REPUBLIC OF KENYA

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TABLED BY Sen. Mary Seneta
COMMITTEE Health
CLERK AT THE TABLE Kavata Mbugua

TWELFTH PARLIAMENT (FIFTH SESSION)

THE SENATE

STANDING COMMITTEE ON HEALTH

REPORT ON THE STALEMATE BETWEEN THE GOVERNMENT OF KENYA AND THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) ON HIV/AIDS COMMODITIES

Rt. Hon. Speaker
You may approve for tabling! 25/05/21

CDS
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Clerk's Chambers,

First Floor,

Parliament Buildings,

NAIROBI.

21st May, 2021

Approved
25/5/2021

ABBREVIATIONS

MOH	-	Ministry of Health
NT	-	National Treasury
PPB	-	Pharmacy and Poisons Board
PSK	-	Pharmaceutical Society of Kenya
USAID	-	United States Agency for International Development

LIST OF ANNEXURES

1. ***Annex 1:*** Minutes of the stakeholder meetings.
2. ***Annex 2:*** Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 Report.
3. ***Annex 3:*** Report by the Kenya Revenue Authority (KRA) to the National Assembly Departmental Committee on Health on the ARVs Consignment at the Port of Mombasa.
4. ***Annex 4:*** Statement by the Ministry of Health (MoH) on the Alleged Stalemate on HIV/AIDS Commodities with United States Agency for International Development (USAID).
5. ***Annex 5:*** Statement by the Ministry of National Treasury and Planning on the Alleged Stalemate on HIV/AIDS Commodities with United States Agency for International Development (USAID).
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PREFACE

Mr. Speaker Sir,

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to, "*consider all matters relating to medical services, public health and sanitation.*"

Committee Membership

The Membership of the Committee is composed of the following:

1. Sen. (Dr.) Michael Mbito, MP.
2. Sen. Mary Seneta, MP.
3. Sen. Beth Mugo, EGH, MP.
4. Sen. Beatrice Kwamboka, MP.
5. Sen. (Prof.) Samson Ongeri, EGH, MP.
6. Sen. (Dr.) Abdullahi Ali Ibrahim, CBS, MP.
7. Sen. Fred Outa, MP.
8. Sen. Ledama Olekina, MP.
9. Sen. Millicent Omanga, MP.

Mr. Speaker,

According to the Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 report, Kenya had 1.3 million adult Kenyans (15-64 years) and 139,000 children (0-14 years) living with HIV in 2018. Of these, the report estimated that 79.4% of adults infected with HIV knew their status (that is, approx. 1,032,000). And of those who knew their status, 95.7% were receiving antiretroviral (ARV) treatment (or approx. 987,816 children and adults).

It is noteworthy that, Kenya has, and continues to be heavily reliant on donors for ARV medication and other HIV/AIDS commodities, particularly the United States Agency for International Development (USAID) and Global Fund.

Mr. Speaker,

The attention of the Committee was first drawn to the looming ARV crisis in Kenya following various media reports published on diverse dates between March and April, 2021 regarding an acute shortage of ARV medication. The shortage of ARVs in the country was reported to have been triggered by an alleged tax row between the Government of Kenya (GoK) and the United States Agency for International Aid (USAID). As a result, public hospitals in the counties were reported to have started rationing dwindling HIV supplies while a consignment of ARVs worth KShs. 1.1 billion was reported to have been stuck at the port of Mombasa since 18th January, 2021. Further, there were unsubstantiated media reports of the Government releasing phased out ARV drugs (that is, Zidovudine/Lamivudine/Nevirapine) to counties ostensibly in response to the ongoing shortage.

Mr. Speaker,

Consequent to the above, at a sitting of the Committee held on Wednesday, 14th March, 2021, the Committee deliberated on the alleged stalemate between the GoK and USAID and resolved to invite the Ministry of Health (MoH) and the Ministry of National Treasury and Planning to a meeting to apprise it on the following:

1. The terms and conditions of the USAID grant for HIV/AIDS antiretroviral (ARV) commodities, and other essential drugs such as antimalarials, anti-tuberculosis treatment etc;
2. Relevant information regarding existing donor financing arrangements between the GoK and development partners, particularly, USAID and Global Fund on the provision of ARVs and other essential medical commodities;
3. A chronology of the events and circumstances that had led to the stalemate between GoK and USAID with regards to the HIV/AIDS antiretroviral (ARV) crisis;
4. What had triggered the impasse, and what remedial and/or mitigating actions the GoK had taken to try and prevent it;
5. What actions/interventions the Government had taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or permanent solution;
6. What actions the GoK had taken, if any, to reduce donor dependency on ARVs and other essential medical commodities; and

7. What remedial legislative measures or interventions may have been required to avoid similar occurrences in the future, not only for ARVs, but also other essential medical commodities such as antimalarials, anti-TB treatment etc.

Mr. Speaker,

The Committee subsequently met with the Cabinet Secretaries of Health and National Treasury and Planning on Friday, 30th April, 2021 and Monday, 3rd May, 2021 respectively.

This report details the responses received from the Ministry of Health and the Ministry of National Treasury and Planning on the alleged stalemate. It further details the Committee's observations and recommendations based on the responses received, and other information available within the public domain.

Mr. Speaker Sir,

It is now my pleasant duty and privilege to present this report of the Standing Committee on Health, for consideration and approval by the House pursuant to Standing Order No. 226(2) of the Senate Standing Orders.

Signed.................... ....

Date...............................**21/05/2021**...

SEN. MBITO MICHAEL MALING'A, MP

CHAIRPERSON, STANDING COMMITTEE ON HEALTH

ADOPTION OF THE REPORT OF THE STANDING COMMITTEE ON HEALTH OF THE SENATE

We, the undersigned Members of the Standing Committee on Health of the Senate, do hereby append our signatures to adopt the Report-

1. Sen. (Dr.) Michael Mbito, MP ....
2. Sen. Mary Seneta, MP ....
3. Sen. Beth Mugo, EGH, MP ....
4. Sen. Beatrice Kwamboka, MP ....
5. Sen. (Prof) Samson Ongeri, EGH, MP ....
6. Sen. (Dr) Abdullahi Ali Ibrahim, MP ... .
7. Sen. Fred Outa, MP ... .
8. Sen. Millicent Omanga, MP ....
9. Sen. Ledama Olekina, MP ....

CHAPTER ONE

INTRODUCTION

A. Establishment, Mandate and Membership of the Committee

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to, "*consider all matters relating to medical services, public health and sanitation.*"

The Membership of the Committee is composed of the following:

1. Sen. (Dr.) Michael Mbito, MP.
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6. Sen. (Dr.) Abdullahi Ali Ibrahim, CBS, MP.
7. Sen. Fred Outa, MP.
8. Sen. Ledama Olekina, MP.
9. Sen. Millicent Omanga, MP.

B. Background

According to various media reports published on diverse dates, Kenya faced an acute shortage of ARV medication from March, 2021, following an alleged tax dispute between the Government of Kenya (GoK) and the United States Agency for International Aid (USAID) over a consignment of ARVs worth KShs. 1.1 billion at the port of Mombasa.

As a result of the impasse between the GoK and USAID and ensuing shortages in ARVs, public hospitals in the country were reported to have started rationing dwindling HIV supplies to patients leading to public alarm and anxiety. Further, there were unsubstantiated media reports of the Government releasing phased out ARV drugs (that is, Zidovudine/Lamivudine/Nevirapine) to counties ostensibly in response to the ongoing shortage.

To note, Kenya has, and continues to be heavily reliant on donors for ARV medication and other HIV/AIDS commodities, particularly the United States Agency for International Development (USAID) and Global Fund.

i) HIV Data and Statistics

According to the Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 report, Kenya had 1.3 million adult Kenyans (15-64 years) and 139,000 children (0-14 years) living with HIV in 2018. Of these, the report estimated that 79.4% of adults infected with HIV knew their status (that is, approx. 1,032,000). And of those who knew their status, 95.7% were receiving antiretroviral (ARV) treatment (or approx. 987,816 children and adults) ***(please see Annex 2).***

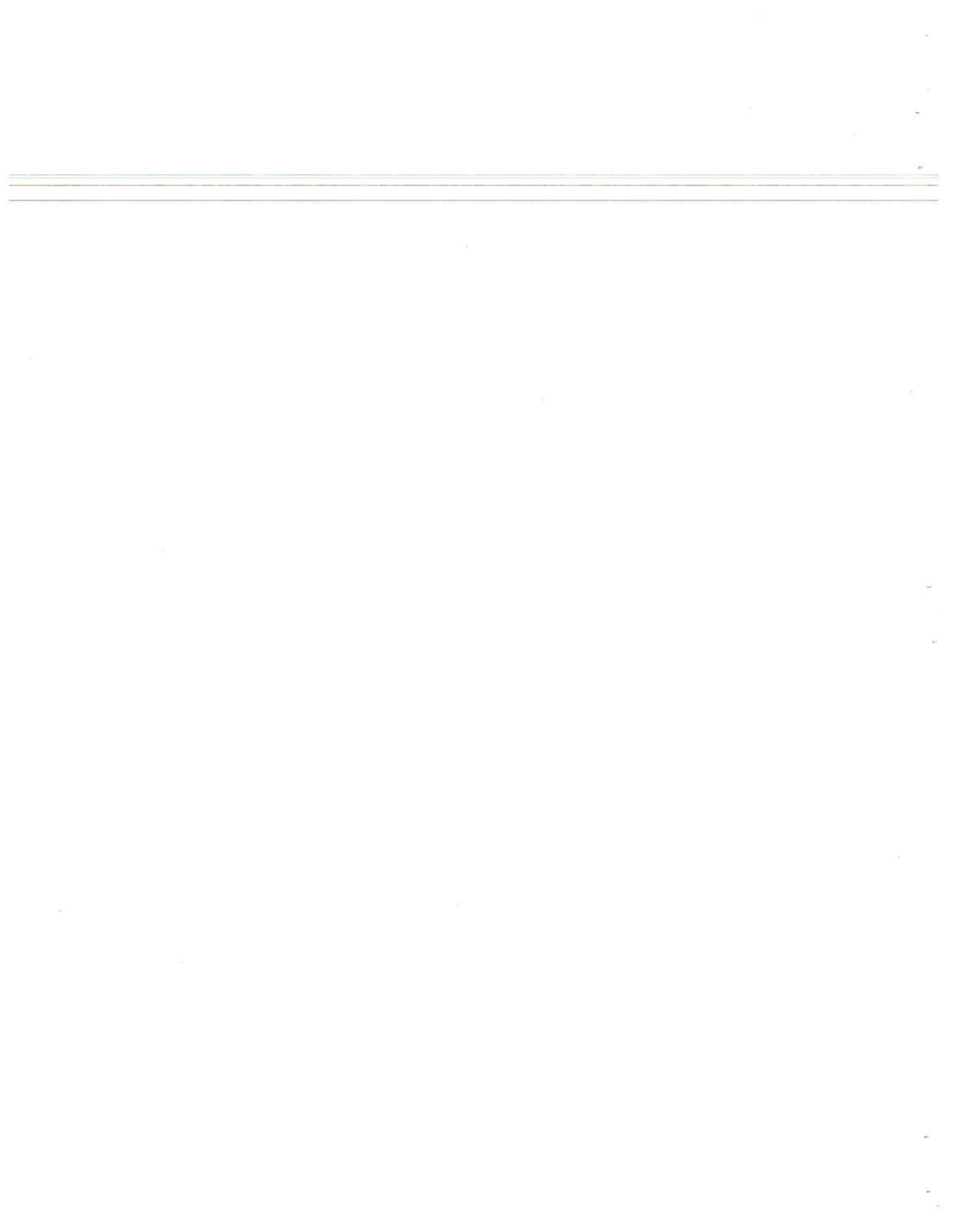
The KENPHIA 2018 report further noted that HIV prevalence was highest in Kisii (6.1%), Turkana (6.8%), Busia (9.9%), Siaya (15.3%), Kisumu (17.5%), Homabay (19.6%) and Migori (13.0%).

ii) HIV Commodities Tax Dispute between the GoK and USAID

According to a report by the Kenya Revenue Authority (KRA) to the National Assembly Departmental Committee on Health on the ARVs Consignment at the port of Mombasa ***(please see Annex 3),*** the total volume of the consignment of HIV/AIDS commodities being held at the port of Mombasa as of 30th April, 2021 was thirteen (13) forty-foot containers broken down as follows:

a) Eight (8) forty-foot containers containing 520,750 HIV self-tests;
b) Three (3) forty-foot containers containing ARVs (Dolutegravir, Lamivudine and Tenofovir Disoproxil Fumarate tablets); and
c) Two (2) containers containing ARVs (Atazor-R and Atazanavir 300mg + Ritonavir 100mg tablets).

According to the report, the MoH *vide* a letter, Ref: MOH/MED/11/3/1, dated 31st March, 2021, requested the Ministry of National Treasury and Planning (NT&P) to issue an undertaking to KRA on its behalf to pay taxes for the consignment amounting to KShs. 45,825,875.15.



Consequently, according to KRA, *vide* a letter, Ref: DFN 415/232/011, dated 6th April, 2021, the Ministry of NT&P undertook to pay the taxes, Railway Development Levy (RDL) and Import Declaration Fees (IDF) for the thirteen (13) containers. However, despite the undertaking by the Ministry of NT&P, KRA reported that owing to delays in the issuance of a permit by the Pharmacy and Poisons Board, and releases by Port Health, the consignment was yet to be cleared from Customs.

To note, prior to the above, KRA reported that since January, 2021, it had cleared seventy-eight (78) forty-foot and one (1) twenty-foot containers of medical supplies consigned to Ms. Chemonics on behalf of USAID.

iii) Evolution of the Dispute

Notwithstanding the aforementioned interventions by the MoH, Ministry of NT&P and KRA to waive taxes on the HIV commodities consignment, according to media reports, USAID is alleged to have subsequently declined to release the HIV commodities to the Kenya Medical Supplies Agency (KEMSA) for warehousing and distribution citing issues with corruption and mismanagement.

C) Methodology

Its attention having been drawn to the looming ARV crisis in the country, at a sitting of the Committee held on Wednesday, 14th March, 2021, the Committee deliberated on the alleged stalemate between the GoK and USAID and resolved to invite the Ministry of Health (MoH) and the Ministry of National Treasury and Planning to a meeting to apprise it on the following:

1. The terms and conditions of the USAID grant for HIV/AIDS antiretroviral (ARV) commodities, and other essential drugs such as antimalarials, anti-tuberculosis treatment etc;
2. Relevant information regarding existing donor financing arrangements between the GoK and development partners, particularly, USAID and Global Fund on the provision of ARVs and other essential medical commodities;
3. A chronology of the events and circumstances that had led to the stalemate between GoK and USAID with regards to the HIV/AIDS antiretroviral (ARV) crisis;

4. What had triggered the impasse, and what remedial and/or mitigating actions the GoK had taken to try and prevent it;
5. What actions/interventions the Government had taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or permanent solution;
6. What actions the GoK had taken, if any, to reduce donor dependency on ARVs and other essential medical commodities; and
7. What remedial legislative measures or interventions may have been required to avoid similar occurrences in the future, not only for ARVs, but also other essential medical commodities such as antimalarials, anti-TB treatment etc.

The Committee subsequently met with the Cabinet Secretaries of Health and National Treasury and Planning on Friday, 30th April, 2021 and Monday, 3rd May, 2021 respectively. A summary of the Committees' findings, observations and recommendations arising from this exercise has been captured in subsequent sections of this report.

CHAPTER TWO

COMMITTEE PROCEEDINGS

The Committee met with the Cabinet Secretaries of Health and National Treasury and Planning on Friday, 30th April, 2021 and Monday, 3rd May, 2021 respectively, in relation to the ARV crisis. Below is a summary of the submissions presented before the Committee during the said meetings.

A. MINISTRY OF HEALTH

The Committee met with the Ministry of Health (MoH) led by the Cabinet Secretary, Hon. Mutahi Kagwe, EGH, on Friday, 30th April, 2021 via the Zoom online meeting platform. Key highlights of the submissions made by the MoH are summarised below:

a) Terms and Conditions of the USAID Grant for HIV/AIDS Commodities and other essential drugs such as antimalarials, anti-tuberculosis treatment etc

According to the MoH, the overall framework guiding donations of HIV commodities from USAID were contained in an annual agreement between the GoK and the United States Government referred to as Kenya's Country Operational Plan (COP).

With specific regards to the terms and conditions for the management of USAID donations of HIV/AIDS ARV commodities and other essential drugs (e.g. antimalarials and anti-TB treatment), the MoH submitted that they were outlined in a contractual arrangement known as the Medical Commodities Program (KEMSA MCP) between USAID and KEMSA for the procurement, warehousing and distribution of medical supplies.

b) Donor Financing Arrangements between the GoK and USAID for the provision of ARVs and other essential medical commodities

Hon. Mutahi Kagwe stated that the first KEMSA MCP was executed on 1st October, 2015 and was scheduled to run up to 25th September, 2020. It was the flagship framework contracting KEMSA for the procurement, warehousing and distribution of medical supplies donated through USAID.

c) Chronology of events and circumstances that led to the stalemate between the GoK and USAID with regards to the ARV crisis

According to the MoH, the flagship KEMSA MCP was first scheduled to lapse on 24th September, 2020. However, before it lapsed, it was extended to 24th December, 2020 under the same terms of procurement, warehousing and distribution by KEMSA.

Subsequently, on the request of USAID, a close-out plan with KEMSA was negotiated whereby USAID reviewed the contractual terms prior to the lapse of the extension period to include warehousing and distribution and exclude procurement. Further to this, the extension period was revised to 23rd April, 2021.

On 17th March, 2021, following reports of a stalemate over HIV/AIDS commodities at the port of Mombasa, the CS, Health requested a meeting with representatives of the US Government and the Ministry of Foreign Affairs. During the meeting, it was established that the said consignment had been imported into the country using a private company without the Ministry's prior knowledge and outside of the agreed framework.

According to the MoH, during the said meeting, USAID elaborated on its intention to review its existing collaboration with KEMSA and to use a third party for purposes of providing ARV commodities to the country. At the request of the MoH, a technical meeting to develop a framework to support this was proposed. This led to a meeting on 19th April, 2021.

That notwithstanding, according to the Cabinet Secretary, Health, the matter was still under discussion between the MoH and the US Government. He further indicated that he had urged the US Embassy to revert to using KEMSA noting that the MoH was willing to take the necessary remedial actions to increase transparency and accountability at the agency.

d) Factors leading to the impasse and the remedial and/or mitigating actions taken by the Government of Kenya to prevent it

With regards to what factors had triggered the impasse between the GoK and USAID, the CS health cited the following:

i. Lack of communication from USAID on their intention to shift the procurement, warehousing and distribution of HIV commodities from KEMSA;
ii. A unilateral decision by USAID to procure their commitment of donations to Kenya without prior notice to the MoH thereby attracting taxes and other levies; and
iii. Failure by the USAID to communicate on a delay in the consignment of ARVs that were expected by October, 2020 as stipulated in the annual forecasting and quantification frameworks.

The CS Health further noted that despite citing various challenges with KEMSA, the undiplomatic manner in which USAID executed its decision to shift to a private third-party was unwarranted.

He further stated that the MoH had remained pro-active in its attempts to help resolve the challenges cited by USAID. For example, he stated that the Moh had initiated communications and extended invitations to USAID in an effort to understand the challenges that they were facing with regards to KEMSA. However, MoH reported that USAID delayed in honoring these invitations until a meeting held on 26th January, 2021 and a letter dated 29th January, 2021 whereby the MoH was informed of its challenges in clearing taxes at the port.

Following receipt of the letter, the MoH submitted that it initiated a budgetary approval process through the National Assembly Departmental Committee on Health in February, 2021 for the clearance of the consignment from USAID. Following approval by the National Assembly, the MoH requested the Ministry of NT&P to undertake to pay taxes worth KShs. 45, 825,875 being the taxable amount for the commodities that were being held at the port as per invoices provided by USAID. The MoH further directed KEMSA to expedite distribution of the commodities once released by USAID.

Further, to prevent a recurrence of the matter, the MoH:

- Guided USAID to sign a contractual framework that allows for tax exemptions in line with Kenya taxation policies;
- Advised USAID to change its consignee to the MoH and other relevant agencies in order to enable swift customs clearance; and

- Initiated reforms of KEMSA through the establishment of a KEMSA Reforms Committee with the support of development partners, including USAID.

e) Actions/Interventions taken by the GoK to address the ARV crisis when it occurred

In order to avert the ARV crisis, the CS Health stated that MoH had:

- Issued guidelines for shorter-term drug prescriptions aimed at averting total stock outs at patient level;
- Called down other consignments funded by Global Fund and the GoK in an effort to re-stock and solve the temporary ARV crisis;
- Initiated and sustained constant discussions with USAID aimed at ensuring that they were facilitated to clear the consignment of donations of ARVs and essential commodities; and
- Recommended long-term solutions aimed at avoiding similar occurrences in the future e.g. securing and ring-fencing domestic resources for the procurement of the life-saving commodities, expediting plans for local production of health products for purposes of promoting self-sufficiency, and donor diversification.

f) Actions being taken by the GoK to reduce donor dependency on ARVs and other essential medical commodities

Noting that Kenya had over the years relied on traditional bilateral and multilateral agreements for off-budget arrangements that were subject to conditionalities and manipulations that undermined institutional capacity-building, the CS Health outlined the following actions that had been taken by the MoH to reduce donor dependency on ARVs and other essential medical commodities:

- Enhanced domestic resource mobilisation in anticipation of reductions in external resources for the HIV response.
- Enhanced efficiency and effectiveness in resource utilisation through the restructuring of strategic health programs to create synergies, eliminate duplication and gain efficiencies.
- Development of a Health Financing Transition Plan aimed at providing short- and long-term options for resource mobilisation.

The CS Health further called for the development of a legal framework to ring-fence funding for strategic health programs at National and County level, particularly with regards to health products.

B. MINISTRY OF NATIONAL TREASURY AND PLANNING

The Committee met with the Ministry of Health (MoH) led by the Cabinet Secretary, Hon.Ukur Yattani, EGH, on Monday, 3rd May, 2021 via the Zoom online meeting platform. Key highlights of the submissions made by the Ministry of NT&P are summarised below:

a) **Terms and Conditions of the USAID Grant for HIV/AIDS Commodities and other essential drugs such as antimalarials, anti-tuberculosis treatment etc**

In his statement, Hon. Yattani noted that the HIV response in Kenya was largely dependent on external resources with USAID and Global Fund together accounting for more than 80% of HIV commodities in the country.

With regards to USAID grants and financing arrangements, he stated that USAID funds were mainly off-budget as they were majorly channeled through non-state actors with only a small amount being channelled through the formal Government budgetary system.

He further stated that the total USAID contribution was estimated at USD 500 million (or KShs. 57.5 billion at an exchange rate of KShs. 115 to the USD) for both on and off budget support.

He stated that a new Development Cooperation Assistance Framework Agreement (DCFA) had been executed in December, 2019. The agreement contained an amplified description of the objectives and results to be achieved in a particular sector. To this end, he submitted that USAID issued Implementation Letters from time to time for the allocation of funds and to communicate on other matters pertaining to the agreements.

He further noted that USAID disburses its funds through a direct payment method whereby GoK entities reflect the funds in their budgets as A in A following which USAID was expected to furnish Accounting Officers in relevant Ministries with expenditure statements for onward transmission to the National Treasury. However, he noted that there were often long delays in reporting by USAID.

b) Donor Financing Arrangements between the GoK and development partners, particularly, USAID on the provision of ARVs and other essential medical commodities

With regards to USAID support to the health sector, he noted that the Development Assistance Grant Agreement (DAGA) on the health sector was signed on 19th August, 2003 for an initial amount of USD 30 million. Following progressive incremental funding, the contribution rose to USD 1.945 billion by 2013. This agreement was extended several times to accomodate the incremental funding and came to a close on 30th September, 2017.

He stated that the objectives of the agreement were to reduce fertility and reduce the risk of HIV/AIDS. Funding for the program was received from the U.S. Presidential Emergency Plans for AIDS Relief (PEPFAR) with a focus on AIDS, TB and malaria.

He further stated that a new Development Cooperation Framework Agreement with USAID was signed on 8th December, 2019. However, its operationalisation was still under discussion as far as Government entities were concerned. He further noted that USAID intended to carry out public financial management risk assessments of various Government entities earmarked to benefit from the support, including the MoH, for purposes of satisfying themselves before providing the support.

c) Chronology of events and circumstances that led to the stalemate between the GoK and USAID with regards to the ARV crisis

The Ministry of NT&P submitted that USAID imported the ARV drugs to Kenya without a formal engagement framework. In order to facilitate clearance, the drugs were consigned to the American Embassy as a stop-gap measure aimed at saving the situation pending the conclusion of a formal engagement framework. He further stated that according to USAID, the delay in the formalization of the Framework had been partly occasioned by the US elections.

In the absence of a formal engagement framework, the MoH requested the Ministry of NT&P to facilitate the clearance of the drugs, an action that was promptly undertaken in the interests of securing service delivery

ARV supplies, and increasing anxiety especially amongst the more than one million HIV patients who are dependent on them for their lives and health.

6. The Committee further observed that according to the MoH, the impasse had been precipitated by a unilateral decision by USAID to import a HIV commodities consignment into the country using a private entity (i.e. M/S Chemonics Ltd) without the prior notice or knowledge of the MoH, and outside of a formal engagement framework citing challenges with KEMSA.
7. In relation to the above, the Committee observed that under Kenya's tax regime and taxation policies, tax and duty waivers only apply where government agencies and ministries are listed as the consignees. Importations through private companies do not qualify for special exemptions and are subject to normal clearance processes and procedures. Accordingly, the Committee observed that upon the USAID-funded ARVs consignment reaching Kenya, USAID was required to pay taxes amounting to KShs. 45.8 million being payment for customs, Railway Development Levy and Import Declaration fees. This however, led to a standoff between the GoK and USAID resulting in the consignment being stuck at the port of Mombasa from January, 2021.
8. The Committee further observed that in an effort to address the resulting standoff, and in light of dwindling ARV stocks at public facilities, the Government took extraordinary measures to get a speedy resolution to the row as evidenced by the following:
    a) The successful initiation and execution of a budgetary approval process by the MoH for a supplementary budget through the National Assembly Departmental Committee on Health in February, 2021 for the clearance of the consignment from USAID.
    b) A request by the MoH to the Ministry of NT&P *vide* a letter, Ref: MOH/MED/11/3/1, dated 31st March, 2021, for the issuance of an undertaking to KRA on its behalf to pay taxes for the consignment amounting to KShs. 45,825,875.15.
    c) Consequently, *vide* a letter, Ref: DFN 415/232/011, dated 6th April, 2021, an undertaking by the Ministry of NT&P to pay the taxes, Railway Development Levy (RDL) and Import Declaration Fees (IDF) for the HIV consignment by USAID.

To note, the Committee observed that in taking these interventions, the GoK through the MoH, the Ministry of NT&P and KRA acted against the country's own established tax policies and procedures in an effort to address the stalemate.

9. Further to the above, the Committee observed that the MoH had demonstrated its commitment and goodwill towards addressing the stalemate through continuous efforts to engage, and meet with representatives of the US Embassy as well as USAID.
10. The Committee further observed that according to a Medical Commodities Program framework that was first executed executed between KEMSA and USAID on 1st October, 2015 and which was subsequently revised and extended to 23rd April, 2021, KEMSA had a contractual agreement with USAID to provide procurement (this was later excluded), warehousing and distribution services for HIV commodities imported into the country through USAID.
11. To note, the Committee observed that the stalemate between GoK and USAID had initially been pegged on the imposition of taxes on the HIV consignment by USAID. However, following the GoK's attempt to amicably resolve the matter through the aforementioned actions taken by the MoH, the Ministry of NT&P and KRA, the impasse had then evolved to a refusal by USAID to release the HIV commodities to KEMSA for warehousing and distribution in accordance with the then operating KEMSA MCP framework citing issues with corruption and mismanagement at the agency. At the time of the writing of this report, this impasse was yet to be resolved.
12. In relation to the above, the Committee observed that in order for the Government to effectively address the current impasse regarding whether or not USAID was justified in seeking to be allowed to use a private third-party (M/S Chemonics) for purposes of procuring, warehousing and distributing ARV commodities, there was a need for USAID to elaborate and substantiate the specific issues and challenges that it had encountered with KEMSA in relation to each of those areas. Further, that there was a need for USAID to make a distinction between accountability issues that may have arisen at facility level *vis a vis* KEMSA.
13. To note, according to an investigation report by the Global Fund that was published on 9th March, 2021, between 2017 and 2019, M/S Chemonics, a privately-owned American firm, was found culpable of defrauding Global Fund-supported programs of USD 3

million by systematically inflating invoices for the distribution of health commodities to warehouses and health facilities throughout Nigeria. According to the report, Chemonics, through its sub-contractor, Zenith Carex, managed an integrated supply chain for Global Fund Principal Recipients in Nigeria and the USAID. During this period, Chemonics approved and paid Zenith's fraudulent invoices for over two years. Combined with Chemonics' percentage-based contract management fees, the fraud resulted in over $3.4 million in non-compliant expenditures charged to the Global Fund. Poor implementation of controls, inadequate financial monitoring and potential collusion between Chemonics and Zenith staff were identified as key factors leading to the fraud (***please see Annex 6***).

14. While acknowledging that KEMSA had also been found culpable of corruption and mismanagement in the past, the Committee observed that the best practise necessitated respecting the country's institutions, and strengthening their institutional capacity.
15. The Committee further observed that according to the MoH, following the allegations and complaints made by USAID against KEMSA, it had undertaken various measures aimed at remedying the situation such as reconstituting the KEMSA Board, and initiating reforms at KEMSA through the establishment of a KEMSA Reforms Committee in collaboration with various development partners including USAID.
16. Further, with regards to demands by USAID to be allowed to use a private third-party for purposes of procuring, warehousing and distributing strategic HIV commodities, the Committee observed that due consideration and care must be taken to avoid avenues for the creation of parallel systems for the procurement, warehousing and distribution of essential medical commodities by development partners that fall outside the normal oversight and accountability structures and processes of Government.

To note, the Committee was handicapped in concluding on the stalemate between MoH and USAID in view of the fact that, as a foreign government agency, USAID falls outside the mandate of the Committee. To this extent, the Committee was unable to invite USAID or its representatives to appear before it to expound on the matters that had arisen. The Committee however notes that in a letter dated 23rd July, 2020, it made a request for copies of USAID's audit reports of KEMSA from the FY 2017/2018. It however did not receive any response ***(please see Annex 7).***

CHAPTER FOUR

COMMITTEE RECOMMENDATIONS

Based on the foregoing, the Committee made the following recommendations:

1. That the Government of Kenya through the Ministry of Health and the National Assembly act urgently to enhance domestic resource mobilisation for the provision of ARVs and other essential drugs and commodities with a view towards reducing donor dependency;
2. That the Government of Kenya through the Ministry of Health and the Ministry of National Treasury and Planning take urgent and immediate steps to reduce Kenya's dependency on donors for the provision of ARVs and other essential medical commodities through the promotion and facilitation of private sector investment in local manufacture of drugs;
3. That the Ministry of Health takes necessary measures to diversify its partnerships and engagements with donors to avoid over-reliance on a single donor for strategic health programs such as HIV/AIDS, malaria and tuberculosis.
4. That the Office of the Auditor General conducts a special audit to investigate allegations of corruption and mismanagement at KEMSA with regards to the procurement, warehousing and distribution of ARV commodities and other essential medical commodities supplied by USAID.
5. That the Ministry of Foreign Affairs takes note of this report and follows up on its findings with the United States Embassy, USAID and other relevant authorities of the US Government with a view towards finding timely and amicable solutions to the issues contained herein.

