kenya’s successful Round 10 grants for HIV and malaria totaling close to \$500 million over their life; and review any non-performing grants at their second and last phase of implementation, in which Kenya had been considered a potential loser. In 2012, the Global Fund attracted previously unavailable donor funding. As of late 2013, the financing situation for the Global Fund and the recipient countries has shifted further. For example, Kenya’s active Round 10 grants have gained new funding, and a new funding model at the Global Fund, reviewed in this study, has been announced. The Global Fund’s 2014–2016 replenishment efforts have secured donor pledges of \$12 billion, a sizable amount, even if the institution had initially sought \$15 billion (GFATM 2013a).

2.3 Inception Report

Based on a request for support made at the Development Partners for Health in Kenya (DPHK) level, technical assistance was offered by GIZ (*Deutsche Gesellschaft für Internationale Zusammenarbeit*) through the German BACKUP Initiative and the USAID-supported Health Policy Project (HPP). GIZ conducted a competitive process for the selection of an appropriately qualified consultant for this assistance, while HPP appointed staff based at its Kenya and Headquarters (Washington, DC) offices.

With the original Terms of Reference as a basis of discussion, an Inception Report was written, which considered the developments at the Global Fund since the development of the original rationale for this study. The Inception Report was developed in consultation with stakeholders and after an initial review of the changes at the Global Fund. It provided the consulting team's comments on the original Terms of Reference, revised objectives for the study, the processes, methodologies and tools that would be utilized, and a proposed workplan and calendar leading to the current study as well as future extensions.

Stakeholder consultation: This study is expected to benefit planners and policymakers, development partners, service providers, and broader civil society in Kenya. At inception, the team reviewed the Terms of Reference in consultation with stakeholders from both government and nongovernmental partners to ensure a broad consensus on the issues at stake. During the development of the current study, the team further consulted the Ministry of Finance as the main PR (see Section 2.1) and some of its sub-recipients (SRs), as well as high-level members of the government.

In general, the stakeholders in this exercise include the HSCC, the MOF, the Ministries responsible for health and their Global Fund implementing programs, civil society PRs and SRs, the members of the Development Partners for Health in Kenya grouping, the National AIDS Control Council (NACC), and the Kenya Country Coordinating Mechanism for Global Fund.

Recommendations of the Inception Report: Following stakeholder consultation, the team re-oriented the study to reflect the following ideas:

- The Global Fund's Secretariat is implementing a "new funding model" as approved by the Board. Hence the risk assessment should focus on these changes in order to remain relevant.
- Nearly all Global Fund financing in Kenya is integrated into existing strategies comprising multiple interventions and multiple funding sources. There are multiple development partners supporting the three priority diseases as well as health systems strengthening. Therefore, the Global Fund grants should be analyzed in the context of the entire disease program in order to reflect the nature of the health sector.
- Similarly, the analysis would be more relevant if it was to analyze the risks of not securing Global Fund financing on the program as a whole, rather than on specific health interventions.
- The timelines are insufficient to allow for the inclusion of operational and performance issues in the risk assessment. Therefore, the study should focus on policy risk—specifically, the ability of and barriers for Kenya to access new funding from the Global Fund.
- The policy risk analysis should draw on properly validated analyses of the projected financial gap, and the governance and economic environment that confront the use of Global Fund financing in Kenya. Validation would occur through sharing of the results with key stakeholders in the Ministries, and with program managers. The results of the analysis should be framed in a way that would be understood by all stakeholder groups.
- The risk analysis should eventually cover the longer term, with appropriate mitigation measures covered in the recommendations based on more exhaustive analysis of the issues, such as the

impact of the project financial gaps on interventions and hence on health outcomes. The scope of the extended analysis is discussed in Table 3 below.

During the presentation of the Inception Report with the recommendations above, stakeholders agreed that much of the rationale for drafting the original Terms of Reference had been overtaken by events. Stakeholders agreed with the consulting team's recommendations, including the suggestion that the study be performed in two phases.

2.4 Objectives and Scope of the Study

Objectives: The original objectives of the Terms of Reference were considered in the Inception Report:

1. Define the implications of the changes at the Global Fund on the three disease programs, including the financial risk of not receiving funds.
2. Determine the implications of the lack of funding in the HIV, tuberculosis, and malaria programs on the country's overall health objectives.
3. Determine the impact of the lack of funding in the three disease programs on related health services where interventions are carried out as part of an integrated model.
4. Classify the respective risks and impacts in a predetermined framework or other suitable, standardized frameworks.
5. Propose feasible recommendations on the mitigation and management of the emergent situation in terms of costed scenarios that allow for strategic decision making.

Scope of work: While the objectives have been retained, the scope of work has changed for reasons discussed in Section 2.3. While the original objectives take the absence of new financing as a fact, our current scope of work involves an investigation of the barriers to—i.e., the reasons behind—a lack of new funding. Adding this step allows for recommended actions to overcome such barriers. The initial analysis for this study was completed over 2012–2013. The results have since then been revised and updated over late 2013 and early 2014, and reflect new knowledge on the NFM as well as on the funding situation of Kenya's grants.

The current study analyzes certain aspects of policy risk that may prevent Kenya from fully accessing new funds from the Global Fund. Broadly, there are two aspects. The first is Kenya's absorptive capacity for Global Fund grants funding. The second is the institutional structure in Kenya as it relates to the oversight and financial management of Global Fund grants, as well as sociopolitical and financial factors that can determine the long-term sustainability of such funding for the country. These analyses partially address the first objective above. In terms of what will be covered later, this report does not include the analysis of the health impact of the lack of new financing, or the fitting of risk and impact measures in a framework. However, recommendations for mitigating the policy risks are provided, which partially addresses the fifth objective from the list above. In summary, the scope includes:

- As agenda setting, conduct a financial gap analysis based upon the scenario where no additional Global Fund support, beyond current grants, is available.
- Conduct a review of Kenya's policy risk profile as it pertains to accessing new funding from the Global Fund, which includes the assessment of the financial gap, as well as institutional barriers, especially given the implications of recent changes at the Global Fund.
- Formulation and validation of related mitigation actions in the form of policy recommendations.

Table 3. Original objectives and revised scope of the study

Objective	Scope
1. Define the implications of the changes at the Global Fund on the three disease programs, including the financial risk of not receiving funds.	Financial gap analyses assuming unavailability of additional Global Fund support over several years per disease
2. Classify the respective risks and impacts in a predetermined framework or other suitable, standardized frameworks.	Review barriers to accessing additional funds based on the risk profile at the policy level
3. Propose feasible actions for the mitigation and management of the emergent situation in terms of costed scenarios that allow for strategic decision making.	Formulate and validate policy recommendations

Source: Authors

2.5 Organization of this Study

Policy risks inherent in accessing new funding from the Global Fund can only be understood once the recent changes at that institution have been reviewed. Based on this understanding, specific barriers, drawing on elements identified in documents from the Global Fund, can be analyzed. This analysis has to be set in the light of the existing financial gap in Kenya for the three disease programs. This financial gap analysis is in itself an important determinant of how the Global Fund will implement the “new funding model” for recipients. Given this logic, the study has been structured to be read in the sequence of background, methods, results, and recommendations.

In Chapter 3, we review the recent changes at the Global Fund, which are not limited to the proposed adoption of the “new funding model” that was formally proposed first in September 2012 and thereafter adopted by the Global Fund board in November 2012. This review forms the basis for the identification of certain elements that could affect access to new funding from the Global Fund for Kenya. These elements are related to policy risk. The description of these elements and the methodology to assess them in the service of an overall evaluation of policy risk are covered in Chapter 4.

Chapter 5 begins with the findings on financial gap analyses for the three disease control programs. It then provides our findings, as structured by the different elements of policy risk.

Chapter 6 provides recommendations for policy options based on the previous chapters. Annexes are provided at the end with additional details.

3. SITUATION ANALYSIS OF RECENT CHANGES AT THE GLOBAL FUND

3.1 Developments at the Global Fund over 2009 to 2012

The management of the Global Fund’s growing portfolio in recent years resulted in a growing number of new policies, guidelines, and requirements. In 2009, the grant architecture shifted from project financing to national program-based grant-making following the adoption of single stream funding with periodic review arrangements. This streamlined management aggregates the same-disease grants of a single PR. A view is that this places the country at higher risk in case of delays or suspensions.

Stakeholders at the Global Fund had commonly expressed a need for simpler processes and more effective in-country structures, with stronger risk management and fraud prevention practices. Overall, enhanced aid effectiveness and value for money were desirable attributes, which are also priorities for many donor governments.

Reforms up to 2012 and implications for Kenya: Some provisions of the changes to operational guidelines and oversight functions over the 2011–2012 period are at odds with arrangements in Kenya.

- Global Fund reforms have led to strengthened influence of global technical partners over its funding priority areas and other key policies. These include organizations such as UNAIDS, through the new HIV/AIDS “Investment Framework” (UNAIDS, 2011); the WHO’s Roll Back Malaria division; and the Stop TB partnership. Occasionally, national and global technical partner policies may not agree.
- Periodic reviews, a key part of the grant architecture as of 2012, include data quality assessments and “value for money” indicators, among other parameters. The PRs are expected to collect these in collaboration with the national health information system. This calls for a strengthened and expanded national M&E framework that many countries have not fully put in place.
- There are shorter timelines for making financial audit reports available. The Global Fund requires audits by the end of 90 days after the financial year, while the Ministry of Finance audits begin 180 days *after* the financial year.
- Kenya continues to procure commodities for its grants with a two year lag, which is a real risk, irrespective of whether the PR is a government or civil society institution.

In its funding model as of 2012 (prior to the “new funding model”), the Global Fund had included a requirement of **counterpart financing**, ranging in percentages, based on the economic status of a country. Kenya is included in the band of low-income countries expected to shoulder at least 5 percent of the resource need by disease, based on the national program. However, based on previous estimates, Kenya’s contribution for the three diseases, excluding the cost of public sector health workers shared by all diseases, does not amount to 5 percent. As we discuss in Section 3.3, this may in the future pose challenges to efforts at attracting future Global Fund grants; especially if other countries continue to meet this 5 percent threshold.

The entire core operational policy manual of the Global Fund underwent a review culminating in a new version in February 2012. Some changes to guidelines for the management and oversight of grants were not controversial, and were adopted in Kenya. Participatory grant oversight, conflict of interest management, and four other functions are now mandatory for the Kenya Coordinating Mechanism (KCM) of Global Fund grants.

The Global Fund's framework and methods for managing risk have been improved recently. The LFA manual has been updated and the Global Fund's expectations from its LFAs now include a risk assessment at the PR and the general country level. In Kenya, the Ministry of Finance, a major PR, is currently planning to develop a risk management plan in reaction to these expectations.

However, many stakeholders contend that Kenya is implementing its grants with a two year lag in performance. Especially, it takes the country twice as long to absorb funds compared to better performing countries in its income bracket and region. This will be a focus in this study later. Few Kenyan grants have received the "A1/A2" ratings from the Global Fund, and fewer still have maintained these ratings. These reflect problems in the efficiency and achievement of results from grants.

The Global Fund's new Strategic Framework: During its 25th Board meeting in November 2011, the Board approved the Global Fund's new Strategic Framework for the years 2012 to 2016. The new strategy was the culmination of an extensive consultative process involving a wide range of stakeholders. It involves investing more strategically on high impact opportunities drawn from national strategies, and eventually replacing the round-based system of financing. Guided by this strategy, the Global Fund will:

- *Invest* more strategically, focusing on highest impact opportunities, and fund based on national strategies; and maximize the impact of investments on improving health;
- *Evolve* the funding model by replacing the current rounds-based system with a radically different funding model, with more predictable and flexible funding and an iterative, dialogue-based application process;
- *Implement* by actively supporting grant implementation success, based on impact, value for money, and risk; enhance quality and efficiency; and make partnerships work
- *Promote* and protect human rights; and
- *Sustain* the gains, mobilize resources by increasing sustainability of programs and attract additional funding.

Cancellation of Round 11: Another major decision reached during the 25th Board meeting was the cancellation of Round 11. This decision was reached mainly because of economic challenges in major donor countries and a poorly performing global economy, which offered low interest rates on the Global Fund's capital reserves. Among other issues cited was the continued withholding of pledged funds by some donors who cited operational risk, weak fiduciary controls, and governance factors, both within the Global Fund and in recipient countries.

Recent Global Fund Reforms: During this meeting, the Global Fund board also appointed a General Manager to assist in reforming the organization. Since the November 2011 meeting, the Global Fund has shed about 22 percent of its Geneva Secretariat staff. In 2012, the Global Fund attracted previously unavailable donor funding which contributed to the highest total contributions pledges in its history. The underlying principles behind the reforms at the Global Fund were informed by its history and experiences during the last decade.

The recent Global Fund reforms go hand in hand with the implementation of its new strategy. The reforms aim to:

- Strengthen fiduciary controls and risk management to achieve sustainability and impact;
- Progressively orient the grant architecture to the Performance Based Funding principle;
- Integrate "value for money" into the Global Fund's operations and requirements;
- Focus all operational, partnership, monitoring and evaluation, and compliance units of the Global Fund to exchange knowledge on each country with a view to taking informed collective decisions and sharing responsibility for grants throughout the entire grant cycle; and

- Strengthen grant and PR oversight by the country coordinating mechanisms, identifying potential challenges and compliance issues, simplifying communication, and increasing the standardization of practices across countries.

Structural Changes: The Global Fund Board, Secretariat structure, membership, composition, and by-laws have changed. The names and roles of important committees have also changed. The *Board's* revised structure comprises three committees with delegated authority to make decisions and perform advisory and oversight functions. The first committee is the Finance and Operational Performance Committee (FOPC), which provides oversight of the financial management of Global Fund resources. The Audit and Ethics Committee (AEC) provides oversight of the Global Fund's internal and external audit and investigation functions, and ensures appropriate standards of ethical behavior by the Global Fund and its grant programs. Finally, the Strategy, Investment and Impact Committee (SIIC) provides oversight of the strategic direction of the Global Fund and ensures the optimal impact and performance of its investments in health. The Technical Review Panel, Technical Evaluation Reference Group, and Market Dynamics Advisory Group now report to the SIIC. These changes affect all future grant-making operations, including any that might involve Kenya.

At the *Secretariat*, four departments now report to the General Manager. These include Resource Mobilization and Donor Relations; Strategy, Investment and Impact; Finance; and Grant Management. In addition, two control divisions (Risk Management, Legal and Compliance) and two support divisions (Communications, Human Resources) report to the General Manager. The Grant Management Department is the one most in touch with the PRs. It has been revised into several divisions, formerly referred to as clusters. These include Grant Management Support, "Africa and the Middle East," "High Impact Countries in Africa 1," "High Impact Countries in Africa 2," "High Impact Countries in Asia," and "Asia, Europe, Latin America and the Caribbean." Kenya belongs to the "High Impact Africa 2" cluster. This classification may change. The CCM team of the Global Fund has been disbanded.

3.2 What is the Global Fund's New Funding Model?

In this section, we review the procedural aspects of the new funding model (NFM). In the next section, we review the implications for Kenya.

The NFM (Box 3) is intended to allow certain strategic priorities for the Global Fund to take shape. One of these is to focus on countries with the highest needs (e.g., disease burden) and the least ability to pay. Another is to support high-impact interventions and tie the grants to robust national strategies, whether for a disease or for the entire health sector.

Official documents describe the NFM process, including the grant architecture that the Global Fund Secretariat (henceforth "Secretariat") has recommended and that was adopted by Board decision (GFATM 2012g).

The NFM process can be broken down into several levels of detail, the highest of which relate to the *grant architecture*, which will be reviewed

Box 3: Key Aspects of Grant-making under the NFM

At its 27th meeting the Board of the Global Fund (September 13–14, 2012) adopted in principle the elements of a new funding model (NFM) which would be implemented beginning in 2013. Most aspects of the NFM were approved at the Board's 28th meeting held over November 14–15, 2012. The NFM is a process in which applicants request funds from the Global Fund based on a concept note that derives from their national strategy or investment case. The note expresses their total demand, of which the Global Fund may choose to finance only a portion. The highest amount a country may request is preset for each defined period. This limit is mainly defined based on predetermined characteristics. Grants are made to cover a fixed allocation period, at the end of which applicants may reapply for new funds.

periodically. The other levels relate to the *grant-making process* to be followed with individual applicants. We will discuss the grant process in detail.

Grant architecture: The NFM was implemented starting with the interim process beginning in 2013 that was part of an overall ‘Transition Phase’ from the past mechanism. The interim period allowed many aspects of the process to be tested and fine-tuned. Several aspects of the grant architecture were discussed within the Global Fund’s Strategy, Investment and Impact Committee (SIIC), and then presented to and ratified by the Board. These aspects of the design are discussed in their logical sequence.

1. **Length of a grant under the NFM:** The Global Fund would like to establish the length of the grants such that the periodicity of grant-making is flexible and responsive enough to changing circumstances in the country. Too short a grant period would mean more frequent requests and a near-continuous process of proposal drafting, which places a burden on applicants and implementers. Box 4 suggests the reasoning in this regard. The Secretariat may extend the length in special circumstances for the continuity of services while a new grant is in process.

Box 4: Length of Grants under the NFM

Length of **three years**, as a middle ground to preserve the relevance of funded interventions, allow stability in the funding, yet also allow enough time for activities with longer outcome and impact windows to bear fruit.

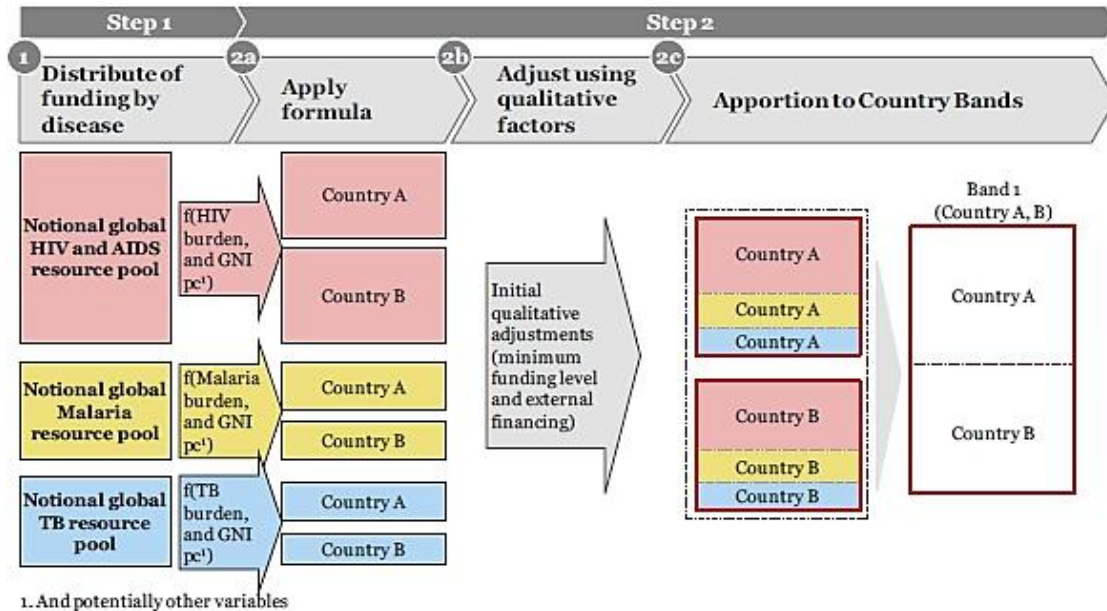
2. **Allocation across the three diseases** of total funds available in each allocation period: until September 2013, the Global Fund used an interim allocation based on “historical funding levels.” However, at a country level the distribution across the diseases might vary, and not all countries would request or be eligible for funding for all diseases. In the transition phase, the Global Fund saw interim applications with the breakdown of the indicative funding of 54 percent for HIV/AIDS, 34 percent for malaria, and 12 percent for tuberculosis (GFATM 2013b). In the 2014–2016 period the Global Fund expects to apportion **50 percent** for HIV/AIDS, **32 percent** for malaria, and **18 percent** for tuberculosis. This allocation involves a slight increase in the share of malaria from its share of disbursement in all previous rounds (from 28 percent to 34 percent). The increase is mostly at the expense of HIV/AIDS.

3. The NFM asks for countries to be placed in multi- ‘**country bands**’. A band is a collection of several countries that share common attributes. The composition of the bands will be formally agreed in 2014. The Global Fund will have a general plan to allocate a share of the total funding available to the Country Bands. In practice, the total funding actually apportioned is the sum of the country-specific allocations within the band, by disease, based on a formula (Box 5). In addition to the formula, the Global Fund will make adjustments for other external funds, and for the minimum funding required in countries that would otherwise fail to receive funds sufficient to continue short-term activities. The process is called “**allocation prior to aggregation**,” shown in Figure 1. The design of bands will be such that a sufficient number of countries are placed in each and that they are logically connected in an easy to understand manner. Bands are not disease-specific.

Box 5: Allocation Formula per Country

The formula involves the use of two inputs: **need** expressed in terms of the *burden of disease* and **ability to pay** expressed as a function of the country’s *Gross National Income per capita*.