The Committee therefore determined that:

1. This report be dispatched to the Ministry of Health and the Ministry of National Treasury and Planning for purposes of taking the necessary steps and measures to make provisions for: enhanced domestic resource mobilisation for the HIV and other essential drugs and commodities; the promotion and facilitation of private sector investment in the local

manufacture of strategic health products and commodities, particularly in relation to HIV/AIDS, tuberculosis and malaria; and, donor diversification. And to recommend appropriate action within **six (6) months** receipt of this report.

2. This report be dispatched be dispatched to the Office of the Auditor General for purposes of conducting a special audit to investigate allegations of corruption and mismanagement at KEMSA with regards to the procurement, warehousing and distribution of ARVs and other essential medical commodities supplied by USAID, and to report back to the Committee within **three (3) months** receipt of this report.
3. This report be dispatched to the Ministry of Foreign Affairs for purposes of following up on its findings with the United States Embassy, USAID and other relevant authorities of the US Government, and to report back to the Committee within **three (3) months** receipt of this report.

REPUBLIC OF KENYA

TWELFTH PARLIAMENT (FIFTH SESSION)

THE SENATE

STANDING COMMITTEE ON HEALTH

REPORT ON THE STALEMATE BETWEEN THE GOVERNMENT OF KENYA AND THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) ON HIV/AIDS COMMODITIES

Clerk's Chambers,

First Floor,

Parliament Buildings,

NAIROBI. **21st May, 2021**

ABBREVIATIONS

MOH	-	Ministry of Health
NT	-	National Treasury
PPB	-	Pharmacy and Poisons Board
PSK	-	Pharmaceutical Society of Kenya
USAID	-	United States Agency for International Development

LIST OF ANNEXURES

1. ***Annex 1:*** Minutes of the stakeholder meetings.
2. ***Annex 2:*** Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 Report.
3. ***Annex 3:*** Report by the Kenya Revenue Authority (KRA) to the National Assembly Departmental Committee on Health on the ARVs Consignment at the Port of Mombasa.
4. ***Annex 4:*** Statement by the Ministry of Health (MoH) on the Alleged Stalemate on HIV/AIDS Commodities with United States Agency for International Development (USAID).
5. ***Annex 5:*** Statement by the Ministry of National Treasury and Planning on the Alleged Stalemate on HIV/AIDS Commodities with United States Agency for International Development (USAID).
6. ***Annex 6:*** Global Fund Investigation Report on Nigeria Supply Chain: Sub-contractor invoice fraud resulted in substantial overcharging.
7. ***Annex 7:*** Request for documentation from USAID.

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PREFACE

Mr. Speaker Sir,

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to, "*consider all matters relating to medical services, public health and sanitation.*"

Committee Membership

The Membership of the Committee is composed of the following:

1. Sen. (Dr.) Michael Mbito, MP.
2. Sen. Mary Seneta, MP.
3. Sen. Beth Mugo, EGH, MP.
4. Sen. Beatrice Kwamboka, MP.
5. Sen. (Prof.) Samson Ongeri, EGH, MP.
6. Sen. (Dr.) Abdullahi Ali Ibrahim, CBS, MP.
7. Sen. Fred Outa, MP.
8. Sen. Ledama Olekina, MP.
9. Sen. Millicent Omanga, MP.

Mr. Speaker,

According to the Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 report, Kenya had 1.3 million adult Kenyans (15-64 years) and 139,000 children (0-14 years) living with HIV in 2018. Of these, the report estimated that 79.4% of adults infected with HIV knew their status (that is, approx. 1,032,000). And of those who knew their status, 95.7% were receiving antiretroviral (ARV) treatment (or approx. 987,816 children and adults).

It is noteworthy that ~~To note,~~ Kenya has, and continues to be heavily reliant on donors for ARV medication and other HIV/AIDS commodities, particularly the United States Agency for International Development (USAID) and Global Fund.

Mr. Speaker,

The attention of the Committee was first drawn to the looming ARV crisis in Kenya following various media reports published on diverse dates between March and April, 2021 regarding an acute shortage of ARV medication. The shortage of ARVs in the country was reported to have been triggered by an alleged tax row between the Government of Kenya (GoK) and the United States Agency for International Aid (USAID). As a result, public hospitals in the counties were reported to have started rationing dwindling HIV supplies while a consignment of ARVs worth KShs. 1.1 billion was reported to have been stuck at the port of Mombasa since 18th January, 2021. Further, there were unsubstantiated media reports of the Government releasing phased out ARV drugs (that is, Zidovudine/Lamivudine/Nevirapine) to counties ostensibly in response to the ongoing shortage.

Mr. Speaker,

Consequent to the above, at a sitting of the Committee held on Wednesday, 14th March, 2021, the Committee deliberated on the alleged stalemate between the GoK and USAID and resolved to invite the Ministry of Health (MoH) and the Ministry of National Treasury and Planning to a meeting to apprise it on the following:

1. The terms and conditions of the USAID grant for HIV/AIDS antiretroviral (ARV) commodities, and other essential drugs such as antimalarials, anti-tuberculosis treatment etc;
2. Relevant information regarding existing donor financing arrangements between the GoK and development partners, particularly, USAID and Global Fund on the provision of ARVs and other essential medical commodities;
3. A chronology of the events and circumstances that had led to the stalemate between GoK and USAID with regards to the HIV/AIDS antiretroviral (ARV) crisis;
4. What had triggered the impasse, and what remedial and/or mitigating actions the GoK had taken to try and prevent it;
5. What actions/interventions the Government had taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or permanent solution;
6. What actions the GoK had taken, if any, to reduce donor dependency on ARVs and other essential medical commodities; and

7. What remedial legislative measures or interventions may have been required to avoid similar occurrences in the future, not only for ARVs, but also other essential medical commodities such as antimalarials, anti-TB treatment etc.

Mr. Speaker,

The Committee subsequently met with the Cabinet Secretaries of Health and National Treasury and Planning on Friday, 30th April, 2021 and Monday, 3rd May, 2021 respectively.

This report details the responses received from the Ministry of Health and the Ministry of National Treasury and Planning on the alleged stalemate. It further details the Committee's observations and recommendations based on the responses received, and other information available within the public domain.

Mr. Speaker Sir,

It is now my pleasant duty and privilege to present this report of the Standing Committee on Health, for consideration and approval by the House pursuant to Standing Order No. 226(2) of the Senate Standing Orders.

Signed.................... ....

Date...............................**21/05/2021**..

SEN. MBITO MICHAEL MALING'A, MP

CHAIRPERSON, STANDING COMMITTEE ON HEALTH

ADOPTION OF THE REPORT OF THE STANDING COMMITTEE ON HEALTH OF THE SENATE

We, the undersigned Members of the Standing Committee on Health of the Senate, do hereby append our signatures to adopt the Report-

1. Sen. (Dr.) Michael Mbito, MP ……………………
2. Sen. Mary Seneta, MP ……………………
3. Sen. Beth Mugo, EGH, MP ……………………
4. Sen. Beatrice Kwamboka, MP ……………………
5. Sen. (Prof) Samson Ongeri, EGH, MP ……………………
6. Sen. (Dr) Abdullahi Ali Ibrahim, MP ……………………
7. Sen. Fred Outa, MP ……………………
8. Sen. Millicent Omanga, MP ……………………
9. Sen. Ledama Olekina, MP ……………………

CHAPTER ONE

INTRODUCTION

A. Establishment, Mandate and Membership of the Committee

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to, "*consider all matters relating to medical services, public health and sanitation.*"

The Membership of the Committee is composed of the following:

1. Sen. (Dr.) Michael Mbito, MP.
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5. Sen. (Prof.) Samson Ongeri, EGH, MP.
6. Sen. (Dr.) Abdullahi Ali Ibrahim, CBS, MP.
7. Sen. Fred Outa, MP.
8. Sen. Ledama Olekina, MP.
9. Sen. Millicent Omanga, MP.

B. Background

According to various media reports published on diverse dates, Kenya faced an acute shortage of ARV medication from March, 2021, following an alleged tax dispute between the Government of Kenya (GoK) and the United States Agency for International Aid (USAID) over a consignment of ARVs worth KShs. 1.1 billion at the port of Mombasa.

As a result of the impasse between the GoK and USAID and ensuing shortages in ARVs, public hospitals in the country were reported to have started rationing dwindling HIV supplies to patients leading to public alarm and anxiety. Further, there were unsubstantiated media reports of the Government releasing phased out ARV drugs (that is, Zidovudine/Lamivudine/Nevirapine) to counties ostensibly in response to the ongoing shortage.

To note, Kenya has, and continues to be heavily reliant on donors for ARV medication and other HIV/AIDS commodities, particularly the United States Agency for International Development (USAID) and Global Fund.

i) HIV Data and Statistics

According to the Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 report, Kenya had 1.3 million adult Kenyans (15-64 years) and 139,000 children (0-14 years) living with HIV in 2018. Of these, the report estimated that 79.4% of adults infected with HIV knew their status (that is, approx. 1,032,000). And of those who knew their status, 95.7% were receiving antiretroviral (ARV) treatment (or approx. 987,816 children and adults) ***(please see Annex 2).***

The KENPHIA 2018 report further noted that HIV prevalence was highest in Kisii (6.1%), Turkana (6.8%), Busia (9.9%), Siaya (15.3%), Kisumu (17.5%), Homabay (19.6%) and Migori (13.0%).

ii) HIV Commodities Tax Dispute between the GoK and USAID

According to a report by the Kenya Revenue Authority (KRA) to the National Assembly Departmental Committee on Health on the ARVs Consignment at the port of Mombasa ***(please see Annex 3),*** the total volume of the consignment of HIV/AIDS commodities being held at the port of Mombasa as of 30th April, 2021 was thirteen (13) forty-foot containers broken down as follows:

a) Eight (8) forty-foot containers containing 520,750 HIV self-tests;
b) Three (3) forty-foot containers containing ARVs (Dolutegravir, Lamivudine and Tenofovir Disoproxil Fumarate tablets); and
c) Two (2) containers containing ARVs (Atazor-R and Atazanavir 300mg + Ritonavir 100mg tablets).

According to the report, the MoH *vide* a letter, Ref: MOH/MED/11/3/1, dated 31st March, 2021, requested the Ministry of National Treasury and Planning (NT&P) to issue an undertaking to KRA on its behalf to pay taxes for the consignment amounting to KShs. 45,825,875.15.

Consequently, according to KRA, *vide* a letter, Ref: DFN 415/232/011, dated 6th April, 2021, the Ministry of NT&P undertook to pay the taxes, Railway Development Levy (RDL) and Import Declaration Fees (IDF) for the thirteen (13) containers. However, despite the undertaking by the Ministry of NT&P, KRA reported that owing to delays in the issuance of a permit by the Pharmacy and Poisons Board, and releases by Port Health, the consignment was yet to be cleared from Customs.

To note, prior to the above, KRA reported that since January, 2021, it had cleared seventy-eight (78) forty-foot and one (1) twenty-foot containers of medical supplies consigned to Ms. Chemonics on behalf of USAID.

iii) Evolution of the Dispute

Notwithstanding the aforementioned interventions by the MoH, Ministry of NT&P and KRA to waive taxes on the HIV commodities consignment, according to media reports, USAID is alleged to have subsequently declined to release the HIV commodities to the Kenya Medical Supplies Agency (KEMSA) for warehousing and distribution citing issues with corruption and mismanagement.

C) Methodology

Its attention having been drawn to the looming ARV crisis in the country, at a sitting of the Committee held on Wednesday, 14th March, 2021, the Committee deliberated on the alleged stalemate between the GoK and USAID and resolved to invite the Ministry of Health (MoH) and the Ministry of National Treasury and Planning to a meeting to apprise it on the following:

1. The terms and conditions of the USAID grant for HIV/AIDS antiretroviral (ARV) commodities, and other essential drugs such as antimalarials, anti-tuberculosis treatment etc;
2. Relevant information regarding existing donor financing arrangements between the GoK and development partners, particularly, USAID and Global Fund on the provision of ARVs and other essential medical commodities;
3. A chronology of the events and circumstances that had led to the stalemate between GoK and USAID with regards to the HIV/AIDS antiretroviral (ARV) crisis;

4. What had triggered the impasse, and what remedial and/or mitigating actions the GoK had taken to try and prevent it;
5. What actions/interventions the Government had taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or permanent solution;
6. What actions the GoK had taken, if any, to reduce donor dependency on ARVs and other essential medical commodities; and
7. What remedial legislative measures or interventions may have been required to avoid similar occurrences in the future, not only for ARVs, but also other essential medical commodities such as antimalarials, anti-TB treatment etc.

The Committee subsequently met with the Cabinet Secretaries of Health and National Treasury and Planning on Friday, 30th April, 2021 and Monday, 3rd May, 2021 respectively. A summary of the Committees' findings, observations and recommendations arising from this exercise has been captured in subsequent sections of this report.

CHAPTER TWO

COMMITTEE PROCEEDINGS

The Committee met with the Cabinet Secretaries of Health and National Treasury and Planning on Friday, 30th April, 2021 and Monday, 3rd May, 2021 respectively, in relation to the ARV crisis. Below is a summary of the submissions presented before the Committee during the said meetings.

A. MINISTRY OF HEALTH

The Committee met with the Ministry of Health (MoH) led by the Cabinet Secretary, Hon. Mutahi Kagwe, EGH, on Friday, 30th April, 2021 via the Zoom online meeting platform. Key highlights of the submissions made by the MoH are summarised below:

a) Terms and Conditions of the USAID Grant for HIV/AIDS Commodities and other essential drugs such as antimalarials, anti-tuberculosis treatment etc

According to the MoH, the overall framework guiding donations of HIV commodities from USAID were contained in an annual agreement between the GoK and the United States Government referred to as Kenya's Country Operational Plan (COP).

With specific regards to the terms and conditions for the management of USAID donations of HIV/AIDS ARV commodities and other essential drugs (e.g. antimalarials and anti-TB treatment), the MoH submitted that they were outlined in a contractual arrangement known as the Medical Commodities Program (KEMSA MCP) between USAID and KEMSA for the procurement, warehousing and distribution of medical supplies.

b) Donor Financing Arrangements between the GoK and USAID for the provision of ARVs and other essential medical commodities

Hon. Mutahi Kagwe stated that the first KEMSA MCP was executed on 1st October, 2015 and was scheduled to run up to 25th September, 2020. It was the flagship framework contracting KEMSA for the procurement, warehousing and distribution of medical supplies donated through USAID.

c) **Chronology of events and circumstances that led to the stalemate between the GoK and USAID with regards to the ARV crisis**

According to the MoH, the flagship KEMSA MCP was first scheduled to lapse on 24th September, 2020. However, before it lapsed, it was extended to 24th December, 2020 under the same terms of procurement, warehousing and distribution by KEMSA.

Subsequently, on the request of USAID, a close-out plan with KEMSA was negotiated whereby USAID reviewed the contractual terms prior to the lapse of the extension period to include warehousing and distribution and exclude procurement. Further to this, the extension period was revised to 23rd April, 2021.

On 17th March, 2021, following reports of a stalemate over HIV/AIDS commodities at the port of Mombasa, the CS, Health requested a meeting with representatives of the US Government and the Ministry of Foreign Affairs. During the meeting, it was established that the said consignment had been imported into the country using a private company without the Ministry's prior knowledge and outside of the agreed framework.

According to the MoH, during the said meeting, USAID elaborated on its intention to review its existing collaboration with KEMSA and to use a third party for purposes of providing ARV commodities to the country. At the request of the MoH, a technical meeting to develop a framework to support this was proposed. This led to a meeting on 19th April, 2021.

That notwithstanding, according to the Cabinet Secretary, Health, the matter was still under discussion between the MoH and the US Government. He further indicated that he had urged the US Embassy to revert to using KEMSA noting that the MoH was willing to take the necessary remedial actions to increase transparency and accountability at the agency.

d) **Factors leading to the impasse and the remedial and/or mitigating actions taken by the Government of Kenya to prevent it**

With regards to what factors had triggered the impasse between the GoK and USAID, the CS health cited the following:

i. Lack of communication from USAID on their intention to shift the procurement, warehousing and distribution of HIV commodities from KEMSA;
ii. A unilateral decision by USAID to procure their commitment of donations to Kenya without prior notice to the MoH thereby attracting taxes and other levies; and
iii. Failure by the USAID to communicate on a delay in the consignment of ARVs that were expected by October, 2020 as stipulated in the annual forecasting and quantification frameworks.

The CS Health further noted that despite citing various challenges with KEMSA, the undiplomatic manner in which USAID executed its decision to shift to a private third-party was unwarranted.

He further stated that the MoH had remained pro-active in its attempts to help resolve the challenges cited by USAID. For example, he stated that the Moh had initiated communications and extended invitations to USAID in an effort to understand the challenges that they were facing with regards to KEMSA. However, MoH reported that USAID delayed in honoring these invitations until a meeting held on 26th January, 2021 and a letter dated 29th January, 2021 whereby the MoH was informed of its challenges in clearing taxes at the port.

Following receipt of the letter, the MoH submitted that it initiated a budgetary approval process through the National Assembly Departmental Committee on Health in February, 2021 for the clearance of the consignment from USAID. Following approval by the National Assembly, the MoH requested the Ministry of NT&P to undertake to pay taxes worth KShs. 45, 825,875 being the taxable amount for the commodities that were being held at the port as per invoices provided by USAID. The MoH further directed KEMSA to expedite distribution of the commodities once released by USAID.

Further, to prevent a recurrence of the matter, the MoH:

- Guided USAID to sign a contractual framework that allows for tax exemptions in line with Kenya taxation policies;
- Advised USAID to change its consignee to the MoH and other relevant agencies in order to enable swift customs clearance; and

- Initiated reforms of KEMSA through the establishment of a KEMSA Reforms Committee with the support of development partners, including USAID.

e) Actions/Interventions taken by the GoK to address the ARV crisis when it occurred

In order to avert the ARV crisis, the CS Health stated that MoH had:

- Issued guidelines for shorter-term drug prescriptions aimed at averting total stock outs at patient level;
- Called down other consignments funded by Global Fund and the GoK in an effort to re-stock and solve the temporary ARV crisis;
- Initiated and sustained constant discussions with USAID aimed at ensuring that they were facilitated to clear the consignment of donations of ARVs and essential commodities; and
- Recommended long-term solutions aimed at avoiding similar occurrences in the future e.g. securing and ring-fencing domestic resources for the procurement of the life-saving commodities, expediting plans for local production of health products for purposes of promoting self-sufficiency, and donor diversification.

f) Actions being taken by the GoK to reduce donor dependency on ARVs and other essential medical commodities

Noting that Kenya had over the years relied on traditional bilateral and multilateral agreements for off-budget arrangements that were subject to conditionalities and manipulations that undermined institutional capacity-building, the CS Health outlined the following actions that had been taken by the MoH to reduce donor dependency on ARVs and other essential medical commodities:

- Enhanced domestic resource mobilisation in anticipation of reductions in external resources for the HIV response.
- Enhanced efficiency and effectiveness in resource utilisation through the restructuring of strategic health programs to create synergies, eliminate duplication and gain efficiencies.
- Development of a Health Financing Transition Plan aimed at providing short- and long-term options for resource mobilisation.

The CS Health further called for the development of a legal framework to ring-fence funding for strategic health programs at National and County level, particularly with regards to health products.

B. MINISTRY OF NATIONAL TREASURY AND PLANNING

The Committee met with the Ministry of Health (MoH) led by the Cabinet Secretary, Hon.Ukur Yattani, EGH, on Monday, 3rd May, 2021 via the Zoom online meeting platform. Key highlights of the submissions made by the Ministry of NT&P are summarised below:

a) Terms and Conditions of the USAID Grant for HIV/AIDS Commodities and other essential drugs such as antimalarials, anti-tuberculosis treatment etc

In his statement, Hon. Yattani noted that the HIV response in Kenya was largely dependent on external resources with USAID and Global Fund together accounting for more than 80% of HIV commodities in the country.

With regards to USAID grants and financing arrangements, he stated that USAID funds were mainly off-budget as they were majorly channeled through non-state actors with only a small amount being channelled through the formal Government budgetary system.

He further stated that the total USAID contribution was estimated at USD 500 million (or KShs. 57.5 billion at an exchange rate of KShs. 115 to the USD) for both on and off budget support.

He stated that a new Development Cooperation Assistance Framework Agreement (DCFA) had been executed in December, 2019. The agreement contained an amplified description of the objectives and results to be achieved in a particular sector. To this end, he submitted that USAID issued Implementation Letters from time to time for the allocation of funds and to communicate on other matters pertaining to the agreements.

He further noted that USAID disburses its funds through a direct payment method whereby GoK entities reflect the funds in their budgets as A in A following which USAID was expected to furnish Accounting Officers in relevant Ministries with expenditure statements for onward transmission to the National Treasury. However, he noted that there were often long delays in reporting by USAID.

b) Donor Financing Arrangements between the GoK and development partners, particularly, USAID on the provision of ARVs and other essential medical commodities

With regards to USAID support to the health sector, he noted that the Development Assistance Grant Agreement (DAGA) on the health sector was signed on 19th August, 2003 for an initial amount of USD 30 million. Following progressive incremental funding, the contribution rose to USD 1.945 billion by 2013. This agreement was extended several times to accomodate the incremental funding and came to a close on 30th September, 2017.

He stated that the objectives of the agreement were to reduce fertility and reduce the risk of HIV/AIDS. Funding for the program was received from the U.S. Presidential Emergency Plans for AIDS Relief (PEPFAR) with a focus on AIDS, TB and malaria.

He further stated that a new Development Cooperation Framework Agreement with USAID was signed on 8th December, 2019. However, its operationalisation was still under discussion as far as Government entities were concerned. He further noted that USAID intended to carry out public financial management risk assessments of various Government entities earmarked to benefit from the support, including the MoH, for purposes of satisfying themselves before providing the support.

c) Chronology of events and circumstances that led to the stalemate between the GoK and USAID with regards to the ARV crisis

The Ministry of NT&P submitted that USAID imported the ARV drugs to Kenya without a formal engagement framework. In order to facilitate clearance, the drugs were consigned to the American Embassy as a stop-gap measure aimed at saving the situation pending the conclusion of a formal engagement framework. He further stated that according to USAID, the delay in the formalization of the Framework had been partly occasioned by the US elections.

In the absence of a formal engagement framework, the MoH requested the Ministry of NT&P to facilitate the clearance of the drugs, an action that was promptly undertaken in the interests of securing service delivery

d) Actions being taken by the GoK to reduce donor dependency on ARVs and other essential medical commodities

With regards to actions being taken by the GoK to reduce donor dependency on ARVs and other essential medical commodities, the CS noted that efforts were ongoing to enhance private sector investment in the local production of drugs in the country. He further stated that the GoK was engaging the private sector with a view towards agreeing on the necessary incentives required to facilitate local manufacturing of drugs.

CHAPTER THREE

COMMITTEE OBSERVATIONS

The Committee made the following observations:

1. The Committee noted that according to the Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 report, Kenya had 1.3 million adult Kenyans (15-64 years) and 139,000 children (0-14 years) living with HIV in 2018. Of these, the report estimated that 79.4% of adults infected with HIV knew their status (that is, approx. 1,032,000). Further, according to the report, of those who knew their status, 95.7% were receiving antiretroviral (ARV) treatment (or approx. 987,816 children and adults). This implied that the GoK-USAID stalemate had effectively put the lives and health of at least one million Kenyan citizens at risk.
2. The Committee further observed that according to the KENPHIA 2018 report, the highest affected counties with regards to HIV prevalence were Kisii (6.1%), Turkana (6.8%), Busia (9.9%), Siaya (15.3%), Kisumu (17.5%), Homabay (19.6%) and Migori (13.0%) in ascending order.
3. The Committee observed that according to the MoH and the Ministry of NT&P, Kenya was heavily dependent on external resources for its HIV response, with USAID and the Global Fund together funding more than 80% of the country's HIV commodities.
4. In relation to the above, the Committee observed that the country's heavy reliance on donor funding for HIV commodities and other essential medical commodities (e.g. antimalarials and antituberculosis treatment) may in itself pose a national security risk to the country particularly in cases where an impasse between the GoK and major development partner(s) risks cutting off supplies of the much needed drugs and essential commodities to a large population of patients who are dependent on them for their health and survival.
5. In view of the above, the Committee observed that the stalemate between the GoK and USAID had led to an acute shortage of antiretroviral (ARV) drugs and other HIV commodities at public hospitals across the country, leading to rationing of the dwindling

ARV supplies, and increasing anxiety especially amongst the more than one million HIV patients who are dependent on them for their lives and health.

6. The Committee further observed that according to the MoH, the impasse had been precipitated by a unilateral decision by USAID to import a HIV commodities consignment into the country using a private entity (i.e. M/S Chemonics Ltd) without the prior notice or knowledge of the MoH, and outside of a formal engagement framework citing challenges with KEMSA.
7. In relation to the above, the Committee observed that under Kenya's tax regime and taxation policies, tax and duty waivers only apply where government agencies and ministries are listed as the consignees. Importations through private companies do not qualify for special exemptions and are subject to normal clearance processes and procedures. Accordingly, the Committee observed that upon the USAID-funded ARVs consignment reaching Kenya, USAID was required to pay taxes amounting to KShs. 45.8 million being payment for customs, Railway Development Levy and Import Declaration fees. This however, led to a standoff between the GoK and USAID resulting in the consignment being stuck at the port of Mombasa from January, 2021.
8. The Committee further observed that in an effort to address the resulting standoff, and in light of dwindling ARV stocks at public facilities, the Government took extraordinary measures to get a speedy resolution to the row as evidenced by the following:
    a) The successful initiation and execution of a budgetary approval process by the MoH for a supplementary budget through the National Assembly Departmental Committee on Health in February, 2021 for the clearance of the consignment from USAID.
    b) A request by the MoH to the Ministry of NT&P *vide* a letter, Ref: MOH/MED/11/3/1, dated 31st March, 2021, for the issuance of an undertaking to KRA on its behalf to pay taxes for the consignment amounting to KShs. 45,825,875.15.
    c) Consequently, *vide* a letter, Ref: DFN 415/232/011, dated 6th April, 2021, an undertaking by the Ministry of NT&P to pay the taxes, Railway Development Levy (RDL) and Import Declaration Fees (IDF) for the HIV consignment by USAID.

To note, the Committee observed that in taking these interventions, the GoK through the MoH, the Ministry of NT&P and KRA acted against the country's own established tax policies and procedures in an effort to address the stalemate.

9. Further to the above, the Committee observed that the MoH had demonstrated its commitment and goodwill towards addressing the stalemate through continuous efforts to engage, and meet with representatives of the US Embassy as well as USAID.
10. The Committee further observed that according to a Medical Commodities Program framework that was first executed executed between KEMSA and USAID on 1st October, 2015 and which was subsequently revised and extended to 23rd April, 2021, KEMSA had a contractual agreement with USAID to provide procurement (this was later excluded), warehousing and distribution services for HIV commodities imported into the country through USAID.
11. To note, the Committee observed that the stalemate between GoK and USAID had initially been pegged on the imposition of taxes on the HIV consignment by USAID. However, following the GoK's attempt to amicably resolve the matter through the aforementioned actions taken by the MoH, the Ministry of NT&P and KRA, the impasse had then evolved to a refusal by USAID to release the HIV commodities to KEMSA for warehousing and distribution in accordance with the then operating KEMSA MCP framework citing issues with corruption and mismanagement at the agency. At the time of the writing of this report, this impasse was yet to be resolved.
12. In relation to the above, the Committee observed that in order for the Government to effectively address the current impasse regarding whether or not USAID was justified in seeking to be allowed to use a private third-party (M/S Chemonics) for purposes of procuring, warehousing and distributing ARV commodities, there was a need for USAID to elaborate and substantiate the specific issues and challenges that it had encountered with KEMSA in relation to each of those areas. Further, that there was a need for USAID to make a distinction between accountability issues that may have arisen at facility level *vis a vis* KEMSA.
13. To note, according to an investigation report by the Global Fund that was published on 9th March, 2021, between 2017 and 2019, M/S Chemonics, a privately-owned American firm, was found culpable of defrauding Global Fund-supported programs of USD 3

million by systematically inflating invoices for the distribution of health commodities to warehouses and health facilities throughout Nigeria. According to the report, Chemonics, through its sub-contractor, Zenith Carex, managed an integrated supply chain for Global Fund Principal Recipients in Nigeria and the USAID. During this period, Chemonics approved and paid Zenith's fraudulent invoices for over two years. Combined with Chemonics' percentage-based contract management fees, the fraud resulted in over $3.4 million in non-compliant expenditures charged to the Global Fund. Poor implementation of controls, inadequate financial monitoring and potential collusion between Chemonics and Zenith staff were identified as key factors leading to the fraud (***please see Annex 6***).

14. While acknowledging that KEMSA had also been found culpable of corruption and mismanagement in the past, the Committee observed that the best practise necessitated respecting the country's institutions, and strengthening their institutional capacity.
15. The Committee further observed that according to the MoH, following the allegations and complaints made by USAID against KEMSA, it had undertaken various measures aimed at remedying the situation such as reconstituting the KEMSA Board, and initiating reforms at KEMSA through the establishment of a KEMSA Reforms Committee in collaboration with various development partners including USAID.
16. Further, with regards to demands by USAID to be allowed to use a private third-party for purposes of procuring, warehousing and distributing strategic HIV commodities, the Committee observed that due consideration and care must be taken to avoid avenues for the creation of parallel systems for the procurement, warehousing and distribution of essential medical commodities by development partners that fall outside the normal oversight and accountability structures and processes of Government.

To note, the Committee was handicapped in concluding on the stalemate between MoH and USAID in view of the fact that, as a foreign government agency, USAID falls outside the mandate of the Committee. To this extent, the Committee was unable to invite USAID or its representatives to appear before it to expound on the matters that had arisen. The Committee however notes that in a letter dated 23rd July, 2020, it made a request for copies of USAID's audit reports of KEMSA from the FY 2017/2018. It however did not receive any response ***(please see Annex 7).***

CHAPTER FOUR

COMMITTEE RECOMMENDATIONS

Based on the foregoing, the Committee made the following recommendations:

1. That the Government of Kenya through the Ministry of Health and the National Assembly act urgently to enhance domestic resource mobilisation for the provision of ARVs and other essential drugs and commodities with a view towards reducing donor dependency;
2. That the Government of Kenya through the Ministry of Health and the Ministry of National Treasury and Planning take urgent and immediate steps to reduce Kenya's dependency on donors for the provision of ARVs and other essential medical commodities through the promotion and facilitation of private sector investment in local manufacture of drugs;
3. That the Ministry of Health takes necessary measures to diversify its partnerships and engagements with donors to avoid over-reliance on a single donor for strategic health programs such as HIV/AIDS, malaria and tuberculosis.
4. That the Office of the Auditor General conducts a special audit to investigate allegations of corruption and mismanagement at KEMSA with regards to the procurement, warehousing and distribution of ARV commodities and other essential medical commodities supplied by USAID.
5. That the Ministry of Foreign Affairs takes note of this report and follows up on its findings with the United States Embassy, USAID and other relevant authorities of the US Government with a view towards finding timely and amicable solutions to the issues contained herein.

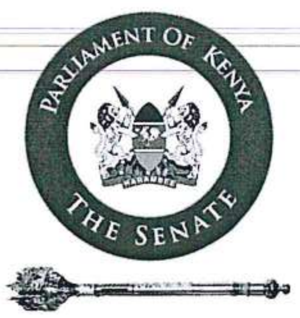
The Committee therefore determined that:

1. This report be dispatched to the Ministry of Health and the Ministry of National Treasury and Planning for purposes of taking the necessary steps and measures to make provisions for: enhanced domestic resource mobilisation for the HIV and other essential drugs and commodities; the promotion and facilitation of private sector investment in the local

manufacture of strategic health products and commodities, particularly in relation to HIV/AIDS, tuberculosis and malaria; and, donor diversification. And to recommend appropriate action within **six (6) months** receipt of this report.

2. This report be dispatched be dispatched to the Office of the Auditor General for purposes of conducting a special audit to investigate allegations of corruption and mismanagement at KEMSA with regards to the procurement, warehousing and distribution of ARVs and other essential medical commodities supplied by USAID, and to report back to the Committee within **three (3) months** receipt of this report.
3. This report be dispatched to the Ministry of Foreign Affairs for purposes of following up on its findings with the United States Embassy, USAID and other relevant authorities of the US Government, and to report back to the Committee within **three (3) months** receipt of this report.

TWELFTH PARLIAMENT |FIFTH SESSION



MINUTES OF THE SITTING OF THE SENATE STANDING COMMITTEE ON HEALTH, HELD ON 30TH APRIL, 2021 AT 2:30 P.M. ON THE ZOOM ONLINE PLATFORM

PRESENT

1) Sen. Ledama Olekina, MP - Chairing
2) Sen. Fred Outa, MP
3) Sen. Beth Mugo, EGH, MP
4) Sen. (Prof) Samson Ongeri, EGH, MP
5) Sen. (Dr) Abdullahi Ali Ibrahim, CBS, MP
6) Sen. Beatrice Kwamboka, MP
7) Sen. Mary Seneta, MP
8) Sen. Millicent Omanga, MP

APOLOGIES

1. Sen. (Dr.) Michael Mbito, MP - Chairperson

IN ATTENDANCE

A. Ministry of Health

1. Sen. Mutahi Kagwe, EGH - Cabinet Secretary
2. Mrs. Susan Mochache - Principal Secretary
3. Dr. Patrick Amoth - Ag. Director General
4. Dr. Willis Akhwale - Chairperson, National COVID-19 Vaccine Taskforce
5. Ms. Rose Mudibo - Director, Parliamentary Liaison
6. Dr. Rabera Kenyenya
7. Mrs. Nurseline Onsongo
8. Dr. Ian Were

B. Pharmacy and Poisons Board

1. Dr. Fred Siyoi - CEO/Registrar

SECRETARIAT

1) Ms. Emmy Chepkwony - Principal Clerk Assistant
2) Dr. Christine Sagini - Research Officer/Clerk Assistant
3) Ms. Farhiya Ali - Sergeant-at-Arms
4) Ms. Sombe Toona - Legal Counsel
5) Mr. Robert Rop - Audio Officer

MIN. NO. SCH2/050/2020 PRELIMINARIES

The Meeting commenced at 2:05 p.m with a word of prayer from the Chairperson.

MIN. NO. SCH2/051/2020 ADOPTION OF THE AGENDA

The Committee adopted the agenda of the sitting, as set out below, having been proposed by Sen. Beth Mugo, EGH, MP and seconded by Sen. Fred Outa, MP:-

1. Preliminaries
   a) *Prayer*
   b) *Adoption of the Agenda*
2. ***Submission of Statements by the Cabinet Secretary, Ministry of Health, on the status of the national COVID-19 vaccination roll-out and the alleged stalemate on HIV/AIDS Commodities with USAID.***
3. Any other business.
4. Date of the Next Meeting.
5. Adjournment.

MIN. NO. SCH2/051/2020 STATEMENT BY THE CABINET SECRETARY OF HEALTH ON THE COVID-19 VACCINATION ROLL-OUT

Led by the Hon. Mutahi Kagwe, Cabinet Secretary, the Ministry of Health (MoH) updated the Committee on the status of the COVID-19 vaccination roll-out as summarised below:

With regards to the role of the MoH and the National Emergency Response Committee *vis-a-vis* that of the Pharmacy and Poisons Board in the approval and revocation of licenses to private entities for the importation, distribution and administration of health products, including

vaccines, the Cabinet Secretary stated that the MoH is responsible for Health Policy under the Fourth Schedule of the Constitution, and is mandated to implement the principles in Articles 10 and 232, and Chapters 6 and 12 of the Constitution.

He further stated that the Pharmacy and Poisons Board (PPB) falls under the MoH , and is the National Medicines Regulatory Authority established under the Pharmacy and Poisons Act (Cap 244). It is responsible for the regulation of health products and technologies, and is mandated, *inter alia,* to: grant or revoke licenses for the manufacture, importation, exportation, distribution and sale of medical substances; ensure that all medicinal products manufactured in, imported into or exported from the country conform to prescribed standards of quality, safety and efficacy; and, ensure that the personnel, premises and practices employed in the manufacture, storage, marketing, distribution and sale of medicinal substances comply with the defined codes of practice, and other prescribed requirements.

He further stated that according to the Pharmacy and Poisons Rules, appeals of decisions made by the PPB lie with the CS, Health.

In specific relation to the cancellation of licenses and permits for the importation, distribution and administration of vaccines, he submitted that it was empowered under Section 158(1) of the Public Health Act, to prohibit the importation, manufacture or use of any such substance, which is considered to be unsafe or liable to be harmful or deleterious, thus: *"the Minister may provide for the inspection, sampling and examination, by officers of the Medical Department, of vaccines, vaccine lymph, sera and similar substances imported or manufactured in Kenya and intended or used for the prevention or treatment of human diseases, and may prohibit the importation, manufacture or use of any such substance which is considered to be unsafe or to be liable to be harmful or deleterious."*

He further stated that the National Emergency Response Committee on the Coronavirus Disease was established by H.E. The President on 28th February, 2020 *vide* Executive Order No. 2 of 2020. Among others, its terms of reference include the coordination of Kenya's preparedness, prevention and response to the threat of the Coronavirus disease.

Noting that the MoH was responsible for issuing and providing policy direction to PPB , and noting that health products and technologies was a key policy orientation under the Kenya Health Policy (2014-2030), he noted that under the unprecedented emergency of the pandemic, regulatory emergency responses , including emergency use authorisation, import licenses for

products under emergency authorisation and Good Distribution Practices, preceded specific policy directions on the same.

Noting that the NERC's mandate enabled it to influence policy relating to the management of the pandemic, he stated that its resolutions had led to the policy decision to restrict import, distribution and administration of COVID-19 vaccines to the Government only. In this regard, the PPB as the implementing agency was expected to enforce the policy.

With regards to reported shortages of the Astrazeneca vaccine, and the measures that the Government had taken to ensure that all eligible persons receive their first and booster vaccine doses in a timely manner, the CS informed the Committee that as 26th April, 2021, out of 1,080, 000 AstraZeneca vaccine doses that the Government had received, there was a balance of 40,000 vaccine doses at the Kitengela Central Vaccine stores.

He further informed the Committee that the total number of persons vaccinated stood at 853,081, 56% of whom were males, while 44% were females.

Of the targeted population groups, 74% of health workers had been vaccinated, 39% of teachers, and 10% of persons aged above 58 years.

With regards to the issuance of the 2nd dose of AstraZeneca, he stated that global supply constraints arising from the decision by the Government of India to prioritise the vaccination of it own population, and the inability of the Serum Institute of India to meet global demand, had led to delays in the delivery of 2.5 million vaccine doses that the Kenya was in line to receive under the COVAX facility. Noting that the issue was global, and beyond Kenya and/or COVAX, he nevertheless stated that there were concerted international efforts to address the challenges.

He further stated that in reliance of current evidence and WHO guidance,the MoH had made a policy decision to extend the duration between the first and second AstraZeneca vaccine doses from 8-12 weeks. Noting that the first recipients of the second dose were expected to receive their booster dose in the first week of June, 2021, he stated that supplies from COVAX were expected to have been received by then.

He further stated that the MoH had engaged the African Union with a view to procure 7 million doses of Pfizer, and 10 million doses of Johnson and Johnson. This was expected to provide for the vaccination of 13.5 million Kenyans.

Further, indicating that the country also expected to receive a further donation of 20 million doses from COVAX, plus 11 million of self-procured vaccines, he stated that Kenya expected to fully vaccinate its entire adult population by the end of June, 2022.

MIN. NO. SCH2/051/2020 STATEMENT BY THE CABINET SECRETARY OF HEALTH ON THE ALLEGED STALEMATE ON HIV/AIDS COMMODITIES WITH USAID

Hon. Mutahi Kagwe, Cabinet Secretary, the Ministry of Health (MoH) updated the Committee on the alleged stalemate between the Government of Kenya and USAID on HIV commodities as summarized below:

According to the CS Health, the overall framework guiding donations of HIV commodities from USAID were contained in an annual agreement between the GoK and the United States Government referred to as Kenya's Country Operational Plan (COP).

With specific regards to the terms and conditions for the management of USAID donations of HIV/AIDS ARV commodities and other essential drugs (e.g. antimalarials and anti-TB treatment), the CS stated that they were outlined in a contractual arrangement known as the Medical Commodities Program (KEMSA MCP) between USAID and KEMSA for the procurement, warehousing and distribution of medical supplies.

He further stated that the first KEMSA MCP was executed on 1st October, 2015 and was scheduled to run up to 25th September, 2020. It was the flagship framework contracting KEMSA for the procurement, warehousing and distribution of medical supplies donated through USAID.

According to the CS Health, the flagship KEMSA MCP was first scheduled to lapse on 24th September, 2020. However, before it lapsed, it was extended to 24th December, 2020 under the same terms of procurement, warehousing and distribution by KEMSA.

Subsequently, on the request of USAID, a close-out plan with KEMSA was negotiated whereby USAID reviewed the contractual terms prior to the lapse of the extension period to include warehousing and distribution and exclude procurement. Further to this, the extension period was revised to 23rd April, 2021.

On 17th March, 2021, following reports of a stalemate over HIV/AIDS commodities at the port of Mombasa, the CS Health submitted that he requested a meeting with representatives of the US

Government and the Ministry of Foreign Affairs. During the meeting, he stated that it was established that the said consignment had been imported into the country using a private company. This had been done without the Ministry's prior knowledge and outside of the agreed framework.

He further stated that during the said meeting, USAID elaborated on its intention to review its existing collaboration with KEMSA and to use a third party for purposes of providing ARV commodities to the country. At the request of the MoH, a technical meeting to develop a framework to support this was proposed. This led to a meeting on 19th April, 2021.

That notwithstanding, he noted that the matter was still under discussion between the MoH and the US Government. He further indicated that he had urged the US Embassy to revert to using KEMSA noting that the MoH was willing to take the necessary remedial actions to increase transparency and accountability at the agency.

With regards to what factors had triggered the impasse between the GoK and USAID, the CS health cited the following:

i. Lack of communication from USAID on their intention to shift the procurement, warehousing and distribution of HIV commodities from KEMSA;
ii. A unilateral decision by USAID to procure their commitment of donations to Kenya without prior notice to the MoH thereby attracting taxes and other levies; and
iii. Failure by the USAID to communicate on a delay in the consignment of ARVs that were expected by October, 2020 as stipulated in the annual forecasting and quantification frameworks.

The CS Health further noted that despite citing various challenges with KEMSA, the undiplomatic manner in which USAID executed its decision to shift to a private third-party was unwarranted.

He further stated that the MoH had remained pro-active in its attempts to help resolve the challenges cited by USAID. For example, he stated that the MoH had initiated communications and extended invitations to USAID in an effort to understand the challenges that they were facing with regards to KEMSA. However, he reported that USAID delayed in honoring these invitations until a meeting held on 26th January, 2021 and a letter dated 29th January, 2021 whereby he was duly informed of the Agency's challenges in clearing taxes at the port.

Following receipt of the letter, the CS reported that the MoH initiated a budgetary approval process through the National Assembly Departmental Committee on Health in February, 2021 for the clearance of the consignment from USAID. Following approval by the National Assembly, the MoH requested the Ministry of National Treasury & Planning to undertake to pay taxes worth KShs. 45, 825,875 being the taxable amount for the commodities that were being held at the port as per invoices provided by USAID. The MoH further directed KEMSA to expedite distribution of the commodities once released by USAID.

Further, he stated that to prevent a recurrence of the matter, the MoH took the following actions:

- Guided USAID to sign a contractual framework that allows for tax exemptions in line with Kenya taxation policies;
- Advised USAID to change its consignee to the MoH and other relevant agencies in order to enable swift customs clearance; and
- Initiated reforms of KEMSA through the establishment of a KEMSA Reforms Committee with the support of development partners, including USAID.

In addition, in order to avert the ARV crisis, the CS Health stated that MoH had:

- Issued guidelines for shorter-term drug prescriptions aimed at averting total stock outs at patient level;
- Called down other consignments funded by Global Fund and the GoK in an effort to re-stock and solve the temporary ARV crisis;
- Initiated and sustained constant discussions with USAID aimed at ensuring that they were facilitated to clear the consignment of donations of ARVs and essential commodities; and
- Recommended long-term solutions aimed at avoiding similar occurrences in the future e.g. securing and ring-fencing domestic resources for the procurement of the life-saving commodities, expediting plans for local production of health products for purposes of promoting self-sufficiency, and donor diversification.

Noting that Kenya had over the years relied on traditional bilateral and multilateral agreements for off-budget arrangements that were subject to conditionalities and manipulations that undermined institutional capacity-building, the CS Health outlined the following actions that had been taken by the MoH to reduce donor dependency on ARVs and other essential medical commodities:

- Enhanced domestic resource mobilisation in anticipation of reductions in external resources for the HIV response.
- Enhanced efficiency and effectiveness in resource utilisation through the restructuring of strategic health programs to create synergies, eliminate duplication and gain efficiencies.

- Development of a Health Financing Transition Plan aimed at providing short- and long-term options for resource mobilisation.

The CS Health further called for the development of a legal framework to ring-fence funding for strategic health programs at National and County level, particularly with regards to health products.

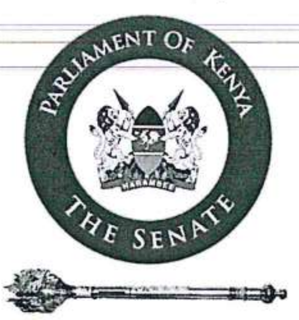
MIN. NO. SCH2/051/2020 ADJOURNMENT

There being no other business, the meeting was adjourned at 5.25 pm.

SIGNED:..

(CHAIRPERSON)

DATE: 10/5/2021



MINUTES OF THE SITTING OF THE SENATE STANDING COMMITTEE ON HEALTH, HELD ON 3RD MAY, 2021 AT 9:00 A.M. ON THE ZOOM ONLINE PLATFORM

PRESENT

1) Sen. (Dr.) Michael Mbito, MP - Chairperson
2) Sen. Ledama Olekina, MP
3) Sen. Fred Outa, MP
4) Sen. Beth Mugo, EGH, MP
5) Sen. (Prof) Samson Ongeri, EGH, MP
6) Sen. (Dr) Abdullahi Ali Ibrahim, CBS, MP
7) Sen. Beatrice Kwamboka, MP
8) Sen. Mary Seneta, MP
9) Sen. Millicent Omanga, MP

IN ATTENDANCE

A. Ministry of National Treasury and Planning

1. Hon. Ukur Yattani, EGH - Cabinet Secretary

SECRETARIAT

1) Ms. Emmy Chepkwony - Principal Clerk Assistant
2) Dr. Christine Sagini - Research Officer/Clerk Assistant
3) Ms. Farhiya Ali - Sergeant-at-Arms
4) Ms. Sombe Toona - Legal Counsel
5) Mr. Robert Rop - Audio Officer

MIN. NO. SCH2/050/2020 PRELIMINARIES

The Meeting commenced at 9:05 p.m with a word of prayer from the Chairperson.

MIN. NO. SCH2/051/2020 ADOPTION OF THE AGENDA

The Committee adopted the agenda of the sitting, as set out below, having been proposed by Sen. (Prof) Samson Ongeri, EGH, MP and seconded by Sen. Mary Seneta, MP:-

1. Preliminaries
   - *a) Prayer*
   - *b) Adoption of the Agenda*
2. ***Submission of Statements by the Cabinet Secretary, Ministry of National Treasury and Planning on the alleged stalemate on HIV/AIDS Commodities with USAID.***
3. Any other business.
4. Date of the Next Meeting.
5. Adjournment.

MIN. NO. SCH2/051/2020 STATEMENT BY THE CABINET SECRETARY OF NATIONAL TREASURY AND PLANNING ON THE ALLEGED STALEMATE ON HIV/AIDS COMMODITIES WITH USAID

Hon. Ukur Yattani, Cabinet Secretary, the Ministry of National Treasury and Planning updated the Committee on the alleged stalemate between the Government of Kenya and USAID on HIV commodities as summarized below:

In his statement, Hon. Yattani noted that the HIV response in Kenya was largely dependent on external resources with USAID and Global Fund together accounting for more than 80% of HIV commodities in the country.

With regards to USAID grants and financing arrangements, he stated that USAID funds were mainly off-budget as they were majorly channeled through non-state actors with only a small amount being channelled through the formal Government budgetary system.

He further stated that the total USAID contribution was estimated at USD 500 million (or KShs. 57.5 billion at an exchange rate of KShs. 115 to the USD) for both on and off budget support.

He stated that a new Development Cooperation Assistance Framework Agreement (DCFA) had been executed in December, 2019. The agreement contained an amplified description of the objectives and results to be achieved in a particular sector. To this end, he submitted that USAID

issued Implementation Letters from time to time for the allocation of funds and to communicate on other matters pertaining to the agreements.

He further noted that USAID disburses its funds through a direct payment method whereby GoK entities reflect the funds in their budgets as A in A following which USAID was expected to furnish Accounting Officers in relevant Ministries with expenditure statements for onward transmission to the National Treasury. However, he noted that there were often long delays in reporting by USAID.

With regards to USAID support to the health sector, he noted that the Development Assistance Grant Agreement (DAGA) on the health sector was signed on 19th August, 2003 for an initial amount of USD 30 million. Following progressive incremental funding, the contribution rose to USD 1.945 billion by 2013. This agreement was extended several times to accomodate the incremental funding and came to a close on 30th September, 2017.

He stated that the objectives of the agreement were to reduce fertility and reduce the risk of HIV/AIDS. Funding for the program was received from the U.S. Presidential Emergency Plans for AIDS Relief (PEPFAR) with a focus on AIDS, TB and malaria.

He further stated that a new Development Cooperation Framework Agreement with USAID was signed on 8th December, 2019. However, its operationalisation was still under discussion as far as Government entities were concerned. He further noted that USAID intended to carry out public financial management risk assessments of various Government entities earmarked to benefit from the support, including the MoH, for purposes of satisfying themselves before providing the support.

With regards to what actions/interventions the Ministry of NT&P had taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or a permanent solution, he stated that USAID had imported the ARV drugs to Kenya without a formal engagement framework. In order to facilitate clearance, the drugs were consigned to the American Embassy as a stop-gap measure. This was aimed at saving the situation pending the conclusion of a formal engagement framework. He further stated that according to USAID, the delay in the formalization of the Framework had been partly occasioned by the US elections.

He further elaborated that in the absence of a formal engagement framework, the MoH had requested the Ministry of NT&P to facilitate the clearance of the drugs, an action that was promptly undertaken in the interests of securing service delivery

With regards to actions being taken by the GoK to reduce donor dependency on ARVs and other essential medical commodities, the CS noted that efforts were ongoing to enhance private sector investment in the local production of drugs in the country. He further stated that the GoK was engaging the private sector with a view towards agreeing on the necessary incentives required to facilitate local manufacturing of drugs.

MIN. NO. SCH2/051/2020 ADJOURNMENT

There being no other business, the meeting was adjourned at 10.25 am.

SIGNED:...

(CHAIRPERSON)

21/5/2021

DATE:...

REPUBLIC OF KENYA

Telegraphic Address
'Bunge', Nairobi
Telephone 2848000
Fax: 2243694
E-mail: csenate@parliament.go.ke

The Senate
Clerk's Chambers
Parliament Buildings
P. O. Box 41842 –00100
NAIROBI, Kenya

PARLIAMENT
OFFICE OF THE CLERK OF THE SENATE

Ref. SEN/DCO/CORR/SCH/02/006/2020 (1)

23rd July, 2020

Mr. Mark Meassick,
Mission Director,
USAID - Kenya and East Africa,
P. O. Box 629, Village Market 00621,
NAIROBI.

Dear Sir,

RE: REQUEST FOR DOCUMENTATION

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to consider all matters relating to medical services, public health and sanitation.

The Committee has learnt of various allegations of procurement irregularities at the Kenya Medical Supplies Authority (KEMSA) from Financial Year 2017/2018 to Financial Year 2019/2020.

At its sitting held on Wednesday, 22nd July, 2020, the Committee considered matters relating to the alleged procurement irregularities at KEMSA and resolved to request your office to submit copies of your audit reports of KEMSA from the FY 2017/2018 to date.

We request that this information be submitted, **by email,** on the address: **csenate@parliament.go.ke** on or before **Wednesday, 5th August, 2020.**

Dr. Christine Sagini, Research Officer (Tel: 0725-052269; Email: christinesagini@gmail.com) is the officer responsible for facilitating this matter.

Yours faithfully,

For:

J. M. NYEGENYE, CBS,
CLERK OF THE SENATE.

REPUBLIC OF KENYA

THE NATIONAL TREASURY AND PLANNING

Telegraphic Address: 22921
Finance – Nairobi
FAX NO. 310833
Telephone: 2252299
When Replying Please Quote

THE NATIONAL TREASURY
P.O BOX 30007 - 00100
NAIROBI
KENYA

Ref: Ref: EA/FA9/03 'TY'VOL.V (3) **29th April 2021**

Mr. J. M. Nyegenye, CBS
Clerk of the Senate
Parliament Building
NAIROBI

Dear

ALLEGED STALEMATE ON HIV/AIDS COMMODITIES WITH THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

Reference is made to your letter Ref: SEN/DCO/CORR/SCH/02/013/2021(1) dated 16th April, 2021 from the Clerk of the Senate, inviting the Cabinet Secretary, National Treasury and Planning to the Parliamentary Standing Committee on Health on **Friday, 30th April, 2020 at 2.30** P.M to apprise on the alleged stalemate on HIV AIDs commodities with the United states Agency for International Development (USAID). The senate has raised a number of issues to be addressed by both The National Treasury and Planning and the Ministry of Health. We wish to respond to the following issues directly relating to The National Treasury and Planning:

1) The terms and Conditions of the USAID grant for HIV AIDs antiretroviral commodities (ARVs) and other essential drugs such as antimalarial, anti-tuberculosis treatment etc.

1. The HIV response in Kenya is largely dependent on external resources. HIV health commodities are mainly funded by three agencies, the Government of Kenya, the Global Fund and USAID. The funding from Global Fund and USAID are grants and together they fund more than 80% of the HIV commodities.

Agreement was extended several times to accommodate the incremental funding and came to a **close on 30th September, 2017.**

2. The **objective of the agreement** was to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health service. The programme receives funding from the U.S Presidential Emergency Plans for AIDS Relief (PEPFAR) fund which is set aside to combat AIDS, tuberculosis and malaria.

3. Based on the Development Assistance Grant Agreement on the Health sector, the Kenya Medical Supplies Agency (KEMSA) and USAID signed the **Medical Commodities Programme (MCP) in September, 2015** amounting to **USD 649,997,960** for a period of five years until 30th September, 2020. The purpose of the programme was to establish and operate a safe, secure, reliable and sustainable supply chain management system for HIV/AIDs commodities (pharmaceuticals, supplies, food commodities, laboratory reagents and equipment) needed to provide care and treatment of persons with HIV/AIDs, warehousing and distribution of family planning, nutrition and malaria commodities. The National Treasury was not involved in the signing of the MCP. The MCP has since come to an end.

4. The new **Development Cooperation Framework Agreement (DCFA)** was signed on 8th December, 2019 and its operationalization is under discussion as far as funding of Government entities is concerned. USAID intends to carry out public financial management risk assessment of various Government entities earmarked to benefit from the support including the Ministry of Health, to satisfy themselves before providing the support.

Global Fund Support and Financing Arrangements

5. The Government of Kenya, through the National Treasury provides co-financing funds for the fight against HIV, TB and Malaria. This is a requirement to access the Global Fund allocation. In the last three financial years the National Treasury provided funding as shown in the table

Program	2018/19	2019/20	2020/21
HIV	2,129,271,881	2,544,458,196	2,246,925,000
TB	400,000,000	427,770,902	465,000,000
Malaria	400,000,000	427,770,902	466,000,000
Total in KES	2,929,271,881	3,400,000,000	3,177,925,000

6. The Global Fund provides grants to Kenya to support the fight against AIDS, TB and Malaria. The allocation cycle for the grants is every three years. The support provided to

the Government of Kenya is on-budget allocation to the National Treasury and the Ministry of Health.

7. Majority of the funds are used for procurement of health products to fight against the three diseases. Examples of health products funded include:
   - Antiretroviral medicines
   - Anti-TB medicines
   - Anti-malarial medicines
   - Laboratory commodities
   - Mosquito nets for prevention of malaria
   - Condoms for prevention of HIV
   - Nutrition commodities
   - Health equipment among others

8. In the 2018 -2021 allocation period, the Global Fund grant allocated approximately USD 310 million to the Government of Kenya as shown in the table:

Category	HIV Grant	Malaria Grant	TB Grant	Total (USD)	Percentage
Health Products	153,216,842	59,623,011	22,962,011	235,801,864	75.8%
Support Activities	37,078,981	14,440,813	23,641,927	75,161,721	24.2%
Total	**190,295,823**	**74,063,824**	**46,603,938**	**310,963,585**	**100.0%**

9. KEMSA is responsible for procurement, warehousing and distribution of the commodities procured through the Government of Kenya funds and the Global Fund grants.

3) What actions/interventions were taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or a permanent solution.

1. Our consultations with the USAID have established that the drugs were imported to Kenya without a formal engagement framework. In order to facilitate clearance, the drugs were consigned to the American Embassy as a stop measure gap in order to save the situation pending the conclusion of the formal engagement framework. According to USAID, the delay in the formalization of the Framework was partly occasioned by the elections in the United States.

2. In the absence of a formal engagement framework, the Ministry of Health requested the National Treasury and Planning to facilitate the clearance of the drugs. This was promptly done vide our letter Ref. No. DFN 415/232/011 dated 6th April, 2021 having taken into account the importance of the drugs in the enhancement of service delivery in

the health sector, particularly during this time of COVID-19 pandemic. In this regard, I would like to emphasize that both the Ministry of Health and USAID have acknowledged the support from the National Treasury and Planning in facilitating the clearance of the drugs.

4) **What actions the Government of Kenya is taking, if any, to reduce donor dependency on ARVs and other essential medical commodities.**

1. On the question of what the Government is doing to reduce donor dependency, I wish to point out that provision of Universal Health Care is one of the Big Four Agenda. In this regard, efforts are being done to strengthen health and human capacity through:

i) Increased Kenyan ownership of Health, education and Social Systems; and

ii) Public and Private Investment in the production of drugs in the country. This is being done through enhanced enabling environment for private sector investment in this critical sector. In addition, the Government has continued to engage the private sector in order to agree on the necessary incentives required to facilitate local manufacturing of drugs. The Public Private Partnership Framework provides for strategic partners to invest in this sector.

5) **What remedial legislative measures or interventions may be required to avert similar occurrences in the future, nor only doe ARVs, but also other essential medical commodities such as antimalarials, anti-TB treatment etc?**

1. In the event of any dispute or controversy there is need for both parties to adhere to the provisions of the financing agreements particularly settlement of disputes and termination clauses.

Other matters raised in the invitation letter will be addressed by the Ministry of Health including Chronology of events and the circumstances that led to the stalemate between the Government of Kenya and USAID with regard to the HIV/AIDs and antiretroviral (ARV crisis) and the actions and interventions taken going forward.

Yours

Hon. (Amb.) Ukur Yatani, EGH
CABINET SECRETARY/NATIONAL TREASURY & PLANNING

Currently, the country is experiencing stock outs of these commodities, and in order to mitigate worsening the situation, the Ministry has opted to pay the pending taxes and levies to get the commodities cleared. Details of the imported commodities that are pending clearance at the Port and Customs bonded facility at Philips Healthcare Ltd. are as follows: -

S/No.	Commodity Description	AWB/BL No.	Invoice No.	Value (USD)	Tax Amount due (Ksh)
A	**Laboratory Commodities (Equipment/Reagents)**				
1	DBS	SCPTAE2012050	13336	5,264,910.12	1,132,207.00
2	Solid bag waste	176-23480553	8304784895	266,824.06	134,998.00
3	Cobas reagent and supplies	176-23480542	8304784896	50,321.00	2,834,967.00
4	KIT Cap	176-28292390	8304784787	363,676.28	8,728,120.00
5	KIT cap Pre extract	176-28292342	8304784790	20,433.00	491,464.00
6	KIT cap consumables	176-23480516	8304784871	88,091.00	3,611,546.00
7	Cobas reagents and supplies	176-28292364	8304784786	1,172,670.64	28,124,333.00
				7,226,926.10	**45,057,635.00**
B	**HIV Medicines (ARVs)**				
1	TLD	INBOM681877	MP2312001304	4,031,913.78	222,005.26
2	TLD	N/A	LLL-CHEMONICS-USAID-0123	4,608,221.76	253,702.20
3	TLD	USG0164427	LLL-CHEMONICS-USAID-0107	2,335,500.00	128,702.50
4	TLD	USG0164599	IOU/20-21/1061	987,148.80	54,543.18
5	TLD	USG0164699	IOU/20-21/1062	1,001,011.20	55,305.62
6	TLD	USG0164699	IOU/20-21/1068	976,934.40	53,981.39
	Subtotal			**13,940,729.94**	**768,240.15**
	GRAND TOTAL			**21,167,656.04**	**45,825,875.15**

The purpose of this letter is therefore to request you to issue the Commissioner General- Kenya Revenue Authority with an undertaking by this Ministry to pay taxes and levies amounting **Ksh. 45,825,875.15**, and also for KRA to release the commodities as the Ministry finalizes the payment process.

Yours Sincerely

Hon. Sen. Mutahi Kagwe, EGH
CABINET SECRETARY

Copies to. Principal Secretary
Ministry of Health

Principal Secretary
The National Treasury

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Office of the Commissioner General

KRA/5/1002/5(5496)

30th April 2021

Mr. Michael Sialai, EBS
Clerk of the National Assembly
P. O. Box 41842-00100
Parliament Buildings
Nairobi

Dear Mr. Sialai, EBS

INVITATION FOR A VIRTUAL MEETING WITH THE DEPARTMENTAL COMMITTEE ON HEALTH REGARDING ARVs CLEARANCE STANDOFF

We acknowledge receipt of your letter Ref: NA/DCS/HEALTH/2021(11) dated 28th April 2021 inviting the Authority to the above mentioned meeting on Tuesday, 4th May 2021 at 9.00am.