Figure 1. “Allocation Prior to Aggregation” Process to Determine Country Band Amounts



Use of the formula in Step 2a from Figure 1 is as follows, using the HIV/AIDS example:

$$\text{Notional HIV amount for the country} = \frac{\text{Country HIV score}}{\text{Sum of all country HIV scores}} \times \text{Total HIV funding} \quad \text{where}$$

$$\text{Country HIV Score} = \text{HIV burden} \times \text{Ability to Pay} \quad (\text{assumes country is eligible for HIV funding})$$

4. **Length of allocation period:** The period for which funds are allocated to the country bands is important in order to define the resource envelope, and to match the Global Fund’s income from its contributors and its grant-making. The Board has adopted a **three-year fixed** allocation period that is aligned with the Global Fund’s replenishment cycle. This periodicity is aimed at being predictable for applicants and also simpler to comprehend for disease-related requests and funding forecasts. However, the period would be static and unresponsive to changes in the epidemics or in the implementation science during the three years.

Grant-making process: Applicants will have access to two streams of funding: the indicative (core) funding stream (“**indicative funding**”) which derives from the notional allocation to a country based on the formula discussed above. The notional allocation to a country is the sum of the amounts available for any of the three diseases, as per eligibility, and any funds expected for cross-cutting Health and Community Systems Strengthening (HCSS). In addition, there is a competitive, unguaranteed incentive funding stream (“**incentive funding**”) which is meant to fund any high-quality programming beyond what is available via the core funding stream. The access-to-funding process has several steps shown in Figure 2.

1. **National Strategy or Investment Case:** Countries should begin to prepare by identifying the highest impact interventions and technologies suited to their country situation that are most effective in reducing morbidity and mortality. They may use tools from partners and the Global Fund Secretariat to do so, such as Country Program Reviews where the countries and partners jointly review what has worked in the response to the disease and what is needed. All interventions should be couched in the national health sector or disease strategy or in an “investment case” which can be disease-specific.

2. **Eligibility:** For the proposed pilot period of the NFM over 2013–2014, it is likely that “underfunded” countries alone would be eligible to request funding. This issue is discussed further below.
3. **Country Dialogue:** Eligible applicants (Country Coordinating Mechanisms or Regional Coordinating Mechanisms) will organize a Country Dialogue around the national strategic plan or investment case. This will be an inclusive, iterative process to determine the appropriate request in which the Global Fund will also take part. During this process, the Global Fund will communicate the overall composition of the band to which the applicant is assigned, the range of core funding to the band based on the aggregation, the indicative split between the three diseases and HCSS, and the availability and size of the incentive funding stream for the applicant’s assigned country band. The Country Dialogue should lead to an indicative split between the four components (three diseases and HCSS). The applicants will have an opportunity to change this split in their actual request. During the Country Dialogue, the Secretariat will communicate key inputs for the funding request in the form of the “*Indicative Funding Ranges by component*.” The actual position of an applicant within the range will depend on the Secretariat’s use of qualitative criteria listed in Table 4.

Table 4. Use of qualitative criteria by the Secretariat for adjustment of funding levels

During	Criteria	Allocation Before Aggregation to Country Bands	Country Dialogue	Actual Grant-making
1. Minimum funding level required	Funding in the first allocation cycle such that resources do not fall below a minimum level.	■	■	
2. Availability of external financing	Adjustments needed in countries where other donors already provide significant resources	■	■	■
3. Willingness to pay	To be decided based on context		■	■
4. Past program performance/ absorptive capacity	Weaknesses in implementation based on findings from program evaluations or Periodic Reviews		■	■
5. Risk	Further elements of operational risk, e.g., from the Qualitative Risk Assessment, Action Planning and Tracking Tool (QUART)		■	■

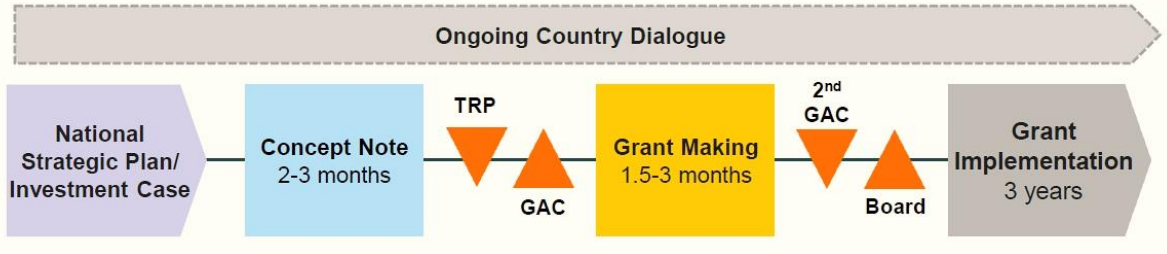
Source: (GFATM 2012a)

4. **Concept Note:** Applicants will develop a Concept Note per disease or across any number of components, aligned with the country’s planning cycle, national strategy, or investment case. This will encapsulate the full expression of demand (Box 6). It is expected that the applicants will utilize a fully costed national strategy for the period covered by the Concept Note; deduct available sources, including existing Global Fund grants; remove the elements that are ineligible for Global Fund financing; and apply any Counterpart Financing if this is not already included under the available sources. The applicant may choose to split the request for each component by core funding (highest priority) and incentive funding (not guaranteed).

Box 6: “Full Expression of Demand”

The total amount of funding needed to finance a technically appropriate response to a disease.

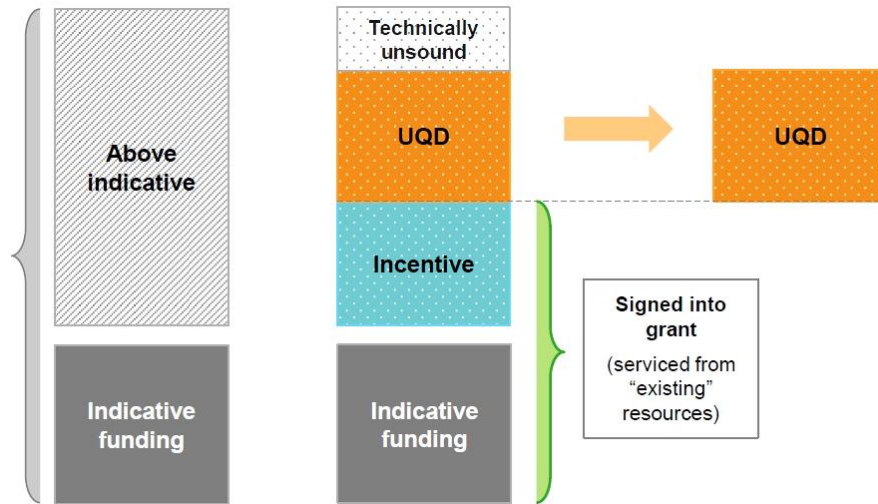
Figure 2. Overview of the grant-making process under the new funding model



Source: GFATM

- Review:** The Concept Note will be assessed by the Grants Approvals Committee (GAC) and the Technical Review Panel (TRP). The Concept Note should contain the identified funding gap, including for activities not presently funded at all; a statement of funding need to fully support the strategic plan or investment case and how it fits into the broader health strategy; and a budget explaining how the applicant will use Global Fund monies. The Global Fund guidance on Concept Note development provides instructions for the level of detail related to these areas. An area of debate is the level of detail for the elements of the demand for which the applicant is not requesting Global Fund support. Concept Notes based on national strategies are likely to see a faster process, higher core funding ranges, and get more access to incentive funding.

Figure 3. Concept Note review and grant-making process



Source: GFATM

The TRP will review the Concept Note for technical soundness and strategic focus. TRP will consider the applicant’s statement of priorities, but will also use its judgment to examine the elements and identify what is deserving of funding. It may ask the applicant to re-submit certain Concept Notes, or require a revision for those that it cannot recommend for grant-making. The TRP will also identify any parts of the funding request that is of high quality but cannot be funded immediately from either core or incentive streams (Figure 3). These will go into a pool known as *unfunded quality demand (UQD)*. Requested amounts held in this pool can be met by other donors, but the pool does not reflect an “entitlement.” The pool will also expire after a certain period after the original review of the source Concept Note.

Based on its deliberations, the TRP will make a technical recommendation to the GAC on the quality of the elements of the Concept Note, assessing and recommending the elements related to incentive funding, if requested by the applicant. The TRP may identify high quality elements that could be placed in the unfunded quality demand pool.

Box 7. Funding from the Incentive Funding Stream

If applicants desire to access the incentive funding stream, they should identify in their Concept Notes some “incremental program elements” that could achieve greater impact beyond all the elements they have prioritized as a request from the core funding stream. The TRP will review this request alongside the request from core funding, and make its recommendations to the Secretariat (see **Figure 2**). The Secretariat will make the final decision on incentive funding for Board approval.

The Secretariat has indicated that the following attributes of applicant requests may increase the possibility of incentive funding being made available:

- *Ambitious* – the request is a full expression of demand for the disease/component
- *Strategic* – the incentive funding would reward a robust national strategy or investment case that can lead to large, quantifiable impact
- *Aligned* – the applicants will access funding aligned to national planning cycles
- *Sustainable* – the request involves the leveraging of other resources, including domestic
- *Simple* – The incentive funding would help to minimize complexity or transaction cost in some way (e.g., by avoiding disruptions to future grant making)
- *Proportional* – The incentive funding would not skew the relative shares of countries that are a principle behind the core funding stream

The Secretariat will allocate an amount for the incentive funding stream during each of the several TRP review windows per year (likely two to four times). In order to succeed for incentive funding, the applicants will need to ensure a high-quality, detailed Concept Note. The appropriate level of detail is suggested in guidelines, incorporates feedback from the interim NFM.

6. **Recommended funding:** Based on the TRP review and recommendation, the GAC will determine a final funding amount by component, again applying the qualitative criteria from Table 4. If the GAC’s Determination of Funding Amount is materially different from TRP recommendations, the GAC could seek further input from the TRP. Unlike in the rounds-based system, the Secretariat staff will engage in discussions with the applicants which will help confirm the final amount. Qualitative criteria, discussed in Table 4, may again play a role. The final amounts will be converted into disbursement-ready grant agreements ready for Board approval. The criteria for the grant-making process have been further developed using the feedback from the interim phase of the NFM, discussed below.

Interim phase of the NFM: The Global Fund implemented an interim phase of the NFM over 2013–2014, which utilized available uncommitted funds at its disposal of up to \$1,507 million for the period 2013–2014. With these funds, the Global Fund made interim NFM funding decisions for 48 discrete country or regional applicants during 2013–2014, including Kenya (HIV/AIDS, malaria). These funds helped to fill gaps emerging from the end of the last round-based system (Round 10). Under the interim period of the NFM countries mostly accessed the funding if they had existing grants eligible for renewal, reprogramming, and/or extension in 2013/14. The Global Fund funded successful interim applicants through the mechanism of existing grants they held. Therefore, the funding through the interim NFM appeared as Phase Two renewals or “top-ups.”

In addition to these interim applicants, “early” applications under the full rollout of the NFM have also been accepted in two waves. In total, nine countries or regional initiatives are part of these two early waves, accessing a total of \$740 million in funding (GFATM 2013b). These early applicants will have completed most elements of the new process of Concept Note submission, TRP and GAC reviews, grant-making, etc. These processes have helped to derive lessons in time for the full implementation of the NFM beginning in 2014.

Full implementation of the NFM: Overall, the early application and full rollout phases will all involve the Country Dialogue and Concept Note steps. The Global Fund’s Disease Committees have recommended high-impact interventions for consideration in the Concept Notes. The full implementation of the NFM is beginning in 2014/15, following the Global Fund’s fourth replenishment conference in December 2013. Including the early applicants, the timeline for the first full grants under the NFM assumes that Country Dialogues and preparation of Concept Notes start from quarter four of 2013. The first TRP review in the NFM design would occur in early 2014, with grant-making and negotiations occurring over quarters two and three of 2014.

3.3 Implications of the New Funding Model for Kenya

Kenya and the NFM “country bands”: With the bands decided by a composite measure of disease burden (need) and GNI per capita (ability to pay), Kenya will be placed in **Band 1**: “lower income, high burden”—i.e., low ability to pay and high need. There are 29 total countries in this band. According to preliminary simulations carried out by the Global Fund, Band 1 may be allocated nearly 50 percent of all funding under the NFM (GFATM 2012a). In comparison, Band 2 (lower income, low burden), with 20 countries, would receive 7 percent of funding; Band 3 (higher income, high/medium burden), with 17 countries, would receive 31 percent of funding; and Band 4, which represents the higher income and low burden set of 60 countries, would receive 10 percent of funding (also called the “targeted pool”). This placement in Band 1 is a positive for Kenya’s chances of accessing sufficient funding in the future.

Kenya and the NFM pilot over 2013–2014: As discussed above, the Global Fund will consider for funding under the NFM pilot countries identified as “underfunded” in the 2013-2014 period. These will be identified by comparing the total recommended amount for the country from the use of the formula in the “allocation prior to aggregation” step (Figure 1), to the actual amount of committed and forecast grant financing from the Global Fund. It is also likely that the Secretariat will take into account the presence of significant funding from other donors. Kenya has been tentatively placed in an illustrative list of 27 underfunded countries as the 10th most underfunded. While this is good for Kenya’s chances of eventually securing funding under the NFM pilot, much is yet to be decided by the Secretariat about its use of the criteria to select both the number and nature of countries for the pilot. Whether Kenya qualifies for the NFM pilot or not, its ability to access funds under the full rollout of the NFM will be unchanged. This ability depends on many other factors, including the aspects of policy risk we consider in Chapter 5.

Box 8: Counterpart Financing

This is a requirement for low-income countries such as Kenya to show that the national government contributes **at least 5 percent** to the national disease program. The denominator for the calculation is the sum of government and Global Fund financing for the disease.

The actual approach will also depend on whether the country is eligible to receive funding for the disease according to the Global Fund’s published eligibility criteria in its *Eligibility, Counterpart Financing, and Prioritization* (ECFP) policy (GFATM 2011a). The ECFP policy applied to the Global Fund’s earlier 2012 funding channels, and under it, Kenya is considered to be a low-income country with severe disease burden for HIV/AIDS and tuberculosis, and a ‘high’ disease burden in malaria. Under the ECFP policy,

Kenya was ineligible for new funding in 2012 for HIV/AIDS and malaria due to it having received recent funding (Round 10) and there being less than 12 months of implementation on those funds. However, this stipulation will not apply in 2013/14, while the severity of the disease burden and low income status will still apply. Therefore, pending the evaluation of the counterpart financing requirements under the ECFP policy (also discussed in Section 5.1), Kenya should be eligible to participate in the NFM pilot.

Synergies and opportunities with the NFM: The NFM can offer both advantages and challenges to Kenya. The NFM creates opportunities for constructive dialogue between the country and the Global Fund during the resource mobilization process. This has been missing before. This creates openings to examine and begin addressing factors that have hindered program implementation in harmony with the Global Fund’s Performance-Based Funding (PBF) principle. We examine such barriers in Kenya in this context in Section 5.2.

Such a dialogue also provides a place for the debate in the country regarding the importance of financing and planning for the overall health sector versus for vertical disease programs (especially the three focal diseases) and where the two needs can converge. At present they do not converge at a sufficiently strategic level, only at the implementation or operational planning level. A critical debate on “value for money” needs to occur in Kenya, inspired by the NFM’s emphasis on a Concept Note articulating the country’s total financial need related to “high impact interventions.” A part of this debate or dialogue may center on prioritization of interventions, utilizing methodologies such as cost-effectiveness and cost-efficiency analysis. These opportunities for convergence and prioritization may involve such sector-wide institutions as the Health Sector Coordinating Committee.

Drawing from PBF, the resource mobilization process under the NFM may inject a sense of urgency for Kenyan policymakers to strengthen and align financial accountability measures with what will be needed to attract most new funding, and make necessary adjustments to the public health sector’s financial systems, the institutional framework, and the legal framework. We discuss the background to these issues in Chapter 5.

Funding of a joint national program through the Concept Note—which can draw on, for example, an HIV/AIDS Plan of Operations or Strategic Plan—offers Kenya a simpler way forward in jointly implementing all health sector strategic plans. This can reduce competition and conflict of interest among health sector agencies, since national Ministry managers can coordinate while different departments, agencies, and faith-based organizations (FBOs) and NGOs implement.

The Global Fund’s demand for demarcation of responsibility/division of labor up to task level prior to funding will encourage negotiations beforehand based on science, rather than political considerations. Currently, departmental tasks are separated, while the Ministry’s senior management is held ultimately accountable by the cabinet and parliament. In contrast, roles and responsibilities under a program-level approach can be more clarified and conflict of interest managed.

Again, program-wide operational planning and funding offers a viable option to consolidate health sector monitoring and evaluation frameworks, and reduce parallel systems such as Global Fund governance and PEPFAR reporting.

The Concept Note-driven process may also benefit tuberculosis and malaria management. Due to intense local and international support throughout the last decade and existing national frameworks and structures that encourage coordination, the HIV/AIDS sub-sector has been better placed to engage multi-sectorally and to comprehensively address systems strengthening issues around for policy and finance. These benefits may now start to accrue to malaria and tuberculosis sub-sectors as well.

Challenges: The proposed NFM resource mobilization process, while potentially cost-saving for the Global Fund, will require the attention of key stakeholders in the health sector of Kenya, in order to focus on the actions needed to prepare a Concept Note that is fully cognizant of value for money and in-country prioritization. Addressing the policy risks which we analyze in this study will also require high-level support. As a consequence, these needs may come into competition with other initiatives in what is a busy health sector agenda for the next few years. This agenda includes implementing devolution in health, and the transformation/unification of the Ministries of Health. There is precedence that such competing priorities can be difficult to manage. The 2009 National Strategy Application (NSA) process shifted focus to advocacy for resources, even before a funding scenario analysis had been performed. That process required significant effort and was very demanding of planning staff time across the health sector.

The application process under the NFM can be tested and simplified in its piloting. While this was promised for the previous NSA process, the end product still lacked simplicity and some of the forms (e.g. for gap analysis) turned out to be more complicated than what countries were accustomed to.

Kenya is relatively advanced in its interventions in the health sector. It could be difficult for the Global Fund TRP, working in Geneva, to evaluate and understand all the aspects of Kenya's disease strategic plans without continuous clarifications. The TRP's mode of operation therefore needs to be evaluated during the piloting of the NFM. The Global Fund's plans to leverage its technical partnerships in the review of the Concept Notes and all relevant background national strategic plans are therefore laudable.

Finally, Kenya is entering a period of major structural change in the health sector, including devolution and the proposed merger of the two Ministries of Health. Governance reforms traditionally take a number of years to realize fruit. In the past, TRP members may have queried the existence of two Ministries of Health and their division of labor, when these had only just been formed. Therefore, Global Fund teams visiting Kenya during the Country Dialogue could consist of multi-disciplinary experts.

The failure to mobilize additional funding from the NFM mechanism would have several implications:

- A prolongation of the financial gaps in Kenya described in Section 5.1.
- Lower local and international confidence in the country's choices, strategies, processes, capacities and structures related to the three focal diseases. The Global Fund's TRP usually provides feedback on the major weaknesses that must be resolved prior to future funding approval. If such weaknesses are structural, as we discuss in Chapter 5, reforming these may take time.
- Failure to plug the financial gaps often leads to a lag in implementing the strategic plans. Failure may also require reprogramming of several interventions to either reduce coverage or to omit interventions that are prioritized lower.
- Intensify the need to set priorities across interventions for the three diseases and strictly implement a process of review of program outcomes with the lens of "value for money."

4. METHODOLOGY

4.1 Methodology and Data for the Financial Gap Analysis

Resources needed: The estimates of financial resources required for service delivery and program management for HIV/AIDS, tuberculosis, and malaria disease programs in Kenya were based on different sources. We estimated the gap for the six financial years from 2012/13 until 2017/18. We focus on the costs faced by the public sector. The cost of the labor of public sector health workers is excluded, since this is covered through the government wage bill. This point is explained further below. The costs of other personnel—whether independent consultants or FBO/NGO staff—were included to the extent they featured in interventions and estimates in the sources discussed below. Costs of service delivery in the private for-profit sector were excluded because of two reasons:

- Reliable estimates of the projected costs of service delivery for HIV/AIDS, tuberculosis, and malaria in the private for-profit sector, which is mostly financed with out-of-pocket payments, were not available.
- We did not have reliable estimates of the total out-of-pocket financing available for tuberculosis diagnosis and treatment, or for malaria. For HIV/AIDS, data from any recent National AIDS Spending Assessment or National Health Accounts (HIV/AIDS sub-account) were not available.
- These issues suggested that private for-profit sector costs of delivery be excluded, so as to not bias the gap analysis.

The exclusion of the private for-profit sector from the estimated resources for these three disease programs has an effect on the interpretation of the financial gap only if there is a chance that government or development partner resources for health will be spent in service delivery via the for-profit sector. This issue is unclear, except for malaria, where there is a link between the Affordable Medicines Facility for Malaria (AMFm) and private first line buyers of drugs for artemisinin combination therapy in Kenya. We discuss this issue in the malaria gap analysis, and explain the related calculations in Chapter 5.

The *HIV/AIDS resource need* was computed for all the four “pillars” of the last strategy (Kenya National AIDS Strategic Plan III), of which Pillar 1 represents the health sector response. The costs of Pillar 1 were computed using the OneHealth Model (Box 9). The total cost of the labor of public sector health workers involved in service delivery or program management is computed within OneHealth, but was not included in Pillar 1 for this gap analysis. The reason is that these costs are primarily covered by the government. Exclusion of the government contribution is discussed further below. The costs of Pillars 2 to 4 were extrapolated for future years from the costs of the National Plan of Operations which covered 2009/10–2010/11, as was calculated during the proposal stage for the Global Fund Round 10.