The Authority will be represented by Ms. Lilian Nyawanda, Commissioner of Customs and Border Control who is conversant with the matter at hand.

Enclosed is our submission on the matter for consideration by the Committee.

Yours sincerely,

CS P. M. Matuku
AG. COMMISSIONER GENERAL

Tulipe Ushuru, Tujitegemee!

Confidential

REPORT TO THE NATIONAL ASSEMBLY DEPARTMENTAL COMMITTEE ON HEALTH ON THE ARVs CONSIGNMENT AT THE PORT OF MOMBASA

APRIL 2021

KENYA REVENUE AUTHORITY
Confirmed
P. O. Box 48240 - 00100, NAIROBI
Date:..
Sign:..

1.0 INTRODUCTION

The National Assembly Departmental Committee on Health vide its letter **Ref: NA/DCS/HEALTH/2021(09),** dated 12th April, 2021 invited Kenya Revenue Authority (KRA) to appear before it to provide information on the following issues:

1. What is the total volume of the consignment of HIV/AIDS commodities being held at the Port?
2. Has the process of paying the taxes and levies for the HIV/AIDS commodities been concluded?
3. When will the consignment that incudes HIV testing commodities, ARVs and laboratories reagents be released from the Port?

This report details Kenya Revenue Authority (KRA)'s response to the above queries.

2.0 KRA RESPONSES

2.1 Total Volume of the Consignment of HIV/AIDS Commodities being Held at the Port

A total of thirteen- forty foot containers (13x40') i.e 10x40' imported by Bollore Logistics Thailand Co Limited and 3x40' imported by Lauraus Lab Limited are currently lying at Mombasa Container Terminal (MCT) Transit Shed.

The table below show the total volumes of the HIV/AIDS cosignment commodities held at MCT:

Table 1: Total volumes held at MCT

BL	ORIGIN	DESCRIPTION	VESSEL	ETA	VOLUMES	WEIGHT (KGS)
608219817	Thailand	ORAQUICK HIV SELF-TEST (5X4-1001.002B ORAQUICK HIV 1/2 (250 CT))	JOHANNES MAERSK	5-Feb-21	8*40 Containers carrying 151 pallets/2400 boxes/520,750 test kits	29,352
USG0164427	India	DOLUTEGRAVIR,LAMIVUDINE AND TENOFOVIR DISOPROXIL FUMARATE TABLETS	XPRESS KILIMAJRO	20-Feb-21	3*40 Containers carrying 113 pallets/ 3150	32,871
USG0165631	India	PHARMACEUTICALS (ATAZOR - R TABLETS (ATAZANAVIR 300MG + RITONAVIR 100MG)	EMIRATES ASANTE	5-Mar-21	2*40 Containers carrying 189 pallets/ 3493 boxes	22,277
Total					**13*40 ft**	**84,500**

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Date: 30/04/2021
Sign: [signature]

2.2 Has the process of paying the taxes and levies for the HIV/AIDS commodities been concluded?

The Ministry of Health vide their letter **Ref: MOH/MED/11/3/1** dated 31st March 2021 to National Treasury and Planning herein attached to this report as **Annex 1** requested the National Treasury & Planning to issue an undertaking to KRA on its behalf to pay taxes amounting to **Kshs. 45,825,875.15.**

The National Treasury and Planning through its letter **Ref: DFN 415/232/011** dated 6th April 2021 conveyed the decision to undertake to pay the taxes, Railway Development Levy (RDL) and Import Declaration Fees (IDF) for the thirteen (13) consignments of medical commodities to the USAID. KRA responded to National Treasury and Planning with regard to the undertaking vide its letter Ref: KRA/5/1002/26(5440), dated 7th April 2021, herein attached to this report.

KRA is in constant engagement with Bollore Transport Logistics (BTL), the Clearing Agent for the consignment to establish the progress they are making in lodging of the entries. BTL reported that they were yet to receive the approved permit from the Pharmacy and Poisons Board, hence unable to lodge an entry and make any progress.

2.3 When will the Consignment that incudes HIV Testing Commodities, ARVs and Laboratories Reagents Be Released from the Port?

Since January 2021, KRA has cleared 78*40 foot and 1*20 foot containers of medical supplies consigned to Ms. Chemonics. Only 13*40 foot consignments detailed in Table above are lying at the MCT CFS, pending Customs clearance.

KRA's role in the cargo clearance process begins once the consignment has been entered (A Customs entry has been lodged) and applicable taxes or levies paid, as automatically computed by the system.

Imported cargo is subject to clearance by various Government Regulatory Agencies. In the case of these consignments, the Pharmacy and Poisons Board Permit and the Port Health releases must be obtained before Customs release.

The importer is additionally required to clear port storage and handling charges before the cargo can be physically removed from the Port.

Clearance of exemption cargo begins with the issuance of an exemption code, by KRA, that enables the system to omit computation of the exempted tax-heads. Customs procedures however, allow for goods to be entered provisionally, pending exemption approval from the National Treasury.

KRA is keen on facilitating the expedited clearance of these consignments once the clearance process is initiated by the importer's Clearing Agent.

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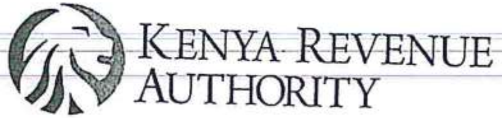
Date: 30/04/2021
Sign: ....

Currently, the cargo remains un-entered because the Clearing Agent (Bollore Transport Logistics) is yet to receive the approved permit from the Pharmacy and Poisons Board, requisite for Customs clearance. Once BTL or its clearing agent obtains the permit from the Pharmacy and Poisons Board they will be able to lodge a Customs entry which will allow the processing of the containers for release.

3.0 CONCLUSION

In conclusion we would like to reiterate to the Committee, KRA's commitment to facilitating clearance of the said consignments once the process is initiated by the Clearing Agent, and that the Authority is ready to provide any additional information that may be required by this Committee.

KENYA REVENUE AUTHORITY
Confirmed
P. O. Box 48240 - 00100, NAIROBI
Date: 30/06/2021
Sign:



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Office of the Commissioner General

KRA/5/1002/26(5440)

7th April 2021

Hon. (Amb.) Ukur Yattani, EGH
Cabinet Secretary
The National Treasury & Planning
Nairobi

Dear CS NT,

PAYMENT OF TAXES, RAILWAY DEVELOPMENT LEVY AND IMPORT DECLARATION FEES: MEDICAL COMMODITIES IMPORTED UNDER THE USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM

We refer to your letter Ref: DFN 415/232/011 dated 6th April 2021 and the referenced Ministry of Health (MOH) letter Ref: MOH/MED/11/3/1 dated 31/03/2021 on the above subject.

We take note of the National Treasury undertaking to pay the taxes, Railway Development Levy (RDL) and Import Declaration Fees (IDF) amounting to **Ksh. 45,825,875.15** for the thirteen (13) consignments of medical commodities to the USAID. On the strength of this undertaking, we are proceeding to release all the consignments. However, we wish to highlight the following:

1. The Ministry of Health (MOH) letter indicates that taxes payable amount to **Ksh. 45,825,875.15** but our calculation based on the values provided in the aforementioned letter indicate that the amount of IDF and RDL payable is **Ksh. 113,364,871** thus a variance of **Ksh. 67,667,699** which is subject to an additional undertaking.

	AWB/ BL NO	VALUE (USD)	MOH TAX CALCULATION (KSHS) (A)	KRA CALCULATION (KSHS) (B)	VARIANCE (KSHS) (C= A-B)
A	LABORATORY COMMODITIES (EQUIPEMENT/ REAGENTS				
1	SCPTAE2012050	5,264,910	1,132,207	31,693,443	-30,561,236
2	176-23480553	266,824	134,998	1,606,214	-1,471,216
3	176-23480542	50,321	2,834,967	302,920	2,532,047
4	176-28292390	363,676	8,728,120	2,189,240	6,538,880
5	176-28292342	20,433	491,464	123,002	368,462
6	176-23480516	88,091	3,611,546	530,286	3,081,260
7	176-28292364	1,172,671	28,124,333	7,059,184	21,065,149
Sub Total		7,226,926	45,057,635	43,504,288	1,553,347
B	HIV MEDICINES (ARVs)				
1	INBOM681877	4,031,914	222,005	24,271,113	-24,049,108
2	N/A	4,608,222	253,702	27,740,343	-27,486,641
4	USG0164699	987,149	54,543	5,942,389	-5,887,846
5	USG0164699	1,001,011	55,306	6,025,837	-5,970,532
6	USG0164699	976,934	53,981	5,880,901	-5,826,919
Sub Total		11,605,230	639,537	69,860,583	-69,221,046
Grand Total		18,832,156	45,697,172	113,364,871	-67,667,699

2. Further, a consignment covered by BL Number USG0164427 (3*40ft Containers of ARVs) is manifested as consigned to Kampala, Uganda. This consignment has been excluded from the tax computation above.

BL NUMBER	CONTAINER NO	CONT SIZE	DESCRIPTION
USG0164427	TTNU8699401, CGMU5346621, TTNU8446810	3X40	Pharmaceutical Products **IN TRANSIT TO Kampala , Uganda**

As a result, and subject to any further clarification which may be given by the MOH, we request that:

a) The MOH provides clarity on the consignments subject to the National Treasury's undertaking.

b) The National Treasury undertaking be adjusted to reflect the correct amount of taxes due.

Yours sincerely,

CS P. M. Matuku
AG. COMMISSIONER GENERAL

Copy to: Sen. Mutahi Kagwe, EGH
Cabinet Secretary
Ministry of Health
Nairobi

Ms. Susan N. Mochache, CBS
Principal Secretary
Ministry of Health
Nairobi

Dr. Julius Muia, PhD, CBS
Principal Secretary
The National Treasury
Nairobi

REPUBLIC OF KENYA
THE NATIONAL TREASURY AND PLANNING

Telegraphic Address: 22921
FINANCE – NAIROBI
Fax No. 315779
Telephone: 2252299

THE NATIONAL TREASURY
P.O. Box 30007 - 00100
NAIROBI
KENYA

Ref. No. DFN 415/232/011

6th April, 2021

KENYA REVENUE AUTHORITY
COMMISSIONER GENERAL'S OFFICE
FORWARDED
07 APR 2021
TO COMMISSIONER C&BC
TIME: 1:50 CG

Mr. Githii Mburu, CBS
Commissioner General
Kenya Revenue Authority
NAIROBI

Dear CG,

RE: PAYMENT OF TAXES, RAILWAY DEVELOPMENT LEVY AND IMPORT DECLARATION FEES: MEDICAL COMMODITIES IMPORTED UNDER THE USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM

Reference is made to a letter Ref. No. MOH/MED/11/3/1 dated 31st March, 2021 (copy attached) from the Cabinet Secretary, Ministry of Health on the importation of the following medical commodities.

No.	Commodity Description	AWB/BL No.	Invoice No.	Value (USD)	Tax Amount due (Ksh)
A	Laboratory Commodities (Equipment/Reagents)				
1	DBS	SCPTAE2012050	13336	5,264,910.12	1,132,207.00
2	Solid bag waste	176-23480553	8304784895	266,824.06	134,998.00
3	Cobas reagent and supplies	176-23480542	8304784896	50,321.00	2,834,967.00
4	KIT Cap	176-28292390	8304784787	363,676.28	8,728,120.00
5	KIT cap Pre extract	176-28292342	8304784790	20,433.00	491,464.00
6	KIT cap consumables	176-23480516	8304784871	88,091.00	3,611,546.00
7	Cobas reagents and supplies	176-28292364	8304784786	1,172,670.64	28,124,333.00
				7,226,926.10	45,057,635.00

B	HIV Medicines (ARVs)				
1	TLD	INBOM681877	MP2312001304	4,031,913.78	222,005.26
2	TLD	N/A	LLL-CHEMONICS-USAID-0123	4,608,221.76	253,702.20
3	TLD	USG0164427	LLL-CHEMONICS-USAID-0107	2,335,500.00	128,702.50
4	TLD	USG0164699	IOU/20-21/1061	987,148.80	54,543.18
5	TLD	USG0164699	IOU/20-21/1062	1,001,011.20	55,305.62
6	TLD	USG0164699	IOU/20-21/1068	976,934.40	53,981.39
	Subtotal			13,940,729.94	768,240.15
	GRAND TOTAL			21,167,656.04	45,825,875.15

Since there is no framework between the Government of Kenya and USAID there is no provision of exemption. However, considering the importance of the above mentioned commodities in the enhancement of service delivery in the health sector, particularly during this time of Covid-19 pandemic, the Government through the National Treasury and Planning undertakes to pay the taxes, Railway Development levy and Import Declaration fee due on these commodities.

By a copy of this letter, the Ministry of Health is advised to follow-up the matter with the Kenya Revenue Authority and provide the necessary documents to facilitate customs clearance.

Yours Sincerely,

HON. (AMB) UKUR YATANI, EGH
CABINET SECRETARY/THE NATIONAL TREASURY & PLANNING

Copy to:

The Commissioner of Customs and Border Control
Kenya Revenue Authority
NAIROBI

Sen. Mutahi Kagwe, EGH
Cabinet Secretary
Ministry of Health
NAIROBI

Ms. Susan N. Mochache, CBS
Principal Secretary
Ministry of Health
NAIROBI

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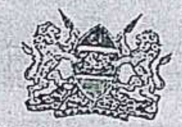


MINISTRY OF HEALTH
OFFICE OF THE CABINET SECRETARY

Telephone: Nairobi 254-20-2717077
Fax: 254-20-2719008
Email: pshealthke@gmail.com

AFYA HOUSE
CATHEDRAL ROAD
P.O Box 30016 -00100
NAIROBI

When replying please quote

REF: MOH/MED/11/3/1

31st March, 2021

Hon. (Amb.) Ukur Yatani, EGH
Cabinet Secretary
National Treasury & Planning
NAIROBI

Dear Waziri,

RE: MEDICAL COMMODITIES IMOPRTED UNDER THE USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM

The Government of the United States through the United States Agency for International Development (USAID) has continued to support the Government of Kenya with supply of various medical commodities. Among these commodities include anti-malarial drugs, HIV medicines, laboratory reagents, etc.

Two main vehicles have been used for importation of these commodities. One is the Grant Aid funded KEMSA-Medical Commodities Project (MCP) which ended on 24th December, 2020 and the USAID- Global Health Supply Chain Program (GHSCP) where importation is done through a third party.

Although the ministry has not experienced any challenges regarding tax exemption on commodities imported under MCP, challenges have been encountered regarding those imported under GHSCP. The main reason being lack of engagement framework between the Ministry and USAID to enable granting of tax exemption by the National Treasury. The process of formalizing the engagement framework is however in progress in line with Development Cooperation Framework Agreement between the US and Kenya Government, and the Treasury Circular No.9/2018.

Meanwhile, in order to avert commodity stock outs in the country, USAID imported some medical commodities under GHSCP. These commodities attract taxes and levies and therefore could not be released by Customs unless taxes are paid or exemption is granted. Some temperature sensitive commodities were cleared under Customs security bond and transferred to Customs bonded facilities for refrigeration.

MINISTRY OF HEALTH

RESPONSES TO ALLEGED STALEMATE ON HIV/AIDS COMMODITIES WITH THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

The Ministry refers to a communication from the Clerk of the Senate vide letter Ref. No. SEN/DCO/CORR/SCH/02/013/2021/ (1) dated 16th April, 2021.

Please find comprehensive responses on the issues raised;

Question 1. The terms and conditions of the USAID grant for HIV/AIDS antiretroviral (ARV) commodities, and other essential drugs such as antimalarials, anti-tuberculosis treatment, e.t.c.

The overall framework that guides the donations of HIV commodities from USAID are contained in an annual agreement between the Kenya Government and United States, Kenya's Country Operational Plan (*COP*). The plan is a public document that is usually available from *PEPFAR's* website www.state.gov.

Since October 2015, the terms and conditions for management of USAID donations of HIV/AIDS antiretroviral (ARV) commodities and other essential drugs, such as antimalarials, anti-tuberculosis treatment are outlined in a Medical Commodities Program (KEMSA MCP), a contractual arrangement between USAID and Kenya Medical Supplies Agency (KEMSA) to procure, warehouse and distribute medical supplies. These donations are included in the country annual forecasting and quantification plans that serves as a further reference document, that is utilized to create a pipeline of commodities donated or procured by the Government of Kenya.

Question 2. Relevant information regarding existing donor financing arrangements between the Government of Kenya and development partners, particularly, USAID and the Global Fund on the provision of ARVs and other essential medical commodities;

USAID donations to Kenya on provision of ARVs and other essential commodities have been managed premised on contract with the KEMSA, named as KEMSA Medical Commodities Program (KEMSA MCP). The first KEMSA MCP was signed on 1st October, 2015 to 25th September, 2020, as a flagship framework contracting Kenya Medical Supplies Agency to procure, warehouse and distribute medical supplies donated by the US Government to the Government of Kenya, through the USAID.

Global fund, grants Kenya funds to procure HIV commodities during the grant period. The current grant is called NFM2 2018-2021. The grants are three years, and the Government of Kenya negotiates with Global fund the proportion of funds that will be for procuring HIV commodities and programmatic. Once the grant is approved the funds are disbursed to The National Treasury, whereas the Ministry of Health provides the technical specifications and quantities of the HIV commodities to be procured.

Question 3. A chronology of the events and circumstances that led to the stalemate between the Government of Kenya and USAID with regard to the HIV/AIDS antiretroviral (ARV) crisis.

For the last five years since 25th September, 2015, the USAID donations have been managed through a five-year contract between KEMSA and USAID . The contract was to end on 24th September, 2020. However, before its lapse it was extended to 24th December, 2020 under the same terms (procurement, warehousing, and distribution).

Prior to the reviewed terms, USAID requested KEMSA to provide a close out plan at the expiry of contractual arrangement in line with their normal procedures of programme close out.

Before the end of the extension period the USAID reviewed the terms in the contract to only warehousing and distribution, and excluding procurement. The extension period was further revised to 23rd April, 2021.

The Cabinet Secretary, Ministry of Health requested for a meeting with the representatives of United States Government and the Ministry of Foreign Affairs on the 17th March, 2021. The Ministry was seeking to understand the stalemate over the HIV/AIDS commodities that were being held at the port of entry. The meeting established that the consignment in question was imported without the Ministry's prior knowledge, and outside of the agreed framework. In an effort to address this matter, the Ministry called for the said meeting to agree on the way forward. It's in this discourse of engagement that USAID elaborated on their intention to review the existing collaboration.

However, in order to progress with the matter and for the sake of Kenyans living with HIV, the Ministry of Health proactively engaged the National Treasury to provide Kshs.500 Million in the Supplementary Estimates that would be used to pay importation duty. The unexpected delivery by a private company was not communicated in good time to allow for planning and avoiding funds for taxes.

At the meeting the United States Government indicated that they would like to use a third party apart from KEMSA. In that regard, the Ministry requested a technical meeting to come up with a framework to support this. This led to a meeting on 19th April, 2021.

This matter is still being discussed between the MoH and US Government.

Further, the Cabinet Secretary urged the US Embassy to revert to using KEMSA, because the Ministry of Health was willing to take the necessary remedial action at the Agency to increase transparency and eradicate misappropriation of funds.

Question 4. What triggered the impasse and what remedial and/or mitigating actions the Government of Kenya may have taken to try and prevent it;

The impasse was as a result of several factors;

i) Lack of communication from USAID on their intention to move away from the systems of procurement, warehousing and distribution that has previously been used under KEMSA Medical Commodities Program for procurement, warehousing, and distribution of commodities.

ii) USAID decision to use a private company to procure their commitment of donations to Kenya without prior knowledge or notification to the Ministry of Health, thereby attracting tax and other levies in line with the country taxation laws. USAID cited challenges with KEMSA for this move but did not provide sufficient information on the undiplomatic manner in which their decision to move away from KEMSA was done.

iii) USAID failure to effectively communicate on a delay in the consignment of ARVs expected by October 2020 as stipulated on the annual forecasting and quantification frameworks which they subscribe to. The plan is organized within utmost good faith where all donations are expected to be delivered within agreed timelines thereby ensuring interruption of the supply chain does not occur.

The Ministry initiated communications and invitations to meet USAID to understand the challenges they were facing on this subject matter. There were delays on their part to honor this invitation until the 26th January, 2021, meeting and USAID letter dated 29th January, 2021, where the Ministry was informed of their challenge of clearing the donations.

Upon receiving this letter, the Ministry factored in the required amounts of taxes based on commitments included in the Kenya Country Operational Plan 20 and initiated a budgetary approval process through the Parliamentary Health Committee in February 2019 to clear the consignments from USAID. Once the budget was secured and relevant documents provided by USAID as required of tax clearance, the Ministry requested National Treasury to clear the donations of

ARVS and other commodities with additional commitments to remit the required taxes in accordance with the law. To date, the Ministry of Health has an undertaking to pay taxes worth Kes. 45,825,875.18 being amounts of the taxes required for commodities at the port as per the invoices provided by USAID. The Ministry has further directed KEMSA to expedite distribution of the commodities released by USAID.

To prevent re-occurrence of this matter, the Ministry of Health guided USAID to sign a contractual framework that allows for tax exemptions in line with the Kenya taxation policies. In addition, USAID was advised to change the consignee of their donations to Ministry of Health or other relevant agencies to enable swift customs clearance and tax issues that a private consignee attracts. Furthermore, the Ministry of Health initiated reforms of KEMSA through establishment of a KEMSA Reforms committee with support from development partners of Health in Kenya which USAID is a member.

Chair and Honourable Members, I therefore submit that the Ministry of Health has remained pro-active to help resolve the challenges experienced by USAID in bringing their donations to Kenya.

Question 5. What actions/interventions were taken to address the ARV crisis when it occurred, and whether they constituted a stop-gap measure or a permanent solution

In order to avert the ARVs crisis, the Ministry of Health actioned as follows;

1. To avert a total stock out at the patient level, the Ministry issued guidelines for shorter term drug prescriptions. The temporary shift from a beneficial arrangement of 3- 6 multi-month ARVs scripting was initiated to ensure no patient missed their doses during the crisis.

2. The Ministry of Health further initiated a process to call down other consignments funded by the Global Fund and Government of Kenya. This move was taken to re-stock and solve the temporary ARVs crisis.

3. As indicated in my response earlier, and evidence presented to the Senate, the Ministry of Health has been in constant discussions with USAID to ensure that they are facilitated to clear the consignments of donations of ARVS and essential commodities.

In addition, to these stop-gap measures the Ministry of Health has explored long term solutions. These include recommendations to; Secure and ring fence domestic resources for procurement of life saving commodities; expedite plans for local production of health products and technologies for self-sufficiency. Donor diversification through forging new partnerships with non-traditional donor countries remain a viable option.

Question 6. What actions the Government of Kenya is taking, if any, to reduce donor dependency on ARVs and other essential medical commodities;

Kenya has over the years relied on traditional bilateral and multilateral agreements. This funding is largely provided through an off -budget arrangement which is subject to conditionalities and manipulations that undermine the quest for institutional capacity building. While it may not be feasible for immediate self-reliance for procurements of all lifesaving and priority strategic public health program commodities needs.

Kenya has been on the quest to increase domestic resources for Health. The Ministry of Health is cognisant of the disruption of the global health funding landscape that has been occasioned by the emergence of the COVID-19 pandemic. Further, the share of external financing in Kenya is likely to decline because of rapid growth and rebasing of the Kenyan economy. In 2020, Kenya had the third largest economy in Sub-Saharan Africa with a GDP of US$ 1,817 per capita (World Bank 2019). Global patterns show external funding accounts for less than one- third of public health spending in most countries with GDP per capita around US$ 2,000. These factors will largely impact on programmes that are heavily dependent on external resources.

The Ministry of Health has taken the following actions;

1. Enhanced domestic resource mobilization.

Anticipating reductions in external resources in HIV response, the allocation of domestic resource envelope has increased from 13% in 2013 to 32% in 2020. The Ministry of Health further plans to secure additional resources to increase on the share of domestic resources specially to procure lifesaving ARVS and for financing strategic health programs.

2 Enhanced efficiency and effectiveness in resource utilization

The Ministry of Health has initiated plans to restructure strategic health programmes to create synergies, eliminate duplication and gain on efficiencies.

3 Resource transition planning

The Ministry of Health has embarked in a process to develop a Health Financing Transition Plan. This plan will provide short term and long-term options for resource mobilization.

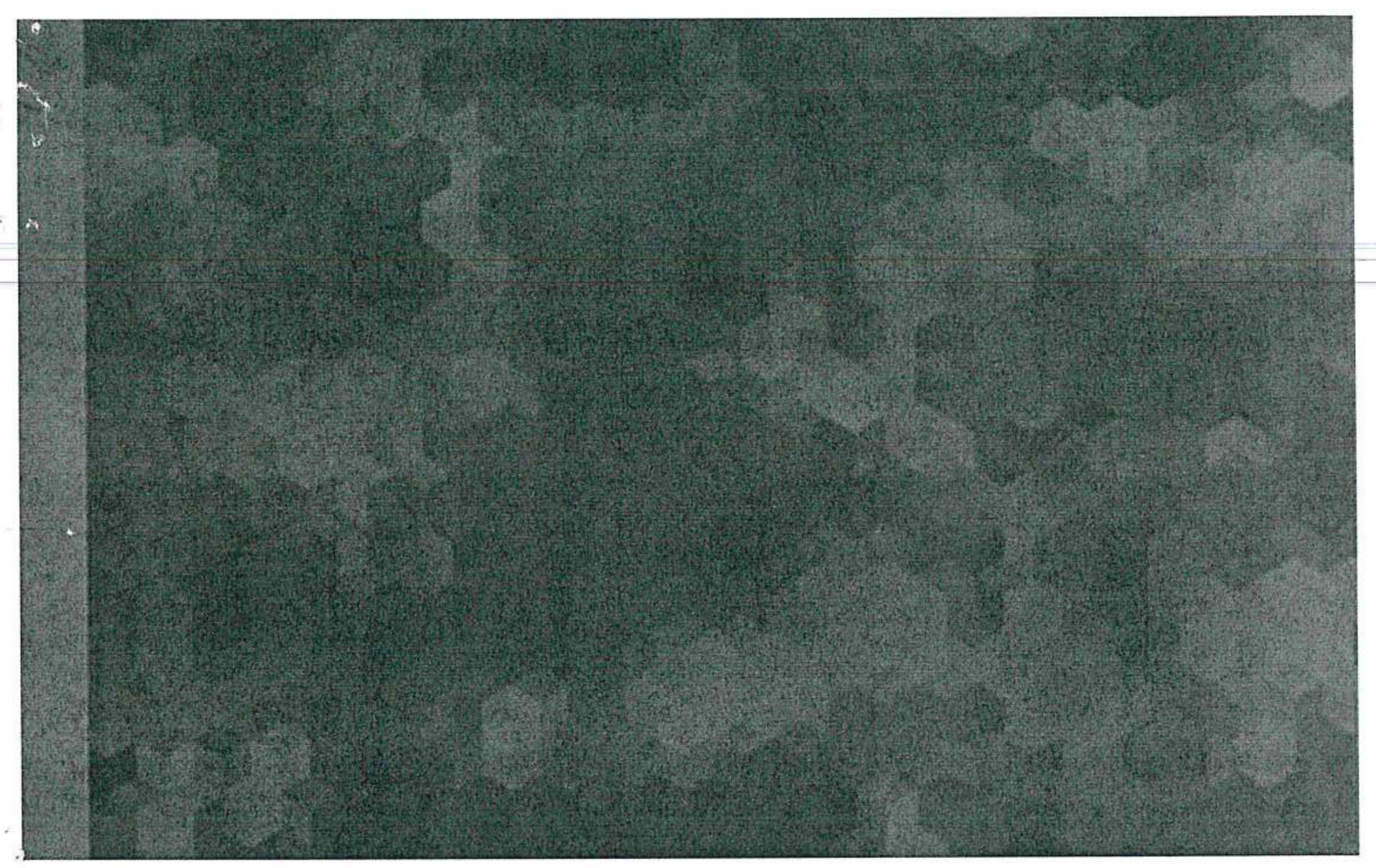
Question 7. What remedial legislative measures or interventions may be required to avert similar occurrences in the future, not only for ARVs, but also other essential medical commodities such as antimalarials, anti-TB treatment etc.

It is the desire of every Country to achieve self-reliance in providing Universal Health Access to her citizen. It is therefore important to develop a legal framework that will ring fence funding for strategic health programmes at the County and National level specifically in regards to medicines and health products. Further this desire will require legal framework to establish institutions with the authority to direct both domestic and off-budget funding.

SEN. MUTAHI KAGWE, EGH,
CABINET SECRETARY.

cc. Principal Secretary
Ministry of Health

30 April, 2021



INVESTIGATION REPORT

Nigeria Supply Chain

Sub-contractor invoice fraud resulted in substantial overcharging

GF-OIG-21-002
9 March 2021
Geneva, Switzerland

The Global Fund
Office of the Inspector General

2. Findings

2.1 Zenith Carex inflated invoices for cold chain commodity distribution services ten-fold, defrauding the Global Fund of US$3 million

Zenith was the primary vendor for both Long-Haul distribution (between warehouses in Abuja, Lagos and Jos) and Last Mile Delivery ("LMD") of cold chain commodities - specialized, low volume items such as HIV testing reagents - to 400 health facilities across Nigeria. Despite cold chain being a low-volume commodity compared to the overall commodities distributed in Nigeria, Zenith's costs were disproportionately high: over one-quarter of total LMD fees, and approximately half of total Long-Haul charges.

Figure 2: Map of Nigeria

Zenith inflated Long-Haul invoices, overcharging the Global Fund by US$712,588

Zenith was paid US$766,223 for Global Fund-related Long-Haul cold chain services, which under the terms of the contract were valued at US$53,636. Zenith defrauded the Global Fund by US$712,588, or 93% of the total charges, by invoicing for **truck tonnage** (the gross weight of the trucks used to transport goods). This was contrary to the distribution contract, and Chemonics' Request for Proposal (RFP) to potential vendors, which stated that Long-Haul cold chain charges were to be based on **commodity weight** (the actual kilogram weight of the goods transported).

This scheme started from the first invoice Zenith submitted to Chemonics in August 2017, which charged US$33,953 for transporting 60,000 kilograms from Abuja to Jos. Zenith inflated the charges tenfold: supporting documentation revealed that only 6,009 kg of packaged commodities had been transported, which should have cost US$3,400. Zenith continued invoicing in truck tonnage until June 2019, invoicing from 2 tons (2,000 kg) to 215 tons (215,000kg) on 113 routes.

In July 2018, Zenith charged the Program US$159,972 for a 210-ton delivery from Abuja to Lagos Premier Medical Warehouse, the single highest charge invoiced for a Long-Haul route. OIG found the 210-ton charge, equivalent to multiple shipping containers, implausible based on the total volume of cold chain commodities in the supply chain: the largest single import of cold chain commodities into Nigeria was nine tons, also in July 2018. Supporting documentation (Proofs of Delivery, "POD") showed only two vehicle movements on the route; OIG calculated the charge should have been US$11,198 for an estimated 14,700 kilograms of packaged commodities.

Zenith confirmed invoicing Long Haul based on truck tonnage, saying this reflected the vehicle volumes required to transport the commodities. Zenith claimed they received verbal approval to charge by truck tonnage in a 2017 meeting with a former Chemonics procurement specialist, but could provide no records, or contract amendment, to support this.

Additionally, Zenith misrepresented the capacity of the vehicles deployed, increasing the overcharging. Several charges were beyond the capacity of the vehicles in Zenith's fleet. Different routes completed by vehicles with the same registration were invoiced at different tonnages, with some charges exceeding vehicle tonnage. For example, one vehicle with an estimated gross truck weight of seven tons was associated with invoiced charges for 5, 10, 15, 25, 35 and 75-ton routes.

Following the Local Fund Agent's review in 2019, Zenith changed its invoicing practice and began invoicing in commodity weight rather than truck tonnage. The commodity weight charged, however, continued to be fraudulently inflated by up to ten times. A 3 March 2020 POD did not have any box or shipment weights recorded from the dispatch or delivery warehouse, indicating Zenith recorded unverified commodity weights after the delivery cycle, to match the fraudulent invoice.

Zenith fraudulently inflated Last Mile Delivery invoices by US$2.3 million

From May 2017, Zenith misrepresented its delivery practices and inflated LMD invoices for a period of over two years, overcharging the Global Fund by US$2,284,518, or 91% of US$2.6 million LMD fees. Zenith invoiced the Program for expensive '**direct**' deliveries, defined in the RFP as dedicated delivery to **three facilities or less**, when they should have charged for '**drops**', defined as **more than three health facilities per route,** resulting in extensive overcharging. These definitions for the two LMD route types - drop and direct - were not included in the distribution contract.

The OIG reviewed over 3,000 PODs and found Zenith usually deployed one vehicle per state for LMD. Deliveries for all health facilities in a state were typically loaded concurrently into the same vehicle at dispatch warehouses. The vehicle would then deliver to between five and 20 health facilities over a two/three-day period before returning to the warehouse. These deliveries should have been charged as 'drops', because the trucks visited more than three facilities, but Zenith predominately charged for 'direct' deliveries. Zenith's mean 'direct' rate was 32 times more expensive than the equivalent 'drop' rate for the same route, leading to extensive overcharging. This practice was evident in Zenith's deliveries across all of Nigeria throughout the life of the project.

Example. On 26 March 2018, a Zenith vehicle in Abuja was supplied with orders for 14 health facilities in Edo state. The vehicle completed all 14 deliveries on 27 and 28 March. As the truck delivered to more than three health facilities, 'drop' rates should have applied. Instead, Zenith charged **US$16,881** for 11 separate 'direct' deliveries from Abuja; if 'drop' prices had been applied, the charge would have been **US$586.**

Tender awarded on 'drop' pricing

Chemonics awarded the 2017 tender to the lowest price, technically qualified bidder. The financial evaluation only took 'drop' prices into account, indicative of the intended delivery method. Direct rates were higher to compensate for the fixed expense of driving directly from the warehouse to the first health facility on a route, and were anticipated to be used for high-volume or emergency deliveries. Zenith's drop prices were around two-thirds cheaper than their competitors, while their direct rates were by far the highest. On average, Zenith needed to complete 32 'drop' deliveries to generate the same revenue as one single direct route. By comparison, other bidders' direct prices were between three and nine times higher than drop prices. Chemonics failed to identify, even when Zenith's sub-contract ceiling was raised in May 2019 due to a cost overrun, that very few drop deliveries were being invoiced.

Chemonics confirmed the 'drop' and 'direct' definitions were not included in the distribution contracts. Chemonics told investigators they intended that 'direct' rates would apply for routes to one to three health facilities within one Local Government Area (LGA), and 'drop' rates for four or more'; however, the definitions of the two route types in the RFP did not refer to LGAs. Other interviewees stated a route should start and finish at a warehouse.

Zenith consistently charged for numerous 'direct' routes, when the same vehicle delivered to multiple health facilities on the same day, exploiting their own LGA-based interpretation of route, which lacked a contractual basis and did not provide value for money for donors. Zenith charged separate direct fees from the warehouse to each health facility visited on a route by the same delivery vehicle.

Example. In April 2019, a Zenith truck delivered to six facilities in four neighboring LGAs in Ibadan, in the space of three hours. Zenith charged the program for four separate Lagos-Ibadan direct deliveries.

OIG found the 'LGA' definition, while aligned to Zenith's practices, was inconsistent with other distributors, who routinely charged for a single route for deliveries from central warehouses to facilities in multiple LGAs involving only one truck. Zenith further overcharged by invoicing the Program for multiple 'direct' rates within the same LGA, failing to adhere even to the broadest definition of routes.

Example. In January 2019, one Zenith vehicle dropped supplies to 11 facilities in Adamawa, including four facilities in Yola North LGA. Zenith invoiced nine direct routes, including two for the Yola North deliveries, failing to invoice drops in line with even the broadest possible interpretation of routes. By contrast, another vendor completing non-cold chain LMD in Adamawa in September 2018 completed 12 direct routes, seven of which delivered to facilities in different LGAs.

In 2019, Zenith told Chemonics that their 2017 'drop' rates, on which they won the tender, were below cost. The OIG found Zenith's 2017 bid pricing – with very low drop and very high direct rates – was suspicious, and likely undercut competitors with an artificially low drop cost as part of a 'bait and switch' scheme, where Zenith intended to incorrectly charge for the more expensive 'direct' rates. Zenith increased the proportion of more expensive direct routes over time. In May 2017, 78% of the routes invoiced by Zenith were 'drops'. The number of drop routes then steadily decreased to 2% in January 2019, resulting in significantly higher costs per cycle, as shown in Figure 3.

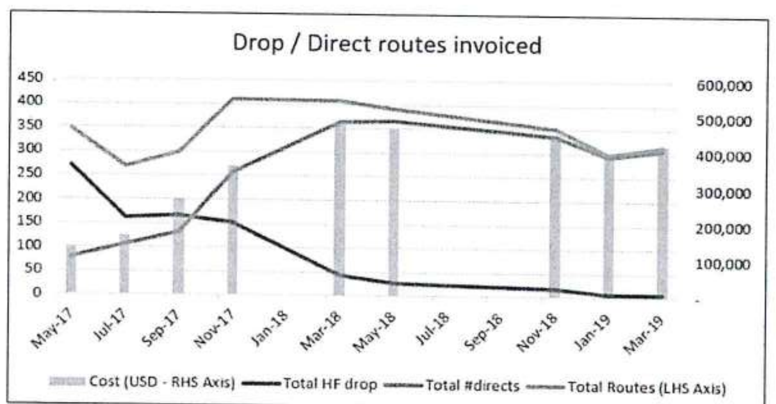


Figure 3: Number of routes (Left Axis, lines) per type and resulting total cost (Right Axis, bars), select months only.

Zenith responded that they prepared routes and invoices per Local Government Area. They rejected the OIG's findings as a 'total falsehood' but did not provide evidence that altered the OIG's conclusions.

Chemonics agreed that Zenith defrauded the Program through deceptive practices. Chemonics proposed the Global Fund's recoverable amount consider the reasonable economic value of the services completed. The OIG agreed that distribution services were largely executed on time and in full. Acknowledging the 'bait and switch' of Zenith's aggressive bid pricing, and that some routes at the contractual prices may have been below the cost of service, the OIG adjusted the proposed recoverable amounts to be based on the next-cheapest 2017 bid. These adjustments (proposed recoverables: Long-Haul US$607,887 and LMD US$2,115,480) are reflected in the difference between the non-compliant and proposed recoverable amounts presented in the Executive Summary.

Chemonics also requested the recoverable amount be adjusted to reflect their stated intention for Local Government Areas to be a feature of the drop/direct LMD pricing definitions. Based on the evidence obtained in the investigation, the OIG concluded not to adjust the amount in that manner.

Based on the above, the OIG and the Global Fund Secretariat have agreed that:

Agreed Management Action 1:

Based on the findings of this report, the Secretariat will finalize and pursue from Chemonics an appropriate recoverable amount from the non-compliant expenditures identified in this report. This amount will be determined by the Secretariat in accordance with its evaluation of applicable legal rights and obligations and associated determination of recoverability.

Agreed Management Action 2:

The Secretariat, in consultation with the OIG, will report findings of Zenith Carex's supplier misconduct for potential referral to the Sanctions Panel.

2.2 Chemonics' Field Office controls were poorly implemented and ineffective at preventing fraud

Chemonics' Nigeria Field Office was responsible for all aspects of managing third-party logistics providers, including selecting vendors, drafting contracts, and reviewing and approving invoices.

Chemonics staff were negligent in their implementation of controls. Staff reviewed and approved vendor invoices without fully understanding the contract terms, and inadequately reviewed supporting documentation. As a result, controls for processing invoices were ineffective in identifying the fraudulent invoices and preventing unsupported payments.

The design of the invoice payment process appeared robust: six internal documents needed sign off by up to six people from different departments, including Warehousing and Distribution and Finance, as well as one senior manager with a delegation of authority (DOA), the authorization to spend money on behalf of Chemonics. Despite Zenith's Long-Haul invoices clearly listing 'tonnage', no Chemonics staff identified, questioned, challenged or prevented the payment of 52 fraudulent invoices which were not in line with the contract charges of per commodity kilograms.

Zenith's first Long-Haul invoice, in August 2017, was approved by staff throughout the hierarchy, including the Country Director, Deputy Country Director, and Warehousing and Distribution Director, none of whom checked whether it was in line with the contract signed three months previously. Both the Deputy Country Director, who held a DOA, and Warehousing and Distribution Director had been closely involved with the vendor selection and contracting process, and would have, or ought to have, known the correct contract terms.

Staff reviewing invoices were inadequately informed and supervised

A Chemonics Logistics Advisor who routinely approved Zenith's invoices which fraudulently charged for vehicle tonnage told the OIG they did not know whether Long-Haul cold chain charges were to be based on commodity weight or vehicle weight.

Some Chemonics staff did not adequately review Proofs of Delivery, submitted with invoices as evidence that deliveries were correctly completed, and that invoices were accurate. On multiple occasions, Zenith's LMD invoices, containing over 1,000 pages of accompanying PODs, were approved by both the Logistics Advisor and Warehousing and Distribution Director on the same day Chemonics received them, indicating there was no proper review. Chemonics' Logistics Advisor told the OIG they did not look at PODs when reviewing invoices as this was 'too time consuming'. In not doing so, Chemonics staff could not ensure invoiced charges were accurate and supported.

A lack of resources for invoice processing was cited as a contributing factor. Sometimes, one single staff member was responsible for reviewing all invoices, and thousands of pages of supporting documents. When long delays in releasing payments ensued, supplier complaints created pressure on Chemonics to quickly reduce the backlog. Chemonics employees from other departments were drafted in to review invoices, however these 'surge' staff could not formally approve documents. One Logistics Advisor admitted to signing their name on Inspection Forms for invoices reviewed by other people. There was no record of Chemonics managers ensuring adequate training or oversight for 'surge' staff, or processes for maintaining a segregation of duties for non-Warehousing and Distribution staff assisting in peak periods.

Manager checks were inadequate

The Warehousing and Distribution Director, who directly oversaw the invoice approval process, did not undertake adequate checks. The Director signed off every fraudulent invoice identified during the investigation, thereby confirming that deliveries were completed as per order requirements and invoices were reviewed and cleared for payment. When confronted with the fraudulent invoices, the Director stated

the team had "reviewed the wrong thing", without explaining their own failure to ensure the accuracy of invoices or to ensure staff were adequately trained and supervised.

Staff did not check the accuracy of invoices, instead over-relying on the sign-off of preceding staff, weakening the effectiveness of controls. One Finance Manager stated that their department focused on reviewing Payment Request Forms, an internally produced document, rather than the underlying invoices, because they relied on Warehouse and Distribution staff to confirm invoices as accurate. Finance checked whether per-kilogram rates aligned with the contract, but were unaware that Long-Haul invoices should have been charged by commodity kilogram, not vehicle tonnage.

Extraordinarily high invoices went unchallenged, including US$330,000 for just eight Long-Haul routes in July 2018 invoice, representing 10% of the entire Zenith annual contract ceiling for Long-Haul and Last-Mile Delivery combined. By comparison, even at the inflated rates, the July 2018 Last-Mile Delivery to around 400 facilities cost US$412,000.

Red flags in the tender process

Chemonics staff missed red flags in Zenith's 2017 tender submission. Zenith submitted unaudited 2016 financial statements with altered entries from the corresponding 2015 audited statements, which misrepresented its financial position by inflating its 2016 turnover by NGN 102 million (67%) compared to the official records held by the Nigerian Corporate Affairs Commission. The statements also showed an unexplained NGN 131.6 million (600%) increase in year-end net assets and lowered liabilities, thereby improving their balance sheet.

Concerned that Zenith was "high risk" financially due to low liquidity and significant liabilities, Chemonics questioned Zenith on its debt levels. Zenith replied that *"it [the debt levels] was erroneously captured in the [2016] management account we submitted due to exigency however our real audited account will be ready by first week in July and we shall submit it to you...In addition we can print our Bank Statement to show our bank balance as at date which is over N70m and $58,000 for your perusal."*

Despite Zenith's admission that its management statements were 'erroneous', Chemonics did not request any subsequent supporting documentation to corroborate the significant financial turnaround from Zenith's 2015 audited statements, which reported year-end liabilities of NGN97 million and cash of only NGN458,000 (approximately US$2,300).

Chemonics identified the Zenith bid as an outlier: their LMD drop prices were up to two-thirds lower than competitors, yet their direct prices were often over double the competitor average. Unlike other bidders, Zenith did not submit a cost narrative detailing how their bid was calculated, as required in the RFP, and Chemonics did not subsequently request them to do so. As this was a blind financial evaluation, Chemonics bid evaluators did not know the low bid came from Zenith and appear to have taken the peculiar costs at face value. Subsequent to the bid award, no additional monitoring was put in place. During 2019 renegotiations, Zenith stated their 'drop' rates were below cost and requested to increase this price.

Shortcomings in contract drafting and implementation

Shortcomings in Chemonics' drafting and monitoring of distribution contracts contributed to an overall environment where Zenith's fraud was able to take root and remain undetected.

Key LMD definitions such as 'drop' and 'direct' were not included in the final contracts, despite being outlined in the RFP. Although Chemonics defined commodity weight as the relevant metric for Long-Haul cold chain invoices, the OIG found no established process to reliably measure and record the commodity weight of consignments at dispatch warehouses. Following a Global Fund LFA review in early 2019, staff at Abuja Premier Medical Warehouse were instructed to weigh shipments. However, the inadequate scale provided meant staff had to measure a sample of commodities and extrapolate the weight. Seemingly unverified and

exaggerated weights were recorded by hand on PODs submitted by Zenith in support of their inflated invoices from mid-2019, indicating that a weighing process remained poorly, if at all, implemented.

Many Zenith route plans did not contain the level of detail required in the contracts, such as estimated cost, States and Local Government Areas covered by each route, volume of health commodities, vehicle registration and capacity, and the expected loading and delivery dates. Some route plans contained non-existent LGA names. The OIG found no indication of Chemonics staff challenging the route plan quality, or holding Zenith to the contractual standard.

Contracts stated that in addition to paper PODs, electronic proofs of delivery (ePODs) and GPS were to be implemented on 25% of routes by September 2017, and all deliveries from January 2018. However, ePODs on the project were not implemented at all during the period in scope.

The Global Fund selected Chemonics as a supplier to help address supply chain deficiencies which had been identified in the OIG's 2016 Audit of Global Fund grants in Nigeria. During the contract, on time and in full commodity delivery was largely fulfilled; programmatic considerations were the core focus for both Chemonics and the Global Fund. However, as this investigation identified, Chemonics' controls failures limited the Global Fund's ability to monitor financial performance of the contract.

As a Global Fund supplier, the assurance mechanisms around Chemonics were relatively more reactive than for grant implementers. Outsourcing a service includes outsourcing third-party risk; Chemonics' 2018 proposal highlighted their experience in Nigeria and cited "extensive oversight" of subcontractors as a benefit to the Global Fund. Nonetheless, the scale and strategic importance of contracts such as these warrant additional assurance than with other Global Fund suppliers. The OIG has agreed with the Secretariat that a more proactive assurance framework will be adopted around prime contractors and strategic suppliers in the future, commensurate with their contract values and risk exposure.

Chemonics told the OIG it *"agrees that staff members involved with the invoicing process were negligent in their duties during the review and payment process. We would, however, like to clarify that Chemonics did indeed have financial controls and standard operating procedures in place. Nonetheless, our investigations have shown that these procedures were not followed as they related to the Zenith Carex tender and invoice review processes."* Chemonics noted administrative actions and process improvements have been, and are being, implemented to strengthen the deficiencies identified through this investigation.

Zenith responded that Chemonics did not request updated 2016 audited financial documents and referred to the due diligence process being the responsibility of Chemonics. Zenith was invited, but declined, to provide the OIG with 2016-2019 audited financials and project ledgers; their response did not clarify or refute the inconsistencies identified.

Based on the above finding, the OIG and the Global Fund Secretariat have agreed that:

Agreed Management Action 3:

Supply Operations and Risk will establish an interim framework which provides guidance on assurances and necessary oversight of identified strategic 4PL & 3PL suppliers and/or prime contractors used by the Global Fund.

2.3 Collusion could have contributed to the fraud remaining undetected

The extent of Zenith's fraudulent billing and the scale of control lapses at Chemonics indicates the possibility of collusion between Chemonics staff and Zenith.

The contract award was very lucrative for Zenith. The first-year distribution contract value (May 2017 – May 2018), over NGN 1 billion per year, was over six times Zenith's previous annual turnover.[1] In 2018, Zenith derived NGN1.5 billion (US$4 million) in revenue from Chemonics alone – ten times their 2016 turnover. In the RFP, Zenith undertook to significantly expand their vehicle fleet if awarded the contract.

Key Chemonics manager's lifestyle contradicted their declared salary

A Chemonics Director who was in a position to be aware of the fraud was living substantially beyond their Chemonics salary. The individual was on the Committee which evaluated third-party logistics provider bids and set contract terms, including the commodity weight charging for Long-Haul cold chain, and the definitions of 'direct' and 'drop' for Last Mile Delivery. This individual signed off on all Warehousing and Distribution invoices and oversaw the invoice review process.

Despite not declaring any secondary employment or income, they made a housing project investment in excess of their entire salary between October 2017 and January 2019. Between March and November 2019, the individual deposited additional cash equivalent to 25% of their annual salary (which was separately credited into their account) into various bank accounts in their name. Other major expenses and luxury purchases further indicated a lifestyle that far exceeded their Chemonics salary.

Zenith's bid pricing was suspicious

In 2019, driven by its new Country Director, Chemonics sought discounts from all its logistics vendors through a renegotiation process, with existing vendors invited to submit new, lower rates. Chemonics staff prepared an initial price comparison dated 1 August 2019 and a further pricing analysis document on 26 August, following a request for further vendor discounts.

Zenith's revised LMD cold chain pricing, submitted on 26 August, mirrored and undercut by a fraction of one percent, that of the lowest bidder (Competitor A) for most direct rates. This strongly indicates Zenith's bid benefited from unfairly obtaining competitors' pricing during the biding process.

Zenith's updated prices were 99% of Competitor A prices for both 'drop' and 'direct' rates, as shown in Figure 4, below. Despite being requested to lower their bids, 93 of Zenith's 111 revised 'drop' rates actually *increased* to 99% of Competitor A's bid, in some cases doubling or tripling their 1 August prices. Zenith's 111 'Direct' prices were modified, often by over 50%, to become 98.4% - 99.9% of Competitor A bids per route.

	Zenith 1 Aug rates		Zenith 26 Aug rates		Competitor A		Zenith 26 Aug rate: % of Competitor A	
Route	Drop	Direct	Drop	Direct	Drop	Direct	Drop	Direct
ABUJA-ABIA	30,000	300,000	32,600	149,700	33,185	150,051	98.24%	99.77%
ABUJA-ADAMAWA	45,000	350,000	49,400	203,850	50,725	204,457	97.39%	99.70%
ABUJA-ANAMBRA	17,000	450,000	35,000	150,950	35,210	151,388	99.40%	99.71%
ABUJA-BORNO	60,000	600,000	50,300	241,900	50,600	242,627	99.41%	99.70%
ABUJA-CROSS RIVER	35,000	300,000	38,600	209,800	38,980	210,040	99.03%	99.89%

Figure 4: Extract of 2019 LMD Cold Chain price comparison, showing the change in bids from Zenith Carex to mirror the bid of 'Competitor A'.

[1] 2016 Corporate regulator returns declared turnover of NGN 153 million.

Some Chemonics staff justified retaining Zenith during the renegotiation on the basis that they were the only competent LMD cold chain provider. The evaluation metric for the 2019 renegotiation changed after prices were received. Chemonics initially evaluated prices on 1 August 2019 based on 100% 'drop' rates. A Warehousing and Distribution staff member told procurement staff that 'direct' rates applied only in exceptional cases, encouraging the evaluation to be based on 'drop' pricing. This contradicted reality: as shown in Figure 1 on page 8, Zenith invariably charged 'direct' prices. On 6 August, analysis based on 0% drop rates produced results that awarded no routes to Zenith, but many to Competitor A. A subsequent evaluation based on the suspicious 26 August prices detailed above, and weighted with 99% drop rates, awarded Zenith the majority of routes.

The OIG, via Chemonics, sought comment from the former employee implicated by the collusion indicators, but they did not respond. Chemonics terminated their dealings with Zenith and took decisive disciplinary action related to associated staff.

Zenith responded to the OIG that *"Zenith Carex did not have any personal or official relationship with any staff of Chemonics before winning the sub-contract, and maintained professional relationship with the staff of Chemonics until we discontinued working for them."* Zenith made no substantive comment refuting the finding of submitting suspicious pricing during the renegotiation, stating instead that they considered Chemonics' request for a price renegotiation to be "fraudulent".

2.4 Chemonics' financial monitoring and oversight were ineffective at detecting fraud

Inadequate financial monitoring by Chemonics led to late identification of cost overruns, making it more difficult to identify fraud for Chemonics and the Global Fund Secretariat alike. Chemonics' Headquarters did not identify fraud as a root cause of a substantial 3PL cost increase, nor irregularities in Chemonics' Abuja Field Office invoice review, which had been compromised by negligence and potential collusion.

Chemonics' Headquarters oversight focused on strategic and programmatic issues; they did not monitor individual third-party logistics provider sub-contracts, or complete secondary checks on invoices. These responsibilities remained with Field Offices, who oversaw individual sub-contracts, including monitoring contract ceilings, an annual maximum contract value. Headquarters prepared donor financial reporting based on aggregated logistics costs, from which Global Fund invoices were prepared approximately every two months.

Prior to May 2019, financial monitoring was based on booked expenses from the Field Office; nobody was responsible for accruals monitoring, and reliable forecasting tools were unavailable. Delays in processing invoices resulted in financial monitoring being several months behind actual costs, meaning there was no contemporaneous monitoring of either Global Fund expenditure or sub-contractors' contract ceilings; the logistics providers themselves often requested extensions from Chemonics when ceilings were neared or breached.

To address these weaknesses, Chemonics implemented a 'Situation Room', a cross-department Field Office unit monitoring logistics invoices and accruals, to facilitate shared access to financial information and improve communication for both Field and Headquarters staff from May 2019.

Retrospective overruns

On 1 May 2019, with just 16 days remaining in the contract period, Chemonics signed a ceiling increase modification for Zenith of over US$2 million, representing a 75% increase of the annual ceiling. The request, prepared by the Field Office, was signed off by Headquarters because the value surpassed local delegation of authority.

This contract ceiling extension represented a significant missed opportunity to identify and act on Zenith's massive overspending. Despite the scale and timing of the increase, it did not trigger any specific Headquarters approval process or analysis to identify its root cause: Zenith's systemic invoice fraud. Nor was Zenith's invoicing for expensive 'direct' deliveries identified or rectified, despite Chemonics awarding the LMD contract on 'drop' prices. There was no process or requirement to notify the Global Fund of increases to underlying third-party logistics provider contract ceilings.

In December 2018, Chemonics asked the Global Fund for a US$1.7 million retroactive extension for the contract period ending August 2018. As the initial overrun was not identified until after the contract period closed, Chemonics and the Global Fund Secretariat were unable to mitigate the causes of budget pressures on the subsequent contract. On 25 April 2019, Chemonics requested a further US$3 million extension for the fixed-price contract period ending August 2019. Chemonics' extension requests to the Global Fund cited increased logistics expenses as a root cause, but did not identify fraud as a driver of cost overruns.

Headquarters-led Annual Finance Compliance Reviews found examples of invoices unsupported by Proofs of Delivery and retrospective third-party logistics providers ceiling extensions. However, the fact that the OIG identified subsequent instances of the same issues indicates these reviews did not take adequate measures to improve Field Office controls.

Chemonics' 2018 Global Fund cost proposal stated "For each of our third-party logistics providers, the Global Fund has the benefit of highly competitive market pricing with extensive oversight applied to each subcontractor both contractually as well as technically..."

Chemonics applied a percentage-based "General and Administrative Expense" and "Fixed Fee" on all contract costs, including staff salaries and logistics, to Global Fund invoices. The OIG considers the expenses and fees levied on payments related to Zenith's fraudulent charges to be recoverable. Prior to this investigation, Chemonics committed to waiving these charges on amounts over the contract ceiling; the final recoverable fees would be offset against this waiver.

Chemonics acknowledged this investigation's findings, stating they recognized the need to strengthen oversight and compliance of Nigerian warehousing and distribution services. Chemonics assert they have already implemented key changes, including changing Field Office leadership, appointing a dedicated expatriate Contracts and Compliance Director, and from Spring 2019 establishing the 'Situation Room' to enhance third-party logistics monitoring.

Based on the above findings, the OIG and the Global Fund Secretariat have agreed that:

Agreed Management Action 4:

The Secretariat will ensure the Nigeria invoice format from Chemonics provides sufficient data to facilitate detailed analysis by Global Fund of contract performance against signed budgets, including on an activity / line-item basis.

3. Global Fund Response

Action to be taken	Due date	Owner
1. Based on the findings of this report, the Secretariat will finalize and pursue from Chemonics an appropriate recoverable amount from the non-compliant expenditures identified in this report. This amount will be determined by the Secretariat in accordance with its evaluation of applicable legal rights and obligations and associated determination of recoverability.	30 September 2021	Head, Recoveries Committee
2. The Secretariat, in consultation with the OIG, will report findings of Zenith Carex's supplier misconduct for potential referral to the Sanctions Panel.	30 September 2021	Head, Supply Operations
3. Supply Operations and Risk will establish an interim framework which provides guidance on assurances and necessary oversight of identified strategic 4PL & 3PL suppliers and/or prime contractors used by the Global Fund.	31 December 2021	Head, Supply Operations
4. The Secretariat will ensure the Nigeria invoice format from Chemonics provides sufficient data to facilitate detailed analysis by Global Fund of contract performance against signed budgets, including on an activity / line-item basis.	31 October 2021	Head, Grant Management Division

Annex A: Methodology

Why we investigate: Wrongdoing, in all its forms, is a threat to the Global Fund's mission to end the AIDS, tuberculosis and malaria epidemics. It corrodes public health systems and facilitates human rights abuses, ultimately stunting the quality and quantity of interventions needed to save lives. It diverts funds, medicines and other resources away from countries and communities in need. It limits the Global Fund's impact and reduces the trust that is essential to the Global Fund's multi-stakeholder partnership model.

What we investigate: The OIG is mandated to investigate any use of Global Fund funds, whether by the Global Fund Secretariat, grant recipients, or their suppliers. OIG investigations identify instances of wrongdoing, such as fraud, corruption and other types of non-compliance with grant agreements. The Global Fund Policy to Combat Fraud and Corruption[2] outlines all prohibited practices, which will result in investigations.

OIG investigations aim to:

(i) identify the nature and extent of wrongdoing affecting Global Fund grants;
(ii) identify the entities responsible for such wrongdoing;
(iii) determine the amount of grant funds that may have been compromised by wrongdoing; and
(iv) place the Global Fund in the best position to recover funds, and take remedial and preventive action, by identifying where and how the misused funds have been spent.

The OIG conducts administrative, not criminal, investigations. It is recipients' responsibility to demonstrate that their use of grant funds complies with grant agreements. OIG findings are based on facts and related analysis, which may include drawing reasonable inferences. Findings are established by a preponderance of evidence. All available information, inculpatory or exculpatory, is considered by the OIG.[3] As an administrative body, the OIG has no law enforcement powers. It cannot issue subpoenas or initiate criminal prosecutions. As a result, its ability to obtain information is limited to the access rights it has under the contracts the Global Fund enters into with its recipients, and on the willingness of witnesses and other interested parties to voluntarily provide information.

The OIG bases its investigations on the contractual commitments undertaken by recipients and suppliers. Principal Recipients are contractually liable to the Global Fund for the use of all grant funds, including those disbursed to Sub-recipients and paid to suppliers. The Global Fund's Code of Conduct for Suppliers[4] and Code of Conduct for Recipients provide additional principles, which recipients and suppliers must respect. The Global Fund Guidelines for Grant Budgeting define compliant expenditures as those that have been incurred in compliance with the terms of the relevant grant agreement (or have otherwise been pre-approved in

[2] (16.11.2017) Available at https://www.theglobalfund.org/media/6960/core_combatfraudcorruption_policy_en.pdf

[3] These principles comply with the Uniform Guidelines for Investigations, Conference of International Investigators, 06.2009; available at: http://www.conf-int-investigators.org/?page_id=13, accessed 1.12.2017.

[4] Global Fund Code of Conduct for Suppliers (15.12.2009), § 17-18, available at: https://www.theglobalfund.org/media/3275/corporate_codeofconductforsuppliers_policy_en.pdf, and the Code of Conduct for Recipients of Global Fund Resources (16.07.2012), §1.1 and 2.3, available at: https://www.theglobalfund.org/media/6011/corporate_codeofconductforrecipients_policy_en.pdf. Note: Grants are typically subject to either the Global Fund's Standard Terms and Conditions of the Program Grant Agreement, or to the Grant Regulations (2014), which incorporate the Code of Conduct for Recipients and mandate use of the Code of Conduct for Suppliers. Terms may vary however in certain grant agreements.

9 March 2021
Geneva, Switzerland

writing by the Global Fund) and have been validated by the Global Fund Secretariat and/or its assurance providers based on documentary evidence.

Who we investigate: The OIG investigates Principal Recipients and Sub-recipients, Country Coordinating Mechanisms and Local Fund Agents, as well as suppliers and service providers. Secretariat activities linked to the use of funds are also within the scope of the OIG's work.[5] While the OIG does not typically have a direct relationship with the Secretariat's or recipients' suppliers, its investigations[6] encompass their activities regarding the provision of goods and services. To fulfill its mandate, the OIG needs the full cooperation of these suppliers to access documents and officials.[7]

Sanctions when prohibited practices are identified: When an investigation identifies prohibited practices, the Global Fund has the right to seek the refund of grant funds compromised by the related contractual breach. The OIG has a fact-finding role and does not determine how the Global Fund will enforce its rights. Nor does it make judicial decisions or issue sanctions.[8] The Secretariat determines what management actions to take or contractual remedies to seek in response to the investigation findings.