The *tuberculosis resource need* was calculated based on the Department of Leprosy, Tuberculosis and Lung Disease Strategic Plan for 2011 to 2015. Resource needs for the financial years 2016/17 and

Box 9. OneHealth Model

The OneHealth model is a tool for medium-term (3–10 years) strategic planning in the health sector at the national level. It was produced by an international consortium including the WHO, other UN agencies, and the Futures Institute. It estimates the costs by disease program and the resource implications of health system components (e.g., human resources, logistics, and health finance). The costs for disease programs are based on the target population size, the percentage of population in need, and the proposed coverage. In Kenya, HPP worked with the two Ministries of Health and the respective departments and divisions therein to determine the scale-up plans, commodities required and unit costs, and other aspects of service delivery. The OneHealth Model estimates were generated as a part of the costing of the Kenya Health Sector Strategic Plan III, 2012–2017.

2017/18 were extrapolated, using the average growth rate in expenditures over the previous years. The *malaria resource need* was calculated from several sources. A recent gap analysis conducted for the Global Fund Round 10 proposal formed the core of the estimate, along with revised assumptions about the cost of artemisinin combination therapy (ACT), the main mode of treating malaria. Further details about these assumptions are provided in Chapter 5 along with the results of the gap analysis.

External resources available: The estimates of resources available come from three different sources. For all *external funding sources* except the Global Fund, the estimates of budgeted resources tied to HIV/AIDS, tuberculosis, and malaria come from a Development Partners for Health in Kenya (DPHK) dataset recently constructed in August 2012 (DPHK 2012), as well as estimates of ‘on-budget’ support from development partners compiled by the two ministries. The DPHK dataset was built from the results of a DPHK Secretariat request to development partners for their projected budgets for the period 2012/13 to 2016/17. Many development partners could not project the budgeted funds for all future financial years, in which case an assumption of flat funding was made unless otherwise indicated. For the largest donors, a percentage of funding that would be spent on the overheads of implementers or the funding agency was deducted. Additional details on development partner funding are provided in Chapter 5.

The baseline *Global Fund resources* available over the period 2012/13 to 2017/18 are estimated based on the grants in current implementation only, given their agreed upon periods without the assumption of extensions. While Kenya may get new Global Fund grants in the future, those amounts are not considered for the gap analysis. For currently implemented grants, we considered the total grant budget at signing as one scenario of resources available. We also consider a scenario where the total financing via all currently implemented grants is the estimated actual disbursement rather than the total of the grant budgets at signing. The distinction is important if grants do not end up with total disbursement equal to 100 percent of the original budget, as has been the case in Kenya. This issue is discussed in Chapter 5 and the reasons are explored.

Exclusion of Government of Kenya resources available: The amount the government will contribute specifically for each of the three diseases cannot be reliably estimated at this time and hence was *excluded*. Investments shared across diseases—such as overall health sector stewardship and management, investment into infrastructure, and the recurring costs of health facilities—are all major government contributions. A portion of these investments applies to the three focal diseases, but this portion has not been reliably estimated at the national level.

In general, for each of the three diseases, the government will contribute the cost of public sector health worker salaries, some training costs, and infrastructure, as well as a portion of the remaining financing gap, especially related to commodity procurement and warehousing. In the financial year 2008/09, the government allocation to HIV/AIDS, malaria, and tuberculosis drugs and commodities was KSh657 million of a stated total cost of KSh15,945, which amounts to 4 percent (Source: Health Sector Report/MTEF 2008/09 to 2010/11). This is the last published estimate of the government allocation to commodities.

In addition to these unknowns, with devolution, there is significant uncertainty about the shape and size of public sector funding for health, given the functions assigned to county governments and their role and responsibility in the procurement of commodities. These issues will be relevant from 2014 onwards.

Interpretation of the financial gap: Given these considerations, the interpretation of the financial gap shown in Chapter 5 is as follows. For each disease, the gap is the unfinanced resource need for drugs and other commodities, service delivery, program management, etc., excluding government health worker salaries, which is not met by currently projected external funding. This financial gap can be reduced by increasing the resources available from external and domestic sources, or by rationalizing targets and/or

eliminating non-priority activities. Reprogramming funds from non-priority activities may allow short-term needs for essential drugs and commodities to be met but leaves the overall gap unchanged.

4.2 Methodology for the Policy Risk Analysis

4.2.1 Governance and Economic Environment Scan (GEES)

This analysis was standardized with the Global Fund-approved country Risk Assessment Framework. Similar criteria have been adopted. These criteria were incorporated as a part of a Governance and Economic Environment Scan (GEES). The various parameters that were reviewed and whose findings are elaborated in the context of the findings Section 5.2, and include those listed in Table 5.

Table 5. Policy Risk: Parameters for the Governance and Economic Environment Scan (GEES)

Parameter	Description
Global Fund portfolio	Size and context in relation to other funding in the country; Number of PRs and SR; Size of each PR's grant portfolio
	Global Fund Office of Inspector General (OIG) audits and investigations; Key risks and findings identified in OIG reports
	Latest grant ratings (alphabetical scale) from the Global Fund
Current socio-cultural factors	Likelihood of conflict, religious beliefs and norms, social injustice, complexity in terms of ethnic diversity, etc.
Political environment	Political uncertainty, frequent changes in political leadership, complexity in terms of administrative and political structure and governance, etc.
Economy	Quality of the banking sector, exchange rate fluctuations, inflation, track record in managing donor funds, high profile corruption cases, sale of fake medicines, etc.
Infrastructure	Availability and quality of health facilities, including laboratories, warehouses, etc.
Global indices	Country rank on the Human Development Index, Corruption Perception Index
Regulation	Government health policies and regulation
	National regulations/laws impacting on transparent and accountable use of funds and procurement processes, adequacy of national drug regulatory system
Oversight	CCM quality and effectiveness of oversight, CCM structure and membership, functional sub-committees, etc.; Programmatic partners' level of involvement and engagement in oversight and support to PRs (e.g., UNAIDS, WHO, World Bank, USAID, DFID, etc.)
Health sector context	Disease burden and national disease strategy, health system and Global Fund resources, health sector staff attrition, increase/decrease in national health budget funding/investment over past five years, additionality of Global Fund resources (are domestic resources also available, and to what extent), etc.
Nature of donor funding	Level of donor funding for the three diseases, are any donors duplicative of each other in the health sector, etc.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis: This SWOT analysis was integrated into the GEES analyses, at the stage of the findings in each area from the first column, Table 4. Each relevant parameter was briefly reviewed from the perspective of the strengths, weaknesses

or challenges, opportunities, and threats or risks that it offered to Kenya in the context of policy risk in accessing new funding from the Global Fund.

4.2.2 Methodology for the absorptive capacity analysis

As discussed in the rationale for this study (Section 2.1), absorptive capacity is one of the five criteria that may affect the total amount Kenya can access from the Global Fund in the future. The Global Fund’s Office of the Inspector General published a “Report on Lessons Learned from Country Audits” (Global Fund, 2011b), in which it identified the *lack of absorptive capacity* as one of the main constraints on grant execution. The definition of absorptive capacity as it relates to foreign aid has long been debated among donors, recipients, and third parties. In its report, the Global Fund defined it as the situation where “large additional funds inflows [strain] national capacity for planning, management and service delivery.” As a result of the lack of absorptive capacity, additional aid “was not used effectively to achieve its intended results.” We investigated this issue for the recent history of Kenya’s Global Fund grant portfolio.

The absorptive capacity analysis for Kenya is divided into two parts. The Global Fund operates under a performance-based financing mechanism where no disbursement is fully guaranteed. Therefore, the first part of the analysis examines whether Kenyan principal recipients on grants (PRs) receive a *disbursement* equal to their request to the Global Fund and, if they do not, to what extent does a shortfall exist, and what reasons are available. The second part of analysis examines the *expenditures* from actual disbursements. Together, both parts of the analysis combine to form a narrative of Kenya’s ability to receive and spend—in other words, absorb—desired levels of funding from the Global Fund.

Methodology for the disbursement rate analysis: All three diseases and an assortment of PRs are represented in the grants in implementation as of October 2012. Given this diversity, we chose to exclude prior grants from the analysis. This also allowed the analysis to focus on the PRs most likely to be involved in future grants in Kenya. The definition of disbursement rate used is shown in Box 10. The seven grants in implementation in 2012 were initiated at different times over a five-year period from 2006 to 2011. The definition of the disbursement rate allows for comparisons across grants at different stages of implementation. In this study, the term “disbursements” refers only to transfers of funds from the Global Fund to the PR. Any transfers of funds from the PR to sub-recipients (SRs) are termed “re-disbursements.” The estimated disbursement rates were derived from different sources. We used recent Grant Performance Reports located on the Global Fund website to determine quarterly budgets and to determine when disbursements were made from the Global Fund to the PR and their amounts. For the latter, we also corroborated the values from the Global Fund’s published periodic updates of its Grant Portfolio and the Progress Update/Disbursement Requests (PUDR). We also confirmed amounts from the PUDRs provided to us directly by the Government of Kenya PR on Global Fund grants, the Ministry of Finance (MOF). In some instances there were discrepancies between sources in the reported disbursements, which we hypothesize, originated from mismatch in reporting vs. fund receipt dates. The discrepancies do not extend to the cumulative disbursement amount.

Box 10. Definitions

Disbursement rate: the cumulative disbursement to date as a percent of the corresponding quarterly budgets

Expenditure rate: the cumulative expenditure to date as a percent of the cumulative disbursement to date

Budget period: In most cases, a quarter corresponding to the funds associated with the disbursement

Methodology for the expenditure rate analysis: Total PR level expenditures consist of expenditures for the PR’s own operations, and re-disbursements to SRs. The bulk of actual grant expenditure occurs at the SR level. However, the regular record of SR expenditures against re-

disbursement amounts is not observable in any sources available to us. Therefore, “expenditures” refer to the sum of PR own expenditures plus re-disbursement, unless otherwise specified.

For the purposes of this analysis, the expenditure rate is defined in Box 10. The estimated expenditure rates to date for all Global Fund grants in implementation in 2012 were based on the Grant Performance Reports, the Grant Portfolio, MOF and other PR financial records, and PUDRs. Discrepancies across the data sources were normally tied with the date of expenditure and did not affect the cumulative expenditures to date, except for the Round 4 malaria grant. In this case, the cumulative expenditures reported by the MOF were less than the cumulative expenditures reported in the various Global Fund sources. Because the absorptive capacity analysis takes on the perspective of the Global Fund as it prepares to implement the New Funding Model, the values published by the Global Fund were used. Details are discussed in Chapter 5.

Along with the disbursement and expenditure analyses, we also tracked the stage of implementation of each grant as the percent of the total grant duration elapsed. This provides the maturity of each grant as additional context for the absorptive capacity discussion. This metric was calculated by determining the cumulative months elapsed as of October 31, 2012, as a portion of the stated total grant duration (months between the grant start date and grant end date).

Case studies: We looked at two grants in Kenya in detail as case studies in order to examine the issues discussed above at the level of individual funding periods, and to illustrate how the Global Fund reacts to ongoing problems in absorptive capacity. The grants chosen as cases had sufficient maturity for trends to emerge. In specific, there were a sufficient number of funding periods with data for these grants that helped to construct a time series. Each time series was charted in order to visually examine the trends, and a narrative analysis was prepared around the changes in the amounts of per-period budgets, disbursement, and expenditures. The case studies are related back to the overall themes of absorptive capacity in Kenya.

5. FINDINGS

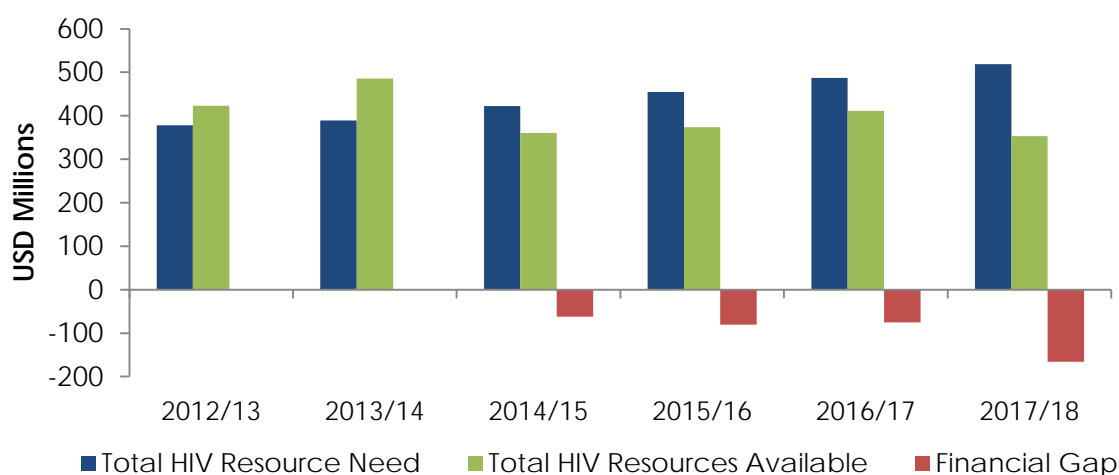
5.1 Financial Gap Analysis for the Three Priority Diseases

5.1.1 HIV gap analysis

As discussed in Section 4.1, the resource need for HIV/AIDS was derived from the OneHealth exercise supplemented with the gap analysis for the Global Fund Round 10 proposal, which was based on the costed National Plan of Operations (NPO) for the period 2009/10 to 2010/11. The NPO in turn drew from the Kenya National AIDS Strategic Plan (KNASP-III). The resource need is based on the four pillars of the KNASP-III: health sector services (Pillar 1), sectoral mainstreaming (Pillar 2), community-based programs (Pillar 3), and governance and strategic information (Pillar 4). The costs relate mostly to the public sector, with some elements relating to the FBO/NGO sector. Public sector health worker salaries were not included. OneHealth results gave us Pillar 1 costs for all years, while costs of Pillars 2 to 4 for 2010/11 were estimated from the costed NPO. The projected average growth rate of HIV/AIDS costs over 2012 to 2016 was 3.3 percent per year from OneHealth. This growth rate was used to estimate the annual resource needs for Pillars 2 to 4 over the period 2012/13 to 2017/18. Pillar 1 was 88 percent of the costs.

The external resources available for HIV/AIDS were determined from the DPHK database covering the years 2012/13 to 2016/17. Budgets that were constant over 2012/13 to 2016/17 were assumed to remain so in year 2017/18. The estimates provided by PEPFAR in Kenya of funding for HIV/AIDS from the U.S. Government are net of the cost of overhead and management. Similar adjustments were made to the budgets of DFID and WHO. These deductions were agreed with the key respondents of these donors or DPHK. Therefore, the estimates for the largest sources of funds are a truer reflection of what is “hitting the ground.” In addition to these, the external resources include Global Fund grants, which were valued based on the annual budgets of the Round 7 grant (PR: Care International) and the recent Round 10 grant with dual-track financing (PRs: Ministry of Finance and the Kenya Red Cross). Maximum funding levels projected were based on the negotiated amounts by phase, as reported by the Global Fund website.

Figure 4. Kenya HIV/AIDS Program Gap Analysis, 2012/13 to 2017/18



Source: DPHK 2012; Global Fund; Authors' calculations.

Discussion: As defined in Section 4.3, the financial gap shown in Figure 4 represents the total HIV/AIDS resource need in the public and FBO/NGO sectors minus the external funding available. Figure 4 reveals a widening financial gap after the financial year 2014/15, but estimated surpluses prior to that. The presence of a surplus does not mean that Kenya has more resources than are needed. It may

indicate that we were unable to remove from the total resources available the amounts that are destined for expenditure areas not included in costs calculated as per our methodology (e.g., overhead, salaries of public health sector workers, expenses incurred in the private sector).

The post-2014 increase in the financial gap may be driven by a stagnant non-Global Fund external resource pool, declining net outstanding amounts from current Global Fund grants, and increasing resource needs. A \$62 million gap is predicted for 2014/15. In the same year, currently anticipated Global Fund grant disbursements are expected to fall by \$124.2 million from the previous year.

The total *net* financial gap over 2012 to 2017 is **\$242.4 million**. This assumes that some of the surplus is available to reinvest in later years when the resources fall below the need. Given the nature of funding appropriations, this may not be true. If only years with deficits are taken into account, the financial gap is \$383.8 million. Accessing additional resources from current or future Global Fund grants and/or increased Government of Kenya funding is critical to maintain service delivery levels and scale-up.

Due to a lack of data, as discussed in Section 4.1, the financial analysis here should not be taken as authoritative. There are some reasons to believe the financial gap estimates may be different:

- **Resource needs** for HIV/AIDS here may be an underestimate if the country chooses to implement new interventions for HIV prevention, such as treatment as prevention, pre-exposure prophylaxis, or Option B+ for the prevention of mother-to-child transmission. All interventions on which an official decision is lacking were absent from the OneHealth estimate for Pillar 1. If these interventions are scaled up, the financial gaps may be *bigger*, and may start earlier than 2014/15.
- **Non-Global Fund external resources available** may be an overestimate if some funding goes to the private sector. Also, while we assumed constant levels of funding, the financial crisis may suggest that there could be declines. If these issues come to bear the financial gap may be *bigger*.
- **Global Fund resources**: The amounts used are based on the maximum that can be disbursed. However, cumulative disbursements do not often reach the maximum or ceiling amount, as discussed in Section 5.3. In this case, the financial gaps may be *bigger*.

Government of Kenya resources for other items than public sector health worker salaries and benefits need to be considered. The government contributed about KSh500 million for HIV/AIDS drugs (mostly antiretrovirals) in the financial year 2008/09, equivalent to \$7 million at historical exchange rates. In overall non-salary costs, the government also contributes to the costs of training, some HIV-specific infrastructure, and meetings. If such contributions continue at historical levels, then this means that when considering the public and FBO/NGO sectors' role in HIV/AIDS, the actual financial surpluses in financial years 2012/13 and 2013/14 may be *larger* and the financial gaps thereafter *smaller*. The government may therefore consider continuing or increasing these allocations to HIV/AIDS.

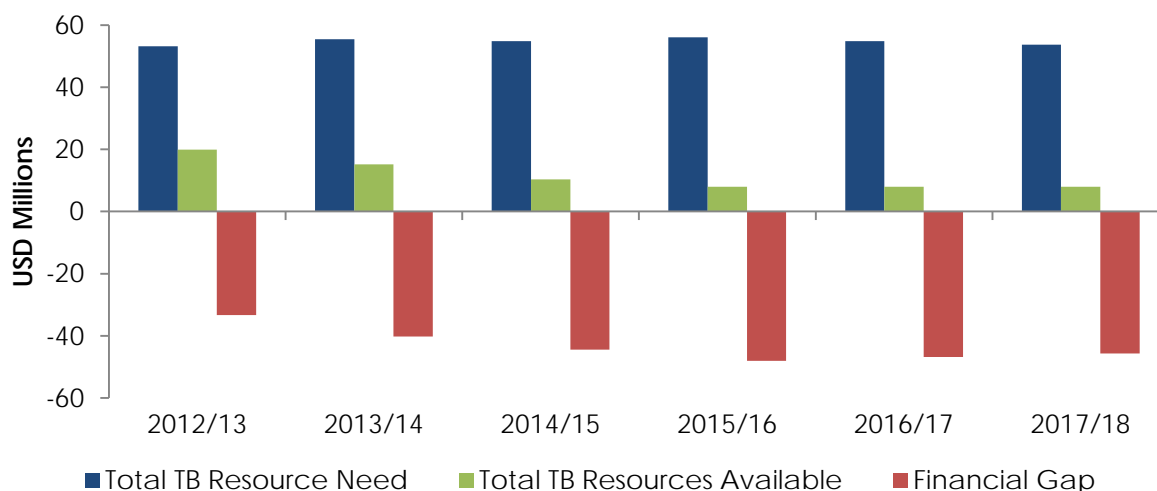
5.1.2 Tuberculosis gap analysis

The tuberculosis program's resource need was derived from the Department of Leprosy, Tuberculosis, and Lung Disease (DLTLD) strategic plan for 2011 to 2015. The average growth rate of TB costs according to the strategic plan is projected to be negative: -2.17 percent. This decline was applied to determine the resource needs for the missing financial years of 2016/17 and 2017/18.

Similar to HIV, the external resources available were determined for tuberculosis-specific line items from the submissions to the DPHK database for the period 2012/13 to 2016/17. For those development partner budgets that remained constant, it was assumed they would continue at the same annual level into 2017/18. Funds from the U.S. Government and through DFID are net of the costs of overhead and management as deducted by the key respondents in the related agencies. For Global Fund grants, the

resources available were estimated based on the yearly budgets of the dual-track Round 9 grant with PRs African Medical Research Foundation (AMREF) and the Ministry of Finance. These were the values as reported by the most recent Grant Performance Reports on the Global Fund website. For the portion of the Round 9 grant managed by the Ministry of Finance, 2012 disbursements to date are greater than the 2012 budget. Therefore, the disbursements were taken as the available funds for those budget periods.

Figure 5. Kenya Tuberculosis Program Gap Analysis, 2012/13 to 2017/18



Source: DPHK 2012; Global Fund; Authors' calculations.