However, the investigation will quantify the extent of any non-compliant expenditures, including amounts the OIG proposes as recoverable. This proposed figure is based on:

(i) amounts paid for which there is no reasonable assurance that goods or services were delivered (unsupported expenses, fraudulent expenses, or otherwise irregular expenses without assurance of delivery);
(ii) amounts paid over and above comparable market prices for such goods or services; or
(iii) amounts incurred outside of the scope of the grant, for goods or services not included in the approved work plans and budgets or for expenditures in excess of approved budgets.

How the Global Fund prevents recurrence of wrongdoing: Following an investigation, the OIG and the Secretariat agree on management actions that will mitigate the risks that prohibited practices pose to the Global Fund and its recipients' activities. The OIG may make referrals to national authorities for criminal prosecutions or other violations of national laws and support such authorities as necessary throughout the process, as appropriate.

---

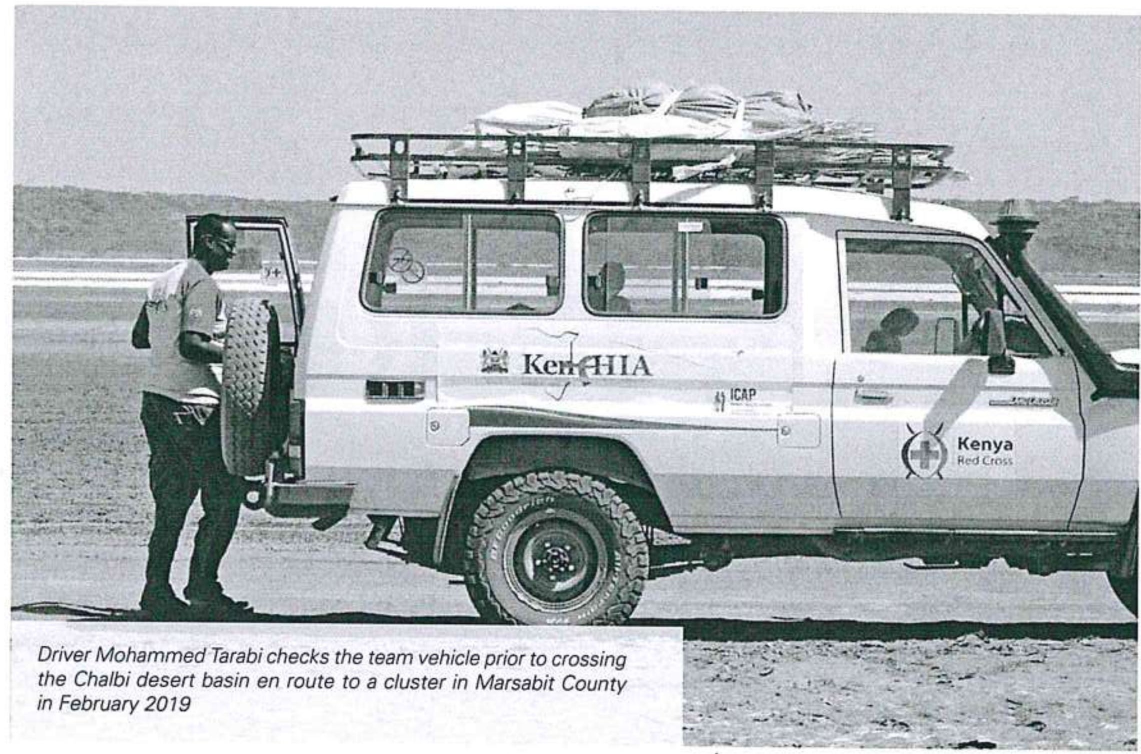
[5] Charter of the Office of the Inspector General (16.05.2019), § 2, 10.5, 10.6, 10.7 and 10.9 available at: https://www.theglobalfund.org/media/3026/oig_officeofinspectorgeneral_charter_en.pdf

[6] Charter of the Office of the Inspector General § 2, and 18.

[7] Global Fund Code of Conduct for Suppliers, § 16-19

[8] Charter of the Office of the Inspector General § 9.1

KENPHIA 2018 PRELIMINARY REPORT



Driver Mohammed Tarabi checks the team vehicle prior to crossing the Chalbi desert basin en route to a cluster in Marsabit County in February 2019

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Kenya Population-based HIV Impact Assessment (KENPHIA) 2018

National AIDS and STI Control Programme (NASCOP),

Ministry of Health, Kenya

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It is with great pleasure that we provide the preliminary findings of KENPHIA 2018 whose results will catalyze policy action at National level. KENPHIA is also the first, amongst a series of HIV surveys, that provides data at the County levels, which aligns perfectly with the objectives of devolution as per Kenya's 2010 constitution. I therefore take this opportunity to encourage County governments to use the County-level data provided in this survey for planning of HIV health service delivery and in updating their County HIV strategic plans. Given the trove of knowledge that KENPHIA 2018 will provide, the Ministry of Health also affirms its intention to take advantage of the demographic and health data generated by this survey to answer relevant questions that will enable the country to plan for universal health access as per the Big Four Agenda spearheaded by The President of the Republic of Kenya.

Dr. Rashid A. Aman
Chief Administrative Secretary
Ministry of Health

The Ministry of Health is proud to have supported KENPHIA with the human resources for health to enable data collection and mobilized resources to help the survey procure some of the necessary supplies and equipment to ensure a successful survey. We are pleased the outcome of this survey will influence policy change and ensure mainstreaming of HIV programs for Kenya.

Susan N. Mochache, CBS
Principal Secretary
Ministry of Health

As the Director General of the Ministry of Health, I commit to translate the findings of this survey into concrete and implementable strategic plans and policies that will enhance our HIV control response. I also urge all counties and HIV implementing agencies to continue with this exemplary partnership to redefine the HIV response and engage communities appropriately as we enter the next phase of controlling the HIV epidemic.

Dr. J. Wekesa Masasabi
Acting Director General Health
Ministry of Health

ACKNOWLEDGMENTS AND APPRECIATIONS

The Ministry of Health acknowledges the scientific, strategic, and technical leadership provided by the Principal Investigators, Dr. Peter Cherutich, Dr. Kigen Bartilol, Dr. Kevin M. De Cock, and Dr. Jessica Justman.

The various planning organs of the KENPHIA through the National Executive Steering Committee under the leadership of the former Director of Medical Services, Dr. Jackson Kioko, the Acting Director General of Health, Dr. Wekesa Masasabi, Head-National AIDS and STI Control Programme, Dr. Catherine Ngugi, the KENPHIA Secretariat under the commendable coordination of Dr. Joyce Wamicwe, the Data Analysis and Advisory Committee chaired by Dr. Peter Cherutich and the KENPHIA Technical Working Group and Technical Sub-Committees drawn from relevant survey partner institutions.

The support, engagement and participation by all survey collaborating institutions listed below:

- Ministry of Health
  - National AIDS & STI Control Programme (NASCOP)
  - National Public Health Laboratories
  - National AIDS Control Council (NACC)
  - Kenya Medical Research Institute (KEMRI)
- Ministry of Planning and Devolution
  - Kenya National Bureau of Statistics (KNBS)
  - National Council for Population and Development (NCPD)
- Council of Governors (CoG)
- 47 County Governments
- Global Fund
- Associations for People Living with HIV
- National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK)
- United Nations (UN) Family
- Westat (a statistical research organization)
- U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Kenya Coordinating Office
- United States Centers for Disease Control and Prevention (CDC)
- ICAP at Columbia University

The operational support from the CoG through the Chief Executive Officer Mrs. Jacqueline Mogeni and the mobilization of the 47 County Governments through the County Executive Committee Members for Health, County Directors for Health, County AIDS and STI Coordination Officers and County Medical Laboratory Coordinators.

The 14 community mobilization coordination officers, 1600 community mobilizers, 5 regional coordination supervisory teams, 50 field data collection teams, 6 roving satellite laboratory teams and the central laboratory team who worked tirelessly to collect high quality data.

Kenyans from all walks of life across the country who participated in this survey.

Lastly, we wish to acknowledge the strategic partner, ICAP at Columbia University who made this survey possible through the financial support from PEPFAR and the Global Fund; and for the unequivocal technical support of the CDC.

KEY MESSAGES

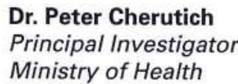
The Ministry of Health acknowledges the gradual decline in the number of annual new adult HIV infections to 36,000 in 2018. KENPHIA measured important National and County HIV-related indicators, including incidence and prevalence of HIV, and progress toward 90-90-90 goals that will guide policy and funding priorities.

Dr. Pacifica Onyancha
Ag Director Directorate of Medical Services/Preventive and Promotive Health
Ministry of Health

This survey found marked gender disparity in HIV prevalence among adults, with prevalence twice as high among women compared to men. Among adolescents and young people aged 20-34 years, the prevalence of HIV was three times as high among women compared to men. Further, the findings demonstrate a gap towards attaining the first UNAIDS 90 target for HIV diagnoses with 79.5% of people living with HIV aware of their status, as well as a 7.9% unmet need for treatment of HIV-positive pregnant women. This highlights the need to improve awareness, further scale-up prevention and treatment programs to enhance HIV testing and effective treatment for all pregnant HIV-positive women attending maternal & child health services. NASCOP, together with National and County health delivery stakeholders will utilize these data to improve HIV services for all Kenyans.

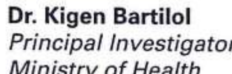
Dr. Catherine Ngugi
Head National AIDS and STI Control Programme
Ministry of Health

This survey was conducted with the highest level of scientific integrity and fidelity to the protocol and I am delighted and privileged to have been a KENPHIA Principal Investigator. My joy will be complete when this work will influence HIV policy in Kenya and help us move closer to HIV elimination.



Dr. Peter Cherutich
Principal Investigator
Ministry of Health

It has been an exciting journey serving as a Principal Investigator and now presenting KENPHIA's preliminary results. These early results will give us a score card on current HIV programs and allow for development of informed, holistic and quality-driven HIV policies for all Kenyans.



Dr. Kigen Bartilol
Principal Investigator
Ministry of Health

KENPHIA documents the important accomplishment of 72% of adults living with HIV in Kenya having HIV viral load suppression (VLS). Those who sustain VLS on stable ART pose very low risk of HIV transmission. CDC is proud to have been part of the many years of collaboration with the Ministry of Health in fighting the HIV epidemic.

Dr. Kevin M. De Cock
Principal Investigator
CDC Kenya

It is with great pleasure that we present the KENPHIA preliminary results adding to 12 other PHIA surveys in sub-Saharan Africa, to give a detailed portrait of HIV response programs and their impact in turning the tide against the disease. We look forward to using KENPHIA data to identify new priorities and implementing data-driven priorities in the fight against HIV.

Dr. Jessica Justman
Principal Investigator
ICAP at Columbia University

KENPHIA 2018 PREL REP fin_alt2_USAID.indd 5 1/30/20 1:10 PM

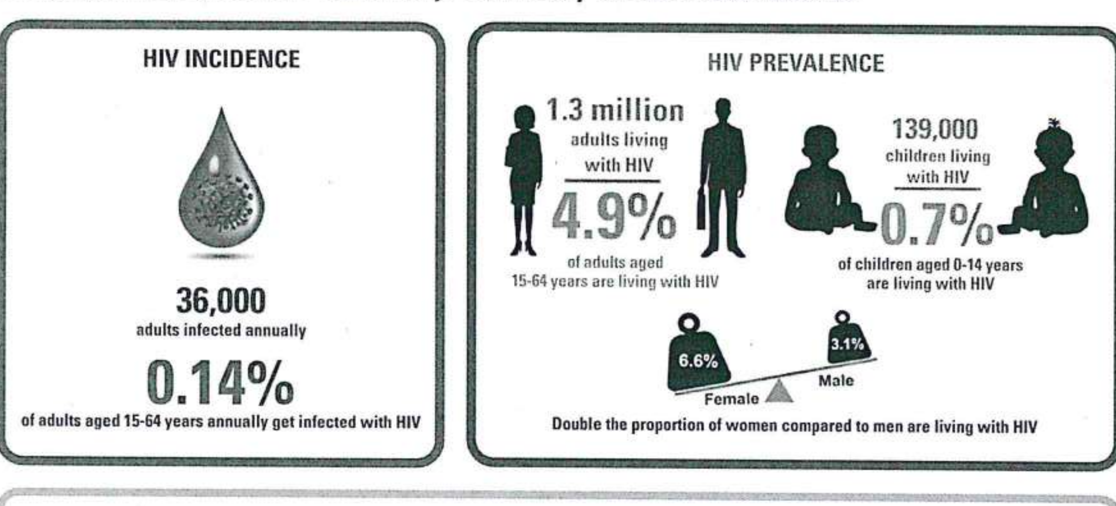
EXECUTIVE SUMMARY

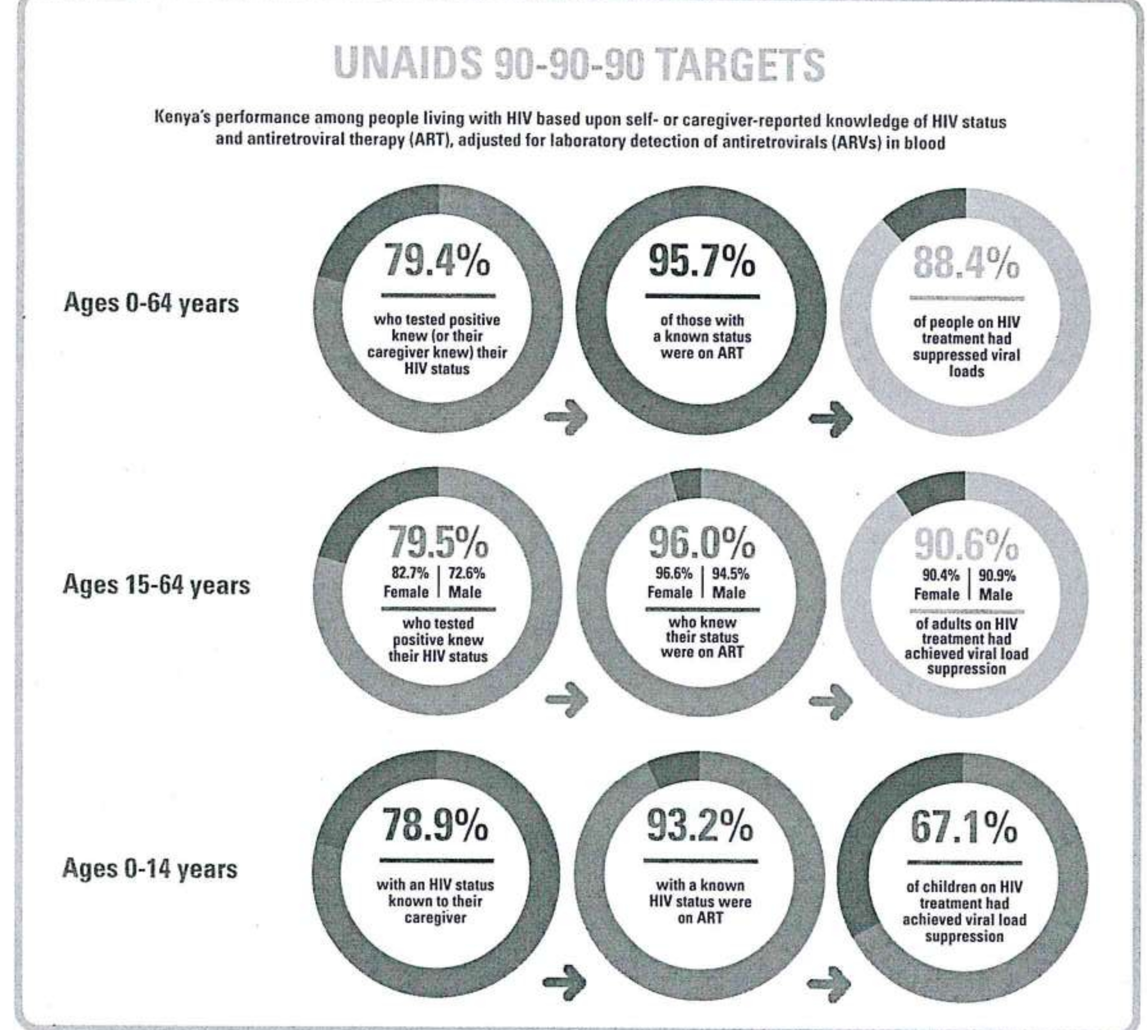
Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 survey is a National household HIV survey that is part of a multicountry PHIA survey assessment being conducted in 13 other sub-Saharan countries in Africa. KENPHIA provides key information for health policy makers and implementers on the size of the HIV epidemic, the impact that recent and ongoing HIV programming are having on the epidemic and a gap-assessment of key areas requiring further focus in the fight against HIV. KENPHIA 2018 is one among several National surveillance data sources, including the antenatal surveillance in pregnant women from 1990 to 2011, the Kenya Demographic Health Surveys (2003, 2009, and 2014) and the Kenya AIDS Indicator Surveys (KAIS 2007 and 2012). KENPHIA 2018 builds upon the previous KAIS surveys and adds some additional unique features that allow it to better assess the impact of HIV programs. The key elements of survey design and differences between KAIS and KENPHIAs are presented in the summary infographic below.

Infographic 1: Descriptive comparison of KENPHIA and KAIS

KAIS 2012	PARAMETER	KENPHIA 2018
Give estimates for persons aged 15-64 years for the below: • HIV Incidence - National • HIV Prevalence - National & regional (10 NASCOP regions) • Former North Eastern Province (Mandera, Wajir and Garissa counties excluded from data collection)	Primary objectives	Give estimates for persons aged 15-64 years for the below: • HIV Incidence - National • HIV Prevalence - National & County (47 counties) • Prevalence of HIV viral suppression - National
• 18 months–64 years	Target population	• 0–64 years
• Total: 15,966	Achieved survey size (blood draws)	• Total: 35,610
• Electronic questionnaires on portable notebook computers running TAPHIK Software	Mode of data Collection	• Electronic questionnaires on tablets running ODK
English, Kiswahili and 11 local languages used to collect: • Household questionnaire • Separate female and male questionnaires for 15-64 years • Child questionnaire for 10-14 years	Questionnaires and interviews	English, Kiswahili and 14 local languages used to collect: • Household questionnaire • Separate female and male questionnaires for 15-64 years • Child questionnaire for 10-14 years
• Central HIV testing • CD4+ T cell counts • HIV Viral load • HIV recent infection • HIV ARV drug detection	Blood tests done	• HIV • HIV early infant diagnostic testing • Syphilis • Hepatitis B virus • HIV viral load • HIV recent infection • HIV ARV drug detection • HIV drug resistance
• Home-based testing for HIV offered as service • Referrals given to collect all other clinically-relevant test results at a later date	Return of test results	• Home-based/point of care testing for HIV • Referrals given to collect all other clinically relevant test results at a later date

Infographic 2: Executive Summary: Summary of KENPHIA Results





Infographic 2: Executive Summary: Summary of KENPHIA Results (continued)

COUNTY HIV PREVALENCE

County Code	County Name	Prevalence	County Code	County Name	Prevalence
001	Mombasa	5.6%	025	Samburu	1.9%
002	Kwale	4.2 %	026	Trans-Nzoia	4.0%
003	Kilifi	2.3 %	027	Uasin Gishu	5.5%
004	Tana River	1.1 %	028	Elgeyo-Marakwet	3.5%
005	Lamu	2.6%	029	Nandi	2.6%
006	Taita-Taveta	5.2%	030	Baringo	1.8%
007	Garissa*	<0.1 %	031	Laikipia	2.0%
008	Wajir	0.2 %	032	Nakuru	3.0%
009	Mandera	0.2%	033	Narok	5.0%
010	Marsabit	1.2 %	034	Kajiado	4.6%
011	Isiolo	2.2 %	035	Kericho	3.4%
012	Meru	3.6 %	036	Bomet	2.8%
013	Tharaka-Nithi	2.4%	037	Kakamega	3.9%
014	Embu	2.7%	038	Vihiga	5.3%
015	Kitui	5.7 %	039	Bungoma	2.5%
016	Machakos	3.7 %	040	Busia	9.9%
017	Makueni	3.9 %	041	Siaya	15.3%
018	Nyandarua	2.2%	042	Kisumu	17.5%
019	Nyeri	5.1 %	043	Homa Bay	19.6%
020	Kirinyaga	3.3 %	044	Migori	13.0%
021	Murang'a	3.0%	045	Kisii	6.1%
022	Kiambu	1.1%	046	Nyamira	3.9%
023	Turkana	6.8 %	047	Nairobi	3.8%
024	West Pokot	1.3%			

Scale: 20 15 10 5 0 | Scale: 0 5 10 15 20

Turkana, Marsabit, Mandera, Wajir, West Pokot, Samburu, Isiolo, Trans-Nzoia, Elgeyo-Marakwet, Bungoma, Uasin Gishu, Baringo, Busia, Kakamega, Laikipia, Vihiga, Nandi, Siaya, Kisumu, Nyandarua, Meru, Kericho, Nyeri, Tharaka-Nithi, Homa Bay, Nyamira, Nakuru, Kirinyaga, Embu, Kisii, Bomet, Murang'a, Garissa*, Migori, Narok, Kiambu, Nairobi, Machakos, Kitui, Tana River, Makueni, Kajiado, Lamu, Kilifi, Taita-Taveta, Kwale, Mombasa

0 100 200 300 400 Kilometers

Prevalence (%)
- <0.1 – <2.0
- 2.0 – 4.0
- >4.0 – 6.0
- >6.0 – 10.0
- >10.0
- Major lakes and ocean

* Garissa had no HIV-positive persons identified, thus is represented as having an HIV prevalence <0.1%.

VI KEY FINDINGS

Table 1: Key findings: National HIV incidence, HIV prevalence and viral load suppression in people living with HIV

HIV Indicator	Female	95% CI	Male	95% CI	Total	95% CI
Annual Incidence (%)						
15-49 years	0.15	0.00-0.31	0.15	0.02-0.28	0.15	0.06-0.24
15-64 years	0.15	0.01-0.29	0.13	0.02-0.24	0.14	0.06-0.23
Prevalence (%)						
0-14 years	0.7	0.2-1.1	0.8	0.4-1.1	0.7	0.4-1.0
10-19 years	1.0	0.6-1.4	0.9	0.5-1.4	0.9	0.6-1.3
15-49 years	6.2	5.7-6.8	2.7	2.4-3.1	4.5	4.1-4.9
15-64 years	6.6	6.0-7.1	3.1	2.7-3.5	4.9	4.5-5.3
Viral Load Suppression (%)						
0-14 years	(53.5)	31.7-75.4	(43.8)	21.0-66.6	48.3	30.9-65.7
10-19 years	(70.9)	53.2-88.5	(52.0)	21.8-82.1	61.4	43.8-79.1
15-49 years	72.8	69.3-76.3	60.6	53.6-67.7	69.2	65.9-72.4
15-64 years	74.6	71.5-77.6	65.1	58.8-71.4	71.6	68.8-74.4

Description: Incidence measurement based on mean duration of recent infection of 130 days with time cutoff=1.0 year and residual proportion false recent =0.00. Viral load suppression is defined as HIV RNA <1,000 copies per milliliter (mL) of plasma among HIV-positive persons; 95% CI: the confidence interval indicates a range of values that most likely encompasses the true value. Parentheses () indicate an estimate that is based on 25-49 persons observations and should be interpreted with caution.

HIV incidence

The annual incidence of HIV among adults in Kenya was 0.14% (95% confidence interval [CI]: 0.06-0.23%): 0.15% (95% CI: 0.01-0.29%) among women and 0.13% (95% CI: 0.02%-0.24%) among men. This corresponds to an estimated 36,000 (95% CI: 16,000-56,000) new infections per year among adults (Table 1).

HIV prevalence in adults

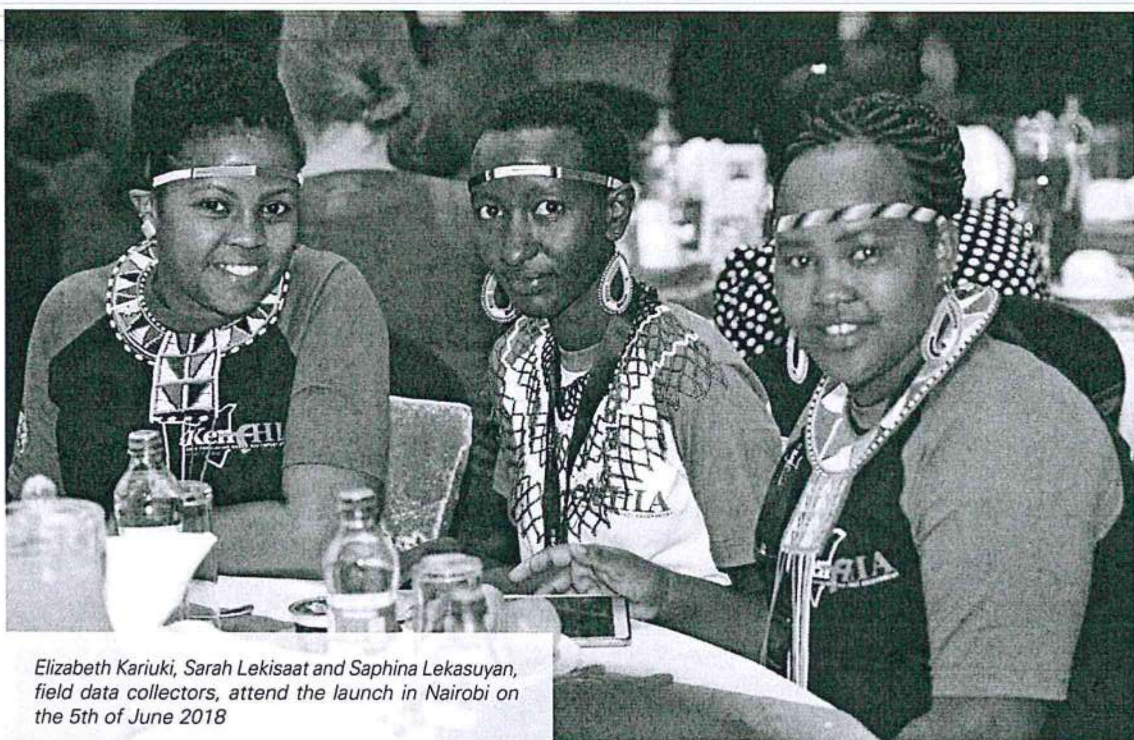
The prevalence of HIV among adults in Kenya was 4.9% (95% CI: 4.5%-5.3%). This translates to approximately 1.3 million (95% CI: 1.2-1.4 million) adults living with HIV in Kenya. HIV prevalence was twice as high among women at 6.6% (95% CI: 6.0%-7.1%), compared to men at 3.1% (95% CI: 2.7%-3.5%) (Table 1).

HIV prevalence in children

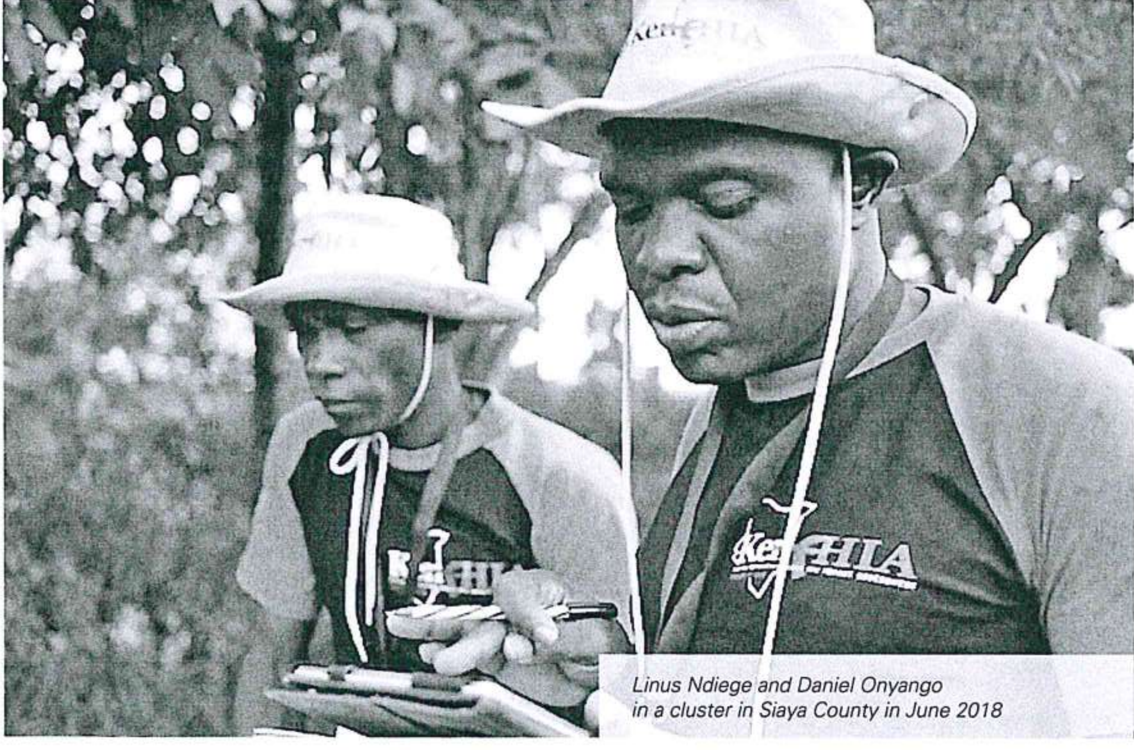
HIV prevalence among children was 0.7% (95% CI: 0.4%-1.0%) which translates to approximately 139,000 (95% CI: 84,000-194,000) children living with HIV in Kenya. There was no difference between girls and boys: HIV prevalence was 0.7% (95% CI: 0.2%-1.1%) among girls and 0.8% (95% CI: 0.4%-1.1%) among boys (Table 1).

Viral load suppression prevalence

The prevalence of viral load suppression (VLS) among all HIV-positive adults in Kenya was 71.6% (95% CI: 68.8%-74.4%). Men had markedly lower prevalence of VLS at 65.1% (95% CI: 58.8%-71.4%) compared to women at 74.6% (95 CI: 71.5%-77.6%). The prevalence of VLS in children was 48.3% (95% CI: 30.9%-65.7%), with no significant difference observed between boys and girls, with boys at 43.8% (95% CI: 21.0%-66.6%) and girls at 53.5% (95% CI: 31.7%-75.4%) (Table 1). Note, these findings of VLS among people living with HIV were regardless of knowledge of HIV status or use of antiretroviral (ARV) therapy (ART).