Discussion: The interpretation of the financial gap is the same as for the HIV/AIDS program. Figure 5 demonstrates a significant increase in the financial gap for tuberculosis through 2015/16 compared to previous years. The annual gaps arise due to a marked decline in currently expected Global Fund financing for the tuberculosis program in Kenya. An important development partner involved in the tuberculosis program is the U.S. Government, which channels funds through USAID and CDC. The estimated annual funding level for these two agencies is projected to be stable at \$4.0 million and \$3.1 million, respectively. All the projected non-Global Fund resources contribute only 15 percent of the need over 2012/13–2017/18. Fortunately, the resource need for tuberculosis in Kenya is projected to stabilize in coming years, as seen in Figure 5. The total financial gap for the period is **\$258.4 million**.

The government contributed about KSh120 million for tuberculosis drugs and commodities in the financial year 2008/09, equivalent to \$1.7 million at historical exchange rates. As in HIV/AIDS, the government also contributes in other ways, beyond the salaries of health workers. However, these non-salary contributions are not likely to make the financial gaps shown above much smaller. Recall that we did not estimate the cost of public health worker salaries and benefits in estimating the financial gap; therefore, the government contributions in this regard do not apply.

The analysis here is subject to the same caveats that apply to the HIV/AIDS gap analysis and which may cause the financial gaps to be larger (likely) or smaller (less likely). In spite of these caveats, the analysis does underscore the critical need (just as in the case of HIV/AIDS) for new funding from the Global Fund. The Government of Kenya may also need to consider increasing its allocations to tuberculosis.

5.1.3 Malaria gap analysis

A recent gap analysis conducted for the Global Fund Round 10 proposal for the years 2012 to 2016 formed the core of the resource need estimate. The main cost headings are long-lasting insecticide-treated nets (LLINs), indoor residual spraying, malaria rapid diagnosis and treatment, intermittent presumptive

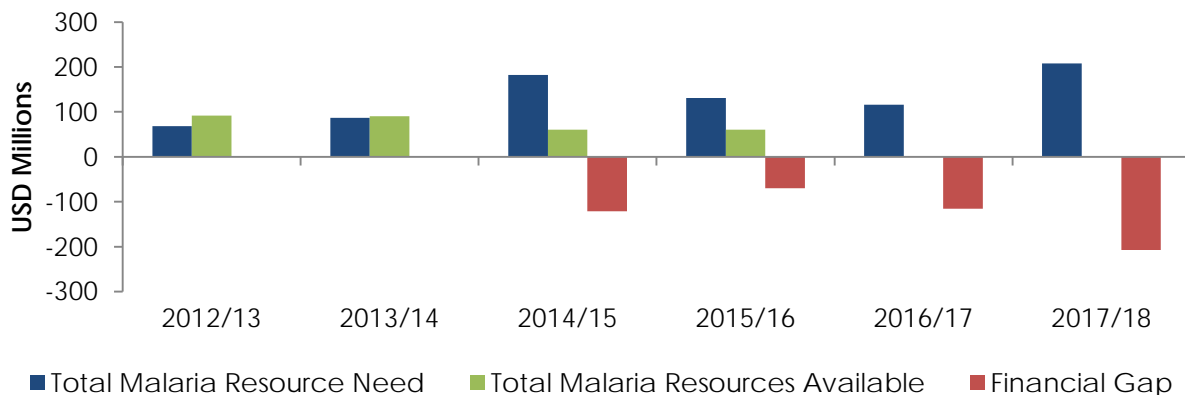
treatment, advocacy and behavior change, and program management. In 2017, it is expected that another major campaign for distribution of LLINs will occur. These campaigns occur every three years. The campaign causes the costs of the LLIN intervention to increase 7.3 times from those in a non-campaign year. This assumption was a basis to extrapolate the overall cost for the financial year 2017/18.

Kenya was a beneficiary of the pilot phase of AMFm, and hence until 2012 faced very low costs for the procurement of drugs for artemisinin combination therapy (ACT), the main mode of treating malaria. The pilot phase of AMFm is coming to an end and there will be a transition period beginning in 2013, during which the AMFm subsidy will be gradually integrated into the Global Fund grant management processes (GFATM 2012g). It is unclear at this stage whether the amount of Global Fund co-payment (i.e., subsidy) on future purchases of ACT and potentially diagnostic tests will be the same as before. It is also not known whether the subsidy will differ based on whether the first-line buyer in-country is government or private sector. For the first estimate shown in Figure 6, we assumed that the negotiated ACT price and the level of co-payment will remain similar to previous years. In estimating ACT resource need in Kenya, we used the number of treatments in public sector facilities and via community case management.

Similar to HIV/AIDS and tuberculosis, the external resources available were determined for malaria-specific line items in the DPHK database for the period 2012/13 to 2016/17. For those budgets that remained constant, it was assumed they would continue at the same annual level into 2017/18. Funds from the U.S. Government and through DFID are net of the costs of overhead and management. For Global Fund grants, the resources available were estimated based on the yearly budgets of the dual-track Round 10 grant with the PRs African Medical Research Foundation (AMREF) and Ministry of Finance.

Discussion: The interpretation of the financial gap is the same as for the HIV/AIDS and tuberculosis programs. Figure 6 shows that a financial gap for malaria programming in Kenya appears in 2014/15, with small surpluses previous to this. Except for a dip in 2015/16 and 2013/14, the annual financial gap increases over time. The annual gaps arise due to a marked decline in currently expected Global Fund financing from 2014/15. The total *net* financial gap over 2012 to 2017 is **\$412 million**. If only years with deficits are taken into account, the financial gap is **\$451 million**.

Figure 6. Kenya Malaria Program Gap Analysis, 2012/13 to 2017/18 with subsidy on ACTs



Source: DPHK 2012; Global Fund; Authors' calculations. Resources available in 2016/17 and 2017/18 are not visible at the scale of the chart.

It is currently unknown when and how the Global Fund's subsidy for ACT procurement (and possibly diagnostic test commodities) will be activated after 2013. This introduces some uncertainty in the resource need estimate. If a subsidy is not available even as the next procurement becomes necessary, then the Kenya Medical Supply Agency (KEMSA) will need to procure directly from manufacturers and

contend with a reduced overall order size. This may mean KEMSA faces a price for ACTs that is higher than what AMFm negotiated in the past on much larger overall orders.

Hypothetically, if a subsidy on ACTs were absent, then given a price of \$1.16 per ACT treatment (average of all formulations, both fixed dose and loose drugs), the additional need would be significant. The absence of subsidy would increase the resource need, and the gap, by *\$82 million*. This would need to be financed from reprogramming Round 10 grant resources, or from other sources.

In summary, these are some reasons that there could be changes in the financial gap estimates:

- **Resource needs** may be an underestimate if the subsidy on ACT procurements is not readily available in coming years, and the KEMSA procurement price for ACTs is high. Some respondents believe the effective price could be closer to \$1.7, or even higher. Each 50 U.S. cents increase in the procurement price per ACT treatment will mean an additional \$37 million needed over the projection period, given the forecast number of treatments in the public sector, inclusive of the community level. Therefore, the total *net* financial gap may be *higher*.
- **Resource needs** may be an underestimate if the number of malaria cases does not decline per year as predicted in the Global Fund Round 10 gap analysis. The caseload in the future is predicated on the success of various ongoing prevention measures. However, these prevention measures can only be implemented at scale if resources are available—i.e., if they are not reprogrammed due to a burgeoning need related to ACTs. Therefore, the need to pay for ACTs in the short term may lead to more ACTs being needed in the future.
- **Non-Global Fund external resources available** may be an overestimate if some funding goes to the private sector. Also, while we assumed constant levels of funding, the financial crisis may suggest that there could be declines. Therefore, the net financial gap may be *bigger*.

The government contributed about KSh37 million for malaria drugs and commodities in the financial year 2008/09, equivalent to \$0.5 million at historical exchange rates. All of the government non-salary contributions are not likely to make the financial gaps discussed above much smaller. The analysis highlights the critical need, just as in the case of HIV/AIDS and tuberculosis, for new funding from the Global Fund. The Government of Kenya may also need to consider increasing its allocations to malaria.

5.1.4 Summary of gap analyses

The total net financial gap projected for the 2012/13–2017/18 period across the three high burden diseases (Table 6) amounts to **\$913 million**. This assumes that some of the 2012/13–2013/14 HIV/AIDS and malaria surplus amounts are available to reinvest in later years when the annual resources fall below the need. Given the nature of funding appropriations, however, this may not be true. If only years with deficits are taken into account, the total financial gap for the three diseases is projected to be **\$1,093 million**. An increase in the total net gap of \$82 million could occur as a result of a lack of subsidy on ACT procurements after 2012.

The annual deficits arise due to a marked decline in currently expected Global Fund financing for the tuberculosis, malaria, and HIV programs in Kenya. The HIV/AIDS program will experience the largest total deficit, while the tuberculosis program will experience the smallest total deficit. Additional resources from current or future Global Fund grants and increased Government of Kenya funding is critical to reach scale-up targets and maintain current service delivery levels in future years. The potential outstanding amounts of funding for next implementation periods of Round 9 and 10 grants will be insufficient.

Table 6. Summary of Financial Gap Analyses, 2012/13–2017/18

	HIV	Tuberculosis	Malaria
Total Resources Needed	\$2,649,334,408	\$327,940,045	\$710,106,158
Total Resources Available	\$2,406,953,205	\$69,538,837	\$297,693,979
Total Net Financial Gap	\$242,381,204	\$258,401,208	\$412,412,179
Maximum Potential Outstanding Funding (Table 2)	\$140,449,962	\$19,840,348	\$84,707,558
Total Gap in Deficit Years only	\$383,788,968	\$258,401,208	\$450,670,761

Source: DPHK 2012; Global Fund; Authors' calculations. All figures expressed in current US dollars.

5.2 Policy Risk: GEES and SWOT Analyses

5.2.1 Background: Kenya's history with the Global Fund

The Global Fund High Level Panel's report on "Fiduciary Controls and Oversight Mechanisms" classified Kenya as a high-risk, high-burden country (Leavitt et al., 2011). The report found that Kenya had grant implementation delays, and these were caused by both operational and structural issues. Financial management challenges were flagged by the Global Fund's High Level Panel and the Office of the Inspector General as the major risk area in Kenya.

As we substantiate with quantitative and qualitative analysis in subsequent sections, the High Level Report's assessment was credible and requires action. The financial management system, especially of the government, has strengths. While accounting procedures are relatively strong at the PR level, those at the SR level face several challenges. The flow of funds lays much emphasis on accountability, but does not consider the delay the process may involve. Accountability in accounting often comes at the cost of time, which can spread to grant performance, as we examine in Section 5.3. This can be a problem, especially since the Global Fund's performance-based financing principle is informed by a grant performance rating whose award factors in time elapsed against results achieved.

Emerging risks: A near-similar process to the NFM, the National Strategy Application (NSA) process was instituted by the Global Fund in February 2009. Kenya failed to receive funding during this process mostly due to structural and process issues, despite adopting rigorous processes in the final proposal submission stage.

Such issues are still evident. As we discuss below, there are problems with PR and SR coordination and grant implementation, procurement planning, and the creation of parallel systems for reporting and financing management. The financial gap analysis above suggests that the Government of Kenya may need to increase "counterpart financing" (drawn from the government budget) for these disease programs. We also devote a section below to issues of absorptive capacity, which will be a repeating criterion in the Global Fund's assessment of requests under the "new funding model," as discussed in Chapter 3.

Kenya's success rate in proposals prior to 2009 was around 30 percent, the lowest in Eastern Africa, while Zanzibar's was about 71 percent. Kenya's Round 9 tuberculosis proposal was successful, and it was not submitted through the NSA process. With the success of Round 9 tuberculosis and Round 10 HIV and malaria, Kenya's success rate has now climbed to 40 percent. However, this is still low, and the issue needs to be evaluated before beginning with the Global Fund's "new funding model."

5.2.2 Governance and Economic Environment Scan (GEES)

5.2.2.1 Country Global Fund portfolio size and context

Since 2002, the Global Fund Board has approved approximately \$715 million across fifteen grants to Kenya. Several five-year grants have been successfully closed. In 2012, eight of those fifteen grants were in different phases of implementation, representing a \$362 million portfolio. Grants for HIV account for 64 percent of all Global Fund's Board-approved funding to Kenya, with a total of \$459 Million.

Principal Recipients (PRs): There are four PRs. The Ministry of Finance is the PR on behalf of the government, while PRs from civil society are the Kenya Red Cross Society (Round 10 HIV), Care International in Kenya (Round 7 HIV), and the African Medical Research Foundation (AMREF, for Round 10 Malaria and Round 9 tuberculosis). Grants managed by the Ministry of Finance account for over 85 percent of the total Global Fund portfolio in Kenya.

According to the Global Fund—with an average of 76 percent of time elapsed as of October 31, 2012 across all grants (using the grant start date indicated on the grant agreement)—the country has been disbursed \$376 million, representing 53 percent of all possible disbursement. However, the Round 10 HIV/AIDS grant, which accounts for more than half of the portfolio, is only in its first year of implementation.

Office of the Inspector General audit: Over June to July 2010, before Kenya began implementing its Round 9 tuberculosis and the Round 10 HIV and Malaria grants, the Global Fund Office of the Inspector General (OIG) performed an audit of all grants in Kenya, then totaling \$376 Million.

The OIG report of April 2012 highlighted weaknesses in the financial control environment at PR and civil society SR level: “control risks included poor maintenance of books of account and absent accountability statements, the use of personal bank accounts for program purposes, irregular payments, expenditure not in line with the grant agreement and funds spent without supporting documentation” (GFATM 2012f). The OIG also found disbursement delays to SRs, and that grant recipients were not audited regularly. Accounting irregularities were found within a few SR and sub-sub recipient (SSR) offices.

The OIG recommended that the PRs in Kenya should improve the effectiveness of grant oversight and monitor the effectiveness of contracted service providers. The OIG also recommended that the PR should work with the Kenya National Audit Office (KENAO) to speed up the finalization of audit reports. The OIG considered inviting the KENAO to outsource the audit of the Global Fund supported programs.

The OIG audit also found issues regarding the timeliness of procurement processes, competitive selection, regular quality assurance, book keeping, local capacity building, transparent application of fees, and the recording of interest and other income.

The criteria for the selection of civil society organizations (CSOs) as implementers, their consistency, and the documentation of selection processes—as well as allocation of funds to civil society organizations acting as sub-recipients—were found to be wanting. While CSO capacity assessments were undertaken, some CSOs contracted included those without sufficient capacity to implement, report, or absorb funds.

Global Fund Financing in relation to other donors for each disease: The United States government (USG), the Global Fund, and DFID are the three largest financers of HIV, tuberculosis, and malaria in Kenya. Together their committed funds constitute 98 percent of the projected resources available over 2012/13–2017/18. Global Fund contributions to these three diseases are second only to the USG. Its contributions will peak in 2012/13 and 2013/14, when the grant funds for the three diseases will amount to 19 percent and 28 percent of the total resources available, respectively for each fiscal year.

However, Global Fund financing relative to other donors varies greatly across the three diseases. Based on the currently known, Board-approved amounts, the Global Fund is projected to finance \$283 million for HIV/AIDS over 2012/13–2017/18, but only \$21.3 million for tuberculosis. Still, Global Fund financing for tuberculosis will make up 30.7 percent of the projected resources available, while the Global Fund financing for HIV represents only 11.8 percent of the total projected resources available. Tuberculosis, therefore, faces the largest overall transitional risk in the years to come.

Although Global Fund financing for HIV is low relative to the USG financing for HIV, its contribution to priority interventions is large. For example, 42 percent of the adults and children currently on ART in Kenya are financed through the Global Fund (Table 7). Over the years 2011 to 2012, the Global Fund’s share of support for patients on ART grew while the USG’s share declined. The high dependency on the Global Fund to procure ARTs is a significant transitional risk as the Round 10 HIV grants prepare to close out in the years leading up to 2016/17.

Table 7. Distribution of ART support among donors, 2011-2012

Year	Global Fund supported patients on ART as a percent (%) of all patients on ART*	PEPFAR supported patients on ART as a percent (%) of all patients on ART**	Other partner supported patients on ART as a percent (%) of all patients on ART
2011	40.3%	58.5%	1.2%
2012	41.8%	57.7%	0.5%

Source: (MOMS & MOPHS 2011; MOMS & MOPHS 2012) *Based on KEMSA, **Based on Kenya Pharma levels

The malaria program is also significantly dependent on the Global Fund for key interventions. Global Fund financing for malaria is mainly used to purchase key commodities, such as test kits, long-lasting insecticide treated nets, and ACTs, as well as to support the associated training and service delivery. These represent priority interventions which must be sustained and which are highly interconnected. The subsidy on ACTs in recent years under the AMFm—the mechanism which was implemented alongside Global Fund grants—may have contributed to a situation where over-prescription of ACTs was not very costly. But ACT prices may increase, and over-prescription needs to be reduced via greater testing of suspected malaria cases prior to diagnosis and prescription. It is in this context that a major scale-up of rapid diagnostic testing (RDT) is needed. Therefore, increased access to RDTs is linked to the delivery of the ACTs, and to hold the number of treatments at the levels used for the gap analysis in this study. Financing through the second phase of the Malaria Round 10 grant is expected to meet 90–100 percent of the country’s RDT and ACTs needs (Table 8). If this funding is not secured in the coming years, as well as in the long-term, the malaria program faces a transition risk similar to HIV and tuberculosis.

Table 8. Importance of Global Fund Round 10 (Malaria) Phase 2 funding

Year	RDT		ACT	
	Total needed	% of need to be financed by Malaria Round 10 Phase 2*	Total needed (all sectors)	% of need to be financed by Malaria Round 10 Phase 2*
2014	14,869,848	90%	17,056,332	100%
2015	17,293,719	100%	16,453,052	100%

Source: (DOMC 2010). * Planned but not yet funded.

Latest grant and PR ratings: Of the eight grants to the country, five have recent ratings (see Box 11). Of these, one had an **A1** rating, two had **A2** ratings, one had a **B2** rating and another had a **C** rating. These ratings tend to change often and may have already changed. A grant rated “**C**” at the end of a funding phase does not receive additional funding.

Box 11. Global Fund Grant Rating

A1: Exceeds expectations

A2: Meets expectations

B1: Adequate

B2: Inadequate, but potential demonstrated

C: Unacceptable

5.2.2.2 Socio-cultural and political environment factors

Since 2011, Kenya has been involved in a war in Somalia, which has cost the national treasury a significant amount. The Kenya Defence Forces began a scale back after capturing the Somali port city of Kismayo in the last quarter of 2012. The regional situation over the next few years looks favorable, but the country is likely to be engaged in an expensive anti-terrorism surge within its borders. In addition, a need has emerged to increase spending on police and paramilitary forces to contain ethnic violence and related insecurity in the Coast Province, parts of Rift Valley, and in the North Eastern province. The likelihood of conflicts arising from ethno-religious beliefs, and/or perceptions of social injustice has not been ruled out, especially in the run up to the general election expected to begin on March 4, 2013.

Political uncertainty: The general election in 2013 will cost the national treasury and engaged development partners at least KSh30 billion (\$350 million). The new constitution prescribes a representative albeit resource-intensive six-tier government structure which will likely double the size of government. The impact on service delivery in the period of transition is uncertain, but there is the chance of short-term disruption. Kenya’s elections since 1992 have been characterized by varying levels of violence which progressively have an effect on the value of the currency. The 2007 post-election violence was estimated to have cost the country more than \$1 billion, trimmed economic growth by half, and triggered an immediate 17 percent drop in the value of the Kenyan shilling. Since the 2008 crisis, Kenya has been growing at an average rate of 3.5 percent per year. In 2011 it grew at the rate of 4.4 percent (World Bank 2012).

5.2.2.3 Economy

Economic growth is currently at the annual rate of 4.4 percent, which is also below the consistent growth rate of 7 percent per year required to alleviate poverty and unemployment (World Bank 2012). Growth rate forecasts until 2014 are expected to be below the sub-Saharan Africa average rate of 5.5 percent per year. However, this is expected to improve from 2015. Kenya’s banking sector is strong relative to other Eastern Africa countries, with net assets of KSh2 trillion or about \$26 billion (Central Bank of Kenya 2011). Banks have responded to high liquidity by hiking interest rates. Bank deposits have not grown at a similar rate, reflecting seepages in the economy due to hoarding or high transfers out of the country.

The Budget Review and Outlook Paper for 2012 expects revenues and grants in 2015/16 to amount to KSh1.4 trillion. This may not have taken into account oil revenues, which are expected to begin flowing from 2016. While there is yet to be a credible valuation of the total financial benefits of the discoveries within each gazetted oil block in Kenya, figures from Tullow Oil indicate that Kenya holds over 10 billion barrels, while the Mbawa block is said to hold “\$70 Billion worth” (of oil). Incoming oil revenues will likely mark an improvement in the country’s economic prospects. The health sector may position itself as a recipient by arguing for a strategic plan and preparing a budget review and outlook paper that fully accounts for oil revenues.

Kenya’s highly fluctuating currency was also the world’s worst performing between July 2011 and June 2012, having lost up to 40 percent of its value, before regaining much of it during the last half of 2012. It

has, however, stabilized to between 83–86 units to the dollar during the last half of 2012. On average, year-on-year inflation is around 9 percent; the monthly inflation rate has been reducing gradually in 2012.

While corruption has been witnessed in the education, governance, energy, and finance sectors, the health sector's track record in managing donor funds is fair, apart from audit queries around procurement and with some SRs. Kenya is a major transit point for either fake or diverted medicines and the WHO, the Global Fund, and the Government of Kenya are taking steps to eradicate these practices (GFATM 2011c).

5.2.2.4 Infrastructure availability for health

With the Public Private Partnership policy now approved, there are now about 8,350 officially recognized health facilities in Kenya, ranging from dispensaries (level 2) to referral hospitals (level 6), with plans to build at least one referral level facility in each of the 47 counties during the term of the next government.

As a health systems issue, access to services is hindered by the long distance to hospitals in most areas, and less than 50 percent of mothers deliver in hospitals. While access to LLINs and malaria diagnosis has now been made easier due to the community level service delivery programme, access to ARVs and Directly-observed Treatment Short-course for tuberculosis (DOTS) is still hindered due to the relatively few health facilities where ART and tuberculosis treatment can be initiated and maintained. By November 2012, only approximately 936 facilities were offering ART, while only about 3,600 (less than half of the facilities) were offering services related to prevention of mother-to-child transmission (PMTCT). Tuberculosis treatment was available in 1,980 facilities.

The government is addressing these issues through task shifting and task sharing initiated in phases, such that cadres other than doctors can initiate ART in some facilities. In addition, dispensing may be done by a trained, qualified nurse in lieu of a pharmacist when the latter are not available. Among the relatively few health facilities that offer ARVs, fewer still are equipped to carry out CD4 testing. For example, until recently, those testing HIV-positive at the Marsabit District Hospital in Kenya's north had to travel to Meru District Hospital, more than 300 kilometers (over 7 hours) to have a CD4 test. In response to this, the National AIDS and STD Control Programme (NASCOP) (through the support of UNITAID and partners such as the Clinton Health Action Initiative) is currently encouraging the use of point of care diagnostics, which will significantly reduce the cost of ART treatment, and provide respite to the areas that do not have adequate CD4 testing equipment.

5.2.2.5 Global indices

On the UN's Human Development Index (HDI), Kenya ranks in the least performing rung of countries with low human development. It has a HDI ranking of 143 out of 188 countries as per the data published by the United Nations Development Programme (UNDP). While years of expected schooling have risen due to the free primary education programme, life expectancy has risen from 47 to 55 years during the last decade, mainly due to lower mortality from diseases such as HIV/AIDS and malaria. Other indicators such as rising income per capita have been offset by rising inflation. Generally, Kenya's HDI is improving compared to the values seen in the last decade.

According to Transparency International's Corruption Perception Index (CPI), Kenya scores 2.2 on a scale of 1 to 10, with 1 being highly corrupt and 10 being clean. The institutions perceived as most corrupt fall in the governance sector and in public service delivery. These include the regular police, cabinet, parliament, civil society, religious leaders, and the education sector. Kenya was jointly ranked 154 out of 182 countries in the 2011 Corruption Perception Index.

There have been many attempts to strengthen the governance sector, especially through the Governance Justice Law and Order Sector project and similar projects, with mixed success. A prime reason of mixed results is that basic principles such as Conflict of Interest Management and Oversight, as well as Results Based Planning and Management are not fully inculcated at the planning stages of programs.

5.2.2.6 Government health policies and regulation

Adequacy of the national drug regulatory system: Guidelines for the selection and the use and transition of medicines are compliant with international standards. The Kenya National Pharmaceutical Policy (KNPP) calls for a biennial update of the Kenya Essential Medicines List (KEML) by the National Medicines & Therapeutics Committee. The KEML and the Clinical Management and Referral Guidelines, which support the local diagnosis and management of common health conditions in Kenya, are the two documents that list the national selection of essential medicines. The KEML is updated based on the prevailing national and international guidelines, and was last updated in 2009. It is expected to be updated again next year (2013). The update is expected to include new second-line and pediatric ARV drugs. On the selection of ARVs, the national HIV program under the management of NASCOP determines the selection of appropriate regimens in line with WHO recommendations.

Regulations impacting on transparent and accountable use of funds: Since 2006, Kenya has undertaken Public Finance Management Reforms to promote the transparent and accountable use of funds. A review of the Public Finance Management Reforms found trade-offs between accountability and efficiency. The tendering process was found to be complicated. These further contributed to low financial absorption capacity, as is discussed in **Section 5.3**. Problems with drugs and other commodity availability mainly stem from an inadequate Procurement, Supply and Management (PSM) system.

The country is implementing measures to stringently follow up on reform, increase financial absorption capacity, and strengthen systems. Global Fund SRs continue to advocate for the fast-tracking of Ministry of Finance funds flow systems, and a draft bill in parliament will enable NACC to better enforce compliance to performance-based funding for implementers. The Global Fund's new funding model, by focusing on program-level financing, could push the country towards better accountability.

5.2.2.7 Oversight

When the country underwent the Global Fund's NSA application process for HIV/AIDS in 2009, the proposal was found rather rigid since it overly focused on the role of the Kenya Coordinating Mechanism for the Global Fund (KCM, then the Country Coordinating Mechanism) as the overall coordinator. The Global Fund's Technical Review Panel focused on the KCM's weaknesses, when it was only responsible for a minor proportion of the proposal development process.

The Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund classified Kenya as "high risk" and recommended changes (GFATM 2011b). It found that operational processes and the health system were equally responsible for delays in grant implementation. Kenya was found weakest in the area of financial management. This and other crosscutting health systems issues result in delays in reporting, procurement, and program implementation.

Past reviews of Kenya's health governance systems for instance during the National Strategy Application have failed to appreciate the interchange of roles played by different agencies. For example, the National AIDS Control Council (NACC), as a member of the KCM, had the actual delegated authority on HIV/AIDS. It oversees an expanded multi-sectoral arrangement for the disease, and could legally sign multilateral and bilateral agreements. Though the KCM is hosted by the Ministries of Health, it is not an independently registered legal entity in Kenya. While NACC is legally mandated as the coordinator of the overall AIDS response, it has no direct authority over all sub-recipients of Global Fund HIV/AIDS grants. It is the KCM that signs the grant agreement, while NACC is represented within the KCM. However, NACC is mandated by an act of parliament, and through the UNAIDS "Three Ones" principles, it is the overall coordinator of the HIV/AIDS response in Kenya. As a result, NACC could bear the responsibility for poor performance even while it has little authority over Global Fund's principal and sub-recipients beyond its membership in the KCM.

The KCM has since reformed and clarified partner roles and functions besides developing oversight and conflict of interest management plans. The KCM reform between 2009 and 2011 led to it complying with Global Fund requirements and standards. Following the mandatory oversight plan, the KCM now routinely performs oversight. However, non-routine oversight needs to be better informed. Its quality and effectiveness need to be further strengthened. The KCM also needs to mobilize additional resources to perform more non-routine oversight of grants and PRs/SRs prior to Global Fund audits. The level of involvement and engagement of partners (WHO, World Bank, USAID/ PMI, DFID) in oversight and support to the Ministry of Finance also needs to be strengthened (GFATM 2011b).

5.2.2.8 Health sector context

Disease burden: Kenya's maternal mortality rate is 488 deaths per 100,000 and the under-five mortality rate is 74 deaths for every 1000 children. Kenya is classified as a high disease burden country. For example, it is considered as one of the six highest HIV burden countries in Africa, alongside Mozambique, Nigeria, South Africa, Tanzania, and Uganda. Kenya has an estimated 1.5 million people living with HIV/AIDS and about 1.2 million children have been orphaned by AIDS. More than 91,000 new HIV infections were estimated to have occurred in 2011. However, Kenya has made tremendous progress in recent years. HIV prevalence peaked at around 15 percent in 2000 and has reduced to 6.3 percent according to the UNGASS 2010 report for Kenya. The reports attribute this decline to increases in education and awareness, but also mortality rates.

Kenya is also one of the 22 high tuberculosis burden countries. Malaria-related bed occupancy as a proportion is reducing from a high of 30 percent. Extrapolation from ACT consumption data shows that there are at least 39 million cases of malaria in the country per year, almost at parity with total population.

National Disease Strategies: The third Kenya National AIDS Strategic Plan (KNASP III) was revised mid-stream and now covers the period up to 2013. A plan covering the years beyond 2014 is being developed, but it is unlikely that it will be completed and reviewed in time for the Global Fund's New Funding Model (NFM) pilot. The new plan may also need reprioritization so that the Global Fund is requested to fund only those interventions in line with the UNAIDS "Investment Framework."

The National Malaria Strategic Plan for 2009–2017 is also in force and its resource implications were analyzed in **Section 5.1**. The malaria strategic plan may be relevant for Concept Note creation and subsequent funding under the NFM. The Division of Leprosy, Tuberculosis and Lung Disease also developed a new strategic plan covering the period from 2011 to 2015 and its resource implications were analyzed in **Section 5.1**. It remains to be seen (and much depends on implementation progress) whether this plan is relevant for funding under the suggested three-year window for all new grants under the NFM.

On the issue of the government contribution to the programs (co-funding), Kenya has since 2008 performed some credible financial gap analyses prior to applying for Global Fund grants. These gap analyses have ensured that Global Fund support is additional to government and other development partner support. At the decentralized level, some duplication in programs has been alluded to in the past, arising from a situation when funding sources pursue the same ultimate beneficiaries in an attempt to meet targets. Still, co-funding levels are low. It is estimated that government co-funding, which should be at least 5 percent as per the Global Fund's counterpart financing policy (GFATM 2011a), is at 3 percent.

Adequate human resources for the health sector have been a problematic issue, with understaffing recorded among nurses and other cadres. This is compounded by complaints of inadequate salary levels among staff in the health sector, which has led to destabilization, some labor migration, and sector-wide strikes among doctors, clinical officers, nurses, and others.

The health sector budget has nearly doubled since 2003, but the increase is not proportional to the increase in the overall government budget, which has more than tripled. The health sector budget for FY

2012/13 across both the ministries of health stands at KSh87 billion (\$1.04 billion), but 63 percent of this is for recurrent expenditure, which is mainly salaries and benefits (MOMS 2012; MOPHS 2012). Specifically, 82 percent of the spending on health from general government revenue is on recurrent expenditures (the denominator excludes funds from the sale of inventories, stock, and commodities reinvested as aid in appropriation). This reinforces the sense of the significant burden carried by the government for salaries, benefits, and training costs of public health workers.

The entire public health budget for 2012/13 represents 7.8 percent of the national budget, considering recurrent and development expenditure votes, below the Abuja Declaration call for health sector budgets to represent at least 15 percent of gross national budgets. It must be noted, however, that the size of the overall budget in FY 2012/13 (KSh1.11 trillion) has more than tripled since 2002 (KSh324 Million.)

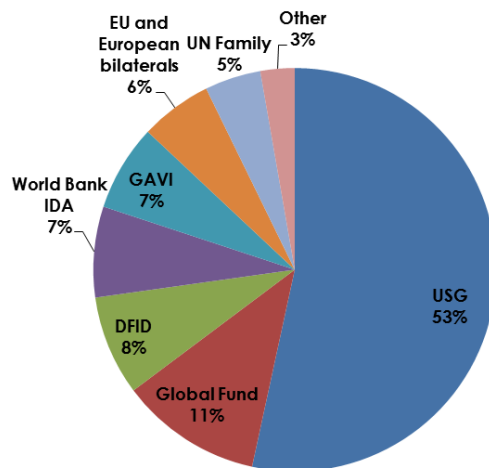
5.2.2.9 Nature of donor funding

As per the estimates for FY 2012/13, development partners currently support 55 percent of the total estimated public sector budget for health with on-budget and off-budget support. Table 9 below summarizes development partner inputs into the health sector budget. Some of the development partner amounts are forecasts, and not finalized. Therefore, the table should be treated as indicative.

Table 9. Development partner support to public sector budget for health for FY 2012/13 (US\$ mil.)

Partner	On-budget	Off-budget
United States Government (via USAID, CDC, etc.)		\$508.8
The Global Fund	\$108.4	
Department for International Development (U.K.)		\$76.3
The World Bank (as International Development Association)	\$69.3	
Global Alliance for Vaccines and Immunization (GAVI)	\$65.9	
UNICEF	\$21.5	
<i>Kreditanstalt für Wiederaufbau (KfW)</i>	\$17.9	
Danish International Development Agency (DANIDA)	\$17.1	
Netherlands Government	\$8.7	
WHO		\$6.1
World Food Programme	\$3.3	\$3.4
United Nations Population Fund (UNFPA)	\$1.3	\$7.4
<i>Gesellschaft für Internationale Zusammenarbeit (GIZ)</i>		\$5.6
European Union		\$5.6
Japan International Cooperation Agency (JICA)	\$5.0	
Bill and Melinda Gates Foundation		\$4.9
Clinton Health Access Initiative (CHAI)		\$3.8
Organization of the Petroleum Exporting Countries (OPEC)	\$3.8	
Arab Bank for Economic Development in Africa (BADEA)	\$1.8	
Government of Kuwait	\$0.7	
Baylor College of Medicine, USA (BCM)	\$0.6	
International Finance Corporation (IFC)		\$0.5
African Development Bank	\$0.1	
Various (primarily for Kenyatta Hospital)	\$5.0	
TOTAL (US\$ mil.)	\$330.4	\$622.3

Figure 7. Distribution of development partner support to the public health sector, 2012/13



Source (Table 9 & Figure 7): (DPHK 2012; MOMS 2012; MOPHS 2012) 1 US\$ = KSh. 84; 1 euro = KSh. 108.1

With the revised expectation of Global Fund grant disbursements as used in this report, we estimate that at least 30 percent of the public health budget in FY 2012/13 will be accounted by on-budget support from development partners, including the Global Fund. Some development partners preferentially provide off-budget support. In fact, the majority of the support from development partners currently appears off-budget, as seen in Table 8, which represents its own challenges.

5.2.3 Diagnosis of strengths, weaknesses, opportunities, and threats (SWOT)

Inadequate health sector budget amidst increasing demands: The health and community system is severely constrained by the burden of communicable and non-communicable diseases, and there is a persistent burden on the average public sector health worker. Health workers in Kenya have recently gone on several strikes to demand more pay; the increased salary bill is likely to be funded from a health budget facing heavy demands.

In line with the overall National Development Strategy (Vision 2030), the country has identified a need for emergency-type funding for overall health systems strengthening, including task shifting, task sharing, and hiring of additional human resources for health.

Successful applications through the new funding model would significantly plug the funding and coverage gaps observed in Section 5.1 above. It would also come with conditions to strengthen reporting, the Financial Management System of PRs, and streamline procurement arrangements, among the other opportunities discussed in Section 3.3.

At about 11 percent of the total development partner contribution in FY 2012/13 as shown in sub-Section 5.2.2.9 above, the Global Fund is a major contributor to Kenya's health sector, the second highest funder after the United States Government. It is even a more critical contributor to the HIV, malaria, and tuberculosis budgets, as discussed in sub-Section 5.2.2.1. Therefore, it is important that all stakeholders should invest in the effort to oversee grants and ensure they perform optimally. Given the size of the Global Fund portfolio, the critical dependencies from sub-Section 5.2.2.1 for ART, etc., the Kenyan health sector would face negative repercussions if Global Fund support is interrupted in the long term.

Potential barriers to accessing funding: The performance and oversight of Global Fund’s grants to Kenya have improved significantly since 2009. Within the period, two grants managed by a state and a non-state PR achieved an **A**-rating reflecting improvements in results within the set timeframe. Despite these positive developments, Kenyan grants have not always maintained this performance in subsequent periods. An overarching reason is that Kenya has been slow to internalize and fully implement the Global Fund’s Performance-Based Funding (PBF) principle (Box 12).

An analysis of Kenya’s grants against the requirements of the PBF principle illustrates that Kenya’s grants secure low ratings due to avoidable issues. The country must move towards a full implementation of the PBF principle. This is the only way to ensure a predictable flow of funding from the Global Fund in an environment of scarcity.

Grants in Kenya are implemented with a delay of between six and 24 months. Financial Management issues include audit delays and accounting anomalies, conflicting policies across the PRs and the Global Fund (e.g., audit and funds flow timelines), and the fact that part of the procurement and supply management system merely encourages delays. These issues are fully explored in the next section, using case studies of recent grants.

The Global Fund grants are aimed to reach people most in need, most of whom (60–70 percent) are found at the rural or sub-county level. Based on the GEES and SWOT analyses, four potential problems can be envisaged in implementation that may become relevant as qualitative criteria in the NFM:

- Weak or underfunded SR structures at the decentralized/sub-county level. For instance, the Division of Malaria Control (a SR) offices/satellites at the sub-county level, over 100 in number, are expected to operate on a budget over several years of about \$500,000 vs. a request of \$2.8 million. These offices are central to achieving and reporting results. The Global Fund’s credo is “no reports, no money.” The sub-county reports are either late or infrequently missing (DOMC 2012).
- There is confusion about the status of future sub-county governance and financing structures, brought about by the hazy transition into the country’s new constitution.
- Global Fund grants and reporting structures are frequently in competition for the time of GOK staff and expertise with those of other development partner programs, who—unlike the Global Fund—are present in-country and have decentralized (for example, the U.S. Government’s AIDS, Population, and Health Integrated Assistance Program (APHIA) projects and the community initiatives supported by other partners). The M&E framework of the health sector is yet to fully consolidate and leverage efforts at data collection, validation, and supervision at the decentralized level (Alando 2011).
- Kenya has relatively large financing gaps within the three diseases, as suggested in Section 5.1. Prioritizing what to fund will be a challenge unless the disease departments focus on the related questions and begin to apply the available evidence in formulating plans.

Box 12. Global Fund’s Performance Based Financing (PBF) principle

Objectives of PBF are: (1) link funding to the achievement of country-owned objectives and targets; (2) ensure that money is spent on delivering services to people in need; (3) provide incentives for grantees to focus on programmatic results and timely implementation; (4) encourage learning that strengthens capacities and improves program implementation; (5) invest in measurement systems and promote the use of evidence for decision-making; (6) provide a tool for grant oversight and monitoring within countries and by the Global Fund Secretariat; and (7) free up committed resources from non-performing grants for re-allocation to grants where results can be achieved. (Global Fund, 2010)

5.3 Policy Risk: Absorptive Capacity Related to Global Fund Grants

5.3.1 Recent grants and their budgets, disbursements, and expenditures

As discussed in Section 4.3, the Global Fund operates under a performance-based financing mechanism which links historical and expected program performance to the level of financing to be provided to the PR. Disbursement decisions, therefore, are indirectly indicative of project performance to date. The PU/DR (Box 13), especially after LFA verification, forms the basis for the Global Fund’s disbursement decision. Ongoing PU/DRs are to be submitted by the PR every one to two budget periods covered by the performance framework of the grant. All the Global Fund-financed grants have established quarterly budget periods; therefore, PU/DRs are expected on a semester basis. The DR submitted by a PR can be granted in whole, granted partially, or denied. In this way, the relative level of disbursement is an indirect indicator of absorptive capacity.

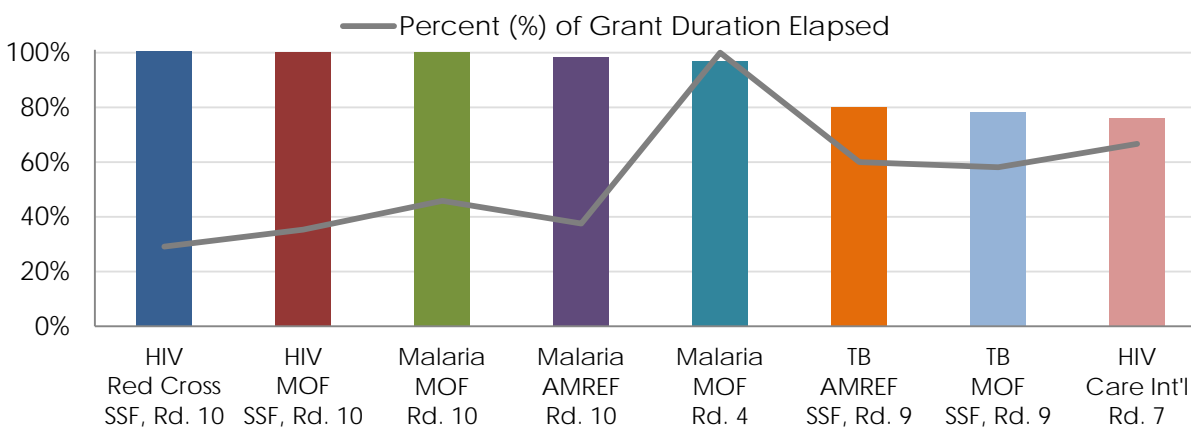
Box 13. Progress Update and Disbursement Request (PU/DR)

Definition: a progress report on the latest completed period of program implementation and a request for funds for the following period of implementation

Purpose: to provide an update of the programmatic and financial progress of a Global Fund-financed grant, as well as an update on fulfillment of conditions precedent, management actions, and other requirements

Ideally, each grant would secure 100 percent of its disbursement request. Figure 8 demonstrates how well each current grant has been able to secure its cumulative budget to-date, as of October 31, 2012. The indicator “cumulative disbursement as a percent of cumulative budget to date” (i.e., disbursement level) can range from 76 percent to 100 percent. The results in Figure 7 suggest that absorption capacity may vary for the same PR across grants. For example, the MOF achieved a 100 percent disbursement level under the Round 10 malaria grant, but only a 78 percent disbursement level under the tuberculosis SSF grant.