Elizabeth Kariuki, Sarah Lekisaat and Saphina Lekasuyan, field data collectors, attend the launch in Nairobi on the 5th of June 2018



Linus Ndiege and Daniel Onyango in a cluster in Siaya County in June 2018

01 INTRODUCTION

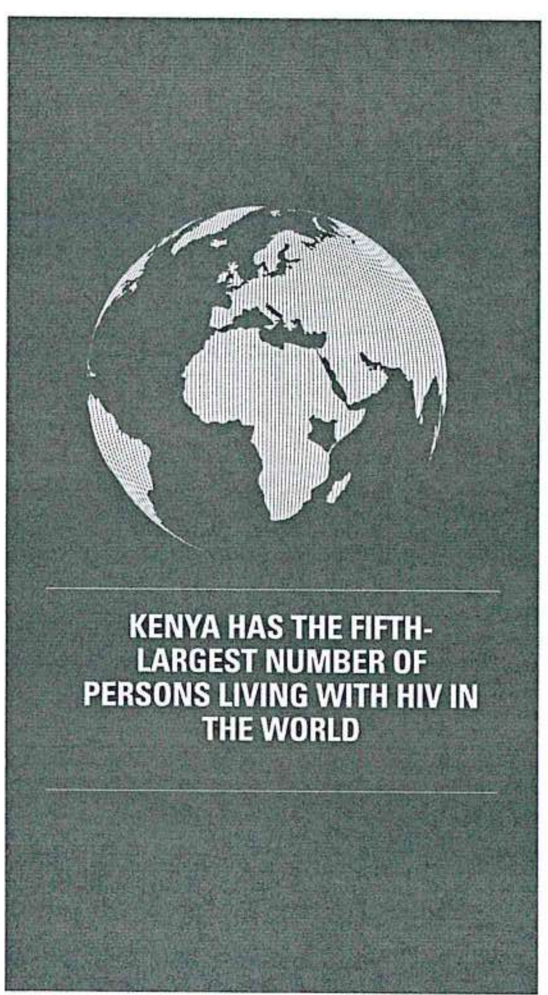
The Kenya Population-based HIV Impact Assessment (KENPHIA) was a cross-sectional household survey undertaken to describe the HIV epidemic in Kenya. KENPHIA had three primary objectives:

1. To estimate the National incidence of human immunodeficiency virus (HIV) infection
2. To determine the National prevalence of viral load (VL) suppression (VLS) among persons living with HIV
3. To assess the prevalence of HIV, nationally and by County

KENPHIA also measured National coverage of HIV services and key HIV-related risk and prevention behaviors using a nationally representative sample of adults and children.

Kenya has the fifth-largest number of persons living with HIV in the world, and HIV continues to be a leading cause of adult morbidity and mortality.[1,2] In order to understand the magnitude of the HIV epidemic, Kenya carried out a Demographic and Health Survey with HIV testing in 2003, followed by a Kenya AIDS Indicator Survey (KAIS) in 2007, leading the field in this type of nationwide assessment. The follow-up 2012 KAIS estimated the National HIV prevalence among adults (defined as those aged 15-64 years) to be 5.6%, which was a significant decline from KAIS 2007, which found a prevalence of 7.1%.[3,4] The HIV incidence rate in 2012 was estimated to be 0.5%. Kenya has marked regional heterogeneity in HIV prevalence, with prevalence ranging from over 20% in some counties to less than 1% in others. According to the National AIDS Control Council (NACC) 2018 HIV estimates, almost half of persons living with HIV in Kenya are located in Kisumu, Siaya, Homa Bay, and Migori counties in western Kenya and Nairobi County.[5]

National surveys such as KAIS, and now, KENPHIA provide important insights into progress toward HIV epidemic control. Kenya, in close partnership with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria has an aggressive program of HIV testing and treatment.[6] In 2016, Kenya adopted "Test and Treat"—a strategy under which those diagnosed with HIV start antiretroviral therapy (ART) as soon as possible. Today, ART is available at a range of facilities throughout the country, from large referral hospitals to small dispensaries. This preliminary report provides important data on the impact of HIV programming in Kenya and will allow us to tailor our strategies to the specific needs of an area or population. These results provide information on National and Country progress towards epidemic control and Kenya's progress toward the UNAIDS 90-90-90 targets.



Director of Medical Services, Dr. Jackson Kioko, U.S. Ambassador, Robert Godec, Chief Administrative Secretary for Health, Dr. Rashid Aman and National AIDS Control Council CEO, Dr. Nduku Kilonzo launching the KENPHIA in Nairobi on 5th June 2018

Dignitaries flagging off the KENPHIA escorted by outrider motorcycles during the launch of the survey in Nairobi on 5th June 2018

02 METHODS

KENPHIA 2018 was a cross-sectional, household-based survey conducted among persons aged 0-64 years in 800 clusters, based on the National Sample Survey and Evaluation Programme, version V, sampling framework developed by the Kenya National Bureau of Statistics (KNBS). Cluster listing updates were conducted six months prior to data collection to facilitate household selection. Survey data collection was conducted from June 2018 to February 2019. The survey targeted 34,610 persons of whom 27,897 were adults aged 15-64 years, and 6,713 were children aged 0-14 years (Figure 1). Adults aged 18-64 years in all sampled households who provided informed consent, adolescents aged 15-17 years whose parents or guardians provided permission, and children aged 0-14 years (in every third sampled household whose parents or guardians provided permission) were enrolled. Adolescents aged 10-17 years were also asked for assent after permission was granted by their parents or guardians. Ethical approval was received from Kenya Medical Research Institute (KEMRI), Columbia University and the United States Centers for Disease Control and Prevention (CDC) institutional review boards (IRB).

County Departments of Health led engagement meetings to sensitize stakeholders to the survey in each of the 47 counties. Survey implementation was preceded by community mobilization teams who sensitized selected communities prior to data collection. Fifty data collection teams (each consisting of a team leader, four home-based testing counsellors/interviewers, and two laboratory technologists) visited selected households in each cluster. Using a tablet with Open Data Kit computer-assisted personal interviewing software, the field data collection teams obtained informed consent, then administered the household, the adult (to those aged 15-64 years) or the young adolescent (to those aged 10-14 years) questionnaires to eligible participants within selected households. Blood was drawn from eligible and consenting participants aged 18 months to 64 years and tested in accordance with the Kenya National HIV Testing Services Guidelines[7] using Determine™ HIV-1/2 (Abbott Molecular, Inc. Des Plaines, Illinois, United States) and First Response™ HIV 1-2.0 (Premier Medical Corporation, Mumbai, India) HIV rapid test kits. Rapid test results were provided to participants in the household. Blood draw and testing were also conducted for infants aged 0-17 months using Determine™ HIV rapid test to screen for exposure to HIV at the household. Specimens from infants with a reactive field test result or whose mother's HIV status was positive or unknown at the time of household testing for early infant diagnostic (EID) testing using GeneXpert's Xpert® HIV-1 Qual (Cepheid, Sunnyvale, California, United States) at the satellite laboratory as well as DNA polymerase chain reaction (PCR) confirmatory testing using Cobas AmpliPrep/Cobas TaqMan (CAP/CTM) HIV-1 Qualitative Test, v2.0 assay (Roche Diagnostics, Branchburg, New Jersey, United States) at the National HIV Reference Laboratory (NHRL). EID results were returned to the infant's guardian at the household. Participants newly diagnosed with HIV were referred to the facility of their choice to initiate ART.

Whole blood specimens collected in the household were transported to satellite laboratories in EDTA tubes on cold packs. At the satellite laboratories, the first fifty tests from each tester and a fraction of negative specimens were subjected to quality assurance testing using the National HIV rapid testing algorithm and confirmatory testing to ascertain the accuracy of results issued in the field. In addition, all HIV-positive specimens were confirmed with the Geenius™ HIV-1/2 supplemental assay (Bio-Rad Laboratories, Redmond, Washington, United States). Within 24 hours of blood draw, dried blood spot (DBS) cards and plasma aliquots were prepared in the satellite laboratory and frozen at -20° C. These specimens were archived at the central laboratory at -80° C for additional testing.

Specimens were transported weekly to the NHRL where samples from HIV-positive participants were subjected to HIV VL testing using the automated Roche CAP/CTM HIV-1 RNA quantitation test (Roche Diagnostics, Mannheim, Germany). Viral load results were dispatched

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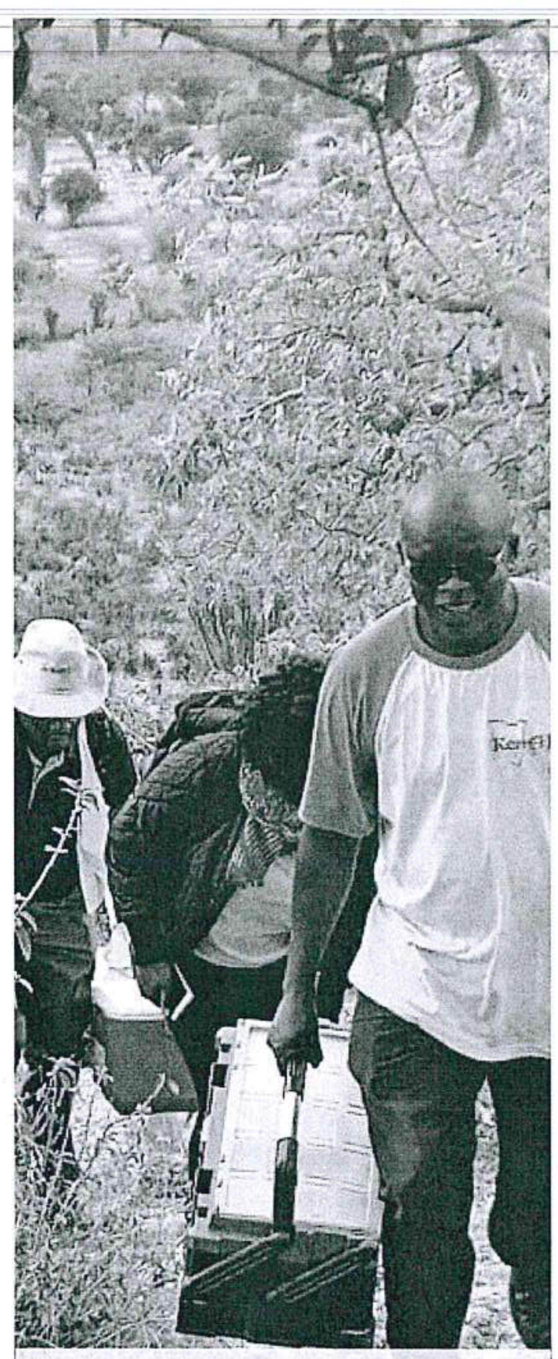
to health facilities designated by survey participants. Additionally, all available HIV-positive samples were tested for recency of HIV infection at the NHRL using either the Sedia HIV-1 Limiting Antigen (LAg)-Avidity Enzyme Immunoassay (EIA) (Sedia Biosciences, Portland, Oregon, United States), or the Maxim HIV-1 LAg-Avidity EIA (Maxim Biomedical; Bethesda, Maryland, United States). The recency infection testing algorithm distinguishes between recent (<1 year) and longer-term infection.[8] Specimens were also tested by the Division of Clinical Pharmacology of the Department of Medicine at the University of Cape Town in South Africa for the presence of antiretroviral (ARV) medications. Detection of ARVs is considered indicative of participant use of ART at the time of blood collection. Laboratory detection of ARVs was then incorporated into incidence calculations and used to adjust self-reported knowledge of HIV-positive status and ART use. Specimens with evidence of recent infection as well as a sample of specimens with long-term infection will also undergo HIV drug resistance testing.

After data cleaning, survey base weights were calculated for all estimates and adjusted for individual interview and HIV testing nonresponse. Weighting was further applied by age group, sex and relevant variables using the standard PHIA (Population-based HIV Impact Assessment) statistical approaches (least absolute shrinkage and selection operator (LASSO) regression, chi-square automatic interaction detector (CHAID), and jackknife resampling)[9] using SAS (SAS Institute Inc., Cary, North Carolina, United States), R (R Foundation for Statistical Computing, Vienna, Austria) and SI-CHAID statistical software. The resulting weights were then post-stratified[10] to the 2018 KNBS population estimates and normalized.



Data collectors; Francis Lowana and Saphina Lekasuyan, and KENPHIA Project Director Dr. Duncan Chege heading to a household to collect data in Alale, West Pokot in January 2019

Figure 1: Summary of survey field and laboratory procedures

SURVEY DESIGN
800 CLUSTERS
18,362 HOUSEHOLDS
PARTICIPANTS
0-64 YEARS 34,610
15-64 YEARS 27,897 | 0-14 YEARS 6,713

HOUSEHOLDS
- COMMUNITY MOBILIZATION
- CONSENT
- QUESTIONNAIRE PREVIEW
- BLOOD SAMPLE COLLECTION
- HIV, SYPHILIS & HEPATITIS B TESTING
- DISPATCH BLOOD TO SATELLITE LABS

SATELLITE LABS
- BLOOD PROCESSING
- HIV PREVALENCE TESTING
- EID POC TESTING
- SAMPLE DISPATCH TO CENTRAL LAB

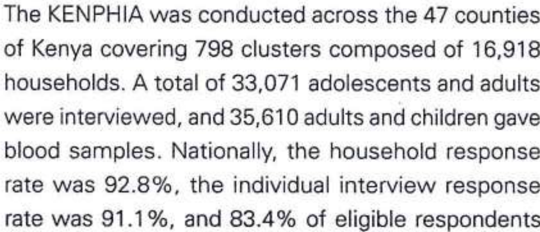
CENTRAL LAB
- ADDITIONAL SAMPLE TESTING (HIV DNA PCR/EID, VIRAL LOAD, DRUG RESISTANCE, RECENCY)
- DISPATCH OF VIRAL LOAD, HIV DNA PCR & EID PCR RESULTS TO HEALTH FACILITIES FOR RETURN OF RESULTS

EID = early infant diagnosis; POC = point of care; PCR = polymerase chain reaction.
Note: Community mobilization occurs at National, regional and community levels in advance of the household visit. Also, one additional laboratory procedure, detection of antiretrovirals, was performed by the Division of Clinical Pharmacology of the Department of Medicine at the University of Cape Town in South Africa.

03 RESULTS

3.1 Response Rates and Laboratory Quality Performance

3.1.1 Response Rates



The KENPHIA was conducted across the 47 counties of Kenya covering 798 clusters composed of 16,918 households. A total of 33,071 adolescents and adults were interviewed, and 35,610 adults and children gave blood samples. Nationally, the household response rate was 92.8%, the individual interview response rate was 91.1%, and 83.4% of eligible respondents provided blood. This translates to an overall National survey response rate of 77.4% (the product of the household and the blood draw response rates), while County-level response rates ranged from 57.3% in Mombasa County to 93.2% in Busia County (Table 2).

Community mobilizer Martin Kamunya in Gathaithi cluster in Karatina, Nyeri County in September 2018

Table 2: Summary of National and County survey response rates

County Code	County	Survey Response Rate (%)	County Code	County	Survey Response Rate (%)	County Code	County	Survey Response Rate (%)
	National	**77.4**	016	Machakos	77.6	032	Nakuru	71.4
001	Mombasa	57.3	017	Makueni	78.6	033	Narok	71.6
002	Kwale	57.8	018	Nyandarua	68.3	034	Kajiado	69.3
003	Kilifi	60.5	019	Nyeri	78.7	035	Kericho	70.5
004	Tana River	82.1	020	Kirinyaga	81.9	036	Bomet	82.0
005	Lamu	64.2	021	Murang'a	81.5	037	Kakamega	80.1
006	Taita-Taveta	83.5	022	Kiambu	63.9	038	Vihiga	80.1
007	Garissa	81.2	023	Turkana	81.9	039	Bungoma	84.2
008	Wajir	79.7	024	West Pokot	92.6	040	Busia	93.2
009	Mandera	76.4	025	Samburu	81.4	041	Siaya	76.8
010	Marsabit	72.6	026	Trans-Nzoia	82.2	042	Kisumu	70.2
011	Isiolo	73.6	027	Uasin Gishu	86.9	043	Homa Bay	85.2
012	Meru	82.9	028	Elgeyo-Marakwet	92.2	044	Migori	88.2
013	Tharaka-Nithi	89.3	029	Nandi	86.4	045	Kisii	87.3
014	Embu	84.2	030	Baringo	76.7	016	Nyamira	86.1
015	Kitui	75.9	031	Laikipia	71.4	047	Nairobi	61.0

The survey response rate is the product of the household and the blood draw response rates.

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3.3 HIV Prevalence

3.3.1 Geographic distribution of HIV among adults 15-64 years

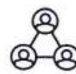


Table 4: National and County HIV prevalence of adults aged 15-64 years

County Code	County/ Strata	HIV Prevalence (%)	95% CI
	National	**4.9**	**4.5-5.3**
	Urban	**4.7**	**4.1-5.3**
	Rural	**5.0**	**4.5-5.5**
001	Mombasa	5.6	3.7-7.5
002	Kwale	4.2	2.4-5.9
003	Kilifi	2.3	0.2-4.5
004	Tana River	1.1	0.1-2.0
005	Lamu	2.6	0.7-4.5
006	Taita-Taveta	5.2	2.0-8.5
007	Garissa*	<0.1	-
008	Wajir	0.2	0.0-0.6
009	Mandera	0.2	0.0-0.7
010	Marsabit	1.2	0.0-2.7
011	Isiolo	2.2	0.6-3.9
012	Meru	3.6	1.7-5.5
013	Tharaka-Nithi	2.4	1.2-3.6
014	Embu	2.7	0.4-5.1
015	Kitui	5.7	2.9-8.5
016	Machakos	3.7	2.5-4.9
017	Makueni	3.9	2.8-4.9
018	Nyandarua	2.2	0.2-4.1
019	Nyeri	5.1	2.8-7.4
020	Kirinyaga	3.3	1.4-5.3
021	Murang'a	3.0	0.9-5.2
022	Kiambu	1.1	0.0-2.2
023	Turkana	6.8	3.2-10.5
024	West Pokot	1.3	0.2-2.4
025	Samburu	1.9	0.7-3.1
026	Trans-Nzoia	4.0	2.8-5.2
027	Uasin Gishu	5.5	3.1-7.9
028	Elgeyo-Marakwet	3.5	1.0-6.1
029	Nandi	2.6	1.1-4.1
030	Baringo	1.8	0.6-3.0
031	Laikipia	2.0	0.0-4.4

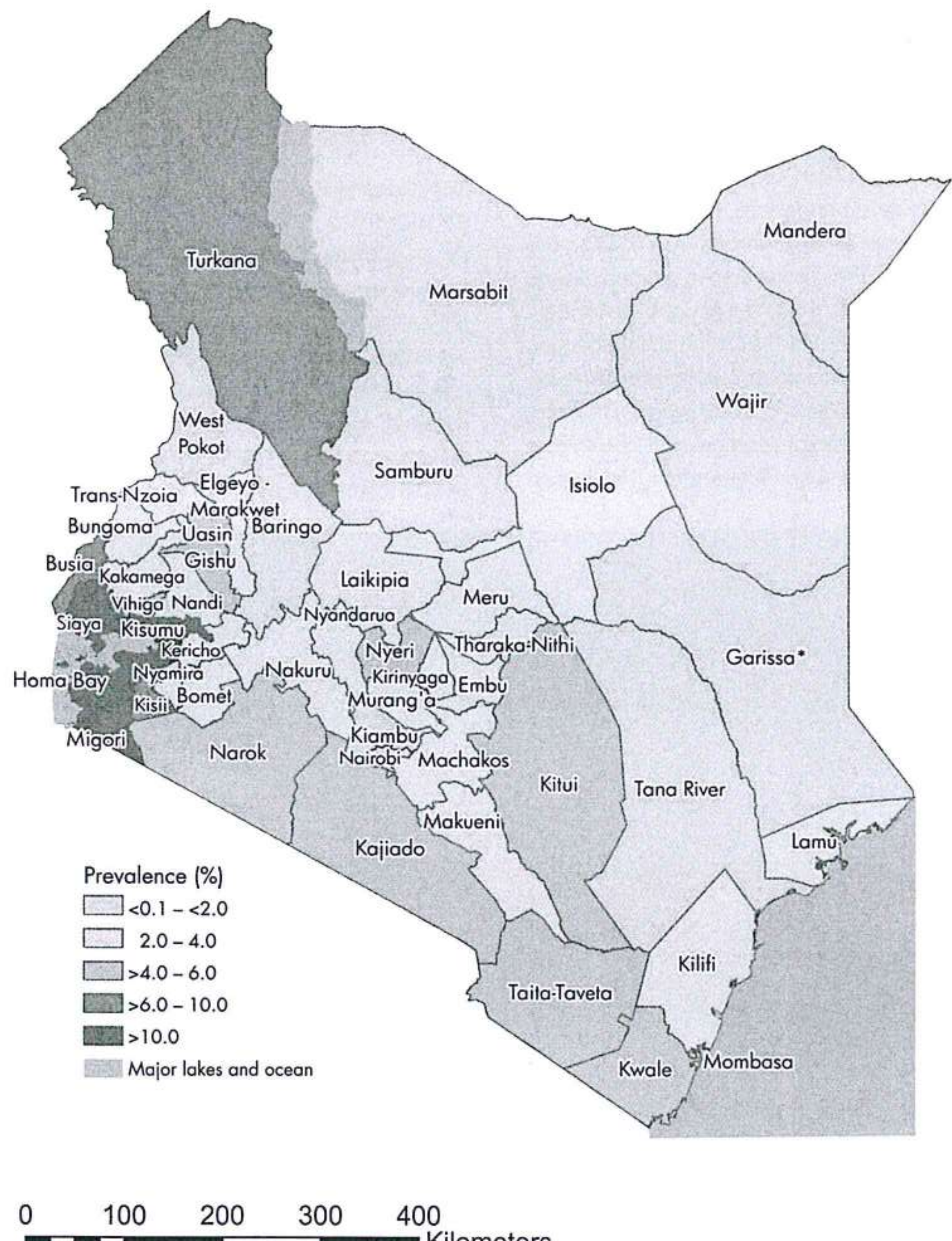
County Code	County/ Strata	HIV Prevalence (%)	95% CL
032	Nakuru	3.0	0.9-5.1
033	Narok	5.0	2.3-7.7
034	Kajiado	4.6	3.1-6.0
035	Kericho	3.4	1.7-5.1
036	Bomet	2.8	0.5-5.1
037	Kakamega	3.9	1.9-5.9
038	Vihiga	5.3	2.3-8.2
039	Bungoma	2.5	1.3-3.8
040	Busia	9.9	5.9-13.9
041	Siaya	15.3	12.2-18.3
042	Kisumu	17.5	13.6-21.3
043	Homa Bay	19.6	15.9-23.3
044	Migori	13.0	9.0-17.0
045	Kisii	6.1	3.1-9.1
046	Nyamira	3.9	2.0-5.8
047	Nairobi	3.8	2.2-5.4

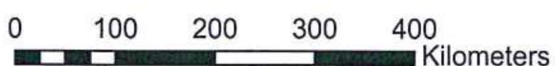
95% confidence interval (CI): This interval indicates the range of values that most likely encompasses the true value.
**Garissa had no HIV-positive persons identified, thus is represented as having an HIV prevalence <0.1%.*

The National HIV prevalence among adults was 4.9% (95% CI: 4.5%-5.3%). This translates to 1.3 million (95% CI: 1.2-1.4 million) adults living with HIV in Kenya. The HIV prevalence was 4.7% (95% CI: 4.1%-5.3%) in urban and 5.0% (95% CI: 4.5%-5.5%) in rural areas (Table 4).

HIV prevalence varied across the country. The top five high-prevalence counties were Homa Bay: 19.6% (95% CI: 15.9%-23.3%), Kisumu: 17.5% (95% CI: 13.6%-21.3%), Siaya: 15.3% (95% CI: 12.2%-18.3%), Migori: 13.0% (95% CI: 9.0%-17.0%), and Busia: 9.9 (95% CI: 5.9%-13.9%); while prevalence was lowest (<2.0%) in nine counties (Samburu, Tana River, Garissa, Wajir, Mandera, Marsabit, Kiambu, West Pokot, and Baringo), (Table 4, Figure 2).

Figure 2: County HIV prevalence of adults aged 15-64 years



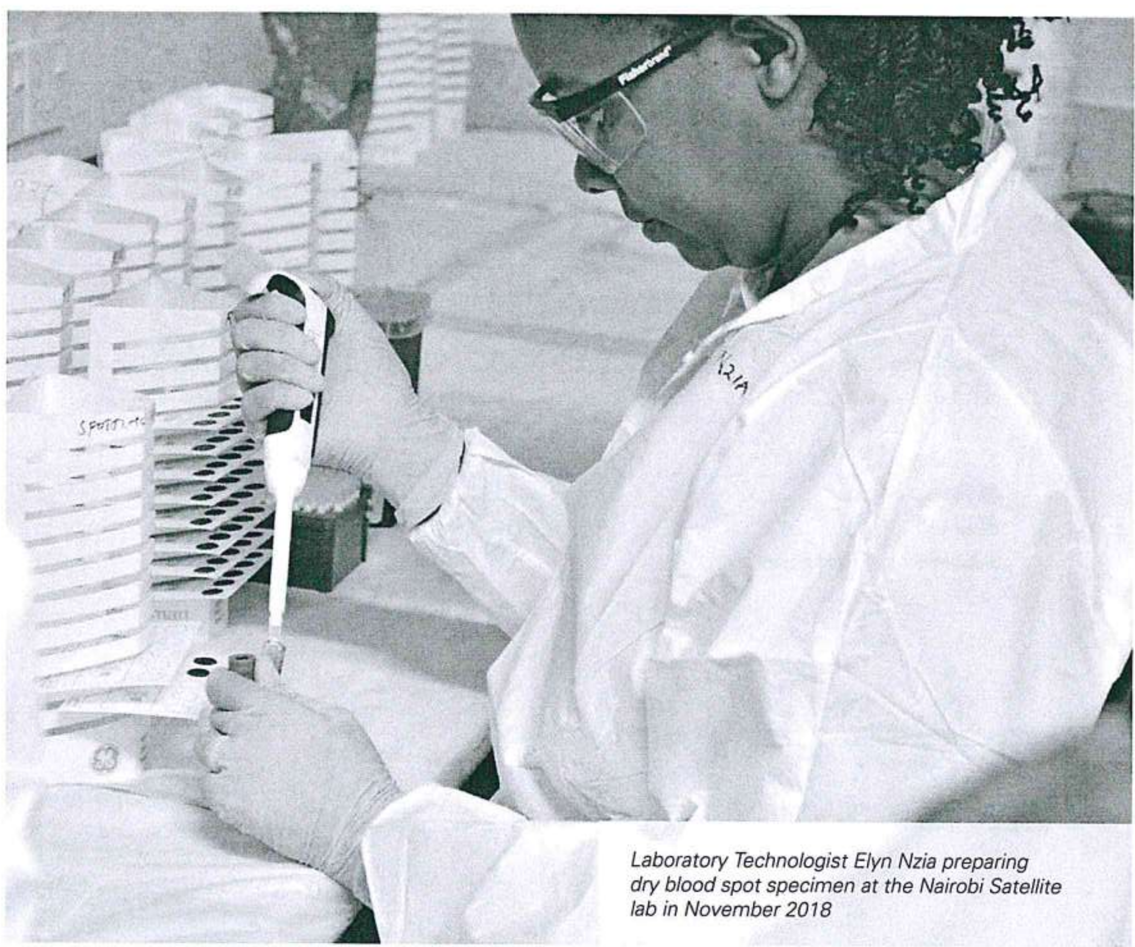


** Garissa had no HIV-positive persons identified, thus is represented as having an HIV prevalence <0.1%.*

3.3.2 HIV Prevalence by Sex and Age

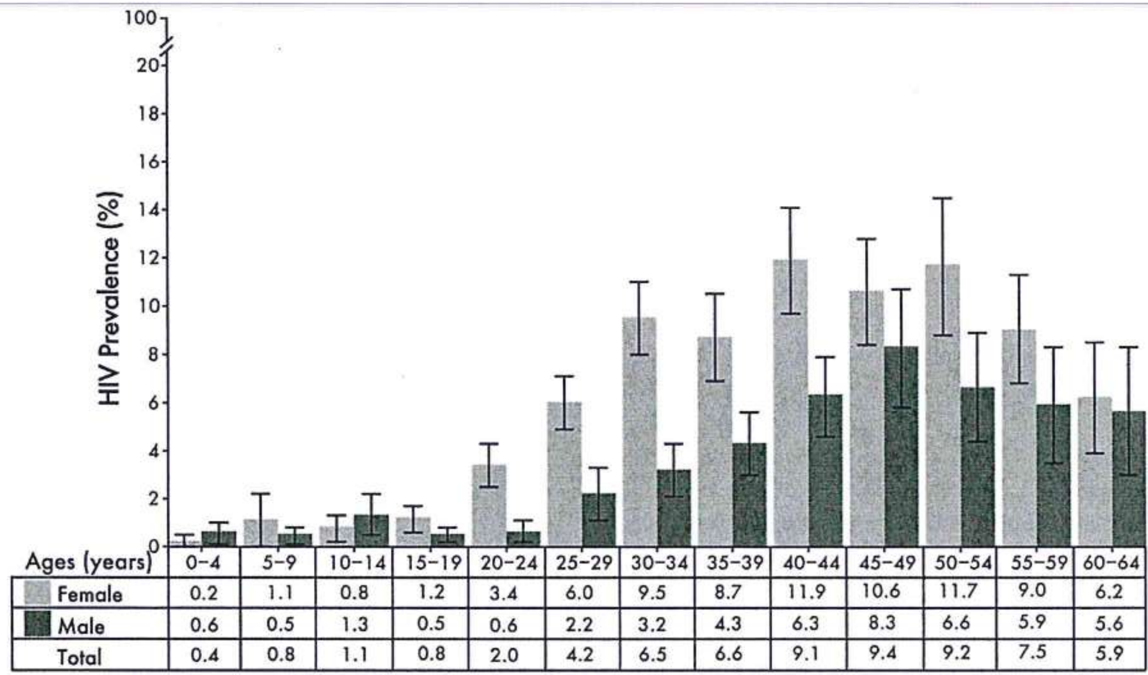
There were marked differences in HIV prevalence between women and men (Table 1), which was twice as high among women at 6.6% (95% CI: 6.0%-7.1%) compared to men at 3.1% (95% CI: 2.7%-3.5%). For both sexes combined, HIV prevalence peaked among adults aged 45-49 years (9.4%, 95% CI: 7.8%-11.1%). However, among adults, HIV prevalence was consistently higher among women than men across all the age groups. Prevalence among women peaked at 11.9% (95% CI: 9.7%-14.1%) at ages 40-44 years and 11.7% (95% CI: 8.8%-14.5%) in the 50-54 year age group. Prevalence among men peaked at 8.3% (95% CI: 5.8%-10.7%) among those aged 45-49 years. Generally, the prevalence in women aged 20-34 years was more than three times higher than that in men of the same age group. The prevalence among men in urban areas was 2.7% (95% CI: 2.1%-3.4%) and in rural areas was 3.4% (95% CI: 2.9%-3.9%). The prevalence among women in urban areas was 6.7% (95% CI: 5.7%-7.6%) and in rural areas was 6.5% (95% CI: 5.8%-7.3%).

The overall HIV prevalence among children was 0.7% (95% CI: 0.4%-1.0%) which translates to 139,000 (95% CI: 84,000-194,000) children living with HIV in Kenya. HIV prevalence among children ranged between 0.4% (95% CI: 0.1%-0.6%) among children aged 0-4 years to 1.1% (95% CI: 0.5%-1.6%) among young adolescents aged 10-14 years (Figure 3). There was no difference between girls and boys aged 0-14 years, with an HIV prevalence of 0.7% (95% CI: 0.2%-1.1%) among girls and 0.8% (95% CI: 0.4%-1.1%) among boys (Table 1).



Laboratory Technologist Elyn Nzia preparing dry blood spot specimen at the Nairobi Satellite lab in November 2018

Figure 3: Prevalence of HIV among persons aged 0-64 years by age and sex



Ages (years)	0–4	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64
Female	0.2	1.1	0.8	1.2	3.4	6.0	9.5	8.7	11.9	10.6	11.7	9.0	6.2
Male	0.6	0.5	1.3	0.5	0.6	2.2	3.2	4.3	6.3	8.3	6.6	5.9	5.6
Total	0.4	0.8	1.1	0.8	2.0	4.2	6.5	6.6	9.1	9.4	9.2	7.5	5.9

Bar graph above depicts National prevalence disaggregated by age and sex.