Figure 8. Current grants: Cumulative disbursement as a percent (%) of cumulative budget to date

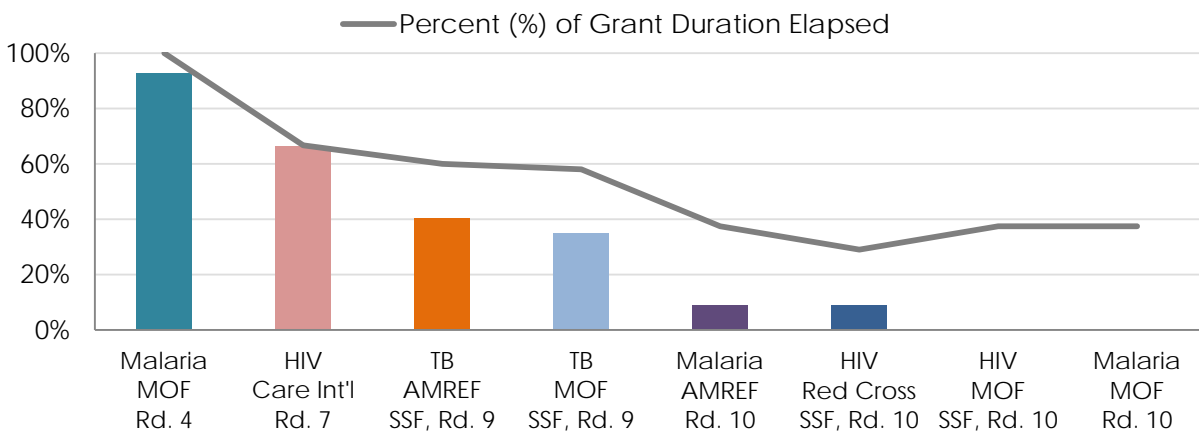


Source: Global Fund. Colors of the bars identify the grants across Figures 7 and 8.

In Figures 8 and 9, the grey line represents the months elapsed as a proportion of the total grant duration. Although it could be argued that a grant’s disbursement level will improve with time as problems are identified and resolved, we find that grant maturity does not appear to be correlated with disbursement level. The cumulative disbursement level for three grants with different PRs all fall below 80 percent. Two of these grants will be discussed in detail in Case Studies 1 and 2.

In reviewing the PR’s disbursement request, the Global Fund examines total reported expenditures and cash balances to gauge the ongoing implementation capacity of the PR. Figure 9 shows the performance for Kenyan PRs in spending the funds disbursed as the indicator “cumulative *reported* expenditure to date as a percent of cumulative disbursement to date” (i.e., expenditure level). This is also often referred to as *absorptive capacity*. Here, relative grant maturity seems to be positively correlated with expenditure level.

Figure 9. Current Grants: Cumulative reported expenditure as percent of cumulative disbursement to date



Source: Global Fund. Colors of the bars identify the grants across Figures 7 and 8.

Discussion: While the Round 4 malaria grant, which was scheduled to close earlier in 2012, achieved a 93 percent expenditure level, two of the four most recent grants have little to no *reported* expenditures as of October 31, 2012 (hence the values are not visible in Figure 9). While these four grants have been in implementation for very little time, all have received disbursements (Figure 8) and completed at least 29 percent of grant life.

In general, it is not definite that the expenditure level will increase over time for current poorly spending grants. Low spending puts additional pressure on a grant to catch up in terms of performance indicators. Current under-performance on these indicators reduces or delays subsequent disbursement because the Global Fund uses performance-based funding on an ongoing basis.

Low observed absorption capacity (expenditure levels), when based on reported data, can also be a demonstration of *poor expenditure reporting*. Such poor reporting of expenditures will also delay future disbursement, in addition to drawing scrutiny from the Global Fund and requiring additional efforts on behalf of the PR to demonstrate the quality of their financial data.

Considering Figures 8 and 9, the data strongly suggest that in Kenya, disbursements decisions have been correlated with expenditure levels. Excluding the four least mature grants, the three grants achieving the lowest disbursement levels are also those achieving the lowest expenditure levels (Box 14). Only the Round 4 malaria grant has achieved over 90 percent in its cumulative expenditure and disbursement levels.

Box 14. Comparing Indicators		
Grant	Cum. Exp. Level	Cum. Disb. Level
HIV (Rd. 7)	66%	76%
TB (Rd. 9)	35%	78%
TB (Rd. 9)	40%	80%

Cum. = cumulative; Exp. = expenditure
Disb. = disbursement; Rd. = round

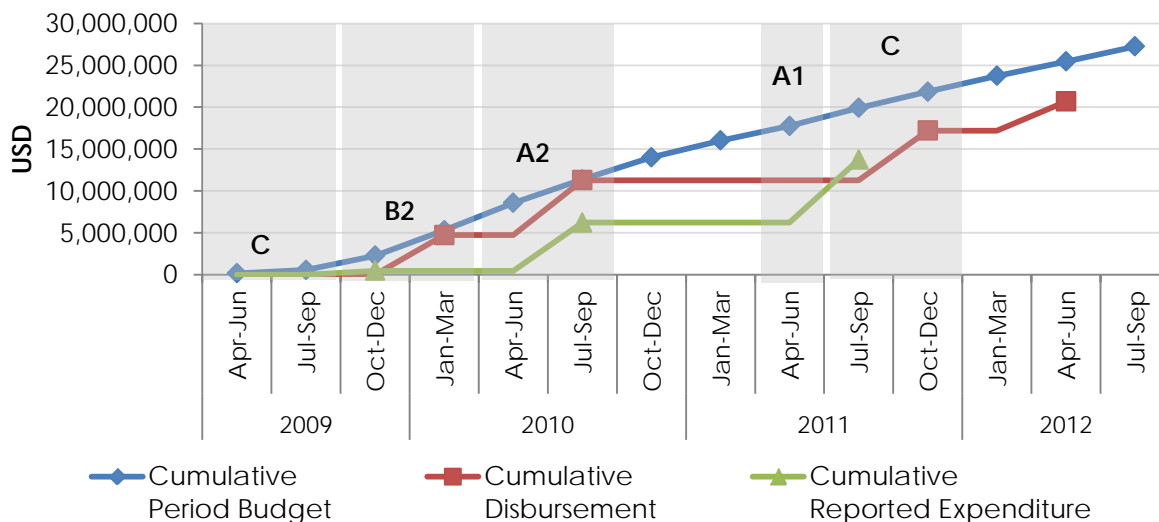
We can safely hypothesize that not only does the Global Fund perceive absorption capacity to be important, but that Kenya has a need for improvement in this context. In the following Case Studies, we examine three instances in which disbursements were affected by poor absorptive capacity of the PR and use it to develop actionable recommendations.

5.3.2 Three grants as case studies

5.3.2.1 Case Study 1: HIV Round 7 (CARE International Kenya, Phase II)

The Round 7 HIV grant will be the most mature grant in Kenya by 2013. Since its inception in April 2009, the grant’s implementation and financial performance have fluctuated dramatically, as evidenced by its receipt of **A1** and **C** performance ratings in two sequential progress update periods in 2011. According to the reports filed, the principal recipient, Care International, failed to address systematic issues which have led to disbursement delays of up to a year and a 66 percent cumulative reported expenditure level (GFATM 2012c).

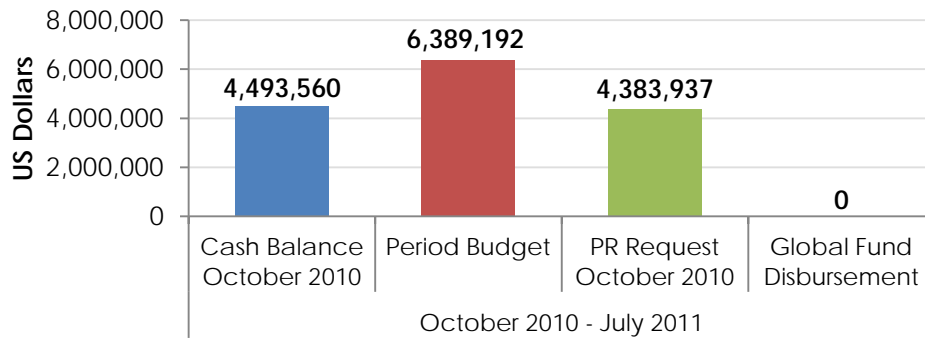
Figure 10. HIV Round 7, Care Intl. (grant Phase II only): Cumulative budget, cumulative disbursement, and cumulative reported expenditure



Source: Global Fund. Letters in bold indicate grant performance ratings awarded for the shaded period.

During the disbursement request review for the period October 2010–July 2011, the PR’s high cash balances trumped very good programmatic performance. This review resulted in the denial of a \$4.4 million disbursement request (Figure 11). This Global Fund decision follows a period in which the grant had achieved 93 percent of its targets and received an **A2** rating. However, the Global Fund noted that poor quality reporting on some indicators persisted during the progress update period leading up to the disbursement request, which affected the validity of the grant’s success (GFATM 2012c).

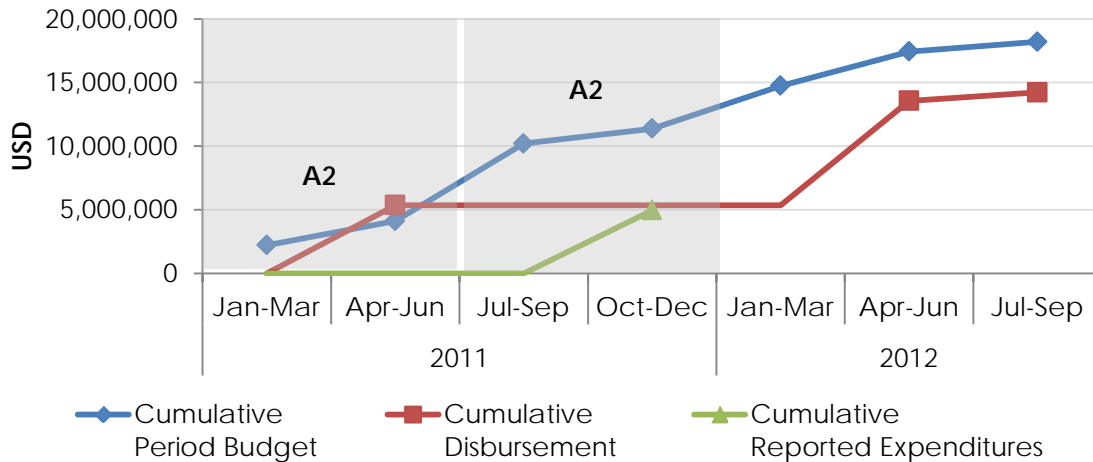
Figure 11. HIV Round 7, Care Intl. (Phase II): October 2010–July 2011 financial details



Source: Global Fund. Letters in bold indicate grant performance ratings awarded for the shaded period.

5.3.2.2 Case Study 2: Tuberculosis Round 9, Single Stream Funding (Ministry of Finance)
 Now in its second year of implementation, the Round 9 tuberculosis grant (MOF as the PR) has struggled to receive consistent disbursements. There was a 12-month lag between first and second disbursements, both of which were only partially granted. In actuality, the two disbursements were separated by another disbursement request, which was denied in totality. Low expenditures are evident, but fail to explain why the first grant was also partially denied and suggests deeper organizational issues.

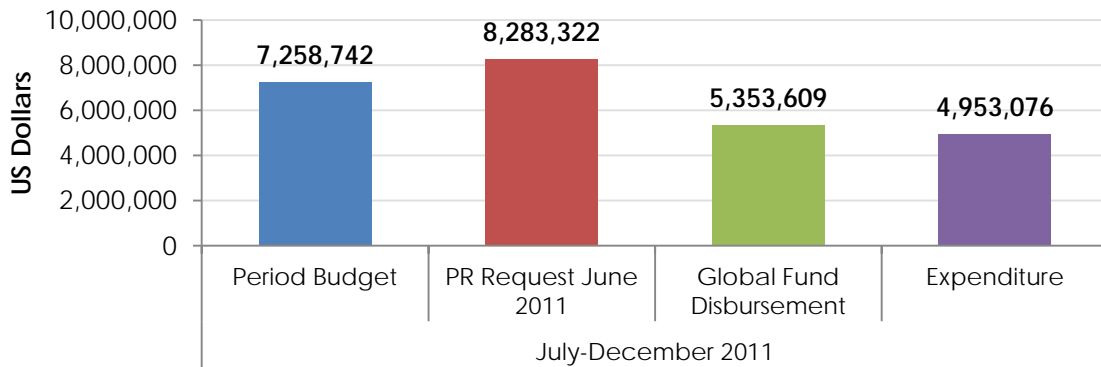
Figure 12. Tuberculosis Round 9, Ministry of Finance: Cumulative budget, cumulative disbursements, and cumulative reported expenditures



Source: Global Fund. Letters in bold indicate grant performance ratings awarded for the shaded period.

As shown in Figure 12, the Ministry of Finance only received 65 percent of the funds requested for the July–December 2011 disbursement period. The Global Fund indicated the importance of non-completion of audits of the Financial Management Agent and the Procurement Consortium (GFATM 2012d). As per the published documentation, the disbursement was eventually only granted to prevent future stock-outs of first-line tuberculosis drugs. By December 31, 2011, the principal recipient had yet to spend the whole disbursement and had accumulated cash balances of \$2,311,023. However, the program was still able to achieve 99 percent of the Global Fund’s top 10 indicators identified for the grant during this period.

Figure 13. Tuberculosis Round 9, Ministry of Finance: July–December 2011 financial details



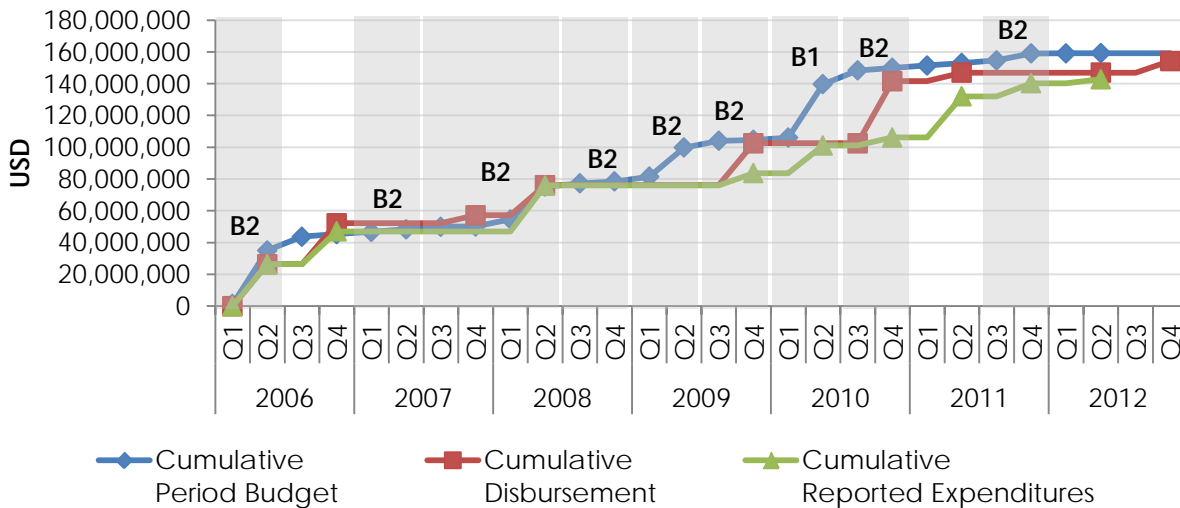
Source: Global Fund

In response to the next disbursement period request, the Global Fund reported that it conducted a thorough review of the forecast presented by the PR, and thereafter cited issues of financial absorption capacity as a reason for revising the disbursement (Figure 13).

5.3.2.3 Case Study 3: Malaria Round 4 (Ministry of Finance)

The Round 4 Malaria grant was implemented from February 2006 till June 2012 under the management of the Ministry of Finance (MOF). The Round 4 grant benefited from the pilot AMFm project. The MOF achieved 97 percent disbursement of budget, and expended 93 percent of disbursement.

Figure 14. Malaria Round 4, Ministry of Finance: Cumulative budget, cumulative disbursement, and cumulative reported expenditure

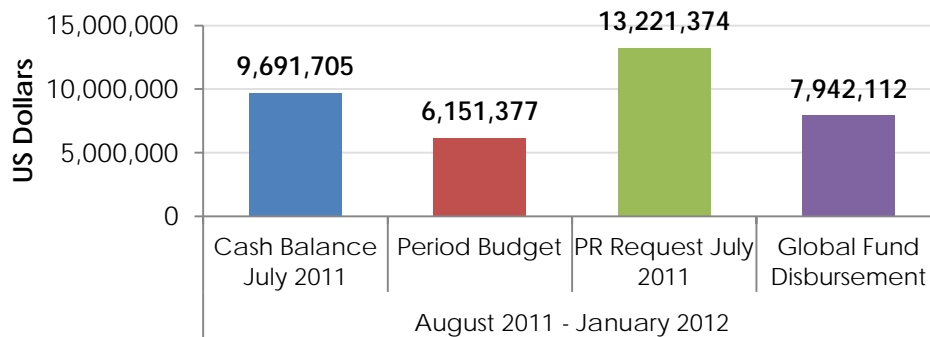


Source: Global Fund. Letters in bold indicate grant performance ratings awarded for the shaded period.

However, issues of financial management weakness impeded the PR’s ability occasionally to secure full disbursements from the Global Fund. In the February–July 2011 progress update, the Global Fund recognized that the program had “succeeded in accelerating implementation” and earned an **A2** rating, the highest rating in over five years of program implementation (GFATM 2012b). But subsequently, the performance rating was reduced to **B1**, due to “financial management weaknesses within the Division of Malaria Control” (DOMC) (GFATM 2012b). Consequently, the Global Fund decided to withhold a

portion of the funds intended for the sub-recipient DOMC from the total of the July 2011 disbursement request, as seen in Figure 15. The Global Fund noted, “the PR’s cash request is not consistent with the budget forecasts, and [the PR] did not provide supporting documentation justifying it” (GFATM 2012b).

Figure 15. Malaria Round 4, Ministry of Finance: August 2011–January 2012 financial details



Source: Global Fund

5.3.3 Discussion

In Kenya, the MOF serves as the PR for the greatest number of grants across the three diseases. Despite its broad and longstanding relationship with the Global Fund and success with the Round 4 malaria grant, delays in the absorption of disbursed funds persist. Discussion with the MOF revealed two causes of the weak absorption capacity: implementation lags (Box 15) and cumbersome processes.

The MOF estimates that its procurement lag averages two years. This cannot be easily synchronized with the procurement of other health sector partners, who implement with an average of a one-year lag.

This may be caused by poor forecasting and procurement planning, coordination problems, or unforeseen circumstances. Given procurement delays, a PR may have high expenditure levels (i.e., a large percentage of funds re-disbursed to SRs) but still fail to achieve outcome or progress indicators. Although the MOF achieved a high expenditure level by the end of the Round 4 malaria grant, Figure 8 shows this is not true of all MOF grants. Because there appears to be a strong correlation between expenditure and grant maturity (Figure 8), it is likely that most grants engage in aggressive “catching up” as the grant’s end date approaches. While sometimes this is successful, it imposes some risk that the grant will end up not receiving and spending all of the funds that were agreed with the Global Fund.

The MOF has suggested that some organizational processes are also limiting the ability to absorb funds. The sub-recipients under the MOF described its fund flow processes to be “cumbersome,” which results in low PR expenditure rates regardless of the status of outcome indicators (DOMC 2012). This issue was demonstrated in Case Study 3, where the Round 4 grant’s performance rating was lowered due to high cash balances, despite high program outcome achievements.

As mentioned in Section 3.1, a stage of the process of funds flow in need of careful consideration is the audit of MOF grants. Kenya’s rules and regulations require MOF grants to be audited by the Kenya National Audit Office (KENAO) rather than independent auditors. External auditors need to be approved by KENAO. However, KENAO completes its audit at least 180 days after the calendar year, which conflicts with the Global Fund’s revised operational policy (which, in turn, requires an audit within 90 days after the end of the calendar year). Meanwhile, sub-recipients have pointed out that the complex funds flow system within the MOF (also see Annex 1) leads them to spend more time awaiting funds

Box 15. Implementation Lags

Definition: Implementation or procurement lags refer to delays between disbursement receipt by the PR and direct expenditure by the PR or, more often, the sub-recipient (SR).

transfers (GOK 2012). Recently, under the Round 4 malaria grant, the local auditor's report misstated that KSh1.4 billion could not be accounted for; when in reality they were still within the funds flow system (DOMC 2012).

The DOMC is the main SR on malaria grants received through the MOF, and has experienced related problems in receiving and expending funds effectively that stem in the Government of Kenya financial management system. These include non-skilled staff, a non-computerized financial system, weak segregation of finance duties and approvals, the lack of a standard internal financial reporting system, and slow reporting from the county and sub-county levels.

Among the non-governmental PRs, CARE International has previously reported to the KCM (in August 2010) that none of its sub-recipients (SRs) had been compliant during Phase 1 of grant implementation. "Compliance" under Global Fund reporting refers to SRs who report complete results for all quarters or semesters. None of the more than 50 SRs had been compliant.

Problems in the absorptive capacity of PRs pose a serious risk to the success of current grants. If these problems continue, they also imperil Kenya's ability to secure funds with the Global Fund's New Funding Model. As discussed in Section 3.2, absorptive capacity is and will be one of the qualitative criteria used consistently by the Global Fund in setting allocation amounts and in deciding the final grant.

6. SUMMARY OF RECOMMENDATIONS

6.1 Policy Recommendations

In this study, we have suggested that significant financial gaps remain between what is needed in the public health sector response to the three priority diseases and what is available, after consideration of the contributions of all development partners and the Government of Kenya's contribution to non-salary costs. Kenya has two choices in this context. The first option is to prioritize interventions and rationalize coverage and programmatic activities, such that more can be achieved while remaining within the resources available. The second option is to aim to pursue a resource mobilization strategy that will increase funds for the three priority diseases from various sources, including increasing government co-funding. The first option requires additional analysis, working with the disease programs to adapt a disease-specific investment framework which also draws on existing national strategies and adopts a value for money approach. This analysis can be conducted in the future under Phase 2 of this activity. We focus here on certain aspects of the second option.

Mobilizing increased government co-funding: Kenya should strengthen its financial sustainability strategy and accelerate approaches towards innovative and local financing. In anticipation of oil revenues that may begin to flow from 2016, for example, a strategic plan could be developed to ring-fence a certain allocation for health. This, in addition to other mechanisms, could aim to increase the current 7.5 percent of the government budget being spent on health incrementally towards the 15 percent recommended under the Abuja Declaration.

Additionally, the two ministries of health (MOPHS and MOMS) and NACC should advocate for increasing the level of Government of Kenya co-funding of expenditures for the three priority diseases within the health sector budget, such that the proportion is at least 5 percent of the sum of government and Global Fund financing for a disease. This threshold is necessary under the Global Fund's counterpart financing rule. In this study, we have shown the growing reliance on the Global Fund for key interventions with major morbidity and mortality benefits, such as ART. This reliance may not be sustainable in the long run. New and existing government co-funding should target key commodities and priority interventions, such as ART, to mitigate the risk of a growing financial gap and maintain current service delivery levels.

Mobilizing additional Global Fund resources: Even with increased government co-funding, it is likely that Kenya may need to seek additional Global Fund resources. In **Chapter 2**, we identified that there are significant "potential outstanding" funds that may yet be accessed from current grants in implementation. Current PRs should ensure that they meet performance and financial obligations to clear the path to accessing these funds during future Periodic Review and Phase Renewal negotiations with the Global Fund, inasmuch as they occur within the paradigm of the NFM. In this context, our recommendations below regarding financial management and oversight are relevant.

Despite these pending outstanding funds for current grants in implementation, Kenya may want to seek new grants under the Global Fund's New Funding Model (NFM). We have suggested that Kenya may be eligible for participation in the pilot phase during the transition period to the NFM. Some national disease strategies will lend themselves more easily to preparation of the Concept Notes needed for the NFM and the prioritization therein. The disease programs (DOMC, NASCOP, NACC, and DLTLD) should begin to look critically at existing strategies and identify critical gaps that could be prioritized for NFM application via a Concept Note. Again, we note that accessing the maximum core stream funding amount and, thereafter, any incentive stream funding will require that Kenya address key issues that are important as criteria in Global Fund evaluation of proposals for the NFM, such as absorptive capacity, co-funding, and

reduction in other forms of operational and programmatic risk. In this context, the recommendations below are important.

6.2 Improved Financial Management

Detailed recommendations in this regard were provided at the end of **Chapters 3 and 5**. In summary, the MOF and other PRs should diagnose their SR's financial management systems (FMS) using the Global Fund FMS guidelines and prepare a timed capacity building plan to strengthen these.

The PRs should hold trainings to strengthen Performance Based Funding. The MOF, SRs, and sub-county level funds flow systems should be reviewed to harmonize them with the Global Fund's performance and timeliness requirements.

The PRs, in collaboration with the Global Fund, should perform an operational risk assessment and develop a Global Fund risk mitigation plan that covers all the areas of risk identified by the Global Fund LFA guidelines.

6.3 Improved Financial and Programmatic Oversight

The two ministries, MOMS and MOPHS, should engage in evidence-based negotiations to redefine the division of labor under a program-level approach that will also be relevant in the future for NFM-related Concept Notes. Specifically, this will clarify roles and responsibilities, in addition to meet the Global Fund's demand for demarcation of responsibility under the NFM.

The Ministry of Finance should consider requesting a waiver of government policy to allow the Kenya National Audit Office to outsource the audit of the Global Fund supported programs in order to comply with the strict Performance Based Funding requirements and ensure an efficient flow of Global Fund disbursements. KENAO would still retain its national obligations under this arrangement, as long as audits are performed in a timely manner.

The Kenya Coordinating Mechanism (KCM) should improve oversight and pre-audits of all grants, with a special emphasis on those previously judged problematic. This should include both non-routine and routine oversight included in its oversight plan.

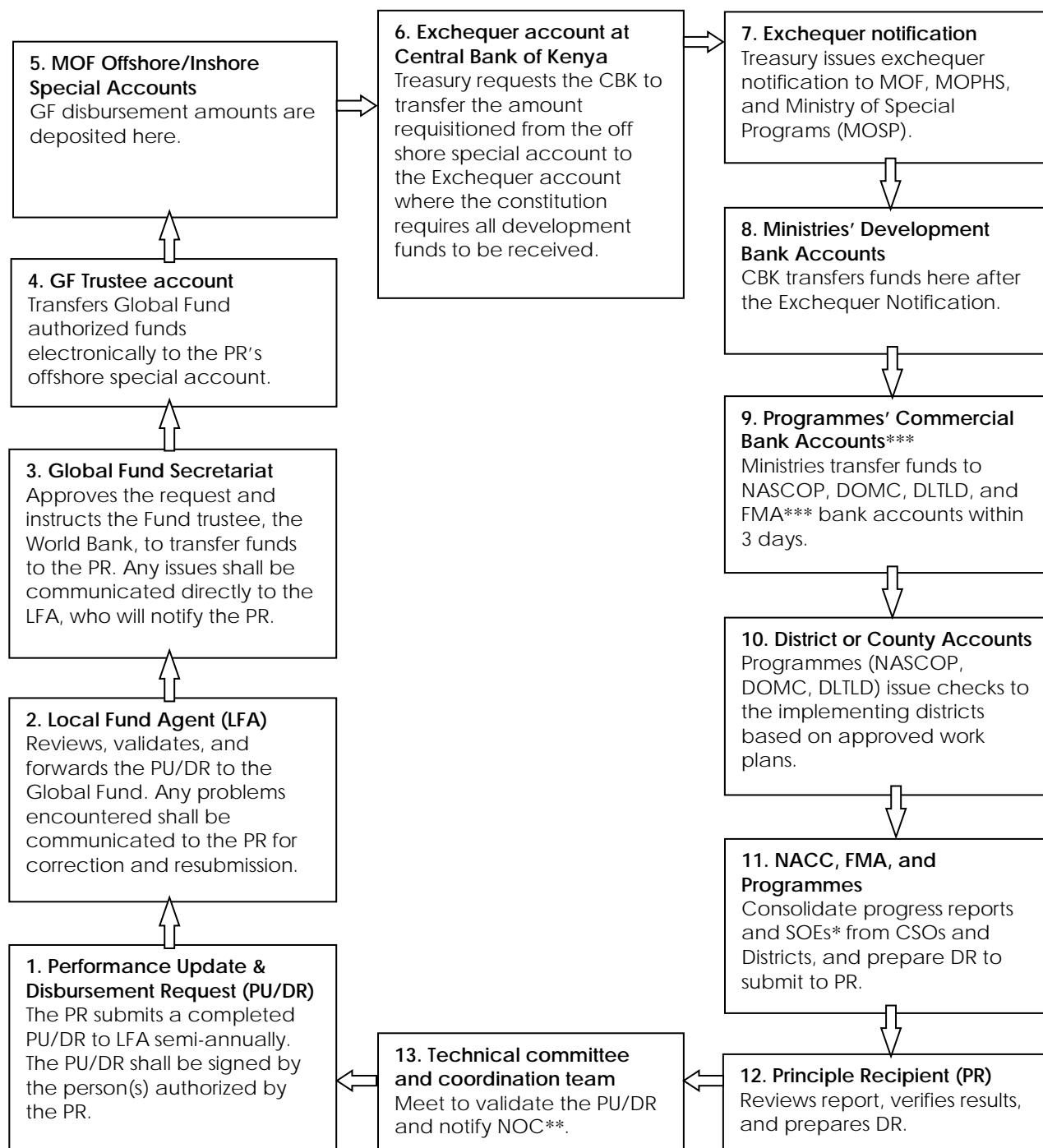
All development partners should invest in the effort to oversee grants and ensure that Global Fund grants perform optimally. The DPHK, HSCC, and other structures should institutionalize more frequent processes through which their designated representatives to the KCM provide feedback and inputs into the oversight processes. Such discussions will also create an opportunity to share best practices among individual disease programs relating to multisectoral engagement and health systems strengthening. Discussion among development partners should also aim to consolidate health sector monitoring and evaluation frameworks to reduce parallel reporting.

DPHK should continue to invest in oversight capacity strengthening processes, including by providing technical and financial support to the NOC/KCM oversight process and following up on the implementation of grant and PR oversight report recommendations.

6.4 For Further Analysis

The costs estimated in this study for the financial gap analysis in Chapter 5 are based on the design of disease programs until now where the center has taken a strong lead. With the implementation of the 2010 Constitution in the health sector and the full impact of devolution activities, the costs may change as service delivery and program management adapt to the devolved situation. Therefore, it is imperative that the resource needs for the three diseases be estimated with the perspective of county-led service delivery.

ANNEX 1. MINISTRY OF FINANCE (MOF) FLOW-OF-FUNDS PROCESS



*Statement of Expenditures (SOE)
**No-Objection Certificate

***For CSOs, the PR releases funds from its local account to the fund management agent (FMA), which then releases it to CSOs.

Process for MOF Funds Flow: The Global Fund disbursements occur at three levels: the Global Fund to the PR, the PR to the SRs, and the SRs to the SSRs. The Flow of Funds chart, above, describes the procedures used to make these transfers. Upon signing the grant, the PR submits a First Disbursement request form to the LFA. The requested amount shall equal the total cash requirements for two quarters, plus one additional quarter to allow for adequate cash flow to begin implementation of activities. For subsequent disbursement requests the PR shall complete and submit the PU/DR as indicated in the Flow of Funds chart. Upon receiving the first disbursement from the Global Fund, the PR shall disburse the first installment to the SR, in accordance with the PU/DR and the annual work plan. For subsequent disbursements, the SRs shall submit a PU/DR to the PR on a semi-annual basis to request more funding. The transfer of funds from the SRs to the SSRs shall be based on the timely submission and review of PU/DRs and work plans.

The Flow of Funds chart illustrates how Global Funds disbursements are transferred to various ministries (i.e., from the MOF, which is the PR, to the sub-recipients, such as the Ministry of Public Health and Sanitation, the Ministry of Special Programs, etc.). In addition, they flow eventually to ministerial departments and programs (i.e. NASCOP, DOMC, DLTLD), districts/counties, or other decentralized accounts.

Funds for the PR's own expenses, civil society organizations (CSOs), and other SRs are transferred into the PR's local commercial account through similar processes. However, for procurements expected to be paid in U.S. dollars, the funds are retained in the special offshore account, budgeted as appropriations in aid (AIA), and paid directly from the special offshore account to suppliers to mitigate exchange losses. In order to release funds to the CSOs, the PR first releases funds from its local accounts to the Financial Management Agent (FMA). Then the FMA issues a check to the CSO in question, the amount of which will be based on the annual work plan, the amount received from the PR, any criteria agreed upon between the FMA and CSO, and fund accountability statements submitted by the CSO.

Process for Other PRs: Under the dual-track financing system, funds for NGO/CSO PRs are sent directly from the Global Fund to the nongovernmental PR's account. These funds are then submitted via operational arrangements described in the operational policy manuals of the non-state PRs.

ANNEX 2. HIV/AIDS DETAILED GAP ANALYSIS

Table A.2.1 HIV Pillar I Costs, 2012–2017

	US\$					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Prevention						
IDU: needle exchange	996,284	1,195,502	1,406,065	1,628,119	1,856,332	1,977,733
IDU: drug substitution	2,939,626	3,527,434	4,148,721	4,803,910	5,477,273	5,835,477
Interventions focused on sex workers	54,690	64,686	73,943	83,080	92,981	99,062
Interventions focused on MSM	74,134	76,648	79,286	82,020	81,567	86,901
Condoms	10,975,546	11,857,574	12,787,950	13,764,161	14,741,662	15,705,743
Male circumcision	6,064,589	6,109,052	6,098,339	6,092,097	6,081,707	6,479,441
PMTCT	19,915,033	20,764,818	21,206,346	21,580,207	22,445,092	23,912,966
Post-exposure prophylaxis	398,554	457,176	519,100	584,329	650,949	693,520
HIV Counseling and Testing	8,488,126	9,042,154	9,626,281	10,238,282	10,844,944	11,554,187
<i>Prevention Sub-Total</i>	<i>49,906,582</i>	<i>53,095,045</i>	<i>55,946,032</i>	<i>58,856,205</i>	<i>62,272,506</i>	<i>66,345,029</i>
Care and treatment						
ART (First-Line Treatment) for adults	157,268,135	175,501,973	191,553,408	207,246,209	222,056,838	236,579,000
ART (Second-Line Treatment) for adults	13,952,642	15,413,150	17,012,717	18,919,053	21,108,881	22,489,368
Management of opportunistic infections	14,855,560	16,221,007	17,745,725	19,264,920	20,691,196	22,044,367
Cotrimoxazole for children	N/A	832,335	1,628,442	2,367,924	3,046,075	3,245,283
CD4 Testing for Routine Monitoring	10,313,884	11,613,817	13,090,490	14,629,130	16,161,116	17,218,027
Viral Load Testing for ART Patients	17,825,859	5,797,825	6,330,327	6,857,125	7,361,369	7,842,791

Other Laboratory Testing for Patients in Care	2,213,133	2,416,553	2,643,701	2,870,025	3,082,507	3,284,098
Therapeutic Foods for Severely Malnourished HIV+ Adults	1,043,535	1,124,391	1,169,950	1,169,043	1,212,818	1,292,134
Multiple Micronutrients for HIV+ Adults	914,964	1,149,713	1,322,136	1,468,371	1,718,781	1,831,187
Exclusive Replacement Feeding (infant formula)	780,884	928,019	1,081,678	1,099,248	1,235,263	1,316,047
Nutritional Supplements for HIV+ children	879,161	991,823	1,106,909	1,220,579	1,359,159	1,448,046
Therapeutic Foods for Severely Malnourished HIV+ Children	2,839,893	3,063,807	3,260,491	3,511,658	3,762,073	4,008,107
Multiple Micronutrients for HIV+ Children	151,598	189,025	215,403	237,017	274,954	292,936
Pediatric ART: Second Line	2,957,762	3,589,264	4,242,563	4,730,807	5,156,525	5,493,753
Palliative and Home-based Care for HIV+ Patients	3,241,296	3,377,645	3,522,854	3,674,214	3,819,438	4,069,223
Nutritional Supplements for HIV+ Adults	1,374,243	1,616,966	1,896,819	1,895,334	2,112,445	2,250,595
Pediatric ART: First Line	16,147,698	19,595,342	23,161,983	25,827,520	28,151,698	29,992,774
Nutrition Supplements for HIV+ Pregnant/Lactating Women	1,141,585	1,202,534	1,253,479	1,313,283	1,376,301	1,466,309
<i>Care and Treatment Sub-Total</i>	<i>247,901,832</i>	<i>264,625,188</i>	<i>292,239,073</i>	<i>318,301,459</i>	<i>343,687,438</i>	<i>366,164,047</i>
Collaborative HIV/AIDS and TB Interventions						
HIV prevention for TB patients	319,082	302,998	298,641	289,264	284,421	303,022
<i>TB/HIV Interventions Sub-Total</i>	<i>319,082</i>	<i>302,998</i>	<i>298,641</i>	<i>289,264</i>	<i>284,421</i>	<i>303,022</i>
Training						
In-service / Refresher Training	89,944	449,720	359,776	N/A	N/A	N/A
<i>Training Sub-Total</i>	<i>89,944</i>	<i>449,720</i>	<i>359,776</i>	<i>0</i>	<i>0</i>	<i>0</i>
Supervision						
Coordination Meetings	92,584	92,584	92,584	92,584	92,584	98,639
National Staff Visiting Local Staff	1,392,085	1,392,085	1,392,085	1,392,085	1,392,085	1,483,125
<i>Supervision Sub-Total</i>	<i>1,484,669</i>	<i>1,484,669</i>	<i>1,484,669</i>	<i>1,484,669</i>	<i>1,484,669</i>	<i>1,581,764</i>

Monitoring and Evaluation						
Design of M and E Frameworks and Systems	102,976	102,976	102,976	102,976	102,976	109,710
Design of Quality Control and Assurance	29,237	29,237	29,237	29,237	29,237	31,149
Design/Review of Data Management Systems	124,461	38,739	38,739	38,739	38,739	41,273
Data Collection and Analysis	11,994,547	7,309	7,309	7,309	7,309	7,787
<i>Monitoring and Evaluation Sub-Total</i>	<i>12,251,221</i>	<i>178,261</i>	<i>178,261</i>	<i>178,261</i>	<i>178,261</i>	<i>189,919</i>
Transport						
New Vehicle Purchase(KES)	494,595	N/A	N/A	N/A	N/A	N/A
<i>Transport Sub-Total</i>	<i>494,595</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>
Communication, Media & Outreach						
Mass Media	4,572,571	4,568,307	4,568,307	4,568,307	4,568,307	4,867,067
Social Outreach Activities	15,647,187	15,647,187	15,647,187	15,647,187	15,647,187	16,670,488
<i>Communication, Media & Outreach Sub-Total</i>	<i>20,219,757</i>	<i>20,215,494</i>	<i>20,215,494</i>	<i>20,215,494</i>	<i>20,215,494</i>	<i>21,537,555</i>
Advocacy						
Planning an Advocacy Strategy	10,781	10,781	10,781	10,781	10,781	11,486
<i>Advocacy Sub-Total</i>	<i>10,781</i>	<i>10,781</i>	<i>10,781</i>	<i>10,781</i>	<i>10,781</i>	<i>11,486</i>
Total	34,550,969	22,338,926	22,248,982	21,889,206	21,889,206	23,320,725

Source: Futures Group OneHealth Projection based on NASCOP inputs (2012)

Table A.2.2. Number of Persons Reached with HIV Pillar I Interventions, 2012–2017

	Number of Persons Reached					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Prevention						
IDU: outreach	4,361	4,601	4,852	5,115	5,383	24,312
IDU: needle exchange	1,308	1,571	1,848	2,141	2,447	9,316
IDU: drug substitution	1,308	1,571	1,848	2,141	2,447	9,316
Interventions focused on sex workers	14,518	17,184	19,651	22,086	24,777	98,215
Interventions focused on MSM	3,140	3,249	3,362	3,479	3,468	16,700
Youth focused interventions - Out-of-school	434,264	462,351	489,770	516,402	544,289	2,447,077
Condoms	2,286,583	2,472,265	2,667,287	2,871,752	3,083,021	13,380,907
Male circumcision	205,531	207,199	206,917	206,766	206,905	1,033,318
PMTCT	50,502	52,698	53,840	54,805	57,137	268,983
Post-exposure prophylaxis	36,567	41,978	47,682	53,690	59,954	239,870
HIV Counseling and Testing	6,105,097	6,508,651	6,931,819	7,374,698	7,830,280	34,750,546
Care and Treatment						
ART (First-Line Treatment) for adults	596,431	665,952	726,981	786,596	844,628	3,620,587
ART (Second-Line Treatment) for adults	31,709	35,056	38,709	43,059	48,157	196,690
Management of opportunistic infections	742,131	810,976	887,551	963,819	1,037,639	4,442,116
Cotrimoxazole for children	N/A	60,333	118,084	171,754	221,464	571,634
CD4 Testing for Routine Monitoring	593,705	669,055	754,418	843,341	933,876	3,794,395
Viral Load Testing for ART Patients	150,754	49,071	53,598	58,076	62,495	373,993
Other Laboratory Testing for Patients in Care	148,426	162,195	177,510	192,764	207,528	888,423
Therapeutic Foods for Severely Malnourished HIV+ Adults	14,709	15,861	16,510	16,502	17,161	80,741

Multiple Micronutrients for HIV+ Adults	30,874	38,826	44,666	49,621	58,221	222,207
Exclusive Replacement Feeding (infant formula)	1,686	2,006	2,339	2,377	2,678	11,086
Nutritional Supplements for HIV+ children	50,797	57,351	64,031	70,627	78,833	321,639
Therapeutic Foods for Severely Malnourished HIV+ Children	21,340	23,041	24,529	26,427	28,379	123,716
Multiple Micronutrients for HIV+ Children	3,410	4,256	4,851	5,340	6,209	24,066
Pediatric ART: Second Line	3,403	4,133	4,887	5,451	5,956	23,832
Palliative and Home-based Care for HIV+ Patients	368,671	384,479	401,165	418,525	436,103	2,008,945
Nutritional Supplements for HIV+ Adults	79,402	93,499	109,725	109,671	122,525	514,822
Pediatric ART: First Line	64,664	78,531	92,861	103,578	113,168	452,802
Nutrition Supplements for HIV+ Pregnant/Lactating Women	29,315	30,905	32,226	33,774	35,479	161,699
Collaborative HIV/AIDS and TB Interventions						
HIV prevention for TB patients	63,360	61,056	61,056	60,008	60,008	305,489

Source: Futures Group OneHealth Projection based on NASCOP inputs (2012)

Table A.2.3. Costs of KNASP Pillars 2, 3, and 4, 2012/13–2017/18

	USD					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Pillar 2: Sectoral Mainstreaming of HIV	12,225,161	13,024,667	13,876,460	14,783,958	15,750,805	16,780,883
Pillar 3: Community/Area-Based HIV Programmes	18,704,217	19,927,443	21,230,666	22,619,117	24,098,371	25,674,366
Pillar 4: Governance and Strategic Information	14,604,019	15,559,099	16,576,639	17,660,725	18,815,708	20,046,225

Source: NPO Gap Analysis 2010 (NACC, NASCOP); extrapolation by HPP

Explanation: The HIV/ AIDS resource need was computed for all the four pillars of the Kenya National AIDS Strategic Plan III, which are defined as follows. Pillar 1 is Health Sector HIV Services, Pillar 2 is Sectoral Mainstreaming of HIV and AIDS, Pillar 3 is Community/Area-based HIV Programmes, and Pillar 4 is Governance and Strategic Information. The cost of Pillar 1 (**Table A.2.1**) is computed using the OneHealth model, which was developed to cost medium-term strategic plans in the health sector at the national level. The tool estimates the costs by disease program and the resource implications of health system components. Health system resources, such as the salary cost of public sector health workers involved in HIV service delivery or program management, are not included in the Pillar 1 costing because these costs are primarily covered by the Government of Kenya. The issue of including Government of Kenya resources for the three disease programs was discussed in Chapter 4.