Error bars represent the 95% confidence interval (CI).

The 95% CI indicates a range of values that most likely encompasses the true value.

3.4 Population-Level Prevalence of HIV Viral Load Suppression (VLS) in People Living with HIV

Viral load suppression (VLS), defined as having <1,000 viral copies per milliliter (mL) of plasma for KENPHIA, is a key indicator of treatment success in HIV-positive persons. Persons living with HIV who achieve VLS suppression have a very low risk of transmitting the virus. The survey was designed to estimate prevalence of VLS nationally as well as for counties with an HIV prevalence greater than 2.2% among adults (ages 15-64 years). Results are presented for counties with at least 25 adults living with HIV identified during the survey.[11] Nationally, the prevalence of VLS among HIV-positive adults was 71.6% (95% CI: 68.8%-74.4%), while among children (ages 0–14 years) living with HIV VLS prevalence was markedly lower at 48.3% (95% CI: 30.9%-65.7%) (Table 5, Figure 4). Note, findings of VLS among people living with HIV were regardless of knowledge of HIV status or use of ART.

3.4.1 County Viral Load Suppression Prevalence Among Adults Living with HIV in Kenya

The County VLS prevalence among adults ranged from 84.0% (95% CI: 71.7%-96.3%) in Machakos County to 39.7% (95% CI: 26.0%-53.3%) in Turkana County (Table 5).

3.4.2 Prevalence of Viral Load Suppression by Age and Sex

The prevalence of VLS among people living with HIV aged 0–64 years was generally higher among girls and women compared to boys and men across all the age groups. Among adults, women had a VLS of 74.6% (95% CI: 71.5%-77.6%) while men had 65.1% (95% CI: 58.8%-71.4%) (Table 1). The highest VLS prevalence was achieved among adults aged 55-64 years at 83.6% (95% CI: 75.8%–91.4%). There was a decreased prevalence of VLS with decreasing age, with the lowest amongst children aged 0-14 years: 48.3% (95% CI 30.9%-65.7%) (Figure 4).

Table 5: Prevalence of viral load suppression among adults aged 15-64 years

County	N	VLS Prevalence (%)	95% CI
Mombasa	29	(69.4)	46.9-91.8
Meru	27	(49.5)	23.5-75.5
Kitui	45	(68.1)	57.6-78.6
Machakos	38	(84.0)	71.7-96.3
Nyeri	27	(77.4)	57.9-96.9
Turkana	39	(39.7)	26.0-53.3
Uasin Gishu	35	(66.0)	53.4-78.6
Nandi	34	(52.2)	37.0-67.4
Narok	29	(48.7)	23.4-74.0
Kericho	25	(44.7)	20.8-68.5
Kakamega	26	(61.4)	38.1-84.7
Vihiga	33	(81.4)	68.9-93.9
Busia	67	81.2	73.8-88.5
Siaya	116	78.7	66.6-90.7
Kisumu	134	83.2	75.5-90.9
Homa Bay	170	83.8	77.8-89.9
Migori	139	76.8	67.9-85.6
Kisii	46	(60.2)	49.9-70.5
Nyamira	26	(68.4)	41.9-94.8
Nairobi	53	72.8	61.5-84.1
National§	**1523**	**71.6**	**68.8-74.4**

Results are presented for counties with at least 25 adults living with HIV identified during the survey.

N is number of HIV-positive participants tested for viral load. Viral load suppression is defined as HIV RNA <1,000 copies per mL of plasma among HIV-positive persons; 95% CI: the confidence interval indicates a range of values that most likely encompasses the true value.

Parentheses () indicate an estimate that is based on 25-49 persons observations and should be interpreted with caution.

§Includes results from participants in all the 47 counties.

Figure 4: Viral load suppression prevalence in persons aged 0-64 years by age and sex

Ages (years)	0-14	15-24	25-34	35-44	45-54	55-64
Female	(53.5)	59.0	70.8	77.0	83.0	85.1
Male	(43.8)	*	52.6	65.0	72.8	81.6
Total	48.3	56.4	66.4	73.1	78.9	83.6

** Indicates that there were <25 men aged 15-24 years of age, and therefore it is not appropriate to estimate the prevalence of VLS for this age group. Parentheses () indicate an estimate that is based on 25-49 persons observations and should be interpreted with caution.*
I Error bars represent the 95% confidence interval (CI). The 95% CI indicates a range of values that most likely encompasses the true value.

3.5 Achievement of the UNAIDS 90-90-90 Targets among Persons Living with HIV

Ensuring that all persons living with HIV know their HIV-positive status, are on treatment and have VLS are key objectives of the National HIV program. By 2020, 90% of all persons living with HIV should know their status; 90% of all persons diagnosed with HIV should receive antiretroviral therapy (ART); and 90% of all persons receiving ART should have VLS.[12]

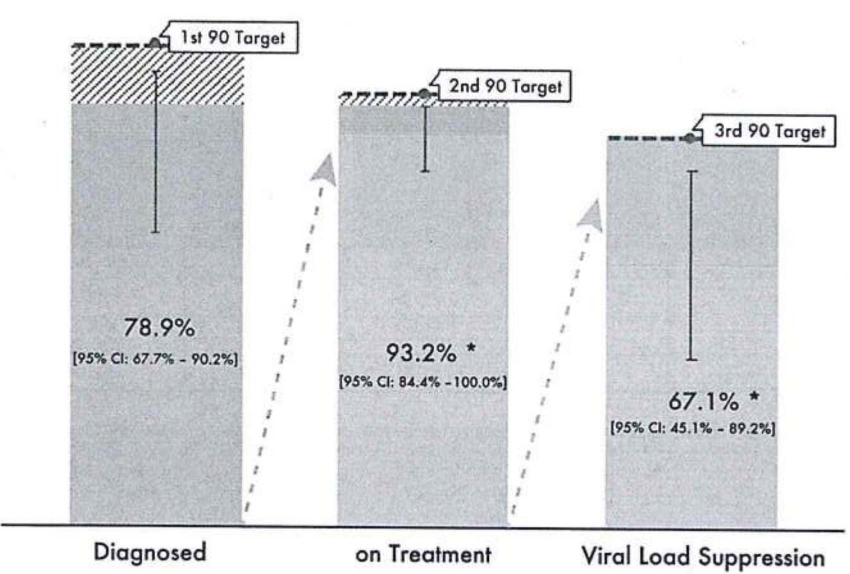
3.5.1 Knowledge of HIV-positive status

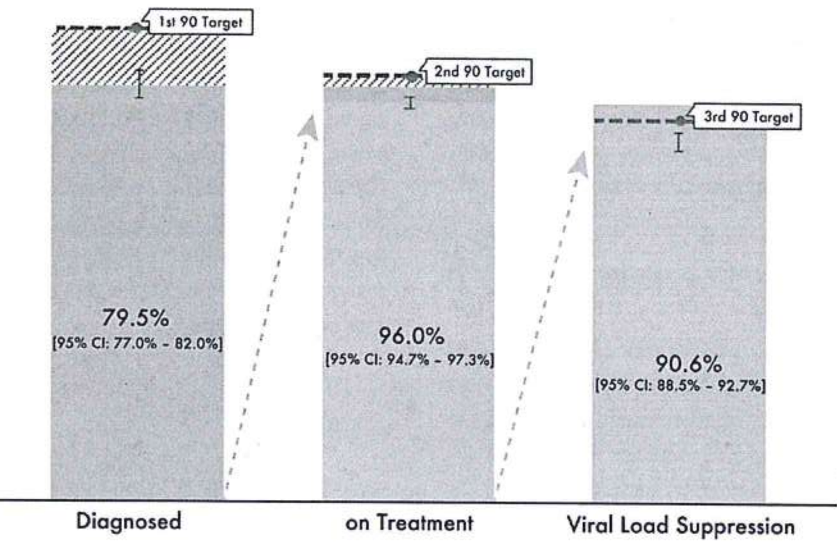
Among adults (ages 15-64 years) who tested HIV positive in the survey, 79.5% (95% CI: 77.0%–82.0%) knew their HIV-positive status, based on self-report and the detection of ARVs in blood: 82.7 (95% CI: 79.9%- 85.5%) among women and 72.6% (95% CI: 67.2%-77.9%) among men. Among HIV-positive children (ages 0-14 years), 78.9% (95% CI: 67.7%-90.2%) had a known HIV-positive status, based on parent-guardian report and the detection of ARVs in blood (Figure 5).

3.5.2 On Treatment

Among adults living with HIV who knew their HIV-positive status, 96.0% (95% CI: 94.7%-97.3%) were on ART, based upon self-report and the detection of ARVs in blood: 96.6% (95% CI: 95.1%0-98.1%) among women and 94.5% (95% CI: 91.8%-97.2%) among men. Among children, 93.2% (95% CI: 84.4%-100.0%) of those who were known to be HIV positive were also on ART, based upon parent-guardian report and detectable ARVs in blood (note, this estimate was based on few (25-49) children and should be interpreted with caution (Figure 5).

Figure 5: 90-90-90 cascade among persons living with HIV aged 0-64 years disaggregated by age and sex





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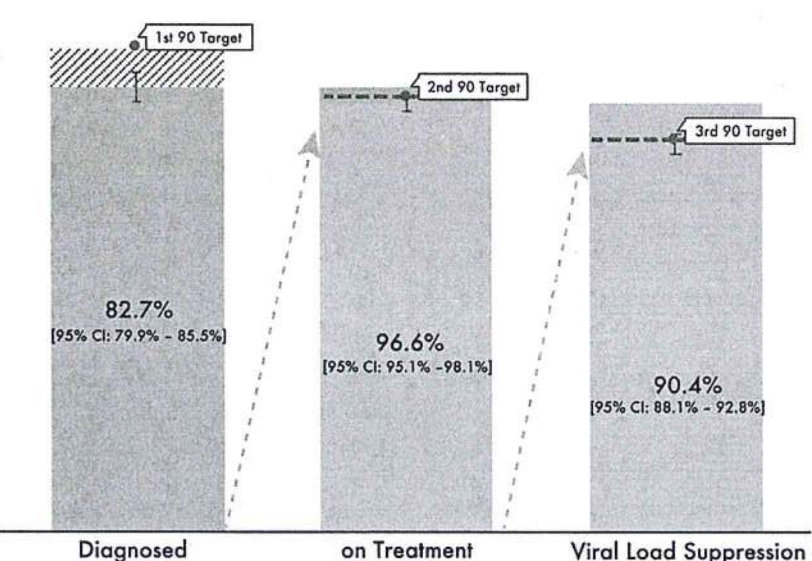
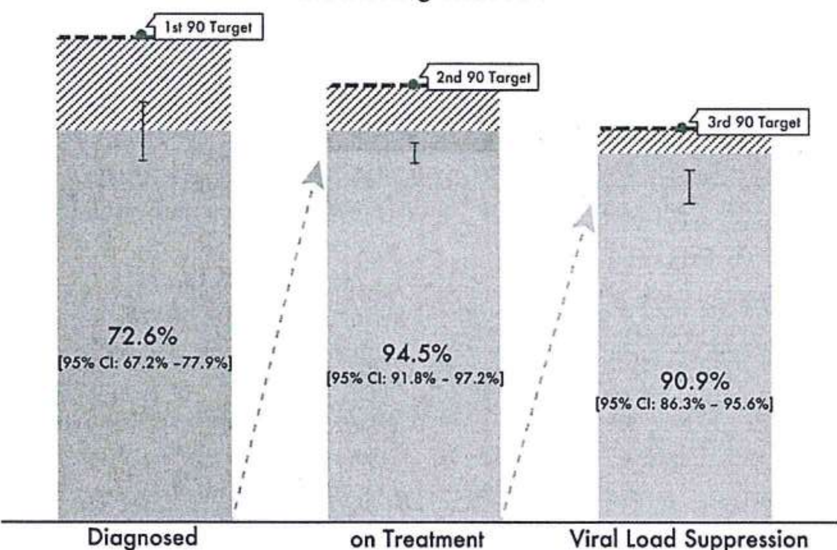
**Indicates that this was based on 25-49 children and should be interpreted with caution.*
95% CI: the confidence interval indicates a range of values that most likely encompasses the true value.
Note: the 90-90-90 targets are that 90% of all people living with HIV should be aware of their status, 90% of those who are aware of their HIV-positive status should be on antiretroviral therapy (ART) (81% of the overall population of people living with HIV) and that 90% of those who are on ART should have viral load suppression (73% of the overall population of people living with HIV). Inset numbers represent conditional proportions.





Legend

- - - Population-level targets
Gap to population-level targets
People living with HIV diagnosed
People living with HIV on treatment (based on self-report and ARV drug detection data)
People living with HIV on treatment (based on self-report and ARV drug detection data) and viral load suppression
95% confidence interval (CI)

3.5.3 HIV Viral Load Suppression

Among adults living with HIV on ART, 90.6% (95% CI: 88.5%-92.7%) had achieved VLS: 90.4% (95% CI: 88.1%-92.8%) of women and 90.9% (95% CI: 86.3%-95.6%) of men. The survey also revealed that among children living with HIV on ART, 67.1% (95% CI: 45.1%–89.2%) had suppressed viral loads—however, this estimate was based on few (25-49) children and should be interpreted with caution (Figure 5).

3.5.4 Overall Population ART Coverage

In order to understand HIV control within the population, it is also important to assess progress by including all persons identified as HIV positive by survey HIV testing (producing a population coverage 90-90-90 cascade).

As reported in section 3.5.1-3.5.2, 79.5% of all the adults who tested HIV positive in KENPHIA were aware of their HIV-positive status prior to the survey, of whom 96.0% were on ART. This translates to 76.3% of all adults living with HIV on ART. This, therefore, means that almost one in four adults living with HIV in Kenya were not on ART.

Among children living with HIV, 78.9% who tested HIV-positive in KENPHIA had known HIV-positive status prior to the survey of whom, 93.2% were on ART. This translates to one in four children living with HIV not on ART.

3.6 Prevention of Mother-to-Child Transmission (PMTCT) of HIV

Kenya aims to eliminate mother-to-child transmission (eMTCT) of HIV by 2021.[13] To achieve this, targets of 90% antenatal care (ANC) attendance, 90% HIV testing among pregnant women, and 90% ART use among HIV-positive pregnant women were set to be reached by 2019.

3.6.1 Antenatal care

ANC is the most critical platform for providing the interventions needed for PMTCT, which reduce risk of death for HIV-positive mothers and their babies. Among women aged 15-49 years who delivered within the three years preceding the survey, 97.3% reported having attended at least one ANC visit for their most recent birth.

However, the target of 90% ANC attendance was not achieved in five counties (Mandera, Wajir, Garissa, Samburu, and Marsabit) (Figure 6).

3.6.2 Self-reported HIV testing and ART status among pregnant women

The HIV testing process is key in reducing mother-to-child transmission. Provider-initiated testing and counseling is offered at all first ANC visits and periodically on subsequent visits according to National guidelines.[7] Among women aged 15-49 years who gave birth within the 12 months preceding the survey and attended ANC, 96.0% knew their HIV status (92.4% reported an HIV-negative status and 3.6% reported an HIV-positive status and 4.0% reported an unknown status (either not tested or tested but had not received results). Among the pregnant women who reported that they tested or were already aware that they were HIV positive at ANC, 92.1% reported receiving ART during their pregnancy.

Figure 6: Antenatal clinic attendance among women aged 15-49 years whose most recent pregnancy was within the past three years preceding the survey

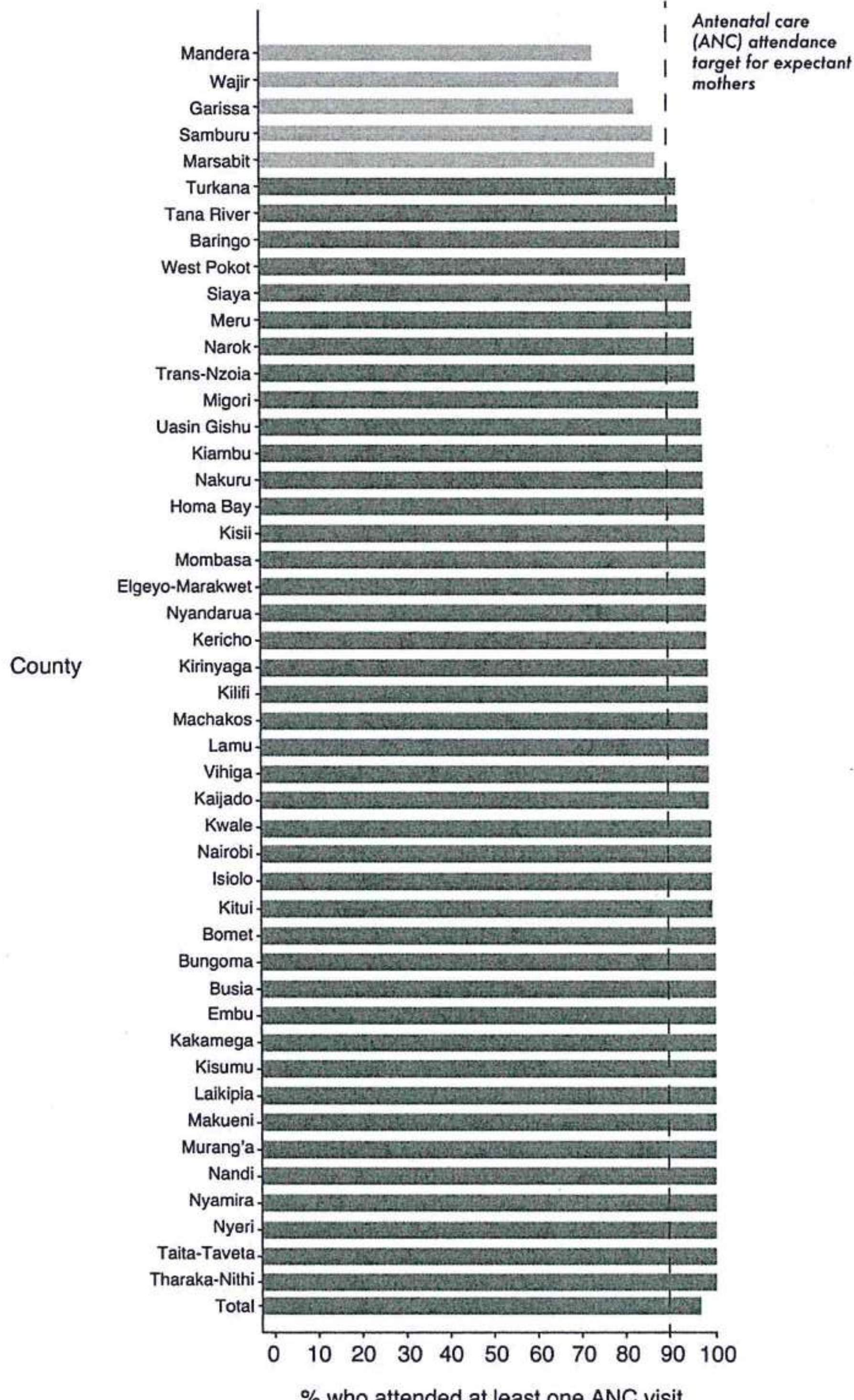
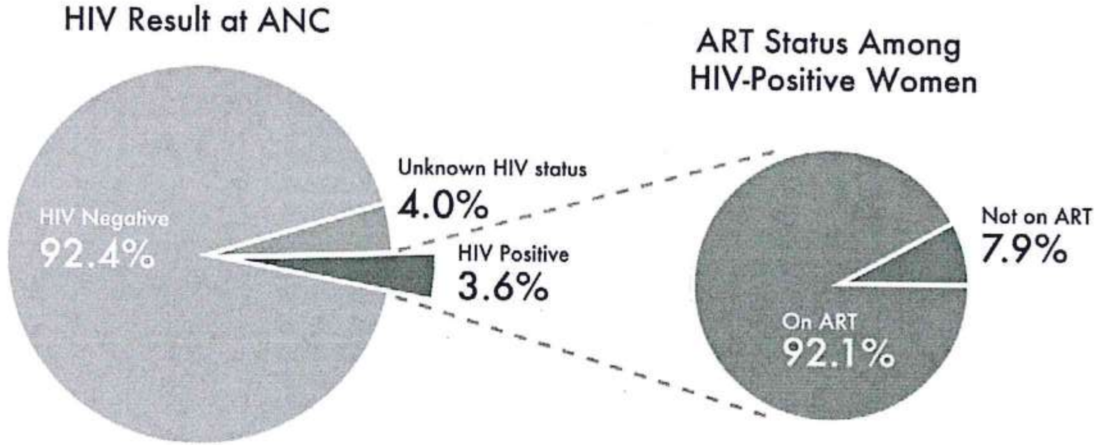
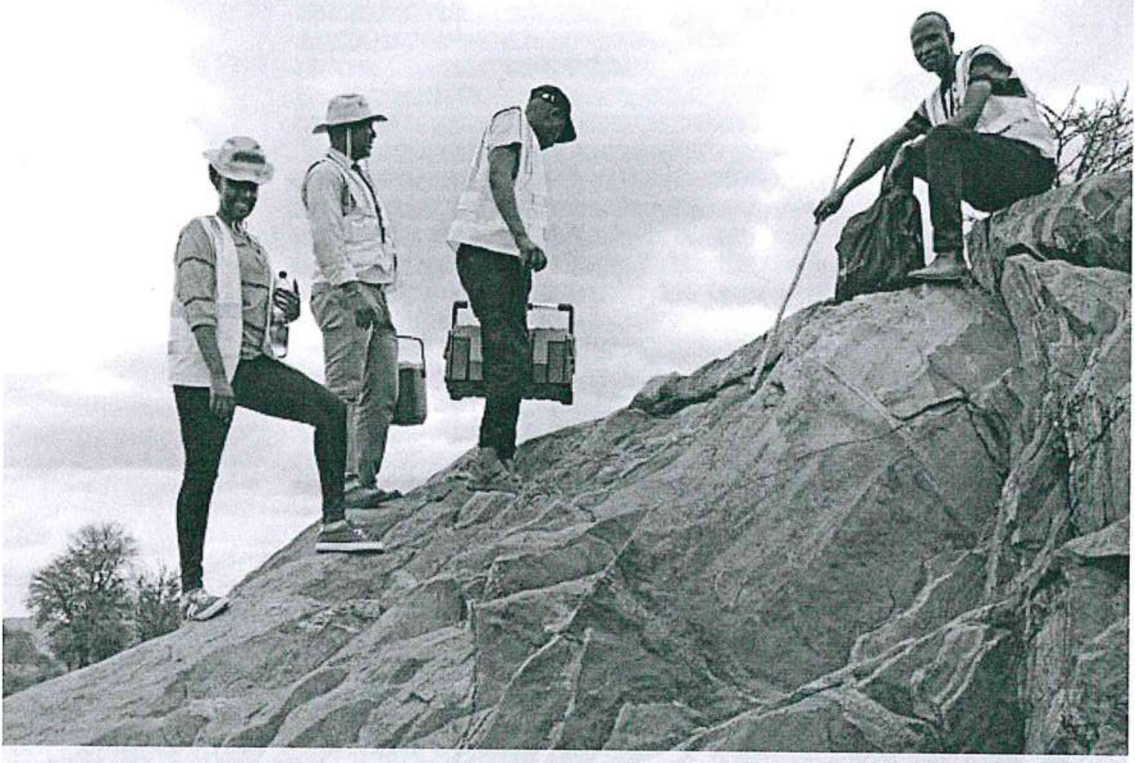


Figure 7: Self-reported HIV testing and antiretroviral therapy (ART) use during antenatal care (ANC) among mothers who delivered in the 12 months preceding the survey





Data collectors Joyce Njeri, Martin Miriti, Celestino Muthee, and Isaac Leteipa at Mutanthara cluster in Tharaka-Nithi County in July 2018

3.7 Prevalence of Male Circumcision

Medical male circumcision (MC) reduces risk of acquiring HIV heterosexually by 60-66%.[14,15] In Kenya, MC is practiced culturally in the majority of the counties, with the exception of Turkana, Siaya, Kisumu, Homa Bay and Migori Counties, the last four of which also have the highest adult HIV prevalence.[3] In addition to the five culturally non-circumcising counties, the voluntary medical male circumcision (VMMC) program also focuses on the eight other culturally circumcising counties with non-circumcising subgroups (Table 6). Since 2008, Kenya has provided VMMC as a component of its HIV prevention program using a phased approach. The program initially prioritized VMMC services for men aged 15 years or older and later, in 2015, refocused services to men aged 15-29 years to maximize its public health impact.

Table 6: Prevalence of male circumcision among men aged 15-64 years

	Medical circumcision (%)	Non-medical circumcision (%)	TOTAL (%)	Uncircumcised (%)	Unknown (%)
National (47 Counties)	54.5	37.2	91.7	7.9	0.4
Culturally non-circumcising counties					
Turkana	49.5	6.9	56.4	43.6	0.0
Kisumu	46.7	6.6	53.3	44.6	2.2
Siaya	55.5	5.7	61.2	38.7	0.1
Homa Bay	56.4	2.7	59.1	40.0	0.9
Migori	42.3	24.4	66.7	32.6	0.7
Culturally circumcising with non-circumcising sub-groups					
Mombasa	61.5	34.2	95.8	3.0	1.2
Marsabit	48.4	49.3	97.7	2.3	0.0
West Pokot	35.6	57.1	92.7	7.3	0.0
Nandi	16.2	74.4	90.5	9.4	0.1
Nakuru	46.8	45.6	92.5	7.5	0.0
Kericho	42.6	53.5	96.1	3.5	0.4
Busia	63.3	18.3	81.6	18.4	0.0
Nairobi	67.7	26.4	94.1	4.9	1.0
Survey HIV test results					
HIV positive	41.2	30.4	71.7	27.1	1.2
HIV negative	54.4	37.5	91.9	7.7	0.4
Not tested	58.6	36.7	95.3	3.8	0.9
Age groups (years)					
Total 15-24	63.2	27.2	90.4	9.3	0.3
Total 15-49	56.9	34.9	91.7	7.8	0.5
Total 25-49	52.5	40.2	92.7	6.8	0.6
Total 50-64	36.0	55.3	91.3	8.3	0.4

Description: Table presents self-reported MC status data among men aged 15-64 years.

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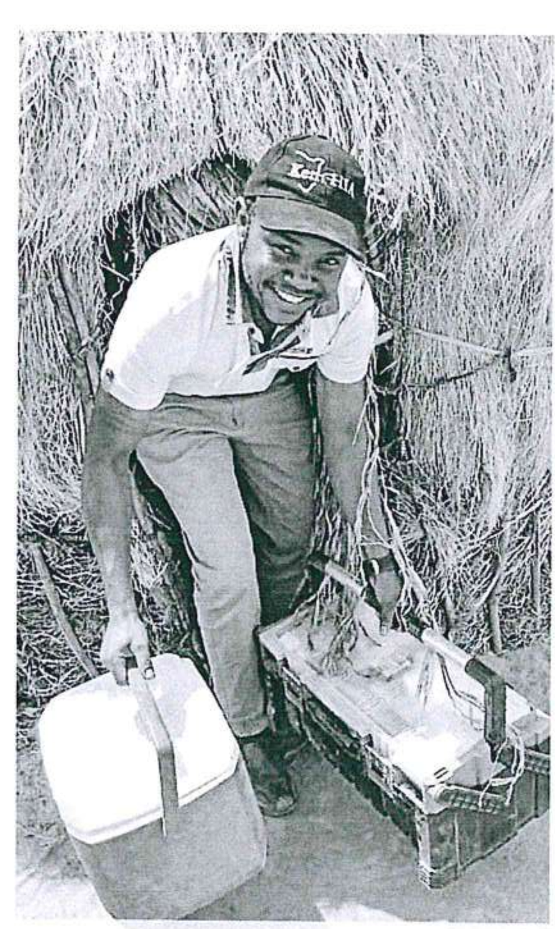
Nationally, 91.7% of men aged 15-64 years self-reported to be circumcised (note, this and the following estimates include both those with medical and non-medical MC). HIV prevalence was more than four times higher among uncircumcised men at 10.3% (95% CI: 8.3%-12.4%) compared to circumcised men at 2.5% (95% CI: 2.1%-2.9%). Among those who tested HIV positive in the survey, 71.7% self-reported being circumcised, while among those who tested HIV negative, 91.9% self-reported to be circumcised (including non-medical MC) (Table 6).

In the thirteen VMMC priority counties, the overall MC prevalence (including non-medical MC) was 83.2% (Table 7). The five culturally non-circumcising counties reported prevalences ranging from 53.3% to 66.7% (Table 6), while the eight culturally circumcising counties reported MC rates from 81.6% to 97.7% (Table 6). Overall, the prevalence of MC in the 13 VMMC priority counties was higher among those aged 20-29 years (89.6%) compared to those aged 30-64 years (79.4%) (Table 7).



Laboratory Technologist Henry Makau in Malka Dende cluster in Tana River County in July 2018

Table 7: Prevalence of male circumcision in 13 VMMC priority counties disaggregated by age

Age groups (years)	Medical circumcision (%)	Non-medical circumcision (%)	TOTAL (%)	Uncircumcised (%)	Unknown (%)
15-19	65.3	15.3	80.5	18.9	0.5
20-29	59.6	30.0	89.6	9.6	0.8
30-64	43.8	35.6	79.4	19.9	0.6
15-49	55.9	28.2	84.2	15.1	0.7
15-64	53.3	29.9	83.2	16.1	0.7

The 13 priority counties are Busia, Homa Bay, Kericho, Kisumu, Marsabit, Migori, Mombasa, Nairobi, Nakuru, Nandi, Siaya, Turkana, and West Pokot.

04 DISSEMINATION OF FINAL RESULTS

This report summarizes key preliminary findings from KENPHIA 2018. The final KENPHIA 2018 report, anticipated for release in early 2020, will offer a more in-depth analysis of the status of HIV in Kenya through a comprehensive analysis of all indicators included in the KENPHIA 2018 questionnaires and results from biomarker testing in order to address the following survey objectives:

- Prevalence of HIV-related risk behavior, knowledge, and attitudes
- Behavioral and demographic determinants of HIV incidence and prevalence
- National prevalence of syphilis
- National prevalence of hepatitis B virus infection

The final KENPHIA 2018 report and complete dataset will be released to the public and institutional stakeholders through a series of dissemination events and will be available through the Government of Kenya partners and online at:

- www.nascop.or.ke/KENPHIA
- www.health.go.ke
- www.knbs.or.ke and at
- phia-data.icap.columbia.edu.

HIV activist James Kamau, NEPHAK CEO Nelson Otuoma, MoH Principal Investigators Dr.Kigen Bartilol and Dr. Peter Cherutich, CDC Co-Investigator Peter Young and ICAP Principal Investigator Jessica Justman at the KENPHIA launch media dissemination briefing on 5th June 2018

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The PHIA Project is a multicountry project funded by PEPFAR to conduct National HIV-focused surveys that describe the status of the HIV epidemic. Results will measure important National and regional HIV-related parameters, including progress toward UNAIDS 90-90-90 targets and will guide policy and funding priorities. ICAP at Columbia University is implementing the PHIA Project in close collaboration with CDC and other partners.

See phia.icap.columbia.edu for more details.

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