Costing the HIV program with the OneHealth model is based on the target population size, the percentage of the target population in need, and the proposed coverage. This generates intervention-specific service targets (**Table A.2.2**), which are applied to the average commodity cost per person reached per year. In Kenya, the Health Policy Project (HPP) worked with HIV program managers in NASCOP to determine the scale up plans, commodities required, unit costs, and other aspects of HIV service delivery. Using this method, the OneHealth analysis estimates 2012/13–2016/17 Pillar I HIV costs. The 2017/18 Pillar I HIV costs were extrapolated using the average annual growth rate in the 2012/13–2016/17 costs, which is 6.54 percent per year.

The costs of HIV Pillars 2–4 are extrapolated for future years from the original two-year costs of the National Plan of Operation (NPO), which covered the period 2009/10–2010/11. These costs were originally calculated during the proposal stage for the Global Fund Round 10. These costs needed to be annualized. We assumed that the two costs were evenly distributed between 2009/10 and 2010/11, and the costs in 2010/11 remained stable for 2011/12. Future costs for the period 2012/13 to 2017/18 are not yet known and may be considerable given the eventual implications of devolution and county-level administration of the HIV/AIDS program. For the current study, the average annual growth rate of HIV Pillar I costs (i.e., 6.54 percent per year) was used to extrapolate Pillar 2–4 costs to future years based on the total for 2011/12. The results are as shown in **Table A.2.3**.

Table A.2.4. Estimate of Donor Resources Available for HIV, 2012–2017

	USD					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
DFID	8,811,547	5,809,574	5,485,620	5,485,620	5,485,620	5,485,620
EU	580,502	0	0	0	0	0
GDC-DED	553,074	500,400	0	0	0	0
Global Fund	64,560,578	131,799,977	7,386,834	20,719,527	58,391,104	0
JICA	461,668	0	0	0	0	0
UNFPA	600,000	600,000	600,000	600,000	600,000	600,000
USAID	203,440,518	203,440,518	203,440,518	203,440,518	203,440,518	203,440,518
CDC	116,663,000	116,663,000	116,663,000	116,663,000	116,663,000	116,663,000
HRSA	13,290,767	13,290,767	13,290,767	13,290,767	13,290,767	13,290,767
DOD	5,818,155	5,818,155	5,818,155	5,818,155	5,818,155	5,818,155
WFP	6,816,281	6,816,281	6,816,281	6,816,281	6,816,281	6,816,281

WHO	232,145	232,145	232,145	232,145	232,145	232,145
Total HIV Resources Available	422,841,982	485,651,012	360,377,520	373,710,213	411,381,790	352,990,686

Source: Development Partners in Health Kenya (DPHK), Global Fund.

Explanation: For all external funding sources (**Table A.2.4**) except the Global Fund, the estimates of budgeted resources tied to HIV come from a Development Partners for Health in Kenya (DPHK) dataset recently constructed in August 2012 (DPHK 2012), as well as estimates of ‘on-budget’ support from development partners compiled by the two ministries. The DPHK dataset was built from the results of a DPHK Secretariat request to development partners for their projected budgets for the period 2012/13–2016/17. Donors such as EU, GDC, and JICA could not project the budgeted tuberculosis funds for all future financial years. For DFID, UNFPA, USAID, CD, HRSA, DOD, WFP, and WHO, funds are projected to flat-line between 2014/15 and 2016/17; therefore, these funds are assumed to extend to 2017/18 as well. The WHO funds available for tuberculosis are part of a joint AIDS, tuberculosis, and malaria program. For the purpose of this analysis, the annual funds are assumed to be shared evenly among the three diseases. Similarly, CDC and HRSA funds target TB/HIV interventions and are assumed to be shared evenly between the two diseases. Additionally, 10 percent and 13 percent of total projected funds are deducted to account for overhead costs from DFID and WHO funds, respectively, based on input from the DPHK Secretariat. All other donors had deducted overhead costs from projected budgets prior to submission to the DPHK Secretariat.

The Global Funds resources available for HIV over the period 2012/13 to 2017/18 are estimated based on the Round 7 and Round 9 grants. The Round 9 HIV grant is a dual track in which the Red Cross Kenya and MOF are PRs. Care International is the PR of the Round 7 grant. The projected 2012/13–2014/15 Global Fund disbursements to Care International and MOF, and 2012/13-2013/14 disbursements to the Red Cross Kenya, are based on the total budgeted amount for the corresponding quarters. Allowing a minimum of six months for evaluation after the close out of each PR’s first commitment from the GF, the second commitment is expected to be disbursed to Red Cross Kenya in 2014/15, and MOF and Care International in 2015/16. A third commitment for the MOF is expected to be disbursed in 2016/17. This assumes later commitments under the Round 7 and Round 9 grants are approved and disbursed in full.

ANNEX 3. TUBERCULOSIS DETAILED GAP ANALYSIS

Table A.3.1. Department of Leprosy, Tuberculosis, and Lung Disease Resources Needed, 2012/13–2017/18

	US\$					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Core TB Case Detection and Management	8,741,978	12,324,490	12,696,233	11,740,138	11,485,367	11,236,125
Laboratory	11,987,778	12,620,519	11,348,456	11,456,636	11,208,018	10,964,795
Logistics and Commodities	9,059,423	9,338,566	9,893,548	10,494,348	10,266,612	10,043,818
TB/HIV	1,976,620	1,652,244	1,546,709	1,765,886	1,727,565	1,690,075
MDRTB/IPC	1,639,096	1,683,301	1,854,676	2,076,901	2,031,830	1,987,738
Childhood TB	203,923	233,571	203,923	233,571	228,502	223,543
Special Groups	1,052,640	1,102,616	1,069,608	1,083,584	1,060,069	1,037,065
Health System Strengthening and Human Resources	6,535,377	6,641,851	6,519,473	6,554,867	6,412,621	6,273,462
Lung Health	590,041	583,857	393,792	419,126	410,031	401,133
PPM	259,460	304,724	259,460	304,724	298,111	291,642
Health Promotion – IPC, ACSM,	3,347,405	3,380,703	3,253,001	3,284,719	3,213,438	3,143,704
Community TB care	2,973,890	3,256,510	2,803,074	2,777,810	2,717,529	2,658,557
TB Poverty and gender	81,280	265,770	356,000	425,770	416,530	407,491
Leprosy	376,697	381,165	376,697	381,165	372,893	364,801
M&E and Operations Research	4,356,576	1,638,730	2,195,767	3,068,276	3,001,692	2,936,553
Grand Total Cost	53,182,183	55,408,616	54,770,416	56,067,519	54,850,809	53,660,502

Source: DLTL D Strategic Plan 2011-2015

Explanation: The tuberculosis resource need (**Table A.3.1**) is calculated based on the Department of Leprosy, Tuberculosis and Lung Disease (DLTL D) Strategic Plan for 2011–2015. Resource needs for the financial years 2016/17 and 2017/18 are extrapolated using the average annual growth rate of DLTL D costs from 2011–2015, or -2.17 percent per year. The negative growth rate reflects high initial fixed-cost investments, such as transportation procurement, facility construction, laboratory equipment procurement, and establishment of new laboratories, which taper off in later years. Trainings for healthcare workers also experience rapid scale-up in early years in accordance with the DLTL D Strategic Plan.

Table A.3.2. Estimate of Donor Resources Available for Tuberculosis, 2012/13—2017/18

	US\$					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Global Fund	11,820,328	7,163,665	2,348,247	0	0	0
JICA	51,569	0	0	0	0	0
USAID	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000
CDC	3,144,454	3,144,454	3,144,454	3,144,454	3,144,454	3,144,454
HRSA	380,897	380,897	380,897	380,897	380,897	380,897
DOD	268,343	268,343	268,343	268,343	268,343	268,343
WHO	232,145	232,145	232,145	232,145	232,145	232,145
Total TB Resources Available	19,897,735	15,189,503	10,374,085	8,025,838	8,025,838	8,025,838

Source: Development Partners in Health Kenya (DPHK), Global Fund

Explanation: For all external funding sources (**Table A.3.2**) except the Global Fund, the estimates of budgeted resources tied to tuberculosis come from a Development Partners for Health in Kenya (DPHK) dataset recently constructed in August 2012 (DPHK 2012), as well as estimates of ‘on-budget’ support from development partners compiled by the two ministries. The DPHK dataset was built from the results of a DPHK Secretariat request to development partners for their projected budgets for the period 2012/13–2016/17. JICA could not project the budgeted tuberculosis funds for all future financial years. For USAID, CDC, HRSA, DOD, and WHO, funds are projected to flat-line between 2012/13 and 2016/17; therefore, these funds were assumed to extend to 2017/18 as well. The WHO funds available for tuberculosis are part of a joint AIDS, tuberculosis, and malaria program. For the purpose of this analysis, the annual funds are assumed to be shared evenly among the three diseases. Similarly, CDC and HRSA funds target TB/HIV interventions and are assumed to be shared evenly between the two diseases. Additionally, 13 percent of WHO funds are deducted to account for overhead costs, based on input from the DPHK Secretariat. All other donors had deducted overhead costs from projected budgets prior to submission to the DPHK Secretariat.

The Global Funds resources available for tuberculosis over the period 2012/13 to 2017/18 are estimated based on the Round 9 grant. The Round 9 grant is a dual-track grant in which the Ministry of Finance (MOF) and the African Medical and Research Foundation (AMRF) are both PRs. The projected 2012/13–2013/14 Global Fund disbursements to AMRF are based on the total budgeted amount for the corresponding quarters. The MOF’s total disbursements received in 2012/13 already outweigh the budgeted amount for the corresponding quarters, and is used in its place to estimate the total 2012/13 funds to be received by MOF from GF. Allowing a minimum of six months for evaluation after the close out of AMRF and MOF’s first commitments from the GF, the second commitments are expected to be disbursed in 2014/2015 and 2013/14, respectively. This assumes the Round 9 second commitments will be approved and disbursed in full.

ANNEX 4. MALARIA GAP ANALYSIS

Table A.4.1. Estimate of Malaria Resources Needed, 2012–2017

	US\$					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Long-Lasting Insecticide-treated Nets						
No. of Nets	2,854,223	1,732,116	14,520,577	1,934,318	1,992,347	16,702,133
Cost per Net	6.66	6.66	6.66	6.66	6.66	6.66
<i>LLINS Sub-Total</i>	<i>18,994,855</i>	<i>11,527,231</i>	<i>96,634,438</i>	<i>12,872,883</i>	<i>13,259,070</i>	<i>111,152,695</i>
IRS						
<i>IRS Sub-Total</i>	<i>14,427,293</i>	<i>18,085,727</i>	<i>28,050,948</i>	<i>58,786,169</i>	<i>36,849,197</i>	<i>27,297,255</i>
RDTs						
No. of RDTs	9,174,874	11,679,519	14,869,848	17,293,719	20,742,302	21,768,754
Cost per RDT	0.49	0.49	0.49	0.49	0.49	0.49
<i>RDT Sub-Total</i>	<i>4,495,688</i>	<i>5,722,964</i>	<i>7,286,226</i>	<i>8,473,922</i>	<i>10,163,728</i>	<i>10,666,690</i>
Microscopy Services						
No. of Microscopy Services	9,174,874	9,732,932	10,621,320	17,293,719	18,149,515	21,768,754
Cost per Microscopy Service	0.53	0.53	0.53	0.53	0.53	0.53
<i>Microscopy Sub-Total</i>	<i>4,862,683</i>	<i>5,158,454</i>	<i>5,629,300</i>	<i>9,165,671</i>	<i>9,619,243</i>	<i>11,537,440</i>
ACTs						
No. of Malaria Cases	18,116,292	15,667,129	14,988,898	14,458,743	13,860,116	13,286,275
Cost per ACT*	0.02	0.02	0.02	0.02	0.02	0.02
<i>Treatment Sub-Total</i>	<i>362,326</i>	<i>313,343</i>	<i>299,778</i>	<i>289,175</i>	<i>277,202</i>	<i>265,725</i>

IPTp						
No. of Doses	23,928,780	24,627,961	25,348,429	26,090,801	26,855,707	27,641,754
Cost per Dose****	0.02	0.02	0.02	0.02	0.02	0.02
<i>IPTp Sub-Total</i>	<i>373,522</i>	<i>384,436</i>	<i>395,683</i>	<i>407,271</i>	<i>419,211</i>	<i>431,481</i>
Advocacy & BCC						
Capacity Strengthening for Advocacy, Communication, and Social Mobilization	612,600	792,240	612,600	612,600	792,927	864,459
Multi-Sectoral IEC/BCC	2,895,100	2,979,833	2,895,545	2,888,245	2,987,853	3,012,464
Development of Appropriate Advocacy for Uptake of Specific Malaria Interventions	7,393,666	8,656,594	7,792,354	7,295,537	9,198,050	9,814,313
<i>Advocacy & BCC Sub-Total</i>	<i>10,901,366</i>	<i>12,428,667</i>	<i>11,300,499</i>	<i>10,796,382</i>	<i>12,978,830</i>	<i>13,691,236</i>
Program Management						
<i>Program Management Sub-Total</i>	<i>8,542,273</i>	<i>8,794,621</i>	<i>8,135,972</i>	<i>8,658,882</i>	<i>9,269,752</i>	<i>9,477,090</i>
M&E						
<i>M&E Sub-Total</i>	<i>5,495,000</i>	<i>6,734,000</i>	<i>7,462,000</i>	<i>4,936,000</i>	<i>7,340,000</i>	<i>8,224,662</i>
Total Malaria Resources Needed	68,455,007	69,149,444	165,194,844	114,386,356	100,176,234	192,744,274

Source: Kenya Malaria Gap Analysis (2012); Futures Group One Health Kenya Projection 2012, and the Global Fund.

*Cost to Kenya. Assumes AMFM continuation.

Explanation: The malaria resource need calculation (**Table A.4.1**) was based on a recent gap analysis conducted for the Global Fund Round 10 proposal. Private sector costs are excluded, while health facility and community case management are assumed to represent the public sector. The sub-category gap analyses were conducted separately, beginning in 2011/12–2012/13 and ending in 2014/15–2017/18. Where data was missing in 2015/16, 2016/17, and/or 2017/18, the annual sub-category growth rate is used to extrapolate costs in later years, with the exception of Long Lasting Insecticide-treated Nets (LLINs).

The fluctuating annual costs are the result of multiple factors. Annual costs peak in 2014/15 and 2017/18 due to a mass LLIN campaign scheduled for 2014/15. We assume this mass campaign will continue to take place every three years and, therefore, we use the 2013/14–2014/15 growth rate to estimate the 2016/17 LLIN cost. The gap analysis also assumes decreasing malaria treatment consumption as a result of increased parasitological diagnosis coverage. Additionally, the cost of Indoor Residual Spraying (IRS) decreases in later years because the structures in targeted districts will be sprayed twice a year for three years prior to exit.

The cost per LLIN includes the cost of commodities, shipping, warehousing, distribution, training, micro-planning, social mobilization, and monitoring and evaluation. Similarly, the IRS annual cost takes into account insecticide, equipment, administrative costs, training and supervision, community mobilization, monitoring, and reporting. Unit costs of various other commodities required for testing and treatment, however, are absent from the gap analysis. The cost of the main malaria treatment, artemisinin combination therapy (ACT), is estimated from the average difference between KEMSA procurement prices under the AMFm and the Global Fund co-payment per unit. The cost per malaria Rapid Diagnostic Test (RDT) and Intermittent Preventive Treatment in pregnancy (IPTp) is based on input from program managers who reported a unit cost of 51 KSh and 1.28 KSh, respectively.

Table A.4.2. Estimate of Donor Resources Available for Malaria, 2012–2017

	US\$					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
CLINTON	243,643	0	0	0	0	0
DFID	19,926,765	25,196,416	21,208,183	21,208,183	0	0
GF	25,538,405	26,007,513	0	0	0	0
USAID	39,243,000	39,243,000	39,243,000	39,243,000	0	0
WHO	232,145	232,145	232,145	232,145	232,145	232,145
Total Malaria Resources Available	85,183,959	90,679,074	60,683,328	60,683,328	232,145	232,145

Source: Development Partners in Health Kenya (DPHK), Global Fund

Explanation: For all external funding sources (**Table A.4.2**) except the Global Fund, the estimates of budgeted resources tied to malaria come from a Development Partners for Health in Kenya (DPHK) dataset recently constructed in August 2012 (DPHK 2012), as well as estimates of ‘on-budget’ support from development partners compiled by the two ministries. The DPHK dataset is built from the results of a DPHK Secretariat request to development partners for their projected budgets for the period 2012/13–2016/17. Clinton, DFID, and USAID could not project the budgeted malaria funds for all future financial years. In the case of USAID, for example, this will largely depend on the renewal of the President’s Malaria Initiative (PMI). For the WHO, funds are projected to flat-line between 2012/13 and 2016/17; therefore, these funds are assumed to extend to 2017/18 as well. The WHO funds available for Malaria are part of a joint AIDS, tuberculosis, and malaria program. For the purpose of this analysis, the annual funds are assumed to be shared evenly among the three diseases. Additionally, 10 percent and 13 percent of total projected funds are deducted to account for overhead costs from DFID and WHO funds, respectively, based on input from the DPHK Secretariat. All other donors had deducted overhead costs from projected budgets prior to submission to the DPHK Secretariat.

The Global Funds resources available for malaria over the period 2012/13 to 2017/18 are estimated based on the Round 4 and Round 10 grants. Care International is the PR for the Round 4 malaria grant. The total disbursements received by Care International in 2012/13 already outweigh the budgeted amount for the corresponding quarters, and is used in its place to estimate the total 2012/13 funds to be received by Care International from the Global Fund. The Round 10 grant is a dual-track grant in which the Ministry of Finance (MOF) and the African Medical and Research Foundation (AMRF) are both PRs. The projected 2012/13–2013/14 Global Fund disbursements to the MOF and AMRF are based on the total budgeted amount for the corresponding quarters. The first commitment for both PRs represents the entire signed amount in the grant agreement.

ANNEX 5. DETAILED GAP ANALYSIS SUMMARY

Table A.5.1. Financial Gap Summary, 2012–2017

US\$	HIV	Tuberculosis	Malaria	Total
Total Resources Needed	2,649,334,408	327,940,045	710,106,158	3,687,380,611
Total Resources Available	2,406,953,205	69,538,837	297,693,979	2,780,640,431
Total Net Financial Gap	242,381,204	258,401,208	412,412,179	906,740,181
Total Financial Gap (deficit years only)	383,788,968	258,401,208	450,670,761	1,157,095,163

The following exchange rates were used, with the exception of the One Health projection in which USD=KES 84 was used:

USD=KES	82.0873
GBP=KES	131.3210
EUR=KES	108.0960
DKK=KES	14.5298
JPY=KES	1.0079

Table A.5.2. Kenya Donor Abbreviations and Acronyms

CDC	<i>Centers for Disease Control and Prevention (United States Government)</i>
CLINTON	<i>Clinton Health Access Initiative</i>
DFID	<i>Department for International Development (United Kingdom Government)</i>
DOD	<i>United States Department of Defense</i>
EU	<i>European Union</i>
GDC-DED	<i>German Development Cooperation</i>
GF or Global Fund	<i>The Global Fund to Fight AIDS, Tuberculosis, and Malaria</i>
HRSA	<i>Health Resources and Services Administration (United States Government)</i>
JICA	<i>Japan International Cooperation Agency</i>
UNFPA	<i>United Nations Population Fund</i>
USAID	<i>United States Agency for International Development</i>
WFP	<i>United Nations World Food Programme</i>
WHO	<i>World Health Organization</i>

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